BACCH response to the Education Committee's inquiry on The impact of COVID-19 on education and children's services
(Submitted: 20/07/20)

1. We would like to submit some comments to the Select Committee on the persistent challenges facing community paediatricians in providing health advice to meet SEND expectations. **Many of our members are Designated Medical Officers and nearly all provide medical advice related to SEND**. We were interested to see comments from other groups to the enquiry recognising how shortfalls in health provision to support for children with SEND can impact on their support. We completely agree with their concerns. While we focus our comments on our own specialty of community paediatrics, the same applies to other health services like health visitors, school nurses and therapists. We would argue that alongside the Select Committee's understandable focus on Education, there needs to be a focus on the health aspects of SEND if the current situation is to improve.

2. Capacity shortfalls

2.1 The Covering All Bases report [1] highlights serious shortfalls in the capacity of community paediatricians to provide timely SEND advice. In response, the BACCH workforce strategy [2] puts forward ideas to improve capacity in community paediatrics. Waiting lists more than twice the standard of 18 weeks, and a failure to meet statutory timescales for statutory advice and reports, are still far too common. Unfortunately, Covid 19 is likely to worsen these difficulties, because of the requirements for social distancing and enhanced hygiene, and staff absence due to illness and self-isolation. Some assessments also are very difficult to provide using PPE.

2.2 As indicated by other informants, re-deployment to support acute services has been an issue during the current crisis: at its peak nearly half of all community paediatric trainees and 15% of trained staff (consultants and SAS doctors) were re-deployed away from their community posts into acute hospitals [3]. We are pleased to see that the NHSE has responded to our concerns and modified its guidance so that re-deployment should now occur only 'if required' rather than 'where possible'.

2.3 It is inevitable that there will be a backlog of work which will present in the months ahead as schools reopen (as many of our referrals are initiated by schools and nurseries). If this is not anticipated and mitigated, it will cause even further delays in providing medical advice. **We would recommend that health services focus on the need to build capacity into the system now to deal with the backlog and to consider how community services can be protected from redeployment in order to meet this need. This is likely to need investment in capacity, training and skills.**

3. Child mental health and safeguarding

3.1 We are aware of the stresses Covid 19 has caused to children and young people (CYP), parents and families. During the pandemic restrictions, community paediatricians adapted their ways of working to include telephone and video consultations so that they could remain in touch with families who need their support during this time. We would like to point out that community paediatricians provide a lot of emotional and behavioural support for CYP with disabilities and neurodevelopmental difficulties, thus avoiding referrals to other stretched services like Child and Adolescent Mental Health Services (CAMHS). We see many calls for increased CAMHS capacity to deal with the mental ill-health Covid 19 may have caused. However, if CAMHS capacity were to increase, without a corresponding increase in community paediatric capacity, it is likely that cases who would usually get support from community paediatrics will simply be referred to CAMHS instead, thus using up any increased CAMHS capacity. We saw the reverse some years ago when CAMHS resources were reduced, flooding community paediatrics with new referrals previous sent to CAMHS. **We recommend that community paediatrics and CAMHS need to be looked at together to deliver real improvement.**

3.2 We entirely agree with the comments already made in oral evidence about the risks to children who are not attending school. RCPCH figures show that many services saw a decrease in statutory work including safeguarding referrals during the pandemic period [3]. This is a pattern we also see during school holidays. Unfortunately a report has already been published from one

institution showing a significant increase in serious child abuse (severe head injury) [4]. This pattern would be entirely consistent with reduced recognition of less serious abuse (either because CYP are not being seen or because services are so stretched they are unable to respond) leading to more serious abuse presenting late. These issues, and the tendency to re-deploy community staff to acute settings, need to be reconsidered in any resurgence to avoid further harm.

4. Consequences of fragmentation of effort

4.1 One of the key challenges we face is the fragmentation of effort and, as highlighted in some of the oral evidence, that joint commissioning is not happening as envisaged. Indeed this is reflected in the focus of the committee's own enquiry. We assume detailed investigation of health aspects are beyond the committee's remit. **We recommend that future enquiries should consider working jointly with the Health Select Committee to provide a joined up approach.** This fragmentation occurs not only at government level but also within local government and the NHS. **We agree that better cooperation/joint commissioning will be needed to improve quality in SEND assessments and provision**.

4.2 It is also reflected in the performance management and inspection. Thus, timescales and targets in education and social care legislation is often not reflected in NHS performance measures, making it very difficult for low profile services such as ours to gain management attention. For example, although there is a 42 day expectation for medical advice to be submitted for EHCP, this standard appears nowhere in NHS quality assurance frameworks, nor does any measure of satisfaction with the quality of the advice provided. A recent analysis of inspections (C Ni Bhrolchain, submitted for publication) shows that inspection of community paediatric services is patchy and inconsistent, making it very difficult for services to benchmark themselves against their peers. It is therefore not surprising that health services are unable to meet their requirements. **We recommend that community paediatrics is specifically included in all the relevant health and joint inspection frameworks (Trust inspections, SEND inspections, Joint Targeted Area inspections and Children Looked After and Safeguarding inspections) to ensure quality.**

References

1. Royal College of Paediatrics and Child Health. Covering All Bases. Community Child Health: a paediatric workforce guide. RCPCH 2017. Available from: https://www.rcpch.ac.uk/sites/default/files/2018-03/covering_all_bases_community_child_health_-_a_paediatric_workforce_guide.pdf (Accessed 20.2.20)
2. British Association for Community Child Health. A workforce strategy for community paediatrics. BACCH 2019. Available from: https://www.bacch.org.uk/resources/43-bacch-workforce-strategy (Accessed 13.7.20)
3. Royal College of Paediatrics and Child Health. Impact of COVID 19 on child health services tool. Available at https://www.rcpch.ac.uk/resources/impact-covid-19-child-health-services-tool-results
4. Sidpra J, Abomeli D, Hameed B, et al. Rise in the incidence of abusive head trauma during the COVID-19 pandemic. Archives of Disease in Childhood Published Online First: 02 July 2020. doi: 10.1136/archdischild-2020-319872