HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Autism and ADHD Diagnostic Pathways for Children and Young People, HC 1090

Wednesday 25 June 2025

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Watch the meeting

Members present: Paulette Hamilton (Chair); Danny Beales; Ben Coleman; Jen Craft; Josh Fenton-Glynn; Andrew George; Alex McIntyre; Joe Robertson; Gregory Stafford.

Education Committee Member present: Helen Hayes.

Questions 1 - 85

Witnesses

I: Anna Collishaw-Nikodemus, Head of Policy, Voice and Influencing, Kids; Jolanta Lasota, Chief Executive, Ambitious About Autism; and Henry Shelford, Chief Executive, ADHD UK.

II: Hayden Ginns, Assistant Director for Children, Portsmouth City Council and Portsmouth ICB; Professor Jonathan Green, Professor of Child and Adolescent Psychiatry, University of Manchester; Professor Mark Mon-Williams, Chair in Cognitive Psychology, University of Leeds; and Professor Anita Thapar, Chair, ADHD Taskforce.

Examination of witnesses

Witnesses: Anna Collishaw-Nikodemus, Jolanta Lasota and Henry Shelford.

Q1 **Chair:** Welcome to today's one-off session of the Health and Social Care Committee looking at autism and ADHD diagnostic pathways for children and young people. I am pleased to say that we will be joined today by Helen Hayes, the Chair of the Education Committee.

Ahead of the session, the Committee partnered with the Ambitious About Autism Youth Network to hear from young people about their experience waiting for, and getting, a diagnosis. You can see some of the responses we received on our media account. Please try to have a look; it is absolutely excellent.

I ask our first panel to introduce themselves, please.

Anna Collishaw-Nikodemus: I am Anna Collishaw-Nikodemus. I am the head of policy, voice and influence at Kids.

Henry Shelford: My name is Henry Shelford. I am the CEO and co-founder of ADHD UK, and I have ADHD.

Jolanta Lasota: I am Jolanta Lasota. I am chief executive of Ambitious About Autism. I also chair the Autism Alliance, which is a national body supporting charities working in the autism sphere. I am the mother of a 20-year-old autistic man.

Chair: Thank you. We will go straight to questioning. I will hand over to Andrew.

Q2 **Andrew George:** First of all, I want to get some ground understanding of the extent of the need and the changes in our understanding over the last 20 or so years. The Children's Commissioner has indicated that there are "huge gaps" in our understanding and in the statistics available to properly appreciate the extent of need, in both ADHD and autism. Jolanta and Henry, in terms of properly understanding, why have the statistics changed so much in recent years and why is the Children's Commissioner still saying that in spite of that there are huge gaps in our understanding and knowledge of the extent of diagnosis?

Jolanta Lasota: First of all, we have seen a very significant growth in the number of children diagnosed with autism. There were 100,000 in 2015-16 and over 235,000 in 2023-24. That is significant growth. It is a good question. Why are we seeing that growth? It is a complex answer.

First of all, we have better awareness of autism and less stigma about autism. Perhaps people are more willing to come forward to get their child diagnosed. We have better clinical practice and better understanding of groups like girls and women, but we also have to think about environmental factors and whether our school system is serving children with special educational needs well, and whether there is not perhaps an

escalation into diagnosis because some children's needs could have been met without the diagnosis. We have to ask ourselves that question.

It is not the only answer. There are lots of factors. We have had discussions about whether we have over-diagnosis, but the research shows us that we have under-diagnosis in large parts of the population such as older people, women and girls, people from minoritised ethnic groups and people with psychiatric conditions. We actually have under-diagnosis. The estimate is that there could be up to 1.2 million people in the UK who are under-diagnosed as adults.

Q3 **Andrew George:** Do you mean 1.2 million on top of the figures that we already have?

Jolanta Lasota: Yes.

Andrew George: So there is an additional 1.2 million.

Jolanta Lasota: The research shows us that there is a range of figures, but at the top end it is 1.2 million. What we really have to think about are the gaps in the data. We do not have consistent reporting across ICBs. We know from the Children's Commissioner's report that what we are reporting is first contact with children. The waiting times are based on first contact, but that is often not seeing a child. It is often professionals getting together to talk about the child. We need to look at the waiting times at second contact, which are much longer.

In answer to all of that, what we need to address is that currently we have 220,000 people waiting for an autism diagnosis. We need to invest in a workforce to meet those children's and adults' needs. We know that those people have been placed on a waiting list for a good reason. They have been triaged and found to be having difficulties. They are not there for fun. Their parents are coming forward for a diagnosis because they want to understand their child better. Quite often, they need a diagnosis to access the statutory system. They need to get an education, health and care plan to get social care and support and to get further health support. We know that we are in a system that does not meet need early and does not identify need early. It waits for diagnosis, and that is why people are going for diagnosis.

Q4 **Andrew George:** We will be coming in a moment to questions about meeting need and the system through which people go. It is just understanding the extent. Henry, do you agree with that broad approach and that there is actually under-diagnosis, and that in the last 20 years or so there have been very significant increases in diagnosed cases, yet still the Children's Commissioner is saying that there are huge gaps in our understanding and the statistics?

Henry Shelford: To answer the earlier part of your question as to why it has changed, for ADHD it is simply because of abject failure to recognise ADHD and then put a service together. ADHD was only recognised for children through NICE in the year 2000, and for adults in 2008. If you are

wondering why there are loads of middle-aged people like me coming forward and saying, "I've realised I've got ADHD," it is because there was a near zero chance of me getting picked up at school.

We find huge prejudice around the numbers. We know that the incidence rate is between 3% and 5%. We have an estimate of 2.5 million people. As we catch up, you see in other areas such as HRT that in the same period it has gone from 1 million people to 2.6 million people, 3 million items to 13 million. Every time those stats come up we get a celebratory thing. Those stats tend to come out when the ADHD one comes out as well. A few pages later it goes, "Oh, ADHD up again. It's awful. What's going wrong in society?" To give you an idea of how decried we are, there was a cartoon in *The Spectator.* It was a picture of Hitler, and it said, "I've been diagnosed with ADHD, and that explains everything about me." We are dealing with that kind of prejudice.

In terms of over-diagnosis, we have wait times of 10-plus years in many parts of the country, and for children it is five-plus years. The idea that you could have over-diagnosis when you have wait times of that quantum is just ridiculous. There was a study published in January from 9 million GP records. It showed an ADHD diagnosis at 0.32%, so nudging around 10% of those we think have ADHD. We are nowhere near the numbers. It is starting to be recognised, but the issue is that we are a large number of people and there is an inadequate service for them.

Q5 **Andrew George:** Let me be devil's advocate. I am not going to be the cartoonist in *The Spectator*, but there is an argument that we are increasingly becoming a snowflake generation. Indeed, the Secretary of State is using the expression "over-diagnosis" as well.

I hear the emotion in what you are saying, but the fact is, as the Secretary of State says, that there is a spectrum. There are severe cases and then there are some less severe cases. Are we not ending up including in our figures and statistics some not particularly severe cases? That seems to be the implication. By doing so, you give people a label and a justification for different treatment. That is the devil's advocate question. Let me ask it.

Jolanta Lasota: I am happy to take that question. I understand that for people who may not be involved in autism, ADHD or neurodiversity the statistics may look negative. But we should celebrate the fact that, as a society, we have recognised differences and we now understand how to diagnose people, how to meet their needs and how to prevent further difficulties either in education or employment, or later in life in health, and that actually it is a positive thing that we identify people early and provide for them early rather than letting their needs escalate.

We think we need more research to understand what brings people to a diagnosis. We need to invest in innovation. How do we help people when they first identify as having a problem? How do we help them without having to wait for a diagnosis? Some people may need a diagnosis and

some people may not, but we are leaving people on a waiting list for years and years. A sixth of autistic children wait over four years for a diagnosis. That means there is a need not being met. They may never need a diagnosis, but we don't know that because while they are on that waiting list they are not getting any help. The most important thing is to identify need early and meet it early. Some people may need a diagnosis. Some people may not.

Anna Collishaw-Nikodemus: Can I come in on the point about over-diagnosis? As Jolanta said, there is no evidence of that. There is evidence that there is under-diagnosis, especially in women and girls.

There is often misunderstanding of the autism spectrum, in particular. I have a case study to demonstrate that example. I heard from a parent last week who was talking about her daughter. She had had no issues at school or in any systems throughout primary. She moved to secondary. The issue was that at home there were a lot of symptoms and signs. The mother had been pushing for an autism diagnosis for three or four years. There were no outward signs, so somebody who did not understand autism might look at that and think that there were no issues. Actually, the mum was trying to identify those issues and was pushing for an autism diagnosis. What then happened was that there was a breakdown and a crisis when her daughter moved to secondary school. This young lady is now about to be sectioned. She had a mental health crisis because she had been masking her autism and was then privately diagnosed autistic. She is now in crisis and about to be sectioned, which is obviously hugely impactful on her and her family.

It is a very complicated and complex picture. In terms of identity, diagnosis is a positive. It offers people understanding of themselves, of coping strategies and of legal protections under the Equality Act, and it sets them up to understand their own support needs and the causes of those going forward into adulthood.

Q6 **Chair:** Thank you, Andrew. Let me push a little more regarding over-diagnosis. Once children and young people are diagnosed, what impact does the narrative of "we have got over-diagnosis" have on young people's ability to get the support they need? Once they have had the diagnosis, what is the family's ability to get the support they need? I have cut into Andrew's question because he cut into mine.

Jolanta Lasota: What is really important to recognise is that families come forward for a diagnosis because they are trying to understand and support their child. They are not chasing a plan or money. They want to support their child; they want to be good parents. Once they have secured a diagnosis, the first thing is that it helps people to have an understanding of their child. They can self-help. People underestimate how much self-help there is for individuals and families. If they really need support, they are able to explain to a school or another service what their child's needs are.

In a resource-strapped system, labels matter. We might say that should not be the way. We should be working on a responsive, preventive approach, but at the moment in order to get support through an education, health and care plan people generally need a diagnosis. Once people have a plan, it brings in specialist resources and specialist support for them. It enables them to get support, for example, in social care and further support in health.

That is not the primary reason people go for diagnosis. The primary reason is to get recognition and to be able to understand themselves and their child, and to be able to provide support at home and, through networks of parents and charities, actually get that support. We are trying to bust the myth that people are chasing some sort of gold pot. There is no gold pot. There is a long fight ahead, once you have a diagnosis, for an education, health and care plan or any support. The main reason is that people want the best for their child.

Q7 **Chair:** Henry, would you like to say a few words?

Henry Shelford: Thank you. I think it misrepresents a lot of the issues and information. A lot of the ways we find out about where there is ADHD are not that people have gone and got a diagnosis; it is because we are testing that population to see if they have ADHD. We have discovered that with NEETs, we are looking at numbers of between 40% and 80% of NEETs having ADHD. It is not because they have chased a diagnosis; they don't have it. What we find is that they have ADHD and then we can know that and use it to change their lives. In youth offender institutions, the number we are confident on is about 40%.

Q8 **Andrew George:** Forty?

Henry Shelford: Forty per cent. Again, what is happening is that people are getting failed in education and fall into trouble and crime. We see, particularly in secondary schools, kids struggling with their attention and getting put into detention, at which point they meet older kids. Those older kids are troubled and take them on the wrong path.

I talked to a father recently, and that is exactly what happened. His child is now in a youth offender institution. I talked to a prison officer who said, "Yes, detention is where I got taught to truant, and it's only by luck that I am on this side of the bars." What seems to be happening to kids with ADHD is that they are sent to detention and get a criminal mentorship scheme. Other kids get a big brother or big sister scheme to help them. It is creating huge disparity.

A lot of the numbers are coming from us finding those populations. In terms of the ability to get support, with wait times of multiple years we see loads of kids ageing out before they can even get a diagnosis. We think that a diagnosis is important. You cannot access medication, for example, without it. Kids in their teens often want to stop taking medication. They want to explore who they are, at which point they get

discharged from CAMHS. If they look to come back on medication, they are at the back of the queue and in effect cannot restart it. They get discharged from CAMHS at 18 and are put to the back of the adult queue. That can be a wait of 10 years. We snatch defeat from the jaws of victory. We have people succeeding, and then we just drop them.

If you move anywhere in England to a different NHS area, you have to get assessed again. I have been assessed three times. We have a ludicrous waste of resources. You get dropped again from medication, so you can spend years succeeding with that support and then suddenly find yourself being dropped. If you are a family and you move with your kids, they are dropped. On your question about accessing support, it is a disaster.

Q9 **Chair:** Thank you for that. I am going to move to my second question. Unlike autism, for ADHD there is no recommended target for how long it should take to get an assessment. Given that the autism target is missed for around 90% of children, would there be value in introducing a similar target for ADHD? I will start with Anna.

Anna Collishaw-Nikodemus: I think I might pass over to Henry for this one.

Henry Shelford: Without targets, ADHD is currently a disaster. We are not part of the Government's 18-week push, so we are not seeing that benefit. We are also not part of the mental healthcare budget of the NHS. Along with autism, we are specifically carved out. As ICBs look to increase their mental health care budget proportionally with other growth, we are excluded. We are actually on the opposite side of the ledger, so because we are not in that part or in the 18-week part, we are being cut. Coventry and Warwickshire recently said that they are stopping all new referrals for anyone over the age of 25. To be honest, with wait times of five-plus years, effectively for a whole load of kids there is no ADHD service because you cannot get to it before you age out. Being part of the 18-week promise of the NHS and benefiting from the Government's initiative would be an incredibly important change.

Q10 **Chair:** Thank you. To what extent are the issues in the SEND system causing an increase in demand for assessment and diagnosis? I will go to you, Jolanta, but I am not sure if you are the right person to answer.

Jolanta Lasota: I am very happy to answer. Ambitious About Autism has been campaigning on the SEND system since its existence in 1997, so I have a lot I could say on this.

First of all, we need to create a system that is inclusive and seamless and serves outcomes for children with SEND. The first priority is to change school culture. We have a culture that is focused on a very narrow curriculum and narrow behaviour attainment. That does not suit all children. We have a system that is not serving all children. We need to build workforce capacity and capability. At the moment, very few

teachers are trained in autism. We need a whole-school approach. We need the whole school to be able to embrace autism and neurodivergence. We also need schools to be able to access specialist support. That is about education and health working together to provide a seamless service for children. We lost a lot of school-based support with academisation. We lost a lot of local authority support for schools. We need to rebuild some of that. It is about making sure that there is mainstream policy supporting children with SEND. We have to make sure, when we make decisions about the curriculum, that we really embrace the whole population of children and that when we make decisions about behaviour, we are not excluding a lot of children in those behaviour policies.

Most of all, we need to protect the rights of children in schools. We should not forget that every child has a right to an education. Yes, the current system is driving demand. We know that if you are autistic you are twice as likely to be excluded from school; 70% of parents report their children having lost learning. We know that around half of children are informally excluded from school. When you are pushed to that extent as a parent, you have no choice but to pursue whatever avenue you can to get your child into education. That includes following legal routes, home education or anything at all to help your child.

Q11 **Chair:** You said that specific parts of the system are driving demand. Could you give me an idea of what part of the system is driving demand? Could you say which part of the system—not a long piece, and then I will ask Henry and Anna—you feel is driving the demand around ADHD and autism?

Jolanta Lasota: We are seeing exclusion increase in all parts of the system. We know that exclusions are always higher in secondary. We are now starting to see an increase in exclusions in primary. We have a whole system that needs reform and a system that needs to focus on early identification and support rather than labels and hurdles.

Q12 **Chair:** Anna, would you say anything different, or do you agree?

Anna Collishaw-Nikodemus: I agree with all of Jolanta's points. Cultural and attitudinal change is needed in mainstream schools. We hear all the time from the parents and young people we work with that, even when there is a diagnosis and an EHCP, those are not upheld. You asked about diagnosis and the need to push for that earlier. I had a parent send me a letter last week on her daughter, who has had a diagnosis. Her new secondary school is saying, "You have claimed that your daughter has SEND support and will be in the SEND support category. We will need to see evidence of that diagnosis by September." Unfortunately, it is seen as a gateway to support, and it should not be. I entirely agree that the issue lies with the workforce, particularly in terms of expertise and understanding.

Q13 **Chair:** Henry, do you want to say a last word, or do you just agree and I

can move on?

Henry Shelford: Very quickly, the thing that is driving it is the failure of ADHD to be picked up. The fact of having ADHD can be extraordinarily difficult. We know that one in 10 men or boys with ADHD will at some point try to take their own life. One in four women or girls with ADHD will at some point try to take their own life. We know that life is shortened, on average, by nine years for a woman and on average by seven years for a man with ADHD.

We talk to people like Tanya Bardsley, who first tried to take her own life when she was seven. For the first two years of this charity, we were almost exclusively funded by parents whose children had taken their own life. The reason people are coming forward is that it is really hard.

Chair: Thank you for that, Henry. I will hand over swiftly to Greg.

Q14 **Gregory Stafford:** I am going to ask some questions around the waiting for assessment period. I am sure you agree that you would want greater support for young people and families while they wait for the assessment. How can services improve information and support during that waiting time?

Anna Collishaw-Nikodemus: At Kids, we provide a lot of services such as the Wakefield Awareness Support Project. It is a crisis intervention project. It is really important that we have holistic, family early interventions. That was a piece that was jointly commissioned in response to the long waiting times for autism diagnosis in Wakefield.

It is important to note that it is a service that looks at supporting the child, the parent and the wider family. A lot of the impact of waiting for diagnosis and not receiving support is obviously on the child, but also on the family. It will impact on parents in terms of their caring abilities, their ability to work and so on. We have provided a lot of support in that area from specialist practitioners with expertise. We work with the services that already exist in a multi-agency way. We provide bespoke packages tailored to those families and to those children.

We have seen the importance of our Autism in Schools programme, which is part of the Government-funded PINS project. We deliver something called the Understanding Me project in schools. It equips children and young people to learn coping skills and to build peer groups and connections. We have a project that helps them to build coping skills and an understanding of themselves and their condition in the transition from primary to secondary. We ensure that that is through multi-year groups. Some year 7s may be paired with year 10s so that they already feel somewhat safer when they enter secondary school. We know a lot of mental health crises and breakdowns can occur in the transition from primary to secondary.

What has been key is joint commissioning from health and education, and flexible commissioning. An example is in Essex, where there was joint

commissioning of the autism hub between three ICBs and Kids. It was co-produced with parents and young people. That was about looking at the waiting list and those who were on the pathway for an autism assessment. The service was then changed to include those who had had a diagnosis in the last two years, recognising that they too needed support and an understanding of self and strategy. Flexible commissioning and earlier intervention have made a huge difference there.

Q15 **Gregory Stafford:** It sounds like you have been doing very good work in that period. Presumably, you are an example of good practice that is not necessarily replicated across the country. What would be a good first step for all services to improve support and information during the waiting for assessment period?

Anna Collishaw-Nikodemus: Flexible commissioning, and certainly co-producing with the parents, children and young people to really understand the need in their local area. That is absolutely crucial.

Q16 **Gregory Stafford:** Thank you. Do you want to come in, Jolanta?

Jolanta Lasota: I think we need to rethink the pathway. At the moment we have a system that is high brinksmanship. You either get or you don't get a diagnosis. You either get or you don't get support. What we need, and I have seen lots of ICBs do this very proactively, is to provide open groups for people to talk about neurodivergence where any parent can come. You do not need to have had a diagnosis. They are low-cost group interventions that help people to start understanding their child and understand some strategies.

We are part of a consortium funded by NHS England called Autism Central, which provides information nationally for parents on different strategies for understanding autism. We fund a programme across schools for autistic young people with a diagnosis or not, where they enter groups to understand more about their autism and support each other. These are relatively low-cost interventions, and they do not require people to have a diagnosis to enter them.

Q17 **Gregory Stafford:** Henry.

Henry Shelford: One of the assumptions in the question is that everyone who should be on the list can get on it. We see massive under-recognition of ADHD in schools. Boys are under-diagnosed, and girls even more. It is an oddity that the NHS outsources medical referrals to non-medical people. Teachers are responsible for that referral and they get almost no support in it. A number of them have very incomplete ideas of what ADHD is. Often parents find that they are battling the school. Because in many cases the school controls the referral, the parents have to argue the case. That creates an equalities issue because some of them go privately to prove their case and then get allowed through, but there are abject failures to pick it up; it is clear in the statistics.

The discussion of getting care while waiting lets the NHS off the hook. It has failed on ADHD for a long time. We are a large population and it needs to uprate, and do a complete review: three assessments, for me, or multiple assessments are a ridiculous waste. The idea that we can get support without a diagnosis is honestly laughable. Often when you try to get support, even with a diagnosis, you don't get it anyway.

To answer the earlier question about whether we diagnose lots of people who do not need it, a diagnosis of ADHD is given only if it has a debilitating impact on your life. We already have the line there. You have heard some of the statistics that give clarity on how tough it is.

Gregory Stafford: Thank you.

Q18 **Jen Craft:** I want to touch a little bit more on waiting times and what can be done to address them. Previously there has been some resistance and controversy when services have introduced additional referral criteria in an attempt to manage waiting lists. What are your thoughts on having additional criteria so that maybe local care authorities, ICBs or the people doing assessments would make sure that those who are potentially most vulnerable, or those with higher needs, are assessed in a timely way? Is that a good use of resource or should there be something more standardised and equitable?

Jolanta Lasota: First we need to separate the idea of some sort of pre-assessment pathway, to support people prior to diagnosis, from diagnosis. We need something to get early identification and early support to children in schools and services, and to avoid long waiting times. We need to reform the system so that it is more needs-based, both in the NHS and education.

Criteria are often misused, as a way to ration. We need to think about the fact that most people enter a waiting list because they have had difficulty in their lives, so they need some sort of solution. I have a slightly different view. I think that people are born autistic and do not become autistic. Whether you meet a threshold for diagnosis will be a different matter. People who perhaps do not meet the threshold would benefit from some form of support, to improve their lives and prevent crisis later in life. That does not mean that everybody needs a diagnosis, but probably everybody needs something.

Q19 **Jen Craft:** Thank you. I will come to you, next, Anna.

Anna Collishaw-Nikodemus: I agree with Jolanta about the criteria set, and that you are either autistic or you are not. There is a need for investment. There is always a need for specialism and expertise. There is a workforce crisis in the professions that are crucial in providing early intervention and support to children and young people with autism and ADHD—occupational therapists, speech and language therapists and educational psychologists. We would say investment in those is needed nationally, to deal with the workforce crisis. That is not just to bring down

waiting times and provide assessments; it is to provide the expertise and specialism, particularly to those within education, or others who may be providing for these needs, to provide early intervention.

Q20 **Jen Craft:** You are looking at it more as addressing the needs—you said that throughout—rather than addressing the need for diagnosis.

Anna Collishaw-Nikodemus: It is about addressing the need, but we strongly feel that there is also a right to diagnosis. Children and adults have the right to understand the condition. It brings to mind a case study. I spoke last week to a parent who believed that her daughter had PTSD because of the symptoms and signs that she was displaying. There were issues in school and at home. Somebody said to her, "Do you think she might be autistic?" This is a mum who works with autistic adults. The symptoms and signs—the need—can often appear the same. That demonstrates the need. She was then assessed and diagnosed as autistic.

That makes the point: if they had followed the path of PTSD and just addressed the needs, that child might have been put forward for talking therapies, which often do not help with autism. A different intervention is needed. That makes the point in terms of diagnosis, as well as the need for protections under the Equality Act, and the setting up of coping mechanisms and a sense of self going forward into adulthood.

Q21 **Jen Craft:** There is a need for diagnosis. Coming back to my question, I will try to put it differently. We can probably all recognise that some people's need for diagnosis is fairly pressing and urgent. I know you will come back and say that due to the current system most people approach it at a level of crisis. Is there a fair and equitable way to modify the current system for waiting times, so that those potentially at risk of a mental health crisis, death by suicide or risk of various other things would be able to access diagnosis more quickly, or is the system in such disarray that looking at it from that angle is unhelpful? Jolanta, you look as if you want to come in.

Jolanta Lasota: Over-focusing on criteria for rationing and prioritising is not helpful in an overloaded system. You only enter that list now if you have already been triaged quite heavily. Very few people get on to those lists any more without having significant needs. You are already dealing with children and young people who are having trouble at school with exclusion, or who have challenges with mental health or challenges at home.

As an example, I spoke the other day to a mother who waited five years for her boy to get a diagnosis. In the end she had to pay privately. Her daughter is now 18 months into a waiting list. Both children are out of school. Mum has had to give up work. That is a massive impact on the children and on the parents' economic wellbeing, but also on the long-term trajectory for this country, in terms of taxpayers' money. Those are three people who potentially will not work for the rest of their lives. That

must be thought about when we think about investment in diagnosis waiting lists.

There is a lot of evidence for supporting early. You will speak later to Professor Green, who has an RCT measured pilot on early support for families. It provides early support for families who do not have to have a diagnosed child. They can enter that support and start making adjustments at home and working with the school early. That averts the crisis that we see with long waiting lists.

Q22 **Jen Craft:** Henry.

Henry Shelford: Where we see prioritisation, basically it just means no to a whole group of people. For ADHD we cannot identify those who are more likely to take their own life or have additional issues. We do not have good criteria to assess risk. The idea that we just force people into crisis to get help is obscene. It is so wrong. We are paying anyway. We pay for depression support and medication, and anxiety support and medication. We have failure in economic life and we see crime increasing, and more likelihood of being a victim of crime. One of the failures in the Government and the NHS is not doing the proper economic analysis so that we can argue those cases well. At the moment it is very obvious to us that cutting here is not a cost saving. It increases expenses for the country.

There was someone called Matty Lock, for example, who had a diagnosis. His parents did not understand the associated risks and Matty took his own life. They are very clear that if they had known, it would have been different. If someone is without a diagnosis and without support, they cannot really know and cannot make the bigger decisions to change their life and situation. Depriving them of that is going to have awful outcomes. It is having awful outcomes right now.

Q23 **Jen Craft:** Thank you. I am running out of time, but I am going to ask a quick question on the equitability of the system. A lot of parents opt to go to independent or private providers to get a diagnosis, which is fairly inequitable itself. Is there something about the way the system currently operates, and the pressure, almost, that parents have to put on to get an assessment, that potentially favours certain groups in identifying children with an unmet need, over those who may slip under the radar? I ask you to be very brief, because I have tried to cover a lot of ground and I can feel the Chair's eyes on the back of my head.

Jolanta Lasota: I am happy to answer. I think a bit of a myth needs to be busted—that autism is a sort of middle-class phenomenon. The latest analysis of NHS records shows that you are more likely to have an autism diagnosis if you are more economically deprived. We have to bust some of the myths. Of course, we know that people pursue diagnosis in the private system. We need the Government to come up with a strategy to meet the backlog of 220,000 people waiting for an autism diagnosis. The private system may or may not be involved in that, but we need much

more strategic commissioning, and national quality standards, to ensure that the money is being well spent and that we are getting good support for the people who are going down those pathways.

Q24 **Jen Craft:** Thank you. Anna.

Anna Collishaw-Nikodemus: I agree with everything Jolanta said. I can give a case study to demonstrate that status does not matter in addressing that point. I spoke to a mum who was a deputy head in a primary school, who suspected that her son was autistic, and spoke to the classroom teacher. The GP and community paediatricians all agreed that it looked like autism, but she could not get an assessment for seven years. Occupational therapy—everybody—was on her side. We come back to the point that Henry made about gatekeeping. Often it is down to the schools, and education, those who have the least expertise in these conditions. The paediatricians and the whole assessment team said they would like to do the assessment, but the school was sending back documents saying, "No, we don't see any sign of it"—and she was the deputy head of that school.

Q25 **Jen Craft:** Henry.

Henry Shelford: There are massive equality issues around ADHD. It is certainly not a middle-class problem. ADHD is predominantly genetic; 76% of ADHD is genetically described. That means generational poverty—parents who did not get support, with children who do not get support. It is continuing, and we deprive them of support with extraordinary wait lists and barriers. We see big race issues. I talked to a parent yesterday whose son's school jumped on his issues as behavioural and refused to acknowledge that they might be ADHD. She strongly believes that that is due to race.

People are going private, but another factor in NHS waste is that if you get an ADHD diagnosis privately, to the clinical guidelines, the NHS just does it again. A slot that could have been freed up is lost. We have a strategy that meets some of the need—the Right to Choose system. A lot of people in England use Right to Choose, particularly adults, and the child area is increasing. NHS England tried to essentially get rid of it—to curtail it to that extent. We were successful in getting 14,000 people to write to their MPs in 14 days—you may have had some emails and letters. We were very pleased that the Department of Health and Social Care changed NHS England's mind on that. We are kind of aware that we have won a battle but not the war; but there is a system there that successfully sees a lot of people.

Q26 **Josh Fenton-Glynn:** Thank you all for coming. When we talk about children in the ADHD and autism diagnosis system, we must also remember the parents who, because the system is not working, must devote themselves, almost as a full-time job, to being advocates for their children. I want to start by paying tribute to those parents. I see them in my surgery all the time, and they are inspiring.

My question is for Jolanta in the first instance. The previous Government had the national autism strategy. You talked about the need for us to have a strategy. They put about £75 million into it. Why is it not working in cutting waiting times in the diagnostic process?

Jolanta Lasota: First of all, the Autism Act didn't originally include children. In 2021 the autism strategy included children. The challenge, since then, is that we have not had a strategy that has focused on system change and measuring outcomes for children. We have had lots of initiatives. They are very worthy but we do not have a holistic cross-government strategy for autism, which was the intention of the Autism Act. We have not seen an implementation plan for a number of years, so we have a strategy without an implementation plan. The statutory guidance has not been updated; that was promised in 2022. We have a strategy that doesn't have any teeth, or a long-term strategic view. We need a cross-government, holistic strategic approach that focuses on better outcomes. We need that strategy to be fully funded. We need accountability to Government; we need people to report back on the strategy.

Q27 **Josh Fenton-Glynn:** Can I interrupt? What does fully funded look like? We have 74.8 million quid in it already. What does fully funded look like, as opposed to that?

Jolanta Lasota: The important thing is for the Government to do that work.

Q28 **Josh Fenton-Glynn:** To have an idea of where the money is going?

Jolanta Lasota: Yes, and a focus on what outcomes we are trying to achieve together. Cross-government, we have to bring together health, education, social care and employment. We have to really understand the whole pathway for autistic people, and where the investment is needed, to improve that outcome.

Q29 **Josh Fenton-Glynn:** That's great. Thank you. Henry, something you said resonated with me, which was that when we see prioritisation, for a lot of people it just means no. Obviously, that is something we must be aware of in the crisis we face, but if we had a national ADHD strategy what could we learn from the autism strategy, to make it work properly?

Henry Shelford: I think the Autism Act is a really smart Act. It has three parts—to have a strategy, and that the strategy must be followed, and that it is paid for by Parliament. One of the things we would love would be for the Act to be uprated to a neurodivergence Act, given the huge crossover between the conditions for autism—over 40% of people with autism have ADHD—and dealing with them together.

We are different in that for ADHD there is a medication option that is life-changing for many, as it is for me. That is available only if you have a diagnosis, so differences include the fact that we need a diagnosis. The medication is causing a lot of issues. Many GPs, as part of their dispute

with the Government, are not providing ADHD medication, and some are actually dropping adults and children from the provision of medication. I can't move GP right now, because I don't know whether, if I moved, I would be able to get medication.

One of the pieces we want to learn is the joined-up analysis, and the proper analysis of difference. One of the big things that the autism strategy brought out is that they are tracked in schools. You can get data on how many kids in schools have autism, and on their outcomes. For ADHD we can't. We don't have the data. The Government do not know how many kids have ADHD. They do not know their outcomes. One of the first things that we would want is just to know that, because we know that it will prove the case for more research and investment to change those outcomes.

Q30 **Josh Fenton-Glynn:** That is helpful. Yes, we often say in this Committee that what gets measured gets mended, so understanding those outcomes is important. Thank you for raising that point.

I am going to move on to a bit more about mainstream education. This question is for Anna and Jolanta. The Neurodivergence Task and Finish Group and the ADHD taskforce are looking at how children can be supported in mainstream education, and what support should not depend on diagnosis. We have some fantastic schools in my constituency, such as Cliffe Hill School, which at key stage 2 has a really good autism curriculum, so people who have concerns about their children are more likely to look favourably on that school. How can we expand such an approach, given the current level of funding provision?

Jolanta Lasota: Obviously, the Neurodivergence Task and Finish Group has not yet published its report, but I think everybody in the sector will agree that we need to move the school system to being needs-based rather than label-based. We have to be able to identify and support neurodivergent children early. We have the knowledge and skills to do that. That early intervention and support will enable children to learn, thrive and succeed, and become fully employed adults who live a good life. It is as simple as that.

I can repeat what I said before. There are layers of this. We need to change school culture and ensure that the universal services in schools are strong, and that every teacher, teaching assistant and member of staff understands neurodivergence. We need more specialist support within schools. We need to ensure that the school landscape is changed and that we concentrate on things like the curriculum reviews and behaviour reviews, so that they are cognisant of autistic and neurodivergent people. Finally, the special school system is collapsing at the moment, with over-demand and inability to meet need.

Q31 **Josh Fenton-Glynn:** That is absolutely true in my constituency. This may be straying a bit more into Helen Hayes's area of expertise, but I sometimes get the sense that, because everything in schools is

overstretched, they want to sort out the neurotypical students before they address autism. That is one of the things that seems to come across. Anna, can I ask you a similar question?

Anna Collishaw-Nikodemus: Yes. I agree entirely with Jolanta. We are clear that comprehensive workforce training is needed, across the entire school system, not just the SENCO but all the teachers. We have to be cognisant of the realities of the systems in which the children exist and the professions operate. Specialism and specialists will always be needed. We are clear on that. It cannot fall just on education; it cannot bear the brunt. That, essentially, was the issue with the Children and Families Act 2014. It fell on education because health was not mandated. We are very clear that that specialism is needed; the ability to pull in experts and specialists will always be needed. The National Education Union is prioritising that message as well.

As you said, we know that the pressures on the school system are huge. Culturally, the Government need to be clear—it needs to come from DFE—that schools need to apply reasonable adjustments to their policies. For attendance and behaviour policies, particularly, that is their duty under the Equality Act. We hear time and again, from the young people we work with, and their parents, that that is not happening.

Josh Fenton-Glynn: Thank you very much for the answers. I have one more question, but I shall go back to the Chair because I have seen the time.

Chair: Josh, you are fantastic. Thank you. I will go swiftly over to Ben. We have until half-past 10 before we change the panel.

Q32 **Ben Coleman:** Thank you, Chair. We have heard a lot about the assessment and diagnosis process not being adequate, so we do not want business as usual. It is good to have you all making these strong points. What are the big things we need to do to change the assessment and diagnosis process—bang, bang?

Jolanta Lasota: Three things: first, we need the workforce to deal with the backlog of the waiting list. Secondly, we need investment in innovation. We need to think differently and think about more holistic pathways. Thirdly, we need reform of the SEND system.

Q33 **Ben Coleman:** Quickly, what do you mean by innovation and holistic pathways?

Jolanta Lasota: How we support people while they are waiting, and post diagnosis, and are there different, innovative services that can get through waiting lists faster? For example, Autism Initiatives in Scotland has a fantastic, bespoke autistic diagnostic service. It hits waiting lists much faster than the NHS and provides support while people are waiting, and after. Some of these services have really got something to show that could be learned nationally.

Q34 **Ben Coleman:** Is that a charitable service?

Jolanta Lasota: Yes.

Ben Coleman: Not public sector. And is it commissioned?

Jolanta Lasota: It is commissioned by the NHS.

Q35 **Ben Coleman:** Thank you. Anna.

Anna Collishaw-Nikodemus: We need to mandate joint commissioning. We need to see it from the very top, between health and education. There needs to be immediate investment focused on the recruitment and retention of the key professionals such as speech and language therapists, occupational therapists and educational psychologists.

Q36 **Ben Coleman:** Right, okay—that was "bang." That was sharp. Thank you. Henry.

Henry Shelford: Honestly, we find ourselves playing defence more than trying to make positive changes. We had to defend to keep Right to Choose, and we are seeing cuts. We would like to be included in the 18-week target, so that we benefit from that gradual push. We would like to be included in the mental health budget, so that we are not excluded and on the other side of the ledger. Track us, so that in schools we know how many people there are, and their outcomes. From that will come targeted research to make a difference. Fund research into the economic impact of ADHD so that we can argue the case.

Q37 **Ben Coleman:** How will that improve assessment and diagnosis?

Henry Shelford: The taskforce identified a £17 billion cost for ADHD. In that situation, we can say, "By not doing this you are costing the economy X." At the moment we do not have those figures, so we are not able to argue it.

Q38 **Ben Coleman:** You are saying, get the research to make the case that makes the Government want to change the system. In itself, that sort of research is not going to improve or change anything.

Henry Shelford: Yes, sorry, that is exactly what I am trying to do. It is because we find ourselves playing defence. Also, from that, comes tracking us; because then we get research and show the outcomes. It was very significant for autism when the Autism Act was first passed and that tracking happened.

Q39 **Ben Coleman:** Some of the things you have said are to do with money and some are to do with processes. Let's assume there is no money. We keep opening the cupboard, since we got in, and there is no money anywhere. It is an absolute nightmare. It will come as a great surprise to you, of course. Let's say we have not got a lot of money to put in. Political decisions will of course be taken, which may mean there is more, but let's take that for a second. You talked about systemic things. What is the one biggest systemic change that would improve assessment and

diagnosis? Anna, can I come to you first?

Anna Collishaw-Nikodemus: It is a good question. I am not sure. I'm going to have a think.

Q40 **Ben Coleman:** Okay, that's fair enough. It is a good, honest answer. I will come back to you. Jolanta.

Jolanta Lasota: I would always say that people who provide simple answers or solutions to something complex are usually selling a pup. They are not telling you the truth. There are a few simple answers. One is to ensure that the money that goes to mental health services ensures that they are able to support neurodivergent people. People are turned away from mental health services because they are neurodivergent. Use that investment better.

Q41 **Ben Coleman:** They are turned away because they are neurodivergent? Why? What do you mean?

Jolanta Lasota: A lot of mental health services—CAMHS—will say, "We do not serve autistic young people." So make sure that those young people can access the existing money going into mental health services. That is not asking for more money. It is asking for those services to be accessible to neurodivergent people.

The second thing is to ensure that our schools are more inclusive. That is a policy and cultural change. There is money involved in training people up front, but that is primarily a cultural change.

Q42 **Ben Coleman:** And a teacher training or teacher support issue.

Jolanta Lasota: And CPD for all staff.

Q43 **Ben Coleman:** Right, Henry, and then I will come back to Anna.

Henry Shelford: Okay, your criterion was not spending more money, so I would stop the repetition. Stop the need, if you move, to get a new assessment. Have a standard so that we can accept private assessments across the country. Have it so that kids can pause their medication without getting discharged so they have to start again and get reassessed. Have a process so that when they hit 18 they get passed to adult care properly and do not have a years-long gap in medication.

We need to do a deal with GPs. Dropping all their ADHD patients and passing them back to secondary care is one of the criticisms of the NHS, but it further swamps the services that we have, because they have to do the monthly repetition.

Q44 **Ben Coleman:** Because GPs are not trained, they don't feel competent in the area?

Henry Shelford: It is not part of a GP's contract to issue ADHD medication or to do the annual review, which is mostly just to measure height and weight and ask, "Are you okay?" They feel unsupported in it. I

hate the fact that we are a pawn in an industrial dispute and I know that it is ruining some lives. I would like that to get on to the political agenda and get sorted because at the moment no one seems to have noticed.

Q45 **Ben Coleman:** People have noticed, but thank you.

Anna Collishaw-Nikodemus: I think it is cultural change and listening to parents. So much time is wasted across education and health by professionals because parents are not listened to. It is about collaborative working, and that goes for the joint commissioning and the multi-agency approach in commissioning, co-producing with parents, children and young people.

Q46 **Ben Coleman:** I notice that the Bristol ICB referral criteria for health and social care brought in a new approach in 2023 which was not developed with the people affected. Maybe that is wrong and I will be corrected later. Is that correct? There are people nodding and shaking heads on the other side of the room. It strikes me that, if you have an arm of government bringing in things that are not properly developed by the people they affect, often you end up with the wrong outcome.

Anna Collishaw-Nikodemus: We have a duty to consult in so many areas. Why are professionals not speaking to the people who best know these children?

Ben Coleman: Thank you very much.

Chair: Thank you, Ben. A massive thank you to the panel. It was very informative and interesting, and it will be needed in forming our report.

Examination of witnesses

Witnesses: Hayden Ginns, Professor Green, Professor Mon-Williams and Professor Thapar.

Q47 **Chair:** Good morning, all. I welcome our second panel today looking at autism and issues relating to it. Can I ask you all to introduce yourselves, starting with Professor Jonathan Green? Sorry, I have just made the introduction for you, but would you introduce yourself?

Professor Green: Yes. Good morning. I am Jonathan Green. I am a child psychiatrist and clinician. I have worked in this area for nearly 40 years. I am also an academic. I am a professor of child psychiatry at the University of Manchester. I have done research in the early detection and care of autism and other neurodivergence for the same time, about 30 years.

Professor Mon-Williams: I am Mark Mon-Williams. I am an academic at the University of Leeds. I am a psychologist by background. I have spent most of my life based in Bradford Royal Infirmary, where we run a large project called Born in Bradford which is following the lives of children and young people and their families. That allows us to start understanding the various factors that play out early in life that have all these long-term

consequences, with a particular interest in neurodivergence in the population.

Professor Thapar: Good morning. My name is Anita Thapar, and I am professor of child and adolescent psychiatry at the University of Cardiff. I have been a jobbing clinical psychiatrist since 1986 and have been doing research on neurodivergence, primarily ADHD, since 1991. My current role is independent chair of the ADHD taskforce, whose interim report was published on Friday. I am working on part two of the report as we speak.

Hayden Ginns: Good morning. I am not a professor.

Q48 **Chair:** Can we apologise on behalf of whoever didn't give you that title?

Hayden Ginns: I am Hayden Ginns, assistant director for children in Portsmouth City Council. I have been developing with colleagues across the NHS, local authority and schools a needs-led model for neurodiversity for the last six years or so. Most of my background is in child protection, safeguarding and youth offending. I also chair a national community of practice-run needs-led models with about 450 professionals from England and Wales.

Chair: By the way, you should be a professor. I will hand straight over to Alex.

Q49 **Alex McIntyre:** Thank you all very much for being here this morning. To kick off, we heard a lot about this from the first panel, but what are the risks of children not being able to get timely access to an autism or ADHD assessment? Perhaps I can turn first to Professor Green.

Professor Green: The risks are that the vulnerability and harms escalate, but all kinds of neurodivergence are fundamentally biologically determined, and as a young child grows and experiences the world, things happen that either make things worse or make things improve. As you go through life, those biological vulnerabilities are either amplified or diminished by your experience. The risks are that, if we do not intervene and get good, appropriate support early, those vulnerabilities escalate and turn into all sorts of mental health and other difficulties, including in education, which can lead to crisis.

Q50 **Alex McIntyre:** I am very conscious of time. Does anyone else want to add anything on top of that?

Professor Thapar: On ADHD, while there are some overlaps in terms of comorbidity, there are some distinctions. It is an early route into mental and physical illness, self-harm and suicide. We have already heard about substance abuse, premature mortality, educational failure, unemployment and early entry to the criminal justice system, so the costs are economic as well as human. Much of it is avoidable. If you get the early support, pre-school and in school, you can avoid many of those

adverse outcomes. We recognise that for other areas in medicine. There are also really effective treatments.

Q51 **Alex McIntyre:** What data or analysis is available on the longer-term cost to society and public services of poor access to assessment and treatment?

Professor Mon-Williams: We have the great benefit in Bradford of having connected datasets on health, education, social care and policing so we can zoom out and look right across time. To support everything you have heard, we can look at the long-term ramifications of early support not being put in place. We start to see children and young people disengaging from the education system; we start seeing them become NEET. That plays out in terms of homelessness and vulnerability. Ultimately, with our colleagues in Cardiff, we have been able to show how that ends up with midlife multi-morbidity. If you do some quick back-of-the-envelope calculations, you realise that we are spending billions as a society sorting out problems downstream, whereas, if we just went upstream and provided some early support, we could dramatically improve individuals' lives and dramatically decrease the pressures on our services and grow our economy.

Q52 **Alex McIntyre:** What would those interventions look like in terms of early support?

Professor Mon-Williams: There are lots of evidence-based approaches, which I am sure we can talk a little more about. You have already heard some from the previous panel. The evidence is overwhelming that early support and evidence-based interventions are effective. The whole of pedagogy tells us about providing early support to help children overcome their learning boundaries.

Q53 **Alex McIntyre:** For the benefit of the Committee's evidence, what are the key interventions that would allow us to address the inequalities in access to assessment and diagnosis, and what barriers would prevent us from making those work?

Professor Thapar: I have been looking at this for part two. I was asked whether I could identify models that may have been used either in some parts of this country or in other nations that have impact and are cost-effective. In terms of pre-school, we have evidence from early years intervention. For example, we used to have Sure Start, that early family support, with evidence-based parenting interventions, and if we include ADHD and neurodivergence early interventions as well—I can certainly speak for ADHD—those have been shown to be cost-effective, and they support parents who may well have neurodivergence themselves. That is one system that works.

At school age, the other systems that have worked are the whole-school approach, changing school cultures, and direct join-up between schools and health. The other thing that has worked very well, which is coming in part two, is integrated youth systems. Twelve to 25-year-olds often fall

through the system and have massive transitions. Those have been evaluated in a number of countries. Probably the most similar in terms of our healthcare systems is Canada, where it looks as though they can get people seen much earlier, and use fewer of the most expensive resources. They basically have a one-stop shop. We have many of those services already, but they are fragmented. They have physical health, mental health, primary and secondary care, education, vocational training and social services all in one centre. We have those models; we have their cost and we have their evidence.

Professor Mon-Williams: At least two of us in this room were at an inspiring event that Barnardo's put on last night. They have done a cost-benefit analysis of the Cygnet course for parents and children with a diagnosis of suspected autism. Their analysis shows that for every £1 spent you get £3.89 back. There is overwhelming evidence of the economic sense of putting that support in place.

Q54 **Alex McIntyre:** It is really integrated.

Professor Green: Particularly in autism, where I have done a lot of work, we have evidence-based approaches, as Anita said, from the year dot, which work with families and parents to help them adjust to neurodivergence in their children. We have shown in clinical trials over 25 years that these have long-term benefits in developmental outcomes and cost-benefit.

Maybe to anticipate further discussion, the key thing is that these evidence-based approaches are not being implemented systematically in the health system at the moment. That is the key issue. We have evidence-based approaches, but there is a system problem for how they are implemented. I can talk more about that now, or when you would like me to.

Alex McIntyre: I am very conscious of time, so I will hand back to the Chair, because I am sure colleagues have lots of questions.

Chair: Thank you, Alex. Can we go swiftly to Joe?

Q55 **Joe Robertson:** Good morning. I have some questions on workforce. Currently, autism and ADHD assessments are delivered by a specialist workforce. What potential do you think there is to make use of a non-specialist workforce?

Professor Green: For autism particularly, I advocate a stepped detection/care approach. You will hear about this as a system change. The fact is that our current models are about 15 years old. They were fit for purpose, but huge amounts have changed since then. We have massively increased referral and awareness patterns, and the current system is overwhelmed. I am sure you already have that impression from other people.

A stepped care approach means that we take a proportionate approach with early detection. It is not diagnosis, but it identifies likelihood, and we introduce care at that point. We avoid people having to be on a waiting list for years, feeling awful and the children getting worse, by giving timely, proportionate care right from the get-go. The key thing about the workforce is that we have done this—partly based on experience in south Asia, where I have done similar work—by what we call task shifting; in other words, if you have a really worked-out intervention protocol you train up other people, non-specialists or non-traditional specialists in the health system workforce, to do that work. Task shifting at system level is the only way we will get out of the current crisis.

My argument would be that we have many people in the healthcare workforce, but they are not all doing what they need to do, and that is based on the evidence. We need to introduce redeployment training. For instance, the detection piece that we do for autism can be done by health visitors; it is part of the generic health visitor assessment. It does not need at that stage the big multidisciplinary specialist assessment pathway where people wait for years. We can do it with health visitor detection, put in care and take a stepped care approach. For people for whom that is sufficient, that is fine, but other people will need to go on to the more comprehensive and specialist diagnostic approach. That is stepped detection care.

What we have shown when we implemented that model in Greater Manchester, which we have done over the past few years, is that we can divert initially about 30% of referrals away from specialist assessment pathways into that care. Immediately you save 30% of your referral load by redeploying other people in your workforce to do the early care work that we have shown to be effective. That is an obvious cost saving. The specialist multidisciplinary team assessments are high level and very rigorous. They were recommended 15 years ago. They are great, but very expensive by their nature. We have to take a proportionate stepped approach, which is more system efficient. I believe that if we do that, as we have shown in Greater Manchester, you can save money and make a big difference. We halved the wait list in about 18 months by doing that.

Hayden Ginns: It is a very similar story around the Portsmouth model that we developed over the last six years. It was done in co-production with parents. When we consulted and engaged with parents one of the key messages we got was, "I want to understand my son or my daughter." That was the key thing. They did not necessarily want a diagnosis; they wanted to understand their youngsters and they wanted the school to understand the neurodifference and neurodiversity of their son or daughter. That is the first bit around co-production. The second bit is that it has to be done jointly with health systems, education systems and the voluntary sector. The point made earlier about joint commissioning between ICBs and local authorities is critical.

The model we developed relies largely on schools through the SEND process profiling children. We developed a profiling methodology with nine dimensions in neurodifference and neurodisability. We have trained probably about a third of the children's workforce in Portsmouth to be able to profile children's needs. We also set up a multidisciplinary team with health and education professionals, and particularly family support workers. We find that our parents value the support they get from family support workers. We have managed to dial down demand for formal diagnoses. About 45% of children who go through the profiling methodology go on to the diagnostic waiting list; about 55% do not. We engage with families to ensure that needs are being met. We call it a needs-led model. What are your actual needs? What is the kind of support that would be of benefit, rather than saying, "We're going to diagnose in two, three or four years' time"? It is very much shifting from an emphasis on diagnosis. There is a massively important place for diagnosis, but a lot of need can be met without requiring a diagnosis.

Professor Thapar: I want to highlight that, in terms of the workforce, the first thing we want to do is uncouple support and diagnosis. The taskforce has highlighted the importance of uncoupling because of needs in other systems. We need diagnosis for clinical decision making, but there is no need to wait to provide support.

In terms of the workforce, the research has matured but our services have not. We have become super-specialised. You have super-specialised people dealing with ADHD. It is very siloed, yet the prevalence is such that it needs a much larger number of the workforce and to be joined up between different systems. One of the really important things is to join up what we already have to see who is going to deliver what. Base it initially on needs. People with ADHD are not all the same. You need different intensities in a stepped care approach.

Joe Robertson: Thank you.

Chair: Thank you, Joe. Can I welcome Helen Hayes? Helen chairs the Education Committee and she is a guest with us today.

Q56 **Helen Hayes:** Thank you, Chair. I am very glad to be here. Thank you for having me this morning. You might know that, at the moment, the Education Committee has a separate inquiry into the crisis in SEND in education. Our inquiry also touches on the role of health.

I have a question that follows on from Joe's questions about workforce, specifically about the role of educational psychologists in the system. You might also comment on any of the other highly qualified professionals that we have working with children and young people. Are educational psychologists correctly and most effectively deployed in the current system? If that is not the case, where can they be used with their expertise to best effect?

Professor Mon-Williams: What educational psychologists? One of the reasons we are in the crisis we're in right now is the decimation of educational psychology services, driven by other problems. I am old enough to remember when it was a one-year course. We now have a three-year course, which is great, but it has dramatically affected the numbers. The pressures on educational psychology mean that increasing numbers are leaving the profession. What that means is that the support that schools used to have to be empowered to support the needs of neurodiverse and other children is no longer present. In terms of workforce developments, we have already heard great examples of how taking a whole-system approach and thinking about innovatively shifting tasks can have a dramatic impart. For me, sorting out the ed psych crisis would be one very sure way of starting to improve the situation.

Hayden Ginns: My response is similar. There is a crisis and a shortage. Obviously, the rise in EHCPs has taken a lot of educational psychology time doing the statutory assessment, as I am sure you are aware. We are involved in the DFE change programme which is innovating at the moment and testing particularly around the inclusion support offer—the team-around-the-school notion. If you talk to schools for too long, you find out that what they could do with is educational psychology expertise, sometimes around individual children, but often around the whole-school approach, and—the point made earlier, which I completely support—around school culture. On the national task and finish group, some of the conversations we have had with young people included a lovely phrase from some people who talked about can-do schools and can't-do schools, as well as a tiny number of won't-do schools, potentially. Educational psychologists are part of the mini-army of expertise that, wrapped around a school, can help drive culture and inclusion, but obviously a lot of time is being spent on individual children through the statutory assessment rather than on that whole-school work.

Professor Green: To support that point, we have good evidence that, particularly for autism, whole-school approaches are more effective than bringing in specialists to do a bit of work with an individual child. We have good evidence for classroom-based, whole-school approaches. There needs to be a system change in perspective on how we approach this work from an evidenced point of view.

Q57 **Helen Hayes:** Starting with Hayden, you have talked about needs-led approaches in schools. It seems as if that is the Government's direction of travel. They are talking about making mainstream schools more inclusive. What is required to implement that approach successfully?

Hayden Ginns: There is outstanding practice in a huge number of schools. We need to recognise that some schools do absolutely incredible work. A colleague talked about schools in his constituency. I think we can all point to schools that are fabulously inclusive and that really think about neurodifference and neurodiversity. I was reflecting with colleagues the other day, having worked in the children's system for nearly 30

years, that the journey we are going on is really interesting and is where the trauma-informed debate was probably 10 years ago. We have a much better understanding of the impact of trauma on children. We are going through that same journey now in our understanding.

We were playing around with the numbers in some conversations the other day. If we are talking about neurodifference in potentially 20% of the population, that is a can-opener to an interesting conversation with schools. Probably one in five children in your class may be experiencing some level of neurodifference, which potentially gets in the way of accessing the curriculum. When we talk about it in those terms, it opens the conversation a little more. As the professor said, we find that schools respond really well to those kinds of PINS, or whole-school approaches, and engage with training and professional development. We found that the training we do on the dimension model that we developed is in itself psycho-educational. We have teachers saying that they think about all 30 children in their class around those kinds of dimensions—where they sit, whether they wear headphones and all the kinds of reasonable adjustments, to use that lovely language, that you can make in the classroom.

On the other hand, I was talking to a youngster last night who had just left school. She was saying that her school had absolutely no idea whatsoever and was telling her she could not possibly be ADHD and dyslexic: "You can't possibly have those two labels." We have a journey to go on for that understanding. We often talk about that psycho-educational approach for all of us, not just schools, to understand neurodifference. I think we are part-way through that journey.

Q58 **Helen Hayes:** Does anyone else want to come in?

Professor Thapar: I want to highlight that for the evidence-based approaches we have talked about, like whole-school approaches, we have systems we can build on. We have mental health support teams. Some areas have partnership between health and education. We can build on those. We have the PINS project. I think it would be helpful to make sure that those include neurodivergence, and that as programmes are rolled out they are co-developed with the whole school, involving all school staff, including leadership, and in partnership with families, and that they are evaluated in real time.

The other thing, which may be more specific to ADHD, and where we have data from the US, is that we have under-diagnosis in England and in the UK more widely. In some areas of the US there have been issues with over-diagnosis, and school policies have been a bit of a driver there. There was research showing that when schools were made to be more accountable and forced to meet many more targets, the drive for diagnosis went up. There are lessons to be learnt. We are not at that point here, but those are things to think about in terms of school policies.

Professor Mon-Williams: I have three very quick points. First, reward schools for inclusivity. Too many of our systems right now reward schools that do off-rolling and other horrible practices. Let's get our system rewarding the schools that step up to the mark. Secondly, we have heard a lot about co-production. This has to be a co-producer piece. By that I mean getting health, education and social care working more closely together. You cannot have an ICB doing something over here and schools doing something else elsewhere. Get system changes, but that also means co-producing with children, young people and their families. As we have heard so much before, the solutions have to lie within our communities; it is not about having solutions pushed on them. The third point is using data more effectively. In Born in Bradford, we pick up signals in routine administrative data that tell us miles out that ultimately these children will end up in our services. There are huge inequalities associated with ethnicity, gender and socioeconomic position. Select and use data more effectively to address those inequalities and get care in at a much earlier stage when we can intervene far more effectively.

Q59 **Helen Hayes:** Our Committee has had evidence that very often there is an overlap between the children and young people who are in the SEND system in education and who are often entirely separately seeking services from CAMHS as well. Often, there is a relationship of failure between the two. They are let down by the SEND system. The consequences of that exacerbate their mental health and they end up seeking help from CAMHS. There is very little join-up between those two parts of our system. How can we fix that? What is needed to get better joint working so that a child is a child is a child and they receive the support they need from whichever bit of the system has a duty to provide that support?

Hayden Ginns: I can tell you how we did it. We developed a multidisciplinary team specifically around neurodiversity. It hangs between the education system and the mental health system.

The point about the MHST is really important. There is a little bit of a journey to ensure that the criteria for that kind of support—what you might call low-level support—is ND-informed. There is a little way to go on that.

Professor Green: I agree that local initiatives across agencies are important, but at Government level more integration between DHSC and DFE on these issues would be tremendous, because there are often parallel tracks in both thinking and funding. As you have suggested, this is an integrated thing, so more integration at a central level would be useful.

Q60 **Helen Hayes:** Thank you.

Professor Mon-Williams: There are no panaceas, but there is one thing that we could and should be doing at pace, and that is connecting our information systems, and that is something central Government could

help with. We are blessed in Bradford to have connected datasets. We can see the intersections and interactions between health and education. Why are we the only place in England with that connected data? Start doing that. It gives both local solutions and the central ability to act effectively.

Professor Thapar: It is important to remove barriers and incentivise people working together. I remember a time when we worked closely with schools, but it has to be recognised as work by all those systems.

Helen Hayes: Thank you.

Q61 **Jen Craft:** Very briefly, before I move on to the questions that I have written down, I want to pick up something that you said, Professor Mark, about rewarding schools for inclusivity. How?

Professor Mon-Williams: Ofsted frameworks. This is DFE's home territory. There are lots of ways that we can incentivise our schools and lots of ways that we can stop schools being punished by not taking the context within which they are operating into account. This is exactly the space that Government should be working within. I am encouraged at the direction of travel, but we have to look at ensuring that schools serve their communities rather than a bunch of KPIs that are centrally imposed and do not make sense to communities on the ground.

Q62 **Jen Craft:** Thank you. That is very interesting. That was a bit naughty of me, but thank you for answering that. You have all spoken very interestingly about this. What are some of the workforce and resource implications for delivering an early identification and early intervention approach? You spoke earlier a little bit about task switching. How could that be rolled out on a more national basis?

Professor Green: First, task shifting; in other words, training and supporting staff with lower levels of specialism to do quite specialist activities. With the right support, we have shown that we can do that effectively. It can be done, but it requires system change. One of the appeals that I would make to the Committee is this. We have a balance between localism, devolved commissioning and the thinking you are doing centrally. At the moment, the system is much too fragmented. Devolved commissioning has, obviously, benefits of localism, but it means that there are over 40 ICBs around the country all trying to make their own decisions about what to do.

The fact is that a lot of this is generically applicable. The evidence does not just apply to one place or another. The way we do science is to make generalisable conclusions. A lot of the evidence is applicable across the board. It is how we can get commissioners across all the ICBs, given that we have devolved commissioning, to take that on board rather than what is happening at the moment, which is, I am afraid, making up their own local solutions to a crisis, always with well-intentioned practice but not always with well-evidenced practice. We have good national evidence that

the NIHR and the national programmes have paid us as clinical academics to develop, which is what has happened. They have given my team almost £20 million over the years to develop the early intervention resource we have. That is the frustration. That money needs to be put in practice. It is very difficult to get that done nationally.

My appeal to the Committee is this. How can we have some sort of central standard setting and guidance for ICBs that is more than just a suggestion but actually says, "We've got a crisis here. We have to get an efficient way out of it"? The redeployment is a good example. Systems need to change to do that. There is inertia against change in complex systems like NHS practice. We have shown it can be done, but it is hard, and we need all the help we can get from central Government across the ICB network to encourage, persuade, cajole or guide their commissioning decisions to do that. Of course, there will be local considerations and co-design locally. That is fine, but there needs to be a national framework, which is what in the NHS historically we have been so good at. We have been so good at co-ordinated evidence-based practice. We are losing that in the current scenario of devolved commissioning. We are losing that coherence, and that is a problem.

Q63 **Jen Craft:** I know that schools have a significant role to play in the assessment process currently. Is it the case that ICBs across the country all have their own different forms, for example centres, schools or early-year settings, to say, "Does this child display potential characteristics of autism or ADHD?"

Hayden Ginns: One of the things that helped us was that my post was for a while shared between the ICB and the local authority, and that is very unusual, so I completely support Jonathan's point. We know that ICBs are going through some change and flux at the moment with the headcount reduction. If you look at the documents that have come out around a model ICB in terms of relationships with local authorities that have internal relationships with the education system and the SEN system, we are losing some opportunities there about how ICBs and local authorities join up around the children's agenda in particular. I am sure my adult services colleagues will probably say the same thing. ICBs are moving into that strategic commissioning space. It is more likely to be NHS trusts and the SEND system that design those pathways, but we need the ICBs and the local authorities to be joined up in their messaging around those joint pathways, because ICBs do not have the headcount to have a relationship with, in my city, 61 schools. We as a local authority absolutely do, so we can link the NHS system to the SEND system, which is largely what we are talking about here. ICBs do not have the bandwidth or the staffing to do that.

Q64 **Jen Craft:** Thank you. Professor Mon-Williams.

Professor Mon-Williams: They are very lucky to have Hayden. The reality is that things are much worse than you are describing because most of our ICBs have no representation from schools, or they feel that if

they have local authority representation, it is sufficient, but that does not take into account academisation. You have might have X number of maintained schools, but if that local authority is not effectively engaged with all the academies in its patch you have a complete disconnect between ICB commissioning and what the schools are doing. That is just one example of the system changes that are desperately required. If we want genuine integrated services, we have to have health and education working effectively, and that means schools have to be sat round or represented in those ICB conversations. Until that is addressed, we are just living in a siloed world, and we can all see the consequences. We have to sort this out at pace.

Q65 **Jen Craft:** Thank you. Professor Thapar.

Professor Thapar: I agree with all the comments that my colleagues have made. In the UK we follow NICE, and one of the issues is that we need to update NICE guidance to be consistent with what can be delivered, and the same with quality standards, whoever the provider is. What are the quality standards and how are we adhering to them? We all want this to change. Is it going to be included in the 10-year plan and will the tweaks we are suggesting be included in health in the spending review?

Q66 **Ben Coleman:** We have reached a really interesting point. To take that last point, Professor Thapar, you are coming up with your report soon. The 10-year plan is almost upon us. Will you look at what it says about the things that you have just raised and make a specific comment in your report on the 10-year plan once it comes out?

Professor Thapar: The interim report is published, and we deliberately timed it—it was finished on 31 March—for the spending review. I sincerely hope ADHD and neurodivergence will be included in the 10-year plan. It is a wonderful opportunity because we framed our taskforce interim report that has been published around the priorities for the 10-year plan, and the same for the spending review as well.

Q67 **Ben Coleman:** Absolutely. I appreciate that. It is very helpful. I am sure the Government found it very helpful. If what comes out, particularly when it comes to the new neighbourhood health approach, is not, you think, going to sufficiently respond to the need that you have identified, or the approach that you have identified, would your final report help talk about how the plan could be implemented in a way that may not be immediately clear from the way that the plan is presented, and help get the approach that you are looking for?

Professor Thapar: It would be wonderful if I could see the 10-year report so that as we are writing the part 2 report we base it on the information that we have. It certainly seems an excellent opportunity. The sorts of points that we are making are about increased generalisation, moving from hospital to community, increased digitisation to make systems much more efficient, and not having to duplicate

systems in clinic. I hope that it would be quite easy to incorporate ADHD, neurodivergence and mental health into what we believe, or at least I hope, will be the community hubs.

Q68 **Ben Coleman:** Thank you, that is really helpful. Coming back to the ICBs, what I am hearing, which is perhaps reflected in the experience of people in the Committee who have been involved in ICBs in previous lives, is that they are very health-driven. The talk about them being a partnership between health, other partners and local authorities particularly is that it is often fitful. It is still the usual top-down NHS approach. The aim of the Government is to try to have, they say, a much more joined-up approach between everybody. How do we get the health people to understand that local authorities are not just the chief executive who turns up to be asked about housing and all the other issues, but actually 61 schools, I think you said, in your area? It is not in every local authority; some schools will be Government-led, there will be foundation schools or free schools. How do we get ICBs to understand what local authorities and the school provision that they offer can bring to the table, and why they are essential? I will ask Professor Green.

Professor Green: I do not have much to say on that. My real expertise is not around ICB structures. Quality standards and commissioning standards for ICBs are in place, but they need to be made more specific and crisp so that there is not too much wiggle room for commissioning bodies. Probably part of that would be how local authorities and education are represented on them.

Q69 **Ben Coleman:** Would it be part of your ideal national framework?

Professor Green: They would pass for the national framework. Anita mentioned NICE, which has traditionally in health been the driver. NICE for autism is now over 14 years old. A lot has changed in that time. Even getting NICE implemented in this devolved commissioning structure is a problem. It is how the ICBs are guided to do this well locally.

Q70 **Ben Coleman:** Thank you. That is very helpful. Mr Ginns.

Hayden Ginns: There are lessons from other parts of the system, aren't there? To answer your question on ICBs, the ICB that I work with, Hampshire and Isle of Wight, has put significant resource into a children's commissioning function that works with the local authorities, but in my journeys up and down the country that is not always the case. We know that when initial plans for ICBs were drawn up a couple of years ago, and when they were first formed, rarely did you see the word "children" mentioned at all, let alone "neurodiversity and autism" because of the pressure on hospitals and adult social care and all the pressures in the system. With the headcount reduction, we will potentially see that again. There is something interesting around statutory partnerships. I have been talking to the DFE recently.

Q71 **Ben Coleman:** Who have you been talking to?

Hayden Ginns: The DFE, particularly around SEND, because there is no statutory requirement to have a SEND partnership. You are inspected against it by Ofsted and the CQC, but there is no statutory requirement, unlike in safeguarding children where there is a statutory partnership between the police, the ICB and the local authority. There is something that could be interesting in statutory partnerships as a requirement. We can badge it as SEND. You could even go as far as saying statutory children's partnerships, which if I remember rightly were statutory for three weeks in 2010, if I am remembering the correct children's Act.

I have a last quick point. Jonathan made the point really well about the difference between national join-up and local join-up. There are three things that affect children locally: the SEND reforms that are emerging; the social care reforms; and the neighbourhood health hubs. It is incumbent on us in local areas to make sense of those developments, particularly thinking about particular groups of children. In this context, it is neurodiverse children, but it might be children with complex care needs, it might be children who are excluded from school or it might be young offenders. We have to make sense at local level of those three big changes that are emerging from central Government.

Q72 **Ben Coleman:** Thank you. Professor Mon-Williams.

Professor Mon-Williams: To answer your question slightly in defence of integrated care systems, they are a step in the right direction. That integration is a good start, but just adding the word "integration" does not mean we end up with integrated systems. Practically encouraging integrated care boards to engage in a meaningful way with the schools and nursery education settings in their patch would be a good thing.

That takes us nicely to Jonathan's point. What is central Government for if it is not for QA, connection and co-ordination and setting expectations?

My third point is back to the one I keep making about the better use of information. It is difficult for an integrated care board to commission if it has no idea what is happening on the ground. Connected information systems that allow that commissioning to understand what is playing out in schools, the social care system, the health system and the criminal justice system, and look holistically would suddenly be game changing.

Q73 **Ben Coleman:** I know that Penny Dash, who is now the head of NHS England, is very keen on data, data, data, and that seems to tie into what you are saying.

Professor Mon-Williams: Absolutely.

Professor Thapar: The need for data was one of the recommendations in our taskforce report.

Q74 **Ben Coleman:** Yes. Is the data there to be pulled together?

Professor Green: Briefly on that, I led the children and young person's theme in the mental health mission, which was and is an ongoing Government initiative to transform mental health care. One key aspect of it that I am driving is digital and data transformation. Is the data there? Yes. Can you get at it to integrate it? Not yet. Are there the systems to do that? Yes, but we need to implement them. We are on the road, but we are aiming for an integrated digitisation of the health and social care and education systems.

Q75 **Ben Coleman:** Data comes from different parts of the system, from health, social care, local councils and charities. Who is going to lead the process of bringing all that together?

Professor Green: What we are doing at the moment within the mental health mission is a digital platform that sits above all those different systems. It will have embedded data—

Q76 **Ben Coleman:** Where does the platform sit? In the Department of Health and Social Care?

Professor Green: It sits in the cloud, but it is owned by a Government-funded initiative called CADRE, as it happens. It is an integrated data system that allows different data sources—they are often coded differently—to be integrated into an integrated platform. It is technical, but it is possible. It is happening; it just needs to be put into place in practice.

Q77 **Ben Coleman:** Thank you. I will take Mr Ginns and Professor Mon-Williams and finish with you, Professor Thapar.

Hayden Ginns: The technology exists. You can match children. There are all sorts of clever systems that match children. I am not convinced we need a national single identifier for each child, because that technology exists. It is the information-sharing governance that is the barrier. I have developed with colleagues exactly that—a matching database that pulls together safeguarding information and education information within my local authority. I cannot get health systems to share data so that I can match health data with children because of the information governance issues.

Professor Mon-Williams: I emphasise that. We have done that. In Bradford, we have health, education and social care, and we have some very clear learnings.

Q78 **Ben Coleman:** How did you overcome the governance issues?

Professor Mon-Williams: The legal pathways are there. Of course, you have to use the right legal pathways. If you say, "Can we just do this?", without engaging with the public, any lawyer will tell you, "No, you can't." If you say, "Can we use our data more effectively in order to deliver our statutory responsibilities as local authorities, health services and social

care services?", the answer is yes. There is a myth that we do not have the appropriate legislative frameworks. They exist.

A single identifying number would help. We have done it without, but that means that we miss some of our children and young people, and, of course, they are the very children and young people you probably most want on your database. We do huge amounts of public engagement. People in Bradford understand what we are doing and support what we are doing because we are able to show how the work helps us improve autism pathway services. One of the things that we have learnt, going back to your question, is who should hold these data. People trust health services.

The reason we have been successful is that we sit within a trusted NHS organisation, and then the Department for Education can push its data through to our secure data environment, and people are comfortable with that. They are comfortable with it because we then use the data for public good. We do it locally. If you said to people in Bradford, "Do you mind us sending all this connected data up to Westminster?", they would say, "Actually, I'm not very comfortable with that." That is where ICBs could play an important role, and we are exploring in Yorkshire how our ICBs can act as data processors that pull together primary care, secondary care and education data. If we do that, it is transformative.

Q79 **Ben Coleman:** That is very helpful. The Government are bringing in a single identifier number, as you know, so I hope that will help.

Professor Thapar: There are some data and there are research data, but the data are not of sufficiently good quality. I speak for ADHD here. You need good-quality data to know who is on your waiting list, how long they have been waiting, how you design your services and the numbers involved. We need much better-quality data, and for that to be a priority. Many of our clinics are still paper and pen. We need that digitised, and it is one of the priorities that we have highlighted in the report. Hopefully, it will be taken forward in the 10-year plan.

Ben Coleman: We will cover different angles. That is really helpful.

Chair: Thank you, Ben. Can I go swiftly over to Danny, please?

Q80 **Danny Beales:** Thank you, Chair, and apologies for the lateness. I was on a Bill Committee. What I caught towards the latter part has been really insightful and helpful; thank you.

It is clear from a number of the speakers so far that there is good practice in evidence. You have talked about some of the drivers of good practice. Conversely, I would be interested to hear from you—Professor Green to start and others as well—what the systemic barriers are to the wider adoption of that good practice. You talked about local solutions and some of the positive aspects, but why do you think those elements of good practice are not more widespread in local systems or nationally?

Professor Green: There are lessons from generic system change and innovation. There is custom and practice. There are professional assumptions and things that people have always done that mean that sometimes system change—what I am suggesting for autism is a more proactive rather than a reactive approach. You are making initial detection, putting in care, and then what we call secondary prevention—preventing things from getting worse. That requires quite a big system change and mental change for a lot of services that are incredibly under stress. They are firefighting, people are knocking at the door, and they do not have time to think.

Those kinds of barriers are very understandable systemic barriers that we have worked with, in Greater Manchester for instance, and done the system change—hearts and minds. It has to be done at each level of the system, from senior commissioning to management to practitioner to the families and the stakeholders in the system. It is the whole thing. The barrier to change is not rocket science. It is about the inertia and for us to be able to advocate and explain the change that is needed. Once people get it, it is transformative because they feel much more on top of everything. They are not feeling overwhelmed all the time.

Q81 **Danny Beales:** Is it a resource problem?

Professor Green: No, I don't think it is primarily a resource issue. It is a conceptual issue, it is a practice issue and it is redeployment of staff resources, which I described earlier. If we make those system changes, we have shown that we can introduce this change cost-neutrally. It does not cost a huge amount of money, but it means that we have to have some conceptual and persuasive evidence for locality services. The issue is how to do that at scale when you have such a locality-based fragmented system. That is the conundrum. I want to support locality solutions, but a lot of people in localities faced with crisis at the moment, particularly the wait lists, say, "We've got to do something," and what they do is a bit knee-jerk sometimes and not always evidence-based. We know that evidence-based practice is more effective and more efficient in the end. That is the conundrum. How can we help localities do the things that we have shown with our research actually work?

Q82 **Danny Beales:** Do you think a transformation programme with targeted resource to go in to support systems to redesign based on your evidence would be the kind of intervention that—

Professor Green: That is what we have done in Greater Manchester. It is just about—

Danny Beales: Scaling that.

Professor Green: —scaling it up and having some sort of more national taskforce approach that can push it through. It is all there to be done, and the systems will be hugely enlivened by it, rather than feeling so demoralised, which a lot of people are at the moment.

Q83 **Chair:** Thank you, Danny. I have one more question, and then we will round things up. Schools and educational professionals are being asked to provide increasing amounts of support to children in schools. What do we need to do to ensure that they get the effective support that they need? I will go to Hayden Ginns.

Hayden Ginns: It is very easy to say "resources", isn't it? One of the things I did a few years ago was to count across our schools the numbers of non-teaching professionals who were working with children, what you might call the pastoral workforce: attendants, assistants and family workers. I did it again about six years later and there were about half as many. The idea that austerity has not hit schools is not true. We know that non-teaching professionals are stretched enormously. We also know that the number of EHCPs is climbing, and therefore the SEND resource in schools is really stretched. The one message we get from our schools all the time is that it only takes one or two children with quite specific SEMH or neurodiversity needs to take a huge amount of resource from other children in school. We know that.

Yes, resources obviously, but I go back to the multidisciplinary support, the team-around-the-school approach, the professional development, and the advice and guidance that we can get. We have all sorts of models up and down the country of speech and language therapists, mental health specialists and, in some areas, even paediatricians who are able to spend their consultancy time with schools, doing professional development and training and the whole school culture piece that we mentioned earlier. It is the deployment of those resources in and around schools and clusters of schools.

We are going to have to navigate our way through academy providers versus maintained schools as to whether it is geographically based or based on who runs the school. We are going to have to work that one through. At the moment, quite a lot of inclusion support services are traded services, so it is incumbent on the school to pay for them. We have been talking to the DFE—to use diagnosis in a slightly different sense—about the diagnostic self-assessment bit for a school that says, "We could do with this kind of advice, guidance and support for professional development or interventions for children," based on a really good understanding of the inclusion practice in that school, which links entirely back to the Ofsted piece, when we get judgment around inclusion. It could be a potential game changer if we get that right. Ofsted inspects schools for the children who are in that school, not the children who are not in that school. We need to understand how inclusive a system is, not just individual schools.

Q84 **Chair:** Thank you. Excellent. Before we close, I always ask every panel—if I miss it, you know that I have forgotten—what are the two most important takeaways from everything that has been talked about today that you would like to ensure that we include in the report that we are writing? I know I am being naughty. I will start with Professor Green.

What are the two takeaways that you believe that we need to ensure that we have in our report?

Professor Green: It is that we have, as I think you have heard, good, rigorously evidenced models of good practice. We know that they can work, but they are not being universally deployed at the moment. The first of the two things is to be clear about the evidence-based practice that we wish to have included. NHS England is very clear; they have done a lot of work on this in terms of autism. The second thing is how we work through the conundrum, the system redesign that we desperately need, integrating top-down guidance from the evidence with locality decision making and square that circle efficiently. Those two things are what a modern NHS needs to go forward.

Q85 **Chair:** Excellent. We have one minute. What are the two things from you, Professor Mon-Williams? Be succinct.

Professor Mon-Williams: I hope you have a sense of consensus, because we are all saying the same thing, as was the previous panel. We have to connect. We have to co-ordinate. There is a role for Government. That will give us hope. We have to start integrating our services. In Bradford, we have the Education Alliance for Life Chances, which brings together everybody around the schools. The Royal College of Paediatrics and Child Health is producing fantastic resources. There is real hope, but we all need to commit to making the changes that are required.

Professor Thapar: The ADHD taskforce has produced a report, and we will be producing part two. It is a lot of work with scientists from across the UK, clinicians and lived experience groups. I would like to see those recommendations implemented. There are two great opportunities in the 10-year NHS plan. Please include ADHD and neurodivergence in it. Secondly, the spending review will give an opportunity to implement some of these recommendations. Invest to save.

Chair: Thank you.

Hayden Ginns: Co-production with families. Don't do anything without co-production with families. Secondly, local accountability for your director of children's services, your director of public health, your ICB commissioners and your schools forum.

Chair: Absolutely brilliant. Thank you all for coming today.