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Nursing Provision in Specialist Education Settings

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COLLABORATE INFLUENCE ADVOCATE

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Coronavirus Pandemic

The planned publication of this report in 2020 was delayed at the request of SSV, due to the disruptive impact of the Covid pandemic. The experiences of headteachers and staff in special schools during the last 18 months has highlighted how the pre-existing concerns set out in this report, have been exacerbated by the additional demands placed on NHS services across the country. This has led to a reported deterioration in the level of services provided in many areas of England. The recommendations in this report are intended to give policy makers a stepping off point for the changes that may need to be made as part of the national SEND Review when it reports in Autumn 2021, and have been updated with that intent.

Contents

1.0 Introduction

1.1 Context

The number of children and young people with statements of special educational needs (SEN) or Education, Health and Care Plans (EHCPs) has increased each year since 2010. In January 2019, there were 354,000 children and young people with EHCPs, an increase of 34,200 (11%) from 2018 (Department for Education (DfE), 2019a). Alongside these increasing numbers there has also been an increase in the complexity of children and young people's health needs (Pinney, 2017).

The Children and Families Act (CFA) 2014 places a duty on health commissioners to arrange EHCP health provision. This duty aimed to ensure that an EHCP assessment of clinical health need set in motion NHS commissioning in line with the NHS Constitution (Public Bill Committee, 2012-13). The NHS Constitution includes principles to promote equality for groups with lower levels of health and life expectancy and to work across organisational boundaries to deliver services (Department of Health and Social Care (DHSC), 2015). The CFA 2014 intended to strengthen the existing NHS duties to meet health needs including the CCG duty to commission nursing services.

Additionally, the NHS has made a clear commitment to children and young people with special educational needs and/or disability (SEND) identifying the need to reduce inequalities and to ensure services are provided in an integrated way. The NHS Long Term Plan made improving the health and wellbeing of children and young people with learning disabilities, autism or both a priority (NHS England and NHS Improvement, 2019). Implementation of this priority should be aligned with local plans for SEND and should take into account the national learning disability improvement standards to promote consistency. Furthermore, the NHS Long Term Plan pledges to work with the DfE and local authorities (LAs) to improve support for this group of children and young people (NHS, 2019).

Unfortunately, despite best intentions the system to arrange health services for children and young people with EHCPs is failing. In 2019, the House of Commons Education Committee reported the role of health was integral but the meshing of the systems had not worked. The report stated that unless health was 'at the table' no progress would be made (House of Commons Education Committee, 2019a, pg. 4). Submissions of evidence from the specialist education sector highlighted that, not only were we no further forward since 2014, the reality was that input from health services had taken retrograde steps (House of Commons Education Committee, 2019b).

1.2 Background

Special Schools' Voice (SSV) has responded to the increasing challenges and concerns surrounding clinical nursing provision within the specialist education sector by establishing a programme of national and regional co-ordinated activity. In January 2020, a Medicines in Specialist Schools (MiSS) steering group was established, led by eight specialist headteachers representing networks

in the DfE regions and chaired by SSV. The MiSS steering group aims to move policy forward at local, regional and national level through partnership working to secure the best health outcomes for children and young people attending specialist settings.

In February 2020, representatives from SSV, DfE and NHS England met to discuss the challenges facing the specialist education sector in terms of meeting clinical nursing needs. A point of discussion was the lack of national data/metrics for this cohort of children and young people which has been a historic and well recognised gap (Kennedy, 2010; Pinney, 2017). As a result, it was agreed that it would be beneficial to conduct a survey of specialist education settings to capture data and evidence to identify specific issues and inform developments. Findings would be shared with the DfE, NHS England and NHS Improvement and other relevant agencies/organisations to add to current understanding.

1.3 The Survey

An online questionnaire was adapted from an information gathering exercise at a Yorkshire and the Humber SEND Leaders Network event held in 2017. The questionnaire was distributed through SSV networks and was open between 28th February 2020 and 10th March 2020. Online responses were received from 179 settings. Based on the number of specialist schools in England (1,044, DfE, 2019b) this represented a response rate of approximately 15%. Responses were obtained from a geographically representative sample of NHS regional commissioning areas and CCGs (80 of the 135 CCGs, April 2020 configuration, see Appendix A).

Responses covered provisions with a total of 24,997 pupils on roll with a range of special educational needs including; autistic spectrum disorders (ASD), moderate learning difficulties (MLD), severe learning difficulties (SLD), physical disabilities (PD), profound and multiple learning difficulties (PMLD), hearing impairment (HI), speech, language and communication needs (SLCN) and social, emotional and mental health (SEMH). Three responses were submitted from Hospital Education Services, three from medical pupil referral units and two responses were submitted from day/residential provisions.

In response to the initial survey communication, the Chief Executive of the Chailey Heritage Foundation contacted SSV. It was agreed that, due to the unique service model at Chailey Heritage School, a telephone interview would be conducted and the information shared would be presented as a case study. This case study was finalised in November 2020.

The findings are in six distinct sections:

- Commissioning/Provision Arrangements
- Training/Delegation Frameworks
- Accessing Advice & Additional Support
- Incident Reporting and Management

- Additional Comments
- Case Study – Chailey Heritage School

There are two points to note. Firstly, on reviewing the responses it was evident there were a number of additional and relevant topics that had not been included in the questionnaire. These included continuing care packages, education staff employment contracts and independent training providers. Secondly, with the exception of Chailey Heritage School, the study was restricted to data collection from specialist education providers. However, in order to develop a comprehensive understanding of nursing provision in specialist education settings, ideally evidence should also be gathered from NHS commissioners and providers, LAs and pupils and their parents/carers. Acknowledging these two points, the findings sections also highlight topics and questions that should be included in future work.

2.0 Findings

2.1 Commissioning/Provision Arrangements

Key Points:

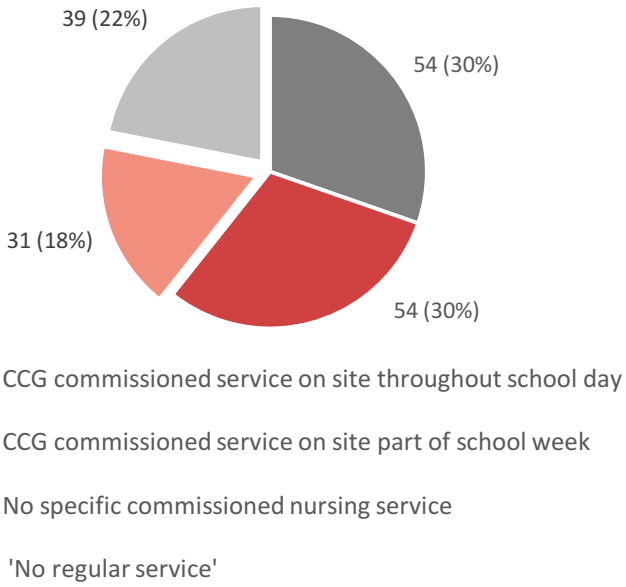
- There is wide variation in the commissioning/provision arrangements for NHS clinical nursing services across geographical areas. These variations do not appear to reflect differing clinical need. Instead, the driver seems to be differing CCG/LA locality approaches.
- The majority (60%) of specialist education settings had some level of NHS clinical nursing support on site but a significant proportion (40%) of settings reported no specific/no regular CCG commissioned service.
- The vast majority of settings had no opportunity to contribute to the type/level of NHS nursing support delivered i.e. via contract negotiations or service level agreements.
- Over a quarter (28%) of specialist education providers commission/fund supplementary NHS or independent nursing services to address gaps in CCG commissioned services.
- CCGs operate within a robust framework of legislation, quality assurance and performance monitoring. When education providers commission/fund clinical nursing services there is no equivalent framework. This has the potential to introduce poor practices and risks into the system.

Health commissioners **must** arrange the health services specified in an EHCP which includes medical treatments, administration of medication and a range of nursing services (DfE and DoH, 2015 pg. 167). Since the introduction of EHCPs, criticisms of the health input and poor joint working have been common and consistent themes (CQC and Ofsted, 2017; Local Government

and Social Care Ombudsman, 2017; House of Commons Education Committee, 2019a). But what does this look like; how has the system responded and how does this impact on the services provided to children and young people in specialist settings? The first part of the questionnaire aimed to provide some answers to these questions.

Q. Please describe the level of CCG commissioned nursing service in school?

All respondents (n=179) provided information on their local commissioned clinical nursing service. The responses were categorised into; 'CCG commissioned service on site throughout the school day', 'CCG commissioned service on site part of school week', 'No specific CCG commissioned service for school' and 'No regular service'.



Within the CCGs commissioned service categories there was wide variation in the provision described. For example, in the category 'CCG commissioned service on site throughout the school day' two seemingly similar schools i.e. both meeting the needs of ASD, SLD and PMLD pupils with similar pupil numbers, reported disparate levels of nursing service:

> *'Always a nurse or health care assistant in school'* (ID 32, 180 pupils)

> *'A team of 6 full time (school day - term time only) nurses and 4 HCAs managed (along with therapy team) by a Band 7 leader. This is across two campuses.'* (ID 26, 150 pupils)

The arrangements described for 'CCG commissioned services on site part of the school week' included;

> *'A half day a week on site, access to some training for staff.'* (ID 94, 180 pupils, MLD and SLD)

> *'1 nurse covers our school, an FE college with over 200 SEND 19-25 year olds and a primary SEND with 80 students.'* (ID 50, 107 pupils, PD and PMLD)

'1 Specialist School Nurse 3 days a week and 1 Specialist School Nurse Assistant – no set days.' (ID 72, 119 pupils, SLD and PMLD)

Specialist settings reporting 'no specific CCG commissioned nursing service' showed that some settings had access to other local nursing services. Comments also demonstrated that in the absence of an NHS special school nursing service some education providers made their own arrangements.

We only have access to the school nursing team at either XXX or XXX clinics, some are part time and the only effective medical communication is between the diabetes or epilepsy team for specific pupils. (ID 112, 110 pupils)

'We have no nursing provision at all. We did have last year, but it was taken away.' (ID 60, 102 pupils)

'We do not have any – we have to buy our own nurse in' (ID 19, 122 pupils)

'0 (as a non-maintained school we employ our own registered nurses)' (ID 30, 21 pupils)

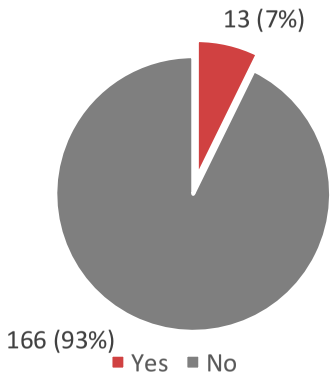
The phrase 'no regular service' was frequently used (n=39) and often referred to support from nursing services that involved telephone/email access to support.

'no regular nursing service only by telephone and attendance at school when meeting is arranged; 1 health care assistant funded by School Nursing but it will be withdrawn from Sept 2020.' (ID 4, 135 pupils)

'No regular nursing service in school but telephone access to community nursing team' (ID 69, 126 pupils)

'No regular nurse. Telephone access to community team. Paediatrician visits three times a year service' (ID 65, 62 pupils)

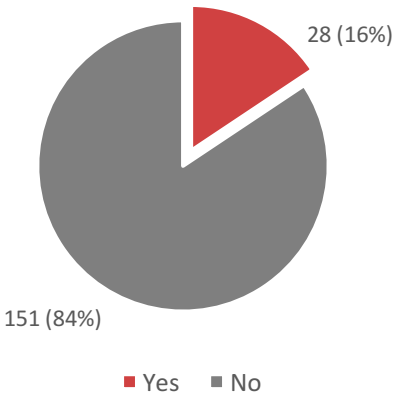
Q. Is the governing body involved in contract negotiations for the NHS nursing service in school?



166 (93%) respondents stated the governing body had no involvement in contract negotiations for the NHS nursing services provided in their setting. Of the 13 (7%) respondents that answered that the governing body was involved in contract negotiations, 6 had some form of joint commissioning/funding arrangement and 2 fully funded the costs of nursing services in school.

Therefore, this is in fact a slightly distorted picture because only 5 (3%) responses related to governing body involvement for nursing services that were fully commissioned by the local CCG.

Q. Does the school have a service level agreement (SLA) in place with the NHS nursing service provider?



For the 28 (16%) respondents that answered 'yes', a follow up question asked for an outline of what the SLA covered. As with the previous question, this included both jointly (NHS/education) and independently (education) commissioned nursing services. In addition to clinical nursing services, the responses also included some references to public health services. For example;

> *'3 HCSW every day paid for by school. HCSW under the management of the school Nurse. They deliver enteral feeds and support the Nurse in other areas. They are not allowed to undertake any tasks which compromise the registration of the Nurses ie they can not attend school visits, give medication or attend to more complex procedures such as intermittent catheterisation.'* (ID 15)

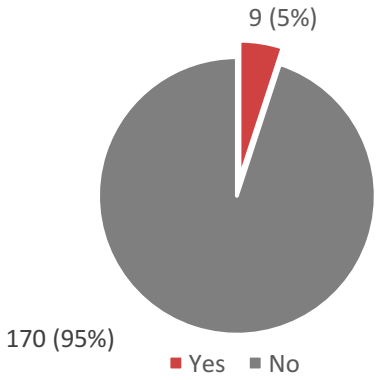
> *'We pay £10,000 per year under a service level agreement for nursing support. This covers support for pupils' health care plans and some training of staff'.* (ID 81)

> *'Staff training, heights and weights, care plans, liaison with paediatrician, parents, continence service, dieticians, SLT's, and safeguarding'* (ID 104)

> *'Information Sharing and Liaison Agreement; covers GDPR, complaints, non-compliance and requests for additional services'* (ID 138)

A high proportion of respondents (n=151, 84%) said there was no SLA in place with the NHS nursing provider. A key inference that can be drawn from these two questions concerning contracts and SLAs is that the vast majority of specialist settings have no/minimal opportunities to contribute to decisions relating to clinical nursing services to meet pupil needs. This prompts the question, how can there be effective working across NHS/education organisational boundaries if formal, structured mechanisms to manage integrated services, cooperation and partnership are absent?

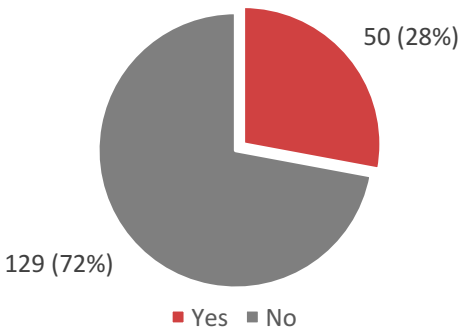
Q. Does the school make a direct financial contribution to local pooled budgets for NHS nursing staff?



Of the 9 (5%) respondents that answered yes, the arrangements for the financial contribution were again highly variable.

> *'1 Clinical Pediatric School Nurse from Children's Community Nursing Team based on site 5 days a week during term time- funded by CCG with annual financial contribution from school. No input at present from Public Health School Nursing Team.'* (ID 85, 112 pupils, SLD, PMLD and ASD)
>
> *'pay for three days'* (ID 97, 200 pupils, SLD, PMLD and ASD)
>
> *'The school pay 50% of the costs of the nursing, whilst the Education Authority pay the remaining 50%. The total cost for nursing is £185,000 per annum.'* (ID 109, 86 pupils, PMLD, SLD and ASD)
>
> *'nursing is commissioned and funded through the high needs block'* (ID 152, 133 pupils, PMLD)
>
> *'2 shared nurses across two schools. They work 9-3. They are funded 50% by schools (25% by XX and 25% by XX) and 50% by health.* (ID 154, 151 pupils, ASD, MLD, SLD and PMLD)

Q. Does the school independently commission/fund a nursing service?



For the 50 (28%) respondents that answered 'yes', examples of the commissioning/funding arrangements that were described;

> *'employ own LD nurse'* (ID 2)
>
> *'Additional hours added to existing contract'* (ID 5)

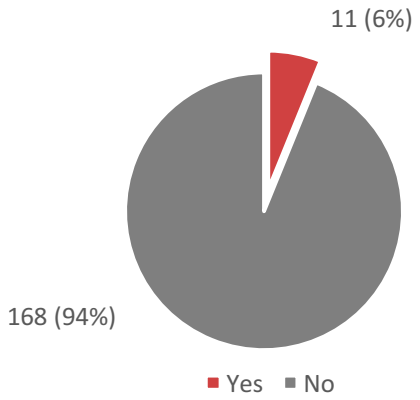
'an external agency is contracted to offer 1:1 support for a medically fragile pupil until all the class staff can be trained to a suitable level by an appropriately qualified medical professional.' (ID 6)

'25hrs/week community team children's nurse from [XX] Community Hospital @ £37500 pa' (ID 10)

'Private companies' (ID 40)

'After school finishes the school has to fully fund nursing and HCA support staff evening and overnight from our own resources. this costs over £150,000 per year due to the clinical needs of the pupils in our residential service' (ID 48)

Q. Does the local CCG make a financial contribution to staff employed by school to undertake delegated nursing tasks?



168 (94%) respondents stated that the CCG made no financial contribution to the education workforce providing nursing services. This is an indication of the extent to which the specialist education sector is absorbing the workforce costs for providing nursing care. For the 11 (6%) respondents that answered 'yes', the CCG did make a financial contribution, examples of the arrangements described included;

'They pay for N3 staff to carry our feeds' (ID 13)

'Temporary arrangement; assistance with the cost of additional HCAs to support the monitoring of pupils on pump feeds. This is following an incident. Our governing board will no longer consider CCG making financial contributions to the costs of staff on the school's payroll as this has cause acute difficulties with regard to accountability.' (ID 26)

'Job role evaluated education health care assistants. 4 posts 50% cost to CCG. School accountable for recruitment and line management however school nurse accountable for training and medical governance.' (ID 32)

'.5 nurse and .5 healthcare assistant and one FT teaching assistant specifically employed for 1;1 to manage a child with a tracheostomy. The school recharges the CCG for this role.' (ID 164)

A key finding in this section is **there is considerable geographical variations in NHS commissioning/provision arrangements.** Considering these variations in the context of pupil numbers and setting designations, the data suggests that the variations do not entirely reflect differing nursing needs but rather differing approaches adopted by CCGs/LAs locality areas. This is no surprise and confirms previous concerns raised about inequity of provision (Williams, 2019; Southfield Grange Trust, 2018). The legal duty on NHS commissioners to arrange the health provision specified in EHCPs is an absolute duty. Therefore, there should be a degree of consistency predicated on clinical need with variations reflecting differing local needs and possibly, differing arrangements for local operational delivery.

The feedback provides an insight into how local systems have responded to the reported inadequate/limited NHS commissioned services. **Education has 'stepped in' to bridge the gap and meet the clinical need either via LAs or education providers commissioning/ funding services.** This is consistent with the House of Commons Education Committee findings (2019a) which identified schools were funding clinical health services. Particularly noteworthy was one respondent reported the LA/school were funding nursing services at an annual cost of **£185,000.** It was unclear if these costs included the LA's public health offer and the source of this funding. However, it is important to note that the dedicated schools grant is subject to restrictions which do not extend to funding clinical healthcare.

When education providers take on the role of clinical commissioner it is not just problematic from a funding perspective; there are wider implications. CCGs are clinically led statutory bodies governed by a raft of legislation and guidance to ensure commissioning secures clinical services that are safe, effective and subject to continual improvement. CCGs undergo annual assessments by NHS England. NHS England and NHS Improvement have a joint approach to oversee CCG performance (NHS England and NHS Improvement, 2019/20). Put simply, CCG activity operates within a robust and rigorous framework of legislation, quality assurance and performance monitoring. **When education providers extend their role to commission clinical nursing services there are no equivalent frameworks. Potentially, this could lead to poor practices and avoidable risks in the system.**

Responses from the residential settings also highlight another disparity. There were instances where EHCP nursing needs were met by an NHS commissioned service during school hours and yet these NHS services were unavailable outside the school day. As a result, education/residential providers were independently procuring the required clinical services. Commissioning clinical nursing services for resident pupils is the responsibility of the originating CCG (NHS England, 2020) and this is outside the remit of residential specialist settings (DfE, 2015a). Difficulties in securing NHS input for residential placements and the inappropriate use of high needs budget to cover health costs have previously been highlighted (Lenehan, 2017). Despite recommendations to tackle these problems, they appear to remain unresolved.

Equality lies at the heart of the NHS Constitution which means that children and young people have the right to high quality health services irrespective of where they live. It is difficult to reconcile the variations described with this fundamental NHS principle and the clear statutory duty on health commissioners to arrange required nursing provision. But perhaps this is unsurprising, given the absence of national guidance and the reliance on local decision making for commissioning clinical nursing services in specialist education settings.

Additional topics that are relevant to this section and should be included in future work;

- *Assessing Need:* NHS commissioning is a continuous cycle of activities and assessing need is integral within this cycle (NHS Information Centre, 2008). The SEND Code of Practice (DfE and DoH, 2015) describes the importance of a shared understanding and the joint strategic needs assessment (JSNA). It sets out the relationship between population needs, commissioned services for children and young people with SEND and individual EHCPs. Future work with CCGs should ascertain their arrangements for establishing the nursing needs in settings and how this information informs commissioning arrangements.
- *Continuing Care Packages:* 9 respondents referred to arrangements for continuing care packages. Unlike adult continuing healthcare, children's continuing care is not underpinned by statutory guidance. It would be interesting to see if this was an area associated with similar geographical variations e.g. thresholds and use of Personal Health Budgets. Also, the continuing care guidance is based on a multiagency approach and acknowledges the involvement of education staff in providing reports and risk assessments (DoH, 2016). It would be beneficial to know how local areas meet this requirement for education input, the type of evidence submitted and how this contributes to the continuing care assessment.
- *Public Health School Nursing:* Although the focus of the survey was clinical nursing services a small number of respondents (n=3) referred to their public health school nursing offer. For example;

  'No input from public health school nursing team' (ID 85)

  'Our public health nurse has delivered training for us that is outside of their commissioned remit as they recognise we require a different service to our mainstream counterparts' (ID 55)

  All children attending school should have access to a public health nursing service. However, the healthy child programme public health guidance is geared towards mainstream education settings. Nationally, it is unclear how commissioning arrangements integrate CCG clinical services and LA public health services, if indeed they do. There is a recognition that pupils attending specialist education settings often miss out on the public health nursing offer and there is a need to develop joint guidance for public health and clinical nursing provision in these settings (Williams, 2019).

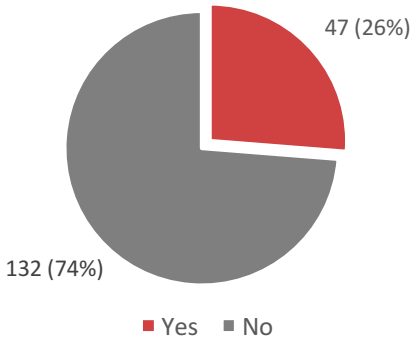
2.2 Training/Delegation Frameworks

Key Points:

- Only 47 (26%) respondents reported there was an agreed training/delegation framework with the local NHS nursing provider. Although, comments outlining the framework illustrated differing interpretations of an 'agreed framework'.
- For the remaining 132 (74%) respondents, training was taking place where and when needed but outside an agreed framework. In the majority of cases, this was provided by local NHS providers but where this was not available education providers had independently commissioned/secured training.
- Whilst some delegation practices referred to training, supervision and competency assessment some arrangements described were cause for concern as they fell short of Nursing and Midwifery Council (NMC) and Royal College of Nursing (RCN) standards and guidance.

The NMC is the regulatory body of the nursing profession and has standards for registered nurses delegating tasks (NMC, 2018a; 2018b). Delegation is defined as *"the transfer to a competent individual, of the authority to perform a specific task in a specified situation"* (NMC, 2018b pg 3). Accountability for the decision to delegate and for the training provided lies with the registered nurse (NMC, 2018b; RCN, 2017). The RCN provides supplementary guidance for delegating nursing procedures in education settings and this identifies an advisory list of 'clinical procedures' suitable for registered nurse delegation to support workers (RCN, 2018). This guidance stresses the importance of robust delegation processes that include risk assessment, both theoretical and practical training, supervision, competency assessment and annual update training. To establish how local areas meet these requirements, the questionnaire asked about arrangements for delegation/training.

Q. Does the school have an agreed delegation/training framework with the local NHS provider service?



Of the 179 respondents, 47 (26%) indicated they had an agreed delegation/training framework. However, comments illustrate this may not be an entirely accurate representation of an 'agreed

framework'. Within this group there were instances where training was deemed inappropriate and sometimes the arrangements described were not in line with nursing professional standards/guidance. The additional information included;

> *'It is not an agreed framework. Training is delivered as and when needed and requested by the school. Any refresher training is initiated by the school and there is very little or non whatsoever ongoing monitoring of staff competencies.'* (ID 4)

> *'The Commissioned Service is responsible for training staff to meet needs in oxygen, SATs, Suction and enteral feeds. The training is through [XXX] and [XXX] and is not appropriate. The staff engaged in the first part of the training before summer and are still not signed off as competent.'* (ID 15)

> *'School nursing team provide all of the healthcare training to TAs at the school and sign off competencies and provide annual updates and refreshers.' (ID 18)*

> *'Asthma, Buccal Midazolam and Epi-Pen training used to be provided by the School Nursing Team but due to reduction in services we have now been signposted to access this training on line. This does not allow for questions and clarification from medical professionals during face to face sessions.'* (ID 143)

> *'The SNSN service has provided a training policy which has been approved by school and this is updated annually. The policy details the type of training provided and how it will be delivered. For example, asthma awareness training, gastrostomy, jejunostomy and medication administration. Components required for each type of training are also included such as theory, practical and the protocol for competency assessment. A training schedule refers to requirements at the start of the academic year and timings of staff annual updates. Additional supervision is available for staff new to delivering an intervention and for staff returning from long term leave.'* (ID 173)

For the remaining 132 (74%) respondents indicating there was 'no agreed training/delegation framework', comments included:

> *'We find it essential to have a nurse employed by the service to support with protocols around medication, support staff training, medication audits, reports for reviews, liaison with external NHS services (GP, Optician, Dentist etc.)'* (ID 2)

> *'The level of delegation is not manageable either in training or checking of competencies. There is no agreed framework for how frequently spot checks are made for meeting compliances. ALL training needs are met BUT NO room for additional CPD linked to education.'* (ID 71)

In total, of the 179 respondents, 17 referred to competency assessments, 4 of these were expressing concern about inadequate processes and 12 respondents referred to supervision with 3 of these relating to an absence of supervision. Some of the feedback raises questions about the quality of delegation practices. It would be reasonable to consider that substandard arrangements for delegation could be detrimental to the quality of nursing care delivered and potentially, could be exposing children and young people to avoidable risk.

A defined delegation framework should be an essential component of commissioning for NHS clinical nursing services in specialist education settings. Delegation arrangements need to be

formalised to ensure professional standards, quality assurance and oversight. The relationship between the delegator and delegatee is critical to delegation and by virtue of this, the relationship between the respective employing organisations is also critical. It is essential that there is a jointly agreed framework between the NHS provider and special education setting to ensure the necessary organisational supporting structures and processes are in place. Also, commissioning arrangements that fail to take into account delegation requirements could mean that nursing teams are insufficiently resourced to meet NMC professional standards. Registered nurses that are unable to delegate appropriately (either by act or omission) could be placing their professional registration at risk.

Another important consideration is that unless explicitly detailed in job descriptions, education staff are not required to provide health interventions for pupils. A small number of respondents (n=3) referred to staff carrying out clinical tasks outside job descriptions and emphasised the reliance on good will. There needs to be recognition that this may place a disproportionate burden on a small number of staff. When things go wrong the impact on education staff can be devastating and should not be underestimated (Schools Week, 2019). It should also be noted that education providers as employers are vicariously liable for delegated activity and as a consequence, poor delegation practices add to education providers organisational risk. **A lack of an agreed delegation framework and practices that are non-compliant with NMC/RCN standards and guidance are serious issues for the NHS/education professionals and the organisations involved.**

Additional points that should be considered:

- *Commissioning Delegated Nursing Services:* Ensuring appropriate commissioning arrangements for the clinical nursing service in its entirety is essential. Following on from the CCG questions in the previous section, questions directed to CCGs should also include how both delegation as an activity and delegated nursing services are commissioned and how service specifications support compliance with professional requirements and standards.
- *Contracts of Employment/Job Descriptions:* It is not possible to quantify the amount of delegated clinical nursing activity from this survey. However, the findings support the view that the current clinical nursing delivery model is heavily reliant on specialist education staff providing nursing care. Nursing bodies and trade unions recommend that job descriptions detail the specific delegated tasks that staff are undertaking (RCN, 2018; Unison, 2017). A national picture is needed of the levels of delegated activity and the extent to which this activity is specified in staff job descriptions.
- *Training/Delegation Variability*: There are many independent training providers offering courses for support workers to administer medication to manage diabetes, asthma and epilepsy often including an assessment of competency (face-to-face and online). Independent providers can have a range of accreditations and endorsements such as the Royal

Pharmaceutical Society, the RCN and Skills for Care. As mentioned, the RCN (2018) guidance sets clear requirements for delegation in education settings. The RCN advisory list of clinical procedures that a registered nurse may delegate includes administering medication for diabetes, asthma and epilepsy. Future work should seek to clarify how NMC and RCN standards and guidance for delegation (training, supervision and competency assessment) fit with these independent training offers.

Furthermore, the Epilepsy Nurses Association (ESNA) guidelines advocate a train the trainer model for the administration of buccal midazolam (ESNA, 2019). An individual with no nursing/medical qualification and no epilepsy experience can attend a 4-6hr training course, pass an 'assessment of learning' and then train others to administer this medication. Again, clarifying how this approach fits with the NMC and RCN standards and guidance for delegation would be beneficial.

- *Statutory Guidance:* The SEND Code of Practice (DfE and DoH, 2015) and the Supporting Pupils at School with Medical Conditions (DfE, 2015b) statutory guidance refer to training education staff to meet medical needs but neither refer to delegation. Although training is an essential component of delegation, the terms 'training' and 'delegation' are not interchangeable. Ideally, guidance should recognise and differentiate between these two activities. This would ensure delegation is fully understood within the context of statutory and professional duties.
- *CQC/Ofsted:* Delegated clinical nursing activity in specialist schools is not within the scope of CQC or Ofsted inspection/regulation. Therefore, there is an absence of independent oversight of this clinical activity in these settings. In light of the survey findings, this lack of oversight should be an additional cause for concern.

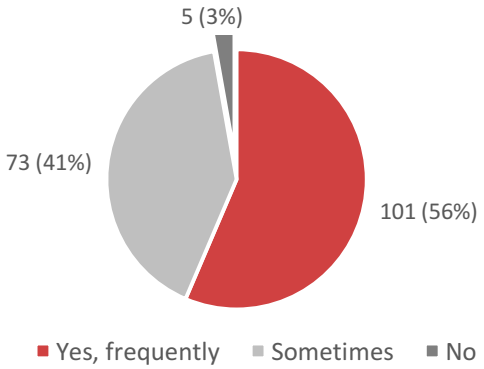
2.3 Accessing Advice & Additional Support

Key Points:

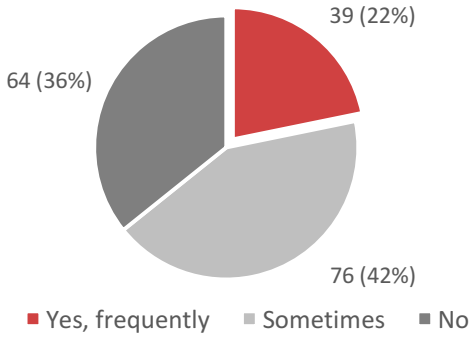
- 174 (97%) of respondents reported that when there were nursing/medical concerns parents/carers were contacted for advice.
- When there were concerns or queries and a nursing service was not on site, a total of 115 (64%) respondents would also contact local nursing services either sometimes or frequently.
- The use of the NHS 111 service was evenly split between education settings that used this service either sometimes/frequently (51%) and those that did not (49%).
- Ambulance call outs for the autumn term 2019/20 was approximately 705. It is likely there are pockets across the country where specialist education settings place a high demand on local NHS ambulance/ emergency services.

In addition to NHS clinical nursing services that may be commissioned specifically for the specialist education setting there are a range of supplementary sources of advice and support that can contribute to meeting pupils' health needs. This includes parents/carers, CCN services, specialist nurses, NHS 111 and if needed, ambulance/emergency services. To build a broader picture, respondents were asked how frequently they accessed different types of advice and support.

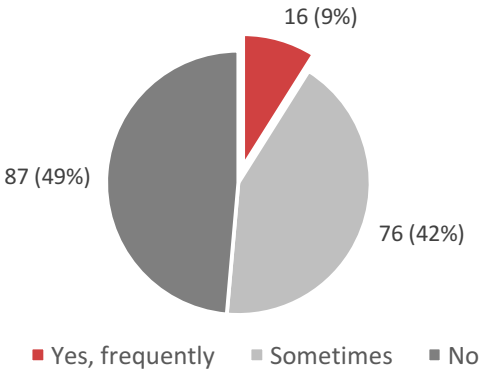
Q. In the event of nursing/medical concerns, are parents/carers contacted for advice?



Q. If there is no nurse on site, is the local nursing service contacted for telephone advice?



Q. Is NHS 111 called for health advice?



174 (97%) respondents stated that in the event of nursing/medical concerns, parents/carers were contacted for advice either frequently (n=101) or sometimes (n=73). Parents/carers are

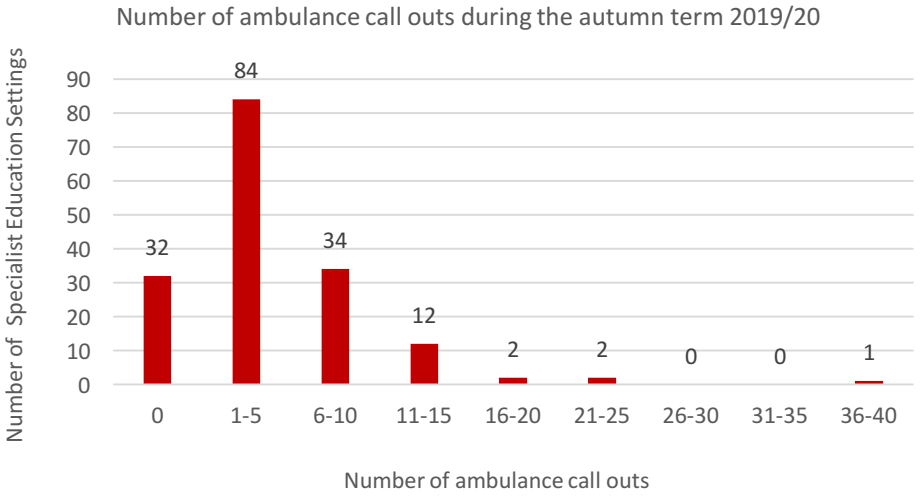
undoubtedly an invaluable source of expertise and information when it comes to meeting their child's health needs. However, if the advice from parents/carers deviates from either a care plan or from NHS training this could create a challenge. It would be interesting to understand how settings manage these tensions and how policies address potentially conflicting views.

Again, a high proportion of respondents (78%) reported that if there was no nurse on site, a local nursing service would be contacted for advice. Responses provided in the commissioning/provision arrangements section would suggest a range of NHS nursing services are accessed depending on local arrangements. The use of NHS 111 was evenly split between settings that used this service either frequently/sometimes (51%) and those that did not (49%).

Q. How many ambulance call outs were made to school during the autumn term 2019/20?

There were 177 responses to this question, although 1 respondent referred to an ambulance call out for a member of staff so this was excluded from the analysis. 9 respondents specifically stated this data was unknown and 32 respondents stated that there had been no call outs during this time period. The remaining respondents provided the number of call outs, although in some cases these were approximate figures. It should be noted that where respondents stated the information was unknown or an approximate figure was given, it was often unclear if this was because the information was unavailable at the time of completing the questionnaire or the information was not recorded.

The graph below shows the number of ambulance call outs made by settings for the autumn term 2019/20. The majority (n=84) of settings that called ambulances did so between 1-5 times. For the 3 settings that recorded in excess of 20 calls, 2 were residential provisions. However, the residential provision recording 25 calls stated this excluded calls outside school hours. Of the 32 that had no call outs, 8 were SEMH specialist settings.



Based on precise and estimated figures, total ambulance call outs for the autumn term 2019/20 was approximately **705**. There were 103 respondents that provided a precise figure which

equated to 541 of this total number. Of these, 67 respondents stated that 309 of these calls were as a result of following care plans. A frequently cited reason for the call out was epilepsy /seizure management.

For a number of children and young people there will always be a requirement for ambulance/ emergency services whilst in school. Ambulance payment schemes are locally determined but an average cost for conveyance is £272 (National Audit Office, 2017) and according to national tariff payments, A&E attendance with minimal investigation and treatment is £130 (NHS Improvement, 2019). Therefore, a minimum total cost for an ambulance call out and attendance at A&E would be around £400. In this survey, data collected was only for one term. Assuming this was replicated across the academic year, there are likely to be certain specialist settings that place a high demand on local NHS ambulance/emergency services in terms of resources.

Aside from the financial implications, ambulance call outs/A&E attendances have a huge personal impact on children and young people, families/carers and education staff. In settings with high numbers of ambulance calls linked to care plans there is an element of predictability. In these instances, consideration could be given to whether more tailored models of care, perhaps involving enhanced NHS support such as access to an Advanced Paediatric Nurse Practitioner could reduce these events offering improved experiences for children and young people and their families/carers. Following on from previous sections, a structured and thorough needs assessment should inform appropriate service models taking into account the use of wider NHS services.

Respondent feedback identified a related issue;

- *Education/NHS Emergency Services Interface:* A small number (n=3) of respondents referred to ambulance delays and staff transporting children to A&E. For example:

  'We have highly complex needs in school and little/no support from CCN teams or the ambulance service. We have logged 3 complaints about the length of time it has taken for ambulances to respond to a call. We feel that there is increasing levels of responsibility being placed on schools to deliver clinical care with no support or back up.' (ID 8)

  The questionnaire did not ask a specific question about the interface between specialist education settings and emergency services. Delays in ambulance attendance would be concerning if this was a more general problem experienced by settings. In order to establish if these were isolated cases or if they reflect a wider issue, this could be a topic included in future work.

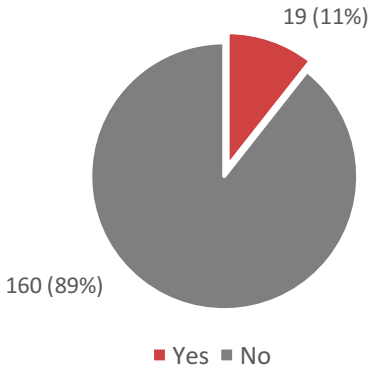
2.4 Incident Reporting and Management

Key Points:

- Only 19 (11%) respondents reported their setting had a joint protocol with the NHS provider for reporting and investigating nursing incidents. Although, descriptions indicated differing interpretations of 'joint protocol'.
- Over half (53%) of the respondents provided specific incident data for the autumn term 2019/20. The highest numbers of incidents recorded for individual settings were 25 and 45. The number of settings reporting no incidents was 64.
- Generally, the questions in this section appeared to cause difficulties. There was confusion about what was being asked and both limited and questionable data. Potentially, this reflects a gap in clinical governance processes.
- Incidents relating to nursing activity are possibly unreported and unmonitored meaning valuable opportunities for proactive risk management and learning could be missed.

The NHS has rigorous systems and processes for incident reporting and management. An incident is defined as any unintended or unexpected event which could have or did lead to harm for one or more patients receiving healthcare (NHS England, 2017). Within the NHS, consistent high reporting is encouraged because it provides opportunities to learn and improve safety (NHS England and NHS improvement, 2020). When NHS clinical nursing procedures are delegated to education staff, the tasks remain clinical procedures and as such there should be appropriate protocols for incident management. Therefore, the questionnaire asked about the processes in place to deal with incidents. In an attempt to provide clarity, the questionnaire included the following statement; *Note: Incident refers to any unintended or unexpected event that could have or did lead to harm for a pupil receiving nursing care in school. This includes medication errors or issues with specific nursing interventions e.g. gastrostomy, suctioning, stoma care etc.

Q. Does the school have a joint protocol with the NHS nursing provider for reporting and investigating incidents relating to nursing activities (including those performed by school staff)?



Of the 179 respondents, 160 (89%) did not have a joint protocol whereas 19 (11%) stated an NHS/school protocol was in place.

Q. If yes, what does the protocol cover?

Respondents stating there was a joint NHS/school protocol in place provided descriptions of what the protocol covered. Examples are shown below;

> *'Yes as in we abide by the training our NHS colleagues provide and the competencies they expect our staff to work on'* (ID 13)
>
> *'We would refer any practice issues/ concerns directly to the CCG.'* (ID 51)
>
> *'Depends on nature of incident. School based staff - near miss and full investigation. Direct breach may mean disciplinary investigation. School nurse - report to nurse manager.'* (ID 71)
>
> *'Safeguarding of pupils recorded via MyConcern by School and recorded via Rio by NHS.'* (ID 82)
>
> *'We use CPOMS to record any incidents, nursing or otherwise. All staff are given access and are expected to contribute. Nursing staff also have to complete a Datex and I am in the process of having access to the datex as part of a nursing incident reporting process. We are just working out the governance procedures for this.'* (ID 110)
>
> *'An agreed incident escalation process is in place between the school and the SNSN service. This ensures staff from both school and the SNSN service have clear lines of communication for reporting and managing incidents. This includes a decision step regarding who would lead an investigation if necessary. All nursing incidents are logged on the NHS system (IRe) by the SNSN service. On a termly basis the SNSN service team leader communicates incident information to the Headteacher highlighting any areas of concern, trends and learning from investigations. In addition, a termly meeting is held for school care leads and the SNSN service team leader to discuss incidents across the local area and to identify and share learning and good practice.'* (ID 130)
>
> *'We would refer to our trust CEO'* (ID 139)

As observed in section 2.2. with 'agreed delegation/training framework' this sample of comments suggests there are different interpretations of a 'joint protocol'.

Q. If no, are incidents formally logged and investigated by school and is this information shared with local NHS colleagues?

Of the 160 respondents that replied there was no joint protocol, 132 respondents stated that incidents were recorded and investigated by school and, of these, 39 settings shared information with the NHS. 9 respondents stated they did not record or investigate. 7 respondents indicated that no incidents had occurred in their setting not just during the autumn term but generally. Interestingly, this covered provisions with PMLD, SLD, ASD and SEMH pupils. Bearing in mind the NHS definition of incident 'an event that could have or did lead to harm' and the level of nursing

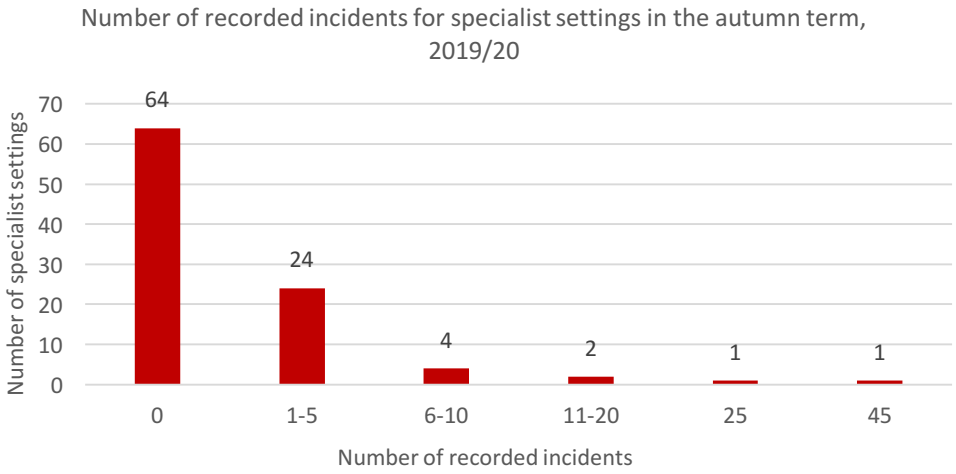
care associated with some of these types of SEND, this is somewhat surprising. Comments in this 'no joint protocol' category included:

> *'Yes. We use CPOMS for all safeguarding concerns and this would be reported through to the NHS safeguarding lead.'* (ID 21)
>
> *'incidents are investigated by both sides but there is no mechanism for bringing this together so learning is constantly lost.'* (ID 26)
>
> *'School carries out their own incident logs and I believe NHS carry out separate ones. NHS do not share any logs with school.'* (ID 64)
>
> *'not sure'* (ID 105)
>
> *'Logged using [XX] Council H&S reporting, but not shared, no one has ever raised this.'* (ID 137)

26 respondents made the specific point that incident information was not shared with the NHS. 13 respondents in this 'no joint protocol' group also referred to notifying the LA either through health and safety or safeguarding reporting systems.

Q. If data is available, could you indicate the number of nursing related incidents during the autumn term 2019/20?

In response to this question, 2 respondents referred to first aiders/incidents and reported extremely high numbers (300+ and 600+). Also, 1 respondent gave an estimate of 'at least 60'. These values were considered outliers and excluded from analysis. There were also 3 responses that were not possible to categorise. For example, 'daily in terms of administering medication, responding to medical concerns and addressing healthcare matters' (ID 35). 41 respondents left this blank and 30 specifically stated the information was unavailable. As the graph below shows, of the settings that provided data 64 settings reported having no incidents, 24 had between 1-5 and the highest numbers of incidents recorded for individual settings were 25 and 45. The latter figure was recorded by a residential provision.



Comments included:

> *'I'm not sure what an incident is but there is a lot of communication between Nurses and parents relating to the complex medical needs of our cohorts'* (ID 15)
>
> *'No data available, not sure what this means. All staff trained to deliver medicine etc. as and when appropriate'.* (ID 22)
>
> *'not available at such short notice. it will take time to collate. my staff have to intervene with pupils every day to prevent and manage health care risks and incidents.'* (ID 48)
>
> *'No data. Frequent, daily nursing related needs'* (ID 86)
>
> *' ? '* (ID 137)
>
> *'None that I am aware of'* (ID 139)
>
> *'not sure what is meant here so can not answer'* (ID 172)

On reviewing the responses, **the questions in this section evidently caused difficulties.** The questions may have been unclear. Alternatively, the responses may reflect gaps in knowledge and/or appropriate clinical governance processes for managing nursing incidents. If the responses are viewed in the context of the findings as a whole, it would seem the latter explanation is more likely.

A registered nurse delegating procedures remains responsible for the overall management of care and they must take reasonable steps to monitor the outcome of the delegated task (RCN, 2017; NMC, 2018b). **The fact that the nursing care is delivered in an education setting by education staff does not change the clinical nature of the activity nor does it remove the need for robust incident management.** Therefore, it is essential that any delegated nursing activity in specialist education settings is accompanied by clearly defined joint protocols for reporting, recording, investigating and managing incidents. Appropriate incident protocols provide valuable opportunities for proactive risk management, learning and improving practice.

When education staff accept a delegated nursing task they become responsible for that task. So undoubtedly, education staff have an important role to play but this should not equate to sole responsibility. Particularly, as this falls outside education professional's scope of expertise. Ideally, NHS professionals delegating the tasks would work with education settings to ensure appropriate incident management processes and protocols are in place. In the absence of an NHS lead on how nursing incidents should be reported and managed, it is unsurprising that education providers will approach these incidents using their frame of reference i.e. first aid, safeguarding and health and safety. There will be occasions where nursing incidents do involve these protocols but these should not be a substitute for well established processes for nursing care incidents.

Additionally, NHS organisations and nursing professionals have a duty of candour which means being open and honest when things go wrong. This includes supporting a learning culture by

reporting incidents that lead to harm or near misses (NMC and GMC, 2015). According to the NMC, in the context of delegation, when an issue or incident arises;

> *"If there is a risk of patient harm, or actual harm, an employer or service provider will want to review the decisions and actions of both parties and establish whether the root cause of an incident was unsafe delegation and/or inappropriate acceptance of a task."* (NMC, 2018b pg. 6)

This suggests that joint protocols are required across NHS/education employing organisations to ensure NHS organisations/nursing staff are aware of incidents involving delegated activity and that mechanisms are in place so that all parties can meet their legal/professional obligations.

The findings in this section are particularly worrying for two reasons. **Firstly, the absence of joint protocols for incident reporting and management means that it is possible that in some settings incidents relating to nursing care are neither recorded nor investigated.** Secondly, some responses point to a general lack of understanding and awareness of effective clinical incident management processes. CCGs need to ensure that commissioned services for the specialist education setting include mechanisms to encourage joint protocols for incident management**.**

2.5 Additional Comments

Key Points:

- The most frequently cited issues were reducing/inadequate NHS support and the burden placed on education staff to meet clinical nursing needs.
- Education settings valued the clinical nursing input they received. Where CCG services were deemed inadequate, education providers felt it necessary to meet the shortfall in provision.
- Respondents identified challenges with joint working, difficulties engaging with health partners and a lack of clarity around roles and responsibilities.
- The risks associated with nursing activity were reiterated as were concerns around arrangements for education staff training.

The final part of the questionnaire invited respondents to share any additional comments and a high number (n=128) of respondents included feedback in this section. Key themes were identified with some comments covering multiple themes.

Key Themes:

- *Reducing/Inadequate Support (n=29):* Comments frequently fell within this theme referring to increasing health needs and complexity but reducing or inadequate NHS nursing support. Examples of comments;

'The complexity of needs of pupils in our school is increasing but the support given to the school by health professionals is inadequate. We have students starting with us with complex needs for whom we don't have healthcare plans. We become lead practitioners who coordinate work of paediatricians, community nurses, schools nurses and therapists. What support was given to the school by School Nursing team is going to be now withdrawn.' (ID 4)

'Nursing provision has reduced every year over a 5 year period whilst the complexities of the pupils have continued to grow.' (ID 33)

'We did have the provision of an offsite nurse, however we then received an email to say that we were no longer entitled to this provision. All incidents are logged and monitored by SLT. Any medical concerns are discussed with parents and mostly we rely on trained first aiders for any incidents. As a special school, we believe we should be entitled to some nursing support, support with health care plans for example.' (ID 60)

'The CCG are currently reviewing our service with a view to reducing support and often refer to nearby authorities that do not have this service.' (ID 74)

'It is appalling I want to employ my own full time who is responsible to just me.' (ID 97)

'Shockingly poor level of service.' (ID 165)

- *Burden on education staff (n=29):* An equally high number of comments described the burden that nursing activities placed on education staff. Feedback highlighted the pressures and the implications e.g. reliance on good will, challenges for recruitment and retention and the detrimental effects on the education offer. The following comments illustrate these points;

'When the special school nurse is present we feel supported by the NHS to provide good medical care for our pupils although we perform ALL care tasks, administration of meds, trache changes and mic-key changes. When the nurse is not present we feel far less supported by the NHS, our staff feel more vulnerable because their primary role is education support not medical support. This has affected recruitment and retention of TA's.' (ID 6)

'The school staff are highly vulnerable without a school nurse full time on site. Education is impaired in some cases due to the delegation of health duties.' (ID 42)

'Increased complexity of need has put a strain on the school. More expected of teaching assistants employed to support education. they spend more and more time doing therapy and medical intervention to keep pupils safe.' (ID 73)

'Staff should not have delegated responsibilities as it is not in their job description and they currently provide such support as a measure of good will.' (ID 74)

'There are 3 children in school who receive 1:1 health support in school, provided by the Complex Care Team. These children's health care is funded externally through NHS [XXX] (Continuing Healthcare). Children are only eligible for this service in school if they are 'vented', which puts additional pressure on school staff who support children with alternative complex health needs; including cough assist and chest physio. The nursing team in school do not support with these activities, which fall to the responsibility of the class team (education)'. (ID 109)

'Staff deliver all medicines and this causes a short fall for their educational duties. Staff deliver all medical interventions except those given by Continuing Care staff: this too causes a massive short fall

/pressure upon their educational duties. This approximately equal to 6 full time support staff (an audit of time spent has not been undertaken this year).' (ID 173)

- *Valued Nursing Support (n=20):* It was apparent from a number of comments that the skills and expertise provided by local nursing services were highly valued. Respondents appreciated the input of their nursing colleagues and considered it essential for a safe and effective learning environment.

  'We are very lucky at [XX], we have an excellent nursing service which results in positive outcomes for many of our children. Joint working is extremely effective, having come from [XX] I appreciate this greatly.' (ID 59)

  'The special school nursing team have been fantastic. they support and training to staff and pupils with medical support and advice. We couldn't manage without them.' (ID 103)

  'Our nurse is absolutely incredible but has no way enough time to devote to our pupil needs.' (ID 119)

  'Its an excellent service that works incredibly well. Pupils with complex medical needs are very well looked after and supported. Their medical needs are met which means that these pupils can stay in school and be taught. Parents are very positive about this system and how well it works. A medical model is crucial to deliver the care is needed.' (ID 160)

  'Is is VITAL that nursing provision is provided and maintained in special school, nurses are extremely important to us.' (ID 162)

- *Filling Gaps (n=13):* Comments referred to approaches the school had taken to address the shortfall in nursing provision. This largely related to settings securing additional nursing services either via the local NHS nursing provider or independently employing nursing staff. Examples;

  'We currently fund a full time learning disability nurse who oversees all training and practice in school - we were lucky to find a nurse as previously this has been hugely challenging from both a recruitment and financial perspective.' (ID 19)

  'Without employing our own medical and welfare team it would be impossible to manage a number of pupils in school.' (ID 66)

  'School nursing support would not be adequate if it was not supported by additional staff supported by the school.' (ID 144)

  'School nursing provision would be inadequate if it were not subsidised by school budget providing nursing assistant.' (ID 147)

- *Challenges of Joint Working (n=11)*: Respondents referred to difficulties and challenges associated with working across education and health boundaries. The comments suggested there were issues engaging with health partners and a lack of clarity around roles, responsibilities and accountabilities.

'We have what looks to be a very advantageous amount of nursing support. This has been hard won. Nevertheless, the complete absence of any agreed ways of working from the CCG to provider and between CCG and school as part of the commissioning process leaves us feeling exposed due to lack of clarity around accountability.' (ID 26)

'We have found it incredibly difficult to engage our local nursing service to access support with training, writing care plans and risk assessments. We have children with high level medical needs - tracheostomy / gastrostomy / bi-pap machine and in the academic year to date, we have not been able to access anything more than some email contact and one meeting to try and establish what we need by way of support. It is the CCGs view that we do not need nursing support in the school. We disagree. The Trust Board are aware as are the Local Authority the situation is currently under review.' (ID 37)

'I have worked hard to get our nursing provision funded by the CCG and supported the TUPE of my staff to the NHS which has been a bumpy ride.' (ID 110)

'The nursing provision that the school currently receives is exceptionally poorly managed by the hospital trust, resulting in health and education working in isolation rather than in a joined up manner.' (ID 132)

- *Exposure to risk (n=10):* The risks associated with nursing activity were cited as a concern. The majority of these related to clinical risk but reference was also made to compliance risk.

'Our biggest concern is we get pupils who start with complex medical conditions, we ask parents to provide us with as much information as possible- paperwork from doctors etc. There is often not a clear management plan. We then try to write our own based on the information provided but this is not checked by and medical professionals. Schools nursing team used to come in check the info with their system and ensure the care plans we wrote were accurate and what the child needs. They are no longer able to do this. This means that we could be legally in a tricky situation as we cannot double check and have to rely on parents to get the correct information. The person writing our care plans does not have a medical background themselves either.' (ID 34)

'School staff are put at risk by having to carry out medical procedures, this includes everything from Gastric feeds, buttons to suction, managing oxygen treatment, measuring SATS and responding to this, managing complex epilepsy alongside routine and lower level issues including asthma, faints etc.' (ID35)

'We believe that it is increasingly dangerous due to staffing cuts made by the health care provider and community nurses seem to have two roles and reduced resources. The impact is that risks are significantly rising and that staff are increasingly anxious and refusing to medicate and intervene and union advice appears to make them more worried and anxious.' (ID 48)

- *Training (n=9):* Concerns were expressed about the arrangements for training and delegation of clinical nursing tasks to education staff. These related to increasing levels of delegated tasks and inadequate/inappropriate training offers.

'The level of delegation is not manageable either in training or checking of competencies. There is no agreed framework for how frequently spot checks are made for meeting compliances. ALL training needs are met BUT NO room for additional CPD linked to education. School meets the full medical needs of all pupils; staff are being asked to undertake medical interventions which causes significant stress. No contribution from health in relation to funding such staff; classes are complex, all staff do is manage medical conditions and deliver therapy plans - so little time for education at all.' (ID 71)

'We receive very little nursing provision. As a special school we do not get any training for gastro feeds and then competency sign off, we only get gastro awareness powerpoint!' (ID 127)

'Care plans are now not readily available and not updated frequently. Nursing support relating to training is hard to get hold of and involves long wait times meaning that staff are not trained in supporting students effectively all the time.' (ID 134)

'School staff undertake significant health care procedures following training and sign off by a nurse. Staff feel vulnerable as there is no provision for medical supervision/reflective time with qualified medical staff.' (ID 148)

- *Use of Education Funding (n=8):* Comments again highlighted the use of education funding for securing clinical nursing services/provision.

'Pupil funding is used for health related funding and school staff are deployed. School nurse provides traditional service, immunisations, sexual health etc and will not undertake any physical hands on work with pupils.' (ID 43)

'receive only funds for the 'education' of our pupils, but still pay for nursing out of this budget.' (ID 58)

'Special School Nursing contract in [XXX] is commissioned from the HNB'. (ID 100)

'Funding is not adequate, pupils who have meds etc do not have a medical top up and therefore do not cover the cost of employing a medical assistant for school. We are also expected to provide all health equipment, such as specialist seating which can cost in excess of £3000 per pupil. This is not provided or supported by the NHS at all, nor is it met by the pupils funding.' (ID 113)

Finally, a small number (n=3) of respondents referred to issues relating to mental health provision which should be noted. Comment extracts:

'We need NHS support that is linked to the care of mental health rather than physical health. We do not have to call an ambulance linked to care plans but there have been times in previous years when we have needed to call the police. Sadly there is no emergency call out for mental health.' (ID 65)

'With all our young people we need some support and guidance around mental health, addictions and issues around medication (for ADHD and sleeping). Parents significantly need support and advice - which we can support in school.' (ID 136)

'We are part of an NHS tier 4 CAMHS and we are valued by our NHS colleagues. We are not supported by the DfE who refuse to recognise the work that we do. Health seems to care for everything and everyone!' (ID 92)

Although NHS support for pupils with mental health needs was not the focus of this survey. The need to enhance NHS mental health provision for children and young people has been widely acknowledged (House of Commons Education and Health and Care Committees, 2018). Feedback from SEMH specialist education providers serves as a reminder there is an acute need for improved access to mental health services and that, similar to clinical nursing services, organisational tensions can exist between health and education.

2.6 Case Study – Chailey Heritage School

Key Points:

- Pupils attending Chailey Heritage School have highly complex health needs and provision of education and health services is based on a unique integrated model.
- It would be neither appropriate nor feasible to replicate this service across the specialist education sector but there are key elements of best practice that could and should be replicated. These include;
    - integrated approaches to CCG and LA commissioning
    - NHS nursing provision tailored to the needs of pupils i.e. based on a needs assessment with appropriate numbers and skill mix of nursing support
    - an agreed delegation framework
    - robust processes for medication management
    - joint incident management protocols that include reporting, investigating, capturing learning and implementing service improvements.

Chailey Heritage School

Chailey Heritage School is an Ofsted 'Outstanding' special school for children and young people with complex disability, high health needs, sensory impairment and associated learning difficulties. Residential provision is available and pupils attend from a wide catchment area across London, the south and south east of the country. Currently, there are 85 pupils aged from 3 years through to 19 years. The majority of pupils have cerebral palsy and other physical disabilities with associated health needs. The children's health needs present as both complex and fluctuating health, with the majority of children scoring red or amber on the complexity matrix and nursing needs tool.[*] As an indication of everyday healthcare needs, all pupils rely on wheelchairs for part or some of the day, there are 42 pupils who are completely reliant on daily enteral feeding and there are 254 medications administered during the school day. At any one time there are usually between 2-5 children who require 1:1 nursing during the school day. There are 8 children with ventilation needs; 31 with complex respiratory needs and 76 children with complex epilepsy.

The Chailey Heritage School arrangements for meeting pupil's health needs are widely considered as best practice due to the unique co-location and partnership with Chailey Clinical Services, which is part of Sussex Community NHS Foundation Trust. A process of joint assessment and offer is in place and funding agreements are obtained from both local authority and CCGs prior to admission. A future target is to develop a single fee structure that would facilitate the commissioning process.

Continued

[*] For further information on the complexity matrix and nursing needs tool see RCN (2019) appendix 5 and 7.

The joint approach enables fully integrated health and education services and clinical provision including therapy support, nursing, consultant paediatrician clinics and rehabilitation engineering services which are incorporated into school life. The nursing skill mix and establishment covers the school day; residential 24 hour provision, 365 days a year. During the school day the number of nurses on duty is flexed according to nursing need, but is usually 5 plus any children requiring allocated 1:1 nursing - currently there are 3 children requiring 1:1 nursing during the school day and a further 6 children who are funded for additional nursing input during the school day. Due to the complexity of health needs, the nursing team and other linked NHS professionals have developed high levels of clinical expertise, for example there are Clinical Lead nursing posts in complexity and disability; enteral feeding and respiratory and long term ventilation.

Registered nurses provide direct clinical response to altered health needs; direct nursing for specified pupils, health care plan management and training for school staff. Based on needs assessment, the nursing team skill mix is tailored to ensure services meet changing pupil needs. A range of everyday care tasks are delegated to school staff and this is within a robust delegation framework. School staff administer medication which is supported by a joint (School/NHS) Medicine Standard Operating Procedure covering school and residential services. Electronic Medication Administration Records (eMAR) system is being introduced into the school and residential services and, longer term, the hope is to introduce electronic stock control and reordering.

There are rigorous systems and processes in place for incident reporting and management. Two parallel systems are in place for ‘Accidents and Incidents’ and ‘Medication Errors’. Accident and incident data is recorded, analysed and reported. Medication errors are categorised based on the degree of harm and a joint (School/NHS) Medicines Management Group meets weekly and errors are monitored and scrutinised. Mechanisms for reporting accidents, incidents and medication errors include detailed termly reports to Governors and the Chailey Heritage Foundation Safeguarding Committee. A strong learning culture is embedded across both Chailey Heritage School and Chailey Clinical Services and this ensures lessons learnt from accidents, incidents and medication errors are identified and improve future practice. There is also an interlinked complaints process in place.

The integrated arrangements for nursing provision and health services on the whole results in the highest standards of care and safety for pupils. These best practice arrangements ensure highly complex medical needs can be met and enable pupils to access an enriching and rewarding educational experience.

November 2020

3.0 Conclusion

National policy and legislation exists for equitable, safe and effective NHS nursing provision for children and young people attending specialist education settings. The survey has demonstrated there are examples of children and young people receiving high quality nursing care including those attending Chailey Heritage School and other anonymised settings. Despite these examples of good practice, the findings do highlight themes of consistent concerns. But these are not new: they have been voiced many times. That said, the rich information provided by respondents does give additional insight into the extent and impact of these issues.

In many areas, NHS clinical nursing services in specialist education settings were described as reducing or inadequate with over a third of education providers reporting no specific/no regular CCG commissioned service. Consequently, more than a quarter of education providers independently commission/fund clinical nursing services. Assuming these findings are reflective of the sector, this is an alarming proportion of specialist settings that have taken on the role of clinical commissioner for health services. High needs funding is not intended for this purpose and equates to an inappropriate burden on already overstretched education budgets. An equally important point is the total absence of quality assurance and performance monitoring when the education sector takes on this clinical commissioning activity.

The survey has uncovered some worrying arrangements for nursing provision specifically, approaches to delegation and also incident reporting and management. Both these elements of practice have the potential to expose children and young people to increased risk and avoidable harm. Information provided shows there are locality areas implementing good practice but this is by no means consistent across all settings. Despite the apparent high levels of delegated activity almost three quarters of settings reported having no agreed training/delegation framework and the vast majority of settings had no jointly agreed protocol for managing nursing care incidents. It is important to recognise that commissioning arrangements must allow nursing staff to meet NMC professional requirements for delegation. Overall, the data relating to incidents suggests there are potentially gaps in processes for reporting and investigation.

It is difficult to see how the reported inadequacies and inconsistencies in commissioning and provision arrangements would not have a detrimental impact on the quality and safety of the clinical nursing care for this group of children and young people. Without doubt this appears far removed from the NHS Constitution principles to promote equality and work across organisational boundaries and the policies to prioritise services for these children and young people. Furthermore, the potential impact is not limited to poorer health outcomes. The repercussions are far wider. From a financial perspective, utilising high needs funding to secure clinical nursing provision diverts funding away from education. Also, within schools, shifting clinical workload to education staff further dilutes the education offer and causes difficulties for education staff

recruitment and retention. Therefore, there is also the possibility that current arrangements for nursing provision are negatively impacting on education outcomes.

Too often the system appears to be failing at a local level and action is needed to bridge the gap between national NHS and SEND policy and local implementation. The solutions are challenging but they are largely known. There are sufficient examples of good practice to build an effective and equitable framework for clinical nursing services. There needs to be a concerted effort to get to grips with the issues so that national NHS and SEND agendas to prioritise, integrate and improve services for this group of children and young people are consistently reflected in practice.

4.0 Recommendations

1. **An NHS commissioning framework for children and young people with additional and complex health needs and disabilities attending specialist education settings.**

Strengthening the link between national policy and local implementation will be paramount in tackling the issues highlighted. National guidance provides examples of the types of health provision that are an NHS commissioning responsibility in an education setting. This includes clinical support for children who have long term conditions and disabilities, nursing interventions such as gastrostomy and tracheostomy care and medication administration (DfE, 2015b pg. 16; DfE and DoH, 2015 pg. 167). Despite this, the responses show high levels of variability in 'what' and 'how' CCGs commission nursing services. In order to address these variations, there is a need to develop an NHS commissioning framework for children and young people attending specialist settings.

The framework should build on existing guidance to provide greater clarity on what services and interventions are an NHS commissioning responsibility. Particularly, where services or needs are currently referred to in broad terms. The framework should draw on national standards and existing good practice models e.g. NICE guidance and quality standards and long term conditions clinical networks and serve as a guide to commissioning integrated NHS services across locality areas. Therefore, this would cover the commissioning of nursing, therapies (health), palliative care, continuing care, CAMHS, specialist equipment, wheelchair services, continence services and medicines optimisation (See Addendum – 2021 Update, Medicine Optimisation Project).

Equally important would be identifying the critical elements of effective NHS and LA joint commissioning to ensure appropriate access to both clinical and public health nursing services and therapy services that meet special educational and health needs. As integrated care systems (ICSs) develop, this commissioning framework would have an important role to play in providing a route to navigate an increasingly complex system.

2. **Annual nursing need assessments undertaken in specialist education settings to inform commissioning and workforce planning.**

The JSNA considers the needs of the local community and is reflected in the services described in the local offer. EHCPs are intended to inform service provision at an individual child and young person level. In addition, a specialist setting assessment would also be beneficial in providing a setting based picture to inform commissioning and workforce planning. In 2018, Trudy Ward, Children's Community Nursing Team Lead (Sussex Community NHS Foundation Trust) developed a Commissioning and Workforce Planning Tool. This provides valuable data to identify nursing levels and skill mix. Three types of complexity are used to identify nursing requirements.

- *Complex and fluctuating health needs:* children's nursing priority input is required and nursing assessment during the school day is likely.
- *Complex long term health conditions:* children's nursing advice and interventions regarding long term condition management will be required during the school day.
- *Everyday complex healthcare needs:* children's nursing is required to train an adult in specific skills under delegated duties.

The tool has been shown to be effective at identifying health needs across a number of schools, with differing models of service provision (Williams, 2019) and has been adopted by a number of CCGs/NHS provider organisations.

3. **Consideration should be given to the legal implications of specialist education settings commissioning and providing clinical nursing care.**

This report has highlighted the extent to which the education sector is involved in the commissioning (education provider/LAs) and provision (education provider/CCG funded) of clinical nursing services. There appears to be a lack of clarity and understanding around the legal responsibilities for this health activity. This is despite the statutory duty on CCGs to arrange the nursing care for children and young people with EHCPs and the LA high needs block restrictions on permitted spend (See Addendum – 2021 Update, High Needs Funding Operational Guide). Importantly, case law has demonstrated that even when nursing procedures are delegated to unregistered, non-health support workers, this does not remove the NHS commissioning responsibility for the service (see case summaries DoH, 2016, Annex C pg. 51-52; Council for Disabled Children, 2018).

Healthcare, social care and education provision are subject to different legislation, different governance and different inspectorate and regulatory arrangements. Undoubtedly, integration of services requires a high degree of coordination between providers but this does not remove the underlying statutory distinctions. For example, within the health sector, there is a statutory duty of quality for NHS funded care. Quality is defined in terms of safety, effectiveness and user

experience. Specific legislation applies to health organisations (commissioners and providers) and forms the basis of systems and processes in place to meet the NHS statutory duty of quality. Therefore, consideration should be given to the limitations and implications of specialist education settings commissioning and providing clinical nursing care within the education statutory framework as opposed to the health statutory framework.

4. Delegation of nursing procedures should be within a robust delegation framework.

As noted, the NMC has explicit professional standards for registered nurses delegating tasks (NMC, 2018a) and the RCN also has comprehensive guidance on delegation in the education setting (RCN, 2019). Additionally, the All Wales Guidelines for Delegation (Health Education and Improvement Wales, 2020) provides detailed guidance. A delegation framework should be jointly developed and agreed by the employing organisations. Ideally, secured through commissioning contractual arrangements. Components of a framework would include:

- *Governance Structure:* Defined roles, responsibilities and accountabilities described on an individual and organisational level. Professional requirements and codes of conduct would be the basis of individual accountability and respective organisational governance structures would be linked to monitor and assure activity within the framework.
- *Risk Assessment*: Risk assessment would include ensuring the procedure was suitable for delegation, specified within the employee's job description and covered by appropriate indemnity insurance.
- *Training, Competency Assessment and Supervision*: A jointly agreed policy would describe the NHS provider offer for theoretical and practical training, competency assessment including defined standards and ongoing support and supervision.
- *Incident Reporting and Management*: A shared approach for reporting and managing incidents to ensure an appropriate response and investigation and that learning is identified to improve practice.

5. Review and clarify how the different training offers and approaches fit with professional requirements and standards for delegation.

The report has highlighted a range of different training offers and approaches to provide education staff with the required knowledge, skills and competency to deliver clinical nursing tasks. This included independent training providers offering online training packages and also 'train the trainer' models. However, these training offers can appear at odds with NMC/RCN requirements and guidance for training in the context of delegation.

Further work is required by the DfE and relevant NHS/healthcare professional bodies to determine where tasks sit in terms of the scope of NHS commissioning responsibility. This is a

necessary step to enable NHS/education staff to understand how different training offers fit with delegation and the wider statutory and professional obligations. Tasks that were considered an NHS commissioning responsibility would be higher level clinical tasks requiring an NHS lead on training within a delegation framework. Whereas tasks that were not considered an NHS commissioning responsibility would be lower level and therefore, suitable for a school to take the lead on making the necessary arrangements to provide support. This clarity would enable local areas to develop arrangements that ensured statutory obligations and professional standards were met and that unregistered staff received training and support appropriate for the task/s being delivered.

6. Explore how delivery of clinical nursing services in specialist education settings could be incorporated into the Ofsted and CQC joint local area SEND inspection framework.

Nursing care provided by specialist education settings via delegated tasks sits outside the scope of the Ofsted education inspection framework and CQC registration. The Ofsted and CQC joint local area inspection may present a mechanism to address this gap. Joint local area inspections aim to provide an independent evaluation of how well a local area meets its legal obligations for children and young people with SEND. Local area inspections not only hold areas to account but also provide assistance in improving and implementing processes and support systems for the benefit of children and young people (CQC and Ofsted, 2016).

CQC and Ofsted have recently been commissioned by the DfE to develop a new area SEND inspection framework (CQC, 2020). The development of a new framework presents an opportunity to consider including local arrangements for delegated nursing services delivered by education (and social care) providers. Potentially, inspecting contracting and governance arrangements, effectiveness of meeting need in different settings, and experiences and outcomes for children and young people with SEND.

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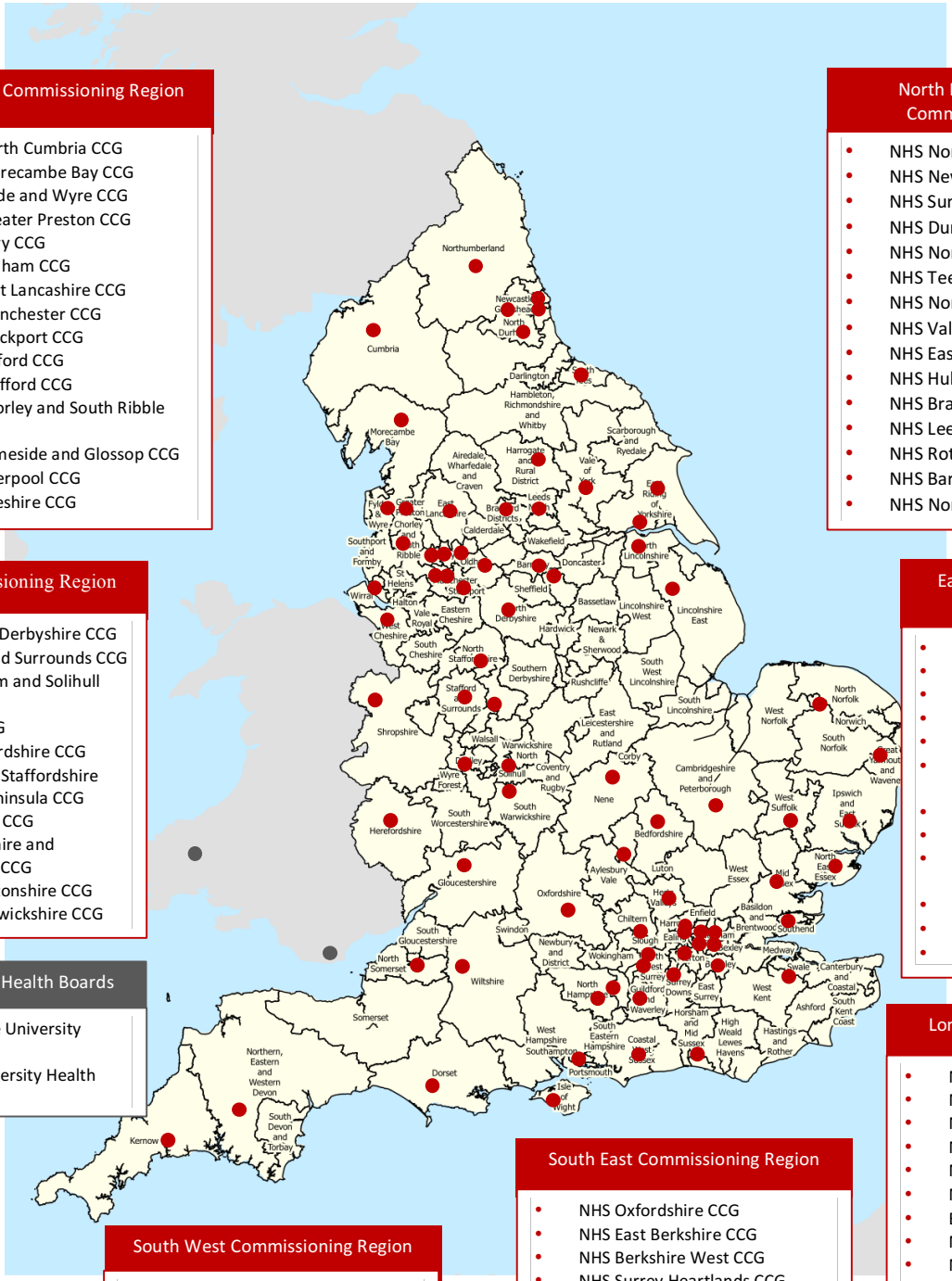
Appendix A – Geographical Coverage of Responses

(See Addendum – 2021 Updates, NHS – CCG Mergers and the Integrated Care Systems Agenda)



North West Commissioning Region

- NHS North Cumbria CCG
- NHS Morecambe Bay CCG
- NHS Fylde and Wyre CCG
- NHS Greater Preston CCG
- NHS Bury CCG
- NHS Oldham CCG
- NHS East Lancashire CCG
- NHS Manchester CCG
- NHS Stockport CCG
- NHS Salford CCG
- NHS Trafford CCG
- NHS Chorley and South Ribble CCG
- NHS Tameside and Glossop CCG
- NHS Liverpool CCG
- NHS Cheshire CCG

North East and Yorkshire Commissioning Region

- NHS Northumberland CCG
- NHS Newcastle CCG
- NHS Sunderland CCG
- NHS Durham CCG
- NHS North Tyneside CCG
- NHS Tees Valley CCG
- NHS North Yorkshire CCG
- NHS Vale of York CCG
- NHS East Riding CCG
- NHS Hull CCG
- NHS Bradford District CCG
- NHS Leeds CCG
- NHS Rotherham CCG
- NHS Barnsley CCG
- NHS North Lincolnshire CCG

Midlands Commissioning Region

- NHS Derby and Derbyshire CCG
- NHS Stafford and Surrounds CCG
- NHS Birmingham and Solihull CCG
- NHS Dudley CCG
- NHS East Staffordshire CCG
- NHS South East Staffordshire and Seisdon Peninsula CCG
- NHS Shropshire CCG
- NHS Herefordshire and Worcestershire CCG
- NHS Northamptonshire CCG
- NHS South Warwickshire CCG

East of England Commissioning Region

- NHS Lincolnshire CCG
- NHS North East Essex CCG
- NHS Mid Essex CCG
- NHS Norfolk and Waveney CCG
- NHS Herts Valleys CCG
- NHS Cambridgeshire and Peterborough CCG
- NHS Milton Keynes CCG
- NHS Bedfordshire CCG
- NHS Ipswich and East Suffolk CCG
- NHS West Suffolk CCG
- NHS Southend CCG
- NHS Thurrock CCG

NHS Wales – Local Health Boards

- Cardiff and Vale University Health Board
- Hywel Dda University Health Board

London Commissioning Region

- NHS North Central London CCG
- NHS City and Hackney CCG
- NHS Barking and Dagenham CCG
- NHS Harrow CCG
- NHS South West London CCG
- NHS South East London CCG
- Ealing CCG
- NHS Hillingdon CCG
- NHS Hammersmith and Fulham CCG

South West Commissioning Region

- NHS Gloucestershire CCG
- NHS Bristol, North Somerset and South Gloucestershire CCG
- NHS Bath and North East Somerset, Swindon and Wiltshire CCG
- NHS Devon CCG
- NHS Dorset CCG
- NHS Kernow CCG

South East Commissioning Region

- NHS Oxfordshire CCG
- NHS East Berkshire CCG
- NHS Berkshire West CCG
- NHS Surrey Heartlands CCG
- NHS Kent and Medway CCG
- NHS Brighton and Hove CCG
- NHS West Sussex CCG
- NHS North Hampshire CCG
- NHS North East Hampshire and Farnham CCG
- NHS Buckinghamshire CCG
- NHS Portsmouth CCG
- NHS Southampton CCG
- NHS Isle of Wight CCG

Appendix B - Glossary and Abbreviations

Quotes from respondents that have been included in the report were replicated as written. Terms and abbreviations used in the quotes are defined below.

Term/Abbreviation	Definition
ADHD	Attention Deficit Hyperactivity Disorder
Bi-pap (also BPAP)	Bilevel Positive Airway Pressure which is a type of non-invasive ventilation or breathing support.
CCN	Children's Community Nursing
CPD	Continuing Professional Development
Datex (Datix)	Datix is an incident reporting and risk management IT software package used by health and social care organisations.
GDPR	General Data Protection Regulation 2016/679 is the legal requirements for data protection and privacy.
HCA and HCSW	Health Care Assistant and Health Care Support Worker
H&S	Health and Safety
HNB	High Needs Block which is part of the LA dedicated schools grant. The high needs block funds special educational provision.
IRe	An electronic report of an incident or near miss event.
LD Nurse	Learning Disability Nurse
N3 Staff	Equivalent to an education level 2 support assistant.
Tier 4 CAMHS	Specialised services that provide assessment and treatment for children and young people with complex emotional, behavioural mental health difficulties. Treatment is usually on an inpatient basis.
Rio	An electronic patient record system for community, mental and child health providers which aims to deliver an integrated picture of care.
SATs	Commonly used term for oxygen saturation which refers to the measurement of oxygen level in the blood.
SNSN Service	Special Needs School Nursing/School Nursing Special Needs Services
SLT/SaLT	Speech and Language Therapy Services
SLT	Senior Leadership Team
TUPE	Transfer of Undertakings (Protection of Employment) regulations. TUPE offers protection to employees when the organisation in which they are employed changes ownership.

Addendum – 2021 Updates

This report was prepared in 2020 but due to the pandemic, publication was paused. In 2021, there were developments relating to information presented.

High Needs Funding Operational Guide

In February 2021, the Education and Skills Funding Agency issued the 'High needs funding: 2021 to 2022 operational guide'. In the guide, Annex 3 provides clarity on the use of high needs funding in relation to health and social care costs and reiterates the legal framework set out in the CFA 2014 and the School and Early Years Finance (England) Regulations 2021. Responsibility for the provision specified in the EHCP sits with the relevant statutory bodies: the LA for special educational and social care provision and NHS commissioners for health provision.

The high needs funding block is intended to meet the educational costs of children and young people with special educational needs. Securing health provision specified in section G of an EHCP should be met by the relevant NHS commissioning body. The guide acknowledges that some types of health (and social care) provision may educate or train (e.g. therapy interventions). In these instances, the provision should be considered special educational and be recorded in section F of an EHCP. Therefore, this would be within the scope of the high needs block. Furthermore, where integrated packages of care are established and charged through a single fee, the LA should charge non-educational costs to the relevant commissioning partners.

NHS – CCG Mergers and the Integrated Care Systems Agenda

On 1st April 2021, 38 CCGs merged to create 9 new CCGs so there are now 106 CCGs in England. These mergers were in line with the integrated care systems (ICSs) agenda. ICSs are collaborations of NHS and LAs which aim to deliver better, more integrated care for local populations using pooled budgets and shared resources. The NHS Long Term Plan proposed that ICSs should cover the whole country by April 2021 and that there would be 'typically' one CCG for each ICS. It is anticipated that ICSs will become statutory bodies by April 2022.

The development of ICSs presents opportunities for improving provision for children and young people with SEND. However, greater integration will inherently lead to greater complexity. Davies, (2021) has identified the potential risk of an integration equivalent of the 'inverse care law'[*]. With the populations most in need of effective integrated care being the least likely to receive it. Increasingly integrated systems will require greater clarity. This will require strong national leadership to drive the legislative and policy frameworks. Additionally, clearly defined local joint commissioning arrangements will be vital to ensure successful integration of provision for children and young people with SEND and their parents/carers.

[*] In 1971, Julian Tudor Hart first described the inverse care law in the Lancet. Hart observed that disadvantaged populations need more health care than advantaged populations, but often receive less.

Medicines Optimisation in Special Schools

The health needs of children and young people attending specialist education settings can result in education staff being responsible for complex medicines management systems and processes. Administration alone can include controlled drugs, complex dosing regimens and specialist devices. Kent Community Health NHS Foundation Trust have undertaken a medicines optimisation project which involves a specialist pharmacy service providing support to local special schools. The medicine optimisation service has a number of key objectives;

- Supporting safe and effective management of medicines for children in school
- Supporting seamless transfer to adopting the new medicines management training, governance, audit and overall quality improvement package
- Introducing an incident reporting and learning culture
- Promoting access to the medicines information service
- Promoting self-care to support the implementation of the March 2018 NHS England guidance to CCGs which prohibits routine prescribing for over-the-counter medicines.

For more information, see NHS Health Education England, Medicines Optimisation in Special Schools, https://www.lasepharmacy.hee.nhs.uk/qualitymanagement/transformation/medicines-optimisation-in-special-schools/