HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Delivering health aspects of Education Health and Care Plans, HC 1824

Wednesday 18 March 2026

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Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Dr Beccy Cooper; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Gregory Stafford.

Questions 1-121

Witnesses

I: Anna Bird, Chief Executive of Contact and Chair of the Disabled Children's Partnership, Dr Tracy Laverick, Senior Educational Psychologist and Senior Lecturer, School of Education and Childhood, Leeds Trinity University, Dr Sally Payne, Professional Adviser for Children, Young People and Families, Royal College of Occupational Therapists, and Gillian Vince, Spokesperson for the Royal College of Speech and Language Therapists, Senior Manager for Speech & Language Therapy, Paediatric Occupational Therapy and Podiatry, and SEND Strategic Lead at Northumbria Healthcare NHS Foundation Trust.

II: Ingrid Bell, Designated Clinical Officer for SEND, Cheshire East Place, Dawn Fenton, Designated Clinical Officer for SEND, Salford Locality, and Elliot Howard-Jones, Chief Executive, Hertfordshire Community NHS Trust.

Examination of witnesses

Witnesses: Anna Bird, Dr Tracy Laverick, Dr Sally Payne and Gillian Vince.

Q1 **Chair:** Welcome to this one-off session of the Health and Social Care Committee, in which we will be exploring the delivery of the health aspects of education, health and care plans. At the top, before we move to introducing our panel, I would like to say a massive thank you to the group of parents who came to meet me in my capacity as Select Committee Chair in Oxford West and Abingdon. I am aware that some are in the room today; their powerful testimony has rooted what we are doing today and will be taken as official evidence.

In particular, two went public with their story, and I want to start by talking briefly about the challenges they face. One is Sonya, who is in the room with us today. She spoke about her son, Stefan, who has an EHCP. As part of the issues he faces, he is in a wheelchair because he has MED, which affects his hips, and he needs adult support to get around, but there just is not that support in his school. So he has a mobile phone that he keeps on him at all times in order that he can call his mother if he ever gets stuck in a classroom and literally cannot get from one class to the next. They identified that it was funding that was the problem here, not the school; the school is not the issue.

The other child is Tommy. Tommy's father, Chris Fulton, came to speak to us. Tommy, who is five, has significant developmental delay. Chris described "battling through the courts" to help to ensure Tommy's provision. He described the health element as "eye opening" and "light touch". He said: "What that leads to is a thin sense of provision for the difficulties he faces". It was extraordinary in that meeting how, almost with one voice, every single family, bar none, had issues.

We will move to asking the members of the panel to introduce themselves, and then I will move to this question: why is the system not currently working? We will start with Dr Tracy Laverick and go down the panel.

Dr Laverick: I am Dr Tracy Laverick. I'm a senior educational psychologist and a senior lecturer at Leeds Trinity University. My area of research is SEND assessment and review teams, so the local authority casework teams.

Anna Bird: I am Anna Bird. I think I am here as chair of the Disabled Children's Partnership, which is 130 organisations that have come together for better education, health and social care for disabled children and their families. In my day job I am chief executive at Contact, who provide information and advice to families with disabled children.

Gillian Vince: Good morning. I am Gillian Vince. I'm a speech and language therapist by background. I work for Northumbria healthcare trust as a senior manager, and speech therapy is one of the services I manage. I am also the SEND strategic lead for the trust.

Dr Payne: Hello, I am Dr Sally Payne. I'm a professional adviser at the Royal College of Occupational Therapists and a children's occupational therapist, which means that I help children and young people to take part in the everyday activities that occupy them and keep them busy, wherever they live, learn and play.

Q2 **Chair:** Thank you. Anna, do those stories sound familiar?

Anna Bird: Really familiar. We hear all the time from families who are really struggling to get health support. When we talk about health support and health within the education, health and care plans, we need to understand that broadly. It could be speech and language therapy, occupational health, clinical needs—managing meds or tracheotomy care—or nursing care through the day. We need to see a broad spectrum of support.

We see that families are not getting the support they need. They are having to wait until there is a crisis and having to wait a long time for a diagnosis, with no care coming until that point. They are waiting until their child falls out of school before any intervention is put in place. That obviously has an impact: children not being in school, not learning and not making friends like their peers—all the ordinary things we want for every single one of our children. It also has a huge impact on the whole family, with parents not being able to work and extreme pressure on the family. It is very common. We are seeing huge waiting lists, a lack of support and a lack of a sense of accountability for delivery.

Q3 **Chair:** What has got us to this point? What are the barriers to working together? Dr Tracy Laverick, would you offer anything on that?

Dr Laverick: One of the key issues for SEND casework officers, whose job is basically to deliver what is in the SEND code of practice, is that they do their job with no training. There are no standards or minimum expectations or qualifications for the job, but it is now such a complex role. Because there has not been an increase in the number of casework officers to match the increase in the numbers of children, they have less time to do the job, which in the past they were maybe doing better. They do not have the time to build up relationships with families, and cannot get to know what is happening.

They just receive all these pieces of advice, although my research found that they find it very difficult to get advice, particularly detailed advice, from health, and more so from social care. They have to spend a lot of their time chasing advice, and then there are issues with the advice they receive—a lack of specificity and it not being particularly clear. They then have all these pieces of advice from all the professionals, and their job is to somehow make this into a comprehensive document. You cannot do that in isolation from the family and the young person, but that is what they are expected to do. It then goes out as a draft. All the time is taken going to and fro, because it is done as a paper exercise. We are not actually working together to make this a comprehensive document in the first instance.

Q4 **Chair:** That thought came out very strongly in the roundtable we did with families: who are these people, who have never even met this child, making these decisions? Gillian, what is your view of the barriers, right now—we will come to the White Paper in a moment—that are stopping us doing the right thing?

Gillian Vince: From a speech and language therapy point of view, there are lots of contributory factors. There is significant variability in how services are delivered and how they are commissioned. There are challenges in the workforce, in that there are not enough speech and language therapists to meet the demand. That often translates into long waiting times, both for initial assessment and for subsequent treatment.

As services have tried to meet that increased demand, there has been a channel of focus into the specialist level of intervention, and sometimes less work at the universal and targeted levels, where we know support and early intervention work. There is a lot of variability in how services work and how they are commissioned, and the workforce is not big enough to meet the demand that is there.

Dr Payne: I echo Gillian's points. There are two primary issues: workforce capacity and commissioning. We carried out a survey of children's occupational therapists just in February of this year. Of the 527 children's OTs who responded, 72% said there had been an increased demand and need for their services since January 2025, 50% said their teams are not fully staffed, and 64% said that, even if all the posts were filled, that would not be sufficient to meet the need and demand. We have a real capacity issue.

The second point is around commissioning. Children's occupational therapists largely work within the NHS, but are being asked to deliver services and support within education. Historically, they have just not been commissioned to deliver that, so the demands have increased, but the capacity hasn't.

Q5 **Chair:** I have one quick follow-up for Dr Tracy Laverick. I was struck by you saying that people are struggling to get the right information from the NHS. Is there meant to be someone within the NHS who helps to co-ordinate with the advisers or not? How is it meant to work? Is it the case that the system is right and there just is not someone on the other end of the line, or is the system itself broken?

Dr Laverick: There are different levels there. With regard to when an assessment comes in for a child, they will write directly to anyone who is known with regards to the child. Any therapist, for example, who was involved would be written to directly so that they could provide advice. There is also a generic centre that it goes to: is there anything on file for the child or anything we need to know?

Q6 **Chair:** Where is that centre? Who holds that information?

Dr Laverick: That is something I would need to clarify. It may vary. One issue we have is that there is no consistency between local authorities, but

even within local authorities they don't work consistently. A parent has no idea what to expect. They may see their casework officer and it may feel more co-ordinated; they may work with a different officer in the same authority, who works in a different way, and it may not. So the variety and the lack of consistency are a huge issue. Health should be on the wider panels, though, with regard to that final decision making.

Chair: Thank you; that is very helpful.

Q7 **Dr Cooper:** Thanks for coming along this morning. I will carry on from where Layla left off. I heard you mention capacity, commissioning and consistency—all very important things—and I want to focus the discussion on how health bodies are doing in this area, compared with local authorities and education. The Education Committee found that health bodies are not pulling their weight in this area, and I wondered whether that is the experience you have found when speaking to parents.

Anna Bird: I am certainly happy to talk about what we hear from parents, which is that the health elements of an education, health and care plan are often the bits that are not being delivered. That is certainly what we hear: there is a sense that the health bit is not pulling its weight, and there is less of a lever—

Q8 **Dr Cooper:** Do you get a sense of why that is?

Anna Bird: There is something about the way education, health and care plans are constituted at the moment. Section G of the plan, which is the healthcare bit, does not have the same statutory force as section F, and that is a big problem. What we see in section G is, as others have said, often quite unspecific; it can say "speech and language therapy", but it might not say by whom, for how long and how much is needed. That makes it quite difficult to enforce that part of the plan. We certainly hear that from parents all the time.

Q9 **Dr Cooper:** Okay, so it is something you have heard. Would anybody else like to comment?

Gillian Vince: Just thinking about the health element of plans, from a speech and language therapy point of view, speech and language therapy is often written into section F. Any provision that educates or trains is seen as a special educational needs provision. The assessment might have been by a health professional, but it will come into educational provision as well.

Q10 **Dr Cooper:** You mentioned before about the commissioning issue: people are not commissioned to go into educational settings, so that is a problem.

Gillian Vince: There is variability around that. Some speech and language therapy services operate a clinic-based model and do specific assessments and treatments in a clinic. A lot of speech and language therapy services will work at place in schools and settings. There is the capacity of the workforce to do that across every school and every early years setting as well.

Q11 **Dr Cooper:** Do you think there is capacity within the healthcare system to

do what needs to be done in EHCPs? Do you get that sense?

Gillian Vince *indicated dissent.*

Dr Payne *indicated dissent.*

Dr Cooper: Dr Payne, you are shaking your head. Would you like to speak?

Dr Payne: I am sure I am not just speaking for occupational therapy, but services are incredibly stretched. We have professionals who are working really hard and who want the same as parents and families, which is to do the best for children and young people in the education setting. But the demand is huge, and services are being delivered through a real patchwork of different models. We have occupational therapists who work in NHS core services. We have provision by local authority-funded occupational therapists and by independent practitioners. We have a real challenge around the inconsistency that we mentioned previously, and that model is pretty unsustainable in the long term.

Q12 **Dr Cooper:** It is a broken commissioning model, by the sound of it. People are doing different bits in different parts of the system.

Dr Payne: There is a lack of co-ordination and lack of accountability.

Q13 **Dr Cooper:** Okay, so how can we improve that accountability? You talked about patchwork commissioning. Do you think integrated care boards becoming strategic commissioners will be a good way forward, because they will be responsible for much more strategic health commissioning? Do you think that is a good idea?

Dr Payne: Integrated commissioning is certainly something that needs to happen between ICBs and local authorities for children's therapy services. That certainly has to be a starting point.

Q14 **Dr Cooper:** Just to be clear, local authorities do not sit currently on the board of ICBs, but you think that working relationship should be much closer.

Dr Payne: That collaboration and that multi-agency working is part of where it is falling down.

Q15 **Dr Cooper:** How else do you think we can improve the accountability of the health part of the EHCP?

Anna Bird: From our point of view, it is about joint commissioning; it is about that integrated approach. It starts from the top, and we need to see special educational needs being a higher priority right across the health service.

Q16 **Dr Cooper:** You do not think it is currently.

Anna Bird: It is not now.

Q17 **Dr Cooper:** And why do you think that is?

Anna Bird: For all sorts of reasons, but there are many priorities in the health service. We have not seen that in the 10-year plan. What we want to see—

Q18 **Dr Cooper:** Just to be clear, you do not think that these issues—this commissioning—are highlighted sufficiently in the 10-year plan as it currently stands.

Anna Bird: No. In the 2026 workforce plan that sits alongside the 10-year plan, we want to see a specific strategy for the workforce around SEND. That is what is needed, so that we can—

Dr Cooper: You are talking about the health workforce around SEND.

Anna Bird: Yes.

Q19 **Dr Cooper:** The commissioning will go ahead with the workforce as it currently stands. Am I hearing that even with good commissioning, we simply do not have the workforce capacity to deliver what is needed? Is that reasonable?

Dr Laverick: Certainly when I sit in tribunal discussions about cases coming up, and we are liaising with health, whatever is written in the plan is fine, but there are not the people on the ground to actually deliver what is in the plan. We are all in a lose-lose position, because even if we say, "This is what is in the plan. We've managed to get the advice and put something together," there is not anyone to deliver it. I want to highlight that we do not get any information from aspects of health such as CAMHS, which can be vital to an education—

Q20 **Dr Cooper:** To be clear, you do not get any report, or is that a GDPR issue? How does that work?

Dr Laverick: As educational psychologists, we do not need detail necessarily with regard to why children may require CAMHS, but we do need to know what provision they require. Is it therapeutic input? Is it adjustments within the school system? Getting any information from CAMHS was one of the most reported difficulties from all the SENAR officers that I reviewed.

Q21 **Dr Cooper:** Do you know why you do not get the information? Is it an administrative issue or a GDPR issue?

Dr Laverick: There has never been a reason given as to why we cannot get the information from CAMHS.

Q22 **Dr Cooper:** Has anybody ever asked?

Dr Laverick: Yes, particularly when we are going to tribunal, because we are trying to make sure we have everyone around the table, but getting any information from CAMHS colleagues can be incredibly challenging.

Q23 **Dr Cooper:** Just to be clear, what is the reason they give?

Dr Laverick: We do not tend to get a response.

Chair: No response!

Dr Laverick: Quite frequently.

Q24 **Dr Cooper:** So you say, "Can we have the information?" and they do not say anything.

Dr Laverick: Obviously, we are generalising here. There will be some CAMHS practitioners—my colleagues in psychology—who will provide it, but it is very limited. I hear consistently from officers that getting information from CAMHS was the most difficult area.

Q25 **Dr Cooper:** I hear you. I just want to be clear that there is no actual reason, as far as you are aware, why they cannot give you the information—there is no legal reason or data protection reason.

Dr Laverick: No. We do not want or need to know the detail of why that young person might need CAMHS, but we do need to know what that provision needs to look like. Do we need therapeutic inputs on a weekly basis? We are not getting that either.

Dr Cooper: You are not getting that.

Dr Laverick: We are not getting that, no.

Q26 **Dr Cooper:** How interesting, and peculiar. Finally, to be really clear, if there is no increase in the workforce in this area and the commissioning becomes much better, is there another way to work smart with the workforce that we currently have?

Dr Payne: There is some possibility of repositioning some of our workforce. There has been a focus on early intervention and prevention work, but if you have a service of three members of staff, you have much less capacity to reposition your workforce, because they are not there. If you have a workforce of 10 or 20, then that is a possibility. But investment will certainly be needed.

Dr Cooper: Thank you.

Chair: That exchange on CAMHS reminds me that we are doing a joint inquiry with the Education Select Committee on issues with CAMHS. That inquiry is open, so if you have more to say on CAMHS, please do send in evidence.

Q27 **Jen Craft:** Good morning. I would like to move on to what the proposed reforms in the schools White Paper might mean for that missing "H". How confident are you? Do you think that the new tiered model proposed in the White Paper—universal, targeted, targeted plus and specialist—and the introduction of individual support plans that goes along with that will ensure that children receive timely support for their health needs, without needing an EHCP order to get it?

Dr Payne: Every school having access to occupational therapy expertise has long been an ambition of RCOT, and the Experts at Hand model in particular has the potential to help us to move towards that. As a profession, we are moving much more towards that tiered model and graduated response, recognising that early intervention is about getting

the right support to children and young people at the right time. Hopefully, offering that early help, and building the capacity of the people around children and young people to support them in the places where they live, learn and play, will prevent some needs from becoming more complex and requiring more specialist intervention, which will mean we then have more capacity to support the children who need a higher level of support in a timely fashion.

Anna Bird: From the Disabled Children's Partnership's point of view, there is lots to celebrate in the White Paper. We are really pleased in particular about the Experts at Hand provision, which will make a difference to the route into schools for health provision. We are pleased to see the introduction of individual support plans.

We have some real concerns, though, about how far it goes on health. There are no new rights to health provision in the package of reforms as they are currently constituted. There has not been an overhaul of health accountability in the proposals, which is a mark of the fact that health professionals have not been round the table as much as we would have liked during the development of the proposals.

We have been doing some focus groups with families over the past couple of weeks, so we are fresh from hearing what they think, and they are really concerned about the lack of definition around complex needs, and what that means for access to health, particularly under an education, health and care plan. They are really concerned about complaint routes, particularly for health. If the Experts at Hand service is not delivering, do you complain to health? Do you complaint to the school? It is not clear what the route is for families.

The process and enforceability of health in an education, health and care plan feels really unclear at the moment. There is the change of some stuff being written in the individual support plan, and some stuff being written in the education, health and care plan, so where the duties are around that feels really difficult to understand. There is lots to unpick, but it does not feel yet like we have the health bit of the system nailed.

Q28 **Jen Craft:** What would drive that accountability around the health part of the new system?

Anna Bird: We want to see really clear joint accountability for local authorities and ICBs around the delivery of education, health and care plans. That is what is required.

Gillian Vince: I think that possibly goes beyond just education, health and plans as well, when it comes to joint accountability for all children, whatever level of support they are accessing through the current system or the new system.

Dr Laverick: There is very little clarity at the moment with regard to the local authority, and who we mean by the local authority. Are we talking about casework teams taking on a casework role, in order to provide supportive challenge when provision is not being put in place? There is not

a role, or capacity for that role, at the moment. How do we work together to make sure that that provision is in place, and what could the local authority's role be in that?

At the moment, it is very difficult to tell from the information. How are local authorities going to make decisions on the specialist provision packages when there is currently very little information about what they would actually entail? It is therefore very difficult to look at how we are going to work together and what this would look like. Is it still going to be a paper exercise within the local authorities? That is actually a very inefficient way of working. Are we going to be working more collaboratively and co-producing these with families? The lack of detail is the issue.

Q29 **Jen Craft:** Do you think that there is enough health input from DHSC, for example, in the design of the new support packages? I know they have not been unveiled yet and they are very high level, but do you think that input is coming through? I think five to seven areas of development have been published.

Dr Payne: We don't know yet.

Anna Bird: I don't think they are developed far enough, but we do not think there has been enough health involvement. In terms of the areas of development, there seems to be an uncoupling of clinical need and education need, which feels quite concerning to us. We are worried that it seems mental health is being taken out of the SEND system. What we need is a really integrated approach. This kind of separating out and saying, "That's your job; this is ours," feels difficult. We need to understand a lot better what the reasons for that change are. Certainly, when we spoke to families over the past couple of weeks, they were really concerned that mental health support will not be there for their children. That is a really fundamental part of the support they need for their children to be well in school.

Jen Craft: I noticed that social, emotional and mental health were not explicitly mentioned in the areas of development, so I can see the concern.

Anna Bird: Yes, exactly.

Q30 **Jen Craft:** I am picking up from you that you do not feel that there is enough join-up between health and education in the publication of the White Paper and the proposals that have been put forward. Is that fair to say?

Dr Laverick: I think there is very little detail in there for us to know how this would work.

Q31 **Jen Craft:** To circle back to accountability, is there an opportunity, when we see the forthcoming SEND legislation, which will probably be in the next parliamentary Session, to bake more accountability into the system when it comes to healthcare needs?

Dr Laverick: It is about how that accountability is going to be built in. Who is going to be holding them accountable? When I was reading the consultation document, I wrote "Who?" and "How?" almost all the way through it. There are lots of very good ideas in there at the moment, but who is going to do that and how are they going to do it in a way that is robust and enables that accountability? If we are collaborating on the provision for children, that accountability is built in. If you are having the meetings and saying, "Why hasn't this been put in? Let's talk about it with the parent, the child and the school. What do we need to do in order that this is in?", then that accountability is built in. At the moment, there is nothing there, and there is no detail in the White Paper with regard to how that would be done.

Anna Bird: One of the big points around accountability for us is that although we really welcome the introduction of individual support plans, the Disabled Children's Partnership recommended that assess, plan, do and review be put on a statutory footing. In the current proposal, we have assess, plan and review on a statutory footing, but the delivery bit does not have statutory force.

Particularly for the health elements of plans—both ISPs and EHCPs—we need to get accountability around delivery. Is this stuff actually happening? Is there a workforce there to deliver it? There that needs to be that force around the actual delivery of what is in the plan. There is something to look at in the legislative bits of this process to make sure that we hold every agency to account for delivering what children need and what is written in those plans.

Gillian Vince: To add to that, many service specifications are very out of date, so there is not up-to-date clarity on what a service needs to provide in relation to the local population need. We know that need has changed, demand has increased and complexity has increased, and service specifications are often very vague and out of date.

Q32 **Jen Craft:** Have you got an example of that?

Gillian Vince: I would need to find one.

Chair: You can write to us.

Q33 **Jen Craft:** It would be really helpful to have an illustrative example of that.

Before I hand back to the Chair, I am trying to get to the heart of what bit of what health is supposed to provide it would be useful to have on a statutory footing. Is it about the commissioning of services? Is it about early intervention and what is supposed to be provided in terms of having an expert at hand? Or is it more about ensuring, when you have an individualised plan that says, "This child needs x, y and z," that there is a statutory obligation to provide those things? Or is all of the above?

Anna Bird: I want to say, "Yes, please." I do think it is all of that. We have come at this from the perspective of what families need for them to

be reassured that the support is going to happen, so we have thought particularly about the individual plan and whether it is being delivered, but accountability around commissioning is just as important to make the systems work.

Gillian Vince: At the moment, the individual accountability within an individual child's plan has sometimes shifted focus to services only having the capacity to deliver against EHCPs. Those other areas—universal, targeted and targeted plus—may be compromised. So the first two points you made are crucial in order for someone to be held to account for delivery against an actual plan.

Q34 **Chair:** I want to be absolutely clear about what we are asking for off the back of that, and I think you might have just landed on it, Gillian Vince. The Education Select Committee said that we should put the "H" on a statutory footing as well; what we are probing is what exactly about it should be statutory.

Anna, you said that delivery is the key thing, but is what is currently happening that because it is not on a statutory footing, everyone thinks, "Well, in a scarce environment we just need to focus on the bits that are on a statutory footing"? Is that why people are clamouring for having elements of the health bit of it on a statutory footing—because they are noticing that that is the bit that is falling off? There are people who say, "This is going to make no difference at all. The real issue here is the lack of workforce and the lack of working with families. If you fix all of that, all this becomes something that hopefully you will never have to use."

Can we be really clear? Should we be recommending to the Government that in the forthcoming White Paper and the draft legislation to come from it, the delivery of the EHCPs must include health, and that is what we are focused on? Is that what we want? Can you each answer that individually? It can be yes, no or something else entirely.

Dr Laverick: In the delivery of health provision, we have to remain child focused. It is about meeting the child's needs. Commissioning and everything else will all lead into that, but the delivery affects the day-to-day experience for that child, and that is what we need to get right.

Q35 **Chair:** Do you think that putting that into legislation will make a difference?

Dr Laverick: You would hope, but then it does lead into things like the workforce issue and whether there are the people to actually deliver the provision in the plan.

Anna Bird: Yes, but it does need to go with workforce.

Gillian Vince: My answer is the same: it is about workforce and joint commissioning.

Dr Payne: Agreed—it is about workforce, accountability and joint commissioning.

Chair: Well, let's talk about workforce then.

Q36 **Josh Fenton-Glynn:** One thing that is coming across is that we need clarity that when families need support, they are going to get it. If the reforms mean anything, they should mean that that is there, and I am sensing that it's not yet at the moment.

Anna, what will the new model of delivery proposed in the White Paper mean for the health workforce? Do you think we are going to need more to deliver it?

Anna Bird: I suspect others around the table might have a stronger view about how many specialists there are to deliver. What is proposed is earlier intervention, and we know that if you intervene earlier, that can reduce needs and an escalation of those needs over time. I do not know whether it needs more. We certainly know that there is a workforce issue, so we have to address that, but I would defer to colleagues on whether what is required to deliver Experts at Hand plus specialist provision packages is more than what we have now.

Q37 **Josh Fenton-Glynn:** Sally, occupational therapy is a huge part of the health role in EHCPs. In your view of the White Paper, where do you think that lands?

Dr Payne: We need investment in the occupational therapy workforce. As I said previously, there is a case for repositioning some of the workforce that we have currently in the graduated model—that tiered response—but we also need to look at where that workforce should be, because it is going to be very different in different areas.

In a rural area, for instance, to make the Experts at Hand model work it has to be about the communication and the relationship between the health specialist and the school team. In a rural area you have more schools with smaller populations, so we are going to need more occupational therapists and speech and language therapists to serve that area. It is really difficult to say how many more we need. I think we will need more, but it is going to be variable.

Q38 **Josh Fenton-Glynn:** It is almost more the shape of it that I am trying to understand. The White Paper emphasises the requirement for the earlier identification of needs; what kind of capacity and workforce changes would be needed to make sure that we could deliver earlier interventions and identify needs earlier?

Dr Payne: An interesting study has just launched called the modelling therapies for improved futures—MOTIF—study, which is looking exactly at how many therapists will be needed to provide support in schools. That is due to conclude in February 2028, and I think it will give us some really useful information about workforce modelling.

Q39 **Josh Fenton-Glynn:** I am going to turn to Gillian, because speech and language therapy has concerned me for a while, partly because constituents get in touch about it a lot. It feels like if the system is working, SALT is regularly provided in school without the need for an

EHCP, but now people with an EHCP who demand SALT are not getting it. In 2024, more than 66,000 children and young people were waiting for their first speech and language therapy appointment, with 20,000 waiting over 18 weeks. How will we get the numbers down? Can we change the model to make SALT more available? What do we need to build the capacity to make that possible?

Gillian Vince: I would say a number of things to answer that question. There are no doubt challenges with the current workforce, and there is a need for an increased supply of speech and language therapists. There is also something around being able to jointly commission across a local area based on a local area need, in terms of the workforce to support children with speech, language and communication needs.

We know there are really good examples out there of interventions that can be supported within schools and early years settings, with oversight from a speech and language therapist, or with staff being trained, but not delivered by a speech and language therapist. It is really important to focus on that overarching, jointly commissioned workforce to support the needs of children in an area, as well as increasing the supply of speech and language therapists and retaining them in the NHS.

We see increasing challenges of staff burnout from high caseloads, including among occupational therapists. Everybody comes into the profession wanting to support children and families, and we know that children are waiting for a long time. We are seeing some therapists leaving the NHS and the workforce entirely, so there is something about workforce planning and joint commissioning for an area across education and health.

Q40 **Josh Fenton-Glynn:** You say "some"; in my research I found that 39% of speech and language therapists are considering leaving their roles. That strikes me as a crisis, given that this is a role that we need more of. If we are reforming the SEND system and making it more reactive, what do we need to put in place to make sure that we are not losing those roles and the expertise that we need in the system?

Gillian Vince: It comes back to some of the things we have talked about: service models, commissioned models and having the capacity to provide support across universal, targeted and specialist levels. In the RCSLT survey from autumn 2024, 40% of SALTs working in the NHS said they were considering leaving their current job. That is a really worrying percentage.

Q41 **Josh Fenton-Glynn:** That is specific to the NHS. Are there things that the NHS needs to do better? You talked about workload; is there something more? Is there an esteem question? Do people feel that their job is delivering? What collection of factors do we need to make a new SALT practitioner, just qualified and out of university, feel like they have a future in the NHS and can continue to deliver, including by working close to kids in schools?

Gillian Vince: Some of it comes back to the significant variability in how services are delivered and commissioned. In the service that I work for in

Northumbria, we have a good staff retention rate and we do not have long waiting times. There are many factors that contribute to how that service model works, but it is about the variability across the country in what services are commissioned to provide and how they can utilise their workforce to do that. If you are going into a role that is almost assessment-only, it is not as attractive as a role where you can actually deliver interventions and support children and families.

Q42 **Josh Fenton-Glynn:** Do you think the new model that we are shifting to is going to have an impact? One assumes that if you are trying to make more early interventions, you are spending more time assessing, but I guess that you are also able to make those interventions. Do you think that could work better?

Gillian Vince: I think there are some real positives in the information that has been outlined on the way forward. The Experts at Hand model is welcome in terms of being able to support the wider workforce, because everybody parenting, caring for and working with children and young people supports their communication. Being able to work in that way to support the wider workforce, to identify early and to deliver evidence-based interventions would be really welcome. It is about ensuring that we have the capacity to be able to do that. The Expert at Hand model is integrated into local services and is not a stand-alone option.

Q43 **Josh Fenton-Glynn:** You have talked about different types of commissioning. Where you work seems to have a very good commissioning model, but other areas have worse commissioning models. One assumes that you do not need the same commissioning in Hackney as you do in rural West Yorkshire, which I represent. What are the elements of a successful commissioning strategy that mean people feel that their job is making a difference and that it is worth continuing as an SAL therapist?

Gillian Vince: I would say it is about having a joined-up approach to looking at a local area need, so that we are not siloing health professionals away from educational professionals. We need an overview of how we support children's communication or children's health needs in partnership, and a workforce plan and strategy to support that.

Josh Fenton-Glynn: It feels like that would work across all the elements if we could have a broader workforce, and a broader sense of meaning and mission.

Q44 **Andrew George:** I notice that the Education Committee, in its inquiry into West Oxfordshire, found that all those who attended a forum had gone to the private sector to undertake assessments in order to speed the process and get their care plans in place. To what extent is that happening around the country, and are you content with the current scenario? It seems that the sharp elbowed and the better off can shorten the waiting time to get care plans in place and to get their child advancing through the system.

Dr Laverick: That is something that SEND officers really struggle with. From an equity point of view, they are very much aware—they spoke about this in my research—that families who have the ability to get private assessments are able to push further through the system, and there is not anyone advocating for those families where that is not the case. That causes quite high stress for them, because what they are trying to do is make sure that the system is as fairly distributed as it should be, but that is not what is happening.

Anna Bird: I have a really important point to add. I do not think that this is just about middle-class families paying their way. We speak to families of all means who are having to pay privately for therapies and for assessment, because they cannot get the support they need. On average, families are telling us they pay £805 a year for therapies that they cannot get on the NHS. We need to expand the horizon a little bit. It is not just about those with means. However, it is certainly true that we have to get to a place where assessment does not rely on a two-year waiting list. There will always be routes to shortcut that. The proposals for schools to take more of a responsibility to identify need rather than waiting for a diagnosis are a real positive. They have to have the tools, specialist input and advice to be able to do that well.

Q45 **Andrew George:** Are you aware of professionals with a foot in both camps?

Dr Laverick: Yes. As an educational psychologist, it is a huge issue now. Within educational psychology, we have welcomed the fact that there will be an increase in the numbers that are trained, but our initial training is only 203 a year. The additional 200 gives us an additional 1.3 EPs per local authority, which does not even replace the people who retire, so we have a huge issue.

A significant proportion of the EP workforce want to work for a local authority, but that work is very high pressure. It is potentially just writing lots of statutory assessments and not being able to do any of the intervention. Private practice enables them to do the intervention, which is the work they really want to do. We have a system that really does not work, but we want it to. Looking at how Experts at Hand might allow educational psychologists to do earlier intervention again would be welcomed.

Q46 **Andrew George:** Does that compromise the ethics of the profession?

Dr Laverick: You would tend not to do private work in the local authority in which you were doing statutory work, but it is an evolving area, which we had not anticipated. When I came into the profession 20 years ago, there were very few private educational psychologists and most worked for the local authority, whereas now a significant proportion do both. There are issues around that as well.

Q47 **Andrew George:** I will not pursue this much further. I want to come on to the issue of the creation of SEND caseworkers as a means of helping families navigate what is inevitably a very complex system. Before I do,

on the previous question of professionals in both camps, there is still a drive for parents who can afford it—I am sorry, Anna; I am bound to say that—to pay for private assessments. Is that not adding to the problem of retention within the state sector because people are leaving the state sector to work in the private sector?

Dr Laverick: Yes.

Q48 **Andrew George:** So that is just a general problem so long as there is a healthy private sector driven by the shortages?

Dr Laverick: Yes. As I say, there is also a desire to do the intervention as opposed to just writing assessments, which are now discrete pieces of work as opposed to longer-term pieces of work where you have got to know the family and the young person. You just have a list of statutory assessments and you work your way through the list. That is not the case in all local authorities, and I have been lucky that it is more balanced in the one I work in, but it is certainly the case in some.

Q49 **Andrew George:** Is the new model proposed in the White Paper likely to result in stronger demand for SEND caseworkers? You have undertaken studies on this.

Dr Laverick: Yes. One of the difficulties we have at the moment is that there is no clarity on the role or how they should perform it. That has come out as a huge issue, because it also means that parents do not know what to expect. Officers themselves do not know what the job is or how they are going to deliver it. There is no basic expectation, no standards and no minimum training.

In my survey, 55% were teachers, so there is a positive move of education-based staff coming into that role. However, as we know from the need for more SEND training, having been a teacher does not necessarily mean that you have expertise in SEND, and 25% have no SEND experience. I would like to see them working more professionally with families, as was set out in 2014. They were envisaged as key workers supporting families. That is why they are caseworkers. They should have had a wraparound role with families. Unfortunately, that has not transpired in the reality of the role now.

Q50 **Andrew George:** Certainly, in the enormous amount of casework that I have as a Member of Parliament—I am sure this is also the case for others—the role of caseworkers does not seem to arise at all. Is that why people end up coming to the MP—because they do not find a caseworker to help them?

Dr Laverick: Yes. Part of that is also that caseworkers receive a high level of abuse—both verbal and through email—because they are the points of blame. For any decisions or any delays, they are held accountable for the local authority. They have then withdrawn. Some of the work that I do with them is about how it is unhelpful to withdraw. We should have a really clear policy: "When are you going to get back to families?" We talk about different strategies for this, because we need to build bridges. We have all retreated into our corners, which is a problem. That is why I want

clarity around this role, which has not been mentioned again in the proposals: what do we expect them to do, and how, therefore, are we going to skill up this workforce to do that?

Q51 **Andrew George:** Isn't the role in which they operate about being the champion of the parent and the child? Or are you suggesting that some take on that role as kind of an arbiter?

Dr Laverick: How it was set out initially was for them to be supporting the parent through the process, but very little of that actually happens; it is up to the individual whether they are comfortable taking on that role. Others see it as, "I'm just the administrator; you just send me stuff and I will create this document". Even within the same local authority you can get those different attitudes and approaches to the role.

They are the central cogs in all of this. That is why I have found it very difficult that we are not talking about them again—and I would welcome the opportunity to come and talk about them—because all these changes and proposals will be delivered by them, as a team.

Q52 **Andrew George:** So it is primarily an objectivised role? They are ambivalent as to which way it goes. They are not instructed, or advised, to be there to help parents and children through the system, to be their champions and to help them, to co-ordinate.

Dr Laverick: They can take that role on, but they have very limited capacity to do that. Sometimes they do try to do that, but the problem is that they do not actually have any levers to do that, so that is another issue for them.

Q53 **Gregory Stafford:** What specific commitments would you like to see in the 10-year workforce plan to enable us to successfully deliver the new White Paper proposals?

Dr Payne: I think it needs to explicitly address the children's therapy staffing that will be needed to deliver a sustainable and sufficient workforce to meet the SEND reform requirements.

Q54 **Gregory Stafford:** Are you suggesting that it should list raw numbers for how many of each specialist or therapy group is needed?

Dr Payne: That would be difficult at the moment, and, as we have said previously, it will vary according to local needs. I think there should be a commitment to understanding what the demand—or the need—will be. That should be explicitly considered when we are thinking about the workforce planning as a whole.

Gillian Vince: To echo that, it is really about thinking about joint workforce planning, spanning education, health and care, to support children and young people.

Anna Bird: We are asking for a fully funded disabled children's health strategy within the workforce plan. We think that needs to include a focus on children with complex needs, and real clarity about what "complex

needs" means, with a read-across to the definition in SEND. We also want to see some ringfenced funding in there and clear accountability for delivery. The point about joint commissioning also needs to be embedded in that workforce plan.

Q55 **Gregory Stafford:** Do you see that as something that you are asking for in addition, because of the White Paper, or would you be asking for it even if we were not seeing a White Paper on special educational needs and disabilities?

Anna Bird: Regardless, yes.

Dr Laverick: There is also greater clarity from health as to what its role is in the education, health and care plan process. There seems to be minimal recognition of the fact that we have the team that is trying to work to their statutory deadlines as well. This is a system where one relies on the other, so I think it is about greater understanding of how the system works together—how we need to work together as professionals—and hopefully then helping to smooth that process, which is currently very hit and miss.

Q56 **Gregory Stafford:** We have talked about workforce difficulties. What do you need in the 10-year workforce plan to attract and retain the relevant staffing groups you are talking about?

Dr Laverick: Currently, we see high stress and high pressure right across the system, I think in all the workforce groups that we have talked about, which includes SEND officers, who tend to last about two to three years before they leave and we get in new people. That is inconsistent for families. It is thinking about how we can develop this together, how we work together so that the systems can be more effective and, coming back, how we have to focus on the needs of the child. That quite often gets missed in those conversations. How, in those commissioning conversations, do we track that down? How does that actually show that the child is getting the provision that they require?

Gregory Stafford: Anna, recruitment and retention?

Anna Bird: I do not have more to say on that.

Gillian Vince: In addition to addressing some of the workforce challenges from a speech-and-language therapy point of view, the expansion of the apprenticeship programme would help with the supply route into the profession as well.

Dr Payne: I absolutely echo that, particularly thinking about apprenticeships in independent practice. We were talking about that previously. Independent practitioners will be an important part of the workforce when we deliver these SEND reforms. At the moment, it is tricky for independent practitioners to support apprentices, particularly thinking about those who work in children's services. For me, that is a clear thing.

I think we should also be looking at our student occupational therapy workforce. We published some guidance last year to help services increase the number of school-based placements for occupational therapy learners. That has real, good potential. We shall be creating a group of newly registered professionals who will come out with confidence and the experience of working in schools. That will really help this workforce.

Q57 **Gregory Stafford:** That is helpful. Would the RCSLT agree?

Gillian Vince: Yes.

Chair: A quick follow-up from Jen Craft.

Q58 **Jen Craft:** To pick up on some of the stuff about workforce, the SEND White Paper proposes schools coming together in clusters or groups—across the academy chains as well—to pool resources to deliver or commission SEND services. Is there a risk in that? Potentially, it exacerbates the situation of having a private marketplace for professionals, because schools would be commissioning that interventionist work that you say professionals really want to do; they will not be commissioning people to do assessments. Unless the workforce exists within the NHS, within ICBs, in the numbers that mean that people are not stuck doing assessments all the time, is the risk that the White Paper, in clustering resources like that, could make the situation worse?

Dr Payne: Yes, I think that is a risk. We risk fragmenting services. We want children to have that seamless service, where they can step up and step down across the different levels as their needs change and, hopefully, improve. If we fragment the services, I think there is a risk that the seamless approach will not happen.

Gillian Vince: I agree. That is a potential risk. I am sorry to keep coming back to this, but I think it is about the joint commissioning across the local area need, which is helpful to avoid silo work, where we have a team with education and workforce responsibility and a team in the NHS that has health responsibility, but the two are not working together.

Q59 **Jen Craft:** To pick up on that, I think there are potential equity issues, if you have clusters of schools in, say, higher-income areas, which are going to be much more able to commission those services than ones in low-income areas. Is that fair to say as well?

Dr Payne: I think that is a concern. Also, we need to look at some quality assurance. What are they commissioning? Who is monitoring? What is being delivered? Are the outcomes what we want them to be—what they need to be?

Gillian Vince: And whether they are evidence-based interventions.

Q60 **Chair:** I will ask a very quick last question. If there was one thing and one thing alone that you would like us to include as a recommendation to Government off the back of today's session, what would it be? You are only allowed one.

Dr Laverick: For me, it would be having greater clarity around how all these different parts fit together. What are health's responsibilities to the local authority and what does that look like? How do we make sure that we then meet those responsibilities, so that we are seen to be working together? We have to move away from siloed working and we have to collaborate much more closely.

Anna Bird: For me, that point about the delivery of plans—ISPs and EHCPs—within the accountability structure is absolutely critical. We would like to see that being recommended.

Gillian Vince: Joint commissioning across a local area, based on population need.

Dr Payne: Explicitly addressing the therapy needs within the NHS workforce plan.

Chair: Thank you very much, all; much appreciated. Could we please bring up the second panel as quickly as possible?

Examination of witnesses

Witnesses: Elliot Howard-Jones, Dawn Fenton and Ingrid Bell.

Chair: Thank you very much to our second panel. Could you please introduce yourselves for the Committee?

Ingrid Bell: I am Ingrid Bell and I am a designated clinical officer for SEND. I currently cover the Cheshire East area.

Dawn Fenton: I am Dawn Fenton. I am the designated clinical officer for SEND for Salford locality.

Elliot Howard-Jones: Hello. I am Elliot Howard-Jones. I am chief executive of Hertfordshire Community NHS Trust.

Q61 **Danny Beales:** Morning, everyone, and thank you for your time. It has been suggested that long waits for assessments, for treatment and for access to care of different sorts might be contributing to rising demand for EHCPs as conditions worsen. To what extent is that your experience in your localities? Is that something that you are seeing?

Ingrid Bell: In my area, I work for Cheshire and Merseyside ICB, and I work predominantly around Cheshire East; I have worked in other areas of the ICB, such as Sefton and Liverpool, as well.

How we have addressed some aspects of this issue is around strengthening the graduated approach. We have worked as a partnership across health, education and social care, and we have the parent carer forum heavily embedded within our strategic work, in order to look at what is driving that need for an EHCP and the feedback that we are getting around the lack of parental confidence in the system. That is why we have focused our energies on that graduated approach, making sure that everybody across our partnership understands what that offer is.

An example is our neurodevelopmental work; we have developed a Knowing Me tool. Again, there is that graduated approach: "What is that signposting offer?" And we are building on that.

Q62 **Danny Beales:** So you are not seeing people being unable to access assessments or treatment early, whether that be speech and language—

Ingrid Bell: There are long waits and nobody wants long waits, so what we are trying to do is to ensure that there is support while people are waiting, and that we are focusing on needs and not on a diagnosis.

Q63 **Danny Beales:** Are you seeing that follow through, in terms of lessening pressure to get an EHCP, if people are getting that early access sooner?

Ingrid Bell: We are having some good feedback; however, we are still early in the process. We are hoping that, as we move along, children will get the right support, at the right time, from the right people and in the right place.

Q64 **Danny Beales:** Okay; thank you. Dawn or Elliot, what is your experience?

Dawn Fenton: In my locality, a lot of EHC needs assessment requests are for children and young people that are already known to services. There are some exceptions, but generally, the children are already in the service and are receiving support when that request for advice comes in. What is being observed is the level and complexity of need of the children coming through, which drives those requests for an EHC needs assessment.

Q65 **Danny Beales:** So from your experience, wider access to treatments of different sorts would not lessen that demand? From what I am hearing, you are just seeing an increasingly complex population. Is that your experience?

Dawn Fenton: And the number of children. As Ingrid talked about, we certainly have early interventions and support in place. Some parents would want some additional support, but I guess what we are seeing is multifactored. But in my locality, children are already known to the service when that request comes in.

Q66 **Danny Beales:** Elliot, from your perspective—the trust perspective—have you seen increasing waiting lists for treatments, assessments and diagnoses?

Elliot Howard-Jones: We have seen the number of assessments in our trust fall; we have managed to do that over the last few years. Going back to your original question, the reasons for the numbers of EHCPs rising are not only about the long waits—although it is a factor, for sure. Another factor alongside that is that people are frustrated because they do not get early intervention, which is partly driven by waits, which are different in different parts of the system.

People also feel that there are a lack of reasonable adjustments in schools, and in educational and other establishments, which means that they feel that the only recourse to get the service that they want for their child is going down an EHCP route. That is part of the problem with the new

system: we still have an EHCP at the end of it, so we might drive demand towards the end. The final factor that drives people towards an EHCP is a frustration with and lack of understanding of the system. They seek an EHCP to explain what the system will do for their child.

Q67 **Danny Beales:** Thank you, that is really helpful. As part of the increasing numbers of EHCPs being granted, in your experience—perhaps this is for Ingrid and Dawn, from the locality and ICB perspective—what engagement is there with the ICB? What kind of map-across do they do to look at the EHCPs that have been granted, and the potential staffing and resource implications for services based on them? Is any analysis being done, live or over a time period, on the level of increasing EHCP demand?

Ingrid Bell: Yes. We work as a partnership, and we have developed the joint strategic needs assessment. The JSNA supports our strategy to understand the needs of the children and where we need to focus our attention. We work collaboratively. Our governance structure is through the SEND partnership board and then the sub-groups that feed into that board.

Q68 **Danny Beales:** How has that worked in practice? Have you, in a board meeting, looked at it and said, "This year we have seen 1,000 more EHCPs, and that means this"?

Ingrid Bell: We have a data dashboard and we follow those trends. Where we see an increase in numbers for a particular need, we will take it back through to, for example, the joint commissioning sub-group and look at, what is the need, what is the offer, where are we lacking and what do we need to strengthen?

Q69 **Danny Beales:** Has that fed through to commissioning decisions, in terms of staffing and specialisms?

Ingrid Bell: As DCOs, we work collaboratively with our commissioning colleagues in the ICB. We will then raise those issues to our transformation colleagues, so that they understand what the needs of our area are and how they can address some of that commissioning arrangement.

Q70 **Danny Beales:** What has that led to, in practice? That sounds like a really good practice—certainly not one that I or many others have experienced in other parts of the country. Given your increasing demand, what has that led to in terms of changing resourcing levels?

Ingrid Bell: An example of that is the jointly commissioned speech and language therapy offer that we have in place. Those therapists are employed by the NHS, but it is a jointly commissioned service. They deliver their offer in educational settings.

Danny Beales: So more speech and language therapy has been commissioned on the back of that data.

Ingrid Bell: And the way they work collaboratively across the whole area with a child—in a clinic setting, for example, and then into school and the community. It is a holistic offer.

Q71 **Danny Beales:** Dawn, from your experience, does your locality have a similar way of working, in terms of looking at demand and need in the system and mapping that on to decisions at a commissioning level?

Dawn Fenton: It does, but the level of detail is sometimes missing. If I think about our EHC hub and the quantification of specialist time, it is difficult to capture how much time has been quantified and then pull that out at a population level and marry it up to what your workforce capacity is going to be with a longer-term projection. Anything that would facilitate that level of detailed collection would be quite helpful, in terms of workforce mapping.

Q72 **Danny Beales:** What would be best, do you think? How could that work better?

Dawn Fenton: At the moment, where children have their needs quantified from a therapy perspective, that is a manual task in the electronic patient record, and we monitor them that way. It would be really helpful if our hub had some more specific detail that you could capture and then use to generate population reports.

Q73 **Danny Beales:** That is really helpful, thank you. From a provider perspective, do you feel that that is happening in your locality on the demand side? When commissioners make decisions, are you seeing increasing resources for the extra specialists that are needed to input into EHCPs and deliver the care promised in them?

Elliot Howard-Jones: There is not a direct proportional relationship between the number of EHCPs and the amount of resource required. It is not a straightforward relationship, because EHCPs specify different things for different children.

Q74 **Danny Beales:** But just to challenge you, if over a year there are 1,000 more EHCPs and a promise of 10% of them getting speech and language therapy, presumably you could model how many speech and language therapists or OTs you would need based on the number of children being promised sessions and support. Would that not be effective?

Elliot Howard-Jones: We have done that from a Hertfordshire perspective. We have worked with the local authority and the ICB to get funding—they are funded jointly from different parts of the system. What we don't see is a national framework that allows that money to flow behind the EHCP support that is required, so it comes down to very localised commissioning decisions. As we discussed in the previous panel, sometimes they are statutory and sometimes they are not. There is no national framework as there is for acute care—for example, for hip replacements—so we cannot say, "This is how the money flows through the system. This is the expectation. If there is increased demand in a particular area, this is how money will flow to meet that need."

Q75 **Danny Beales:** Just to follow up on the previous question, which links to this, Elliot, do you think EHCPs should be scrapped? Do you think they are not an effective tool for the resource decision making that you are discussing?

Elliot Howard-Jones: I certainly don't think they should be scrapped, but I do think they should be used much less. In the rest of the system, all the things that we know would be really effective—reasonable adjustments, support without diagnosis, and shorter waiting times for children in speech and language, OT and physiotherapy—should be in place. That would reduce the complications of the system and people's need for EHCPs. My concern is that if we do not address the fundamentals, we can move the bar for where EHCPs exist, but parents will still feel frustrated and will not get the care that they want, so EHCPs will still be used by parents to mitigate a system that they do not think works for them.

Q76 **Danny Beales:** When making staffing decisions, there are obviously competing pressures, even within paediatrics, let alone in the broader system. How much do educational impacts weigh on prioritisation? For instance, in my area, nursing input is really valuable, particularly to specialist schools. There are competing community nursing pressures, and often the nursing that is provisioned for is not available, so nurse shifts do not materialise. That can mean that a lot of children in specialist provision have to not attend school because their feeding tube might fall out and the staff are not trained to put it back in safely, so they might have to go to A&E. How much does children's presence in school—their education—weigh on prioritisation, over other clinical pressures in the system?

Ingrid Bell: From a special school nursing perspective, these are delegated tasks. Where you do not have delegated tasks, children would be eligible for children and young people's continuing care. It is how you work as a partnership across your local area to understand where that delegation comes from and who is responsible for the training, the sign-off, the competency, the care plan, the risk assessment, the escalation plan—whatever is required—and the supportive offer, so that people who are being delegated to feel that they are able to undertake these tasks.

Q77 **Danny Beales:** How much does the health system have to carry? What I am inferring from what you said is that you can decide where those tasks sit and support others to do those tasks. Is that what you are saying?

Ingrid Bell: Yes.

Q78 **Danny Beales:** From a school perspective, what I have heard is that they often do not feel able to carry those health risks—for example, putting back quite complex feeding tubes is not something that teaching assistants are necessarily trained or insured to do; these are health-based tasks that they are left to do. How much resourcing is there to upskill staff to understand those risks and where they might lie?

Ingrid Bell: It is the duty of the person who is delegating that task to ensure that it is safe. It is about relationship building across your partnership, so that staff within schools feel that they are supported, but they understand that that is part of their role if they are in a special

school—they are going to be doing some of those health tasks as well. Again, it is about how we wrap around these children so that we all have a role to play, and we are clear where the accountability lies, so that it is safe practice.

Q79 **Jen Craft:** You mentioned continuing care. I think only 10% of the most complex and serious cases that apply for it—these are children with life-limiting conditions—actually get it. Does that not speak to a wider issue in the system that even though there are supposedly funding streams that should be helping, the access and the ability for people to be helped via those routes just is not available?

Ingrid Bell: Continuing care is based on a framework of need. There are 10 areas of need and of varying intensity of need. That is what the continuing care assessment determines—what is the need? Where is the provision to meet that need? What is the unmet need? It pulls that out. These are for the complex of the complex children. The lower-end needs are met through universal, targeted and specialist services. However, children's needs are increasing and becoming more complex. Because of the advances in science and medical technology, we can ensure that children can get home and access school with more complex needs. That is where we need to strengthen and make sure that these children are supported fully.

Q80 **Jen Craft:** Coming back to continuing care, I know of several cases where people would think, "This is a child with significant and the most complex of the complex needs," to use your phrase, but they cannot access that fund. It speaks to a broader point: these parents are not able to co-ordinate their child's medical care or get them to school because they cannot even access this one small bit of funding that would allow them, for example, to have the right kind of provision in place to even get them on home-to-school transport or make sure they have adaptations at home so that they can get dressed with dignity. Should that be put on a statutory footing, similar to continuing care for adults? There are two different systems at the moment.

Ingrid Bell: It comes back to joint commissioning. If you have a joint commissioning group as part of your governance structure, that is where that conversation sits around understanding the complexity of the needs and who is responsible and accountable for those needs. That has worked well in areas I have worked in—when we have had a joint commissioning group, we have been able to unpick these more complex cases. If a child has been identified as having a health need, it is the responsibility of the NHS to meet that need, regardless of whether it is in an EHCP or not.

Q81 **Jen Craft:** Do you think that continuing care funding is sufficient to meet need at the moment for children with the most complex needs, or should it be expanded?

Ingrid Bell: I believe the needs of children are more complex than they have been previously. Children are living longer with more complex needs, but they may not reach that threshold of continuing care, so it is a question of how we meet the needs of those who have complex needs but

do not meet the threshold of continuing care through the joint commissioning arrangement.

Chair: We are going to come back to funding a bit later, but thank you; that is clear.

Q82 **Danny Beales:** You have described how the system should work, but I want to press you on this question: does it work in that way? You talk about upskilling the school workforce and say that these should be things that they do. In your patches, how much training and support does the health system provide for the education system? In my patch, the nurse does not appear and the teaching staff are not trained and given the legal certainty that they are able to deal with complex medications, epilepsy support, in-school transport and putting back feeding tubes, and children are just not able to attend the school.

Elliot Howard-Jones: As a service, we provide a lot of support to schools to upskill what goes on in schools. That is a fundamental part of what we do; it is a fundamental part of making the system work better for children. There are two points I would make on it. One is that EHCPs often provide quite an inflexible response to that. They will prescribe speech and language therapy rather than a speech and language therapy assistant, which means that the model for providing that workforce will be much more rigid under an EHCP. It won't allow for upskilling of education workers; it will just say that you have to have a health professional in at that time.

That brings me on to the second point, which is that there are three elements of staffing. There is staffing that we need, as per the demand; there is staffing that we are funded for; and there are the staff that are actually in post. They are three really different things. In some cases, where the vacancy rate is low, that is fine. We have in place the staff that we are funded for. But there isn't, as you suggested earlier in your questioning, the real direct, responsive link between demand and funding that would allow us to address the needs of the children as we see—

Q83 **Danny Beales:** What about for an adult population? If there was a group of adults who needed feeding tubes put back in in the community, there wouldn't necessarily be a plan that would always deliver that specific funding for the NHS, but you would still resource nurses to go out to elderly patients and do that, so why must it be fully resourced in an EHCP for the NHS to resource a school nursing service?

Elliot Howard-Jones: It doesn't have to be fully resourced, but it has to be resourced somewhere in the system; it doesn't have to be resourced through an EHCP. Then you come to differentials between the adult waiting times across the country and children's waiting times.

Q84 **Danny Beales:** Is this symptomatic of the broader low prioritisation that paediatrics has?

Elliot Howard-Jones: It is symptomatic of a broader focus on adults. As someone said in the first part of the session about the 10-year plan, it is

focused very much on adults rather than on children. If we look at the waiting times across the country, there are 7.5 million people on an acute trust waiting list, of whom only 300,000 are children. Of the 3.5 million who are on community and mental health waiting lists, 900,000 are children. There is a 25% chance that as a child you will wait over 52 weeks, but there is only a 2% chance that as an adult you will wait over 52 weeks. Behind your question, there is a fundamental difference between the response of the system to children and the response of the system to adults.

Q85 **Danny Beales:** Why do you think that is?

Elliot Howard-Jones: If I asked and you went to the House of Commons Library and got the data on waiting lists, it would tell you that 7.5 million people are on a waiting list. Actually, there are 7.5 million people on an acute waiting list and an additional 3.5 million on community and mental health waiting lists. This runs all the way through—maybe we'll come back to the system point later.

Q86 **Chair:** We have done various reports on mental health. This is well documented by us.

Elliot Howard-Jones: We will come back to the system later, because I think it is the design of the system that will drive better outcomes for that. There will be greater visibility and greater recognition, and through greater visibility and greater recognition, there is greater funding, generally.

Chair: We are going to come back to some of these questions for sure, but first we go to Paulette Hamilton.

Q87 **Paulette Hamilton:** Good morning, all. I have a few questions, based predominantly on integration and improving delivery. Let me preface that by saying that the Education Committee did a great deal of work and a lot of effort was put into looking at how you strengthen collaboration and partnership between agencies, and what they came up with was that it is very limited at the moment. With that in mind, what further leadership and direction from the Department of Health and Social Care do you feel is needed most to improve joint working between health, education and local authorities, just to meet the rising demand, which you keep talking about, from people needing EHCPs? Elliot, will you start?

Elliot Howard-Jones: I listened to the previous session, and we have talked about the system. We have talked about what the system needs to do. I have lots of conversations with parents who are frustrated with the system, and I have lots of healthcare professionals who are frustrated with the system and asking how we can get it to work. There is a very real possibility that there is not a system. We might be living in a sort of Kafkaesque world where everybody thinks that there is a system and, if only they could understand it, everything would be all right. That might be the situation, including for health professionals, you or the public.

We do not have—and I think that you have heard this in various forms—a consistent framework that operates at a national level, that has nationally available data and that you could put your hands on and say, "This is how many people are waiting for assessments, pre-EHCPs and post-EHCPs," if I can put it that way. That information is just not available. In that context, people are trying to make the best of a system, locally, in various different ways. Yesterday, I spoke to a member of staff who gave me this pamphlet, called "My Journey", which outlines all the services that a person with SEND could be referred to—there are some blank pages in the back, just in case you run out of all the rest.

Chair: For those reading the transcript, you are showing us a little pamphlet with five or six pages with lots of boxes of lots of different people that they could be referred to.

Elliot Howard-Jones: And not everybody will need to be referred to every service, but this is why I think it does not operate coherently as a system. Leaving it in the hands of parents and families to navigate such a complex system across health and social care—which is what that booklet covers—and education is why the system does not work.

Q88 **Paulette Hamilton:** Let me flip the switch, go back and ask you the question again. What do you think that DHSC can actually do to help with that? We agree that it should not stay with parents—I am with you on that; I have a grandson with issues—but at the end of the day, how can DHSC help in that situation?

Elliot Howard-Jones: Don't describe the levels of rising need within the system; rather, design a framework and a system that works to understand what the commissioning requirements are, to report clearly on the demand in the system and on where ICBs are meeting their responsibilities to meet those demands and where they are not, to report on the same framework for ICBs, local authorities and education. Within a particular area, all those should be able to be seen in the same place at the same time. It would be a national framework, reported nationally, with national metrics. There are plenty of great examples across the country where you could pick up some local reporting, but it needs to have a system behind it that commits to reduce children's waiting times to get early access so that their needs will be addressed quicker, and they will not escalate as they wait in the system and move away from their peer group. It should be a properly described system; we just do not have that from the Department at the moment.

Q89 **Paulette Hamilton:** Thank you. Ingrid, you highlighted that you were a nurse. Both of you hold very similar roles but, Ingrid, as someone who has been a nurse, what would you like to see?

Ingrid Bell: I agree with Elliot—that shared framework, that understanding and clear metrics, so that everybody is measuring the same things. At the moment, it is really difficult to piece it all together.

Q90 **Paulette Hamilton:** Okay, that is very interesting. I will preface my next question by saying that ICBs are supposed to have some accountability in

this area. They have the health commissioning for children and young people with SEND, and each ICB must have an executive lead for children and young people with SEND. Saying all that, the Education Committee said there was a lack of accountability in this area and a lack of inter-departmental co-ordination between DFE and DHSC, and that that results in gaps in healthcare support and inconsistencies in outcome. Those are all the negatives. With that in mind, what actions are you taking to reduce the reported gaps in health provision specified in EHCPs and that are leading schools and local authorities to take on responsibilities and costs that should sit with the NHS?

That was a long-winded question, so let me shorten it by asking: what actions you are taking to help reduce the reported gaps in the system within your areas of work?

Dawn Fenton: Locally, we come together as local authority and health services for interventions such as our neurodiversity network. There, health and local authority teams are in one place, and parents and carers can walk in and seek advice and support linked to any questions that they have. We are really trying to bring those teams together to support people at an earlier stage. That is not linked to a waiting list; instead, you can access it as and when you need. It is linked into any of those services that attend—speech and language therapy, CAMHS, SEN, SEND services and caseworkers, along with local authority early health practitioners. We are thinking about holistic needs to try to support families at a much earlier stage and without the need for referrals and to sit on waiting lists and instead provide access to intervention support at the earliest possible opportunity.

Q91 **Paulette Hamilton:** Do you feel that system is working for you?

Dawn Fenton: It is quite new, in that it is new within the last six months. We are receiving positive feedback from our parents and carers in terms of answering questions, signposting and people being picked up by a service as they need—so, referral into a service. There are still challenges on waiting lists, but we are seeing that we can answer questions much earlier and can guide parents and carers in what needs to happen.

Q92 **Paulette Hamilton:** How do you feel the ICBs are interacting with what you are doing, considering that they hold that lead role?

Dawn Fenton: It is at a local level at the moment. It is about how our SEND partnership system works and how we direct our vision. We have ICB representatives on that board. However, our relationships at a locality level are really supporting some of that very practical work.

Q93 **Paulette Hamilton:** Ingrid, I am going to ask you the very same question.

Ingrid Bell: SEND is taken very seriously within our ICB. We have our associate director of quality safety improvement as a member of the SEND partnership board. We have heard first hand from families, carers, children and young people through different networks about what is not working in the system. We have worked together through the partnership. I have

already discussed the joint commissioning group. That is where we have those conversations about what the needs are and what we can do better together.

Q94 **Paulette Hamilton:** You are having the conversations, but how are the actions being taken?

Ingrid Bell: It is because we then have a plan. We have a plan with targets and that reports back.

Q95 **Paulette Hamilton:** Is the plan time-limited? Do you have a requirement to get this done within x amount of time?

Ingrid Bell: Yes, we do. Where we have drift and delay, that is where we have the challenge back from the SEND partnership board.

Q96 **Paulette Hamilton:** Is there funding connected to this? Much has been said about there being no direct funding and people struggling to get that—you may have a plan or a good idea, but there is nothing attached to ensure that it gets carried out.

Ingrid Bell: It is within our current commissioning budgets. There is not additional money. It is a question of how we use what we have already got.

Q97 **Paulette Hamilton:** I will ask Elliot the same question.

Elliot Howard-Jones: I back up what has been said. Within Hertfordshire, we have an effective SEND partnership board within the local authority, the ICB and the providers of the services. We constantly measure the waiting times, and we try to respond to the demand, although the demand often outstrips the supply—that comes back to the funding point. We try to make the most of what we can with the funding that we have, including being more efficient and, as a service, doing two things principally: we have started to use ambient voice technology, to make sure that we have more clinically-facing time; and we will focus on the use of speech and language assistants, but as I say, within EHCP, that usually becomes specified out, so that reduces the flexibility to stretch the workforce in the—

Q98 **Paulette Hamilton:** Elliot, tell me a little about the cost element. At the moment, listening to all three of you, I think you are wonderful, but it sounds very kumbaya. As a local MP, that is not what I am hearing on the ground. Re the cost, I am just asking you a question: there never seems to be enough money out there, so for the NHS, local authorities and others, how is that cost shared across all three areas?

Elliot Howard-Jones: There is not enough. In many areas, we have seen the waiting times for SEND in general going up, and we have not had the funding to respond. This comes back to the clear national system. There is something about the accountability coming from clarity, and there is not clarity nationally about what is required. You might have a responsible person within the ICB—they are engaged generally, and responsive—but that is not linked, in the same way that it is in a national cancer

framework or plan, to a real focus on a commitment to putting the money in to reduce the waiting times and to address the deficits that we see in supply and demand.

Q99 **Paulette Hamilton:** For my last question, I am just looking for snappy answers. What national policy changes would help health bodies to meet their statutory responsibilities for children and young people living with SEND? What would you like to see in the national guidance? Make only one or two points.

Elliot Howard-Jones: It is similar to asking what the equivalent is of a cancer plan nationally for SEND. What do we want within that? What are the nationally mandated metrics that we want? How do we get those from all areas? How does that help us to see, across all areas, the mismatch between demand and the provision of services?

Q100 **Chair:** To be clear, you are not seeing that in the White Paper?

Elliot Howard-Jones: I do not think that it is very clear in the White Paper. I think the White Paper talks more about the targeted, the targeted plus and then the EHCPs, which I would say is shifting the boundaries of the existing system, rather than designing a new system. It is hoping that, by shifting those boundaries, we will move away from EHCPs, but as I think I said earlier, the reason people get EHCPs is that they are frustrated with the system not working beneath that. Part of the framework therefore has to address how people get access earlier and how that is mandated. Mandating a health input into an EHCP will merely drive people, in my view, towards EHCPs, but if the health input is mandated through a similar thing to the cancer plan—I will come back to that—then we can get that earlier intervention, which is better for children and the system. It reduces costs and frustration.

Q101 **Paulette Hamilton:** Dawn, the same question.

Dawn Fenton: I agree. One of the things that is a challenge in my locality is outcomes and impact, or some kind of standard framework around outcomes ultimately reducing waiting lists. Commissioning arrangements are about what we see in children's lives, and I think it is a struggle sometimes to have really clear standards on outcomes. If we had a national framework for what we want to see for children and young people, that would help some of the joint working and have a positive impact on what we are doing.

Paulette Hamilton: I love that: clear standards for outcomes. I like things that are simple. Thank you.

Dawn Fenton: We have started to develop that, but it is a very complex area.

Q102 **Paulette Hamilton:** Ingrid, to round up.

Ingrid Bell: I agree with what has already been said about reducing the risk of a postcode lottery by agreeing the framework of the core offer, so that everyone is getting access to meet their needs, regardless of what

the diagnosis is. It is about asking what the need is and how it is going to be met, and then making sure that is consistent.

Paulette Hamilton: Fantastic, thank you.

Q103 **Chair:** I want to drill down to clarify this point. It was striking with the first panel that in answer to the question, "Do we want to put the delivery element of the plan on a statutory footing?", they all agreed that that was the thing, but I am hearing a different thing from this panel, so let us be clear that I am hearing it correctly. Elliot, we are hearing, "We want a national plan, and are concerned with putting the health element on a statutory footing with everything else on the EHCPs," because that will just keep driving the demand towards EHCPs. So is the better thing to ask for, for all health needs of children to be met regardless? Would you say actively that you do not want the health part of an EHCP to be mandated? Or are you just saying, "It could be, but I am warning you that it may not solve the problem"? Can I be really clear what you are actually saying? Elliot, this came out of your intervention, but I do want to hear quickly from the other two on this point.

Elliot Howard-Jones: To be really clear, I think it is not a bad thing in itself, but just doing that in order to solve the "H" part of the EHCP is still going to drive people within the currently described system towards the EHCPs. What is required is a real focus on reducing waiting times for children across the board, so that they can get access earlier to speech and language therapy, and to reasonable adjustments. We could be more flexible in the way we deliver that, because we could deliver it with assistance or through schools. I think if we funded that bit of it—if we were going to make the "H" bit of the EHCP statutory—you would also need to have a framework that made additional requirements and the rest of it statutory as well. Otherwise, you are just going to drive it to the top end.

Q104 **Chair:** I think I understand that better. Do the others agree?

Dawn Fenton: I agree. A well-resourced system, you would hope—

Chair: And you agree as well, Ingrid?

Ingrid Bell: Absolutely. Not all reports that are used in the EHCPs are from the NHS; some are from private independent practitioners. From an NHS perspective, it is around meeting need, and sometimes from a private report it will look very different.

Chair: Thank you.

Q105 **Jen Craft:** I just wanted to pick up on something. The SEND White Paper contains a joint foreword by the Secretaries of State for Health and Education, and I noticed that they said, "We will join services up, wrapping health and care around our nurseries, schools and colleges" and so on. What seems to be coming from you quite loud and clear is that the health element of that, other than being on the first two pages, is somewhat missing from the rest of the White Paper. Is that fair to say?

Elliot Howard-Jones: I am not sure that I would necessarily put it like that. The commitment is there. What we need to recognise is that there is a wider problem of access to children's services and long waiting times, which is then driving a parental frustration with the system. I think most SEND children would be seen and helped in educational settings. Health is a part of that, but it is for the more complex end. Actually, we could make that more complex end less difficult if we intervened earlier and had a focus on being able to get access to speech and language therapy earlier, to audiology services earlier. There is a whole range of things that drive that demand. I don't disagree that the focus should be on schools, because that is where children are most of the time, but it needs to be appropriately supported, and it can't be when it becomes at the really complex end of EHCPs.

Q106 **Jen Craft:** Do the other panellists think that health is potentially missing from the White Paper in terms of how you are going to drive that direction of travel?

Dawn Fenton: I think that, as Elliot said, what you ultimately want it to capture is that early intervention—access to support. If that message is strong and clear, you would expect children's needs to be met at SEN support level, and you would want the majority of children to have their needs met earlier, so that it does not become more complex and a crisis situation for a child or young person.

Q107 **Jen Craft:** It is interesting, because the direction of travel in the White Paper is to address needs at the earliest opportunity, with early intervention and with Experts at Hand, which is very much delivered by the health service. What I am hearing from you is that you are asking for a national framework—something that sets the scene. There is some of that in the White Paper, which says, "This is what we expect local healthcare services to deliver in terms of SEND." Is that not clear enough? Is that not an articulation of what you would need? Or do you need something much more directive from DHSC that says, "This is how we are going to support this body of work"?

Elliot Howard-Jones: I would say that it needs to be more crunchy. The accountability for all in the system will come through clarity. If you can report clearly about early interventions and early access, you can then say, "Where does that make a real difference within the system?" Otherwise, the responsibilities are too diffuse. In a system where children are accessing local authority social care, education and health, things becomes vague. As Paulette described it, it becomes a sort of kumbaya moment. How do you get some really crunchy data that says, "This is how we are responding to children's needs through the system"? That is where it could be really enhanced as a framework.

Q108 **Jen Craft:** Ingrid and Dawn, you are both DCOs for SEND. Our documents do not list that you are from ICBs, but that is who you work for. Do you have the capability or capacity to commission what is set out in the SEND White Paper? We heard in the first panel that a lot of specialists and paediatric therapists are used for a large majority of the time for

assessment rather than intervention, which is not what they want to be doing. Do you have the capacity in the current system to flip that on its head and deliver a much more early-interventionist approach? Or do you need that direction from the top of Government to say, "This is where you need to head"?

Ingrid Bell: As a partnership, we all want to make sure children get what they need when they need it. Local ways of working strengthen some of that. For example, to take an area I work in, we have the early years forum, which is multi-agency. We all discuss the needs of the children and work as a partnership to resolve some of that. The ICBs are going through a restructure, and we do not know what that new structure will look like and what the impact of some of that will be. It comes down to local partnerships and the culture of people wanting to make a difference, and working in partnership rather than working against each other in silos.

Dawn Fenton: As Ingrid said, in our locality we have integrated commissioning services. I guess that that would be developed at a local level in terms of what our population need is, using our data to understand that. Does that need to come directly from Government? It would be helpful, but as a local partnership, we do have those commissioning arrangements in place to support our population.

Q109 **Jen Craft:** What I am driving at is that, in the White Paper, you have a model where you are looking at trying to avoid EHCPs, which is very much what you are speaking to—not having that demand at the higher end of the system. It sets out that people whose children are on an individual support plan, or are going through the four new tiers of support, can expect some kind of support and for teachers and parents to be taught intervention methods by Experts at Hand. Experts at Hand will very much need to be delivered by yourselves, unless we end up with the situation we heard about in the first panel, where you get clusters of schools potentially commissioning from the private market, which causes a whole other wave of issues. Are you already looking at how you would deliver that switch or model, and what kind of workforce would you need to deliver it? Or do you need a bigger sense of direction? Do you need it on a statutory footing, and to be told that commissioners should look at commissioning x amount of early intervention and delivering Experts at Hand? Would that be helpful?

Dawn Fenton: I would say that the services in my locality do operate on that level—at a universal, targeted, specialist level—and there are different layers of support that would go in. An example would be our speech and language therapy service, which provides access to universal training. Then they would support staff in schools around delivering targeted groups. On what the White Paper looks like, it is not a significant shift in how care is delivered at the moment. It comes back to the earlier point in the panel and what we have said: it is about the level of resource required to deliver that.

Q110 **Jen Craft:** Are you able to get an accurate idea of the level of resource, or do you need more data and help? What do you need to understand it?

Dawn Fenton: Data is always a challenge, in terms of pulling it from multiple different areas—local authority and health—and how children's needs overlap. So, yes, we do have a sense, but a system that supports more detailed analysis would be helpful.

Elliot Howard-Jones: There is a slight danger with the Experts at Hand, which is that everybody wants everybody in every school all the time. If I am honest, there are too many schools to be able to provide that all the time. It needs the work that Dawn has described brilliantly—the education of the educators. We can work on that.

It is not about making the earlier intervention part of the system statutory or non-statutory; it is about visibility. You don't need to make it statutory for it to be a national framework and for it to be visible across all areas. As we have seen in lots of other areas, that would push people to commission the right services, commission more where they need to, increase the level of provision, and therefore reduce the waiting times. The fact that the waiting times are not as visible as they are in the rest of the system means that it is too easy for people making commissioning decisions to say, "I will put some money into access in hospitals," or, "I will put some money into hip replacements," rather than, "I will put money into speech and language therapy for children."

Q111 **Chair:** I am going to end by wrapping up a few loose ends and trying to lift the bonnet. One is about funding. I just want to repeat back what I understand I have heard so far. Ingrid and Dawn, you talked about what you are doing in your local areas. Ingrid, do you want briefly to describe the EHCP hub that you guys have?

Ingrid Bell: The request for an EHCP depends on which area it is. We have nine local authorities within our ICB. Liverpool and Sefton, for example, will go through to One Front Door; they go out to all the health providers, get it back within five weeks, do a bit of admin, and get back to the local authority, compliant with the six-week turnaround. As a DCO team, we will deliver training to make sure we are keeping the quality high with the timeliness.

In another area, we have done a piece of work to identify each of our work providers—there are five providers for one area—and which email address that goes to. Again, the admin pick that up and get it back to the local authority within six weeks.

Q112 **Chair:** Okay. What I am hearing from you both is that where there is the culture and the will to do this locally, despite the system as it is currently designed, you guys have managed to work out that if you get everyone in the same room, you can hold each other accountable and work out how to make efficiencies, and the money does flow, but it is not easy to do that. Is that fair?

Dawn Fenton *indicated assent.*

Ingrid Bell *indicated assent.*

Q113 **Chair:** That is clearly best practice. I am sure there will be local authorities and parents listening in, saying, "Oh, my God! Really? That sounds amazing." How did you do that? I know I am going to hear "culture" and "leadership", but how do you bake that in in a way that is sustainable and replicable across the country?

Dawn Fenton: I am sorry to say that it is culture and leadership. Relationships are key, and so is a shared vision. In Salford locality, having a really clear SEND strategy and an agreed vision and standards that we want to work towards really helps us to keep our focus on what we are trying to achieve as a system, and working together as a system.

Q114 **Chair:** If we overlay this national strategy that Elliot has spoken a lot about—you guys have agreed that it is necessary—would it be a set of principles? Would that strategy say to local authorities, "Right, here are the things that you need plans for"? Maybe it would not tell them exactly how to do it, but it would give them a very clear idea of what they should be looking at and how. Is that fair?

Ingrid Bell: And co-production. Strengthening co-production with your parent carer forum has to happen. If you don't have them at the table, you are not making the right decisions, because you are guessing.

Q115 **Chair:** Which is what we heard very strongly in the first panel. Elliot, is that right? Is this what we are aiming for—a national strategy, feeding down into ICBs, working with parents in co-production to create a local system that is genuinely responsive to its local population? Is that correct?

Elliot Howard-Jones: You describe it as best practice but, to be fair, a lot of areas have that kind of local framework. I have described it; we have it in Hertfordshire as well. We make the best of what we have, with the funding that we have. That would be the way I would describe it. The culture, the leadership and the relationships can push that as far as it can be pushed, but there is only so far that it can be pushed.

Q116 **Chair:** What would help you to unlock it?

Elliot Howard-Jones: There are some things. I could say having a target of no child waiting more than three months for audiology and three months for autism or ADHD assessment. That is a mile away from where we are across the country, but those really measurable targets for where we should be in terms of the system will force a different dynamic and a different question about what support we should give and how we should do this. There will be a range of ways that come out of that in terms of how we support this. The funding will then flow in order to meet those targets of three months for an assessment—

Q117 **Chair:** I am going to put the question to you. We ask this of the Secretary of State all the time, and you will have noticed from DHSC that there is a clear move away from targets and towards outcomes. If we are saying that we want all children to get timely help in a way that is appropriate to them, why can't localities set their own targets? Why do you need that from Government to get you to do the right thing?

Elliot Howard-Jones: As I have described, the individual areas will do what they can with the funding that is available. What we have clearly seen when there has been national progress on cancer and on acute trust waiting times is that national funding flows to support the targets that are nationally mandated. So you can have targets based on outcomes; I wouldn't necessarily disagree. But you have to measure that in a consistent way in order to hold people to account across the system about their role in provision and commissioning of that.

Q118 **Chair:** I think I have understood that. Is there anything else about funding that you feel is important to make your jobs easier in what you are trying to do? Ingrid, is there anything about the funding flows, section 75 arrangements or whatever else? What could be done better?

Ingrid Bell: What makes my life easier is having a joint commissioning group. If I work in an area that does not have a joint commissioning group, it's backwards and forwards, backwards and forwards, but if we have a joint commissioning group, that is where that conversation goes, and the right people are in the room to be making the decisions.

Chair: Thank you. Dawn?

Dawn Fenton: I would agree.

Chair: A joint commissioning group.

Elliot Howard-Jones: I would agree with that, but I would say that some of the funding flows that we already have should be available to the statutory bodies and the NHS.

Q119 **Chair:** What do you mean by that? Which ones?

Elliot Howard-Jones: We have not mentioned the right to choose. The right to choose is a massive issue in where funding flows. At the moment, it flows to private providers, where people have sought to get their assessment done elsewhere within the time limit. That drains money away from NHS organisations, which cannot claim the same money in the same way the private providers can. It just seems a bit mad.

Q120 **Chair:** That is very interesting; thank you. I want to take this just one step further. You will know that an NHS reorganisation Bill is coming through. A conversation happening in Parliament currently is about who should sit on the boards of ICBs. Many people suggest that local authorities should be mandated to sit on those boards, because without them, you are essentially absenting a very important partner, particularly in areas like SEND, from key decisions at key moments. Would you agree with those who say that we should be mandating local authorities, or at least the right representation of local authorities, on ICB boards? Would that make your lives easier?

Dawn Fenton: I think it would strengthen the partnership working. I think it helps people to understand one another's roles and support ways of working. So I think it would be a good idea.

Chair: You would agree with it. Elliot?

Elliot Howard-Jones: Yes, I would agree with it. I would also say that if we can build in public accountability and get families represented on that, they will do more, quicker, than anyone else within the system.

Chair: How radical! Ingrid?

Ingrid Bell: I agree about families.

Q121 **Chair:** Families—we'll come back to that. That's very interesting; thank you very much.

I often end these sessions by saying, "You get one thing now." We are taking the national framework as read, guys, because I feel that if there was one thing you sought to land in our brains today, it was that, and you have done that successfully. You are saying, "We want a national framework," but you get something else. What is the other thing—you are allowed only one other thing—in addition to a national framework, that you think would help with the crisis that we are seeing in SEND and, in particular, the missing "H's" from EHCPs? You have made the point that that is not the answer on its own. Ingrid?

Ingrid Bell: Just clarity about roles and responsibilities—that accountability—and how the parts of the system, as we have mentioned, can work together better.

Chair: Thank you.

Dawn Fenton: Digital solutions, and systems working together in a far more effective way.

Elliot Howard-Jones: The one point I would make is that there isn't a silver bullet. If there was a silver bullet, someone would have fired it by now. I think it's a recognition that this is complex and it needs a complex solution.

Chair: Thank you all very much. Thank you to you, thank you to the first panel and thank you especially to the families who fed in to our work.