



Issued under the Education Tribunal for Wales Regulations 2021

Decision

Child's Name: The Child

Appeal of: Parent A

Against: The Local Authority

Hearing Date: 2024

Panel: Judge
Specialist Member
Specialist Member

Other Persons Present:

The Child
Parent A
Parent B
Parents Witness
Counsel for the LA
ALN Lead Officer and LA Representative
Lead (Mainstream Schools) Speech and Language
Therapist
Clinical Lead Occupational Therapist
Observer

1. **Introduction** – this appeal is brought under section 70 of the Additional Learning Needs and Education Tribunal Act 2018 (the 2018 Act). It is against:

- the description of The Child’s Additional Learning Needs (ALN) in their IDP,
- the additional learning provision (ALP) in their IDP, or the fact that the ALP required is not in the IDP,
- a decision by the local authority not to take over responsibility for their IDP, which a school maintains, when the child or their parent, a young person or the governing body of that school has asked the local authority to maintain it instead.

2. **Background** - The Child has Trisomy 21 Downs Syndrome with associated motor, learning and some sensory differences. The Child lives at home with their parents. They have an older sibling, and two younger siblings. They attend Primary School along with their siblings. They are happy attending there and there is no issue about them continuing to do so.

3. The Child communicates using a mix of talking, gesture, Makaton signing, body language and behaviour. They prefer to learn by engaging in play and activities they are interested in rather than in a more formal structured way. They understand more than they are able to express.

4. **Representation** - The Parents represented themselves with Parent A taking the lead. Counsel, represented the local authority (LA). We thank them for their hard work in preparing and presenting their respective cases.

5. **Evidence** – We have considered the bundle of documents helpfully prepared by the LA and the evidence we have heard orally. We were also provided with a Working Document, being a version of The Child’s IDP that both parties had worked upon and inserted the wording they respectively proposed be adopted.

6. **The Parents’s Case** – They wish The Child to continue to be educated in a mainstream setting but are concerned that in order for them to do so they require appropriate support. They argue that they require direct and indirect Speech and Language Therapy (SALT) (54 hours per year) and Occupational Therapy (OT) (30 hours per year). The SALT they argued for was a one hour session each week at school in term time and six hours at their home during the school holidays. The specific wording was set out in the Working Document. The Parents also assert that as this is all ALP to meet The Child’s educational needs it should be set out in section 2B of their IDP. They relied upon expert reports from the Independent Advanced Clinical

Specialist Speech & Language Therapist 1 (Down's Syndrome,) Independent Speech and Language Therapist 2, and Independent Advanced Practitioner Occupational Therapist (OT)

7. **LA Case** – There was a fundamentally different approach put forward by the LA. It asserted that The Child's needs can be met and are being met by the NHS approach in delivering therapies through a psychosocial model in collaboration with their school. They assert the NHS model takes into account the balance between The Child's ALN and their therapeutic needs. The LA relied upon expert reports and oral evidence from the Lead (Mainstream Schools) Speech and Language Therapist and Clinical Lead Occupational Therapist (OT)

8. The LA also argued that if it were directed to fund private therapies this would firstly be in conflict with the NHS model currently in place leading to confusion, and secondly would result in unreasonable public expenditure as the NHS can provide the required provision.

9. **The Expert Evidence** – We have noted from the up-to-date SALT reports the following evidence.

10. **Report of the Independent Speech and Language Therapist (SALT) 2 dated 2024** – We note that they have worked with The Child since 2016. They states:

“The Child has a diagnosis of Down Syndrome (DS) Trisomy 21. Independent speech, and language therapy for The Child is informed by a syndrome specific approach. One key aspect of this is that DS is associated with a distinct speech and language profile that does not mirror cognitive development. Speech, language, and communication development in children with DS is not merely delayed in line with their cognitive skills.”

“The Child communicates using a mix of talking, gesture, Makaton signing, body language and behaviour”

“Independent school-based therapy comprises a combination of direct in-person therapy, and closely supported activities for follow up work. Coaching and modelling strategies is an intrinsic part of my role in working alongside school staff and parents.

“The Child's speech, language, and communication needs directly affect their access to the curriculum and are considered educational needs.”

“A specialist speech and language approach such as Shapecoding (by Susan Ebbels) is useful to visually reflect to them the grammatical patterns”

“School staff require ongoing coaching and support to use the Shapecoding that The Child needs.”

“They have complex speech needs that are not simply delayed. Their speech requires direct speech and language therapy as well as an indirect, closely supported delegated programme of work in school and at home.

11. The Independent SALT 2’s recommendations are at pages 541/542 in the bundle. They include:

“The Child needs intensive school-based speech and language therapy intervention, involving weekly speech and language therapy sessions, (or a minimum of 10 sessions per term) each of 1 hour duration, to include direct and indirect intervention, during term time.”

“In addition, half termly home sessions would support carry over and development at home.”

“This intensity would support ongoing progress in speech and language. DS CEN national guidelines highlights that the amount of direct in-person intervention matters.”

“The Child needs a combination of direct speech and language therapy and indirectly, a delegated programme of work in school, with ongoing support from a speech and language therapist for implementation by school staff.”

“Within their school environment, The Child speech, language and communication development needs a familiar, attuned adult who can provide:

- Active Makaton signing to accompany targeted vocabulary and grammatical development,
- Focused speech practise under close guidance from a speech and language therapist,
- Flexibly tailored curriculum linked language activities that include specialist strategies eg: Shape Coding,
- A playful, positive approach that actively encourages initiation and interaction with peers.”

“The Child needs continuity and regularity in face-to-face therapy provision because their relationships and rapport with supporting adults underpins the

support they receive, and affects their communicative confidence, engagement, and progress in therapy.”

12. Lead (Mainstream) SALT’s Evidence - We note that the NHS therapists have also known The Child for some years. Lead (Mainstream) SALT’s report dated 2024 states:

“Over the past academic year, The Child has broadly been offered 4 sessions each half term. This consisted of two sessions at the beginning of the half term for the SLT to demonstrate and discuss the targets with school staff. Two further sessions were then offered towards the end of the half-term to review how things have been going and support with any issues that had arisen.”

“We consider that, in line with a social model of healthcare, the professional is the catalyst for change and that targeted work aims to embed therapeutic principles in the daily life of the child or young person, rather than taking children out of their context and into a clinical setting, and potentially causing harm through missed interaction with peers and learning opportunities in education”

“We consider that a combination of direct and indirect speech and language therapy intervention, following the model provided this academic year, with a focus on building the capacity of those adults around The Child to provide an appropriate communicative environment and use effective support strategies specific to their individual needs, will allow them to continue to develop and will reduce the impact of their current needs.”

13. The Lead (Mainstream) SALT recommendations are at page 565, as follows:

“4x hour-long sessions, to include both direct and indirect elements of intervention, per half-term, with both family and school staff involved in sessions.”

“Working jointly with both family and school staff ensures that The Child can access an intensity of support which promotes both overall progress and generalisation of skills into everyday life. It ensures that The Child is not dependent on a particular individual to be able to access the communication support they need, but rather can be confident that the support is available from all their trusted adults within any learning activity they are involved in.”

14. **Assessment** – It will be seen that there is a difference in these expert recommendations. The difference is not a large one. They are both of the view that some direct speech and language therapy input is required. They are both of the view that a programme of activities is also required, which is overseen by a SALT, but provided by staff at the school, and that it is important that the approach taken is the same throughout the school day and also in The Child’s home. The Lead (Mainstream) SALT has recommended four periods of direct work per half term, two towards the beginning of the term and two towards the end. The oral evidence provided by The Lead (Mainstream) SALT was firm, that their suggested intervention was what The Child required, and nothing more. The Independent SALT 2 recommended direct work each week, which would amount to 6 sessions per half term. There is therefore a difference in the frequency of involvement of the SALT. This reflects the difference in view about The Child’s needs. The Independent SALT 2 is specific about the need for more frequent involvement based upon the research they refer to in respect of children with their diagnosis. This suggests that frequent input and specific targeted input from a SALT, both in language and in speech benefits children with Trisomy 21 Downs Syndrome.

15. In their report The Lead (Mainstream) SALT based their approach on working with The Child to provide an “appropriate communicative environment”. This was the basis for their view that that the environment around The Child was more important than directly teaching them skills. When questioned, however, they conceded that, “They won’t necessarily learn through just exposure. They will need support regarding the structures of language” and “They will need the strategies to be taught. We have used colourful semantics as a visual prompt. We are now using shapecoding.” Based on this evidence we decided that there is a place for direct work with The Child by a SALT, and that teaching them strategies and techniques, which they can then apply on a daily basis, is the appropriate way forward. That accords more with the model put forward by The Independent SALT 2.

16. We also noted The Lead (Mainstream) SALT’s view, given in answer to a question about having SALT from more than one provider, that, “..having 2 different approaches is unhelpful.” We agree that two approaches might be confusing for The Child.

17. We gave particular weight to the fact that The Independent SALT 2 has worked with The Child directly over a number of years, and has particular expertise of the speech and language difficulties of children with a diagnosis of Trisomy 21 Downs Syndrome. The Lead (Mainstream) SALT has not worked with The Child directly for the same period of time and does not have

a specialism in the communication profile of children with Trisomy 21 Downs Syndrome. Whilst they are obviously an experienced professional, we found their evidence of the provision that The Child requires to be based on the model of provision offered by the local NHS service rather than their needs.

18. We also remind ourselves that in Wales we have to consider the United Nations Convention on the Rights of the Child (UNCRC) specifically referred to in paragraph 5.11. of the Additional Learning Needs Code for Wales 2021. Those include:

“Article 23

1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child’s active participation in the community.

2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child’s condition and to the circumstances of the parents or others caring for the child.

Article 29

1. States Parties agree that the education of the child shall be directed to:
(a) The development of the child’s personality, talents and mental and physical abilities to their fullest potential;”

19. Balancing all of these factors, and the Convention rights, for the reasons given above we prefer the evidence and approach of The Independent SALT 2 and conclude that the greater frequency of direct SALT engagement they recommend is the appropriate provision for The Child. We agree with their report that for The Child the frequency of such intervention is capable of making a significant difference to their development of speech and language skills.

20. We have further concluded that both direct and indirect work should be carried out during the one hour per week of speech and language provision. We do so on the basis that although a skilled therapist will provide a variety of tasks for them, and that there are different aspects of speech and language therapy which will be worked upon during each session, The Child is unlikely to be able to concentrate fully for a one-hour session.

21. The SALT input will also need to include monitoring, advice and modelling, so that teaching staff are able to continue the work during the course of the school day. The Child’s parents will also of course need to be

aware of the work that is being carried out so that they can maintain the same approach at home.

22. In relation to the question of the six sessions of speech and language therapy during the school holiday period, the evidence we heard from The Lead (Mainstream) SALT was that appointments could be arranged during the school holidays. This was in answer to the point that otherwise The Child would lose the continuity of the provision over the holidays. The Lead (Mainstream) SALT said, "We are a school age service not a school based service." They did not seek to argue against such provision in theory. They did not say the Health Board would provide it either, however. Based on the evidence of The Independent SALT 2 and the need to ensure continuity for The Child to help prevent them losing skills during the holidays, we consider it appropriate to order such provision

23. **Occupational Therapy** - The up to date reports we received were from Independent Advanced Practitioner OT, dated the 2024, which related to The Child's activities at a specialist summer camp, and the Report of The Clinical Lead OT dated 2024.

24. The Independent Advanced Practitioner OT flagged up the following issues for The Child:

"i) Concern about The Child's handwriting, where it would be appropriate to consider additional support around letter formation and handwriting, but also alternative ways of recording written information e.g. learning to type.

ii) Difficulty leaving school at the end of the day; they will sometimes sit down and refuse to move. It is helpful that the family live on the same street, but also stressful when it happens frequently.

iii) The Child has frequent meltdowns at mealtimes at home.... The meltdowns often occur with food that is more visually complex or requires higher skills to eat. Cutting up The Child's food does not make a difference, nor does eating separately to their family."

25. The Independent Advanced Practitioner OT does not make specific recommendations.

26. The Clinical Lead OT's report, supported by their oral evidence, was that The Child does not presently require direct occupational therapy within the school setting. They state:

“With a practice approach they are able to splinter occupational skills and there is underlying evidence of improvement in their motor skills to complete tasks as well as self-confidence and independence.”

27. In relation to handwriting The Clinical Lead OT states:

“The Child’s opportunity to record work will be reduced by handwriting fluency and stamina. Alternative methods of recording work need to be considered alongside appropriate opportunities to continue to develop their handwriting skills. School will be best placed to consider augmentation to recording based on the learning outcome being expected in each subject”

We take from this that it is, in their view, an issue the school can manage.

28. The Clinical Lead OT’s recommendations, at page 600, are to address targets they set out, and are:

“The Child will receive 4 sessions of direct 1:1 intervention with a review session after [amounting to 5 hours, travel time not included]. These sessions will take place at school and will be 2 weeks apart to give The Child time to practice and consolidate their learning between each session with their 1:1. This will then be reviewed.”

29. The Clinical Lead OT addressed the issue over The Child’s issue with transitions and conceded direct sessions of work were required to address this. They recommended direct work for three sessions of three hours duration each to assist with transitions, adding “going home” to their visual schedule, and the use of a special seat at home.

30. Otherwise, The Clinical Lead OT stressed that in their view The Child will learn new skills best by practising them in a real-life situation. They also recommended a termly review and agreed that OT would need to provide information for the annual reviews.

31. Unfortunately, The Parents have been unable to afford an up to date OT assessment of The Child. The wording that they suggested in relation to OT was not supported by any expert evidence. Parent A told us that they had set out wording they had gleaned from sources such as books, and taken the times from The Independent Advanced Practitioner OT, but they conceded the lack of supporting evidence. In these circumstances we have amended the OT ALP to reflect the evidence we read and heard from The Clinical Lead OT as it is the more current. We also note that the most recent written evidence we have from an occupational therapist on the appellant’s

side confirmed that two blocks of provision have been undertaken, and it was time now to move to a consultancy model of provision, which is in line with the evidence from the local authority.

32. **Who Should Maintain the IDP?** – Towards the end of the hearing it was conceded on behalf of the LA that it would maintain The Child’s IDP.

33. **Specific Amendments to Wording in the IDP** - No challenge was raised by The Parents to the items set out in italics by the LA in section 2A of the IDP. Unless they conflict with our own conclusions, therefore, we have accepted these suggestions.

34. We have removed some sections as they are repetitious. In relation to other specific wording, we have amended the IDP as follows in the next paragraphs.

35. *“There should be at least four specific short term (termly) targets, which should include targets related to the four components of speech and language: communication, vocabulary, grammar and speech clarity. ‘All experts identify the need to have separate targets for the four components of speech and language skill’ (Buckley and Le Prevost, 2002).”* - Applying our expert knowledge, we consider this to be unnecessarily specific and that it is better left in the hands of the SALT working with The Child.

36. *“Ring-fenced annual funding of £200 will be available to purchase suitable and motivating educational resources for The Child”.* – We do not consider this is required. It is subsumed into the advice and indirect work set out above and does not need to be specifically ring fenced to meet The Child’s needs.

37. *“interrupt them **for 10 seconds.**”* We consider this to be too specific and better left to those working with The Child.

38. *“To support The Child’s literacy and numeracy development, their daily sessions should be structured to maximize engagement and reinforce learning. It is recommended that The Child receives 15-20 minutes each for both reading and numeracy activities daily, as this duration allows for a deeper focus and retention of skills without overwhelming them.*

Structured, Skill-Specific Program: The Child will benefit from evidence-based programs like “See and Learn” and “Maths for Life,” with activities tailored to their current skill level. Each activity should be clearly aligned with The Child’s learning goals, ensuring a steady progression of skills. Training:

The trusted adult working with The Child should receive training on the “See and Learn” and “Maths for Life” programs, ensuring they understand how to implement each activity correctly and adapt them based on The Child’s responses. Training should cover program structure, individual activity techniques, and strategies for effective engagement.

Progress Tracking and Adjustments: To monitor The Child’s progress effectively, the trusted adult supporting them should keep simple records of their daily achievements and areas needing improvement. Regular review of their progress will allow for timely adjustments to the program, ensuring it remains challenging and engaging without being overwhelming.

Consistent, Trained Adult Support: A trusted adult who has received guidance on Down syndrome-specific teaching techniques and training in “See and Learn” and “Maths for Life” should work with The Child daily. This adult’s role will be to provide consistent support, reinforcing The Child’s learning strategies, and helping them stay focused and motivated throughout each session.”

We deleted these as we do not consider we have sufficient current evidence to support placing them in the IDP.

39. *“Multi sensory”* – We have left this in the wording as we heard evidence that this was agreed.

40. **Legal Issues** – Counsel for the LA cogently and forcefully argued that the provision for OT and SALT should be set out in section 2C of the IDP “Description and delivery of to be ALP secured by an NHS body.”

41. We note that the law prior to the passing of the 2018 Act did not make provision for the Tribunal to set out provision that was to be provided by an NHS body in this way. It is “new law” contained in the 2018 Act and the Code. Counsel for the LA relied on the Act and the Code, referring us to sections of both. They pointed out that the powers the Tribunal now has include specifying provision to meet Additional Learning Needs in section 2C, and the responsibility for providing this would then fall on the Health Board, even though it is educational provision. We will now set out the legal provisions and guidance so far as we consider relevant.

42. Section 3 of the Act sets out the definition of Additional learning provision as:

(1) “Additional learning provision” for a person aged three or over means educational or training provision that is additional to, or different from, that made generally for others of the same age in—

(a) mainstream maintained schools in Wales”

It will be noted that this is a broad definition. The provision merely has to be different or additional to that usually made available. Direct SALT and OT are capable of falling within this definition. There was no dispute in this case that the provision to be set out in section 2B or 2C was Additional Learning Provision.

43. Section 14 sets out:

“Duties to prepare and maintain plans: local authorities

(1) The duty in subsection (2) applies if a local authority is responsible for a child or young person and—

(a) in the case of a child the local authority decides under section 13 that the child has additional learning needs,

(b) in the case of a young person who is a registered pupil at a maintained school in Wales or enrolled as a student at an institution in the further education sector in Wales, the local authority decides under section 13 that the young person has additional learning needs, or

(c) in the case of any other young person, the local authority—

(i) decides under section 13 that the young person has additional learning needs, and

(ii) decides in accordance with regulations under section 46 that it is necessary to prepare and maintain a plan under this section for the young person to meet his or her reasonable needs for education or training.

(2) The local authority must—

(a) prepare and maintain an individual development plan for that child or young person,”

“(10) Where a local authority maintains an individual development plan for a child or a young person, the authority must—

(a) secure the additional learning provision described in the plan,”

This section places the duty on the LA to provide the ALP set out in an IDP it maintains.

44. Section 20 of the Act sets out the following:

“Additional learning provision: Local Health Boards and NHS trusts

(1) The bodies specified in subsection (2) may refer a matter to an NHS body, asking it to consider whether there is any relevant treatment or service that is likely to be of benefit in addressing the additional learning needs of a child or young person.

(2) The bodies are—

(a) where the referral would relate to a child, or to a young person who is a registered pupil at a maintained school, a local authority;

(b) where the referral would relate to a young person who is not a registered pupil at a maintained school, the body that prepares or maintains an individual development plan for the young person.

(3) But a body may not make a referral under subsection (1) unless—

(a) it has informed the child or young person and, in the case of a child, the child's parent, that it intends to make the referral,

(b) it has given the child or young person and, in the case of a child, the child's parent, an opportunity to discuss whether the referral should be made, and

(c) it is satisfied that making the referral is in the best interests of the child or young person.

(4) If a matter is referred to an NHS body under this section, the NHS body must consider whether there is a relevant treatment or service that is likely to be of benefit in addressing the child's or young person's additional learning needs.

(5) If the NHS body identifies such a treatment or service, it must—

(a) secure the treatment or service for the child or young person,

(b) decide whether the treatment or service should be provided to the child or young person in Welsh, and

(c) if it decides that the treatment or service should be provided to the child or young person in Welsh, take all reasonable steps to secure that the treatment or service is provided in Welsh.

(6) In this section, and in section 21, “relevant treatment or service” means any treatment or service that an NHS body would normally provide as part of the comprehensive health service in Wales continued under section 1(1) of the National Health Service (Wales) Act 2006 (c. 42).”

45. Section 21 sets out,

“Individual development plans: Local Health Boards and NHS trusts

(1) If an NHS body identifies a relevant treatment or service that is likely to be of benefit in addressing a child's or young person's additional learning needs following a referral under section 20 it must—

- (a) inform the body that made the referral of that treatment or service,
- (b) if the referral was not made by a body that maintains an individual development plan for the child or young person, inform the body that maintains the individual development plan of that treatment or service, and

(2) If an NHS body does not identify a relevant treatment or service that is likely to be of benefit in addressing a child's or young person's additional learning needs following a referral under section 20 it must—

- (a) inform the body that made the referral of that fact, and
- (b) if the referral was not made by a body that maintains an individual development plan for the child or young person, inform the body that maintains the individual development plan of that fact.

(3) If an NHS body informs a body that maintains an individual development plan for a child or young person that there is a relevant treatment or service likely to be of benefit in addressing a child's or young person's additional learning needs, the body that maintains the plan must describe the treatment or service in the plan, specifying that it is additional learning provision to be secured by the NHS body.

(5) If an individual development plan specifies under this section that additional learning provision is to be secured by an NHS body, the following duties do not apply to that additional learning provision—

- (a)...
- (b) the duty of a local authority to secure provision under section 14(10)(a)
- (c) ...

(6) The description of the additional learning provision specified in a plan under this section as provision an NHS body is to secure may only be

removed or changed on review of a plan in accordance with section 23 or 24 and with the agreement or at the request of the NHS body.

(7) If, on review of a plan, the NHS body requests a governing body or a local authority that maintains an individual development plan for a child or young person to remove or change the description of the additional learning provision specified in the plan under this section as provision the NHS body is to secure, the governing body or local authority must comply with the request.

(8) Nothing in this section affects the power of the Education Tribunal for Wales to make an order under this Part.

(9) If the Education Tribunal for Wales orders the revision of an individual development plan in relation to additional learning provision specified under this section as provision an NHS body is to secure, an NHS body is not required to secure the revised additional learning provision unless it agrees to do so.

(10) Regulations must provide that where an NHS body is under a duty to inform under subsection (1) or (2), it must comply with that duty within a prescribed period, unless a prescribed exception applies.”

46. Guidance as to the operation of these provisions is set out in the Code. The following are of relevance:

“ ALP to be secured by NHS bodies

21.21. Some children and young people will require the support of NHS bodies to help meet their needs. NHS bodies can help meet the needs of children and young people in a range of ways. For instance, they can:

- provide advice on the ALP to be secured;
- provide advice to improve effective and timely identification for a child or young person with ALN;
- provide advice to staff on the modification of the environment within which the child or young person receives their education;
- provide training for staff in a school or FEI to meet particular needs for a child or young person with ALN;
- support the monitoring of the child’s progress and provide reports as required.

21.23. In addition, under the ALN system, NHS bodies have a role to play in delivering ALP, where the ALP is something they would normally provide as

part of the health service in Wales (see Chapter 23 for more information on ALP and its intended outcomes).

21.29. If the NHS body identifies such a treatment or service it must-

- secure the treatment or service for the child or young person,

21.34. If a relevant treatment or service is identified and the NHS body informs the body maintaining the IDP of it, the body maintaining the IDP must then describe the treatment or service in the IDP, specifying that it is ALP to be secured by the NHS body.

21.36. As noted above, the NHS body must secure for the child or young person the ALP that is a treatment or service it has identified. The description of this ALP must not be removed from the IDP or revised except on review of the IDP and with the agreement, or at the request, of the NHS body. The NHS body may request a review at any time and if it does so, the body maintaining the IDP must review it. If, on review, the NHS body requests the body maintaining an IDP to remove or change the description of the ALP that the NHS body must secure; the school, FEI or local authority that maintains the IDP must comply with the request.

21.39. If the Tribunal orders the revision of an IDP in relation to ALP specified as ALP an NHS body must secure, an NHS body is not required to secure the revised ALP unless it agrees to do so. The body maintaining the IDP should work with the NHS body in such circumstances to see what agreement can be reached.

NHS bodies: evidence and Tribunal recommendations

33.20. In relation to an appeal made under Part 2 of the Act, the Tribunal may require an NHS body to provide evidence about the exercise of the body's functions and make recommendations to an NHS body about the exercise of the body's functions.

33.21. If the Tribunal makes a recommendation to an NHS body, that body must report to the Tribunal, before the end of 6 weeks beginning with the date on which the recommendation was made. The report must state:

- the action the NHS body has taken or proposes to take in response to the Tribunal's recommendation; or
- why the body has not taken and does not propose to take any action in response to the recommendation.

47. It will be seen from the above that the primary duty to make Additional Learning Provision for a child or young person's ALN is placed on the LA.

The intention of the legislation is that where a child or young person is referred to the Health Board it must decide if there is “any relevant treatment or service that is likely to be of benefit in addressing the additional learning needs of a child or young person.” Only if it identifies such a “relevant treatment or service” must it be included in the IDP section 2C and provided by the Health Board. If it does not, it is under no obligation to provide it. The Health Board can insist on the alteration or removal of the treatment or service on a review of the IDP.

48. On review of the ALNET, relevant Regulations and the ALN Code we cannot identify anything to support the LA’s argument that provision which it is agreed, either by the Health Board, or following a recommendation of the Tribunal, is to be secured by the NHS, should be specified in section 2C only. The requirement to specify all ALP that it is identified that the child or young person requires in s2B remains. The duty on the Health Board under s.2C is specifically to secure the ALP and is a consequential duty once provision has been identified then specified in s.2B. It means that the LA no longer has that duty under ALNET s.14(10)(a). It does not mean that it is no longer ALP which must be specified in s.2B.

49. If the approach advocated by the LA was correct, then following a recommendation of the Tribunal if then the Health Board refused to secure the provision, a parent may have to resort to the lengthy, expensive and uncertain (in this context) remedy of judicial review to ensure that provision was delivered. We do not consider the “Putting Things Right” service referred to by the LA in this case as being an adequate independent alternative, particularly in a case where the disagreement is about the provision required to meet Additional Learning Needs. The service is not the equivalent to a specialist Tribunal such as the Education Tribunal for Wales. If the provision is specified in s.2B then the duty to secure the provision would remain with the LA until any such dispute is resolved. The child or young person would not be disadvantaged by any dispute between education and health professionals.

50. In this case, from the evidence we have heard from The Lead (Mainstream) SALT and their written report, the Health Board is unlikely to agree to provide the direct weekly speech and language intervention we have found necessary to meet The Child’s needs. In the circumstances, unless that ALP is also specified in s.2B of the IDP there will be uncertainty about who will deliver this provision until there is any “agreement” arrived at thereafter between the local authority and the health board. The powers of the Tribunal under ALNET s.76 do not extend to ordering NHS bodies to make provision but only to make recommendations. We note that the

provision suggested by the Health Board is based on a different model of provision and that weekly SALT would be inconsistent with that model.

51. Perhaps with this difficulty in mind, the Act contains the emboldened provision above at section 21(8). “This Part” refers to the section of the Act dealing with ALN and ALP. It gives the Tribunal the power to make an order which is unaffected by the section. This power cannot relate to the ordering of an NHS body to make the provision set out within the section i.e. the regime set out in the section. It must be a power outside of this and can only relate in our view to ordering the LA to provide the ALP found to be required. There is no other body that can be ordered to provide the ALP under the Act. It is also consistent with the Act’s provisions to make the LA in a particular geographical area the body ultimately responsible for the education of children and young persons in its area.

52. There is a further point in the case concerning what the Health Board must provide. The SALT that we are ordering is not that recommended by the Health Board. It has set out what it says it is necessary for it to provide to meet The Child’s needs. Anything outside of its recommendation is arguably not a “relevant treatment or service” that it will provide. It therefore need not provide it. The Tribunal could override this and make a recommendation about what the Health Board is to provide to meet The Child’s needs but that then leaves the difficulties with enforcement referred to above.

53. Taking into account the provisions and guidance set out above, it is our view that the fundamental responsibility for providing the ALP necessary to meet the ALN of a child or young person should still be that of the LA. We have therefore directed that the SALT and OT provision in this case should be set out in section 2B and it should be the responsibility of the LA to provide it.

54. For the reasons already set out, we do not therefore agree with the submission advanced on behalf of the LA that if we set out the ALP required in The Child’s case in section 2B, making the LA responsible for providing it, we are acting in a way which is “wrong in law.”

55. We have also considered if we should order the provision that the Health Board has agreed to provide in 2C, and then specify additional provision within section 2B of the IDP. We bear in mind that the difference between the parties’ positions is a small one, and that there is a risk that a piecemeal approach involving more than one speech and language therapist would not meet The Child’s needs. We also bear in mind that if we specify

provision in section 2B the local authority will have to provide it, and it will not be subject to any form of “veto” because the health board does not “agree” to provide it. We therefore have decided it is appropriate to order all of the provision is set out in section 2B.

56. In relation to the provision of OT we have accepted the evidence of The Clinical Lead OT. We have therefore specified this provision in section 2B and also 2C. The latter is specified either because it has been considered as a “relevant treatment or service” or because it was conceded during the evidence we heard, and we recommend it. If it is not provided the “fallback” position will be that it must be provided by the LA until the IDP is reviewed as it has been specified in section 2B.

57. **Comparative Cost** – An argument was raised by the LA which related to the cost of the alternative models of provision under consideration. There is no requirement in the legislation to do so. In essence it was argued that the cost of the NHS providing SALT and OT for The Child was cheaper than the cost if it were to be provided by therapist who were being paid privately. It was argued that it was only provision that was sufficient to meet need that was required, and not the best available provision. Whilst we accept that proposition, we have in this case decided that the NHS suggestion of SALT provision is not sufficient to meet The Child’s needs. We consider the suggestion of The Independent SALT 2 to be adequate to meet their needs, for the reasons set out above. In relation to the provision of OT we have set out our position above. There is, in these circumstances, no need for us to look at comparative costs.

58. **Conclusion** – We have therefore decided it is appropriate to allow this Appeal and to order the SALT provision set out in section 2B, and the OT provision in 2B and 2C, of the amended IDP.

Order:

1. The Appeal is allowed.
2. The Individual Development Plan of The Child will be amended as per the copy annexed to this Order.
3. The Individual Development Plan of The Child will be maintained by the Local Authority.

Judge
Dated 2024