

Special Educational Needs and Disability

Understanding Local Variation in Prevalence, Service Provision and Support

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Executive Summary

Introduction

This research study, undertaken by the NCB (National Children's Bureau) and Thomas Coram Research Unit, Institute of Education, was commissioned by the Department for Children, Schools and Families (DCSF) to explore the nature, extent and implications of local variation in special educational needs (SEN) prevalence and provision. The research considered hearing impairment and Autistic Spectrum Disorders (ASD) as exemplar conditions.

Background

There is a growing recognition of the variation between local authorities in the proportions of children¹ with SEN, the apparent composition of these groups, and the nature and quality of services provided to support them. Local area data collected on children with SEN, particularly the termly School Census and the annual SEN2 return by local authorities, show differences in the number of children with SEN, the nature of their recorded conditions and the Code of Practice level of support they are receiving. This variation was highlighted by the House of Commons Education and Skills Select Committee which commented on a '*postcode lottery*' or a '*lottery of provision*', and reports by the Audit Commission and Ofsted which also highlighted variation in provision and standards.

Our literature review found a substantial body of good practice guidance, standards of quality and quality improvement tools aimed at improving services for disabled children and those with SEN, including guidance which focuses on supporting children with ASD and hearing impairment. A range of strategic and operational factors are identified in the literature as contributing to good practice and quality provision for disabled children and those with SEN: strategic planning and using data to inform policy; multi-agency approaches and joint working; early identification, intervention and multi-agency assessment; working in partnership with parents, children and young people; good early years provision; high quality mainstream provision and specialist placements; good education support services; outreach by specialist services; effective workforce development, and attention to the gap in attainment between children with SEN and those not thus identified.

Aims and objectives

The aims of the study were to explore why there was variation in the way local authorities provided for SEN, and whether and when this variation amounted to inequitable provision. The specific objectives of the study were therefore:

- to explore the extent and nature of local variation in the apparent prevalence of children with SEN, how it arises, and the implications for the ability of local authorities to identify and meet the needs of children with SEN
- to explore the nature and extent in local variation in the classification of children with SEN in terms of both their condition and the Code of Practice level of support they are receiving, how this variation arises and implications for the ability of local authorities to meet children's needs

¹ We use the term 'children' as opposed to 'children and young people' throughout this document and the report in the interests of brevity, but recognise that this is not the term preferred by all young people.

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- to explore local variation in the nature and quality of support provided to children with SEN, looking at variation in the availability of different types of support and how it arises
- to identify the approaches and systems that appear to support more effective practice in identification, provision and working practices to support children with SEN
- to explore how the issues of identification, classification and provision are linked
- to highlight implications for policy and practice.

Methodology

The study involved a literature review; analysis of existing data on SEN prevalence and practice, and case studies in 16 local authorities which involved interviews with strategic leads for SEN, inclusion or disability; strategic leads for ASD and hearing impairment; Parent Partnership Service Coordinators, and voluntary and community sector representatives. We also interviewed SEN leads in 21 schools.

To identify the local authorities in our sample, we looked at four possible sources of evidence about quality: nominations of stronger and struggling local authorities by stakeholders; rating of provision by Parent Partnership Service Coordinators; assessments made by the National Strategies SEN and learning difficulties and disability programme, and analysis of five SEN measures. An important early finding was that these possible indicators of quality were not consistent with each other.

Statistical analysis

The prevalence of pupils with SEN varies from 167.4 children per 1000 pupils in the lowest prevalence quintile of local authorities to 219.8 in the highest quintile. This has a high correlation with two measures of disability: children identified in the 2001 Census as having a limiting long-term illness, and identified by the Department for Work and Pensions (DWP) as receiving Disability Living Allowance. This suggests that these three measures were each related to the underlying level of need in the area. However, overall correlations masked patterns of variation for individual authorities. Rates of SEN, children's long-term illness and receipt of Disability Living Allowance were all related to deprivation, but the rate of pupils with SEN statements per thousand pupils was not. This suggests significant local authority variation in policies on statementing.

The prevalence of ASD, using data from the DCSF School Census, varies from 4.1 children per 1000 in the lowest quintile of local authorities to 7.2 in the highest. For children with hearing impairment, prevalence varies from 1.1 to 2.2 children per 1000. Both these figures are consistent with some estimates of the prevalence of these conditions but below others.

We looked at five SEN indicators that relate to local authority policy and practice, drawing on DCSF SEN data and the degree of variation between the lowest and highest quintiles of local authorities:

- The *percentage of pupils with SEN who have a statement* varied from 12.1 percent to 17.6 percent. The percentage of pupils with SEN who had a statement was lower where there were more pupils with SEN.
- The *gap between attainment across Key Stages 2-4, for pupils with SEN and all pupils* also varied: overall, pupils with SEN were only half as likely as all pupils to be performing at the level deemed appropriate for their age. The attainment gap was smaller in more deprived areas. This reflects the lower average attainment for all pupils in more deprived areas.

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- *Spending on SEN excluding special schools* varied from £1045 per child with SEN to £1818. SEN spending was negatively correlated with the number of pupils with SEN, meaning the more pupils with SEN there were, the less was spent on each of them, on average. This may reflect limited resources or different thresholds for assessing a child as SEN. The level of spending was not related to deprivation.
- The *percentage of children with statements who were not in mainstream school provision* varied from 34.2 percent to 49.7 percent. Local authorities with lower rates of statementing among pupils with SEN made more use of non-mainstream schools for those children with statements.
- The *rate of appeals* varied from 1.7 per 10,000 children to 6.2. But there is no association between the rate of statementing and the rate of appeals, and no association between the use of non-mainstream schools and the rate of appeals.
- Although the overall rate of pupils with statements was not related to *deprivation*, the percentage of pupils with SEN who had a statement was, but negatively. This means that more deprived areas had more children with SEN but fewer of them had statements.

Main findings

Multi-agency and multi-disciplinary working

Across the case study local authorities there was a commitment to the principle of multi-agency working, and an acknowledgement that this facilitated the development of more holistic and child-centred services. There was considerable variation in how embedded this was in planning and practice, sometimes in response to local circumstances and need, but the key factors which appear to facilitate strategic multi-agency working are strong leadership, senior management commitment across education, social care and health, well-embedded Children's Trust arrangements, coherent and strategically linked systems and processes, established information-sharing protocols, some joint commissioning and/or pooled budgets and involvement of staff, parents and the voluntary and community sector. Well-embedded multi-agency and multi-disciplinary strategic practice were generally characterised by clear and integrated systems, processes and strategies facilitated through multi-agency groups.

At an operational level the case study local authorities had different combinations of integrated working in place, either integrated teams, locality working, co-location or most commonly a combination; child-centred approaches such as team around the child and key-working also varied. Factors which facilitated good operational multi-agency practice were: addressing workload and resource implications of changes, especially during transition; good communication systems, within and between services; joint training and team building.

Identification, assessment and referral

There was significant variation between and within local authorities and few authorities appeared strong in identification, assessment and referral across all age groups and for all conditions. Good practice in these areas, however, did appear to be influenced by strong multi-agency and integrated approaches to working, particularly good communication and the sharing of information between agencies, especially with health. It was also influenced by a number of practices to increase early identification, particularly the training of frontline staff, and having sufficient staff capacity within services to meet demand.

In authorities with identification systems where children with SEN were reported to be less likely to be missed, there was more likelihood of integrated services and good communication between education and their partner agencies; a specific focus on

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developing practitioner skills and raising awareness through training; and opportunities for practitioners to raise concerns with specialists and support staff.

Multi-agency assessments and good data sharing were more likely to occur in authorities where there was greater integration of services and multi-agency working, and the Common Assessment Framework and Early Support Programme were well established.

A number of explanations were put forward for the variation in prevalence of SEN, ASD and hearing impairment: the perceived unreliability of School Census data, the different approaches taken by schools in identifying children with SEN, the efficacy of identification and diagnostic procedures for ASD, the support and provision available within a local authority, and characteristics of the population. Lower prevalence rates may be attributable to weaker identification systems, but as we have seen there are other explanations too. Authorities where a narrower definition was applied to SEN because the needs of more children were said to be met without the need to identify SEN, or where support was available without a diagnosis (eg for ASD), were less likely to have above average prevalence for SEN. This is not to suggest a causal relationship, but rather to illustrate that the relationship between identification and prevalence is not a simple one and that prevalence rates are affected by a number of interacting variables.

Explaining variation in provision

All the case study local authorities said that they were looking at reducing and reorganising school provision to build a spectrum encompassing special schools, specialist mainstream provision and mainstream schools, with the focus generally shifting away from special schools. There were many influences on this, from interpretations of inclusion to size and history. But an important part of what made change in this area successful was winning the confidence of mainstream schools and of parents. Leadership, consultation and partnership were seen as key.

Ensuring that schools have the tools to do the job was also important. There were different approaches to providing specialist support to mainstream schools, particularly differences in focus between supporting an individual child and influencing a whole school approach. Schools were not always thought to be making full use of what was available, highlighting the importance of winning hearts and minds. Training and capacity building were also important ways of ensuring people have the tools for the job. There were different approaches to monitoring the progress of children with SEN: a focus on attainment or on inclusion, and a schools-led advice-seeking approach or a local authority-led scrutiny approach. This is an area where there is scope for more support in developing a common system.

Finally, other forms of support – audiology services, speech and language therapy, mental health provision and social care – also play an important role in assessment and provision, but capacity is often constrained.

Use of the Code of Practice levels and statements

The use of statements varied considerably, more obviously because of differences in the link with funding and schools' confidence than because of differences in intention. Many of the case study local authorities reported wanting to reduce the level of statements by providing support for children in mainstream schools and using statements almost exclusively for access to special school placements. However, what distinguished high and low statementing authorities was whether statements carried additional funding. Several local authorities had introduced systems of non-delegated 'top up' funding available for children at

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School Action Plus or with statements, which was seen as a quicker and fairer approach and also an effective means of reducing the demand for statements.

How far local authorities worked in partnership with schools and families was also key in reducing statements. High statementing authorities acknowledged the need for more moderation of schools' use of the Code of Practice levels. There was also a clear link with local provision: the local authorities with more special schools had higher rates of statements, and the quality and extent of independent provision and of special schools in neighbouring areas was also relevant.

Implications for policy and practice

Ensuring greater equitability

The study found differences across local authorities in the range of school provision for children with SEN, influenced by such factors as strategy, funding approach and support for schools, which appears to challenge the objective of greater consistency in provision. Some degree of variation between local authorities is inevitable and may indeed be positive where it reflects the different needs and the preferences of local children and parents, local systems fitting local contexts, and more generally the process of local democracy. Local variation is clearly undesirable when it reflects unmet need and inequities in access to, and level of, services.

Different interpretations of inclusion can also affect the levels and type of provision available. There were calls for government to give more consistent and positive messages about inclusion, to promote inclusion and ambition for all children more forcefully, and to address the underlying tensions with inclusion created by the attainment agenda, league tables, and greater financial autonomy in schools.

Our research suggests the need to consider a minimum entitlement of support, training and advice for mainstream teachers as well as a review of the implementation of the quality standards for SEN specialist services published during the course of this study. Concern was expressed about protecting SEN budgets in the face of general spending cuts and about the implications of an increasing focus on safeguarding and child protection.

Need for reliable, consistent and comparable data

To plan services effectively local authorities need reliable data. Yet only a few of our case study authorities said that they had databases that could provide accurate information on numbers of children with SEN, or ASD and hearing impairment, and there were also reported differences across authorities in their auditing of need. There is a need to ensure greater consistency in the recording of primary condition in the School Census, but also to consistently record multiple conditions where they occur so as to have a full prevalence.

There is also a need for reliable data on DDA disability which can be correlated with SEN data (DCSF have recently announced their intention to include questions on disability in the 2011 School Census).

Workforce training and capacity

The different approaches to identification and assessment and the key role played by teachers and other professionals in identifying SEN suggests the need for further training and support that could lead to greater consistency in this area. The changing role of health

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visitors and school nurses has had a negative impact on identification systems in some areas, and school entry screening is no longer routinely carried out across all schools. This could be an area that government may wish to review. It is also important to ensure that all professionals working with young children, including teachers and early years practitioners, have the necessary skills to recognise and raise concerns about SEN.

Workforce capacity is a key issue at both an operational and strategic level. All local authorities need adequate numbers of professional staff such as speech and language therapists and educational psychologists, but the study has highlighted a lack of sufficient staff leading to long delays for assessments and services in some areas.

Stronger quality assurance and monitoring mechanisms

The strongest and most consistent call from interviewees was for sharing models of good practice at both a national and a regional level, supported by clear standards and guidance – ‘defining ‘best’ or ‘showing what good practice looks like’. This was seen as useful, As there is already a considerable body of good practice guidance available to local authorities, something more is needed to help put the guidance into practice, for example more effective dissemination, additional support for local authorities or mechanisms to ensure greater implementation of the published guidance. Consideration could also be given to putting some guidance on a statutory footing which might raise standards and reduce variation between local authorities.

Alternatively, there may be a stronger role for educational psychologists, school improvement partners (SIPs) and Ofsted to play in ensuring awareness and looking at how this guidance is being used by local authorities and schools where relevant. For example, we found differences in how closely schools’ spending is monitored by local authorities, but Ofsted and SIPs could monitor how many schools are using the guidance produced by the Audit Commission for schools to monitor and assess their available resources. Their role could also include closer scrutiny of schools with unusually high or low prevalence rates to address issues of over-use of SEN identification and inconsistency in identification procedures.

Chapter 1: Introduction and background

This is the report of a research study commissioned by the Department of Children, Schools and Families (DCSF) and undertaken by NCB (National Children's Bureau) and Thomas Coram Research Unit, Institute of Education. The study was undertaken between March 2008 and August 2009.

This chapter outlines the aims and objectives of the study, provides a brief policy background, describes the methods used, and outlines the structure of the report.

1.1 Aims and objectives

The background to the study was a growing recognition of the variation between local authorities in the proportions of children and young people² with SEN, the apparent composition of these groups, and the nature and quality of services provided to support them. Local area data collected on children with SEN, particularly the termly School Census (previously known as PLASC, the Pupil Level Annual School Census) and the annual SEN2 return by local authorities, show differences in the number of children with SEN, the nature of their recorded conditions and the Code of Practice level of support they are receiving. This variation was highlighted by the House of Commons Education and Skills Select Committee (House of Commons, 2006) which commented on a '*postcode lottery*' or a '*lottery of provision*' (para 129). Earlier reports by the Audit Commission (2002) and Ofsted (2004) had similarly highlighted variation in provision and standards.

The aims of the study were to explore why there was variation in the way local authorities provided for SEN and whether and when this variation amounted to inequitable provision. The specific objectives of the study were therefore:

- to explore the extent and nature of local variation in the apparent prevalence of children with SEN, how it arises, and the implications for the ability of local authorities to identify and meet the needs of children with SEN
- to explore the nature and extent in local variation in the classification of children with SEN in terms of both their condition and the Code of Practice level of support they are receiving, how this variation arises and implications for the ability of local authorities to meet children's needs
- to explore local variation in the nature and quality of support provided to children with SEN, looking at variation in the availability of different types of support and how it arises
- to identify the approaches and systems that appear to support more effective practice in identification, provision and working practices to support children with SEN
- to explore how the issues of identification, classification and provision are linked
- to highlight implications for policy and practice.

The study was initially intended to include both children with a SEN and disabled children. These groups overlap, but there will be some children with a SEN who are not disabled and some who are disabled but do not have a SEN (eg Porter and others, 2008). As discussed in more detail in chapters two and three, there is currently no reliable data at either the national or local level on the number of disabled children. Therefore at an early stage in the study it was decided to focus on children with SEN, on whom there is more reliable data, as this

² We use the term 'children' as opposed to 'children and young people' throughout this report in the interests of brevity, but recognise that this is not the term preferred by all young people.

would allow more in-depth exploration of the complex issues surrounding prevalence and provision.

The study considered two groups of children as exemplar conditions: hearing impairment and autistic spectrum disorders (ASD)³. These were chosen to give more focus to a broad-ranging study. Both have varying levels of severity and include children with complex needs, and they provided a useful comparison in issues such as prevalence and ease of identification.

1.2 Policy background

The SEN and Disability Act 2001 established a framework for current SEN policy by giving disabled children and those with SEN a strengthened entitlement to mainstream education and protection from discrimination for disabled pupils in schools. The cornerstone of this policy is Removing Barriers to Achievement (DfES, 2004a), which presents the government's vision for the education of disabled children and those with SEN. It reinforces the commitment made in Every Child Matters (DfES, 2004b) to early intervention, inclusion, the raising of expectations and achievement, and the development of partnership networks. The SEN Code of Practice (DfES, 2001) provides advice to local authorities, schools and early education settings on carrying out their statutory duties to identify, assess and make provision for children's special educational needs and sets out guidance on policies and procedures aimed at enabling pupils with SEN to reach their full potential, to be included fully in their school communities and make a successful transition to adulthood.

The Code of Practice uses the definition of SEN laid out in the Education Act 1996. It defines children as having SEN if they have a learning difficulty (ie significantly greater difficulty than the majority of children of the same age, or an impairment that hinders them making use of education facilities provided for children of the same age), not solely because of their home language, which calls for special education provision to be made for them.

The five general principles informing the code are that: a child with SEN should have their needs met; they should normally be met in mainstream schools or settings; the views of the child should be taken into account; parents⁴ have a vital role to play in their child's education; and that children with SEN should be offered full access to a broad, balanced and relevant education (DfES, 2001: 7). The Code highlights the importance of strategic planning partnerships between all those involved - local authorities, schools, parents, pupils, health and social services and other agencies - and provides guidance on identification, assessment and provision in early years settings, the primary and secondary sectors, statutory assessments and statementing, annual reviews, pupil participation, and working in partnership with parents and in partnership with other agencies.

The commitment to inclusion, and to improving the quality of support for children with SEN, has been developed in a number of subsequent policy initiatives. The ten year strategy for SEN, Removing Barriers to Achievement, sets out a plan for action to improve early intervention, remove barriers by embedding inclusive practice in schools and early years settings, develop teachers' skills and sharpen the focus on progress, and develop effective partnerships between services and with parents (DfES, 2004a). The new Disability Equality Duty requires all public sector organizations including schools to ensure that disabled people are fairly treated and included in policy development.

³ We use the term 'hearing impairment' and rather than 'deafness' or 'deaf' throughout the report, and 'ASD' or 'autism', but we recognise that other terms are preferred by some groups.

⁴ Throughout this report we use the term 'parents' to refer to parents and carers.

The Children's Plan (DCFS, 2008), included a commitment to improve teaching professionals' knowledge and skills in working with children with SEN and disabled children, to improve the data on how well children with SEN progress, to work towards introducing nationally accredited training arrangements for Special Educational Needs Coordinators (SENCOs), and to identify good practice in reducing exclusions of children with SEN. DCSF's Quality Standards for SEN Support and Outreach Services (DCSF, 2008a) outline 16 standards for outcomes and for service management and delivery.

The Lamb Inquiry was set up in 2008 as part of the government's response to the House of Commons Education and Skills Committee Report, Special Educational Needs: Assessment and Funding. It investigated a range of ways in which parental confidence in the SEN assessment process might be improved, and compliance with processes by local authorities increased. It carried out extensive consultation and commissioned a range of innovative projects to support this. It recommended: measures to strengthen compliance; better communication and engagement with parents and carers; tighter Ofsted procedures on SEN and disability. These measures include the right of appeal for parents if a local authority decides not to amend a statement after a review, and placing a specific duty on Ofsted to report on the quality of the education provided for disabled children and children with SEN (Lamb, 2009)⁵.

The National Strategies programme has an important focus on SEN and learning difficulties and disabilities and provides advice and support to local authorities and schools within its broad aim of improving the quality of learning and teaching in schools and early years settings and raising standards. The programme includes a self-evaluation framework for local authorities to review their own provision and services. The Inclusion Development Programme, which is designed to help teachers and early years practitioners gain the skills necessary to work with children with a range of SEN, will run from 2008 to 2010 and focus initially on children with speech, language and communication needs, dyslexia and those on the autistic spectrum. In March 2007, 18 pilot local authority hubs of effective practice in SEN were launched, focusing on developing a flexible range of local provision, supporting services to build mainstream capacity, and effective use of data at local authority and school level to help meet needs. This was then developed further with a programme of regional hubs which focus on three national development strands: continuing the work of the Inclusion Development Programme; narrowing attainment gaps, progression and evaluating progress; and increasing parental confidence and developing special provision.

Looking more broadly at support for disabled children, the National Service Framework for Children, Young People and Maternity Services sets standards for service provision for disabled children and young people across the next ten years (DfES and DH, 2004). The report of the government's Disabled Children Review, Aiming High for Disabled Children: Better Support for Families (HM Treasury and DfES, 2007), sets out a 'core offer' to disabled children and their families, which encompasses minimum standards in five areas in the delivery of responsive services: having access to information; transparency of eligibility criteria for service; parents' and children's participation in planning services; the extent to which assessments are 'joined-up'; and parents' awareness of accountability and complaints procedures. The disabled children's services national indicator (NI 54) looks at parental experiences of services for disabled children and young people aged 0 to 19 and the extent to which these services are delivered according to core offer standards. The indicator is a core part of performance management arrangements aimed at improving the quality of services for disabled children⁶.

⁵ The final report from the Lamb Enquiry was published in December 2010.

⁶ <http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/ahdc/AHDC/>

1.3 Study methods

The study involved several different stages.

1.3.1 Literature review

A literature review – reported in chapter two - was conducted at an early stage. It reviewed published information about local level variation in the prevalence and categorization of disabled children and those with SEN⁷ and in provision to meet their needs. It also identified the factors emerging from the literature as contributing to good practice in supporting disabled children and those with SEN, particularly to inform the issues to cover in the subsequent case study work.

The review drew on material published since 2001. We included research evidence related to service provision and the factors influencing quality, government guidance and reports on how policy is implemented in practice, and good practice guidance including audit tools for quality improvement developed by government departments and national organizations. Much of the relevant material was identified through using internet search engines and searching relevant websites such as those of government departments and national and voluntary organizations. A search was also made of electronic databases such as the Applied Social Sciences Index and Abstracts (ASSIA), the British Education Index (BEI), Current Educational Research in the UK (CERUK) and Child Data Abstracts (the NCB database).

1.3.2 Analysis of existing datasets

We analysed existing datasets on SEN to explore the nature and extent of local area variation. Here we used SEN statistics published by DCSF, drawing largely on the School Census and the SEN2 local authority survey. This is reported fully in chapter three.

1.3.3 Local authority case studies

We also carried out qualitative research among 16 local authorities. Qualitative research methods were used because we needed an in-depth understanding of strategies, systems and approaches, which went beyond, and would enable us to interpret, quantitative measures of performance or population. We needed to gather informants' own assessments of the local authority's approaches to understand how different approaches had come to be taken, and how they were seen to support quality in support for children with SEN. The process was thus one of 'strategic assembly', looking at how issues emerging as important from the literature review and the statistical analysis were being managed in individual local authorities.

Selection of case study areas

We wanted to ensure our selection of local authorities would allow us to explore variation in the quality of approaches and of support for children with SEN, as well as variation in prevalence and classification. Prevalence and classification were relatively easy to factor into our selection. For prevalence, we used data on children with SEN and with hearing impairment and ASD from published DCSF datasets (see chapter three).

⁷ Since disabled children and those with SEN are not necessarily distinguished in the literature, and much of the literature about services for disabled children would be relevant to those with SEN, the literature review covered both these groups.

We also used data on the proportion of children with SEN who have a statement. We decided it was not feasible to use more indicators for selecting a small sample such as this.

Incorporating a measure of quality was much more difficult, since there is no single source of information on this. We therefore used a number of approaches:

1. Asking 12 selected stakeholders to nominate up to five individual local authorities that they saw as particularly strong in their support for disabled children or those with SEN, ASD or hearing impairment, and up to five that they thought were experiencing more challenges. Information was collected through telephone calls with representatives. Ten responses were obtained, which between them identified 58 local authorities as being particularly strong and 46 as facing more challenges.
2. Using NCB's National Parent Partnership Network e-forum to email all Parent Partnership Service Coordinators and ask them to rate their local authority's SEN, hearing impairment and ASD provision, on a five-point scale from 'very poor' to 'excellent'. 26 provided responses.
3. Asking the National Strategies programme on SEN and learning difficulty and disability to identify 15 local authorities they regarded as particularly strong and 15 (in fact they nominated 14) they regarded as facing more challenges. This assessment is based on a number of indicators relating to SEN (such as appeal rates, level of statementing, proportion of draft statements completed within 18 weeks) and to learning difficulty and disability attainment and progression (attainment levels in English⁸ and Mathematics and percentage inequality gap in attainment across all assessment scales). These scores are then weighted to reflect the greater number of learning difficulty and disability attainment and progression items, and moderated by reference to quality standards and local authorities' self-evaluations.
4. Using our own analysis of five key SEN indicators (see chapter three):
 - the number of pupils with SEN per 1000 pupils
 - the percentage of pupils with SEN with a statement
 - the number of SEN appeals per 10,000 pupils
 - the gap in attainment between pupils with SEN and all pupils, averaged across Key Stages 2-4
 - SEN spending per SEN child population.

As we describe in more detail in chapter three, we ranked all local authorities on each indicator and then placed them in quintiles, so that the highest quintile indicated stronger performance.

Our hypothesis was therefore that a combination of the following might be indicative of higher quality approaches and provision:

- higher prevalence of pupils with SEN (our initial hypothesis being that this would be indicative of good identification)
- lower levels of statementing (which we hypothesized would indicate better ability to meet needs without needing a statement)
- lower levels of appeals (which we hypothesized would suggest higher parental satisfaction with the use of statementing and with provision)
- lower levels in the attainment gap between pupils with SEN and all pupils (our hypothesis being that this indicated relatively good educational support for pupils with SEN)

⁸ Reading and writing at Key Stage 1

- and higher SEN spending (which we hypothesized would signify more extensive and/or better quality provision for children with SEN).

Clearly each of these indicators is capable of multiple readings on its own and they are linked. For example a low prevalence of statementing might imply that statements are used for pupils with more complex needs, so that one might expect to see a higher gap between their attainment and that of all pupils. Similarly a low rate of statementing coupled with a high level of appeals might indicate a local authority whose low use of statementing is unacceptable to local families. However, our assumption was that as a *whole* these measures might be indicative of stronger performance. We thus used these five indicators to create a composite score for each local authority.

We therefore had four different assessments of ‘quality’: the stakeholder nominations; the Parent Partnership Service Coordinator ratings; nominations by National Strategies (these three methods identified a total of 94 local authorities nominated by one or more source), and our own composite SEN indicators scores.

An important early finding was that there was generally a low level of consistency between the four assessments. Table 1.1 shows how the three nomination sources map against our composite SEN indicators scores. The first column of figures shows the nominations from those sources, and the second and third show how they were distributed between higher and lower composite SEN indicator scores. It is also important to note here that the composite scores provided a useful mix of local authorities but scores were often not consistent with likely prevalence or the quality of provision as described in the case study interviews. We therefore do not identify local authorities as being ‘stronger’ or ‘weaker’ performers in the case study analysis – the picture was much more varied than this would suggest.

Table 1.1 Inconsistencies in quality assessment methods

		Number	Composite SEN indicator scores	
			Higher scoring	Lower scoring
National Strategies nominations	High	15	7	8
	Low	14	8	6
Stakeholder nominations	Positive	32	17	15
	Negative	21	11	10
	Mixed	12	5	7
Parent Partnership Service Coordinator assessments	Good	8	6	2
	Adequate	5	2	3
	Poor	6	4	2
	Mixed	5	3	2

We therefore used all four assessments of quality in our selection of case studies, aiming to include a set of eight local authorities which as many as possible of our four assessments suggested were stronger performers, and a set of eight which as many as possible of the assessment methods suggested were struggling.

Our selection of case study local authorities was also designed to include variation in:

- region
- local authority type: to include unitary, metropolitan districts, shires and London boroughs
- proportion of minority ethnic group population

- and to include local authorities which were selected as hubs of effective practice in the National Strategies pilot programme.

Having selected local authorities, we then approached the Director of Children's Services (or equivalent) initially by letter followed by a telephone call. Of the 16 local authorities selected for inclusion, seven chose not to participate and were replaced with as close as possible a match across the criteria. Table 1.2 shows the profile of the 16 local authorities involved in the study.

Table 1.2 Local authority sample profile

Region	n	Local authority type	n
South West	2	Shire	4
South East	3	Unitary	6
North West	1	Metropolitan District	4
North East	2	London Borough	2
East of England	3		
West Midlands	2		
East Midlands	0		
Yorkshire and the Humber	1		
London	2		

Case study informants

Within each local authority we sought to interview:

- *Three strategic local authority informants*: aiming where possible for coverage of leadership of SEN or inclusion strategies, and for strategies for working with children with hearing impairment and with ASD. The precise make-up varied since some informants fulfilled more than one role. Overall leads had roles such as Assistant Director, Head of Services for SEN, Inclusion or Disability, or were Principal Educational Psychologists. Hearing impairment and ASD leads were people who focused on those conditions, led teams addressing wider conditions eg speech, language and communication or sensory impairment, or had wider strategic roles.
- *The Parent Partnership Service Coordinator*.
- *Representatives from two voluntary and community sector (VCS) organizations* – Chief Executives or Heads of Service. We sought to include voluntary and community sector organizations which would have insight into local authority practices and the strategies and systems behind them, and thus particularly organizations which had been involved in strategic planning or as service providers to the local authority. We asked local authority informants for suggestions or used internet searching to identify possible organizations. Across the voluntary and community sector organizations involved we sought a combination of ASD and hearing impairment specialist organizations and generic disability organizations. However, few hearing impairment services were nominated and one declined to participate so we only included one hearing impairment group in the interviews, although 16 interviews were with pan-disability groups which generally included hearing impairment.

Overall a total of 84 interviews were carried out involving 96 individuals. The profile of informants is shown in Table 1.3.

Table 1.3 Case study informants sample profile

	Interviews	Individuals
Local authority	42	49
Parent Partnership Service	16	20
Voluntary and community sector	26	27
Total	84	96

Data collection methods and analysis

Data were collected through in-depth interviews, carried out either face to face or over the telephone, and in some cases two or three informants were interviewed together at their request. Interviews generally lasted for an hour to over two hours. They followed a topic guide which listed key issues and sub-topics for exploration: a summary version was sent to interviewees in advance. The topic guides (see Appendix I) – one used with local authority strategic informants and one with Parent Partnership Service and voluntary and community sector informants - covered broadly the same ground, encompassing:

- strategic planning and policies
- multi-disciplinary or multi-agency working
- prevalence of children with SEN and with ASD and hearing impairment, identification and assessment
- use of the Code of Practice levels of support and especially statementing
- information to and involvement of children and parents
- school-based provision
- monitoring pupil progress
- funding systems
- workforce issues
- other key areas of provision, particularly mental health services, speech and language therapy and social care.

This was a challenging breadth of issues to explore. The interviews focused on descriptions of provision and approaches; interviewees' assessments of quality; identifying the systems structures and approaches that support better quality and the challenges faced; and interpretation of the SEN indicators used in selection.

Before the interviews we asked the local authority lead to coordinate the completion of a pre-interview checklist. This collected information about the range of services provided and an assessment of the proportion of children needing each component whose needs were met in full within a reasonable timescale. This allowed us to focus the interview on key issues and provided data that could be analysed alongside the qualitative data, although the checklist was only completed by ten of the sixteen case study local authorities.

All interviews were digitally recorded and transcribed verbatim. They were analysed using Framework, a systematic and in-depth qualitative analysis method (Ritchie and others, 2003). A series of eight thematic charts were drawn up: in each there were separate columns for key sub-topics, and a row for each individual informant. The themes and sub-topics emerged from the data and reflected the objectives of the study. Data from each transcript were then summarized in the relevant cell, with the page number noted so that the transcript could be examined and data extracted for verbatim quotation.

Some points about our use of the qualitative data should be noted. There were often inconsistencies between information provided by individual interviewees within the same

local authority, reflecting different levels of knowledge, different roles and perspectives, and different views. The interviews with Parent Partnership Service and voluntary sector representatives also played an important part in giving us another perspective on quality that was often more obviously rooted in parents' and children's experiences, although sometimes with an orientation to those who were finding SEN provision or systems most challenging. This variation provided rich data with multiple perspectives on the quality of provision in each case study authority. However we were reliant on the insight and honesty of interviewees and their willingness to critique what happens in their local area. The findings therefore reflect the views and subjective experiences of interviewees, and do not allow us to make objective statements about relative quality.

The data used for case study selection (see above) suggests variation within, as well as between local authorities. This was borne out by analysis of the interview data and is considered further in our discussion of the findings.

1.3.4 Schools

Given the importance of schools in meeting the needs of children with SEN, we also wanted to ensure the study captured information about SEN provision within schools and their assessments of the quality of support the local authority provided. Resources and the time available meant that this aspect of the study could not cover a large sample of schools nor cover all case study areas and non-mainstream schools. Instead, we sought to explore the issue of variation across schools overall, rather than focusing on the variation between schools within local authorities.

Selection of schools

During the case study recruitment process, we outlined our intention to carry out research with schools in eight of our 16 case study areas all of whom agreed to participate in this part of the study. Our selection of these eight case study local authorities was designed to include local authorities performing well and not so well on our indicator ranking (see 1.3.3 above) and to represent different regions and local authority type.

We asked strategic informants in each local authority to identify between six and 12 schools which allowed for some selection by us and the possibility that some schools might refuse to take part. We asked them to nominate schools which had low, medium and high numbers of children with SEN relative to the average in the local authority, and a mix of mainstream primary and secondary schools with and without specialist provision (focusing on ASD and hearing impairment).

We approached the headteacher, or other named contact identified by the local authority, initially by letter or email followed by a telephone call. Our aim was to interview the SENCO or SEN lead in up to three schools in each of the eight local authorities. In the event, we were able to secure interviews with 21 school representatives. Fifteen were qualified teachers, and 12 were members of their schools' senior management team; their length of time in the role varied from a few weeks to 19 years.

Table 1.4 shows the profile of the schools involved in the study.

Table 1.4 School sample profile

	No.
Total number of schools in sample	21
Primary school	14
Secondary school	7
Low SEN	6
Medium SEN	6
High SEN	9
Without specialist provision	13
With specialist provision	8
- ASD unit	4
- speech and language unit	1
- hearing impairment unit	3

Data collection methods and analysis

Data were collected through in-depth telephone interviews. Interviews took on average an hour and followed a topic guide (see Appendix I) which mirrored the local authority interviews and explored:

- schools and local authority policies
- identifying children with SEN
- use of the Code of Practice levels of support especially statementing
- provision
- information for and involvement of children and parents
- funding levels and delegation processes
- monitoring educational outcomes.

All interviews were digitally recorded and transcribed verbatim. They were analysed using Framework, described above.

1.3.5 The voice of children and families

We did not involve children and families directly in the case studies because to do so would have required a sample which would have been beyond the scope of the study, given the variation in the population of children with SEN. We felt that to include a small sample only – one or two focus groups, for example – would have been tokenistic. Instead we relied on Parent Partnership Service Coordinators and voluntary and community sector organizations to report the experiences of the families with whom they work. Clearly the study would have been enhanced by hearing the direct voice of children and families.

We had intended to carry out a small scale consultation exercise alongside the literature review to ensure that the issues explored in the case studies reflected the perspectives of children and parents on quality in support for children with SEN. However, the literature review revealed a considerable body of work involving consultations with children and parents (see Appendix II for annotated bibliography) and we were not confident that further research would be a justified intrusion on their time. We relied instead on extracting key messages from the existing literature on what constitutes good quality services from the perspective of children with SEN or disability and their parents, and used this to inform our analysis of variation in the quality of provision.

1.4 Structure of the report

- *Chapter two* summarises the findings from the literature review, describing key publications covering good practice guidance, quality standards and quality improvement tools; studies looking at variation in identification, funding and service provision; and highlighting indicators of quality and good practice discussed in the literature.
- *Chapter three* reports on the analysis of existing datasets. It explores: variation in the apparent prevalence of children with SEN, the linkage with local area deprivation and associations with the prevalence of disabled children using different measures; variation in the apparent prevalence of children with hearing impairment and ASD; and variation in the SEN indicators used, correlations and associations with data on prevalence.
- *Chapters four to six* draw on the local authority case studies. *Chapter four* looks at what supports good multi-disciplinary work. It explores strategic management structures and operational practice, including integrated teams, team around the child and similar models, joint planning, joint commissioning and pooled budgets, and joint decision-making about placements. It also looks at the involvement of children and young people and parents in strategic planning.
- *Chapter five* explores variation in practices in identification, assessment and referral. It looks at practices in identifying and recording SEN and in information sharing, and discusses apparent differences in the prevalence of children with SEN and with hearing impairment and ASD. It looks at differences in assessment and in referral practices, including how transparent and documented assessment and referral practices are, and at the provision of information to children and families at this stage and approaches to their involvement in individual case planning.
- *Chapter six* looks at what supports effective practice in support for children with SEN at early years and in school. It discusses the role of special schools, specialist mainstream units and out of area provision in early years and schools, and at variation in strategies and services to support mainstream schools in working with children with SEN. It also looks at other areas of provision, particularly speech and language therapy, mental health services and social care.
- *Chapter seven* explores how the Code of Practice stages, particularly statement, are used, and at how funding arrangements contribute to supporting school provision.
- Finally, *Chapter eight* draws together the key findings and discusses their implications for policy and practice.

Chapter 2: Literature Review

This chapter reports the results of the literature review on variation in prevalence and categorization of children with SEN and disabled children and in provision to meet their needs, and the factors contributing to quality in service provision and support. The aims of the review were to provide contextual information for the study and inform development of the interview schedule for the case studies. The review considered a range of literature as described in chapter one, but was not intended to be a systematic review of all literature relating to SEN and disability. The chapter begins with an overview of the key reports, good practice guidance and quality improvement documents that the review drew upon before focusing on variation and then quality.

2.1 Key reviews

A number of significant reviews of SEN education and services for disabled children and their families have been published over recent years, looking at the SEN system as a whole or specific aspects of it (eg Audit Commission, 2002; Audit Commission, 2003a; Audit Commission, 2007; Bercow, 2008; Daniels and Porter, 2007; House of Commons Education and Skills Committee, 2006; House of Commons Education and Skills Select Committee, 2007; Lamb, 2009; Ofsted, 2004; Ofsted, 2005a; Ofsted, 2005b; Ofsted, 2006; Steer, 2009). In addition, a number of key reports and studies have focused on services concerned with our two exemplar conditions, ASD (eg HMIE, 2006; NAS, 2008; Peacey, 2006) and hearing impairment (eg HMIE and NDCS, 2007; NDCS, 2007; RNID, 2005) as well as a national audit of support services and provision for children with low incidence needs including those with severe ASD and severe sensory impairments, which was undertaken for the Department for Education and Skills (Gray, 2006).

2.2 Good practice guidance

2.2.1 Overview of good practice guidance

Recent years have also seen proliferation in the publication of good practice guidance, standards of quality and quality improvement tools aimed at improving services for disabled children and those with SEN. The review identified upwards of 30 such documents published by a range of organizations including central and regional government departments and national organizations representing disabled children and their families.

Nationally, the National Service Framework for Children, Young People and Maternity Service sets clear standards for promoting the health and well-being of children and young people and for providing services of high quality that meet their needs. Standard 8 of the 11 National Service Framework standards covers disabled children and those with complex needs (DH, 2004a). Regionally, the Regional Partnerships⁹ have produced a number of good practice guides, including a good practice guide for professionals on transition (East of England, 2005), guidance on support services for children with SEN (East Midlands, 2002), quality standards for sensory impairment (South East, 2003), standards for services for young children with ASD (West Midlands, 2001) and an ASD training framework (West Midlands, 2006).

⁹ The Regional Partnerships, although no longer funded by DCSF, were set up to promote inclusion and positive outcomes for children with special educational needs and/or disabilities and looked after children. They played an important role in supporting national policy and sharing best practice regionally and nationally. Please note that many of these references may be difficult to access because the regional partnership programme has now ended.

Audit and self evaluation tools such as the self evaluation schedule for monitoring SEN provision in the West Midlands and the self evaluation tool for monitoring mainstream funding of SEN systems (Yorkshire and Humberside, 2005) were also produced.

The development of good practice guidance, standards of quality and quality improvement tools has usually been based on research involving consultation with key stakeholders, and can be broad in their coverage as with the Audit Commission's handbook for those working with disabled children (Audit Commission, 2003b) or the Early Support Service Audit Tool (DfES and DH, 2004). They can focus more narrowly on particular topics such as lead professionals (DfES, 2005a), transitions (DH, 2008; DH and DfES, 2007) or support and outreach services (DCSF, 2008a) or focus on specific impairments such as ASD (DfES and DH, 2002; DH, 2004b; NIASA, 2003) or hearing impairment (NDCS, 2007; DfES, 2003). We review six of these documents: the Early Support Service Audit Tool; the Quality Standards for SEN Support and Outreach Services; the National Service Framework Autism Exemplar; ASD Good Practice Guidance; the National Autism Plan; and guidance for developing early intervention and support for deaf children.

2.2.2 The Early Support Service Audit Tool

The Early Support Programme, funded by DCSF and DH (Department of Health), aims to improve the delivery of services for young disabled children and their families (DfES and DH, 2004). It is a national programme that provides a standard framework and set of materials that can be used by agencies providing services for disabled children and their families. The programme promotes services that work in partnership with parents and carers and that integrate service planning and delivery. The materials include the Early Support Service Audit Tool which is a multi-agency service audit instrument for use across health, education and social care and other agencies to review current service provision and plan integrated services. The audit tool has 26 standards across four functional areas of service delivery: 1) leadership, management and organization of services; 2) referral, identification and initial assessment; 3) ongoing support; and 4) providing and sharing information. Standard eight of the National Service Framework recommends that local authorities, Primary Care Trusts (PCT), early years and day care providers integrate Early Support Programme materials into service delivery and use the service audit tool to jointly review and evaluate the standard of their service to disabled children and their families (DH, 2004a).

2.2.3 Quality Standards for SEN Support and Outreach Services

These 16 standards were drawn up by the South East and South West Regional Partnership through a DCSF-funded project and are intended to illustrate good practice, help in the development of local provision and lead to improved outcomes for children (DCSF, 2008a). The standards are focused on outcomes and service management and delivery. They include: the regular monitoring of programmes and interventions, monitoring the progress of pupils after an intervention has finished, consultation with parents and children and provision of accessible information, service delivery that increases the capacity of schools, early years settings and other provision to meet children's needs within their own resources and expertise, the use of service development plans which are regularly reviewed, regular review of resource allocation to children whilst maintaining high levels of specialist knowledge in service staff, and collaboration with other service providers so that services are effective and joined-up.

2.2.4 National Service Framework Autism Exemplar

Supporting material for the National Service Framework includes the publication of exemplar 'patient' journeys which illustrate some of the key themes of the National Service

Framework. They are aimed at a range of professionals from education, health, social care and the voluntary sector.

The exemplar on autism (DH, 2004b) presents an example of good practice in the case of one boy with autism, from the point at which parents raise concerns about their child through to adulthood. Good practice includes: professionals who are trained to recognize signs of ASD; early identification and intervention; timely advice and services; easily accessible and timely information about condition and services; multi-agency assessment with appropriate protocols; parental involvement in decisions about their child; clear referral pathways to services; a key worker for children with complex needs; coordination of care; information sharing between agencies and disciplines; and access to a full range of support services.

2.2.5 ASD Good Practice Guidance

The ASD Good Practice Guidance (DfES and DH, 2002) provides an introduction to ASD and the range of educational interventions used to support children with ASD and offers a set of pointers to good practice for schools and local authorities embracing early identification and intervention, policy and planning, family support and partnership, involvement of children, and cooperation with other agencies. It lists the constituents of an ASD friendly school and an ASD friendly local authority. The guidance was developed following consultation with stakeholders and is intended to be used as an audit tool.

2.2.6 National Autism Plan for Children

The National Autism Plan for Children (NIASA, 2003), an initiative by the Royal College of Paediatrics and Child Health (RCPCH) and the Royal College of Psychiatrists and published by the National Autistic Society, is a set of guidelines for the identification, assessment, diagnosis and access to early interventions for pre-school and primary school aged children with ASD. They were developed by a multi-disciplinary core group of professionals from health, education, and social services and parent and voluntary sector representatives. The evidence for all recommendations is graded in line with RCPCH guidelines and the Plan highlights training needs and specifies timeframe and service specification targets.

2.2.7 Developing early intervention/support services for deaf children and their families

This guidance (DfES, 2003) is intended for local authorities, teachers of the deaf and other professionals working with very young deaf children and their families after deafness has been diagnosed and hearing aids have been fitted. The guidance is organized under a number of headings, including: partnership with parents; multi-agency service delivery; early involvement of local education authorities; developing professional expertise and experience; meeting the needs of children and families; monitoring progress in the preschool years.

2.3 Variation in identification, funding and service provision

2.3.1 Identifying SEN

Wide variations in the numbers of pupils identified as having SEN in different schools and local education authorities have been reported (Ofsted, 2004; Steer, 2009):

'The inconsistency with which pupils are defined as having SEN continues to be a concern. Some schools use the term to cover all who are low-attaining, or simply below average, on entry, whether or not the cause is learning difficulty.' (Ofsted 2004:10)

In emphasizing the need for accurate identification of children with SEN, Steer (2009) highlighted inconsistency of practice in the system as a whole, and problems with over identification as well as under identification:

'Some schools identify far higher numbers than found in other schools in a similar context.' (para:54)

Over and above variation in how SEN is defined, there is also variation in determining the primary SEN category. Research commissioned for the Bercow Review found differences between local authorities in criteria and definitions for the SEN category speech, language and communication needs and whether ASD was categorized as a subset of speech, language and communication needs or as a separate category (Lindsay and others, 2008). An unpublished paper by the National Deaf Children's Society (NDCS), based on an analysis of 2007 School Census data on the numbers of pupils at School Action Plus and with statements where hearing impairment was the main type of SEN, found variation in the identification rates in mainstream primary and secondary schools.

Several reasons have been suggested for this variation. First, the large body of legislation and statutory and non-statutory guidance creates a complex set of requirements and suggestions, which are open to local interpretation (Audit Commission, 2002; House of Commons Education and Skills Committee, 2006; Ofsted, 2004). This can for example lead to variation in the application of criteria used to determine eligibility for School Action and School Action Plus and the criteria for determining eligibility for a statement. Second, the variation in level and quality of support services, such as the availability of speech and language therapists or educational psychologists, may affect the category under which additional funding is sought (House of Commons Education and Skills Committee, 2006; Peacey, 2006).

2.3.2 SEN spending

The benefits of delegating SEN funding to schools include greater staff stability (DfES, 2001), more flexibility to respond to needs as they arise, and a reduction in the demand for statements (DfES, 2004a). Despite the desire for greater delegation and greater consistency between authorities in the level of delegated funding (DfES, 2004c), the degree to which local authorities delegate SEN funding varies between local authorities (Peacey, 2006). At the school level, concerns have been raised that schools may not be using all their delegated funding for SEN, suggesting the need for closer monitoring by local authorities (Bercow, 2008; House of Commons Education and Skills Committee, 2007; Ofsted, 2005b).

Looking at expenditure patterns and how these relate to statementing practice, Pinney (2004) found no significant correlations between statementing levels maintained by individual local authorities and any section 52¹⁰ spending, including totals for 2002-2003, but concluded that it was difficult to draw any firm conclusions using the data that was available at the time. There did appear to be a difference in the pattern of spending; low statementing authorities spent more on SEN than high statementing authorities. Research in a small number of case study authorities suggested that this increase in spending may reflect investment in building the capacity of mainstream schools to respond to a wider range of pupil needs.

¹⁰ Local authorities are required under section 52 of the School Standards and Framework Act 1998 to publish a budget statement at the beginning of each year and an outturn statement at the end showing their planned and actual expenditure in a prescribed format. This includes details of spending on SEN.

Although there is considerable variation between authorities in the level of planned expenditure on children with SEN in mainstream schools (DfES, 2006), evidence from the Welsh Audit Office suggests that variation in spending does not account for variation in service quality. There was wide variation between Welsh councils in the level of spending on SEN and in the way they planned and deployed their SEN budgets, yet little correlation between these factors and the quality of provision as determined by inspections by HMIE for Education and Training in Wales and the Wales Audit Office (Wales Audit Office, 2007).

2.3.3 Provision and support services

Significant differences have been found between local authorities in the use of out of authority placements (Gray, 2006) and in the use of independent and non-maintained special school (The Regional Partnership, 2007). A lack of local packages of support for children and families, for example mental health support and short-break care, often leads to the need to place a child in residential care or in provision out of their local area (Audit Commission, 2007). Studies have highlighted the shortages in the provision of speech and language therapy, occupational therapy, mental health support and short-break care (Audit Commission, 2007; Bercow, 2008; Gray, 2006).

Considerable variation in the amount spent by authorities on placements in the independent and non-maintained sector has also been reported (Audit Commission, 2007). However, high spending on such placements may not necessarily be due to a lack of provision within the authority. The analysis and work by the Regional Partnerships suggested that authorities with high levels of spending on their own SEN provision tended to spend more per pupil on out of authority placements, though the variations in spending were not easily explained.

Significant differences have also been found between areas in access to services, such as Child and Adolescent Mental Health Services (Ofsted, 2009), and in the number of speech and language therapists between areas with similar levels of deprivation (Bercow, 2008). Differences between schools have been reported too, for example in the time allocation given to SENCOs and the amount of administrative support they are provided with (Audit Commission, 2003a).

Studies specifically focusing on the level of service for children with a hearing impairment or with ASD have also reported variation across areas. A report published by the Royal National Institute for the Deaf (2005) found significant variations in the type and amount of support given by specialist support services. Indicators of this variation were the frequency of visits to children with similar needs, responsiveness to requests for support and direct support for pupils. A survey of local authorities by the National Autistic Society (2008) reported significant variation between local authorities in the implementation of good practice guidance, the extent and nature of post-diagnostic support, and respite care.

Variation between local authorities in support services provided by education was found to be related to the history of individual authorities more than the demographic type and size of the authority (Gray, 2001). At the time of this study some authorities retained very large central services whilst others were much smaller and linked to more specialist or advisory functions, but the number of authorities with large central support services has since declined (DfES, 2006).

2.4. Indicators of good practice in meeting the needs of children with SEN

Unsurprisingly, given that the review scoped services for disabled children and those with SEN from birth to post 16, and their families, across health, education and social care, many factors both strategic and operational were identified as contributing to good practice and quality provision. These centre on the following broad areas around which we have structured this section:

- planning and policies
- a multi-agency approach and joint working
- early identification and intervention
- engaging with parents, children and young people
- provision, support and access
- narrowing the attainment gap.

2.4.1 Planning and policies

Good practice guidance emphasizes the importance of strategic planning in order to meet needs effectively (eg Audit Commission, 2002; Audit Commission, 2003b; DfES and DH, 2002; Wheatley, 2006). Lack of strategic planning has been blamed for inequalities in service delivery. It has been suggested for example, that having no specific strategy for children with autism results in resources and services that are patchy (House of Commons Education and Skills Committee, 2006). Where strategic planning for SEN is effective, there is strong leadership, a shared understanding of local needs based on detailed research, and a clear strategy to develop in-house provisions to meet this, including an effective inclusion strategy agreed with local schools (Audit Commission, 2007).

2.4.2 Use of data to inform policy

Reliable data on children's needs is an essential prerequisite to effective planning. However, several studies have highlighted the lack, or effective use, of good quality data to inform policy making and commissioning at local level (eg Audit Commission, 2003a; Bercow, 2008; Mooney and others, 2008; Morris and others, 2008), and integrated data systems which combine local authority and health information are far from common (Lindsey and others, 2008; Mooney and others, 2008). Variation between authorities in the degree to which data is used to inform SEN planning, evaluate the quality of provision, and improve pupil outcomes has been reported (Lindsey and others, 2008). Ofsted has likewise noted weaknesses in needs analysis, with partnerships often lacking sufficient local data to enable them to monitor and plan with sufficient accuracy (Ofsted, 2009).

As discussed in more detail in the following chapter, there is currently no reliable data at either the national or local level on the number of disabled children. A recent study considering disability data collection for children's services using data collected from parents and pupils found that a quarter of children who met the DDA definition of disability did not have SEN (Porter and others, 2008). In all mainstream schools involved in the study there were children with a disability about whom schools and local authorities had no knowledge. Conversely, over half the children with SEN in mainstream schools were not seen by parents to meet the DDA criteria.

Because of the lack of reliable data, it is difficult to accurately estimate the prevalence of different impairments (PricewaterhouseCoopers, 2006). Improved data on the prevalence of different impairments, such as ASD is therefore needed and this data needs to be shared (Autism Education Trust, 2008).

The ASD Good Practice Guidance recommends that information on numbers of children with an ASD is collected and collated by local authorities to assist in forward planning (DfES and DH, 2002).

2.4.3 A multi-agency approach and joint working

Parents want to see agencies working together (eg Mitchell and Sloper, 2003) and integrated children's services. The delivery of joined-up services is at the heart of Every Child Matters and strategies such as Removing Barriers to Achievement. Where there is a lack of joint planning and delivery of services and a lack of clarity in the responsibilities of health and education services, parents often find themselves repeating information to professionals and falling through the gaps between services (Audit Commission, 2003a; Bercow, 2008).

Important in the development of integrated services are distinctive tools and frameworks such as 'a team around the child' (TAC) and/or a lead professional, locality and panel working, and joint screening tools. Not only are these tools and frameworks evident in authorities where integration had been longer established, but these authorities also report single management structures with services delivered by front-line teams and better access to services for children and families. This includes a quicker response in providing support, a more coordinated response and earlier identification (Lord and others, 2008).

Good partnerships between local authorities and other agencies are characterized by high levels of trust and commitment, clarity of purpose with shared goals, and good working relationships and communication (Lord and others, 2008; Ofsted, 2009). Local authorities that have established close partnerships with the voluntary sector in order to extend the range of services available are more successful in improving the outcomes for children with a learning difficulty and disability (Ofsted, 2009). Yet, in the review of services for children with speech, language and communication needs, structures and processes to facilitate cooperation across health and local authority services were found to be at an early stage of development (Bercow, 2008).

The priority given to disabled children and those with SEN within integrated children's services would appear to be important. For example, research commissioned by the NDCS to consider the impact of integrated children's services on social care service for deaf children and families found that the emphasis given to deaf children and families in the structuring of children's services had a significant effect on practice (Young and others, 2008). Where insufficient attention had been given to the needs of deaf children, there was evidence of unrecognized need, limited resource allocation, poor joint working between social care, health and education, and ambiguous pathways for services.

An opportunity for better multi-agency service delivery to the families of deaf babies at local level is provided by the Children's Hearing Services Working Groups (CHSWG), which bring together paediatric audiology personnel, teachers of the deaf, social workers, parents and other interested agencies (DfES, 2003). These working groups, where they exist, can provide a regular forum for agencies to come together, assist with strategic planning and the integration of services, and promote the sharing of information.

Integrated working both facilitates and is facilitated by joint commissioning. Factors contributing to effective joint commissioning include taking an integrated approach to assessing need, agreeing desired outcomes, planning appropriate provision, and developing and supporting the workforce (Bercow, 2008). In areas where services are not jointly commissioned and where strategic inter-agency governance arrangements are not in place there tends to be poor integration at operational level (Bercow, 2008). Although areas vary in how well they are doing in the joint commissioning of services, where joint commissioning is

effective, it has a positive impact on increasing the numbers of children being supported closer to home rather than having to be placed elsewhere (Ofsted, 2009). An earlier report by the Audit Commission also found that strong multi-agency arrangements for agreeing placements helped to encourage jointly funded alternatives to out of authority placements (Audit Commission, 2007).

2.4.4. Early identification and intervention

Good practice guidance highlights the importance of the early identification of children with SEN and effective early intervention and support for families and children (eg Audit Commission, 2003b; DfES and DH, 2002; DH, 2004a). Effective early identification and appropriate provision which meets need is more likely to occur where there is good strategic management and close collaboration between the relevant services (Ofsted, 2009). Good multi-agency working is most often seen in services that deal with the needs of younger children and their families, with the best performing areas marked out by all services working together with the pre-school age range, collaborating closely and thus facilitating identification of a problem at an early age. Evidence to the Bercow Review, however, points to the difficulty of getting assessments and the long waits for provision following identification for children with speech, language and communication difficulties (Bercow, 2008).

A review of the literature on how the needs of children with SEN are met concluded that there was increasing evidence that targeted early interventions can lead to improved child outcomes and that appropriate support for parents can enhance the effect of the interventions although there was little evidence in terms of how identification leads to appropriate planning of provision and support (Dockrell and others, 2002). However, there is no direct empirical evidence that early compared to later intervention has a specific positive benefit for children with ASD, though there is a consensus that developmental principles support the notion of early intervention (Charman and Clare, 2004).

In a review of the research evidence on narrowing the gap in outcomes for vulnerable children, effective early intervention and prevention were found to be built upon through: effective multi-agency working with strong partnerships, shared priorities and action plans; joint systems and processes for needs analysis and the identification of gaps, target setting and planning, data sharing, commissioning and referral; and the development of initiatives that included the involvement of users in service development and provision through multi-agency teams (Kendall and others, 2008).

2.4.5 Assessment

The development of protocols for identification with clear referral pathways (DfES and DH, 2002; NIASA, 2003) and multi-agency assessments which help to build a whole picture of the child and avoid families having to attend repeated assessments by different professionals, are seen as good practice (Audit Commission, 2003b; DfES and DH, 2002; DfES and DH, 2004; DH, 2004a; DH, 2004b; NDCS, 1999; NDCS, 2002).

Research considering joint assessments found that they worked better when they were underpinned by the development of trust, communication, and strong inter and intra-agency working relationships (Boddy and others, 2006). Factors facilitating joint assessment included pooled budgets and governance structures, sharing data and documentation, face-to-face working through co-location or frequent joint meetings, key worker and lead professional roles, common training and cross-agency working groups. The Common Assessment Framework (CAF) was seen as complementary to the principles and practice of joined-up assessment for disabled children and/or children with significant and complex health needs.

2.4.6 Engaging with parents, children and young people

Whereas some studies of parents' satisfaction with services for disabled children and/or children with SEN point to poor relationships between parents and local authorities (eg Duncan, 2003) and poor communication (Audit Commission, 2003a), other studies have reported greater satisfaction with local authorities (Peacey, 2006) and with educational provision (Parsons and others, 2009), although parents may be more satisfied with primary than secondary provision (Peacey, 2006). A recent survey of over 12,000 parents of disabled children across 30 local authorities found that compared with health and education services, parents were least satisfied with the level and quality of social care services received (Hamlyn and Grant, 2009).

Research concerned with parental satisfaction with services for children with SEN, identifies a lack of readily available and accessible information as a reason for dissatisfaction (Audit Commission, 2002; Bercow, 2008; Contact a Family, 2003; House of Commons Education and Skills Committee, 2006; Slade and others, 2009). The quality and nature of the service are likely to affect parents' perceptions and experiences. For example, Ofsted report that where support provision for children with learning difficulty and disability was no better than adequate, parents experienced problems in getting relevant information, either because it was not available or because it was difficult to understand (Ofsted, 2009). The SEN assessment, statementing and tribunal system itself is complex - in the way it is resourced, the language used in the processes, and the guidance for assessment and statementing thresholds - and this leads to confusion, anxiety and frustration among parents (Penfold and others, 2009). Where communication between parents, schools and local authorities is clear and open, the escalation of issues to appeal can in some cases be avoided (Penfold and others, 2009).

As outlined in chapter one, Aiming High for Disabled Children (HM Treasury and DfES, 2007) established a 'core offer' for parents, setting out minimum standards covering information and transparency, assessment, and participation and feedback. The Lamb Inquiry, which was set up to consider a range of ways in which parental confidence in the SEN system of assessment and provision might be improved, reinforces the need for parents to be provided with the necessary information, feel that they are listened to, that policies and practices are explained to them, and that they are informed of their rights and entitlement (Lamb, 2009).

Working in partnership with parents, children and young people is recognized as good practice in service delivery and given high importance in policies and guidance (eg DfES, 2001; DfES, 2007; Lamb, 2009). Indicators suggesting good practice in this area include: recognising and valuing parents' knowledge and expertise about their child; providing clear, timely and accessible information; involving parents and children in assessments and reviews; and in service development (Audit Commission, 2003b; DCSF, 2008a; DfES, 2001; DfES, 2003; DfES and DH, 2002; NDCS, 2002; NDCS, 2007).

2.5 Provision, support and access

2.5.1 Early years and childcare

Taking our two exemplar conditions as examples, a range of early years provision and support including home-based programmes, nursery schools, opportunity groups, pre-school play groups and outreach support in a variety of settings is considered good practice for young children with ASD and for hearing impaired children and their families. However, research suggests that support for early years settings to enable them to meet the needs of disabled children and those with SEN may be insufficient.

Dickens (2003) review of the literature on children with SEN in preschool education concludes that although inclusion in mainstream services is now widely considered to be good practice for disabled children and those with SEN, as supported by current legislation and guidance, funding for early years settings, particularly for support and advice, falls short of that available in schools.

A recent survey found that parents of children with severe or complex needs and some parents of autistic children had a low level of childcare service use due to a lack of suitable places, trained staff and appropriate facilities (Daycare Trust, 2007). Ofsted (2005a) found that across the private, voluntary and independent sector, the largest provider of childcare services, good practice was not widespread, consistent or adequately disseminated. They recommended that local authorities should support childcare providers in this sector, for example in developing plans to promote the best outcomes for children with special needs, and in raising awareness and addressing barriers to inclusion through training programmes, guidance and building links between providers and specialist services.

2.5.2 Schools

To meet the diverse needs of disabled children and/or children with SEN, the availability of appropriate mainstream placements and a range of specialist provision is seen as an indicator of good practice (eg Audit Commission, 2003b; DfES and DH, 2002; NDCS, 2007; Peacey, 2006). For low incidence needs, authorities generally try to maintain a continuum of provision though most authorities make some use of provision outside their area (Gray, 2006). For hearing impaired children, for example, a full range of provision is likely to involve provision across local authorities as no one authority will have all the specialist resources (NDCS, 2007). More generally, the number of children with SEN being taught in local mainstream provision across most authorities is increasing and the number being educated in other authorities is decreasing (Ofsted, 2009).

In terms of pupil progress, it is the quality of the provision that seems to be more important than whether the school is a specialist or mainstream school (Ofsted, 2006). Although effective provision is found equally across mainstream and special schools, there would appear to be more good and outstanding provision in resourced mainstream schools than elsewhere (Ofsted, 2006). Key factors associated with effectiveness are: the involvement of a specialist teacher; good assessments where progress is carefully checked; work that is sufficiently challenging and tailored to pupils' needs; and a commitment from school managers to ensure good progress for all pupils (Ofsted, 2006, 2007). Effective planning ensured that resources and support were targeted to meet pupils' particular needs so that their skills and confidence developed at a good pace. Teaching assistants provided a high quality of support. Conversely, in schools in which pupils with SEN underachieved, work was not planned to match their needs. As a result, the tasks set were too hard or they were not demanding enough to extend pupils' skills and understanding. The quality and range of support provided by teaching assistants was also uneven.

2.5.3 Education support services and outreach

A research report from the University of Cambridge recommends that SEN policy:

'Should not rely on individual schools struggling to contain children with special needs but should be conceived as a collaborative effort, sharing resources in a spirit of mutual support. Special schools should have a significant role to play as an expert resource for mainstream schools while they in turn have a supporting role to play in partnership with special schools.' (MacBeath and others, 2006: 65)

This follows earlier recommendations that local authorities should encourage specialist services to build productive links and outreach support to mainstream providers and disseminate examples of good practice (Ofsted, 2004; Ofsted, 2005b) and that schools have access to specialist support (DfES and DH, 2002).

In the most effective education support and outreach services staff are committed to inclusion and this commitment pervades all aspects of their work (Ofsted, 2005b). Long-term funding to schools to provide specialist services facilitates planning and secures the stability of the service, but difficulties arise when delegated funds received by schools are too low to buy sufficient support when needed (Ofsted, 2005b).

2.5.4 A key worker or care coordinator

Parents want and value having one person who acts as a single point of contact who can coordinate services across agencies so avoiding constant repetition of information and professional duplication and inconsistency (Audit Commission, 2003a; Contact-a-Family, 2003; Lord and others, 2008). Research has shown that families of disabled children who have a key worker benefit from this service and although different models have been adopted for keyworking schemes, particular characteristics of the service such as carrying out more aspects of the role, regular training, and a dedicated service manager, are related to better outcomes for children and families (Sloper and others, 2006).

Several policy and good practice guidelines recommend that families have access to a key worker or someone fulfilling a similar role (eg DH, 2004a; DH, 2004b; DfES and DH, 2004; NIASA, 2003) and a set of key worker standards have been produced (Care Coordination Network UK, 2008). These standards are at both strategic and operational levels and include: multi-agency commitment at a strategic and practice level; an agreed referral system and specific guidelines for eligibility for the key worker service; a manager for the service; ongoing resources to run the service including the provision of administrative support, induction and ongoing training and supervision for key workers.

2.5.5 Staff expertise and training

From the perspective of children and their families, an important component of service quality for disabled children and/or children with SEN is having competent staff with the necessary skills and training (Batten and others, 2006; Beresford and others, 2007; Marchant and others, 2007; Mitchell and Sloper, 2003). Good practice guidance emphasizes the importance of ensuring those working with children and young people are appropriately trained. It recommends for example the training of all teaching and learning support staff in disability awareness and core skills for working with children with SEN especially in mainstream schools, with a pool of staff trained in particular specialisms such as British Sign Language or autism (Audit Commission, 2003b; DfES and DH, 2002; NDCS, 2007).

Despite, for example, a recommendation that professionals working with autistic children should receive ASD specific training (NIASA, 2003; Preece and Jordan, 2007), the fact that training is usually optional and monitoring of take-up often inadequate, means that some staff may not receive any training even though a local authority may provide training for all their staff (NAS, 2008). This has led to the recommendation that local authorities should plan staff training programmes systematically, by evaluating the need for training and monitoring take-up and impact (Peacey, 2006).

One of the aims of the ASD training policy developed by the West Midlands Regional Partnership was to provide a structure to ensure more consistency in ASD training across local authorities in the region (West Midlands Regional Partnership, 2006).

Although it is recommended within the SEN Code of Practice that SENCOs should be part of the senior management team, this may not always be the case, and there is evidence of teaching assistants taking on the role of SENCOs in some schools (House of Commons Education and Skills Committee, 2006). The research report, *The Costs of Inclusion*, recommended that SENCOs should always be qualified teachers, that training and support be provided for them and that they be given a substantive role in planning and policy development (MacBeth and others, 2006). In July 2008, DCSF announced plans to enable all new SENCOs to undertake nationally accredited training to meet the new requirement for all new SENCOs to be both qualified teachers and to receive additional training from September 2009.

2.6 Narrowing the attainment gap

In 2008, only 11 percent of pupils with a statement of SEN achieved five A*-C GCSE grades compared with 74 percent of pupils with no identified need (DCSF, 2008b). This finding underlines the importance of monitoring pupil progress as outlined in the SEN Code of Practice (DfES, 2001) and in evaluating the impact of interventions on progress as recommended in the recent review of behaviour standards and practices in schools (Steer, 2009:171):

'Schools need to monitor and evaluate the impact of interventions on the progress made by pupils with Special Educational Needs (SEN) and disabilities and consider what further additional or different provision can be made where progress is unsatisfactory.'

In an overview of the 2007-8 Joint Area Reviews (JARs), better performing areas had introduced more rigorous monitoring arrangements, provided effective support and challenged schools to promote inclusion (Ofsted, 2009). Generally, however, too few schools and local authorities were using the data collected on pupil progress effectively particularly for those children working below National Curriculum levels.

In the past, few schools evaluated their provision for pupils with SEN systematically in order to establish how effective the provision was, partly because of the limited data on outcomes for pupils with SEN (Ofsted, 2004). The introduction of P scales, which became statutory in May 2008 for children with special educational needs working below level one of the National Curriculum, is likely to change this situation. Schools will need to use P scales to record and report the attainment of those children in the core subjects of English, Mathematics and Science. The data collected on the attainment of pupils with SEN using the P scales will be shared with schools and LAs to support their monitoring and target setting processes.

2.7 Summary

There is significant variation between authorities in terms of prevalence, funding and service provision. Although reasons to explain this variation are suggested in the literature, the case study work in our 16 local authorities will explore this variation and the reasons for it in greater depth. The review has highlighted a range of quality and good practice indicators to do with:

- *Planning and policies*: eg effective strategic planning, a shared understanding of local need based on a needs analysis, an effective inclusion strategy, and data sharing.
- *Multi-agency working*: eg good partnerships between local authorities and other agencies including the voluntary sector, joint planning and delivery of services, clarity in

the responsibilities of health and education, team around the child, and locality and panel working.

- *Identification and early intervention:* eg good strategic management, strong inter and intra agency working, multi-agency assessments with appropriate protocols, use of the CAF and ESP, and clear referral pathways.
- *Engagement with parents and children:* eg parental involvement in decisions about their child, recognizing and valuing parents' knowledge and expertise about their child, providing clear, timely and accessible information, and involving parents and children in assessments, reviews and service development.
- *Provision, support and access:* eg a range of early years provision and support, appropriate mainstream placements and a range of specialist provision, a Key worker or care coordinator where more than one agency is involved, and appropriately trained and competent staff.
- *Narrowing the attainment gap:* eg regular monitoring of the effectiveness of interventions; good assessments where progress is checked, good links between mainstream and specialist provision and effective support to promote inclusion.

Interviews with key individuals within the case study authorities will consider what underpins good practice in these areas – what are the challenges and facilitators – and how this impacts on service provision. In chapter four we start by looking at multi-agency working, but first consider the statistical analysis in the following chapter.

Chapter 3: Statistical analysis

In this chapter we consider a number of statistical indices of prevalence and aspects of practice and look at patterns and associations between them. We begin by looking at data on the prevalence of disabled children and those with SEN, using different measures to draw out the variation between local authorities and looking at the correlations between them. We also report analysis that controls for the level of area deprivation. In section 3.2 we look specifically at the prevalence of children with ASD and hearing impairment. In section 3.3 we look at the SEN indicators that, as we outlined in chapter one, we saw as potential indicators of quality. We look at the variation between local authorities and at associations between these indicators and indicators of prevalence, and at relationships between these indicators themselves.

All the figures used are in the public domain, mostly published on the DCSF website¹¹. We draw particularly on two sources which cover slightly different populations. One is the School Census, a termly census completed by schools. This covers all maintained nurseries, primary schools, middle schools and secondary schools; maintained and non-maintained special schools; and academies and some other types of school. Schools complete an electronic record, including a record for each pupil. The data therefore cover all children educated in these types of schools within each local authority – but not those educated outside the local authority area, who will appear in the return for the authority where they attend school. The other source is the SEN2 Survey. This is an annual survey completed by local authorities which covers all pupils for whom the local authority is responsible, whatever type of school they attend and whether or not it is in the local authority area. In all cases the most up to date figures available were used. Detailed definitions for the derivation of each indicator are given in Appendix III.

3.1 Prevalence of SEN and disability

3.1.1 Indicators of prevalence

Local authorities will vary in the levels of SEN and disability, which will in turn result in different levels of need for services. We used four indicators concerned with prevalence:

- pupils with SEN per 1000 pupils: 2008 (School Census)
- pupils with SEN statements in LA schools per 1000 pupils: 2008 (School Census)
- children with limiting long-term illness per 1000: children 0-17 (census 2001)
- children in receipt of Disability Living Allowance per 1000 children: aged under 18: 2007.

The means for all four prevalence indicators, including the rate of pupils with SEN per thousand, are shown in Table 3.1. (For all the tables shown in this chapter the two local authorities of City of London and Isles of Scilly have been removed because of small numbers. Figures are therefore based on 148 local authorities). What is clear from Table 3.1 is that the rate of pupils with SEN is much higher than the rates for the other three measures, but the other three rates are very similar.

¹¹ <http://www.dcsf.gov.uk/rsgateway/>

Table 3.1 Means on prevalence indicators (based on 148 local authorities)

	Mean	Std. Deviation	Lower Quintile	Upper Quintile
Total pupils with SEN per 1000 pupils: 2008	195.1	35.20	167.4	219.8
Pupils with statements per 1000 pupils: 2008	27.8	5.54	22.3	32.1
Limiting long-term illness per 1000: children 0-17: census 2001	44.0	6.75	37.6	49.8
In receipt of Disability Living Allowance aged under 18: per 1,000	25.8	4.97	21.6	29.7

SEN measures

Table 3.1 shows that, on average, there were 195.1 pupils assessed as having SEN per thousand pupils - that is almost 20 percent, or one in five. However, there is also variation between authorities, from a minimum of 79.4 to a maximum of 288.6. The table also shows the lower and upper quintiles (ie the 20% of local authorities with the lowest level of pupils with SEN per 1000 pupils, and the 20% of local authorities with the highest level) to give an indication of the spread of values. (Quintiles have been used instead of the overall minimum and maximum as the latter can be distorted by extreme values, and quintiles are used in the analysis later). Therefore sixty percent of all local authorities lie between the lower quintile of 167.4 and upper quintile of 219.8 pupils per thousand assessed as having SEN. The coefficient of variation¹² for this measure (a measure of how compact the distribution is) is 18 percent, indicating quite a high level of consistency between local authorities on the rate of pupils with SEN. How and why variation occurs is explored further in chapter five.

A higher threshold than SEN is the rate of pupils with a SEN statement per thousand total pupils. This figure is a subset of the first figure of pupils with SEN, but is likely to represent the pupils with higher levels of need. The average rate of pupils with statements is also shown in Table 3.1, and is 27.8 per thousand, or just under one in 40. This is less than 15 percent of all pupils with SEN (variations in this percentage are discussed in section 3.3). The range is between 11.0 and 42.0. The inter-quintile range on this indicator was from 22.3 per 1,000 in the lowest quintile to 32.1 per 1,000 in the highest quintile, and the coefficient of variation was 20 percent. This suggests that the decision to statement a pupil would vary between local authorities, either by policy or by practice. This is explored further in chapters six and seven.

It was noted above that the number of pupils with statements is collected in two different ways: for pupils attending school in the local authority area (using the School Census) and for pupils living in the area, wherever they attend school (from the local authority SEN2 return). These two figures give slightly different results: the figure that has been used here is from the School Census. That figure was chosen because more data are provided on the School Census than on the SEN2, so the School Census figures have been used wherever possible. However, the two measures of the rate of pupils with statements are very similar: the means are 27.8 and 29.0 respectively, and the correlation between them is 0.88. Consequently, the results here would change little if the SEN2 prevalence figure had been used.

¹² The standard deviation divided by the mean (Martin and Grey, 1971)

Disability measures

There is no register of disabled children, either nationally or locally¹³ (Mooney and others, 2008). It is therefore currently not possible to obtain directly the number of disabled children in each local authority area. Instead, two approximate measures have been used here: limiting long-term illness per 1000 children 0-17, from the 2001 census, and children in receipt Disability Living Allowance per thousand aged under 18, provided by the Department for Work and Pensions (DWP).

The census figure is the rate of children described as having a long-term illness or disability which limits daily activity. This is a very broad definition, and might well include children whose level of disability would not mean they had a SEN requiring a statement. To qualify for Disability Living Allowance, a child must have a physical or mental disability sufficiently severe to need a lot more help or supervision than other children of the same age with activities such as washing, dressing or communicating. To receive Disability Living Allowance, a child either has to have an assessment of their disability or have a statement from their GP. Clearly these are quite stringent criteria, and it is likely that some children who fail to qualify for Disability Living Allowance might still have education support needs requiring a statement. Consequently, the actual level of disabled children who have statements might be expected to be between these two measures of disability.

The census figure is a self-report (or parental-report), with no validity check. The Disability Living Allowance figure is possibly more robust in that recipients will have had to supply evidence of disability. However, an unknown number of children who would be eligible for Disability Living Allowance may not be claiming or receiving it: the figure is thought to be an underestimate, but to what degree is unknown (Kasparova and others, 2007). The advantage of both measures in our analysis is that they are independent of local authority practice, as they do not depend on an assessment by the local authority. So they should be unaffected by local authority policy and practice with respect to SEN, and variations in their level should reflect underlying differences between the areas.

The rates for these two measures are shown in Table 3.1. The mean for children with limiting long-term illness from the 2001 census was 44.0 per thousand (or one in 23) with a range from 29.6 to 69.1; the mean for children in receipt of Disability Living Allowance was 25.8 (or one in 39) with a range from 11.8 to 40.6. The lower and upper quintiles for each measure show little variation, and the coefficients of variation are 15 percent for limiting long-term illness and 19 percent for receipt of Disability Living Allowance. As expected, the limiting long-term illness figure was much higher than that for Disability Living Allowance, and the figure for pupils with statements of SEN is between them, although nearer to the Disability Living Allowance figure. The overall figure for the rate of SEN is much higher than these other three.

These figures are also broadly consistent with two other widely used estimates of disability in children. The first comes from a major survey of disability conducted by the Office for Population Censuses and Surveys (OPCS) in the late 1980s (Bone and Meltzer, 1989), which gave an estimate of 32 children per thousand. The other was derived from the Family Resources Survey (FRS), an annual national household survey conducted for the DWP, which gave a much higher estimate of 73 per thousand (Read and others, 2007). Although this is a wide range for the estimates, they are certainly of a similar magnitude to the limiting long-term illness and Disability Living Allowance estimates generated here, and are consistent with the statemented SEN figure.

¹³ Although local authorities under the Children Act 1989 are required to maintain a register of children with disabilities, because registration is voluntary it is not a good source of data on the prevalence and characteristics of children with disabilities.

3.1.2 Correlations between SEN and disability prevalence measures

As these four measures are all meant to reflect the overall level of SEN and disability in local authority areas, they should be closely related. Even if their overall levels differ, due to the varying levels of severity measured by each, they should nevertheless be highly correlated – a high level of one would be expected to be found with a high level of the others.

The correlations between the indicators are shown in Table 3.2. The correlation between the two SEN measures (0.29) is quite low, considering that these should each be reflecting the underlying level of need. This low correlation means that the level of pupils with statements is not much related to the overall level of SEN, suggesting that the use of the two categories differs markedly within local authorities. Consequently, pupils with an equivalent level of SEN are likely to have very different likelihood of having a SEN statement, depending on the local authority in which they live.

Table 3.2 Correlations between prevalence indicators

	Total pupils with SEN per thousand: 2008	Pupils with statements per 1000 pupils: 2008	Limiting long-term illness per 1000: census 2001	In receipt of Disability Living Allowance per thousand
Total pupils with SEN per thousand: 2008	*	0.29	0.57	0.55
Pupils with statements per 1000 pupils: 2008	0.29	*	0.13	0.28
Limiting long-term illness per 1000: 2001	0.57	0.13	*	0.81
Disability Living Allowance per thousand	0.55	0.28	0.81	*
Index of Multiple Deprivation	0.61	0.03	0.83	0.55

The correlation between the other two measures (limiting long-term illness and Disability Living Allowance) is very high (0.81), indicating that these two measures are probably measuring the same underlying level of disability. They are both strongly correlated with the rate of total pupils with SEN (limiting long-term illness: 0.57 and Disability Living Allowance: 0.55), indicating that overall level of SEN assessments is strongly related to levels of disability (although, as Table 3.1 showed, the actual levels are very different). The correlation with statemented pupils (limiting long-term illness: 0.13 and Disability Living Allowance: 0.28) are much lower. This suggests that the rate of statementing depends much less on the level of disability in the area, and is more influenced by local policy and practice.

3.1.3 SEN and disability prevalence and deprivation

There is evidence that levels of disability are related to overall deprivation in an area (eg Dorling and Thomas, 2004; Elwan, 1999). Consequently, deprivation might account for some of the variations in prevalence of SEN and disability between authorities. The bottom row on Table 3.2 above shows the Index of Multiple Deprivation. This is an overall measure of deprivation published by the Department for Communities and Local Government (Department for Communities and Local Government, 2007). It 'combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score' (Noble and others, 2008: 9). A higher score indicates more deprivation.

Consequently a positive correlation indicates that areas with higher levels of deprivation also have higher levels of SEN and disability.

From Table 3.2 it is clear that there is a strong correlation between deprivation and the percentage of pupils with SEN (0.61), but no correlation between deprivation and the rate of pupils with a statement (0.03). So deprivation is strongly related to the overall level of SEN, but is not at all related to local authority practice on statementing. The likelihood of a pupil receiving a statement varies by local authority, but is not related to the level of deprivation in the authority, unlike the overall level of SEN which is strongly related to the level of deprivation.

However, there are much stronger correlations with limiting long-term illness (0.83) and Disability Living Allowance payments (0.55). Levels of limiting long-term illness in children are strongly related to deprivation in the area, and levels of Disability Living Allowance are also clearly correlated with deprivation.

The next stage of our analysis used regression analysis to see how far prevalence of SEN and disability varied after taking into account the variation that would be expected because of different levels of deprivation. Regression is used to remove the influence of one variable on variation in a correlated variable. A linear regression was fitted for each of the four prevalence indicators, using the average deprivation score as the predictor.

Summary statistics from these regression analyses are shown in Table 3.3. These, of course, reflect the results from the correlations. The rate of SEN, the limiting long-term illness indicator from the 2001 census and the rate of Disability Living Allowance payments all have highly significant regressions against deprivation, but the indicator for the rate of SEN statements was not statistically significant.

Table 3.3 Regression statistics

	F(1,146)	p	Beta	R squared
Total pupils with SEN per 1000 pupils: 2008	84.2	<0.001	0.61	0.362
Pupils with statements per 1000 pupils: 2008	0.10	0.75	0.03	0.001
Limiting long-term illness per 1000: children 0-17: census 2001	314.2	<0.001	0.83	0.683
In receipt of Disability Living Allowance aged under 18: per 1,000	64.4	<0.001	0.55	0.299

The regression was used to estimate scores which show the level of SEN or disability that would be expected for an authority, taking account of its level of deprivation. Consequently, the difference between this expected value from the regression and the observed value from the statistics – what is known as the residual (observed-expected) - would be the difference in level from what would be expected, and so reflects differences in prevalence over and above what might be expected by deprivation alone.

The correlations between these residuals are shown in Table 3.4. The pattern is not very different from that for the raw scores. Local authorities with higher levels of SEN than would be expected from their level of deprivation also have somewhat higher levels of pupils with statements (0.34). Both of these SEN indicators are less strongly correlated with the residuals for limiting long-term illness (0.16 and 0.20 respectively) than for Disability Living Allowance (0.32 for both). The residuals for these two prevalence indicators were strongly

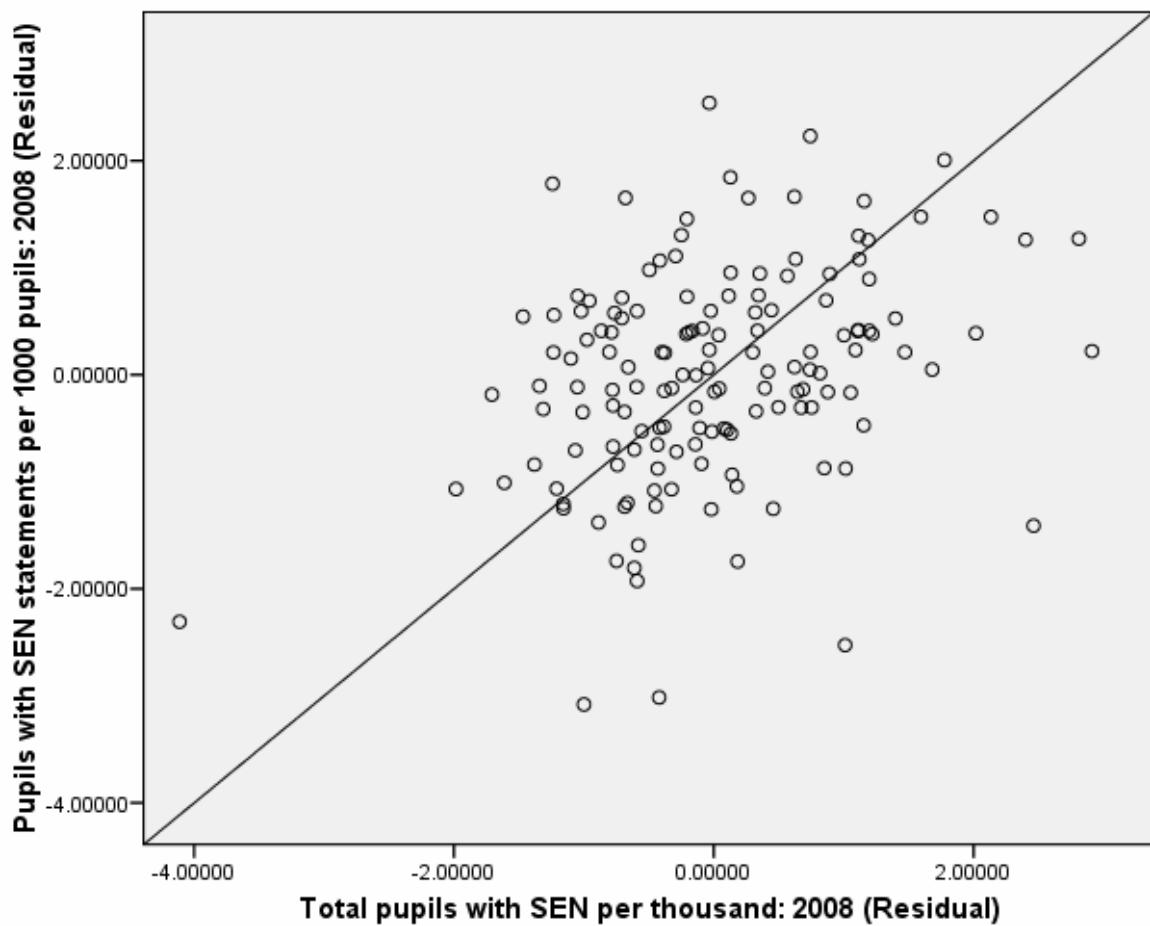
correlated (0.75), showing that areas with higher levels of limiting long-term illness than would be expected by deprivation alone also had higher levels of Disability Living Allowance recipients. This suggests that there are other important factors than deprivation that are influencing overall levels of disability.

Table 3.4 Correlations between prevalence indicators: residuals

	Total pupils with SEN per thousand: 2008	Pupils with statements per 1000 pupils: 2008	Limiting long-term illness per 1000: census 2001	In receipt of Disability Living Allowance per thousand
Total pupils with SEN per thousand: 2008	*	0.34	0.16	0.32
Pupils with statements per 1000 pupils: 2008	0.34	*	0.20	0.32
Limiting long-term illness per 1000: 2001	0.16	0.20	*	0.75
Disability Living Allowance per thousand	0.32	0.32	0.75	*

The relationships between the variables can also be illustrated graphically. The relationship between the residuals for the rate of pupils with SEN and the rate of pupils with statements is shown in Figure 3.1. This shows the rate of SEN per thousand pupils, after controlling for deprivation, plotted against the rate statements per thousand pupils, also after controlling for deprivation (ie residuals). Since these are the residuals from the expected values, they are in standard deviation units, not the original 'per thousand' units. The more positive each of these indicators, the higher the rate relative to what would be expected from the level of deprivation alone; the more negative, the lower the rate compared to what would be expected: a value of zero would be exactly the value expected. Each circle represents a single local authority. The diagonal line shows where the two rates are equal, so that the difference for the rate of SEN overall is the same as for the rate of pupils with statements. Local authorities above the diagonal have more statements than would be expected from their overall level of SEN, whereas local authorities below the diagonal have fewer pupils with statements relative to their overall rate of SEN. The dispersion around the line shows that for any level of SEN overall, the rate of pupils with statements can vary. For example, taking the residual for total pupils with SEN per thousand pupils, the bottom axis, the points just above zero represent local authorities with the rate of pupils with SEN that would be expected, for their level of deprivation. But these local authorities can have very different values on the other axis, of the residual for pupils with SEN statements per thousand pupils. This shows that despite the moderate correlation between these two measures (0.34), there is still variation between local authorities to be accounted for.

Figure 3.1 Total pupils with SEN per thousand against Pupils with statements per thousand (Residuals)



3.1.4 Analysis of prevalence variation using quintiles

To facilitate comparison of prevalence between local authorities, they were grouped into five bands, or quintiles, based on these differences from the expected value. The residuals from the regression against deprivation for the four prevalence measures were each divided into five roughly equal sized groups, or quintiles. To illustrate the procedure, Table 3.5 shows the five quintile bands for the first variable, pupils with SEN per thousand pupils. The first row shows the mean of that variable: in the lowest quintile, the average rate of Pupils with SEN was 164.1 per thousand, or about one in six. In the next quintile the mean was 177.3. The mean rises to 241.3 per thousand, or about one in four, for the fifth quintile. However, it needs to be remembered that the quintiles were defined *not* by the rate of pupils with SEN, but by the difference between that rate and the rate that would be expected given the overall level of deprivation within the local authority: the mean for that difference (the residual) is given in the last row of the table. These residuals are in standard deviation units. The mean residual for the first quintile is -1.24, showing that for this group, the level is a long way below what might be expected by deprivation alone; for the fifth quintile the mean residual is 1.45, indicating that for this group there were far more pupils with SEN than would be expected by taking into account deprivation.

Table 3.5 Mean pupils with SEN per thousand by quintiles

	Total pupils with SEN per thousand (residual): 2008					
	First quintile	Second quintile	Third quintile	Fourth quintile	Fifth quintile	Total
Mean	164.1	177.3	189.8	204.2	241.3	195.1
N	30	30	29	30	29	148
SD	31.0	21.9	19.3	19.3	24.1	35.2
Residual	-1.24	-.55	-.09	.48	1.45	0

The same procedure was applied to the other three indicators. The relationship between the quintiles for the number of pupils with SEN per thousand and the quintiles for these other three are shown in Table 3.6. The table shows just those 29 local authorities in the upper quintile of the distribution of pupils with SEN, against the five quintiles for pupils with statements, limiting long-term illness and Disability Living Allowance. If there were no correlation between the number of pupils with SEN and the other indicators, the distribution of local authorities across the table should be uniform, with each cell having the same number – about six. (There were 148 local authorities in the analysis, and 29 of these were in the top quintile for pupils with SEN.) This is clearly not the case, with fewer local authorities in the lower quintiles and more in the upper ones. This shows that a higher rate of SEN per thousand pupils is associated with a higher rate of statements per thousand pupils and with higher rates of limiting long-term illness and receipt of Disability Living Allowance. This reflects the positive correlations between the variables.

However, the first column of Table 3.6 shows that three local authorities in the *highest* quintile for the rate of pupils with SEN were in the *lowest* quintile for each of the other three indicators – these are not the same three authorities in each case. So, three local authorities have the highest rate of pupils with SEN but the lowest rate of statements. This shows the detailed variation that sits beneath measures of correlation, and is an issue explored further in chapter seven.

Table 3.6 Upper quintile: pupils with SEN per thousand pupils

	Lower quintile	2	3	4	Upper quintile
SEN statements	3	3	4	8	11
Limiting Long-term Illness	3	5	7	5	9
Disability Living Allowance	3	4	4	10	8

More difficult to explain is the fact that three authorities with the highest rate of pupils with SEN have the lowest rate of limiting long-term illness and three have the lowest rate of Disability Living Allowance recipients - since these three indicators might broadly be expected to reflect the overall level of disability within the authority. It is unlikely that either parental assessment for the census of whether a child has a long-term illness, or the DWP assessment of a child meeting the criteria for Disability Living Allowance, will be affected by the local authority in which the child lives. So this suggests the influence of local policy or practice.

3.1.5 Summary of prevalence variation

In summary, we have used four measures for the prevalence of SEN and disability. These are the rate of SEN, the rate of SEN statements, the rate of limiting long-term illness and the rate of receipt of Disability Living Allowance (DLA). The rate for pupils with SEN is much higher than for the other three: for statements this is not surprising, as pupils with statements are a subset of all pupils with SEN. However, the other three indicators have very similar rates. Nevertheless, the overall rate of SEN is correlated with illness and DLA, despite being at a much higher rate, whilst the rate for statementing has much lower levels of correlation. This indicates that the rate of statementing is much more influenced by variations in local practice, whereas the overall rate of SEN is more closely related with illness and disability. This is also reflected in the correlations with the average level of deprivation, as SEN, illness and DLA are all strongly related to deprivation, but statementing is not.

3.2 Prevalence of autism spectrum disorders and hearing impairment

We also looked at variation in the prevalence of the two exemplar conditions, ASD and hearing impairment. DCSF collates and publishes statistics on 11 specific types of need, including these two, drawing on the School Census data. However, the reported numbers are likely to be underestimates of the real numbers. Firstly, whilst the figures cover both maintained and non-maintained special schools, only maintained primary and secondary schools are included in this analysis. Secondly, only children with a SEN statement or at School Action Plus are included in the figures – although it is likely that children with ASD or hearing impairment would have a statement or be at School Action Plus level of support. Finally, and most importantly, the published figures only count a child's primary need, although the school census can collect a second need type. Consequently, a child with ASD or a hearing impairment will not be included in the published statistics if this is not recorded by the school as their primary need – an issue we explore further later in this report. Overall, ASD was the fifth most common of the 11 specific needs and hearing impairment was the eighth.

For this statistical analysis, the two needs have been expressed as a rate per thousand pupils. The data used were for 2008.

Table 3.7 Autistic Spectrum Disorders and Hearing Impairment per thousand pupils

	Mean	Std. Deviation	Lower Quintile	Upper Quintile
Autistic Spectrum Disorder per thousand	5.8	2.2	4.1	7.2
Hearing Impairment per thousand	1.8	1.1	1.1	2.2

The means are shown in Table 3.7. The average rate for ASD across all local authorities was 5.8 per thousand, or a little less than one in 200; for hearing impairment the average was less, 1.8 per thousand, or one in almost 600. ASD shows less variation between authorities than hearing impairment: the coefficient of variation was 38 percent for ASD and 60 percent for hearing impairment. This indicates more variation in rates between local authorities for ASD than for SEN overall and even higher variation for hearing impairment. So either there is a lot more variation between authorities in these two specific needs than overall variation in SEN, or local authorities are using the classification at different rates for otherwise similar children.

The rate for ASD was consistent with the average rate calculated from a recent review, of 3-6 per thousand (Rutter, 2005); However, the review noted that the rate had been increasing. The most recent robust study of prevalence in England found a much higher rate for ASD, 11.6 per thousand (Baird and others, 2006), more than twice the rate found from the School Census. The observed rate for hearing impairment is consistent with that from a recent UK study which found a rate of 1.65 per thousand for nine-year olds, although that study suggested the rate might well increase with age and since the DCSF statistics cover all school-aged children, it might be expected that this rate would be higher (Fortnum and others, 2001). However, a recent report as part of the Health Technology Assessment programme (Bamford and others, 2007) uses a prevalence rate of 3.47 children with permanent hearing impairment per thousand children at school entry screening age, which would suggest the DCSF rate is a significant under-estimate. The fact that the DCSF rate relates only to children with statements or School Action Plus level support does however make it difficult to make comparisons.

Correlations of prevalence rates for these two specific needs with earlier prevalence indicators are shown in Table 3.8. Correlations with the overall rate of pupils with SEN and with the rate of pupils with statements are modest and similar for both specific needs, between 0.2 and 0.3. However, the correlations with limiting long-term illness are quite low (ASD: 0.09; hearing impairment: 0.11), suggesting that rates of limiting long-term illness are not strongly related to levels of ASD or hearing impairment. This suggests a specificity for each of these types of need, so that areas high in one are not necessarily high in others. The correlations with receipt of Disability Living Allowance are more complex: ASD has a moderate correlation (0.33) but hearing impairment has a low correlation (0.18). However there is no obvious reason why levels of ASD should be more closely related to overall levels of disability than hearing impairment. The correlation between ASD and hearing impairment is also low (0.16), so that ASD and hearing impairment would be expected to be correlated differently with overall disability.

Table 3.8 Correlations between prevalence indicators and specific needs: ASD and hearing impairment

	Autistic Spectrum Disorder per thousand: 2008	Hearing Disorder per thousand: 2008
Total pupils with SEN per thousand: 2008	0.26	0.25
Pupils with statements per 1000 pupils: 2008	0.20	0.29
Limiting long-term illness per 1000: 2001	0.09	0.11
Disability Living Allowance per thousand	0.33	0.18
Index of Multiple Deprivation	-0.06	0.11

Just as for the overall prevalence variables, local authorities were assigned to five groups on the basis of their prevalence of ASD and of hearing impairment. Table 3.9 shows the quintile distribution for ASD and hearing impairment for local authorities in the top quintile for pupils with SEN. As can be seen, although ten local authorities in the highest quintile for pupils with SEN were also in the highest quintile for ASD, four were in the lowest quintile, indicating that high levels of SEN are compatible with low levels of ASD.

The pattern for hearing impairment is similar: eight local authorities in the highest quintile for pupils with SEN were in the highest quintile for hearing impairment, and three local authorities in the highest quintile for pupils with SEN were in the lowest quintile for hearing impairment.

Table 3.9 Upper quintile: pupils with SEN per thousand pupils

	Lower quintile	2	3	4	Upper quintile
Autistic Spectrum Disorder	4	5	6	5	10
Hearing impairment	3	3	6	10	8

3.3 Other SEN indicators

As we noted in chapter one, we used five SEN indicators as potential pointers to stronger performance in our selection of case study local authorities. These were the number of pupils with SEN per 1000 pupils (discussed above) and:

- the percentage of pupils with SEN who have a statement: 2008
- the attainment gap between all pupils and pupils with SEN at Key Stages 2-4: 2007
- SEN tribunal appeals per 10,000 pupils: 2005-07
- SEN spending per child with SEN population: 2006 (£).

We also included in our analysis here a further indicator:

- Statemented pupils not in mainstream education per 1,000: 2008.

These indicators do not relate to overall prevalence but are indicative of local authority policy and practices.

In this section we describe the indicators and look at mean levels. We then look at correlations with indicators of prevalence, and finally we look at how these five measures correlate with each other.

3.3.1 Variation in the indicators and correlations with prevalence

The means for the indicators and the variation between quintiles are shown in Table 3.10, and the indicators are then discussed in turn.

Table 3.10 Means on SEN indicators

	Mean	Standard Deviation	Lower Quintile	Upper Quintile
Percentage of pupils with SEN who have a statement: 2008	14.6	3.3	12.1	17.6
Gap between mean KS for all pupils and for pupils with SEN: 2007	35.7	4.3	32.2	38.8
Average rate of appeals per 10k: 2005-07	4.1	3.2	1.7	6.2
SEN spending per child with SEN: 2006 (£)	1,466	568	1,045	1,818
Statemented pupils not placed in mainstream: % of all statemented: 2008	42.5	9.1	34.2	49.7

Percentage of pupils with SEN who have a statement: 2008

The percentage of pupils with SEN who have a statement should be an indicator of local policy and practice, although it may also reflect variation between local authorities in the profile of local children in terms of level of need. There is clear guidance about the use of statements in the Code of Practice (DfES, 2001) but scope for local variation – an issue we explore further in chapter seven.

The overall mean for the percentage of pupils with SEN who have a statement is 14.6 percent, with a range from 5.0 to 23.4. The lower quintile was 12.1 percent and the upper was 17.6 percent, with a coefficient of variation of 22 percent.

Table 3.11 Correlations between indicators

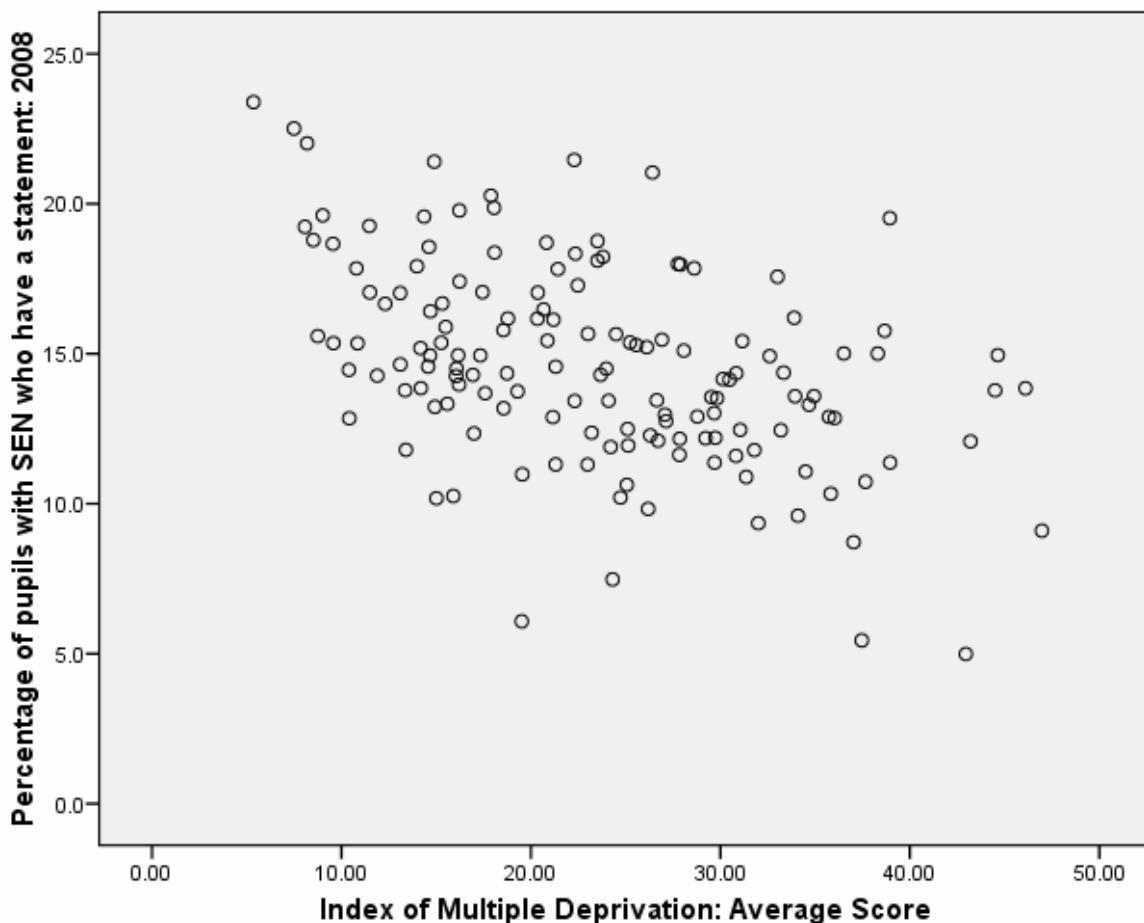
	Percent-age of pupils with SEN with statement: 2008	Gap between mean KS for all pupils and for pupils with SEN: 2007	Average rate of appeals per 10k: 2005-07	SEN spending per child with SEN: 2006	Statemented pupils not placed in mainstream %: 2008
Total pupils with SEN per thousand: 2008	-0.55	-0.53	0.03	-0.21	0.14
Pupils with statements per 1000 pupils: 2008	0.62	-0.06	0.09	-0.03	-0.26
Limiting long-term illness per 1000: 2001	-0.35	-0.21	-0.17	-0.15	0.28
Disability Living Allowance: per thousand	-0.21	-0.03	-0.18	-0.21	0.29
Index of Multiple Deprivation	-0.47	-0.41	-0.09	-0.03	0.18

It can be seen from table 3.11 above that there is a large negative correlation between the percentage of pupils with SEN who have a statement and the rate of pupils with SEN (per thousand pupils) (-0.55). In other words, authorities with *more* pupils with SEN were statementing a significantly *lower* percentage of them. It makes sense that local authorities with a proportionately larger group of pupils with SEN (suggesting a lower threshold) should

use statements for a smaller proportion of them than a local authority with a smaller rate of SEN (suggesting a higher threshold). The correlation of the percentage of pupils with SEN with a statement is positively correlated with the rate of all pupils with a statement (0.62), but this is hardly surprising.

The percentage of pupils with SEN who have a statement was negatively correlated with the other two prevalence indicators (limiting long-term illness: -0.35; Disability Living Allowance: -0.21), suggesting that *higher* rates of disability were associated with *lower* rates of statementing among pupils with SEN. This is despite the fact that the rate of statements among all pupils was positively correlated with both limiting long-term illness and receipt of Disability Living Allowance. The percentage of pupils with SEN with a statement was also negatively correlated with the Index of Multiple Deprivation (-0.47), indicating that more deprived areas, on average, had *lower* rates of pupils with SEN who have statements. These correlations suggest a complex relationship between levels of SEN and statementing. Whilst the rate of pupils with SEN was strongly related to deprivation, the overall level of statementing was not; however, the percentage of pupils with SEN who have a statement was negatively correlated with deprivation. This suggests that more deprived areas have higher levels of SEN, but give statements to fewer of the pupils with SEN. The correlation is shown as a scatterplot in Figure 3.2 It is clear from this figure that, although there is a negative correlation with the Index of Multiple Deprivation, very different levels of the percentage of Pupils with SEN who have a statement are found for any level of deprivation.

Figure 3.2 Percentage of pupils with SEN who have a statement



Attainment gap at Key Stages 2-4: 2007

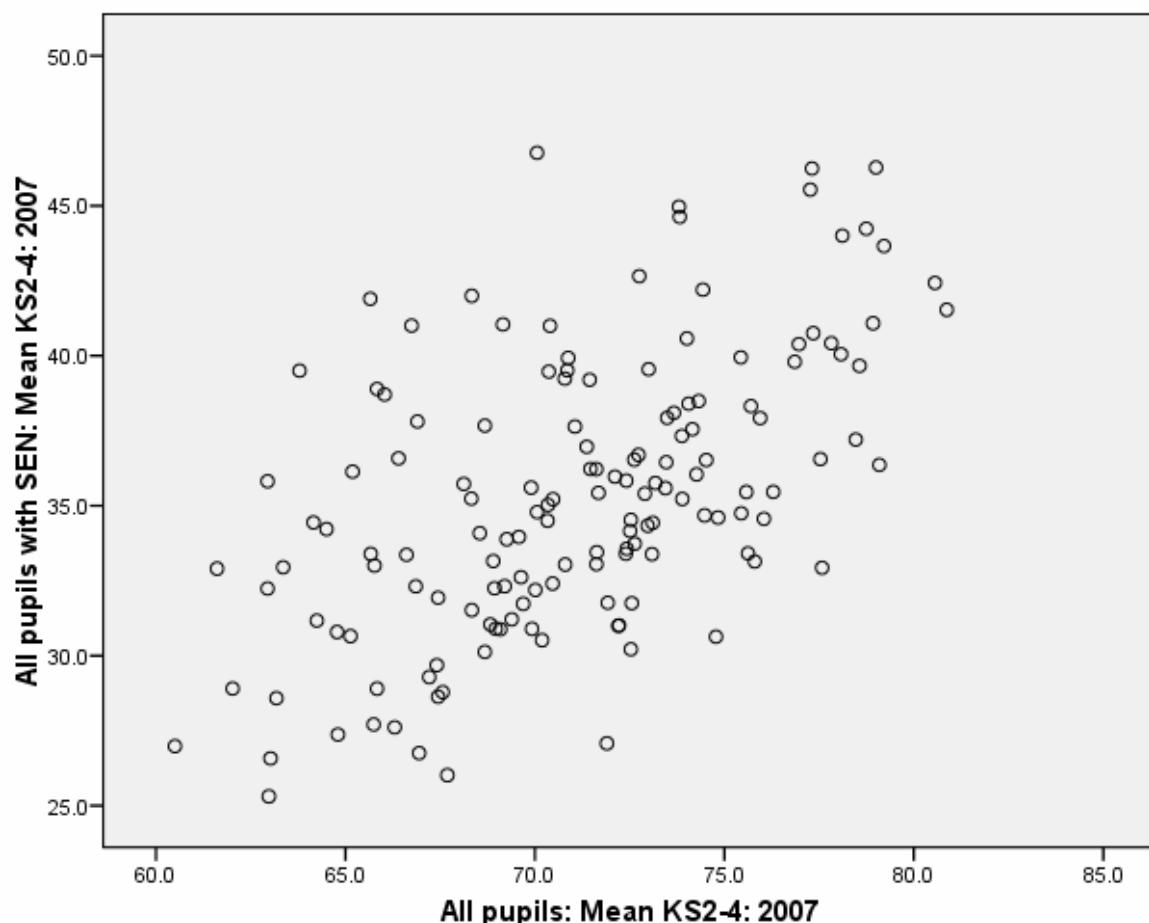
DCSF publish statistics on performance at Key Stages 2, 3 and 4 both for all children in each local authority and for pupils with SEN. The statistics are in the form of the percentage of pupils performing at the level expected for their age. For this analysis, an average across these three stages has been calculated, and the means are shown in Table 3.12. DCSF publish statistics on Key Stage performance both for pupils with SEN who have statements and for those without. For this analysis, those were combined to give an overall figure for all pupils with SEN. The reason for this was that it is the gap between attainment of all pupils and all pupils with SEN that is used in the National Indicators (DCSF, 2009): ‘National Indicator 104 is the percentage point difference in performance at KS2 between pupils with and pupils without special educational needs.’ (p. 59) and ‘National Indicator 105 looks at the percentage point difference in performance between pupils with and without special educational needs. We measure this through those who achieved at least five A* to C GCSE grades or equivalent including English and Maths at the age of 16.’ (p. 63).

It can be seen that 71.1 percent of all pupils, across these three stages, were performing at the expected level. The range was from 60.5 to 80.9. The lower quintile was 66.9 and the upper quintile was 74.8, indicating quite a narrow range of percentages across local authorities. This is reflected in the coefficient of variation, which is just 6.6 percent. The mean for pupils with SEN was much lower, at 35.3 percent, just half of the percentage for all pupils. The coefficient of variation is also low, at 13 percent, but this is again double that for all pupils, indicating that local authorities vary more on the average Key Stage performance of pupils with SEN than of all pupils. The correlation between attainment scores for all pupils and pupils with SEN was very high (0.56), showing that where all pupils do well on the Key Stage tests pupils with SEN also tend to do well. This is shown graphically in Figure 3.3.

Table 3.12 Means of Key Stages 2-4

	Mean	Std. Deviation	Lower Quintile	Upper Quintile
All pupils: 2007	71.1	4.5	66.9	74.8
All pupils with SEN: 2007	35.3	4.6	31.2	39.5

Figure 3.3 Mean scores for Key Stages 2-4: 2007



For each local authority, the difference between the average for all pupils and for pupils with SEN was computed. The average was 35.7 percent (shown in Table 3.10), with little variation: from 32.3 percent in the lowest quintile to 38.8 percent in the highest, with a coefficient of variation of 12 percent. Table 3.11 shows that the correlation with the overall number of pupils with SEN was negative (-0.53), so that the lower the number of pupils with SEN the higher the average gap, with pupils with SEN doing relatively worse than all pupils. This indicates that the more children with SEN a local authority has as a percentage of all pupils, the smaller the attainment gap between pupils with SEN and all pupils. This in turn suggests that authorities with a higher percentage of pupils designated as SEN are setting a lower threshold, so that their pupils with SEN are performing closer to all pupils in the area compared to authorities with a higher threshold, and a lower percentage of pupils designated as SEN. These pupils might be expected to have more severe problems, and so their performance is much poorer than that of all pupils in the area.

The correlation with the Index of Multiple Deprivation was negative (-0.41), indicating that areas with higher deprivation had smaller gaps in the Key Stage data, between all pupils and pupils with SEN. The correlation between deprivation and the average score for Key Stages 2-4 for all pupils was much higher than this, at -0.74, reflecting the known tendency for more deprived areas to have worse education performance. However, the correlation with the average score for all pupils with SEN was lower, at -0.34, indicating that deprivation has a higher impact on the gap between all pupils and pupils with SEN than on the scores of the pupils with SEN. These correlations indicate that in more deprived areas, all children, on average, have lower attainment than in less deprived areas. Consequently, the gap for pupils with SEN will be smaller.

This is confirmed by the partial correlation between deprivation and the attainment gap, controlling for the average attainment of all pupils in the area: this was 0.13, a very small positive value but not statistically significantly greater than zero. So the attainment gap is not related to deprivation after controlling for the overall level of attainment in the area.

SEN appeals per 10,000 pupils: 2005-2007

As we noted in chapter one, parents can appeal to the Special Educational Needs and Disability Tribunal (SENDIST)¹⁴ concerning decisions made by the LEA regarding the decision to assess, to write a statement and the content of statements. The average rate of appeals was very low, just 4.1 per 10,000 pupils (Table 3.10). The variation between authorities was very high, with a coefficient of variation of 78 percent and a variation from 1.7 appeals per 10,000 pupils in the lowest quintile to 6.2 in the highest. But such small annual numbers of appeals (the figure used here was averaged over two years) means that differences between authorities are probably not reliable, and could vary from year to year.

However, it was expected that appeals would be more frequent where the rate of statements was low, with the potential for more parents being dissatisfied with their child with SEN not having a statement. In fact, the correlation was almost zero (0.09), indicating no relationship between the rate of statementing and the rate of appeals.

SEN spending per child with SEN population: 2006 (£)

Local authorities are required to report annually to DCSF on educational spending. Our analysis here focuses on the item reported which shows 'SEN funding (Not for special schools)'. For this analysis, that figure has been divided by the number of pupils with SEN, to give a figure for SEN spending per child. The average for this spending was £1,466 in 2006; the lower quintile was £1,045 and the upper quintile was £1,818 (Table 3.10). The coefficient of variation was 39 percent, indicating that spending is much more variable between authorities than the rates of SEN and disability.

Spending per SEN pupil was negatively correlated with the rate of pupils with SEN (-0.21: Table 3.11), indicating that spending per pupil was less the more pupils with SEN there were. However, the correlation with the rate of statemented pupils was zero (-0.03), indicating that the level of spending per SEN pupil did not depend on the rate of statemented pupils, only on the rate of pupils with SEN overall. The correlation with the Index of Multiple Deprivation was also zero (-0.03), showing that spending was not related to the overall level of deprivation.

Statemented pupils not in mainstream education per 1,000

Finally, we also looked at the degree to which children with statements were being educated outside mainstream education. This figure comes from the annual SEN2 survey completed by local authorities, so covers children resident in (but not necessarily educated in) the local area. Pupils not in mainstream education was calculated as the sum of children in maintained and non-maintained special schools, independent special schools and other independent schools, hospital schools, and pupil referral units.

The average rate of statemented pupils not in mainstream schools was 42.5 per thousand or one in 24 (Table 3.10). The variation between local authorities in this rate was similar to the

¹⁴ From 3rd November 2008 the Special Educational Needs and Disability Tribunal ceased to exist as a stand-alone body and became part of a new two-tier Tribunal structure; the First-tier Tribunal and the Upper Tribunal. Cases are now heard by the SEN and Disability Panel (SENDISP) within the new Health, Education and Social Care (HESC) Chamber of the Tribunal.

variation in the number of statemented pupils: the coefficient of variation was 24 percent and the rate varied from 34.2 percent of children with statements in the lowest quintile to 49.7 percent in the highest. The rate of use of non-mainstream schools was negatively correlated with the rate of statementing, so local authorities with lower rates of statements had more children with statements in non-mainstream education. This makes sense since a lower rate of statements suggests they are being used for children with relatively high levels of needs. We also found a low positive correlation between the use of non-mainstream education and the two measures of prevalence of disability, limiting long-term illness and receipt of Disability Living Allowance. This might be explained by local authorities with larger populations of disabled children having more specialist schools, an issue we discuss further in chapter six.

3.3.2 Correlations using quintiles

As with the other indicators, the quintiles for these SEN indicators were compared with quintiles for the prevalence indicators to help to illustrate and look further at the correlations reported above. The results for the upper quintile of pupils with SEN per thousand pupils are shown in Table 3.13.

Table 3.13 Upper quintile: pupils with SEN per thousand

	Lower quintile	2	3	4	Upper quintile
Percentage SEN with statement	12	12	4	2	0
Attainment gap	15	10	4	0	1
SEN appeals	5	3	8	7	7
SEN spending per child with SEN	11	4	6	6	3
Statemented not in mainstream	3	7	7	6	7

The high negative correlation of the overall rate of SEN with the percentage of pupils with SEN with a statement and the attainment gap is reflected in the larger numbers of authorities in the lower quintile for these two indicators who were in the upper quintile for pupils with SEN per thousand (12 and 15 respectively). At the other end the numbers are very small: there were no local authorities in the upper quintile for the rate of SEN who were also in the upper quintile for the percentage of pupils with SEN with a statement, and only two in the fourth quintile. For the attainment gap there was just one authority in the upper quintile, and none in the fourth quintile.

The negative, but lower correlation, with SEN spending per child with SEN is also apparent: there were 11 authorities in the lower quintile for SEN spending per child with SEN who were in the upper quintile for pupils with SEN; however, there were also three in the upper quintile for spending, indicating that both high and low levels of spending were compatible with high levels of pupils with SEN.

The rate of SEN appeals and statemented pupils with SEN not in mainstream each had a correlation of almost zero with the rate of pupils with SEN per thousand, and this is reflected in the much more even distribution across the quintiles for these two indicators.

3.3.3 Correlations between the SEN indicators

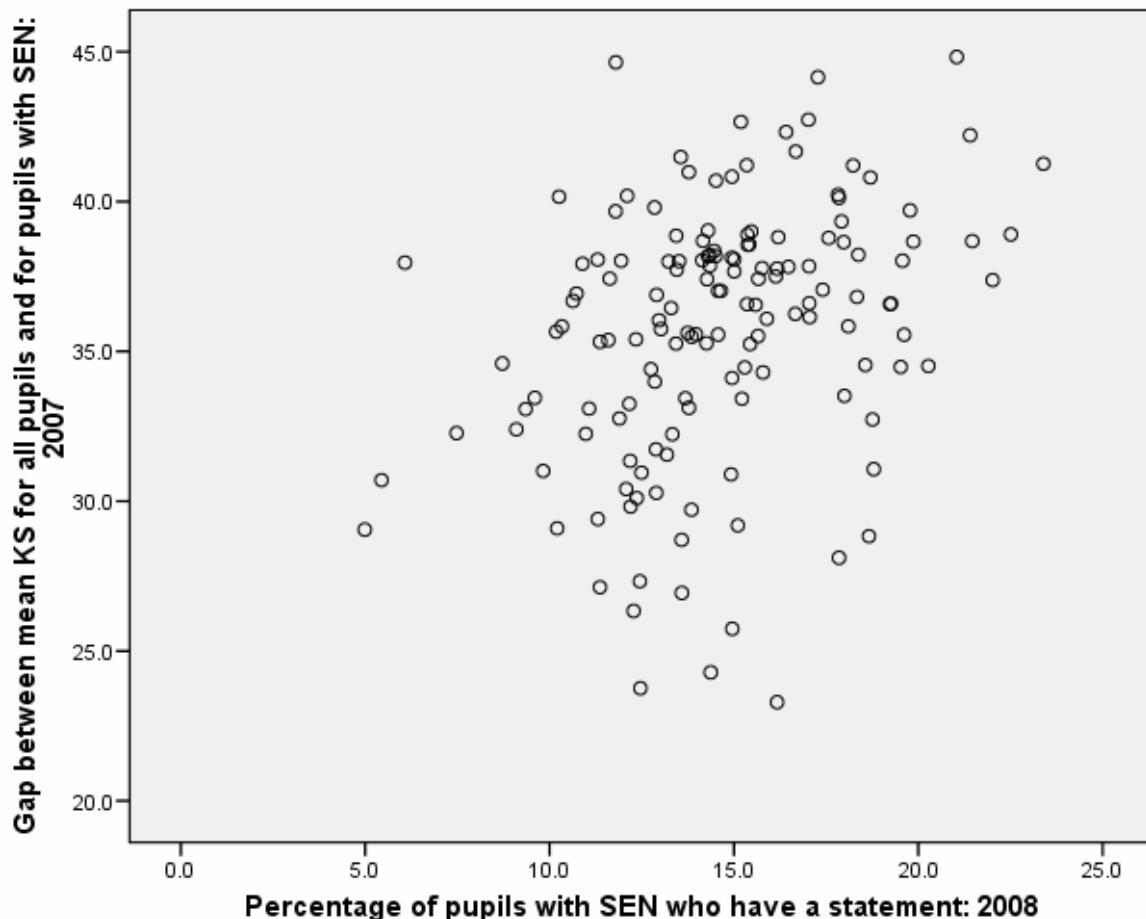
We also looked at patterns of association between the five SEN indicators. The correlations are shown in Table 3.14. The first column shows that there was a positive correlation between the percentage of pupils with SEN who have a statement and the attainment gap (0.34) – so local authorities who statement more of their pupils with SEN also had a bigger attainment gap. It is not obvious why statementing fewer of the pupils with SEN should be associated with a smaller attainment gap for all pupils with SEN. Perhaps local authorities who statement fewer of their pupils with SEN are working with the pupils with SEN in such a way as to improve their overall performance. The relationship is shown in figure 3.4. This shows that, although there is a moderate correlation, there is still a lot of variation in the relationship: for most values of the percentage of pupils with SEN who have a statement (along the bottom axis) there can be a wide range of values for the attainment gap between all pupils and pupils with SEN. This means that although, on average, the higher the percentage of pupils with SEN in an authority who have a statement then the bigger the gap in attainment, for any single authority the percentage of pupils with SEN who have a statement is not a good predictor of the attainment gap.

Table 3.14 Correlations between the SEN indicators

	Percent-age of pupils with SEN who have a statement: 2008	Gap between mean KS for all pupils and for pupils with SEN: 2007	Average rate of appeals per 10k: 2005-07	SEN spending per child with SEN: 2006	Statemented pupils not placed in mainstream: % of all statemented: 2008
Percentage of pupils with SEN who have a statement: 2008	*	0.34	0.08	0.15	-0.34
Gap between mean KS for all pupils and for pupils with SEN: 2007	0.34	*	-0.40	-0.01	0.07
Average rate of appeals per 10k: 2005-07	0.08	-0.40	*	0.04	-0.13
SEN spending per child with SEN: 2006	0.15	-0.01	0.04	*	-0.22
Statemented pupils not placed in mainstream: % of all statemented: 2008	-0.34	0.07	-0.13	-0.22	*

The first column also shows a negative correlation between the percentage of pupils with SEN who have a statement and the percentage who are educated outside mainstream schools. This is consistent with the earlier analysis and suggests that local authorities with a low percentage of statements for pupils with SEN are targeting statements to children with higher levels of need and particularly using them to access specialist placements (given that a statement is required for a child to attend a special school). Consequently, areas with fewer of their pupils with SEN having statements make more use of placements outside of mainstream schools for them.

Figure 3.4 Percentage of pupils with SEN who have a statement against attainment gap



As we found when we looked at our other measure of the use of statements – statements per thousand pupils – the correlation between the percentage of pupils with SEN who have a statement and the rate of appeals is almost zero (0.07). The third column shows that the rate of appeals is negatively correlated with the attainment gap. In other words, local authorities with a higher rate of appeals also have a lower level of gap in attainment. This is surprising since one might have expected to find a higher rate of appeals where pupils with SEN are falling further behind their peers. But the appeal rate is likely to be a more imprecise measure.

Table 3.15 shows some of these relationships looking at the highest quintile in terms of the percentage of pupils with SEN who have a statement. The table shows the association between the percentage of pupils with SEN who have a statement and the attainment gap – of the 28 local authorities in the top quintile for statements, 16 are in the highest two quintiles for the attainment gap. It also shows that there is an association between the percentage of pupils with SEN who have a statement and the level of appeals. We found the opposite picture in our correlation analysis which showed a negative correlation – so this illustrates the level of variation that sits within the overall picture. The distribution of the highest statement quintile across the groups relating to SEN spending is broadly even, consistent with our earlier finding of no correlation here. And finally the table shows that the local authorities with the highest rates of statements for pupils with SEN are less likely to use non-mainstream education for them, and so less likely to use specialist placements.

Table 3.15 Upper quintile: percentage of pupils with SEN who have a statement

	Lower quintile	2	3	4	Upper quintile
Attainment gap	3	4	5	10	6
SEN appeals	3	6	3	8	8
SEN spending per child with SEN	6	7	5	6	4
Statemented not in mainstream	11	6	6	3	2

3.4 Summary

This chapter has presented a large number of statistics on SEN and disability in local authorities, with a particular emphasis on SEN, and has examined the relationships between the statistics and variations between local authorities.

Starting with prevalence, we looked at the rate of pupils with SEN and the rate of pupils with statements, and at two measures of disability—the rate of children with a limiting long-term illness in the 2001 census and the rate in receipt of Disability Living Allowance. The correlations between the rate of SEN and disability were quite high, suggesting that these three measures were each related to the underlying level of need in the area, but the correlation with statements was lower. However, overall correlations masked patterns of variation for individual authorities. We also looked at the prevalence of the two exemplar conditions, ASD and hearing impairment. The correlations with overall SEN and with the two indicators of disability prevalence were positive, but not high, indicating the specificity of each SEN, such that areas with a high level of children with one condition may not have a high proportion of children with the other.

It was expected that overall levels of SEN and disability would be related to economic deprivation, so these four measures were correlated with the Index of Multiple Deprivation. Rates of SEN, children's long-term illness and receipt of Disability Living Allowance were all related to deprivation, but the rate of pupils with SEN statements per thousand pupils was not. This suggests significant local authority variation in their policy on statementing.

We also looked at a range of measures likely to be indicative of local authorities' policies and practices. Although the overall rate of pupils with statements was not related to deprivation, the percentage of pupils with SEN who had a statement was, but negatively: this means that more deprived areas had more children with SEN but fewer of them had statements.

Strikingly, on the average Key Stage measure, pupils with SEN were only half as likely as all pupils to be performing at the level deemed appropriate for their age. These measures showed an interesting pattern of relationships with overall levels of SEN. The percentage of pupils with SEN who have a statement was much lower where there were more pupils with SEN. There was a negative correlation between the rate of pupils with SEN per thousand pupils and the gap in Key Stage attainment between all pupils and pupils with SEN. This is not surprising, as higher rates of pupils with SEN imply a lower threshold, and consequently a group with less severe needs, and so less different in attainment to all pupils.

The attainment gap was negatively related to deprivation, such that more deprived areas had smaller attainment gaps: this reflects the much lower average attainment for all pupils in more deprived areas, so that poor performance by pupils with SEN was less different than that for all pupils. SEN spending per child with SEN was negatively correlated with the number of pupils with SEN, meaning the more pupils with SEN there were, the less was spent on each of them, on average. This may reflect limited resources – as the number of pupils with SEN increases the spending has to be spread thinner – or it may reflect different thresholds for assessing a child as SEN, so that in areas with lower thresholds the average level of need within the SEN population is lower, and so less spending is required. We saw that local authorities with lower rates of statementing among pupils with SEN make more use of non-mainstream schools for those children with statements. Finally, we saw that there is no association between the rate of statementing (using either measure) and the rate of appeals, and no association between the use of non-mainstream schools and the rate of appeals.

So the statistical analysis has supplied us with a lot of valuable information about SEN and disability and how they vary between local authorities. These issues were discussed further in the case study research with local authorities and reported in the chapters that follow.

Chapter 4: Multi-agency and multi-disciplinary working

This chapter looks at the extent and nature of multi-agency and multi-disciplinary working in the case study local authorities, the forms that this takes at strategic and operational levels, and how this helps or hinders local authorities to develop and deliver effective services for children with SEN. By multi-agency we mean working across two or all of education, social care and health, as well as with the voluntary and community sector. Of course, as Children's Trust arrangements bed-in these are not necessarily still separate agencies. By multi-disciplinary working we mean working across professional groups, which might be within education, for example, or across agencies. We use the term 'multi-agency' where this distinction cannot be made.

The literature review outlined the role that an integrated, multi-agency approach plays in the provision of services which most effectively support children with SEN. In section 4.1 we begin by looking at the strategies and systems that underpin effective multi-agency working, and how these support the development of services for children with SEN. We consider what facilitates, and hinders, strategic links between statutory agencies and other stakeholders. In section 4.2 we explore the operational aspects of multi-agency practice, including multi-agency teams and child-centred approaches such as team around the child. In section 4.3 we discuss the links between strategic and operational multi-agency practice, and in section 4.4 we consider how size and type of authority can impact on multi-agency working. Finally in section 4.5 we look at the involvement of parents and Parent Partnership Services, children and the voluntary and community sector in strategy and service planning. Multi-agency and multi-disciplinary work is discussed further in the following chapters in relation to identification, assessment and referral, and SEN provision in schools.

4.1 Strategy and systems

4.1.1 Multi-agency strategies

Across the case study local authorities there was a commitment to the principle of multi-agency working, although there was considerable variation in how embedded this was in planning and practice. The most embedded multi-agency and multi-disciplinary practice was generally characterized by clear and integrated systems, processes and strategies, and a commitment to these across agencies and by staff in senior, service management and front line roles.

The case study local authorities were at different stages in the development of multi-agency strategies on inclusion, SEN or disability. This ranged from those who had an established and embedded multi-agency strategy, to those who were in the process of developing or planning the development of one which would update an existing strategy that was not multi-agency. Almost all recent and planned strategic development work involved a multi-agency process which included a range of statutory and other organizations (see 4.1.3 and 4.1.4 below). Authorities felt that integrated strategic processes resulted in a 'common cause' or 'shared vision' which facilitated more holistic and child-centred services, as agencies, services and staff had a better understanding of each others' roles and priorities, as well as 'buy-in' to a multi-agency approach. The authorities with the strongest and most embedded multi-agency working practices also tended to have inclusion or SEN strategies which were clearly linked to other local and national strategies and policies, eg their Children and Young People's Plan or Every Child Matters outcomes (DfES, 2004).

Very few authorities had a separate strategy for hearing impairment, although the majority said that they had a separate multi-agency strategy or plan for ASD services.

A number of reasons were given for this difference: greater demand for ASD-specific planning and services from ASD steering, monitoring or service development groups (many of which included parents and the voluntary and community sector); higher prevalence; and the complex needs of many children with ASD. Most ASD strategies had been developed within the authority, but one case study had undertaken a regional multi-agency review of ASD services which resulted in a strategy which covered two neighbouring local authorities. While this was felt to have been a useful process, there was a view that there needed to be more clarity about ownership of this strategy and how it would be implemented and reviewed. This echoes a wider point made in many of the case studies about the importance of ensuring that strategies are clearly linked into structures and processes (see section 4.1.2 below). As with SEN and inclusion strategies, it was felt by many of those local authorities who had, or were developing an ASD strategy or plan, that this was a key factor in improving multi-agency working in ASD. Similarly, multi-agency hearing impairment strategies were also thought useful.

4.1.2 Multi-agency groups

Most SEN, disability or inclusion strategies in the case study authorities were developed and reviewed through multi-agency groups. These groups undertook a range of roles including development and monitoring of strategies, planning and commissioning. Membership varied but generally included:

- SEN, disability, access and inclusion leads.
- *Education staff* including: Headteachers, school governors and other school representatives both from mainstream and specialist provision, SENCOs, educational psychologists, education welfare, school improvement and behaviour support services.
- *Social care and other local authority staff* including: Social workers and social work managers, Connexions, managers of Specialist Disability Services (eg ASD or hearing impairment support services), representatives from safeguarding boards, youth and youth offending services.
- *Health staff* including: PCT managers and hospital representatives, paediatricians, diagnostic teams, clinical psychologists, speech and language and occupational therapy, Child and Adolescent Mental Health Services (CAMHS) and Mental Health Trust managers.
- Parent representatives, Parent Partnership Services and voluntary and community sector organizations (although their inclusion varied, see 4.1.4 below).

Those authorities with the strongest and most integrated multi-agency working generally had established groups clearly linked to each other and also to decision-making and strategic planning processes.

Several authorities mentioned the need to keep such groups under review, in order to ensure that they did not get too big, lose focus or become disconnected from other systems and processes. In some local authorities where multi-agency strategic working was felt to be proceeding less well, there was a perception that initiatives and groups were operating without a clear strategy, key agencies were missing and there was a less coherent overall approach:

'We had a SEN strategic group which I was involved in, the SEN Manager ... the Principal [Educational Psychologist], and various other key officers in the authority [including the school improvement lead officer] but that was disbanded ... and we now have... someone from the PCT ... a parent... education but also social care ... [health are] not quite [on board] in my view but ... next month I think we've got a new [health] person coming in so everyone's quite optimistic.' (Unitary, Parent Partnership Service Coordinator)

As noted above, many case study authorities had, or were developing ASD-specific strategies. Other ASD groups were focusing on the development of pathways and provision, but not linked to a specific strategy. The overall picture in relation to ASD is of a strong commitment to stakeholder involvement, and of processes and groups that included the views and priorities of a range of stakeholders. Other areas in which specific groups were mentioned included complex or high care needs, where close working between education, health and social care was seen as particularly important. As with strategies, there were far fewer examples of multi-agency groups for children with hearing impairment. However, several authorities mentioned Children's Hearing Services Working Groups (CHSWGs): multi-disciplinary groups which involve professionals and local service users, and take the lead in monitoring and developing integrated service delivery for deaf children and their families. These groups are linked into the NHS Newborn Hearing Screening Programme (see chapter five), were generally linked to particular hospital or a PCT and typically included a broad range of professionals and other representatives:

'The Paediatrician, the Educational Audiologist, myself [Head of Sensory Needs Service], the [Children's Trust] Commissioning Officer, Audiologists Head of the Newborn Hearing Screen, parent representatives, voluntary agencies.' (Shire, Head of Children with Sensory Needs Service)

Most of the CHSWGs mentioned by interviewees were involved in some joint commissioning of services, but several interviewees identified as problematic that this was often done informally. It was also felt that CHSWGs were more effective when they operated at a strategic level rather than: '*getting bogged down with the day to day operational stuff*' (Metropolitan, District Hearing Impairment Lead).

4.1.3 What facilitates strategic links between statutory services?

There were strong links between the stage of a local authority's implementation of Children's Trust arrangements and how embedded and effective their strategic multi-agency working appeared to be. In fact several of the authorities which appeared to be strongest in this area had been pilot or pathfinder Children's Trusts, whereas several of those who had the least developed multi-agency working had either not yet become a Children's Trust or had only done so very recently.

Strong leadership and senior management support were also identified as key drivers in the development and implementation of multi-agency and multi-disciplinary working, particularly in relation to the development of links between services. They were central features in those local authorities with the most established practice, and acknowledged to be lacking in the few authorities who felt that they did not yet have the strategies and systems in place to support multi-agency working:

'We haven't yet developed the relationship or the working practices which bring us, social care and health, as close together as we can be... we don't have the processes to guarantee it but ... we have, I think, on occasions, outstanding practice ... there are issues around leadership which still get in the way... [but] the new Director has said very clearly that we are going to introduce integrated locality working.... we're putting in place the structures now, as we restructure children services.' (Shire, Head of Inclusion and Complex Needs)

As one would expect, particularly given the establishment of Children's Services in local authorities, the closest and most established strategic links tended to be between education and social care, though there were some challenges because of the different populations with which each agency is concerned:

'Because [social care] criteria is tight, in terms of what constitutes disability, the majority of the children in mainstream schools don't fit their criteria.' (Shire, Principal Educational Psychologist)

'Social care see things slightly differently [than] say from an educational perspective because the young people who tend to present more challenges for schools are those with perhaps not the top end of difficulties... and I think that's a problem because it sort of slants criteria in a way doesn't it?' (Unitary, Parent Partnership Service Coordinator)

However these issues are being addressed in many of the case study Children's Trusts, as well as through strategic groups and joint training. The involvement of health was felt by interviewees to be key to the development of effective services for children with SEN, many of whom are also disabled. One interviewee who talked about a strong link with health mentioned links at a number of different levels:

'I think the relationships with health in [local authority] are extremely good, and certainly if I make the comparison to my experience in [other local authorities, we have] excellent links with paediatricians, with health, the school nurses, even the hospital ... helped by the fact that [local authority] is coterminous with the PCT, so the boundaries are the same.' (Unitary, Head of Assessment, Intervention and Psychology)

But with the exception of speech and language therapy, there were far fewer examples of multi-agency working with health. Several authorities had struggled with engaging health for various reasons, particularly the authority not being coterminous with PCT boundaries and differing priorities and structures, for example the fact that health services are not age-limited and are structured around different specialisms which do not necessarily fit well with definitions of SEN or social models of disability. In some areas, the lack of a consistent health lead on disabled children or those who have SEN (eg due to restructures or changes in role) had further complicated joint working.

'There are difficulties with health, particularly in terms of [their] capacity and ... actually finding the right person who's going [to be able to] impact and influence practice.' (Shire, Head of Inclusion Services)

Another interviewee mentioned a tension between local authority targets '*which obviously revolves around the needs of children and young people*' and health targets which are focused on the general population and acute health problems. This created challenges in terms of information sharing (see 4.1.6 below) and in terms of '*finding the right person*' to facilitate the development of multi-agency working.

4.1.4 Strategic links with other services and parents

Those authorities with strategies that had been written relatively recently, or were about to be reviewed, often had input from the voluntary and community sector, the Parent Partnership Service and parents. There was a general understanding that this would lead to better and more integrated services for children with SEN. However, there was a lot of variation in their involvement, and little involvement of children with SEN. This is discussed further in section 4.5 below, but it is worth noting here that those authorities who broadened their definition of 'multi-agency' beyond the statutory agencies to include these organizations or individuals, tended to have more 'buy-in' and generally more robust multi-agency working at all levels:

'We are doing some evaluation [of a child and family support service] ... and I think almost invariably the feedback and from all the other national research about multi-agency working, more integrated working, is that parents and young people and children actually think it's a much better way of working.' (Metropolitan District, Manager Children's Disability Team)

There was a general commitment to involving a range of stakeholders (although there was sometimes a difference in opinion between local authorities and voluntary sector or Parent Partnership Services about how wide and how 'equal' their involvement was). Conversely, those local authorities with less developed multi-agency working also tended to have limited or patchy involvement of the voluntary and community sector, Parent Partnership Service and parents at a strategic level.

4.1.5 Joint commissioning and budgets

Joint commissioning and pooled budgets were acknowledged by all the case study local authorities to be important, and were seen as facilitators to effective multi-agency working:

'Part of the advantage [of multi-agency commissioning] will be to be able to worry a little bit less about exactly whose responsibility something is...I think if we have got some more joint commissioning and pooled budgets then we would be able to worry a little bit less about that and a little bit more on just looking at, well, what are the child and family's needs?'
(Metropolitan District, Inclusion and Access Manager)

The arrangements local authorities had in place varied, for historical reasons as well as in response to local circumstances and need, but all had at least one of the models below, which were often interlinked:

- pooled education and social care budgets as part of Children's Trust arrangements
- pooled budgets for specific services (eg speech and language therapy, out of area placements)
- tripartite funding arrangements, generally taking the form of pooled education, health and social care budgets allocated on an individual needs-led basis to children in specific SEN groups, particularly high care or complex needs, often linked to a multi-agency assessment panel or process
- multi-agency commissioning groups, some with their own (pooled) budgets and some which made referrals or recommendations to budget holders
- jointly funded posts, including some focused specifically on commissioning.

Generally it appeared to be easier for education and social care budgets to be pooled, which is linked to the establishment of children's services departments. While some authorities were able to develop tripartite and other joint funding and commissioning arrangements with health, this was complicated by the different structures and priorities of health providers. Several authorities said that they were '*moving towards*' more joint commissioning and pooled budgets with health. Of those who were already doing so, many said that they already had good working relationships with health at strategic and operational levels. Joint commissioning with health, was generally managed through groups focused on children with complex or high care needs, who were felt to be most in need of multi-disciplinary support. These groups either had a pooled budget from which they could commission services, or negotiated which agencies should fund services on a case by case basis. The former, underpinned by formal processes and protocols, had the most positive feedback from interviewees, although there were sometimes challenges caused by the focus on different population groups (as noted above) or how much each agency was able or willing to contribute.

Multi-agency commissioning groups were used particularly in decisions regarding out of area residential placements for children with complex or high care needs or social and behaviour problems. It was felt though that these placements are often driven by social care or family support needs rather than educational needs, and that better social care support would reduce the demand for such placements; this was seen as a particular issue for children with ASD. Further information regarding the use of out of area placements is given in chapter six.

4.1.6 Information sharing

Information sharing was seen as important for the strategic development and commissioning of multi-agency services, as well as for operational aspects. However, this was another area with considerable variation across authorities. There was an acknowledgement by many authorities that information sharing between agencies needed to be more systematic, and some were seeking to address this through multi-agency data groups or the development of shared databases. Information sharing is covered in greater detail in the next chapter (5.5).

4.2 Operational multi-disciplinary working

4.2.1 Integrated teams

All local authorities had some form of integrated working, including:

- *Integrated teams*: different disciplines working together in a team, eg education and social care staff working in the same team across the Children's Trusts.
- *Locality working*: multi-agency and multi-disciplinary teams based on different local authority localities rather than a service.
- *Co-location*: teams from different agencies physically based in the same location but continuing to operate fairly distinctly.

Integrated teams included a range of professionals, for example:

- *Diagnostic assessment teams* (see chapter five) including: clinical and educational psychologists, disability social workers and specialist education support staff.
- *Integrated services for disabled children* including: SEN early years and sensory support teams, Social workers for disabled children, community health and child development.
- *Multi-agency speech and language teams* including: Specialist teachers and learning support assistants, educational psychologists and speech and language therapists.
- *Early years communication teams*: brought together previously separate early years and speech and language therapy teams.
- *Locality teams* including: educational psychologists, education welfare officers, health visitors, school nurses, mental health services and family support workers.

Integrated teams were sometimes linked to specific types of service (eg speech and language therapy, outreach or assessment services), age groups (particularly early years) or areas of need (eg specific impairment groups, complex needs). Several of the most established multi-disciplinary services based around types of service or areas of need, as opposed to locality, had emerged in response to local need identified through groups and stakeholders or through existing working relationships between services and staff. Some of these then provided models which could be rolled out:

'Two of my speech and language teachers ...decided they wanted to work... in a multi-agency way. So they've developed a ... team which consists of the two specialist teachers, an educational psychologist and a speech and language therapist and some [specialist] support assistants....As a result of their work they've been able to identify much more'

specifically the needs of these children and put in the appropriate type of intervention, which has resulted in the fact that we no longer have waiting lists for the speech and language extra provision within the mainstream schools...it's really, really effective.' (Metropolitan District, Head of SEN Assessment, Provision and Review)

Examples of locality-based teams included:

- locating all education and social care staff in locality-based integrated teams as part of Children's Trust restructuring
- neighbourhood-based integrated services including staff from looked after children and social work teams, education, welfare and youth services
- integrated area teams including social workers, education welfare officers, learning and behaviour support services.

Both locality-based and other integrated multi-disciplinary teams were seen by many interviewees as a very effective model as it brought together staff from different disciplines, enabled service and staff development, facilitated better and more consistent communication and information sharing between parents, services and schools, and through improved communication enabled local authorities to better meet the needs of children who were most vulnerable or had complex needs.

Most of the above examples were also co-located, but there were also a few examples of co-location which were distinct from integrated and locality working, including:

- *Multi-agency 'locality bases'* where staff from different agencies could use these bases when they were working in a locality but were still based and managed within their original teams.
- *A multi-agency 'team around the child'* (see 4.2.2 below) which co-located the education inclusion support service, education welfare and social care inclusion support services. Management structures and referral processes had been kept within-agency, but it was hoped that these would at some point be integrated along with the inclusion therapy services. (There had been some resistance from health)

A number of obstacles to moving to better integrated operational working were identified. Some local authorities were less enthusiastic about locality working, because for many it was something that had only recently been implemented and was therefore fairly untested, and also because for some:

'If you try to create teams around a locality artificially you impose a management structure on top of [existing structures].' (London Borough, Principal Educational Psychologist)

The resource requirements of moving to multi-agency and multi-disciplinary operational working were also identified as an obstacle:

'We were tending to work in silos... [but there were anxieties about the move] to an integrated locality working methodology without any funding in between to make a transition ... we cannot jeopardise what we're currently doing because it's good, and we don't want to lose that...I think intellectually, morally, philosophically, everyone is signed up to it [multi-agency working]. It's a pragmatic question of how do we get from here to that.' (Shire, Head of Inclusion and Complex Needs)

Multi-agency working at an operational level in these authorities was more likely to be ad hoc or exist only in pockets of good practice, with a lack of information sharing, 'silo' mentality within services and resistance from managers:

'I'm finding middle management is the big issue around integration, because actually, they have the most to lose by it. They've had a lot of autonomy for a lot of time...and I think to a degree, in the multi-professional team, they're going to lose some of that.' (Metropolitan District, Principal Educational Psychologist)

Local authorities also spoke about concerns regarding the balance between developing 'homogenous' multi-disciplinary teams and having a 'common language', and retaining professional expertise and specialist provision. However, other local authorities said that they found initial resistance to multi-disciplinary working was addressed through securing commitment based on an understanding of the value of joint working; joint training and support from senior and service managers; and allowing sufficient time for new structures and ways of working to become embedded.

4.2.2 Team around the child and key-working

Different models of child-centred working, and different combinations of these models were used across the case study local authorities, mainly variations on team around the child, and key worker or lead professional roles. Several authorities said that they were moving towards a 'team around the family', school or community approach, shifting the focus to the wider context of children's lives. Those authorities who were using these child-centred models generally had more established multi-agency working practices, and were doing so in the context of established Children's Trust arrangements, strong strategy and planning and established multi-disciplinary teams, as well as a general strategic focus on inclusion and child-centred services. A child-centred approach was seen to be a valuable way to ensure that children got the most appropriate services quickly, and to facilitate information sharing and communication between professionals, services and with families.

As with integrated teams, both teams around the child and key-working were focused on particular groups of children with SEN, and in general areas in which multi-agency working was already well-established, such as early years or complex needs:

'Early years I'd have to say is an absolute strength [in multi-agency working]. I think sometimes that it's the obvious place to start I think, because ... it's a distinct group of people who are often involved with a child.' (Shire, Principal Educational Psychologist)

Several authorities suggested that implementation of the Early Support Programme had played a key role in the development of team around the child and key-working roles in early years, (also highlighted in chapters five and six) as well as the fact that services were generally better linked at the point of early diagnosis and assessment. One interviewee suggested that integrated working with older children was more resource-intensive, as well as an area that is less developed in social care.

Challenges to implementing child-centred models included a lack of funding to allow time for taking on these additional duties, leading to staff being reluctant to take on this role:

'It's a huge role and if you do take on that sort of key-working role then you take on the responsibility of everybody in the family. So that does become very, very time consuming.' (Unitary, Teacher for Hearing Impaired Children)

In case study areas where key-working was said to be working well the key worker or care coordinator role was often a specific role with associated status and clear responsibilities, although often combined with another role. Key-working also worked best when it was well-embedded into existing systems of referral, assessment and service planning.

4.3 Linking strategic and operational aspects of multi-agency working

The local authorities who appeared to have the strongest multi-agency working all said that they had strong links between strategic and operational aspects of their practice.

Communication across agencies and between managers and staff at all levels was a key facilitator, including regular staff briefings, joint training and conferences and other events to facilitate communication and share key messages and good practice. These authorities also spoke about having a ‘shared vision’ or ‘common cause’ across and within agencies, resulting in buy in from staff at all levels and other stakeholders (including parents and the voluntary and community sector), as well as good processes for information sharing:

‘There is an expectation on people that [multi-agency working] is part of their work and [when] they come round the table that they are committed to the agenda, they’ve got ownership of the strategies....and understand what their responsibilities are... it’s almost a given that [staff are] there for the common purpose of making a difference to children and young people.’ (Metropolitan District, Head of Inclusion, Children’s Services)

Those authorities who said that they had faced challenges with multi-agency working at a strategic level, or were at a fairly early stage, generally reported much weaker operational aspects of multi-agency working. There was often a lack of strategic planning in relation to multi-agency working alongside capacity and resourcing issues. There were also a few shire and small unitary authorities whose operational multi-agency practice was more developed at an operational than strategic level. Various reasons were given for this including a general lack of strategic leadership and absences or changes at senior management level, and problems with getting other statutory agencies, particularly health, on board. Several of them also said that their multi-agency working had developed fairly informally, and that they were now trying to develop more formal structures and processes. The operational practice in these authorities, while good in places, tended to be more patchy and ad hoc, often developed through historical links between services and teams rather than being underpinned by a broader vision of multi-agency working.

4.4 Local authority-specific factors

The size and type of local authority also had an influence on multi-agency working. Several interviewees in small local authorities felt that this gave them an advantage, and many of the authorities with the most embedded and integrated practice were the smaller case studies:

‘In a small place like [this local authority] ... people will come and will stay and so everyone knows each other.’ (Unitary, ASD Lead)

‘Because it is a very small borough... you can pick up a phone or you email somebody actually knowing who they are.’ (Metropolitan District, Inclusion Service Manager)

There were no clear overall differences in terms of the forms of multi-agency working employed between different types of local authority (unitary, metropolitan district, shire or London borough). However, shires were more likely to be at a development stage with multi-agency working than other types of authority, mention the challenges caused by having a number of PCTs within local authority boundaries, and discuss the difficulties of supporting multi-agency working across geographically dispersed services.

4.5 Involvement of service users and other agencies in strategy and planning

While not always directly related to multi-agency working, the involvement of parents, children, the voluntary and community sector and Parent Partnership Services in strategy and planning is closely linked to many of the systems and processes discussed earlier in this chapter. Many local authorities with strong multi-agency working also talked about the importance of involving a wider range of stakeholders in strategic groups and service planning.

4.5.1 Involvement of parents

Where parents were involved in the development of strategy or services this was seen to add value both to strategy and the resulting services, with increased input from parents, Parent Partnership Services and other parent organizations contributing to a sense of greater stakeholder buy-in to the local authorities vision for SEN services. This involvement tended to be through representatives on strategy and planning groups or through larger consultation exercises. The latter were often events focused either on a specific issue (eg transitions or short breaks) or more general reviews of SEN provision or strategy:

'Parents and carers were involved in [the development of the inclusion strategy], they weren't actually around the table ... [but] they were asked about it and consulted on and that information was then fed back into the strategy development itself.' (Metropolitan District, Head of Inclusion and Children's Services)

In a number of authorities the views of local authority managers on how well parents were involved differed from those of voluntary and community sector and Parent Partnership Service interviewees. For example, some strategic managers felt that a consultation process had gone well, but others said that parents needed to know more about the impact and outcomes resulting from their involvement, both through direct feedback and seeing changes in services. In authorities where involvement of parents was acknowledged to be an area in need of development interviewees mentioned issues such as:

- involvement not being seen as a strategic priority
- lack of expertise and knowledge of models of involvement in strategy and planning
- a perception that parents would not understand '*the bigger picture*'
- concerns about representativeness and that some groups of parents would dominate (eg educated, middle class parents or those who are more active in campaigning such as parents of children with ASD).

Those authorities who had more developed practice in this area and good feedback from Parent Partnership Services often mentioned having some or all of the following in place:

- a commitment to inclusion and seeking the views of all parents, including those who may be unlikely to engage with conventional methods of participation (attending planning meetings or consultation events)
- parents feeling that their views were listened to and acted upon by senior managers
- coordinated and strategic involvement, planned well in advance with times, locations and methods which were accessible to parents
- someone in the local authority with expertise in, and lead responsibility for participation (eg a dedicated Participation Officer)
- a participation 'champion' at senior management/strategic level
- training and support for parents
- an awareness of national guidance and resources on participation practice.

4.5.2 Parent Partnership Services

Parent Partnership Services, which became statutory through the SEN and Disability Act 2001:

'Work with parents of all children with SEN, to provide information and publicity, training, advice and support, to foster networking and collaboration, and to inform and influence local SEN policy and practice.' (National Parent Partnership Network, 2009).

PPSs were seen by interviewees as a key link with parents, and a means of representing parents' views in strategy and service planning. Local authority interviewees generally thought that PPS played an important role in disseminating information to parents and advocating on their behalf. However there was substantial variation in the extent to which PPSs were involved at a strategic level, and the amount of influence that they felt they had on strategy and planning. This variation in focus and strategic involvement appeared to be partly a reflection of the diverse ways in which PPSs were linked to the case study authorities, with some directly funded and based within or alongside local authority children's services, some directly funded but run as an '*arm's length*' service, and others commissioned from the voluntary and community sector as an independent service.

Resourcing also had an impact: many PPSs had a very small staff (one or two full-time equivalents) which meant that much of their time needed to be spent on casework. The reporting arrangements for PPSs into the local authority also varied, with several complaining of frequent changes in lead contact or line manager creating a feeling of not being connected to '*the bigger picture*'. There was a general feeling amongst PPSs that they should be involved in strategy and planning in order to represent parents' views as well as give their own perspective as a service, but several felt that they either were not given sufficient opportunities to do so, or did not have the capacity to attend as many meetings and groups as they would have liked:

'We need to be involved strategically, however I've been told, whenever I've raised it, as I say, over the last five years that you're always telling me how busy you are so you obviously don't have time to go to these other things as well do you?' (Metropolitan District, Parent Partnership Service Coordinator)

In those authorities where the service was seen to be working well the PPS was generally perceived as well connected to local authority strategy and planning, and playing a key role in facilitating the local authorities links to parents (both getting their views and disseminating information to them). The national guidance and benchmarking for PPSs (National Parent Partnership Network, 2009) were seen by both local authority and PPS interviewees as useful reference points, and several PPS interviewees also mentioned them in the context of informing their practice through regional and national links:

'Parent Partnerships have been doing benchmarking exercises now for... five years... [the regional meetings] compare how government strategies are being delivered [in different areas]....cover training, updating knowledge and sharing good practice ...the national meeting is where we have people from [DCSF] come and discuss new national initiatives.' (Unitary, Parent Partnership Service Coordinator)

The benchmarking, regional and national meetings were mentioned in many of the case study local authorities as a really useful way to share and develop good practice through training and information sharing. Information sharing between PPSs and the case study local authorities was more varied, with several PPS interviewees suggesting that the local authority could use their case data more effectively to inform service planning.

4.5.3 Involvement of children and young people

The involvement of children and young people was generally at a much less developed stage than that of parents. Most involvement of children was at the level of individual planning rather than strategy and service development. Several authorities mentioned Aiming High for Disabled Children (HM Treasury and DfES, 2007), the Disability Equality Duty (DRC, 2006) and other national guidance as an impetus to involve disabled children and those with SEN in the development of strategy and services, and some were starting to do this. One local authority involved children in scrutiny of children's services and described a recent Children's Trust meeting involving a large group of children and being chaired by them, and there were some other examples of creative approaches. But on the whole involvement at this level was taken to mean involvement of parents, and there were few examples of children's views directly influencing strategy and planning:

'This piece of work that's going out to tender now to create established pathways to consult and confer with disabled young people needed to be done a while ago ... information in our strategy groups should be accessible and time should be taken to feedback to young disabled people... there should be ways that young people could communicate on that.'
(Metropolitan District, Voluntary and Community Sector Service Manager)

In those authorities where there was work going on to involve children this included specific consultation events (eg regarding short breaks provision) or seeking children's views via schools. There was some acknowledgement that, as with parents, a more strategic and co-ordinated approach would be useful, as well as a need for specific expertise on involving children in ways which were accessible to them. Some interviewees also mentioned the need to consider how to include a wide range of children with SEN, including exploring methods of engaging children who do not use speech, those with challenging behaviour and ASD and also the '*forgotten*' group of children with mild or moderate SEN who do not engage with as many services and are therefore consulted less.

4.5.4 Involvement of the voluntary and community sector

As noted in 4.1.4, the involvement of the voluntary and community sector in local authority strategy was felt by many interviewees to lead to better and more integrated services for children with SEN. There was more voluntary and community sector input into service development than strategy, but this was often felt to be limited and some voluntary and community sector organizations said that they could have offered a lot more than they were given the opportunity to:

'There's an awful lot of skill and expertise out there in various third sector organizations and private organizations that [the local authority] don't seem to want or tap into.' (Shire, Voluntary and Community Sector Chief Executive)

In authorities with good links to the voluntary and community sector, they tended to be involved both as service providers and representatives of the views of parents and children with SEN. The expertise of specialist voluntary and community sector organizations in working with specific impairment groups, particularly ASD, was seen as particularly helpful by many local authorities.

Challenges to the involvement of the voluntary and community sector in service planning included the limited and short-term nature of the funding of many voluntary and community sector organizations working with disabled children and those with SEN.

Limited resources, as well as the fact that many voluntary and community sector organizations covered more than one local authority, meant that it could be difficult for voluntary and community sector staff to find the time to attend local authority strategy and

planning meetings even when they were invited. Another issue was the perceived conflict between the roles of many voluntary and community sector organizations as service providers receiving funding from the authority and involvement in strategy, service development and planning:

'There are times when I just wish I was involved [in strategy and planning] a little bit earlier so that we could maybe suggest things that might work for [the local authority] I think one of the assumptions that they and other authorities make is that [voluntary and community sector service providers] shouldn't really be involved... [but] we understand the rules about commissioning really well....if we weren't successful ... at least we would have been able to give an experienced view on what might work for [the local authority] in relation to these children.' (Metropolitan District, Voluntary and Community Sector Service Manager)

Several voluntary and community sector interviewees mentioned the importance of contracts and other means of formalising relationships between local authorities and voluntary and community sector organizations. This echoes the points made by Parent Partnership Services about the importance of the national benchmarks, with formal recognition of the role that these stakeholders can play in strategy and planning.

4.6 Summary

Across the case study local authorities there was a commitment to the principle of multi-agency working, and an acknowledgement that this facilitated the development of more holistic and child-centred services. There was considerable variation in how embedded this was in planning and practice, sometimes in response to local circumstances and need, but the key factors which appear to facilitate strategic multi-agency working are strong leadership, senior management commitment across education, social care and health, well-embedded Children's Trust arrangements, coherent and strategically linked systems and processes, established information-sharing protocols, some joint commissioning and/or pooled budgets and involvement of staff, parents and the voluntary and community sector. Well-embedded multi-agency and multi-disciplinary strategic practice were generally characterised by clear and integrated systems, processes and strategies facilitated through multi-agency groups.

At an operational level all the case study local authorities had some form of integrated working in place; either integrated teams, locality working, co-location or most commonly a combination. These multi-disciplinary teams, alongside child-centred approaches such as team around the child and key-working, were seen as a very effective way to bring together different services and disciplines in order to better meet the needs of children with SEN, although this needed to be balanced against retaining specialist skills and experience and providing time and support for new teams to gel and processes and systems to embed. Other factors which facilitated good operational multi-agency practice included addressing workload and resource implications of change, especially during transition; good communication systems within and between services and joint training and team building. The local authorities who appeared to have the strongest multi-agency working all had strong links between strategic and operational aspects of their practice, as well as good processes for sharing information across and within agencies and to other stakeholders. The involvement of stakeholders including parents, children with SEN, Parent Partnership Services and the voluntary and community sector was seen to add value both to strategy and the resulting services, contributing to better, more child-centred services and greater stakeholder buy-in to inclusion strategies.

Chapter 5: Identification, assessment and referral

The importance of early identification, multi-agency assessments and early intervention in meeting the needs of children with SEN were highlighted as good practice in the literature review (see 2.4.4). This chapter looks first at what local authorities were doing in terms of identification, assessment and referral and considers what supports effective practice in these areas. As we shall see, the picture is by no means a clear one and there was considerable variation both between and within the 16 case study authorities with systems described as better for some conditions or some age groups than others. We then consider variation in prevalence of children with SEN, with ASD or with a hearing impairment and what might explain this variation.

5.1 Identification

There were differences across local authorities in how robust identification systems were thought to be and therefore the confidence interviewees had in whether most children with SEN were being identified. In some authorities it was thought that identification of children with a significant SEN and/or disability was good, but identification of children at the lower end of the SEN spectrum, children performing well academically (such as children with Asperger's syndrome who were more likely to receive a late diagnosis), and children with late onset hearing impairment and conductive hearing loss, was less robust. In other authorities there was greater confidence that the systems they had in place, such as regular meetings between specialists and practitioners, specialist teams working within schools and early years settings, and training practitioners to recognize the signs of a special educational need, meant that most children in their authority were being identified. There was sometimes greater confidence in systems for identifying children within particular age groups such as the early years or primary-school age, or with particular conditions such as hearing impairment and less confidence about others, such as ASD.

5.1.1. Identifying children with SEN

Children thought to have SEN were usually first identified either by teachers or staff in early years settings; health practitioners such as health visitors, school nurses, paediatricians and GPs; or were brought to the attention of practitioners by parents with concerns that there might be a problem. Identification therefore appeared to depend very much on the skills of these frontline staff. Those authorities where leads were more confident that children were not being missed spoke about the investment the authority had made in staff training:

'We do put a lot of emphasis on early identification. We've done a lot of work around training in schools, whole schools training, training with other agencies as well, and a lot of work around SENCOs about identification.' (Metropolitan District, Assistant Director of CYP Service)

Concern that children were being missed was raised by leads in authorities where health visitors had stopped doing routine developmental checks. Leads in one authority described how health visitors had been the major referrers of children with a possible SEN, but since their developmental checks had stopped, there was now a gap in the system. There was no mention in this authority of the role of practitioners in early years settings, but reliance was said to be placed on parents to raise concerns.

Identification was often judged, especially by Parent Partnership Coordinators and voluntary and community sector representatives, to be better in the pre-school years than for school-age children. This was thought to be because in many authorities there was an emphasis

placed on early identification and intervention, as well as the particular skills of practitioners working in the early years:

'I think it's, it's about better skills and sort of an earlier recognition where the community health visitors and portage workers are picking up concerns about a child and somehow it seems like everybody has a real focus on finding out what the problems are in those early years.' (Metropolitan District, Voluntary and Community Sector Representative)

Some, but not all authorities said that there were regular school and pre-school 'review' meetings between practitioners and specialist staff from the local authority where concerns about a child who might have a special educational need could be raised and the most appropriate action discussed. Sometimes these meetings were multi-disciplinary or multi-agency, giving staff in schools and early years settings access to a range of professionals. These were said in school interviews to be an effective means of discussing concerns and identifying next steps.

Identification was also aided by the pre-school SENCOs (special educational needs coordinators) or pre-school SEN teams working in early years settings, family support workers attached to nurseries and primary schools, and the children's centre framework, which in one authority was central to early identification. Leads in this authority described the authority's extensive network of children's centres and the programme of universal visits by centre staff to families in the centre's catchment area, who were able to raise initial concerns about a child with appropriate health and educational professionals. Under this programme, contact is likely to be made with hard to reach families and those who generally do not engage with pre-school services – groups where children with possible SEN may be missed and not identified until starting school.

Few local authority leads mentioned routine school entry assessments that might pick up children with a possible special educational need, such as the assessment undertaken in one local authority of language skills for all children entering reception class. Nor were routine school entry assessments mentioned often in our interviews with primary school staff although secondary schools were more likely to have routine assessments at transfer. A study on the school entry hearing screen found that 10 per cent of services were no longer screening on school entry and there was considerable variability in coverage, referral rates, test techniques and protocols (Bamford and others, 2007).

5.1.2 Systems for identification at school level

Overall the school representatives felt that they had good procedures in place for identifying children who might have SEN. The main procedures highlighted were:

- teacher-led identification and reporting systems
- regular tracking of pupils' progress by SENCOs using school information systems
- pupil assessments; including reading, comprehension, spelling and cognitive ability tests, hearing screening on school entry (in place in some schools).

There appeared to be a difference in the relative emphasis between SENCOs regularly reviewing all pupils' progress to identify children who were struggling, versus relying on teachers to identify children to SENCOs which might then prompt the SENCO to review their progress. In either case, SENCOs clearly play a key role.

Schools in our sample said that they had several procedures in place to facilitate teacher-led referrals: referral forms, regular questionnaires to all teachers on their pupils' progress, termly meetings between SENCOs and teachers to discuss the progress of all children, and

SENCOs being available for informal, ad hoc contact. Analysis of data held on school information management systems provided an opportunity for some schools to track the progress of all pupils across the school. SENCOs, sometimes with members of the schools senior management team, reviewed this information on a termly basis, to try to identify the early signs of children experiencing difficulties. Alongside this, some schools, particularly primaries, had in place regular assessments of pupils' abilities in order to flag up children not progressing as anticipated.

Knowing that a child might have SEN before they started reception year or secondary school was felt to be important in identifying children needing support, both those already diagnosed and those about whom concerns had been raised. Primary schools, for example, said that they made use of transition meetings and visits to early year's settings to learn about children coming to them and secondary schools relied on the transfer of information from the child's previous school in enabling them to put support in place.

Secondary school informants saw primary schools as critical in the identification and assessment of children with SEN, and their own role as one of 'consolidation or escalation' of support. They reported that they usually got full pupil records on transfer, as required by the Education (Pupil Information) (England) regulations 2005. However, one secondary school reported that primary schools occasionally did not pass on information about behavioural concerns in a misguided attempt to give a child a 'fresh start' in their new school, and it was noted that getting full information was more difficult if a child joined the school through a route other than Year 7 entry.

5.1.3 Identifying children with ASD

In addition to the identification systems described above, identifying children thought to have ASD was in several authorities said to be assisted by ASD advisory teams and specialist teachers working in schools and early years settings. We were also told that more schools were referring as teachers became more aware of the characteristics of ASD. Health visitors were seen as playing a key role in the early identification of children thought to have ASD and, as described above, in those authorities where health visitors had stopped developmental checks, concern was expressed that children would be missed. Because there is no universal screening for ASD, and because of the developmental nature of the condition, both the National Autism Plan (NIASA, 2003) and the National Service Framework Autism Exemplar (DH, 2004b) emphasize the importance of child developmental surveillance programmes by primary care teams such as heath visitors to facilitate better identification.

There was variation between authorities in how confident leads felt that children with ASD were being identified early. In an authority with a higher than average prevalence of ASD, the lead commented that:

'There is that cohort of children who are diagnosed early on, they've got quite clear needs, and then there's another cohort that tends to surface around secondary transition ... [and] the really late diagnosis of the children in adolescence.' (Unitary, Educational Psychologist)

In another authority also with high prevalence for ASD, this time a shire, the key age for diagnosis was between seven and nine, which was said to reflect the national picture, although the average age for diagnosis is five (Howlin and Moore, 1997 cited in DfES and DH, 2004).

A number of reasons were suggested to explain late identification. There was a view that the very different structure and ethos of primary schools compared with secondary schools meant that it was only when some children transferred to secondary school that problems

arose. Primary school staff were thought to have a better understanding of autism than their secondary school peers, who often seemed to place less emphasis on identification in the assumption that children would already have been identified in the early years or at primary:

'... actually there's a better understanding [in primary schools] now of what the autistic spectrum can present itself as, because a lot of the youngsters I think in the early days were just deemed to be very naughty ... I think secondary schools particularly, if it's been identified then they are dealing with it, but it's when it hasn't been identified that's the issue.'

(Metropolitan District, Head of SEN Assessment, Provision and Review)

School staff failing to recognize or to misread signs of autism was another reason given for late identification. This emphasizes the importance of appropriate training and raising awareness of what to look for in identifying autism, as highlighted by both local authority leads and school informants. There were, however, fewer references to specific training on identification in those authorities where leads were less confident about identification and where schools were said to be missing children or referring inappropriately.

Finally, in an authority with a high Black and minority ethnic population but a low prevalence of ASD, cultural and language differences affecting how autistic behaviour is interpreted and understood were said to result in some parents from Black and minority ethnic groups not raising concerns about a child who might be autistic. It was said to be difficult for example when autism has no equivalent word or concept in the parent's first language.

5.1.4 Identifying children with a hearing impairment

The NHS Newborn Hearing Screening Programme is a national programme but, due to its phased roll out, had been running in some of the 16 authorities longer than in others – from seven years to just 18months. In most authorities interviewees felt confident that the Programme was picking up almost all children at birth with a hearing impairment and that it was having a significant impact on identification. The Programme was viewed to be working well in most of our case study authorities, although nationally this is not the case (MRC Hearing and Communications Group, 2008). This was attributed in part to the length of time the Programme had been running in an authority, so that initial problems with the new Programme had been resolved. Also, the national quality assurance procedures¹⁵, referenced by some leads, were likely to be impacting on service quality.

There were however two authorities where the Programme was said to be working less well. In one, the practice had been assessed as good, but interviewees felt that reporting between the screening service and other services was less robust. In this authority, multi-agency working was still developing and the integration of health had been slow. In the other, a shire authority covered by two PCTs, the service was said to be working well in one PCT, but not in the other due to staffing difficulties within the PCT. The hearing impairment lead explained that for the area of the authority covered by this PCT, there were significantly fewer referrals from the screening service.

Identification of late onset hearing impairment and conductive hearing loss was said to rely on the skills of practitioners, such as early years workers and teachers, in recognising the signs of a hearing impairment as well as the developmental checks and routine screening carried out by health visitors and school nurses. In authorities where there were problems with these identification systems it was thought that children with late onset hearing impairment or conductive hearing loss were being missed. The problems were to do with health visitors no longer doing hearing checks, school nurses unable to carry out the school

¹⁵ Involving visits to the service every 18 months to assess the screening service, and also audiology, education and social care services for deaf children under three, against a set of quality standards.

hearing screen due to capacity issues, and schools varying in their ability to identify children with a possible hearing impairment with some making no referrals and others referring inappropriately.

School representatives echoed local authority informants regarding the identification of hearing impairment. Initial screening was said to be done by the school nurse, a specialist teacher, an educational psychologist, the specialist hearing impairment unit at the school, an educational audiologist, or the central audiology service, but capacity issues within school nursing teams could lead to problems:

'Where there are concerns about hearing impairment I make a referral to the school nursing team ... probably the single most difficult and frustrating part of the job at the moment is trying to get support from them ... I don't know whether it's an organizational issue ... [but] we have really struggled over the last two years to get the school nurse in at all. We have the system to make the referral, but they're not getting picked up.' (SENCO, Primary School)

5.1.5 Supporting effective identification systems

Integrated services, multi-agency working and good communication between education and their partner agencies appeared to facilitate effective identification systems. Those authorities where interviewees were more confident that children were not being missed were characterized by a focus on practitioners' skills and raising awareness through training, good communication between agencies and regular opportunities for practitioners to discuss their concerns with specialists and support staff, and were more likely to be further along the road to multi-agency working.

5.2 Assessment and referral

5.2.1 Different assessment models

Following identification of children who are thought to have a special educational need, it is necessary to assess the level of need and the support and services that may be required. Not all children with special educational needs require the involvement of more than one agency, but where this is the case, for example for children with complex needs, a multi-agency assessment is a mark of good practice.

The assessment models described by our interviewees varied considerably in terms of who was involved and where they took place. At one end of a spectrum were multi-agency assessments involving relevant professionals from across the agencies in one single assessment, and at the other end, single agency assessments. Multi-agency assessments appeared more likely to occur in authorities where there was better integration and multi-agency working. As with identification, assessment in some authorities was reported to be better for the pre-school age group than school-aged children. It was said by many local authority leads and Parent Partnership Coordinators that a diagnosis was 'easier' to make for some children than others, when the condition was more obvious, for example there was a physical disability, or the child's needs were complex.

For children thought to have ASD, we found three models of assessments:

- *Multi-agency assessments*: involving, for example an educational psychologist, community paediatrician and speech and language therapist, with each doing their own separate assessment and then meeting to discuss results and reach a diagnosis. Much rarer were a single multi-agency assessment with all the

professionals on site at the same time, coming to a joint decision about the diagnosis – often referred to as a single joint assessment.

- *Assessments which were predominately health-led*, but professionals from other agencies were called upon as and when needed. In authorities with this model, it was sometimes the case that where the diagnosis was clear it would be made by the health professionals, but where there was some doubt or the case was complex professionals from across the agencies would meet to discuss and reach a diagnosis.
- *Single agency assessments* following a more traditional model involving only health – either paediatric or specialist Child and Adolescent Mental Health Services (CAMHS) in the assessment and diagnosis.

In five of the sixteen authorities, leads reported that families were referred to a Child Development Centre for assessment. More often, though not always, assessments at Child Development Centres were reported to be multi-agency. Some centres only covered the pre-school age-range whereas others covered children from birth to 19. Two authorities had access to specific ASD assessment centres. For example, the ASD coordinating centre in one of these authorities was a co-located service for diagnostic assessment specialising in ASD. Assessment varied in reported duration, from a single agency assessment in one authority which was said to involve a 1.5 hour clinic visit with a paediatrician, to a multi-agency assessment in another taking place over six months, though we were told that support was provided to the family during this time.

Paediatricians failing to make a diagnosis, but saying that they thought it ‘might’ be ASD or that the child had ‘ASD traits’, was said by leads in two authorities to cause difficulties. This practice was seen as particularly unhelpful for parents and local authorities and as one lead said, *‘they either meet the criteria for ASD or they don’t’*. There was also the suggestion that health-only assessments had the potential to lead to over-diagnosis because a full picture of the child may be lacking:

‘It’s quite easy for a professional, a medical professional, to hear the story and identify ASD and diagnose ASD out of context and we’re working on that. A key strand in our ASD strategy is for multi-disciplinary assessments, and in different settings as well.’ (Shire, Head of Access and Disability)

There appeared to be variation in the extent to which local authorities were following the good practice standards suggested by the National Service Framework Autism Exemplar or National Autism Plan. In one authority, the National Autism Plan for diagnosing ASD was generally said to be followed, but in other authorities it seemed that only some recommendations in the Plan such as multi-agency, multi-disciplinary assessments were being implemented. The Plan’s timetable from referral to assessment was adhered to in some authorities and not in others where there were long delays. These delays were often due to capacity issues, and could occur whether assessments were single or multi-agency in nature. For example, in a shire authority an assessment and diagnostic pathway had been developed whereby referrals were made to a multi-agency diagnostic team. Families could however have a lengthy wait for an assessment due to capacity issues in the speech and language and educational psychology services:

‘Waiting for an EP [educational psychologist] to do a full assessment. That takes forever. Sometimes we could get the process started quite early, but for the assessments and for the professionals to become involved can take a long time because of lack of them.’ (Shire, Parent Partnership Coordinator).

Recent data reported by the Association of Educational Psychologists (2009) shows significant regional differences in the number of full-time equivalent educational psychologists for children aged from birth to 16.

Diagnosing a hearing impairment involved assessments undertaken by health which were rarely multi-agency at the point of diagnosis, although there were authorities where specialist teachers were invited to attend the audiology clinic for the diagnostic assessment. The impression gained and occasionally articulated was that hearing impairment was more straightforward to diagnose than ASD.

Local authorities again varied as to whether there were clear pathways and protocols covering identification and assessment. Most had ASD pathways, though some of these covered assessment and diagnosis only, whilst others covered from the point where it was thought it might be ASD through assessment, diagnosis and intervention. For some local authorities, the pathway only covered the early years, although in one authority a pathway to cover school-age children was in development. There seemed to be variation between local authorities in whether these pathways and protocols were formalized and written.

Assessment and diagnostic pathways did not necessarily guarantee a smoother process. There were authorities where there was a pathway in place, but poor multi-agency working resulted in poor communication between health and education in terms of notification, and delays between referral and assessment.

Few leads mentioned using the National Deaf Children's Society guidelines, though some did describe the hearing impairment pathways and protocols that were in place in their local authority for identification and assessment. The Newborn Hearing Screening Programme has its own protocols and set of quality standards for diagnosis and referral that some interviewees referred to.

5.2.2 The school's view of assessment

School representatives said that where a concern had been raised, SENCOs played an important role in doing initial assessments, and they described using classroom observation and discussions with parents to find out more. To varying degrees they described having access to specialist advice at this initial stage, and some felt they needed more support and, particularly those new in the role, more training.

School representatives' experiences and perceptions of the quality of multi disciplinary support for assessment varied. The main factors which appeared to support effective and timely assessment of SEN were:

- good working relationships with authority inclusion support services, facilitating a quick response to requests for advice and assessment
- clear guidance from the local authority, particularly in relation to referral pathways and thresholds for referral to different agencies
- regular SENCO cluster meetings, particularly with a training focus on identification and assessment issues
- use of school planning meetings, involving school staff and representatives from multi agency groups such as health, education and social care.

Schools in two local authorities described termly multi-agency planning meetings, involving the SENCO, other senior school staff, the educational psychology service, speech and language service, CAMHS and sometimes the school nurse, to discuss concerns and identify which agencies needed to take the assessment process forward.

Particular problems in relation to ASD assessments were identified by school interviewees. Some reported good access routes to assessment, with clear referral pathways, good guidance from the local authorities, good access to multi-disciplinary ASD assessment centres, and good awareness of ASD by school staff. However, there were also schools that experienced long delays, with waiting times of up to 18 months reported for multi-disciplinary assessments. The assessment process was sometimes seen as cumbersome: in one area, school representatives reported a standard 26 week period for assessment by CAMHS, speech and language and the child development team. In other areas, SENCOs reported that multi-disciplinary assessments were not yet in place, or not routinely used. Although some school representatives said they would start providing support before waiting for the outcome of the assessment, others said that assessment delays meant that children's needs were going unmet.

Interviewees described several factors as contributing to difficulties in assessment:

- complicated referral systems and long waiting times for assessment from speech and language services
- constrained capacity in speech and language services, resulting in no capacity to assess or support secondary school pupils
- capacity constraints in educational psychology services, resulting in reduced access for specialist units which took children from more than one local authority, difficulties working across a number of local authorities (including different referral pathways, varying levels of access to key assessment services and varying charges levelled by each authority for services)
- having to pay for assessments.

5.2.3 Common Assessment Framework and Early Support Programme

The Common Assessment Framework is aimed at promoting early identification of additional needs, a coordinated response to service provision and reducing the number of assessments that children go through. It is designed for use by practitioners across all children's services, and all local authorities were expected to implement the Common Assessment Framework by March 2008.

Our case study authorities were at very different stages in the implementation of the Common Assessment Framework, from those where it appeared to be embedded in practice to those where it was just getting off the ground. Authorities where the Common Assessment Framework seemed to be well established were also authorities that had a stronger profile in multi-agency working and were more likely to have multi-agency assessments. The Common Assessment Framework was seen by local authorities as supporting the assessment process and helping in the reshaping of a multi-agency approach to assessment.

Where the Common Assessment Framework was said to be working well, interviewees generally reported that there had been clear guidance, comprehensive training involving a wide group of practitioners and an approach that built and extended upon what had previously been in place. Where the Common Assessment Framework was less well established, difficulties included confusion about when it should be used, fear that it would take too long and reluctance among practitioners to become a lead professional (see also 4.2.2):

'The Common Assessment Framework has taken a long time to embed, and it's still in that process, and I think there's been a lot of concerns about it maybe because there hasn't been a clear enough message ... about when to do a CA [common assessment], how long it takes

and things like that ... and it's that fear that it's something additional that's going to take a huge amount of time and they have to do it.' (Unitary, Principal Educational Psychologist)

The Common Assessment Framework was only mentioned by representatives from schools in two authorities where the Common Assessment Framework was more established. In another area it was felt that the Common Assessment Framework was not being used consistently by all agencies, despite clear guidance from the local authority.

As with the Common Assessment Framework, use of the Early Support Programme was variable, from those authorities where its use was limited or unclear to others where it was embedded in the assessment process and where it was seen as having a positive impact on facilitating a multi-agency coordinated approach and in the development of care and referral pathways. As discussed in 4.2.2, those authorities where the Early Support Programme was more established had stronger multi-agency structures and one authority had been a pathfinder for Early Support Programme.

5.2.4 Referral to services and support

There were differences between local authorities in whether they said that they had clear and transparent pathways to services and support following assessment and diagnosis. There were also differences within and between authorities in the age group covered by a pathway, whether the pathway was formalized and written, and whether pathways were in place for both ASD and hearing impairment. There was greater variation between authorities for ASD than for hearing impairment. Good referral systems were said to be facilitated by good links between agencies, community nursing teams linking in to other support systems, and integrated support systems. They could be hampered by delays in the writing and forwarding of reports, poor notification systems between different agencies, and lack of shared databases.

For children diagnosed with ASD, the referral pathways were clear and in place when assessment took place at a Child Development Centre. Generally, pathways were reported to be more likely to cover the early years only rather than school-age children although the gap for this age group was often acknowledged and pathways to cover school-age children were said to be in development. The driver for developing these pathways was often said to be the increasing number of children diagnosed with ASD.

Access to services varied between local authorities, and occasionally within an authority. For example, in a shire county, the Early Bird¹⁶ support programme was only available in certain parts of the county. In local authorities where support to families depended on a formal diagnosis, take up of early support programmes such as Early Bird could be affected by lack of an early diagnosis. There could be long delays too for services sometimes because of a shortage of key staff such as speech and language therapists and occupational therapists, and long delays for services following assessment.

For children with a hearing impairment and their families, there were reported to be clear referral protocols and pathways from the Newborn Screening Service to support services following diagnosis and little variation between local authorities, although earlier we referred to the two authorities which were experiencing difficulties in referral and notification. The Sensory Impairment Service or Specialist Advisory Service for deaf and hearing impaired children were said to contact families within 48 hours of notification of a diagnosis, a quality standard of the Newborn Hearing Screening Programme. The Newborn Hearing Screening Programme and, it was sometimes reported, the Early Support Programme had been the

¹⁶ Early Bird is a programme of training and support for parents of pre-school children once a diagnosis of autism has been made.

drivers for establishing these pathways. For children with a later diagnosis of a hearing impairment, it was said that the same care pathways as for children referred through Newborn Hearing Screening Programme were followed once the sensory impairment or advisory service was notified of the diagnosis. It did seem in some authorities, however, that without the quality standard of the Newborn Hearing Screening Programme to adhere to, support for these families did not always happen as speedily as with diagnosis through the Newborn Hearing Screening Programme.

It was difficult to identify the underlying factors that distinguished those authorities with clear pathways from those where the pathways were unclear, in part because of the considerable variation so that no clear patterns emerged. Only four of the 16 local authorities said that they had a specific ASD strategy, although a further two had a draft strategy and two more were developing one (others said they had ASD plans, see 4.1.1). Of the eight authorities with current or draft strategies, five had average or above average prevalence of ASD. There appeared to be no clear relationship between having or developing an ASD strategy, good multi-agency working and whether a local authority had a clear formalized pathway or not. As we noted in chapter four, very few leads said that there was a strategy for deaf and hearing impaired children in their local authority.

5.2.5 Information for parents at assessment and referral stage and involvement of parents and children in reviews

There were many individual examples of good practice when it came to the information provided to parents in the assessment and referral process. But overall for most authorities the picture was somewhat mixed, with practice seeming to be better with some groups than others. Parent Partnership Coordinators and voluntary and community sector representatives tended to be more critical of local authorities and PCTs. Generally information systems appeared better when assessment and diagnosis occurred in the early years rather than later, was better for families with hearing impaired children than for families with a child with autism, and better when assessment had taken place at a Child Development Centre.

Where assessments were predominately health focused and not multi-agency, the quality of the information provided to parents was said to vary depending on the doctors involved, which was not specific to local authorities. Some Parent Partnership Coordinators described how they were sometimes involved in helping parents understand what the condition meant because other professionals had not succeeded in providing information that was accessible to parents. On the other hand, multi-agency assessments at Child Development Centres or ASD assessment centres, described earlier, were more likely to offer appropriate information and support to families. In one area for example, all families referred to the Child Development Centre for assessment were visited by one of the support workers from the SEN team for under fives who would work with the family and explain the assessment to them.

Interviewees stressed the importance of providing information, but that there was a need to be sensitive to a family's needs about how much information they may be ready for:

'I think they're very good at it [information at diagnosis], I think they are actually very good ..., I think sometimes they may be too good, almost it's too much information to take in at a time because I think at times like that people need that information in small doses because you're actually, you're suddenly in a whole new world that you didn't know anything about.' (London Borough, Parent Partnership Coordinator)

Those authorities who appeared strong in providing information and involving parents, considered different ways in which information could be communicated, recognising that it sometimes needs to be phased, but with parents knowing who to go to for further advice and help. In some authorities the referral pathways were transparent and clearly communicated to parents and in others there was a lack of transparency and informants, especially Parent Partnership Coordinators and voluntary and community sector representatives, reported that parents were not always aware of the services available to them:

'There are no clear pathways of what they're entitled to, the eligibility criteria [and process] aren't transparent ... there's no collective support for parents that comes directly from the local authority.' (Metropolitan District, Voluntary and Community Sector Representative)

There was an acknowledgement from some leads in these authorities that they needed to do more to ensure that parents understood the decision-making process and the eligibility criteria for services.

The difficulties experienced by families who do not meet the diagnostic criteria and who in some local authorities are unable to access support, but who nevertheless still have problems, were of particular concern. This led one Parent Partnership Service to organize some support for these parents, which was seen as lacking from other agencies:

'I linked up with a voluntary organization to set up a drop-in at the hospital. It's a signposting service for parents. Yes, you might not have a label, but there are organizations that can give you emotional support at this early stage.' (Shire, Parent Partnership Coordinator)

Good practice in authorities where information for parents and involvement in reviews was said to be working well included: information provided pre-assessment and a continuing dialogue involving parents and professionals throughout assessment; parents and children involved in individual planning; child friendly reviews – in one authority meetings were chaired by the young person; support provided at time of diagnosis, for example from a parents' advice centre or specialist teachers; parent support networks; meeting language needs of parents and helping them to understand policies, eligibility criteria and the options available to them; and good signposting to services.

At the local authority level, good practice in providing information for parents at assessment and referral appeared to be associated with good multi-agency working, particularly at an operational level, with co-located or integrated services, a good working relationship between the Parent Partnership Service and the voluntary and community sector, parents more involved in planning and strategic development, and good systems for sharing information.

5.3 Explaining variation in prevalence of SEN

In chapter three we saw how the prevalence of SEN, ASD and hearing impairment varied between authorities. Reasons for this variation were explored with interviewees and in this section we consider these reasons, addressing first SEN and then ASD and hearing impairment. Interviewees raised issues to do with identification in explaining both high and low prevalence of SEN while perverse incentives and characteristics of the population were suggested to explain higher than average SEN prevalence. For ASD and hearing impairment, explanations provided by interviewees for variation in prevalence included reliability of the School Census data, identification and diagnosis, characteristics of the population, and the provision available within their authority.

5.3.1 Variation in schools' approaches to identifying children with SEN

In the review of the literature (chapter two), the variation in determining and applying the eligibility criteria for the graduated stages was reported. Local authority leads and occasionally Parent Partnership Coordinators were of the view that prevalence, both high and low, could be explained by the approach taken by schools to identifying children with SEN and determining which children were placed on School Action. In some local authorities it was said that schools were over-identifying children with SEN by identifying children as having SEN who were in fact under-achieving.

'A lot of the children on SEN Registers are under-achievers rather than SEN and I'm conveying that message to my SENCOs and saying, look at your children again, apply [the criteria], because we have some very good, very rigorous criteria for School Action, School Action Plus ... part of the monitoring is going to be a moderation exercise ... [to see if] the guidance is being applied consistently across the borough, because I [and the SENCOs] suspect it's not.' (Unitary, Senior SEN and Inclusion Adviser)

Although some schools may be inappropriately applying the Code of Practice criteria, as suggested here and occasionally confirmed by school respondents (see 7.1.6), it may also be that not all schools are fully signed-up to the inclusion agenda. The tensions between the inclusion and school attainment agendas, referred to by several interviewees, may lead schools to over identify children with SEN rather than jeopardize the school's attainment results – a point we return to later in this section.

How SEN is defined by schools – whether broadly or narrowly – was also said to explain variation in prevalence rates. For example, one school may include in their SEN population all children who receive school-based support over and above good classroom teaching, whereas another school may not consider within their SEN population any support delivered within the classroom: '*And you can see it's a very different definition then... it's all about labelling*'.

This was supported by the school data which revealed differences between schools in terms of whether it was necessary for a child to be recorded as having SEN before they could access specific within-school interventions. School representatives said that the treatment of children who were being monitored but not yet identified as needing school support varied; in one school the SEN register was only used once a child was accessing outside support.

The lower prevalence rate among some of the local authorities was explained by the label of SEN not having significance in terms of access to school-based services or support. In these authorities leads said that the needs of more children were being met without being identified as SEN and placed at School Action. In these authorities too, a diagnosis of ASD was said not to be required to secure additional support:

'Well, I think we would run here on presentation [of need], rather than on a strict criteria of diagnosis. There are lots of parents, for all sorts of sensitive reasons who actually don't want to have a formal diagnosis...[but this] wouldn't be a barrier to accessing what you need. I think we have to be careful that what you need isn't accurately identified if you're not being presented with [a diagnosis].' (Metropolitan District, Principal Educational Psychologist)

'So if you can describe a need it doesn't have to be called something for you to get the support, the provision ... and I'm almost sure that in those places where you have to have the word before you get the service, there's a hell for leather rush for diagnosis, diagnosis.' (Metropolitan District, Area Team Manager)

High prevalence, on the other hand, may reflect confidence that support services are available to schools. One interviewee in an authority with a high prevalence of SEN speculated that the high level of good quality support services provided to schools, a policy that had received significant investment as part of their inclusion strategy, could result in schools identifying more children because they knew the support would be there for them to access. The suggestion has been made in evidence to government reviews that the identification of SEN may be linked to the services and support available to children and their families.

5.3.2 Perverse incentives

In three of the five authorities with above average prevalence for SEN, explanations suggested for the higher prevalence included perverse incentives which unintentionally may lead schools to place more children on School Action and School Action Plus. As the following quotes illustrate, these ‘incentives’ included the way in which SENCO time is allocated within schools, increased delegated funding since the formula included the number of children with SEN in a school, and the contextual value-added mechanism in terms of school performance.

‘While SENCO time is still allocated, based on numbers on the SEN Register and so on, they have a vested interest don’t they, actually? And schools will, are very honest and say that the more children they’ve got on their SEN Register, the better their value added looks, so there are a number of things around that we’ve got to overcome if we’re going to get an honest reporting in terms of SEN in schools, I think.’ (Unitary, Senior SEN and Inclusion Adviser)

‘But there is a slight incentive for schools to identify children in terms of accessing funding that is then delegated, because higher incidence of special needs will bring more funding ... [and] some schools, I think, have kept children at School Action when they haven’t needed to because they’ve recognized it has an impact on their achievement results.’ (Shire, Manager for SEN Pupil and School Improvement)

‘I think it’s over identification. I think in some of our schools they’ve lost the plot as to what the normal ... is, and that’s driven by [attainment] targets, it absolutely is. And it’s quite a neat way of where a school is struggling, and some of our schools are struggling, it’s quite a neat way of saying, it’s not about the teaching and learning, it’s to do with the child.’ (Unitary, Assistant Director for Inclusion)

5.3.3 Characteristics of the population

Population characteristics were put forward to explain higher numbers of children with SEN in only three of the 16 authorities. Leads in two shire authorities said that although low overall on the indices of deprivation, there were areas of significant deprivation in the authority that could explain their higher SEN prevalence. A high level of need together with a significantly high proportion of transient families within the population was said to explain high numbers in a unitary authority.

5.4 Explaining variation in prevalence of ASD and hearing impairment

In addition to exploring reasons for variation in the prevalence of SEN, we also asked specifically about the two exemplar conditions, ASD and hearing impairment. As described in chapter three, the prevalence indicator for ASD and for hearing impairment was calculated from the School Census using the primary special need category recorded for pupils with

statements and on School Action Plus¹⁷. As we noted there, prevalence for these two conditions varies and is consistent with some estimates of the prevalence of these conditions, but below others.

5.4.1 Comprehensiveness of School Census data

In explaining high or low prevalence for ASD and hearing impairment, local authority interviewees questioned whether the comprehensiveness and accuracy of the School Census data, despite government guidance (DfES, 2005), could be relied upon to provide an accurate prevalence figure. They highlighted the fact that determination of a child's primary condition was not straightforward, particularly when a child had complex needs or where schools gave prominence to learning needs and difficulties rather than the diagnosed condition. How it was determined could therefore vary both across schools and between local authorities. In fact, as we discuss in more detail at the end of this section, local authorities generally did not rely on the School Census as a source of prevalence data and some interviewees were indeed surprised at our focus on this data in the interviews.

Interviewees explained how schools gave prominence to learning needs and difficulties, rather than to diagnosis, which alone did not indicate level of need. Thus, children with ASD may be recorded on the School Census as having a moderate learning difficulty or with behavioural, emotional and social difficulties. Furthermore, it was difficult to determine a primary condition for those children with complex needs, who were said to be increasing in number across all authorities, and decisions were often needs led. For example, in one authority the guidance to schools was to record the condition where the child was having most difficulty.

Our interviews with SENCOs tended to confirm the picture presented by our local authority informants. Determining a child's primary condition was reported as straightforward when the child had a statement, a clear diagnosis from an outside agency, or where there were reports from educational psychologists and other professionals. Without a statement or a clear steer in a report, determining the primary condition became more difficult for some SENCOs. There was a high degree of local interpretation in determining the primary condition, with some SENCOs more confident than others in doing so. SENCOs described choosing the description which best described the child's needs, giving prominence to learning needs, particularly where there was more than one condition. Some school databases were unable to record a secondary condition for their pupils with SEN. For some, the selection of primary condition was somewhat arbitrary, the process difficult, and it was said to be the source of much discussion at SENCO conferences. It was an area where, for some, more guidance from the local authority would be welcomed. Although there were occasional reports of local authorities providing training or written guidance on completing the School Census, for the majority of the SEN leads this was not the case.

Across local authorities we were told that ASD should only be recorded as the primary condition in the School Census if there had been a formal diagnosis of ASD, but some thought that schools were not adhering to this requirement and were including children who did not have a formal diagnosis. On the other hand it was also said that speech, language and communication difficulties or behavioural, emotional and social difficulties were sometimes recorded as the primary condition for some children diagnosed with ASD. For example, in one authority with below average prevalence of ASD according to the School Census, which the ASD lead felt was not an accurate reflection of the actual prevalence, an examination of the local authority SEN database had found that some children with a diagnosis and statement for ASD were recorded on the School Census under speech, language and communication difficulties.

¹⁷ Primary condition is not recorded for pupils on School Action.

It was also commented upon that schools did not always update the primary condition when a diagnosis changed, even when they themselves had been the initiator of the change. This was particularly common for ASD where speech, language and communication difficulty was often first recorded before a formal diagnosis was made.

Hearing impairment too was not always recorded as a child's primary condition. One head of a hearing impairment service had compared the numbers of children with a hearing impairment held by his service with those on the SEN database, and found the latter recorded fewer children as hearing impaired: '*they don't come up because it's not their primary need*'. One explanation provided by some interviewees was that hearing impaired children are increasingly presenting with additional needs and that hearing impairment would not therefore be recorded as the primary condition.

Despite government guidance and descriptions aimed to improve data collection for the School Census (DfES, 2005b), leads in some authorities commented on the difficulty in monitoring or regulating this data (discussed further in 7.1.7), and for some the time and effort such monitoring would take was viewed as wasted energy. Given the perceived unreliability of the School Census data, it is unsurprising that few local authorities relied solely on this data for planning purposes, but undertook needs analysis and mapping exercises (see chapter four). However, concern was occasionally expressed about how this data might be used at a national level as articulated by this SEN Lead:

'That is a worry for me, really, in terms of how much reliance people place on [School Census data] ... it's much more about how we're viewed from the outside, than how we do it from the inside. ... Now, are you very sure that we have coded those children exactly like [neighbouring local authorities]? There will be difference in the way we've done that.'
(Metropolitan District, Principal Educational Psychologist)

5.4.2 Identification and diagnosis

Good identification and diagnostic procedures for ASD were felt in some local authorities to explain higher prevalence rates. Others believed the diagnostic thresholds were lower now than had previously been the case so that more children were meeting the diagnostic criteria. Conversely, poor identification procedures were said to explain a lower prevalence of ASD. In one authority with low prevalence, the two voluntary and community sector representatives said that there was late identification in the authority due to poor identification systems in the early years and parents' concerns not being taken seriously. The local authority lead commented that their identification systems for ASD were not as good as they could be, but hoped that the development of a new ASD pathway would improve this situation.

There was some concern that a higher prevalence of ASD may reflect over-diagnosis. In several authorities with high prevalence rates (although, as we have noted, below other estimates of prevalence), where over-diagnosis was suggested, the driver was said to be parents feeling the need to push for a diagnosis in order to get support or provision. It did appear that in these authorities a diagnosis of ASD was required in order to secure support. In one, the ASD lead wondered if the higher number of children with ASD in one half of the county was attributable to the fact that the Early Bird support programme (which required a formal diagnosis to access) was available there, and not in the other part of the county where numbers were significantly lower. The voluntary and community sector representative in this authority, however, suggested that differences in diagnosis were likely to be due to there being two PCTs covering the county.

There was certainly a view within some authorities that variation in prevalence could in part be explained by differences in diagnostic procedures and that the same condition might be diagnosed differently depending on the clinician. In an authority with a low prevalence of ASD, and where services were provided without a formal diagnosis, it was said that careful consideration was given in the diagnostic process as to whether the condition was ASD or a specific receptive language disorder. This contrasted with another authority, this time with high prevalence, where the perception was that paediatricians were more likely to diagnose ASD rather than a speech disorder:

'My experience leads me to believe that the paediatricians here are much more inclined to diagnose social communication difficulties [as] Autistic Spectrum Disorder, than they are speech and language difficulty, or disorder, that's the hypothesis ... I thought when I came here that there were remarkably few pupils with a speech and language disorder, or severe delay diagnosis.' (Unitary, Head of Assessment, Intervention and Psychology)

Cross authority differences in prevalence were also described by a Parent Partnership Coordinator in a unitary authority, but this time in the levels of ASD and Attention-Deficit Hyperactivity Disorder (ADHD). ADHD prevalence was higher and ASD lower in the more socially deprived area of the authority and vice versa in the socially advantaged area of the authority. This led her to speculate as to whether professionals were overly influenced in their diagnosis by other factors, such as family backgrounds and parenting styles, and whether more able and articulate parents were less likely to accept a diagnosis of ADHD because it was perceived socially as less acceptable.

Identification and diagnostic procedures were rarely mentioned in explaining a high or low prevalence of hearing impairment, but the high prevalence in two authorities was attributed to the good identification systems particularly in the early years, for example, the Newborn Hearing Screening Programme, the role played by health visitors, and the training practitioners received from the advisory teachers for the deaf in recognising the early signs of a hearing impairment.

5.4.3 Characteristics of the population

Although by no means common, some interviewees referred to having higher numbers of adults with autism in the authority as a possible explanation for the higher prevalence of ASD among children in these authorities. Interviewees in one authority with a large number of companies in the Information Technology (IT) industry in the surrounding area speculated that this might explain the higher numbers because there was a tendency for adults on the autistic spectrum to be drawn to jobs in IT.

In the case of hearing impairment, a high or low prevalence was sometimes thought to be linked to a high or low Black and minority ethnic population; a higher rate of hearing impairment was attributed to a high Black and minority ethnic population. Looking at the Black and minority ethnic population in each of the 16 case studies, there is some correspondence between high or low rates of hearing impairment and high and low rates of Black and minority ethnic population. There is evidence that prevalence rates are higher in some ethnic minority groups with more than a two-fold increase in prevalence among Asian children reported (Fortnum and Davis, 1997).

5.4.4 Provision

In two of the eight authorities with higher than average ASD prevalence, interviewees suggested that families were moving into the area because of the reputation of specialist provision within the authority or close to its borders, whilst the lack of provision in one authority was thought to explain the lower prevalence of hearing impairment.

However, one interviewee did question whether this explanation was robust because empirical evidence was lacking.

5.5 Sharing data on prevalence

Providing data on prevalence was clearly very difficult in some authorities. Although ASD and Sensory Impairment Services said that they usually kept their own databases of the children they work with, few authorities reported keeping separate registers of children with ASD or hearing impairment. There were examples of leads explaining how difficult it was to establish the number of children with ASD or with a hearing impairment in their authority. One said she thought the most accurate data was kept by parents' groups, while another said that they could only identify those children with autism who had a statement.

To inform the planning of services for SEN and disabled children, good quality data shared between agencies is essential. The difficulties in this area have been well documented (see chapter two) and centre particularly on different definitions and incompatible databases. At one end of the spectrum were those authorities among our 16 case studies, albeit small in number, where data was routinely shared between health, education and social care and where there were shared or compatible databases. At the other end were local authorities where data was not shared systematically and where differences in definitions and IT problems impeded progress in this area. In between were those authorities who said that sharing information worked well between education and social care but not with health again for reasons to do with different definitions and models of care. In some cases it was also because the local authority needed to work with more than one PCT. Some authorities had set up multi-agency working groups to address these issues and others already had existing data groups that facilitated data sharing. All three authorities where data sharing was described as good were more likely to have good integrated systems and multi-agency working.

Some of the difficulty in sharing data is to do with differences between agencies in the models of disability that underpin their work and the children that they are working with. Health takes a medical model and is involved with children with complex health needs and in diagnosing particular conditions such as ASD or hearing impairment. Social care is also working with children with severe and profound disabilities, but adopts a social model of disability, which is particularly focused on the impact of the disability on a child's life and that of their family. Education embraces a much wider group of children with SEN and its primary focus is on how the disability impacts on children's education and learning. Whereas health may be focused on diagnosing and treating the disability, for education and social care it is the impact of the disability rather than the disability itself which is likely to be more meaningful in terms of planning services and meeting needs - a point made by several of our interviewees:

'Of course from an education point of view, we're not really, we do use the label autism but we're not really interested in that, we're interested in what difficulties they are having and overcoming those difficulties.' (Unitary, Inclusion Support Service Manager)

5.6 Summary

This chapter has described the significant variation between and within local authorities in identification, assessment and referral procedures. Establishing a clear pattern was difficult because few authorities appeared strong in identification, assessment and referral across all age groups and for all conditions.

Good practice in these areas, however, did appear to be influenced by strong multi-agency and integrated approaches to working, particularly good communication and the sharing of information between agencies, but especially with health. It was also influenced by a number of practices to increase early identification, particularly the training of frontline staff, and having sufficient staff capacity within services to meet demand. Specifically:

- In authorities with identification systems where children with SEN were less likely to be missed as reported by interviewees, there was more likelihood of:
 - integrated services and good communication between education and their partner agencies
 - a specific focus on developing practitioner skills and raising awareness through training
 - opportunities for practitioners to raise concerns with specialists and support staff.
- There was less confidence in the robustness of identification systems in authorities where:
 - specific training in identifying children with SEN was less evident
 - schools were said to be missing children or referring inappropriately
 - health visitors were no longer carrying out routine developmental checks
 - school entry screening was not in place.
- Multi-agency assessments were more likely to occur in authorities where there was greater integration of services and multi-agency working.
- Where assessments were undertaken at Child Development Centres, referral pathways were said to be clear with appropriate information and support offered to parents.
- Good practice in providing information for parents such as information provided pre-assessment; parents and children involved in individual planning; and helping parents to understand policies, eligibility criteria and the options available to them, was associated with:
 - good multi-agency working, particularly at an operational level
 - a good working relationship between the local authority and the PPS and voluntary and community sector
 - parents more involved in planning and strategic development
 - good systems for sharing information.
- Where data sharing was described as good, local authorities were more likely to have systems that were integrated and a strong profile for multi-agency working.
- The Common Assessment Framework and Early Support Programme were said to be well established in authorities where multi-agency working was more developed and they were more likely to undertake multi-agency assessments.
- Multi-agency and multi-disciplinary review meetings were more likely in authorities where services were co-located.

The early identification of children with a hearing impairment was said to be significantly improved by the introduction of the Newborn Hearing Screening Programme and the guidance and quality assurance procedures associated with this programme seemed to be making a difference in how quickly support was available. In the majority of the 16 case study local authorities the Programme was said to be working well, although significant

variability in the performance of audiology services across the country has been reported (MRC Hearing and Communications Group, 2008).

A number of explanations were put forward for the variation in prevalence of SEN, ASD and hearing impairment – the unreliability of the School Census data, the different approaches taken by schools in identifying children with SEN, the efficacy of identification and diagnostic procedures for ASD, the support and provision available within a local authority, and characteristics of the population. Lower prevalence rates may be attributable to weaker identification systems, but as we have seen there are other explanations too. Authorities where a narrower definition was applied to SEN because the needs of more children were said to be met without the need to identify SEN, or where support was available without a diagnosis say for ASD, were less likely to have above average prevalence for SEN. This is not to suggest a causal relationship, but rather to illustrate that the relationship between identification and prevalence is not a linear one and that prevalence rates are affected by a number of interacting variables.

Chapter 6: Explaining variation in provision

This chapter looks at the provision available in the case study local authorities, how and why this varies, and what the implications are for meeting children's needs. We begin by looking at specialist provision: special schools, additionally resourced mainstream provision, and out of area placements. We then look at mainstream provision and at variation in the support available from and to schools to meet needs. Finally we look at variations in the availability of other services – particularly social care, mental health services and speech and language therapy.

6.1 Specialist provision

6.1.1 Differences in the nature of specialist provision

Across the case study local authorities there was a pattern of developing a continuum of provision. This often involved reducing or reorganising special schools and building up specialist resources in mainstream schools, both through establishing additionally resourced centres in different forms¹⁸ and through building capacity in mainstream classrooms. Most local authorities reported that as a result of this restructuring, the population of children in special schools had more complex needs than previously, and that there were children in mainstream classes, who would once have been in special schools.

However, the local authorities were operating in different local contexts, varied in terms of starting point, priority of strategic developments and local support or resistance to changes. As a result there were clear differences in the nature of local specialist provision which were not wholly explained by the relative sizes of population in each area, and clear differences in views about its adequacy which were not wholly explained by the extent of provision.

Across the local authorities we found four patterns in provision:

- *Few special schools and few specialist mainstream settings*: in the (small unitary) authority with least such provision there were only two of each type.
- *Several special schools and few specialist mainstream settings*: for example four special schools and one specialist mainstream setting.
- *Several specialist mainstream settings and few special schools*: some areas for example had three to five special schools and eight or more specialist mainstream settings.
- *Fuller provision of both special schools and specialist mainstream settings*: up to 18 special schools and over ten specialist mainstream settings.

In terms of early years settings, some areas had special schools with nursery provision, some had enhanced provision in some mainstream nurseries and others had no specialist provision.

There were also differences across the case study authorities in the extent of specialist settings for children with hearing impairment and those with ASD, and most areas reported more specialist settings for the latter group than the former. In terms of ASD provision, two

¹⁸ For example local authorities referred to additionally resourced centres, specialist bases, enhanced resource provision, resourced units and integrated provision, some of which could only be accessed with a statement. We did not explore funding, governance or access in detail and so refer to these forms of provision collectively as specialist mainstream provision.

had a designated special school; others had provision within special schools catering for broader groups. Specialist provision in mainstream settings was in the form of: designated ASD units; a unit for children with Asperger's syndrome; or units for children with behavioural difficulties or speech, language and communication disorders. For children with hearing impairment there were designated special schools, provision within special schools catering for broader groups, and some specialist units in mainstream primary and secondary schools. Some areas had no designated specialist provision. Across the piece some areas had no settings of any sort specifically designated for children, others had provision in either mainstream settings or special schools, and some had both.

From our sample of 21 schools, eight had specialist provision in the form of bases or units for ASD, hearing impairment, speech and language and visual impairment. The provision for children with ASD in particular was said to be in demand and oversubscribed.

6.1.2 Explanations for this variation

There were a number of factors driving local authorities to change the nature of their provision, and differences between them in their significance.

Firstly, a central plank of local authority inclusion strategies was the restructuring of specialist provision so children could be educated in mainstream settings wherever possible and where appropriate. Specialist mainstream provision was seen as having an important role in supporting mainstream education and enabling movement from special schools to mainstream settings. However, there was some debate in authorities about the role of specialist mainstream provision which influenced the strategic direction taken:

- Some local authority interviewees held the view that this could detract from the responsibility of mainstream settings to support children with SEN. For example, one area was closing additionally resourced centres and was focusing instead on providing peripatetic support for mainstream schools.
- There were also concerns about how inclusive additionally resourced units actually were. There were descriptions from local authority interviewees of units where children spent almost all their taught time; others were spaces where children spent very little time. SEN leads from the schools sample reported in the main that the provision is inclusive, meaning that children spent as little time there as possible and spent much of their time with peers in the mainstream school. However different levels of time spent in provision were reported. At one end of the spectrum, the provision was being used to deliver an entire differentiated curriculum, whilst at the other end children were integrated into mainstream classes, sometimes through the support of teaching assistants.
- Finally, there were some concerns about whether specialist mainstream settings detract from children's ability to participate fully in the life of the school. In one area for example a recent consultation had highlighted that children in a hearing impairment unit felt excluded from school activities outside the unit, and this was leading to re-consideration of special schools as better able to support full inclusion. More broadly the view was expressed that inclusion does not necessarily mean mainstream education settings but a child being educated at the most appropriate setting for them. In some local authorities this meant that there had been no reduction in the number of special schools.

A second important driver in reshaping specialist provision was replacing out of area provision with local provision. In some areas the emotional and social advantages of educating children closer to home were described as a key element of the inclusion strategy. In others it was financial drivers that seemed to be more dominant due to the higher costs associated with out of area provision.

'Our inclusion policy...isn't just about wanting children in mainstream schools. It was also that we wanted children educated in [this local authority] because of all the disadvantages of having them dislocated from local health, social care, never mind the local community, family and all the rest of it.' (Unitary, Assistant Director, Head of SEN)

The third driver for restructuring was changing local demand and family preferences. In some areas extensive consultation with parents was reported, for example, parents with children at special schools had been centrally involved in planning groups to look at re-configuration, and some authorities described falling rolls at special schools.

'Our new primary special school really has quite low numbers now and that's in spite of being a wonderful new building, because parents I think are opting into inclusive provision in mainstream primary school, and continue to challenge us in terms of what's possible. And really many of those children [in mainstream school] have flourished But I think we've done this in genuine collaboration with parents, so we've not taken an evangelical zealous approach to forcing the issue...and of course sometimes it's parents who are actually pushing the boundaries.... our rate of tribunal cases remains very low, so I think working with parents ... we've actually achieved a good outcome without loss of confidence.' (Unitary, Principal Educational Psychologist)

Conversely, there were authorities which had not been able to reduce the number of special schools, or not been able to do so as fully as planned. In some instances this was because family demand for special schools remained high, reflecting a perception of poor mainstream support for children with SEN. Having support from mainstream schools was also critical to making this restructuring work successfully, discussed more fully in section 6.3.1 below.

There were also other factors that explained variation in the current structure of provision:

- *The size of the local population of children needing specialist provision:* large authorities were more able to sustain specialist provision. Also, some were aware of growing incidence of particular conditions, ASD being one of those noted.
- *The emphasis placed on the inclusion strategy:* some local authorities where the inclusion strategy had only recently become high profile were now embarking on reviews of provision which had already taken place in other areas.
- *History:* local authorities which had historically had more special schools generally still had more.
- *Provision in neighbouring local authorities:* some local authorities had a good special school in a neighbouring borough which they chose not to match with local provision, particularly if the distance families were travelling was small.
- *Financial constraints* were particularly acute in some local authorities and meant that specialist provision could not be established even if the need for it was acknowledged.

6.1.3 The role of out of area placements

Out of area provision was a feature that varied across authorities. However, in all the case study local authorities, the number of such placements was said to be declining, responding both to an emphasis on local education as an important element of inclusion and to financial drivers.

Out of area provision appeared to be used predominantly to meet the needs of: deaf children (whose communication preferences were not met locally or where parents wanted children

to experience a school more embedded in the Deaf culture); children with behavioural and social difficulties; children with severe and complex needs or where an intensive package of social care support was needed; and children who needed autism-specific provision. The view was put forward by some local authority interviewees that parental requests for out of area provision sometimes reflected family rather than educational needs, and that better social care support for families with disabled children would reduce demand.

The level of use of out of area placements was influenced by a number of factors, and it was clear that some local authorities used out of area placements for needs that other authorities are able to meet through local provision. The extent of specialist provision was thus relevant. Local authorities with strong special schools in neighbouring authorities also saw this as a driver of out of area placements – and in some areas boundary changes meant that a setting which had once been in the local area was now out of area, but continued to be supported in the interests of stability of education. But there also appeared to be differences between local authorities in their willingness to support out of area placements, reflecting in part financial constraints. Finally the extent of multi-agency working and pooled budgets was also relevant, and some local authorities described an emphasis on multi-agency solutions replacing what would once have been out of area placements.

6.1.4 Sufficiency of provision

Overall, whether or not specialist provision was seen as sufficient by case study informants was not simply a reflection of its nature and extent. Instead it was an interaction between this, the ability of mainstream settings to support children with SEN, and the degree of involvement of parents in decisions about the structure of local provision. Within the local authority sample, three different dynamics combining these elements were identified.

First, where there was extensive specialist provision this was seen to influence the level of parental trust in mainstream provision, and indeed removed a helpful lever on schools to increase their ability to meet need, thus undermining attempts to increase the use of mainstream provision:

'I think [the local authority's use of special schools] is high because we've got a lot of provision. I think it's chicken and egg...if we doubled our provision, our percentage [of children with SEN in special schools] would probably go up We also have an average proportion of children placed in out of authority special schools. Having a lot of your own special provision does not mean that you won't have many children placed out of authority...The more that you place children out of the mainstream and the more availability of provision you have, then the more likely it is they'll be pushed up the continuum.' (Shire, Head of Inclusion Services)

Second, where local specialist provision and mainstream specialist provision were described as insufficient, this increased pressure to use out of area placements, children being inappropriately placed in mainstream schools and increased pressure to statement emerging from schools and from parents.

Third, there were areas where the dynamic was a much more successful one and a virtuous cycle was described. Here, strong parental consultation, strong support for and within mainstream schools to meet the needs of children with SEN, and some use of out of area placements, combined to mean that provision was broadly seen as successful – even in areas where there was relatively little in the way of specialist provision.

6.2 Early years provision

Overall, early years provision emerged as an area that local authority interviewees felt most confident about. All our case study authorities offered a range of home-based and community services including some or all of the following: Portage, Early Bird, family support models, Children's Centres (some with additional resources to provide specialist provision), mainstream and non-mainstream nurseries, early years SENCOs and area SENCOs. The Early Support Programme, mentioned previously in chapters four and five, was said to be highly influential in some local authorities. Consequently it was reported to have changed elements of practice, leading to positive impacts on multi-disciplinary work and 'locking in' support swiftly following diagnosis. In other local authorities it was seen as a 'tightening up' of existing processes.

For authorities where early years services were reported to be working well, co-ordination of services appeared to be more embedded, with smooth interaction between identification, family support and early education, and a more strategic approach to linking up Children's Centres and local mainstream and special schools. There was a strong emphasis on early intervention and referral to services, and a focus on actively developing relationships with parents. There was some variation between local authorities in how far their approach included investing in SEN support for private and independent early years providers.

By contrast, where local authorities described less confidence in their early years provision, there was sometimes less coordination of funding, poorer planning, problems with early diagnosis and assessment (see chapter five), and a more limited range of provision. There was also sometimes a less systematic use of, or an over reliance on, children's centres, with reports of geographical boundaries making it difficult for parents to access provision, less experienced and trained staff, and weaker relationships with local authority SEN staff.

6.3 Mainstream provision: primary and secondary schools

As described in section 6.1, although all the local authorities in our sample emphasised the importance of children with SEN attending mainstream schools wherever possible and where appropriate, there was variation in the quality of support given to and offered by mainstream schools. A combination of issues appeared to interact to determine the nature of mainstream provision and thus explain variation. Key to all of these however is the issue of buy-in from schools, to both the concept of inclusion, and to the local authority strategy.

6.3.1 Buy-in from schools

Fundamentally, achieving this was said by local authorities to require adopting a partnership approach to working with schools. Where 'hearts and minds' were said to have been won, this was attributed to investing in building trust, good relationships, and a shared vision: crucial as a basis for overcoming challenges. Taking a gradual approach to implementing an inclusion strategy with schools, 'building the foundations' rather than imposing top-down direction, was also said to have been important. This included using methods such as consultation events, linking with headteachers' networks, and involving schools in decision-making processes. One local authority representative explained this in terms of building a shared values base:

'We've always started with a philosophy and core values, and I find that really helpful, that we can go back and challenge individuals, challenge the systems, challenge the schools, and go back to those core values... about equality, about sharing, about inclusion,

participation...we share philosophy before any operational policies come into place.'
(Metropolitan District, Principal Educational Psychologist)

Leadership was also seen by authorities as important to securing buy-in, within the authority itself and individual schools. This meant clarity of vision, being ambitious for children, developing strong relationships with stakeholders and families, being persuasive, having a strong ethos of inclusion, and being prepared to challenge practice and push for excellence.

'I think again it's leadership. If you've got a headteacher who's very inclusive and creative...ethos and attitude are more important than anything else [including] skills. I think that if a school is determined to include a child they will find ways of doing that...but if they start off not wanting to do it then almost no amount of training is going to change that.'
(London Borough, Principal Educational Psychologist)

Where relationships with schools were described as being strong, local authority officers reported forging consistent and influential routes in to the school, creating links with key change makers, particularly the SENCO or headteacher. School representatives generally described these relationships with local authority SEN and inclusion teams as supportive, having either regular or more ad hoc contact. The general view from school leads interviewed was that advice about local authority policies was easy to access and forthcoming. They also described a range of methods used by local authorities to raise awareness about policies and wider issues: SENCO cluster meetings in particular were highlighted as an effective method of consultation by SEN leads. The role of the Parent Partnership Service was also highlighted as key in supporting relationships between the local authority and the school.

Other incentives and levers to buy-in emerged. Some authorities had found 'Inclusion Award' schemes useful, providing a detailed framework for schools to follow and rewarding good practice. In one authority there was a view that the system did not change practice, but elsewhere such schemes were thought influential, especially if they operated on progressive levels or where there was external validation such as a regional charter mark.

In some local authorities however, there were reports of less or inconsistent support for inclusion. Here, schools were thought to be reluctant to take some children, or not proactive in providing support. Tension between inclusion and attainment was also commonly described as a barrier. There were reports of individual schools with disproportionately high levels of children with SEN which tested commitment to inclusion, for example, schools with a good reputation for inclusion that have become oversubscribed to the point where they are less able to support children effectively. This view was echoed to some degree in interviews with the sample of schools where the existence of specialist provision was thought to bring more children to one school than it could support. The structure of school provision was also said to be relevant by local authority representatives. This was highlighted in one area with a polarised school structure, where placements of students with SEN fell disproportionately on one sub-set of schools:

'We're a selective area, and our grammar schools don't take the top two percent, they're taking the top 30 to 35 percent, which leaves high schools with a hell of a challenge to meet the five A star to C GCSEs including English and Maths. So we've got national challenge schools, and once you're a national challenge school actually you can say no to admitting children who have got particular levels of need.' (Unitary, Assistant Director)

Most school representatives were aware of their local authority SEN and inclusion policies, describing them as clear and well written. Where weaknesses were identified, these focused on a lack of specificity with some aspects of local authority policy.

In other instances, authority policies did not easily align with some of the approaches outlined in the schools' SEN policies. In one example, a SEN lead said the local authority policy emphasised 'SMART' target setting for children with SEN, but the school used 'child friendly' Individual Education Plans where children were encouraged to set their own learning targets.

Local authority informants also thought schools found supporting high numbers of children with behavioural, emotional and social difficulties particularly challenging, and in tension with the pressure to reduce exclusions. As noted some authorities reported gaps in behavioural, emotional and social difficulties specialist provision, particularly for girls. Finally, in some areas relationships between local authority and schools were seen as weaker, with schools described as '*too autonomous*' and key players within schools described as '*hard to reach*'.

6.3.2 School ethos

School representatives we interviewed stated that their school had a strong commitment to inclusion, with high levels of buy-in from senior management teams and the wider school community. Staff training on school policies, identification of SEN and differentiation, and strong pastoral care and awareness-raising activities with pupils, were seen as important to embedding an inclusive ethos across the school.

However some interviewees felt that they had to work hard to remind managers and staff that '*all teachers are teachers of SEN*', and that working with pupils with SEN was not solely the responsibility of the SENCO. Commitment was felt to weaken where there had been a high turnover of staff, when a school was given notice to improve, or when there were other management priorities. It was sometimes noted that teachers felt very stretched, and there were also comments about the scope of the school to continue to take more children with SEN being limited. A conflict with pressure on attainment and league tables and with initiatives to support attainment was occasionally noted, but this issue was given markedly less priority among school lead interviewees than by local authority staff interviewees.

There was also occasionally a tension between school representatives' views about the role of special schools and interviewees' perceptions of local authority policy. There was a view among many school interviewees that the local authority was too dogmatic about educating children in mainstream settings. In these situations the school representatives wanted recognition from the authority that their decisions were based purely on the needs of the child, rather than any reluctance to support inclusion of children with SEN.

'I think their [local authority] key objective is to keep children with even the most significant special needs in mainstream school...we've had children here in the past who clearly are not right for mainstream...but mentioning a [possible] move to a special school is always met with huge resistance from the authority...quite rightly and parents want their child in mainstream. But I think occasionally you have to accept that's not working and that a special school provision, even if it's just in the short term, is what's most useful for that child and that family' (Headteacher and Inclusion Lead, Primary School)

6.3.3 Supporting transitions

Some authorities described having a strategic approach to transition, with written pathways and policies in place, and it was common for transitions to be managed and delivered through multi-agency steering groups and teams. Continuity of staff across transition seemed greater for hearing impaired children as a teacher of the deaf can follow a child throughout their school career.

A range of resources to support transition were outlined. These included DVDs, school visits, advice and support for parents and transition conferences (involving parents and professionals and children). However, there were differences in how long support was available for, ranging from three weeks to a year. In addition thresholds for transition support vary, ranging from being for those with intensive care packages to broader groups. Finally, school structures can mean additional transitions, with some areas operating infants and junior schools, or primary and middle schools, rather than one primary school.

Both primary and secondary school representatives emphasised the importance of good transitions support. This was seen as important for all children with SEN, but some interviewees particularly stressed its importance for children with ASD, as they were particularly thought to find change difficult. Preparations for transition involved:

- secondary SEN leads visiting primary schools and vice versa
- secondary SEN leads observing children in their primary settings
- passing on of documentation such as Individual Educational Plans
- informal meetings with parents and children
- children with SEN making extra visits to secondary school
- children being introduced to SEN staff and the resources at secondary school.

There were mixed views amongst school representatives as to whether children with SEN (except those with statements) actually received additional transition support to other children. Children with statements were said to have transition plans put in place from their Year 6 annual review, and SEN leads from secondary schools reported attending these. Some SEN leads felt that it was mainly up to the schools to plan and organize children's transition, although some authorities were reported to have good transition planning in place.

We did not look in detail at the transition to adult settings since this is the subject of other initiatives, particularly the Transitions Support Programme. Overall there appears to be more support at transition *into* compulsory education (ie early years to primary) than *out of* compulsory education (ie into further education or adult services). This was widely reported to be an area of concern.

6.3.4 Specialist support for schools

Specialist support was seen by many local authority interviewees as a key ingredient in achieving good quality mainstream provision: giving schools the '*tools to do the job*', maintaining levels of buy-in, and supporting parental confidence in school configuration. As such this features as a vital part in their strategies to achieve their goals, and is a further factor explaining variation in local authority provision. The main types of support that local authorities said they provided were:

- general support for schools from local authority SEN teams, delivered centrally or through localities
- interventions delivered to individual children within schools by visiting specialists
- targeted support or capacity building for teachers so they can continue to support individual children independently.

The most widespread model amongst our case study areas involved central teams delivering advice and support to schools, as well as managing statutory assessments and placements. (Some were education-led teams but others were multi-agency, and differed reflecting an authority's progress in integrating children's services.) Beneath these structures sat a variety of specialist peripatetic teams delivering discrete teaching sessions and in-class support on-

site in schools. The teams included specialist teachers, support workers, and other professionals.

For children with hearing impairment, there were differences in whether there was a specific hearing impairment service or team, a wider Sensory Impairment Service or team, or specialist staff within a wider team. However, the bulk of support was delivered by teachers of the deaf. Often this teacher was said to have been supporting the child since diagnosis, thus having a strong relationship with the child and family.

Support for ASD was more differentiated. Some local authorities said they had a dedicated multi-agency outreach 'ASD service', based within the authority or a special school. In other areas this support was provided by a social communication difficulties team or a language and learning disability team. The latter broad-based structure was designed to remove dependence on a diagnosis to access support, but there were sometimes concerns that such services could become too generalist and lack a strong focus on ASD. In some areas support was largely provided by the Educational Psychology service, but there were differences in whether an identified educational psychologist was attached to each school and some areas reported particularly constrained educational psychology capacity generally.

Local authorities differed in their balance between offering individualised specialist intervention to support individuals, and a 'whole-school' approach. Some local authorities described a deliberate shift from the former to the latter. The underlying belief was that enabling school staff to support children themselves through building skills would reduce reliance on specialist staff and ensure fuller and quicker support. Whilst the model was thought to be working well in some areas, in others it had led to a perception among school staff and parents of support being withdrawn, and it was not being pursued by all authorities.

'We're shifting from the model of support where somebody with knowledge and skills went into the school and took Johnny out of the classroom and took him down the corridor and did something magic to him and then put him back... we've now got to shift even further into the services that monitor and challenge what schools are doing, that support them...to manage those issues and deals with them, so it's empowering schools to do the job, rather than coming along on the white charger and doing the job for them.' (Metropolitan District, Principal Educational Psychologist)

'At the moment there are two camps really, you have the camp... [where parents can feel that] if suddenly [someone] takes my child away and does individual therapy with them, that will be better...then you've got the other camp, which says your child's needs are met if we skill you up on the establishment they're in, their peers and everybody that works with them.' (Shire, Principal Educational Psychologist)

There was also variation between authorities in how schools access support. In some areas advice and support is accessible from multi-disciplinary locality teams that schools link in with to discuss concerns about individual children. In other areas there are more formal referral systems. There were also, as noted in chapter five, differences in whether there were documented protocols and transparent thresholds, and how much local authorities were active in making aware of these.

Overall, local authorities were generally confident about the specialist support available to schools. In addition, support from central local authority teams, such as behavioural support, inclusion support, specialist teachers and teams, educational psychologists and learning support services was generally viewed positively by the school interviewees. However, some local authority representatives reported insufficient capacity to meet need, or lengthy delays in support being provided and this concern was echoed in interviews with school SEN leads. There appeared to be variation in the amount of specialist support school representatives

said that they had accessed, and some said they were not able to access as much as they needed. There were reports of gaps in provision, particularly for children with ASD (for example where there was felt to be a lack of expertise in the authority) and behavioural support (for example where the service had to be bought in and where the threshold for help was high).

Constraints in the educational psychology service were also stressed by SEN leads. In some areas the service was free and in others it had to be bought in. Interviewees described educational psychologists attached to schools with up to weekly visits to review children's progress, conduct assessments and set up programmes for teaching assistants to deliver. In other areas schools had to request visits or said educational psychologists really only provided advice, and in one area the Educational Psychology Service was said to have ceased doing visits and now only provided help via a telephone helpline. In one authority interviewees said it was not even possible to access an educational psychologist for children with statements; in another, only children with complex needs were considered eligible to see an educational psychologist. One SEN lead whose school had to pay for their educational psychologist explained how the presence of just one child with a high level of need could derail this system:

'It's mostly funding. For example this year we had a really nice rolling programme of [the educational psychologist] coming in, assessing, doing joint problem solving meetings, and it was going very nicely and then one of our pupils decided to really kick off. And he has now used up all our time. And it is very frustrating, because at the end of the day, we know he's not in the right place with us, but we can't find him somewhere else to go. And it's just caused this backlog now of children that we need to refer.' (SENCO, Primary School)

In some local authorities there appeared to be an over-reliance on SENCOs with limited additional support provided. Unreliable systems for notification of diagnosis and a lack of awareness about support available were also said to prevent schools from seeking support altogether. There were also circumstances where schools have chosen not to access support, where they are thought to be highly autonomous or reluctant to 'buy-back' support, and a view that many schools are not clear about the extent to which they are already funded through delegated funding to provide support.

6.3.5 Training and capacity building for school staff

Training and capacity building were also portrayed by local authorities as key to schools having '*the tools to do the job*'. A range of training and capacity building activity was described, but there were some variations underlying local authorities' approaches.

First there appeared to be some variation in how far workforce development was a core element of their inclusion strategy. Where this was the case, training was presented as an integral part of implementing change. There was a systematic structure for the delivery of training (through localities or school clusters) and for identification of changing needs and skill gaps. Training was also more likely to be free or cover provided for teaching staff to be released. Conversely, where there appeared to be a more ad-hoc approach to training, individual schools were relied upon to identify their own training needs and they were required to buy this back from their funding allocation. School SEN leads also reported training to be widely available. This was said to be either offered by the local authority completely free to schools or had to be paid for, and there were some references to training being very expensive. It was common for SEN leads to report that the authority was amenable to requests for new or additional training courses.

There were also differences in who was targeted for training; a 'core' of staff or a broader approach. SENCOs were commonly identified as primary targets by local authority

interviewees, with some authorities appearing to rely heavily on SENCOs to cascade learning within their schools. Interviewees from the schools sample suggested that induction and training for new SENCOs was offered by some of the authorities in the sample, but by contrast one SENCO who was new in post said the authority had not offered any formal induction training. This SENCO felt overwhelmed by the new role, describing attending a SENCO network meeting:

'I just didn't know, everything was... just like sitting listening to a foreign language...Common Assessment Framework and CAT and everything's just abbreviated and it was talked about like you should be expected to know what that was. I found that very frightening.' (SENCO, Secondary School)

Teaching assistants were also considered key by case study informants given the amount of one-to-one time they spend with children. There were different levels of satisfaction with the amount of training received, and differences in whether the local authority or individual schools employed and trained teaching assistants. Other local authorities described a broader approach with an emphasis on training being delivered to the whole school including teaching staff, governors, lunchtime and secretarial staff.

'The starting point is building up the confidence and expertise and skills within our mainstream schools. Support services role is increasingly focused on building up that capacity and skill. So in other words...even if the support services are working with an individual child, and they might also be delivering school focused training, that leaves the school in a better position to cope with those sorts of needs later on...trying to change their teaching approaches in the school to benefit all. Because we know that, that if a class teacher puts in approaches to meet a child with autism that might involve visual support, materials, etc, actually that's probably going to benefit more children.' (Shire, Head of Inclusion Services)

Some local authorities had a centralised rolling programme of training whilst in others training was provided specifically following a diagnosis. The benefits of the latter approach lie in the fact that training is tailored within a specific context, but it was felt to be problematic where notification of diagnosis from health was poor, and to risk gaps in knowledge and skills. The range of training available varied between local authorities, encompassing condition specific courses, disability awareness training, the Inclusion Development Programme¹⁹ (IDP), inclusion conferences, peer support, SENCO networks and clusters, and there was variation in whether training was delivered by and for multi-disciplinary and multi-agency staff. Training outlined by school representatives included many of those mentioned above, for example, condition specific courses. The IDP was said to be a new focus and training in the use of Code of Practice stages was also mentioned. SEN cluster groups were reported by the school sample to be a popular mode of delivering training—seen as cost-effective and an opportunity to discuss and assimilate new initiatives. School interviewees also highlighted some gaps, particularly training to work with children with hearing or visual impairment, dyslexia or ASD; training in sign language; and training on SEN policy and the use of the Code of Practice.

Barriers to workforce development were also identified by interviewees from local authorities, creating variation within and between authorities. Take-up was said to be influenced by levels of buy-in from individual schools, discussed above, and some authority staff felt schools did not understand that their SEN funding allocation also covered training costs. A high turnover of staff, including SENCOs, has made it difficult to sustain training or to retain expertise in some areas. School SEN leads highlighted that attending training was

¹⁹ A DCSF initiative, being taken forward by the National Strategies initiative, which focuses on dyslexia, autism and speech, language and communications difficulties.

sometimes an issue. Twilight sessions (from end of the school day until early evening) could cause childcare difficulties, but it was also difficult to take time out of the school day especially if this meant that schools incurred supply staff costs.

6.3.6 Linkages between specialist and mainstream settings

Another form of support given to mainstream settings is outreach from special schools and specialist bases, involving joint placements, direct interventions and capacity building. This has been implemented to varying degrees across case study areas.

At one end of the spectrum, outreach operates in an ad-hoc manner, or on a limited scale, and schools themselves reported this to have been initiated by them rather than by the local authority. Other local authority interviewees reported outreach support to be underpinned by an authority-wide strategy to increase placements in mainstream schools (it was particularly referenced in relation to support for children with autism or Asperger's syndrome) and took a structured and well-developed approach.

'We have a complete set of procedures around [SEN] and a policy that goes with it and a steering group and an operational group, that's been something that's developed in this last year. And we've now invested a significant amount of money in outreach to special schools... to sustain staff working in the special schools, to work out in the mainstream schools. But the schools in requesting it have to put forward a portfolio of evidence of what they've already done, what they've already tried, the training that they've got, so that it's seen as a continuum of skill building rather than just the special school teacher comes out and shows them how to do it.' (Shire, Principal Education Officer)

For these authorities, special schools are viewed as 'hubs of excellence' and there is a desire to share expertise through training, consultation, and secondment opportunities for mainstream staff. Some school representatives also described their highly valued links with local special schools. These had involved receiving advice, support and training from special school staff; using their facilities; staff swaps (for example teaching assistants), and students at special schools using mainstream school facilities.

There were also differences between authorities in the use of dual placements, with children using both special and mainstream school provision. Where this was used it was believed by local authorities to ensure that children get the right mix of educational provision, help meet needs as they change over time, aid in developing peer group relationships, and provide specialist assessments of children's needs. Where dual placements were not being encouraged this was due to a desire to increase skill levels in mainstream schools rather than have children travelling between two schools. There were suggestions in one local authority that dual placements where the child is formally enrolled only at the special school, are also used to overcome schools' concerns about the impact on attainment levels and encourage them to agree to accept children with SEN. School interviewees also described some dual placements, however these links were said to have been established directly by the schools and not, to the interviewees' knowledge, initiated by the authority concerned.

Linkages between special and mainstream schools were seen as important to local authorities, not only to build capacity but also to blur the boundaries between the two types of settings. This was seen as important to facilitate the movement of children between them and to secure the confidence of parents in a child moving from a special school to a mainstream setting.

6.3.7 Provision mapping

Interviewees from a small proportion of authorities described provision mapping as being embedded, with others currently encouraging its use. In most of these, there was a shift towards provision mapping as an alternative to Individual Education Plans (IEPs), although one authority operates both processes, with provision mapping being used for more complex cases. Local authorities reported providing support for schools around provision mapping, ranging from a one-off training initiative to ongoing support, often provided by the School Improvement Service.

Where this was described as being embedded by authorities there was a strong commitment to provision mapping at management level. Schools are asked to demonstrate provision mapping as part of evidence submitted to the Code of Practice moderating panel. Where take-up was less consistent, provision mapping was presented as an option for schools or as an additional activity to IEPs. One challenge highlighted by local authority interviewees was the need for parents to be on board in order to avoid anxiety with the shift from IEPs.

There was also variation in how far along school representatives said that they were with using provision mapping, ranging from those who had been using it for at least three years, through to those who were on the verge of introducing it. Those using or about to implement provision management had had training by their local authority, sometimes several sessions demonstrating various forms of provision mapping that could be used. Many SENCOs felt that provision maps simplified matters, especially in comparison to IEPs which were seen as overcomplicated. There was a view that putting together a provision map was initially a daunting and time consuming task, but that the results were worth it.

Many school representatives held the view that provision mapping was not useful for children who are at the level of School Action Plus, as these children needed a much more detailed and specific account of the particular support they receive, and that children with statements still need IEPs. This contrasts with views put forward by some local authorities who appeared to see provision mapping as a replacement. Introducing provision mapping was sometimes delayed by the need for SENCOs to train new staff, and the introduction of other school-wide initiatives to improve attainment.

6.3.8 Monitoring progress and attainment

Monitoring processes outlined by local authority interviewees generally followed one of two models: a focus on attainment or on inclusion. In the case of attainment, monitoring was largely carried out by the school improvement team, with the progress of the lowest achieving children monitored rather than specifically those pupils with SEN. Conversely, where inclusion seems to be the focus, this function was carried out by the Inclusion Service or SEN team. Here, there is a broader monitoring function with attainment being viewed alongside the quality of inclusive practice and monitoring of the SEN budget.

There was variation between authorities with regards to the processes and systems in place to monitor attainment and challenge school provision, and in the extent to which school and authority processes are joined up. Some central local authority teams said that they put in place routine data management systems for schools to share information. Having this overview was said to enable planning, comparison between schools, and challenge. In other areas, schools were said to have developed individual systems themselves or local authorities appeared not to have a clear monitoring process in place.

'We all have a monitoring role but it's not written into anybody's contract so somebody may think that they don't ... Certainly they would not necessarily see it as part of their role to challenge the school if they felt a child's needs wasn't being met. We don't have that sort of

process in place. So if you did have concerns, you'd either have to deal with it yourself or do nothing or contact the SIP [school improvement partnership].... But again that's a system I've worked with before but it doesn't happen.' (Shire, ASD Lead)

A range of review systems were evident, with authorities differing with regards to how often they said reviews took place and for whom. Some described conducting annual reviews of statements, although a proportion of authorities were planning to introduce more regular reviews. In other areas, regular meetings (each half-term or term) were held between the school and local authority officers. Two different approaches were described: a school-led process where schools identify the children who will be discussed (more common amongst the schools sample), with an emphasis on seeking advice; and an authority-led approach focusing on children with greatest needs or who appear not to be progressing, with the focus on scrutinizing of school approaches as well as on advice and solutions.

'One of the shifts we're trying to make...is away from being reactive to what school wants to talk about and being proactive in terms of what we want to talk about ... because if we can identify by the data we hold centrally, that there are children who appear not to be making the progress they should, those are the children that we' should be talking about at the consultation meetings... that's when you pull up that the identification is robust in children and not being missed.' (Metropolitan District, Assistant Director of Children and Young People Services)

There are also differences in whether these meetings included staff from a range of disciplines and agencies, whether parents are involved, and whether they have a wider care co-ordination remit or were focused on attainment.

Finally, there were differences between authorities in the way they described data being collected and analysed. A number of indicators or data were mentioned as being used to look at progress; P-levels, PIVATs, standard achievement tests, 'Average Point Scores' and Individual Education Plans. Some authorities said that they had invested in software packages such as 'RAISE online' and CASPA to capture and analyse data. Some said that they used the Family Fisher Trust methodology, which was felt to be more meaningful as it takes demographic factors into account.

School SEN leads also described their methods for monitoring progress. Some reported making extensive use of their information management systems and other tracking systems to monitor individual pupil progress across the graduated stages, and in particular at School Action Plus and statements. Some monitoring systems described involved tracking the success of interventions via regular assessments, for example reading and spelling ages. In a couple of instances, monitoring of pupil progress was extended to their wider participation in school activities, including after school clubs. In two primary schools, children were given the opportunity to track their own progress, using target sheets on the front of books to tick off their progress when they achieved small targets.

6.3.9 Involvement of parents and children

As noted in chapter four, local authority interviewees described differences in the quality of information for and the involvement of parents, and this was evident in their feedback about the strength of schools' relationships with parents. In some areas schools were praised for the way in which they communicated with parents. In others it was said that parents feel uninformed about problems their child is experiencing or the support that has been put in place. Indeed some local authority representatives felt their school provision was excellent but that parents were often unaware of this and so there was conflict between parents and schools and a lack of parental trust in mainstream provision.

There were also mixed views about how well local authority and school staff engage parents and children in review meetings.

The school leads interviewed described systems to alert parents as soon as a concern is identified. For some schools, making contact with parents as early as possible was important, not only to gain consent for assessments or visits from outside agencies, but also to access the parents' own views on their child's development. In some cases it was recognised as an area for improvement, and parent and child involvement was high on the agenda for discussions between SENCOs and authority staff. SENCOs outlined different methods used to involve parents and children:

- creating opportunities to meet with parents, via review meetings, parents' evenings and coffee mornings – sometimes involving other agencies and the local authority inclusion support teams
- keeping parents up to date on the progress of their child by sending home copies of Individual Educational Plans and provision maps
- signposting parents to Parent Partnership Services and other agencies and voluntary groups in the area.

Schools said that they also sent information about the assessment processes and the support levels to parents, although many SENCOs preferred to talk with parents face-to-face. With regards to the involvement of children, the most common practice was to involve children in drawing up Individual Educational Plans, ascertaining their views on their progress and helping to set targets.

6.4 Other support

A range of other types of support were seen as influential on children's needs being identified, assessed and met and in supporting schools.

6.4.1 Audiology services

There was generally a high level of satisfaction expressed with audiology services across the case study local authorities. This function is mainly provided by health, but supplemented by some expertise within specialist teaching and disabilities teams. Audiology support was characterised by good multi-agency working and early intervention - partly underpinned by systems surrounding the Newborn Hearing Screening Programme. Joint clinics and home visits involving health service audiologists and hearing impairment specialists from the authority were described. Some areas operate drop-in or open-door clinics but there were also reports of audiology clinics that are not easily accessible by public transport.

'It's very, very difficult for parents to get [to the audiology clinic]... they'll take a cab up there because it's the only way they can get up there...and they'll be going up there three, four, five times...these families are on benefits and can't afford it.' (London Borough, Head of Sensory Impairment Services)

Audiology services were infrequently mentioned by schools, but when they were, the view was that they were accessible and that it would only take a telephone request to secure a visit to the school.

Not all local authorities had specialist educational audiologists. Where they existed they were felt to add value, but there was also a view that the Newborn Hearing Screening

Programme meant they were less necessary. Finally, not having co-terminus local authorities and PCTs was sometimes a barrier to easily accessing audiology services.

6.4.2 Speech and Language Therapy

The situation regarding speech and language therapy was much more complex. Concern was expressed across many local authorities that speech and language therapy is difficult to secure for children that need it. This was largely attributed to a national shortage of therapists and a lack of funding. Also, where geographical boundaries of local authorities and PCTs are not aligned, there were said to be real challenges for commissioning and co-ordinating services.

The shortage in therapy and therapists was a concern for many local authority interviewees, and schools and families were said to be experiencing very long waiting times to receive support. This concern was mirrored in the views of school interviewees who reported access to speech and language therapy to be very constrained. There were also some clear examples of eligibility criteria that prevented some children accessing therapy at all. There were examples of local authority and school informants reporting policies not to provide speech and language therapy to children of secondary school age. Local authority interviewees described not offering speech and language therapy to children with ASD, or where language impairment was considered to be consistent with cognitive ability, and school interviewees said that access to therapy sometimes depended upon a statement.

Not all local authorities reported having therapists who were specialists in either ASD or hearing impairment. However, there appeared to be more specialist speech and language therapists available for hearing impairment than for ASD, and having this support was important in being able to meet statement requirements. However, there did appear to be some dedicated speech and language input for children with ASD where there were social communication difficulties teams in place and through autism strategy groups.

Across our local authority sample, there were differences as to who funds speech and language therapy. Alongside the health-led and health-funded service, some local authorities have funded additional therapist posts located in special schools or in specialist SEN and inclusion teams. There were occasional examples of joint commissioning or pooled budgets, and in one local authority education, health and social care formed a strategic commissioning group to fund, monitor and look at outcomes jointly. Joint funding was more likely to result in joint or co-ordinated delivery. Where therapy was funded separately by health and the local authority, school interviewees described a referral 'game', with school staff referring to two agencies simultaneously to try and access any kind of intervention. In others areas systems had been developed to better join up provision, as discussed in chapter four.

Some interviewees from the schools sample did describe instances where all children could access speech and language provision. Schools reported speech and language therapy: seeing pupils on a one-to-one basis; going into schools, developing a programme and training teaching assistants or Learning Support Assistants to deliver it; or providing advice only. In one authority, the school lead interviewed said the speech and language service was going to be restricted to a telephone helpline only (in line with the educational psychology service). By contrast, one school bought in speech and language therapy on a weekly basis and another had the advantage of a speech and language base, with a resident specialist.

6.4.3 Mental health provision

Altogether, authorities offered a combination of preventative and reactive services in relation to mental health and emotional well-being, largely provided by CAMHS. However, as is the case with speech and language therapy, there was a general perception that this support is difficult to get at the level required. Long waiting lists and delays were often reported by authority interviewees, and largely attributed to a lack of capacity within CAMHS services and high thresholds (for mental health disorder or for IQ) being in place to access support. These views were regularly echoed by the school sample.

However, some areas were said to have overcome this in different ways by local authority respondents. This has included investment in staff teams to create extra capacity, development of locality-based mental health posts to offer support to schools, and restructuring in order to form a fast-response service. Aside from one-to-one therapeutic services for children, CAMHS in some areas have also set up consultation systems to support other staff working with children. In one authority, a solution involved using charitable funding to set up a service with a pupil referral unit which also provided an outreach therapeutic programme.

There were differences between authorities in their view as to how much CAMHS was said to work in partnership with other agencies. In some, there was a reported shift towards increased integration, for example through joint commissioning panels, service planning groups or teams around the child. However, some schools reported a lack of feedback or information sharing following referral:

*'There is little communication between CAMHS and the school. Confidentiality is one of the problems I believe... there's a database problem there as well. But I just have a problem with children who are dealt with by somebody else and then they don't share the information. I believe it's a requirement that we're *in loco parentis* of those children while they're in school, and we need that information. The only place we get it from is if parents decide to let us know, and that also includes children [to whom] we give the drugs, Ritalin. And we get that information from parents, not from the CAMHS.'* (Inclusion lead, secondary school)

Local authorities also described broader preventative approaches, not always led by CAMHS. The Social and Emotional Aspects of Learning programme has been implemented in some areas and in others there is central funding for nurture groups. Some authorities also fund family support workers, attached to each school, who provide a holistic range of support to children and families. Indeed, some schools said that they now had primary mental health workers attached to them, and the SEN leads in question were very positive about these roles. A cluster of schools had grouped together to pay for this service, as the CAMHS in their authority was reported to be poor. Another SEN lead, who said that their local CAMHS had been 'dire', but was now improving, attributed this to the positive effect of having a primary mental health worker attached to the school.

This approach is supplemented in some areas by tier one CAMHS training for schools staff, raising awareness about mental health issues and referral pathways. Peer-group development, deaf 'role-model' systems or 'buddying' programmes, were all referenced and seen as useful to minimise isolation and mental health problems for hearing impaired children. It was expressed that there is a high level of mental health problems among children with hearing impairment and that it is difficult to access specialist CAMHS support. However, some were able to access specialist provision for children with hearing impairment within the region, for example a hospital-based service that London and South East boroughs can access.

6.4.4 Social care

Across all local authorities, high thresholds and capacity constraints created barriers to access to social care for many children with SEN. This was also largely evident in feedback from schools who found provision and communication inadequate. Conversely, one school SEN lead had regular meetings with social care and used joint referrals to CAMHS to speed up access.

It was widely said by local authority interviewees that better social care support for families with a child with complex needs, and better inter-agency support, would reduce out of area placements. Across the board there was said to be a short fall in capacity for short breaks provision - and a view that this is under-recognised in relation to children with hearing impairment - but many interviewees were currently enthusiastic about the new influx of *Aiming High* funding, and some were pilot areas. Some interviewees discussed the benefits of using Direct Payments to give parents more control and flexibility, but several areas reported that a shift to this system was hampered by an insufficient pool of support workers.

Finally, there were also said to be gaps in play provision (although this was developing in some areas which had secured funding through the children's play programme); independent living; transport particularly to support children's inclusion in wider school activity, and leisure facilities.

6.5 The attainment gap indicator and funding levels indicator

As described in chapter one, we used an indicator of the gap in attainment between children with statements and other children, based on performances at Key Stages 2, 3 and 4. There seemed to be some association between a low attainment gap and reports of good quality provision across the board. However, there were several outliers - areas where provision appeared good but attainment was in the lowest quintile, and vice versa. Interviewees largely felt that this indicator was not robust because it also reflected differences in the rate of statementing and in overall attainment levels, and felt that a measure of progress made or that indicates children's starting points would be more meaningful.

In authorities where there was a low gap in attainment, this was said to be linked to a number of causes: good quality provision, a focus on early intervention, a focus on positive emotional development, and an overall priority on attainment were thought to be influential. Parental engagement was also cited as key in supporting children's learning and in the school gaining information about the child.

Reasons given for a high gap focussed on high attainment levels for children without SEN, and on statements being reserved children for with most complex needs.

We also used an indicator of the funding per child with SEN, excluding special schools. The level of funding was seen to reflect overall local authority allocation from central government, the priority of SEN provision among elected members, and in some areas low council tax intentions. However, we did not find a clear link between spending levels and the extent, or views about the quality, of SEN provision. The indicator will be influenced by local practice in identifying children as having SEN and the use of special schools.

6.6 Summary

All local authorities were looking at reducing and reorganising school provision to build a spectrum encompassing special schools, specialist mainstream provision and mainstream schools, with the focus generally shifting away from special schools. There were many influences on this, from interpretations of inclusion to size and history.

But an important part of what made change here successful was winning the confidence of mainstream schools and of parents and leadership, consultation and partnership were key here.

Ensuring that schools have the tools to do the job was also important. There were different approaches to providing specialist support to mainstream schools, particularly differences in focus between supporting an individual child and taking a whole school approach. Schools were not always thought to be making full use of what was available, highlighting the importance of winning hearts and minds. Training and capacity building were also important ways of ensuring people have the tools for the job. There were different approaches to monitoring the progress of children with SEN: a focus on attainment or on inclusion, and a schools-led advice-seeking approach or a local authority-led scrutinizing approach. This is an area where there is scope for more support in developing a common system.

Finally, other forms of support – audiology services, speech and language therapy, mental health provision and social care – also play an important role in assessment and provision, but capacity is often constrained.

Chapter 7: Use of the Code of Practice levels and statements

This chapter looks specifically at variation in the use of statements. We begin by describing the reduction in the use of statements and exploring the link between statements and funding. We then look at parents' and schools' involvement in statementing and how local provision and population influences the use of statements. Finally we look at the use and monitoring of Code of Practice levels and funding.

7.1 Variation in the use of statements

7.1.1 Local authorities approach to using statements

Most interviewees in our case study areas reported that their use of statements had declined, and this assertion was echoed by the schools sample (see 7.1.6). This policy was said to have been driven by the emphasis on the role of mainstream schools in educating children with SEN, and also by recognising the resource demands, stress and bureaucracy that statutory assessment involves. It also reflected a perception of pressure from elected members and central government to reduce statementing.

The reduction in statements was said to have come about despite it being generally noted that the number of cases of children with severe and complex needs was rising. Many local authorities talked of writing statements almost exclusively where a child needed a special school, out of area or independent placement, or had particularly high level and complex needs: other local authorities said that they were moving deliberately in this direction.

To assess how far local authorities were using statements predominantly for these purposes, we looked at the proportion of children with statements who were not educated in mainstream schools²⁰. Overall, as chapter three describes, there was some correlation between this and the number of statements written: the more statements were written, the smaller the proportion of children with SEN in non-mainstream provision. In authorities where a statement did not automatically carry resources (see next section) a lower proportion of children with statements were in mainstream provision, and statements seemed to be mainly used to access specialist provision.

There were some differences between our case study local authorities in their reported use of statements for pre-school children. Some said they rarely used them since provision was generally good enough to meet needs without a statement. Others where statementing was higher reported that this reflected the success of policies to identify and intervene earlier and indeed one local authority reported that around half of new statements were issued to pre-school children.

Overall, though, there seemed little to distinguish high and low statementing authorities in how they described their intended use of statements. What appeared to be more significant was the structure of funding for mainstream schools and the extent of support from schools and parents for educating children with SEN in mainstream schools.

7.1.2 The influence of local provision and local populations on statementing levels

Variation in local provision and in local populations emerged as explanations for variation in the level of statementing. All three of the local authorities with ten or more special schools

²⁰ That is, in maintained, non-maintained and independent special schools, hospital schools and pupil referral units – see chapter 2 for more details.

had high rates of statementing (and all also had low levels of appeal). Other local authorities with high levels of statementing attributed this to the prevalence of independent special schools within their area, or the quality of special schools in neighbouring areas. Some local authorities with high levels of statementing said that this could be due to the prevalence of Black and minority ethnic groups or migrant communities: one such local authority said that over a quarter of their statements were made for recently arrived migrant children. Having a more affluent or assertive population was also felt to lead to more pressure for statements. As outlined in 3.3.1 more deprived areas have higher levels of SEN, but have lower statementing rates, which might support the assertion made by some interviewees that parents in more socially advantaged areas are better able to push for a statement.

7.1.3 Local authority funding models and links with use of statements

Local authorities described delegating much of their funding to schools under formulae based on area deprivation measures, free school meals entitlement, and attainment. Some also included the proportion of children identified as having SEN, or being at School Action Plus, or having a statement whilst others avoided these, seeing them as creating perverse incentives to increase the assignment of children to these categories (also discussed in 5.3.2). Gender and ethnicity were also occasionally taken into account. Schools in one local authority, where all funding was delegated to schools, reported a clear authority-led approach, covering both educational outcomes and how funding for provision at School Action Plus and statements was spent.

What was more significant however was whether additional money was available to schools from the local authority to meet the needs of specific children. In authorities where this was the case this was managed by centrally retaining a proportion of funding that would otherwise have been delegated, and distributing it to schools as additional funding. The research found a strong association between high use of statements and funding systems under which statements carried additional resources. Overall we found two main models:

- *Delegation plus statements*: here, as well as the delegated funds, schools were allocated further funding linked to statements, so that statements carried additional resources. This group included most of the local authorities with high or average statementing levels: only one was in a low statementing quintile²¹. The group was also characterised by relatively high levels of appeals²², and by accounts of more challenges in securing schools' and parents' commitment to inclusion.
- *Delegation plus top-up funding*: the second model was where statements did not carry additional resources. Instead there were systems for top-up funding for children with higher levels of need, which applied at School Action Plus as well as when children had a statement. This meant that the same provision could be available to both groups of children, and indeed we were told some children at School Action Plus had more funding than some with statements. There were different mechanisms to ensure consistency in decision-making: multi-agency panels to determine applications, individual negotiation with schools reflecting the school's financial situation and whether the school was already accessing relevant provision for similar children, a combination of individual negotiation for swift resource allocation but with retrospective review by a panel, and clusters of schools whose SENCOs met to agree whether an application to the funding panel should be made. The fund varied from a small top-up fund to a very significant

²¹ And indeed interviewees in this local authority were surprised at our assessment of their statementing level and felt it was inconsistent with local intelligence

²² As we note in chapter 2, appeals can be made against the content of statements as well as the refusal to assess or write a statement, but local authority interviewees generally saw the level of appeals as an indication of the quality of their relationships with schools and parents.

amount. This group was characterised by low levels of statementing, low levels of appeals, and generally more support by schools and parents for mainstream education.

There were also two local authorities which said that they used both funded statements and top-up funds. In one, all statements carried additional funds, and here again there were high levels of appeals and a strong attachment to statements by schools and parents was reported. Just one local authority delegated all funding to schools without any system for additional funding. They had a low level of statementing according to our analysis of the SEN indicator (although all three local authority interviewees felt this was inconsistent with local information), high rates of appeals, and schools' buy-in to inclusion was said to be a challenging area.

Where the top-up funding system had been introduced, this was part of a deliberate policy to reduce the use of statements, and was seen as having been successful in achieving this.

'We're relatively low and we're reducing in terms of issuing statements of SEN because we have a good system of delegated funding, which has been in place since 2005, the funding for inclusion. So in fact statementing numbers are falling because there is now no incentive for schools to request a statement for a child. For children who require additional support, the funding is generally within the schools. For exceptional cases we have central funding, irrespective of whether the child has a statement or not.' (Shire, Principal Education Officer)

Top-up funding was valued for a number of reasons within the case study areas. First it was seen as a fairer system than fuller delegation. It meant that money could '*follow the child*' so a school was appropriately funded especially for children with low incidence but high cost needs. It was also seen to support parental choice: the family could choose the school knowing the funding for their child would be in place. It was viewed as a quicker way of getting resources to schools than via statements, freed professionals from the stress and bureaucracy of statutory assessments, and was seen as a less stressful route for parents too. Some shortcomings were acknowledged though, particularly around consistency in decision-making. One interviewee felt there was less clarity about parental involvement in the process than in statutory assessment. In some areas it was thought that not all schools were aware of and making full use of the system. Generally however this model was seen as consistent with inclusion, supportive of schools and families, and integral to reducing statements.

Local authorities who said that they were using a model under which statements carried additional resources found it harder to point to advantages: indeed it was widely felt that this model explained higher levels of statementing. The fact that statements continued to carry resources was said to reflect the expectations of schools and parents, and it was noted that it was very difficult to challenge this culture.

'We do have quite a high expectation amongst parents and schools that a statement somehow is a useful thing... a goal in itself and [the local authority has] an objective to move away from that. At the moment we have a funding system for schools whereby a statement brings quite a lot of money, and our current objective is to try and break that link, because obviously if the schools need the money they then want to go through the statutory assessment process, which is drawn-out [and] quite challenging for parents. We're seeking to make more of the money flow through to the schools without the need for [a statement] so they can meet the needs earlier.' (Shire, Head of Access and Disability)

7.1.4 Monitoring schools SEN funding

There was also a general recognition amongst local authorities that more needed to be done to monitor schools' spending of money allocated to schools for SEN provision. (Indeed

awareness of funding monitoring was varied amongst the schools sample, and a number of SEN leads were not directly involved with budget monitoring or liaison with local authority staff.) Some local authorities said that they had specific teams to monitor spending, or did this as part of overall school monitoring processes. Provision mapping, where it had been introduced, was felt to help. One local authority informant felt there was little scope to monitor spending of delegated funds.

There was also a view amongst authorities (especially where schools were said to be less engaged with the inclusion agenda) that schools do not always understand exactly what they are and are not already funded to provide. One (low statementing) authority said that they had begun a policy of writing to the headteacher, SENCO and SEN Governor at every school annually to outline the funds delegated for SEN provision.

School representatives also described varying levels of understanding of SEN funding for their school. Funding formulae were not always understood in detail, and were not always seen as appropriate ways of allocating between schools. Two interviewees in particular were concerned that funding formulae based only on deprivation data would not adequately take into account the individual needs of children. Statements were sometimes seen as a significant source of additional funding and there was some preference for funding systems within which funding follows the child:

'With the best will in the world, an index of deprivation formula is not necessarily an indication of what you've got in your school...there is an extent to which putting the funding in relation to individual needs ensures that it follows the children who need it rather than [having] a global figure that's attached to a school.' (SENCO, Primary School)

One SENCO reported having no knowledge of the level of the SEN budget or what it covered, but others were more informed. School representatives described varying levels of access to additional funding via panels, either an enhanced School Action Plus or other systems. However, not all school interviewees were clear about the scope to access additional funding. There were widespread concerns about budget cuts, and a view that SEN funding needed to be better ring-fenced. It was also recurrently said that the level of funding was too low, and that covering both staffing costs and additional services was difficult:

'We can access some speech and language support, but it's based on whether we've got the finance to do that...unfortunately, the budget that's allocated for SEN, it includes my wages as well as the Learning Support Assistants [and] when we hold reviews [it covers] supply staff to release teachers. So the budget is taken up with wages, where it could really be used for interventions and resources.' (Inclusion Lead, Primary School)

7.1.5 Partnership with schools and parents in the use of statements

Local authorities where staff were reported to be working to reduce levels of statementing talked about the need for buy-in from schools and parents to support this approach. They saw the ability of schools to provide creative, proactive support to pupils with SEN, and to develop close and positive relationships with parents, as being central to being able to move away from dependence on statementing. Explaining and actually demonstrating to parents that their child's needs would be met without a statement was seen as critical to winning parents' trust. Direct communication with parents, being open and honest, and the support of the Parent Partnership Service were seen as important in achieving a cultural change away from dependency on statements. However interviewees sometimes felt there remained some anxiety on the part of parents:

'We would much rather be conciliatory and work with families, schools and children to meet their needs...[but] that's almost a whole mind shift for people who ... feel that they've got to fight for everything they can for their child.... We do try to work really closely with parents and families, in terms of trying to find the best provision ... and [explaining how] their needs are being met...We have regular meetings and keep the lines of communication open... the parents have to trust that we are doing the right thing And also that they can see that their child is progressing, that their condition is acknowledged and respected within school and that the people who are working with their child have some level of training.' (Unitary, ASD Lead)

In areas with higher statementing, or with relatively low statementing but high appeals, local authority interviewees described schools pushing for statements because they did not trust the local authority to support the child adequately, encouraging parents to apply for statements or telling parents they were not funded to meet their child's needs. Parents were described as wanting the security of a statement – even where the statement did not bring additional funding – and being mistrustful of the school or local authority to support their child without one. Generally, there was recognition of the need for more partnership work with parents to explain how their child could be supported without a statement.

7.1.6 Interpreting the Code of Practice

Interviews with schools further demonstrated differences across authorities in highlighting variation in the interpretation and use of statements and other Code of Practice stages in schools. In addition, there were differences as to whether application of the stages was understood to impact on resources available for the school.

As highlighted previously, across the schools sample there was a recurrent view that fewer statements were being issued. In some areas, school representatives suspected that the local authority was cutting back on statements in order to save money, and in one area there were reports of a cap placed on the rate of statementing. However, when statutory assessments were being undertaken, the process was seen as slow, restrictive and cumbersome, and there were concerns that the delay meant children were not getting appropriate support and children's needs were not being met.

With regards to how much statements were seen to bring additional resources, in some local authorities, having a statement was seen by schools as the only way to access one-to-one support for a child. One SEN lead was particularly frustrated by this in relation to children with ASD, saying that the lack of one-to-one support exacerbated behaviour problems and the intervention was needed much earlier. Another school highlighted issues raised by the practice of naming a specific school on a statement:

'The notion that parents can name a school on the statement, if they want to, without any consultation with the school, is very problematic. A huge issue that I experience in my job is having to say no to parents, because we've already got four children in that class with a statement and we cannot take a fifth, it will be to the detriment of the other children. It doesn't happen often, but when it does happen it's an enormously distressing and time consuming experience. I think there could be much more dialogue beforehand.' (SENCO, Primary School)

SEN leads at primary schools attached value to statements in that a child with one would have their choice of secondary school and guaranteed provision:

'Obviously the statement is the magic golden ticket in secondary, in terms of having extra support, in that transition for children with a statement has to be monitored...there are more checks and balances for it to be done well. ... I think, in terms of transition in

children at School Action and School Action Plus are very vulnerable, particularly if their need is emotional and behavioural.' (SENCO, Primary School)

The fundamental line between School Action and School Action Plus was generally seen as clear by schools in that it depended upon whether or not support from outside the school was being used. However, beyond this, understanding and application was less clear-cut across authorities as thresholds and practice appeared to vary. For example, school representatives occasionally described using School Action for any child who was substantially below the expected cognitive ability test level or where behavioural problems had not been resolved following initial intervention. In addition, in one area a SENCO said they accessed outside support informally for some children placed at School Action. In another it was said that the distinction is meaningless if it is not possible to access the outside support, such as speech and language services.

There were also some examples amongst school interviewees of an enhanced School Action Plus system being in place. The system was welcomed by interviewees in that it providing speedier access to provision, although one interviewee was concerned that such provision was not protected as it would be with a statement and could be taken away.

Finally there were differences in opinion as to whether recording a child as having SEN affected the school's funding allocation, although this was not explicitly linked by interviewees to the school's use of the Code of Practice.

7.1.7 Monitoring the use of Code of Practice levels

Ensuring consistency in the use of the Code of Practice levels of support was seen as important by local authority interviewees in reducing reliance on statements, but the management of this varied across the case studies. Local authorities with relatively low rates of statements reported having panels for top-up funding and saw these as a useful forum for reviewing the use of School Action Plus and statements. Some low statementing authorities also described moderating panels or groups which reviewed the use of School Action Plus and proposed applications for statutory assessment to agree whether they should be taken forward. In others this was an aspect of the work of school monitoring teams.

In high statementing authorities there was more acknowledgement of the need for moderation. Some local authorities felt that School Action Plus was over-used by local schools, to massage their value-added or because the numbers at School Action Plus were reflected in the allocation of SENCO resources. Some said there was no moderation or review of the use of the Code of Practice.

In line with this, there was variation in whether school representatives had experienced moderation of the use of the levels. Some SEN leads reported that they were unaware of a monitoring process or that there definitely was none. More formal monitoring systems were said to be in place in some local authorities (particularly those which delegated SEN funding to schools) whereby inclusion officers would go into the school once or twice a year to review pupil progress and their placing within the graduated levels. SEN leads reported anecdotal evidence from colleagues that schools were using the stages differently. Where monitoring was reported not to be in place there was also a feeling of isolation, with one SENCO noting that they simply did not know how they were using the stages in comparison with other schools in their authority.

Clear guidance and training for SENCOs was also seen as critical aspects of ensuring consistency by local authority representatives.

'If you have a very robust system for making decisions that's clear, transparent and is as objective as it possibly can be, then people don't put things in on spec schools won't immediately rush and put a child in, because they know they've got to wait, we need to see the evidence because otherwise we can't be fair ... you try and create a feeling that there is no system to play here, we're being fair and honest.' (Unitary, Head of Assessment, Intervention and Psychology)

Despite this, feedback from school representatives suggested that there were differences in the amount and quality of guidance provided by local authorities to schools about the use of the graduated stages in the form of handbooks, guidelines and matrices of need. Whilst some SENCOs reported that their local authority had issued clear guidance on the use of the stages, for others authority guidelines were 'woolly' (including descriptors but no examples) or did not have strict criteria for each stage. In some areas training on the use of the levels was available through courses and workshops or on a one-to-one basis with a SEN advisor, and in areas where such training was not available, this was identified as a gap.

7.2 Summary

The use of statements varies considerably, more obviously because of differences in the link with funding and schools' confidence than because of differences in intention. Systems where the money *'follows the child'* seem to support a reduction in the use of statements and were viewed very positively. But there seems to be scope for more work to ensure that schools understand their SEN budgets and know what they are expected to cover with them, and for closer monitoring of their spending by local authorities.

Chapter 8: Discussion

In this chapter we draw out key themes from the study findings and discuss their implications for policy and practice. We begin by looking at the nature of variation drawing out key issues relating to the two exemplar conditions, ASD and hearing impairment, before turning to consider how this variation arises. We discuss the implications of this variation for interpretation of the SEN statistics used in the study, the degree to which these statistics are meaningful and revisit the hypotheses outlined in chapter one. We identify factors that appear to underpin quality across the various aspects of practice and provision that we have considered. However it should be noted that although the literature review identified factors contributing to good practice, there is a lack of evaluation of effectiveness and ‘what works’. Lacking an objective and robust measure of quality, the study relied on interviewees’ assessments of their practices and services and the components of good practice that were said to be in place. We finish by looking at the implications of the findings for policy and practice and how the performance of all local authorities could be brought up to the level of the best.

8.1 The nature of local variation

The study has highlighted variation between local authorities in the proportion of children identified as having SEN; the prevalence of ASD and hearing impairment; the models and quality of identification and assessment; transparency and consistency in assessment and referral pathways; the degree, forms and quality of multi-agency and multi-disciplinary working; the type, the extent and quality of support in early years and in schools; the nature and extent of specialist provision, including the use of out of area placements; the relative attainment of pupils with SEN and all pupils; the use of the Code of Practice levels of support; how funding is organized and accessed; and the availability of other forms of support.

This means that, as other studies and reviews have documented, if we imagine a group of identical children living in different local authorities, they could have quite different experiences of the SEN system – differences in whether and when their condition is diagnosed; whether they are identified as having SEN; what is recorded as their primary condition; whether knowledge of their needs is shared between agencies and teams; what level of the Code of Practice their needs are assessed as being and particularly whether they have a statement; what type of school they attend; how they are supported there; whether the school receives money specifically identified for their provision; how far they are included fully in school life, and their educational outcomes.

To illustrate this variation we draw together the key issues relating to hearing impairment and ASD highlighted in the preceding chapters.

8.1.1 Variation relating to hearing impairment

The prevalence of hearing impairment varied from 1.1 children per thousand in the lowest prevalence quintile to 2.2 children per thousand in the highest with a mean of 1.8 children per thousand. This is broadly consistent with Fortnum and others’ study (2001) of nine-year-olds but well below the level of 3.47 children per thousand at school entry screening age (Bamford and others, 2007). Given that the primary condition is not recorded in the School Census for children at School Action this figure is likely to be a considerable underestimate.

The Newborn Hearing Screening Programme was generally seen as operating well in our case study local authorities, and as having improved identification, although problems were noted in two authorities and the NHS audit has highlighted significant regional differences in the quality of the service (MRC Hearing and Communications Group, 2008). Assessment was said to be health-led and rarely multi-disciplinary or multi-agency, but there was specialist teacher input in some local authorities. There were generally thought to be good systems for notification between health and education, although sometimes less so with social care. There was variation in whether local schools did hearing screening, and there were mentions of children with hearing impairment being missed – children who were under-performing and quiet in class, and children seen as having poor concentration and attention span or challenging, disruptive behaviour. More training for school staff in recognising that these may be signs of hearing impairment was widely thought necessary. Few leads mentioned using the National Deaf Children's Society guidelines (NDCS, 2007), although more described clear pathways and protocols being in place for identification and assessment.

Children with hearing impairment were described by interviewees as varying from those where hearing loss is the only condition to those with severe and complex disabilities, with the latter group particularly dominant among younger children. Hearing impairment was not always recorded as the primary condition – some children with hearing impairment were reported to be recorded in the School Census as having multi-sensory impairment; or in the profound and multiple, severe, or specific learning disability groups. Although hearing impairment could be recorded as a secondary need, this was not always the case.

Very few of the case study local authorities had specific strategies or multi-agency planning groups for hearing impairment. Children's Hearing Service Working Groups were seen as useful but not always sufficiently strategically focused, and with limited access to pooled funding. The low incidence and fluctuating population of children with hearing impairment was said to make planning difficult. Hearing impairment specialists were often in an integrated team which was seen as beneficial, although there was also some concern that the focus on hearing impairment and on education needs could sometimes be lost.

Most local authorities in our sample said that they had no designated provision in special schools for children with hearing impairment; children with hearing impairment who attended special schools were in schools designated for wider groups such as children with profound or moderate learning disability. Some had no designated specialist provision in mainstream schools, while others had additionally resourced provision of different kinds. Out of area placements were used to fill gaps in provision particularly where preferred communication methods could not be met locally, where education within the deaf culture was sought, and for children with complex needs.

Nevertheless, there was a perception among many interviewees that the needs of children with hearing impairment who were in mainstream schools could be met well and quickly. teachers of the deaf played a central role in providing this support, and it was rare that gaps or difficulties in accessing support were described by local authority leads, or indeed by the Parent Partnership Service and voluntary and community sector representatives. This contrasts with the findings from the interviews with school staff, however, where variability in the support provided for children with a hearing impairment was described.

Although audiology services were often seen by local authority leads as working well, this was less likely to be the case in areas where PCT and local authorities were not co-terminous. Some interviewees, particularly in schools, referred to long delays for assessment following referral; and the NHS audit has highlighted variability across the country in the performance of audiology services (MRC Hearing and Communication Group, 2008).

Hearing impairment specialists were rarely described within speech and language services or mental health services and this was seen as more of a gap. There was some concern that the needs of children with hearing impairment for short break provision were not recognised, and that there was unmet need for social care support. This was also identified as an area of concern in research commissioned by the National Deaf Children's Society (Young and others, 2008).

8.1.2 Variation in relation to Autistic Spectrum Disorders

The prevalence of ASD reported in the SEN statistics varies from 4.1 children per thousand in the lowest prevalence quintile to 7.2 children per thousand in the highest quintile, and the mean of 5.8 children per thousand is considerably lower than the most recent robust estimate of 11.6 children per thousand (Baird and others, 2006). ASD appeared to expose more frailties in SEN systems than hearing impairment in a number of ways. Children recognised as having ASD were reported to be a fast-growing group, and provision was often seen as lagging behind need.

There were different models for diagnosis among the 16 case study local authorities: a multi-disciplinary assessment often coordinated through the Child Development Centre versus a health-led assessment by paediatricians or CAMHS. Not all local authorities were following the good practice standards suggested by the National Autism Plan (NIASA, 2003) or National Service Framework Autism Exemplar (DH, 2004) in their entirety. There were widespread reports of delays in assessment by speech and language therapists and educational psychologists, and the clarity of the assessment and diagnostic pathway also appeared to vary. The implication, sometimes stated directly, was that ASD was harder to diagnose than hearing impairment, despite the availability of standardised diagnostic tools. Several local authorities described some children being diagnosed later than might be expected. Although it was generally thought that only a child with a specific diagnosis of ASD would be thus recorded in the School Census, some children with ASD were said to be recorded as having other primary conditions, particularly behaviour, emotional and social difficulty or speech, language and communication needs.

Referral pathways tended to be clearer for younger than for older children, and notification systems between health and education were not always thought to be robust. Access to services varied and interviewees said that there could be long delays for services such as speech and language therapy.

More specialist education provision for children with ASD than children with hearing impairment was reported by our case study local authorities, although this was not necessarily ASD-specific. Some local authorities had special schools or bases designated for children with ASD; others had placements in schools designated for children with behavioural, emotional and social difficulties or speech and language difficulties. Out of area placements were used for children with more severe needs. Almost all local authorities had specialist provision within mainstream schools, usually both primary and secondary although sometimes just one of these, and sometimes with either a narrower focus on children with Asperger's syndrome or a wider focus on children with behavioural, emotional and social difficulties or speech and communication difficulties. Some concern was expressed about the use of behavioural, emotional and social difficulties provision for children with ASD.

Where children were in mainstream schools, the impression given was of more difficulties in meeting ASD needs fully than emerged in relation to children with hearing impairment – managing children's behaviour and adapting the wider school environment seemed to be particularly challenging. Support in mainstream schools appeared to be more differentiated for children with ASD. It was rare for interviewees to mention specialists in ASD within speech and language services or in mental health services or social care.

8.2 Explaining variation

A key aim of the study was to increase understanding of the kind of factors that might help to account for variation. However, the very wide range of practices and approaches we found both within as well as between local authorities make it difficult to disentangle cause and effect and arrive at a simple explanation. Instead, variation appears to be a product of a number of interrelated factors, which we discuss here.

8.2.1 Structural area differences

There are differences in the size and structure of local authorities that could explain part of the variation we have described. Smaller authorities may lack the funding or critical mass of need to allow some types of provision – but they may also find it easier to develop multi-agency working across a smaller professional group. There are suggestions that wider population differences explain some of the differences in the prevalence of SEN, disability and particular conditions, and we have seen that deprivation explains some of this variance. Whether boundaries with PCTs are co-terminous affects the ease of development of multi-agency working and pooled budgets or joint commissioning. Recent boundary changes, or the excellence of provision in a neighbouring authority, could help to explain higher levels of out of area provision. The structure of school provision – the legacy of a large number of special schools; a strong independent sector; the number of grammar schools, academies or national challenge schools; and attainment levels overall – is influential. The availability of funding for SEN, influenced in part by the level of the Direct Schools Grant (DSG), is relevant although there is insufficient data from the case studies to draw any conclusions about the relationship between DSG and local authority spending on SEN.

8.2.2 Different stages in policy and practice development

It was clear from the case study interviews that some local authorities are going through substantial restructuring as they move to integrated Children's Trust arrangements, with implications for organization at both structural and operational levels. For some, SEN and inclusion strategies have been a high priority for several years; for others they appear to be only just becoming a priority area. The configuration of school provision is changing and the pace of this varies. Many of the local authority leads we interviewed were relatively recently in post or were 'acting up', and they talked of the impact that instability and capacity issues within the senior management team has on implementing and achieving positive change. Several of the people that we interviewed told us that if we came back in a year or two years' time, we were likely to find a different picture. Part of the story in variation is that some local authorities are further down the road in policy and practice development than others.

8.2.3 Interpretations of inclusion

Another level of variation is different interpretations of the concept of inclusion. All the local authorities we visited had inclusion strategies, and all the local authority leads we interviewed were committed to the principle of inclusion, although there were some differences in how far they felt that commitment was shared by councillors and by schools. But beneath this broadly collective commitment to inclusion we heard some very different discourses:

- inclusion in the sense of education in mainstream settings or in the sense of full participation in mainstream school life, not only during teaching time and not only on site
- inclusion as meaning education in a mainstream setting or education in the type of setting that provides the best education to a child

- inclusion meaning a focus on providing specialist support to an individual child or changing aspects of the whole school culture with implications for all children
- inclusion requiring clear diagnosis and documenting of conditions, or an approach that is wary to 'label' too early and where identifying a child as having an SEN is not significant in their eligibility for support.

These different interpretations are not necessarily held explicitly or consistently within local authorities, and they are differences in emphasis rather than profoundly held philosophies across the local authority. But they can have implications for the approaches taken, as there are some inherent contradictions in these different discourses.

8.2.4 Overarching aspects of local authority approaches

There were differences in several overarching aspects of local authorities' approaches.

First, there were differences in the reported degree of multi-agency working at a strategic and operational level, and in the degree of multi-disciplinary working. At the strategic level there were differences in the move to integrated Children's Trust arrangements and particularly in how far health is part of multi-agency working; in the nature and function of strategic groups and how far their work has progressed; and in moves to joint or pooled commissioning arrangements. At the operational level there were differences in the use of integrated teams, co-located teams, locality-based multi-disciplinary working, and models such as team around the child (or family, or school), keyworking and lead professionals. There were also differences in the degree and nature of information sharing, and in how far information technology and data protection barriers were said to have been overcome.

Second, there were differences in the level and nature of strategic planning, and in the degree to which there has been extensive audit or review of needs and planning of provision. Local authorities were at different stages in the development of written pathways and protocols, in how transparent the provision available is to parents and professionals, and in the quality and emphasis on systems for giving information to parents and young people.

Finally, and perhaps most importantly, there were differences in the degree to which work on inclusion was reported to have involved partnership with families, children; with organizations that work to support them - Parent Partnership Services and the voluntary and community sector; and with schools. In relation to parents and children, there were differences in how far consultation and involvement, both at the level of policy or service development and at the level of individual case planning, was coordinated and strategically-driven, its extent and quality, and whether it was seen as being influential. There was generally less evidence of initiatives to involve children than parents. There were differences between local authorities in whether their provision was seen as responsive to and driven by the wishes of local parents, and how far local families and local authorities were seen as working together or as having somewhat conflicting needs, interests and viewpoints. There were differences in whether Parent Partnership Services and the voluntary and community sector were said to be involved in strategic planning. There were also differences in how far schools were seen as having bought into the inclusion agenda, the proximity and cooperative nature of relationships between schools and local authority teams, how far tensions existed between inclusion and attainment, and how far the local authority's role was one of constructive and effective challenge of schools.

8.2.5 Specific policies, practices and services

Finally, there was variation in specific policies, practices and services. Here there are a number of issues.

First, there were different approaches to identification and assessment, particularly in the range of ways in which a child with SEN might be identified and assessed, the use of multi-agency and multi-disciplinary assessment, the availability of specialist professionals and speed of access to diagnoses, the implementation of the Common Assessment Framework and of the Early Support Programme, how smoothly and quickly referral following assessment happened, and the quality of information and involvement of parents at this stage. These will affect how consistently children are identified as having SEN and assessed, and local authorities acknowledged their systems were not water-tight for all groups of children.

But beyond this there were also differences between local authorities in the use of the SEN designation. There appeared to be varying levels of resistance to perverse incentives associated with identifying more children as having SEN –such as increased SEN funding or SENCO resource, improving results in terms of contextual value-added measures, and framing children who were not being well-served by education as children who have special needs. There was said to be scope for schools to over-use SEN identification to massage performance, though it is difficult to know to what extent they did so, and this relates to the degree to which they were active and willing collaborators in inclusion strategies.

Schools' buy-in to inclusion was also reflected in the use of the SEN Code of Practice levels of support and particularly statementing. Although there were not obvious differences in the way in which local authorities intended the Code of Practice support levels to be used, there were differences in how they were said to be used in practice. This is linked to differences in how far there was active moderation by the local authority, but a key additional issue is whether or not a statement brings additional resources to a school.

A further important influence on schools' engagement in inclusion was the extent to which they were able to access specialist support and training. There were differences in how far this was seen as strategically-driven and coordinated, the models of provision, and how far the focus was on building capacity to meet the needs of individual children or on making schools inclusive environments for all children. There were differences in the methods and models used to assess the progress of individual children, and in how far this was schools-led with the emphasis on advice and shared solutions, or led by central local authority teams with a focus on accountability for poor outcomes and challenge as well as advice. There were also differences in how far schools were using provision mapping, and how closely their spending was monitored by local authority teams.

There were also differences in the ease of access to other services, particularly audiology, speech and language therapy, mental health services and social care. There were differences in how far they were integrated with other provision particularly with schools and in availability and speed of access, and there were important areas of shortfalls in services. The move to integrated strategic structures is relevant here, and local authorities have to varying degrees found ways of overcoming challenges.

8.3 Variation and the SEN indicators

The variation in approaches within local authorities raises the question of how meaningful and robust the SEN indicators we used are as a way of differentiating between local authorities. We also revisit the hypotheses outlined in chapter one that influenced our

selection of local authorities, but it is important again to note that when we refer to quality, it is the perceptions of quality from the interviews with local authority and voluntary sector staff together with the features of best practice that interviewees described in their accounts that we are drawing on.

- The SEN prevalence indicator (total pupils with SEN per thousand) varies from 167.4 in the lowest quintile of local authorities to 219.8 in the highest. This variation does not appear to link strongly with identification and assessment processes, as we had hypothesised. Intervening influences are whether significance is placed on the SEN ‘label’ for accessing services or support within schools, and perverse incentives to over-identify. Thus our hypothesis that a higher prevalence of children with SEN is indicative of better identification is not proven.
- The prevalence rates of ASD and hearing impairment (per thousand pupils) were generally not seen as robust measures by our sample, largely because allocation to condition categories in the School Census was seen as unreliable. However, good identification systems, such as the Newborn Hearing Screening Programme, were said to be associated with higher prevalence rates for these conditions.
- The rate of statements ranges from 22.3 per thousand in the lowest quintile of local authorities to 32.1 in the highest; the proportion of pupils with SEN who have a statement varies from 12.1 percent to 17.6 percent. The former is a reliable and accurate measure of the use of statements, though the latter measure will be influenced by variation in policies and practices such as the identification of children as having SEN and enhanced School Action Plus systems which substitute for some use of statements. Our hypothesis that a lower use of statements indicated better support for children with SEN in mainstream schools was broadly supported by the data. The local authorities which appeared most confident about their mainstream provision generally had a lower percentage of SEN pupils with a statement, a lower rate of appeals²³, and a higher rate of children with statements being educated in non-mainstream provision – in other words, statements being used primarily to access special school placements which was the stated intention of many local authorities. We did find that the attainment gap between pupils with SEN and all pupils was smaller for authorities with a higher percentage of its pupils with SEN having a statement, but this relationship was not strong: there was still considerable variation and, furthermore, this does not imply a causal relationship.
- The rate of appeals varies from 1.7 per 10,000 pupils in the lowest quintile of local authorities to 6.2 in the highest. This did appear to be a reasonably robust indicator of parental satisfaction with local authorities’ SEN policies and provision as reported by interviewees. Thus our hypothesis that lower rates of appeal indicate higher parental satisfaction with the use of statements and with provision seemed to hold.
- The gap in attainment between children with SEN and all children (a measure we developed reflecting performance in Mathematics, English and Science at Key Stages 2 and 3 and performance in GCSEs at Key Stage 4) varies from 32.2 in the lowest quintile to 38.8 in the highest. This was to some extent associated with the quality of school provision reported overall (see 6.5). However there were several outliers, and approaches to identifying children as having SEN, levels of statementing and overall attainment levels are intervening influences. Thus our hypothesis that a lower attainment

²³ Whether an appeal is upheld or not may be a better measure than rate of appeal since an LA with a low rate of appeal may have them all upheld, whereas an LA with a high rate may have them all overturned, but this data is not published.

gap was indicative of better educational support for children with SEN was not strongly supported. Local authority representatives generally thought a measure of relative progress would be more useful.

- The level of spending (SEN spending per child with SEN not including special schools) varied from £1045 per child in the lowest quintile to £1818 in the highest. It did not appear to link with the quality of SEN provision overall, and thus our hypothesis that it would signify more extensive provision for children with SEN was not supported. Approaches to use of the SEN category and of special schools are intervening influences.

There are ways in which the indicators might be improved, such as requiring more consistency in whether or not a child is recorded as having an SEN, improving the condition categories in the School Census so that they identify either condition or need consistently, or allowing recording of multiple conditions. A review of the indicators and how to improve them would be useful, and was beyond the scope of this study.

As we described in chapter one, our overall hypothesis was that these measures might *collectively* if not individually be indicative of performance level, given that there are interactions between them. Although there was some association between overall score and quality across the aspects of provision we considered, there were also several outliers. Thus overall score did not emerge as a useful indicator of overall quality.

8.4 Factors supporting best practice

A number of issues emerge as critical to supporting best practice. They are features of approaches that appear to distinguish stronger and weaker local authorities, and approaches that individual local authorities point to as important.

First is the importance of a strong ethos of inclusion and of a shared understanding of the principles underpinning it, across Children's Trust partners and including securing the commitment of elected members. A strategically focused approach, with strong high level planning of approaches and provision, is important, and local authorities have variously approached this by focusing on inclusion, SEN, early years or specific groups of children. The importance of leadership - at strategic levels and within schools - is clear.

Second and linked with this, strong and effective multi-agency and multi-disciplinary working is important, at operational and strategic levels and at all stages, including planning, commissioning, identification, assessment and service delivery. Securing commitment across Children's Trust partners is essential to this, and leadership and vision seem to help here. The forms of successful strategic and operational multi-agency approaches vary, but appropriate structures, management of change, team development and good working relationships, maintaining specialisms and clarity about roles and responsibilities, information sharing and commitment to and clarity about the use of multi-agency models such as the Common Assessment Framework, team around the child and keyworking all appear to be important.

Well-developed processes for identifying and assessing children are important, and start with all professional groups who work with children, young people and families being able to recognise what might be early signs of a child having a condition which might give rise to an SEN. Access to specialist advice, speedy multi-disciplinary assessment and clear protocols and pathways are important here.

Partnerships with parents, young people, Parent Partnership Services and the voluntary and community sector are also clearly key. They involve scope for these groups to have an input at both strategic and service delivery levels, a coordinated approach, finding effective and creative ways of consulting and involving, a commitment to listening and being influenced by views, information sharing and transparency about decision-making. They also involve moving away from an approach that 'the professionals know best', to giving more control and choice to families.

Partnerships with schools are critical, and appear to be supported by communication and dialogue at strategic levels so that schools buy into and are able to influence the direction of change. Access to specialist input and advice and appropriate mechanisms for funding it, a strategic approach to monitoring, willingness to challenge and a focus on a wide and ambitious vision of children's outcomes all seem to be important.

A number of workforce issues also emerge as important – people are at the heart of meeting the needs of children with SEN. There needs to be sufficient capacity throughout the system, and everyone needs the tools to do the job well. High turnover of staff and vacant posts are a real challenge in some local authorities – but perhaps indicative of, as well as contributing to, shortcomings. The importance of a strategic approach to capacity building, training and skills development, linked with a coherent vision of inclusion, is clear.

8.5 Implications for policy and practice

In this final section we consider the implications of our findings for policy and practice. Where relevant we refer to the suggestions made by interviewees when at the end of the interview they were asked what would help all authorities to rise to the standard of the best.

8.5.1 Ensuring greater equitability

We have described considerable variation in policies and services for children with SEN both between and within local authorities. Some degree of variation between local authorities is inevitable and may indeed be positive where it reflects the different needs and the preferences of local children and parents, local systems fitting local contexts, and more generally the process of local democracy and choice. Local variation is clearly undesirable when it reflects unmet need and inequities in access to, and level of, services

Removing Barriers to Achievement, the government's strategy for SEN, notes the need for greater consistency:

'We want to see more consistency between local authorities in their strategic management of SEN, particularly in their use of statements, the level of delegated funding to schools and in special school provision' (DfES, 2004:75)

The Children, Schools and Families Bill going through Parliament at the time of writing provides a number of guarantees for pupils and parents, including the right of every pupil to go to a school that meets their needs.

Nevertheless, the study found differences across local authorities in the range of school provision for children with SEN, influenced by such factors as strategy, funding approach and support for schools, which appears to challenge the objective of greater consistency in provision. Regional commissioning could help in providing a full range of provision, which smaller authorities and more rural authorities may find difficult to offer.

Different interpretations of inclusion, as outlined in 8.2.3, can also affect the levels and type of provision available. Our data suggests that there could be potential conflicts between policy makers, both at national and local level, parents and schools in terms of how inclusion is understood. There were calls from local authorities for government to give more consistent and positive messages about inclusion, to promote inclusion and ambition for all children more forcefully, and to address the underlying tensions with inclusion created by the attainment agenda and league tables. This emphasises the need for local authorities to engage children, parents and other agencies in developing their inclusion strategy, as some local authorities had done, to encourage greater commitment and buy-in at all levels.

But different government policies may lead unintentionally to tensions that some local authorities find difficult to reconcile such as the policies around inclusion and academic attainment, between inclusion and offering a full range of provision, and between wanting to ensure greater consistency between local authorities and policies that may potentially though unintentionally create more variation – such as giving schools more flexibility in how they spend their budgets.

Schools' buy-in and commitment to inclusion is influenced too by the extent and nature of specialist support and training that they have access to, yet schools report wide variation in this. Our research suggests the need to consider a minimum entitlement of support, training and advice for mainstream teachers as well as a review of the implementation of the quality standards for SEN specialist services²⁴ published during the course of this study.

Although our analysis suggested that there was no link between SEN spending and the quality of SEN provision overall, as reported in other studies (e.g. Wales Audit Office, 2007), there was a call for more resources for SEN and a belief by local authority leads that this would help reduce variation. We were told that budgets have not matched the huge increase in need, which is seen to lead inevitably to prioritisation, rationing and patchy provision. Much concern was expressed about protecting SEN budgets in the face of general spending cuts and there were also concerns about the implications of an increasing focus on safeguarding and child protection.

8.5.2 Need for reliable, consistent and comparable data

To plan services effectively local authorities need reliable data on the number of children, for example with a hearing impairment or with ASD, and their needs. Yet only a few of our case study authorities said that they had databases that could provide accurate information on numbers, and there were also reported differences across authorities in their auditing of need. We have already discussed the need to ensure greater consistency in the recording of primary condition in the School Census and previous studies have identified the need for better ways to record children with a range of disabilities (e.g. Mooney and others, 2008; Porter and others, 2008), and the need to consistently record multiple conditions where they occur so as to have a full prevalence. There is also a need, as discussed in chapters two and three, for reliable data on DDA disability (ie those children who are covered by the Disability Discrimination Act) and an understanding of how this relates to incidence of SEN. The government have acknowledged that this lack of disability data is likely to restrict the ability to understand and respond to the needs of disabled children and their families within either national or local policy or school practice, including responsibilities under the Disability Equality Duty. Reliable pupil level data would also provide data on incidence of disability in relation to SEN. There is therefore an intention to include questions on disability (ie whether

²⁴ The Quality Standards for SEN Support and Outreach Services (DCSF, 2008) were published during the fieldwork period and we did not specifically explore awareness and use of them – no specific references to them were made by interviewees.

an individual pupil is DDA disabled and if so, what is the nature of their impairment) in the 2011 School Census²⁵.

The Scottish Government have recently announced a pilot scheme of local records of deaf children aimed at improving the information held on the number of children diagnosed with a hearing loss (Scottish Government Press Release, 2009). It might also be useful for audiology departments to keep a database to record details of children with a hearing loss which could be collated at national, regional and PCT level. The ASD Good Practice Guidance (DfES and DH 2002) recommend that local authorities keep a register of children with ASD, but few local authorities had a comprehensive register.

8.5.3 Workforce training and capacity

The different approaches to identification and assessment and the key role played by teachers and other professionals in identifying SEN suggests the need for further training and support that could lead to greater consistency in this area. The changing role of health visitors and school nurses has had a negative impact on identification systems in some areas, and school entry screening is no longer routinely carried out across all schools. This could be an area that government may wish to review. In any case, it is important to ensure that all professionals working with young children, including teachers and early years practitioners, have the necessary skills to recognise and raise concerns about SEN.

Workforce capacity is a key issue at both an operational and strategic level. All local authorities need adequate numbers of professional staff such as speech and language therapists and educational psychologists, but the study has highlighted a lack of sufficient staff leading to long delays for assessments and services in some areas. There were senior management teams too where capacity was a problem and staff were stretched due to staff vacancies and temporary posts. Valuing and rewarding staff appropriately is an important part of offering a good service.

8.5.4 Stronger quality assurance and monitoring mechanisms

The strongest and most consistent call from interviewees was for sharing models of good practice, supported by clear standards and guidance – ‘defining ‘best’ or ‘showing what good practice looks like’. This was seen as useful at both a national and a regional level, and the demise of the Regional Partnerships was regretted by some as these were seen to have been very helpful in developing local networks and good practice. There were different emphases on whether this should be a permissive approach involving clear information and guidance, or more rigorously implemented as a required set of minimum standards supported for example by national benchmarking and scrutiny.

As the literature review highlights, there is already a considerable body of good practice guidance available to local authorities. This suggests that something more is needed to help put the guidance into practice, for example more effective dissemination, additional support for local authorities or mechanisms to ensure greater implementation of the published guidance. However, it needs to be remembered that guidance is just that – there is no requirement that it must be implemented – and consideration could be given to whether putting some guidance on a statutory footing might raise standards and reduce variation between local authorities.

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<http://www.dcsf.gov.uk/research/programmeforresearch/projectinformation.cfm?projectId=15730&type=1&resultspage=1>

Alternatively, there may be a stronger role for education psychologists, school improvement partners (SIPs) and Ofsted to play in ensuring awareness and looking at how this guidance is being used by local authorities and schools where relevant. For example, we found differences in how closely schools' spending is monitored by local authorities, but Ofsted and SIPs could monitor how many schools are using the guidance produced by the Audit Commission for schools to monitor and assess their available resources.

Their role could also include closer scrutiny of schools with unusually high or low prevalence rates to address issues of over-use of SEN identification and inconsistency in identification procedures.

8.6 Conclusions

The overall finding from this study is that there is no simple explanation for the variation in prevalence and practice between local authorities, and that it is likely to be the product of a number of factors interacting in complex ways. There is also no simple link that can be made between different models of service provision and the quality of the service that children with SEN and their families receive. Variation in provision is often read as variation in quality, but it is difficult to draw strong conclusions about this because there is little information on how outcomes for children with SEN are affected by the way that services are organized or delivered. There is a need for local authorities and individual services to collect better outcome data, and a need for more evaluative research on 'what works'. The new national indicator (NI 54), which measures parental experiences of services for disabled children and the extent to which these services are delivered according to 'core offer' standards, should provide local authorities with additional information on how well local services are perceived to meet needs, although not on outcomes for individual children.

This study also suggests that some types of local variation are inevitable, and not necessarily undesirable. Local authorities approach their populations of school children in different ways, and the population of children with SEN will also vary. Differing proportions of children with statements, or in different kinds of specialist or mainstream provision, may reflect not differences in the quality of services available to children with SEN or disabilities and their families, but the response of democratically elected bodies reacting to local needs and circumstances. What is likely to be more important is that the principles underlying the core offer are adhered to – for example, that services are developed in partnership with parents, children, and schools; that policies are transparent, good practice is shared and that information is easily accessible to families. Within that, there should be scope for local variation. What matters most is that however services are planned and delivered, they contribute to better outcomes for disabled children and those with SEN.

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Appendix I: Topic guides

TOPIC GUIDE FOR LA INTERVIEWS

1. STRATEGIC PLANNING AND POLICIES

Inclusion strategy: key features; development and ownership; CYPP targets

- what is the overall ethos on inclusion within the authority?
- what are the key features of their inclusion strategy (SEN and disability)
 - which agencies contributed to its development, were parents and young people involved
 - is everyone signed up to it (e.g. partner agencies, schools, etc): how did they achieve this or what difficulties did they encounter
 - are there any particular priority areas identified in it

Specific strategies for ASD and HI; development, implementation and review

- is there specific reference to ASD and HI in Inclusion Strategy and CYPP
- do they have specific strategies for ASD and HI
 - who was involved in developing them
 - where does responsibility for implementation and review sit

What's working well and not so well with strategic planning and policies

- overall, how happy are they with the strategy, the buy in and how it's working
- how do they monitor implementation and achievement (of SEN/disability/inclusion strategy, of SEN elements of CYPP, of ASD/HI strategy)
- what has supported or hindered this

2. MULTI-AGENCY WORKING

- what do they see as the key features of their multi-agency working in relation to SEN/disability or HI/ASD

Multi-agency planning and strategy groups

- what multi-agency working is there at a strategic level e.g. multi-agency planning and strategy groups and who is represented on them
 - do they have specific multi-agency coordinating groups for ASD and HI (eg Children's Hearing Services Working Groups)
 - who is on such groups (inc parents; ASD and HI specialists from education, health and social care)

Joint commissioning, information sharing, joint training

- are there examples of joint commissioning e.g. for speech and language therapy (SLT) and joint decisions and funding for school placements: what difference does this make
- are there clear protocols for information sharing and joint working between education, health and social care
- what joint training is available

Engagement with other LAs and voluntary sector

- do they do any planning or commissioning with other neighbouring LAs
- do they engage with the voluntary sector in planning or service delivery
- what difference do these initiatives make

Better coordination of services for parents: key worker systems –implementation, eligibility criteria, training/support; team around the child

- how far is there integration at an operational level in planning for individual children
 - is the team around the child model or similar used: what eligibility criteria
 - do they use key worker model: what eligibility criteria
 - how well do these systems work
- are they using the Early Support Programme (ESP) and what difference has it made to multi-agency working
- what would parents say about the quality of coordination, would they routinely experience multi-agency meetings

Key features of multi-agency working: what works well and what is challenging?

- what has helped them to get where they are and what is needed to move forward?

3. EARLY IDENTIFICATION, PREVALENCE AND INTERVENTION

Refer to pre-interview checklist throughout this section and pick up on areas of low (absolute or relative) provision

Systems for identification: protocols and pathways for identification; communication with partner agencies and with parents; single joint assessments;

- how good are their systems overall at identifying children with SEN/disability/HI/ASD
 - how confident are they all children would be identified
- what happens when suspicion of a SEN/disability/HI/ASD is first raised
 - would all practitioners involved know what action is required?
- do they have protocols or established practices for assessment:
 - who is involved in assessments; is it a multi-agency model
 - do they use single joint assessments
 - did they draw on any specific good practice guidance or tools in developing their approach in ASD/HI (eg National Service Framework autism exemplar, ASD good practice guidance, DCSF/RNID guidance)

Prevalence of children with SEN/HI/SEN: what explains relatively high or low prevalence; understanding population and profile; sharing and using this data

- share with them prevalence of children with SEN compared to other LAs
 - does this match their information
 - what explains relatively high / low prevalence
 - discuss different approaches described by other LAs with different prevalence (eg policy of not identifying as SEN but providing services – what implications would that have?)
- do they have a separate register for ASD and for HI or record numbers
- how is information about prevalence (of SEN/ASD/HI) shared across education, social care and health
 - are there common systems, definitions and language
 - what implications does this have for provision and meeting needs
- how good is their understanding of the population of children identified as having SEN/HI/ASD
 - how much do they know about the profile of the population
 - what needs analysis work have they carried out and did this involve partners
 - are they carrying out work to forecast prevalence, profile and needs

- what significance is placed on primary condition in SEN datasets, is there any further analysis or recording of condition
 - how is this data used for planning purposes
 - would ASD and HI always be primary conditions, how does this overlap with speech, language and communication needs and other categories
 - share with them data on prevalence of HI/ASD from SEN dataset
 - does this match their information
 - what explains relatively high/low prevalence

Intervention and services in the early years: pathways for referral; range of provision to meet needs; transition to school; what has helped and what are challenges

- when a child is diagnosed with SEN/disability/ASD/ HI what happens in terms of referral, intervention and support
 - are there clear and documented referral pathways
 - are parents told at an early stage about the likely pathway
 - do they have an established protocol across education, social care and health
- how far are they able to meet needs of children with SEN/ASD/HI in the early years
 - what is the range of provision in home, nursery, family groups
 - what specialist support is available in mainstream provision
 - what specialist non-mainstream provision do they have
 - how is the transition from early years to school provision supported, how well does this work
 - what would parents say about the quality of provision and support
- what has helped towards early identification and service provision and what are the challenges

4. USE OF THE GRADUATED APPROACH / SCHOOL-BASED STAGES

Use of the stages: thresholds; transparency; consistency in application;

- any specific objectives in use of the stages (eg minimise use of SA+ / statements)
 - what significance does the stage have for access to provision or funding and how does this influence the use of the stages
 - do they encounter any difficulties (eg meeting provision of former LA if child moves without statement; maintaining support if child moves to FE without a statement)
 - do they feel children are appropriately placed at each stage
 - how consistently are the stages applied and what monitoring / support do they give schools
 - what is the policy around use of the stages for HI / ASD and how well does this work
- are schools asked to do provision mapping and how is this supported
- share data on use of statements compared to other LAs
 - does this match their information
 - what explains relatively high / low prevalence
 - what is the rate of statementing for HI and ASD and what explains this
 - is it changing – how and why, what's driving this
 - what would they like to see and what is supporting or hindering this for SEN / HI / ASD
- how satisfied do they think parents are with use of school-based stages
- what has helped in implementation of their strategy for school-based stages and what has been difficult

SENDIST appeals: level of appeals

- what level of appeals do they have against refusal to assess or issue a statement and what issues do they highlight for SEN / HI / ASD
 - share with them data on appeals levels compared with other Las
 - does this match their information
 - what explains relatively high / low levels

5. SCHOOL PROVISION

Refer back to their inclusion strategy and ensure we have information on role of mainstream and different types of specialist provision

Refer to pre-interview checklist throughout this section and pick up esp on areas of low provision

- what do they think are the key features of their school provision. What have they got right, what needs more development

Mainstream provision: meeting needs of SEN and of ASD and HI; support to schools; transparency; links with specialist schools

- what additional support is provided to enable children with SEN / ASD / HI, to attend mainstream provision and how well does this work
 - are they able to draw in resources from health and social care where needed (e.g. environmental adaptations, learning and communication aides)
 - which are the children whose needs are hardest to meet
 - what access do mainstream staff / providers have to specialist advice and support
 - what links are there between mainstream and specialist schools
- overall how good do they think their mainstream provision is
 - is the focus just on accessing the curriculum or also on participating in wider school activity

Non-mainstream provision

- share with them data on use of non-mainstream provision compared to other Las
 - does this match their information
 - what explains relatively high / low levels (inc whether provision draws children into area)
 - what facilitates / hinders getting to where they want to be
- what level of use do they make of non-mainstream provision in ASD / HI
 - how far are they able to meet needs
 - what is the range of provision for HI/ASD, does it draw children into the area
 - what are their ambitions, what facilitates / hinders achieving them

Out of area placements: policy; high/low level of placements; objectives

- what is their policy on out of area placements and what use do they make of them – for SEN / HI / ASD
- what are their objectives in this area and what supports or hinders meeting them

School workforce: training and support; learning and support assistants

- what training is available to teaching / support staff working with disabled children / SEN / HI / ASD and on communicating the inclusion ethos
 - what additional training do SENCOs receive generally / re HI and ASD

Funding levels and delegation to schools

- share with them data on funding levels compared to other LAs
 - does this match their information
 - what explains relatively high / low funding levels
- what is their policy on delegation to schools
 - how is implementation of the policy monitored
 - how is school-level spending of delegated budgets monitored
 - how do they monitor outcomes for children in relation to per capital spend
- do they have systems for schools to access additional funding outside statemented provision

Attainment: narrowing the gap in attainment for children with SEN

- share data on attainment gap compared with other LAs
 - does this match their information
 - what explains relatively high / low gap

Systems for monitoring educational outcomes

- how do they monitor educational outcomes and track individual progress
 - what do they monitor and how
 - whose responsibility is this
 - what happens with the results
 - how do they support schools in monitoring / using findings

Overall

- what is working well and what has supported them in getting there
- what is working less well and what is needed to move forward

6. OTHER KEY ASPECTS OF PROVISION

Refer to pre-interview checklist throughout this section and pick up on areas of low (absolute or relative) provision

Overall

- what do they see as key other aspects of provision for children with SEN / HI / ASD
 - what is working well or less well
 - what has supported or hindered this

Audiology services: how well they work (e.g. who is involved, specific guidance and protocols; able to meet needs)

- how well does their audiology service work?
 - which professionals does it include (eg educational audiologists, paediatric audiologists, Teachers of the Deaf, and SLTs / Social Workers / health visitors with specialist audiology training)
 - how adequate is their provision of medical interventions and communication aids, how do they ensure parental choice, transparency and consistency
 - is the service always able to meet children's and parents' requirements – what is more difficult to meet

Communication and language support: how well meeting needs; SLTs trained for ASD and HI

- how well are services meeting the needs of children needing this support
 - do they have SLTs specifically trained in ASD / HI
 - are there clear models and guidelines re type and frequency of SLT for children with ASD / HI
 - are they able to provide full choice re communication options
 - is the service always able to meet children's and parents' requirements – what is more difficult to meet

Mental health provision: access and meeting need

- how well are mental health services meeting the needs of children with SEN / HI / ASD
 - do they have specialist services / practitioners for HI / ASD
 - is the service always able to meet children's and parents' requirements – what is more difficult to meet

Social care provision: how well meeting need

- how well is social care supporting children with SEN / HI / ASD
 - do they have specialist services / practitioners for HI / ASD
 - is the service always able to meet children's and parents' requirements – what is more difficult to meet

7. INFORMATION FOR AND INVOLVEMENT OF PARENTS AND YOUNG PEOPLE

Overall how well are their systems for involvement of and information for parents and young people working

- what is working well / less well
- what is supporting / hindering this

Systems for involvement at strategic and individual levels

- what systems do they have in place
 - in strategic planning forums
 - in needs analysis, service development, audit of provision
 - in individual care planning, assessments and reviews
 - how do they support this

Operation of their Parent Partnership Service

- about their Parent Partnership Service
 - is it provided by LA or external provider
 - how 'arms length' – do they have a published confidentiality and impartiality policy
 - what contribution does it make, what impact does it have
 - how is it linked in with strategic planning
 - how are quality and outcomes monitored

8. FINALLY (select from these questions to conclude)

- anything else we need to know
- across the country there is variation in the services and support available to disabled children and children with SEN. What do they think would help to bring all LAs to the standards of the best?
- what are the key things they have got right or that other LAs could learn from them; what are the key areas for development or where they could learn from other LAs

TOPIC GUIDE FOR PPS AND VOLUNTARY SECTOR ORGANIZATION INTERVIEWS

1. BACKGROUND

Their remit and role

- their organization's role, and remit
- which part of the population of children with SEN would they see (eg higher end of need; dissatisfaction with LA provision; all)
- if Parent Partnership Service representative
 - is PPS provided by LA or external provider
 - how well supported is it by the LA
 - how is it linked in with strategic planning
 - do they have clear protocols re arms length working
 - what is working well, what changes would they like to see
- how closely have they worked with LA, any involvement in strategic planning or service provision
- whether their role and experience extends across other LAs
- From their experience of working with other local PPCs – how do they think other local authorities work differently with PPS

2. STRATEGIC PLANNING AND POLICIES

Profile of disability / SEN / HI / ASD

- overall what priority / profile do they see disability / SEN / HI / ASD as having within the local authority
 - how does this vary between partners / areas of work
 - what has contributed to high / low profile, what is needed to raise profile

Priority placed on working with voluntary sector

- what priority does the LA place on working with the voluntary sector: is it a genuine partnership

Awareness and views of strategic planning

- awareness of the LA's disability / SEN / inclusion / HI / ASD strategy
 - perceived strengths and weaknesses
 - is it a multi-agency strategy
 - awareness of involvement of children, parents and representative organizations in development of the strategy
 - awareness of needs analysis or understanding of needs informing strategy and provision

3. MULTI-AGENCY WORKING

Multi-agency planning: quality; key features

- how strong do they see the LA as being in multi-agency planning
 - are there specific multi-agency coordinating groups for disability / SEN / ASD / HI
 - is there joint commissioning

Multi-agency working at operational level: quality; key features; team around the child and key worker model

- how strong do they see the LA as being in multi-agency working in screening, assessment, planning, delivery
 - what would parents say about the quality of coordination

- does the LA use team around the child and/or key worker models: are they used consistently where needed
- would parents routinely experience multi-agency meetings

Overall

- what has the LA got right in multi-agency working and what has helped here
- what needs to improve and what is required to make this happen

4. INFORMATION FOR AND INVOLVEMENT OF PARENTS AND YOUNG PEOPLE

Involve ment and consultation at strategic and individual care planning levels: systems; quality

- how good is the LA at involving or consulting with parents and young people
 - in strategic planning forums
 - in individual care planning, assessments and reviews
 - what is working well, what changes would they like to see

Information and support at diagnosis and ongoing: systems; quality

- how good is the LA at providing information and support at diagnosis and ongoing
 - how well and how consistently is this working
 - how far is the LA able to meet parents / children's communication preferences
 - what is working well, what changes would they like to see
- any insight into how well the PPS service works

5. PREVALENCE, EARLY IDENTIFICATION AND EARLY YEARS PROVISION

Quality of identification and assessment; support for parents; prevalence

- how good do they think the LA is at identifying and assessing children with disability / SEN / HI / ASD
 - do some children get missed or identified late and why
 - are there clear pathways, good multi-agency working
 - how well are parents supported at this stage
 - what is working well, what improvements are needed
- share with them prevalence of children with SEN / HI / ASD
 - does this match their information
 - what do they think explains relatively high / low prevalence

Quality of processes for referral

- how good is the LA at referral to provision
 - do children have access to key services sufficiently quickly, are there transparent processes and good multi-agency working
 - how well does the LA support parents at this stage
 - what is working well, what improvements are needed

Quality of early years provision; support for transition to school

- what is the range of early years provision for children with SEN / HI / ASD in home, nursery, family groups
 - what specialist support is available to mainstream provision
 - what specialist non-mainstream provision is there
 - how good is the LA at planning and preparing for school and supporting transitions
 - what is working well, what changes would they like to see

6. USE OF THE SCHOOL-BASED STAGES

Appropriateness and consistency in use of school-based stages

- how well and how consistently does the LA use the stages for ASD / HI
 - is there consistency in their application, how is this supported
 - are children appropriately placed
 - how does use of the stages influence the support provided
 - how well is it working, what changes would they like to see
- how satisfied do they think parents are with use of school-based stages
 - what do complaints or tribunal appeals highlight

7. MIX OF SCHOOL PROVISION

Ethos and appropriateness of use of mainstream and non-mainstream provision

- how appropriate is the LA's use of mainstream and non-mainstream provision
 - what is working well and what would they like to see change

Mainstream provision: meeting needs; support to schools; transparency

- how far is the LA able to meet needs re SEN / HI / ASD in mainstream schools
 - what support do they provide to mainstream school
 - how transparent is eligibility and how consistent is access to provision
 - do mainstream schools have enough access to specialist provision / advice
 - whose needs are not met
 - what is working well, what changes would they like to see

Non-mainstream provision: meeting needs; transparency

- what is the range of non-mainstream provision for children with SEN / HI / ASD
 - how far do they think the LA is able to meet needs
 - how transparent is eligibility and how consistent is access to provision
 - what is working well, what changes would they like to see

Out of area placements: use made and appropriateness

- what use is made of out of area placements and how appropriate is this

School workforce: how well equipped

- how well equipped is the school workforce to meet the needs of disabled children / SEN / HI / ASD

Monitoring pupil progress

- how good is the LA at monitoring educational outcomes and tracking individual progress

8. OTHER KEY ASPECTS OF PROVISION

Overall: key aspects and how well needs are met

- what other aspects of provision do they see as key for disabled children / with SEN / HI / ASD and how well are needs met
 - what is working well and what supports this
 - what is working less well and what change is needed here

Audiology services: quality; transparency; supporting choice; meeting needs

- what do they think of the quality of the audiology service
 - are the right specialists involved
 - is there transparency about provision and eligibility and consistency
 - is the service able to support choice and meet needs – what are the gaps

Communication and language support: quality, transparency, supporting choice; meeting needs

- what do they think of the quality of communication and language support for children identified as disabled / SEN / HI / ASD
 - are the right specialists involved
 - is there transparency about provision and eligibility and consistency
 - is the service able to support choice and meet needs – what are the gaps

Mental health provision: quality, transparency, meeting needs

- what do they think of the quality of mental health services for children identified as disabled / SEN / HI / ASD or work to support emotional well-being
 - are the right specialists involved
 - is there transparency about provision and eligibility and consistency
 - is the service able to meet needs – what are the gaps

Social care provision: quality, transparency, meeting needs

- what do they think of the quality of social care provision for children identified as disabled / SEN / HI / ASD
 - are the right specialists involved
 - is there transparency about provision and eligibility and consistency
 - is the service able to meet children's and parents' requirements – what are the gaps

9. FINALLY

- any other aspects of the LA's approaches that they see as particularly strong or particularly weak
- what are the key areas where the LA needs to improve and what needs to happen to move forward: what could other LAs learn
- background to the study is variation in prevalence and provision: what is needed to bring all LAs up to the standards of the best

TOPIC GUIDE FOR SCHOOL INTERVIEWS

The aim of the interview is to explore how local authorities support the work of schools; what is helpful about the LAs approach and what more they could usefully do to support schools work around SEN and disability. The interview is not about evaluating what happens in each individual school.

1. BACKGROUND

NB mention that first series of questions about the school are to give an understanding of the context, before focusing on the LA.

Their role

- their role and responsibilities (*broadly how much time spent on SEN/disability vs other activities, non-contact time, amount of admin support for SEN role etc.*)
- length of time in post; any experience of similar roles in other schools in the area or in schools in other LAs
- training and qualifications relevant to SEN
 - are they a trained teacher; if not what is the LA doing to support them to become a teacher by 2011 (new SENCO regulations)
 - are they a member of the school senior management team

The school

- type, number of pupils and staff, age group
- number of pupils with SEN, number with statements, main characteristics of the SEN population (conditions and needs)
- prevalence of children with ASD/HI
- whether there is a specialist unit and its size/focus, broadly how it is used, is a statement required
- whether there is a resource base – size, focus, how used
- which staff have a specific role in supporting children with SEN
 - who champions SEN in the school/senior management team
 - in secondary schools how do they coordinate/communicate across departments; do they operate a system of ‘link SENCOs’ in each department

2. SCHOOL AND LA POLICIES

- school policy: key features; development and ownership
- what is the school’s overall ethos on inclusion; (briefly) response to the Disability Equality Duty
- what are the key features of the school’s SEN/inclusion policy
 - are there any particular priority areas identified in it
 - any specific reference to ASD/HI
 - whether focus is on learning support or inclusion/participation more broadly
 - how is it made available to parents
- who contributed to its development- were parents and young people involved
- is everyone signed up to it, how did they achieve this or what difficulties did they encounter
- how regularly is SEN policy reviewed, by whom
- where does responsibility for SEN policy implementation and review sit

- what support did the school receive from the LA in developing school SEN policy

LA policy: key features

- awareness of the LA SEN/inclusion policy and key features
- LA policies on exclusion and admissions and how they support or otherwise SEN policies in schools
- perceived strength and weaknesses of LA policy and how it relates to schools

3. IDENTIFICATION

Note – during the course of the interview both identification and graduated approach will be covered interchangeably

Systems for identification of children with SEN: protocols and pathways for identification; communication with the LA and other partner agencies

- Overall, how good are their systems at identifying children with SEN/disability/HI/ASD
- What assessments are routinely done at the school on all children that would identify a child with SEN (including hearing screening)
- What happens if concerns are raised about a specific child
 - would all staff involved know what action is required
 - at what point would parents/carers be informed of a concern

Assessment and diagnosis

- assessment once SEN has been identified as a possibility
- what assessments would be done, who is involved in assessments, what diagnostic tools are used (esp for HI and ASD)
- what liaison would occur, with whom; at which point are parents involved in do they have any formal protocols or established practices for the process

School access to specialist support including from LA

- would the school be able to access specialist support from LA or elsewhere
- how do the school work with LA central staff
- what other support from the LA would the school receive at this stage
- what happens when a child comes to the school with needs already flagged/identified; how would the system described be different
- What significance is attached to a child being placed on the SEN register, in terms of resources, provision.

PLASC / School Census

- identification of primary condition in the School Census / PLASC data set
 - who in school completes the PLASC census
 - what information or resources do they draw on
 - what significance is placed on it; how accurate do they see the data as being
 - how ‘primary’ is interpreted and how dual conditions are treated
 - categories that ASD and HI overlap with and how this is resolved
 - what support do they receive from the LA and what more is needed

Overall

- what has the LA got right in supporting the school in the identification of children with SEN; what has helped here
- what more could the LA do to support the school in the identification of children with SEN; what needs to improve and what is required to make this happen

4. USE OF THE GRADUATED RESPONSE**Guidance and support from the LA, consistency in application**

- what guidance and support do the school receive from the LA in terms of use of the graduated response
 - LA protocols or established practices for schools in the use of the school based stages – what exists, how do they use it
 - What other influences are there on school's decisions about placing children at the various stages
 - does the LA provide training or other support to staff
 - how does the LA monitor consistency in their use of the stages and support them
 - Is there any other system for moderation of thresholds
 - how does their use of the stages (ie the number of pupils at each) compare with other schools
 - what is the policy around the use of the stages for HI/ASD; any specific issues this raises
- awareness and understanding of the LA policy/ideology around the use of the stages, perceived strengths and weaknesses
- what difference does it make what stage of support a child is assessed as needing
 - how does this affect the support the school can access
 - does this make a difference when a child moves school
- are the school asked to do provision mapping or management by the LA and how is this supported

Overall

- what has the LA got right in supporting the use of the graduated response; what has helped
- what more could the LA do; what needs to improve and what is required to make this happen

5. PROVISION

Refer back to the schools SEN/inclusion policy and information we have on the nature of the provision

School provision; meeting needs and support from LA and other agencies

- what types of support is the school able to provide or access from elsewhere (eg school environment, communication aids, specific learning support) and where does it come from
- what support does the school currently provide for children with ASD and with HI
 - what are the gaps and pressure points
 - what support does the LA provide in this respect

- are they able to draw in support/resources from health and social care where needed eg speech and language therapy, audiology, CAMHS
- do they have any formal protocols for what support the LA will provide
- how far are they able to tailor support to individual needs
- what information do they draw on when determining what support is given
- how are children and parents involved in decisions about provision

Staff training and other support

- what is the LA training policy and what training does the LA make available
- what training is available within the school
- how adequate is this – what issues in staff awareness and skills remain, how do they need to be addressed

Links with special schools and specialist bases

- what links are there between the school and special schools or specialist bases
 - what access do staff have to specialist advice and support
 - how does the LA support/promote this

If have a specialist base:

- what has this added to the school's resources
 - what links are there between the base staff and other staff
 - what guidance/support has the school received from the LA to inform or support this

Transitions

- how well do the LA's policies for planning and supporting transitions work
 - at phase transfer
 - at transition from school to adult life and services
 - what support does the LA provide to the school in this respect
 - how well does it work and what more is needed
 - what are the particular issues at transition for children with HI/ASD

Overall

- what has the LA got right in supporting provision; what has helped here
- what more could the LA do; what needs to improve and what is required to make this happen

6. INFORMATION FOR AND INVOLVEMENT OF PARENTS AND YOUNG PEOPLE

- how would parents and young people with SEN be involved or consulted (e.g. involvement in IEPs, meetings on child's progress etc)
- what information is provided to parents and young people (what formats are available)
- are parents and children signposted to independent sources of support and information
- how does the LA support parent and child involvement; what is working well, what changes would they like to see

7. FUNDING LEVELS AND DELEGATION

- what is the LAs policy on SEN funding delegation to schools
- how does the LA support and monitor the implementation of delegated funding
- how does the school access funding for additional support
- overall what is their view about funding levels and the delegation policy
- what has the LA got right in its support for schools; what more is needed

8. MONITORING

- how do they monitor educational outcomes and track individual progress of children with SEN
 - what do they monitor and how (including participation as well as achievement)
 - whose responsibility is this
 - how are children and parents involved
 - what is the LA's policy and involvement in this area
 - how does the LA support schools in monitoring and using findings
- what has the LA got right in its support for schools; what more is needed

9. OVERALL

- what is the LA doing right in supporting schools; what are the areas where more support is needed and what form should it take
- what is the LA doing right more broadly in its policies and practices to support children with SEN; where is more work needed
- background to the study is variation in prevalence and provision: what is needed to bring all LAs up to the standards of the best

Appendix II: Annotated bibliography on disabled children and their parents' views on service quality²⁶

Authors	Date	Publication	Sample	Focus	Findings
Audit Commission	2003	Review of services	250 disabled children and their families consulted	Experiences of services	Difficulties in accessing services including universal services. Long waiting lists for interventions, equipment and adaptations. Services not always age-appropriate. Lack of available information and transparency . Lack of joint planning/delivery of services means repetition of information to professionals and falling through gaps between services. Transitions: Unsuitable placements or lack of independent supported housing. Valued flexibility in services, staff who went 'the extra mile'; info and key workers. Often lack of information, support, planning, and involvement at this time.
Band and others	2002	Journal	Parents of children with SLCN	Extent and nature of collaboration between health and education profs at key stages in assessment and provision in educational settings	Lack of transparency in process of assessment and provision, particularly at transition between primary and secondary Parents emphasised: early professional engagement with SLC problems; receiving clear and prompt information; keyworker/coordinator. Concerns raised about vaguely worded statement perceived to evade provision which adequately meets needs; better understanding between teachers and SLTs with more training for teachers; continuity of provision particularly across educational transitions.
Batten and others	2006	NAS Report	Survey of NAS members and interviews with 25 children	Educational provision	Access: wanted a range of provision; support when needed – often long delays. SLT problematic for some. Workforce: specialist staff, SLT should be delivered by trained staff; Lack of information about options etc., Transition: lack of appropriate support, planning and involvement of adult services variable

²⁶ NB: literature search undertaken in Spring 2008

Bercow Review	2008	Review of services	Evidence from children with SLCN and their parents including online survey and focus groups	Experiences of services	Importance of early identification/diagnosis , but can be difficult to achieve - parents concerns not always taken seriously by professionals. Want accessible information and clearly sign-posted services. Problems included no coordinated system to provide info and difficulty in locating right person/dept. Continuity of support particularly at transition points; having continuity in SLT and regularity of this support. More specialist support and personalised services tailored to meet individual needs. Statements seen as a means of accessing services though often too vague and resource led (<i>mirrors Band et al findings table 1</i>). Even with services specified not necessarily guaranteed. Want to see effective joint working between services and between pros and families – often a lack of clarity in responsibilities of health and education services – parents often feel ‘caught in the crossfire’. Concerns about delegated funding for SEN not being ring-fenced or monitored by LA and therefore risk of these funds being diverted.
Beresford and others	2007	Research Report for DH	95 families (108 parents and 31 children inc ASD, CHN and NS)	Desired outcomes for support services	Included wanting a partnership with services and having confidence in services: Involvement : in decision-making, expertise recognised - listened to/respected. Workforce : Child looked after well in all settings, understanding and skilled staff, continuity. Services : reliability
Bryson and others	2005	Research Report	Parents of children with SEN	Use of childcare	Experienced more problems than other families accessing services - the type of c/c wanted at the times it was needed and more likely to say that it was hard to find current c/c provider otherwise few differences in views of parents of children with and without SEN
Contact a Family	2003	Report to the Birmingham Children's Fund	Parents of disabled children	Consultation about allocation of resources	Most important in services rated as good was access to information, advice and support , which was missing from poorly rated services. Want accessible information delivered in a variety of ways, emotional support in caring for their child, short breaks and inclusive mainstream and specialist leisure opportunities for their children

Contact a Family	2003	Report for Welsh Assembly	Parents of disabled children	Consultation for the NSF in Wales	Child-centred care. Parents wanted automatic right to advocacy and a trained independent advocate; implementation of DDA to improve access to services : e.g. community facilities and local groups; joint working i.e. information sharing between agencies and parent held records; endorsed key worker system ; clear multi-agency plan of support around diagnosis; more family support and greater access to short breaks; more involvement in planning services ; Workforce : more trained therapists; range of local educational options; Transition : assessment at transition with all involved leading to an agreed transition plan used by all services.
Corbett and Perepa	2007	NAS report	BME parents of children with ASD	Educational provision	Information : evidence about the prevalence of autism in various communities and its impact on family life is inconsistent; communities may not be aware of autism, their rights and relevant services; Services that are available do not always meet needs of these parents
Daycare Trust	2007	Report for London Dev Agency	Parents of disabled children living in London	Views on childcare provision – needs, gaps and experiences	Access to services and Workforce : Childcare use varies, but low among those with children with severe or complex needs and some parents of autistic children due to lack of suitable places, trained staff and appropriate facilities. Information : Perception that accessing information and places is a constant battle.
DfES: Early Support Programme	2004	Guidance for using service audit tool	Disabled children and their families	Consultation process in development of Early Support Programme materials	Families said they wanted information about conditions and how to support development, the options that they had, Workforce : access to professional support and expertise and confidence in the professionals working with them.
Jarvis	2003	Journal	Deaf pupils	Views about the support provided in mainstream schools	Some felt over-supported and feared effect this would have on peer relations. Friendships were important and good peer relationships key in terms of social and academic inclusion.
Lord and others	2008	Stage 1 report for LARC study (NfER)	Disabled children (including ASD)and their families	Evaluating early impact of integrated children's services on outcomes	Parents value the following aspects of integrated services: early identification and intervention ; communication and information sharing; clarity of info and procedures; workforce : greater understanding and involvement of schools and GPs; service reliability ; Joint working : one contact person; being included and involved . Asked about support they currently receive and difference it has made, children say they are getting on better at school and at home, feel happier and safer.

Marchant and others	2007	SCIE Knowledge Review	25 families with children with complex health needs (CHCN)	Review of social care needs for CHCN and services	Good practice in service provision includes flexibility, responsiveness and continuity; working in partnership with families – valuing knowledge and expertise; joint working with other agencies settings. Workforce: competence of staff; Access to facilities, equipment and finances
Mitchell and Sloper	2003	SPRU research briefing	Disabled and chronically ill children (27) and parents (21) in development. Phase and Survey of 14,000 from FFT	Exploring parents; and children's views of quality in services	<p>Workforce: Children's views included staff attitudes and approach, meeting and making friends, opportunities for making choices (involvement) and age appropriate community based activities.</p> <p>Parent's focused on broader organisational and whole family issues, including workforce: staff training and ability to listen, accessible information, access to services that meet their needs and agencies working together.</p> <p>View that there were core indicators that all services should meet and specific quality indicators for different types of services Core indicators for Children included staff being responsive to their needs e.g. Staff understand about my illness or disability, know how to help and look after me, listen to me and allow me to make choices. Core indicators for Parents: Meeting the child and whole family's needs; Listening to the child and their family; Treating the child and all family members with respect; Staff knowledge and training; Welcoming and helpful staff; Service respects family's culture. Specific indicators for children for example in leisure and short break services: Services providing me with opportunities to meet and make friends; Having a variety of activities to choose from; Opportunities to develop independence; Having a break from my family</p> <p>Specific indicators for parents for example in services providing multi-agency co-ordination: Professionals working together and communicating; Accessible information: Services that are reliable, ie. there when you need them; Service continuity.</p> <p>Survey highlighted differences between parents/children's views of quality and also that listening to children, meeting needs of different cultures, multi-agency working and social opportunities were aspects of quality less likely to be experienced by families.</p>
Peacey, L	2006	Research report for NAS	60+ parents with children with an ASD	Good practice indicators	What parents valued most: range of specialist ASD provision; appropriate mainstream placements across age range defined by workforce (staff attitudes and training); individuals willing to go 'extra mile'. Involvement: supportive partnership with parents including planning.

Turner, C	2003	Report to Welsh Assembly	105 disabled children inc ASD and hearing impairment	Consultation to inform Welsh NSF	Workforce: attitudes and behaviour of staff; Information: not received directly, gaps in knowledge; Service Access and Availability: little if no choice, access often difficult, support not routinely available to all; Involvement/ Participation not consistent across services, adults making decisions, little involvement in planning. Transition: services do not always meet needs, more options and support when leaving school
University of Herts	2002	Report for RNID	83 Key Stage 3 pupils of whom 61 were deaf		Views and experiences of hearing impaired and hearing pupils on the inclusion of hearing impaired children in mainstream education. Identifies barriers to inclusion, factors facilitating inclusion and considers the academic and social aspects of inclusion
Wooster and Parnell	2006	Report for Scope	260 parents of disabled children+6 interview	Parents' experiences of choosing a school	Access to services: Reports parents' difficulties in getting child's needs met and that parents rarely have a real choice in terms of provision

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Appendix III: Derivation of SEN indicators

- **Pupils with SEN statements in LEA schools per 1000 pupils: 2008**

This indicator comes from the DCSF annual publication on SEN, the most recent being for January 2008 (Department for Children Schools and Families, 2008). It comes from Table 13, 'All schools: Pupils with statements of special educational needs, based on where the pupil attends school'. It includes nursery, primary, middle, secondary, independent and special schools, pupil referral units, city technology colleges and academies. Data come from the School Census, and so counts children attending school in the local authority area. It is given in the table both as a number and as a percentage: here it is expressed as a rate per thousand.

- **Pupils with SEN per 1000 pupils: 2008**

No figure for the total number of SEN pupils (with or without a statement) is published for each local authority. The figure used here was derived from figures in the DCSF annual publication. It combines the figure for all statemented pupils (above) with a figure for SEN pupils without a statement. Figures for non-statemented SEN pupils are given for pupils in maintained primary schools (Table 14) and state-funded secondary schools (including city technology colleges and academies) (Table 15). These figures are also derived from the Schools Census so are also based on where pupils attend school. The figure might be a slight underestimate of the total as there may be non-statemented SEN pupils attending other types of school who are not counted. Figures in all three tables are given as numbers and percentages: here the indicator is expressed as a rate per thousand by adding the numbers from the three tables for each authority and dividing by the total pupils also given in table 13.

- **Percentage of SEN pupils with a statement: 2008**

This indicator is the percentage of SEN pupils who have a statement. It uses the two measures described above. It expresses the number of SEN pupils with a statement as a percentage of all SEN pupils.

- **Limiting long-term illness per 1000: children 0-17: census 2001**

The most recent national census in 2001 included a question on limiting long-term illness. The question in England was: '13. Do you have any long-term illness, health problem or disability which limits your daily activities or the work you can do?' Results from this question are made available to the academic community on the Census Dissemination Unit web site²⁷ using the Casweb (Census Area Statistics on the Web²⁸) interface. They are part of Standard Table 16. The figure used here is the number of people aged 0-17 who were described as having a limiting long-term illness per thousand young people aged 0-17.

- **In receipt of Disability Living Allowance aged under 18: per thousand: 2007**

The Department of Work and Pensions (DWP) keeps records of people receiving Disability Living Allowance (DLA) payments. The figures are taken from the Work and Pensions Longitudinal Study and cover all claimants (Department for Work and Pensions, 2005). The numbers in each local authority, by age, are published on the DWP web site each quarter and can be accessed using the DWP Tabulation Tool²⁹. The figure used here is the number of people aged 0-17 in receipt of DLA payments,

²⁷ <http://cdm.census.ac.uk/2001/index.htm>

²⁸ <http://casweb.mimas.ac.uk/>

²⁹ <http://83.244.183.180/100pc/tbtool.html>

averaged over the two quarters ending May 2007 and November 2007. The number is expressed as a rate per thousand people aged 0-17.

- **Achievement gap on Key Stages 2-4: 2007**

This indicator comes from the DCSF annual publication on National Curriculum assessments and GCSE attainments for each local authority, the most recent being for 2007 (Department for Children Schools and Families, 2007). The results are presented as the percentage of pupils who achieve a specified level, both for all pupils and for pupils with SEN. The results for Key Stage 2 are presented as the percentage who achieve level 4 or above in English (Table 44), mathematics (Table 45) and science (Table 46): these have been averaged to give an overall Key Stage 2 score for each local authority. Similarly the results for Key Stage 3 are presented for pupils achieving level 5 or above for English (Table 70), mathematics (Table 71) and science (Table 72): these have been averaged to give an overall Key Stage 3 score. For Key Stage 4 the figures are for the percentage of pupils achieving GCSE or equivalent passes: three categories are reported – 5 passes A*-C, 5A*-C including English and mathematics and any passes. The percentage of with 5 A*-C passes has been used here as the Key Stage 4 score. The derived scores for Key Stages 2, 3 and 4 have been averaged to give overall Key Stage attainment scores. The achievement gap is the difference between the mean score for all pupils and all pupils with SEN.

- **SEN spending per SEN child population: 2006 (£)**

DCSF publish annual Section 52 outturn statements which detail education spending for each local authority³⁰, required under Section 52 of the School Standards and Framework Act 1998 (1998). The most recent is for 2006-2007. The Detailed Report Table A gives data for each local authority; line 38 is described as 'SEN funding (Not for special schools)'. The indicator used here is this expenditure figure expressed as pounds per SEN pupil, the figure for SEN pupils being the one calculated above. The indicator is in pounds.

- **SEN appeals per 10,000 pupils: 2005-2007**

Parents of SEN children can appeal to the Special Educational Needs and Disability Tribunal (SENDIST) concerning decisions made by the LEA regarding their child's education. The numbers of appeals are published annually by SENDIST, giving both numbers and the rate per 10,000 school population. This indicator is the average number of appeals in each LEA for the two years 2005-2006 and 2006-2007 (Special Educational Needs and Disability Tribunal, 2008: Appendix 2), expressed as a rate per 10,000 school population.

- **Statemented SEN pupils not in mainstream education per 1,000: 2008**

This indicator comes from the DCSF annual publication on SEN, Table 19, which shows the placement of pupils for whom the local authority maintains a SEN statement. Figures come from the annual SEN2 survey completed by local authorities. It covers all pupils resident in the local authority area: 'SEN2 is completed by LAs and records those children for whom the LA is responsible (regardless of whether they are educated in the LA's own maintained schools, in other LA's schools, in the non-maintained or independent sectors or educated other than at school).' (Department for Children Schools and Families, 2008: Note 4) Pupils not in mainstream education was calculated

³⁰ <http://www.dcsf.gov.uk/localauthorities/section52/subPage.cfm?action=section52.default&ID=64>

as the sum of children in maintained special schools; non-maintained special schools, independent special schools and other independent schools; and hospital schools and pupil referral units. The indicator is expressed as a percentage of statemented SEN children, also given in Table 19. (The total figure of statemented SEN pupils for England was 230,640, which differs slightly from the figure of 223,610 in Table 13 derived from the Schools Census.) (Table 19 contains a number of suppressed figures, 'based on 1 or 2 pupils': for this calculation it has been assumed that each of these was one pupil, to avoid large amounts of missing data.)

- **Autistic Spectrum Disorder and Hearing Impairment per 1,000 pupils: 2008**

Tables 20, 21 and 22 of the DCSF publication on SEN show the numbers of pupils with each type of special need in maintained primary schools, state funded secondary schools and all special schools respectively. Pupils either have an SEN statement or are at School Action Plus: it does not include SEN pupils at School Action. The tables give numbers and rates as a percent of all pupils with SEN statements or at School Action Plus. The indicators were calculated by summing the numbers over the three tables and are expressed as a rate per thousand pupils: the figure for total pupils was taken from Table 13. Rates have been calculated for the two exemplar conditions of Autistic Spectrum Disorder and Hearing Impairment.

- **Index of Multiple Deprivation.**

A set of deprivation indices are published by the Department for Communities and Local Government (Department for Communities and Local Government, 2007): 'The Index of Multiple Deprivation 2007 combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score'. The most recent version is for 2007. The Average Score is a summary measure of multiple deprivation: 'The Index of Multiple Deprivation 2007 (IMD 2007) is a measure of multiple deprivation at the small area level. The model of multiple deprivation which underpins the IMD 2007 ... is based on the idea of distinct dimensions of deprivation which can be recognised and measured separately. These are experienced by individuals living in an area. People may be counted as deprived in one or more of the domains, depending on the number of types of deprivation that they experience. The overall IMD is conceptualised as a weighted area level aggregation of these specific dimensions of deprivation.' (Noble et al., 2008: 9). A higher score indicates more deprivation.

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