Disabled children and young people up to 25 with severe complex needs: integrated service delivery and organisation across health, social care and education

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comment 5pm on 14 September 2021 **email:** CYPseverecomplexneeds@nice.org.uk

Checklist for submitting comments

- Use this comments form and submit it as a **Word document (not a PDF)**.
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **document name, page number and line number** of the text each comment is about.
- Combine all comments from your organisation into 1 response form. **We cannot accept more than 1 response from each organisation**.
- **Do not** paste other tables into this table – type directly into the table.
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- **Clearly mark any confidential information or other material that you do not wish to be made public. Also, ensure you state in your email to NICE that your submission includes confidential comments.**
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Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.

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	Please read the checklist above before submitting comments. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment. In addition to your comments below on our guideline documents, we would like to hear your views on these questions. **Please include your answers to these questions with your comments in the table below.** 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) 4. The recommendations in this guideline were largely developed before the coronavirus pandemic. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication. See Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name (if you are responding as an individual rather than a registered stakeholder please specify).	[**ESC Management Services Ltd**]
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Name of person completing form	[**Emma Smith**]

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Comment number	**Document** [e.g. guideline, evidence review A, B, C etc., methods, EIA]	**Page number 'General'** for comments on whole document	**Line number 'General'** for comments on whole document	**Comments** • Insert each comment in a new row. • Do not paste other tables into this table, because your comments could get lost – type directly into this table. • Include section or recommendation number in this column.
1	Guideline	1	4-7	A minor formatting point. Throughout the Final Scope document (June 2019) the format is '*health, social care and education*.' The title of this draft guideline also uses this format. However, within the actual guideline this is persistently reordered to '*education, health and social care'*. This inconsistency is acknowledged in the Evidence Review document referring to the 'NICE style' of health, social care and education but that the education, health and care (EHC) format has been used to align with EHC plans. It may be beneficial to replicate this Evidence Review explanation in the guideline.
2	Guideline	3	12-13	**Contents:** The guideline includes recommendations on specialist support for disabled children and young people with particular needs and lists a range of specific requirements. A notable gap is continuing care. Whilst section 1.5 covers 'Personal budgets and Direct Payments' this is focused on funding streams. There can be challenges around continuing care services and the different contractual arrangements across organisational/sector boundaries. For example, continuing care health services provided in the education setting via direct payments can result in significant operational issues for schools e.g. safeguarding, governance, accountabilities and insurance. It would be beneficial if recommendations could be made on how continuing care arrangements can be integrated and effectively managed across orgainsational/sector boundaries.
3	Guideline	9	24	Could the committee consider adding *'……education, health and social care practitioners who know the child or young person and are involved in their support'.*
4	Guideline	22	1	**'Writing the plan' title:** The committee may wish to consider the word 'Writing' in the title and when used in

				this section. It is the local authority that has the statutory duty to prepare the EHC plan (The SEND Regulations 2014 s.11). The SEND Code of Practice has a section with the title 'Writing the plan' which starts with the statement '*The following principles and requirements apply to local authorities and those contributing to the preparation of an EHC plan* (para 9.61, pg.160/161). This makes the distinction between local authority and professional responsibilities and recognises that the statutory duty on practitioners is to contribute advice and information. Although it may be considered subtle, there is a difference between practitioners 'contributing' advice and information for plans and practitioners 'writing' plans. The current use of the word 'writing' could inadvertently over-extend the responsibilities placed on health, education and social care professionals which go beyond their statutory duties. This may result in EHC plan administrative tasks being inappropriately shifted from local authorities to these professionals. The committee may wish to consider being more explicit in the distinction between the duties on local authority and professionals. Perhaps '*Preparing the plan'* may be a more appropriate title and when referring to practitioner contributions, rather than 'writing' plans, this should align to statutory duties e.g. practitioners *'contributing advice and information'.*
5	Guideline	22	2-6	**Rec 1.4.7** The 'Writing the plan' section advocates that services should co-ordinate and agree the content of the EHC plan together. As there are later recommendations relating to reviews and reassessments, it would seem this relates to the preparation of the initial EHC plan. Joint working and integration are positive and consistent themes of the SEND reforms and whilst there would be definite advantages in this approach, this recommendation could be challenging to implement. Since the SEND reforms, the national picture has been one of difficulties with compliance around the statutory EHC process. Most notably, this has related to timings but problems have also been evident in the quality of assessments/information. Over recent years, national data shows the proportion of EHC plans that were issued within the 20 week statutory time limit has hovered at around 60% and there is significant

				pressure on local authorities to comply with/improve timescales. Hence, compliance with statutory timescales is a key driver for local authority improvement plans. The implementation challenge will be that the statutory process for assessment and preparation of EHC Plans is limited in terms of facilitating professional co-production. Unlike the annual review, which specifies a meeting between a child's parents/young people and professionals, no such step exists in the statutory process for initial assessment and preparation of the EHC plan. There is a statutory requirement to share the draft plan with a child's parents/young person but there is no equivalent statutory step to share/amend the draft plan with professional contributors. Consequently, this recommendation will require steps that are additional to the statutory process and this is likely to significantly impact on timescales. In 2020, only eight local authorities achieved 100% compliance for the 20 week timescale and the national average was 58%. Given this national picture and the priority to achieve statutory compliance, it is difficult to envisage how local areas could adopt what is likely to be a lengthier process and still make progress against the 20 week target. The committee may view this an aspirational recommendation and if this is the case, perhaps it would be helpful to supplement the recommendation with additional practical detail. For example, of the eight local authorities achieving 100% statutory compliance, are there best practice examples of either 'how does' or 'how could' this co-production recommendation work whilst achieving compliant timescales.
6	Guideline	22	12-15	**Rec 1.4.9:** The meaning of this recommendation is a little unclear. Specifically, using healthcare professional information to describe special educational needs and social care needs. The SEND Code of Practice provides guidance on what to include in different sections of the EHC Plan. Using health professional information in section B (SEN) would have relevance when the needs require 'traditional' health services that have been deemed provision that educates or trains. For section D (social care) content, there is no mention of using healthcare information to describe social care needs (SEND Code of Practice pg. 165).

				Could this recommendation be expanded to provide more detail or include the relevant SEND Code of Practice reference on the use of healthcare professional information in sections B and D.
7	Guideline	22	16-18	**Rec 1.4.9:** Placing the responsibility on practitioners to determine whether therapeutic interventions educate or train is entirely appropriate and reasonable. Decisions about whether health provision educates or trains must be made on an individual basis (SEND Code of Practice para. 9.74, pg. 170). This appears relatively straightforward but the committee may wish to consider the contextual factors that may influence professional decision-making and whether it is necessary to strengthen this recommendation. External influences include local arrangements for NHS therapy services and Tribunal powers, this is illustrated by the Association of Paediatric Chartered Physiotherapists (APCP) guidance on writing advice for EHC plans (2017 current version available via APCP website). This states (text format as presented in guidance); ‘Health professionals asked to contribute to the EHCP often find their reports listed in section G of the plan: Any health provision reasonably required by the learning difficulties or disabilities which result in the CYP having SEND. **(See section on legal issues as to why you may want to encourage your advice to be included in section F).’** pg. 11 The ‘Legal Issues’ section of the guidance contains a description of the SEND Tribunal powers and the impact and implications when physiotherapy services are placed in either section F or G. This details that the local authority is responsible for delivering (including funding) section F services and for this reason, professionals may wish to ensure that the physiotherapy requirements needed for daily life such as postural management are listed in section F. The guidance goes on to say that this will secure provision regardless of local therapy provider arrangements. Therefore, this appears to suggest that services required for ‘daily activities’ i.e. not services that are for the specific purpose of educating or training are specified as section F special educational provision.

				The APCP guidance warns that local authorities should not be using blanket approaches to allocate physiotherapy services as health provision but then appears to '*encourage*' registered professionals to include physiotherapy services in section F as special educational provision. Although specifying provision as special educational rather than health may increase the likelihood of securing services, there are wider implications. These include inappropriate use of local authority special education funding and the impact on standards of care when what should be NHS services sit outside the NHS commissioning and quality statutory framework.
8	Guideline	23	1-2	**Rec 1.4.10:** Although not explicitly stated in the recommendation, the assumption is that local authorities would commission services specified in section F and H and that the relevant NHS commissioner would commission the services specified in section G. This would be aligned to the legal framework. This distinction between the local authority and health commissioning functions is critical because it determines the statutory scheme for service provision. NHS commissioning initiates the NHS pathway to ensure compliance with the NHS statutory quality duty and adherence to the NHS constitution. A consideration for the committee is that a significant proportion of section G health services delivered within the education sector sits outside NHS commissioning. The current service delivery model for section G health provision is largely reliant on the education workforce providing health services via delegation. This delegated activity is often not associated with a CCG commissioning arrangement. This lack of formal NHS commissioning for what should be NHS activity has serious implications in terms of clinical governance, accountabilities and funding. There is no national metric/data that quantifies or monitors delegated health services within education and this contributes to the 'hidden' nature of this activity. Although this model applies to all schools, this is particularly relevant for specialist schools which due to the needs of pupils can represent unique clinical environments led and managed by education professionals.

				Within the specialist school sector, the national picture is that these arrangements are subject to highly variable levels of NHS input and oversight. So in effect, for children and young people with severe complex health needs there is a two-tier standard of healthcare; an NHS service underpinned by the NHS statutory duty for quality and an education healthcare service functioning outside the NHS statutory and operational framework. This two-tier system along with the postcode lottery of approaches, variability of NHS support and the hidden nature of delegated activity, paint a picture which is of significant concern. Since the Francis Inquiry into Mid-Staffordshire NHS Foundation Trust and the Cavendish Review, much has been done to improve the quality of services delivered by unregistered workers in the health and care sectors but this has not extended to healthcare delivered in the education sector. Over recent years, education leaders report that NHS services and support in school have actually decreased, this is despite increasing numbers and complexity of health needs. Unsurprisingly, school leaders persistently raise concerns and warning about the gaps in clinical governance, accountability, funding and inspectorate/regulatory oversight. There are discussions taking place in the specialist school sector about the legal aspects of the current service delivery model. Firstly, taking the view that NHS commissioning responsibilities remain even when care can be delegated to unregistered support workers (see case law Haringey 2005; Nascot Law 2018). This suggests that where there is an NHS commissioning responsibility for health services, if the healthcare is delegated then the delegated activity should be NHS commissioned. However, if a CCG did commission a school to provide NHS funded health services, questions then arise including, do schools have the statutory power to function as an NHS service provider? and how can a school provide NHS 'quality' services when it sits outside the NHS 'quality' statutory framework? Currently, a special school could provide NHS care plan services to 250+ children and young people with EHC plans but there is no requirement for the school to be registered with the CQC as a provider of NHS services.

				It may be beneficial for the committee to be aware of these discussions in relation to this recommendation.
9	Guideline	23	12-15	**Rec 1.4.13:** *Local authorities should ensure* that EHC plans are *written* by practitioners who have the right expertise and knowledge of the child or young person. a) This recommendation implies that local authorities should ensure all practitioners including health practitioners contributing to the EHC plan have the right knowledge and expertise. In terms of the health input, this might be considered unreasonable, impractical and outside the scope of local authorities. NHS commissioning bodies have a legal duty to identify the appropriate health professional to provide health information and advice (SEND Regulations 2014, regulation (6)(1)(c)). The Committee may wish to draw on this health statutory duty in this recommendation i.e. '*Local authorities and health commissioners should ensure that EHC Plans….'* b) As noted in comment 4, the statutory requirement and process for professionals contributing to EHC plans is to provide advice and information to local authorities either directly or via schools in a school-led annual review. Local authorities have the statutory duty to prepare the plan taking into account professional advice and information and considering how best to achieve the outcomes sought (SEND Regulations 2014 s.11). As noted previously, a more appropriate phrase could be *'practitioners contributing advice and information' have the right expertise and knowledge of the child or young person.'*
10	Guideline	28	5-8	**Rec 1.5.2:** The example of a family commissioning health and care support using direct payments states that the local authority should ensure that those providers still have access to health and care advice directly from statutory providers. Again, it might be considered unreasonable and impractical to allocate the task of ensuring health providers receive appropriate health advice to local authorities. Particularly, when CCGs have statutory duties under the NHS (Direct Payment) Regulations 2013 to ensure care planning and support from a care coordinator (Regulation 8) and access to information, advice and other support (Regulation 9). The committee may wish

				to reflect these statutory duties in this example and add *'the local authority and health commissioner should ensure…...'*
11	Guideline	52	15	**Title 'Competency in delegated clinical tasks'** a) This set of recommendations cover a number of aspects of delegation; training, supervision, insurance and incident management. Delegation of healthcare tasks encompasses far more than competency as the recommendations illustrate. Therefore, the committee may wish to consider removing '*Competency in*'. b) The title specifies 'clinical' tasks and coupled with the focus on nursing (i.e. references to Nursing and Midwifery Council (NMC) and Royal College of Nursing (RCN) pg. 52 line 17/18) there could be an impression that this recommendation is limited to nursing activity. If the intention is to focus on 'health' provision then this would incorporate therapy services specified in an EHC plan section G e.g. postural support and dysphagia management that are also delegated to unregistered, non-health support workers. Therefore, this would draw in the professional standards for delegation stipulated by the Health and Care Professions Council (HCPC) i.e. Standard 4 - to delegate appropriately. Perhaps the committee may wish to consider whether 'clinical' implies a limited scope of delegated health tasks and whether a better option may be *'Delegated health tasks'*.
12	Guideline	52	16	**Rec 1.15.27:** a) The beginning of this sentence is a little confusing 'For staff, services….'. It has been difficult to decipher with certainty if this is intended for the staff that are delegating the activity or the organisations employing the delegator and/or the delegatee. On balance, the consensus is that this recommendation probably relates to registered healthcare professionals/NHS organisations but it would be helpful if this could be clarified. b) This recommendation states '*services must follow guidance on training and competency.*' The NMC and HCPC set the professional standards for delegation, which for both NMC and HCPC includes the

				requirement for supervision. NMC guidance also emphasises the importance of risk assessment (NMC Delegation and Accountability 2018). The phrase 'training and competency' is used by the CQC in guidance for medicines optimisation in adult social care and by NICE in the guideline 'Managing medicines for adults receiving social care in the community' [NG67]. However, in both these, medicines support tasks do not appear to be specifically related to delegated activity. If this recommendation is intended to reinforce professional delegation standards in their entirety, rather than limiting to 'training and competency', ideally this recommendation would read *'services must follow guidance on delegation'* to capture all the professional requirements for delegating activity.
13	Guideline	52	16-19	**Rec 1.15.27:** This list appears to focus on nursing e.g. NMC and RCN references. However, as noted, delegated activity encompasses a range of 'health' interventions such as therapy and dietetic provision. So it may be helpful to also include the HCPC as a statutory regulatory body governing professional standards. There is also the potential that professional bodies may have different interpretations of standards for delegation (see comment 15). This could result in confusion. Therefore, it may be beneficial to limit this list to NMC, HCPC and CQC. As an aside, the RCN guidance 'Meeting health needs in educational and other community setting' 2018 was due to be reviewed in January 2021. If the RCN is retained on this list, it may be helpful for the committee to request a status update on this guidance.
14	Guideline	53	1	**Rec 1.15.27:** *'only train support workers….*' There is a widely held view that health professionals provide training for the specialist education workforce but they do not delegate. The absence of NHS commissioning for delegated activity and a belief that a school providing health services for pupils with complex needs is simply a scaled up version of mum at home providing care for her child are possibly contributory factors.

				The terms 'train' and 'delegate' are often used as though they are interchangeable. Whilst training is an important component of delegation, they are not one in the same. As noted, delegation comprises of a wider set of activities and standards such as risk assessment, competency assessment and supervision. To ensure the recommendations reflect the requirements for delegation, the committee may wish to consider the distinction and use of these two different terms. For example, should this bullet point read *'tasks should only be delegated to support workers if these support workers are employed…..'*
15	Guideline	53	6-7	**Rec 1.15.27:** '*ensure that ongoing clinical supervision arrangements are in place for support workers.*' It would be helpful if the recommendation could provide clarity around delegation and requirements for supervision. This appears to be a perennially thorny issue. For example, the Royal College of Speech and Language Therapists (RCSLT) has guidance available on its website (only accessible to members but can be requested) which relates to delegation. This guidance refers to registered Speech and Language Therapists (SLT) being unable to formally delegate tasks to the wider workforce, unless the SLT has managerial or supervisory responsibilities for their actions. When the wider workforce is involved, this RCSLT guidance signposts registrants to another RCSLT guidance document 'Upskilling the wider workforce.' This states *'the term delegation is often used loosely to explain, for example, the process between an SLT and a teaching assistant asked to undertake carry-over therapy activities.'* Within this guidance there are numerous references to the wider workforce covering education staff. Upskilling is presented as a different activity to delegation. For example, the upskilling guidance has no reference to assessing competence. There is an urgent need for greater clarity on the 'training' v's 'delegation' distinction. There is a potential risk that standards for delegated activity are being side stepped because cross-organisational delegation arrangements have not been pinned down. For example, when an EHC plan section G specifies delegated dysphagia interventions potentially, this NHS activity could be associated with support worker 'upskilling' and

				training but with no requirements for supervision or competency assessment. This not only has implications for children and young people receiving care but also for the support workers/organisations providing the services i.e. those accepting responsibility and liability for the activity. The CQC 'Scope of Registration' guidance covers supervision and delegation (pg. 29/30). This states a health care professional employed by one provider will not be responsible for the supervision of staff of another provider. The CQC guidance then signposts to the NMC Code of Practice standards for delegation which obviously includes the requirement for supervision. There is an opportunity for this NICE guideline to not only reinforce the NMC and HCPC delegation professional standards but also provide greater clarity on the supervision component. The ever increasing levels of NHS activity delegated across organisational/sector boundaries to non-health, unregistered support workers means it is more important than ever to ensure consistent standards of NHS care regardless of who is providing the care and where the care is delivered.
16	Guideline	53	8-12	**Rec 1.15.28:** This recommendation is for delegatees and their employing organisations and as the definition of support worker refers to education staff presumably, this is aimed at not only health and social care but also education. This is likely to pose challenges for the education sector. In effect, what this recommendation means is that schools employing teaching assistants who have been delegated clinical tasks must follow guidance from; • Care Quality Commission • Nursing and Midwifery Council • Royal College of Nursing • Professional governance organisations allied to medicine This recommendation is indicative of how normalised it has become for schools to provide delegated NHS health services. In that, a school must follow guidance from the health sector regulatory/inspectorate body

				and professional governance organisations which have no reach into a school functioning within the education statutory framework. For example, CQC requirements for training and competency are to ensure registered providers comply with the statutory obligations in the Health and Social Care (HSC) Act 2008 (Regulated Activities) Regulations 2014. Schools are not CQC registered and are not subject to the HSC Act 2008 Regulations 2014. Therefore, is it reasonable and practical to expect a school leader to know, understand and implement CQC standards and guidance. Put another way, if NHS providers were informed that when therapists provide EHC plan section F provision that educates or trains, they must follow the guidance and standards set by the DfE Teachers' Standards and the Teaching and Regulatory Agency, this would probably be considered unreasonable and impractical. It is likely, that this suggestion would be dismissed fairly abruptly. Whilst it is understandable that there is an aim to improve standards of clinical activity within the education sector, this recommendation illustrates the fundamental flaw with the current service delivery model and the system attempts to 'square the circle'. Schools are expected to operate as fully functioning NHS healthcare providers but the foundations for high quality, safe NHS provision do not exist in the education sector.
17	Guideline	53	8-12	**Rec 1.15.28:** These recommendations in conjunction with the definition of 'support worker' (pg. 63) indicate that NICE is endorsing the current custom and practice of schools providing NHS care plan services via delegation which sits outside the NHS statutory commissioning/provision framework. It is noted that the committee list (2019) refers to a lawyer as a co-opted member. Assuming that this post has now been filled, the committee may wish to take legal advice on this recommendation in light of the ongoing discussions in the specialist education sector (referred to in comment 8). Of particular importance would be potential organisational risks to NICE. A legal view may advise that mitigation and future proofing steps may be prudent. For example, at some point within this set of

				recommendations, making reference to delegating health tasks '*where legally compliant'* may mitigate NICE organisational risk and future proof the guidelines against developments in this area.
18	Guideline	53	12-13	**Rec 1.15.28:** *'In particular, employers must: ensure support workers are competent to carry out these tasks'* Again, this could prove challenging for schools, could the committee clarify what is meant by this element of the recommendation. School leaders/staff are education professionals. Generally, they are not clinically trained and have no experience of working in the NHS. Recommending that schools ensure their workforces are competent in carrying out NHS care plan health procedures, does not seem feasible. NHS commissioners/providers have a duty of care to ensure NHS services including delegation are appropriately commissioned/provided. Registered health professionals also have professional obligations to ensure competency when they delegate tasks. To ensure this recommendation can be applied to the school setting, would a more appropriate phrase be employers must: '*have arrangements in place to ensure support workers are competent to carry out these tasks'*. Schools/NHS partners should have jointly agreed robust governance policies for delegation but it is the health organisation/professional that must be responsible and accountable for ensuring standards and competency for this activity.
19	Guideline	53	17-19	**Rec 1.15.28***: 'ensure that training providers or other suitable organisations will provide ongoing supervision of support workers when a clinical competency must be assured to a required standard'.* In the context of delegation of health interventions and tasks, this recommendation is unclear. As noted in comment 12, the CQC has guidance on training and competence for medicines optimisation in adult social care. This guidance appears to make a distinction between medicines support tasks in which accredited training providers and external assessors are recommended and medicine administration that requires registered nurse delegation. The linked CQC guidance on delegating medicines administration focuses on the responsibilities of both the registered nurse delegating the task and the support worker

				accepting the task. For example, registered nurses must make sure that everyone they delegate tasks to is adequately supervised and supported. Additionally, both the registered nurse and care worker should understand accountability, liability and responsibility and they should make a record of their understanding. The title of this set of recommendations suggest that they relate specifically to the delegation of health interventions. So presumably, these interventions would be specified in a child or young person's NHS care plan, and require registered NHS professional delegation in line with professional standards for risk assessment, training, competency assessment and supervision. As noted previously, there is a lot of confusion about 'delegation' v's 'training'. Could the committee clarify within the context of delegation and an NHS pathway i.e. NHS commissioning responsibility, NHS care planning and NHS registered professional delegation, what is meant by a 'training provider' and 'other suitable organisation.' Do these terms refer to NHS provider Trusts/registered professionals delegating the activity?
20	Guideline	53	24	**Rec 1.15.28:** Following the statement *'when a collaborative investigation is needed'*, the committee may wish to consider adding a statement about a mechanism to capture and disseminate learning to improve practice.
21	Guideline	53	25-29	**Rec 1.15.29:** Previous point applies re. including HCPC as a statutory regulatory body with specific professional standards for delegation.
22	Guideline	56	5-6	**Rec 1.17.1:** This recommendation states that outcomes should be specified in contracts and the rationale given for this is services will be better equipped to meet needs (Evidence Reviews pg. 29, lines 25-28). This is a positive. However, as noted, a significant proportion of EHC plan health provision in the education sector is delivered by the education workforce outside NHS commissioning. Consequently, there is neither funding nor contractual arrangements for this activity. The committee may wish to consider this recommendation in light of the fact that schools providing EHC plan health provision do so outside any contractual arrangement.

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23	Guideline	63	1-3	**'Support Worker' definition** a) Support workers for disabled children and young people with severe complex needs carry out a vast array of tasks across the education, health and social care sectors. Whilst the guideline focuses on support workers involved in delegated health tasks it does also include reference to support workers providing assistance in seeking employment (rec 1.13.10 pg. 44 lines 3-7). This latter support worker activity does not appear to fit with the guideline definition of support worker. b) The support worker definition includes '……*(including teachers, teaching assistants and other staff in education or care settings).'* Given the discussions that are taking place in the specialist school sector, the committee may wish to consider future proofing the guideline i.e. removing explicit references to the education workforce and replacing with '*non-health, unregistered employees'*.

Insert extra rows as needed

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