SEND Emerging needs 0-4 years in Cheshire West and Chester

What is a JSNA?

The Joint Strategic Needs Assessment (JSNA) is the comprehensive assessment of the current and future health and social care needs of children and young people aged 0 to 19 (25 with SEND) and their families, with a focus on improving the health and wellbeing and reducing inequalities. There are nine individual chapters that comprise this JSNA.

A Joint Strategic Needs Assessment (JSNA) looks at all the information available around the current and future health and social care needs of populations in the local area. It will then use the data to inform and guide the planning and commissioning of health, well-being and social care services within a local authority. The implementation of recommendations will be overseen by the Health and Wellbeing Board.

As part of the JSNA's development, we have ensured the following principles and values have been considered:

- Think Family
- Our Way of Working and trauma informed practice.
- Prevention, early intervention and avoiding escalation of need.
- The voice of children, young people and families is central to the design, delivery and evaluation of service provision.
- Strength-based, personalised service provision focussed on relationships.
- Integrated services which mean that families tell their story once and can easily access seamless support.
- Equality.
- Reducing inequality.

Chapters Introduction

Cheshire West and Chester Councils 0-19 (25 with SEND) JSNA aims to bring benefits by identifying key health, wellbeing, and social care needs. Findings will help the Council and its partners to make more informed decisions about how we provide support and services to achieve the best outcomes for our children, young people, and their families/carers.

Each chapter has considered literature relevant to the assigned area of focus, drawing on this information to highlight key points that could contribute to findings and recommendations.

Although each JSNA chapter can be read as an individual report. Throughout every chapter, there were common themes relating to how we collect and analyse data particularly in relation to outcome information for certain groups; how inclusive and consistent messages are communicated and how we would like to do more coproduction and peer mentoring.

1. Prevalence of additional needs in children aged under five

1.1 Introduction

Special educational needs refer to children with learning difficulties or disabilities that make it harder for them to learn than most children the same age. Some physical disabilities and learning disabilities can be identified from birth, other needs will emerge as the child develops, engages with the world, and enters education.

This means we do not know how many children aged under five have additional needs, as their need may not be identified until they are older. Those who are identified as having a need at an early age tend to have a physical or sensory disability, or a complex and severe behavioural or developmental need.

However, we can calculate an estimated prevalence of the number of children who are likely to have an additional need that may require support. Estimated prevalence may be higher than any known prevalence as it is it includes numbers of children yet to be identified as having a need, that will emerge as they age and learn.

1.2 Estimated prevalence of additional needs

There are an estimated 17,500 children aged under five residing in Cheshire West & Chester (Population estimates mid-2021, Office for National Statistics). Of these an estimated 4% will have a complex or severe need, approximately 700 children. A further 11% are estimated to have a moderate need, approximately 2,000 children.

This equates to approximately 2,700 children aged under five with an additional need in Cheshire West & Chester, 15% of the under-five population. This is a rate of 154 per 1,000 under-fives.

Those with a severe or complex need are more likely to have their needs identified at a younger age than those with moderate needs whose needs may not emerge until they are in a learning environment.

1.3 Observed prevalence

Primary Care general practitioners (GPs) do not currently flag children who have additional needs or emerging needs on their system, so we do not know how many children have a need in Cheshire West & Chester. There is no one source or figure to help our understanding of this.

However, we do know approximately how many children in 2021 had a disability as defined by the Equality Act, as this was collected as part of the 2021 Census. This will be lower than the number of children with additional needs as the definition of disability under the Equality Act 2010 is ‘a physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative effect on your ability to do normal activities.’ Substantial is defined as more than minor or trivial, and long-term is defined as 12 months or more.

In 2021, there were 463 children aged under 5 with a disability as defined by the Equality Act.

- This is a rate of 264.6 per 10,000, 3% of the under 5 population.
- This is a higher rate than the England average of 231.8 per 10,000, 2% of the under 5 population.

Therefore, this demonstrates the number and proportion of children with a disability increases with age.

Table 1: Number of under 5's Disabled under the Equality Act (2021 Census)

Age	Number disabled under the Equality Act	% of their age group with a disability under the Equality Act
Under 1 year	46	1.4%
Aged 1 year	58	1.7%
Aged 2 years	72	2.1%
Aged 3 years	118	3.3%
Aged 4 years	169	4.6%
Total	**463**	**2.6%**

Source: Disability by single year of age, Census 2021, applied to Office for National Statics Mid-Year Population Estimates 2021

2. Type of need(s)

2.1 Estimated number of children with an identified or unidentified need by SEN category

Estimates indicate that the most prevalent type of special educational need in children in Cheshire West & Chester is a specific learning difficulty and a moderate learning difficulty (Cognition and Learning). Approximately 3% of the under-five population are likely to be affected. However, these needs are unlikely to be identified until the age of four plus, once the child is in a school setting. The SEN support data confirms this as there are no under-fives receiving support for a specific learning difficulty, and few for a moderate learning difficulty – but these needs will emerge as they get older and will need to be planned for and interventions put in place as early as possible.

The third most prevalent need is speech, language and communication needs affecting an estimated 2% of the under-five population as a special educational need. This is the need most likely identified in under-fives so will appear most prevalent for this age group.

Table 2: Estimated SEND prevalence by SEND type

SEN type	Estimated population of under 5's with the need	Rate per 1,000 under 5's	% of under 5 population with the need	% of under 5 SEND population with the need
Specific learning difficulty	544	30.9	3.1%	20.7%
Cognition and learning (moderate learning difficulty)	530	30.1	3.0%	20.1%
Speech, language and communication needs	364	20.7	2.1%	13.8%
Social, emotional and mental health*	350	31.8	2.0%	13.3%
Autistic spectrum disorder	319	18.1	1.8%	12.1%
Physical disability	81	4.6	0.5%	3.1%
Severe learning difficulty	51	2.9	0.3%	1.9%
Hearing loss	39	2.2	0.2%	1.5%

Visual loss	33	1.9	0.2%	1.3%
Medical	16	0.9	0.1%	0.6%
Multi-sensory impairment	7	0.4	0.0%	0.3%
Profound and multiple learning difficulty	7	0.4	0.0%	0.3%
Other	169	9.6	1.0%	6.4%
Those needing support but no type of need assigned	121	6.9	0.7%	4.6%

*Applied to those aged 2 to 4 only
Source: Rates of SEND type calculated from SEN2 2020 and School Census 2020 for children aged 8-15 years only. Rates applied to children aged under 5 using Office for National Statistics 2020 mid-year population estimates.

2.2 Observed need by type

Although there is no source to capture the number of children with a known additional need or the type of need they have, there are some data sets to help us begin to understand identified need.

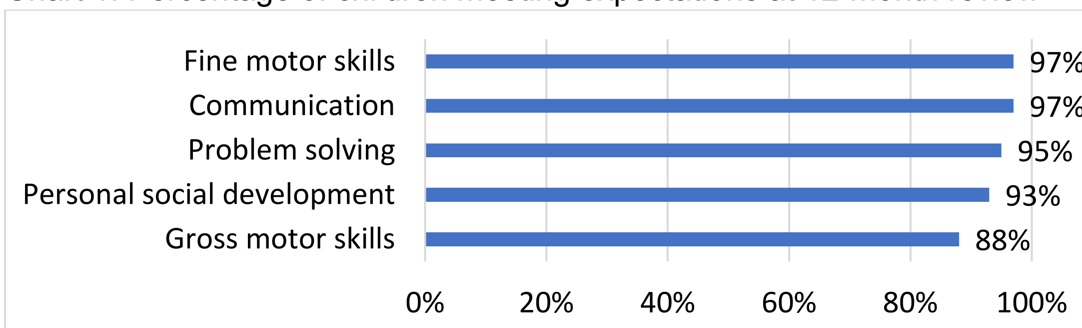
For very young children, the 12-month review Ages and Stages data provided by the Starting Well Service, shows that gross motor skills are the area with the lowest number of children achieving expectations at one year of age. However, this skill jumps to the highest performing developmental area by the 2/2.5 year review. The developmental area showing most need at this age is, and has consistently been over the last five years, communication.

Table 3: ASQ3 scores at 12 month review in 2021/2022

ASQ3 Developmental area	Achieving above expectations	Achieving close to expectations	Achieving below cut off score
Communication	89%	8%	3%
Gross motor skills	80%	8%	13%
Fine motor skills	89%	8%	4%
Problem solving	87%	8%	6%
Personal social development	89%	4%	4%

Source: Starting Well Performance Management Tool Dashboard, Cheshire West and Chester Council. Note: Scores have been averaged from four quarters and rounded.

Chart 1: Percentage of children meeting expectations at 12-month review



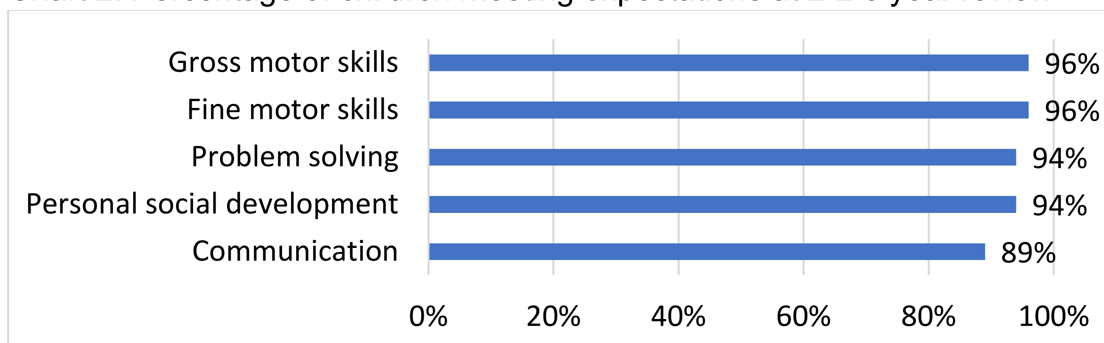
Source: Starting Well Performance Management Tool Dashboard, Cheshire West and Chester Note: The data presented is ‘achieving above expectations’ and ‘achieving close to expectations’.

Table 4: ASQ3 scores at two and a half year review in 2021/2022

ASQ3 Developmental area	Achieving above expectations	Achieving close to expectations	Achieving below cut off score
Communication	81%	8%	11%
Gross motor skills	88%	8%	5%
Fine motor skills	87%	9%	4%
Problem solving	88%	6%	6%
Personal social development	84%	10%	7%

Source: Starting Well Performance Management Tool Dashboard, Cheshire West and Chester Council. Note: Scores have been averaged from four quarters and rounded

Chart 2: Percentage of children meeting expectations at 2-2.5 year review



Source: Starting Well Performance Management Tool Dashboard, Cheshire West and Chester. Note:
The data presented is ‘achieving above expectations’ and ‘achieving close to expectations’

Other data sets, also show, that the biggest identified need in children aged under five is for speech, language, and communication. This includes School Census data which captures children accessing SEN Support, and SEN2 data which details children with an Education, Health and Care Plan.

Schools and early years settings must support children with special educational needs. The Early Years Specialist Teaching Support Team (EYSTS) support settings to support all children. Children identified with a need can be provided with SEN support and planned strategies and interventions can be put into place. The provision of SEN support means that most children who are identified as needing support to learn or interact will have their needs met by their educational setting without the need for an Education, Health and Care Plan (EHCP).

In January 2022, 343 children aged under five were receiving SEN support. The majority of these children were aged four (75%). Just over half of children receiving SEN support, had a speech, language and communication need (189 children; 55%). This was the most common need, followed by a social, emotional and mental health need (60 children; 17%).

Table 5: Primary needs of children aged under five receiving SEN support in a school setting.

Primary need	Number of under fives receiving SEN support	% of those receiving SEN support aged under five

Speech, language and communication	189	55%
Social, emotional and mental health	60	17%
Autistic spectrum disorder	22	6%
Moderate learning disability	20	6%
Specific learning disability	13	4%
Not yet assessed	12	3%
Other	8	2%
Physical disability	6	2%
Hearing loss	5	1%
Severe learning disability	<5	-
Multi-sensory impairment	<5	-
Profound and multiple learning disability	<5	-

Source: School Census January 2022

If, despite the school taking relevant action, the child is still not making expected progress, the school or parents then should request a EHC needs assessment. An education, health and care plan (EHCP) are for children and young people aged up to 25 who need more support than is available through special educational needs support. EHCPs identify education, health and social needs and set out the additional support to meet those needs (Department for Education). Few children aged under five will have an EHCP as children are not generally assessed for a plan until they begin to learn and engage with education, or the current provision is no longer sufficient. EHCPs are most common for school aged children with complex and/or severe needs. A setting may be able to meet the child's needs at a young age but not as the child ages and learning become more focused.

In January 2022, 119 under-fives had a plan with 34% for a speech, language and communication need (40 children). 33% were for Autistic Spectrum Disorder (39 children). The majority of children with a plan (75%) are aged four. For those aged three, speech, language and communication were the most common need.

Table 6: Special educational need category for under 5's with an EHC plan in Cheshire West & Chester

Special educational need category	Number of under 5's
Speech, language and communication needs	40
Autistic spectrum disorder	39
Cognition and learning (moderate learning difficulty)	17
Physical disability	7
Medical need	<5
Severe learning difficulty	<5
Visual loss	<5
Social, emotional, and mental health	<5
Profound and multiple learning difficulty	<5
Blank	<5

Source: SEN2 Census January 2022, Cheshire West and Chester Council

Speech and language therapy supports children with additional communication needs. Not all children who access speech and language support will go on to have a continued special

educational need, some will be experiencing a developmental delay, or need extra support at this stage, which can be enhanced with effective intervention. Therefore, early identification is vital.

3. Increasing need

3.1 Declining child development at age two

It can be difficult to distinguish where there is a genuine increase in need, or better identification of need. Either way, any increase will impact on services and require extra capacity and resource.

The ASQ screening tool is the accepted check on a child's development. ASQs are undertaken at age 2-2.5 years old, to help identify children who may be at risk of developmental delays or disability and may require extra support. Children who are at or above the expected level in five areas of development are considered to have a good level of development.

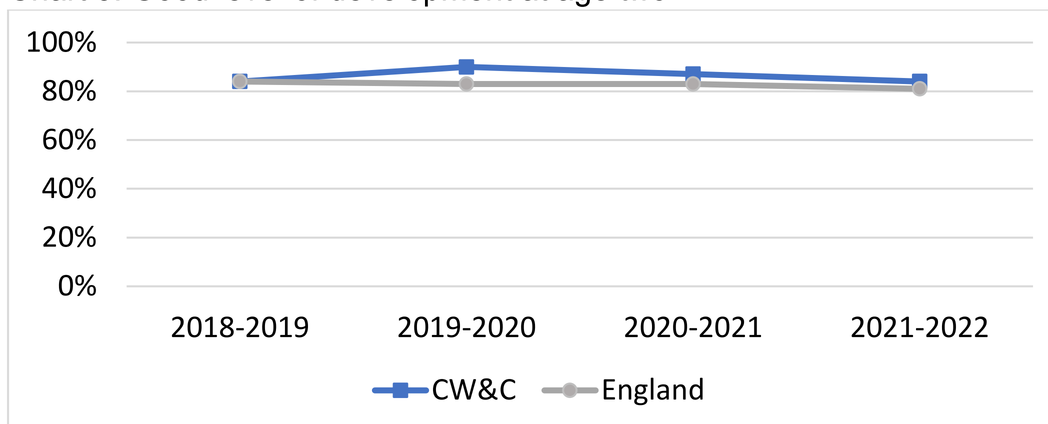
In Cheshire West & Chester the proportion of children who had a good level of development at age two in 2021-2022 has been decreasing since 2019-2020. Nationally the trend was similar with 2021-2022 seeing a decrease from the previous year. The reasons for this are unknown, but those children aged two in 2021-2022 may have had their development disrupted by the Covid-19 pandemic during 2020 and 2021, due to fewer social interactions and prolonged absences from early learning environments. Future trends will need to be assessed to understand this better.

Table 7: Good level of development at age two

Year	Number of children achieving good level of development Cheshire West & Chester	% if children achieving good level of development: Cheshire West & Chester	% if children achieving good level of development: England
2021-2022	2,217	84%	81%
2020-2021	2,015	87%	83%
2019-2020	2,357	90%	83%
2018-2019	2,326	84%	84%

Source: Child development outcomes at 2 to 2 and a half years, Department for education

Chart 3: Good level of development at age two



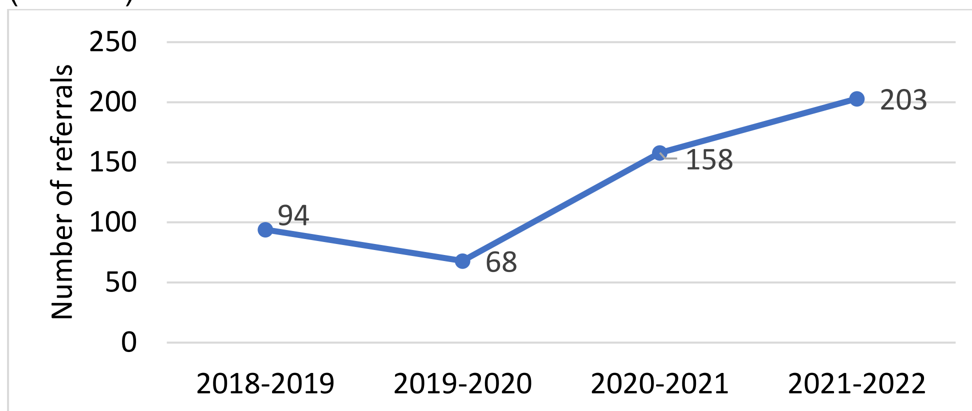
Source: Child development outcomes at 2 to 2 and a half years, Department for education

3.2 Increase in demand on services

An increase in demand on services may not mean an increase in the number of children with a need – it could mean that identification of needs has improved, or that the providers supporting children with needs may require extra help. However, the two may go hand in hand.

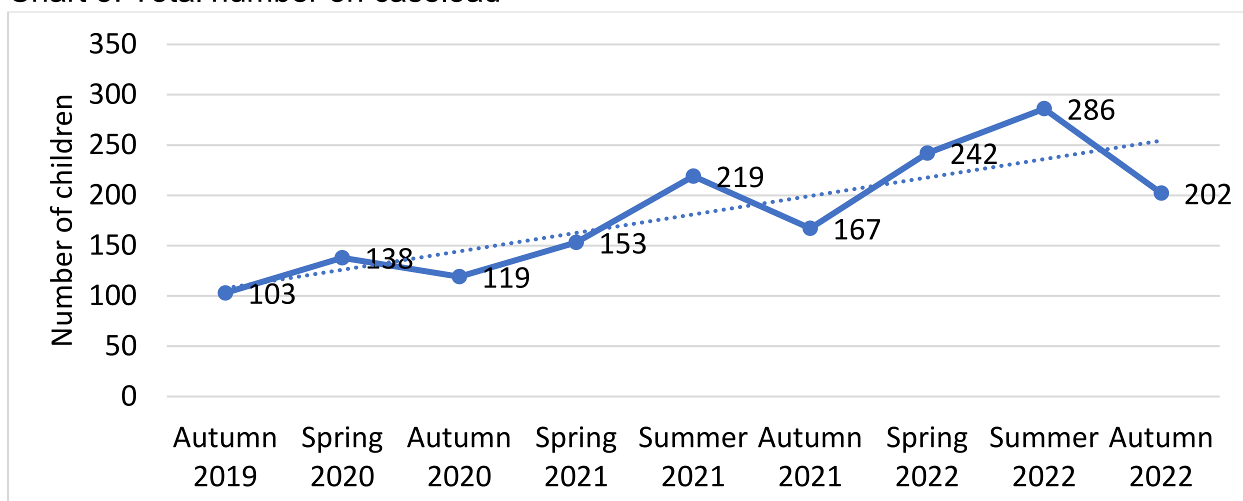
The Early Years Specialist Teaching Support Team (EYSTS) supports settings and children with additional needs. Caseloads for EYSTS and the number of new referrals has been rising. In 2020-2021 there were 158 new referrals to the service which increased to 203 in 2021-2022. The majority of children supported have complex needs. Children remain on caseloads until they go to school.

Chart 4: Number of new referrals to Early Years Specialist Teaching Support Team (EYSTS)



Note: In 2018-19 early years settings were unable to refer directly into the service. In 2019-2020 referrals stopped in February 2020 due to the Covid-19 pandemic.
Source: Early Years Specialist Teaching Support Team data, Cheshire West and Chester Council

Chart 5: Total number on caseload



Note: Children entering school are removed from the caseload each Autumn resulting in a dip in caseload. The dip has been less each Autumn due to a higher number of new referrals each autumn.
Source: Early Years Specialist Teaching Support Team data, Cheshire West and Chester Council

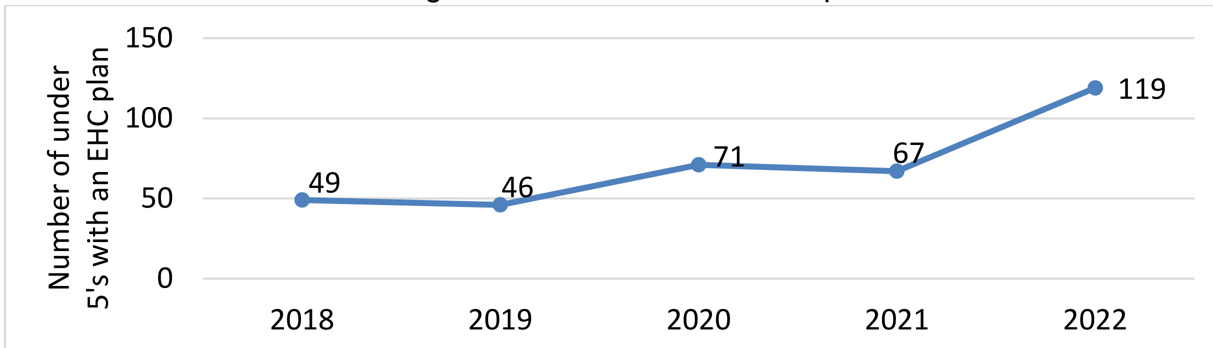
Children in an educational setting with special educational needs have their needs met by:

- SEN Support: All children with an identified educational need will have their needs met by the provision in their educational setting.
- Education, Health and Care Plan (EHCP): Most children will have their needs met via SEN support but if the child has a high level of need which cannot be met through the current provision, they will be assessed for an EHCP. This takes a holistic view and sets out the health, care and educational needs of the child.

Few children aged under five will have an EHCP as they are not generally assessed for a plan until they engage with an educational setting such as nursery or school. Because of this, the number of children identified as needing an EHCP increases with age and as they progress from early year settings through school years. However, the number of under 5's with an EHCP in Cheshire West & Chester has been increasing since 2019.

In January 2022, there were 119 children aged under five with an EHCP - all aged two to four. The majority were aged four, 71% (85 children). 91 (76%) had their plan made for the first time during the 2021 calendar year. The number of under 5's with an EHCP increased from 67 at January 2021 to 119 at January 2022. The January 2022 figure is more than double the January 2019 figure.

Chart 6: Number of children aged under five with an EHC plan in Cheshire West & Chester



Source: SEN2 Census, Cheshire West and Chester Council

The proportion of EHC plans that were for children aged under five also increased from 3% to 5% in 2022. This is a larger proportion than the England average which was 3% in 2022, a slight decline from 4% the previous year.

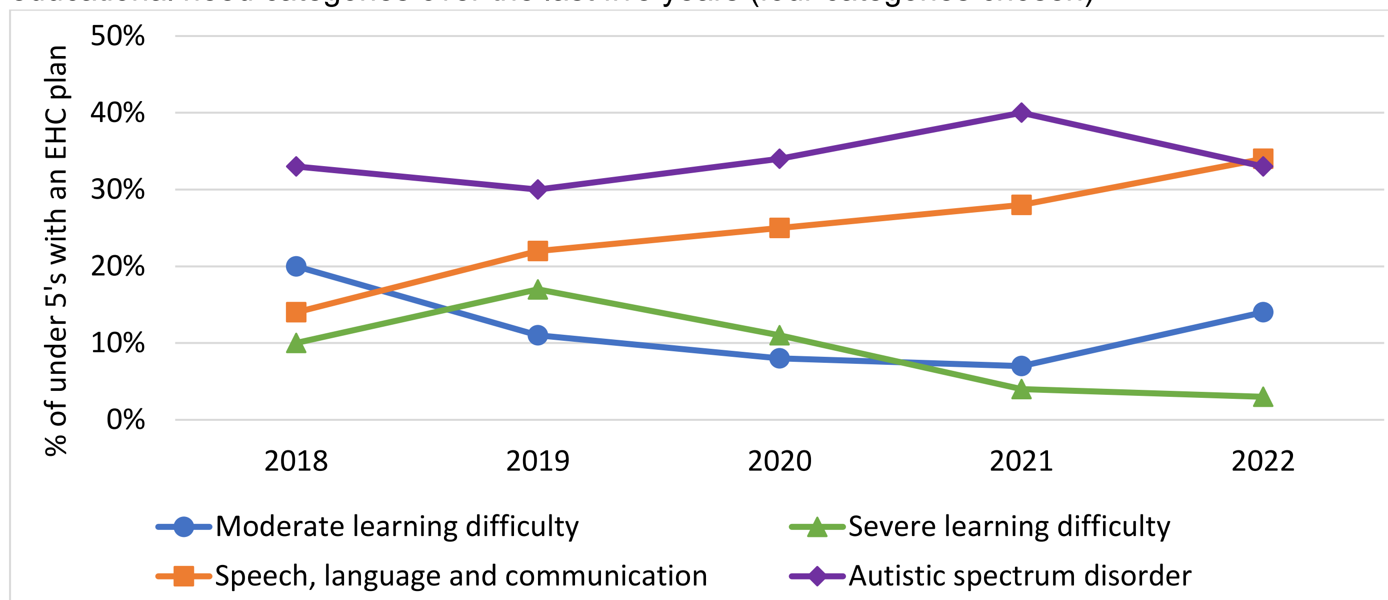
Table 8: EHC plans in Cheshire West & Chester for under Five's

Year	Number of EHC plans	Number of under 5's with an EHC plan	Proportion of EHC plans that are for under 5's
2022	2,588	119	5%
2021	2,289	67	3%
2020	2,065	71	3%
2019	1,857	46	2%
2018	1,664	49	3%

Source: SEN2 Census, Cheshire West and Chester Council

This increase in EHCPS is not reflected in SEN support which decreased. This suggests more complexity in needs, although EHCPs for severe learning difficulty and Autism decreased. The increase in needs for an EHCP are for speech, language and communication which has been consistently increasing since 2019, and for moderate learning difficulties.

Chart 7: Percentage of EHC plans for children aged under five: Changes in special educational need categories over the last five years (four categories chosen)



Source: SEN2 Census, Cheshire West and Chester Council

Increase in need and support in educational settings may again be related to disrupted development during the Covid-19 pandemic. This can be more thoroughly explored as time goes on with future years data.

4. Identification of need

4.1 Maternity Care

Pregnant women undergo screening to understand if their baby has a higher or lower chance of having a health condition. Screening can detect spina bifida, HIV and Hepatitis, and assess whether there is a higher chance of Down's syndrome.

All new-borns undergo new-born antenatal screening. The screening includes a physical examination, hearing screening and blood spot screening. The blood screening tests for nine rare but serious health conditions including cystic fibrosis, sickle cell disease, congenital hypothyroidism, and inherited metabolic diseases. These needs are not emerging, but an additional need or disability observed from birth.

4.2 Health visitor contacts as part of the healthy child programme

All families with children aged under five are offered mandated health visitor contacts. Health visitors have expertise in child development and are important for identifying emerging needs along with the parent/care giver. The Healthy Child Programme provides significant opportunities for highly skilled professionals to identify and deliver appropriate interventions. The mandated contacts are:

- Face-to-face new birth visit

- 6-8 week review
- 12 month review
- Two to two and a half year review

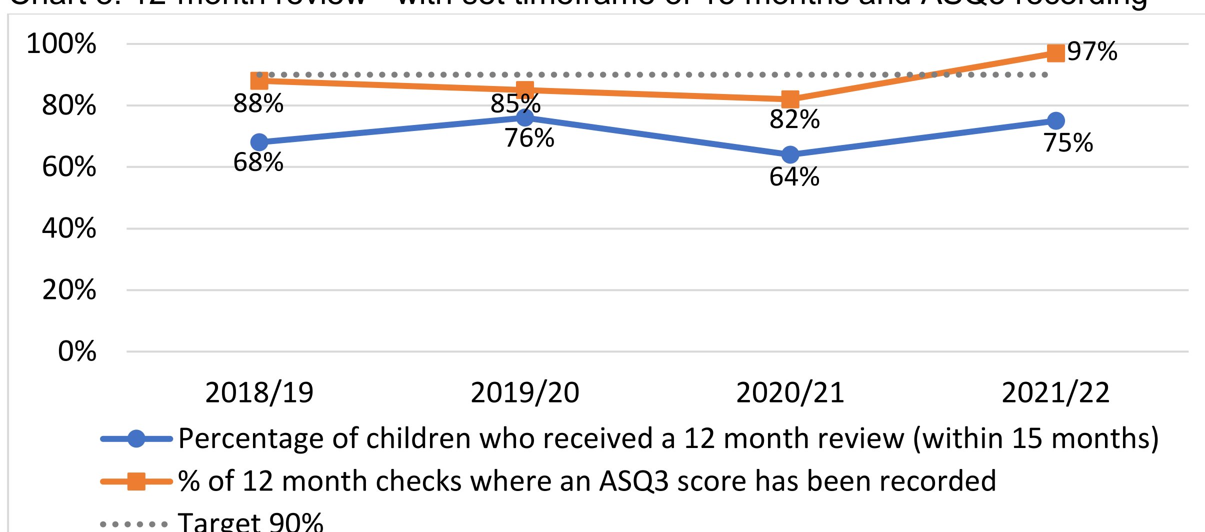
The above reviews should take place within specified timescales highlighting the importance of early detection of developmental delays. All children will have their reviews, but the aim is for this to be within the guidelines and targets met. The sooner developmental delays are identified, the more quickly interventions can be put in place to impact outcomes during the baby's critical first years. The Ages and Stages Questionnaire version 3 (ASQ3) website states that 'Evidence shows that the earlier development is assessed—the greater the chance a child has to reach his or her potential.'

In 2021/2022, 92% of births received a face-to-face newborn visit (NBV) within 14 days by a Health Visitor and 87% of children received a 6-8 week review by the time they were 8 weeks. The NBV is above the 90% but the 6-8 week reviews are below target.

At the 12 month and two/two and a half year reviews, the Ages and Stages tool is used (ASQ3) to identify a child's strengths and where there are emerging needs. It helps to identify when a referral to health professionals is needed. The aim is for 100% of children having a review to have an ASQ3 score recorded.

In 2021/2022, 75% of children who were eligible for a 12-month review received their review within the guideline of 15 months. This is below the 90% target but does see a return to pre Covid-19 pandemic levels following a pandemic dip in timely reviews in 2020/21. Of those who had their 12-month review, 97% had an ASQ3 score recorded, which is the highest it has been in recent years and above the 90% target.

Chart 8: 12-month review - with set timeframe of 15 months and ASQ3 recording

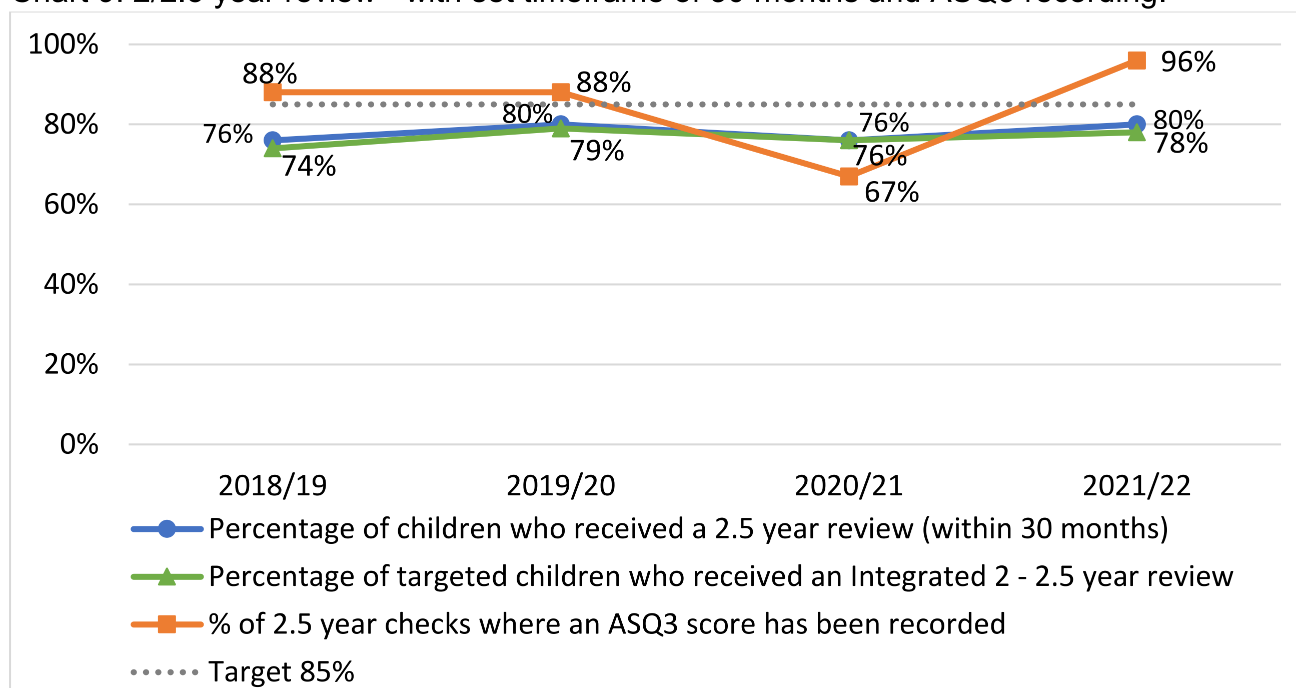


Source: Starting Well Performance Management Tool Dashboard, Cheshire West and Chester Council. Note: Scores have been averaged from four quarters and rounded.

In 2021/2022, 373 babies at their 12-month review were below the cut off score for where they should be in their development. These babies may have an emerging need. This is 15% of babies who had a review with an ASQ3 score recorded.

In 2021/2022, 80% of children who were eligible for a two/two-and-a-half-year review, received their review within 30 months (2,752 children). This is below the target of 85% but does see a return to pre Covid-19 pandemic levels following a pandemic dip in 2020/21. For those children who were targeted for an integrated review, 78% received their review within 30 months. Of those who had their review, 96% had an ASQ3 score recorded which is the best it has been in recent years and above the 90% target. This is despite a large fall in 2020/21 during the pandemic to 67%.

Chart 9: 2/2.5 year review - with set timeframe of 30 months and ASQ3 recording.



Source: Starting Well Performance Management Tool Dashboard, Cheshire West and Chester Council. Note: Scores have been averaged from four quarters and rounded.

In 2021/2022, 410 children at their 2/2.5 year review were below the cut off score for where they should be in their development. This is 16% of children who had a review with an ASQ3 score recorded. These children may have an emerging need and a referral made to appropriate services.

4.3 Childcare and early education

In addition to the formal health assessments and checks, early years practitioners play a crucial role in monitoring and reviewing the progress and development of all children. Observations and professional judgements may identify that a child has, or potentially has, special educational needs. Settings can contact EYSTS if they require advice or assessment. (See section Early Development: Giving Children the Best Start in Life for early education provision - number of children who are benefitting from funded early education at age 2, and 3 and 4).

5. Inequalities

Literature and research indicate that more children living in deprived areas will have a disability or special educational need (SEN). As there is no dataset that captures all children with emerging needs, we are unable to paint a thorough picture of the link between deprivation and emerging needs in Cheshire West & Chester. However, we can look at children accessing SEN support and those with EHCPs.

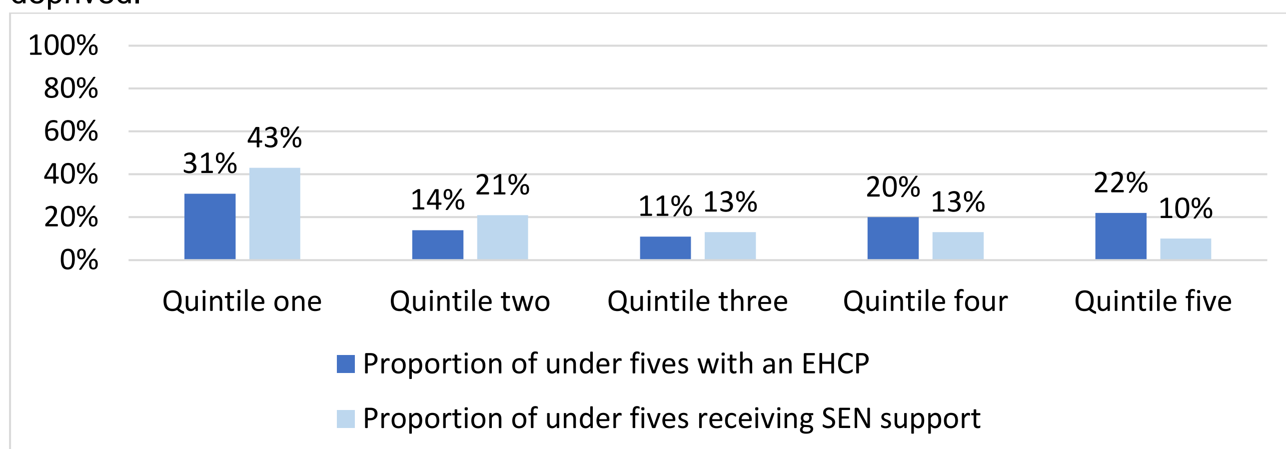
The Index of Multiple Deprivation (IMD) is a measure of relative deprivation for small geographical areas. IMD classifies these geographical areas into five quintiles based on relative disadvantage, with quintile 1 being the most deprived and quintile 5 being the least deprived.

SEN support and EHCP data shows that children living in the most deprived neighbourhoods in the borough are more likely to be receiving support for special educational needs.

If we look at SEN support (January 2022 data), 43% of children receiving SEN support aged under five (148 children), lived in the most deprived neighbourhoods in the borough (those areas which are in IMD quintile one in the Index of Multiple Deprivation 2019, the 20% most deprived neighbourhoods in England). As deprivation increases, the number of children with identified SEN support increases.

The data for children aged under five with an EHCP shows a different pattern. It is still those children living in the most deprived neighbourhoods that have a greater proportion of EHCPs – a third of children (31%) aged under five with a EHCP reside in IMD quintile one. However, the second highest proportion of EHCPs are for children in the least deprived neighbourhoods, with 22% of children aged under five with a EHCP residing in IMD quintile five. This shows that of children with identifying SEND requiring support, those who are least deprived are more likely to have a plan in place than be receiving SEN support. There are fewer children in quintile two and three with a plan compared to the most and least deprived areas of the borough.

Chart 10: % of children aged under five with an EHC plan or receiving SEN Support by which IMD quintile they reside with quintile 1 being most deprived and quintile 5 least deprived.



Source: Indices of Multiples Deprivation 2019 applied to School Census January 2022 and SEN2 2022, Cheshire West and Chester Council.

6.Provision and assets in Cheshire West & Chester

6.1 Services

SEND Services for Cheshire West are provided by:

- Countess of Chester Hospital NHS Foundation Trust (COCH)
- Mid Cheshire Hospital NHS Foundation Trust (MCHFT)
- Central Cheshire Integrated Care Partnership (CCICP)
- Bridgewater Community Healthcare NHS Foundation Trust (BCHFT)
- Cheshire and Wirral Partnership NHS Foundation Trust (CWP)

Services are provided from ages 0-16 (age 19 if in specialist education)

6.2 Community Paediatrics

Community Paediatric Services available for Cheshire West children and young people are located at Countess of Chester NHS Trust Foundation Hospital, Kingsway Children's Centre, Mid Cheshire NHS Foundation Trust Hospital and Wharton Primary Healthcare Centre. Paediatricians also conduct clinics in special schools, children's centres, and health centres in the community.

It provides a service for the assessment of children and young people with neurodevelopmental needs e.g., autism, ADHD, developmental delay, and other aspects of disability from 0-16 years.

The Community Paediatric Team assess children for ASD up to 11 years of age (preschool and primary school children). The service will assess and treat children with ADHD up to the age of 16 years.

Community Paediatricians are also responsible for statuary duties which include undertaking Initial Health Assessments (IHA) for Children in Care, medical assessment for Education Health and Care Plans and undertaking child protection medicals.

6.3 Occupational Therapy

The Occupational Therapies teams provide targeted and specialist intervention for children predominantly with long term conditions and physical disabilities.

The teams work with children, families, and Multi-Disciplinary Teams to assist children to achieve their maximum functional potential. Children are assessed by a therapist and if appropriate an individual goal orientated treatment programme is devised with agreed intervals and evaluations.

Interventions may be focused on fine motor skills and daily living skills, in a location suitable to need.

Countess of Chester NHS Trust Foundation Hospital team also cover Neonatal and Children's Ward.

6.4 Physiotherapy

The Physiotherapy teams provide targeted and specialist intervention for children predominantly with long term conditions and physical disabilities.

The teams work with children, families, and Multi-Disciplinary Teams to assist children to achieve their maximum functional potential. Children are assessed by a therapist and if appropriate an individual goal orientated treatment programme devised with agreed intervals and evaluations.

Interventions may be focused gross motor (mobility) skills or posture management, in a location suitable to need.

6.5 Speech and Language Therapies (SALT)

The Speech and Language Therapies team are an agile workforce operating in a variety of locations across all localities. The team provide assessment diagnosis and treatment interventions to support children and young people with identified speech, language, and communication needs (SLCN's) and those with feeding and swallowing difficulties. Interventions may be via advice and support to parents and education settings on appropriate universal and targeted programmes or via individualised programmes for children and young people requiring specialist support. Supporting with a range of SLCN's including difficulties understanding and using language, difficulties with speech sounds and other communication problems associated with conditions such as Hearing Loss, Cleft Palate and Autism.

7. Trends

In 22/23 the following trends have been identified:

7.1 CCICP / COCH Therapies

- An increase in the number of referrals for children aged 0-5, specifically those with complex needs.
- This complexity of children referred into the service has continued to increase, this is demonstrated by the upwards trajectory of EHCP's being implemented.
- Some suggestion that families are moving from the city into more rural areas following opportunity to work remotely could be a reason for increase in referrals.
- Increase referrals to Physiotherapy for talipes and torticollis have been identified, specifically torticollis which is not being picked up until approximately 6-12 months, and potentially indicating a developmental issue.
- An increase involvement in safeguarding cases since COVID-19.
- There has been a continual increase of EHCPs being completed, and as special school places are rapidly filling, children with complex needs are being supported in mainstream settings, creating challenges for therapists.
- The data collected reflects the increasing demand, with caseload numbers for Early Years teams also increasing post-COVID-19.
- Post COVID-19 there has been a change in universal services offering more remote/virtual work which led to an increase in referrals for children with developmental delay before a professional had seen the child e.g., Mum reports child not yet walking, please accept this referral.
- Post COVID-19 an increase in referrals for the cohort of children who were babies/toddlers through the pandemic who have difficulties with fine motor skills, social/communication difficulties, developmental delay through lack of opportunities.
- An increase in older children who are struggling to attend education placements post pandemic – chronic pain, chronic fatigue, non-organic conditions.

7.2 Community Paediatrics

- The service has seen a significant increase in referrals for pre-school ASD post COVID-19 and a higher number of autism diagnosis.
- There has been no change in the number of children with physical disabilities and other complex needs.
- Children with complex physical disabilities are usually seen by the general paediatricians due to their ongoing medical needs.

7.3 Data

- Comparing audits completed 2017/2018 (April-March) and 2022/2023 (April-March), there has been an 18% increase in number of referrals received over a 5 year period.
- The number of accepted referrals accepted has seen a 4% increase.
- This data only compares those referred for Social Communication/Autism Assessments and does not include children who are seen in general appointments, including those with complex needs, Downs Syndrome, or Physical Disabilities.
- The comparison between these two data sets highlights a change in Social Communication referrals, in 2017/2018 32% of referrals were for social communication difficulties, this increased to 62% in 2022/2023.

8. Working Well

8.1 Therapies

- Multi-Disciplinary Team working with colleagues supports identification of SEND needs early.
- Joint Commissioning
- Well managed waiting lists in Occupational Therapies and Physiotherapy
- Service Delivery Model for Functional Skills Pathway
- Special Educational Needs and Disability Inclusion Panel (SENDIP)
- Health services are co-located within Children's Centres which aids Multi-Disciplinary Team working within health.
- Screening clinic for children at high risk of developmental concerns following neonatal stay, but further investment is required.
- Health services note Special Educational Needs at an earlier age than other services and are good at Early Notification of Special Educational Needs.

8.2 Community Paediatrics

- The service has streamlined referrals, to request that referrals are only made to the service after children have had a SALT assessment. This ensures the children receive early intervention by the SALT Team and ensures that only children with social communication difficulties, as a primary need, are referred for an assessment by the paediatrician.
- The service has developed an ASD Joint Assessment clinic for complex cases who have language difficulties and are relatively high functioning. The multiagency assessments are delivered through a core ASD assessment team that includes two disciplines. The dual assessments which include a developmental history with the parent and an ADOS /observation with the child, allows the assessments to be completed and feedback given to the family on the same day. Facilitating good

multiagency discussion and agreement on diagnostic criteria, allowing rapid diagnostic assessments within the first appointment as a One Stop Shop model.

- Less complex cases receive separate assessments by SALT and a paediatrician, followed by feedback by the paediatrician.

9.Recognised risk factors

Those with SEND are not a homogenous group and there is not a commonly defined set of risk factors. In many cases the cause is unknown or due to a combination of causes. However, there are some recognised risk factors for developing a SEND of which a number are preventable.

Though all children and young people with a disability will not have a SEN, there is an overlap between disability and SEN. Causes of disability include but are not limited to:

- Chromosomal and genetic abnormalities
- Conditions during pregnancy including smoking, poor maternal nutrition and obesity, alcohol and drug consumption, and health of the mother.
- Premature birth
- Low birth weight
- Complications during pregnancy and birth
- Childhood illness
- Childhood injury

Early childhood experiences may result in delayed development and social and communication difficulties. These children do not have a biological disability but can fall behind their peers. Risk factors include:

- Abuse, maltreatment, and neglect
- Caregiver drug and alcohol misuse
- Poor parental mental health including perinatal and post-natal mental health
- Teenage parents
- Experiences of being in care
- Homelessness

Data is collected and reported for a number of the above risk factors. However, there are gaps in current local knowledge with some of these risks factors not being reported on including maternal health, nutrition, obesity, alcohol and drug consumption; childhood illness; parental mental health (including perinatal and postnatal mental health); and homelessness. This section will look at what intelligence that is available to us to begin to understand risk factors in Cheshire West and Chester.

10.Lived Experience

A short survey was designed and promoted for parents of children aged 0-5, developed with the aim to capture lived experience. However, responses were limited the following analysis has been possible to indicate and support recommendations from the JSNA chapter for SEND Emerging Needs 0-5.

The following themes were identified from the survey:

- Peer support for parents
- Support for families with children with additional needs, specifically in identification and accessing early support
- Support for parental mental health and wellbeing
- More focus groups for parents and children, and in particular play sessions for babies
- Better signposting to available services and support accessible through Children's Centre
- More frequent reviews of a child's milestones/development
- Greater availability of activities/locations to take children

Anecdotal feedback from the Parent Carer Forum highlighted the importance of parental mental health and wellbeing, early parental engagement and the need to effectively communicate to parent's what support is available.

Following feedback from the Parent Carer Forum, a working group developed a pathway for Additional or Special Education Needs to support parents and carers who feel that their child may have SEND emerging needs, called the Cheshire West Early Year Roadmap, which can be located on the Cheshire West and Chester Council Live Well site

11.Conclusion

- 0–5-year-old children require further support in relation to communication and language and personal, social and emotional development.
- The COVID-19 pandemic has had a significant impact on service delivery and demand as well as on parental confidence to support their children with their early development.
- The increase in demand for SEND related services is not matched by resources.
- There is a need for more effective communication about what support is available across Cheshire West. Greater coordination of messaging will help ensure that parents receive the same messages from different professionals and are aware of all the support available to them.
- Access is needed to universal and targeted support that helps parents build their confidence and skills. However, there are funding challenges for SEND related services supporting children and families with the related needs identified.
- SEND data and ASQ data is not currently reported to commissioners with enough granularity, this makes it harder to assess emerging needs and target provision for 0-5 years.

12.Recommendations

- Evaluate the effectiveness of current systems to determine the best approach within all early year's services that aim to support the development of a universal, targeted and specialist level of delivery and help to promote early identification and intervention through upskilling the wider workforce and help with the increased demand on Specialist Services.

- Evaluate wider demand on SEND related services at pre-school level due to increasing referral numbers and complexity of children, to ensure that capacity within services can meet demand.

- Ensure that all agreed performance and data sets are reported monthly and consistently across all services and that each provider has the appropriate Data Systems and Business Intelligence support to facilitate this.

- Review the local area SEND data dashboard with particular emphasis on any data pertaining to early years provision. This recommendation is reflected within the Early Years chapter.

- It has been clear through the completion of this chapter of the JSNA that parents and practitioners value support to help them feel confident in supporting children's development. However, not all parents and providers are clear about the support available. This could be addressed through consideration of wider communication of evidence-based models such as 'Five to Thrive' and 'Look Say, Sing, Play.' Along with opportunities for co-production to support all services working with children and families to deliver consistent messaging.

- Communication – All services provide inclusive, clear and consistent messaging around their service offer for communication to health services, schools, settings, and families, including reviewing information available via the Local Offer (Live Well Cheshire West).

- All services to review available training offers to identify integration opportunities, gaps in provision and to consider enhancing appropriate training packages for the workforce, families, and early years settings. This will support clear and consistent messaging in relation to child development across the health and social care systems.

- Consider implementation of patient records to flag children who have additional needs or emerging needs on their system Primary Care, EMIS web. GPs do not currently have this function available, so the number of children who may have a need in Cheshire West & Chester is unknown.

- Through the current Cheshire West Joint Commissioning Framework (2023-2027) continue to identify opportunities for further joint commissioning of SEND related services.

13. Literature Reviews

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