

## Education Committee

### Oral evidence: [Special Educational Needs and Disabilities](#), HC 968

Tuesday 5 March 2019

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Members present: Robert Halfon (Chair); Lucy Allan; Ben Bradley; James Frith; Emma Hardy; Ian Mearns; Lucy Powell; Thelma Walker; Mr William Wragg.

Questions 410-475

#### Witnesses

**I:** Caroline Dinenage, Minister of State for Care, Department of Health and Social Care; Fran Oram, Director for mental health, dementia and disabilities, DHSC; Michelle Morris, Consultant Speech and Language Therapist/Designated Clinical Officer—Salford CCG; Dr Sally Payne, Professional Adviser—Children, Young People and Families, Royal College of Occupational Therapists; Steve Inett, CEO, Healthwatch Kent; Dr Tracey Crockford, Associate Specialist Community Paediatrician, Designated Medical Officer for SEND, West Cheshire; and Professor Jacqueline Dunkley-Bent OBE, Head of Maternity, Children and Young People—Nursing Directorate, NHS England.

Written evidence from witnesses:

[Department for Education and Department for Health and Social Care](#)

NHS England [written evidence](#) and [supplementary written evidence](#)

[Royal College of Occupational Therapists](#)

## Examination of Witnesses

Witnesses: Caroline Dinenage, Fran Oram, Michelle Morris, Dr Sally Payne, Steve Inett, Dr Tracey Crockford and Professor Jacqueline Dunkley-Bent.

**Chair:** Good morning, everybody. Thank you so much for coming. The Minister will be relieved that this session is slightly more informal than previous ones. Nevertheless, we want some good evidence today. For the benefit of the tape and for those watching on the internet, starting on my right, could everyone introduce themselves? Please remember that the microphones are not brilliant in this place, so speak clearly and loudly, so that people watching can hear you.

**Ian Mearns:** I am only physically on the Chair's right. I am Ian Mearns, MP for Gateshead.

**Lucy Powell:** Lucy Powell, MP for Manchester Central.

**Steve Inett:** I am Steve Inett, CEO of Healthwatch Kent. Healthwatch is the statutory consumer champion for people using health and social care services, and I cover Kent.

**Ben Bradley:** Ben Bradley, MP for Mansfield, in Nottinghamshire.

**Mr Wragg:** William Wragg, MP for Hazel Grove.

**Professor Dunkley-Bent:** Jacqueline Dunkley-Bent, head of maternity, children and young people at NHS England.

**James Frith:** James Frith, MP for Bury North.

**Michelle Morris:** Michelle Morris, consultant speech and language therapist and designated clinical officer for Salford CCG. I am representing the Royal College of Speech and Language Therapists today.

**Fran Oram:** Frances Oram, director of mental health and dementia and disabilities and the Department of Health and Social Care.

**Caroline Dinenage:** Caroline Dinenage, Minister of State for Care at the Department of Health and Social Care.

**Lucy Allan:** Lucy Allan, MP for Telford.

**Dr Payne:** I am Sally Payne, from the Royal College of Occupational Therapists.

**Thelma Walker:** Thelma Walker, MP for Colne Valley.

**Emma Hardy:** Emma Hardy, MP for Hull West and Hessle.



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**Dr Crockford:** I am Tracey Crockford, a community paediatrician in Chester and the designated medical officer for West Cheshire CCG.

Q410 **Chair:** I am Robert Halfon, MP for Harlow and Chair of the Committee.

I will start off with a general point; we will tease out the specifics. We have had quite a few sessions on special educational needs and a lot of evidence has been sent through—something like 650-plus submissions. Time and again, particularly in terms of health, we hear that there is a lack of accountability and a degree of buck-passing; there is a view from the schools that whether it is properly resourced is a bit of a lottery—in some areas it is and in some it is not—and a lot depends on the individual personalities involved and whether people have good connections. Clearly, accountability is key.

We have also been told time and again by schools and other people in the education field that the health element is really not fit for purpose and is not living up to the aspirations and expectations set out by the former Children's Minister, Edward Timpson; the intentions were good but the result has been pretty poor. I ask the experts to comment on that first, and then for the Minister to respond.

**Dr Payne:** I am an occupational therapist. We work across education, health and social care. Within the healthcare setting, the services we provide depend on how they are commissioned locally. That would be a conversation between the health services and the local services about what is provided for which population of children and young people. Our remit, as occupational therapists, is to look at the everyday activities that children and young people carry out—the things that keep them busy at home, at school and in community settings. We work across health, education and social care, so we are well placed to deliver on many of the visions of the legislation; certainly personalised care is a key component of the legislation and is very important to us as a profession.

**Michelle Morris:** Some really good things have come as a result of the reforms. One of those things was the appointment of the designated clinical or medical officer. The role of that person is supposed to be to support CCGs to take their health responsibilities, and although we have a variable picture across the country, there are some really good examples where CCGs have really embraced their contribution to the health reforms and are driving that forward. I am a speech and language therapist. Like occupational therapists, we see children and young people in all different contexts. Some of the issues are still around who commissions what and for whom, linked to age. Some clarity on that would be immensely useful.

**Steve Inett:** I absolutely concur, based on what we hear from parents and young people across Kent, that people often feel very alone in terms of how they negotiate the system and who is dealing with what in education or in health. There is a real lack of a co-ordinator role for parents and families. In terms of commissioning, I agree; we have seven CCGs in Kent, and the services that are commissioned across the area are very variable. There are areas of good practice and things that CCGs do well, but that variability is the issue.



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**Chair:** That has been reinforced in the evidence from Kent Council as well.

**Dr Crockford:** I absolutely agree with what you say, as well. There is often a difficulty in discerning what is a health need and what is a health need that does not need provision by a health professional. That is a sticking point for us, particularly dealing with schools. I see my role as DMO very much as encouraging my health colleagues to step up and say, "Yes, this is for us to do," and get involved when it is a health responsibility to take on, but when it is not necessary for us to directly deliver, we need to support our other agency colleagues in going about that.

Q411 **Mr Wragg:** May I ask for specific examples, so we can understand that better?

**Dr Crockford:** Care needs, for example: where there is a child with a health need in school—a child with diabetes, for example—the teaching assistant in class can be trained up to deliver the healthcare; it does not need to be a health professional. Sometimes schools get quite worried about that, but obviously we can deliver the training. As a parent would give the care at home, so the majority of schools—probably all schools—will do that, but it is a scary thing to do without training.

Q412 **Thelma Walker:** Multi-agency working is known to be the most effective. Would you say that the practicalities of that are one of the biggest challenges to achieving success for children and families? How would you suggest we bring agencies together to be most effective for children and families?

**Michelle Morris:** I absolutely concur with what you are saying about multi-agency working. There is an evidence base that supports the effectiveness of that approach and people taking very specific roles. There may be a number of needs, but we should prioritise what needs are addressed first with a young person and their family, so we are not addressing everything all at once but working out what is the best and most effective way of delivering at that particular point. The solution to that is about integrated teams, better locality working and integrated commissioning.

Q413 **Thelma Walker:** In terms of the practicalities, in my previous experience of multi-agency working one of the biggest challenges was the flexible work patterns, depending on whether it was health or education, and that practicality of how to bring everybody together when some agencies were on night shifts or different timetables. How do we get over that? What practically could be done to bring them together more effectively?

**Michelle Morris:** That is about embracing a model that is neither a pure education model nor a pure health model, but a multidisciplinary model, so that you can align things such as holidays and working hours. It takes effort, time and strong leadership to do that, but it is possible to do.

Q414 **Thelma Walker:** And is it being done?

**Michelle Morris:** I think it is being done in some places, yes.



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Q415 **Chair:** Before I ask the Minister to respond, let me I read you a quote from the chair of the Disabled Children's Partnership, Amanda Batten, who said, "Just that integration between health and social care and education was one of the key bits of the reforms, and it is one of the bits that really has not delivered. There is a huge amount of variation locally and a huge range of different working relationships. I think that some of the cuts in health and social care are going a little bit under the radar. They might be news stories locally, but that is very varied. The consistent thing is families telling us that either they have experienced cuts to health and social care for disabled children, or they know of specific cuts that are on their way. That will really undermine the reforms." That goes back to what I started with, which is accountability and not delivering. How would you respond to what the panel has said, and to Amanda Batten?

**Caroline Dinéage:** Thank you for inviting me to join you today. I suppose I would start by pointing out the obvious. We exist in a world that, particularly within the Government and local government, has not always been naturally designed to work collaboratively. All MPs here will have experienced how different Departments tend to work in silos, and it has sometimes been tricky to break those down and encourage the collaboration we want. It is the same in local areas: encouraging collaboration and joint working in a partnership between CCGs and local authorities is tricky. The Children and Families Act includes a requirement to get people working together more collaboratively, and to put individual children at the heart of everything they do, which is fantastic, but it has exposed where the weaknesses are. Geographically there is a different story in different parts of the country.

The Care Quality Commission and Ofsted doing local inspections has shone a light on where there are certain issues. That is healthy because clearly those issues have been going on for a long time, although we may not have known about them to the extent we do now. The other interesting thing is that the CQC and Ofsted are going back to areas where problems have been highlighted. They have recently been back to Rochdale, and where concerns had been highlighted they are now saying that they have seen huge improvements.

There is still a long way to go, and geographically there is a different picture across the country. We have a lot of work to do, but I want to get across that the Committee should not underestimate our passion in the Department of Health and Social Care to get this right. We understand that this issue is fundamental, and that if we do not support children at the earliest stages, we store up problems for them for the rest of their lives, as well as for the systems that support them.

Q416 **Chair:** What work is your Department doing to consider whether the Children and Families Act is working, and whether there is proper co-ordination and resourcing of the services, and accountability?

**Caroline Dinéage:** To start with we are looking closely at how this is operating on the ground. The joint inspections by the CQC and Ofsted are



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shining a light on where those issues are. That enables us to produce much more work, to support CCGs in the way they commission, as well as to support best practice, send out guidance and advice, and to share any groundbreaking work we see. I have a range of examples in my pack of areas that are doing things that are slightly different, and where they are beginning to see a measurable difference.

**Q417 Lucy Allan:** As the Chair said, we have had eight evidence sessions on this subject and what has strongly come through is the lack of accountability for the health element of these reforms; the lack of integration of health and social care, which was the driver behind the reforms in the first place; and lack of collaboration. Has the implementation of the reforms failed, and if so should we seek to change legislation, or is it just a lack of will in driving that implementation?

**Caroline Dinéage:** I think neither. We have seen problems that have been there for a long time being exposed. We are really shining a light on issues that have prevented the health and care system working collaboratively for a long time. Actually, it is painful and it is a process that will take time to get right, because we are really breaking down silos and encouraging organisations that in some parts of the country work together really well.

The multidisciplinary teams that you talk about are so important. There are so many angles, even just in health and social care, so sometimes breaking down those barriers is difficult. When you bring health and social care and education in together, you can see the difficulties. We have to hold our nerve. We must not be afraid to say that things are not good enough, and to put all the focus into where we find that things are not good enough.

**Q418 Lucy Allan:** Are you seeing progress?

**Caroline Dinéage:** Yes, we are.

**Q419 Lucy Allan:** If we went round the table of experts, would they also agree that there has been progress over the period?

**Dr Payne:** Yes, absolutely. We have some areas of really good practice where systems and teams have come together to focus on better outcomes for children, young people and families across all parts of their lives. There are certainly some areas where that is happening.

**Q420 Lucy Allan:** What do we need to do that we are not doing to accelerate that progress?

**Dr Crockford:** I am not sure that there has been a hugely discernible amount of progress; there have been pockets of progress. Special educational needs and disability is about development, so we need to have a long-term view.

You talk about multidisciplinary teams. My view is that the focus is on the child at the centre and the team should be around that child. It should not be a team into which the child fits, so our multidisciplinary teams should



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be fluid. I am not quite sure exactly how you achieve all that. In my area, the best practice is seen when you have the focus on the child at the centre and all the professionals involved with that child working with the family.

**Caroline Dinénage:** I agree, and that has very much been a change of focus in how we look at and deal with health and social care as well—having person-centred care, making sure that the individual is at the centre of everything we are trying to do and that the services wrap around that individual. It is very easy to say that, but doing it is much harder, and making sure that you have the right teams to come and provide the right support when it is needed is tricky to do. The fact that we recognise that that is where we want to get to is really important. It sounds simplistic, but you have to have a clear sense of direction and know what you want to achieve.

**Fran Oram:** To build on that, and to respond to the question about whether there is a problem with the legislation, as the Minister said, the Ofsted and CQC individual local area reports show there is patchy performance across the country. In some areas, there is some good practice that is quite widespread throughout the system, but in other areas, progress is not as great as we would like. The one year on report from Ofsted and the CQC did highlight some generalised areas where there is good practice in most areas—

Q421 **Chair:** What are you doing proactively—not just looking at Ofsted and CQC reports—to spread best practice?

**Fran Oram:** We in the Department have issued guidance. We have worked with the Council for Disabled Children. We have issued guidance to health and wellbeing boards. We have produced quick guides for health services.

There is lots of guidance out there, but the key thing, as Michelle said, is around leadership and setting the direction from the top. In the Department, we are working closely with the Department for Education and the Ministry of Housing, Communities and Local Government to set the direction from the top there. Obviously there is then local leadership that can be really instrumental. The fact that some local areas are managing to make this work suggests that the legislation is right and it is about getting the local area up to the level it needs to be.

Q422 **Ian Mearns:** On that point, it is all very well issuing guidance to the local organisations that are involved in the process, but how is the Department holding those organisations accountable? That is the important thing.

**Chair:** You know as well as everyone that guidance can mean diddly-squat in many cases and it is often not followed. I know all about that because of hospital car parking charges, where the guidance is not followed by the hospitals.

**Caroline Dinénage:** The accountability comes through the Ofsted and CQC inspection. To be able to measure how you are performing as a local



authority and as a clinical commissioning group is a step in the right direction to be able to change the way best practice is decided.

**Professor Dunkley-Bent:** I support what some of the specialists have talked about regarding holistic care for a child with special educational needs and disabilities. I am thinking about some of the pragmatic things that we managed to implement from an NHS England perspective. We have a programme of work that is supported by a multi-sector children and young people with complex needs and SEND board. That board is supporting us in delivering some really pragmatic things. If I can start with the levers, we have introduced into the NHS standard contract some narrative around education and healthcare plans and the timeliness of their completion and delivery. That is in the NHS standard contract. The CCGs will be able to use that in their quality surveillance and governance frameworks to ensure that there is accountability for meeting that contract objective.

We have also talked about guidance and publications, but other things we have done from that board, driven by the senior children's nurse for SEND at NHS England, are to work with providers on SEND leadership and knowing the role and responsibility. We have not just published quick guides but have used them in education environments to help our colleagues in the sector in the CCG and other parts such as the local authority, to be able to provide holistic care for the child with those needs.

Those are some practical examples. We have commissioned the Council for Disabled Children to develop a CCG assessment so that the CCG can use that assessment toolkit to assess whether they are complying with the SEND reforms and how successful or not they are. Those are some of the practical things we are doing, not just about guidance but working with people to ensure that children have that holistic care.

Q423 **James Frith:** I absolutely endorse the need to focus on practical solutions, otherwise we risk speaking outside the city walls rather than to the kids inside the school. Schools we speak to are crying out for additional resources. I am not trying to make this a funding argument—that was well rehearsed yesterday in a Westminster Hall debate—but sooner or later, guidance, tones of legislation and well-meaning suggestions and examples will not do much without additional resource in schools. The multi-agency work is personified in active work through professionals in schools.

I want to come back to your point, Minister, on inspections. I absolutely agree that the joint inspections approach is a real turning point for how we expect regions to think about their joint commissioning. The revisits are good; they hit the bottom rung and are climbing up rapidly, and are enjoying the improvement partnership approach, which Ofsted could do a lot more of in isolation. My concern is that as a model it needs flipping. We should not wait to hit rock bottom before we say, "Actually, we all believe in this, don't we? Let's get on and do it?"

How do we flip the model to be not just issuing guidance? How do we





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incentivise upstream commissioning, so we are preventing in the first place so many of our kids getting to a point where they hit crisis? Do you have any examples of that upstream work that we have heard is so important in schools?

**Caroline Dinéage:** I think you have hit the nail on the head. There is no doubt that pressures on funding in recent years have made life very difficult for local authorities and schools. The Department of Health and Social Care's investment in the NHS is now enormous—as a result of the long-term plan funding there will be an addition £20 billion a year. That is growing at double the rate of the British economy. The money we are spending on mental health, for example, is growing faster than that, and the money we are spending on children's mental health is growing faster than that. It is a case of not only spending more money but prioritising how that money is spent. We also devolve a lot of this money down to clinical commissioning groups, so it is also about raising the awareness of commissioners and providers about how that money is best spent to drive the sorts of improvements we all want to see.

Q424 **James Frith:** Do you agree that that can be best translated, from an impact point of view, as actual people—professionals—in schools with a multidisciplinary approach?

**Caroline Dinéage:** Yes, completely.

Q425 **James Frith:** Can schools in my area and elsewhere expect more support in professional terms? There is a fear that CCG work is somewhat removed from the realities of the school, and that the school is left doing all the firefighting while everybody talks about the well-meaning liaison work elsewhere.

**Caroline Dinéage:** From the perspective of my Government portfolio, I can see how early intervention—investing in the right support, whether that is mental health support, occupational therapists or speech and language therapists—at an early age immeasurably improves the life chances, experience and life of an individual child, their family and their carers. I have also seen the challenges we have with the whole transforming care system with trying to get people out of in-patient hospital settings, when they have reached crisis point and ended up in an assessment and treatment unit or a residential care setting. The cost of that to society is vast. It is in everybody's interests to provide the right support.

Q426 **Mr Wragg:** Building on that, regardless of the particular budgets or their increases, is there not an aspect of funding tension inherent in the system? I use the example—perhaps Steve can corroborate this—of the evidence that Kent County Council gave us. They talked about therapists—I am not sure whether they were talking about speech and language therapists or occupational therapists. They are employed by the national health service, but the budgets are held by the CCG, and the responsibility for ensuring provision sits with the local authority. It seems to me that there is a tension there. How can that be resolved?



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**Fran Oram:** The key principle in the 2014 Act is partnership working and collaborative working across the different services for the benefit of children, and putting children and families at the heart of outcomes. We should not commission on narrow silo bases but think about outcomes and what the community needs. To respond to an earlier question, I do not think there is a one-size-fits-all approach that a national agency can suggest needs to be adopted everywhere. It is about best practice locally and support from national bodies to build on that.

Q427 **Mr Wragg:** It might be the experience of other people—my colleagues or the professional representatives here—that they are in fact adhering to that very laudable aim of the Act, but if you have that inherent potential for funding tension, that will become the driver of how they integrate with one another.

**Fran Oram:** But it does not have to. You are absolutely right that it does in too many areas, but that is a failure to comply with the spirit of the Act, if you like. There are other areas that are managing to comply with the spirit, so I do not think there is a failure of legislation. It is a failure, perhaps, of local leadership or of being able to take innovative approaches for the benefit of local citizens, which is ultimately the objective of the legislation.

Q428 **Mr Wragg:** I would be interested if anybody had any further thoughts on that from their experience in the professions or localities.

**Steve Inett:** As a layperson, hearing from the public but sitting with both commissioners and providers, it seems to me as if it is absolutely in the gift of CCGs and local authorities to work better together. That is about relationships. What accountability you can have with organisations that do not have those relationships would be really interesting. There are structural issues. The fragmentation of health and education means it is incredibly difficult to have a strategic approach across a county the size of Kent. That variation means that a child is unsure what is happening to them. They have behavioural issues, perhaps, and there is talk about exclusion from school. It is an absolutely disempowering, terrifying and exhausting experience. You have heard the evidence from people who have talked about how they feel they have to fight. That lack of co-ordination is a real issue.

**Michelle Morris:** I have a couple of points that I want to make. First, I have the privilege of working in Greater Manchester, and I am seconded for part of my time to the combined authority. I see at first hand the impact of the joint leadership of the health and social care partnership and the combined authority together having shared priorities, and the difference that that makes. We have talked a lot about systems around the child, but what enables that to happen is the system enablers of concentrated, integrated leadership and support. It is not perfect in Greater Manchester—I am not saying it is—but there are levers there that we can use to drive things forward, and that is happening apace across Greater Manchester.



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The second point I want to pick up is an unintended consequence of the reforms. Where there is paucity of provision, it drives provision towards delivery to the children with education, health and care plans, so the vast majority of children who are known to health services do not qualify, and it is shaping how health services are delivered. In speech and language therapy, for example, 86% of children do not have a education, health and social care plan. However, 40% of speech and language therapy services say they can no longer provide for those children, which is very concerning indeed.

**Q429 Emma Hardy:** I want to talk a bit about support for children with EHCPs. I am particularly interested in working together. The evidence we have had from many different sources is that the health teams do not understand the roles going on in school, and vice versa. The schools do not really understand the roles of the health professionals, which can lead to bad or confused advice being given to parents. Schools say that health professionals cannot come into schools for meetings when they plan them, so health professionals often write things without having actually met the child in question, and they say that some of the plans end up being heavily weighted towards education with not enough about health.

What can be done to ensure that health professionals are much more involved in the writing and delivery of the EHCP plans? Perhaps I have got this wrong, but it feels a little bit like no one wants to be holding the funding hot potato at the end and everyone is desperately trying to throw it on to the next one. Is that perhaps the motivation for health not wanting to be too involved, because they might be left holding the bill?

**Dr Crockford:** I do not think it is that. It is about knowing that the review will take place, being invited to it in a timely fashion and having the opportunity to attend. I am a practising doctor. I have a clinic on a Monday morning. If I am invited to a review on a Monday morning, I need six weeks' notice. It is about organisation to a large extent.

**Q430 Emma Hardy:** So you are saying it is just that the schools plan them at times you cannot make.

**Dr Crockford:** No, that is the first step. Let's all agree that we need to go to a review. We do not need to go to all of them, but there are some children whose review I would very much like to be at. However, I need notice and so do my colleagues, I am sure.

**Michelle Morris:** For me, it is about the specification of the service we are talking about. When the CCGs review specifications, are they making sure that they are specifications that enable staff to do all the things? I also think it is the role of the designated clinical or medical officer to do lots and lots of training and make sure people are aware of what their obligations and responsibilities are.

**Q431 Emma Hardy:** We are talking at the moment about when the plans are being developed, not about who is going to deliver it, or the training that you mentioned for the TA. The evidence that we have had is that the health professionals are missing at the time the plans are being



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developed, so they are being weighted towards education; they do not have as much health in there. Also, when health has been put in by the local authority case officers, the things that have been put in are perhaps not suitable or cannot be delivered by the local area. It seems to show that it is because health is not in the room at the time the plans are being developed. What I am asking you as professionals is what can be done to change that—or is that something that the Minister needs to be involved in?

**Dr Crockford:** Health needs to be involved in the co-production of the plans when there is a heavy health element of that child's need. For example, if there is a child with a physical disability and there is a physiotherapist involved, in my view the physiotherapist should be involved in writing that plan. When the child's primary need is a speech and language communication need, the speech and language therapist should be involved in writing that plan, with the family and the SEN team.

Q432 **Emma Hardy:** If they are not—and they are not, because that is what the evidence is showing us—what needs to change to make that happen?

**Dr Crockford:** Again, it goes back to organisation and planning. You have a fast turnaround time. Everything has to be done—bang, bang, bang. Sometimes the timescales perhaps need to be a bit more flexible in order to get a good outcome of a plan, rather than an adequate one within the timescales.

Q433 **Emma Hardy:** Do any of the other professionals have an opinion on this?

**Dr Payne:** I think there was a problem in the early days around communication between local authorities and health in terms of asking for information in a timely manner. Those communication channels have improved. We have a big disconnect between information systems held by education and health. That has been a real challenge. In the early days, certainly, asking for information at the right time so that health professionals were able to respond within the timescales was a real problem. I think we are moving on from that, and the processes are improving, but that was a problem.

Q434 **Ben Bradley:** This is in a similar vein. Emma is absolutely right: we have heard in evidence that health has been missing from those discussions. For my own local authority, there are elements of health input that get put in the plans that are then not delivered, for whatever reason. The struggle that certainly comes across to me is the ability for that education provider—the local authority—to hold health to account and to tie them in to that. Ultimately, the fall-back from that from parents and the schools comes into the local authority and the Department for Education, not directly into the health service. I wonder what powers the local authority has to tie all that in.

**Caroline Dinéage:** A lot of this is about leadership, real cultural change and embracing the vital importance of the partnership working that Michelle talked about in Manchester and Greater Manchester. We have the designated clinical officers and the designated medical officers. It is about



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making sure that they play an informed role, bringing everybody to the table.

There are some workforce issues. It is about making sure that we have sufficient speech and language therapists and other professionals—medical professionals, in some cases—to do the job properly. That is why we have Baroness Harding at the moment doing a workforce review, and why we have another review of the allied health professionals—things like speech and language therapists and occupational therapists—going on concurrently.

The key here is a culture change, which will take time, and leadership is fundamental. It is about having leaders across the piece who have really bought into the importance of this.

**Q435 Ben Bradley:** What power does the LA actually have? The impression I get, certainly from talking to my own authority, is that if those things are not delivered, bar the director from the education department ringing somebody and saying, "Please can you deliver the service that you promised to deliver?" they do not have the ability to compel anybody to fulfil the plan. It seems as though ultimately, as Emma touched on at the beginning, it feels to them as though they have been left holding the funding hot potato, and left to take responsibility for what is actually a failing within health.

**Caroline Dinenege:** I can understand that that would be a massive frustration, but that again is about leadership. We took a decision to devolve a lot of decision making about the way the health and care money is spent to local areas. The difficulty of that is that when you tell people to make their own decisions and have their own priorities about their own areas, you cannot then tell them that they are doing it wrong. It is very difficult to tell them that they are doing it wrong, which is why it is so important to get leaders who really understand the value of that and to back them up with the money to do it properly, and I feel we are investing very heavily in it.

**Q436 Chair:** Clearly, the problem highlighted by my colleagues is, in essence, who is paying for this. Let me quote again the principal of Severndale Specialist Academy. Her school currently pays more than £90,000 just for nursing care. She says that health "should be a big player, and there should be a partnership with education. That is what the Act was trying to achieve...We can bat around stuff like funding and resource and all the rest of it, but education is currently paying for health needs within schools. That could be speech and language therapy, it could be mental health, it could be nursing and all sorts. As a special school, we are currently paying in excess of £90,000 a year just for nursing care, for our students who have been assessed by health to need wraparound care provision for their health needs." So this is a lottery—it is a kind of wild west out there. If they are lucky, the health authority might pay for it. Just as Ben has highlighted, I know that schools in my own constituency are paying a lot for the health side of special educational needs and can barely afford it. Clearly, it cannot just be left to leaders to decide; there



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has to be some kind of ruling from the Government that part of the health authorities' budget has to pay for this.

**Caroline Dinenge:** We do not earmark CCGs' budgets, because that flies in the face of giving people the decision making about their own areas, but we do send, and NHS England send, very clear messages about what our priority is. NHS England, in their long-term plan for the NHS, have set out that, for example, learning disability and autism are one of the clinical priorities of the long-term plan. There are only four clinical priorities, and learning disability and autism, under one umbrella, is one of them. So you can set out very clearly where you think the focus should be.

Q437 **Chair:** It goes back to my original question: who is accountable and who is paying? We just do not seem to have an answer to that, because it is a postcode lottery, and that is not fair to schools.

**Fran Oram:** The expectation in the legislation is for partnership working, and that would entail, quite often, joint commissioning. Where there are arguments about which side of the line different expectations should be funded from, that is a failure of the partnership working to deliver for local residents. The expectation should be for local areas to work together for better outcomes for their children and young people.

Could I just say a few words on investment in mental health? I know that is not directly the subject of this inquiry, but it is very related. The Government published a joint Green Paper in 2017 on children and young people's mental health. We are rolling that Green Paper out now and we will ensure, in the roll-out of it, that it benefits children with special educational needs and disabilities, so that they can obtain access to good mental health support in their schools, before they reach any threshold for formal CAMHS support and so on, so it is a fully additional service, which I think will be a big, powerful help here.

Q438 **Thelma Walker:** Minister, you talked about the need for a culture change. Could I ask about upskilling the workforce and training and the provision? I know from my previous career that in education we can be very guilty of using education-speak and the acronyms that we know and understand, and health is the same. Do you think that training and provision of training and funding for training to get that mutual understanding could or might be provided?

**Caroline Dinenge:** It is a really good point, Thelma. That is why I am really fascinated by this particular review that you are doing. We have to take advice from studies like this, which really do shine a light on the issue and look at how we can make things better. I personally think training is fundamental. We are doing at the moment a big review about ensuring that every single health and care professional has learning disability and autism training. That has come out of some studies about deaths of people with learning disability that we have been looking at and the frightening statistics—

Q439 **Thelma Walker:** Is that across the country?





**Caroline Dinenaige:** It will be. The consultation is happening right now—it concludes at the beginning of August. Every single person who works in health and care—not just medical professionals; it might be a receptionist—who has contact with individuals with learning disability or autistic people needs to be trained in what constitutes a reasonable adjustment and how you communicate with people and make them feel at ease. By definition, people who work in health and care are normally seeing people when they are not very well, when they are anxious or when they are a bit frightened about being in that environment.

Q440 **Thelma Walker:** The language can sometimes be a barrier.

**Caroline Dinenaige:** That is right, and knowing what people's rights are under the Equality Act—they have the right to have a meaningful engagement with services, but sometimes that is not being delivered. That is translated into life expectancy, which for women with learning disability is 18 years less than the rest of the population, and for gentlemen is 14 years less. That is not good enough and that is why I am a great believer in the training.

Q441 **Chair:** Would any of the professionals like to ask the Minister a question directly? You do not often have such an opportunity.

**Dr Crockford:** One of my big concerns is the retention of experienced staff in all our health disciplines. How would you tackle that?

**Caroline Dinenaige:** It is a really big issue and a huge concern, because we have some phenomenally experienced and well-trained people and we cannot afford to lose them. There is a whole raft of issues around workforce, not just retention but recruitment and the levels of training and so on.

That is why Baroness Dido Harding is leading a workforce review for the Department of Health and Social Care along with David Behan, who used to be the head of the Care Quality Commission and previously worked in local government. They will report in September. It is a document that goes alongside the NHS long-term plan, because there is no point having great aspirations for how we want to deliver health and care unless we have a brilliant workforce to be able to do it.

**Fran Oram:** Return to practice is another area that is very important. Along with retention, it is about bringing back in some of the more experienced people who have left practice. There are some programmes under way that it would be fantastic to build on to try to bring more people back in. As the Minister says, the workforce needs are very significant. It is fantastic to train up new people to come through, but we need to retain the more experienced professionals too.

Q442 **Chair:** Who else would like to ask the Minister a question?

**Steve Inett:** We have talked about accountability between organisations and commissioners. There is a real issue about accountability to children and parents. How do you feel that that could be strengthened? At the moment, we have heard about the confusion about who you speak to if



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you have a concern about how all those different professionals are working together. How could that be strengthened?

**Caroline Dinelage:** You hit the nail on the head, Steve. In your evidence, you said that the Children and Families Act had put the responsibility to listen, and children and their families, at the heart of the process, but that sometimes that was not being delivered, so you have built up expectations but the delivery is falling short. That is absolutely fundamental.

Part of the training that we are pushing forward with learning disability and autism for health and care professionals is about learning how to listen to people—children, their families and their carers—and making sure that they are not completely sidelined in a process that, fundamentally, is about them. They should be right at the heart of any form of decision-making process.

**Fran Oram:** We have talked before about the joint CQC and Ofsted inspections. A big factor in those reports is the views of parents. I appreciate that is a bit too late—the point earlier was about why wait until we know there is a problem—but it is surely better to be highlighting where there is a problem and to be taking full account of the views of parents, children and young people in those.

Some of the reports that have highlighted good practice have talked a lot about co-production and involving families and children with SEND in the development of the local offer, so that they understand what is on offer to them. They can then understand that there are balancing acts and trade-offs and that the budget is finite, but they are at least involved in determining how best that budget should be deployed for the best outcomes.

Q443 **Chair:** Michelle?

**Michelle Morris:** My question is about 18 to 25-year-olds and how the commissioning from a health perspective sits across two camps. Some of this is paediatric commissioning and some of it is adult commissioning. How do we drive bridging those gaps, to make sure that services are commissioned that are appropriate for young people?

**Caroline Dinelage:** This is something that I do have concerns about. I am really aware that for some people, once they hit the age of 18, that can really be a cliff edge. That is why the Children and Families Act extended that to 25. There is a big disparity between services with a cliff edge at 18 and those that finish at 25. That is something that we do need to get 100% right. That transitional support in SEND particularly can make an unbelievable difference in the way that someone moves forward with their lives and whether their crisis points are tackled professionally.

**Professor Dunkley-Bent:** I just wanted to support the Minister in terms of the long-term plan and the workforce strategy that Dido Harding is leading on. I think she articulated that, and I just wanted to support that.



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**Fran Oram:** To add to that, on the cliff edge of 18, the long-term plan commits to changing the boundary for CAMHS services to 25 in line with SEND services. I think that is a really powerful step, to smooth that off, so that people are not falling off a cliff.

Q444 **Chair:** Sarah?

**Dr Payne:** I have a question about funding of equipment at home, that transition from hospital to home, and in schools. I am thinking about powered wheelchairs and specialist equipment, and what you have in mind on that.

**Caroline Dinenage:** That is really good question that I don't know much about.

**Fran Oram:** Again, that comes down to local decisions and local commissioning, so it is a question of local areas understanding their population's needs and ensuring that they are commissioning the right services. I don't know whether there is anything specific in your mind about a gap?

**Dr Payne:** There are gaps hospital to home, but one that is perhaps of more interest to this Committee is around specialist seating within schools. We have talked about accountability for funding. There is a lot of uncertainty about what should be provided by who, and there is a real need for that integrated joint commissioning. We have some examples of where it has worked well but only because of the goodwill of the people who are getting the equipment.

**Caroline Dinenage:** We would be very keen to hear those. That is something that we would be very happy to take away.

Q445 **Emma Hardy:** We have heard a bit of evidence about the problems with workforce and the lack of staff and retention issues. Michelle, I have heard a few people talk before about the problems of speech therapists and people trying to access their support. I think it is shocking that so many people need it and can't get it without an EHCP. I would like to return to the points I was making before. Do you think the lack of professionals being available is having an impact on the quality of the EHCP plans being written?

**Michelle Morris:** I imagine it would do. I can only speak for my personal experience of my local area in Salford, and when a health professional is required to write advice for an education, health and care plan, they do. No plan goes out without any health advice. I can say that 100% of plans have health advice in them.

**Dr Crockford:** It is often quite difficult for the professionals writing the plans to write totally honestly from the point of the child's needs and completely forget what provision is in the local area. That is what we should be doing—we should be writing the plan based on the need, and if the provision is not there, we should be writing for that provision. That is part of our role as DMO or DCO.



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Q446 **Emma Hardy:** That is a really powerful comment. Lots of the evidence has shown that people are concerned that the local authority that is commissioning the support needed is the same body that is writing the plans. I think we settled, not on “conflict of interest”, but on the word “tension”. Would the health professionals here agree that there is a tension if you are writing the plan and having to pay for its delivery?

**Michelle Morris:** Absolutely. I would agree with that. It is a very difficult thing for a health professional to do. We specify and quantify, but we are aware that sometimes when we say what a child needs, we know that actually it is also difficult to provide it.

Q447 **James Frith:** There are cost implications.

**Michelle Morris:** Yes.

Q448 **Chair:** Just specifically, whose responsibility is it to ensure that joint commissioning is happening as required by section 26 of the Children’s Act?

**Fran Oram:** It is a shared responsibility, as I understand it. In terms of where the ultimate accountability lies, the Department for Education and our Department are in close discussions with areas where there are problems. I know that our Minister’s counterpart in the Department for Education is writing letters to all the local areas where they have critical reports—

Q449 **Chair:** Are you saying that the legislation does not make it clear enough whose responsibility it is?

**Fran Oram:** I will have to check.

**Caroline Dinéage:** It is a piece of education legislation.

Q450 **Chair:** This is at the heart of the questions we are all asking you today: who is responsible, who is accountable and who pays?

**Caroline Dinéage:** The legislation is a piece of education legislation, but the Department of Health and Social Care works very closely on the development of it. The fundamental governmental responsibility lies with the Department for Education, because that is where the Bill came from, but clearly the fact that this has a huge health element to it means that we have a very important footprint in there, too.

Q451 **Chair:** But would you not say that the fact that it is difficult to answer that question shows that there is a flaw in the—

**Caroline Dinéage:** It shows the challenges, doesn’t it? Would you say a flaw? The fact that a Bill has to come out of a Government Department gives responsibility to that Government Department. It shows the silo working we have within Government in producing legislation, but it doesn’t have to be a flaw. A huge frustration of mine as a Government Minister has been trying to break down those barriers and work collaboratively across Government Departments so that we are not jealously possessive of our pots of cash, but are thinking about the best investment for an



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individual, rather than a Department, a CCG, a local authority or whatever.

Q452 **Ben Bradley:** It strikes me that there is the exact same problem at the local level as at the national. Ultimately, the Department for Education or the local education authority is responsible to parents to provide the service, and it comes back on the DFE. The challenge is how you tie Health into that and exactly what responsibility it has within that, in exactly the same way as you have described for the Government. Your answer for the local level was about leadership and about having the right people and personalities to pull that together. The same applies at the Government level.

**Caroline Dinenage:** Yes, it is about leadership. It is about having people in place who want to break down those silos. That is why I work very closely with Nadhim Zahawi in the Department for Education, because I recognise that. I think it is harder at the local level. I think I am right in saying that eight different CCGs cover Steve's county, Kent. Having eight CCGs in one local authority is a hell of a challenge, with all the personalities involved. Maybe I am hugely aspirational and wildly optimistic, but I want to get to a stage, like in Greater Manchester, where what is whose pot of cash and what is whose responsibility somehow gets slightly pushed to the edges and working collaboratively becomes the norm, so that we do not get all caught up in whose role and responsibility something is. It is the utopia we all need to aspire to.

Q453 **James Frith:** We do not want to be accused of mis-selling Greater Manchester. It is not some Shangri-La.

**Caroline Dinenage:** No, but it has definitely shown a way of working that measurably delivers outcomes for individuals.

Q454 **Ben Bradley:** Isn't the point about Greater Manchester that we are trying to ascertain here who is ultimately accountable at a local authority level, whereas in Greater Manchester, it is very clear who is ultimately accountable because all those powers are within one authority?

**Caroline Dinenage:** Yes, that's true.

Q455 **James Frith:** To a degree, but the problem still exists that while GMCA has some health responsibilities, it does not have responsibility for schools. There is still that ambiguity about who the buck ultimately stops with. It strikes me that a lot of the work that has had the most profound change is the preventive work, yet you are readily called in for the EHCP work, because the bureaucracies involved understand the labelling terms given to the EHCP and the requirement of a healthcare professional. Upstream there is as much requirement to involve—perhaps more tacitly, perhaps more informally, perhaps on a one-to-one, school-by-school basis—the sorts of professions that we have discussed in the round today.

I wanted just to ask what experience there is of schools or areas that are best involving you in the mainstream SEN support, as opposed to only when it gets to crisis, and the EHCP. It strikes me that that is the



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measure that we need to reward and support. It is less expensive and ultimately saves money in the long run. It also expected to be a bit better for day-to-day work. I completely understand your experience of having six weeks. Equally, some things will not wait for six weeks, so what are schools doing better? Schools are not great at reaching out to outsiders, for protective reasons, obviously. Any examples of that from the professionals would be welcome.

**Dr Payne:** We have some really good examples of occupational therapists working collaboratively with schools—so spending time in schools working with the teachers, almost being an extra person in the classroom. They then offer advice and information about how things could be done and about different tools that could be used, helping with writing and different positioning to enable all the children within that class to achieve their academic and personal potential, without waiting for specialist interventions.

The challenge for us—I think for speech and language therapy it is the same—is releasing staff from that specialist intervention and one-to-one intervention that children with EHCPs would perhaps be expecting to receive, to free up staff to deliver that universal level. Actually, doing so really makes a difference for all children's outcomes.

**Michelle Morris:** In Manchester, we have an early language and communication pathway that identifies very early in a child's life any issues that may occur. The interventions are supported by and delivered by early years workers, so a very targeted approach is built into that pathway even before the children get to school.

Other examples are when schools commission speech and language therapists to support reception and early years, because of the paucity of language of many of the children who are starting school, so they actually co-teach in the classroom.

Q456 **James Frith:** If there is a remit within the 10-year plan, for example, around learning difficulties and autism, where is there an example of the health sector commissioning the school, not the other way around, because of the challenges that the health sector has within the long-term plan, and within the responsibilities in their purview? The Chair made the point about schools having to spend hundreds of thousands of pounds on health-based provision. It should really be coming from the CCGs bringing schools together and saying, "We've got pots of money, resources, people and professions to support," as opposed to waiting for schools to ring them. That is why I talked at the beginning about needing to flip the model on this.

**Michelle Morris:** I see what you are saying. In terms of the health provision and responsibilities for health provision, some things are very clearly health provision, some things are a joint contribution, and some things are an education responsibility. We have to be very clear about what we are talking about in those three categories. For example, I would see school nursing as a health responsibility. However, I would see





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occupational therapy and speech and language therapy, where it impacts on the child's learning, as an integrated or combined responsibility. It is about teasing that out.

Q457 **James Frith:** That was really helpful. That is two of three examples; what is the third, where it is exclusively health, but within an education setting?

**Michelle Morris:** I would say, for example, that supporting a child with swallowing difficulties is an exclusively health contribution, because that is a medical condition. That does not impact on their ability to access the curriculum, but it requires support in school because children are being fed in schools.

**Fran Oram:** Is it possible to build on the legislation question that you had? There is obviously more legislation in this space than just the 2014 Act. There is also the NHS Act of 2006, which places a responsibility on CCGs to meet children and young people's health needs to a reasonable extent. They are obviously legally required to do that, and to provide adequate health services. They are then accountable to NHS England, which is ultimately accountable to our Department.

Those are the formal structures, but what is more important here is the partnership working. Although understanding which services lie on which side of the line is important, what ultimately matters more is working together to deliver the outcomes, and not getting too hung up on the minutiae of the legislation and so on. I did not want to leave the impression that there was any deficiency in the legislation. From our perspective, it is joint working for better outcomes that is key.

Q458 **Chair:** Except for the fact that it is not working. The evidence we have had has, for the most part, indicated that there is a lack of clarity and that everybody is passing the buck to one another and saying, "You're responsible," "No, you're responsible," or, "You're funding it," "No, you're funding it."

**Fran Oram:** My point is that I do not think legislation necessarily would change that. That is about relationships and building trust.

Q459 **Chair:** Maybe the legislation is not clear enough about who is responsible for what.

**Caroline Dinéage:** As a Committee, you have taken a phenomenal amount of evidence on this, and I think the Government would be foolish not to take on board any findings that come out of that. Legislation can always be improved, but we also have to be very careful not to put all our store in legislation without recognising that it is about how it is interpreted and delivered on the ground, where it affects people's lives.

Q460 **Ian Mearns:** It seems to me that, in the Department of Health and Social Care, among Ministers and across Parliament, we are saying we are going to take mental health much more seriously. We have to focus on the importance of the health contribution to the development of strategies to benefit children with profound needs. If we do not have that, we are



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going to carry on doing what we have always done. All the evidence we have had—it is not a new phenomenon, by the way—suggests that in the preparation of education, health and care plans, health all too often is missing from the table. That is not universally the case, but it is missing from the table all too often. How are we going to get the message out there that health has to be a presence in helping to develop a properly comprehensive, rounded plan to meet the needs of each individual child?

**Caroline Dinénage:** You are right. The Government and the Department of Health and Social Care have a huge responsibility to set out what we regard as priorities. NHS England has a huge responsibility to set out its priorities. It has done that very clearly in the 10-year plan, and it will be doing it even more clearly in the implementation document that goes alongside that. As I say, learning disability and autism are very clearly a clinical priority for NHS England. Our Secretary of State, Matt Hancock, has set out his three priorities for the Department of Health and Social Care. One of them is workforce, which is fundamental to the delivery of that, but another is prevention, which is absolutely key to a lot of the challenges that we have spoken about today.

Q461 **Chair:** Can I ask you about this cliff edge between those who get EHCPs and those who do not? Although it is very hard to get an EHCP—there are all sorts of separate issues around that, some of which we have discussed today—if you get one, you get resources. Are we creating a system that is too binary and too siloed between the SEND system and EHCPs? The evidence we have had suggests that the health side is ignoring children who do not have EHCPs.

**Caroline Dinénage:** I am very disappointed that that has come out of your evidence. As far as I am concerned, if you are a child with a learning disability, autism or a physical disability, you should be getting the help and support you need, irrespective of whether you have an EHCP. Clearly, the responsibility for determining those needs lies with local commissioners, but it should not rely on a piece of paper that differentiates between one group and another.

**Fran Oram:** I referred earlier to the Ofsted and CQC “One Year On” report. They acknowledge that some local areas mitigate that risk and have worked to deliver good support to children and young people without EHCPs. I do not think it needs to be a cliff edge, but I appreciate that some of the evidence you have received suggests that that is how it feels to children and families. Clearly, that is disappointing.

Q462 **Chair:** Clearly, there has been an issue with dedicated clinical officers or dedicated paediatrician officers, in that there have not been enough in certain areas. Again, that is evidence we have had. However, we have also seen evidence from Cheshire West and Chester Council that suggests that it is working, and that some quite good things are going on in those areas. Why is that, and what are you doing to spread best practice around the country, which is the opposite of what I asked at the beginning of this session?



**Caroline Dinénage:** I think that is where these reviews by Ofsted and the Care Quality Commission have so much value, because they are shining a light on areas where there is excellent practice, but also exposing areas where a lot more needs to be done. We identify where there is a need for support and we put that support in—where issues are identified, a SEND expert goes in and offers help and advice—and then we re-inspect, so we know that any changes and any improvements are resilient and long-lasting, not just a patch-up measure. That is how you build a better service that is going to last into the long term and be sustainable, rather than a quick fix.

**Fran Oram:** The two key mechanisms for spreading best practice are the regional nursing leads that NHS England looks after and the Department for Education's SEND advisers, who are out in the regions, helping to disseminate that best practice. It is not really something that our Department leads on directly.

**Professor Dunkley-Bent:** Fran has just repeated what I was about to say. Just thinking about the upstream analogy and ahead of the inspections, when we learn from inspections and we receive the reports, a programme of work at NHS England involves going out to the regions, particularly the DMOs and the DCO networks and the regional SEND leads, to cascade that learning and prepare them for their inspections—so being more proactive, rather than reactively waiting for the outcome of the inspection. There is a whole network; there are forums that we have set up to share best practice. We have best practice examples that drive forward improvement within the CCG, so that is a more pragmatic perspective on the overall improvement.

Q463 **Emma Hardy:** The Chair was talking before about the fact that some children are not getting the support of having an EHCP plan; I think Michelle has mentioned this in terms of speech and language therapy. We have had so much evidence from parents about the almost desperate fight that they are having to try to get these EHCP plans, because parents know that without them, their child is not going to get the support that they need. Are you as concerned as I am, Minister, about all the children whose parents—for various reasons—cannot fight in the same way, and who therefore are deserving of support and are not getting it?

**Caroline Dinénage:** I completely am, and I am very clear that the level of support that an individual child and their family gets should be based on nothing other than the level of need. It shouldn't be based upon what plan there is in place; it needs to be based on the individual needs of that child, and it always concerns me that sometimes, when parents feel least able to fight because of all the responsibilities that they have, they feel that they have to fight the most in order to get what they need for their children. We should not be seeing that. As Fran said, the National Health Service Act 2006 sets out the responsibility of CCGs to provide the right level of care to individuals, but clearly, ensuring that happens is a huge priority.

Q464 **Emma Hardy:** What can be done, then, for those children who do not have an EHCP plan—using the example of children with speech and



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language difficulties—to get them the support that they need? They are not getting it universally. You have seen the figures, and we have seen them: the number of EHCP plans is increasing, and the tribunal costs are increasing. You can speak to any parent about the battle that they have had to go through; the amount of money, if nothing else, wasted in this system is astonishing. What more can be done to support those children without ECHP plans so that their parents do not have to go through the hell of having to fight the system to get the support they need?

**Caroline Dinenage:** It is partly about making sure that we have a robust system that can identify the need and support people. That means making sure that we have the up-front investment in all of the preventive services that we have discussed, and that we have the workforce to deliver it. That is very much what my Department and NHS England are working on.

**Fran Oram:** As we said earlier, the long-term plan is growing the investment in this area, but I appreciate that does not help the children and families who are in these difficulties now. As the Minister said earlier, they are local commissioning decisions, so there is a limited amount that we are able to do to intervene in individual decisions and so on. I would expect, however, that CCGs would want to listen to their local residents. As we said earlier, they have a statutory duty to provide adequate healthcare support.

Q465 **Emma Hardy:** Michelle, as someone from the royal society, what do you think needs to happen for speech therapists to be able to provide support to children without EHC plans? What needs to change?

**Michelle Morris:** There are a number of things. First, there is a level before education, health and care plans that is SEN support. It is difficult for health professionals to know which children are on SEN support, because that information is held by schools rather than the local authority. That is one thing that could be done.

How services are commissioned is really critical, because if you are commissioning only for a very medicalised model, you are commissioning the top end of the pyramid—that is, those children who need plans. There needs to be a look at how services are commissioned for language and communication, which looks at the environment, workforce development and so on, so children are working in an environment that supports their language and communication needs. Those are a couple of examples of how things could change significantly.

**Dr Crockford:** Early intervention and language development in the home in those early years would, hopefully, be a long-term help.

Q466 **Emma Hardy:** Would it need a change in commissioning to fund that?

**Dr Crockford:** I think the early intervention is already coming in, but it is how that is focused and delivered, and whether the workforce is available to provide it across the board.

Q467 **Chair:** In the final few minutes, I would like the professionals to tell the Minister very briefly one thing that they would like changed in what we



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have been discussing today and in their respective areas.

**Michelle Morris:** I would like the Minister to embed, in terms of commissioning for all therapy services, but in speech and language in particular, a more holistic approach to delivery so we are taking into account all the early identification and how we support other people, including families. It is much better to manage children not just by doing direct treatments. Please do not misunderstand—direct treatment for those who have diagnosable disorders is essential, but there are other things as well.

**Chair:** Before I come to you, Jacqueline, Ian has a quick question.

Q468 **Ian Mearns:** Something that we have been dealing with, which is a concern to the whole Committee, is the question of youngsters being taken off school rolls. There has been some recent coverage of an Inspiration Trust school in Great Yarmouth that has somehow lost 160 pupils, many of them with special educational needs, in the space of less than a year. What can the Department do to make sure that that sort of mass off-rolling of pupils with significant problems, which does not do their educational prospects any good, is brought to a halt?

**Caroline Dinenge:** I am going to be honest with you, Ian—I am not sure. I think it is more of a question for the Education Minister when you speak to him. Certainly, I would not want there to be anything that we were not doing—that health services locally were not doing—that would enable that kid to be able to stay in school.

Q469 **Ian Mearns:** I would make the rejoinder, Minister, that if the children have special educational needs, they are in your bag.

**Caroline Dinenge:** Yes, but it is not us who are chucking them out of school.

Q470 **Chair:** We have 4,000-plus children with special educational needs who are excluded every school week from our schools, so it is clearly a big problem. I appreciate that it is predominantly Education, but it is also the Home Office and yourselves, particularly given your role with the Act. Jacqueline, what is your one ask of the Minister? It may be difficult for you because you are NHS England.

**Professor Dunkley-Bent:** It is not necessarily an ask but a supportive comment. We at NHS England are committed to continuing to support care provision that is wrapped around the holistic needs of the child. With the long-term plan and the workforce plan that Dido Harding is leading on, we are committed to ensuring that we focus our attention on areas of the greatest need. From the evidence that you have shared today, that will need a lot of work, because of the complexities of commissioning and other things. That is our commitment to ensuring that we get it right at a granular level from NHS England, regions and local authorities.

Q471 **Chair:** Steve, a brief wish?



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**Steve Inett:** Prevention—so more information, training, information about rights and independent advocacy for parents and families so they can manage the issues earlier and bring in the support they need earlier, so it does not get to crisis.

**Dr Crockford:** Make the DMO and DCO role a statutory role.

Q472 **Chair:** How many would you have in each area, ideally?

**Dr Crockford:** Sufficient to do the job.

Q473 **Chair:** What would that be? How many could cover a number of schools, for example?

**Dr Crockford:** In our local authority area, I work four sessions, and it is not quite enough. My DCO in Vale Royal has seven sessions for her post and her area is half as much.

Q474 **Chair:** In an ideal world, how many would be needed per 10 schools, for example?

**Dr Crockford:** I will have to give you those figures afterwards.

Q475 **Chair:** Okay. But you want it properly legislated so that there are enough.

**Dr Crockford:** It is more about the statutory element—equivalent to looked-after children.

**Dr Payne:** I would echo Michelle and Steve's comments about enabling therapists particularly to get into school early, working collaboratively with our partners in education to embed early intervention and prevention, to enable the best outcomes for children and young people.

**Chair:** Thank you. First, I thank the professionals. It has been very good of you to come and give us your evidence, which is really important to our inquiry. I thank the Minister and the director particularly, because you have been willing to take questions from the experts as well as from the MPs. It is really appreciated. I hope that you take on board some of the suggestions that have been made, and that when our report is published you will look at that seriously.

**Caroline Dineneage:** Thank you, Chairman. May I mention one final thing that I forgot to mention earlier? We are shortly launching a national call for evidence, because we are reviewing the autism strategy, which goes alongside the Autism Act—the only condition-specific piece of legislation on the statute book. This time it is including children and young people, so we would be very keen to hear thoughts and feedback on that from the Committee.

**Chair:** Thank you. We should be publishing our report sometime in early summer, hopefully. I think that will contribute.