

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

Updated September 2017

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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

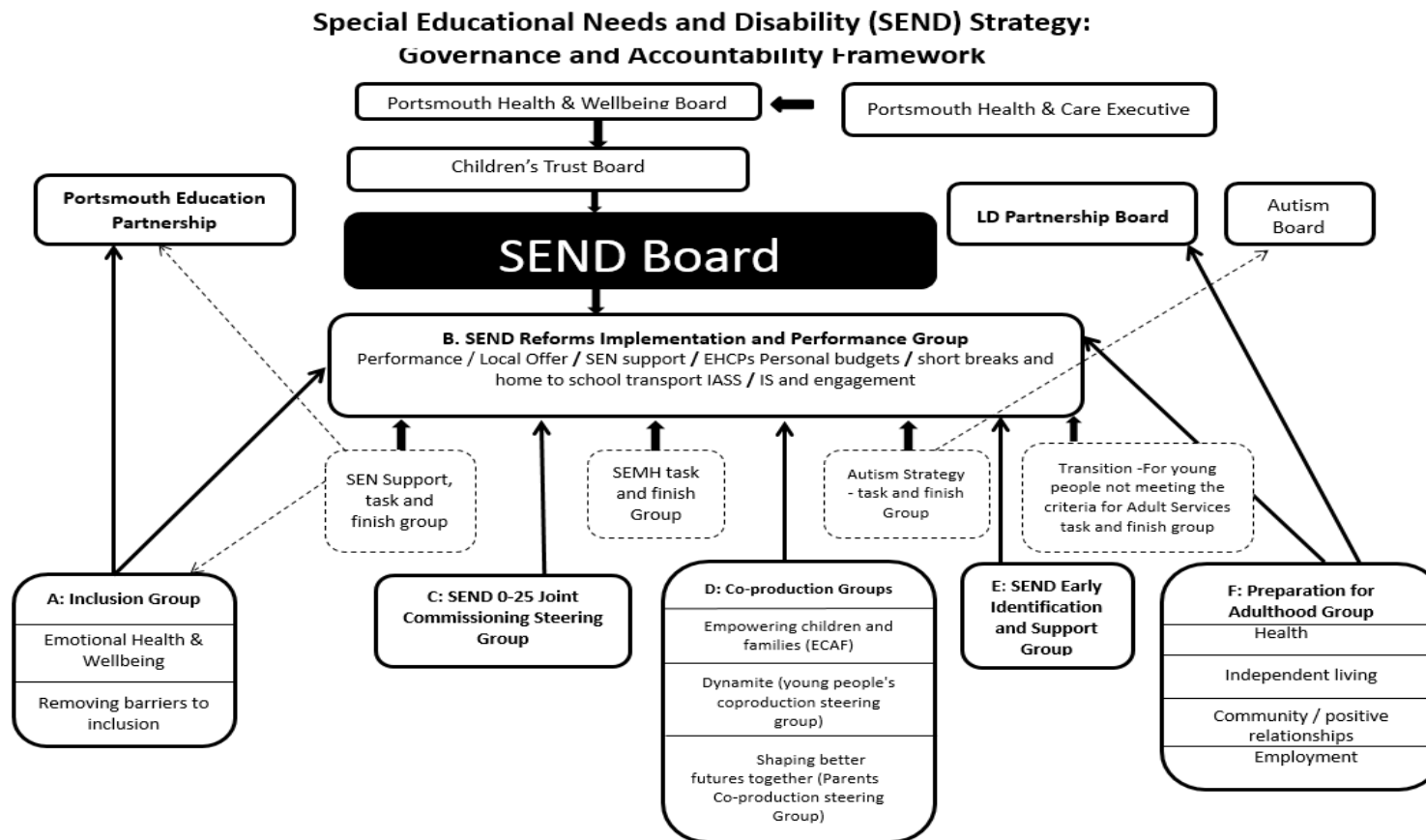
Portsmouth is the most densely populated city in England and has a higher than average level of deprivation.

- 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

A SEND Needs Assessment has been completed and will be refreshed annually.

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.

User feedback informs commissioning priorities e.g. new special free school for children with Autism.

Coproduction is embedded as the way that commissioning activity is undertaken in the city e.g. Future in Mind.

There is increasing demand for services and this is putting pressure on resources e.g. special school places.

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.

There is a need to ensure that early identification and information from individual EHCPs is used to inform future commissioning priorities.

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>

		<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.</p>
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?

Processes for early identification of SEND in Portsmouth are robust

There are a number of processes for identification of SEND including:

- Early years panel 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 ordinarily available provision 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 Inclusion Support Panel, which has been highlighted by the DfE as an example of good practice. The panel includes trained parent representatives.

Further examples of good practice include support provided by Portage/Pelican, Specialist Health Visitors etc.

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.

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.

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>
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		<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
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 - 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

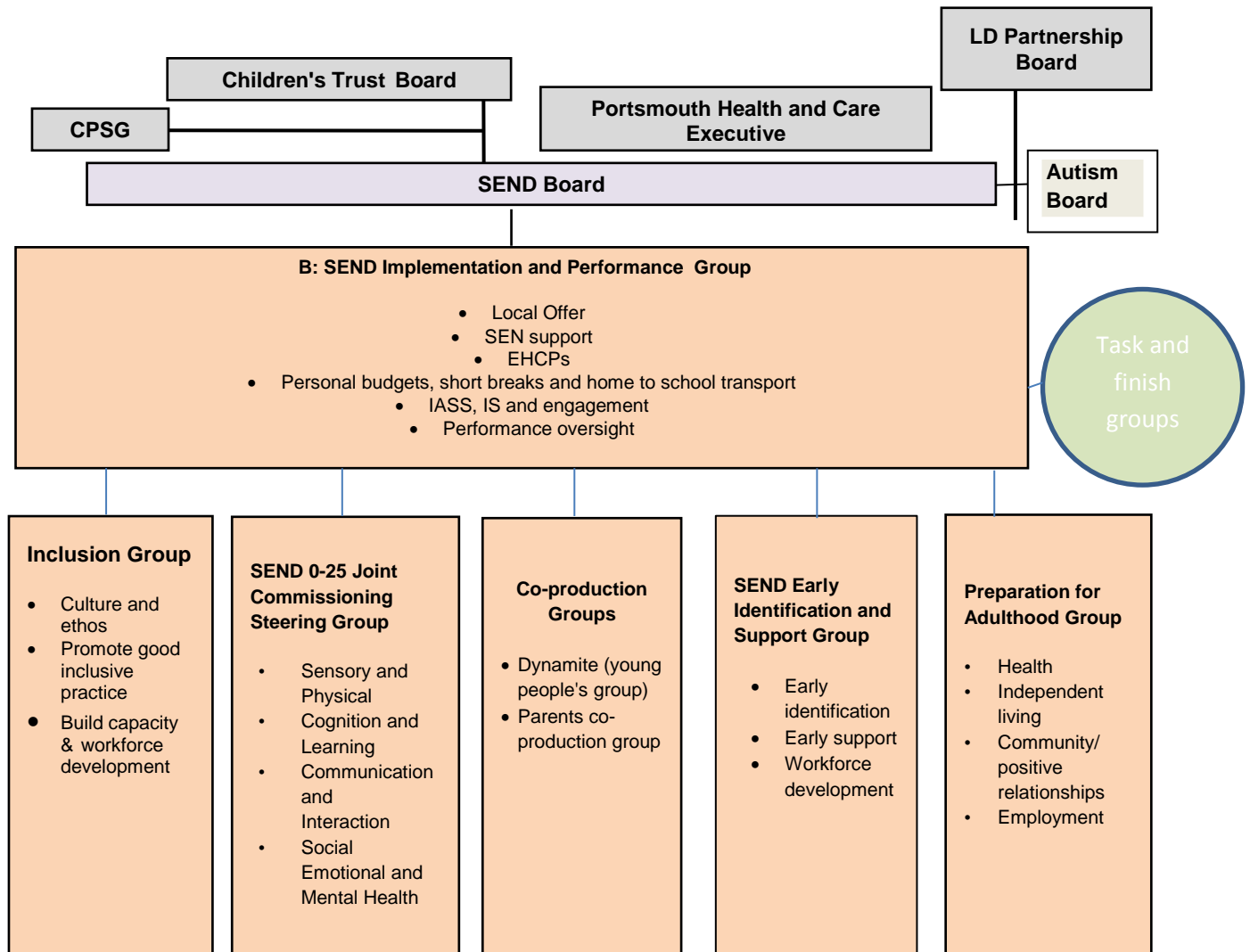
Strand C: Effective joint commissioning to improve outcomes

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

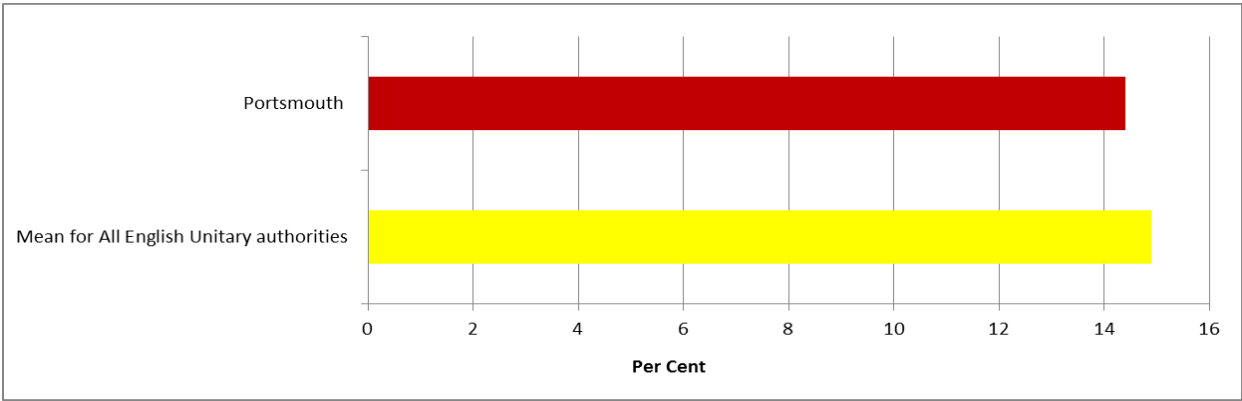
TBD

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.

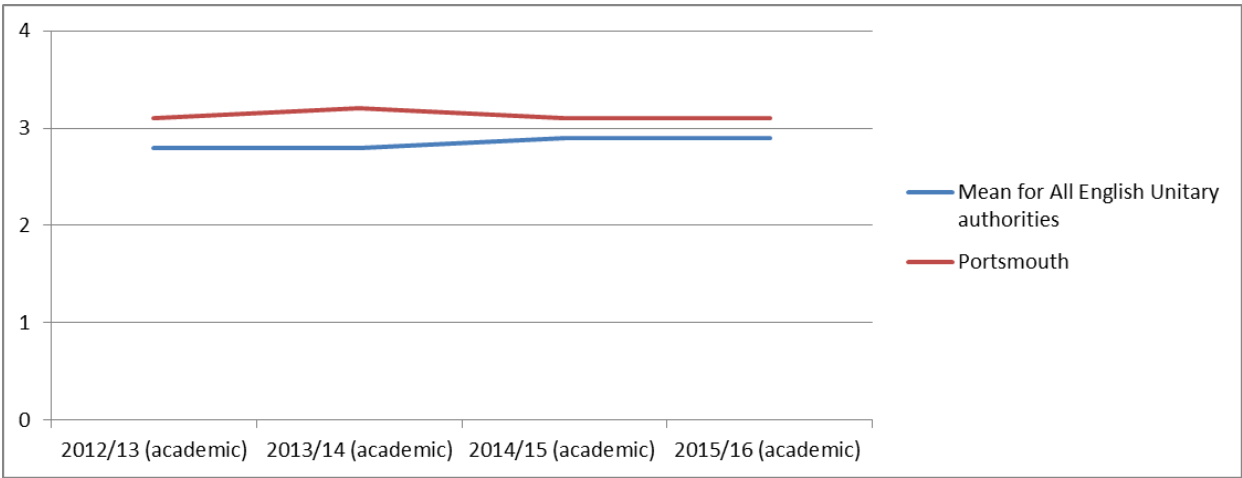
NB these figures, and those in the first three charts below, are for pupils attending schools in Portsmouth. They do not include children and young people for whom Portsmouth is responsible but has placed out of borough.

% pupils with SEN (2015/16 academic)



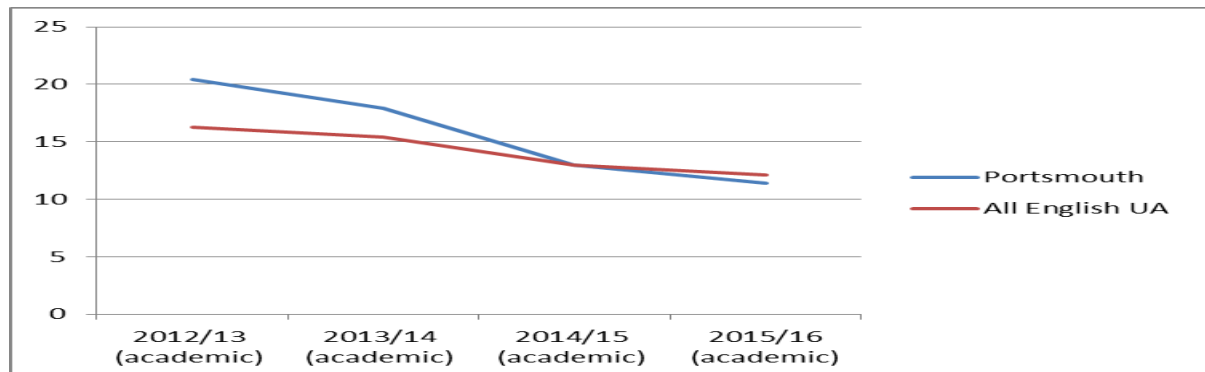
Across All English unitary authorities, the proportion of pupils with statements or education, health and care (EHC) plans ranges from 1.5% to 4.5%. Portsmouth has a value of 3.1%, compared to an average of 2.9% in All English unitary authorities.

% 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

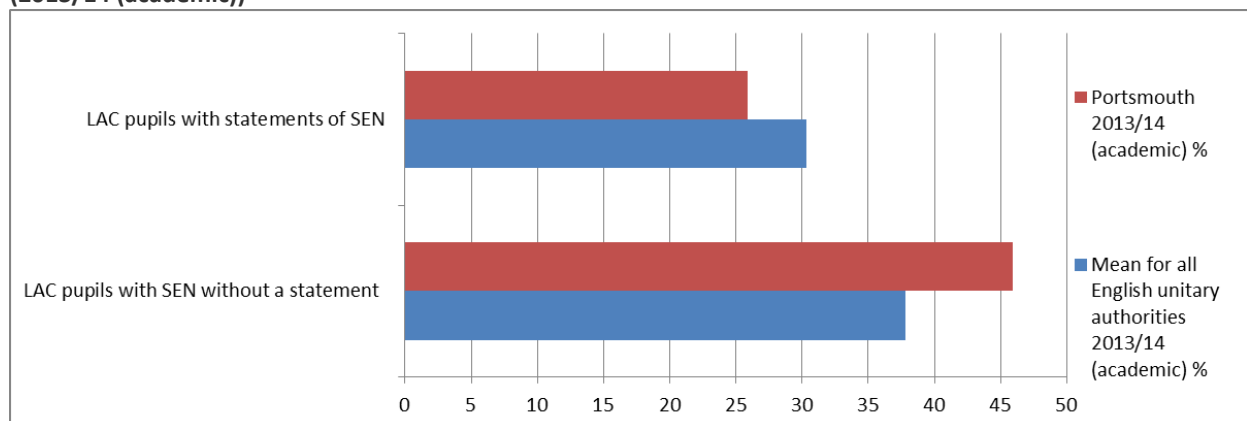
The percentage of pupils identified as having SEN is slightly lower in Portsmouth than the national average, although the percentage of pupils with a statement or EHC is slightly higher in Portsmouth than the national average.

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

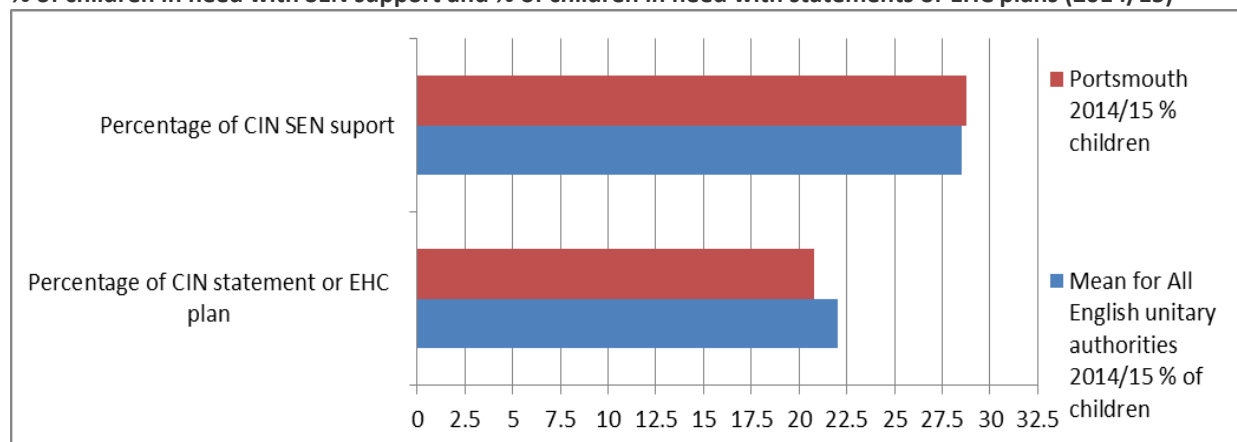
The percentage of pupils with SEN Support has come more closely in line with the national average as SENCoS have become more confident and consistent in identifying need, supported by professional development through the SENCo Network and seconded SENCo programme both of which began in 2013.

Children in Need

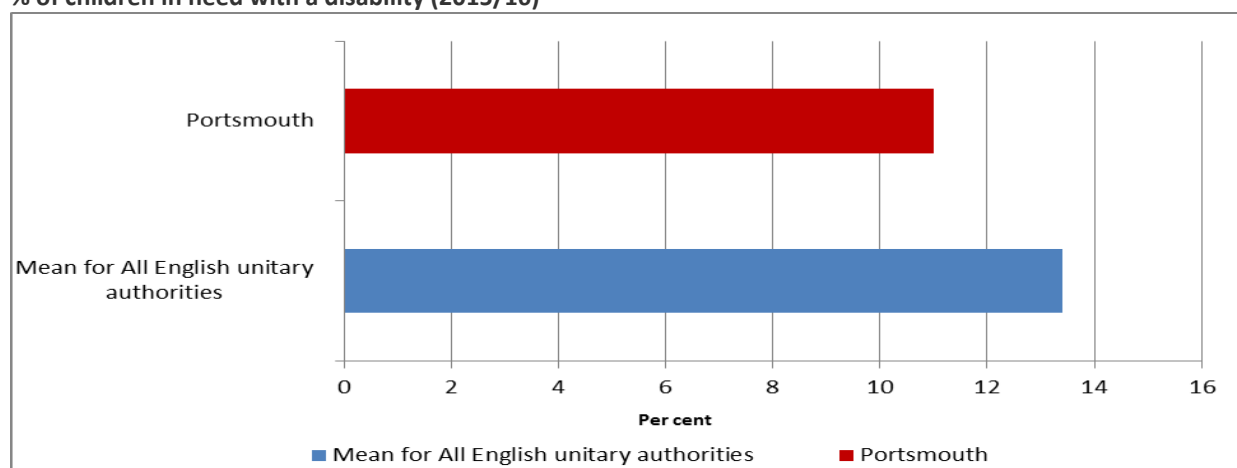
% of looked after children with statements of SEN and % looked after children with SEN without a statement (2013/14 (academic))



% 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

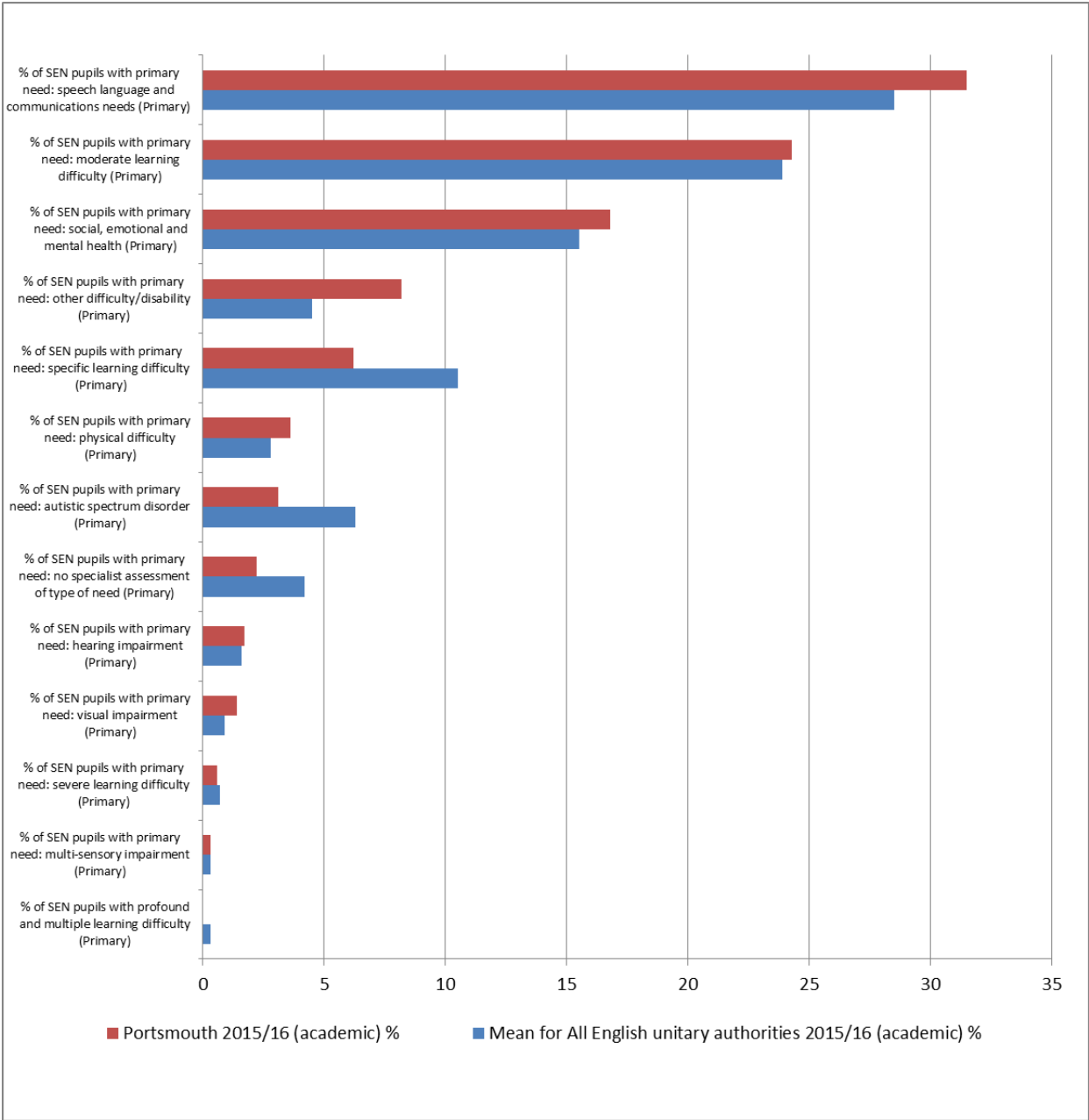
Portsmouth have fewer LAC with statements than national, but more on SEN support. It is difficult to draw firm conclusions from this as the numbers involved are so small. It could be that LAC are effectively supported with SEN support. There is also likely to be an impact of those who have historically 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.

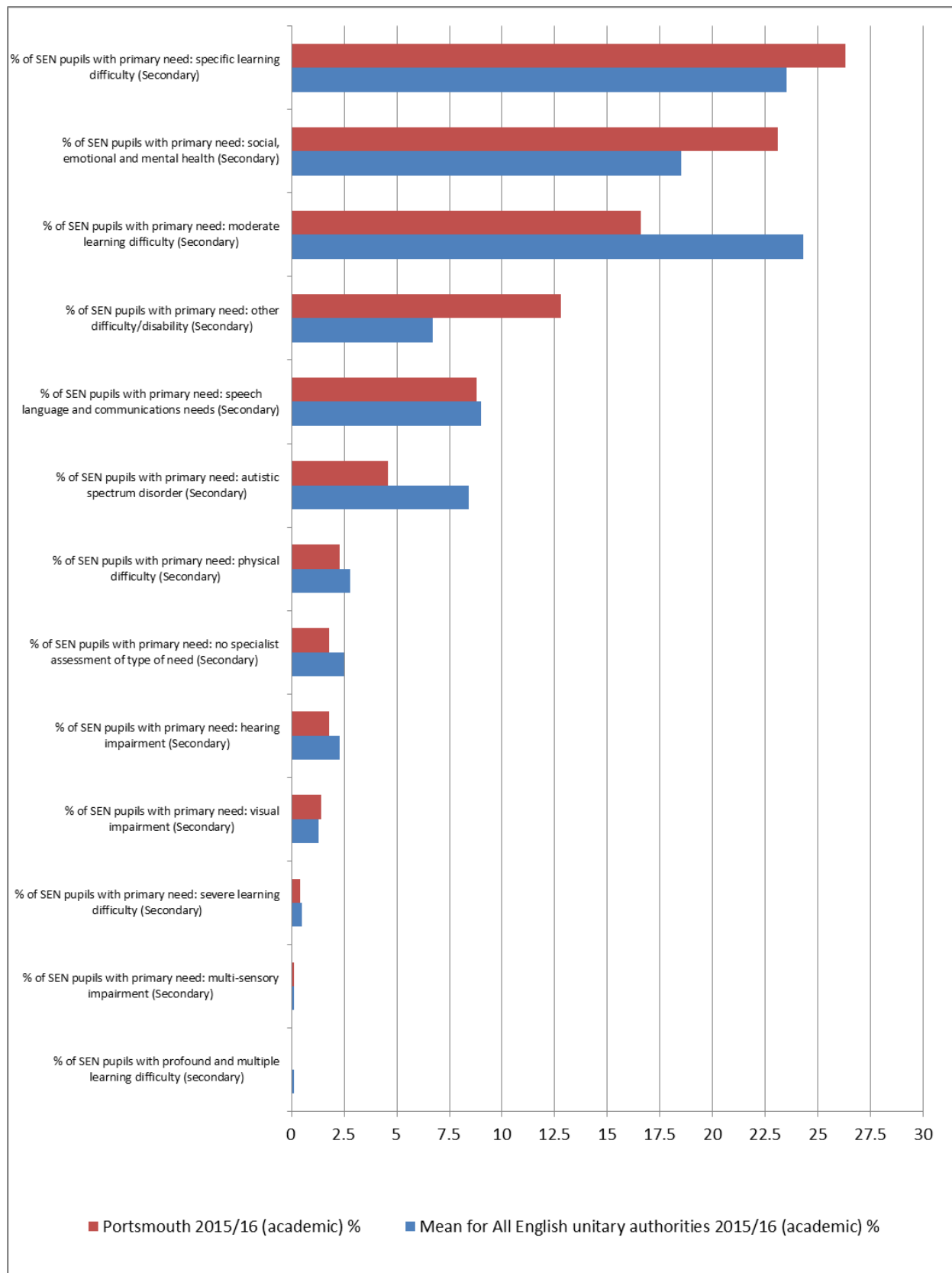
Primary Need

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.

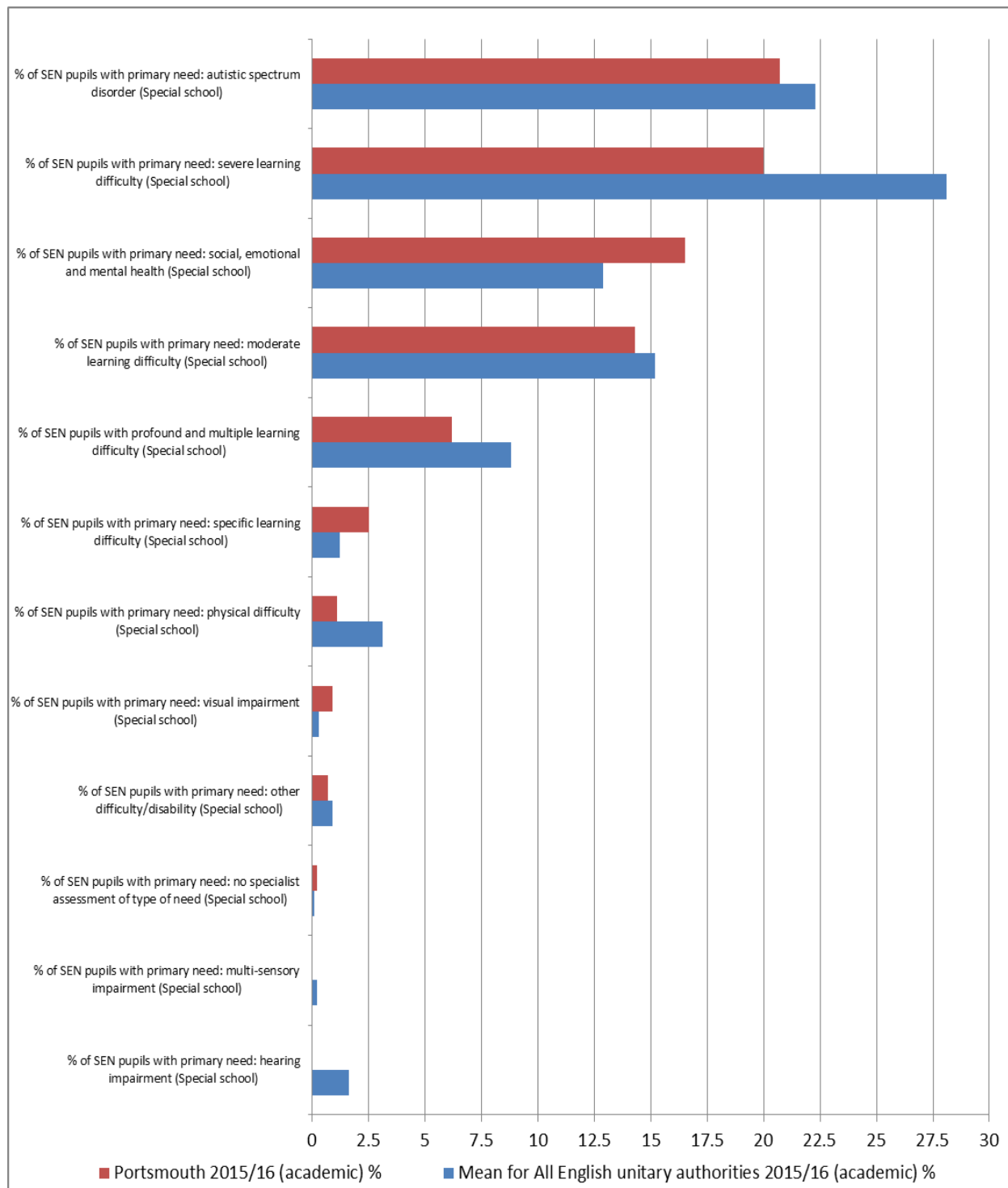
Primary need in primary schools



Primary need in secondary schools

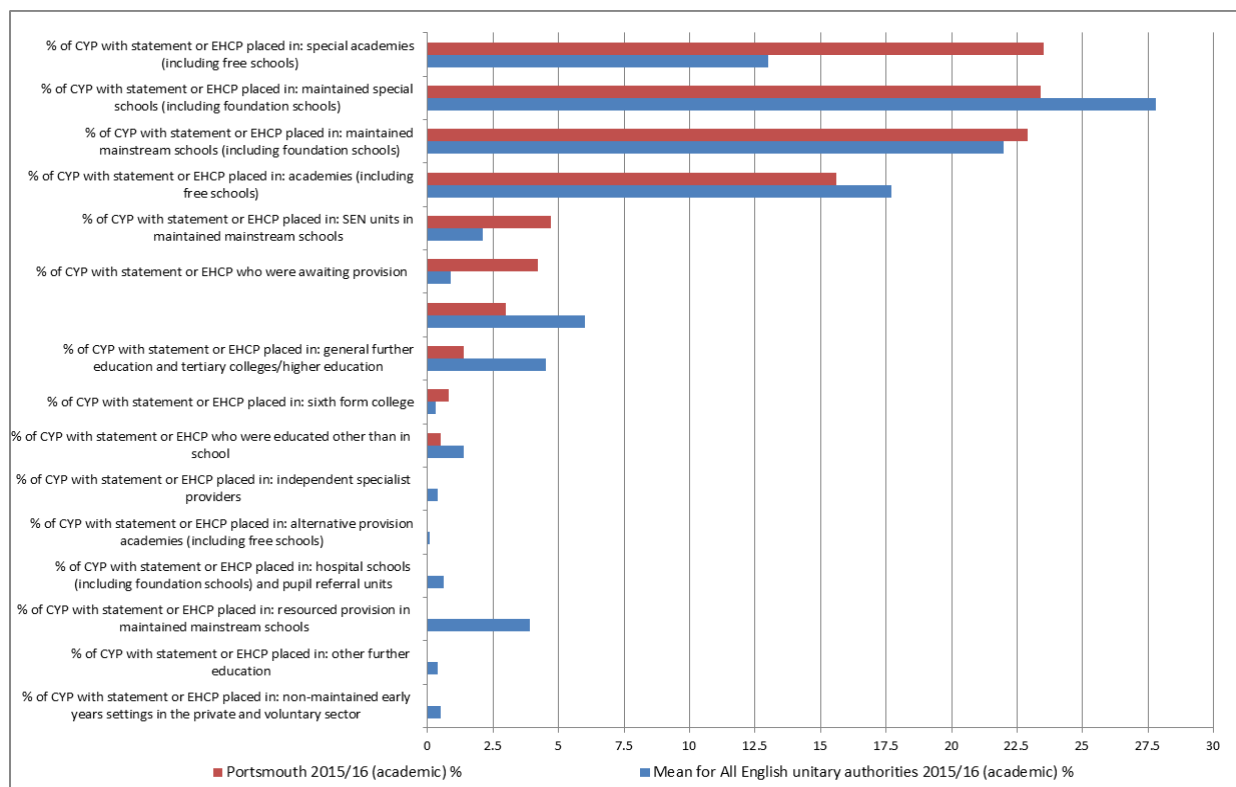


Primary need in special schools



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.

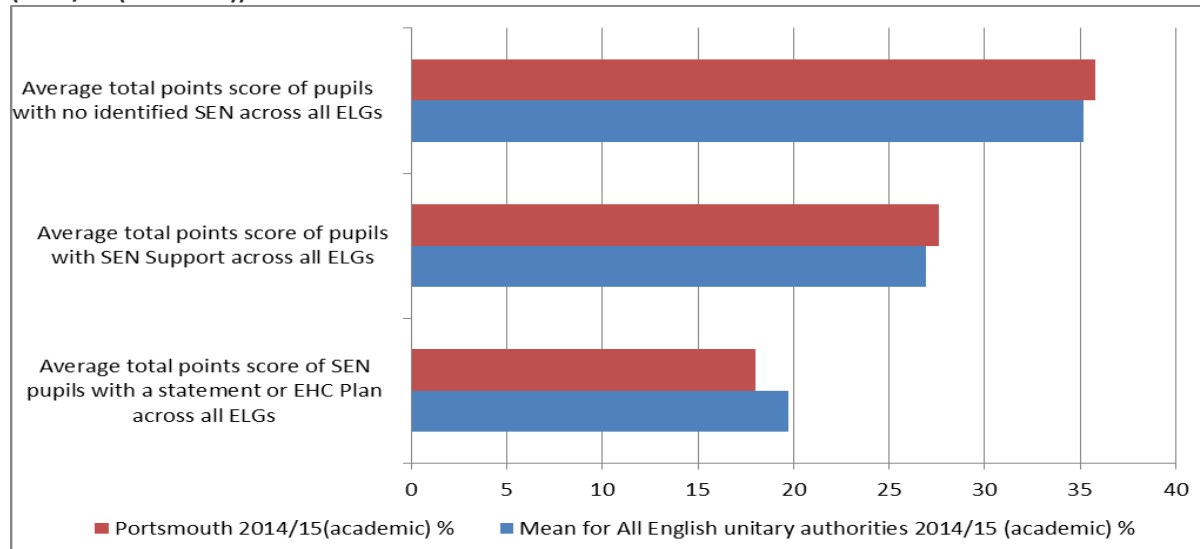
The percentage of pupils in Portsmouth special schools identified as having social emotional and mental health difficulties (SEMH) is higher than the national average. This has been impacted on by the 'power to innovate' which has meant that pupils with SEBD/SEMH needs could be placed in the SEBD/SEMH 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

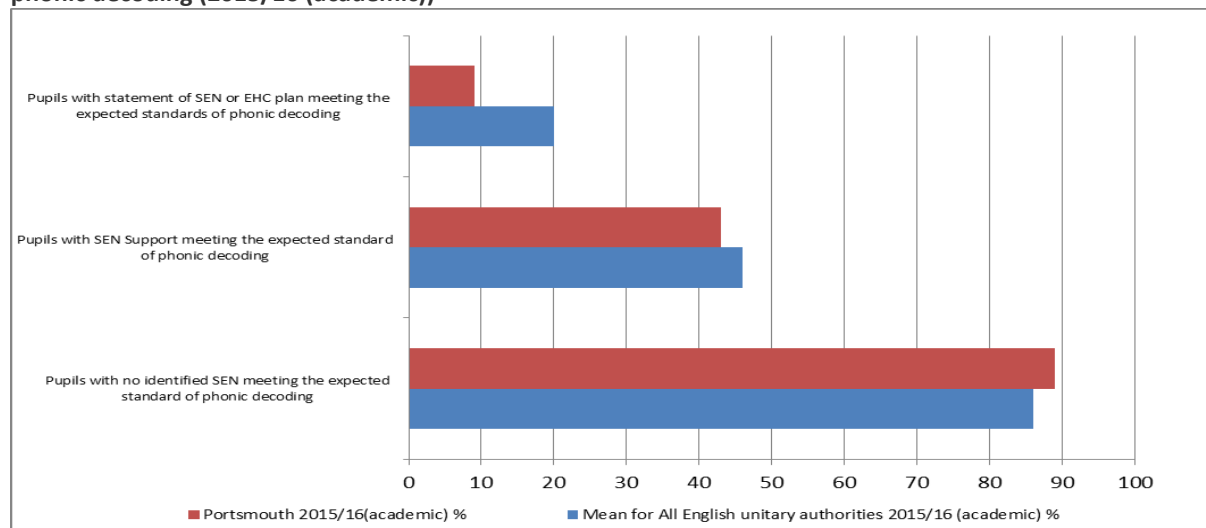
Headline outcome: Learning and Making Progress

Attainment of pupils with SEN

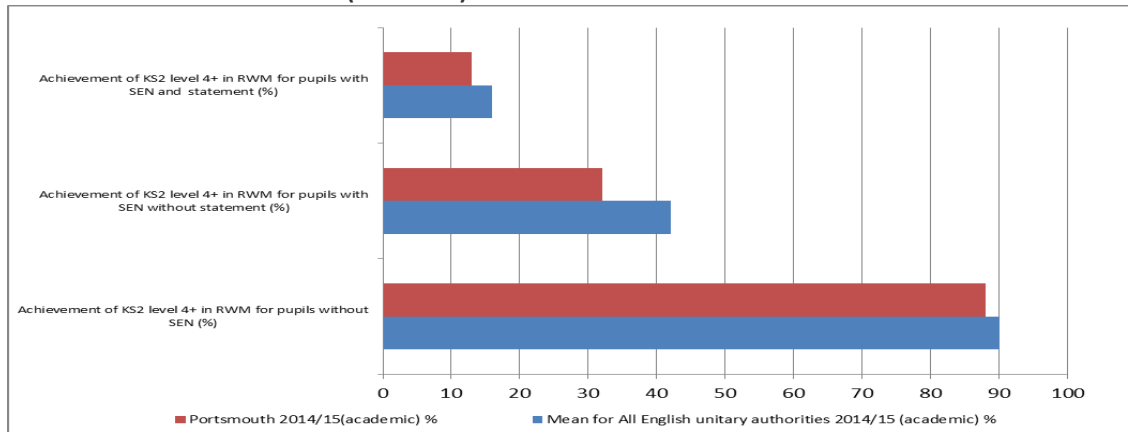
% of SEN pupils with a statement or EHC plan achieving a 'good level of development' at foundation stage (2014/15 (academic))



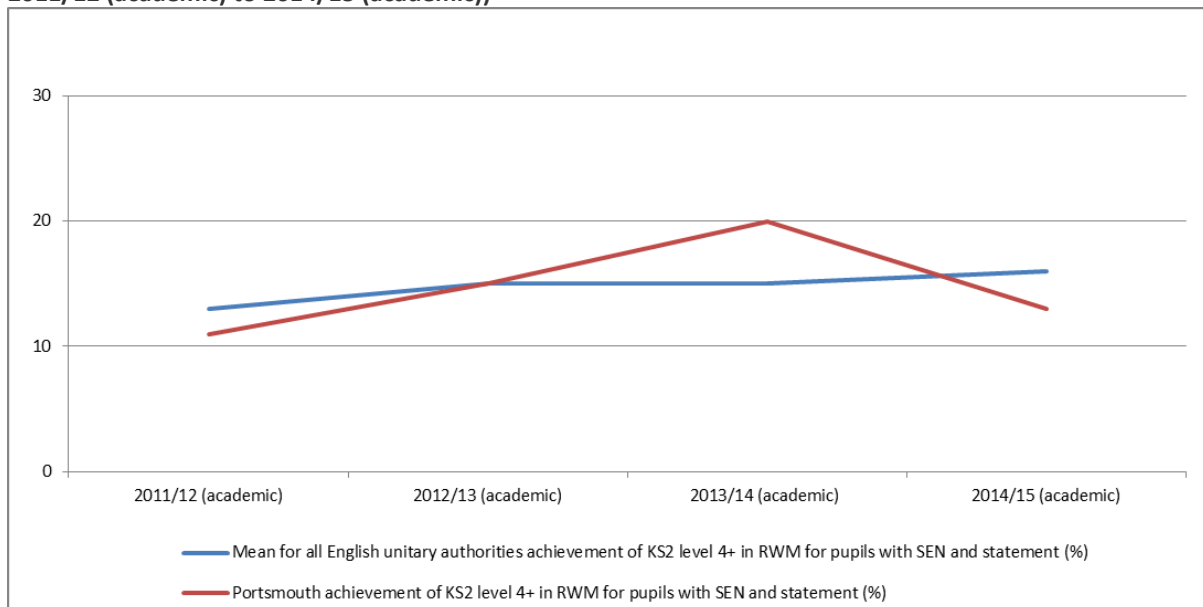
% of pupils with SEN support and % of pupils with a statement or EHC plan meeting the expected standard of phonic decoding (2015/16 (academic))



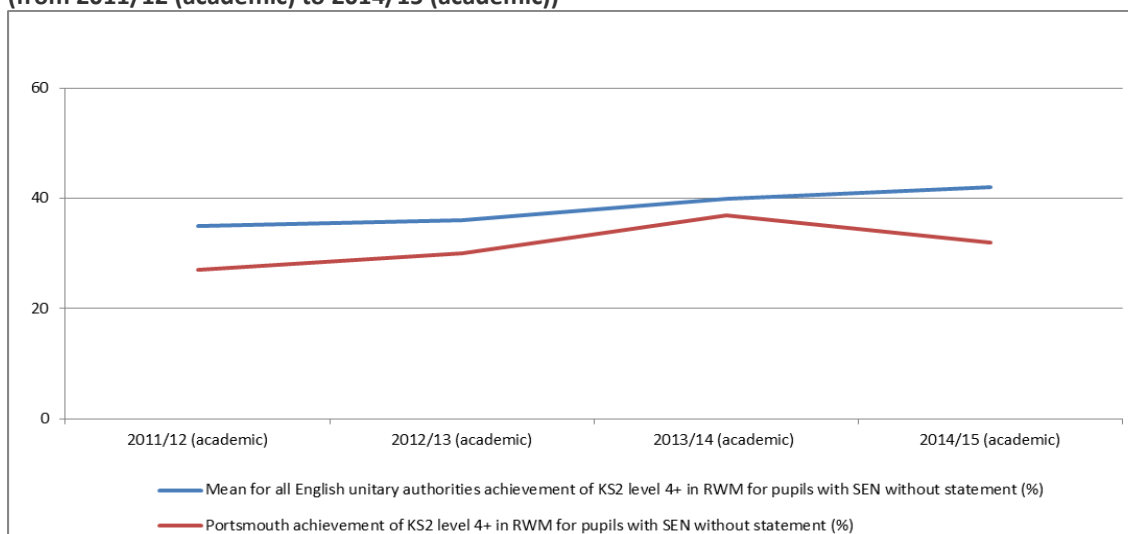
% with level 4 or above at KS2 (incl. E&m)



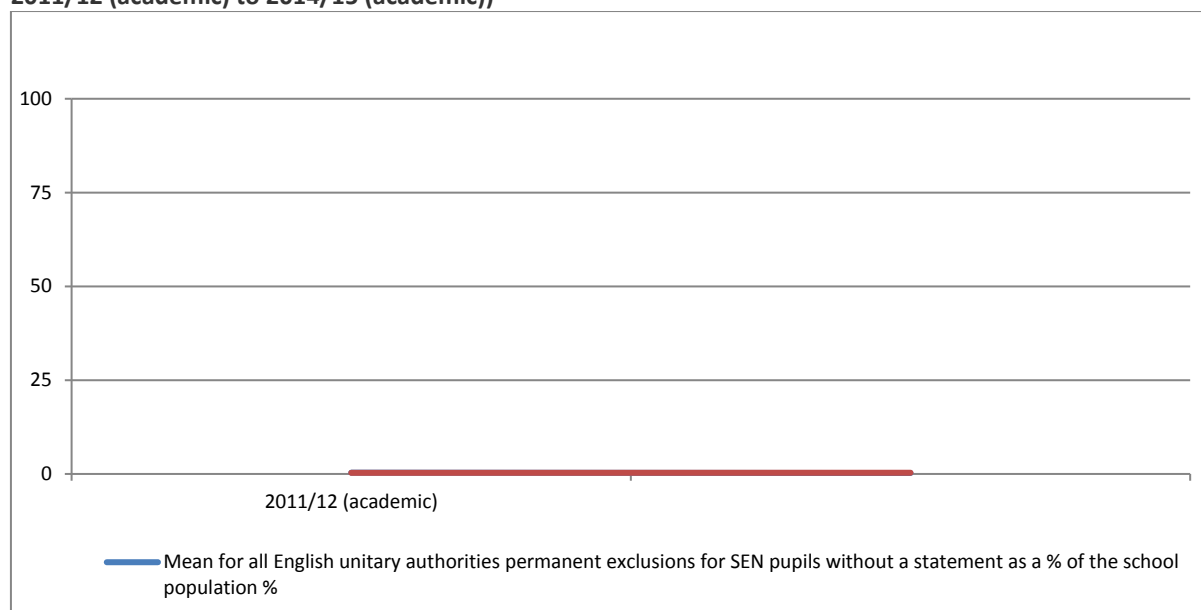
% of pupils with SEN with a statement attaining level 4 or above at KS2 in reading & writing and maths (from 2011/12 (academic) to 2014/15 (academic))



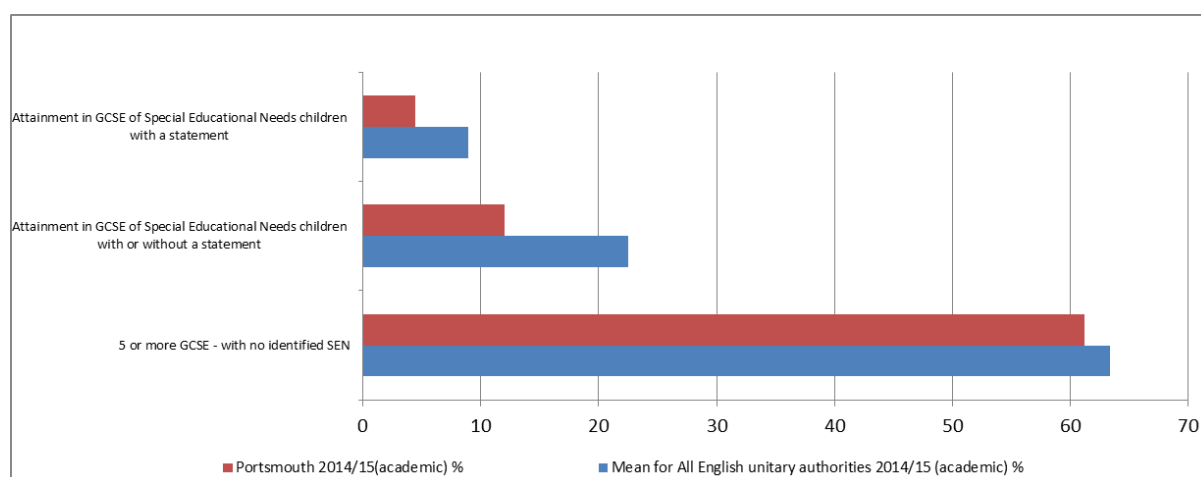
% of pupils with SEN but without a statement attaining level 4 or above at KS2 in reading & writing and maths (from 2011/12 (academic) to 2014/15 (academic))



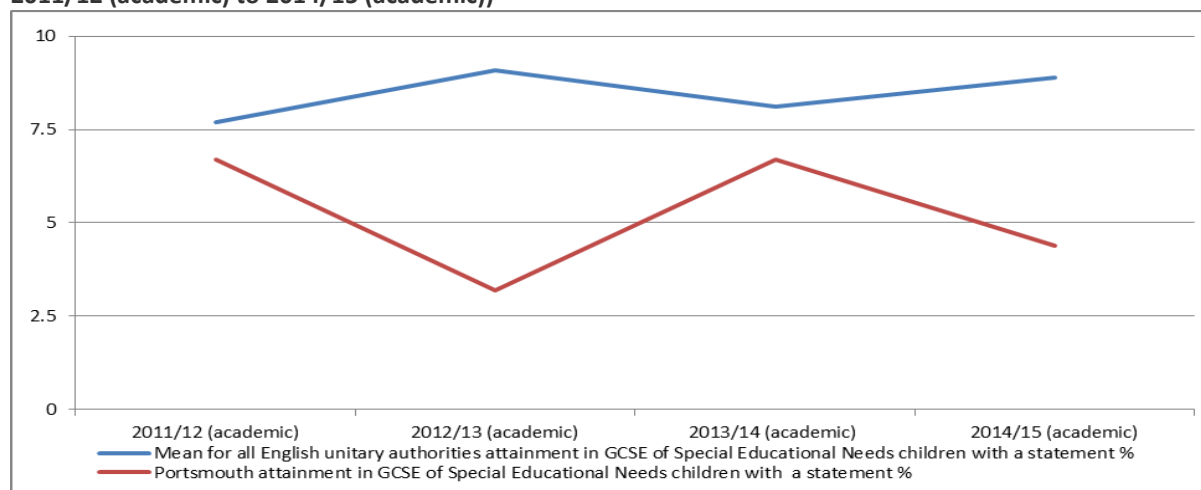
% of pupils with no identified SEN attaining level 4 or above at KS2 in reading & writing and maths (from 2011/12 (academic) to 2014/15 (academic))



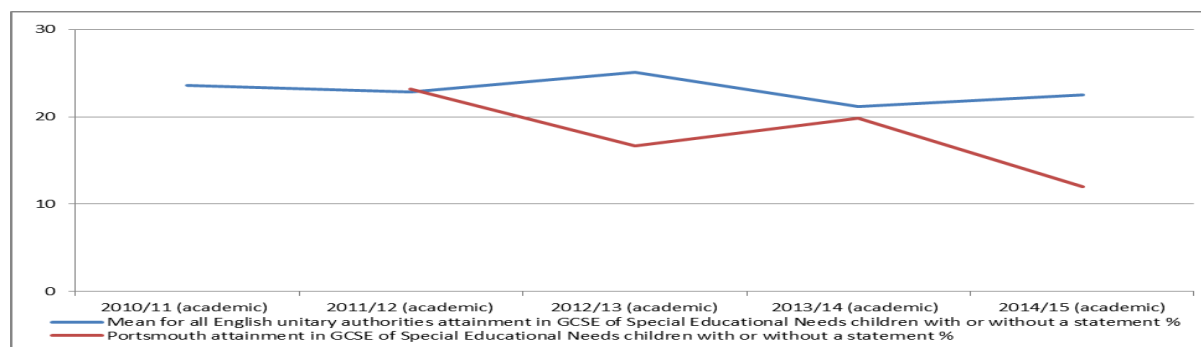
% achieving 5 or more A*-C GCSEs (incl. E&m)



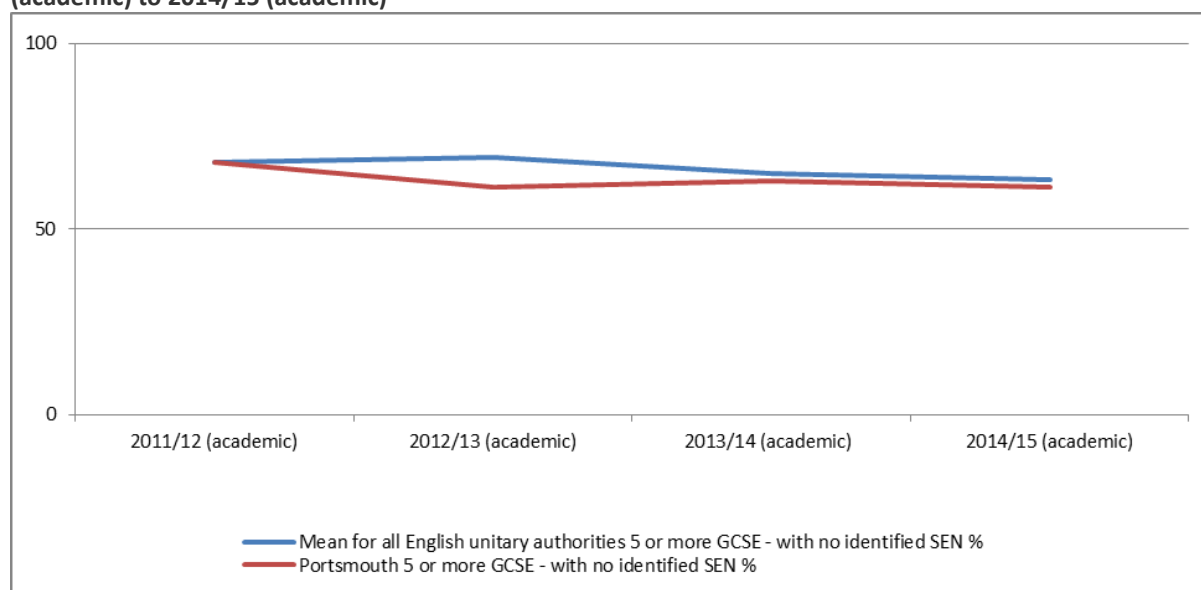
% of pupils with SEN with a statement or plan achieving 5 or more A* to C GCSEs (incl.English & maths) (from 2011/12 (academic) to 2014/15 (academic))



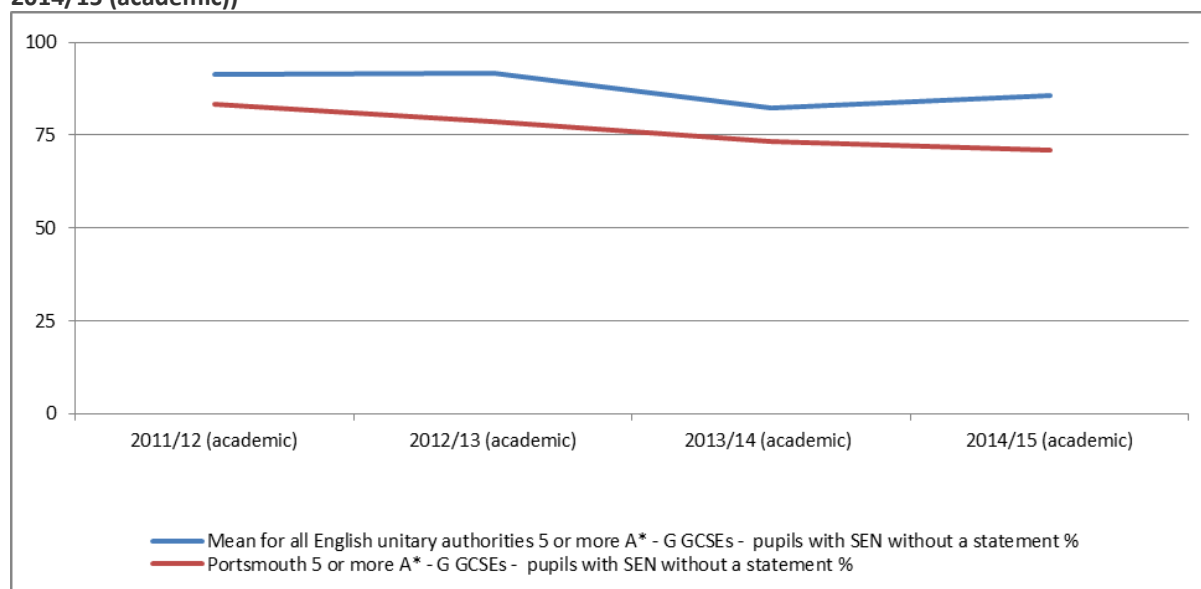
% of pupils with SEN support achieving 5 or more A* to C GCSEs (incl. English & maths) (from 2010/11 (academic) to 2014/15 (academic))



% 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))

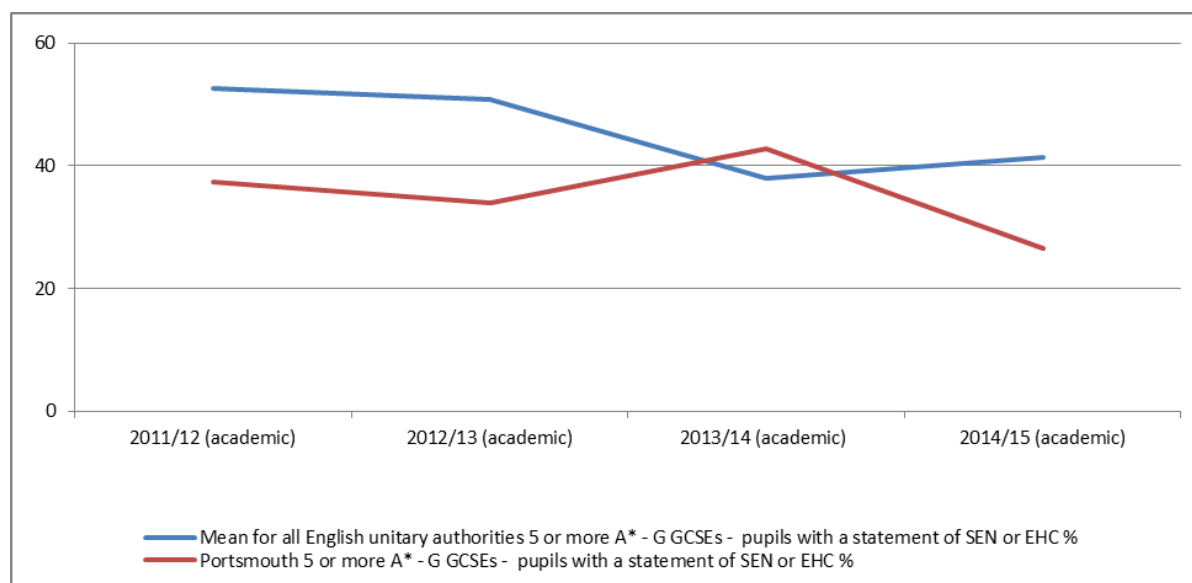


% of pupils with SEN without a statement achieving 5 or more A* to G GCSEs (from 2011/12 (academic) to 2014/15 (academic))

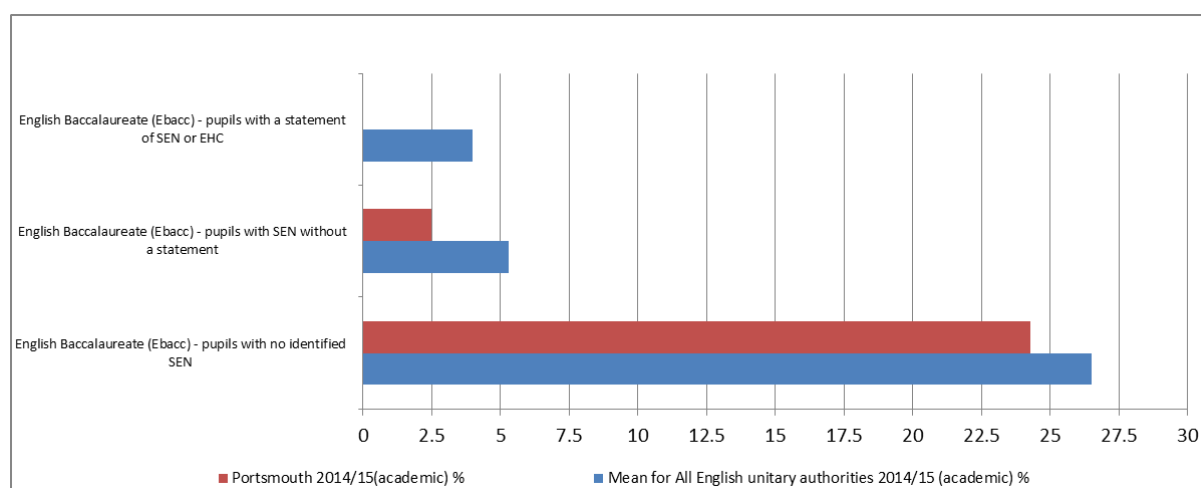


% of pupils with a statement of SEN achieving 5 or more A* to G GCSEs (from 2011/12

(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.

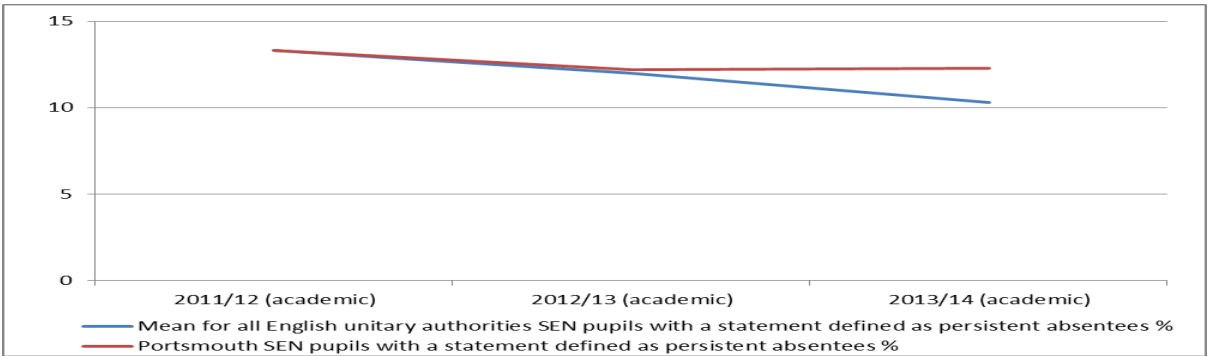
There is variation across the years with things dipping, particularly in 2014/15 for a number of indicators. There are bigger gaps at KS4 for progress for those with SEMH but not for attainment. It is difficult to make comparisons across other areas as national results are not broken down by primary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

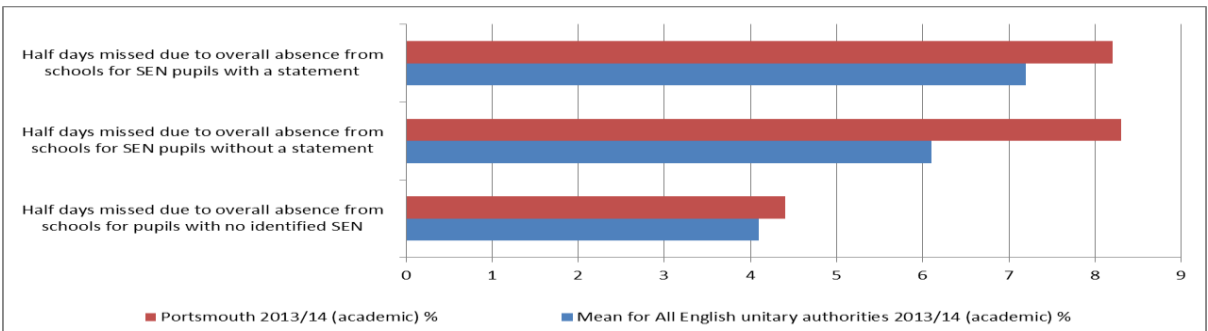
This will be an area of focus for the Task and Finish Group, and work will be reported through this Board. It is anticipated that figures will soon be updated on the national report to take account of more recent years, and the move to different systems of measurement.

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

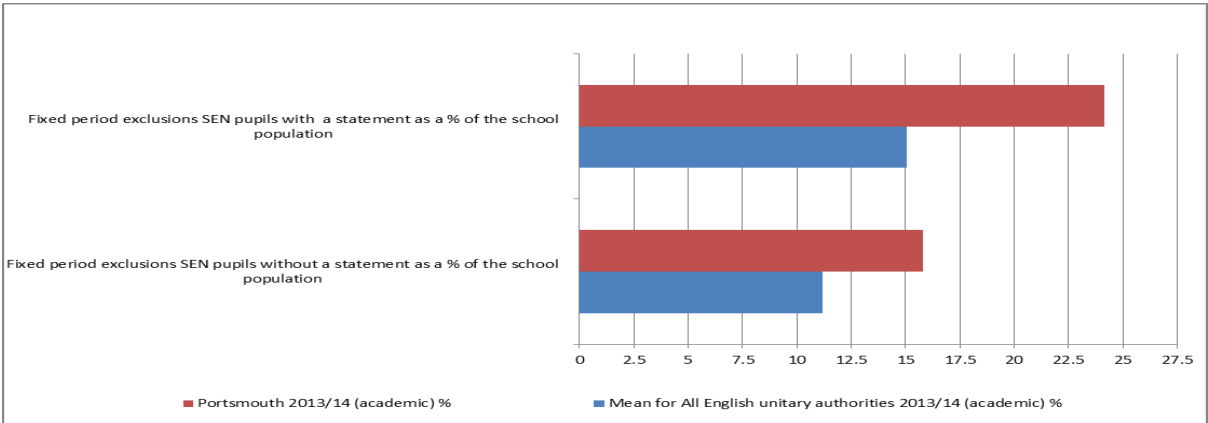
12.3% = 7th of 11 Statistical Neighbours (1 being the highest levels of PA) (11.1 for the South East and 11.0 for England) - However 3rd in comparison to statistical neighbours when looking at those with no SEN. Also Portsmouth were the highest in comparison to statistical neighbours when looking at 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

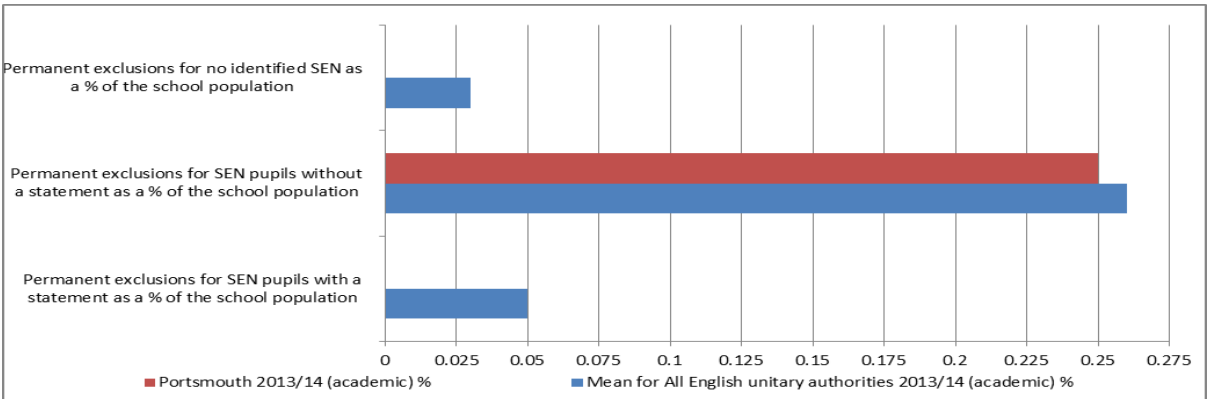
with statements are better with regards to this indicator than those with no SE. Overall attendance is improving and the attendance strategy should assist this. The biggest different would be made through improved attendance at our SEMH special school which significant work has gone into. The evidence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

Exclusion - Neil Stevenson

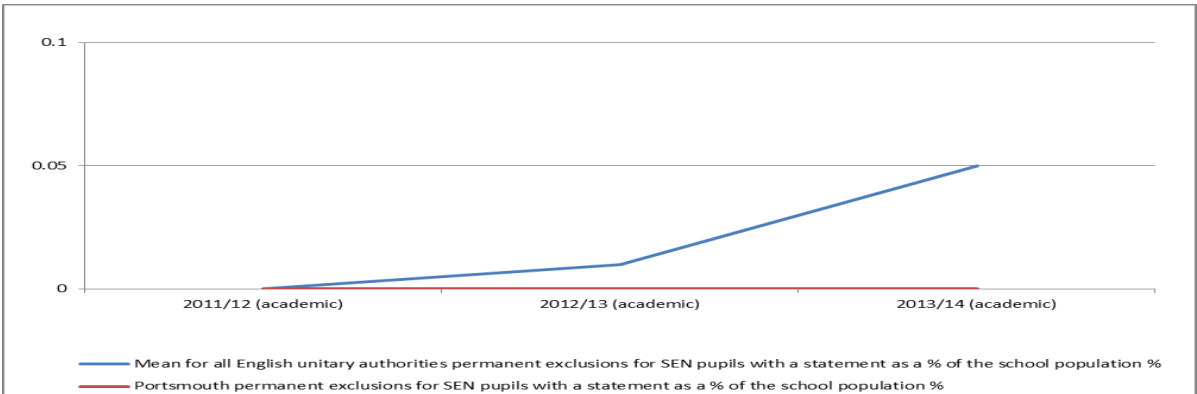
Fixed period exclusions for SEN pupils as a % of the school population (2013/14 (academic))



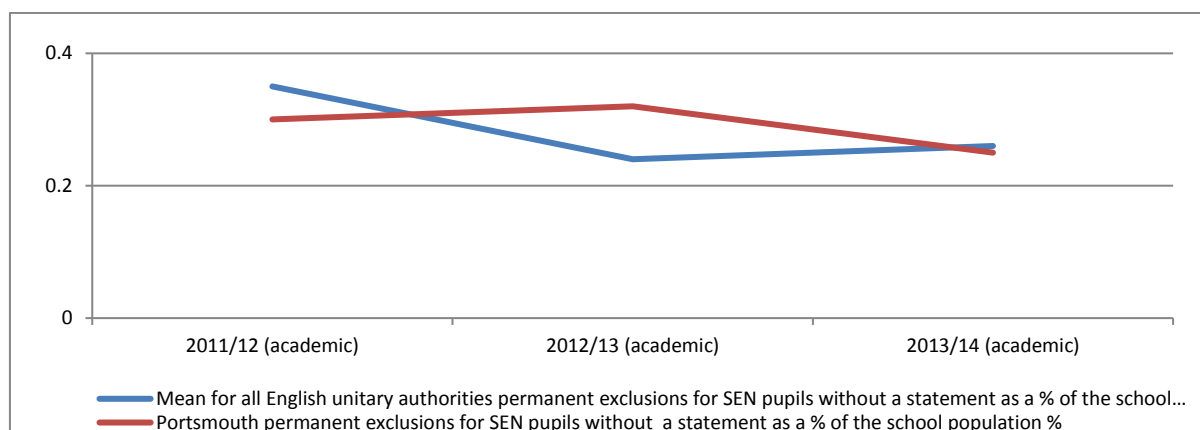
Permanent exclusions from school as a % of the school population



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

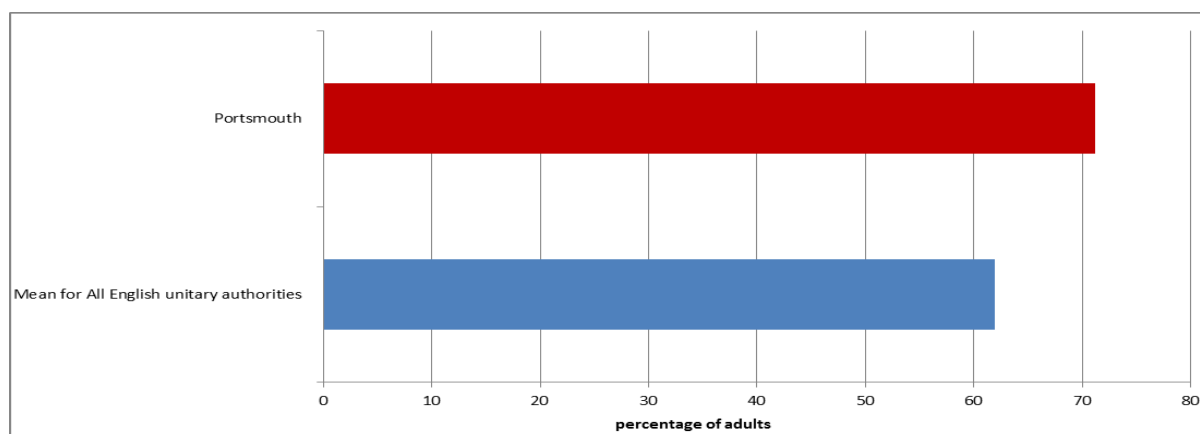
In relation to fixed period exclusions, this picture was not improving and the disproportional representation of the SEN Statement/EHCP population was increasing. The introduction of the ordinarily available provision, pupil and curriculum pathways document and rigorous tracking of vulnerable groups 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.

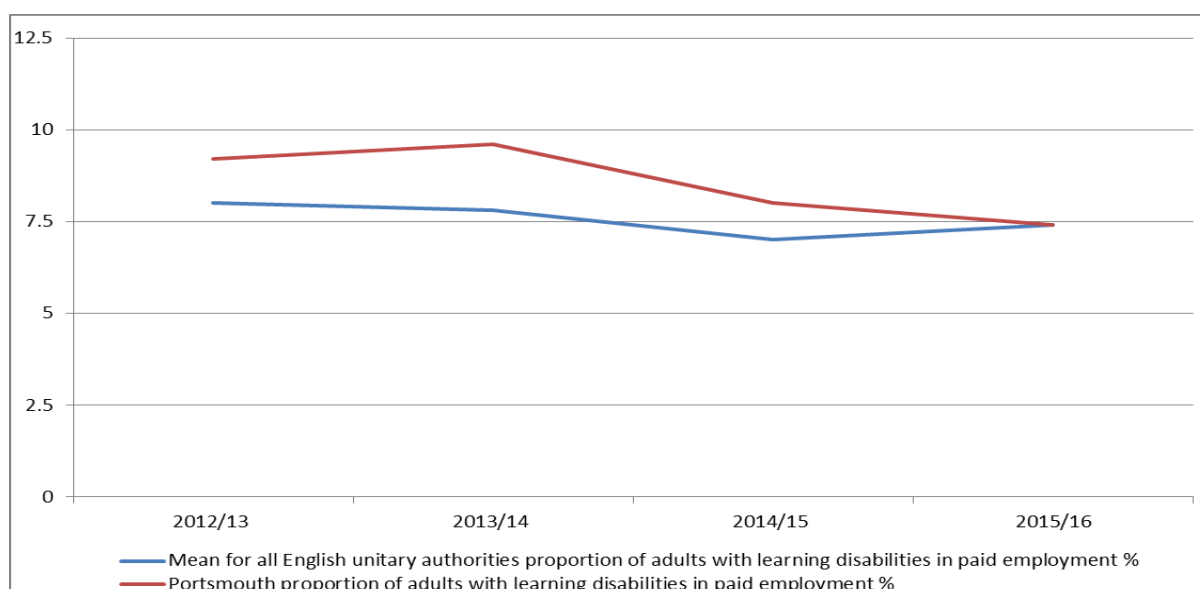
HEADLINE OUTCOME: MAKE AND MAINTAIN POSITIVE RELATIONSHIPS IN THEIR FAMILIES AND COMMUNITIES

% 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:

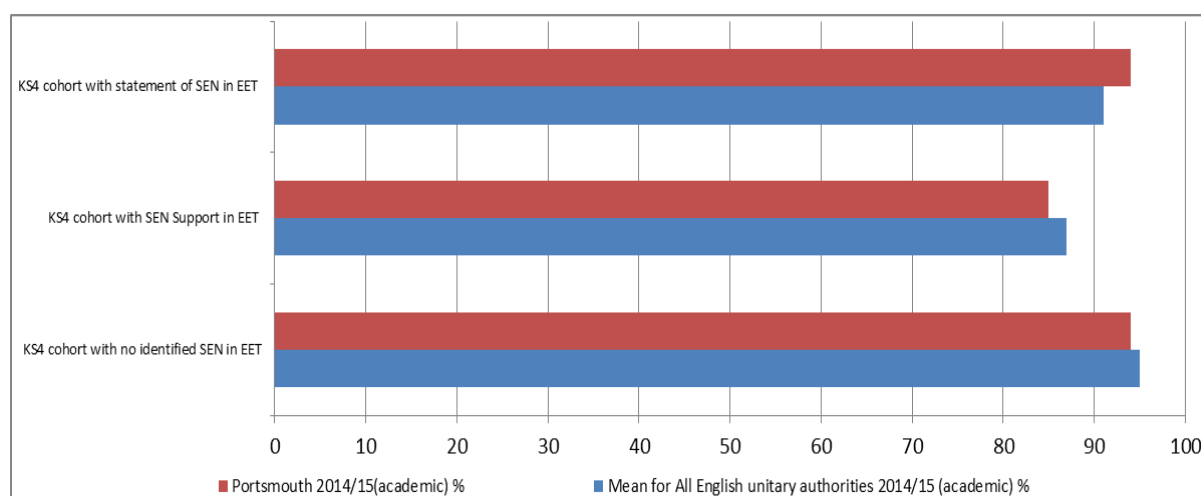
- commissioned a work assessment, finding and support service
- made employment a key outcome in support planning,
- assigned a named worker to proactively work with everyone re the outcome of work
- freed up the money by significantly reducing block expenditure which in turn allows the growth and funding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

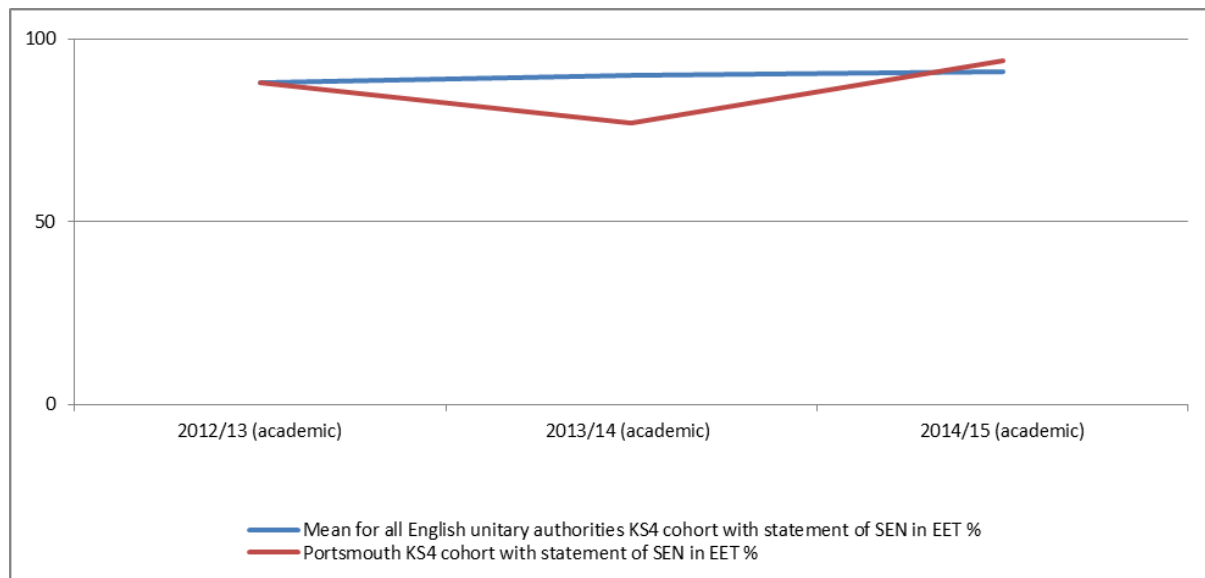
HEADLINE OUTCOME: Participate in education and training post-16 and prepare for employment

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/>.

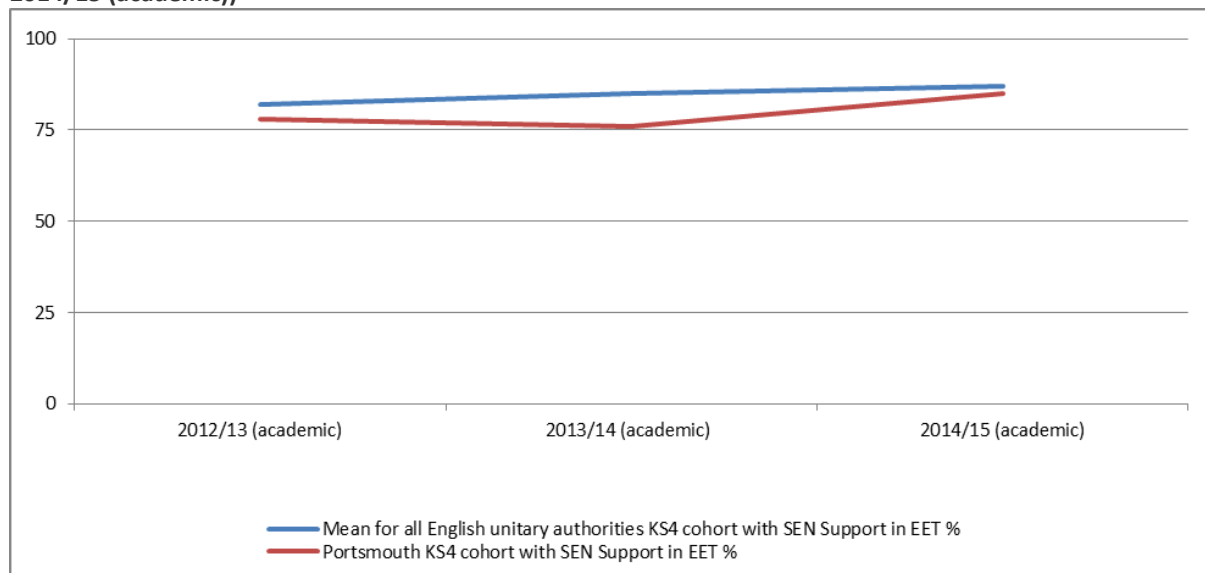
Percentage of KS4 cohort in Education, Employment or Training at 17



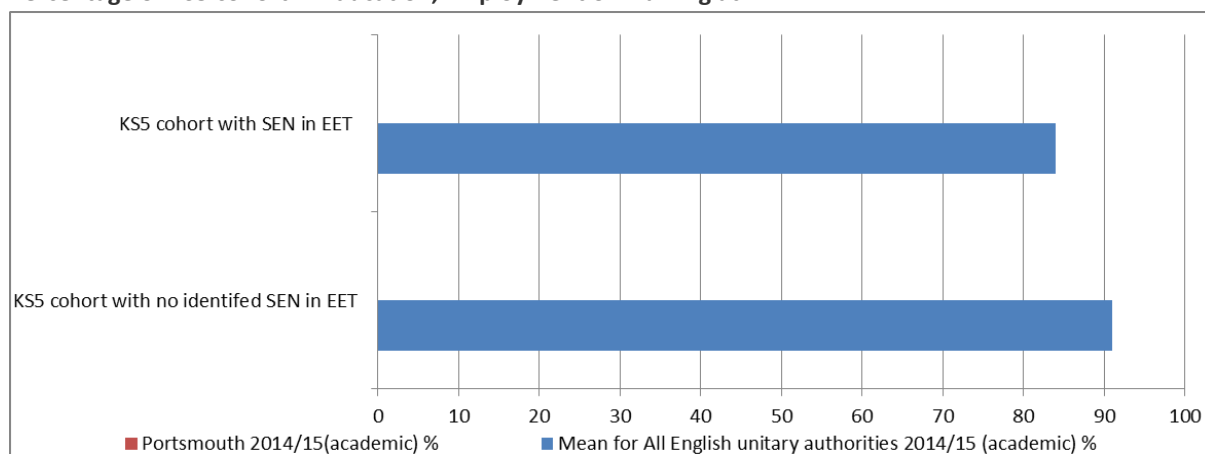
% of KS4 cohort with statement of SEN in Education & Employment or Training at 17 (from 2012/13 (academic) to 2014/15 (academic))



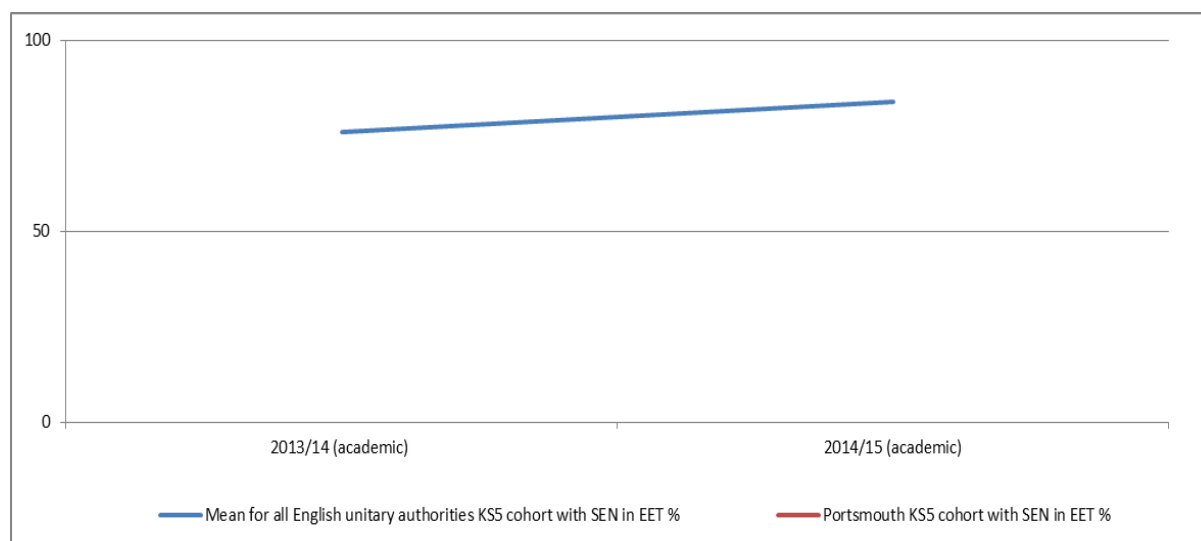
% of KS4 cohort with SEN Support in Education & Employment or Training at 17 (from 2012/13 (academic) to 2014/15 (academic))



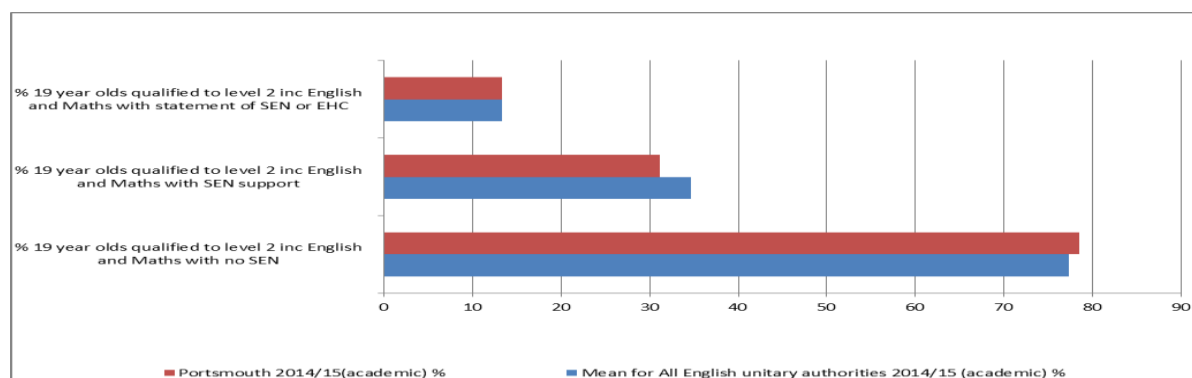
Percentage of KS5 cohort in Education, Employment or Training at 17



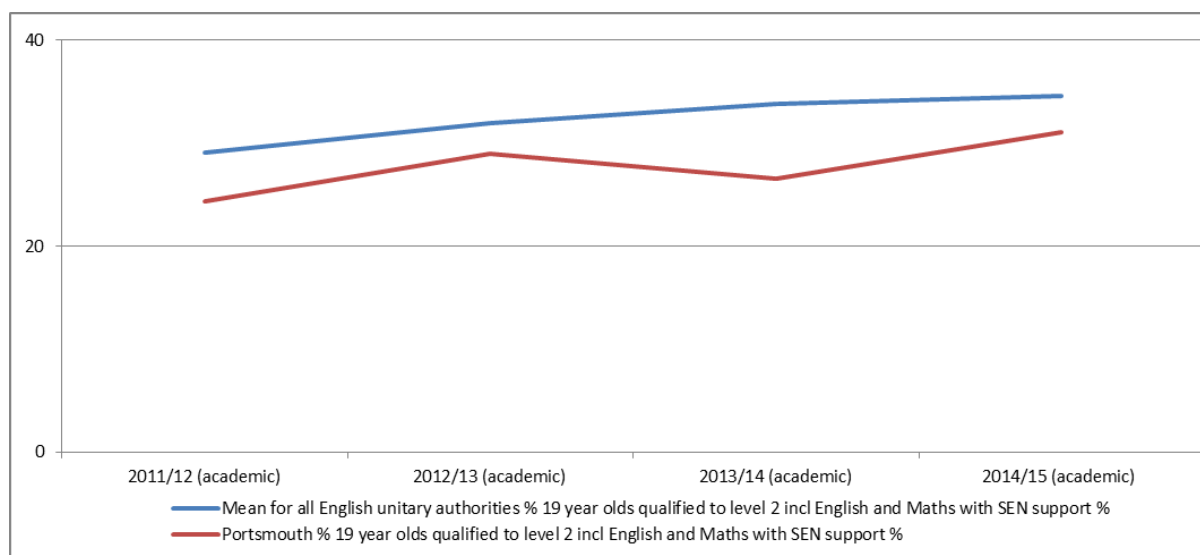
% of KS5 cohort with SEN in Education & Employment or Training at 17 (from 2013/14 (academic) to 2014/15 (academic))



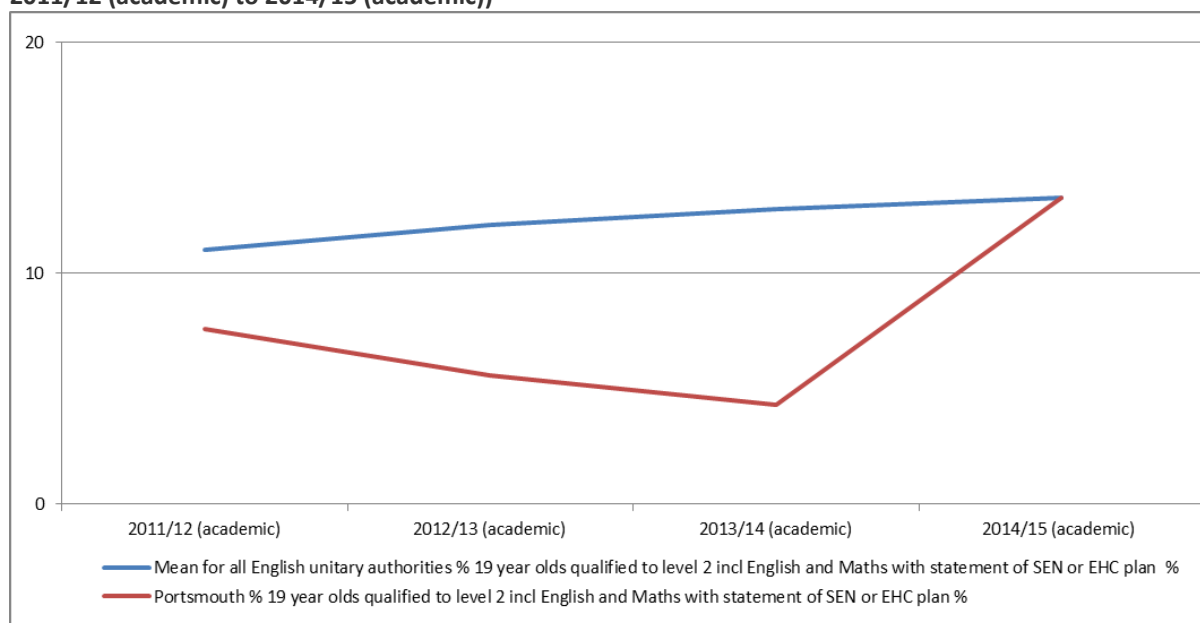
Percentage of 19 year olds qualified to level 2 including English and Maths



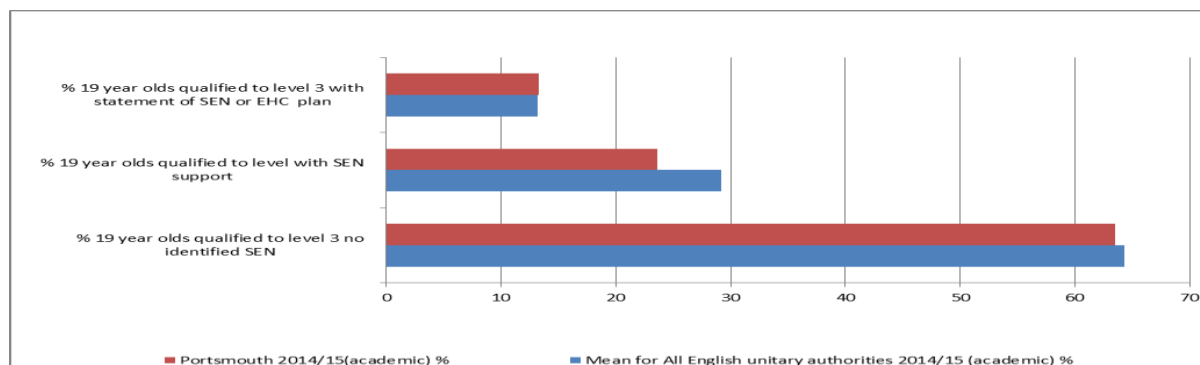
% of 19 year olds with SEN Support qualified to level 2 including English and Maths (from 2011/12 (academic) to 2014/15 (academic))



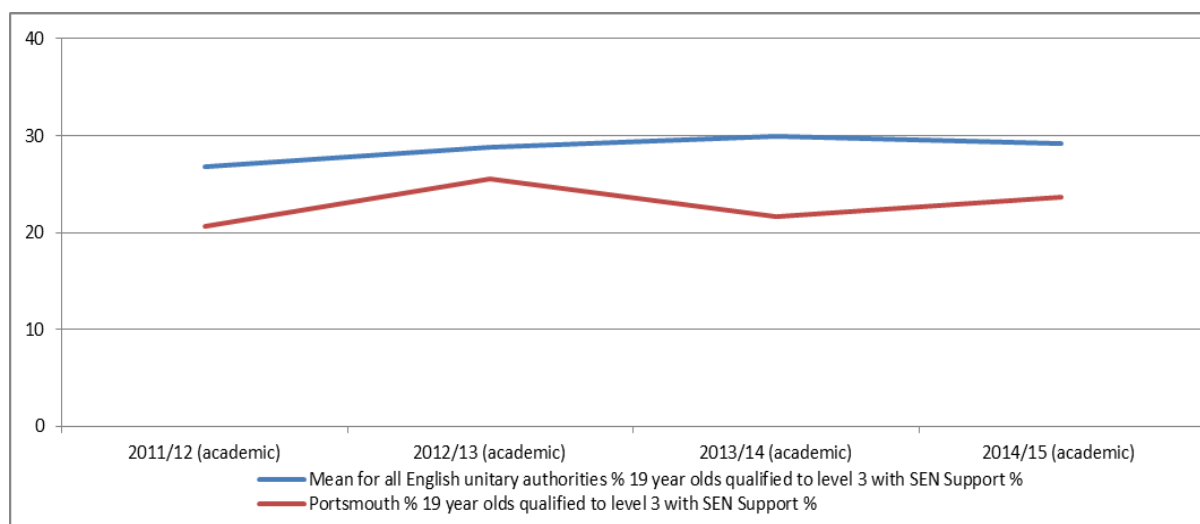
% of 19 year olds with statement of SEN or EHC plan qualified to level 2 including English and Maths (from 2011/12 (academic) to 2014/15 (academic))



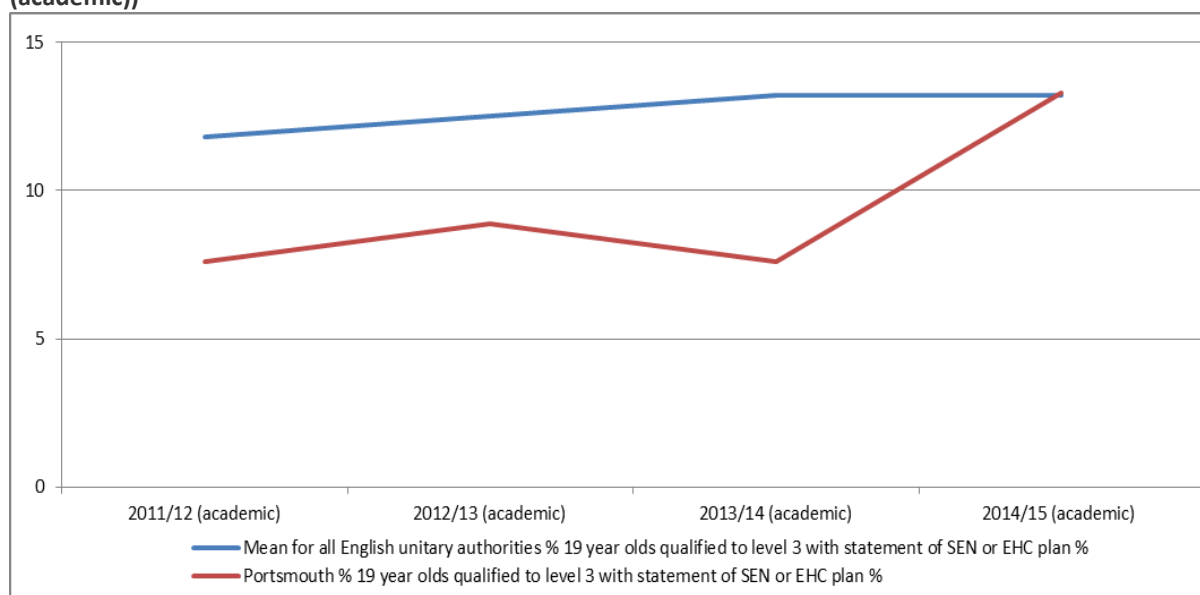
Percentage of 19 year olds qualified to level 3



% 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

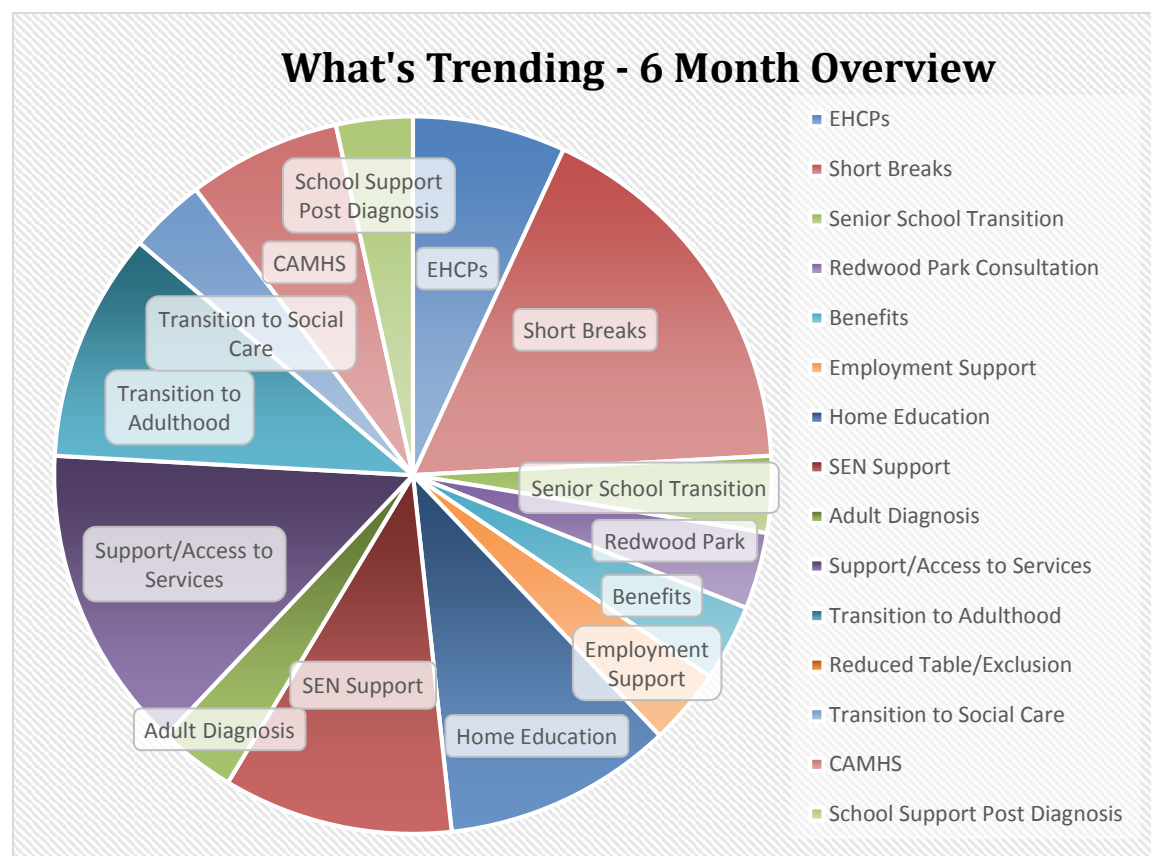
Feedback summary - Julia Katherine

Issues from feedback this quarter

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

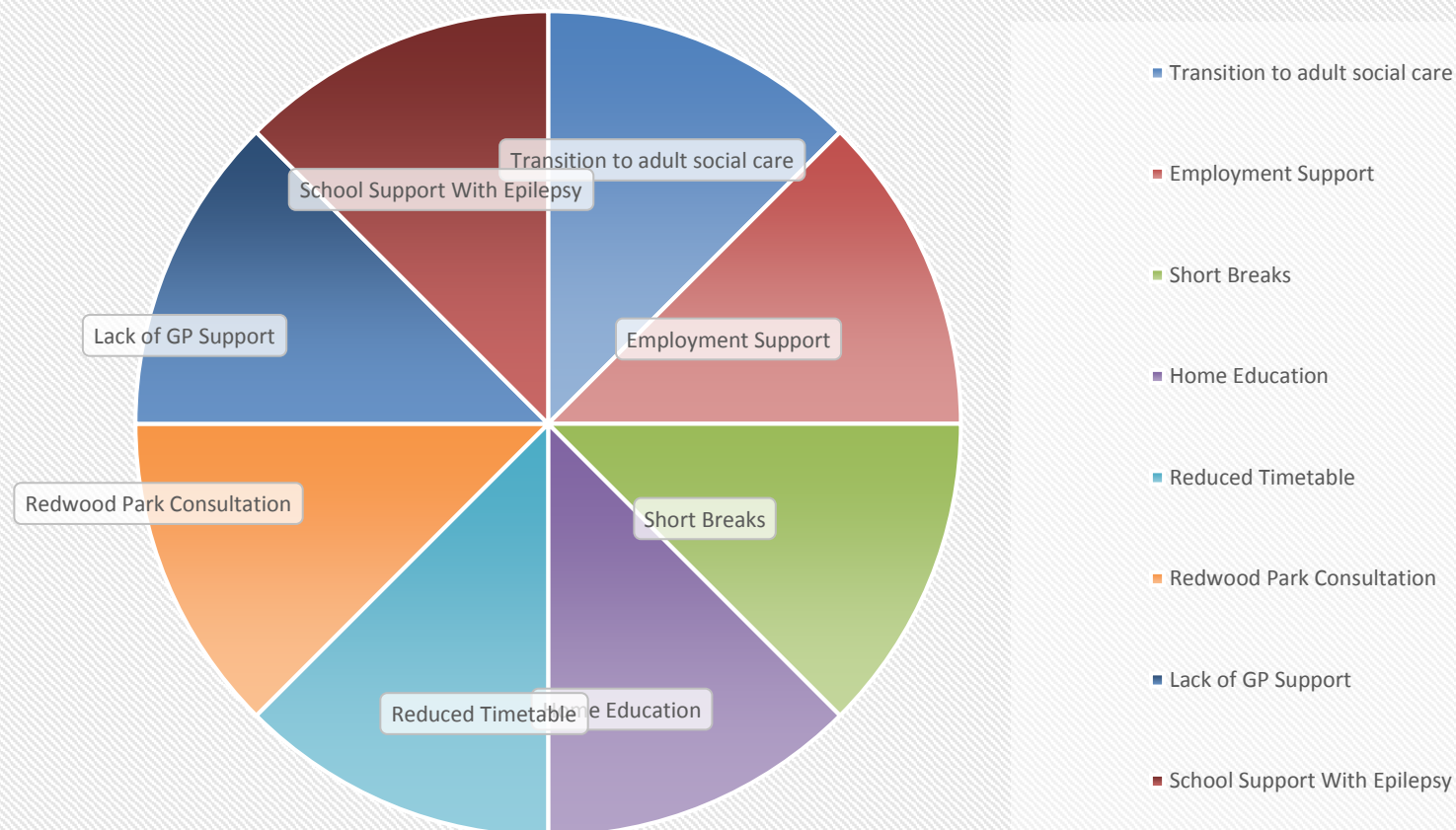


What's trending report



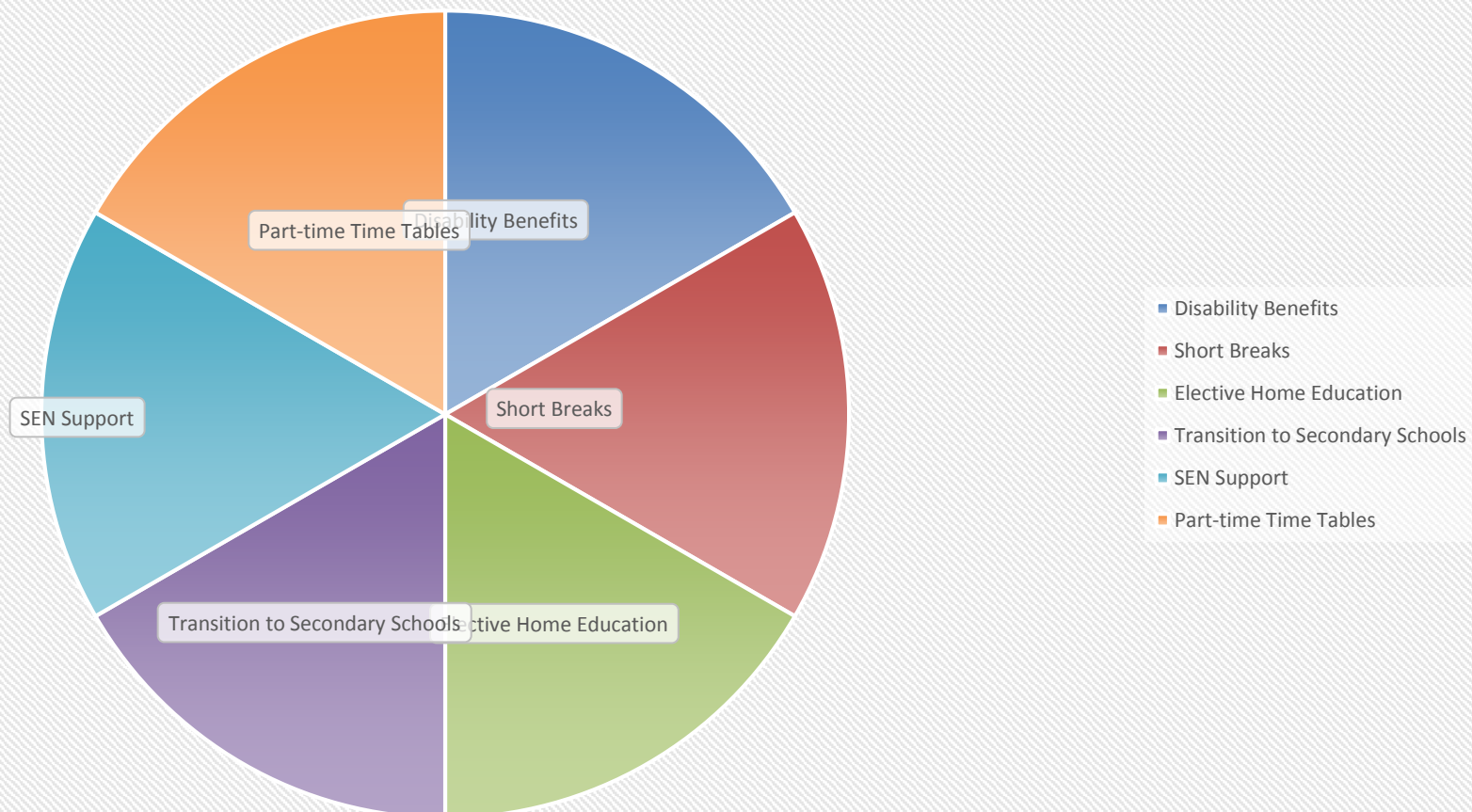


What's Trending - October 2016



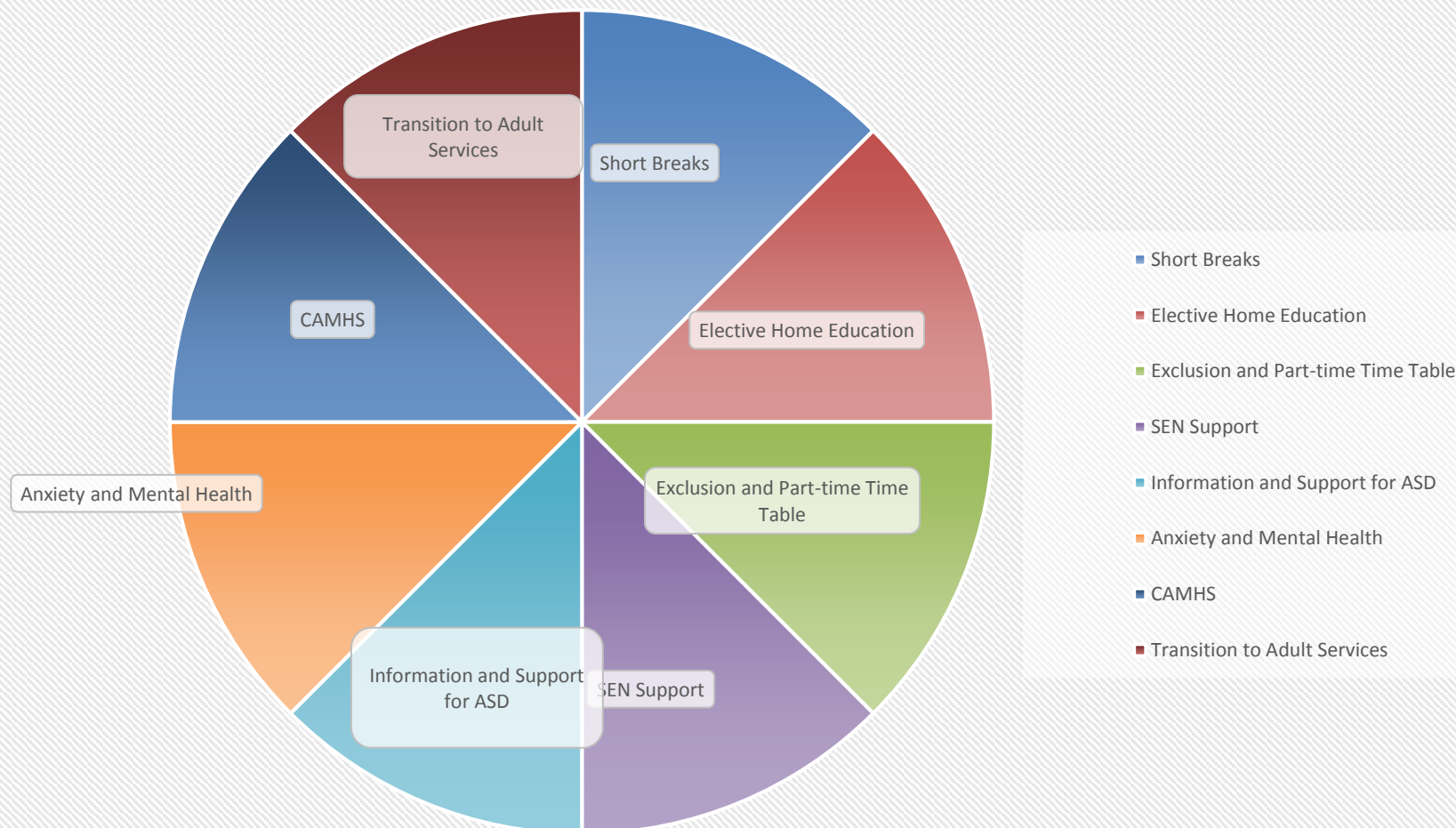


What's Trending - November 2016



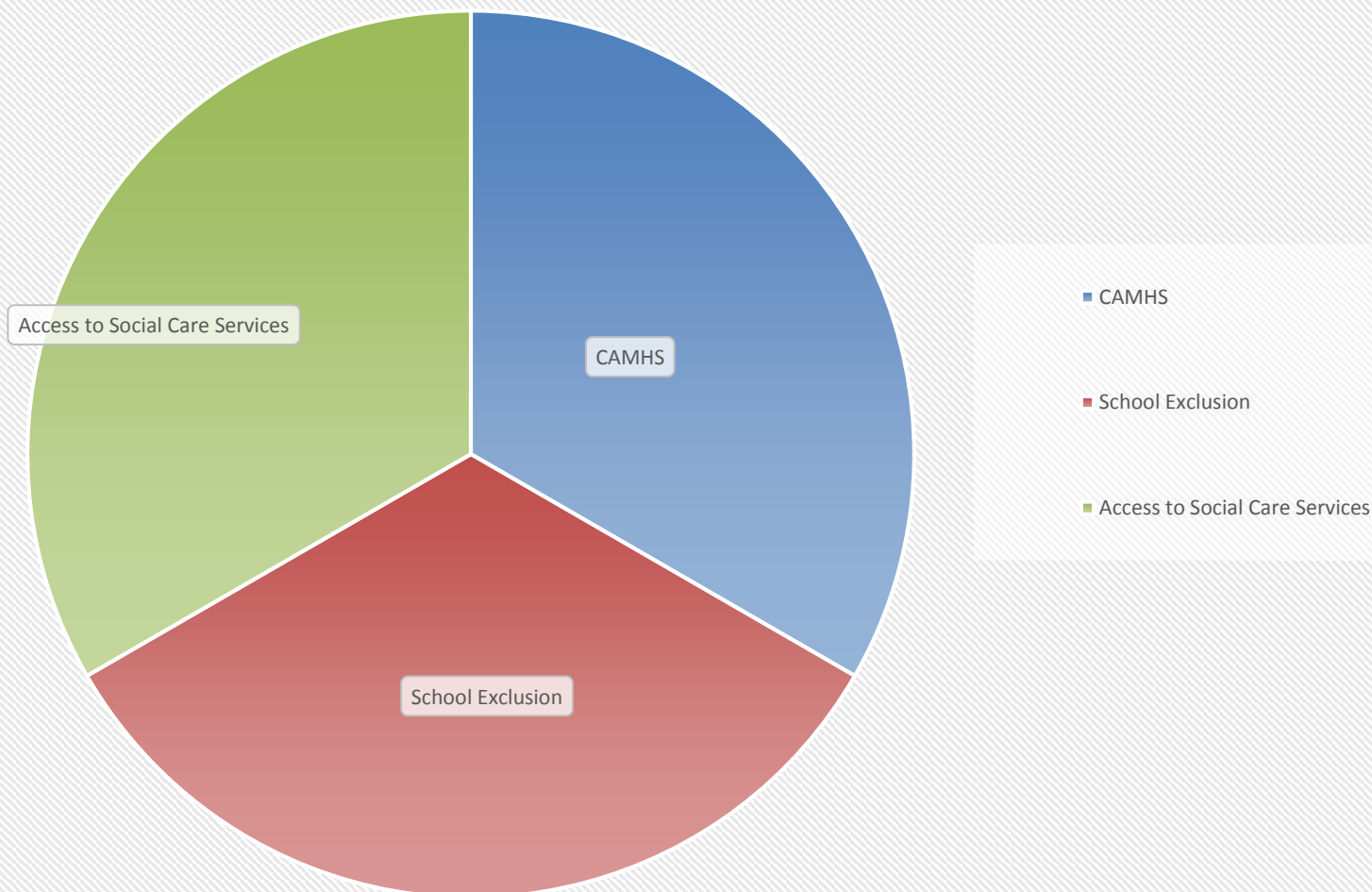


What's Trending - December 2016



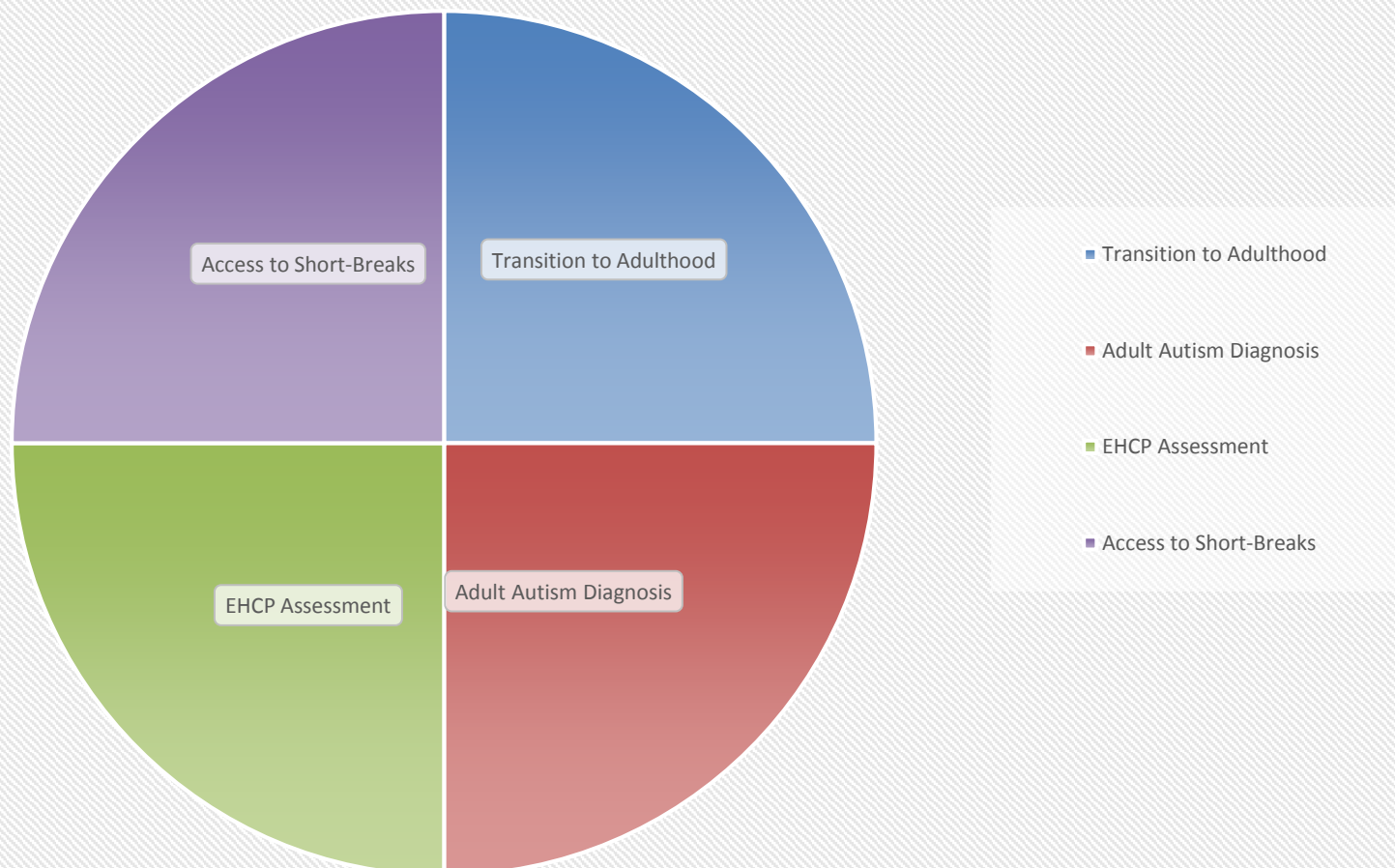


What's Trending - January 2017



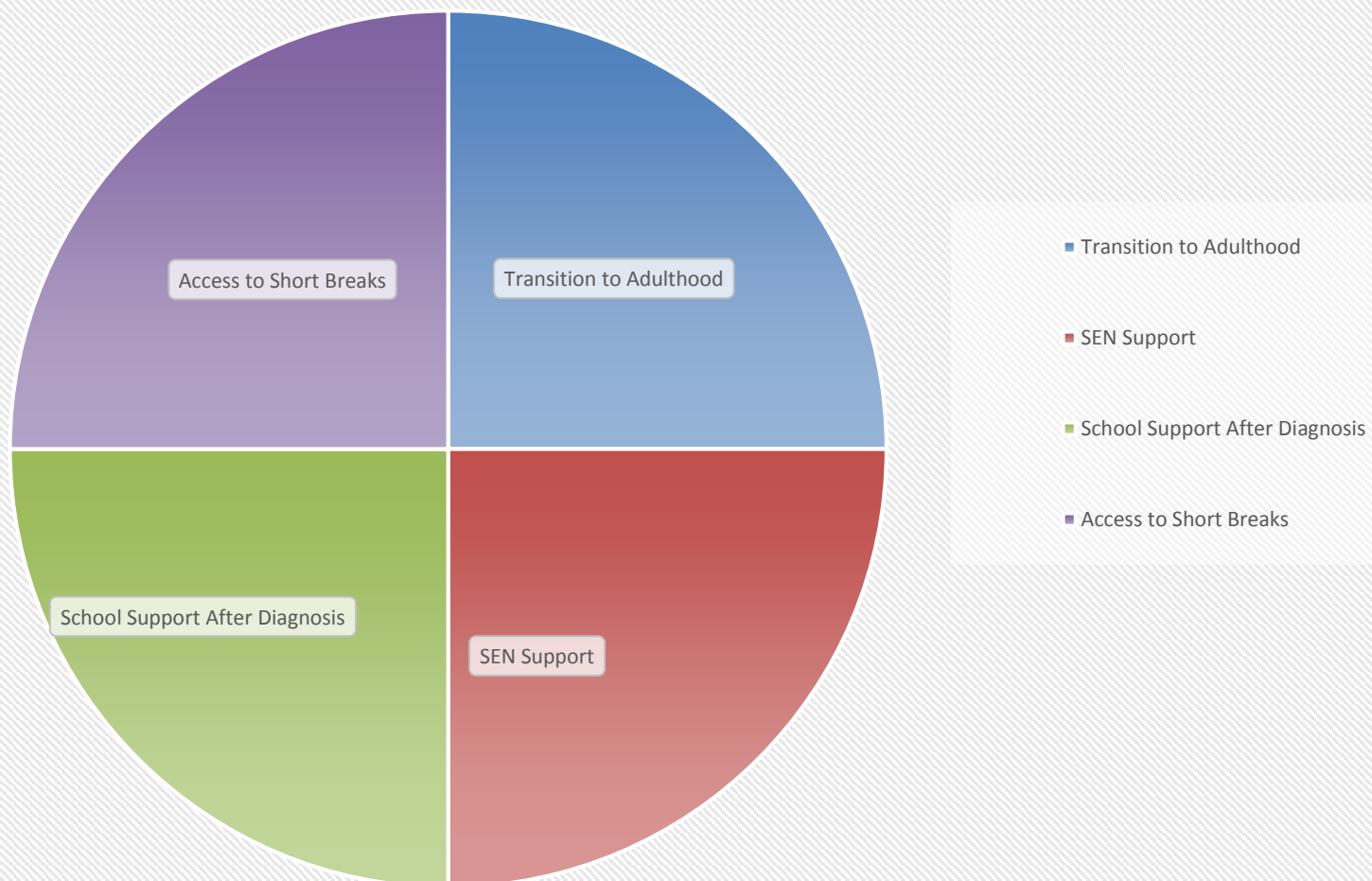


What's Trending - February 2017





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.

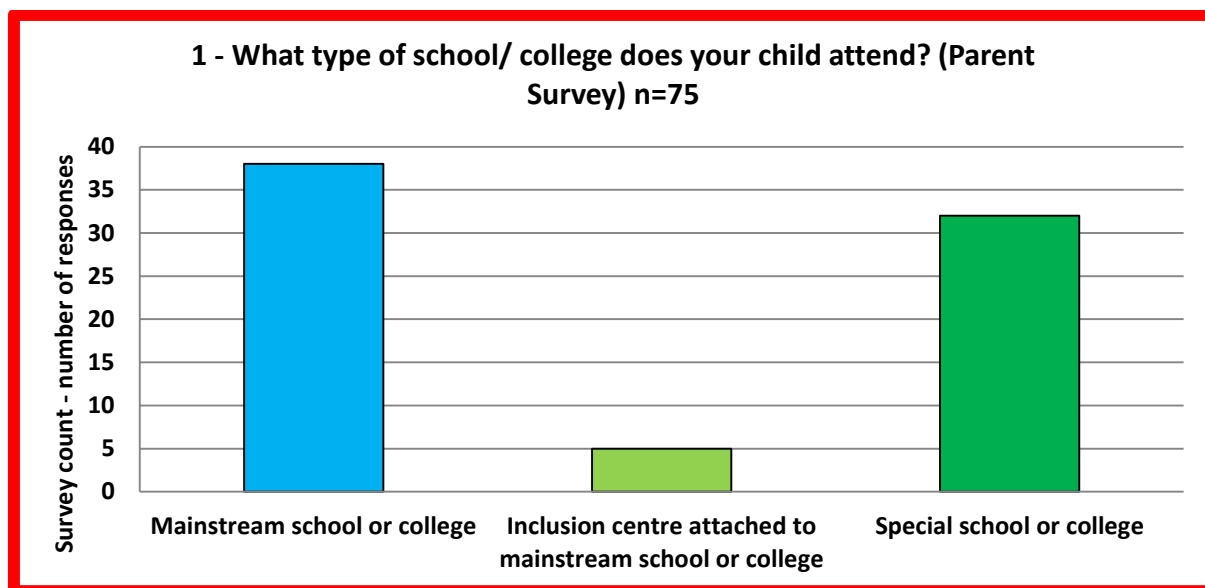
The remainder of this paper will set out the analysis of the parent and children's "with EHCP" surveys and what conclusions we can draw from this work to inform on future developments. There will be a basic level analysis for each of the 2 surveys and a more in depth look at certain key features. The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

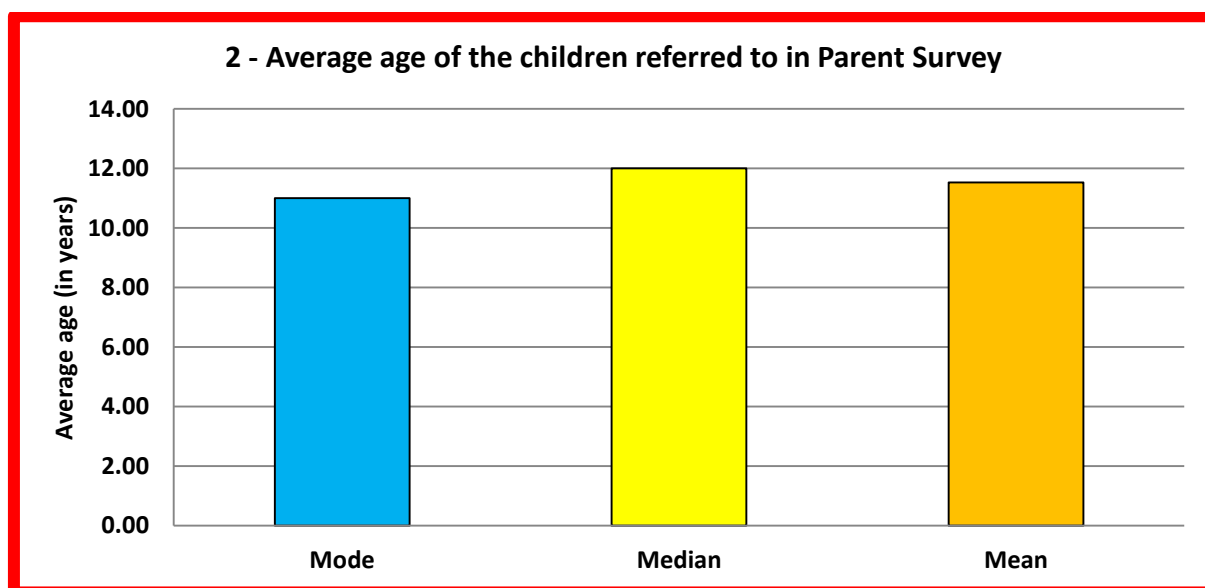
There will also be 3 appendices showing the survey forms employed to gather the information upon which this paper is based as well as a mini thematic analysis of the free text feedback received from the "without EHCP" survey respondents to ensure that any learning we can achieve through this small number 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.

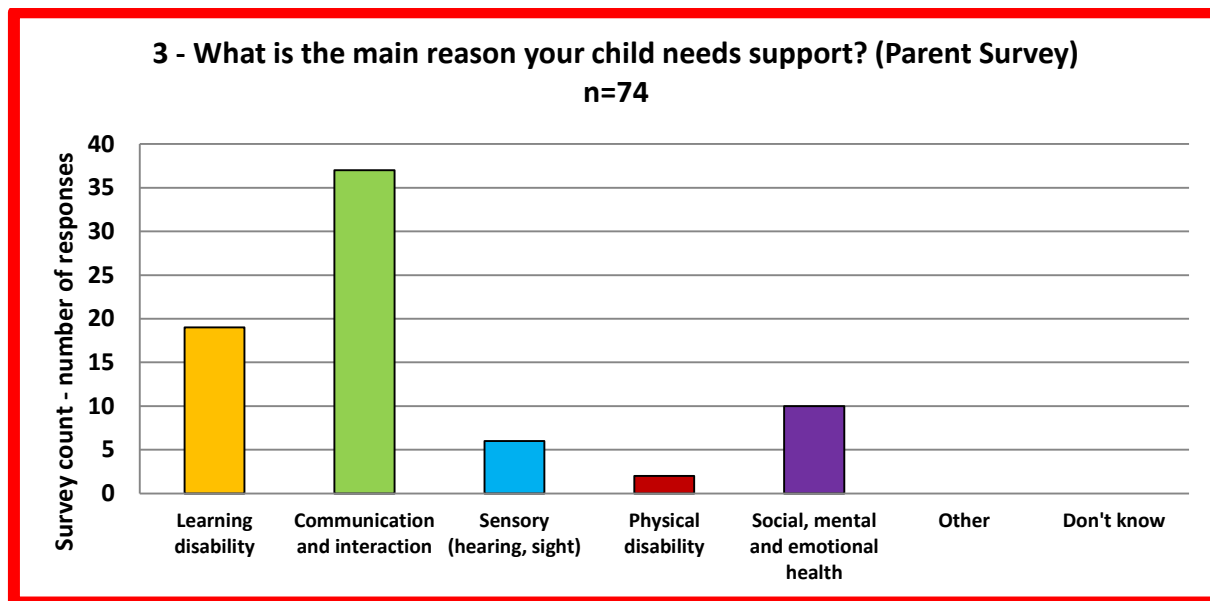


Just over 50% of respondents had a child in mainstream schooling, just over 42% in special schooling and around 6% were in inclusion centres attached to mainstream school settings. The average age of the children subject to EHCP will clearly reflect this as per figure 2.



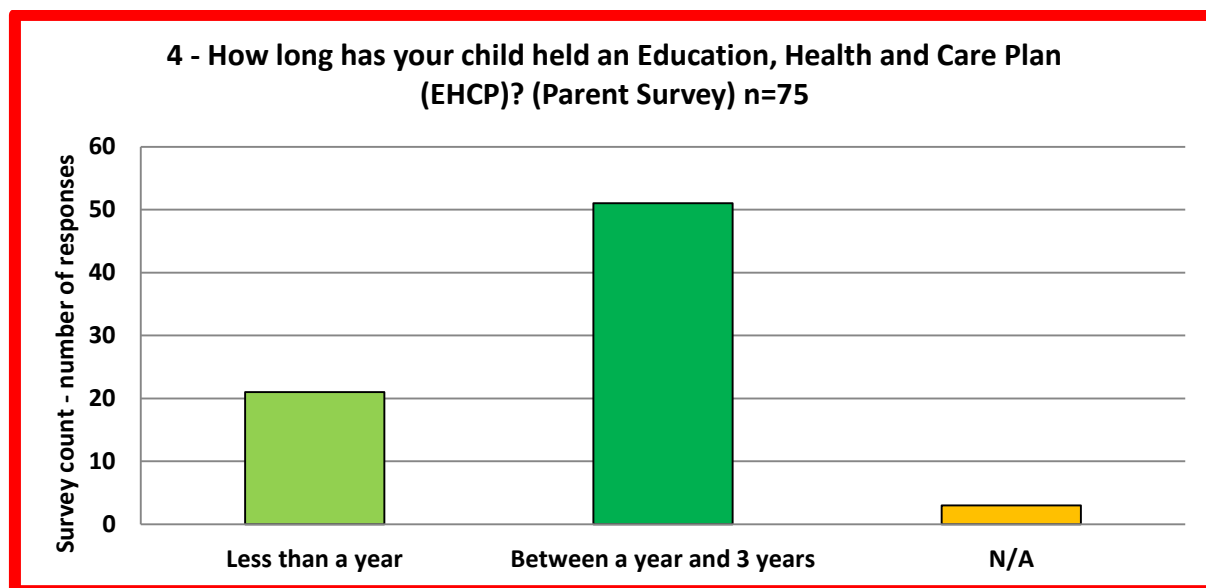
The most common age of the children of parents being surveyed in this work was 11 years old. The age range of children parents reported in this survey ran from 3 years old to 21 years old. The median figure for this range was 12 years old. The mean average fell somewhere between 11 and 12 years old. 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.

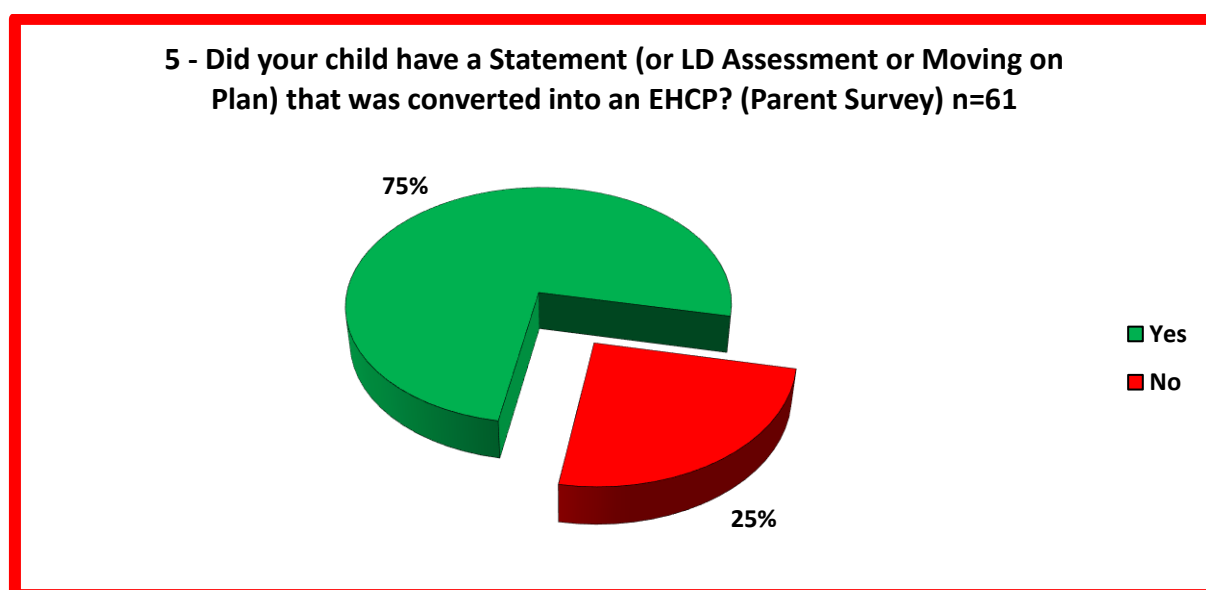


Communication and interaction proved the most common reason why an EHCP was formulated (just over 50% of cases) with learning disability (just over 25%) and social, mental and emotional health (over 13%) also prominent. Even in these fairly broad categories there are a wide range of reasons why children 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.

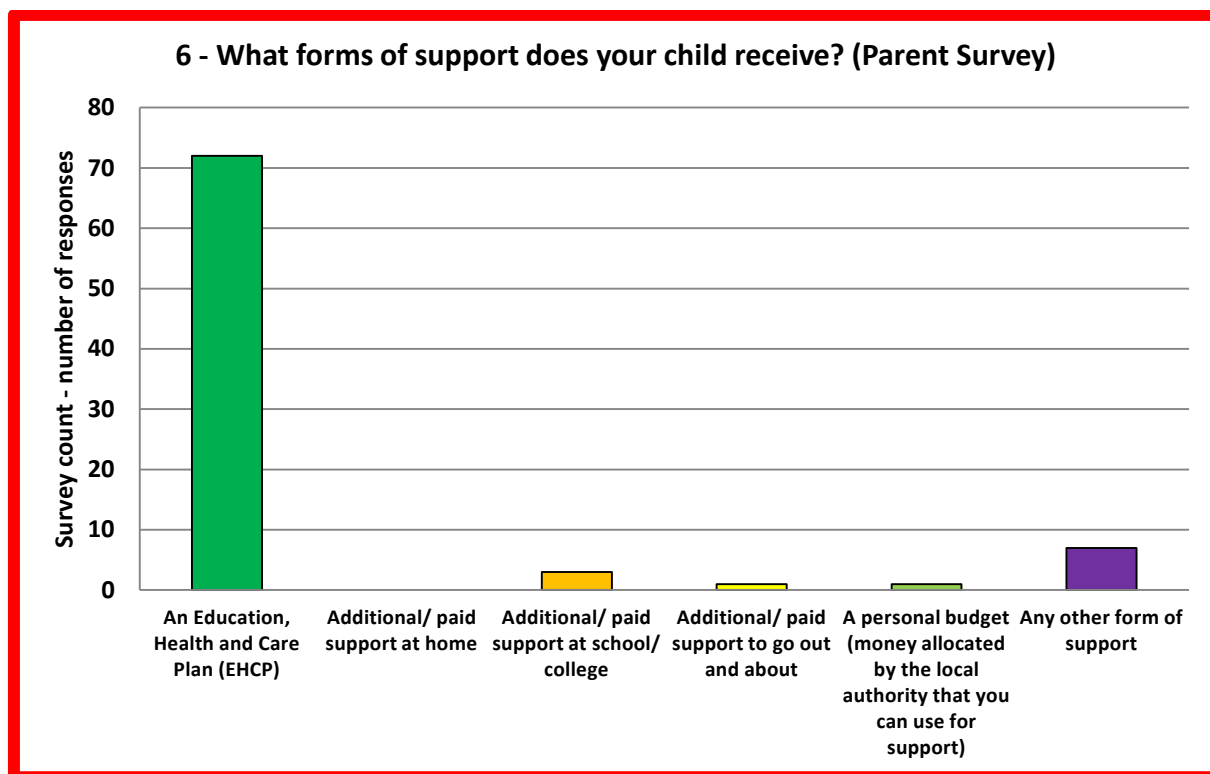


Further, we can see that the majority (75%) of EHCP were founded on a conversion process from the old "statement" system in place previously. This is demonstrated in figure 5.

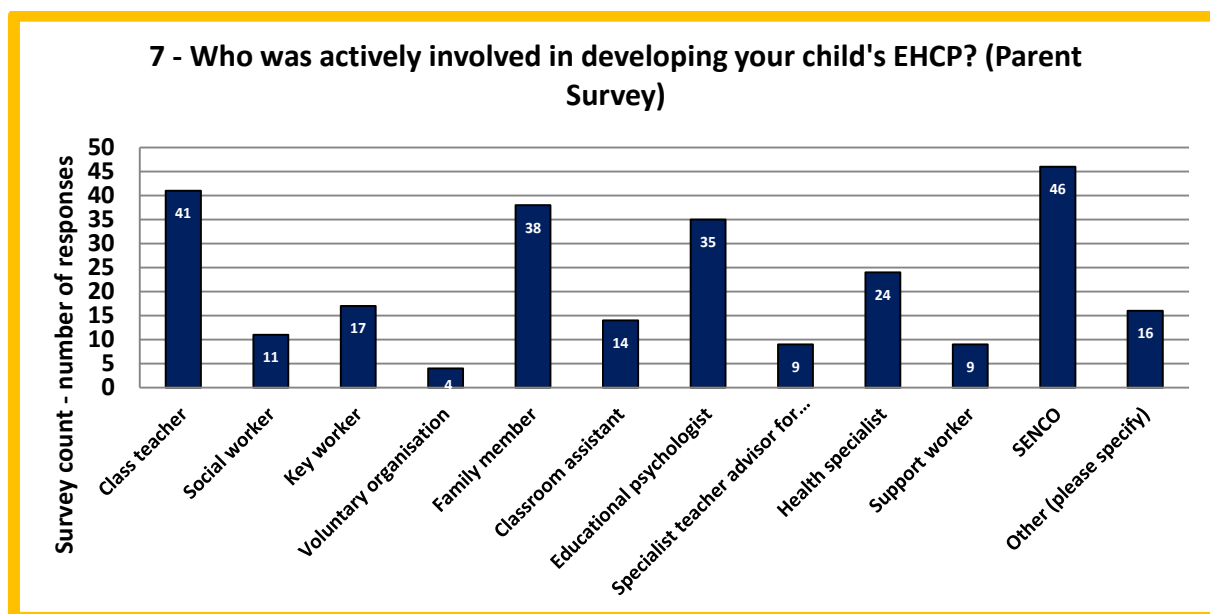


As this conversion process continues we should see a shift in this as eventually all children previously on a "statement" will be on an EHCP and so the new EHCP processes will increasingly outweigh the conversions in the future.

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.



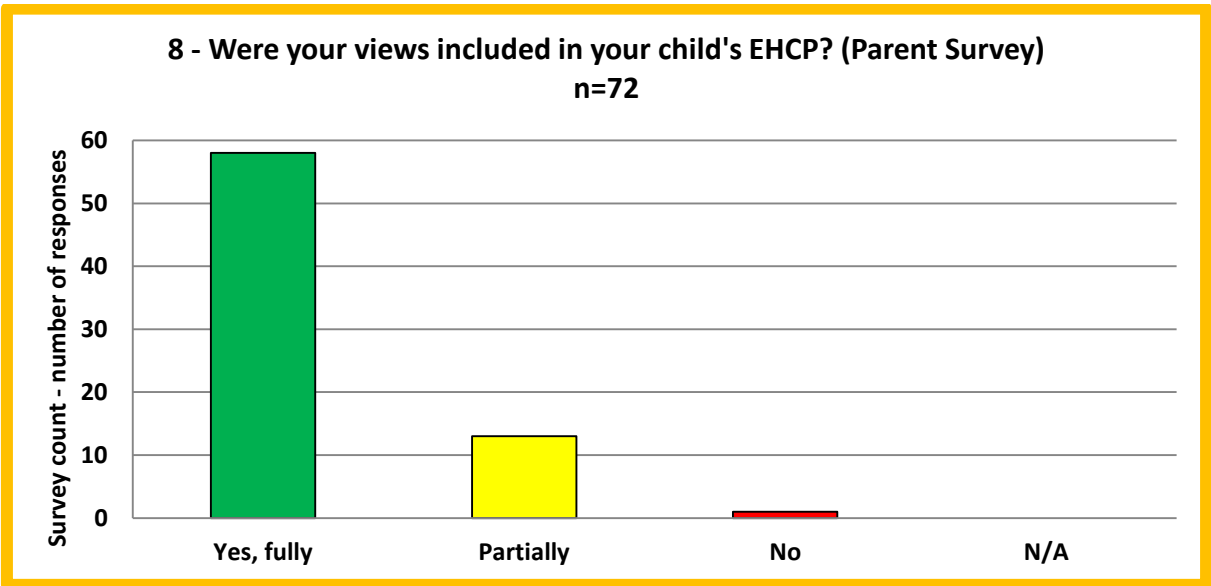
Next we turn to those involved in formulating the EHCP. Anecdotal evidence from how things used to work is that the planning process was driven by the professionals, the feeling being that care and support was "done to" the recipient. Clearly EHCP cannot be put together without the knowledge and expertise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

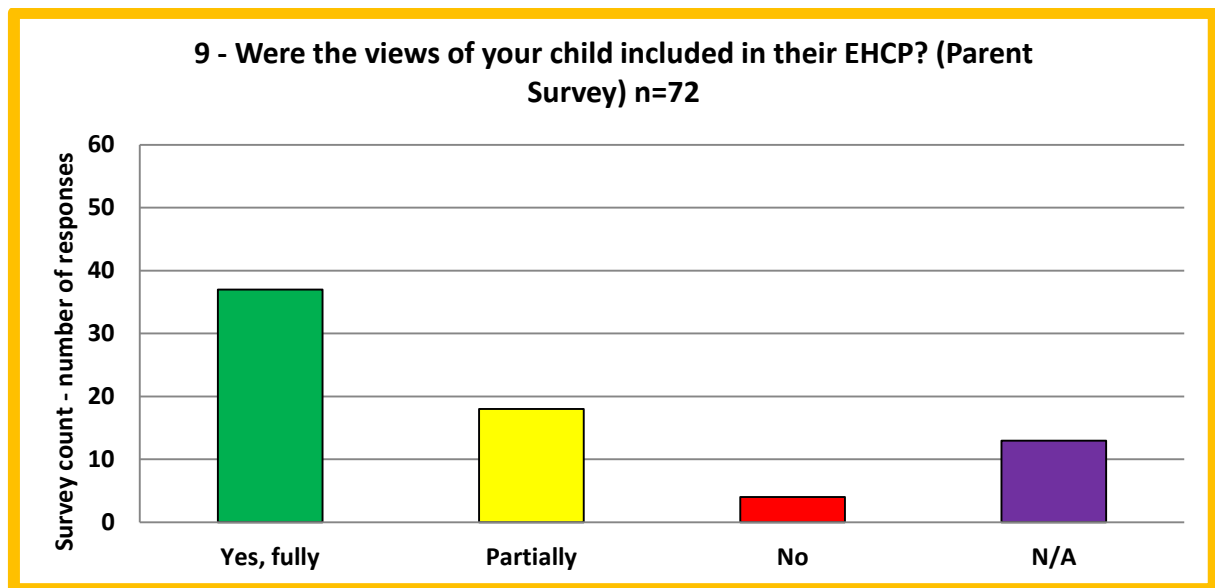
Psychologists, Health Specialists and Key Workers. As EHCP are very much focussed on education we would expect to see educational professionals represented strongly in this feedback (SENCOs, EPs & Class teachers). Crucially, however, we are seeing representation from Health and Social Care professionals 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.

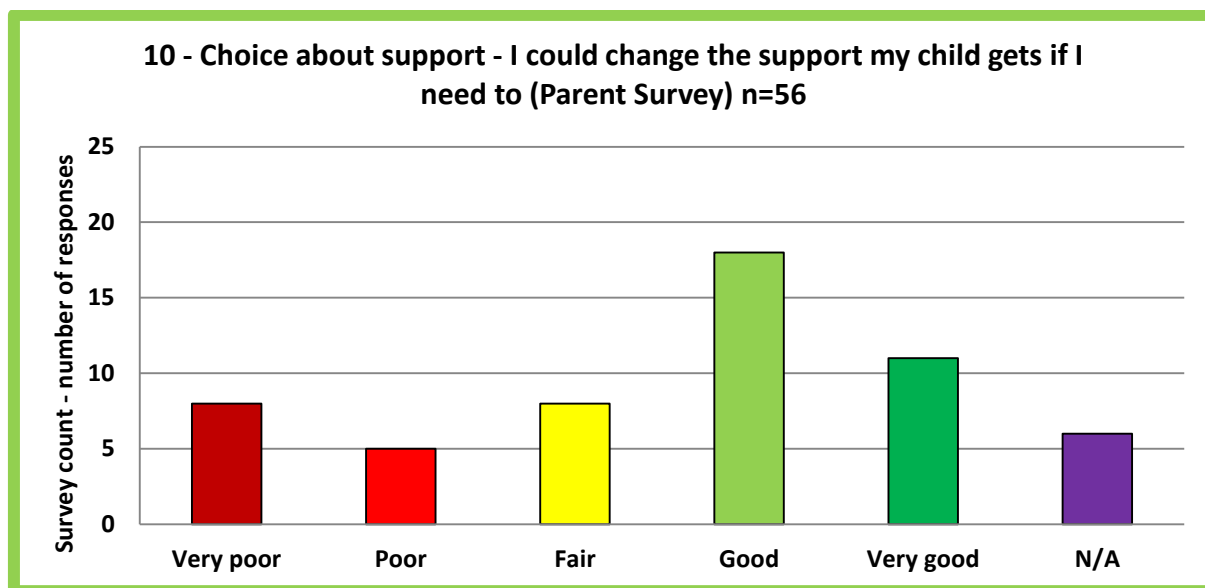


From this we can still see a majority that believe their child's views were fully or partially taken into account when putting the EHCP together and only 4 of the 72 parents felt their child's views not been acknowledged. There were a significant number of not applicable answers to this question (13). 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.

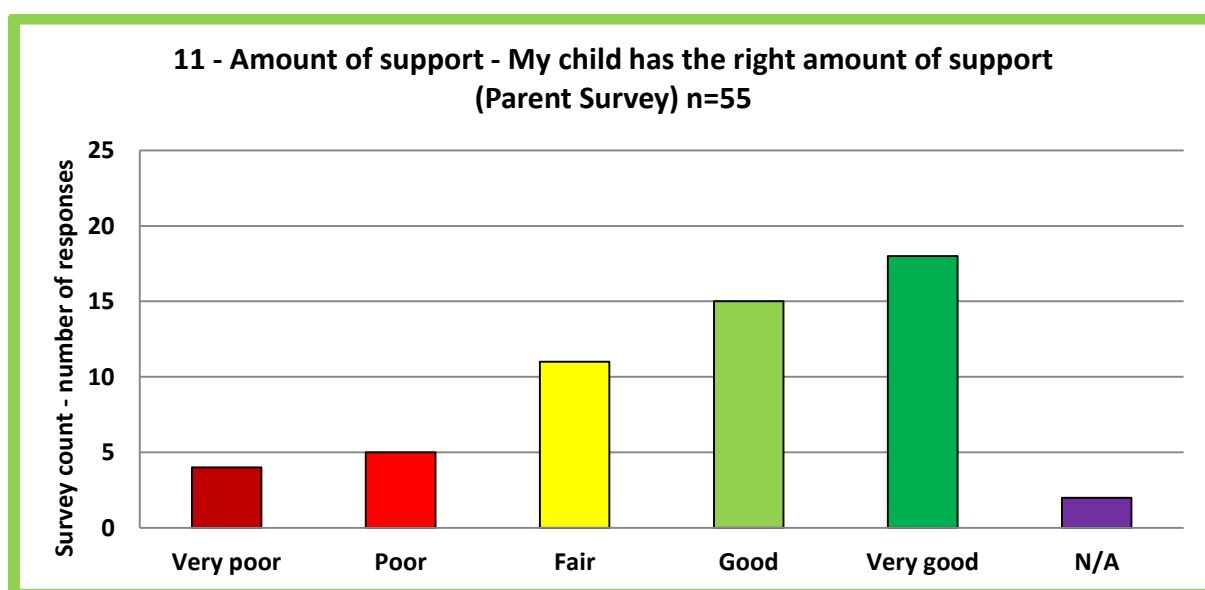
This brings the analysis to the questions relating to support for children that stems from the EHCP. Parents were asked to rate what they felt about being able to change that support if necessary, whether the amount of support was right and the quality of that support in treating their child with dignity 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?

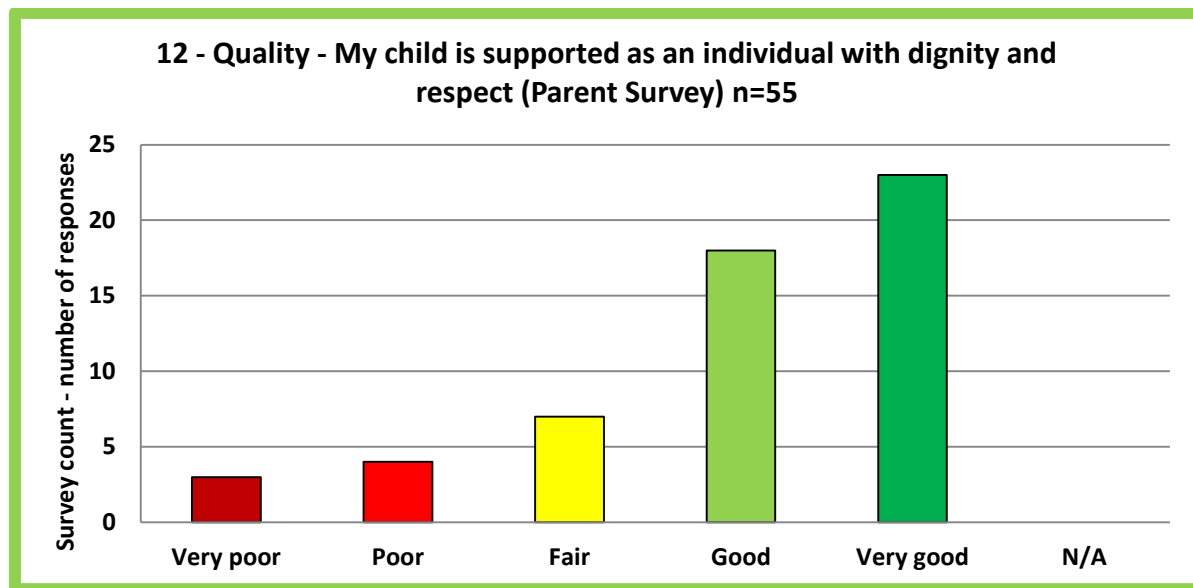
Shown in figure 10 we see what parents reported back to us in the latest survey.



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.

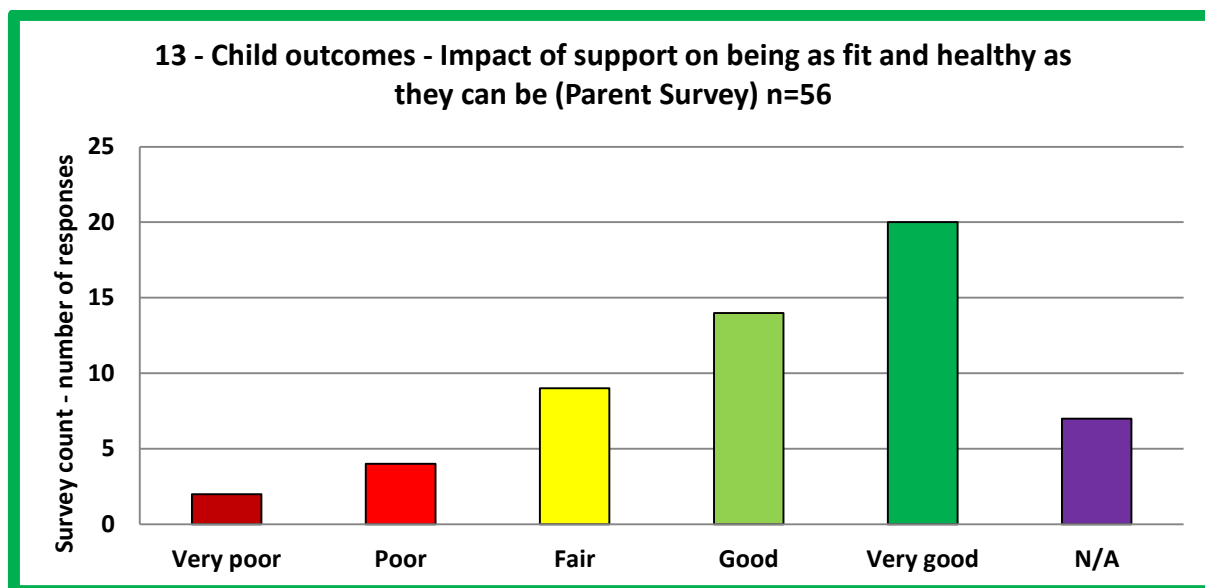
Of course this is only part of the picture. A key feature of EHCP is the focus on outcomes rather than the process and service delivery as an end in itself. The following sections examine outcomes from the point of view of children and their parents. The seven outcomes for children under examination 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

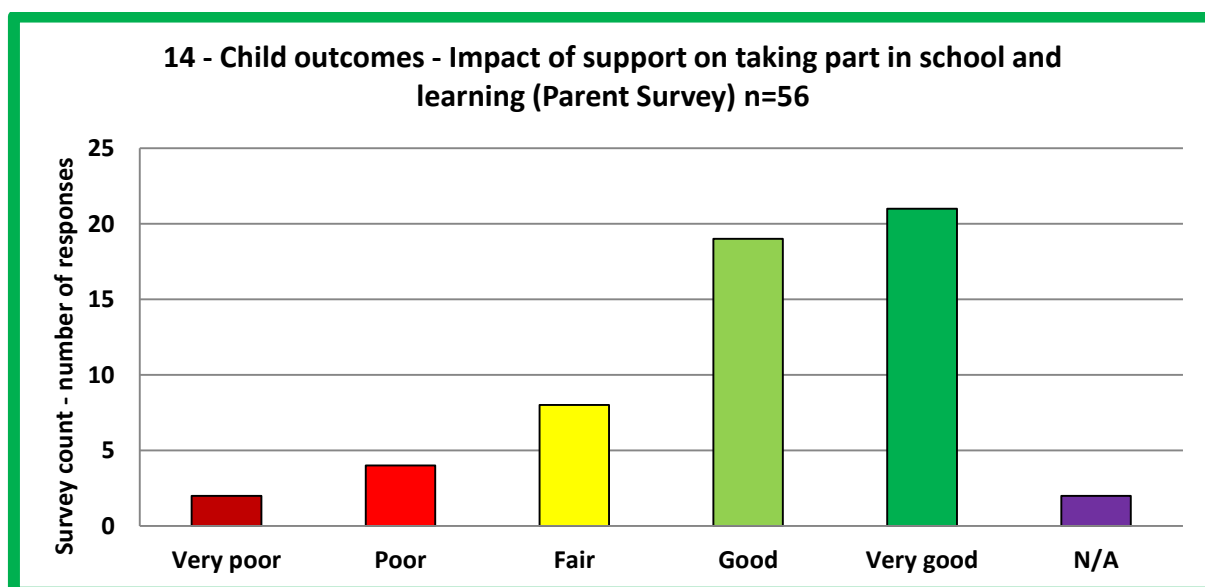
On top of this three outcome themes are investigated for parents themselves, these being:

- 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.

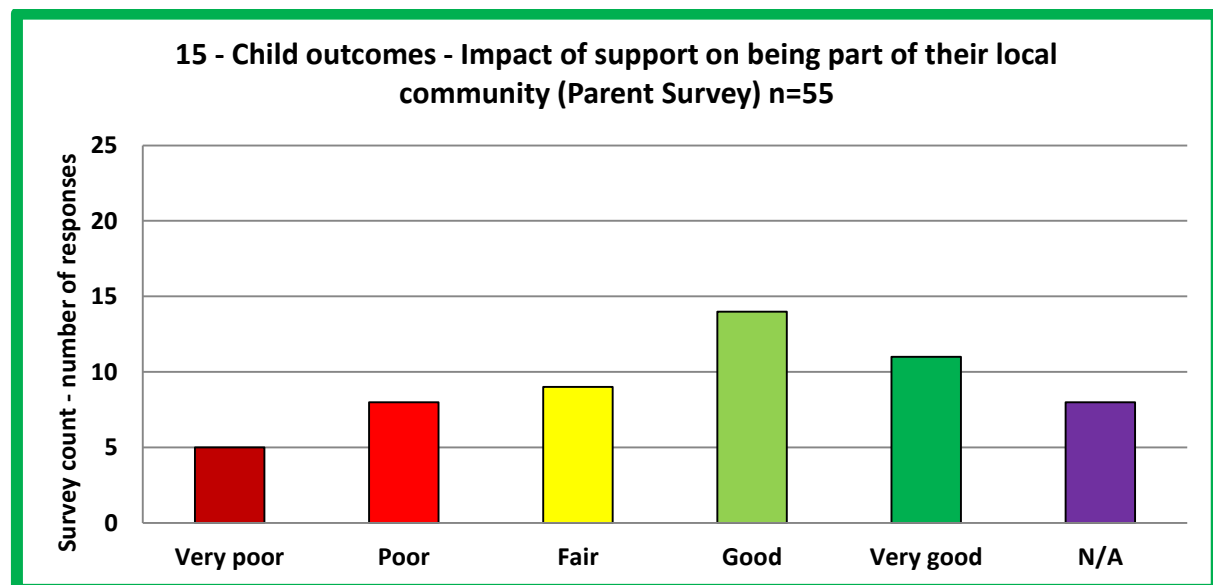


43 of the 56 parents expressed a positive view of this outcome. This indicates that a large majority of parents perceive the support being offered by way of an EHCP as a positive influence on the health of their children with only 6 parents feeling more negative on this issue. This addresses the fact 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.



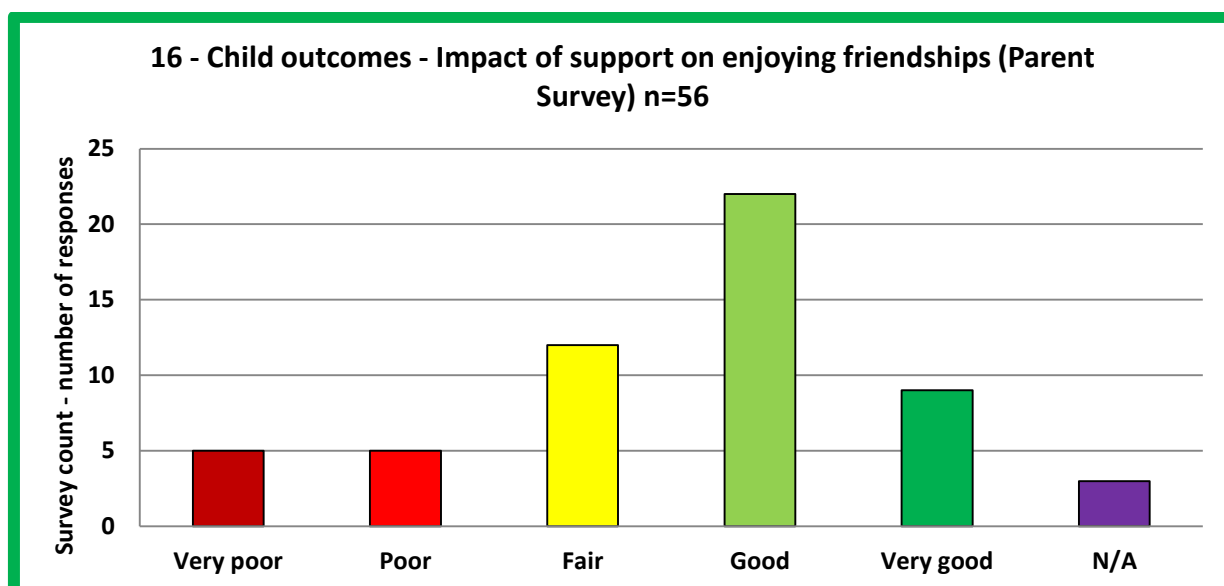
Here we see 48 of the 56 parents answering this question expressing a positive perception of the impact of EHCP in their child participating in school and learning. At face value this is hardly surprising given the focus on education implicit in EHCPs as well as the involvement of educational professionals 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.

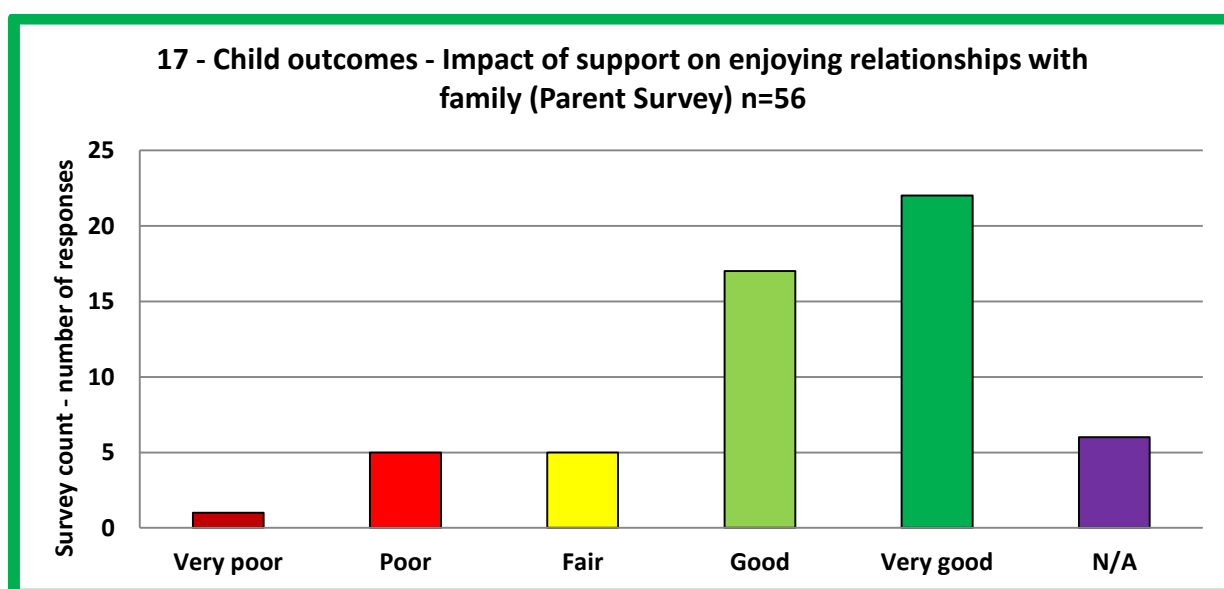


Here we see a smaller majority of parents expressing a positive view of their child being part of their local community (34 out of 55) with the question provoking the greatest incidence of the contrary view (13 out of 55) and the not applicable answer (8 out of 55). This question appears to provoke the 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.

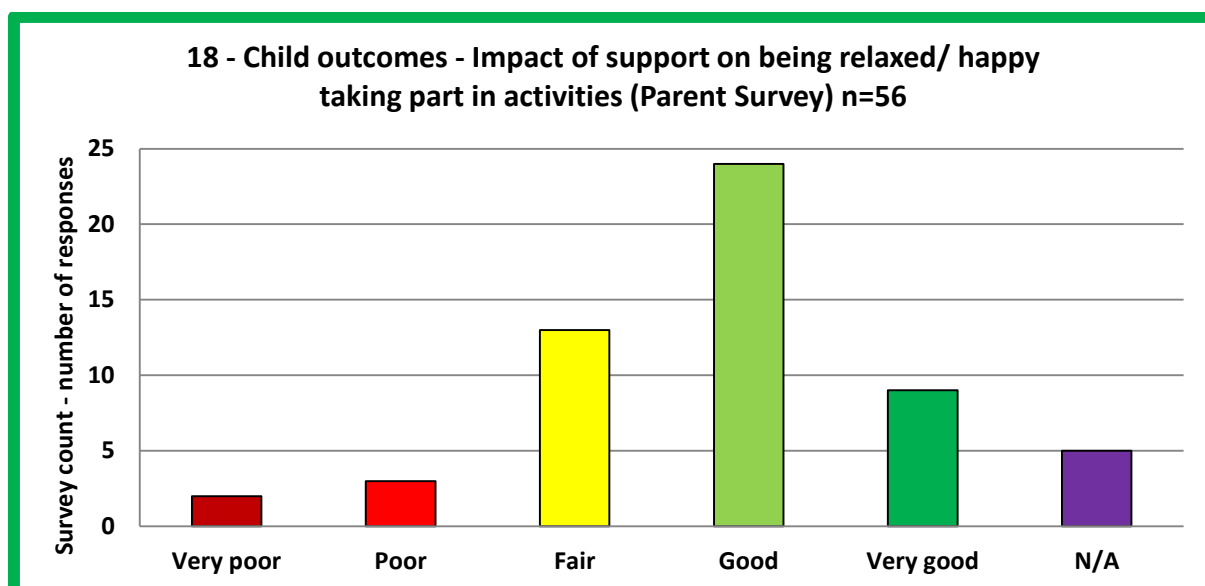


A similar, albeit stronger message is conveyed from the answers to the question about EHCP enabling a child to enjoy the relationship with their family as in figure 17.



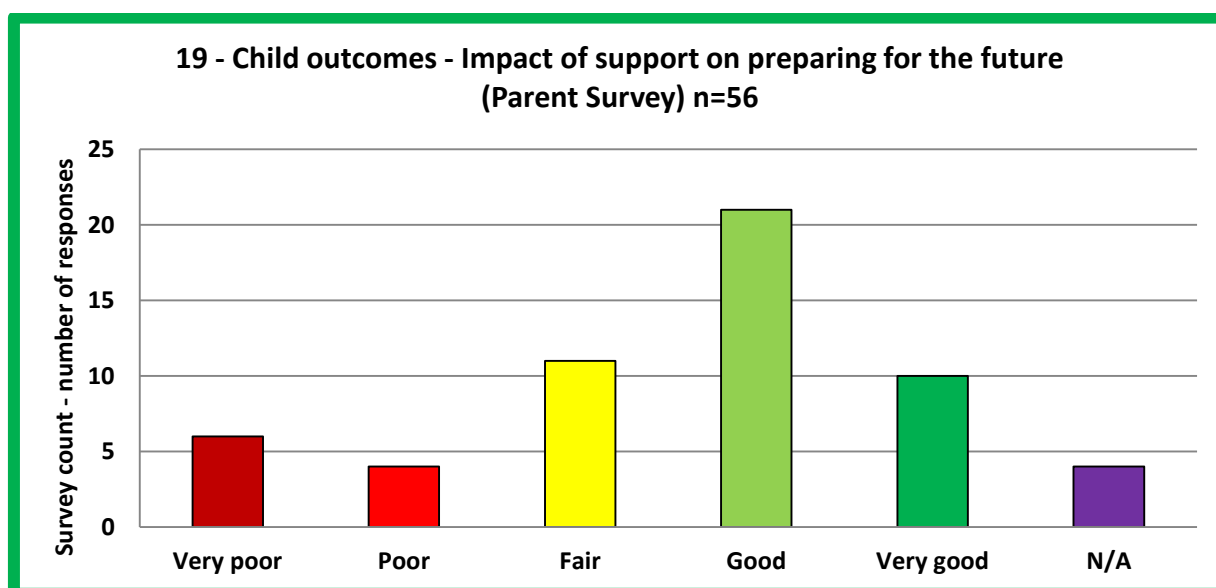
44 parents from the 56 answering this question felt that the EHCP had allowed the child to experience a better relationship within the family group. Given that when the reasons why children needed EHCP support were explored there were many instances of communication and interaction issues as well as 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.



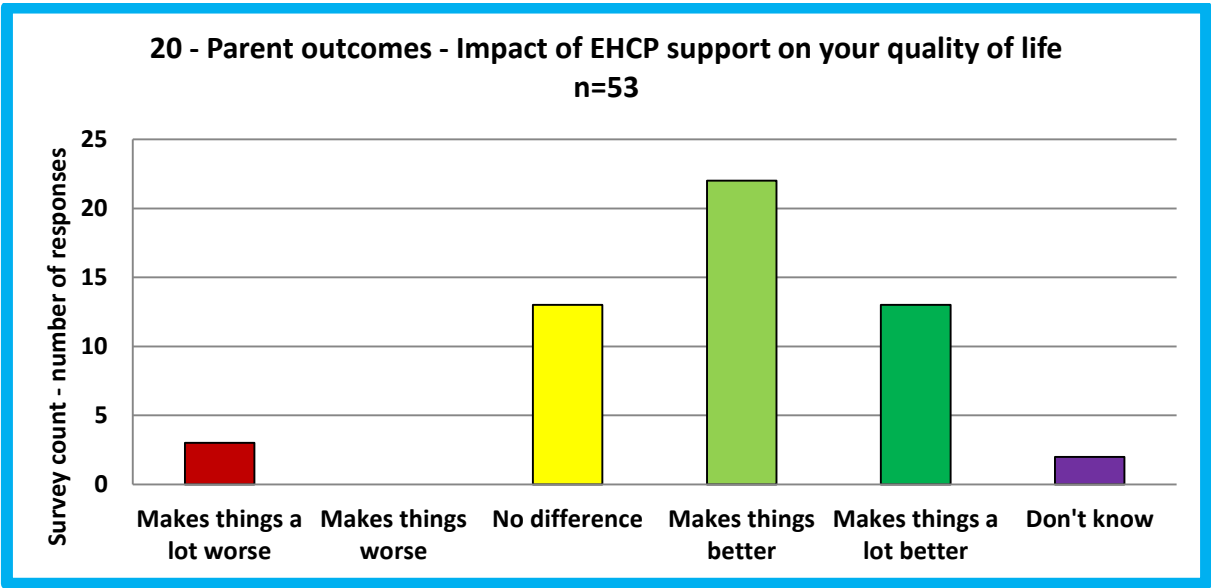
From this we can see that 46 of the 56 parent responses to the question indicated a positive view of EHCP in what is essentially a combination issue capturing social, mental and emotional wellbeing. Only 5 parents expressed a contrary view. Certainly from the evidence of this survey these wellbeing factors 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.

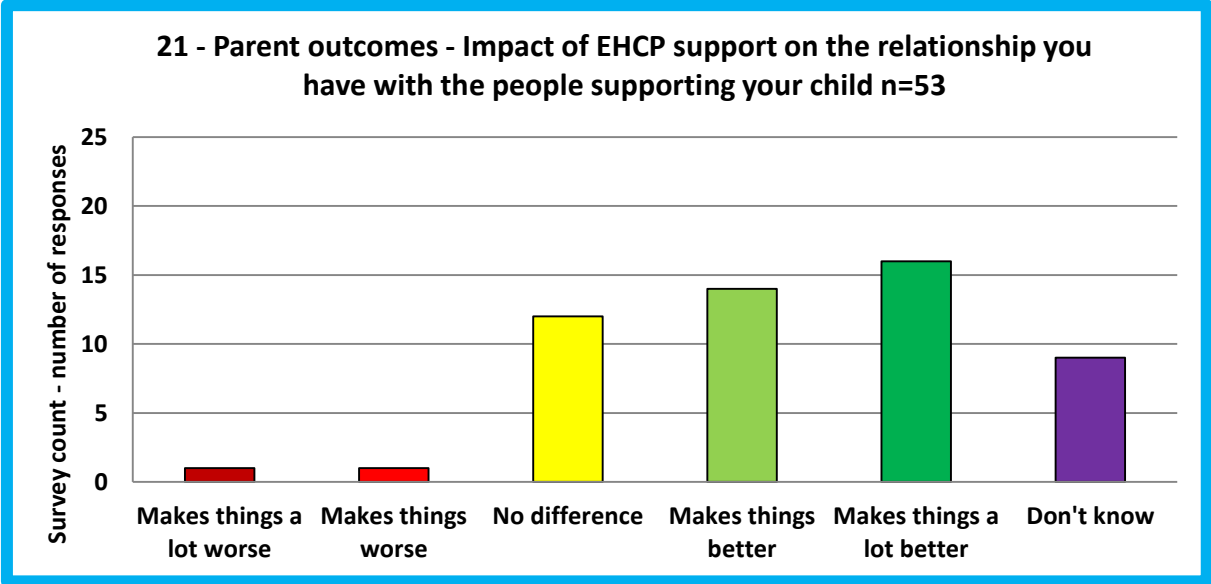


42 of the 56 parents in the survey group thought that the support underpinned by the EHCP was beneficial for preparing their child for their future life. 10 parents thought otherwise. Clearly EHCP have a definite future focus to them as they are all about setting and achieving goals, activities that 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

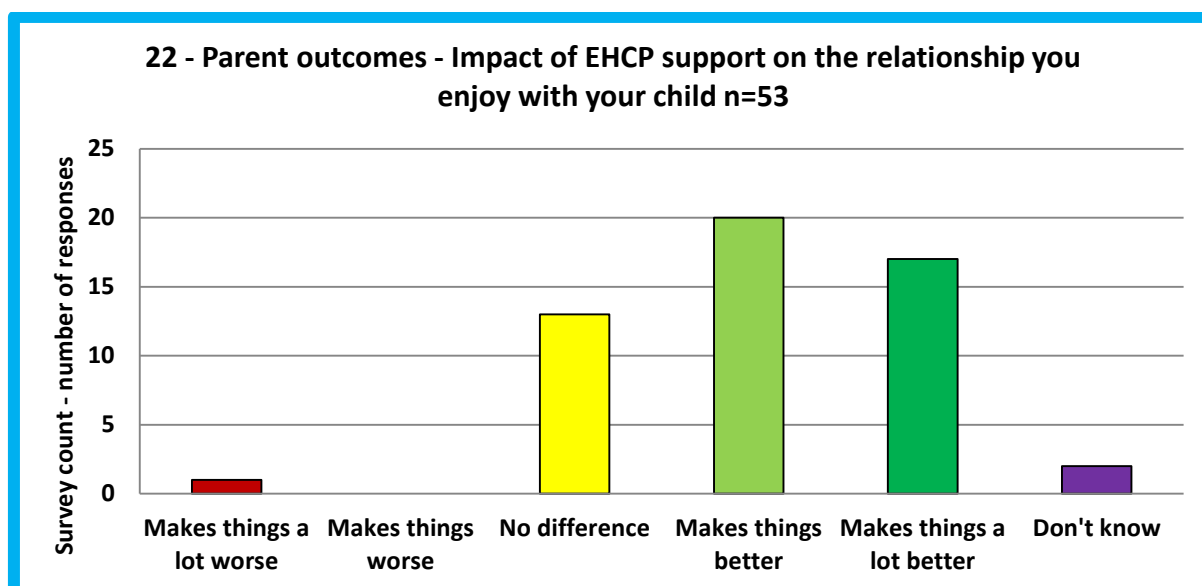
well. From our survey of 2016 we saw strongly positive messages emerging from parents as to how the EHCP was impacting on them as parents. The 3 parental outcomes on the POET® survey were explored again in 2017. The first question on parental outcomes focusses on a parent's quality of life. The results 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.

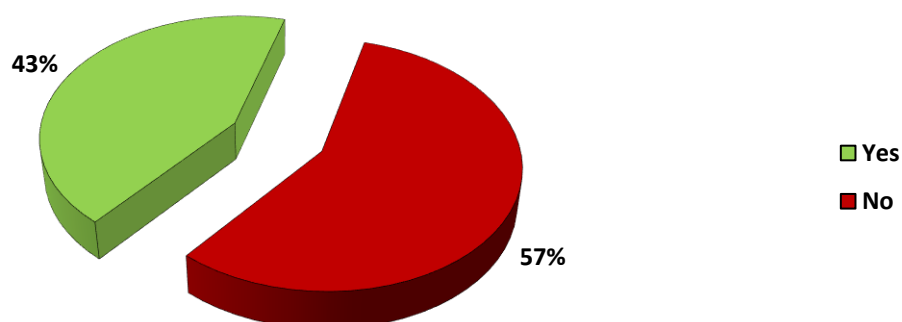
From an examination of the outcomes based questions in this survey we are seeing strongly positive messages emerging from parents that reinforce what we saw from the 2016 survey, albeit that we had a smaller pool of participants for last year's work.

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.

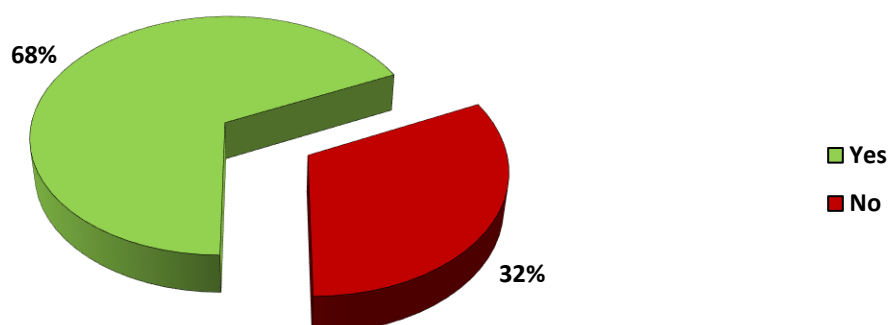
The intention was to examine in the first instance what the usage level of the local offer was amongst the parents taking part in the survey. Lack of use can indicate problems with communication (getting the message out there to those who could benefit). Secondly we wanted to identify, of those who had 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

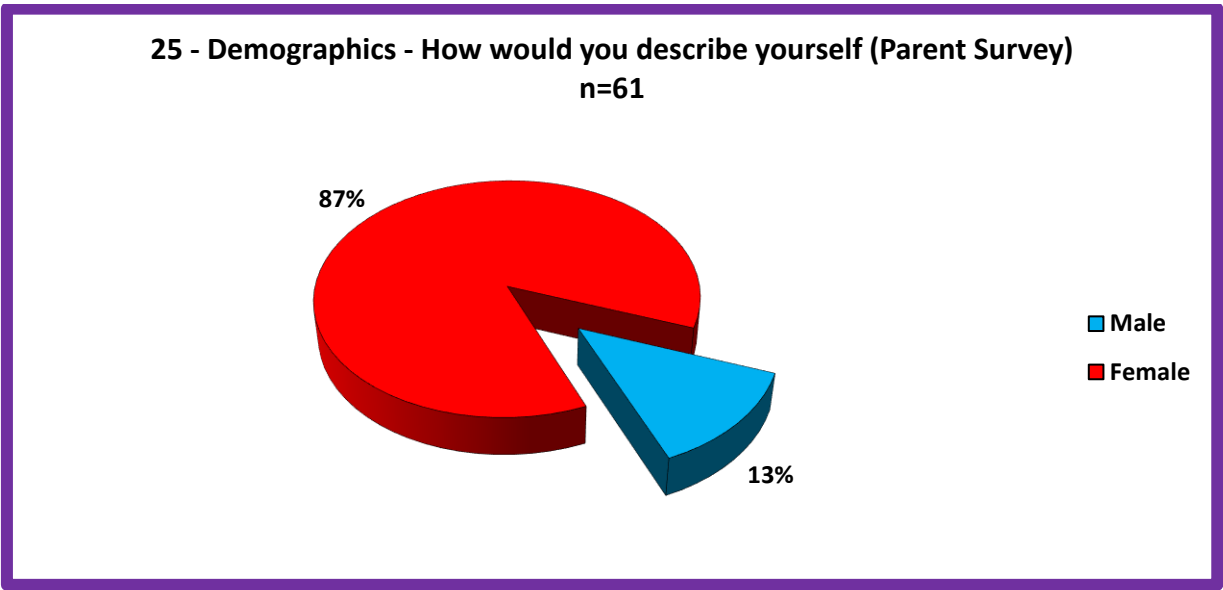


From the survey feedback we found that 58 parents had answered these questions. Of these, 25 parents had used the local offer to explore services that may be available which was 43% of the group. 33 parents had not used the local offer or 57% of those who had answered on this question. Therefore over 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.

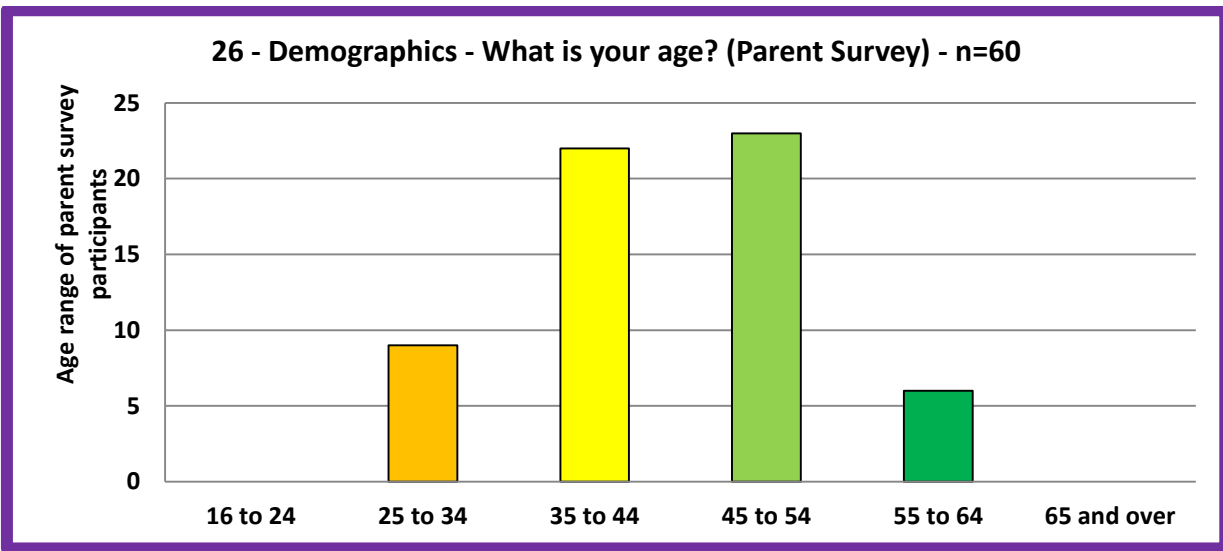
However, once we drill down into those who did use the local offer an altogether different picture emerges. Of the pool of 25 parents who had used the local offer 17 parents indicated that they had found what they were looking for which was 68% of the local offer users with only 8 not locating useful 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.



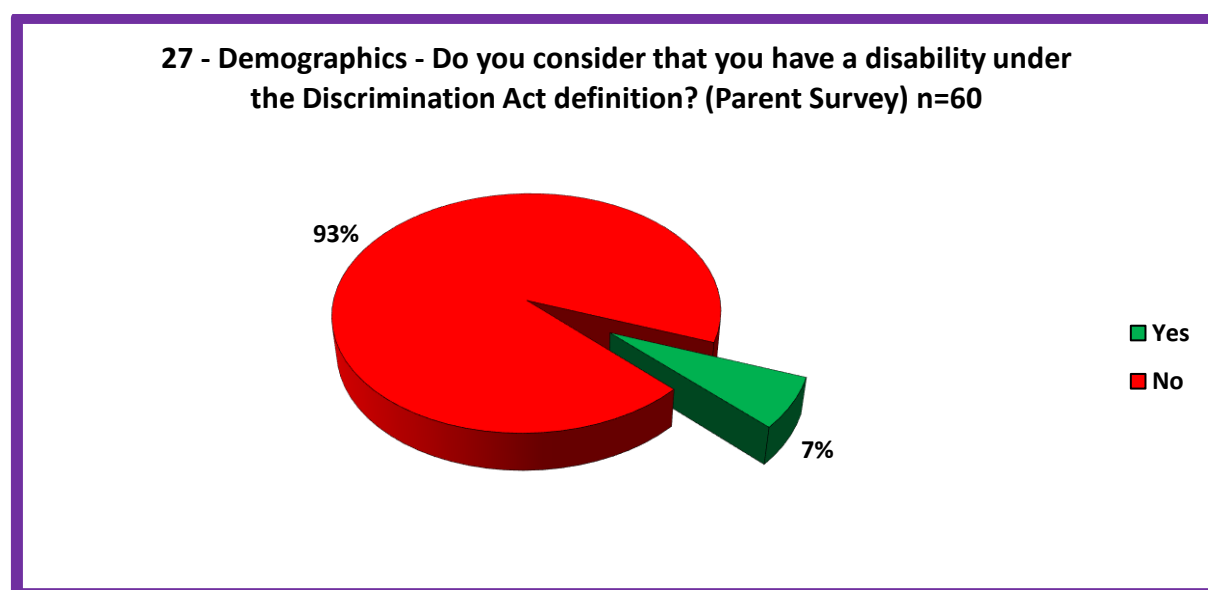
So we see that 13% of survey respondents answering this question were male (or 8 fathers) with the remaining 87% being female (or 53 mothers).



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,

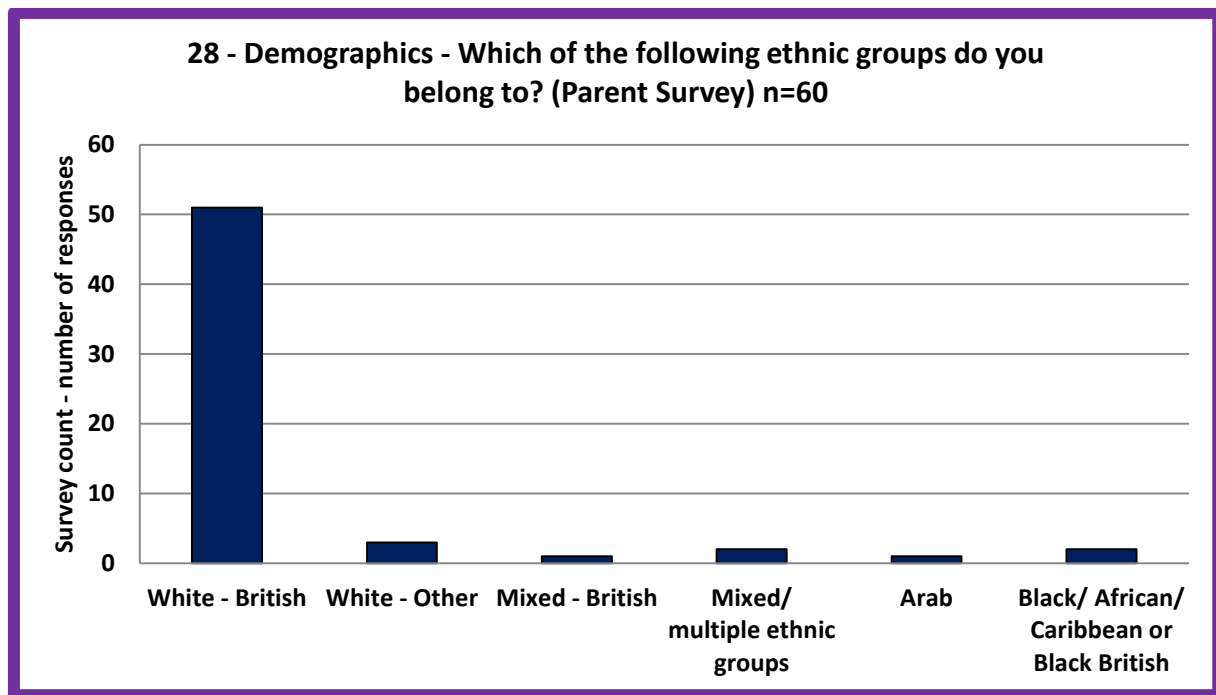
25 to 34, 35 to 44, 45 to 54, 55 to 64 and the over 65s. The results from this question are shown in figure 26. What we can see immediately from this is that 75% of parents who answered this question were aged between 35 and 54 with the remainder aged either between 25 and 34 or 55 and 64. What we do 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?

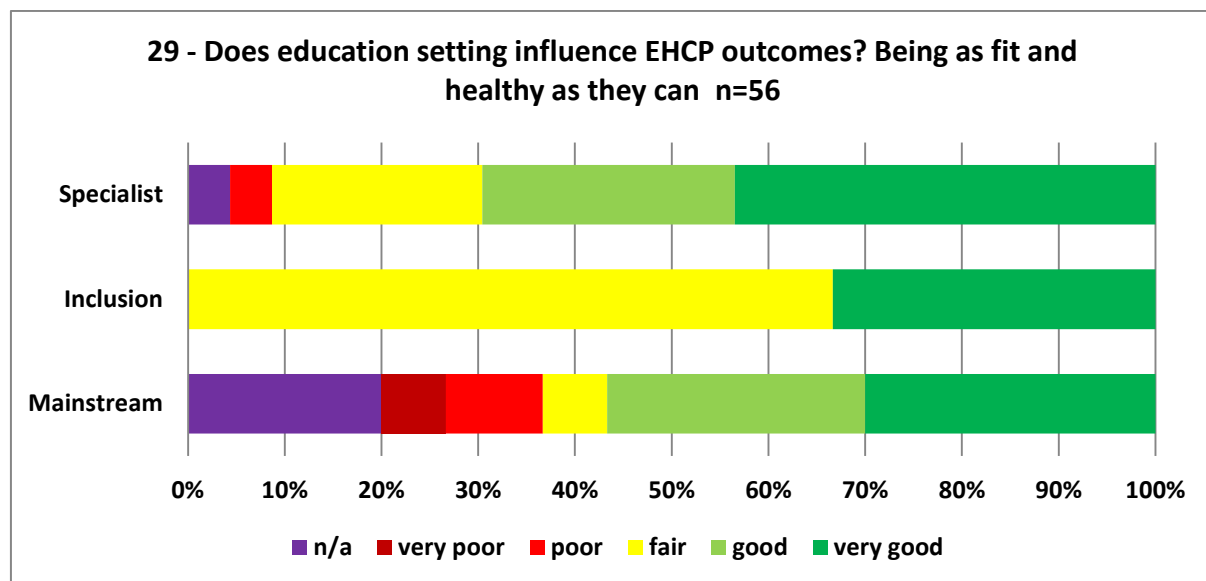


Figure 29 shows the proportion of each response to the outcome question relating to children being as fit and healthy as they can be when read against the options for educational setting. While all the education settings seem to give a positive answer to this question it is in specialist schools where 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.

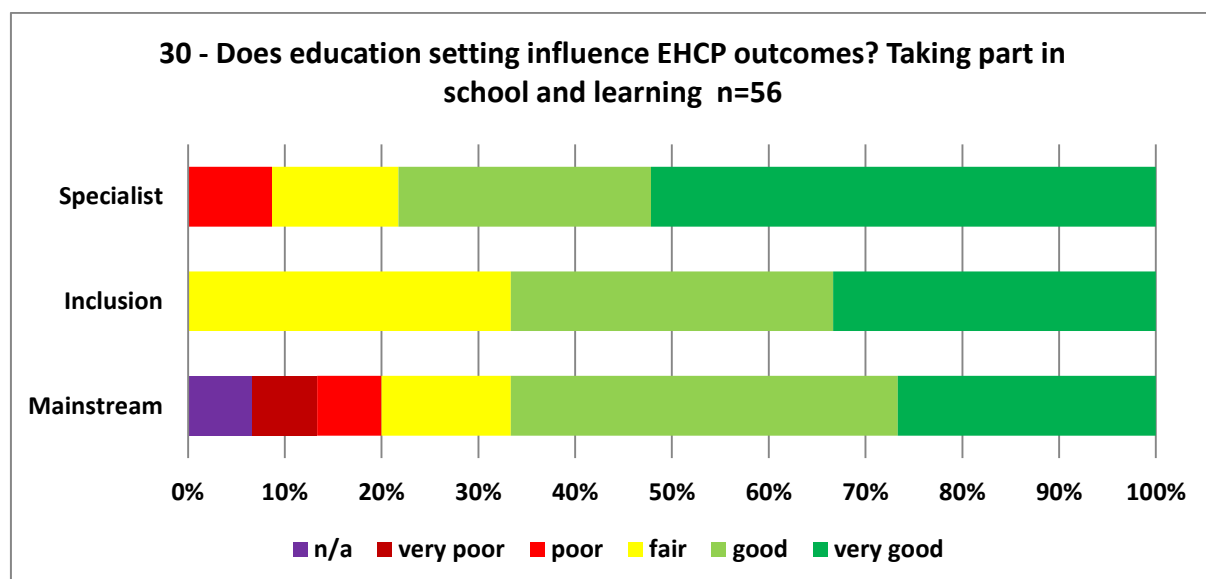


Figure 30 shows this proportion on the question relating to taking part in school and learning. Again all the settings produce a positive answer and, again, specialist schools appear to be the setting where the greater proportion of parents are indicating that the EHCP is positively influencing their child's ability to take part in school and learning.

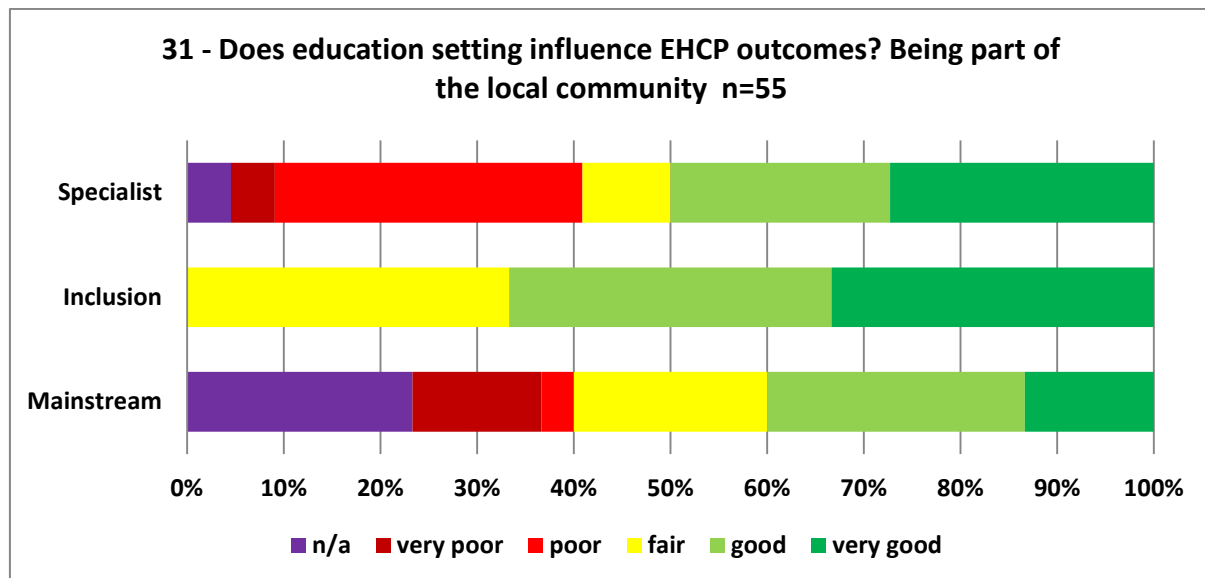
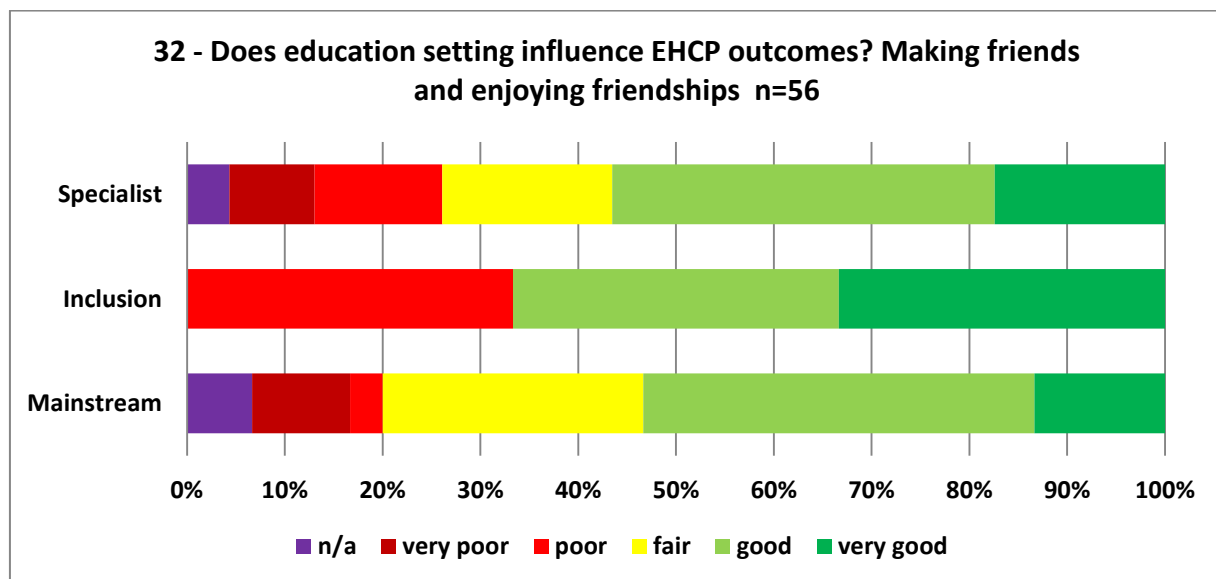
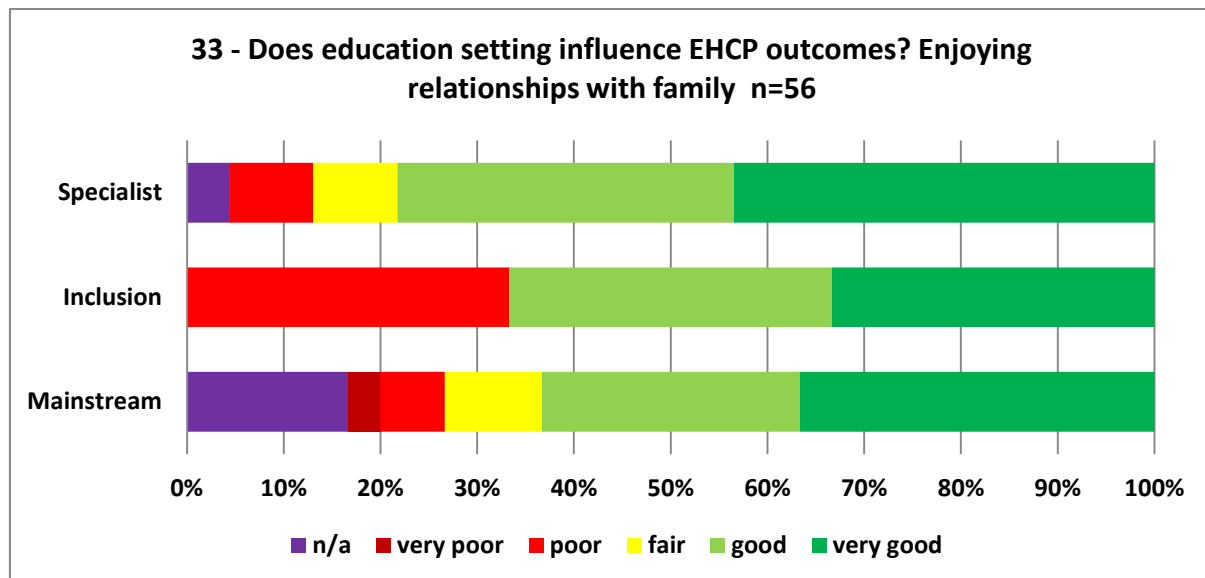


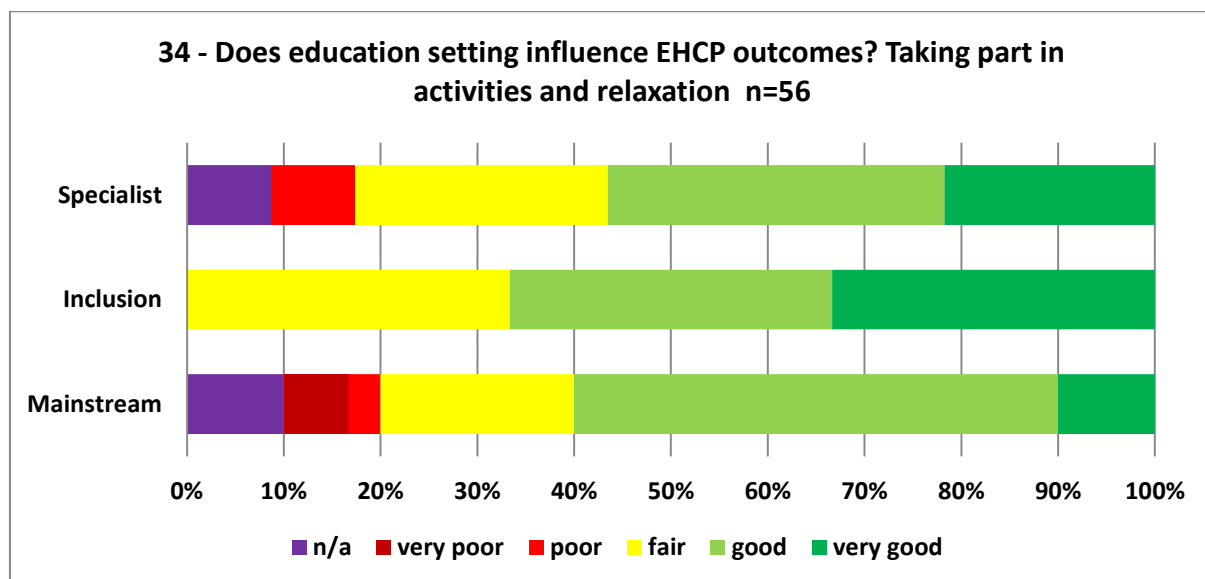
Figure 31, regarding community involvement, shows that the highest proportion of parents indicating a positive outcome were where their child attended an inclusion centre attached to a mainstream school. Conversely the highest proportion of dissatisfaction emerged from specialist schools although, in spite of this, specialist schools still had a higher proportion of outright approval on this matter than mainstream schools.



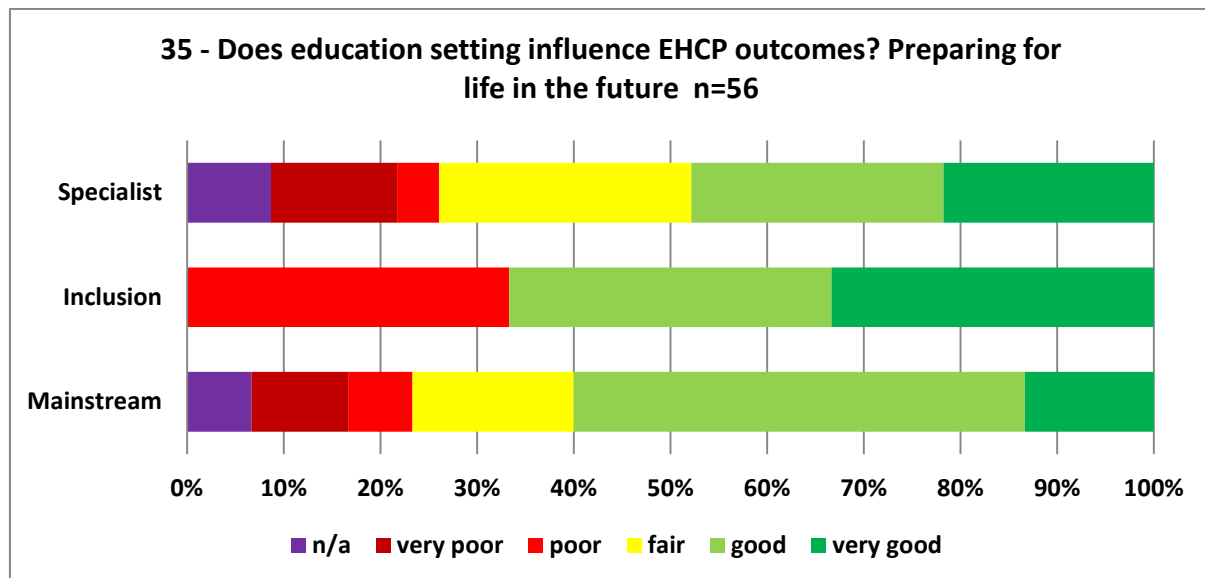
From figure 32 we see that inclusion centres attached to mainstream schools show a higher proportion of positive outcomes reported when examining how EHCP influence a child making and maintaining friendships. There is also no middle ground as the highest proportion of dissatisfaction is also reported 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.

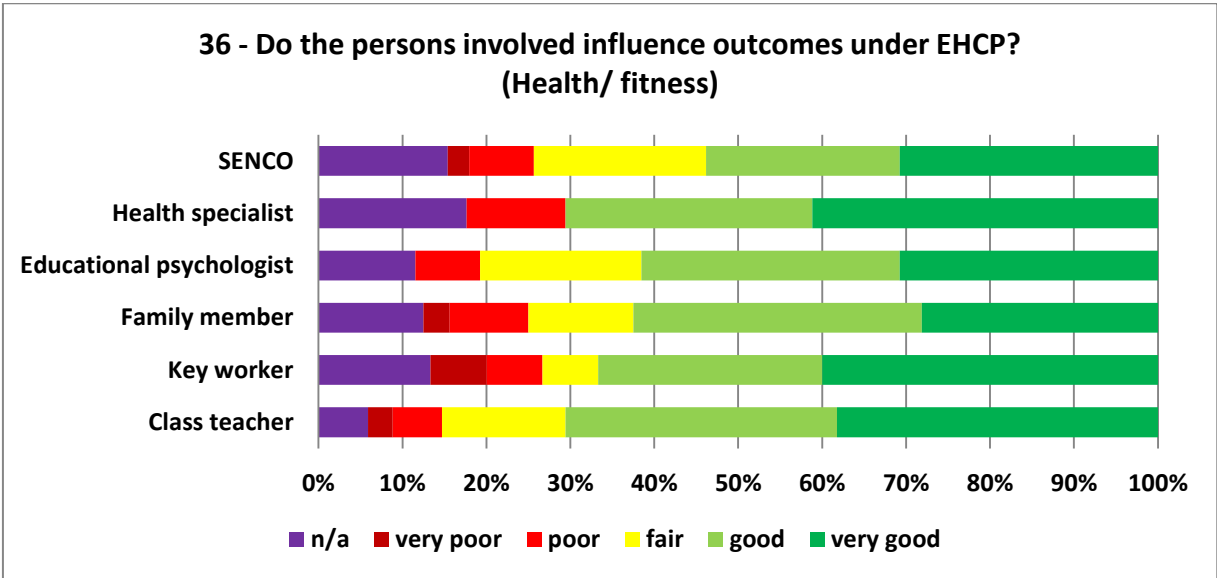


Lastly we examine the EHCP outcome around preparation for a child's future. In parental feedback on this question we see the highest proportion of positive outcomes for parents reporting on children in inclusion centres. Counter to this we also see the highest proportion of parents expressing a negative view in this respect. Again we see the positive outcomes proportions favour mainstream schools compared to specialist schools based on parent feedback.

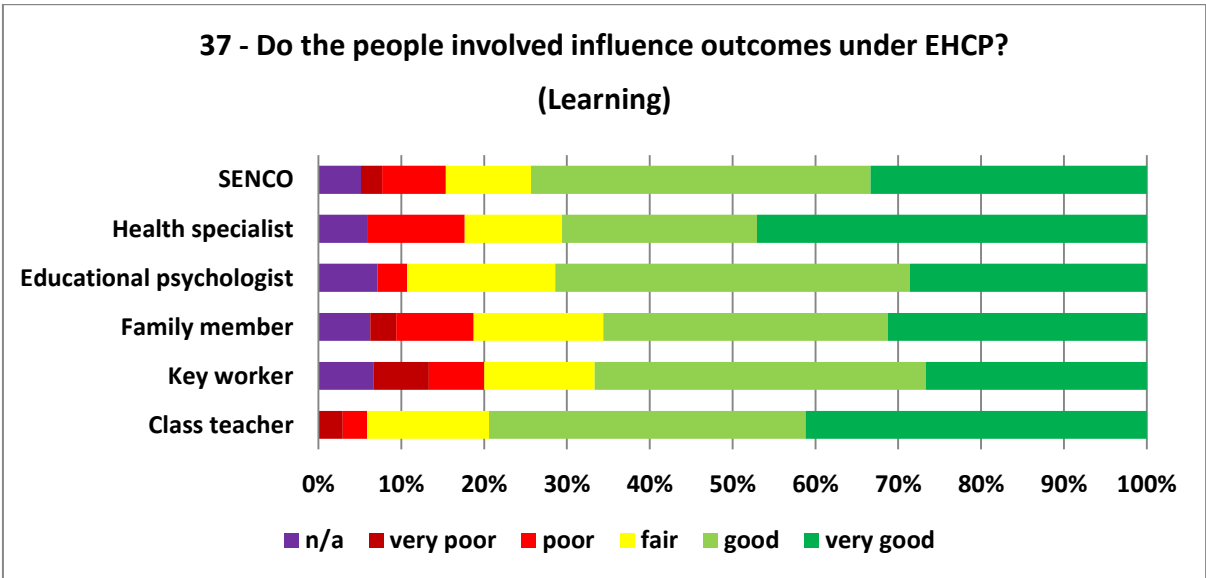
What we learn from this is that there does seem to be some influence being exerted by the educational setting on a child's outcomes as reported by their parent. This depends on the nature of the outcome being explored and the starting position of the child concerned. Specialist schools tend to show best 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.

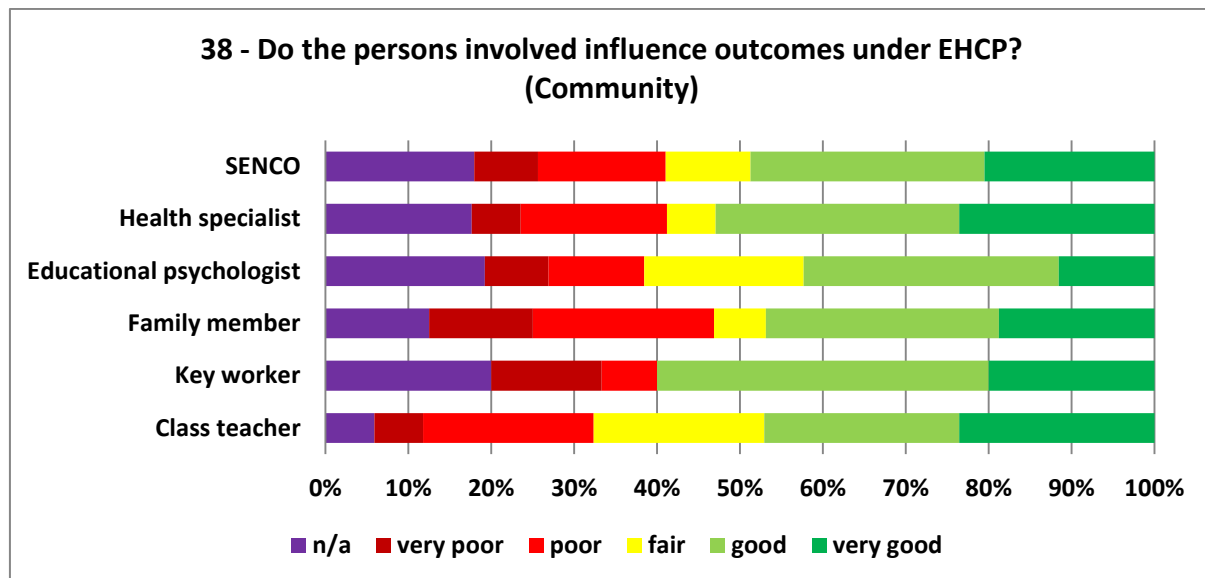
Question 2 - Do the people involved in the care and support planning influence a child's outcomes under EHCP?



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.

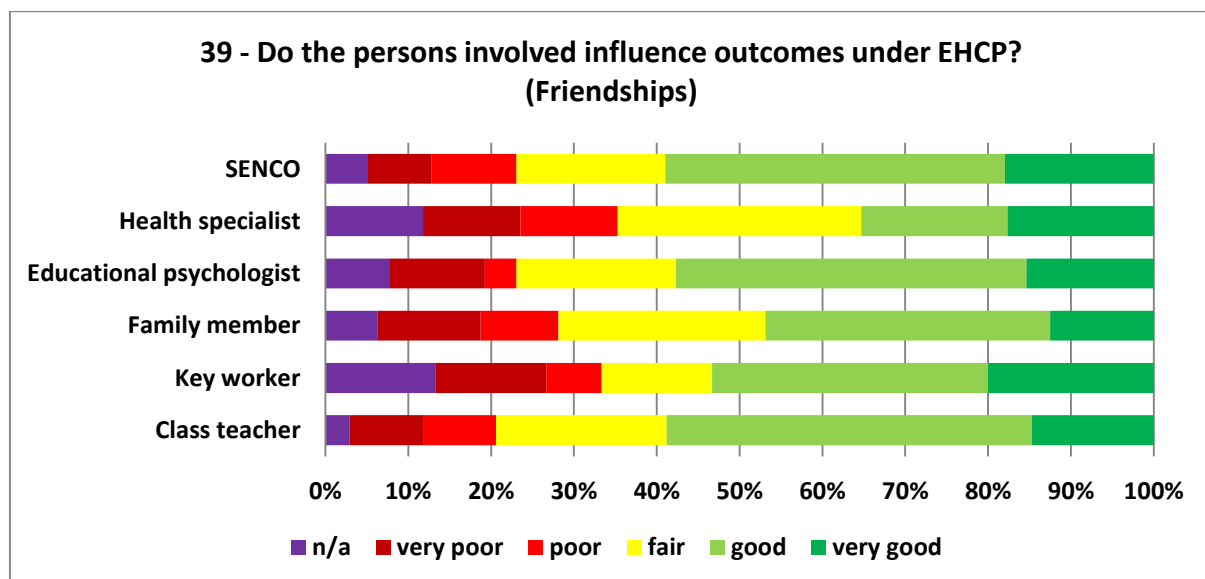
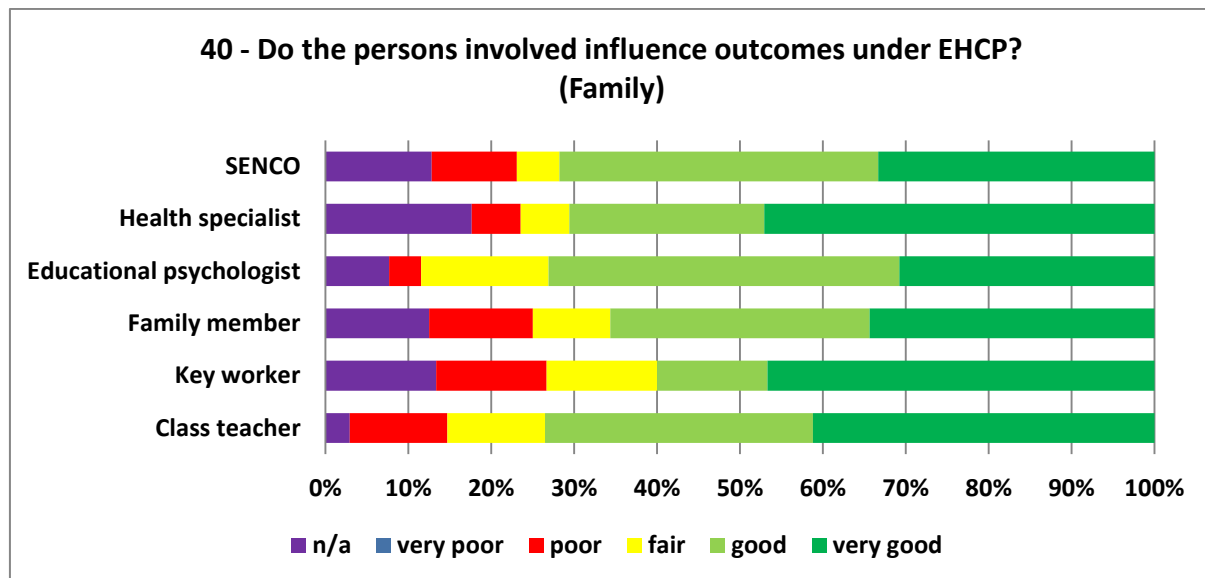
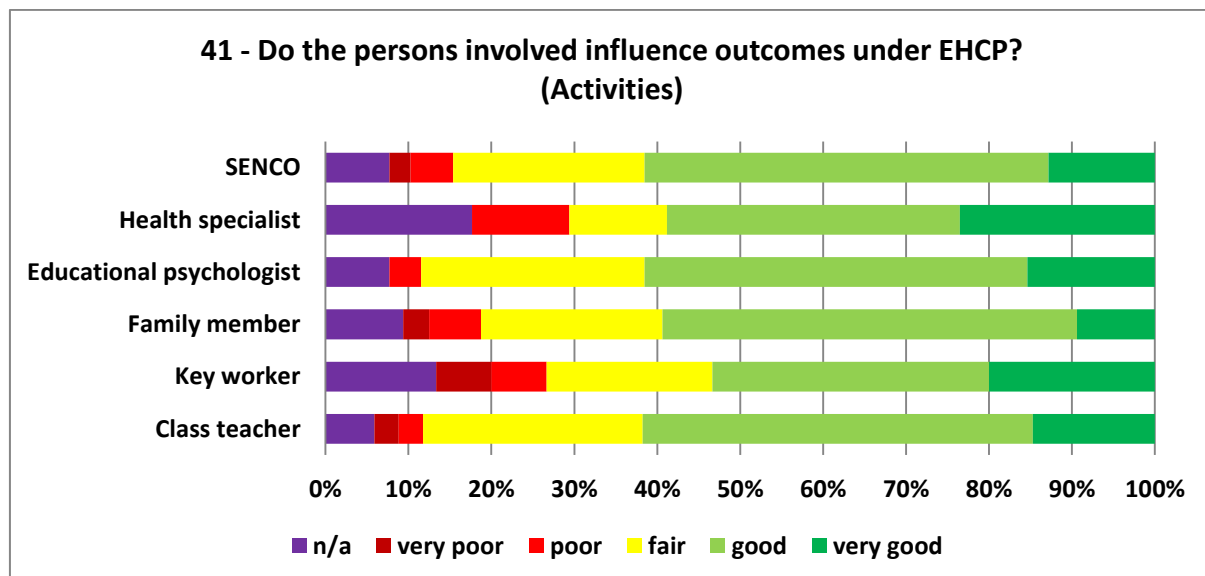


Figure 39 describes another clear positive outcomes picture for making and maintaining friendships where the education specialists tended to show best of the people/ professionals involved in EHCP processes. As most children will make friends at school, by working to make a more conducive environment 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.

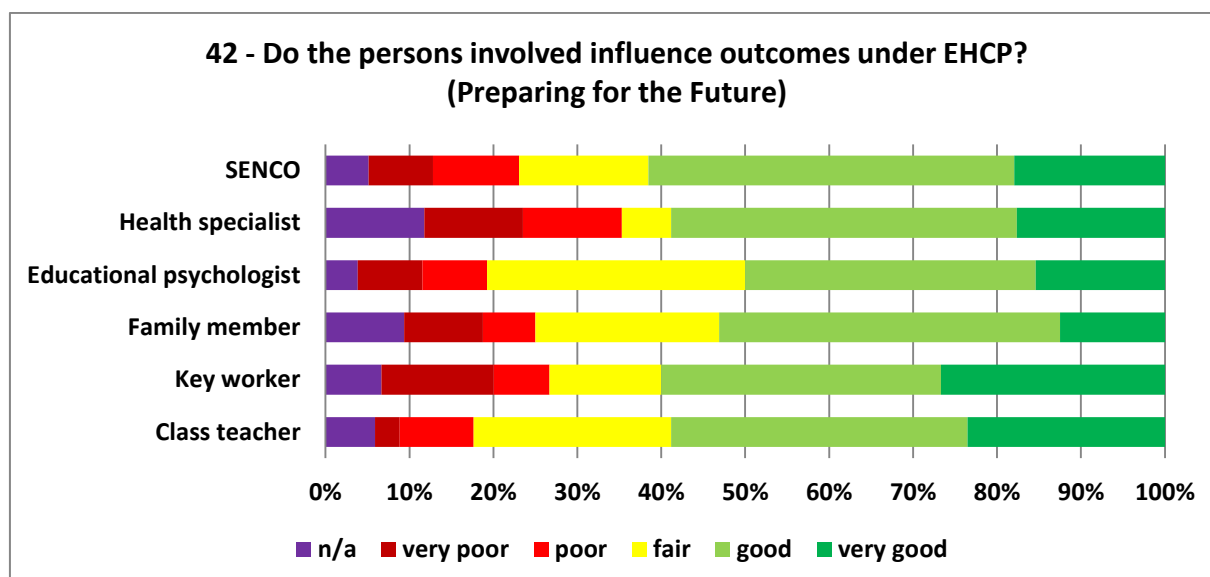
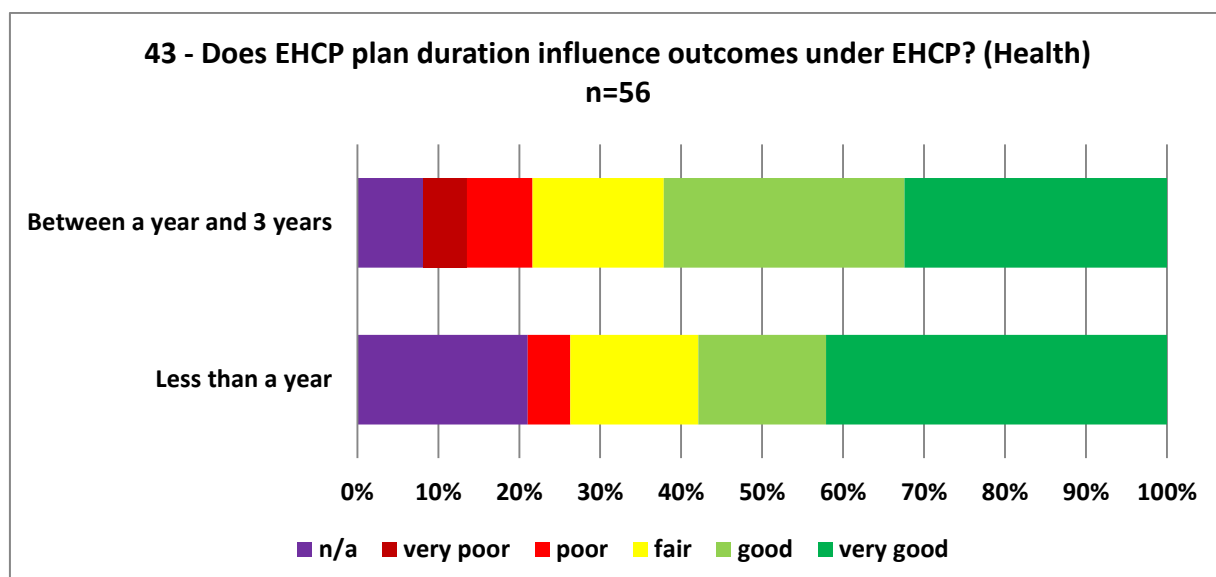


Figure 42 describes a more balanced picture looking at the influence of people/ professionals on outcomes around preparing for the future. The three key figures in this are the SENCO (education focus), Health Specialist (health) and the Key worker (Social Care) as these 3 show the highest link to positive 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.

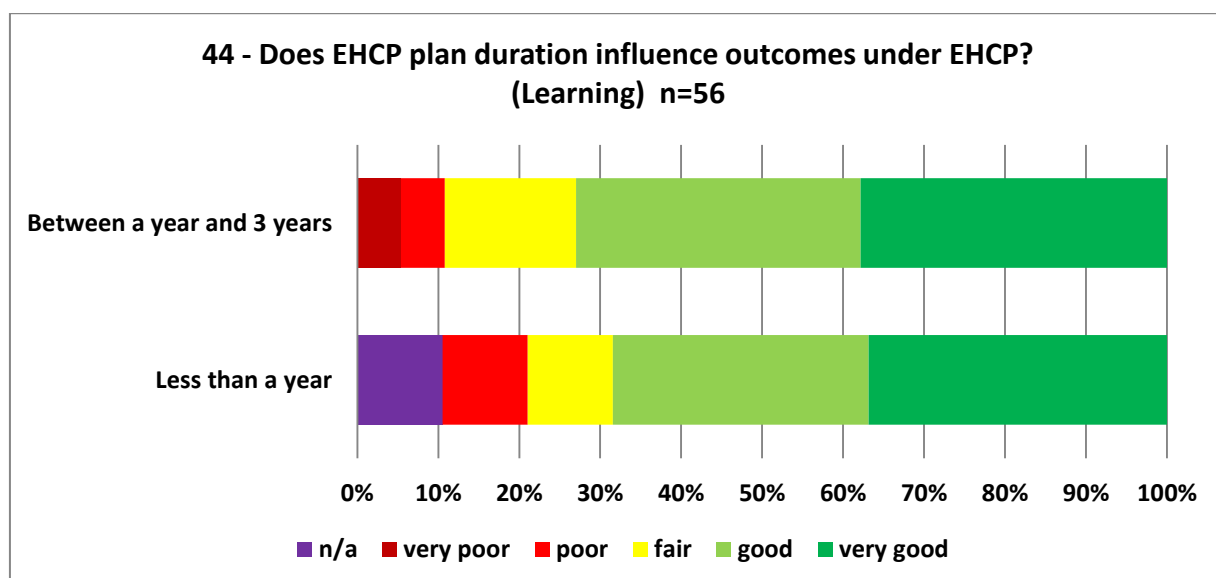
From this examination of children's outcomes, as reported by their parents, there does appear to be a clear link between their outcomes and those individuals involved in the care and support planning processes. In the main these links are fairly self-explanatory with the health based outcome showing 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.

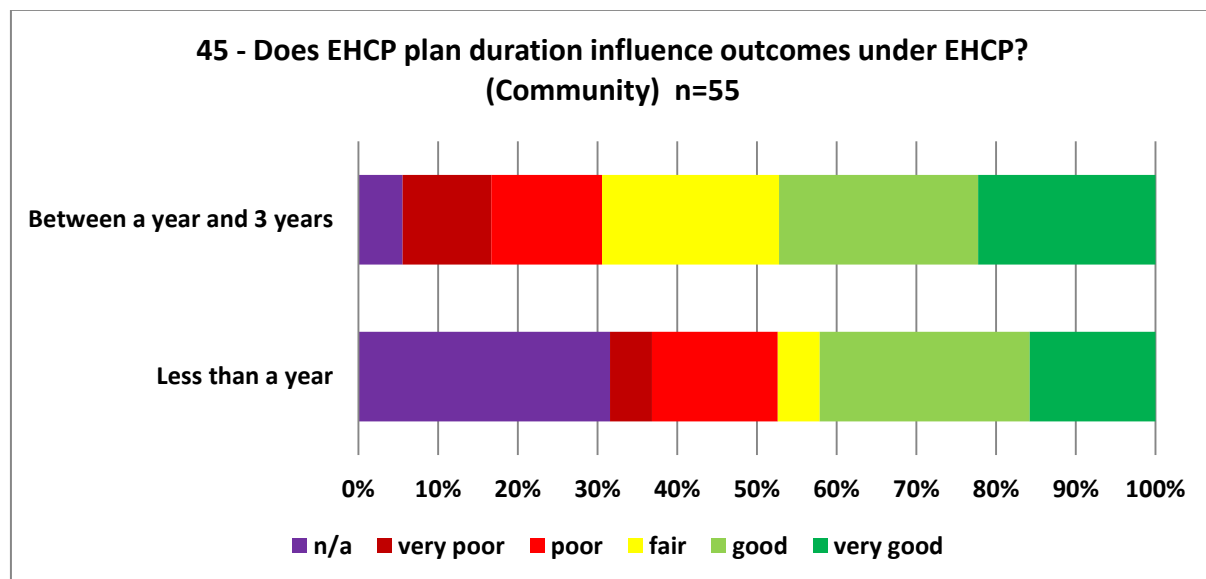
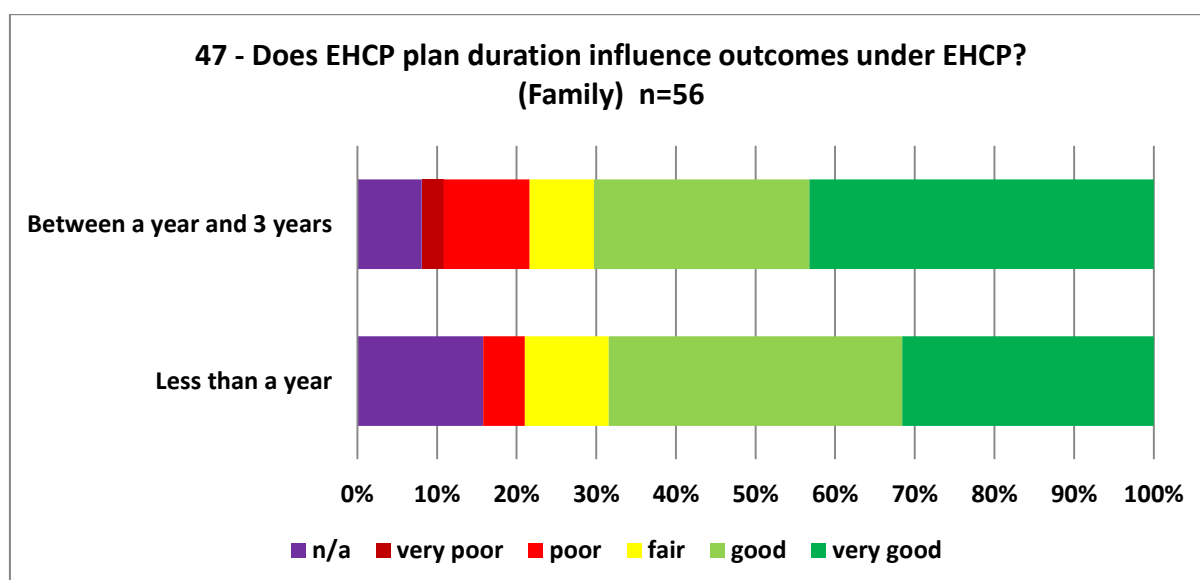
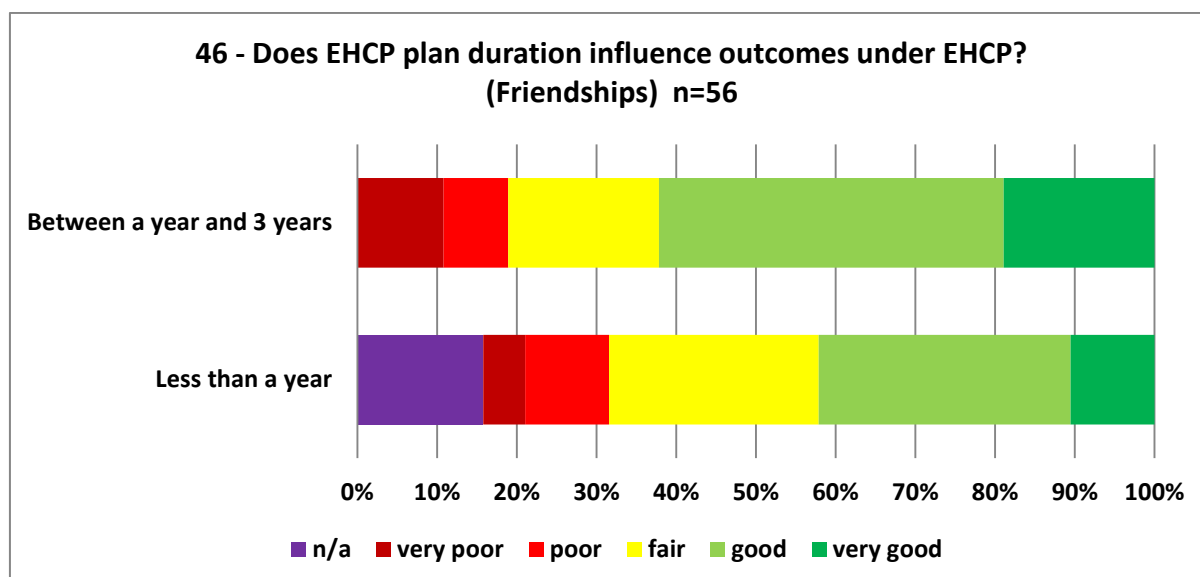


Figure 45 shows a weaker set of positive outcomes when looking at EHCP duration influencing children's community outcomes. The most positive outcomes are not in the majority for newer plans or for plans that are over a year old although there are a higher proportion of the positive outcomes for older 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.

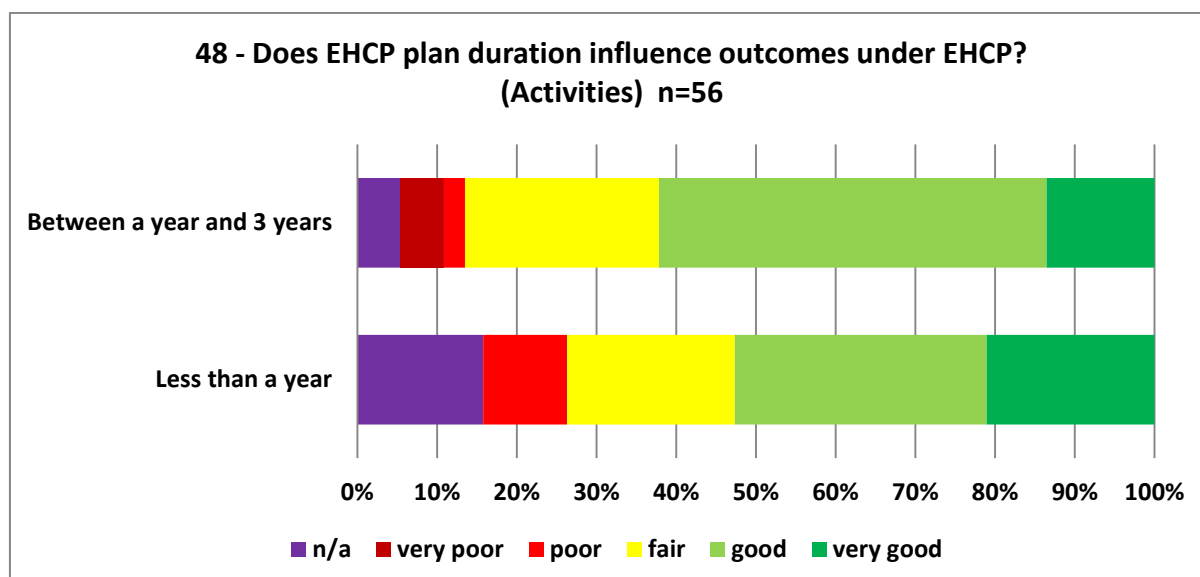
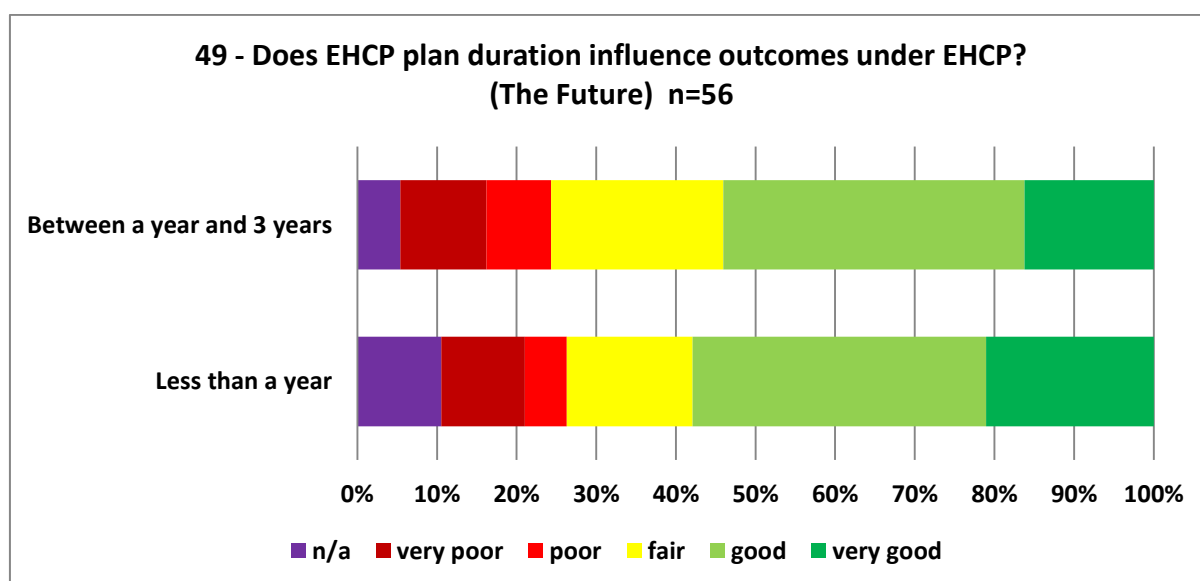


Figure 48 shows the relationship between EHCP duration and activities based outcomes. Once more we see the pattern of the proportion of the more positive outcomes increasing as the plan gets older. This is likely due to similar reasons that were explored in the community based outcomes we have already 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

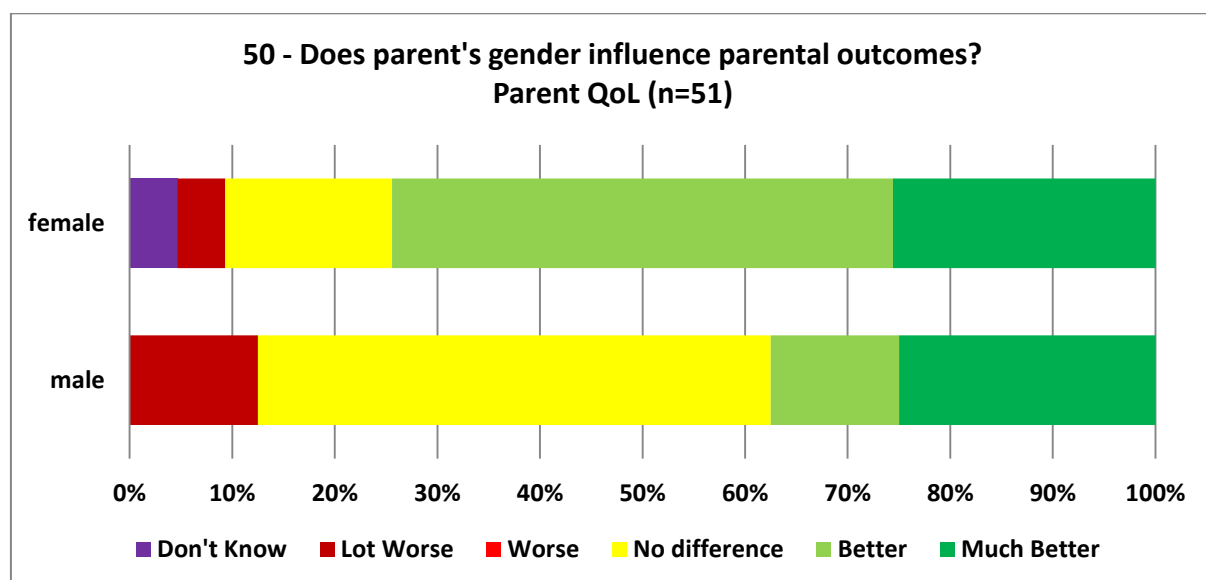
changes as these may not be necessary. This may explain why the proportion of the more positive outcomes declines over time on this outcome measure.

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.

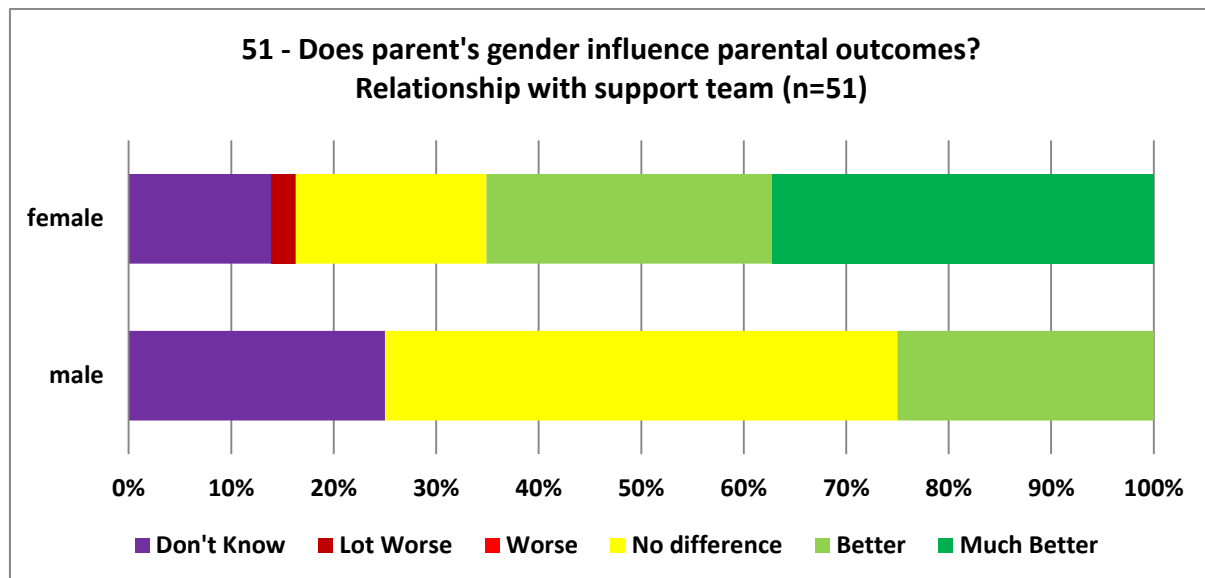
Question 4 - Does the parent's gender influence parental outcomes under EHCP?

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.



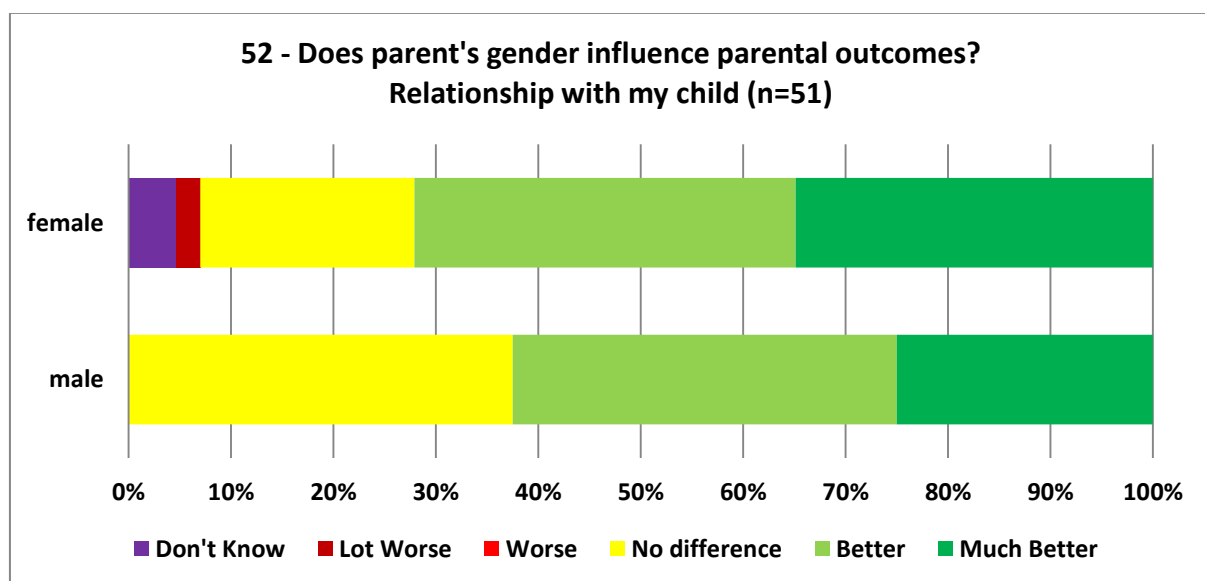
A clear result is shown in that around twice as many mothers report positive quality of life outcomes as fathers do although the proportion reporting the best outcomes is roughly the same.

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.

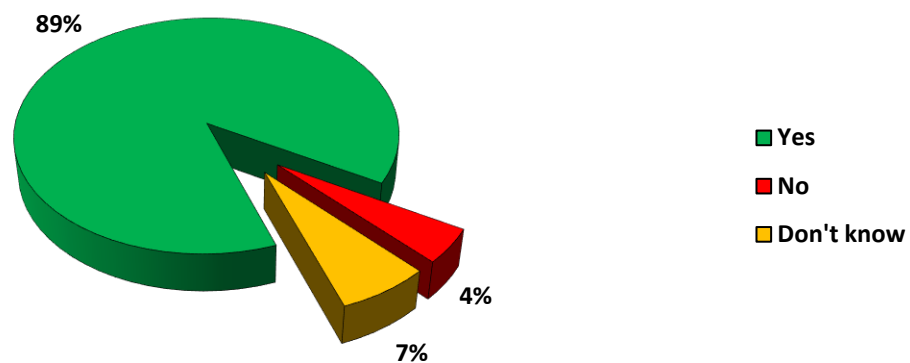
It would seem on the face of it that mothers appear to report better parental quality of life outcomes compared to fathers across the board on the 3 specific parent outcomes measures used by POET®. The difference is particularly strong when parents report on their quality of life and how well they are 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

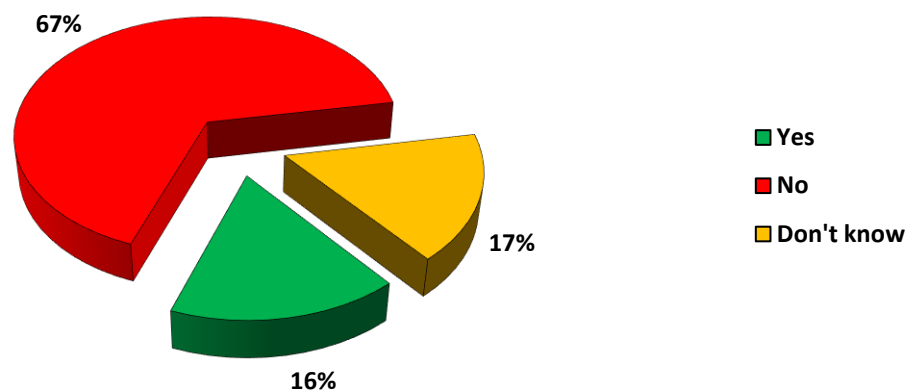
When examining the feedback from the POET children's "with EHCP" survey we were encouraged by the sharp rise in participation, up from 7 in 2016 to 44 in 2017. In the first instance we wanted to gauge what proportion of children taking part had an EHCP. The results can be seen in figure 53.

**53 - Do you have an Education, Health and Care Plan?
(Child Survey) n=44**



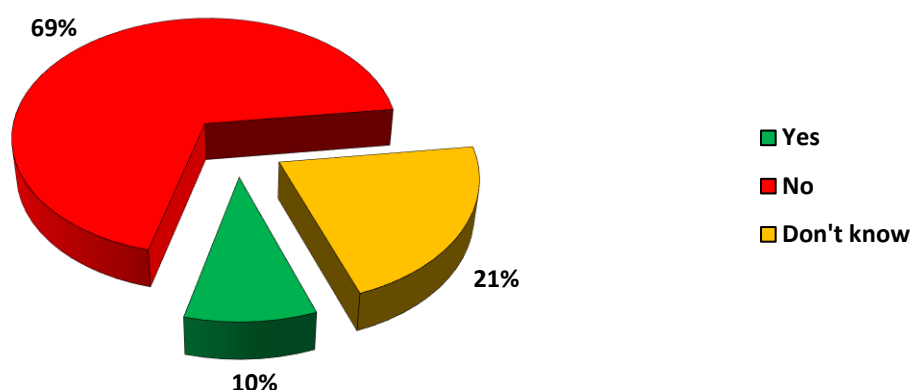
Due to the very young age of some of the survey participants some deviation from 100% on the yes answer is to be expected. The overwhelming majority however do report having an EHCP. We also wanted to examine what other support children were aware that they were receiving. The first of these is the support 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**



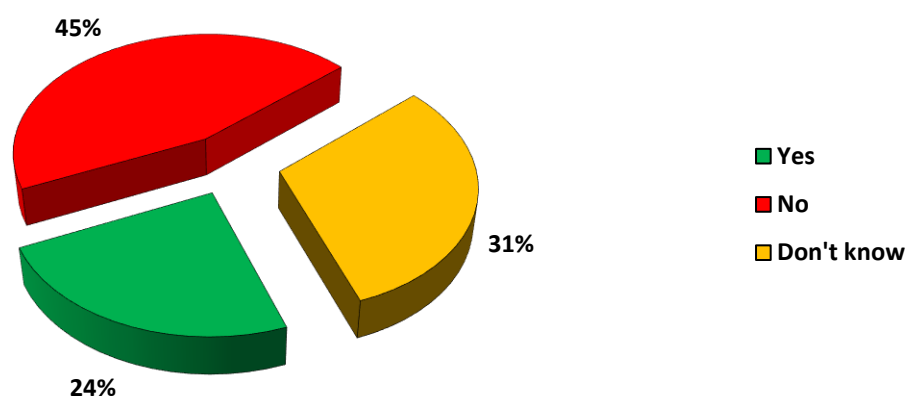
This produced a majority answer for no personal budget although 7 answers from the children's survey indicated that they thought that they did. It is very difficult to ascertain if parents or children fully understand what is meant by a personal budget given the generic question the survey asks children 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.

55 - Do you have additional/paid support at home?
(Child Survey) n=42

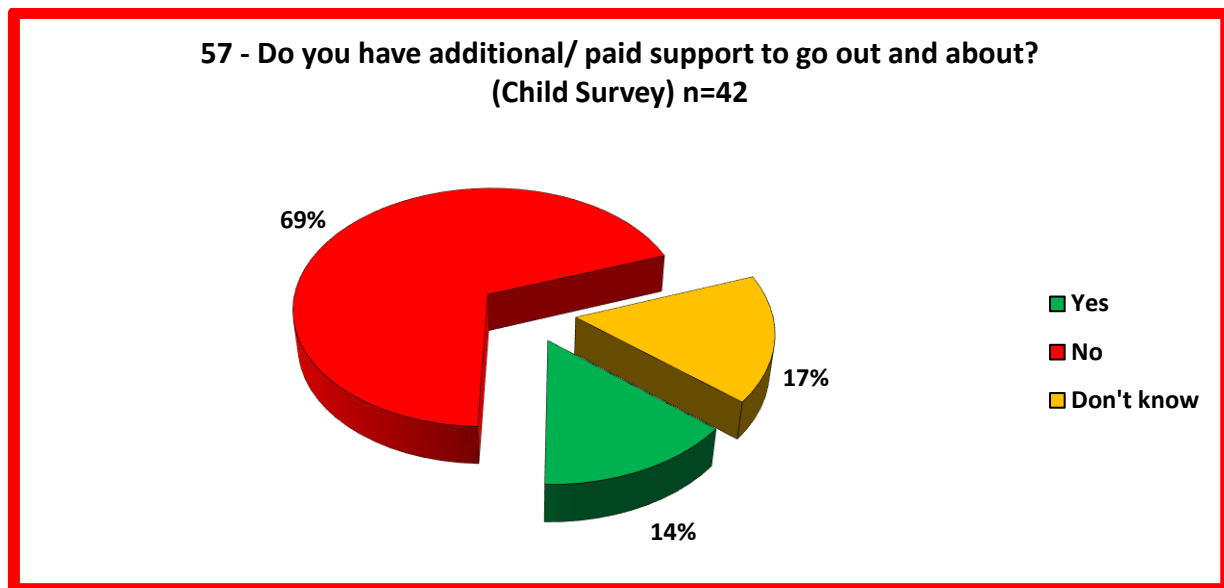


Only a relatively small number of children report that they receive support at home (4 out of 42) with the majority saying they do not receive such assistance. This pattern is somewhat different for children reporting on getting support at school. This is shown in figure 56.

56 - Do you have additional/ paid support at school?
(Child Survey) n=42



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.

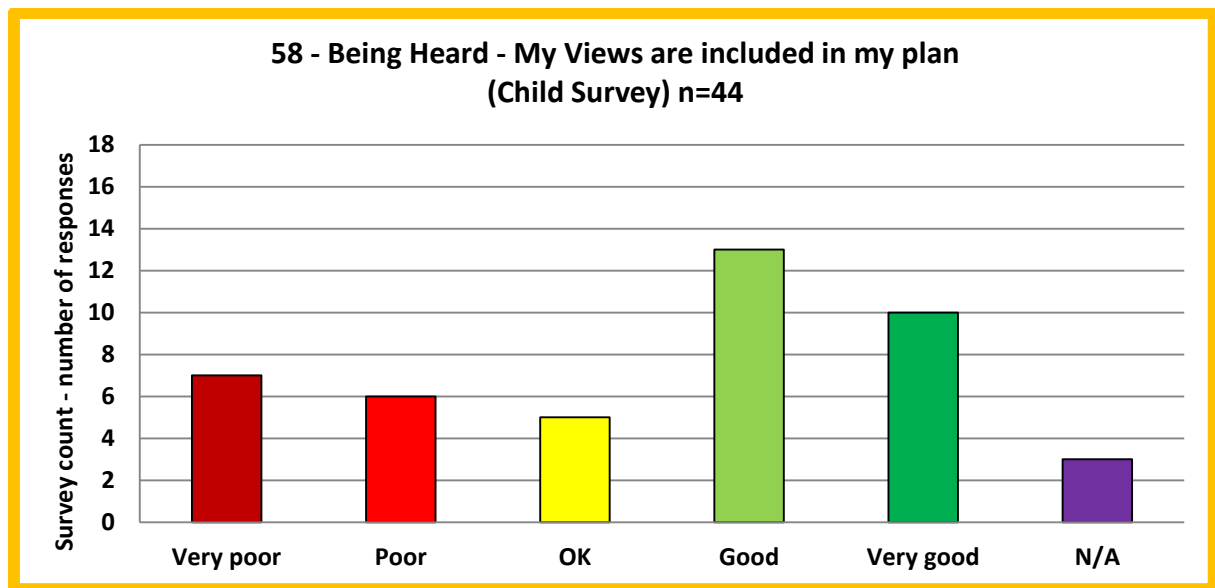


Again we see only a small proportion replying yes to this question (6 out of 42) and the majority replying no.

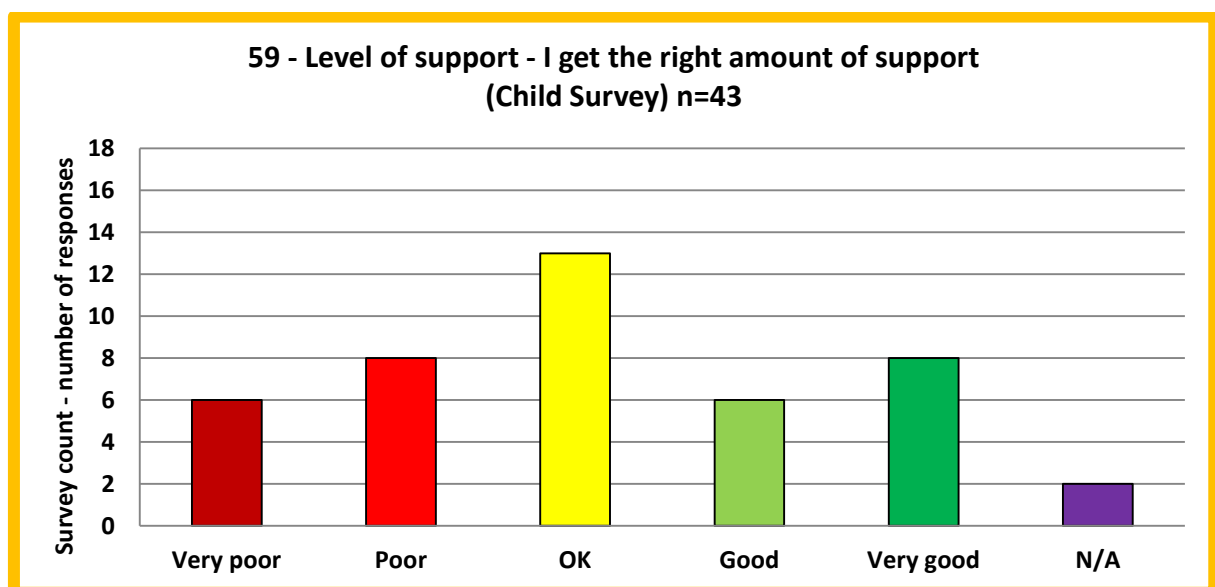
What this tells us is that although most of the children participating in the survey have got help and support through an EHCP, this focusses on matters that are relatively intangible (organisation and planning behind the scenes) within the classroom. A higher incidence of paid support in the educational 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.

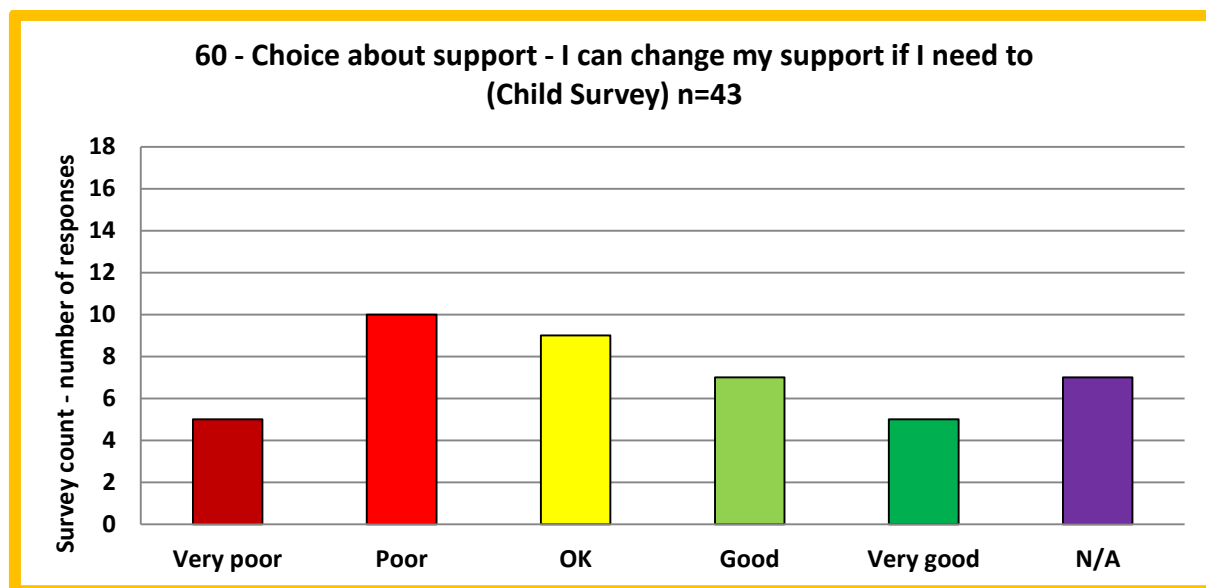


Next the children were asked about whether they felt they were getting the right amount of support. The results are shown in figure 59.



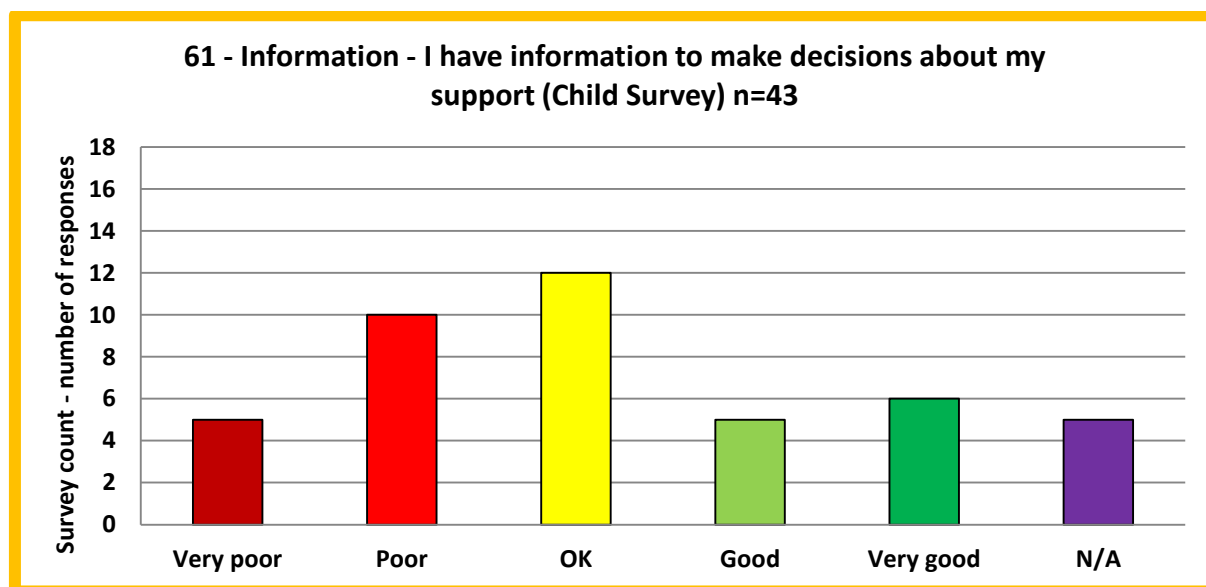
This produced a very balanced cross section. The same number of children gave positive answers (14 out of 43), indicating they felt the amount of support was right for them, as gave negative answers, highlighting that they felt there was insufficient (or, possibly, too much) support. Coupled with this 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.



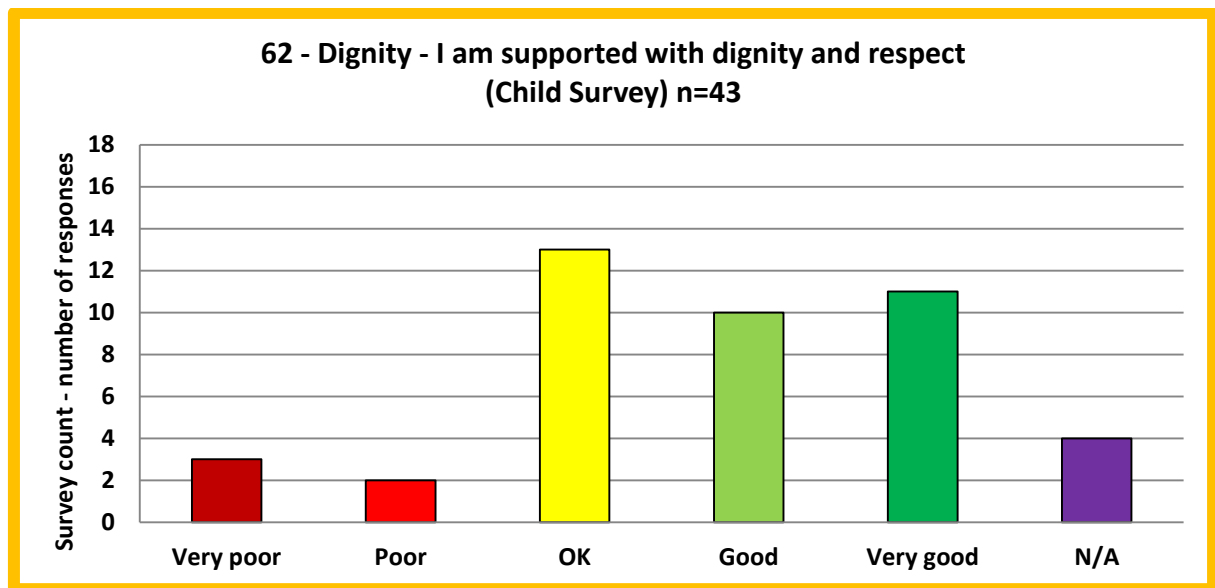
Here we see, after a relatively positive start, that children indicating the negative answer (15 out of 43) outweigh those who felt more positive on this issue (12 out of 43) although this is not the majority position.

Next we investigated whether children felt whether they had enough information to inform their decision making, results of which are shown in figure 61.



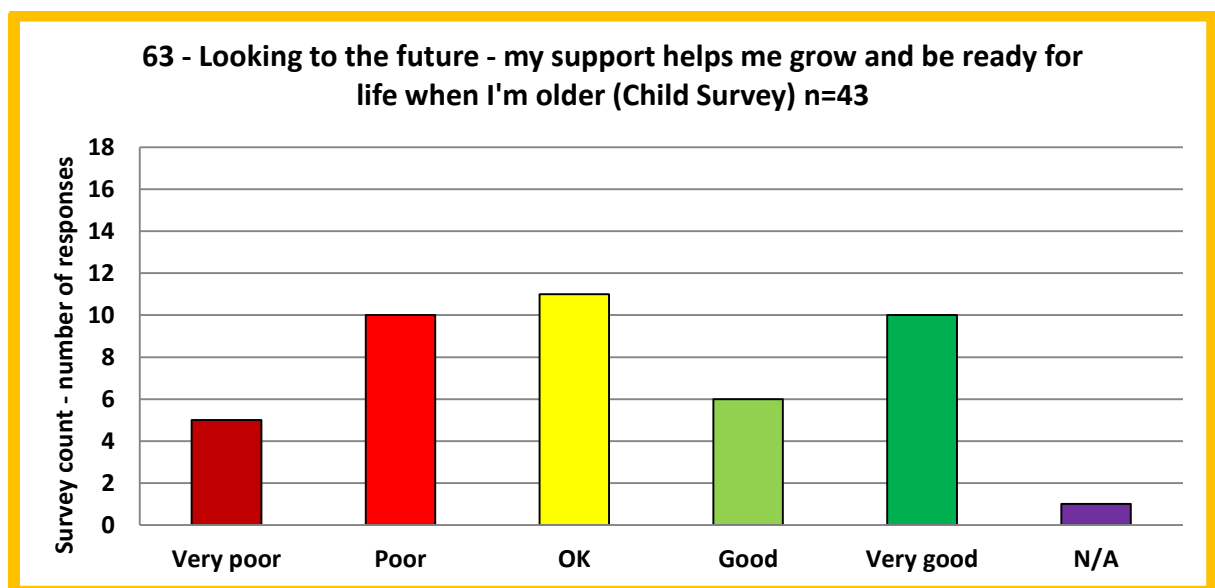
Once more we see that children tendering a negative opinion on this (15 out of 43) again outweigh those who felt positive on this (11 out of 43) although, again, this is not the majority position for this question in the survey.

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.

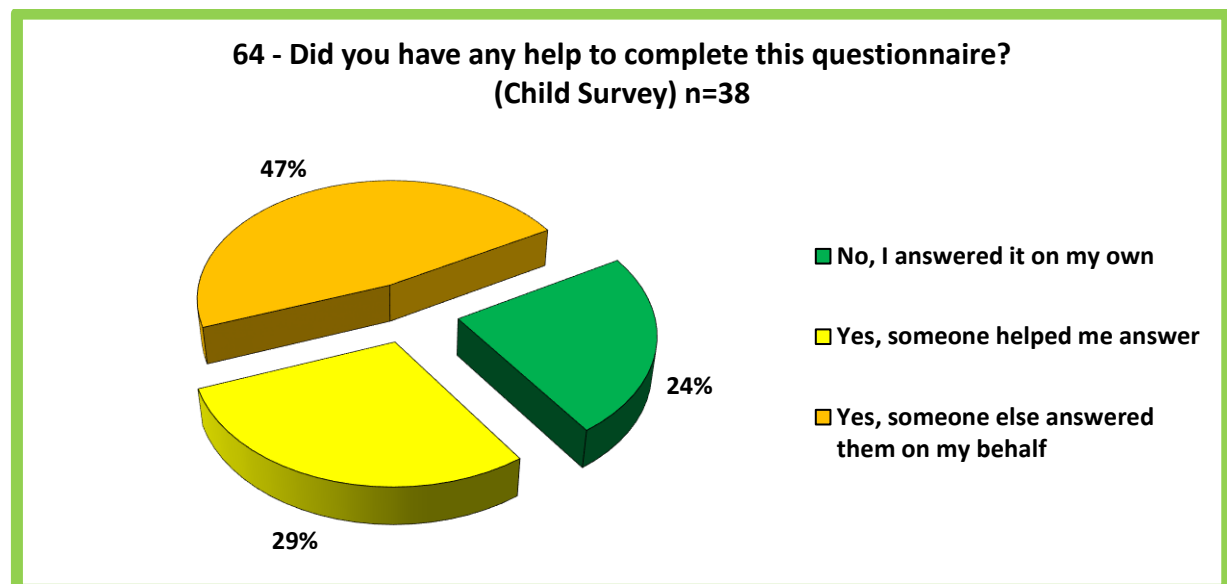


Narrowly, children tendering the positive responses (16 out of 43) outweighed those who felt more negative (15 out of 43) on this issue. Again, no consensus emerged from the survey participants on this question.

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.



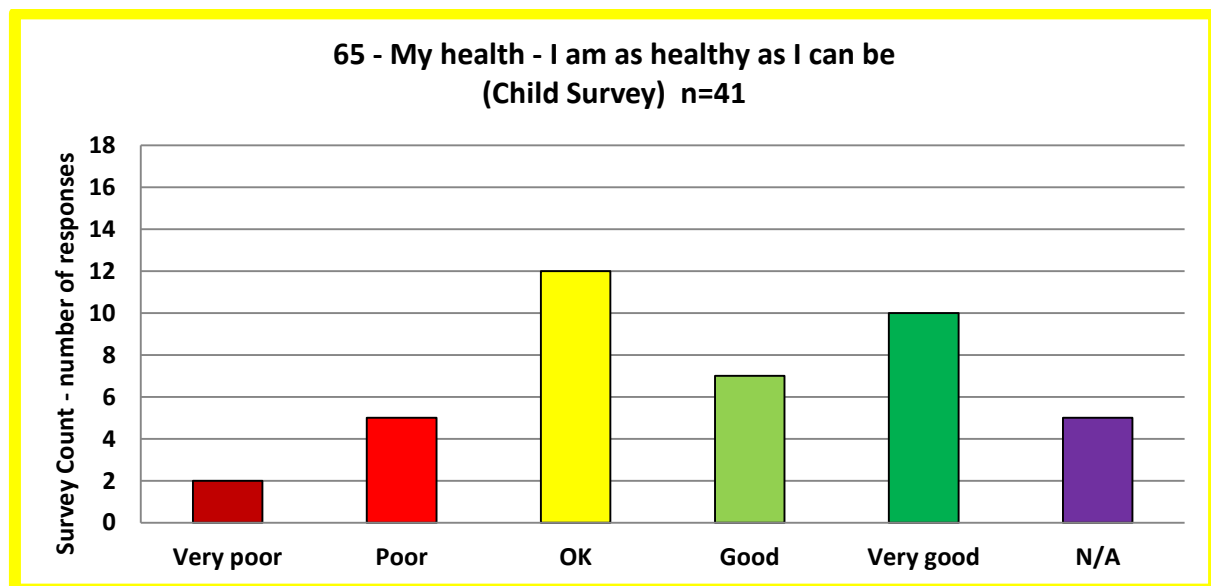
While the majority of these survey returns include some, if not total, parental input we see nearly a quarter have been completed, in the entirety, by the children concerned and just under a third where, although some parent input has been made the child has answered some questions for themselves. While 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?

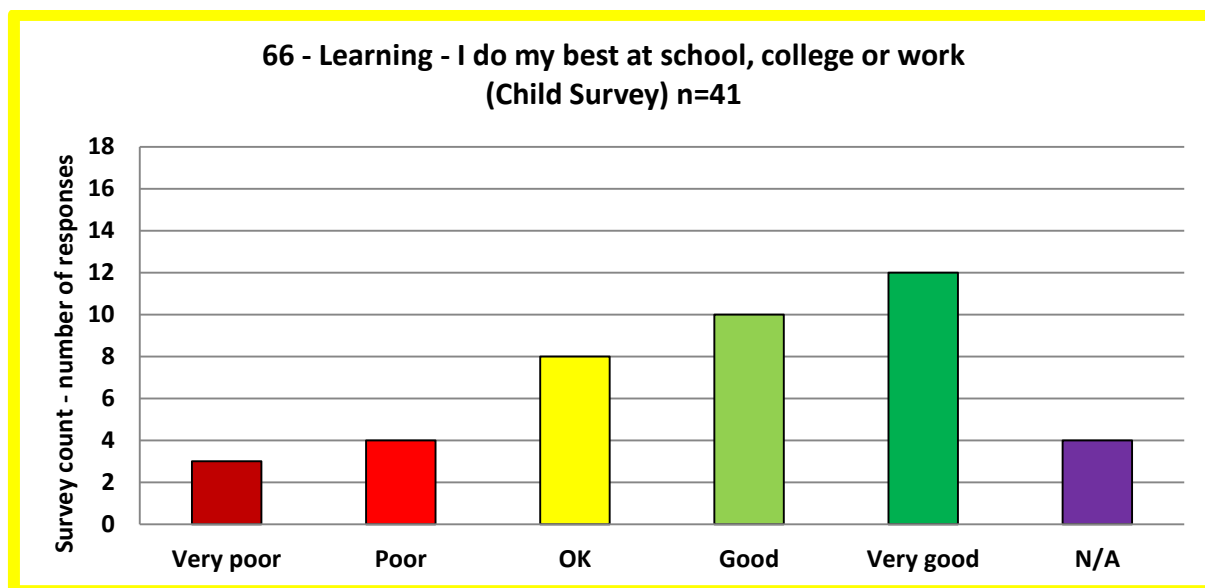
Initially children were asked how well their support has enabled them to be fit and healthy. The results are shown in figure 65.



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.

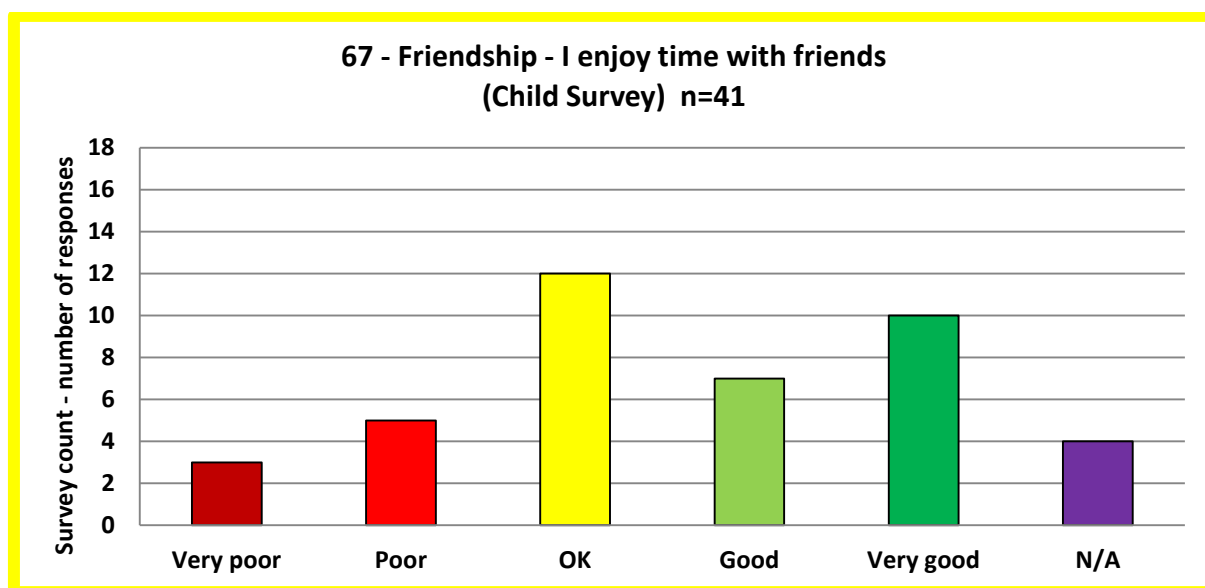
Next, the survey examines what the education based impact is. In other words, how well does the support being provided help the children do the best they can in school, college or workplace (for older children/ young people).

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.



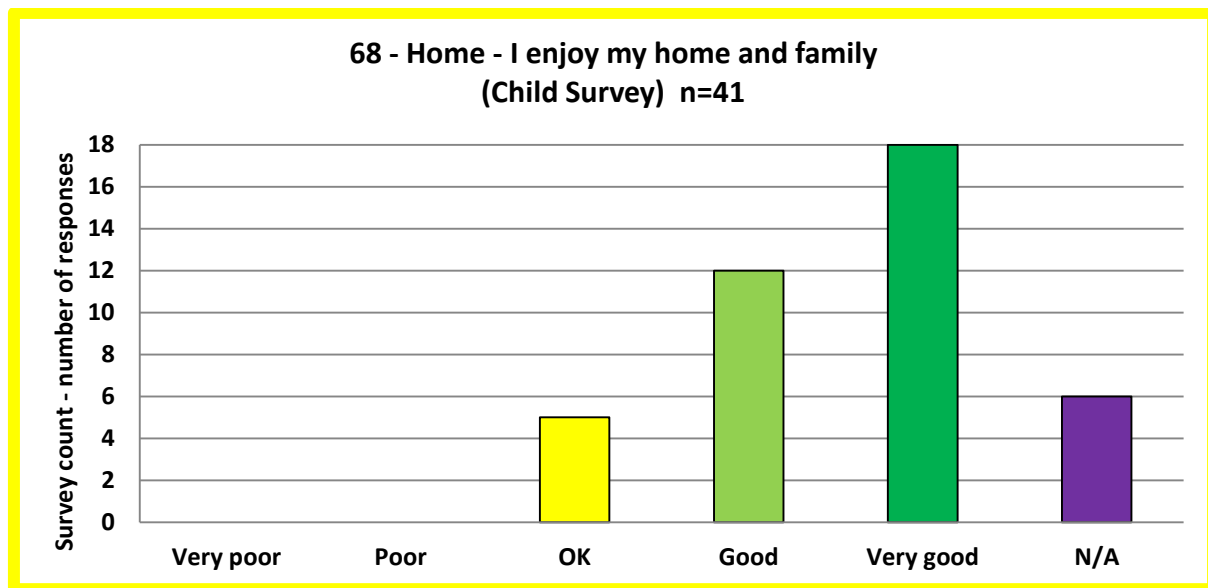
Clearly EHCP have an impact on how well children feel they are doing in their learning which is clearly demonstrated.

Figure 67 shows the results for the outcome based on how well children enjoy their friendships.



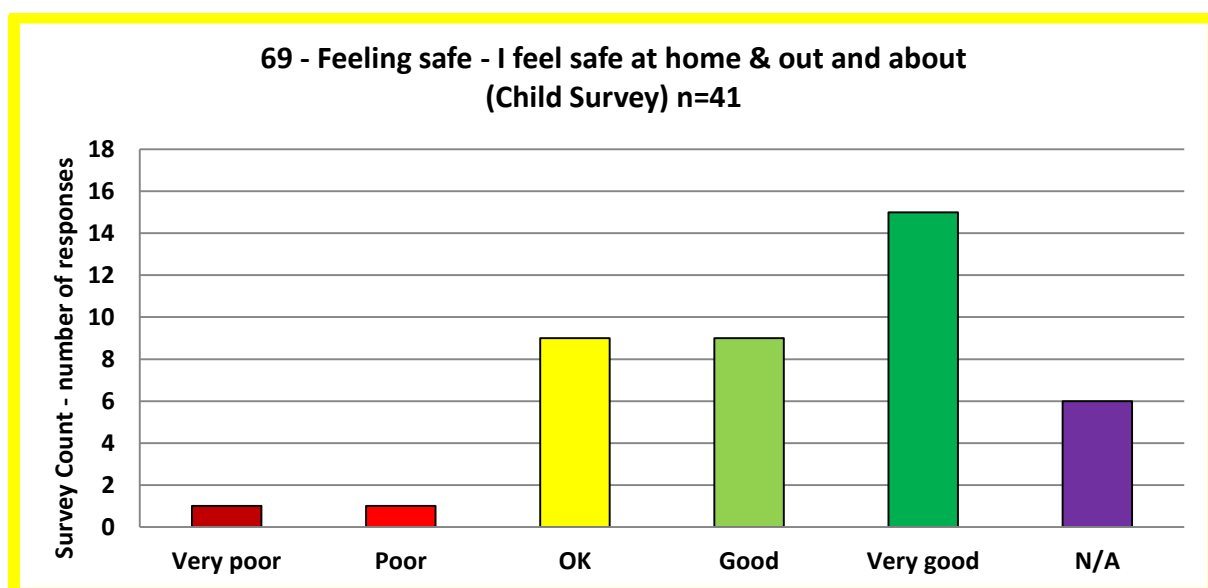
Here, again we see a positive message reported back. 17 of the 41 children answering this question indicated positive outcomes and 8 out of 41 indicated the reverse. This is in keeping with feedback from the parental survey where we saw positive links between EHCP and children's ability to make and maintain 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.



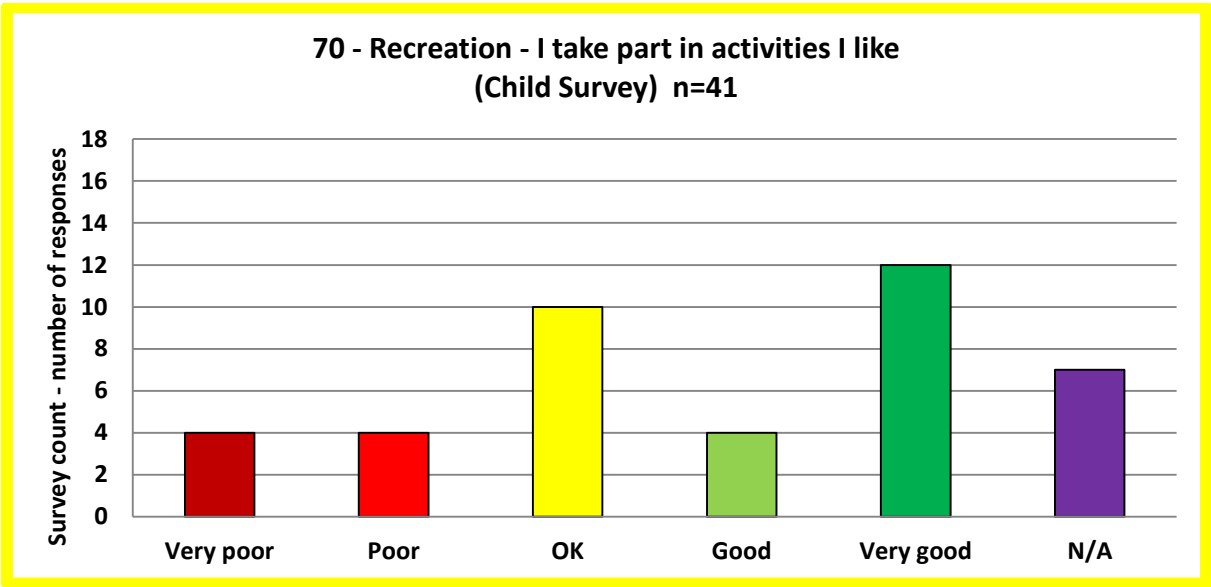
Here we see a strong majority (30 out of 41) reporting a positive outcome for home and family life and zero instance of any negative outcomes being reported. This follows on from the previous point in that EHCP have those wide ranging effects well outside the school environment.

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.



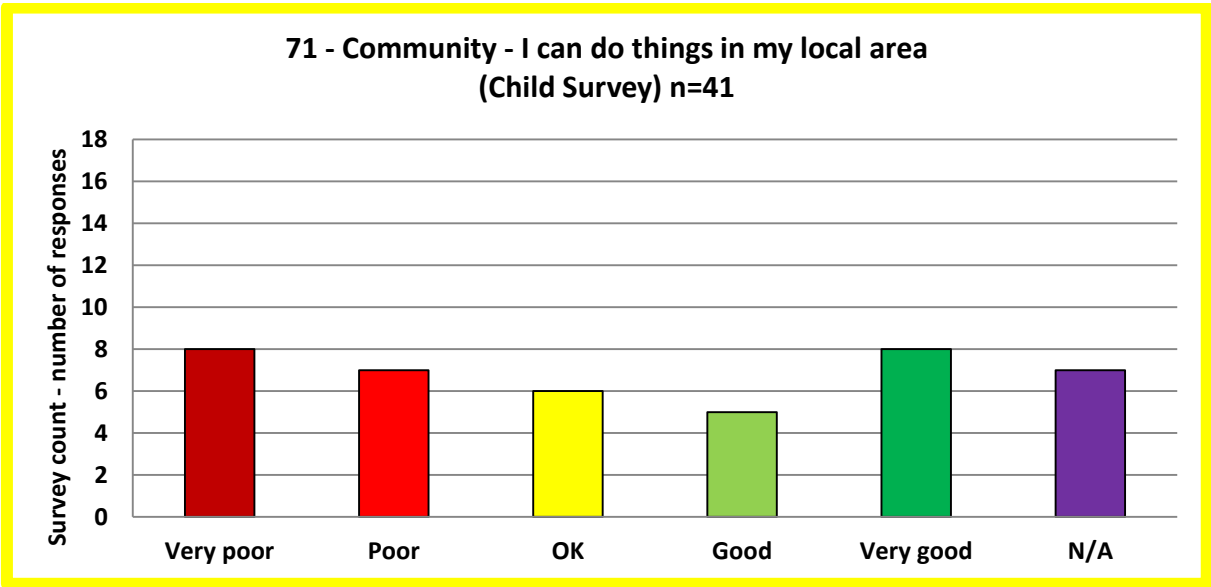
Here, again, we see a good majority of children (24 out of 41) indicating they feel safer as a result of their support and only 2 children reporting they felt less safe as a consequence. As the children's survey does not allow children to provide free text support for their answers it is unclear as to 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.



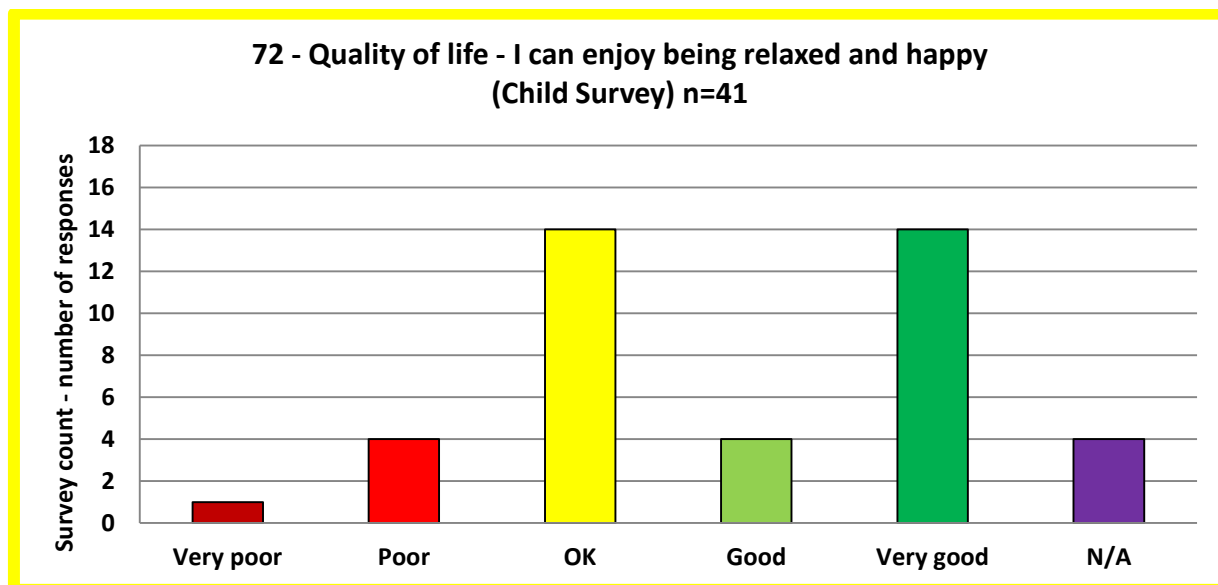
Again, the reported outcomes are largely positive (16 out of 41) and these are double the returns compared to those reporting poorer outcomes (8 out of 41). While not a majority view this result is a significant plurality on the positive side of the equation.

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.

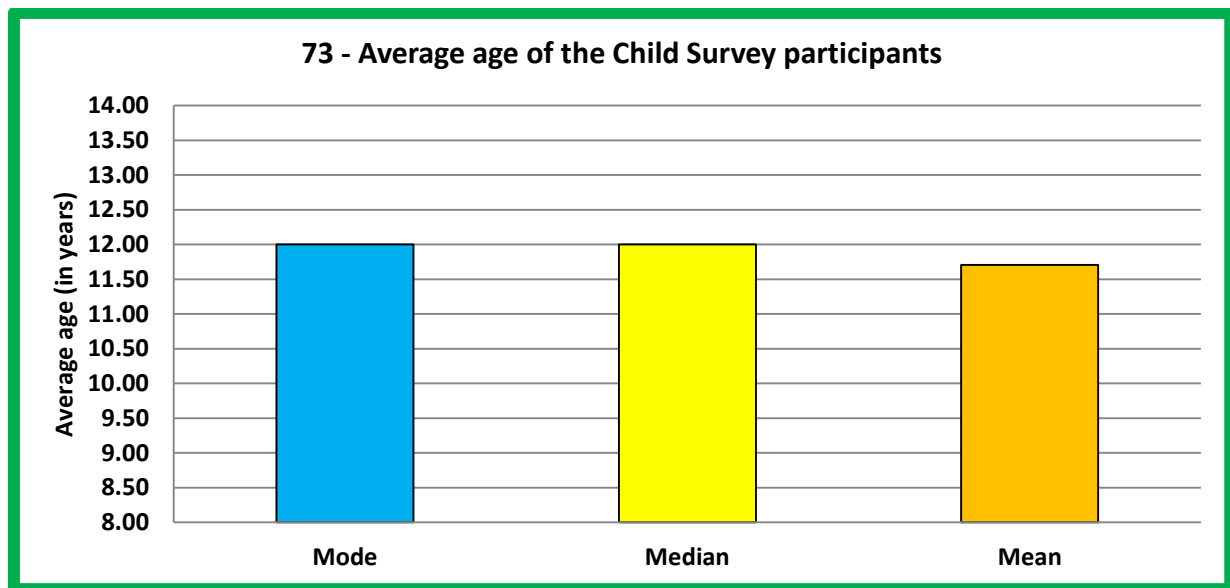
Rounding off this section of the survey figure 72 shows the results when the survey asks children about their quality of life and how their EHCP has helped them feel relaxed and happy.



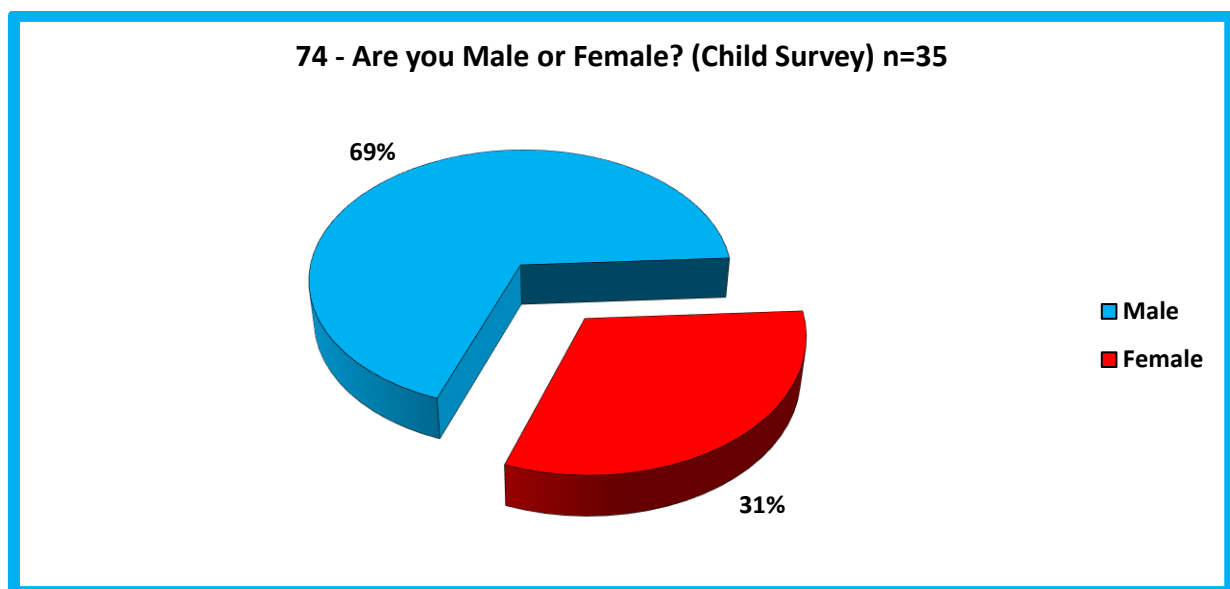
18 out of the 41 children who answered this reported positive outcomes. This is not quite a majority view but contrasts favourably with the number of children who expressed the contrary view (5 out of 41). While not as emphatic as the equivalent question in the parent survey it does demonstrate that 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.

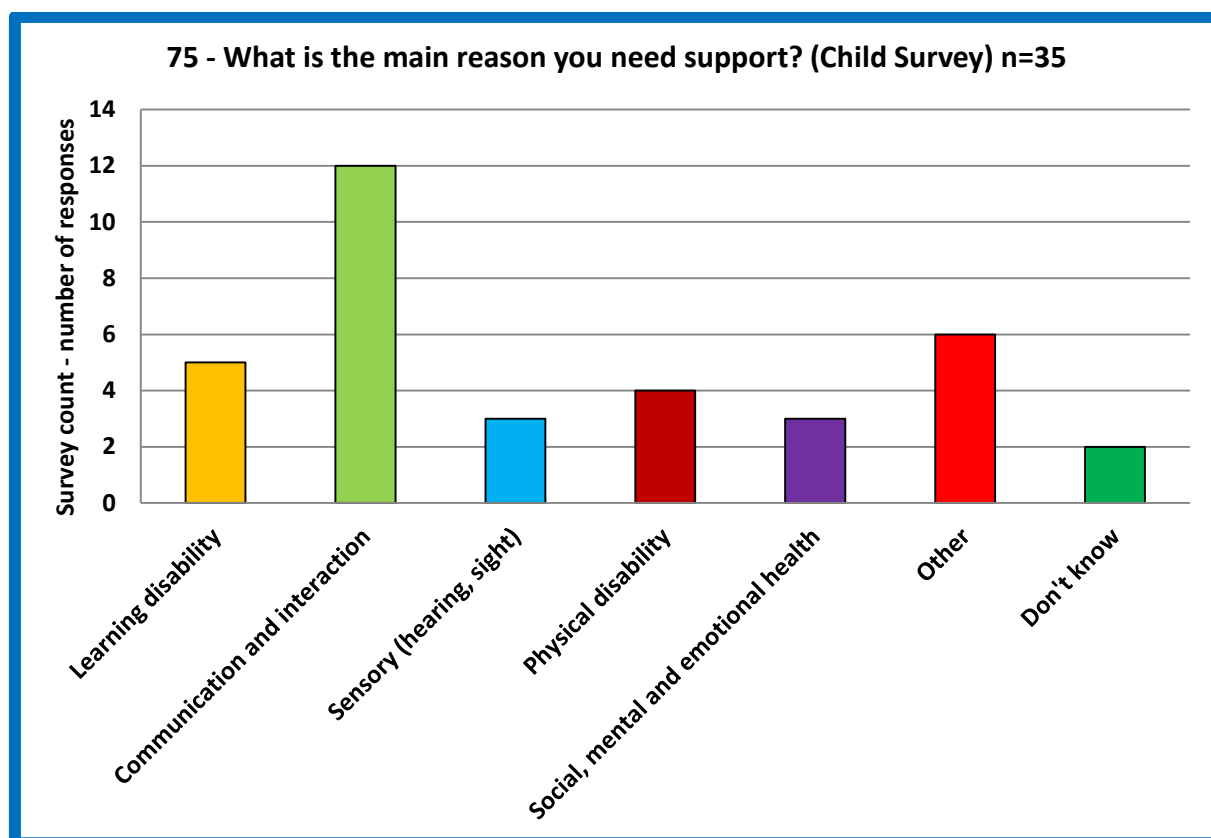
Having seen what feedback the participants in the children's survey have provided it is well that we delve a little deeper into the characteristics of the children who participated. In terms of the ages of the children taking part, the most common age was 12 years old. Looking at the age range we see 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.



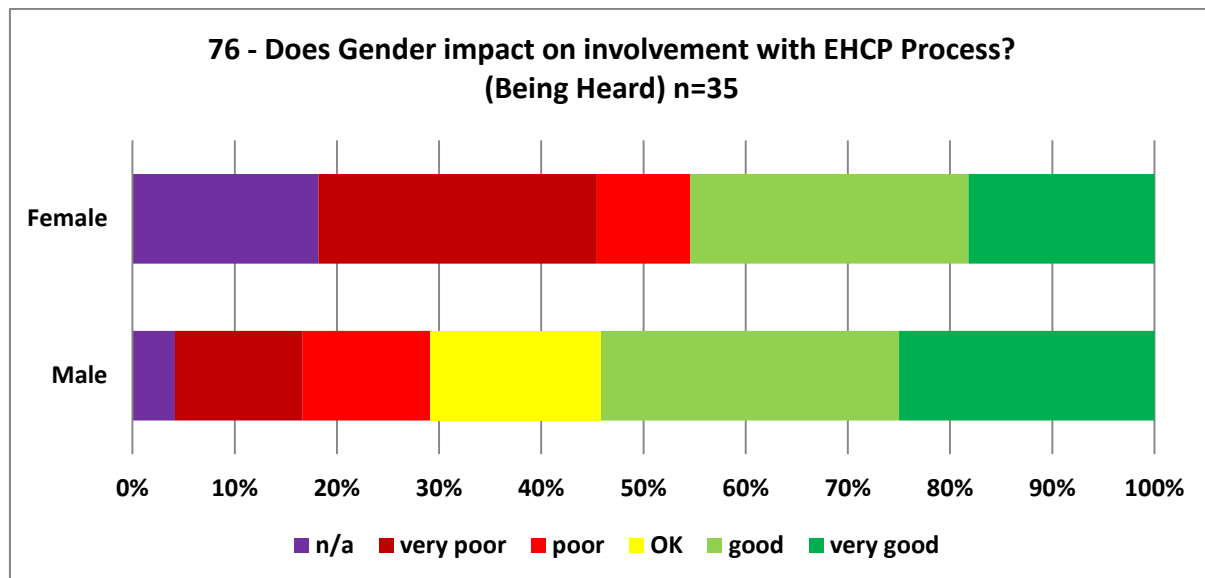
In-depth focussed Analysis of the Children's "with EHCP" survey returns

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:

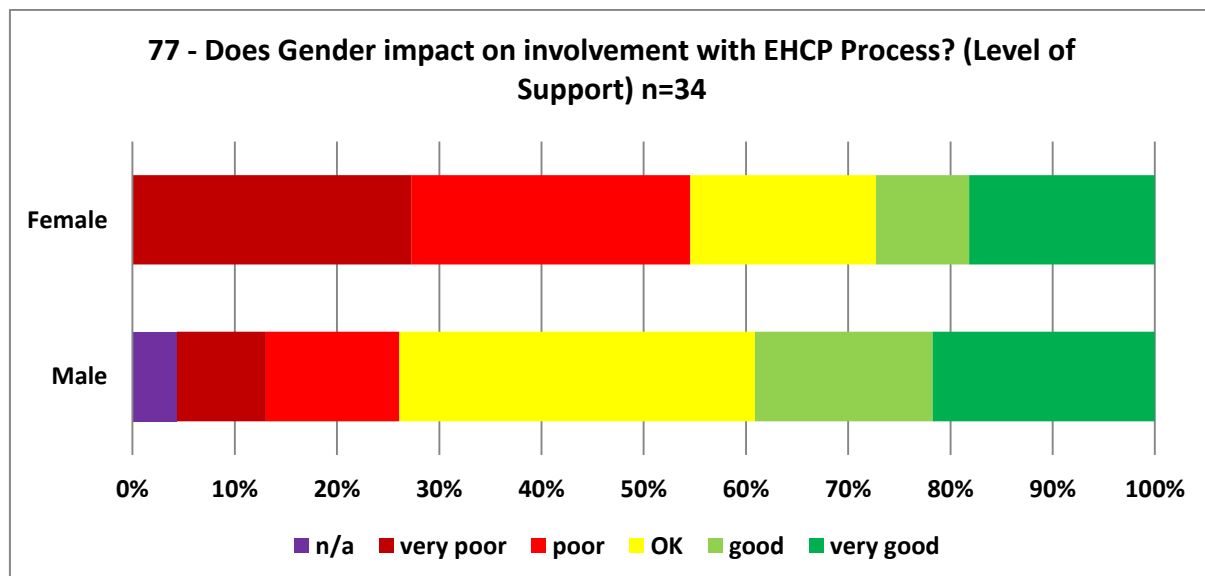
- Does gender impact on issues of involvement with EHCP processes?
- Does gender have any impact on the reported outcomes under EHCP?

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.

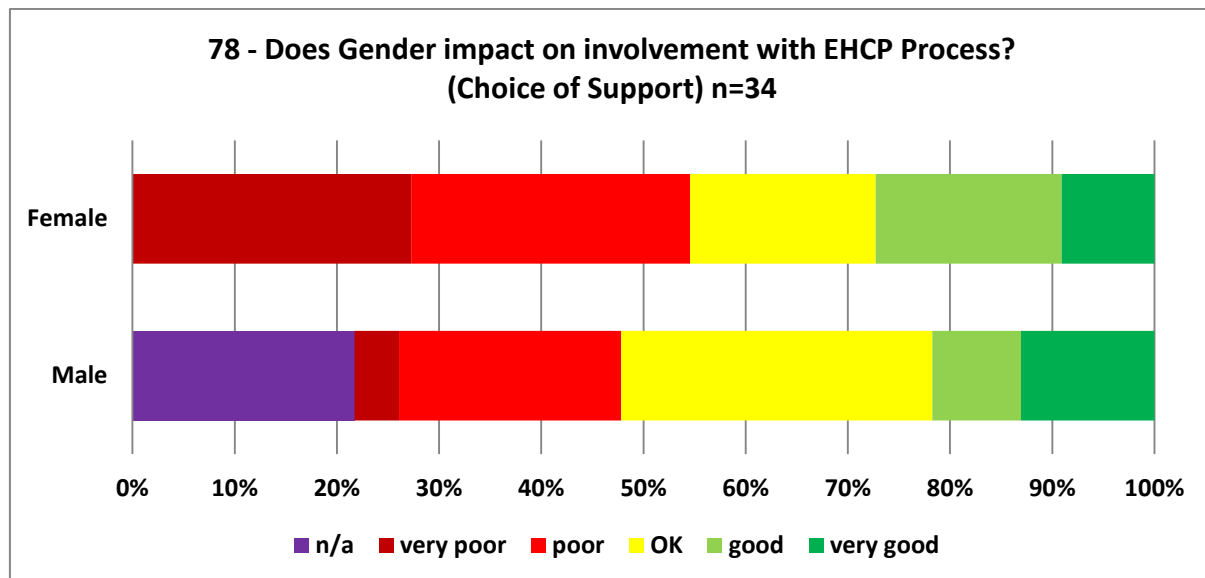
Question 1 - Does a child's gender impact on issues of involvement with EHCP processes?



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.

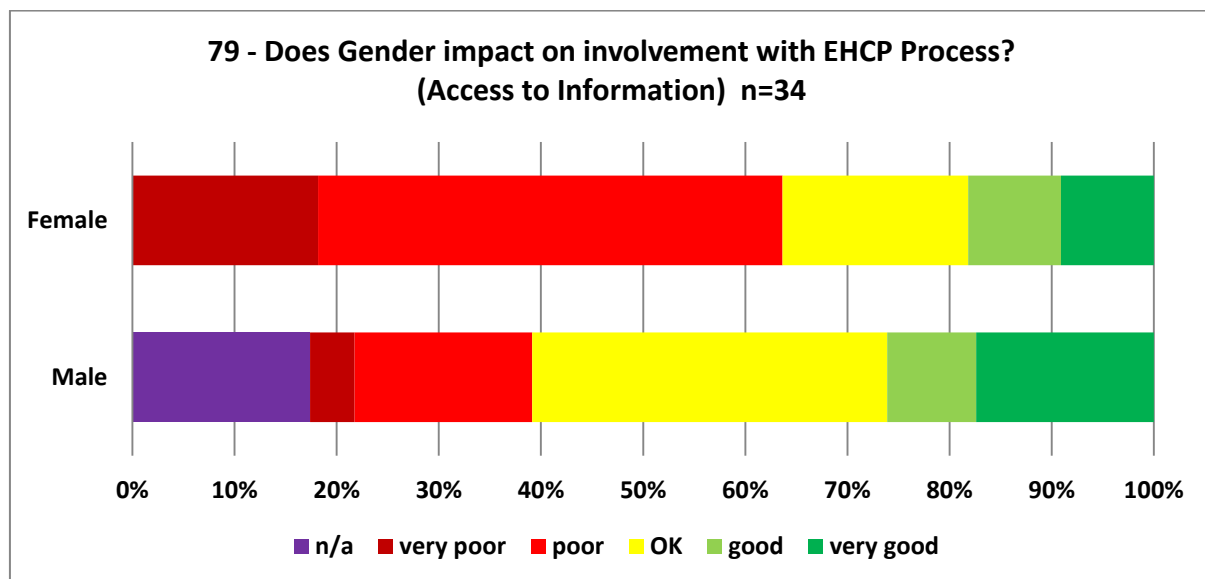
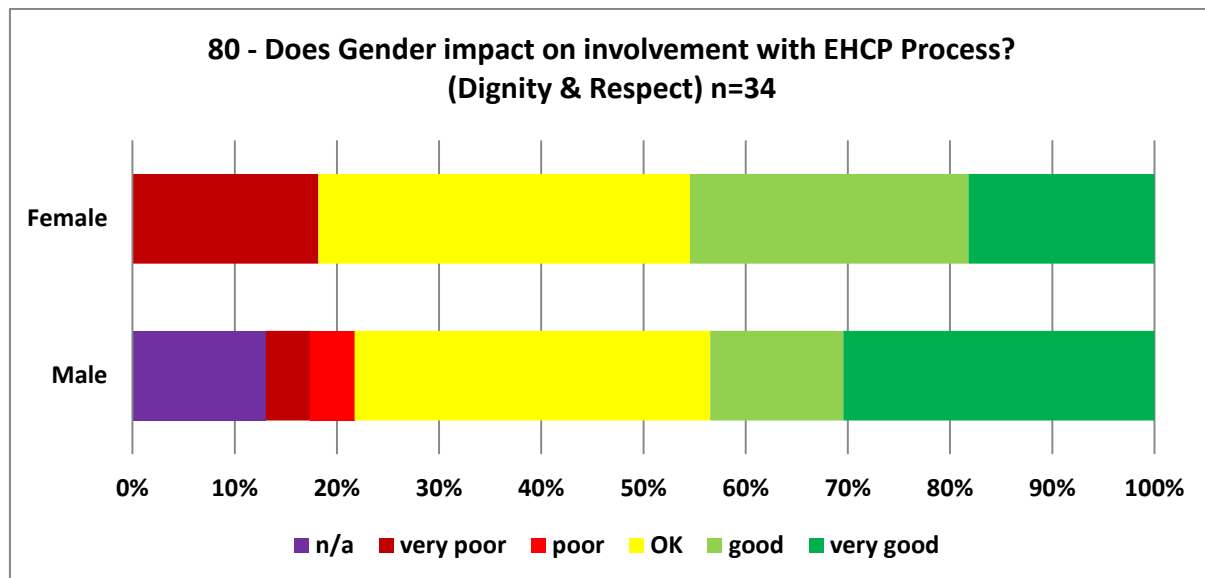
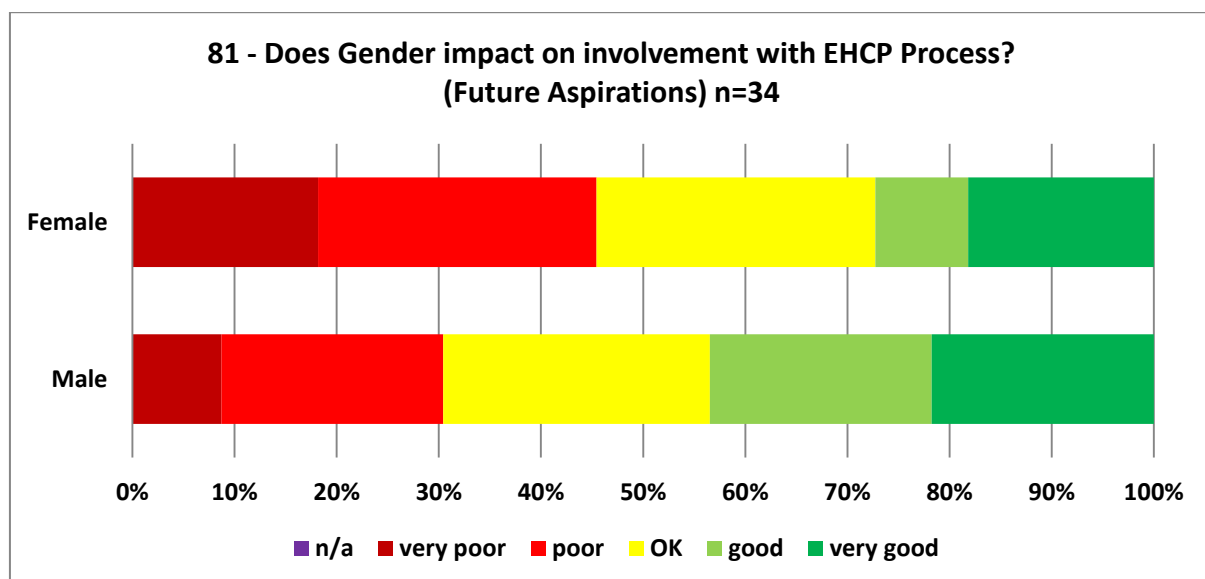


Figure 79 demonstrates another weak showing for positive answers relating to access to information and a weak relationship overall. Boys report a greater proportion of positive answers than girls although these are both low level. The most important feature here is that over 60% of girls are reporting 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.

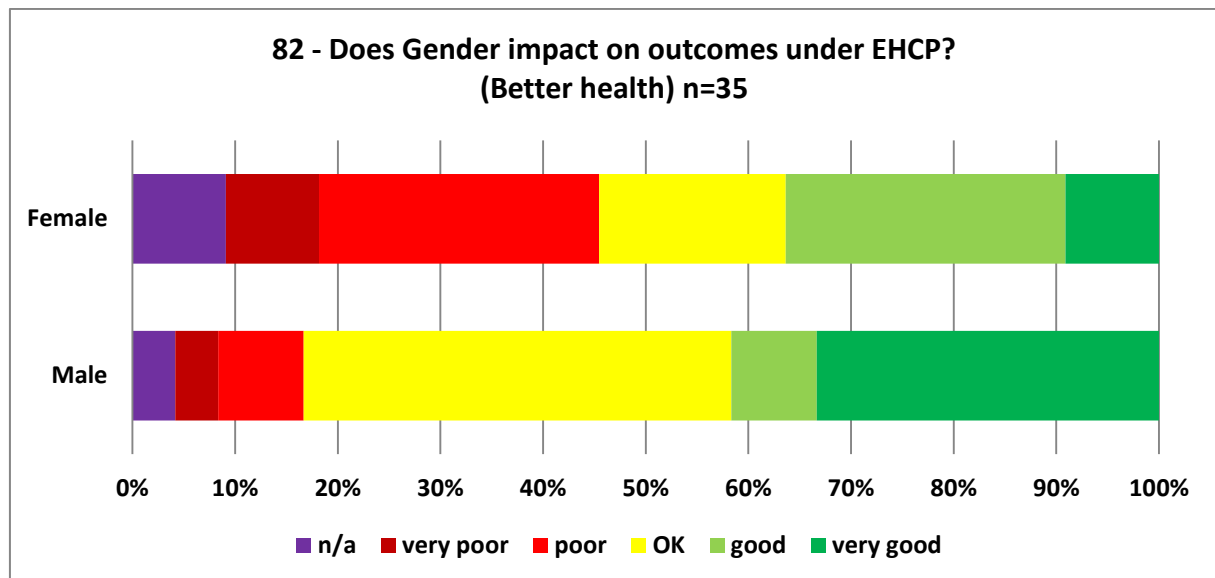
From this set of results we can see some influence that gender may have with a child's involvement with EHCP processes. Boys reported a higher proportion of positive feelings on their sense of being heard, their level of support, their access to information and their future aspirations than girls have 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.

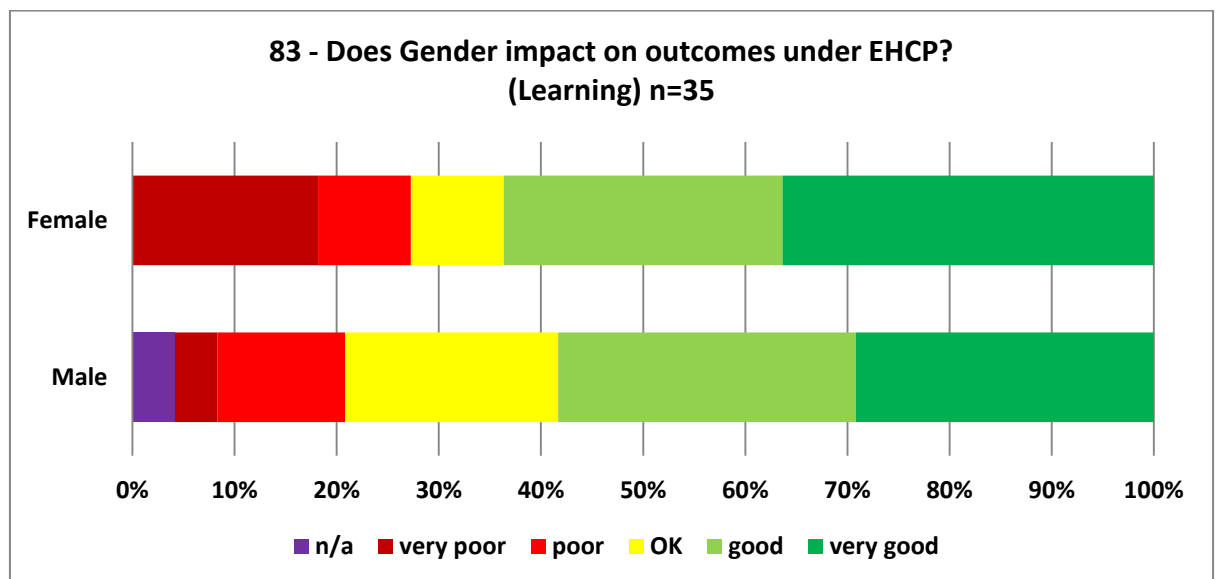
It is crucial to remember that over twice as many boys participated in this survey run compared to girls (based on those who answered that question in the survey). There is a possibility that had more girls participated the result could have been different but that can only be speculation. What we can 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?

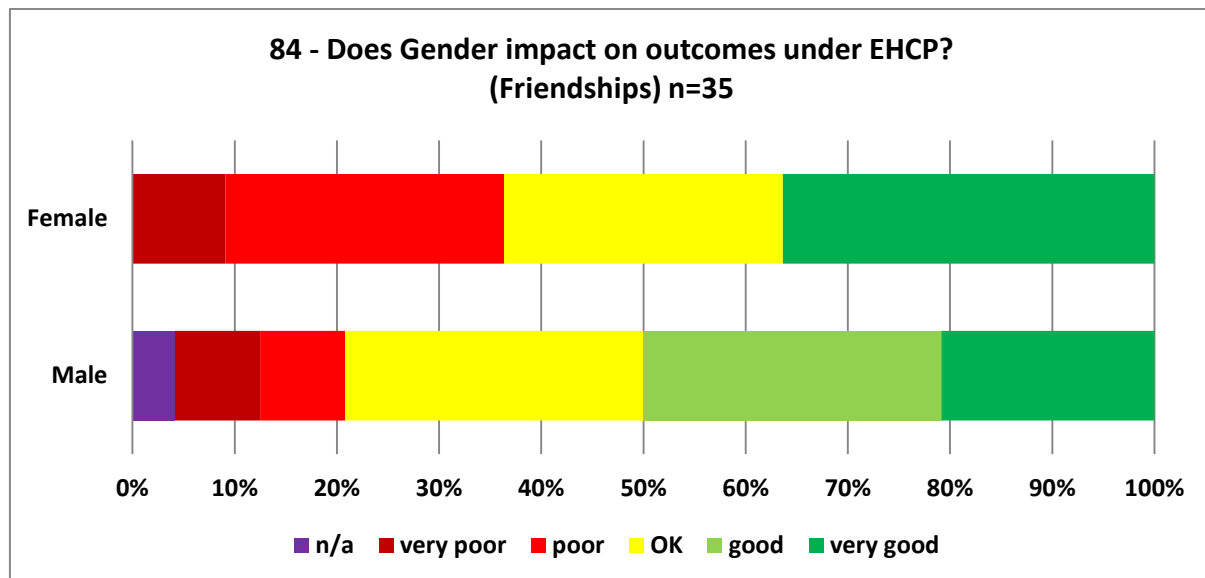
On the other side of the coin we now examine whether the outcomes that stem from the involvement already explored vary depending on the gender of the child concerned.



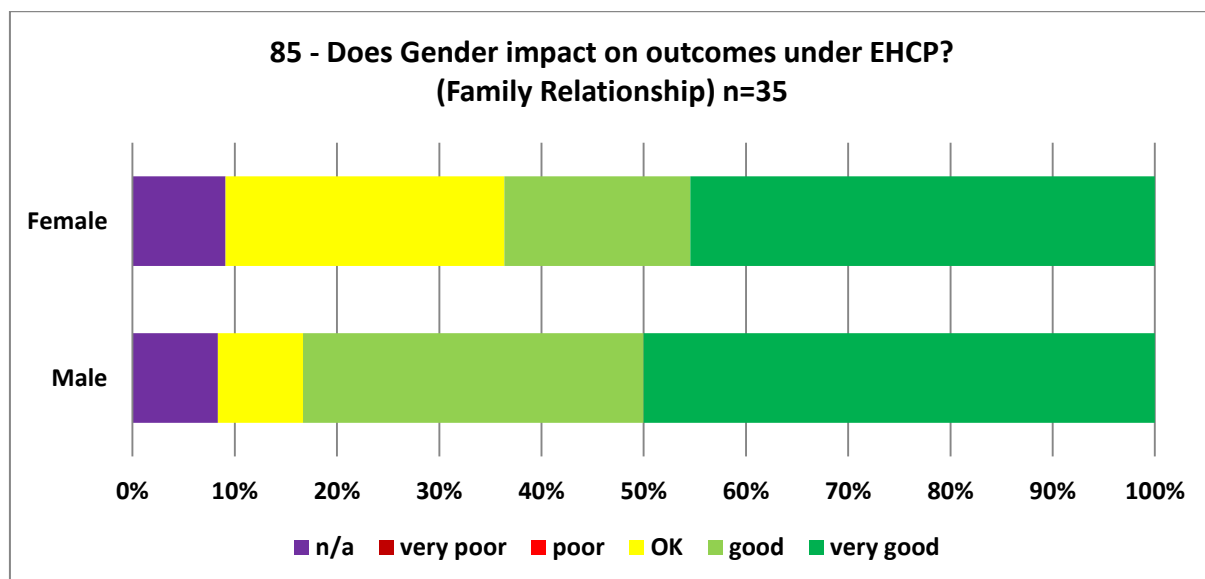
Looking at health based outcomes (Figure 82) we can see the proportion of boys reporting better outcomes is higher than the equivalent result for girls, although this is not by a wide margin. Conversely we see that girls are reporting a higher proportion of the poorer outcomes than boys by a much wider margin. In neither case did we see a majority opinion emerge however.



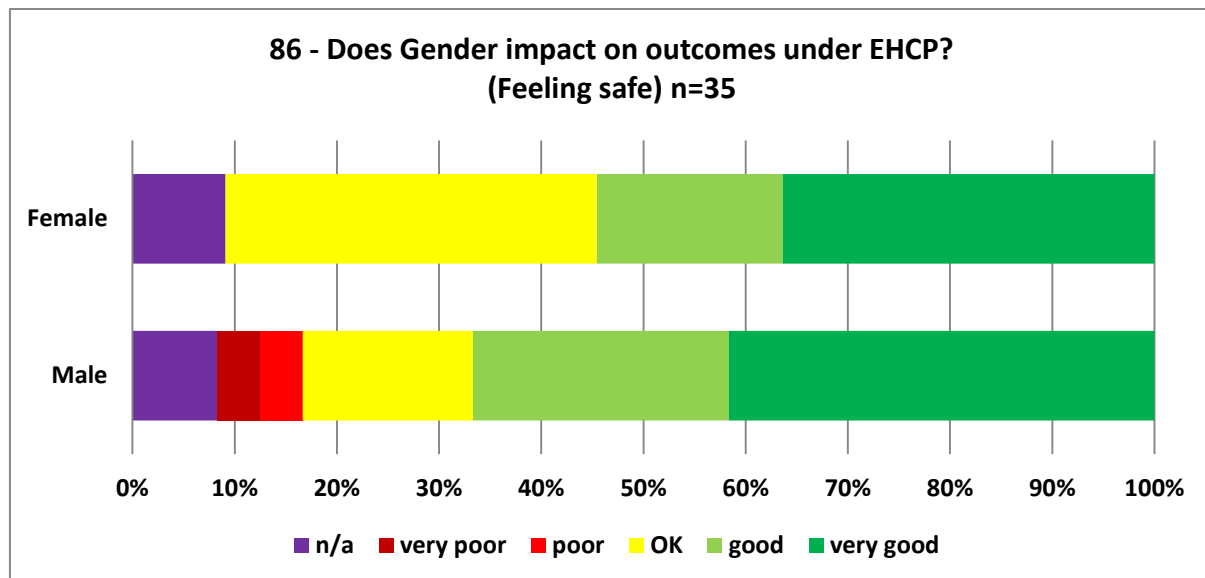
On learning outcomes (Figure 83) we see that the highest proportion of better outcomes is being reported by girls by a narrow margin compared to boys. We also see a recurrence of the theme whereby girls are also reporting a higher proportion of poorer outcomes. It is encouraging to see that the better outcomes are the majority opinion for both boys and girls.



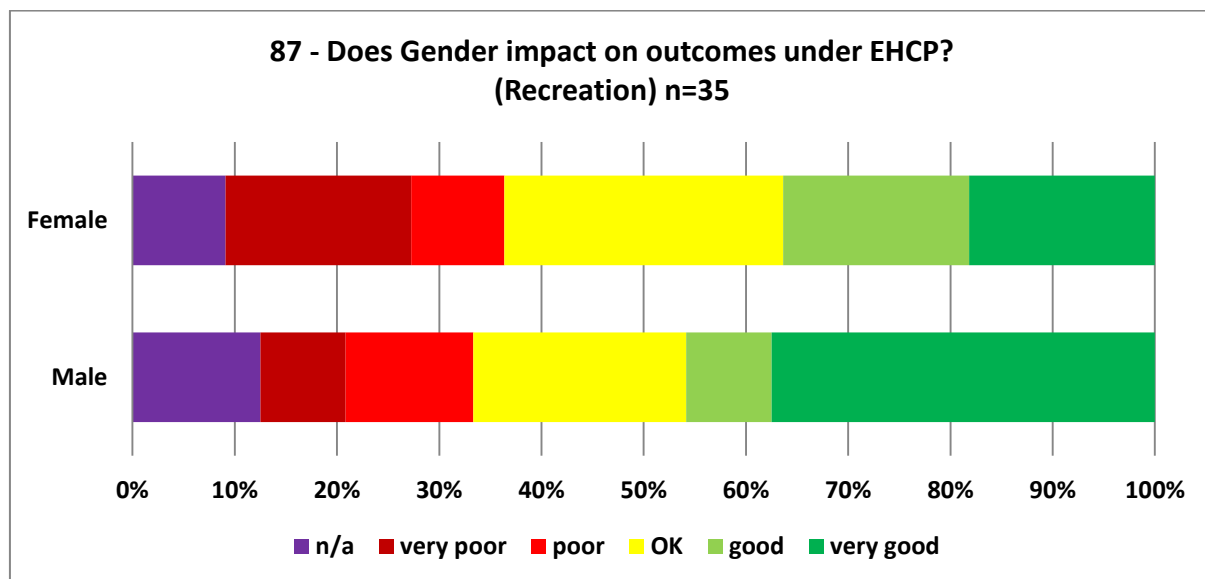
Concerning friendship outcomes (Figure 84) the largest proportion of better outcomes is reported by boys compared to girls, and by a significant margin. This is also the majority position for boys. We also see over one third of girls reporting poorer outcomes, this again being significantly higher than the proportion of poorer outcomes reported by boys.



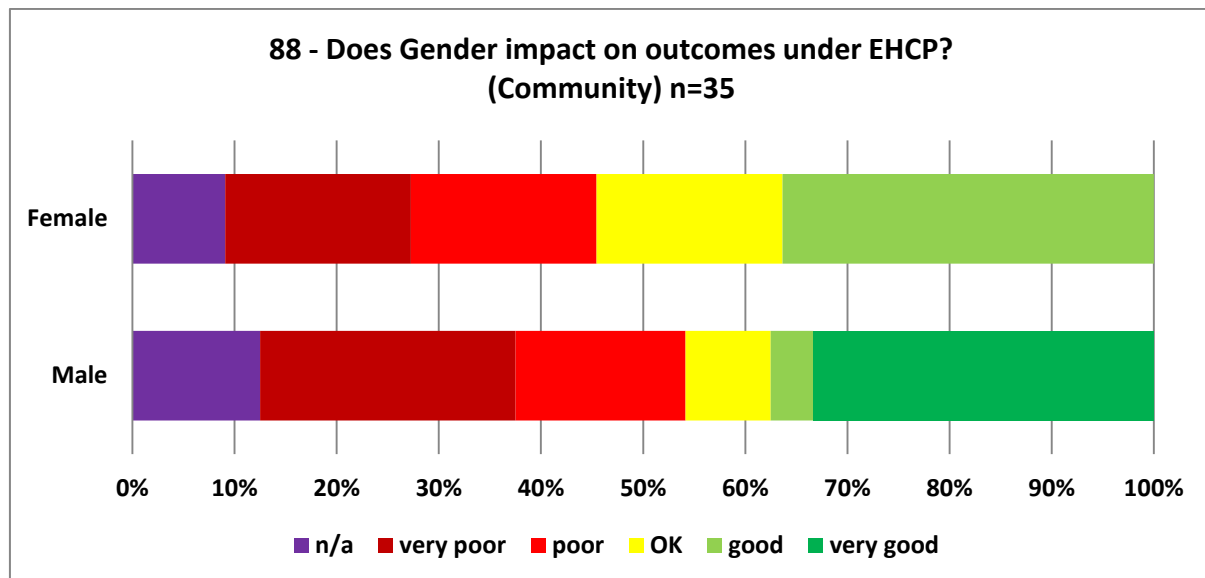
Looking at family outcomes (Figure 85) we see a very strong, positive set of results for both boys and girls. The largest proportion of positive outcomes was reported by boys by a wide margin. However girls also reported positive outcomes more often than not. This was the majority position for both boys and girls. Also of note is the absence of any reporting of poorer outcomes at all.



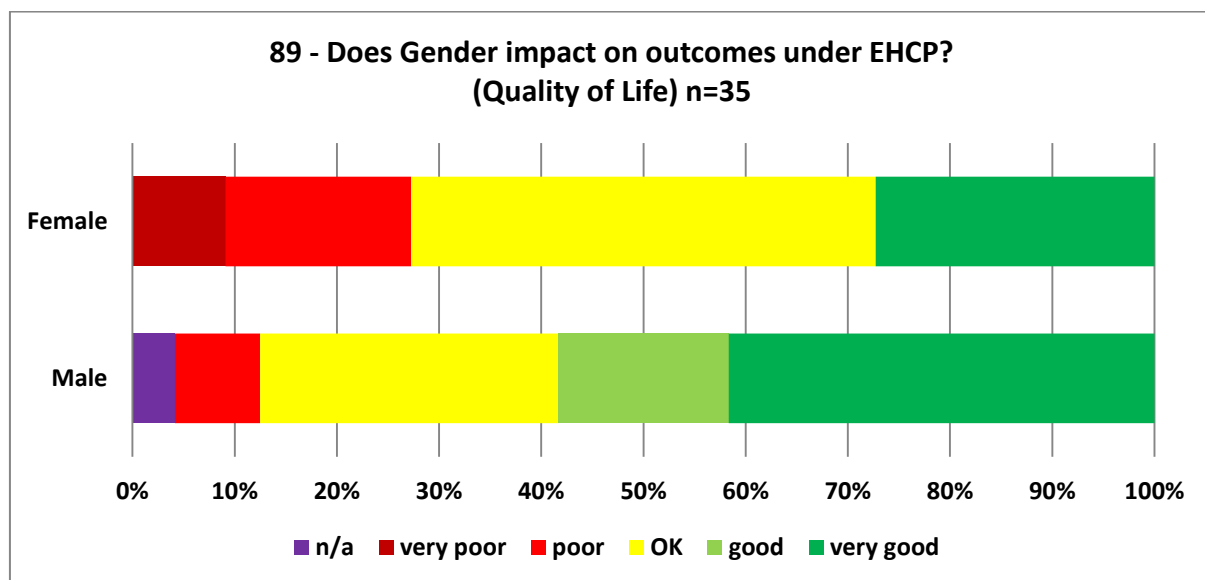
Seeing the results on safety outcomes (Figure 86) we see another strong showing from the evidence obtained from the survey for both boys and girls. The higher proportion of better outcomes was reported by boys. This was by a fair margin from the equivalent figures for girls although, for boys and girls, 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 | <input type="checkbox"/> | After school clubs:
Including play schemes and holiday club. | <input type="checkbox"/> |
| Break from caring:
Support that enables the family carer to have a rest or do other things than care | <input type="checkbox"/> | Personal assistant:
1-1 support from a paid carer | <input type="checkbox"/> |

Spending time together as a family

Equipment: ☐ **Transport:** ☐
Such as specialist sensory communication
or clothing, aids and adaptations

--

Being part of their local **community**:

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
		<input type="checkbox"/>	
Asian or Asian British	Indian	<input type="checkbox"/>	Pakistani
		<input type="checkbox"/>	Bangladeshi
		<input type="checkbox"/>	
	Any other Asian background		<input type="checkbox"/>
Black or Black British	Caribbean	<input type="checkbox"/>	African
		<input type="checkbox"/>	Any other Black background
		<input type="checkbox"/>	
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 ☐

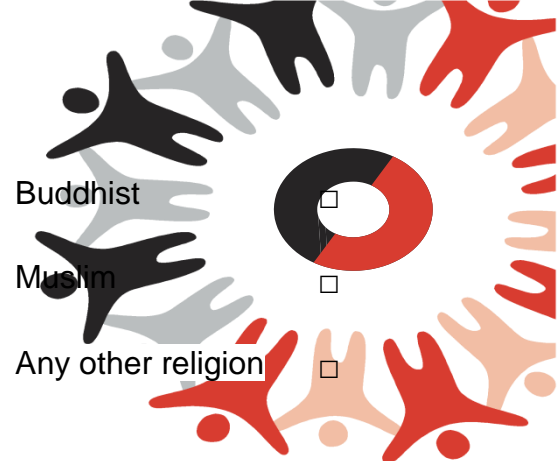
Muslim ☐

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

Information:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have information to make decisions about my support						
Dignity:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am supported with dignity and respect						
Looking forward to the future:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The support I get helps me grow and be ready for life when I'm older						

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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am as healthy as I can be.						
Learning:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I do the best I can at school, college or work.						
Friendships:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I enjoy time with friends.						
Your Home:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I enjoy my home and family.						
Feeling safe:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel safe at home and out and about.						
Recreation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take part in activities I like						
Community:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?

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						
---	--	--	--	--	--	--

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	<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	<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

2.3 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	<ol style="list-style-type: none"> 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)		<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 	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	<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 	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>					

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.					

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	

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/carers 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/carers 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.nhs.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

- 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.

[illegible]

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

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.

Formal section 75 agreements or other formal arrangements, 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. 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).

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.

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.

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.

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 a / user involvement representation?	<i>Established routes / fora for joint discussions, at which SEND can be considered.</i> SEND arrangements are part of arrangements for joint lead commissioning for children.	Andrea Havery - 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 Havery - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Partially Achieved: Some Progress/Implemented in some areas	Please select	Please select	Poolled 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 Havery - 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 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 Havery - 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 Havery - 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

The Health and Wellbeing Board (HWP) 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.

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.

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>• Does the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy include SEND?</p>	<p><i>CCG as a member of HWB highlights local complex needs.</i></p>	Innes Richens, Chief Executive Officer, Portsmouth Clinical Commissioning Group & Head of Adult Social Care, Portsmouth City Council	Full Compliance: Fully Achieved/Implemented	Please select	Please select	<p>The CCG JSNA identifies SEND in Priority 1. http://democracy.portsmouth.gov.uk/documents/s13253/JSNA%20Annual%20Summary%202016.pdf</p> <p>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/external-hth-jwellbeingstrategy/2014-17.pdf</p>
<p>• How does the CCG engage with the Health and Wellbeing Board and local Healthwatch?</p>		Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	<p>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?Cld=150&M=3634&Ver=4</p>
Summary RAG Compliance		Total Green	2	0		
		Total Amber	0	0		
		Total Red	0	0		

FURTHER INFORMATION:

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

Operating Principles for Health and Wellbeing Boards.
http://www.local.gov.uk/c/document_library/get_file?uuid=1ccc06cb-d44b-43c6-b04c-f7b713e03122&groupId=10180

Rochdale's Joint Health and Wellbeing Strategy:
<http://www.hmr.nhs.uk/attachments/article/81/jointhealthwellbeingstrategy12-15.pdf?sm.au=HVokN6tWJ5nrVW>

Wiltshire's Joint Health and Wellbeing Strategy:
<http://www.wiltshire.gov.uk/healthandsocialcare/jointhealthandwellbeingstrategy.htm>

3. Commissioning

Assessing local need

CCG (or partners, such as Public Health) can determine demand based on:

- 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.

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.

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.

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.

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.

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:

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>
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>

Affordability and demand

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).

They also provide a basis for strategic discussions on contractual flexibilities, informing dialogue between the CCG and the provider on changing demand.

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		

4. Education, Health & Care Plan

Coordinated Assessment

The Education, Health and Care plan is a key focus for the new SEND arrangements. The plan is a statutory document, which captures:

- 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.

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.

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.

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.

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.

Prompts for Implementation	Key Indicators / Evidence	CCG Named Lead	1st Audit RAD Rating: DD/MM/YY	2nd Audit RAD Rating: DD/MM/YY	Trend	Comments/Evidence
• Has the CCG been involved in developing the EHC plan templates for its relevant local authorities?	<i>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.</i>	Andrea Heavey - 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 Commissioner 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 Heavey - 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 timeframes. http://www.portsmouthlocaloffer.org/local-offer-search/item/139
• Does the CCG oversee providers and ensure they have a pathway?	<i>CCG has an agreed process in place (with appropriate personnel to oversee and manage) for receiving requests for EHC plan input. 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.</i>	Andrea Heavey - 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?	<i>This should include monitoring /reporting, however light touch, allowing the CCG to assess how timely is the health service response.</i>	Andrea Heavey - 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?	<i>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/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.</i>	Andrea Heavey - 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 health's 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

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.

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).

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 Havery - 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 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 of 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 Havery - 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 Havery - 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		

FURTHER INFORMATION:

Nottinghamshire County Council's EHC plan animation:
<https://www.youtube.com/watch?v=3zf8BqtMKsQ>

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-RefcorPaedsBACCHRACD23Sent2014.pdf>

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.

The SEND Pathfinder Information Pack - Coordinated Assessment Process and Education, Health and Care (EHC) Plan:
<http://www.sendpathfinder.co.uk/coordinated-assessment-process>

A guide to EHC plans for health professionals.
<http://www.councilfordisabledchildren.org.uk/resources/ehc-plans-for-health-professionals>

5. Engagement

Users

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.

To fulfil these statutory obligations there are a number of elements which should be in place:

- 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.

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:

- 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.

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).

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.

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>CCG has a [published] policy on engaging with hard to reach groups and is active in ensuring this is implemented.</p> <p>CCG has specific events or engagement activities with hard to reach groups.</p> <p>CCG is able to demonstrate how it responds to the feedback from engagement in its policies, particularly in relation to commissioning.</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 35</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%20and%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?	CCG has regular contact with its local PCF.	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>CCG has a mechanism for engagement with children and young people with SEND and their families.</p> <p>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.</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>CCG (or its providers) have involved children or young people with SEND and their families in their contribution to the:</p> <p>- Local Offer</p> <p>or have made sure that the local authority, in its engagement with children and young people, takes account of children's health needs.</p>	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Partially Achieved: Some Progress/Implemented in some areas	Please select	Please select	<p>Dynami (CYP with health needs), PPV, CAG 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 engage with and need to be encouraged to have a say in their care and this is not Solent NHS Trust quarterly report includes feedback 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>CCG measurement of user / patient experience allows experiences of children and young people with SEND to be identified.</p> <p>CCG or its providers uses the Parent Carer Forum to survey experiences of children and young people and their families.</p> <p>Friends and Family test allows experiences of children and young people with SEND to be identified.</p> <p>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.</p> <p>CCG or its providers use bespoke feedback gathering (e.g. survey, feedback forms, focus groups).</p>	Andrea Havey - Portsmouth Childrens Commissioning Programme Manager for CYP & Maternity	Full Compliance: Fully Achieved/Implemented	Please select	Please select	
Summary RAG Compliance		Total Green	4	0		
		Total Amber	1	0		
		Total Red	0	0		

FURTHER INFORMATION:

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:
<http://www.sendpathfinder.co.uk/engagement-and-participation-information-pack>

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

A full list of Parent Carer forums can be found at the National Network of Parent Carer Forums: www.nnpf.org.uk

NHS England's guidance on patient and public involvement is Transforming Participation in Health and Care. The NHS belongs to us all.
<http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-oid1.pdf>

6. Monitoring & Redress						
Data to Monitor Progress						
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.						
See the annex for suggestions for monitoring information.						
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?	CCG has monitoring embedded in its joint arrangements, with appropriate executive oversight. CCG produces regular performance reports using a range of relevant indicators, and reflects on their implications.	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	ICS Commissioning Managers hold quarterly commissioning contract review meetings with the Provider to review each service. 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. 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. For children with SEND, POET has now been adopted as the Outcome Measurement Tool for EHC Care Plans The POET evaluation report is sent to CCG for information and identify any health issues to be actioned. This is done annually. CSC/Education will only be flagged up if provision does not meet needs. 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..... - cross reference against performance framework.
<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.	CCG has mapped existing data sources and collects new data and intelligence where relevant.	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).	CCG has a process of collecting evidence systematically to support assurance, informed by CCG Assurance Framework and CQC / Ofsted inspection framework.	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						
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.						
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.						
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?	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	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 standards 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. http://www.saferportsmouth.org.uk/home/information-sharing-framework/
<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. For details of the above process and the description of the DCO role, see Leadership tab, line item 29 and 41.
<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	See line item 20 above
Summary RAG Compliance		Total Green	4	0		
		Total Amber	0	0		
		Total Red	0	0		
FURTHER INFORMATION:						
The revised Caldicott Principles: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251750/9731-2901141-TSO-Caldicott-Government_Response_ACCESSIBLE.PDF						
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						
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						
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						
For recipients, see Guidance for recipients of an encrypted NHSmail email (January, 2015) http://systems.hscic.gov.uk/nhsmail/secure/recipients.pdf						
Further information on the encryption feature in general can be found at: http://systems.hscic.gov.uk/nhsmail/secure						

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><i>Historic data on mediation / complaints etc. obtained from local authority.</i></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		