INSTITUTE FOR GOVERNMENT

Joining up SEND

How government can make special educational needs and disabilities services more cohesive

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About this report

The Commons Education Committee has said the special educational needs and disabilities (SEND) system is "broken". This report sets out how to begin fixing it – by making the system more joined-up and with stronger partnership working. It is based on extensive Institute for Government research into public service reform and more than 50 interviews with parents and families, practitioners working in the SEND system and third sector, policy experts and civil servants, as well as a roundtable held at the Institute in May 2026.

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Summary

In the words of the House of Commons Education Committee, the special educational needs and disabilities (SEND) system is "broken".[1] It is hard to disagree. The system was not designed to cope with anything like today's levels of demand. Spending is unsustainably high – and growing. Outcomes are deteriorating, confidence in the system collapsing.

Since Labour came to power in 2024, fixing the SEND system has come to be seen as an important test of its ability to deliver public service reform. It is also a growing source of political pressure from backbench MPs and campaigners, compounded by the fiscal risks of continued inaction.

Currently, children and families face a dysfunctional, and sometimes adversarial, system where the services delivering the SEND offer – including schools, councils and GPs – often act in isolation. This drives up costs to the public purse and can lead to children missing out on the support they need. One of the core challenges of SEND reform, then, is to deliver a system that *appears* like one cohesive offer when in reality it depends on interactions with these distinct organisations. Here, collaboration across public services will be key.

Successive governments have long recognised the importance of partnership working in SEND, though they have long failed to achieve it. Strengthening collaboration was a central aim of the coalition government's SEND reforms in 2014, but if anything, the system has since become more adversarial. The problem is, and has long been, design: central government set rules, incentives and responsibilities that made it easier for services to work against, rather than with, each other. As one interviewee for this paper put it:

> **"The system is set up in such a way that if everyone behaves rationally, from their own point of view, it puts them in conflict with each other".**[2]

This government risks repeating some of these same design flaws under its proposed reforms.* To its credit, it has set out a vision for SEND centred on early intervention and inclusion that could help align different parts of the system, and has begun exploring ways to make it easier for services to pool resources around shared priorities.

But to stop services slipping back into bad practice, central government must go further and recognise itself as a critical partner in the SEND system – and take responsibility for the conditions it creates.

* These reforms are not final. The government opened a consultation on the proposals, which closed in May 2026, and has not yet set out its response.

That starts with setting clear objectives that bind services together, and ensuring the resources exist to deliver them. It means co-ordinating reform across Whitehall, being realistic about what the health system can deliver, and funding services in ways that reward collaboration rather than 'cost-shunting'. It should involve standardising processes where there is little benefit in asking every area to design its own.

This report sets out how to do that. It is based on extensive Institute for Government research into public service reform and more than 50 interviews with parents and families, practitioners working in the SEND system and third sector, policy experts and civil servants, as well as a roundtable held at the Institute in May 2026.

It is formed in two parts: Part 1 looks at the fragmented SEND system as it is now, and the negative outcomes it perpetuates for children, families and the public finances; Part 2 sets out our detailed recommendations for how the system can be strengthened by more joined-up, stronger partnership working, which are summarised below.

Recommendations in brief

1. DfE must make essential policy decisions about its vision for SEND reform, including guidance on 'prevention', before implementation is fully under way

2. DfE, MHCLG and DHSC should build a clearer national picture of spending and workforce capacity across SEND and children's services to guide decisions about reform

3. A minister in the centre of government must integrate SEND reform with the government's wider priorities for public service reform

4. DfE must establish a cross-government working group, commissioned by No.10 and bringing together DfE, DHSC and MHCLG, to oversee the implementation of SEND reform, resolve conflicts between departments and address problems raised by those delivering and using the system

5. A minister in the centre of government should ensure DHSC clearly explains how SEND reform fits alongside other health priorities

6. DHSC must work with NHS England to make sure workforce cuts in Integrated Care Boards (ICBs) do not leave SEND services without the required staff and capacity

7. The government should develop funding models that make joint working on SEND easier

8. The cross-government working group on SEND must create shared national systems and processes for SEND

Box 1 **What are special educational needs and what support is currently available?**

A child is considered to have special educational needs and disabilities (SEND) if they have a learning difficulty or disability that requires extra or different educational provision from what is typically available.[3]

SEND provision is currently organised into three tiers:

- At the base is **ordinarily available provision** – everyday adjustments that education settings are expected to make for all pupils through standard teaching practice.
- Where this does not meet a child's needs, non-statutory **SEN Support*** offers more targeted interventions, sometimes drawing on external specialists such as speech and language therapists and educational psychologists.
- The highest tier is an **education, health and care plan (EHCP)**, a legal document setting out a personalised package of support for children and young people aged up to 25.

* Throughout this report, 'SEN Support' is capitalised when referring to this tier of SEND provision, to more clearly distinguish it from 'SEND support', which is used more broadly to refer to all forms of support for children with SEND.

1. Why SEND services need to be better joined up

The SEND system in England is under incredible strain. Spending is unsustainably high – and growing – while outcomes are deteriorating and confidence in the system has collapsed.[1] As the government itself acknowledges, "it is clear that for too many children and for too many families our system is failing".[2]

Weak co-ordination between various arms of the state – in particular local government, education settings and health partners[*] – is a well-established driver of these pressures.[3] While there are examples across England of good collaboration, interactions between services are often dysfunctional and even, as the House of Commons Education Committee has put it, "adversarial".[4] Weaknesses in partnership working and strategic governance were identified in over half of Ofsted inspections of SEND services in the two years to 2025 – and in as many as 86% of those that received the outcome 'widespread and/or systemic failings'.[5]

Some multi-academy trusts allegedly train their schools to resist local authority requests,[6] local authorities and health services can become locked in disputes over who should fund essential equipment for children with SEND,[7] and many schools can only access health professionals, particularly educational psychologists, once an EHCP assessment is under way, limiting opportunities for early support.[8] This leaves many families feeling that the education, health and care systems are "completely separate".[9]

These fractious relationships also exist within services. One local authority interviewee noted that often "schools don't even trust each other", with some calling on councils to "expose the non-inclusive schools in the borough".[10] We also heard of tensions within local authorities, between SEND teams (focused on provision) and finance teams (focused on spending and deficits).[11] And children's health services were described by two interviewees as "Cinderella services": frequently sidelined and overlooked within ICBs in favour of acute adult care and hospital discharge targets.[12]

It is no surprise, then, that one of the government's five principles for SEND reform is to strengthen partnership working across local government and education, health and care services.[13]

The stakes are high. If it fails in this aim, it will struggle to improve outcomes for children and families, or to make the system more financially sustainable – the two core reasons for reform. As one senior civil servant put it, at a roundtable hosted by the Institute for Government:

> **"[The government's] reforms live and die by its ability to galvanise people to work together in partnership".**[14]

[*] This report focuses primarily on local government, and education and health services as partners in SEND reform. While children, young people and parents are essential stakeholders, the report examines partnership working through the lens of incentives and structures set by central government, and therefore focuses on the main government bodies responsible for delivering these services.

Box 2 **Delivery of SEND services**

Many organisations have roles and responsibilities in delivering SEND services. Key points include:[15]

- **Identifying SEND.** Local authorities must try to identify all children with SEND in their area. This typically happens in education or health settings.

- **Delivering lower tiers of SEND provision.** Education settings are responsible for delivering lower tiers of SEND provision. Health professionals such as educational psychologists often play a crucial role in supporting schools here.

- **Requesting an EHCP.** Parents and education providers have the right to request an EHCP from the local authority, which must then decide whether to issue a plan in consultation with the parents and child. (While entitlement to an EHCP is not legally determined by a medical diagnosis, in practice access is often dependent on one.)[16]

- **Delivery of an EHCP.** If a plan is issued, the local authority must co-ordinate its delivery and periodic review across education, health and care. To do this:

    - Health partners must provide an assessment for inclusion in the plan.

    - Local authorities must arrange a place in a suitable setting: education providers are only required to admit a child if they are explicitly named in the EHCP, which they must have been consulted on.

    - Education, health and care partners must deliver the support specified in the plan.

- **Appeals.** Parents can appeal individual decisions made by local authorities about EHCPs, including their contents and whether they are issued at all, to a tribunal. Its rulings on education provision are legally binding; its rulings on health and social care are not.

- **Engagement with parent carer forums.** PCFs are representative local groups of parents and carers of children and young people with disabilities. Local authorities are encouraged to involve them, alongside children and young people, in the design or commissioning of SEND services.[17]

A fragmented system

Poor cross-agency working harms outcomes across many public services,[18] but it is particularly damaging in SEND, where delivery is so dispersed across different bodies (see Box 2). As one attendee at our roundtable put it:

> **"There is no real such thing as the SEND system – it is a myriad of systems that overlap."**[19]

To some extent, this fragmentation is not a bug but a feature of a system designed to meet complex needs: while education settings are the main delivery point for SEND services, they often rely on input from health and social care professionals because a child's needs may cut across all of these domains.

Poor outcomes

While there is no consistent cross-system understanding of what 'good' looks like in SEND – either within the current system or a reformed one (discussed further below) – this government has signalled its ambition to move towards a more inclusive and preventative system. In essence this would prioritise children being supported in mainstream settings wherever possible, with their needs identified early and addressed promptly.

Delivering this vision will depend on strong partnership working that can secure the confidence of families. Research from the Centre for Education Systems examined 14 SEND systems across the world and found that strong partnership working between schools, health and social care is widely seen as helping children with SEND "access support earlier and experience more positive, inclusive trajectories".[20]

Conversely, where there is poor collaboration, there is a risk children's learning is further disrupted, even up to temporarily blocking their access to education. One local authority interviewee described a child who could not attend school while the council and health services argued over who should fund the specialist seat they required.[21] Other interviewees talked about schools simply removing children from the school roll when they felt the local authority or health partner was not providing the necessary support.[22]

The education secretary, Bridget Phillipson, and the former health secretary, Wes Streeting, have also indicated that a key aim of SEND reform is to ensure children and young people make "successful transitions into adult life".[23] Again, strong partnership working is critical to achieving this. In the current system, some young people remain in inappropriate education settings until age 25 simply because suitable adult social care is not available.[24]

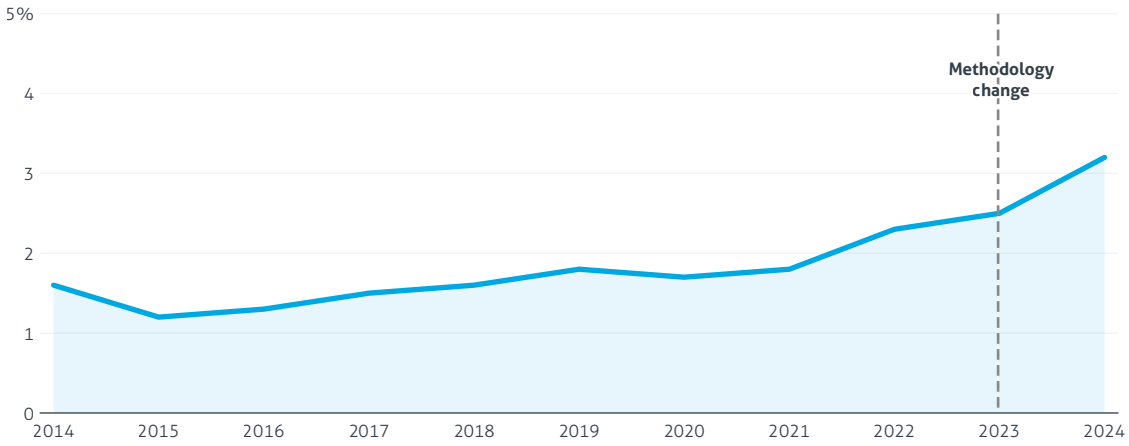
Others face abrupt and uncoordinated transitions because age thresholds for adult health services vary across England and often do not align with transition points for education or social care. One interviewee highlighted a case where parents, despite being responsible under a care plan for administering their child's medication, stopped being informed of dosage changes once the young person turned 16.[25]

Strained parent–services relations

Better collaboration in SEND provision is also typically associated with more positive stakeholder views of the system.[26] As the above example suggests, poor co-ordination in England's SEND system is painfully clear to families who are often burdened with the time consuming and stressful job of "chasing missing input".[27] In 2023, the DfE recognised that parents' interactions with the system were "increasingly adversarial"[28] as they were forced to fight, sometimes at personal expense, to try to get the system to work for them.[29] This also creates inequalities in access to support, as better-off families are more likely to have the time and resource to navigate (and challenge) the system.[30]

This change in relationship is reflected most clearly in the rate of appeals families have made to the SEND tribunal, doubling from 1.6% of all appealable decisions in 2014 (or 4,108 appeals) when EHCPs had just been introduced, to 3.2% (or 22,300 appeals) in 2024.[*,31]

Figure 1 **Education, health and care plan decisions resulting in SEND tribunal appeals, 2014–24**



Source: Institute for Government analysis of DfE, 'Education, health and care plans', 2025. Notes: The denominator is the total appealable decisions in any year, as calculated by DfE; the numerator is the number of appeals registered. Caution should be taken when comparing figures from 2023 onwards to those from previous years due to transition to new data collection in 2022. Analysis covers England only.

Interviewees described the "horrible conflictual cultures"[32] that can develop. Two alleged that some local authorities have taken appeals to the latest stage without intending to defend themselves as a way to postpone having to pay for support – though to the detriment of the child.[33]

It also takes a toll on those working in the system, who are often put in invidious positions. One interviewee described local authority staff who have received death threats from frustrated parents.[34]

[*] DfE notes that caution should be taken when comparing figures from 2023 onwards to those from previous years due to transition to new data collection in 2022. The figure for 2022 (2.3%) is still higher than that in 2014, and rates had consistently increased between 2015 and 2022, with the exception of a slight decrease between 2019 and 2020, which was likely the result of the pandemic.

Poor use of specialist expertise

And in many instances, poor public service co-ordination means staff are not being used efficiently. Specialists – particularly educational psychologists and speech and language therapists – are diverted away from the direct therapeutic work that often motivates them and into the bureaucracy of undertaking needs assessments and writing reports.[35] As the Education Committee writes: "This has to change, for the benefit of professionals who are becoming harder to retain, and in order to deliver a genuinely inclusive system."[36]

It also affects staff in schools: in a 2025 survey, over two thirds of teachers reported that limited access to external support such as mental health services and educational psychologists was a "significant barrier" to making their setting more inclusive (68%).[37] In some cases, this gap in support results in teaching assistants or teachers carrying out medical procedures, such as changing children's breathing tubes.[38] Medical associations and front-line staff have expressed concern that this leaves everyone vulnerable if mistakes are made.[39]

Unsustainable finances

Box 3 **SEND's fragmented funding landscape**

Funding for SEND provision is spread across several systems. In 2024, the National Audit Office concluded that "it is not possible to identify all government funding for children, from birth to 25 years, with [SEND]".[40]

The DfE provides local authorities with the Dedicated Schools Grant (DSG) to fund, among other things, support for children with SEND. This is ring-fenced and includes both mainstream and high-needs funding components. While local authorities ultimately carry financial liability for overspends, most is distributed to schools.

Education settings have considerable discretion over how they spend mainstream funding, which forms the core budget for day-to-day provision. While schools are expected to meet most lower-level SEND needs from this funding, including the first £6,000 of SEND costs per pupil each year, there is no national data on how much of it is spent on SEND.

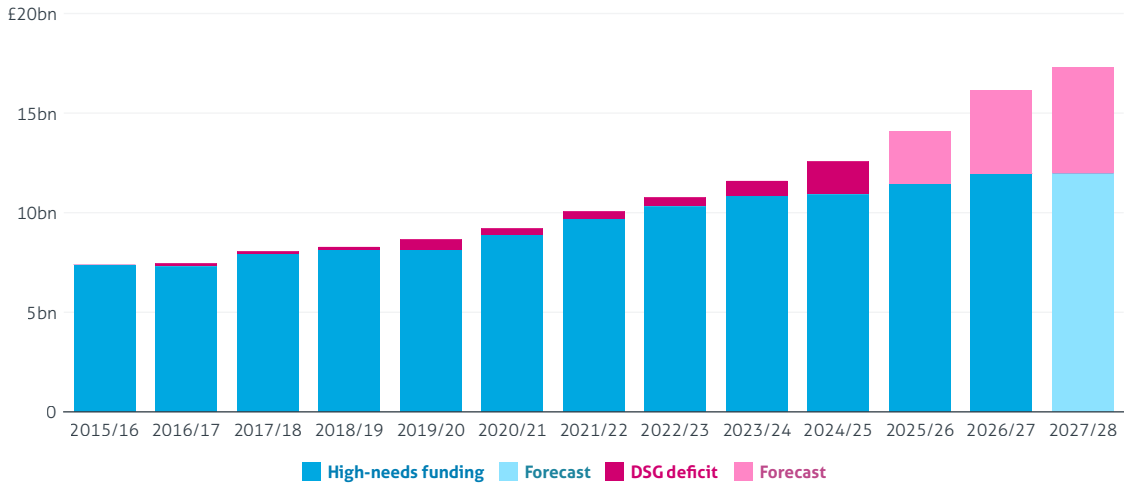
High-needs funding is more directly controlled by local authorities. It typically finances specialist places in education settings, 'top-ups' for individual pupils when SEND costs exceed the £6,000 threshold,* and high-needs services delivered by the local authority.[41]

Local authorities also draw on other funding (council tax and grants from central government) to provide services like home-to-school transport, or to deliver social care services and administer EHCPs. Meanwhile, most local health services in England are commissioned by Integrated Care Boards (ICBs) using NHS funding.

* For special education, that threshold is £10,000.

There is no single, national figure for how much is spent on SEND in England (see Box 3), though it is clearly putting pressure on local authority finances. Indeed, while the high-needs component of the DSG has increased by three fifths in real terms since 2026/17, spending on SEND services grew even faster, driven by rapid increases in the number of EHCPs and greater use of specialist settings.*,42 As a result, the DSG has been overspent in every year of that period – that is, for nearly a decade – with local authorities covering the shortfall and further straining their finances in the process.**,43 The Office for Budget Responsibility now identifies SEND as a major pressure on government spending.44

Figure 2 **Selected local authority spending on special educational needs and disabilities, actual and forecast, 2015/16 to 2027/28 (2026/27 prices)**



Source: Institute for Government analysis of OBR, 'Economic and fiscal outlook – November 2025' and OBR, 'Economic and fiscal outlook – March 2026'. Notes: Selected local authority spending on SEND is defined as the high-needs block part of the Dedicated Schools Grant plus the in-year deficit on the dedicated schools grant – local authorities spend more than this on SEND, including through social care budgets.

The government recognises the role poorly joined-up services plays in this picture. As the Ministry of Housing, Communities and Local Government (MHCLG) noted in its provisional finance settlement for 2026/27:

> **"The financial sustainability of the [SEND] system will depend on local authorities, along with system partners such as education, health and care services, managing it effectively."**45

This is in part because local authorities carry the financial liability for overspends on the DSG, but many of the key decisions that drive that spending are made elsewhere (See Boxes 2 and 3).46 Indeed, local authorities often only become involved if a child has acute needs, and even then they do not have direct control over how EHCPs are delivered. Managing the DSG therefore depends on co-ordination across multiple bodies.

* Especially independent special schools, which cost more than mainstream provision. Spending on SEND administration and transport also increased significantly over this period, but most of these costs are funded outside of the DSG so they represent an additional source of pressure on local authority finances beyond the deficits we set out here (see Box 3).

** Using estimates from the Office for Budget Responsibility – figures differ if other data sources are used.

Duplication, of resources and effort, is another element.[47] We heard several stories of local authorities and health services independently commissioning close-to-identical services – such as SEND family support or support for cohorts not in education, employment or training (NEETs), leading to 'double-funded' providers and inefficient use of limited local pots.[48]

And where join-up between services does occur, it is primarily through EHCPs at the level of the individual child rather than system-wide co-ordination. This limits opportunities to pool provision across groups of children with similar needs and benefit from economies of scale.[49] As we have already seen, the same lack of co-ordination also limits the scope for early intervention. Without this, the risk is that needs escalate and require far more expensive crisis interventions and specialist placements.[50]

Finally, conflict itself carries a cost to the public purse. A study from the National Foundation for Educational Research found many examples of multi-academy trusts expending resource on 'fighting' with local authorities.[51] Two of our interviewees highlighted how schools sometimes do not trust assessments and strategies put in place for children within early years settings, redoing the assessments once a child joins them.[52] And Pro Bono Economics estimated that, in 2021/22, the public sector spent £62 million in cash terms on SEND tribunals (equivalent to 0.8%* of high-needs funding that year).[53] High tribunal success rates may also be encouraging greater risk-aversion among local authorities, contributing to the growth in the number of statutory plans and specialist placements.[54]

Services struggling to work together has been a thorn in the side of past reforms – and could be again

The government has long recognised the importance of strong partnership working in the SEND system. Indeed, a core aim of the SEND reforms in 2014 – the last major overhaul of the system – was "to establish a more joined-up, whole system approach across education, health and care on SEND".[55] This ambition is reflected in the very name 'education, health and care plans', and in the current SEND code of practice, which dedicates an entire chapter to collaboration between education, health and care services.[56]

Yet, as this report has shown, this has not come to pass. This failure is a key reason why further reform is now needed, and getting it right this time will be one of the most challenging tasks on the public service reform agenda.

* This calculation is purely illustrative – it is not clear how much of this spending was drawn from high-needs funding. Pro Bono Economics estimates that 23% (£14m) of the £62m is spent by HM Courts and Tribunals Services, and therefore does not come from high-needs budgets. The remaining spend, largely staff costs, is drawn from local authority budgets, but not necessarily from high-needs allocations.

Why attempts to strengthen partnership working failed in 2014

Attempts to strengthen partnership working failed in 2014 largely because of the rules that central government set for different actors in the SEND system, through funding, accountability, legal and operational frameworks. As one interviewee put it:

> **"The system is set up in such a way that if everyone behaves rationally, from their own point of view, it puts them in conflict with each other."**[57]

These tensions have been exacerbated by funding and capacity shortages, limiting organisations' ability and headspace to work beyond their own immediate pressures.

This challenge is not unique to England. International evidence shows that many countries have struggled to build genuinely joined-up SEND systems because services are organised separately, funded separately and held accountable in different ways.[58] Successful reform will therefore require changes to the structures and incentives that shape how services work together.

Central government did not set a clear definition of success

One of the most striking gaps in the SEND system is the absence of a definition of success. A few interviewees contrasted this with children's social care, where a national framework clearly sets out the purpose, principles for practice and expected outcomes.*[,59] In SEND, however, "there is not one phrase or one paragraph that sums up what 'good' is".[60]

This makes collaboration much harder. Work on cross-organisational leadership suggests that shared objectives are one of the most important success factors in any partnership.[61] Without them, organisations struggle to manage trade-offs between competing priorities and – as the National Audit Office (NAO) has noted – often default to their own objectives, which can actively undermine outcomes for users of the service.[62] This is evident, for example, in the off-rolling or exclusion of children with SEND when schools are under pressure to meet attainment targets.[63]

Central government did not align priorities, powers or accountability frameworks with the responsibilities it handed out

Another NAO report said in 2024 that "misaligned incentives, accountabilities and priorities across [the SEND system] create challenges in building effective working and a whole-system approach".[64]

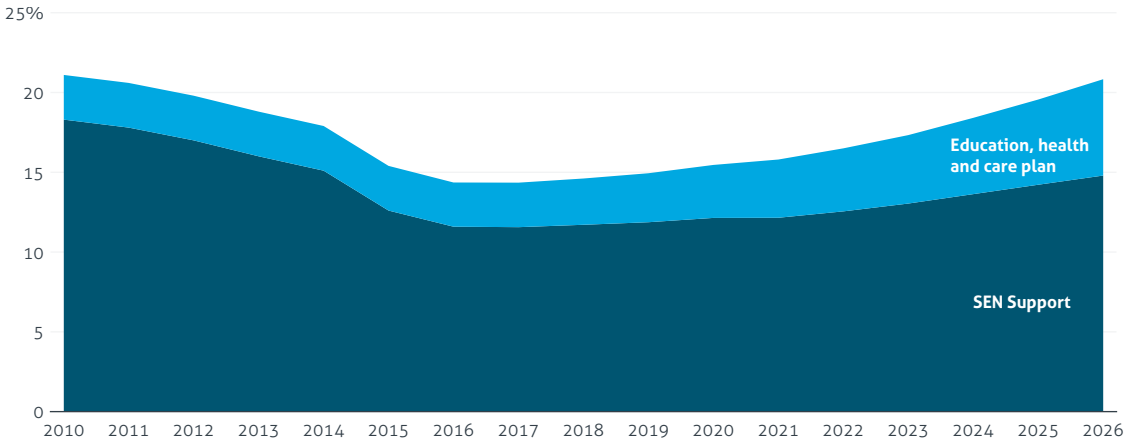
These misalignments include SEND being a clear departmental focus for DfE, but featuring far less prominently in the NHS's priorities.[65] They also extend to the local level, where health services and councils share responsibility for supporting children with SEND, but they do not share accountability. While local authorities

* This is not to say that children's social care is without its own problems (see, for example, 'Performance Tracker 2025: Children's social care' and 'Fixing the children's social care market'). A definition of success is not, by itself, sufficient to ensure good partnership working, but it is a precursor.

are legally bound by SEND tribunal rulings, health and social care services are not,* and local authorities have limited powers to hold health services to account or drive improvements.

There are also tensions within the education system itself. While underlying need likely plays a role,[66] patterns over the last 15 years in the proportion of children receiving support for SEND point to the powerful influence of wider incentives facing schools and local authorities.

Figure 3 **Pupils receiving support for special educational needs and disabilities, by type, 2010–26**



Source: Institute for Government analysis of DfE, 'Special educational needs in England', 2009/10–2025/26. Notes: 'SEN Support' includes its predecessor, School Action/School Action Plus and 'Education, health and care plan' includes its predecessor, SEN statements. Figures include pupils in state-funded nursery, primary, secondary and special schools, non-maintained special schools, pupil referral units and independent schools, in England. Data is as of January each year.

As the figure above shows, the proportion of pupils receiving any level of formal SEND support fell from 21.1% in 2010, plateauing between 2015 and 2020 at 14–15%, before rising again – driven mostly by an uptick in EHCPs – to reach 20.8% in 2026. Meanwhile, we have seen the following changes to incentives in education:

- After 2010, the government's headline school performance measures no longer took into account contextual factors such as having a large number of pupils with SEND,[67] which has been seen as penalising more inclusive schools.[68]

- Since 2014, mainstream schools have been required to fund the first £6,000 of additional support for each pupil with SEND from their own budgets, creating a financial disincentive to have these pupils on roll. For pupils whose support costs exceed £6,000, schools have an incentive to secure an EHCP rather than rely on SEN Support, as, in practice, only EHCPs attract additional funding beyond this threshold,[69] while SEN Support costs must continue to be met in full by schools.

- The £6,000 threshold has never been uprated with inflation, so every year more children's support costs exceed it, further incentivising schools to secure EHCPs.[70]

* Local authorities are legally bound by SEND tribunal rulings on education provision. SEND tribunal rulings in relation to health or social care provision are not legally binding on any organisation.

Together these changes have reshaped behaviour in ways that put schools and local authorities at odds. Funding arrangements can incentivise schools to seek more intensive, individualised support than may be necessary, which sometimes conflicts with local authorities' responsibilities to ensure value for money and secure suitable placements for children with SEND.*

For one interviewee, these tensions reflect

> **"the dereliction of duty the DfE has demonstrated towards its role as a 'system steward' across education and SEND, recognising and adjusting parameters in mutually reinforcing ways – instead [it] pursued mutually incompatible objectives that turned the system against itself".**[71]

Central government did not align systems and processes across delivery partners

Several key systems and processes are different across education, health and local government, meaning that co-ordination often depends on local workarounds rather than built-in integration. Some principal differences include:

- **Commissioning models.** The NHS typically uses large, longer-term contracts, while local authorities tend to commission more flexibly through multiple smaller contracts.

- **Service timelines.** As already discussed, age thresholds for adult health services vary across England and often do not align with transition points for education or social care.

- **Data systems.** Information often does not flow easily across the SEND system – within health (such as between acute and community services), within education (between early years and schools), within a local authority (between social care and education teams) – across these partners, or between different parts of the country.

- **Interpretations of statutory definitions.** The legislation does not set out what support schools are expected to provide as part of 'ordinarily available provision' or SEN Support, or what changes if an EHCP is put in place.[72] Without this clarity, the boundaries between different tiers of provision are continually contested.

* This tension is heightened because councils cannot compel academy schools to admit children with SEND. They can, however, ask the secretary of state to intervene in such cases.

Central government did not give services the capacity and resource they needed to deliver reforms

These frictions that government built into the system have been heightened by a lack of resource and capacity.[73] There are signs of severe financial distress in local government, with reserves now lower than at any point since 2011/12 and an increasing number of councils relying on emergency funding powers.[74] All of this, local authorities told the Education Committee, affects SEND provision:

> **"Decisions not to issue an EHCP or to offer less support than is needed are often driven by limited resources [or] capacity constraints."**[75]

Pressures are also evident across education. Cuts to services like children's centres[76] and long waiting lists for children's mental health care[77] have left schools picking up a growing share of need.[78]

Meanwhile, multi-academy trust leaders report persistent difficulties recruiting and retaining special educational needs co-ordinators (SENCos, qualified teachers responsible for leading a school's SEND provision), reflecting a combination of funding pressures, high workload, limited opportunities for career progression and a shortage of applicants.[79] Even where roles are filled, time acts as a binding constraint to partnership working, with SENCo forums – meetings that are often seen as a key mechanism for sharing best practice – frequently undermined by the reality that many SENCos carry teaching responsibilities, leaving little scope for strategic leadership.[80]

And while health services are an "essential enabler" for children and young people with SEND,[81] they are often the least reliably engaged delivery partner.[82] This is the result of a critical lack of resources for SEND in health rather than any lack of commitment from front-line staff. According to a survey from the Royal College of Speech and Language Therapists, 17% of speech and language therapist posts in England were vacant in spring 2025,[83] substantially higher than the 7.2% vacancy rate across the wider NHS in the year to March 2025.[84] Evidence given to the Education Committee suggests that even when these services are fully staffed, it is "massively insufficient" to meet demand.[85]

It is no surprise, then, that when reflecting on the 2014 SEND reforms, former children's minister Edward Timpson noted that he "wished we had done more capacity building in the system before legislation".[86] At an Institute for Government event earlier this year, Baroness Louise Casey – the government's lead non-executive director – was more direct, describing the reforms as "'performative' legislation that [had] no back-up, no strategy, no money, and no ability to really get it done".[87]

Box 4 **What does strong partnership working look like?**

We have developed a set of principles for effective partnership working in SEND, drawing on interviews and wider literature.[*,88] They are not built around merging services into a single organisation: local government, education, health and care services have different roles, expertise and priorities and it is appropriate for them to continue to operate under distinct frameworks. But children and families, and the public finances, would be better served by a more coherent and joined-up SEND offer.

1. **Governance.** Central government should:

    a. **Agree a common purpose** and measurable shared objectives,[**] at a reasonably high level, for services delivering SEND support. Partners should be clear on the level of collaboration expected and what they individually stand to gain from working together.

    b. **Establish a cross-ministerial working group** to lead the iterative design and delivery of these reforms, in the process executing principles 1c–1e.

    c. **Define roles, but leave flexibility on implementation.** Clarify responsibilities without over-prescribing how services are delivered, allowing space for local innovation.

    d. **Align accountability and regulation** with roles, ensuring partners' performance and inspection frameworks incentivise joint working. Introduce quality assurance for local and national partnerships, with regular feedback from children and families, practitioners and partners.

    e. **Clarify decision making structures** at a national and local level, including robust mechanisms to resolve disputes between partners.

2. **Operations.** Central government and local systems should:

    a. **Understand the resource constraints** across national and local systems, and use this to support longer-term planning of staffing and provision.

    b. **Support collaboration through funding**, including central government providing long-term funding settlements for all partners and piloting pooled budgets.

* These are structured around, and heavily inspired by, Archer and Cameron's 'three-legged governance stool'. See Archer D and Cameron A, *Collaborative Leadership: Building Relationships, Handling Conflict, Sharing Control,* 2nd edition, Routledge, 2013.

** Some of these objectives should be outcome measures that focus on improving children's lives – see the section below on objectives for more detail.

c. **Align systems and processes** wherever possible – including commissioning processes, operational timelines, external and internal communications, and data systems.

3. **Behaviour and culture.** Central government and local systems should:

   a. **Foster a culture of joint problem-solving**, where partners focus on their contribution to solving problems, rather than attributing blame.

   b. **Lead by example.** National and local leaders should model the collaborative behaviours they want to see and challenge staff who avoid personal responsibility.

2. How to build a more cohesive SEND system

In February 2026, the government set out its plans to reform the SEND system and launched a consultation on the proposals, which closed in May 2026.*[1] One of its five principles for reform is to strengthen partnership working across local government and education, health and care services.

In the current SEND system, join-up between services occurs primarily through EHCPs at the level of the individual child. However, as this report has shown, this is often inefficient and difficult to sustain at scale given the volume of demand. To its credit the government has recognised this and has said it intends to shift towards a model of earlier intervention and inclusion where support is provided sooner and more consistently within mainstream settings.

Controversially, part of this will involve reducing the number of children with EHCPs by trying to tighten eligibility criteria. To do this, the government plans to replace the current bespoke system with several nationally defined specialist provision packages, setting out the types of need that qualify for an EHCP, the expected support and the associated funding.

To support those children with SEND but without EHCPs, whose number will grow as eligibility is tightened, it is seeking to expand lower-level provision. To do this the government plans a range of measures including:

- Placing schools under a new legal duty to support a wider group of pupils using new individual support plans (ISPs). These plans will not carry individualised funding; instead, schools will receive a general annual allocation with discretion over how it is used.

- Requiring every mainstream secondary school to develop an 'inclusion base', intended to "combine access to the mainstream curriculum – adapted where required – alongside bespoke specialist teaching and support".[2]

- Establishing a new 'experts at hand' offer, which will fund local authorities to improve mainstream schools' access to specialist education and health support for children, including those without EHCPs.

It is helpful to think of central government as a critical partner in the delivery of these reforms, not least because weaknesses at the centre are a defining feature of the current, failing, system. When comparing the government's current approach to the principles laid out in Box 4, there are some clear gaps. Below is a set of recommendations for what central government should do to meet those criteria for effective partnership working.

* These proposals are the government's latest stated position at the time of writing.

As a first step, the government must be clear about what it is trying to achieve with its SEND reforms, and understand the funding and wider resources it has available to deliver those objectives. From there, it must ensure those resources are used well – through stronger cross-departmental co-ordination, clearer prioritisation within the health system in particular, and funding arrangements that support, rather than undermine, collaboration. Greater consistency in systems and processes will also be essential to make it easier for local services to work together than to work in silos.

DfE must clarify the goals of SEND reform

1. DfE must make essential policy decisions about its vision for SEND reform, including guidance on 'prevention', before implementation is fully under way

The government has tried to remedy the lack of clarity on objectives in SEND outlined in Part 1 by anchoring reform to two core ideas: inclusive mainstream education and early intervention.[*,3] However, when it published its proposed SEND reforms in February 2026, it had yet to make key policy decisions about how these principles should be implemented in practice – for example, how funding should be spent and how systems should be set up.[**]

In the absence of answers to these questions, local areas have been left to interpret these concepts themselves. One local authority, having convened a working group of headteachers to develop a shared framework for 'inclusion', described how little consensus there was.[4] As Matthew Evans, CEO of a school trust, recently asked:[***]

> **"Inclusion for whom, into what, and for what purpose?"**[5]

Ambiguity also surrounds the phrases 'prevention' and 'early intervention' because they have been used by this government to refer to services that are traditionally considered acute rather than preventative, such as child protection.[6]

This lack of clarity mattered because reforms were already under way. Central government asked local areas to submit a 'Local SEND Reform Plan' by mid-June 2026, "to clearly set out how [they] will improve and further strengthen [their] system, tilting provision towards stronger inclusive practice and early intervention".[7] More than £6billion will flow to local areas (both to schools and local authorities) between 2026/27 and 2028/29 to support the transition, including to create 'inclusion bases' in every secondary school.[8]

* As it writes in its reform plan: "We have a clear objective: children and young people who can achieve and thrive in mainstream education will be supported to do so; and children and young people who need specialist support will receive it promptly and with dignity, clarity and care."

** One interviewee also suggested a similar pattern could be seen in the government's Change programme (a national programme to test aspects of its SEND reforms), where insufficient attention was given to the implementation and scaling phase. While the programme has produced a number of learning products, the interviewee reported that there was no clear mechanism to support non-participating local authorities to incorporate that learning into their transformation planning.

*** In doing so, quoting Armstrong et al. (2009), *The Current State of Inclusive Education: Contradictions and Concerns.*

These are not low-stakes processes. Although the plans are supposed to be iterative, access to funding to address high-needs deficits – available from autumn 2026 – is contingent on them being approved by central government.[9] The funding for reform is deliberately front-loaded, reflecting the time required to establish new provision and realise its impact, meaning it represents a substantial share of the total resource that will be available for SEND reform. And services could be held accountable for their use of this new funding from 2026/27.[10]

Asking tens of thousands of institutions to pull in the same direction without first telling them where they are meant to be heading was, as one roundtable participant put it, "a moment of maximum danger" for the reforms.[11]

To its credit, the government published guidance on inclusion bases in late June, providing greater clarity on issues such as how expertise within these specialist settings should be distributed across an area.[12] While this unhelpfully came after the deadline for local SEND reform plans, it was sensible to prioritise guidance on the design and construction of inclusion bases, given that these decisions will be particularly difficult to reverse.

DfE also plans to introduce national inclusion standards to define what support mainstream settings should provide. It has decided not to do so immediately, however, because there is very little robust evidence on what actually improves outcomes for children with different special educational needs. Therefore, these standards may not be published until 2028, to allow time to build the underlying evidence base.[13]

In the meantime, the government should focus initial action on areas where evidence is stronger – such as support for social, emotional and mental health needs and speech, language and communication needs[14] – although this will need to be balanced against short- to medium-term workforce constraints in key specialist services. This focused approach would also give local partnerships a more manageable starting point. Early collaboration on more contained, lower-risk initiatives helps build trust between partners and demonstrates the value of joint working – creating a foundation for more complex and interdependent reforms over time.[15]

While 'inclusion' is beginning to take clearer shape, 'prevention' remains much harder to pin down. DfE (and other departments) should set out, in partnership with front-line services, working assumptions for how it understands and applies the concept of 'preventative' spending in practice.[16]

Previous Institute for Government research shows that greater clarity makes it easier for policy makers and local areas to protect preventative services, and boost spending on them over time.[17] That report argued that for an intervention to be considered preventative it should, at a minimum, reduce the likelihood or severity of acute need, not be incurred in response to acute need, and improve the allocative efficiency of spending.[*,18]

[*] The Chartered Institute of Public Finance and Accounting has outlined a more detailed four-step approach to quantifying preventative spending. See Chartered Institute of Public Finance and Accounting, 'Public sector preventative spend can be quantified, CIPFA finds', press release, 30 October 2025.

1(a) DfE must set clear outcome-based metrics for success, using feedback from children, young people and parents

Once clearer objectives are in place, DfE must operationalise them by defining success metrics. Some of these metrics should focus on outcomes, rather than inputs (such as spending) or outputs (such as the number of EHCPs).

Outcomes can be difficult to target directly because they are often shaped by a wide range of factors beyond a single policy.[19] But recent Institute for Government case studies of the last Labour government's approaches to reducing school absence[20] and teenage pregnancy[21] highlight the importance of setting clear outcome ambitions, both to measure progress and to maintain momentum for reform.

Measuring success through outcomes can also help keep the focus on early intervention, which can otherwise easily be overlooked.* For example, SEN Support was neglected during the 2014 reforms in part because of the heavy emphasis placed on transferring 'SEN statements' to EHCPs.[22] Had success instead been measured through outcomes such as pupil wellbeing, early intervention may well have been prioritised as one of the most cost-effective ways to meet that goal.

One way of grounding SEND reform in outcomes would be to use feedback from children, young people and parents as a core measure of success. The government could support this by designing a consistent national survey, so results can be compared across areas and over time. Depending on the government's priorities, these surveys could track issues such as:

- how well children with SEND feel supported in school
- how involved they feel in decisions about their support
- their mental health and wellbeing.

Whichever metrics are chosen, they should be embedded within MHCLG's Local Outcomes Framework given its intended role as a more joined-up set of expectations across government.[23]

1(b) DfE must ensure its performance framework for the education system appropriately balances inclusion, attainment and attendance objectives

* It is difficult to use performance management to drive a shift towards prevention because results often take a long time to emerge and are especially hard to link to a specific policy. As well as measuring success through outcomes, one of the most effective approaches may be to set targets for increasing the share of service spending on prevention in SEND (we make more detailed recommendations below about how this might work in education).

Alongside its goals on inclusion, DfE is also pursuing renewed objectives on attainment and attendance. It recently set new and ambitious national targets to increase the proportion of children reaching expected standards in reading, writing and maths at Key Stage 2, raise GSCE attainment, halve the gap between disadvantaged pupils and their better-off peers at GCSE level, and reduce absence rates by nearly a fifth.[24]

It is legitimate for DfE to pursue objectives on inclusion, attainment and attendance simultaneously. However, it has not acknowledged that they can come into conflict. In fact, the government writes in its proposals for SEND reform that teachers "should never have to choose between academic excellence and inclusion" and that "excellence and inclusion go together hand-in-hand".[25]

In reality, tensions between these aims have been a persistent feature of the education system over the past decade, as discussed above. The experience of Southern Cross School in Manchester illustrates this clearly (see case study 1 in the Annex). The school has developed an innovative model for pupils with emotionally based school avoidance (EBSA), enabling children with extremely low attendance to re-engage with education.

As a result, it has become a 'magnet school' for children with EBSA, with a waiting list of around 20 children for 20 spots on the programme. However, during a 2023 Ofsted inspection, the school spent a full day justifying why certain pupils were not on-site to inspectors who were concerned about attendance rates.

If DfE is serious about delivering a more inclusive SEND system, it needs to look at how its current performance and funding frameworks – especially its attainment metrics – shape behaviour, and whether this is compatible with its goals. These frameworks are the main driver of school behaviour, so that is where the government must focus to change practice.

The government needs to understand resource constraints across SEND and children's services

As we have seen, decisions in the SEND system are often driven as much by resource pressures as by children's needs. In recognition of this, the government is investing billions into local services with its SEND reforms. This includes, between 2026/27 and 2028/29, £200m to ensure local authorities have the capacity to deliver reform, another £200m for a new national SEND training programme for education staff, and £40m to expand specialist workforces (all in cash terms).[26]

2. DfE, MHCLG and DHSC should build a clearer national picture of spending and workforce capacity across SEND and children's services and use it to guide decisions about reform

The more fundamental problem is that these resource pressures are only partially understood. The government has a national blind spot over the resources currently flowing into SEND, making it difficult to see how its spending plans can be based on a robust understanding of existing capacity.

As outlined in Box 3 it is not possible to calculate a single figure for SEND spending in England. There is limited visibility over how schools use their budgets, and ICBs often do not treat children's services as a distinct category, with spending instead folded into all-ages block contracts.[27] Even at a local level, areas do not understand the total resource for SEND. One local authority reported manually going through every active EHCP in its area to estimate the total health funding contribution.[28]

There are also major gaps in data on the workforce delivering SEND services. The government holds little information on the size and make-up of local authority staff.[29] For example, the capacity of those delivering preventative children's services is largely unknown, with no routinely published data on early help or family support staff, despite SEND and children's social care reforms placing mounting demands on this group.[30]

In education, while DfE publishes data on the number of support staff in schools, it offers little insight into their roles, making it difficult to assess how many directly support children with SEND.[31] And DfE acknowledged in 2023 that fragmented data made it impossible to provide precise estimates of the number of active educational psychologists in England.[32]

Data on community health services is also riddled with gaps. The Nuffield Trust has found that NHS workforce statistics do not reliably capture how many staff work in community settings.[33] As a result, the Department of Health and Social Care (DHSC) does not hold data on the total number of speech and language therapists employed in each ICB area in England.[34] NHS data is also not detailed enough to identify vacancy rates among specific specialists, necessitating the use of survey data in the section above.[35]

It is therefore unsurprising that many of the primary concerns about the government's SEND reforms relate to whether they are deliverable. A lack of capacity also undermined the 2014 reforms, and current plans risk repeating the same pattern.

Plans to create tens of thousands of inclusion bases and establish an experts at hand offer in every local area have triggered warnings from a leading SEND charity that the specialist workforce required simply does not exist.[36] New research from the Education Policy Institute estimates that the educational psychologist workforce would need to grow by 40% just to bring staffing levels in England up to those currently seen in the best-performing quarter of local areas for SEND outcomes.[37] This does not account for any additional demand on the workforce that will arise from the government's reforms.

A school representative also raised a "basic administrative concern"[38] about proposals to require schools to produce individual support plans (ISPs) for all pupils with additional needs.* Even if transferring each pupil currently receiving any formal support for SEND** took just two hours, the process would consume 3.5 million working hours across England's schools, or eight hours per classroom teacher.***,[39] As Sam Freedman notes: "If too much process is created around [ISPs] it will reduce capacity to do anything else."[40]

As a priority, the government should develop a clearer national picture of spending and workforce capacity across SEND and children's services.**** Alongside any one-off exercise, the government should improve routine data collection so that the flow of resources to SEND, or children's services more widely, can be tracked over time. This would allow government to assess whether its investment in workforce development is translating into meaningful increases in capacity.

This may include requiring ICBs to track spending on children's services as a distinct category. Where new data collection is introduced, it should be designed from the outset to support timely sharing across local partners, allowing them to build a coherent and current view of SEND provision in the area.

The centre of government must co-ordinate SEND reform across Whitehall

3. A minister in the centre of government must integrate SEND reform with the government's wider priorities for public service reform

SEND reform is not happening in isolation. It is being implemented at the same time as a wide-ranging and ambitious set of public service reforms, from NHS restructuring to local government reorganisation, a shift towards a trust-based education system and reform in children's social care (see the Annex for a list of key reforms). As a result, every partner in the SEND system is contending with some of the most ambitious reforms their service has seen in over a decade.[41]

Some of these align with the direction of SEND policy. New duties on schools to co-operate with local authorities on place planning, for example, should help ensure there are sufficient local places for children with SEND and reduce the time families spend waiting for these places. Likewise, Ofsted's introduction of a standalone 'inclusion' judgment in its inspection framework for schools signals a shift in accountability in

* They should already be producing individualised plans for pupils on SEN Support, but that duty is not statutory.
** For instance, SEN Support or EHCPs.
*** The 'eight hours per classroom teacher' figure was calculated by excluding pupils in hospital schools and independent schools from the SEND support data, to better match the coverage of the school workforce statistics, and dividing by the number of FTE classroom teachers.
**** There are two main routes to building this picture. A top-down approach, whereby central government estimates spending and workforce at a national level, would likely be faster and less burdensome for local areas. However, it would inevitably miss important detail – particularly given existing data gaps – and would offer limited insight into how resources are distributed across the country. A bottom-up approach, led by local authorities, would map spending and workforce across councils, schools and the NHS within local areas. This would provide a more accurate and helpful picture for local areas, but would require strong co-ordination and buy-in across MHCLG, DfE and DHSC to ensure consistent participation.

line with SEND priorities.* And, if properly integrated into local services, Best Start Family Hubs offer a clear opportunity to improve the early identification of SEND.

However, these points of alignment are outweighed by a much wider set of misalignments. Despite extensive interdependencies between services, these reforms have largely been designed and pursued within departmental silos, with little attempt from the centre of government to co-ordinate efforts and ensure coherence.[42] This inevitably creates frictions, which local services are left to manage.

Officials in DfE and MHCLG told us they have raised concerns with the Cabinet Office about the lack of co-ordination, but to no avail.[43] As a result, both departments are now – independently – running projects to understand what the reforms mean for their departmental priorities. In other words, ongoing attempts to co-ordinate the reforms in the centre are themselves uncoordinated. This cannot continue if the government is serious about integrating SEND services.

As we have recently recommended, Darren Jones – in his role as chief secretary to the prime minister, responsible for overseeing cross-government delivery[44] – should take responsibility for aligning these disparate reform programmes using the public services cabinet committee as the forum for co-ordination.[45]

3(a) Departments must provide early clarity on structural changes

Key details – particularly on the structural changes services will undergo – remain unresolved across the various reform programmes.** As a result, no service yet knows the system within which it will ultimately be delivering SEND services, or even who its local partners will be. As one local authority representative put it, "it's risks and pitfalls and potholes at every turn".[46]

Uncertainty in health services is perhaps the most debilitating for SEND reform.[47] In May 2025, the NHS designated SEND services as under "review for transfer" out of ICBs.[48] More than six months later, it confirmed to ICBs that SEND would remain their responsibility,[49] but has provided no further public clarification of how those services will be managed. At the same time, plans for neighbourhood health providers – which could offer a natural, smaller-scale, footprint for SEND delivery – are not yet well developed.[50]

* Although, as we explain in the section on system objectives, this presents its own risks given that DfE has not yet settled on a final definition of 'inclusion' so Ofsted cannot yet know what it is measuring against.

** Plans for local government reorganisation are still being approved, leaving areas' future administrative boundaries, financial situation and staff capacity unclear. In children's social care, commissioning responsibilities are likely – but not certain – to move out of local authority hands, and there is no confirmed model or geography for regional care cooperatives, or clarity on which responsibilities local authorities would retain. In education, the national curriculum is still a year away from publication, and schools lack both a clear timeline and technical detail on the expectation to join or form trusts.

This level of uncertainty makes effective partnership working extremely difficult. Without early clarity from DHSC about how SEND services will be managed in the health system, there is a real risk that reform effort is dissipated, and that decisions taken now will need to be revisited later at significant cost to delivery and outcomes.

3(b) DfE should factor structural reorganisations into SEND reform timelines

Structural reorganisation is highly disruptive. It severs personal relationships that often underpin effective partnership working,[51] and often consumes enormous organisational bandwidth.[52]

Our interviews repeatedly highlighted that connections between individuals in different services were instrumental to local collaboration on SEND.[53] And ICB reorganisation, for example, is already distracting health services from delivery, with most staff losing their jobs, focused on fighting to keep them, or else trying to redesign their organisations – leaving little spare bandwidth for SEND reform.[54]

Recent Institute for Government research recommends that the centre of government actively confront the consequences of structural reorganisation, taking a view on whether to prioritise it even if it slows progress on improving services in this parliament.[55] Off the back of that decision, DfE must consider whether timelines for SEND reform are realistic. For example, should local areas have been required to commit to their reform plans by June 2026 (discussed above) in the context of significant system upheaval and uncertainty?

Mitigating the loss of relationships from these reshuffles is essential to any realistic attempt to join up SEND services. Central government could therefore seek to institutionalise connections between services; for example, through pooled funding arrangements, as we discuss in a section below.

3(c) DHSC and MHCLG should work together to align local health providers with local authority services

SEND reform is also being implemented across a system where the geographies of key services are increasingly misaligned, making partnership working harder.

The consolidation of ICBs will widen the gap between the level at which local authorities operate and the level at which health services are organised. Each new ICB will serve around six upper-tier local authorities, up from four today, which inevitably makes collaboration more onerous for the ICB. Similar pressures will arise if commissioning responsibilities for children's social care shift from local authorities to regional care co-operatives, and if the move to a more trust-based education system leads, as it has in the past, to school networks operating across less localised geographies.

Geographical misalignment is only part of the problem. As recent Institute for Government research highlights, successful service integration often comes when working to a shared desire to solve a specific, localised problem.[56] Yet many reforms are shifting decision making to bodies covering far larger areas. The new ICBs, for example, will cover populations of around 2.3 million people, making it almost impossible for them to understand the needs of individual school communities.[57]

Instead, as we have recently recommended, Darren Jones and the Cabinet Office should use the fact these structural reforms are happening concurrently to ensure there is alignment between geographies.[58] Even if this required revisiting the timetable for some government reforms, it would materially strengthen the prospects for effective service integration.

If, however, the government does not wish to alter the footprints of ICBs or local authorities, it will need to find a way for organisations operating at very different scales to work together.

Connecting health and local government at a local level provides the most practical solution. At present, this would likely involve councils working with primary care networks, which typically serve populations of 30,000 to 50,000 people and are far more embedded in communities than entire ICBs. If, as expected, these networks develop into neighbourhood health providers in the coming years, the government should take the opportunity to bring health and council boundaries into closer alignment.

Some interviewees also suggested an alternative approach: using regional organisations, such as strategic authorities or regional care co-operatives, to bridge the gap between health, social care and local government.*[59] But compared with a more local model, this would add another layer of bureaucracy to an already fragmented system, dilute accountability and push decision making further from local communities, contrary to the government's stated principle of public service devolution.[60]

Regional structures should therefore be used only for functions where scale brings clear benefits. This may include workforce planning: given strategic authorities' role in setting strategic direction for skills in an area,[61] they would be well-placed to co-ordinate workforce planning for SEND, reducing competition between social care, health and education services for the same pool of trainees. Their scale would also make it easier to work with universities to train sufficient specialist staff, such as educational psychologists. It may also include, as the government identifies in its reform proposals,[62] the commissioning of highly specialist support that may only be required by one or two children within a given local authority area.

* This would work particularly well where those footprints match up with ICB boundaries.

4. DfE must establish a cross-government working group, commissioned by No.10 and bringing together DfE, DHSC and MHCLG, to oversee the implementation of SEND reform, resolve conflicts between departments and address problems raised by those delivering and using the system

If the government wants SEND reforms to be iterative – often a critical part of policy making success[63] – there must be clear ownership of the reforms, sustained input from multiple departments,* regular review of progress informed by those delivering and using the system, and a mechanism for course correction.

Implementing SEND reform will also require political trade-offs. As an example, just three months before DfE published its SEND reform plans, the then health secretary launched a review into mental health conditions, ADHD and autism, with a remit to develop recommendations "for responding to rising need both within government and across the wider health system and wider public services".[64] The review's scope sounds worryingly similar to the SEND reforms themselves, underscoring the need for ongoing political co-ordination to avoid the two programmes pulling in different directions.

Success in SEND reform therefore requires a cross-government mechanism. Indeed, research from the Centre for Education Systems, examining 14 SEND systems across the world, finds that:

> **"SEND policy making is typically siloed from other policy domains. Where there is integration, it tends to involve institutional structures that connect different government departments, such as formal meetings between sections of education departments or other departments..."**[65]

This cross-government mechanism does not yet currently exist – something several roundtable participants identified as a major threat to effective partnership working.[66]

One example of what this could look like is a centrally mandated cross-government SEND working group. The prime minister could write to Georgia Gould, the minister in DfE responsible for SEND, commissioning the group and setting out its remit and objectives, based on those defined by DfE. This would provide the political backing needed for Gould to convene the group and secure engagement across government. Evidence from previous public service reform programmes shows that visible leadership at the centre of government is often pivotal in pulling disparate parts of government together.[67]

The government will need to strike a careful balance when deciding who should sit on the group. Closer involvement from the centre would make it easier to resolve disagreements between departments, but would place additional demands on already stretched central capacity and risks discouraging departments from resolving issues

* DfE sets policy on education and children's services, DHSC sets policy on health services for children and young people, MHCLG provides grant funding to local authorities, including for children's social care, the Department for Work and Pensions provides financial support for young people with disabilities, and the Department for Culture, Media and Sport provides funding to support youth services.

themselves.[68] At one end of the spectrum, the group could be chaired by the prime minister or their chief secretary; at the other, it could operate at junior ministerial level. The strongest option may lie somewhere in between: a junior ministerial group, supported by senior officials who will be closer to delivery, with a clear in-built reporting mechanism to the Cabinet Office.

The Children's Commissioner, who the government proposes will take on a new role overseeing and scrutinising the implementation of its SEND reforms,[69] could also be included as a formal member, to introduce greater external challenge and ensure the perspectives of children and families are reflected in the group's decision making.

Health input into SEND provision should be commissioned locally rather than through the NHS – if SEND is not a priority for DHSC

The government has pitched its SEND reforms as a joint venture between education and health. In practice, however, there is little evidence of a meaningful shift in health's priorities. For example, while DfE committed around £4bn of day-to-day spending and another £4bn of capital spending (in cash terms) to SEND reform by 2030,[70] DHSC did not dedicate any funding to SEND in the most recent spending review. And even though both Bridget Phillipson, the education secretary, and Wes Streeting, the former health secretary, wrote the foreword to the SEND consultation, the proposals in it will be funded almost entirely from DfE's budget.*[,71]

The NHS medium-term planning framework makes limited reference to the SEND reforms, noting only that ICBs and providers are expected to work with NHS England and DHSC "to respond to reform plans once published".[72] Moreover, as we have already mentioned, the NHS was exploring options to transfer responsibility for SEND out of ICBs and to providers in May 2025.[73]

It is damaging both for outcomes and trust if the government portrays SEND as a health priority if this is not the case.[74] Previous Institute for Government research has also found that pressure to meet unrealistic targets can damage front-line workers' morale and service performance.[75]

We therefore recommend that the government is explicit about what degree of collaboration it expects, and is realistic, from health on SEND. In particular:

5. A minister in the centre of government should ensure DHSC clearly explains how SEND reform fits alongside other health priorities

* There are two exceptions. The first is the £900m Best Start Family Hubs and Healthy Babies programme, of which £700m is jointly funded by DfE and DHSC. It is not clear what the departmental split is and this joint funding had already been announced as part of the government's opportunity mission prior to the SEND reforms. The second exception is that DHSC will contribute £25m to the 'experts at hand' fund, which will total £429m in 2026/27 and £1.8bn over the three years to 2028/29.

As the NAO recommended in 2024, the government should "[develop] a shared understanding of how identifying and supporting [SEND] should be prioritised, including within the health system".[76] DHSC will need some direction from the centre on how SEND reform should be balanced against competing pressures in the health system, such as the government's elective waiting-time target (for 92% of patients to start elective treatment within 18 weeks of referral by March 2029).*

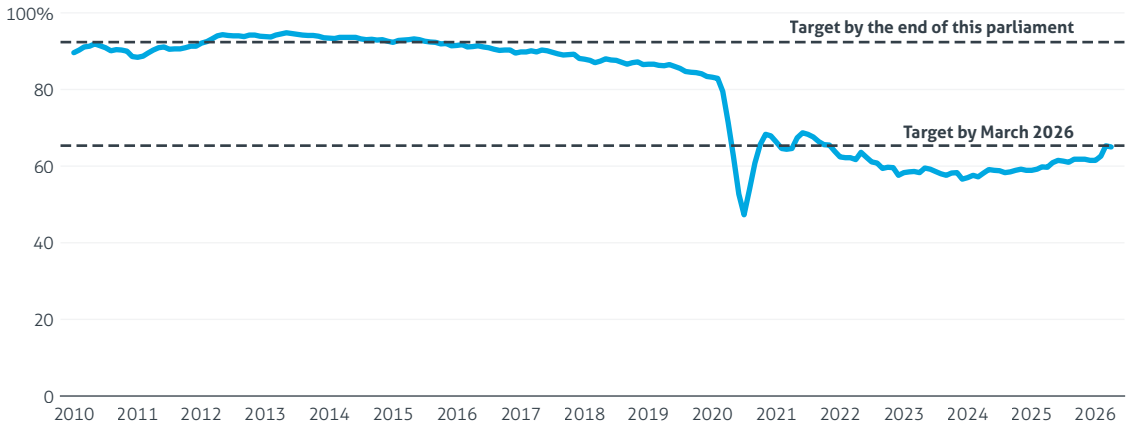
This decision must be clear and public so that local bodies, such as schools and local authorities, understand what is expected of health partners and can organise their services accordingly.

5(a) If DHSC considers SEND reform a priority, the health secretary must ensure health services are resourced to deliver it, which will likely require trade-offs with other priorities

Even though aspects of SEND provision have appeared on the NHS's long list of priorities for several years, health remains the least reliably engaged partner in the SEND system. The NHS is already overstretched, and when resources are tight they tend to flow to acute care, not community services where most SEND provision sits.[77]

Despite recent reductions, the number of targets and expectations that the government requires the NHS to meet still far exceeds what is deliverable.[78] The NHS has hit the government's interim target for elective care, but performance will need to improve much faster over the next three years to meet the overall target by March 2029. Progress in other areas like A&E waiting times, discharge from hospital, and 'corridor care' has been far slower.[79]

Figure 4 **NHS elective waiting cases waiting less than 18 weeks since joining the waiting list, January 2010 to April 2026**



Source:Institute for Government analysis of NHS England, 'Referral to treatment waiting times' ('Full time series' table), April 2026. Notes:Figures relate to England.

* The 'weight' that should be put on each priority may not be easily quantified, but governments nonetheless make practical choices about which objectives receive political attention, operational focus and resource when services cannot realistically deliver everything at once.

Alongside working to operational targets, the NHS is also undergoing an enormous structural reorganisation, as discussed earlier. Most staff are now losing their jobs, focused on fighting for them, or else trying to redesign their organisations.

Bandwidth is therefore severely limited,[80] and SEND reform faces an additional disadvantage when competing for resource in the NHS: SEND services are, for the most part, delivered in the community. While this government's ambition to shift care into the community should, in theory, work in its favour, this has been a goal of all governments since the 1970s,[81] with very little to show for it. Instead, acute services like hospitals continue to crowd out preventative, community provision.[82]

As a result, simply saying that SEND is a priority for DHSC is unlikely to have a meaningful impact, as it does not address the pressure on the NHS to focus resources on acute care.

Instead, if the government is serious about making SEND reform a health priority, it will need to recognise that, in the short term, this will likely involve trade-offs with its priorities in the acute health system, rather than assuming that both can be progressed in parallel without consequence.* Over the longer term, however, investment in community services such as SEND provision may help to reduce demand on acute services and make targets in that part of the system more achievable.

5(b) If DHSC does not consider SEND reform a priority, DfE and MHCLG should enable a more transactional, locally driven model of engagement with health services

In this scenario, the government should rely less on national-level partnership, and instead enable local areas to secure health input for SEND provision through more direct, transactional routes. In practice, this means channelling funding through local areas – whether through school clusters (discussed more below) or local authorities – so that they can directly commission health services for SEND provision, rather than funding flowing through the NHS. As one interviewee put it, rather than continuing to 'nudge' the health system to deliver preventative, community services – a strategy that has struggled for decades – alignment is more likely where there is "money in it" for providers.[83]

The government may already be moving in this direction. Its proposed 'experts at hand' offer will channel £1.8bn into local areas over the next three years in cash terms, enabling councils to commission specialist practitioners, such as educational psychologists and speech and language therapists to work in mainstream education settings.[84]

* One way to change behaviour in the NHS is to strengthen how SEND or community services are reflected in NHS performance frameworks and accountability mechanisms, potentially including through the introduction of headline targets. But, given how difficult the NHS is already finding it to deliver against existing commitments, this cannot simply mean adding another target without reducing expectations elsewhere or increasing the resources available to deliver them. Targets – like priorities – are only meaningful when governments are willing to back them with sustained political attention and resource. Another option is to pool health budgets with other services, allowing spending decisions to be shaped jointly rather than solely by the NHS's own priorities. We discuss this approach in more detail later in the paper.

There is precedent for this approach. Since 2013, many public health functions, such as sexual health, obesity and substance misuse services, have been commissioned by local authorities. While evidence is mixed – and complicated by the fact the change coincided with huge cuts to local government budgets – the King's Fund think tank judges that the transfer of responsibilities is likely to have improved outcomes overall, "through innovation, and a stronger connection and influence over the local policies and decision-makers that affect the population's health".[85] The experience also shows that, to fully realise these benefits, local areas need enough funding to meet demand.

Similar models have also already emerged within SEND. Some of the most inclusive schools have (with additional funding) effectively bypassed constrained NHS pathways by commissioning their own support.* For example, Aylsham High School in Norfolk – described by one parent as "the shining light at the end of a very long dark tunnel"[86] – funds** its own speech and language therapist, psychotherapist, and social, emotional and mental health team.[87]

This is a more transactional model of partnership than the aspirational vision of mutual, system-wide integration, and it comes with trade-offs. It limits health's role as a strategic partner in SEND, risks fuelling variation in service quality across areas, and could intensify competition for scarce specialist practitioners.

It also brings advantages, however. It helps protect funding from being absorbed into acute services, and may support local innovation by bringing decision-making power closer to service users, given the smaller geographic scale of local authorities or school clusters compared with ICBs. Both of these – prevention and devolution – are principles the government wants to guide its approach to public service reform.[88]

Most importantly, however, this approach reflects a pragmatic choice: it is better to design a system around departmental priorities than to rely on health services to collaborate when they are not incentivised to. In the current context, funding health input to SEND provision through local authorities or school clusters, rather than via the NHS, may be the most realistic way to secure meaningful collaboration with health services around children with SEND.

6. DHSC must work with NHS England to make sure workforce cuts in ICBs do not leave SEND services without the required staff and capacity

* We are not suggesting that, in the reformed system, schools should individually commission support. That would risk what one interviewee described as "commissioning spaghetti" – characterised by support offers that are duplicated and very difficult to navigate. Instead, we suggest that schools could commission support via school clusters or local authorities.

** For more detail, see the case study on Aylsham in the section on funding.

Once the government has clarified the role ICBs should play in SEND, it must ensure that ICB reorganisations reflect that role. At present, extensive and difficult-to-reverse decisions are being taken without that clarity. One proposed ICB restructure would consolidate responsibilities for urgent care, mental health, and children's services – previously spread across 15 members of staff – into a single role.[89] And at our roundtable, one front-line health professional reported that, in their area, recent ICB redundancies have fallen disproportionately on SEND teams, who were already severely stretched.[90]

Cuts of this magnitude risk eroding institutional knowledge and capacity, and leaving front-line staff doubtful that SEND is a priority – yet all this is happening entirely independently of the government's SEND reforms.

Even more concerning is that DHSC appears unaware of this. We understand the department was shocked to hear where redundancies were falling and insisted this should not be happening.[91] Yet when asked how much oversight DHSC had over who was losing their jobs in ICBs, the response was that NHS England was the decision maker, and that they were the head office, not DHSC.[92] It is unacceptable that DHSC is not taking greater oversight of a system it is expected to lead in under a year. Without urgent intervention, the restructuring of ICBs threatens to derail SEND reform before it has properly begun.

The Treasury should ensure funding flows support better partnership working in SEND

7. The government should develop funding models that make joint working on SEND easier

7(a) DfE and DHSC should provide multi-year funding settlements for education and health services

Several interviewees identified short-term funding settlements as a key barrier to effective partnership working in SEND.[93] Greater certainty over funding allows public services to move beyond year-to-year fire-fighting and engage in long-term strategic commissioning with other services.[94]

The Starmer administration has, to its credit, taken steps to improve funding certainty across the system. The 2025 spending review set day-to-day budgets for departments from 2026/27 to 2028/29, and MHCLG extended the benefits of this certainty to local authorities, which in December 2025 received their first multi-year settlement in a decade.[95] DHSC is also making progress towards multi-year budgets for the NHS with the publication of the medium-term planning framework, which covers the period up to 2028/29.[96]

However, this approach has not been applied to education.* School funding continues to be determined on an annual basis, with DfE communicating allocations only one year ahead.** It also undermines some of the benefit for local authorities and the NHS of having long-term settlements, as they are still unable to align planning cycles or enter into longer-term joint commissioning arrangements with schools.

The benefits to collaboration are clear where greater funding certainty exists in schools. For example, Aylsham Cluster Trust has been able to develop early intervention provision with health professionals by drawing on funding streams outside of government – including profits from community use of a local high school's facilities – where income is more predictable (see case study 2 in the Annex).[97]

While many schools lack the facilities to generate stable additional income, a simple, costless, starting point for DfE is to make the funding it does provide more predictable over the long term.

7(b) DfE is right to rebalance school funding towards mainstream budgets – and should extend this logic to the funding model for specialist provision

DfE has committed to rebalance school funding by, over time, shifting some money from the high-needs block into the core budgets of schools and colleges.[98] This is a welcome move. Systems that rely heavily on individualised funding – such as top-up funding in the high-needs block (see Box 3), where resources are tied to diagnoses or statutory plans – create a perverse incentive for schools and parents to escalate requests for support through formal, statutory routes such as EHCPs.[99]

By contrast, core mainstream funding distributes resource based on population indicators, such as total pupil numbers or deprivation indices, without requiring formal identification of SEND. International evidence suggests that shifting a greater share of SEND funding into these budgets can make schools less dependent on formal, statutory plans to access additional resource.[100] This, in turn, supports earlier intervention in mainstream settings by enabling schools to put support in place before needs escalate to the point of requiring statutory assessment.

To counter the system's tendency to pull towards acute provision, DfE should set a long-term national objective for the balance of funding between mainstream and high-needs budgets,*** supported by interim milestones to guide the transition.

* Though Bridget Phillipson, the education secretary, has set a precedent by asking the School Teachers' Review Body, which advises the government on teachers' pay, for formal recommendations for 2026/27 and 2027/28, as well as an indicative recommendation for 2028/29. Agreeing longer term pay settlements provides greater certainty for teachers and schools, and other ministers should follow suit.

** If, in line with recommendation 5b, the government opts to channel funding for health input into SEND provision through councils or school clusters, it will be particularly important for this to be provided through multi-year settlements, given its strategic nature.

*** This balance may vary across areas to account for different local contexts.

This logic should also be applied consistently across the education system. DfE intends for specialist settings, such as special schools and alternative provision (AP), to play a more flexible role in the reformed system, including through providing time-limited placements for children in mainstream school who need temporary additional support, and expanding outreach into mainstream settings to advise staff and share effective approaches.[101] However, specialist settings are currently funded primarily on a per-pupil basis, giving them a vested interest in keeping their places permanently filled and their staff occupied within their own setting.

DfE should explore funding models that alter this incentive. One option is to introduce a separate funding stream for specialist settings that rewards work which supports other schools, such as providing advice and assistance to mainstream settings. Under this model, special schools and AP would continue to be funded for the pupils on their roll, but would also receive funding for outreach work with mainstream schools, including supporting the reintegration of pupils into mainstream settings.

7(c) The Treasury should create a ring-fence around preventative spending

A natural extension of the government's ambition to protect preventative spending is to ring-fence it. While shifting resources into mainstream school budgets is a welcome first step, it is unlikely to be sufficient on its own. Schools have significant discretion over how they spend these budgets and funding will inevitably be pulled towards the most acute pressures.

Preventative services are often the first to be cut when budgets are tight,[102] and services are likely to struggle to manage competing pressures within the funding envelope set for the coming years.[103] We were told that even in a council renowned for its preventative approach to children's services the staff delivering early intervention were the only group within the service not offered permanent contracts, as the council needed the flexibility to cut that spending in response to unexpected funding pressures.[104] The Aylsham case study mentioned above similarly illustrates the benefits of effectively ring-fencing funding for prevention, because it ties resources to a clear purpose through a dedicated charity.

DfE, alongside other departments, should therefore go further. Once it has defined which broad areas of spending it considers preventative – as we call for above – the Treasury should create a ring-fence around them.[*,105] Previous Institute for Government research sets out how such an approach could be implemented in practice.[106]

[*] One interviewee raised a concern that ring-fenced preventative funding could, in practice, still be used to meet acute pressures if councils' legal duties to provide acute support (for example, to follow what is set out in an EHCP), take precedence over their duties to abide by government ring-fencing. The government should set out how these duties are supposed to interact and make any legislative changes required to support this.

7(d) A minister in the centre of government should pick one of our options to break down funding silos from our line-up

As much of this report has shown, financial incentives (and disincentives), coupled with funding silos, significantly obstruct the ability of SEND services to collaborate, as different services try to avoid landing responsibility for costly provisions – even if the result is greater overall cost to the state.

These funding silos also discourage investment in prevention because preventative work often cuts across service boundaries, and requires one agency to incur costs while the saving or benefit accrues to another.[107]

The vast majority of the 50 people we spoke to for this project saw pooled funding arrangements as a promising way to reduce financial friction between agencies. The government has several options:*

Option 1: Pilot the creation of cross-cutting local roles, that act as a bridge between services

Some local areas have created cross-cutting roles that act as bridges between services, reducing duplication and aligning how budgets are used. Sunderland's jointly funded Strategic SEND Commissioning Lead (see case study 5 in the Annex) is one such example. While the role has no formal control over budgets, its position across both the local authority and the ICB has helped cross-cutting work.

Scaling this approach would not necessarily require new funding. In Sunderland, the role emerged organically when the organisation delivering children's services on behalf of the council** and the ICB realised they were both looking for a strategic SEND commissioner, allowing them to fund one, not two, salaries. A nationally co-ordinated pilot could encourage other areas – particularly those without strong pre-existing relationships – to take a similar approach.

A more ambitious variant would give such roles direct oversight of commissioning and budgets. One council we spoke to has a single officer responsible for the children's budgets of both the local authority and the local NHS integrated care system, as well as commissioning across both systems, enabling improved partnership working in the area.[108]

The effectiveness of these roles is likely to depend heavily on the skills and experience of the individual post-holder. In Sunderland, prior experience working in health services helped build relationships quickly. There is also a risk of fragmentation if multiple 'bridging' roles emerge in an area without co-ordination. And ultimately, these roles remain a workaround for siloed funding rather than a solution to them.

* If – as we have already discussed – SEND is simply not a priority for DHSC, it will likely be best to proceed with the option where health services' input is simply commissioned, but budgets across education settings and local authorities, for example, could still be pooled.

** In Sunderland, children's services are delivered by Together for Children on behalf of Sunderland City Council.

Option 2: Create a nationally mandated 'section 75 arrangement' in the style of the Better Care Fund

Section 75 of the NHS Act 2006[109] is the principal mechanism through which NHS bodies and local authorities can pool budgets. Local areas can set up their own, bespoke section 75 arrangements, but the act also underpins nationally mandated programmes such as the Better Care Fund (BCF), which supports integrated, preventative care for adults. In 2021/22, some 94% of local areas agreed that joint working had improved as a result of the BCF.[110]

However this mechanism is not well embedded in children's services. A commissioning expert told us that, while the universal nature of the BCF meant that section 75 arrangements are widely understood in the adult system, awareness is much lower in children's services, where teams do not always know they exist.[111] The government could therefore do more to promote these arrangements as a route to integrating SEND services locally.

While the government could simply encourage councils and health services to make greater use of section 75s, there would be substantial benefit to establishing a nationally mandated BCF-style pooled funding pot for SEND. Without dedicated funding for or stronger mandates on their use in SEND, uptake is likely to remain limited. This is because:

- First, as a recent call for evidence on section 75s highlighted, these arrangements require upfront financial investments, which many services are simply unwilling to make voluntarily.[112] A commissioning expert told us that local authorities have become increasingly nervous about tying their budgets to section 75s given their fragile financial positions and the reduced flexibility the arrangements create.[113]

- Second, the existence of section 75s does not, in and of itself, do anything to improve relationships between services. Whether a bespoke arrangement gets set up often depends on the presence of strong, pre-existing relationships, and a willingness to collaborate.[114]

- Third, locally negotiated section 75s are ultimately another workaround for siloed funding rather than a solution to it. One of the top recommendations made by respondents to the call for evidence on changes to section 75s that would improve integration: "addressing financial and funding barriers, mostly through integrated funding and aligned budgets".[115]

One limit of any such model – even if nationally mandated – is that section 75s do not facilitate integration with other key parts of the SEND system, including education services and voluntary sector organisations. Respondents to the call for evidence identified this as a gap, limiting the potential of section 75s for truly joined-up and preventative support.[116]

Option 3: Pilot a 'Total place 2.0' with specific focus on SEND

Another option is for the government to launch a revitalised version of the Total Place initiative, introduced under Gordon Brown in 2009.[117] The initiative encouraged

agencies in a local area to count how much they collectively spent on services, identify duplication, and pool budgets to redesign services around user need. Evaluations found that programmes either delivered or were on track to deliver a range of improved outcomes, and reported falling demand for acute services.[118]

Our 2025 report sets out in detail how such an approach could be implemented, but we do not believe it requires large amounts of additional investment, instead making better use of the money that SEND services already spend in an area.[119]

The cross-government working group on SEND must create shared, national systems and processes for SEND

8. The cross-government working group on SEND must create shared national systems and processes for SEND

Local areas that want to work together must currently devote considerable time to "reinventing the wheel" to align systems and processes across partners.[120] As a result, more than 150 parallel efforts may be under way – one in each local authority in England with responsibility for education – to solve a problem created by a lack of co-ordination in central government. When all areas are facing the same problems, localised problem-solving is inefficient and cannot overcome issues that arise when services need to work across geographic boundaries, such as when children move between areas.

This does not mean eliminating local flexibility over how services are delivered, but areas should not have to build the basics from scratch. The government should standardise core systems and processes in SEND, creating a national 'backbone' that enables consistency and interoperability between partners and across areas, while leaving local areas free to adapt delivery to their circumstances.

8(a) Set out a clear role for local authorities in the SEND system, leaving flexibility over the tasks they must carry out

A senior government official at our roundtable accepted that the core responsibilities of local authorities in the reformed SEND system have yet to be defined.[121] This is particularly concerning given local authorities had to submit SEND reform plans by mid-June 2026 – without a clear understanding of where they fit into the system.

As set out above, strong partnerships rely on all parties being clear about what is expected of them and of others – it cuts down on distrust, time-wasting and turf wars.[122] It is therefore critical that the role of local authorities is clearly defined and centrally mandated, so that local areas are not left to interpret and reconstruct these roles independently.

Their role may, for example, include oversight of emerging delivery models such as school clusters (more on which below).* There are also important gaps in responsibility for young people with SEND who are out of education, which local authorities may be best placed to fill. For example, while EHCPs can legally extend to the age of 25, the services available beyond education are often very different, and in practice support frequently falls away.[123]

However, most interviewees were clear that central government should not prescribe *how* local authorities fulfil these roles.[124] Some degree of flexibility will be essential. Local authorities face markedly different structural constraints – for example, there is variation in how local authority boundaries align with ICB footprints and rural areas, where populations and services are more dispersed, face specific practical challenges

in delivering integrated services. Instead, the government should define *what* local authorities are responsible for, while leaving flexibility over how those responsibilities are delivered.[125]

One stakeholder raised concerns that this level of local autonomy may sit uneasily with the current lack of trust in local decision making.[126] But instead of responding by prescribing how services should be delivered, the government should focus on setting clear outcome-based success metrics (as recommended above). If well-designed, these will reflect what both the government and families ultimately care about. Trust is more likely to be rebuilt by showing progress against these measures than by imposing a single delivery model that may not work in all areas.

That said, while central government should avoid prescribing delivery models, one area of emerging best practice that local authorities may find it helpful to adopt – given the emphasis in these reforms on inclusion and early intervention – is the closer alignment of their SEND functions with other school-facing functions. Two interviewees noted that these often sit in separate teams, with narrow school admissions and school improvement functions hived off from teams focusing on the statutory end of SEND.[127] This separation can undermine inclusive practice by disconnecting decisions about school placements from an understanding of a child's needs. It also reinforces a reactive model, where SEND expertise is concentrated in statutory processes, rather than embedded across the local authority.

Hertfordshire County Council provides an example of a more integrated approach. It dissolved its isolated statutory SEND service team and instead embedded education, health and care co-ordinators across multiple service areas.[128] This means statutory accountability sits across multiple teams, creating a sense of collective responsibility for inclusion and enabling SEND staff to more easily build a holistic view of the child across different services.[129]

* The clusters, as envisaged in the section below, may also provide a mechanism for local authorities to ensure trust-led schools are accessing appropriate specialist input (although see also the issues relating to trusts discussed in that section).

8(b) Establish 'school clusters' as local strategic commissioning hubs for SEND support

DfE proposes, as part of its SEND reforms, that schools could come together in local groups, which "will pool some funding, share resources and work together to improve and expand the help and support available to children".[130] It has yet to flesh out what exactly these structures will do, what they will look like, or how they will interact with other institutions: it should do this.

Based on case studies of two areas with similar models already in place (case studies 4 and 5 in the Annex), we propose that these groups, or school clusters, could operate as local strategic* commissioning hubs for specialist SEND support. This could, for example, be the ideal level at which to eventually commission support for the 'experts at hand' offer, allowing constituent schools to share scarce expertise such as educational psychologists, speech and language therapists and occupational therapists.

Evidence from those existing models suggest that the effectiveness of school clusters depends on several key design features:

- **Stable, multi-year funding** to enable strategic decision making and avoid short-term, school-level competition for resources, as seen in the initial roll-out of Kent's Communities of Schools model.

- **Alignment with administrative health boundaries.** Kent aligned its clusters with primary care networks, enabling schools to signpost more effectively to external support. As single neighbourhood health services develop, they could provide a similarly sensible geography for organising school clusters. Geographic alignment is also important for the 'experts at hand' offer, as it allows specialist staff who are commissioned through the clusters to be more easily integrated within NHS structures, ensuring they have appropriate clinical supervision and clear opportunities for career progression.

- **A clearly defined relationship with local authorities**, otherwise clusters risk commissioning provision that conflicts with the wider local SEND offer. Local authorities may also need to play a formal role in oversight and, where necessary, arbitration, providing a clear point of authority for resolving disagreements between schools. As the Manchester Special Schools Partnership illustrates, the absence of a clear arbiter can lead to decisions that default towards pragmatism rather than system-wide efficiency.

- **Empowered participants.** Effective participation in clusters depends on members having the authority to act on behalf of their institutions. In Kent, meetings are

* We suggest that school clusters are better suited to strategic decision making (as in the Kent case study) than to allocate funding for individual children (as in the Manchester case study). Given the system shift towards earlier intervention, clusters are likely to add most value when used to plan provision at a cohort or system level, rather than adjudicating individual cases. This also links back to the importance for early intervention of shifting away from individualised funding models, explained in more detail in the section above on funding.

attended by SENCos, but interviewees noted that their ability to take decisions varies significantly across schools.[131] Where SENCos are trusted and empowered by headteachers, the model works more effectively; where they are not, decision making is constrained and engagement is weaker.

- **Diverse membership across school phases.** As the Aylsham case study illustrates (see case study 2), if school clusters bring together schools across different phases, they can support more effective transition planning (the process of supporting children as they move between educational stages).

- **Time to build relationships and change behaviour.** Kent's experience in establishing its Communities of Schools model highlights that significant time is required to build trust between schools and with the local authority, as well as to shift behaviours towards prioritising system-wide interests rather than individual institutional priorities.[132]

One key outstanding question is how school trusts will fit into this picture. Many trusts are not geographically bounded, so may sit across dozens of school clusters, each with different priorities, commissioning practices and inclusion strategies.

This creates operational tensions. If a trust straddles many school clusters, this will introduce more variation into how SEND provision is organised across its schools. As a result, it may be less able to deliver some of the key benefits associated with trust structures, such as streamlined administrative processes and the pooling of specialist resources.[133]

This disconnect between clusters and trusts also risks muddying accountability. Responsibility for SEND provision and inclusion would become harder to attribute in trust-led schools, as both trusts and clusters take relevant decisions.

8(c) Design a robust mechanism to resolve disputes between local delivery partners

Even with the recommendations set out in this report, some disagreements between delivery bodies will inevitably arise, and will need to be managed. But there is currently no effective mechanism for resolving these disputes.

This is particularly critical given that, under the proposed reforms, schools will have statutory responsibility for all tiers of SEND provision, and local authorities only for the highest tier. As we have illustrated, similar disconnects have previously created incentives for schools to escalate children into higher tiers of provision, even where this is not necessary.

There is no obvious way to resolve disputes between delivery partners, and interviewees and roundtable participants expressed uncertainty about the best approach. One option would be for existing regional bodies to mediate when local partners cannot agree, but the government would need to do more work to flesh out whether and how this would work in practice.

8(d) Develop approaches to regulating services in a place

Currently, local area partnerships are held to account for the quality of SEND services through joint Ofsted and Care Quality Commission inspections. However, the consequences of these inspections tend to fall disproportionately on local authorities, which have limited levers to hold academy schools and health services to account or to drive system-wide change.[134]

At the same time, each service remains subject to their own inspection framework. This creates confusion about priorities within local systems and can encourage organisations to retreat into their own silos, rather than working collaboratively. As a result, joint inspections risk being treated as a standalone exercise, rather than embedding partnership working into business-as-usual delivery.

The government should therefore develop a more integrated approach to regulating SEND services across local areas. Forthcoming Institute for Government work will set out recommendations for how this can be achieved.[135]

8(e) Establish clear and consistent communication channels between service users and local partnerships – as in Northumbria and Hertfordshire

There are myriad services designed to help parents navigate the SEND system,* which points to a fundamental failure of signposting and communication. Parents explained how difficult it was to know where to direct their feedback, leading to frustration and disengagement.[136] Practitioners also reported challenges understanding what services were available locally and identifying the right points of contact within them, making it difficult to signpost families and coordinate support.[137]

Research on partnership working emphasises the importance of families experiencing the SEND system as a single, coherent entity, and of local services having clear channels for communication.[138]

One practical solution is the introduction of dedicated roles within local areas to act as single points of contact.[139] The NHS trust in Northumbria appointed a 'strategic lead', who acts as a clear contact for parents, local authority staff and health professionals seeking to engage with providers of health services for children with SEND (case study 6 in the Annex). Emerging learning from the government's change programme (a national programme to test some of the SEND reforms) suggests that roles like this give services and families a clearer understanding of local pathways to support, and can help reduce unnecessary referrals.[140]

These roles can also provide channels for feedback from children, parents and practitioners. To ensure this feedback is captured, escalated and acted upon, these channels must be supported by formal governance arrangements.

* There is, for example, a SEND information advice and support service (or SENDIASS) in every local authority in England that provides free, impartial and confidential information to young people with SEND and their parents and carers.

In Northumbria, the strategic lead sits on various governance boards, where they can raise issues identified by parents with providers, and escalate concerns to a trust-wide committee. This creates a clear line of sight between front-line issues and senior trust leadership, strengthening accountability.

Hertfordshire's SEND quality assurance board also uses feedback to drive improvement, including through audits of EHCPs that capture the views of parents, carers and children (case study 7 in the Annex). The council created two practice development lead roles to translate learning from the audits into action, such as by updating staff training.

Following these changes, and alongside a wider transformation programme, the proportion of parents and carers in Hertfordshire reporting satisfaction with the EHCP process rose from 43% to 68% in just over two years.[141]

A common theme across all these models is the importance of proper resourcing and protected capacity, to stop the roles, or board membership, from being absorbed into already overstretched functions.[142]

8(f) Establish data sharing arrangements so that areas can link the health, education and social care data of children with SEND

Local areas – even those with strong partnership working – consistently identified data sharing as a major barrier to service integration.[143] Information about children with SEND can sit on upwards of five different systems in any given area, and is often fragmented even within individual services. For example, community and acute services within the same ICB often operate on separate platforms to each other. This leaves community teams unaware when a child with complex needs is admitted or discharged from hospital, forcing them to rely on parents to relay critical information.[144] We also heard examples within community services, where, for example, school nursing teams were unable to access data from child and adolescent mental health services to know which children needed support while they were on waiting lists.[145]

These challenges are particularly acute at transition points, such as when a child moves from primary to secondary school, or between local areas – where incompatible systems can make it difficult to track a child's progress over time. They also undermine early intervention. Health services often have the earliest insight into a child's needs and are required to notify local authorities if they identify a child under school age with SEND in the area. But in some areas, this function does not work at all, meaning children with complex needs can arrive on a school's doorstep at age five, unknown to the school or local authority.[146]

Weak data sharing also undermines accountability and trust within local partnerships. Without a shared, reliable evidence base, services lack a single source of truth to guide decisions, resolve disputes, and demonstrate the benefits of collaboration.[147] Parents, meanwhile, are too often left repeating the same information to multiple services.

Interviewees also highlighted the importance of data linking: creating an enhanced data source by combining datasets relating to the same person.[148] Linked data can help services systematically identify children at risk of adverse outcomes, target support, and assess the impact of interventions, but is rarely used.[149]

Work led by the University of Sunderland identified several barriers to linking children's data in Sunderland and South Tyneside, including the absence of a consistent way to identify children across services, unclear and inconsistent data protection processes, the significant resource it required from services, and cultures of risk aversion within organisations.[150]

The planned introduction of a single unique identifier for children – intended to make it easier for the multitude of services interacting with children to share and link information – is a promising development in this space.[151] Beyond this, the University of Sunderland recommends that central government develop best practice guidance and information governance templates, alongside setting out a national mandate and funding to link the health, education and social care data of children with SEND.[152] And at a local level, one possible approach is for services to set up a shared, jointly funded office for data analytics – a model that has proved successful in Suffolk.[153] Forthcoming Institute for Government research sets out further actions that central government must take to improve data sharing across local areas.[154]

8(g) Promote shared language across services by a national needs classification or by providing shared training programmes

Agencies often use different terminology to describe the same children and needs, making it difficult for them to connect around the child. Research led by the University of Sunderland found a startling lack of overlap between how services categorise children's needs – with, for example, education services using the phrase 'learning difficulties' where health and social care typically use 'learning disabilities'.[155] This can, unintentionally, affect children's eligibility for services and ultimately make it harder for services to plan provision together as they do not have a common understanding of the needs of the cohort.

A second, related, problem is that elements of the SEND code of practice – statutory guidance setting out how services identify, assess and support children with SEND – rely on diagnosis to define need, potentially delaying support for children who have not yet received a diagnosis or who may never require one. This sits uneasily with the government's ambitions on early intervention.

Recent research finds that countries with the most comprehensive multi-agency approaches tend to use standardised classification tools, such as the World Health Organization-endorsed International Classification of Functioning, Disability and Health, to provide a common language focused on children's needs, rather than relying on diagnostic categories.[156]

In this vein, the government plans to update the SEND code of practice to move away from a reliance on diagnosis, instead focusing on key areas of child development.[157] The intention is that this will support needs-led provision by focusing more directly on barriers to learning and participation.

The government's proposals mainly envisage this classification being used by "educators",[158] but, as noted above, consistent use across education, health and care would be needed to support joined-up working. Joint learning and development programmes could help to embed this shared language across education, health and care services.[159] Parents and children should also play an active role in shaping how this needs classification is communicated to families.

Conclusion

The government's SEND reforms will succeed or fail on their ability to bring services together around children and families. And when poor partnership working is the norm across England, the problem is not local – it is systemic.

Central government cannot afford to stand on the sidelines. It must recognise itself as a critical partner in the SEND system and take responsibility for the conditions it creates, from incentives and funding to processes and accountability. If it does not, it risks recreating the trends that have beset the SEND system over the last decade: rising costs, frustrated services and poor outcomes for children.

That starts with being clearer about what success looks like, how it will be measured, and the resources needed to deliver it. It will require a working group to keep departments aligned and maintain momentum behind reform. Government must be realistic about what the health system can achieve, and design funding arrangements that reward collaboration rather than cost-shunting. All this would benefit from standardised systems and processes where there is little benefit in asking every area to design its own.

Annex 1: Key ongoing public service reforms

Table 1 **Key reforms affecting services that deliver SEND provision**

Service	Reforms from this government	Timeline
Early years	• Implementing a 'Best Start in Life' strategy, including roll-out of Best Start Family Hubs, local hubs with SEND support functions.[1]	• Create up to 1,000 hubs across England by 2028.[2]
Schools	• Indicating it would like all state schools to join or be part of trusts[3] and applying many of the same rules that apply to local authority-maintained schools to academy trusts.[4] • Reforming the Ofsted education inspection framework, including introducing a new judgment on 'inclusion'.[5] • Reforming the national curriculum, including changes to allow better adaptation of teaching to children with SEND.[6]	• No confirmed timeline for a fully trust-led system.[7] • New framework in use since November 2025. • New curriculum in use from September 2028 (published in spring 2027).[8]
Health	• Abolishing NHS England, bringing many of its functions into DHSC. • Consolidating the existing 42 ICBs into 26, while cutting 50% of ICB staff. • Introducing 'integrated health organisations' and single- and multi-neighbourhood providers.[9]	• By April 2027.[10] • By April 2027.[11] • By ~ March 2029 (less developed plans).[12]
Local government	• Consolidating the 21 areas with two tiers of local government – county and district councils – into unitary authorities; 19 existing, smaller unitary authorities have also been invited to reorganise.[13]	• Most new councils are expected to be operational in April 2028.[14]
Children's social care	• Introducing regional care co-operatives, which will sit above local authorities and plan and commission children's social care.[15] • Rolling out the Families First Partnership Programme – a suite of reforms to children's social care, including the establishment of multi-agency child protection teams in every local area.[16]	• No confirmed national roll-out (two pilots already under way).[17] • Multi-agency teams established from 2027.[18]

Annex 2: Case studies

Case study 1: EBSA provision in Southern Cross School

In response to a growing cohort of children missing school due to extreme anxiety,[1] Southern Cross School – a special school in Manchester for pupils in Years 5 to 11 – developed a specialist offer for children with EBSA, in partnership with Manchester City Council.

This model is based on the principle that, for these children, the school building itself is the primary barrier for learning. As a result, the school delivers support in the child's home or community, following a structured pathway that builds gradually from relationship-building to academic support in core skills like English and maths – and if the offsite model is successfully facilitating progress, there is no pressure to return to the main school.

This model has enabled children with extremely low attendance (some as low as 3%) to re-engage with education and work towards qualifications. Nearly half (46%) of pupils in Key Stage 2 or 3 on the EBSA pathway have improved their attendance by more than 5 percentage points compared to the previous year; in Key Stage 4, 21% on the EBSA pathway have achieved the same level of improvement.[2]

Case study 2: The Aylsham Community Trust (Families)

Aylsham Cluster Trust – comprising Aylsham High School and eight feeder primary schools in Norfolk – established a charity, TACT(Families), in 2020. The charity's primary funding comes from grants and donations, supported by income from Aylsham High School's community-use facilities, including a 3G sport pitch, gym and swimming pool.

TACT(Families) supports the funding of a social emotional and mental health team, including a former nurse and a former social worker, that works across the trust. The team delivers one-to-one and group support for pupils, alongside workshops for parents on issues such as anxiety and school avoidance. And through outreach to the feeder primaries, the team works with children from as early as Year 1, supporting earlier identification and intervention. This reduces the number of pupils arriving at the high school with unmet needs, while also allowing the school to 'horizon scan' and plan provision around future cohorts. It also means pupils transition to the high school with an existing relationship with staff, making the move smoother.

Through the support of the same charity fund, the trust has engaged a psychotherapist, who works with children and families, while also supporting the wellbeing of school staff – particularly designated safeguarding leads.

Case study 3: Sunderland's jointly funded SEND commissioning role

Together for Children (a company that delivers children's services on behalf of Sunderland City Council) and North East and North Cumbria ICB jointly fund a 'strategic SEND commissioning lead' who works across both the NHS and council, including spending time in both offices throughout the week.

The role relies on influence and relationships rather than formal authority, acting as an impartial bridge between services. This is enabled by the post-holder's strong understanding of each partner's strategies, priorities and culture, so they can take a system-wide view to identify opportunities for alignment and collaboration. The post-holder describes their approach as akin to a "Dragon's Den pitch", making the case for collaboration to public health, social care, health and education leads, while working from within each service's perspective and culture.[3] Much of the work takes place behind the scenes, building agreement in advance so that formal joint commissioning meetings become a point of agreement rather than conflict.

The impact has been both practical and cultural. Sitting across organisations gives the role-holder a unique vantage point to identify duplication and overlap in service delivery. The role has also streamlined internal processes, merging meetings to reduce duplication, and providing clear ownership for tracking progress and risks in joint commissioning projects, where responsibility had previously been unclear.

Over time, this has shifted behaviour across services. Instead of having to go "cap in hand" to ask for funding for a project, the role-holder now sees partners proactively bring forward pots of money and asking where the gaps are.[4]

An example of a joint-funded project facilitated by the role is the roll-out of Early Talk Boost – an intervention developed by the charity Speech and Language UK in which speech and language therapists train school staff to identify and support communication needs in three- and four-year olds.[5] The role-holder identified that public health services, the local authority education lead and NHS trusts were each planning separate speech and language interventions, and brought partners together to deliver a single, co-ordinated programme that met individual service requirements.

All education settings catering to this age group now have access to the programme. Since April 2025, 234 education practitioners have been trained and 171 children have completed the intervention, with 51% closing the gap with their peers and 31% narrowing it by half or more.[6]

Case study 4: The Manchester Special Schools Partnership

The Manchester Special Schools Partnership was established in 2014 by Manchester City Council in partnership with local state-run special schools. The model devolves a portion of the local authority's high-needs block funding to a shared pot, managed collectively by special school headteachers.

The pot is intended to support children whose complex needs cannot be met through standard budget allocations, enable peer review of proposed interventions, and support placements within local state provision rather than independent special schools.

The partnership meets on a half-termly basis. All state special school headteachers attend, alongside local authority finance representatives. Schools submit cases for additional funding, which are subject to a peer moderation process. This involves two headteachers from other schools visiting the pupil and returning to the next meeting with a recommendation to either confirm funding or suggest alternative approaches.

Since the introduction of the model, the proportion of pupils with EHCPs educated in independent special schools has reduced from 4–5% in 2010–13 to 2–3% from 2019 onwards. In contrast, rates across the North West and England have remained at around 5%.

It is, however, reported to be "very rare" for headteachers to refuse their peers' requests for funding.[7] This reflects both a reliance on professional trust and the absence of a clear mechanism to manage disagreement. Where requests for funding are not agreed, the school may inform the local authority that they are unable to meet a child's needs. This can result in the local authority securing a placement in an independent setting, often at significantly higher cost than the original funding request, or agreeing to fund provision through a different budget, bypassing the partnership process. In this context, agreeing funding is often the more viable option, even where headteachers consider that needs could be met without additional resource.

Case study 5: Kent Communities of Schools

Following a few years of preparatory work with schools, Kent County Council began roll-out of its Communities of Schools (CoS) model in September 2025. CoS brings groups of schools together into local clusters, each responsible for allocating a shared funding pot to meet the needs of pupils with SEND across their area. Funding is intended to be used strategically at cohort level, rather than for individual children on a case-by-case basis. It represents a shift towards school-led decision making, aiming to make better use of school expertise, support collaboration between schools, and move away from a 'them and us' dynamic with the local authority by embedding greater shared understanding of the system's financial constraints.

Each community is led by an independent chair, typically a headteacher from a different part of the county, and supported administratively by a clerk, with the council funding both roles. Communities meet eight times per academic year and are attended by local SENCos, who are expected to take decisions on behalf of their schools. Chairs also meet separately to review progress across CoS and update operational guidance for the clusters.

The model is supported by wider system infrastructure. Clusters are aligned with primary care networks – groups of GP practices working with other health and care providers – to support closer integration between schools and health services.

A Professional Resource Group, a Kent-specific multi-agency body funded from the high-needs block that includes educational psychologists and speech and language therapists, also provides co-ordinated support to schools.

Prior to roll-out, Kent undertook a few years of groundwork to improve relationships between schools and the local authority, and between schools themselves. This included the use of 'inclusion champions' to lead practice change, including a trust-based SENCo working across primary, secondary and special schools, whose independence from the local authority and professional credibility helped build trust with schools. As part of this work, schools developed a shared 'continuum of needs and provision', a document that establishes a common understanding of 'exceptional need' and supports more consistent decision making. According to an interviewee, this has contributed to schools becoming more open in sharing practice with each other and with the local authority.[8]

The model remains at an early stage of implementation, and initial roll-out has been accompanied by behavioural challenges and funding anxiety. Despite the intention to use the funding strategically, some clusters have approached the model as an opportunity to secure resources for their own settings, in part reflecting uncertainty around future funding for CoS.* In other clusters, however, discussions have been more strategic, focusing on improving transitions between school phases, developing parental workshops, and making use of shared local resources.

Case study 6: A dedicated voice for providers in Northumbria Healthcare NHS Foundation Trust

In 2019, Northumbria Healthcare NHS Foundation Trust created a 'SEND strategic lead' role to act as a single point of contact for health providers delivering SEND services. Historically, parents, local authorities and those working within the ICB needed to contact individual services directly if they had a query. The role provides a clear front door for engaging with providers, enabling more effective co-ordination across services. While the lead does not hold all the operational detail, they are able to navigate the trust's internal structures and draw on established relationships to identify the appropriate contacts.

The strategic lead also represents providers within the local SEND partnership boards. In many partnership boards, the health perspective is primarily represented by commissioners or designated clinical officers responsible for the ICB's statutory SEND functions. The addition of a provider voice enables more detailed operational insight. For example, in discussions about gaps in provision, the lead is able to articulate specific clinical criteria for service access and provide a detailed understanding of local need.

The role is embedded within various governance arrangements and provides a route for escalating issues identified on the ground. The strategic lead maintains links with local parent carer forums through their participation in the strategic boards of the two

* The model has to date been funded through the government's time-limited Safety Valve programme, which supports local authorities with significant DSG deficits.

local authorities covered by the trust, also attended by forum representatives. They also respond to parents' queries and feedback relating to health providers as part of their role. While the strategic lead does not directly manage all services working with children and young people, they maintain links with these services through an internal SEND forum that monitors performance and discusses quality improvement initiatives and challenges related to SEND. And formal reporting mechanisms ensure that SEND-related issues can be escalated to trust-wide governance structures as needed.

Together, these arrangements create a clear line of sight from front-line issues to senior leadership within the trust, strengthening accountability for addressing SEND-related concerns.

A key challenge for the role is capacity. The strategic lead continues to hold additional senior management responsibilities and also leads some clinical services. They noted that having additional administrative support for two days a week has been invaluable in helping them manage the extra workload.

Case study 7: Hertfordshire's quality assurance process

Hertfordshire County Council launched a SEND transformation programme in 2023 to address rising EHCP demand and parental dissatisfaction with service quality. A key element was the establishment of a quality assurance (QA) function for SEND, including via a QA board and underpinning QA framework, designed to move the system away from a "blame culture" and towards a model of continuous quality improvement and multi-agency working.[9]

The board is co-chaired by the local authority and the ICB, with representation from NHS and local authority commissioners, providers of health services for children and young people, council services for young people and the chair of the local parent carer forum.[10] The NHS SEND regional lead also attends, supporting the exchange of learning between the board and other areas.

To evaluate service quality, the board reviews routine performance data, carries out both thematic and individual audits of EHCPs that capture direct feedback from parents, carers and children, and visits local authority and NHS services to follow the patient pathway and understand how young people and families experience the system.

The QA function places particular emphasis on 'closing the loop' between front-line feedback and workforce development. Two practice development lead roles were created to ensure that learning is translated into action, including through updating the curriculum of the SEND Academy – a six-week intensive training programme for staff – so that identified issues inform staff training and practice.

Following these changes, alongside wider transformation activity, the proportion of parents and carers reporting satisfaction with the EHCP process rose from 43% in April 2023, to 68% in June 2025.[11] And over each of the four quarters to Q2 2025/26, compliments exceeded complaints for the first time since data collection began.[12]

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