



NOTICE OF MEETING

HEALTH AND WELLBEING BOARD

WEDNESDAY, 29 NOVEMBER 2017 AT 10.00 AM

CONFERENCE ROOM A - CIVIC OFFICES - FLOOR 2

Telephone enquiries to Joanne Wildsmith Democratic Services Tel: 9283 4057
Email: joanne.wildsmith@portsmouthcc.gov.uk

If any member of the public wishing to attend the meeting has access requirements, please notify the contact named above.

Health and Wellbeing Board Members

Councillors Luke Stubbs (Joint Chair), Donna Jones, Gerald Vernon-Jackson CBE, Ryan Brent, Jennie Brent and Leo Madden

Innes Richens, Dr Jason Horsley, Dr Linda Collie (Joint Chair), Dr N Moore, Peter Mellor, Ruth Williams, Healthwatch Portsmouth, Dianne Sherlock, Sue Harriman, Alison Jeffery and Andy Silvester

Dr Linda Collie (Joint Chair)

Plus one other PCCG Executive Member: Dr Elizabeth Fellows , Dr J. Lake, Dr A Eggins and Dr N Moore

(NB This Agenda should be retained for future reference with the minutes of this meeting.)

Please note that the agenda, minutes and non-exempt reports are available to view online on the Portsmouth City Council website: www.portsmouth.gov.uk

Deputations by members of the public may be made on any item where a decision is going to be taken. The request should be made in writing to the contact officer (above) by 12 noon of the working day before the meeting, and must include the purpose of the deputation (for example, for or against the recommendations). Email requests are accepted.

A G E N D A

- 1 Welcome by Dr Collie, Apologies for Absence and Introductions**
- 2 Declarations of Members Interests**
- 3 Membership Change (information item)**

Jackie Powell has informed Democratic Services of a change to the CCG lay membership for the Health and Wellbeing Board, with Andy Silvester replacing her. Jackie passed on her best wishes to members of the Board.

RECOMMENDED that the change be noted and Jackie Powell be thanked for her services on HWB as the Portsmouth CCG Lay Representative.

4 Minutes of previous meeting - 20 September 2017 (Pages 5 - 10)

RECOMMENDED that the minutes of the Health & Wellbeing Board held on 20 September 2017 be agreed as a correct record.

5 Portsmouth Safeguarding Adults Board - Annual Report (Pages 11 - 28)

The annual report for 2016-17 will be presented by the PSAB's independent Chair, Robert Templeton.

6 SEND Strategy and Self-Evaluation (Information report) (Pages 29 - 362)

The purpose of the report by Julia Katherine, Head of Inclusion (on behalf of the Director of Children, Families and Education) is to update the Health and Wellbeing Board on the refreshed Special Educational Needs and Disability (SEND) Strategy and the SEND Local Area Self-evaluation which identifies current areas of strength and areas where further development is required in readiness for the Local Area SEND Inspection.

This update is for noting.

7 Future in Mind Update (Information item) (Pages 363 - 406)

Update report by Stuart McDowell and Andrea Havey from the Integrated Commissioning Team.

The information report is for the Health and Wellbeing Board members to review the refreshed Future in Mind Transformation Plan recently submitted to government.

The update is to be noted.

8 Pharmacy Consolidation Application Response Procedure and application for Pharmacy Consolidation (Pages 407 - 420)

The following reports have been submitted by Claire Currie, Consultant in Public Health on behalf of Dr Horsley:

a) Pharmacy Consolidation Application Response Procedure

Purpose: Since 5th December 2016, the Health and Wellbeing Board has a statutory duty to make a representation to NHS England on consolidation applications of community pharmacies in its area (i.e. where pharmacy businesses on two or more sites propose to consolidate to a single existing site). The Health and Wellbeing Board must respond within 45 days.

This briefing presents a proposed process for formulating a response to a consolidation application of community pharmacies, which the Board is asked to approve. The timeline for a response may fall outside of the usual schedule of Health and Wellbeing Board meetings. It is proposed that this process be adhered to for all pharmacy consolidation applications received, with responses noted at the subsequent Health and Wellbeing Board.

RECOMMENDATION: The Health and Wellbeing Board is asked to approve the procedure for responding to pharmacy consolidation applications.

b) An Application for Pharmacy Consolidation -

Rowlands Pharmacy 129 Eastney Road (continuing site) and 117 Winter Road (closing site)

RECOMMENDED that the Health and Wellbeing Board agree that:

(1) The proposed consolidation of two pharmacies would not create a gap in pharmaceutical services that could be met by a routine application to meet a current or future need for pharmaceutical services.

(2) The proposed consolidation of two pharmacies would not create a gap in pharmaceutical services that could be met by a routine application to secure improvements, or better access, to pharmaceutical services.

9 Suicide Prevention Plan update (Pages 421 - 444)

The information report by Amy McCullough seeks to:

- To update the HWB on the development of a Portsmouth Suicide Prevention Plan (currently in draft).
- To seek HWB support for a Suicide Prevention Plan, and specifically commitment from members that their respective organisations/teams will *own* actions – as appropriate - within the Plan.
- To gain any initial feedback, and to ask that further comments are sent to Amy McCullough, Consultant in Public Health (Amy.McCullough@portsmouthcc.gov.uk).

To be noted.

10 Health and Wellbeing Strategy (Pages 445 - 474)

The purpose of the report by Dr Jason Horsley as Director of Public Health is present to the Health and Wellbeing Board a consultation document for approval.

RECOMMENDATIONS

The Health and Wellbeing Board is recommended to:

- (1) Approve the document for consultation as attached at Appendix A.
- (2) Agree the proposals for consultation set out in section 6.

11 Date of Future Meeting

Please note that the next Health and Wellbeing Board will be held at 10am on Wednesday 21st February 2018.

There will be an item on Adults with Complex Needs at that meeting.

Members of the public are now permitted to use both audio visual recording devices and social media during this meeting, on the understanding that it neither disrupts the meeting or records those stating explicitly that they do not wish to be recorded. Guidance on the use of devices at meetings open to the public is available on the Council's website and posters on the wall of the meeting's venue.

Agenda Item 4

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING of the Health and Wellbeing Board held on Wednesday, 20 September 2017 at 10.00 am in Conference Room A, Civic Offices, Portsmouth.

Present

Councillor Luke Stubbs (in the Chair)

Councillor Jennie Brent
Councillor Leo Madden

Innes Richens
Dr Linda Collie
Peter Mellor
Jackie Powell
Alison Jeffery

Officers Present

Kelly Nash
David Williams
Claire Currie

15. Apologies for Absence, Declarations of Interest and Introductions (AI 1)

Councillor Stubbs opened the meeting welcoming members and officers and inviting introductions.

Apologies for absence had been received from Councillors Gerald Vernon-Jackson and Ryan Brent. Councillor Donna Jones was detained in another meeting. Apologies had also been received from Dianne Sherlock, Sue Harriman and Patrick Fowler. Dr Jason Horsley was represented at the meeting by Claire Currie.

There were no declarations of interest at the start of the meeting but Jackie Powell did explain her counselling role with young people when discussion took place on the Public Health Annual Report.

16. Minutes of previous meeting - 21 June 2017 (AI 2)

There was a small error in Minute 12 last full paragraph the "ACF Leadership" should refer to "ACS Leadership".

RESOLVED, that subject to the minor amendment, the minutes of the Health & Wellbeing Board held on 21 June 2017 were agreed as a correct record.

17. Draft Pharmaceutical Needs Assessment (PNA) (AI 3)

Claire Currie, PCC Consultant in Public Health, presented this report. There is a statutory responsibility for the Health and Wellbeing Board to publish a PNA every 3 years. The purpose of this report is to seek approval of the report for consultation from 23 October until 22 December 2017. The primary purpose of a PNA is that it is used to respond to applications to open a community pharmacy. The PNA aims to identify gaps in current services or improvements that could be made to current or future service provision. The steering group who have undertaken the assessment represents key stakeholders. . In conducting this assessment, a survey of community pharmacy contractors was undertaken to which 30 of the 41 local pharmacies responded, and a public survey had 168 complete responses. Data was also gathered to understand contracts held by community pharmacies with NHS England Area Team, the CCG and the PCC public health team.

The PNA considers pharmaceutical services serving the Portsmouth residents to meet the need of the population. This is based on there being good coverage, good access, including delivery services to housebound residents, and a good range of services offered through pharmacies. Consideration has also been given to anticipated changes over the three year period the PNA will cover, including known developments.

In response to questions the following matters were clarified:

- How the consultation was taking place - there are a list of statutory consultees and the public would be consulted. PCC communications colleagues and Healthwatch were involved and had advised regarding the forthcoming public consultation and would help with promoting the consultation.
- As this is a weighty document the executive summary aimed to provide a summary of the conclusions of the assessment. In the same format as the previous PNA, there would be a survey of 6 questions which will be posted on the PCC consultation page of the website; help would be given to individuals where needed to complete this. A communications strategy for advertising the survey was being compiled, which may include an article in Flagship.
- Is Portsmouth below the national average for provision? Claire responded that the number of community pharmacies per head of population Portsmouth is broadly in line with the national average.
- The process for applying for new pharmacies via NHS England was explained. An individual wishing to open a community pharmacy

makes an application to NHS England. This application is considered with reference to the PNA as it is this document which determines whether there is a gap in current provision and therefore where there is a need for a community pharmacy to open.

- The effect of future developments (such as the large scale plans at Tipner) and increased student numbers in the city on the need to ensure the 1.6km proximity - this is a guideline distance and walking and driving times are also considered. The Tipner development is likely to have good road access to pharmacies and the student halls were mainly central where there was good coverage. Most pharmacies offer a home delivery service (over 90% in Portsmouth).
- The take-up of the provision to dispose of unwanted medicines at pharmacies was queried - GPs do advise patients of this facility as GPs are not able to accept patient medications for disposal. GPs and community pharmacists do review of prescriptions routinely.
- Community pharmacies provide flu vaccinations. This service provides greater access to flu vaccinations in the city and there is good coverage of providers in the city.

It was noted that the 3 year review process would allow for changes in local population requirements, patterns of demand and trends (such as increased delivery of prescriptions from distance selling pharmacies) to be analysed.

RESOLVED - the Health and Wellbeing Board:

(1) Approved the Draft Portsmouth Pharmaceutical Needs Assessment (PNA) report for public consultation from 23rd October to 22nd December 2017.

(2) Approved that the steering group respond to consultations of PNA's from neighbouring areas on behalf of the HWB where the Portsmouth HWB is a statutory consultee and ask the HWB to note the response.

18. Public Health Annual Report (information item) (AI 4)

Claire Currie, PCC Consultant in Public Health, presented this item. The draft annual report "The stories behind the statistics" was almost ready for sign-off however small adjustments could be made. Alison Jeffery requested reference to the range of the education strategy and she would liaise with Claire to give her comments.

During the discussion of this item the following comments were made:

- The document clearly showed how smoking and drinking were being tackled but there was concern at the high level of road traffic related incidents, which were preventable accidents and it was asked how this was being tackled? The city council are promoting active travel and quieter cycle routes as well as key messages on cycling safety and safer school routes, and there was clear liaison between public health and transport to address these issues.
- Air quality issues linked in with the promotion of open spaces and encouragement of use of parks; it was reported that Victoria Park would have improved lighting to help encourage extended use. The air quality monitoring information is handled by Environmental Health colleagues and this issue was being also being examined on a regional and national level.
- The promotion and expansion of hire bikes in the city - it was reported that discussions were taking place between the University of Portsmouth and private providers, and the scheme at Park & Ride may be expanded.
- The issues covered in the report would help inform the Local Plan and Local Transport Plan.
- Self-harm - there was concern expressed regarding the higher local levels compared to the national average and this is being tackled with an in-depth assessment taking place with partner agencies to form a multi-agency action plan, which also linked in with work to prevent suicide and young persons' mental health. Other work has also been undertaken in working with schools on emotional resilience.
- Substance mis-use - the work being undertaken by the recovery hub was commended and its capacity and number of users was queried. There is also a nationally recognised specialist alcohol nursing service at the hospital.

The Director of Public Health's Annual Report for 2016 was noted.

19. Health & Wellbeing Strategy - Refresh (AI 5)

Kelly Nash, PCC Corporate Performance Manager, presented the Director of Public Health's report which set out the themes that had been discussed with stakeholders and would then go out to a wider, public consultation. This was focusing on where value can be added and to see if there are any gaps. The updated draft would then be brought back to the Health & Wellbeing Board in November.

The style of the document was welcomed and comments made included:

- The need to ensure that young people's mental health was not overlooked as a theme, and that this along with the links to poverty and substance mis-use could be strengthened, as well as mental health issues for older persons too (substance mis-use here was a concern for GPs where patients were self-medicating). Therefore mental health for all settings was seen to be a key theme for the HWB.
- It was suggested that the Sustainability and Transformation Plan was referenced (but not duplicated within the document and work was continuing for the Health Overview & Scrutiny Panel on the STP)
- There was variation on population figures due to sources used, therefore census or projection status should be stated
- What was the process for "holding leaders to account"? It was reported that invitations would be made to attend the Health and Wellbeing Board.

All the HWB partner organisations would have the opportunity to discuss the themes in more detail before the Strategy goes out to public consultation and the refreshed document would be brought back to HWB in November for approval.

The Chair asked that the minutes be circulated to the HWB members to remind them of this discussion.

RESOLVED - The Health and Wellbeing Board:

- (1) Commented on the proposed principles, objectives and focus areas set out in Appendix A**
- (2) Agreed the proposals for next steps set out in section 5.**

20. Dates of future meetings (Information item) (AI 6)

The next HWB dates of 29th November 2017 and 21st February 2018 at 10am were noted.

21. Alcohol Related Liver Disease (additional item - for information) (AI 7)

Councillor Stubbs had agreed to the addition of this information item to the agenda, which had been circulated to members. Dr Nick Moore presented the updates received from Dr Elizabeth Fellows, showing data relating to both the wider Wessex region and the Portsmouth area. Dr Keogh's report on the Portsmouth statistics, and drew attention to the 284 ARLD patients in 2015, this represented using over 4,600 bed days for Portsmouth Hospitals. This data was important to feed into strategies for reducing harm.

During discussion of this item, the following was raised:

- Whilst the potential costs and savings can be estimated there are also the quality of life issues for patients and the pressures on the medical system
- There are public campaigns to reduce alcohol consumption although there can be mixed messages in the media about the effects of alcohol which do not always reflect the effects on long term health. Early intervention is key therefore work with schools in raising awareness is important.
- Dr Moore also explained the fatty liver links with obesity and cirrhosis which are preventable illnesses
- Nationally there is strong advocacy through bodies such as Alcohol Concern, to help lobby for legislative changes.

The meeting concluded at 11.20 am.

Councillor Luke Stubbs
Chair



Portsmouth Safeguarding Adults Board



**2016 – 2017
Annual Report**

Portsmouth Safeguarding Adults Board is funded by:



Working in partnership with:



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Statement from the Independent Chair



I am very pleased to introduce this Annual Report from the Portsmouth Adults Board (PSAB). The Annual Report shows how the PSAB has delivered on the areas of work previously identified as priorities for 2016/17. This is important because it shows what the Board aimed to achieve and what was actually done both as a partnership and through the work of participating partners.

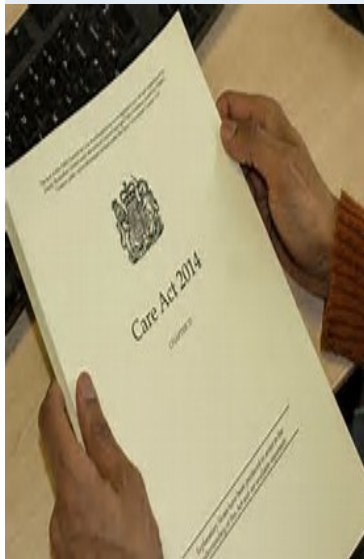
The report aims to provide a picture of who is safeguarded in Portsmouth, in what circumstances and why. Financial abuse of older people is a significant issue in Portsmouth and elsewhere and we are working with the trading standards and police to minimise this. We have heard nationally in recent years of cases where adults have suffered harm in care homes and hospitals and because of this we are working closely with partners to identify places where poor care may be happening.

I am very mindful of pressures on partners in terms of resources and time and am grateful to all those who have engaged in the work of the PSAB. I would like to acknowledge all the hard work that takes place on the frontline, and across the partnerships every day and you should feel proud of the contribution you make.

A handwritten signature in black ink, reading 'R.S. Templeton'.

Robert Templeton,
PSAB Independent Chair

Introduction to the PSAB?



What Is Safeguarding?

“Safeguarding means protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.”

Care Act (2014)

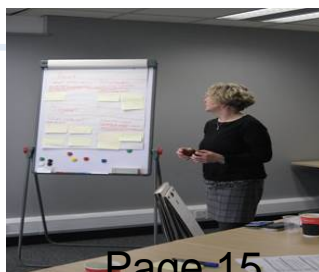
Who are we?

The Portsmouth Safeguarding Adults Board (PSAB) is a partnership of key organisations in Portsmouth who work together to keep adults safe from abuse and neglect. These include:

- Adult social care
- Health
- Emergency services
- Prison and probation services
- Housing
- Community organisations

The board has an independent Chair that can provide some independence from the local authority and other partners. This is especially important in terms of:

- offering constructive challenge
- holding member agencies to account
- acting as a spokesperson for the PSAB.



Our Vision

“Portsmouth is a city where adults at risk of harm are safe and empowered to make their own decisions and where safeguarding is everyone's business “



The Care Act 2014 sets out a clear legal framework for how local authorities and other organisations should protect adults at risk of abuse or neglect. Safeguarding Adults Boards are a legal requirement and work to the Department of Health's six principles of safeguarding:

Empowerment

- Presumption of person led decisions and informed consent.

Protection

- Support and representation for those in greatest need.

Prevention

- It is better to take action before harm occurs.

Proportionality

- Proportionate and least intrusive response appropriate to the risk presented.

Partnership

- Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability

- Accountability and transparency in delivering safeguarding.

What is Abuse and Neglect?

The Department of Health gives the following as examples of abuse and neglect. However, as abuse and neglect can take many forms, local authorities should not be constrained in their view of what constitutes abuse or neglect, and should always consider the circumstances of the individual case.

Physical

- including hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions;

Sexual

- including rape and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting;

Psychological

- including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or unreasonable and unjustified withdrawal of services or supportive networks;

Exploitation

- either opportunistically or premeditated, unfairly manipulating someone for profit or personal gain;

Financial or material

- including theft, fraud, exploitation, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;

Neglect and Acts of Omission

- including ignoring medical or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating;

Discriminatory

- including discrimination on grounds of race, gender and gender identity, disability, sexual orientation, religion, and other forms of harassment, slurs or similar treatment; and

Institutional (or organisational)

- including neglect and poor care practice within an institution or specific care setting like a hospital or care home, for example. This may range from isolated incidents to continuing ill-treatment.

Safeguarding Duty

Under Section 42 of the Care Act, a local authority has a duty to make enquiries or cause others to make enquiries in cases where it has reasonable cause to suspect

- that an adult has needs for care and support (whether or not the local is meeting any of those needs) and
- is experiencing, or at risk of, abuse or neglect and
- as a result of those care and support needs, is unable to protect themselves from either the risk of, or experience of, abuse or neglect.

Portsmouth has an Adult Multi- agency Safeguarding Hub (MASH). Hampshire Constabulary and Portsmouth City Council have created the MASH with a team of social workers and police officers working together who have direct links with colleagues in areas such as health, trading standards and children's safeguarding. The MASH manages a high volume of referrals.

Safeguarding Activity



A **concern** is a 'worry' raised regarding a person's safety.

There were **1620** concerns received during 2016/17



An **enquiry** is what needs to be looked at to confirm a person is safe.

303 were deemed to require further input and were taken forward as enquiries

19% of concerns raised were taken forward as Section 42 enquiries. This is 3% less than the previous year. The number of S42 enquiries per 100,000 of the adult population in Portsmouth is lower than the average for comparator councils, the region and the national average. The PSAB has requested that work is carried out during 2017/18 to understand the reason for this.



Section 42 Concerns

Male
43%

Female
57%



Section 42 Enquiries

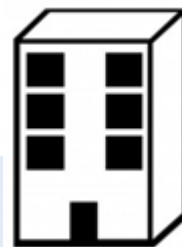
Male
44%

Female
56%



Source of Abuse – Completed Section 42 Enquiries

14% Service Provider
26 % Known to Individual
60% Unknown to individual



Location of Abuse – Completed Section 42 Enquiries

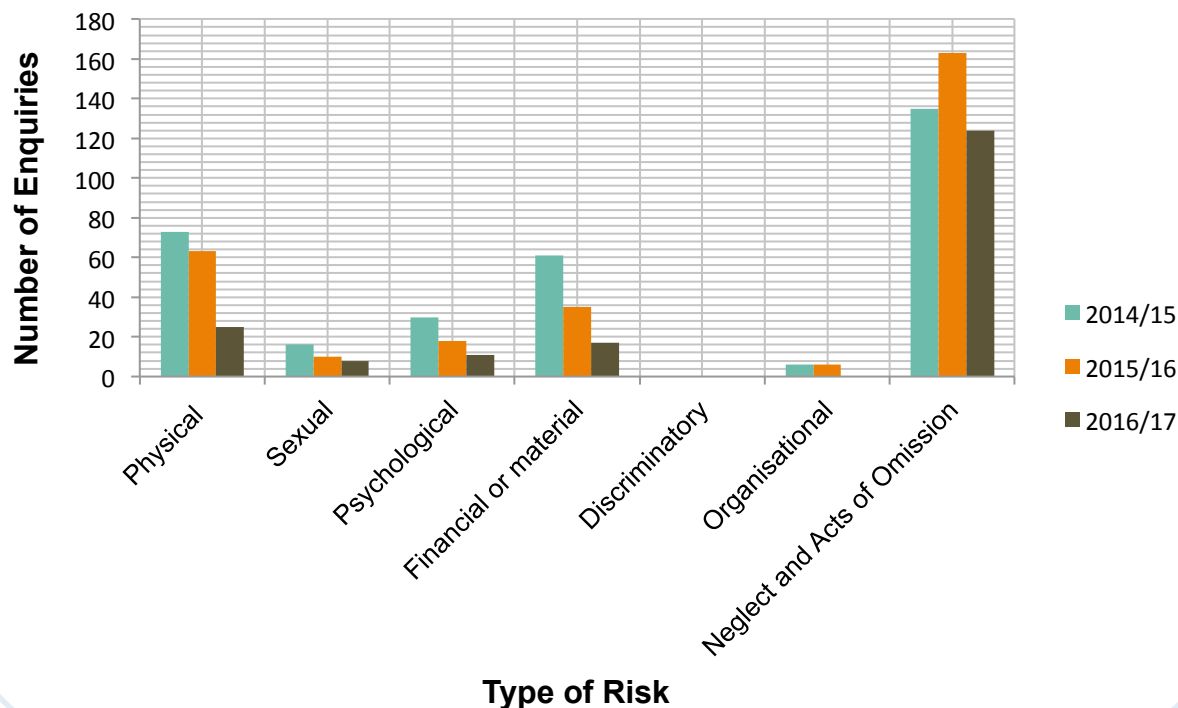
39% in own home
8% in a community service
13% in a residential care home
8% in a nursing care home
27% in an acute hospital
1% in a mental health hospital
4% in other settings



Age Range - Safeguarding Concerns :

39% 18 – 64 years
14% 65- 74 years
20% 75 – 84 years
22% 85 – 94 years
4% 95+ years

The graph below show counts of enquiries by type of risk:



How does the local data compare to the national picture?

The distribution of enquiries by type of risk is identical to that of the national picture with neglect and omission being the largest category and discriminatory being the smallest. However, we are aware that enquiries relating to financial abuse have decreased over the past two years and this is not in line with a general increase in financial abuse. Work needs to be carried out to understand what this data is telling us.

The 60% of enquiries show the source of abuse being unknown to the individual. However, this is not reflective of both the national and regional picture where most individuals know the source of abuse. Again, the PSAB is requesting that this is reviewed to understand the reason.

The breakdown of enquiries by gender is broadly reflective of the national picture and what we would expect to see.

A Safeguarding Example:

Safeguarding Concern

A woman with a diagnosis of a Learning Disability was sexually assaulted when doing voluntary work for a charity. Her mother was not satisfied with the charity's internal investigation and raised a safeguarding concern with the Portsmouth Adult MASH.



S42 Enquiry

Initial information gathering showed that a second incident had occurred and the risk had not been removed. The decision was made to undertake a safeguarding enquiry under Section 42 of the Care Act.



Making safeguarding Personal

The enquiry involved working with the individual in a way that she felt comfortable e.g. obtaining information from her over several shorter visits. The individual wanted the outcome to be able to continue volunteering without any further abuse.



Recommendations

On the balance of probabilities, the adult safeguarding team felt that the concern was substantiated and made recommendations to the charity to improve their safeguarding as they had many adults at risk volunteering with them.



Outcomes

The outcome was that the charity implemented more robust safeguarding policies and the individual and their family were provided with reassurances that the recommendations and desired outcomes had been met.



Progress against Priorities for 2016 -2017

In 2016 – 2017 we had four priority areas:

**1. Data -
knowing our
population**

**2. Learning from
Safeguarding
Adult Reviews**

**3. Workforce
development**

**4. Leadership
and Governance**

Priority 1: Data – Knowing our population

A multi-agency sub-group of the PSAB was chaired by the Ch. Supt. Prevention and Neighborhoods, Hampshire Constabulary and met throughout the year with colleagues from Public Health, Hampshire Fire and Rescue Service, NHS agencies and Portsmouth City Council. The group mapped the current data available relating to safeguarding and importantly, identified where there are gaps in the data. As a board, one of the focuses in 2017 -2018 is to ensure that a comprehensive data set is collected by the PSAB in order to understand the picture of safeguarding across the city, be aware of trends and be able to respond at a strategic level.

Individually, organisations have been striving to improve their knowledge and data. Hampshire Fire and Rescue Service (HFRS) have developed partnerships with Age UK and the Local Energy Advice Service Programme to identify adults at risk within the community. HFRS submit data to the PSAB on a quarterly basis.

During 2016/2017 Solent NHS Trust improved their data collection systems to ensure they record and understand the safeguarding themes and trends of their population. This includes data such as number of safeguarding concerns raised by Solent staff, the number of section 42 enquiries completed by Solent staff and types of abuse.

Hampshire constabulary submit quarterly data to the PSAB which includes information on incidents of hate crime, domestic violence and by type of abuse. Portsmouth City Council Safeguarding Team collect data on all section 42 enquiries as part of an annual statutory return.

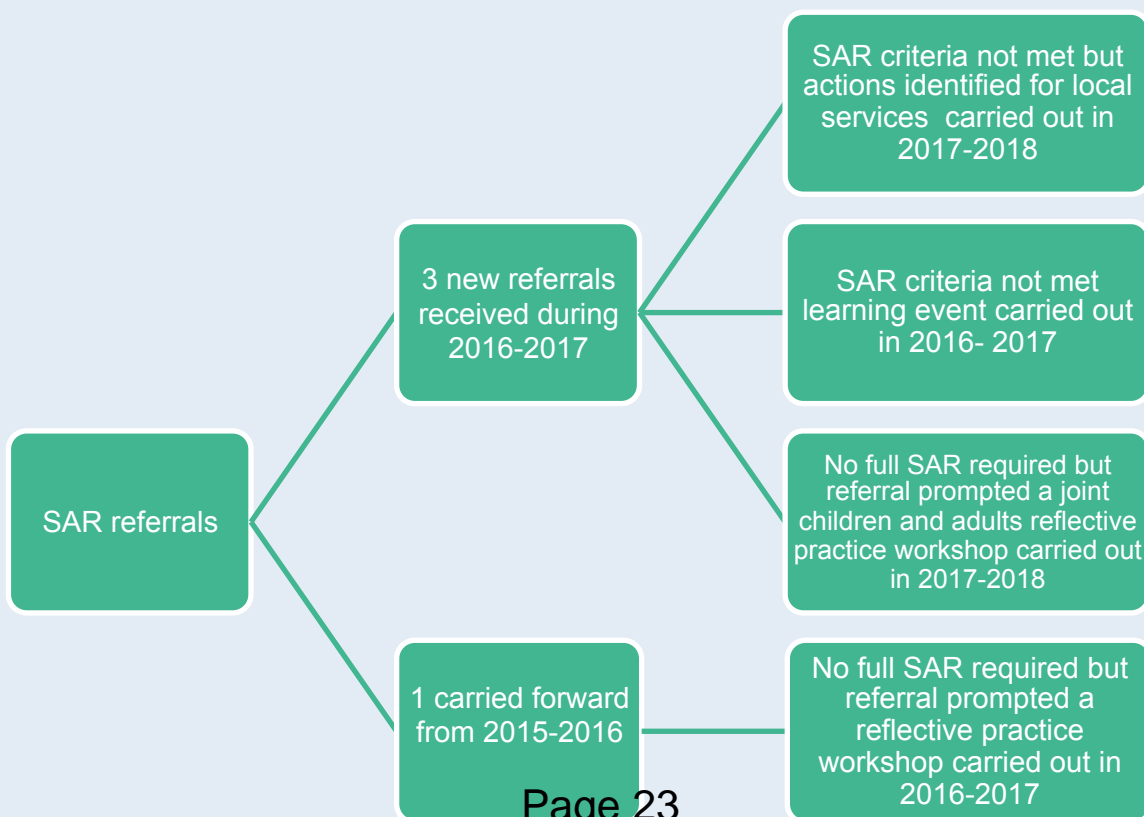
Priority 2: Data – Learning from Safeguarding Adult Reviews

The Care Act 2014 states that a Safeguarding Adult Review (SAR) must take place when:

"There is reasonable cause for concern about how the Safeguarding Adult Board, members of it or others worked together to safeguard the adult, and death or serious harm arose from actual or suspected abuse"

The PSAB has a SAR subgroup which is chaired by the Deputy Director for Quality and Safeguarding from NHS Portsmouth Clinical Commissioning Group. The group is a multi-agency group with members who have a specialist role or experience in safeguarding adults. The group met monthly during 2016 - 2017 and during this time reviewed and improved the SAR process including introducing a new decision making tool to support practitioners to recognise when it is appropriate to make a SAR referral.

Summary of SAR activity during 2016 - 2017:



In March 2017, the SAR sub-group started a pilot joining up with the Portsmouth Children Safeguarding Board's Case Review Committee to work together on cases which might involve both children and adult services. The pilot will be reviewed during 2017-2018.

The SAR sub-group held two multi-agency learning events for two separate SAR referrals which did not meet the criteria for a full SAR but the potential for learning was identified. Examples of some of the learning points or recommendations are improved transfer processes for people with mental health issues moving from one NHS Trust to another, the need to escalate if agencies are not sharing information appropriately, and the need to identify a lead professional in complex cases where multiple agencies are involved. Any strategic recommendations are taken to the PSAB and individual agencies are responsible for ensuring learning is disseminated throughout their organisation.

Priority 3: Workforce Development

One of the core functions of the PSAB is to lead on policy and strategy development for safeguarding adults. This provides frameworks, structure and guidance to support the workforce in their safeguarding responsibilities. During this year the PSAB formally adopted the Multi-Agency Risk Management Framework and the Allegations Management Framework. These have been developed in partnership with the Hampshire, Southampton and Isle of Wight Safeguarding Adults Boards.

Training is a key part of workforce development. During 2016-17, Solent NHS Trust recruited an additional Band 6 nurse whose remit was to focus on training. Since early 2017, the Adult Safeguarding Team have also been trainers in Workshops to Raise Awareness of Prevent, which aims to reduce the number of people becoming or supporting violent extremists. Monthly level 3 safeguarding training is offered within the Trust.

Hampshire Constabulary (HC) extended their training during 2016/2017 to include input for District Commanders on the Care Act 2014, Section 42 enquiries and professional development. HC have also provided training on the relevance of Adults at Risk and principles of Making Safeguarding Personal to frontline supervisors within the police. Hampshire Fire and Rescue Service ensured that all operational staff within the organisation in the Portsmouth Group area have received training on 'Making Every Contact Count'.

Healthwatch Portsmouth recognises the importance of safeguarding and that it is everyone's business. They train their staff, board members and other volunteers to understand the different forms of abuse and how to report concerns should any arise. This learning was applied when they undertook a visit to a residential care home in the city, as part of our wider programme of obtaining views of people using health and social care services. During the visit, concerns were raised over the well-being of a resident and these were reported to the care home management team and the Adults Safeguarding Team at Portsmouth City Council (PCC). PCC followed this matter up with the care home provider to ensure all correct protocols were in place to protect individuals in their care.



Priority 4: Leadership and Governance

During 2016 – 2017 the PSAB set up a Governance Group comprising of its statutory partners. The group met quarterly throughout 2016/17 and its membership includes the Chief Operating Officer (NHS Portsmouth CCG / PCC) , the Deputy Director Adult Services (Portsmouth City Council), the Ch. Supt. Local Policing Response & Control (Hampshire Constabulary) and the PSAB Independent Chair.

The function of the group is:

1. To ensure the PSAB has appropriate governance arrangements in place
2. To provide an executive decision making function to the PSAB
3. To ensure the PSAB is functioning in order to meet its aims and objectives
4. To ensure the PSAB meets its statutory duties under the Care Act 2014.

The statutory partners also fund the PSAB. Contributions for 16/17 were :

- Portsmouth City Council £32k
- NHS Portsmouth Clinical Commissioning Group £26k
- Hampshire Constabulary £11k

In addition to financial contributions, partner agencies contribute significant amounts of staff time to support the delivery of the Board's work programme, and to support training delivery. The Independent Chair of the PSAB reports to the Health and Well-Being Board and meets regularly with the Director of Adult Services and the Chair of the Safeguarding Children Board. Links are being established with the Safer Portsmouth Partnership. The Chair is also The Chair of the National Safeguarding Board Chairs Network, ensuring good links between the local, regional and national safeguarding agenda.

During this year the PSAB renewed its Terms of Reference and reviewed its membership to ensure appropriate representation to enable the PSAB to fulfil its duties.

Safeguarding Week

14th – 20th November 2016



One of the core aims of the PSAB is to raise awareness of neglect and abuse of adults at risk and how to report it. The Portsmouth Safeguarding Adults Board held a safeguarding week during November of this year to raise awareness amongst the general public and people working with adults at risk.

The PSAB worked with the council's libraries to have information stands across the city during the week. These had information on many different types of safeguarding issues and how to access help.

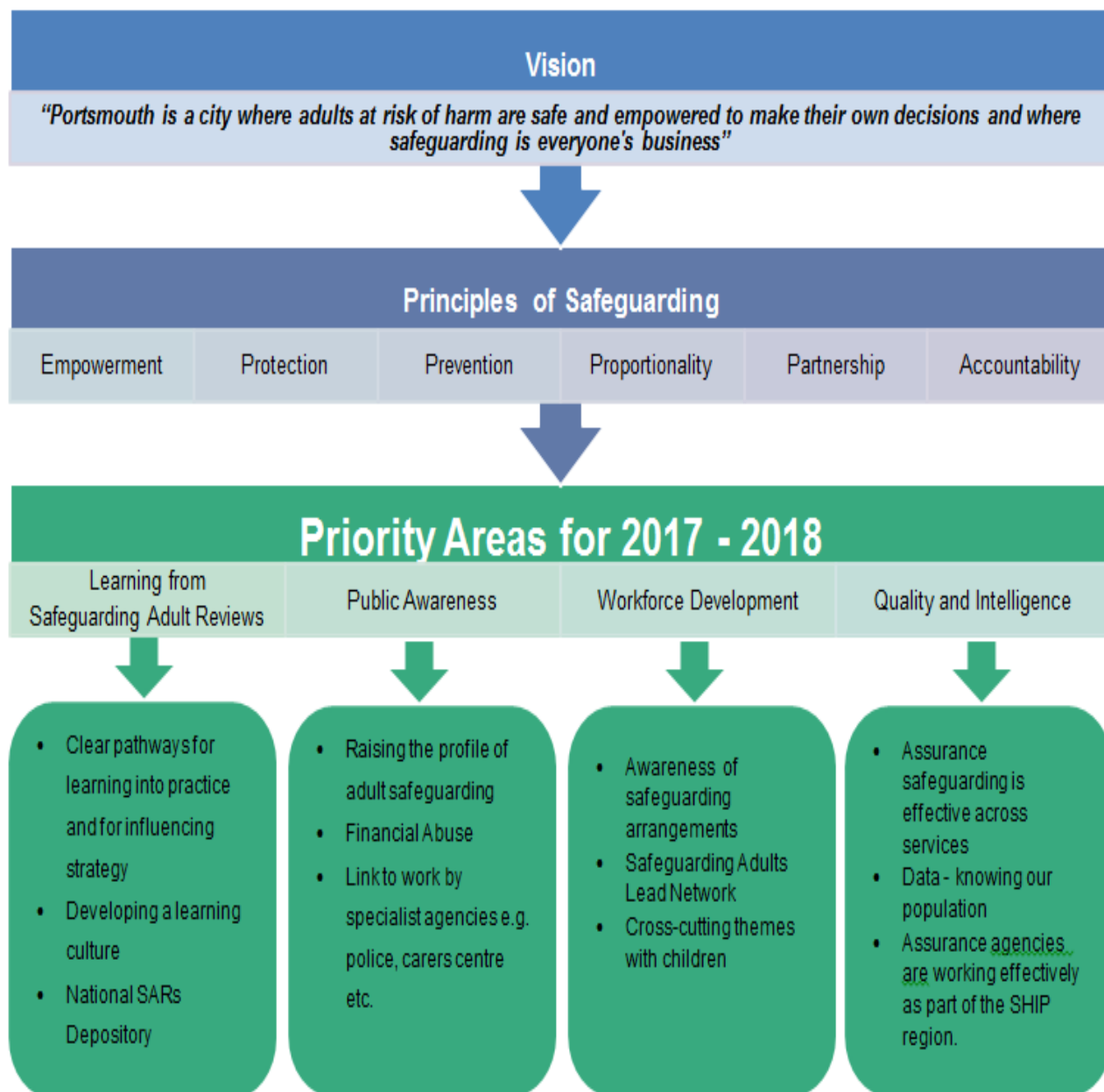
Events were held throughout the week. The PSAB, Portsmouth Hospitals NHS Trust and Hampshire Fire and Rescue Service had a full day information stand in the entrance of Queen Alexandra Hospital. Solent NHS Trust held similar events in St Mary's Hospital. Many partner agencies held additional learning and awareness raising events during this week such as an additional Prevent training session for frontline workers. Portsmouth City Council Safeguarding Team provided training to the Department of Work and Pensions on Self-Neglect.

The PSAB worked with the Portsmouth Safeguarding Children Board and PCC to put joint adult and children safeguarding messages in Portsmouth City Council's magazines that are distributed to all residents in the city and all pupils in Portsmouth schools.



Priorities for 2017 -2018

Portsmouth Safeguarding Adults Board Strategic Plan 2017 - 2018 Summary





If you are concerned
about an adult at risk:



call Adult Safeguarding
on
02392 680810

Get in touch with us:



02392 841786



Portsmouth City Council
Floor 5, Core 5,
Civic Offices
Guildhall Square
PO1 2AL



psab@portsmouthcc.gov.uk



[@portsmouthsab](https://twitter.com/portsmouthsab)

Agenda Item 6

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Portsmouth
CITY COUNCIL

Title of meeting:	Health and Wellbeing Board
Subject:	SEND Strategy and Self-evaluation
Date of meeting:	29 th November 2017
Report from:	Alison Jeffery - Director Children, Families and Education
Report by:	Julia Katherine, Head of Inclusion
Wards affected:	All

1. Requested by

A six-monthly update on the SEND Strategy has been requested by the Health and Wellbeing Board

2. Purpose

The purpose of this report is to update the Health and Wellbeing Board on the refreshed Special Educational Needs and Disability (SEND) Strategy and the SEND Local Area Self-evaluation which identifies current areas of strength and areas where further development is required in readiness for the Local Area SEND Inspection.

3. Information Requested

- 3.1 The SEND Strategy continues to be a priority within the Children's Trust Plan and has been agreed by the Children's Trust Board. The aim of the SEND strategy remains to promote inclusion and improve the outcomes for Portsmouth children and young people aged 0-25 years with SEND and their families. The full document is included as an appendix at the end of this report.
- 3.2 The SEND Strategy has been refreshed and updated following feedback from and discussion with all stakeholders. The strategy includes six key strands of work, as set out below.

3.2.1 Inclusion

This work strand seeks to ensure more children with SEND are educated in mainstream school settings by developing a shared ethos across the city, promoting and celebrating good inclusive practice, building capacity in mainstream schools, developing the workforce and identifying a removing



barriers to inclusion. The Inclusion group is chaired by a secondary head teacher and also oversees the Emotional Health and Wellbeing in Education Strategy.

3.2.2 Implementation of the SEND Reforms

This strand of work ensures the effective implementation of the national SEND Reforms introduced in 2014. This includes the publication of the Local Offer, clear support for children at 'SEN Support', the introduction of Education Health and Care assessments and plans to replace 'statements', implementing personal budgets, offering short breaks and providing independent advice and support

3.2.3 Joint Commissioning

The Joint Commissioning Steering Group has overseen the refreshed annual SEND needs analysis, which is required to be published as part of the Joint Strategic Needs Assessment (JSNA). The Joint Commissioning Plan has been developed to identify the commissioning priorities across health, education and care to ensure that a comprehensive 'local offer' of support is in place for children and young people with special educational needs and disabilities and their families, including support for 0 to 25 year olds with Social Emotional and Mental Health needs.

3.2.4 Co-production

Co-production with children, young people and parents and carers has long been established as key to designing services that best meet needs. We have established a vibrant forum for young people (Dynamite) and Portsmouth Parent Voice continues to engage large numbers of parents and carers in helping shape services through the 'Shaping Better Futures Together' and 'Empowering Children and Families' groups as well as via a range of engagement and coproduction activities.

3.2.5 Early identification and early support

This work strand includes work to ensure that there is early identification and assessment of children with SEND and effective joint working across health and education services in order to ensure that the right support is put in place at the earliest opportunity to secure good outcomes for children.

3.2.6 Preparation for Adulthood

The SEND Reforms place responsibilities on local areas to provide support for young people up to the age of 25. There is a range of work under this strand to improve engagement in post-16 learning, secure employment and make effective and smooth transitions into adulthood, including accessing adult health and care services, where appropriate.

3.3 Readiness for Local Area SEND Inspection

- 3.3.1 A Local Area SEND inspection will take place at some point over the next 3 and a half years. The inspection will be undertaken by Ofsted and the Care

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Quality Commission. There will be 5 days' notice of the start of the inspection and inspectors will be on site in the city for 5 days.

3.3.2 The inspection will focus on how well local leaders know the effectiveness of local area SEND services across health and the local authority in identifying special educational needs and disabilities, meeting needs and improving outcomes. For this reason we have worked with all stakeholders, including professionals and service users, to develop a self-evaluation which sets out our areas of strength and areas where we know further work is required. The self-evaluation of is included as an appendix at the end of this report.

3.3.3 The views of children and young people (aged 0 to 25) with SEND and their parents as to the effectiveness of services and support will be central to the inspection. The ways in which we, in Portsmouth seek the views of children, young people with SEND and their parents and carers about the services available to them is set out in the self-evaluation document.

3.4 The **areas of strength** we have identified are:

- Partnership working across health and the local authority,
- Co-production with parents/carers and young people,
- The quality and timeliness of education health and care needs assessments and statutory plans,
- The quality of local specialist provision, including special schools.

3.5 The areas we have identified where further development work is required are:

3.5.1 **SEN Support** - The attainment and progress of children at the 'SEN Support' level of need continues to be a major challenge. Strategic alignment between the SEND Strategy and the Education Strategy led by the Portsmouth Education Partnership has placed greater emphasis on securing better educational outcomes for children in receipt of SEN Support. Monitoring systems are in place via the School Improvement Board and an offer of support for schools has been developed by the Teaching School Alliance to support schools to improve outcomes for those on SEN Support.

3.5.2 **Capturing, monitoring and reporting outcomes at an individual level and using this information to inform commissioning** - Current report systems do not yet enable us to report on some of the wide range of information that we would like to use to inform commissioning priorities e.g. identifying costs of health provision within EHC plans is currently not possible due to CCG commissioning via block contracts. A mechanism or tool needs to be developed to be able to match health interventions identified in EHCP to potential costs using a cost matrix.

- 3.5.3 Further development of joint working arrangements with the newly integrated Prevention and Early Help service** - There is a key role for professionals within the Prevention and Early Help service such as Health Visitors and School nurses in identifying SEND. Workforce develop activities are underway to ensure that processes for early identification and joint working arrangements are in place, effective and widely understood.
- 3.5.4 School attendance and exclusions** - Children with SEND, particularly those with social emotional and mental health difficulties (SEMH), are more likely to be persistent absentees from school and are more likely to receive a fixed period exclusion from school. In order to improve this we are providing targeted support and challenge to schools where school absence and/or fixed period exclusions are high via the Portsmouth Education Partnership. Impact is monitored via the School Improvement Board.
- 3.5.5 Transition** - Transition arrangements to adult services for those with physical disabilities, complex learning difficulties and who attend a special school are good. The pathway is, however, less clear for those who do not meet the criteria for learning disability services, including some young people with autism spectrum difficulties, or those with SEND who are in mainstream schools. Young people tell us that they would like improved information on support to get into employment and to live independently. Whilst participation rates for young people with SEND are above national, there is a need to increase the numbers of young people with SEND in paid employment. In order to improve this we are coproducing with young people clear and accessible transition information and guidance for young people, to be published as part of the local offer, including information to clarify the pathway from the Annual Review at age 14 onwards. In addition we have been invited to be part of a funded pilot by the Department of Work and Pensions to provide support for young people with SEND in Years 10 and 11 to access supported work experience placements.
- 3.5.6 Autism** - Feedback from parents/carers and young people tells us that we still have further work to do with regards to the offer of support for children and young people with Autism. In order to improve this we have therefore started work on a specific children and young people's Autism pathway which will be aligned to the all-age Autism strategy and monitored via the SEND Board. In recognition that there is a growing need for specialist educational provision for children and young people with Autism we have created an Inclusion Centre for secondary aged pupils with Autism within one of our mainstream schools and have been successful in our bid for a new special free school for children with Autism.

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3.6 **Peer Review** - On 30th November 2017 we have asked a team from Reading to undertake a peer review of SEND services, to test readiness for inspection. The outcomes and any implications from this peer review will be report to the Health and Wellbeing Board at a future meeting.

.....
Signed by (Director)

Appendices:

1. SEND Strategy
2. SEND Local Area Self-evaluation

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

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Portsmouth Children's Trust
Children's Trust Plan 2016 - 2019



Special Educational Needs and Disability (SEND) Strategy:
A strategy to promote inclusion and improve outcomes for
children and young people with SEND and their families

Priority 4

Version 6
Revised September 2017

Lead Partnership Board:	SEND Board
Programme Sponsors:	Alison Jeffery, Director of Children's Services, PCC Innes Richens, Chief Operating Officer, CCG
Lead:	Julia Katherine, Head of Inclusion, PCC
Contact Details:	julia.katherine@portsmouthcc.gov.uk

Version Control		
Version 1	4 th April 2016	Early Draft
Version 1	15 th April 2016	DCS approval
Version 1	19 th April 2016	CSPG
Version 1	29 th April 2016	SEND Board
Version 2	26 th May 2016	DCS approval
Version 2	26 th May 2016	CCG approval
Version 2	26 th May 2016	DPH approval
Version 2	6 th June 2016	Lead Member for Children and Education
Version 2	7 th June 2016	Children's Trust Board
Version 3	22 nd June 2016	Health and Wellbeing Board
Version 4	30 th September 2016	SEND Board
Version 5	8 th September 2017	SEND Board
Version 5	19 th September 2017	Children's Trust Board
Version 6	20 th September 2017	Children's Trust Board

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PART I: OVERVIEW

1. INTRODUCTION & VISION

The aim of the special educational needs and disability (SEND) strategy is to promote inclusion and improve the outcomes for Portsmouth children and young people aged 0-25 years with SEND and their families.

In order to improve outcomes, we aim to ensure that there are in place a range of high quality support services that contribute to removing the barriers to achievement for all Portsmouth children and young people, in particular those with special educational needs and disabilities. This includes enabling children and young people to lead healthy lives and achieve wellbeing; to benefit from education or training, with support, if necessary, to ensure that they can make progress in their learning; to build and maintain positive social and family relationships; to develop emotional resilience and make successful transitions to employment, higher education and independent living.

Principles underpinning the strategy:

- Inclusion of children and young people with SEND, with needs met locally wherever possible
- Co-production with children and young people and their parents and carers
- Joined-up multi-agency working across the local area
- Personalisation and person-centred approaches
- Early identification and support
- Holistic, multi-agency, co-ordinated outcomes-focused assessment and planning
- Key working and family-centred systems
- A skilled and confident multi-agency workforce
- Informed and empowered parents and young people
- More choice and control about the services received
- Joint planning for transitions, including a smooth transition to adult services
- Improved care pathways and clear lines of responsibility
- Equal access to services for children and young people with SEND
- High aspirations for children and young people with SEND to achieve the best possible outcomes

Legislation which underpins this strategy:

The delivery of support for children and young people with SEND and their families is underpinned by a number of key pieces of legislation, including:

- Children and Families Act 2014 and the SEN code of practice
- Children Act 1989 and 2004
- Care Act 2014

- Working Together to Safeguard Children 2015
- Children and Young Persons Act 2008
- Care Planning, Placement and Case Review (England) Regulations 2010
- Care Leavers (England) Regulations 2010
- Chronically Sick and Disabled Persons Act 1970
- Mental Capacity Act 2005
- National Health Service Act 2006
- Mental Health Act 2007
- Equality Act 2010
- NHS Mandate
- Public Health Outcomes Framework

The Children and Families Act 2014, introduced significant changes to the ways services are provided for children and young people aged 0 to 25 with SEND, and their families. Key changes include:

- Joint commissioning of services required across education, health and social care to meet the needs of children and young people with SEND.
- Publication of a 'local offer' of services available, as a 'one stop shop' for accessing information, as well as feeding into the commissioning cycle.
- Implementation of a multi-agency co-ordinated statutory assessment process to identify the education, health and care needs of children and young people aged 0 to 25 and the provision required to meet those needs.
- For the identified needs and provision to be set out in a statutory 'Education, Health and Care Plan' (EHCP), with a new duty on health to deliver the health element of the EHC Plan.
- For all those who have an EHCP in place, to have the option to request a 'Personal Budget' for delivery of identified aspects of the EHCP.
- Statutory protections currently available to school-age children with special educational needs, through a statement, will be extended from 0 to 25 years, where additional resources are required to enable access to education or training.
- Independent information and support will be available to parents and to young people about the services available to them and how to access support, where appropriate.
- The above new duties will apply to all education providers, schools, academies, FE colleges, training providers etc.

In Portsmouth, we are working hard to successfully implement the reforms in compliance with the new SEN Code of Practice and in the spirit of the reforms. This includes planning for the transition from the current system to the new system by 2018.

Alongside the introduction of a new system for the delivery of SEND services across education, health and care, there are existing pressures on special educational provision within the city, including pressure on the places available to meet some areas of need, as well as pressure on the budget available to resource such provision. In addition, there are new initiatives which have an impact on the support available for children and young people with SEND.

National initiatives which have an impact on SEND include:

- Future in Mind
<https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people>
- Educational Excellence Everywhere white paper
<https://www.gov.uk/government/publications/educational-excellence-everywhere>
- High needs funding reforms white paper
https://consult.education.gov.uk/funding-policy-unit/high-needs-funding-reform-2/supporting_documents/High%20needs%20funding%20reform%20%20government%20response%20and%20stage%20%20proposals.pdf
- Transferring Care Programme
<https://www.england.nhs.uk/learning-disabilities/care/>
- Integrated Personalised Commissioning (demonstrator site for NHS England)
<https://www.england.nhs.uk/commissioning/ipc/>
- Sustainability and Transformation Plan
<https://www.england.nhs.uk/stps/>

Local initiatives which have an impact on SEND include:

- Stronger Futures
- Education Strategy
- Autism Strategy
- Portsmouth blueprint

The combined impact of these initiatives will bring about significant changes in the way that services are provided to children and young people with SEND. An aim of this strategy is to co-ordinate the implementation of these changes in order to improve outcomes for children and young people with SEND.

Key outcomes to be achieved

This strategy aims to achieve increased percentages of children and young people with SEND who are able to:

1. Be included within their local community,
2. Lead healthy lives and achieve wellbeing,
3. Learn and make progress,
4. Make and maintain positive relationships within their family and community
5. Participate in education and training post-16 and prepare for employment

2. STRATEGIC OVERVIEW

The aim of the special educational needs and disability (SEND) strategy is to promote inclusion and improve the outcomes for Portsmouth children and young people aged 0-25 years with SEND and their families.

There are six strands of the SEND Strategy:

- | | |
|------------------|---|
| Strand A: | Promote good inclusive practice to improve outcomes |
| Strand B: | Successful implementation of the SEND reforms |
| Strand C: | Effective joint commissioning to improve outcomes |
| Strand D: | Co-production, embedded as a way of working with children, young people and their parents and carers |
| Strand E: | Early identification and early support for children with SEND and their families |
| Strand F: | Effective preparation for adulthood and smooth transitions to adult services |

Strand A: Promote good inclusive practice

Portsmouth currently identifies a higher percentage of children as requiring SEN Support and maintains a higher percentage of pupils with statements/EHCPs than the national average (3.1% compared to 2.8%). Portsmouth is currently experiencing:

- Increasing numbers of requests for statutory assessment,
- Increasing requests for element 3 funding as recommendations from annual reviews of statements/EHCPs,
- Increasing requests to place pupils in specialist provision,
- Increasing numbers of first tier tribunals as a result of managing these pressures.

The numbers of pupils being placed at independent or non-maintained special schools outside of Portsmouth has grown significantly since 2012. This is, in part, due to an increase in the numbers of looked after children (LAC) with statements being placed in foster or other care arrangements outside of the city, and where the LAs in which they are placed have no capacity in any maintained special educational provision suitable to meeting their needs. This has increased the pressure on the SEN budget drawn from the dedicated school grant (DSG).

Speech, language and communication needs (SLCN) and Autistic Spectrum Disorders (ASD) account for more than 40% of all PCC statements. Numbers of children with these areas of needs are increasing nationally, with growing sophistication in assessing and diagnosing these conditions contributing towards increased identification. Prevalence of Severe Learning Difficulties (SLD) and Visual Impairment (VI) are also growing while traditional identification of, for example Moderate Learning Difficulty (MLD), are falling. In addition the Children and Families Act 2014 (Section 100) places a duty on governors of schools and academies to make arrangements for supporting pupils at their school with medical conditions.

Portsmouth mainstream schools are better resourced and enabled than ever to deliver inclusive practice and make provision for pupils with special educational needs & disabilities. Underpinning pedagogical approaches such as quality first teaching and the waves of SEN interventions are now well embedded in school culture to enable good teaching; since 2009, all school SENCOs have been required to achieve accreditation at MA level and be recognised as senior leaders within their schools; Portsmouth's SEN funding formula (in line with DfE guidance) now makes resources available to schools in order to make *up* to the first £6,000 of *additional and different* provision; the local authority commissions specialist teaching advice to mainstream schools and academies from the city's maintained and academy special schools which offers a broad menu of specialist teaching advice and training.

Pupils with SEN achieve better outcomes, in general, when educated in mainstream schools alongside mainstream pupils¹. The converse is only true for pupils who require specialist provision because they have significant or complex needs. However, more than half of Portsmouth's pupils with statements are educated in

¹ Inclusive education and students without special educational needs: (Nienke M. Ruijs, Ineke Van der Veen & Thea T.D. Peetsma, 2010)

special schools, resourced provisions or units. A local culture has grown among professionals and parents who have an overreliance and expectation of making pupils statements, seeking element 3 funding and to seek placements in resourced provisions, units and special schools.

The aim of this strategy is to improve services in order to increase inclusion and improve outcomes for children and young people with SEND, and their families. Every child and young person with SEND deserves to be included within their local community and to receive services locally wherever possible. In order to improve outcomes for children and young people with SEND in the city, we need to ensure that we are targeting the resources available in order to ensure that needs are met from ordinarily available provision where appropriate so that targeted and more specialist support can be provided for those who most need it.

Achieving a more inclusive ethos across education, health and care services across the city will require whole system change. There will need to be a change in expectations for professionals commissioning and providing universal, targeted and specialist services, as well as for services users including parents and carers. This strategy aims to develop a shared understanding across all of those groups and services about what makes good inclusive practice, and why it is important.

We will work with commissioners to promote inclusive practice and ensure that the eligibility criteria for services promotes inclusion and with providers to ensure that all services contribute to the shared outcomes of increased school attendance and reduced fixed period exclusions from school for children with SEND, by ensuring that there are clear pathways in place to resolve issues of managing inclusion particularly in relation to social emotional and mental health difficulties, alongside the Future in Mind work that is progressing.

We will build capacity within universal services through the provision of outreach, support and workforce development to increase the confidence and competence of practitioners in meeting the needs of children with SEND. We will celebrate and further promote good inclusive practice in the city through the annual Portsmouth Inclusion Conference.

The development of more inclusive practice within educational settings (schools, colleges and early years settings) will be overseen by the **Inclusion Group**.

Strand B: Successful implementation of the SEND reforms

The changes set out in Part 3 of the Children and Families Act came into force in September 2014. Successful implementation of the SEND Reforms will establish a more person- and family-centred system for identifying and assessing the needs of children and young people with SEND and a more co-ordinated approach to commissioning the provision to ensure that these needs are met effectively.

The co-production and maintenance of an up to date and comprehensive Local Offer of all services available to Portsmouth children and young people with SEND and their families across education, health, care and the voluntary sector, remains central to the successful implementation of the SEND Reforms. This 'one stop shop' of information about services and support available to families will need to continue to be developed to ensure that it provides the information families need, enables them to provide direct feedback about the offer of services available and feeds in to the SEND joint commissioning cycle.

The SEND Reforms focus on those children and young people who require SEN support as well as those who require additional resources via an Education Health and Care Plan. We will work to develop a shared understanding of what support can be provided from universal and targeted services via the publication and dissemination of an agreed 'Ordinarily Available Provision' suite of documents which set out what services are available to children and young people with SEND and their families across education, health, care and the voluntary sector, without the need for an Education Health and Care Plan. This work will be taken forward by the School Inclusion Group which will identify and implement the key factors required to develop more inclusive practice in mainstream schools across the city.

For those children and young people with the most complex needs, who require an Education health and care needs assessment and plan, we have implemented a co-ordinated, multi-agency, outcomes-focused assessment process, compliant with the new SEN Code of Practice. We will continue to refine this process, as a result of the feedback we receive from families e.g. from User Journey Mapping. We will continue to monitor and improve the quality of Education Health and Care Plans via termly audits.

We want to give more choice and control to families about the way in which they access the support they are entitled to such as targeted and statutory short breaks and home to school transport assistance. We will do this by expanding the use of personal budgets and direct payments for those entitled to access this support and implementing the use of pre-paid cards for direct payments.

We want families to be empowered to make best use of the resources available to them. In order to do this, parents and young people will continue to need access to independent information advice and support and we will ensure that effective and high quality IASS is available to families in Portsmouth.

The successful implementation of the SEND reforms self-assessment and implementation plan in Portsmouth is overseen by the **SEND Implementation Group**.

Strand C: Effective joint commissioning to improve outcomes

We want to have in place a genuinely co-produced and transparent joint commissioning plan for SEND in Portsmouth that sets out the priorities for commissioning and the resources available as well as the shared outcomes to be achieved.

The principles which will underpin this commissioning plan include:

Making effective use of data - including the SEND Children and Young People's strategic needs assessment (Part of the Joint Strategic Needs Assessment) to identify gaps in provision and ensure that services are commissioned to meet the identified need.

Ensuring a continuum of provision that promotes inclusion - eligibility criteria and access to all services for children and young people with SEND across education health and care should ensure that:

- children and young people's needs are met at the least restrictive level, wherever possible,
- needs are met locally, where appropriate and
- there is efficient and effective use of the resources available.

Co-production - all services are designed in partnership with service users as key stakeholders. Ongoing feedback from service users and stakeholders is sought proactively and this is used to inform ongoing commissioning priorities.

In working towards this, we have undertaken SEND reviews in the 4 key areas of special educational needs and disabilities:

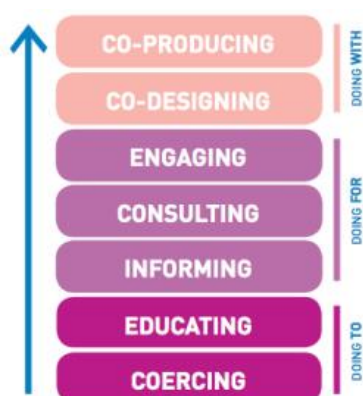
- Cognition and learning
- Communication and interaction
- Sensory and physical
- Social emotional and mental health

Priority actions within each area of SEND have been identified, and a number of actions have been undertaken already to progress this.

A stakeholder workshop has been held to start the process of co-producing the commissioning plan. The SEND Joint Commissioning Plan will be overseen by the **SEND 0-25 Joint Commissioning Steering Group**.

Strand D: Co-production, embedded as a way of working with children, young people and their parents and carers

Co-production is working in collaboration with service users, as equal partners in the strategic planning, design, review and (re-)commissioning of services.



Source: new economics foundation

‘Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change.’

New economics foundation: The Challenge of Co-Production 2010

We want to embed co-production as the way of doing business in Portsmouth when planning and commissioning services for children and young people with SEND and their families because we believe that where services are co-designed with service-users they are more likely to meet needs effectively and they enable service users to have more choice and control over increasingly personalised solutions to achieve their identified outcomes

In Portsmouth we have a strong track record of partnership working with parents and carers, building on work highlighted within the Lamb enquiry report (2009). Parents and carers take part in decision-making (e.g. as trained members of the Inclusion Support Panel) and contribute to all subgroups of this strategy, including co-chairing the SEND Board. We want to build on this good practice to further embed co-production in all areas of working to support children and young people with SEND and their families.

The embedding of co-production with young people and parents and carers as a way of working in Portsmouth will be overseen by the **Co-production Group**.

Strand E: Early identification and early support for children with SEND and their families

Early identification is essential to ensure good outcomes, but without early intervention it can result in labelling and a within-child model of thinking where problems are seen to be the result of within-child factors and therefore not able to change.

In Portsmouth we see SEND as the result of the interaction between the child and their environment. We believe that all children can make progress, with the right environmental factors in place. We want to ensure that assessments are undertaken and services provided on the basis of need, rather than a label or diagnosis. We are therefore keen to promote a needs-led process of assessment and planning for children and young people with SEND across all services.

For young children, it is often health professionals, from universal services who are first involved with families when difficulties are identified. We want to ensure that all practitioners are working to an agreed set of principles of key-working, needs-led assessment and collaboration to ensure that the families of very young children who are experiencing SEND have the best possible experience of receiving support from the necessary services to ensure that needs are assessed and support put in place at the earliest opportunity.

Ensuring that effective early identification and support is co-ordinated in Portsmouth will be overseen by the **SEND Early Intervention and Support Group**.

Strand F: Effective preparation for adulthood and smooth transitions to adult services

Ultimately, young people with SEND want what all young people want, to live healthy, independent lives and have positive relationships within their family and community. Our expectation is that young people with SEND will engage in education and training in order to prepare for employment to be able to live independently.

We have high aspirations for all our young people and want to ensure that there are services and support in place to enable them to achieve their own personal goals in relationship to the four PfA outcomes. We aim to work with young people with SEND post-16 to empower them to access the support that is available in order to achieve their potential.

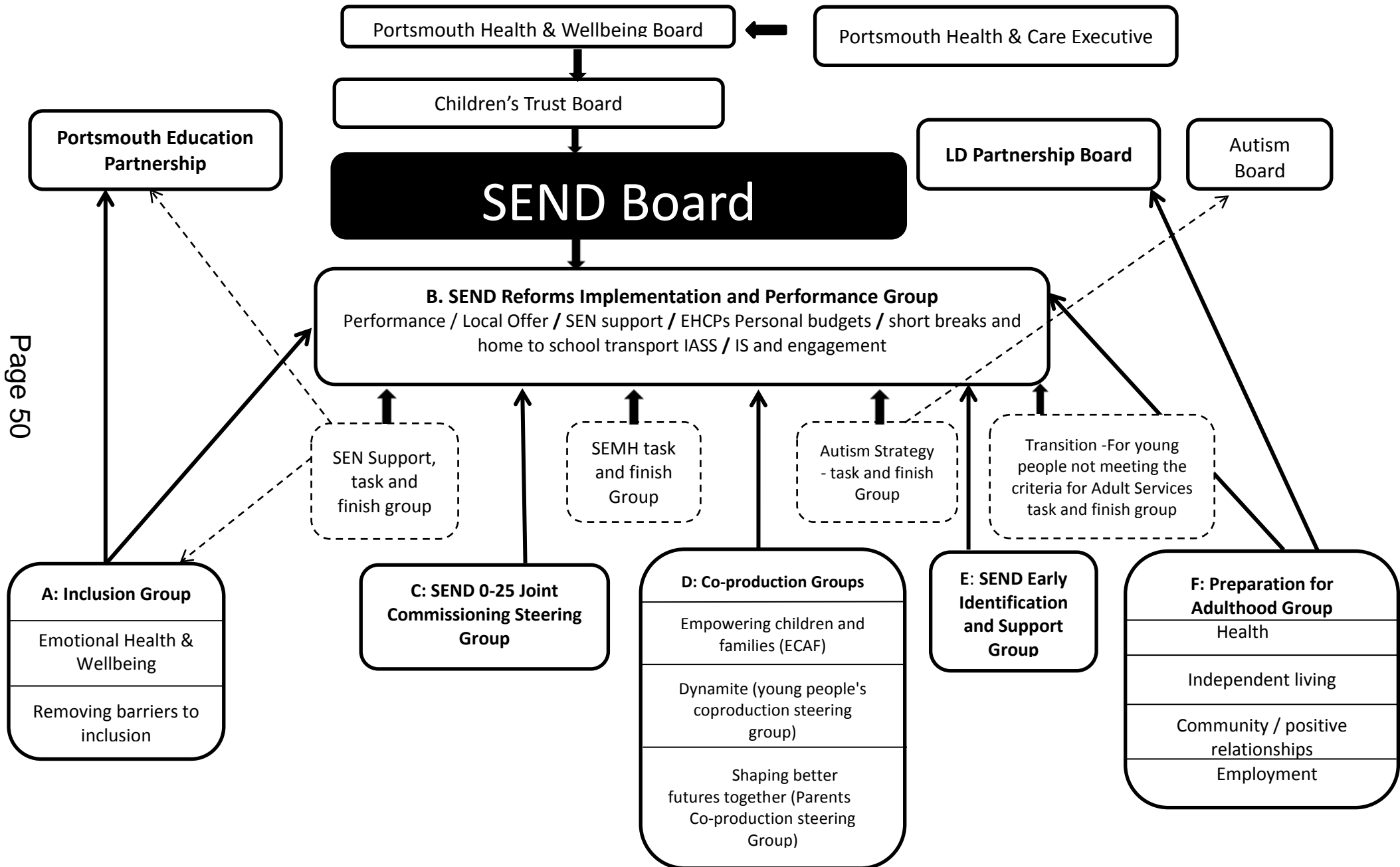
Ensuring that all young people with SEND are able to achieve a smooth and successful transition to adulthood is overseen by the **Preparing for Adulthood Group**. This group also reports to the Learning Difficulties and Disability Partnership Board.

The work of Preparing for Adulthood group has a focus on the achievement of 3 outcomes:

- To be assured that the Education, Health and Care planning process identifies and works towards the realisation of PfA outcomes for the those in transition.
- To be assured that the Education, Health and Care planning process supports commissioning including for people with autism.
- To be assured that processes enable effective transition for people into and following on from post-16 education and training.

The PfA group is working closely with post -16 providers to support the development of their provision and improve collaboration with other services in order to deliver PfA outcomes. This includes a clear focus on inclusion, independence and progression to employment.

Special Educational Needs and Disability (SEND) Strategy: Governance and Accountability Framework



PART II: THE STRATEGY

Here we outline the main workstrands of the strategy, provide the long-term plan, a summary of the current position and the next steps to be taken in 2017/18.

STRAND A: PROMOTE GOOD INCLUSIVE PRACTICE

The Long-Term Plan
For Portsmouth to be a leading example of good, inclusive practice, with the vast majority of children and young people with SEND able to have their needs identified early and met within what is 'ordinarily available' (universal and targeted services) across education, health and care. Staff are confident to meet the needs of the majority of children with SEND. Where additional support is required, this is accessed in a timely way and is of a high quality so that needs are met and outcomes improve.
Priorities for this strand of work
A1. Removing barriers to inclusion A2. Well-being and resilience A3. Build capacity and develop the workforce
What we achieved in 2015-16
<ul style="list-style-type: none">Established an annual conference to share and celebrate good practiceRevised the service level agreement for the provision of outreach servicesDeveloped an 'Ordinarily Available Provision' document for school SENCOs
What we have achieved in 2016-17
<ul style="list-style-type: none">Developed the Ordinarily Available Provision suite of documentsDeveloped a shared understanding of how we monitor 'good progress' for those on SEN SupportDeveloped an offer of school SEN support to promote good inclusive practiceMonitored the impact of the outreach service in building capacity within mainstream schoolsDelivered the annual Inclusion ConferenceDeveloped the well-being and resilience strategy
What we will deliver in 2017-18
To remove barriers to inclusion by: <ul style="list-style-type: none">Mapping the resources available to education providers to support children and young people with SEND

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

- Monitoring the progress and educational outcomes for pupils receiving SEN Support
- Mapping the Alternative Provision offer and monitoring the impact of Alternative Provision

Implement the emotional well-being and resilience strategy, including:

- Provide a central source of information about social, emotional and mental health (SEMH)
- Improve communication between agencies and education providers supporting children and young people with SEMH needs
- Provide training on SEMH for education professionals
- Make self-help and peer support available for children, young people and their families
- Improve access to specialist services for children and young people with SEMH needs

Monitored via

Inclusion Group
Chair: Nys Hardingham

Removing barriers to inclusion subgroup
Chair: Neil Stevenson

Emotional health and well-being subgroup
Chair: Sarah Christopher

STRAND B: SUCCESSFUL IMPLEMENTATION OF THE SEND REFORMS

The Long-Term Plan

For Portsmouth to have successfully implemented the SEND reforms, as outlined in part 3 of the Children and Families Act 2014 (often described as a 10 year whole system change programme). Ultimately this will be independently tested via the Ofsted/CQC SEND inspections process.

The SEND Strategy (alongside its sister strategy 'Stronger Futures') makes up the children's element of the Portsmouth 'Blueprint' for health and care in the city, which sets the ambition to more strongly integrate public service spending across the local public service system.

Priorities for this strand of work

- B1. Local Offer
- B2. SEN Support
- B3. EHC assessments and plans
- B4. Personal budgets, short breaks and home to school travel assistance
- B5. Independent advice and support and engagement

What we achieved in 2015-16

Good progress has been made in implementing the SEND Reforms to date. Portsmouth are compliant with all new statutory duties.

A self-assessment has been undertaken and an implementation plan is in place.

What we achieved in 2016/17

- Further developed the Local Offer
- Maintained the high quality of our EHCPs
- Improved the % of EHCPs completed within statutory timescales to 98%
- Increased the number of Personal Budgets included within EHCPs
- Published the revised Short Breaks statement and eligibility criteria
- Increased the number of direct payments in place
- Commissioned Portsmouth IASS
- Continued parent and young people's engagement work, including coffee mornings and pizza evenings delivered by PPV and Dynamite

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

What we will deliver in 2017-18

- Develop a shared understanding of Ordinarily Available Provision and the threshold for requesting an EHC needs assessment
- Improve outcomes for children and young people on SEN Support
- Improve quality and timeliness of EHC evidence/statutory advice
- Maintain quality and timeliness of EHCPs
- Further develop the Local Offer in response to feedback from young people
- Recommission targeted short break offer
- Increase the number of personal budgets and direct payments included within EHCPs
- Monitor progress and improve outcomes for children and young people with SEND from vulnerable groups
- Improve the experience of transition for children and young people with SEND and their families
- Co-produce all EHCPs with children, young people and parents/.carers
- Enable children and young people with SEND and their parents/carers to contribute to strategic decision-making about local provision
- Maintain strong leadership and lines of accountability for the SEND Strategy
- Joint plan and commission provision for children and young people with the most complex needs who require jointly funded packages of support
- Continue to improve services by learning from complaints and tribunal cases

This group will take on the role of monitoring the performance indicators across the whole SEND Strategy, prior to quarterly performance being reported to the SEND Board.

Monitored via

SEND Implementation and Performance Group
Chair: Julia Katherine

STRAND C: EFFECTIVE JOINT COMMISSIONING TO IMPROVE OUTCOMES

The Long-Term Plan

Education, health and care work together to carry out an annual joint strategic needs assessment of the needs of children and young people aged 0-25 with SEND and their families as part of the Joint Strategic Needs Assessment. This data is used to identify gaps in provision and to agree priorities for commissioning with service users. The joint commissioning plan is co-produced with children and young people with SEND and their parents and carers.

Priorities for this strand of work

- C1. Cognition and learning
- C2. Sensory and physical
- C3. Communication and interaction
- C4. Social emotional and mental health

What we achieved in 2015-16

An initial joint strategic needs assessment for 0-25s with SEND has been carried out.

Reviews have been carried out in each of the 4 areas of need and action plans have been developed based on the recommendations of each:

- Sensory and Physical
- Cognition and Learning
- Communication and Interaction
- Social Emotional and Mental Health

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

What we have achieved in 2016-17

- SEND Needs Assessment has been completed
- Joint Commissioning Plan has been agreed across the CCG, local authority, Schools, Solent and Portsmouth Parent Voice.

Specific achievements include:

Sensory and Physical

- Reviewed the wheelchair service - following feedback re: waiting times

Cognition and learning

- Re-designated Cliffdale and Redwood Park as special schools for children with complex needs and autism
- Began phased remodelling of the accommodation at Cliffdale and Redwood Park in order to enable these schools to provide effectively for children with more complex needs and autism

Communication and interaction

- Established a new Inclusion Centre for secondary aged pupils with communication and interaction needs (including autism) at Trafalgar school
- Established new Inclusion Centres for primary pupils with communication and interaction needs (including speech and language difficulties and autism) at Devonshire Infants and Portsdown Primary schools.

Social emotional and mental health difficulties

- Re-defined the AP and SEN pathways for children with SEMH
- Developed new SLAs with The Harbour School and Flying Bull for the provision of SEMH support to children and young people within the city
- Included Future in Mind developments within joint commissioning plan

What we will deliver in 2017-18

- SEND needs assessment to be refreshed
- SEND Strategic Review to be carried out to inform future commissioning
- SEMH mapping and stock-take to be carried out
- Complete CAMHs needs assessment and new CAMHs specification
- Children and young people's Autism strategy to be developed
- Provider to be identified for new special free school for children and young people with Autism
- Integrated Personalised Commissioning to test out methodology for delivering Personal Health Budgets for children

Monitored via

SEND 0-25 Joint Commissioning Steering Group

STRAND D: CO-PRODUCTION, EMBEDDED AS A WAY OF WORKING WITH CHILDREN, YOUNG PEOPLE AND THEIR PARENTS AND CARERS

The Long-Term Plan

For Co-production with children and young people with SEND and their parents and carers to become embedded as a way of working both at the strategic level and at an individual case work level.

Priorities for this strand of work

- D1. Co-production with parents and carers
- D2. Co-production with young people

What we achieved in 2015-16

A Parents and Carers Co-production group is established and has completed key tasks including designing the Local Offer website.

There is a parent/carers co-chair of the SEND Board and parent/carers reps on all subgroups of the SEND Strategy

A Young people's Co-production group is established 'Dynamite' and has completed tasks including a young people's survey 'The Big Bang'.

What we achieved in 2016-17

- Dynamite coproduced 2nd annual survey which reached over 100 young people
- Established of a Young Inspectors programme - 12 trained Young Inspectors are regularly visiting a range of services and submitting reports
- Training delivered by young people to 25 professionals across agencies
- Widened parent/carers engagement activity to include parents of children on SEN Support and recruited 13 SEN Champions in mainstream schools
- Appreciation awards have been presented to around 30 professionals
- Recruited and trained new parent/carers reps on the Inclusion Support Panel

What we will deliver in 2017-18

- Incorporate ECAF into the SEND Strategy governance and accountability structure, with the parent/carers co-production group and Dynamite (young people's co-production group) reporting to ECAF, which in turn reports to the SEND Board

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

- Re-purpose and refresh the terms of reference of the parent/carer co-production group (renamed Shaping Better Futures Together) to take on a more strategic role
- Embed coproduction across the city e.g. via Top Tips for professionals, Coproduction pledge, celebration events and a Coproduction Conference
- Continue to develop the Social Emotional and Mental Health (SEMH)/Future in Mind (FiM) work in partnership with the FiM Co-production group
- Continue Young Inspectors programme
- Co-produce information for Parents/Carers and Young People including:
 - Easy read SEND Strategy
 - Transition guide for parents/carers
 - Enuresis & Encoporesis pathway
 - Parenting Offer

Monitored via

Empowering Children and Families (ECAAF)
Chair: Lynne Rigby and Richard Souter

Shaping Better Futures Together
Chair: Kara Jewell

Dynamite Core Group
Chair: Joe McLeish

STRAND E: EARLY IDENTIFICATION AND EARLY SUPPORT FOR CHILDREN WITH SEND AND THEIR FAMILIES

<p>The Long-Term Plan</p> <p>For children's needs to be identified and support put in place at the earliest opportunity.</p> <p>For families to experience the involvement of various professionals in assessment and providing support as a joined up and co-ordinated process.</p>
<p>Priorities for this strand of work</p> <p>E1. Early identification and assessment</p> <p>E2. Early support to improve outcomes</p> <p>E3. Workforce development</p>
<p>What we achieved in 2015-16</p> <p>There is an effective Early Years Panel in place whereby health and education professionals share information and jointly plan to ensure that the needs of young children and SEND are identified and met.</p>
<p>What we have achieved in 2016-17</p> <ul style="list-style-type: none"> • Robust multi-agency Early Years Panel in place to co-ordinate assessments and track progress of 0-4 year olds with SEND to ensure that needs are identified and planned for prior to starting school • The Early Years Panel has taken on the allocation of the Inclusion Fund • Re-established the Early Years SENCo network meetings • Early Years settings are making EHC requests with support from EYATs • Developed training offer for early years practitioners
<p>What we will deliver in 2017-18</p> <ul style="list-style-type: none"> • Revise the Early Years pathway, ensuring that there is a co-ordinated process that enables early identification of needs and effective sharing of information between agencies to plan and implement timely support • Review the Early Years Panel process to ensure that information is shared effectively across agencies and is used to inform commissioning priorities • Ensure that 'key working' is in place for families, where appropriate • Strengthen the links with the Prevention and Early Help service
<p>Monitored via</p> <p>SEND Early Intervention and Support Group Chair: Carol Stevens</p>

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

STRAND F: EFFECTIVE PREPARATION FOR ADULTHOOD AND SMOOTH TRANSITIONS TO ADULT SERVICES

The Long-Term Plan For all young people with SEND to have a clear plan in place that identified outcomes and resources to enable a smooth transition to adulthood, able to access the support they are entitled to in order to achieve their identified outcomes.
Priorities for this strand of work To ensure that each young person has a plan in place which they 'own' and which identifies clear outcomes and actions relating to each of the PfA outcomes i.e. <ul style="list-style-type: none">• Health• Independent Living• Positive relationships/community• Employment To develop a range of services and support that will help young people achieve these outcomes To have a clear pathway in place for 14 to 25 years olds with SEND
What we achieved in 2015-16 <ul style="list-style-type: none">• Rolled out person-centred approaches to all young people with SEND• Worked with colleges to develop supported internship programmes
What we have achieved in 2016-17 <ul style="list-style-type: none">• Extended the provision of supported internships• Ensured that clear transition pathways are in place so that young people do not 'fall through the net' when they reach 18.• Developed tools and guidance to ensure that PfA reviews are focused and effective• Carry out pilot of 'Ready Steady Go' health transition programme with schools• Review the role of the Child Autism Co-ordinator
What we will deliver in 2017-18 <ul style="list-style-type: none">• Ensure that the education health and care planning process identifies and works towards the realisation of PfA outcomes for those in transition

- Explore good practice relating to the PfA outcomes and benchmark against local practice
- Develop tools to support the PfA outcomes
- Devise method of collating information from PfA outcomes in EHCPs to inform commissioning
- Ensure there are clear pathways for assessment and support for people with Autism
- Ensure that processes enable effective transition for people into and following on from college, including supporting the Partners in Policymaking project

Monitored via

Preparing for Adulthood Group
Chair: Mark Stables

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

PART III: DELIVERY

The next section includes the detailed delivery plans for each of the workstrands of the strategy for 2016/17 and 2017/18. Monitoring arrangements are via each of the Subgroups of the SEND Board, with quarterly reports from each of the subgroups to the SEND Board.

2017/2018 Delivery Plans (Below)

Childrens Emotional health and wellbeing (Page 29 - 34)

Removing Barriers to Inclusion (Page 35 - 38)

SEND Reforms Implementation Plan (Page 39 - 46)

Joint Commissioning Plan (Page 47 - 63)

Early Identification plan (Page 64 - 65)

PFA Sub group Action Plan (Page 66 - 74)

Appendices

Appendix I: Performance Framework (Page 75 - 118)

DELIVERY PLAN (September 2017 – September 2018) - Emotional Health and Wellbeing

1. To improve access to specialist services including direct work with young people and advice and training and consultation for professionals

Areas to develop:

- a) Review the current CAMHs offer to schools
- b) Develop a traded offer of additional support to schools and colleges
- c) Develop a Quality Assurance Framework for selecting private and voluntary sector
- d) Increase School awareness of current services, thresholds and professional advice available

Recommendations	Expected impact	Actions	Lead	By When	Evidence
1a) Review the current CAMHs offer to schools and colleges	An analysis of the existing offer will inform commissioning and increase equity across education settings	Review the impact of current school clinics and CAMHS' capacity to provide ongoing or additional clinics. All secondary schools have equitable access. Review the offer for primary schools	Stuart McDowell	Dec 2017	Findings of review fed back to Inclusion Group
1b) Develop an offer of additional support to schools and colleges including traded services	Settings will be able to access support from reliable sources. Central commissioning and the option to pool budgets will provide better value.	Identify the central resources available to support or subsidise the offer. Involve all current providers eg EPS, MABS, CAMHS, U Matter. Use an analysis of the survey monkey results to inform the new offer	Stuart McDowell/ Sarah Christopher	February 2018	PEP, local offer and traded services websites
1c) To map the existing training offer to schools from different providers And provide a collaborative approach	Use the findings from mapping and analysis of the Survey Monkey results (Summer 17) to develop a coordinated approach to a	Work with partners, including CAMHS, EPS, TSA and MABs to provide a coherent overview of training available for the academic year	Sarah Christopher	March 2018	Training brochure and information on websites.

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

to planning ongoing training	training programme for 18/19.				
1d) Increase School awareness of current services, thresholds and professional advice available	Education settings will be clear about what services are available, how to access them and the criteria for referral.	Information about services and regular updates are sent to all settings via the wellbeing leads. Feedback from networks, including SENCO, Primary Behaviour and Pastoral Strategic leads and lead links are used to inform updates, information and training	Sarah Christopher	Nov 2017	Service information documents are in settings and online, There is an increase in te number of appropriate referrals to specialist services.

2. To provide a central source of information

Areas to include:

- a) An SEMH section on the PEP website
- b) Access to online SEMH advice and resources for parents/carers and young people
- c) The role of the named wellbeing leads

Recommendations	Expected impact – how will this improve outcomes?	Actions	Lead agency Lead officer	By When	Evidence
2a) Develop an SEMH section on the PEP website. Page 65	Education settings have access to a one stop shop for information relating to SEMH.	Provide a clear structure to the SEMH pages on the pep website Provide links to all relevant local and national services, resources and information Keep all information under regular review	Sarah Christopher	Jan 2018	Website
2b) Develop access to online SEMH advice and resources for parents/carers and young people	Parents/ Carers, Children and young people have access to a one stop shop for information relating to SEMH	Review the current information on the Local Offer in relation to SEMH. Review the information on the PEP website Provide dedicated pages for parents/ carers and young people.	Barbara McDougall and Joe McLeish	July 2018	PEP Web pages and link to Wessex Healthier together website.
2c) Develop the role of named wellbeing leads	Information shared with education settings gets to the right people in a timely fashion. Settings know who they can contact for advice and support.	Collect and collate names of wellbeing leads from all education settings. Review these annually. Establish clear means of communication with leads via regular newsletters.	Sarah Christopher	Dec 2017	Central list of named leads

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

		Make named leads aware they can contact CAMHs SPA, or Sarah Christopher			
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3. To provide access self-help and peer support for children, young people and parents/ carers.

Areas to include:

- a) Anti- Bullying
- b) Peer mentoring
- c) Parenting offer
- d) PSHE curriculum
- e) Restorative approaches are developed across all education settings in Portsmouth

Recommendations	Expected impact – how will this improve outcomes?	Actions	Lead agency Lead officer	By When	Evidence
4a) To refresh the Anti-Bullying guidance and resource pack for schools	Bullying is addressed effectively in all settings	<p>Review Resource pack to reflect changes to guidance, legislation and services</p> <p>Publish pack including discrete sections on different types of bullying</p> <p>Produce guidance for schools on supporting young people who identify as Trans</p>	Sarah Christopher	<p>Nov 2017</p> <p>March 2018</p>	Resource Pack
4b) Peer Mentoring is used to provide support to children and young people	There is a sustainable programme of Peer Mentoring which provides direct support in schools and colleges.	<p>Develop a Training the Trainers programme for Peer Mentoring</p> <p>Provide networking opportunities city wide for peer mentors and staff who supervise peer mentors</p>	December 2018	<p>March 2018</p> <p>Sept 2018</p>	Case studies

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

4c) Link with Early Help to align the parenting offer with the schools wellbeing and resilience strategy. Review the "parenting offer" and the support that is available to parents	Parents access non-judgemental support in relation to their child's mental health and behavioural needs. Schools are able to support parents in accessing support and advice.	Establish and Maintain links with the parenting pathway, behavioural support and the early help offer to provide co-ordinated information to schools.	Sarah Christopher with Early Help		Early help and parenting offer on PEP website, local offer and links of schools websites.
4d) Curriculum approaches including PSHE develop wellbeing and promote resilience Page 68	Children and young people have a range of opportunities, cross-curricular and through PSHE to learn about and discuss wellbeing	Information and resources from the PSHE association and Public Health England are shared with schools. Ascertain the support school require from the PSHE development offer to assist in recruitment to this post.	Sam Belfrage	July 2018	Links on website and in EHWP Newsletter.
4e) Restorative approaches are developed across all education settings in Portsmouth	Education settings have a good level of awareness of restorative practices and use restorative approaches	Evaluate the impact of trailblazer restorative schools Use the Restorative Schools Network and PEP website to share case studies and good practice Extend the invite to the restorative schools network to all schools (all schools to be involved by September 2019)	Sarah Christopher and Matt Hutton	May 2018	Reports to the Restorative Practice Group and Restorative Schools Network

DELIVERY PLAN (April 2017 – March 2019) - Removing Barriers to Inclusion

1. To develop a shared understanding of what we mean by successful inclusion and seek the support of key stakeholders and leaders across the city in working towards Portsmouth becoming an inclusive city.

2. To understand the resources that are available to mainstream schools, colleges and early years settings to support children and young people with SEND

Areas to develop:

- e) Map the existing offer of external support for schools, colleges and early years settings.
- f) Provide guidance for schools, colleges and early years settings in identifying SEND
- g) Refresh the Ordinarily Available Provision documents for schools, colleges and early years settings.

Recommendations	Expected impact	Actions	Lead	By When	Evidence
2a) Map the existing offer of external support for schools, colleges and early year's settings	Education providers will be clear about the external support available, including from health	Clear information for schools, colleges and early years settings will be published on the local offer and the PEP websites	Sarah Christopher	Jan 2018	Web page links to Local Offer and PEP websites
2b) Clarify threshold for identification of SEN support (using profile and need) and to provide guidance for schools, colleges and early years settings in identifying SEND	SENCOs will be consistent in the way they identify pupils for SEN support and will be clear about thresholds for requesting EHC needs assessments	Guidance documents will be refreshed and published on the local offer with input from SENCOs	Sarah Christopher	March 2018	Link to Local Offer web page
2c) Refresh the Ordinarily Available Provision (OAP) documents for schools,	Parents will be clear about what SEN Support can be provided by schools, colleges and early years from notional SEN funding.	Schools will sign up to a minimum standard of OAP. Document to be published on the Local Offer	Sarah Christopher	Sept 2018	Link to Local Offer web page

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

colleges and early years settings					
3. To monitor the progress and educational outcomes for pupils receiving SEN Support					
<u>Areas to develop:</u> <p>d) To build a range of criteria that measure the progress, attainment and outcomes of pupils on SEN support.</p> <p>e) Progress, attainment and wider outcomes for pupils receiving SEN support to be monitored by the Inclusion Group in order to identify ways to improve outcomes.</p>					
Recommendations	Expected impact – how will this improve outcomes?	Actions	Lead	By When	Evidence
3a) To build a range of criteria that measure the progress, attainment and outcomes of pupils on SEN support	There will be clarity about performance in the city in comparison to national data and analysis of nature of cohort and inconsistencies across schools.	Criteria to be identified to enable regular reporting to inclusion group	Sarah Christopher	Jan 2018	Data report to come to the Inclusion Group
3b) Progress, attainment and <u>wider outcomes</u> for pupils receiving SEN support to be monitored by the Inclusion Group in order to identify ways to improve outcomes	Close monitoring will enable analysis of barriers to performance and identification of actions to be taken to address these and improve outcomes	Regular report to be provided to the Inclusion Group. Further actions may be identified in the light of this analysis e.g. actions to address the barriers experienced by particular groups or cohorts	Sarah Christopher	March 2018	Data report to come to the Inclusion Group

3c) Identify wider measures of inclusion e.g. Parental satisfaction -	A set of measure that Portsmouth schools sign up to.				
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4. To map the alternative provision offer and monitor the impact of Alternative Provision

Areas to include:

- a) To map the range of Alternative Provision commissioned by schools, internal and external
- b) To monitor the impact of Alternative Provision. Including reintegration and educational outcomes.

Page 7	Recommendations	Expected impact – how will this improve outcomes?	Actions	Lead agency Lead officer	By When	Evidence
4a)	To map the range of Alternative Provision commissioned by schools - internal and external	Education providers will be clear about the range of Alternative Provision available. There will be a consistent approach to identifying which pupils require Alternative Provision, and in establishing quality and intended outcomes	Alternative Provision document to be published on the Local Offer website	Neil Stevenson	Jan 2018	Link to webpage

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

4b) To monitor the impact of Alternative Provision, including reintegration and educational outcomes	Monitoring outcomes of Alternative Provision will lead to improved quality and outcomes, including re-integration appropriateness of allocation and waiting list prioritisation (KS4)	A regular report will be provided to the Inclusion Group to include use of Alternative Provision and outcomes, including reintegration.	Neil Stevenson	March 2018	Report presented to the inclusion group
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SEND REFORMS IMPLEMENTATION PLAN (April 2016 – March 2018)

How effectively do we identify disabled children and young people and those who have special educational needs in Portsmouth

1. Early intervention/SEN Support (success criteria)

- a) There is a shared understanding of 'ordinarily available provision'
- b) There is a shared understanding of the threshold for requesting an education health and care needs assessment
- c) Children and young people receiving SEN Support make good progress, including at points of transition
- d) Children and young people with SEND from vulnerable groups make good progress

Objectives	Expected impact – how will this improve outcomes?	Actions	Lead officer	By When	Evidence	Evaluation (updated quarterly)
1 a) There is a shared understanding of 'ordinarily available provision'	A shared understanding across schools colleges, early years setting, parents and young people of what constitutes 'ordinarily available provision' to ensure consistency in meeting children and young people's needs.	Review and update the 'Ordinarily Available Provision' documents in partnership with schools and other providers. Publish and publicise summary version on Local Offer Website	Sarah Christopher	Jan 2018	Add link to document published on the local offer website www.portsmouthlocaloffer.org	
1 b) There is a shared understanding of the threshold for requesting an education health and care needs assessment	Professionals are able to make consistent judgements about whether to request an education health and care needs assessment or when needs can be met within available resources.	Guidance documents are updated in partnership with SENCoS and other professionals. Documents are published and publicised on the local offer.	Karen Spencer	Jan 2018	Add link to document published on the local offer website www.portsmouthlocaloffer.org	
1 c) Children and young people receiving SEN Support make good progress, including at points of transition	Children and young people will make good progress, when compared to the same group nationally.	SEN Support Task and Finish Group to develop an offer of support to schools to develop their practice in relation to pupils on SEN Support.	Sarah Christopher	March 2018	Add link to published offer of support on PEP website when available	
1 d) Children with SEN from vulnerable groups make good educational progress	The educational progress of children with SEN from the following vulnerable groups is monitored: <ul style="list-style-type: none"> Looked after children/care leavers CIN/CPP Educated out of area EHE Medical Tuition 	Support is put in place to enable children and young people to make progress. An annual report is presented to Director of Children, Families and Education management team meeting and PCSB.	Julia Katherine/ Debbie Price	Dec 2017	Annual report presented to Director of Children, Families and Education management team meeting and PCSB.	


DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

	<ul style="list-style-type: none"> Children of Service Personnel Children known to YOT					
Position statement	This is an area where further development is needed. Children and young people in Portsmouth do not make sufficient progress compared to the same group nationally. There is a lack of consistency in the identification of those requiring SEN Support and those for whom an EHC needs assessment is required. There is further work to do to strengthen the early intervention for children with SEND with the early help work of the newly formed Prevention and Early Help service.					

How effectively do we meet the needs and improve the outcomes of disabled children and young people and those who have special educational needs in Portsmouth?

2. Quality and timeliness of EHCPs (success criteria)

- a) Professional education, health and care advice is provided within statutory timescales and is of good quality
- b) EHC needs assessments are co-ordinated and completed within statutory timescales
- c) EHCPs are of good quality


Objectives	Expected impact – how will this improve outcomes?	Actions	Lead officer	By When	Evidence	Evaluation (updated quarterly)
2 a) Professional education, health and care advice is provided within statutory timescales and is of good quality	Professionals provide reports that are outcomes focused and are able to be used to write good quality EHC Plans.	Training is provided for education, health and social care professionals to improve the quality of evidence provided. Monitoring and oversight processes are in place to ensure that advice is provided within statutory timescales.	Neil Smith (health) Michael Henning-Pugh (social care) Liz Robinson (education)	Jan 2018	Case studies Training pack embedded.	 EHCP Writing workshop.pptx
2 b) EHC needs assessments are co-ordinated and completed within statutory timescales	Plans completed within statutory timescales will ensure that support is put in place at the earliest opportunity.	Review of process of co-ordinating EHC needs assessments to ensure that it remains as streamlined as possible.	Karen Spencer	Jan 2018	SEN2 data	
2 c) EHCPs are of good quality	High quality EHCPs mean that children and young people can receive the right support to enable them to improve outcomes.	A termly audit of EHCPs seeks to monitor the improving quality and ensure that learning takes place to provide a framework of continual improvement.	Karen Spencer / Liz Robinson	Mar 2018	Termly audit reports	
Position statement	This is an area of strength. The vast majority of new EHC assessments and transfers are completed to a high standard and within statutory timescales.					

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

How effectively do we meet the needs and improve the outcomes of disabled children and young people and those who have special educational needs in Portsmouth?

3. Local Offer, short breaks and personal budgets (success criteria)

- a) The local offer is well publicised and kept under review to ensure that it continues to provide families and professionals with the information they need.
- b) Targeted and specialist **short break** care in Portsmouth is effective in meeting children and young people's needs
- c) **Personal budgets** in Portsmouth are effective in meeting children and young people's needs

Objectives	Expected impact – how will this improve outcomes?	Actions	Lead officer	By When	Evidence	Evaluation (updated quarterly)
<p>3 a) The local offer website is well publicised and kept under review to ensure that it continues to provide families and professionals with the information they need.</p> <p>To continue to promote the Local Offer and to check the effectiveness of this. (Commons Team)</p>	An effective local offer website ensures that families have the information they need to make informed decisions and to access the support they need.	<p>Monitor the effectiveness of the local offer website monthly using a 'mystery shopper' approach and incorporate feedback and improvements in the annual report.</p> <p>Review Local Offer Early Years information.</p>	<p>Jane James</p> <p>Ella Harbut</p>	<p>Sep 2017</p> <p>March 2018</p>	<p>Link to local offer website annual report</p>	 <p>Annual Report 2017 - Final 31082017.docx</p>
3 b) Targeted and specialist short break care in Portsmouth is effective in meeting children and young people's needs	Short breaks provide respite for families with a child with significant special educational needs and disabilities.	Targeted short break offer to be re-tendered in co-production with families.	Michael Henning-Pugh	Apr 2018	Link to targeted short break offer on the local offer website	

3 c) Personal budgets in Portsmouth are effective in meeting children and young people's needs	Personal budgets and direct payments enable families to have more choice and control about the way they access support.	Increasing numbers of personal budgets and direct payments to be included in EHCPs, as each EHCP is co-produced or reviewed via the Annual Review process.	Michael Henning-Pugh	Jan 2018	SEN2 data	
Position statement	This is an area of strength. Our local offer website has been co-produced with parents/carers. Targeted and statutory short breaks are in place, some support is accessed as direct payments. We are continuing to work with families to increase the take up of personal budgets (using pre-paid cards) and to ensure that short break provision is fully integrated into the EHC planning and transfer process.					

How effectively do we work in partnership with children and young people and their families to improve the outcomes for those with special educational needs and disabilities in Portsmouth?

4. Co-production (success criteria)

- a) Children and young people contribute to their assessment
- b) Parents and carers contribute to their assessment
- c) Children and young people and their parents and carers participate in decision making about local provision (strategic)

Objectives	Expected impact – how will this improve outcomes?	Actions	Lead officer	By When	Evidence	Evaluation (updated quarterly)
4 a) Children and young people contribute to their assessment.	All children and young people contribute meaningfully to their EHCP needs assessment.	All children and young people are invited to contribute to their assessment at various stages throughout the process. 'This is me' contributions received as part of the assessment and review processes will be monitored. Dynamite survey to seek children and young people's views	Karen Spencer Joe McLeish	Mar 2018 Mar 2018	Collation of contributions received. Survey results	

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4 b) Parents and carers contribute to their assessment	All parents and carers contribute meaningfully to their son/daughter's EHC needs assessment.	All parents and carers are invited to contribute to their son/daughter's assessment at various stages throughout the process. Parental contributions received as part of the assessment and review processes will be monitored.	Karen Spencer	Jul 2018	Collation of contributions received.	
		Survey to seek Parent/carers views	Barbara McDougall	Jul 2018	Survey results	
4 c) Children and young people and their parents and carers participate in decision making about local provision (strategic)	Partnership working to improve outcomes is more effective where families are involved in decision-making	All children and young people and their parents/carers are invited to a person centred coproduction meeting to coproduce their plan and to renew this annually with the education provider.	Karen Spencer	Jan 2018	Person Centred reviews - guidance for SENCOs	
		Training for parent/carers representatives is provided in order to enable them to contribute to the Inclusion Support Panel.	Karen Spencer	Jan 2018	Updated ISP Guidance / Training	
Position statement	This is an area of strength. Portsmouth has a strong history of partnership working with parents/carers and service users. Co-production with young people with SEND and their parents/carers is becoming the way of doing business in the city - both at a strategic level as well as with regards to individual assessments. A coproduction celebration event took place on 4 th July to recognise the progress that has been made so far in the area.					

How do we evaluate the effectiveness of our local area arrangements to identify disabled children and young people and those who have special educational needs; and to meet their needs and improve their outcomes?

5. Governance, accountability and joint working (success criteria)						
a) Effective strategic leadership and governance is in place b) Joint commissioning arrangements are in place for education, health and care services c) Processes are in place to identify and address areas for development						
Objectives	Expected impact – how will this improve outcomes?	Actions	Lead officer	By When	Evidence	Evaluation (updated quarterly)
5 a) Effective strategic leadership and governance is in place	Strong leadership and clear lines of accountability for the SEND Strategy will ensure that progress is made towards improving outcomes for children, young people and their families.	Refreshed SEND Strategy to be endorsed by the Children's Trust Board and Health and Wellbeing Board	Julia Katherine	Nov 2017	Link to refreshed SEND Strategy published on line	
5 b) Joint commissioning arrangements are in place for education, health and care services.	Commissioners work together effectively to assess the needs of 0-25 year olds with SEND and to jointly commission services and provision to meet their needs.	A strategic management plan is in place. A shared database is in place for the children and young people known to the High Support Needs Panel. This is used to monitor and review the provision and outcomes for this group of children, young people and their families. An annual report is taken to the Director of Children, Families and Education management team to update on outcomes for this group.	Andrea Havey/ Debbie Price/ Julia Katherine	Dec 2017	Report to DMT in Oct 2017.	

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<p>5 c) Processes are in place to identify and address areas for development</p>	<p>Where areas for development are identified and acted on by managers, there will be a cycle of continual improvement in the services and support provided to service users.</p>	<p>An annual report is provided of issues arising from tribunals, complaints and other sources of service user feedback in order to inform service improvement.</p> <p>This is reported to the Director of Children, Families and Education Management group.</p> <p>Refresh commissioning Plan.</p> <p>Needs assessment -latest performance information</p>	<p>Julia Katherine</p> <p>Hayden Ginns</p>	<p>Mar 2018</p>	<p>Annual Report</p>	
<p>Position statement</p>	<p>This is an area of strength. Robust governance arrangements are in place and there are good processes for joint commissioning both at the individual child and young person level and the strategic level. A joint needs assessment has been completed and a joint commissioning strategy is in place.</p>					

Special Educational Needs and Disabilities (SEND)

Joint Commissioning Plan

Delivery Plan Only

April 2017

Version 3



Delivery Plan Only

The SEND Joint Commissioning Plan has been agreed by the SEND Board.

This Version contains ONLY the Delivery Plan (Section D) and is used by the SEND Commissioning Steering Group to monitor progress across the wide range of Commissioning Projects and Programmes in place.

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

D1. Cognition and learning

Our Ambition:

- To enable children with cognition and learning difficulties to be educated mainstream settings wherever possible, ensuring that Special Schools are focussed on those with the most complex needs.
- To enable children with complex cognition and learning difficulties to be educated within the city wherever possible
- To ensure multi-disciplinary support is in place to support the successful inclusion of children in mainstream education.

SEND Strategy Link:

Strand A: Promote good inclusive practice to improve outcomes

Strand C: Effective joint commissioning to improve outcomes

Commissioning Project/Programme	Leads	Completion By	Key Milestones	Progress
1.1 Cliffdale and Redwood Park special schools to be re-designated and remodelled to enable them to effectively educate children with complex learning difficulties and autism. To ensure all parents are engaged and communicated to about the changes.	Julia Katherine (PCC)	Sept 2018	<ol style="list-style-type: none"> 1. Redesignation of Redwood Park - complete 2. Admission criteria and banding description updated - Apr 17 - Underway 3. Redesignation of Cliffdale - July 17 - Underway 	Green
1.2 To ensure the SLA and service spec for the outreach offer provided by Special Schools to support mainstream schools to meet the needs of those with cognition and learning needs.	Julia Katherine (PCC)	Sept 2017	<ol style="list-style-type: none"> 1. Current outreach offer presented to PEP Inclusion Group 2. Feedback from schools 3. Revised service specification - Sep 17 	Green

D2. Communication and interaction (including speech, language and communication needs and autism)

Our Ambition:

- To enable children with communication and interaction needs to be educated in Portsmouth and in mainstream settings, wherever possible
- To ensure multi-disciplinary support is in place to support the inclusion of children in mainstream education
- To ensure speech and language services and pathway meets statutory requirements and supports the inclusion agenda
- To ensure autism pathway meets statutory requirements, supports the inclusion agenda and enables young people with autism to make a successful transition to adulthood

SEND Strategy Link:

Strand A: Promote good inclusive practice to improve outcomes

Strand C: Effective joint commissioning to improve outcomes

Commissioning Project/Programme	Lead	Completion By	Key Milestones	Progress
2.1. A new 6-place Inclusion Centre (additionally resourced provision) to be opened at Trafalgar School in September 2016 for 11-16 year olds with an EHC plan for communication and interaction difficulties, specialising in autism spectrum conditions.	Julia Katherine (PCC)	Sept 2016	COMPLETE	COMPLETE
2.2. A new 9-place Inclusion Centre (additionally resourced provision) to be opened at Devonshire Infant School in September 2017 for 4-7 year olds with an EHC plan for communication and interaction difficulties, specialising in speech, language and communication needs.	Julia Katherine (PCC)	Sept 2017	1. Updated admission criteria - Mar 17 2. Special ISP meeting to be held to allocate places - Apr 17 3. Placements begin - Sep 17	Green

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

2.3 A new 9-place Inclusion Centre (additionally resourced provision) to be opened at Portsdown Primary School in September 2017 for 4-11 year olds with an EHC plan for communication and interaction difficulties, specialising in speech, language and communication needs.	Julia Katherine (PCC)	Sept 2017	<ol style="list-style-type: none"> 1. Updated admission criteria - Mar 17 2. Special ISP meeting to be held to allocate places - Apr 17 3. Placements begin - Sep 17 	Green
2.4 Joint review of the health and education offer and outcomes for the children in each of the five Inclusion Centres to ensure it is meeting the needs and statutory requirements.	Lois Pendlebury (Solent NHS) Julia Katherine (PCC)		<ol style="list-style-type: none"> 1. Joint visits to schools by education and Solent - Summer term 2. Clear description of current health offer and gaps - May 2017 3. Proposal to SEND Commissioning Steering Group - May 2017 	Green
2.5 Complete an Autism Strategy and revised autism pathway for young people age 0 - 25	TBC	Dec 2017	Meeting on 17 th May to discuss	Red
2.6 To review the impact of the Autism Co-ordinator role	Andrea Havey (CCG)	July 2017	<ol style="list-style-type: none"> 1. Report from Solent NHS Trust to be submitted to ICS by beginning August 2017 2. Evaluate pilot project with Solent NHS Trust and present a business case to CSC if additional funding required to 	Green

			continue Autism Navigator post.	
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DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

D3. Sensory and physical

Our Ambition:

- To enable children with sensory and physical needs to be educated wherever possible in mainstream settings.
- To ensure multi-disciplinary support is in place to support the inclusion of children in mainstream education
- To ensure there are minimal waiting times for key pieces of equipment

SEND Strategy Link:

Strand A: Promote good inclusive practice to improve outcomes

Strand C: Effective joint commissioning to improve outcomes

Commissioning Project/Programme	Lead	Completion By	Key Milestones	Progress
3.1 To review the primary Inclusion Centre (additionally resourced provision) for sensory impairment at Northern Parade Infant and Junior Schools.	Julia Katherine (PCC)	Sept 2017	1. Formal review - Mar 17 2. Changes made to Service Level Agreement 3. Implementation against new SLA - Sep 17	Green
3.2 To develop a secondary Inclusion Centre (additionally resourced provision) for sensory impairment at St Edmunds Catholic School.	Julia Katherine (PCC)	Sept 2016	COMPLETE	COMPLETE
3.3 Joint review of the health and education offer and outcomes for the children in each of the two Inclusion Centres to ensure it is meeting needs and statutory requirements	Julia Katherine (PCC) Lois Pendlebury (Solent NHS)		1. Joint visits to schools by education and Solent - Summer term 2. Clear description of current health offer and gaps - May 2017	Green

			3. Proposal to SEND Commissioning Steering Group - May 2017	
3.4 To evaluate the wheelchair provider to ensure minimal waiting times for receipt of wheelchairs	Andrea Havey (CCG)		<ol style="list-style-type: none"> 1. Performance report to SEND Steering Group - complete 2. Updated performance report to SEND Commissioning Group - Jan 17 - Complete 3. Agreed joint approach with Hampshire Commissioner to address performance - May 17 	Amber

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

D4. Social emotional and mental health (SEMH)

Fully aligned with Future in Mind Transformation Plan

Our Ambition:

- To establish a clearly understood needs-led model of support for children and young people with SEMH difficulties across the city that makes the best use of the resources available
- For all professionals working with children and young people to have a shared understanding of SEMH and to promote resilience and emotional wellbeing in their work with children and young people
- To ensure there is a range preventative and early help support available to children and young people to prevent SEMH difficulties escalating
- To jointly commission a clear pathway of support (including prevention, early help and intensive therapeutic intervention) and provision for SEMH which ensures that difficulties are picked up and addressed at the earliest opportunity and that those with more complex needs can access the specialist support available.

SEND Strategy Link:

Strand A: Promote good inclusive practice to improve outcomes

Strand C: Effective joint commissioning to improve outcomes

Strand E: Early intervention for children with SEND and their families

Commissioning Project/Programme	Leads	Completion By	Key Milestones	Progress
4.1 To complete a CAMHS Needs Assessment	Andrea Havey (CCG)	Jan 2017	1. Draft to FiM Steering Group - Complete 2. Recommendations discussed at SEND Commissioning Group - Jan 17 - Delayed	Red
4.2 To review and remodel the SEMH educational provision delivered by The Harbour School to	Julia Katherine (PCC)	Sept 2017	1. Secure additional strategic support from Delta Education Trust - Complete	Green

commission distinct pathways for Alternative Provision (AP) and Special Educational Needs (SEN) provision.			2. Revised Service Level Agreement for Harbour - Mar 17 3. Revised provision in place - Sep 17	
4.3 Develop a single CAMHS Specification - reviewing the service in the context of inclusion, the needs of children in the Harbour school and Multi-Agency Teams including restorative practice	Andrea Havey (CCG)		1. Xxx 2. Xxx 3. Xxx 4. Xxx	Red
4.4 To commission an Early Help (pre-CAMHS) community based service that supports early intervention and prevention for children and young people between 11 - 25 years of age and their families. Ensure appropriate pathways into CAMHS provision for children and young people with mental health needs.	Andrea Havey (CCG)	Mar 2017	1. Procurement exercise - Complete 2. Mobilisation plan for new provider - Complete 3. Referral pathway and assessment process in place - Underway	COMPLETE
4.5 To develop a strategy that will lead to effective whole school approaches in supporting pupils social, emotional and mental health wellbeing across Portsmouth schools.	Sarah Christopher (FiM/School)	Feb 2017	1. Draft Strategy - Complete 2. Final published strategy - Underway 3. Revised governance arrangements for implementation linked to Stronger Futures and PEP Inclusion Group - Underway 4. Delivery Plan in Place - Underway	Green
4.6 To enhance the Eating Disorder service locally to ensure children and young people get expert help	Andrea Havey (CCG)		COMPLETE	COMPLETE

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early and are treated with effective evidence based treatment.				
4.7 Portsmouth CAMHS joined up with a Children and Young People IAPT collaborative in 2017 which will improve collaborative practice between therapists, children, young people and their families.	Andrea Havey (CCG)	April 2018	<ol style="list-style-type: none"> 1. Identify key staff to take part in the programme - Apr 17 2. CYP IAPT Steering Group to be set up to drive the implementation of programme - Aug 17 3. CAMHS staff to attend Leadership, Supervision and CBT courses - Nov 2017 	Green
4.8 To review the self-harm pathway from hospital into the acute and community services with the aim of developing an integrated paediatric mental health liaison service.	Andrea Havey (CCG)		<ol style="list-style-type: none"> 1. Working Group set up - Complete 2. Decision-making tool developed 3. Self-harm training delivered - Complete 	Green
4.9 To enhance the crisis care offer in CAMHS through the recruitment of a Crisis Care post that will assess, treat and risk manage young people	Andrea Havey (CCG)		COMPLETE	COMPLETE
4.10 To enhance the YOT CAMHS Provision	Andrea Havey (CCG)		COMPLETE	COMPLETE
4.11 To develop low-cost responses to child anxiety	Sarah Christopher Sonia King (Solent)		<ol style="list-style-type: none"> 1. Xxx 2. Xxx 3. Xxx 4. Xxx 	Red

4.12 To develop the response to primary age children with mental health concerns			<ol style="list-style-type: none"> 1. Xxx 2. Xxx 3. Xxx 4. Xxx 	Red
4.13 Update SEMH Ordinarily Available Provision	Sarah Christopher and PEP Inclusion Group Sub Group	Sept 2017	<ol style="list-style-type: none"> 1. Draw together working group - underway 2. Agree scope 3. Return to Steering Group in July 17 for consideration on links to MATs provision 	Green
4.14 To roll-out Restorative Practice in 10 - 15 'trailblazer' schools	Hayden Ginns (PCC)	Sept 2017	<ol style="list-style-type: none"> 4. Identify trailblazer schools - Complete 5. Deliver training to school-based Restorative Champion - Sept 2017 - Underway 6. Create schools network - Underway 7. School level Action Plan in each school - Oct 2017 8. Publish first evaluation - Jan 2018 	Green

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

D5. Pre-birth to 5: SEND provision for pre-school children

SEND Strategy Link:

Strand A: Promote good inclusive practice to improve outcomes

Strand C: Effective joint commissioning to improve outcomes

Our Ambition:

- To enable pre-school children with SEND to access mainstream pre-school settings wherever possible
- To ensure multi-disciplinary support is in place to support the inclusion of children in mainstream early education settings

Commissioning Project/Programme	Lead	Completion By	Key Milestones	Progress
5.1 To review and remodel the pre-school SEN education and childcare provision to ensure that children can be supported within their mainstream pre-school and childcare setting wherever possible.	Julia Katherine (PCC)	Sept 2018	<ol style="list-style-type: none"> 1. To secure external consultant resource to develop a range of models - Complete 2. Project scope discussed at SEND Commissioning Group - Complete 3. Consultation with parents - Summer Term 4. Formal consultation on preferred model - Autumn Term 5. Lead member decision - Nov 2017 	Green
5.2 To develop the Single Point of Access (including multi-disciplinary assessment) for health and developmental assessment and align with the statutory Education Health and Care Plan process.	Lois Pendlebury (Solent NHS)		<ol style="list-style-type: none"> 1. Mapping key pathways e.g. Autism, 0-5s etc - July 2017 2. To develop standard operating procedures for 	Green

	Julia Katherine (PCC)		internal health referrals - Sept 2017 3. Co-location of Falcon House and Battenburg Ave - 2018 4. Consideration of establishment of SEND/High Needs hub across health, and education - 2018	
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D6. Transition into adulthood				
Our Ambition: <ul style="list-style-type: none"> To ensure young people with SEND have successful transitions into adulthood (link to PfA outcomes) To enable post-16 education settings to be fully inclusive To increase the numbers of 16-25 year olds with SEND in education, employment or training 				
SEND Strategy Link: Strand A: Promote good inclusive practice to improve outcomes Strand F: Effective preparation for adulthood and smooth transitions to adult services				
Commissioning Project/Programme	Lead	Completion By	Key Milestones	Progress

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6.1 To review the transition arrangements from CAMHS services to adulthood in the context of revised CAMHS offer 0 - 25	Andrea Havey (CCG)		<ol style="list-style-type: none"> 1. Xxx 2. Xxx 3. Xxx 4. Xxx 	Red
6.2 Ensure robust post-16 education provision is in place for young people with SEND	Amanda Percy (PCC)		<ol style="list-style-type: none"> 1. Curriculum Mapped and gaps in provision is identified. Consultation to secure required provision. 2. Development of Supported Internships Programme 3. Support post-16 providers to develop transition support both into and from post-16 education and training. 4. Monitor participation and put in place effective support for those young people at risk of not progressing or who are NEET. 	Green
6.3 Deliver the PFA Outcomes Plan	Mark Stables (PCC)		<ol style="list-style-type: none"> 1. PFA Outcomes plan completed - Green <p>Most recent plan indicates number of Reds and Ambers but progress is being made</p>	Amber

D7. Parent and families support

Our Ambition:

- To ensure the parents and carers of children with SEND are provided with appropriate advice, information and support
- To locally embed the ambitions of Future in Mind transformation programme in responding to infant mental health
- To ensure Local Offer website is widely used as the single point of information for parents and carers of children with SEND

SEND Strategy Link:

Strand E: Early intervention for children with SEND and their families

Commissioning Project/Programme	Lead	Completion By	Key Milestones	Progress
7.1 To commission an early intervention service for women with mild to moderate mental health issues in the perinatal period.	Andrea Havey (CCG)		COMPLETE	COMPLETE
7.2 To enhance the Infant Mental Health provision locally to support parents in the family home to focus on the attachment relationship with their babies aged 0 -2 years.	Andrea Havey (CCG)		COMPLETE	COMPLETE
7.3 To develop a community based specialist perinatal mental health team in Portsmouth for women experiencing severe and complex mental health issues during the perinatal period.	Andrea Havey (CCG)		COMPLETE	COMPLETE
7.4 Revised Parenting Pathway (linked to Stronger Futures Strategy and incorporating restorative practice	Hayden Ginns (PCC)		1. Multi-agency Mini-Team set up - complete 2. Underpinning model of practice agreed - Feb 17	Green

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

			3. Revised Pathway consulted upon and published - Apr 17 4. Training in place for professionals - May 17	
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D8. Personal budgets

Our Ambition:

- To enable as many families as possible to make use of personal budgets, in line with the national ambitions of the SEND reforms

SEND Strategy Link:

Strand B: Successful implementation of the SEND reforms

Commissioning Project/Programme	Lead	Completion By	Key Milestones	Progress
8.1 Pilot of the new Personal Health Budget methodology with a small number of Children with SEND to inform a wider rollout at a later stage if successful.	Jo Atkinson (ICU) Jo York (CCG)		1. Pilot with a small number of children - In process 2. Learning report completed - Delayed 3. Roll-out plan for personal budgets	Amber

D9. Decision-making for high cost placements

Our Ambition:

- To ensure that children who require high-needs placements are effectively identified and good multi-agency decision-making on placement, funding and reviews are in place.

SEND Strategy Link:

Strand B: Successful implementation of the SEND reforms

Commissioning Project/Programme	Lead	Completion By	Key Milestones	Progress
9.1 Review of High Needs Panel	Julia Katherine (PCC) Andrea Havey (CCG)		1. Revised Terms of Reference - complete 2. Referral form updated - complete 3. Implementation - underway	Green
9.2 Analysis of current out of city placement cohort	Julia Katherine (PCC) Hayden Ginns	Sep 2017	1. Scope of analysis completed - July 2017 2. Commissioning implications discussed at SEND Commissioning Group - Oct 2017	Green

SEND Early Identification and Early Support Delivery Plan

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

Objectives	Expected impact – how will this improve outcomes?	Actions	Lead officer	By When	Evidence	Evaluation (updated quarterly)
<p>1. Carry out a review of Early Years Panel</p> <p>Page 98</p>	<p>Early Years Panel fulfils the statutory duty to share information between health and education about pre-school aged children who are likely to have special educational needs and require additional support at school.</p> <p>Information about children known to Early Years Panel is used to inform commissioning priorities (e.g. commissioning special school places). CCN, School Nurse provision, Early Years settings, mainstream schools, equipment and outreach support.</p> <p>Early Years Panel is efficient and effective.</p>	<p>Links with outreach support Transitions - managed appropriately. Send Inclusion Fund - How it fits.</p> <p>Review process of panel and membership</p>	Liz Robinson	March 2018		
2. Update the Early Years Pathway (on the local offer)	The Early Years Pathway published on the Local Offer website is up to date and demonstrates early identification of SEN and the provision of timely support.		Ella Harbut			

3. Consider the effectiveness of key working for pre-school age children with SEND.	<p>Families with a pre-school age child with SEND have access to a key worker to help them 'navigate through the system'.</p> <p>Key workers are clear about their role and can provide accurate information about education, health and care services available to support families.</p>		Carol Stevens & Sharon Ensor			
4. The views of parents and carers are sought and used to inform any changes that are made to the way in which services are delivered.	<p>Parents and carers have the opportunity to work in co-production with commissioners and providers to review and shape the services that are available to support them.</p> <p>Parents and carers report that they feel listened to and that their input has helped to improve processes and services.</p>	<p>Seek feedback from parents through</p> <ul style="list-style-type: none"> - ECAF - SBFT - Portage coffee morning - Willow parents - Early Years Cluster 	Kara Jewell & Louisa Paston			

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion
Preparing for Adulthood Group Action Plan 2017 - 2018

PfA Sub-Group Outcome 1: To be assured that the Education, Health and Care Planning process identifies and works towards the realisation of PfA outcomes for those in transition					
PFA Objective 1.1: To establish if current EHCPs identify and support the realisation of PfA outcomes					
Action	Measures	Lead	Timescale	Progress comments	RAG rating
1.1.1. To establish a task and finish group to undertake an audit of current EHCPs	Task and finish group established with appropriate membership.	Sharon Cooper/Mark Stables / Amanda Percy	Mar 17	Completed	Green
1.1.2. To audit 50 current EHCP's	50 plans audited.	As above	July 17	3 completed future meeting dates set	Amber
1.1.3. To produce recommendations for the SEND board.	Report sent to SEND board.	As above	Sep 17		Red

PFA Objective 1.2: To explore good practice relating to the PfA outcomes and benchmark against local practice.					
Action	Measures	Lead	Timescale	Progress/ comments Progress / Progress /	RAG rating
1.2.1 To review current local practice against NICE guidance	The PfA group will agree how local practice fits against the guidance and will respond or update action plan accordingly.	All	May 17 - next meeting		Amber
1.2.2 To make links with the 'Ready, Steady, Go' project and explore the possibility of piloting on a wider scale	Information to PfA group to enable decision to conduct pilot or not.	Lois Pendlebury	May 17	Lois invited to next meeting	Amber
1.2.3 To review range of planning tools and consider how they may work together/best	Inventory of tools. Agreement re role of each and consideration to one overall planning summary form	PfA group	Nov 17		Red

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

PfA Objective 1.3: To ensure appropriate tools are available to support the PfA outcomes					
Action	Measures	Lead	Timescale	Progress comments	RAG rating
1.3.1 Through being a National Demonstration Team for inclusion (NDTi) PfA demonstration site, develop information and decision-making tools which support the PfA outcomes.	Tools for each PfA outcome to be shared with the PfA group and agreed to be fit for purpose. Self-assessment tools to be shared with PfA group that support identification of need and determination of eligibility	Mark Stables	May 17	Outcomes Planning overview in place. Draft Housing Tool	Amber
1.3.2 To Review the Local Offer with respect to whether it provides information of a nature and in a form that supports planning for PfA outcomes	Group will prepare report and present recommendations to SEND Board	PfA group	July 2017	Dynamite Audit completed	Amber
1.3.3 To develop an exemplar page for Local Offer and principles to inform the content of all pages	Page to come back to PfA Group List of principles To be then shared with SEND Board	Dynamite/Lily and Lime	July 2017		Red

1.3.4 Local Offer to be developed to form comprehensive and coherent Offer consisting of both information and tools (to go beyond a directory of Services). Linking with PCC website work	Priority list of pages needed to be established Pages to be developed	PfA group Sara Langston	Aug 2017	Some tools developed. And work to develop exemplar	Amber
PFA Sub-Group Outcome 2: To be assured that the EHC Planning process supports commissioning including for people with autism					
PFA Objective 2.1: To explore how to collate information from PfA outcomes in ECHPs to inform commissioning					
Action	Measures	Lead	Timescale	Progress comments	RAG rating
2.1.1 To establish what mechanisms are in place currently to collate information.	Information to PfA group	Sharon Cooper	May 17	Sharon looking at what is in place and what can be developed	Amber
2.1.2 To explore what mechanisms are used elsewhere	Information / options to PfA group to inform further actions	Mark Stables	May 17	Contact being made with Kingston	Amber
2.1.3 To explore how other NDTi pilot sites looking at commissioning are tackling / addressing this.	Information / options to PfA group to inform further actions	Mark Stables	May 17	As above	Amber

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2.1.4 To use planning with a cohort of people with autism as part of Partners in Policymaking to develop commissioning intentions and inform the Autism Strategy and wider commissioning	Recommendations contained in Partners in Policy making Report	PiP	June 18	Ptmth College signed up. Anticipated start Sept	Amber
PFA Objective 2.2: To be assured / ensure there are clear pathways for assessment and support for people with including people with autism					
Action	Measures	Lead	Timescale	Progress / comments	RAG rating
2.2.1 To collaborate with the Autism Board on its development of an Autism Strategy to establish clear pathways for assessment and support by Adult Social Care services for people with autism. Carry out Gap analysis to identify and respond to the needs of young people who have been receiving support form children's services but who are not able to get support from adult services. To inform local planning and commissioning	Updates to PfA group outlining: <ul style="list-style-type: none"> • Clarity of responsibilities and • Tools and methods 	Barbara McDougall Mark Stables	Initial Strategy meeting 30.3.17	Planning group established to refresh strategy	Amber
2.2.2 To explore the extent to which assessments and support planning tools can be aligned to promote continuum	Identification of range of assessment and support planning tools for consideration	Sharon Cooper/Mark Stables/Ian	July 17 Aug 17		Red

	Secured commitment of stakeholders to consideration of amendment Aligned formats developed	Chalcroft/Andy Biddle	Nov 17		
PFA Sub-Group Outcome 3: To be assured that processes enable effective transition for people into and following on from college.					
PFA Objective 3.1: To support / oversee the Partners in Policymaking project with which will work with two cohorts (one of people with Autism) to ensure the planning process is cumulative and a continuum is established from school to college into adulthood.					
Action	Measures	Lead	Timescale	Progress comments	RAG rating
3.1.1 To explore the extent to which the college curriculum can focus on PfA outcomes	To be assured that the college curriculum supports the PfA outcomes as far as is possible	Sharon Cooper Amanda Percy	Ongoing Partners in Policy making Sept 2017	PiP Meeting with Colleges April	Amber

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3.1.2 To explore and identify opportunities and challenges to maximise collaborative working	Process in place that ensures that any service which complements college input is working with the college to support achievement of outcomes identified in the EHCPlan	As above	As above	Sept 2017	Amber
3.1.3 Work with stakeholders to develop innovative ways of planning that produce EHCPs that identify clear aspirational outcomes and an Action Plan that supports their achievement	P in P Report Comparative data - start and end of project	As above	As above	Sept 2017	Amber
3.1.4 To be the core membership of the PiP Project Board and in that capacity to consider the Final Report and take forward recommendations	Development and implementation of action plan developed from recommendations included in the PiP Report	PfA group	As above	Sept 2017	Amber
3.1.5 Bring Colleges together to <ul style="list-style-type: none"> Review outcomes from recent SEND area inspections Share good practice around planning, co-production and transition to and from Post-16 Receive updates on the changing Adult Services provision in Portsmouth and look at opportunities 	Event	Amanda P Sharon Cooper ongoing	6 th April 2017	Actioned	Green

<ul style="list-style-type: none"> for developing joint programmes PfA outcomes 					
<ul style="list-style-type: none"> Provide an opportunity for young people to be asked if services have helped to achieve their identified outcomes (could link to 2.1.1?) Feedback to the young person about the effect their involvement has had (2.1.1.?) 					
<ul style="list-style-type: none"> Develop a process that supports the young person to make decisions and builds their confidence to direct their own care and support over time, to include fully involving the young person in planning, implementation and review and agreeing outcomes. (Link with 2.2.2.?) 					
<ul style="list-style-type: none"> Develop a joint mission statement (Health and social care service managers) in children's and adult services to develop a joint mission statement or vision for transition, agreeing shared transition protocols and approaches (could this link with 3.1.3?) 					
<ul style="list-style-type: none"> Develop Advocacy service to support people through transition where required. 					
<ul style="list-style-type: none"> Build into plan, opportunities for the young person to visit and experience 					

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<ul style="list-style-type: none">• Consideration should be given to health input where an individual does not have specialist health involvement, e.g. GP?					
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DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion



SEND Board Performance Framework Quarterly Report Quarter 2 - July - September 2017



- I. Introduction
- II. Performance Summary
- III. Local Area SEND information
- IV. Performance Data
 - A. Outcome Indicators
 - B. Inputs, Outputs & Process Indicators
 - C. Demand Management Indicators
 - D. Experience of the system narrative
 - E. What's trending report

I. INTRODUCTION

The aim of the special educational needs and disability (SEND) strategy is to promote inclusion and improve the outcomes for Portsmouth children and young people aged 0-25 years with SEND and their families.

In order to improve outcomes, we aim to ensure that there are in place a range of high quality support services that contribute to removing the barriers to achievement for all Portsmouth children and young people, in particular those with special educational needs and disabilities. This includes enabling children and young people to lead healthy lives and achieve wellbeing; to benefit from education or training, with support, if necessary, to ensure that they can make progress in their learning; to build and maintain positive social and family relationships; to develop emotional resilience and make successful transitions to employment, higher education and independent living.

Key outcomes to be achieved.

The strategy aims to achieve increased percentages of children and young people with SEND who are able to:

6. Be included within their local community,
7. Lead healthy lives and achieve wellbeing,
8. Learn and make progress,
9. Make and maintain positive relationships within their family and community
10. Participate in education and training post-16 and prepare for employment

The quarterly performance reports provide the SEND Board and Children's Trust Board with key data to understand performance at a system-wide level, and to manage the impact of work in support of the overarching SEND strategy.

There are six strands of the SEND Strategy:

Strand A: Promote good inclusive practice to improve

Strand B: Successful implementation of the SEND reforms

Strand C: Effective joint commissioning to improve outcomes

Strand D: Co-production, embedded as a way of working with children, young people and their parents and carers

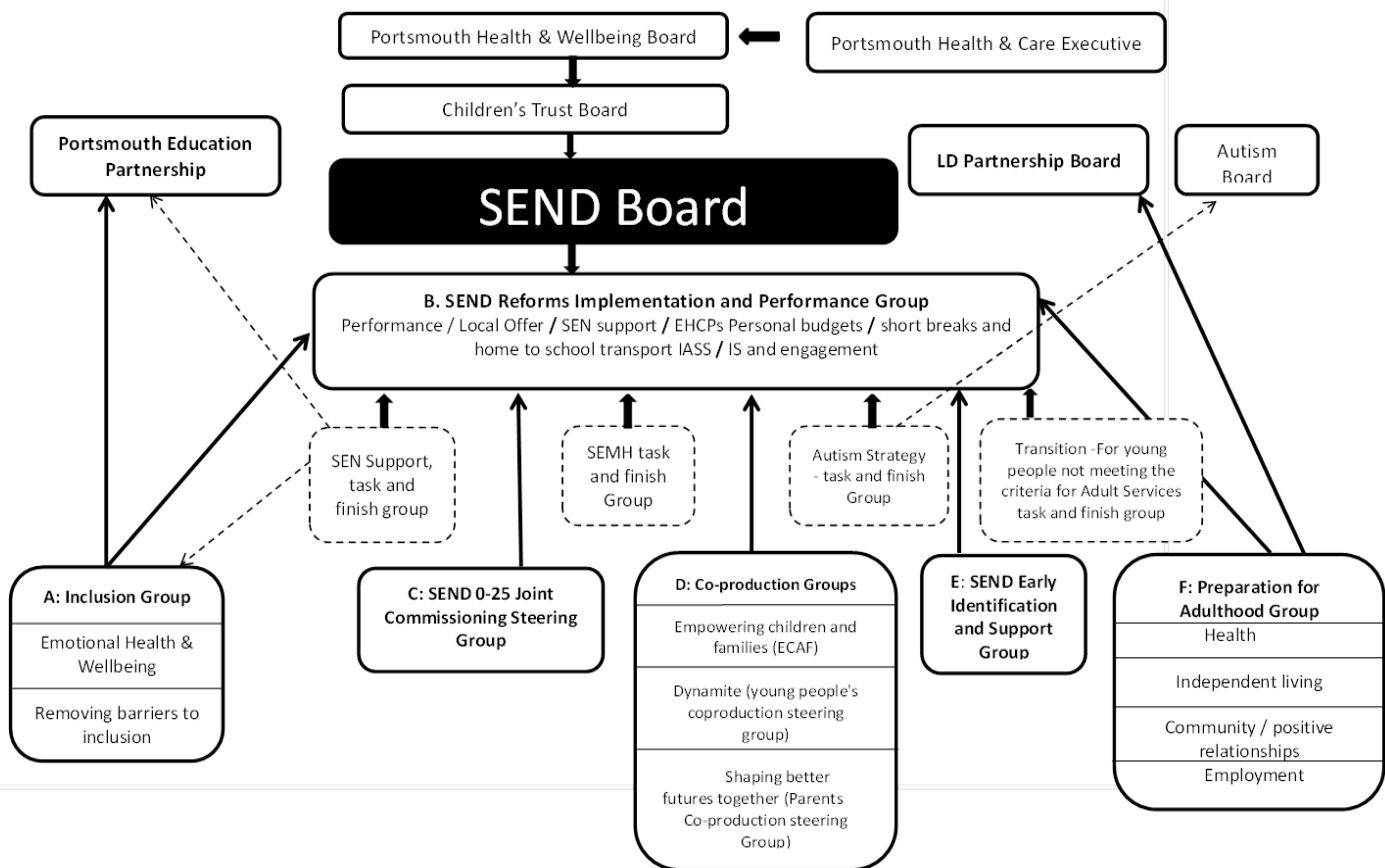
Strand E: Early identification and early support for children with SEND and their families

Strand F: Effective preparation for adulthood and smooth transitions to adult services

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Performance Management Reporting Structure

Special Educational Needs and Disability (SEND) Strategy: Governance and Accountability Framework



PERFORMANCE SUMMARY

1. Areas of good performance

- a) In relation to timely issue of EHC plans, Portsmouth is performing above the national average.
- b) Fewer statements have been discontinued as part of the transfer process than the national average.
- c) Participation of young people at age 17 and 18 is positive for young people with an EHCP. The latest data is 91% national and 95% for Portsmouth.

2. Encouraging signs of Improvement

- a) In 2015/16, a smaller percentage of statements were transferred to plans than the national average. Transfers will have significantly increased during 2016/17, and we retain confidence that we will achieve the March 2018 deadline.
- b) We are working towards completing EHCPs for year 11 and 12.
- c) Rates of progress of pupils on SEN support, whilst still a priority area, improved significantly in KS2 Reading from -4.0 to -2.5 and slightly in Maths -3.8 to -3.1.
- d) In relation to settled accommodation, we have moved from 60/40 Residential Care care/Supported Living split 4 years ago to 42/58 now. A recent ADASS commissioned Report concluded that we are the 3rd highest in the South East region in terms of proportion of Supported Living.

3. Areas for Concern and proposed responses

- a) The percentage of pupils on SEN support meeting age related expectations in KS1 and KS2 remained significantly below national average in 2017. Progress in Writing at remains of concern -4.8 to -4.7.
- b) Attendance is a general concern for Portsmouth, although this is improving - significant improvement needs to be made at out SEMH special school.
- c) In relation to fixed period exclusions, this picture was not improving and the disproportionate representation of the SEN statement/EHCP population was increasing. Pupils with SEMH as a need type dominate amongst the pupils with exclusion incidents, and that this is most prevalent amongst the special school pupils. Permanent exclusions are very low.
More needs to be done to support the progression in education, employment and training of young people with SEND support and this will be a focus of work moving forward.

4. Further Observations

- a) The take-up of personal budgets so far has been low, and relates to those families who have taken up school transport budgets. This is likely to gradually increase over time, with personal budgets for respite included as part of the transfer process.

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- b) Portsmouth continues to have low numbers of appeals to tribunal. The SEND team works hard to co-produce EHCPs in partnership, resulting in a relatively small number of cases where there is a disagreement.
- c) Data received in response to our POET survey was broadly positive
- d) There is little data supporting our activity around transition - this could be an area of focus.

5. Recommendations to the SEND BOARD

Note that Behaviour and Attendance group will consider data relating to attendance and exclusions at January meeting.

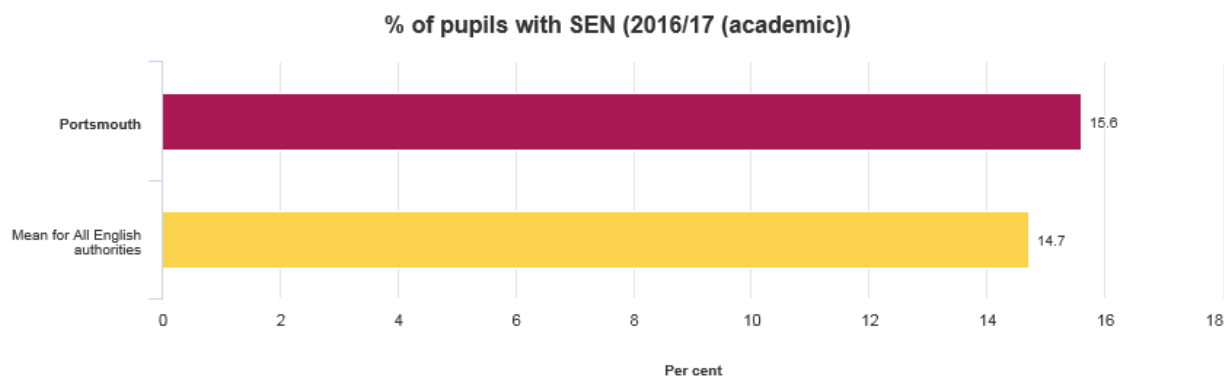
Note that CAMHS indicators are still not available.

Note plans for increased systematic capture of child, young person and parent feedback.

Consider what information may be useful in relation to transition.

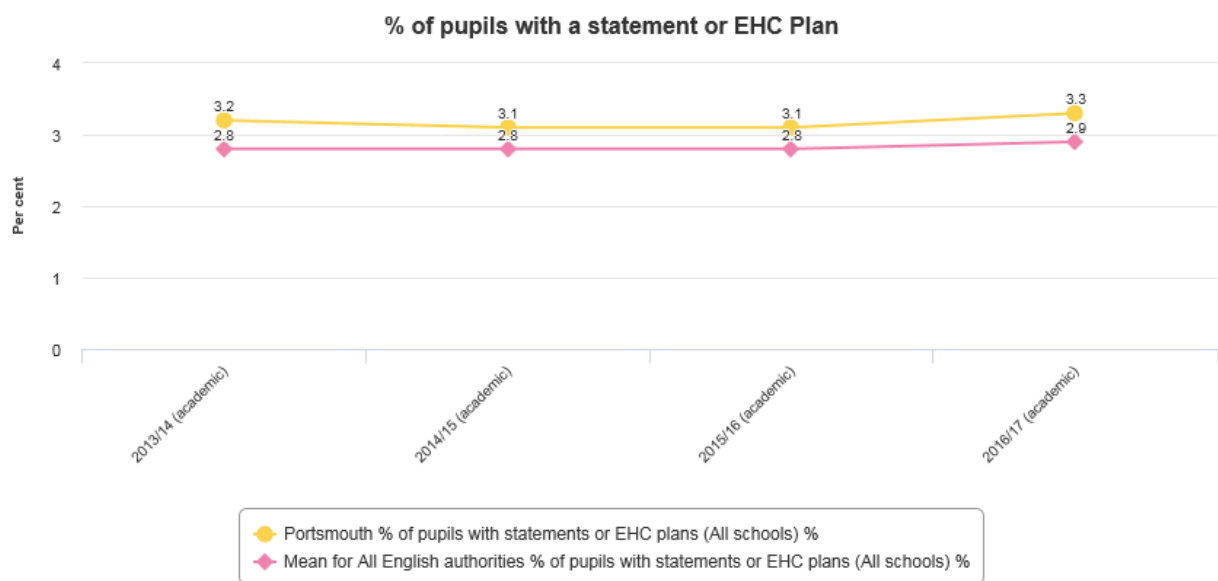
II. Local Area SEND information (inclusion in the community)

NB these figures, and those in the first three charts below, are for pupils attending schools in Portsmouth. They do not include children and young people for whom Portsmouth is responsible but has placed out of borough.



Source:
Metric ID: 2212, Department for Education, Special Educational Needs in England

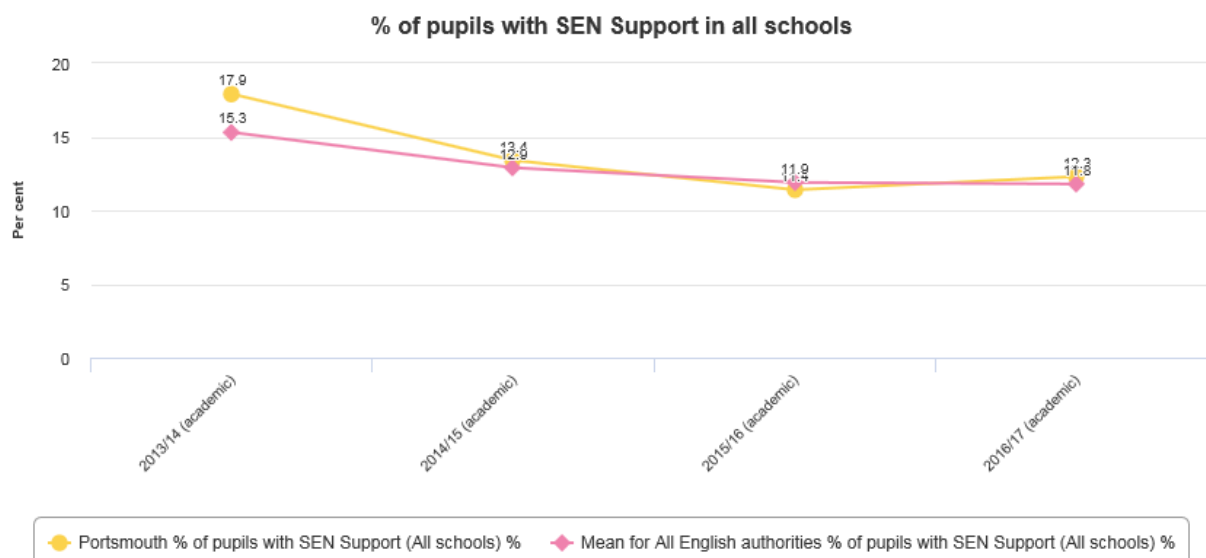
Across All English authorities, the proportion of pupils with statements or education, health and care (EHC) plans ranges from 0.8% to 4.5%. Portsmouth has a value of 3.3%, compared to an average of 2.9% in All English authorities.



Source:
Metric ID: 2213, Department for Education, Special Educational Needs in England

For SEN support the proportion for All English authorities ranges from 6.5% to 16.8%. Portsmouth has a value of 12.3%, compared to an average of 11.8% in All English authorities.

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Source:
Metric ID: 2214, Department for Education, Special Educational Needs in England

Commentary

The percentage of pupils identified as having SEN is slightly lower in Portsmouth than the national average, although the percentage of pupils with a statement or EHC is slightly higher in Portsmouth than the national average.

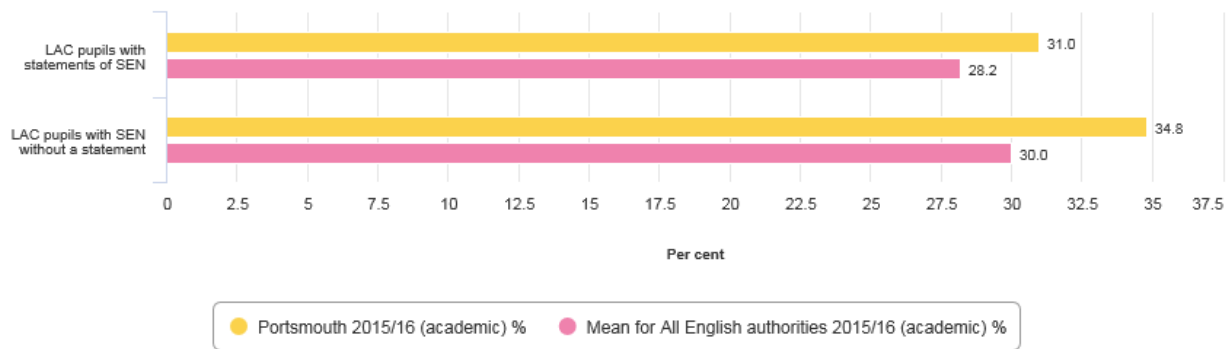
These are likely to be accurate figures, given the Portsmouth demographic, and have remained stable over the past few years.

The percentage of pupils with SEN Support has come more closely in line with the national average as SENCO have become more confident and consistent in identifying need, supported by professional development through the SENCO Network and seconded SENCO programme both of which began in 2013.

Looked after children and Children in need.

Looked after children are defined as those looked after by the local authority for one day or more. In Portsmouth, 34.8% of looked after children are on SEN support, compared to 30.0% in All English authorities. 31.0% of looked after children in Portsmouth have a statement of SEN or EHCP, compared to 28.2% in All English authorities.

% of looked after children with statements of SEN and % looked after children with SEN without a statement (2015/16 (academic))

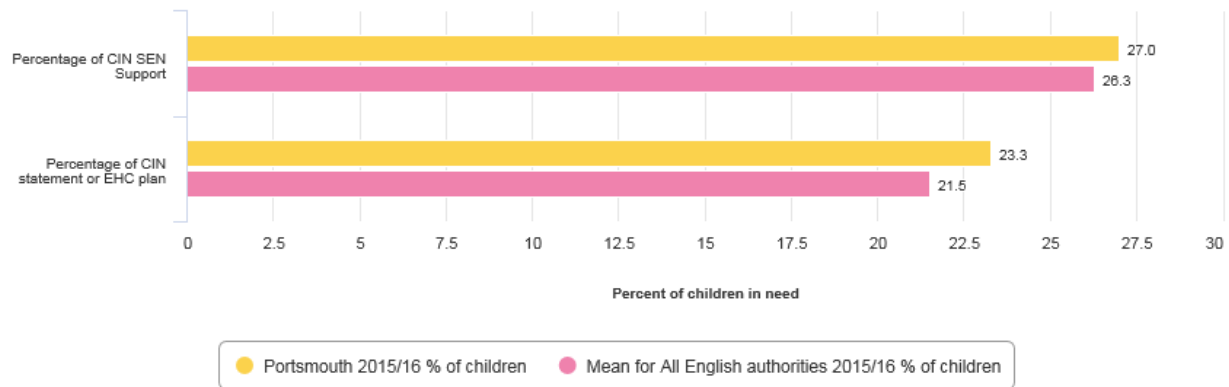


Source:

Metric ID: 2133, Department for Education, Outcomes for Children Looked After by Local Authorities in England

Metric ID: 2134, Department for Education, Outcomes for Children Looked After by Local Authorities in England

% of children in need with SEN support and % of children in need with statements or EHC plans (2015/16)

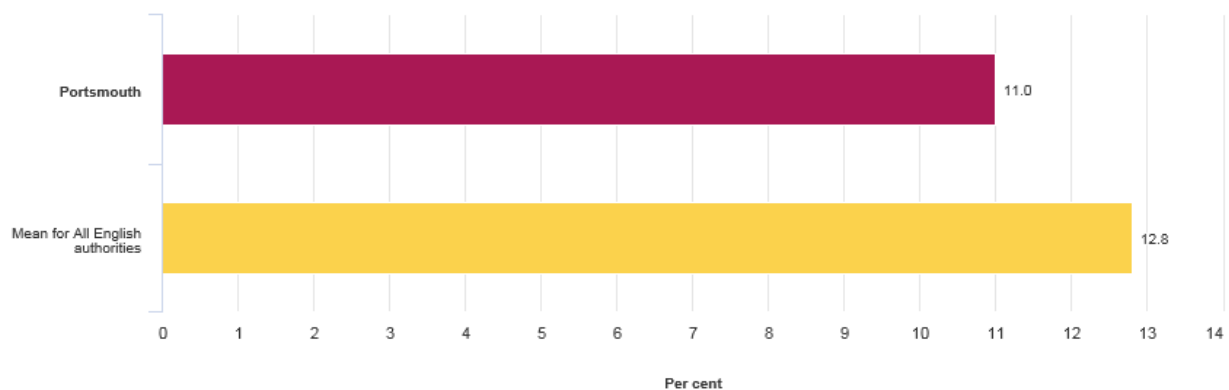


Source:

Metric ID: 4852, Department for Education, Characteristics of Children in Need in England: Outcomes tables

Metric ID: 4855, Department for Education, Characteristics of Children in Need in England: Outcomes tables

% of children in need with a disability (2015/16)



Source:

Metric ID: 2246, Department for Education, Characteristics of Children in Need in England

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COMMENTARY

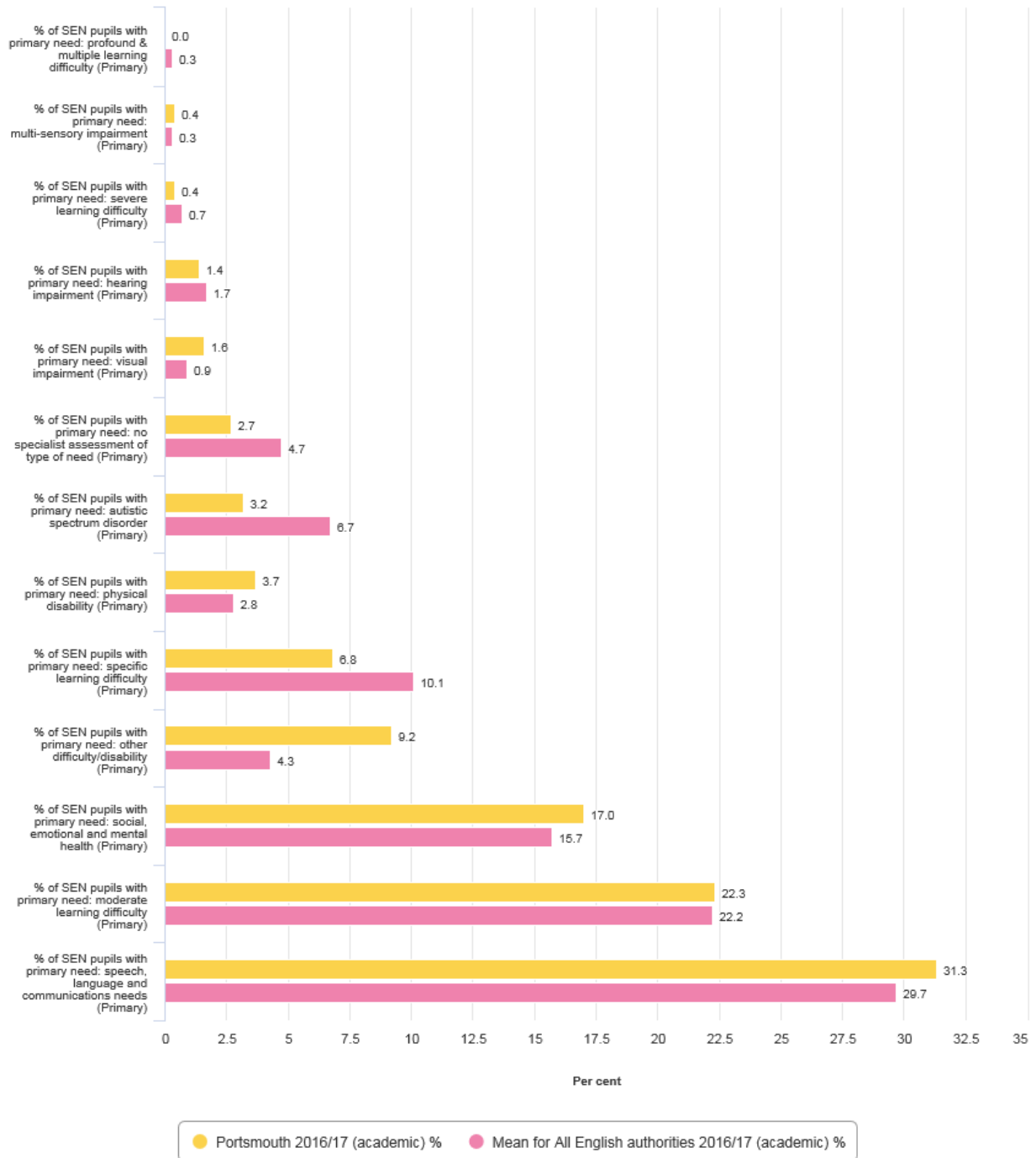
Portsmouth has fewer LAC with statements than national, but more on SEN support. It is difficult to draw firm conclusions from this as the numbers involved are so small. It could be that LAC are effectively supported with SEN support. There is also likely to be an impact of those who have historically been placed at The Harbour School (under the power to innovate) without a statement or EHC plan.

The issues are the same for CiN, although the Portsmouth percentages are closer to the national average in this case. It is difficult to draw firm conclusions from this as the numbers involved are so small. Given the definition of CiN, it could just be that those CYP known to the LA in that reporting period did not have SEN support or Statement/EHCP. Portsmouth has slightly lower percentage of children in need with a disability. Again, it is difficult to draw conclusions from this figure as the rate will vary depending on what criteria are used to record a child as disabled within this context.

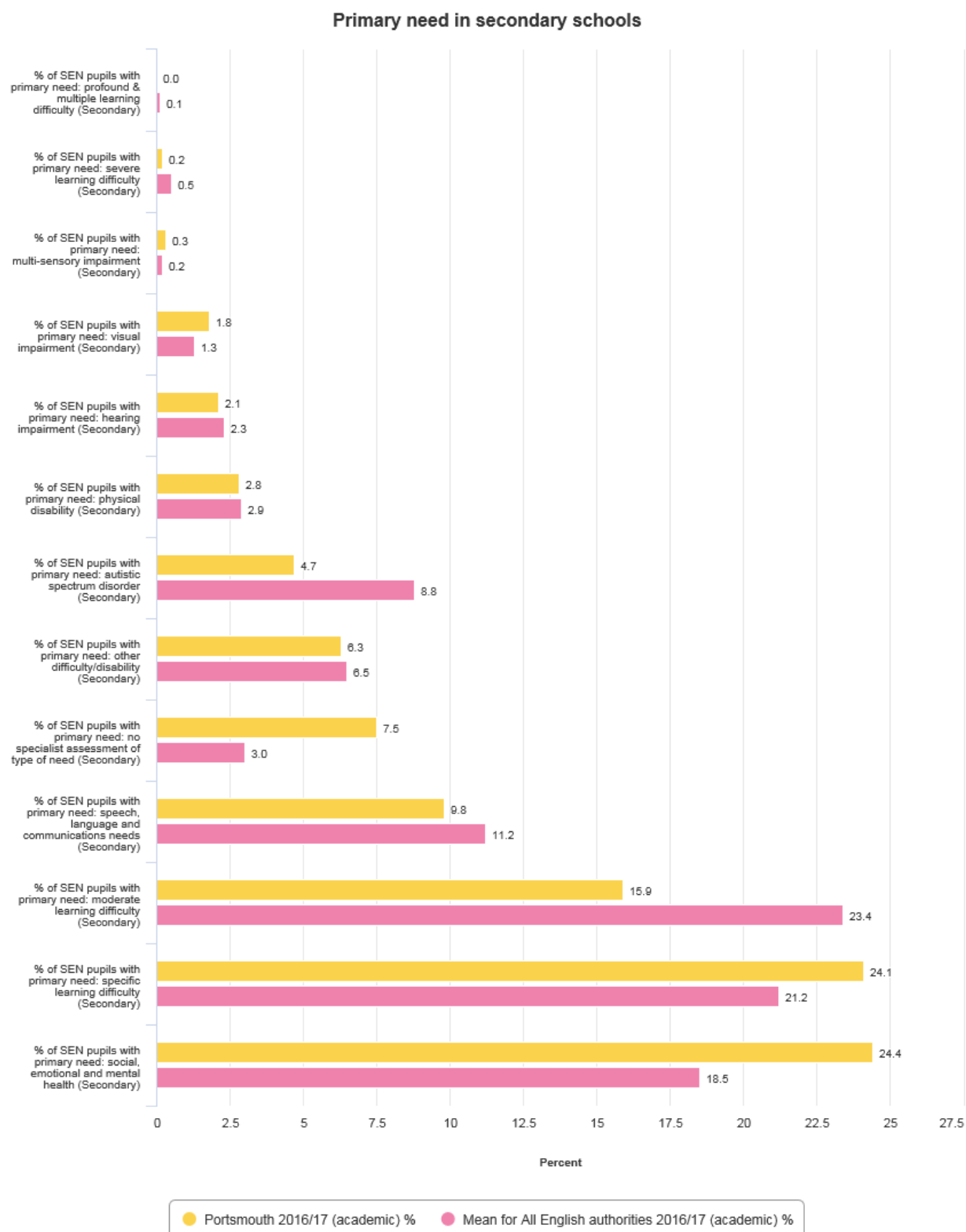
Primary Need

A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for them. All pupils with SEN have an assessment of their primary need. The following charts show the breakdown of need in Portsmouth by primary, secondary and special school, compared to the national averages and ranked by prevalence.

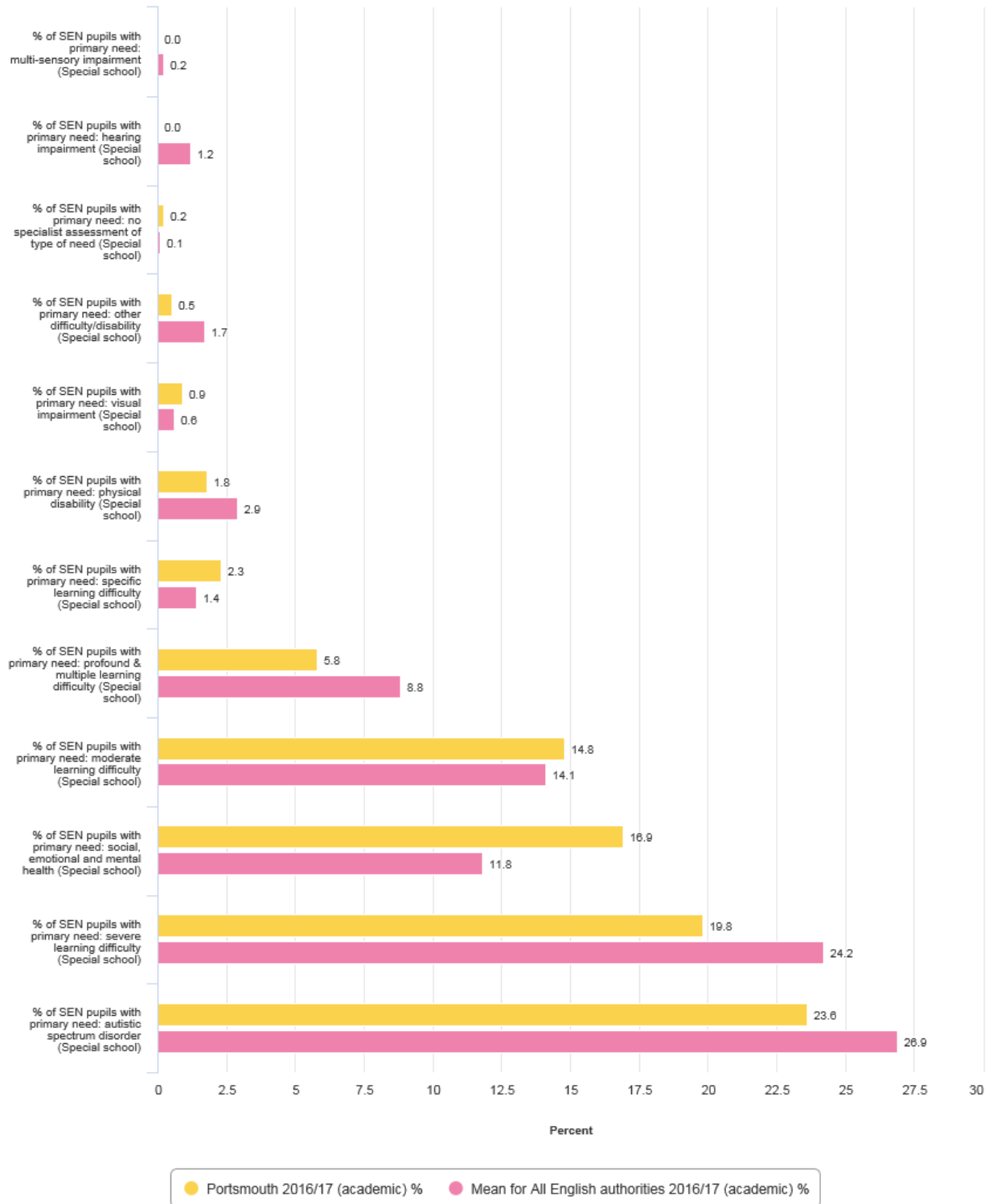
Primary need in primary schools



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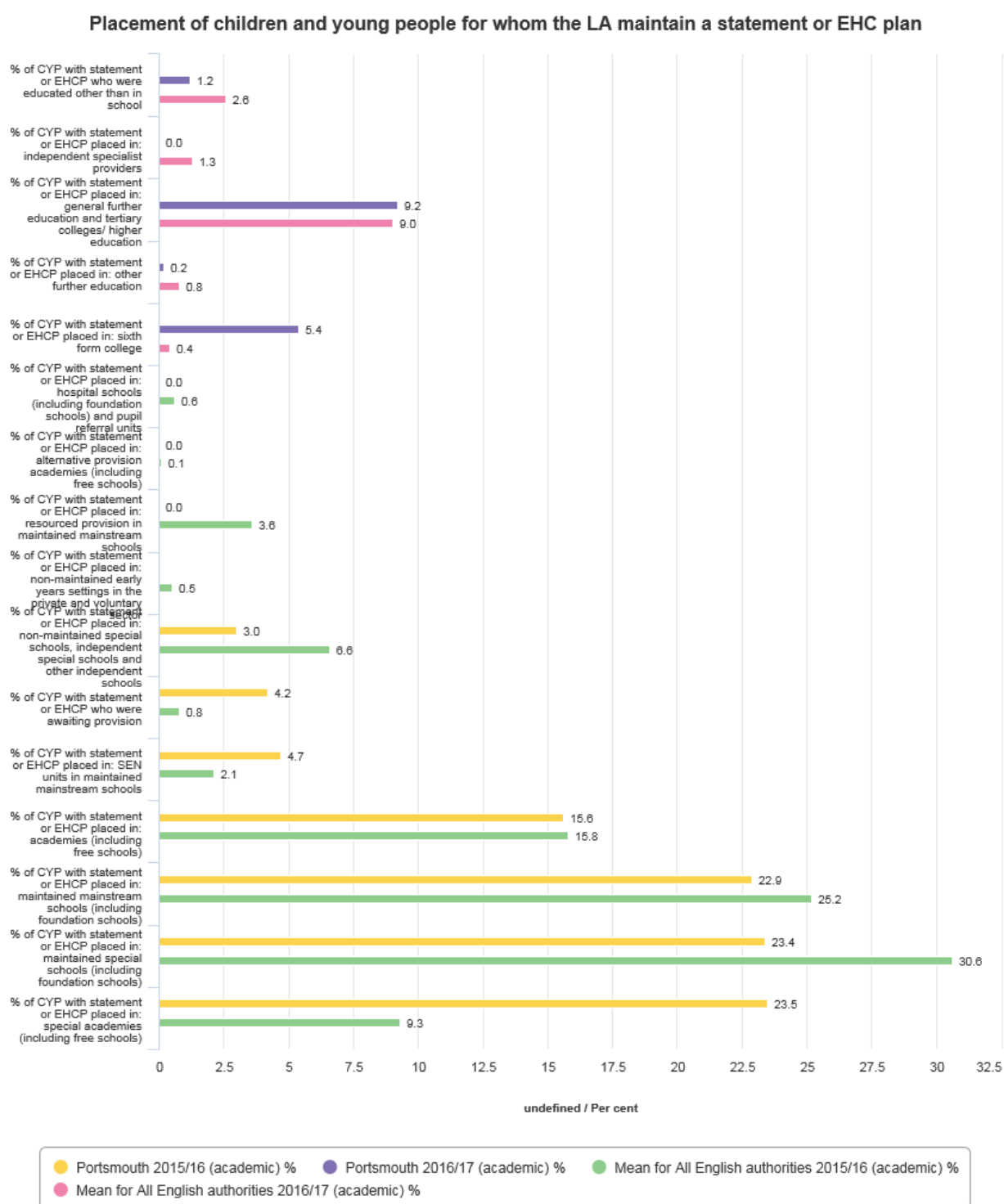


Primary need in special schools



The child's parent or the young person has the right to request a particular school, college or other institution to be named in their statement or EHC plan. The chart below "Placement of children and young people for whom the LA maintain a statement or EHC plan" shows the type of schools pupils with statements or EHC plans have been placed in by Portsmouth, compared to national averages and ranked by frequency.

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COMMENTARY

Primary need in primary schools: Portsmouth has a higher percentage of pupils with speech, language and communication needs (SLCN) than the national average. This is likely to be impacted by the additionally resourced provision available in primary schools in the city for pupils with SLCN as their primary need. Portsmouth has a lower

percentage of pupils with autism spectrum disorder (ASD) identified as the primary need. This is likely to be related to the lower than average number of diagnoses of autism in the city. It is likely that some of these pupils have been recorded as having SLCN as their primary need, rather than ASD, particularly younger children within the primary phase.

Primary need in secondary schools: The percentage of pupils in Portsmouth secondary schools identified as having a primary need of SEMH is above the national average. It is anticipated that the work taking place on the SEMH pupil pathway will bring this more in line with the national average. The percentage of pupils in Portsmouth secondary schools identified as having MLD, SpLD and SLCN as their primary area of need is lower than the national average. There is further work to be undertaken to give secondary schools within the city the competence and confidence to meet the needs of pupils with a wide range of SEN. The SEND Strategy and inclusion agenda is taking forward this piece of work, with an Inclusion group being established in the Autumn term to focus on this identified area for development.

Primary need in special schools: The percentage of pupils in Portsmouth special schools with a primary need identified as severe learning difficulties (SLD) and autism spectrum disorder (ASD) is lower than the national average, whereas for moderate learning difficulties (MLD) and specific learning difficulties (SpLD) it is higher than the national average. This is likely to be impacted on by the current designation of the special schools in the city - 2 of which are undergoing a process of re-designation. It is anticipated that over time this will become more in line with national averages.

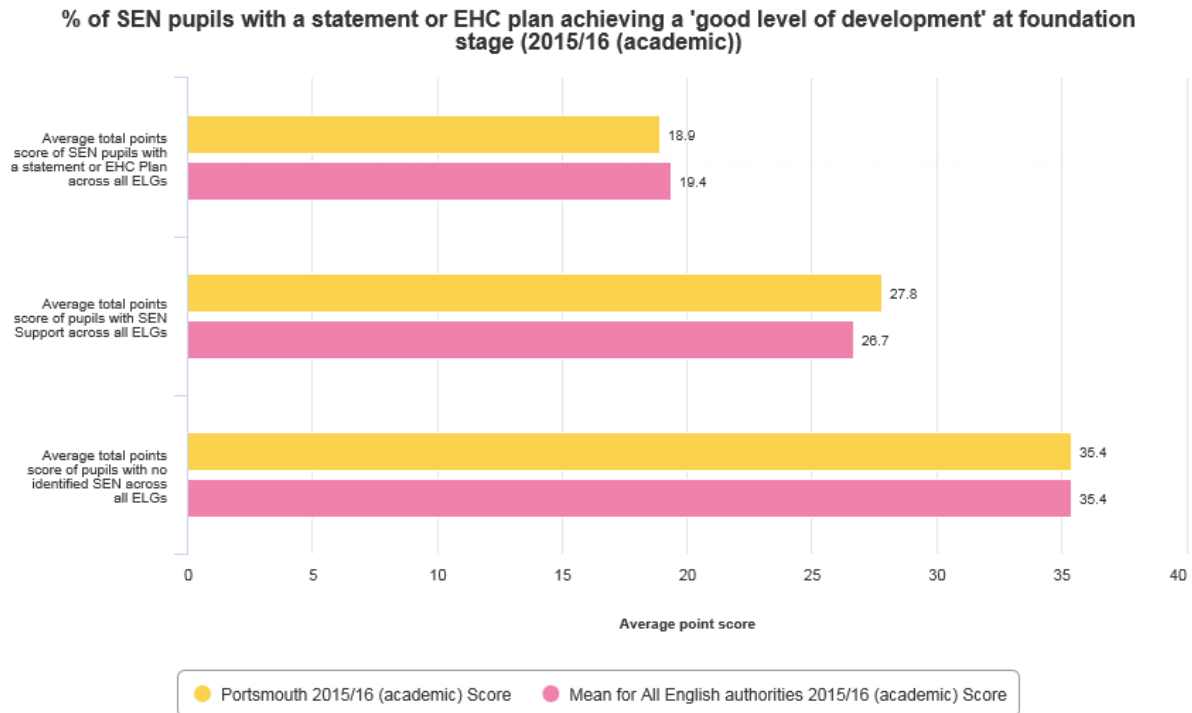
The percentage of pupils in Portsmouth special schools identified as having social emotional and mental health difficulties (SEMH) is higher than the national average. This has been impacted on by the 'power to innovate' which has meant that pupils with SEBD/SEMH needs could be placed in the SEBD/SEMH special school in the city without a statement or EHC plan. The 'power to innovate' has now come to an end and so this anomaly is being addressed. It is anticipated that the work taking place on the SEMH pupil pathway will bring this more in line with the national average.

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III. PERFORMANCE DATA

Headline outcome: Learning and Making Progress

Attainment of pupils with SEN

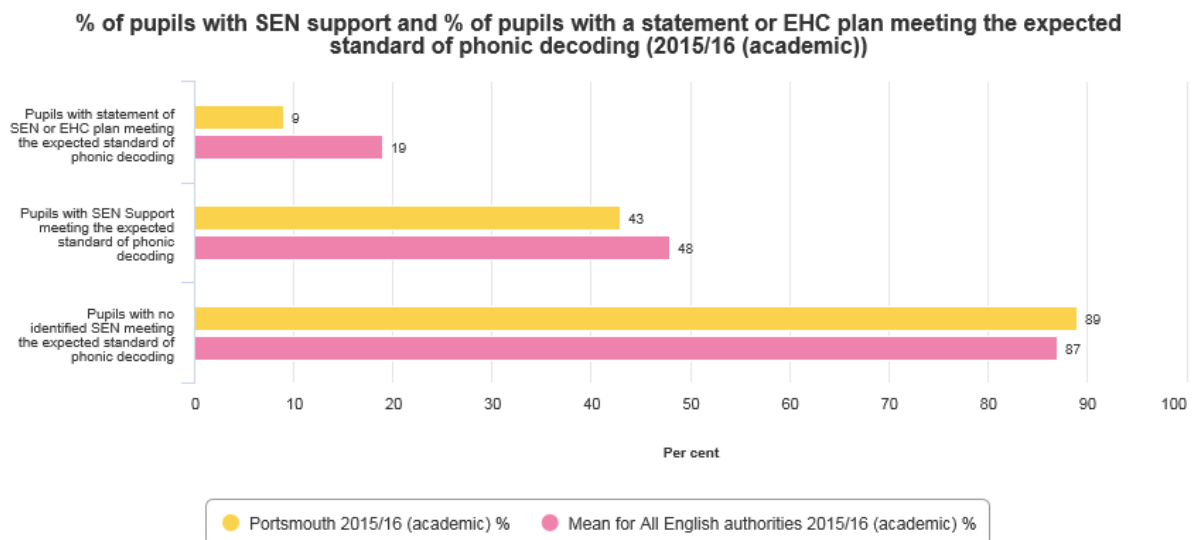


Source:

Metric ID: 5387, Department for Education, Early years foundation stage profile attainment by pupil characteristics

Metric ID: 5386, Department for Education, Early years foundation stage profile attainment by pupil characteristics

Metric ID: 5383, Department for Education, Early years foundation stage profile attainment by pupil characteristics



Source:

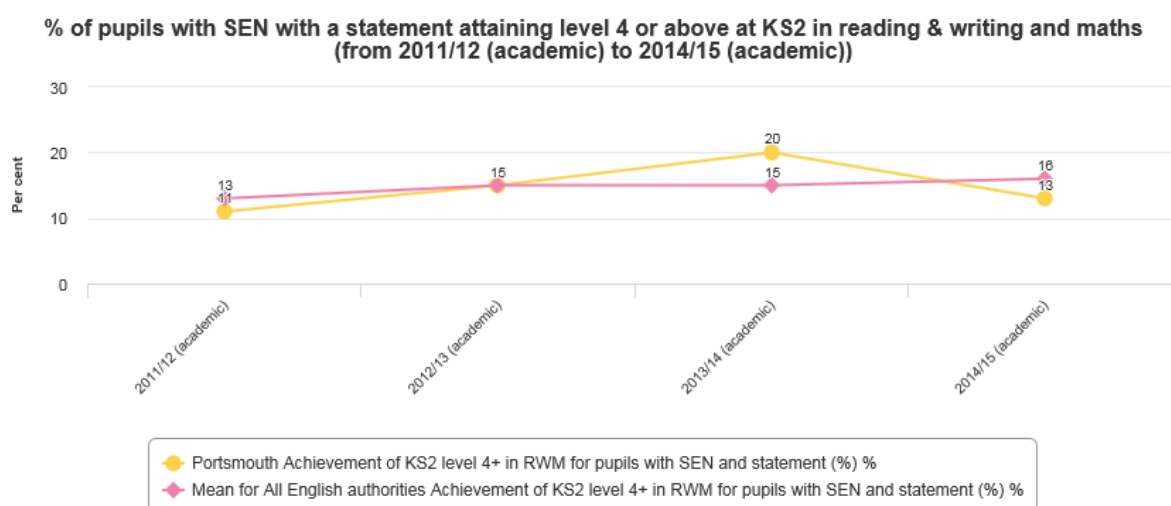
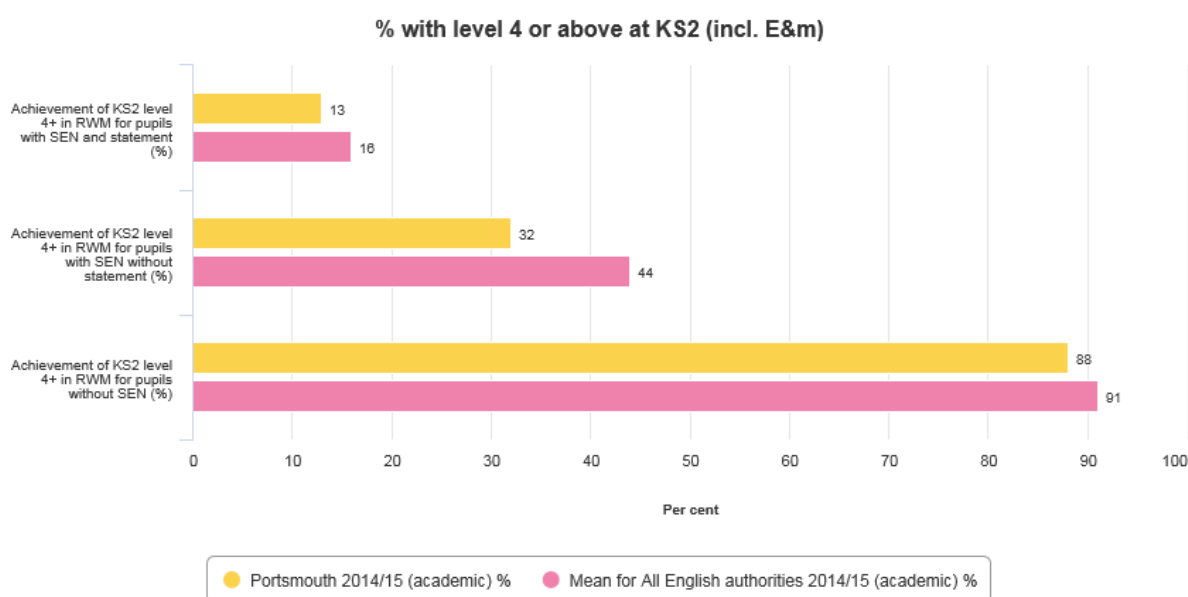
Metric ID: 4668, Department for Education, Phonics screening check and key stage 1 assessments: England

Metric ID: 4667, Department for Education, Phonics screening check and key stage 1 assessments: England

Metric ID: 4664, Department for Education, Phonics screening check and key stage 1 assessments: England

Key Stage 2

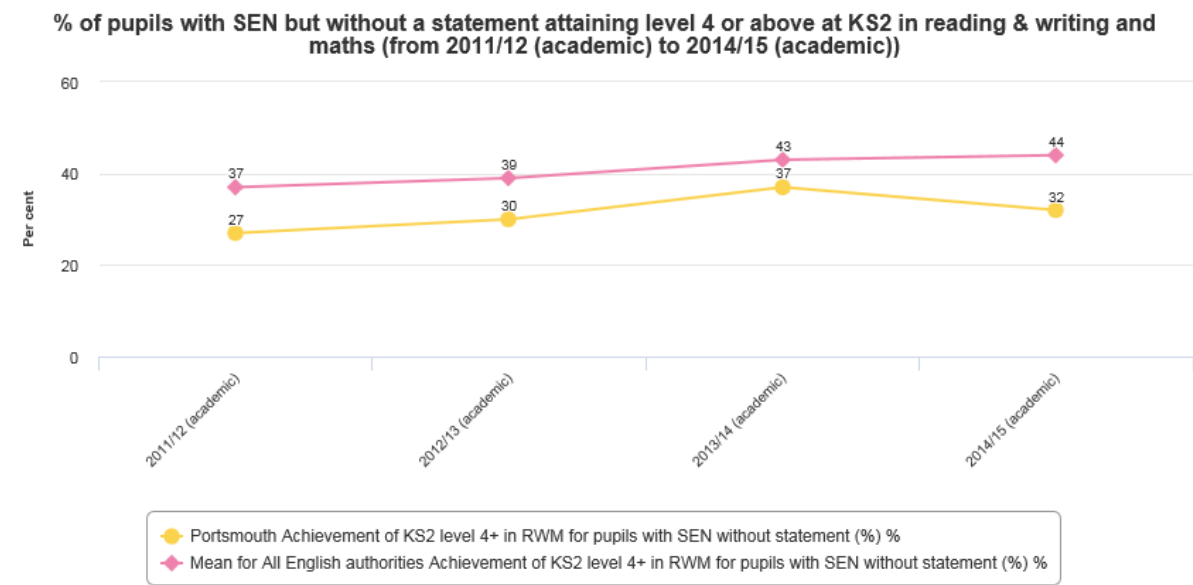
13% of pupils with statements of SEN or EHC plans and 32% of pupils on SEN support in Portsmouth achieve a level 4 or above in reading, writing and mathematics at KS2. For pupils with statements, this is worse than the previous period (20%) and for pupils with SEN support this is worse than the previous period (37%). This compares an All English authorities' average of 16% for pupils with statements of SEN or EHC plans, and 44% for pupils on SEN support. The third chart in this series shows attainment for children with no SEN, which stands at 88% in Portsmouth and 91% in All English authorities.



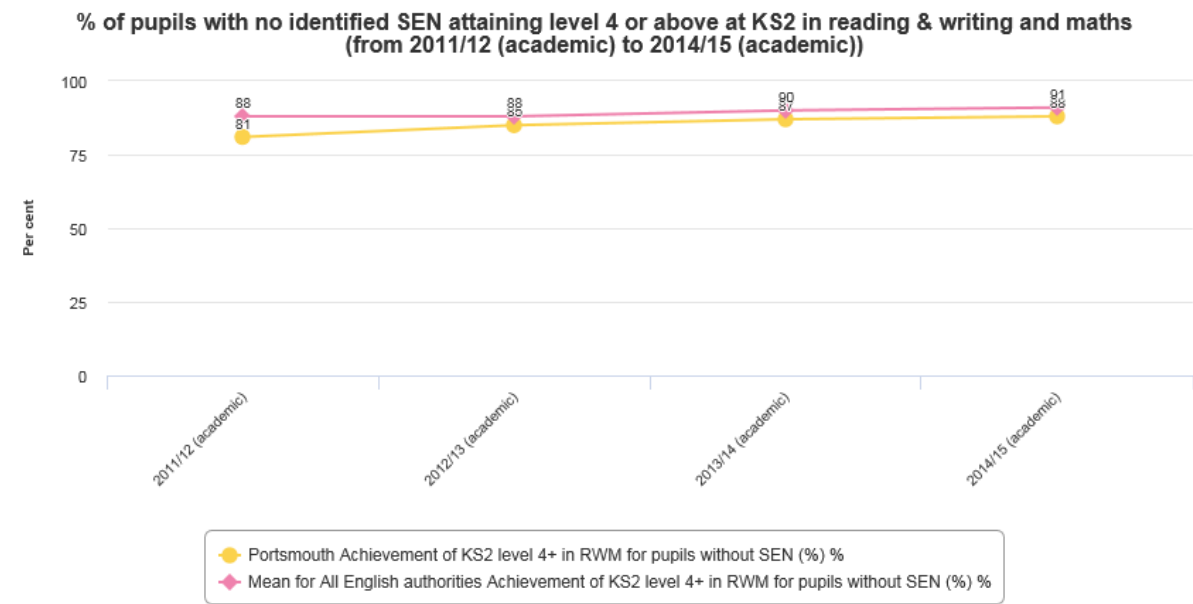
Source:

Metric ID: 4307, Department for Education, National curriculum assessments at Key Stage 2 (KS2)

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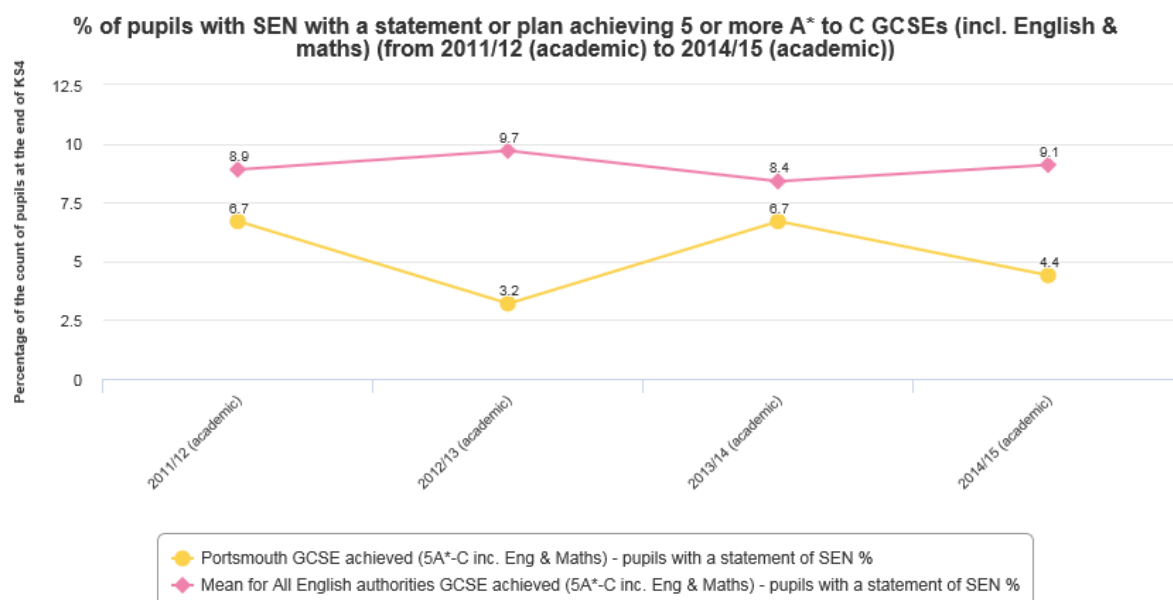
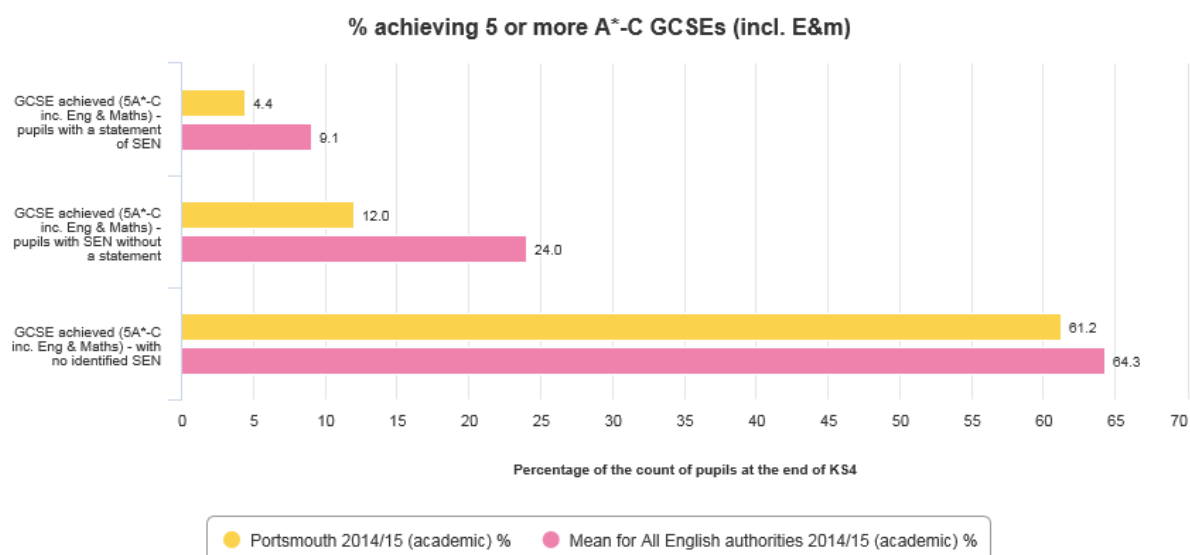


Source:
Metric ID: 4306, Department for Education, National curriculum assessments at Key Stage 2 (KS2)



Source:
Metric ID: 4303, Department for Education, National curriculum assessments at Key Stage 2 (KS2)

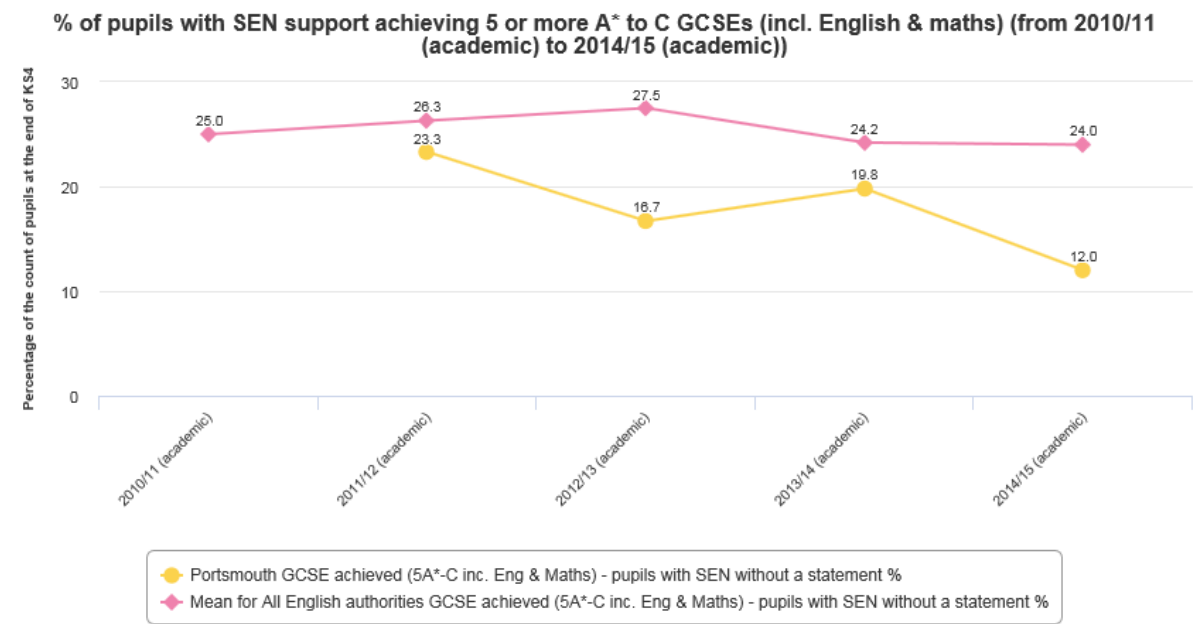
Key Stage 4 (GCSE)
4.4% of pupils with statements of SEN or EHC plans and 12.0% of pupils on SEN support in Portsmouth achieve 5A*-C inc. English and maths at KS4. This compares to the All English authorities average of 9.1% for pupils with statements of SEN or EHC plans, and 24.0% for pupils on SEN support. For comparison, of pupils with no SEN, 61.2% in Portsmouth and 64.3% in All English authorities achieve 5A*-C inc. English and maths at KS4.



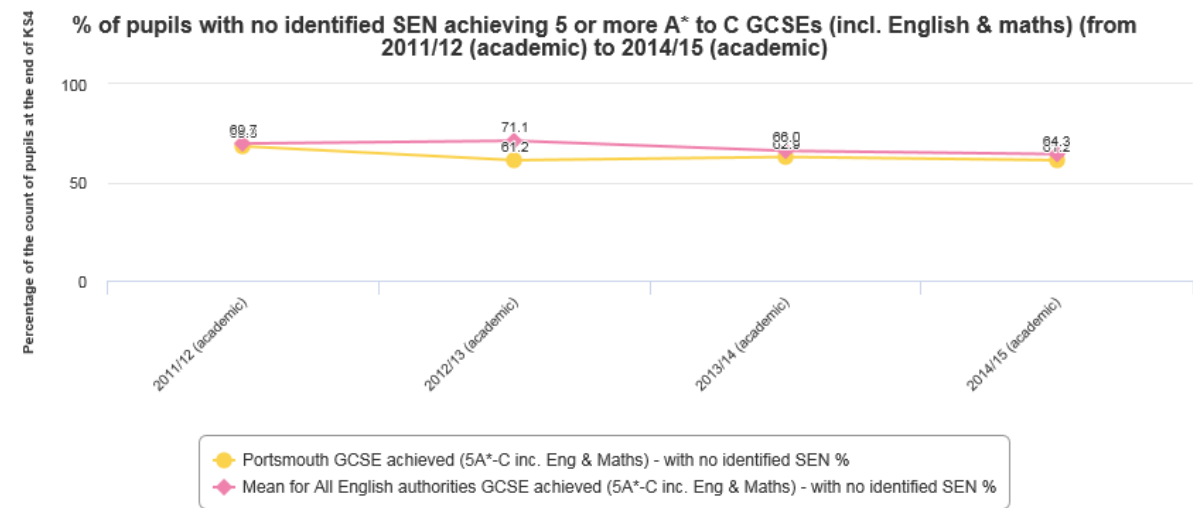
Source:

Metric ID: 921, Department for Education, GCSE and equivalent attainment by pupil characteristics

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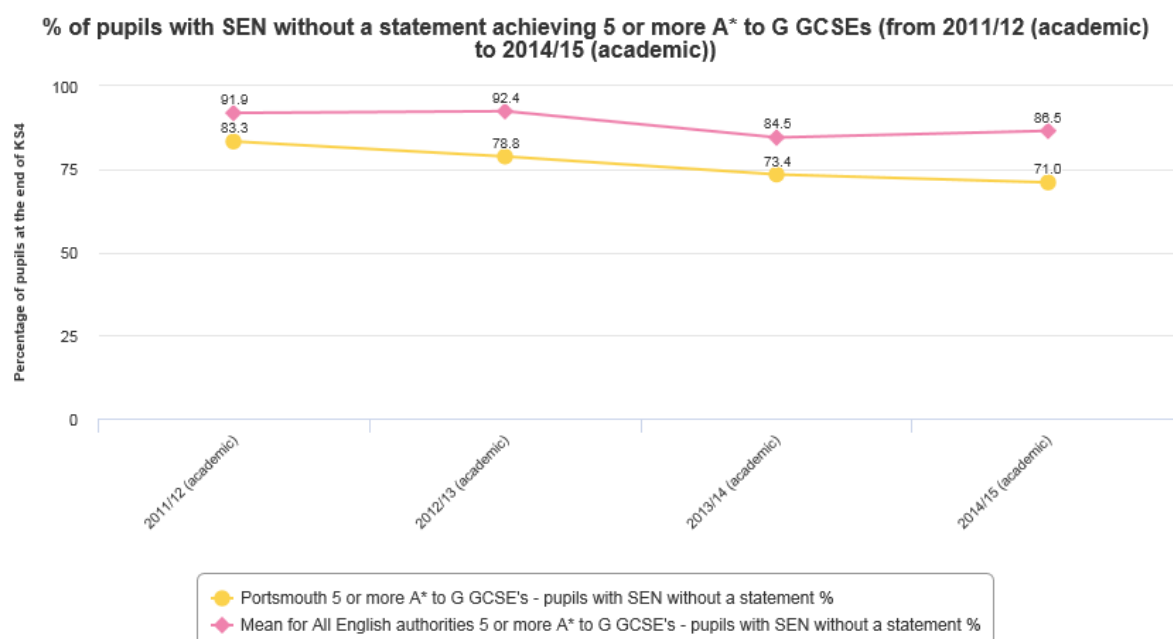


Source:
 Metric ID: 897, Department for Education, GCSE and equivalent attainment by pupil characteristics



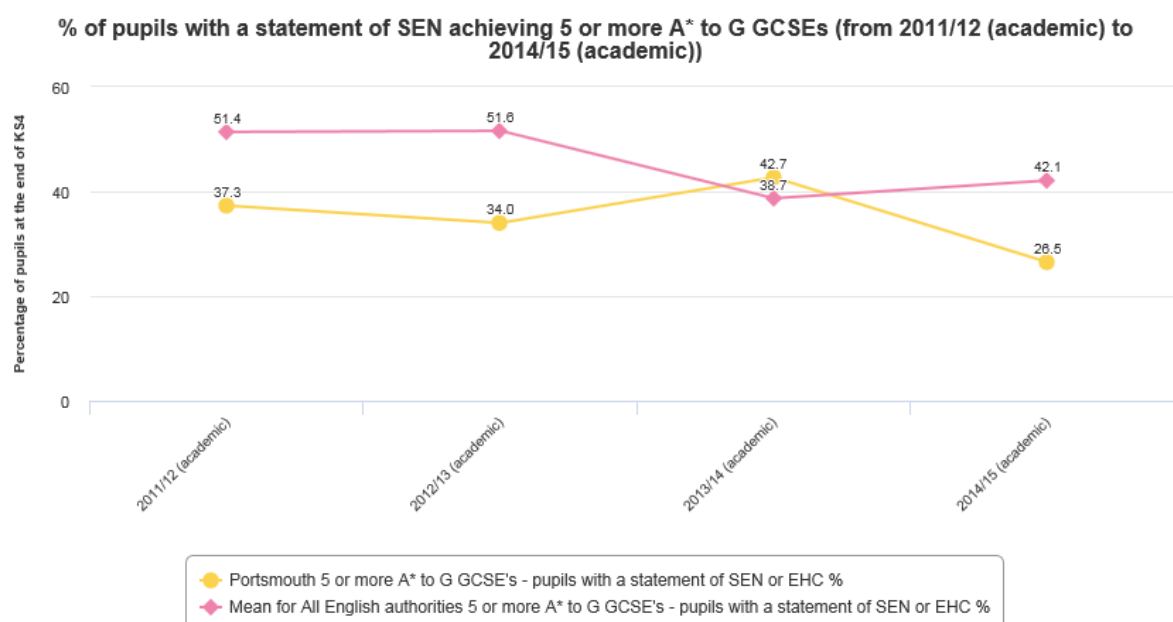
Source:
 Metric ID: 2181, Department for Education, GCSE and equivalent attainment by pupil characteristics

26.5% of pupils with statements of SEN or EHC plans and 71.0% of pupils on SEN support in Portsmouth achieve 5A*-G inc. English and maths at KS4. This compares to the All English authorities average of 42.1% for pupils with statements of SEN or EHC plans, and 86.5% for pupils on SEN support.



Source:

Metric ID: 4662, Department for Education, GCSE and equivalent attainment by pupil characteristics

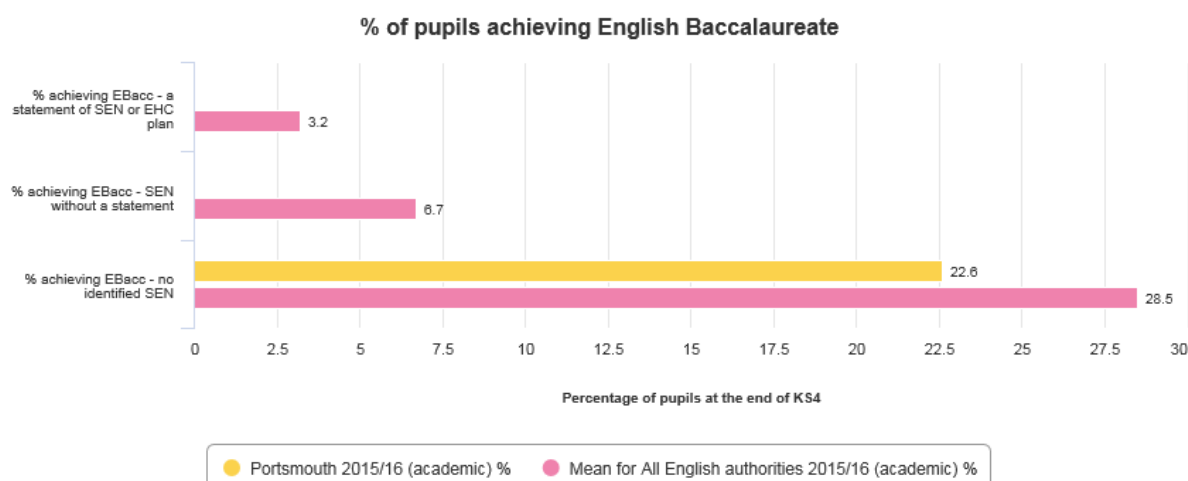


Source:

Metric ID: 4663, Department for Education, GCSE and equivalent attainment by pupil characteristics

Please note that where values are not displayed, this is a result of them being suppressed, which means that the number of pupils is too low to be published.

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Source:
Metric ID: 4653, Department for Education, GCSE and equivalent attainment by pupil characteristics

COMMENTARY

Attainment in Portsmouth has been increasing overall and this was broadly maintained in 2017. However attainment is still well below national expectations and this is particularly the case for pupils with SEN, notably those on SEN Support.

There is variation across the years with things dipping, particularly in 2014/15 for a number of indicators. There are bigger gaps at KS4 for progress for those with SEMH but not for attainment. It is difficult to make comparisons across other areas as national results are not broken down by primary need.

In line with the national picture, it is very difficult to make comparisons between schools, as the numbers of pupils are low in many schools and the criteria for identification of SEN differ. Schools in Portsmouth are getting better at more accurately identifying SEN, as opposed to low attainment, however there are no clear criteria nationally. SENCOs have discussed this and shared some of the criterion used in individual schools or clusters of schools. The SENCO Network is working towards developing some shared criteria for identifying pupils on SEN support which will enable us to better target support and identify practice to share.

The percentage of pupils meeting age related expectations in KS1 and KS2 remained significantly below national average in 2017. Rates of progress of pupils on SEN support, whilst still a priority area, improved significantly in KS2 Reading from -4.0 to -2.5 and slightly in Maths -3.8 to -3.1. Progress in Writing at remains of concern -4.8 to -4.7

We know that we need effective targeted support, and tracking and monitoring of pupils' progress if we are to see improvements in these outcomes. This is an area where we are working through the Portsmouth Education Partnership (PEP) and as part of our overall school improvement strategy (working with the Portsmouth Teaching School Alliance) to bring about sustained improvement.

We have identified a cohort of 6 priority schools to do some focussed work on SEN Support, using a framework developed by Challenge Partners, working in collaboration with a national leader of SEN (David Bartram).

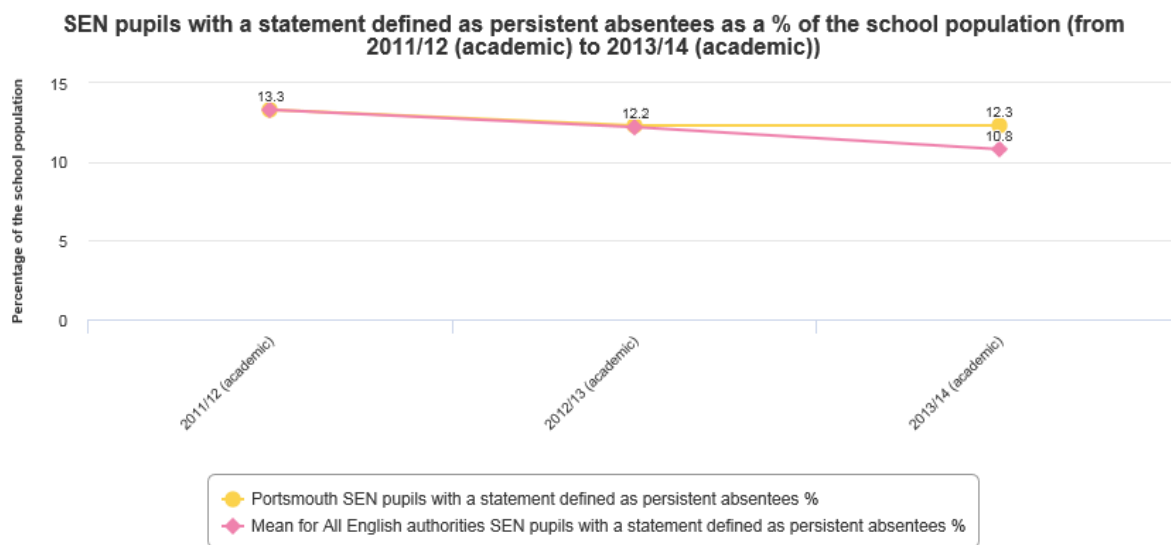
We have put forward a bid to the SSIF which, if successful, will involve a further 14 schools in this work.

Alongside maintaining the drive towards raising overall attainment in Portsmouth there is now an increased understanding and recognition across our schools of the need to focus on the attainment and progress of pupils with SEND, strategies to address this have been shared via the Leadership Conference, the Inclusion Conference and the SENCO Network.

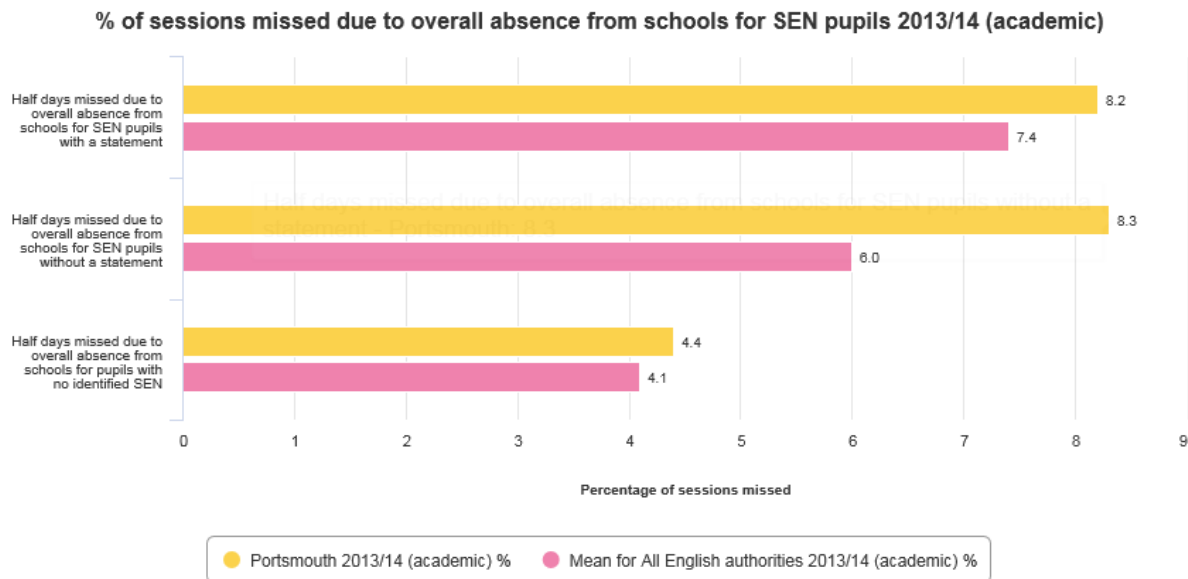
The learning and case studies from our work with the schools involved with Challenge Partners through our School Improvement work and, hopefully the SSIF work will be shared with schools across the city through dedicated workshops and our existing networks.

Absence

Persistent absentees are defined as pupils who have missed 15% or more of school sessions through authorised or unauthorised absence. A session is defined as half a day – morning or afternoon. Overall absence is the total number of overall absence sessions as a percentage of the total number of possible sessions available to that enrolment.



DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion



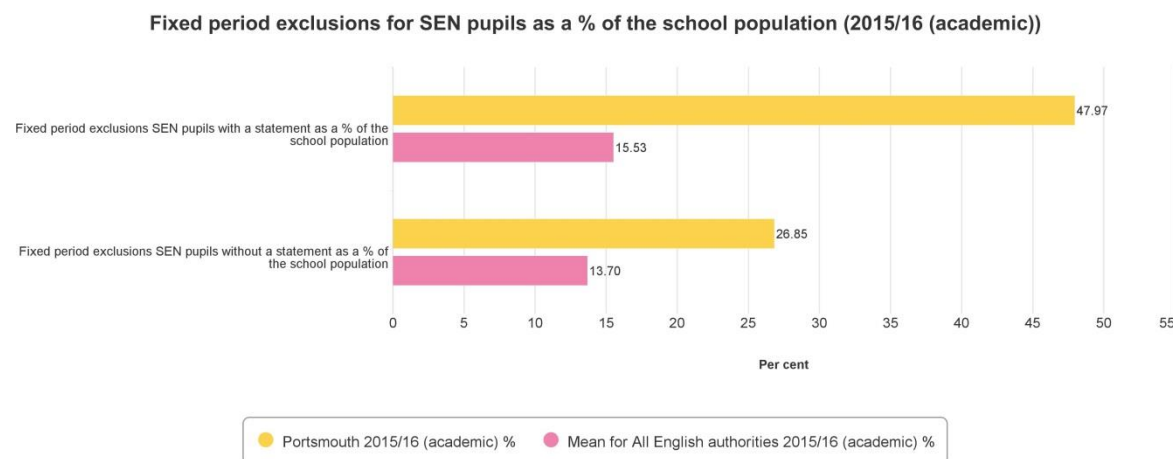
COMMENTARY

Overall attendance is improving and the introduction of the attendance strategy should assist this. The biggest different would be made through improved attendance at our SEMH special school which significant work has gone into.

. The evidence supports the suggestion that SEMH pupils are "over-represented" in both absence and exclusion data.

Exclusion

Fixed period exclusion refers to a pupil who is excluded from a school for a set period of time. A fixed period exclusion can involve a part of the school day and it does not have to be for a continuous period. A pupil may be excluded for one or more fixed periods up to a maximum of 45 school days in a single academic year.



Source:

Metric ID: 4732, Department for Education, Permanent and Fixed Period Exclusions from Schools in England

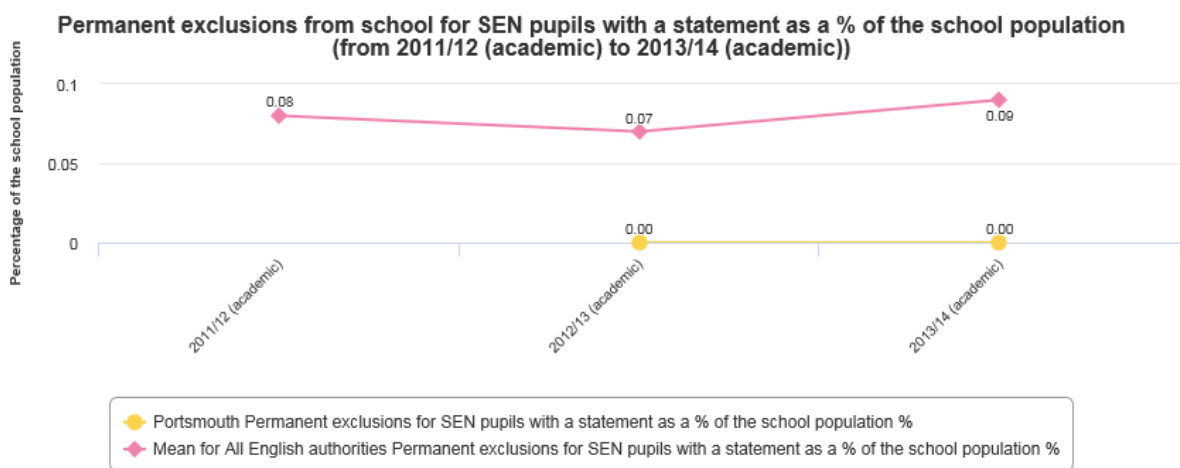
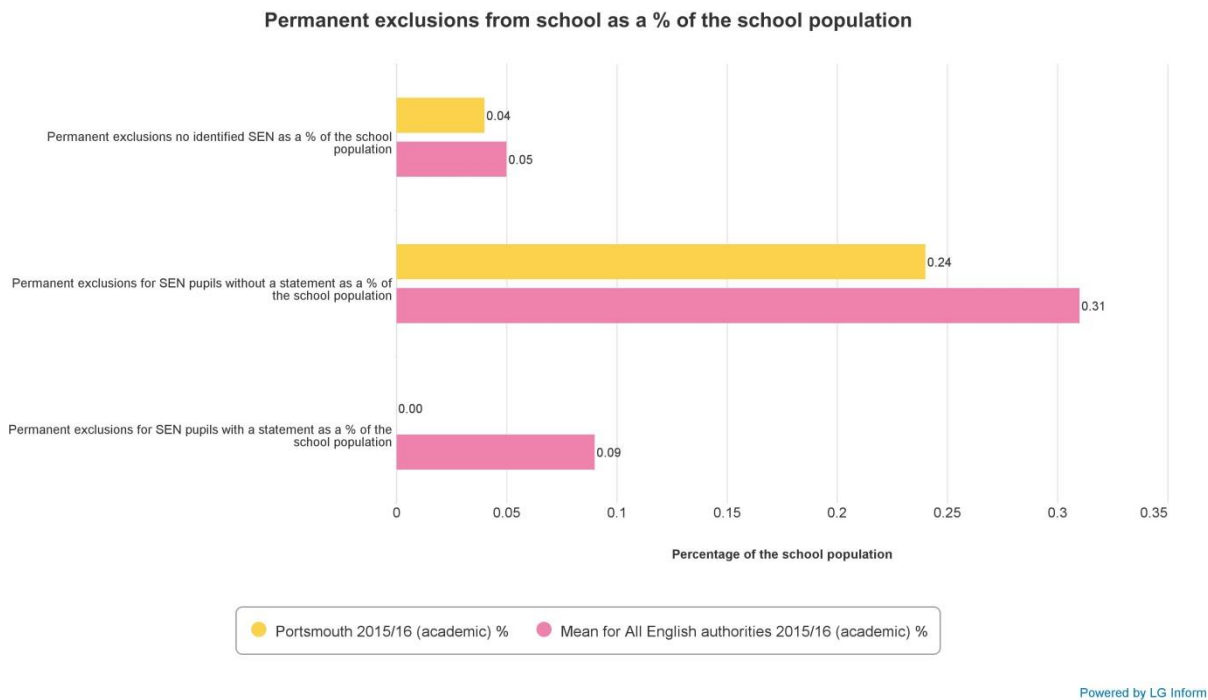
Metric ID: 4729, Department for Education, Permanent and Fixed Period Exclusions from Schools in England

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Permanent Exclusion

A permanent exclusion refers to a pupil who is excluded and has their name removed from the school register. Such a pupil would then be educated at another school or via some other form of provision.

Please note that where values are not displayed, this is a result of them being suppressed, which means that the number of pupils is too low to be published.



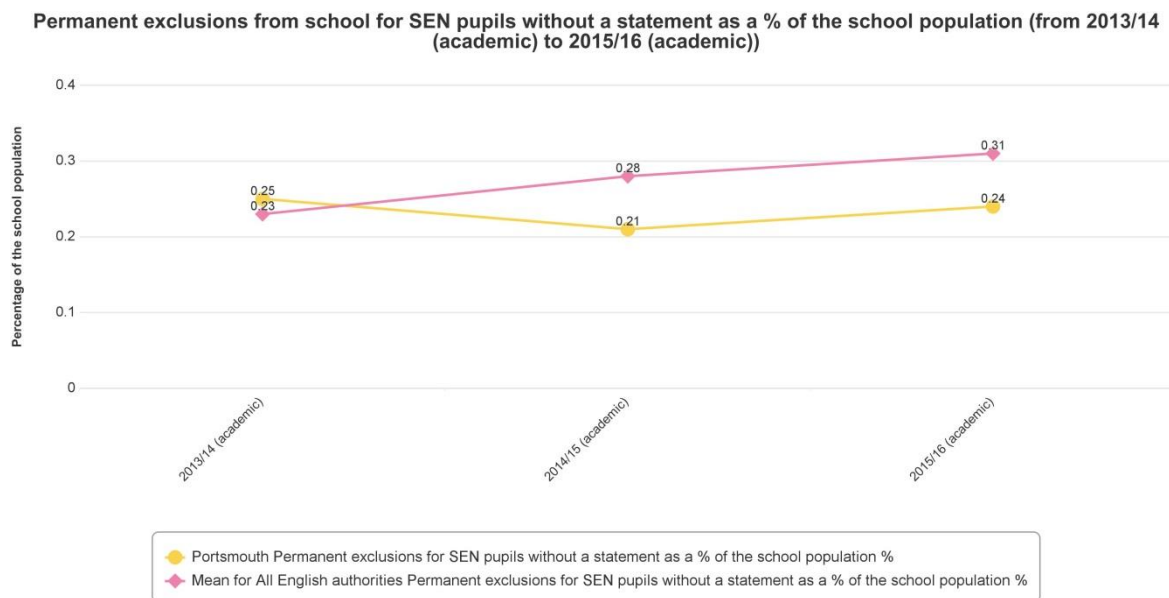
Source:
Metric ID: 4709, Department for Education, Permanent and Fixed Period Exclusions from Schools in England

In Portsmouth the permanent exclusion rates for SEN pupils without a statement was 0.24%, compared to the previous period when it was a rate of 0.21%. In

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

All English authorities the rate is 0.31%, which has increased since the previous period (0.28%).

Please note the time series may be broken if values are suppressed.



Source:

Metric ID: 4706, Department for Education, Permanent and Fixed Period Exclusions from Schools in England

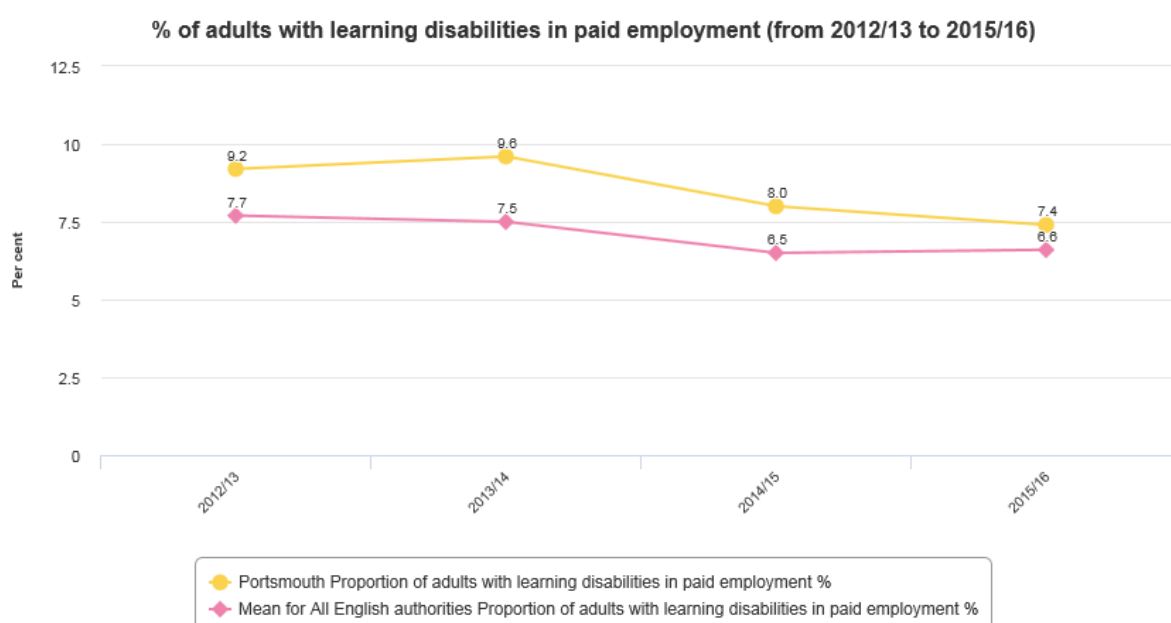
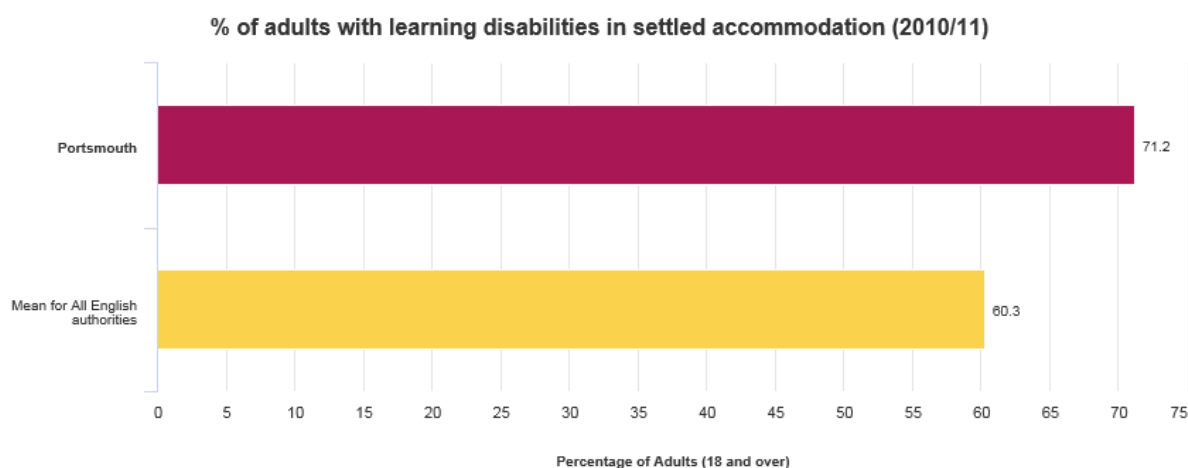
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COMMENTARY

In relation to fixed period exclusions, this picture was not improving and the disproportional representation of the SEN Statement/EHCP population was increasing. The introduction of the ordinarily available provision, pupil and curriculum pathways document and rigorous tracking of vulnerable groups and multiple exclusions have shown improvement in the data. Pupils with SEMH as a need type dominate amongst the pupils with exclusion incidents. However, it also shows that this is most prevalent amongst the special school pupils. Therefore there is improvement necessary at the Harbour school to shift this significantly, and recent figures are showing that improvement following the change of management and the beginnings of the implementation of the recommendations of the recent SEMH review.

Permanent exclusions are very low and much work has gone into ensuring that this becomes a redundant tool. Pupils can be catered for equally with or without a permanent exclusion and the inclusion agenda combined with processes around Fair Access and the availability of dual registered alternative provision have meant that schools don't tend to use this sanction.

HEADLINE OUTCOME: MAKE AND MAINTAIN POSITIVE RELATIONSHIPS IN THEIR FAMILIES AND COMMUNITIES



COMMENTARY

In relation to settled accommodation, we have moved from 60/40 Residential Care care/Supported Living split 4 years ago to 42/58 now. A recent ADASS commissioned Report concluded that we are the 3rd highest in the South East region in terms of proportion of Supported Living. We spend £11,567,750 on accommodation and support for people with a learning disability per annum of which £5,416,818 is spent on Supported Living. We commission Supported Living for 228 people, 219 within the City. In 2017/8 we will have an additional 4 Supported Living schemes which will increase the number of Supported Living places to 242.

Our recently published Housing and Support Transformation Plan sets out 3 Key Aims:

- Change in shape and size of service provision
- Change in culture to one of Independence.
- Supporting people to be part of their Community

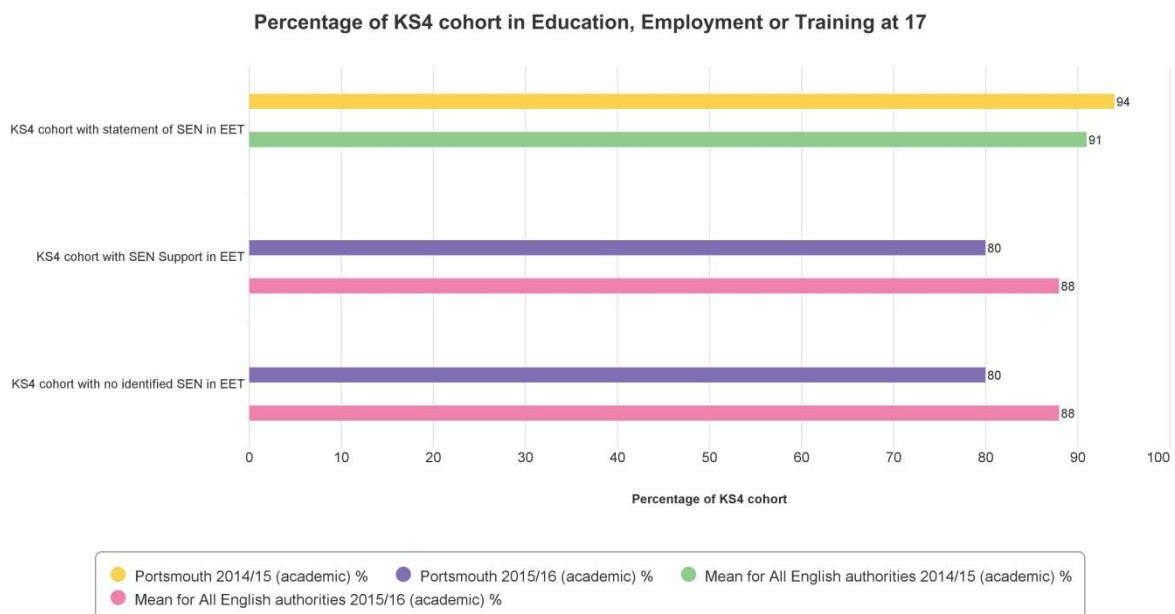
DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

And 9 Desired Outcomes - to:

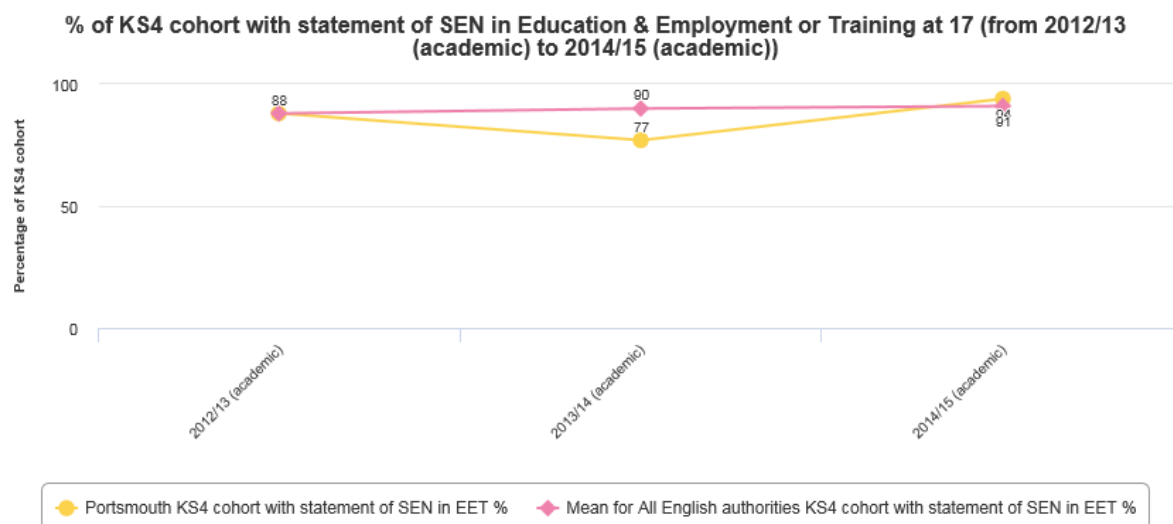
- Increase the range and choice of available housing and support options
- Maximise independence, sense of ownership, and, personal responsibility
- Be cost effective
- Develop and maintain a local market
- Support Transition into adulthood
- Reduce financial vulnerabilities around limited provision for 'specialist' services
- Empower choice and decision making
- Increase quality in both accommodation and support
- Increase the sense of belonging, social inclusion and social benefit

HEADLINE OUTCOME: Participate in education and training post-16 and prepare for employment

The reforms placed increased emphasis on supporting children and young people with SEND to make a positive transition to adulthood, including paths to employment, good adult health, independent living and participating in society. For more information visit <http://www.preparingforadulthood.org.uk/>.

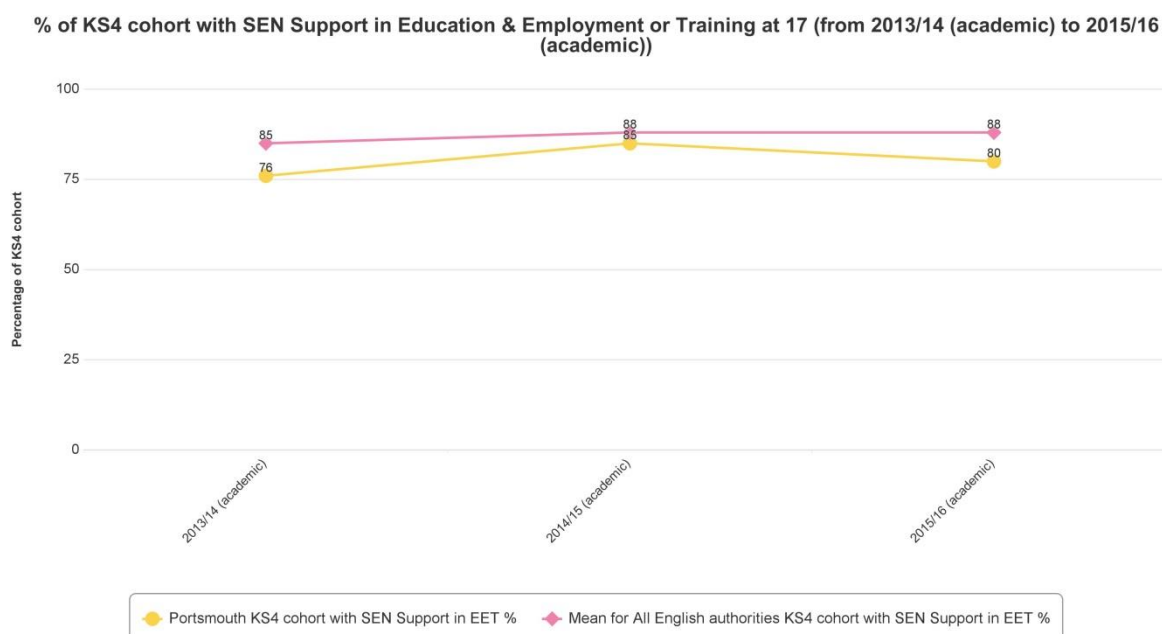


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Source:

Metric ID: 4689, Department for Education, Destinations of key stage 4 and key stage 5 pupils



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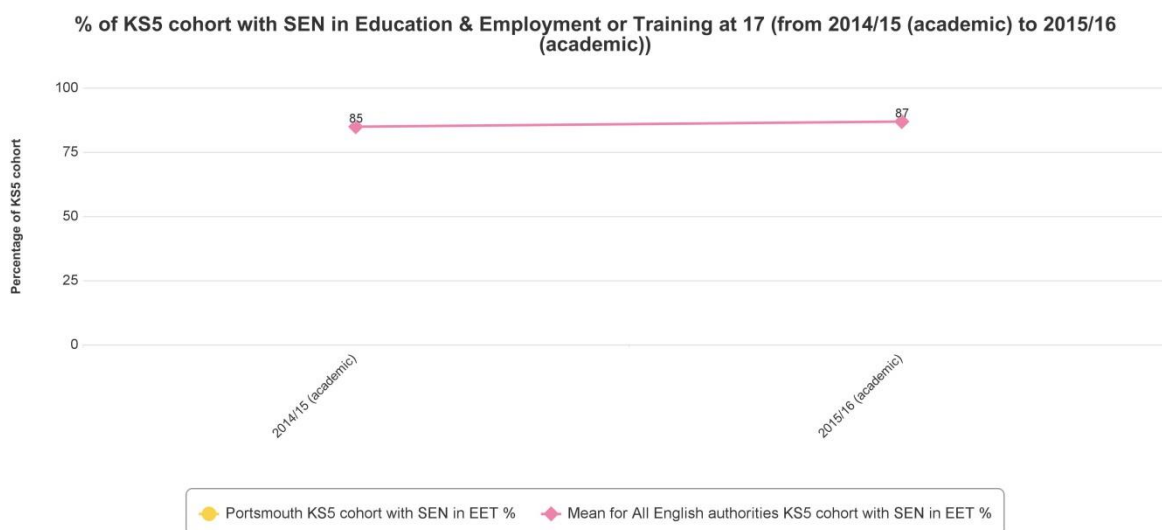
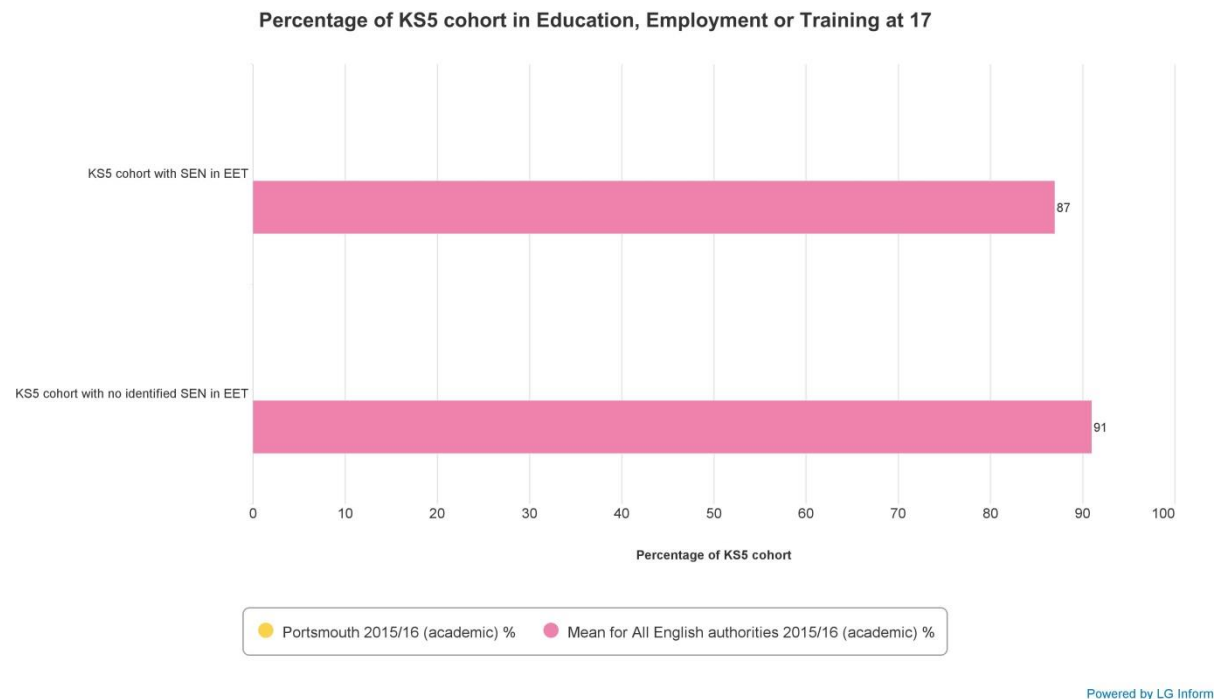
Metric ID: 4688, Department for Education, Destinations of key stage 4 and key stage 5 pupils

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Key Stage 5

Key Stage 5 is the period of education covering pupils aged 16-18. The next chart shows the percentage of the Key Stage 5 SEND cohort in a sustained education, employment or training destination in the first two terms of the year after they completed A level or other level 3 qualifications. This is Missing in Portsmouth, which compares to Missing in the previous period, and the All English authorities average of 87%.

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion



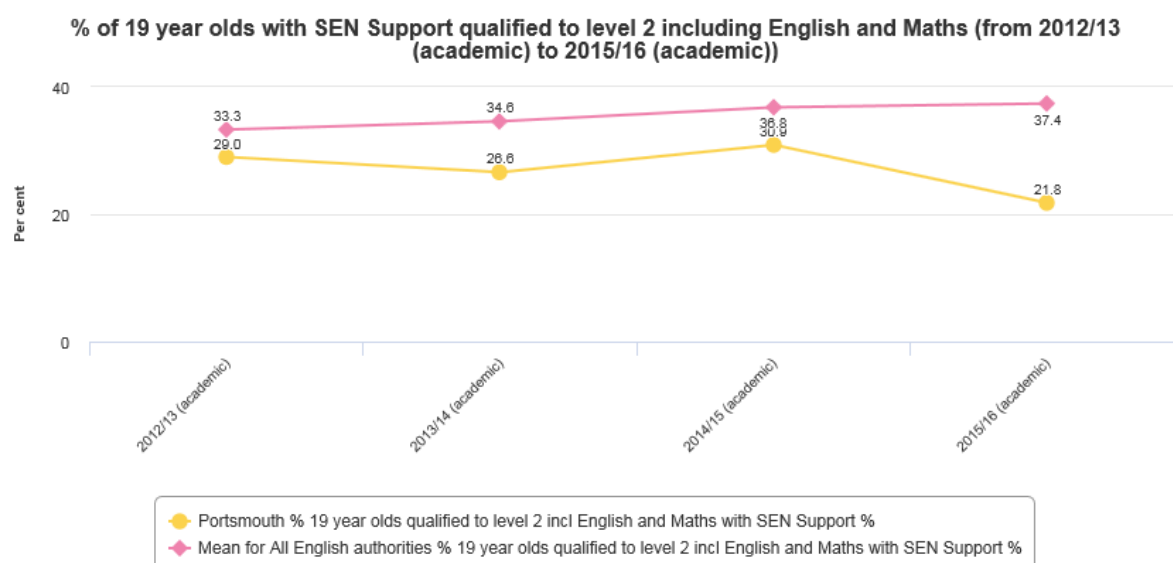
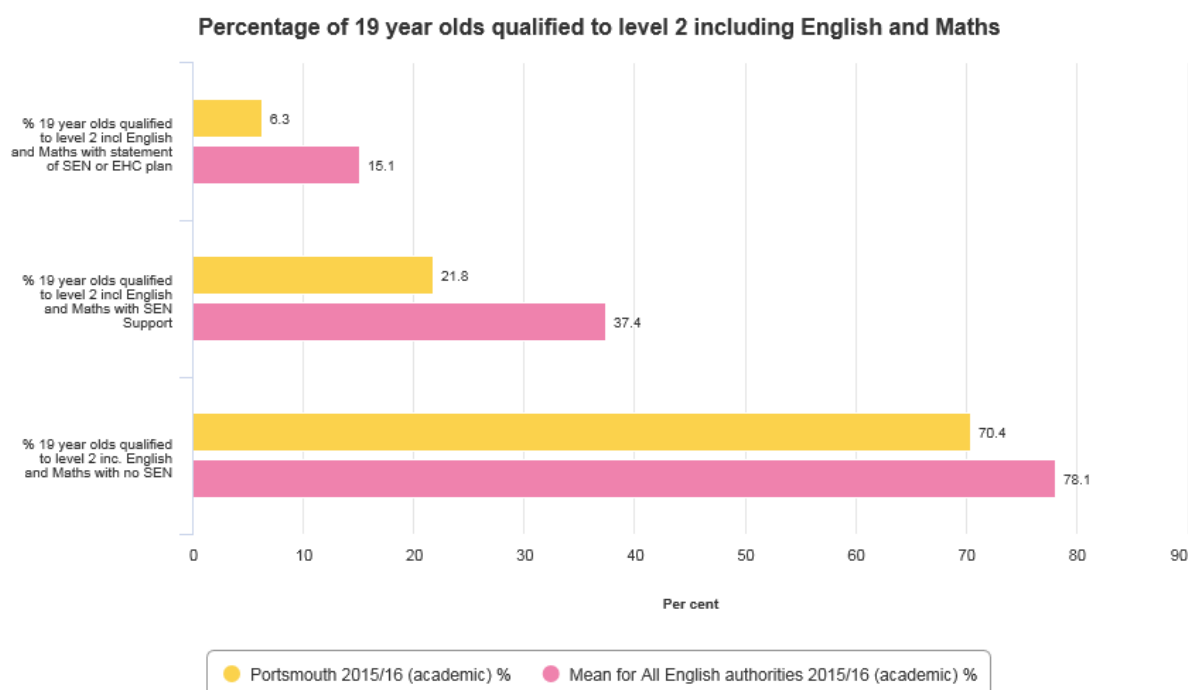
Source:
Metric ID: 4691, Department for Education, Destinations of key stage 4 and key stage 5 pupils

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Level 2

Attainment of Level 2 equates to achievement of 5 or more GCSEs at grades A*-C or a Level 2 vocational qualification of equivalent size. The next chart shows that the percentage of the SEN cohort studying in Portsmouth at the age of 16 (academic age 15) who attain a Level 2 qualification, including English and Maths, by the age of 19, is 21.8%, compared to an average of 37.4% across All English authorities. This compares to those with statement of which 6.3%

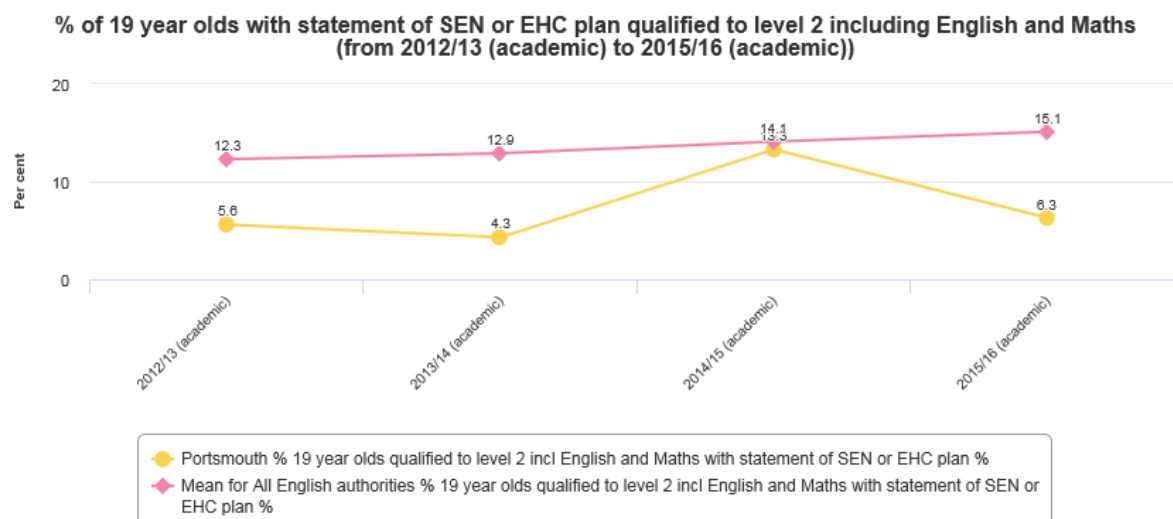
attained a Level 2 qualification, including English and Maths in Portsmouth and 15.1% in All English authorities.



Source:

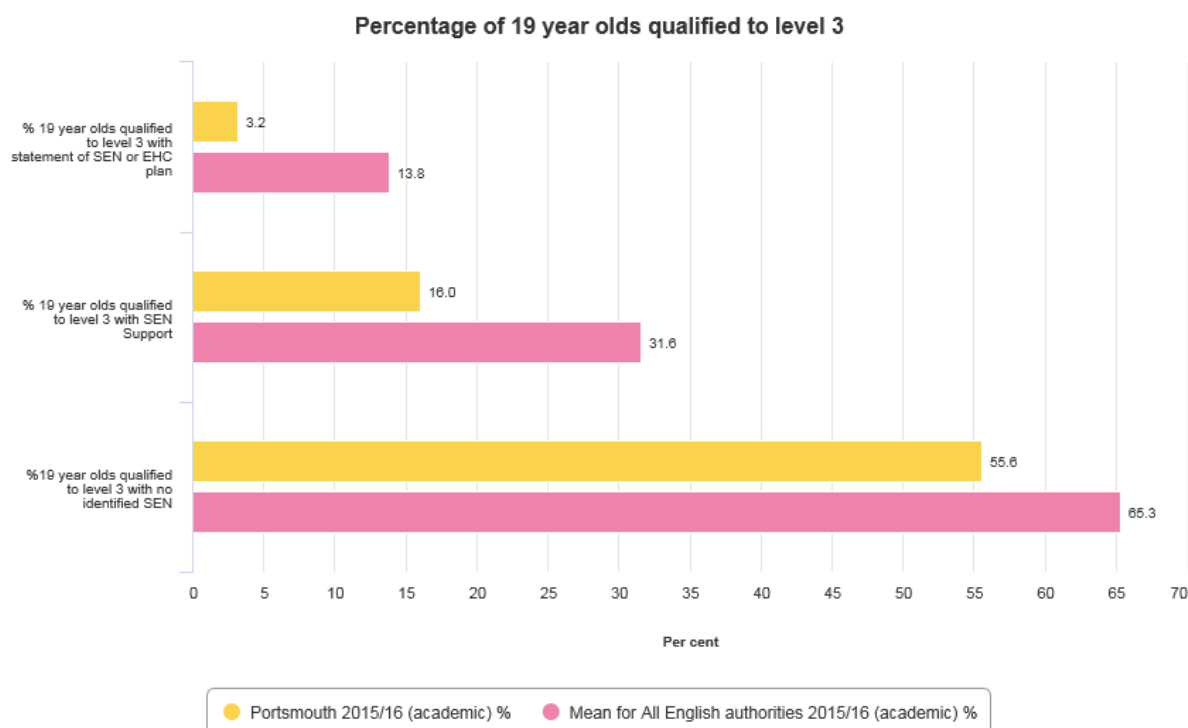
Metric ID: 4672, Department for Education, Level 2 and 3 attainment by young people aged 19

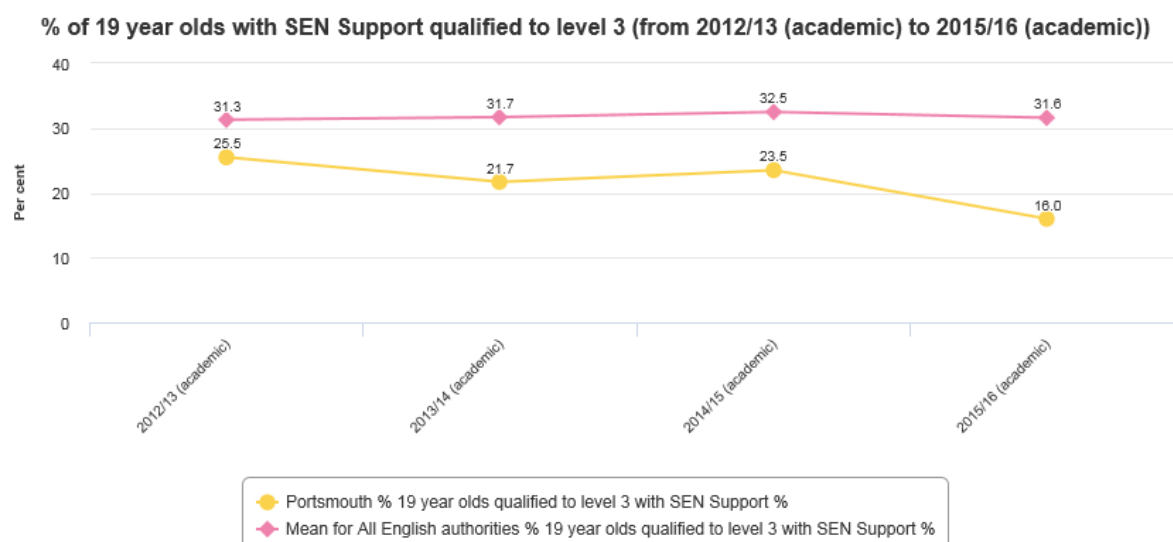
DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion



Level 3

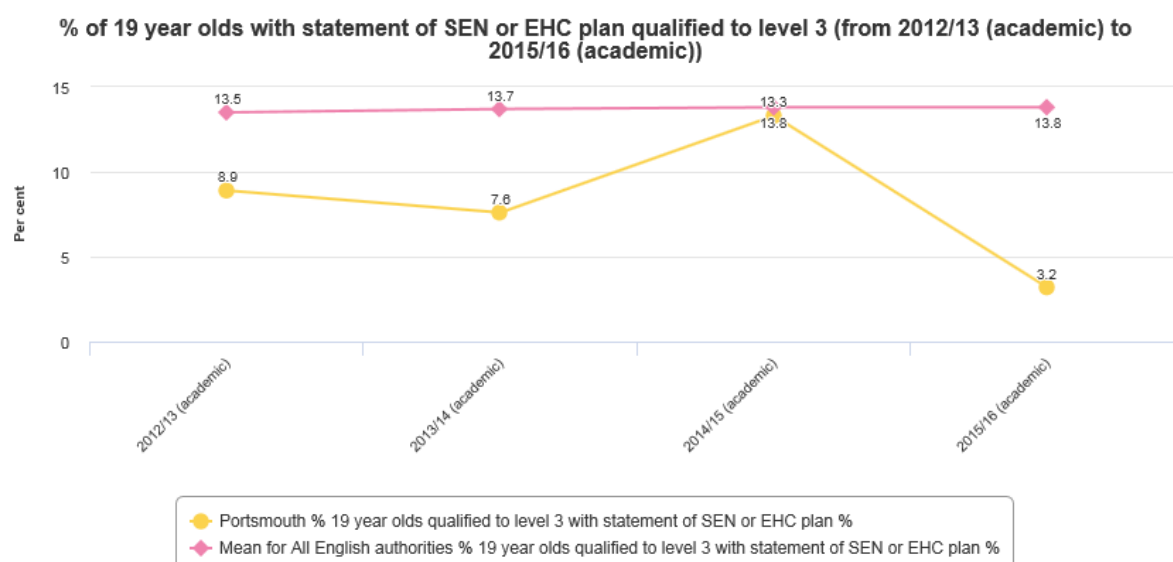
Attainment of Level 3 equates to achievement of 2 or more A-levels or equivalent qualifications. The following chart shows the percentage of the SEN cohort studying in Portsmouth at the age of 16 (academic age 15) who attain a level 3 by the age of 19 is 16.0% for those with SEN support and 3.2% for those with a statement or EHCP.





Source:

Metric ID: 4678, Department for Education, Level 2 and 3 attainment by young people aged 19



Source:

Metric ID: 4679, Department for Education, Level 2 and 3 attainment by young people aged 19

COMMENTARY

Participation in Post-16 Education

Participation of young people at age 17 and 18 is positive for young people with an EHCP. The latest data is 91% national and 95% for Portsmouth. More needs to be done to support the progression of young people with SEND support and this will be a focus of work moving forward.

Current programmes including a Youth NEET Prevention programme that supports young people on the RONI list (including young people with SEND) to progress will be reviewed to ensure they include young people with SEND support.

DELIVERY PLAN (September 2017 – September 2018) - Removing Barriers to Inclusion

Tri-Work: Young Person's Supported Work Experience for Schools

The Department for Work and Pensions have invited us to join a funded pilot programme to support young people in years 10 and 11 with SEND to participate in a four week work experience placement. The aim is improve transition to employment (traineeship/apprenticeship) for these young people at 16 or after post-16 education. The programme will be designed to be flexible and work around best options for the school and the young person

Further work needs to be done to continue to support NEET young people with SEND to engage. SEMH continues to be the main reason young people with SEND are NEET. Colleges and other Post-16 Providers are concerned about SEMH and the impact on participation and progression.

We are working with providers to support them with a joint approach through the post-16 Forum and Portsmouth Education Partnership.

Advisers who work with young people who are NEET will receive further training to help them support young people with SEND

A SEND transition guide is being developed to support young people and their families and carers to make a positive transition to post-16 education

Supported Internships continue to be developed across the travel to learn area.

In relation to increasing numbers of adults with learning disabilities in paid employment, this is an area we are actively working on. We have:

- commissioned a work assessment, finding and support service
- made employment a key outcome in support planning,
- assigned a named worker to proactively work with everyone re the outcome of work
- freed up the money by significantly reducing block expenditure which in turn allows the growth and funding of Social Enterprise.

We are working closely with current and potential providers to create a rich and diverse market and have created a post whose focus is this area of activity.

SECONDARY INDICATORS

Headline Outputs	Performance Measure	2015/16	2016/17	2017/18 Qtr 1	2017/18 Qtr 2	2017/18 Qtr 3	2017/18 Qtr 4	RAG	TREND AND NOTES
Lead healthy lives and achieve wellbeing	% children at Year R (age 4-5) receiving height and weight checks	95%	95%	n/a - report Q3	n/a - report Q3			Green	This is an annual report in Q3
	% children at Year R (age 4-5) receiving hearing and vision checks	95%	95%	n/a - report Q3	n/a - report Q3			Green	This is an annual report in Q3
	% of eligible young people and adults aged 14 years and above with a learning disability having a GP health check	n/a	n/a	n/a	37.07%			New measure	
	Numbers of referrals to paediatric therapies of CYP aged 0-19 years. Only just started reporting on this so only have July and August data	n/a	n/a	n/a	222 (new measure so only July and August)			The Paediatric therapy measures were bought into the service specification in early 2017. These were added into System One and were reportable from July; therefore the data available is only for July and August. There have been no targets set against these measures as it was agreed they are for understanding the demand on the service as the aim is to be more outcome and quality focused, with the exception of the " Paediatric therapies: Percentage of patients waiting 18 weeks or less from referral to	
	% of children and young people seen within 12 weeks from referral by integrated Therapy Team	n/a	n/a	n/a	74% (new measure so July and August average)				
	Paediatric therapies: Percentage of routine referrals	n/a	n/a	n/a	98% (new measure				

					so July and August average			treatment" which is set at 95%. This is currently averaging 96%. Exception reporting and qualitative data will be reported on at quarterly service reviews, the next one is due on 8 th November.	
	Paediatric therapies: Percentage of inappropriate referrals	n/a	n/a	n/a	3% (new measure so July and August average)				
	Paediatric therapies: Percentage of patients waiting 18 weeks or less from referral to treatment	n/a	n/a	n/a	July 100% in August 92%			Amber	Should be 100% without exception - likely to be an issue with August holidays
	Paediatric therapies: Percentage of first assessment appointments which are DNA'd	n/a	n/a	n/a	3% average July and August			Green	Requirement for <10%
	Paediatric therapies: Percentage of follow up appointments which are DNA'd				11% average July and August			Amber	Requirement for <10%
	CAMHS indicators (from reporting set - see below)See below								
Implementation of the reforms	% children and young people (0-25) with statements assessed and EHCP issued	3.1%	3.3%	1511	1443			n/a	Data available annually via DfE SEN2 SFR: uses DfE school population data.

									For quarters, provided total Numbers at end of quarter from Capita ONE.
	% new EHC plans issued within 20 weeks, excluding exceptions	86.7%	98.0%	95.6%	83.8%			Amber	2017 SEN 2 SFR has up to calendar 2016 (treated as 2016/17)
	Proportion of new EHC plans issued within 20 weeks, including exceptions	59.8%	80.9%	95.6%	83.8%			Amber	2017 SEN 2 SFR has up to calendar 2016 (treated as 2016/17)
	Number of children and young people (0-25) with statements assessed and no EHC plan issued	0	6	0	0			n/a	
	% children and young people (0-25) with statements assessed and no EHC plan issued	0% of Statements maintained at 15th January 2015 or 0% of the total number of Children and young people with statements who were issued with an EHC plan by 21st January 2016 with	0.71% of Number of statements maintained at 21st January 2016 or 1.38% of the total number of Children and young people with statements who were issued with an EHC plan by 19th January	0%	0.0%			n/a	

		the Children and young people with statements assessed and decision made not to issue EHC plan	2017 with the Number of children and young people with statements assessed and decision made not to issue EHC plan by 19th January 2017						
	Number of personal budgets taken up for EHC plans issued and transferred or reviewed	5	29	-	-				DfE Changing definitions from next year Jan 2018 so won't be consistent SFR.
Experience of the system (see narrative section D)	Number of SEND mediation cases that have been held	X	1						
	% SEND mediation cases that went on to appeal	0%	100.0%						
	Number of SEN appeals per 10,000 of school population								

CAMHS Indicators (national performance measures to be reported from mental health services dataset when available)

REFERENCE NUMBER	PERFORMANCE MEASURE
CYP01	People in contact with children and young peoples' mental health services, end of reporting period
CYP23	Open referrals (children and young peoples' mental health services), end of reporting period
MH01a	People in contact with mental health services aged 0-18, end of reporting period
MHS32a	Referrals starting in reporting period, aged 0-18
MHS38b	Referrals active at any point in the reporting period, with indirect activity in the reporting period, aged 0-18
MHS39a	People with a referral starting in reporting period, aged 0-18
MHS57a	People discharged from a referral in reporting period, aged 0-18
MHS55a	People attending at least one contact in reporting period, aged 0-18
MHS30d	Attended contacts in reporting period, aged 0-18

MHS61a	First attended contacts for referrals open in reporting period, aged 0-18
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c. DEMAND MANAGEMENT INDICATORS

The Children's Trust Board has indicated that it would be helpful to begin considering indicators of demand management in the city - the indicators below will begin to be measured from the second half of 2017/18

Demand Area	Performance Measure	2015/16	2016/17	2017/18 Qtr 1	2017/18 Qtr 2	2017/18 Qtr 3	2017/18 Qtr 4	RAG	TREND AND NOTES
Education, Health and Care Plans - monitor demand	Number of EHCPs requested								
Out of city placements - monitor to ensure this is not increasing	Number of out of city placements								
Continuing healthcare - ensure good value for money from placements	Number of new placements								
	Number of placements reviewed								
	% placements meeting need								
	Average placement costs								

Experience of the system narrative appendix

Tribunals - issues and learning summary

This report will be available from January 2018.

Feedback summary

Extract taken from the Personal outcomes Evaluation Tool 'POET Final Report' The full report can be found in the embedded document below.

Executive Summary

We wanted to understand how the EHCP process was working from parent's and children's perspectives. This work was conducted in partnership with the SEND team, the corporate team and the communications team who undertook the task of enabling the online surveying to proceed. It was hoped that we could get a survey response group large enough to carry out a detailed analysis, certainly in excess of the 19 responses achieved in 2016. As it transpired the online format was a success and we received a total of 119 responses from parents and children.

The surveying was designed to capture a broad range of views that parents and children had about their involvement in and outcomes from EHCP processes. What we saw from the data we received back was a broadly positive in outlook with a number of interesting caveats.

- Parents are feeling more optimistic about EHCP matters than their children
- Mothers tend to get more from their involvement in EHCP than fathers do
- Girls appear to be operating at a disadvantage in EHCP processes

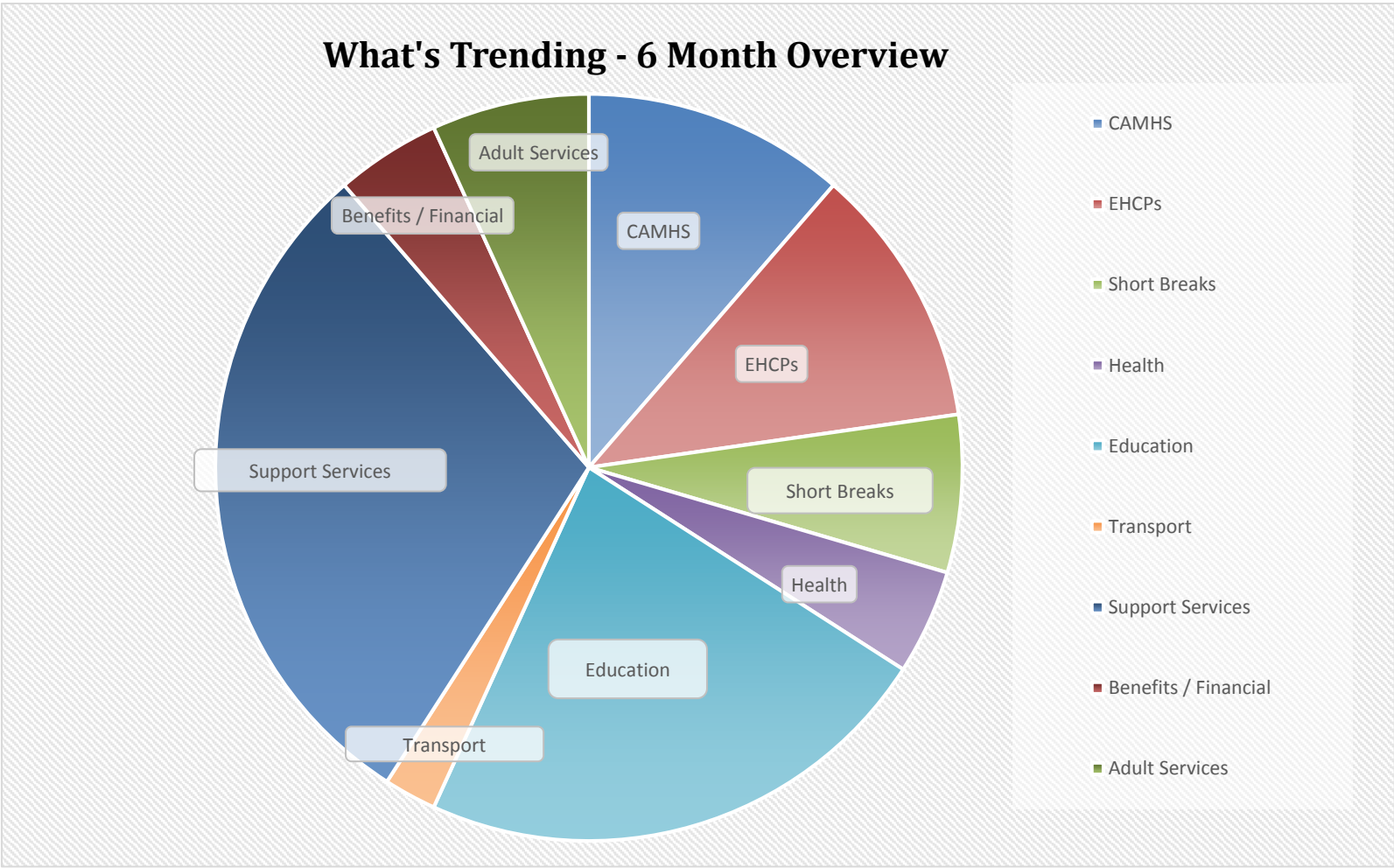
As a result of the valued feedback that parents and children have provided us, we have understood the following points.

- Our survey pool is broadly representative of the populace in general
- Personal Budgets are still not a significant factor in connection with EHCP
- Generally the EHCP process is working well

- Education settings are influencing some outcomes
- Mature EHCP are perceived to influence some outcomes positively due to individuals becoming accustomed to them as time moves on
- Gender differences are evident in children's involvement and outcomes
- Gender differences are evident in parental outcomes
- The local offer needs more publicity

Based on these points a number of recommendations are made at the end of this paper that will hopefully address the concerns of interested parties. We will also continue to work alongside all our partners on similar surveying projects in the future.

SECTION E - PPV "WHAT'S TRENDING?" REPORT



**PORTSMOUTH LOCAL AREA
SPECIAL EDUCATIONAL NEEDS AND DISABILITIES
SELF-EVALUATION**

Updated September 2017

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Appendices

- I SEND Strategy
- II Performance Framework
- III SEND Needs Assessment
- IV Parent/Carer survey
- V Joint Commissioning Plan (SEND 0-25)
- VI SEND Reforms Implementation Plan
- VII LA Audit
- VIII CCG Audit

Introduction

The purpose of this document is to provide a self-evaluation of the current provision in Portsmouth local area around education, health and care services to support children and young people aged 0 to 25 with special educational needs and disabilities, and their families, considering

- How effectively are children and young people aged 0-25 with special educational needs and disabilities in Portsmouth identified,
- How effectively are the needs of children and young people aged 0-25 with special educational needs and disabilities in Portsmouth met, and
- How effectively are the outcomes improving for children and young people aged 0-25 with special educational needs and disabilities in Portsmouth.

This document is intended as a summary, pulling together the key points, summarised from a range of documents and other sources of evidence. The evidence on which this self-evaluation is based is included within the appendices.

Summary of key strengths and areas for further development

KEY STRENGTHS

S1. Strong partnership working

There is strong leadership, clear governance and shared accountability for improving outcomes for children and young people with SEND in Portsmouth. This strong partnership working is evident across organisations and at all levels. This is evidenced by:

- Clear reporting lines to the Children's Trust Board, Health and Wellbeing Board (and via the Portsmouth Blueprint for Health and Care) linking to the Transforming Care Partnership.
- Regular briefings for elected members.
- SEND Strategy, identified as a priority within the Children's Trust Plan since 2007, refreshed in 2016.
- An agreed Joint Commissioning Plan in place.
- Detailed SEND reforms Implementation Plan in place and monitored quarterly.
- Multi-agency planning and decision-making for SEND via the Inclusion Support Panel and High Support Needs Panel.

S2. Co-production

There is a commitment to co-production as the way that we work with families in Portsmouth. This is evidenced by:

- Co-production group of parents/carers meets monthly to work strategically with the LA and partners on SEND e.g. co-design and on-going review and development of the Local Offer website, Future in Mind etc.
- Dynamite (young people's co-production group) annual 'Big Bang' survey and positively evaluated Young Inspectors programme, where trained young people inspect all services on the local offer and provide a feedback report.
- Trained parent/carer representatives are members of the Inclusion Support Panel (the decision-making panel for SEND), Inclusion Transport Appeals Panel etc
- Parent/carer SEN Champions established in mainstream schools across the city.
- Evidence that this approach has been adopted more widely than SEND (e.g. Top tips for professionals, Co-production pledge, CAMHs developments, targeted short breaks etc), as referenced in recent Co-production celebration event etc.

S3. Quality and timeliness of EHCPs

Portsmouth deliver a person centred EHC needs assessment process that results in high quality EHC Plans. This is evidenced by:

- All new EHC needs assessments and transfers of SEN statements to EHCPs include a person centred co-production meeting to co-produce the plan.
- 98% of new assessments are being completed within 20 week statutory timescales.
- On track to complete transfers by March 2018.
- Low level of complaints and appeals to the first tier tribunal.
- Parent/carers and children and young people's feedback via annual survey.
- Continual improvement of EHCPs via ongoing multi-agency workforce development and termly multi-agency EHCP audit.

S4. Quality of specialist SEN provision

The quality of provision for children and young people with statements or EHCPs is good and this is ensuring that many outcomes for children and young people with statements or EHCPs are in line with national or better. This is evidenced by national data and the SEND Strategy quarterly performance reports.

- All Special schools in the city are rated as 'Good' or 'Outstanding' by Ofsted.
- Two successful academy trusts are currently operating in the city, both with a track record of outstanding performance and improved outcomes for children with SEND, with formal links to 4 out of the 5 special schools.
- Recent developments have seen significant improvements in the vocational curriculum offer for children and young people with social emotional and mental health needs, with early encouraging improvements in attendance.
- Successful Special Free School bid, in partnership with Hampshire, to set up a new special free school for children with Autism and associated behaviour, learning or sensory integration needs.

AREAS FOR FURTHER DEVELOPMENT

D1. Educational outcomes for those on SEN Support

Educational outcomes for those with SEND follow the pattern for all children in Portsmouth i.e. outcomes are above national for Key Stage 1 but below national for Key stages 2, 3 and 4. There is evidence that good and outstanding schools in the city achieve above national average progress for pupils on SEN support, however this is not consistent across all schools. The Portsmouth Education Partnership's School Improvement Board (SIB) has identified the need to improve outcomes for those on SEN Support in mainstream schools as a priority. Challenge and support for school improvement is provided to schools via the Partnership. A task and finish group has been in place during the summer term of 2017 to develop the offer of support to schools which will include a range of programmes and interventions: SEND Reviews; deployment of SEN Specialist Subject Leaders (SLEs); outreach support; CPD; etc . A bid to the Strategic School Improvement Fund (SSIF) has been made to enhance this support offer.

In order to improve this we are using the schools dashboard to prioritise schools requiring support to improve outcomes for those on SEN Support and providing targeted programmes and interventions. Impact is monitored via the SIB.

D2. Capturing, monitoring and reporting outcomes at an individual level

It is not currently possible to record (and therefore robustly report on) the health and social care provision specified within EHCPs and the outcomes achieved via Annual Reviews. The use of detailed information about education health and care provision and outcomes for individual children will be used to inform the commissioning of education health and care provision to meet needs and improve outcomes. In addition, identifying costs of health provision within EHC plans is currently not possible due to CCG commissioning via block contracts. A mechanism or tool needs to be developed to be able to match health interventions identified in EHCP to potential costs using a cost matrix.

In order to improve this, the development of the recording mechanisms to enable this to happen has been prioritised.

D3. Further development of joint working arrangements with the newly integrated Prevention and Early Help service

We have recently established a new integrated, multi-agency Prevention and Early Help service, which incorporates a range of professionals such as school nurses and health visitors who are working to a locality model and have a key role in the early identification of SEND.

In order to improve this we are further embedding the place of Early Help Assessments and the understanding of Professionals around the links with EHCPs and SEN Support as well as reviewing the processes that feed into the information-sharing between health and education that takes place via the Early Years Panel to ensure that this information informs commissioning priorities.

D4. Attendance and inclusion

Children with SEND are 4 times more likely to receive a fixed period exclusion from school than those without SEND. The majority of children who are subject to fixed period exclusions, however, are those whose SEND fall into the social emotional and mental health difficulties (SEMH) category. Exclusions rates and trends are monitored by the Behaviour and Attendance Group (BAG).

In order to improve this we are providing targeted support and challenge to schools where school absence and/or fixed period exclusions are high via the Portsmouth Education Partnership. Impact is monitored via the School Improvement Board.

D5. Transition

Transition arrangements to adult services for those with physical disabilities, complex learning difficulties and who attend a special school are good. The pathway is, however, less clear for those who do not meet the criteria for learning disability services, including some young people with autism spectrum difficulties, or those with SEND who are in mainstream schools. Young people tell us that they would like improved information on support to get into employment and to live independently. Whilst participation rates for young people with SEND are above national, there is a need to increase the numbers of young people with SEND in paid employment.

In order to improve this we are coproducing with young people clear and accessible transition information and guidance for young people, to be published as part of the local offer, including information to clarify the pathway from the Annual Review at age 14 onwards.

D6. Autism

Feedback from parents/carers and young people tells us that we still have further work to do with regards to the offer of support for children and young people with Autism.

In order to improve this we have therefore started work on a specific children and young people's Autism pathway which will be aligned to the all-age Autism strategy and monitored via the SEND Board. In recognition that there is a growing need for specialist educational provision for children and young people with Autism we have created an Inclusion Centre for

secondary aged pupils with Autism within one of our mainstream schools and have been successful in our bid for a new special free school for children with Autism.

Portsmouth Context

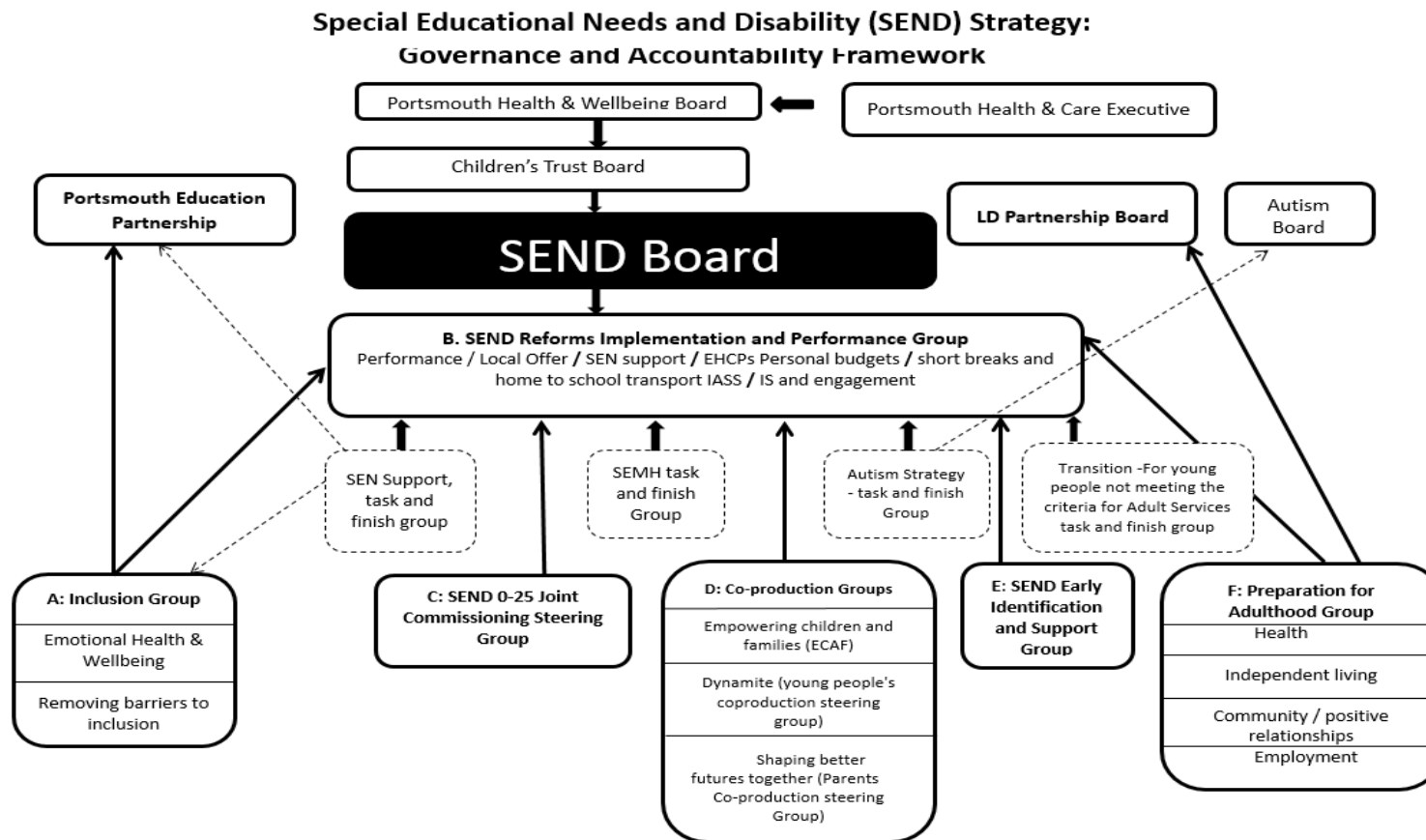
Portsmouth is the most densely populated city in England and has a higher than average level of deprivation.

- Based on the latest child poverty data (2014), 23.3% of all dependent children under the age of 20 are living in poverty, which is above both the England and South East averages of 19.9% and 14.4%. There are significant differences at ward level, e.g. in Charles Dickens, which is the most deprived ward in the city, 47.0% of children are living in poverty.
- The percentage of pupils known to be eligible and claiming free school meals was 18.5% in January 2017, which is 4.6 percentage points higher than the national average for England of 13.9%.
- The proportion of FSM pupils in Portsmouth is high compared to most of our statistical neighbours, and considerably higher than the national average.
- 15.6% of pupils attending Portsmouth schools in 2017 had special educational needs (SEN), which includes 3.3% (940 pupils) with a statement of SEN /EHC Plan
- The proportion of SEN pupils in Portsmouth has changed considerably since 2015 and is now lower than our statistical neighbours, and the gap to national has reduced.

There are 63 state funded schools in Portsmouth - 48 Primary phased, 9 Secondary phased, 1 All through and 5 Special schools.

SEND STRATEGY

The Portsmouth SEND Strategy is one of the priorities within the Children's Trust Plan. There has been a strategy in place since 2012 aimed at improving services and outcomes for children and young people with special educational needs and their families. The current strategy covers the period 2016-2019. Governance and accountability is via the SEND Board to the Children's Trust Board and Health and Wellbeing Board.



The aim of the SEND Strategy is to promote inclusion and improve the outcomes for Portsmouth children and young people aged 0-25 years with SEND and their families.

The strategy includes 6 key workstrands:

- Strand A - Promote good inclusive practice to improve outcomes
- Strand B - Successful implementation of the SEND reforms
- Strand C - Effective joint commissioning to improve outcomes
- Strand D - Co-production, embedded as a way of working with children, young people and their parents and carers
- Strand E - Early identification and early support for children with SEND and their families
- Strand F - Effective preparation for adulthood and smooth transitions to adult services

The work undertaken within each of these workstrands is overseen by a subgroup of the SEND Board. Each Subgroup reports quarterly to the SEND Board

In 2014, Portsmouth was asked by the Department for Education to take on a champion role, providing support to other local authorities across the South East, in particular around the development of EHCPs and also in the development of the local offer. Portsmouth was the first local authority to have EHCPs published by the DfE as exemplars, fully compliant with the new SEN Code of Practice.

In 2015, Portsmouth was successful in a bid to lead the SEND Peer Network across the 19 local areas in the South East region. Portsmouth were asked to continue this role through 2016/17 and 2017/18. The South East Directors of Children's Services have provided additionality to this through the ADCS sector-led improvement programme. The strategic lead for the implementation of the SEND reforms in Portsmouth also represents the ADCS on the DfE national SEND advisory board.

The full SEND Strategy can be found in **Appendix I**

The accompanying Performance Framework can be found in **Appendix II**

CO-PRODUCTION

Portsmouth has a strong history of working in partnership with parents and carers of children with SEND, as a demonstrator site for the Lamb enquiry in 2009. One of the outcomes of this was the establishment of trained parent/carers representatives on the decision making panel for SEND, the Inclusion Support Panel. A parents' co-production group was established in 2012, a group which continues to meet monthly and works in partnership with the local area on a range of strategic priorities e.g. the co-production group designed the local offer website and continue to oversee its development.

Coproduction continues to be a key workstrand within the SEND Strategy and the SEND Board is co-chaired by the chair of the Parent/Carer Forum.

Co-production with parent/carers has been facilitated by joint funding for Portsmouth Parent Voice from the Local Authority and CCG, as well as funding for a Parents Engagement Officer. Key achievements have included:

- The parents co-production group has become the parent/carers strategic co-production steering group, renamed Shaping Better Futures Together. This group monitors the Local Offer website on a monthly basis using case studies and a 'mystery shopper' approach to provide feedback and further develop the website.
- The Shaping Better Futures Together group monitors and provides monthly feedback on the Local Offer website in order to facilitate further development of the website and identify gaps in provision.
- SEN Parent Champions have been established in a number of mainstream schools to engage particularly with parents of children receiving SEN Support.
- Co-production is becoming embedded across Portsmouth, in health as well as the local authority e.g. A Future in Mind Co-production group has been established with CAMHs service users.
- Parent/carers views are sought in a number of ways (e.g. coffee mornings, annual parents/carers survey) and fed back to commissioners via a monthly 'What's trending' report.
- Parents nominate professionals for Parent Appreciation Awards to celebrate and share good practice.
- Appreciation awards have been presented to around 30 professionals

- New parent/carer representatives have been recruited and trained as members of the Inclusion Support Panel, where decisions are made about EHCPs.

Co-production with Children and Young People has been facilitated by funding for a Young People's Engagement Officer. This role has contributed to:

- Setting up a young people's co-production group, Dynamite. The Core group meets monthly to discuss a range of issues, including planning regular Pizza evenings to engage with a wider group of young people with special educational needs and disabilities on a range of issues.
- Developing the Young Inspectors programme whereby 12 young people with SEND have been trained to visit services included within the local offer and to provide an inspection report giving feedback on that service from the perspective of young people.
- Conducting an annual 'Big Bang' survey of the views of young people with SEND about the services and support they receive.
- Delivering training to professionals from a range of agencies on listening to the voice of young people.
- Training delivered by young people to 25 professionals across agencies

In the refreshed strategy the Empowering Children and Families (ECAAF) group will oversee the work of the various co-production groups and report on their behalf to the SEND Board.

Local Offer

A summary of the Local Offer is provided below, covering education, health and social care services for children and young people with SEND and their families. The full Local Offer is published on www.portsmouthlocaloffer.org.

EDUCATION

Early years

- The city invests in early years provision so that children have a positive start to their formal education. 99% of eligible 3 and 4-year olds and 82% of eligible 2-year olds access free early education, compared to 72 % nationally.
- There are 6 Children's Centres, 4 of which have been inspected since 2013 and judged as Good.
- The Ofsted profile to 31 March 2016 shows that of the 92 childcare providers on non-domestic premises, 87% are judged 'good or better' (26% of which are outstanding compared to 17% nationally). It also shows that of the 105 childcare providers on domestic premises, 89% are judged 'good or better' compared to 83% nationally.

Mainstream schools

The vast majority of children with SEND are educated within a mainstream school. Schools receive a notional SEN budget with which to make available up to the first £6,000 of SEN support which a child might require in order to access the curriculum and make progress.

Inclusion Centres within mainstream schools

There are 9 mainstream schools with an Inclusion Centre (additionally resourced provision) for children with SEND. Of these,

- 2 are for sensory impairment (1 primary and 1 secondary),
- 2 are for communication and interaction difficulties (focusing on speech language and communication needs),
- 2 are for communication and interaction difficulties (focusing on social communication needs),
- 2 are for communication and interaction difficulties (focusing on children and young people with autism, 1 primary and 1 secondary),
- 1 is for alternative provision places for pupils with social, emotional and mental health difficulties.

Additional support for mainstream schools

- An outreach service is commissioned from a partnership of all special schools within the city to provide support to mainstream schools to enable them to effectively meet pupils' special educational needs and enable children to continue to be included within mainstream schools.
- Specialist support for children with a sensory impairment is provided by the Inclusion Service.
- In addition, schools can buy in additional support e.g. from the educational psychology service for pupils on SEN support.

Special schools

There are 5 special schools: of these 2 are maintained and 3 have academy status. These include:

- 1 specialist nursery,
- 1 primary and 1 secondary school for children with complex needs and autism,
- 1 all-through school, including a small nursery for children with profound and multiple learning difficulties,
- 1 secondary school (which also includes a Year 6) for children with social emotional and mental health difficulties. This school also delivers alternative provision for children from year 6 to year 11, and education for children who are not able to access school for medical reasons. In addition, this school also provides individual tuition and Multi-agency Behaviour Support as traded services.

Further education

After attending school, students largely attend one of four local Colleges either in Portsmouth (Highbury and Portsmouth Colleges) or Havant (South Downs and Havant Colleges); 2 of which are judged good and two outstanding (1 of each in Portsmouth). Portsmouth College includes specialist provision for young people with significant cognition and learning needs. Highbury College includes specialist provision for young people with social emotional and mental health needs.

HEALTH

Health Services are commissioned by using a graduated response - Universal, Targeted and Specialist and Highly Specialist.

Maternity Services (Portsmouth Hospital Trust (PHT)

Portsmouth City maternity services are provided by Portsmouth Hospital Trust (PHT). The acute care provision is delivered across both the main Queen Alexandra hospital (QAH) providing a choice of obstetric /consultant lead care, a midwifery led unit and a separate midwifery led unit located in the St Marys' community health campus, which supports home deliveries and doubles as a virtual children's centre. The commissioning arrangements for antenatal and newborn screening fall within the remit of NHS England.

Specialist Health Visitors (Solent NHS Trust)

The team deliver a specialist health visiting service with targeted support and interventions to children with disabilities and their families from the antenatal period up to the end of a child's first year at school (Reception Year).

Specialist School Nursing (Solent NHS Trust)

Provision of assessment and treatment of children / young people with identified health care needs attending the school. This includes family & professional liaison, Care planning, training, Child Health Promotion and attending clinical emergencies.

Childrens Community Nursing (Solent NHS Trust)

This service is provided by Solent NHS Trust and consists of 3 elements with a joint aim to prevent children being admitted to hospital unless it is unavoidable and to support children being safely discharged from hospital as soon as possible. The aim of these services is to provide a high quality in reach and outreach nursing service and to enable early, safe planned discharge from hospital and to prevent unnecessary admissions. These services are a link between primary and secondary care and support and encourage the development of partnership working. The three teams are:

- **Childrens Community Nursing Team** - provide specialist nursing care, support and co- ordination of care to children and young people with a range of complex health care needs and disabilities. The CCN team also provides nursing support into Mary Rose Special School and has a Nurse Therapist who provides loss and bereavement support.
- **Children's Continuing Care Team** - NHS continuing care is support provided for children and young people under 18 who need a tailored package of care due to healthcare needs arising from a disability, accident or illness that cannot be met by universal or specialist health services alone. provide individualised packages of care to children and young people with long term, complex

health needs, many of whom are technology dependant. This care is provided around the clock and all receiving the service must meet the criteria for children's continuing care. Direct nursing care is provided 24/7 by a team of nursery nurses and qualified paediatric nurses.

- **Children's Outreach, Assessment and Support Team (COAST)** - The C.O.A.S.T team provides care to acutely unwell children for short periods of time. This team includes an Advanced Paediatric Nurse Practitioner (APNP) and also includes a community respiratory nurse and a community diabetes nurse. The team visit the children in their own homes to monitor and reassess their condition until they recovered from their illness

Community Paediatric Medical Service (Solent NHS Trust)

The CPMS is a consultant led secondary care, community service which is provided by Solent NHS Trust. The service provides specialist assessment for children and young people with developmental problems and neurodisability, e.g. motor and speech and language delay, for those with physical and or learning disabilities, children with suspected chromosomal or syndrome diagnoses, children with social communication difficulties and possible autism. They provide including ongoing management and treatment for relevant medical problems associated with their neurodisability particularly where the medical needs are complex.

Paediatric Therapies Service (Solent NHS Trust)

The Solent NHS Children's Therapy Service provides community based Speech and Language Therapy, Physiotherapy and Occupational Therapy to children and young people aged 0-19 years (if in education) who are registered with a Portsmouth City GP or who attend a Portsmouth school. Children develop in different ways and when they have specific problems with their development, they may need specialist assessment and advice from a Therapist. After assessment and in discussion with you, the therapist will decide the best way to support your child which may include one or more of the following:

- Therapy activities / advice to support your child in day to day situations. This will be carried out by those people involved in your child's daily care e.g. preschool staff or teaching assistants
- Training and advice for parents/carers and other services involved in your child's care (health, teachers, social care)
- Individual therapy with you and your child
- Therapy in a group
- Advice regarding possible need for specialist equipment.
- Involvement with educational services and planning for transition e.g. moving up to school.
- Advice on other relevant services who may be able to help.
- Referral on to a more appropriate or specialist service

Progress is reviewed regularly in partnership with parents and others and further recommendations and actions may be made. Therapy may not be required once a child's needs can be managed and supported effectively by their everyday environment.

CAMHS (Solent NHS Trust)

CAMHS - Child and Adolescent Mental Health Service

The provision of CAMHS is jointly commissioned by Portsmouth CCG and Portsmouth Children's services. It describes the role, function and responsibilities of the following elements of the service.

- The Single Point of Access (SPoA)
- Specialist and Extended CAMHS
- The Targeted Looked After Children Team
- The Targeted Learning Disability Team

CAHMS Learning Disabilities Team (LD) (Solent NHS Trust)

CAMHS-LD is a specialist team within CAMHS that offers assessment and treatment options for a range of behavioural, emotional and mental health difficulties in children with learning disabilities. The team is multi-disciplinary and includes practitioners from Nursing, Psychology, Psychiatry and Occupational Therapy. CAMHS-LD works in partnership with families and with professionals from other services including Education, Social Care, Respite services and Voluntary Services such as Enableability

Autism Diagnostic Service - (Solent NHS Trust)

This service is provided by Solent NHS Trust and is delivered by two separate teams, Community Paediatric Medical Service (CPMS) receive referrals for young children 0-6 years and Child and Adolescent Mental Health Services (CAMHS) receive referrals for young people aged 6-18 years for concerns around Autism (Autistic Spectrum Disorder) or other developmental problems. The aim of this ASD Assessment Pathway is 2 fold: to assess children to get a profile of their strengths and difficulties to see if their difficulties fit with the diagnosis of ASD or other developmental disorders. The second aim is to support families through the entire assessment process and provide clear information and guidance to access the appropriate support services to help you with your child's behaviours.

Wheelchair Service (Millbrook Healthcare)

The Hampshire wheelchair service will provide wheelchairs to all patients registered with a GP within the boundaries of NHS Portsmouth. Assessment for children will be undertaken in family-friendly, child-orientated facilities by staff specially trained in the assessment of children with requirements for wheelchairs and seating.

Specialist Peri-Natal Mental Health Services (Southern Health NHS Foundation Trust)

The Community Perinatal Mental Health Service aims to ensure that women in pregnancy and postnatally who have current or previous history of mental illness who cannot be appropriately managed by primary care receive timely and high quality treatment, care and support to minimise the high risks posed to themselves, families and services.

Low-level Peri-Natal Mental Health Services (Solent NHS Trust and Respond)

The service is an early intervention, low intensity service for those with low level (mild to moderate) mental health issues or who are at risk of developing mental health issues in the perinatal period. The primary purpose of the service is to provide support to enable individuals, partners and families to self-manage their mental wellbeing and prevent escalation in their condition.

Bladder & Bowel - Continence (Solent NHS Trust)

The service will deliver a specialist high quality, cost effective, clinically led specialist service in the community for children and adults with bladder and bowel dysfunction, with or without associated incontinence. The service will be based within the city and offer a range of clinic and home (individual and residential care settings) appointments as required.

Enuresis and Encopresis (Solent NHS Trust)

There are many different pathways for this service. It is still being worked on to have a definitive pathway therefore there is no more information at this time. A copy of the draft pathway can be requested.

SOCIAL CARE

Targeted short breaks

The local short break offer is hosted by Inclusion Service and administered by the Short Breaks Officer. The local short break offer provides a base line level of support to those children and young people who meet the published eligibility criteria. The eligibility criteria were revised in April 2016 following a consultation with parent carers and other significant stakeholders. The short break offer including eligibility criteria can be found on the local authority's Local Offer web-site:

<http://www.portsmouthlocaloffer.org/local-offer-search/item/14>

Specialist offer

Children's Social Care & Safeguarding (CSCS) take the lead in safeguarding and protecting vulnerable children and young people in the city. CSCS work with children and families and outside agencies to ensure children and young people in the city are protected and well cared for as well as promoting quality childcare that works to improve the outcomes for children, including:

- **Multi-agency Safeguarding Hub (MASH)** - Access to services is determined by means of an inter-agency referral through the multi-agency safeguarding hub, known as MASH. MASH consists of representatives from a range of agencies including Police, Health, Education, Children's Social Care and Safeguarding, Probation, Adult Social Care, Mental Health and others. The benefit is that they can quickly share information and make decisions as to the required level of intervention.
- **Through Care Team** - work with children and young people who are looked after by the local authority either by voluntary agreement with the parent(s) holding parental responsibility for the child, or by virtue of the child being the subject of a legal order. Where a looked after child is deemed to have special educational needs and/or disabilities, the child's allocated social worker will assume the role of corporate parent, and actively engage and participate in the Education, Health and Care Plan (EHCP) process. **Children's Disability Team** - provides a specialist service for those children and young people between the age of 0-18 years who have profound needs arising from complex disabilities and health needs. This includes working with both so-called 'child in need' and 'looked after' cases.

Intervention typically involves:

- Undertaking assessments using the SAF to identify unmet needs
- Overseeing the development and coordination of plans to address any unmet needs identified in the assessment.
- Referring on and joint working cases with professionals from other disciplines and agencies
- Commissioning a range of services to address unmet needs and deliver the outcomes specified in the child's plan. These can include both community support within and outside of the home, as well as overnight short breaks through the Family

Link Scheme or Beechside Short Break unit. Where it has been assessed and deemed necessary to commission community based support as opposed to overnight short breaks, the support can take two forms. It can either be commissioned on behalf of the child/family from a local service provider, or the parent can receive a direct payment from the local authority to enable them to arrange their own support.

- Reviewing progress at the required intervals prescribed by CSCS case management procedures. This includes having to complete reviews at between 4-6 monthly intervals and updating the assessment every 13 months.
- Transition planning/Preparing for Adulthood: There is an established process in place for supporting transition planning which typically starts around the time of the Year 9 Annual Review.

Case work involving looked after children is typically concerned with those children who are voluntarily accommodated with parental agreement due to the complexity of the child's disability related needs. However, it also includes those children whose legal status has been secured through a legal order and where the child has been formally long-term linked to their current carer. In both cases the CDT will actively engage and contribute to the EHCP process and participate in the co-production meeting as described above.

Commissioned support

CSCS commission a range of community based support services from local and regional service providers. This can involve support in the family home working alongside parent carers, as well as community based support to enable the child/young person to access local leisure and community activities.

Data Analysis

A 0-25 SEND needs assessment was conducted in 2016 and is published as part of the Joint Strategic Needs Assessment. This needs assessment will be refreshed annually. **An updated version is due to be published in September 2017.**

In addition, performance data is published as part of the Performance Framework. This includes national and regional data, with a commentary detailing local performance.

The SEND Performance Framework can be found in **Appendix II.**

The SEND Needs Assessment can be found in **Appendix III.**

User feedback

Feedback is sought from children, young people and parents and carers in a number of ways, including:

- Annual Parent/Carer survey.
- 'What's Trending' monthly report of key issues being discussed by parents on social media.
- Local Offer Feedback, included within Local Offer Annual Report.
- Dynamite annual 'Big Bang' survey.

This feedback is reported to the SEND Board via ECAF and the Implementation Group and is used to inform service improvement and service development.

The report from the latest Parent/Carer survey can be found in **Appendix IV.**

Service Improvement cycle

Our ambition in Portsmouth is to continually improve services for children and young people with SEND and their families in order to improve their experience of the system and the outcomes achieved. In order to do this, there is a continuous cycle of improvement, which includes the following:

- An analysis of complaints and appeals to the first tier tribunal is completed annually in order to identify emerging themes for learning and service improvement.
- Portsmouth are the lead for the South East regional SEND peer network and is actively engaged in a wide range of activities organised by the network with the aim of sharing good practice and providing peer support.
- Portsmouth have engaged in a Peer Review with Reading local area of the Local Offer and in preparation for SEND inspection.

Self-evaluation of Portsmouth local area's effectiveness in identifying the special educational needs and disabilities of children and young people, meeting needs and improving outcomes

	Areas of strength	Next steps for development
1. Leadership		
	<p>There is strong strategic leadership, clear governance and shared accountability across the partnership through the SEND Board, Children's Trust Board and the Health and Wellbeing Board, as set out in the SEND Strategy.</p> <p>Improving outcomes for children and young people with SEND is one of the four priorities of the Children's Trust. The Children's Trust Board is chaired by the Cabinet Member for Children's Social Care, and has senior level representation from agencies across the city. The Board regularly considers progress against the outcomes set out in the plan, and regular reports also go to the Health and Wellbeing Board (twice a year), to the Learning Disability Partnership Board and the Parent/Carer Board. The Portsmouth SEND strategy is owned and delivered by a wide operational partnership of services for 0-25 year olds with SEND, including schools, colleges, early years settings, children's centres, health services etc.</p>	<p>We are working hard to communicate developments with provision so that all partners appreciate the link between SEND and Early Help, Future in Mind etc.</p> <p>We have not chosen to implement structural changes across children's and adults services in order to create an integrated 0-25 service for children and young people with SEND as Portsmouth is a small city and there are positive professional relationships between services so it is considered that joined up service provision can be achieved without structural integration and pooled budgets. The Children's Disability Service is, however, integrated with the SEN service within Education.</p> <p>Current mechanisms for recording and reporting on EHCPs don't easily allow for reporting on the health provision included within individual EHCPs in order to inform commissioning priorities, This is being addressed.</p>

2. Joint arrangements

There is excellent partnership working with education settings to drive forward the inclusion agenda

There are many examples of good practice in working with schools in the city, including work to develop alternative exclusions, the development of the SENCO network and the development of the Ordinarily Available Provision documents.

There is a positive working relationship with colleges which has enabled the authority to support development of provision. Examples of this include the Engage Programme at Highbury and the new Portsmouth College Life Skills Centre. The Portsmouth College Skills Centre has ensured that young people with complex needs can continue their education in the City rather than having to travel out of area.

We also work very positively with Early Years settings and providers. Settings use and follow the early years pathway in line with the Local Offer in order to identify needs early (early identification). Settings fully engage in multi-agency working and make timely and appropriate referrals to outside agencies as appropriate. Support and training is offered to settings to meet the needs of children with SEND in mainstream settings, with further specialist provision offered via the Portsmouth SEN Support Partnership (PSENSP).

Whilst there is a good awareness of the SEND reforms among the workforce directly impacted, there is a need to ensure there is ongoing awareness raising and workforce development among the wider workforce e.g. universal services/primary care to ensure that professionals are informed about the impact of the SEND reforms on their practice. Some examples of good practice include the workforce development that has taken place with health practitioners in community children's services (CAMHS, Health Visitors etc) and also the development of an SEMH training offer in response to an identified need.

There is further work to be done to join up the Early Help offer with SEN Support, including workforce development for professionals who may be supporting families where a child has SEND.

Joint working needs to be further developed across transition points e.g. primary to secondary school, children's to adults' service, particularly for children and young people on SEN support.

3. Commissioning		
	<p>A SEND Needs Assessment has been completed and will be refreshed annually.</p> <p>A Joint Commissioning Plan has been agreed across the CCG, local authority, Schools, Solent and Portsmouth Parent Voice. This sets out the agreed joint commissioning priorities for 0 to 25 year olds with SEND.</p> <p>User feedback informs commissioning priorities e.g. new special free school for children with Autism.</p> <p>Coproduction is embedded as the way that commissioning activity is undertaken in the city e.g. Future in Mind.</p>	<p>There is increasing demand for services and this is putting pressure on resources e.g. special school places.</p> <p>A SEND Strategic Review is underway and due to report by March 2018. This will inform future commissioning priorities and help to ensure that commissioning plans are sustainable going forwards.</p> <p>There is a need to ensure that early identification and information from individual EHCPs is used to inform future commissioning priorities.</p>

4. Education, Health and Care Plans

Portsmouth was the first local area to have EHCPs published by the DFE as exemplars, fully compliant with the new code of practice. Since then, the quality of EHCPs has been further developed and improved.

This in an area where the authority and partners have retained a relentless focus. Work to ensure quality has included:

- Termly multi-agency EHCP audit identifying strengths and areas for development
- Workforce development for evidence-writers in education, health and social care
- Regular EHCP writers 'masterclass' sessions with DfE SEND adviser.

Timeliness of EHCPs/transfers has improved rapidly in response to identified parental concerns

This has been a key area of focus since the first year of the reforms. A review of the EHCP process and of the reasons for late completions of plans was undertaken over August 2015, in co-production with parents and a number of changes were implemented. In the last academic year (2016-17) the rate rose significantly to 98% of EHC needs assessments (both new and transfers) completed within statutory timescales. The main reason for EHCPs being issued late is late receipt of evidence.

Further work is underway in community health provision to ensure that information and evidence requirements are identified and addressed swiftly, as part of the Quality Improvement Programme.

The Designated Clinical Officer has played a pivotal role in ensuring that the practice of health professionally has developed in response to the new code of practice.

An induction programme for all new staff across the children's workforce is being developed to clarify roles and responsibilities in relation to SEND.

Criteria are being developed for health professionals to clarify priorities for attendance at Co-production meetings and person-centred Annual Reviews.

	Transfers of statements to EHCPs take place through the same person-centred process as for new assessments, with all families invited to a Co-production meeting to coproduce their Plan.	
5. Co-production		
	<p>Portsmouth has a strong history of working in partnership with parents and carers of children with SEND, building on work as a demonstrator site for the Lamb enquiry.</p> <p>In Portsmouth children, service users are engaged strategically in co-production through the Shaping Better Futures Together parent/carers' strategic co-production group and the Dynamite children and young people's strategic co-production group. The work of both of these groups is overseen by the Empowering Children and Families (ECAf) groups and is reported to the SEND Board. Young people and parent/carers are represented on the SEND Board and all subgroups. Parent/carers contribute to decision-making, as trained members of the Inclusion Support (decision-making) Panel.</p> <p>Children, young people and their parents and carers contribute to the coproduction of their EHCPs via This is Me documents and by being invited to a person-centred Co-production meeting. All transfers from statements to EHCPs take also place via a co-production meeting. All EHCPs are reviewed via a person-centred Annual Review.</p>	<p>Whilst there is good evidence that co-production has become the way of doing business in Portsmouth, it is early days in terms of being able to evidence that services are being commissioned differently as a result. One example where this can be seen is the commissioning of the new mental health provision under the Future in Mind agenda.</p> <p>Parent /carer representatives contribute to all subgroups of the SEND Board, including the joint commissioning steering group, and have helped shape the commissioning priorities, but specific contracts are reviewed on an annual cycle and so this will take a while to be evidenced in service redesign and improved outcomes.</p> <p>In relation to the young people's co-production group, the numbers of young people engaging with Dynamite are small and it is early days in terms of being able to evidence that this is having an impact on commissioning decisions.</p> <p>Work is now ongoing to support the next steps for development for the co-production groups, ensuring that we engage with a wider group of parents and</p>

		young people, including those who are harder to reach. This work includes funding for a Parent Engagement Officer who has established SEN champions in a range of mainstream schools.
6. Monitor and redress		
	<p>Portsmouth historically has a low level of complaints and appeals to the first tier tribunal.</p> <p>Analysis of the reasons for complaints has been identified and used to identify key issues. For Portsmouth, these are SEMH provision, provision for children with autism and challenging behaviour.</p> <p>Following each tribunal a reflection meeting takes places to identify lessons learnt and to implement any necessary changes to practice as a result.</p>	<p>Steps have been taken to address these areas e.g.</p> <ul style="list-style-type: none"> • working in partnership with The Harbour School to improve the SEMH offer, • Successfully bidding for funding for a new special free school for children with autism and challenging behaviour. <p>As a small city where relationships between professionals across agencies are generally good, most disagreements between agencies are able to be resolved informally, however consideration is being given to whether there is a need for a more formal process to resolve potential disputes.</p>

7. How effectively do we identify disabled children and young people and those who have special educational needs?		
	<p>Processes for early identification of SEND in Portsmouth are robust</p> <p>There are a number of processes for identification of SEND including:</p> <ul style="list-style-type: none"> - <u>Early years panel</u> process ensures information is shared between agencies when difficulties are identified by health professionals before a child reaches school age - SENCOs have collaborated to develop the <u>ordinarily available provision</u> document to ensure consistency on demonstrating impact of SEN Support provided before requesting an EHC needs assessment - Decisions about EHC needs assessment are made by the <u>Inclusion Support Panel</u>, which has been highlighted by the DfE as an example of good practice. The panel includes trained parent representatives. <p>Further examples of good practice include support provided by Portage/Pelican, Specialist Health Visitors etc.</p>	<p>In order to improve consistency across schools/settings we have established the SENCO Network and Early Years Inclusion networks to share best practice in relation to SEN. We are aware however that outcomes are not as good as we would like them to be for children and young people on SEN Support e.g. children with SEND are four times more likely to be persistently absent from school and to receive a fixed period exclusion from school than those without SEND.</p> <p>The majority of children who are subject to fixed period exclusions are those whose needs fall into the social, emotional and mental health difficulties category. Exclusion rates and trends are monitored by the Behaviour and Attendance Group (BAG). Support and challenge is provided to schools where fixed period exclusions are high via the Portsmouth Education Partnership.</p>

8. How effectively do we meet the needs of disabled children and young people and those who have special educational needs?

The local offer is published at www.portsmouthlocaloffer.org . The website has been co-produced with parents/carers and young people. Its review and continued development in response to feedback is overseen in partnership with parents/carers and young people.

The local offer website includes over 32 pages of information, guidance and forms, and has been accessed by parents, young people and professionals with positive comments on how useful the website is. In the first year there have been 8,162 visitors to the website visiting 29,566 pages.

A range of methods and activities have been employed to raise awareness of the Local Offer, particularly for those who have difficulty in accessing the information. Work undertaken includes:

- Letters of appreciation sent to local services to celebrate good, inclusive practice
- Local Offer Live annual event for families
- Mystery shopping on the website

The local offer website also includes statements of ordinarily available provision, and these statements and availability on the website were recently highlighted as good practice by the Council for Disabled Children

We need to ensure that the information remains useful and accurate. Without this the reputation of the Local Offer site will suffer, and we need to look at a range of ways of generating quality feedback that can help inform commissioning of local provision. We also need to improve some known information gaps on early year's settings and information and on post 16 work and careers that needs improvement.

	<p>(http://councilfordisabledchildren.org.uk/help-resources/resources/local-offer-briefing).</p> <p>We have recently taken part in a peer review of the local offer with Reading and made a number of improvements as a result of the feedback received.</p>	
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9. How effectively do we improve outcomes for disabled children and young people and those who have special educational needs?		
	<p>The outcomes for children and young people with statements/EHCPs in Portsmouth are in line with national or better including attendance, attainment and participation</p> <p>The 3.1% of children and young people with an EHCP were very much the focus of the SEND Strategy through to 2016. Outcomes have been monitored by the SEND Board and the Children's Trust Board. The new Strategy for 2016-19 has broadened the focus to include outcomes for the 11% receiving SEN Support.</p>	<p>Educational outcomes for those on SEN support follow the pattern for all children in Portsmouth i.e. outcomes are above national for KS1 but below national for KS 2 and 4.</p> <p>There is a clear process for monitoring the performance and progress at a school level via the Portsmouth Education Partnership and following up, where necessary, with support commissioned from the Teaching School Alliance.</p> <p>However, educational outcomes for those children and young people at the SEN Support level remains a concern, and we are working with the Portsmouth Education Partnership on improving this, in particular considering where there is particular good practice that can be identified and shared.</p>

		<p>In relation to post-16 education, employment and training, we note that whilst participation rates for young people with SEND are above national, there is a need to increase the numbers of young people with SEND in paid employment.</p> <p>Transition arrangements to adult services for those with complex learning difficulties and who attend a special school are good; however, the pathway is less clear for those who do not meet the criteria for Adults Services.</p> <p>This includes some young people with autism spectrum difficulties, or those with SEND who are in mainstream schools. Further work is underway to provide clear information and guidance in order to clarify the pathway from the Annual Review at age 14 onwards.</p>
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What do parents, carers, children and young people tell us?

SEN Support

Parents tell us that they are frustrated around SEN support where the help and support provided by schools across the city is not consistent. Some SEN support plans provide little detail and poorly defined outcomes, leaving parents at a loss as to what it means. Some schools excel in this area and have a great communication with parents by being very responsive and engaging and by organising drop-ins within their schools to encourage the sharing of information and signposting to available support.

In order to address this,

- School SEN champions have been established in mainstream schools across the city,
- Information and professional development is provided via the SENCO Network,
- Professional development is provided via the Inclusion Conference,
- Portsmouth Parent Voice have widened their engagement with schools and colleges,
- Information has been included on the Local Offer website.

Transition

Parents are often left bewildered by the complexity of post-16 transition in several areas: education, benefits, health, social care and mental capacity. Parents have mentioned that they would like to have a guide to explain what happens post-16. This is particularly relevant for young people on SEN support as a lot of them seem to be 'falling through the gap'.

In order to address this, a Post-16 guide is being designed in co-production with parents, as part of the work of the Preparing for Adulthood group.

Home Education

There has been an increase in the number of home educated children. Many families who have decided to home educate have children with anxiety, behavioural issues or autism and took the decision following repeat exclusions, part-time time tables, breakdown of communication with the school, lack of understanding of child's needs and lack of adequate provision locally.

In order to address this,

- Portsmouth Parent Voice organises Home-Education parent workshops,
- Information has been included on the Local Offer website,

- Additional information is being provided to parents choosing to home educate, e.g. about health services available to them.

Autism, behaviour and anxiety

The majority of enquiries from parents and carers to Portsmouth Parents Voice are around autism, behaviour and anxiety issues. Parents express frustrations when trying to access services. They receive conflicting advice about whether or not they need a diagnosis to receive support, who can refer for support etc. Parents tell us that they would like to access to practical advice and that they don't like being put automatically on a parenting course in order to have access to CAMHS. Early help and support and an informed response from schools would give parents confidence in the system.

In order to address this,

- A children's autism pathway is being developed, aligned to the all-age autism pathway, overseen by the Autism Board,
- The Autism Coordinator role has been continued,
- The 'U Matter' service has been commissioned, in co-production with parents,
- The whole school emotional health and well-being strategy is being implemented.

Parents in Portsmouth are very positive about the specialist services available to them. Parents whose children attend special schools in the city are generally very happy. CAMHS LD, Specialist health visitors, Portage and short break provision are all highly valued by parents.

Parents have been particularly proud of their involvement in the Future in Mind Strategy, and their work in developing the new Early Help Service from service design to tendering process. Other work that parents have highlighted as an achievement includes the work of the School SEN Champions, and the development of Appreciation Awards to recognise an excellent experience.

Appendices

- I SEND Strategy - Page 36**
- II Performance Framework - Page 37 - 75**
- III Parent/Carer survey - Page 76 - 169**
- IV Joint Commissioning Plan (SEND 0-25) - Page 170 - 186**
- V SEND Reforms Implementation Plan - Page 187 - 194**
- VI LA Audit - Page 195 - 209**

I. SEND Group Headteacher representative contact details

A. Promote Good Inclusive Practice

Primary HT TBA & Diane Cook d.cook@arundelcourt.com
 Secondary HT TBA

B. Successful Implementation of The Send Reforms

Primary HT TBA & Diane Cook
 Secondary HT TBA & Sarah Christopher schristopher@priory.portsmouth.sch.uk

C. Effective Joint Commissioning

Primary HT Sandra Gibb sgibb@stgeorges.portsmouth.sch.uk & Polly Honeychurch head@cottagegrove.co.uk
 Secondary HT TBA

D. Co-Production

Primary HT ?
 Secondary HT ?

E. Early Identification

Primary HT TBA
 Secondary HT ?

F. Preparation for Adulthood

Secondary HT



SEND Board
Performance Framework Quarterly
Report
Quarter 1 - April - June 2017



Contents

- I. Introduction
- II. Performance Summary
- III. Local Area SEND information
- IV. Performance Data
 - A. Outcome Indicators
 - B. Inputs, Outputs & Process Indicators
 - C. Demand Management Indicators
 - D. Experience of the system narrative
 - E. What's trending report

I. INTRODUCTION

The aim of the special educational needs and disability (SEND) strategy is to promote inclusion and improve the outcomes for Portsmouth children and young people aged 0-25 years with SEND and their families.

In order to improve outcomes, we aim to ensure that there are in place a range of high quality support services that contribute to removing the barriers to achievement for all Portsmouth children and young people, in particular those with special educational needs and disabilities. This includes enabling children and young people to lead healthy lives and achieve wellbeing; to benefit from education or training, with support, if necessary, to ensure that they can make progress in their learning; to build and maintain positive social and family relationships; to develop emotional resilience and make successful transitions to employment, higher education and independent living.

Key outcomes to be achieved

The strategy aims to achieve increased percentages of children and young people with SEND who are able to:

1. Be included within their local community,
2. Lead healthy lives and achieve wellbeing,
3. Learn and make progress,
4. Make and maintain positive relationships within their family and community
5. Participate in education and training post-16 and prepare for employment

The quarterly performance reports provide the SEND Board and Children's Trust Board with key data to understand performance at a system-wide level, and to manage the impact of work in support of the overarching SEND strategy.

There are six strands of the SEND Strategy:

Strand A: Promote good inclusive practice to improve

Strand B: Successful implementation of the SEND reforms

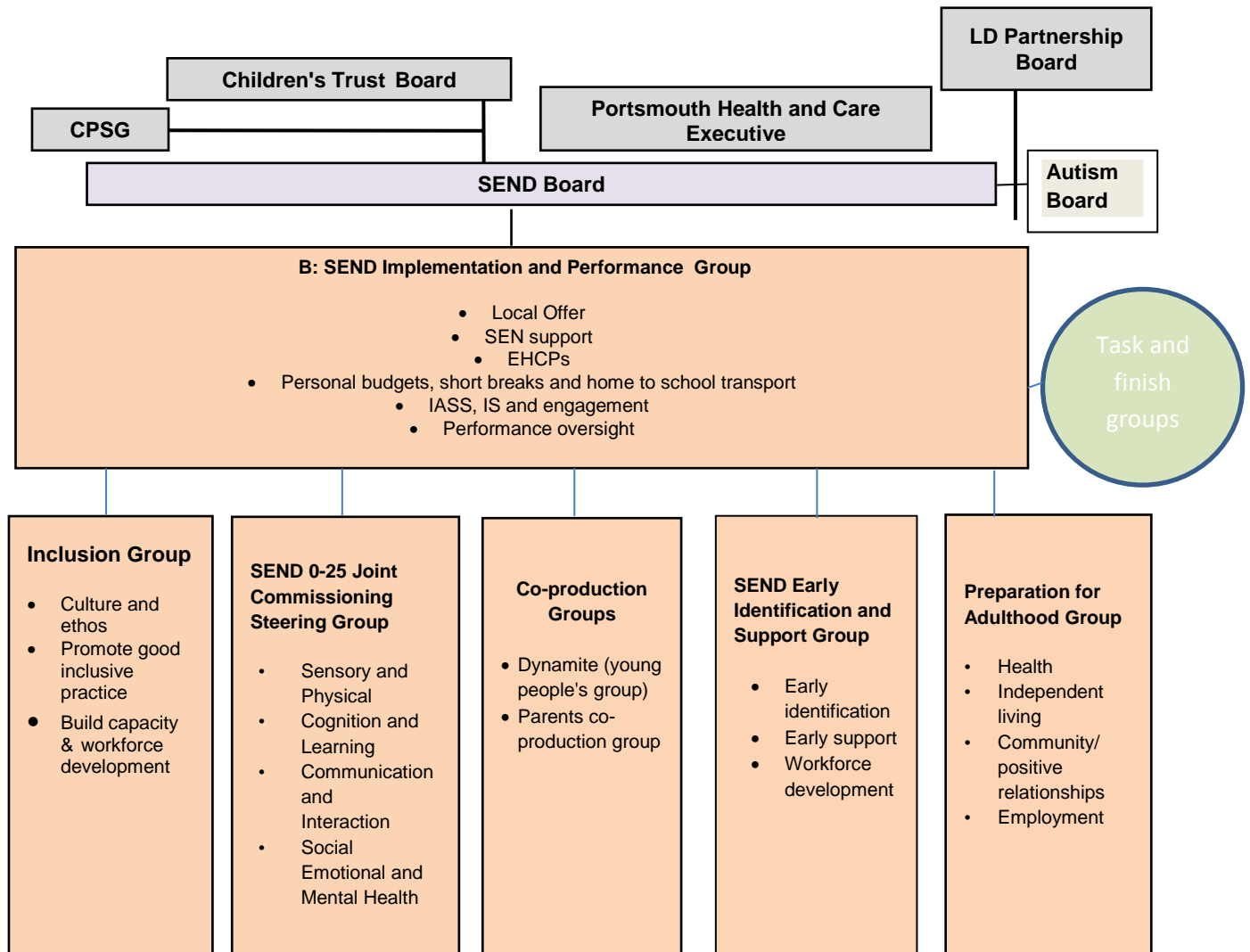
Strand C: Effective joint commissioning to improve outcomes

Strand D: Co-production, embedded as a way of working with children, young people and their parents and carers

Strand E: Early identification and early support for children with SEND and their families

Strand F: Effective preparation for adulthood and smooth transitions to adult services

Performance Management Reporting Structure



II. PERFORMANCE SUMMARY

1. Encouraging Signs of Improvement

- a) In 2015/16, a smaller percentage of statements were transferred to plans than the national average. We anticipate that the number of transfers will have significantly increased during 2016/17.
- b) In relation to timely issue of EHC plans, Portsmouth are performing above the national average.
- c) Fewer statements have been discontinued as part of the transfer process than the national average.
- d) We are working towards completing EHCPs for year 11 and 12.

2. Areas for Concern and proposed responses

- a) Portsmouth underperforms for all pupils, but we know that pupils with SEN are attaining worse than they should be at all key stages, with the gap bigger in secondary than in primary. This is an area to be considered in the **SEN Support Task and Finish Group**.
- b) Attendance is a general concern for Portsmouth, although this is improving - significant improvement needs to be made at our SEMH special school.
- c) In relation to fixed period exclusions, this picture was not improving and the disproportionate representation of the SEN statement/EHCP population was increasing. Pupils with SEMH as a need type dominate amongst the pupils with exclusion incidents, and that this is most prevalent amongst the special school pupils. Permanent exclusions are very low.

3. Further Observations

- a) The take-up of personal budgets so far has been low, and relates to those families who have taken up school transport budgets. This is likely to gradually increase over time, with personal budgets for respite included as part of the transfer process.
- b) Portsmouth continues to have low numbers of appeals to tribunal. The SEND team works hard to co-produce EHCPs in partnership, resulting in a relatively small number of cases where there is a disagreement.

4. Recommendations to the SEND BOARD

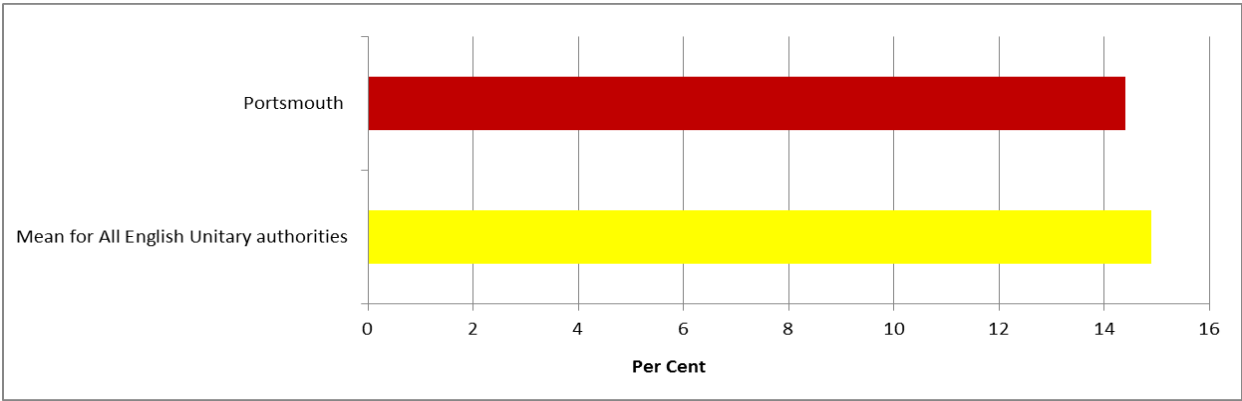
TBD

III. Local Area SEND information (inclusion in the community)

In Portsmouth 14.4% of pupils have a have a statutory plan of SEN (statement or EHC plan) or are receiving SEN support (previously school action and school action plus). This compares to an average of 14.9% across All English unitary authorities.

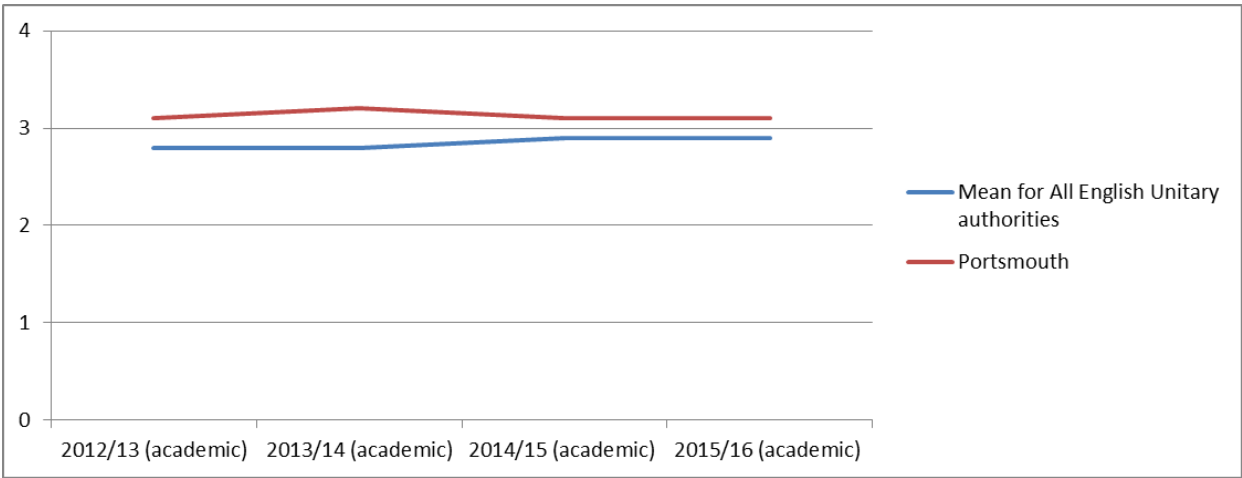
NB these figures, and those in the first three charts below, are for pupils attending schools in Portsmouth. They do not include children and young people for whom Portsmouth is responsible but has placed out of borough.

% pupils with SEN (2015/16 academic)



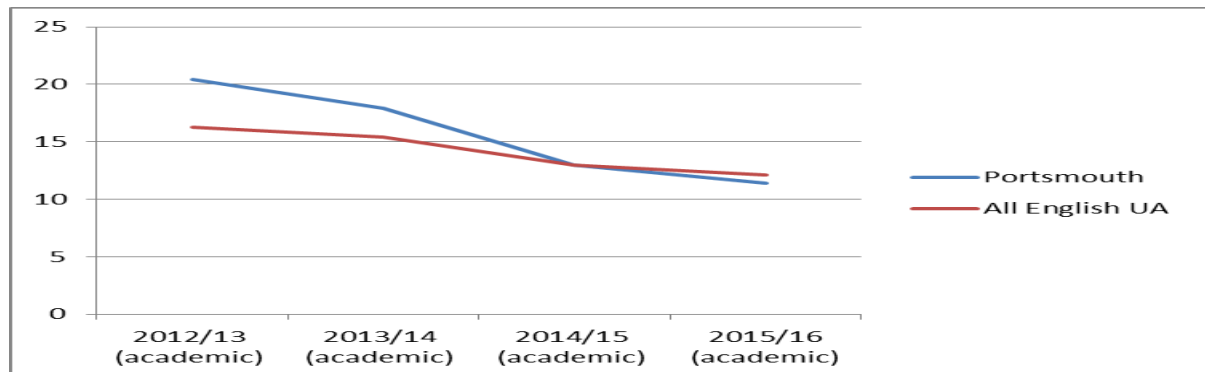
Across All English unitary authorities, the proportion of pupils with statements or education, health and care (EHC) plans ranges from 1.5% to 4.5%. Portsmouth has a value of 3.1%, compared to an average of 2.9% in All English unitary authorities.

% of pupils with a statement or EHC Plan



For SEN support the proportion for All English unitary authorities ranges from 7.0% to 16.7%. Portsmouth has a value of 11.4%, compared to an average of 12.1% in All English unitary authorities.

% of pupils with SEN support in all schools



Commentary

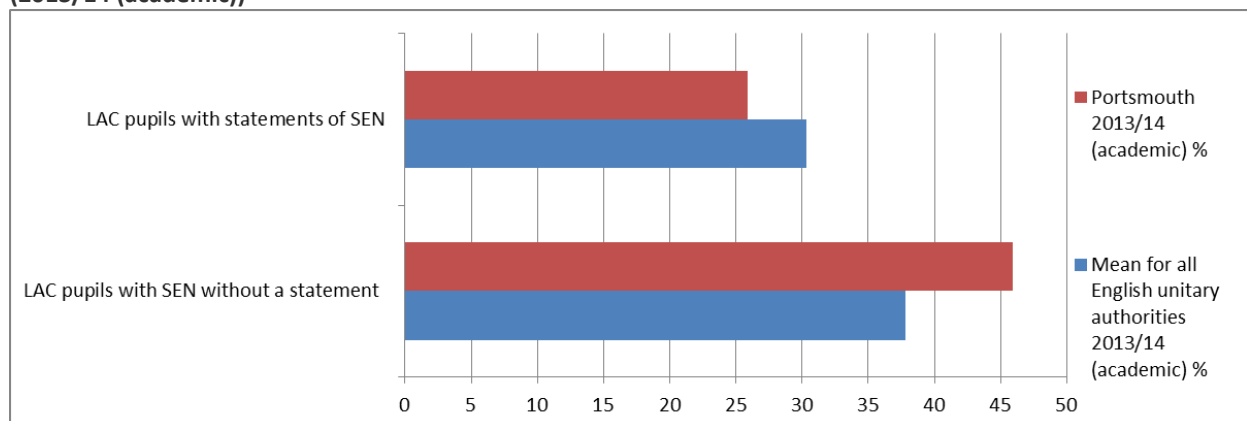
The percentage of pupils identified as having SEN is slightly lower in Portsmouth than the national average, although the percentage of pupils with a statement or EHC is slightly higher in Portsmouth than the national average.

These are likely to be accurate figures, given the Portsmouth demographic, and have remained stable over the past few years.

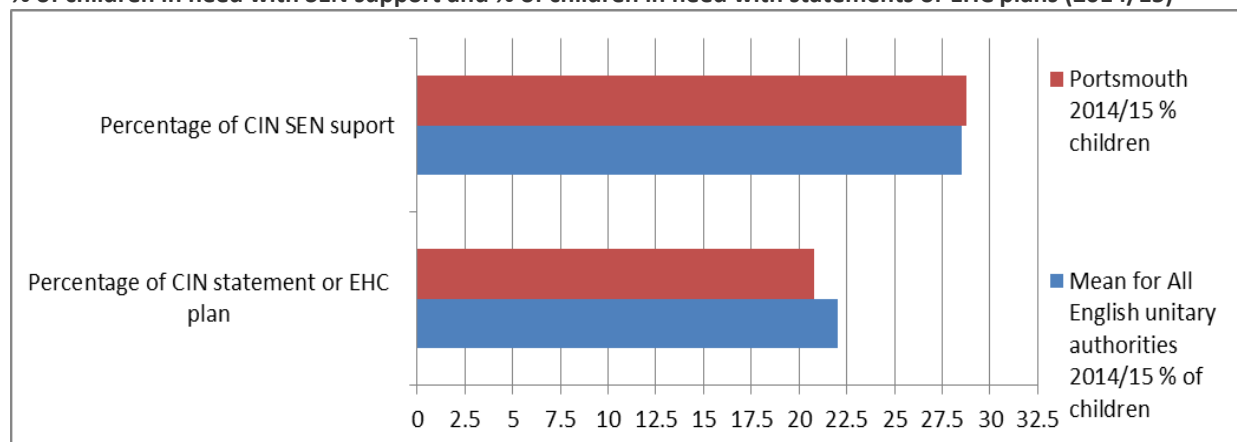
The percentage of pupils with SEN Support has come more closely in line with the national average as SENCos have become more confident and consistent in identifying need, supported by professional development through the SENCo Network and seconded SENCo programme both of which began in 2013.

Children in Need

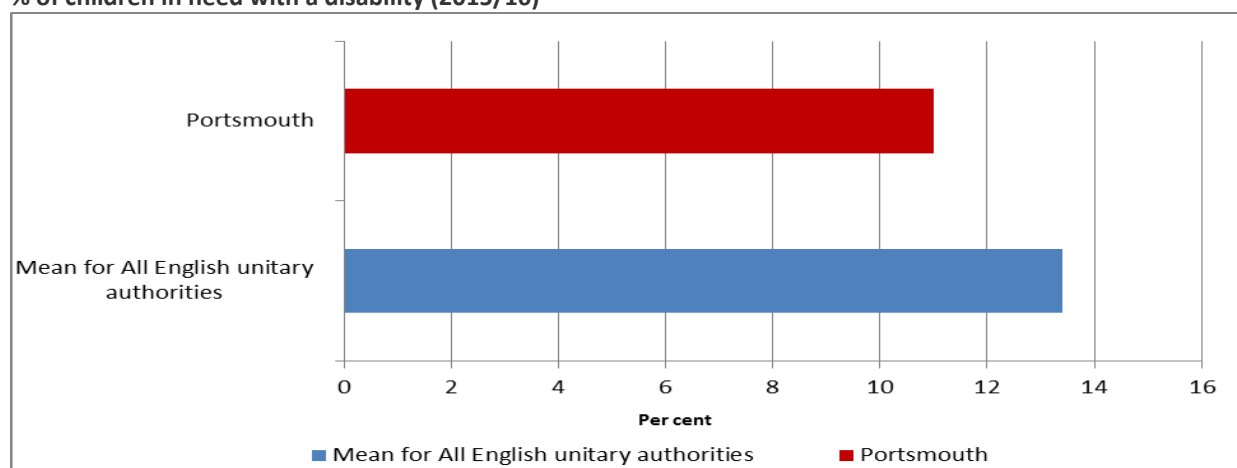
% of looked after children with statements of SEN and % looked after children with SEN without a statement (2013/14 (academic))



% of children in need with SEN support and % of children in need with statements or EHC plans (2014/15)



% of children in need with a disability (2015/16)



COMMENTARY

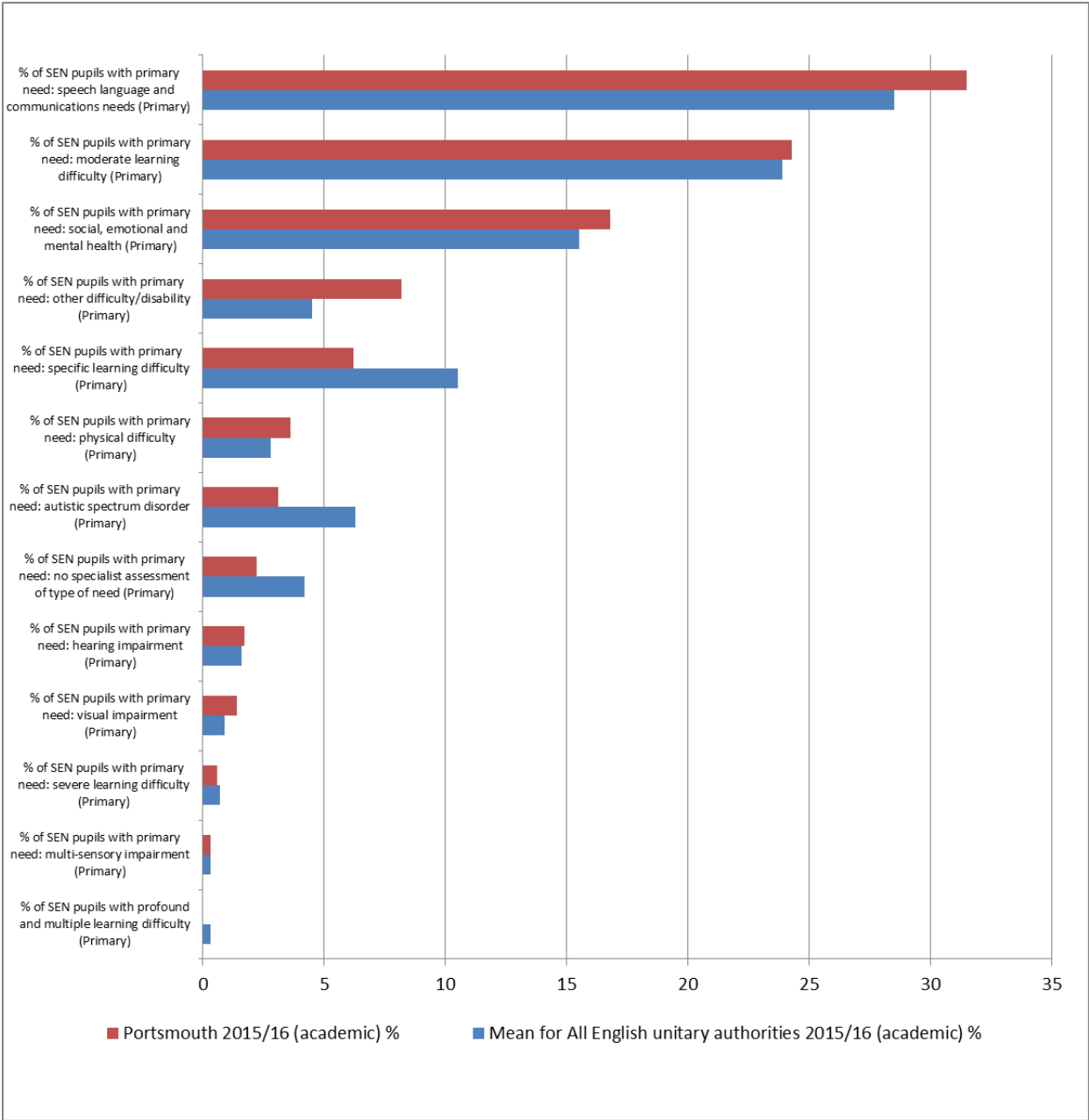
Portsmouth have fewer LAC with statements than national, but more on SEN support. It is difficult to draw firm conclusions from this as the numbers involved are so small. It could be that LAC are effectively supported with SEN support. There is also likely to be an impact of those who have historically been placed at The Harbour School under the power to innovate without a statement or EHC plan.

The issues are the same for CIN , although the Portsmouth percentages are closer to the national average in this case. It is difficult to draw firm conclusions from this as the numbers involved are so small. Given the definition of CiN, it could just be that those CYP known to the LA in that reporting period did not have SEN support or Statement/EHCP. Portsmouth has slightly lower percentage of children in need with a disability. Again, it is difficult to draw conclusions from this figure as the rate will vary depending on what criteria are used to record a child as disabled within this context.

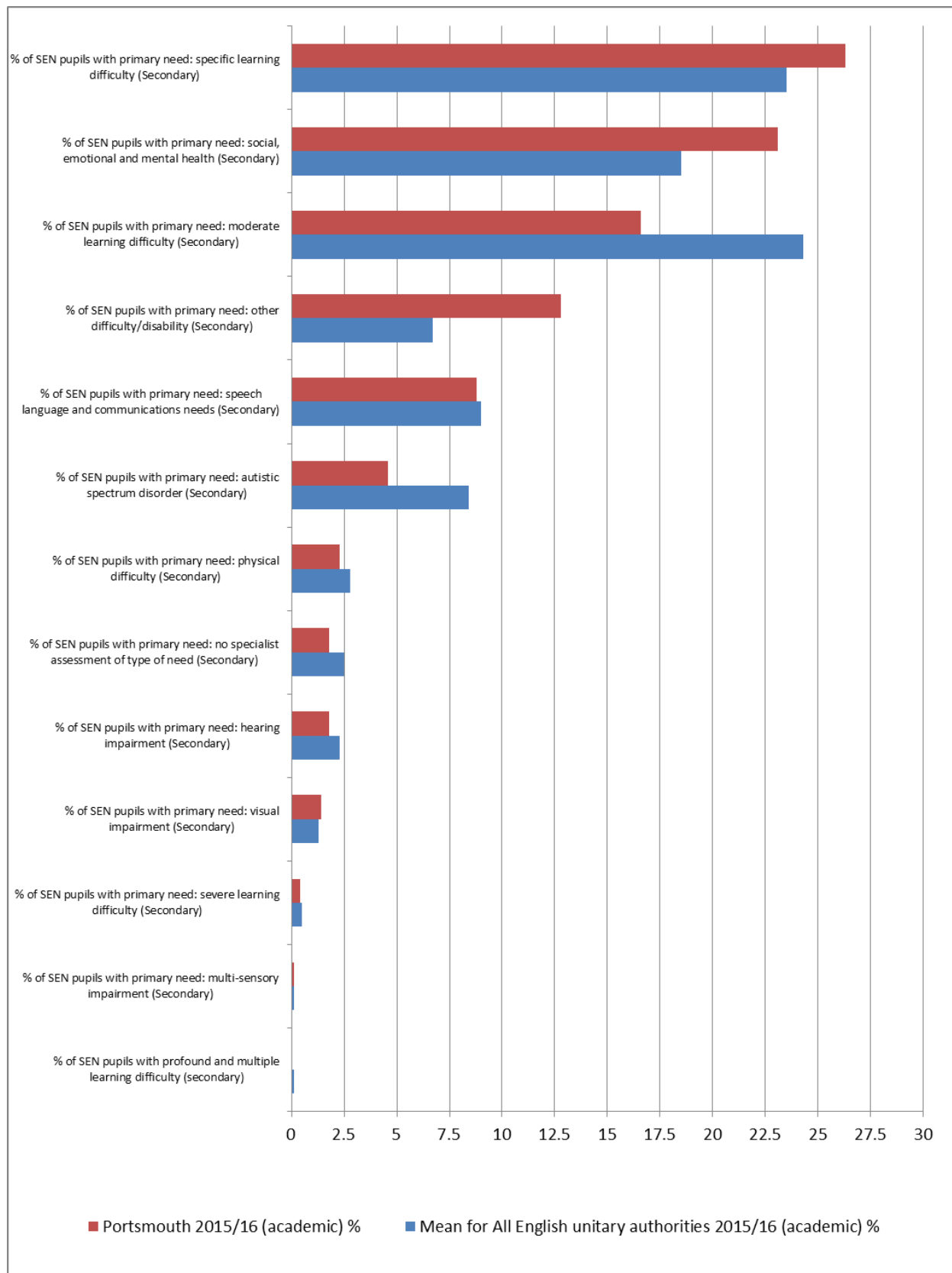
Primary Need

A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for them. All pupils with SEN have an assessment of their primary need. The following charts show the breakdown of need in Portsmouth by primary, secondary and special school, compared to the national averages and ranked by prevalence.

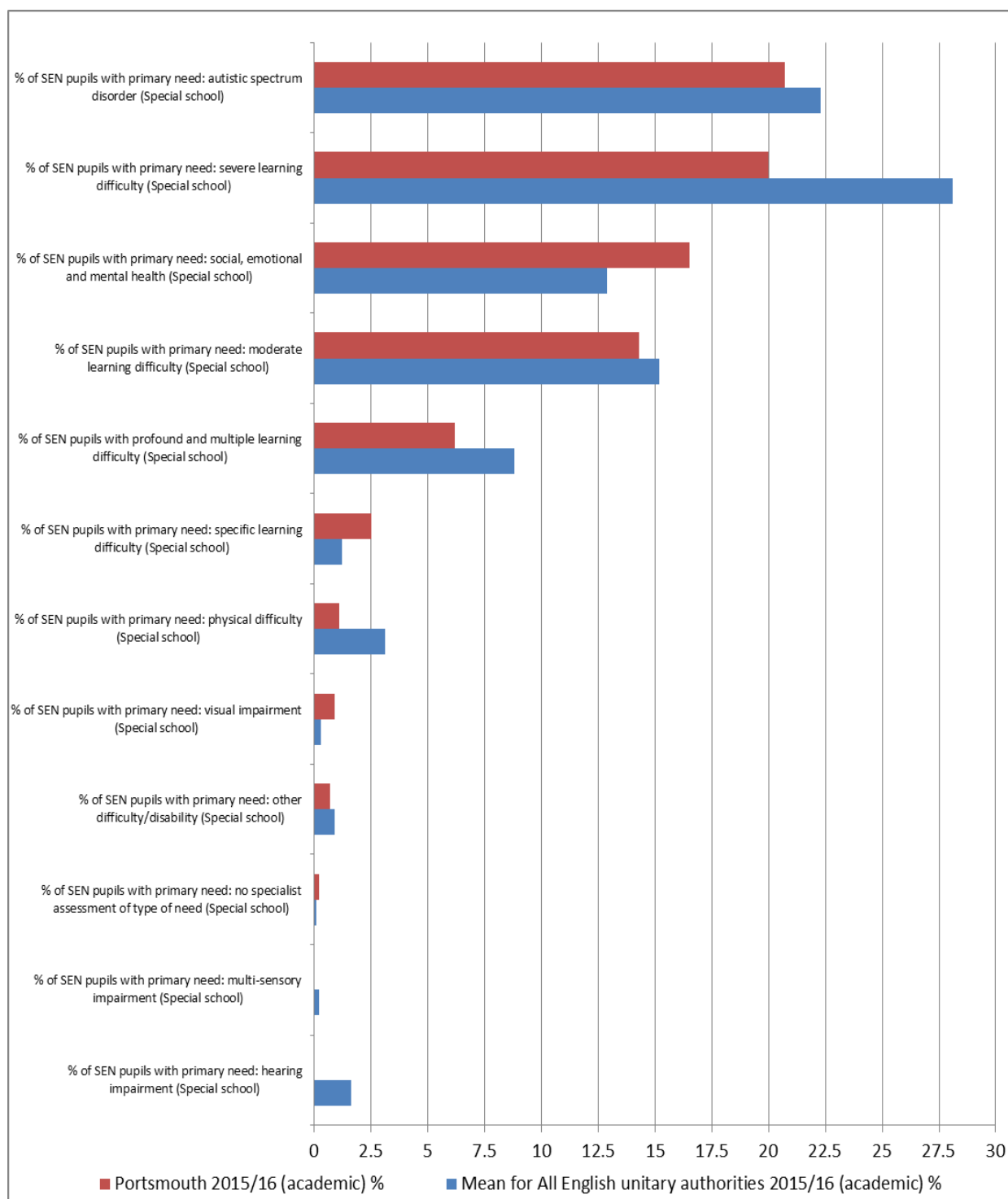
Primary need in primary schools



Primary need in secondary schools

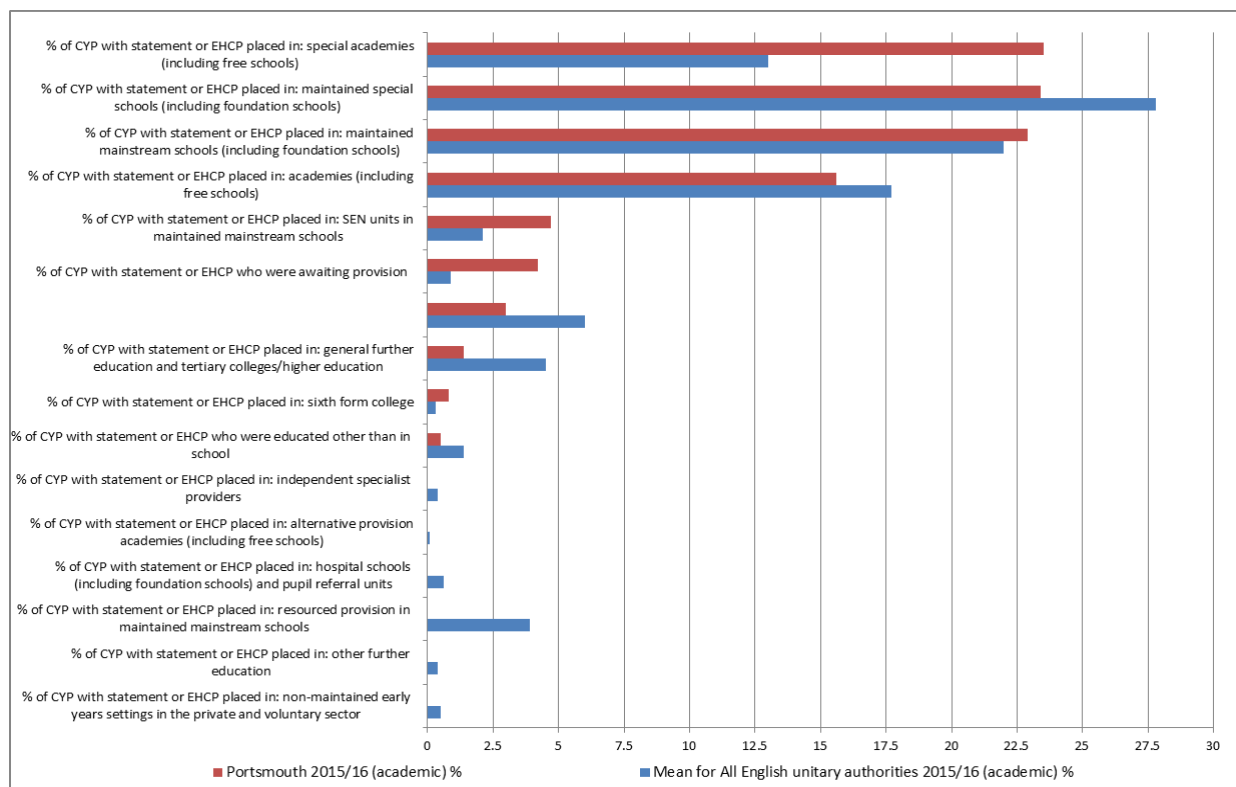


Primary need in special schools



The child's parent or the young person has the right to request a particular school, college or other institution to be named in their statement or EHC plan. The chart below "Placement of children and young people for whom the LA maintain a statement or EHC plan" shows the type of schools pupils with statements or EHC plans have been placed in by Portsmouth, compared to national averages and ranked by frequency.

Placement of children and young people for whom the LA maintain a statement or EHC plan



COMMENTARY

Primary need in primary schools: Portsmouth has a higher percentage of pupils with speech, language and communication needs (SLCN) than the national average. This is likely to be impacted by the additionally resourced provision available in primary schools in the city for pupils with SLCN as their primary need. Portsmouth has a lower percentage of pupils with autism spectrum disorder (ASD) identified as the primary need. This is likely to be related to the lower than average number of diagnoses of autism in the city. It is likely that some of these pupils have been recorded as having SLCN as their primary need, rather than ASD, particularly younger children within the primary phase.

Primary need in secondary schools: The percentage of pupils in Portsmouth secondary schools identified as having a primary need of SEMH is above the national average. It is anticipated that the work taking place on the SEMH pupil pathway will bring this more in line with the national average. The percentage of pupils in Portsmouth secondary schools identified as having MLD, SpLD and SLCN as their primary area of need is lower than the national average. There is further work to be undertaken to give secondary schools within the city the competence and confidence to meet the needs of pupils with a wide range of SEN. The SEND Strategy and inclusion agenda is taking forward this piece of work, with an Inclusion group being established in the Autumn term to focus on this identified area for development.

Primary need in special schools: The percentage of pupils in Portsmouth special schools with a primary need identified as severe learning difficulties (SLD) and autism

spectrum disorder (ASD) is lower than the national average, whereas for moderate learning difficulties (MLD) and specific learning difficulties (SpLD) it is higher than the national average. This is likely to be impacted on by the current designation of the special schools in the city - 2 of which are undergoing a process of re-designation. It is anticipated that over time this will become more in line with national averages.

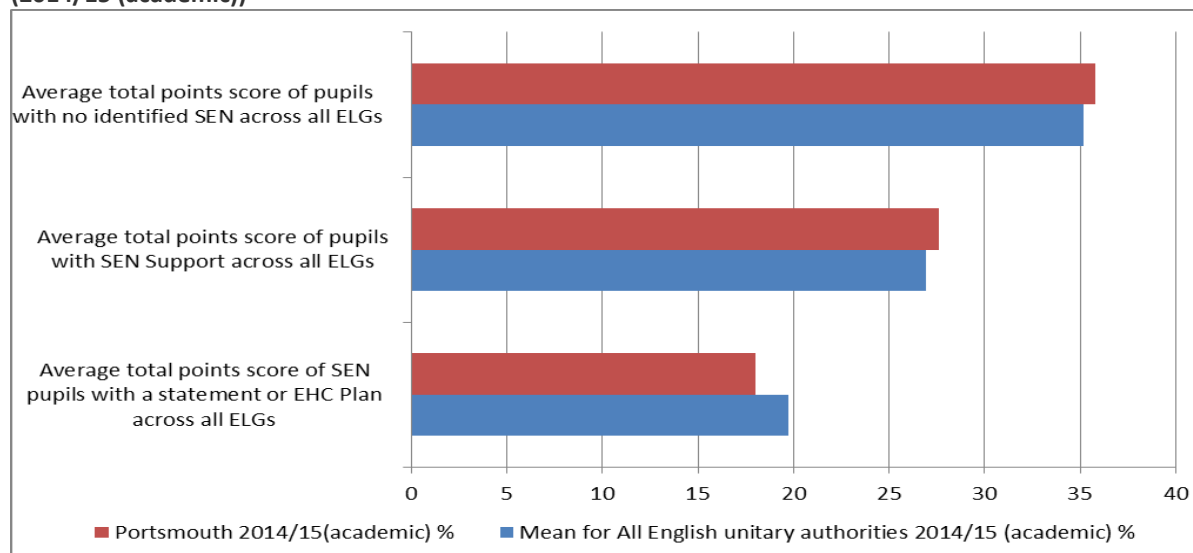
The percentage of pupils in Portsmouth special schools identified as having social emotional and mental health difficulties (SEMH) is higher than the national average. This has been impacted on by the 'power to innovate' which has meant that pupils with SEBD/SEMH needs could be placed in the SEBD/SEMH special school in the city without a statement or EHC plan. The 'power to innovate' has now come to an end and so this anomaly is being addressed. It is anticipated that the work taking place on the SEMH pupil pathway will bring this more in line with the national average.

IV. PERFORMANCE DATA

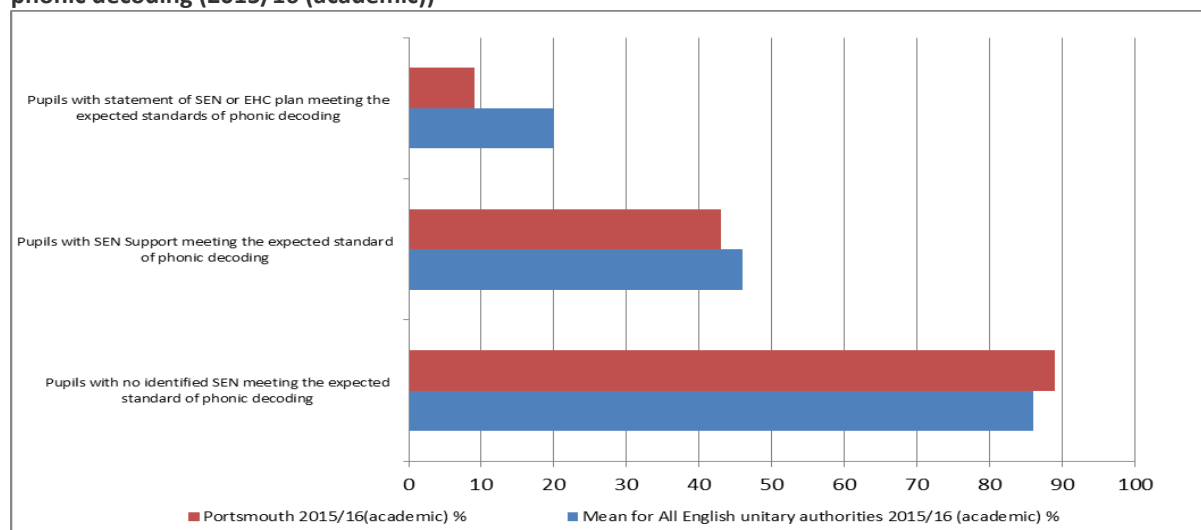
Headline outcome: Learning and Making Progress

Attainment of pupils with SEN

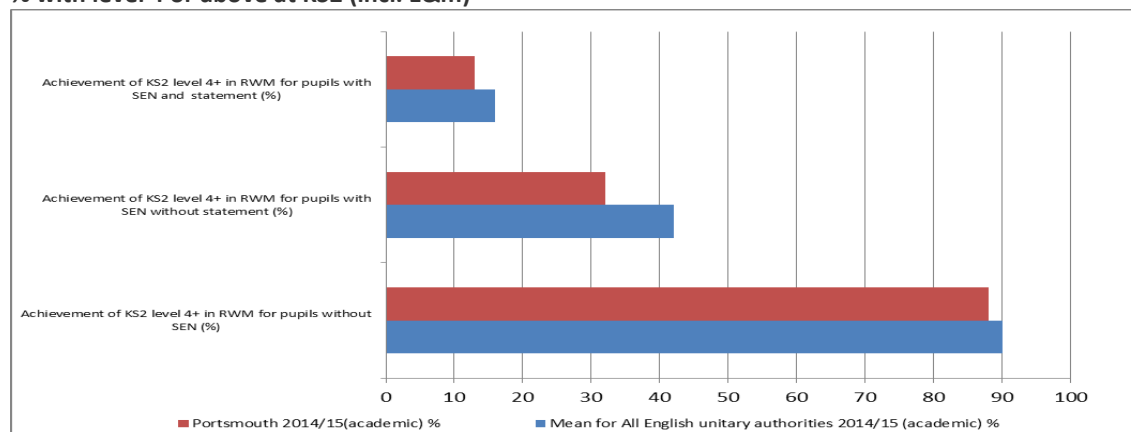
% of SEN pupils with a statement or EHC plan achieving a 'good level of development' at foundation stage (2014/15 (academic))



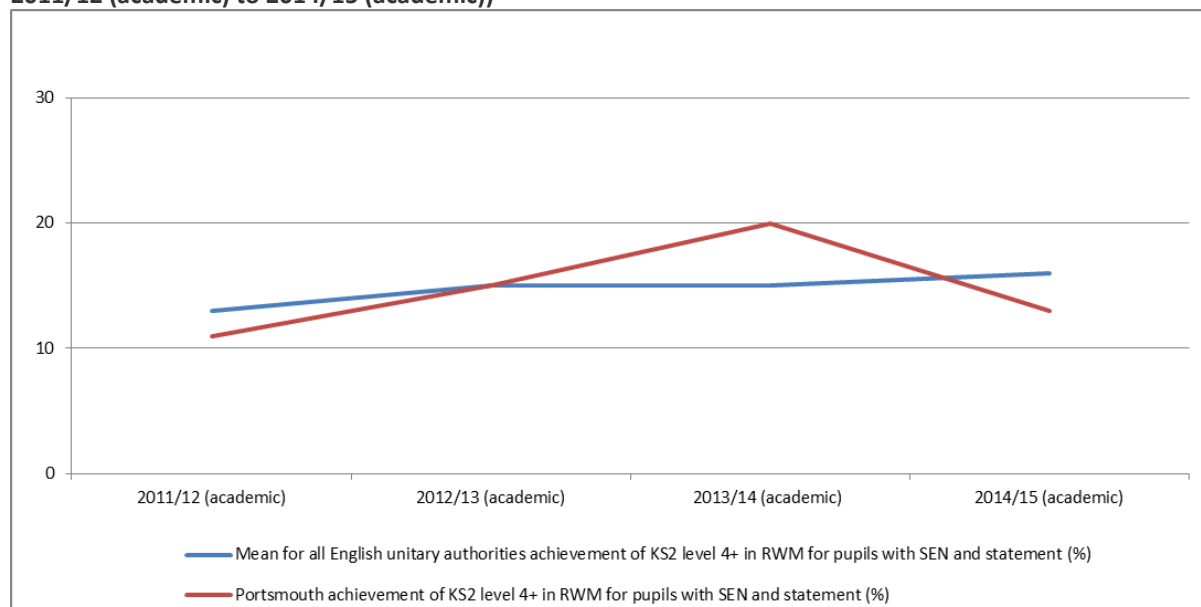
% of pupils with SEN support and % of pupils with a statement or EHC plan meeting the expected standard of phonic decoding (2015/16 (academic))



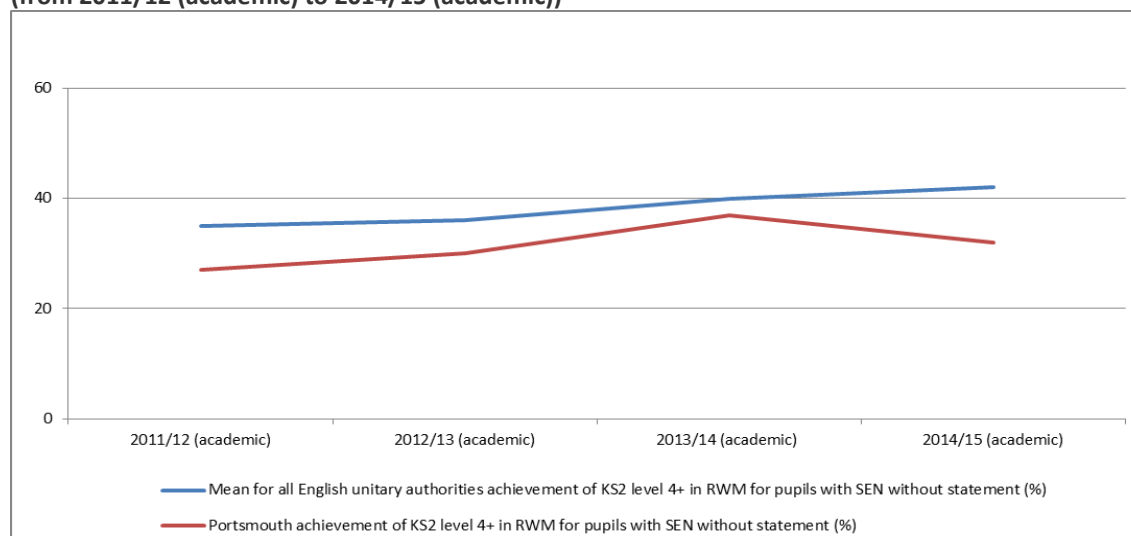
% with level 4 or above at KS2 (incl. E&m)



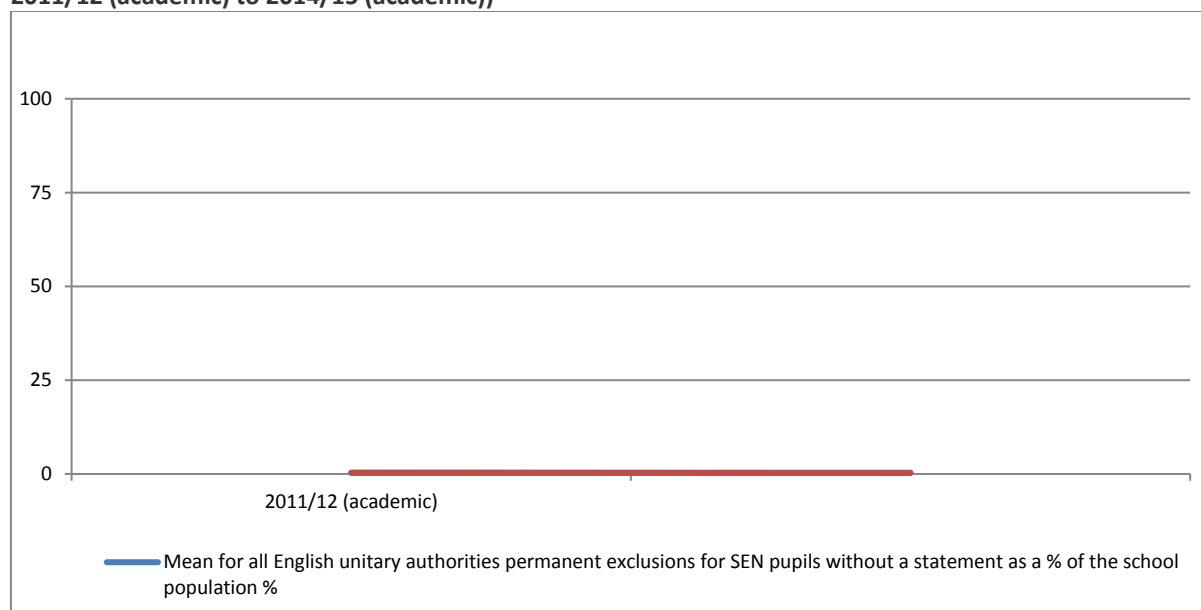
% of pupils with SEN with a statement attaining level 4 or above at KS2 in reading & writing and maths (from 2011/12 (academic) to 2014/15 (academic))



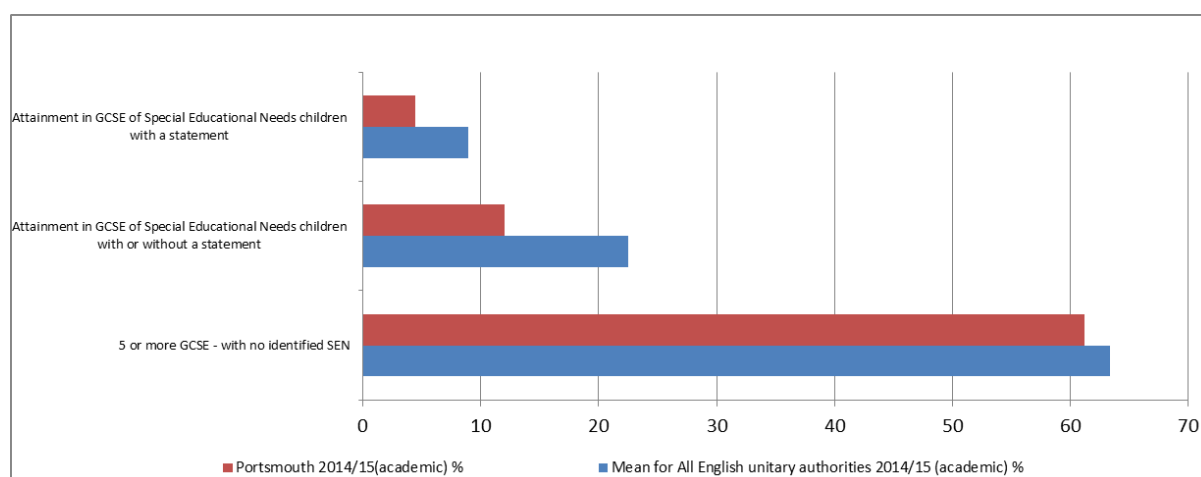
% of pupils with SEN but without a statement attaining level 4 or above at KS2 in reading & writing and maths (from 2011/12 (academic) to 2014/15 (academic))



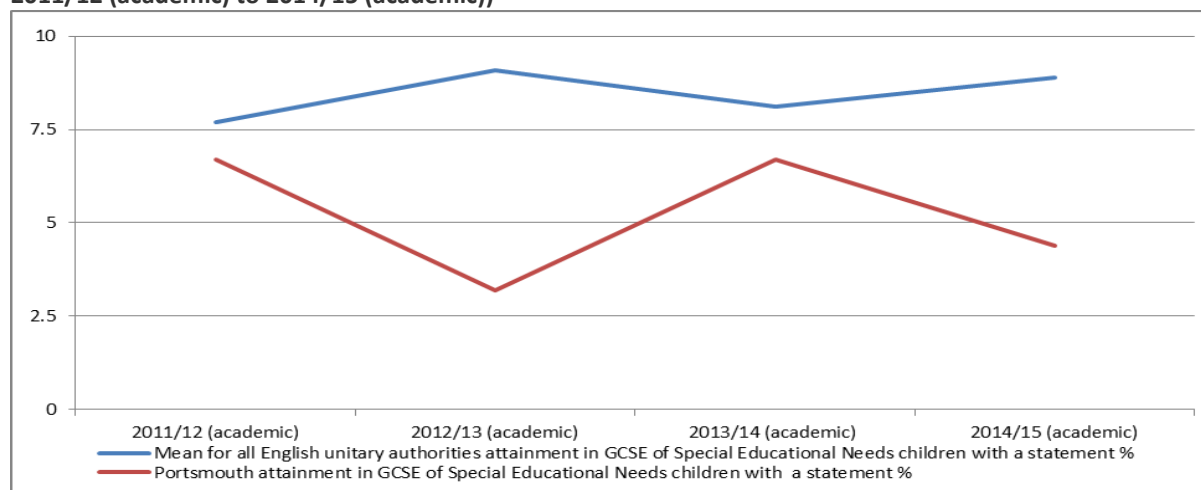
% of pupils with no identified SEN attaining level 4 or above at KS2 in reading & writing and maths (from 2011/12 (academic) to 2014/15 (academic))



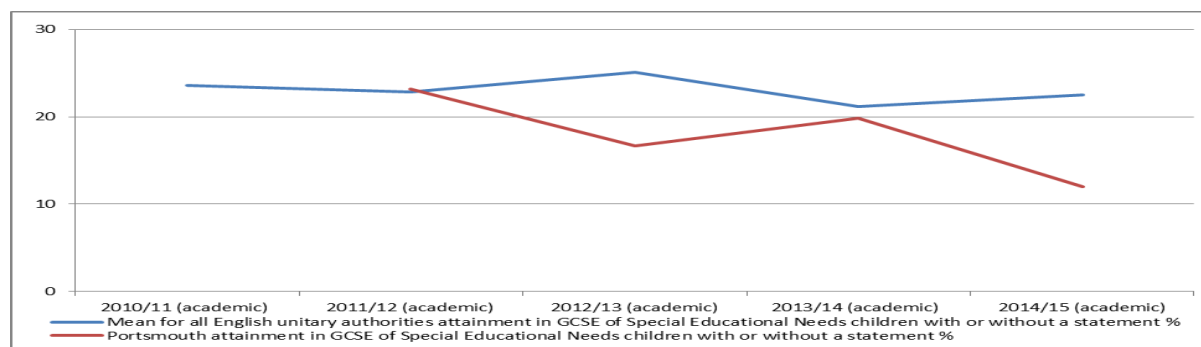
% achieving 5 or more A*-C GCSEs (incl. E&m)



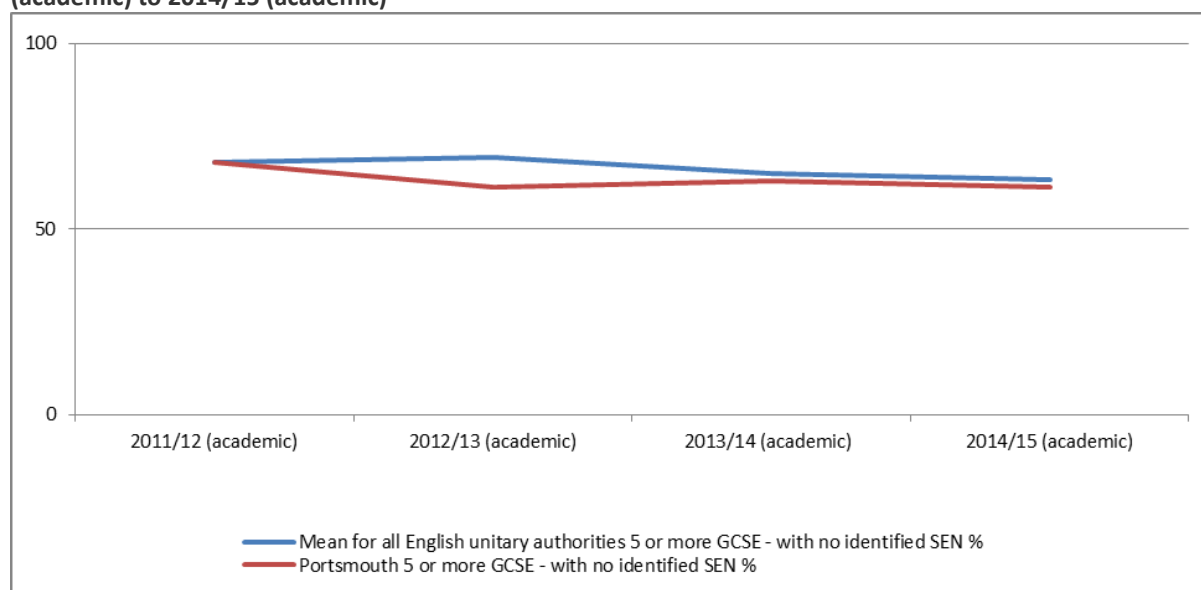
% of pupils with SEN with a statement or plan achieving 5 or more A* to C GCSEs (incl.English & maths) (from 2011/12 (academic) to 2014/15 (academic))



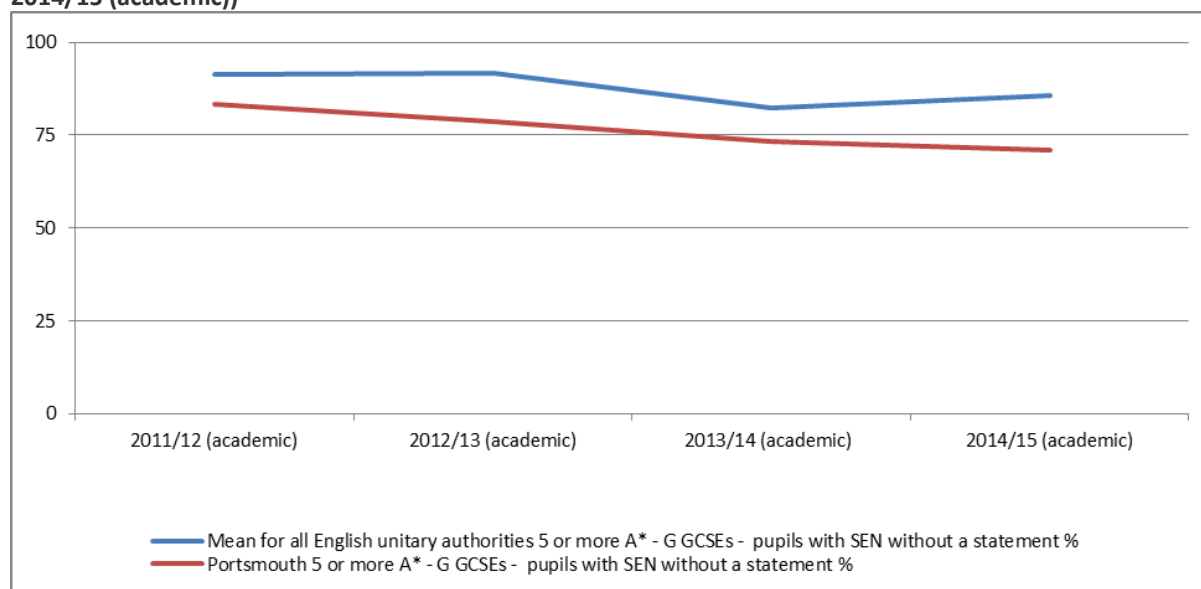
% of pupils with SEN support achieving 5 or more A* to C GCSEs (incl. English & maths) (from 2010/11 (academic) to 2014/15 (academic))



% of pupils with no identified SEN achieving 5 or more A* to C GCSEs (incl. English & maths) (from 2011/12 (academic) to 2014/15 (academic))

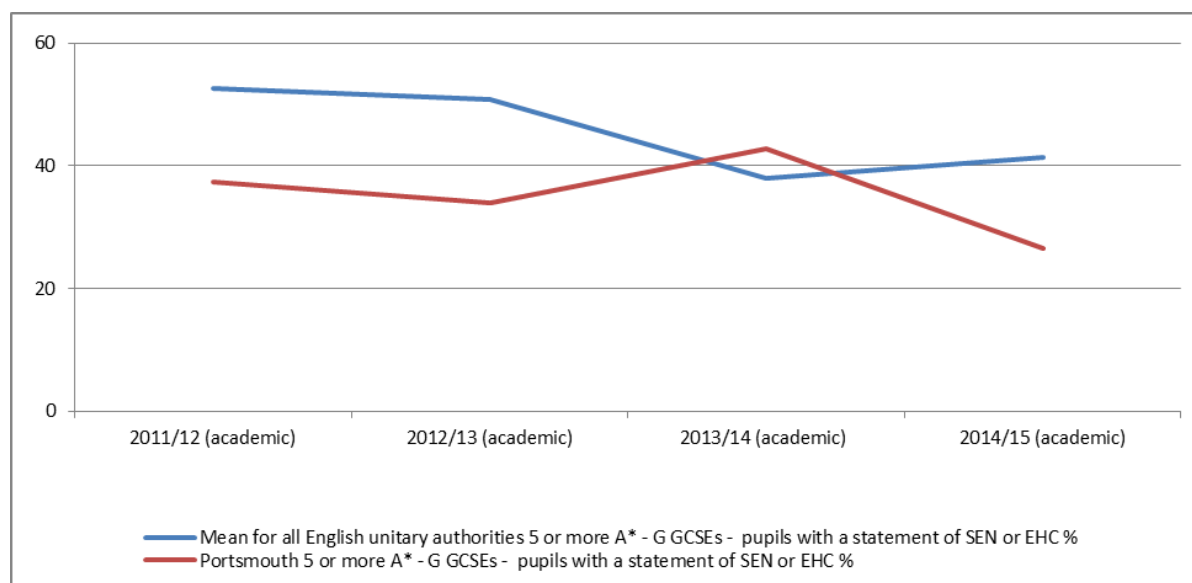


% of pupils with SEN without a statement achieving 5 or more A* to G GCSEs (from 2011/12 (academic) to 2014/15 (academic))

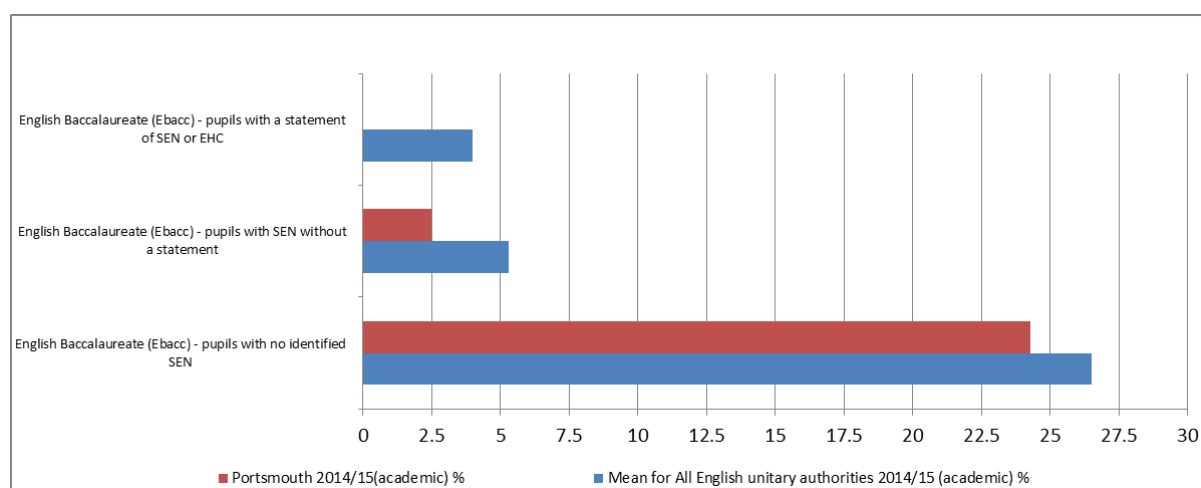


% of pupils with a statement of SEN achieving 5 or more A* to G GCSEs (from 2011/12

(academic) to 2014/15 (academic))



% of pupils achieving English Baccalaureate



COMMENTARY

Portsmouth underperforms for all pupils, but we know that pupils with SEN are attaining worse than they should be at all key stages, with the gap bigger in secondary than in primary.

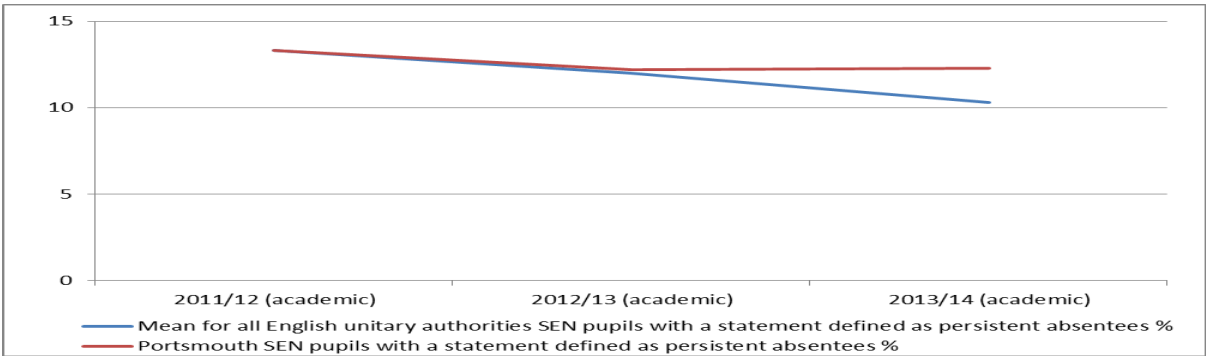
There is variation across the years with things dipping, particularly in 2014/15 for a number of indicators. There are bigger gaps at KS4 for progress for those with SEMH but not for attainment. It is difficult to make comparisons across other areas as national results are not broken down by primary need.

We know that we need effective targeted support, and tracking and monitoring of pupils' progress if we are to see improvements in these outcomes. This is an area where we are working through the Portsmouth Education Partnership to bring about sustained improvement. We do also know that there are examples of good practice in the city, for example, at St Edmunds.

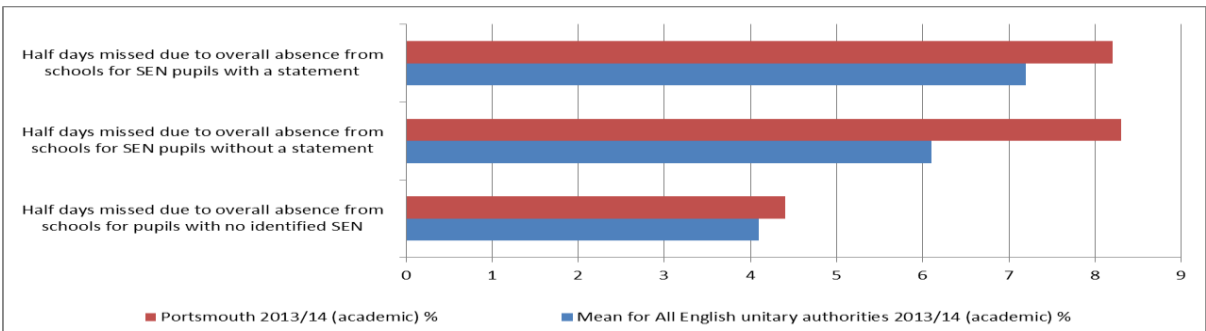
This will be an area of focus for the Task and Finish Group, and work will be reported through this Board. It is anticipated that figures will soon be updated on the national report to take account of more recent years, and the move to different systems of measurement.

Absence

SEN pupils with a statement defined as persistent absentees as a % of the school population (from 2011/12 (academic) to 2013/14 (academic))



% of sessions missed due to overall absence from schools for SEN pupils 2013/14 (academic)



COMMENTARY

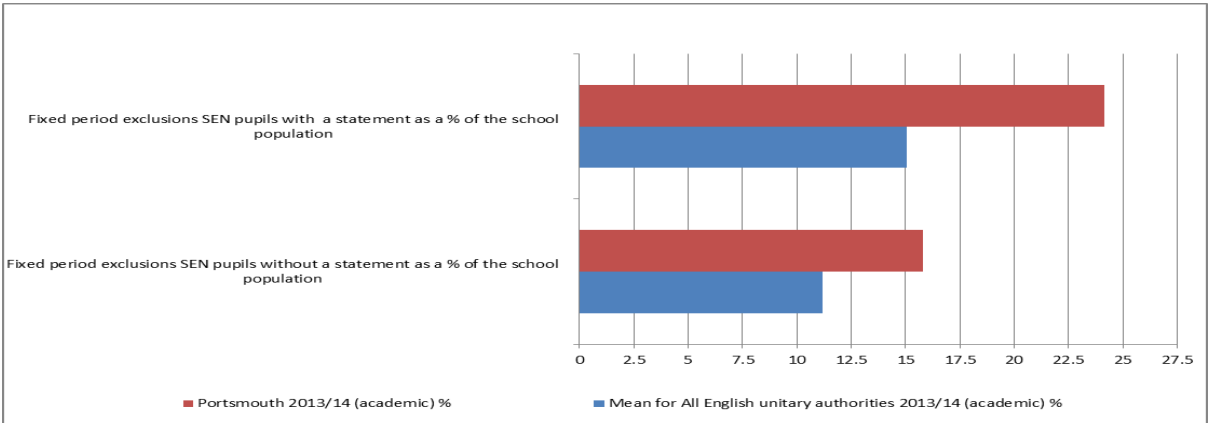
12.3% = 7th of 11 Statistical Neighbours (1 being the highest levels of PA) (11.1 for the South East and 11.0 for England) - However 3rd in comparison to statistical neighbours when looking at those with no SEN. Also Portsmouth were the highest in comparison to statistical neighbours when looking at all pupils for this indicator. Therefore whilst as an authority from 2013/14 data there needs to be work in relation to PAs, relatively those with statements are better with regards to this indicator than those with no SEN. Overall attendance is improving and the introduction of the attendance strategy should assist this. The biggest different would be made through improved attendance at our SEMH special school which significant work has gone into.

8.2% = 6th of 11 in comparison to statistical neighbours (7.5 for both England and the South East) - However 4th in comparison to statistical neighbours when looking at children with no SEN - Also Portsmouth were the highest in comparison to statistical neighbours when looking at all pupils for this indicator. Therefore whilst as an authority from 2013/14 data there needs to be work in relation to overall absence relatively those

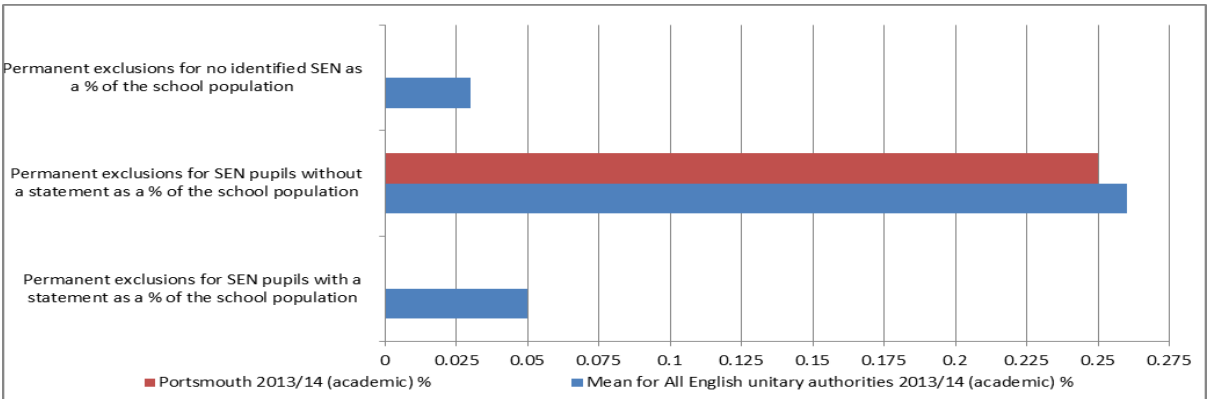
with statements are better with regards to this indicator than those with no SE. Overall attendance is improving and the attendance strategy should assist this. The biggest different would be made through improved attendance at our SEMH special school which significant work has gone into. The evidence supports the suggestion that SEMH pupils are "over-represented" in both absence and exclusion data.

Exclusion - Neil Stevenson

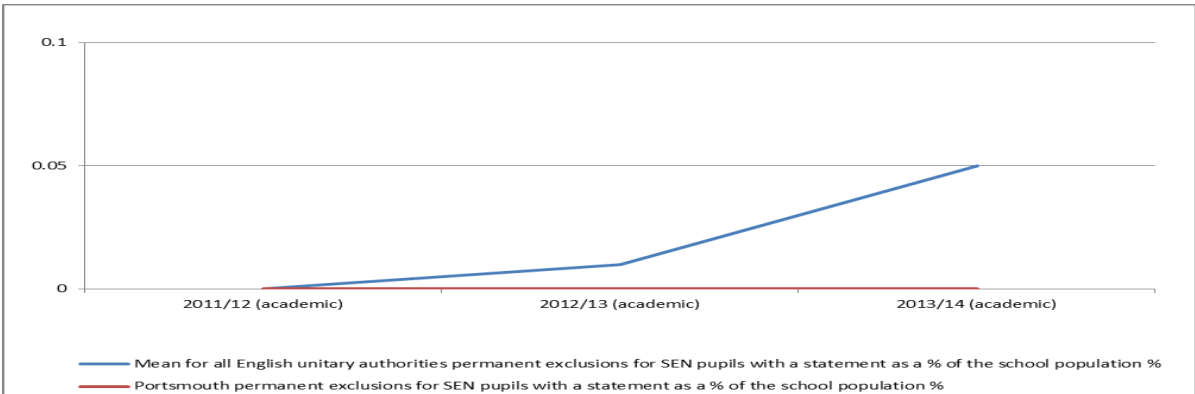
Fixed period exclusions for SEN pupils as a % of the school population (2013/14 (academic))



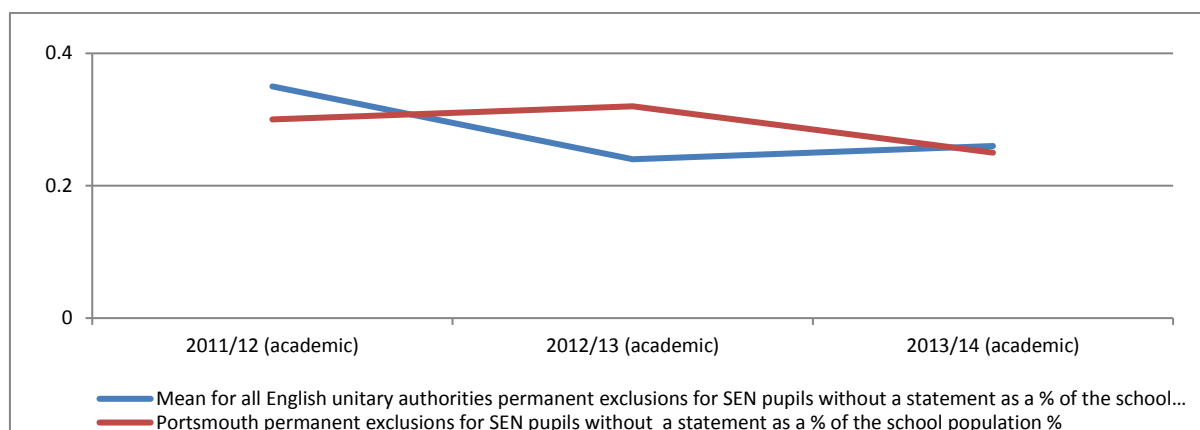
Permanent exclusions from school as a % of the school population



Permanent exclusions from school for SEN pupils with a statement as a % of the school population (from 2011/12 (academic) to 2013/14 (academic))



Permanent exclusions from school for SEN pupils without a statement as a % of the school population (from 2011/12 (academic) to 2013/14 (academic))



COMMENTARY

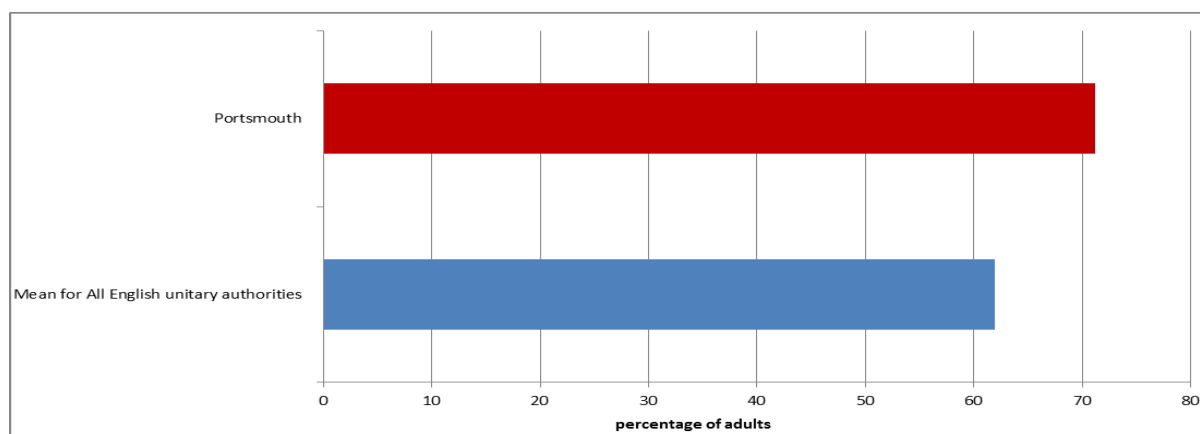
In relation to fixed period exclusions, this picture was not improving and the disproportional representation of the SEN Statement/EHCP population was increasing. The introduction of the ordinarily available provision, pupil and curriculum pathways document and rigorous tracking of vulnerable groups and multiple exclusions have shown improvement in the data. Pupils with SEMH as a need type dominate amongst the pupils with exclusion incidents. However, it also shows that this is most prevalent amongst the special school pupils.

Therefore there is improvement necessary at the Harbour school to shift this significantly. HT1 2016/17 figures are showing that improvement following the change of management and the beginnings of the implementation of the recommendations of the recent SEMH review.

Permanent exclusions are very low and much work has gone into ensuring that this becomes a redundant tool. Pupils can be catered for equally with or without a permanent exclusion and the inclusion agenda combined with processes around Fair Access and the availability of dual registered alternative provision have meant that schools don't tend to use this sanction.

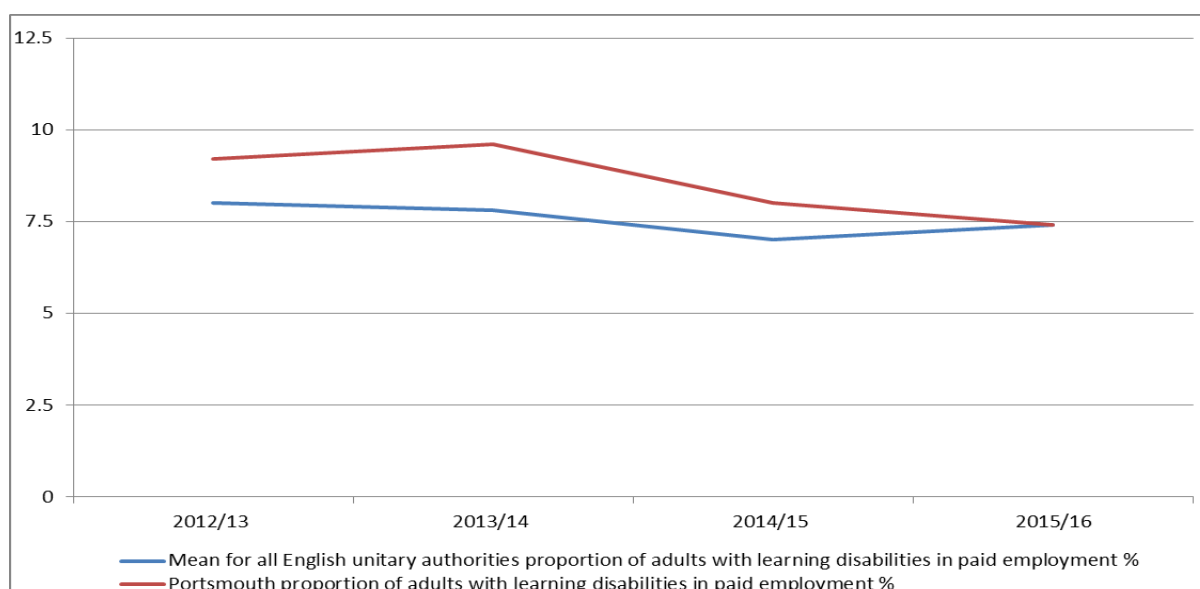
HEADLINE OUTCOME: MAKE AND MAINTAIN POSITIVE RELATIONSHIPS IN THEIR FAMILIES AND COMMUNITIES

% of adults with learning disabilities in settled accommodation (2010/11)



In Portsmouth, 7.4% of adults with learning disabilities are in employment, compared to 8.0% last year and a national average of 7.4%.

% of adults with learning disabilities in paid employment (from 2012/13 to 2015/16)



COMMENTARY

In relation to settled accommodation, we have moved from 60/40 res care/SL 3.5 years ago to 42/58 now. So we have made a shift to people having their own tenancies. However we are reviewing this as what counts in terms of own home is not necessarily formal arrangement but whether it feels like its yours, whether independence is being promoted, who you live with, choice you have etc which is why we are talking together with service users and carers re the 4 key questions:

- How do we extend the range of what we offer to include among other things KeyRing, Home Ownership/bespoke solutions
- How do we support decision making? which fits with the SEND PfA stuff around tools and decision making tools that service users can access and be supported to use
- How do 'we' together decide what is 'good' of whatever model and how do 'we' want to measure it?

- What are the rules that we as stakeholders want to observe re commissioning housing and support models

In relation to increasing numbers of adults with learning disabilities in paid employment, this is an area we are actively working on. We have:

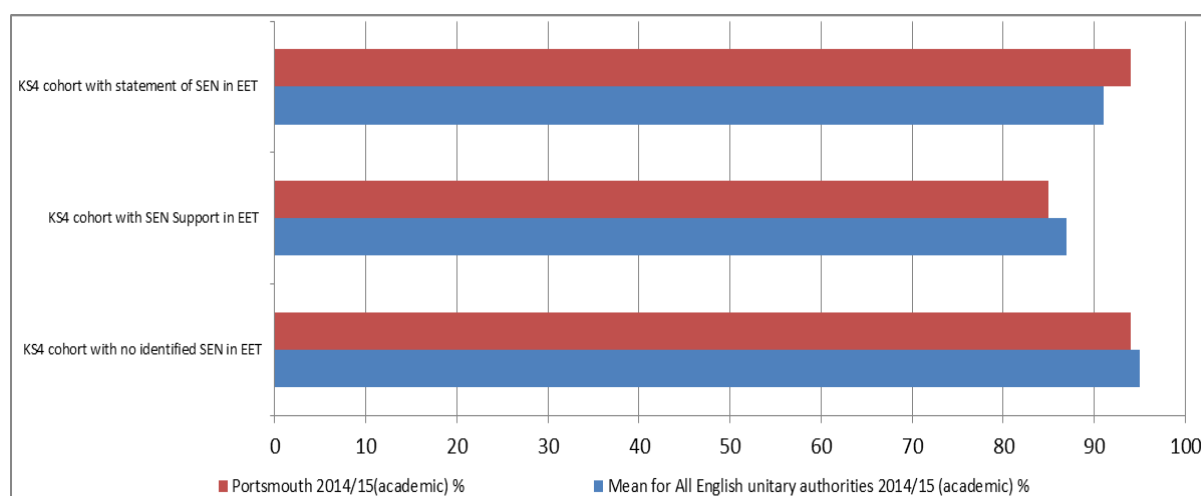
- commissioned a work assessment, finding and support service
- made employment a key outcome in support planning,
- assigned a named worker to proactively work with everyone re the outcome of work
- freed up the money by significantly reducing block expenditure which in turn allows the growth and funding of Social Enterprise.
-

We are working closely with current and potential providers to create a rich and diverse market and have created a post whose focus is this area of activity.

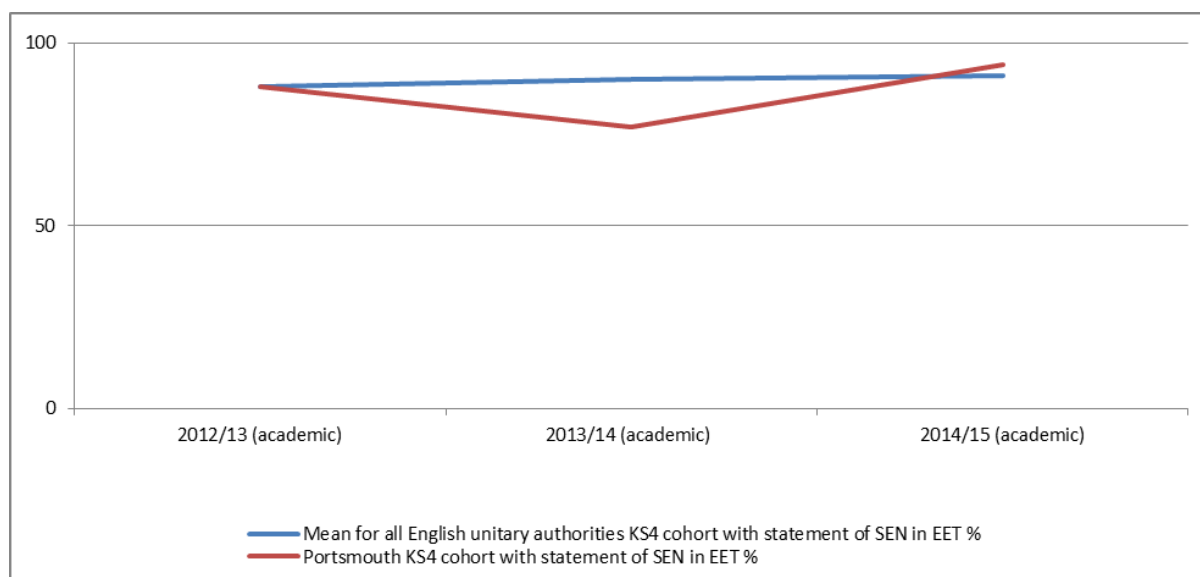
HEADLINE OUTCOME: Participate in education and training post-16 and prepare for employment

The reforms placed increased emphasis on supporting children and young people with SEND to make a positive transition to adulthood, including paths to employment, good adult health, independent living and participating in society. For more information visit <http://www.preparingforadulthood.org.uk/>.

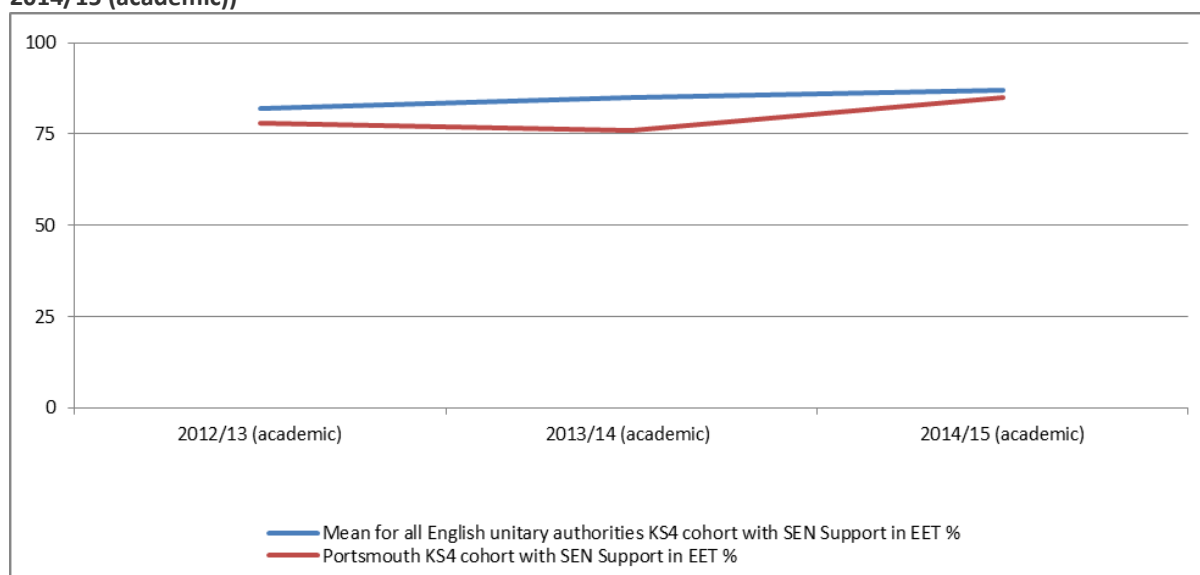
Percentage of KS4 cohort in Education, Employment or Training at 17



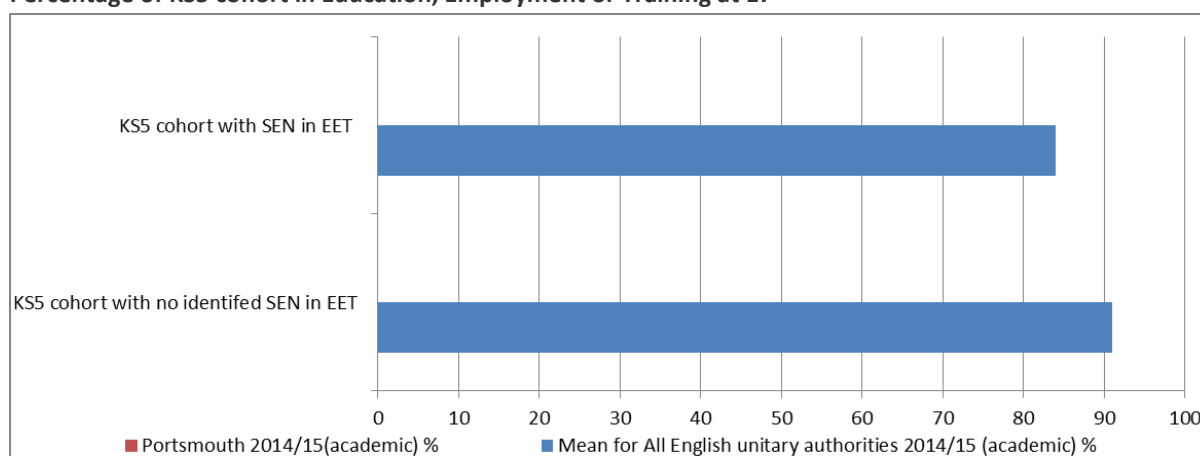
% of KS4 cohort with statement of SEN in Education & Employment or Training at 17 (from 2012/13 (academic) to 2014/15 (academic))



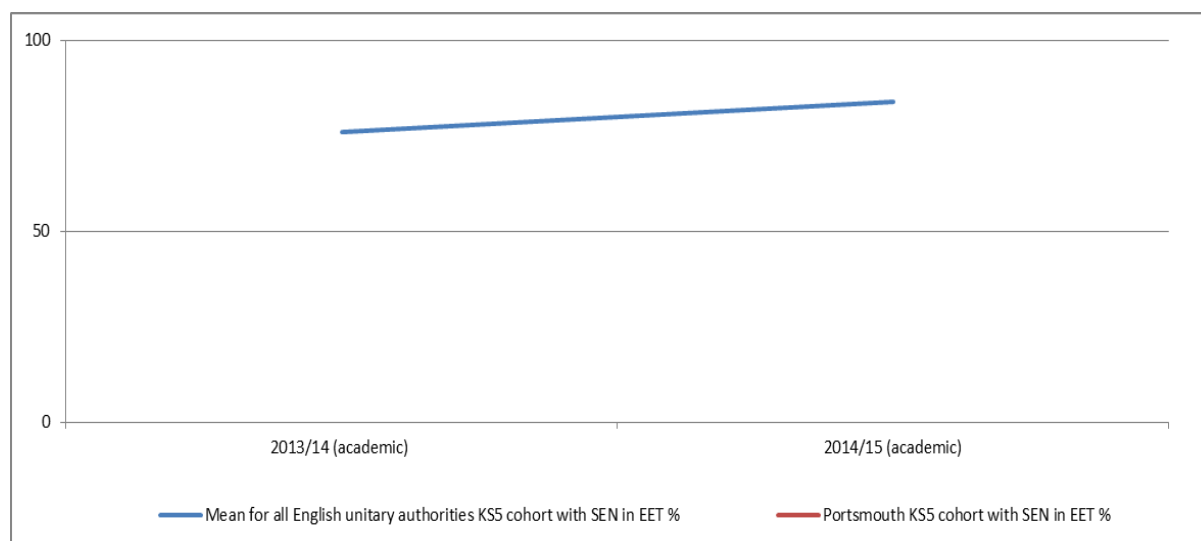
% of KS4 cohort with SEN Support in Education & Employment or Training at 17 (from 2012/13 (academic) to 2014/15 (academic))



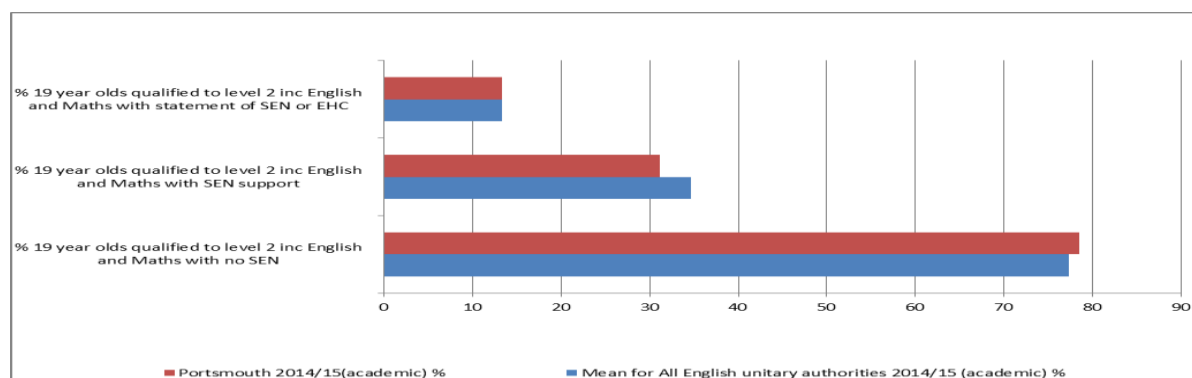
Percentage of KS5 cohort in Education, Employment or Training at 17



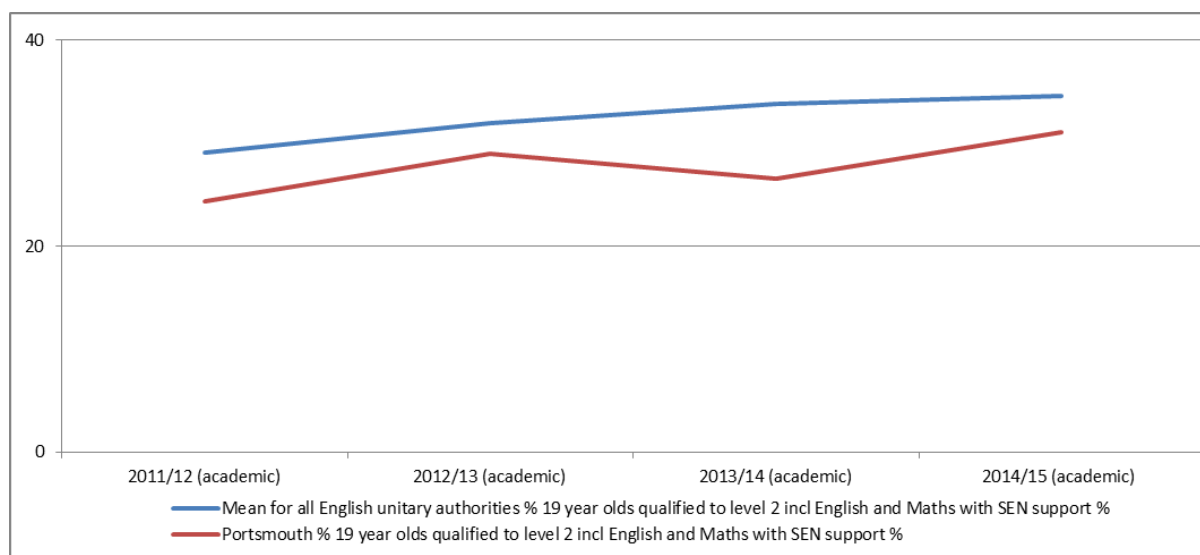
% of KS5 cohort with SEN in Education & Employment or Training at 17 (from 2013/14 (academic) to 2014/15 (academic))



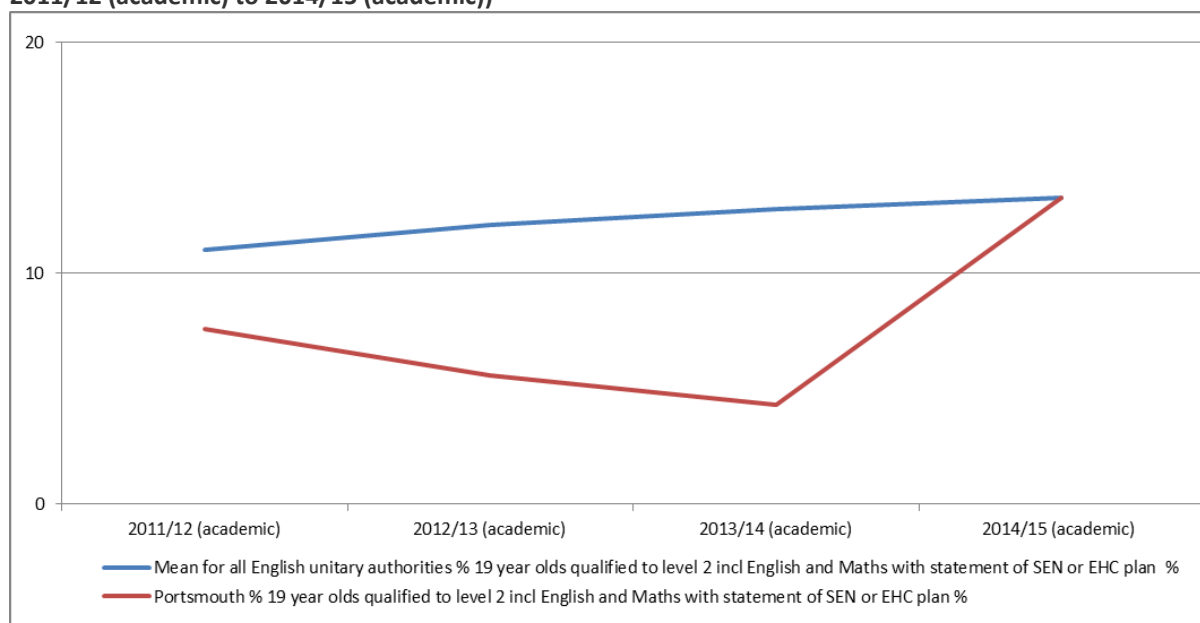
Percentage of 19 year olds qualified to level 2 including English and Maths



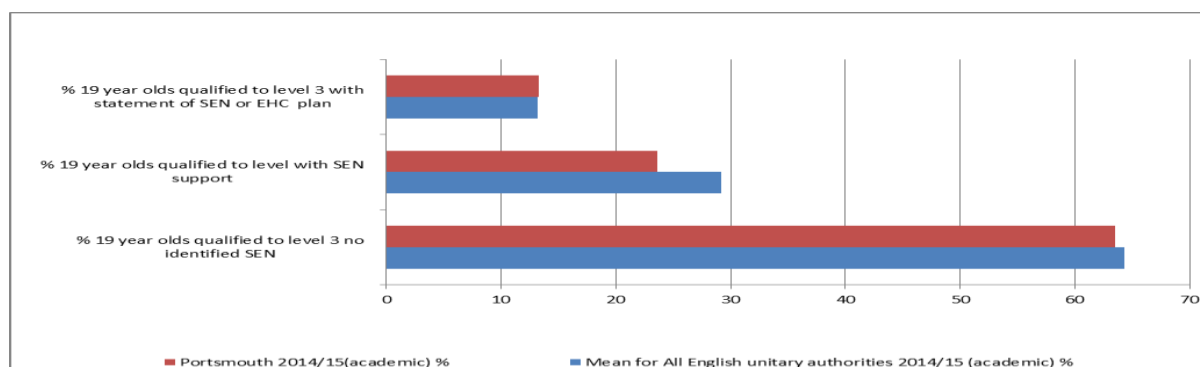
% of 19 year olds with SEN Support qualified to level 2 including English and Maths (from 2011/12 (academic) to 2014/15 (academic))



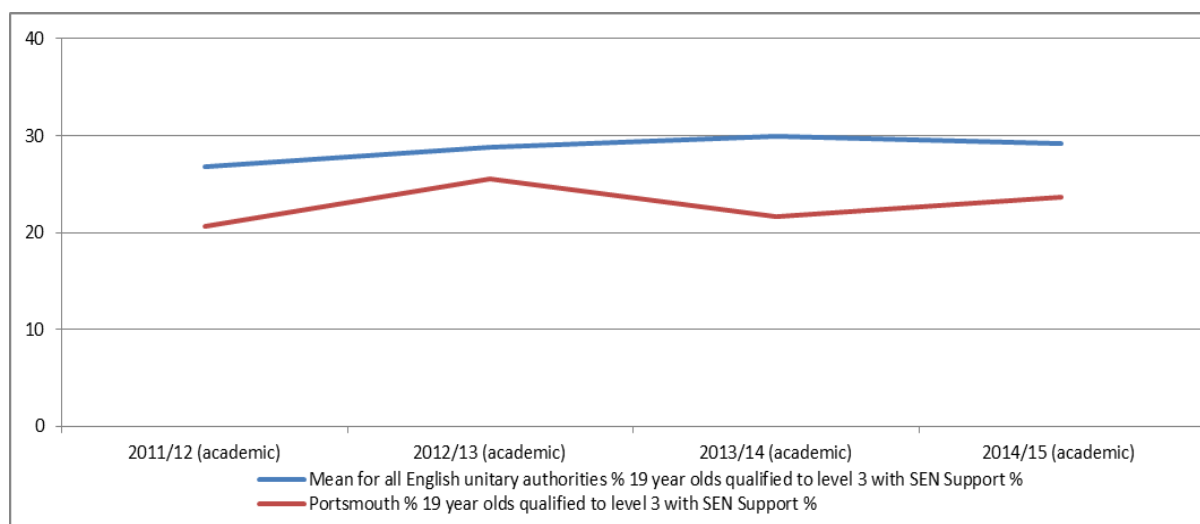
% of 19 year olds with statement of SEN or EHC plan qualified to level 2 including English and Maths (from 2011/12 (academic) to 2014/15 (academic))



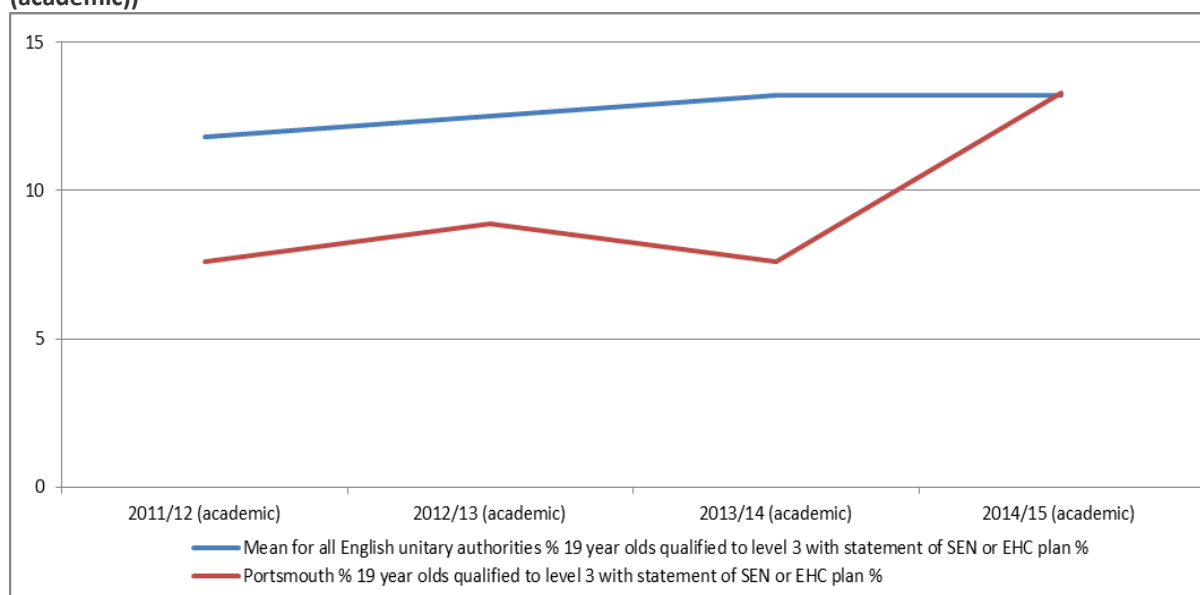
Percentage of 19 year olds qualified to level 3



% of 19 year olds with SEN Support qualified to level 3 (from 2011/12 (academic) to 2014/15 (academic))



% of 19 year olds with statement of SEN or EHC plan qualified to level 3 (from 2011/12 (academic) to 2014/15 (academic))



COMMENTARY

There is a good offer for young people in Portsmouth. We have a positive working relationship with colleges which has enabled the authority to support development of provision. Examples of this include the Engage Programme at Highbury and the new Portsmouth College Life Skills Centre.

A termly meeting with colleges is well attended and the agenda includes: EHCP updates, conversions, college responsibilities, processes and annual reviews

What difference has this made?

The Portsmouth College Skills Centre has ensured that young people with complex needs can continue their education in the City rather than having to travel out of area. Working with Highbury College to support the development of the Engage has ensured that there was no loss of provision following the closure of the Portsmouth College courses at the John Pounds Centre.

What are our areas for further action/ next steps?

- Developing protocols for admissions procedures for specialist provision.
- Continue to monitor the local offer to ensure that there continues to be sufficient provision at Entry and Level 1.
- Review and monitor other training providers and charities offering entry and level 1 provision.
- Ensure colleges can support SEND learners at Level 3.
- Further work needs to be done to review study programmes and ensure they are personalised to meet the progression plans and identified needs of the learners.
- Monitoring progression to ensure learners move onto sustained education, employment, training or an apprenticeship or are more independent in their everyday lives.
- Supported traineeships are at an early stage of development and it is important to continue to work with providers and set a culture of high expectations for progression and impact
- Further support to colleges to carry out statutory duties with regards to EHC Plans and Annual Reviews.

Portsmouth local area services for SEND 0-25: Self-evaluation



SECONDARY INDICATORS

Headline Outputs	Performance Measure	2015/16	2016/17	2017/18 Qtr 1	2017/18 Qtr 2	2017/18 Qtr 3	2017/18 Qtr 4	RAG	TREND AND NOTES
Lead healthy lives and achieve wellbeing (Vicki Rennie)	% children at Year R (age 4-5) receiving height and weight checks								
	% children at Year R (age 4-5) receiving hearing and vision checks								
	% children receiving a health review at school transition in Year 6 (10-11 years)								
	% of eligible young people and adults aged 14 years and above with a learning disability having a GP health check								
	Numbers of referrals to paediatric therapies of CYP aged 0-16 years								
	% of children and young people seen within 12 weeks from referral by integrated Therapy Team								
	Paediatric therapies: Percentage of routine referrals								
	Paediatric therapies: Percentage of inappropriate referrals								

Portsmouth local area services for SEND 0-25: Self-evaluation



	Paediatric therapies: Percentage of patients waiting 18 weeks or less from referral to treatment								
	Paediatric therapies: Percentage of first assessment appointments which are DNA'd								
	Paediatric therapies: Percentage of follow up appointments which are DNA'd								
	CAMHS indicators (to be added)								
Implementation of the reforms Karen Spencer	% children and young people (0-25) with statements assessed and EHCP issued								
	% new EHC plans issued within 20 weeks, excluding exceptions								
	Proportion of new EHC plans issued within 20 weeks, including exceptions								
	Number of children and young people (0-25) with statements assessed and no EHC plan issued								
	% children and young people (0-25) with statements assessed and no EHC plan issued								
	Number of personal budgets taken up for EHC plans issued and transferred or reviewed								
Experience of the system (see	Number of SEND mediation cases that have been held								

Portsmouth local area services for SEND 0-25: Self-evaluation



narrative section D) Karen Spencer	% SEND mediation cases that went on to appeal								
	Number of SEN appeals per 10,000 of school population								

Commentary:

Karen Spencer, Vickie Rennie and Stuart McDowell

Portsmouth local area services for SEND 0-25: Self-evaluation



DEMAND MANAGEMENT INDICATORS

Demand Area	Performance Measure	2015/16	2016/17	2017/18 Qtr 1	2017/18 Qtr 2	2017/18 Qtr 3	2017/18 Qtr 4	RAG	TREND AND NOTES
Education, Health and Care Plans - monitor demand (Karen Spencer)	Number of EHCPs requested								
Out of city placements - monitor to ensure this is not increasing (Karen Spencer)	Number of out of city placements								
Continuing healthcare - ensure good value for money from placements	Number of new placements								
	Number of placements reviewed								
	% placements meeting need								
	Average placement costs								



Experience of the system narrative appendix

Tribunals - issues and learning summary

To be added - Julia Katherine

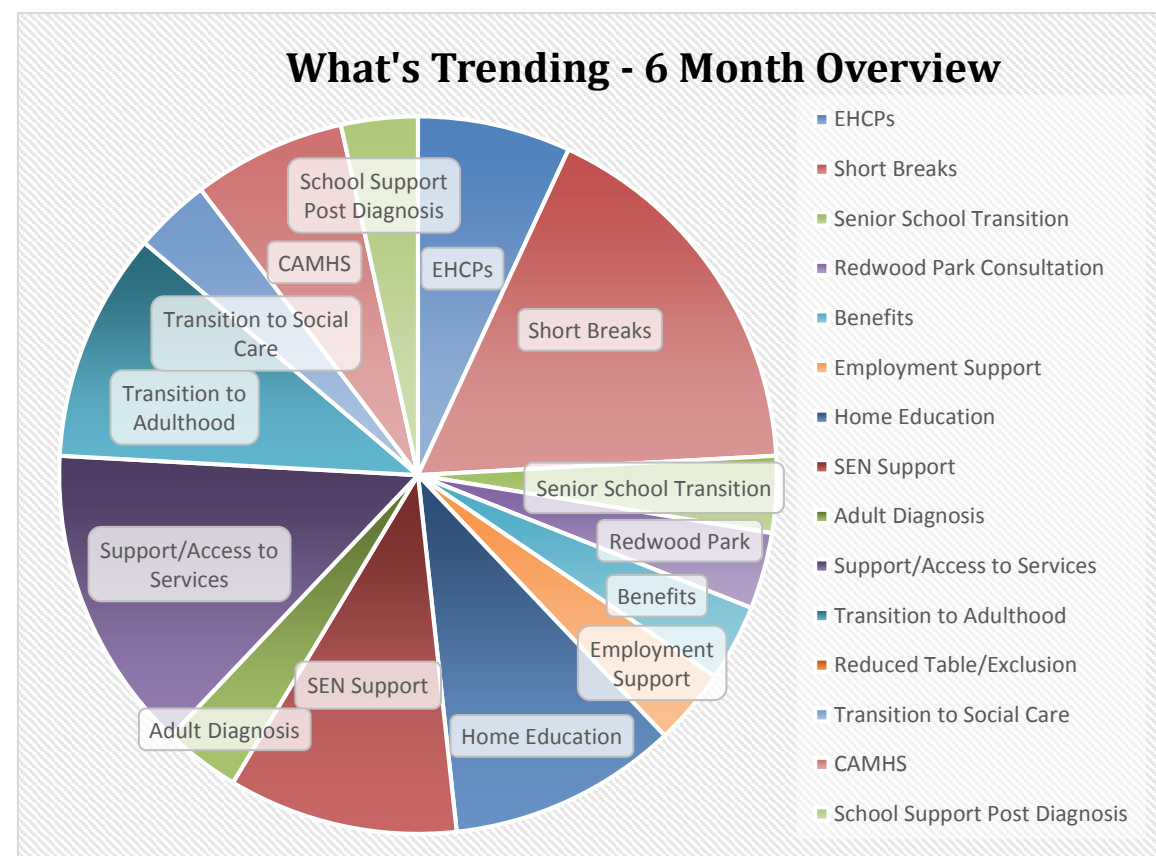
Feedback summary - Julia Katherine

Issues from feedback this quarter

Portsmouth local area services for SEND 0-25: Self-evaluation

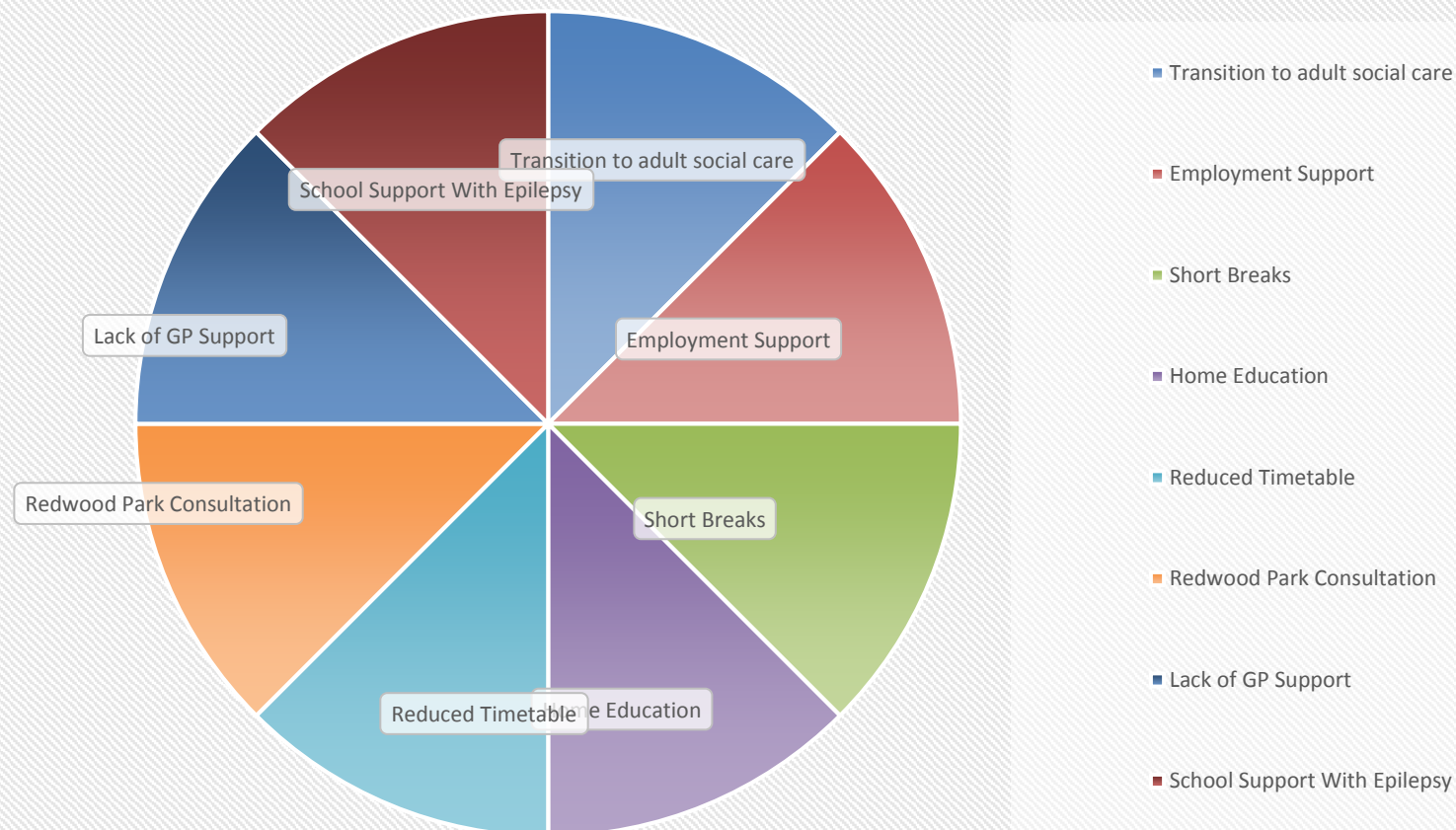


What's trending report



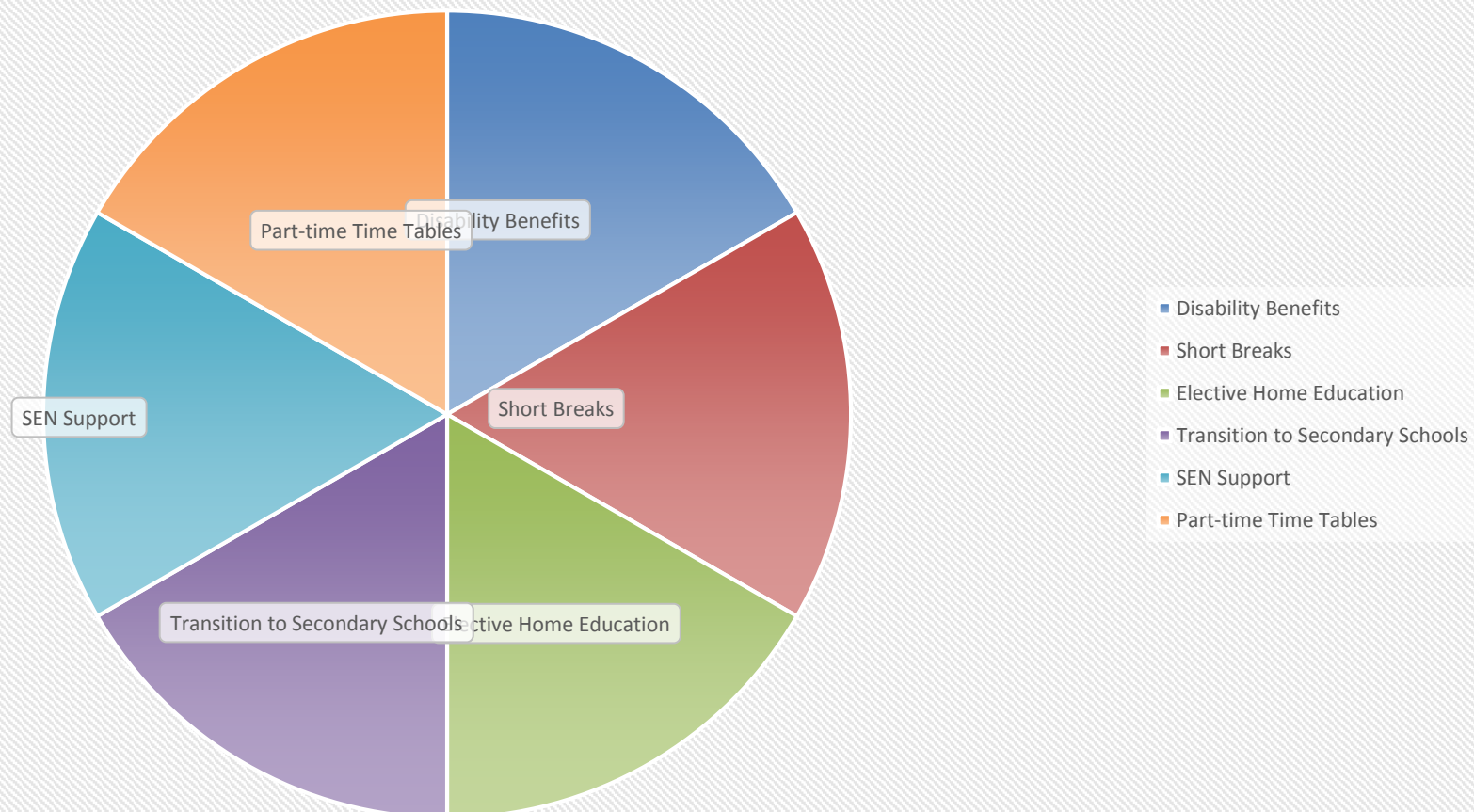


What's Trending - October 2016



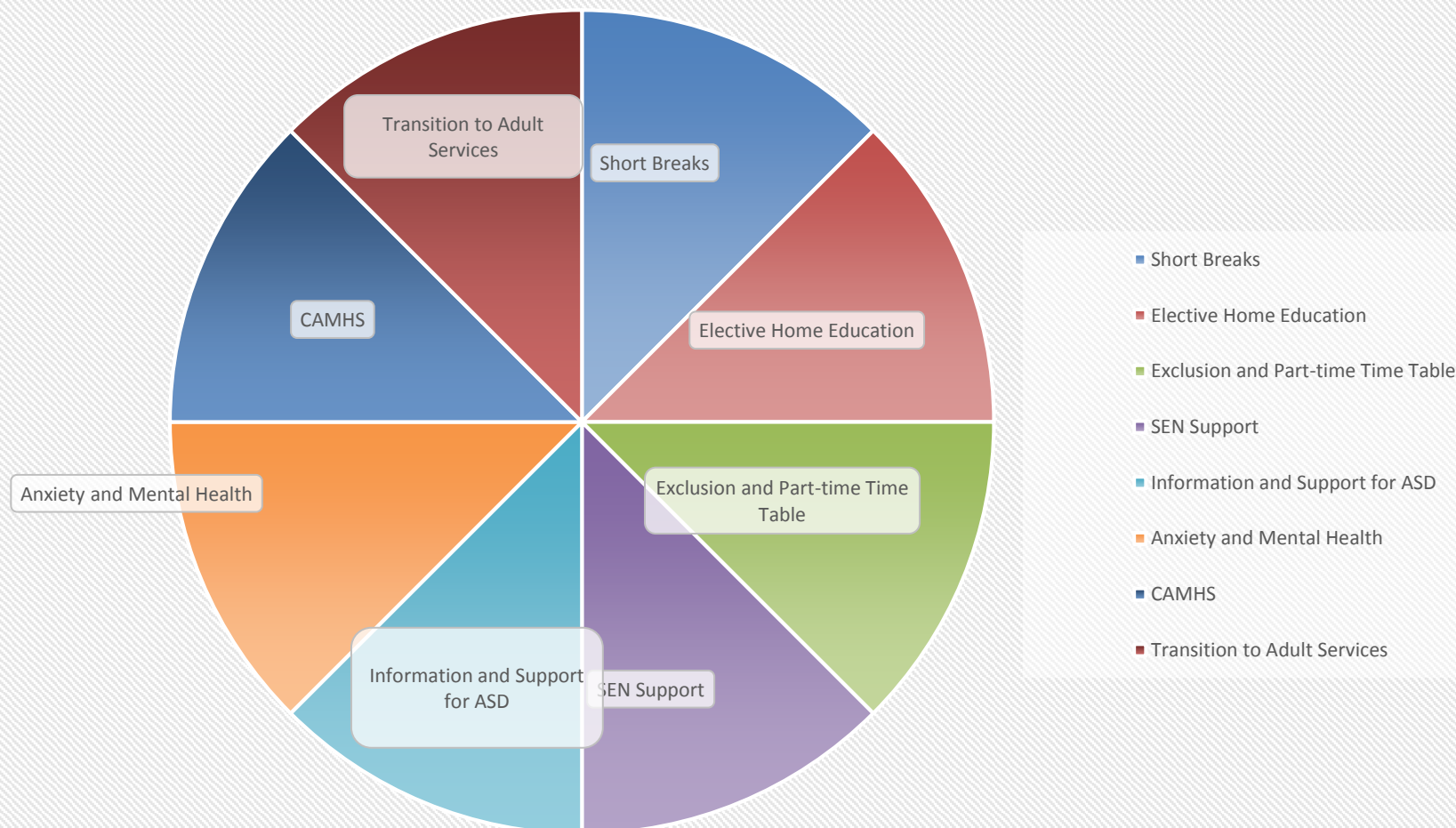


What's Trending - November 2016



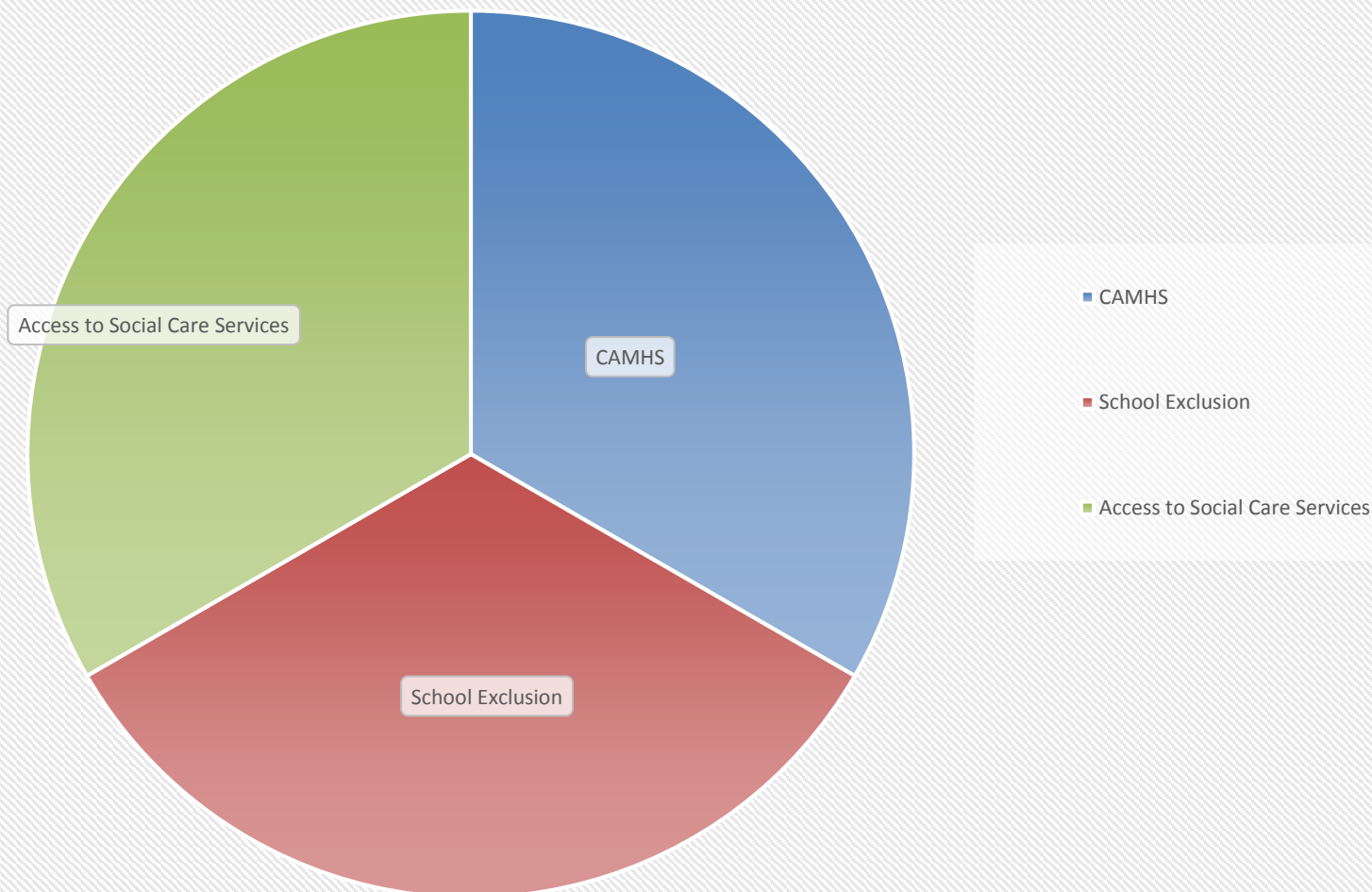


What's Trending - December 2016



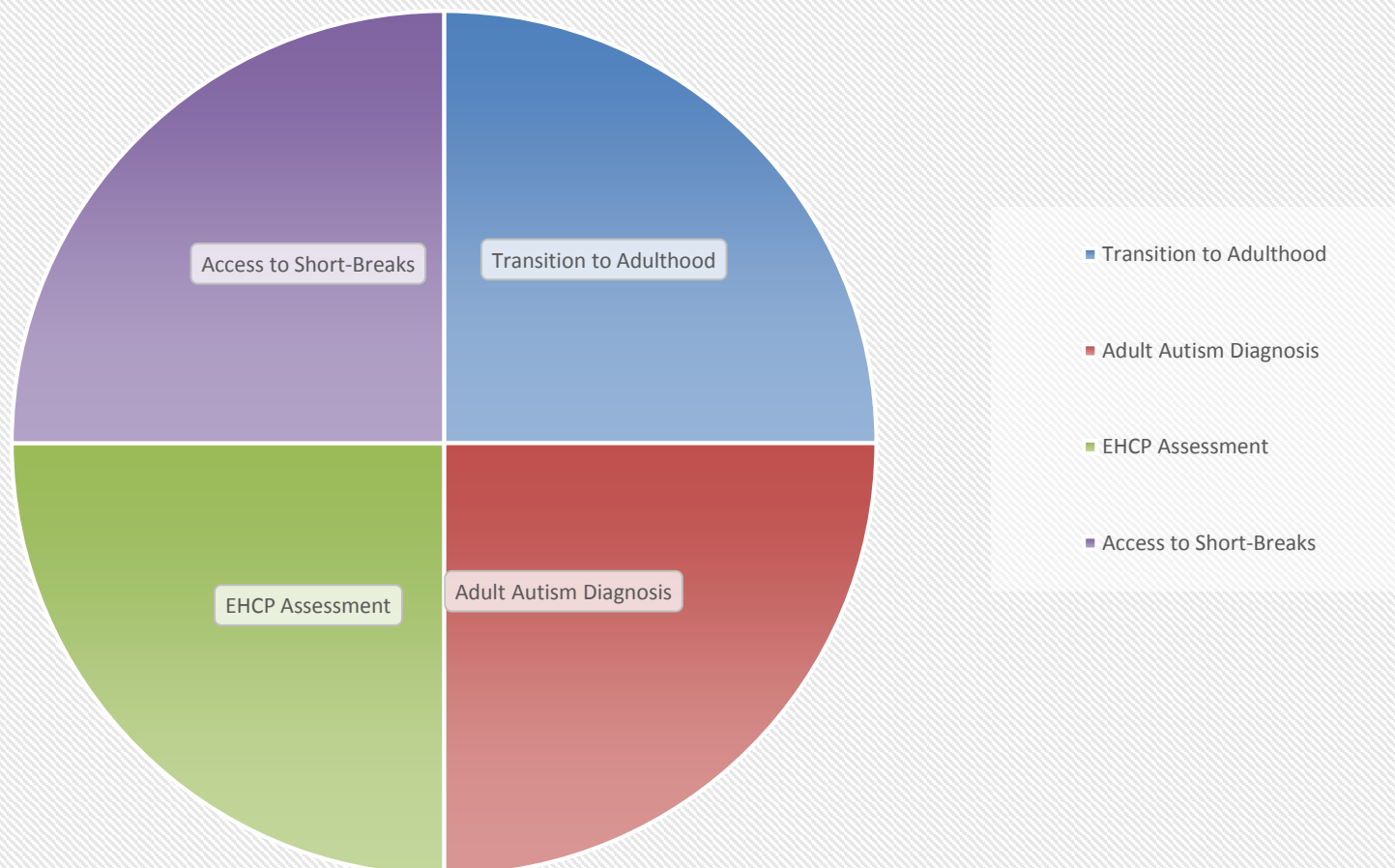


What's Trending - January 2017



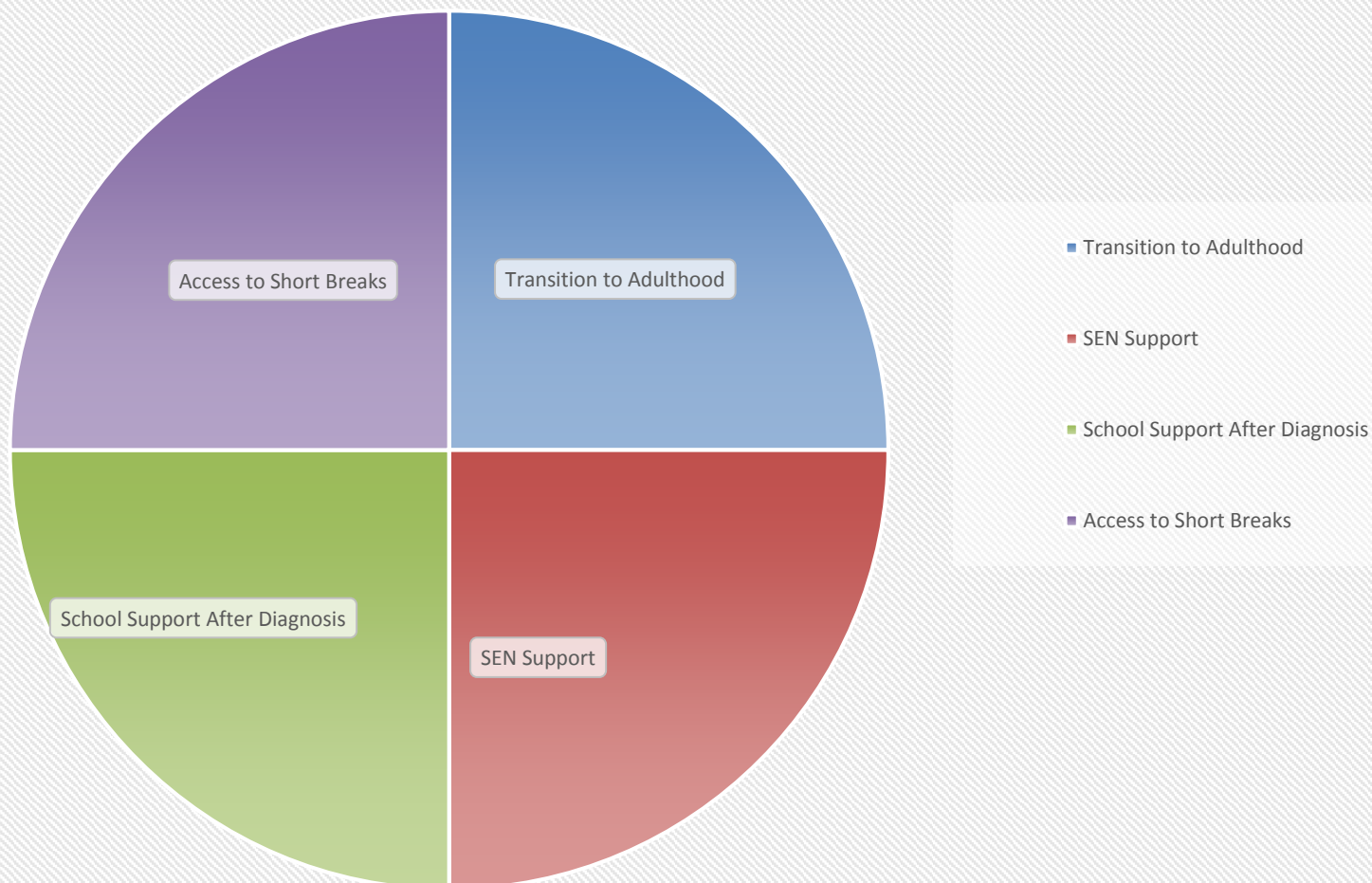


What's Trending - February 2017





What's Trending - March 2017



Analysis of Personal Outcomes Evaluation Tool (POET®) survey returns from a survey conducted in June/ July 2017 with Parents and Children who have an Education, Health and Care Plan (EHCP).

Executive Summary

The purpose of this paper is to assess the feedback from parents and children who participated in a POET® survey around various features of Education, Health & Care Plans (EHCPs). We wanted to understand how the EHCP process was working from parent's and children's perspectives. This work was conducted in partnership with the SEND team, the corporate team and the communications team who undertook the task of enabling the online surveying to proceed. It was hoped that we could get a survey response group large enough to carry out a detailed analysis, certainly in excess of the 19 responses achieved in 2016. As it transpired the online format was a success and we received a total of 119 responses from parents and children.

The surveying was designed to capture a broad range of views that parents and children had about their involvement in and outcomes from EHCP processes. What we saw from the data we received back was a broadly positive in outlook with a number of interesting caveats.

- Parents are feeling more optimistic about EHCP matters than their children
- Mothers tend to get more from their involvement in EHCP than fathers do
- Girls appear to be operating at a disadvantage in EHCP processes

As a result of the valued feedback that parents and children have provided us, we have understood the following points.

- Our survey pool is broadly representative of the populace in general
- Personal Budgets are still not a significant factor in connection with EHCP
- Generally the EHCP process is working well
- Education settings are influencing some outcomes
- Mature EHCP are perceived to influence some outcomes positively due to individuals becoming accustomed to them as time moves on
- Gender differences are evident in children's involvement and outcomes
- Gender differences are evident in parental outcomes
- The local offer needs more publicity

Based on these points a number of recommendations are made at the end of this paper that will hopefully address the concerns of interested parties. We will also continue to work alongside all our partners on similar surveying projects in the future.

Introduction

Developments in legislation have changed the way in which statutory bodies approach and deal with children with special educational needs/ disabilities (SEND). Previously the approach involved the formulation of a "statement" but this has changed in recent years with the new process involving the construction of a wider ranging document, the Education, Health and Care Plan (EHCP). The relevant legislative drivers underpinning this are listed below.

- Part 3, Children and Families Act 2014 and its associated regulations, provisions and code of practice (2014 & 2015)
- The NHS Act 2006: Sections 3, 3A and 2A
- The Equality Act 2010

At the same time this legislation (and the wider political and economic climate) has driven the advance of many projects across England that embody the move toward an integrated approach to matters of health, social care and education. In Portsmouth this has been evident in being involved, as a demonstrator site, in the Integrated Personalised Commissioning (IPC) programme. The aims of this programme, with reference to children, are to get recipients of health, social care and education services (and their parents/ guardians) to the very heart of the support planning process. This is a major change as the emphasis is no longer on processes and service provision (as an end in themselves) but on the individual child being able to set and achieve meaningful outcomes, the plan being a blueprint for what support is put in place to help the child in question to achieve those goals.

Portsmouth is in the final year of the IPC programme and the work with children is well established and ongoing. This report follows on from two previous reports written in 2016 that outlined, firstly, how parents viewed what was then a fairly new process in obtaining for their child an EHCP that took the form of a thematic analysis as well as, secondly, a POET© survey designed to determine what the outcomes were for parents and children who had already got an EHCP in operation. POET© is a tool designed and produced by In-Control in conjunction with Lancaster University as means of measuring the outcomes being achieved in the use of EHCP rather than a tick-box exercise for identifying process and service delivery as means in itself. This survey, then, reflects the change in emphasis that is happening in working in a more integrated way towards outcomes based care and support planning. This paper presents the results and analysis of a second POET© survey run one year on from the first.

Methodology

There are two versions of the POET© survey that were used to base this survey run upon. These forms can be seen in *Appendix B*. These were:

- Survey for parents of children and young people who have an Education, Health and Care Plan;
- Survey for children and young people who have an Education, Health and Care Plan, their life and the support they get.

The first survey run conducted in 2016 was postal in nature. Based on the experience of that first exercise a number of changes in approach were considered and some of these were implemented. The most important of these involved rendering the hard copy versions of the survey into an online (SurveyMonkey) format so that the survey could be carried out more easily and more quickly by more people. This had two key advantages.

The first was that it allowed for the addition of extra questions in addition to the main survey that would allow us to ascertain the impact of important local activity as well as seeking answers to the survey questions as they are found on the hard copy survey form. The most obvious additions were the questions relating to the Portsmouth local offer. The second was that participation and submission of the completed online form would all, essentially, take place in the same period of activity by the parent or child/ young person concerned. This was felt desirable as the weakness of any postal survey lies in the fact that a completed survey form has little use if it is not, also, put back in the post to return to base. Previous experience has shown that the return rate for the last POET© postal survey was around 19% for adults and around 11% for children which, given that the number of survey packs sent out was 62, was insufficient to conduct an analysis at anything more than the anecdotal level. We needed more returns.

In addition we wanted to conduct a parallel survey with parents and children/ young people who were not covered by an EHCP but who were receiving some form of support in their educational settings. This is a much larger group than those formally captured under EHCP arrangements and the decision to survey was a good opportunity to find out more about those receiving more limited support in a less formalised way than would ordinarily happen under EHCP arrangements. This necessitated the construction of online survey forms that were, in the main, similar to those in the POET© EHCP surveys with some obvious amendments needed such as the elimination of irrelevant references (for example removal of references to EHCP in the survey forms for those who didn't have an EHCP).

The end results were 2 surveys for parents and children with EHCP and 2 surveys, suitably amended, for parents and children without EHCP (*Appendix C*).

Intentions

The intention of this report is to gain insight into the impact of the support being received either through EHCP or through other means. This covers a variety of areas including:

- What sort of support is being received and in what setting;
- What reasons the support is needed;
- What parents and children think and feel about this support;
- To what extent the support is helping children or otherwise;
- How long any provision has been in place;
- Who is involved in formulating plans for support in place;
- Are parent's and children's views being heard;
- Use of Personal Budget (PB) facilities;
- What outcomes are coming through for both parents and children;
- What is/ isn't working;
- What changes parents are suggesting.

These areas and others are covered in the highly structured framework provided by the survey forms. Parents and their children were identified through the rolls maintained by the SEND team here in Portsmouth to ensure we were only going to be requesting survey returns from those living and being educated within the locality. A letter was sent to each such household inviting parents and children to take part. The links to the appropriate surveys were given in the letters and so the survey could be conducted within the individual's own home without the necessity to post any forms back to base.

The strength of any survey comes from the content of the forms and POET© is nationally validated through prolonged use. The surveying that was carried out in this instance also has some drawbacks and it is, perhaps, useful to outline these. There was no set figure that was aimed at as a target for returns. The intent was simply to get as many returns as possible and, in so doing, exceed the relatively poor returns of last year's survey run (comprising 12 parent and 7 children's survey returns). As far as the numbers participating in the "with EHCP" surveys are concerned we increased participation more than six fold by using an online format as we obtained 75 parent survey responses and 44 children's survey responses. The situation regards the "without EHCP" surveys was less happy as only 9 parents and 4 children's responses came back to us.

This initial positive (for the "with EHCP" survey) must be tempered with a note of caution. Due to errors in the logic of that online survey that were not picked up in the initial few days of the survey run there were a number of surveys that were missing large sections of answers. This was traced to a logic problem whereby a negative answer to a question on Personal Budgets enabled the skipping of most of the rest of the survey questions. Fortunately this only affected the first few surveys received and once corrected it was seen that most parents were happy to answer all the questions and so we did not identify a significant issue with survey fatigue where the answers dropped off the longer the survey went on. No similar issues emerged with any of the other 3 surveys being carried out so this logic error was, thankfully, an isolated problem quickly resolved and had relatively little impact on later activity.

Whilst wholesale skipping of questions was not a significant problem there were some questions that attracted a higher rate of skipping than others. This could have been

rectified by configuring the logic of the online survey to require an answer to the question before moving on. It is unclear if this would have had the desired effect or whether a respondent unwilling to answer particular question(s) would have simply stopped their survey altogether. Whatever the case, had the respondents been filling out a hard copy survey form to be posted back they would have had the same opportunity to skip questions so it would appear not much was lost in the change of format that was employed.

The upshot was that we had significant quantities of detailed survey data from the "with EHCP" surveys upon which a detailed analysis can take place. This will form the bulk of this paper. This was, alas, not the case for the "without EHCP" surveys. As these 2 surveys between them only attracted 13 survey responses there is little merit in trying to undertake a detailed analysis. What we did receive from these 13 responses, however, was a large quantity of free text in the sections relating to things going well, going badly and changes that should be made. After discussion with colleagues we felt that rather than just dropping this part of the surveying we could engage in a mini thematic analysis on this raw respondent data, principally to explore the opinions on the system from those parents and children who currently do not have EHCP but who do receive some form of support and this can be found in *Appendix A*.

Due to the small number of survey returns in the 2016 survey we did find that there were some very striking similarities in the respondents taking part. Key amongst these were that all the parent participants were women, all the EHCP under scrutiny were less than 1 year old and ethnicity was given as "white" in all cases and that in the children's survey none of the participants had filled out the survey completely by themselves. With over 6 times the number of responses attracted for both "with EHCP" surveys we have found that these areas of complete commonality have been largely eliminated. What remains is that:

- All respondents live within the Portsmouth City Council LA area
- No respondent was altogether clear over matters relating to Personal Budgets
- All the children have an EHCP

On this basis we are still capturing respondents in the correct geographical location and we are capturing the views of those for whom EHCP is a factor. On the down side there still does appear to be an issue with the clarity and transparency of information relating to funding and Personal Budgets. Surveying seems to indicate that, except in a very few rare cases, there is little knowledge in the hands of parents and children/ young people on these matters and the paucity of information leads to the conclusion that either we (as the LA) are not being open enough with our populace or that these factors are, to a large extent, irrelevant to parents and children/ young people. Certainly the impact of Personal Budgets is yet to be felt in any significant way, if at all.

What the greater numbers answering the parent "with EHCP" survey have added is that we are now seeing feedback from individuals where the EHCP plan is more than one year old. This is key as an EHCP remains relevant to a child/ young person from when it

is formulated to the age of 25 potentially. Thus we get a first opportunity to assess mature, more established, EHCP arrangements. We also saw input from male parents in this survey so we can see if mothers and fathers have differing views on the matters in question. We have also seen survey feedback from individuals whose ethnicity is other than white. Again it raises the possibility of seeing if non-white parents face different challenges around matters of the EHCP. We must stress, however, that although we have a broader pool of survey respondents the numbers of fathers and of non-white survey respondents is still relatively small and that mothers and those with a white ethnicity are still the overwhelming majority of our pool of survey respondents.

In addition we now have children answering the "with EHCP" survey for themselves. Although they are by no means in the majority in that part of the survey the fact that they are there means we have a much stronger children's voice emerging from this survey compared to the previous survey in 2016.

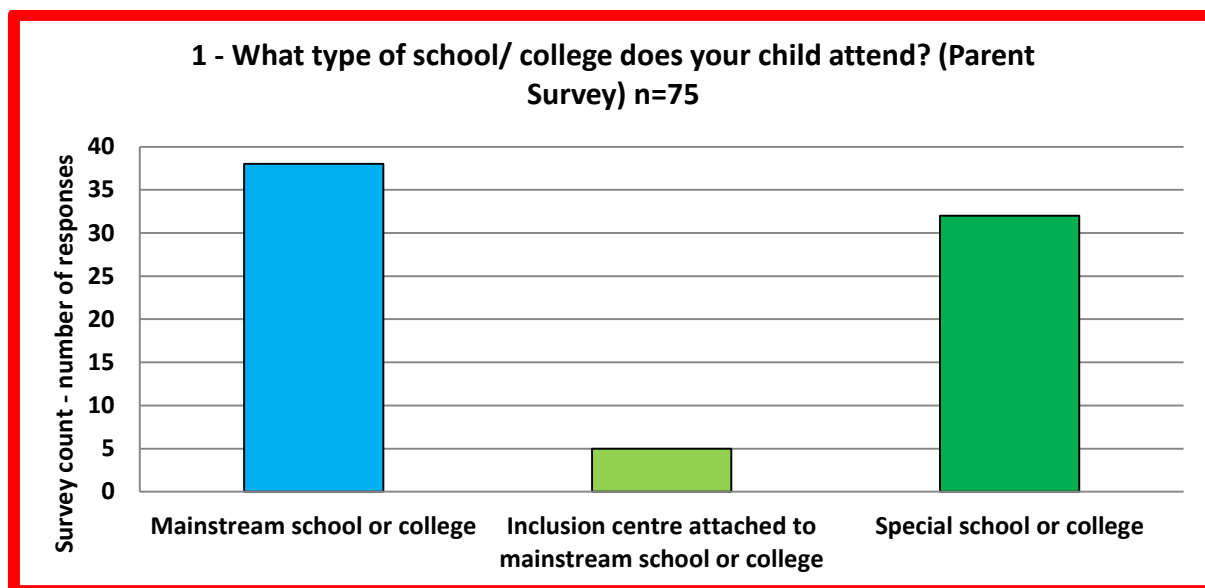
The remainder of this paper will set out the analysis of the parent and children's "with EHCP" surveys and what conclusions we can draw from this work to inform on future developments. There will be a basic level analysis for each of the 2 surveys and a more in depth look at certain key features. The first (and larger part) will focus on the parental survey for 2017, the second being on the children's survey of 2017.

Following the analysis will be the conclusions that can safely be drawn from this survey feedback, again set out separately for each "with EHCP" survey with an overall conclusion to finish the paper.

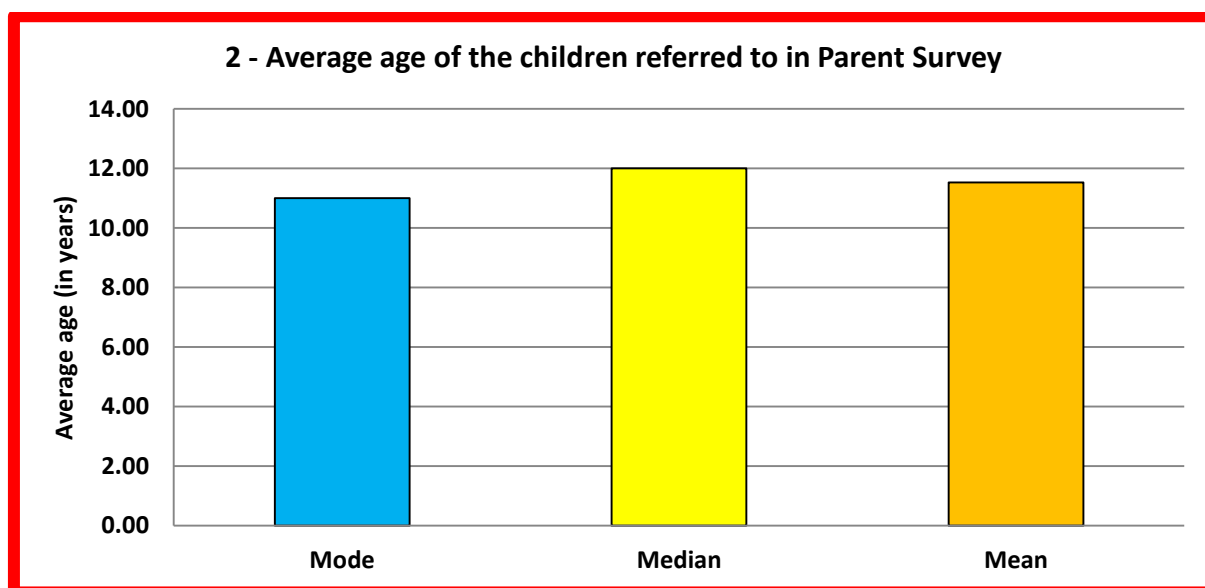
There will also be 3 appendices showing the survey forms employed to gather the information upon which this paper is based as well as a mini thematic analysis of the free text feedback received from the "without EHCP" survey respondents to ensure that any learning we can achieve through this small number of responses to our other 2 surveys is realised and, again, to inform any changes or future developments.

Basic Analysis of the Parent "with EHCP" survey returns

This analysis is based upon the survey returns submitted by 75 parents in the 2017 POET© survey run. All the parents reported that their child had an EHCP but this does not necessarily indicate where the child is going to school. A useful jumping off point is to show where these EHCP are in operation day to day as per figure 1.

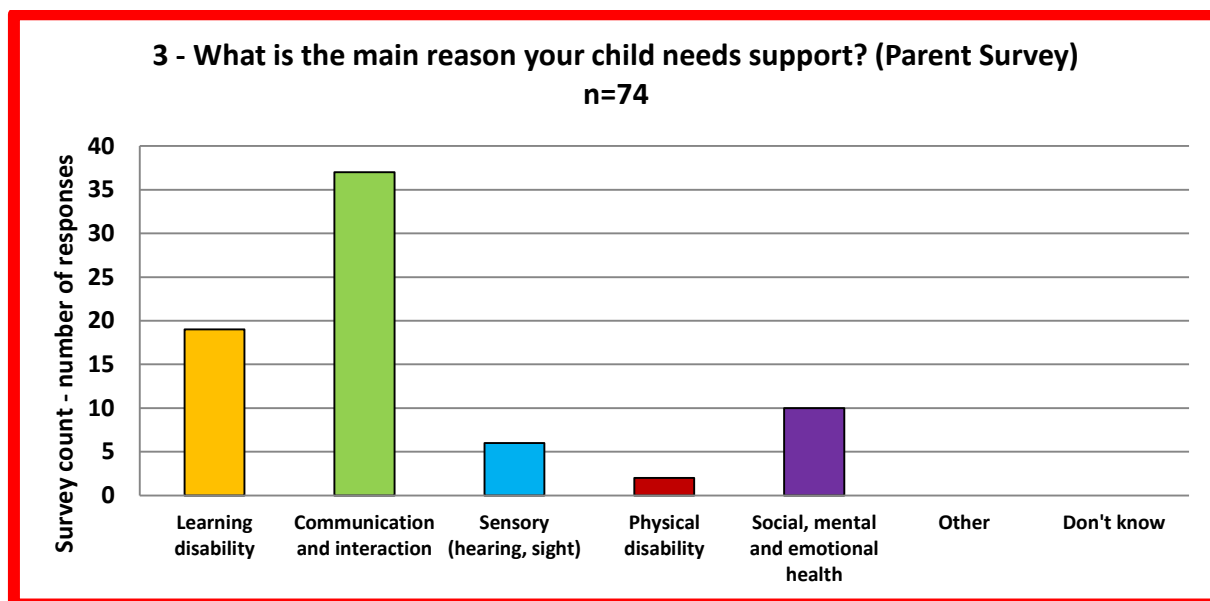


Just over 50% of respondents had a child in mainstream schooling, just over 42% in special schooling and around 6% were in inclusion centres attached to mainstream school settings. The average age of the children subject to EHCP will clearly reflect this as per figure 2.



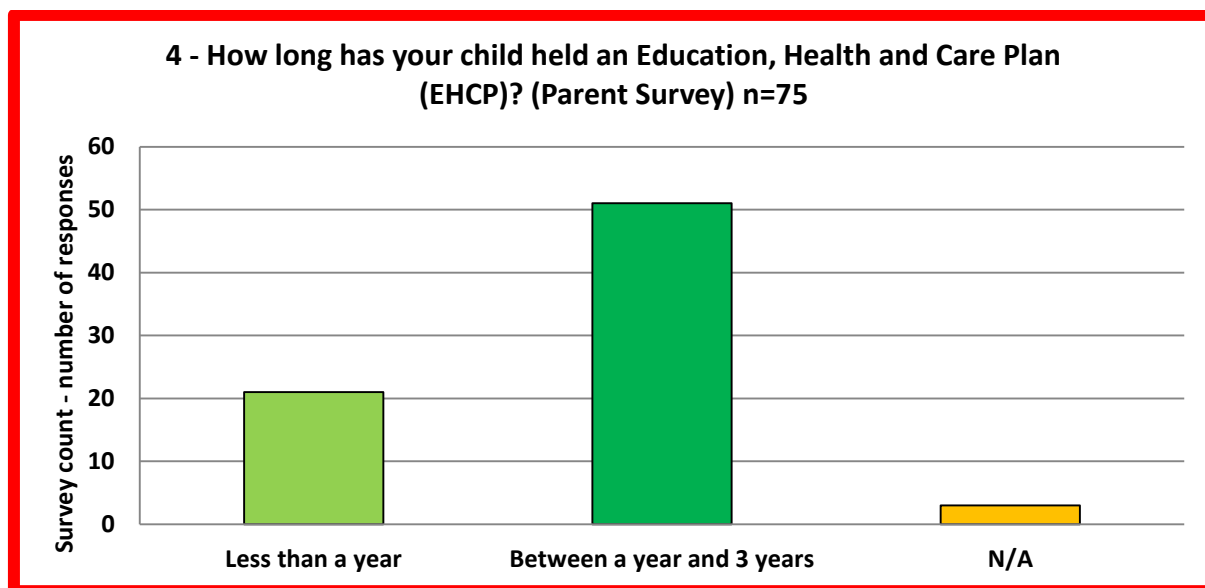
The most common age of the children of parents being surveyed in this work was 11 years old. The age range of children parents reported in this survey ran from 3 years old to 21 years old. The median figure for this range was 12 years old. The mean average fell somewhere between 11 and 12 years old. This is interesting as this age range coincides with the transition from primary to secondary education. It is worth noting the large range involved showing how early EHCP could be put in place where necessary and also the long term nature of EHCP as the oldest child was 21 years old. EHCP can be operational for an individual up to 25 years old so we can clearly see this long term focus in operation from this surveying.

EHCP are usually triggered for very good reasons. The survey asked parents what these reasons were and this is displayed in figure 3.

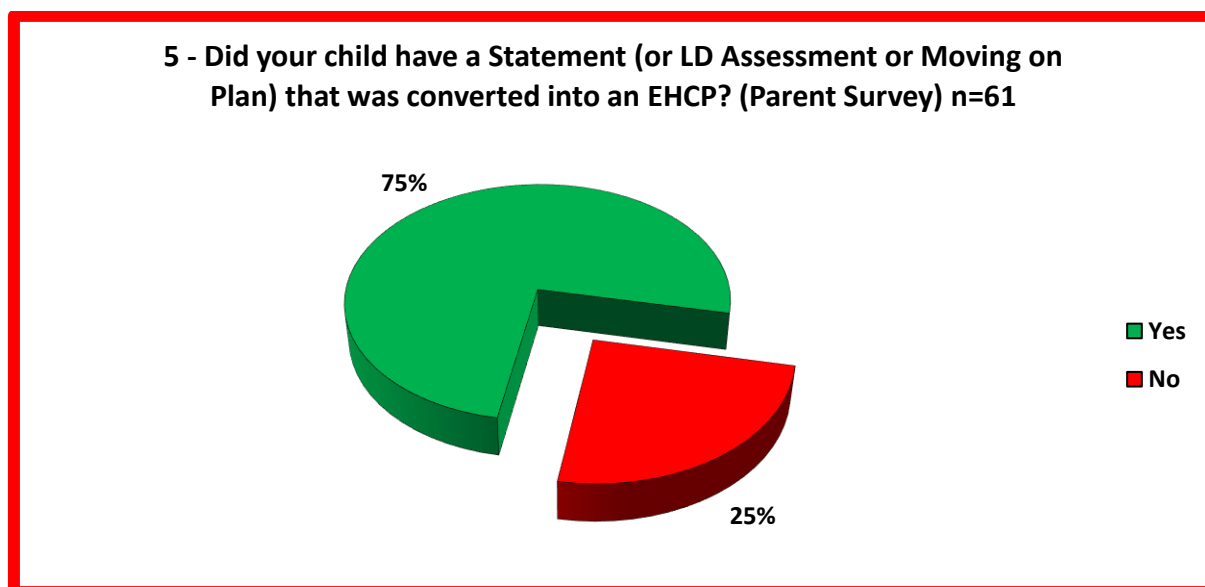


Communication and interaction proved the most common reason why an EHCP was formulated (just over 50% of cases) with learning disability (just over 25%) and social, mental and emotional health (over 13%) also prominent. Even in these fairly broad categories there are a wide range of reasons why children require the additional help implicit in the EHCP. Each case is unique (as evidenced by parental free text feedback) and this is the issue that EHCP are designed to address, being person-centred and integrated across services.

From the previous survey in 2016 we saw a small sample of responses based on what were, at the time, relatively new EHCP. Our survey in 2016 failed to capture any responses based on more mature EHCP. From this year's survey we have seen a change in this as most of the survey responses (68%) described plans that were somewhere between 1 and 3 years old. This is understandable from the viewpoint of what has been taking place due to legislation in recent years. The old "statement" type system is in the process of being phased out and replaced with EHCPs. This means that as well as children being assessed from scratch as requiring an EHCP (28%) we also have a large number of children who have had some form of assessment previously, to inform their "statement", and who therefore need their "statement" converted to an EHCP. This is reflected in figure 4.

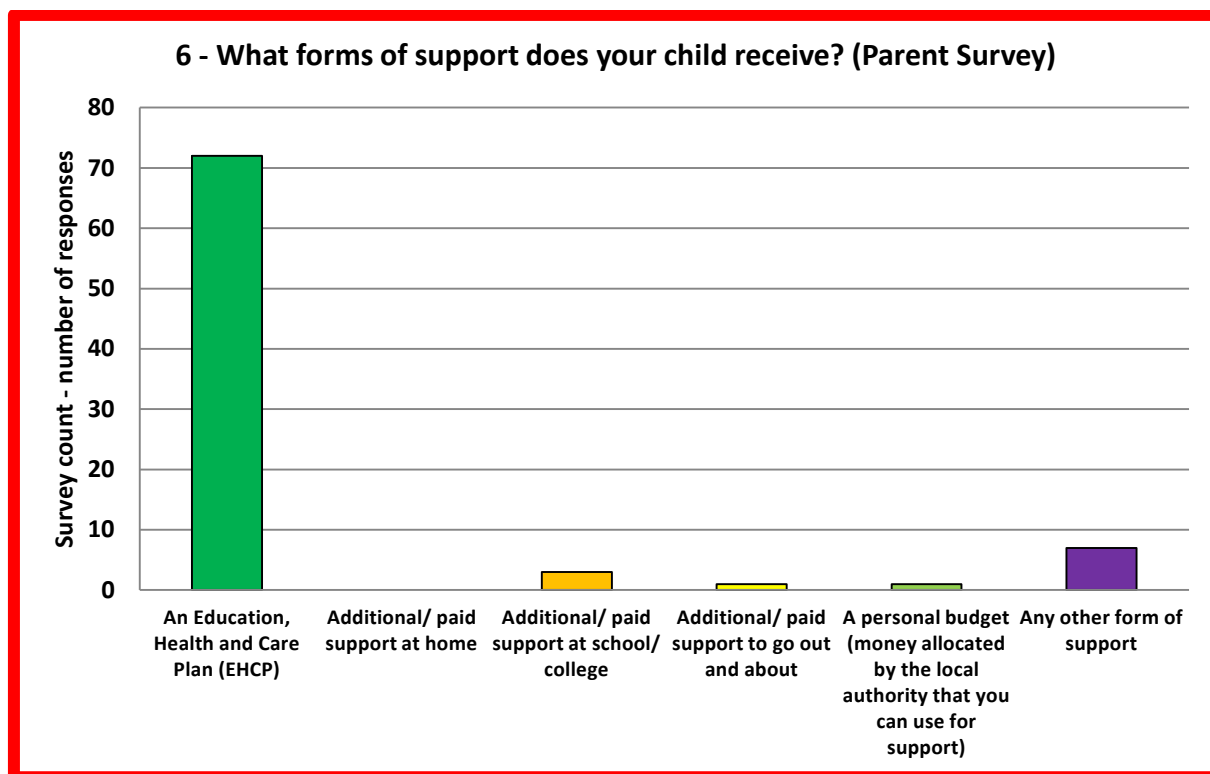


Further, we can see that the majority (75%) of EHCP were founded on a conversion process from the old "statement" system in place previously. This is demonstrated in figure 5.

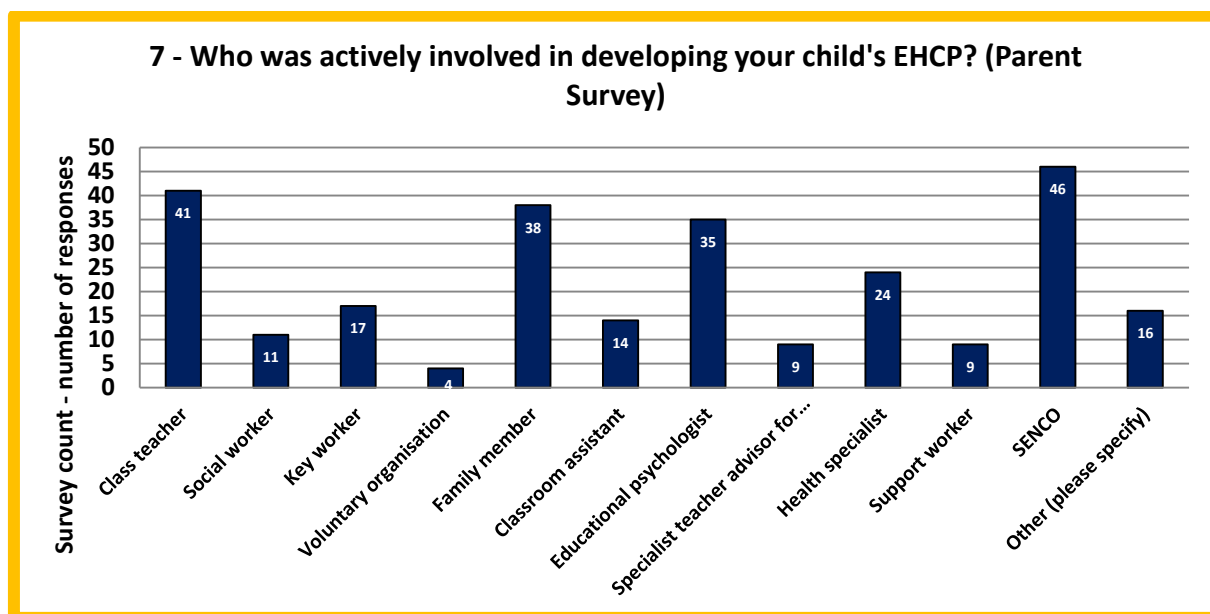


As this conversion process continues we should see a shift in this as eventually all children previously on a "statement" will be on an EHCP and so the new EHCP processes will increasingly outweigh the conversions in the future.

What this feedback is demonstrating is that there is very little that children subject to EHCP have in common except for their EHCPs, whether that is education setting, their ages, their reasons for needing the support of an EHCP, how long their plans have been in operation or whether they are new to the process or have had a "statement" in the past. A small number of children do receive additional support apart from the EHCP which is shown in figure 6.



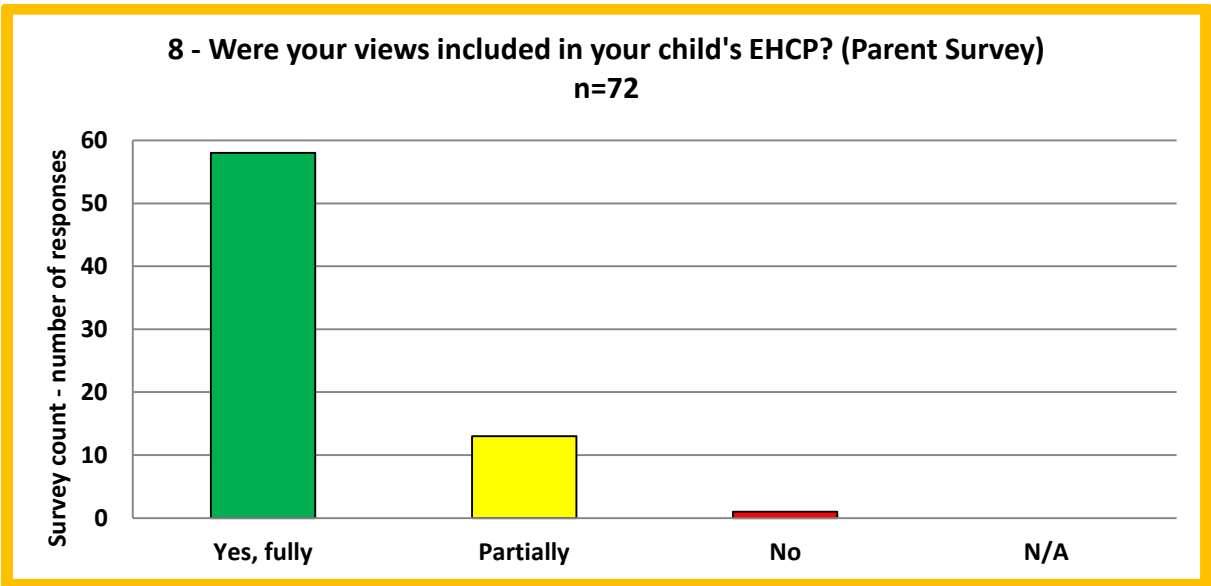
Next we turn to those involved in formulating the EHCP. Anecdotal evidence from how things used to work is that the planning process was driven by the professionals, the feeling being that care and support was "done to" the recipient. Clearly EHCP cannot be put together without the knowledge and expertise of a whole range of professionals and this range of people potentially involved is shown in figure 7.



Although there are many individuals potentially involved, from our survey feedback we can see some individuals that tend to be involved more often and these professionals are crucial to ensure the widening success of EHCP. For the purposes of this analysis the key individuals tend to be SENCOs, Class Teachers, Family Members, Educational

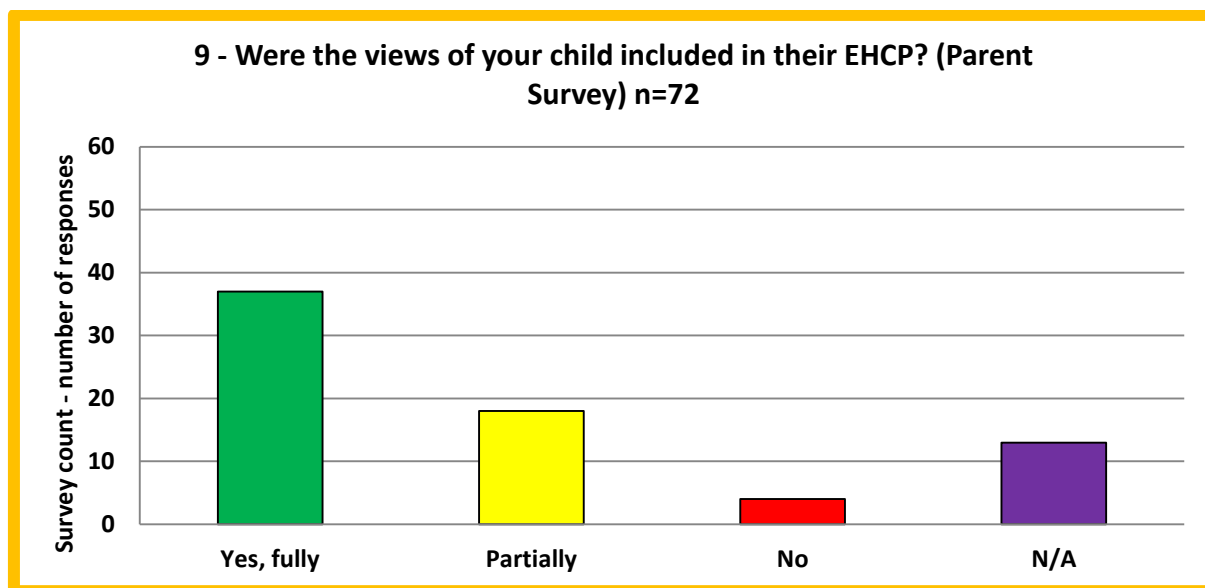
Psychologists, Health Specialists and Key Workers. As EHCP are very much focussed on education we would expect to see educational professionals represented strongly in this feedback (SENCOs, EPs & Class teachers). Crucially, however, we are seeing representation from Health and Social Care professionals as well.

Underpinning all this we also see that families are represented. This may seem obvious to point out. Families have the most experience of a child and the best knowledge around the reasons why their child needs support. They tend also to be the individuals who spend most time with the child. However, touching on the point raised earlier in this paper, families tended to have only peripheral involvement in care and support planning in the past, with care and support being "done to" a child rather than reflecting what the child and parents wanted and felt would be best for them. The EHCP was brought into being partly as a way of redressing this imbalance and placing the child and his/ her family right at the heart of the care and support planning process. Parents were asked their views on how involved they (and their children were in the planning processes leading towards an EHCP and its ongoing operation. The feedback for parental involvement is shown in figure 8.



This is a positive result as it shows that the overwhelming majority of parents felt that their input to EHCP was acknowledged and played a part in putting together their child's EHCP. In fact only 1 of the 72 parents who answered this question felt that their voice had not been heard or acknowledged at all.

To a lesser degree we also see this enhanced involvement reflected when parents were asked to gauge whether their child's views were included in their EHCP. This is shown in figure 9.

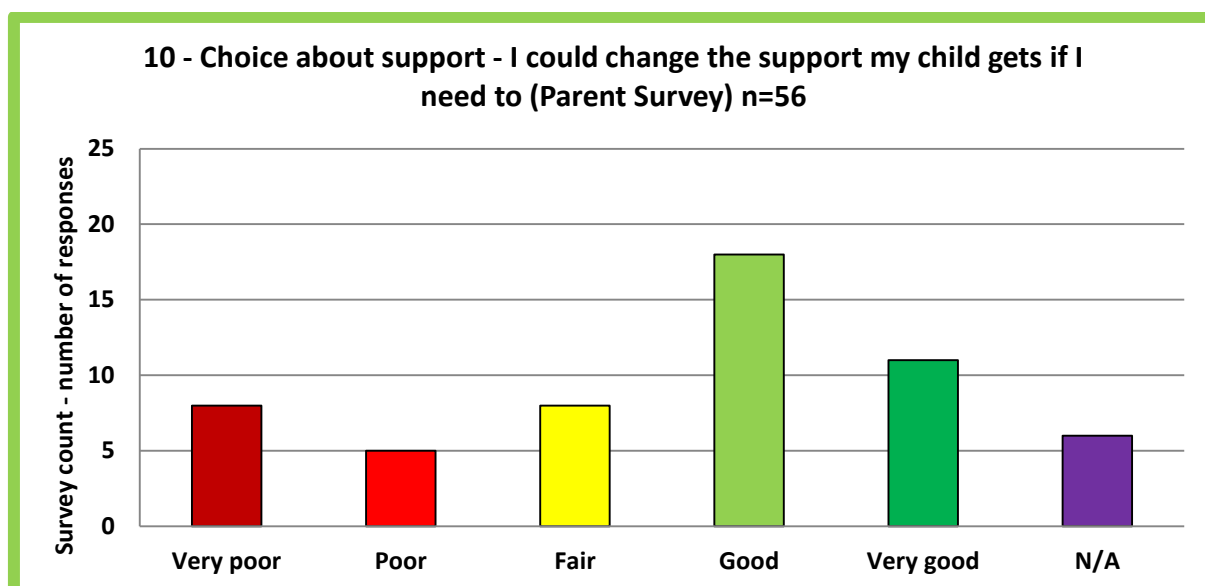


From this we can still see a majority that believe their child's views were fully or partially taken into account when putting the EHCP together and only 4 of the 72 parents felt their child's views not been acknowledged. There were a significant number of not applicable answers to this question (13). Looking back at the data we can see that there are also 13 children aged 5 years old or younger which seems to correspond quite strongly. Whilst this would seem to indicate that age is a factor in how readily a child's views are taken into account in their EHCP (the younger the child, the less likely their voice will be heard) it is also encouraging as even relatively young children from the age of 6 years and upwards seem to be having inputs into their own EHCP and that perhaps the younger children are not old enough to have entered school full time or to have formed strong opinions of their own yet on the care and support they receive or might like to receive.

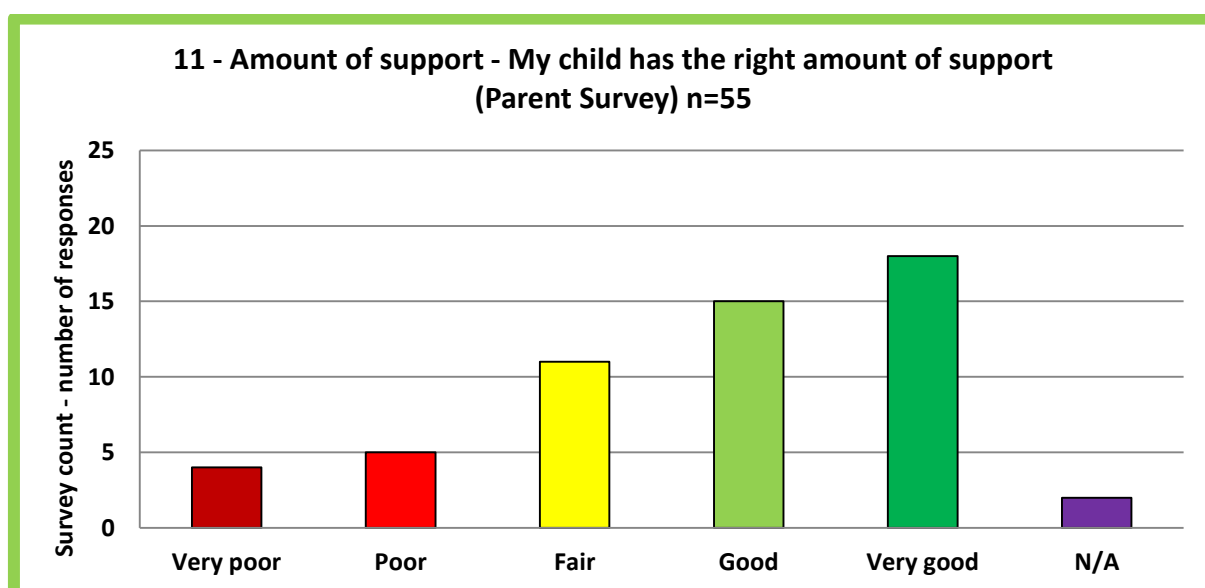
This brings the analysis to the questions relating to support for children that stems from the EHCP. Parents were asked to rate what they felt about being able to change that support if necessary, whether the amount of support was right and the quality of that support in treating their child with dignity and respect.

This shifts the parent's involvement to more than just the planning phase and into being an active player in the more day to day observances. Can parents help change support if what is on offer isn't working well? Can they influence decisions on how much support is needed (whether more or less than previously)? How do parents see the support in maintaining their child's dignity and self-respect and their development as an individual?

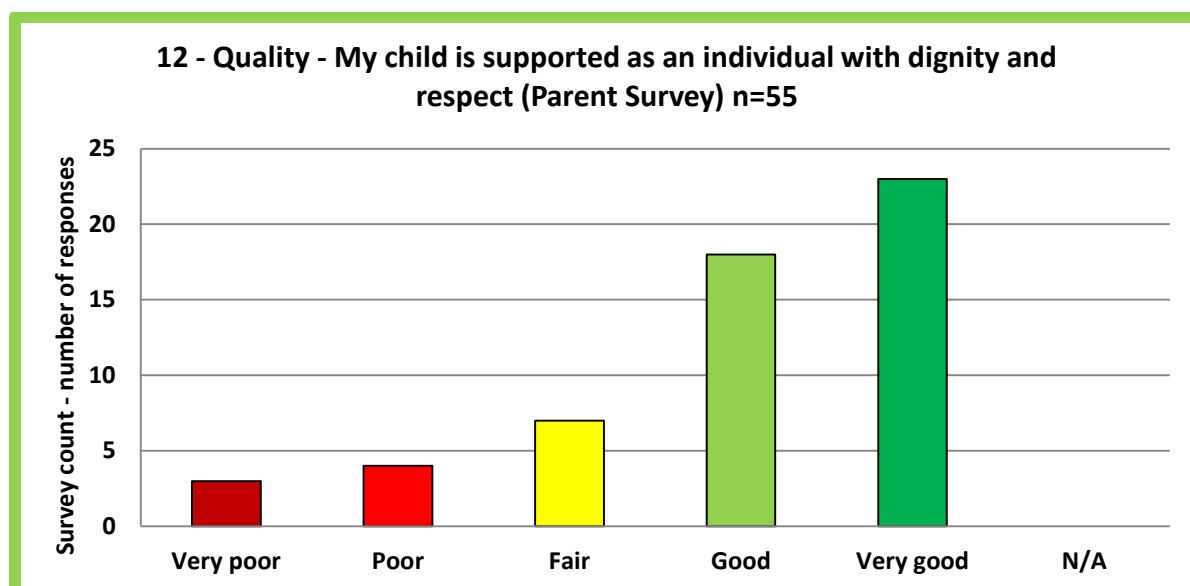
Shown in figure 10 we see what parents reported back to us in the latest survey.



From the feedback we see a clear positive result in that the majority (37 out of 56) consider they had a substantial choice of support through EHCP processes and would be able to change the support their child receives if it was felt necessary with only 13 out of 56 expressing the opposite view. This positive message is reinforced by the follow up question regarding the amount of support being received as per figure 11.



Here we see a stronger positive message coming through. The majority (44 out of 55) are happy that the amount of support provided through their child's EHCP is right for their child with only 9 parents expressing the opposite opinion. Following on from this another very strong message is conveyed from the survey. Parents expressed the majority opinion that their children were being supported as individuals with dignity and respect as per figure 12.



48 out of the 55 parents answering this question felt in some way positive about how their children were being supported and only 7 felt more negatively on this matter.

Taken together this means that parents appear satisfied in the main about how they are able to contribute and influence the support for their child once it is in place and how they feel about that support as a feature of their child's life underpinned by their EHCP.

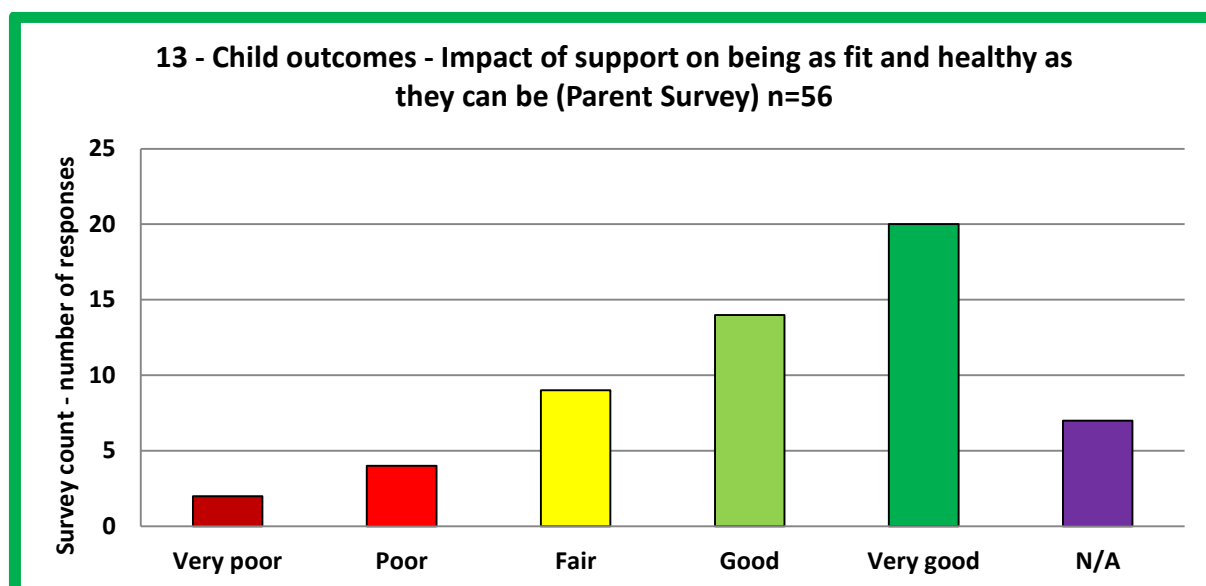
Of course this is only part of the picture. A key feature of EHCP is the focus on outcomes rather than the process and service delivery as an end in itself. The following sections examine outcomes from the point of view of children and their parents. The seven outcomes for children under examination are:

- Child being as fit and health as they can be
- Child taking part in school and learning
- Child being a part of their local community
- Child enjoying friendships
- Child enjoying the relationship with their family
- Child being relaxed and taking part in activities
- Child preparing for life in future

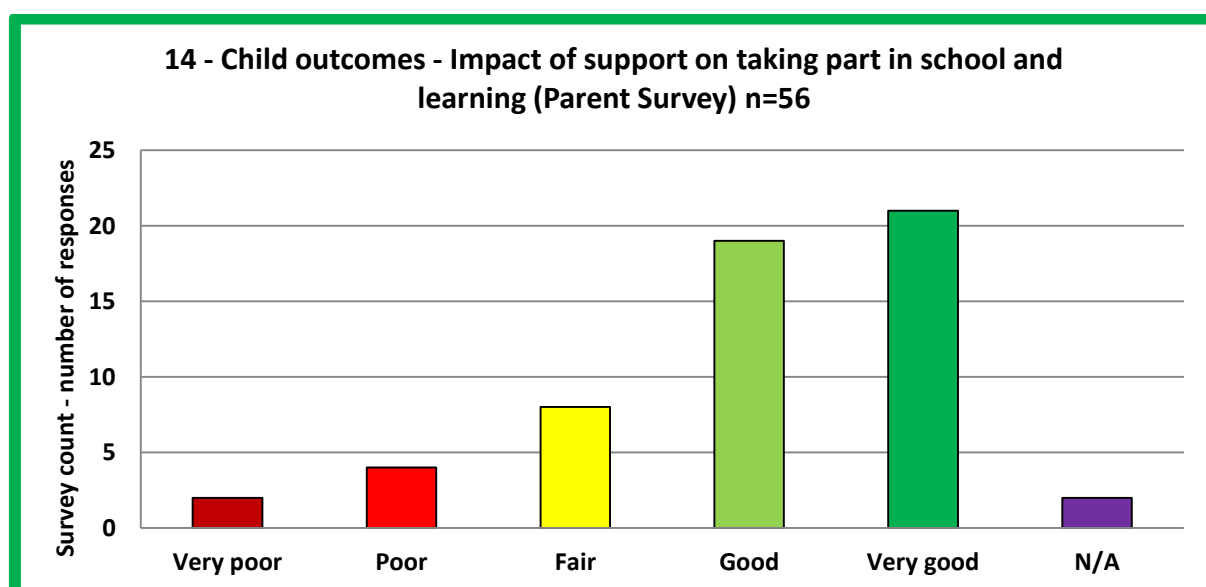
On top of this three outcome themes are investigated for parents themselves, these being:

- Parent's quality of life
- Parent's relationship with the people paid to support their child
- Parent's relationship with their child

The first outcome for children to be examined is being as fit and healthy as they can be. The survey results are shown in figure 13.

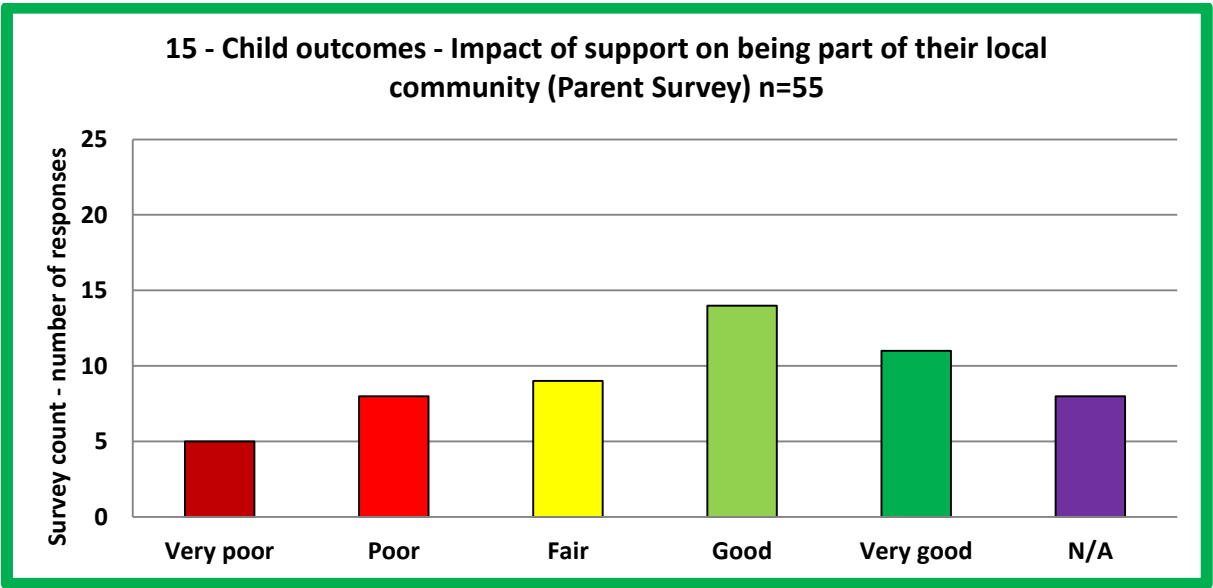


43 of the 56 parents expressed a positive view of this outcome. This indicates that a large majority of parents perceive the support being offered by way of an EHCP as a positive influence on the health of their children with only 6 parents feeling more negative on this issue. This addresses the fact that EHCPs are about more than schooling and that there is a health component involved. Physical health is important to children and, given the current integration agenda, cannot be viewed in isolation from other factors in a child's life. Bringing in the explicit education component of outcomes we see another strongly positive message coming through from parents as per figure 14.



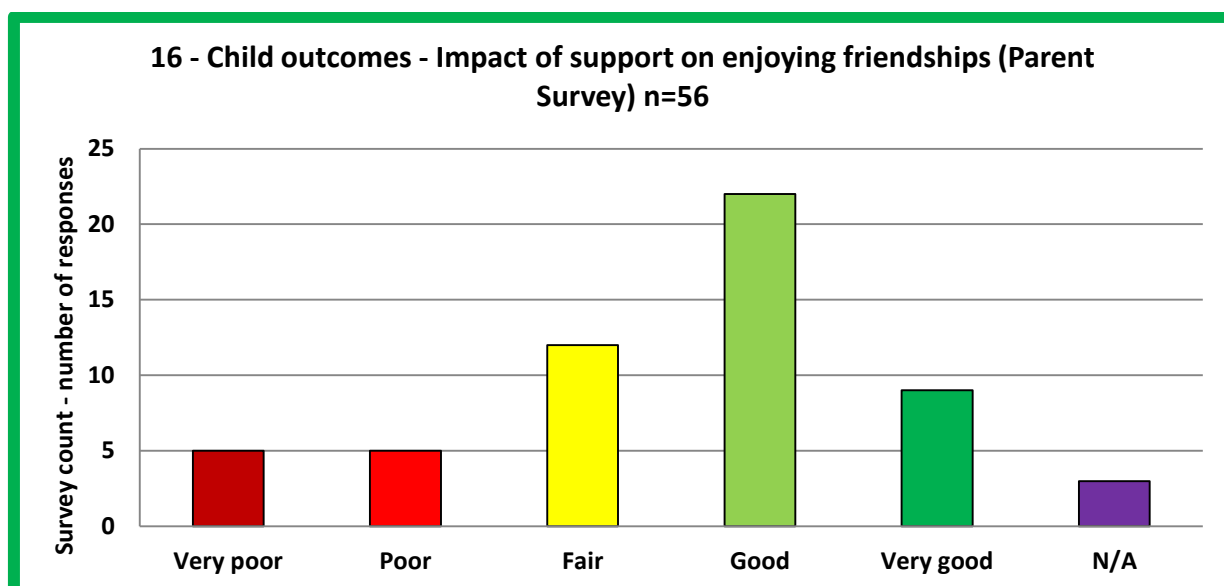
Here we see 48 of the 56 parents answering this question expressing a positive perception of the impact of EHCPs in their child participating in school and learning. At face value this is hardly surprising given the focus on education implicit in EHCPs as well as the involvement of educational professionals in helping put EHCPs together (as evidenced earlier in this paper). This positive message contrasts favourably with parents expressing a negative view who only accounted for 6 of the 56 responses to this question.

A somewhat weaker positive message emerges from the question relating to children being a part of their community (which is the most overtly Social Care related question), the results for which are shown in figure 15.

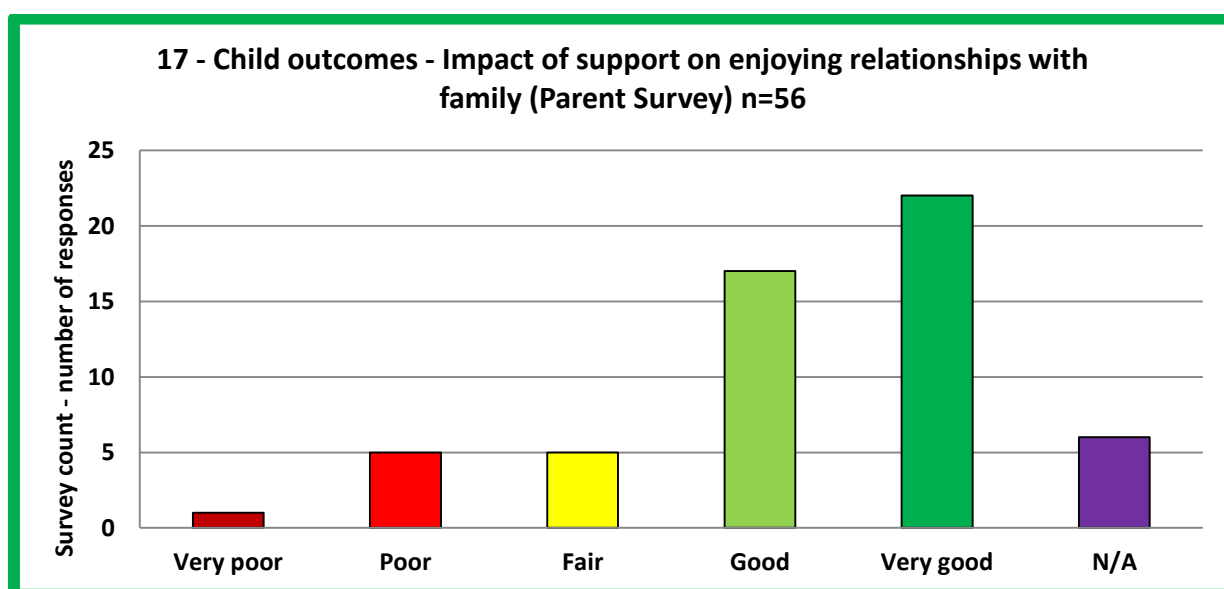


Here we see a smaller majority of parents expressing a positive view of their child being part of their local community (34 out of 55) with the question provoking the greatest incidence of the contrary view (13 out of 55) and the not applicable answer (8 out of 55). This question appears to provoke the most mixed reaction from the parent group answering the survey. As the survey does not ask parents to qualify their answers it is difficult to assess why this should be the case. There is some truth in the fact that as 13 of the children with EHCP under scrutiny are under 5 years old parents may wonder at the relevance of such young children being part of the local community, thinking this question may be more suited to older children. Other parents may have children with particular needs that make it difficult for their child to be an active member of the community (for example having challenging behaviours).

The next outcome addresses how well EHCP enable children to enjoy friendships. Being able to enjoy friendship is important. Previously children with SEND would have experienced care and support in different ways than is now the case, many of which methods may have been quite isolating for the children concerned. We can see from the results, in figure 16, another strongly positive message being reported back by the parent group responding to the survey. 43 of the 56 respondents thought that the EHCP was enabling their child to enjoy their friendships either by addressing issues that make it difficult for the child to make and maintain friendships or by providing opportunities to meet new people and make friends.

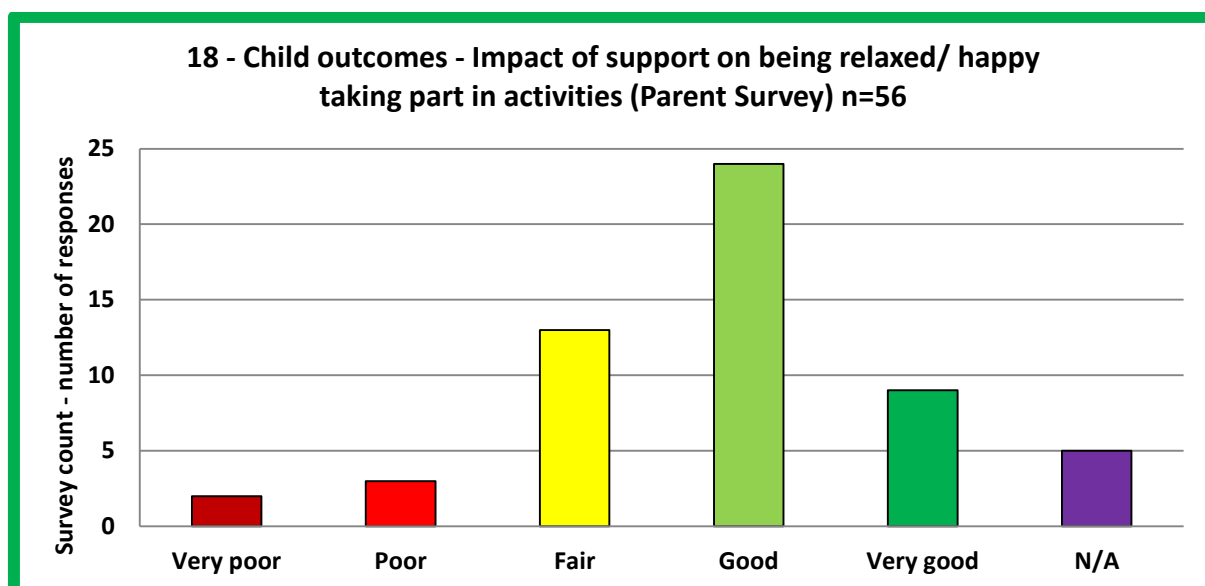


A similar, albeit stronger message is conveyed from the answers to the question about EHCP enabling a child to enjoy the relationship with their family as in figure 17.



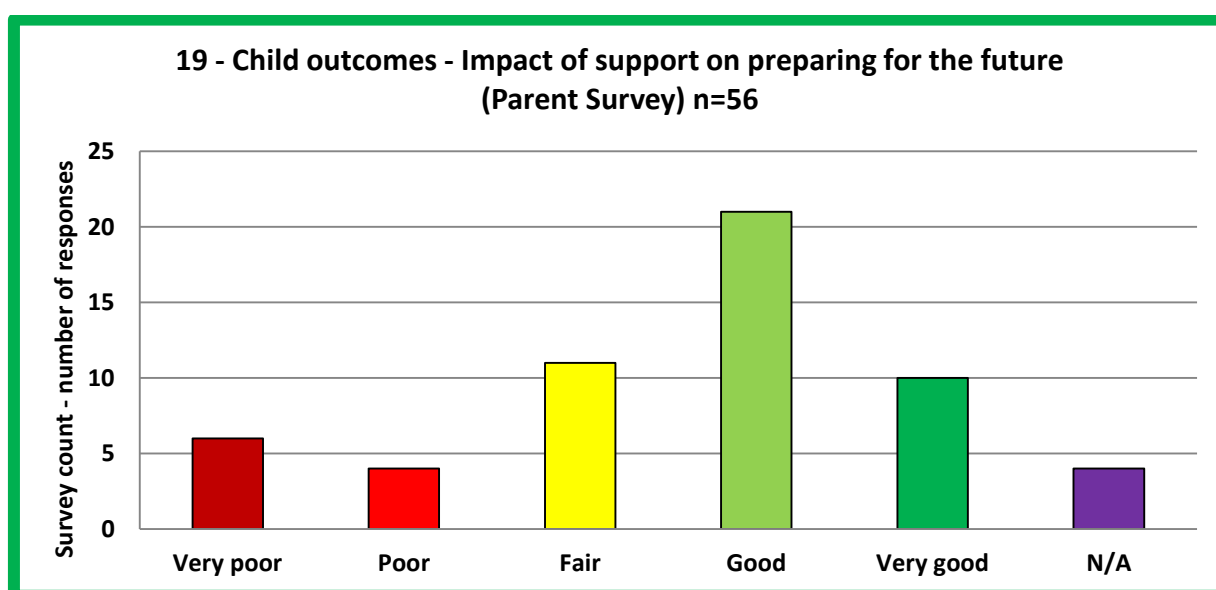
44 parents from the 56 answering this question felt that the EHCP had allowed the child to experience a better relationship within the family group. Given that when the reasons why children needed EHCP support were explored there were many instances of communication and interaction issues as well as health/ wellbeing issues leading to challenging behaviours it is hardly surprising that in addressing these some welcome side effects occur outside the educational setting. It appears, from these results, to be the case that family life improves when an EHCP is put into operation even if this was not the primary intention of any actions being undertaken.

Parents were also questioned about how EHCP enable their children to be relaxed/ happy taking part in activities they like. The feedback is shown in figure 18.



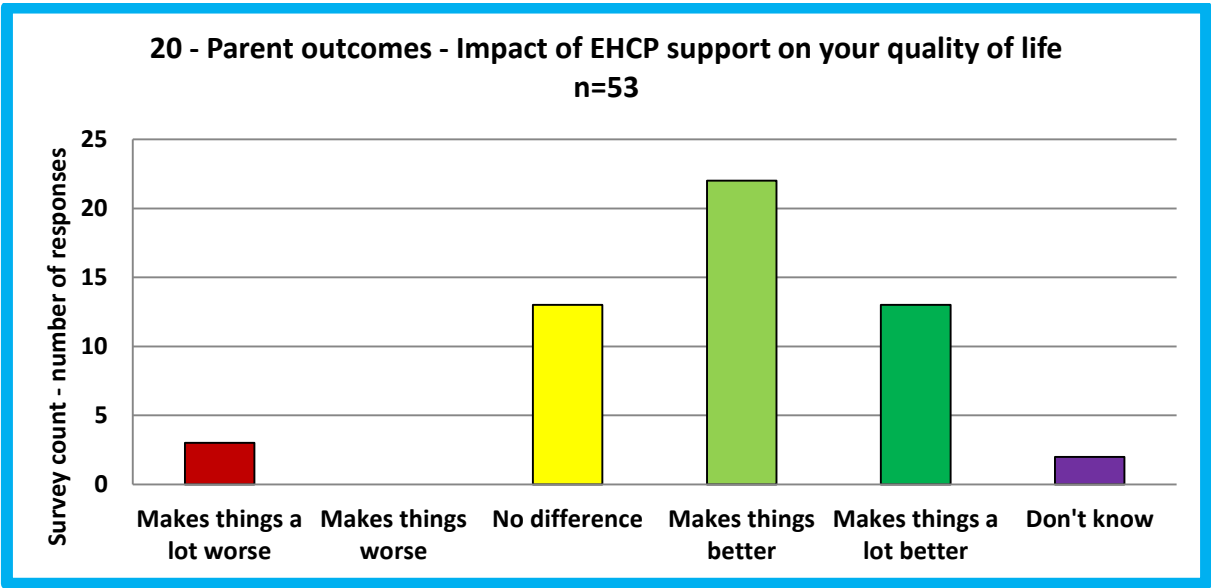
From this we can see that 46 of the 56 parent responses to the question indicated a positive view of EHCP in what is essentially a combination issue capturing social, mental and emotional wellbeing. Only 5 parents expressed a contrary view. Certainly from the evidence of this survey these wellbeing factors are supported by EHCP.

The last of the child outcomes explored is that of EHCP helping prepare children for the future. The results are as per figure 19.

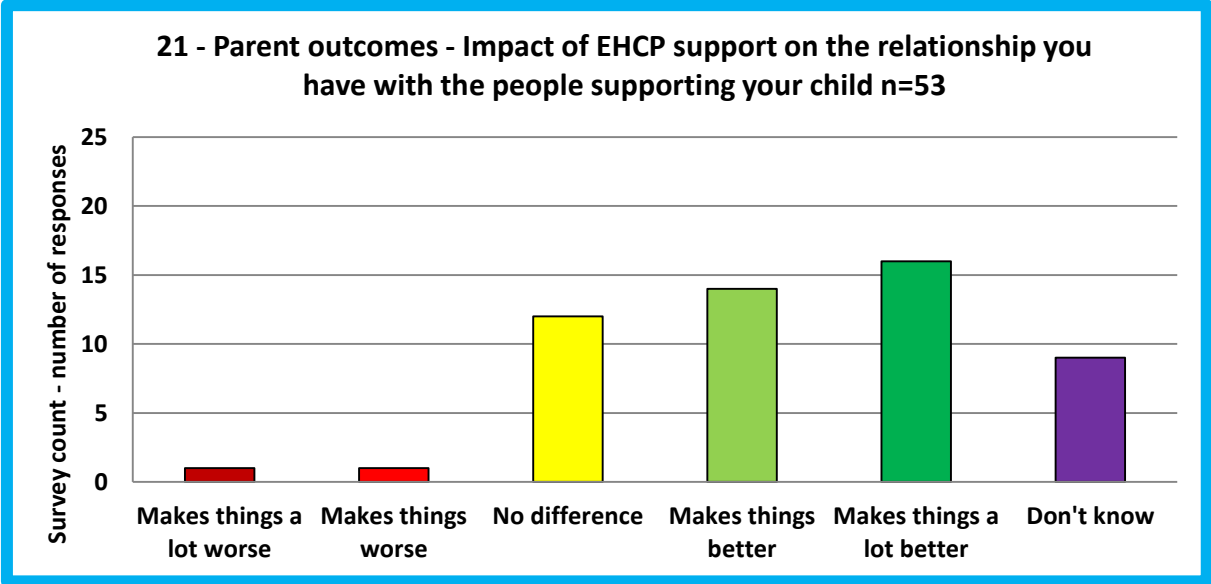


42 of the 56 parents in the survey group thought that the support underpinned by the EHCP was beneficial for preparing their child for their future life. 10 parents thought otherwise. Clearly EHCP have a definite future focus to them as they are all about setting and achieving goals, activities that very much look forward rather than assess what has already happened and this result from the survey seems to validate that purpose of the EHCP. Whilst the focus of the EHCP is very much on the child who is intended to benefit from the care and support that the EHCP documents, it is clear that parents benefit as

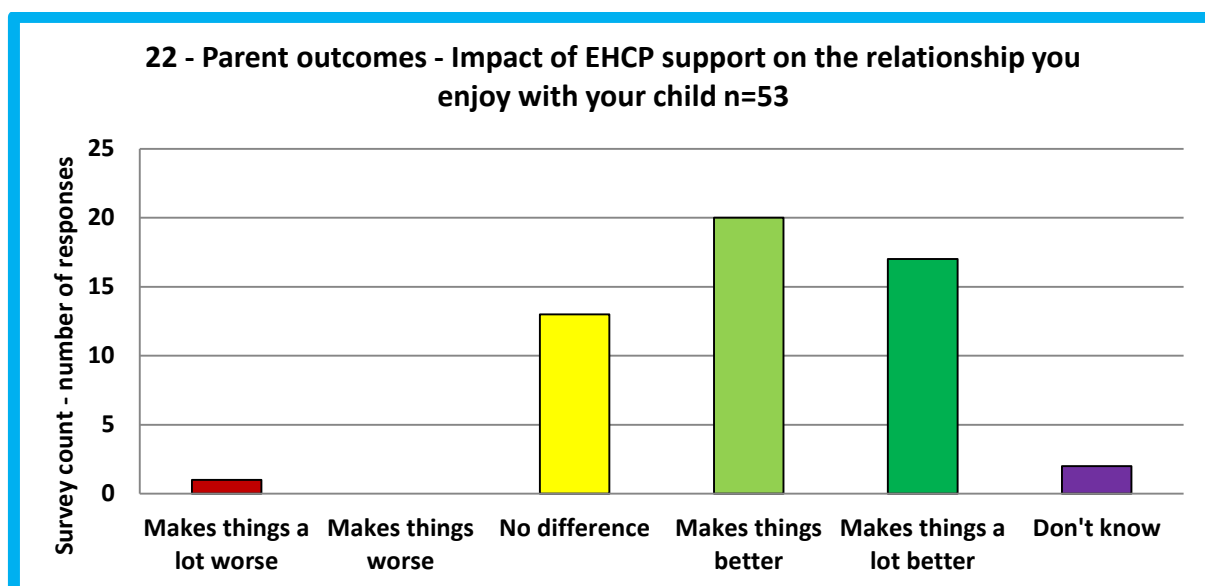
well. From our survey of 2016 we saw strongly positive messages emerging from parents as to how the EHCP was impacting on them as parents. The 3 parental outcomes on the POET® survey were explored again in 2017. The first question on parental outcomes focusses on a parent's quality of life. The results are shown in figure 20.



35 of 53 parents answering this felt that the EHCP enabled their quality of life to be better. Only 3 felt that things had deteriorated as a consequence of being involved in EHCP processes. This is also reflected in the feedback around a parent's working relationship with their child's paid support staff/ team as per figure 21.



Here, again, we see a majority view that EHCP are enabling parents to have a better relationship with the people paid to support their children. 30 of 53 parents felt they were getting on better with their child's support team after EHCP processes were engaged. Strongest of the results emerging from the parental outcomes is that around a parent's relationship with their child. This is shown in figure 22.



In this, 37 of the 53 parents answering this question felt that their relationship with their child had improved and only a solitary parent felt their relationship with their child had gotten any worse.

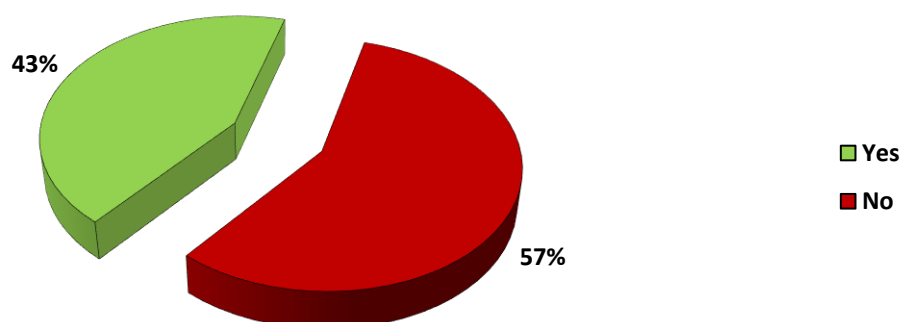
From an examination of the outcomes based questions in this survey we are seeing strongly positive messages emerging from parents that reinforce what we saw from the 2016 survey, albeit that we had a smaller pool of participants for last year's work.

A new feature that has been incorporated into the 2017 survey is parent's use (or lack thereof) of the local offer. The local offer is information about services that are available to meet the needs of parents and children who may have requirements over and above what is routinely available to individuals who don't face specific challenges because of issues that are presented with a child with SEND.

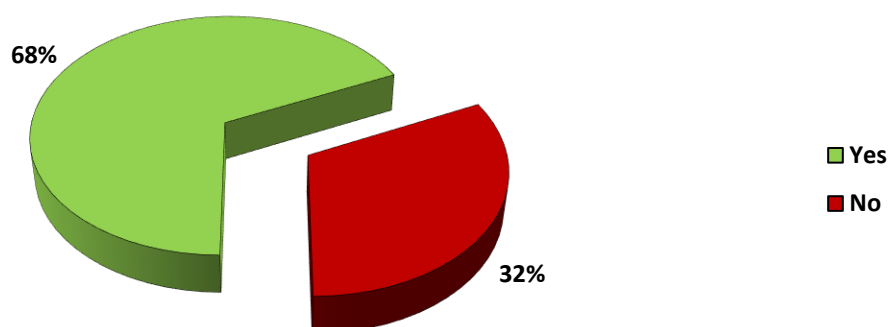
The intention was to examine in the first instance what the usage level of the local offer was amongst the parents taking part in the survey. Lack of use can indicate problems with communication (getting the message out there to those who could benefit). Secondly we wanted to identify, of those who had used the local offer, whether the parent concerned had found the information on services that they were looking for. In other words we wanted to know if the local offer is fulfilling its purpose or if changes are needed to ensure that it becomes more useful in the future.

The feedback from parents is displayed in figures 23 and 24.

23 - Have you used the local offer to find out about services available to support you, your child or family? n=58



24 - If yes, did you find what you were looking for? (Parent Survey) n=25

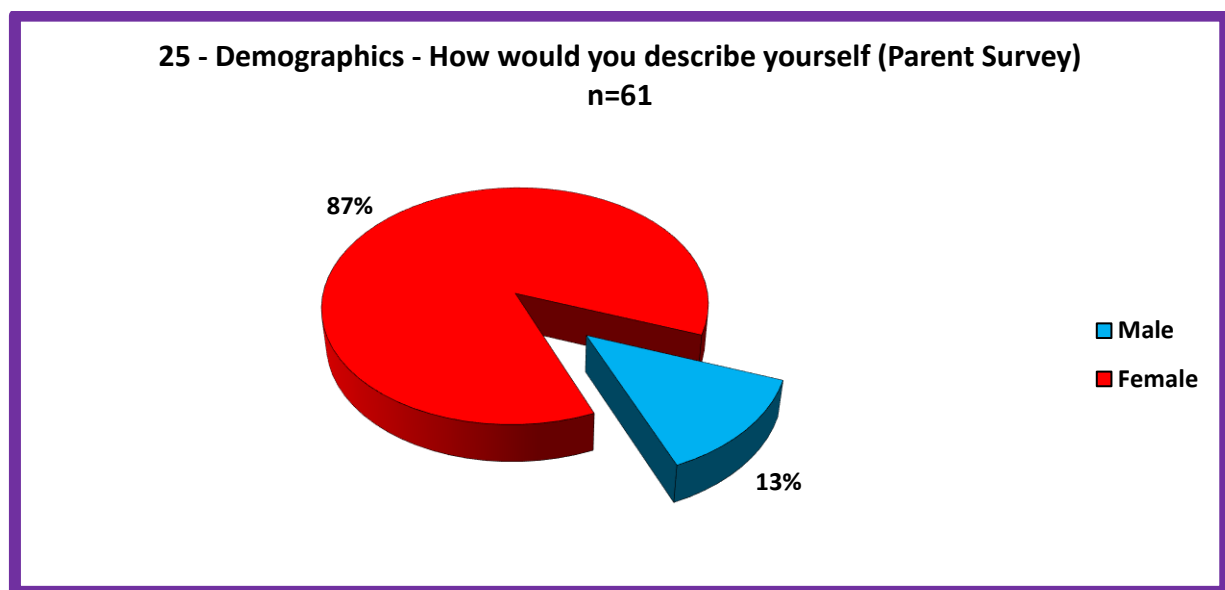


From the survey feedback we found that 58 parents had answered these questions. Of these, 25 parents had used the local offer to explore services that may be available which was 43% of the group. 33 parents had not used the local offer or 57% of those who had answered on this question. Therefore over half of parents answering on this point had not used the local offer when trying to identify services that may assist in matters around their child's EHCP. This could indicate that there is a problem with communicating what is available in the local offer to the populace or that there is a perception that what is contained in the local offer is not meeting the needs of that populace, who therefore simply don't look at the contents.

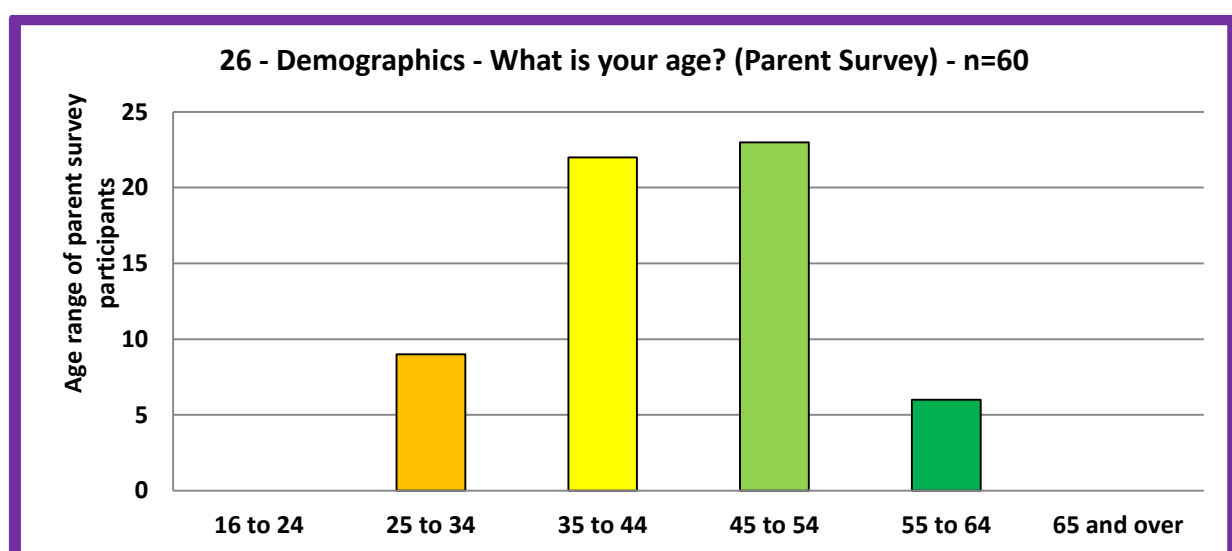
However, once we drill down into those who did use the local offer an altogether different picture emerges. Of the pool of 25 parents who had used the local offer 17 parents indicated that they had found what they were looking for which was 68% of the local offer users with only 8 not locating useful information in their case. This indicates that if we can get parents looking on the local offer initially then two thirds of those doing so will

have some positive results flowing from that activity. Although this is from a relatively small pool of the total participants in the survey as a whole it describes a situation whereby the lack of knowledge of what information is available from the local offer and where to find it is the problem rather than the more difficult issue of the information that is available not meeting parent's needs.

In rounding off this section of the analysis we need to look at the demographic details of those parents. In the previous survey back in 2016 the survey group comprised only women (ie mothers). Whilst the overwhelming majority of survey respondents this time round were still women we did receive feedback from men as well. This is depicted in figure 25.



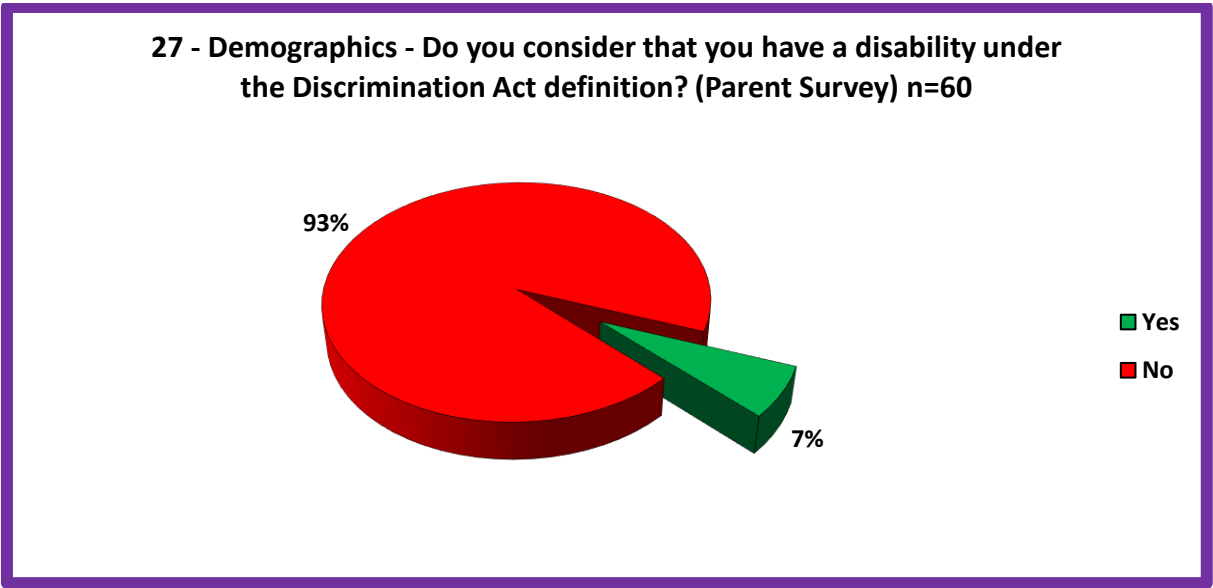
So we see that 13% of survey respondents answering this question were male (or 8 fathers) with the remaining 87% being female (or 53 mothers).



This section also sought to determine how old our survey participants were. The ages were not taken explicitly but rather as a series of age ranges. These were from 16 to 24,

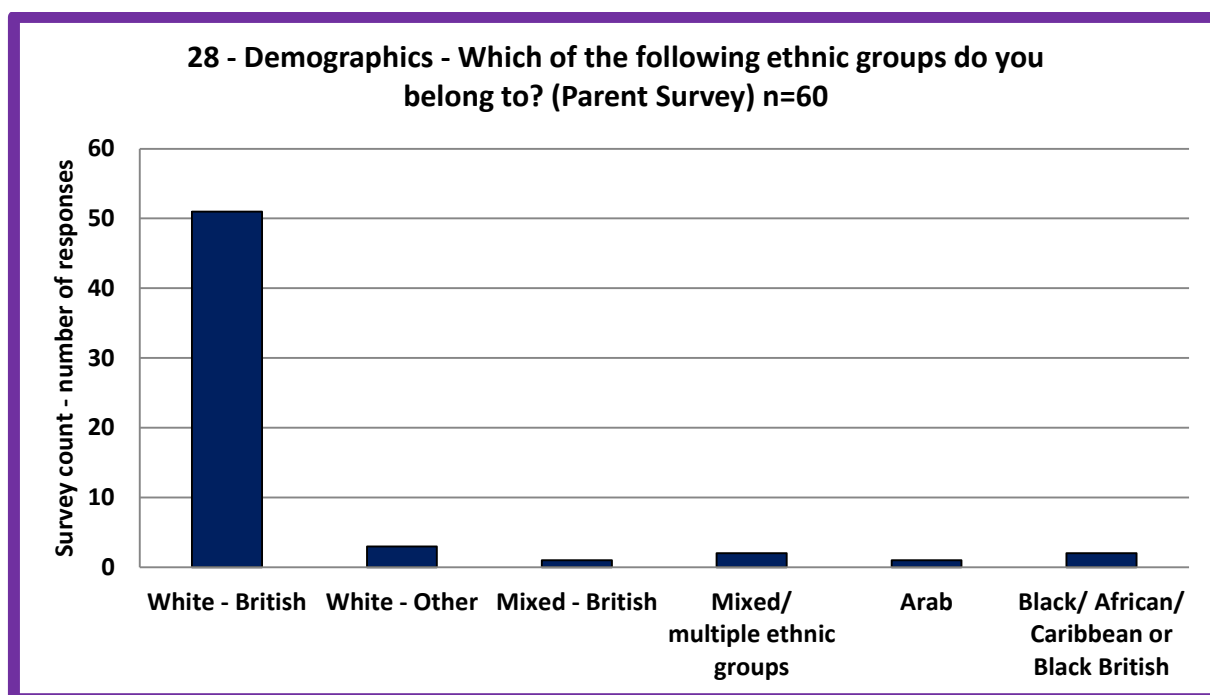
25 to 34, 35 to 44, 45 to 54, 55 to 64 and the over 65s. The results from this question are shown in figure 26. What we can see immediately from this is that 75% of parents who answered this question were aged between 35 and 54 with the remainder aged either between 25 and 34 or 55 and 64. What we do see in this is also the absence of feedback from any parents who are themselves defined as young people (ie under 25 years old) or any parents who are 65 years old or older.

Also, although this survey is designed to assess how well care and support planning via an EHCP works for children with challenges around SEND it should also be remembered that parents, too, sometimes have challenges that they face in their everyday lives. The question was therefore also asked as to whether parents had a disability as defined under the Disability Discrimination Act. The feedback is shown in figure 27.



Of the 60 parents who answered this question, 4 indicated that they have such a disability whilst 56 indicated they did not have such a disability. Lastly parents were asked to describe their ethnicity. Another shortcoming of the 2016 survey was that the survey pool had no respondents who were not white as their ethnicity. With a much larger survey pool in 2017 we have had parents responding who have given their ethnicity as something other than white although white ethnicity is still in the majority. What the ethnicity figures show is that the survey group of parents answering this question is actually broadly representative of the populace of Portsmouth as a whole when compared to the equivalent figures as collected in the 2011 population census.

The ethnicity numbers for this survey are shown in figure 28.



In-depth focussed Analysis of the Parent "with EHCP" survey returns

Having taken an overview approach with the survey questions to this point there is an opportunity to use the survey data to address some more detailed questions relating to the outcomes for children and their parents. There are 4 questions that emerge from the basic analysis of the outcomes questions in particular. These are:

- Does the education setting influence the outcomes under EHCP?
- Do the people involved in the care and support planning influence outcomes under EHCP?
- Does the duration of the EHCP influence outcomes under EHCP?
- Does the parent's gender influence parental outcomes under EHCP?

This phase of the analysis involves cross-referencing the survey answers to tables and then charting the results of the combined criteria. To give an example, on the first question we eliminate all survey responses that do not supply an answer for the education setting question and the outcomes questions. This leaves a pool of survey responses where both points are addressed. Then we chart the incidence of survey answers on the outcomes against the education setting. So, for example, we obtain how many instances of a "very poor" answer to an outcomes question occur where that same respondent has also indicated their child attends a mainstream school. This is repeated for all possible answers to the outcomes question versus all possible answers for the education setting question which forms a table. Based on this a chart can be produced showing the proportions of parents giving each survey response against each education setting. From this we can see any patterns in data.

Question 1 - Does the education setting influence the child's outcomes under EHCP?

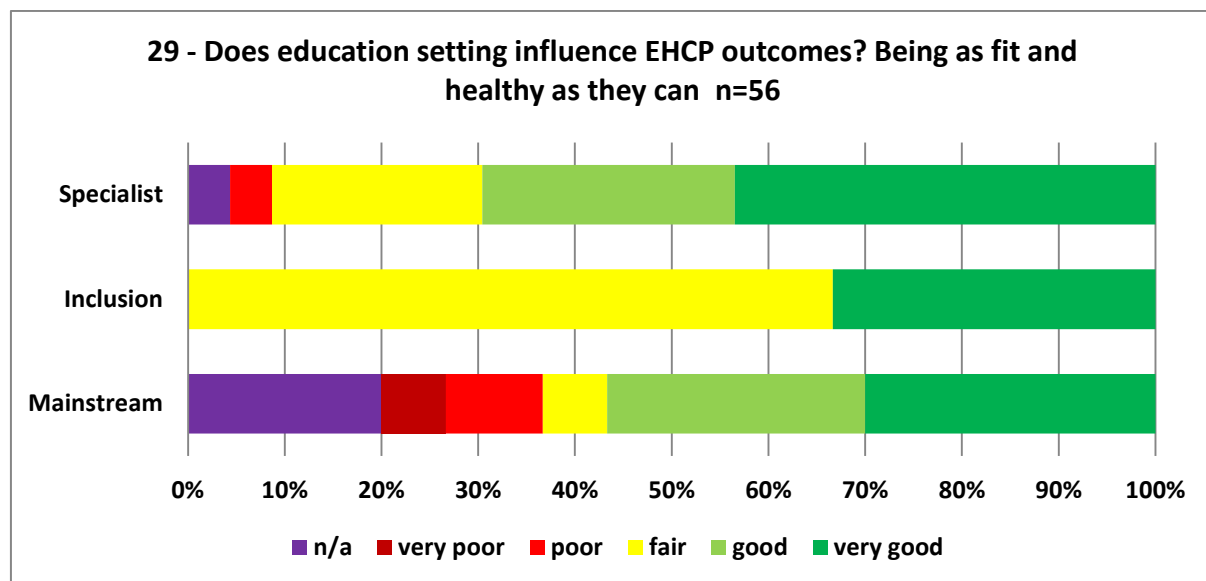


Figure 29 shows the proportion of each response to the outcome question relating to children being as fit and healthy as they can be when read against the options for educational setting. While all the education settings seem to give a positive answer to this question it is in specialist schools where we see the highest proportion of parents indicating that the EHCP is positively influencing their child's ability to be fit and healthy and mainstream schools where we see the highest dissatisfaction on this matter.

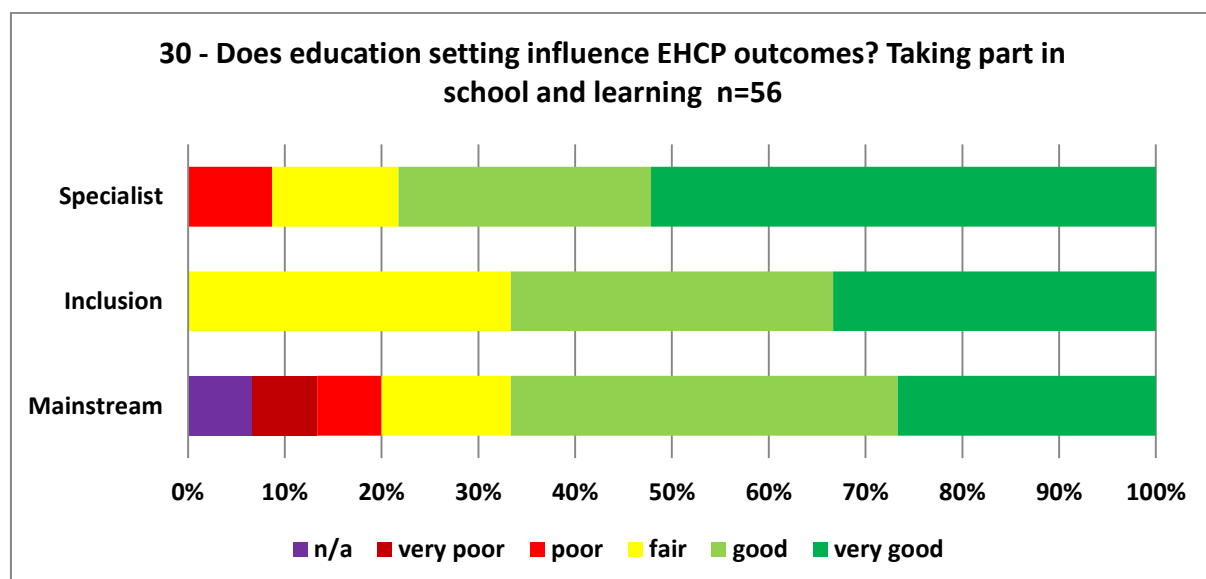


Figure 30 shows this proportion on the question relating to taking part in school and learning. Again all the settings produce a positive answer and, again, specialist schools appear to be the setting where the greater proportion of parents are indicating that the EHCP is positively influencing their child's ability to take part in school and learning.

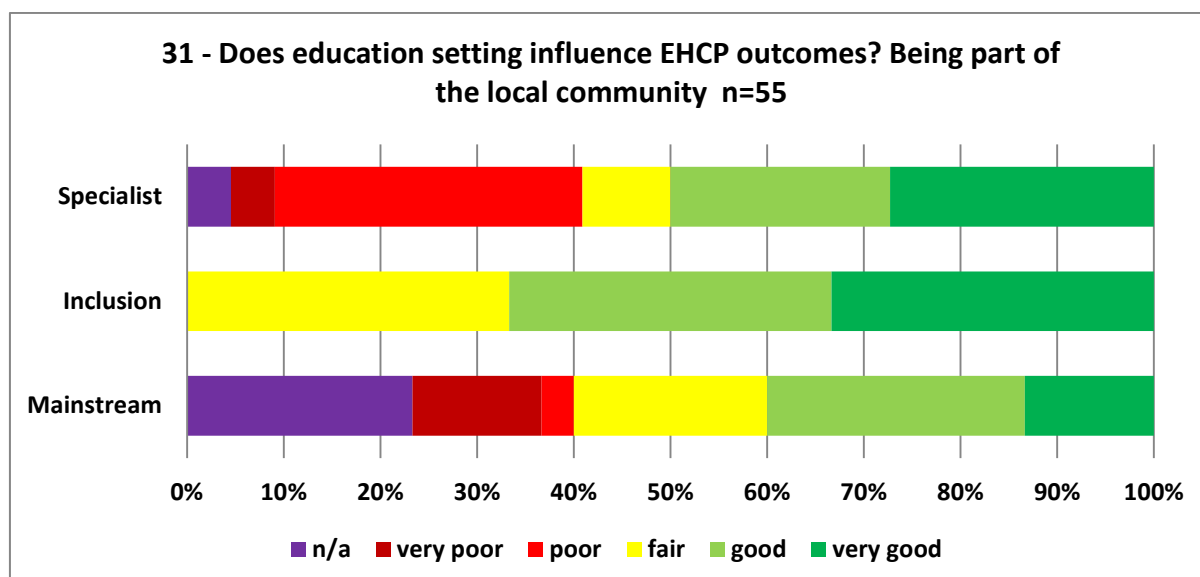
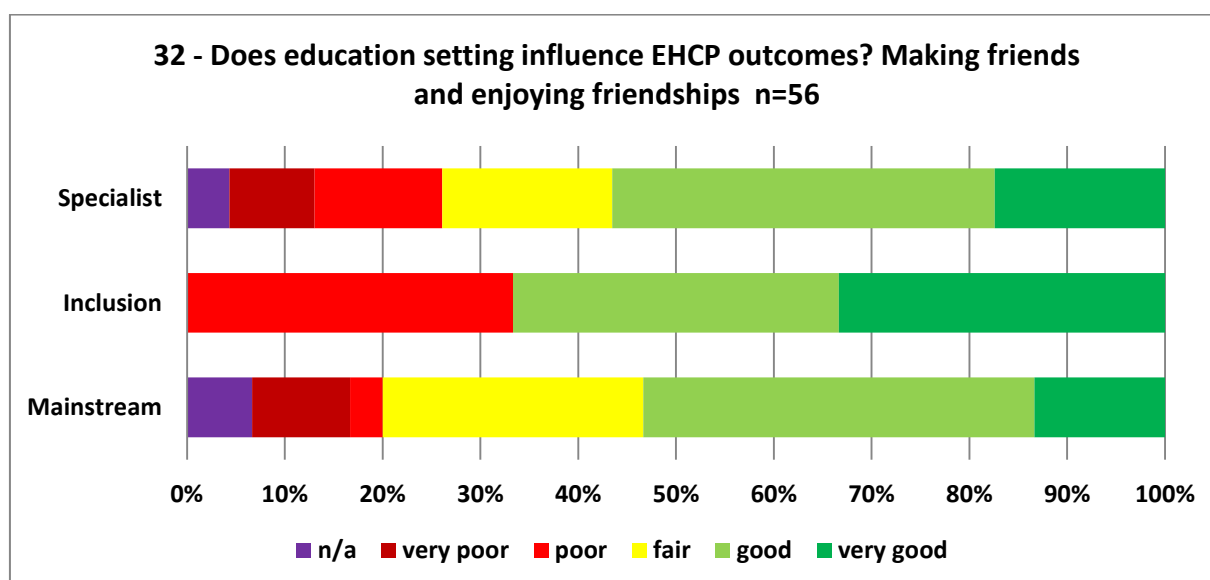
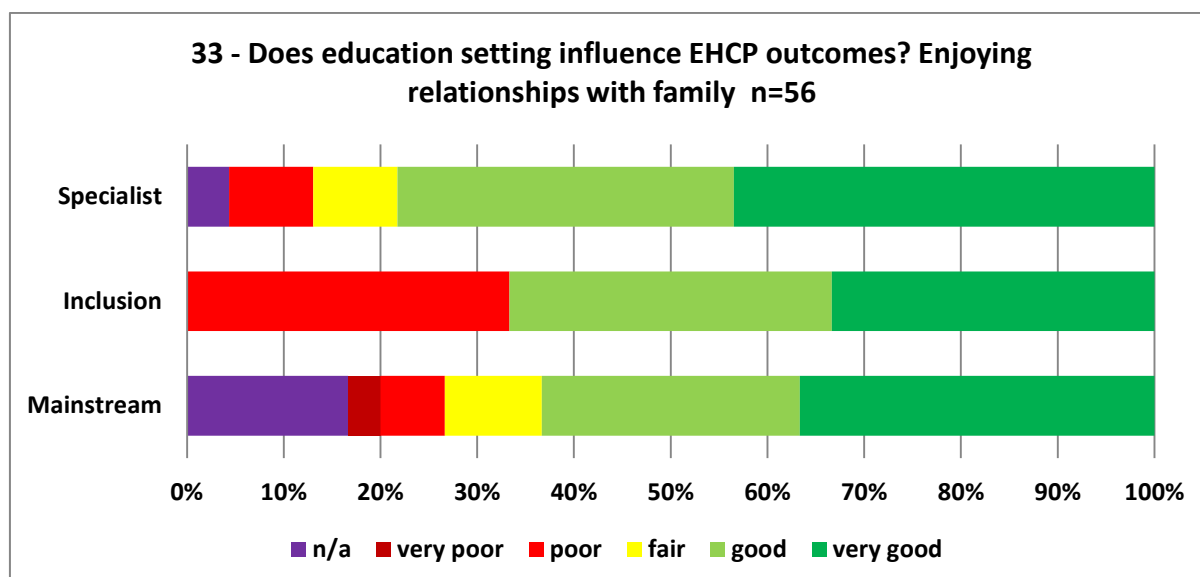


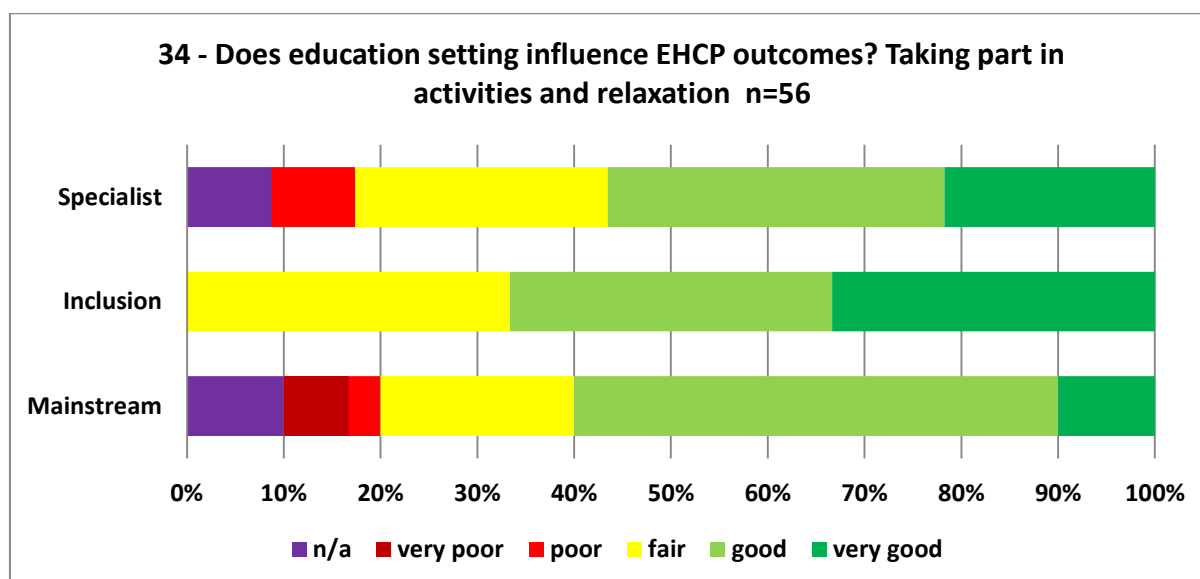
Figure 31, regarding community involvement, shows that the highest proportion of parents indicating a positive outcome were where their child attended an inclusion centre attached to a mainstream school. Conversely the highest proportion of dissatisfaction emerged from specialist schools although, in spite of this, specialist schools still had a higher proportion of outright approval on this matter than mainstream schools.



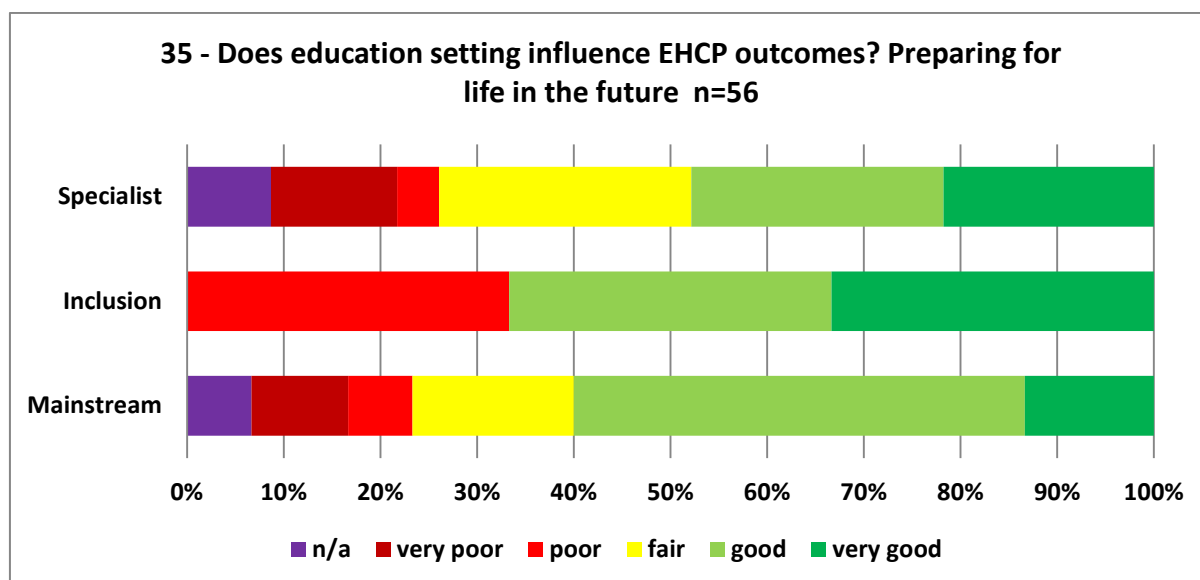
From figure 32 we see that inclusion centres attached to mainstream schools show a higher proportion of positive outcomes reported when examining how EHCP influence a child making and maintaining friendships. There is also no middle ground as the highest proportion of dissatisfaction is also reported in this setting. Positive outcomes are broadly similar for specialist and mainstream schools but outright dissatisfaction is lowest in the mainstream school setting.



In figure 33 we see another positive set of results on the outcome for a child enjoying the relationship with his/ her family. Once again specialist schools are the setting where the highest proportion of parents indicated positive outcomes for this under EHCP and in this case also the lowest incidence of the contrary view.



In figure 34 when examining parent's views on EHCP positively influencing their child taking part in activities and enjoying relaxation another positive set of results emerges with each setting appearing to contribute well towards this outcome. Parents with children at inclusion centres showed the highest proportion of positive outcomes but it also shows one of the few instances where parents with children at mainstream school reported better child outcome results under EHCP than their counterparts at specialist schools.

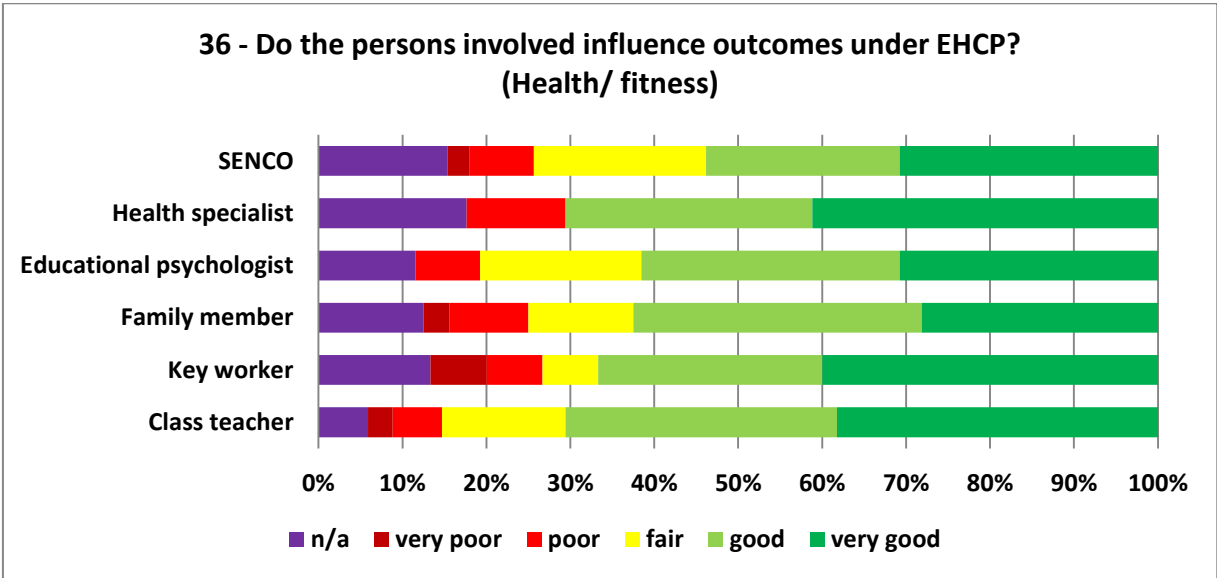


Lastly we examine the EHCP outcome around preparation for a child's future. In parental feedback on this question we see the highest proportion of positive outcomes for parents reporting on children in inclusion centres. Counter to this we also see the highest proportion of parents expressing a negative view in this respect. Again we see the positive outcomes proportions favour mainstream schools compared to specialist schools based on parent feedback.

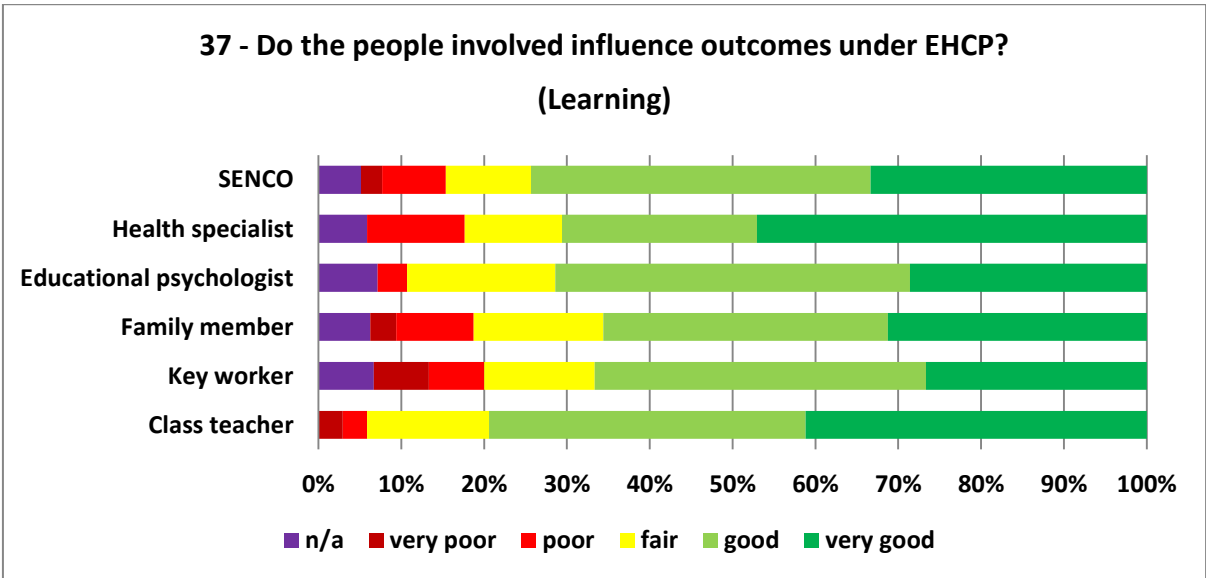
What we learn from this is that there does seem to be some influence being exerted by the educational setting on a child's outcomes as reported by their parent. This depends on the nature of the outcome being explored and the starting position of the child concerned. Specialist schools tend to show best when the outcomes relate to health & fitness, education and family. Inclusion centres came out best where the outcomes related to community participation, friendships, activities & relaxation and future preparation. In none of these outcome measures did mainstream schools show the highest proportion of positive outcomes reported by parents although in all but one instance strongly positive views were in the majority.

On the issue of a child's starting position it is clear that the specialist nature of the care and support available in specialist schools would encourage good outcomes in health & fitness and education by being tailored to the needs of its student community. This may also impact on family as this may also help resolve problems at home. Inclusion centres would foster a better sense of community as children with SEND are not isolated from their peers that don't have those challenges in that setting. This would likely lead to being able to make more friends from a wider community of people. Inclusion centres would likely have more activities to cater for the wishes of children with SEND being attached, as they are, to mainstream schools and a more general education would perhaps enable better future preparation than the potentially narrower curriculum that may be available in more specialised settings. There does appear to be some causal relationship at work here.

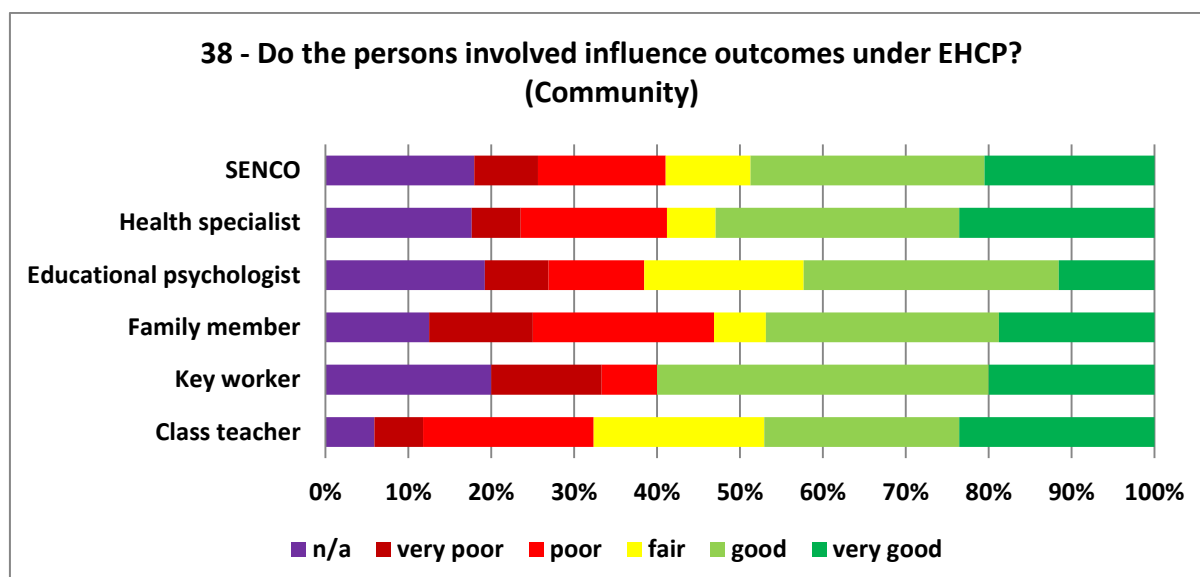
Question 2 - Do the people involved in the care and support planning influence a child's outcomes under EHCP?



When looking at the 6 people/ professionals that are typically involved in most EHCP care and support planning processes and their influence of the health outcomes (Figure 36) of children it is no surprise to see the health specialist showing as the most positive influence followed by class teachers in whose care children spend a fair proportion of their day in term time. Positive outcomes are in the majority for all professionals against this outcomes aspect of EHCP.



Not surprisingly, on a question about influence on children's education outcomes (Figure 37) we see the highest proportions of positive outcomes reported for the 3 education based professionals in the list (SENCO, Educational Psychologist and Class Teacher). Once again we see a highly positive picture emerge as positive outcomes are in the majority for all the professionals under scrutiny involved in EHCP processes.



In figure 38 we see that the closest outcome issue to a social care context shows the highest proportion of positive outcomes for the Key worker. This question tended to produce the most mixed results and only Key workers and Health specialists showed positive outcomes in the majority for EHCP outcomes.

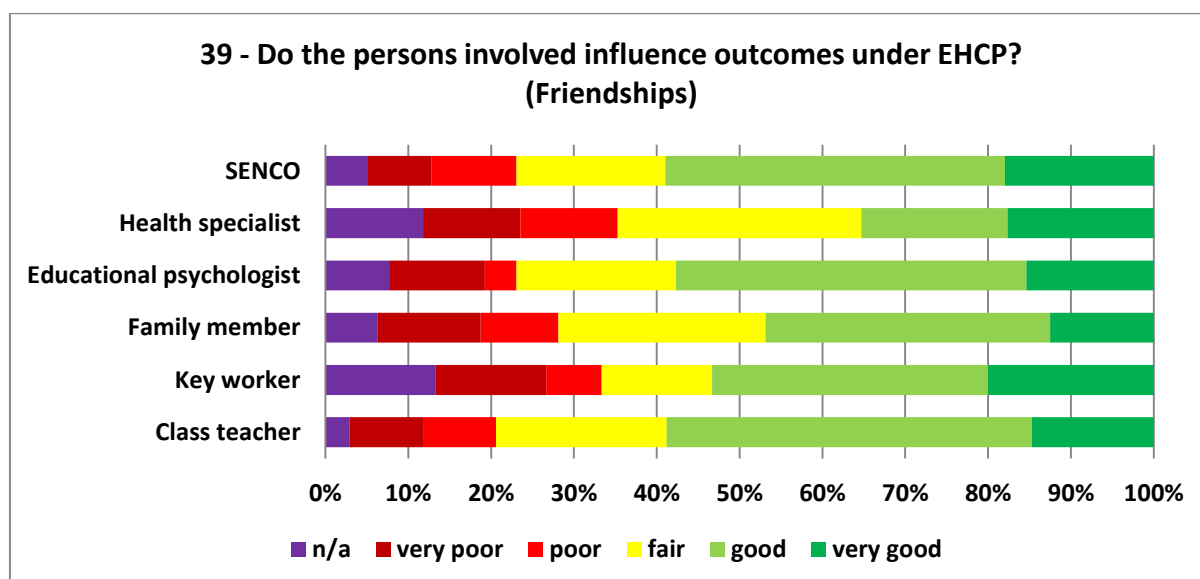
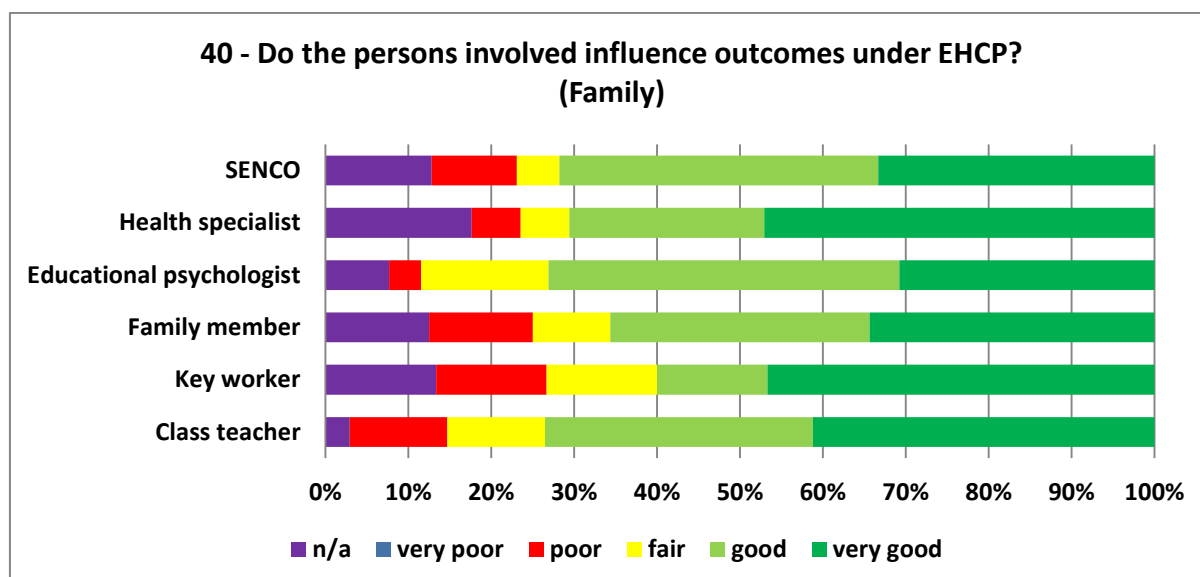
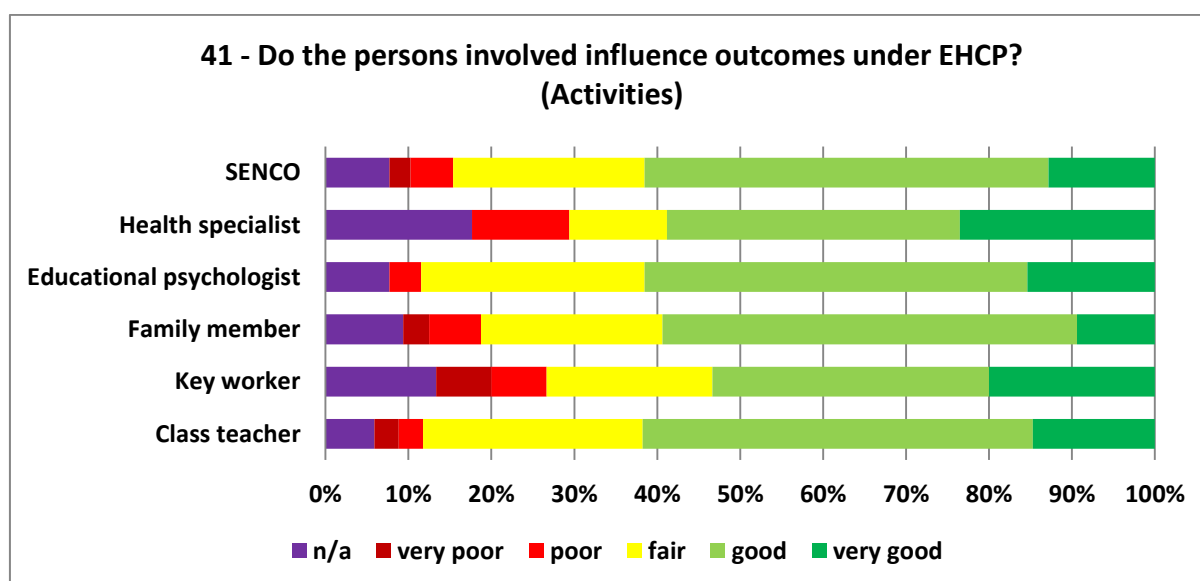


Figure 39 describes another clear positive outcomes picture for making and maintaining friendships where the education specialists tended to show best of the people/ professionals involved in EHCP processes. As most children will make friends at school, by working to make a more conducive environment for good learning outcomes, these 3 professionals, in particular, are also acting to enable children to have more positive outcomes in making friends.

Figure 40 shows the most puzzling set of outcomes results based on the influence people/ professionals have on the outcome of a good family life.



The proportions speak in favour of the educational professionals again as being of highest import in children achieving good family outcomes. The role of family member is the puzzling element as this person appears to be comparatively less important in achieving good family outcomes than would be expected. Clearly a child's education has implications beyond the classroom in achieving outcomes and these radiate back to the family home based on this set of results.



Again, examining the achievement of Activities based outcomes (Figure 41) the educational professionals appear to be exerting the most influence on positive outcomes being reported although the results across the professionals are fairly close apart from the Key worker role whose importance is comparatively smaller. It is clear from this that education professionals, in particular, are having a crucial role in children achieving positive activity based outcomes.

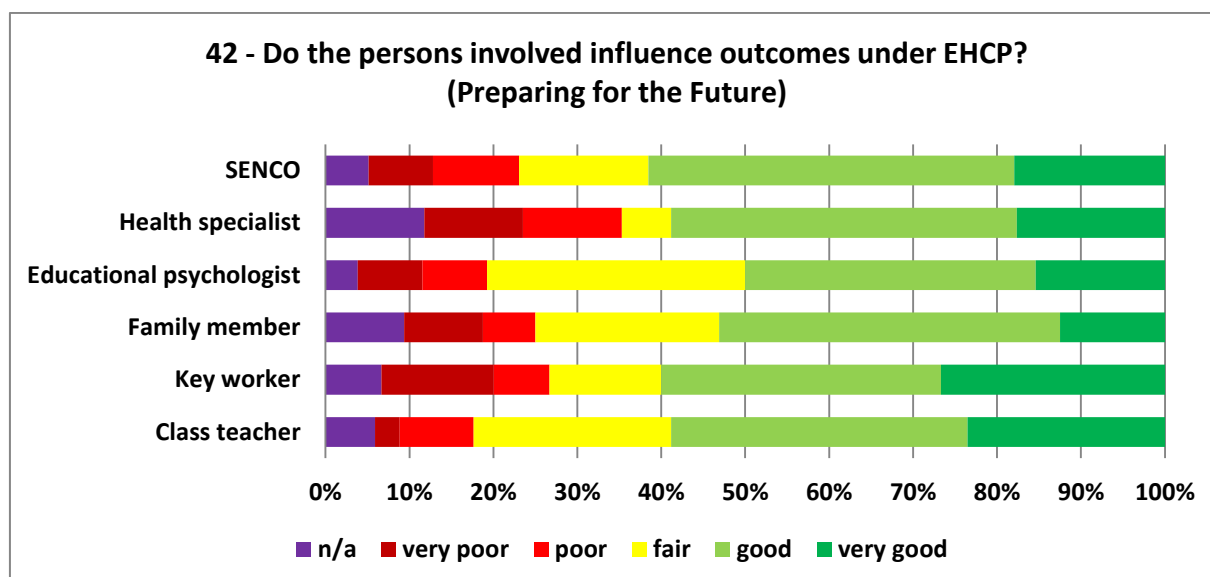
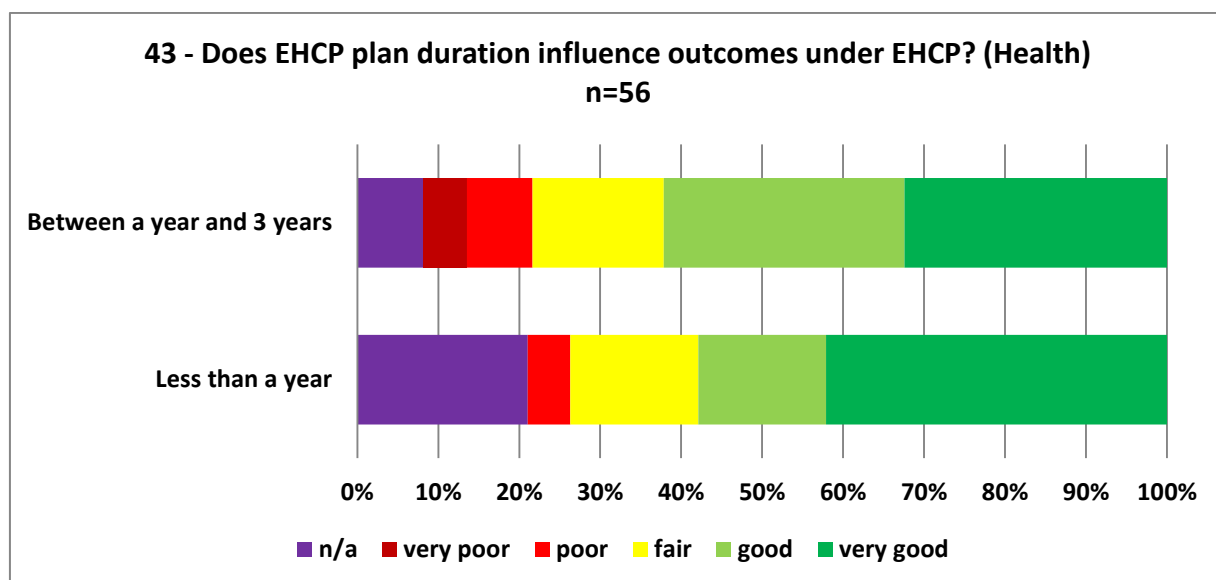


Figure 42 describes a more balanced picture looking at the influence of people/ professionals on outcomes around preparing for the future. The three key figures in this are the SENCO (education focus), Health Specialist (health) and the Key worker (Social Care) as these 3 show the highest link to positive outcomes. This not only amply demonstrates the necessity for an integrated approach due to the range of disciplines involved but also validates the whole point of an EHCP where the input of the 3 disciplines is combined in 1 plan. Clearly future preparation involves more than just a child's education and is rather a combination of his/ her education, health and social care aspirations/ needs being addressed.

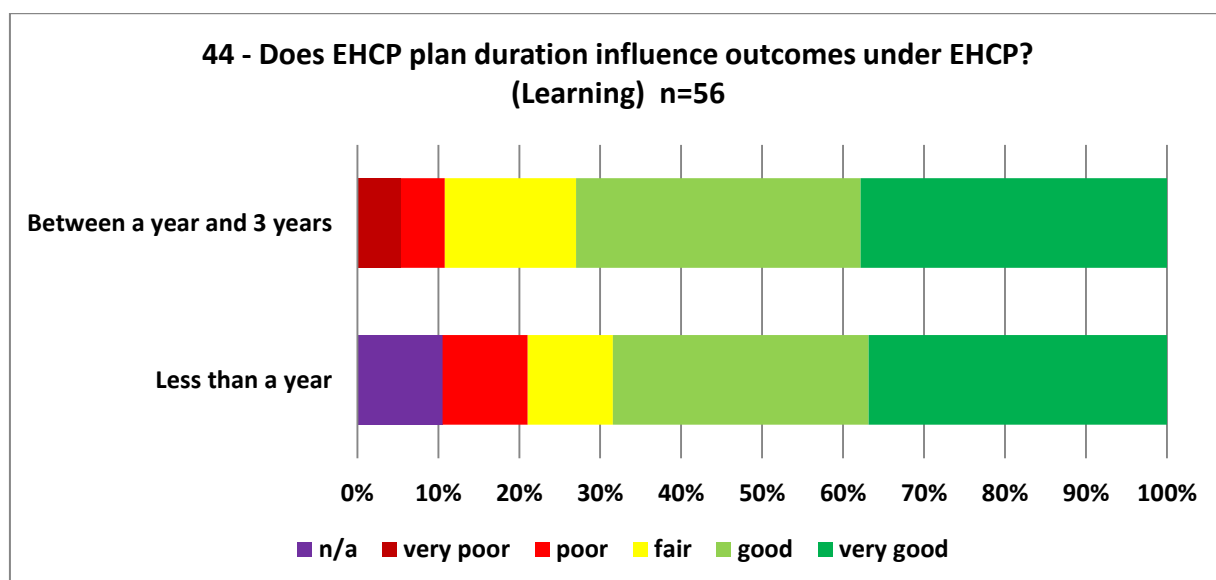
From this examination of children's outcomes, as reported by their parents, there does appear to be a clear link between their outcomes and those individuals involved in the care and support planning processes. In the main these links are fairly self-explanatory with the health based outcome showing the best results for the health specialist, the community based outcomes showing the best results for the social care professional and the learning based outcome showing the best results for the educational professionals. What was most striking is the influence that educational professionals have on children achieving positive outcomes beyond the classroom, as evidenced by the results for outcomes around friendships, family life and activities.

Furthermore the results shown in the outcome around future preparation depict not only the necessity for an integrated approach but a validation for the EHCP approach itself where multiple, disparate threads of care and support can be brought together in one place to ensure that the best outcomes possible can be achieved with all the professionals cooperating and pooling their knowledge and expertise to the child's ultimate benefit.

Question 3 - Does the duration of the EHCP influence a child's outcomes under EHCP?



Looking at the health outcome (figure 43) the proportion of the more positive outcomes is higher for EHCP that have been operational for more than a year than for less established EHCP but the best outcomes emerge from younger plans. Potentially this is due to EHCP enabling health issues to be more rapidly identified and therefore also enable faster commencement of treatment/ therapy. As this activity is most likely to occur shortly after the plan is brought into being health matters should tend to get addressed/ resolved more quickly and this would tend to be in the first year of an EHCP. Once these issues are addressed the key is to maintain any health regimen that has become necessary which would also explain the comparatively lower influence of more established EHCP on the best child's health outcomes.



For the learning outcome (Figure 44) we see that the higher proportion for the most positive outcomes emerges from plans that are more established and over 1 year old. This would make sense as learning is an ongoing activity and new learning is always built on what has gone before. For this reason EHCP have a significant impact in the

shorter term on positive learning outcomes but this is then magnified over time as learning never really ceases for children/ young people. EHCP are also amended over time to include new learning goals and support to achieve those. Positive learning outcomes, therefore, can become almost self-sustaining.

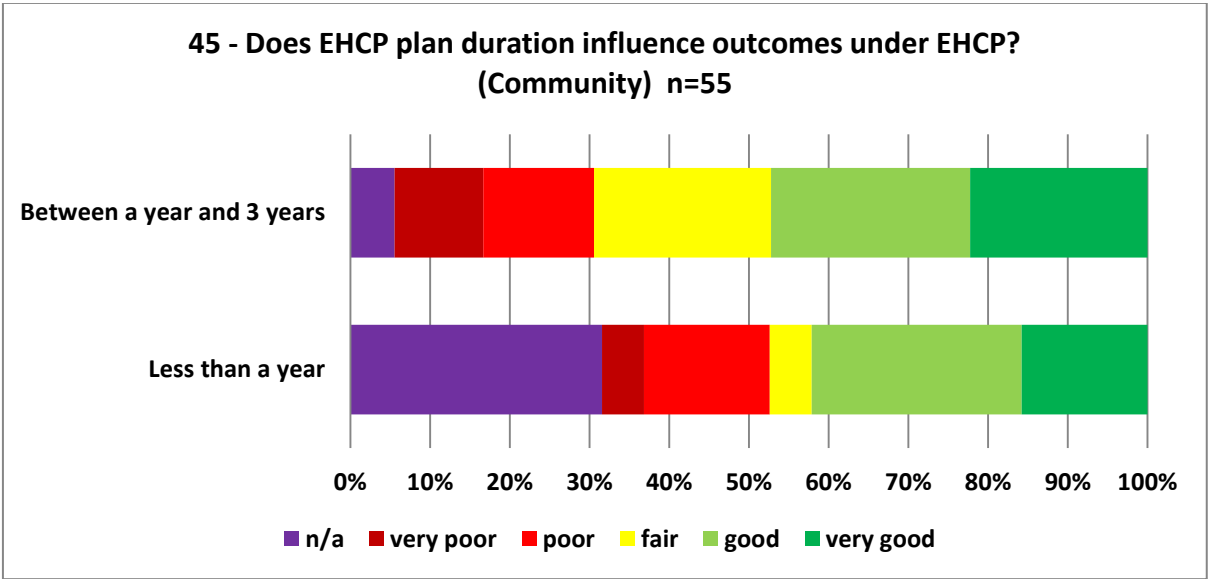
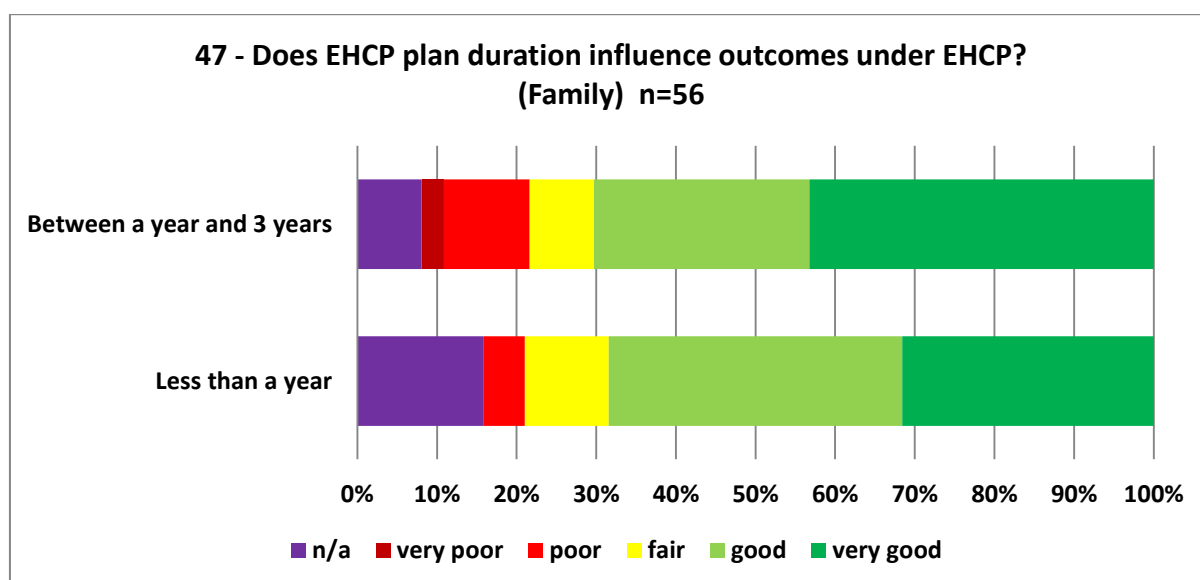
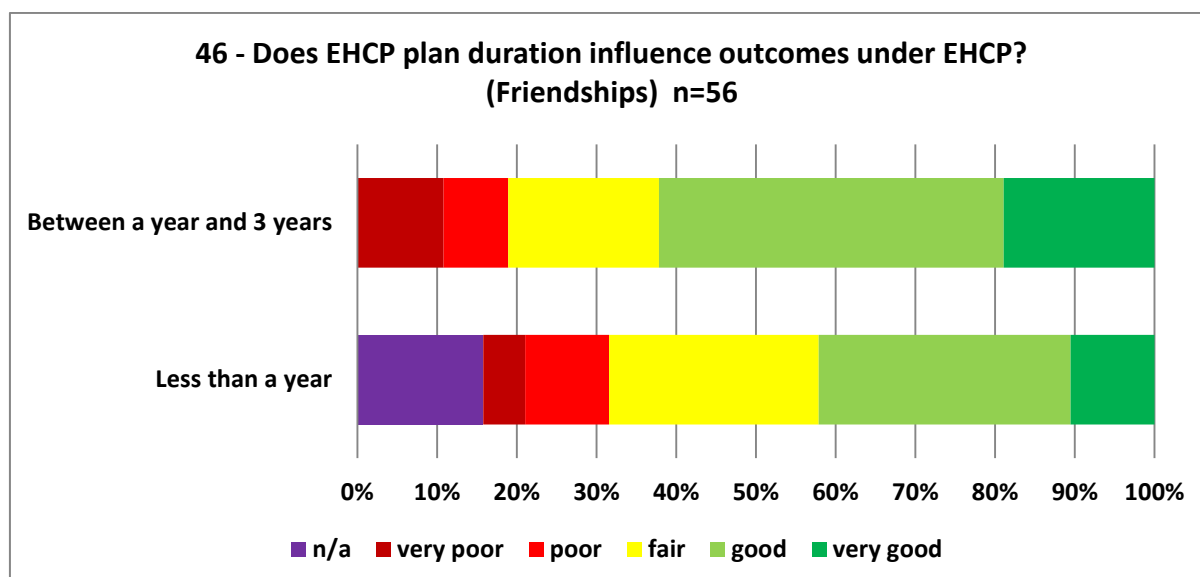


Figure 45 shows a weaker set of positive outcomes when looking at EHCP duration influencing children's community outcomes. The most positive outcomes are not in the majority for newer plans or for plans that are over a year old although there are a higher proportion of the positive outcomes for older established plans. This is likely due to the benefit of experience where the child spends a period of time becoming involved in the community in whatever form that takes. Children will like certain aspects of this and dislike others. Over time a child will determine what aspects of community life they like being involved with and it is these which will sustain ongoing involvement. In effect the trial and error period at the start of the EHCP will depress more positive outcomes and this will improve over time. It should be mentioned, though, that there does not appear to be a strong relationship between EHCP duration and community based outcomes from these results.

Figure 46 shows the relationship between EHCP duration and outcomes around friendships. It describes a situation where EHCP has a relatively weak relationship with friendship outcomes in the first year but a much stronger one once the plan is more than a year old. In part this can be attributed to results we have already seen in the section on those who are involved in putting EHCPs together where we saw education professionals having an influence on children making friends. An extension of this thinking would be that as the improvements EHCP seek to create become more bedded in at school (where children make most friends) the conditions for making friends become better and so the outcomes improve.



A strong relationship generally between EHCP and family based outcomes is shown in figure 47. Whilst there is little difference in the proportion of the most positive outcomes dependent on the duration of the EHCP, that would indicate a weak causal relationship, older established EHCP show a slightly higher proportion of the most positive outcomes but also a higher proportion of the negative outcomes. This may be a feature of family relationships already being strong and this would not likely change over the course of a year. It may also describe situations we have seen in anecdotal feedback from parents and free text submissions in this survey whereby there have been difficulties in getting plans changed/ amended as and when circumstances change. While the initial phase of EHCP creation is relatively cooperative, frustrations can emerge when things need to change and how sometimes this is difficult. This may introduce some small strains in family dynamics.

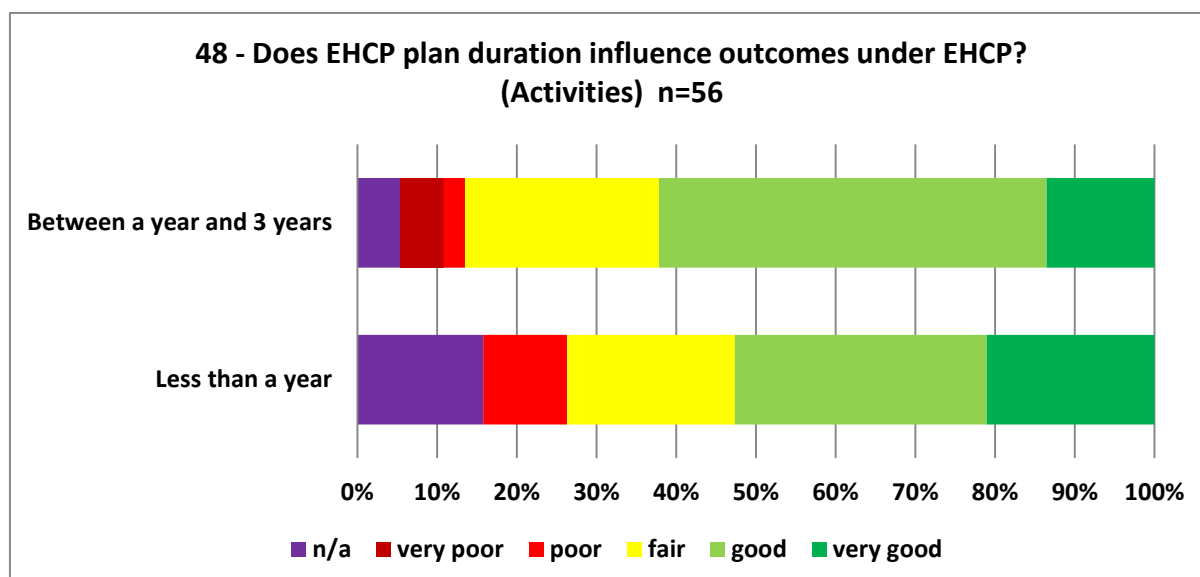
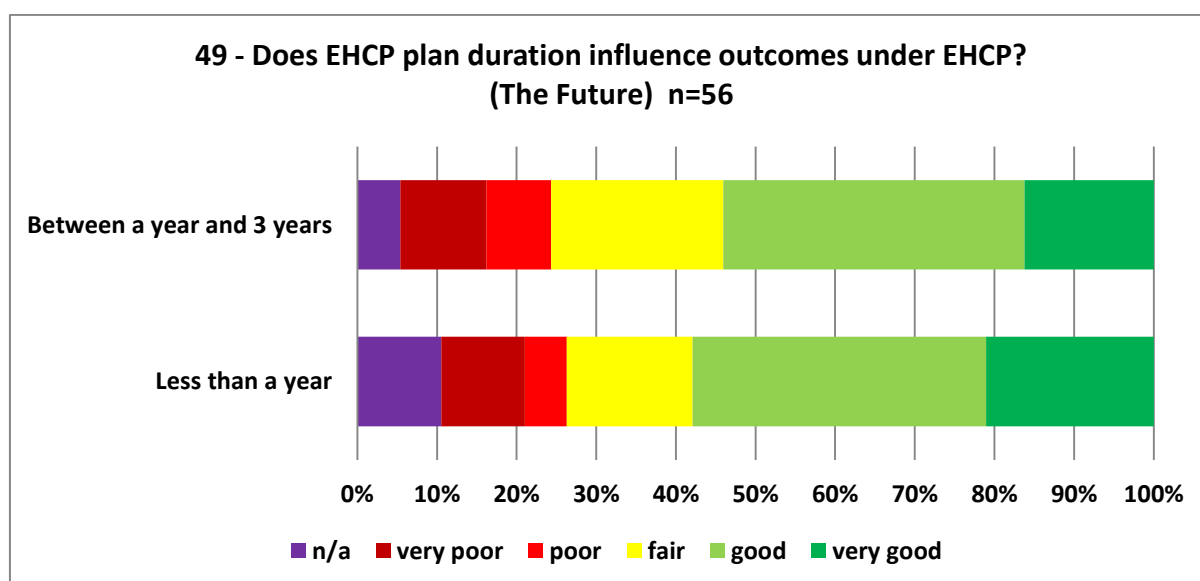


Figure 48 shows the relationship between EHCP duration and activities based outcomes. Once more we see the pattern of the proportion of the more positive outcomes increasing as the plan gets older. This is likely due to similar reasons that were explored in the community based outcomes we have already examined with a trial and error period early on where positive outcomes are perhaps depressed as options are explored/ discarded then steadily improving over time as a child homes in on their preferred activities.



Lastly figure 49 shows the results based on the question as to whether EHCP duration has any influence on outcomes around a child's preparations for the future. Plans of less than a year's duration show a higher proportion of more positive outcomes than older EHCP. This could describe a situation where plans are very forward looking to start with and can sometimes trigger radical changes in care and support approaches very quickly. Over time these get bedded in and become the new normal and the plan becomes more a vehicle to keep progress ticking over and less of a stimulus for further ongoing radical

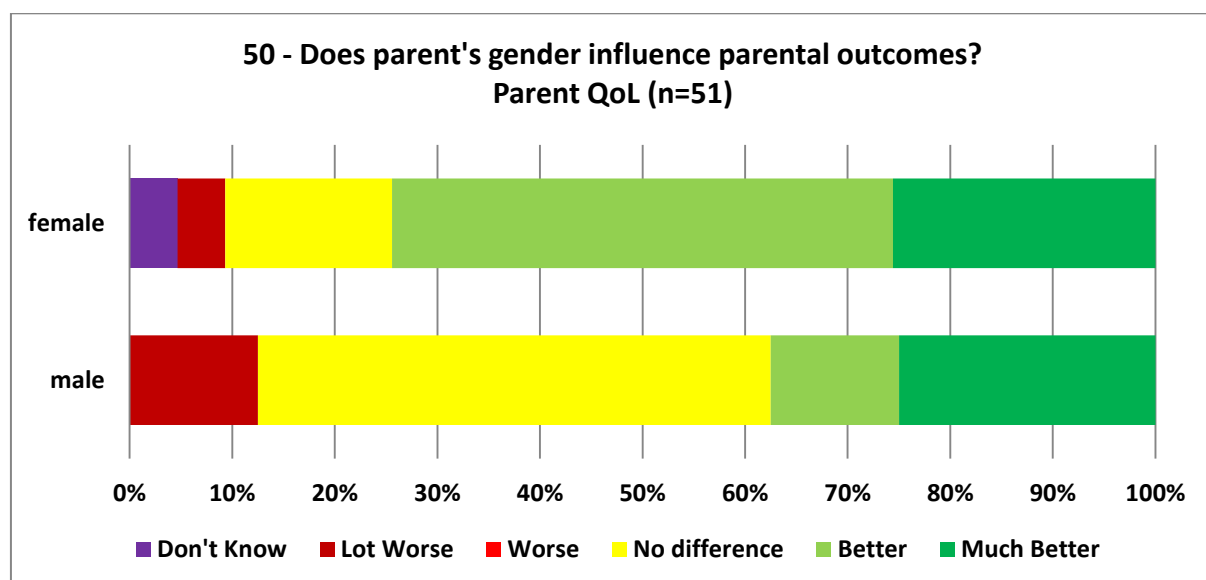
changes as these may not be necessary. This may explain why the proportion of the more positive outcomes declines over time on this outcome measure.

Overall we see a general trend for the older, more established, EHCP to produce a higher proportion of the better outcomes. On the surface older plans would seem to work better in this respect as they have had more input from the child, their parents and the range of education, health and social care professionals who contribute to their creation and maintenance. Also more is known about the child over time than is known at the outset when the EHCP is new.

Some of these relationships appear fairly weak in outcomes areas like health, community and family indicating there are other competing and/ or underlying factors also having an impact. In other areas the relationship between older EHCP producing better outcomes is much stronger such as in outcomes areas like learning, friendships and activities where the improvement is more marked. This could mean there is a stronger causal relationship between the age of the EHCP and the child's outcomes and less interference from external factors. Lastly there is the outcome based on future preparation which bucks the trend, this appearing to produce the strongest positive outcomes in the first year and showing a lower proportion of positive outcomes over time thereafter.

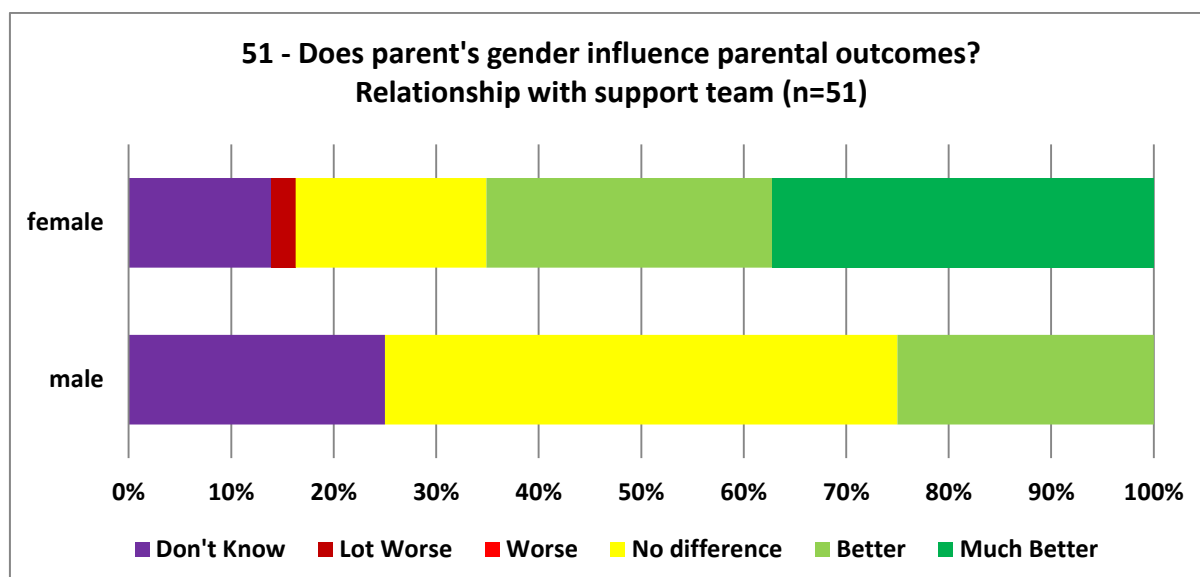
Question 4 - Does the parent's gender influence parental outcomes under EHCP?

This question examines if there is any linkage between a parents gender and the outcomes they report after being involved in EHCP processes. Figure 50 shows the relationship between gender and parent quality of life.



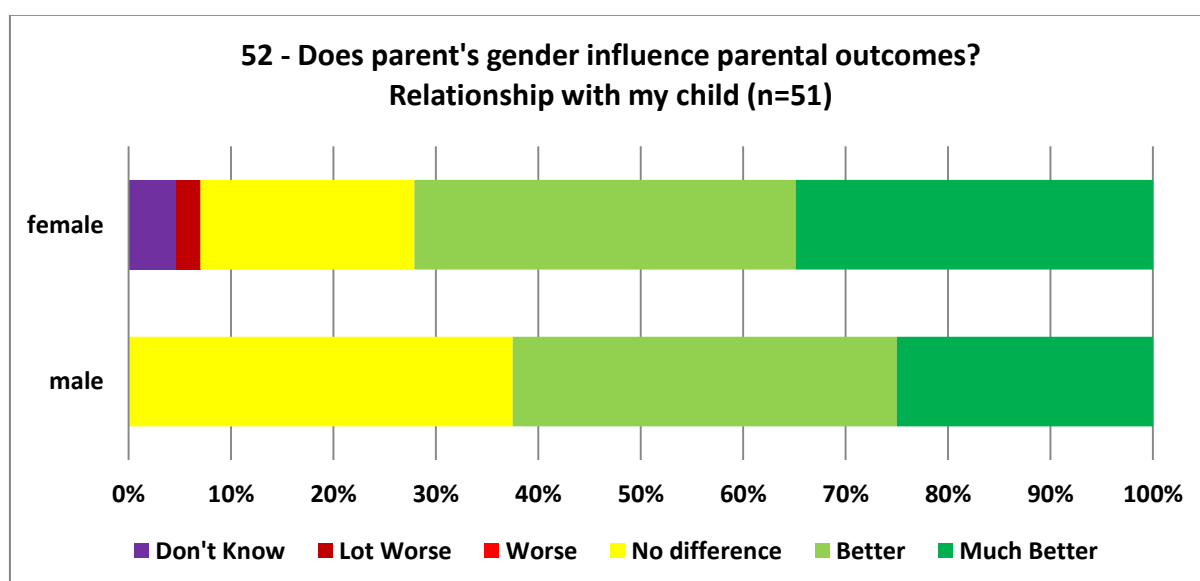
A clear result is shown in that around twice as many mothers report positive quality of life outcomes as fathers do although the proportion reporting the best outcomes is roughly the same.

Figure 51 goes on to examine if gender has any influence on how well a parent gets on with the support team paid to support their child.



Again another clear result is shown in that mothers are over twice as likely to report positive outcomes as fathers in how they get on with their child's support team.

Lastly we examine whether EHCP processes are improving the relationship between parents and their children who need these EHCP. Figure 52 shows the result.



This result is less clear cut although mothers are still more likely to report positive outcomes than fathers in how they are getting on with their child.

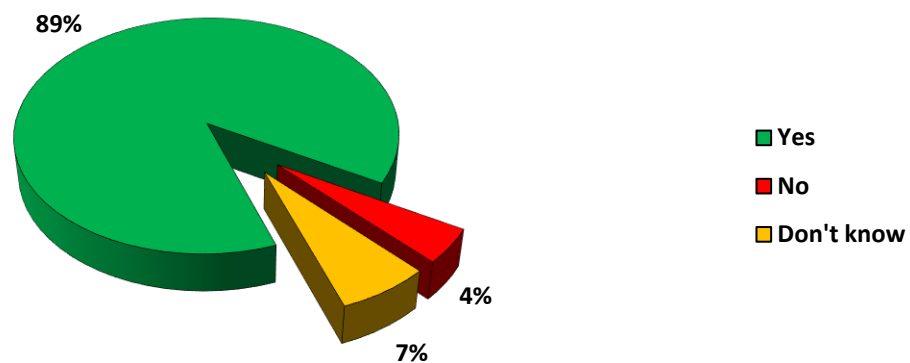
It would seem on the face of it that mothers appear to report better parental quality of life outcomes compared to fathers across the board on the 3 specific parent outcomes measures used by POET©. The difference is particularly strong when parents report on their quality of life and how well they are getting on with their child's support team. It is present also in the outcome around getting on with their child although the difference is less marked.

There are many reasons why this might be so. Initially it needs to be borne in mind that the group answering both these features in the survey contained over 5 times as many women as it did men. If more fathers had participated then the results might have been different but that can only be speculation. What certainly seems to be apparent is that mothers in Portsmouth seem to be the most likely parents to be involved in processes leading to things like EHCP and perhaps have a clearer understanding of how processes like this impact on their lives. This type of activity may have an element of gender perception attached to it on the one hand making it more likely for women to lead on this matter and conversely make men less likely to do so. Based on the results above women are reporting better outcomes than men by being involved in EHCP processes.

Basic Analysis of the Children's "with EHCP" survey returns

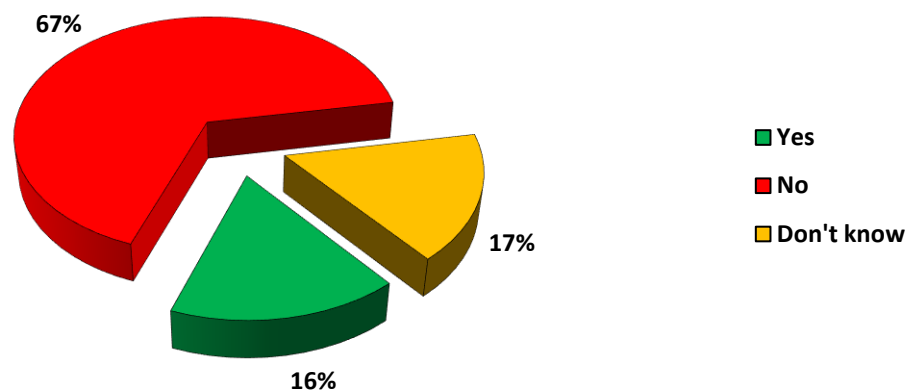
When examining the feedback from the POET children's "with EHCP" survey we were encouraged by the sharp rise in participation, up from 7 in 2016 to 44 in 2017. In the first instance we wanted to gauge what proportion of children taking part had an EHCP. The results can be seen in figure 53.

**53 - Do you have an Education, Health and Care Plan?
(Child Survey) n=44**

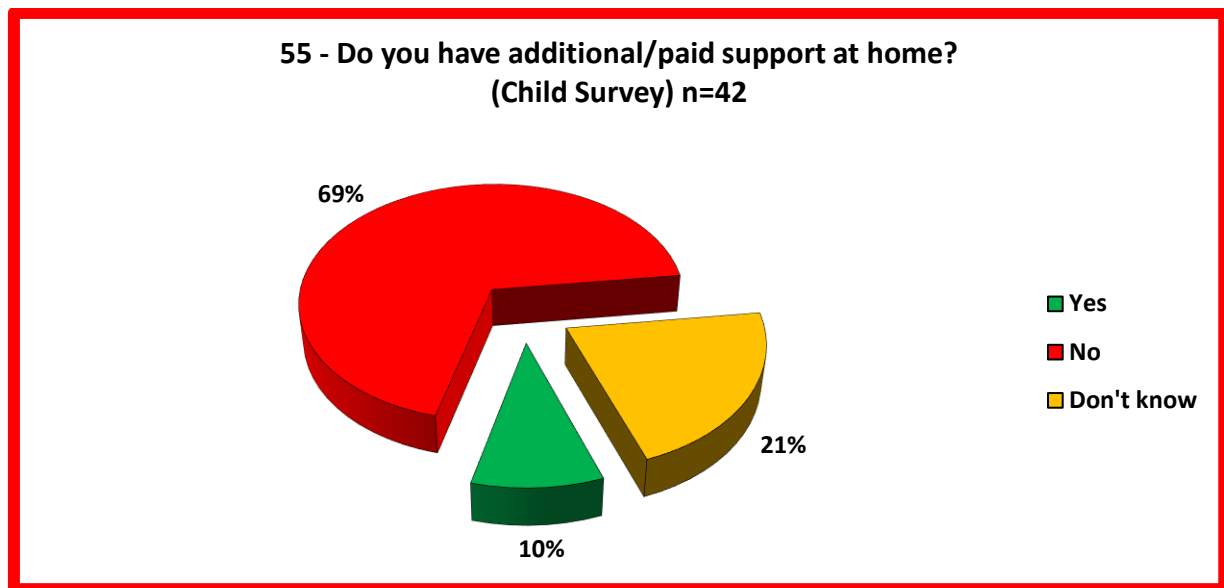


Due to the very young age of some of the survey participants some deviation from 100% on the yes answer is to be expected. The overwhelming majority however do report having an EHCP. We also wanted to examine what other support children were aware that they were receiving. The first of these is the support of a personal budget. The results are shown in figure 54.

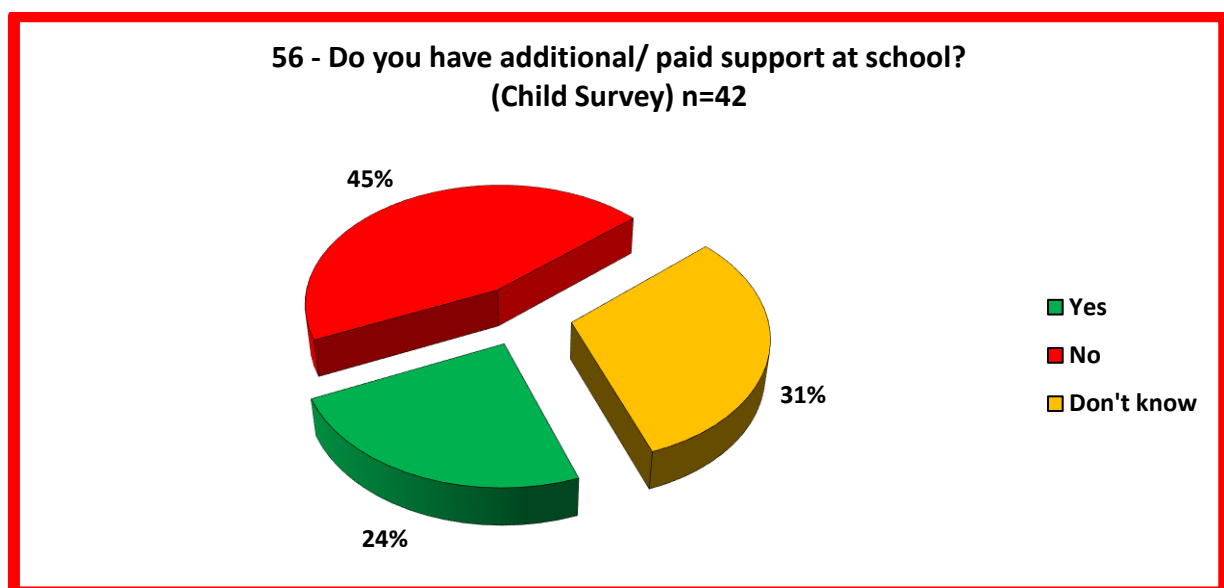
**54 - Do you have a personal budget (that you or your parent can use
for your support)? (Child Survey) n=42**



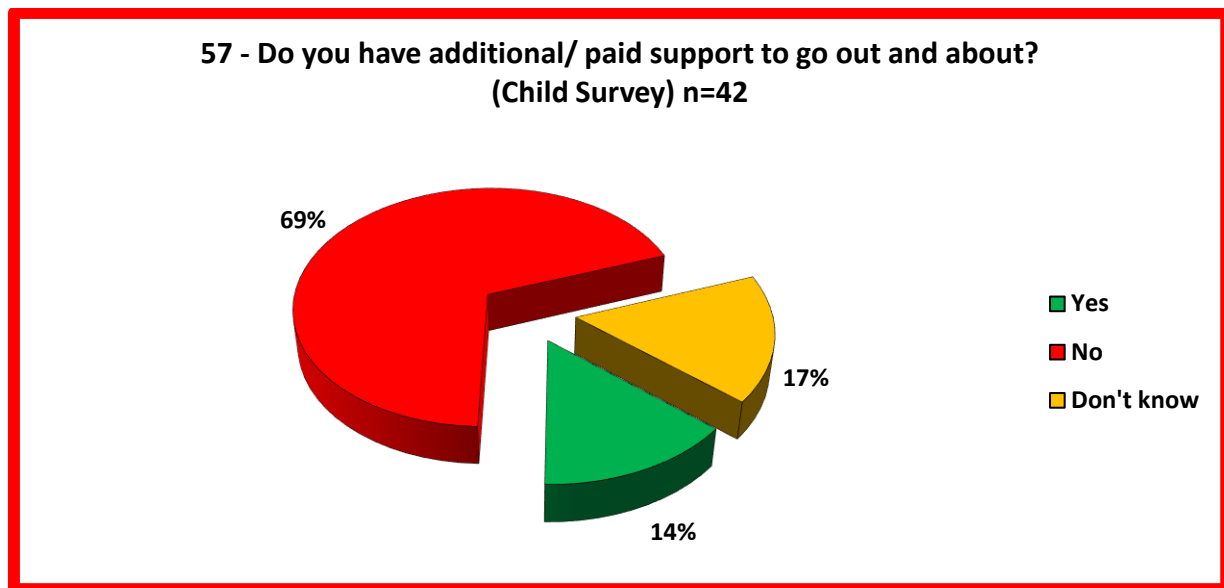
This produced a majority answer for no personal budget although 7 answers from the children's survey indicated that they thought that they did. It is very difficult to ascertain if parents or children fully understand what is meant by a personal budget given the generic question the survey asks children and the relative dearth of information forthcoming from the parental survey where very little detail actually emerged. In figure 55 we see the incidence of children receiving paid support at home.



Only a relatively small number of children report that they receive support at home (4 out of 42) with the majority saying they do not receive such assistance. This pattern is somewhat different for children reporting on getting support at school. This is shown in figure 56.



From this we can see that nearly a quarter of the children participating in the survey reported they were getting some form of support in school/ the classroom. Lastly in this section of the survey we see feedback on children receiving support while they are out and about as per figure 57.

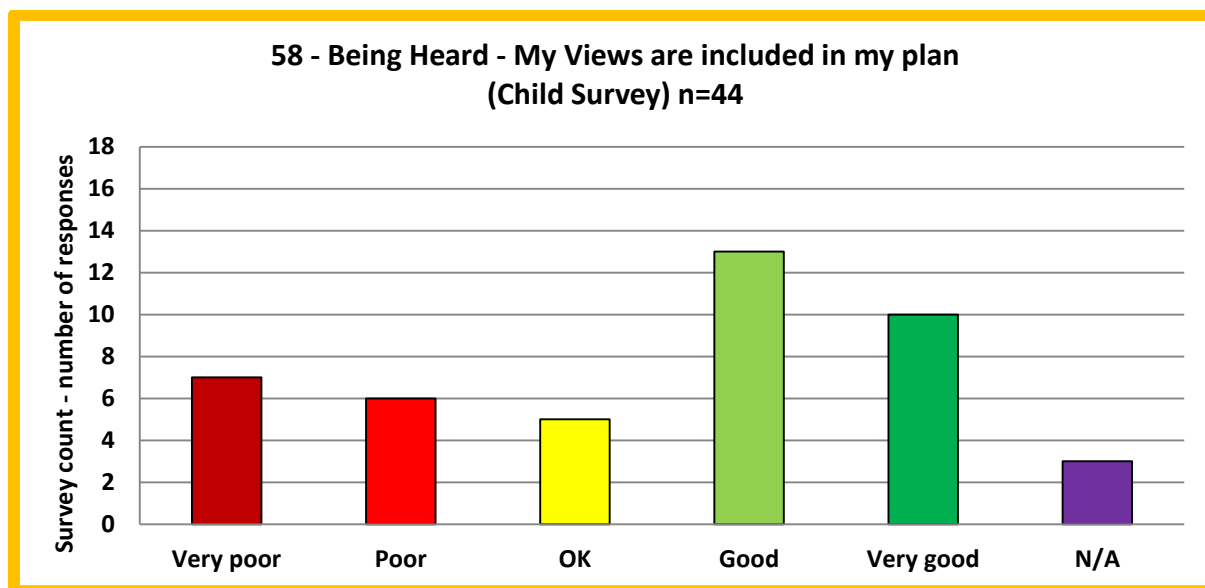


Again we see only a small proportion replying yes to this question (6 out of 42) and the majority replying no.

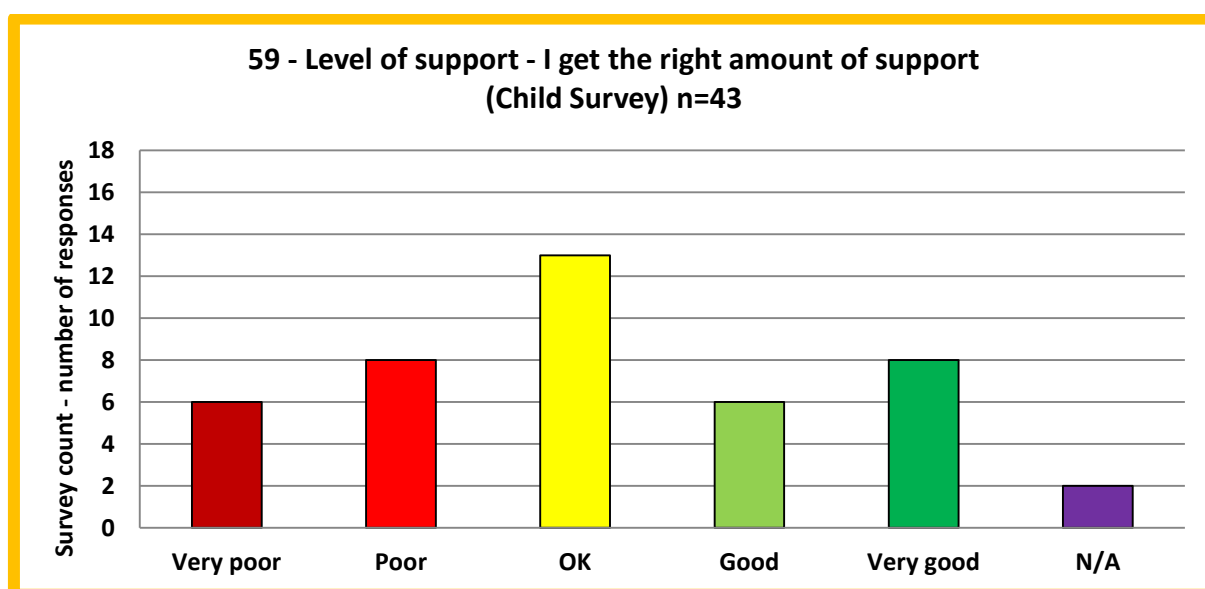
What this tells us is that although most of the children participating in the survey have got help and support through an EHCP, this focusses on matters that are relatively intangible (organisation and planning behind the scenes) within the classroom. A higher incidence of paid support in the educational setting compares in striking fashion with relatively low levels of support at home, while out and about or, indeed, the possession of a personal budget facility. Another striking feature of this section of the survey is the incidence of the "don't know" answer. In all instances, except on the EHCP question specifically, the "don't know" answer outweighs a reply in the positive. This may indicate that although children may be receiving support of some description they have a relative lack of knowledge as to what that support means. Whether this indicates that there is a lack of transparency from professionals to their child clients or whether this represents some aspect of a child's particular SEND challenges remains unclear.

The next section of the children's survey focussed on what children think about the support they receive. Over the six questions of this section children are asked about a range of particular issues that occur around the care and support they receive and what their views are on this.

The first question relates to how involved a child has been in the EHCP process and whether they felt their views were taken into account when decisions were being taken. The results are demonstrated in figure 58 shown below. What we see is that the majority tender a positive answer (23 out of 44) while 13 of the 44 participants gave the opposite view.

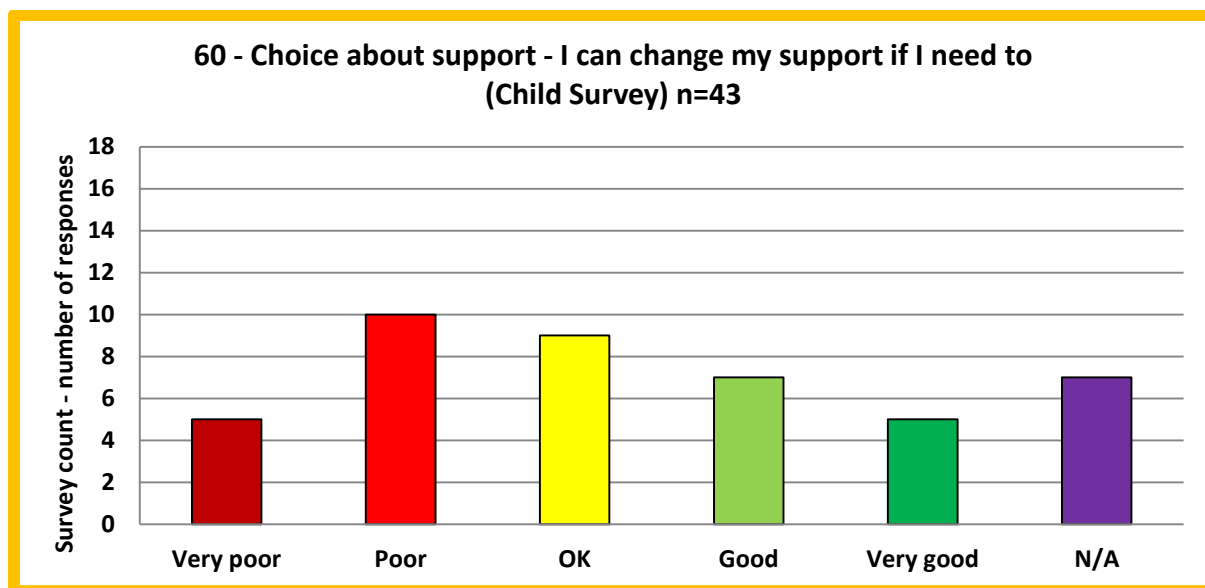


Next the children were asked about whether they felt they were getting the right amount of support. The results are shown in figure 59.



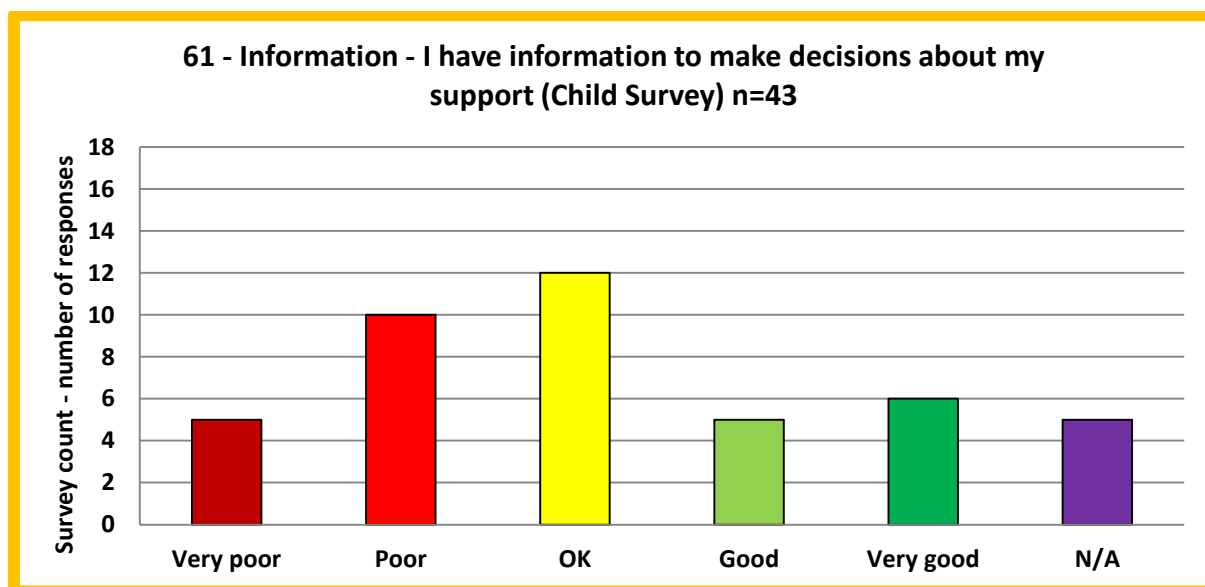
This produced a very balanced cross section. The same number of children gave positive answers (14 out of 43), indicating they felt the amount of support was right for them, as gave negative answers, highlighting that they felt there was insufficient (or, possibly, too much) support. Coupled with this we also see only a slightly smaller number (13 out of 43) giving the more ambivalent "OK" answer. On this question we do not see any consensus majority position emerging.

The next theme addressed involves the concept of choice. Children were asked if they felt they could change their support if they felt they needed to do so. The results of this are shown in figure 60.



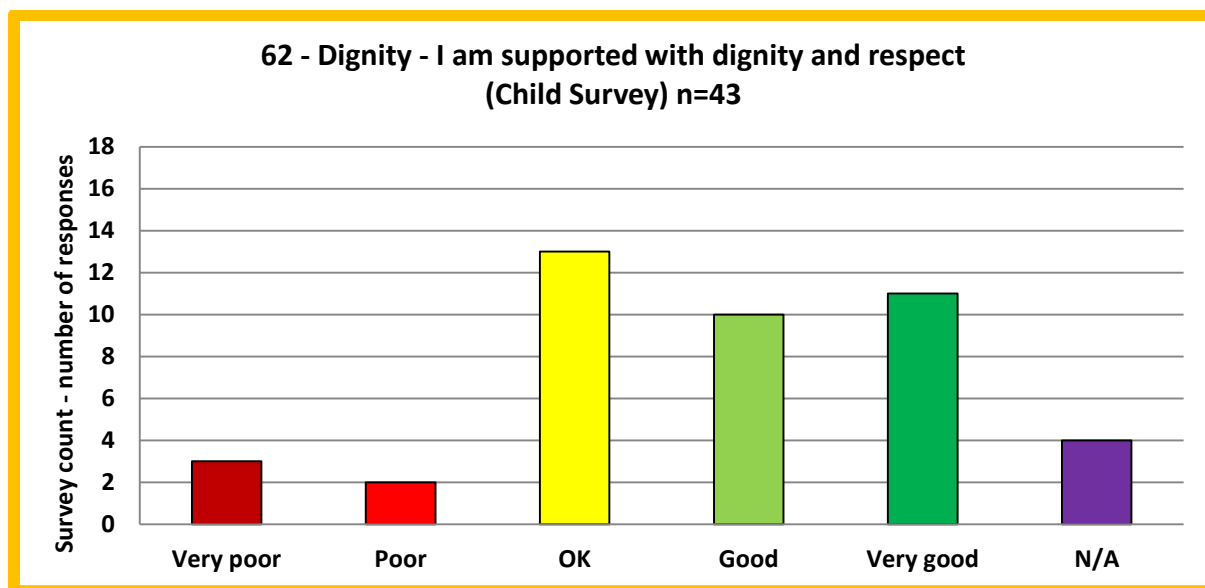
Here we see, after a relatively positive start, that children indicating the negative answer (15 out of 43) outweigh those who felt more positive on this issue (12 out of 43) although this is not the majority position.

Next we investigated whether children felt whether they had enough information to inform their decision making, results of which are shown in figure 61.



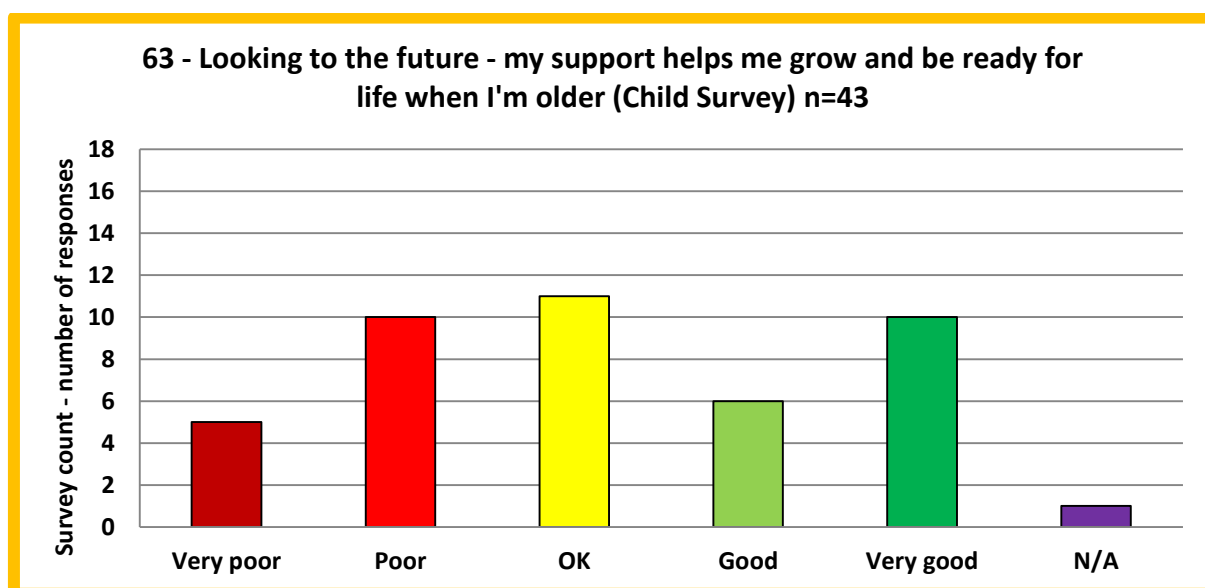
Once more we see that children tendering a negative opinion on this (15 out of 43) again outweigh those who felt positive on this (11 out of 43) although, again, this is not the majority position for this question in the survey.

Next, children were asked if they felt that they were supported with dignity and respect. This question strikes to the heart of the change in emphasis that the EHCP approach espouses whereby children are not, simply, passive recipients of care and support but thinking, feeling individuals with ideas of their own. The results are as per figure 62.



This is a much more encouraging result. 21 out of the 43 children answering this question felt positive on this issue while only 5 out of 43 held the contrary view. Although the positive viewpoint was not in the majority it was striking that over 4 times as many felt positive as felt negative.

Lastly the survey examined how children felt their care and support helped them in preparing for life in the future. This is shown in figure 63 below.

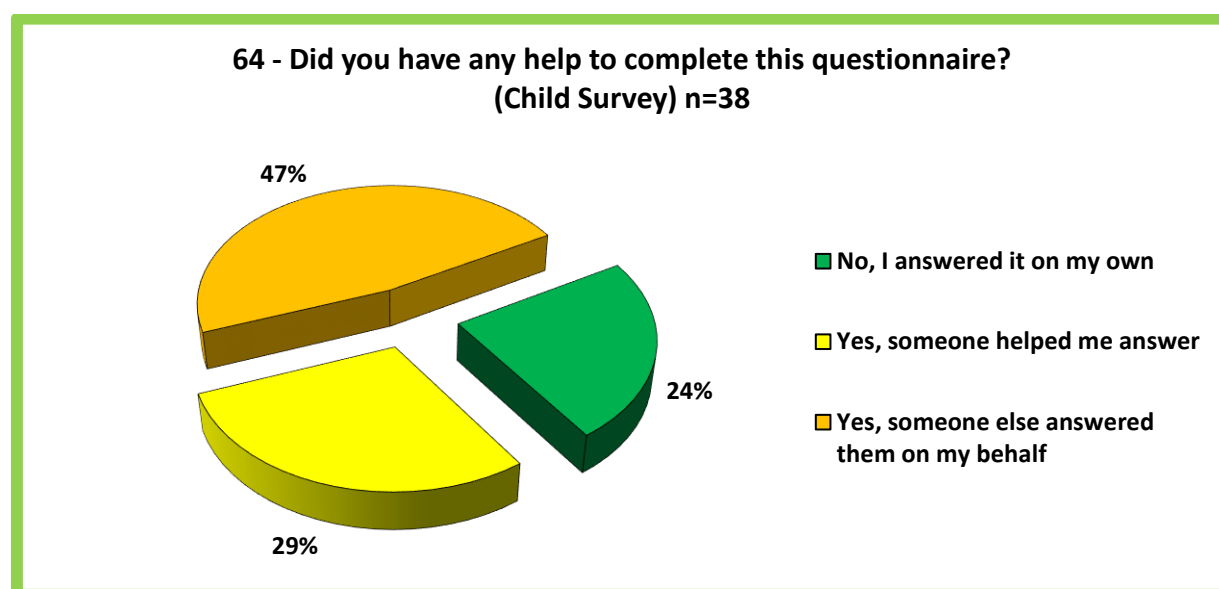


Narrowly, children tendering the positive responses (16 out of 43) outweighed those who felt more negative (15 out of 43) on this issue. Again, no consensus emerged from the survey participants on this question.

Given this feedback, what can be said as to how children are viewing their care and support? We do see that the feedback from the children's survey in this respect is more nuanced than the equivalent questions asked in the parental survey. Children did feel that their voice was being heard and indicated this in the only majority to emerge from

this section of the survey. Positives could also be taken from the questions relating to children feeling they were treated with dignity & respect (significant plurality) and preparing for future life (narrow plurality). On a less positive note we did see negative answers outweigh the positive ones on the themes of choice about support and information provided to inform decision making (both significant pluralities). We also saw a deadlocked survey pool when addressing the question about the amount of support on offer with equal numbers feeling positive and negative on this matter.

What can be seen is that the survey feedback from 2016, which was wholly positive (albeit from a much smaller survey pool), appears to have been somewhat unrepresentative of children's views. This is hardly surprising in that none of the children's surveys from 2016 were completed in entirety by the child concerned. This is reflected in the question related to how much help children had received in completing their survey online. This is portrayed in figure 64.



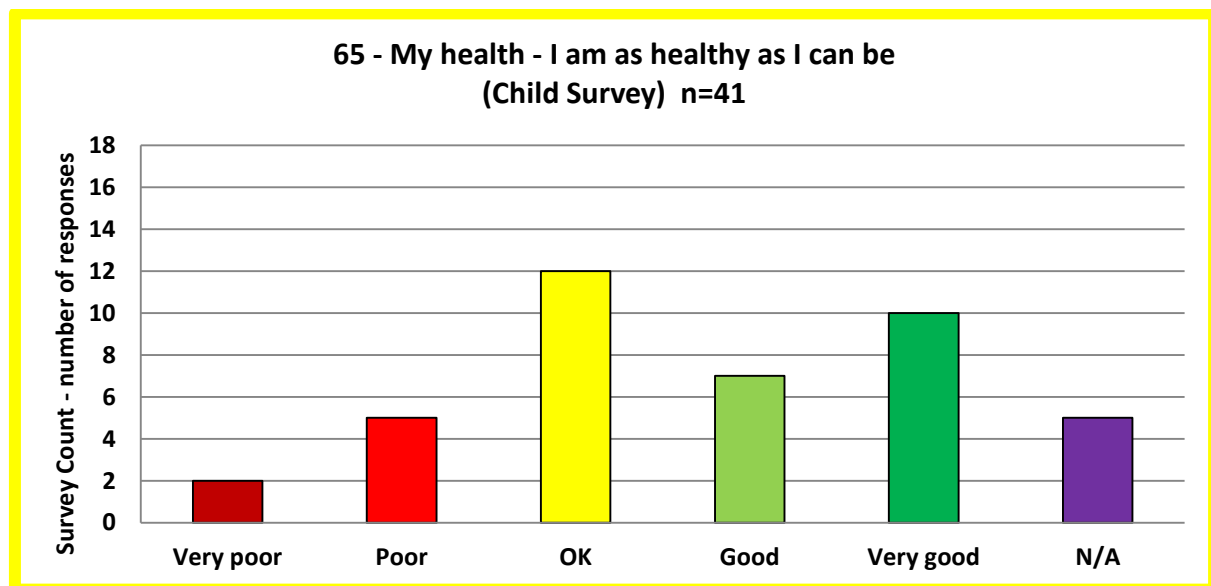
While the majority of these survey returns include some, if not total, parental input we see nearly a quarter have been completed, in the entirety, by the children concerned and just under a third where, although some parent input has been made the child has answered some questions for themselves. While the parental input needs to be viewed with some caution we can confidently state that the children's voice emerging from this year's survey is orders of magnitude greater than that we could discern from the 2016 survey.

In common with the parental survey children were asked questions about their outcomes over the past year. There are 8 outcomes under investigation with this children's survey shown in the list below.

- Am I as healthy as I can be?
- Have I done as well as I can at school, college or work?
- Have I enjoyed time with my friends

- Have I enjoyed home and the relationship with my family?
- Have I felt safe at home and while out & about?
- Have I taken part in activities I like?
- Have I done positive things in my local area?
- Have I had good quality of life and been relaxed and happy?

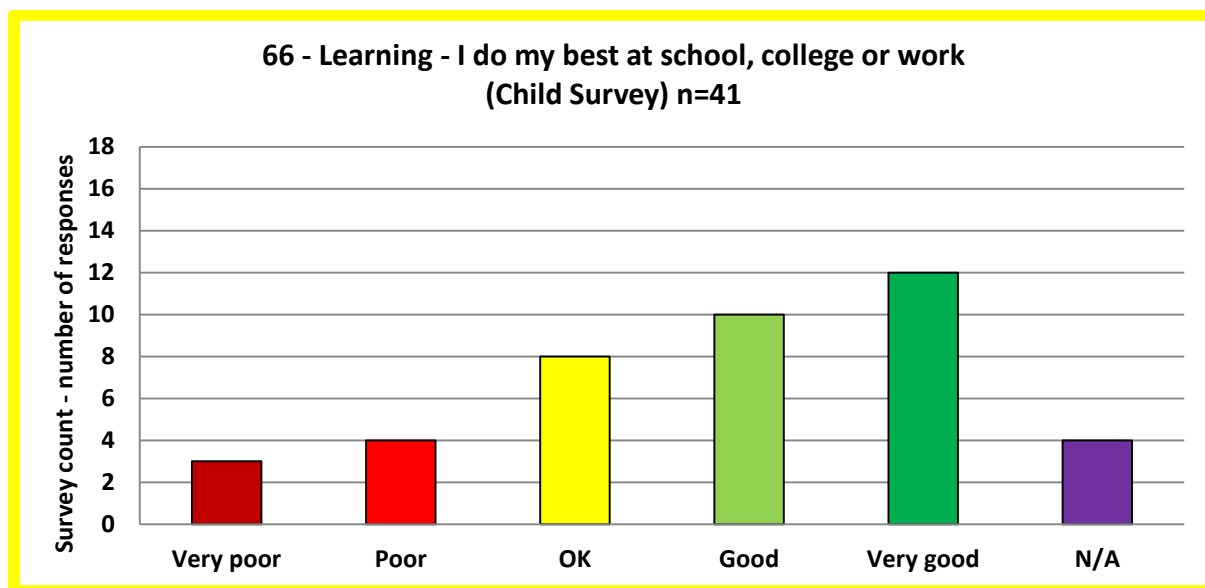
Initially children were asked how well their support has enabled them to be fit and healthy. The results are shown in figure 65.



This demonstrates an encouraging start to this phase of the survey. 17 of the 41 children answering this question gave a positive outcome as their answer comparing favourable with those holding a negative view (7 out of 41). While positive answers are not in the majority, they are more than double the number of those holding the contrary view.

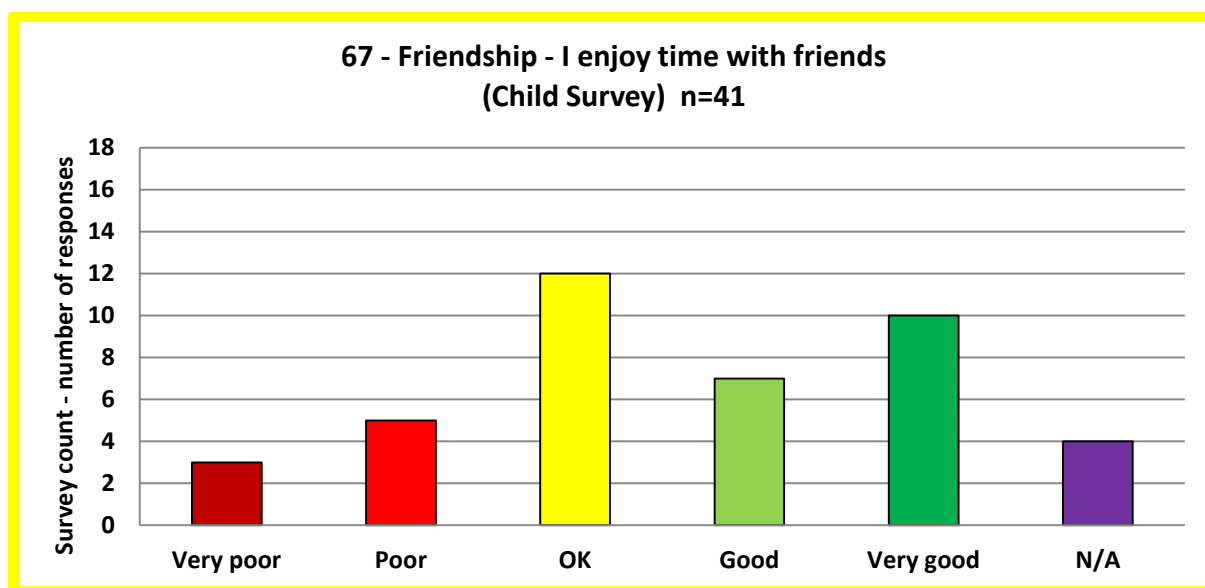
Next, the survey examines what the education based impact is. In other words, how well does the support being provided help the children do the best they can in school, college or workplace (for older children/ young people).

What we see here is a narrow majority giving a positive indication of their outcome (22 out of 41) comparing very favourably with those not so happy with their outcomes on this issue (7 out of 41). While positive results are narrowly in the majority it does provide further encouragement. The results can be seen in figure 66.



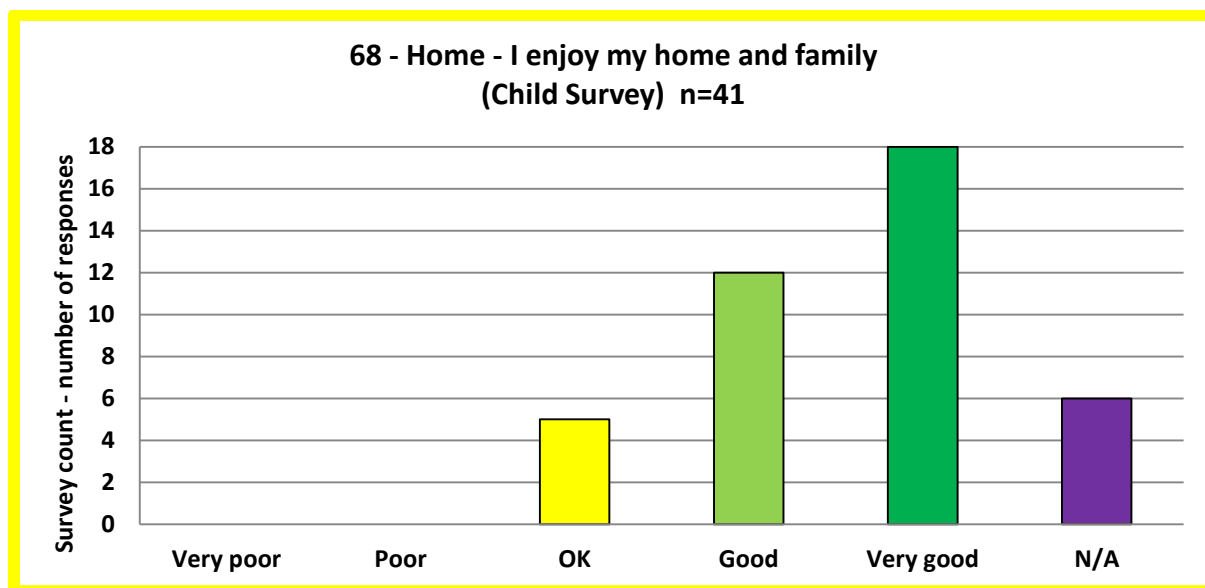
Clearly EHCP have an impact on how well children feel they are doing in their learning which is clearly demonstrated.

Figure 67 shows the results for the outcome based on how well children enjoy their friendships.



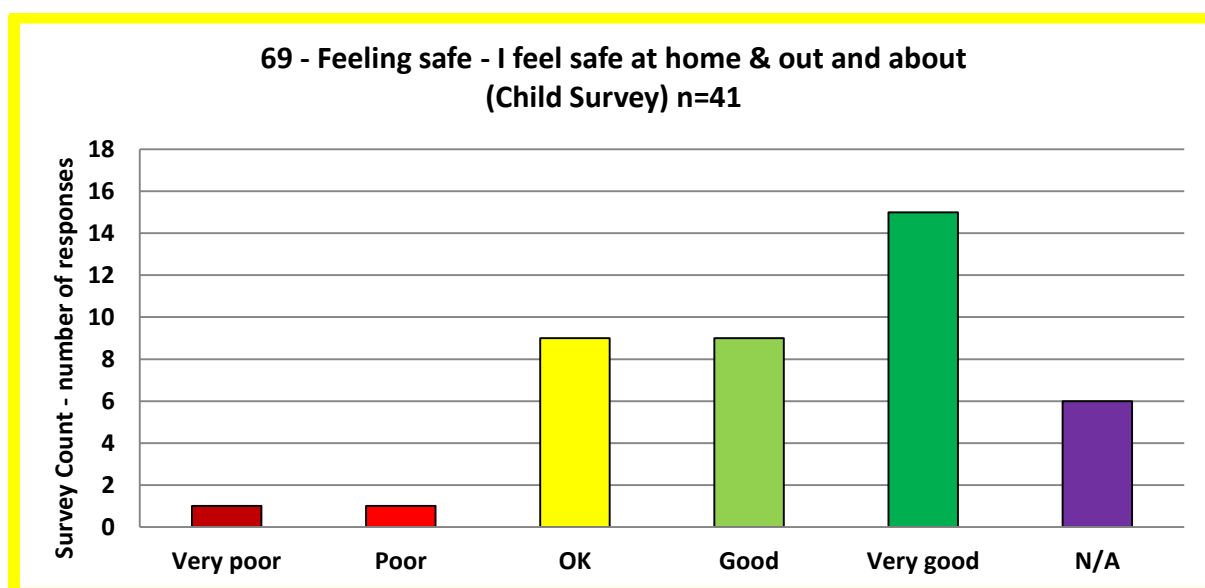
Here, again we see a positive message reported back. 17 of the 41 children answering this question indicated positive outcomes and 8 out of 41 indicated the reverse. This is in keeping with feedback from the parental survey where we saw positive links between EHCP and children's ability to make and maintain friendships. This reinforces the message that EHCP appear to have wide ranging positive consequences well beyond the classroom and school times.

Figure 68 presents the results for EHCP influencing family outcomes. When children were asked about enjoying home and family life a very strong result was returned.



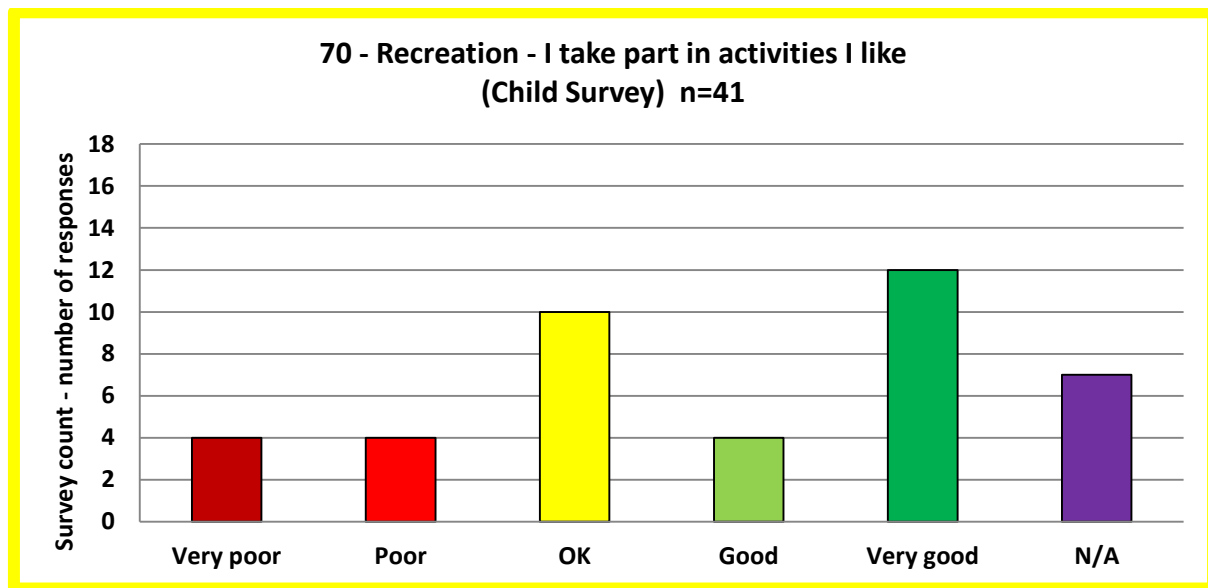
Here we see a strong majority (30 out of 41) reporting a positive outcome for home and family life and zero instance of any negative outcomes being reported. This follows on from the previous point in that EHCP have those wide ranging effects well outside the school environment.

The next question asks children how safe they have felt as a feature of the support they receive. These results are shown in figure 69.



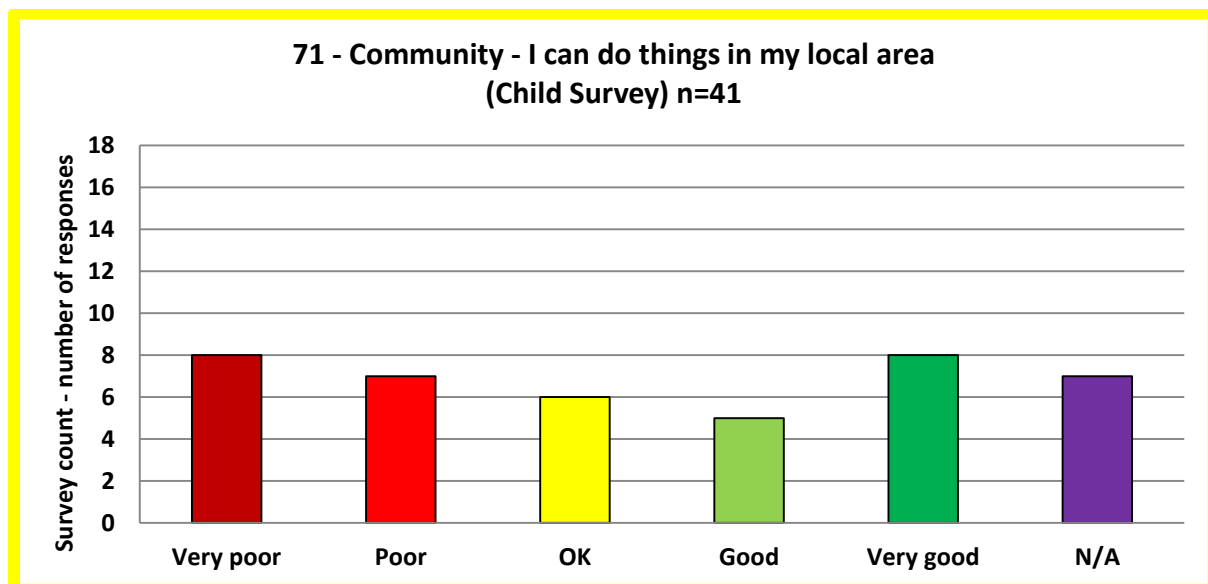
Here, again, we see a good majority of children (24 out of 41) indicating they feel safer as a result of their support and only 2 children reporting they felt less safe as a consequence. As the children's survey does not allow children to provide free text support for their answers it is unclear as to exactly what is happening to cause this effect. The fact of its occurrence is welcome and provides further encouragement to the EHCP approach.

Figure 70 displays the results of the answers to the question relating to activities outcomes.



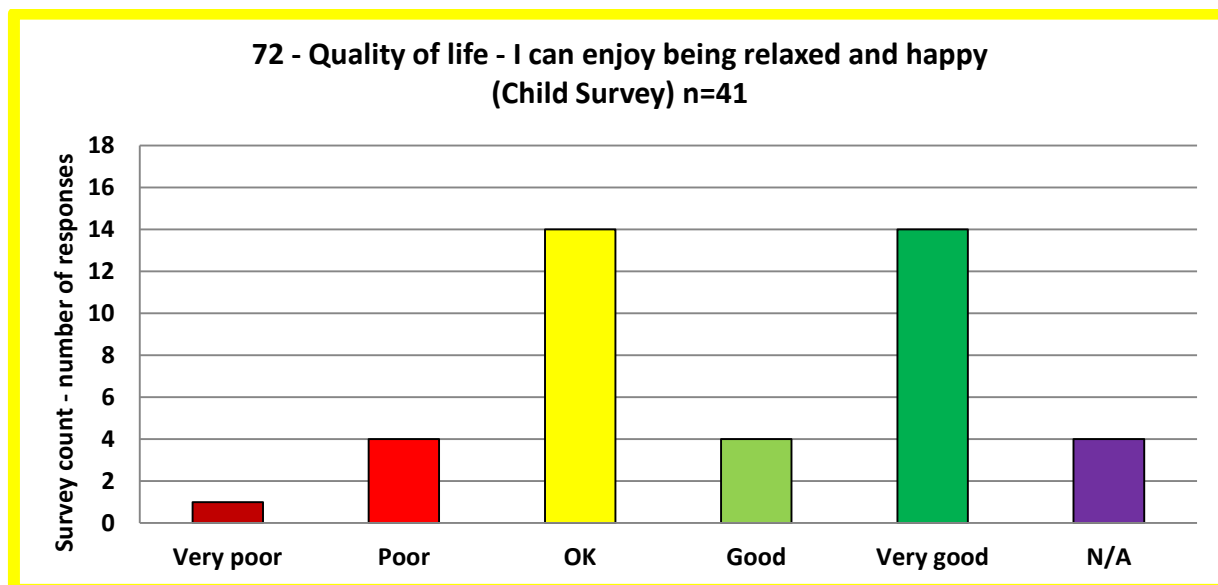
Again, the reported outcomes are largely positive (16 out of 41) and these are double the returns compared to those reporting poorer outcomes (8 out of 41). While not a majority view this result is a significant plurality on the positive side of the equation.

Figure 71 highlights the outcomes when the community based outcomes are investigated.



This produces the most mixed result of this phase of the survey for children. Negative outcomes were reported by 15 of the 41 children answering this question. This outweighed the 13 out of 41 who answered in the positive. This was the only instance where children reported more poor outcomes than positive ones although it must be stressed that it was not the majority view in what was a more balanced set of viewpoints being provided.

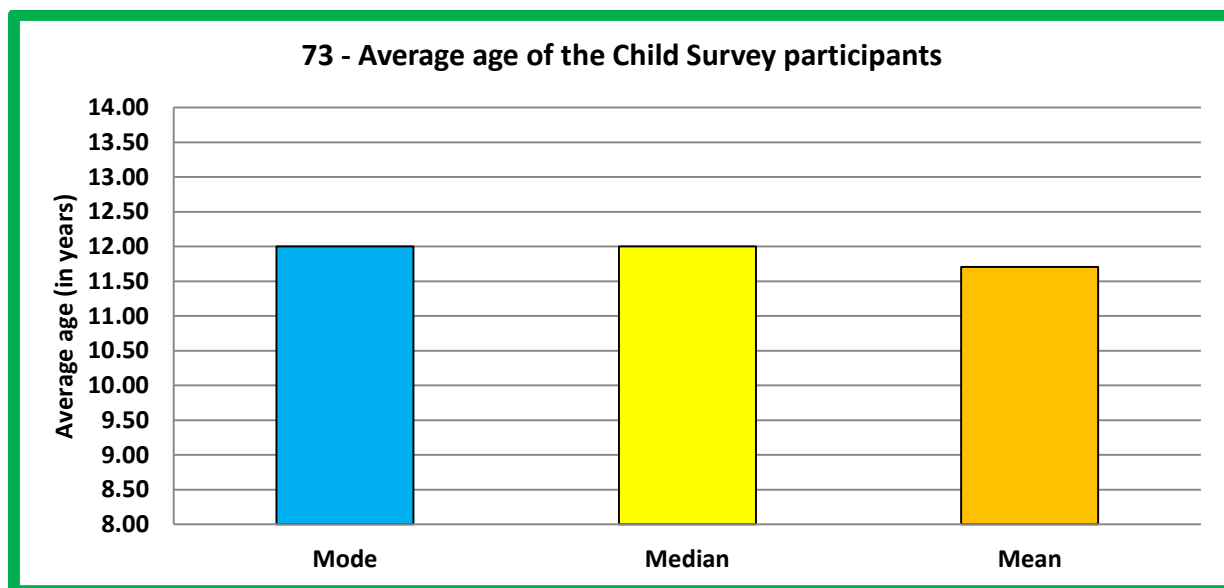
Rounding off this section of the survey figure 72 shows the results when the survey asks children about their quality of life and how their EHCP has helped them feel relaxed and happy.



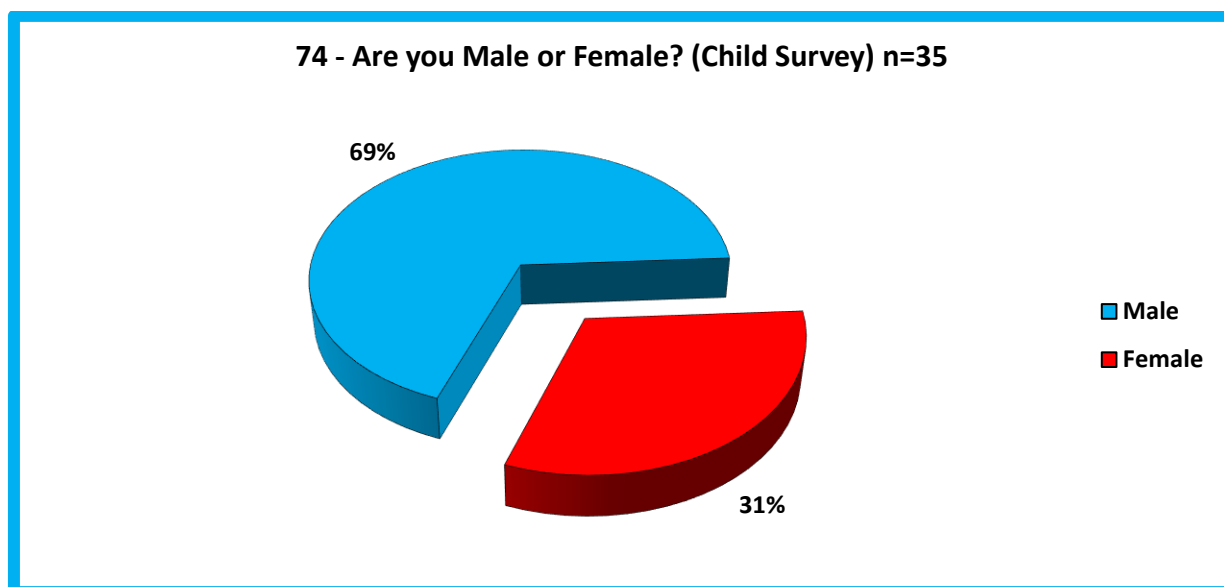
18 out of the 41 children who answered this reported positive outcomes. This is not quite a majority view but contrasts favourably with the number of children who expressed the contrary view (5 out of 41). While not as emphatic as the equivalent question in the parent survey it does demonstrate that parents and children are, more often than not, enjoying a better quality of life as a result of EHCP actions and processes.

While the end results for children reporting their experience of being involved in the process left something to be desired, when considering the questions about outcomes the picture is much better. Learning, family and safety based outcomes are being reported positively by the majority and significant numbers of children are reporting positive outcomes more often than not for health, quality of life, recreation and friendships. Only community based outcomes spoil what is otherwise an encouraging set of results, being the only instance where poorer outcomes were reported more often than the better ones.

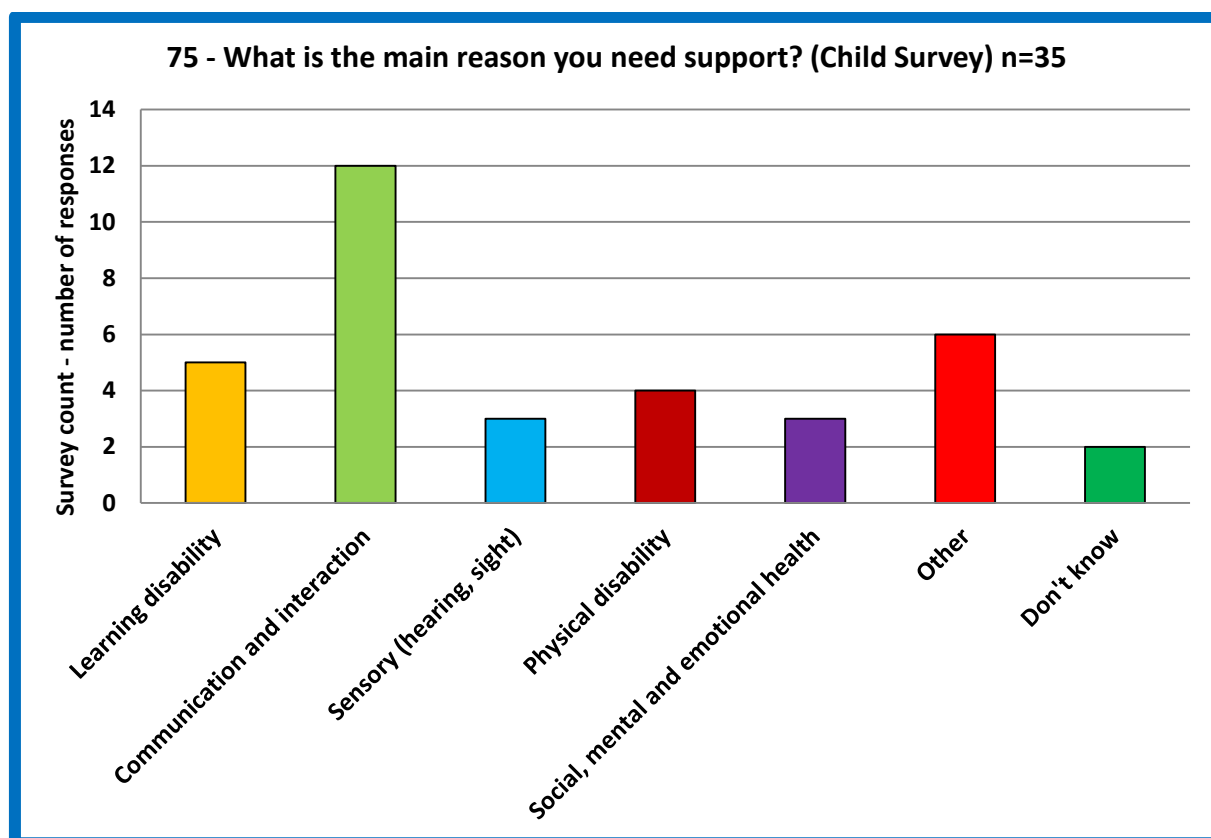
Having seen what feedback the participants in the children's survey have provided it is well that we delve a little deeper into the characteristics of the children who participated. In terms of the ages of the children taking part, the most common age was 12 years old. Looking at the age range we see that the youngest child with survey answers in this survey run was 3 years old, the oldest submitting feedback was aged 19 years old. The median age of this range was 12 years old. The mean average was around 11.75 years old. Again this corresponds quite closely with the parental survey and these average ages correlate closely with the transition period between primary and secondary education. This is shown in figure 73.



In terms of the gender split we see that more than twice as many boys participated compared to girls based on the answers of the 35 children who gave an answer to this question, shown in figure 74.



Lastly the survey asked children for an indication as to the main reasons why those children needed the additional care and support as documented in their EHCP. This same question was asked of the adults and what was noticeable was that the results in the parental survey showed similar (albeit not identical) patterning to the feedback we got from the children who participated. This is most likely due to the smaller number of children participating compared to the parents who took part in the equivalent survey as well as matters of knowledge and perception (note that the "other" and "don't know" options are used in the children's survey question on main support reason but did not feature in the parental equivalent question). These results are shown in figure 75.



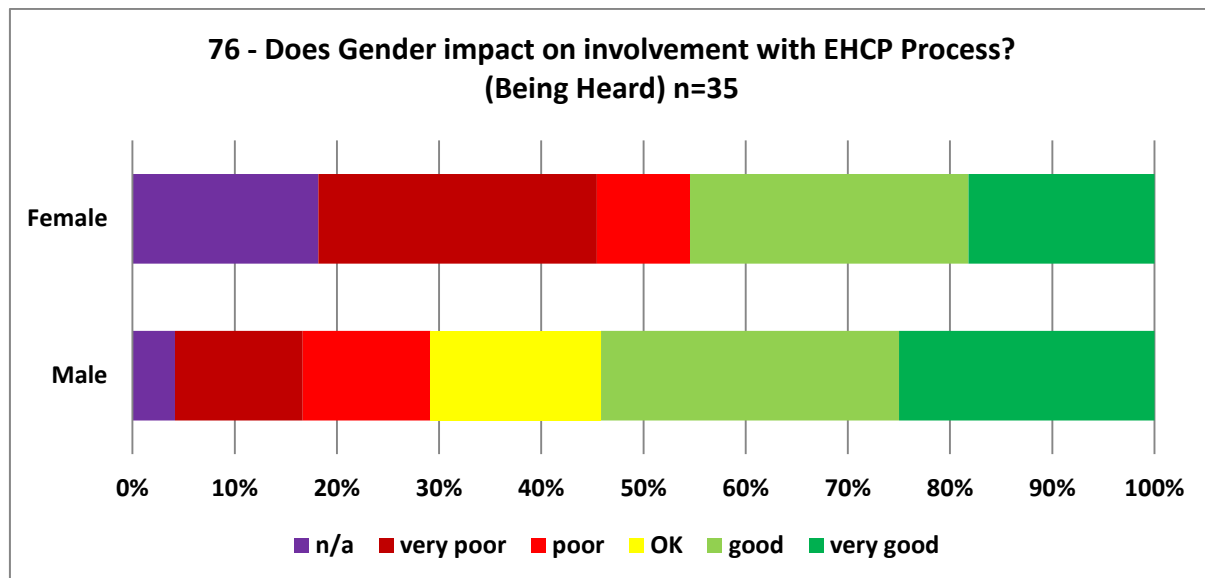
In-depth focussed Analysis of the Children's "with EHCP" survey returns

Having completed the basic analysis of the survey forms there were 2 particular questions that presented themselves for a more in-depth examination based on the available data. These questions were somewhat different to the ones that formed the in-depth analysis from the parental survey data. The reason for this was the parental survey does not incorporate a question asking for the gender of the child whereas the children's survey does. Based on this the 2 questions that bore further investigation were:

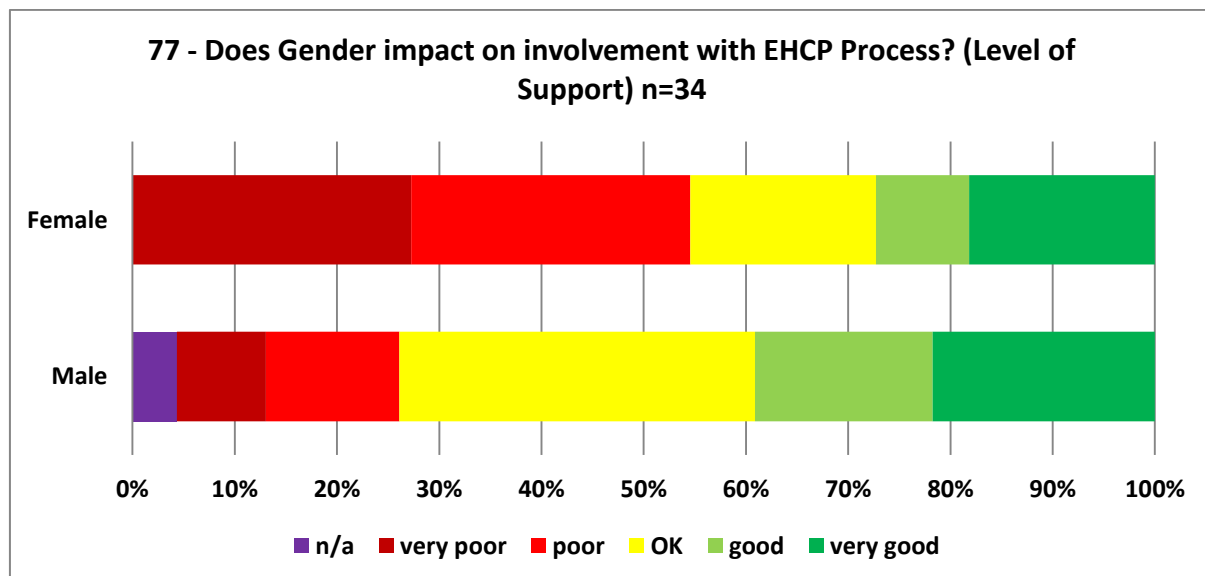
- Does gender impact on issues of involvement with EHCP processes?
- Does gender have any impact on the reported outcomes under EHCP?

What we are hoping is that the available data will support or disprove the role of a child's gender in the 6 features of involvement in EHCP process already investigated and also in the 8 outcome areas investigated earlier in the survey. Using a similar process to before we capture only those children who answered the questions on gender as well as answering the questions about EHCP involvement/ outcomes.

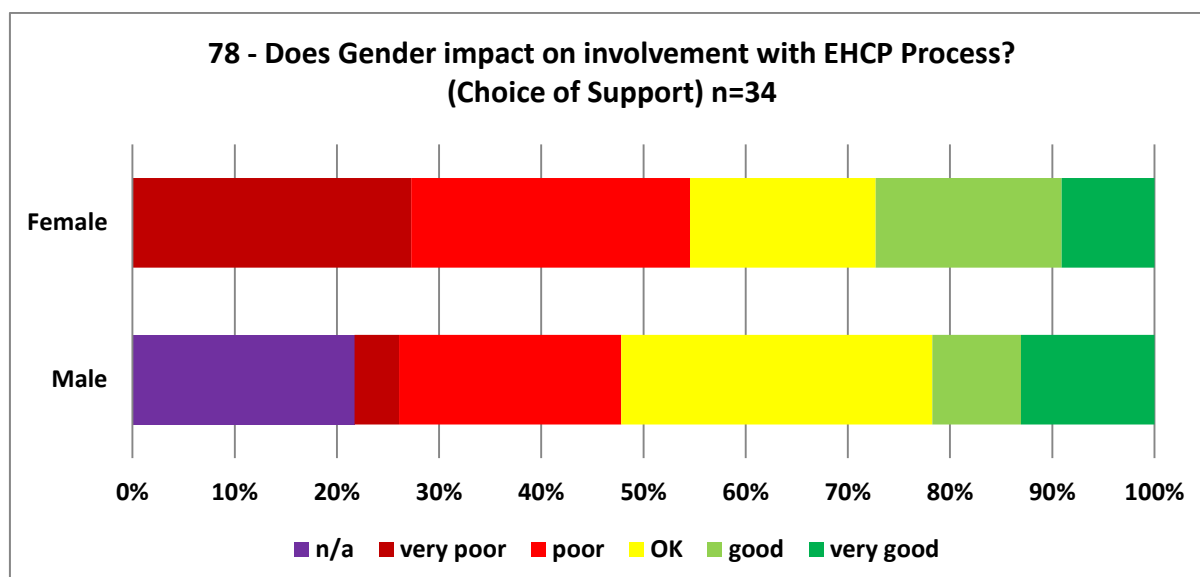
Question 1 - Does a child's gender impact on issues of involvement with EHCP processes?



In terms of the child's voice being heard we see a majority of boys reporting that they felt their voice and input was heard and taken into account. This contrasts with girls where the positive answers were less than half of the submitted answers and where we also see a higher proportion of negative answers as well. On this matter boys seem to be able to get their opinion across more easily than girls based on survey feedback and displayed in figure 76.



In the main part of the survey the question on level of support produced a very balanced set of answers. When considering level of support and the gender question we see a weak relationship between the 2 features with neither boys nor girls showing a majority for the positive view. However boys showed a higher proportion of positive answers compared to girls. Girls also reported back a higher proportion of dissatisfaction with level of support. This was a majority view for girls. Girls, therefore, are unhappier with the levels of support more often than not. This is shown in figure 77 above.



Again we see another weak relationship between gender and positive answers on the choice of support. In this instance, when examining if gender plays a role in the choice of support on offer (Figure 78) we see that girls do report a higher proportion of positive answers to this point than boys. However, more striking is the majority view of girls that their choice is poor. Girls, therefore, are unhappier with the choices on offer to them.

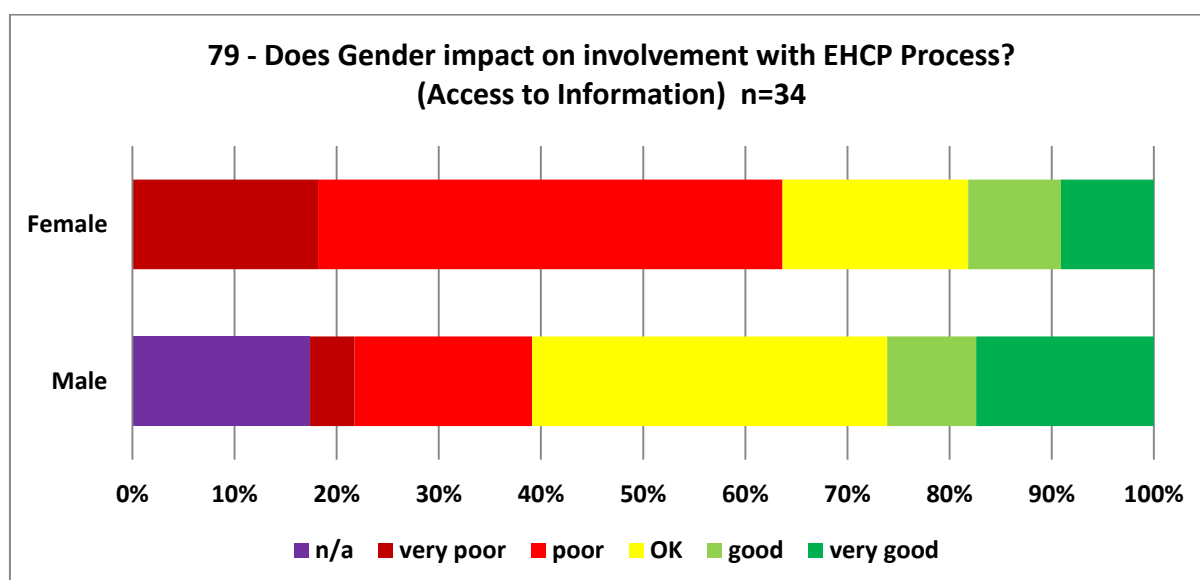
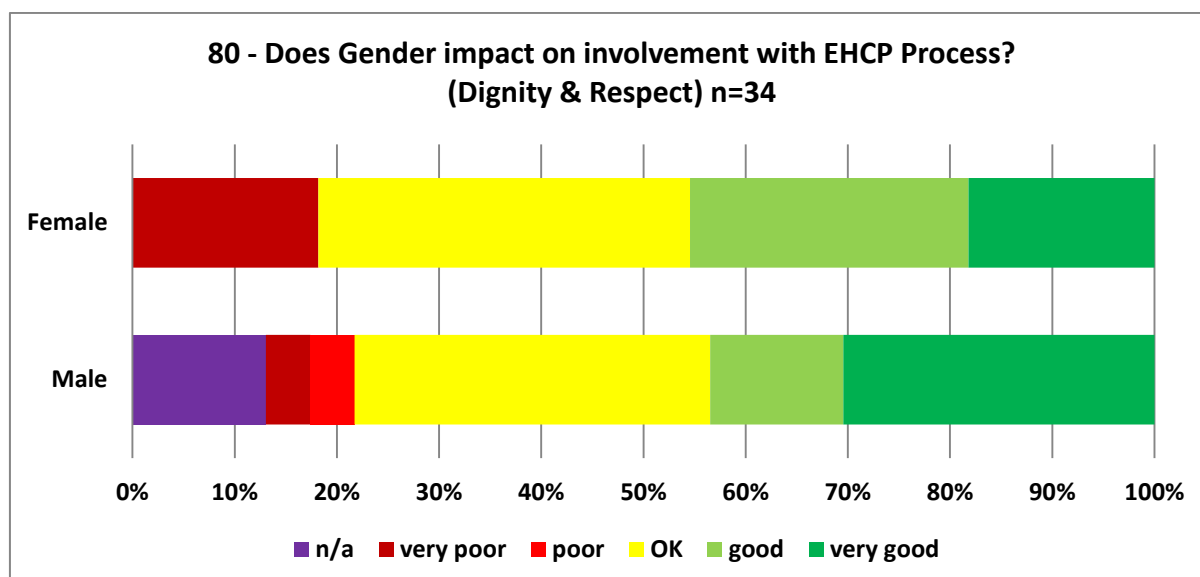
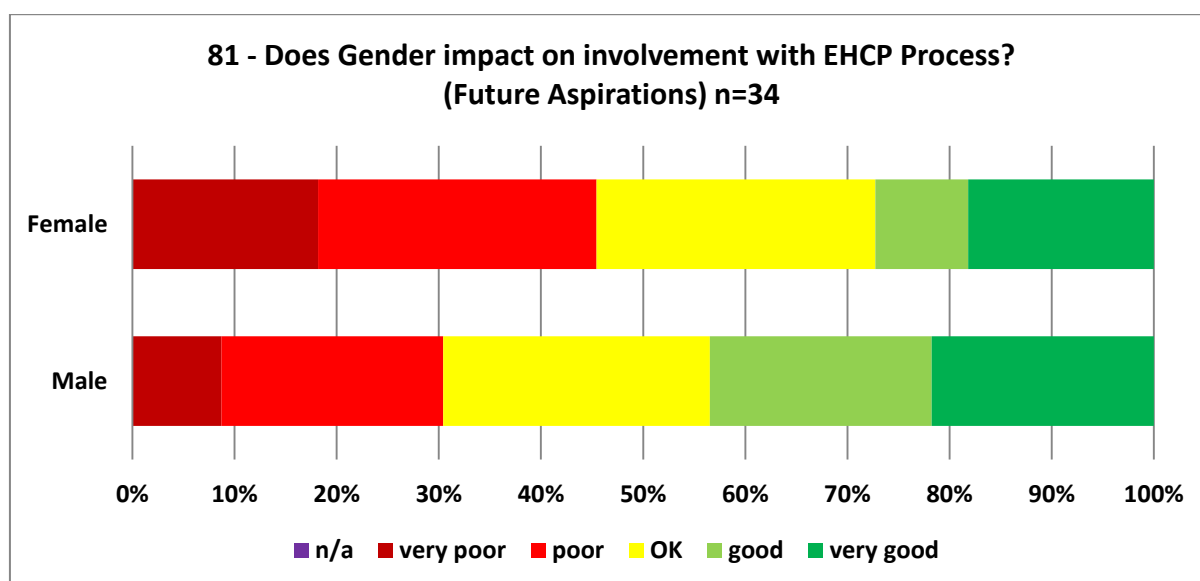


Figure 79 demonstrates another weak showing for positive answers relating to access to information and a weak relationship overall. Boys report a greater proportion of positive answers than girls although these are both low level. The most important feature here is that over 60% of girls are reporting negative views in terms of the information available to them to help decision making. Girls are, therefore, unhappiest with the information made available to them.



The relationship between gender and positive views on being treated with dignity and respect is somewhat stronger and boys and girls show similar proportions of positive views on this although the proportion of girls is slightly higher than boys. Unusually the higher proportion of the positive view from girls is balanced by a higher proportion of negative views from girls as well as a higher proportion of the strongest positive views from boys. From this mixed picture we can infer that there is more going on and that other factors may be at work in this respect.



When considering the final question about children being involved in EHCP processes and how that impacts on their future aspirations (Figure 81) we see that boys report a higher proportion of positive answers than girls. Girls also reported a higher proportion of dissatisfaction about their future aspirations than boys. However neither the boys' positive outlook nor the girls more pessimistic outlook was a majority position from this set of the results. Boys appear to be happier with their involvement to prepare for the

future with their EHCP than girls, the girls being unhappy with their ability to shape their future aspirations.

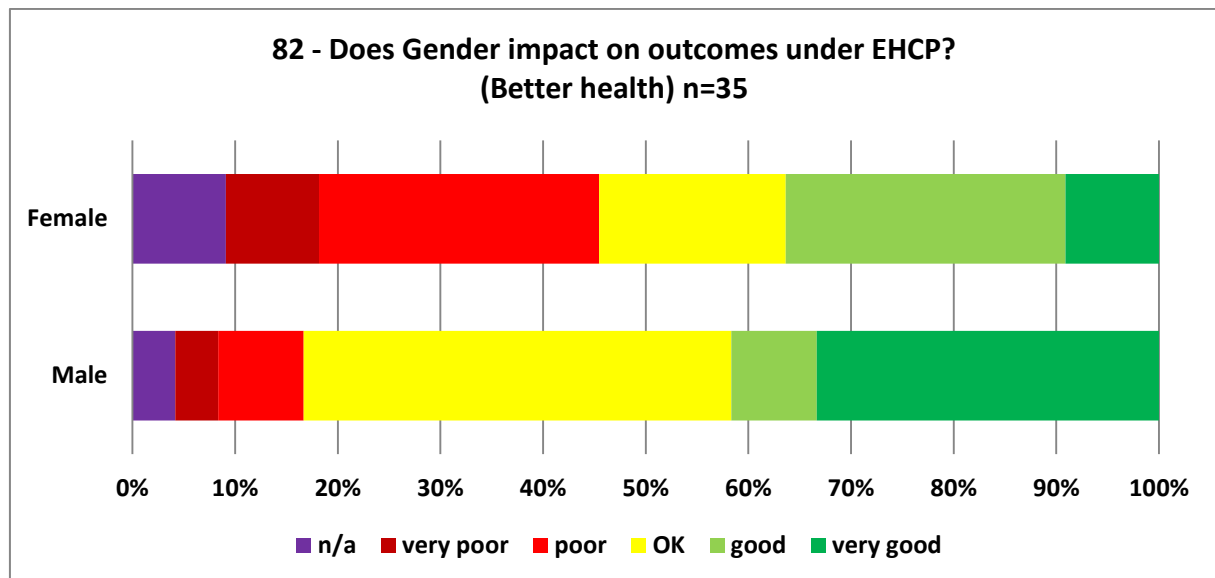
From this set of results we can see some influence that gender may have with a child's involvement with EHCP processes. Boys reported a higher proportion of positive feelings on their sense of being heard, their level of support, their access to information and their future aspirations than girls have done. Girls fared better, and reported a higher proportion of positive feelings, around their sense of the choice of their support and being treated with dignity and respect. It should be mentioned, however, that in only one instance did positive feelings form the majority opinion. This was the boys' reported sense of being heard.

Conversely we see a somewhat clearer picture when examining negative feelings. From the survey results we see that girls invariably reported a more pessimistic viewpoint than boys on each of the 6 questions with the proportion of girls reporting negative feelings always outweighing the boys' equivalent results. More striking still is the fact that from these results we see that these negative feelings being reported are the majority view for girls in terms of their level of support, their choice of support and their access to information to inform their decision making. Clearly there is something occurring within the system or the processes that is hampering children in general from feeling more positive on their involvement with EHCP processes. However it is clear to see that boys seem to be doing better than girls in getting more from their involvements with EHCP processes with the system as it currently is.

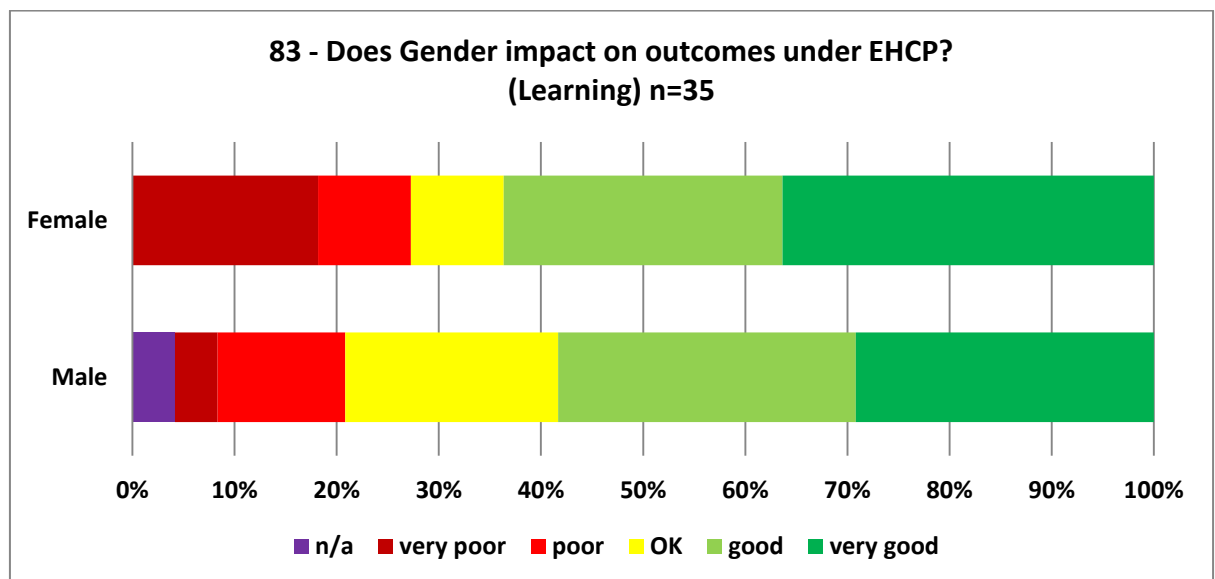
It is crucial to remember that over twice as many boys participated in this survey run compared to girls (based on those who answered that question in the survey). There is a possibility that had more girls participated the result could have been different but that can only be speculation. What we can infer from this relative imbalance in participation is that perhaps boys are involved in EHCP processes more often than girls are and that the people and professionals involved in putting EHCP together are more used to dealing with boys, therefore allowing boys to get more out of their involvements compared to girls. Certainly the sense of unhappiness evident from the input provided by girls in this survey run is indicative of some problems in the system itself, problems that are described by the stark contrast between the comparative results between boys and girls this question has thrown up.

Question 2 - Does gender have any impact on the reported outcomes under EHCP?

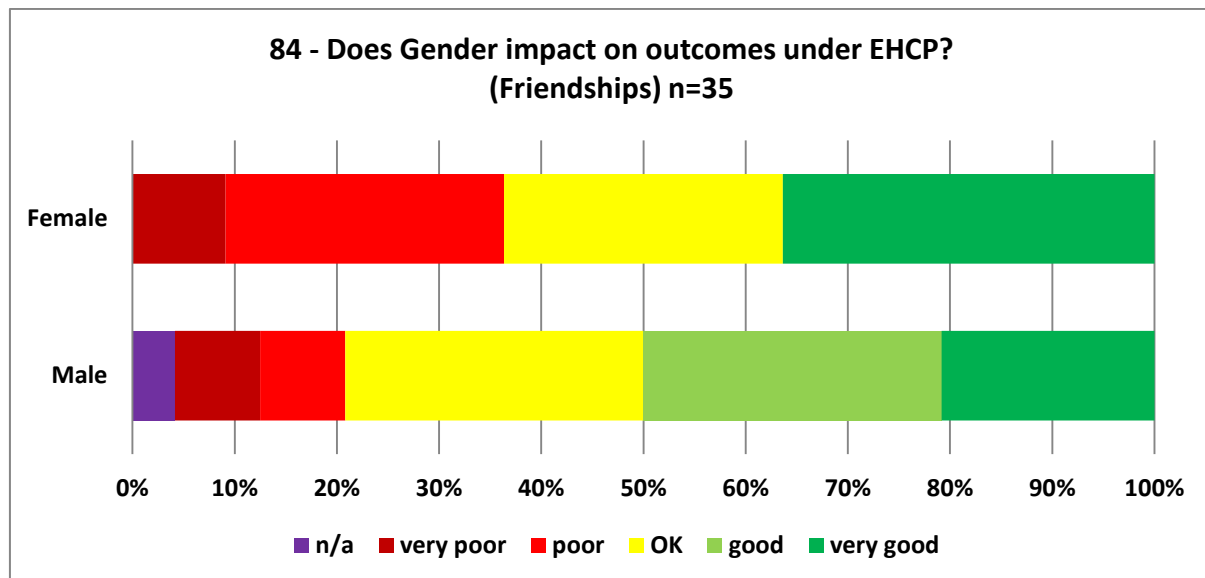
On the other side of the coin we now examine whether the outcomes that stem from the involvement already explored vary depending on the gender of the child concerned.



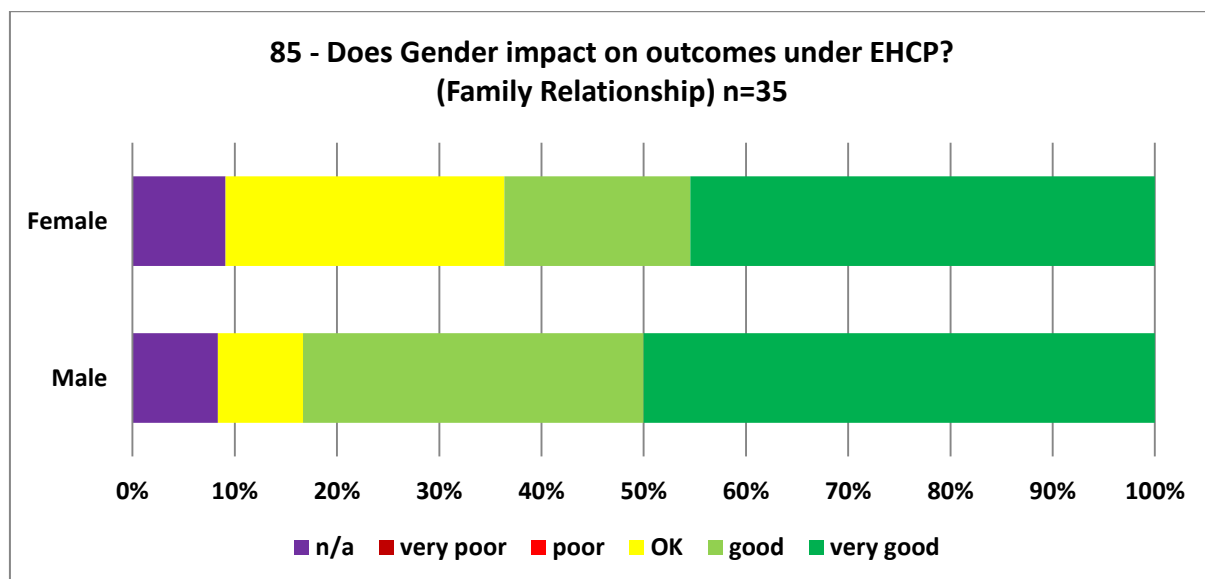
Looking at health based outcomes (Figure 82) we can see the proportion of boys reporting better outcomes is higher than the equivalent result for girls, although this is not by a wide margin. Conversely we see that girls are reporting a higher proportion of the poorer outcomes than boys by a much wider margin. In neither case did we see a majority opinion emerge however.



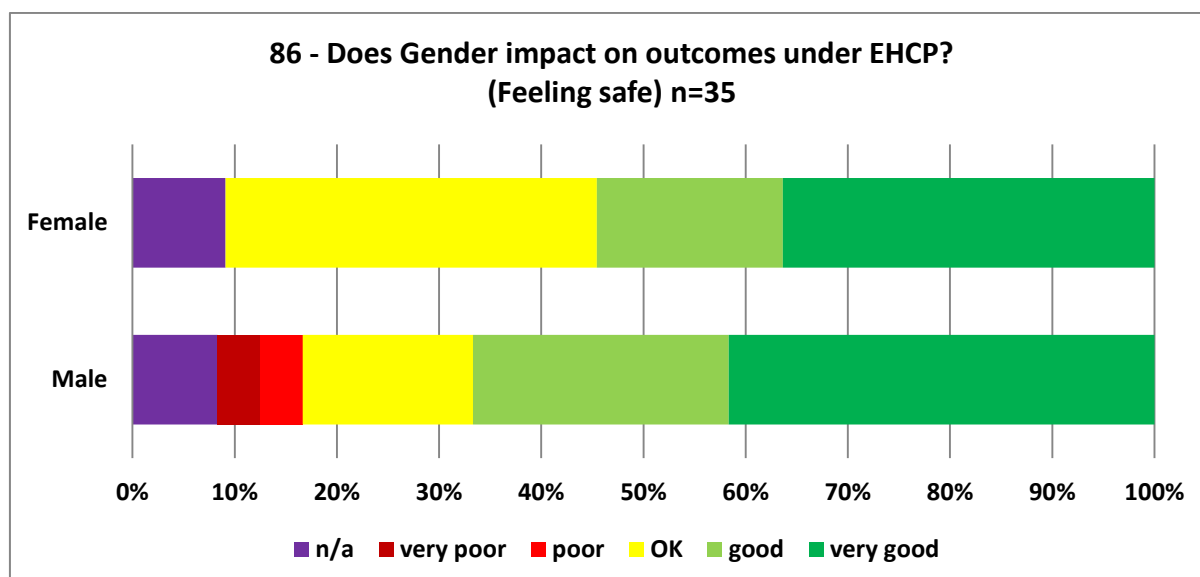
On learning outcomes (Figure 83) we see that the highest proportion of better outcomes is being reported by girls by a narrow margin compared to boys. We also see a recurrence of the theme whereby girls are also reporting a higher proportion of poorer outcomes. It is encouraging to see that the better outcomes are the majority opinion for both boys and girls.



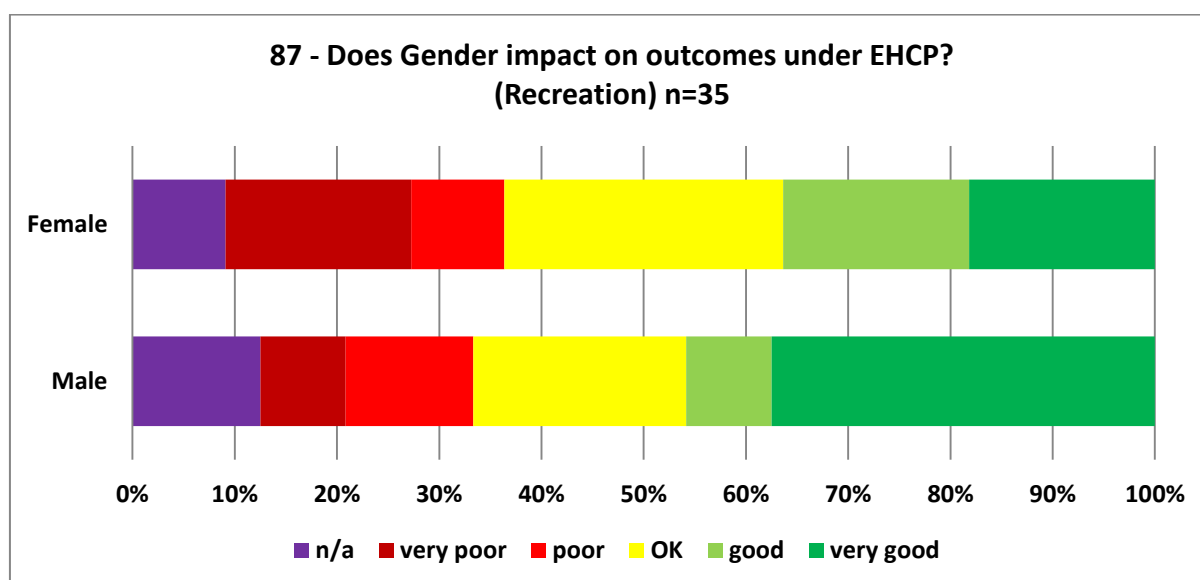
Concerning friendship outcomes (Figure 84) the largest proportion of better outcomes is reported by boys compared to girls, and by a significant margin. This is also the majority position for boys. We also see over one third of girls reporting poorer outcomes, this again being significantly higher than the proportion of poorer outcomes reported by boys.



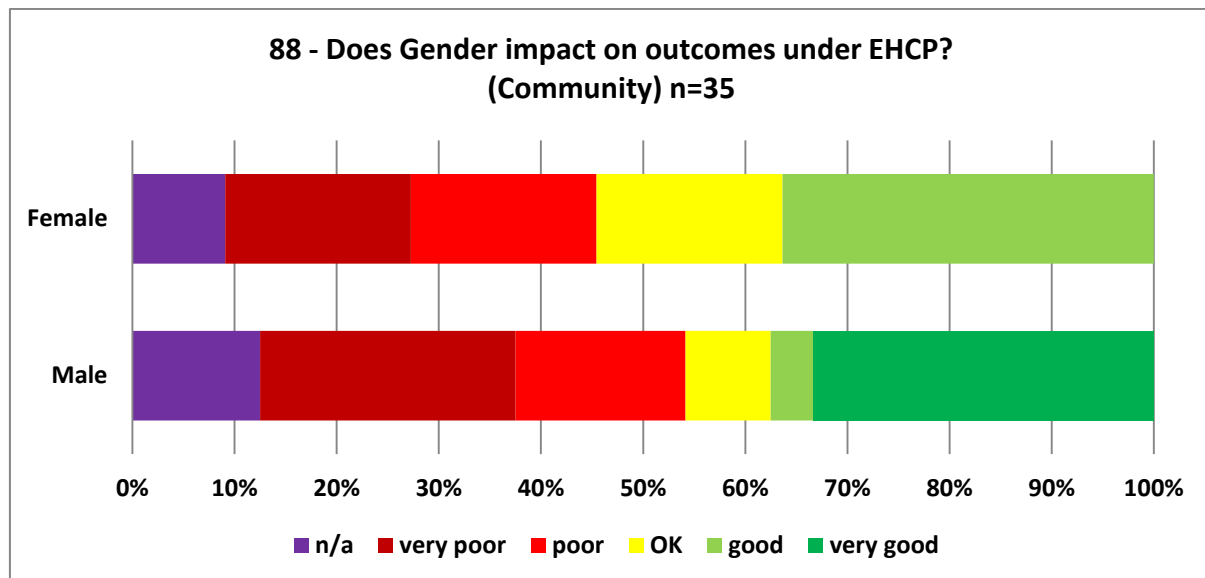
Looking at family outcomes (Figure 85) we see a very strong, positive set of results for both boys and girls. The largest proportion of positive outcomes was reported by boys by a wide margin. However girls also reported positive outcomes more often than not. This was the majority position for both boys and girls. Also of note is the absence of any reporting of poorer outcomes at all.



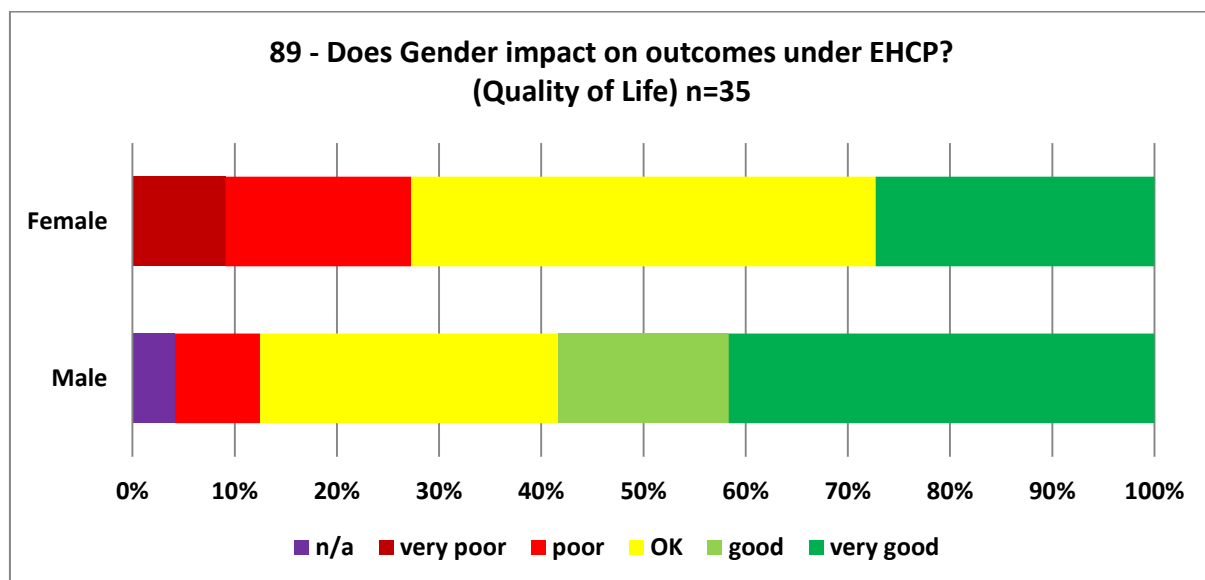
Seeing the results on safety outcomes (Figure 86) we see another strong showing from the evidence obtained from the survey for both boys and girls. The higher proportion of better outcomes was reported by boys. This was by a fair margin from the equivalent figures for girls although, for boys and girls, better outcomes were in the majority. This was also the only question where boys reported poorer outcomes and girls did not.



Concerning recreation outcomes (Figure 87) the largest proportion of better outcomes are, again, reported by boys. This proportion exceeded the girls reporting of the equivalent better outcomes by some way. Conversely we also see a return of the pattern of a higher proportion of poorer outcomes being reported by girls compared to the equivalent reporting of poorer outcomes for boys. There was no consensus position arrived at from this question as neither positive or negative outcomes were in a majority position for this issue.



On community outcomes (Figure 88) we see that the proportion of better outcomes being reported is roughly the same for boys and girls, boys perhaps reporting better outcomes more by a fairly narrow margin. Of note here is that boys were reporting a higher proportion of the best outcomes. Better outcomes were not the majority position for either boys or girls. We also saw relatively large proportions of poorer outcomes being reported for boys and girls, in this case boys being responsible for the higher proportion of poorer outcomes as well. The community question has created a number of these very mixed results sets and this set is no different.



Lastly on the quality of life outcome (Figure 89) we can see that a higher proportion of boys reported the better outcomes compared to girls. The better outcomes were also the majority position for boys. Just over a quarter of girls reported a better outcome. In common with previous questions we also see that girls reported more of the poorer outcomes than boys. On quality of life boys appear to reporting better outcomes than girls.

It would be fair to say that there are a number of distinct areas where a child's gender is playing a role in the outcomes they reported back during the course of this survey run with girls, generally, tending to come off poorly when the results are analysed. In only one area did the proportion of girls reporting better outcomes exceed that of the boys' equivalent data and this was around learning outcomes. It has long been understood that girls tend to do better in learning environments and this is, perhaps, reflected in the data received back. In all other question data sets boys were reporting better outcomes as a higher proportion of outcomes feedback than girls did. In addition boys reporting better outcomes were in the majority in several outcomes areas, namely learning (although not as strongly as girls), friendships, family, safety and their quality of life (5 outcomes). In the equivalent data for girls we saw majority positions for those reporting better outcomes in learning, family and safety based (3) outcomes only.

Shifting to the poorer outcomes we saw that girls were reporting these as a higher proportion of feedback than boys in 4 outcome areas, these being health, learning, friendships and recreation. In the equivalent boys data set we found that boys reported a higher proportion of poorer outcomes than girls in only 2 outcome areas, namely safety and community.

Fortunately the proportion of reported poorer outcomes was not the majority position for either boys or girls. However, it does seem from this data set that there appears to be a negative connection between being female and the incidence of reporting of poorer outcomes. This indicates that, in terms of achieving good outcomes, being female is perhaps something of a disadvantage and that something in the system or process is hampering girls in their pursuit of good outcomes, certainly when compared to the equivalent data for males.

This is further borne out when we look at the data in the boys and girls datasets in isolation. For boys we see, numerically, that better outcomes were reported more times than poorer ones in 6 of the 8 outcome areas. We also saw poorer outcomes were reported more often than better ones in 1 outcome area and one outcome area where poorer outcomes were absent.

For girls, we saw, numerically, that better outcomes were reported more times than poorer ones in only 2 outcome areas, 4 outcome areas where the reported frequency of better and poorer outcomes was identical and 2 further outcome areas where the reporting of poorer outcomes was absent.

Whilst there are several positives to take from the analysis of this question some work remains to try to ensure that girls get the same chances to achieve good outcomes as boys do.

Conclusions to the Parent "with EHCP" survey

Firstly there is a need to address the issue of personal budgets. A significant number of the survey questions dealt with personal budgets but the information provided by parents

was sketchy to say the least. On the numbers, personal budgets are not a significant factor for parents in EHCP matters at this time. 9 of 75 parents indicated they had a personal budget facility but only 6 of these provided any additional detail over and above this. Of these all indicated they knew who held the money but none stated how much money was involved even though 5 parents indicated they knew the figure. In terms of decision making 3 parents said they had full control of how it was spent while 1 other had partial control. 2 others indicated they had no choice in the matter at all. There were also some indications as to what areas the money was spent on.

Given this rather sparse picture it is debateable whether these arrangements that these 9 parents reported are, in fact, personal budgets at all. Considering that personal budgets are governed by some very strict criteria the fact that the survey has presented a picture of parents who have little or no background knowledge on personal budgets to share, didn't know who held the money, how much money was involved and had varying degrees of control over the money and what it was spent on lends credence to these reported personal budgets being nothing of the sort at all. Rather, as in the 2016 survey, these may be specific arrangements that this limited number of parents may have been made aware of and that have been confused with personal budgets. There is simply insufficient information from the survey to arrive at any other conclusion. For this reason personal budgets formed no part of the analysis undertaken previously in this paper. They are not a significant or compelling factor in EHCP matters at this time.

Some work was carried out to understand more about the children that the parents were reporting on. In 2016 the survey answers received showed a majority of parents feeding back that their child was in a Special Education setting. Our findings from this year are much more balanced with children from mainstream settings being represented in just over half of the survey responses, only a few less from Specialist Education settings and a small number representing Inclusion centres attached to mainstream schools. The average ages of the children parents were reporting back on was also interesting. Using mode, median or mean averages we saw the average age of these children as between 11 and 12 years old. This represents a crucial phase of a child's education and development, being as it is the transitional phase between primary and secondary education. What was striking was that there was a large age range of children being reported on. Feedback was given on children, the youngest being 3 years old and the oldest being 21 years old. Proof positive that a child does not necessarily need to have entered formal education for an EHCP to exist already or that the EHCP ceases to have relevance beyond the point where they would ordinarily have left school.

We also received good feedback about how old the EHCP were that parents were reporting back to us about. In 2016 all the feedback related to young plans less than 1 year old. However this year we saw that the majority of EHCP under scrutiny had been in operation for more than a year. This is backed up by the fact that there has been a reversal of the 2016 findings as to whether the EHCP under scrutiny was "brand new" or had been converted from an old "statement". In 2016 we saw that a quarter of EHCP were "statement" conversions, the majority being new EHCP. This was reversed in the

work of 2017 with results showing that three quarters of EHCP were conversions from old "statements" and only a quarter being brand new. This is understandable as the Local Authority are in the process of converting old "statements" into EHCP whilst also formulating new EHCP for those who have not needed support before. The 2017 figures are more representative of the process at this time but what we should see in the years to come, if this survey were rerun, would be that the number of conversions dwindles as they are completed and a much higher proportion, year on year, would be new EHCP.

Some more in-depth research was carried out concerning how some of these factors may influence outcomes, in particular whether the education setting impacts on outcomes and whether how long the EHCP has been in operation has any effect. On the influence of the education setting we saw a relationship emerge in that Specialist setting and Inclusion Centres tended to show a higher proportion of the better outcomes than mainstream schools. In no instance did mainstream schools show a higher proportion of the better outcomes than both Specialist schools and Inclusion Centres. What we did see from mainstream settings, however, was a fairly consistent level of achievement on better outcomes except, perhaps, in the community outcome. Specialist schools and Inclusion centres did get more significant incidences of achievement of better outcomes but were more inconsistent in some outcome areas with a wider variation in positive outcomes achievement.

Largely, when we interrogated the data on the influence that EHCP plan duration had on achievement of outcomes, we saw roughly what was expected in that the more established EHCP were promoting a higher incidence of better outcomes than newer EHCP less than 1 year old. However this wasn't by any significant margin with the difference being quite narrow in the main, apart from in the outcome area on friendship where older plans appeared a much more significant influence and also in the outcome area of future development where the opposite was true and the younger plans seemed to promote reporting of the better outcomes when compared to older EHCP.

On the issue of involvement in putting EHCP together we did see findings that will help inform on future developments. Although there are many individuals and professionals who, potentially, will be involved in the planning and construction phase of a child's EHCP there are some individuals/ professionals that appear more often when parents reported who took part in this work. This is very much in keeping with the survey conducted in 2016 although we had a lot more data to work with this time round. The "Big Six" comprised SENCOs, Class Teachers, Family Members, Educational Psychologists, Health Specialists and Key Workers. These individuals were reported to be most involved in EHCP processes. These individuals will, most likely, be responsible for the successful planning and construction of EHCP. It is also interesting to see that these reflect the multidisciplinary work that goes on and the necessity for an integrated approach. Education, Health, Social Care and the Family are all represented here. This all reflects that a child's interests need to be considered in the round and that no effective case can now be made for considering a facet of a child's needs in isolation. This is a clear indication that silo thinking on care and support planning and delivery needs to cease.

It is clear that the EHCP that parents have been answering this survey about are very inclusive with over 80% of parents and 50% of children being reported as having their views fully taken on board. This bespeaks an element of ownership of these plans that was evident in the 2016 survey on what was a small survey group and is continuing given the data from this survey run from a much larger group. This feature appears a constant with the EHCP approach and another encouraging result.

If we look forward to the influence of these individuals on a child's reported outcomes there is also a definable pattern that emerges. At face value this seems fairly straightforward. On the health outcome we saw the key influence on the health specialist on the better outcomes. Similar positive patterns emerged with Education and Social Care professionals in the outcomes most pertinent to their activities. The interesting finding from this work was that as well as being a key positive influence on Educational outcomes, the Education professionals also seemed to have a positive influence on outcomes outside the school/ classroom environment in widely disparate outcome areas like friendships, family life and activities. Their positive influence appeared to radiate well beyond the classroom and into a child's everyday home and social life as well. We did not see this as much from the Health Specialist, the Key Worker or the family member. Indeed the family member involvement threw up the biggest anomaly as, from the reported results we saw family member as only the 5th strongest influence on family based outcomes with all the educational professionals and the Health Specialist appearing to have a stronger influence on family based outcomes.

When the support itself was investigated in the survey parents appeared to be presenting a very positive view. We saw strong results for parents feeling able to contribute and influence the support their child receives and how they are viewing their child's support as a significant factor in their child's life. The results reflect a consensus view that parents are, in the main, valuing this support highly which is, perhaps, inevitable as we have seen from other results that both parents and children are contributing to EHCP and so are taking ownership. This feature, more than any other, will help with acceptance of the EHCP by the child and his/ her parent and will also encourage achievement against the EHCP as well which will allow children to reach their outcome goals and full potential.

Regarding these child outcome goals we see a very positive picture being painted by the parent respondents to the survey. Of the seven child outcomes themes that were explored in the survey all but one showed a majority position for children achieving the better outcomes. This one was about being part of the local community. It is not surprising that this may be so. Community is a somewhat hazy concept to answer questions about and there are, inevitably, going to be parents thinking about the relevance of community to their child. Whilst not an exact correlation it was interesting to see that 13 parents reported poorer outcomes on community involvement while also reporting that there were 13 children aged 5 years old and younger in the same data set. Age is, seemingly, a factor in achieving against community outcomes in that in order to do so there has to be an appreciation of what community means and this may only be arrived at once a child has grown up a little and thought about it and is able to be active in the community in

their own right and appreciate what is there. This positive slant on the survey results is very much in keeping with what we found in the 2016 survey, more encouraging still is the fact that such a positive view of children's outcomes achievement was replicated with a survey group 6 times the size of the 2016 pool.

This outcomes picture is not complete, however, as the survey also asks parents to rate how they have fared in achieving outcomes for themselves. What we saw from the parent feedback to the survey was another reinforcement of the 2016 survey. Parents are reporting positive outcomes for themselves against outcomes about their quality of life and the relationships they have with their child and their child's support team. This reporting of better outcomes was the majority position for parents across all three outcome themes here. It is another clear indication that EHCP have positive repercussions outside the school/ learning environment, radiate back into the family home and affect more individuals than just the child alone. EHCP may be focussed on the child in question but the child is not the only person who benefits.

We also explored in more detail whether these parental outcomes were influenced by the parent's gender. What we found was that there did appear to be some considerable difference between men achieving positive parental outcomes and women doing so. Of key significance was that women were reporting much higher proportions of better parental outcomes than men for quality of life and better relationships with their child's support team. The findings also pointed to women achieving higher proportions of better outcomes than men in terms of the relationship they had with their child although the margin was much narrower. Women, therefore, appear to be getting more from involvement in the EHCP process as a parent than men are doing. It is unclear as to whether this is a feature of the women themselves who answered this question or if something in the system is causing this effect.

A new feature of the survey that is, somewhat, a cause for concern is the local offer. As mentioned before this is information about services available to meet the needs of children with SEND. A good local offer empowers parents and helps them get what their children need in ways they may not have thought of or been offered before. When interrogated on their use of the local offer it was concerning that only 43% of parents had used the local offer. This could, potentially, be a problem as either we, as a local authority, are not doing enough to promote knowledge of the local offer or, conversely parents know about the local offer but disregard what is there as they feel it does not meet the needs of their children or their informational needs as parents looking out for their children. While more publicity around the local offer would offer some value it is unlikely that the information in the local offer is not useful as we clearly saw that for those parents who did avail themselves of the information on offer, over two thirds found it useful. In effect 68% of parents using the local offer found what they were looking for which is, by any stretch, a fairly decent endorsement.

Lastly we wanted to determine various facets of the parents who participated in the survey. Most striking was the gender question. In the 2016 survey we had a small pool

of parents who participated, all of whom were women. While not spectacular numerically we did have some participation from men this time so we were able to get the voice of fathers, albeit a small number of them. 8 men participated for definite out of the 61 parents who answered the gender question and this could, potentially, be more considering a further 14 parents participated who did not answer on this matter.

Also we investigated the age of the parent participants. Whilst the results from this section were broadly expected (the majority of parents being aged between 35 and 54 years old) we also saw smaller numbers aged between 25 and 34 as well as aged between 55 and 64. What was absent from the survey pool was the voice of parents who are either at/ approaching/ beyond retirement age or parents who are, themselves, defined as young people. Had there been some representation of these age categories it may have been of some value to examine if age is a factor in achieving parental outcomes, whether the particular attributes of/ challenges faced by these age groups help or hinder the achievement of good outcomes. Sadly this was not possible.

While much of the focus has been on the challenges Children with SEND face (and the reasoning behind EHCP) it is also fair to say that parents are not immune to having challenges of their own. 6.6% of our survey pool of parents (4 from 60 individuals) indicated they had a disability of their own as defined under the relevant legislation. This was actually a drop from the proportion in the 2016 survey where 17% of parents (2 from 12 individuals) indicated they had a disability. The 2017 figure is closely in keeping with the disability figure for Hampshire from the 2011 population census where a rate of 6.7% for significant disability as defined under the relevant legislation was reported. The Portsmouth equivalent figure was not available. This means that the numbers of participants reporting they had a disability was representative of the regional population as a whole.

This theme of representation is mirrored when we examined the ethnicity of the survey participants. The 2016 survey provided a survey pool that was exclusively of White-British ethnicity. However, as has been mentioned earlier in this report, we have had survey input from other ethnicities in 2017. While the White-British ethnicity is still the largest contributing group to the survey this year we have seen that, with those voices not previously represented, the ethnicity figures are broadly in keeping with the population of Portsmouth as a whole.

While not an exact match there was a high degree of correlation between the survey groups' demographic profile and that of the City of Portsmouth/ Hampshire locality which allows us to have faith in the data we received as being representative of our city's population in general.

Conclusions to the Children's "with EHCP" survey

The survey returns from the children's group indicate that the care and support planning and delivery are focussed on features that are not immediately evident. While a significantly large majority of children's responses indicate that they have an EHCP the

clarity on matters of additional support in place is less clear cut. On matters around personal budgets, additional support at home, school or while out & about we see a much lower incidence of the "yes" answer. Therefore the provision of the additional support an EHCP offers is centred on the intangibles and this, largely, takes place behind the scenes given the low levels of additional paid support, especially outside the classroom.

When considering their support, children appear to have a less optimistic viewpoint than their parents do as to their personal involvement in EHCP processes. The collected data from the survey indicates there are areas where positive views prevail such as being heard and being treated with dignity and respect. What became clear, as the patterns emerged from the data, was that in matters concerning the level of support, choice of support, information and future aspirations positive views were not in the majority. This indicates there is some work to be done on identifying why children are feeling this way and, in so doing, tackling the barriers that are preventing more children feeling positive about such matters around involvement in their EHCP.

This was reflected in the more in-depth work carried out around whether a child's gender was having any influence on matters of involvement. We saw that there was very little consensus on this question. In only one aspect of this did we see a majority position emerge for positive views from the data, this being about boys being having their views listened to. Boys, collectively, tended to get more from their involvement than girls judging by the incidence of positive answers. Worryingly we saw that when we looked at negative views on involvement girls were more likely to feel this way. In three areas of involvement (namely level of support, choice of support and access to information) girls reporting negative views were in the majority and so appeared, generally, to be getting less from involvement in the EHCP process.

In examining outcomes as reported by the children participating in this year's survey we are seeing the same sort of pattern emerging as we saw when children were rating how they had found their involvements. Again we saw a more pessimistic appraisal given by children than by the parents in the equivalent questions in the parent survey. In simple terms there were only 3 of the 8 outcome themes that produced a majority of children who were reporting better outcomes, these being learning, home & family life and safety. In other outcome themes we see that although there is no clear majority emerging there is a higher incidence of better outcomes than poorer ones. This was so for health, friendships, activities and quality of life. Lastly we saw one outcome area, that of community, where poorer outcomes outweighed the better ones. The positive to take from this very mixed picture is that children reporting poorer outcomes were never in the majority across the 8 outcome themes. Taken together, this is a significant change from the 2016 survey where the participants were much more optimistic about their outcomes. While we have no reason to consider the survey returns for last year's work invalid we do have to conclude that, for children at any rate, the 2016 survey was largely unrepresentative based as it was on returns from 7 children as opposed to the 44 returns we gained this year.

This mixed view is further demonstrated when we did some more in-depth work as to whether there is any connection between gender and the outcomes achieved. We saw a general theme emerge where girls were reporting achieving a lower proportion of better outcomes than boys across many outcome themes. We also saw a much higher reporting of poorer outcomes from girls as a proportion of the results tendered leading to an impression of a sense of dissatisfaction given that we have already seen that girls were also unhappy with how they rated their involvement in EHCP. While the survey does not provide any facility for us to interrogate why girls appear to be getting less from the EHCP process compared to the boys who participated the fact remains that girls, comparatively, don't seem to be doing quite so well in either involvement or outcomes as matters currently stand and this does need to be addressed.

Some caution needs to be taken with these findings. Certainly we saw this in the 2016 children's survey where of the 7 participants none had completed the survey on their own and so we saw a replication of parent data by other means. This year's survey is by no means perfect in this sense but it is undeniable that it contains a much stronger voice from the children concerned. Nearly a quarter of children completed this survey for themselves and a further 29% had someone help them answer. This leaves 47% of the survey returns where a parent has completed on behalf of a child. While there is value in this data nonetheless it would be improbable to suggest a parent could complete a survey form absolutely as their child would have done if left to their own devices. That parental input in children's survey runs exists is inevitable given that the children have widely varying needs and challenges and may not, for instance, be able to complete the form on their own in all cases. We also have to assume that parents will not enter answers that are patently not true or submit answers that are not reflective of their child's views on the subject matter the survey raises. It is unavoidable to have parental input here but there is no other way to approach this that would get us anywhere near the quantity of data we needed to conduct a thorough analysis.

Finally, in a more limited way, we wanted to discover something about the children whose contributions enabled this analysis and report to be carried out. In terms of average age we saw a very similar answer emerge as we found with the parental survey. The mode, median and mean averages all fell between 11 and 12 years old showing, once again, that crucial transition period between primary and secondary education. Over two thirds of the child contributions to this survey came from boys and when we examined the reasons why these children needed support we saw similar patterning to the spread of reasons (to those given in the parental survey) with some understandable differences that are largely due to the ages of the children involved and, perhaps, some differences of perception or knowledge.

Overall conclusion for both surveys

Drawing all these separate threads together we see that the sample group that contributed to the surveys is broadly representative of the local population as a whole both in terms of ethnicity and of the reporting of disability.

We see some similarities with the survey group of 2016 in that there is still a lack of information parents are conveying on the financial side of matters (hence the absence of any analysis on personal budgets, this not being possible with the sketchy data available from the survey) and that support is targeted at less concrete features of care and support planning and delivery given the relatively low levels of individuals indicating they are able to access additional paid help/ support.

There is a very generally positive outlook on show on features of involvement and outcomes. It appears, at face value, that EHCP are fulfilling their purpose and that parents and children are satisfied with them and the circumstances they are trying to create more times than not.

Where we see the most interesting findings from this year's survey is in the differences that have emerged. From the data we can see that parents are feeling much more optimistic than their children. Parents appear happier with matters around their own involvement in planning and process matters and are reporting more positive child outcomes than was indicated when looking at the children's survey returns. Parental outcomes were also very encouraging.

We have seen that there are some influences at work that were not considered in 2016. We have seen that the education setting can have an influence on some outcomes, as can some of the individuals involved in the process. We have also seen that how long an EHCP has been operational for can also have some influence on the achievement of outcomes, an analysis not possible last year as no surveys were returned that related to an EHCP over 1 year old.

What has been most surprising is that there are differences emerging through gender that were not apparent in 2016. Parents generally reported good outcomes for themselves but upon closer examination we saw that mothers were achieving better parental outcomes than fathers, with the caveat that only a small number of fathers participated. In the children's survey boys appeared to be doing a lot better than girls under the EHCP system as it currently stands with a higher incidence of positive views and better outcomes. Counter to this we saw a pessimistic view expressed by girls taking part in the survey relating dissatisfaction with their involvements and outcomes.

Interesting findings emerged from the new feature of the survey about the local offer. Less than half of parents were using the local offer indicating issues around knowledge of/ access to the local offer or issues around the contents. However a different picture comes to light for those that did use it where we saw a majority finding what they were looking for.

While it is difficult to compare survey returns where the difference in participation is so stark (19 total in 2016 compared to 119 in 2017) we have seen some improvements, some deteriorations (particularly in children's outcomes/ involvement reporting) and some new factors emerging. While in some particular areas the picture painted is very mixed, overall the message has to be positive.

However this does need to be tempered with an appreciation that some work needs to be done to resolve problems we have seen emerge from the survey work, analysis and the conclusions that have been drawn here. This informs the following recommendations.

Recommendations

- More emphasis on the child's voice and getting child's views in EHCP
- More needs to be done on getting children involved in their local communities
- Increase the knowledge/ visibility of the local offer
- Schools need to improve their linkages to their local communities
- Some work is needed to help fathers get more from being involved with EHCP
- More Personal Budgets need to be launched as a feature of EHCP
- More transparency around the care/ support/ funding process from LA needed
- Necessary changes need to take place more quickly
- Professionals need to listen to parents and children more
- Parents and children need access to more/ better information
- Some help is needed to help girls get the most out of their involvement in the EHCP processes
- Some investigation may be needed to see why girls appear to do less well in their outcomes

Appendix A - Examination of parental opinion from the "without EHCP" surveying running parallel to the POET "with EHCP" surveys.

Originally, there was an intention to conduct a full analysis of parent and children's responses to an additional set of surveys based upon the POET© framework but reconfigured for parents and children where an EHCP is not a factor. These surveys can be seen in *Appendix C*.

What was hoped was to capture the views of parents and children for whom some form of support was being provided around their education but who had not reached the threshold where the formulation of an EHCP becomes necessary. This was important as

this potential pool of survey recipients would be much larger than the pool of parents and children for whom EHCP are an active feature of their lives.

However, it became evident at the end of July 2017 when the online survey portals closed that there would be insufficient feedback from parents and children to do this full analysis. It was disappointing as only 9 parents had tendered feedback to this reworked survey and, more disappointingly still, only 4 children.

Discussions were had with colleagues as to how to proceed given this response level. It was felt that we didn't want to lose the input we had gained from this limited number of responses and so dropping all aspects of this phase of the work was ruled out as an answer. It was suggested that instead of a quantitative assessment of the aggregated answers provided (that underpinned the "with EHCP" surveys and which wasn't enough for the "without EHCP" surveys) we could undertake a more qualitative piece of work teasing out the themes that parents had communicated to us in the three questions set out in the "without EHCP" survey and that are listed below.

- Would you make any specific changes to the way Education, Health and Care plans work in your area?
- In relation to services to support children and young people with special educational needs and disabilities in the area, what do you think is working well, or improving?
- And still in relation to services to support children and young people with special educational needs or disabilities in the area, what do you think is working less well, and could be improved?

The following short piece of work is intended to fulfil this brief.

Question 1 - Would you make any specific changes to the way Education, Health and Care plans work in your area?

What became clear from examining the feedback to this question was that it was largely negative in nature. Responses to this question from the 9 parents involved indicated that they all, to a greater or lesser degree, felt that their child should be receiving more support than was actually being provided at the time they completed the survey. There was a sense that each of the parents who submitted feedback may have "an axe to grind". However some positive actions can still flow from such feedback simply by viewing it in a different light. In looking at the combined feedback to this question several actions are indicated that, if implemented, could vastly improve matters for parents and children alike who don't currently benefit from an EHCP. To paraphrase the feedback the following points emerged.

- A need to work harder to meet statutory duties where this is not currently happening
- Go further than current practice indicates by giving all children with SEND an EHCP rather than constrain the numbers by some arbitrary threshold
- Work with the schools to foster conditions where the schools are more supportive of the children who face SEND challenges and their parents
- Take action to shorten the process needed to initiate EHCP proceedings as the time lag is, in some cases jeopardising appropriate school placements
- Increase the reporting and assessment of children who show difficulties that are potentially caused by SEND challenges so that the solutions are arrived at more rapidly
- Increase service provision to the north of the city

Clearly, from this feedback, we can see that the status quo situation for children without an EHCP (but who have some SEND issues) is challenged at all stages. From this we can deduce that parents want to be more involved in helping to identify the problems their children are having, want a system that intervenes sooner and more comprehensively than may currently be the case, want to extend the EHCP system to more children, want processes that move more rapidly and efficiently so they can forward plan better themselves instead of reacting to crises and want a system that supports them through their challenges at all stages wherever they happen to live in the city.

The logical consequence of taking such actions is that a system emerges where interventions happen sooner, more rapidly and the thrust of activity is not reacting to situations approaching or in crisis but taking on a more preventative role that may actually benefit all parties concerned, not just the parents and children and doesn't involve a postcode lottery. Clearly not all of this will be possible within current resource constraints but progress towards any of these goals will benefit the whole system if implemented.

Question 2 - In relation to services to support children and young people with special educational needs and disabilities in the area, what do you think is working well, or improving?

With the feedback provided in the survey used to inform this piece of work it was difficult to elicit, from the parent's responses, anything that could be construed as positive.

As the parent's that participated all had very particular issues a sense of unhappiness with the status quo emerged. However, some positives did emerge from the feedback that provides us, as a local authority, with a foundation on which to build future successes. The positives elicited from feedback were as follows.

- Service provision in the Central and Southern parts of the city is good as many of the facilities and manpower are concentrated in these areas
- The role of Portsmouth Parent Voice (PPV) is very much appreciated, giving parents independent, practical advice and guidance in navigating situations and processes

- The role of Child/ Adolescent Mental Health Services (CAMHS), especially in the diagnostic phase of work, was acknowledged
- The provision of specialised knowledge and training courses (specifically the example of the Autism course was cited) was valued

From these foundations it could be possible to improve matters on these issues still further. There was an indication that the northern part of the city was not as well served by services as the central and southern zones. Widening the geographical reach of services would address these concerns. The role of PPV is much appreciated. Strengthening and deepening the relationship with this organisation will only pay more dividends. While CAMHS input was welcomed in the diagnostic phase it may engender further improvements if the support they provide is not withdrawn immediately that diagnosis occurs, as was indicated by feedback received. Lastly the specialised courses helping parents to understand and respond to the challenges faced by their children were also valued. If a broader range of courses was offered it may help many problems be identified earlier and remedial action to take place sooner and by those who know the child best, their parents.

The consequences of building upon our successes are apparent. We get a system that works for all, irrespective of where in the city they live. We have an organisation dedicated to helping parents make the best out of what can seem daunting and difficult situations and that have the expertise to make the process work for parents. A crucial stumbling block between identifying problems and the necessary actions to confront and overcome them could be removed if CAMHS assistance was carried on a little further and education for parents in dealing with their children's challenges would create a smoother working system that had a more preventative role.

Question 3 - And still in relation to services to support children and young people with special educational needs or disabilities in the area, what do you think is working less well, and could be improved?

When dealing with limited feedback a section such as this, about the current shortcomings of the system, could turn into a rehash of the first question concerning where improvements need to be made. However on examining what parents were saying it is clear that there are several areas where their unhappiness is most concentrated and which would benefit from investigation. These areas are listed below.

- A failure to meet statutory duties
- CAMHS support is felt to be currently insufficient to meet the needs of children with SEND challenges beyond diagnosis
- Reported problems with the ability of services and teams to identify Autistic Spectrum Disorders
- Communication by services with parents and also between authorities is below what is needed

- Individualised support for each child is not being given (where with an EHCP such individualised support is taken as a given)

Statutory duties cover a whole range of issues. It is not clear from the feedback what the precise nature of the problem is. For example failure to do something the statute book says we should is a worse scenario than doing something we should but missing a timescale because of resource issues or extenuating circumstances. The fact that CAMHS are involved is appreciated but the extent of their involvement has been called into question. There is a long standing problem around many matters surrounding Autistic Spectrum Disorders, particularly as they are not easy to diagnose and require a significant number of professionals to work together over a prolonged period of time to arrive at diagnosis and because of the potentially challenging behaviour that children with these disorders may display. Communication appears to be a perennial issue especially where multi-disciplinary teams and a number of professionals need to be involved. It seems that professionals are still not talking enough between themselves and with parents who may feel isolated and disengaged with the processes they may be involved with. Lastly it is difficult for parents to accept that support that may benefit their child as an individual is not provided, especially when they see that other children (with EHCP) do get that individualised support and all the benefits that stem from it.

It is likely these are individual problems reported by parents and as such do not point to major systemic issues requiring root and branch surgery to cure. However, perception is crucial as not dealing with these issues reduces the bond of trust between parents, children and the systems in place to support them and no-one benefits from this.

Appendix B - POET survey forms underpinning the with EHCP survey



Survey for parents of children and young people who have an Education Health and Care Plan.

A survey about you, your child,
and the support they get.



Who is the survey for?

It's for all children and young people who have an Education Health and Care Plan.
(also known as an EHC Plan).

What's an Education Health and Care Plan?

It's the plan that describes what is important to a child or young person, their needs
and says what support they should get.

Who's asking?

The survey is being carried out by a charity called 'In Control' and is in part funded by
the Department for Education.

Why do you want to know?

We want to know how the process of getting an Education Health and Care plan
worked for you and what difference it has made to your child, so we can help improve
things for others who need support.

Who will read my answers?

Your Local Authority, school or health service may get a copy of your answers but
they will not know who wrote them. We will also read your answers. People who read
your answers will not know who wrote them. We may also make the answers
available through a public archive.

What are you going to do with my answers?

We will use them to help improve the way Education Health and Care plans work where you live and across the country. The answers will also be used to write reports that will be made public.

Do I have to answer the questions on my own?

No; you can ask someone you trust to help you complete the survey.

Do I have to answer the questions?

No; If you do not want to take part then that is absolutely fine. You can also choose to answer some or all of the questions. If you do answer them we will only use them in the way we have described.

About your child

1. **Name of your Local Authority.**

2. **Name of the school or college your child attends:**

3. **Type of school/college:** ☐ Mainstream ☐ Special Education

4. **Child's Age :**

5. What is the main reason your child needs additional support?

- | | | | |
|--|--------------------------|--|--------------------------|
| Communication and interaction | <input type="checkbox"/> | Learning disability (Cognition and learning) | <input type="checkbox"/> |
| Social, emotional (behaviour that challenges services) | <input type="checkbox"/> | Physical disability | <input type="checkbox"/> |
| Sensory (hearing/sight) | <input type="checkbox"/> | | |

6. Does your child have? (tick all that apply)

	Yes	No	Don't know
An Education Health and Care plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paid support at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paid support at school/college	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paid support to go out and about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A personal budget (money allocated by the local authority that you can use for support)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. How long has your child had an Education Health and Care plan?

Less than a year ☐ Between a year and 3 years ☐ N/A ☐

8. Did your child have a statement (or learning disability assessment) that was converted to an Education Health Care plan?

Yes ☐ No ☐

About your child's Education Health and Care plan.**9. Who was actively involved in developing the Education Health and Care plan? (tick all that apply)**

Class teacher	<input type="checkbox"/>	Classroom assistant	<input type="checkbox"/>
SENCO	<input type="checkbox"/>	Education specialist (educational psychologist)	<input type="checkbox"/>
Social worker	<input type="checkbox"/>	Health specialist (nurse, occupational or speech and language therapist)	<input type="checkbox"/>
Key worker	<input type="checkbox"/>	Planning co-ordinator	<input type="checkbox"/>
Voluntary organisation	<input type="checkbox"/>	Support worker	<input type="checkbox"/>
Family member	<input type="checkbox"/>	Other	<input type="text"/>

10. Were your views included in your child's Education Health and Care plan?

Yes, fully ☐ Partially ☐ No ☐ Not applicable ☐

11. Were the views of your child included in their Education Health and Care plan?

Yes, fully ☐ Partially ☐ No ☐ Not appropriate ☐

About your child's personal budget

If you do not have a personal budget GO TO question 16

12. How is the personal budget held?

- You hold the money ☐
- A friend or family member holds the money ☐
- A local family / parent led organisation holds the money ☐
- A service provider holds the money ☐
- The Local Authority/school holds the money ☐
- I do not know ☐

13. Do you know the amount of money allocated to the personal budget?

Yes ☐ No ☐

Annual payment ☐ One off payment ☐ Both ☐

Amount per year: _____

14. Could you decide how the money in your personal budget was spent?

Yes, fully ☐ Partially ☐ No ☐

15. How have you used the personal budget? (Tick all that apply)

Community based social activities:

Local sports leisure facilities, clubs and youth groups

☐

After school clubs:

Including play schemes and holiday club.

☐

Break from caring:

Support that enables the family carer to have a rest or do other things than care

☐

Personal assistant:

1-1 support from a paid carer

☐

<p>Family time: Spending time together as a family</p>	<p><input type="checkbox"/> Specialist service: Groups, activities, therapies or services specifically for children who are disabled.</p>	<p><input type="checkbox"/></p>
<p>Equipment: Such as specialist sensory communication or clothing, aids and adaptations</p>	<p><input type="checkbox"/> Transport:</p>	<p><input type="checkbox"/></p>
<p>Other: <input style="width: 630px; height: 20px;" type="text"/></p>		

About your child's support

16. Over the past year, what do you think about these areas of your child's support?

	Very poor	Poor	Fair	Good	Very good	N/A
Choice about support :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I could change the support my child gets if I need to.						
Amount of support:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child has the right amount of support.						
Quality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child is supported as an individual with dignity and respect.						

Outcomes for your child

17. Over the past year, how well has the support your child gets helped them with the following areas of their life?

	Very poor	Poor	Fair	Good	Very good	N/A
Being as fit and healthy as they can be:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking part in school and learning :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being part of their local community :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Enjoying friendships :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enjoying relationships with family :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of life : Being relaxed and happy taking part in activities they like :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing for the future :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Outcomes for you

18. Over the past year, has the support your child gets made a difference to these areas of your life?						
	Makes things a lot worse	Makes things worse	No difference	Makes things better	Makes things a lot better	Don't know
Your quality of life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The relationship you have with people who are paid to be involved in the support of your child.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The relationship you enjoy with your child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thinking about your experience of Education Health and Care plans:

What worked well?

What didn't work well?

Would you make any specific changes to the way Education Health and Care plans work in your area?

Thank you for answering these questions. Unfortunately we are unable to respond to individual issues, if you would like to raise an issue that requires action please do so with the person or organisation who gave you this questionnaire

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Equalities Monitoring

The next questions are to help us see if Education Health and Care plans and personal budgets are working for different groups of people, these questions are about you not your child

You can skip any of the questions you do not want to answer.

1. Are you:

A man ☐

A woman ☐

2. How old are you?

16 to 24 years old ☐ 25 to 34 years old ☐

35 to 44 years old ☐ 45 to 54 years old ☐

55 to 64 years old ☐ Older than 65 years old ☐

A law called the Disability Discrimination Act says that you are disabled if:

- It is very hard for you to do normal everyday things
- You have found these things hard for at least 1 year

3. Do you have a disability that affects you like this?

Yes ☐

No ☐

4. Please tell us about any disabilities you have:

If your disability is not in the list please choose 'other'.

Physical Disability	<input type="checkbox"/>	Learning disability	<input type="checkbox"/>
Sensory impairment (sight / hearing)	<input type="checkbox"/>	Long standing illness or health condition	<input type="checkbox"/>
Mental health condition	<input type="checkbox"/>	Other	<input type="checkbox"/>

Other (tell us if you want to)

5. Are you?

White	Any White background		<input type="checkbox"/>
Mixed	White and black Caribbean	<input type="checkbox"/>	White and black African
		<input type="checkbox"/>	White and Asian
Asian or Asian British	Indian	<input type="checkbox"/>	Pakistani
		<input type="checkbox"/>	Bangladeshi
	Any other Asian background		<input type="checkbox"/>
Black or Black British	Caribbean	<input type="checkbox"/>	African
		<input type="checkbox"/>	Any other Black background
Chinese or other ethnic group	Chinese	<input type="checkbox"/>	Other
		<input type="checkbox"/>	
	Prefer not to say		<input type="checkbox"/>

6. What is your religion?

No religion ☐

Christian ☐

Buddhist ☐

Hindu ☐

Catholic ☐

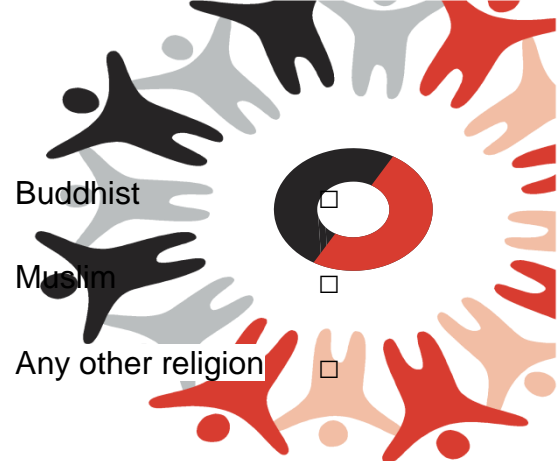
Muslim ☐

Sikh ☐

Jewish ☐

Any other religion ☐

Prefer not to say ☐



7. Are you?

Heterosexual/Straight ☐ Gay or Lesbian ☐ Bisexual ☐

Other ☐ Do not want to say ☐



Survey for children and young people who have an Education Health and Care Plan, their life and the support they get.

How's life?

A survey about you, your life and the support you get

Who is the survey for?

It's for all Children and Young People who have an Education Health and Care Plan (also known as an EHC plan).

What's an Education Health and Care Plan?

It's the plan that describes what is important to a child or young person, their needs and says what support they should get.

Who's asking?

The survey is being carried out by a charity called 'In Control' and is in part funded by the Department for Education.

Why do you want to know?

We want to know how helpful your support is to you, so we can help improve things for others who need support.

Who will read my answers?

Your Local Authority, school or health service may get a copy of your answers but they will not know who wrote them. We will also read your answers. People who read your answers will not know who wrote them. We may also make the answers available through a public archive.

What are you going to do with my answers?

We will use them to help improve the way Education Health and Care plans work where you live and across the country. The answers will also be used to write reports that will be made public.

Do I have to answer the questions on my own?

No; you can ask someone you trust to help you complete the survey.




Do I have to answer the questions?

No; If you do not want to take part then that is absolutely fine. You can also choose to






answer some or all of the questions. If you do answer them we will only use them in the way we have described.

If you are under the age of 16 you must have agreement from your parent or guardian to complete this questionnaire

About your support

1. Do you have?	Yes 	No 	Don't know 
An Education Health and Care plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A personal budget (money that you or your parent can use for your support)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paid support at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paid support at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paid support to go out and about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>







2. Over the past year, what do you think about these areas of your support?

	Very poor 	Poor 	OK 	Good 	Very good 	N/A
Being heard: My views are included in my plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of support: I get the right amount of support.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Choice about your support: I can change my support if I need to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Information: I have information to make decisions about my support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dignity: I am supported with dignity and respect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking forward to the future: The support I get helps me grow and be ready for life when I'm older	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

About your life

3. Over the past year, how well has your support helped you with the following areas of your life?

	Very poor 	Poor 	OK 	Good 	Very good 	Don't know 
Your Health: I am as healthy as I can be.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning: I do the best I can at school, college or work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friendships: I enjoy time with friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your Home: I enjoy my home and family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling safe: I feel safe at home and out and about.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation: I take part in activities I like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community: I can do things in my local area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your quality of life:

I can enjoy being relaxed and happy

☐ ☐ ☐ ☐ ☐ ☐

4. Did you have help to complete this questionnaire?

No, I answered it on my own

☐

Yes, someone helped me answer

☐

Yes, someone else answered them on my behalf

☐

About you

5. How old are you?

6. Are you Male or Female? Male ☐ Female ☐

7. What is the main reason you need support? Please select one from the list

Learning disability

☐

Communication and interaction

☐

Sensory (hearing, sight)

☐

Physical disability

☐

Social, mental and emotional health (behaviour that challenges services)

☐

Other

☐

Don't know

☐

Thank you for answering these questions.

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Appendix C -Survey forms underpinning the "without EHCP" surveys

Questions for SEND questionnaire (without EHCP/ statement of special educational need)

About Your Child

1. Type of school or college your child attends
 - a. Mainstream school or college
 - b. Inclusion centre attached to a mainstream school or college
 - c. Special school or college
2. Child's age
3. What is the main reason your child needs additional support?
 - a. Communication and interaction (e.g. speech and language difficulty, autism)
 - b. Social, emotional or mental health (including behaviour that challenges services)
 - c. Learning difficulty/disability
 - d. Sensory impairment(hearing/sight)
 - e. Physical disability
4. Does your child have:
 - a. A statement of special educational need/ Education, Health and Care Plan
 - b. Additional/paid support at home
 - c. Additional/paid support at school/college
 - d. Additional/paid support to go out and about
 - e. A personal budget (money allocated by the local authority that you can use for support)
 - f. Any other form of support (please specify)
5. If no, who is actively involved in providing services or support for your child? (tick all that apply)
 - a. Class teacher
 - b. Social Worker

- c. Key Worker
- d. Voluntary Organisation
- e. Family Member
- f. Classroom Assistant
- g. Educational psychologist
- h. Health specialist (nurse, occupational or speech and language therapist)
- i. Support worker
- j. Other (please specify)

6. Do you feel your views are reflected in the support or services provided to your child?
- a. Yes, fully
 - b. Partially
 - c. No
 - d. Not applicable

7. Do you feel the views of your child are reflected in the support or services provided?
- a. Yes, fully
 - b. Partially
 - c. No
 - d. Not appropriate

ABOUT THE LOCAL AREA

8. Would you make any specific changes to the way Education, Health and Care plans work in your area? (text)
9. Have you used the Local Offer to find out about services available to support you, your child or family?
- a. Yes
 - b. No
10. If yes, did you find what you were looking for?
- a. Yes
 - b. No
11. In relation to services to support children and young people with special educational needs and disabilities in the area, what do you think is working well, or improving?
12. And still in relation to services to support children and young people with special educational needs or disabilities in the area, what do you think is working less well, and could be improved?

ADD EQUALITIES MONITORING

Questions for SEND questionnaire (children and young people without EHCP)

About You

1. Do you have
 - a. a statement of special educational need/ Education, Health and Care Plan (yes/no/don't know)
 - b. support for a special educational need or disability (yes/no/don't know)
2. Do you feel your views are reflected in the support or services provided to you?

	Very poor	poor	ok	good	Very good	N/A
Being heard: my views are included in my plan						
Level of support: I get the right amount of support						
Choice about your support: I can change my support if I need to						
Information: I have information to make decisions about my support						
Dignity: I am supported with dignity and respect						
Looking forward to the future: The support I get						

helps me grow and be ready for life when I'm older						
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ABOUT YOUR LIFE

3. Over the past year, how well has your support helped you with the following areas of your life?

	Very poor	poor	ok	good	Very good	Don't know
Your health: I am as healthy as I can be						
Learning: I do the best I can at school, college or work						
Friendship: I enjoy time with friends						
Your home: I enjoy my home and family						
Feeling safe: I feel safe at home and out and about						
Recreation: I take part in activities I like						
Community: I can do things in my local area						
Your quality of life: I can enjoy being relaxed and happy						

4. Did you have help to complete this questionnaire?
 - a. No, I answered it on my own?
 - b. Yes, someone helped me answer
 - c. Yes, someone else answered on my behalf

ABOUT YOU

5. How old are you?
6. Are you male or female?
 - a. Male
 - b. Female
7. What is the main reason you need support?
 - a. Communication and interaction (e.g. speech and language difficulty, Autism)
 - b. Social, emotional or mental health (including behaviour that challenges services)
 - c. Learning difficulty/disability
 - d. Sensory impairment (hearing/sight)
 - e. Physical disability
 - f. Other

ADD EQUALITIES MONITORING

Special Educational Needs and Disabilities (SEND)

Joint Commissioning Plan

Delivery Plan Only

April 2017

Version 3



Delivery Plan Only

The SEND Joint Commissioning Plan has been agreed by the SEND Board.

This Version contains ONLY the Delivery Plan (Section D) and is used by the SEND Commissioning Steering Group to monitor progress across the wide range of Commissioning Projects and Programmes in place.

D1. Cognition and learning

Our Ambition:

- To enable children with cognition and learning difficulties to be educated mainstream settings wherever possible, ensuring that Special Schools are focussed on those with the most complex needs.
- To enable children with complex cognition and learning difficulties to be educated within the city wherever possible
- To ensure multi-disciplinary support is in place to support the successful inclusion of children in mainstream education.

SEND Strategy Link:

Strand A: Promote good inclusive practice to improve outcomes

Strand C: Effective joint commissioning to improve outcomes

Commissioning Project/Programme	Leads	Completion By	Key Milestones	Progress
1.1 Cliffdale and Redwood Park special schools to be re-designated and remodelled to enable them to effectively educate children with complex learning difficulties and autism. To ensure all parents are engaged and communicated to about the changes.	Julia Katherine (PCC)	Sept 2018	1. Redesignation of Redwood Park - complete 2. Admission criteria and banding description updated - Apr 17 - Underway 3. Redesignation of Cliffdale - July 17 - Underway	Green
1.2 To ensure the SLA and service spec for the outreach offer provided by Special Schools to support mainstream schools to meet the needs of those with cognition and learning needs.	Julia Katherine (PCC)	Sept 2017	1. Current outreach offer presented to PEP Inclusion Group 2. Feedback from schools 3. Revised service specification - Sep 17	Green

D2. Communication and interaction (including speech, language and communication needs and autism)

Our Ambition:

- To enable children with communication and interaction needs to be educated in Portsmouth and in mainstream settings, wherever possible
- To ensure multi-disciplinary support is in place to support the inclusion of children in mainstream education
- To ensure speech and language services and pathway meets statutory requirements and supports the inclusion agenda
- To ensure autism pathway meets statutory requirements, supports the inclusion agenda and enables young people with autism to make a successful transition to adulthood

SEND Strategy Link:

Strand A: Promote good inclusive practice to improve outcomes

Strand C: Effective joint commissioning to improve outcomes

Commissioning Project/Programme	Lead	Completion By	Key Milestones	Progress
2.1. A new 6-place Inclusion Centre (additionally resourced provision) to be opened at Trafalgar School in September 2016 for 11-16 year olds with an EHC plan for communication and interaction difficulties, specialising in autism spectrum conditions.	Julia Katherine (PCC)	Sept 2016	COMPLETE	COMPLETE
2.2. A new 9-place Inclusion Centre (additionally resourced provision) to be opened at Devonshire Infant School in September 2017 for 4-7 year olds with an EHC plan for communication and interaction difficulties, specialising in speech, language and communication needs.	Julia Katherine (PCC)	Sept 2017	1. Updated admission criteria - Mar 17 2. Special ISP meeting to be held to allocate places - Apr 17 3. Placements begin - Sep 17	Green

2.3 A new 9-place Inclusion Centre (additionally resourced provision) to be opened at Portsdown Primary School in September 2017 for 4-11 year olds with an EHC plan for communication and interaction difficulties, specialising in speech, language and communication needs.	Julia Katherine (PCC)	Sept 2017	<ol style="list-style-type: none"> 1. Updated admission criteria - Mar 17 2. Special ISP meeting to be held to allocate places - Apr 17 3. Placements begin - Sep 17 	Green
2.4 Joint review of the health and education offer and outcomes for the children in each of the five Inclusion Centres to ensure it is meeting the needs and statutory requirements.	Lois Pendlebury (Solent NHS) Julia Katherine (PCC)		<ol style="list-style-type: none"> 1. Joint visits to schools by education and Solent - Summer term 2. Clear description of current health offer and gaps - May 2017 3. Proposal to SEND Commissioning Steering Group - May 2017 	Green
2.5 Complete an Autism Strategy and revised autism pathway for young people age 0 - 25	TBC	Dec 2017	Meeting on 17 th May to discuss	Red
2.6 To review the impact of the Autism Co-ordinator role	Andrea Havey (CCG)	July 2017	<ol style="list-style-type: none"> 1. Report from Solent NHS Trust to be submitted to ICS by beginning August 2017 2. Evaluate pilot project with Solent NHS Trust and present a business case to CSC if additional funding required to 	Green

			continue Autism Navigator post.	
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D3. Sensory and physical

Our Ambition:

- To enable children with sensory and physical needs to be educated wherever possible in mainstream settings.
- To ensure multi-disciplinary support is in place to support the inclusion of children in mainstream education
- To ensure there are minimal waiting times for key pieces of equipment

SEND Strategy Link:

Strand A: Promote good inclusive practice to improve outcomes

Strand C: Effective joint commissioning to improve outcomes

Commissioning Project/Programme	Lead	Completion By	Key Milestones	Progress
3.1 To review the primary Inclusion Centre (additionally resourced provision) for sensory impairment at Northern Parade Infant and Junior Schools.	Julia Katherine (PCC)	Sept 2017	1. Formal review - Mar 17 2. Changes made to Service Level Agreement 3. Implementation against new SLA - Sep 17	Green
3.2 To develop a secondary Inclusion Centre (additionally resourced provision) for sensory impairment at St Edmunds Catholic School.	Julia Katherine (PCC)	Sept 2016	COMPLETE	COMPLETE
3.3 Joint review of the health and education offer and outcomes for the children in each of the two Inclusion Centres to ensure it is meeting needs and statutory requirements	Julia Katherine (PCC) Lois Pendlebury (Solent NHS)		1. Joint visits to schools by education and Solent - Summer term 2. Clear description of current health offer and gaps - May 2017	Green

			3. Proposal to SEND Commissioning Steering Group - May 2017	
3.4 To evaluate the wheelchair provider to ensure minimal waiting times for receipt of wheelchairs	Andrea Havey (CCG)		<ol style="list-style-type: none"> 1. Performance report to SEND Steering Group - complete 2. Updated performance report to SEND Commissioning Group - Jan 17 - Complete 3. Agreed joint approach with Hampshire Commissioner to address performance - May 17 	Amber

D4. Social emotional and mental health (SEMH)

Fully aligned with Future in Mind Transformation Plan

Our Ambition:

- To establish a clearly understood needs-led model of support for children and young people with SEMH difficulties across the city that makes the best use of the resources available
- For all professionals working with children and young people to have a shared understanding of SEMH and to promote resilience and emotional wellbeing in their work with children and young people
- To ensure there is a range preventative and early help support available to children and young people to prevent SEMH difficulties escalating
- To jointly commission a clear pathway of support (including prevention, early help and intensive therapeutic intervention) and provision for SEMH which ensures that difficulties are picked up and addressed at the earliest opportunity and that those with more complex needs can access the specialist support available.

SEND Strategy Link:

Strand A: Promote good inclusive practice to improve outcomes

Strand C: Effective joint commissioning to improve outcomes

Strand E: Early intervention for children with SEND and their families

Commissioning Project/Programme	Leads	Completion By	Key Milestones	Progress
4.1 To complete a CAMHS Needs Assessment	Andrea Havey (CCG)	Jan 2017	1. Draft to FiM Steering Group - Complete 2. Recommendations discussed at SEND Commissioning Group - Jan 17 - Delayed	Red
4.2 To review and remodel the SEMH educational provision delivered by The Harbour School to	Julia Katherine (PCC)	Sept 2017	1. Secure additional strategic support from Delta Education Trust - Complete	Green

commission distinct pathways for Alternative Provision (AP) and Special Educational Needs (SEN) provision.			<ul style="list-style-type: none"> 2. Revised Service Level Agreement for Harbour - Mar 17 3. Revised provision in place - Sep 17 	
4.3 Develop a single CAMHS Specification - reviewing the service in the context of inclusion, the needs of children in the Harbour school and Multi-Agency Teams including restorative practice	Andrea Havey (CCG)		<ul style="list-style-type: none"> 1. Xxx 2. Xxx 3. Xxx 4. Xxx 	Red
4.4 To commission an Early Help (pre-CAMHS) community based service that supports early intervention and prevention for children and young people between 11 - 25 years of age and their families. Ensure appropriate pathways into CAMHS provision for children and young people with mental health needs.	Andrea Havey (CCG)	Mar 2017	<ul style="list-style-type: none"> 1. Procurement exercise - Complete 2. Mobilisation plan for new provider - Complete 3. Referral pathway and assessment process in place - Underway 	COMPLETE
4.5 To develop a strategy that will lead to effective whole school approaches in supporting pupils social, emotional and mental health wellbeing across Portsmouth schools.	Sarah Christopher (FiM/School)	Feb 2017	<ul style="list-style-type: none"> 1. Draft Strategy - Complete 2. Final published strategy - Underway 3. Revised governance arrangements for implementation linked to Stronger Futures and PEP Inclusion Group - Underway 4. Delivery Plan in Place - Underway 	Green

4.6 To enhance the Eating Disorder service locally to ensure children and young people get expert help early and are treated with effective evidence based treatment.	Andrea Havey (CCG)		COMPLETE	COMPLETE
4.7 Portsmouth CAMHS joined up with a Children and Young People IAPT collaborative in 2017 which will improve collaborative practice between therapists, children, young people and their families.	Andrea Havey (CCG)	April 2018	<ol style="list-style-type: none"> 1. Identify key staff to take part in the programme - Apr 17 2. CYP IAPT Steering Group to be set up to drive the implementation of programme - Aug 17 3. CAMHS staff to attend Leadership, Supervision and CBT courses - Nov 2017 	Green
4.8 To review the self-harm pathway from hospital into the acute and community services with the aim of developing an integrated paediatric mental health liaison service.	Andrea Havey (CCG)		<ol style="list-style-type: none"> 1. Working Group set up - Complete 2. Decision-making tool developed 3. Self-harm training delivered - Complete 	Green
4.9 To enhance the crisis care offer in CAMHS through the recruitment of a Crisis Care post that will assess, treat and risk manage young people	Andrea Havey (CCG)		COMPLETE	COMPLETE
4.10 To enhance the YOT CAMHS Provision	Andrea Havey (CCG)		COMPLETE	COMPLETE
4.11 To develop low-cost responses to child anxiety	Sarah Christopher Sonia King (Solent)		<ol style="list-style-type: none"> 1. Xxx 2. Xxx 3. Xxx 4. Xxx 	Red

4.12 To develop the response to primary age children with mental health concerns			<ol style="list-style-type: none"> 1. Xxx 2. Xxx 3. Xxx 4. Xxx 	Red
4.13 Update SEMH Ordinarily Available Provision	Sarah Christopher and PEP Inclusion Group Sub Group	Sept 2017	<ol style="list-style-type: none"> 1. Draw together working group - underway 2. Agree scope 3. Return to Steering Group in July 17 for consideration on links to MATs provision 	Green
4.14 To roll-out Restorative Practice in 10 - 15 'trailblazer' schools	Hayden Ginns (PCC)	Sept 2017	<ol style="list-style-type: none"> 4. Identify trailblazer schools - Complete 5. Deliver training to school-based Restorative Champion - Sept 2017 - Underway 6. Create schools network - Underway 7. School level Action Plan in each school - Oct 2017 8. Publish first evaluation - Jan 2018 	Green

D5. Pre-birth to 5: SEND provision for pre-school children

SEND Strategy Link:

Strand A: Promote good inclusive practice to improve outcomes

Strand C: Effective joint commissioning to improve outcomes

Our Ambition:

- To enable pre-school children with SEND to access mainstream pre-school settings wherever possible
- To ensure multi-disciplinary support is in place to support the inclusion of children in mainstream early education settings

Commissioning Project/Programme	Lead	Completion By	Key Milestones	Progress
5.1 To review and remodel the pre-school SEN education and childcare provision to ensure that children can be supported within their mainstream pre-school and childcare setting wherever possible.	Julia Katherine (PCC)	Sept 2018	1. To secure external consultant resource to develop a range of models - Complete 2. Project scope discussed at SEND Commissioning Group - Complete 3. Consultation with parents - Summer Term 4. Formal consultation on preferred model - Autumn Term 5. Lead member decision - Nov 2017	Green
5.2 To develop the Single Point of Access (including multi-disciplinary assessment) for health and developmental assessment and align with the statutory Education Health and Care Plan process.	Lois Pendlebury (Solent NHS)		1. Mapping key pathways e.g. Autism, 0-5s etc - July 2017	Green

	Julia Katherine (PCC)		2. To develop standard operating procedures for internal health referrals - Sept 2017 3. Co-location of Falcon House and Battenburg Ave - 2018 4. Consideration of establishment of SEND/High Needs hub across health, and education - 2018	
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D6. Transition into adulthood

Our Ambition:

- To ensure young people with SEND have successful transitions into adulthood (link to PfA outcomes)
- To enable post-16 education settings to be fully inclusive
- To increase the numbers of 16-25 year olds with SEND in education, employment or training

SEND Strategy Link:

Strand A: Promote good inclusive practice to improve outcomes

Strand F: Effective preparation for adulthood and smooth transitions to adult services

Commissioning Project/Programme	Lead	Completion By	Key Milestones	Progress
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6.1 To review the transition arrangements from CAMHS services to adulthood in the context of revised CAMHS offer 0 - 25	Andrea Havey (CCG)		<ol style="list-style-type: none"> 1. Xxx 2. Xxx 3. Xxx 4. Xxx 	Red
6.2 Ensure robust post-16 education provision is in place for young people with SEND	Amanda Percy (PCC)		<ol style="list-style-type: none"> 1. Curriculum Mapped and gaps in provision is identified. Consultation to secure required provision. 2. Development of Supported Internships Programme 3. Support post-16 providers to develop transition support both into and from post-16 education and training. 4. Monitor participation and put in place effective support for those young people at risk of not progressing or who are NEET. 	Green
6.3 Deliver the PFA Outcomes Plan	Mark Stables (PCC)		<ol style="list-style-type: none"> 1. PFA Outcomes plan completed - Green <p>Most recent plan indicates number of Reds and Ambers but progress is being made</p>	Amber

D7. Parent and families support

Our Ambition:

- To ensure the parents and carers of children with SEND are provided with appropriate advice, information and support
- To locally embed the ambitions of Future in Mind transformation programme in responding to infant mental health
- To ensure Local Offer website is widely used as the single point of information for parents and carers of children with SEND

SEND Strategy Link:

Strand E: Early intervention for children with SEND and their families

Commissioning Project/Programme	Lead	Completion By	Key Milestones	Progress
7.1 To commission an early intervention service for women with mild to moderate mental health issues in the perinatal period.	Andrea Havey (CCG)		COMPLETE	COMPLETE
7.2 To enhance the Infant Mental Health provision locally to support parents in the family home to focus on the attachment relationship with their babies aged 0 -2 years.	Andrea Havey (CCG)		COMPLETE	COMPLETE
7.3 To develop a community based specialist perinatal mental health team in Portsmouth for women experiencing severe and complex mental health issues during the perinatal period.	Andrea Havey (CCG)		COMPLETE	COMPLETE

7.4 Revised Parenting Pathway (linked to Stronger Futures Strategy and incorporating restorative practice)	Hayden Ginns (PCC)		<ol style="list-style-type: none"> 1. Multi-agency Mini-Team set up - complete 2. Underpinning model of practice agreed - Feb 17 3. Revised Pathway consulted upon and published - Apr 17 4. Training in place for professionals - May 17 	Green
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D8. Personal budgets

Our Ambition:

- To enable as many families as possible to make use of personal budgets, in line with the national ambitions of the SEND reforms

SEND Strategy Link:

Strand B: Successful implementation of the SEND reforms

Commissioning Project/Programme	Lead	Completion By	Key Milestones	Progress
8.1 Pilot of the new Personal Health Budget methodology with a small number of Children with SEND to inform a wider rollout at a later stage if successful.	Jo Atkinson (ICU) Jo York (CCG)		<ol style="list-style-type: none"> 1. Pilot with a small number of children - In process 2. Learning report completed - Delayed 3. Roll-out plan for personal budgets 	Amber

D9. Decision-making for high cost placements

Our Ambition:

- To ensure that children who require high-needs placements are effectively identified and good multi-agency decision-making on placement, funding and reviews are in place.

SEND Strategy Link:

Strand B: Successful implementation of the SEND reforms

Commissioning Project/Programme	Lead	Completion By	Key Milestones	Progress
9.1 Review of High Needs Panel	Julia Katherine (PCC) Andrea Havey (CCG)		1. Revised Terms of Reference - complete 2. Referral form updated - complete 3. Implementation - underway	Green
9.2 Analysis of current out of city placement cohort	Julia Katherine (PCC) Hayden Ginns	Sep 2017	1. Scope of analysis completed - July 2017 2. Commissioning implications discussed at SEND Commissioning Group - Oct 2017	Green

SEND REFORMS IMPLEMENTATION PLAN (April 2016 – March 2018)

How effectively do we identify disabled children and young people and those who have special educational needs in Portsmouth


1. Early intervention/SEN Support (success criteria)

- a) There is a shared understanding of 'ordinarily available provision'
- b) There is a shared understanding of the threshold for requesting an education health and care needs assessment
- c) Children and young people receiving SEN Support make good progress, including at points of transition
- d) Children and young people with SEND from vulnerable groups make good progress

Objectives	Expected impact – how will this improve outcomes?	Actions	Lead officer	By When	Evidence	Evaluation (updated quarterly)
1 a) There is a shared understanding of 'ordinarily available provision'	A shared understanding across schools colleges, early years setting, parents and young people of what constitutes 'ordinarily available provision' to ensure consistency in meeting children and young people's needs.	Review and update the 'Ordinarily Available Provision' documents in partnership with schools and other providers. Publish and publicise summary version on Local Offer Website	Sarah Christopher	Jan 2018	Add link to document published on the local offer website www.portsmouthlocaloffer.org	
1 b) There is a shared understanding of the threshold for requesting an education health and care needs assessment	Professionals are able to make consistent judgements about whether to request an education health and care needs assessment or when needs can be met within available resources.	Guidance documents are updated in partnership with SENCos and other professionals. Documents are published and publicised on the local offer.	Karen Spencer	Jan 2018	Add link to document published on the local offer website www.portsmouthlocaloffer.org	
1 c) Children and young people receiving SEN Support make good progress, including at points of transition	Children and young people will make good progress, when	SEN Support Task and Finish Group to develop an offer of support to schools to develop their	Sarah Christopher	March 2018	Add link to published offer of support on PEP	

	compared to the same group nationally.	practice in relation to pupils on SEN Support.			website when available	
1d) Children with SEN from vulnerable groups make good educational progress	<p>The educational progress of children with SEN from the following vulnerable groups is monitored:</p> <ul style="list-style-type: none"> • Looked after children/care leavers • CIN/CPP • Educated out of area • EHE • Medical Tuition • Children of Service Personnel <p>Children known to YOT</p>	<p>Support is put in place to enable children and young people to make progress.</p> <p>An annual report is presented to Director of Children, Families and Education management team meeting and PCSB.</p>	<p>Julia Katherine/ Debbie Price</p>	Dec 2017	Annual report presented to Director of Children, Families and Education management team meeting and PCSB.	
Position statement	<p>This is an area where further development is needed. Children and young people in Portsmouth do not make sufficient progress compared to the same group nationally. There is a lack of consistency in the identification of those requiring SEN Support and those for whom an EHC needs assessment is required. There is further work to do to strengthen the early intervention for children with SEND with the early help work of the newly formed Prevention and Early Help service.</p>					


<p>How effectively do we meet the needs and improve the outcomes of disabled children and young people and those who have special educational needs in Portsmouth?</p>	
<p>2. Quality and timeliness of EHCPs (success criteria)</p> <p>a) Professional education, health and care advice is provided within statutory timescales and is of good quality</p> <p>b) EHC needs assessments are co-ordinated and completed within statutory timescales</p> <p>c) EHCPs are of good quality</p>	

Objectives	Expected impact – how will this improve outcomes?	Actions	Lead officer	By When	Evidence	Evaluation (updated quarterly)
2 a) Professional education, health and care advice is provided within statutory timescales and is of good quality	Professionals provide reports that are outcomes focused and are able to be used to write good quality EHC Plans.	Training is provided for education, health and social care professionals to improve the quality of evidence provided. Monitoring and oversight processes are in place to ensure that advice is provided within statutory timescales.	Neil Smith (health) Michael Henning-Pugh (social care) Liz Robinson (education)	Jan 2018	Case studies Training pack embedded.	 EHCP Writing workshop.pptx
2 b) EHC needs assessments are co-ordinated and completed within statutory timescales	Plans completed within statutory timescales will ensure that support is put in place at the earliest opportunity.	Review of process of co-ordinating EHC needs assessments to ensure that it remains as streamlined as possible.	Karen Spencer	Jan 2018	SEN2 data	
2 c) EHCPs are of good quality	High quality EHCPs mean that children and young people can receive the right support to enable them to improve outcomes.	A termly audit of EHCPs seeks to monitor the improving quality and ensure that learning takes place to provide a framework of continual improvement.	Karen Spencer / Liz Robinson	Mar 2018	Termly audit reports	
Position statement	This is an area of strength. The vast majority of new EHC assessments and transfers are completed to a high standard and within statutory timescales.					

How effectively do we meet the needs and improve the outcomes of disabled children and young people and those who have special educational needs in Portsmouth?

3. Local Offer, short breaks and personal budgets (success criteria)

- a) The local offer is well publicised and kept under review to ensure that it continues to provide families and professionals with the information they need.
- b) Targeted and specialist **short break** care in Portsmouth is effective in meeting children and young people's needs
- c) **Personal budgets** in Portsmouth are effective in meeting children and young people's needs

Objectives	Expected impact – how will this improve outcomes?	Actions	Lead officer	By When	Evidence	Evaluation (updated quarterly)
<p>3 a) The local offer website is well publicised and kept under review to ensure that it continues to provide families and professionals with the information they need.</p> <p>To continue to promote the Local Offer and to check the effectiveness of this. (Commons Team)</p>	An effective local offer website ensures that families have the information they need to make informed decisions and to access the support they need.	<p>Monitor the effectiveness of the local offer website monthly using a 'mystery shopper' approach and incorporate feedback and improvements in the annual report.</p> <p>Review Local Offer Early Years information.</p>	<p>Jane James</p> <p>Ella Harbut</p>	<p>Sep 2017</p> <p>March 2018</p>	<p>Link to local offer website annual report</p>	 <p>Annual Report 2017 - Final 31082017.docx</p>
3 b) Targeted and specialist short break care in Portsmouth is effective in meeting children and young people's needs	Short breaks provide respite for families with a child with significant special educational needs and disabilities.	Targeted short break offer to be re-tendered in co-production with families.	Michael Henning-Pugh	Apr 2018	Link to targeted short break offer on the local offer website	
3 c) Personal budgets in Portsmouth are effective in meeting children and young people's needs	Personal budgets and direct payments enable families to have more choice and control about the way they access support.	Increasing numbers of personal budgets and direct payments to be included in EHCPs, as each EHCP is co-	Michael Henning-Pugh	Jan 2018	SEN2 data	

		produced or reviewed via the Annual Review process.				
Position statement	This is an area of strength. Our local offer website has been co-produced with parents/carers. Targeted and statutory short breaks are in place, some support is accessed as direct payments. We are continuing to work with families to increase the take up of personal budgets (using pre-paid cards) and to ensure that short break provision is fully integrated into the EHC planning and transfer process.					

How effectively do we work in partnership with children and young people and their families to improve the outcomes for those with special educational needs and disabilities in Portsmouth?

4. Co-production (success criteria)

- a) Children and young people contribute to their assessment
- b) Parents and carers contribute to their assessment
- c) Children and young people and their parents and carers participate in decision making about local provision (strategic)

Objectives	Expected impact – how will this improve outcomes?	Actions	Lead officer	By When	Evidence	Evaluation (updated quarterly)
4 a) Children and young people contribute to their assessment.	All children and young people contribute meaningfully to their EHCP needs assessment.	All children and young people are invited to contribute to their assessment at various stages throughout the process. 'This is me' contributions received as part of the assessment and review processes will be monitored.	Karen Spencer	Mar 2018	Collation of contributions received.	
		Dynamite survey to seek children and young people's views	Joe McLeish	Mar 2018	Survey results	

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4 b) Parents and carers contribute to their assessment	All parents and carers contribute meaningfully to their son/daughter's EHC needs assessment.	All parents and carers are invited to contribute to their son/daughter's assessment at various stages throughout the process. Parental contributions received as part of the assessment and review processes will be monitored. Survey to seek Parent/carer views	Karen Spencer	Jul 2018	Collation of contributions received.	
			Barbara McDougall	Jul 2018	Survey results	
4 c) Children and young people and their parents and carers participate in decision making about local provision (strategic)	Partnership working to improve outcomes is more effective where families are involved in decision-making	All children and young people and their parents/carers are invited to a person centred coproduction meeting to coproduce their plan and to renew this annually with the education provider. Training for parent/carer representatives is provided in order to enable them to contribute to the Inclusion Support Panel.	Karen Spencer	Jan 2018	Person Centred reviews - guidance for SENCos	
			Karen Spencer	Jan 2018	Updated ISP Guidance / Training	
Position statement	This is an area of strength. Portsmouth has a strong history of partnership working with parents/carers and service users. Co-production with young people with SEND and their parents/carers is becoming the way of doing business in the city - both at a strategic level as well as with regards to individual assessments. A coproduction celebration event took place on 4 th July to recognise the progress that has been made so far in the area.					

How do we evaluate the effectiveness of our local area arrangements to identify disabled children and young people and those who have special educational needs; and to meet their needs and improve their outcomes?

5. Governance, accountability and joint working (success criteria)

- a) Effective strategic **leadership and governance** is in place
- b) **Joint commissioning** arrangements are in place for education, health and care services
- c) Processes are in place to identify and address areas for development

Objectives	Expected impact – how will this improve outcomes?	Actions	Lead officer	By When	Evidence	Evaluation (updated quarterly)
5 a) Effective strategic leadership and governance is in place	Strong leadership and clear lines of accountability for the SEND Strategy will ensure that progress is made towards improving outcomes for children, young people and their families.	Refreshed SEND Strategy to be endorsed by the Children's Trust Board and Health and Wellbeing Board	Julia Katherine	Nov 2017	Link to refreshed SEND Strategy published on line	
5 b) Joint commissioning arrangements are in place for education, health and care services.	Commissioners work together effectively to assess the needs of 0-25 year olds with SEND and to jointly commission services and provision to meet their needs.	<p>A strategic management plan is in place.</p> <p>A shared database is in place for the children and young people known to the High Support Needs Panel. This is used to monitor and review the provision and outcomes for this group of children, young people and their families.</p> <p>An annual report is taken to the Director of Children, Families and Education management team to update on outcomes for this group.</p>	Andrea Havey/ Debbie Price/ Julia Katherine	Dec 2017	Report to DMT in Oct 2017.	
5 c) Processes are in place to identify and address areas for development	Where areas for development are identified and acted on by managers, there will be a cycle of continual improvement in the services and support provided to service users.	An annual report is provided of issues arising from tribunals, complaints and other sources of service user feedback in	Julia Katherine	Mar 2018	Annual Report	

		<p>order to inform service improvement.</p> <p>This is reported to the Director of Children, Families and Education Management group.</p> <p>Refresh commissioning Plan.</p> <p>Needs assessment -latest performance information</p>	Hayden Ginns			
Position statement	<p>This is an area of strength. Robust governance arrangements are in place and there are good processes for joint commissioning both at the individual child and young person level and the strategic level. A joint needs assessment has been completed and a joint commissioning strategy is in place.</p>					

CCG Diagnostic checklist

The Children and Families Act

Improving outcomes and experiences for disabled children and young people and those with SEN requires significant input from professionals and services across health, social care and education.

The Children and Families Act is a statutory framework for the integration and personalisation of services for children and young people that requires health services in England to work closely alongside education and social care services to provide the right support for children and young people and their families. This is at both a strategic joint commissioning level and integrated services for individuals through Education Health and Care Plans.

Implementing the Children and Families Act and developing a shared local vision and strategy with partner local authorities will be key in developing integrated, person centred services for children and young people in line with the existing commitments in the NHS Mandate and the vision of the 5 Year Forward View.

These joint working arrangements will be crucial for delivering current system transformation programmes for children and young people, including:

- Transforming Care Programme
- CAMHS Local Transformation Plans
- Local Area Sustainability and Transformation Plans
- New Care Models Programme Vanguard
- Meeting the ambitious targets for the increase in Personal Health Budgets or Integrated Personal Budgets.

The Tool

This tool pulls together in one place the key pieces of evidence that the CCG will wish to assure itself on in terms of its progress in implementing the 2014 Children and Families Act reforms in relation to disabled children and young people and those with SEN.

The tool presents this information in an easily accessible “at a glance” RAG rating system to update the relevant CCG Board on progress in implementation. It also includes a facility for a follow up audit which enables the responsible CCG officer to demonstrate trends in terms of implementation and flag up any areas which are not moving towards full compliance.

CQC and Ofsted will view completed audit tools as evidence demonstrating an active commitment to and interest in implementing the reforms.

For brevity the document generally talks about CCGs in the singular. However, we are very aware that in some local authority areas up to 7 CCGs may need to work together to enable progress on integration, and this can be reflected in the notes section of the document. It should be noted that this is likely to be less problematic where CCGs have appointed a single DMO or DCO to help co-ordinate implementation across an authority area.

The questions provide a framework for considering progress to date; and are divided into the 6 key areas of the role of a CCG in supporting children with SEND.

RAG rating scores and trend description options can be chosen from a drop down menu as can the name of your CCG, or this can be overwritten if you are answering on behalf of a consortium of CCGs.

Special Educational Needs & Disability (SEND) Diagnostic Checklist for CCGs

CLINICAL COMMISSIONING GROUP:

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1. LEADERSHIP

Senior / executive leadership for SEND in the CCG

The CCG governing body (or other executive arrangements) should oversee the joint arrangements for SEND, and the contribution of health and ensure a clear line of accountability. The CCG is subject to a number of statutory duties, and the decisions made by the professionals working for the providers from whom it commissions services may have significant cost implications. CCGs will want therefore to ensure there is appropriate leadership and governance arrangements in place. Senior leadership support will be required to secure strategic partnership arrangements with local authorities. The CCG has to be part of joint arrangements; contributing to the published Local Offer of services for children and young people with SEND, and securing input from provider services. A senior champion in the CCG would help to ensure the needs of children and young people with SEND or complex needs are being considered and ensure adequate oversight.

Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
Does the CCG have a senior champion or Senior Responsible Officer for SEND who is a member of the CCG governing body (or other executive body)?	Identified role in Job Description, CCG strategy or other documentation.	Innes Riches, Chief Executive Officer, Portsmouth Clinical Commissioning Group & Head of Adult Social Care, Portsmouth City Council	Full Compliance: Fully Achieved/Implemented	Please select	No Change	In addition to the joint director/ officer role, the Children's Programme Manager in the Integrated Commissioning Service represents CCG and attends the SEND Board as well as reporting through programme management group to CCG. The SEND Board reports into Portsmouth Health and Care Executive and Health and Wellbeing Board. See Appendix 5 structure and highlight report from governing board page 32. Appendix 1 https://www.portsmouth.gov.uk/intranet/about-us/partnership/health-and-care-portsmouth.aspx
CCG's statutory responsibilities towards SEND are reflected in a formal statement or strategy (or acknowledged in their constitution).	Published or internal statement of arrangements.	Innes Riches, Chief Executive Officer, Portsmouth Clinical Commissioning Group & Head of Adult Social Care, Portsmouth City Council	Full Compliance: Fully Achieved/Implemented	Please select	No Change	CCG Operating Plan 2016-17 Appendix 2 page 39, section Legislation, 8.4.1 identification and Support, Children and Families Act 2014 is listed among the legislation the CCG is adhering to. The SEND Joint Commissioning Panel has developed a Joint Commissioning Plan (Appendix 3) which outlines the commissioning priorities arising from the SEND Reforms for CCG as well as LA.
Has the CCG governing body (or other executive body) signed off the joint arrangements required by the Children and Families Act?	Published CCG constitution, or published statement.	Innes Riches, Chief Executive Officer, Portsmouth Clinical Commissioning Group & Head of Adult Social Care, Portsmouth City Council	Full Compliance: Fully Achieved/Implemented	Please select	No Change	Portsmouth Clinical Commissioning Group and Portsmouth City Council have signed a Joint Commissioning Memorandum of Understanding - Appendix 4 . This agreement is solely for the purposes of ensuring that both the Council and the CCG are clear as to how they will work together to ensure all the statutory duties relating to supporting children and young people with SEND (aged 0-25 years) as outlined in the SEND Code of Practice and the Children's and Families Act 2014 legislation are met.
Does the CCG governing body (or other executive body) receive a regular report on SEND?	Report and minutes of discussion.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	No Change	Portsmouth CCG Executive Board receive monthly project updates via the use of Covalent project monitoring tool ICS Commissioners attend SEND Implementation & SEND Joint Commissioning & SEND Strategy Board meeting to provide project updates. (SEND Governance and Delivery Structure is in Appendix 5 along with a copy of meeting minutes Appendix 6)
SEND is regularly discussed at a senior level.	Regularity of reports / discussion.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	No Change	Please see above section. SEND Strategy Board has representation from CCG Commissioning Team, Health Providers, Education and Social Care. Portsmouth CCG Executive Board receive monthly project updates via the use of a project monitoring tool of children's community health service.
How does the CCG report into the NHS England Assurance Framework?	Monitoring of progress by CCG against Assurance Framework indicators.		Partially Achieved: Some Progress/Implemented in some areas	Please select	No Change	Monitoring of progress by CCG Quality against Assurance Framework indicators. SEND Assurance report is sent by Juliet Glanfield to NHS see Appendix 7
How do the CCG or CSU staff with responsibility for SEND report to the governing body?	Agreed line of accountability, e.g. in job description of relevant staff.	Andrea Havey - Portsmouth Childrens Commissioner for CYP & Maternity - Lead is Vicky Rennie - Commissioning Manager	Full Compliance: Fully Achieved/Implemented	Please select	No Change	See line 11
Summary RAG Compliance		Total Green	6	0		
		Total Amber	1	0		
		Total Red	0	0		

FURTHER INFORMATION:

[The Children and Families Act 2014.](#)

[Special educational needs and disability code of practice: 0 to 25 years. Statutory guidance for organisations who work with and support children and young people with special educational needs and disabilities \(2014\).](#)

[The CDC has produced free e-learning for CCGs on the Children and Families Act 2014](#)

[Disability Matters is a free training resource for anyone working with those with a disability or special educational need \(of all ages\).](#)

[In addition to the above resources, there is a health guide to the SEND Code of Practice](#)

[NHS England's model CCG constitution guidance](#)

Special/Unusual Commissioning Requests: e.g. for complex needs

Children with SEND may have high-cost health needs, which the CCG will have to ensure are met under its statutory duties under section 3 of the NHS Act. The CCG will also need to be able to consider an ad hoc requests for care which is not routinely commissioned. Advice on a child's health needs as part of the EHC assessment process will usually be provided by professionals employed by a provider commissioned by the CCG. It could include a wide range of professionals: paediatricians, therapists, nurses etc. The professional may make a recommendation in the plan for care which would need to be commissioned specially, or which goes beyond routine allowance (e.g. a greater volume of SLT than might usually be made available), and there must be a mechanism in the joint arrangements for the CCG to be alerted to these non-routine requests, and to consider them.

The continuing care process is similar to that for SEND, involving a multi-disciplinary assessment, and a decision on what care should be commissioned which is not part of universal or specialised services. The same panel, or other arrangements could be used to consider both continuing care packages, and the health element of the EHC plan. CCGs and local authorities may wish for the same oversight arrangements to apply to both.

Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
What are the arrangements for the CCG to consider requests for high-cost, low incidence care (this would go wider than SEND)?		Andrea Havey - Portsmouth Childrens Commissioner for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	No Change	The high cost- low incidence care requests are considered by the High support needs panel. This is led by ICS Commissioning Programme Manager. This is a joint panel with health and social care taking joint commissioning responsibility. Each case is considered on an individual basis. These placements/packages may often be high cost, such decisions may fall outside of the jurisdiction of the Inclusion Support Panel who will refer cases for consideration and approval by the High Needs Budget Decision Panel. - TOR see Appendix 8 In the case where requests for EHCP medical sections are over and above commissioned services and do not meet High Needs Support Panel criteria, the request is forwarded to the ICS Commissioning Programme Manager for approval. These requests are reviewed by ICS Continuing Care Nurse and only approved for funding by health where there is NICE / DH Guidance to support this. These requests form part of the Individual Funding Request Process - Appendix 11
Is there an agreed and publicised protocol setting out how professionals raise these requests with the commissioner?	Formal communication on the above process with providers, local professionals.	Andrea Havey - Portsmouth Childrens Commissioner for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	No Change	Details of how to access the high support needs panel are included on the local offer - http://www.portsmouthlocaloffer.org/local-offer-search/item/80 There is a single point of access for all assessment requests. See Appendix 10 Individual funding requests (IFR's) have a clear process for requesting funding. The details are available to GP's and other health professionals via PIP and through commissioners. Funding decisions are made through the Commissioning Support Unit. There are details of the IFR process on the CCG website - http://www.portsmouthccg.nhs.uk/Downloads/Individual%20Funding%20Request%20leaflet.pdf
How are these requests scrutinized?	Framework / protocol includes procedure for reaching a decision. e.g. panel drawing on assessor recommendation, and executive oversight.	Andrea Havey - Portsmouth Childrens Commissioner for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	No Change	There are details on proportionate funding decisions by health and social care in Appendix 9 Members of the High support needs panel are authorised to undertake any actions within the Terms of Reference and within the powers and management responsibilities of its members. If required the panel will invite external/ independent professional advice or gain additional approval from executive/ senior staff members of their teams as stated in the TOR (Appendix 8)
What evidence does the CCG draw on in making a decision on such requests? Does the CCG use peer review to consider requests or evidence from other commissioners?	Framework includes parameters for evidence gathering – e.g. single assessor, as for continuing care, with which local professionals are familiar. CCG is part of a local network for sharing benchmarking information; CCG arrangements include representatives from outside the CCG to provide quality assurance (e.g. on a panel).	Andrea Havey - Portsmouth Childrens Commissioner for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	No Change	The high support needs panel is an MDT panel, therefore peer to peer review takes place. External/ independent advice. See TOR (Appendix 8) IFR's are considered under NICE / DH Guidance. Appendix 11
How do the arrangements for SEND dovetail with the process of continuing care assessments?	CCG uses continuing care process as a model for SEND, e.g. in relation to decisions on care, use of multi-disciplinary input, and how it monitors timescales for contributions.	Andrea Havey - Portsmouth Childrens Commissioner for CYP & Maternity and Liz Clay Childrens Continuing Care Lead.	Full Compliance: Fully Achieved/Implemented	Please select	No Change	There are a small number of C&YP with highly complex needs who will not be able to have their needs adequately met by provision and services that are available within Portsmouth. These children have continuing care needs and/or additional social care/education needs. Continuing care nurse works with Education and social care to address continuing care needs within the EHCP's. See Appendix 12 for anonymised information.
Summary RAG Compliance		Total Green	5	0		
		Total Amber	0	0		
		Total Red	0	0		

FURTHER INFORMATION:

The framework for Children and Young People's Continuing Care has been revised to take account of the new SEND framework.

Monitoring and agreeing plans

For more detailed advice on monitoring, see the annex. The role of the CSU could be pivotal in providing expertise and engagement with providers to ensure a smooth process, and ensuring that SEND is adequately reflected in commissioning plans. CSUs could provide:

- Analytical support – looking at demand and prevalence
- Servicing of joint arrangements with LA and other partners
- Interaction with providers, and monitoring of arrangements and progress.

Monitoring and agreeing plans

For more detailed advice on monitoring, see the annex. The role of the CSU could be pivotal in providing expertise and engagement with providers to ensure a smooth process, and ensuring that SEND is adequately reflected in commissioning plans. CSUs could provide:

- Analytical support – looking at demand and prevalence
- Servicing of joint arrangements with LA and other partners
- Interaction with providers, and monitoring of arrangements and progress.

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Resourcing joint arrangements.

Ensuring effective implementation of the new statutory framework for SEND should not be resource intensive as long as providers are set to participate in EHC plan development. Ensuring appropriate strategic links with the local authority will require some senior input. Monitoring implementation on a day-to-day basis can be subsumed within on-going monitoring of commissioning services for children. Where mediation or complaints handling is necessary, more intensive input would be required, but this would be on an occasional rather than a routine basis.

The CCG will want to ensure the effectiveness of its role in joint arrangements, and the effectiveness of the services it is commissioning for this cohort. This will require a mix of evidence, some of process (the relationship with the local authority), some of volume (the number of EHC plans, compared with anticipated demand), user experience, and outcomes (both at cohort level, and in terms of the EHC plan delivering the specified outcomes for the individual).

- Is there a mechanism for adjusting resources to take account of changes in demand?
- Is there formal workforce development of the team, including time spent with providers?
- Is the team able to liaise with providers on a routine basis outside of the formal performance management / monitoring routes?
- How does the CCG quality assure its work in relation to SEND?

Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
What personnel has the CCG dedicated to SEND? Is it a small team, or a lead individual, with administration support?	Dedicated team or individual, as reflected in CCG business or workforce plan, job descriptions etc.	Andrea Havey - Portsmouth Childrens Commissioner for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	No Change	ICS CYP Project Manager and Programme Manager Appendix 17
Is SEND their sole responsibility, or is it part of a larger portfolio (e.g. children's commissioning)? If the latter, what safeguards are in place to ensure time remains dedicated to SEND?		Andrea Havey - Portsmouth Childrens Commissioner for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	No Change	SEND is part of a larger portfolio for both the programme and project manager. Regular meetings and attendance at SEND Board, Joint Commissioning Meetings and SEND Implementation Group assure that the ICS remains focussed on SEND as required. Appendix 18
What governance arrangements cover the team or individual's work?		Andrea Havey - Portsmouth Childrens Commissioner for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	No Change	Report to SEND Implementation Board, Joint Commissioning Board and Implementation Group. SEND governance is shown in Appendix 5
How does the CCG know it has sufficient resources dedicated to SEND? Does it discuss expectations and demand with other CCGs or its LA? Does a local network exist to allow this?	Regular management review of SEND arrangements, drawing on performance indicators, and staff feedback. CCG uses networks to formally compare expectations and arrangements with peers. Joint arrangements with the local authority include reviews of joint capacity in relation to servicing the SEND arrangements.	Andrea Havey - Portsmouth Childrens Commissioner for CYP & Maternity	Partially Achieved: Some Progress/Implemented in some areas	Please select	No Change	SEND management is reviewed regularly through staff supervision and issues escalated to senior management as required. ICS Commissioner have co-produced the SEND Joint Commissioning Plan taking into account the SEND Health Needs Assessment to identify future commissioning priorities and these will be discussed at the SEND Joint Commissioning Meeting (TOR Appendix 20) and the SEND Implementation Group meetings (Agenda attached) Appendix 19 including exception reporting on staff capacity across the system. ICS Commissioning Managers hold quarterly service review meetings with health service providers and discuss any issues with service delivery related to SEND health related services. Amber has been given as the CCG does not use networks to formally compare expectations and arrangements with peers, although a peer review is to be arranged in Autumn 2017 with another LA to review SEND arrangements.
Summary RAG Compliance		Total Green	3	0		
		Total Amber	1	0		
		Total Red	0	0		

Working with the local authority						
<p>Any formal agreements should be signed-off at executive / Governing body level in the CCG (depending on how the executive function is exercised). There will be lower-level elements of joint working which fall within the delegated authority of the CCG officer. Even then, the CCG would need to ensure it had sufficient oversight to assure itself that it was fulfilling its statutory obligations.</p> <p>Formal section 75 agreements or other formal arrangements are not mandatory, however, many local areas find that once set up they provide a more efficient and streamlined approach to the allocation of resources. The new statutory framework requires CCGs and local authorities to agree joint arrangements, focused on the assessment and planning of an individual Education, Health and Care plan for each child with special educational needs.</p> <p>The joint arrangements are also intended to provide a basis for integrated working to support children with SEND who are not eligible for an EHC plan. The CCG and local authority should agree a reasonable set of arrangements for how they manage their day-to-day interactions. A written agreement is recommended, to ensure parties to the agreement have a common point of reference (dispute resolution in particular will need to refer to the original terms of the joint arrangements).</p> <p>CCGs and health providers are likely to have to work with more than one local authority, each with their own approach and EHC plan format. Each local authority will have to meet the same statutory requirements, and each EHC plan has to have the same sections. These provide a basis for the CCG and providers to take a consistent approach to each local authority; agreeing with providers on an approach for their contributions to plans, which individual local authorities would incorporate. A consistent template or methodology could be used for interaction with each local authority, and codified as part of the joint arrangements.</p> <p>The local authority has the lead in implementing the new SEND framework locally, but there has to be partnership working in developing joint arrangements which both parties can support. Ensuring the robustness of arrangements cannot be undertaken by local authorities and CCGs in silos; the arrangements are designed to develop integrated approaches, and should be assessed in an integrated way. The CCG need to work with partners in assessing local demand, and promoting SEND within local health and care strategies.</p> <p>If the local authority cannot work with the CCG, then this will impact significantly on its ability to deliver effective services for children and young people with SEND. Another local authority or CCG might be able to provide peer support or arbitrate where there is a significant disagreement.</p>						
Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
• Are the joint arrangements fully documented, and subject to a written agreement?	Documentation of agreement	Innes Riches, Chief Executive Officer, Portsmouth Clinical Commissioning Group & Head of Adult Social Care, Portsmouth City Council	Full Compliance: Fully Achieved/Implemented	Please select	Please select	Portsmouth Clinical Commissioning Group and Portsmouth City Council have signed a Joint Commissioning Memorandum of Understanding - Appendix 4 This agreement is solely for the purposes of ensuring that both the Council and the CCG are clear as to how they will work together to ensure all the statutory duties relating to supporting children and young people with SEND (aged 0-25 years) as outlined in the SEND Code of Practice and the Children's and Families Act 2014 legislation are met.
• Is there a forum or working group for designing and reviewing joint arrangements? Does this have strategic links to HWB etc.? Is there any user involvement representation?	Established routes / fora for joint discussions, at which SEND can be considered. SEND arrangements are part of arrangements for joint / lead commissioning for children.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	ICS commission Childrens Community Services on behalf of Portsmouth CCG. ICS Commissioning Manager attends SEND Board and Joint Commissioning Board which provide updates to the Childrens Trust Board. The Childrens Trust Board provide updates into the Portsmouth Joint Health and Wellbeing Board. See Appendix 14 for childrens trust board details, Appendix 21 for health and wellbeing report and Appendix 5 for governance structures. In addition Public Health Consultant, Provider Service Managers & DCO attend SEND Working Groups as well as the SEND Board meetings - Appendix 6 .
• Have budget pooling or lead commissioning arrangements been considered?	Section 75 agreement or similar.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Partially Achieved: Some Progress/Implemented in some areas	Please select	Please select	Pooled budgets have been considered but have been discounted at present, as they have not been proven to be successfully implemented in other fields. Continuing care do have joint funding arrangements in place for high need placements and governance to ensure the allocation of funds is a fair and transparent process. See Appendix 8 for information on high support needs panel.
• Is there a mechanism for ongoing review of joint arrangements, drawing on evidence of implementation?		Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	Joint Commissioning Working Group meet bi monthly (for Agenda and Minutes, Appendix 6 attended by ICS SEND Joint Commissioning Plan is on Leadership page, line item 9 Commissioning Priorities have been derived from the SEND Health Needs Assessment Report which is now saved in the Portsmouth JSNA - see line 44 on Leadership tab
• Is there a published statement of joint working / information on the joint arrangements (separate from the Local Offer)?		Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	https://www.portsmouth.gov.uk/intranet/about-us/partnership/health-and-care-portsmouth.aspx
• How is the CCG involved in the development of the timetable for transition from statements to EHC plans?	CCGs is involved in the development of the local authority transition plans as part of joint arrangement; CCG has articulated the need for statement reviews to providers.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	CCGs is involved in the development of the local authority transition plans as part of joint arrangement; CCG has articulated the need for statement reviews to providers. The following statement is included in all CCG commissioned children's health service specifications to ensure the provider is involved in the transition programme of statements to EHC Plans in order to meet statutory timescales. "Contribute to the assessment process to convert Statements and Learning Disability Agreements into Education Health Care Plans (EHC) Plans as requested from now until April 2018."
Summary RAG Compliance		Total Green	5	0		
		Total Amber	1	0		
		Total Red	0	0		
FURTHER INFORMATION: The Joint Commissioning Information pack has abundant evidence on effective collaboration.						
Health and wellbeing boards						
<p>The Health and Wellbeing Board (HWB) has a pivotal role to play in supporting local services, including schools and colleges to address the needs of children with SEND. HWBs should act as a forum for strategic discussions between local authorities and CCGs. Some areas may also have existing multi-agency groups which lead or co-ordinate on issues relating to children and young people, which the HWB can link with as appropriate. The HWB might provide a good arena for discussing key issues regarding joint arrangements and integration.</p> <p>The local JSNA / JHWS must take account of the needs of children and young people with SEND; however, absence of any explicit reference to SEND should not deter the CCG from meeting its obligations re: SEND. Ideally CCGs and local authorities as members of HWBs should ensure JSNA and JHWS articulate the local SEND need, which joint arrangements will focus on.</p>						
Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
• Does the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy include SEND?	CCG as a member of HWB highlights local complex needs.	Innes Riches, Chief Executive Officer, Portsmouth Clinical Commissioning Group & Head of Adult Social Care, Portsmouth City Council	Full Compliance: Fully Achieved/Implemented	Please select	Please select	The CCG JSNA identifies SEND in Priority 1. http://democracy.portsmouth.gov.uk/documents/13253/JSNA%20Annual%20Summary%202016.pdf The Health and Wellbeing Strategy, Priority 1 is "Giving children and young people the best start in life" and links with the Children Trust. See link to the strategy, specifically in work stream 1b, although SEND is not explicitly mentioned. https://www.portsmouth.gov.uk/ext/documents-external/1111-jhwellbeingstrategy2014-17.pdf
• How does the CCG engage with the Health and Wellbeing Board and local Healthwatch?		Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	ICS Commissioning Manager inputs into the report that is presented every 6 months to the Health and Wellbeing Board on the progress of the SEND Reforms from the LA and CCG perspective. http://democracy.portsmouth.gov.uk/ieListDocuments.aspx?CId=150&M=-3634&Ver=4
Summary RAG Compliance		Total Green	2	0		
		Total Amber	0	0		
		Total Red	0	0		
FURTHER INFORMATION: <p>Guidance for HWBs on children's complex needs are be found at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/357447/DH_HWB_children_s_guidance.pdf</p> <p>Operating Principles for Health and Wellbeing Boards. http://www.local.gov.uk/c/document_library/get_file?uid=1ccc06cb-d44b-43c6-b04c-f7b713e03122&groupid=10180</p> <p>Rochdale's Joint Health and Wellbeing Strategy: http://www.hmr.rnhs.uk/attachments/article/81/jointhealthwellbeingstrategy12-15.pdf?_sm_a=HvGkN6WJ5nrVWj</p> <p>Wiltshire's Joint Health and Wellbeing Strategy: http://www.wiltshire.gov.uk/healthandsocialcare/jointhealthandwellbeingstrategy.htm</p>						

Dispute Resolution						
<p>Joint arrangements need dispute resolution – a basic forum bringing the CCG and LA together, with appropriate senior oversight, directly linked to those with responsibility for determining commissioning strategy / plans, and with financial input. Joint arrangements could include a protocol for decision making and escalation and could plan for challenge points within the process (e.g. at referral, following joint assessment of evidence, mediation)</p> <p>Local authority and CCGs could take stock of existing commissioning plans, and capacity; the significance of the overlap of speech and language therapy would recommend a specific stocktake of SLT services across education and health, and how providers in particular manage demand, with a view to adopting a collaborative approach. Joint commissioning of SLT between schools, LA and CCG would be a sensible basis for an integrated, equitable approach.</p> <p>The SEND framework is about integrated commissioning; CCGs will necessarily have to commission SLT for children with communication support needs – and the joint arrangements provide a basis for agreeing joined-up commissioning of SLT across education and health. Schools will often be commissioning SLT through delegated budgets, the pupil premium etc., and the local authority can help broker a joint approach between schools and the CCG.</p>						
Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
• Is there an existing framework for strategic dispute resolution which could be adopted for SEND?	<i>CCG and local authority joint arrangements include a formal, documented process for resolving disputes.</i>	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	CCG are part of the Global Mediation Contract - see Dispute/Mediation process on Local Offer and Notice to all settings ref Dispute Resolution process - available on the Local Offer - Appendix 22 and 23 The CCG has a robust complaints procedure to manage disputes if they reach Tribunal stage. General Condition 14 of the NHS Standard Contract General Conditions applies There is an arbitration process through the Contract Dispute Resolution process Appendix 24
• Has peer review, arbitration or lay involvement been considered (e.g. neighbouring CCGs or local authorities giving their views).	<i>This includes the monitoring by each party, and escalation procedures, and identifies personnel with delegated responsibility.</i>	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Partially Achieved: Some Progress/Implemented in some areas	Please select	Please select	A peer review is due to take place in early Autumn and will include dispute resolution.
• Is there a mechanism for resolving fundamental disputes about the joint arrangements, and disputes over who pays? What is the existing framework for disputes / deadlock on the responsible commissioner?		Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Partially Achieved: Some Progress/Implemented in some areas	Please select	Please select	ICS Commissioner has the final say when a request comes in for funding for an EHC Plan that requires health services that are over and above normally commissioned service using the Individual Funding Request route via CSU. Appendix 11 General Condition 9 of the NHS Standard Contract General Conditions applies to payment disputes (See line 32) . Guidance from NHS England is attached - Who Pays 2013. Appendix 25
Summary RAG Compliance	Total Green		1	0		
	Total Amber		2	0		
	Total Red		0	0		
FURTHER INFORMATION: The Communication Council briefing on SLCN for health audiences www.thecommunicationstrust.org.uk/sendreforms The Royal College of Speech and Language Therapists has a range of information resources on speech and language therapy to support effective commissioning. http://www.rcslt.org/speech_and_language_therapy/commissioningintro						
Local Offer						
<p>The local offer will be published on the local authority website, and this should include details of all services relevant to children and young people with SEND, including to access, eligibility criteria, and details of how individuals may seek more information or make a complaint.</p> <p>CCGs should ensure that, in relation to health, the local offer is not just a summary of services which are commissioned for this group of children, but a useful tool for families, in navigating services and understanding remit and eligibility. CCGs may wish to map with providers the key services available / commissioned, and the development of the health element of the local offer provides an opportunity for dialogue with providers about what is commissioned, and the gaps in provision / service pressures.</p>						
Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
• How has the CCG mapped services to inform the Local Offer?	<i>Health services for children with SEND included in the published local offer.</i> <i>Published local offer includes: (a) speech and language and other therapies, including any criteria that must be satisfied before this provision can be provided;</i>	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select		The CCG has been part of the development of EHC Plans, processes/pathways, and have worked with social care and education and parents/carers to develop the local offer since the outset in preparation for the SEND Reforms through the ICS Commissioning Managers. All health commissioned services are detailed on the local offer website and updated regularly. http://www.portsmouthlocaloffer.org/
• Has the CCG been engaged in the design of the Local Offer?	<i>(b) services relating to mental health, including any criteria that must be satisfied before this provision can be provided, and;</i>	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select		ICS Commissioning Managers were involved in the design and development of the Portsmouth local offer through the SEND Implementation Meeting on behalf of the CCG. The Portsmouth local offer was co-produced with parents. http://www.portsmouthlocaloffer.org/
• Is the CCG able to provide definitive information on eligibility and access?	<i>(c) services for relevant early years providers, schools and post-16 institutions to assist them in supporting children and young people with medical conditions.</i>	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select		High level eligibility criteria for each child community service is available for each service on the Portsmouth Local Offer. Any gaps should be identified through the mapping exercise discussed in line 43, and uploaded to the local offer. Solent have developed a Therapy Pack for Schools to show their Paediatric Therapies Service offer, demonstrating the graduation from universal, through to targeted and on to specialist level according to a child's clinical assessment and need http://www.solent.nhs.uk/page-service.asp?fidArea=16&fidMenu=2&fidSubMenu=5&fidKey=730
Summary RAG Compliance	Total Green		3	0		
	Total Amber		0	0		
	Total Red		0	0		
FURTHER INFORMATION: North Yorkshire County Council interactive local offer map: http://www.northyorks.gov.uk/media/26040/Local-offer-map.pdf#Local_Offer_site_map_final_v11.pdf There is a wide range of examples on how to approach the local offer in the Local Offer Information Pack. https://www.mottmac.com/download/file/6736?cultureid=127						

3. Commissioning						
Assessing local need						
<p>CCG (or partners, such as Public Health) can determine demand based on:</p> <ul style="list-style-type: none"> • Child and Maternal Health Intelligence Service (CHIMAT) Needs Assessment Report - Children and young people with disabilities http://www.chimat.org.uk/disability; • GP practice QOF registers of learning disability; • provider contracts / historic demand; • local authority registers of disability; • national prevalence data on key conditions; • engagement with Parent Carer Forums, other engagement with children, young people and families. • feedback from GP practice members, and from commissioned providers. <p>The local authority should maintain as a statutory duty a register of people with a learning disability; GP practices, to quality for Quality and Outcome Framework points should establish and maintain a register of patients with learning disabilities (ID LD003). The provider perspective on the scope of current provision is essential.</p> <p>CCGs have to ensure that their commissioning plans are appropriate to meet local demand, and to ensure they have an effective relationship with the key providers to ensure the joint arrangements are delivering completed and implemented EHC plans.</p> <p>Services for children with special educational needs could include a wide range of support, including speech and language therapy, assistive technology, children's mental health services, occupational therapy, habilitation training, physiotherapy, specialist equipment, wheelchairs and continence supplies.</p> <p>Where applicable, CCGs should work with neighbouring areas (LAs, CCGs and providers) to identify synergies and where provision can be improved by working across boundaries.</p>						
Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
• Does the CCG or CSU acting on its behalf, have a sense of local prevalence of SEND or likely demand?	CCG has articulated local need (if not covered in JSNA etc.)	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	SEND Health Needs Assessment provides data to understand the SEN prevalence and therefore future demand for services. http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/children-and-young-people/health-and-wellbeing/special-educational-needs-and-disabilities
• Does the CCG know how many children will need EHC plans?	CCG plans include projected activity levels of SEND.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Partially Achieved: Some Progress/Implemented in some areas	Please select	Please select	SEND Health Needs Assessment provides data to understand the SEN prevalence and therefore future demand for services. IT systems in CSC are being updated to include tabs for identifying health needs in an EHCP. This is due to go live on 1st April 2107. Full years data is expected next April. The CCG are informed by education on the expected number of EHC plans per year, currently at 3.1%. The impact of the increases in EHCP's is monitored through CRMS and reported through SEND joint commissioning group. This is not having an impact on timescales for completion. http://data.hampshirehub.net/def/concept/folders/themes/jsna/portsmouth-jsna/children-and-young-people/health-and-wellbeing/special-educational-needs-and-disabilities
• Do GP practice members of the CCG keep a register of children with LD, in line with the QOF? Does the CCG have access to the local authority register of disability?	CCG has mapped need via GP practices.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Partially Achieved: Some Progress/Implemented in some areas	Please select	Please select	GP's are starting to keep a record of all people with LD. Next steps are to be decided by CCG Exec Board as advised by the QOF - see link There is a joint children's disability register currently under development. LD commissioner has access to the numbers on the GP register by age. The CCG has access to the local authority register of disability. http://www.nhsemployers.org/-/media/Employers/Documents/Primary%20care%20contracts/QOF/2016-17/2016-17%20QOF%20guidance%20documents.pdf
• Has the CCG mapped existing services for children with SEND, e.g. through provider contracts?	CCG has identified needs through discussions with providers (e.g. assessing levels of need for SLT and other therapies, number of children under care of a relevant paediatrician etc.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	All health commissioned services are detailed on the local offer website and updated regularly. http://www.portsmouthlocaloffer.org/ See line 12 for details of service reviews which help identify gaps. Health services have been mapped see Appendix 12 . The services are monitored through service reviews and monthly CORB meetings Appendix 26
• How is the CCG assuring itself that there are no gaps in provision?	CCG commissioning plan is informed by a needs assessment of children with complex needs / SEND – which could be the JSNA where relevant	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Partially Achieved: Some Progress/Implemented in some areas	Please select	Please select	SEND Board reviews the SEND Health Needs Assessment Appendix 16 to identify gaps. The SEND Joint Commissioning Plan includes CCG commissioning priorities see Appendix 3 . CCG Commissioners hold quarterly service reviews with the Health provider where each Childrens Community Service is reviewed within the quarterly service monitoring meetings and any issues with provision to children with SEN plans or EHC Plans from a health perspective is discussed see Appendix 27 The CCG will know of gaps in provision but cannot be assured that there are no gaps in provision.
Summary RAG Compliance		Total Green	2	0		
		Total Amber	3	0		
		Total Red	0	0		
FURTHER INFORMATION:						
<p>The Child Needs Assessments Reports include one developed for children and young people with disabilities, showing likely prevalence for each local authority area. http://atlas.chimat.org.uk/IAS/profiles/needsassessments</p> <p>The Multi-Agency Planning and Improvement Tool (MAPIT) supports service improvement for children and young people with special educational needs and disabilities and their families. http://www.councilfordisabledchildren.org.uk/resources/mapit-multi-agency-planning-and-improvement-tool</p>						
Affordability and demand						
<p>The new arrangements between CCGs and local authorities provide a means of reaching a consensual decision on difficult choices (and possible mitigation of impact – e.g. the flexible use of communication support to offset the need for clinical SLT).</p> <p>They also provide a basis for strategic discussions on contractual flexibilities, informing dialogue between the CCG and the provider on changing demand.</p>						
Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
• Is there a local mechanism for anticipating changes in demand?	CCG has a mechanism for dialogue with providers on local SEND prevalence.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	Changes to demand reported through JSNA, SEND Board, Quarterly Contract Meetings. The CCG have annual discussions with providers as part of contract negotiations, in addition to the quarterly contract reviews. See lines 8 and 12 for further details.
Summary RAG Compliance		Total Green	1	0		
		Total Amber	0	0		
		Total Red	0	0		

Contracts						
Contracts or other agreements with providers may not have to change (although the new framework provides an opportunity for looking at what is commissioned). For instance agreement with providers that the EHC process would be appropriately supported and that information on services would be provided for the Local Offer.						
Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
• How does the CCG communicate with its providers on SEND?	CCG has a mechanism for communication with providers on SEND.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	Any communications for providers are shared at contract review meetings and through provider attendance at SEND board and implementation meetings.
• How is the provider supported in Pathway design –e.g. with development money, clinical reference group; is the redesign demand-led?	CCG is active in supporting pathway design for children with complex needs.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	SEND Joint Commissioning Plan see -Appendix 3 JSNA informs any changes to pathway/redesign of services and these will be discussed at the SEND Joint Comm meeting. Funding requests are presented to CCG Clinical Strategy Committee (CSC) through a business case. CSC is made up of GP Executives and CCG Executives (including the Chief Operating Officer, Chief Finance Officer and Chief Commissioning Officer). Delivery and change management through the year is managed by the Programme Board. Details of this hierarchy of decision making can be found in section 12.0 of the Portsmouth CCG Operating Plan 2016/17 Appendix 2
Summary RAG Compliance		Total Green	2	0		
		Total Amber	0	0		
		Total Red	0	0		
Personal Budgets						
Under the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013, the families of a child or young person eligible for continuing care have a 'right to have' a personal health budget, covering the part of their care package which would be provided by the NHS.						
Personal health budgets are not restricted to children and young people eligible for continuing care. They can be offered to other children on a discretionary basis.						
Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
• Has the CCG considered its response to requests for PHBs for continuing care?	CCG local plans meet 5 Year Forward View expectations of offering PHBs to children with continuing care needs, and SEND.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	In line with current legislation Personal Health Budgets are available for children & young people between the ages 0 and 18 years and who are eligible for Continuing Healthcare Funding. PHB currently offered to children with continuing care needs (2 have accepted in Portsmouth) Personal Budgets Policy to cover CCG and LA - see web link http://www.portsmouthlocaloffer.org/local-offer-search/item/210
• Has the CCG considered the options for personal budgets? - a direct payment made to the young person or their family; - the agreement of a notional budget to be spent by the CCG following discussions with the child or young person, and their family (or other representative) as to how best to secure the provision they need; - the transfer of a real budget agreed as above, to a person or organisation which applies the money in a way agreed between the CCG and the child or young person, and their family (or other representative).	CCG publicises and promotes the availability of personal health budgets to children and young people eligible for continuing care, and provides information, advice and other support to children and young people who are eligible, and their families or representatives.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	Families who choose PHB's are given the choice of how they would like their PHB, through direct payment, notional budget or transfer of real budget. Appendix 28 Integrated Personalised Commissioning (IPC) has similar objectives to SEN(D), including: the development of integrated plans personalised to the individual; improving outcomes; self-management and community resilience, and; access to an integrated personal health budget (notional or direct payment) see Appendix 29/ 30/ Portsmouth is an IPC pilot site and the potential to widen the offer of PHB to children other than continuing care is being reviewed under this programme. Appendix 31/32 A pilot has taken place through IPC to identify if parents, given the choice would take up the PHB offer. The final report is due in early March 2017.
Summary RAG Compliance		Total Green	2	0		
		Total Amber	0	0		
		Total Red	0	0		
FURTHER INFORMATION:						
NHS England's information hub on personal budgets: http://www.peoplehub.org.uk/						
For more guidance on personal health budgets, see Guidance on the "right to have" a Personal Health Budget in Adult NHS Continuing Healthcare and Children and Young People's Continuing Care (September 2014). http://www.personalhealthbudgets.england.nhs.uk/_library/Resources/Personalhealthbudgets/2014/Personal_health_budgets_right_to_have_guidance.pdf						
Understanding the Resource Allocation System (RAS). Developing a self-directed support approach to resource allocation for children, young people and families (2013) http://www.in-control.org.uk/media/131598/understanding_the_ras%20-%20final%20for%20print.pdf						
Making It Personal 2 is a resource for families and commissioners and providers to support developing personalisation in care, through use of personal budgets. http://www.kids.org.uk/mip2						
The SEND Pathfinder Information Pack - Personal Budgets. http://www.sendpathfinder.co.uk/personal-budget-information						
Designated Medical Officer / Designated Clinical Officer						
Partners should ensure there is a Designated Medical Officer or Clinical Officer (DMO / DCO) to support the CCG in meeting its statutory responsibilities for children and young people with SEND, primarily by providing a point of contact for local partners, when notifying parents and local authorities about children and young people they believe have, or may have, SEND, and when seeking advice on SEND. This does not alter the CCG's responsibility for commissioning health provision.						
The DMO / DCO provides the point of contact for local authorities, schools and colleges seeking health advice on children and young people who may have SEND, and provides a contact (or contacts) for CCGs or health providers so that appropriate notification can be given to the local authority of children under compulsory school age who they think may have SEND.						
The DMO / DCO should have an appropriate level of clinical expertise to enable them to exercise these functions effectively, and should be designated as the DMO / DCO in their job description. There may be one DMO / DCO for several CCGs and local authorities, where there are joint arrangements or shared commissioning responsibilities, and given the age range of EHC plans from birth to 25, the DMO / DCO may need to liaise with colleagues outside paediatrics.						
This is a non-statutory role. When carried out by a paediatrician the role is a Designated Medical Officer, when undertaken by a nurse or other health professional the role would be a Designated Clinical Office. Nurses can be dual registered and this can be an advantage when considering the remit of the role from 0-25.						
Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
CCG have agreed resourcing for the DMO/DCO Role? The post has been appointed to and has sufficient PA's to carry out the role.	Formally identified local health professional, with job description and dedicated time. DMO name is contactable (information for example on the Local Offer pages).	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	DCO in post for job description see Appendix 13. DCO is on local offer and contactable via Solent NHS Trust Single point of access or via email.
Summary RAG Compliance		Total Green	1	0		
		Total Amber	0	0		
		Total Red	0	0		
FURTHER INFORMATION:						
The BACD have published a model job description for a DMO: http://www.bacds.org.uk/policy/documents/DesignatedDr.DforSEND.pdf						
Dr. Karen Horridge, Chair of the BACD has published a presentation capturing the scope of the DMO role in an effective SEND system. http://www.bacds.org.uk/policy/documents/MedicalAdviceforEducation-ReclorPaedsBACCHBACD23Sept2014.pdf						

4. Education, Health & Care Plan						
Coordinated Assessment						
<p>The Education, Health and Care plan is a key focus for the new SEND arrangements. The plan is a statutory document, which captures:</p> <ul style="list-style-type: none"> the child or young person's special educational needs and any health and social care needs; the services which the relevant commissioners intend to secure; the outcomes which they will aim to deliver, based on the child or young person's needs and aspirations. <p>If the plan specifies health care provision, the responsible commissioning body – usually the CCG - must arrange the specified health care provision for the child or young person.</p> <p>There is no easy answer to the issue of capacity constraints. It is vital that the CCG talks to the local authority, so that the EHC process is not held up for a diagnosis which may take months – and a methodology can be agreed for allowing for pending assessments, and for reviews following an assessment.</p> <p>There will be cases where a child or young person has been discharged from a clinic but where a programme of care advised by the clinic is being followed. In such instances it is important that this programme of care is provided to the local authority as the health advice, rather than the information that the child has been discharged, and it is important that the CCG ensures that providers understand this. There will also be cases where a child is not known to clinical services but where it has been identified that there is a health need. In such instances CCGs will wish to consider a process which supports the timetable for completion of the plan. Some areas are holding spare appointments whilst others are including a health assessment as an action for the EHC plan.</p> <p>Where a child does have a special educational need arising from a significant health issue, their health needs must be captured in the EHC plan, along with the services required to help deliver improved outcomes for them. It may be the case that the CCG would not need to commission any service which wasn't already being secured, but they must ensure that their health needs are adequately covered by the EHC assessment and planning process.</p>						
Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
Has the CCG been involved in developing the EHC plan templates for its relevant local authorities?	CCG has ensured that key personnel are familiar with the EHC plan templates, and its statutory elements (which are consistent for all plans). CCG has been involved in development of all relevant plan formats, or failing that, has seen and discussed all relevant formats with local authorities, so expectations are clear.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	The CCG has been involved in developing the EHC plan templates via: Send Board and Send Implementation Group CCG have worked in co-production with: Education, Children's Social Care, Parent Representatives CCG Commissioners have worked with members of the Education team to deliver training to clinicians in writing the medical evidence sections of the EHC plans using clear language, explaining the offer and how the child will be monitored to show outcomes. This work is now being carried out by the DCO to deliver training to new staff.
Does the CCG have a clear process / pathway for referrals directed to it?		Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	There is a clear/secure referral pathway to start the EHC assessment process from the single point of access email in the SEN team The Portsmouth Local Offer shows how to request an EHC assessment, including timelanes http://www.portsmouthlocaloffer.org/local-offer-search/item/139
Does the CCG oversee providers and ensure they have a pathway?	CCG has an agreed process in place (with appropriate personnel to oversee and manage) for receiving requests for EHC plan input.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	The Solent EHC Assessment process flow document include detailed steps along with timescales in which the EHC Plan medical section must be completed & returned to the LA SEN Team See Appendix 33
Does the CCG have a strategy for mitigating impact of service pressures on EHC process?	Similarly, relevant providers (NHS Trusts, FTs, Community and MH Trusts etc.) are all apprised of the EHC process, and CCG ensures that providers, either through contract with management or otherwise, are ready to participate in EHC plans. This should include monitoring / reporting, however light touch, allowing the CCG to assess how timely is the health service response.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	The formal Commissioner led Quarterly Contract Reviews offer the opportunity for the provider and Commissioner to discuss any issues pressures as a result of the EHC process. Provider and Commissioner regularly contact each other and should an issue come up relating to a child/children with SEND, this will be addressed at the time. For copy of example Quarterly Provider report - see Appendix 26
How are local health providers able to respond to requests for input?	CCG ensures that all relevant health providers are aware of the EHC process, and the expectations of the plan. CCG has in place light-touch monitoring of response times (monitored via the local authority if necessary), and considers performance implications for contract management. CCG has a strategic approach to managing the logistics of the health input to the EHC process.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	There is a clear/secure referral pathway to start the EHC assessment process from the single point of access email in the SEN team The Solent EHC Assessment process flow document includes detailed steps along with timescales in which the EHC Plan medical section must be completed & returned to the LA SEN Team Appendix 33 . Portsmouth Local Offer holds information about how to request an EHC assessment along with timeframe of tasks in order to complete by week 20. http://www.portsmouthlocaloffer.org/local-offer-search/item/139 Further development would include a short e-learning course at induction re: EHC plans and healths involvement in developing them. This is being explored by education department.
Summary RAG Compliance		Total Green	5	0		
		Total Amber	0	0		
		Total Red	0	0		
Sign off						
<p>The CCG has discretion under section 3 of the NHS Act 2006 as to what it chooses to commission, and therefore, what services it will make available to the children and young people for whom it has responsibility. It is likely to be already commissioning paediatric and other services for children who would be eligible for EHC plans, so there would be no reason for not including these in a plan.</p> <p>If a CCG were to change its commissioning for children, and this meant some services were no longer made available, it would have to review the plans affected (and clearly the CCG would need to consider carefully the evidence on which it drew in making that decision).</p>						
Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
How does the CCG resolve disputes on individual plans	How does the CCG resolve disputes on individual plans?	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	EHCP letters include information regarding who to contact if they wish to make a complaint or enter the mediation/dispute resolution process. PPV offer advice and guidance to parents/carers of younger children ref EHC and SEN process IASS support older children with advice and guidance on EHC & SEN process CCG are part of the Global Mediation Contract - see Dispute/Mediation process on Local Offer and Notice to all settings ref Dispute Resolution process - available on the Local Offer - see Appendix 22 and 23 The CCG has a robust complaints procedure to manage disputes if they reach Tribunal stage Appendix 24
Is there sufficient scope for an iterative process before plan sign-off?	CCG has mechanism for plan sign-off, which is the culmination of plan development and scrutiny by all relevant parties.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	Health Provider - Solent are developing a quality assurance process internally to ensure that the medical section of the EHC plan is clinically assured and from within commissioned service. If the medical input is over and above commissioned service, DCO will advise on whether provision is appropriate and this is then forwarded to the ICS Programme Manager for approval to go through either the IFR route or the High Needs Support Panel for funding approval. http://www.portsmouthccg.nhs.uk/Downloads/Individual%20Funding%20Request%20leaflet.pdf http://www.portsmouthlocaloffer.org/local-offer-search/item/80
Does the CCG have a clear sign-off process in place?	CCG either has its own sign-off arrangements in place (e.g. by suitable personnel with appropriate links to strategy and finance), or has a protocol for delegation to a senior clinician or the DMO.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select		EHCP come to the inclusion panel for sign off, a health practitioner sits on the panel and the decision as to whether or not to approve EHC plans are decided at this meeting. Data sharing for the individual child is an issue including how information is shared across Education, Health and Social Care. There is no requirement for health to sign off plans.
Summary RAG Compliance		Total Green	3	2		
		Total Amber	0	0		
		Total Red	0	0		
<p>FURTHER INFORMATION:</p> <p>Nottinghamshire County Council's EHC plan animation: https://www.youtube.com/watch?v=3z8B8gMksg</p> <p>The British Academy of Childhood Disability has developed detailed guidelines for professionals who are asked to contribute to an EHC plan: http://www.bacdis.org.uk/policy/documents/MedicalAdviceforEducation-ReforPaedsBACCHBACD23Sept2014.pdf</p> <p>NB. DH is developing guidance for health services on responding to requests for information on a child's health, for the EHC plan assessment process.</p> <p>The SEND Pathfinder Information Pack - Coordinated Assessment Process and Education, Health and Care (EHC) Plan: http://www.sendpathfinder.co.uk/coordinated-assessment-process</p> <p>A guide to EHC plans for health professionals. http://www.councilfordisabledchildren.org.uk/resources/ehc-plans-for-health-professionals</p>						

5. Engagement						
Users						
<p>The NHS has a duty to promote the participation of the patient and public in decisions about their health and care. These duties are brought together in the NHS Constitution and apply to children and young people as well as adults.</p> <p>To fulfil these statutory obligations there are a number of elements which should be in place:</p> <ul style="list-style-type: none"> A policy on engaging with hard to reach groups and an active strategy for its implementation which includes events and activities. Able to demonstrate how it responds to the feedback which results from engagement activities, particularly in relation to commissioning. A mechanism for engagement with children and young people and their families – this may be through its local parent carer forum. <p>Children, young people and families should experience well coordinated assessment and planning leading to timely, well-informed decisions. Local authorities must consult the child and the child's parent or the young person throughout the process of assessment and production of an EHC plan, and families should be closely involved in the process, by:</p> <ul style="list-style-type: none"> being provided with access to the relevant information in accessible formats; given time to prepare for discussions and meetings, and being allowed dedicated time in discussions and meetings to air their views. <p>The lay representation in the CCG's Governing Body would provide a means for lay scrutiny of joint arrangements, but there does need to be a clear line of sight from the CCG executive. Senior understanding of the statutory duties could be assured through a regular, although not too frequent standing item on the agenda of executive meetings (or an appropriate sub-group).</p> <p>Note that local Parent Carer forums and other patient / user representation groups are likely to be determined in their wish to hold CCGs to account for their role in relation to children's disability, an area which can attract significant local press attention.</p>						
Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
	<p><i>CCG has a [published] policy on engaging with hard to reach groups and is active in ensuring this is implemented.</i></p> <p><i>CCG has specific events or engagement activities with hard to reach groups.</i></p> <p><i>CCG is able to demonstrate how it responds to the feedback from engagement in its policies, particularly in relation to commissioning.</i></p>	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	<p>NHS Portsmouth CCG has a Communications and Engagement Policy CCG Commissioner has worked in partnership with Portsmouth Parent Voice and local authority to coproduce the Local Offer</p> <p>In addition Portsmouth Parent Voice hold meetings 'Empowering Children and Families 'ECAF' to gather feedback on services and these are provided to CCG Commissioners Appendix 34</p> <p>CCG Commissioners have recently worked with parents to understand their views on the child autism assessment process and the role of the Autism Coordinator which resulted in securing funding for a further 12 months of the Autism coordinator role. Appendix 36</p> <p>***PPV: parent reps have been involved in the Future in Mind Strategy and have developed the new Early Help Service from service design to tendering process. PPV 'What's Trending' report is also shared at the Joint-Commissioning Steering Groups to identify gaps in services. Appendix 35</p> <p>http://www.portsmouthccg.nhs.uk/Communications%20%20Engagement%20Strategy%20APPROVED%20GB19%2011%2014.pdf</p> <p>Engagement Policy</p> <p>http://www.portsmouthlocaloffer.org/LocalOffer</p>
* Does the CCG link with its Parent Carer Forum?	<i>CCG has regular contact with its local PCF.</i>	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	<p>Portsmouth Parent Voice are involved in many projects with CCG/ SEN Team. These are detailed in Appendix 37</p> <p>PPV website - http://www.portsmouthparentvoice.org/</p> <p>The parent carer forum has also been involved in IPC Childrens pilot. See attached. Appendix 38</p>
* How does SEND feature in the CCG's exercise of its statutory duties in relation to engagement?	<p><i>CCG has a mechanism for engagement with children and young people with SEND and their families.</i></p> <p><i>CCG is able to demonstrate how it responds to the feedback from engagement with children and young people with SEND, and their families, in its policies, particularly in relation to commissioning.</i></p>	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	See Line Item 8 above
* Has the CCG worked with children and young people and their families in developing its role in joint arrangements?	<p><i>CCG (or its providers) have involved children or young people with SEND and their families in their contribution to the:</i></p> <ul style="list-style-type: none"> - Local Offer - EHC plan <p><i>or have made sure that the local authority, in its engagement with children and young people, takes account of children's health needs.</i></p>	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Partially Achieved: Some Progress/Implemented in some areas	Please select	Please select	<p>Dynamille (CYP with health needs), PPV, CA and CCG as well as Health Provider are represented at the SEND Working Groups and the SEND Strategy Board - All have worked together to develop the EHC plans, processes and templates along with the Local Offer. Now the focus of the work has moved to developing the SEND Strategy and SEND Joint Commissioning Plan - see SEND Strategy Document Appendix 14 and draft SEND Joint Commissioning Plan Appendix 3</p> <p>PPV is jointly funded whose role it is to engage with representative groups of families, CYP.</p> <p>PPV uses several method to obtain feedback from parents to inform joint commissioning arrangements.</p> <p>Surveys, focus groups, events, social media drop - ins in schools.</p> <p>Feedback is collated on a monthly basis and shared at the joint- commissioning steering groups every 6 months.</p> <p>PPV have very good working relationship with health partners who are quick to deal with issues raised at meetings. Having contact names such as Neil Smith (DCO), commissioners and health practitioners have enabled us to resolve issues effectively.</p> <p>Engagement with younger children is not fully developed. This group are difficult to access with SEND and therefore need to be developed in order to meet their needs.</p> <p>Solent NHS Trust quarterly report includes feedback on services from patients. See Commissioning Tab line 30 for example quarterly report from Provider.</p> <p>Provider and Commissioner regularly contact each other and should an issue come up relating to a child/children with SEND, this will be addressed at the time .</p> <p>Solent are developing Friends and Family Test Feedback forms to provide to commissioning in line with NHS Mandatory guidance. Work has been completed on mapping FFT reporting to reflect Solent geographical locality data from children services. Commissioners to work with Solent DCO to further develop this so that pertinent data is supplied for the SEND Quarterly Monitoring Report.</p> <p>The POET tool feedback has been used to analyse EHCP's.</p> <p>Matt Fowkes currently working on report - should be available in about 2 weeks</p>
* How can the CCG measure the patient experience of children with SEND?	<p><i>CCG measurement of user / patient experience allows experiences of children and young people with SEND to be identified.</i></p> <p><i>CCG or its providers uses the Parent Carer Forum to survey experiences of children and young people and their families.</i></p> <p><i>Friends and Family test allows experiences of children and young people with SEND to be identified.</i></p> <p><i>Implications of NHS National Children's Inpatient and Day Case survey results from local Trusts for children and young people with complex needs are considered.</i></p> <p><i>CCG or its providers use bespoke feedback gathering (e.g. survey, feedback forms, focus groups).</i></p>	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	<p>Solent NHS Trust quarterly report includes feedback on services from patients. See Commissioning Tab line 30 for example quarterly report from Provider.</p> <p>Provider and Commissioner regularly contact each other and should an issue come up relating to a child/children with SEND, this will be addressed at the time .</p> <p>Solent are developing Friends and Family Test Feedback forms to provide to commissioning in line with NHS Mandatory guidance. Work has been completed on mapping FFT reporting to reflect Solent geographical locality data from children services. Commissioners to work with Solent DCO to further develop this so that pertinent data is supplied for the SEND Quarterly Monitoring Report.</p> <p>The POET tool feedback has been used to analyse EHCP's.</p> <p>Matt Fowkes currently working on report - should be available in about 2 weeks</p>
Summary RAG Compliance		Total Green	4	0		
		Total Amber	1	0		
		Total Red	0	0		
FURTHER INFORMATION:						
<p>The SEND Pathfinder Information Pack - Engagement & Participation – has a very extensive collection of good practice and resources on engaging with children, young people and their families:</p> <p>http://www.sendpathfinder.co.uk/engagement-and-participation-information-pack</p> <p>Contact a Family: for examples of how parent carer forums have helped improve services and resources on parent participation, see www.cafamily.org.uk/parentcarerparticipation</p> <p>A full list of Parent Carer forums can be found at the National Network of Parent Carer Forums: www.nnpcf.org.uk</p> <p>NHS England's guidance on patient and public involvement is Transforming Participation in Health and Care: http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf</p>						

6. Monitoring & Redress						
Data to Monitor Progress						
<p>Effective implementation can only be ensured through appropriate monitoring of the joint commissioning arrangements between CCG and local authority, of the process for developing individual EHC plans, and the success of the plans in delivering the outcomes specified for the child or young person. Given the comparative paucity of data collected on children's disability, the CCG will need to identify and collect its own dataset of indicators of effective implementation, covering both process measures, and health and wellbeing outcomes for the child or young person. Engagement with children, young people and their families will also allow evidence of the user-reported experience to inform a view of implementation. Deep dive scrutiny of individual plans might identify gaps between need and provision (e.g. for SLT). The Children and Young People's Dataset has been mandated for central flow from all NHS providers to HSCIC since September 2015. This will, when fully implemented provide a rich source of data for CCGs and they will wish to ensure that providers are implementing the dataset.</p> <p>See the annex for suggestions for monitoring information.</p>						
Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
<ul style="list-style-type: none">What evidence does the CCG use to monitor progress of its SEND arrangements?Does the CCG consider evidence of:<ul style="list-style-type: none">the effectiveness of joint arrangements;the effectiveness of engagement with stakeholders and service users;progress on individual EHC plans;the numbers of requests for EHC plans / requests for input by the LA;how providers are participating in the progress;timeliness of advice;progress against outcomes in EHC plans;improvements in health and wellbeing outcomes for children and young people with SEND for whom the CCG is responsible?	<p>CCG has monitoring embedded in its joint arrangements, with appropriate executive oversight.</p> <p>CCG produces regular performance reports using a range of relevant indicators, and reflects on their implications.</p>	ICS Programme Mgr/Solent Head of Children Services/LA Inclusion Support Manager/PPV Manager/IPC Programme Manager	Full Compliance: Fully Achieved/Imp lemented	Please select	Please select	<p>ICS Commissioning Managers hold quarterly commissioning contract review meetings with the Provider to review each service.</p> <p>In addition, Provider and Commissioner regularly contact each other and should an issue come up relating to a child/children with SEND which are addressed at the time.</p> <p>The SEND Quarterly Monitoring Report includes IR and KPI from Health contracts, these are currently under review to assess if they provide the right kind of information needed to inform progress on children with SEND/and highlight any issues with health provision to SEND children/and provide feedback on services.</p> <p>For children with SEND, POET has now been adopted as the Outcome Measurement Tool for EHC Care Plans</p> <p>The POET evaluation report is sent to CCG for information and identify any health issues to be actioned. This is done annually.</p> <p>CSC/Education will only be flagged up if provision does not meet needs.</p> <p>Exception reports only. Look at annual audit of snapshot of children. Analyse tribunal data annually to identify trends, gaps in analysis. This is the evidence we use.....</p> <p>- cross reference against performance framework.</p>
<ul style="list-style-type: none">Has the CCG considered potential gaps and new collections, e.g. <ul style="list-style-type: none">questionnaires of service usersa regular data return from designated providers etc.data from the local authority on requests and timeliness of response.	<p>CCG has mapped existing data sources and collects new data and intelligence where relevant.</p>	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Imp lemented	Please select	Please select	Developing through the commissioning strategies and need assessment processes. Use POET tool for analysis.
<ul style="list-style-type: none">What evidence does the CCG use to demonstrate compliance with its statutory duties, and to inform National Assurance (e.g. by NHS England, or CQC / Ofsted joint inspections).	<p>CCG has a process of collecting evidence systematically to support assurance, informed by CCG Assurance Framework and CQC / Ofsted inspection framework.</p>	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Imp lemented	Please select	Please select	NHS England Assurance Form- see attached.
Summary RAG Compliance		Total Green	3	0		
		Total Amber	0	0		
		Total Red	0	0		
Data Sharing						
<p>Consent for sharing of personal data should be fundamental to the EHC process; consent should be obtained initially for sharing plan documentation with potential contributors, and sharing evidence to inform co-ordinated assessment. Plan portability will support better data sharing. Some local authorities have developed web-based portals / electronic records, which allow contributors to be granted consent by the child or young person, and to add their advice remotely.</p> <p>The new NHSmail encryption feature means that health and social care staff now benefit from a secure service which allows them to communicate across organisation boundaries and industry sectors. NHSmail can now be used securely across the entire health and social care community – in fact with anyone using any email account. This feature will allow health professionals to submit their contributions to EHC plans, and to discuss cases involving confidential data, by e-mail.</p>						
Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
<ul style="list-style-type: none">Has the CCG worked with the local authority to map data flows to support EHC plans?	<p>Has the CCG ensured there is a proportionate way for different professionals both to contribute advice to the plan, and to scrutinise and sign-off the draft – e.g. through an electronic plan</p>	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Imp lemented	Please select	Please select	The CCG worked with the LA to map data flows when developing the referral and monitoring processes for EHCP's. This took place during SEND Implementation groups and SEND board meetings.
<ul style="list-style-type: none">Is there a policy in place for local data sharing, fundamental to a co-ordinated assessment and planning process? Different professional teams may have different systems (e.g. GPs, community nurses, hospital paediatricians) – has the CCG checked with providers how effectively – if at all – these can talk to each other?		Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Imp lemented	Please select	Please select	Portsmouth Childrens Trust Board has developed Portsmouth Information Sharing Agreement. It is an overarching Framework which outlines the principles and standard of expected conduct and practice of the signatories. It includes templates for privacy impact assessments and information sharing operational agreements which agencies can use in specific circumstances or projects.
<ul style="list-style-type: none">Are arrangements in place for data sharing via secure networks (or by using the encryption function in NHSmail e-mails)?data from the local authority on requests and timeliness of response.		Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Imp lemented	Please select	Please select	Solent NHS Trust has secure SPA email at Battenburg Office Admin Team who receive emails from SEN Team to request EHC Plan Assessment. Solent Battenburg Team then direct the EHC Plan requests to appropriate clinicians, gather inputs and send back to the SEN Team secure SPA email; thereby ensuring the most effective and secure route back to the SEN Team for the completed EHC Plans.
<ul style="list-style-type: none">In the absence of electronic data sharing, has the CCG overseen a protocol for e-mail or paper-based communication, which meets the expectations of the EHC template, and can support a co-ordinated process (e.g. e-mails to a central local authority or CCG mailbox)?		Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Imp lemented	Please select	Please select	For details of the above process and the description of the DCO role, see Leadership tab, line item 29 and 41.
Summary RAG Compliance		Total Green	4	0		
		Total Amber	0	0		
		Total Red	0	0		
FURTHER INFORMATION:						
<p>The revised Caldicott Principles: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251750/9731-2901141-TSO-Caldicott-Government_Response_ACCESSIBLE.PDF</p> <p>A guide to confidentiality in health and social care. Treating confidential information with respect (HSCIC, 2013). http://www.hscic.gov.uk/media/12822/Guide-to-confidentiality-in-health-and-social-care/pdf/HSCIC-guide-to-confidentiality.pdf</p> <p>Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers (HM Government, 2015). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419628/Information_sharing_advice_safeguarding_practitioners.pdf</p> <p>Further resources to support safe and effective information sharing can be found at the Centre for Excellence for Information Sharing (http://informationsharing.org.uk/) and the Information Governance Alliance (http://systems.hscic.gov.uk/infogov/iga). For a step-by-step guide for senders in the NHS using NHSmail see Sending an encrypted email from NHSmail to a non-secure email address (January, 2015) http://systems.hscic.gov.uk/nhsmail/secure/senders.pdf</p> <p>For recipients, see Guidance for recipients of an encrypted NHSmail email (January, 2015) http://systems.hscic.gov.uk/nhsmail/secure/recipients.pdf</p>						

Complaints						
As per the legislative framework in the Local Authority Social Services and National Health Service Complaints Regulations 2009 [SI 2009; No 309], a complaint may be made to an NHS body, and when the complaint is dealt with, to the Parliamentary and Health Service Ombudsman, if the complainant is still dissatisfied.						
The joint arrangements for SEND must include arrangements for ensuring that disputes between the parties to those arrangements are resolved as quickly as possible, and arrangements for dealing with complaints in relation to the EHC plan.						
Analysis of complaints in relation to EHC plans would reflect on the efficacy of assessment and planning for health.						
Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
• Does the CCG have a clear policy for complaints handling which can be applied in relation to SEND?	CCG complaints handling policy or system recognises the particular issues relevant to SEND.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Imple mented	Please select	Please select	CCG Complaints Policy along with Flow Chart to explain process is held in this document- see below... Complaints that are sent directly to the Provider are discussed at the Quarterly Contract Review meetings that are chaired by the Commissioning Team on behalf of the CCG
• Has the CCG or providers identified likely foci for complaints in the new framework (e.g. a long-standing long wait for assessment, delays in providing children's wheelchairs).	CCG monitors complaints relevant to SEND, and has a mechanism for reflecting on / acting on issues raised A potential KI would be the % of complaints relating to SEND (as % of complaints overall. One would expect the percentage of complaints to be broadly in line with local prevalence of SEND - e.g. less than 3%).	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Imple mented	Please select	Please select	Each Childrens Community Service is reviewed within the quarterly monitoring meetings and any issues with provision to children with SEN Plans or EHC Plans from a health perspective is discussed. Provider and Commissioner regularly contact each other and should an issue come up relating to a child/children with SEND; this will be addressed at the time. For a copy of Quarterly Provider report - see Commissioning Tab, line 30 The SEND Quarterly Monitoring Report includes IR and KPI from Health contracts. See Line Item 8 above. Portsmouth is Demonstrator Site for IPC Programme and are in the process of reviewing the use of the POET Tool to monitor outcomes for children with SEND. See Commissioning tab line 39. The outcomes from the parent survey would be used to flag up issues within health services. PPV's whats trending will also identify current issues with parents.
• Does the CCG have a PALS- type service for patient / user liaison? Is it fully sighted on the new SEND arrangements?	CCG has a PALS-type service, with published contact details. The service is primed for supporting families in the SEND process (e.g. representatives have training or supporting information on SEND, and onward routes of contact for resolving issues).		Full Compliance: Fully Achieved/Imple mented	Please select		How to make a complaint or raise a concern, comment or compliment If you have an issue about health services in your local area please contact the Complaints and Concerns Team: Email: portsmouthccgcomplaints@portsmouthccg.gov.uk Phone: 023 9283 4456 Portsmouth City Council Corporate Complaints Team Civic Offices Guildhall Square Portsmouth PO1 2BG Web link is below:- http://www.portsmouthccg.nhs.uk/Join-In/Tell-us-what-you-think/Make-a-complaint/Make-a-complaint.htm
• Has the CCG / local authority worked with local Healthwatch, or other partners, to ensure clear advice is available locally on the SEND arrangements?	Contact details are included in the published local offer.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Imple mented	Please select		Dynamite (CYP with health needs/Id), PPV, LA and CCG as well as Health Provider are represented at the SEND Working Groups and the SEND Strategy Board - All have worked together to develop the EHC plans, processes and templates along with the Local Offer . Now the focus of the work has moved to developing the SEND Strategy and SEND Joint Commissioning Plan - see SEND Strategy Document and draft SEND Joint Commissioning Plan on Engagement Tab, line 11 Information advice and support service- delivered by rose road.
• Has the CCG / local authority a co-ordinated or common framework for handling complaints.	CCG and Local Healthwatch have routine contact on SEND, complex needs.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Imple mented	Please select		See Line Item 32 & 34 above and embedded documents
• Is the PALS service appropriate for the joint arrangements? Is there a way for the PALS service to act as an advisor along the EHC plan process timeline (or to liaise with the local authority plan lead)?	CCG and local authority have an agreed approach to complaints handling, and share information, feedback etc. between them. CCG and local authority have a single point for making complaints in relation to an EHC plan (which could be via the local authority).	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Imple mented	Please select		See Line Item 32 & 34 above and embedded documents In the first instance the SEN Team will receive complaint from parent ref EHC Plan and if this involves health provision - SEN Team will contact ICS Programme Manager to discuss and look for ways to overcome the issue prior to mediation CCG are part of the LA Global Mediation Contract and pay for mediation on a case by case basis. CCG Commissioner recently attended Mediation meeting with LA SEN Manager in relation complaint ref health element of EHC Plan. If Mediation does not solve the issue, then those EHC plans with health provision that are being questioned by parents will fall into the formal NHS Complaints procedure. http://www.portsmouthccg.nhs.uk/Join-In/Tell-us-what-you-think/Make-a-complaint/Make-a-complaint.htm
Summary RAG Compliance		Total Green	6	0		
		Total Amber	0	0		
		Total Red	0	0		

Mediation						
<p>Mediation must be offered to any child or young person (or their family), dissatisfied with the health element of the EHC plan.</p> <p>The local authority will have arrangements for mediation for the education element of the EHC plan, and as part of the joint arrangements, the LA and CCG could agree to use the same mediators or participate in a single framework or contract for the provision of independent mediation. Some CCGs have agreed to spot purchase mediation from the local authority mediation provider.</p> <p>Effective working with the family in developing the plan and managing expectations should avoid the need for mediation in relation to the health element of the plan.</p> <p>Mediation is typically only a valuable process if there is the potential for a compromise or alternative option on each side; a CCG entering into mediation will need to consider what the possible additional options might be in relation to a child's EHC plan health element.</p>						
Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAG Rating: DD/MM/YY	2nd Audit RAG Rating: DD/MM/YY	Trend	Comments/Evidence
• Has the CCG arrangements in place to provide mediators?	CCG has a contract or other supply arrangements in place with an independent mediator.	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/implemented	Please select	Please select	<p>CCG are part of the LA Global Mediation Contract and pay for mediation on a case by case basis. The provider is to be reviewed towards the end of the contract to include quality checking audit.</p> <p>The CCG is assisted in responding to any complaints by Portsmouth City Council. This is a free, impartial and confidential service for anyone with concerns about the services we commission or who needs advice or information about the NHS.</p> <p>EHCP letters include information regarding who to contact if they wish to make a complaint or enter the mediation/ dispute resolution process.</p> <p>• PPV offer advice and guidance to parents/carers of younger children ref EHC and SEN process</p> <p>• IASS support older children with advice and guidance on EHC & SEN process</p> <p>• CCG are part of the Global Mediation Contract - see Dispute/Mediation process on Local Offer and Notice to all settings ref Dispute Resolution process - available on the Local Offer.</p> <p>• The CCG has a robust complaints procedure to manage disputes if they reach Tribunal stage, see line item 34 above</p> <p>The CCG is assisted in responding to any complaints by Portsmouth City Council. This is a free, impartial and confidential service for anyone with concerns about the services we commission or who needs advice or information about the NHS.</p>
• Is there a procedure in place for initiating mediation?	CCG has an agreed process for escalating a request for mediation (agreed with local authority).	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/implemented	Please select	Please select	<p>With reference directly to SEND - EHCP letters include information regarding who to contact if they wish to make a complaint or enter the mediation/dispute resolution process.</p> <p>• PPV offer advice and guidance to parents/carers of younger children ref EHC and SEN process</p> <p>• IASS support older children with advice and guidance on EHC & SEN process</p> <p>• CCG are part of the Global Mediation Contract - see Dispute/Mediation process on Local Offer and Notice to all settings ref Dispute Resolution process - available on the Local Offer - see below files</p> <p>• The CCG has a robust complaints procedure to manage disputes if they reach Tribunal stage</p> <p>For processes - see line 32, 34 & 45 above</p>
• Has the CCG considered the capacity needed for mediation, and factored this into capacity planning?	<p>Historic data on mediation / complaints etc. obtained from local authority.</p> <p>CCG has projected potential referrals based on this data, anticipated demand etc.</p> <p>CCG has included costs of mediation in annual admin resources for SEND.</p>	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/implemented	Please select	Please select	CCG are part of the LA Global Mediation Contract and pay for mediation on a case by case basis.
Summary RAG Compliance		Total Green	3	0		
		Total Amber	0	0		
		Total Red	0	0		

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Agenda Item 7

THIS ITEM IS FOR INFORMATION ONLY

(Please note that "Information Only" reports do not require Equality Impact Assessments, Legal or Finance Comments as no decision is being taken)



Portsmouth
CITY COUNCIL

Title of meeting: Health and Wellbeing Board

Subject: Revised Future in Mind Transformation Plan

Date of meeting: 29 November 2017

Report by: Stuart McDowell - Integrated Commissioning Service

Wards affected: All

1. Purpose

The Health and Wellbeing Board members to review the refreshed Future in Mind Transformation Plan we recently submitted to government.

2. Background and Context

Future in Mind Transformation Plan

1. In September 2014 a National Children and Young People's Mental Health and Wellbeing Taskforce was established to consider ways to make it easier for children, young people, parents and carers to access help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided.
2. The final report Future in Mind – Promoting, protecting and improving our children and young people's mental health and wellbeing was published by the government in March 2015.
3. Local CCGs were required by NHS England to draw up Transformation Plans based on the recommendations of the Future in Mind report and the identified need locally. We submitted our plans which were agreed and will receive additional funding to help us deliver those plans.
4. We have recently had to submit a refreshed Transformation Plan to our NHS Regional Strategic Network which provides a progress update on the plans we set out in our original transformation plans. This update had to be submitted by the end of October 2017.
5. A key line of enquiry document was issued to all CCG's which identified all those areas we should cover in our revised plan. One of the KLOE was that we should have our plans ratified off by the CCG, the Health & Wellbeing Board and local partners.

THIS ITEM IS FOR INFORMATION ONLY
(Please note that "Information Only" reports do not require Equality Impact Assessments, Legal or Finance Comments as no decision is being taken)

This proved very challenging due to timescales and so we had to submit our plans with just CCG sign off. This was an issue for all CCG's across the region and so we have all sought retrospective sign off by local partners.

3. Information Requested

None

Suzannah Rosenberg
Signed by Director of Quality & Commissioning, NHS Portsmouth Clinical Commissioning Group

Appendices:

Revised Future in Mind Transformation Plan

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location
Revised Future in Mind Transformation Plan	Attached

Future in Mind

Portsmouth

Promoting, protecting and improving our children and young people's mental health and wellbeing



Local Transformation Plan Refresh - October 2017

FOREWORD

Mental health is something that affects us all - how we think and feel about ourselves and others, how we cope with difficult situations and how we manage our lives. Mental health problems are widespread - and improving outcomes for our children and young people is a priority for us as we shape future services across Portsmouth. It's essential that young people and their families remain at the heart of our planning as the design and delivery of mental health provision continues to evolve.

The National Future in Mind report describes an integrated whole system approach to driving future improvements in mental health outcomes with the NHS, Public Health, Voluntary and Community, Local Authority Children's Services, Education and Youth Justice sectors working together.

Future in Mind offers us an important opportunity to build on existing strategies and plans to strengthen the emotional resilience and mental wellbeing of children, young people and their families to improve future health outcomes.

We have now developed a joint delivery plan (as part of the Hampshire and Isle of Wight Sustainability Transformation Plan) for the next two years which aligns with our local Future in Mind Transformation Plan in respect of the following priorities:

- Improving resilience and positive emotional wellbeing in children and young people.
- Strategies to address maternal mental health problems during pregnancy and to promote good parent/carer-child relationships.
- Staff in schools, primary care, local authority children's services and the voluntary sector agencies possess enhanced knowledge of common emotional/mental health problems and neurodevelopmental disorders and are able to signpost individuals to appropriate services.
- Extended hours support, crisis resolution and home treatment should be available for those young people otherwise at risk of psychiatric admission.
- A smoother experience of transition between services aimed at children and young people and services aimed at adults.
- For children and young people thought to require admission due to mental health issues, all agencies and professionals involved in the child's care should be included in decision making about whether admission is in the best interest of the child and family.

In Portsmouth, we are keen to make sure that we both take advantage of the opportunities of alignment with the HIOW STP and target our local resources effectively to best meet the needs of the city. We will be reviewing carefully our recently refreshed local needs assessment information to make sure that we address key local needs and priorities within our developing strategy.

It is important to ensure that mental health becomes a part of everyday conversation and is something that everybody is aware of and cares about. It also means making sure we remain focused on quality and safety, sharing decisions between young people, families and clinicians so that children and young people receive the responsive care that they need, in the right place, at the right time.

Dr Annie Eggins

NHS Portsmouth Clinical Commissioning Group
Executive Member (Children and Families)

VIEW OF THE DIRECTOR OF CHILDRENS SERVICES

Promoting the emotional health and wellbeing of children and young people is central to improving their life chances. It makes a critical difference to their engagement and success in education; it affects all aspects of their wider health; and it is vital in supporting families and in making a success of alternative care arrangements. For this reason all members of the Portsmouth Children's Trust Partnership are committed to playing their part in an effective "Future in Mind" strategy for the city. That commitment can be seen in all the strategies underpinning our local Children's Trust Plan. In Education, the new strategy developed by partners across the education landscape has the promotion of emotional wellbeing as a key strategic objective and the City Council has invested, jointly with the CCG, in central coordination for the implementation of the "Future in Mind" strategy for emotional resilience and wellbeing in education. The new Prevention and Early Help Service for the city, designed to improve family resilience and reduce demand for expensive statutory social care intervention, has the promotion of emotional wellbeing at its heart. And effective response to children with social, emotional and mental health needs is a key priority in the Portsmouth strategy for supporting children with Special Educational Needs and Disability.

Responding proportionately to the differing needs of children and young people in the city is crucial and I welcome the refreshed needs assessment compiled by the Future in Mind team with support from colleagues in Public Health. I know that partners across the city will be keen to work together to review our services and strategy so that the needs identified in that assessment can be addressed as effectively as possible, through continuing creative joint working.

Alison Jeffery

Director, Children, Families and Education, Portsmouth City Council

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1. INTRODUCTION

As part of the governments challenge that every local area needs to improve how children and young people's mental health services are organised, commissioned and provided we are required to update our Future in Mind transformation plans on a yearly basis.

This document describes how as a local system we plan to improve the emotional wellbeing and mental health of all Children and Young People across Portsmouth in line with the national ambition and principles set out in Future in Mind – Promoting, protecting and improving our children and young people's mental health and wellbeing.

This plan describes the local/regional context; outlines the service offer; demand on services and describes our achievements and challenges alongside an action plan that sets out how we are going to develop and transform the support offer across Portsmouth.

This plan has been developed by the Social Emotional and Mental Health multi-agency group and has been informed by a whole range of other stakeholders including parents and young people.

The Portsmouth Vision

We want all children and young people in Portsmouth to enjoy good emotional wellbeing and mental health.

The way in which we will achieve this vision is by:

- Establishing a clearly understood needs-led model of support for children and young people with Social Emotional Mental Health difficulties which will provide access to the right help at the right time through all stages of their emotional and mental health development.
- Ensuring that every child and young person has access to early help in supporting their emotional wellbeing and mental health needs which will prevent difficulties escalating and requiring specialist mental health services.
- Supporting professionals working with children and young people to have a shared understanding of Social Emotional Mental Health and to promote resilience and emotional wellbeing in their work.

There is a clear shared ambition in Portsmouth to adopt a whole system approach to developing and transforming the support for children and young people's mental health and wellbeing. Fundamental to this approach is the importance of partnership working alongside our colleagues in the local authority, health, education, youth justice system and the voluntary sector.

To support this approach we have agreed that we will work alongside all partners across the system in a healthy constructive way by adopting the following principles, behaviours and values.

We will ensure our behaviours support these principles through:

- Openness, transparency and trust
- Honest and mature conversations
- Openness to constructive challenge
- Making realistic assessments of delivery and risk
- Collaborative working
- Respecting each other's challenges and views

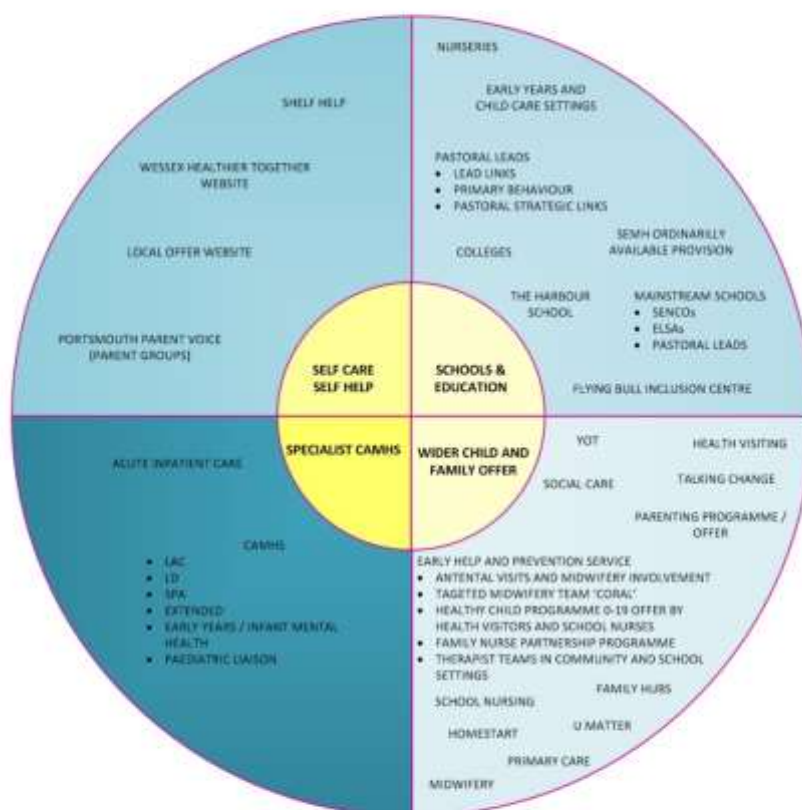
We will also ensure that we involve children, young people and parents throughout the review and redesign process using the principles of co-production. We will make sure co production occurs during the co-design, co-decision making, co-delivery and the co-evaluation of services.

Social Emotional and Mental Health Transformation

As a result of a stakeholder event in the summer of 2017 we chose to no longer use the term Future in Mind to describe our ambition as it was felt this term was narrowing our view and what we want to achieve. It's important to note that we still fully agree with the principles, ambition and spirit set out nationally it's just that we feel a better term for us to adopt locally would be Social Emotional and Mental Health transformation. We feel this change in language will support us to mainstream our plans across the whole children and families system with the ambition that social and emotional mental health becomes 'everyone's business' in the same way as safeguarding has become 'everyone's business' across Portsmouth.

At this stakeholder event we mapped out what the local Social Emotional and Mental Health offer was in the city using the diagram below. This will help us to further understand where the key areas of support are and also understand what support those areas need from specialised CAMHS services using the Team around the Worker model that is described further in this document.

PORTSMOUTH SOCIAL, EMOTIONAL AND MENTAL HEALTH OFFER
CHILDREN, YOUNG PEOPLE AND FAMILIES



Summary of Achievements

It has been a very busy year this year in delivering our transformation plans and we are proud with what we have been able to achieve alongside young people, parents and our strategic partners from the local authority, health, education and the voluntary sector. What follows is a summary of our achievements this year with more detail towards the end of this document.

Strategy for Improving Wellbeing and Resilience in Education

The strategy is complete; a working group is in place alongside a robust delivery plan.

Children and Young People's Improving Access to Psychological Therapies (CYP IAPT)

CAMHS staffs have been accepted on the courses and the service is now part of the Reading/Oxford collaborative.

Co-Production

We have established both a young persons and parent's user led groups that have helped to support local development and transformation plans.

Restorative Practice

We have trained over 200 professionals in RP and a third of our schools have signed up to becoming restorative schools.

CYP Mental Health Guides for professionals, parents & young people

The guides are now complete and are being widely used to access support.

Early Help - U Matter service

The service is fully operational, in demand and working with young people in a timely responsive way.

Early Years Team

The enhanced offer is supporting the Multi Agency Teams to recognise and intervene to support families with attachment issues.

Crisis Post

The Crisis worker has delivered packages for young people that have resulted in reduced numbers of Tier 4 admissions as well as length of stay of admissions.

Early Intervention and Specialist Perinatal Support services

The new services are both fully operational and supporting women in the community in a timely responsive way.

Key Priorities for 2017/18

Priorities	What will success look like?	Next steps
Complete the Social Emotional And Mental Health Needs Assessment	System leaders will gain a better understanding of needs and capacity in the system	Review the current needs assessment with Public Health and partners; identify gaps and review what the needs assessment is telling us and whether our current service offer sufficiently addresses key needs.

Priorities	What will success look like?	Next steps
Review the Eating Disorder offer	Commissioners and NHS England will be assured that the service model they choose to adopt will meet the standards as set in the national guidance.	Update the regional Eating Disorder gap analysis to understand how the local offer meets the standards as set out in the national guidance and potentially undertake a peer review that will help commissioners and providers to compare and contrast models.
Commission an all age psychiatric liaison service	Young people who attend/admitted to hospital will receive rapid access to specialist mental health assessment and timely appropriate follow up support in their community.	Work with the CAMHS providers of the paediatric liaison offer to understand how we shift the financial resource associated with the current contracts and to understand the future funding to commission an all age psychiatric liaison service.
Strategy for Improving Wellbeing and Resilience in Education	Children and young people feel that their school and other local services are helping them to be resilient and to cope with life situations.	Review the current CAMHS offer to schools and colleges and develop an offer of additional support to schools and colleges through a traded services arrangement.
Early Intervention in Psychosis	Young people with a first episode of psychosis are treated as early as possible with appropriate support and treatment.	The EiP virtual team and CAMHS to produce a clear joint working framework that describes the pathways and working arrangements between the two services.
Managing demand into the Early Help - U Matter service	Increased capacity of the service to cope with demand meaning young people are supported at an earlier stage therefore reducing their need for specialist mental health services.	A proposal to be taken to the Clinical Strategy Committee for further funding and consideration to be given as to whether we reduce the age criteria for the service to up to 18 rather than up to 25.
Embed the Team around the Worker model	Professionals across the young people's workforce will be more confident in being able to support young people's wellbeing and resilience.	Understand the needs of the SEMH workforce to enable them to better support children and young people's mental health, wellbeing and resilience. The initial focus will include Health Visitors, School Nurses and Early Help & Prevention practitioners.

Priorities	What will success look like?	Next steps
Behaviour Management Guide	Families know how to access the behaviour management support across the community if they need it.	Map out the support offer available for parents across Portsmouth and promote this widely through a support guide.
Embedding Children and Young People's Improving Access to Psychological Therapies (CYP IAPT)	Improved access to evidence based interventions and reduced waiting times for treatment.	CAMHS staff to complete the CYP IAPT courses and embed the principles in the CAMHS service. System Leaders to consider how we could potentially adopt CYP IAPT principles across the SEMH network.
Performance Measures	System leaders will gain a better understanding of how well the system is performing which will help to continually improve how it responds.	Work will continue to agree a set of individual and local CAMHS service performance measures as well as agreeing the national data reporting requirements and process.
Wessex Healthier Together website	Young people and their families will have access to a range of online information advice and guidance relating to mental health and wellbeing.	Agree what information, advice and guidance should be included on the Wessex Healthier Together website and promote this resource across the community.

Further challenges identified

- Increased demand for services - Early Help, Specialist & Neurodevelopmental Assessments
- Recruitment challenges in CAMHS
- Bereavement and Loss
- Mental Health Support for Children and Young People who are victims of abuse & neglect
- Sleep Difficulties
- High Risk Adolescents
- Lack of Self Help/Self-Management
- Self-Harm
- Conduct Disorder
- Behavioural Issues
- Autism
- Primary Age i.e. 5 - 11
- Transition
- Anxiety

2. LOCAL STRATEGIC CONTEXT

2.1 Hampshire and the Isle of Wight Sustainability Transformation Plan (STP)

The Hampshire and Isle of Wight Health and Care System recognises the importance of good emotional wellbeing and mental health in children and young people (CYP), not only during childhood and adolescence, but also as predictors for positive mental health outcomes in adulthood.

As such there are a number of strategic commitments/work streams across the STP which directly affect CYP mental health:

Core Programme 6 - Mental Health Alliance

The STP is committed to working towards parity of esteem for mental health services, reviewing and aligning mental health care pathways, out of area placements, and crisis care. Each LTP gives more local-level detail for these priorities and how they affect CYP.

Enabling Programme 9 - Workforce

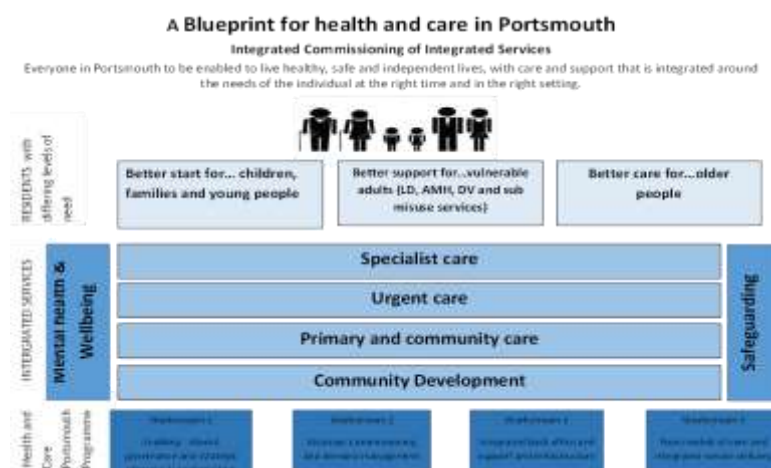
A comprehensive review of mental health workforce requirements is currently under way across the STP footprint, with a commitment to moving towards a flexible workforce shared across geographical and organisational boundaries, enabling care to be more responsive to CYP needs.

The Children's Programme undertakes to:

- implement New Models of Care, ensuring repatriation of CYP in Tier 4 beds back into locally-based provision (thus releasing money into the local CYP mental health care system); and
- strategically review ASC/ADHD provision across Hampshire to ensure consistency in pathways and information and support available to parents/carers of CYP undergoing assessment or diagnosed with these conditions.

2.2 Health and Care Portsmouth

The Health and Care Portsmouth project was launched in 2015 to help change the way health and social care is provided in the city. The co-location of health and care staff has been successfully completed and in Children's Services, integrated management has also been established across community children's public health services (health visiting, the Family Nurse Partnership programme and school nursing) and City Council early help services for families.



2.3 Stronger Futures

The Stronger Futures programme is about enabling and empowering families in Portsmouth to build good futures for themselves, improving the quality of their lives and reducing the need for expensive, reactive statutory services.

The programme builds on the implementation of the Multi-Agency Teams in 2015 -16. Key parts of the programme include - developing a new Early Help and Prevention Service to deliver targeted family-based support, developing clear early help pathways to improve early help assessment, planning and support, increasing the use of volunteering in the city, enabling family self-help where possible and developing Family Hubs.

In Children's Services, the new Head of Prevention and Early Help is bringing together the full range of preventative and early help services in the Multi-Agency Teams (MATs), across NHS Solent Trust and Portsmouth City Council. Contracted family support services are also integrated within the new service.

A critical part of the Stronger Futures transformation programme is the roll-out of a shared way of working with children, young people and families across the public service system. We have selected Restorative Practice as the key approach. This approach is about moving away from 'doing to' or 'doing for' towards a way of 'doing with' children, young people and families. Restorative practice works on a model of 'high support - high challenge', seeking to foster strong relationships to prevent and reduce harm. The model has applicability in a wide range of contexts including safeguarding, schools, health services and community services.

3. COMMISSIONING ARRANGEMENTS

Portsmouth City Council and the NHS in Portsmouth have a long history of positive and productive joint working. In 2010 our integrated commissioning arrangements were formalised using section 75 flexibilities (NHS act 2006) giving Portsmouth City Council delegated lead commissioner function from NHS Portsmouth CCG to commission a wide range of community health and social care services for adults and children.

3.1 Integrated Commissioning Service

The Integrated Commissioning Service (ICS) was established to deliver these arrangements and over the last seven years it has grown with the ambition to be an innovator in the commissioning of whole life pathways to deliver efficiencies and improve outcomes for vulnerable adults, children and families in the city. The ICS mission is to "Improve health and wellbeing outcomes for the people of Portsmouth through excellent commissioning" The service continues to evolve in line with the changing commissioning landscape.

The ICS is a joint commissioning service for Portsmouth City Council and NHS Portsmouth Clinical Commissioning Group with the aim to deliver efficiencies across departments and improve outcomes for vulnerable adults, children and families in Portsmouth through the commissioning of whole life pathways, joining up the delivery of services, and adopting a strategic approach to the wider determinants of health and wellbeing. The ICS also works in partnership with the Voluntary and Community Sector in Portsmouth and delivers commissioning and contracting functions across a range of areas.

4. HEALTH NEEDS ASSESSMENT

An Emotional Health and Wellbeing Health Needs Assessment has been produced which is currently being reviewed. It aims to describe and quantify (where possible) the need for preventative and other mental health services for children and adolescents in Portsmouth; to assess whether the use of services by children and adolescents with mental health problems in Portsmouth reflects need; and to make recommendations.

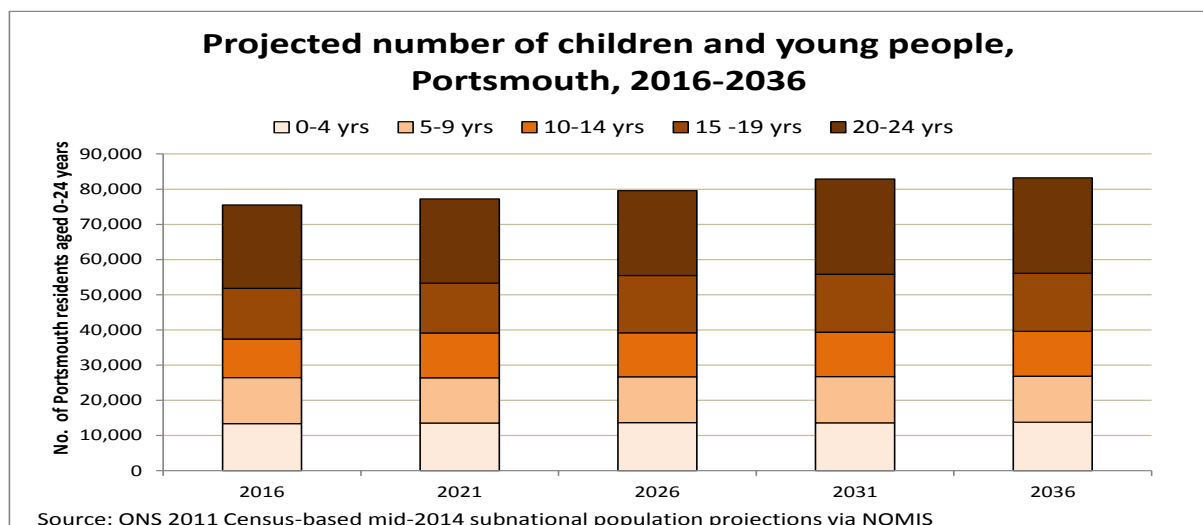
The needs assessment covers the mental health and wellbeing of children and young people in Portsmouth aged 0 to 24 years, highlighting where possible, groups at increased risk of experiencing mental health problems and links directly to the strategic plans of several boards.

4.1 Prevalence Rates

Population Growth and Projections

Between 2001 and 2011, Portsmouth's population of 0-24 year olds increased from 63,336 to 74,223 - with the largest increases of around 3,200 in 15-19 year olds and around 6,100 in 20-24 year olds.

In 2021, a projected 77,232 0-24 year olds will be living in the city. The greatest increase will be in those aged 10-14 years old which will increase by around 1,800 children (16% increase). The other age groups are predicted to decrease or increase by less than 2%. Looking further in the future, the graph below indicates projected increases in the number of children/young people in Portsmouth between 2016-2036.



It is estimated that there could be 2,126 pre-school children aged 2-5 living in Portsmouth who have a mental health disorder, studies in children aged 2-5 found that average prevalence rate of any mental health disorder in the age group was 19.6%.

There are 14,423 young people aged 15-19 and 23,688 young adults aged 20-24 in Portsmouth. Together, those aged 15-24 account for 18% of Portsmouth's population. The population of young adults aged 16-24 in Portsmouth is divided between 18.9% males and 16.8% females.

Children aged 11-16 years are more likely than those aged 5-10 to experience mental health problems. On the whole, boys are more likely than girls to experience conduct disorders and other mental health problems. However, girls are more likely to experience or have experienced certain conditions such as eating disorders.

Nationally, it is estimated that nearly 1 in 10 children aged 5-16 has a mental disorder. Emotional and conduct disorders are the most common mental disorders as seen in the table below. It is estimated that 19.2% of children and young people aged between 5-16 years have a mental health disorder in Portsmouth.

An estimated 4,120 to 6,180 children in Portsmouth are in need of Tier 1 services, falling to between 30 and 190 in need of Tier 4.

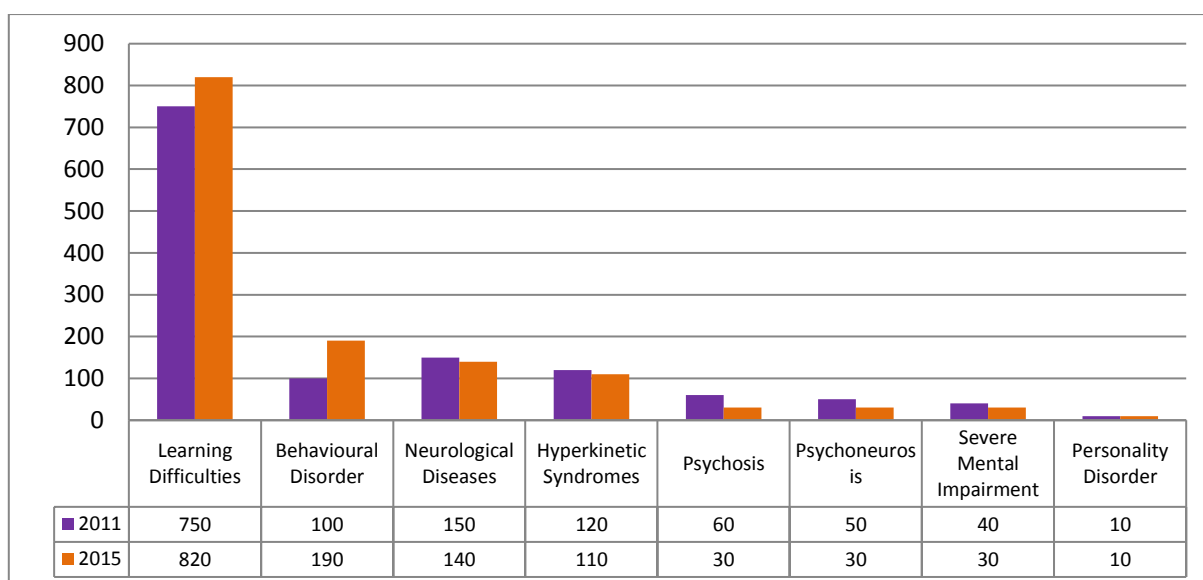
Estimated Level of Need by Service Tier for Portsmouth (2016)

	Model by Kurtz, 1996		Model by Campion and Fitch, 2013 (Joint Commissioning Panel for Mental Health model)	
	Prevalence, under 17 years old	Estimated number, under 17 years	Prevalence, under 17 years old	Estimated number under 17 years
Tier 1	15.00%	6,180	10.00%	4,120
Tier 2	7.00%	2,880	7.00%	2,880
Tier 3	1.85%	760	3.00%	1,240
Tier 4	0.075%	30	0.47%	190

4.2 Groups at Higher Risk of Mental Ill Health

Children with Disabilities or Physical Ill Health

One estimate of the number of young people with a disabling condition can be obtained through claimants of Disability Living Allowance (DLA). The SEND Needs Assessment gives more information about this dataset. Learning disabilities accounts for the greatest proportion of claimants at all age groups, (44% of all claimants aged 0-24 years) but the number of claimants for this disability is fewer than the 1,400 predicted by researched prevalence levels. The graph below shows the changing number of DLA claimants aged 0-24 years (2011-2015).



Looked after Children

The mental health of looked-after children is significantly poorer than that of their peers, with almost half (45%) of children and young people in care meeting the criteria for a psychiatric disorder. March 2016, there were 322 looked after children in Portsmouth (including 34 unaccompanied minors) - applying a prevalence of 45% yields an estimated 145 looked after children meeting the criteria for having a psychiatric disorder.

Children in Need

Section 17 of the Children Act defines 'Children in need' as someone aged under 18 years who is unlikely to achieve or maintain or develop a reasonable standard of health or development without provision or services from the local authority, and/or if they have a disability. 'Development' can refer to physical, intellectual, emotional, social or behavioural development. 'Health' can refer to mental or physical health. Of all children in need, the primary need was due to factors with direct implications for mental health as indicated in the table below.

Factor	Number	Percentage
Abuse or Neglect	868	60%
Dysfunctional Family	276	19%
Disability or Illness	116	8%
Family in Acute Stress	59	4%
Socially Unacceptable Behaviour	44	3%

Risk Mapping Project

A new initiative will be rolled-out City-wide over the coming months. The Risk Mapping Project aims to be proactive in disrupting the exploitation of young people in Portsmouth. It works by receiving information from professionals working in the City with young people and this information being recorded safely, securely and confidentially on a database. On-going work with Hampshire Police allows the provided information to link relationships, places where young people may congregate and will list young people who are at risk from:

- Child sexual exploitation
- Criminal and drug exploitation
- Drug / alcohol use
- Radicalisation
- Domestic Violence
- Neglect

This is an innovative and ground-breaking piece of work that will contribute to safeguarding children in the City and reduce opportunities for exploitation.

Children with Special Education Needs

The SEND Needs Assessment found that Portsmouth has seven areas of primary need for young people with SEN in all state-funded schools within Portsmouth that are **above** both national and statistical neighbour averages. The categories for speech, language needs – social, emotional and severe learning difficulties (includes autism spectrum disorders (ASD)) are related to mental health.

The table below indicates these areas:

Areas of Need above National and Statistical Neighbour Averages	Portsmouth (%)	National (%)
Speech, language and communication needs	21.7	18.8
Social, emotional and mental health difficulties	19.3	16.7
Other difficulty/disability	7.8	5
Severe learning difficulty	3.6	3.2
Visual Impairment	1.2	1.1
Multi-Sensory Impairment	0.3	0.2
SEN support but no specialist assessment of type of need	3.4	2.8

Homelessness

Nationally, young people aged 16-25 years account for over 30% of all homeless people. One London study found that an estimated 67% of rough sleeping young people aged 16-24 years have mental health problems.

Portsmouth's Housing Options service moved 156 young people (under 18 years) into services over two years before 2015, with the majority of referrals following parental evictions. It also moved 230 single homeless people into services, the majority of whom had substance misuse issues, mental health problems, or behavioural disorders.

The Foyer - Portsmouth

A mental health needs assessment of young, homeless people in The Foyer, was conducted in 2016. The report confirmed that the young people at The Foyer have a far higher rate of mental health symptoms than the general population, particularly in areas of self-harm, suicidal thoughts, anxiety and drug use. Alongside these mental health issues, are varying levels of drug and alcohol use, with a wide range of illicit substances being used by young people, this is particularly concerning within a group reporting high levels of suicidal ideation and anxiety.

Children with Learning Disabilities

Children and young people with learning disabilities are more likely to experience mental health problems with prevalence rates of up to 40% compared to 10% of children and young people without a learning disability. The table below indicates the prevalence rates for learning disability applied to the relevant Portsmouth population

Age Category	Rate	Numbers
Children aged 5-9 years with a learning disability	0.97%	121
Children aged 10-14 years with a learning disability	2.26%	240
Children aged 15-19 years with a learning disability	2.67%	361

Young Offenders

The prevalence of mental health problems for young people in contact with the criminal justice system ranges from 25% to 81%. The prevalence of a diagnosed disorder is highest for those in custody (ranges from 46% to 81%, compared to 25% to 77% for those in the community). Applying the prevalence's of 25% to 81% to the 224 Portsmouth young people who committed offences (with substantive outcomes) in 2015/16, suggests that there may be between 56 and 181 young offenders with a mental health problem.

Lesbian, Gay, Bisexual, Transgender and Questioning Young People

The experience of poorer mental health in LGBTQ people compared with the general population is in part explained by the stress associated with minority status and related discrimination. The rates of self-harm and suicidal ideation in the groups of respondents are higher than those previously reported in the 2007 APMS and may be indicative of an increased prevalence of poor mental health amongst all young people. The table below indicates the prevalence of mental health problems in young LGBTQ people aged 16 to 25 years.

	2014 LGBTQ Respondents	2014 Heterosexual Non-Transgender respondents	2007 APMS Study ¹
Going for medical help for depression or anxiety	42%	29%	
Self-harming, either now or in the past	52%	35%	12%
Ever thought about suicide	44%	26%	21%

Source: Youth Chances (2014) Summary of First Findings: the Experience of LGBTQ Young People in England

4.3 Self-Harm

Portsmouth's national outcome measure for those aged 10-24 years admitted as a result of self-harm shows an increasing trend and has been significantly higher than the England average for the past three financial years. In 2014/15 the local rate was the highest of 150 county/unitary authorities. Detailed data relating to the Emergency Department attendances and hospital admissions for self-harm (2013/14-2015/16) is set out below.

Emergency Department Attendances for Intentional Self-Harm

Between April 2013 and March 2016, attendances at Emergency Departments by 0-18 year olds for deliberate self-harm increased from an average of 7 per month to 18 per month. The table below indicates the Emergency Department admissions for deliberate self-harm.

Age Band	2013/14	2014/15	2015/16	2016/17 Apr-May	Total April 2013 to May 2016
0-4 years	2				2
10-14 years	34	44	38	5	121
15-18 years	94	105	95	22	316
Total	130	149	133	27	439
Average per month	10.8	12.4	11.1	13.5	11.6

¹ The NHS Information Centre for Health and Social Care. 2009. Adult Psychiatric Morbidity in England 2007: results of a household survey, p. 82. London: NHS Information Centre.

Hospital Admissions for Intentional Self-Harm

In 2015/16, there were 280 hospital admissions by 0-24 year olds with a secondary diagnosis of 'Intentional self-harm'. Of the 280 local admissions for Intentional self-harm, 13% (n36) were for 0-14 year olds - accounting for 25% of all mental health related admissions by this age group. The 244 Intentional self-harm admissions by 15-24 year olds accounted for 32% of all mental health-related admissions by this age group.

Local analysis of Intentional self-harm (X60-X84) hospital admissions for 0-18 year olds where the diagnosis was recorded in any diagnostic position found that the average number of admissions per month increased between 2014/15 and 2016/17 (part year) from 10.8 admissions to 13.5 admissions as indicated in the table below.

Age Band	2013/14	2014/15	2015/16	2016/17 Apr-May	Total April 2013 to May 2016
0-4 years	2				2
10-14 years	34	44	38	5	121
15-18 years	94	105	95	22	316
Total	130	149	133	27	439
Average per month	10.8	12.4	11.1	13.5	11.6

4.4 Transition

A review of the number of transitions out of CAMHS at 17.5+

A snapshot of CAMHS East caseloads undertaken in 2017 showed that there were 30 people approaching 17.5 years and above in a 6 month period (across Learning Disability (4), Looked after Children (4), Extended Team (22). However, due to new referrals of those 17.5 and above in that time it is likely that there would be 35-40 young people approaching their 18th birthday in a 6 month period. Of these young people the majority are referred back into primary care (GP) with a discharge summary.

Around 15% of these young people start the transition process to Adult Mental Health with young people starting the transition process to Adult Learning Disability Services between 20-25 years of age. Some of these young people do not complete a transition into either the Adult Mental Health or Adult Learning Disability Services and are transitioned to primary care or other agencies.

National Transition CQUIN Scheme

Currently there is a national CQUIN scheme which includes a CQUIN which aims to incentivise improvements to the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services (CYPMHS).

There are three components of this CQUIN:

- a case note audit in order to assess the extent of Joint-Agency Transition Planning;
- a survey of young people's transition experiences ahead of the point of transition (Pre-Transition / Discharge Readiness);
- a survey of young people's transition experiences after the point of transition (Post-Transition Experience).

Solent NHS Trust have drawn up an implementation plan to ensure that all young people in Portsmouth have a transition plan which has been produced with the young person, their parents/carers and dedicated key worker.

4.5 Service Offer with Staffing Numbers and Activity Data

Universal Services

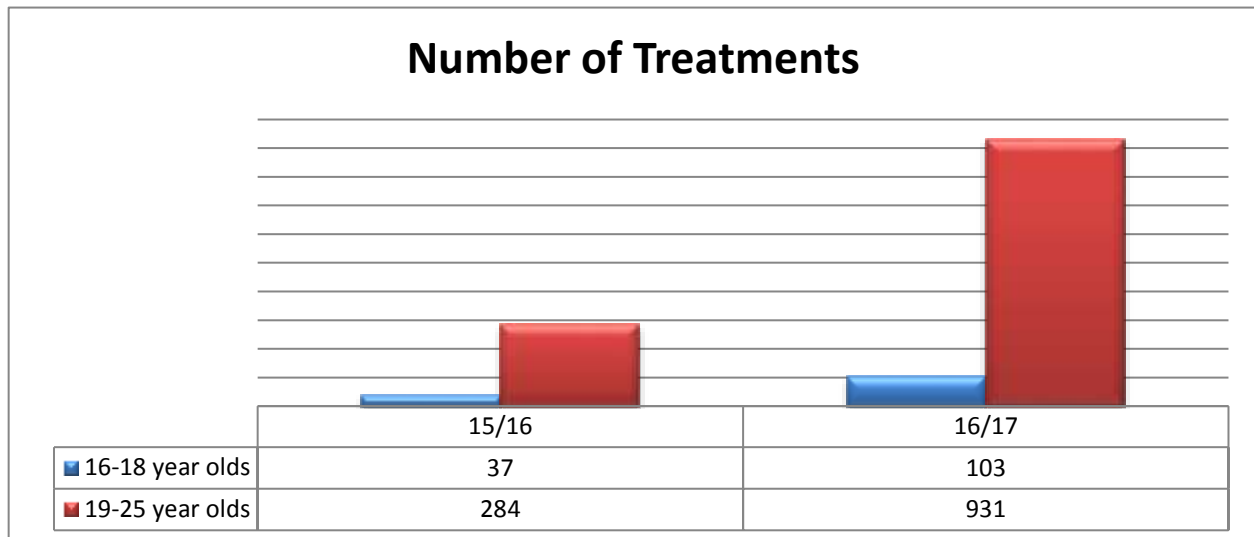
You and Your Baby	Pre and Post-natal depression group that support mother and baby bonding and reduce isolation, including relaxation, breathing and mindfulness; general group discussion, sharing of experiences; support and advice on healthy eating and living; advice about baby and mother's sleep; Cognitive Behavioural Therapy (CBT) group to help manage stress/anxiety.
Respond Portsmouth	Pre and Post-natal depression group that support mother and baby bonding and reduce isolation, including relaxation, breathing and mindfulness; general group discussion, sharing of experiences; support and advice on healthy eating and living; advice about baby and mother's sleep; Cognitive Behavioural Therapy (CBT) group to help manage stress/anxiety.
Shelf Help	The books provided by Shelf Help offer tips and ideas to help young people understand and manage emotions as well as cope with difficult situations. Some of the recommended books suggest useful self-help techniques. The Shelf Help collection is comprised of 125 books.
4U	Public Health Portsmouth supports lesbian, gay, bisexual, transgender and questioning young people aged 11-19 through the 4U LGBTQ Youth Services in Portsmouth. This service offers a regular youth group, 1-1 support in schools, Personal, Social, Health Education (PSHE) citizenship lessons in schools as well as supporting gay/straight alliance groups in secondary schools.
The Healthy Child Programme (including targeted early help for families)	The Healthy Child Programme is an evidence based programme for children and families, including developmental reviews, information and guidance needed to achieve their optimum health and well-being. The programme aims to improve a range of outcomes such as: strong parental-child attachment; better child social and emotional well-being; a reduction in childhood obesity; prevention of serious and communicable diseases; improved readiness for school and learning; better short and long-term outcomes for children at risk of social exclusion. The workforce includes health visiting and school nursing (commissioned by Children Services) and also the wider community child health services, city council targeted early help services, voluntary services and school professionals.
Family Nurse Partnership	The Family Nurse Partnership (FNP) is a preventive programme, usually offered to first-time young mothers who are under 20 years of age and before they are 20 weeks pregnant. The same family nurse works with families from early pregnancy up until the child is two years old. The programme's primary focus is the future health and well-being of the child and mother.
Young Carers	Public Health Portsmouth works with schools to identify young carers and find appropriate ways to share information between education and carer services. The aim is to give school-age carers the guidance and support they need in order to fulfil their caring role and reach their maximum educational potential.

Targeted Services

Talking Change

Talking Change is a service which provides a range of therapies and treatments for those dealing with common mental health problems. The service is for people aged 16 and over who are registered with a GP in Portsmouth and who are experiencing mild to severe depression and/or anxiety. The service is delivered by a team of specialist therapists and counsellors. The support provided is often described as "Talking Therapies" and follows guidance from the National Institute for Health and Care Excellence (NICE) to ensure the best care based on needs is provided.

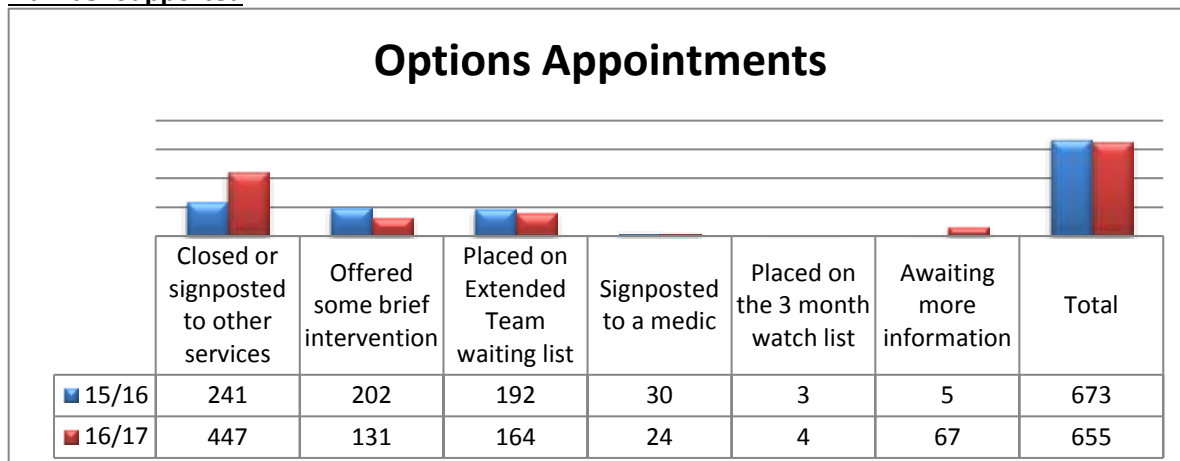
Number Supported



CAMHS Single Point of Access

The aim of this team is to promote the mental health and psychological wellbeing of all Portsmouth's children and young people and to provide a range of high quality, accessible services that are responsive to needs as they arise. The role of the CAMHS SPA is to act as an interface between universal first contact services for children and families and specialist CAMHS (Extended Team).

Number Supported



Workforce

Band 7: 1WTE (Clinical Team Leader)

Band 7: 1WTE x 2 + 0.8WTE x 1 + 0.5WTE x 1

Band 6: 1WTE x 4 + 0.8WTE x 1

CAMHS Waiting Times

Our CAMHS service has worked very hard over the last year to ensure children, young people and their families are seen in a timely responsive way. Their waiting times compare very well to other CAMHS services both regionally and nationally despite continued rise in demand. The CAMHS service has also been successfully accredited by the Quality Network for Community CAMHS (QNCC) whose standards are set by the college of psychiatrists and they have recently been inspected by CQC who gave an overall rating of good and outstanding in the area of care.

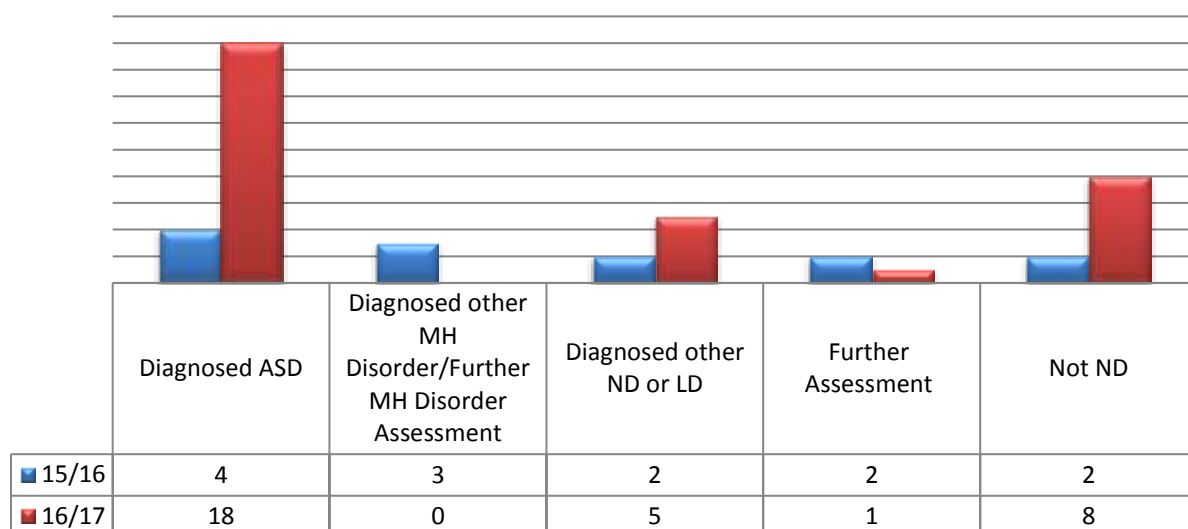
Target for Assessment	Longest current wait for initial assessment	Target for treatment	Longest wait for treatment
4 weeks	2 weeks	18 weeks	16 weeks

The average wait time in January 2017 from referral into extended CAMHS to being offered a partnership/ clinic assessment for Neurodevelopmental is currently at 6 months.

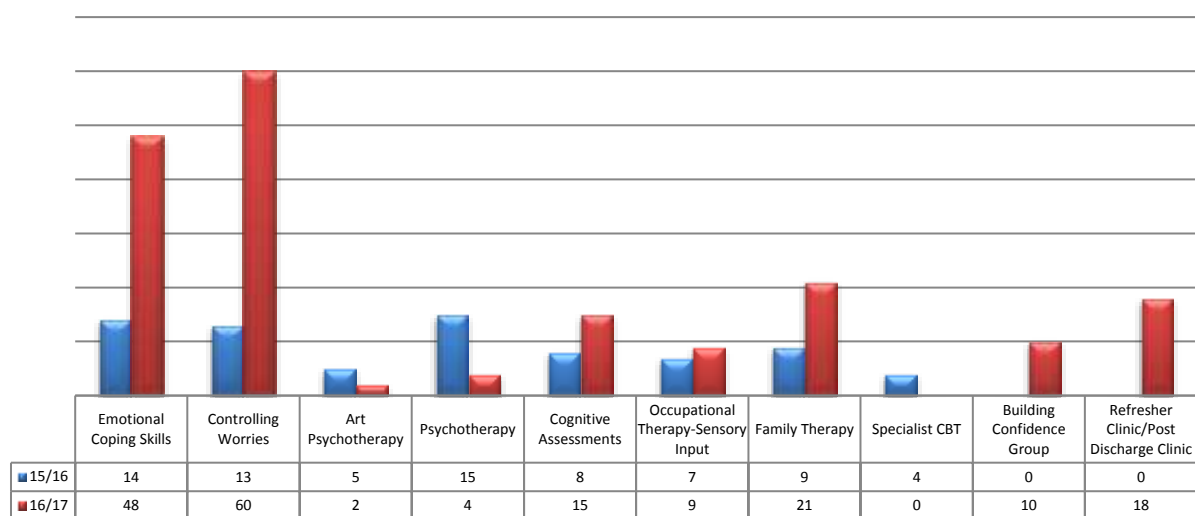
Specialist Services

Extended CAMHS Team								
<p>The aim of this team is to provide longer term individualised treatment interventions designed to address the needs of children and young people and their families/support networks who have serious to severe mental health disorders. They also provide an assertive outreach approach to assist young people who may otherwise find CAMHS services difficult to access.</p> <p>The Extended CAMHS team fulfils a variety of functions in meeting the needs of children and young people with mental health problems in the city. The main four functions are:</p> <ul style="list-style-type: none"> • Intervention for children and young people in mental health crisis • Intervention for Targeted and Specialist level mental health difficulties • Assessment for neurodevelopmental disorders <p>Specialist treatments where indicated by type/level of impairment.</p>								
<p>Number Supported</p> <div style="text-align: center;"> <h3>Partnership Appointments</h3> <table border="1" style="margin: 10px auto; width: 80%;"> <thead> <tr> <th></th> <th>15/16</th> <th>16/17</th> </tr> </thead> <tbody> <tr> <td>Partnership Appointments</td> <td>296</td> <td>237</td> </tr> </tbody> </table> </div>				15/16	16/17	Partnership Appointments	296	237
	15/16	16/17						
Partnership Appointments	296	237						

Neuro-developmental Assessments



Specialist Treatments



Workforce

Band 8b: 1WTE

Band 8a: 1WTE + 0.8WTE x 1

Band 7: 1WTE (Clinical Team Lead) + 0.91WTE x 2 (1 x Vacant) + 0.49WTE x 1 + 0.09 WTE x 1 + 0.2WTE x 1

Band 6: 1WTE x 3 + 0.6WTE x 1

Band 5: 1WTE + 1WTE (Vacant)

Looked After Children Team

Looked After Children Team

The aim of this team is to promote the mental health and psychological wellbeing of all Portsmouth's Looked After Children and Young People and to provide a range of high quality and accessible services that are responsive to needs as they arise and to promote and support placement stability.

Youth Offending Team

The Youth Offending Team is a multi-disciplinary Community Youth Justice Team. It provides an assessment and intervention service for children and young people (10-18 years) who have committed a criminal offence. The team has a specialist CAMHS nurse attached, who provides mental health consultation, training and direct work.

Foster Carers

All approved foster carers will have an allocated, suitably qualified supervising social worker. The allocated supervising social worker is responsible for supervising and supporting carers, ensuring that they have the necessary guidance, support and direction to maintain a quality service, including safe caring practices. This will include an understanding that they must work within the National Minimum Standards for Fostering and the agency's policies, procedures and guidance.

Workforce

Band 7: 0.8WTE (Clinical Team Lead)

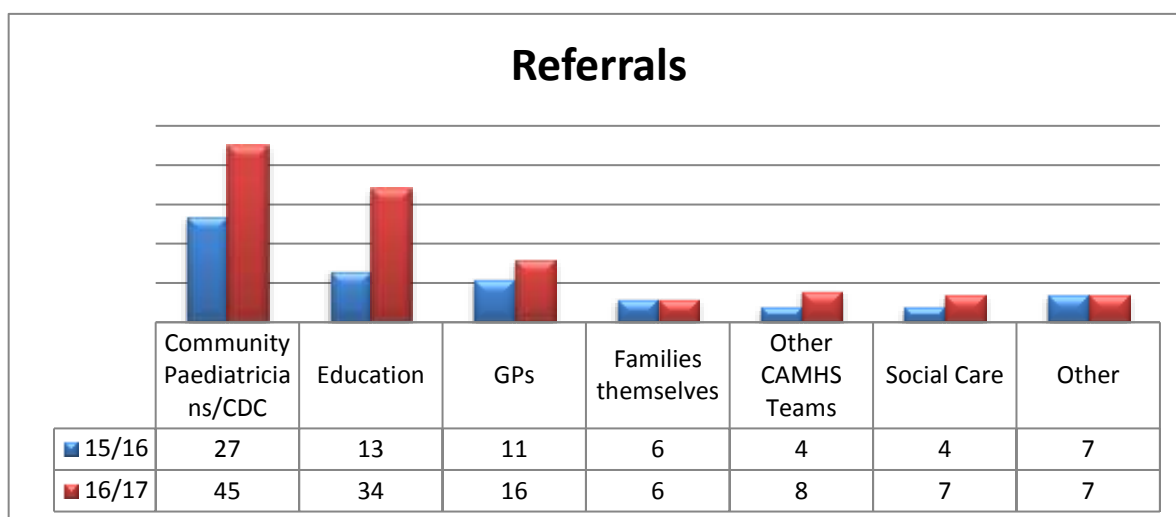
Band 7: 0.4WTE x 1

Band 6: 1WTE x 2 + 0.8WTE x 2

CAMHS Learning Disability Service

The aim of this service is to improve the quality of life for young people with learning disabilities and their families through helping them participate fully in education, social activities and family life and manage the difficulties associated with having or being part of a family where a child has a learning disability. To minimise the intensity, frequency, duration and impact of challenging behaviour and mental health difficulties in children and young people with learning disabilities.

Number Supported



Workforce

Band 7: 0.69WTE (Clinical Team Lead)

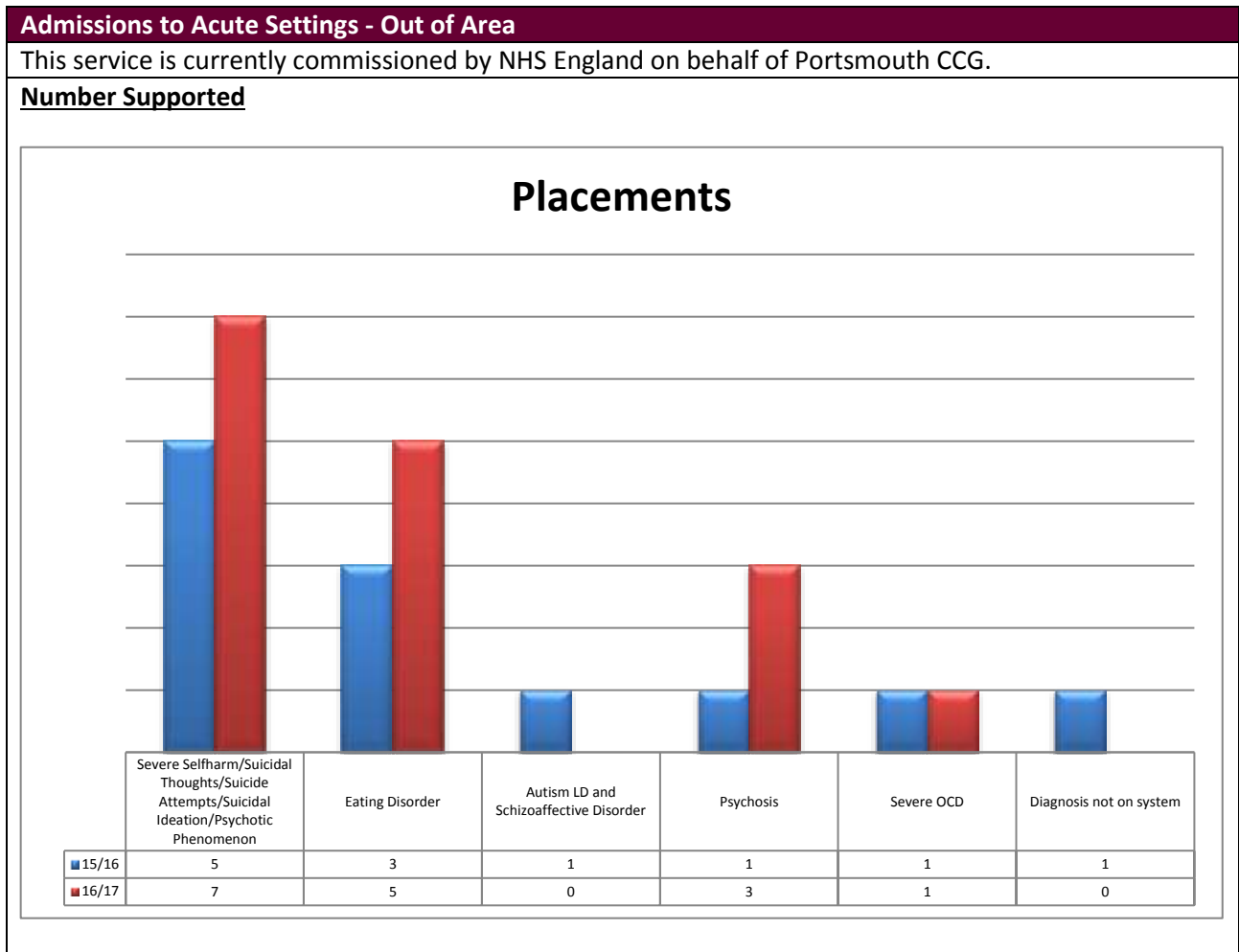
Band 7: 1WTE x 1 + 0.6WTE (Medical)

Band 6: 0.8WTE x 3

Band 5: 1WTE x 2

Hampshire Liaison & Diversion Service	This service covers South East and South West Hampshire court areas with two teams based in Portsmouth and Southampton. Working in partnership with Solent NHS Trust, the Southampton and Portsmouth teams assess and engage with vulnerable people who find themselves within the criminal justice system. Practitioners take a proactive role in ensuring that individuals receive the right care and interventions.
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Highly Specialist Services



5. SERVICE TRANSFORMATION PLANS UPDATE 2016/17

5.1 Promoting Resilience, Prevention and Early Intervention

With system enabling monies and investment in 2016 and beyond we said we would:

- Commission a lower threshold open access service that supports CYP and Families which includes a CYP peer support model.
- Commission an Infant Mental Health Service based on national ambition and local need.
- Enhance current perinatal and post-natal depression pathways to provide early intervention and support.

Progress Update

U Matter (Emotional Health and Wellbeing Service)

This service commenced in January 2017 and is a citywide Emotional Health and Wellbeing service for children, young people and their families. The service supports children, young people and their families by building resilience, improving emotional wellbeing and supporting good mental health by providing the following:

- Informal support for young people and their families.
- A citywide targeted therapeutic counselling service for young people and potentially their families.
- A model of peer support for young people and their families.

The new service offers flexible opportunities for self-referral at a range of different locations that are child and young person friendly. The service operates at times which are convenient for young people and families.

The expected outcomes of the service will be as follows:

- The emotional wellbeing and resilience of vulnerable children and young people is improved.
- More support is available earlier for children; young people and families where problems arise that prevent more serious problems developing.
- More support is available for young people in transition who are at risk of poor mental health.

Please see below some key points from the quarterly review for the U Matter Service (January to July 2017):

- YTD 200 Registrations – 186 seen LL AOM first support sessions.
- 109 Cases presenting for counselling and 123 first counselling consult appointments completed;
 - 89 Clients attended counselling consult.
 - 47 Clients accessing seen ongoing counselling (some may have gone on to access in Q2).
 - Including no shows and consult appointments 51 clients have accessed counselling at an average of 5.25 sessions per case, but some are still in progress.
- The primary referral routes have come from CAMHS 20%, and then joint second, both with 16% Parents/Carer and Self-Referral. GP & Schools Joint 3rd, both @ 11%

- 11-15 years olds have dropped from 85% to 77% referrals, more over 18s presenting.
- 62% are Female, remains consistent
- Highest seen clients from postcodes from PO2 - 22%, followed by joint 18% for 4/6/1.

Infant Mental Health

The list below is the current expectation of this provision:

- Accessibility to wider CAMHS knowledge and skills.
- Triage CAMHS possible referrals to avoid delay or inappropriate referrals.
- Consultation on complex cases in a timelier and prompt way which is assessable to the health visiting team.
- To offer bespoke training and teaching to the team if and when necessary.
- To offer home visits to role model interventions, provide observations and encourage good practice to staff.
- To encourage the use of the Australian Attachment Questionnaire to enhance and outcome the interventions during health visiting listening visit.
- Nursery observations.
- Observational reports and consultation for CP.

As a result of Future in Mind funding the CAMHS Early Year Team have enhanced the current provision to:

- Increase current provision to offer consultation, home visit observation and attachment training to the full MATS teams' including social care and Barbados.
- Training for health professionals to be sourced and developed to enhance their skills in Infant Mental Health (IMH).
- Specialist Infant Observation supervision provided by CAMHS experts in IMH will be used to enhance and support any training given to health professional for IMH.
- A needs analysis re future provision and costing for this based on data from previous provision of IMH to the city and demand from this expansion of provision.
- Re-branding of the 'early years provision' to reflect the IMH agenda.

As a result of this enhancement the expected outcomes will include:

- To up skill the health workforce in IMH to be able to recognise and intervene to support families with attachment issues.
- To reduce numbers of individuals that go on to require Tier 4 interventions.
- Reduction in referral to CP plans.
- Promotion of a positive attachment between mother and infant.
- To target consultation for vulnerable and high risk families.

Perinatal Mental Health

An early intervention service for perinatal mental wellbeing has been commissioned which commenced on the 3rd January 2017. The service provides, low intensity support for those with low level (mild to moderate) mental health issues or who are at risk of developing mental health issues in the perinatal period.

The expected outcomes of the service will be as follows:

- To reduce the impact of mental health problems on women, fathers and their families
- To reduce the likelihood of mental health problems during pregnancy by proactively working with high risk population.
- Reduction in numbers of admissions to acute care
- Reduce the number of individuals accessing secondary specialist care.

5.2 Improving Access to Effective Support - a System without Tiers

With investment in 2016 and beyond we said we would:

- Develop and agree a service model to assess, treat and support CYP with Eating Disorders
- Review the Early Intervention in Psychosis Model
- Research the use of mental health apps
- Work towards creating a central point of information (Website)
- Create a Management Behaviour Guide

Progress Update

Eating Disorders

Current Eating Disorder Offer

During the year 2016/17, there have been a number of complex aspects and developments to Eating Disorders service provision. The extra revenue from Future in Mind money was used to increase staff resources and Eating Disorders intervention, resulting in:

- Dedicated early intervention around supporting mealtimes.
- Parents and Carers Support Group. The feedback from users of this group is that they find it consistently useful and helpful.
- Specific released hours of clinician time to support developing Eating Disorders pathway.
- Quarterly returns to NHS England, using 'Unify', recording the amount of 'Urgent and Routine' Eating Disorders cases. This first year of data collection has been an opportunity to see the effects of the extra resources and time to iron out any problem areas.
- Eating Disorders audit of the 'Unify' data. This shows that the cases that meet the National Eating Disorders criteria. Three areas were identified as to why breaches happened and have subsequently been resolved.

Additional and On-going Work

- Making clearer the referral and transition pathway between CAMHS Eating Disorders and Adult (Hampshire) Eating Disorders Services.
- Current and future liaising with QA Hospital to ensure an Eating Disorders pathway is agreed based on Marsipan Guidelines so there is a clear expectation of what families should expect if there is a need for QA referral and assessment/input. This will also ensure there is no discrepancy in care experienced by Solent East and Solent West families.

- Finalising a Eating Disorders flowchart (for School Nurses and other staff), that will enable better identification and referring of Eating Disorders cases in educational settings. This flowchart/information was based on feedback from workshops delivered at Portsmouth Inclusion Conference.

It is envisaged that this outstanding work will be completed by the end of 2017.

Regional Plans

In addition to the local enhancements we are also working alongside regional commissioners and CAMHS providers to ensure there is a consistency and equity of service offer across the region for young people and their families who need support with Eating Disorders.

We are aware alongside our commissioning colleagues across Southampton and the Isle of Wight that our current eating disorders offer that sits within our community CAMHS services are not in line with the national ambition of having local dedicated community eating-disorder services. As a result of recent discussions with Anne O'Herlihy, the Children and Young People's Mental Health lead at the Department of Health we have agreed to explore where other areas have transformed their eating disorders services in line with the national standards.

Further Plans

Early Intervention in Psychosis

We recognised alongside our CAMHS and AMH colleagues that there was an urgent need to review the offer and pathways for young people up to 18 who are experiencing first episodes of psychosis. We identified that there were roughly 5 young people supported by the CAMHS service who have first episodes of psychosis but these young people wouldn't be supported by the dedicated EIP team as it's set up to work with over 18's. As a result of recent conversations there has been an agreement that a clear joint working framework will be developed by the end of 2017 which will include the need for the EIP Service to monitor whether the young person has received a NICE compliant service.

Mental Health Apps

We are currently researching the possibility of the use of mental health apps to support young people suffering with mental health difficulties. We recognise that the use of apps offers young people flexibility of access as well as discretion for those worried about stigma and privacy. Research has been undertaken to better understand how useful the apps could be and a research paper has been taken to the Improving Wellbeing in Education Group.

Wessex Healthier Together Website Plans

As a result of our stakeholder consultation exercise in early 2016 a key issue that emerged was the lack of communication on the services and support available across the city. This has led to a number of meetings with regional CAMHS colleagues to investigate the current advice and guidance available via the Wessex Healthier Together website with a view to scope out how we improve the information that's available to young people, families and professionals. It is envisaged that this will create a central point of information for all children and young people's mental health and wellbeing services across the city.

This also forms part of the Children's STP where there are plans to explore how we use the regional Wessex Healthier Together website to promote self-help materials and messaging/tools for schools and families. There has also been a suggestion that we use the same website to highlight local clinical pathways for emotional wellbeing and up to date information on local services.

The website will need to be beneficial to children, young people and their families by supporting their wellbeing and building their resilience. To make it easier for them to access the support that they need when and where they need it by providing information for individuals who have, or are at risk of developing, emotional and behavioural problems.

Behaviour Management Guide

We are currently working alongside our colleagues in the Early Help and Prevention Team to produce a 'Behaviour Management' guide, along the same lines as the 'Emotional Health and Wellbeing' guide recently produced (please see the Appendix 2 on page 40). This forms part of our efforts to bridge the gap regarding the lack of information which is available, highlighted by all stakeholders during the consultation held in 2016. Work is currently ongoing with a planned completion date of November 2017.

5.3 Care for the most Vulnerable

With system enabling monies and investment in 2016 and beyond we said we would:

- Develop a model of care and support for CYP to manage and prevent mental health crisis
- Enhance the Community Specialist Perinatal Mental Health Support
- Review Pathway for Vulnerable CYP within the Youth Justice
- Review Acute and Community Self-harm Pathway and Service Offer

Progress Update

Crisis Care for CYP

There was an identified need for a robust crisis care package for young people, which could include out of hours provision where indicated, in order to reduce numbers of Tier 4 admissions as well as the length of stay of admissions.

This has resulted in the development of a Crisis care post to co-ordinate, deliver and evaluate crisis care within CAMHS. The post is able to assess, treat/risk manage, prescribe medications and develop multi-agency care plans. The role would also involve supporting the family and the network to plan for and manage crisis.

This post has now been recruited to and the post holder has undertaken 86 cases between December 2016 and August 2017. All of the work undertaken during this period prevented admission and has been particularly helpful with Eating Disorder cases. Please see attached which outlines the outcomes.

The post holder has successfully completed the Nurse Prescribing course and will be able to add this to the range of interventions offered. In the short term the post holder will be offering a group to reduce the pressure on the priority appointments offered. This will be a 4 week distress tolerance group.

Enhance the Community Specialist Perinatal Mental Health Support

There was an absence of a Community based specialist perinatal and infant mental health team in Portsmouth. As a consequence, mothers and their families were supported through services which were not expertly trained. NICE Guidance 192 recommends women should be able to access specialist Perinatal Mental Health teams and inpatient units. In some circumstances this has meant mothers being admitted to AMH wards and separated from their infants.

Portsmouth successfully bid and subsequently awarded development funding by NHSE to provide a tier 3/4 Specialist Perinatal Community Service. The service extends the catchment area of the award winning Hampshire Perinatal Mental Health Community Service provided by Southern Hampshire. The service commenced in Portsmouth in March 2017 and delivers support to mothers experiencing severe mental illness. This is through a programme of treatment and support in the community which includes advice and support over the telephone; outpatient consultations in clinics, GP surgeries or at home; support and guidance for an individual's family; medication; and a range of therapy sessions. The expected outcomes of the service will be as follows:

- Women can access appropriate, high-quality specialist mental health care, closer to home, when they need it during the perinatal period.
- Women and their families have a positive experience of care, with services joined up around them.
- There is earlier diagnosis and intervention, and women are supported to recover, and fewer women and their infants suffer avoidable harm.
- There is more awareness, openness and transparency around perinatal mental health in order that partners, families, employers and the public can support women with perinatal mental health conditions.

Review Pathway for Vulnerable CYP within the Youth Justice Pathway

An opportunity arose for local areas to bid for additional monies as part of the Future in Mind programme and we were successful in the bid. These monies came via Health and Justice Commissioning who were seeking proposals on how best these monies could be used locally.

It was agreed that this additional funding would be used to commission a service for young people the details of the service offer is as follows:

- An additional .5 post would be able to provide further input for young people over the age of 10 who are at risk of coming under the Youth Justice System, by providing assessment to young people who are arrested by police for anti-social behaviour which causes them to spend time in police custody or become known to the Liaison and Diversion team. These young people are often 'Looked After' or living in a family that is not able to provide the boundaries and structure needed, which increases the risk of further offending.
- The assessment would include assessment of the young person's motivation to change, their mental health needs and need for referral to other agencies.
- The post holder would also have a remit to provide psycho education with a systemic approach to parents and carers of young people, either 1:1 or in groups, to promote stronger care and monitoring of young people, in order to prevent further offending.
- The post holder would provide an outreach service to young people to maximise engagement.

Intended outcomes:

- Improved mental health and well-being in this cohort.
- Reduction of risk of harm from self-harm, anti-social behaviour and other behaviours linked to offending and poor mental health.
- Reduction of episodes of being detained by the police.
- Support to access relevant referrals across local agencies.
- Promotion of social inclusion.

Review Acute and Community Self-harm Pathway and Service Offer

It's been widely known both locally and nationally that self-harm hospital admissions for young people have risen considerably over the last 5 years. In Portsmouth this issue is a particular concern as our national outcome measure for those aged 10-24 years admitted as a result of self-harm shows an increasing trend and has been significantly higher than England for the past three financial years. In 2014/15 the local rate is the highest of 150 county/unitary authorities.

We have drilled deeper into the data locally through a recent all age self-harm needs assessment that our Public Health team led on and reviewed our acute and community pathways and service offer. It is clear that the paediatric liaison model that is currently in place at Queen Alexandra Hospital is very fragmented due to complicated commissioning between CAMHS providers and there are continued frustrations from our colleagues at Portsmouth Hospitals Trust that the current offer does not best meet the needs. In order to improve the clinical assessment pathway for people who self-harm, Portsmouth and Hampshire commissioners intend to commission an all age Psychiatric Liaison service across the system.

5.4 Accountability and Transparency

With system enabling monies and investment in 2016 and beyond we said we would:

- Enhance Project Management and Contracts Support across the Integrated Commissioning Service
- Review Performance Measures
- Inform, engage, consult & co-produce with Stakeholders on Future in Mind

Progress Update**Enhance Project Management and Contracts Support**

In our transformation plan we said we would use some of the system enabling monies to enhance the Project Management and contracts support across the Integrated Commissioning Service. In early 2016 we recruited a full time Senior Commissioning Manager which enabled the current CAMHS/Future in Mind Programme Lead to fully focus on delivering the FiM programme alongside another member of the team who provides further project management support. This development has been very positive in raising the profile of Children and Young people's mental health across the CCG and local authority and ensures there is dedicated resource in taking this important programme of work forward.

Performance Measures

We have identified alongside our CAMHS colleagues that there is a need to review and agree a better set of performance measures that will help us to understand how well the service is performing and identify what needs to change to better meet the needs of children, young people and their families.

We have agreed to use the following framework which will support us in understanding what data requirements are expected nationally through the mental health data set and what are the crucial measures we need to collect locally both service/system wide and individual measures.

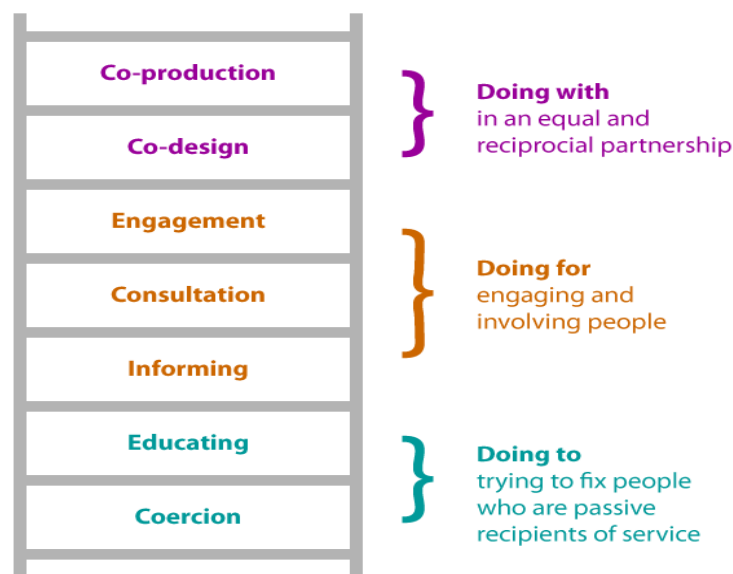
Individual Outcomes	Local System Performance Measures	National Performance Targets
i.e. Outcome Rating Scales Strengths & Difficulties questionnaires	i.e. Waiting time for internal referrals to the extended CAMHS Team	i.e. 95% of CYP in need of Eating Disorder services will receive treatment within one week for urgent cases and four weeks for routine

Our intention is to ensure that all performance measures are derived from purpose so in essence good measures will demonstrate achievement of purpose.



Co-Production

Co-Production Principles



The Co-Production Group for Future in Mind was set up in the spring of 2016 with the aim of attracting young people and parents to get involved in the design and delivery of plans associated within the Future in Mind programme. During the 2016/2017 financial year the group undertook the following pieces of work:

Work Undertaken
The creation of an Activity Plan.
The creation of a Co-Production Pledge which was meaningful and clearly understood.
Involvement in the tender process for the U Matter Service (Young Peoples Emotional and Wellbeing Service).
Young people and parents created a service guide depicting the main services available across the city.

Two separate Co-Production Groups have now been set up under contract using Future in Mind funding, a young person's group and a parents group. The objectives set for 2017-2019 for these groups are listed below:

Young Person's Group

Objective	Outcome
Design, promote and publicise the Mental Health Guide for Children and Young People and monitor with young people as to whether it is useful.	Young people are aware of the main emotional health/mental health services across the city and how to access them.
Involve young people in the development of the mental health section of the Wessex Healthier Together website by identifying the relevant content and ensuring the website is widely promoted to all young people across the city.	The website is widely known by young people and they are easily able to access online information, advice and guidance relating to mental health, emotional health and wellbeing matters.
Support the involvement of young people in identifying how the system responds to children and young people seeking emotional support and seek ways in which the service/system can improve.	The services/system is more responsive and effective in responding to children and young people seeking emotional/mental health support.

Parents Group

Objective	Outcome
Promote and publicise the Mental Health Guide for Parents and monitor with parents/carers as to whether it is useful.	Families are aware of the relevant services and support available and they receive a range of information about services and support for families which is accessible to all and easy to use.
Involve parents in the development of the mental health sections of the Wessex Healthier Together website by identifying the relevant content and ensuring the website is widely promoted to all parents/carers across the city.	The website is widely known by parents and they are easily able to access online information, advice and guidance relating to mental health, emotional health and wellbeing matters.
Work with commissioners to understand whether the U Matter service is effective and meeting the needs of young people and families.	Commissioners have greater assurance that the U Matter service is delivering an effective service that responds to the needs of young people and parents/carers.
Support the involvement of parents/carers in identifying how the system responds to children and young people seeking emotional support and see ways in which the service/system can improve.	The services/system is more responsive and effective in responding to children and young people seeking emotional support.

Next Steps

It is planned to merge the CAMHS Participation Group with the Young People's Future in Mind Group as funding for the CAMHS Participation Group will cease shortly. The Future in Mind group will then organise a Young Person Mental Health Event in January 2018 for other young people within the city.

Strong links have also been made with the Council of Portsmouth Schools who has mental health for children and young people as one of their priorities this year.

Future in Mind - Events

Launch Event - 11.1.17

A Future in Mind stakeholder event was held on the 11th January 2017 to reflect on our achievements, launch the new services and identify the key Future in Mind priorities.

'Follow Up' Event - 20.7.17

The above event was held to bring the main stakeholders together to review progress made and update on the current landscape and work in progress.

5.5 Developing the Workforce

With system enabling monies and investment in 2016 and beyond we said we would:

- Adopt Restorative Practice/Approaches
- Create a School Strategy
- Adopt the 'Team Around the Worker' Model
- Embed CYP IAPT

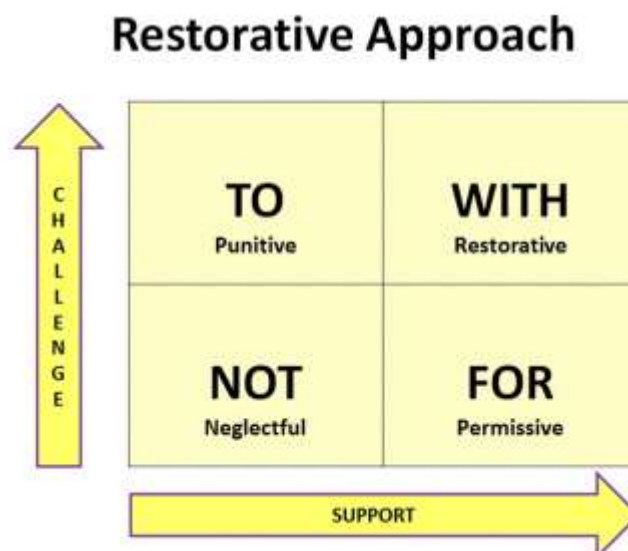
Progress Update

There are two major strands of work associated with developing the workforce that are connected to the overall Future in Mind programme which are embedding restorative approaches across the CYP workforce and the development of a whole school strategy that will support pupils' social, emotional and mental health wellbeing across Portsmouth's schools. These two strands of work are intrinsically linked.

Restorative Practice/Approaches

As part of the Stronger Futures/Future in Mind transformation programme Portsmouth has adopted a way of working with children, young people and families which is known as Restorative Practice. Restorative Practice or Restorative Approaches are essentially a way of affecting change in people's behaviours by focussing on their relationships; seeking to prevent relationship breakdown or restore it when it has. In Portsmouth, the Multi-Agency Teams (MATs) are committed to providing joined-up support for children and families in the city. The MATs and wider children and family services in the city are adopting a Restorative Practice model of working. Schools work in close collaboration with the MATs and will be key partners in delivering this strategy.

Restorative practice places responsibility on families to make positive changes using a 'high support - high challenge' approach and it is an intention that all services working with children and young people will adopt this approach in the future.



Portsmouth Children's Social Care has recruited a Children's Workforce Remodelling Manager which has been partly funded by Future in Mind monies. The post-holder is responsible for managing the roll out of the Restorative Practice strategy for the city. The scope of the post will extend significantly beyond Social Care and includes both the locality Multi-Agency Teams and the wider workforce in nurseries, schools, colleges, the NHS, adult services and community services.

Strategy for Improving Wellbeing and Resilience in Education

We have developed 'A Strategy for Improving Wellbeing and Resilience in Education' that will lead to effective whole school approaches in supporting pupils' social, emotional and mental health wellbeing across Portsmouth's schools. The strategy includes case studies of good practice from Portsmouth Schools. Sarah Christopher, a SENCO Lead at a local Secondary School Priory was seconded one day a week through Future in Mind to develop the schools strategy. Sarah is now in a substantive post with PCC (part funded through Future in Mind) which includes responsibility for leading the implementation of the strategy.

Head Teachers, staff in schools and partners in Health and Children's Services have welcomed the strategy, which has been widely distributed. Two thirds of our schools have already identified a named Wellbeing Lead as Recommended in Future in Mind and reinforced in our strategy.

The strategy is being implemented through our Inclusion Group. This group reports into both the SEND Strategic Board and the Portsmouth Education Partnership (PEP) Strategic Board. Through the PEP, school and education leaders have identified Emotional Health and Wellbeing as one of the key priorities for the partnership (SO6). This is reflected in our Education Strategy. This is currently being revised following consultation. The consultation confirmed the commitment of all stakeholders to this priority).

There is a multi-agency group working together to implement the recommendations in the strategy; this group also includes parents and young people. Schools have been surveyed during the Summer Term 2017 to get a detailed view of their needs, including training needs. The implementation plan has incorporated the results from the survey to inform the actions.

Team Around the Worker Model - 'Working with'....not just 'referring on'...

We are currently exploring how CAMHS services could more fully adopt the Team Around the Worker model that's been implemented across Children's Services. To a certain extent CAMHS services in Portsmouth already use this way of working in terms of providing consultation, supervision and training to the network especially with regards to the CAMHS LAC team and the Early Years team that support social workers, family hub workers and Health Visitors. Our shared ambition is to widen the Team Around the Worker model further through CAMHS where possible and our intention in the near future is to better understand the expectations of the network and its needs and how best CAMHS can support that.

What is Team Around the Worker?

- It's a concept that originally emerged out of the original MATs Change Team transformation programme in 2015.
- It's informed by feedback from parents, captured in the quote:
"I want one worker for my family not one for each of my problems"
- It's linked to the concept of a Family-based Lead Professional – for which there is a competency framework.
- It's a model that challenges the 'refer-on' culture to specialist services.

Why was the Team Around the Worker developed

What did families say:

"I want a worker for my family not a worker for each of my problems"

"There are too many people involved in my family"

"I keep getting different messages from different people working with me"

"Once one problem is sorted out, professionals just close down the case when there are still other issues to deal with"

What did practitioners say:

"Specialist services are asked to get involved when the severity of need isn't necessarily there"

"There is a 'refer-on' culture in the city"

"We don't always have the skills or knowledge to work with a family on some issues - with a bit of support we could"

"Ten minutes spent 'chewing over' a case with a colleague is far more efficient and affordable than referring a case to that professional unnecessarily"

Our hopes for adopting the model across CAMHS

- More confident professionals learning from one another across the localities/system
- Excellent practice being shared across the localities/system
- Reduction in referral on culture leading to reduced waiting times for some specialist services
- Make the system more affordable by releasing professional time

CYP IAPT

Meetings have been attended by Solent NHS Trust representative from February 2017. The meetings provide updates on how other services are progressing, relevant information is shared, national data reporting discussed and any issues those in the collaborative want to raise. Planning meetings have also been taking place to plan how to progress IAPT locally. These meetings will be replaced by a steering group which will be co-ordinated by the Transformational Lead.

Three members of staff have been identified to complete the training the compulsory elements that they will be required to attend are:

Transformational Leadership Course	November 2017
Supervisors Course	November 2017
CBT Course	January 2018

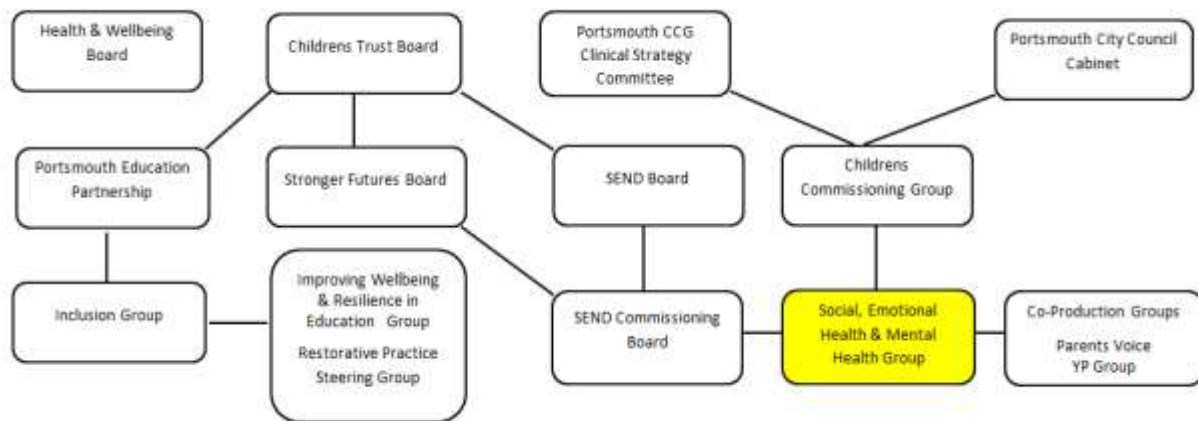
The Supervisor and CBT Therapist identified have both completed their application forms and due to be interviewed by Reading University in October 2017. A business case is due to be submitted to the Clinical Strategy Committee for backfill funding to enable CAMHS to release staff to be trained. The issue of the central funding coming to an end has also been highlighting as this presents a risk to the CYP IAPT programme continuing.

6. GOVERNANCE ARRANGEMENTS

We have robust governance structures in place that provides the appropriate level of scrutiny, support and guidance needed to deliver our plans.

The programme of work is led by the Integrated Commissioning Service on behalf of Portsmouth CCG and the accountability for the finance and commissioning of this will rest with Portsmouth CCG.

The governance arrangements are as follows:



6.1 SEMH Working Group

The SEMH Working Group is responsible for driving transformation, the membership (which is currently under review) of the group includes the following:

- Children's Services
- Integrated Commissioning Service
- Public Health
- Parent Rep
- Young Person Rep

6.2 Covalent

The Integrated Commissioning Service use Covalent as a reporting system used by Portsmouth CCG to monitor the progress of the various programmes/projects undertaken each year. The system records milestones and financial data which is regularly updated (on a monthly basis) by Project Manager Leads. The system is used by the Planning Team in the CCG to ensure that projects remain on course and financial activity is recorded.

The Planning Team uses the reports produced by Covalent to update the Clinical Strategy Committee whose function is to oversee the planning and prioritisation process and the development of solutions to needs and delivery in order to drive service transformation and design making recommendations, consider options for future service delivery and commissioning strategies taking into account clinical quality, safety and effectiveness.

Local Transformation Plan Refresh - October 2017 Project Plan

WORKSTREAM	MILESTONES	LEAD	TIMESCALE
Eating Disorders	Update the referral and transition pathway between CAMHS Eating Disorders and Ault (Hampshire) Eating Disorders Services.	CAMHS	December 2017
	Update the Eating Disorders pathway in line with Marsipan Guidelines so there is a clear expectation of what families should expect if there is a need for QA referral and assessment/input.	CAMHS	December 2017
	Finalise the Eating Disorders flowchart (for School Nurses and other staff), that will enable better identification and referring of Eating Disorders cases in educational settings.	CAMHS	December 2017
Review the Eating Disorder Model	Update the regional Eating Disorder gap analysis to understand how the local offer meets the standards as set out in the national guidance.	Commissioners	October 2017
	Explore where other areas have transformed their eating disorders services in line with the national standards with the possibility of a peer review that will help commissioners compare and contrast models.	Commissioners	November 2017
	Decision to be made as to what Eating Disorder model we want to adopt.	Commissioners Solent NHS Trust	February 2018
Implement CYP IAPT	Family Therapist in CAMHS to take part in the Transformational Leadership course.	CAMHS	November 2017
	Practitioner to take part in the Supervisors course.	CAMHS	November 2017
	Practitioner to take part in the Supervisors course.	CAMHS	January 2018
EIP Offer/Pathway for Young People	A clear joint working framework to be in place that describes the pathways and working arrangements between the EIP virtual team and CAMHS.	EIP Service CAMHS	December 2017

WORKSTREAM	MILESTONES	LEAD	TIMESCALE
Commission an all age Psychiatric Liaison Service	Understand alongside Hampshire Commissioners how we shift the financial resource associated with the current contracts and the future funding needed to commission an all age psychiatric liaison service.	Portsmouth & Hampshire Commissioners	December 2017
	Implementation of the new all age Psychiatric Liaison Service.	Portsmouth & Hampshire Commissioners	April 2018
Health Needs Assessment	Review the draft Health Needs Assessment with Public Health and other system leaders.	System Leaders	October 2017
	Final Health Needs Assessment complete.	System Leaders	March 2018
Performance Measures	Understand what the data requirements are nationally through the National Mental Health Data Set and the 5 Year Forward View and identify a set of performance measures covering national, local service/system and individual outcomes measures.	Commissioners CAMHS	December 2017
	Formally agree the overall CAMHS service performance measures and the mechanisms for collecting and reporting.	Commissioners CAMHS	February 2018
	Develop and agree a further set of performance measures and indicators with partners that will evidence system wide transformation.	System Leaders	February 2018
	Solent NHS Trust to begin reporting on the agreed performance measures through the formal contractual monitoring arrangements.	CAMHS	April 2018
Wessex Healthier Together Website	Agree what information, advice and guidance should be included on the Wessex Healthier Together website for professionals that relates to children and young people's mental health.	Commissioners Regional CAMHS Leads	November 2017
	Agree what information, advice and guidance should be included on the Wessex Healthier Together website for parents and young people that relates to children and young people's mental health.	Commissioners Parent/YP Co-Production Groups	February 2018
	Wessex Healthier Together website to be up to date with all stakeholder information, advice and guidance on CYP mental health matters.	Wessex Healthier Together website Co-ordinator	March 2018

WORKSTREAM	MILESTONES	LEAD	TIMESCALE
Behaviour Management Guide	Map out the support offer available for Parents and families across Portsmouth in relation to behaviour support.	Early Help & Prevention Service	October 2017
	Promote the offer to all the relevant stakeholders through a guide that captures all the support available across the community for different needs.	Early Help & Prevention Service	November 2017
Embedding Team around the Worker	Understand the needs of the SEMH workforce to enable them to better support children and young people's mental health, wellbeing and resilience. The initial focus will include Health Visitors, School Nurses and Early Help & Prevention practitioners.	CAMHS	December 2017
	CAMHS to support those staff through a mixture of training, supervision and consultation.	CAMHS	February 2018
Review the current Mental Health support for Children and Young People who are victims of abuse & neglect	Further understand the scale of the issues through the Social Emotional Mental Health Needs Assessment work that's underway with Public Health and partners.	Commissioner	November 2017
	Undertake a review of the mental health support available locally for Children and Young People who are victims of abuse and neglect.	Commissioner	December 2017
Strategy for Improving Wellbeing and Resilience in Education	Review the current CAMHS offer to schools and colleges.	Commissioner	December 2017
	Develop an offer of additional support to schools and colleges including traded services.	Working Group	February 2018
	To map the existing training offer to schools from different providers and provide a collaborative approach to planning ongoing training.	Working Group	March 2018
Restorative Practice	CAMHS managers and Restorative Champions to explore the place of restorative practice in their support and treatment pathways.	CAMHS	November 2018
	CAMHS managers and Restorative Champions to embed restorative practice in their support and treatment pathways and ensure CAMHS adhere to the Restorative Practice standards.	CAMHS	March 2018

Please Note: The work streams highlighted in bold above have more detailed delivery plans alongside associate strategies

Main services available in Portsmouth for children and young people with emotional or mental health needs (Up to 25 years of age)

LEVEL OF NEED	PRESENTATIONS/SYMPTOMS	SERVICE AND CONTACTS	SERVICE OFFER
CRISIS An extreme event that could mean a risk to life of self or others	<ul style="list-style-type: none"> Acute Emotional Distress with high risk to self and others e.g. – young person is verbalising a plan to harm self or others and the family or network around the young person is not able to contain or manage the issue without urgent intervention from a mental health professional Usually lasting no longer than 2-3 days 	<ul style="list-style-type: none"> In a Medical Emergency call 999. <u>In Hours (09.00-17.00)</u> Up to 18 years old call GP if they are not known to CAMHS or CAMHS Single Point of Access if they are known to CAMHS. 0300 1236632 18 years plus call CRHT(Adult CRISIS TEAM) 02392 683400 <u>Out of Hours (After 17.00)</u> Up to 16 year olds contact '111' out of hours GP 16-18 year olds that are known to CAMHS can contact CRHT 02392 683400. Those not known to CAMHS, a health professional can liaise with CRHT e.g. GP, MHLT, QA Hospital. 	<ul style="list-style-type: none"> CAMHS Crisis Intensive crisis care package for short term support (in hours) Crisis Resolution Home Treatment Intensive crisis care package for short term support (out of hours) GP- brief assessment and facilitation of mental health advice/ access (An on call Psychiatrist or SPA Clinician is available for advice for making a care plan)
SEVERE Severe and complex mental health symptoms that are chronic, ongoing, and significantly impacting daily life	<ul style="list-style-type: none"> Post-Traumatic Stress Disorder Obsessive Compulsive Disorders Eating disorders Psychosis Suicidal thoughts WITH intentions Self-harm (deep cuts requiring immediate medical attention, burning, attempted suicide) Anxiety (high anxiety affecting daily functioning, i.e. unable to leave house or attend school) Neurodevelopmental differences (ND) such as autism spectrum disorder or attention deficit disorder (CAMHS ONLY) 	<ul style="list-style-type: none"> Up to 18 years old call/refer to CAMHS Single Point of Access. Please note referrals for neurodevelopmental assessments are preferred via schools 16 years plus can self-refer to Talking Change(minimal risk i.e. those young people who are able to keep themselves safe for up to two weeks whilst waiting for treatment) 02392 892920 Mon-Thurs: 08.00-20.00/Fri:08.00-17.00/ Sat:09.00-13.00) (Not Neurodevelopmental Differences) 18 plus access Adult Mental Health Team through a health professional e.g. GP, Midwife, Substance Misuse Practitioner (Not Neurodevelopmental Differences) 02392 680200 	<ul style="list-style-type: none"> CAMHS Information resource and evidenced based treatment for mental health disorders. This can include medication and talking therapies on a 1-2-1, group or family basis. Talking Change A range of therapies and treatments for those dealing with common mental health difficulties in a 1-2-1 or group setting (only Young People at minimal risk i.e. those young people who are able to keep themselves safe for up to two weeks whilst waiting for treatment) Adult Mental Health – Information resource and Treatment provided to adults of working age with severe and enduring mental health problems in the community and in hospital if required.
MODERATE Moderate mental health symptoms that are ongoing and impacting daily life	<ul style="list-style-type: none"> Self-harm (regular surface cuts) and suicidal thoughts without intent to seriously harm. Anxiety (frequent and increased impact on some areas of life - e.g. occasionally struggles to leave house or attend school) 	<ul style="list-style-type: none"> Up to 18 years old call CAMHS Single Point of Access. Please note referrals for neurodevelopmental assessments are preferred via schools 16 years plus can self-refer to Talking Change (minimal risk i.e. those young people who are able to keep themselves safe for up to two weeks whilst waiting for treatment) 02392 892920 Mon-Thurs: 08.00-20.00/Fri:08.00-17.00/ Sat: 09.00-13.00(Not Neurodevelopmental Differences) 	<ul style="list-style-type: none"> U Matter - The Early Intervention Emotional Health and Wellbeing Service for 11-25 year olds Informal early support, counselling and peer mentoring.
MILD Behavioural and emotional responses to relationships and life events	<ul style="list-style-type: none"> Self-esteem issues Difficult family relationships Bullying and difficult relationships at school Life transitions (divorce, moving home, moving school) School work issues and poor behaviour Anger management and self-regulation issues Self-harm (surface cuts, head banging, occasional, without intention to seriously harm oneself) Anxiety (low level, relating to a recent event, i.e. response to bereavement, divorce, changing schools) 	<ul style="list-style-type: none"> Young people/parent referrals can call - 02392 827026 Mon–Thurs: 0800–2200/Fri:0800-1800/Sat:0900-1700 Drop In: 58d High St Cosham Mon–Thurs: 0930–2100/Fri:0930-1430/Sat:0900-1330 Referrals from Health Professionals must use web-form: https://www.relate.org.uk/portsmouth-district/agency-referral Referrals from parents/young people must use web-form: https://www.relate.org.uk/portsmouth-district/self-or-parent-referral Email address: relate@relateportsmouth.org.uk 	<ul style="list-style-type: none"> Early Help and Prevention Service via the Multi Agency Safeguarding Hub (MASH) for 5-19 year olds Family help following Early Help Assessment with allocation by the (MASH). School Nurse may get involved following this assessment as part of Early Help Service.
	<ul style="list-style-type: none"> Substance misuse including alcohol use and risky behaviours Whole Family Based work Healthy weight Parenting and behaviour help School Attendance 	<ul style="list-style-type: none"> Early Help and Prevention Service via (MASH) pcc.raduty@portsmouthcc.gov.uk 02392688793 or 0845 6710271 	

Please note this document is only intended as a guide as it does not include all support available

DOCUMENT REFERENCE INDEX

Page No:	Section No:	Section Title	Document
11	4	Health Needs Assessment	Emotional Health and Wellbeing Health Needs Assessment All Age Self-Harm Needs Assessment
16	4.2	Transition	Transition Implementation Plan
17	4.5	Service Offer with Staffing Numbers and Activity Data	CAMHS Service Specification
23	5.1	Promoting Resilience, Prevention and Early Intervention	U Matter Quarterly Review (Jan17-Jul17)
25	5.2	Improving Access to Effective Support - A System Without Tiers	Mental Health Apps Research Paper (Jul17)
27	5.3	Care for the Most Vulnerable	Feedback on Crisis Post (Dec16-Aug17) Transformation Bid (Jan17)
29	5.4	Accountability and Transparency	National Performance Measures Local Performance Measures Co-Production Activity Plan Co-Production Pledge Parents Evaluation Question Children and Young People Service Guide Parents Service Guide and Poster Future in Mind Launch Event Programme 11.1.17 Future in Mind Follow-Up Event Programme 20.1.17
33	5.5	Developing the Workforce	A Strategy for Improving Wellbeing and Resilience in Education Portsmouth Education Strategy 2017-2020 Wellbeing and Resilience Implementation Plan 2017-2018 Restorative Strategy Restorative Update
35	6	Governance Arrangements	Governance Table

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Title of meeting:	Health and Wellbeing Board
Date of meeting:	29 th November 2017
Subject:	Procedure for response to pharmacy consolidation applications
Report by:	Director of Public Health
Wards affected:	All
Key decision:	No
Full Council decision:	No

1. Purpose of report

1.1 Since 5th December 2016, the Health and Wellbeing Board has a statutory duty to make a representation to NHS England on consolidation applications of community pharmacies in its area (i.e. where pharmacy businesses on two or more sites propose to consolidate to a single existing site). The Health and Wellbeing Board must respond within 45 days.

1.2 This briefing presents a proposed process for formulating a response to a consolidation application of community pharmacies, which the Board is asked to approve. The timeline for a response may fall outside of the usual schedule of Health and Wellbeing Board meetings. It is proposed that this process be adhered to for all pharmacy consolidation applications received, with responses noted at the subsequent Health and Wellbeing Board.

2. Recommendations

2.1 The Health and Wellbeing Board is asked to:

- Approve the procedure for responding to pharmacy consolidation applications.

3. Background

3.1 Access to a community pharmacy has an impact on health. Pharmacies are essential for the supply of medications to the population, but also may offer a wide range of other services in the community that promote health. Pharmacies are independent businesses, commissioned by NHS England.

3.2 The Health and Wellbeing Board has a statutory responsibility to publish a statement of the needs for pharmaceutical services of the population in its area, referred to as a Pharmaceutical Needs Assessment (PNA). The PNA is a report on the local needs for pharmaceutical services and is used to identify gaps in current services or improvements that could be made to current or future service provision. As per the NHS (Pharmaceutical & Local Pharmaceutical Services) Regulations 2013, it is a statutory requirement for the

Health and Wellbeing Board to publish a PNA each three years. The current Portsmouth PNA was published on 1st April 2015 (appendix 1) with the 2018 PNA currently in development.

3.3 From 1st April 2013, pharmaceutical lists have been maintained by NHS England. Applications for new, additional or relocated premises must be made to the NHS England Area Team. Applications for a new pharmacy will be assessed against the PNA for the area.

3.4 As specified by the Regulations, in response to a pharmacy consolidation application, the Health and Wellbeing Board must provide its opinion on whether, if the application were granted, the proposed removal of premises from the pharmaceutical list would or would not create a gap in pharmaceutical services that could be met by a routine application

- (a) to meet a current or future need for pharmaceutical services, or
- (b) to secure improvements, or better access, to pharmaceutical services.

3.5 Where pharmacy premises are removed from a pharmaceutical list as a consequence of the grant of a consolidation application, if, in the opinion of the relevant Health and Wellbeing Board the removal does not create a gap in pharmaceutical services provision that could be met by a routine application, the relevant Health and Wellbeing Board must publish a supplementary statement explaining that, in its view, the removal does not create such a gap. This statement becomes part of its PNA.

3.6 The Health and Wellbeing Board is only required to make a representation to NHS England in response to consolidation applications of community pharmacies. This is not the same as a situation where a community pharmacy gives notice to NHS England to voluntarily close a premise. The conditions for voluntary closure of premises are set out in Section 67 of the NHS (Pharmaceutical & Local Pharmaceutical Services) Regulations 2013.

4. Reasons for recommendations

4.1 Procedure to respond to a pharmacy consolidation application where the Chair of the Health and Wellbeing Board and the Director of Public Health believe the application **not to be contentious:**

4.1.1 The Chair of the Health and Wellbeing Board and the Director of Public Health will consult with Health and Wellbeing Board members and the ward Councillor(s) impacted by the consolidation application.

4.1.2 Responses to this consultation will form the basis of the representation to NHS England and conclude whether or not a proposed consolidation is likely to create a gap in pharmaceutical services that could be met by a routine application.

4.1.3 The consultation will be based upon information provided in the consolidation application and, where considered useful, spatial analysis undertaken by the Portsmouth City Council health intelligence team to support identification of gaps in pharmaceutical provision.

4.1.4 The Director of Public Health will be responsible for co-ordinating the written response to NHS England.

4.1.5 The Health and Wellbeing Board will be asked to note the response at its subsequent meeting.

4.2 *Proposed procedure to respond to a pharmacy consolidation application* where the Chair of the Health and Wellbeing Board and the Director of Public Health believe the application **to potentially be contentious**:

4.2.1 A sub-committee, which will meet on an ad-hoc basis, is formed which is given delegated authority to make a decision on whether a proposed consolidation is likely to create a gap in pharmaceutical services that could be met by a routine application. Those appointed to the sub-committee will be:

- Both the Co-Chairs of the Health and Wellbeing Board
- The Director of Public Health, Portsmouth City Council (or senior delegate)
- The Chief Operating Officer, NHS Portsmouth Clinical Commissioning Group (or senior delegate)
- A senior Healthwatch Portsmouth representative

4.2.2 The sub-committee will consult with Health and Wellbeing Board members and the ward Councillor(s) impacted by an application.

4.2.3 The sub-committee will consider information provided in the application and, where considered useful, spatial analysis undertaken by the Portsmouth City Council health intelligence team to support identification of gaps in pharmaceutical provision.

4.2.4 The Director of Public Health will be responsible for co-ordinating the written response to NHS England.

4.2.5 The Health and Wellbeing Board will be asked to note the response at its subsequent meeting.

4.2 *When will this procedure be reviewed?*

4.2.1 This procedure will be reviewed following any change to the Regulations.

4.3 *How will potential conflicts of interest be handled?*

4.3.1 As part of this process, all those consulted with will be required to highlight any potential conflicts of interest which may arise in response to an application.

4.4 *How is the final decision made in response to the application?*

4.4.1 NHS England will consider representations that are received and will arrange an oral hearing to determine the application if a matter is identified on which further evidence is needed.

4.4.2 NHS England will only grant the application if it considers that no gap in provision will be created.

4.4.3 NHS England must refuse any 'unforeseen benefits applications' that purport to fill any alleged gap resulting from a closure of premises under a consolidation application until at least the next revision of the PNA.

4.4.4 If the application is granted by NHS England, the Health and Wellbeing Board must publish a supplementary statement explaining that, in its view, the removal does not create a gap (as per 3.4 a and b). This supplementary statement will become part of the PNA. The supplementary statement will use the representation made to NHS England in response to the consolidation application.

4.4.5 If a consolidation application is refused, an applicant can still apply for closure using existing procedures (Section 67 of the NHS (Pharmaceutical & Local Pharmaceutical Services) Regulations 2013) but will not benefit from protection from future 'unforeseen benefits applications'.

5. Equality impact assessment

5.1 To be undertaken as part of each pharmacy consolidation application response.

6. Legal implications

6.1 The NHS (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016 requires the Health and Wellbeing Board to make representations on consolidation applications to NHS England. This amendment came into effect on 5th December 2016.

7. Director of Finance's comments

7.1 No financial implications noted.

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Signed by: Dr Jason Horsley, Director of Public Health

Appendices:

Appendix 1: Portsmouth City Council Pharmaceutical Needs Assessment 2015:

<https://www.portsmouth.gov.uk/ext/documents-external/hlth-pharma-needs-assessment-consultation.pdf>

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location
None	

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by on

.....
Signed by:

Title of meeting:	Health and Wellbeing Board
Date of meeting:	29 th November 2017
Subject:	Response to pharmacy consolidation application
Report by:	Director of Public Health
Wards affected:	Central Southsea, Milton
Key decision:	No
Full Council decision:	No

1. Purpose of report

1.1 The NHS (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016 requires the Health and Wellbeing Board to make representations on consolidation applications to NHS England. This amendment came into effect on 5th December 2016. A consolidation application of community pharmacies is where pharmacy businesses on two or more sites propose to consolidate to a single existing site. This paper presents the decision and response made to NHS England by the Health and Wellbeing Board in response to a consolidation application of two community pharmacies:

Continuing site

L Rowlands & Co LTD T/A Rowlands Pharmacy, 129 Eastney Road, Southsea, Portsmouth, PO4 8DZ

Closing site

L Rowlands & Co LTD T/A Rowlands Pharmacy, 117 Winter Road, Southsea, Portsmouth, PO4 8DS

1.2 This is the first consolidation application that has been made in the Portsmouth City Council area. The Health and Wellbeing Boards' representation needed to be received by NHS England by 24th November 2017 and has therefore was brought to the attention of Board members and relevant ward Councillors outside the usual schedule of meetings.

2. Recommendations

2.1 The Health and Wellbeing Board agreed that:

1. The proposed consolidation of two pharmacies would not create a gap in pharmaceutical services that could be met by a routine application to meet a current or future need for pharmaceutical services.
2. The proposed consolidation of two pharmacies would not create a gap in pharmaceutical services that could be met by a routine application to secure improvements, or better access, to pharmaceutical services.

3. Background

3.1 Access to a community pharmacy has an impact on health. Pharmacies are essential for the supply of medications to the population, but also may offer a wide range of other services in the community that promote health, from medication services to smoking cessation services. Pharmacies are independent businesses, commissioned by NHS England.

3.2 The continuing site and the closing site are located in a mainly residential area in the south locality of the city. Bransbury Park and Milton Park are located near to these pharmacy sites. St Marys Treatment Centre is located slightly east of these pharmacy sites. There are several other community pharmacy sites in the south locality.

4. Reasons for recommendations

4.1 Will the proposed consolidation affect accessibility?

4.1.1 Opening hours

- The continuing site will retain its current opening hours.
 - o Core opening hours = 40 hours a week.
 - o Supplementary opening hours (additional opening hours, and which can be amended if NHS England consents) = 44 hours a week).
- The overall provision of opening hours will not be affected.
 - o Both sites had the same total supplementary opening hours (although the closing site had a shorter lunchtime closure leading to an earlier closing time).
- Weekend opening hours will not be affected.
 - o Both sites had the same Saturday opening times. For the continuing site, these hours will remain unchanged. Both sites did not open on Sundays, this will remain unchanged.
- Evening opening hours will not be affected.
 - o The continuing site was open until 6pm, which will remain unchanged. The closing site was open until 5.30pm.
- Lunchtime opening hours are half an hour longer at the continuing site, compared to the closing site.
 - o The continuing site had a lunchtime closure from 1pm to 2pm. This will remain unchanged. The closing site had a shorter lunchtime closure between 1.30pm to 2pm.

4.1.2 For people with specific needs

- Both the continuing and closing sites had the same provision of access for wheelchair users, access without steps and an induction loop. The application states that the induction loop will not continue to be provided at the continuing site. It is requested that NHS England clarify whether this is accurate.

4.1.3 Travel times

- These two pharmacies are 0.4miles apart, approximately an 8 minute walk.
- Reviewing the maps drawn for the Portsmouth City Council Pharmaceutical Needs Assessment (PNA) 2015 (appendix one), this proposed consolidation is considered to have a negligible effect on travel times to a pharmacy for Portsmouth residents. These pharmacies are situated in an area well served by pharmaceutical services.

- The 2015 PNA concluded that:
 - o The population of Portsmouth can access a pharmacy within 1.6km or less from all parts of Portsmouth (assuming it's possible to travel in a straight line).
 - o In 'rush hour'/'heavy' traffic a pharmacy in Portsmouth should still be accessible within a 5 minute drive for most parts of the city, with only a few small areas with low residential density being a 10 minute drive or more from a pharmacy.

4.2 Will the proposed consolidation affect provision of pharmaceutical services?

4.2.1 The application has considered the type of pharmaceutical activity undertaken in each site. Predominant activity in the closing site is described to be monthly monitored dosage system packs (MDS). The application states that MDS packs are currently provided and will continue to be provided at the continuing site.

4.2.2 The application states that at the closing site there are low levels of walk-in prescriptions and a low volume of over the counter sales, the need for which could be met by the surrounding pharmacies.

4.2.3 With respect to advanced, enhanced and locally commissioned services, the closing site provided a wider range of pharmaceutical services. However, the two services not currently provided at the continuing site will be taken on. Pharmaceutical services continuing are Medicines Use Reviews, New Medicines Service, collection and delivery service, flu vaccinations, emergency hormonal contraception, smoking cessation, urgent repeat medicine service, concordance - monitored dosage scheme, minor ailments scheme. The two services currently provided at the closing site which will be taken on by the continuing site are needle exchange and nicotine replacement therapy voucher scheme.

4.2.4 Neither the continuing or closing sites are currently distance selling premises or appliance contractor premises.

4.3 Are there anticipated changes which may affect local demand for pharmaceutical services?

4.3.1 Major regeneration projects are identified in the city as well as new student accommodation anticipated. These sites are not in the immediate area of the closing and continuing sites relevant to this application and therefore, are not expected to change demand for pharmaceutical services in the local area.

4.4 How will a decision be made in response to the application?

4.4.1 The proposed consolidation has been notified by NHS England to a range of stakeholders.

4.4.2 NHS England will consider all representations that are received and will arrange an oral hearing to determine the application if a matter is identified on which further evidence is needed.

5. Equality impact assessment

5.1 See Appendix 2. The equality impact assessment concludes that this proposed consolidation would not lead to a detrimental impact on any equality group. There will be no change to pharmaceutical provision through services and access provided by the continuing site.

6. Legal implications

6.1 The NHS (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016 requires the Health and Wellbeing Board to make representations on consolidation applications to NHS England. This amendment came into effect on 5th December 2016.

7. Director of Finance's comments

7.1 No financial implications noted.

.....
Signed by: Dr Jason Horsley, Director of Public Health

Appendices:

Appendix 1: Portsmouth City Council Pharmaceutical Needs Assessment 2015:
<https://www.portsmouth.gov.uk/ext/documents-external/hlth-pharma-needs-assessment-consultation.pdf>

Appendix 2: Equality Impact Assessment

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location
None	

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by on

.....
Signed by:



Equality Impact Assessment

Preliminary assessment form v5 / 2013

www.portsmouth.gov.uk

The preliminary impact assessment is a quick and easy screening process. It should:

- identify those policies, projects, services, functions or strategies which require a full EIA by looking at:
 - negative, positive or no impact on any of the equality groups
 - opportunity to promote equality for the equality groups
 - data / feedback
- prioritise if and when a full EIA should be completed
- justify reasons for why a full EIA is not going to be completed

Directorate:

Director of Public health

**Function e.g. HR,
IS, carers:**

Public Health

Title of policy, service, function, project or strategy (new or old) :

Response to pharmacy consolidation application

Continuing site

L Rowlands & Co LTD T/A Rowlands Pharmacy, 129 Eastney Road, Southsea, Portsmouth, PO4 8DZ

Closing site

L Rowlands & Co LTD T/A Rowlands Pharmacy, 117 Winter Road, Southsea, Portsmouth, PO4 8DS

Type of policy, service, function, project or strategy:

☐

Existing

☐

New / proposed

Q1 - What is the aim of your policy, service, function, project or strategy?

To make a response to NHS England by the Health and Wellbeing Board in response to a consolidation application of two community pharmacies as required by the NHS (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016. Should this consolidation application be approved, this will make a change to pharmaceutical provision in Portsmouth.

Q2 - Who is this policy, service, function, project or strategy going to benefit or have a detrimental effect on and how?

This proposed consolidation is not anticipated to have a detrimental impact on local residents as a whole, or any particular group, following consideration of access to a pharmacy, provision of pharmaceutical services and health and wellbeing needs of local residents. If approved, this pharmacy consolidation has a potential impact on individuals who currently choose to use the closing site and who will need to access an alternative pharmacy.

Q3 - Thinking about each group below, does, or could the policy, service, function, project or strategy have a negative impact on members of the equality groups below?

Group	Negative	Positive / no impact	Unclear
Age	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Disability	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Race	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Gender	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Transgender	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Sexual orientation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Religion or belief	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pregnancy and maternity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other excluded groups	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

If the answer is "negative" or "unclear" consider doing a full EIA

Q4 - Does, or could the policy, service, function, project or strategy help to promote equality for members of the equality groups?

Group	Yes	No	Unclear
Age	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Disability	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Race	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Gender	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Transgender	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Sexual orientation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Religion or belief	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pregnancy or maternity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other excluded groups	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

If the answer is "no" or "unclear" consider doing a full EIA

Q5 - Do you have any feedback data from the equality groups that influences, affects or shapes this policy, service, function, project or strategy?

Group	Yes	No	Unclear
Age	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Disability	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Race	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Gender	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Transgender	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Sexual orientation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Religion or belief	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pregnancy and maternity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other excluded groups	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

If the answer is "no" or "unclear" consider doing a full EIA

Q6 - Using the assessments in questions 3, 4 and 5 should a full assessment be carried out on this policy, service, function or strategy?

☐ yes ☒ No

Q7 - How have you come to this decision?

This conclusion has been informed by the Portsmouth Pharmaceutical Needs Assessment (PNA) 2015 (which is the current PNA and included extensive information gathering and consultation) and by the information provided in the pharmacy consolidation application.

The consolidation application states that the closing site is quiet with a significant proportion receiving compliance aids (known as monitored dosage system (MDS) packs). While individuals may choose to use a regular pharmacy, individuals can access any pharmacy for dispensing of prescriptions, over the counter medicine sales and for other pharmaceutical services, for which there will be no change in provision of services. The current PNA concludes that there is good pharmaceutical provision in Portsmouth. This would not change to any notably extent should this consolidation application be approved.

The consolidation application also states that MDS packs currently are, and will be provided at the continuing site. It should be noted that provision of MDS packs is not an essential service for any pharmacy. If a pharmacy has a patient that is covered by the Equality Act then the pharmacy has to consider what reasonable adjustment it might make to help the patient to make use of its services. An MDS is just one possibility but there are many others including use of reminder charts, large print labels, information sheets, reminder alarms, among others. Furthermore, in general, there is insufficient evidence to support widespread use of MDS packs in improving medicines adherence in patients. A MDS pack may be of value for some patients whose needs have been assessed on an individual basis with any intervention tailored to the patient's specific requirements.

The Royal Pharmaceutical Society provides guidance on this:

<http://psnc.org.uk/wp-content/uploads/2017/08/PSNC-Briefing-060.17-Equality-Act-2010-A-quick-reference-guide-Sep-2017-update.pdf>

<https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Support/toolkit/rps-mca-july-2013.pdf>

Both sites have access for wheelchair users and access without steps. The application states there is an induction loop at the continuing site currently which will not continue to be in place. NHS England should clarify whether this information is correct.

No specific impact from the proposed consolidation has been identified following consideration of potential impacts on access to a pharmacy and provision of pharmaceutical services and based on the demography, health and wellbeing needs of local residents which are summarised in the accompanying paper.

If you have to complete a full EIA please contact the Equalities and diversity team if you require help
Tel: 023 9283 4789 or email:equalities@portsmouthcc.gov.uk

Q8 - Who was involved in the EIA?

Claire Currie, Consultant in Public Health

This EIA has been approved by: Dr Jason Horsley

Contact number: 023 9284 1779

Date: 16/11/17

Please email a copy of your completed EIA to the Equality and diversity team. We will contact you with any comments or queries about your preliminary EIA.

Telephone: 023 9283 4789

Email: equalities@portsmouthcc.gov.uk

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Agenda Item 9

THIS ITEM IS FOR INFORMATION ONLY

(Please note that "Information Only" reports do not require Equality Impact Assessments, Legal or Finance Comments as no decision is being taken)



Portsmouth
CITY COUNCIL

Title of meeting: Health and Wellbeing Board

Subject: Portsmouth Suicide Prevention Plan (DRAFT)

Date of meeting: 29th November

Report by: Director of Public Health

Wards affected: Relevant to all wards

1. Requested by: Jason Horsley, Director of Public Health

2. Purpose:

- To update the HWB on the development of a Portsmouth Suicide Prevention Plan (currently in draft).
- To seek HWB support for a Suicide Prevention Plan, and specifically commitment from members that their respective organisations/teams will *own* actions – as appropriate - within the Plan.
- To gain any initial feedback, and to ask that further comments are sent to Amy McCullough, Consultant in Public Health (Amy.McCullough@portsmouthcc.gov.uk).

3. Information Requested

Please refer to the enclosed DRAFT Portsmouth Suicide Prevention Plan.

Background information:

Suicide is often the end point of a complex history of risk factors and distressing events. Suicide affects children, young people and adults – whether by taking their own life or as a person bereaved by suicide. Whilst death by suicide is highest in middle-aged men (i.e. 40-44 years), suicide is also a leading cause of death (nationally) for young people aged 15-24 years. In Portsmouth around 24 people, about 78% males, take their own lives by suicide each year. This is higher as a rate than the England average.

Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides. In Portsmouth, we **aim to reduce the number of suicides in the city by at least 10% over the next three years.** This 10% reduction is in line with the 5 Year Forward View for Mental Health (Independent Mental Health Taskforce for NHS England, 2016), which also recommends every local area having a multi-agency suicide prevention plan in place.

By combining the national and local evidence base, seven key areas for action have been identified to support delivery of our aim:

1. Achieve city wide leadership for suicide prevention
2. Reduce the risk of suicide in key high-risk groups
3. Tailor approaches to improve mental health in specific groups
4. Reduce access to the means of suicide
5. Provide better information and support to those bereaved or affected by suicide
6. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
7. Support research and data collection

As well as suicide being preventable, key messages learned from practice and research are that suicide is everyone's business, and that collaborative working is key to successful suicide prevention. In Portsmouth a multi-agency partnership group (*Portsmouth Suicide Prevention Partnership*) has been set up to oversee the development and implementation of the Suicide Prevention Plan. The Partnership includes representatives from Portsmouth City Council, Portsmouth Clinical Commissioning Group, the voluntary sector, community and acute health providers, emergency services, and other partners (see **Appendix 1** of the Suicide Prevention Plan for further detail).

Having all partners committed to contributing time to supporting action, and identifying any supporting resource, is all the more important given that there is no new financial resource to support this Plan.

Why we are tabling the draft Suicide Prevention Plan

Tabling the Suicide Prevention Plan while it is a draft enables the HWB to feedback and inform the final Plan, both in terms of the content and the process for developing the Plan (i.e. stakeholder engagement). It also provides an opportunity for Public Health to gain the commitment of HWB members to supporting the delivery of the Plan, which will inform further more detailed discussions with stakeholders on which actions are appropriate for different organisations/teams to own. It is envisaged that the final Plan will be submitted to the HWB for sign-off in February 2018.

.....
Signed by (Director)

THIS ITEM IS FOR INFORMATION ONLY
(Please note that "Information Only" reports do not require Equality Impact Assessments, Legal or Finance Comments as no decision is being taken)



Portsmouth
CITY COUNCIL

Appendices: Please refer to the enclosed DRAFT Portsmouth Suicide Prevention Plan.

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location
Portsmouth Suicide Prevention Plan (DRAFT)	See attached paper.

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Working Draft - Suicide Prevention Action Plan for Portsmouth

Page 425

Name:	Portsmouth Suicide Prevention Action Plan
Duration:	2018 – 2021
Relevant strategies:	
Board responsibility for monitoring plan:	Portsmouth Health and Wellbeing Board
Owner:	Portsmouth Suicide Prevention Action Partnership
Implementation date and review date:	Implementation: March 2018. Quarterly monitoring and annual review

Plan on a page: The Portsmouth approach to suicide prevention:

To be inserted once main document agreed. Will highlight: Approach; what the evidence and data say; risk factors/protective factors locally and nationally (which need to address/focus upon); importance of partnership and leadership; key areas for action.

Aim

Death by suicide is preventable. Each life lost is a tragedy. One suicide will always be one too many.

We aim to reduce the number of suicides in the city by at least 10% over the next three years, and provide support for those bereaved or affected by suicide.

By combining the national and local evidence base, we have identified seven key areas for action to support delivery of this aim:

1. **Achieve city wide leadership for suicide prevention**
2. **Reduce the risk of suicide in key high-risk groups**
3. **Tailor approaches to improve mental health in specific groups**
4. **Reduce access to the means of suicide**
5. **Provide better information and support to those bereaved or affected by suicide**
6. **Support the media in delivering sensitive approaches to suicide and suicidal behaviour**
7. **Support research and data collection**

Context

- Suicide is used in this Plan to mean a deliberate act that intentionally ends one's life.
- Suicide is often the end point of a complex history of risk factors and distressing events.
- Suicide is a major issue for society and a leading cause of years of life lost. Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides.
- Around 24 people, about 78% males, take their own lives by suicide each year in Portsmouth. This is higher as a rate than the England average.

- Suicide affects children, young people and adults – whether by taking their own life or as a person bereaved by suicide. Nationally, suicide is a leading cause of death for young people aged 15–24. Death by suicide (both nationally and locally) is highest in middle-aged men (i.e. 40-44 years).

Approach

Inclusive of self-harm: The relationship between suicide and self-harm is complex. We know that many people who die by suicide have a history of self-harm, and we know that self-harm is a significant concern in its own right. This strategy will consider self-harm in relation to suicide risk.

Partnership: As a large percentage of suicidal individuals are not in contact with health or social care services, action is also required beyond the health and social care system. Real partnership is required with community groups, local business and the third sector to help identify and support people at risk of suicide and those bereaved by suicide. Key messages – learned from practice and research – are that suicide is preventable, that it is everyone’s business, and that collaborative working is key to successful suicide prevention. This Suicide Prevention Action Plan has been developed by a wide range of partners to ensure that is a collaborative effort, and that action to prevent suicide is a shared responsibility across Portsmouth. Having all partners committed to contributing time to supporting action, and identifying any supporting resource, is all the more important given that there is no new financial resource to support this Plan.

Prevention and early intervention: The Plan supports taking early action to prevent individuals from reaching the point of personal crisis where they feel suicidal. This requires action much earlier and across a range of settings from general practice, schools and the workplace to community groups and web and social media.

Life-course: This Plan takes a “life course” approach as set out in national mental health and suicide prevention strategy, and advocated by the Marmot Review.

Evidence based: This Plan is informed by the evidence base. It uses national and local evidence to both identify areas of focus and specific need, and to inform the actions that will be taken to meet need.

NB. Will further consult with partners on the following:

Zero suicides: Whether we advocate a zero suicides approach in our city, which is a commitment to taking action towards achieving zero suicides among people receiving care. This approach requires action across the whole of the health and social care system, not only by practitioners providing clinical care.

Suicide safer communities: An approach first used in Canada, and which Southampton are drawing upon. UK national guidance is aligned in calling for a Partnership approach to suicide prevention.

How we will measure success

Ultimately, we want to see a reduction in Portsmouth's suicide rate. However, due to the low numbers of suicides it is difficult to show a statistically significant improvement in suicide rates across a local area and additional (proxy) measures will be used to assess the Plan's success. This includes for example, levels of self-harm and stigma in the population. Achieving a reduction in suicides is challenging in times of austerity as we know that higher levels of people are living with financial stress, which is a risk factor for poor mental health and wellbeing and increases suicide risk.

National policy

In 2012 the government published *Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives* (reference). The strategy identifies six key areas for action:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

Public Health England (PHE) has published a document designed to assist in the implementation of the national guidance, which refers to the same six key areas for action. It also includes recommendations from the All-Party Parliamentary Group (APPG), which suggested that there are three elements vital to successful implementation of the national strategy (reference):

- a. Undertaking a 'suicide audit' to understand local risk factors for suicide (PHE highlighted the need to make sense of local and national data).
- b. Developing a suicide prevention action plan.
- c. Establishing a multi-agency suicide prevention group to implement the plan throughout the local community.

In 2017 a (third) progress report of the cross-government suicide prevention strategy was published by the Department of Health. The report is used to update the 2012 strategy in five main areas:

- Expanding the strategy to include self-harm prevention in its own right.
- Every local area to produce a multi-agency suicide prevention plan.
- Improving suicide bereavement support in order to develop support services.
- Better targeting of suicide prevention and help seeking in high risk groups.

- Improve data at both the national and local levels.

The advice of these national documents, as well as the experiences of other local authorities and international developments in suicide prevention have been taken into account in the development of our Portsmouth Plan.

Other key suicide and self-harm prevention national documents can be viewed via the following PHE link: <http://www.nspa.org.uk/wp-content/uploads/2017/10/TVP-PHE-South-East-Suicide-Prevention-Resources-all.pdf>

Data and intelligence on suicide in Portsmouth

Key local data and intelligence sources that inform this section are as follows:

- Portsmouth JSNA
- Public Health England Suicide Profile
- Portsmouth Suicide Audits; 2013-14 audit, 2016 update (covering the period 2013 to 2015).
- Portsmouth Self-Harm Needs Assessment (2017)

Suicide rates

In 2016 there were 22 deaths due to suicide or undetermined intent¹ in Portsmouth, and between 2013 and 2016 97 deaths, which equates to roughly 24 deaths due to suicide or undermined intent each year.

Over the last few years, the suicide rate in Portsmouth been significantly higher than the national average. Over 2013-15 Portsmouth had an average of 14.1 deaths by suicide per 100,000 persons, which is significantly higher than the rate for England (10.1) and the South East (10.2). This is the highest local rate since 2001-03, and also higher than many of Portsmouth's comparator areas (using the CIPFA nearest neighbours definition²). Nationally, suicide rates have increased over the last ten years, coinciding with the economic downturn.

Gender and age

¹ Undetermined intent

² The Chartered Institute of Public Finance and Accounting (CIPFA) nearest neighbours attempts to relate Local Authorities by their traits by using descriptive features of the area each authority administers such as population, socioeconomic, household and mortality characteristics, rather than the services it provides.

Between 2013-16 78% of deaths due to suicide or undetermined intent were male and 22% were female. Men are therefore almost 4 times more likely to die from suicide or undetermined intent than women, which is in line with the national trend (3.5 times more likely). For 2007-2016, female deaths have an older age profile compared with male deaths: 42% of all female deaths were aged 50+ years compared with 32% of male deaths. Female deaths peak at 45-49 years compared to the slightly younger 40-44 years for males. However, deaths by suicide account for a greater proportion of deaths in younger compared to older age groups (younger people are less likely than older people to die of any cause), and particularly for males aged 18-19 years.

Contact with health services

8% of cases had seen a General Practitioner six days or less before their death, and 23% had within four weeks before their death. Of the cases who had seen a GP within the four weeks prior to their death, 64% of cases were in contact about their mental health; 33% about their physical health; and 3% were opportunistically seen. 28% of cases were in contact with mental health services, most commonly the Mental Health Recovery Team and IAPT/Talking Change.

Hotspots

Most deaths by suicide in Portsmouth take place at home (58%), but of those that take place in public spaces, the most common places were train stations and/or train lines and open spaces such as countryside (including woodland), the beech, or parks. More people lived in the most, compared to the least, socio-economically deprived areas of Portsmouth.

Groups at higher risk of suicide

The following groups are at higher risk of suicide in Portsmouth. These locally defined groups are in line with at risk groups identified by national guidance such as the national strategy report *Preventing Suicide in England: Two Years On*.

- Men, particularly middle-aged men and young men aged 18-19 years.
- People with a mental health diagnosis, especially depression – both those in the care of mental health services and those not in current treatment. For those in treatment high risk periods include the first 3 months (and especially first 2 weeks) post-discharge from acute mental health services (i.e. hospital).
- People experiencing:
 - Chronic pain, disability or other physical health status (the most commonly occurring “life event” identified by Portsmouth Suicide Audit)
 - Relationship difficulties (particularly for men)
 - Unemployment and/or financial difficulties
 - Housing difficulties and/or social isolation i.e. homelessness/living in a hostel/living alone
 - Bereavement
- People with a history of self-harm or of attempting to die by suicide.

- People that have been a former prisoner/convicted of crime
- People with a history of alcohol and/or substance misuse (and including those with dual alcohol/substance misuse and mental health illness).
- People that have experienced violence and/or abuse.

The national strategy also identifies children in care, care leavers, young people in the justice system and veterans as being at higher risk of suicide. These groups may have been less visible in the audit findings of Coroner records where past occupations such as serving in the army may not have been recorded.

Groups identified in national guidance as needing a *tailored approach* to both improve their mental health and reduce their suicide risk, are as follows:

- Looked after children and/or care leavers.
- Military veterans.
- People who are lesbian, gay, bisexual (LGB) or gender reassigned.
- Black and Minority Ethnic (BME) groups and asylum seekers.

Compared to England, the risk factors section of Public Health England's suicide profile illustrates that Portsmouth has lower rates of people who end their own lives with long-term health problems, long-term unemployment, and domestic abuse incidents. However, Portsmouth has higher rates of people who are separated or divorced, people living alone, people who are (statutory) homeless, children who are looked after, children leaving care, children in the youth justice system, alcohol related hospital admissions, and estimated prevalence of opiates or crack cocaine. Portsmouth has similar rates to England of recorded severe mental illness, self-reported happiness and anxiety scores, older people living alone, and unemployment.

Self-harm

Self-harm is a concern in its own right, as well as being a risk factor for completed suicide. Not everyone that self-harm's will have suicidal thoughts, whilst not everyone that dies by suicide will have self-harmed. However, we know that previous self-harm is an important predictor for suicide. Between 2013 and 2015 57% of cases in Portsmouth had a record of self-harm or of attempting to die by suicide³. As there are links between the two, self-harm has been identified for inclusion in the Plan as a priority for action.

National and local Portsmouth data suggest levels of self-harm are increasing, although only the 'tip of the iceberg' presents to healthcare services. Young people and adolescents (especially females) have disproportionately high rates of self-harm, both nationally and in Portsmouth. Self-harm in adults of all

³ The definition of 'Self-harm' in the Coroner's files is not clear - it may refer to trying to die by suicide or it may refer to self-harm such as cutting. The audit will also under-estimate the individuals that have self-harmed as it is well documented that many people who self-harm do not seek help from health or other services and so self-harm episodes are not recorded.

ages, taken together, also represents a significant health (and healthcare) burden. Public Health England (PHE) publish a metric which shows that local hospital admissions for 10-24-year-olds for self-harm are significantly higher than the national average, and have been for at least the last six years⁴.

Risk factors for self-harm have been determined to be (but are not limited to):

- Women - rates are two to three times higher in women than men.
- Young people - 10-13% of 15-16-year-olds have self-harmed in their lifetime.
- Mental health disorders including depression and anxiety;
- People who have or are recovering from drug and alcohol problems.
- People who are lesbian, gay, bisexual or gender reassigned.
- Socially deprived people living in urban areas.
- Women of black and South-Asian ethnicity.
- Groups including veterans, prisoners, those with learning disabilities, and those in care settings;
- Individual elements including personality traits, family experiences (being single, divorced or living alone), exposure to trauma (including bullying, abuse or adverse childhood experiences), life events, cultural beliefs, social isolation and income.

Action planning for suicide prevention in Portsmouth

A multi-agency partnership group (Portsmouth Suicide Prevention Partnership) has been set up to agree strategy and actions to reduce the rate of suicide in Portsmouth. This partnership group includes representatives from the local authority, voluntary sector, community and acute health providers, emergency services, and other partners (see **Appendix 1** for details). The partnership has overseen the development of the Suicide Prevention Plan, which presents key areas and actions, with Leads from the partnership taking ownership for the delivery of different actions.

Delivery and governance

Portsmouth Suicide Prevention Partnership (PSPP) has responsibility for delivering on and monitoring progress towards the Suicide Prevention Plan. PSPP will report to the Health and Wellbeing Board, which has overall responsibility for suicide prevention. PSPP will meet quarterly and will report to the Health and Wellbeing Board on an annual basis.

⁴ Figures and chart adapted from <https://fingertips.phe.org.uk>. Data represents Hospital Episode Statistics (HES) for finished admission episodes, courtesy of NHS Digital. Rates are directly standardised per 100,000 Portsmouth population aged between 10-24y.

Action Plan:

NB. Further consultation will now take place on the actions set out below and it is anticipated that there will be change. Some need to be made SMART(er), and anticipated outcomes and timescales completed. Also want to see some actions shifted from Public Health to Partners.

1. Objective: Achieve city wide leadership for suicide prevention					
This Suicide Prevention Action Plan has been developed by a wide range of partners to ensure that is a collaborative effort, and that action to prevent suicide is a shared responsibility across Portsmouth.					
Ref	Target Group	Action	Timescale	Lead officer/partner	Anticipated outcome
	All groups	Establish a functioning multi-agency strategic group overseeing delivery of this Plan and related suicide and self-harm prevention activities (meeting quarterly).	June 2017	Public Health	
	All groups	Members of the Suicide Prevention Action Partnership to advocate suicide and self-harm prevention in their work areas and disseminate key messages, as well as “own” specific relevant actions.	Ongoing	All partners	
	All groups	Members of the Suicide Prevention Action Partnership share good practice, highlight current issues, identify funding and commissioning opportunities, and support collaborative work.	Ongoing	All partners	
	All groups	The Suicide Prevention Action Partnership establishes strong links with national, South East and Hampshire-wide networks on suicide prevention.	Ongoing	Public Health ICU Providers	

2. Objective: Reduce the risk of suicide in key high-risk groups

The following groups are at higher risk of suicide in Portsmouth. These locally defined groups are in line with at risk groups identified by national guidance such as The national strategy report: Preventing Suicide in England: Two Years On.

- Men, particularly middle-aged men and young men aged 18-19 years.
- People with a mental health diagnosis, especially depression – both those in the care of mental health services and those not in current treatment. For those in treatment high risk periods include the first 3 months (and especially first 2 weeks) post-discharge from acute mental health services (i.e. hospital).
- People experiencing:
 - Chronic pain, disability or other physical health status (the most commonly occurring “life event” identified by Portsmouth Suicide Audit)
 - Relationship difficulties (particularly for men)
 - Unemployment and/or financial difficulties
 - Housing difficulties and/or social isolation i.e. homelessness/living in a hostel/living alone
 - Bereavement
- People with a history of self-harm or of attempting to die by suicide.
- People that have been a former prisoner/convicted of crime
- People with a history of alcohol and/or substance misuse (and including those with dual alcohol/substance misuse and mental health illness).
- People that have experienced violence and/or abuse.

Ref	Target Group	Action	Timescale	Lead officer/partner	Anticipated outcome
Support, commission and deliver suicide intervention services:					
	All age groups	Embed suicide prevention in the Crisis Care Concordat programme.		CCG Solent NHS Trust	Improved risk identification, support and pathways to care. Suicide Prevention Plan linked with key programmes such as the MH Concordat.
Support, commission and deliver proactive suicide prevention activities:					
	All age groups Particular focus on middle-aged men, those living with depression and anxiety, and people living with chronic pain.	Map the different services, organisations and support groups (i.e. Citizens Advice, Foodbanks, Gyms, Libraries, Men in Sheds, Housing services as well as health services) that each of the at risk groups		ICS Public Health	Robust pathways in place.

		are likely to have frequent contact with – their “touch points” in order to identify gaps and where pathways can be improved.			
	<p>All age groups</p> <p>Target services and settings to train include the following:</p> <ul style="list-style-type: none"> • Schools and Collages; • Primary care (targeting those in high deprivation areas and with high levels of chronic pain); • Housing services; • Alcohol and substance misuse services; • Services and organisations in contact with people in socio-economic hardship i.e. DWP, debt and benefit advice agencies); • Services/groups/business frequented by our target groups. 	Provide mental health, self-harm and suicide prevention training to frontline staff and “touch points” (see above) to enable them to better identify those in need of help, provide support, and sign-post/refer.		Public Health CCG	
	All age groups	Use the above to identify opportunities for establishing and improving robust prevention activities, risk identification, sign-posting, and referral to support services (including referral to mental health services such as Talking Change - IAPT - and support services such as Bereavement support).		ICS Public Health	

	Adults	Complete a review of gaps in psychosocial support for vulnerable groups between Portsmouth CCG and public health.	December 2017	Kerry Pearson - Integrated Commissioning Unit (ICS) / CCG	
	Adults	Partners to fully engage with the Sustainability Transformation Plan (STP - NHS) dual diagnosis priority working group and subsequent action plan.	September 2017	CCG Solent NHS	Improve the response to people with comorbid mental health and alcohol and/or substance misuse.
	All age groups	Implement the recommendations of the Self-harm Needs Assessment 2017 (as prioritised by the Self Harm Sub-Group of the Suicide Prevention Partnership Group).		Public Health Partners as appropriate	Reduction of self-harm in population from current baseline
	Adults Target groups include middle aged men, those with depression and anxiety, and people living with chronic pain.	Contribute to the Portsmouth City Council workplace health programme to advocate good practice workplace health in relation to mental health and wellbeing (for PCC and target employers in Portsmouth).		HR, PCC (internally) Solent Mind (externally)	Connect 5 (mental wellbeing and resilience training) & engagement with local employers/ Public Health Portsmouth (PHP) Business Plan 18/19
	All age groups Target groups include middle aged men who are socially isolated and/or economically inactive, adults with chronic pain, and young women (the later in relation to self-harm)	Deliver public awareness mental health campaigns (including suicide prevention and self-harm) that target at risk groups, reduce stigma, and encourage people to seek support.		Comms, PCC	

3. Objective: Tailor approaches to support improvements in mental health in specific groups

The following groups may need tailored approaches to support improvements in their resilience and contribute to (with other actions) improved mental health:

- Looked after children and/or care leavers.
- Military veterans.
- People or are lesbian, gay, bisexual (LGB) or gender reassigned.
- Black and Minority Ethnic (BME) groups and asylum seekers.
- Those with complex (i.e. often multiple) needs.
- Plus some of the “at risk” groups identified through Priority 1.

Ref	Target Group	Action	Timescale	Lead officer/partner	Anticipated outcome
	Adults Vulnerable groups because of their mental health illness and/or because they are in the above groups.	Review how the Suicide Action Partnership Group and the Adult Safeguarding Board can most effectively work together on common issues to protect vulnerable adults from self-harming and/or committing suicide.		Public Health Adult Safeguarding Board	
	Children and young people Vulnerable C&YP including looked after children and care leavers	Review how the Suicide Action Group and the Children’s Safeguarding Board can most effectively work together on common issues to protect vulnerable children and young people from self-harming and/or committing suicide (including looked after children and care leavers).		Public Health CYP Safeguarding Board	
	Adults Those with complex needs i.e. MH, substance misuse, rough sleeping	Engage and support the Safer Portsmouth Partnership's work with the Complex Needs System Review group. Seek to support recommendations from the group.		PCC (including Public Health), Solent NHS Trust, CCG	Senior leaders from these organisations
	All age groups	Identify individuals/groups/organisations that can help engage with those identified as requiring		Could our voluntary sector support this?	

	Target groups: LGBT, BME, Veterans (ex), young offenders, bereavement support services.	tailored support (i.e. LGBT, BME groups, those with learning disabilities) and ensure they are aware of the pathways, services and resources in place so that they can best support individuals.			
	Adults and children and young people	Commissioned services recognise and put in place measures to support the specific needs of at risk and/or potentially vulnerable groups in need of additional support i.e. men only as well as mixed gender groups, LGBT groups.		NHS Solent CCG ICU	

4. Objective: Reduce access to the means of suicide

Ref	Target Group	Action	Timescale	Lead officer/partner	Anticipated outcome
	Adults Those experiencing chronic pain	Promote safe prescribing of painkillers and antidepressants through the following: <ul style="list-style-type: none"> - Provide information to the Clinical Commissioning Group, GPs and hospital prescribers on deaths caused by prescription drugs, with recommendations. - Undertake a needs assessment for people addicted to prescribed medication. - Establish a time limited working group to oversee the needs assessment and make recommendations. 	October 2017 ? April 2018	Alan Knobel, Public Health Alan Knobel, Public Health CCG	
	All age groups	All agencies to work together to identify and manage hotspots for both completed and attempted suicides, including through the following:		Public Health	

		<ul style="list-style-type: none"> - Mapping the location of confirmed and possible suicides and self-harm locations to identify “hot spot” locations. - Informing partner agencies and those that have responsibility for buildings/land used for suicide in order to raise awareness and target and deliver training. - Establish a process for alerting train station staff if someone with high suicide risk goes missing from acute care. - Take action to reduce risk (i.e. install signage, barriers) as needed and in line with evidence base. 		<p>Samaritans? (work with Network Rail)</p> <p>NHS Solent</p> <p>Samaritans, Network Rail and other partners as needed.</p>	
	All age groups	Work with planning and developers to include suicide risk in building design considerations, especially in relation to multi-storey car parks, bridges and high rise buildings that may offer suicide opportunities.		Planning Housing	

5. Objective: Provide better information and support to those bereaved or affected by suicide

The right support at the right time.

Ref	Target Group	Action	Timescale	Lead officer/partner	Anticipated outcome
	Families bereaved by suicide or a death of undetermined intent	Strengthen effective referral to bereavement support/services by emergency services that attend the death and those in contact with the families		Police NHS South Central Ambulance Service	

		soon after bereavement from suicide occurs (i.e. Coroner's Office), so that referrals are appropriate and timely.		Bereavement services	
	Families bereaved by suicide or a death of undetermined intent	Update the bereavement support pack "Help is at Hand" (nationally produced) with supporting local information (i.e. including details of local bereavement support services), working with local bereavement support services.		Public Health NHS Solent Coroner's Office	
	Families bereaved by suicide or a death of undetermined intent	Distribute and make available a Portsmouth Crisis Card to all appropriate agencies/services, which references local support and the national "Help is at Hand" pack. Make available the national/local pack as appropriate.		Public Health NHS Solent CCG Voluntary sector	
	Families bereaved by suicide or a death of undetermined intent	Implement Suicide Real-Time data collection process by the Police (which will support the actions above); to early identify 'clustering' that would inform prevention and postvention planning.		P Colin Bullpett (Hampshire Police)	
	Families bereaved by suicide or a death of undetermined intent	Review the current bereavement support offer to families in Portsmouth, determine how best needs can be met, and work with services to strengthen the provision of suicide-specific bereavement support.		Public Health ICS	
	Families bereaved by suicide or a death of undetermined intent	Build awareness raising on suicide-specific bereavement into core mental health and suicide prevention training for front line staff (including with first responders).		Public Health NHS Solent CCG	

6. Objective: Support the media in delivering sensitive approaches to suicide and suicidal behaviours

Promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media and reduce the risk of additional suicides

Ref	Target Group	Action	Timescale	Lead officer/partner	Anticipated outcome
	All age groups	Promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media, including by encouraging use of guidance and advice on responsible reporting, and challenging the publication of harmful or inappropriate material with reference to the updated laws on promoting suicide.		PCC media team Samaritans?	
	All age groups	Encourage local media to support the signposting of national helplines and local services for people that are affected by local campaigns and coverage of deaths by suicide or undetermined intent.		PCC media team	
	All age groups	Work with our local media to prevent imitative suicides and tackle suicide “hotspots”.		PCC media team	
	All age groups	Build a proactive suicide prevention media campaign, which includes supporting World Suicide Prevention Day.		PCC media team	

7. Objective: Support research, data collection and monitoring

Build on the existing research evidence and other relevant sources of data on suicide and suicide prevention

Ref	Target Group	Action	Timescale	Lead officer/partner	Anticipated outcome
	All age groups	In relation to the Suicide Audit: - Periodic audit of suicide and open verdicts undertaken to inform the JSNA and future refresh of the Suicide Prevention Action Plan.		Public Health Coroner’s Office	

		<ul style="list-style-type: none"> - The audit should continue to include findings of all serious incident reviews. - Explore with Coroner's office how occupational status can be better identified and recorded (to enable better targeting of prevention activities). 			
	All age groups	Circulate the key findings of the suicide audit to partners, including general practice and healthcare providers, to encourage learning from suicides locally.		Public Health CCG/GP Alliance	
	All age groups	Explore the need for additional/extended information sharing protocols to support multi-agency suicide prevention, implementation options, and deliver agreed option/s as appropriate.		Emergency services, NHS Solent, CCG?	
	All age groups	Put in place processes to ensure that information on self-harm and attempted suicides informs suicide prevention activities.		Public Health, NHS Solent	
	Children and young people	Include a section in the YouSay Survey (with schools), which will provide supporting information on the status and views of children and young people in relation to mental health, social and emotional wellbeing – to support identification of need and preventative activities.		Public Health	
	All age groups	Establish links with local and leading University's on suicide and self-harm prevention to strengthen research links and academic input to the Partnership.		Public Health	

Appendix 1: Stakeholders engaged in developing Portsmouth's Suicide Prevention Plan

NB. Some of the stakeholders below will be engaged between now and January to inform the final Plan.

Stakeholder organisation
Suicide Prevention Action Partnership (SPAP) membership
Public Health Consultant, PCC (Chair)
Public Health MH Lead and Suicide Prevention Lead (adults)
Public Health CYP, PCC
Public Health, Substance Misuse Development Manager
British Transport Police
Network Rail
Portsmouth Police
Coroner's Office
University of Portsmouth
Solent MIND
MH service providers
Red Lipstick (bereavement support for families bereaved by suicide)
Portsmouth Survivors of Bereavement by Suicide (SOBS?)
Service users
Service users (adults)
Service users (children and young people)
Other Portsmouth City Council stakeholders
Portsmouth City Council Cabinet Members
Director of Public Health
Director of Children's Services
Deputy Director of Children's Services
Children & Young People's Lead, Public Health
Director of Adults Services
Deputy Director of Adults Services

ICU Mental Health Lead (adults)
ICU Mental Health Lead (children's)
ICU Children's Lead
Adult Strategy
C&YP Strategy
Portsmouth City Council (MCC) Homelessness Team
Children's Safeguarding
Adult's Safeguarding
Mental health services
NHS Solent
CAHMS
CCG and primary care
CCG strategic lead
CCG Clinical Lead
GP Alliance
Other voluntary sector stakeholders
Samaritans
Portsmouth Voluntary Service
Any other charities that have a strong local presence? Including those that work with people with chronic physical health conditions.
What about men's sports/men's stakeholders i.e. Portsmouth FC? This is something we can talk to Cheryl about developing a relationship with if not already. Works really well in Southampton.
Other stakeholders
University of Southampton (research interests around suicide prevention). Leading Universities for suicide prevention include University of Bristol.
Workplace Health
Schools
Early Help Team
Young people represented enough? Do we have a voluntary sector group representing CYP MH and emotional wellbeing? No Limits in Southampton.



Title of meeting:	Health and Wellbeing Board
Date of meeting:	29 th November 2017
Subject:	Health and Wellbeing Strategy refresh, 2018-2021
Report by:	Jason Horsley, Director of Public Health
Wards affected:	n/a
Key decision:	No
Full Council decision:	No

1. Purpose of report

- 1.1 To present to the Health and Wellbeing Board a consultation document for approval.

2. Recommendations

- 2.1 The Health and Wellbeing Board is recommended to:
 - a. Approve the document for consultation as attached at Appendix A.
 - b. Agree the proposals for consultation set out in section 6.

3. Background

- 3.1 There is statutory duty on local Health and Wellbeing Boards to produce a strategy for the Health and Wellbeing of their population. Portsmouth's current strategy runs from 2014-2017. At the last meeting of the Board, it was agreed that the refreshed strategy would run from 2018-2021, and that a process would take place to ensure that the new strategy is adopted in March 2018.

4. Reasons for recommendations

- 4.1 The next Health and Wellbeing Strategy needs to focus on the highest impact issues for the city, and the areas where the work of the Health and Wellbeing Board can add maximum value. The proposals set out in Appendix A represent early suggestions that could be developed through the drafting process.
- 4.2 The recommendations for the timeline for development will ensure that the Health and Wellbeing Board achieve the development of a strategy by March 2018.

5. Principles for refreshing the strategy

5.1 At the last meeting of the Board, an advanced consultation document was agreed, subject to the addition of a priority around promoting mental wellbeing. The document has been amended to reflect this request (priority 2c). The document reflects previous decisions that:

- our overarching aims should be to improve healthy life expectancy in the city; and reduce inequality by improving the areas with lowest expectancy fastest
- we do this by working to principles around promoting prevention, supporting independence and intervening earlier
- that the strategy needs to work on all dimensions of the city in a whole systems approach
- that broad themes are supporting physical good health, supporting social, emotional and mental health, working to improve outcomes for marginalised groups fastest; and improving access to services.

5.3 Subject to the comments of the Health and Wellbeing Board, it is proposed to use the document attached as Appendix A as the basis for consultation with stakeholders.

6. Consultation

6.1 The document will be sent to organisations represented on the Health and Wellbeing Board for detailed comment and for these organisations to subsequently share with their own key partners. Officers involved in drafting the document will be happy to attend meetings to discuss the content in detail.

6.2 The document will also be placed on the website for the city council and promoted, with an on-line consultation facility available, aligned with the questions in the document.

6.3 Healthwatch will support any individual who wishes to make comment on the document but requires support, and this will be made clear on the consultation page.

6.4 These proposals for consultation reflect the experience that there is less public appetite for involvement in strategy development than in commenting to the particular initiatives that follow from strategies. The expectation is that any resultant service changes would be subject to their own detailed consultation in the usual way.

6.5 Results from consultation will be presented to the HWB, along with an amended document that takes account of responses, in February. This will be accompanied by a high-level action plan and an associated work programme for the HWB, including consideration of the wider determinants where work is led through other partnerships.

7. Equality impact assessment

- 7.1 A preliminary EIA was completed for the document and concluded that there will be no negative impact on any of the protected characteristics arising from the development of a refreshed Health and Wellbeing Strategy. Any individual projects or measures arising from the strategic approach outlined will be subject to impact assessments in their own right. The preliminary EIA is attached as Annex 1.

8. Legal implications

- 8.1 Legal implications are set out in the body of the report.

9. Director of Finance's comments

- 9.1 Not sought. This work will be undertaken using existing staffing resources and will not incur additional costs.

.....
Signed by:

Appendices: Draft Health and Wellbeing Strategy for consultation

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by on

.....
Signed by:

Draft Health and Wellbeing Strategy for consultation

Introduction

Developing the draft Health and Wellbeing Strategy

There is a statutory duty on local Health and Wellbeing Boards to produce a strategy for the Health and Wellbeing of their populations. The strategy should inform work that is done to improve health and wellbeing in local areas.

Portsmouth's previous strategy (2014-2017) is wide-ranging and provided a comprehensive overview of health and wellbeing matters in the city. In refreshing this for 2018-2021, we are focusing on the relationships to other work in the city, and on the areas of work that will have the highest impact in the context of the wider system.

We have sought to identify priorities based on the strong evidence we have about the city and the huge range of stakeholder information and feedback that members of the Board have access to. We remain committed to the reduction of health inequalities, by improving outcomes for those in the worst position fastest. We recognise that inequalities can be identified according to where people live, and that this is particularly true in some areas where there are high levels of deprivation and need; but there are also inequalities between genders, ethnicities, ages and abilities that we need to tackle.

In developing the draft, we have taken account of:

- the most up to date evidence of what is happening around health and wellbeing outcomes in Portsmouth, as summarised in our Joint Strategic Needs Assessment
- an assessment of our progress against the previous strategy
- latest relevant national guidance, strategies and plans
- local strategies and plans
- insight from local residents and communities

The strategy will be a critical piece of documentation for:

- Underpinning commissioning decisions: setting a framework for commissioning plans across the NHS, local authority and other agencies in the city
- Influencing decisions: providing a source of evidence and direction for policy and decision making in a wide range of areas across the city, such as development, community safety and education.
- Holding leaders of organisations across the city to account for improving outcomes: the strategy will be reviewed each year and provide a basis for conversations about where we are improving outcomes, and where more needs to be done.

We are consulting on our draft strategy, and the responses to this will be used to shape the final document. We will consult in detail with lead agencies and partnerships to ensure that the work programmes proposed in the strategy are complementary to programmes already underway, and consider where the Health and Wellbeing Board can add additional value to those programmes.

For example, Portsmouth's Children's Trust Board will take the lead on issues relating to education and supporting families at the earliest point. Similarly, the Safer Portsmouth Partnership will lead on issues relating to violent crime. However, there are some issues with a very specific health and care emphasis, such as dealing with alcohol and substance misuse, or supporting people with special educational need and disability and we are proposing to reflect those in the Health and Wellbeing Strategy.

However, identifying where the biggest impact can be made by the Health and Wellbeing Board is the key element of this first stage consultation.

Critically, we want to know:

- 1. Have we identified the right priorities and issues***
- 2. How do you think the Health and Wellbeing Board can add value and bring about positive change?***
- 3. Where are the examples of what is already working well in the city? How can we learn from and build on successes in working successfully together to achieve better outcomes?***
- 4. What do you think will tell us if we are making an impact.***

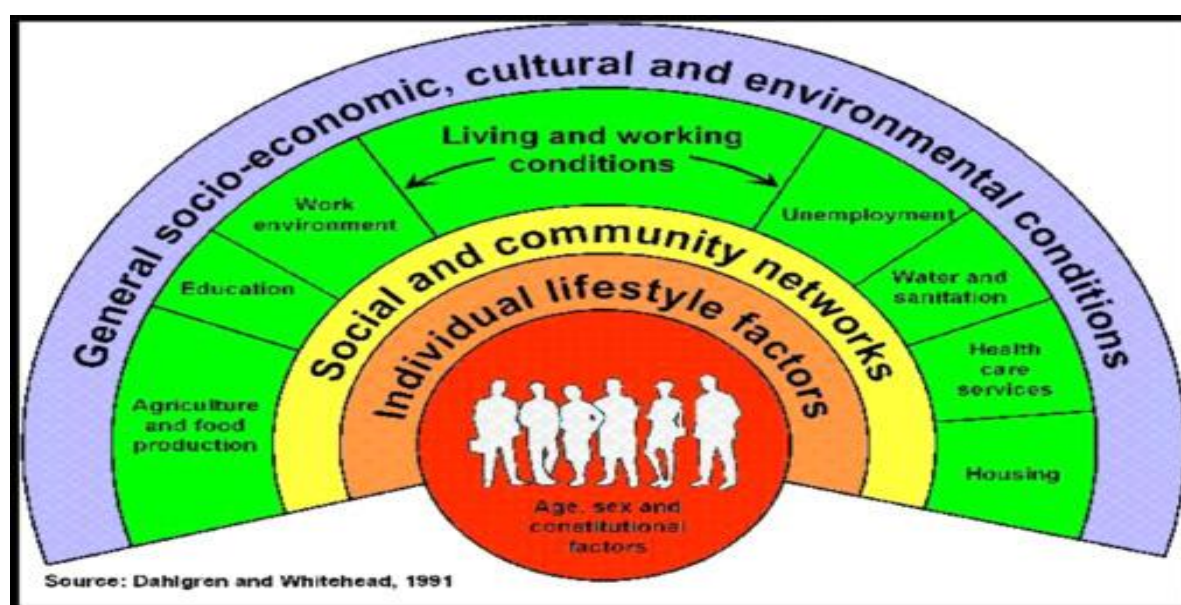
Portsmouth - in a nutshell and the case for change

Portsmouth is a great waterfront city, home to over 200,000 people, with all the diversity, opportunities and challenges that come with that.

The city has great assets and potential. We have an extraordinary natural environment, world-leading status in industries including marine technology, aerospace and defence, and a vibrant cultural sector. Our university is thriving and respected and we have plans for regeneration of the city, including the development of thousands of homes on the Tipner site to the west of the city.

Despite this, the most recent summary of the Joint Strategic Needs assessment for the city showed that life expectancy in the city is lower than the national averages for both men and women. Main areas of concern for Portsmouth, when considering health and wellbeing data, are educational achievement at 16, high levels of recorded violence against the person, premature mortality from cancer, high levels of death from drug misuse and deaths from suicide.

We believe that if the city is to unlock its potential, we need to tackle these issues - and other areas where Portsmouth may be making improvements but is still in a poor position relative to other areas of the country, such as smoking prevalence and smoking-related deaths, and premature mortality from heart disease and stroke. We know that outcomes in health are more than about managing health problems and that the wider determinants of health are critical:



Put simply, people who have good quality and secure jobs and housing in the areas communities where they have families and social networks stay healthier, feel happier and live longer. In order for them to secure work, homes and relationships, they need a good start in life, support when they have problems, and care when they need it. When these conditions exist, areas are attractive to investors and visitors, creating more opportunities for residents, and more resources that can be directed to support the most vulnerable.

The case for improving health and wellbeing in Portsmouth is clear - unlocking the potential of the city and securing the prosperity it can generate depends on it.

Our vision and approach

We want to improve healthy life expectancy in the city; and reduce inequality by improving the areas with the lowest expectancy fastest.

We will do this by working to principles around:

- Promoting prevention
- Supporting independence
- Intervening earlier

We know that we want to give people the best possible start in life, empower them to live healthy lives and enjoy a healthy older age. In order to do this we will:

- Empower people to take care of their physical health
- Empower people to take care of their social, emotional and mental health
- Work with marginalised groups to make improvements for them fastest

Our strategy on a page

Themes	Priority	Example action areas where the health and wellbeing board can add value
Improve healthy life expectancy in the city; and reduce inequality by improving the areas with the lowest expectancy fastest		
Support physical good health	Reduce the harms from tobacco	<ul style="list-style-type: none"> - Promoting smoke-free environments - Helping people to quit - Promoting e-cigarettes as a harm reduction product
	Reduce the harms from physical inactivity	<ul style="list-style-type: none"> - Promoting healthy environments and good quality public realm - Supporting active travel in the city - Working with school and community groups to increase options for physical activity - Creating options for people who are currently inactive
Support social, emotional and mental health	Reduce the harms from alcohol and other substance misuse	<ul style="list-style-type: none"> - Support the recovery community in the city - Reduce the availability of low-cost, high strength alcohol - Use licensing powers to promote the responsible and moderate use of alcohol
	Reduce the drivers of isolation and exclusion, including poverty	<ul style="list-style-type: none"> - Promote the creation of quality employment in the city, including promoting healthy workplaces - Promote access to good quality homes - Use a combination of planning and licensing powers to reduce the harms of problem gambling
Make improvements for marginalised groups fastest	People with complex needs	<ul style="list-style-type: none"> - Promote access to housing for vulnerable people, recognising that having stability is the first step in addressing substance misuse and helping people deal with poor mental health
	People in the armed forces community	<ul style="list-style-type: none"> - Support a full needs assessment for the Armed Forces community and inform actions in response to this
	People with SEND	<ul style="list-style-type: none"> - Maintain oversight of the strategy for Special Educational Needs and disabilities in the city
Improve access to health and social care support in the community	Implementation of the Portsmouth Blueprint for health and care	

How we will deliver the strategy

Our approach will consider the complete environment in which people live, and the whole range of influences on their lives:



In our work with individuals, we will:

- ensure that people are empowered to take responsibility for their own well-being, transferring responsibility to them wherever possible to self-care and self-manage, to opt for personal budgets and to have a full say in designing and shaping the policies, services and plans that will affect them.
- Ensure we see the whole person and their whole set of issues, consider how these link together and support them to tackle problems holistically.

In our work with communities, we will:

- Take an asset-based approach, recognising the many strengths that already exist in our cities and communities
- Consider community-based ideas and solutions to tackle problems, building on schemes such as community connectors.

In our work with each other, we will:

- Continue to work together on commissioning and delivering services, so that organisational structures and boundaries don't stand in the way of delivering the best solutions, and residents don't experience difficulty in access and navigating services
- Hold each other to account respectfully and supportively for delivering on the objectives in the Health and Wellbeing Strategy.

TELL US:

Where are these approaches being used well in the city? How can we learn from and build on successes in working successfully together to achieve better outcomes?

Theme 1: Support good physical health

Lifestyles, particularly physical inactivity, unhealthy diets, drinking alcohol to excess, and smoking are challenges in Portsmouth, with a significant proportion of adults exhibiting more than one unhealthy behaviour, which adversely contributes to the health inequalities of those living in Portsmouth's more deprived areas, and affects the predicted poor long-term health of those currently of middle age (35 to 64 years) living anywhere in the city. There is also a real challenge that many of these behavioural issues in adults impact negatively on children from pregnancy onwards (eg smoking in pregnancy, offering unhealthy food, snacks and drinks, not taking children to dental and other health appointments).

Priority 1a: Reduce the harms from tobacco

Why is this a priority?

Smoking remains the main reason for the gap in life expectancy between rich and poor. The Local Tobacco Control Profiles show that compared to England, Portsmouth has significantly higher rates of:

Measure	Portsmouth	England
Prevalence of current smokers in 15 year olds, 2014/15	10.9%	8.2%
Prevalence of regular smokers in 15 year olds, 2014/15	8.2%	5.5%
Smoking prevalence in adults 2015	19.8%	16.9%
Pregnant women smoking at the time of delivery	14.7%	11.4%
Smoking attributable mortality 2012/14	333 deaths per 100,000 persons aged 35+ years	275 deaths per 100,000 persons aged 35+ years

The national Tobacco Control Plan for England states "...nicotine addiction for most people starts in adolescence. In England, almost two-thirds of current and ex-smokers say that they started smoking regularly before they were 18 years old.... Very few people start smoking for the first time after the age of 25" The local Health and Lifestyle Survey found that 49% of all current tobacco smokers started to smoke when they were younger than 16 years, 24% between 16 and 17 years of age and 20% between 18 and 24 years of age.

The most recent local 'You say' survey of secondary school pupils encouragingly found an increase in pupils who had never tried tobacco from 78% in 2015 to 85.7% in 2016.

The local Health and Lifestyle Survey of adults found the highest levels of adults smoking daily or occasionally in Central locality (21% compared to 16% in North and 11% in South localities). Those with the lowest levels of mental wellbeing were more likely to smoke tobacco than those with the highest levels of mental wellbeing (16% compared to 9%). Seventy-seven per cent of local smokers say they would like to stop smoking. Of those who had given up smoking, 71% said they gave up without any help or support.

The Tobacco Control Alliance has recently agreed 'Smoke-free Portsmouth: Tobacco Control Strategy 2016-2020'. This four-year strategy covers all aspects of smoking and tobacco control to improve the health and wellbeing of the people of Portsmouth by reducing inequalities and by nurturing a tobacco free generation. Creating a smokefree generation is a key priority for us and we will ensure that we focus on preventing young people from starting to smoke to help achieve this.

This will be achieved through a reduction in the prevalence of smoking consistent with national targets and by addressing the wider tobacco control agenda.

We aim to:

- i. Reduce smoking prevalence in Portsmouth, both overall and in identified target groups
- ii. Support local communities to create a tobacco-free culture for Portsmouth

The strategy focus on the three important areas of protection, prevention, and cessation; with our key priorities for achieving a Smoke-Free Portsmouth being to:

1. Promote smokefree environments across the city
2. Motivate and assist every smoker to stop
3. Deliver effective communications and campaigns around the tobacco agenda
4. Provide leadership to create a smokefree city
5. Develop a workforce confident and competent to help reduce the harms of smoking
6. Improve health outcomes and reduce smoking related inequalities targeting young people, pregnant women, adults in routine and manual occupations and adults with mental health disorders.

Smoking is a significant issue reflected in the Public Health Outcomes Framework, and therefore there is a great deal of data about prevalence and harms linked to smoking, including low-birth weight babies, respiratory diseases and attributable mortality.

Priority 1b: Reduce the harms from physical inactivity

Why is this a priority?

The list of benefits of regular and adequate levels of physical activity is huge; some of the main ones were highlighted by the World Health Organisation:

- improve muscular and cardiorespiratory fitness;
- improve bone and functional health;
- reduce the risk of hypertension, coronary heart disease, stroke, diabetes, breast and colon cancer and depression;
- reduce the risk of falls as well as hip or vertebral fractures; and
- fundamental to energy balance and weight control.

Being physically active improves the health of everyone, regardless of age, sex, ethnicity, disability, wealth or waist size. Physical activity is commonly linked with obesity and healthy weight and whilst activity is an essential component in maintaining a healthy weight it should be regarded as a health priority in itself. The health benefits of physical activity extend beyond weight loss and are just as important for those overweight, underweight or at the correct weight.

As measured by the Active Lives Survey 65.4% of the Portsmouth population are classed as active. This is in line with the national averages but below that of the region and Hampshire. 22.7% of Portsmouth residents achieve less than 30 minutes per week of moderate intensity activity.

Levels of physical activity in the city decline with age. The largest increases in inactivity take place from 55 years of age. People with a disability are far more likely to be inactive than those without, and people of Asian, Black and Chinese ethnicity are more likely to be inactive. Household income and social status also demonstrate a distinct difference in levels of physical activity. The residents of Drayton & Farlington, St Judes and Eastney & Craneswater (the most prosperous wards in the city) have the highest levels of activity. The wards of Charles Dickens, Nelson and Paulsgrove, and parts of Cosham, Fratton and St Thomas, have the highest levels of inactivity. These are the areas where we see highest levels of deprivation in the city.

A number of surveys exploring attitudes and trends in regards to the health, including physical activity, of the Portsmouth population have been conducted recently the key findings for physical activity are details below.

The overall aim is to ensure that everyone meets the recommendations for physical activity. However, targeting those who are the most inactive to become more active will produce the greatest reduction in chronic disease. This applies even when this new activity falls short of the CMO's guidelines.

Therefore, we will aim to:

1. Create Active Environments

Engineering activity back into daily life through infrastructure, transport, housing, workplaces and open space. Influence how people live their lives and choose being active

2. Enable Active starts

Creating positive attitudes and behaviour amongst all children and young people. Ensuring that positive habits are resilient into adulthood and through periods of change.

3. Support Active Lives

Engage and empower individuals, families and communities to be active every day. Build a culture of activity throughout every corner of daily life.

4. Practice Active Medicine

Valuing and utilising physical activity to prevent and treat health conditions. Activity is viewed as a key component for physical and mental health and wellbeing.

This is an area where there is strong data available about levels of activity undertaken in the city (often commissioned by outside agencies) and around areas that we know are linked to activity, including healthy weight data. Therefore, we will propose to track progress against the following indicators:

1. Increase physical activity levels amongst children and young people
2. Reduce the number of physically inactive adults
3. Retain levels of activity through the life course
4. Reduce inequalities of activity levels amongst females, people with a disability, some ethnic groups and people living in Portsmouth's most deprived communities

TELL US:

In relation to Theme 1:

Are these the right priorities? Have we identified the right challenges?

What are the opportunities for the Health and Wellbeing Board to add value in this area and bring about change?

Where are the examples of what is already working well in the city? How can we learn from and build on successes in working successfully together to achieve better outcomes?

How will we know if we are making change for the better? What would be the measures or indicators of success?

Theme 2: Support social, emotional and mental health

We know that Portsmouth has significantly higher rates of factors which are risks for mental ill health (eg relative deprivation, alcohol misuse and violent crime) but lower recorded rates than the national average of, for example, depression.

Priority 2a: Reduce the harms from alcohol and other substance misuse

Why is this a priority?

Digestive conditions, including chronic liver disease and cirrhosis, contribute to the comparatively shorter life expectancy of males and females in the most deprived compared to the least deprived areas of the city. Liver disease is affected by physical activity, diet, tobacco smoking and alcohol as well as by Hepatitis B and C viruses: it is a largely preventable disease.

The Liver Disease Profiles and the Local Alcohol Profiles for England show that Portsmouth has significantly higher rates than England across for:

- Claimants of benefits due to alcoholism, 2015
- People admitted to hospital for alcohol-specific conditions, 2014/15
- Admission episodes for males aged 40-64 years, 2014/15
- Admission episodes for mental and behavioural disorders due to use of alcohol condition (broad definition) for males and for females, 2014/15
- Admission episodes for mental and behavioural disorders due to use of alcohol condition (narrow definition) for males 2014/15
- Admission episodes for intentional self-poisoning by and, exposure to, alcohol condition for males and for females, 2014/15
- Alcohol-specific mortality for males and for females, 2012/14
- Alcohol-related mortality for males, 2014
- Mortality from chronic liver disease for males and for females, 2014
- Premature mortality rate from liver disease for males and for females, 2012-14
- Premature mortality rate from alcoholic liver disease for males, 2012-14

The local Health and Lifestyle Survey found that 33% of adults are drinking alcohol at levels that put them at 'increasing risk' of developing an alcohol use disorder, with a further 12% drinking at 'high risk' levels. People from lower socio-economic groups do not necessarily drink more alcohol than people from other groups, but they do suffer disproportionately from alcohol-related illness due to the adverse impact of other lifestyle and socio-economic factors (the 'alcohol harm paradox').

The survey also found the highest rates of negative impacts of drinking alcohol to excess were reported in Central locality. A significantly higher proportion of people aged 16-34 years are at 'increasing risk' of developing an alcohol use disorder (44%) compared to 35-64 year olds (30%) or 65+ years (20%). A significantly higher proportion of 35-64 year olds are at 'high risk' of developing an alcohol use disorder (18%) compared to 16-34 year olds (9%) and 65+ year olds (3%).

The use of alcohol or drugs is strongly associated with suicide in the general population and in sub-groups such as young men and people who self-harm.

Data around the use of alcohol and associated harms is a feature of the Public Health Outcomes Framework.

Priority 2b: Reduce the drivers of isolation and exclusion, including poverty

Why is this a priority?

Compared to England, the risk factors section of Public Health England's suicide profile illustrates that Portsmouth has lower rates of people with long-term health problems and of long-term unemployment, but has higher rates of people who are separated or divorced, people living alone, children who are looked after, children leaving care, children in the youth justice system and estimated prevalence of opiates or crack cocaine. Portsmouth also has a higher than national rates of mental health clients receiving services from adult social care, of adult carers who have as much social contact as they would like, and of clients receiving specialist alcohol and drug services. Isolation is also a recognised driver of mental ill health. Mapping from Age UK shows that the most deprived communities in the city also have the highest risk of loneliness in those aged 65 and over.

The Mental Health Alliance has agreed 11 pledges to improve mental health and will also identify and monitor outcome measures. One of the 11 pledges in the mental health strategy is to: "work to reduce the number of suicides in the city and provide support for those bereaved by suicide"

For overall deprivation, Portsmouth is now ranked 63rd worst of 326 local authorities (where one is the most deprived, previously ranked 76th worst of 326 local authorities). The Tackling Poverty Needs Assessment was refreshed in January 2015 in the light of the recession and changes in the welfare system. The needs assessment identifies the multiple factors which adversely and positively affect poverty including educational outcomes, employment and low-pay employment, financial exclusion and debt and the way services are organised to respond to people in crisis. Current priorities for the Action Plan include re-commissioning a social welfare advice service for Portsmouth (Advice Portsmouth's contract expires in March 2017); responding to welfare reform (including the introduction of Universal Credit and the reduced Household Benefit Cap); and supporting access to resources for people in financial hardship, following the closure of the Local Welfare Assistance Scheme.

The confidential audits of deaths by suicide 2013-2015(part) identified potentially adverse life events affecting individuals before their death – bearing in mind that individual cases are complex and it is impossible to reduce suicide events to a single cause. Many people experienced more than one potentially adverse life event. The audits found that 39% of males and 25% of females were unemployed or were worried about employment, and 24% of males and 26% of females had finance worries. The audit cited a Royal College of Psychiatrists' report on the relationship between debt and mental health: people in debt are more likely to have mental health problems, and people with mental health problems are more likely to be in debt. One in two adults with debts has a mental health problem; and one in four people with a mental health problem is in debt. However, the relationship between mental health and debt is complex and one does not inevitably lead to the other.

Some groups are more vulnerable to low pay and poverty, and further research is required to understand how Portsmouth residents are affected, and how they can be assisted. This includes self-employed people, people with health and care plans or disabilities and black, minority ethnic and refugee communities.

Priority 2c: Promote positive mental wellbeing across Portsmouth

Stigma and discrimination often means that mental health problems are not openly talked about. However, illnesses linked to mental health account for a third of GP consultations, and research shows mental health issues are closely associated with poorer outcomes for employment, personal relationships and physical health.

By promoting wellbeing and building emotionally resilient communities we can reduce the number of people going on to experience a mental health problem. In addition, supporting early identification and intervention we can reduce the impact for individuals experiencing a mental health problem.

This means ensuring that mental health becomes a part of everyday conversation and is something that everybody is aware of and cares about. Whether it is a midwife supporting a mother through the birth of a child, a school nurse helping children to develop emotional literacy, or a member of our new integrated community health and social care teams.

The New Economics Foundation assessed evidence and identified that there "five ways to wellbeing":

- Connecting with the people around you
- Being active - exercise makes you feel good
- Taking Notice - be aware of the world around you and what you are feeling
- Keep learning - learning new things builds confidence and is fun
- Giving - do something nice for a friend or stranger - seeing yourself, and your happiness linked to the wider community can be incredibly rewarding and create connections.

The evidence also shows that people have different levels of "mental capital" throughout their lives, and this is something that planning needs to take into account. A particularly critical time, including for building resilience, is in childhood and adolescence.

Future in Mind is a five-year strategy to transform children's mental health and wellbeing provision, so that by 2020 England could lead the world in improving outcomes for children and young people with mental health problems. The local priorities for this strategy are:

- ADD PRIORITIES

The Strategy is overseen by the Health and Wellbeing Board.

We know that building emotional resilience, and improving the life experiences of people with mental health issues is not something that can be managed in isolation. Instead, we must work with other health and social care agencies, the voluntary sector, patients, carers and the public, to look at services needed to enable people to live stable and happier lives, where they feel supported and in control of their own mental wellbeing.

TELL US:

In relation to Theme 2:

Are these the right priorities? Have we identified the right challenges?

What are the opportunities for the Health and Wellbeing Board to add value in this area and bring about change?

Where are the examples of what is already working well in the city? How can we learn from and build on successes in working successfully together to achieve better outcomes?

How will we know if we are making change for the better? What would be the measures or indicators of success?

Theme 3: Make improvements for marginalised groups fastest, including our most vulnerable children, young people and adults.

Priority 3a: People with complex needs

Why is this a priority?

There is growing national and local evidence that a small cohort of adults in our communities are likely to experience 'severe and multiple deprivation' (SMD cohort), including substance misuse, homelessness, offending and mental health problems. They are likely to have ineffective contact with services that are often designed to deal with one problem at a time, and so regularly and persistently 'fall between the cracks' that open up between services.

The inter-relationship of these individual issues is complex and efforts to improve outcomes for this cohort of people have been ongoing for many years across different agencies and agendas and across the UK a range of responses are being developed. This is not a new issue and Portsmouth is not unique in its experience. This group of people can have a disproportionate impact on those around them; their partners and the neighbourhoods in which they live - including businesses and visitors to the city - and most importantly, any children they may have.

Services have a range of processes, pathways, panels and interventions in place to support adults with a variety of complex needs. Services have in the main been commissioned or directly provided to meet a defined individual need - often successfully - but generally not designed to address composite and compounding needs e.g. homeless/mental health/substance misuse/criminal justice.

Similarly, individual assessments of need by statutory services tend to focus on the presenting issue and there are different eligibility thresholds for accessing services that do not necessarily take into account complexity of needs and associate behaviour, the nature of 'recovery'.

As a result, customers with complex needs who are frequent (or inappropriate) service users may have contact with a range of services, have several "key workers", have a number of personal plans in place and be involved in a number of panels/pathways/case management processes simultaneously or sequentially.

It is clear from the case studies that valuable work is already being undertaken. There are some successes in supporting people to achieve positive outcomes, and there are examples of good practice in effective collaborative working. However, customers, advocates and professionals have questioned the consistency of the effectiveness, efficiency and value of current approaches, particularly for those service users present with the most complex needs.

Recent research has also shown that adverse childhood experiences (ACEs), including witnessing domestic abuse for example, increase the likelihood of 'health harming behaviours'¹ in adulthood, so it's also important to act early when these risk factors are present to 'turn off the tap', reducing the numbers of people in this cohort in future years. This work is therefore complimentary to (and could inform) the current re-design and re-structuring of children's services in the city.

Priority 3b: People in the armed forces community, including veterans

Why is this a priority?

The armed forces community is made up of anyone who is or has served for at least 1 day in the armed forces (regular or reserve, including national service) as well as Merchant Navy Seafarers and fisherman who have served in a vessel that was operated to facilitate military operations by the armed forces. The armed forces community also includes spouses, civil partners and dependent children of those who currently are or have served for at least 1 day, even if the serving person is now deceased.

National estimates suggest 4.9% of adult population of England are Veterans. Pension data demonstrates more veterans live in the south east of England than anywhere else, however not all veterans get a pension, and the community is far larger than veterans. On 1st April 2016 140,450 Regular service personnel were stationed in the United Kingdom, the majority located in the South East and South West of England. Portsmouth's military significance makes it likely that a higher concentration of service personnel are based in the area. There is no way of fully knowing how many dependants, spouses and civil partners currently reside in Portsmouth.

National research suggests that the vast majority of this community have needs in line with the general population. However age, service undertaken and position within the Armed Forces community brings with it specific issues. For example Older Veterans are known to experience more hearing, skin and musculoskeletal issues than the general population, and a small yet significant number of people who leave service early experience mental health and substance misuse issues. Little is known about the health and wellbeing needs of reservists and their families, however the limited research that has been undertaken suggests family stress and mental health are emerging issues.

A needs assessment for the sub-Solent area is currently underway, and therefore a better picture of need and gaps in support will be available in Spring 2018.

Priority 3c: People with special educational need or disabilities

Why is this a priority?

Portsmouth Children's Trust publishes a strategic children's needs assessment as part of the city's Joint Strategic Needs Assessment (JSNA) process. In 2016, a detailed SEND Needs Analysis was undertaken as part of this process. The key findings are:

1. There is a wide range of potential disabilities or conditions which could start to affect someone from conception or during pregnancy, during labour, as a baby or as a child or young person. Understanding the cause of some disabilities is necessary to support multi-agency health promotion and early identification and intervention.
2. Overall prevalence of a child or young person having any special educational need has decreased by 38% since 2009 - mostly due to a fall in pupils identified as needing SEN Support (from 23.9% to 13.4%). Portsmouth has seen a steeper decrease than nationally with the overall percentage of SEN in Portsmouth now only 1 percentage point above national, having previously been much higher. This substantial decrease is considered to be due to the more accurate identification of those with SEN following implementation of the SEND reforms.
3. Between 2010 and 2015, there was a 13% increase in the number of children with statements of SEN or an Education, Health and Care Plan (EHCP) issued and maintained by Portsmouth LA. However, the proportion of the total population of young people identified as having a statement of SEN or EHCP has stayed fairly static throughout this time both nationally (2.8%) and within Portsmouth (3.1%).
4. There are gender differences in the prevalence of SEN, with twice the proportion of Portsmouth boys (17.4%) being SEN Support compared to girls (9.5%). Five per cent of boys have either a Statement of SEN or EHCP compared to 1.9% of girls. This reflects the national picture.

Compared to national outcomes for SEN pupils, Portsmouth has poorer education outcomes for children with SEN in the following areas:

- Attaining a Good Level of Development in the Early Years Foundation Stage Profile
 - Making progress between Key Stage 1 and Key Stage 2 in Reading, Writing and Maths
 - Key Stage 2 attainment of Reading, Writing and Maths (combined)
 - Making progress between Key Stage 2 and Key Stage 4 in English and Maths
 - 5+ GCSEs graded A*-C, including English and Maths
 - Achievement of a Level 2 or Level 3 qualification by age 19
5. The local survey of children and young people aged 7 to 18 years found that children who say they are disabled, or who have difficulties with learning, had significantly lower than average wellbeing compared to other children. SEN is over-represented in groups including looked after children, and the care leaving population. 65% of the average Youth Offending Team (YOT) caseload have SEN. National prevalence rates predict that 60-90% of them will have a communication disorder.
 6. Overall, children with SEN are about four times as likely to be persistently absent from school than those without SEN. Nine per cent of all pupils with SEN Support were persistently absent; 11% of those with a statement of SEN or EHC plan were persistently absent.

7. Pupils with SEN were more than eight times as likely to receive fixed period exclusions than those without SEN. Compared to non-SEN pupils, higher percentages of children with SEN were excluded from school with no alternative provision for education being made.
8. The proportion of 16 and 17 year olds with SEN participating in education and training is slightly higher in Portsmouth than nationally and is lower for those with SEN than those without SEN, reflecting the national picture. However, the proportion of learners with SEN who progressed to education or employment/training is considerably lower in Portsmouth than nationally at the end of both Key Stage 4 and Key Stage 5.
9. Higher rates of disability prevalence are found in the most disadvantaged socio-economic groups nationally. Pupils with SEN in Portsmouth are twice as likely to be eligible for free school meals than those without SEN (26% compared to 13%). Children aged 0-15 years with a long-term health problem or disability, are almost twice as likely to be living in socially rented homes in Portsmouth than children with no limiting long-term health problem or disability.
10. The Dynamite Survey of young people with SEND found that Health and Employment were the areas that are most important to them, and that Employment was the area on which they found it most difficult to find out about choices and support.

The aim of the special educational needs and disability (SEND) strategy is to promote inclusion and improve the outcomes for Portsmouth children and young people aged 0-25 years with SEND and their families.

In order to improve outcomes, we aim to ensure that there are in place a range of high quality support services that contribute to removing the barriers to achievement for all Portsmouth children and young people, in particular those with special educational needs and disabilities. This includes enabling children and young people to lead healthy lives and achieve wellbeing; to benefit from education or training, with support, if necessary, to ensure that they can make progress in their learning; to build and maintain positive social and family relationships; to develop emotional resilience and make successful transitions to employment, higher education and independent living.

TELL US:

In relation to Theme 3:

Are these the right priorities? Have we identified the right challenges?

What are the opportunities for the Health and Wellbeing Board to add value in this area and bring about change?

Where are the examples of what is already working well in the city? How can we learn from and build on successes in working successfully together to achieve better outcomes?

How will we know if we are making change for the better? What would be the measures or indicators of success?

Theme 4: Improve access to health and social care support in the community.

Priority 4a: Implement the Portsmouth Blueprint for Health and Care in Portsmouth

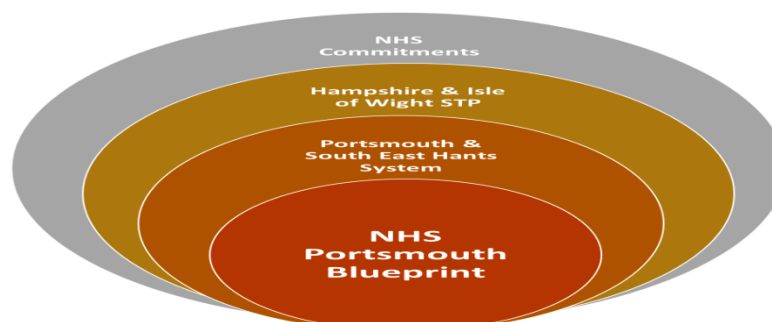
Why is this a priority?

208,900 people live in the City and 217,562 people are registered with a Portsmouth GP. We know there are significant health and care challenges in Portsmouth. Too many people have poorer health and wellbeing than in other similar cities. Demand for our health and care services is increasing and more people tell us that what matters to them is ease of access and joined up services. The Blueprint for Health and Care in Portsmouth is now well-established as the set of guiding principles that set out how the key health and care organisations in the city will work together, with an overarching goal *where everyone is supported to live healthy, safe and independent lives by health and social care services that are joined up around the needs of individuals and are provided in the right place at the right time.*

The Blueprint sets out a vision for the delivery of health and care services in the City that will be less fragmented and better able to support people to stay well and remain independent, through the delivery of 7 key commitments. The delivery of the Blueprint is integral to improving the long term health of the population.

There is a great deal of work underway in all organisations and services, as business as usual, in order to achieve savings and efficiencies, and in order to achieve more transformational change as envisaged in the Blueprint. This landscape is increasingly complex as work also develops across a wider Portsmouth and South East Hampshire geography around an accountable care system, as well as responding to the county-wide STP footprint. Portsmouth is also increasing links with Southampton via the public health agenda.

Health and care systems across Hampshire and Isle of Wight (HIOW) have come together in partnership to develop a strategic transformation plan (STP), setting out the strategic aims and objectives for transformation across the county. The key aims and objectives of the Portsmouth Blueprint are reflected within this wider system plan. It has been agreed that delivery of the STP needs to take place at local level, within local delivery systems. The City of Portsmouth forms part of the Portsmouth and South East Hampshire (PSEH) delivery system. Health and care partners in PSEH have come together to form an accountable care system (ACS) as a vehicle for delivering the New Models of Care set out in the NHS 5 Year Forward View publication. Once again the aims and objectives and key work programmes to deliver the Blueprint are reflected in the ACS plans.



This multi-layered planning approach enables system partners in the City to focus the delivery of the commitments through either local delivery or with wider system partners where it makes sense to do so and whereby incoming together maximum gains can be achieved. We are working on the principles across the wider system that transformation must be based on local needs and where possible delivered locally. However, effective partnership working across PSEH and HIOW allows us to work together in areas of commonality and shared aims to ensure alignment and ability to operate on a wider footprint to achieve efficiencies from a truly 'do it once' approach where it makes sense to do so.

Projects include:

- development of the Stronger Futures programme for integrating care services for children, and supporting earlier intervention through a restorative approach
- developing integrated locality teams for adults services
- developing a multi-speciality community provider model for services in the city
- developing a programme for workforce development across the city.

TELL US:

In relation to Theme 4:

Are these the right priorities? Have we identified the right challenges?

What are the opportunities for the Health and Wellbeing Board to add value in this area and bring about change?

Where are the examples of what is already working well in the city? How can we learn from and build on successes in working successfully together to achieve better outcomes?

How will we know if we are making change for the better? What would be the measures or indicators of success?

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Equality Impact Assessment

Preliminary assessment form v5 / 2013

www.portsmouth.gov.uk

The preliminary impact assessment is a quick and easy screening process. It should:

- identify those policies, projects, services, functions or strategies which require a full EIA by looking at:
 - negative, positive or no impact on any of the equality groups
 - opportunity to promote equality for the equality groups
 - data / feedback
- prioritise if and when a full EIA should be completed
- justify reasons for why a full EIA is not going to be completed

Directorate:

Director of Public health

**Function e.g. HR,
IS, carers:**

Strategy

Title of policy, service, function, project or strategy (new or old) :

Health and Wellbeing Strategy refresh 2018-2021

Type of policy, service, function, project or strategy:

- ☐ Existing
- ☒ ★ New / proposed
- ☐ Changed

Q1 - What is the aim of your policy, service, function, project or strategy?

There is statutory duty on local Health and Wellbeing Boards to produce a strategy for the Health and Wellbeing of their population. Portsmouth's current strategy runs from 2014-2017, so it is now necessary to consider how this needs to be refreshed.

The next Health and Wellbeing Strategy needs to focus on the highest impact issues for the city, and the areas where the work of the Health and Wellbeing Board can add maximum value. The proposals above set out early suggestions that will be developed through the drafting process, and through wider consultation.

The recommendations for the timeline for development will ensure that the Health and Wellbeing Board achieve the development of a strategy by March 2018.

Q2 - Who is this policy, service, function, project or strategy going to benefit or have a detrimental effect on and how?

The strategy should have a beneficial effect on the population of the city, by bringing about improved healthy life expectancy and reduced health inequality by improving the areas with lowest expectancy fastest. We do this by working to principles around:

- promoting prevention,
- supporting independence
- intervening earlier

We know we want to give people the best start in life, empower them to live healthy lives, and enjoy a healthy older age. In order to do this, we need to:

- o Empower people to take care of their physical health
- o Empower people to take care of their social, emotional and mental health
- o Work with marginalised groups to make improvements for them fastest (including income deprived households).

Q3 - Thinking about each group below, does, or could the policy, service, function, project or strategy have a negative impact on members of the equality groups below?

Group	Negative	Positive / no impact	Unclear
Age	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Disability	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Race	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Gender	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Transgender	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Sexual orientation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Religion or belief	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pregnancy and maternity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other excluded groups	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

If the answer is "negative" or "unclear" consider doing a full EIA

Q4 - Does, or could the policy, service, function, project or strategy help to promote equality for members of the equality groups?

Group	Yes	No	Unclear
Age	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Race	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Gender	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Transgender	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sexual orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Religion or belief	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pregnancy or maternity	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Other excluded groups	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

If the answer is "no" or "unclear" consider doing a full EIA

Q5 - Do you have any feedback data from the equality groups that influences, affects or shapes this policy, service, function, project or strategy?

Group	Yes	No	Unclear
Age	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Race	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Gender	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Transgender	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sexual orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Religion or belief	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pregnancy and maternity	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Other excluded groups	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

If the answer is "no" or "unclear" consider doing a full EIA

Q6 - Using the assessments in questions 3, 4 and 5 should a full assessment be carried out on this policy, service, function or strategy?

☐ yes ☒ No

Q7 - How have you come to this decision?

This is a high-level strategic framework. At this development stage, there are no identified negative impacts for the protected groups, and a number of positive direct and indirect impacts, particularly around age, gender and income expected, given the purpose of the Health and Wellbeing Strategy. It is expected that as the strategy is developed and consulted to identify actions, these plans will be subject to individual equalities impacts assessments to ensure that there are no negative impacts, and indeed that positive impacts are maximised.

If you have to complete a full EIA please contact the Equalities and diversity team if you require help
Tel: 023 9283 4789 or email:equalities@portsmouthcc.gov.uk

Q8 - Who was involved in the EIA?

Kelly Nash, Corporate Performance Manager, PCC

This EIA has been approved by: Jason Horsley

Contact number:

023 9243 7685

Date:

20th November 2017

Please email a copy of your completed EIA to the Equality and diversity team. We will contact you with any comments or queries about your preliminary EIA.

Telephone: 023 9283 4789

Email: equalities@portsmouthcc.gov.uk

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