Response to The House of Commons Education Committee report on Special Educational Needs and Disabilities 2019

British Association for Community Child Health (BACCH)*

We welcome the report of the Committee on SEND. The key findings resonate with our experience as paediatricians with responsibility for delivering SEND provision and we support the Committee's recommendations.

In particular, we welcome recommendations:

(Para 70) **to re-instate the statutory requirement to have a Designated Medical Officer for each Local Authority**.

BACCH advised that the DMO post should remain statutory at the time of the reforms but this advice was not heeded. We are somewhat concerned that the Committee were led to believe DMO posts was first established in 2014. This may refer to the role of Designated Clinical Officer (DCO), which was new. In fact, DMOs had long been a statutory requirement in previous Codes of Practice. We believe that having a statutory DMO gives the role more influence and therefore support the move to re-instate this.

There is also an inaccuracy in the evidence given that almost all areas now have DMOs. This perhaps should read DMO and/or DCO. The 2019 DFE statistics showed the following distribution:

2019 SEND statistics

Local authorities	152	
DCO only	66	43.4%
DMO only	24	15.8%
Both	55	36.2%
None	7	4.6%
Total with DMO	79	52.0%
Total with DCO	121	79.6%

We note with interest that 55/79 areas with a DMO also have a DCO (a non-medical health professional) alongside, whereas 66 areas have a DCO only. The DCO role was envisaged as a substitute for a DMO if one could not be appointed. We suspect that a model of DMO+DCO represents the actual need – particularly during the transition from Statements to EHCPs – and where a DMO has been present, they have succeeded in arguing for sufficient resources to meet demand. The assertion in evidence to the Committee that a good DMO is associated with fewer health challenges at Tribunal would seem to support that conclusion.

(Para 29) ***The joint CQC and Ofsted inspections should not continue to be one-offs but should become part of an annual inspection process to which all local authorities and their partners are subject. CQC and Ofsted should be funded to be able to deliver this rigorous inspection timetable. CQC and Ofsted should design and implement an***

inspection regime that not only improves practice but has a rigorous framework that enables local authorities and their partners to be held to account and sets a clear timeframe for re-inspections. Ofsted and CQC should also clearly set out the consequences for local authorities and health bodies that fail their annual inspection.

and (Para 50) ***As part of the Government's SEND review, it should map therapy provision across the country and identify cold spots. This should be a priority and the results of the mapping published as soon as it is completed. Separately and subsequently, the Government should set out a clear strategy to address the problem.***

and (Para 73) ***There is not sufficient emphasis on joint working within the Government. We recommend that the Department for Health and Social Care, NHS England, and the Department for Education should design an outcomes framework that local authorities and CCGs are held jointly responsible for, to measure the health-related delivery of support for children and young people with SEND. Ownership of these outcomes should belong jointly to CCGs and LAs, as well as the Department for Health and Social Care, NHS England and the Department for Education.***

We entirely support the push to join up outcome frameworks and quality assurance (QA) across Educations, Health and Social Care. As a body of paediatricians, we have long argued that the QA requirements, e.g. timescales to provide medical advice for EHCPs, should be included in NHS outcomes/targets. This also applies to timescales around Looked After Children and adoption. The lack of joined up thinking means that Local Authorities have no real leverage with local CCGs, as they are not monitored on such timescales as they are with hospital waiting times. This has led to underfunding and lack of capacity in community child health (CCH) services with long waiting times for assessment and the mismatch between health and education assessment times mentioned in your report.

We also agree with your findings on inspections. A recent analysis of inspections by regulators showed that information on CCH services was patchy and spread across various types of inspections. The CQC rarely if ever inspect CCH services in Trust inspections. SEND letters rarely mentioned community paediatric services or DMOs. While they often identified difficulties with accessing diagnostic services for ADHD and autism spectrum disorder (ASD), it was often impossible to identify which organisations or services were responsible for delays. As a result, quality assurance of community paediatric services is impossible using routine NHS inspections.

We support the views expressed in Dame Lenehan's evidence that the dismantling of Child Development Teams and Centres, who provided co-ordinated assessments and diagnosis, and the withdrawal of Portage schemes, which provided early intervention, has had a detrimental effect on early recognition, diagnosis and support for children with developmental disorders, and would urge the Government to review this as a matter of urgency.

We welcome the news of increased training places for Educational Psychologists and NHSE/I's review of therapist numbers. Lack of capacity in these professions have had a knock-on effect on community paediatricians, requiring them to take on work that could be done by others in addition to their own medical work e.g. a lack of speech and language

therapists with expertise in ASD requiring paediatricians to conduct detailed assessments of communication themselves and a lack of educational psychologists putting pressure on paediatricians to diagnose learning disabilities without the benefit of psychometric testing. Having to do this work takes their time away from their medical duties. We are therefore concerned that Para 50 refers only to therapy provision. Omitting community paediatricians (workforce shortages are outlined in several reports available here: https://www.rcpch.ac.uk/resources/covering-all-bases-community-child-health-workforce-2017), will continue to be a limiting factor to diagnosis and health provision if it not addressed alongside the other shortages. We have recently published our strategy to improve recruitment and retention, which may be of interest to the Committee: https://www.bacch.org.uk/policy/documents/BACCH_Workforce_strategy_for_community_paediatrics_2019_final.pdf

Dr Cliona Ni Bhrolchain

BACCH Workforce Officer

*The British Association for Community Child Health (BACCH) is the professional organisation representing the 1200 community paediatricians in the UK and is affiliated to the RCPCH. Our members work mostly in non-acute settings and are the main providers of paediatric medical services in childhood disability, safeguarding, adoption and looked after children, also contributing significantly in child mental health (especially autism and ADHD) and in child public health. Our members provide much of the statutory medical advice for special educational needs, Adoption and Fostering and Safeguarding including court reports.

Contact details:

Chair Dr Lisa Kaufmann

Workforce Officer Dr Cliona Ni Bhrolchain

British Association for Community Child Health

5-11 Theobalds Road, London, WC1X 8SH

T. 020 7092 6084/ F. 020 7092 6001

E. bacch@rcpch.ac.uk

W. www.bacch.org.uk