JSNA

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.

Figure 3 Dental access in the South East Coast PCTs

There were 540 Looked after Children (LAC) in 2010 in Medway (Department for Education, 2010). LAC access dental care in Medway though a recognised referral and dental care pathway. There is multidisciplinary input which can include initial assessment and treatment planning at the community dental service. This results in referral to specialist paediatric dentists if required or referral on to a general dental practitioner for treatment and regular recalls as appropriate.

Oral health promotion services are commissioned from the salaried and community dental services providers. A coordinated strategy is needed to reduce the oral health inequalities in children, focussing especially on pre-school children.

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[2].

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

Summary

Introduction

This chapter will focus on the special educational needs and disabilities (SEND) of children and young people aged 0–25. ‘Special educational needs and disability’ (SEND) is a broad term that encompasses a range of disabilities, disorders and difficulties.

Most children and young people will have their needs identified and met at early stages and they will access support through their school or early years setting, known as ‘SEN support’. Only children and young people with the most severe needs will have an Education Health and Care Plan (EHCP). The EHC Plan is statutory and sets out the child or young person’s special educational needs along with the provision they need to help them overcome the barriers to learning that these needs present.

The definition of disability under the Equality Act 2010 is a physical or mental impairment that has a ‘substantial’ and ‘long term’ negative effect on a person’s ability to do normal daily activities. This needs analysis adopts the social model of disability, which recognises that children and young people can be disabled by barriers in society such as the absence of a ramp alongside steps preventing access to a building or lack of support in paying rent to allow someone with a learning difficulty to live independently in their own home.

Failure to adequately address the learning needs of children and young people hinders their ability to fulfil their potential in terms of educational attainment and future employment prospects but also has an impact on the quality of life of both the individual and their family.

Key issues and gaps

There is a clear downward step in educational attainment from children without special educational needs (SEN) to children in receipt of SEN support and another downward step to those with an Education Health and Care Plan (EHCP). The prevalence of Social, emotional and mental health needs is rising. There is still a high level of exclusions from Medway schools, although this is improving. There is a low proportion of children with an EHCP placed in mainstream education. The rate of asthma admissions in young children (aged under 10) is 30% higher than the England average. Local analysis of attendances at accident and emergency has identified poor inhaler technique and lack of understanding of likely triggers as being key factors in exacerbation of asthma symptoms. There are services in place to address this need and they need to continue.

A single, consistent data recording system is required for children with needs and disabilities. All special schools are full with some operating over capacity and it is difficult to increase the number of places at the special schools any further due to space and buildings capacity. Over recent years, waiting times for assessment and treatment for neurodevelopmental conditions has been high but this is improving.

Processes for transition (from child-centred to adult-orientated services) are in place relating to different groups of children and young people in Medway although clear
protocols relating to specific groups of children and young people, for example those with SEND are not present. This gap provides the potential for the needs of young people to be unmet when transitioning to adult services.

**Recommendations for commissioning**

Wherever possible, pooled funding arrangements between Health and Local Authority commissioners should be explored in order to promote child-centred service delivery, in support of the BMA’s recommendation of ‘access to necessary services for emergent difficulties, untramelled by organisational boundaries’. [4]

Continue to commission the Medway-wide training to embed Positive Behaviour Support as the accepted framework in Medway for helping children and young people with behaviours of concern.

Widen the offer of respite care to families with disabled children to those whose prefer not to have social care involvement.

Enhance the offer of short breaks and emergency respite to include services such as play therapy and functional behaviour assessment.

Improve public education within the local population on inhaler technique and potential triggers of asthma exacerbations in children and young people. Link with local general practices to ensure effective asthma management plans are in place.

Increase investment in diabetes prevention such as services that decrease childhood obesity. Type 2 diabetes is much more aggressive in children and young people than in adults, with a higher overall risk of complications that tend to appear much earlier.

**Introduction**

This chapter will focus on the special educational needs and disabilities (SEND) of children and young people aged 0–25.

‘Special educational needs and disability’ (SEND) is a broad term that encompasses a range of disabilities, disorders and difficulties. Some, such as physical impairments, may be relatively straightforward to identify; others are less obvious and are in some cases contested. Identification of need is therefore problematic. Children are identified with additional needs, and have those needs supported, on the basis of their educational difficulties. These may arise as a result of a disability or disorder but equally may arise from other factors such as behaviour towards teachers or structural factors such as the home learning environment. [5]

**Special Educational Needs (SEN)**

The SEND Code of Practice (CoP) defines SEN as follows:

‘A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for him or her.’

A child of compulsory school age or a young person has a learning difficulty or disability if he or she:
has a significantly greater difficulty in learning than the majority of others of the same age, or

has a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions

The SEND Code of Practice describes four broad areas of need as below:

- communication and interaction
- cognition and learning
- social, emotional and mental health
- sensory and/or physical needs

Individual children often have needs that cut across all these areas and their needs may change over time. For instance speech, language and communication needs can also be a feature of a number of other areas of SEN, and children with an Autism Spectrum Disorder may have needs across all areas.[6]

Most children and young people will have their needs identified and met at early stages and they will access support through their school or early years setting, known as ‘SEN support’. Only children and young people with the most severe needs will have an Education Health and Care Plan. The EHC Plan is statutory and sets out the child or young person’s special educational needs along with the provision they need to help them overcome the barriers to learning that these needs present.

Failure to adequately address the learning needs of children and young people hinders their ability to fulfil their potential in terms of educational attainment and future employment prospects but also has an impact on the quality of life of both the individual and their family.

Furthermore, there is a strong link between poverty and SEND. Children from low-income families are more likely than their peers to be born with inherited SEND, are more likely to develop some forms of SEND in childhood, and are less likely to move out of SEND categories while at school. At the same time, children with SEND are more likely than their peers to be born into poverty, and also more likely to experience poverty as they grow up.[5]

Children with SEN are currently categorised as follows:

**SEN support**: Extra or different help is given from that provided as part of the school’s usual curriculum. The class teacher and SEN Coordinator (SENCO) may receive advice or support from outside specialists. This category has replaced the former ‘School Action’ and ‘School Action Plus’ categories.

**Statement/ Education, Health and Care (EHC) plan**: A pupil has a statement of SEN or an EHC plan when a local authority issued one following a formal assessment. This document sets out the child’s needs and the extra help they should receive.
**Definition of disability**

The definition of disability under the Equality Act 2010 is a physical or mental impairment that has a 'substantial' and 'long term' negative effect on a person's ability to do normal daily activities.[7]

'Substantial' is more than minor or trivial, for example if it takes much longer than it usually would to complete a daily task like getting dressed, and 'long term' means 12 months or more.

There is a broad range of conditions, with varying levels of impairment and activity limitation that can affect children. Broad categories may include:

- Physical disabilities such as cerebral palsy, hearing impairment and visual impairment
- Long term conditions such as diabetes, epilepsy and asthma
- Learning disabilities, which may be associated with global developmental delay, and as a co-morbidity of attention deficit hyperactivity disorder (ADHD) and autism.

Please note there is a separate JSNA examining children and young people’s emotional wellbeing and mental health. [JSNA home -> Children.](#)

**Disability and SEN**

SEN is of limited use as a proxy indicator of disability as not all disabled children will have a special educational need and not all children with an educational need will have a disability or long lasting illness.

One estimate suggests that 75 per cent of those identified as disabled under the Equality Act 2010 also have special educational needs.[8] This is subject to debate however as assessments and trends in SEN may reflect changes in policy and practice, as well as changes in the prevalence of disability.

**Social model of disability**

The medical model of disability focuses on impairments or differences. This needs analysis adopts the social model of disability, which recognises that children and young people can be disabled by barriers in society such as the absence of a ramp alongside steps preventing access to a building or lack of support in paying rent to allow someone with a learning difficulty to live independently in their own home.[9]

**Who is at risk and why**

As at January 2019 across all schools in England, the percentage of pupils with a special educational need was 14.9% (equating to over 1.3 million pupils). The percentage with SEN support was 11.9% and the percentage with a statement of special educational needs or an education, health and care (EHC) plan was 3.1%. Since 2007, the percentage of pupils classified as SEN support has reduced from a peak of 18.3% in 2010 to a low of
14.4% in 2016 and the percentage of pupils with statements or EHC plans has remained constant at 2.8% until the increases in 2018 and 2019.[10]

**Type of Need**

The most common types of primary need for those on SEN support is speech language and communication needs (23.4%), moderate learning difficulty (22.8%), social, emotional and mental health (18.1%) and specific learning difficulty (14.9%). The profile for those with a statement or EHC plan differs with a far greater proportion with Autistic spectrum disorder (29.0%) and speech, language and communication needs (15.0%). In addition, social, emotional and mental health problems, severe learning difficulty and moderate learning difficulties and are common. Physical disability accounts for 2.9% of all pupils identified with SEN. Hearing and visual impairment account for 1.8% and 1.1% respectively.[10]

**Table 1: Types of SEND recorded in England, January 2019**

<table>
<thead>
<tr>
<th>Type of Need</th>
<th>SEN support</th>
<th>SS %</th>
<th>EHC plan</th>
<th>EHCP %</th>
<th>All</th>
<th>All %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific LD</td>
<td>142132</td>
<td>14.9</td>
<td>8996</td>
<td>3.6</td>
<td>151128</td>
<td>12.5</td>
</tr>
<tr>
<td>Moderate LD</td>
<td>217827</td>
<td>22.8</td>
<td>29010</td>
<td>11.5</td>
<td>246837</td>
<td>20.4</td>
</tr>
<tr>
<td>Severe LD</td>
<td>3005</td>
<td>0.3</td>
<td>29885</td>
<td>11.9</td>
<td>32890</td>
<td>2.7</td>
</tr>
<tr>
<td>Profound &amp; multiple LD</td>
<td>892</td>
<td>0.1</td>
<td>9834</td>
<td>3.9</td>
<td>10726</td>
<td>0.9</td>
</tr>
<tr>
<td>SEMH</td>
<td>172671</td>
<td>18.1</td>
<td>33422</td>
<td>13.3</td>
<td>206093</td>
<td>17.1</td>
</tr>
<tr>
<td>SLC</td>
<td>223845</td>
<td>23.4</td>
<td>37873</td>
<td>15.0</td>
<td>261718</td>
<td>21.7</td>
</tr>
<tr>
<td>Hearing impairment</td>
<td>16482</td>
<td>1.7</td>
<td>5862</td>
<td>2.3</td>
<td>22344</td>
<td>1.8</td>
</tr>
<tr>
<td>Visual impairment</td>
<td>9313</td>
<td>1.0</td>
<td>3374</td>
<td>1.3</td>
<td>12687</td>
<td>1.1</td>
</tr>
<tr>
<td>MSI</td>
<td>2457</td>
<td>0.3</td>
<td>914</td>
<td>0.4</td>
<td>3371</td>
<td>0.3</td>
</tr>
<tr>
<td>Physical disability</td>
<td>22594</td>
<td>2.4</td>
<td>13033</td>
<td>5.2</td>
<td>35627</td>
<td>2.9</td>
</tr>
<tr>
<td>ASD</td>
<td>59328</td>
<td>6.2</td>
<td>73017</td>
<td>29.0</td>
<td>132345</td>
<td>11.0</td>
</tr>
<tr>
<td>Other difficulty</td>
<td>45964</td>
<td>4.8</td>
<td>6684</td>
<td>2.7</td>
<td>52648</td>
<td>4.4</td>
</tr>
<tr>
<td>SEN support no specialist assessment</td>
<td>39766</td>
<td>4.2</td>
<td>0</td>
<td>0.0</td>
<td>39766</td>
<td>3.3</td>
</tr>
<tr>
<td>Total</td>
<td>956276</td>
<td>100.0</td>
<td>251904</td>
<td>100.0</td>
<td>1208180</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Note: LD = Learning difficulty, SEMH = Social, Emotional and Mental Health, SLC = Speech, language and communication needs, MSI = Multi-sensory impairment, ASD = Autistic Spectrum Disorder, NSA = no specialist assessment of type of need.*

**Age and sex**

Special educational needs are more prevalent in boys than among girls. 4.4% of boys and 1.7% of girls had an EHC plan. Similarly, boys are almost twice as likely to be on SEN support - 15% compared to 8% of girls.

SEN is most prevalent among boys at age 9 (23% of all boys), and for girls at age 10 (13% of all girls). SEN support is most prevalent among primary age pupils, before decreasing with age. For EHC plans however, as age increases the percentage of pupils
with EHC plans also increases, up to age 16, where nearly 4% of pupils have an EHC plan.[10]

**Poverty**

There is a strong link between poverty and SEND. Children from low-income families are more likely than their peers to be born with inherited SEND, are more likely to develop some forms of SEND in childhood, and are less likely to move out of SEND categories while at school. At the same time, children with SEND are more likely than their peers to be born into poverty, and also more likely to experience poverty as they grow up.[5]

Child poverty is predicted to increase over the next decade and lies at the root of many risk factors for infant mortality and children and young people’s health. A recent visit by the UN Special Rapporteur on extreme poverty and human rights highlighted serious concerns about the disparate impact on children of changes to social support and the lack of regard given to the impact of budget decisions on child poverty and inequality.[11]

**Free school meal eligibility**

Pupils with special educational needs are more likely to be eligible for free school meals — 28% compared to 13% of pupils without special educational needs. Pupils with EHC plans are more likely to be eligible for free school meals than pupils on SEN support (33% compared to 27%).

**Ethnicity**

Special educational needs are most prevalent in travellers of Irish heritage and Gypsy/Roma pupils with 30% and 26% respectively.

Travellers of Irish heritage and black Caribbean pupils have the highest percentage of pupils with EHC plans (4.5% and 4.4% respectively). Indian pupils had the lowest percentage of pupils with EHC plans at 1.9%, compared with 3.1% of all pupils nationally.

**English as a first language**

Pupils whose first language is known to be English are more likely to have special educational needs (15% of these pupils have SEN) than those whose first language is known to be other than English (12%).

**Looked after children**

In 2018, 55.5% of looked after children had a special educational need, compared to 45.7% of children in need and 14.6% of all children. For those on SEN support or with an EHC plan, social, emotional and mental health is the most common primary type of special educational need for looked after children, covering 38.5% of those with a statement or EHC plan and 46.3% of those with SEN support.[12]
Disability

Assessments of the rate of UK childhood disability vary somewhat according to the source, the definition and the ages of the children considered.

Two useful studies are helpful in assessing prevalence: the Family Resources Survey (FRS)[13] and research conducted by the Centre of Longitudinal Studies.[14]

According to the latest Family Resources Survey for 2016/17, which uses the Equality Act definition of disability, 8% of the UK's childhood population is disabled. This is a rise of 3% compared to the 2006/07 FRS.

The Centre of Longitudinal Studies (CLS) led Millennium Cohort Study (MCS) researches the lives of more than 19,000 children born in 2000/01. It found that 11% of the sample were considered to have a long-standing illness which limited day-to-day activity e.g. Type 1 diabetes, asthma, and physical impairments.

The CLS also led the Longitudinal Study of Young People in England (LSYPE), a large scale representative study of nearly 16,000 young people born in the early 1990s. Seven percent fell into the category of long standing illness which limited day to day activity, mirroring the findings of the Family Resources Survey.

Types of impairment

How individuals are affected by their disability was also measured by the FRS:[13]

Table 2: Impairment types reported by disabled people, by age group, United Kingdom

<table>
<thead>
<tr>
<th></th>
<th>% all disabled people</th>
<th>% all disabled children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility</td>
<td>51</td>
<td>22</td>
</tr>
<tr>
<td>Stamina / breathing / fatigue</td>
<td>39</td>
<td>26</td>
</tr>
<tr>
<td>Dexterity</td>
<td>28</td>
<td>11</td>
</tr>
<tr>
<td>Mental health</td>
<td>24</td>
<td>22</td>
</tr>
<tr>
<td>Memory</td>
<td>17</td>
<td>11</td>
</tr>
</tbody>
</table>

Note: children are defined as being under 16, or 16 to 19 and unmarried, living with a parent/carer and in full time education.

Risk Factors for disability in children and young people

The causes of childhood disability are not always clear. Many conditions result from social and genetic factors coming together in complex ways.[15]

Pre-birth.

According to a BMA report published in 2013, undernutrition during pregnancy can determine chronic diseases including cardiovascular disease, type II diabetes, osteoporosis, obesity, asthma and certain forms of cancer in later life.[4]

Pre-Term Birth.
Children and young people born preterm are at increased risk of developmental problems and disorders; characterised by impairments of personal, social, academic or occupational functioning.[16]

It is predicted that 4.2% of all preterm (i.e. <37 weeks gestation) survivors in England and Wales would have a severe disability at age 18. This rises to 7.9% for those born at less than 28 weeks gestation.[17]

**Infection.**

Maternal infection can cause deafness and blindness[18] as well as meningitis (infection of the tissues surrounding the brain) which can lead to permanent disability.[19]

**Injury and trauma.**

Unintentional injuries are a leading cause of preventable death for children and young people and a major cause of ill health and serious disability.[20]

**Poor housing.**

Children in overcrowded housing are up to 10 times more likely to contract meningitis than children in general. Meningitis can be life threatening. Long-term effects of the disease include deafness, blindness and behavioural problems.[21]

There is a direct link between childhood tuberculosis (TB) and overcrowding. TB can lead to serious medical problems and is sometimes fatal.[21]

Overcrowded conditions have been linked to slow growth in childhood, which is associated with an increased risk of coronary heart disease in later life.[21]

Almost half of all childhood accidents are associated with physical conditions in the home.[21]

**Adverse Childhood Experiences (ACEs).**

There is a growing evidence base regarding the negative impact of adverse childhood experiences such as exposure to ill treatment, parental violence and drug misuse on child development and later life outcomes.

Exposure to chronic stress in childhood has been shown to have a detrimental effect on the immune system and neurological development[22] and to lead to poor physical and mental health, including the earlier development of diseases, and increased use of health services.[23]

**Quality of life.**

Research by Contact[24] shows that there is a marked difference between the quality of life and opportunities available to families with disabled children compared to those without disabilities.

Disabled children and their families are at a significant disadvantage in many key aspects of life including their economic situation, health, employment and housing.

When compared with non-disabled children, disabled children are:
- Twice as likely to live in a home where there is no parent in paid work (34% compared to 17%)
- More likely to live in a lone parent household
- More likely to live in a household without a car, in a home without central heating, and in overcrowded housing
- More likely to live in larger households
- More likely to live in a household with other disabled people.

When compared with other carers, parent carers are:
- Twice as likely to care for 100+ hours per week (24% compared with 12%)
- Twice as likely to care for 35+ hours a week (56% compared with 28%)
- More likely to care for more than one person (20% compared with 15%). This other person included a partner, parent, or another disabled child
- More likely to be managing on a low income
- More likely to feel they have a poor quality of life, with restricted social and life choices
- More likely to report problems with their own health.

**Level of need in the population**

**Total SEND numbers, SEN support, EHCP, disabilities / LTC estimates**

In 2019, Medway reported 6,485 school pupils receiving SEN support and 2,126 children and young people with a statement or education, health and care plan (EHCP). There is no single register of disability or long-term conditions among children and young people in Medway. The most recent Family Resources Survey (FRS) for 2017/18 estimated the prevalence of disability among children to be 8%.[25] This equates to between 5,000 and 5,500 children in Medway. The definition of disability used in the FRS is consistent with the core definition of disability under the Equality Act 2010. A person is considered to have a disability if they have a long-standing illness, disability or impairment which causes substantial difficulty with day-to-day activities.

Schools and other educational settings are required to review their SEND registers on an annual basis and publish a SEND report on their websites.

In Medway the proportion of children who are in mainstream schools and settings, identified as being on SEN Support is higher than the England average.

**Table 1: Percentage on SEN Support, year as at January SEND2 return**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway</td>
<td>14.2</td>
<td>13.4</td>
<td>13.6</td>
<td>13.5</td>
</tr>
<tr>
<td>England</td>
<td>11.6</td>
<td>11.6</td>
<td>11.7</td>
<td>11.9</td>
</tr>
</tbody>
</table>
New EHCPs each year, number reviewed and discontinued

In Medway, the overall number of EHCPs for ages 0-25 that the Local Authority maintains is rising taking into account the extension of the age range since the reforms were introduced in 2014. There is a great deal of mobility in Medway and about 50 children and young people with SEND move into the area each year.

Table 2: Number of Education, Health and Care Plans, year as at January SEND2 return

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of EHC plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>1409</td>
</tr>
<tr>
<td>2015</td>
<td>1500</td>
</tr>
<tr>
<td>2016</td>
<td>1678</td>
</tr>
<tr>
<td>2017</td>
<td>1779</td>
</tr>
<tr>
<td>2018</td>
<td>2034</td>
</tr>
<tr>
<td>2019</td>
<td>2126</td>
</tr>
</tbody>
</table>

The proportion of school age children with an EHCP has increased in recent years from 3% in 2017 to 3.5% in 2019, compared to 3.1% nationally.[26]

Primary need (primary school, secondary school and special school) — are needs becoming more complex?

Analysis of data in January 2018 shows that for children of primary school age in Medway who have an EHCP or are supported at SEN Support stage, the most prominent need recorded by schools is SLCN and this has increased over recent years. This area of need often changes as children move to secondary school. By which time they may have had a diagnosis of ASD, which therefore changes the type of need that schools record on their registers.

The next two highest areas of need in primary schools in Medway are SEMH needs (a significantly growing area of need in Medway) and Moderate learning disabilities.

Mental and emotional health is fundamental to good health and wellbeing and there are clear links to the personal and social development of children and young people and good educational outcomes.

The latest Mental Health of Children and Young People Survey in 2017 (NHS Digital 2018) suggests that one in eight (12.8%) of children and young people in England had a mental disorder.

Social and Emotional and Behavioural difficulties are much more common. It is estimated that these can affect in excess of 30% of children and young people at some time. For children in care or in the criminal justice system this figure can be even higher (up to 70%). This is also evident in the data from the school census which shows the rise in the recording of SEMH in schools.

Educational attainment (Foundation, KS2, GCSE / attainment 8)

There is a clear step in educational attainment between children without SEN, those on SEN support and those with an EHCP across early years and key stages of the national curriculum. This is the case in Medway and nationally. For example, taking an average of 2017 and 2018, the proportion of Medway children achieving the expected level in reading, writing and mathematics at key stage 2 is about 71% among children without SEN, 27% among those receiving SEN support and 9% of those with an EHCP.[26] Compared to the national average and local authority peer group, Medway generally has similar outcomes to the national average in children with an EHCP and better outcomes among those receiving SEN support. Please note: The peer group for Medway comprises
Exclusions

There is a high level of fixed-term and permanent exclusions in Medway schools. In 2016/17, the rate of fixed-term exclusions as a percentage of the school population was 2.9% in Medway compared to 1.4% nationally. The rate of permanent exclusions in primary schools was lower than the national average but higher in secondary schools (0.3% compared to 0.2%). Fixed term exclusions in secondary schools were higher than the national average at 11.5% but similar to local authority peer group.[26]

National figures show that the fixed-period exclusion rate is approximately five times higher in pupils receiving SEN support or with an EHCP. The permanent exclusion rate is two-and-a-half times higher in those with an EHCP and nearly six times higher among SEN support pupils.[27]

Medway has a comparatively low proportion of children with an EHC plan placed in mainstream education. In 2018, the figure was 30.6% compared to 40.1% nationally.[28] In 2019 the figure increased slightly to 32.8%. [29]

Childhood disability in Medway

General Prevalence

There is not a register of all disabled children or those with a long-term condition in Medway. The 2011 Census found that 5.3% of children and young people aged 0 to 19 had a long-term health problem or disability which limited their day-to-day activities. Medway was higher than the local authority peer group but below the national average.

Epilepsy

Epilepsy is one of the most common serious neurological conditions, and is often co-morbid with other disabilities. In April 2019, about 350 children under the age of 18 (0.11%) are diagnosed with epilepsy in Medway.[30]

Asthma

Asthma is a chronic inflammatory disorder of the airways affecting many children and young people. It is a complex and episodic disorder. Asthma is the most common long-term medical condition: according to the British Thoracic Society about a fifth of children (21%) have a diagnosis of asthma.

Asthma typically begins much earlier in life than other chronic diseases, and consequently imposes a high lifetime burden on individuals, their caregivers and the community. Severe problematic asthma that is poorly responsive to the common asthma treatments has been reported in approximately 4.5% of children with the condition.

The crude rate of hospital admissions for asthma in children aged under 10 is 30% higher in Medway compared to England.[31] The 10-18 year old age group has a lower rate than the England average.

Diabetes
Diabetes is a serious condition, which causes a person’s blood sugar (glucose) level to become too high. Over 200 Medway children and young people are on the caseload of Diabetes Service based at Medway Foundation NHS Trust, the majority of whom have Type 1 diabetes. In Type 1 diabetes, the body cannot produce the insulin needed to allow the glucose in the bloodstream to fuel the body.

In Type 2 Diabetes, the insulin does not work effectively or not enough is produced. The risk of developing this type increases with age and has associations with obesity, smoking and having a close relative with diabetes.

In November 2018 Diabetes UK warned that nearly 7000 children and young people are reported to have Type 2 Diabetes in England and Wales[32], and with rising obesity amongst young people this figure could increase significantly.

Cerebral Palsy

Cerebral Palsy is the most common disability affecting movement and co-ordination in children and young people. The prevalence of cerebral palsy in the UK is about 2 per 1000 live births. This figure has not changed significantly in the past 40 years. Around 40% of children with cerebral palsy were born prematurely. In many of these children, the precise cause of cerebral palsy is not apparent, but various risk factors can be identified, including maternal illness and postnatal events.[33]

Complex and life-limiting disabilities

Continuing Care is funded nursing support for children with highly complex needs, over and above those, which can be met by other community or specialist services.

Table 3: Continuing Care caseload, NHS Medway CCG

<table>
<thead>
<tr>
<th>Year</th>
<th>Caseload at year end</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>18</td>
</tr>
<tr>
<td>2015/16</td>
<td>24</td>
</tr>
<tr>
<td>2016/17</td>
<td>23</td>
</tr>
<tr>
<td>2017/18</td>
<td>25</td>
</tr>
</tbody>
</table>

Current services in relation to need

Universal services

Health

Every Medway child should be able to access appropriate universal health services such as health visiting, public health nursing in schools, GPs and emergency care via the children’s emergency department at Medway Foundation Trust (MFT). Reasonable adjustments should be made to ensure equity of access for children with a disability. Some services, such as health visiting, deliver focused provision for disabled children.

Education

This includes the standard provision of education according to the national curriculum, facilitating participation in clubs and societies during lunchtime and after school, school trips and offering pastoral support to those pupils who need it.

Other
The Council supports various youth and leisure activities. There are also a number of public health services, many of which are school-based. These include children and young people’s mental health and emotional wellbeing, Personal, Social, Health and Economic (PSHE) education and Relationship and Sex Education (RSE).

Community/targeted services

Health

- Assessment and interventions delivered by speech and language therapists, physiotherapists, occupational therapists, continence specialists, podiatrists and dieticians
- Multi-disciplinary assessment and diagnosis of neurodevelopmental conditions such as ADHD and ASD
- Assessment nursery for children aged 18 months to 4 years old with learning disabilities, global developmental delay and complex health care needs
- Nursing provision, including community nursing, learning disability nursing, specialist school nursing and continence
- Multi-disciplinary support for children with congenital and acquired neurological conditions

Social care

The 0–25 disabled children’s team is a social work team (also including occupational therapists and support workers) working with children and young people who have a severe and profound learning, physical or sensory disability/long-term, complex medical needs/life-limiting or threatening illnesses. Support delivered includes assessment, social work support, and access to respite.

The Early help service works with families with multiple and complex needs at level 3, below the threshold for safeguarding (level 4). The service supports families in their homes, schools and communities. They deliver direct work with the whole family to reduce their risk and vulnerabilities as well as improve their resilience.

Education

SEN support. Extra or different help is given from that provided as part of the school’s usual curriculum. The class teacher and SEN Coordinator (SENCO) may receive advice or support from outside specialists. This category has replaced the former ‘School Action’ and ‘School Action Plus’ categories.

Other

There are a number of local voluntary and community sector organisations for example Medway Autism Group and Information Centre (MAGIC), 21 Together (Down Syndrome) and Peter’s Place supporting young people with life limiting illnesses. Family Action Medway provides parents/carers, children and young people with special educational needs and disabilities with free impartial information, advice and support.
Specialist services

Acute health services (hospital based)

Children aged up to 16 can access specialist paediatric care through MFT’s Cardiology, ear, nose & throat, endocrinology, gastroenterology, haematology, immunology, metabolic disorders, nephrology, neurology, respiratory, rheumatology, paediatric surgery and urology departments.

Children and young people may have their care shared between MFT locally and specialist teams in the London tertiary centres such as Great Ormond Street, Evelina and the Royal Marsden hospitals.

Special educational provision in Medway

The percentage of children with an EHCP attending specialist schools or specialist provision as opposed to mainstream schools has increased in Medway and is higher than national. This is putting pressure on the demand for specialist school places in Medway. We need to acknowledge that there will always be a number of children whose needs can only be met in a highly specialist or residential setting. Indeed, for some children a special school place out of the Medway area may well be their local school and nearer to where the child/young person lives.

The current capacity of Medway special schools and mainstream schools is insufficient to meet the demand for places. In 2018/19, there were 825 children in special schools in Medway compared to 801 places that were commissioned. In mainstream education, there were 388 children compared to 371 places.

The place planning strategy aims to plan for sufficient places for children and young people with SEND both in resourced provision within a mainstream setting or in a special school and enable a further expansion of the existing rich range of provision and expertise in Medway.

The majority of Medway children and young people who are placed in independent provision have a primary need of Autistic Spectrum Disorder (ASD) or Social, Emotional and Mental Health needs (SEMH). There are 223 children and young people in day schools, 125 of whom attend school outside Medway. There are 40 of Medway’s children and young people placed in an independent residential school or college. Their needs include Moderate Learning Difficulty, ASD, SEMH and Severe Learning Difficulty.

Planning for post 16 provision

There is a range of provision available locally for young people post 16. Most stay on at their special school or go to Mid Kent College. There are also opportunities in North Kent or Hadlow colleges for courses in horticulture, forestry and agriculture. A programme of supported internships is underway with 12 at Bemix, five at Bradfields and three at Mid Kent College. Plans are in place to increase these numbers with up to 45 places overall in 2019. However, there is a need to plan for more provision for our older young people to ensure continuity of learning and care right up to age 25 or independence whichever comes sooner.

The place planning strategy is to develop special provision locally wherever possible to reduce the need for out of area placements and children and young people travelling
long distances to school or respite provision. However, it is recognised that for a few children with very complex needs an independent school or out of area placement will still be required and will be cost effective.

**End of Life Care**

End of life care for children and young people is delivered by a range of practitioners and services working together. These include: Demelza Hospice, Medway NHS Foundation Trust, Tertiary Centres, South East Ambulance Trust, GPs and allied health professionals.

There is also a children’s outreach and specialist team at Medway NHS Foundation Trust which provides continuing care health services to children outside of the hospital with life-threatening and life-limiting illnesses, aiming to keep them out of hospital as much as possible.

**Projected service use**

The report ‘Understanding the needs of disabled children with complex needs or life limiting conditions’[42] estimates that the numbers of children in this category of need have increased by over 50% between 2004 and 2016. Complex needs are comprised of profound and multiple learning difficulties, severe learning difficulties, autistic spectrum disorder and multi-sensory impairments. Two key trends have been identified:

- improved survival rates of preterm babies and babies with congenital conditions
- increased life expectancy for children with complex disabilities, including children with severe cerebral palsy, cystic fibrosis and Duchenne muscular dystrophy

Since 2014 Medway is supporting 725 more children and young people (age 0–25) who have an EHCP. This represents an average increase of 9.6% per year. If this trend continues then there is the potential that Medway will be supporting 3,216 children and young people by January 2023.[43]

**Evidence of what works**

**SEND Code of practice**

The SEND code of practice outlines the responsibilities schools and local authorities and other stakeholders have in regard to taking decisions about pupils with special educational needs or disabilities. Children, parents and young people must be involved in the process, which should be tailored to the child or young person as an individual. Teachers are responsible for identifying children with potential SEN and local authorities are responsible for assessing education, health and care (EHC) needs. Following the decision that an EHC plan is required, the young person or parents have the right to request a personal budget to take greater control of the care and support they need. All these responsibilities and available services should be published in a local offer.
The British Medical Association (BMA) identified the following as essential to good quality child disability services:

- early identification of difficulties and timely multidisciplinary assessment
- access to necessary services for emergent difficulties, untrammelled by organisational boundaries
- coordinated care, minimising disruption to family life
- clear protocols and pathways for the management of particular difficulties
- effective information sharing

EHCP best practice

The SEN code of practice stipulates that the whole EHCP process should take no more than 20 weeks subject to certain exemptions.[6]

The Council for disabled children has produced best practice guidance for completing Education, Health and Care plans that meet the letter and spirit of the Children and Families Act 2014.[44] The key points include making it personal, reflective of the views and aspirations of the young person in simple terms, free of specialist terminology. The necessary support services in terms of both health and care should be clearly articulated.

Speech, Language and Communication Needs — Royal College of SLT

The Royal College of Speech and Language therapists produced guidance to help members understand their role in relation to special educational needs.[45]

The purpose of the SLT’s contribution to an EHC assessment and planning process is to offer professional advice and evidence-based recommendations as regards speech, language, communication, eating and drinking, as part of a multi-agency assessment and planning process with the child or young person and their family.

ASD — NICE Guidance

Within the NICE guidance for support and management of autism spectrum disorder in under 19s,[46] the recommendations under general principles of care include: ensuring that all children and young people with autism have full access to health and social care services, including mental health services, regardless of their intellectual ability or any coexisting diagnosis. Local agencies should coordinate the assessment process and support they provide via specialist community-based multidisciplinary teams.

Social Emotional and Mental health — National Children’s bureau and NICE

The National Children's Bureau has produced a best practice framework[47] to help schools to promote social and emotional well-being and mental health. The emphasis is on developing a school and classroom climate which builds a sense of connectedness and purpose so that all children can thrive. It also highlights the need to promote staff wellbeing and particularly to address their stress levels.
The framework demonstrates how to engage the whole school community so that pupils feel their voice is heard and parents, carers and families feel they genuinely participate, particularly those of pupils in difficulties who otherwise may feel stigmatised.

NICE public health guideline PH12 relating to social and emotional wellbeing in primary education,[48] states that schools and local authority children's services should work closely with child and adolescent mental health and other services to develop and agree local protocols. These should support a 'stepped care' approach to preventing and managing mental health problems (as defined in the NICE guideline on depression in children and young people). The protocols should cover assessment, referral and a definition of the role of schools and other agencies in delivering different interventions, taking into account local capacity and service configuration.

**Specific learning difficulty — Dyslexia action**

The policy and practice review report from the Dyslexia-SpLD Trust[49] summarises that effective learning for children with dyslexia depends on:

- A whole school ethos that respects individuals’ differences, maintains high expectations for all and promotes good communication between teachers, parents and pupils.
- Knowledgeable and sensitive teachers who understand the processes of learning and the impact that specific difficulties can have on these.
- Creative adaptations to classroom practice enabling children with special needs to learn inclusively and meaningfully, alongside their peers.
- Access to additional learning programmes and resources to support development of key skills and strategies for independent learning.

**Learning disability — NICE**

NICE guideline NG93[50] is concerned with service design and delivery for people with learning disabilities and behaviour that challenges. This guideline is based on the principle that children, young people and adults with a learning disability and behaviour that challenges should have the support they need to live where and how they want. It will help local areas shift their focus towards prevention and early intervention, enabling children, young people and adults to live in their communities, and increasing support for families and carers. Local authorities should provide a range of services including education, and general and specialist learning disability support services in the community, as an alternative to residential placements away from home and to reduce the potential need for such placements.

**Cerebral Palsy / spasticity**

NICE recommends four quality statements concerning cerebral palsy in children and young people.[51]

1. Children with any major risk factor for cerebral palsy have enhanced clinical and developmental follow-up from birth to 2 years.
2. Children with delayed motor milestones are referred to a child development service.

3. Parents and carers of children and young people with cerebral palsy are given information about the diagnosis and management of cerebral palsy.

4. Children and young people with cerebral palsy have a personal folder to help them make decisions about how their condition is managed.

**Asthma**

NICE recommends five quality statements concerning Asthma.[52]

1. People aged 5 years and over with suspected asthma have objective tests to support diagnosis.

2. People aged 5 years and over with asthma discuss and agree a written personalised action plan.

3. People with asthma have their asthma control monitored at every asthma review.

4. People who receive treatment in an emergency care setting for an asthma attack are followed up by their general practice within 2 working days of discharge.

5. People with suspected severe asthma are referred to a specialist multidisciplinary severe asthma service.

**Diabetes**

NICE recommends six quality statements concerning Diabetes in children and young people.[53]

1. Children and young people presenting in primary care with suspected diabetes are referred to and seen by a multidisciplinary paediatric diabetes team on the same day.

2. Children and young people with type 1 or type 2 diabetes are offered a programme of diabetes education from diagnosis that is updated at least annually.

3. Children and young people with type 1 diabetes are offered intensive insulin therapy and level 3 carbohydrate counting education at diagnosis.

4. Children and young people with type 1 diabetes who have frequent severe hypoglycaemia are offered ongoing real time continuous glucose monitoring with alarms.

5. Children and young people with type 1 diabetes are offered blood ketone testing strips and a blood ketone meter.

6. Children and young people with type 1 or type 2 diabetes are offered access to mental health professionals with an understanding of diabetes.
**Epilepsy**

NICE recommends nine quality statements concerning Epilepsy in children and young people.[54]

1. Children and young people presenting with a suspected seizure are seen by a specialist in the diagnosis and management of the epilepsies within 2 weeks of presentation.

2. Children and young people having initial investigations for epilepsy undergo the tests within 4 weeks of them being requested.

3. Children and young people who meet the criteria for neuroimaging for epilepsy have magnetic resonance imaging.

4. Children and young people with epilepsy have an agreed and comprehensive written epilepsy care plan.

5. Children and young people with epilepsy are seen by an epilepsy specialist nurse who they can contact between scheduled reviews.

6. Children and young people with a history of prolonged or repeated seizures have an agreed written emergency care plan.

7. Children and young people who meet the criteria for referral to a tertiary care specialist are seen within 4 weeks of referral.

8. Children and young people with epilepsy have a structured review with a paediatric epilepsy specialist at least annually.

9. Young people with epilepsy have an agreed transition period during which their continuing epilepsy care is reviewed jointly by paediatric and adult services.

**Inclusion**

Inclusion is the process of conceiving, designing, planning and maintaining all parts of the physical and cultural community to cater for the widest spectrum of ability and need[55]. Inclusive practice improves outcomes for all children and young people, including those with disabilities.

Paragraphs 6.8 and 6.9 of the SEND Code of practice[6] make clear that schools should regularly review and evaluate the breadth and impact of the support they offer or can access. All schools have duties under the Equality Act 2010 towards individual disabled children and young people. They must make reasonable adjustments, including the provision of auxiliary aids and services for disabled children, to prevent them being put at a substantial disadvantage. These duties are anticipatory â€“ they require thought to be given in advance to what disabled children and young people might require and what adjustments might need to be made to prevent that disadvantage. Schools also have wider duties to prevent discrimination, to promote equality of opportunity and to foster good relations.
Transition

Transition between services and to adult services is an area of difficulty for many children and young people with additional health needs, often causing anxiety and exacerbations in health needs. NICE recommends five quality statements concerning transition from children’s to adults’ services.[56]

1. Young people who will move from children’s to adults’ services start planning their transition with health and social care practitioners by school year 9 (aged 13 to 14 years), or immediately if they enter children’s services after school year 9.

2. Young people who will move from children’s to adults’ services have an annual meeting to review transition planning.

3. Young people who are moving from children’s to adults’ services have a named worker to coordinate care and support before, during and after transfer.

4. Young people who will move from children’s to adults’ services meet a practitioner from each adults’ service they will move to before they transfer.

5. Young people who have moved from children’s to adults’ services but do not attend their first meeting or appointment are contacted by adults’ services and given further opportunities to engage.

User views

One of the main findings of the annual parent / carer’s survey is that respondents expect the various services involved in the care of a child to work more closely together to share important information. For example, to consolidate assessment visits where appropriate and avoid having to ‘tell the story more than once.’ There is also a strong desire for services to communicate better with families. In response, the Special Educational Needs team within the council has introduced a co-production meeting where the child and their family are central to the process of drafting the education and health care plan (EHCP).

Between April and June 2016 and January 2017, a series of focus groups and questionnaires relating to the re-commissioning of Medway’s children’s community health services were conducted with Health Visitors, Children’s Centres, School nurses, Social Care and Early Help, GPs, Specialist Health professionals, Parents and Carers. The following areas were highlighted:

- A need to improve communication between services and organisations
- The need for support and early intervention for children with behavioural needs
- More robust and consistent assessments of conditions such as Autistic Spectrum Disorder and Attention Deficit Hyperactivity Disorder
- Improved use of technology- services need to keep up with parent/carer use of technology for communication, but still value face to face services
• Being listened to and having confidence in your health professional were the most important areas for people in a child health service

• The top three things that young people value in health professionals were;
  – Confidentiality
  – Feeling at ease
  – Having patience

• The top three things that parents saw as being the most important for their child were:
  – Being happy
  – Having the best possible health
  – Being supported to understand their choices and achieve their goals

Parents and carers of disabled children were also consulted in September 2018, particularly in relation to respite provision. Findings included:

• Diagnosis led criteria for access to respite is unhelpful as many children with complex needs do not yet have a diagnosis. The impact of the disability should be what matters

• Some parents with younger children don’t need help at that point, but may do when their children are teenagers

• It was felt that there is a lack of short break/respite services

• Concerns about transition to adult services were raised as a general point.

**Unmet needs**

*Data recording*

Consistent systems of recording and reporting needs, including disabilities, are required. A single system of recording disabilities is not in place; this means that data held at local authority level and by commissioned providers is often not directly comparable.

*Specialist school place planning*

All special schools are full with some operating over capacity and it is difficult to increase the number of places at the special schools any further due to space and buildings capacity.

It is estimated that if the predicted growth in demand for specialist provision continues, there will be a need for 484 more special school places, 200 more resourced provision places and 500 more children with EHCPs in mainstream schools by 2024/25 to meet the demand.
A bid for a new free school for children with Profound and Multiple Learning Difficulties (PMLD) has already been submitted and, if successful, this will go some way to expanding the number of places in Medway.

Analysis indicates that there is also an urgent need for additional secondary PMLD/SLD/Complex ASD special school places, additional complex ASD and SLD special school primary places and additional SEMH special school places.

**Waiting times**

Over recent years, waiting times for assessment and treatment for neuro-developmental conditions has been high. NHS Medway CCG has recommissioned these services and robust assessment and treatment pathways for ASD and ADHD, compliant with NICE guidance, are now in place. This has seen numbers of children waiting for assessment and treatment decline significantly.

**Exclusions**

The local authority is working with schools to offer some support and challenge. This is now leading to notable improvements. Fixed-term exclusions and permanent exclusions are still higher than the national average. Work is underway in the five secondary schools with the highest exclusion rates to support their strategies to prevent exclusions.

Medway has a comparatively low proportion of children with an EHC plan placed in mainstream education.

**Transition to adult health services**

Transition is the purposeful planned movement of young adults with chronic conditions from child-centred to adult-orientated health care systems[57]. If transition is not well managed, adolescents with long-term health conditions and disabilities sometimes fall into a gap in services, and their health can deteriorate.

Processes for transition are in place relating to different groups of children and young people in Medway although clear protocols relating to specific groups of children and young people, for example those with SEND are not present. This gap provides the potential for the needs of young people to be unmet when transitioning to adult services.

**Behaviour of concern to families and services**

Children and young people with a learning disability and autism may exhibit problematic behaviour. In some cases this has led to family breakdown and placement of the child in long term residential or hospital care. Children with SEND are also disproportionately excluded from school. Medway has begun the process of adopting and embedding Positive Behaviour Support as the key component in provision for children and families experiencing difficulties.
Psychological support specific to children and young people with long term conditions and life limiting/life threatening illness

Some targeted support is available e.g. to children and young people with diabetes as part of the Best Practice Tariff funding arrangements, but there is no routine offer.

Asthma

Local analysis of attendances at accident and emergency has identified poor inhaler technique and lack of understanding of likely triggers as being key factors in exacerbation of asthma symptoms. There are services in place to address this need and they need to continue.

Recommendations

Pooled funding

Wherever possible, pooled funding arrangements between Health and Local Authority commissioners should be explored in order to promote child-centred service delivery, in support of the BMA’s recommendation of 'access to necessary services for emergent difficulties, untrammelled by organisational boundaries'.[4]

Positive Behaviour Support

Continue to commission Medway wide training to embed Positive Behaviour Support as the accepted framework in Medway for helping children and young people with behaviours of concern. In future this should be informed by a review and mapping exercise of the support available for parents of children and young people with social, emotional and mental health needs. The aim being to enable parents to support their child or young person at home and in the community.

Short breaks and emergency respite

Respite care is currently only offered to children and young people open to the 0–25 children's disability team, which precludes those disabled children whose parents/carers prefer not to have social care involvement.

Commissioners should develop an enhanced offer of short breaks and emergency respite which actively contributes to positive outcomes for children, young people and their families (e.g. by offering play therapy and functional behaviour assessment) and which maintains consistency of approach between home, educational setting and respite provision. The development of short breaks services should prioritise personalised care, in line with the aspirations set out within the NHS Long Term Plan.[58]

Asthma

Improved public education locally on inhaler technique and potential triggers of asthma exacerbations in children and young people. Link with local general practices to ensure effective asthma management plans are in place.
Diabetes

The treatment target for diabetes involves a reduction in blood sugar levels: a reduction is associated with the development of fewer complications such as blindness, amputations, heart disease and kidney failure.

Medway has been assessed as an outstanding area by the NHS Diabetes Assessment 2017/18[59], partly evidenced by the proportion of children and young people reaching the target measure for blood sugar levels.

Prevention of more young people developing Type 2 diabetes should be a commissioning priority as this condition is much more aggressive in children and young people than in adults, with a higher overall risk of complications that tend to appear much earlier. Services which decrease levels of childhood obesity will also reduce the Type 2 diabetes in children and young people.

Further needs assessment

The information about changing needs is important to help map where our specialist provision is across Medway and also where we need to ensure we develop the right expertise to meet those needs.

Develop a consensus view amongst healthcare providers, the local authority and schools about how special educational needs and disabilities are recorded and reported.

Mapping existing local arrangements for young people with SEND and long-term conditions transitioning to adult services.

Review of epilepsy services locally for children and young people.

Map and review the support that is available for parents including those of children and young people with SEND particularly autistic spectrum disorder and social, emotional and mental health needs (SEMH), before and after any relevant diagnosis. Following this review, establish programmes of support and training to enable parents to support their CYP at home and in the community.

Work with schools and partner organisations in the healthcare system to undertake a review of services for children and young people with SEMH. The aim is to achieve greater integration and co-ordination of services as well as effective use of resources and expertise available.

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.[60]

After clean water, vaccination is the most effective public health intervention in the world for saving lives and promoting good health.[61] 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.[60] 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.[62]


**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.[60] 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.[63]*

<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</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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</td>
<td>Diptheria, tetanus, pertussis, polio and</td>
</tr>
<tr>
<td>Age Range</td>
<td>Vaccine</td>
<td>Disease/Condition</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>4 months</td>
<td>Infanrix IPV Hib</td>
<td>Haemophilus influenza type b (Hib)</td>
</tr>
<tr>
<td></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>
<tr>
<td>12 to 13 months</td>
<td>MMR (Priorix or MMR VaxPRO)</td>
<td>Measles, mumps and rubella (German measles)</td>
</tr>
<tr>
<td>2,3 and 4 years</td>
<td>Flu nasal spray (Fluenz Tetra – annual – if Fluenz unsuitable, use inactivated flu vaccine)</td>
<td>Influenza</td>
</tr>
<tr>
<td>3 years 4 months</td>
<td>FTaP/IPV (Infanrix or Repevax)</td>
<td>Diphtheria, tetanus, pertussis and polio</td>
</tr>
<tr>
<td>3 years 4 months</td>
<td>MMR (Priorix or MMR VaxPRO – check first dose has been given)</td>
<td>Measles, mumps and rubella (German measles)</td>
</tr>
<tr>
<td>12 to 13 years - girls only</td>
<td>HPV (Garasil)</td>
<td>Cervical cancer caused by human papillomavirus types 16 and 18 (and genital warts caused by types 6 and 11)</td>
</tr>
<tr>
<td>Around 14 years</td>
<td>Td/IPV (Revaxis) and check MMR status</td>
<td>Tetanus, diphereria and polio</td>
</tr>
<tr>
<td>Around 14 years</td>
<td>MenC (Meningtite, Menjugate or NeisVac-C)</td>
<td>MenC</td>
</tr>
</tbody>
</table>

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>
<thead>
<tr>
<th>Quarter</th>
<th>Area</th>
<th>By age 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DtaP/IPV/Hib</td>
</tr>
<tr>
<td>Apr 2010 - Jun 2010</td>
<td>Medway</td>
<td>95.4</td>
</tr>
<tr>
<td></td>
<td>South East Coast</td>
<td>91.8</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>93.5</td>
</tr>
<tr>
<td>Jul 2010 - Sept 2010</td>
<td>Medway</td>
<td>95.2</td>
</tr>
<tr>
<td></td>
<td>South East Coast</td>
<td>92.0</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>93.4</td>
</tr>
<tr>
<td>Oct 2010 - Dec 2010</td>
<td>Medway</td>
<td>94.5</td>
</tr>
<tr>
<td></td>
<td>South East Coast</td>
<td>92.2</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>93.9</td>
</tr>
<tr>
<td>Jan 11 - Mar 11</td>
<td>Medway</td>
<td>96.1</td>
</tr>
<tr>
<td></td>
<td>South East Coast</td>
<td>93.5</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>94.2</td>
</tr>
<tr>
<td>Apr 11 - Jun 11</td>
<td>Medway</td>
<td>94.1</td>
</tr>
<tr>
<td></td>
<td>South East Coast</td>
<td>93.2</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>94.1</td>
</tr>
<tr>
<td>Jul 11 - Sep 11</td>
<td>Medway</td>
<td>93.7</td>
</tr>
<tr>
<td></td>
<td>South East Coast</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Table 1: Percentage of children immunised by their first birthday, by PCT 2010–11.[64]
### Table 2: Percentage of children immunised by their second birthday, by PCT 2010–11.[64]

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Area</th>
<th>By age 24 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DTap/IPV/Hib (Prim)</td>
</tr>
<tr>
<td>Apr 2010 - Jun 2010</td>
<td>Medway</td>
<td>97.3</td>
</tr>
<tr>
<td></td>
<td>South East Coast</td>
<td>94.6</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>95.5</td>
</tr>
<tr>
<td>Jul 2010 - Sept 2010</td>
<td>Medway</td>
<td>97.6</td>
</tr>
<tr>
<td></td>
<td>South East Coast</td>
<td>95.4</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>95.8</td>
</tr>
<tr>
<td>Oct 2010 - Dec 2010</td>
<td>Medway</td>
<td>98.8</td>
</tr>
<tr>
<td></td>
<td>South East Coast</td>
<td>94.7</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>96.0</td>
</tr>
<tr>
<td>Jan 11 - Mar 11</td>
<td>Medway</td>
<td>98.4</td>
</tr>
<tr>
<td></td>
<td>South East Coast</td>
<td>95.1</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>96.1</td>
</tr>
<tr>
<td>Apr 11 - Jun 11</td>
<td>Medway</td>
<td>98.6</td>
</tr>
<tr>
<td></td>
<td>South East Coast</td>
<td>95.4</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>96.1</td>
</tr>
<tr>
<td>Jul 11 - Sep 11</td>
<td>Medway</td>
<td>97.1</td>
</tr>
<tr>
<td></td>
<td>South East Coast</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Table 3: Percentage of children immunised by their fifth birthday, by PCT 2010–11.[64]

<table>
<thead>
<tr>
<th>Less than 80</th>
<th>80 or more but less than 90</th>
<th>90 or more but less than 95</th>
<th>95 or more</th>
</tr>
</thead>
</table>

### 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.[65]

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

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.[64][67]

<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.[67]](image)

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.[67]**

<table>
<thead>
<tr>
<th>Number of children</th>
<th>DT.IPV. reinforcement doses</th>
<th>Courses of MMR completed</th>
<th>Number of children n.1</th>
<th>DT.IPV. reinforcement doses n.1</th>
<th>Courses of MMR completion ed.1</th>
<th>Number of children n.2</th>
<th>DT.IPV. reinforcement doses n.2</th>
<th>Courses of MMR completion ed.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3551</td>
<td>10</td>
<td>3</td>
<td>3657</td>
<td>9</td>
<td>12</td>
<td>3567</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>3716</td>
<td>28</td>
<td>5</td>
<td>3582</td>
<td>815</td>
<td>10</td>
<td>3669</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</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.[68]

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%.[69] 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 aboard 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.[70] 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.[71] Most teenage pregnancies are unplanned and approximately half end in a termination.[72] 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.[73]
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.[73]

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:[73]
• 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.[73]

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,[74] 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 2: The percentage of under-18 conceptions aborted, 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).

Figure 3: Under–16 conceptions for Medway, South East and England, 2001–2013, 3-year-pooled data
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.[73]

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 disproportionally 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.[75] 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 as 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**

**Summary**

Mental and emotional health is fundamental to good health and wellbeing. There are clear links between the emotional wellbeing of children and young people, their personal and social development, and educational performance.[76] As such it is an important factor in ensuring that they achieve their full potential. According to the latest Mental Health of Children and Young People survey, 1 in 8 (12.8%) children and young people had a mental disorder in England in 2017.[77]

In reality social, emotional and behavioural difficulties are likely to be much more common and affect in excess of 30% of children and young people at some time.[78] For children in care this figure may be as high as 50% [79] and for young people involved with the criminal justice system, the figure may be as high as 70%.[80]

Risk factors that increase the likelihood of a child experiencing poor emotional wellbeing and mental health problems include:

• Environment: poverty, social housing, homelessness, or refugee status.

• Family: parental unemployment, poor parenting, or circumstances that result in a child being looked after by the local authority.

• Child health: physical disability, chronic health problems, or learning difficulties.

• School: bullying (several of the above risk factors may result in relative social exclusion at school which may further increase the risk of bullying).

Medway’s Local Transformation Plan for Children and Young People’s Mental Health and Wellbeing sets out our vision for improving access to and quality of support for emotional and mental health issues. It is refreshed annually to reflect progress against the original 2015 plan and incorporate learning and revised strategies and priorities. NELFT, the Young People’s Wellbeing Service provider, is a key strategic and delivery partner in the Plan.
At the core of Medway’s strategy for transformation is the establishment of a Young People’s Wellbeing Service (YPWS) that is NICE compliant, focussed on achieving young people’s goals, working in partnership with other agencies and in particular supporting providers of early intervention services.

The new provider, NELFT, took on the contract in September 2017 and we are already seeing improvements in the quality of care and interaction and joint working with partners. The YPWS is present in Medway’s family hubs. Demand is much higher than anticipated, as is the case nationally, so waiting lists for treatment are currently long; however, we are funding additional capacity which is starting to decrease waiting times.

**Introduction**

Mental and emotional health is fundamental to good health and wellbeing. There are clear links between the emotional wellbeing of children and young people, their personal and social development, and educational performance.[76] As such it is an important factor in ensuring that they achieve their full potential.

Emotional wellbeing includes confidence and self-esteem, which contributes to an ability to form good relationships with family and friends. Poor emotional and psychological health or mental health problems may result in educational failure, family disruption, anti-social behaviour and offending. Unrecognised and untreated mental health problems create distress not only for children and young people, but also for their families and carers, continuing into adult life and affecting the next generation.

The significant majority of children and young people will experience positive emotional wellbeing most of the time and develop along normal emotional, social and behavioural pathways. They will almost certainly experience challenges and periods of instability as part of the process of growing up, but will receive sufficient support from the family, school and wider community to cope with times of stress without serious or long-term impact on their wellbeing.

Social, emotional and behavioural difficulties are common and affect in excess of 30% of children and young people at some time.[78] Normal development will include behaviour of concern to adults. Young children may show certain behaviours, such as poor concentration, aggression, lying, stealing, tantrums, toileting or bedtime problems, food fads, specific fears or anxiety; whereas teenagers may have relationship problems or poor anger control or conflict with adults over appearance, school progress or household rules.

In today’s fast-paced, ever-changing society, young people are faced with increasingly complex lives and a diverse set of challenges. For some children and young people, this can lead to emotional problems and mental ill health.

**Who is at risk and why**

**Prevalence of mental disorders**

Previous surveys, in 1999 and 2004, focused only on the five to 15-year-old age group, however for the first time the 2017 survey covered children aged two to 19.[77]

Looking at the five to 15-year-old age group over time, the report reveals a slight increase in the overall prevalence of mental disorders. For this age group, this has risen from 9.7% in 1999 and 10.1% in 2004 to 11.2% in 2017. When including five to 19-year-olds, the 2017 prevalence is one in eight (12.8%), but this cannot be compared to earlier years.[77]

Mental disorders were grouped into four broad categories: emotional, behavioural, hyperactivity and other less common disorders (see page 7 of the survey's Summary of key findings. Emotional disorders were the most prevalent type of disorder experienced by 5 to 19 year olds in 2017 (8.1%) and have become more common in 5 to 15 year-olds; going from 4.3% in 1999 and 3.9% in 2004 to 5.8% in 2017. All other types of disorder, have remained similar in prevalence for this age group since 1999.

It is important to note that the prevalence data presented in the survey is likely to be an under-estimation of real need. The term mental disorder is generally used in the survey. This is because the survey did not screen for general mental health ‘problems’ or ‘issues’, but applied the diagnostic criteria for specific disorders set out in the tenth International Classification of Disease (ICD-10) (World Health Organisation, 1992).[77]

In reality social, emotional and behavioural difficulties are likely to be much more common and affect in excess of 30% of children and young people at some time.[78]

For children in care this figure may be as high as 50% [79] and for young people involved with the criminal justice system, the figure may be as high as 70%.[80]

Characteristics of children and young people with a disorder

The 2017 survey presented the characteristics of children and young people with a mental disorder:[81]

- **Sex:** Overall rates of disorder were similar in boys (12.6%) and girls (12.9%). Rates were highest in girls aged 17 to 19 (23.9%).

- **Age:** The likelihood of having a disorder increased with age: from 9.5% of 5 to 10 year olds to 14.4% of 11 to 16 year olds and 16.9% of young people aged 17 to 19.

- **Ethnic group:** White British 5 to 19 year olds were about three times more likely (14.9%) than Black/Black British (5.6%) or Asian/Asian British (5.2%) children to have a disorder.

- **Socioeconomics:** Living in a low-income household or with a parent in receipt of income-related benefits was associated with higher rates of mental disorder in children. However, there was no association with neighbourhood deprivation.
Social and educational context

The 2017 survey also presented data to place the mental health of children and young people in England into wider social and educational contexts:[81]

- **Sexual identity:** A third (34.9%) of the young people aged 14 to 19-years-old who identified as lesbian, gay, bisexual or with another sexual identity had a mental disorder, as opposed to 13.2% of those who identified as heterosexual.

- **Social media use:** Young people with a mental disorder were more likely to use social media every day (87.3%) than those without a disorder (77.8%).

- **Bullying:** Children with a mental disorder were nearly twice as likely to have been bullied in the past year (59.1%) as those without a disorder (32.7%).

- **Health risk behaviours:** Risky health behaviours (tobacco, e-cigarettes, alcohol and illicit drug use) were more common in young people with a disorder.

- **Self-harm and suicide attempt:** A quarter (25.5%) of 11 to 16-year-olds with a mental disorder had self-harmed or attempted suicide at some point, compared to 3.0% of those who were not diagnosed as having a mental disorder. In 17 to 19-year-olds with a mental disorder, nearly half (46.8%) had self-harmed or made a suicide attempt.

- **Exclusion:** School exclusion was also more common in children with a disorder (6.8%) than in those without (0.5%). Boys with a disorder (9.9%) were more likely than girls with a disorder (2.4%) to be excluded from school.

- **Special education needs:** Over a third of 5 to 19 year olds with a disorder (35.6%) were recognised as having special educational needs.

It is important to note that the cross-sectional survey data can be used to profile circumstances and associations at one point in time, but cannot show whether one factor cause another.[81]

Groups of children and young people at risk of mental health problems

Public Health England (PHE) and the National Child and Maternal Health Intelligence Network (ChiMat) previously produced Child and Adolescent Mental Health Services (CAMHS) needs assessments for all local authorities and Clinical Commissioning Groups (CCGs). Within the needs assessment the following groups were identified at being particularly at risk of experiencing mental health problems:

**Children and young people with learning disabilities:** People with learning disabilities are more likely to experience mental health problems, have poorer health and much more likely to live in poverty than the general population. Further analysis of the 2004 survey found that 36% of children and young people with an intellectual disability had a mental health disorder, whilst 8% of children and young people with no intellectual disability had a mental health disorder.[82]
**Looked-after children:** Looked-after children are more likely to experience mental health problems. It has been found that among children aged 5 to 17 years who are looked after by local authorities in England, 45% had a mental health disorder, 37% had clinically significant conduct disorders, 12% had emotional disorders, such as anxiety or depression, and 7% were hyperkinetic.[83]

**Homelessness and sleeping rough:** Homeless adolescents and street youth are likely to present with depression and attempted suicide, alcohol and drug misuse, and are vulnerable to sexually transmitted diseases, including acquired immune deficiency syndrome (AIDS).[84] Two major studies of this group in London and Edinburgh found significant histories of residential care, family breakdown, poor educational attainment and instability of accommodation. These were associated with sexually risky behaviours, substance misuse and comorbid psychiatric disorders, particularly depression.[85][86]

**Youth Offending:** Children and young people at risk of offending or within the youth justice system often have more unmet health needs than other children. Mapping relevant risk factors associated with youth crime can help inform local authority and NHS commissioning of evidence based early intervention, therefore maximising the life chances of vulnerable children and improving outcomes for them. A lack of focus in this area could result in greater unmet health needs, increased health inequalities and potentially an increase in offending and re-offending rates, including new entrants to the system. The impact of incorporating these vulnerable children into mainstream commissioning also has the potential benefit of impacting on a young person’s wider family now and in the future, particularly when they may already be parents themselves.[87]

**Perinatal mental health and attachment:** Mental ill health during pregnancy and early motherhood, or ‘perinatal mental illness’, is a serious health issue with potentially harmful consequences for women’s life-long mental health and the health and wellbeing of their children and families. For example, postnatal depression is the most common of the potentially serious perinatal mental illnesses and can trigger a relapse or recurrence of previous mental illness. It can also signify the onset of long-term mental health problems and is associated with increased risk of maternal suicide.[88]

**Level of need in the population**

The majority of Medway wards have a very high number of people aged 0 to 19 years. Based on the 2017 mid-year population estimates from the Office for National Statistics (ONS), it is estimated that there were 70,705 people aged 0 to 19 years in Medway in 2017.[89] Medway has a larger proportion of people aged 0-14 years and 15-24 years compared to the England average.

**Overall:** The number of children and young people in Medway with a mental disorder has been estimated (Table 1) by applying national prevalence data by sex and age from the 2017 Mental Health of Children and Young People Survey[90] to the local 2017 mid-year population estimates for Medway.[89] It should be noted that these estimates do not take into account differences in other factors which may influence prevalence.
Table 1: Estimated prevalence of mental disorders in children and young people aged 5-19 years (2017)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Medway estimate (aged 5-19 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any mental disorder</td>
<td>6,655</td>
</tr>
<tr>
<td>Emotional disorder</td>
<td>4,190</td>
</tr>
<tr>
<td>Behavioural (or conduct) disorders</td>
<td>2,418</td>
</tr>
<tr>
<td>Hyperactivity disorders</td>
<td>856</td>
</tr>
<tr>
<td>Other less common disorders</td>
<td>1,100</td>
</tr>
</tbody>
</table>

Please see the ‘Who’s at risk and why’ section for definitions of these conditions.

**Self-harm:** The rate of hospital admissions in Medway as a result of self-harm among 10-24 year olds has been low historically compared to England with about 160 per year (2016/17). This represents only a small fraction of the total number, but does provide an insight into the most serious cases.[91]

Figure 1: Trend in hospital admissions as a result of self-harm (10-24 years)

Certain groups of children and young people are at increased risk of developing mental health problems, taking account of background, life experiences, family history and individual emotional, neurological and psychological development. The remainder of this section will examine the risks and associated factors with mental health in children and young people.
**Environmental:** Medway has relatively high levels of child deprivation and homelessness. The proportion of dependent children under 20 living in low income households (defined as household income less than 60 percent of median household income before housing costs) was 18.3% (2016).[92] Family homelessness (defined as priority need categories as either dependent children or pregnant woman) is 1.9% (2017/18), which equates to 222 applicants.[93]

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.

**Family:** The rate of looked after children in Medway aged under 18 years is similar to the national average. As at 31 March 2018 there were 414 children being looked after by the local authority. Over the previous five years, this number has fluctuated between 379 and 430.[94] On average, the difficulties score of looked after children is above normal indicating borderline cause for concern.[95]

**Child health:** The proportion of primary, secondary and special school children identified as having specific, moderate, severe, profound or multiple learning disabilities is 4.7% which is lower than the England rate of 5.5%.[96]

**School:** During the 2016/17 academic year, a total of 749 pupils were excluded for a fixed term from state-funded primary school and three were permanently excluded. The rate of 2.9% fixed term exclusions was the highest in England. In state-funded secondary schools, the number of fixed term exclusions was 2,159 (11.5%) and 60 (0.3%) permanent exclusions. All of these figures are significantly higher than the England average.[27]

**Special educational needs and disability (SEND):** Certain disabilities increase vulnerability to mental health problems, for example, studies show that children who are deaf have a higher rate of emotional and behavioural problems.[97] Families with disabled children are more likely to experience social isolation, which is a risk factor for mental health problems in children and adults.[98]. Department for Education research[99] outlines the link between SEN and wellbeing in secondary school pupils.

The SEND Code of Practice defines SEN as follows: [6]

‘A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for him or her. A child of compulsory school age or a young person has a learning difficulty or disability if he or she has a significantly greater difficulty in learning than the majority of others of the same age, or has a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions.’

In 2019, Medway reported 6,485 school pupils receiving SEN support and 2,126 children and young people with a statement or emotional health and care plan (EHCP). Analysis of data in January 2018 shows that among children of primary school age in Medway who have an EHCP or supported at SEN Support stage, the most prominent need recorded by schools is speech, language and communication needs and this has increased over recent years. This area of need often changes as children move to
secondary school. By which time they may have had a diagnosis of autistic spectrum disorder, which therefore changes the type of need that schools record on their registers.

The next two highest areas of need in primary schools in Medway are social, emotional and mental health needs (a significantly growing area of need in Medway) and moderate learning disabilities.

Nationally, 29% of children and young people have autistic spectrum disorder identified as their primary need in education health and care plans.

For further information, please see:

- SEND JSNA chapter: Medway JSNA -> Children -> Special educational needs and disabilities
- Medway draft SEND strategy
- Medway's Local Offer

**Current services in relation to need**

Child and Adolescent Mental Health Services (CAMHS) have traditionally been commissioned as Tiered services. Tier 1 typically includes early help and support interventions for lower level and emerging emotional health and wellbeing needs below the threshold for CAMHS services, e.g. school counselling and behaviour support provision, often commissioned or provided in education settings or other targeted/universal frontline services. Tier 2 typically includes targeted support and interventions where needs cannot be effectively addressed within universal services and Tier 3 includes specialist mental health services for children and young people with more severe and pervasive difficulties. Tier 4 includes highly specialised provision, e.g. forensic services and support in inpatient settings.

**Medway Young Persons’ Wellbeing Service**

The Medway Young Persons’ Wellbeing Service (MYPWS), commissioned from 1 September 2017, progressed the integration of Tiers 2 and 3 CAMHS accommodating the provision, staffing and early intervention in collaboration with other Medway frontline services utilising a ‘Team Around the Family’ approach. This delivers an integrated service with cross fertilisation of skills and knowledge across partner agencies.

The service provider, NELFT (North East London NHS Foundation Trust), is delivering a multi-disciplinary service offering community-based NICE-concordant treatment. The MYPWS teams comprise clinical staff with significant expertise, appropriate capacity and skill-mix. The service focuses on the outcomes children and young people want to achieve, as well as clinical goals; and aims to produce higher throughput through the service by deploying a more intensive treatment model. This should, ultimately, reduce waiting times for treatment.
The service offers direct access to treatment through self-referral and primary care services and will be committed to the principles of The Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme, which include:

- evidence-based practice;
- routine outcome measures;
- high quality clinical supervision and training; and
- increased young people's participation.

In line with the objective to support transition to adult services and better meet the needs of young people with differing levels of need, Primary Mental Health services are provided to young people up to a young person's 19th birthday (in line with extended participation age) for initial referral and up until the age of 25 for young people with special educational needs or as part of a wider network of support for children and young people in the care of the local authority.

**CAMHS Tier 4**

CAMHS Tier 4 are specialised services that have been commissioned by NHS England since April 2013. Typically these are inpatient settings ranging from generic adolescent CAMHS beds, to PICU (Psychiatric Intensive Care Units), low to medium secure units and specialist units for specific conditions, e.g. learning disabilities or eating disorders.

All NHS Trusts providing CAMHS in the South East report major difficulties in finding a bed when needed in a reliable way, with a great deal of staff time spent trying to navigate the current system. NHS England, commissioners and local provider consortia are engaged in the planning of ‘New Care Models’, a national programme to transition planning, operational delivery and ultimately budgets for these services to local areas.

**School Mental Health Services**

Schools provide a substantial amount of emotional support to pupils, whether directly through their pastoral support teams and Special Educational Needs Coordinators (SENCOs), through contracts with providers such as ‘Place2Be’ or individual counsellors and/or through participation in initiatives such as peer mentoring, mindfulness training and speech and language interventions. This provision differs from school to school, in terms of what is provided, how much support is offered and how it is managed.

**Medway Local Transformation Plan**

Medway Council and Medway Clinical Commissioning Group (CCG) provide direct support to schools under the Local Transformation Plan for children and young people's mental health and wellbeing.

This includes:

- workforce development;
• projects to raise awareness of how young people can improve their own mental and emotional health, and support each other; and
• an action research project with Canterbury Christ Church University to explore and evaluate effective classroom practice.

Other Services

Medway Public Health also deliver a range of preventative programmes in relation to emotional wellbeing, including Personal, Social and Health Education (PHSE) and Youth Mental Health First Aid.

A specialist all-age Eating Disorder service (8+ years) has also been commissioned from 1 September 2017 to provide more timely support and interventions across a range of evidence based treatment modalities for children and young people.

Most importantly, however, we are taking the opportunity presented by new providers of children’s community health to join up services that have previously been disparate. The main aim is to support earlier intervention. To this end, MYPWS and children’s community health services are working with schools to provide staff development and consultation. They are also working with the School Improvement team to develop a more effective philosophy around behaviour management that seeks to understand what a child is trying to communicate through their behaviour, rather than to punish and often exclude them. Giving schools the insight and practical support to do this will make a big difference to inclusion in Medway.

Projected service use

Population projections

Current population projections predict that Medway’s under 25 population will change considerably over the next 20 years, increasing by 8.6% from 2018-2028 and 14.3% from 2018-2038.[100]

Assuming that the current levels of mental health 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 mental health disorder in Medway over the next two decades.

Accessing community mental health services

The Five Year Forward View for Mental Health was published in February 2016 and outlines a strategic approach to improving mental health outcomes across the health and care system. One of the priority actions to be achieved by the NHS by 2020/21 is to help at least 70,000 more children and young people access high-quality mental health care when they need it (Mental Health Taskforce, 2016). To achieve this target there is an expectation that there will need to be an increase in the percentage of those accessing services. At least 30% of children and young people with a diagnosable mental
A health condition will need to receive treatment from an NHS-funded community mental health service in 2017/18, with a trajectory rising to 35% by 2020/21.[101]

The number of children and young people in Medway with a mental disorder has been estimated by applying national prevalence data by sex and age from the 2017 Mental Health of Children and Young People Survey [90] to the local 2017 mid-year population estimates for Medway.[89] It is estimated that 6,655 children and young people in Medway aged 5 to 19 years had a mental disorder in 2017. Based on this estimate, 35% equates to approximately 2,329 children and young people in Medway requiring treatment within commissioned services in 2017/18.

There are three main providers which will flow data to the Mental Health Services Data Set (MHSDS) in Medway:

1) NELFT Medway Young Persons Wellbeing Service and All-Age Eating Disorder Service;
2) Medway Community Healthcare (MCH) who provide ASD and ADHD assessment and diagnostic services for children under the age of eleven; and
3) Kent and Medway NHS and Social Care Partnership Trust (KMPT) who provide specialist Early Intervention in Psychosis services for a small cohort of young people aged 14 and above.

Other mental health providers may also flow data into the MHSDS for Medway in cases where treatment has been provided for residents out of area or for specialist treatments.

In 2017/18, the average referral rate to the Medway Young Persons’ Wellbeing Service was 200 per calendar month (or 2,400 per year). Around 30% of these referrals (720) are signposted to other sources of support, which means that approximately 1,680 are accepted into the service. It will therefore be necessary to look at how the gap of approximately 649 children and young people per annum might be addressed.

**Evidence of what works**

**Guidance and Quality Standards**

The National Institute for Health and Care Excellence (NICE) provide evidence-based recommendations for antenatal/postnatal mental health (CG192)[102], as well as for pre-school, primary and secondary school aged children.[103] [104] [105] 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.[103] 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 supportive and safe environment.[104] [105] Public Health England (PHE) also promotes the building of resilience of children and young people in schools.[106]
The Department for Education provides guidance to schools on how to identify and support pupils whose behaviour suggests they may have unmet mental health needs.\textsuperscript{[107]} NICE advise local authorities 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 ensure that children have access to specialist advice and support that they require.\textsuperscript{[104]} NICE have also produced clinical guidance and quality standards for young people with specific mental health disorders, such as depression, psychotic disorders, ASD, ADHD, bipolar disorder and self-harm.\textsuperscript{[108]} [109] [110] [111] [112] [113]

All of the work funded by the Local Transformation Plan has reinforced the core Public Health England messages about what supports good emotional and mental health, i.e.:

- Physical exercise
- Talking
- Sleep
- Limiting screen time
- Good diet
- Positivity
- Taking time to relax

In addition to a whole school approach to supporting emotional wellbeing, all of our services promote these messages to young people in Medway.

**Future in Mind**

In April 2015, NHS England and the Department of Health published *Future in Mind*.\textsuperscript{[114]} The report established a clear direction and some key principles about how to make it easier for children and young people to access high quality mental health care when they need it. The key themes of the report include:

- Promoting resilience, prevention and early intervention
- Improving access to effective support - a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

Following this report, in May 2015 Clinical Commissioning Groups (CCGs) were asked to initiate work with local partners across the NHS, public health, children’s social care, youth justice and education sectors to jointly develop and take forward local plans to
transform the local offer to improve children and young people's mental health and wellbeing at the local level.

The Medway Local Transformation Plan (LTP) was first published in September 2015 and set out shared commitment and priorities towards achieving a brighter future for children and young people's emotional and mental health and wellbeing in Medway, regardless of their circumstances. The plan is updated annually and describes the progress made against the objectives and actions set out in the original LTP, as well as progress against the delivery plan: Medway Local Transformation Plan for Children and Young People's Mental Health and Wellbeing.

**Five Year Forward View for Mental Health**

In February 2016, the independent Mental Health Taskforce published a *Five Year Forward View for Mental Health* for the NHS in England.[115] This national strategy, which covers care and support for all ages, signifies the first time there has been a strategic approach to improving mental health outcomes across the health and care system. In July 2016, NHS England published an Implementation Plan to set out the actions required to deliver the Five Year Forward View for Mental Health. The Implementation Plan brings together all the health delivery partners to ensure there is cross-system working to meet the recommendations made by the Taskforce and secured an additional £1 billion in funding for mental health.

Children and young people are a priority group for mental health promotion and prevention, and the strategy called for the Future in Mind recommendations to be implemented in full. Early intervention and quick access to good quality care is vital - especially for children and young people. Waiting times should be substantially reduced, significant inequalities in access should be addressed and support should be offered while people are waiting for care. One of the priority actions to be achieved by the NHS by 2020/21 is to help at least 70,000 more children and young people access high-quality mental health care when they need it (as discussed in the previous section, Projected service use).

**Transforming children and young people’s mental health provision: a green paper**

At the end of 2017, the Department of Health and Social Care and Department for Education published *Transforming children and young people’s mental health provision: a green paper*. [116] This green paper builds on Future in Mind and the ongoing expansion of NHS-funded provision, and focuses on earlier intervention and prevention, especially in and linked to schools and colleges. The proposals include:

1) Incentivise every school and college to identify a Designated Senior Lead for Mental Health to oversee the approach to mental health and wellbeing.

2) Fund new Mental Health Support Teams, supervised by NHS children and young people’s mental health staff, to provide specific extra capacity for early intervention and ongoing help.

3) Trial a four week waiting time for access to specialist NHS children and young people’s mental health services.
The NHS Long Term Plan

The NHS Long Term Plan was first published in January 2019 and sets out the key ambitions for the service over the next 10 years - to improve the quality of patient care and health outcomes.[117] Under this Long Term Plan, the NHS is making a new commitment that funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending.[58] In its Long Term Plan, NHS England make the following pledges:

- Continue to invest in expanding access to community-based mental health services to meet the needs of more children and young people.
- Boost investment in children and young people’s eating disorder services.
- Children and young people experiencing a mental health crisis will be able to access the support they need.
- Mental health support for children and young people will be embedded in schools and colleges.
- A new approach to young adult mental health services for people aged 18-25 will support the transition to adulthood.

The NHS mental health implementation plan (2019/20 – 2023/24) provides guidance for local systems to meet the Long Term Plan targets beyond the Five Year Forward View to ensure transformation of mental health services becomes a reality.

User views

To inform the commissioning of a new Child and Adolescent Mental Health Service (CAMHS), Medway Council and Medway Clinical Commissioning Group (CCG) launched a consultation exercise which ran from 6 May to 29 July 2016.

The Draft Service Model formed the basis of the consultation and provided stakeholders with a detailed description of how commissioners felt the new service could be structured, together with operational functions and service standards. The new service has been designed to meet the expectations of stakeholders, as well as NICE Guidance.

A summary of responses, by interest group, is set out below.

From a focus group of children and young people who have used either CAMHS or emotional support services

Feedback from children and young people highlighted the value they placed on direct access to advice and also support outside of core school/working hours and outside of formal services, e.g. GP and school pastoral support. They also valued services which reduce the stigma that many young people associate with mental health counselling, offering them anonymous, anytime, free access to a range of counselling and peer group support services and enabling them to maintain a degree of control about what happens next.
Service users and their families/carers

Users and their families were especially keen to see improvements to communications and clarity about who is doing what. This applied both to information about service availability and improved levels of contact and information once a referral has been made. They felt strongly that we should take the opportunity to deliver all support for emotional and mental health needs in a continuum where practitioners communicate with each other and offer some level of support to children and their families once the treatment phase has ended.

Speedier response times were a big issue, though it is striking that families were as dissatisfied with lack of communication from the current service as with the length of the wait for treatment.

The hope was expressed that mental health needs could be prioritised more and that schools might be more proactive in offering support to children who are likely to be affected by their situation, for example if they have been bereaved or are a carer; or are transferring to secondary school, having had additional support in the primary phase.

Finally, they talked about trust. The importance of gaining the trust of children and young people in order to be able to meet their emotional needs; of respecting confidentiality; and practitioners delivering what they say they will do. This also applied to not over promising on the service overall.

Schools and colleges

School based staff also wanted to see quicker response times and better communication with specialist mental health workers.

Schools overwhelmingly supported the concept of reducing escalation of demand through prevention, early intervention and increasing awareness of emotional and mental health issues. They believed that this is only possible, however, with better professional development for school based staff in each of these areas and with greater provision of more specialist support, for example from primary mental health workers within school.

School based staff would also value additional support from and contact with practitioners working with pupils who have more severe mental health needs.

Practitioners in partner agencies also strongly supported the provision of better advice and professional development for school based staff, so that issues do not escalate, along with more preventative, universal support for children and young people.

Emotional health and wellbeing practitioners

As with other groups, they responded that the speed of access should be improved. This group felt particularly strongly that is should be possible to provide immediate access to support for young people and that initial assessments should be fast tracked to assess risk and ensure children and young people are not left trying to manage quite difficult situations and emotions. They also felt that this system needs to be as simple and clear as possible from the user’s point of view.
This group was strongly in favour of a holistic approach to support, that included the family where appropriate and makes use of other expertise, for example in parenting support, to build resilience. They also felt that a nominated mental health worker should be the point of contact for colleagues and the family.

**Role of schools**

This was a distinct question within the survey. It is highlighted here because of the very strong level of agreement among all of the interested parties, including schools, about what this should mean. This includes:

- Provision of an effective universal offer, supported by ongoing training and support and good links to more specialist provision.
- Ideally placed to coordinate support, for families as well as their pupils, but other services (not just those to support emotional wellbeing) need to be more willing to offer their time and expertise.
- Fuller involvement of schools in decisions about how the continuum of support works.

**Unmet needs and service gaps**

The Medway Young People’s Wellbeing Service (MYPWS), and other activities stimulated by the Local Transformation Plan (LTP), are focussed on meeting the needs identified in the 2015 LTP. Many of those needs - and certainly the groups most at risk - still exist, but Medway is now in a position to monitor progress against our priorities, reflected in a set of KPIs with NELFT.

**Key service improvements**

- The MYPWS operates within the context of the whole continuum of support, with newly the appointed providers developing strong pathways with other providers and partners in health, education and social care.
- Evidence-based, IAPT treatment from appropriately qualified practitioners which is already reducing referrals to tier 4 mental health services.
- Substance misuse support, post abuse support, support dedicated to harmful sexualised behaviours, multi-disciplinary neurodevelopmental assessment and parental support are included in the new service model, facilitating more effective support for children and young people with multiple needs.
- A whole family approach is expected of all providers, whereby we proactively seek to resolve any issues in a child or young person’s environment that are impacting on their emotional wellbeing. This is facilitated by MYPWS’s presence in our locality based family hubs.
- A dedicated neurodevelopmental pathway for young people aged 11 and over, able to provide support to families and linked to additional health services for those young people who need them.
• A clinician led Single Point of Access, which is developing the ability to provide information about the alternative support that is available.

• An option for self-referral and a quick response through online, telephone and drop-in support.

• A mobile workforce, that works with children and families where they are most comfortable.

• Stronger emphasis on crisis support and interventions which support young people and their families within the family home and, wherever possible, prevent unnecessary admissions to inpatient settings.

• Greater emphasis on the needs of fostered, looked after and adopted children.

Work still to be done

As MYPWS becomes established, we continue to support their in-reach and pathway development work and continue to work with other providers to develop awareness, skills and access. The actions below are for the whole system.

• Continue to improve prevention and early identification in response to emotional and mental distress by building a pre-CAMHS (Child and Adolescent Mental Health Services) pathway.

• Work with schools to support them in identifying additional needs earlier and more accurately.

• Develop better awareness in universal services and the community of how to help people with low level emotional and mental health issues and ensure expert advice is more widely available to non-specialist practitioners.

• Promote better understanding of effective low level interventions that can be delivered in schools and elsewhere to promote good mental and emotional health.

• Clarity about what is expected of schools and other non-specialist practitioners.

• A continuing programme of workforce development to enable expert practitioners in schools and elsewhere (e.g. special educational needs coordinators) to deliver key interventions.

• Better communication between commissioned service providers and schools about individual children and young people, in particular about the nature of their support plan and ensuring school nurses are linked into sustaining progress made in treatment.

• Development of the Positive Behaviour Support model across Medway, so that children with challenging behaviours and their families benefit from the support and understanding they need.

• Enhancement of young people’s role in informing and improving the MYPWS.
More widely it is recognised that there are gaps and issues regionally and nationally in relation to effective management and support for children and young people experiencing an escalation and crisis in their mental health.

All NHS Trusts providing CAMHS in the South East report major difficulties in finding a bed when needed in a reliable way, with a great deal of staff time spent trying to navigate the current system. This issue also leads to a number of out of area placements, which has a major impact on the ability of families to keep in touch with their children, especially when a placement may be many miles away. Evenings and weekends can be particularly difficult times to find an appropriate bed in a timely manner.

Across the South there is a need for a broader network of specialist services and local beds, including re-provisioning beds for specific groups, such as low secure, CAMHS acute and eating disorders.

There is also a lack of funding and appropriate placements for residential provision when young people are unable to return home on discharge from a Tier 4 bed. This has led to young people post-discharge being placed in residential care or schools a long way from home. CAMHS staff report a lack of multi-agency assessment and discharge planning on admission, which may lead to possible gaps in step-down services. It therefore important to ensure that Clinical Commissioning Groups (CCGs), local authorities and any other relevant agencies are engaged to ensure that young people receive care in the least restrictive environment, as close to home as possible.

**Self-harm**

A multi-agency task and finish group, including key representatives from across the child health and social care system, was convened in early 2018 led by Public Health. This working group was formed as a result of some of the needs analysis and primary research undertaken in 2017 as part of the reconfiguration of Child Health services in Medway, which identified gaps in knowledge and a lack of clear pathway, and approved resources across the system in this area of need. The working group meets every 8/10 weeks to look at the following areas:

1) Identify the levels of need in this area via existing data sets, primary research and engagement with young people.

2) Co-produce an action plan and clearly identify the infrastructure/resource that is in place to implement this plan and also identify any gaps or opportunities for service development in this area.

3) Ensure there are clear pathways in place and that these are clearly communication to schools, GPs and any other services coming into regular contact with young people, including clear communication and information sharing protocols.

4) Identify a common set of resources to be promoted by all professionals in Medway (including preferred online resources).

5) Improve data collection and use of data on self-harm.
Recommendations

The Medway Young Person’s Wellbeing Service has been commissioned to address many of the identified gaps and issues within children and young people’s emotional wellbeing and mental health support services. Changes to be fully embedded include:

- Support across an extended age range (>0-<25) for the most vulnerable children and young people.
- Quicker response times.
- All enquiries assessed and appropriate next steps recommended.
- Self-referrals and referrals by parents and carers encouraged.
- No more distinction between mental health issues and emotional issues; children and young people who require help will get the support they need.
- Evidence based and outcomes focussed treatment plans, intensive support, and recovery expected quickly in most cases.
- Most patients seen by mental health practitioners, under supervision of psychologists and psychiatrists, in a care pathway appropriate to their individual needs.
- Five distinct pathways i.e. behaviour and conduct; mood and anxiety neurodevelopmental; sexual trauma and recovery; substance misuse.
- A more family focussed approach, which develops resilience around the child or young person.

These changes will be achieved more quickly and sustainably if they are developed collaboratively, so that key players understand each other’s’ position; new approaches are embedded widely across the work force; and we make the best use of available resources and expertise. This includes:

- Creating the knowledge and capacity in the Medway workforce that will facilitate a focus on early, insightful, identification and swift, appropriate treatment.
- Establishing strong links between the provider, schools and other providers, in order to promote collaboration and clear mutual expectations.
- Developing a working group of head teachers, with the provider, Public Health and commissioners, who take forward these ideas and advises on the specific actions that will support the provider’s service transformation plan and ensure widespread participation.
Reduce inpatient bed use

A new clinical model is required to reduce the total length of stay and numbers of children and young people needing an inpatient mental health bed as a result of crisis. This includes additional investment in innovative community services to keep children and young people closer to their homes and out of hospital. Together with better bed utilisation and management and improved co-ordination amongst services, we will be able to have the biggest impact on length of stay and discharge processes. 'Tier 4' beds are currently commissioned by NHS England but the New Models of Care Programme will see responsibility and budgets devolved to local provider consortia, and Clinical Commissioning Groups (CCGs) and community Child and Adolescent Mental Health Services (CAMHS) providers are expected to have increasing influence.

The Transforming Care programme ensures that children and young people with a learning disability receive the support they need to thrive and ultimately live as independently as possible. Many of Kent and Medway’s ‘tier 4’ mental health beds are occupied by children and young people with a learning disability or autism spectrum disorder (ASD). Providing the right support for them and their families from an early stage will mean they do not find themselves inappropriately in inpatient mental health beds, but in community-based, supported arrangements for education and work.

Further needs assessment required

More local information is required on the mental health needs of specific at-risk groups including Black and Minority Ethnic (BME), homeless, lesbian, gay, bi-sexual, transgender, questioning and traveller communities and any potential barriers, perceived or otherwise, to accessing commissioned services by these groups. With regards to children in care, this JSNA has focused on children in the care of Medway Council; however, as it is known that many children are placed in Medway by other local authorities, this may also be an area for further investigation in terms of equity of access and any potential impact on service capacity. In accordance with Responsible Commissioner Guidance Medway Clinical Commissioning Group and Medway Council are responsible for ensuring adequate service capacity locally to meet the needs of all children and young people placed in Medway. Additionally, the higher than average ‘strength and difficulties scores’ of Medway’s looked after children requires further investigation.

Data from the January 2018 school census shows that 73.7% of pupils in Medway are White British and 25.7% of pupils are of minority ethnic origins. This may suggest a large change in the overall population distribution in Medway since the 2011 Census. There is, therefore, a need for better research into the prevalence of child mental health problems in minority ethnic groups, service utilisation among these groups and whether perceived or actual service barriers are specific to certain groups.

Medway (and Kent) currently have significantly higher volumes of inpatient admissions for children and young people with mental health needs, as well as those with challenging behaviour arising from Learning Disabilities or Autism Spectrum Disorder diagnoses. This trend requires further investigation to identify any underlying causal issues and potential gaps in community services.
Further work needs to be done to understand what interventions, if any, schools are directly commissioning as well as to understand the scope and capacity of services operating below referral thresholds for NHS commissioned services and service user experiences. Greater alignment with school-based provision may be beneficial in responding to established and emergent risk factors such as bullying, cyber-bullying and harms arising from websites or online forums that normalise anorexia and self-harm.

**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 may have 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

**Key Contacts**

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**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 [118][119]
- Teen parenting [120][121]
- Domestic Violence [122][123]
- Environmental and social factors [124][125]
• 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.[126] 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.[126] In 2012 The Medway Drug and Alcohol Team commissioned a report to determine the needs of this population.[127] 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.[128] 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.[129] 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 .[130] It is estimated that 140,000 children live in homes where there is a high risk of domestic abuse .[131] 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.[132]

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.[133][134] 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).\[135] 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 .\[136] In Medway in at the end of April 2014 there were 4005 adults in contact with mental services.\[135]

Figure 1: Deprivation affecting dependent children under 20 years, Medway 2012[137]

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.[138]*

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Table 1 above shows the total number of Looked After Children as at 31st March each year across England and Medway.[139] 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[138]. 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[26]*

<table>
<thead>
<tr>
<th></th>
<th>Medway</th>
<th>South East</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>205</td>
<td>4275</td>
<td>36800</td>
</tr>
</tbody>
</table>
Table 3: Number of Looked After Children having dental checks[26]

<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[138]

<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[140]

<table>
<thead>
<tr>
<th>Cumulative number of pupils</th>
<th></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>1009</td>
</tr>
<tr>
<td>June 2013</td>
<td>1089</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”.[141]

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[26]

<table>
<thead>
<tr>
<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>
</tr>
<tr>
<td>Mathematics %</td>
<td>47</td>
<td>53</td>
</tr>
<tr>
<td>Reading %</td>
<td>60</td>
<td>59</td>
</tr>
<tr>
<td>Writing %</td>
<td>47</td>
<td>48</td>
</tr>
<tr>
<td>Grammar, Punctuation and Spelling %</td>
<td>X</td>
<td>41</td>
</tr>
<tr>
<td>Reading, writing and mathematics %</td>
<td>40</td>
<td>39</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[138].

Figure 2: Percentage of looked after children by placement type, 2014

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.
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. [142]

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.[26]

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[138]

<table>
<thead>
<tr>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of new placements for all children</td>
<td>440</td>
</tr>
<tr>
<td>All placements within 20 miles</td>
<td>350</td>
</tr>
<tr>
<td>Inside LA boundary within 20 miles</td>
<td>240</td>
</tr>
<tr>
<td>Outside LA boundary within 20 miles</td>
<td>110</td>
</tr>
<tr>
<td>All placements over 20 miles</td>
<td>60</td>
</tr>
<tr>
<td>Inside LA boundary over 20 miles</td>
<td>0</td>
</tr>
<tr>
<td>Outside LA boundary over 20 miles</td>
<td>60</td>
</tr>
<tr>
<td>Not recorded or not known</td>
<td>30</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[138]. 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.*[26]

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%.[26]
Figure 6: Percentage of care leavers who were in suitable accommodation.[26]

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 timeframe. 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 ae 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.
Figure 7: Number of 4 year olds potentially needing a reception place.

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 differering levels of need. To drive up the quality of all placement types while working 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.[144] 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. 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. 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”, 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.

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.
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>Age Group</th>
<th>2017</th>
<th>2022</th>
<th>2027</th>
<th>2032</th>
<th>2037</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 15</td>
<td>701</td>
<td>740</td>
<td>759</td>
<td>765</td>
<td>770</td>
</tr>
<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>
</tbody>
</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.[149]

**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.[147]

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.[147]

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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