SEND reform: putting children and young people first

The RCSLT response to the Government's proposals to reform the special educational needs and disabilities (SEND) system

May 2026

Background and context

In February 2026 the UK Government published a document detailing their plans to reform the special educational needs and disabilities (SEND) system in England, SEND reform: Putting Children and Young People First. A 12-week consultation was launched, seeking comments on the proposals.

Over the consultation period, the RCSLT surveyed it members, and sought the views of parents/carers and other stakeholders, to inform this response to the consultation questions.

Part one: putting children and young people first

Consultation question: How can we ensure that children are best supported by the Universal offer?

Speech, language and communication (SLC) must be central to universal support - communication access should be as fundamental as physical access. Speech, language and communication needs (SLCN) should be supported through whole school/setting approaches and teaching, and considered business as usual for class teachers.

The universal offer should include systematic, evidence-based approaches to identifying needs as early as possible.

Universal provision must be realistically resourced. To deliver high quality universal support, schools and settings need sufficient teachers, teaching assistants, and access to specialist staff.

To ensure equity, the universal offer must recognise the different starting points of individuals and communities, and provide support that is adapted to meet those needs.

Training for the children's workforce must be embedded and ongoing. One-off training is insufficient; sustained implementation support through coaching, modelling, and feedback is needed to embed practice.

Integration of speech and language therapists working alongside education staff can facilitate a stronger universal offer - speech and language therapists should be seen as key partners in education and core members of the team around a school/setting.

Partnership with parents/carers and communities is essential - parents need early, accessible information about SLC development. For further support, families should be able to access signposting and advice from speech and language therapists in community-based support such as Family Hubs.

Consultation question: How can we ensure that children in the Targeted layer are best supported?

Training should ensure that staff have the skills to spot early signs that targeted support is required.

Targeted support must be properly resourced. Schools need the staffing capacity to deliver interventions consistently, with time allowed for preparation and measuring progress. Evidence-based interventions must be delivered with fidelity - effectiveness depends on delivery with the right skills, frequency, quantity, quality, and review to monitor progress.

Senior leadership buy-in is essential - targeted interventions are not always prioritised by senior leaders in education, and as a result training is frequently not taken up due to immediate staffing pressures.

Language interventions should be prioritised and recognised as fundamental to other skills, including phonics. The phonics screening test means schools will often redirect resources from language interventions to phonics interventions even when children are not ready to access them.

Strong collaboration between speech and language therapists/support workers, families, and school/setting staff is essential for embedding strategies across the school day and at home, ensuring skills learned in sessions can be applied in real life.

Targeted approaches are valuable but cannot replace specialist input for all children with speech, language and communication needs. It’s essential that timely input from a qualified speech and language therapist, including assessment and reviews, is available for those children who need it.

Consultation question: How can we ensure that children in the Targeted Plus layer are best supported?

The Targeted Plus layer must be more clearly defined: the current definition “for children and young people who need more specialist support to thrive in inclusive mainstream education” is open to interpretation.

Targeted Plus support should be integrated with learning: linked to classroom learning goals, delivered collaboratively with school staff, and embedded within the school day. Children should receive support without being isolated from their peers, which can impact their social and emotional skills.

Embedding specialists such as speech and language therapists in settings enables timely and flexible access to advice, assessment and intervention. Regular contact with the same therapist is important for continuity and effectiveness, and to enable a team identity to be built with education colleagues.

Clarity is needed around the role of the Experts At Hand (EAH) offer in relation to Targeted Plus support, and what “high-quality support from education and health professionals” means in this context. Where clinically indicated, individual children must be able to access specialists for timely assessments to identify their needs, and evidence-based intervention. If this is not through EAH then Government must explain how this will be provided. This access is vital to rebuilding parental trust that appropriate support is available without an EHCP.

Clear lines of accountability around funding, commissioning and delivery of Targeted Plus support are also required.

Consultation question: How can we ensure that children in the Specialist layer are best supported?

- Clear lines of accountability around funding and commissioning to ensure that expectations around provision of specialist support are met.
- Timely access to specialists such as speech and language therapists who can provide assessment to ensure needs are identified and provision put in place as soon as possible.
- Individualised, needs-led provision which is based on the child’s unique profile of needs, not just their primary need.
- Sufficient funding to enable specialists to carry out assessments and provide evidence-based intervention. Interventions should be delivered with the right skills, frequency, quantity, and quality, and outcomes should be measured to evaluate effectiveness.

- Sufficient funding for schools and settings to enable partnership working with specialists to embed support in everyday practice.
- Workforce planning for the whole children's workforce to ensure there are enough staff (including speech and language therapists, as well as early years practitioners, teachers and teaching assistants), including steps to improve retention and reduce turnover.

Consultation question: How do you think early years settings, schools, and colleges can best support the mental health and wellbeing of children and young people?

- Recognise speech, language and communication (SLC) as foundational to wellbeing, behaviour and mental health.
- Provide training to ensure all education and pastoral staff have a sound understanding of child development, trauma, SEND, speech, language and communication needs (SLCN), emotional regulation and behaviour, including the links between them.
- Identify SEND early and seek advice and support from appropriate professionals, including speech and language therapists, before difficulties escalate.
- Reform the curriculum to reduce pressure - develop curricula aligned with child development that include practical, vocational, activity-based and interest-led learning pathways.
- Create inclusive environments which remove barriers and providing reasonable adjustments that allow children to succeed; communication accessible schools as standard.
- Provide joined-up mental health support, with Mental Health Support Teams that are trained in SLCN, and work in partnership with speech and language therapists as part of the EAH offer.
- Ensure that mental health support within schools can be tailored to children with SLCN, including adapting or offering alternatives to talking therapies.
- Address system capacity and resourcing - tackle shortages in trained staff and overstretched services so that good practice can be delivered consistently, and meaningful relationships between staff and children can be established.
- Listen to the voice of children and their parents, including to understand how children present at home.

Consultation question: Do you agree that the refreshed ‘areas of development’ will support educators to understand and address barriers to learning and participation?

We support the intention to move towards a needs-led framework that focuses on removing barriers to learning and participation rather than diagnosis. With the right training, the proposed areas of development could provide a framework to help educators think about functional skills such as attention and communication in everyday contexts. However, the following issues should be considered / addressed:

- We welcome the inclusion of speech, language and communication as a separate area. The definitions of speech, language and communication would benefit from being refined with input from speech and language therapists; the RCSLT can support with this.
- Literacy, numeracy and cognition appear to be missing. These are key aspects of development, and it is not clear how the barriers for children and young people with specific learning difficulties or learning disabilities will be understood or addressed within the current framework.
- Executive function is not well understood - as a new term in SEND this may need additional explanation / training. Without clear definitions and training expectations, this risks becoming a broad, non-specific category that does not translate into effective practice.
- More clarity is needed about how the areas of development will be used in practice, and how children’s needs will be recorded in the school census. It is important that data on children’s special education needs continues to be collected at both local and national level.

Consultation question: What arrangements would best support effective joint working between early years providers, Best Start Family Hubs, health, local authorities, and parents for children with SEND in the early years?

Support should be community-based, inclusive and culturally responsive, building trust and engagement with families. Open lines of communication and empathy are key when working with parents of children with SEND in the early years. Parents have told us it can feel like a grieving process where you are thrust into an unknown world, so making support available - and ensuring families know where to find it - is vital.

Specialist professionals should be readily available for screening, triage and early intervention. A link speech and language therapist for every Best Start Family Hub would enable parents and members of the early years workforce to quickly access a speech and language therapist for advice and support without the need to make a referral and wait for an appointment.

Wherever possible, education, health and care services should be co-located to enable real collaboration, joint delivery and faster access to help. Shared infrastructure - including IT systems, communication tools, consent policies and workspaces - can all enable smoother information-sharing, coordinated decision-making and joined up support.

Commissioning and performance measures should incentivise joined-up working and meaningful outcomes for families.

Expectations for Reception and early schooling should support developmentally appropriate practice and joint working, not undermine it through overly formal curricula.

Consultation question: How can the early years foundation stage (EYFS) two-year old progress check and the Healthy Child Programme development review be improved so that children's needs are identified and supported more quickly?

Efforts to recruit, retain and fund Health Visitors are key to enabling the 2-year progress check to be delivered consistently, on time and face-to-face, reducing reliance on telephone assessments that miss need and increase safeguarding risk.

Improvements should include strengthening early identification of speech, language and communication needs (SLCN) to support earlier recognition of children whose needs will persist throughout education.

In order to accurately identify the children in the early years who will go on to have persistent SLCN, the evidence points to a surveillance system that moves beyond screening at a single time point and builds in the child, family and environmental determinants which increase the risk of later language problems

Earlier identification of persistent needs would enable earlier access to appropriate, evidence-based support and better planning for education provision, including where children may require an Inclusion Base or specialist setting.

A senior Public Health speech and language therapist role in every area could provide local leadership and advice on universal and targeted approaches to SLCN across the system, supporting service development and designing training for the wider workforce.

See: Reilly & McKean (2023) Creating the conditions for robust early language development for all - Part 1: Evidence-informed child language surveillance in the early years) and Part 2: Evidence informed public health framework for child language in the early years.

Consultation question: What should the top three priority areas be for building and sharing evidence within the National Inclusion Standards?

1. Effective universal strategies and high-quality, inclusive classroom practice for supporting speech, language and communication needs (SLCN). This includes practical, easy-to-implement strategies that can be embedded into everyday teaching, rather than add-on interventions.
2. Evidence-based targeted interventions for SLCN - clearer guidance on which targeted interventions are effective, how they should be delivered, and what level of training and support is required for staff delivering them.
3. Identification, thresholds and pathways for escalation - evidence to support clearer identification of needs, including how to distinguish between children who can be supported at a universal or targeted level and those who require specialist input. This includes developing consistent pathways to ensure children are escalated appropriately and not left without adequate support or bounced between different parts of the system.

We would also signpost the Government to the RCSLT's Developmental Language Disorder (DLD) Research Priorities, which were shaped by the views of people with DLD, their families and professionals. The top research questions are:

- What training do education staff need so they can help people with DLD learn and have a better time in schools, colleges and universities?
- How can we make it easy for people with DLD to get a diagnosis? How can we best support them before, during and after a diagnosis?

See the full report: https://bit.ly/3PjDvsC

Consultation question: What are the most important issues for national training to cover, to help support children and young people with SEND?

- The importance of working with families and the skills to do this successfully.
- Understanding that speech, language and communication (SLC) skills are foundational and underpin educational, emotional and social outcomes.
- Understanding typical vs atypical SLC development, and awareness of red flags which may indicate a child needs additional support. Initial teacher training should include information about SLC development and difficulties as standard.
- Recognising that speech, language and communication needs (SLCN) may present as externalising behaviour, so should be considered in all children and young people at risk of exclusion.

- Information about specific profiles of need, including common needs such as developmental language disorder (DLD), stammering and speech sound disorders, as well as rarer conditions such as childhood apraxia of speech.
- How to create communication-accessible and inclusive, neuro-affirming learning environments, including how to embed language support into everyday practice, how to support alternative forms of communication and how to differentiate teaching and the curriculum, such as phonics for children with SLCN.
- Knowing when and how to escalate concerns and involve specialists; this will need to be adapted to reflect local service delivery models.
- It is important to recognise that one-off, external training packages do not change practice. Training must be embedded, with access to experts to provide ongoing coaching and modelling.

Part two: new Targeted and Targeted Plus support that is written into law

Consultation question: What would provide assurance for families that an Individual Support Plan (ISP) is high-quality and contains the essential information?

Early support and advice for families on the contents of ISPs is important to support their understanding and engagement with the process. Families must be given assurances, backed by meaningful accountability measures, that ISPs will be:

- Person-centred and individualised - they should be written to reflect the child or young person’s individual strengths and needs, not using generic wording.
- Provision must be specific and measurable, and clearly indicate who is to provide each element of the plan.
- Co-produced - plans are more credible, effective, and trusted when families and children are genuine partners in the process. The young person’s voice should be clearly evident in their ISP, and the process to produce it should be communication accessible.
- Developed and reviewed by all relevant professionals who have worked directly with the child, considering observations of the child’s functioning in a range of everyday settings.

A digital, standardised national ISP template with clear specification of what must be included, and clear timescales for writing, implementing, and reviewing plans, would help to assure families that ISPs are being implemented consistently.

Once developed, ISPs must be robustly monitored to ensure plans are actually delivered, with clear escalation routes for parents when provision is not implemented, or when reasonable adjustments are not made in line with the Equality Act.

Consultation question: How can we ensure Individual Support Plans are clear, concise and practical for professionals to use?

Clear, standardised ISP templates should be provided to ensure consistency across schools and settings. National training should be provided for staff who are expected to write ISPs.

Guidance should specify what ISPs must cover, including the child's needs, strengths, outcomes, strategies, responsibilities, frequency, and review points. ISPs should be relevant to the child's real context and grounded in strengths and existing strategies, not deficits or norms.

ISP targets should be SMART and evidence-based. They must be deliverable, measurable, and clearly owned.

Guidance should also set a clear expectation that plans should be concise, practical, and easy to understand by all involved, using Plain English, and avoiding professional jargon.

Responsibility for writing and reviewing ISPs should sit with appropriately trained professionals who have direct knowledge of the child. SENDCos and others responsible for ISPs will need training and adequate time to make plans meaningful.

ISPs should be reviewed termly or at least every 6 months and updated promptly when needs or provision change.

The implementation of ISPs must ultimately reduce the time that professionals such as speech and language therapists currently spend on administration and bureaucracy related to providing advice for education, health and care plans.

Consultation question: How can we best support transition for young people with SEND, so that they are well supported into post-16 provision and further education, training or employment?

Speech and language therapists can support transition by facilitating early conversations with the young person about their aspirations and goals, and providing support to develop the functional skills they need for their next steps such as time management, organisation, travel skills.

The introduction of the Experts at Hand offer to secondary schools and post-16 settings could help support transition. At the moment, there is often limited access to speech and language therapy for young people at secondary school, and even less post-16. Given the current lack of provision, local areas may need more time and support to develop this aspect of the offer. It will be important to consider where existing providers in this area, including those employed directly in education or independently, may be able to contribute their expertise.

Speech and language therapists can also provide training on speech, language and communication needs (SLCN) and communication accessibility to the wider post-16 workforce, such as careers advisers and employers. This could include training on reasonable adjustments, and resources that can support young people to succeed in education, training or employment, including communication passports and Easy Read guidance.

Where young people have been successfully using Augmentative and Alternative Communication (AAC) at secondary school, this must continue to be supported in post-16 provision. Post 16- education providers and internships should be supported to engage with AAC.

Consultation question: How can we make sure that every area can meet the full range of the needs of children and young people through Inclusion Bases?

Bases must be adequately funded and jointly planned with health partners to ensure specialist workforce capacity is available and integrated with existing services.

Inclusion bases should be planned across a local area based on population need, making use of partnership data and trends to support planning.

This should include securing suitable provision for children with severe and persistent speech, language and communication needs (SLCN), such as children with severe developmental language disorder (DLD) or complex speech sound disorders, such as childhood apraxia of speech (CAS).

Planning should ensure equity of access so that a child in a rural area has access to the same level of specialist support as a child in a large city, where possible endeavouring for bases to be geographically spread to minimise travel time. Where geography makes this impossible, additional resource should be available to support the extra 1:1 needed in local schools, and to enable meet ups with peers and role models.

It is important to recognise that not all children’s needs can be met in Inclusion Bases, and special schools will still be required. Equally, in many cases it should be possible for a child to be supported to thrive in their local mainstream school, without access to an Inclusion Base, if the mainstream school is truly inclusive with access to appropriate specialists. The child and parent voice must be central to these decisions.

Consultation question: How can we make sure that Inclusion Bases help children and young people succeed in mainstream settings?

To help children and young people success in mainstream settings, inclusions bases should be:

- Communication accessible as standard.
- Embedded within a more inclusive mainstream system, with students meaningfully integrated into the school community, and inclusion base staff acting as an outreach resource, sharing expertise with the wider school.
- Jointly planned and adequately funded, including regular access to consistent specialists.
- Clearly defined – each base must be clear about the type of needs it is able to meet.
- Led by teachers or other specialist staff who are knowledgeable and experienced in working with the specific cohort of students that the base aims to support, working in collaboration with multi-disciplinary teams and highly trained support staff.
- Offering individualised support, based on an assessment of the child’s individual strengths and needs.
- Evidence-based - where specialist provisions are commissioned for children with severe and persistent speech, language and communication needs, this must include funding for speech and language therapists to deliver intervention at the intensity and frequency set out in the evidence base.
- Flexible and temporary where appropriate. There must be meaningful inclusion and flow between the base and setting, with flexible movement between the two based on the child’s strengths, readiness, and needs.

Consultation question: Through the Experts at Hand offer, we want to ensure that mainstream settings can get quick specialist support for children and young people. What arrangements are needed between local area partners (education, health, social care) to deliver this Experts at Hand offer effectively?

Clarity is needed about the scope of the Experts at Hand (EAH) offer; currently there are differing expectations within the system. The funding is unlikely to be sufficient across universal, targeted and targeted-plus levels.

The EAH offer must build on existing provision, especially where there are already school-based models of therapy provision. Support from specialists is most effective when it is embedded, relational, and visible in schools, with named speech and language therapists acting as consistent points of contact who know the staff and children.

The process to develop a local EAH offer must involve all existing delivery partners, including any providers commissioned by schools to provide traded services. While it is essential that LAs and ICBs work together to develop this offer, this is a challenge where boundaries do not align.

Local areas will need both support and scrutiny to ensure that EAH offers are effective and integrate with specialist services. Robust governance arrangements and data collection requirements are needed.

Where the EAH offer is commissioned jointly by the LA and ICB as part of integrated commissioning arrangements across all four layers, this will deliver the most effective, joined-up support.

Local partners will need to work collaboratively and creatively to find solutions to workforce challenges. It is vital that qualified speech and language therapists are central to the EAH offer, working alongside trained support workers. The new speech and language therapy advanced practitioner roles will be key.

Part three: specialist support for those with complex needs

Consultation question: What needs to be in place so that children and young people with low incidence, highly complex needs can always access the right specialist placement?

- Data on low incidence, high need conditions should be collected regionally and nationally to inform service and workforce planning - ensuring there is sufficient capacity within specialist placements, as well as professionals with the required level of specialist skill and expertise, in order to provide early and ongoing intervention.
- Commissioning for low-incidence, high need conditions should include consideration of specialist health professional input.
- In addition to planning for direct support, commissioners should consider how training will be provided to the wider team around the child. Clinical specialists at the ICB or regional level can have a key role in supporting staff at the local level to develop the knowledge and skills needed to effectively respond to children's needs.
- Examples of this from the field of speech and language therapy include the regional Cleft Palate networks and augmentative and alternative communication (AAC). However, in many areas families experience difficulty accessing speech and language therapists with appropriate levels of specialism, for example in

using AAC. The DHSC should consider its role in workforce planning to ensure professionals are supported to develop specialisms.

- The commissioning and service model for highly specialist speech and language therapy services for children and young people who are deaf in Cheshire and Merseyside is considered an example of good practice. See: https://bit.ly/3PBt1oz

Consultation question: How can Specialist Provision Packages be designed to effectively support the main types of need we currently recognise?

Speech, language and communication needs (SLCN) are the second most common type of need for children with EHCPs, but are not included in the published draft of SPPs, except where they co-occur with social and emotional needs, or with a learning disability. This is a matter of significant concern to the RCSLT.

Examples of the children who we are concerned about include those with severe or complex speech sound disorders (such as childhood apraxia of speech); severe developmental language disorder (DLD) or complex AAC needs.

It is vital that SPPs are designed in such a way that they guarantee support for those children with SLCN who need more intensive intervention than can be provided through the Targeted Plus layer.

More widely, we are concerned that standardised packages could constrain therapeutic approaches, limiting professional judgement and flexibility to respond quickly to fluctuating or escalating needs.

The plans must recognise that two children allocated to the same 'package' may require very different provision in terms of therapy approach or frequency, and that many children have multiple needs. They must also recognise that in some clinical areas the evidence base will not provide clear 'prescriptions' about the therapy provision that is required for every individual.

If the SPPs are to effectively support children, speech and language therapists with expertise across a range of relevant clinical areas should be closely involved in designing the packages.

Consultation question: We propose that EHCPs will guarantee educational provision set out in a Specialist Provision Package, with day-to-day provision captured in Individual Support Plans. What is needed to make these proposals work effectively?

More clarity is needed about the provision that will be set out in an SPP, as opposed to the provision that will be captured in an ISP - what is meant by 'day-to-day' provision?

More clarity is also needed on how support will be funded. The consultation document includes "weekly interventions with a speech and language therapist" as an example of something that would be captured in an ISP rather than an EHCP. How will the funding for this be guaranteed?

ISPs must be dynamic, specific, flexible and regularly reviewed - provision and targets must accurately reflect the child's current profile and functioning in real settings, based on input from relevant specialists.

Schools need the time, staffing, funding, and training to write, implement and review ISPs properly. They also need access to specialists such as speech and language therapists so that plans can be co-developed. There must be sufficient capacity within both the education and specialist workforce to enable this.

There must be clear lines of accountability for ensuring provision in ISPs is delivered, including where this is provided by an external professional.

A clear process must also be set out for resolving any conflicts that may arise between education professionals, specialist staff and families in relation to the contents of the ISP. It is imperative that ISPs are more collaborative and less combative than the current EHCP process, which often results in stressful mediation and tribunal hearings.

Consultation question: We propose creating a more direct route to Specialist Provision Packages and EHCP assessments for children under 5 with complex needs. How can we make sure this works in practice?

Children with complex needs must be able to access places in early years settings, with support from multi-disciplinary teams who can enable an early and holistic assessment of their needs.

Children with a diagnosed genetic condition should be fast tracked to the relevant specialist services, underpinned by a joined up approach to their overall care.

Appropriate evidence-based interventions should be implemented at the earliest opportunity, avoiding a 'wait and see' approach.

Consultation question: What would you expect to be considered as part of the needs assessment, for example evidence and expert or professional input.

The voice of the child or young person and their parents / carers should be central to the process. Early support must be given to families to help them understand the EHCP process so they can effectively contribute and collaborate with professionals. Families know their child the best, so their input is vital.

The needs assessment should include a holistic multi-disciplinary assessment by all relevant professionals who are currently working with the child or young person, regardless of their employer. The assessment should identify the child’s strengths, preferences and priorities, not just their deficits.

Evidence should be based on knowledge of the child over time, drawing on current and historic assessments from all professionals involved, and observations in real-life contexts, for example in the home, at the early years setting / school - including observations not just in the classroom but also in the wider school environment.

Evidence of the interventions that have already been put in place, and whether they have been effective should be included.

Professionals must be appropriately qualified, and should only provide recommendations within their scope of practice.

Recommendations should be based on needs of the child and not restricted by available provision.