ESC Management Services Limited

Clinical Nursing Services in Special Schools: Why we Need to Revisit Statutory Duties

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Abstract

The Children and Families (CAF) Act 2014, part 3 initiated reforms that aimed to create an integrated, improved and consistent offer of support for children and young people with special educational needs and disabilities. Education, Health and Care (EHC) plans are a key vehicle for the SEND reforms. In special schools, the established service model for providing clinical nursing services relies on education staff delivering nursing interventions. A legal perspective has been taken to critically analyse this service delivery model. The paper proposes that the activity of delegation is a fault line in the current model which potentially, exposes Clinical Commissioning Groups (CCGs), Local Authorities (LAs) and special schools to legal challenge.

Four key questions are raised in relation to the CAF Act 2014: a) Are CCGs in breach of s. 42? b) Are LAs acting beyond statutory duty under s. 42? c) Are special schools acting beyond authority and power under s. 100? and d) Are LAs implementing unlawful policies ('high needs block' funding models)? The position presented is that within the service model, delegation has led to a shift in boundaries i.e. statutory duties v's actual activities. As a result, a two-tier system of NHS clinical nursing provision has emerged. The paper concludes with thoughts on statutory compliance and future opportunities which includes delegation within a statutory compliant framework.

Introduction

The special educational needs and disability (SEND) reforms set out in the Children and Families (CAF) Act 2014, part 3 were described as 'landmark' changes (Timpson, 2014). The legislation initiated reforms that aimed to create an integrated, improved and consistent offer for children and young people with SEND. Whilst many examples of high quality provision have emerged, systematic failings in implementation are also evident (House of Commons Education Select Committee, 2018/19). The aims of the paper are two-fold. The first is to take a legal perspective to critically analyse the accepted delivery model for clinical nursing services in special schools. This identifies previously overlooked issues regarding delegation and challenges the legality of the model. The second is to encourage professionals to revisit statutory duties and discuss the points raised so that this new perspective can be incorporated into future policy, guidance and practice.

In the first instance, it is essential to provide context. Education, Health and Care (EHC) plans are a key vehicle for the SEND reforms. Special school settings represent a concentrated population of children and young people with EHC plans many with complex, fluctuating and life threatening health needs. Therefore, if the system to secure EHC plan health provision is failing, it is special schools that acutely experience the impact and, more importantly, where there is greatest potential for harm. The national picture is that, within special school settings, there is the continuous challenge to ensure high quality, safe nursing care against a backdrop of reducing NHS services, workforce issues and funding constraints (NAHT, 2018; Smith, 2016; House of Commons Education Select Committee, July 2019). It is for these reasons that special schools are the focus of this paper.

A stepwise approach has been taken to analyse the legal aspects of the established service model for clinical nursing services. Judge McConnell, SEND Tribunal's lead Judge is known for the phrase '*know the law and apply the law'.* Taking this lead, the first part of the paper revisits statutory duties in relation to EHC plan health and education provision to provide context and the basis for discussion. The second and third parts consider how legislation is applied in relation to special school nursing. This brings scrutiny to the activity of delegation and proposes that there are grounds to challenge the legality of the service model. Adding to the discussion, the 'real world' consequences and challenges of the model are outlined. Part four initiates the discussion about a statutory compliant approach and concludes with final thoughts.

1) Legislation and Statutory Guidance

This provides an overview of legislation for the provision of EHC plan health and education services, the full legislative framework is extensive and complex so it is not intended to be exhaustive. Sufficient information has been covered concerning primary and secondary legislation, case law and statutory guidance to allow an informed discussion of legal responsibilities.

The CAF Act 2014: Statutory Duties on the NHS and LAs

The CAF Act 2014 part 3 sets out requirements for children and young people in England with SEND. S. 26 places a legal duty on LAs and NHS bodies to work together to jointly arrange provision of education, health and care services. This fits in with the statutory duty of s. 75 of the NHS Act 2006 (amended) which allows NHS bodies and LAs to enter into arrangements to exercise their respective responsibilities for health provision. LAs are responsible for education and social care services as well as public health functions (imposed by Health and Social Care Act 2012). CCGs are responsible for section 3 NHS Act 2006 services which include clinical nursing. Importantly, in terms of special schools this represents two distinct types of nursing care; clinical and public health which CCGs and LA are respectively responsible.

S. 21 of the CAF Act 2014 states that health or social care provision which "educates or trains" is to be treated as special educational provision. Case law has shown that NHS therapies such as speech and language, physiotherapy and occupational therapy can be classed as special educational provision (R v Lancashire County Council ex parte M, 1989; London Borough of Bromley and Special Educational Needs Tribunal and others, QBD and CA (1999) ELR 260). It has been established in the courts that speech and language therapy is usually always deemed special educational provision as communication is fundamental to learning.

S. 42 specifies statutory duties for special educational provision and health care provision. LAs are responsible for arranging specified educational provision and the relevant health commissioning body is responsible for arranging specified health care provision. S. 42 explanatory notes clarify the responsible commissioning body would typically be the relevant CCG but may also be the NHS Commissioning Board (now NHS England). 'Specified' means specified in the EHC plan. S. 42 states:

(2) The local authority must secure the specified special educational provision for the child or young person.

(3) If the plan specifies health care provision, the responsible commissioning body must arrange the specified health care provision for the child or young person.
(4) "The responsible commissioning body", in relation to any specified health care provision, means the body (or each body) that is under a duty to arrange health care provision of that kind in respect of the child or young person. (CAF Act, 2014. S. 42, ss. 2, 3 and 4)

This legal duty is important. The CCG duty imposed by section 3, NHS Act 2006 to arrange provision is written in broad terms "to such an extent as it considers necessary to meet reasonable requirements of the persons for whom it has responsibility." In contrast, s. 42 is a legally enforceable duty on CCGs to provide the specific health services in the EHC plan.

S. 42, ss. 5 removes the duty on health commissioners to arrange provision if the child's parent or young person makes suitable alternative arrangements. This allows parents to arrange care using personal health budgets (PHBs). Two points have relevance. Firstly, when CCG PHBs are used, a CCG retains a legal duty to be satisfied that health needs and outcomes are likely to be met. This includes ensuring advice, guidance and monitoring arrangements are in place. Secondly, parental duty to 'look after' does not extend to providing NHS care as such, when parents provide care this is choice and not a legal duty. See Parliamentary and Health Service Ombudsman (2019) investigation into the arrangements for Dylan Gray's NHS service provision.

Corresponding statutory guidance for CAF Act 2014 part 3 is DfE and DH (2015), SEND code of practice: 0 to 25 years (hereafter referred to as 'the Code'). This reiterates the health commissioner responsibility to secure EHC plan health care provision. This would be the relevant CCG but may be NHS England, if highly specialist services are specified. The Code also sets expectations for information to be included in the EHC plan "Provision should be detailed, specific and should normally be quantified for example, in terms of the type of support and who will provide it." (p.167)

Within the Code, special educational need is catergorised into four areas; communication and interaction, cognition and learning, social, emotional and mental health difficulties and sensory and/or physical needs. The latter category describes needs relating to disability including visual impairment, hearing impairment, multisensory and physical disability.

The CAF Act 2014: Statutory Duties on Schools

The statutory duty on schools is s. 100, part 5 therefore, not limited to pupils with SEND. The duty is to "make arrangements for supporting pupils at the school with medical conditions." The wording 'make arrangements' is used in other public sector legislation and

allows schools discretion to decide suitable arrangements. The Landmark Chambers (2018) discusses NHS services and states legal guidance on the term 'make arrangements' is limited. However, this has been interpreted as intention rather than outcome so the *way* in which outcomes are achieved (R (Nash) v Barnet London Borough Council (Capita plc and others, interested parties) [2013] EWHC 1067 (Admin)). In this sense, schools would have a duty to ensure appropriate arrangements are in place to meet medical needs including access to NHS services and that school policies describe arrangements.

Statutory guidance for this duty is DfE (2015) Supporting Pupils with Medical Conditions (hereafter referred to as 'the Supporting Pupils guidance'). Two specific references are made to children and young people with SEND. Firstly:

> For children with SEN, this guidance should be read in conjunction with the special educational needs and disability (SEND) code of practice. The SEND code of practice explains the duties of local authorities, health bodies, schools and colleges to provide for those with special educational needs under part 3 of the CAF 2014. For pupils who have medical conditions that require EHC plans, compliance with the SEND code of practice will ensure compliance with this guidance with respect to those children (DfE, 2015, p. 6).

Indicating that for pupils with EHC plans, the CAF Act 2014 part 3 and the Code are the primary references and compliance with SEND legislation would lead to compliance with the s. 100 duty. Secondly, the Supporting Pupils guidance highlights CCGs role in special schools:

> **Advice on the role of clinical commissioning groups (CCGs)**
> Since 2013 Local Authorities have been responsible for commissioning public health services for school-aged children including school nursing. CCGs should be aware that this does not include clinical support for children in schools who have long-term conditions and disabilities, which remain a CCG commissioning responsibility. Children in special schools in particular may need care which falls outside the remit of the local authority commissioned school nurses, such as gastrostomy and tracheostomy care, or postural support. CCGs should ensure their commissioning arrangements are adequate to provide the ongoing support essential to the safety of these vulnerable children whilst in school (DfE, 2015 p. 16).

Additional Relevant Legislation

Safeguard and Promote Welfare: The Children Act (CA) 2004, s. 11 imposes a duty on organisations and agencies to safeguard and promote the welfare of children which includes preventing impairment of a child's health or development. This duty applies to LAs and schools (and CCGs). The Education Act (EA) 2002, also places a duty on LAs and school

governing bodies for safeguarding and welfare of children. EA 2002, s. 175 provides that a LA exercises the safeguarding and promoting welfare duty in respect of obligations imposed by Part 3, CAF Act 2014. Both CA 2004 and EA 2002 duties are to "make arrangements."

Case law gives an insight into the courts view of nursing services and the duty to safeguard and promote the welfare of children. In R (T, D and B) v Haringey LBC. [2005] EWHC 2235 (Admin); (2006) 9 CCLR 58), the High court found tracheostomy nursing care was a health commissioner responsibility, in accordance with the NHS Act 1977 [now NHS Act 2006]. This nursing care was beyond the LA duty to safeguard and promote welfare. Mr. Justice Ousley commented, interpreting the LA duty to safeguard and promote welfare so widely would result in "a substitute or additional NHS for Children." (para. 68)

Equality: Part 6 of the Equality Act 2010, places a duty on schools to make reasonable adjustments to ensure access to education. DfE (2014), clarifies the term auxillary aids as including aids or services which are "things or persons which help." However, there are limits, the key being "reasonable". The guidance refers to aids not directly related to educational need i.e. "necessary for all aspects of their life" (para 4.19, p. 27), it is likely to be held unreasonable for a school to provide these. It is also likely to be held unreasonable for a school to provide services beyond its statutory powers.

Turning to the phrase '***know the law*** *and apply the law'*, the legal framework appears clear. In summary:

- CCGs have a legal duty to arrange section 3 NHS Act 2006 health services specified in an EHC plan this includes clinical nursing services.
- LAs have a legal duty to secure special educational provision specified in an EHC plan, this may include NHS services e.g. therapies, if educates or trains.
- Schools have a legal duty to ensure arrangements are in place to support pupils with medical conditions.
- LAs duty to safeguard and promote the welfare of children does not extend to providing NHS clinical nursing services which remain a NHS responsibility.
- Schools have a duty to make 'reasonable' adjustments for disabled pupils. Adjustments not considered an education need or beyond the scope of statutory powers are likely to be deemed unreasonable.

2) Applying the Law – The Service Delivery Model

Building on the legislation review, a legal perspective has been taken to examine the approach for the provision of clinical nursing services in special schools. Three areas are covered: joint working and EHC plans; the nursing delivery model and delegation of clinical nursing procedures. The activity of delegation is a focus and main assumptions and key questions are identified. These key questions highlight possible grounds for legal challenge.

Joint Working and EHC Plans

Joint working is central to the SEND reforms. However, a consistent theme identified by Local Area SEND Inspections has been ineffective collaboration and joint commissioning approaches (CQC & Ofsted, 2017). Criticisms levelled at EHC plans have included poor quality health input specifically, unspecified and unquantified information (Local Government & Social Care Ombudsman, 2017; Sales & Vincent, 2018). CQC & Ofsted (2017) noted, "common weaknesses" (p. 6) in processes for securing health contributions so the reasons for this are likely to be complex. Given the legally enforceable duty (s. 42) on health commissioners to arrange specified provision this is of great concern. However, when EHC plans do include health information detailing "type of support" and "who will provide it" i.e. the NHS nursing team usually, this is only part of the story.

NHS Clinical Nursing – Service Delivery Model

The Healthy Child Programme 0-19, public health school nursing is supported by a suite of national policy, guidance and resources (PHE, 2018; RCN 2017). The public health approach covers four levels of nursing services, community through to partnership plus. Partnership plus covers provision for children with complex health needs and disabilities. However, core public health services such as health promotion and safeguarding run through all four levels. PHE (2018), Commissioning Guide 2, stresses joint commissioning and integrated services are essential to ensure LAs and CCGs meet their respective public health and clinical care commissioning responsibilities. The guide outlines examples of CCG commissioned clinical services including Children's Community Nursing (CCN), Special Needs School Nursing (SNSN), Paediatric Palliative Care and Continuing Care.

In contrast, there is no national model or guidance for clinical nursing care in special schools. Although, nationally recognised examples of best practice do exist where SNSN services have developed innovative approaches to identify and meet needs of special school pupils. For example, Sussex Community NHS Foundation Trust and Bradford District Care NHS Foundation Trust (RCNi, 2018; Children & Young People Now, 2019). There are no

national sources of information or databases and anecdotally, there are significant national and regional variations in levels of NHS clinical nursing support. Despite the variations, what is consistent is the reliance on education staff to deliver clinical nursing care.

When EHC plans specify nursing care, the provision of care would usually involve two elements: registered nursing and unregistered activities. Registered nurses take responsibility for the overall clinical management of care and professional responsibilities for delegating tasks. Unregistered workers, when trained and assessed as competent, have responsibility for delivering nursing procedures. Typically, in the special school setting the unregistered workers are teaching assistants. Clearly both registered and unregistered roles are vital. Delegation underpins this activity and it is at this point the legality of the service model requires further examination.

Delegation of Clinical Nursing Procedures

Over recent years, the nursing profession has experienced increasing workloads and reducing workforce. Coupled with policy drivers such as care closer to home and personal health budgets: an increasing number of nursing tasks are delivered by unregistered/non-health support workers. The Cavendish Review (2013) highlighted, there were over 1.3 million frontline unregistered health and social care staff who were delivering the bulk of hands-on care. The Nursing and Midwifery Council (NMC), the professional regulator of nurses in the UK defines delegation as "the transfer to a competent individual, of the authority to perform a specific task in a specified situation" (NMC, 2018a. p. 3). Registered nurses are regulated by statute and are accountable to the NMC. The NMC has explicit professional standards for registered nurses when delegating tasks (NMC, 2018b). The Royal College of Nursing (RCN) (2018) also has comprehensive guidance and provides an advisory list of "clinical procedures" suitable for delegation within education settings (p. 18).

Questioning the legality of the service model is based on two assumptions. Firstly, when delegating nursing procedures to education staff, the act of delegation does not change the nature of the task i.e. it remains a clinical procedure. Both NMC and RCN guidance detail registrant's accountabilities and responsibilities to ensure unregistered workers have access to training, supervision, competency assessment and support. NHS England (2017) provides comprehensive guidance for delegation within PHBs and also stresses the importance of governance frameworks. These publications indicate procedures remain clinical activities when delegated. Furthermore, case law shows the court recognises the unchanging clinical nature of delegated tasks. In the Haringey case, Mr. Justice Ousley stated:

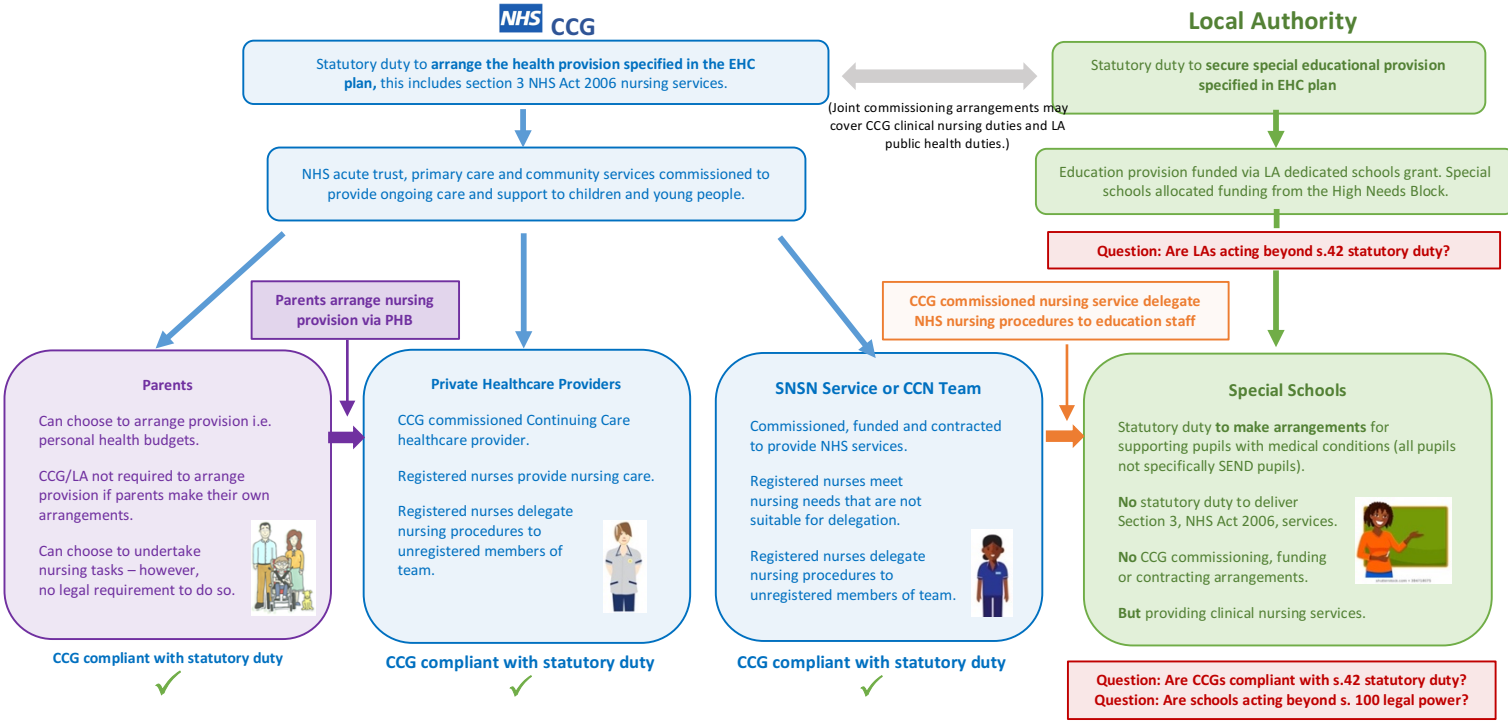
> The nurses themselves require specific training in tracheostomy care. While it is possible for others to be trained in that specific care, it would still clearly be an important medical procedure in which they were trained. (R (T, D and B) v Haringey LBC. [2005], para. 67)

More recent case law, R (Juttla and others) v Herts Valleys CCG [2018] EWHC 267 (Admin) reiterated this position. The CCG argued that because non-health support workers could be trained to provide the nursing services this fell outside the scope of NHS Act 2006 services. The Judge dismissed this argument.

The second assumption is that the RCN advisory list of "clinical procedures" equally serves as a list of nursing services under section 3 NHS Act 2006. Strengthening this assertion, referring back to the Haringey case, tracheostomy nursing care included on the RCN advisory list was held to be a service under the NHS Act 1977 (now NHS Act 2006).

Based on these two assumptions, what emerges is the **critical point:** delegating clinical nursing procedures to education staff results in special schools and their workforces providing NHS Act 2006 nursing services. Registered nurses may have transferred authority to an individual school support worker but on what legal basis are schools, as the employing organisation, providing these NHS Act 2006 clinical nursing services? In this model, delegation appears to be a 'fault line' leading to system wide, statutory breaches. Three key questions are illustrated in Figure 1.

Figure 1: Children and Families Act 2014, part 3 statutory duties and the provision of clinical nursing services.



Key Questions – CAF Act 2014

a. Are CCGs compliant with their s. 42 statutory duty when special schools provide clinical nursing services specified in EHC plans, independent of CCG commissioning?

b. When LAs take responsibility for arranging clinical nursing services specified in EHC plan as health provision, is this beyond statutory duty under s. 42?

c. When special schools provide clinical nursing services in the absence of CCG commissioning arrangements, is this beyond legal authority and power under s. 100?

Nationally, these questions have not featured in discussions. Therefore, the issues are yet to be fully explored. NHS policy leaders, professional nursing organisations and associated medico-legal advisors are required to provide a view on the assumptions underpinning these key questions. This would develop an understanding of the validity of this reasoning and the parameters that would apply. Similarly, the legal position on delegation, in relation to EHC plans and education settings, has not been tested in the courts. It is possible legal arguments and criteria not referred to in this paper are relevant. However, there does appear to be a basis for questioning the legality of the service model with the key questions being possible grounds for challenge.

3) Applying the Law – 'The Real World'

The CAF Act 2014 part 3 aimed to construct a framework for integrated, improved and consistent SEND support. With this in mind, a 'real world' view has been taken to explore the service model further. Two lines of discussion are presented. Firstly, focusing on the specific points in question the associated consequences and challenges are outlined. Secondly, a hypothetical stance is taken to answer the question, how could an unlawful service model become established as custom and practice?

Consequences and Challenges

CCGs – CAF Act 2014, S. 42

S. 42 places a legally enforceable duty on CCGs to arrange EHC plan health provision. However, as highlighted a large proportion of EHC plan nursing care is delivered by education staff outside CCG commissioning. The importance and significance of this is evident when considering the underlying components of CCG commissioning.

CCG commissioning is a broad range of activities covering; planning, procurement and contracting, performance and quality monitoring. CCGs have a duty to secure NHS services in a way which promotes principles of the NHS constitution, including promoting equality and protecting the vulnerable, and working across organisational boundaries (NHS England, 2015). There is also a specific legal duty to improve the quality of services commissioned.

The Code states CCGs should work with LAs to ensure sufficient capacity is contracted to deliver necessary services. CCG procurement and contracting serves to ensure NHS clinical services have sufficient capacity and are funded via appropriate funding streams. Additionally, contracting provides mechanisms for incorporating robust systems for performance monitoring and quality assurance. These frameworks are essential for high quality, safe NHS services. The consequences of providing clinical services in the absence of these NHS frameworks could feasibly be an unsecure workforce, an absence of NHS performance monitoring and quality assurance and inappropriate funding mechanisms.

LAs – CAF Act 2014, S. 42

The potential ground for challenging LAs is acting beyond the statutory duty in relation to the CAF Act 2014 s. 42 and the duty to arrange special educational provision. Reflecting on this, it is necessary to have a basic understanding of special school funding. Education provision is funded by the Dedicated Schools Grant (DSG). This budget is split into notional blocks and includes the 'high needs block' which funds special school provision. Spend is governed by the School and Early Years Finance (England) (No.2) Regulations (2018) and can only be used for purposes specified. The regulations state:

> Expenditure on the provision of special medical support for individual children and young people in so far as such expenditure is not met by an NHS Trust, NHS foundation trust, Clinical Commissioning Group or Local Health Board. (Part 5, s. 39)

This enables LAs to utilise funding for NHS services identified as special educational provision and specified as such in an EHC plan. These regulations are a Statutory Instrument i.e. secondary legislation. Therefore, it is imperative that s. 39 is viewed in the context of primary legislation in this case CAF Act 2014 s. 42. To illustrate this point, the Education and Skills Funding Agency sets context:

> ESFA makes an allocation to local authorities for high needs as part of the DSG to support them in meeting their responsibilities for children and young people with SEND set by the Children and Families Act 2014. (High Needs Funding Operational Guide, 2019 para 18 p. 10)

Failing to recognise this context could lead to an excessively wide interpretation of s. 39 whereby this was considered a 'catch all' for any NHS service.

High needs block funding is allocated in two parts. A core element, 'place funding' centrally set and a second, top-up element 'place plus' based on individual pupil need. The Education and Skills Funding Agency (2019) recognised banding models are frequently used to allocate place plus funding. As place plus allocations are determined by local arrangements, it is difficult to establish a comprehensive picture. However, a small sample of funding models provides some insight.

Unsurprisingly, there is alignment to the Code's areas of need but there can be additional strands for medical provision (Leeds City Council, 2019; Suffolk County Council 2018; Somerset County Council, 2018; North Somerset Council, 2019; City of York, 2018). Descriptors across the bands include reference to NHS therapies in accordance with legislation. But medical descriptors refer to clinical nursing services, and needs listed are those requiring interventions from the RCN advisory list of clinical procedures. For example:

> **Medical**
> Long term medical condition/s that impact on their ability to access the academic and social curriculum. Examples of the medical condition would include severe uncontrolled epilepsy, tube feeding or oxygen dependency, frequent suctioning. Individual Healthcare Plan in place due to the potentially serious nature of their condition (North Somerset Council, 2019 p. 20).

These medical needs require provision that should/would have been specified in the health section of an EHC plan. This approach appears to be at odds with CAF Act 2014 S. 42 duties.

This links back to the consequences of the provision of NHS clinical care in the absence of CCGs commissioning arrangements. It is established in law that a policy encouraging unlawful acts is in itself unlawful (R (AD (by his mother and litigation friend LH)) & Ors v London Borough of Hackney [2019] para. 44-51). Therefore, this represents a fourth key question and consequently, an additional possible ground for legal challenge.

Key Question

d. Are LA high needs block funding models that resource clinical nursing services unlawful policies?

At this point, it is worth noting the current situation with high needs block funding. The House of Commons Select Committee Report (2019) described SEND funding as "completely inadequate" (para 105). Phrases such as 'tipping point' and 'breaking point' are synonymous with high needs funding (EPI, 2019; Parish, Bryant & Swords, 2018). The high needs funding landscape is complex and it is not suggested that the current challenges are simply a consequence of funding clinical nursing care, but undoubtedly, this is a substantial burden on already stretched budgets.

Special Schools – CAF Act 2014, S. 100

Whilst s. 100 CAF Act 2014, places a duty on schools to make arrangements to support medical needs of pupils, this is not a duty to provide NHS Act 2006 nursing services. In the established service model, when clinical nursing procedures can be delegated, there is an expectation and assumption that special schools would/should provide this care.

EHC plans often fail to acknowledge the role of education staff in nursing service provision. Hence, there are no joined up arrangements with CCGs to plan and secure the workforce to provide this care. Education staff are under no obligation to undertake nursing procedures unless included in employment contracts. Thus, providing nursing interventions has relied on the good will of staff. The fragility of this situation has been immensely challenging. Smith (2016) noted, special schools had undergone substantial workforce restructuring. Emerging roles have borne more resemblance to health workers than education workers. This brings challenges, as education leaders become responsible for education staff primarily, delivering clinical nursing services.

Ward (2018) noted, standards of health care should be consistently high, but a lack of process and provision in specialist education settings pose serious health risks. Headteachers report that health services expect schools to simply 'manage' health needs (Surrey Special School Headteachers, 2018). In some areas, a lack of appropriate NHS oversight has meant school leaders have been left to fill gaps and navigate complex clinical governance processes to create 'safe' environments. For education providers, this is outside the scope of their expertise and knowledge. A lack of national public data makes it difficult to cite specific examples, but anecdotal evidence shows avoidable incidents of harm to pupils due to inconsistent approaches and disjointed working between special schools and the NHS.

The real world picture does not appear to fit with the intended aims of the SEND reforms i.e. to create integrated, improved and consistent services for children and young people with SEND. The reality looks more like a fragmented, two-tier system of care. Returning to the notion that delegation is a fault line in the system, it is easy to visualise how these individual pieces fit together and how the boundaries of legal duties v's actual activities may have shifted. It is plausible that within the system, one point of non-compliance has caused a 'theoretical' gap which has been filled, but at the expense of statutory compliance at other points in the system. The fact that the gap has been 'theoretical' may have contributed to the delegation issues remaining hidden up until now.

The Service Delivery Model - Encouraged and Embedded?

At this point, it would be helpful to address the question, how could it be possible that an unlawful clinical nursing service model could become established as custom and practice? Legislation is not applied in isolation, a mesh of policy and practice plays a part. It could be that the model has been encouraged and embedded by an inter-play of a number of factors including a failure to acknowledge 'delegation', high needs block funding models and misunderstanding and misrepresentation of legislation.

The Activity of Delegation

There is a widespread lack of recognition of the true nature of 'delegation.' Whilst there is evidence that this activity is accurately described, notably by the NMC and RCN, the dominant message nationally and locally, is that education staff are simply 'trained.' Arguably, this terminology conceals the implications of the actual activity of delegation. The Code has one reference to nursing services within education, it states:

> Health professionals advise education services on managing health conditions such as epilepsy and diabetes, and health technologies such as tube feeding, tracheostomy care and ventilation in schools. They are able to provide an ongoing overview of health and wellbeing. They seek advice from paediatric specialists when necessary and facilitate training for education staff. (para. 3.62)

Conditions listed are covered by procedures on the RCN (2018) advisory list which require delegation, but 'training' does not capture the significance of this. Additionally, what is also highly relevant, this paragraph implies health professionals provide training and oversight for education providers to manage these health conditions and technologies. This does not appear to be compliant with CAF Act 2014 duties? Could it be that the Code intended to

advise on the application of the SEND legislation actually conflicts with the legislation and encourages an unlawful practice?

High Needs Block Funding Models

LA high needs block funding models which include nursing provision have undoubtedly, been a key driver for establishing the service model as accepted practice. Two clues point to the potential premise for this inclusion. Firstly, some range models use the term "Individual Healthcare Plans," this is the Supporting Pupils guidance terminology. Secondly, the Cornwall Council (2017-18) funding model, includes "Medical" descriptors which cover a range of needs described as 'long term medical conditions' and 'chronic or degenerative medical conditions.' This category signposts readers to the Supporting Pupils guidance "for further statutory advice" (p. 4). This is striking as it suggests schools are responsible for this provision. The earlier review of legislation identified this is not the case.

Legislation – Misunderstood and Misrepresented

Linking to the previous point, there is evidence of extensive misunderstanding and misrepresentation of the CAF Act 2014. House of Commons Education Committee (May, 2019) highlighted the confusion around legal responsibilities, EHC plans and school nursing. The narrative on this topic appears to be biased in the way CAF Act 2014 duties are presented and interpreted. There tends to be a focus on schools' duty to "make arrangements for supporting pupils" and an omission of the CCG duty to "arrange the specified health care provision." The majority of pupils with medical conditions do not have an EHC plan. Therefore, generally this emphasis is understandable. However, this emphasis still remains when discussing EHC plan health provision. Examples shown below:

- RCN (2018) refers to EHC plans and the Code but the only duty mentioned is that on schools (p. 8). Guidance contains no reference to the CCG duty to arrange EHC plan health provision.
- NHS England (2018) guidance outlines the role of health visiting and nursing teams. This states that the Children's Community Nursing Team role includes "Providing clinical training for school staff aligned to the child's EHC plan" (p. 18).
- National Association for Special Educational Needs (nasen) (2016) guidance on SEND reforms and responsibilities, covers EHC plan statutory responsibilities but there is no reference to the CCG duty to arrange health services.

It appears possible that a combination of these factors have led to a system wide perception that delegation of clinical nursing procedures to school staff *should* happen, but seemingly,

with little/no consideration to statutory compliance. It is also noteworthy that arrangements for both clinical nursing services and high needs block funding are locally determined. It could be argued, a lack of national leadership and guidance in this area could also have played a part in masking the issues highlighted. Whilst this real view does not advance the legal argument, it does provide pause for thought and strengthens the position that statutory duties should be revisited.

Returning to the phrase '*know the law and **apply the law'***, application of the CAF Act 2014 in terms of EHC plan clinical nursing provision a number of points have been raised. In summary:

- **Critical point:** delegating clinical nursing procedures results in special schools providing NHS Act 2006 nursing services.
- Delegation may be a fault line in the service model which creates system wide statutory non-compliance in relation to CAF Act 2014 s. 42 and s. 100 duties.
- The 'real world' picture supports the suggestion there has been a shift in boundaries in terms of legal responsibilities v's actual activities. This is in relation to workforce issues, NHS clinical governance frameworks and funding mechanisms.
- It is feasible that policy and practice may have contributed to establishing what could be an unlawful model. Possible factors; failure to acknowledge the activity of delegation, high needs block funding models and misunderstanding and misrepresentation of legislation.

4) Statutory Compliance

Smart (2019) argued that the law is clear and if implemented would meet the needs of pupil with SEND. The discussion presented in this paper supports this view. First and foremost, special schools are education settings but often health needs mean they are also unique clinical environments. This paper has called into question the legality of the current service model and in doing so has brought to the fore the need for increased NHS involvement. However, it is not the intention to advocate an overly medical model but rather, ensure the provision of NHS clinical nursing services is tailored to the education setting within NHS frameworks. Without this, pupils with nursing needs in special schools are disadvantaged and in some cases exposed to harm. The aspiration of the reforms was an integrated,

improved and consistent service offer for children and young people with SEND. These principles have been taken in turn as starting points for statutory compliance discussions:

Integrated

The legislative framework and infrastructure for integrated working is in place. Joint working arrangements such as pooling budgets under s. 75 NHS Act 2006 are extensively used to support integration across LAs and CCGs. Statutory Health and Wellbeing Boards are best placed to drive this agenda along with relevant Strategic Delivery Partnerships. Local commissioning, contracting and funding mechanisms need to be identified which enable CCGs, LAs and special schools to comply with CAF Act 2014 s. 42 and s. 100 duties. This approach should be considered along with existing arrangements for joint commissioning of public health and clinical nursing services.

This is a system wide problem that requires a system wide solution. This may be increases in traditional NHS services that are tailored to the education setting or it could involve a new special school support role e.g. a 'hybrid' teaching and health support worker. Examples do exist of CCG part commissioned/funded school support workers. Whatever approach is taken it has to ensure all local partners are compliant with legislation and that NHS frameworks cover all aspects of NHS clinical care.

Improved

The SEND reforms place an emphasis on outcomes. In order for children and young people with nursing needs to achieve the best possible outcomes, their needs should be managed by high quality nursing provision. The NHS quality duty should cover all aspects of NHS nursing care in special schools regardless, of whether delivered by a traditional NHS provider or a school based worker. Therefore, it is essential that appropriate NHS monitoring and governance systems are in place to achieve this. The activity of delegation would require robust delegation policies and frameworks drawing on existing good practice such as Sussex Community NHS Foundation Trust (RCN, 2018. P. 5). Engagement with a range of education, health and trade union organisations would be necessary to develop a blueprint for a compliant education and health support role.

Consistent

The NICE guidance (2019) for children and young people with disabilities and severe complex needs is due in 2021 and provides an opportunity for clarity and guidance in this area. Under NICE Statutory Instrument (2013) regulation 5, NICE guidance is not presently

legally binding. However, NICE guidance now has greater legal weight by virtue of case law (For example, R (on the application of Elizabeth Rose) v Thanet Clinical Commissioning Group [2014] EWHC 1182 (Admin)). The guidance will be invaluable for setting national standards for commissioning and provision of clinical nursing services in education settings. It is critical that the legal issues identified are widely discussed and debated to arrive at a position of understanding and clarity to inform this guidance.

CQC and Ofsted Local Area SEND Inspections offer another route to ensure local partners are meeting statutory obligations in this area. Inspections should consider this new legal perspective when reviewing EHC plan provision to add further scrutiny and challenge to local area arrangements. This would not only establish a national picture but also identify areas of good practice to inform national guidance. Furthermore, although the NHS England SEND programme has now closed, the SEND agenda is to continue via the NHS Long Term Plan, Children and Young People's Programme Board. This would also provide an opportunity for leadership in this area.

Final thoughts

This paper has taken a legal approach to critically analyse the accepted service model for providing clinical nursing in special schools. In doing so, it has contributed a new perspective regarding delegation and questioned the legality of the current arrangements for providing nursing care. Inevitably, as this is a new line of thinking, the assumptions and arguments have not been exposed to scrutiny or wider discussions so no firm conclusions can be made. The hope is that information presented encourages professionals working in this area to revisit statutory duties and reassess their own arrangements. It is imperative that at both national and local level the issues highlighted receive attention and the challenging questions are raised. Discussion and clarification are required to ensure an accurate interpretation and understanding of the CAF Act 2014 s. 42 and s. 100 duties informs future policy, guidance and practice.

Undoubtedly, if the points raised are valid and the current model does contravene law, the implications would be far reaching. The scale and complexity of the system change would be immense. That said, the CAF Act 2014 legal framework is in place, and ultimately, the accurate application of the legislation is critical if the reforms are to have any chance of success.

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