Salford City Council

Children with Disabilities Needs Assessment
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Executive Summary

1.1 Introduction

Children with disabilities are a diverse group. Some will have highly complex needs requiring much assistance and are likely to have multi-agency support across health, social services and education – the most extreme example perhaps being those who are technology-dependent. Other children will require substantially less support, with their needs often able to be met by the family and universal services. Substantial inequalities persist between disabled children and young people and their peers. This is an issue nationally and locally reflected within this needs assessment.

1.2 Aim

This needs assessment aims to bring together the key data and definitions to help understand the demand, risk factors, provisions and outcomes for children with disabilities to inform strategic planning and how families can be helped to achieve positive outcomes for their children.

1.3 Scope

This needs assessment has identified a child or young person as aged between 0 and 24. Not all data sources reflect this age group, if this is the case it has been appropriately identified. A full literature review has not formed part of this needs assessment. Some evidence based practice has been included where appropriate. Spending practice and budgets have not been included in this document.

1.4 Defining ‘disability’

This is a complex issue. There are several definitions relating to disability all of which use different thresholds, categories and age groups. Data is collected by numerous health and social care agencies along with education and published prevalence estimates, none of which use the same definition of a disability. In addition, few children have just one disability and some children have complex needs often having a combination of physical, sensory, learning and behavioural disabilities all of which require differing services. Therefore, planning which focuses on just one disability or the ‘primary’ disability can be challenging in terms of need, cost and priorities.

Routine data collected by local authorities on special educational need (SEN) do not reflect the spectrum of disability and is a weak proxy for severity. The SEN data also records primary need and doesn’t reflect the multi or complex disabilities that a child has.

The definitions have also changed over time which gives further issues to the calculation of populations of children with disabilities. Added to this is the further complication that each service partner has their own criteria and thresholds for support.

There are eight Acts which directly influence the definition for ‘Disability’, all with differing thresholds. Each service has their own criteria within which they need to establish the need and level of a disability a child may have, plus different services have different priorities under the different legislations.

Therefore, there is no consistent definition with makes it difficult to quantify the population.
1.5 Findings

1.5.1 Prevalence of disabilities in children and young people

Census estimations - the main sources of evidence are Census (2011) or General Lifestyle Survey (2011), which become outdated quickly, even if the proportions suggested are applied to a recent population estimate. The surveys are self/parental-reported and as such there is no validity check. Notwithstanding this there are current estimations of 7559 children aged 0-19 years with a long-term illness or disability and a further 3569 children and young people where this is limiting. Children aged 0 to 4 and 5 to 9 years display a lower prevalence than children in the higher age groups. This is likely because certain longstanding illnesses or disabilities are not diagnosed until later in childhood.

Gender - boys have a higher rate of disability than girls and are more likely to experience social and behavioural, learning and memory difficulties. They are more likely to have a limiting illness or disability especially at a more severe level.

Socio-economic background - the rate of severe disability or limiting illness is greatest amongst children from ‘never worked’ and ‘long term unemployed’ family backgrounds, whilst the lowest rates were for children from ‘higher managerial’ family backgrounds. This situation compounds the already vulnerable group of children with disabilities.

BME - the ethnic diversity makeup of Salford is changing. The numbers of those with SEN and a BME background is increasing and has doubled between 2007 and 2017. The needs of those from ethnic backgrounds are often different to those from white backgrounds in terms of language, family/community relationships and religious beliefs.

Speech, Language and Communication Needs (SLCN) - it is estimated that as many as 10% of all children have SLCN, in Salford that is 7,926 children and young people aged 0-24 years, however, this is a likely underestimation given the levels of deprivation and poverty identified across Salford – a known causal factor of SLCN.

SEN prevalence - More boys than girls require SEN Support or have an Education Health Care Plan (EHC). The proportion of EHC plans for males is more than double the rate for females (4.1% Male, 1.8% female, Salford January 2017). Boys outnumber girls at SEN Support level by 1.7:1 (20.2% male, 11.8% female, Salford January 2017)

The likelihood of having SEN support in Salford females peaks around age 10 and 11 (Year groups 6 and 7). In males, age 7 to 8 years (Year group 3) is the highest. Those with a statement or EHC Plan peaks for boys in year groups 8, 10 and 11 (aged 12/13, 14/15 and 15/16 years) and girls aged 15/16 years are most likely. (Salford, January 2017)

SEN type - children in Salford primary schools with SEN is highest due to SLCN, Social Emotional and Mental Health (SEMH), and Profound and Multiple Learning Difficulties. Children with Autistic Spectrum Disorder is around half the level in England. At secondary schools those with a moderate LD, SEMH or SCLN are higher in Salford than the North West and England. Children with Autism Spectrum Disorder (ASD) as the primary need of SEN are two thirds lower in Salford than in England. Children at special schools in Salford are more likely to have a severe learning difficulty, SEMH, Moderate LD, specific LD, or SCLN when comparing to national figures. (January 2016). The figures around autism need more exploration as they are unlikely to reflect the real picture within Salford.
SEN where educated - children with SEN support are most likely to be educated in their mainstream school, the proportions of children with SEN support in Salford is higher than the national and North West averages at 15.7% in primary schools and 14.5% in secondary schools compared to the national proportions of 12.1% and 11% respectively. The proportions of children with EHC plans are higher in primary and secondary schools across Salford than in the North West and England. This could be due to the deprivation and other socio-economic issues across the city giving rise to more children requiring SEN support, or could be due to reporting issues.

SEN and deprivation - children with EHC Plans show a significantly higher proportion than the Salford average living in Weaste & Seedley and Irlam. Significantly lower proportions reside in Boothstown & Ellenbrook, Worsley and Claremont. Children with SEN support follow the pattern of deprivation across the city with areas of lower deprivation showing a lower proportion of children with SEN support. Worsley and Boothstown & Ellenbrook have proportions at less than half of the average across the city at 7.6%. The rate is significantly higher than the Salford average in Broughton, Langworthy, Little Hulton, Swinton North and Winton.

Projections - numbers of children with disabilities (aged 0-24 years) is estimated, in Salford, to be between 14,294 and 17,284 by 2026. However, estimations of projections are unlikely to be accurate as they cannot take into account external factors e.g. limited maternal education, social deprivation and poverty, low birth weight, poor maternal health or problems in childbirth.

1.5.2 Outcomes of children and young people with disabilities

Poverty – the cost of raising a disabled child is three times higher than non-disabled peers. Family income of those with a disabled child averages £15,270 which is 23.5 per cent below the UK average income of £19,968. (2016)

Looked After Children (LAC) – Nationally LAC are almost four times more likely to have SEN and around ten times more likely to have Statements of Special Educational Needs or an Education Heath and Care Plan than all pupils (2014). The issues around this are complex and in Salford services have been developed to ensure LAC with SEN are given every opportunity to achieve their potential.

Children in Need - the percentage of children in need having a disability recorded is 15.5% in Salford which is a higher proportion than in the North West (9.7%) and England (12.7%). (March 2016)

Housing - families with a disabled child are less likely to be living in a decent home compared to families with a non-disabled child. They are 50 per cent more likely than other families to live in overcrowded accommodation, to rate their home as being in a poor state of repair, and to report problems with wiring, draughts and damp in the child's bedroom. Unsuitable housing makes the task of caring harder, contributes to higher stress and frustration levels and for severely disabled children is a significant barrier to enjoying childhood experiences.

Carers - 57 children were known to the carers centre (36 female, 21 male) who were fulfilling caring duties for a disabled sibling, 10 of these children also cared for a parent. The average age of these young carers was 12 years.

LGBT - the lack of available data to estimate the prevalence of LGBT amongst disabled children is exacerbated by the lack of services and understanding available for this particularly vulnerable group.
Transition - substantial challenges at transition exist limiting opportunities for full participation in adult life. This is both in terms of the young person’s learning, social, physical and cognitive limitations combined with environmental barriers – people’s attitude, lack of opportunities and choices.

Obesity – Nationally, 40% of children aged under 8 with a limiting illness and a learning disability are overweight or obese compared to 22.4% who have neither condition (2011).

Emotional health and wellbeing - Children and adolescents with intellectual disabilities are more than six times as likely to have a diagnosable psychiatric disorder than their non-intellectually disabled peers.

Bullying - nationally 96% of parent carers said that their disabled child has been bullied at school with the most common forms being verbal (36 per cent) followed by emotional (30 per cent) and physical (28 per cent).

Key Stage 2 - 25% of pupils with SEN Support reached the expected standard in all of reading, writing and mathematics, compared with 67% of pupils with no identified SEN, resulting in an attainment gap of 42 percentage points. (2015/16)

Key stage 4 - the gap between attainment of SEN Support and no SEN is 36.5 percentage points between Salford peers. The gap between no SEN and SEN (Statement) is even higher at 52.6 percentage points. (2014/15)

Persistent Absentee - in Salford, those who are SEN Support are twice as likely to be a persistent absentee than those with No SEN. When comparing to those with a statement/EHC Plan the figure is more than three and a half times higher. (2013/14)

Exclusions - the proportion of fixed period exclusions as a percentage of the school population were nine times higher for children with a statement and more than five times higher for those with SEN but no statement than those children with no identified SEN. (Salford, 2013/14)

NEET - in December 2016, Salford had the highest proportion of young people aged 16/17 years in NEET across Greater Manchester at 19.8%, this is three times higher than when compared to 6.5% in England and 8% in the Northwest. This reflects the situation in the total 16/17 year old cohort where the NEET figure is more than double that of England at 5.7%.
1.6 Service provision

1.6.1 Services provided

Special school places - 552 children attended one of the special schools located within Salford in 2016/17. There are a further 208 places available at mainstream schools offering an enhanced provision.

Sensory Impairment Team – in 2016/17 the sensory impairment team worked with 199 visually impaired children and young people and 313 hearing impaired, of these 12 have multi-sensory impairments.

Starting Life Well - in June 2017 the Starting Life Well team (portage team) had 151 open involvements with children aged under 5 years. Of these more than two thirds were male and of the cases where ethnicity had been obtained almost 30% were from a BME background (15% had no ethnicity record). A fifth of the cases were resident in each of the neighbourhoods of Eccles and Little Hulton & Walkden, and just over 3% of open cases were resident in Worsley neighbourhood.

Short breaks - the male:female ratio of attendees for short break care follows national and local prevalence of more boys presenting with disabilities than females. Although the numbers are small, there is a disproportionately high number of young people attending short break sessions from BME backgrounds, particularly of ‘Black’ origin. Jewish, although not a BME classification shows a higher proportion of attendees at short break care but this will be due to specific services being commissioned for this group.

A higher proportion of individuals attend SBC from Winton and Broughton, this follows the same pattern for DLA claimants and students with SEN support. Broughton and Winton is significantly higher for SEN support than the Salford average and parts of Broughton show a significantly higher rate of DLA claimants than the Salford average in August 2016.

CAMHS - the majority of children attending the CAMHS LD service were aged under 16 years, were male and of a ‘white’ ethnicity. Across both the CAMHS LD service and the overall service around 40% were attending because of ASD.

Social care team - as at January 2017 there were 222 children on the caseload of the CWD social care team. 70% of these were aged 6-16 years, 26.6% aged 0-5 years and just over 3% aged 17-25 years. The data available split the children into localities within Salford, there was an even split between south and central localities of 32% and 35% respectively, with the remaining proportions of 22% in West locality and 11% in the North.

Transport - in January 2017, 760 children received transport to and from school. The majority of these were to a school (special or mainstream) within Salford but 135 children (18%) were transported to specialist schooling outside of Salford. There is a spread of children who have transport provided by Salford city council across the city. There are higher densities of those requiring transport from the more deprived areas, however, this does not account for siblings within the same family both requiring transport.

1.6.2 Service issues

To assess whether the service provision is adequate across Salford and whether there are any gaps in provision is difficult as there is no definitive population. A full and audited register would be required for an accurate measure of both the population at local level and to track any gaps in services.
Service thresholds are different and therefore individuals may qualify for certain services and not for others e.g. they may be included in the SEN prevalence figures but do not qualify for short break care.

Individual need varies so widely that an individual may require many services or only one or two. Therefore whether individuals access services is not necessarily the best way to evaluate any gaps as the needs of CWD is very varied, and covers many aspects of disabilities and LD with service provision quite different for each. To formulate a gap analysis taking into account such variations is difficult and possibly not accurate for the services as a whole.

The data provided from services shows that the attendees are not particularly biased towards any BME background, gender or location and generally follows the patterns of prevalence discussed in section 5. However, data quality needs to be improved and audited on a regular basis to fully understand the demographics of all children with disabilities.

Short breaks – Salford provides a range of short break care for all ages but is working to develop more provision for under eights. There is a need to travel to access provision, which can be a barrier to its take up. During 2017 a small grants scheme has increased the amount of provision in different parts of the city to address this.

Overnight residential short breaks for children aged over 14 years are via a contract with Granville (ASPIRE). However, the service has been under used for the duration of the contract, indicating that there was an over estimation of the projected take up/ number of nights of provision required.

Leisure - Some parents have suggested the cost of activities as well as distance can prohibit their use and parents cannot commit to attending on a regular basis due to the child’s health.

Transition – Although a significant amount of work has been done in relation to transition there is still a small cohort of young people being referred late to transition. These Young People often have not been known to Children’s Services. This affects their health and wellbeing as well as adversely impacting on cost. Cases supported by transition are complex with almost half previously being a looked after child.
1.7 Recommendations

The recommendations should be used to inform the development of Salford’s Children with Disabilities Transformation Project.

1) Greater emphasis on preparing young people for adulthood including,
   a. managing transition,
   b. improved and greater availability of travel training
   c. earlier targeted work on preparing for independence.
2) When designing, commissioning and delivering services for SEND there is a need to;
   a. ensure they meet the needs of all children and young people irrespective of cultural or ethnic background
   b. ensure that the higher proportion of males to females is considered
   c. ensure demographics of the population are considered
3) Looked After Children with SEN need to access appropriate services.
   a. Strong working relationship between the Virtual school and the SEN team.
4) Ensure the plans for future housing and accommodation meet the needs of families with a child or young person with SEND and those young people moving into adulthood who want to live independently.
5) Ensure the voice of the child and parents and carers are central to everything we do.
6) Ensure all systems and processes for assessing and meeting need are as fit for purpose for Children and Young People with a late diagnosis as those diagnosed in infancy.
7) The significant numbers of children and young people with a speech, language or communication need necessitate a requirement for all staff to have a good understanding of how to meet their needs.
8) Further investigation is required into attendance rates and exclusions to ensure adequate interventions are in place.
9) Ensure the anti-bullying strategy specifically addresses the high incidence for children and young people with a disability.
10) Ensure parents are supported in navigating and understanding the systems and pathways to accessing services.
11) Design systems and pathways that simplify assessment and access to services and ensure parents only need to tell their story once.
12) Develop an agreed definition of disability across all services, including health, social care and education.
13) Further investigation into the primary coding of autism in SEN published reports to establish the reasoning behind the low reported figures.
14) Future needs assessments to include information on children and young people with a disability.
15) Effectiveness of services and delivery to be monitored rigorously through agreed performance indicators.
Children and young people with disabilities

- Approximately **7.5%** of the population are disabled.
- More disabled children from families who have never worked or long-term unemployed.
- More boys than girls are disabled. Boys are 2.5 times more likely to have an EHC plan than girls.

**Education**

- Only 16% of SEN Support reached expected standard at KS2.
- Fixed period exclusions are 9 times higher for EHC and 5 times higher for SEN.
- 30% of disabled young people do not have a qualification higher than Level 2.

**The cost of bringing up a disabled child is **x3** higher than that of a non-disabled child.**

**The UK average income is £19,968.**

**The income of families with disabled children averages £15,270.**

**One in five families with a disabled child have said isolation has led to the breakdown of family life.**

**Children with disabilities are **x6** more likely to have a psychiatric disorder.**

**NEET**

- Disabled young people are **twice as likely to be NEET.** 28% compared to 13%.

**Two thirds of looked after children have SEN.**
2 Introduction, aim and objectives

2.1 Introduction

Children with disabilities are a diverse group. Some will have highly complex needs requiring much assistance and are likely to have multi-agency support across health, social services and education – the most extreme example perhaps being those who are technology-dependent. Other children will require substantially less support, with their needs often able to be met by the family and universal services.

2.2 Aim

This needs assessment aims to bring together the key data and definitions to help understand the demand, risk factors, provisions and outcomes for children with disabilities to inform strategic planning and how families can be helped to achieve positive outcomes for their children.

2.3 Objectives

The objectives of this needs assessment are to:
- Describe the children with disabilities population in Salford by looking at national prevalence and trends, quantified against local data in order to understand the Salford population
- Describe the outcomes for children with disabilities
- Describe current provision of services for children with disabilities,
- Assess current and future demand, identify gaps and inform and shape services
- Provide recommendations to address gaps in services and current unmet needs

2.4 Scope

This needs assessment has identified a child or young person as aged between 0 and 24. Not all data sources reflect this age group, if this is the case it has been appropriately identified.

A full literature review has not formed part of this needs assessment. Some evidence based practice has been included where appropriate.

Spending practice and budgets have not been included in this document.

2.5 Limitations

There are different types of Special Educational needs, long term conditions, sensory, learning and physical disabilities of which there are too many to focus on in detail. Further areas of research surrounding the needs of individual types of disabilities, the outcomes and life chances of such children could establish a needs assessment in itself. This document aims to provide an overview of the main types of disabilities.
2.6 Definitions

This is a complex issue. There are several definitions relating to disability all of which use different thresholds, categories and age groups. Data is collected by numerous health and social care agencies along with education and published prevalence estimates, none of which use the same definition of a disability. Without a standardised reporting system or a comprehensive national register of disabled children it is difficult to accurately measure the local picture. The local register is voluntary for parents to have information collected and stored and is not being promoted, so it is not a useful indicator of need.

In addition, few children have just one disability and some children have complex needs often having a combination of physical, sensory, learning and behavioural disabilities all of which require differing services. Therefore, planning which focuses on just one disability or the ‘primary’ disability can be challenging in terms of need, cost and priorities.

Routine data collected by local authorities on special educational need do not reflect the spectrum of disability and is a weak proxy for severity. The SEN data also records primary need and doesn’t reflect the multi or complex disabilities that a child has.

The age groups of data collected differs by agency, some classify a ‘young person’ as up to age 16, others to age 19 and others to age 25. Care records can hold in depth information about individuals but are often not linked to other services and it is difficult to extrapolate and translate individual experiences into population needs required for effective commissioning.

The definitions have also changed over time which gives further issues to the calculation of populations of children with disabilities. Added to this is the further complication that each service partner has their own criteria and thresholds for support.

Summary boxes
Throughout this needs assessment, there are summary boxes at the end of each section. These present the most important findings within the section and indicate where evidence is the strongest.
3 Salford demographics and context

3.1 Salford demographics

Salford is centrally located within the Greater Manchester conurbation. It is bounded on the south east by the River Irwell, which forms its boundary with the city of Manchester and by the Manchester Ship Canal to the south, which forms its boundary with Trafford. The metropolitan boroughs of Wigan, Bolton and Bury lie to the west, northwest and north respectively, with Warrington bordering to the southwest.

3.1.1 Population density

The city covers 37.5 square miles combining a mix of urban and rural landscapes. Some parts of the city are highly industrialised and densely populated, but around one third of the city consists of rural open space. Figure 1 shows there are six areas within Salford with a population density higher than 105 persons per hectare.

Figure 1: Urban population density per hectare, Salford, 2015

3.1.1 Deprivation

Salford is 22nd most deprived of the 326 local authority districts in England, as according to the English indices of Deprivation 2015. There is an uneven spread of deprivation across the city with more than 29% of LSOAs falling within the most 10% deprived nationally and only 4% falling within the least deprived 10%. Further to this, of the 150 LSOAs in Salford, 7 are ranked in the worst 1% of deprived LSOAs across England.

Figure 2 shows that the areas with the highest deprivation are in East Salford close to Manchester city centre, with a smaller, less severely deprived cluster in West Salford, in the ward of Little Hulton.
3.1.3 Age/gender structure

In 2015 the population in Salford was **245,614**.

Salford has a younger population compared to England: 17.4% of the total population in Salford were between the ages of 25 and 35, but in England the same age group made up only 13.7% of the total population. There is also a lower proportion of over 75 year olds within Salford compared to England (6.6% of total population compared to 8.1%).

Figure 3 below shows the spread of age ranges across Salford in 5 year bands for males and females in 2005, 2015 and projected to 2035.
ONS 2014 based population projections show Salford’s total population is forecast to increase to 269,465 in 2025 and then further increase to 288,978 in 2035. This is an increase of 17.7% over the period 2015 to 2035. Within these figures, all the age groups are expected to increase with the 75 years and over predicted to rise the fastest. The younger population aged 0-24 years is expected to rise in Salford by 14.4% from 78,890 in 2015 to 90,270 in 2035.

3.1.4 Ethnicity
Salford is less ethnically diverse than the national population as, according to the 2011 census, Salford has a population made up of 84.4% White British compared with both the England and Greater Manchester averages of 79.8%. The diversity of the population is changing and the number of people identifying themselves as from a Black or Minority Ethnic Group (BME) has almost trebled from 2001 to 2011, at 33,606. Based on projected population trends, by 2051 in Salford it is estimated that the BME population will have increased to approximately 90,000 people (31.7% of the total population).

3.1.5 Health
Salford has some of the worst health and wellbeing outcomes in the country and is worse than the national average. Life expectancy is increasing, but for women is 2.3 years less than the England average, for men 2.8 years less. The life expectancy gap within the city is increasing.

Smoking rates across the city are almost a third higher than England and mothers smoking at time of delivery at a rate that is significantly higher than England.

Hospital admissions due to alcohol are amongst the highest in the country and the major causes of ill health include CHD/CVD/cancers and respiratory conditions. Death rates are reducing but not fast enough to narrow the gap with the England average.
3.1.6 Poverty and worklessness

Almost 27% of young people under 16 in the city (12,730 children) live in poverty. Salford has the second highest proportion of primary school children eligible for free school meals in GM, at 21.4%, one and a half times the England average. Nearly a fifth of all households are workless and almost 15% of the working age population claim out of work benefits.

3.2 Context – all ages with a disability

People of working age (16 – 64 years) with a health condition or disability that limits their day-to-day activities: 48,417 (20.70% population). This is a decrease of 895 (-1.8%) from 2001 but remains 2.7% higher than for England. Of these, 11% of Salford’s population felt that their day-to-day activities were affected or limited ‘a lot’ by their long term health problems or disability. Another 9.7% said they were limited ‘a little’.

The number of households with one person with a limiting long term illness or disability fell by 8,500 to 30,100 between 2001 and 2011 (drop of 22%). However 5,300 of these households contained at least one dependent child. Around half of successful incapacity benefit claims are given on the basis of mental health and behavioural conditions.

Disabled people are less likely to be in employment. In January 2016, the UK employment rate among working age disabled people was 46.5%, compared to 84% of non-disabled people. Disabled adults are nearly three times as likely as non-disabled adults to have no formal qualifications, 30% and 11% respectively. Disabled people face a disproportionate likelihood of living in a deprived area, and are more likely than non-disabled people to live in poor housing.

Disabled people are more likely to be in receipt of state benefits. 84% of families with at least 1 disabled adult are in receipt of benefits, compared to 48% of families with non-disabled adults. Disabled people are twice as likely as non-disabled people to be social housing tenants. There is a shortage of housing that is specifically designed to meet disabled people’s needs.

Disabled people travel 33% less often than the general public. 60% of disabled people do not have a car available to their households, compared to 27% of the overall population. Disabled people are significantly more likely to be victims of crime than non-disabled people. This gap is largest amongst 16-34 year-olds, where 39% of disabled people reported being victims of crime, compared to 28% of non-disabled people.

Only 17% of disabled people were born with their disabilities. The majority of disabled people acquire their disability later in life. In 2012/13, the most common impairments that disabled people had were: mobility (57%), stamina/breathing/fatigue (38%), dexterity (28%) and mental health (16%).
The older people get, the greater their risk of sight loss. 1 in 9 people in the UK aged 60 and over are living with sight loss. Of those people registered as blind with an additional disability, 60% recorded a physical disability, 26% have a hearing impairment, 9% have a learning disability, and 5% live with mental ill health. It is estimated that there are more than 10 million people in the UK with some form of hearing loss, or 1 in 6 of the population. Hearing loss increases with age, 71.1% of over 70s and 41.7% of over 50s have some form of hearing loss.

Less than 33% of people with a learning disability have some choice of who they live with, and less than half have some choice over where they live. People with a learning disability are 58 times more likely to die aged under 50 than other people and four times as many people with a learning disability die of preventable causes compared to people in the general population. Over one in four disabled people say that they frequently do not have choice and control over their daily lives. 75% of GPs have received no training to help them treat people with a learning disability.

**Summary**

This information indicates we need to do more with young disabled people to prepare them for adulthood. If not they will leave school with few qualifications and their chance of employment will be low. They will have less choice about who they live with, less control over their lives and are likely to live in the more deprived areas of the city in poor quality housing and be susceptible to crime.
4 Statutory Acts

Each Act and the thresholds in terms of disability are broadly defined below.

Statutory Acts

Disability Discrimination Act (2005)
Equality Act (2010)
Education Act (1996)
Children Act (1989)
Children Act (2004)
Children and Families Act (2014)
The Care Act (2014)
Learning and skills Act (2000)

4.1 Disability Discrimination Act (2005)

The Disability Discrimination Act (DDA) 2005 definition of disability

*A child or young person is disabled if they have a physical or mental impairment which has substantial and long term adverse effect on his/her ability to carry out normal day to day activities. The condition must have lasted or be likely to last at least 12 months in order to be classed as a disability.*

The DDA definition reflects accurately that disability is a broad category and is not limited to what have traditionally been regarded as ‘disabled children’, i.e. those with physical and/or cognitive limitations of a developmental nature. The important point about this definition is that it makes no reference to the origin of these difficulties, nor any attempt to exclude particular classes of condition. For example, children with Asperger’s syndrome, anorexia nervosa, or cystic fibrosis are all disabled (although may not define themselves as such), and have a right to protection under the Act.

4.2 Equality Act (2010)

The definition of ‘disability’ under the Equality Act 2010

In the Act, a person has a disability if:

- they have a physical or mental impairment
- the impairment has a substantial and long-term adverse effect on their ability to perform normal day-to-day activities

For the purposes of the Act, these words have the following meanings:

- 'substantial' means more than minor or trivial
- 'long-term' means that the effect of the impairment has lasted or is likely to last for at least twelve months (there are special rules covering recurring or fluctuating conditions)
- 'normal day-to-day activities' include everyday things like eating, washing, walking and going shopping

People who have had a disability in the past that meets this definition are also protected by the Act. People can also choose not to declare their disability and it is self-declared, therefore giving rise to under representation if choosing not to declare but also over reporting in certain instances. Neither of which can be captured accurately.
Progressive conditions considered to be a disability
There are additional provisions relating to people with progressive conditions. People with HIV, cancer or multiple sclerosis are protected by the Act from the point of diagnosis. People with some visual impairments are automatically deemed to be disabled.

Conditions that are specifically excluded
Some conditions are specifically excluded from being covered by the disability definition, such as a tendency to set fires or addictions to non-prescribed substances. Disability has a broad meaning. It is defined as a physical or mental impairment that has a substantial and long-term adverse effect on the ability to carry out normal day-to-day activities. ‘Substantial’ means more than minor or trivial. ‘Impairment’ covers, for example, long-term medical conditions such as asthma and diabetes, and fluctuating or progressive conditions such as rheumatoid arthritis or motor neurone disease. A mental impairment includes mental health conditions (such as bipolar disorder or depression), learning difficulties (such as dyslexia) and learning disabilities (such as autism and Down’s syndrome). Some people, including those with cancer, multiple sclerosis and HIV/AIDS, are automatically protected as disabled people by the Act. People with severe disfigurement will be protected as disabled without needing to show that it has a substantial adverse effect on day-to-day activities.

To qualify for protection from discrimination, a disabled person no longer has to show that their impairment affects a particular ‘capacity’, such as mobility or speech, hearing or eyesight.

### 4.3 Education Act (1996)

The 1996 Education Act defines a child as having Special Educational Needs (SEN) “if they have a learning difficulty which calls for special educational provision to be made for them”. Children have a learning difficulty if they:

a. have a significantly greater difficulty in learning than the majority of children of the same age; OR
b. have a disability which prevents or hinders them from making use of educational facilities of a kind generally provided for children of the same age in schools within the area of the local authority; OR
c. are under compulsory school age and fall within the definition at a. or b. above or would do so if special educational provision was not made for them.

(Sec. 312 Education Act 1996) Special Educational Provision means: “…educational provision which is additional to, or otherwise different from, the educational provision made generally for children of their age in schools maintained by the Local Authority…”

How is “disability” different from Special Educational Needs?
Various Education Acts and the SEN Code of Practice provide what we refer to as the SEN framework. The SEN framework is there to identify and meet any needs the child may have that affects their ability to access learning and that require additional and different provision from what is normally available to all children. However, the duties under the Equality Act (EA) are there to ensure that disabled pupils are not discriminated against. They seek to promote equality of opportunity between disabled and non-disabled pupils.

A disability might give rise to a learning difficulty that calls for special educational provision to be made for a child. Many children who have SEN will also be defined as being disabled under the EA. However, not all children who are defined as disabled under the EA will have SEN. For example,
pupils with severe asthma, arthritis or diabetes may not have SEN but will have rights under the EA. Similarly not all children with SEN will be defined as having a disability under the EA.

### 4.4 Children Act (1989)

Defines a child as a child in need if he or she is disabled and for the purpose of the part a child is disabled if he is blind, deaf or dumb or suffers from mental disorder of any kind or is substantially and permanently handicapped by illness, injury or congenital deformity or such other disability as may be prescribed; and in this Part—“development” means physical, intellectual, emotional, social or behavioural development; and “health” means physical or mental health.

As a “Child in Need” The council has a duty to provide the following services under the Children Act 1989.

- short break services
- holiday play schemes
- care at home
- some aids and adaptations
- financial help, e.g. money towards travel costs for hospital visits

### 4.5 Children Act (2004)

The Children Act 2004 provides the legal basis for how social services and other agencies deal with issues relating to children. It strengthens the 1989 Act and encourages partnerships between agencies and creates more accountability.

These guidelines have been laid down so that all individuals who are involved in looking after children, be it in the home, the work place, school or other locality are aware of how children should be looked after in the eyes of the law.

**Principles of the Act**

The Children Act 2004 was designed with guiding principles in mind for the care and support of children. These are:

- To allow children to be healthy
- Allowing children to remain safe in their environments
- Helping children to enjoy life
- Assist children in their quest to succeed
- Help make a contribution – a positive contribution – to the lives of children
- Help achieve economic stability for our children’s futures

This act was brought into being in order for the government in conjunction with social and health service bodies to help work towards these common goals.

The Children Act 2004 provides the legal underpinning to 'Every Child Matters: Change for Children' (2004). In response to the Children Act 2004 there have been some structural changes. From April 2006, education and social care services for children in each local authority have been brought together under a Director of Children's Services.
Key Areas of the Act
Several key areas of the Children Act 2004 are the levels of Inter-Agency co-operation when it comes to matters relating to the wellbeing of children. This particular element of the Children Act ensures that any agency that is aware of the maltreatment of a child – or the misconduct of a child’s legal guardian – should make their findings known to other agencies that might have a hand in the protection of a child who would normally go unmonitored.

The Children Act 2004 also deals with Children’s Trusts; bodies that have been set up independently of Health and Social Services and other government agencies as a means of introducing co-operation not only between these agencies but between teachers parents, guardians and children alike who would normally choose not to accept intervention from outside sources.

In addition to this the Children Act 2004 also made provision for a Children’s Fund; this fund is designed to aid in the eradication of poverty and financial hardship felt by underprivileged children or children who’s family's financial circumstances leave them disadvantaged.

4.6 Children and Families Act (2014)

Part 3 of the Children and Families Act 2014 is entitled ‘Children and Young People in England with Special Educational Needs and Disabilities’. Part 3 places duties on local authorities and other services in relation to both disabled children and young people and those with SEN, although not all the sections of the Act apply to both groups:

- The strategic planning duties generally apply to all disabled children and young people and those with SEN;
- The individual duties generally apply only to children and young people with SEN. (Individual duties to disabled people are contained in the Equality Act 2010)

A child or young person has special educational needs if they have a learning difficulty or disability which calls for special educational provision to be made for them (Section 20). Special educational provision is provision that is additional to or different from that which would normally be provided for children or young people of the same age in a mainstream education setting (Section 21). This definition of SEN is the same as the definition of SEN in the Education Act 1996.

References to disabled children and young people in the Act cover any child or young person who is disabled under the Equality Act 2010. Under the Act, a ‘child’ is a person under compulsory school age. A ‘young person’ is a person over compulsory school age but under 25. A person is no longer of compulsory school age after the last day of summer term during the year in which they become 16 (Section 83(2)). This distinction is important because once a child becomes a young person they are entitled to take decisions in relation to the Act on their own behalf, rather than having their parents take the decisions for them. This is subject to a young person ‘having capacity’ to take a decision under the Mental Capacity Act 2005.

4.7 Carers Act (2014)

A carer is someone who helps another person, usually a relative or friend, in their day-to-day life. This is not the same as someone who provides care professionally or through a voluntary organisation.

The Carers Act 2014 sets out carers’ legal rights to assessment and support. It came into force in April 2015. It relates mostly to adult carers – people aged 18 and over who are caring for another
adult. This is because young carers (aged under 18) and adults who care for disabled children can be assessed and supported under children’s law.

The Act also contains new rules about working with young carers or adult carers of disabled children to plan an effective and timely move to adult care and support. The Carers Act gives local authorities a responsibility to assess a carer’s need for support, where the carer appears to have such needs. This replaced the law which said the carer must be providing "a substantial amount of care on a regular basis" to qualify for an assessment. This means more carers are now able to have an assessment. The local authority will assess whether the carer has needs and what those needs may be. This assessment will consider the impact of caring on the carer.

It will also consider the things a carer wants to achieve in their own day-to-day life. It must also consider other important issues, such as whether the carer is able or willing to carry on caring, whether they work or want to work, and whether they want to study or do more socially. If both the carer and the person they care for agree, a combined assessment of both their needs can be undertaken.

**Adults caring for disabled children**

An adult caring for a disabled child can get support through children's services. This is usually the best way to meet their needs, as they are not covered by this Act. However, there is provision in the Act for an adult carer of a disabled child to ask for an assessment of their caring needs before the child reaches 18.

When a local authority carries out such an assessment, it has the power to provide support to the carer, even though they are caring for a child, rather than an adult. This would, for example, enable a local authority to provide the support available through an adult carers' centre.

**Young carers: transitioning to adult services**

The Act says adult social services need to be involved in planning the support a young carer may need once they reach 18. This also applies to adult carers of children where it appears likely that the adult carer will have needs for support after the child turns 18.

**Summary**

All the Acts suggested directly influence the definition for 'Disability' with differing thresholds. Each service has their own criteria within which they need to establish the need and level of a disability a child may have, plus different services have different priorities under the different legislations.
5 Prevalence of disability in children

5.1 Prevalence summary

There have been many attempts to provide accurate estimates of disability in children and young people. Some of these have provided condition-based estimates based on the literature, others have utilised specific survey data and some are based on local knowledge with known issues around the stigma and different criteria used to collect the information.

There is no definitive national or local data on the proportion of the child population which is defined as disabled using a commonly understood definition that fits all services. All estimated prevalence figures based on literature research are likely to be an underestimation for Salford due to the socio-economic makeup of the population and higher than average levels of deprivation across the city.

Such a variance in number and estimated prevalence is influenced by the take up of services (e.g. children with an EHC plan) but these children may just have an educational need. Whereas others (e.g. those with epilepsy) have a health need but with appropriate medical intervention do not require any other services, these children and young people are not a focus of this report. Some children, however, will hit all thresholds in all services and require a wide-ranging holistic package which cannot easily be defined as it is based on individual needs and circumstances.

There are differing thresholds within the definition of disability. Figure 4 shows the numbers of children and young people up to age 25 who hit different thresholds according to the educational and health definitions within Salford. Some figures are proxy measures based on the school population proportions which have been applied to the Salford population aged 0-24 years.

Figure 4: Children and young people up to age 25, Salford, 2016
5.2 Prevalence - Literature based estimates

There is no reliable single source providing actual numbers of children with disabilities in local areas. The following estimates use national prevalence figures and apply them to the Salford population, this provides a very rough approximation of the likely number of children with disabilities in each area and these figures should only be considered as an indication of the scale of the issue.

5.2.1 Office for National Statistics

The Office for National Statistics define disabilities as 

"disabled people are identified as those who report any physical or mental health condition(s) or illness(es) that last or are expected to last 12 months or more and which limit their ability to carry out day-to-day activities"

A person is considered to have a disability if they have a long-standing illness, disability or impairment which causes substantial difficulty with day-to-day activities. Some people are classified as disabled and having rights under the Equality Act 2010 but are not captured by this definition. That is people with a long-standing illness or disability which is not currently affecting their day-to-day activities.

The General Lifestyle Survey, formerly known as the General Household Survey (GHS), ran from 1971-2012. It was a multi-purpose continuous survey conducted by the Office for National Statistics that collected information on a range of topics from people living in private households in Great Britain. Those responding to the questionnaire gave resulting information around their ethnicity and any longstanding (and limiting) illness or disabilities. This survey is the basis for the numbers estimated in 5.2.1.1 (Long standing illness or disability), 5.2.1.2 (Limiting longstanding illness or disability), 5.3.1 (gender) and 5.3.2 (socio-economic breakdown).

5.2.1.1 Longstanding illness or disability

In 2011, the General Lifestyle Survey estimated the prevalence of long-standing illness or mild disability by age band for males and females. Figure 5 shows the totals of 4,401 boys and 3,130 girls in the Salford population aged 0-19. The proportions are different between genders and all person age groups, hence the differences in the totals. Children aged 0 to 4 and 5 to 9 years display a lower prevalence than children in the higher age groups. This is likely because certain longstanding illnesses or disabilities are not diagnosed until later in childhood.

These figures are self-reported or parental reported and as such there is no validity check. The impact of these children will probably hit upon SEN support services and could be managed within a mainstream school, with extra support.
**5.2.1.2 Limiting longstanding illness or disability**

Those reporting a limiting long standing illness were between 3% and 12% of the childhood population, figure 6 displays the break down by gender and age band with totals of those aged 0-19 years of 2,199 boys and 1,546 girls. The proportions are different between genders and all person age groups, hence the differences in the totals. Again, children aged 0 to 4 and 5 to 9 years display a lower prevalence than children in the higher age groups. This is likely because certain longstanding illnesses or disabilities are not diagnosed until later in childhood.
5.2.1.3 Children and Young People’s Wellbeing measures

The Children’s and Young People’s Well-being measures estimate the numbers of children and young people with a long-term limiting illness and disability as 2,725 aged 0-14. Under this definition a person is considered to have a disability if they have a long-standing illness, disability or impairment which causes substantial difficulty with day-to-day activities. Some people classified as disabled and having rights under the Equality Act 2010 are not captured by this definition, that is people with a long-standing illness or disability which is not currently affecting their day-to-day activities. Figure 7 shows the differences in age band and gender for this measure.
Figure 7: Age specific estimates of long-term limiting illness or disability, Salford

Age-specific estimates of long-term limiting illness or disability, Salford,
Children’s Wellbeing Measures (2013/14) applied to mid 2015 population

Source: Family Resources Survey, Department for Work and Pensions. As quoted in ‘Children’s Wellbeing measures, October 2015 release, ONS.

Those aged 16-24, in May to July 2015, who reported a long term illness or disability is estimated to be 11.2% of the population, this is an increase from 9% in May to July 2013. When applied to the Salford population this equates to 3,444 young people aged 16-24. Under this definition those aged 16 to 24 who have either work-limiting disabilities only, disabilities that limit their day-to-day activities in accordance with the core definition in the 2010 Equality Act only, or both. This will exclude anyone with a progressive condition that does not affect their day-to-day activities, recognised as non-core as defined by the 2010 Equality Act.

Summary

The main sources of evidence are Census (2011) or General Lifestyle Survey (2011), which become outdated quickly, even if the proportions suggested are applied to a recent population estimate. The surveys are self/parental-reported and as such there is no validity check.

Notwithstanding the above there are current estimations of 7559 children aged 0-19 years with a long-term illness or disability and a further 3569 children and young people where this is limiting. Children aged 0 to 4 and 5 to 9 years display a lower prevalence than children in the higher age groups. This is likely because certain longstanding illnesses or disabilities are not diagnosed until later in childhood.
5.3 Prevalence estimates - population demographics

5.3.1 Gender

Among disabled children, boys have a higher rate of disability than girls and are more likely to experience social and behavioural, learning and memory difficulties\textsuperscript{34}. Estimates taken from the General Lifestyle Survey (2011) suggest that more boys than girls are likely to have a limiting illness or disability especially at a more severe level\textsuperscript{35}. When equating these figures to the Salford population to age 19, Figure 8 shows that there are 4,401 boys and 3,130 girls with a longstanding illness or disability and a further 2,199 boys and 1,546 girls with a severe or limiting illness.

Figure 8: Age specific estimates with longstanding and limiting illness by gender and age group, Salford

5.3.2 Socio-economic background

National research suggests that the prevalence rates of children and adolescents with mild disabilities were found to be higher for those from semi-routine, never worked and long term unemployed family backgrounds. The prevalence of children with mild disabilities from professional family backgrounds is lower in comparison to the other socio-economic groups. Salford has proportionately more families from unskilled manual occupation types, therefore the prevalence in these occupation groups in Salford is likely to be an underestimate\textsuperscript{36}.

The rate of severe disability or limiting illness was found to be greatest amongst children from never worked and long term unemployed family backgrounds, whilst the lowest rates were for children from higher managerial family backgrounds. When applied to the Salford population proportionately more families than England are long term unemployed, therefore the estimates
quoted in Figure 9 are likely to be too low when considering the deprivation and socio-economic make up of Salford.\textsuperscript{17}

Figure 9: Children with long standing illness and limiting illness and socio-economic background, General Lifestyle Survey 2011

5.3.3 Ethnicity
The school census collates information every year about the population of school children within each local authority aged 4 – 16 years. Figure 10 shows children identified with a SEN need by the proportion of their ethnicity in 2007 and 2017. Table 1 shows the numbers in each ethnic background in 2007 and 2017. The population of children with SEN from a BME background is increasing within Salford, particularly those from Mixed, Asian and Black or Black British where the proportion has more than doubled over the decade. This corresponds with increases in the school age BME population between 2007 and 2017.
The needs of those from ethnic backgrounds may be different to those from white backgrounds in terms of language, integration, religious beliefs, family and community relationships.

### 5.3.4 By Lesbian, Gay, Bi-sexual and Transgender (LGBT)

There is no evidence at national or local level around the prevalence of sexual orientation in children with disabilities.
5.3.5 Religion

The most up to date and accurate reflection of the faith and religion across Salford is the census 2011. It collected information on households with ‘Day-to-day activities limited a lot’ and ‘Day-to-day activities limited a little’ by age group and religion across the UK\textsuperscript{38}. Within Salford, the majority of those aged 0-15 with a long term health problem or disability whose day-to-day activities are limited a lot were from a ‘Christian’ or ‘No religion’ background. The same two top categories were ‘Christian’ or ‘No religion’ for day-to-day activities limited a little. Those with a Jewish religion made up 5.3% of the day-to-day limited a lot category followed by Muslim at 3.2%.

Summary

Boys have a higher rate of disability than girls and are more likely to experience social and behavioural, learning and memory difficulties. They are more likely to have a limiting illness or disability especially at a more severe level.

The rate of severe disability or limiting illness is greatest amongst children from ‘never worked’ and ‘long term unemployed’ family backgrounds, whilst the lowest rates were for children from ‘higher managerial’ family backgrounds. This situation compounds the already vulnerable group of children with disabilities.

The ethnic diversity makeup of Salford is changing. The numbers of those with SEN and a BME background is increasing and has doubled between 2007 and 2017. The needs of those from ethnic backgrounds are often different to those from white backgrounds in terms of language, family/community relationships and religious beliefs.
5.4 Prevalence – literature based estimates by type of disability

5.4.1 Visual Impairment

5.4.1.1 Definition – Visual impairment
Most of the available data about visual loss in children comes from registers or from surveys of providers of health care, social care or educational services to children with visual loss. Thus the available estimates rely on children with visual loss being known to the relevant services. This may be a reasonable assumption for children, because substantial visual loss is very likely to be detected, particularly at school.
Around half the children receiving support from visual impairment services may have additional disabilities, and this proportion may be even higher for children with severe visual loss.

5.4.1.2 Estimates of prevalence – Visual Impairment
Variation in definitions and service provision means that great caution is required in interpretation of any single estimate of the prevalence of visual impairment or blindness among children in the UK. However, using a broad and pragmatic definition of visual loss of sufficient severity as to mean a child is identified as being in need of special educational or social services, the existing data suggest a prevalence of visual impairment in the region of 10-20 per 10,000 children. In Salford this could be a range of 60 and 120 aged 0-19 years.

National active surveillance schemes were used to identify children newly diagnosed with severe visual impairment or blindness during 2000. The annual incidence was highest in the first year of life, being 4.0 per 10,000, with a cumulative incidence by 16 years of age of 5.9 per 10,000. The study was restricted to those children with a severe visual impairment or blindness. Applying the national estimates to the local Salford population would suggest 2 children per year from age 0 years with severe visual impairment or blindness giving a total by age 16 of 29.

A recent report by See Ability found that children with learning disabilities were 28 times more likely to have a serious sight problem than other children. Although the aim of that report was to outline the challenges of meeting the eye care needs of children with learning disabilities, there does appear to be an increase in the number of children with multiple needs diagnosed with a visual impairment locally. This may be due to increased awareness or a growing recognition of non eye related conditions such as neurological (cerebral/cortical) visual impairment. In Salford the VI caseload approximately matches the national average of children with visual impairment and an additional need (50%). This is important as it reflects the changing landscape of VI support.

5.4.2 Deaf and hard of hearing
Approximately 1 in every 1,000 children is born with a severe or profound hearing loss. In Salford this could mean up to 4 children born each year are born with severe or profound deafness, giving a total population of around 100 children aged between 0 and 24.

Of these deaf children up to 40% have an additional or complex need.

Vaccination has meant fewer babies are born deaf as a result of their mothers having German measles (rubella) during pregnancy, however, this drop has been offset by more babies being born deaf from other causes.
5.4.3 DDA - defined disability prevalence

5.4.3.1 Definition - DDA
The Disability Discrimination Act (DDA) define a disabled person as a person with ‘a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities’.

5.4.3.2 Estimates of prevalence - DDA
A study by Blackburn\(^4\) suggested a rate for disability of 7.3 per cent, indicating that 5.787 children in Salford have a disability (as defined by the DDA). The study classifies disability by difficulty in classes of activity, not diagnosis as reflected in Table 2.

Table 2: Estimates of prevalence (DDA) by class of activity applied to Salford population estimates, 2015

<table>
<thead>
<tr>
<th>Difficulty/problem experienced</th>
<th>% of population*</th>
<th>Salford numbers aged 0-24 years (2015 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility</td>
<td>1.5</td>
<td>1190</td>
</tr>
<tr>
<td>Lifting and carrying</td>
<td>0.7</td>
<td>555</td>
</tr>
<tr>
<td>Manual dexterity</td>
<td>0.8</td>
<td>635</td>
</tr>
<tr>
<td>Continence</td>
<td>0.7</td>
<td>555</td>
</tr>
<tr>
<td>Communication</td>
<td>2.0</td>
<td>1586</td>
</tr>
<tr>
<td>Memory, concentration, learning</td>
<td>2.2</td>
<td>1744</td>
</tr>
<tr>
<td>Recognising physical danger</td>
<td>1.3</td>
<td>1031</td>
</tr>
<tr>
<td>Physical coordination</td>
<td>1.3</td>
<td>1031</td>
</tr>
<tr>
<td>Other</td>
<td>2.1</td>
<td>1665</td>
</tr>
<tr>
<td>Difficulty if didn’t take medication</td>
<td>1.9</td>
<td>1507</td>
</tr>
</tbody>
</table>

* Numbers add up to more than 7.3% due to multiple impairments (difficulties/impairments are counted separately in the breakdown table but counted only once for the overall estimate).

The last category will include children with well-controlled chronic disease, who strictly qualify as disabled, even if not experiencing any ongoing impairment. The figures for this category are therefore an underestimation as it is not clear how many qualify as having a disability purely on this basis.

These categories do not give a comprehensive picture of the level and patterns of need. It is, however, important to note that the most prevalent needs are learning (broadly) and communication.
Table 3: Estimates of prevalence by condition (DDA) applied to Salford population, 2015

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence/1,000</th>
<th>Numbers in Salford population aged 0-24 (2015 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language disorders</td>
<td>30-50</td>
<td>2379 - 3964</td>
</tr>
<tr>
<td>Severe learning disability</td>
<td>3</td>
<td>238</td>
</tr>
<tr>
<td>Moderate learning disability</td>
<td>20</td>
<td>1586</td>
</tr>
<tr>
<td>Dyspraxia/developmental coordination disorders (DCD)</td>
<td>50</td>
<td>3964</td>
</tr>
<tr>
<td>ADHD</td>
<td>10-20</td>
<td>793 - 1586</td>
</tr>
<tr>
<td>Severe ADHD</td>
<td>7</td>
<td>555</td>
</tr>
<tr>
<td>Autistic Spectrum disorders (ASD)</td>
<td>10</td>
<td>793</td>
</tr>
<tr>
<td>Fetal alcohol syndrome (FAS)</td>
<td>0.3</td>
<td>24</td>
</tr>
<tr>
<td>Syndromes</td>
<td>3</td>
<td>238</td>
</tr>
<tr>
<td>Physical disability (apart from DCD)</td>
<td>1</td>
<td>80</td>
</tr>
<tr>
<td>Profound and multiple learning difficulties</td>
<td>1</td>
<td>80</td>
</tr>
</tbody>
</table>

Many children have more than one diagnosis and for many of the more common conditions (e.g. DCD), only a more severe presentation would be likely to fulfil the definition of disability. Patterns of disability differ between sexes with boys having a higher rate overall and more likely than girls to experience difficulties with physical coordination; memory, concentration and learning; communication.

5.4.4 Speech, Language and Communication Needs (SLCN)

5.4.4.1 Definition

SLCN is the umbrella term used by education to cover all difficulties with speech, language and communication, this term can be subdivided into:

- Speech and language difficulties associated with social and environmental disadvantage. Anecdotal evidence suggests that in some areas up to 50% of children fall below developmental norms. This means these children are starting school without the language to learn. Many of these children’s difficulties will resolve with the early identification and frequent structured interventions of targeted input from staff in setting and families supported by specialist services. The early years foundation stage profile (EYFSP) show the proportions of those classed as ‘emerging’ to be at least 3.5 percentage points higher than the England average across all three communication and language learning goals.

- Developmental language Disorder (DLD), previously known as Specific Language Impairment, has no known aetiology although the latest research using highly detailed scanning processes is starting to identify subtle differences neurological differences in brain structure. Children with DLD have language and communications skills which are significantly below their other abilities and these children are not responsive to universal or targeted interventions. This is also known as a primary language disorder.

- Secondary Language Disorder is a language disorder associated with a condition e.g. autism, hearing impairment, Down’s syndrome or Cerebral palsy.

- It is important to recognise that these categories are not mutually exclusive i.e. a child can have autism but also have a Developmental Language Disorder, similarly they may have
language difficulties associated with disadvantage and a Developmental Language Disorder.

- Other Speech, Language and communication needs. These are associated with speech problems for example, developmental stammering.

A child with SLCN will not be following the expected pattern of speech, language and communication development for their age. The causative and risk factors of SLCN are varied and complex, including congenital disorders and neurological or physiological impairments. SLCN may co-exist with other conditions such as Autistic Spectrum Disorder (ASD) or a hearing impairment. Environmental factors impact on speech, language and communication development, with social disadvantage and the home environment playing a role. In some cases the cause of a child or young person’s SLCN is simply unknown.

SLCN is one of the most common childhood disabilities. It is estimated that as many as 10% of all children have SLCN, the most prevalent special educational need identified by primary schools; for a substantial proportion of this group, their needs will be long term and persistent.45

In October 2017 the government concurrently released three reports illustrating overwhelming data on the incidence of SLCN and the harm this causes to the life chances of children and young people, the government is likely to make SLCN a future reportable public health indicator.

5.4.4.2 Estimates of prevalence - SCLN
The prevalence of SLCN is higher in areas of social deprivation and studies have demonstrated that in some areas upwards of 50% of children may start school with impoverished speech, language and communication skills.49

The city of Salford has a population of 79,26850 children and young people aged 0 – 24 years, using the estimation of 10% by Law this would suggest that 7,926 children within Salford aged 0-24 had some form of SLCN, this however, is a likely underestimation given the levels of deprivation and poverty identified across Salford. The different prevalence estimates based on literature research and applied to the Salford population aged 0-24 years are reflected in Table 4.
Table 4: Prevalence of speech impairment, Salford, 2015\(^{31}\)

Some information is quite out of date and is likely now to under-represent the current situation due to changes in population demographics and deprivation. The figures have been calculated against the mid-year population estimates from ONS (2015).

<table>
<thead>
<tr>
<th>Prevalence</th>
<th>Numbers (2015 population)</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3% of 0-16 year olds (excluding learning difficulty and developmental delay). Of these: Males peaked in prevalence at 5 years (6.5%) Females peaked at 3-4 year olds (1.8%)</td>
<td>664</td>
<td>Keating, Turrell, Ozanne, 2001 (UK)</td>
</tr>
<tr>
<td>Estimated: 1.5% at 3-5 years 4.6% at 5-7 years 12.6% at 6-12 years 7.3% at 12-14 years Figures for speech delay were highly variable ranging from 2.3% to 24.6%</td>
<td>154 445 2543 542</td>
<td>Law, Boyle, Harris, Harkness, 2000 (UK)</td>
</tr>
<tr>
<td>14% of 3 year olds have speech delay. Prevalence was higher in children with otitis media, male, low socioeconomic group, low parental education, minority group, urban dwelling. 3.8% in 6 year olds</td>
<td>486 121</td>
<td>Shriberg, Tomblin, &amp; McSweeney, 1999 (US)</td>
</tr>
<tr>
<td>Approximately 10-15% of pre-schoolers (age 0-4 years) have an articulation and phonological disorders. Approximately 6% of school age (5-17 years) children have an articulation and phonological disorder. (Office of Scientific and Health Reports 1988)</td>
<td>1753-2630 2179</td>
<td>Bleile, 2003 (US)</td>
</tr>
</tbody>
</table>

Calculated using Mid-2015 population estimates for Salford, ONS

5.4.4.3 Prevalence of stammering\(^{32}\)

Studies suggest around 1 in 20 young children go through a phase of stammering. Around four in five children who stammer will grow out of it, although it’s difficult to predict when this will happen in a particular child.

Stammering is more common in boys than girls. Differences in brain development between the sexes might make boys more vulnerable to speech and language difficulties.
Summary
Estimations suggest 7.3 per cent of the population fall under the Disability Discrimination Act definition, indicating that 5,787 children and young people (aged 0-24 years) in Salford have a disability. The most prevalent needs being learning and communication.

It is estimated that as many as 10% of all children have SLCN, in Salford that is 7,926 children and young people aged 0-24 years, however, this is a likely underestimation given the levels of deprivation and poverty identified across Salford – a known causal factor of SCLN.

Stammering is thought to affect 1 in 20 young children, although around four in five will grow out of this.

5.5 Prevalence - chronic conditions

The children’s community team at SRFT has a caseload incorporating children (up to age 18 years) with disabilities and chronic conditions. As at May 2016, there were

- Oxygen dependent - 11 children
- Technically dependent - 11 children
- Epilepsy - 300 children
- Chronic conditions - 98 children
- Cancer - 6 children
- Asthma - 200 children

Many of the children overlap these categories. For example, one child who has cerebral palsy may be oxygen dependent, have epilepsy and have a chronic condition. The most dominant category is selected, rather than having the same child in several different categories. Children with asthma would still be under the GP however, they may be followed up by the asthma specialist nurse because their condition has flared up or is difficult to manage. Children with Epilepsy would still be under the care of GP and consultant, the specialist nurse follow up those with complex epilepsy.

5.6 Prevalence – benefits estimates

5.6.1 Disability Living Allowance and Personal Independent Payment

Disability Living Allowance (DLA) is a tax-free benefit for disabled people who need help with mobility or care costs. Recipients have to provide evidence of disability, so the dataset gives a definite number who have met a determined threshold. However, an unknown number of children who would be eligible for DLA may not be claiming or receiving it, so the figures below are an underestimation, but to what degree is unclear. DLA is paid to parents of children who have difficulties walking, or need more looking after than a child of the same age who doesn’t have a disability. In August 2016 there were 2,663 children and young people in Salford aged 0-24 years claiming DLA.

Personal Independence Payment (PIP) helps with some of the extra costs caused by long-term ill-health or a disability for people aged 16 to 64. PIP started to replace Disability Living Allowance (DLA) for people aged 16 to 64 from 8 April 2013. There were a further 545 young people aged 16-24 years claiming PIP in August 2016.
PIP has different qualifying criteria to DLA so the two benefit types are not a direct comparison. For the purpose of showing the need in young people and the gender split the two benefit claimant types have been amalgamated to give a breakdown of numbers. Figure 11 below shows the numbers of claimants by gender and single year of age. There is a reduction in numbers claiming DLA from age 16 years following the introduction of PIP claimants. The total of claimants also reduces from age 17, possibly due to the differences in qualifying rules for PIP’s.

*Note Numbers may not tally as suppression rules apply

Figure 11: Disability Living Allowance and Personal Independent Payment, Salford, August 2016

Figure 12 shows that across GM the DLA and PIP claimants (combined) crude rate per 1,000 is significantly higher in Salford, Stockport, Oldham and Rochdale when compared to Greater Manchester overall. Manchester shows a lower rate which, although highly deprived with a diverse community, is also influenced by a high student population which is possibly skewing the figures to a lower level than its deprived peers.
Figure 12: Disability living Allowance claimants aged 0-24, Greater Manchester, August 2016

Figure 13 shows that within Salford, parts of the city show a significantly higher rate of Disability Living Allowance claimants than the Salford average. The data included is only ages 0-15 years as the PIP claimants’ breakdown is not available at a geographical area lower than local authority from DWP. As the impact of PIPs begins to show from age 16 if they are included in the lower geographies rates the results skew the figures. Therefore, figure 13 below shows DLA claimants by MSOA with age groups from 16 years not included. There are significantly higher rates of DLA claimants (aged 0-15 years) in MSOA areas 001(Little Hulton), 004 (Little Hulton), 016 (Broughton), 017 (Irwell Riverside), 029 (Irlam) and significantly lower in 006 (Swinton North), 013 (Boothstown and Ellenbrook), 014 (Worsley), 015 (Claremont) and 018 (Claremont). The pattern of claimants generally follows the pattern of deprivation across the city with those areas of significantly lower claimants in areas of reduced deprivation and vice versa.
Summary

There were 3,208 DLA or PIP claimants (those in receipt of benefits) aged 0-24 years in Salford in August 2016.

Boys outnumber girls in the claiming of DLA or PIP by 2:1 between the ages of 0-24 years. The number of claimants is at least 2.5 times higher than girls at age 5, 9, 12 and 18 years.

There are significantly higher rates of DLA claimants (aged 0-15 years) in MSOA areas 001 (Little Hulton), 004 (Little Hulton), 016 (Broughton), 017 (Irwell Riverside), 029 (Irlam) and significantly lower in 006 (Swinton North), 013 (Boothstown and Ellenbrook), 014 (Worsley) and 015/018 (Claremont).

Salford shows one of the highest rates of DLA to younger age groups along with Oldham, Rochdale and Stockport; all are significantly higher than the Greater Manchester average in August 2016. The areas of increased deprivation across the city also have significantly higher claimant rates for DLA.
5.7 Prevalence – Educational estimates

If a child has a learning disability or other disability, their 'special educational needs' (SEN) can be met either in a mainstream school with either extra support or in an enhanced provision, or in a special school.

The Special Educational Needs and Disability (SEND) provisions in the Children and Families Act 2014 were introduced on 1st September 2014. This is a new system for supporting children and young people with SEN, and their parents. It aims to ensure that any support your child gets, from their school or other setting, such as their nursery or child-minder, should meet their needs.

If a child has SEN, they will be able to access help (called SEN support) from nurseries or child-minders, schools, further education institutions (such as colleges) and 16-19 academies. Under the new system, SEN support replaces school action/school action plus (in schools) and early years action/early years action plus (in early years settings, such as nurseries and child-minders).

Children and young people with more complex needs might need an Education, Health and Care (EHC) plan. EHC plans replace statements of SEN and Learning Disability Assessments (LDAs). The definition of SEN has not changed. If pupils were previously receiving support under "school action" and "school action plus", they should continue to do so, unless they no longer need it. All existing statements apply until a child is transferred to their new EHC plan.

Young people aged 16 to 25 are fully involved in designing their own SEN support and provision.

5.7.1 SEN - classifications

5.7.1.1 SEN Support
Extra or different help is given from that provided as part of the school's usual curriculum. The class teacher and special educational needs co-ordinator (SENCO) may receive advice or support from outside specialists. The child will get SEN support at their school or college. Children requiring SEN support could need assistance with:

- a special learning programme
- extra help from a teacher or assistant
- to work in a smaller group
- observation in class or at break
- help taking part in class activities
- extra encouragement in their learning, e.g. to ask questions or to try something they find difficult
- help communicating with other children
- support with physical or personal care difficulties, e.g. eating, getting around school safely or using the toilet

5.7.1.2 Education, Health and Care (EHC) Plan
An education, health and care (EHC) plan is for children and young people aged up to 25 who need more support than is available through special educational needs support that their school can provide.

EHC plans identify educational, health and social needs and set out the additional support to meet those needs.
5.7.2 SEN - national comparisons
The percentage of pupils at school in Salford with statements Special Educational Needs (SEN) or an Education Health and Care Plan (EHCP) has increased from 2.6% in 2007 to 3.0% in 2016, the proportion has remained at the same or slightly higher rate since 2009. (Data is based on where the pupil attends school).

The number of children with SEN support has remained significantly higher than the Northwest and England since 2015 with a rate that is 3.1 percentage points higher than England of 14.7% in 2016.

Table 5: SEN Support and EHC, Salford and comparators, 2016

<table>
<thead>
<tr>
<th></th>
<th>SEN Support</th>
<th>EHC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage</td>
<td>Number</td>
</tr>
<tr>
<td>England</td>
<td>11.6%</td>
<td>991,981</td>
</tr>
<tr>
<td>North west</td>
<td>11.5%</td>
<td>129,452</td>
</tr>
<tr>
<td>Salford</td>
<td>14.7%</td>
<td>5,677</td>
</tr>
</tbody>
</table>

5.7.3 SEN - timeline
The number of children with SEN support has fallen from 18% in 2009 to 14.7% in 2016. The fall may be due to more accurate identification of those with SEN following implementation of the SEND reforms.

Figure 14: Pupils with SEN support and EHC Plans (or equivalent), Salford 2009 - 2016
5.7.4 SEN - gender and age breakdown

Across all age groups, nationally, and within state-funded primary, secondary and special schools 16% of boys are SEN support compared to 9.2% for girls in January 2015\textsuperscript{57}. Salford, at the school census in January 2017, follows the same pattern, although a higher proportion, with more boys than girls requiring SEN support at 20.2% for boys and 11.8% for girls.

The gender difference for those with statements or EHC plans in Salford in January 2017 is 4.1% of boys and 1.8% of girls, these figures are similar to the national average of 4.1% of boys and 1.6% of girls in 2015.

Figure 15 identifies that in females, the likelihood of having SEN support in Salford peaks around age 10 and 11 (Year groups 6 and 7). In males, age 7 to 8 years (Year group 3) is the highest.

**Figure 15: Pupils with SEN Support, Salford January 2017\textsuperscript{58}**

Figure 16 shows that boys in year groups 8, 10 and 11 (aged 12/3, 14/15 and 15/16 years) are most likely to have a statement (circa 7%) and girls aged 15/16 years (3.5%) most likely within the gender breakdown in Salford.
Figure 16: Pupils with statements or EHC plans, Salford, January 2017

The Department for Education provides statistics on the type of special educational need within primary, secondary and special schools. Salford is higher than the Northwest and England averages for ‘Speech, Language & Communications needs’ and ‘Social, Emotional and Mental Health’ across all school settings.

5.7.5 SEN - by school and type of need
The Department for Education provides statistics on the type of special educational need within primary, secondary and special schools. Salford is higher than the Northwest and England averages for ‘Speech, Language & Communications needs’ and ‘Social, Emotional and Mental Health’ across all school settings.

5.7.5.1 Pupils at primary school with special educational needs by type
Figure 17 shows children in primary school with SEN by type is higher in Salford due to SLCN, SEMH, and PMLD. Children with Autistic Spectrum Disorder is around half the level in England, this could be due to late diagnosis in Salford or the diagnosis not being amended from earlier Special Educational needs assessments.
Figure 17: Primary school children with SEN by type, Salford and comparators, 2016

5.7.5.2 Pupils at secondary school with special educational needs

Figure 18 identifies the type of SEN of secondary school age children. Those with a moderate LD, SEMH or SLCN are higher in Salford than the North West and England. Children with ASD as the primary need of SEN are two thirds lower in Salford than in England, again this could be a coding issue and lack of ongoing audit to amend the type of primary need of the child.

Figure 18: Secondary children with SEN by type, Salford and comparators 2016
5.7.5.3 Pupils at special schools with special educational needs

Figure 19 identifies that children at special schools in Salford are more likely to have a severe learning difficulty, SEMH, Moderate LD, specific LD, or SCLN when compared to national figures.

Figure 19: SEN at special schools by type, Salford and comparators, January 2016

5.7.6 SEN - locality of children within Salford

The distribution of children with SEN support and EHC plans has been calculated as a proportion of total children in each ward according to school census data. The figures are calculated slightly differently than in the published figure in 5.6.2 and 5.6.3 above in that the data by ward is based on where the child lives rather than where the child attends school, hence the total figures do not tally completely.

There is a higher proportion than the Salford average of children with EHC plans in nine out of the twenty wards in Salford, as identified in figure 20. Only Weaste and Seedley and Irlam are significantly higher than the Salford average and the rate significantly lower in Boothstown & Ellenbrook, Worsley and Claremont.
Figure 20: Children with EHC plans by ward, January 2017

Figure 21 shows the proportions of children with SEN support follow the pattern of deprivation across the city with areas of lower deprivation showing a lower proportion of children with SEN support, for example, Worsley and Boothstown & Ellenbrook have proportions at less than half of the average across the city at 7.6%. Ten out of the 20 wards in Salford have rates higher than the Salford average of 16.3%, with the rate being significantly higher than the Salford average in Broughton, Langworthy, Little Hulton, Swinton north and Winton.

Figure 21: Children with SEN Support by ward, January 2017
5.7.7 SEN - where children are educated

Table 6 shows the numbers and proportions of children across the city with SEN in primary, secondary and special schools. Children with SEN support are most likely to be educated in their mainstream school, the proportions of children with SEN support in Salford is higher than the national and North West averages at 15.7% in primary and 14.5% in secondary compared to the national proportions of 12.1% and 11% respectively. The proportion of children with EHC plans is higher in primary and secondary schools across Salford than in the North West and England.

This could be due to the deprivation and other socio-economic issues across the city giving rise to more children requiring SEN support, or could be due to reporting issues. This should be investigated further.

Table 6: SEN by school type, Salford, January 2016

<table>
<thead>
<tr>
<th>School Type</th>
<th>Total Pupils</th>
<th>Pupils with statements or EHC plans</th>
<th>Pupils with SEN support</th>
<th>Total pupils with SEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>England</td>
<td>4,615,172</td>
<td>60,646</td>
<td>12.1</td>
</tr>
<tr>
<td></td>
<td>Northwest</td>
<td>638,144</td>
<td>7,843</td>
<td>12.4</td>
</tr>
<tr>
<td></td>
<td>Salford</td>
<td>23,324</td>
<td>346</td>
<td>15.7</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>3,193,418</td>
<td>55,738</td>
<td>1.7</td>
</tr>
<tr>
<td></td>
<td>Northwest</td>
<td>412,375</td>
<td>7,031</td>
<td>1.7</td>
</tr>
<tr>
<td></td>
<td>Salford</td>
<td>10,607</td>
<td>228</td>
<td>2.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Special</th>
<th>Total Pupils</th>
<th>Pupils with statements or EHC plans</th>
<th>Pupils with SEN support</th>
<th>Total pupils with SEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary</td>
<td>England</td>
<td>4,615,172</td>
<td>105,274</td>
<td>96.4</td>
</tr>
<tr>
<td></td>
<td>Northwest</td>
<td>15,725</td>
<td>15,134</td>
<td>96.2</td>
</tr>
<tr>
<td></td>
<td>Salford</td>
<td>567</td>
<td>559</td>
<td>98.6</td>
</tr>
</tbody>
</table>

*Table 6: SEN by school type, Salford, January 2016*
Summary

Children with an EHC Plan or statement in Salford has increased from 2.6% in 2007 to 3.0% in 2016, the proportion has remained at a similar rate since 2009. (Data is based on where the pupil attends school).

More boys than girls require SEN Support or have an EHC Plan. The proportion of EHC plans for males is more than double the rate for females (4.1% Male, 1.8% female, Salford January 2017). Boys outnumber girls at SEN Support level by 1.7:1 (20.2% Male, 11.8% female, Salford January 2017)

The likelihood of having SEN support in Salford females peaks around age 10 and 11 (Year groups 6 and 7). In males, age 7 to 8 years (Year group 3) is the highest. Those with a statement or EHC Plan peaks for boys in year groups 8, 10 and 11 (aged 12/13, 14/15 and 15/16 years) and girls aged 15/16 years are most likely. (Salford, January 2017)

Children in Salford primary schools with SEN is highest due to SLCN, SEMH, and PMLD. Children with Autistic Spectrum Disorder is around half the level in England. At secondary schools those with a moderate LD, SEMH or SCLN are higher in Salford than the North West and England. Children with ASD as the primary need of SEN are two thirds lower in Salford than in England. Children at special schools in Salford are more likely to have a severe learning difficulty, SEMH, Moderate LD, specific LD, or SCLN when comparing to national figures. (January 2016). The figures around autism need more exploration as they are unlikely to reflect the real picture within Salford.

Children with SEN support are most likely to be educated in their mainstream school, the proportions of children with SEN support in Salford is higher than the national and North West averages at 15.7% in primary schools and 14.5% in secondary schools compared to the national proportions of 12.1% and 11% respectively. The proportions of children with EHC plans are higher in primary and secondary schools across Salford than in the North West and England. This could be due to the deprivation and other socio-economic issues across the city giving rise to more children requiring SEN support, or could be due to reporting issues. This should be investigated further.

Children with EHC Plans show a significantly higher proportion than the Salford average living in Weaste & Seedley and Irlam. Significantly lower proportions reside in Boothstown & Ellenbrook, Worsley and Claremont.

Children with SEN support follow the pattern of deprivation across the city with areas of lower deprivation showing a lower proportion of children with SEN support. Worsley and Boothstown & Ellenbrook have proportions at less than half of the average across the city at 7.6%. The rate is significantly higher than the Salford average in Broughton, Langworthy, Little Hulton, Swinton North and Winton.
5.8 Population projections

The younger population aged 0-24 years is expected to rise in Salford by 8% from 79,387 in 2016 to 85,870 in 2026\textsuperscript{64}. School age children (aged 4-16 years) are estimated to rise by 15.2% over the same time period.

The increasing general population will bring with it increases in the numbers of children with disabilities, projecting this future population is challenging given the lack of appropriate and accurate estimates of current cohorts. However, by applying the proportions of school census SEN classifications together with a simple regression formula against published population projections some estimates of future need have been approximated.

The projections can be used as an approximation of increases in the disabled population but they do not take into account population illnesses or trauma and the higher survival rates of babies with congenital anomalies, or any changes in SEND legislation. The figures split the approximation of need by type of disability in the future, however, it is possible that higher weightings should be given to SCLN, SEMH, MLD and ASD. It should also be noted that eventually the population will plateau, a point at which cannot be estimated.

Figure 22 shows the numbers of lower and higher estimated figures for each SEN classifications in 2026. The lower estimated figures were calculated by using the school census in 2016 to identify proportions of the Salford population in each category then applying them to the population at 2026.

The higher estimated figures were calculated by projecting the school census numbers by primary need using simple regression and then calculating this number as a proportion of the population. These proportions were applied to 0-24 years population estimate in 2026 to give a higher estimate.

The projections are based purely on past reported numbers of people and children with SEN; external factors (e.g. limited maternal education, social deprivation and poverty, low birth weight, poor maternal health, problems in childbirth) may affect future populations differently than they have in the past and may be affected by random fluctuations. Further advances in medical technology and treatment may reduce the level of disabilities in individuals. These factors are not included in the projections.

Definitions around the terminology of SEN and disabilities are confusing with the categories often overlapping. It is likely that a child or young person will have more than one underlying issue and will fit into several categories, the most prominent of which is often described as the primary diagnosis. Alongside this, the needs of the child and therefore the primary diagnosis may change over time but the corresponding paperwork and data may not be amended. The projections cannot take these inaccuracies into account.

The numbers should be used with caution and only as a guide to the future numbers of children with disabilities due to the limitations suggested.
Figure 22: Projected numbers of children with disabilities aged 0-24 years, Salford

The projections estimate that the proportions of the total population aged 0-24 years with disabilities are at 16.6% for the lower estimate and 20.1% of the higher. Using these figures the total numbers of children with disabilities is estimated to be between 14,294 and 17,284 by 2026. The overall SEN rate of school age children in 2016 was 17.7%.

Projected numbers of children with disabilities aged 0-24 years, Salford, 2026

<table>
<thead>
<tr>
<th>Category</th>
<th>2026 (lower estimate)</th>
<th>2026 (higher estimate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical disability</td>
<td>1,462</td>
<td>1,764</td>
</tr>
<tr>
<td>Speech, language and multi-sensory</td>
<td>288</td>
<td>368</td>
</tr>
<tr>
<td>Moderate learning difficulty</td>
<td>3,180</td>
<td>5,123</td>
</tr>
<tr>
<td>Profound and multiple learning disability</td>
<td>2,683</td>
<td>2,975</td>
</tr>
<tr>
<td>Specific learning difficulty</td>
<td>7,13</td>
<td>7,74</td>
</tr>
<tr>
<td>Social, emotional and mental health</td>
<td>478</td>
<td>568</td>
</tr>
<tr>
<td>Severe learning difficulty</td>
<td>388</td>
<td>734</td>
</tr>
<tr>
<td>Hearing, Visual or multi-sensory</td>
<td>150</td>
<td>236</td>
</tr>
<tr>
<td>Other difficulty / disorder</td>
<td>388</td>
<td>4060</td>
</tr>
<tr>
<td>Total number of children</td>
<td>14,294</td>
<td>17,284</td>
</tr>
</tbody>
</table>

Summary

Numbers of children with disabilities (aged 0-24 years) is estimated, in Salford, to be between 14,294 and 17,284 by 2026.

Estimations of projections are unlikely to be accurate as they cannot take into account external factors e.g. limited maternal education, social deprivation and poverty, low birth weight, poor maternal health or problems in childbirth.

The numbers should be used with caution and only as a guide to the future numbers of children with disabilities due to the limitations suggested.
6 Causes and outcomes

6.1 Causes of disability in children

Disability imposes a large burden on individuals and their families; health, education and social care expenditures and economies as a whole. Five major lifestyle-related factors have been shown in observational studies to increase the risk of disability for individuals: obesity, diabetes, hypertension, high cholesterol, and smoking, however, these studies focus on the individual becoming disabled later in life rather than causing disabilities in children.

The possible causes of disability are usually grouped into the four categories listed below:

**Before birth (pre-natal):** this covers genetic or ‘congenital’ causes, including Down’s syndrome or Fragile X syndrome, as well as other things that affect a baby before it is born; such as drug or alcohol use, nutritional deficiency by the mother.

**During birth (peri-natal):** this includes oxygen deprivation during birth, which can lead to brain damage. It can also include injury to the baby because of complications during birth, and difficulties resulting from premature birth. Difficulty in delivery can cause temporary stoppage of oxygen supply to the brain of the baby, it damages nervous tissues of the brain or spinal cord and this effect is permanent.

**After birth (post-natal):** covers causes such as illnesses, injury, accidents or environmental conditions, for example, meningitis, brain injury or children being deprived of attention to their basic needs - undernourished, neglected or physically abused. If the child gets infectious diseases the immunity power of the child gets diminished, and they become susceptible to various diseases. If the child is not properly immunised they become susceptible to infectious diseases like 'mumps' which can cause hearing impairment or 'polio' which can cripple the child.

**Multiple causes:** this refers to when a person’s disability is caused by a combination of before, during and after birth factors.
6.2 Life outcomes

6.2.1 Poverty

It is estimated that it costs up to three times as much to raise a disabled child, as it does to raise a child without disabilities. More than half of families with a disabled child are at risk of experiencing poverty.\textsuperscript{66}

National studies have suggested that disabled children live in different personal and social situations from their non-disabled counterparts, and are more likely to live with low-income, deprivation, debt and poor housing. This is particularly the case for disabled children from black/minority ethnic/mixed parentage groups and lone-parent households.\textsuperscript{67}

Research into the finances of more than 3,500 families with disabled children across the UK was conducted in 2014 by Contact a Family. They concluded that 83 per cent of families with disabled children say they are going without and of those, 22 per cent say their child's health has worsened as a result.\textsuperscript{68} A further one in three say they are worse off as a result of benefit changes. More than 30% of families with disabled children are going without either heating or food. Only 16 per cent of mothers with disabled children work, compared to 61 per cent of other mothers.

The income of families with disabled children averages £15,270 which is 23.5 per cent below the UK average income of £19,968, and 21.8 per cent have incomes that are less than half the UK mean.\textsuperscript{69}

There is a socio-economic trap that disability sets for families. This situation is likely to worsen, given the reduction in tax credits effective from 2011 and the restrictions on Disability Living Allowance (DLA) under the Welfare Reform Act. Not only do these families live more impoverished lives, but they are also significantly more in debt than the rest of the population. They are less likely to own their own home, and thus hold no capital with which to reduce the cost of borrowing. Given the long-established link between low socio-economic status and poor health outcomes, it is easy to see how families become trapped by disability into a cycle of poverty and worsening health.\textsuperscript{70}

6.2.2 Housing and disabled children\textsuperscript{71}

The majority of disabled children live at home on a permanent basis with their families. Families with a disabled child are more likely to be renting their homes than families with non-disabled children. Whilst there has been an increase in the proportion of families as a whole being home-owners, the proportion of families with a disabled child becoming home-owners has remained the same. They are less likely to be living in a decent home compared to families with a non-disabled child. Those with a disabled child are 50 per cent more likely than other families to live in overcrowded accommodation, to rate their home as being in a poor state of repair, and to report problems with wiring, draughts and damp in the child's bedroom.

Unsuitable housing makes the task of caring harder, contributes to higher stress and frustration levels and for severely disabled children is a significant barrier to enjoying childhood experiences. Compared to other groups of disabled people, disabled children requiring specifically adapted homes are the least likely to be living in suitable accommodation. The great majority of families with disabled children report that their homes are unsuitable for their child's needs and the associated needs of other family members. Often the home is unsuitable in a number of ways.

All disabled children and their families, not just children with physical disabilities, are likely to experience difficulties with their housing. The sorts of problems with housing most frequently reported by families include lack of family space, and lack of space for storing and using therapeutic
equipment. Other common problems are difficulties with location and unsuitable or inaccessible kitchens, toilets and bathrooms. Moving, as opposed to adapting the current home, is the preferred option for dealing with unsuitable housing for around half of families.

Disabled children and young people spend more time at home than non-disabled children, but there is evidence to suggest that their homes are the most restrictive environments in which they spend their time. Improvements in families’ housing situation can lead to increased independence, more confidence and greater self-reliance among disabled children. However, families can experience significant difficulties accessing support and services to help them address the problems with their housing.

Data on families with very severely disabled children suggests that these families are even more likely to be renting their homes. Beresford and Oldman’s survey of just under 3,000 families with a severely disabled child (2002) found just 43 per cent were home-owners while 54 per cent rented. It should be noted that the sample used for this research is biased towards low income families and thus is not fully representative of all families. At the same time, the strong association between low income and disability is well-established.

6.2.3 Leisure
Play is a fundamental part of childhood. It enables children to develop social skills, form friendships, develop physical skills and learn about and become confident in their environment. However, for many disabled children opportunities are severely restricted. Community-based facilities, such as sporting activities, play schemes, and organised clubs and groups frequently exclude disabled children. In addition, disabled children often attend specialist schools or nurseries away from where they live, reducing their opportunities to make friends in their own communities.

Reduced opportunities for play and leisure also affect disabled children’s families. Most parents can take a break from parenting responsibilities when their children are playing with friends or involved in leisure activities. Parents of disabled children often do not experience these breaks; also brothers and sisters may be required to play with their disabled sibling rather than pursuing their own friendships and interests.

Social exclusion of disabled children and young people exists with families sometimes not even attempting to use leisure services. Parents can be put off by public attitudes, perceptions and by practicalities such as long queues, inaccessible transport and unsuitable toilet facilities.

Physically disabled children and young people are clearly dependent upon basic physical access. Their parents or carers need allocated disabled parking spaces. Children have to be able to get into the building, park or play space – hence the need for:
- ramps
- doors which they can open
- large cubicles for wheelchairs
- accessible toilets
- changing areas for older children needing intimate care
- low sinks
- play equipment which can include wheelchairs.

Children and young people with Autism and Asperger Syndrome, for example, can find long queues and large crowds intolerable. Many children with learning difficulties long to play sport and join clubs but are excluded because of their unusual behaviour or need for extra support.
In Salford a range of commissioned services are currently being accessed by over 300 children and young people with disabilities. Commissioning is based on identified need and from feedback and consultation with parents and young people. The activity programme includes activities for different ages and needs in a range of venues across the city. Children and young People with more complex needs can access individual support to allow them to access activities. The Local Offer (https://www.salford.gov.uk/children-and-families/local-offer-for-children-and-young-people-with-sen-or-disabilities/) is slowly building information on non commissioned services that deliver or can be accessed by Children and Young People with disabilities across the city and close by.

(For further information please see Current Service Provision, Section 7)

6.2.4 Carers
Carers fulfil a highly important role in looking after the health and wellbeing of family members and friends who have care needs. Children and young people with disabilities often need a carer to help them with general daily tasks, feeding and transportation. The impact of caring on an adult’s or young person’s life will vary and depend on the person’s circumstances and factors such as the number of hours spent caring and level of support available to the carer. However, carers can themselves experience poor health and financial stresses and this can put them at a higher risk of becoming in need of care themselves. Carers often find it hard to leave the cared-for person to attend their own appointments and can find it hard to prioritise their own health and wellbeing. As a result stress and tiredness are prevalent amongst Salford adult carers.

Seven out of ten families caring for someone with profound and multiple learning disabilities have reached or come close to ‘breaking point’ because of a lack of short break services.

Nationally, there are approximately 166,000 young carers under 18 years of age looking after a disabled parent or sibling. In Salford, in December 2016, there were 57 children (36 female, 21 male) fulfilling caring duties for a disabled sibling, 10 of these children also cared for a parent. The average age of these young carers was 12 years. The emotional and physical strain of caring for a disabled sibling along with the time taken to complete this takes away from the young carer’s education and time for their own social life and makes young carers a vulnerable group.

6.2.5 Looked After Children - child protection plan
Looked After Children are almost four times more likely to have SEN; and around ten times more likely to have Statements of Special Educational Needs/ EHC Plan than all pupils. Nationally, 67.8% of the children Looked After for at least a year (at 31 March 2013) had SEN, compared to 17.9% of all pupils in January 2014. From 2015, the statistical release containing this information has been cancelled; the previous year (and therefore most current) is shown here for information.

In February 2016, in Salford, there were 15 Looked After children, 7 disabled children subject to a Child Protection Plan and 65 children who had a direct payment, these figures relate to children open to the children with disabilities social work team.

6.2.6 Children in need
The Department for Education has been collecting the children in need census from local authorities for the full 12 month period since 2009-10. It collects information on all referrals to children’s social care, assessments carried out upon those children and whether the child become the subject of a child protection plan.
When a child is referred to children’s Social Care with a request for services to be provided, an assessment is carried out. If it is deemed that a child needs support then the main reason why the child is in receipt of services is recorded as the primary need. Children with a disability or illness recorded as the primary need stands at 9.6% nationally, and 4.9% in Salford.8

The children in need census also collates figures around the number of children in need by disability type, these figures are all children not necessarily those who received services. Table 7 shows the percentage of Children in Need as at 31 March 2016 having a disability recorded is 15.5% in Salford which is a higher proportion than in the North West (9.7%) and England (12.7%).79

Table 7: Number and proportion of children in need with a disability recorded, March 2016

<table>
<thead>
<tr>
<th></th>
<th>Number of children in need</th>
<th>Number of children in need with a disability record</th>
<th>Percentage of children in need with a disability recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>394,400</td>
<td>49,990</td>
<td>12.7%</td>
</tr>
<tr>
<td>North West</td>
<td>57,820</td>
<td>5,590</td>
<td>9.7%</td>
</tr>
<tr>
<td>Salford</td>
<td>2,306</td>
<td>358</td>
<td>15.5%</td>
</tr>
</tbody>
</table>

Table 8 identifies the type of disability Children in Need are reported to have. Salford shows higher than regional and national proportions of Children in Need reported with a disability across behaviour, communication, consciousness, incontinence, mobility, personal care and ‘other’ categories.

Table 8: Percentage of children in need with a disability recorded by type, March 2016

<table>
<thead>
<tr>
<th>Percentage of children in need at 31 March with a disability recorded broken down by disability</th>
<th>Autism/Asperger Syndrome</th>
<th>Behaviour</th>
<th>Communication</th>
<th>Consciousness</th>
<th>Hand Function</th>
<th>Hearing</th>
<th>Incontinence</th>
<th>Learning</th>
<th>Mobility</th>
<th>Personal Care</th>
<th>Vision</th>
<th>Other Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>31.7</td>
<td>22.1</td>
<td>22.2</td>
<td>5.3</td>
<td>4.3</td>
<td>5.4</td>
<td>8.3</td>
<td>44.8</td>
<td>20.2</td>
<td>71.2</td>
<td>8.5</td>
<td>20.1</td>
</tr>
<tr>
<td>North West</td>
<td>29.5</td>
<td>20.9</td>
<td>19.5</td>
<td>4.4</td>
<td>1.9</td>
<td>4.6</td>
<td>6.2</td>
<td>44.3</td>
<td>19.4</td>
<td>8.8</td>
<td>8.2</td>
<td>15.8</td>
</tr>
<tr>
<td>Salford</td>
<td>20.4</td>
<td>52.2</td>
<td>36.3</td>
<td>8.1</td>
<td>2.0</td>
<td>5.2</td>
<td>10.3</td>
<td>27.1</td>
<td>23.0</td>
<td>13.9</td>
<td>4.2</td>
<td>27.1</td>
</tr>
</tbody>
</table>

Note: A child may have more than one disability and so the total number and percentages will not calculate.

6.2.7 Lesbian, Gay, Bi-sexual and Transgender (LGBT)

According to research by the charity ‘National Children’s Bureau’ half of the children who identify as LGBT have experienced bullying relating to their gender preference or sexual orientation, with disabled children and those with SEN at increased risk. Their survey of LGBT young people in the UK found that two thirds (66%) of children with disabilities or SEN had experienced homophobic bullying, compared to 55% among the sample as a whole.80

A meta-synthesis by Duke, ST discusses a literature analysis addressing the intersection of disability with homosexuality and gender identity in schools, other educational and social contexts. The research found that lesbian, gay and bisexual individuals are defined by their sexual preferences while people with disabilities are defined almost exclusively through their impairments.

LGBT young people with disabilities appear to be at greater risk of experiencing negative mental health outcomes and diagnosis than young people in the general population. Furthermore, young people with LGBT and emotional/behavioural disorders are less likely to receive effective treatment for their mental health problems than heterosexual young people with similar mental health issues.
LGBT young people with physical disabilities (e.g., young people who use wheelchairs, scooters, and walking aids, the deaf who communicate through sign language and young people who stutter) commonly encounter prejudice, discrimination, and exclusion because of their sexual orientation, gender identity/expression, and disability status, and many of these young people must also contend with other forms of social oppression, including sexism and racism.

Many LGBT venues and events do not accommodate mobility and/or sensory impairments, making access to the LGBT community problematic (and, in some cases, all but impossible) for young people with physical disabilities. As they are completely dependent on their parents or caregivers (e.g., young people who are medically fragile, quadriplegic, or with deaf-blindness); “coming out” can be particularly problematic for these young people (as they must rely upon parents or caregivers), yet access to the LGBT community often requires the support of able-bodied family members or caregivers (e.g., to provide transportation to social events).

LGBT young people with physical disabilities commonly experience isolation, loneliness, and depression; this isolation and loneliness is exacerbated by ableism within the LGBT community, lack of access to the LGBT community, and homophobia and heterosexism within the disability community which can lead to serious mental health problems for these young people.

People often have misconceptions about the sexualities of individuals with physical disabilities, incorrectly believing that they are physically incapable of having sexual experiences, that they lack sexual or emotional desire and experience, and that they are exclusively heterosexual. Schools can play an important role in dispelling these (and other) false notions or assumptions about the sexualities of people with physical disabilities by infusing physical diversity and sexual diversity throughout their curricula (in the same way that many schools have, in recent years, embedded cultural diversity in their curriculum).

School-based sex education programs rarely address issues related to physical disabilities or LGBT sexualities; LGBT young people with physical disabilities, therefore, frequently lack access to information and resources that might help them develop positive sexual identities and/or participate in safe, satisfying sexual experiences. Sex education is important for young people with autism, but literature on this topic is very limited. Very little research is available on intersex, transgender and questioning young people who have been labelled with emotional/behavioural disorders.

The lack of available data to estimate the prevalence of LGBT amongst disabled children is exacerbated by the lack of services and understanding available for this particularly vulnerable group.

6.2.8 Transition
Adolescence can be a difficult transition for all young people, but there can be specific issues and challenges for young people with a long term condition or disability. Transition needs to promote the aspirations, independence and autonomy of the young person as they move to become a young adult. In the past, ineffective arrangements between education, health and social care agencies have impacted on the ability of high needs learners to successfully transition from school, to post-16 provision and to adult life. The Children and Families Act 2014 made a firm commitment to tackle this.

Planning for transition can help to make it a more positive experience. In addition, it can help to prepare young people for the social and emotional changes, such as changes to friendships, affecting self-esteem and self-confidence. Transition often coincides with the young person’s growing
independence and becoming more responsible for their own life. Not all young people are ready for this responsibility and some may find self-organisation difficult therefore making the process extremely challenging.

There are substantial personal challenges such as physical, sensory, cognitive and communicative limitations along with environmental barriers this coupled with people’s attitudes, lack of opportunities and choices can limit opportunities for full participation in adult life.

**Summary**

Poverty – the cost of raising a disabled child is three times higher than non-disabled peers. Family income of those with a disabled child averages £15,270 which is 23.5 per cent below the UK average income of £19,968. (2016)

Nationally LAC are almost four times more likely to have SEN and around ten times more likely to have Statements of Special Educational Needs or an Education Heath and Care Plan than all pupils (2014). The issues around this are complex and in Salford services have been developed to ensure LAC with SEN are given every opportunity to achieve their potential.

The percentage of children in need having a disability recorded is 15.5% in Salford which is a higher proportion than in the North West (9.7%) and England (12.7%). (March 2016)

Families with a disabled child are less likely to be living in a decent home compared to families with a non-disabled child. They are 50 per cent more likely than other families to live in overcrowded accommodation, to rate their home as being in a poor state of repair, and to report problems with wiring, draughts and damp in the child's bedroom. Unsuitable housing makes the task of caring harder, contributes to higher stress and frustration levels and for severely disabled children is a significant barrier to enjoying childhood experiences.

57 children were known to the carers centre (36 female, 21 male) who were fulfilling caring duties for a disabled sibling, 10 of these children also cared for a parent. The average age of these young carers was 12 years.

The lack of available data to estimate the prevalence of LGBT amongst disabled children is exacerbated by the lack of services and understanding available for this particularly vulnerable group.

Substantial challenges at transition exist limiting opportunities for full participation in adult life. This is both in terms of the young person's learning, social, physical and cognitive limitations combined with environmental barriers – people’s attitude, lack of opportunities and choices.
6.3 Health outcomes

6.3.1 Visual impairment
The characteristics of the population of children with severe sight problems or blindness is changing. This is because:

- There has been a decline in the incidence of treatable or preventable disorders such as retinopathy of prematurity and congenital cataract.
- There has been an increase in untreatable disorders such as cerebral sight problems, the inherited retinal dystrophies, optic nerve atrophy and hyperplasia.
- The decline is linked with improvements in primary prevention, early detection and medical and surgical management.
- The increase is linked with changing trends in childhood chronic disease and disability that are themselves linked with increased survival of premature and very low birth weight babies and children with major anomalies, complex neurological and metabolic diseases and malignant disease.

The consequences of these changes are that:

- Proportionally more children with severe sight problems and blindness now have additional, often very complex, disabilities.
- Very premature and low birth weight babies are at particular risk of severe sight problems and blindness.
- There is an increased rate of severe sight problems and blindness in children from ethnic minorities. There is also an association with socio-economic deprivation. These two factors may also be correlated, although with certain ethnic groups where inter-cousin marriages are common, autosomal recessive disorders are found.

A study commissioned by RNIB in 2009 found that visual impairment did make a difference to educational attainment, but that the strongest effect was that of other or additional SEN. This effect was sustained even when socio-demographic differences between pupils with and without SEN were taken into account. Analyses of English, Welsh and Northern Irish pupil data revealed stark differences in educational attainment between young people with visual impairment as their sole SEN and those with visual impairment and additional SEN. In general, pupils with 'VI only' typically performed better than pupils who had a visual impairment and an additional SEN. Pupils with 'VI only' also performed less well than pupils without SEN.

6.3.2 Hard of hearing
Children who are hard of hearing will find it much more difficult than children who have normal hearing to learn vocabulary, grammar, word order, idiomatic expressions, and other aspects of verbal communication.

Although deafness is not a learning disability, educational attainment is poorer for deaf children compared to those with no special educational need (SEN), although there has been a steady increase in attainment over the last few years. Data from the Department for Education statistical first Release 2013 shows that in 2012/13 73.5% of children with hearing loss achieved 5 A* to C in their GCSEs compared to 89.4% of children with no identified SEN. In the same period 42.7% achieved 5 A* to C in their GCSEs including Mathematics and English compared to 70.4% of children with no identified SEN.
6.3.3 Obesity
Nationally the percentage of children who are classified as either overweight or obese is highest where the child has a limiting illness. Where the child also suffers from a learning difficulty, 27% are classified as overweight and a further 15% are classified as obese.

40% of children aged under 8 years of age with a limiting illness and learning disability are obese or overweight compared to 22.4% of children who have neither condition.

The percentage of children classified as overweight or obese in the 8 to 13 years old category with a limiting illness and a learning disability increased to almost 45%. Boys with a limiting illness are more likely to be obese or overweight than girls, particularly where the child also has a learning disability.

NICE guidance identifies children who are disabled or from a disabled family as those where physical activity is hindered. Children with physical disabilities, even those with severe impairments, can take part in activities to benefit their physical and social development. Many children who are disabled highlight social issues, rather than their impairment, as a barrier to participation. If they are encouraged to communicate their preferences, changes can be made to the physical environment, activities and the attitudes of others to help them to participate. Practitioners can encourage and nurture positive peer interaction through play and other physical activity opportunities.

6.3.4 Vaccinations
Vaccination of children with disability is not included in uptake data for the routine childhood immunisations. Children with disability are not coded differently than the rest of the population. There is very limited data on flu vaccinations given to children in at risk groups. The ‘at risk’ groups are broken down into different categories, i.e. diabetes, respiratory disease and include neurological disease which would include some children with disability. However the categories are very generic and there isn’t a specific ‘disability’ category.

6.3.5 Emotional health and wellbeing
Mental ill health among all young people across the UK is a growing problem, with large proportions not receiving the help they need.

The incidence of poor mental health among vulnerable children, such as those with a disability or experiencing poverty, is disproportionately high. Children and adolescents with intellectual disabilities are more than six times likely to have a diagnosable psychiatric disorder than their non-intellectually disabled peers, with one in three (36%) having a diagnosable psychiatric disorder in Britain.

It is well established that children with learning disabilities and communication disorders may well also have a mental health need but are unable to communicate this to their carers.

Information about the number of school children accessing specialist CAMHS is not collected in a way which would make it possible to identify the actual incidence of mental health disorders in each local area.

Summary
Data collection for health outcomes particularly for mental ill health and vaccinations by disability is poor at the local and national level. Identifying actual incidence and gaps in local areas is not possible due to the lack of consistent and accurate data recorded in a way that can be interrogated.
6.4 Personal outcomes

6.4.1 Stigma and discrimination
Having a disability or chronic health condition saddles the person with more than just the physical complaint. Often society is not very accepting of illness and disability and the person affected becomes stigmatized as a result. Stigma is a common problem among the disabled community, it not only affects the person with the disability but may extend to include his or her whole family as well.

National research into the finances of more than 3,500 families with disabled children by ‘Contact a Family’ concluded that 70% of families say stigma of claiming disability benefits for their children has increased and that understanding and acceptance of disability from their community or society is poor.

Half of the families with disabled children say that their isolation is a result of the discrimination or stigma they experience and 62% of families don't tell people that they claim benefits for their disabled child. Just over 10% of families received verbal insults from friends or family members because they claim benefits for their disabled child.

6.4.2 Family life and relationships
Having a disabled child can have a huge impact on family life. Parent carers face a unique combination of emotional, social, physical and financial pressures that impact on family life. Without support, families find it difficult to take part in normal daily activities and can become very isolated and feel unable to cope - this can affect the wellbeing of the whole family.

More than three quarters of families with disabled children say that the opportunity to spend time with their spouse or partner away from the role of caring is poor or unsatisfactory. Further to this, more than half of parents say that caring for a disabled child has caused major difficulties or the breakdown of their relationship, resulting in one in five families with a disabled child saying that isolation has led to the break-up of their family life. Three out of four parents/carers of children with disabilities experience mental ill health such as anxiety, depression or breakdown due to isolation.

6.4.3 Bullying
The stress of having to deal with bullying of a child at school can be considerable, and it being dealt with well or badly can have a massive impact on the rest of the family life.

An online survey undertaken in 2011 by the anti-bullying alliance asked parents and families with disabled children about their experiences of bullying at school and how it was dealt with. Nearly all respondents (96%) of parent carers said that their disabled child has been bullied at school with the most common forms being verbal (36%) followed by emotional (30%) and physical (28%). The majority of respondents (85%) believed this bullying was because their child had disabilities or special educational needs.

Nationally, disabled children and young people report that bullying or fear or bullying spoils their experiences of, or stops them accessing, inclusive activities or using local leisure and recreation facilities.
The Annual Bullying Survey 2016 is the fourth edition of a yearly benchmark of bullying in the UK. Of the 8,850 complete responses from respondents aged 12-20 15% identified that they had a disability, 9% learning disability, 3% have Autism/Asperger's and 3% have a physical disability. Of those who had been bullied within the past year, 10% thought that they were bullied because of attitudes towards a disability they have.

6.4.3.1 Salford anti-bullying survey
The Salford anti-bullying survey 2015 was completed by Salford City Council in November 2015 and is the sixth year of completion. Children in Years 5 and 6 at primary school and across school years 7-11 in secondary schools and years 12 and 13 in sixth form were invited to take part. Of the 1,539 responses the main type of bullying seen happening to others was due to a disability or illness in 2% of cases.

6.4.4 Crime – hate
Children with disabilities can be the victims of crimes and are particularly vulnerable to high levels of sexual, physical, verbal and emotional abuse. However, the actual recording of such crimes is low with children or their carers unsure of how to report the crime or feel that they will not be taken seriously.

In Salford there were 10 hate crimes/incidents recorded between 2013 and 2015 to victims aged under 25, this relates to less than 5% of all hate crimes reported in each calendar year. The type of hate crime ranged from harassment; common assault; and public fear, alarm or distress. The recorded data makes some reference to a disability but this does not necessarily mean that the victim of hate crime is disabled.

Summary
Bullying because of a child’s disability or SEN is high. The bullying or fear of bullying spoils experiences of, or stops them accessing, inclusive activities or using local leisure and recreation facilities.
6.5 Educational, training and employment outcomes

6.5.1 Attainment of pupils with special educational needs
Pupils with SEN have learning difficulties or disabilities that make it harder for them to learn than most pupils of the same age.
National curriculum data supplied by the Department for Education at Key stage 2 (Year 6) and Key Stage 4 (Year 11) are available by SEN provision at local authority.
There were significant changes in curriculum content, assessment methods, and the reporting of results from 2016 introducing scaled scores based on raw test marks to enable greater comparability from year to year of students’ progress.
Because of the changes to these assessments these results cannot be easily compared to previous years’ figures. The results are intended to help schools and parents understand pupils’ performance relative to that of the rest of the country, not how pupils have performed relative to the previous cohort.

6.5.1.1 Key stage 2 attainment
Salford shows higher than the national average results at Key Stage 2 in 2016 for all children and all levels of SEN provision. Pupils with SEN have the largest attainment gap when compared to those without any identified SEN. Figure 23 shows that nationally, in 2016, 16% of pupils with SEN Support reached the expected standard in all of reading, writing and mathematics, compared with 62% of pupils with no identified SEN, resulting in an attainment gap of 46 percentage points. In Salford the gap was less at 42 percentage points.

Figure 23: Educational attainment at Key Stage 2, Salford and England, 2016

Pupils with visual impairments were most likely to achieve the expected levels, followed by those with hearing impairments and physical disabilities; less than 1% of those with profound and multiple learning difficulties achieved the standard.  

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6.5.1.2 Key stage 4 attainment

The published data for 2015/16 for KS4 attainment in Maths and English at A*-C has been suppressed due to low numbers attaining this level.

To give an indication of attainment at KS4 with SEN provision the results for 2014/15 are given. Figure 24 shows that nationally, in 2014/15, 23.5% of pupils with SEN Support achieved the standard, 41.1 percentage points lower than those with no SEN (64.6%). This compares to an attainment gap of 44.2 percentage points in 2012/13. The Salford gap between attainment of SEN Support and no SEN is 36.5 percentage points between Salford peers. The gap between no SEN and SEN (Statement) is even higher at 52.6 percentage points.

Figure 24: Educational attainment at Key Stage 4, Salford and England, 2014/15

![Educational attainment chart]

Nationally, less than 1% of pupils with severe learning difficulties achieve the standard at GCSE, those with visual impairments perform the best out of all types of SEN. In 2012/13, 45% of pupils with visual impairments achieved the standard followed by those with hearing impairments (42.7%) and with physical disabilities (33.2%).

Looked after Children with SEN were less likely to achieve the standard at GCSE than other pupils with SEN. In 2012/13, 11.7% of Looked after Children with SEN achieved the standard compared to 23.4% of all pupils with SEN.

6.5.2 School Attendance

Data is collected by the Department for Education around the school attendance and exclusions of children with special educational needs. However, from 2015 the statistical release has been cancelled. The following data and commentary is the most up to date published data.
Nationally, in 2013/14, pupils with a statement of SEN had the highest level of absence due to medical/dental appointments (11.9% of sessions missed). Of those with a type of need recorded in 2013/14, those with Profound and Multiple Learning Difficulties (PMLD) have the highest percentage of sessions absent due to illness (61.7%) and those with a physical disability have the highest percentage of sessions missed due to medical/dental appointments (21.1%)\(^\text{103}\).

In England, boys were less likely to be persistent absentees in 2013/14 than girls. Of those with a statement of SEN who were boys, 10.8% were persistent absentees compared to 11.5% of girls with a statement of SEN.

In Salford for the same time period, the percentage of sessions missed due to overall absence is slightly higher than the England average for all pupils and those with no SEN. Those absences defined as persistent absentees were slightly higher than the England average across all categories other than SEN without a statement. Those who are SEN without a statement are twice as likely to be persistent absentees than those with No SEN. The figure is more than three and a half times higher when comparing to those with a statement as reflected in Table 9\(^\text{104}\).

**Table 9: Persistent absentees by SEN type, Salford and comparators 2013/14**

<table>
<thead>
<tr>
<th></th>
<th>All pupils</th>
<th>No SEN</th>
<th>SEN - No Statement</th>
<th>SEN with a statement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage of sessions missed due to overall absence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>4.5</td>
<td>3.6</td>
<td>4.1</td>
<td>2.6</td>
</tr>
<tr>
<td>North West</td>
<td>4.4</td>
<td>3.6</td>
<td>4.0</td>
<td>2.6</td>
</tr>
<tr>
<td>Salford</td>
<td>4.7</td>
<td>3.8</td>
<td>4.3</td>
<td>2.9</td>
</tr>
<tr>
<td><strong>Percentage defined as persistent absentees</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>3.6</td>
<td>2.6</td>
<td>4.1</td>
<td>6.1</td>
</tr>
<tr>
<td>North West</td>
<td>3.6</td>
<td>2.6</td>
<td>4.0</td>
<td>6.0</td>
</tr>
<tr>
<td>Salford</td>
<td>3.8</td>
<td>2.9</td>
<td>4.3</td>
<td>6.0</td>
</tr>
</tbody>
</table>

### 6.5.3 Exclusions

Nationally, in 2013/14 boys had higher rates of exclusions than girls, of those with a statement of SEN 7.81% of boys received at least one fixed period exclusion compared to 2.7% of girls.

Boys with Behaviour, Emotional and Social Difficulty had the highest rate of exclusions in 2013/14 – 19.2% of pupils with this type of need recorded received at least one fixed period exclusion compared to 1.9% of all pupils.

In England, pupils with SEN were more likely to be excluded due to physical assault against an adult in 2013/14 compared to those without SEN – 19.6% of fixed period exclusions for those with a statement of SEN were for this reason compared to 2.6% of those with no SEN. Of those with a type of need recorded, the highest number of fixed period exclusions was for those with Behaviour, Emotional and Social Difficulty and the largest percentage of these was for persistent disruptive behaviour (27.5%).

In Salford, the proportion of fixed period exclusions as a percentage of the school population was nine times higher for children with a statement and more than five times higher for those with SEN but no statement than those children with no identified SEN.

Table 10 shows the percentage of those receiving at least one fixed term exclusion was lower than the England average across all categories of SEN, all pupils and no identified SEN. Children with a statement in Salford, in 2013/14, were six and a half times more likely to receive at least one fixed term exclusion than those with no identified SEN\(^\text{105}\).
### 6.5.4 Further/higher education

At 19 years of age, 28% of disabled young people do not have a qualification higher than Level 2, compared to only 17% of non-disabled young people in the same age group. For the same age range, 53% of disabled young people do not have a qualification higher than Level 3, compared to 42% of non-disabled young people.\(^\text{106}\)

In 2015/16, of the 573,560 undergraduates entering higher education across the UK, 12.2% were disabled learners (70,115), a proportion which is three times higher than in 2000/01. Figure 25 shows that the majority of those reporting a disability had a specific learning difficulty (43% in 2015 and 35% in 2000/01); the proportion with a mental health condition has quadrupled. \(^\text{107}\) This implies that those with a disability are more supported to continue in education and the types of disability becoming more accurately recorded.

Figure 25: Undergraduates accessing higher education by type of disability, UK, 2000/01 and 2015/16

---

<table>
<thead>
<tr>
<th>SEN - without a statement</th>
<th>SEN - with a statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>All pupils</td>
<td>No SEN</td>
</tr>
<tr>
<td>England</td>
<td>3.50</td>
</tr>
<tr>
<td>North West</td>
<td>3.51</td>
</tr>
<tr>
<td>Salford</td>
<td>2.59</td>
</tr>
</tbody>
</table>
6.5.5 Training – Not in Education, Employment or Training (NEET)
Nationally, at 19 years of age, disabled young people are twice as likely as their non-disabled peers to not be in any form of education, employment or training (NEET), 28% compared to 13%. They are more likely to remain in the long term NEET group for longer than 12 months (15% compared to 8%) and are more likely between the ages of 16 and 19 years to be in the NEET group at least once (33% compared to 24%).  

In December 2016, Salford had the highest proportion of young people aged 16/17 years with SEN in NEET across Greater Manchester at 19.8%, this is three times higher than when compared to 6.5% in England and 8% in the North west. This reflects the situation in the total 16/17 year old cohort where the NEET figure is more than double that of England at 5.7% as reflected in Table 11.

Table 11: Proportion of 16-17 year olds with SEND and in NEET

<table>
<thead>
<tr>
<th></th>
<th>December 2016</th>
<th>All 16-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16-17 yr olds with SEND</td>
<td>% In Learning</td>
</tr>
<tr>
<td>ENGLAND</td>
<td>43,712</td>
<td>86.4%</td>
</tr>
<tr>
<td>NORTH WEST</td>
<td>6,381</td>
<td>86.0%</td>
</tr>
<tr>
<td>Bolton</td>
<td>240</td>
<td>99.5%</td>
</tr>
<tr>
<td>Bury</td>
<td>238</td>
<td>88.8%</td>
</tr>
<tr>
<td>Manchester</td>
<td>451</td>
<td>74.5%</td>
</tr>
<tr>
<td>Oldham</td>
<td>212</td>
<td>83.0%</td>
</tr>
<tr>
<td>Rochdale</td>
<td>226</td>
<td>83.2%</td>
</tr>
<tr>
<td>Salford</td>
<td>252</td>
<td>78.6%</td>
</tr>
<tr>
<td>Stockport</td>
<td>293</td>
<td>87.0%</td>
</tr>
<tr>
<td>Tameside</td>
<td>164</td>
<td>84.1%</td>
</tr>
<tr>
<td>Trafford</td>
<td>247</td>
<td>83.0%</td>
</tr>
<tr>
<td>Wigan</td>
<td>255</td>
<td>81.5%</td>
</tr>
</tbody>
</table>

As at December 2016 there were a total of 397 young people (aged 16-24 years) known to Connexions who fell under a SEND definition – most likely to have come from them holding an EHC Plan (or statement) whilst at school. Table 12 shows that of these young people 62.5% (248 young people) were in some form of Education, Employment or Training, 19.6% (78 young people) were NEET with a further 17.9% (71 young people) with an unknown or other outcome. Unknown outcomes increase with the age of the young person.

Table 12: SEND by age with NEET/EET, December 2016

<table>
<thead>
<tr>
<th>Age</th>
<th>EET</th>
<th>%</th>
<th>NEET</th>
<th>%</th>
<th>Not Known/Other</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>101</td>
<td>77.1%</td>
<td>29</td>
<td>22.1%</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>17</td>
<td>75</td>
<td>82.4%</td>
<td>15</td>
<td>16.5%</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>18</td>
<td>52</td>
<td>74.3%</td>
<td>18</td>
<td>25.7%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>19</td>
<td>16</td>
<td>26.2%</td>
<td>10</td>
<td>16.4%</td>
<td>35</td>
<td>57.4%</td>
</tr>
<tr>
<td>20</td>
<td>2</td>
<td>10.5%</td>
<td>3</td>
<td>15.8%</td>
<td>14</td>
<td>73.7%</td>
</tr>
<tr>
<td>21</td>
<td>1</td>
<td>7.7%</td>
<td>1</td>
<td>7.7%</td>
<td>11</td>
<td>84.6%</td>
</tr>
<tr>
<td>22</td>
<td>1</td>
<td>16.7%</td>
<td>0</td>
<td>0.0%</td>
<td>5</td>
<td>83.3%</td>
</tr>
<tr>
<td>23</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>20.0%</td>
<td>4</td>
<td>80.0%</td>
</tr>
<tr>
<td>24</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>100.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>248</td>
<td>62.5%</td>
<td>78</td>
<td>19.6%</td>
<td>71</td>
<td>17.9%</td>
</tr>
</tbody>
</table>

Of the 248 young people with a SEND definition and aged 16-24 years, 85.1% remained in Education. Table 13 shows the training, employment or internship/apprenticeship destination of the cohort.
Table 13: Destination of those in EET with SEND, December 2016

<table>
<thead>
<tr>
<th>Destination</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apprenticeship</td>
<td>7</td>
<td>2.8%</td>
</tr>
<tr>
<td>Employment</td>
<td>13</td>
<td>5.2%</td>
</tr>
<tr>
<td>Internship</td>
<td>3</td>
<td>1.2%</td>
</tr>
<tr>
<td>Training</td>
<td>14</td>
<td>5.6%</td>
</tr>
<tr>
<td>Education</td>
<td>211</td>
<td>85.1%</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>248</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Summary

At Key Stage 2, 25% of pupils with SEN Support reached the expected standard in all of reading, writing and mathematics, compared with 67% of pupils with no identified SEN, resulting in an attainment gap of 42 percentage points. (2015/16)

The Salford gap between attainment of SEN Support and no SEN is 36.5 percentage points between Salford peers. The gap between no SEN and SEN (Statement) is even higher at 52.6 percentage points. (2014/15)

In Salford, those who are SEN Support are twice as likely to be a persistent absentee than those with No SEN. When comparing to those with a statement/EHC Plan the figure is more than three and a half times higher. (2013/14)

The proportion of fixed period exclusions as a percentage of the school population were nine times higher for children with a statement and more than five times higher for those with SEN but no statement than those children with no identified SEN. (Salford, 2013/14)

In December 2016, Salford had the highest proportion of young people aged 16/17 years in NEET across Greater Manchester at 19.8%, this is three times higher than when compared to 6.5% in England and 8% in the North west. This reflects the situation in the total 16/17 year old cohort where the NEET figure is more than double that of England at 5.7%.
7 Current service provision

7.1 Education Services

There are four special schools in Salford, located in Swinton South, Eccles and Barton. Figure 26 shows the location with ward overlay. The school census in January 2017 collated information about the children attending all schools across the city. Table 14 shows the number of places at each special school split by SEN Support and Statement or EHC plan provision according to the school census. Any children who are resident in Salford but educated by another local authority are not included.

Table 14: Special school provision, Salford, school census 2017

<table>
<thead>
<tr>
<th>DfE No.</th>
<th>School</th>
<th>SEN Support</th>
<th>Statement or EHC Plan</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>7025</td>
<td>Oakwood High School</td>
<td>2</td>
<td>189</td>
<td>192</td>
</tr>
<tr>
<td>7026</td>
<td>Chatsworth High Community Special School</td>
<td>93</td>
<td>93</td>
<td>93</td>
</tr>
<tr>
<td>7027</td>
<td>New Park High School</td>
<td>15</td>
<td>77</td>
<td>92</td>
</tr>
<tr>
<td>7029</td>
<td>Springwood Primary School</td>
<td>12</td>
<td>163</td>
<td>175</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>29</strong></td>
<td><strong>522</strong></td>
<td><strong>552</strong>*</td>
</tr>
</tbody>
</table>

* One pupil awaiting SEN status

Figure 26: Special school provision, Salford

7.1.2 Enhanced Provision

Enhanced provision is provided through special units in main stream schools. An enhanced resource school is one where the local authority has given extra funding to the school so that it can build up expertise and resources in meeting the specific needs of a specific group of children. The level of

All children and young people accessing an enhanced resource provision are likely to require more intensive specialist support to meet their needs and enable them to make good progress and achieve their identified outcomes. They will have an Education Health and Care Plan or have been assessed to be at a high level of SEN support and would benefit from accessing the provision whilst an EHC assessment is undertaken. The placement process will comply with the legal guidance in the SEN Code of Practice (2015)\textsuperscript{112} and is the responsibility of the Local Authority.

Salford has 208 places available with 110 of these available to Key Stage 3 and 4 with the type of provision ranging from Moderate Learning Difficulties, Speech and Language, SEMH, and ASD.

7.1.3 Sensory Impairment Education Team

The Salford education service for children and young people with a sensory impairment/disability consists of two teams of highly skilled, experienced staff. This is a teaching service which supports children and young people with diagnosed hearing, visual or multi-sensory impairments from birth to 19 years (aged 25 years with EHCP).

Table 15: Visual and hearing impaired students supported students - 2016/17

<table>
<thead>
<tr>
<th></th>
<th>Visually impaired</th>
<th>Hearing impaired</th>
<th>Multi-Sensory impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-School (0-3 years)</td>
<td>14</td>
<td>34</td>
<td>1</td>
</tr>
<tr>
<td>Primary school age</td>
<td>87</td>
<td>137</td>
<td>4</td>
</tr>
<tr>
<td>Secondary school age</td>
<td>57</td>
<td>91</td>
<td>4</td>
</tr>
<tr>
<td>Aged 16+ years</td>
<td>41</td>
<td>51</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>199</td>
<td>313</td>
<td>12</td>
</tr>
</tbody>
</table>

Following referral, (usually from health), babies, children and their families are supported and assessed to ascertain the level of need and support required from the Sensory Support Service. After the information finding stage, children and young people are allocated an agreed support level using the National Sensory Impairment Partnership (NATSIP) eligibility criteria\textsuperscript{113} framework to ensure support is allocated fairly and equitably.

Students are scored each subsequent year using the framework, alongside the Salford Support Matrix. Students scoring 40 plus are referred to as the ‘teaching caseload’ whilst students scoring less than 40 are referred to as the ‘monitor caseload’

7.1.3.1 Teaching and monitoring caseload

Teaching caseload

Visual Impairment

The majority of what a child or young person learns occurs through a process of observation and imitation. Even a moderate visual loss places a young person at a distinct educational disadvantage to their peers. As such, specialised and direct instruction is often necessary to develop compensatory skills aimed at reducing this disadvantage. This is often referred to as the Additional (or Expanded) Core Curriculum. It is usually deemed necessary for the children in the ‘teaching’ caseload to develop these skills in order to access the National Curriculum and to develop independence. As Visual Impairment is a Low Incidence Special Educational Need/Disability (LISEND) these skills are outside of the usual expertise of school staff and are therefore delivered by specialist staff.
Hearing Impairment
The same applies to children who are hearing impaired/deaf. Hearing is critical to speech and language development, communication, and learning. Hearing impaired children continue to be an under-identified and underserved population.

The main areas at risk due to permanent childhood deafness are:
- Delays in communication and language acquisition
- Language deficit causing learning problems resulting in lower academic achievement
- Delays in social and emotional development (deaf children are significantly delayed in their development of pragmatics and theory of mind).
- Impact on their vocational choices

The allocated QTVI/HI (Qualified teacher Visual Impairment/hearing impairment) is responsible for planning, coordinating and reviewing the additional curriculum in line with the Assess, Plan, Do, Review cycle.

Monitoring caseload
VI and HI
Students on the monitor caseload are visited between once and six times within an academic year depending on their NATSIP score. With the correct training, advice and adaptations, schools are generally able to meet the needs of this group without direct specialist teaching. Students with a low need are categorised as ‘advice as requested’. This means that the Sensory Education Team would not have any additional input unless requested by school, parents or any other agency. All schools are sent a letter at the start of the academic year to highlight that they have a particular pupil with a sensory impairment.

Mobility Officers teach students how to move around as safely, efficiently and independently as possible. This might be by introducing specialist aids such as a symbol or long cane or by working with students on areas of transportation such as bus routes. Mobility Officers provide environmental advice to schools and may support the development of daily living skills such as cooking or shopping independently.

7.1.3.2 Specific provision for Visually Impaired and Hearing Impaired Early Years
Specific provision for babies and children in the early years includes:
- Support at the point of diagnosis through home and clinic visits
- Monitoring development
- Functional vision assessment
- Multi agency working
- Attendance at Family Service Plan/Team Around the Child meetings
- Specific training for Early Years providers
- Weekly pre-school parent and child support groups
- Direct assessment and teaching
- Advice, support and training for early years settings and agencies
School years

Specific provision for school age students includes:

- Advice on access strategies to support inclusion
- Advice on setting up and use of assistive technology
- Specific training on hearing/visual impairment
- Awareness raising/encouraging high expectations
- Advice on access arrangements for examinations
- Environmental audit (Mobility)
- Acoustic audit
- Functional Vision Assessment and advice
- Learning Media Assessment (when necessary)
- Specialist delivery of the Additional Curriculum
- Signposting/advice and guidance for parents
- Support during transition
- Planning meetings with teachers
- Providing advice for formal assessment
- Contribution to review meetings
- Multi-agency liaison
- Braille club (every two weeks)
- Braille ‘pen pals’
- Visual stimulation group
- Salford Deaf Children Society Youth Club (every half term)

Sensory Enrichment Experiences (SEE)

Experiences are at the core of literacy development but due to reduced access to observational learning, many students with visual impairments lack the conceptual understanding that occurs organically in other children. To address this disadvantage, the SEE project was created based on the research of Koenig & Farrenkopf (1997) which identified 22 global areas of experience essential to create a strong foundation for literacy. Each half term, all students on the teaching caseload are invited on an educational visit based on one of the 22 global areas. This learning is reinforced within school. From 2016-17 the focus has been on transportation and students have experienced steam trains, aeroplanes, tractors, minibuses and methods of travelling in the snow.
7.2  Salford City Council Starting Life Well service

The Starting Life Well service supports parents and childcare providers in Salford.

7.2.1  Early Support Key Workers
These workers support children and their families who have a child aged 0-5 years with complex health and care needs which requires a complex support package of 4 or more professionals. The child’s complex needs must be having a significant impact on the family’s wellbeing.

The types of support offered are –
- Co-ordination of services
- Arranging multi-agency meetings
- Providing information
- Sign posting to appropriate services
- Emotional support around the impact of a child with disabilities on the family
- Transition support

7.2.2  Portage Home Visitors
These workers provide a home visiting service for children in Salford who have a developmental delay (i.e. 6 months or more) in two or more areas of development, or have a condition where the likelihood is that a developmental delay will occur. They support children from birth until they uptake their 3/4 year old funding entitlement. They focus on the development of play, communication, relationships and learning. It is a partnership with parents supporting them to acquire the skills necessary to promote their child’s learning. They work closely with other professionals known to the child to ensure a consistent approach to their learning. For example:
- Support the First Steps Groups at Little Hulton Children Centre and Langworthy Cornerstone. This group is for children with additional needs and their families.
- Liaise with the child’s early years setting and support transitions.
- Deliver training to Early Years Settings – “Positive Approaches to Learning for Children with SEN, Using the Portage Model.”
- They are able to take up the role of Lead Professional for a family.

Within Early Years children will attend a range of settings i.e. private day nurseries, child minders, Local Authority nurseries. From 2 years of age some children will meet the criteria for 15 hours funded childcare and from the age of 3 years all children are entitled to 15 hours funded childcare. From September 2017, 30 hours of free childcare is available to parents of children aged 3 years and over who meet certain eligibility criteria.

The staff within the settings have access to a range of support from Starting Life Well.

7.2.3  Area Special Educational Needs Co-ordinators (SENCO’S)
These workers provide advice and guidance on the development of inclusive early learning environments and how to best support and plan to meet the individual child’s needs.

They facilitate transition for children into compulsory schooling and support settings with the completion of EHCP’s and gathering of evidence to support this. They also support the development and delivery of training.

7.2.4  Starting Life Well Quality Development Advisors
They provide support and advice to individuals regarding setting up new provision. This includes advice and support around assisting children with Special Educational Needs and Disabilities (SEND). Quality Development Advisors will recommend and support the purchase of resources, setting up the environment, staff training and policy and procedures that all need to be in place to support children with SEND.

Starting Life Well organises and offers a range of training for private, voluntary and independent (PVI) providers to support their continual professional development, which includes a section on inclusion. This enables practitioners to access training based on individual children’s needs and ‘up skilling’ the PVI workforce. The range of training includes ASD, ‘Signalong’ and role of the SENCO.

7.2.5 Starting Life Well involvements
In June 2017 the Starting Life Well (Portage team) team had 151 open involvements with children aged under 5 years. Of these more than two thirds were male and of the cases where ethnicity had been obtained almost 30% were from a BME background (15% had no ethnicity record). A fifth of the cases were resident in each of the neighbourhoods of Eccles and Little Hulton & Walkden, and just over 3% of open cases were resident in Worsley neighbourhood.

7.3 Social Care

7.3.1 Referral
Salford City Council and its partners have a multi-agency hub called the Bridge Partnership which provides a single point of entry for requests for early help services and referrals regarding the welfare and safety of children. Social Workers at the Bridge screen all contacts concerning the welfare or safety of a child to children’s services. All enquiries concerning the welfare or safety of a child must go through the Bridge Partnership. An initial contact is progressed to a referral where the social worker or manager considers an assessment and/or services that may be required for a Child in Need. The Duty and Assessment Team provides a single point of entry for all referrals that are received on all children and young people. If the child has a significant disability this referral will be sent directly to the Children with Disability Team who will consider an assessment.

7.3.2 Family Assessment process
The family assessment is an asset based assessment that is completed with children/young people and their family’s when a more holistic picture is needed to identify the family’s strengths and needs. It is used as an early help assessment at level 2 – ‘targeted and co-ordinated early help’ within Salford’s Thresholds of Need and Response\textsuperscript{114}. It helps to identify in the early stages the family’s strengths and any additional needs they might have. It works in a solution focussed way, focussing on the assets the family have in order to empower the family in making change. Often a multi-agency team can support the family too and this is called a ‘Team Around the Family’ meeting. The family assessment can be initiated by any practitioner working with a family and consent from the family has to be given in order to complete it. There is a scoring part to the assessment where each family member being assessed scores themselves in 16 areas saying how confident they feel in managing the identified need, and what strengths they might have in this area too.

The data on any SEN or disability a child may have is not collected systematically and does not form part of the Family Assessment process.
7.3.3 Children and Families Assessment (CAFAS)
The Children and Families Assessment replaces the previous initial assessment and core assessment within the children and young person’s assessment framework, and incorporates the initial Child Protection Social Worker’s report for Case Conference. The Children and Families Assessment provides an opportunity for social workers to focus on the specific needs of the child/young person and allows appropriate time within the assessment for reflection and direct work with the child/young person to ensure a robust and analytical assessment.

There were 233 referrals assigned to the Children with Disabilities (CWD) team during 2015/16. Of these 131 (56.2%) led to a Children and Families Assessment (CAFAS). Of the 131 cases that had a CAFAS, 59 closed after the assessment and 72 led to further action, with 63 of these going on to Child in Need status and the remaining 9 leading to a Child Protection Plan.

7.3.4 Social care team
The CWD social care team offer support services to children and families within Salford. The criteria is the more serious continuum of disabled and sick children with a caseload of over 200 children at any one time, made up of short-term, long term and Looked After children. Children can be supported by the Team until they are 18 years old.

As at January 2017 there were 222 children on the caseload of the CWD social care team. 70% of these were aged 6-16 years, 26.6% aged 0-5 years and just over 3% aged 17-25 years. The data available split the children into localities within Salford, there was an even split between south and central localities of 32% and 35% respectively, with the remaining proportions of 22% in West locality and 11% in the North.

7.4 Short breaks
Section 25 of the Children and Young Persons Act 2005 requires local authorities to provide short breaks for disabled children. The regulations relating to this duty, which came into force on 1st April 2011, require each local authority to produce a Short Break Services Statement, so that families know what services are available, the eligibility criteria for these services, and how the range of services is designed to meet the needs of families with disabled children in the area. Short breaks can give families a rest from caring and give children and young people the chance to meet other people and have fun in a safe, friendly environment.

There are a number of services that Salford City Council commissions to meet the requirements of the Short Breaks Duty.

7.4.1 Groups
There were six organisations commissioned to deliver groups and activities for disabled children up to 31st March 2017
- Autistic Society of Greater Manchester Area
- Chatsworth High School
- Core Assets
- Federation of Jewish Services
- Salford Community Leisure
- You Can Youth Group
The total number of children on registers for short break care (groups) in 2016/17 is 487, consisting of 327 males and 160 females. The young people may attend more than once with more than one provider, resulting in more than 200 children and young people attending group sessions in each quarter.

Table 16: Children and young people attending short break care (groups), Salford 2016/17

<table>
<thead>
<tr>
<th>Attendees to short break care (groups)</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendees to short break care (groups)</td>
<td>241</td>
<td>234</td>
<td>210</td>
<td>210</td>
</tr>
</tbody>
</table>

Of those attending, more than 80% were aged 8 years and over with a gender split of males to females of 2:1. Almost 85% of those attending were ‘White British’ or ‘White Irish’ with 5% from ‘Black – African, other Black or Black British’ and a further 1.5% from ‘Asian – Pakistani or any other Asian background’. Some providers have also included Jewish within the ethnicity classifications, with a further 3% of attendees stating this. However, some people from the Jewish community would describe themselves as White British and religion as Jewish so this may be an under-representation.

Of these individuals there is a mixed distribution across Salford by ward. Almost four times as many individuals from Winton and Broughton attended short break group services compared to Cadishead, Ordsall and Pendlebury; this pattern has been the same for some time.

All these organisations have been re-commissioned under a new contract, effective from 1st April 2017. The new contract also includes a new provider Special Spirits, to provide services for children aged over 11 years from the Orthodox Jewish Community.

These organisations provide a range of services, details of which can be found on Salford’s Local Offer pages. The eligibility criteria for short break care services for disabled children in Salford has recently been updated. Further detail around the levels of short break care and the local offer can be found at  https://www.salford.gov.uk/children-and-families/local-offer-for-children-and-young-people-with-sen-or-disabilities/

Some parents have suggested the cost of activities as well as distance can prohibit their use and parents cannot commit to attending on a regular basis due to the child’s health.

With this in mind, a contract has been set up with Salford CVS for the delivery of a small grants pilot. The purpose is to encourage new or existing providers to deliver local community based activities for disabled children. If successful, the range and accessibility of local activities will increase.
7.4.2 Domiciliary Care
There is a Framework Agreement for the provision of domiciliary care for disabled children.
Services provided under this agreement include care in the child’s home, or one to one support
taking a child on community activities.
As of 31st March 2017 there were four providers operating under this agreement:

- Crossroads
- Fairfield Care
- Federation of Jewish Services
- Reed Care

There were 52 children provided for at the end of 2016/17, more than one third of these were from
a BME background with males outnumbering females by 2:1. The majority of children who use these
services have autism and associated learning disabilities and behaviour that is challenging. There is a
smaller number with complex physical disability such as cerebral palsy. There are three children on
support packages that are jointly funded by health (CCG). Access to these services is on the basis of
a social worker assessment and agreement by the Children with Disabilities Resource Panel.

There have been an increasing number of challenges to brokering services under the framework, the
main one being the difficulties for providers in recruiting staff. In addition, the high demand for
services at the weekend and during school holidays, is proving difficult for providers to deliver.

The Framework expired on 30th September 2017 and plans for alternative commissioning
arrangements are being developed.

7.4.3 Overnight Residential Short Breaks
There is no local provision for overnight residential short breaks for children aged under 14 years if
fostering is not an option.

Where this is required, it is spot purchased from external providers. There are currently seven
children in receipt of overnight short break care from external providers.
Again, the driver for requests for overnight residential care is autism, learning disabilities and
behaviour that is challenging.

Granville (ASPIRE): There has been a block contract in place with Aspire since 1st April 2013,
whereby Children’s Services purchases 695 bed nights a year from the Granville Short Breaks Unit.
This service is for children aged over 14 years. There are currently 10 children using this service, to a
total of 347 nights a year. This is approximately 50% occupancy for the contract (based on average
maximum use of 58 beds per month).

The service has been under used for the duration of the contract, indicating that there was an over
estimation of the projected take up/ number of nights of provision required.
7.5 Health

7.5.1 Children’s Community Nursing Team (CCNT)

Following the publication of the Department of Health National Framework for Children and Young People’s Continuing Care in January 2016, Salford CCG has worked with partners to develop a local pathway to enable decisions around continuing care to be made in a swift and efficient manner. A continuing care package will be required when a child or young person has needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone. As part of this process a role was identified within the CCNT to support co-ordination of the assessment process. In addition, the CCG made a strategic decision to ensure that as much of the care as possible delivered to children and young people (CYP) with continuing care needs was delivered by NHS staff. Therefore work is taking place to move towards SRFT provision of continuing care packages to CYP with continuing care needs. This will ensure a seamless assessment process and ensure that the service is responsive to the needs of CYP with continuing care needs.

The Salford CCNT will include the following elements of nursing care to Salford CYP and their families, however, these must not be seen as disparate nursing teams, rather groups of staff brought together to achieve the flexibility to adapt the service when children move from one group to another, and to meet the changing needs at times of crisis, deterioration or end-of-life.

 Unscheduled Care - this is a short term intervention of acute care at home or in a clinic setting to either prevent a hospital attendance or facilitate early discharge.

 Children with long-term conditions, disabilities, complex conditions, life limiting and life threatening illnesses, including palliative care – provide nursing input to this cohort of children and young people.

 Learning Disability - this is a specialist team providing behavioural assessment with recommended individual behavioural interventions for families of CYP with severe learning disabilities and challenging behaviour.

 Special school nursing - to provide healthy child programme, nursing advice, professional liaison, assessment, care planning, health care training for school staff, contribution to EHC plans and statutory health professional for CIN and child protection.

 Asthma and Epilepsy Nurses - specialist nurses to educate and empower children and their families to manage these conditions at home and at school and to ensure that children with these conditions have co-ordinated, consistent and standardised care across primary and secondary care.

 The team will work as an integrated, multidisciplinary and multiagency team around the child ensuring the child / young person’s needs are managed in a holistic manner. The team will empower CYP to lead independent lives, working in partnership with families, carers, education, social care and other health professionals working around the child.
### 7.6 Child and Adolescent Mental Health Services (CAMHS)

The Specialist CAMHS Learning Disability (LD) team is provided by Central Manchester Foundation Trust (CMFT) from Salford CAMHS at the Pendleton Gateway Centre. The service ensures that the mental health needs of children and young people with severe Learning Disabilities and/or autism are identified, assessed and treated. The service works closely with professionals from other agencies to support children, young people and their families. The service works particularly closely with professionals and services provided by Salford Royal Foundation Trust.

The Specialist CAMHS LD team provides assessments and interventions for children and young people with additional needs; particularly those with learning disabilities and or autism. The service sees children and young people for the assessment and diagnosis of developmental delay, autistic spectrum conditions and other conditions such as attention deficit hyperactivity disorder, anxiety, depression etc. Children and young people seen within the service are offered individualised assessments utilizing a wide range of assessment measures and evidence-based research-informed interventions are offered thereafter. Interventions might be in the form of the provision of information, pharmacological management, individual child or parental psychological support or group based interventions. Interventions are also offered alongside other professionals from health, education and social care.

At the time of referral children and young people may be presenting with ‘challenging behaviour’ such as aggressive, disruptive and destructive behaviour. They may also be presenting with eating and feeding difficulties and sleep problems, which impact upon their own well-being and that of their parents, carers and wider family system.

The parents and carers of the children referred may be presenting with difficulties adjusting to and coping with their child’s disability, difficulties or chronic illness. They may benefit from an opportunity to reflect upon how their child’s disability impacts upon themselves, family members and the wider system and at times parents and carers may need additional support from other services such as Adult Mental Health and liaison with these services is important. The service seeks to provide responsive and timely home and clinic-based advice and support to parents and carers’ and works collaboratively with other professionals involved in children’s lives.


Summary findings from the document indicate the referrals, open cases, and new appointments for the Learning Disabilities part of CAMHS have all reduced from 2014/15 – 2016/17, alongside the reduction the proportions of ‘did not attend’ have increased. The range of children attending for the Learning Disability service, in 2016/17, were aged under 16 years with the majority (55%) aged under 5 years and only 10% from ages 11-16 years. Of the young people seen at the CAMHS LD service, males outnumbered females by nearly 4:1, almost half (48.6%) had a ‘White British’ ethnicity and 15.3% BME, however; a further 36.2% did not state their ethnicity or it was ‘not known’. The majority of all appointments (40%) were for ASD.

The CAMHS service overall saw 1,325 individuals attending in 2016/17, the majority (59%) with ADHD/Hyperkinetic Disorder and 36% for ASD.
7.7 Occupational Therapy

7.7.1 Wheelchair and Special Seating Provision – Waits for wheelchairs
Salford Disability Services will assess a person with a permanent mobility problem and provide equipment to meet assessed clinical need. The service will accept referrals from any source, for example: a person living with a disability, a carer, family member, or any health or social care professional.

All people referred to the service will be issued with equipment, or wheelchairs will be provided through the Salford Wheelchair Service, if the following guidelines are met:
1. The person with a disability is a permanent resident of Salford or registered with a Salford GP
2. Mobility must be permanently restricted
3. The wheelchair is required for longer than six months
4. The person has severely limited mobility and needs a wheelchair for indoor and outdoor use.

Clinics including the ‘Wait for Wheelchairs’ process are held in all Salford Special schools once a month, therefore children attending one of these schools would wait for a maximum of one month to be seen. Bespoke equipment is usually provided to the child at the next clinic (i.e. within 4 weeks).

As at February 2017 there were 40 children and young people aged 0-25 years with a classification of wheelchair attached to their CareFirst record. The CareFirst system is a large service user and information management system internal to Salford City Council and is in use across three service groups: Community, Health and Social Care, Children’s Services and Environment and Community Safety.

7.8 Transport

The Education Act 1996 sets out the statutory requirements that all councils must comply with. The local authority has a duty to make such travel arrangements as they consider necessary to facilitate attendance at school for ‘eligible children’. An ‘eligible child’ must live within the Salford boundary and be of compulsory school age. Salford local authority exercises its discretionary duty in relation to those children below statutory school age in cases where transport is required to allow them to attend a provision outlined in their Statement of SEN or EHCP (i.e. nursery and reception age children under 5 years who are required to attend at Springwood or other specialist provision).

Transport assistance will be provided for such children if they are attending their nearest qualifying school within statutory walking distance, if they could not be reasonably expected to walk to school because of the nature of their SEN, disability or mobility problem (including temporary medical conditions). Where a child is considered eligible for free transport, a number of travel solutions will be considered.

In January 2017, 760 children received transport to and from school. The majority of these were to a school (special or mainstream) within Salford but 135 children (18%) were transported to specialist schooling outside of Salford. There is a spread of children who have transport provided by Salford city council across the city. There are higher densities of those requiring transport from the more deprived areas, however, this does not account for siblings within the same family both requiring transport.
7.9 Transition

Support received by young people with SEN and/or disabilities at transition helps them make decisions and develop to achieve their aspirations. This may be in terms of education, preparing for and getting work, living arrangements and support for hobbies, interests and a social life. Salford’s local offer describes, in further detail, the facilities and options available [https://www.salford.gov.uk/children-and-families/local-offer-for-children-and-young-people-with-sen-or-disabilities/preparing-for-adult-life/](https://www.salford.gov.uk/children-and-families/local-offer-for-children-and-young-people-with-sen-or-disabilities/preparing-for-adult-life/)

Young people requiring support at transition are often coming through the system late (post age 16 years) so are not receiving the services available to them in a timely manner. The cases are generally extremely complex, requiring accommodation and support. Late support at transition will add to the stress, impact on emotional health and will be more costly long term. Anecdotal evidence suggests that this could be because the young people are not known to Children’s Services or that staff are not referring young people correctly. The reasoning behind late referral to transition should be investigated further.

In 2016/17 and 2017/18 of the 46 cases supported at transition, 21 had been previously Looked After and required accommodation and support. Cases were complex with additional health needs, for example mental health, autism and learning disabilities.

7.10 Leisure

The sessions within the local offer are not the full range of activities offered for this target group by Salford Community Leisure (SCL). There are other organisations that use the facilities to run their own sessions, specifically for young people with disabilities. Additionally, the following activities are available:

- School swimming lessons in all six swimming pools (attended by children of all abilities – and accompanied by additional teaching staff where appropriate)
- Sure Start sessions – run by the Children’s Centres – that also provide for all abilities
- Wheels For All. As well as the Saturday Short Breaks session they provide sessions on a Wednesday and Friday for users of all ages
- Chatsworth High School has a hydro pool that SCL staff use so that young adults from the Waterside student village can attend / swim. This is a weekly session.
- Holiday activities: All sessions are inclusive and all ages and abilities are encouraged. If a child requires additional support (extreme medical needs) it is asked that a parent / carer attends alongside the child. This has been positively received.

However, there are issues with group based sessions as defined below:

Hydro-pools: Very popular and huge need, but there are only two in the City (Springwood School and Chatsworth High). Springwood is managed by the school and spaces are full and booked in advance. Chatsworth High is a BSF (Building Schools for the Future) facility, therefore the management is completely different to primary schools. The hire costs are quite expensive and there is also a need to provide qualified lifeguards. A working group has been set up to look at how this hydro-pool can be used more by the general public, possibly linking with the hospital to assist in extending provision as demand is high.
Children’s Activity Session: Following consultation with parents set up on a Sunday afternoon (18 months ago) at Irlam & Cadishead Leisure Centre. The session stopped after four months due to poor attendances. Mostly only two children attended, often only one (this was the child of the staff member that was taking the session). Feedback was that the session was great but parents couldn’t commit to attending on a regular basis due to the child’s health and other children’s activities.

### 7.11 Employment

Connexions is the main service the LA provides to support young people to engage in education, employment and training (EET). This is commissioned to an organisation called Career Connect and targeted towards 16 to 24 year olds who are not in education, employment or training (NEET), or who are vulnerable to becoming NEET. As part of this offer, they provide some targeted support to young people with SEND if NEET. Young people who have SEND and are in EET would be expected to access support from their school or college.

In addition to this, a Supported Internship programme is funded, which is hosted by Salford Royal and delivered by Salford City College and Pure Innovations. The programme supports ten young people with SEND to undertake high quality work experience placements within a supported employment environment. Each year, over half of the interns progress to paid employment upon completion of the programme.

Traineeship programmes are also offered to young people with low level SEND through the Salford Futures initiative. These include work experience placements with local authority teams and services, with over half of the participants usually progressing into paid work or an apprenticeship upon completion.

### 7.12 Carers Personal budgets

A Carers Personal Budget is a form of Direct Payment, but due to the fact that there are limits to what is payable, and a policy which covers exactly what can be purchased, they are commonly known as Carers Personal Budgets. This is common terminology across Greater Manchester.

It is a sum of money paid by a council’s Adult Social Care department to help a carer to pay for things which will help them in their caring role. It allows a carer to have more control over how they are supported. The carer must first be assessed by a social worker to obtain the budget, there are three levels of awards based on the need of the carers.

From 19th May 2016 (when the 2016/17 Carers Personal Budget scheme opened) to 31st December 2016, 89 Carers Personal Budgets were awarded to the carers of children (up to age 18 years).

- Two carers banded as ‘Low’ and awarded up to £150.00
- 41 carers banded as ‘Medium’ and awarded up to £300.00
- 46 carers banded as ‘High’ and awarded up to £450.00

There is a higher concentration of carers living in Winton, Walkden North, Kersal, Eccles and Irlam, with a lower concentration in Barton, Boothstown & Ellenbrook, Claremont, Swinton South and Walkden South. However, the proportion is of the total of carers’ budgets not a proportion of need in each ward.
Summary – services provided

Special school places. 552 children attended one of the special schools located within Salford. There are a further 208 places available at mainstream schools offering an enhanced provision.

Sensory Impairment Team. Work with 199 visually impaired children and young people and 313 hearing impaired, of these 12 have multi-sensory impairments.

Starting Life Well. In June 2017 the Starting Life Well team (Portage team) had 151 open involvements with children aged under 5 years. Of these more than two thirds were male and of the cases where ethnicity had been obtained almost 30% were from a BME background (15% had no ethnicity record). A fifth of the cases were resident in each of the neighbourhoods of Eccles and Little Hulton & Walkden, and just over 3% of open cases were resident in Worsley neighbourhood.

Family assessment. This is an asset based assessment and helps to identify in the early stages the family’s strengths and any support they might need. However, data on any SEN or disability a child may have is not recorded.

Short breaks. The male:female ratio of attendees for short break care follows national and local prevalence of more boys presenting with disabilities than females.

Although the numbers are small, there is a disproportionately high number of young people attending short break sessions from BME backgrounds, particularly of ‘Black’ origin. Jewish, although not a BME classification shows a higher proportion of attendees at short break care. This will be due to specific services being commissioned for this group.

A higher proportion of individuals attend SBC from Winton and Broughton, this follows the same pattern for DLA claimants and students with SEN support. Broughton and Winton is significantly higher for SEN support than the Salford average and parts of Broughton show a significantly higher rate of DLA claimants than the Salford average in August 2016.

CAMHS. The majority of children attending the CAMHS LD service were aged under 16 years, were male and of a ‘white’ ethnicity. Across both the CAMHS LD service and the overall service around 40% were attending because of ASD.

CCNT. The children’s community nursing team have undergone a service re-specification from April 2017.

Social care team. As at January 2017 there were 222 children on the caseload of the CWD social care team. 70% of these were aged 6-16 years, 26.6% aged 0-5 years and just over 3% aged 17-25 years. The data available split the children into localities within Salford, there was an even split between south and central localities of 32% and 35% respectively, with the remaining proportions of 22% in West locality and 11% in the North.

Transport. In January 2017, 760 children received transport to and from school. The majority of these were to a school (special or mainstream) within Salford but 135 children (18%) were transported to specialist schooling outside of Salford. There is a spread of children who have transport provided by Salford city council across the city. There are higher densities of those requiring transport from the more deprived areas, however, this does not account for siblings within the same family both requiring transport.
Summary – Service issues

To assess whether the service provision is adequate across Salford and whether there are any gaps in provision is difficult as there is no definitive population as described in section 5. A full and audited register would be required for an accurate measure of both the population at local level and to track any gaps in services.

Service thresholds are different and therefore individuals may qualify for certain services and not for others e.g. they may be included in the SEN prevalence figures but do not qualify for short break care.

Individual need varies so widely that an individual may require many services or only one or two. Therefore whether individuals access services is not necessarily the best way to evaluate any gaps as the needs of CWD is very varied, and covers many aspects of disabilities and LD with service provision quite different for each. To formulate a gap analysis taking into account such variations is difficult and possibly not accurate for the services as a whole.

The data provided from services shows that the attendees are not particularly biased towards any BME background, gender or location and generally follows the patterns of prevalence discussed in section 5. However, data quality needs to be improved and audited on a regular basis to fully understand the demographics of all children with disabilities.

Short breaks. Salford provides a range of short break care for all ages but is working to develop more provision for under eights. There is a need to travel to access provision, which can be a barrier to its take up. During 2017 a small grants scheme has increased the amount of provision in different parts of the city to address this.

Overnight residential short breaks for children aged over 14 years are via a contract with Granville (ASPIRE). However, the service has been under used for the duration of the contract, indicating that there was an over estimation of the projected take up/ number of nights of provision required.

Leisure. Some parents have suggested the cost of activities as well as distance can prohibit their use and parents cannot commit to attending on a regular basis due to the child’s health.

Transition. Although a significant amount of work has been done in relation to transition there is still a small cohort of young people being referred late to transition. These young people often have not been known to Children’s Services. This affects their health and wellbeing as well as adversely impacting on cost. Cases supported by transition are complex with almost half previously being a looked after child.
8 Conclusions

The national picture indicates that more children and young people with profound disabilities and long-term conditions are living longer and surviving into adulthood. Many of these children and young people have complex needs that require support from a range of professionals from diverse disciplines in order to achieve their potential. Transition to adult services can be particularly challenging for these children and young people.

Some of this group of children and young people require daily support as their health is dependent on interventions such as tracheotomies, enteral (tube) feeding, parenteral (intravenous) feeding, home oxygen therapy, indwelling venous devices, overnight oxygen saturation monitoring and/or ventilation. Most of this support is provided on a daily basis by parents/carers and, for many, caring responsibilities place pressure on relationships and wider family life. Providing ‘short breaks’ for children and young people can help to ease this pressure.

Advances in medicine have led to increased survival rates for pre-term infants and those born with congenital impairments, and improved the prognosis for children with chronic diseases and cancer. These advances, combined with a shift to caring for disabled and sick children in their own homes has meant that a small but growing group of children with complex and continuing health care needs are now being cared for at home. Many of these children and young people have complex needs that require support from a range of professionals from diverse disciplines in order to achieve their potential. The numbers maybe small, but they constitute a significant claim on resources - physical, emotional and financial. Equally, there is an increasing recognition of the prevalence of ADHD and Autism and disabling problems with coordination and motor planning. Given these factors, it is easy to see how demand for child disability services has exploded in the last decade.

Disabled children and young people have many of the ‘universal needs’ of their non-disabled peers, including advice on healthy eating, support to remain emotionally healthy and access to contraception and sexual health information and services. In addition to this group, there are many more children and young people who have additional learning needs that can affect how they are able to access universal services such as GPs, health visitors and school nurses.

Disabled children have a vast and complex array of need to be met by a variety of services. They stand to benefit from joined up approaches to joint commissioning and planning.

Providing parenting support early on around behaviour and sleep might reduce the number of referrals to CAMHS. Early support for disabled children can reduce costs of additional support later on once they attend school.

There is a lack of current local information on the numbers of children and young people with disabilities and long-term conditions. This combined with the difficulties in accurately estimating the population of disabled children and young people makes identifying specific gaps, assessing full levels of unmet need and the subsequent interpretation challenging.

Data is not always available but where it is routine sharing protocols and data analysis for the benefit of service users is not completed. These result in children and families having to repeat their story too often, and continued silo working practices among professionals.

There are a substantial number of services which offer support and interventions to children and young people with varying levels of disabilities and/or SEN. There seems however often to be a lack of coordination of these services and interventions for families as services and teams often work
very separately from each other. It is difficult to navigate around the different services. This with the added pressures of caring for a disabled child causes extra stress for the families concerned. This observation has led to the 0-25 Transformation Test case for Children with a disability to increase coordination, reduce duplication and work towards an ever increasing integrated way of working where this increases effectiveness and efficiency.

In recognition of the inequalities and needs identified, the following recommendations have been formulated. These should be considered by commissioners and providers of services in Salford with the aim of improving the wellbeing and health outcomes of the disabled children and young people of the city.
9 Recommendations

The recommendations should be used to inform the development of Salford’s Children with Disabilities Transformation Project.

1) Greater emphasis on preparing young people for adulthood including,
   a. managing transition,
   b. improved and greater availability of travel training
   c. earlier targeted work on preparing for independence.

2) When designing, commissioning and delivering services for SEND there is a need to;
   a. ensure they meet the needs of all children and young people irrespective of cultural
      or ethnic background
   b. ensure that the higher proportion of males to females is considered
   c. ensure demographics of the population are considered

3) Looked After Children with SEN need to access appropriate services.
   a. Strong working relationship between the Virtual school and the SEN team.

4) Ensure the plans for future housing and accommodation meet the needs of families with a
   child or young person with SEND and those young people moving into adulthood who want
   to live independently.

5) Ensure the voice of the child and parents and carers are central to everything we do.

6) Ensure all systems and processes for assessing and meeting need are as fit for purpose for
   Children and Young People with a late diagnosis as those diagnosed in infancy.

7) The significant numbers of children and young people with a speech, language or
   communication need necessitate a requirement for all staff to have a good understanding of
   how to meet their needs.

8) Further investigation is required into attendance rates and exclusions to ensure adequate
   interventions are in place.

9) Ensure the anti-bullying strategy specifically addresses the high incidence for children and
   young people with a disability.

10) Ensure parents are supported in navigating and understanding the systems and pathways to
    accessing services.

11) Design systems and pathways that simplify assessment and access to services and ensure
    parents only need to tell their story once.

12) Develop an agreed definition of disability across all services, including health, social care and
    education.

13) Further investigation into the primary coding of autism in SEN published reports to establish
    the reasoning behind the low reported figures.

14) Future needs assessments to include information on children and young people with a
    disability.

15) Effectiveness of services and delivery to be monitored rigorously through agreed
    performance indicators.
# Glossary of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<tr>
<td>APDG</td>
<td>Autism Post Diagnostic Groups</td>
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<tr>
<td>ASD</td>
<td>Autistic Spectrum Disorders</td>
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<tr>
<td>ASGMA</td>
<td>Autistic Society, Greater Manchester Area</td>
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<tr>
<td>BSF</td>
<td>Building Schools for the Future</td>
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<tr>
<td>CAF</td>
<td>Common Assessment Framework</td>
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<tr>
<td>CAFASS</td>
<td>Children and Families Assessment</td>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<tr>
<td>CCNT</td>
<td>Children's Community Nursing Team</td>
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<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
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<tr>
<td>CIN</td>
<td>Children in Need</td>
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<tr>
<td>CMFT</td>
<td>Central Manchester University Hospitals NHS Foundation Trust</td>
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<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
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<tr>
<td>CVD</td>
<td>Cardio-vascular disease</td>
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<tr>
<td>CVS</td>
<td>Community and Voluntary Services</td>
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<tr>
<td>CWD</td>
<td>Children with Disabilities</td>
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<tr>
<td>DCD</td>
<td>Development Coordination disorders</td>
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<tr>
<td>DDA</td>
<td>Disability Discrimination Act</td>
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<tr>
<td>DFE</td>
<td>Department for Education</td>
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<tr>
<td>DLA</td>
<td>Disability Living Allowance</td>
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<tr>
<td>DLD</td>
<td>Development language disorder</td>
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<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>DWP</td>
<td>Department for Work and Pensions</td>
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<tr>
<td>EA</td>
<td>Equalities Act</td>
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<tr>
<td>EHCP</td>
<td>Education Health and Care Plan</td>
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<tr>
<td>EYFSP</td>
<td>Early Years Foundation Stage Profile</td>
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<tr>
<td>FAS</td>
<td>Foetal Alcohol Syndrome</td>
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<tr>
<td>GHS</td>
<td>General household Survey</td>
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<tr>
<td>GLS</td>
<td>General Lifestyle Survey</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>HI</td>
<td>Hearing Impairment</td>
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<tr>
<td>IMD</td>
<td>Index of Multiple Deprivation</td>
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<tr>
<td>LA</td>
<td>Local authority</td>
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<tr>
<td>LD</td>
<td>Learning Difficulty</td>
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<tr>
<td>LDA</td>
<td>Learning Difficulty Assessment</td>
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<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bi-sexual and Transgender</td>
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<tr>
<td>LISEND</td>
<td>Low Incidence Special Educational Need/disability</td>
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<tr>
<td>LSOA</td>
<td>Lower Super output Area</td>
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<tr>
<td>MLD</td>
<td>Moderate Learning Difficulties</td>
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<td>MSI</td>
<td>Multi-Sensory Impairment</td>
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<td>MSOA</td>
<td>Middle Super Output Area</td>
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<tr>
<td>NATSIP</td>
<td>National Sensory Impairment Partnership</td>
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<tr>
<td>NEET</td>
<td>Not in education, employment or training</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<tr>
<td>ONS</td>
<td>Office for National Statistics</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>PbR</td>
<td>Payment by Results</td>
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<tr>
<td>PHOF</td>
<td>Public Health Outcomes Framework</td>
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<tr>
<td>PMLD</td>
<td>Profound and multiple learning difficulties</td>
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<td>PRU</td>
<td>Pupil Referral Unit</td>
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<tr>
<td>PVI</td>
<td>Private, Voluntary and Independent (childcare) settings</td>
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<tr>
<td>QTVI/HI</td>
<td>Qualified teacher visual impairment/hearing impairment</td>
</tr>
<tr>
<td>RNIB</td>
<td>Royal National Institute of Blind People</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>SBC</td>
<td>Short Break Care</td>
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<td>SCL</td>
<td>Salford Community Leisure</td>
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<td>SEE</td>
<td>Sensory Enrichment Experience</td>
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<td>SEMH</td>
<td>Social Emotional and Mental Health</td>
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<td>SEN</td>
<td>Special Educational Needs</td>
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<td>SENCO</td>
<td>Special Educational Needs Co-ordinator</td>
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<tr>
<td>SEND</td>
<td>Special Educational Needs and Disability</td>
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<tr>
<td>SLCN</td>
<td>Speech, Language and Communication Needs</td>
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<tr>
<td>SRFT</td>
<td>Salford Royal Foundation Trust</td>
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<tr>
<td>VI</td>
<td>Visual Impairment</td>
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<tr>
<td>WTE</td>
<td>Whole Time Equivalent</td>
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