Cynulliad Cenedlaethol Cymru | National Assembly for Wales
Y Pwyllgor Plant, Pobl Ifanc ac Addysg | Children, Young People and Education Committee
Bil Anghenion Dysgu Ychwanegol a'r Tribiwnlys Addysg (Cymru)| Additional Learning Needs and Education Tribunal (Wales) Bill

ALN 15

Ymateb gan: Bwrdd Iechyd Prifysgol Aneurin Bevan
Response from: Aneurin Bevan University Health Board

1. **The general principles of the Additional Learning Needs and Education Tribunal (Wales) Bill and whether there is a need for legislation to deliver the Bill's stated policy objectives;**

A jointly developed integrated, mUlti-agency single plan is to be welcomed, particularly one that reinforces the child and family voice in its production. Whilst there was nothing in the existing legislation that prevented that, it is clear that interpretation and practice has did not facilitated this on many occasions. Strengthening the voice of the child and requiring a graduated, needs based response to additional learning needs is welcome. Changing the labels used may help reduce stigma and any discrimination in the short term, but history tells us to new labels can become new terms of abuse unless underlying culture changes are also supported and enabled. Stronger reference to the UN Convention on the Rights of the Child would therefore be welcomed.

2. **Any potential barriers to the implementation of the key provisions and whether the Bill takes account of them;**

The biggest challenge to implementation will be the need to change the prevailing culture and levels of trust parents, in particular, have in the system. Feedback from parents within the system indicate that, without the "Golden ticket" of a statement and or diagnosis, support will not be secured. A parallel development of trust is also required between LEA inclusion services, schools and classroom teachers. The associated changes required by the Donaldson Report in terms of curriculum and training of staff are vital to deliver the changes required and enable children, parents, carers and staff to have faith in the new system.

Two further obstacles remain, particularly for Health Boards:

a) Consistency of interpretation, definitions and expectations across different LEAs. The Code of Practice needs to be robust in developing agreed definitions for "health" needs as is the case in Part 2 of the Act for additional learning needs. Our experience is that there is a difference of understanding of what may be considered "health" issues in other agencies such as education, which can result in an over estimation of what therapy is able to do and, more importantly, develops an over expectation from teachers, families and children on the importance of a "diagnosis" or the availability of a "treatment" to the whole process, provision of care and eventual outcome.

b) It is suggested that, when a health referral is being considered at a planning meeting, health professionals should be present, consulted with and support the referral. This will potentially reduce the likelihood of problems and disagreement.

c) Further consideration needs to be given to the availability of resources in terms of finance and individuals with the necessary competencies to fulfil the role of the Designated Education Clinical Lead officer. There is a national shortage of most child health professions and the burden of work through safeguarding and child care legal work is growing. Working through the role in the pilot areas and preferably working in LEA clusters that match Health Board footprints would help with this position. The prinCiples behind the role are excellent and we would support its development and the move to a role focusing on coordination, liaison and troubleshooting. Clinicians already involved with children or young people can then contribute specific clinical advice. There is however a training requirement across health staff now providing treatment to enable them to provide informed advice into the new system, which will require resource and the decrease of some clinical availability of frontl ine services in the short term to support the training.

3. **Whether there are any unintended consequences arising from the Bill;**

The main unintended consequence is that there may be confusion as to which single unified plan is applicable, given the requirements of Social Care legislation and Mental Health Measure legislation to provide a plan. Some clarity as well as unification of templates may be helpful for families and young people.

4. **The financial implications of the Bill (as set out in Part 2 of the Explanatory Memorandum, and the appropriateness of the powers in the Bill for Welsh Ministers to make subordinate legislation (as set out in Chapter 5 of Part 1 of the Explanatory Memorandum.**

It is suggested that the financial impact of the additional 16-25 year old work is underestimated and the back fill and recruitment costs of the backfill for the DECLO role is underestimated. Given trends that indicate needs are escalating it is doubtful whether true savings to the public purse will be made in the short term, but rather a minimisation of escalation or a control and stabilisation of costs will be achieved in the first instance.

5. **Whether the Welsh Government's three overarching objectives (listed at para 3.3 of the Explanatory Memorandum) are the right objectives and if the Bill is sufficient to meet these;**

The aims are correct but, as indicated in answer 2, a need for the work in curriculum change and training of staff must occur in parallel.

6. **Whether the Welsh Government's ten core aims for the Bill (listed at paras 3.5-3.16 of the Explanatory Memorandum) are the right aims to have and if the Bill is sufficient to achieve these;**

The 10 core aims are the correct aims but there needs to be consideration as to the overlap with other legislation that similarly seeks to develop integrated, person centred, multiagency plans. Consideration in the code of practice needs to be given for potential dispute resolution with NHS providers given concerns identified in reply 2(a) as this can arise as an issue

in the current system when families and education departments are at an impasse.

7. **The provisions for collaboration and mUlti-agency working, and to what extent these are adequate;**

The current provisions are proportionate for legislation at this time. The codeof practice and the development of an effective DECLO role should ensure that inter department and interagency relationships move away from relying on statutory requirements to deliver. Ensuring that all organisations have performance measures that ensure the aspired outcomes for the child and young person, described in the Bill, are achieved would facilitate this. In a time of austerity and stretched resource, stronger legislation on health runs the risk of health resource being allocated on the basis of legal requirement rather than clinical need as is the underlying principle at present.

8. **Whether there is enough clarity about the process for developing and maintaining Individual Development Plans (lOPs) and whose responsibility this will be;**

The Health Board considers that it provides enough clarity with regard to process and responsibilities.

9. **Whether the Bill will establish a genuinely age 0-25 system;**

The Bill alone cannot deliver a genuinely 0-25 system, as many services in health and social care will continue to operate with a predominantly 16-18 transition. It is important that strong consideration is given to transition at 25 as simply moving the age does not resolve the problem. The current legislative rights and responsibilities for children in the UK at present require transition ages of anything between 14 and 25 and, whilst 25 is likely to be easier, it will not suit 100% of people 100% of the time. Flexibility is key around the strengths, needs and wishes of the young person.

In addition there are a number of practical obstacles to address. The current adult health system has few generalists to provide the necessary overview of need required in the process. The development of professionals to work

across this age range is particularly challenging. From a developmental level, the skills necessary to work with this age group are different to younger children, not least the understanding of some of the legal requirements of consent etc.

10 . The capacity of the workforce to deliver the new arrangements;

Also, please see responses to Questions 2 and 9.

There is concern around the numbers of available staff to fulfil the role of DECLO. There is also a significant training requirement for all public sector staff to increase awareness of and participation in the ALN procedures effectively. In the short term this will have an impact on service delivery, however mitigated.

11. The proposed new arrangements for dispute resolution and avoidance.

As indicated above, consideration of resolution over NHS provision needs to be considered as it already is a point of difference and the new system has the potential to exacerbate this. Clear, mutually understood expectations of the system need to be established between all participants and agencies. Agreement as to who needs to be present to agree plans impacting on other agencies needs to be agreed.
I hope the above information is helpful to you. If you require any additional information, please do not hesitate to contact me.