Background papers: children

Dental health in children

Overview

Introduction

Oral health refers to the condition of gums, teeth, surrounding bone and soft tissues of the mouth enabling function and being free of disease and pain. Although the oral health of children in England has generally improved over the past few decades, there are still children with unacceptable tooth decay levels. Furthermore, the distribution of tooth decay varies geographically across Kent and Medway, with proportionately more children in the more deprived local authority areas experiencing tooth decay. Tooth decay in children is often not treated, the consequences of which include pain and discomfort on chewing, which may affect children’s growth and development.

Tooth decay in children is largely preventable. The risk factor is a frequent and high sugar diet, which is also common to diabetes and obesity. The availability of topical fluoride such as in toothpastes, varnishes and mouthrinses helps to prevent tooth decay.

NHS dental access rates for children for the years 2012-14 indicate that Medway has a higher rate than the South East region (80% and 69% respectively), however there are still variations in the uptake of services across Medway.

Key issues and gaps

- Lack of comprehensive census survey data of tooth decay experience
- Current available data suggest that nearly one in five, five- and 12-year-old and one in 12, three-year-old children have experience of tooth decay,
- Lack of a coordinated approach to oral health promotion activities that include topical fluoride therapy for children
- Inequality in uptake of primary care dental services

Recommendations for consideration by commissioners

- Ensure the continuation of the National Epidemiological programme in Medway
- Promote a coordinated approach to the control of tooth decay through evidence-based oral health promotion interventions
• Promote orientation of primary care dental services to focus on prevention in line with Delivering Better Oral Health - a toolkit for prevention (Department of Health, 2014)
• Promote regular dental visits for prevention
• Promote development of an appropriate skills-mix workforce in order to meet the dental needs of the population effectively and efficiently
• Promote collaboration with other health workers such as health visitors to deliver oral health messages

Who is at risk and why?

Tooth decay is caused by the frequent consumption of sugary foods and drinks, which are metabolised by bacteria in the mouth resulting in the production of acids. These acids dissolve the substance of the tooth and over time, can eventually lead to the formation of cavities.

Children of all ages are at risk of tooth decay. However, in common with other chronic diseases, those from socially deprived backgrounds are more likely to experience tooth decay (Watt and Sheiham, 1999; Locker, 2000). Additionally, vulnerable groups such as children with a learning disability are more susceptible to tooth decay.

Fluoride in drinking water is protective against dental decay. In Kent the population does not benefit from fluoridated water as natural levels are low and none is added[1].

The level of need in the population

The level of dental need may be estimated from national dental health surveys of 5- and 12-year-olds carried out in 2007/08 and 2008/09 respectively.

While most children were free of tooth decay, some 23.5% of 5-year-olds and 23.6% of 12-year-olds in Kent and Medway were estimated to have experience of tooth decay (Figure 1).

Figure 1 Prevalence of tooth decay experience in 5- and 12-year-olds in Kent/Medway (Average for 5-year-olds=23.5% and for 12-year-olds=23.6%). (Source: NHS Dental Epidemiology Programme for England: Oral Health Survey of 5- and 12-year olds in 2007/08 and 2008/09)

Of the 229 (7.6%) Medway five-year-olds examined, 21.6% were estimated to have at least one decayed, missing or filled deciduous (or milk) tooth (dmft), compared to 30.9% for English five-year-olds (Figure 2). For the first time, positive consent was sought for dental examination, resulting in lower participation from those from lower
socio-economic backgrounds. Therefore comparison with previous survey results would not be appropriate.

Of those with experience of tooth decay, an average 2.8 decayed, missing and filled deciduous teeth (dmft) was reported for 5-year-olds and an average 2.0 decayed, missing and filled permanent teeth (DMFT) for 12-year-olds (Figure 2). Although lower in prevalence and severity when compared to the regional (South East Coast SHA) and national average, geographical variations in the experience of tooth decay within Kent and Medway are clearly evident.

**Current services in relation to need**

Most NHS dental services for children are provided in the primary care setting. Dental services are commissioned geographically but individuals may access any dentist they wish. Since introduction of the new dental contract in 2006, primary care dental services have been procured in areas of need as identified in PCTs’ oral health needs assessments (OHNAs). Medway is not affected by marked differences in geographical variation of services, however there are still variations in the uptake of services across Medway.

The use of dental services as measured by the numbers of patients seen as a proportion of the population also suggests that access in Medway is better than other parts of Kent (Figure 3). NHS dental access in Medway is relatively higher than in West Kent and Eastern and Coastal Kent. This difference in dental access may be due to geography, relatively easier access to services and greater awareness of dental services.

**Projected service use and outcomes in 3-5 years and 5-10 years**

Medway has a higher population of children than the regional and national average. This is expected to continue over the next 25 years. Although numbers of children are increasing the proportion they make up of the population is decreasing because of the increasing numbers of older people.

Current guidance recommends that all children should visit the dentist at least twice a year for prevention of tooth decay through topical fluoride therapy. Service use for
prevention should therefore be promoted, especially in areas of high tooth decay prevalence.

**Evidence of what works**


Prevention and management of dental decay in the pre-school child:

A national clinical guideline outlines the evidence-based strategies for controlling tooth decay in preschool children (SIGN 83, 2005).

Scottish Intercollegiate Guidelines Network

Guideline 83: Prevention and management of dental decay in the pre-school child

NHS Dental Epidemiological Survey of 3 year olds : school year 2012/13

**Unmet needs and service gaps**

Although most children in Kent and Medway enjoy good oral health, one in five, five- and 12-year-olds experience an average of at least two teeth affected by decay. Further oral health promotion services are therefore needed to address this disparity.

Additionally, dental attendance rates are variable across Kent and Medway. The need for clinical prevention would not appear to have been met and this needs to be developed.

**Recommendations for consideration by commissioners**

- Ensure the continuation of the National Epidemiological programme in Medway
- Promote a coordinated approach to the control of tooth decay through evidence-based oral health promotion interventions
- Promote orientation of primary care dental services to focus on prevention in line with Delivering Better Oral Health - a toolkit for prevention[3]
- Promote regular dental visits for prevention
- Promote development of an appropriate skills-mix workforce in order to meet the dental needs of the population effectively and efficiently
- Promote collaboration with other health workers such as health visitors to deliver oral health messages

**Further needs assessment required**

- Oral health need of families with young children
• Oral health need of children with a disability

**Special educational needs and disabilities [Update in progress]**

**Summary**

**Introduction**

The last five years have seen an increasing number of children and young people requiring additional support. This has had a significant impact on services at all levels — universal, targeted and specialist. This chapter considers children and young people with Special Educational Needs and disabilities (SEND) and their health, education and social care needs.

**Key issues and gaps**

1. Medway Council’s ambition is to ensure we have effective, local provision to meet the needs of children with SEN and disabilities as specified in the Medway SEN Strategy 2009–14. Research has taken place recently which indicates that the number of children with SEN and disabilities requiring specialist provision and services in Medway will increase over the course of the next five years. The reasons for the expected increase are:
   - A recent increase in the birth rate, which will increase the overall number of primary age pupils;
   - The raising of the participation age from 16 to 18 from September 2013, which will result in some more pupils remaining in education for longer;
   - An increase in the proportion of children with statements of special educational needs nationally;
   - Inward migration to the Medway area;
   - Increase in survival rate of pre–term babies.

Taking these factors into account the net increase in pupils with statements requiring specialist provision over the course of the next five years, relating to normal population growth alone is expected to be 59 pupils. However if the level of inward migration to the Medway area of pupils requiring specialist SEND provision continues at two thirds of its current rate, the shortfall could be as much as 258 places. Projections took into account the likelihood that some pupils will continue to require a highly specialist placement for low incidence needs which could not viably be provided by Medway. Pupils currently placed in independent non–maintained placements are unlikely to move until they are at a natural transition point to avoid disruption to their studies and relationships. Therefore, projections assumed that in the medium term it is necessary to plan to provide additional capacity for around 151 pupils.

If no further provision is developed these children will have to be placed in independent provision, some outside Medway, putting significant pressure on the local authority’s budget. More seriously, independent provision is not available for some age groups and
needs, particularly primary aged pupils with severe and complex learning difficulties, meaning there is a risk of some children having no school place at all.

2. Medway's special schools are all outstanding or good, according to their Ofsted reports. Sometimes, although pupils’ SEN needs can be met in Medway, their social needs require a residential element that cannot be met locally. This results in pupils having to attend residential schools outside Medway.

3. Medway has a higher proportion of pupils with SEN and with Statements of SEN than the national average, in spite of demographic data that indicates Medway should be in line with the national average. It also has a higher proportion of those with Statements of SEN in specialist provision than the national average. This suggests that Medway schools are not consistently able to include young people with SEND. SEN provision for children and young people with SEND is largely undertaken by schools. Most pupils with SEND are in mainstream schools without statements of SEN and their needs are met by schools using their delegated budgets. The capacity of schools to do this effectively is a key issue.

4. Rates of exclusion are rising in Medway, increasing the need for interim provision for primary and secondary aged pupils. Approximately 60% of those given fixed term exclusions (FTE) are identified as having SEND. 50% of those with SEND were at School Action. It should be recognized that one reason for identifying a pupil with SEND is behavioural difficulties and approximately 35% of those with FTE were at school action plus because of behavioural, emotional and social difficulties (BESD). However, those with Autistic Spectrum disorders (ASD), moderate learning difficulties (MLD) and specific learning difficulties (SpLD) were also represented. For those with Statements of SEN who received FTE, 16 had BESD, 16 ASD and 11 MLD. This suggests strongly that some SEND are not being addressed in all schools and are leading to behavioural difficulties.

5. Changes to the diagnosis of ASD need to fall in line with recent guidance by the National Institute For Clinical Excellence (NICE) Autism Pathways.[6] Medway needs early identification of ASD via multi agency diagnosis and better links within the teams that identify and provide services for young people with ASD. This has implications for speech and language and occupational therapy and educational psychology.

6. Development of Medway's operational and strategic SEN processes for assessing and supporting children and young people with SEND and their families in line with the SEND draft legislation is required so that:

- Children’s special educational needs are picked up early and support is routinely put in place quickly;
- Staff have the knowledge, understanding and skills to provide the right support for children and young people who have SEN or are disabled wherever they are;
- Parents know what they can reasonably expect their local school, college, authority and services to provide, without them having to fight for it and are more closely involved in decisions about services;
• Children who would currently have a statement of SEN and young people over 16 who would have a learning difficulty assessment have an integrated assessment and a single Education, Health and Care Plan which is completed, implemented and reviewed over time without families having the stress of going from pillar to post to get the support they need; and,

• Parents have greater control over the services they and their family use with:

  – Every family with an Education, Health and Care plan having the right to a personal budget for their support and

  – Parents whose children have an Education, Health and Care Plan having the right to seek a place at any state-funded school, whether that is a special or mainstream school, a maintained school, Academy or Free School.

The legislation has significant implications for how services for children and young people with SEND work together to reduce overlap and maximise the efficiency of resources. Improvements to integrated working around children and young people with SEND and their families across children’s and adult’s services in the education, health and social care are required, including resources to enable better information sharing and to support new assessment processes.

**Recommendations for consideration by commissioners**

To transform the services for young people with SEND and their families Children’s Services and NHS Medway should commission, provide or further develop:

**Provision for SEND**

• A multi agency diagnostic pathway for children with ASD and ADHD ensuring that service provision is able to meet their needs and to support ongoing needs.

• Appropriate levels of SALT, OT and physiotherapy support for schools and Early Years settings

• Local provision for residential or highly increased support for pupils with severe and complex needs to enable them to continue to benefit from local special school education

• Local specialist school provision to meet assessed need

• Local interim provision for those with SEND excluded from school

**Improved joint working**

• Resources to enable compliance with legislation requiring improved information sharing and integrated working between partner agencies to enable more accurate and joined up assessments of need, clearer signposting of services and more efficient targeting of resources: this is likely to include IT and human resources.

• Better links between services provided for children and young people with emotional, behavioural and mental health difficulties particularly between school focussed services and clinic based ones
- A comprehensive and seamless transition service for young people with SEN and disability, including robust integrated care pathways, for access to education and care provision post-16
- A wider range of accessible learning and employment opportunities post-19
- A review of ways of pooling or aligning budgets across education, health and social care to enable single plans to be delivered and resourced

Workforce Development
- A comprehensive training framework for universal, targeted and specialist services, regularly reviewed to ensure that new research-based practices are embedded quickly

Further assessment
- Further needs assessments relating to SEND and minority ethnic communities, including consultation with parent-carers and young people from these communities

Abbreviations used

SEN Types:
Statemented (S)
School Action Plus (SA+)
School Action (A)

SEN Need Types:
Cognition and Learning Needs
SpLD — Specific Learning Difficulties
MLD — Moderate Learning Difficulties
SLD — Severe Learning Difficulties
PMLD — Profound Learning Difficulties

Behavioural, Emotional and Social Development Needs
BESD — Behavioural, Emotional and Social Difficulties

Communication and Interaction Needs
ASD — Autistic Spectrum Disorders

Sensory and/or Other Physical Needs
HI — Hearing Impairment
VI — Visual Impairment
MSI — Multi Sensory Impairment
Physical Difficulties

Other — Other Physical/Sensory Needs

**Who is at risk and why**

The Medway vision for children and young people with SEND within the Children and Young People’s Plan (CYPP) for developing special educational needs is:

- To enable children and young people’s needs to be met in a holistic way enabling them to have a fulfilled adult life
- To deliver educational provision in buildings that are fit for purpose
- To develop the workforce ensuring they are equipped with the skills, knowledge and understanding to provide the quality and scope of the provision required
- To have provision that is quality assured and which gives good value for money
- To have a continuum of provision with mainstream schools accessing the support and expertise within the special provisions
- To enable children and young people to be educated near to where they live and reduce the numbers of children and young people being educated outside of Medway
- To have good post–16 provision, progression and choices

The fundamental principles for SEN in Medway are:

- A child with special educational needs should have their needs met
- The special educational needs of most children will normally be met in a mainstream school (as set out in the Education Act 1996)
- Children’s needs will be met in an appropriate provision
- The views of the child should be sought and taken into account
- Parents/carers have a vital role to play in supporting their child’s education
- Children with special educational needs deserve full access to a broad, balanced and relevant curriculum with clear post–16 progression routes and options

**Special Educational Needs**

The Special Educational Needs (SEN) Code of Practice describes children with special educational needs as having “a learning difficulty which calls for special educational provision to be made for them”. A ‘learning difficulty’ is experienced by school–age children who:

- have significantly greater difficulty in learning than the majority of children of the same age: or
• who have a disability which prevents or hinders them from using the regular educational facilities provided by the local education authority.

Recently the term Special Educational Needs and Disability (SEND) has become more widely used to describe this population. This term will be used throughout this document to refer to all children falling under the SEN Code of Practice definition above. It should be noted however that some pupils with disabilities do not require SEN provision, such as many of those with diabetes.

**Levels of intervention**

Three levels currently exist for pupils with SEN in England as shown in Table 1.

*Table 1: Levels of intervention for SEN in England*[9]

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>School action</td>
<td>The school decides to make its own special provision that is in addition to or different from its usual differential approach to help children learn</td>
</tr>
<tr>
<td>School action plus</td>
<td>The school provides support to the child but requires the support of external specialists and services</td>
</tr>
<tr>
<td>Statement</td>
<td>Local authority arranges provision for a child who requires support beyond which can be provided under the above two interventions</td>
</tr>
</tbody>
</table>

Data from January 2012 puts the number of school children nationally with SEN at 1,618,340 (19.8% of the school population). Of these, 226,125 pupils (2.8% of the school population) had statements of SEN. Nationally the number of statements has increased by 1,915 since 2011 with the population increasing by 54,515. Locally the percentage of the school age population who have a statement is broadly 3.1% whereas the percentage of children with SEN other than a statement has fallen since 2009 from 24.1% to 23.5% in 2010, 22.8% in 2011 and 21.3% in 2012. This number is higher than the national average (19.8%).

A 2010 Ofsted report*[10]* evaluated how well the legislative framework had served children with SEN, and highlighted concerns about the current system. Among its findings:*[11]*

- The proportion of pupils with a statement of SEN decreased slightly from 2003 (3.0%) to 2010 (2.7%), but increased for those requiring support at School Action or School Action Plus from 14.0% to 18.2%.

- For up to half the pupils identified for School Action this could have been avoided if schools had focused on improving teaching and learning for all, with individual goals for improvement.

- Legislation, guidance and systems linked to SEN have become very complex resulting in a system that is difficult to navigate, especially for parents and young people.

This review prompted the government to start a consultation process through a Green Paper, aiming to achieve better educational outcomes and life chances for children and young people with SEND, better early intervention to prevent problems later; and
greater choice for parents in the schools their children attend and the support and services they receive.[9]

A focus on achieving better outcomes for children and young people with SEN is important to increase engagement despite a range of health and social inequalities:

- Those with SEN are recognised as being at higher risk of safeguarding issues, poverty and poor lifelong educational attainment. They may have restricted access to services due to lack of coordinated assessments and provision, and may be at increased risk of family breakdown.[9]

- As the disabled population increases, without a commensurate increase in service provision there is a risk that children with a range of SEND, are excluded from their local community, universal and targeted provision, and from appropriate short breaks.

- Educational achievements and other outcomes (for examples please refer to p22 of the Green Paper)

- Fixed term exclusions

- Secondary health problems in addition to those mentioned in the statement

- Children and young people who are from vulnerable or disadvantaged backgrounds are much more likely to be identified as having SEN, as shown in Figure 1

Figure 1: Children and young people with SEN or disability (SEND) against other factors.[9]

Figure 1: Children and young people with SEN or disability (SEND) against other factors.[9]

Level of need in the population

Levels of SEND in Medway

Medway demographics indicate that the level of SEND should be close to the national average. Medway is at the 50th centile for deprivation which is generally a very good indicator for levels of SEND.

Establishing a definitive picture of need around SEND within Medway is difficult due to different agencies working with individuals and different definitions of disability and its severity. As noted above in relation to the Ofsted report, identification of children as having SEN at school action or school action plus is by schools, and practice is variable nationally, meaning that a pupil in school A identified as having SEND may not be identified by school B. There are also different thresholds for issuing a statement of SEND across the country. SEND data therefore needs to be viewed with this in mind.

Twice per year Medway Council collects census information from schools. The January 2012 school census data is a very comprehensive and current source of information on children with SEND within Medway. The Department for Education Statistical First Release[12] is used as the key source of national data on SEND. It draws from two
sources: the School Census, completed by schools each January, and the SEN2 Survey, completed by local authorities.

- The incidence of overall SEND within Medway schools has fallen over the past 5 years.

- The last five years have seen an increasing number of children and young people with complex needs requiring specialist provision. This has had a significant impact on services at all levels; universal, targeted and specialist

- Medway has a higher level of SEND than the national average

The January 2012 Medway School census shows that there are 42,269 young people on the school roll in Medway. Of this 10,274 have SEND. This represents 24.3% of the school population, compared to 19.8% nationally. 3.1% have a statement compared to a national figure of 2.8%. This suggests that Medway schools are identifying much higher proportions of children and young people as having SEND than the national average.

Medway also has a high rate of pupils with Statements or at School Action Plus (SA+) who are identified with having behavioural, emotional and social difficulties (BESD). 21.5% of primary and 33% of secondary pupils with Statements or at SA+ had BESD as their primary need compared with 18.6% and 29% nationally. The gap increases by a percentage point at secondary level.

Medway has a higher rate of speech, language and communication needs (SLCN) identified as a primary need on Statements and at SA+ for primary pupils (31.2%) than the national average (29.1%). The massive drop at secondary phase (8.4%) mirrors the national picture.

Medway has a much higher proportion of children and young people with Statements for Autistic Spectrum disorders (ASD) than the national average. 12.1% of primary pupils with a Statement in Medway had ASD compared with a national average of 8.5%. 20% of secondary aged pupils with Statements in Medway had ASD compared with 9.6% nationally. This could be related to prevalence rates within Medway as a whole. It is known prevalence rates vary widely across the country. One possible contributing factor is diagnostic procedures. It is noted that currently Medway's diagnostic pathway is not compliant with NICE guidelines.
Figure 1: SEN Type — Medway, National and South East 2012.[13]

SEND and poverty in Medway

There is a direct relationship between SEND levels and poverty within the Medway area. The more deprived wards have higher levels of incidence amongst pupils.

Table 1: The percentage of SEND and statemented pupils by ward, ranked by deprivation

<table>
<thead>
<tr>
<th>Rank</th>
<th>2008 All</th>
<th>2009 All</th>
<th>2010 All</th>
<th>2011 All</th>
<th>2012 All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton and Wayfield</td>
<td>1</td>
<td>38.</td>
<td>4.0</td>
<td>37.</td>
<td>3.7</td>
</tr>
<tr>
<td>Chatham Central</td>
<td>2</td>
<td>34.</td>
<td>3.4</td>
<td>31.</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>7</td>
<td>31.</td>
<td>3.3</td>
<td>30.</td>
</tr>
<tr>
<td>Location</td>
<td>3</td>
<td>33.</td>
<td>3.0</td>
<td>31.</td>
<td>3.2</td>
</tr>
<tr>
<td>----------</td>
<td>---</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Gillingham North</td>
<td>2</td>
<td>8</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Gillingham South</td>
<td>4</td>
<td>31.</td>
<td>3.5</td>
<td>29.</td>
<td>3.7</td>
</tr>
<tr>
<td>Strood South</td>
<td>5</td>
<td>34.</td>
<td>3.2</td>
<td>35.</td>
<td>3.3</td>
</tr>
<tr>
<td>Rochester East</td>
<td>6</td>
<td>26.</td>
<td>2.0</td>
<td>25.</td>
<td>2.0</td>
</tr>
<tr>
<td>Twydall</td>
<td>7</td>
<td>26.</td>
<td>3.3</td>
<td>27.</td>
<td>3.2</td>
</tr>
<tr>
<td>Strood North</td>
<td>8</td>
<td>30.</td>
<td>2.6</td>
<td>28.</td>
<td>2.4</td>
</tr>
<tr>
<td>Princes Park</td>
<td>9</td>
<td>30.</td>
<td>3.2</td>
<td>32.</td>
<td>3.2</td>
</tr>
<tr>
<td>River</td>
<td>10</td>
<td>27.</td>
<td>2.2</td>
<td>26.</td>
<td>2.2</td>
</tr>
<tr>
<td>Rochester West</td>
<td>11</td>
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<td>2.8</td>
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<tr>
<td>Walderslade</td>
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<td>27.</td>
<td>3.9</td>
<td>28.</td>
<td>3.7</td>
</tr>
<tr>
<td>Peninsula</td>
<td>13</td>
<td>26.</td>
<td>2.7</td>
<td>28.</td>
<td>2.8</td>
</tr>
<tr>
<td>Rainham North</td>
<td>14</td>
<td>24.</td>
<td>2.5</td>
<td>25.</td>
<td>2.3</td>
</tr>
<tr>
<td>Lordswood &amp; Capstone</td>
<td>15</td>
<td>30.</td>
<td>1.8</td>
<td>26.</td>
<td>1.7</td>
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<tr>
<td>Rochester South and Horsted</td>
<td>16</td>
<td>20.</td>
<td>2.1</td>
<td>20.</td>
<td>2.3</td>
</tr>
<tr>
<td>Watling</td>
<td>17</td>
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<td>2.4</td>
<td>20.</td>
<td>2.5</td>
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<tr>
<td>Strood Rural</td>
<td>18</td>
<td>24.</td>
<td>2.5</td>
<td>23.</td>
<td>2.1</td>
</tr>
<tr>
<td>Rainham South</td>
<td>19</td>
<td>24.</td>
<td>3.4</td>
<td>25.</td>
<td>3.1</td>
</tr>
<tr>
<td>Rainham Central</td>
<td>20</td>
<td>21.</td>
<td>2.6</td>
<td>23.</td>
<td>2.3</td>
</tr>
<tr>
<td>Cuxton and Halling</td>
<td>21</td>
<td>22.</td>
<td>3.6</td>
<td>21.</td>
<td>3.1</td>
</tr>
<tr>
<td>Hempstead and</td>
<td>22</td>
<td>16.</td>
<td>2.8</td>
<td>16.</td>
<td>2.7</td>
</tr>
</tbody>
</table>
Table 2 shows instances of SEND ranked by deprivation across all 22 Medway wards; 1 is the most deprived and 22 the least. ‘All SEND’ indicates both school action and school action plus. The ‘S’ indicates statemented young people. Historically Luton and Wayfield ward has had the highest percentage of young people with all types of SEND (38.7% in 2008 falling slightly to 37.5% in 2012). This compares to 16.2% and 17.9% respectively for Hempstead and Wigmore ward ranked with the lowest level of deprivation. Similarly Luton and Wayfield ward has the highest instance of statemented young people falling slightly from 4.0% in 2008 to 3.6% in 2012.

This is in line with the national picture:[12]

- The proportion of pupils known to be eligible for and claiming free school meals was much higher for pupils with SEN than for pupils with no SEN.

- In primary schools, 31.5 per cent of pupils with SEN (with and without statements) were known to be eligible for and claiming free school meals, compared with 15.2 per cent of pupils with no SEN.

- In secondary schools the comparable figures were 26.9 per cent for pupils with SEN and 11.7 per cent for pupils with no SEN.

- In special schools, 35.8 per cent of pupils were eligible for and claiming free school meals.[13]

Impact of gender, age and ethnicity on SEND in Medway

**Gender**

- Males with SEND outnumber females and account for approximately 65% of all pupils with an SEN status.

- Although not shown in the table below, this is even starker in the higher need categories; as males who are supported at SA+ outnumber females by over 2 to 1 (31% vs 69%) and with Statements by almost 3 to 1 (27% vs 73%).

- Data shows that males are more prevalent in the cognition and learning difficulties category (over 77% male), whereas young people with physical disabilities have a more even gender split. This matches the pattern seen nationally.[13]

This is in line with the national picture:[12]

- In primary schools, the incidence of pupils with statements of SEN was much higher for boys (2.0 per cent) than for girls (0.8 per cent). Similarly, the incidence of pupils with SEN without statements was higher for boys (21.8 per cent) than for girls (12.2 per cent).
Secondary schools show a similar picture regarding gender. The incidence of boys with statements (2.9 per cent) is nearly three times that for girls (1.0 per cent). The incidence of pupils with SEN without statements was 22.1 per cent for boys and 14.5 per cent for girls.

**Age**

Age of those on school roll in Medway[13]

- Of the 10,274 young people in Medway with an identified SEN status 64% are of primary school age (0–11) and 36% are of secondary age (12-18).
- Of the 64% of primary school pupils 51.8% are at School Action, 38.5% are at School Action Plus and 9.7% have Statements.
- Of the 36% in secondary 56.1% are at School Action, 28.4% School Action Plus and 15.5% have statements.

The age group with the largest number of SEN young people is 10 years old representing 9.4% of the overall total. This is generally because schools or parents believe that although the pupil has managed in mainstream primary school, they would not be able to cope with mainstream secondary school. Pupils need a statement to access special schools and those places are generally requested at the end of Year 5 when the child is 10.

National Picture:[12]

- In primary schools, the percentage of pupils with statements of SEN increased with age. For secondary school age pupils in secondary schools, the percentage of pupils with statements was fairly constant through the age range.
- The percentage of pupils with SEN without statements in primary schools increased fairly constantly with age. In secondary schools, for pupils of secondary school age, the percentage of pupils with SEN without statements decreased from age 11 onwards, falling sharply at age 16.

**Ethnicity**

The January 2012 school census shows that the school population is 42,275 young people. There are 7,857 BME young people (18.6%), BME is defined by the census as “all ethnic groups except; English, Irish, Scottish, Welsh, Other White British, Refused and Not Obtained”.

Within Medway, key points on ethnicity are:

- 82.4% of those with SEN are White–English, with 25.18% of this group within the school population having SEN;
- Some groups are under–represented: 12.99% of ‘Asian, or Asian British–Asian Indian’, 14.76% of Black, or Black British–Black African and 18.48% of ‘Asian or Asian British–Asian Bangladeshi’ are identified with SEN;
• All of these groups are over-represented at SA and under-represented at SA+ compared with the White British group. This is significant as more resources are allocated to pupils with SA+ than SA within schools;

• Some groups are over-represented. The most striking issue is that 54% of the 222 pupils in Medway identified as ‘Gypsy Roma’ are also identified as having SEN.

There needs to be further assessment of the issues underpinning this data including consultation with parents and young people from the communities in question as well as schools.

**Educational outcomes and SEN in Medway**

*Key stage 2 performance*

Young people with a SEN status do not perform as well academically as those with no SEN status. Young people who have no SEN have an average points score over the three subjects of 28.9, those at school action have 24.0, those at school action plus have 23.8 and those young people who have the lowest average point score of 17.4.

*Attendance*

During the first term of the 2012–13 academic year primary aged young people (0–11) with an identified SEN had an overall absence rate of 5.39%. Of this 4.44% were authorised absences and 0.95% were unauthorised. In the same period secondary aged young people (12–18) with SEN had an absence rate of 6.18% authorised and 1.09% unauthorised.

The number of pupils who are persistent absentees in Medway (5.9%) is lower than the national figure of 6.2%. However, it is slightly higher than regional figures of 5.8%.

Comparing the January 2012 school census data to historic information collected from the DoE, the rate of recorded absence is higher (September 2011 to December 2011), for young people with SEN compared to the whole population.

*SEND and Fixed Term Exclusions (FTEs)*

In academic year 2011–12 1,007 young people received 1,989 fixed term exclusions from Medway schools resulting in 5,517.5 school days lost. Of this 577 young people with SEND had received 1,276 FTEs resulting in 3,525 school days lost.

57.2% of young people who have received a FTE have a SEND status. Of these, approximately 47% are at SA and approximately 40% are at SA+ because of BESD.

*Current services in relation to need*

The proportion of pupils with statements who are educated in local maintained provision has increased since 2009. The numbers of pupils awaiting placement has significantly reduced since 2009.
Table 1: Percentage of statemented pupils as at September

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintained LA</td>
<td>52.8%</td>
<td>51.0%</td>
<td>70.7%</td>
<td>81.8%</td>
</tr>
<tr>
<td>Not yet placed</td>
<td>29.1%</td>
<td>28.0%</td>
<td>12.0%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Out of area mainstream</td>
<td>1.4%</td>
<td>1.0%</td>
<td>1.1%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Out of area special</td>
<td>5.2%</td>
<td>6.0%</td>
<td>4.6%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Independent non-maintained</td>
<td>9.4%</td>
<td>12.0%</td>
<td>10.2%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Independent tuition</td>
<td>2.1%</td>
<td>2.0%</td>
<td>1.4%</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

Currently the following major service areas exist in Medway:

- Special schools
- Pupil Referral Units (PRU)
- Inclusive Mainstream Provision
- Specialist support services

**Special schools**

Medway currently resources four special schools, these are for pupils who have (significant) vulnerabilities including complex medical needs, complex Moderate, Severe and Profound and Multiple Learning Difficulties.

Danecourt School is the Primary phase provision for pupils who have Moderate Learning Difficulties (MLD) and MLD with autism. As mainstream schools become more adept at supporting pupils with moderate learning difficulties Danecourt School will support them to develop further expertise to enable them to meet the needs of more challenging pupils and those with complex speech and language needs.

Bradfields School is the Secondary phase provision for pupils who have Moderate Learning Difficulties, with additional layers of complexity. Within Bradfields is Blue Zone which supports pupils with MLD or SLD who are within the autistic spectrum. Bradfields has Post 16 provision offers basic and other skill courses, skills for life, vocational skills, work experience, link courses and leisure pursuits. This provision relocated in September 2011, as the old site will be used in a new academy build.

Abbey Court School is a cross phase provision for pupils who have Severe Learning Difficulties (SLD) and Profound and Multiple Learning Difficulties (PMLD). They have a primary school site (Foundation Stage and Key Stages 1 and 2) in Gillingham and the secondary site (Key Stages 3 and 4) is in Strood. Abbey Court also offers a facility for post 16 education. The Foundation provision now admits children from age 3 years for those children who are likely to need specialist provision and allows earlier intervention.

Rivermead is a Community School providing education for learners who are unable to access mainstream schooling. It provides a nurturing environment and small group teaching for children with a range of complex needs. It also provides hospital and medical tuition. Many of the students attending Rivermead have a mainstream school to
return to although some children have Rivermead named on a statement of special educational needs.

It is an aim that all children have access to a peer group so that they can develop reciprocal friendships. There are groups of children who can best develop these through the careful support and intervention of skilled staff working with pupils who have similar needs and experience related difficulties.

_Pupil Referral Units (PRUs)_

There are 2 pupil referral units in Medway, Silverbank Park and Will Adams. They have a particularly important role as Medway does not have any EBD special schools. Although they have good post 16 progression, they don't in themselves offer post 16 placements.

The Onside project based at Silverbank Park aims to develop therapeutic provision for young people at risk of exclusion and/or where their emotional distress puts them at risk of developing more entrenched mental health difficulties. Outreach currently operates from Silverbank Park but not Will Adams.

The PRUs work closely with the Inclusion Team and have been enabling schools to find alternatives to permanent exclusion. Both PRUs have a clear potential to further develop and embed skills within mainstream settings on supporting distressed and distressing adolescents whose behavior is very challenging.

Silverbank Park is unusual as a PRU since it has a high proportion of statemented pupils placed there. Recently a bid was made to enable part of Silverbank to become an EBD school, rather than remain as a PRU.

_Inclusive Mainstream Provision (sometimes called ‘Special Units’)_

In addition to the special schools described above, Medway supports places at specific inclusive mainstream provision. This is part of specialist support within mainstream provision.

The variety of needs catered for in this inclusive way are:

- Autism — primary and secondary schools
- Hearing impairment — primary
- Visual impairment — primary and secondary
- Physical impairment — primary with secondary in ‘designated’ schools
- Emotional and behaviour difficulties — primary
- Speech and language — primary and secondary
- Specific learning difficulties — secondary
- Vulnerable — secondary
- Moderate learning difficulties — primary and secondary
Post–16 Rivermead/Mid–Kent Partnership based at Mid–Kent College for vulnerable pupils, many with autism/Asperger Syndrome

The purpose of the additionally resourced places is to provide specialist support for children who have complex needs and require additional resources not normally available to the mainstream school. The physical organisation of Medway’s inclusive additionally resourced provision, in relation to their mainstream school, depends on the needs of the pupils they support.

Flexibility to adapt the focus of the provision if need changes over time is important and will be discussed and planned with schools. For example an existing Key Stage 1 and Key Stage 2 provision for children who have physical difficulties (completely integrated within the mainstream setting) now has significant vacancies due to parents choosing a local mainstream option.

Specialist Services

Current SEN legislation recognises that additional support is required for the most complex needs. Traditionally such additional support was offered by local authorities. In Medway schools and academies now hold much of the budget for purchasing these additional services. The LA still provides some specialist services free of charge to schools and some of these have a statutory role. These include Educational, Child and Community Psychology Service, Inclusion Team, Autism Outreach Team and Physical and Sensory Service. A key function of all these teams is to increase schools' ability to meet the complex needs of those identified with SEND. In addition, the LA commissions support for schools from outreach teams based at Chalklands BESD unit, Danecourt primary and Bradfields secondary schools for those with significant behavioural or learning difficulties, sometimes with autism. These services are essential in order to offer pupils with SEND the best opportunity for succeeding in mainstream schools.

Pupils with SEN are supported by specialist support services provided by the Local Authority. These include:

- Educational, Child and Community Psychology Service
- Physical and Sensory Service
- Inclusion Team
- Autism Outreach
- Specialist Behaviour and Learning Support Teachers

Educational and Child Psychologists are available to schools and other professionals when additional support is needed to help understand why a pupil is not making progress or is struggling with aspects of school in spite of school based interventions being put in place. Support can take the form of consultations with staff, direct work with individual or groups of pupils or staff, training, whole school development or further assessment. They also take part in CAFs or Annual Reviews where there are complex issues requiring psychological input.
Between April and September 2012, ECPs offered 1275 consultations to school staff, gave direct support or assessment to clarify need and inform intervention to 437 pupils and took part in 57 CAFs.

Pathfinder – SEN Financing

The Green Paper has clearly signaled that there will be a requirement to have more joined up services and there will be one assessment and plan for health, education and social care needs and a duty for all agencies to co-operate in single assessment and planning. This will mean that at a strategic level there will need to be ways of allocating and providing resources according to assessed need. Draft legislation places a duty on health and local authorities to jointly commission health, social care and education services for children and young people with SEND.

The new single assessment will replace the current system where those transferring from school to FE college have a completely different assessment, a Learning Difficulties Assessment. It is anticipated this will aid transition which has been reported on by many families nationally as not streamlined or supportive enough. Improved transition into further education, training and employment is a key outcome focused on at a national level currently.

One of the central ideas in the Special Educational Needs Green Paper is making sure that services and support are more “personalised”. This means that children, young people and their families have as much choice and control as possible over the support they need and that support is built around the individual rather than trying to fit into existing services or ways of support.

One way of making this happen is the introduction of a Personal Budget — an up-front allocation of resources (which could be a direct payment) that the child, young person or family can use to meet an identified need. The Pathfinder will explore ways in which Personal Budgets can be made available using resources currently in social care, health and education. This work will include identifying what money can be used, what it can be used for and a method for deciding how much the budget will be.

The trials will also include making sure that the support people need to manage a personal budget is also in place. Personal budgets should link with the single assessment process and the single plan which will specify outcomes for the young person and the resources required to achieve these.

As part of the SEND Pathfinder, Medway is planning to pilot personal budgets for a group of disabled children and young people. We are investigating how to include funding from a range of sectors, including health and some education costs if appropriate and possible. There are implications for all services working with children and young people across health, social care and education to ensure that new legislative requirements which are due to be in place by 2014 can be met.

School funding, and in particular, funding for special needs, is being radically overhauled. This may have implications for the commissioning of specialist educational provision in the near future.
Projected service use

A consultant was commissioned in 2011 to undertake a special educational needs assessment looking at baseline pupil numbers and initiating a basis upon which to build a robust forecasting system to enable future planning of required provision. This has been further developed in 2013 to take account of increased local SEN capacity and updated demographic information.

One factor that needed to be accounted for as a separate (unpredictable) factor was the anticipated impact of an emerging pattern of inward migration to Medway of children requiring specialist SEND provision. This resulted in 60[5] unexpected additional children moving into Medway in 2011 with statements requiring specialist provision. These children had moved into Medway from other parts of the UK, with a large proportion moving in from other parts of the south of England. This high level of pupils moving into Medway requiring specialist placement was maintained in 2012, with 53 requiring specialist placement moving in between January and December 2012.

Between January and May 2013, 27 additional children requiring specialist provision moved to Medway. We are aware from phone calls from parents, ahead of their move date, that this number is likely to increase during July and August.

This has implications for SEN planning as current predictions were based on an assumption that the 2011 increase was unlikely to be maintained but that we should plan for at least one third of the increase being maintained over the next five years. Current evidence indicates that we should plan for at least two thirds of the increase being maintained over that period.

If the short-term increase seen in 2011 and 2012 were to continue at the same rate over the next five years, then this would result in an additional 300 pupils with statements requiring specialist provision, over and above the 59 projected through normal population growth. The increase experienced since January 2011 is unprecedented and may not be sustained at this level in the future. However, we must seek to plan for a proportion of inward migration as part of our planning for special educational needs and it is recommended that we should plan for at least two thirds of this increase being sustained over the next five years.

If no further provision is developed, this could result in 258 additional children being placed in independent out of area provision taking the total number of children to 561 over the next five years (303 existing plus 258 future need projected).

The final factor incorporated into the projections are the number of children the authority aims to a) return to local placements or b) specialist needs currently provided out of area that in future we aim to place locally. Realistically, it is unlikely to be possible, and/or cost effective to create sufficient provision to meet the needs of all children with statements requiring specialist provision in Medway Schools. This is because there will be some pupils, who will have particularly specialist needs, which a particular provider is well placed to meet, where the costs of creating Medway based provision, for a small number of pupils, would not be justified. Our assessment of live cases indicates that it is more realistic to plan to provide additional capacity for half of the type of needs currently educated in independent or out of area provision in the medium term accounting for 151 places.
The forecast increase is shown in the table below by main disability need type based on the forecast increase of 59 pupils plus 33% of the current unpredictable inward migration which represents 99 pupils, plus 50% of the places currently provided in independent and out of area provision which represents 151 pupils. This would require the creation of 309 additional local places overall.

Table 1: SEN need forecasts. More recent calculations reflecting the actual level of continued inward migration suggests that 66% of the 2010-11 inward migration figures should be used to more accurately predict future need for specialist provision. Therefore this would double the figures in this column and lead to a need for an additional 100 places in specialist provision over the next 5 years.[5]

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>Forecast population increase</th>
<th>33% of unpredictable inward migration</th>
<th>50% places currently provided out of area/independently</th>
<th>Total planned increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>VI</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SPLD</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>13</td>
<td>14</td>
<td>30</td>
</tr>
<tr>
<td>SLD</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>13</td>
<td>10</td>
<td>10</td>
<td>33</td>
</tr>
<tr>
<td>SLCN</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>10</td>
<td>11</td>
<td>24</td>
</tr>
<tr>
<td>PMLD</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>3</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>MLRD</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>11</td>
<td>20</td>
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<td>HI</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>BESD</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>12</td>
<td>33</td>
<td>29</td>
<td>74</td>
</tr>
<tr>
<td>ASD</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>13</td>
<td>10</td>
<td>50</td>
<td>73</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>18</td>
<td>15</td>
<td>8</td>
<td>3</td>
<td>59</td>
<td>99</td>
<td>151</td>
<td>309</td>
</tr>
</tbody>
</table>

Since this forecast there has been the development of additional provision, with more planned. It is likely that this will start to address some of the additional needs set out above:

- the creation of an ASD unit at Bradfields School in September 2012 created provision for up to 40 additional pupils with severe and complex ASD need across all key stages.

- Each of the three new build Academies will include accommodation for secondary pupils with special educational needs, which will provide an additional 40 places in total. This consists of new provision for 20 pupils with a main need type of ASD or
MLD at Strood Academy, which is due to open in September 2014 and for 20 pupils with a main need type of ASD or MLD at the Bishop of Rochester Academy, which will be completed in September 2013. The provision at Brompton Academy will be for the same number of pupils currently provided for, where the need type has since 2011 been re-balanced to take account of the changing profile of need in Medway. It now includes provision for vulnerable children as well as those with SPLD, and SLCN.

- The expansion of specialist provision at Twydall Primary School in September 2012, provides additional capacity for up to 12 children with hearing impairments, in addition to the school’s existing provision for children with physical difficulties.

This additional capacity (shown below), will therefore provide for up to 98 additional pupils overall leaving 211 places to plan for in this strategic planning phase. The impact of these additional places on the projected forecast need and the profile of these pupils are shown in the table below. This projected forecast will be kept under review based on actual and emerging need trends.

In addition to the development of new places support services need to develop to match the new demands placed on the service. Also, those young people who are already in situ need to be identified and any new services created through the reorganisation of services must be advertised to them.

*Table 2: Forecast of additional special educational needs*[5]

<table>
<thead>
<tr>
<th>Projected forecast of additional need</th>
<th>Provision already planned</th>
<th>Remaining forecast of additional need</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPLD</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>SLD</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>SLCN</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>PMLD</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>PD</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>MLD</td>
<td>45</td>
<td>35</td>
</tr>
<tr>
<td>HI</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>BESD</td>
<td>74</td>
<td>74</td>
</tr>
<tr>
<td>ASD</td>
<td>73</td>
<td>51</td>
</tr>
<tr>
<td>Total</td>
<td>309</td>
<td>98</td>
</tr>
</tbody>
</table>

There is currently school based nursery provision for children with SEND in Medway at Abbey Court Special School, Twydall Primary and All Faiths Primary. In addition, the health service special needs nursery has provision for disabled children with medical needs and provide assessment for a wide spectrum of needs.

There is currently a gap in additional provision for children with other needs, most commonly ASD, who are typically educated in private nursery provision. This means that there are some children for whom a placement at the Marlborough Centre is likely, who cannot be placed in the most appropriate early years provision. The Marlborough Centre is based a Hoo St Werburgh Primary School and has 61 places for young people
with ASD. The centre itself has been identified in the SEN strategic plan for development on integrated foundation stage provision.

This also restricts the opportunities to assess the needs of some children until they start at specialist provision in Reception (year R). Also, as significant progress can often be made for all children including those with SEND, if early years provision is good, there may be some pupils, who with the right support form a specialist provision, could be placed in a mainstream provision from year R.

**Table 3: Number of statements of SEN issued per year academic years 2006 to 2010.[14]**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of new statements issued</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>188.0</td>
</tr>
<tr>
<td>2009/10</td>
<td>201.0</td>
</tr>
<tr>
<td>2008/09</td>
<td>225.0</td>
</tr>
<tr>
<td>2007/08</td>
<td>223.0</td>
</tr>
<tr>
<td>2006/07</td>
<td>194.0</td>
</tr>
<tr>
<td>5 year average</td>
<td>206.2</td>
</tr>
</tbody>
</table>

Table 3 shows that there was a peak in 2008–09 of the number of statements issued by Medway SEN team. This figure reduced to 201 in 09–10 and 188 in 2010–11 with a 5-year average of 206.2.

**Evidence of what works**

Through reporting requirements for National Indicator 54, services should look to offer:

- Good provision of information
- Transparency in how the available levels of support are determined
- Integrated assessments
- Participation of disabled children and their families in local services
- Accessible feedback and complaints procedure.

The Government’s Disabled Children Review has culminated in the report ‘Aiming High for Disabled Children: Better Support for Families’

The evidence gathered through the Disabled Children Review determined that the most effective way of transforming the life chances of disabled children and young people is through:

- Enabling access and empowerment
- Providing responsive services and timely support
- Improving service quality and capacity
Principles and guidance for implementing a successful joint commissioning programme for children’s services across local authorities and primary care trusts can be found here.

The national review of Targeted Mental Health identified the effectiveness of early intervention to support emotional and behavioural needs and identified educational psychologists as an important professional group being sought out to help schools provide for complex emotional and behavioural needs. It identified them as a key group to provide a link between schools and specialist CAMHS.

The Government’s white paper ‘Choosing Health’, published in November 2004, presents the results of an extensive public consultation into the reshaping of public health policy. That process established three core principles of a new public health strategy:

- Informed choices based on reliable information
- Personalisation of services
- Effective multi-agency working

The Department of Health document ‘Better Care: Better Lives’ sets out the Government’s commitment to ensuring that a choice/range of services is available when needed to enable every child or young person with life-limiting or life-threatening conditions to live as full a life as possible, as well as providing the necessary support to their families.

Above all, the emphasis is on the requirement for services to be designed around the needs of children and families rather than the criteria of different agencies or organisations, or professional boundaries.

The Childcare Act 2006 requires Local Authorities and partner agencies including Primary Care Trusts to prioritise the needs of disabled children as part of their new duties to assess childcare needs of families and to secure sufficient childcare to children up to and including age 14 (18 for disabled children).

**User views**

Through participation and consultation, customers have identified that they require holistic, joined up assessments, access to universal settings, transport, and to have a choice of the quality services they receive.

This means developing flexible links to early years and universal, targeted and specialist service provision.

Recent feedback from parents is that they want a ‘one stop shop’ approach to SEND. This was highlighted in 2010 when the Sandridge Child Development Centre (CDC) closed during a reconfiguration of hospital premises. Since then parents and clinicians have clearly stated that a new CDC with clinicians relocated is what they want enabling a more coordinated and holistic approach to assessment.

Children, young people and their families have been integral in the design and development of SEND processes. Medway is one of 21 local authorities taking part in the
The Pathfinder Evaluation is collecting information at a national and local level from young people, parents and professionals about the current services provided and the changes proposed in the SEND Green Paper. This information will be published by the DFE.

Schools have identified an interest in commissioning additional educational and child psychology services and this will be taken forward from September 2012. In addition, the Educational, Child and Community Psychology Service (ECCPS) will offer evidence-based interventions to support adoption and fostering placements to Social Care as a pilot project.

Parents and children have expressed the need for one voice to inform a co-ordinated holistic assessment to identify provision to meet their needs and to prevent the risk of family breakdown (see references to ‘Every Child Matters’ and ‘Think Family’ in section 5). This is being addressed by the SEND Pathfinder work, which is working with families to trial more streamlined and joined up assessment and planning processes.

Parental consultation has suggested that there is a lack of disability awareness within universal and targeted services and their capacity to successfully include and address the needs of this group of young people. This has partially been addressed as part of the Pathfinder workforce development work and Aiming High by the purchase of an e-learning tool, which is available to all parent carers and staff in Medway who work with children and young people. It is being administered by the LA Learning and Development Unit.

**Equality impact assessment**

A Diversity Impact Assessment screening will be completed in relation to any specific proposals that are taken forward.

**Unmet needs**

- The shortfall in specialist provision for school aged and pre-school pupils with SEND has been noted above.

- The effect on SEND provision of schools changing their school type to academy status is yet to be fully understood. There has been a rise in exclusions from some academies since status change which has increased the need for the LA to have in place alternative curriculum and tuition options at least for interim provision. An increase in permanent exclusion (PE) of primary aged pupils has resulted in a need to provide interim provision for this age group.

- The increase in pupils with complex needs being educated in Medway has implications for specialist services and in particular speech and language and occupational therapy. In order to match the level of provision offered in the independent sector many of our new specialist provisions would need allocated speech and language therapy time. Also, some pupils can have their SEN needs met in mainstream as long as sufficient direct SLCN is available. Currently SEN is having to spot purchase SLT support to supplement what is generally available. At least
one special school who provide their own therapy team from their own resources are struggling to access any support for their pupils from the community teams.

- Managing children and young people with challenging behaviour in school is a high priority (CYPP). Social, Emotional and Behavioural Difficulties (SEBD) must be included in this work as young people who have SEBD face significant barriers to learning and development. TAMHS evaluation highlighted the importance of educational psychology services in supporting complex emotional and behavioural needs in schools. In Medway opportunities for greater join up between CAMHS and school focussed services provided by educational psychology should e explored.

- Joint work and better information sharing between services up to avoid overlap, evidence based interventions, early intervention with child and family. More join up between mental health, psychological and behaviour support services to ensure effective deployment or resources and better targeted interventions at whole school, group and individual levels.

- Evidence informed interventions to support children and young people with SEND in schools are important and a Medway framework for training could help reduce overlap and offer a more strategically focussed, evidence informed programme. However, research[15] increasingly shows that factors relating to the way programmes are implemented are critical in whether they are effective. This means the training framework needs to extend into or link with school based support by appropriately trained professionals to ensure programme fidelity.

Recommendations

To transform the services for young people with SEND and their families Children’s Services and NHS Medway should commission, provide or further develop:

**Provision for SEND**

- A multi agency diagnostic pathway for children with ASD and ADHD ensuring that service provision is able to meet their needs and to support ongoing needs.

- Appropriate levels of SALT, OT and physiotherapy support for schools and Early Years settings

- Local provision for residential or highly increased support for pupils with severe and complex needs to enable them to continue to benefit from local special school education

- Local specialist school provision to meet assessed need

- Local interim provision for those with SEND excluded from school

**Improved joint working**

- Resources to enable improved information sharing and integrated working between partner agencies to enable more accurate and joined up assessments of need and more efficient targeting of resources: this is likely to include IT and human resources.
• Better links between services provided for children and young people with emotional, behavioural and mental health difficulties particularly between school focussed services and clinic based ones

• A comprehensive and seamless transition service for young people with SEN and disability, including robust integrated care pathways, for access to education and care provision post–16

• A wider range of accessible learning and employment opportunities post–19

• A review of ways of pooling or aligning budgets across education, health and social care to enable single plans to be delivered and resourced

Workforce Development

• A comprehensive training framework for universal, targeted and specialist services, regularly reviewed to ensure that new research–based practices are embedded quickly

Further needs assessment

Key areas for the recommendations should be geared to commissioning and gathering relevant data through our management information systems (MIS). This will enable all services to identify who is accessing services, and whether there are parts of the community under–represented in the take–up of services. This would support the gathering of detailed information to identify trends relating to nature of need, disability, gender and ethnicity to inform future planning of services.

Further assessment of the needs and possible barriers for specific communities within Medway highlighted in current data, such as Eastern European and Gypsy/Roma community to enable services to target support to this vulnerable group of young people. This should be informed by SEND data and must include consultation with parent–carers and young people from those communities.

Immunisations and vaccinations

Summary

Immunity is the ability of the human body to protect itself against infectious disease. Active immunity is protection that is produced by an individual’s own immune system and is usually long lasting — it can be acquired by natural disease or via vaccination. Passive immunity is protection provided from the transfer of antibodies from immune individuals, most commonly across the placenta or less often from the transfusion of blood or blood products including immunoglobulin. Passive immunity is temporary but provides immediate short–term protection against disease.[16]

After clean water, vaccination is the most effective public health intervention in the world for saving lives and promoting good health.[17] Vaccination generally provides a similar immunity to that provided by natural infection, but without the risk of
complications of the disease. Vaccinations work by producing immunological memory, so that when the immune system is subsequently exposed to natural infection it is able to recognise and respond to it, thus preventing or modifying the disease. In some cases more than one dose of the vaccine may be required initially to produce this response and/or booster doses may be required to maintain it. While the main aim of vaccination is to protect the individual who receives it, high levels of immunity in a population mean those who cannot be vaccinated, for example because they are too young, are also at reduced risk of being exposed to a disease. This is known as herd immunity. When vaccine coverage is high enough a disease may be eliminated from a community, however if this is not maintained the disease may return.[16] Vaccine coverage is evaluated against World Health Organization (WHO) targets of 95% coverage annually for each vaccine (except Meningitis C) at the national level, and at least 90% in each Strategic Health Authority.[18]


Who’s at risk and why

Protection provided by the cross-placental transfer of antibodies from mother to child is more effective against some infections (e.g. tetanus and measles) than for others (e.g. polio and whooping cough). This protection however is temporary — commonly for only a few weeks or months.[16] It is therefore important that all children start receiving vaccinations at the appropriate time. The current childhood vaccination schedule is shown below:

Table 1: Routine child vaccination schedule, 2014.[19]

<table>
<thead>
<tr>
<th>Age</th>
<th>Vaccine</th>
<th>Diseases protected against</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 months</td>
<td>DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)</td>
<td>Diptheria, tetanus, pertussis (Whooping cough), polio and Haemophilus influenzae type b (Hib)</td>
</tr>
<tr>
<td>2 months</td>
<td>PCV (Prevenar 13)</td>
<td>Pneumococcal disease</td>
</tr>
<tr>
<td>2 months</td>
<td>Rotavirus (Rotarix)</td>
<td>Rotavirus</td>
</tr>
<tr>
<td>3 months</td>
<td>DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)</td>
<td>Diptheria, tetanus, pertussis, polio and Haemophilus influenzae type b (Hib)</td>
</tr>
<tr>
<td>3 months</td>
<td>MenC (Menjugate or Neisvac C)</td>
<td>Meningococcal group C disease (Men C)</td>
</tr>
<tr>
<td>3 months</td>
<td>Rotavirus (Rotarix)</td>
<td>Rotavirus</td>
</tr>
<tr>
<td>4 months</td>
<td>DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)</td>
<td>Diptheria, tetanus, pertussis, polio and Haemophilus influenzae type b (Hib)</td>
</tr>
<tr>
<td>4 months</td>
<td>PCV (Prevenar 13)</td>
<td>Pneumococcal disease</td>
</tr>
<tr>
<td>12 to 13 months</td>
<td>Hib/MenC (Menitorix)</td>
<td>Hib/MenC</td>
</tr>
<tr>
<td>12 to 13 months</td>
<td>PCV (Prevenar 13)</td>
<td>Pneumococcal disease</td>
</tr>
</tbody>
</table>
12 to 13 months

- MMR (Priorix or MMR VaxPRO)
- Measles, mumps and rubella (German measles)

2,3 and 4 years

- Flu nasal spray (Fluenz Tetra – annual – if Fluenz unsuitable, use inactivated flu vaccine)
- Influenza

3 years 4 months

- FTaP/IPV (Infanrix or Repevax)
- Diptheria, tetanus, pertussis and polio

3 years 4 months

- MMR (Priorix or MMR VaxPRO – check first dose has been given)
- Measles, mumps and rubella (German measles)

12 to 13 years - girls only

- HPV (Garasil)
- Cervical cancer caused by human papillomavirus types 16 and 18 (and genital warts caused by types 6 and 11)

Around 14 years

- Td/IPV (Revaxis) and check MMR status
- Tetanus, diptheria and polio

Around 14 years

- MenC (Meningtite, Menjugate or NeisVac-C)
- MenC

Non-routine vaccinations are also offered to those at increased risk such as:

- Infants whose mothers have been detected to be hepatitis B positive via antenatal screening — these infants require Hepatitis B vaccination at birth, 1 month old, 2 months old and 12 months old. A preschool booster is also recommended.

- Infants who are more likely to come into contact with tuberculosis than the general population — these Infants are offered BCG vaccination soon after birth

Other vaccinations given to children and young people include:

- seasonal flu vaccination if in a clinical risk group
- hepatitis B vaccination if at increased risk of hepatitis B because of lifestyle, occupation or other factors e.g. a household contact of someone who is infected with hepatitis B
- travel vaccinations (generally not funded by the NHS although there are some exceptions)

The level of need in the population

COVER (Cover of Vaccination Evaluated Rapidly)

The COVER programme monitors immunisation coverage data for children in the United Kingdom who reach their first, second or fifth birthday during each evaluation quarter. This is a mandatory collection at a local level which is then collated nationally and comparators are made available.

Historically in Medway vaccination uptake rates in children have been high. In 2010/11 they were above those achieved in England and within the South East Coast Strategic
Health Authority (SEC SHA) area for all childhood immunisations, exceeding the 90% level in all and the 95% level in several. However, analysis at practice level (link to APHR 2011/12) has shown considerable variation, which needs further investigation and action.

The following tables show the most recent COVER data for Medway and comparators where available.

Table 1: Percentage of children immunised by their first birthday, by PCT 2010–11.[20]

Table 2: Percentage of children immunised by their second birthday, by PCT 2010–11.[20]

Table 3: Percentage of children immunised by their fifth birthday, by PCT 2010–11.[20]

Key to tables 1 to 3

Hepatitis B vaccine uptake

In 2010/11, 81.3% of babies of mothers with Hepatitis B infection (13 of 16), in Medway, had received three doses of Hepatitis B vaccine before reaching their 1st birthday, but only 40% had received four doses before their 2nd birthday (four of 10).

Table 4: Number and percentage of children given Hepatitis B vaccination.[21]

<table>
<thead>
<tr>
<th></th>
<th>Denominator 1</th>
<th>Percentage coverage at 12 months</th>
<th>Denominator 2</th>
<th>Percentage coverage at 24 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr - Jun 2011</td>
<td>4</td>
<td>100</td>
<td>6</td>
<td>50</td>
</tr>
<tr>
<td>Jul - Sep 2011</td>
<td>7</td>
<td>71</td>
<td>3</td>
<td>66</td>
</tr>
</tbody>
</table>

The BCG (Bacillus Calmette–Guérin) programme

Until 2005, all children aged 10–14 were offered a tuberculin skin test in school to see whether they had immunity against TB and then BCG vaccination if they had not. This ceased following a continued decline in TB rates in the indigenous UK population.

The BCG programme is now a risk based programme. BCG vaccination should be offered in the neonatal period to all infants (0–12 months) living in areas of the UK where the annual incidence of TB is 40 per 100,000 or greater. In areas with lower incidence (fewer than 40 cases of TB per 100,000 population) like Medway, BCG is offered selectively to infants at increased risk due to having a parent or grandparent who was born in a country where the annual incidence of TB is 40 per 100,000 or greater.

Neonatal BCG is offered via the chest clinic with referrals from both midwives and health visitors.
BCG should also be offered to previously unvaccinated older children who were born, or have lived for at least 3 months, in a country where the annual incidence of TB is 40 per 100,000 or greater or who have a parent or grandparent who was born in such a country. Children over 6 years of age require tuberculin testing prior to vaccination.[22]

The number of children and adults who have received BCG vaccination via the chest clinic is shown in Table 6.

Table 5: The number of BCG vaccinations per 1,000 population over the past 3 years in Medway compared to SEC SHA and England.[20][23]

<table>
<thead>
<tr>
<th></th>
<th>2008/09 All ages</th>
<th>2008/09 Age under 1</th>
<th>2008/09 Age 1 and over</th>
<th>2009/10 All ages</th>
<th>2009/10 Age under 1</th>
<th>2009/10 Age 1 and over</th>
<th>2010/11 All ages</th>
<th>2010/11 Age under 1</th>
<th>2010/11 Age 1 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway</td>
<td>582</td>
<td>321</td>
<td>261</td>
<td>560</td>
<td>339</td>
<td>221</td>
<td>447</td>
<td>292</td>
<td>155</td>
</tr>
<tr>
<td>South East Coast</td>
<td>12761</td>
<td>7988</td>
<td>4773</td>
<td>11986</td>
<td>9383</td>
<td>2603</td>
<td>6727</td>
<td>5547</td>
<td>1180</td>
</tr>
<tr>
<td>England</td>
<td>23924</td>
<td>14894</td>
<td>90293</td>
<td>22316</td>
<td>11561</td>
<td>67556</td>
<td>22531</td>
<td>15325</td>
<td>72063</td>
</tr>
</tbody>
</table>

In 2005 when the changes occurred, Kent and Medway PCTs decided to screen in Year 9 via a questionnaire and then offer Mantoux testing followed by BCG vaccination by school nurses to those found to be at high risk.

The HPV (Human Papillomavirus) programme

This was first introduced in the school year 2008/09 and is made available to girls in school year 8. A catch up programme for older girls also occurred. The type of HPV vaccine used will change in 2012/13 to one that also protects against genital warts.

Figure 1: Uptake of HPV vaccination in school year 8, past 3 years in Medway by date of birth.[23]

School leaving booster

In Medway the school leaving booster is offered to young people in school in year 10, which is the school year when they are or become 15 years of age, with catch up via GP practices. Table 7 shows in addition that MMR continues to be offered by GP practices to those children who have not had both doses earlier in life.

Table 6: Immunisations given to school leavers and other children aged 13–18 in the academic year 2010/11.[23]

<table>
<thead>
<tr>
<th></th>
<th>DT.IPV. Course n.1</th>
<th>DT.IPV. Course n.2</th>
<th>MMR Course n.1</th>
<th>MMR Course n.2</th>
<th>DT.IPV. Course n.1</th>
<th>DT.IPV. Course n.2</th>
<th>MMR Course n.1</th>
<th>MMR Course n.2</th>
</tr>
</thead>
</table>
**Current services in relation to need**

The delivery of the childhood vaccination programme is primarily via practice nurses in all general practices in Medway via a Directly Enhanced Service (DES). The 2011/12 Annual Public Health Report shows that in Medway overall uptake rates in practices for childhood vaccinations are very good, there is considerable variation between practices. This needs further investigation.

The HPV vaccination programme for girls aged 12–13 years is delivered through the school nursing service. A general practice Local Enhanced Service (LES) is in place for girls up to the age of 18 who have missed vaccination in school.

The school nursing service also delivers the school leaving booster, with a LES in place for those who miss this in school.

The neonatal BCG programme is delivered by the chest clinic at Medway Foundation NHS Trust. The school nursing service should be screening all children in Year 9 and then offer Mantoux testing followed by BCG vaccination to those found to be at high risk. New entrants to schools in Medway should be screened for risk factors on entry.

The HPU provide a two day training programme on immunisation and vaccination for all new vaccinators and a half annual update for all others as per Health Protection Agency guidelines.

An Immunisation Co-ordinator who is a community paediatrician at Medway Foundation NHS Trust provides clinical advice and some training on immunisation and vaccination to those who vaccinate in Medway in addition to that provided by Kent Health Protection Unit (HPU)

Ensuring that Looked after Children are fully vaccinated is a priority for the nurses from the Looked after Children’s Health Team.
Projected service use

The number of births to mothers resident in Medway has increased by 8.6% over the past 5 years from 3,257 in 2006 to 3,538 in 2010. Although it is projected that the number of women of child bearing age will fall slightly over the next 5 to 10 years, the overall number of births and therefore children requiring vaccination, may continue to increase if women decide to have larger families. The latter may be affected by the economic situation and also the degree of inward migration as the number of live births per 1,000 females of childbearing age for UK born women in 2010 was 1.88 compared to 2.45 for non-UK born women.[24]

Several new vaccines have become available in the past 10 years and it is quite likely that more will become available in years to come. At least 2 new vaccines (against Meningitis B and Staphylococcus Aureas) are being clinically trialled. Also there are vaccines licensed in the UK which are not included in the UK schedule but are within those of other countries e.g. Varicella (chickenpox) and Rotavirus which may in the future be added to the UK schedule.

High uptake rates in Medway should not lead to complacency — new parents need to be made aware of the benefits of vaccination as do others at risk. MMR uptake rates dropped in the UK from 1998 as a result of a paper published in The Lancet asserting a link between the vaccine and autism and cases of measles subsequently increased. Although the theory was disproved by other international studies and the co-authors of the 1998 paper issued a retraction in 2004, it took several years for uptake rates to increase again. This has resulted in a cohort of children now approaching their teens who are not immune to measles which is of concern as the case—fatality ratio for measles is high in children under 1 year, lower in children aged 1–9 years and then rises again in teenagers and adults. Measles outbreaks have occurred in the UK in recent years and in 2011 there were several in European countries such as France which may be holiday or study destinations for these unvaccinated young people.

Migrants make up an increasing proportion of the UK populations. In 2001 it was estimated that 8% of the total UK population were born abroad by 2010 the figure was closer to 12%.[25] The majority of long term migrants are young people with plans to study or work. Some of these will have children and be less aware of the need for vaccination in childhood due to language or cultural issues. The HPA launched the online Migrant Health Guide in 2011 to assist primary care practitioners caring for people who have come to live in the UK from abroad and this gives helpful information on vaccination of those who have not been immunised according to the UK schedule.

Evidence of what works

NICE Public Health Guidance: 21

NICE public health guidance entitled “Reducing differences in the uptake of Immunisations (including targeted vaccines) in people younger than 19 years” was issued in September 2009.[26] Ensuring that there is high uptake of vaccinations is childhood involves many different organisations and individuals. Recommendations include
• Having multifaceted, coordinated immunisation programmes which monitor uptake

• Having information systems to support the programmes so that details of who requires vaccination and who has had the various types is reliably recorded

• Training for those who advise on and provide immunisations services

• Ensuring the contribution of nurseries, schools and colleges of further education to promote vaccination

• Targeting groups at risk of not being fully immunised such as children in care, young people who missed previous immunisations, children with physical or learning difficulties, children of lone parents, children not registered with a GP, children in larger families, hospitalised children, and minority ethnic groups

**Heath Protection Agency (HPA)**

The Health Protection Agency is an independent UK organisation that was set up by the government in 2003 to protect the public from threats to their health from infectious diseases and environmental hazards. It does this by providing advice and information to the general public, to health professionals such as doctors and nurses and to national and local government and includes specific information about immunisations and vaccinations.

**Public Health England Vaccinations**

**NHS choices immunisation website**

A comprehensive, up-to-date and accurate source of information on vaccines, disease and immunisation for the UK for the public.

**NHS choices**

**Joint Committee for Vaccinations and Immunisations**

The Joint Committee on Vaccination and Immunisation (JCVI) is an independent expert advisory committee first set up in 1963 to advise the Secretaries of State for Health, Scotland, Wales and Northern Ireland on matters relating to communicable diseases, preventable and potentially preventable through immunisation. JCVI gives advice to Ministers based on the best evidence reflecting current good practice and/or expert opinion. The process involves a robust, transparent, and systematic appraisal of all the available evidence from a wide range of sources. The committee is appointed by the Appointments Commission and is independent of the Department of Health.

**Joint Committee for Vaccinations and Immunisations**

**Department of Health Immunisation against Infectious Disease – ‘The Green Book’**

The most recent printed version was published in 2006, but the website is regularly refreshed with updated chapters. Each chapter gives details on the disease, vaccine available, efficacy of the vaccine, contraindications, side effects and the correct dosage etc.
User views

No research has been conducted into user views over the past 3 years in Medway.

Equality Impact Assessment

Unmet needs and service gaps

A campaign is required to raise the need for MMR in the cohort who missed this as children and who are now approaching adolescence.

Recommendations for commissioning

- Identify the reasons for the variation in uptake rates between practices
- Ensure that the move to Gardasil within the HPV vaccine programme is successful and this is adequately funded
- Ensure the newly agreed pathway for hepatitis B vaccination for infants at risk is robustly implemented
- Ensure there continue to be campaigns to publicise vaccination programmes especially new ones so that appropriate coverage is achieved

Recommendations for Needs Assessment

Assess the number of children who may be unprotected against measles as a result of the MMR scare and where they are in Medway so that a targeted campaign can be undertaken working with partners in schools and primary care.

Teenage pregnancy

Summary

Introduction

Reducing conceptions of young people aged under 18 (under-18 conceptions) has been a long standing national and local priority and is a key indicator in the Public Health Outcomes Framework.[27] Most teenage pregnancies are unplanned and approximately half end in a termination.[28] For many teenagers, bringing up a child can be very difficult and challenging, impacting on outcomes for both the parent and child in terms of the baby’s health, the emotional well-being of the mother and the long term likelihood of the child living in poverty.[29]
Considerable work has been undertaken locally over the last year to improve the provision of high quality relationship and sex education which is considered key in reducing the number of teenage conceptions. This is a broader and more equitable offer to schools that provides a range of projects enabling children and young people to receive information and support on a range of health and wellbeing issues. Work has been undertaken with the PSHE Association to ensure all schools-based resources/projects and training are in line with best practice principles and provide children and young people with the necessary knowledge and skills to make informed choices about their health and wellbeing.

**Key Issues and Gaps**

- Medway has a high teenage conception rate; whilst there has been a reduction it still remains higher than England and the South East.

- Not all Medway schools are engaged in Relationship and Sex Education (RSE). It is an ambition to engage the remaining schools to create equitable provision of RSE locally.

- The uptake of long acting reversible contraception (LARC) is low amongst young people and therefore a greater focus needs to be applied to increasing the access and uptake of LARC to young women.

**Recommendations for Commissioning**

- Commissioned services should aim to increase access to LARC for all women living in Medway.

- An integrated model (GUM and CASH services together) operating through a range of venues, plus outreach and self-managed care to maximise entry points that feed into universal services.

- Work to engage all schools in Medway with PSHE Association quality assured RSE resources

- Continue with Risk Avert programme to engage schools in working with young people identified as being most vulnerable to risk-taking behaviour.

- Develop a dedicated teenage parent’s pathway through health visiting.

**Who’s at risk and why?**

In England, around 40,000 young women (22,830 under 18 and 15,155 under 16 conceptions) become pregnant each year. The England under-18 conception rate is at its lowest point for 20 years at 24.3 conceptions per 1,000 females aged 15-17 in 2013.[29]

There is now extensive research providing clear justification for why reducing teenage pregnancy is important. Longitudinal studies have demonstrated that young parents and their children are more likely to experience a wide range of health and social inequalities including:[29]
• Teenage mothers are less likely to finish their education, and more likely to bring up their child alone and in poverty;

• The infant mortality rate for babies born to teenage mothers is 60 per cent higher than for babies born to older mothers;

• Teenage mothers have three times the rate of post-natal depression compared to older mothers and a higher risk of poor mental health for three years after the birth;

• Children of teenage mothers are generally at increased risk of poverty, low educational attainment, poor housing and poor health, and have lower rates of economic activity in adult life.

The cost associated with teenage pregnancy provides a strong economic argument for ensuring that reducing teenage pregnancy is prioritised. Young mothers (and fathers) are more likely than older mothers to require extensive support from a range of local services, for example to help them access housing and/or re-engage in education, employment or training.[29]

A wealth of evidence exists identifying risk factors, which influence a young woman’s likelihood of becoming a teenage parent. With teenage pregnancy rates far greater among deprived communities, the poorer outcomes associated with teenage motherhood also mean the effects of deprivation are passed from one generation to another, increasing inequality. Ward level teenage conception figures published for 2011-13 show that Luton and Wayfield, Gillingham North, Chatham Central and Gillingham South have the highest teenage conception rates in Medway, which correlates with high levels of deprivation.

**Level of need in the population**

**Medway under–18 and under–16 conception data**

Areas of high social disadvantage and deprivation typically correlate with high teenage pregnancy rates for reasons such as low aspirations, poor uptake of services and the cyclical nature of teenage pregnancy. Medway is typical of this trend. Medway is ranked within the 37% most deprived areas nationally,[30] teenage pregnancy rates are also high with rates higher than the South East and England as a whole.

Under–18 conceptions in Medway have fluctuated over recent years (figure 1), but we are experiencing the lowest rate since 1998.
In Medway the number of conceptions resulting in abortion to young people aged under 18 has increased compared to 1998 to 40.4% in 2013, but this figure has decreased in the last couple of years to the lowest since 2005 (figure 2). Medway now has a lower proportion than the England average of 51.1% and the South East average of 52.9%.

Figure 1: Under-18 conceptions for Medway, South East and England, 1998-2013
Under–16 conceptions in Medway are not significantly different from 2001–03 figures (figure 3). The 2011-13 figures show Medway as having 6.4 conceptions per 1,000 females aged 13–15 compared with 8.4 per 1,000 in 2001–03.
In Medway the percentage of conceptions resulting in abortion to young people under 16 has increased from 52.6% in 2001–03 to 59.8% in 2011–13 (figure 4).
Whilst the percentage of conceptions resulting in abortion to young people under 16 has increased from 2001–03 figures, the 2011–13 abortion rate for young people under 16 has remained largely unchanged from a few years prior. Considerable work has been undertaken over the last few years to provide high quality Relationship and Sex Education (RSE) and good access to CASH and GUM services. Young people have an increased awareness of abortion as a choice and are more informed about services available to support them.

**Medway under–18 conception rates by ward**

Teenage pregnancy rates across Medway wards vary greatly, with some wards displaying significantly higher rates than the 2011–13 Medway average of 35.3. In terms of the number of under–18 conceptions the four highest wards are: Gillingham North, Chatham Central, Gillingham South and Luton and Wayfield. As expected these areas also correlate with high levels of deprivation and experience issues such as low income, unemployment, poor health and crime.
Progress to date

There has been encouraging work from Local Authorities across England and Wales with Medway seeing a 29.7% reduction since the Teenage Pregnancy Strategy was launched in 1999 (from 249 to 175). Whilst this is a positive achievement there is work still to do to achieve the target of 50% and continue the downward trend. The establishing of the Medway Sexual Health Network has enabled clinical staff, outreach staff, third sector organisations, school nurses and youth setting staff to develop links that promote multiagency working. The working partnerships between GUM and CaSH providers have been developed and have built on the consultations that have taken place with the public, service users and stakeholders. Continued progress can be achieved with a focussed strategic and policy driven approach, with services being young people friendly, good comprehensive RSE provision across all schools, access to good quality sexual health services and agencies working together to drive the agenda forward.

Current services in relation to need

An integrated model of sexual health service delivery has been commissioned to improve access to contraceptive services and improve client journey.

- 22 Pharmacies offer free Emergency Hormonal Contraception across Medway
- Student Health Services run in 7 schools across the Medway area
- There are 8 CASH clinic venues across Medway, and 3 clinics are dedicated to young people to access without appointments.
- Outreach is used to support young people who are not accessing universal or targeted services.
- There is a sexual health nurse dedicated to meeting the needs of looked after children and young people.
- 13/17 secondary schools in receipt of PSHE Association quality assured RSE resources
- All SEN schools in receipt of PSHE Association quality assured RSE resources

Relationships and Sex Education

Whilst Personal, Health and Social Education (PHSE) including RSE was not made compulsory following its withdrawal from the Children’s Bill in April 2010, Medway has remained committed to ensuring that young people have access to high quality, age appropriate RSE.

In 2013 Medway LA piloted an RSE project and worked with local secondary schools in Medway to develop a comprehensive series of lesson plans. This project evolved and
now comprises a series of 12 PSHE Association quality assured lesson plans for years 7, 8, and 9.

In 2015 Medway LA built on established RSE work and developed a series of 6 PSHE Association quality assured lesson plans for the SEN schools. Alongside this, a series of 5 PSHE Association quality assured lesson plans were developed for Primary schools.

All schools involved in any of our RSE work receive access to the Medway Public Health Directorate for on-going support including training and all accompanying resources necessary for delivery. Our ambition is to create equity of access to high quality RSE for children and young people in Medway.

**Contraceptive and Sexual Health Services**

Significant investment has been placed on improving Medway’s contraceptive and sexual health services. Progress includes:

- 7 educational establishments now have student health clinics providing school based sexual health services
- 22 pharmacies offering free emergency hormonal contraception
- The C Card Scheme has been reviewed for both registration and distribution of C Card and will be fully operational from 1st April 2014. The majority of registrations and distributions take place in educational and youth settings. Access points based in pharmacies have not been used as often as anticipated.
- A contraceptive and sexual health outreach nurse post funded by Public Health was piloted in 2012 for one year and this funding was extended for 2013/14. The aim of the post was to improve access to contraceptive and sexual health services for looked after children and young people. This role has now been folded into the outreach element of the contract.
- Alongside commissioning an integrated sexual health service, the local authority have refurbished a building to act as a hub for the new service. This will provide services outside working hours and will offer Saturday opening to increase accessibility.

**Projected service use and outcomes in 3-5 years and 5-10 years**

To date, no service projections have been undertaken.

**Evidence of what works**

A strong evidence base exists to demonstrate that the biggest factors that impact on teenage pregnancy are:

- Comprehensive information, advice and support from parents, schools and other professionals alongside
• Accessible, young people friendly sexual and reproductive health services, combined with accessible, young people-friendly sexual and reproductive health (SRH) services.[29]

There is also a continued policy focus on reducing teenage conceptions. The following are priorities and indicators we are working towards locally:

• A Framework for Sexual Health Improvement in England highlights the need to continue to reduce the rate of under-16 and under-18 conceptions and STIs.

• Child Poverty Strategy — Under 18 conception rate a measure of national and local progress

• Raising the Participation Age — Pupils who left year 11 in summer 2013 need to continue in education or training until at least the end of the academic year in which they turn 17. Pupils starting year 11 or below in September 2013 will need to continue until at least their 18th birthday.

• Children’s centres — Improving outcomes for young parents and their children is central to their statutory guidance core purpose.

• Public Health Outcomes Framework — Under-18 conception rate and other indicators disproportionately affecting teenage parents and their children.

User Views

In 2010, social marketing research in Medway found that young people in Medway generally had a low awareness of the range of contraceptive options available beyond the male condom and contraceptive pill especially with regards to long acting reversible contraception.[31] Furthermore, whilst young people had a good awareness of where contraception could be available, accessibility around sexual health provision was identified as an issue.

A self completed paper based survey was taken of 188 young people aged between 15 and 25 and took place between January and April 2015. It was completed in youth and education settings, the process was supported by a trained youth leader. The young people were asked about sexual health services and their responses should not be viewed as representative of all young people in Medway, but only representing the views of those completing the survey. Sexual health clinics were regarded by the majority of participants as the place they would attend if they had concerns about their sexual health. Youth settings were also scored highly, but this may have been biased by where the survey was conducted. This survey and a wider public survey have been used to inform the Integrated Sexual Health Service specification.
Equality Impact Assessments

Unmet needs and service gaps

Termination services: At present there is one service provider operating from one location for the whole of Kent and Medway, situated in Maidstone. This presents a challenge for many young people — especially those who live in rural areas of Medway.

There is currently no universal risk assessment tool used in Medway to highlight and work with young people who are most likely to display risky behaviour and those most at risk of becoming pregnant.

Recommendations for Commissioning

From April 2013 Medway Local Authority took over responsibility for commissioning the school nursing service and became responsible for the Healthy Child Programme 5–19 years, teenage pregnancy needs to be incorporated into all areas of the Healthy Child Programme and co-ordinated by the Child Health Programme Manager.

- Integrated Sexual Health Service with quality outcome indicators that focus on reducing teenage pregnancy
- Work to engage all schools in Medway with PSHE Association quality assured RSE resources
- Continue with Risk Avert programme to engage schools in working with young people identified ad being most vulnerable to risk
- Develop a dedicated teenage parent’s pathway through health visiting

Recommendations for needs assessment work

- A full sexual health needs assessment was conducted in 2007. A rapid Sexual Health Needs assessment was conducted in 2013 and an Insights research was conducted in June 2014. All these were used to inform the Integrated Sexual Health Service specification. A needs assessment should be conducted 12 months after the new service is mobilised.
- Regular consultation within the Medway Sexual Health Network should be used to identify emerging trends or issues.
Emotional health and wellbeing of children and young people
[Update in progress]

Summary

Introduction

For children and young people, being emotionally healthy is associated with a range of positive outcomes in later life and having the resilience to face future challenges.

The most recent government mental health (MH) strategy, No Health without Mental Health (2011),[32] states that 60% of people who go on to develop a severe mental illness have experienced their first episode of mental illness by the age of 14 years. Research suggests that mental ill-health has its greatest impact for people between the ages of 15-25 years.

The development of emotional health starts before birth, with the first two years of life being particularly critical. Key to this is the development of effective perinatal MH services for mothers and infants, and the early parent/child relationship. Early intervention, particularly amongst children, is known to limit the long-term consequences of mental illness.[32][33]

Key Issues and Gaps

There is a national lack of robust data on local prevalence of MH problems amongst children and young people. Information is not routinely collected for many MH problems that do not involve CAMHS contact.

Issues with CAHMS services:

- Gaps exist in transition services both between tiers of CAMHS services and from CAMHS to adult services, in part due to discrepancies in eligibility criteria.
- Service activity and performance data were not available for Tier 2 CAMHS.
- Average waiting times from tier three assessment to treatment, although substantially improved over recent years, remain higher than the improvement target of 10 weeks.
- Of the Tier 4 admissions in 2013/14, 13.1% were to a unit outside of Kent and Medway.

ASD and ADHD prevalence amongst Medway’s children and young people is substantially higher than national estimates. The reasons for this are not understood.

Recommendations for commissioning

Redesign of the local CAMHS system to support access to services for young people up to the age of 25 years. Consideration should be given to the increased numbers of children and young people who will require CAMHS input as services move towards provision for those up to 25 years of age.
Who is at risk and why

Resilience has been defined as "the human capacity to face, overcome and be strengthened by life's adversities and challenges".[34] Learning emotional resilience can increase the range of strategies available to us to cope with challenges. Factors known to promote resilience against the development of MH problems have been located within the child, the family and in the wider community. These include having secure early relationships, good communication skills, family support for education, a wider social network and good housing. Deterioration of these factors, even during the pre-conception or pre-natal periods, is a risk to future emotional and MH.[35]

Specific groups of children and young people at higher risk of developing MH conditions include: looked after children (LAC); those with special educational needs (SEN); those within the Youth Justice System; young carers; the physically disabled; migrants; Black and Minority Ethnic (BME) Groups; children exposed to adverse early experiences, e.g., domestic abuse, parental substance misuse, sexual exploitation, bullying, parent/carer with mental illness; and those from deprived socio-economic backgrounds.

Level of need in the population

Determining an accurate number of young people with MH needs is not possible, in part because of stigma and a reluctance to discuss mental health. Therefore, much of the data presented in this chapter are local estimates derived from national prevalence data. Issues also exist relating to schools' capacity to assess need and interpret it correctly as an emotional, rather than a behavioural, issue. Medway has a larger proportion of people aged 0-14 and 15-24 years than the national average. Department for Education data indicates that, at January 2014, there were 45,040 pupils on the school roll in Medway; including 53.1% in State primary schools, 41.6% in State secondary schools, 1.4% in special schools and 0.3% in Pupil Referral Units.

A review of four studies of 1,021 children aged 2 to 5 years found that the average prevalence of any MH disorder was 19.6%.[36] Applying this rate to Medway's population gives a figure of 2,740 children aged 2 to 5 years living in Medway who have a MH disorder. National prevalence estimates for MH disorders in children aged 5-16 years were estimated in a 2004 study.6 The study found that nationally:

- The overall prevalence for MH disorder amongst children and young people aged 5-16 years residing within private households was 9.6%.
- Prevalence varies by age and sex, with boys more likely (11.4%) to have experienced/be experiencing a MH problem than girls (7.8%).
- 11-16 year-olds were more likely (11.5%) than 5-10 year-olds (7.7%) to experience MH problems
- One in 10 children aged five-15 years had a clinically significant MH problem (11% and 8% for boys and girls respectively):
  - 5.8% had clinically significant conduct disorders (e.g. stealing, defiance, fire-setting, aggression and/or anti-social behaviour)
3.7% had clinically significant emotional disorders (e.g. separation anxiety, phobias, anxiety states and depression; these may manifest as physiological symptoms such as chronic headache, abdominal pain or nightmares)

1.5% had clinically significant hyperkinetic disorders (e.g. disturbance of activity and attention, sufficiently serve to cause the child distress or impairment in social functioning)

Table 1 shows the estimated number of children with MH disorders in Medway, by applying the above prevalence rates (NB: some children have more than one disorder). Less common disorders include development disorders (e.g. delay in acquiring certain skills such as speech, bladder control and/or social ability; can be associated with autism), eating disorders (e.g. anorexia nervosa and bulimia nervosa), habit disorders (e.g. tics, sleeping problems and soiling); post-traumatic stress disorder; somatic disorders (e.g. chronic fatigue syndrome) and psychotic disorders (e.g. schizophrenia, bipolar disorder or drug-induced psychoses).

Table 1: Estimated number of children living withing private households living with an mental health disorder in Medway, by type of disorder, by age group.[37]

<table>
<thead>
<tr>
<th></th>
<th>Emotional disorders</th>
<th>Conduct disorder</th>
<th>Hyperkinetic disorders</th>
<th>Less common disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>5-10 years</td>
<td>220</td>
<td>245</td>
<td>685</td>
<td>275</td>
</tr>
<tr>
<td>11-16 years</td>
<td>425</td>
<td>600</td>
<td>855</td>
<td>505</td>
</tr>
</tbody>
</table>

Economic disadvantage is known to be associated with increased vulnerability to MH problems. Gillingham North, Chatham Central and Luton & Wayfield wards had the highest proportion of children living in low income families in 2011, with 35%, 33.5% and 31.8% children respectively in those wards living in low income families. Medway’s child poverty rate is significantly higher than the England and regional averages. The proportion of LAC in Medway who may require MH interventions is considerably higher than nationally, and a considerably higher proportion of children are being identified as having SEN locally compared with the national average.

Cultural and socio-economic influences which are relevant to Medway’s growing school age population who are from Ethnic Minority Groups (EMGs) may be important to this population’s emotional health and wellbeing. Fourteen percent of Medway’s under-25 population are from an EMG (the largest group being Asian/Asian British), compared with the Kent average of 10%.
Emotional disorders

A national study conducted in 2001[38] estimated prevalence rates for neurotic emotional disorders (e.g. anxiety, depression and phobias) in young people aged 16-19 years. Table 2 shows how many 16-19 year-olds would be expected to have a neurotic disorder if these prevalence rates were applied to the population of Medway.

Table 2: Estimated number of children with neurotic disorders living in private households in Medway.[38]

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Males 16-19 years</th>
<th>Females 16-19 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed anxiety &amp; depressive</td>
<td>390</td>
<td>880</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>125</td>
<td>80</td>
</tr>
<tr>
<td>Depressive episode</td>
<td>70</td>
<td>195</td>
</tr>
<tr>
<td>All phobias</td>
<td>50</td>
<td>150</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>70</td>
<td>65</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>40</td>
<td>45</td>
</tr>
<tr>
<td>Any Neurotic Disorder</td>
<td>660</td>
<td>1360</td>
</tr>
</tbody>
</table>

Development disorders

ADHD

The number of children with attention deficit hyperactivity disorder in Medway is considerably higher than expected. In total, 1328 children born between 01/09/1994 and 31/08/2009 living in Medway were identified through CarePlus in 2013. Data from CarePlus may be an under-estimation as some children with these conditions may be solely under the care of CAMHS rather than community paediatricians.

Autism/ASD

A 2006 study[39] estimated the national prevalence of autism in children aged 9-10 years at 38.9 per 10,000, and that of other autism spectrum disorders (ASDs) at 77.2 per 10,000 (total prevalence of all ASDs: 116.1 per 10,000). A further study in 2009 estimated the national prevalence of other autism spectrum conditions in children aged 5-9 years as 157 per 10,000.

Applying this to Medway’s 2014 population estimate:

- Predicted prevalence of autism spectrum conditions amongst children aged 5-9: 275
- Predicted prevalence of all ASDs amongst children aged 9-10 years: 75 (including 25 with autism)

In 2013, 1,605 Medway children aged 4-19 years with ASD were identified through CarePlus. This figure is considerably higher than predicted through using nationally prevalence estimates.

When a child or young person is diagnosed with ASD in Medway, education services, Medway’s Autism Outreach Team and, where appropriate, the social care team, are
automatically notified. The Autism Outreach Team supports mainstream schools, enabling successful inclusion of diagnosed pupils. Information from the team supports the likelihood that ASD is particularly high in Medway. Table 3 shows the cumulative number of children diagnosed and supported by the team since it was established in 2003.

**Table 3: Number of children and young people diagnosed with ASD and supported by the autism outreach team attending mainstream schools.**[40]

<table>
<thead>
<tr>
<th>Date</th>
<th>Number of pupils (cumulative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2004</td>
<td>294</td>
</tr>
<tr>
<td>April 2007</td>
<td>631</td>
</tr>
<tr>
<td>July 2008</td>
<td>899</td>
</tr>
<tr>
<td>September 2010</td>
<td>949</td>
</tr>
<tr>
<td>July 2011</td>
<td>986</td>
</tr>
<tr>
<td>June 2012</td>
<td>1,009</td>
</tr>
<tr>
<td>June 2013</td>
<td>1,089</td>
</tr>
</tbody>
</table>

A CAMHS Needs Assessment for Medway, undertaken in 2009, noted a year-on-year increase in ASD since 2003. It is currently not understood why the prevalence of ASD is substantially higher than national estimates in Medway.

**Psychotic disorders**

Young people with Bipolar disorder are often under the care of specialist CAMHS and it is vital that they and their families are helped to understand the condition, as intervening early in an episode can prevent escalation. There are several types of BPAD and tailored treatment is required accordingly.

The prevalence of psychosis in children aged between five and 18 years has been estimated to be 0.4% nationally (the figure across all ages in the UK is 0.7%), which would be 190 cases in Medway.

**Self-harm**

Self-harm is most common in young people aged 11 to 25 years. Evidence shows a rise in hospital admissions for self-harm by young people in recent years. There appears to be a difference in the female-to-male ratio for emergency hospital admissions for self-harm in Medway from 2010-2013 with increasing age, 8:1 females to males in 10 to 14 year olds and 3:1 in 15 to 19-year-olds. For all age groups except males aged 10 to 14 years, A&E attendances appear to have risen over recent years (figure 1a). This finding is most striking for females aged 15-19 years.
Figure 1: A&E attendances of Medway resident children and young people attending any hospital where the primary and/or secondary diagnosis was ‘Intentional Self-Harm’, by age group
Figure 2: Emergency hospital admissions of Medway resident children and young people attending any hospital where the primary and/or secondary diagnosis was ‘Intentional Self-Harm’, by age group

Although it is acknowledged that not all self-harm will be reported, figure 1b shows that the incidence of emergency admissions for self-harm reduced in Medway from 2009/10 to 2012/13 in the 15 to 19 year old age group but appears to have risen from 2012/13 to 2013/14. For males and females aged 20-24 years, an overall decline in the number of admissions for self-harm has been seen since 2006/07. Admissions for females aged 10-14 appear to have risen steadily since 2006/07. The trends shown in figures 1a and 1b should be interpreted with caution given the small numbers of admissions/attendances. For 2010/11-2012/13, the rate of hospital admissions for self-harm amongst those aged 10-24 years for Medway is significantly lower than the England average.
Current services in relation to need

CAMHS currently aim to meet the MH and emotional wellbeing needs of children and young people up to 18 years of age. CAMHS services are multidisciplinary and, in line with the strategy to improve MH services for children, young people and families laid out in Together We Stand (1995), are formed of four tiers that recognise differing levels of need and aim to better deliver the necessary care pathways. The tiered approach has guided the current structure of CAMHS services in most areas, including Medway. CAMHS services consist of medical, psychological, educational nursing and social work professionals working in a variety of teams and settings across the four tiers.

Tier 1

Tier 1 is a term loosely used to describe a level of need that is higher than the normal day-to-day expectations of a population, but where the client does not yet require the intervention of a specialist practitioner. These services can be provided as a dedicated offer, e.g. from the Health for Learning team at Medway Council, or as part of wider provision, e.g. via a GP surgery or the Educational Psychology Service. CAMHS also offers a tier one service as part of its remit and there is also a MH Promotion Specialist within Medway Council’s Public Health Team.

Tier 1 encompasses a number of services in Medway including; Family Nurse Partnership, Educational Psychology Service, Emotional and MH First Aid, Onside therapy services, Youth workers, Medway Youth Diversion Service Triage, Integrated Youth Support Service (IYSS), Positive Parenting Programme and Medway Children’s Action Network (CAN).

Tier 2

Sussex Partnership NHS Foundation Trust (SPNFT) provides Tier 2 CAMHS, delivery of which is led by the Child and Adolescent Support Team (CAST). The CAST is a multi-disciplinary, early intervention team that offers services to young people up to the age of 18 years and their families. CAST offer short-term help with emerging emotional difficulties, including mild to moderate anxiety, phobias, low mood, sleeping difficulties, eating difficulties, encopresis and enuresis, low-risk self-harming behaviour, underlying issues expressed as anger and early risk of educational or social exclusion. The CAST meet regularly with Tier 3 services to review care plans in complex cases.

The single point of access (SPA) for Medway CAMHS was designed to simplify access to CAMHS, provide advice, support and appropriate signposting to referrers and ensure that decisions made about referrals are taken in a timely and integrated way. This function is embedded in the Tier 2 service in Medway. The service received 1,486 referrals in 2014/15, the main referrers being general practitioners (36.7%), educationalists (10.4%) and paediatricians (6.2%).

Tier 3

SPNFT provide specialist community MH Services for children and young people aged under 18 years with complex MH needs. Referrals for depression, ASD, ADHD, OCD, PTSD, eating disorders, self-harm and suicidal ideation are usually accepted, provided that the condition has been assessed as moderate or severe in nature.
Services include assessment/formulation/diagnosis of MH disorders; therapeutic interventions including psychotherapy, psychiatric/psychological assessment, art therapy, family therapy, cognitive behavioural therapy (CBT); Children in Care team. The Kent and Medway out-of-hours service also provides a crisis response service to the Medway NHS Foundation Trust Accident and Emergency department, local police custody suites and related service locations.

**Tier 4**

Based at Woodland House Adolescent Unit in Kent, South London & Maudsley NHS Foundation Trust (SLaM) provides inpatient and specialist outreach for people aged 12 to 18 years across Kent and Medway. Referrals are primarily received through tier 3 CAMHS. The service includes inpatient provision for young people in crisis, a dedicated in-patient and day eating disorder service, and management pathways for, e.g., neuropsychiatry, forensic services and secure provision. Young people requiring highly specialist inpatient care, e.g., secure, psychiatric intensive care, specialist eating disorder care or care for complex learning disabilities are accommodated in NHS or private/third sector units commissioned by NHS England. If Woodland House is full, other adolescent units within the SLaM estate are used, namely the Snowsfield and Bethlem Units in London.

**Estimated need for services at each tier**

The MH Foundation report “Treating Children Well”11 estimates the number of children and young people aged up to 17 years who may experience MH problems appropriate to a CAMHS response. Using these prevalence estimates to Medway’s population, table 4 shows the estimated number of children and young people in Medway who are likely to require CAMHS input at different tiers.

Table 4: Estimated number of Medway children/young people aged 17 years and under who are likely to require CAMHS input. Source: ChiMat. Calculated using population estimates from Office for National Statistics mid-year population estimates for 2014 and CCG population estimates aggregated from GP registered populations (Oct 2014) and prevalence estimates from Kurtz, 1996.[42]

<table>
<thead>
<tr>
<th>Tier</th>
<th>Estimated Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9,385</td>
</tr>
<tr>
<td>2</td>
<td>4,380</td>
</tr>
<tr>
<td>3</td>
<td>1,160</td>
</tr>
<tr>
<td>4</td>
<td>50</td>
</tr>
<tr>
<td>Total</td>
<td>14,975</td>
</tr>
</tbody>
</table>

Thirty young people aged 17 years and under were admitted for Tier 4 services in 2013/14: this is almost half the estimated number who may require tier 4 services as
described in table 4. It has not been possible to ascertain the actual numbers of children and young people in Medway currently receiving Tier 1, 2 or 3 services.

In addition to CAMHS, there are also a number of services in Medway aimed at identifying and monitoring child MH needs, such as the Educational Psychology Services in schools; perinatal MH services; Autism Spectrum Disorder diagnostic pathway; and the ADHD care pathway. In Medway, a specialist Early Intervention in Psychosis service spans the years of adolescence and early adulthood.

Projected service use

Current population projections predict that Medway’s under-25 population will change considerably over the next 20 years, increasing by 2.5% from 2013-2023 and 9.5% from 2013-2033.

Assuming that the current levels of MH disorders remain constant within age bands, the predicted growth of the population aged 25 years and below is likely to result in an increase in the numbers of children living with a MH disorder in Medway over the next two decades.

Evidence of what works

NICE provide evidence-based recommendations for antenatal/postnatal mental health (CG192),[43] as well as for pre-school, primary and secondary school aged children (PH12,[44] PH20,[45] PH40 [46]). Pre-school guidance includes support through home visiting, childcare and early education to those children classified as “vulnerable”; children who are at risk of or are already experiencing social and emotional problems. In later years, preventative measures can be taken up in schools to help children develop their social and emotional wellbeing and to ensure that the child is in a secure environment.[47] Public Health England also promotes the building of resilience of children and young people in schools.[48]

Department for Education have provided behaviour and discipline advice to schools of how they can manage behaviour in schools and support children whose behaviour may be related to an unmet MH need.[49] NICE advise LAs and schools to make sure that teachers and other staff are trained to identify when children show signs of anxiety or social and emotional problems and that children should have access to specialist advice and support that they require.[50],[51] NICE have also produced clinical guidance and quality standards for young people with specific MH disorders, such as depression, psychotic disorders, ASD and ADHD.[51],[52],[53],[54]

Department of Health commissioned a review of the wide-ranging literature on policy, practice and service delivery issues relating to children’s mental health and psychological well-being in 2008.24 They came up with a number of recommendations, including the establishment of a National Advisory Council to champion wellbeing for children. They noted that there should be a clear strategic approach to monitoring, evaluation, service improvement, knowledge management and inspection across all children’s services for mental health and psychological wellbeing. At the time of writing, they commented that many areas of CAMHS were currently still operating as separate
services, and that the resource and expertise available within universal services not being used as effectively as it could be.[55]

National Support Team also undertook a review of children and young people's emotional wellbeing and MH, based on 480 visits to local partnerships. Their report “What good looks like” provides insights into improving outcomes locally for the emotional wellbeing of all children and young people, as well as children and young people with a specific mental health need.[56]

**User views**

*Kent Youth MH Project*

The objectives of this Kent and Medway-wide project, undertaken in 2012, were to: build resources in local communities to support young people's mental wellbeing; consult young people about what helps or hinders their mental health; and develop options for commissioning a youth MH service. The results were presented at a meeting led by young people in August 2013. Key suggestions made by the young people included:

- development of peer supporters in secondary schools;
- extension of the Place 2 Be service to all primary schools;
- mental wellbeing to be addressed in Personal Social Health Education (PSHE) classes with interested young people themselves being involved in the development of these sessions;
- improve information on how and where to get advice from for MH problems;
- provision of young-person friendly information on emotional and mental health and wellbeing;
- the ability to self-refer to the single point of access.

The Youth Parliament are keen to collaborate with commissioners in any service redesign.

*Medway Youth Wellbeing Community*

This forum regularly brings together representatives from Medway Youth Parliament, Medway Youth Trust and other young people resident in Medway. The forum aims to:

- improve the emotional and mental health and wellbeing of children and young people across Medway. Learning, through training delivered during forum meetings, is cascaded by young people to peers across their community/ schools;
- influence strategy development and service planning.

*Workshop: future commissioning priorities*

Medway Clinical Commissioning Group held this stakeholder event in August 2013 to inform the development of future commissioning priorities. Stakeholders included
members of Medway Youth Parliament. Recommendations made by the young people and supported by other attending stakeholders included:

- better MH awareness training access and incorporation into Curriculum for Life;
- development support for prevention, including peer and pastoral support;
- schools and services must recognise and respond to self-harm;
- use of school nurses as a MH resource;
- take time to talk to the young person before making a referral to services.

**Equality Impact Assessments**

**Unmet needs and service gaps**

In Medway there is an intention that tier one services should have a two-fold purpose: the actual delivery of a service, plus the early identification of people (including children) who have problems which are at risk of escalating. There are a range of tier one services available in Medway, although these can be viewed as working largely independently of one another and with minimal co-ordination. There has historically been no opportunity for sharing information or practice and no agreed methodology for assessment, referral or case allocation.

**Recommendations**

- Review the robustness of managing referrals to Tier 2 and 3 CAMHS through single point of access (SPA) arrangements, with the aim of reducing waiting times for assessment, intervention and treatment, and facilitating self-referral to the SPA.

- Commissioning plans should be developed jointly with adult MH services to ensure good transitional arrangements are in place.

- Ensure clear, evidence based pathways for MH conditions in children and young people with clear step up/down criteria to ensure that children and young people with MH needs do not fall out of services through the gaps between the tiers and at transition to adult services. Ensure links across partner agencies and areas of support, e.g., substance misuse, Youth Justice and domestic violence.

- Review CAMHS specialist service provision to specific vulnerable groups, ensuring effective identification of and targeting/improved accessibility of services for children and young people who are at an early stage/high risk of MH problems or poor outcomes due to predisposing factors. A strong focus is needed on earlier intervention for these groups.

- Further exploration of the possible influences on emotional health and wellbeing and access to services which are experienced by children and young people from Medway's Ethnic Minority Groups should be considered.
• Investigate the reasons for the higher than expected prevalence of ASD and ADHD. ADHD and ASD pathways should be reviewed to ensure that the appropriate range of assessments and interventions is offered, adopting a multidisciplinary approach to the long-term management of conditions. Coordination between health and other key services such as education, social care and the voluntary sector is important.

• Review the self-harm pathway for Medway against the NICE Quality Standard.

• Further work is required in order to determine whether there is unmet need at Tier 4, in particular to explore access to inpatient services and the setting for provision of care whilst inpatient bed availability is awaited.

• Children and young people should be directly involved in the identification of needs and issues affecting them in order that their views are reflected in the design and delivery of emotional health and wellbeing services.

• Increase support for schools in promoting emotional wellbeing and resilience. Raise awareness of MH issues in schools, involving teachers and school nurses in MH awareness and prevention.

• Consider support for schools to address issues such as domestic abuse within a Personal, Social and Health Education framework.

Further needs assessment required

Looked After Children

Overview

Introduction

This chapter of the JSNA looks at the level of need and key issues faced by Looked After Children (LAC) in Medway. It outlines the needs of Looked After Children and how the current service is meeting those needs. It highlights key issues and gaps and makes recommendations for Commissioning.

Within our care population there are groups of children with particular needs which must be recognised and responded to by everyone working with them to ensure they too can achieve the best possible outcomes. Key priorities for looked after children include; supporting provisions to ensure where possible that children return home, increasing the pool of high quality foster carers particularly those able to offer placements to children and young people with complex and or specialist needs. Securing sufficiency of high quality accommodation and support for our 16+ Looked After Young People and Care Leavers. Raising aspirations of looked after children through effective placement matching and the development of close relationships that support educational attainment and emotional resilience. In addition wherever possible we will continue to seek permanent placements for our children and young people, if
this is not possible within their own families we will seek to achieve this through adoption or Special Guardianship arrangements or Residence Orders.

Finally we know that the transition to leaving care can be challenging for some young people experience and as such we will support our young people to secure work, training or further and higher education, ensuring they are prepared and armed with the skills and knowledge for adulthood and living independently.

**Key Issues and Gaps**

1. There is a clear gap in the provision of robust data at a local level in order to inform service provision.

2. Historically poor contractual arrangements have meant that some provision is not of sufficient quality.

3. The current commissioned health and mental health services are not meeting the needs of our Looked After Children and the single point of access is not managing all the referrals.

4. There are an insufficient number and type of placements, within Medway to meet the needs of Looked After Children.

5. There is a need to continue to proactively support the use of Special Guardianships and Residence orders where appropriate in order to secure permanency for our Looked After Children.

6. There is a need to evaluate and monitor better outcomes for children placed out of area.

7. There is a need to monitor the impact on services of children from out of area who are placed within Medway. Of particular concern is the impact this maybe having on the LAC health team provision.

8. There is a need to undertake further analysis with regards to the numbers of children at risk of child sexual exploitation and those currently being abused in this way.

9. There is a need to support our 16+ transition into adulthood by offering quality and choice in accommodation and support through a range of cost effective provisions.

10. The needs of Looked After Children with profound and multiple disabilities are not fully understood and as such there may be more gaps in provision than the lack of residential services for this group.

11. Whilst Medway Council recognises the skill and commitment many foster carers there is still a need to increase the number of carers who can respond to complex and specialist needs of looked after children at short notice.

12. Educational attainment level of Looked After Children requires the concerted effort of educational professionals and children’s social services in order to improve the position at all key stages.
13. The extent of Child Sexual Exploitation is not yet clear in Medway despite recent efforts to collect and collate reliable data.

**Recommendations for commissioning**

1. For commissioning to work with the Children in Care to develop services and support around the continuum of care model. The provision of standard, complex and specialist services and support should sit at the heart of further provision.

2. To map against the continuum of care all current services and support for Looked After Children in order to identify gaps in provision. Particular attention to be paid to gaps in provision in mental health services, services for those with complex needs, challenging behaviour and wellbeing services.

3. To undertake a review of disabled Looked After Children placements to assess current and future configuration and funding.

4. To continue to secure best value prices from IFA and Residential providers and to capture potential savings.

5. To provide routine monitoring data to senior management with regards to placement activity.

6. To increase awareness of CSE and to ensure that providers have the appropriate systems in place to support children at risk of CSE.

7. To complete an in-house fostering review and present options for moving forward.

8. To develop a quality and performance framework for supported accommodation providers.

9. To review the Medway Foundation Trust block contact in-conjunction with Medway Clinical Commissioning Group in order to inform current and future service configuration.

10. To robustly monitor the performance of the LAC health team and provide feedback via the CCG when contractual agreements are breached.

11. Support the implementation of the Emotional Wellbeing Strategy.

12. To review the effectiveness of the single point of access for LAC Health.

13. To work with the Virtual Head teacher to address identified barriers to educational achievement.

14. To work with Children in Care Services and the Virtual Head Teacher to ensure that children placed out of area are achieving their potential.

15. To ensure that the needs of Unaccompanied Asylum Seeking Children inform the development and provision of future services.

16. To ensure that Medway feeds into the neuro-developmental pathway or ADHD and ASD being developed across Kent and that the needs of Medway Looked After Children informs the planning of new services.
Who is at risk and why

There are a number of well-known risk factors associated with child abuse and neglect that can consequently lead to a child becoming “Looked After” by the local authority. Some of these risk factors are:

- Parental substance abuse [57][58]
- Teen parenting [59][60]
- Domestic Violence [61][62]
- Environmental and social factors [63][64]
- Lack of secure attachments
- Chronic and enduring mental health illness of parents

Substance abuse—Overall in 2011/12 there were an estimated 293,879 opiate and/or crack users in England; this corresponds to approximately 8 per thousand of the population age 15-64.[65] In Medway there were an estimated 1,291 opiate and/or crack users which corresponds to approximately 7.27 per thousand of the population age 15-64.[65] In 2012 The Medway Drug and Alcohol Team commissioned a report to determine the needs of this population.[66] What they found amongst other things was that use of some drugs like Cocaine had become “normalised” and that treatment and support services for users were many and varied. Crucially however the services were not joined up or well-resourced and as such did not meet the needs of this population.

Teen parenting—During the period 2010–2012 there were 621 conceptions in Medway for females aged under 18 years of age.[67] This represents a rate of 38.9 per 1000 of girls and young woman in that age group. This is above the national rate for England of 30.9 per 1000 of girls and young women in that age group. It is now recognised that one of the key failings of the Governments 1999 ten year strategy to tackle teenage pregnancy was that none of the strategies were aimed at addressing social disadvantage.[68] As such in 2007 the rate of teenage pregnancy had reduced by only 11.8% and was showing no signs of reaching the 2010 target of 50%. The rate of teenage pregnancy in Medway remains higher than the national average despite the fact that it has fallen year on year since 2010.

Domestic violence—In 2013-14 the police recorded 887,000 domestic abuse incidents in England and Wales.[69] It is estimated that 140,000 children live in homes where there is a high risk of domestic abuse.[70] 62% of children living with domestic violence are directly harmed by the perpetrator of the abuse. After a peak in 2013 the rate of referral to children’s social service per 10,000 of the population has decreased and in 2014 was lower than the national average and statistical neighbours.
Environmental and Social Factors—There is a well-known link between deprivation and children coming into care such as unemployment, low income lone parents and inadequate accommodation. All of these factors, either individually or in combination, can lead to family breakdown. In 2011 Medway was ranked within the 41% most deprived boroughs nationally and when broken down further by child poverty, employment, health and disability, crime and income deprivation was amongst the worse in the England.[71]

Lack of secure attachments—Many looked after children suffer ongoing trauma as a result of developing insecure attachments in their early years. The lack of a secure attachment has effects on the development of the child’s emotional intelligence and their ability to cope with the complex feelings that can be involved with separation and loss.[72][73] We know that the main function of attachment behaviour is to keep the primary attachment figure (usually the mother) close by. For looked after children this basic human need can remain unfulfilled and the resulting distress can lead to children lacking resilience to cope with life’s inevitable challenges.

Chronic and enduring mental health issues of parents—In May 2014 the health and Social Care Information Centre reported that there were 963,769 adults in England who were in contact with secondary mental health services. Of these 23,646 were in patients in a psychiatric hospital (2.5 per cent). 16,352 were subject to the mental Health Act 1983 and of those 11,965 were detailed in hospital (73.2 percent).[74] The data in relation to mental illness across England has shown that an ever increasing number of adults experience some form of mental distress. The NSPCC have determined that across the UK 1:5 babies live with a parent with a common mental health disorder, which may place them at increased risk of harm.[75] In Medway in at the end of April 2014 there were 4005 adults in contact with mental services.[74]
Figure 1: Deprivation affecting dependent children under 20 years, Medway 2012[76]

Figure 1 shows that Gillingham North, Chatham Central and Luton and Wayfield wards had the highest proportion of children living in low income families in 2012, with 33.5%, 33.2% and 31.8% children respectively in those wards living in low income families.

It is safe to assume that the effects of these risk factors are reflected in the number and complexity of Looked After Children and young people in Medway.

We know that coming into care itself; and the child or young person’s previous experiences can have a profound and ongoing impact on their emotional and physical health, ability to learn and settle in such a way that they develop and grow into confident healthy individuals. In addition Looked After Children and young people are significantly more likely than their peers to leave school with few or no qualifications. These young people are at higher risk of becoming involved in offending, becoming a teenage parent and of not being in education, employment or training once they have left school.
Level of need in the population

Table 1: Number of Looked After Children as at 31 March each year.

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway</td>
<td>425</td>
<td>440</td>
<td>410</td>
<td>380</td>
<td>425</td>
</tr>
<tr>
<td>England</td>
<td>65510</td>
<td>67070</td>
<td>68060</td>
<td>68800</td>
<td>69540</td>
</tr>
</tbody>
</table>

Table 1 above shows the total number of Looked After Children as at 31st March each year across England and Medway. The children looked after rate declined between 2012 and 2014, then rose again in 2015 to 68 per 10,000 of the population aged under 18 compared to 60 per 10,000 for England. Between April and September 2014 there were a 100 new entrants into care in Medway. As of March 2015 there were 425 Looked After Children in Medway. In addition traditionally the largest number of children coming into care has been in the 11–15 year old age range. However during 2014 a 100% increase in the 1–4 age range and 170% increase in the 5–9 age range was seen.

Modelling taking account of housing and regeneration plans has been undertaken by the School Organisation and Capital Team. This modelling supports the assertion of continued population growth up to and including 2019 in the under-five age range (see ‘Projected service use’ section for further information.)

The increase in looked after children can also safely be assumed to be as a result of:

- Greater awareness of child protection and safeguarding amongst all agencies
- Thresholds for intervention are appropriate and consistently applied

The knock on effect is that the need across a number of areas and support services has also increased. Amongst these are the provision of health services, services that support emotional well-being, education, the availability of placements, and child sexual exploitation.

The Clinical Commissioning Groups have responsibility for the health of Looked After Children, even when that child is placed out of area. Since 2012, there has been a continual reduction in health checks and dental checks undertaken as shown in tables 2 and 3 below.

Table 2: Number of Looked After Children having health checks

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway</td>
<td>205</td>
<td>185</td>
<td>200</td>
<td>270</td>
<td>265</td>
<td>255</td>
<td>245</td>
</tr>
<tr>
<td>South East</td>
<td>4275</td>
<td>4300</td>
<td>4710</td>
<td>4970</td>
<td>5100</td>
<td>5140</td>
<td>5460</td>
</tr>
<tr>
<td>England</td>
<td>36800</td>
<td>37200</td>
<td>38840</td>
<td>40200</td>
<td>41200</td>
<td>42140</td>
<td>43140</td>
</tr>
</tbody>
</table>
Table 3: Number of Looked After Children having dental checks

<table>
<thead>
<tr>
<th>Year</th>
<th>Medway</th>
<th>South East</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>200</td>
<td>4540</td>
<td>37300</td>
</tr>
<tr>
<td>2010</td>
<td>170</td>
<td>4400</td>
<td>36400</td>
</tr>
<tr>
<td>2011</td>
<td>190</td>
<td>4600</td>
<td>37970</td>
</tr>
<tr>
<td>2012</td>
<td>260</td>
<td>5100</td>
<td>38370</td>
</tr>
<tr>
<td>2013</td>
<td>250</td>
<td>5090</td>
<td>38720</td>
</tr>
<tr>
<td>2014</td>
<td>155</td>
<td>5030</td>
<td>40240</td>
</tr>
<tr>
<td>2015</td>
<td>140</td>
<td>5330</td>
<td>41250</td>
</tr>
</tbody>
</table>

Mental Health and Emotional Well Being

Improving the mental health of children has a positive impact on their ability to form positive relationships with peers and adults whilst helping them to succeed at school and make a success of their lives as adults.

The Strength and Difficulty Questionnaire is used to assess the emotional and behavioural health of children. The questionnaire scores children on a range between 0 and 40 with scores of 17 and above being cause for concern.

Table 4: Emotional and behavioural health of children looked after continuously for 12 months at 31 March for whom a Strengths and Difficulties Questionnaire (SDQ) was completed, Medway

<table>
<thead>
<tr>
<th>Year</th>
<th>LAC aged 5–12</th>
<th>SDQ score completed</th>
<th>SDQ score submitted</th>
<th>Avg. score</th>
<th>Normal %</th>
<th>Borderline %</th>
<th>Concern %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>195</td>
<td>185</td>
<td>94</td>
<td>15.5</td>
<td>38</td>
<td>11</td>
<td>50</td>
</tr>
<tr>
<td>2014</td>
<td>190</td>
<td>170</td>
<td>88</td>
<td>16.0</td>
<td>35</td>
<td>16</td>
<td>49</td>
</tr>
<tr>
<td>2015</td>
<td>200</td>
<td>175</td>
<td>89</td>
<td>15.9</td>
<td>38</td>
<td>15</td>
<td>46</td>
</tr>
</tbody>
</table>

In Medway 46% of looked after children scored within the range for concern during 2015 compared with 37% nationally. The norm for British children as scored by parents is around 9.8%. This suggests that presently looked after children in Medway are almost five times more likely to have emotional and behavioural problems than would be expected across all children in Britain. In addition the average score has seen a small year on year increase over the past three years and now sits at 15.9.

Table 5: Number of children and young people diagnosed with ASD and supported by the autism outreach team attending mainstream schools in Medway

<table>
<thead>
<tr>
<th>Year</th>
<th>Cumulative number of pupils</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2004</td>
<td>294</td>
</tr>
<tr>
<td>April 2007</td>
<td>631</td>
</tr>
</tbody>
</table>
In addition 6.2% of looked after children in Medway have a learning Disability, whilst 4.7% are on the Autistic Spectrum and 2.8% have a behavioural disorder. It is well documented that these children have an increased risk of developing a mental disorder. If as the table above suggests the numbers of children with ASD are increasing year on year then again it is likely that this increase will be replicated in the population of Looked After Children. Further information can be found in the JSNA chapter “Emotional Health and Wellbeing of Children and Young People”.

Educational Attainment

“A lack of educational achievement is one of the biggest barriers to children looked after realising their potential”. [81]

Table 6: Eligibility and performance of children who have been looked after continuously for 12 months at Key Stage 2, 2013. Percentage who achieved at least Level 4[79]

<table>
<thead>
<tr>
<th></th>
<th>Medway</th>
<th>South East</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number eligible to sit Key Stage 2 tasks and tests</td>
<td>15</td>
<td>300</td>
<td>2300</td>
</tr>
<tr>
<td>Mathematics %</td>
<td>47</td>
<td>53</td>
<td>59</td>
</tr>
<tr>
<td>Reading %</td>
<td>60</td>
<td>59</td>
<td>63</td>
</tr>
<tr>
<td>Writing %</td>
<td>47</td>
<td>48</td>
<td>55</td>
</tr>
<tr>
<td>Grammar, Punctuation and Spelling %</td>
<td>X</td>
<td>41</td>
<td>45</td>
</tr>
<tr>
<td>Reading, writing and mathematics %</td>
<td>40</td>
<td>39</td>
<td>45</td>
</tr>
</tbody>
</table>

Table 6 above demonstrates those Looked After Children regionally and locally during 2013 were underperforming in relation to their peers. Data marked with an ‘X’ has been suppressed to preserve confidentiality. No data is available for 2014 due to the smaller number of children in Medway compared to 2013.

Placement - Overview

The Sufficiency report 2015 - 16 identified that there was risk of insufficient suitable accommodation being available in Medway for Looked After Children. The children’s Act 2008 states that “For those looked after, Local Authorities and their partners should seek to secure a number of providers and a range of services, with the aim of meeting the wide-ranging needs of looked after children and young people within their local area”. Medway has a rate of 68 Looked After Children per 10,000 which is above the national average[77].
Figure 2 above denotes the percentage of looked after children by placement type.

In order to ensure that the placement service is able to offer the sufficient provision to meet the needs of Looked After Children there is a need to increase the number of foster carers, ensure the quality and range of supported living accommodation, residential services and increase the quality and type to wrap round provision on offer.

As the demand for placements increases there is a reliance on independent fostering provision in order to meet the needs of our children and young people. There is also a need to recruit foster carers who can be flexible in responding to critical and emergency situations and who can offer different types of placements. In addition there is a need to increase the number of foster carers who are able to support young people up to the age of 21 through our “staying put” drive.

Placement Stability

Improving outcomes for our children and young people requires that there is a continued focus on reducing the number of moves they experience in their lives. We
know the chance to build trusting long term relationships through quality day to day care is a key factor in children and young people being able to realise their full potential in adulthood.

Reducing the number of unnecessary moves is a priority as stable and nurturing placements are thought to directly influence the child’s ability to recover from the abusive and neglectful experiences, which they have previously had. [82]

Figure 3: Percentage of children who have been looked after for more than two and a half years and of those, have been in the same placement for at least two years or placed for adoption.[79]

The graphs above shows that placement stability in 2013 and 2014 was roughly in line with rates across the Southeast and England.

Placement stability is the result of a number of factors which include: listening to the wishes and feelings of the child, choice and matching of each placement, good initial information and assessment of the needs of the child, training and support of foster carers, multi-agency commitment to meet the educational and health needs of each child and monitoring and rapid response when difficulties occur.
Placed Out of Area (POLA)

Due to rising numbers of Looked After Children and the increased pressure on available placements Medway Council has 99 children (as of April 2015) placed out of area in either residential services or independent foster carers. Some of these young people have been appropriately placed to be nearer to extended family members or further away from potential risk of harm. However there is a growing recognition that being placed over 20 miles away can bring challenges in ensuring that the Looked After Child is well supported and is able to make good use of resources available to them with their local authority.

Table 7: New placements for children looked after during 2014/15 by locality of placement and distance between home and placement - Medway[77]

<table>
<thead>
<tr>
<th>Placement Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of new placements for all children</td>
<td>440</td>
<td>-</td>
</tr>
<tr>
<td>All placements within 20 miles</td>
<td>350</td>
<td>79</td>
</tr>
<tr>
<td>Inside LA boundary within 20 miles</td>
<td>240</td>
<td>54</td>
</tr>
<tr>
<td>Outside LA boundary within 20 miles</td>
<td>110</td>
<td>25</td>
</tr>
<tr>
<td>All placements over 20 miles</td>
<td>60</td>
<td>14</td>
</tr>
<tr>
<td>Inside LA boundary over 20 miles</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Outside LA boundary over 20 miles</td>
<td>60</td>
<td>14</td>
</tr>
<tr>
<td>Not recorded or not known</td>
<td>30</td>
<td>7</td>
</tr>
</tbody>
</table>

Placements with Family and Friends, Special Guardianship and Residence Orders

Where appropriate family and friend carers are supported to apply for Special Guardianships or Residence Orders as this provides permanence and longer stability. The number of children who ceased being “Looked After” due to Special Guardianship Orders was 25 in 2013, 15 in 2014 and 10 in 2015[77]. However across England the rate of Special Guardianships awarded is increasing at a significantly faster rate.

Adoption and Permanence

The aim for most children when they become Looked After Children is for them to be returned back to their family in due course, or for them to be placed permanently with another family via Adoption, Special Guardianship or Residence Order, if it would not be appropriate for them to return to their original family.

The number of children placed for adoption has increased significantly across England as the Adoption Reform requirements for Local Authorities has seen an increase in approved adopters who are now being approved within shorter timescales.
Unaccompanied Asylum Seeking Children - UASC

In Medway there is a small number of unaccompanied asylum seeking children. These children and young people often have additional needs as a result of traumatic experiences, a loss of custom, culture and separation. In Medway where particular racial, cultural and religious needs can't be met consideration is given to UASC being placed in communities out of area where their needs can be better met. It is difficult to anticipate the future number of UASC due to a range of external factors that impact on this.

Child Sexual Exploitation

Child Sexual Exploitation (CSE) is a national priority area and is an area recognised by Medway that needs careful monitoring and action to ensure that none of our children and young people are abused in this way. Multi agency working and information sharing are particularly key issues in tackling CSE. In November 2014 there were 14 adolescents in care known to be at risk of CSE. Of these only two were determined to be actively
exposed to CSE. More work needs to be done to determine if this figure is a true reflection of children at risk of CSE or known to be involved in CSE.

**Leaving Care**

As a corporate parent Medway has a responsibility to ensure that all young people leaving care receive the support and encouragement they need to move confidently into adulthood. This means providing emotional support, financial advice and guidance about making plans for the future as well as practical support with accommodation and personal needs. Preparation for adulthood begins a long time before independence and is carefully planned through the development of a Pathway Plan prior to their 16th birthday. We know that encouraging young people to “stay put” in safe and secure homes will help them deliver on realising their potential.

Figure 5: Percentage of care leavers who were in not in education training or employment.[79]

Figure 5 shows that numbers of care leaves not in education, employment or training was previously very high in Medway. Following the reduction in 2013, there has been a rise to 49%.[79]
Figure 6: Percentage of care leavers who were in suitable accommodation.[79]

Figure 6 shows that the numbers of care leavers in suitable accommodation in Medway has fluctuated between 80 and 100 percent for many years. However a more recent drive to review in particular supported accommodation is identifying that this number maybe much lower as standards and expectations are raised.

**Current services in relation to need**

**Early Help & Edge of Care**

Medway Council recognises that key to ensuring children have the best start in life is providing support to families, so that children don’t become “Looked After”. As such in addition to providing and supporting universal services Medway Council has also developed a range of early intervention and prevention services that focus on supporting the family for example the use of Family Group Conferences. An Edge of Care Strategy is currently being developed and will focus on providing crisis intervention and mediation in order to prevent family breakdown.
Health

The Looked after Children's Health Team is managed by Medway Foundation Trust and is based at Medway Maritime Hospital. The aim of the service is to provide assessments and monitoring of Looked After Children and training for foster carers within Medway. This includes undertaking:

- Initial health assessments
- Review health assessments
- Adoption assessments
- Health histories
- Foster carer training.

The service is required to meet the statutory timeframe of 28 days as set out in the Statutory Guidance under section 9.8 for the first health assessment. Between January and March 2015, a total of 159 health assessments were requested. Of these 52 were for initial health assessment and 107 were for review health assessments. In Q.4 January to March 2015 81% of initial health assessments were completed within the statutory time frame. In addition 96 of the 107 review health assessments were seen on time. Of the remaining eleven health review assessments, 3 were refused, 4 were not completed as the looked after child was no longer being looked after and 4 were overdue. Adoption assessments continue to perform well and continually exceed the 85% target. Completion of health histories remains a challenge as refusal from the young person to engage in the process is a recurring theme. During October to December 2014 only 50% of health histories were completed with refusal to engage being cited in all cases.

Mental Health and Emotional Well-being

The services in Medway are based like many across the country around a 4 tiered approach.

**Tier 1**

Universal services which support and promote emotional wellbeing. Services are provided by Schools, Public Health and the Voluntary sector

**Tier 2**

Services are managed by Sussex Partnership NHS Foundation Trust although the majority of the staff are employed by Medway Council. The tier 2 provision for Looked After Children is the specialised Children in Care CAMHS service. The Tier 2 team does work with the Children in Care CAMHS service however these are meant to be two distinct teams in order to ensure that there is a clear focus on supporting Looked After Children.

**Tier 3**

Services are in the main provided by Sussex Partnership NHS Foundation Trust (SPFT). Specialist provision is supported on the basis that the condition is assessed as moderate to severe in nature.
Tier 4

Services are provided by South London & Maudsley NHS Foundation Trust (SLAM) which provides inpatient and outreach services. During 2013/14 there were a total of 30 in-patient admissions for Medway.

Additional commissioned services are provided such as All Saints for post sexual abuse, Oakfield Psychology (MFT) who offer therapeutic intervention for psychological and developmental difficulties, the NSPCC 12 week programme and Chilston which offer behavioural interventions and counselling.

Some of the services listed above are accessed via Single Point of Access which provides advice, support and signposting to referrers to ensure that decision making is timely. In 2014/15, 1021 referrals were received with 37 being referred to Tier 3 Looked After Children Services. However in some cases the services are spot purchased and as such there is no interface with the single point of access. This can lead to delays and several hand offs as referrals are not being logged or tracked. Waiting times for Children in Care and Tier 3 CAMHS have varied from 27 working days to 77 working days. In contrast to 20 Looked After Children referred to Oakfield Psychology an average waiting time of 21 days from referral to first appointment. Further Information can be found in the JSNA Chapter: Emotional Health and Wellbeing of Children and Young People

Educational attainment

There is a virtual Head teacher who reports to the Corporate Parenting board. In addition, the implementation of the Virtual Head teacher’s Improvement Plan is approved and monitored by the Education and NEET sub-group. The Assistant Director for School Effectiveness and Inclusion chairs this group. The Virtual Head teacher monitors the achievement of all pupils and is responsible for ensuring that the achievement gap with national outcomes is closing. The Personal Education Plan (PEP) review is the means by which each young person’s achievement is monitored and supported. The PEP review is also the process which monitors the use of pupil premium plus to secure appropriate support for individuals.

Placements

Currently children in Medway have 5 placement options as detailed in figure 4. Placements in most instances are made via the placement co-ordinator and officers who are based in the Access to Resources Team. The Access to Resources Panel meets weekly to agree and discuss placements some of which may have been an emergency and as such have not gone through the Access to Resources Team to be placed. Medway has a number of gaps in provision including placements for children with profound and multiple disabilities, sibling groups and young people leaving care at 16+. As of 30th October 2014 Medway had a total of 12 parent and Child placements in Independent Fostering.

In September 2014, just over 10% (40 children) of Looked After Children in Medway had a disability. This represents a 38% increase on the previous year. Currently there is no residential provision for Looked After Children with profound and multiple disabilities in Medway. As such children travel routinely over an hour from outside of Medway to access Medway schools.
The numbers of large sibling groups are increasing with April 2015 seeing one group of 7 siblings and one group 5 siblings being placed. Sufficient data doesn't currently exist to determine whether or not this trend will continue.

In September 2014 there were 58 young people aged 16+ in care and 198 eligible for leaving care services. The Southwark Judgement 2009 clarified the responsibilities of Local Authorities to provide accommodation to a young person assessed as a “Child in Need” under section 20 of the Children Act 1989. The Institute of Public Care projected that the numbers of eligible Looked After Children in Medway aged 16 and 17 and Care leavers aged between 18 and 24 would be between 241 and 221 in the next five years adequate provision must be made to address their needs.

**Placement Stability**

Nationally it is recognised that in-house fostering provision provides the most cost effective and efficient provision for the majority of Looked After Children. Since 2012 there has been a year on year decline in the number of in-house foster carers. In November 2014 the number sat at 183. In this same period the number of placements to Independent Foster Care Agency carers has increased from 77 to 95 and private and voluntary residential homes has increased from 12 to 29.

**Child Sexual Exploitation**

External providers who are currently supporting young people with CSE have identified greater information sharing and more specialist training as the two greatest needs of providers. The Medway Safeguarding Children Board (MSCB) has agreed 6 priority areas for 2014-17. Amongst these priorities action will be taken to monitor and evaluate the effectiveness of safeguarding children activities, undertake a case file audit, to ensure that a culture of learning and improvement exist across the organisation, to ensure that the policy and procedures co-ordinates the multi-agency approach.

**Leaving care**

The duties and responsibilities that Local Authorities have towards care leavers are set out in The Children Act 1989 which was updated in 2010 to include Planning Transition to Adulthood for Care Leaves. It includes The Care Leaves (England) Regulations 2010. We have high aspirations for our children just like any other parent and helping them plan for their future educational and employment careers is essential. A Leaving Care nurse has joined the Looked After Children’s health team to ensure amongst other things that health histories for all care leavers are produced in a timely manner and that ongoing contact, support and advice in relation to health issues is provided to care leavers. Pathway Plans prior to a young person reaching age of 16 years and 3 months are produced by the Children in Care social work team in conjunction with the child, families and other agencies in order to support the child’s progress into adulthood in an order way. The development of Personal Education Plans for all 16-18 year olds is now underway and the Care2Work scheme is becoming increasingly embedded in order to support apprenticeships, traineeships and work opportunities.
Projected service use

The population growth for 2013 in Medway was above that seen in Kent, the Southeast and England and Wales with continuing increases being seen in the population of children and adults of working age. Recent population growth can be attributed to births exceeding deaths and inward migration with inward migration becoming a more significant factor since 2011. Population growth is predicted to continue and as such the numbers of Looked After Children in Medway is anticipated to rise over the coming years.

Table 8: Population of Medway and comparator areas by broad age group in 2014

<table>
<thead>
<tr>
<th></th>
<th>0-15</th>
<th>16-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway</td>
<td>20.2</td>
<td>64.5</td>
<td>15.3</td>
</tr>
<tr>
<td>Kent</td>
<td>19.2</td>
<td>61.3</td>
<td>19.5</td>
</tr>
<tr>
<td>South East</td>
<td>19.0</td>
<td>62.4</td>
<td>18.6</td>
</tr>
<tr>
<td>England</td>
<td>19.0</td>
<td>63.5</td>
<td>17.6</td>
</tr>
</tbody>
</table>

Modelling taking account of housing and regeneration plans has been undertaken by the School Organisation and Capital Team. This modelling supports the assertion of continued population growth up to and including 2019 in the under-five age range as detailed in figure 7 below.
If a similar increase in all child age ranges is seen the forecast for Looked After Children of 430 in 2015/16 and 388 in 2019/20 will need to be revised upwards.

Evidence of what works

User views

Views of our Children and Young People

Medway Council has a Children in Care council which meets regularly to address issues raised by young people and feeds back to corporate parents on gaps in service provision and improvements made. In addition to this Looked After Children have access to the Children’s Rights and Advocacy Service which assists children expressing their views of professionals and services delivered by the council. There is also a Care Leavers Group and Children with Disabilities Group that meet every six weeks. A key feature of these
groups is a “You said and We did” section that enables children to get feedback as to how their views are informing service delivery. An example of this in practice is the redesign of the complaints leaflet that was undertaken and sent out to everyone aged 12 and upwards feedback from children had made it clear that the old format was confusing and acted as a barrier.

Involving children and young people, families and carers as much as possible in the design, delivery and monitoring of all services is vital so we know that we are getting it right and importantly the care of Looked After Children is improved as a result.

Equality Impact Assessments

Unmet needs and service gaps

Health–The current LAC health provision has seen a number of improvements in increasing the number of initial seen within the statutory 28 day time frame. The service is also seeing sustainable increases in the number of review and adoption assessments. The current review of Medway Foundation Trust block contract includes the LAC health team and it is envisaged that this review will inform a revised outcomes focused specification with agreed measures to enable more robust quality and performance monitoring. It is also envisaged that the review will inform how the expertise and knowledge of the nursing team in particular can be better utilised in order to address the increasingly complex needs of looked after children.

Mental health & Emotional Wellbeing–Commissioners are working with the provider to ensure that in future a better more targeted service based on the needs of the children and young people is provided. A review of the single point of access processes needs to take place to ensure that all referrals are managed through this service in such a way that significantly reduces waiting times. Increased support in the community (including schools) in promoting emotional well-being and resilience needs to be targeted and well resourced. There is a need to ensure that evidenced based pathways for children and young people exist and that a comprehensive quality and performance framework exist in order to monitor and evaluate outcomes. ADHD and ASD pathways are reviewed to ensure that assessments and interventions are aligned.

Placements–to secure sufficiency of provision for 16+ homeless and care leavers ensuring that the placements can meet differing levels of need. To drive up the quality of all placement types whilst driving down the cost especially where it is known that Medway pays above and beyond the price paid by other local authorities for the same provision. To increase the number and abilities of foster carers who can support standard, complex and specialist needs.

CSE–For the Medway Safeguarding Children Board to drive through establishment of MASE panels in order to ensure that the prevention, intervention, diversion and disruption elements of the CSE strategy are consistently put in place in order to reduce the impact of CSE risk.

Leaving Care–The provision of accommodation and support that meets the need of a range of care leavers need to be secured. There is a need to ensure that Pathway Plans
are completed within the timescale and shared with all the relevant individuals or groups. Similarly health histories need to be completed prior to the young person leaving care so that they take with them a clear record.

**Recommendations**

**Emotional Health and Well-being**
1. To assess the emotional health of each Looked After Child to identify needs
2. To address each child needs through the shared development of an emotional well-being plan
3. To provide a package of services and support that addresses each child or young person’s emotional health and well-being.
4. To ensure foster carers and residential staff are appropriately trained and experienced to positively respond to the emotional health and well-being of looked after children.

**Educational Attainment**
1. To ensure that every Looked After Child attends school and is able to achieve their potential
2. To address the needs of Looked After Children that impact on their ability to learn
3. To ensure that foster carers and residential staff are appropriately trained in order to support educational attainment of Looked After Children.
4. To continue to use the PEP process to monitor and ensure that pupil premium plus is used effectively and appropriately for all pupils to support their educational achievement.
5. To make better use of mentoring and coaching programmes to support educational attainment

**Placements**
1. To ensure where possible that children and young people are supported to return home.
2. To increase the available placements for sibling groups, children and young people with complex and challenging behaviours as well as children with profound and multiple disabilities.
3. To develop greater provision of “Staying Put” placements

**Placement stability**
1. To improve matching and planning for permanence so that children and young people are placed with foster carers that can meet their needs and provide a safe and caring environment
2. To provide a therapeutic support that can meet the needs of complex and challenging children and young people
3. To provide training and support for foster carers that develop resilience and expertise that sustains them through periods of turbulence.

4. To monitor placement stability and provide a rapid response before during and after a period crisis.

5. To provide a multi-agency response to placement instability to ensure a comprehensive response that addresses all the child or young person’s needs.

**Placed out of local area**

1. To reduce the number of children placed out of area by increasing local foster carer either through development of in-house fostering or increase in accessible and cost effective independent provider provision thereby offering more placement choice to children and young people.

2. To strengthen the supported accommodation service to ensure that there is increased quality provision for young people wishing to return from “out of area” placements.

3. To monitor children and young people placed “out of area” to ensure they receive the appropriate services to meet their needs.

**Placements with family, friends, special guardianships**

1. To support more children and young people into permanent family arrangements.

2. To enable and encourage more kinship families to become special guardians.

**Adoption and Permanence**

1. To reduce the time taken to match a child after a placement order has been made.

2. To reduce the shortage of adopters by encouraging more adopters.

**Unaccompanied Asylum Seeking Children (UASC)**

1. To ensure that suitable placements are available to meet the needs of UASC.

2. To ensure UASC are supported to adapt to the local culture whilst retaining their links with their home country cultures.

3. To ensure that education and health needs are addressed.

**Children Looked After and Offending**

1. To recruit foster carers able to offer placements to children and young people on remand or involved in criminal activity.

2. To develop foster carers that can offer stability, reduce risk and develop resilience thereby reducing the risk of reoffending.

3. To increase health education and support to young people who are at risk of substance abuse.

**Child Sexual Exploitation**

1. To raise awareness of child sexual exploitation and ability to identify the signs and symptoms whilst addressing the needs of victims.
2. To consider the possibility of CSE whenever a child goes missing or is displaying tell-tale signs

3. To implement Multi Agency Child Sexual Exploitation (MASE) panels in order to communicate and collate information with regards to children at risk and agree a way forward.

**Leaving Care and raising aspirations**

1. To ensure that there is a range of support provision for care leavers up to the age of 25 that meets their needs

2. To encourage young people to remain in care until the age of 18 and in foster care until the age of 21

3. To expect and support care leavers to continue with education and employment

4. To give care leavers additional opportunity to achieve

5. To ensure that pathway plans include a clear outline of support into employment

6. To reduce the experience of loneliness and isolation of Care Leavers by anticipating need an preparing them to live confidently in the community

7. To increase the number of care leavers accessing higher education

**Taking note of the views of children and young people**

1. To continue to develop strong partnership working with young people

2. To raise the profile and impact of the Children in Care Council, Care Leavers Group and Children with Disabilities Group

3. To ensure that the views and concerns of young people are included in service redesign or development as a matter of course

4. To have effective feedback mechanisms to young people so that they know when they have expressed their views that they have been taken into account and actioned.

**Further needs assessment required**

**Child Carers**

**Overview**

**Summary**

The term “unpaid carer” encompasses individuals of any age who provide unpaid support to a relative or friend who could not manage without this help.[84] This could include the provision of support to someone who is ill, frail, disabled or has mental health or substance misuse problems. Anyone under the age of 18 who is in some way
affected by the need to take physical, practical and/or emotional responsibility for the care of another person is termed a ‘young carer’. In Medway there are an estimated 2,300 unpaid carers under 25 years of age.[85] Although, many carers do not make themselves known to services, therefore this number is likely to underrepresent the actual value.

Caring can have detrimental effects on the health and education of the young carer. It is important that young carers are identified and supported early to ensure that the health and wellbeing of the carer, and the person being cared for, are protected. Young carers can be particularly vulnerable as they are often undertaking a level of responsibility that is inappropriate to their age or development and for this reason may also be reluctant to seek help. In addition, caring may have detrimental effects on the young carers’ education and can therefore impact on the carer’s future earning potential and thus their ability to support themselves financially.

Key issues and gaps

The Care Act 2014 came into force in April 2015 and, for the first time, allows carers the same rights to assessment and support as the persons they care for.[86] This shift in focus has highlighted the need for change nationally, to put legislation from the health and social care reforms into action. This includes the increased monitoring of the impact on carers, to ensure that future priorities for action to support carers are identified. In response to the Care Act 2014, Medway has formed a new strategy entitled “NHS Medway and Medway Council Joint Carers’ Strategy”,[87] which sets out to identify carers in need of help and put in place the structures necessary to deliver advice and support. This support is hoped to maximise the carers’ potential through the delivery of training, identification of resources already available to them in their family and community networks and, in some instances, provision of financial assistance.

Level of need in the population

Using figures from the 2011 Census, there are an estimated 661 children and young people in the age range 0 - 15 provided unpaid care in Medway, with an additional 1,632 in the 16 - 24 age range. Changes to the age ranges displayed at Local Authority level mean that direct comparisons for the younger age ranges cannot be made with previous surveys. However, national figures in the 2011 Census show a 2.1% rise in young carers identified as providing unpaid care compared with the preceding survey.[85][88]

Current services in relation to need

For an up-to-date list of current services please contact Caroline Friday.

Table 1 shows projected carer provision required in the years 2017 to 2037. These projections assume that the proportion of the population providing care in the future, by age, remains the same as in 2011.[85]
Table 1: Estimated number of young carers in Medway, by age, 2017 to 2037. Projections calculated using Census 2011 carer numbers and 2012-population projections (ONS).

<table>
<thead>
<tr>
<th></th>
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<th>2032</th>
<th>2037</th>
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<td>0 to 15</td>
<td>701</td>
<td>740</td>
<td>759</td>
<td>765</td>
<td>770</td>
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<tr>
<td>16 to 24</td>
<td>1,548</td>
<td>1,495</td>
<td>1,577</td>
<td>1,697</td>
<td>1,749</td>
</tr>
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</table>

This assumption is unlikely to be accurate as it does not take into account changes in the prevalence of age-related conditions of those requiring care, such as dementia, which has shown a rapid increase in prevalence. In addition, the proportion recognised as providing care is likely to increase due to better identification of unpaid carers. Thus we are likely to see much higher numbers recorded in the future than those estimated in Table 1.

Evidence of what works

Early identification of young carers is critical to ensure that the correct support is provided. Options to increase identification of carers may include routinely asking about whether someone is a carer at new registrations and routine health checks, or on repeat prescriptions. Carer support workers may be helpful in providing carers with advice and signposting to relevant agencies.[89]

User views

In 2012 four focus groups were held with carers from across Medway, including young carers. One of the key points raised was identification. Carers felt that there was often a delay in recognition of their role as a carer, by authorities and the carer themselves. Carers felt that GPs and hospitals were in an ideal position to recognise that they were carers and offer support and felt that the carer should be identified as soon as the person being cared for received their diagnosis.

There was felt to be a lack of training for unpaid carers in the skills they needed in their caring role, for example using a hoist. Carers also expressed that they would like more information about the condition of the person they cared for as well as clear information relating to available support. Carers felt that a single information booklet with necessary information and contact details would help greatly.

In order to keep themselves healthy, carers highlighted a need for support to take breaks from their caring responsibilities in addition to respite care, which was deemed too costly for some. In addition, counselling was mentioned as something that could be useful in helping carers maintain their mental health. Carers also expressed the desire for free travel and other treatments, such as free swimming.

Further consultation will be undertaken in the 2017 leading up to review of the carers’ strategy.
Unmet needs and service gaps

Only a small proportion of carers in Medway will become known to services. There is a need to improve the way in which carers are identified in order that they are provided with appropriate support. The discussion of a carers’ lead role in GPs surgeries is planned to take place shortly will assist in raising the awareness and better identification of carers and carers’ issues within primary care settings. Once identified carers should be given the correct information and training for their needs to support them in their caring role.

Recommendations for Commissioning

Medway Council and Medway NHS CCG value their young carers. As such, there is the recommendation to ensure that carers should be recognised by the wider community and receive appropriate support where necessary to help them provide care safely and maintain a balance between their caring responsibilities and a life outside caring. This includes assisting them in achieving their potential, maintaining mental and physical health and wellbeing, ensuring access to training and employment and supporting them to be as independent as possible.[87]

A list of principles underpinning ‘Medway’s Commitment to Carers’ can be found under section 7 of the NHS Medway and Medway Council Joint Carers’ Strategy 2015–2017. The ongoing development and testing of the new Citizen’s Portal, MyMedway.org, will carry a full suite of information, advice and guidance as well as an “E-Marketplace” which is being developed to ensure that those looking for support can research appropriate solutions for themselves.[87]

In line with the requirements of the new Care Act 2014, Medway Council will offer assessments for carers who request them. This will enable the council to determine the carers’ level of need, including whether or not they are eligible for any additional funding.

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