

## About respondent questions

1. Would you like us to keep your response confidential? [See the [Privacy information: members of the public](#) for more details].  
No
2. What is your name?  
Emma Smith
3. What is your email address?  
[emma@escmanagementservices.co.uk](mailto:emma@escmanagementservices.co.uk)
4. Which local authority area are you responding from?  
City of Bradford Metropolitan District Council
5. Are you replying in an individual or organisational capacity?  
Organisation
6. If applicable, what type of organisation are you from?  
Other  
If Other, please specify:  
Independent consultancy
7. What is the name of your organisation?  
ESC Management Services Limited (ESC)
8. What is your role within the organisation?  
Director
9. If you are responding as an individual, in what capacity are you providing views to this consultation?
  - a. Parent or carer
  - b. Child or young person
  - c. Governor
  - d. Head or principal
  - e. Teacher
  - f. Teaching assistant
  - g. Healthcare professional
  - h. Interested member of the public
  - i. If Other, please specify:  
N/A

## Q10. Principles

Do you agree with the principles we have identified for including children and young people with medical conditions (including allergy) as fully as possible in education?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree

Comments (optional):

ESC strongly agrees with the principle of inclusive education. Ensuring pupils with medical conditions can access and fully participate in education alongside their peers is essential. However, ESC considers that the framing of inclusion in the draft guidance is problematic. Despite covering medical conditions and relating to health needs requiring a range of health services and support, the guidance presents inclusion as an educational responsibility with minimal recognition of the wider responsibilities of statutory partners.

Inclusion is positioned around the UN Convention on the Rights of the Child (UNCRC), Article 28, the right to education, but there is no mention, let alone equivalent recognition of Article 24, a child's right to health and health services. By any reasonable standard, in the context of medical conditions, this is a significant omission. A child's right to education and their right to health services should be treated as equally important and mutually reinforcing. However, the principles do not reflect this.

Under the proposed SEND reforms, the approach to inclusion is guided by the definition set out in the UN Convention on the Rights of Persons with Disabilities (UNCRPD), which focuses on identifying and removing barriers to participation ([SEND Reforms](#) pg. 4). The draft guidance acknowledges that many children and young people with medical conditions, including severe allergies, are likely to meet the Equality Act 2010 definition of disabled.

The current [Medical Conditions Guidance \(2015\)](#) states that the NHS is responsible for the clinical support for pupils' long-term conditions, disabilities and additional health needs. Despite this, the principles provide no indication that the NHS has a role in supporting pupils with health-related disabilities in accessing and participating in education. In fact, there is minimal reference to the role, responsibilities and duties of the NHS, which is striking.

Arguably, this lack of NHS visibility reflects the current reliance on schools to provide healthcare services, which results in a far from ideal situation and, in all likelihood, has masked gaps in NHS services. Revised guidance presents an opportunity to establish a framework rooted in law and compliant service models.

Achieving this would require resetting the principles to uphold children's rights to education **and** health services. It would also require reviewing and reconfiguring how NHS services meet the clinical needs of children and young people in education. For example, a needs-led, NHS-commissioned clinical school nursing service would provide a strong foundation, aligning with a [coalition of unions' call](#) for such a model.

**[Also see Additional Points – Equality Impact Assessment]**

## Q11. Wellbeing

Do you agree with the proposals for promoting the wellbeing of children and young people with medical conditions (including allergy)?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree

Comments (optional):

### Wellbeing

ESC agrees with the proposals based on the sections explicitly addressing wellbeing, namely:

- Wellbeing of children and young people with medical conditions (pg. 27)
- Supporting wellbeing following a serious incident (pg. 43)
- Wellbeing of children and young people with allergy (pg. 93)
- Attendance and wellbeing (pg. 96)

Within these sections, the draft guidance sets out expectations for schools to promote wellbeing and welfare that are consistent with section 100 of the Children and Families Act (CFA) 2014, Part 5 (Welfare), alongside the wider duties set out in the guidance (pg. 7,8).

It is welcome that the draft guidance refers to the responsibility for improving wellbeing sitting with a range of statutory partners, including local authorities, Integrated Care Boards (ICBs), and NHS providers (pg. 111). The inclusion of a discrete, albeit brief, section on mental health also helps to acknowledge wider partner responsibilities. (pg. 107).

### Wider Interpretation of Health-Related Duties

The Q.11 preamble also refers to proposals for medical conditions policies that would set out how the welfare of children and young people with medical conditions, including allergies, will be supported. As this section adopts a wider interpretation of the school's health-related duties, on this point, ESC disagrees.

The [Equalities Impact Assessment \(EqIA\)](#) states that duties on schools remain unchanged and revised guidance would not create new statutory requirements (pg. 5). However, the draft guidance appears to extend the scope of schools' general health-related duties to include healthcare activities that would typically sit under NHS Act 2006 services. This suggests a potential shift in the boundary between NHS services and schools' health support.

It is worth noting that the adult social care sector is subject to comparable general health-related duties to those applying in education. However, where adult social care providers undertake healthcare activities equivalent to those referenced in the draft guidance (e.g., diabetes management), this is underpinned by delegation arrangements linked to specific statutory provisions rather than general health-related duties (see [DHSC - Guiding principles for delegation](#) pg. 19). Furthermore, [statutory guidance](#) (para. 8) acknowledges a historical reliance on "goodwill and/or the adoption of complex workarounds, as organisations have been legally constrained" in how they could work together. This was before the Health and Care Act 2022 introduction of additional delegation and joint working provisions.

This provides useful context and a clear point of comparison. In health and social care, such healthcare activities are accommodated through defined delegation frameworks and statutory mechanisms. In the education sector, however, delegation remains an unresolved issue, with the DfE and DHSC committing to issue a joint position in 2024 and again in 2025, which has yet to be published. **Although the draft guidance expressly states that delegated healthcare is out of scope, it nevertheless includes healthcare activities associated with delegation.**

### **Mental Wellbeing and Managing Medical Conditions**

The draft guidance appropriately recognises that children and young people with medical conditions are more likely to experience poor mental wellbeing, including anxiety about the support they will receive and the consequences of inadequate care. However, if the proposals proceed, shifting responsibilities for healthcare from the NHS to schools would place clinical activity within education frameworks, where standards for quality and safety of healthcare are not comparable. This is likely to increase instances of inadequate care and incidents, thereby exacerbating these risks to mental wellbeing.

#### **Q12. Oversight of medical condition policies**

Do you agree with the proposal that a named governor and a named senior leader should be responsible for the medical conditions policy?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree

Comments (optional):

A named governor and senior leader should be responsible for the medical conditions policy, as this supports clear accountability and oversight within the setting. In addition, it would be helpful for key local partners to be clearly identified within the policy, i.e. explicitly named, with acknowledgement of their respective roles in meeting health needs. This would include the key clinical and public health commissioners and providers, confirmation of agreed responsibilities, and a named lead contact. Clear identification of these partners would support effective partnership working, as well as accountability.

#### **Q13. Review of medical condition policies**

Do you agree with the proposal that medical conditions policies should be reviewed at least annually, and after any serious incident or near miss, as described in the guidance?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree

Comments (optional):

Medical conditions policies should be reviewed at least annually, and following serious incidents or near misses, as appropriate. Regular review is essential to ensure arrangements remain effective and responsive.

The draft guidance refers to governing bodies ensuring that policies are reviewed, with no reference to partner agencies. Reviews should not focus solely on school-led arrangements. They should also consider the effectiveness of arrangements for children and young people to access partner services within school, including NHS clinical services and local authority public health services. As partner arrangements are grounded in statutory duties, their role in the review of medical conditions policies should be clearly reflected in the guidance.

In addition, a policy “review” is open to interpretation. As the guidance includes non-statutory, good practice advice, there is an opportunity to set out what an effective review could involve, for example:

- Learning from complaints, incidents and near misses
- Incorporating structured feedback from children, young people, parents and staff
- Assessing whether partner roles and responsibilities are being met
- Reflecting changes in school and partner operational arrangements
- How the use of health needs data is supporting responsive services
- How information sharing agreements are working in practice
- Effectiveness of partner arrangements in supporting complex health needs

#### **Q14. Scope of medical condition policies**

Do you agree with the proposed scope of medical conditions policies?

Strongly agree    Agree    Neutral    Disagree    Strongly disagree

Comments (optional):

The framework for supporting children and young people with medical conditions in schools requires all statutory partners to fulfil their respective responsibilities. Under section 100 of the CFA 2014, the school’s duty is to “*make arrangements*”. A reasonable interpretation is that this involves school-led arrangements, together with arrangements with partners to enable the delivery of their services within the school. This approach ensures pupils have access to the range of NHS, local authority and school services that may be required.

Consequently, an important aspect of medical conditions policies would be to have a collaborative and integrated focus. Supporting this position, the current statutory guidance states:

*“An essential requirement for any policy therefore will be to identify collaborative working arrangements between all those involved, showing how they will work in partnership to ensure that the needs of pupils with medical conditions are met effectively.”* (pg. 12)

This aligns with the [Jigsaw Principles of integration](#), with distinct individual components, defined and complementary boundaries, and clear, secure links between them. Throughout the policy, the respective roles and responsibilities of schools and partners should be clearly set out, including how school-led arrangements are operationalised alongside partner arrangements within this framework.

However, following the direction set by the draft guidance principles, the proposed scope of the medical conditions policies focuses almost exclusively on school-led arrangements, with only limited reference to health services. Where health input is mentioned, it is framed as “*health professionals*” providing advice, guidance and instructions. In the absence of clear content on the NHS role, this emphasis on individual clinicians working with schools underplays the responsibilities and statutory duties of NHS bodies and presents an unbalanced picture.

Within the draft guidance, the seemingly narrow interpretation of the duty to “*make arrangements*” contrasts with other statutory guidance using the same framing, such as [Working Together to Safeguard Children](#) and [Keeping Children Safe in Education](#), where safeguarding and welfare duties are clearly situated within a multi-agency framework. In those contexts, statutory guidance supports shared responsibility, with partner roles explicitly articulated within their respective remits. This is the approach that would genuinely strengthen the arrangements for supporting medical conditions in schools but is conspicuously absent from the draft guidance.

### **Healthcare activities**

As noted, the proposed scope of medical conditions policies includes healthcare activities which, when delivered by unregistered staff, would typically fall within formal delegation arrangements. For example:

- *“The policy should be clear that staff should receive suitable training to ensure they can provide the necessary support safely (which may include giving prescription medicines or undertaking healthcare procedures in accordance with an individual healthcare plan).”*
- *“Where children and young people have specific medical support needs requiring named members of staff to be trained and/or assessed as competent, the medical conditions policy should set out sufficient supply or cover arrangements.” Pg. 24*

The draft guidance does not explain the basis on which healthcare activities are considered to sit within or outside delegation arrangements. Nor does it provide clarity on why certain healthcare activities are framed as school-led support, linked to school responsibility for training, while the same activities in other sectors would fall under delegation.

If schools’ general health-related duties are taken to extend to responsibilities for healthcare activities that, outside education, require compliant delegation, this raises significant concerns. In particular, this approach risks undermining established legal, regulatory and governance boundaries designed to ensure children and young people’s health needs are met safely and

appropriately. It also raises questions about how school-led health support, operating outside formal delegation and care quality frameworks, would compare in terms of standards, assurance and oversight.

### Medical conditions policy template

The draft guidance refers to the DfE making a template medical conditions policy available. ESC has found template policies to be problematic. Although well-intentioned, school policies based on templates often resemble a tick box exercise where minimal local/school-specific information is included, and as a result, they can have limited meaning and value. For example, a school's [Medical Conditions Policy 2025/26](#) based on a template. Therefore, ESC would suggest a set of principles and practical tips on developing the policy, including engaging with partners and also establishing review parameters (as per Q.13 response).

### Q15. Identification of children and young people with medical conditions

Do you agree with the medical conditions which we propose should be covered by medical condition policies?

- Strongly agree    Agree    Neutral    Disagree    Strongly disagree

Comments (optional):

ESC is unable to answer this question due to its confusing structure and inconsistencies. The question heading refers to “*identifying children and young people with medical conditions*” and appears to relate to the section of the draft guidance with that title (pg. 22). However, the accompanying preamble and wording of the question focus instead on the types of medical conditions to be covered, eligibility, and diagnostic status, which more closely relate to the medical conditions policy scope rather than identification processes.

As the question header, explanatory text and the question itself appear to refer to different sections of the draft guidance, it is unclear what respondents are being asked to agree or disagree with. This makes the question difficult to answer meaningfully. The DfE should consider this when analysing responses, as its format risks misrepresenting respondents' views.

### Q16. Staff training on medical conditions

Do you agree that our proposals set reasonable expectations for staff training on medical conditions?

- Strongly agree    Agree    Neutral    Disagree    Strongly disagree

Comments (optional):

ESC does not agree that the proposals set reasonable expectations for school staff training. While staff need to be suitably trained to support children and young people with medical

conditions, the expectation that schools lead training for healthcare activities that, in other sectors, would require compliant delegation is concerning. The draft guidance does not provide clarity or rationale for assigning this responsibility to schools.

It is important to distinguish between different types of training. Firstly, school-led, standalone training, such as first aid or training to administer over-the-counter medicine. Secondly, training to deliver healthcare interventions under the instruction of a health professional, which would sit within a delegation framework. Such frameworks are characterised by shared, ongoing responsibilities and accountabilities across those staff involved, the health professional and support worker, and their respective employers.

The draft guidance identifies a range of healthcare activities for school staff, and as delegated healthcare is out of scope, presumably, the associated training is the school's responsibility. These include administering prescribed medication for asthma, monitoring blood glucose and administering insulin, and managing epilepsy, including administering buccal midazolam. Set against the wider framework already outlined in relation to health and adult social care sectors, the following examples illustrate how these activities sit within delegation arrangements:

- [Care Quality Commission \(CQC\)](#): Guidance refers to care workers administering medication in line with prescribed instructions and care plans, as delegated activity.
- [DHSC - Guiding principles for delegation](#): Examples of activities which would sit under delegation, including managing diabetes through insulin administration and monitoring.
- [Diabetes UK and NHS England](#): Structured delegation frameworks for managing diabetes in adult social care settings.
- [London Asthma Standards for Children and Young People \(2021\)](#): Standard 49 unregistered staff, carrying out delegated asthma care (non-education settings).
- [Tees, Esk and Wear Valleys NHS FT \(2024\)](#): Protocol for administering buccal midazolam under registered nurse delegation.

This demonstrates the standards considered necessary for quality and safety when delivering these activities in both health and other non-health settings. On any reasonable assessment, supporting activities of this nature through standalone, school-led training outside delegation arrangements would represent lower standards. Not only would clinical activity sit within education frameworks that are not designed for healthcare delivery, but it would do so without the clinical governance and assurance mechanisms outlined above.

The current medical conditions statutory guidance states that a health professional should confirm the proficiency of staff providing support for a pupil, as set out in their healthcare plan. In contrast, the draft guidance indicates that a health professional may advise if competency assessment is required. However, competency assessment involving a health professional would usually be associated with delegated healthcare. Therefore, given that delegation is out of scope, this reference adds to a confusing and unclear picture and adds to the lack of clarity around how responsibilities have been defined and assigned.

## **Workforce and financial implications**

As the draft guidance notes, school staff may be asked to support children and young people with medical conditions, but they are not required to do so. National Joint Council (NJC) support staff role profiles do not describe a general expectation that school staff will undertake healthcare activities, and under the [School Teachers' pay and conditions](#), teachers are not expected to administer medication on a routine basis. This raises questions about how secure and sustainable a service model reliant on school staff would be, particularly against the backdrop of existing pressures on schools and their staff in terms of recruitment, retention, and workload. In contrast, NHS-commissioned providers have a workforce where healthcare delivery is a core, defined function.

In addition, there is significant geographical variation in the healthcare activities schools support, often shaped by the availability of local NHS services. Formally directing responsibility for healthcare delivery and training to schools through statutory guidance may reduce existing NHS support. This would have implications for school staffing, workload, and training budgets. However, there appears to be no assessment of the potential workforce or financial implications accompanying the consultation. Clarification from the DfE on whether these impacts have been considered, and if so, the assessment outcome, would be helpful.

## **Epilepsy Nurse Association (ESNA) guidelines**

The draft guidance refers to training that meets the standards set out in the [ESNA guidelines](#) (pg. 58). The ESNA guidelines relate to the administration of buccal midazolam for the treatment of epileptic seizures. The training approach does not require a health professional competency assessment. Instead, the [ESNA Competency Checklist](#) places responsibility for assuring competence with the employer of the support worker, citing CQC requirements. ESNA also cites the current DfE medical conditions guidance as support for the approach, this is despite the requirement for a health professional to confirm proficiency.

In 2023, ESC raised issues about the guidelines with the CQC by [email](#), and these were subsequently discussed at a meeting. CQC endorsement was described as “*pragmatic*”, and, in any event, related to adult social care, not to children and young people in education settings. In 2024, the issues were raised with the Nursing and Midwifery Council (NMC) by [letter](#), with a written response received in 2026. However, the NMC response did not clarify whether the ESNA guidelines are compliant with the NMC Code. The concerns were also raised with ESNA, but no response was received.

Given these issues, it is concerning that the draft guidance adopts the ESNA guidelines as a good practice benchmark, potentially requiring schools and local authorities arranging home-to-school transport to source training based on guidance with unresolved compliance issues. The endorsement of this approach raises questions as to whether the DfE is aware of these issues and whether any clarification has been sought from the CQC or NMC. In the absence of assurances and given the unresolved delegation issues, the inclusion of the ESNA guidelines in the draft guidance is questionable.

**[Also see Q.25 Specific Considerations – Controlled drugs]**

### Q17. Who needs an Individual Healthcare Plan

Do you agree with the proposal for which children and young people will need an Individual Healthcare Plan?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree

Comments (optional):

ESC fully supports children and young people having plans that set out their individual needs arising from medical conditions and supports school plans that cover education-related arrangements. However, ESC does not agree with the proposal to include clinical content/plans in a school-owned Individual Healthcare Plan. ESC views this as a fundamentally flawed approach and, as a result, is unable to respond to the question about which children and young people would require a school-owned Individual Healthcare Plan.

### Education, Health and Care (EHC) Plans

Within the *'Who may need an Individual Healthcare Plan'* section, there is a subsection *'EHC plans which specify health provision'*. This states that Section G of an EHC plan typically describes provision at a strategic level and may not include the practical, supervisory or emergency information needed in education settings. This does not reflect the current statutory framework.

The SEND Code of Practice requires Section G to specify detailed and specific health provision required to meet health needs. The Code also states that individual healthcare plans should be included in Section G of the EHC plan, making these arrangements the responsibility of the relevant NHS commissioning body.

Framing Section G health provision as 'strategic' departs from the current statutory framework based on child or young person-tailored provision. While the draft guidance may reflect the SEND reform intent to move away from EHC plan specification towards Specialist Provision Packages and Individual Support Plans, these proposed changes are subject to separate consultation and have not been finalised.

Even if progressed, such reforms would require amendments to primary legislation and would not take effect in the short term. Given that the revised statutory guidance will be issued before any changes to EHC plans would come into effect, including statements that do not reflect the legal framework, risks inconsistency and incorrect representation.

### Q18. Scope of Individual Healthcare Plans

Do you agree with the proposed scope of Individual Healthcare Plans?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree

Comments (optional):

The draft guidance section setting out Individual Healthcare Plans recognises the distinction between a school-led plan and a health professional plan. It also states that the school-owned Individual Healthcare Plan is not a clinical document. This distinction is welcome. However, the proposed approach that health professional plans are to be “included” or “incorporated” into the school-owned plan is concerning. Such a model, in which school-owned plans absorb clinical content/plans, undermines the distinction and blurs the boundary between a school-owned plan and a clinical plan.

When a child or young person has a diagnosed medical condition, they are likely to have a personalised, health-led plan, as recognised in the draft guidance. Care planning is integral to regulated health sector activity, and clinical plans are health-owned medical documents for which registered health professionals are professionally accountable. For many conditions, national guidance sets clear standards for commissioners, providers and health professionals in relation to care planning and the content of plans.

As noted in the Q14 response, clear boundaries between education and health arrangements are essential; this requires school-led and health-led plans to sit alongside one another, as distinct documents owned by the respective services. The DfE’s proposed approach conflates fundamentally different types of plans. This would be operationally problematic, weaken ownership, dilute accountability, and, given that schools would be responsible for arrangements within the school-owned plan, redirect responsibility for healthcare onto schools. While this may align with the overall position of the draft guidance, the appropriateness of this approach and its implications raise significant and legitimate concerns.

### **School-owned plan and clinical plans - Interdependency**

The operational challenges with this approach cannot be underestimated and are not addressed in the draft guidance, including recognising and managing the interdependency between school-owned plans and clinical plans. Anecdotally, many schools already report challenges in obtaining timely clinical plans from health partners. Placing responsibility on schools to develop, maintain and review plans that rely on clinical content creates risks, particularly where health engagement, data sharing and timely NHS care planning are lacking.

As an example, under the proposals, a child with a medical condition may have a school-owned Individual Healthcare Plan incorporating a clinical plan. If the school’s Individual Healthcare Plan is due for review, but the relevant NHS service has not recently reviewed the clinical plan and is not engaging, the school may feel obliged to proceed with parents to review and update the school’s Individual Healthcare Plan in the absence of clinical input. Although parents play a vital role in providing information, this cannot substitute for appropriate health professional care planning. Proceeding in this way may compromise standards for healthcare planning and delivery and may result in school arrangements misaligned with the clinical plan, with potential implications for risk and school liabilities.

Given the inclusion of clinical content within school-owned Individual Healthcare Plans, and the considerations this involves, it is surprising that a [Freedom of Information request](#) revealed that the DfE did not engage with health regulators such as the CQC and the NMC on this specific aspect of the draft guidance. Engagement with the relevant health regulatory bodies

on this point is essential to ensure that the associated risks, implications, and regulatory considerations are properly understood.

### **Individual Healthcare Plans and Individual Support Plans**

The draft guidance indicates that the DfE intends for the school-owned Individual Healthcare Plan to be incorporated within the proposed Individual Support Plan under the SEND reforms. These Individual Support Plans will have a statutory footing. While the details of this remain unclear, this could provide a legal basis for attributing responsibility for healthcare activities to schools. In the absence of a resolved position on delegated healthcare in schools, this direction risks addressing the issue by default, through wider reform rather than explicit legislation governing access to NHS services.

While this would not constitute a direct legislative change, it may represent an incremental shift with the potential to bring healthcare activity, which would typically fall under NHS Act 2006 health services, within schools' statutory responsibilities. In effect, this could result in a downgrading of healthcare within the education sector, not mirrored in the health or adult social care sectors. Any change of this nature and significance should be transparent and subject to appropriate scrutiny through established policy and legislative processes. Therefore, greater clarity from the DfE regarding school-owned healthcare plans and clinical content is necessary.

### **Q19. Incident reporting**

Do you agree with the proposed approach for recording, reporting and learning lessons from serious incidents and “near misses” relating to medical conditions and allergy?

Strongly agree    Agree    Neutral    Disagree    Strongly disagree

Comments (optional):

ESC fully supports the principle of effective incident management in relation to supporting children and young people with medical conditions. Robust reporting, review, and learning from incidents and near misses are essential for robust risk management and improving the safety and quality of care. Where incidents relate to appropriate school-led health support, the proposals represent a positive strengthening of practice and are therefore welcome.

However, where the draft guidance positions healthcare activities that are associated with delegation as school-led health support, ESC disagrees with the proposed approach. In these circumstances, the proposals for school management would result in a weaker system compared to NHS services and compliant delegation arrangements.

The NHS has well-established incident systems focused on healthcare quality, risk and service improvement, e.g. [Patient Safety Incident Response Framework](#) and [Learn from Patient Safety Events](#). These systems provide structured investigation processes, mechanisms for system-wide learning, and trend analysis and oversight. In addition, national guidance sets expectations and standards for incidents relating to delegated healthcare in

health and adult social care settings, e.g. [DHSC guidance](#) and [NICE guideline \[NG213\]](#). These frameworks, which do not apply to education, ensure a consistent level of scrutiny, accountability, and learning across both health and non-health settings.

By contrast, school incident management frameworks are not designed to manage healthcare incidents and do not operate to an equivalent standard of clinical governance and oversight. Under the proposals, incidents arising from healthcare interventions delivered by school staff and underpinned by school-led training would be managed internally. In all but the most serious cases, they are likely to remain within the school, with limited external oversight and without system-wide mechanisms for learning and accountability. A recent [Freedom of Information response](#) indicates that the DfE does not hold a dataset or structured system for monitoring healthcare-related incidents in schools.

Taken together, these factors point to materially different standards for incident management across the health, adult social care and education sectors. This is not merely an inconsistency, but a difference that would result in lower standards for managing healthcare incidents in education settings. As a result, the role of incident management as a mechanism for learning, quality improvement, and managing risk would be undermined, with implications for the safety and quality of children and young people's healthcare.

### **Learning from past system failings**

Historical experience in health and social care demonstrates the risks of unregistered staff undertaking healthcare activities without clear role boundaries, consistent training, and clinical oversight. These issues were evidenced in a series of high-profile failures and subsequently examined in the [Cavendish Review \(2013\)](#), which identified gaps in training, supervision, and accountability as contributing to unsafe practice. This ultimately led to systemic reform and strengthened governance across the health and social care sectors.

ESC is aware that the DfE has engaged with key stakeholders, including the DHSC and the CQC, both of whom have direct experience of the system failings that informed subsequent reforms. However, the lessons from past failings do not appear to have informed the proposals. Rather than aligning with NHS-commissioned services and compliant service delivery models, the approach appears to move towards conditions and risks previously identified as unsafe.

As the DfE is setting direction at a sector level, it retains system-level responsibility for associated risks and safeguarding across the system. In this context and given the issues identified in relation to school-led healthcare, it would be helpful to understand whether a systemic risk assessment has been undertaken. In addition, considering the parallels with arrangements previously found to be unsafe, further clarity is needed on what mitigations are in place and what assurances can be provided that children and young people will not be exposed to avoidable harm.

## Q20. Oversight of allergy safety policies

Do you agree with the proposal that a named governor and a named senior leader should be responsible for the allergy safety policy?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree

Comments (optional):

A named governor and senior leader should be responsible for the allergy safety policy. However, as with the wider medical conditions policy, it would be helpful for key local partners with responsibilities for allergy safety and management to be clearly identified, with explicit acknowledgement of their respective roles. This could include a named lead contact for relevant local health services, e.g. paediatric allergy and asthma services, where applicable and catering services, where appropriate. Clear identification of these partners would support effective partnership working, as well as accountability.

## Q21. Review of allergy safety policies

Do you agree with the proposal that allergy safety policies should be reviewed at least annually, and after any serious incident or near miss, as described in the guidance?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree

Comments (optional):

ESC agrees that allergy safety policies should be reviewed at least annually, and following serious incidents or near misses, as appropriate. However, due to the scope of allergy management, like the medical conditions policy, the review should not focus solely on school-led arrangements but also review the effectiveness of relevant partner services in supporting effective management and creating a safe environment for children and young people (and adults) with allergies in school.

For example, this could include considering how effective NHS arrangements are in ensuring that pupils with asthma have a personalised asthma action plan in line with [NICE Guideline \[NG245\]](#) and [NICE Quality Standards \[QS25\]](#). It could also include considering the effectiveness of arrangements for ensuring the timely sharing of plans and that plans include review dates, in line with [CQC guidance](#).

## Q22. Scope of allergy safety policies

Do you agree with the proposed scope of allergy safety policies?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree

Comments (optional):

ESC agrees in part with the proposed scope of the allergy safety policy, particularly the focus on minimising the risk of exposure to known allergens, managing food allergy risks, and ensuring staff receive appropriate allergy awareness and emergency response training.

However, ESC does not agree with the scope of the policy, which includes healthcare activities that, outside the education sector, would sit within delegation arrangements. For example, where a child or young person has a clinical plan to manage their asthma and receives healthcare interventions, including prescribed medication, as instructed by a health professional. As with the general medical conditions policy, the draft guidance does not explain the basis on which healthcare activities are considered to sit within or outside delegation arrangements, resulting in unclear and unexplained differences of approach between education and other sectors.

The draft guidance recognises that medical emergencies may arise unexpectedly, such as a first-time anaphylactic reaction, and that anyone may need to take reasonable steps to preserve life. This is necessary and appropriate. However, the guidance appears to place significant emphasis on 'emergencies', without sufficient recognition that in the vast majority of cases these situations will be managed in accordance with a child or young person's clinical care plan, including agreed emergency actions. Framing such healthcare primarily as 'emergency' responses risks bypassing NHS-commissioned service arrangements and compliant delegation.

### **Q23. Allergy awareness training**

Do you agree with the proposals for allergy awareness training for all staff?

Strongly agree    Agree    Neutral    Disagree    Strongly disagree

Comments (optional):

ESC agrees that all staff should receive allergy awareness training. However, the proposed scope of 'awareness' training extends to delivering healthcare set out in clinical care plans. In these instances, where a child or young person requires a direct healthcare intervention, as noted, the draft guidance lacks clarity on when or why this would be associated with school-led training rather than training within a delegation arrangement.

As the draft guidance sets out, specific exemptions within the Human Medicines Regulations allow schools to hold and use a spare salbutamol inhaler and, separately, an adrenaline auto-injector for emergency use where a child or young person's own prescribed medication is unavailable or where anaphylaxis occurs unexpectedly. Parental consent for the management of medical conditions in school, including consent to use "spare" medication when a child or young person's own prescribed medication is unavailable, should sit within compliant service delivery and clinical governance arrangements for planned care. Consent should be integrated within these structures, rather than operating independently of them.

## Q24. Adrenaline devices

Do you agree with the proposal that all schools should stock “spare” adrenaline devices for emergency use?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree

Comments (optional):

Schools should stock “spare” adrenaline devices for emergency use where prescribed medication is unavailable or in cases of a first presentation of anaphylaxis. As noted in the draft guidance, cases of a first presentation and unforeseen circumstances would be rare. The normal expectation would be that those at risk of anaphylaxis would be identified and appropriate arrangements would be put in place ([MHRA \(2023\)](#)).

## Q25. Specific considerations

Do you agree that the information provided here is helpful?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree

Comments (optional):

While parts of this section are helpful, others raise concerns or lack clarity. There are also aspects where the guidance misses opportunities to reinforce the statutory framework and good practice.

The inclusion of sections on clean air and food provision are positive additions. The data protection section provides useful clarity on permissions relating to health information, and the section on first aid is helpful in confirming that first aid does not generally include the administration of tablets or medicines.

### Home-to-school transport

This section sets out local authorities’ responsibilities to arrange home-to-school travel for eligible children, including the need to manage health needs and work in partnership with NHS services. Although the NHS is responsible for healthcare on home-to-school transport, gaps in NHS arrangements for children and young people accessing education extend to this area (see [ISOS Partnership Report \(2025\)](#)). As a result, local authorities’ transport services often fill these gaps, with implications for funding and accountability, as highlighted in [UNISON's correspondence](#) to the Public Accounts Committee. The guidance could more clearly reflect NHS responsibility for children and young people requiring clinical support during home-to-school transport.

### Insurance and indemnity

The insurance and indemnity section refers to the DfE’s Risk Protection Arrangement (RPA), which requires members to comply with statutory guidance on medical conditions.

The draft guidance represents a shift in responsibility for clinical support from the NHS to schools, which would have implications for risk and potentially liability. It would be helpful to know what consideration has been given to this. In line with Q.19 response, it would be beneficial to understand the DfE's engagement with the RPA scheme administrator and also commercial insurers in relation to these proposals, including any assessment of the implications for risk, liability and indemnity cover.

### **Managing medicines**

It would be beneficial for this section to more explicitly recognise the role of NHS-commissioned pharmacy support services in supporting the safe and effective management of medicines within schools. While provision of such services will appropriately vary according to local need and commissioning arrangements, a needs-led, proportionate approach aligned to risk is consistent with established good practice and supports safe, integrated working between schools, health services, and parents.

In practice, particularly within specialist education settings, pharmacy involvement within multidisciplinary arrangements is already contributing to strengthened medicines governance, improved accountability and documentation, and reduced risk of medication-related error (e.g. [RCPCH - Medicines Optimisation in Special Schools](#)). Greater clarity within the statutory guidance would support more consistent commissioning and application of safe systems, help reduce unwarranted variation, and reinforce effective clinical governance across the interface between education and health systems.

### **Controlled drugs**

The draft guidance states that schools, colleges, early years settings and home-to-school transport staff may administer controlled drugs where prescribed for a child or young person, citing Regulations 7(1) and 7(3) of the Misuse of Drugs Regulations (MDR) 2001. While these provisions allow “*any person*” to administer a controlled drug in accordance with a prescriber's directions, they are a limited exemption protecting against criminal liability. They do not override the statutory duties and powers that apply to NHS bodies and education providers relating to NHS Act 2006 healthcare activities. Therefore, presenting MDR 2001 provisions in isolation creates a narrow view.

MDR 2001 provisions should sit alongside the wider statutory duties and powers for healthcare activities. This would recognise that the administration of controlled drugs is often part of broader clinical care, supported by a health-led care plan with content extending beyond a prescriber's directions. National condition-specific standards such as [NICE guideline \[NG217\]](#) for epilepsy and [NICE guideline \[NG87\]](#) for Attention Deficit Hyperactivity Disorder explicitly require such plans, which set out clear clinical management and oversight arrangements, which may include the administration of controlled drugs.

Viewing the MDR 2001 provisions alongside the wider statutory framework would be associated with compliant service delivery models, which in turn would ensure the appropriate assurances and oversight for the administration and management of controlled drugs in

schools, e.g. links to the [Controlled Drugs Accountable Officer](#) monitoring and reporting framework.

As with the points raised in relation to allergy awareness training and medicines legislation provisions, it is unclear how the DfE envisages the MDR 2001 fits within the wider statutory and healthcare governance framework. By focusing primarily on the MDR 2001, the draft guidance appears to adopt a minimal legal threshold. Instead, the guidance should reflect the full legislative framework to ensure that controlled drugs are managed safely within appropriate regulatory and governance structures. This would be aligned with the DfE's intended aim to strengthen arrangements.

### **Q26 FE colleges and post-16 institutions**

Do you agree that FE colleges and post-16 institutions should be subject to a statutory duty to make arrangements for supporting learners in statutory 16-19 education (including those up to 25 if they have an EHC Plan) with medical conditions and allergy?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree

Comments (optional):

In principle, a consistent expectation across education settings is important and would be beneficial. The draft guidance, however, raises fundamental issues that need to be addressed. In addition, there is insufficient information and clarity about the health service arrangements in place for supporting young people in FE and post-16 institutions. In these circumstances, extending a statutory duty to these providers would be premature.

### **Q27. Non-maintained special schools**

Do you agree that non-maintained special schools should be subject to a statutory duty to make arrangements for supporting pupils with medical conditions and allergy?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree

Comments (optional):

In principle, a consistent expectation across education settings is important and would be beneficial. The draft guidance, however, raises fundamental issues that need to be addressed. In addition, there is insufficient information and clarity about the health service arrangements in place for supporting children and young people in non-maintained special schools. In these circumstances, extending a statutory duty to these providers would be premature.

## Q28. Independent schools

Do you agree that independent schools should be subject to a statutory duty to make arrangements for supporting pupils with medical conditions and allergy?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree

Comments (optional):

In principle, a consistent expectation across education settings is important and would be beneficial. The draft guidance, however, raises fundamental issues that need to be addressed. In addition, there is insufficient information and clarity about the health service arrangements in place for supporting children and young people in independent schools. In these circumstances, extending a statutory duty to these providers would be premature.

### Additional Points

#### Draft guidance format

The draft guidance, like the current guidance, contains both statutory guidance and non-statutory advice. However, the draft does not clearly distinguish between these two types of content. This lack of clarity risks creating uncertainty for schools when determining legal expectations versus recommended practice. The current guidance, initially published in 2014 was amended in 2015 to address this issue by revising the formatting to clearly separate statutory guidance and non-statutory advice, through the use of text boxes (see [updates](#)). Future medical conditions and allergy guidance should apply a similar clear distinction between the two types of content, as this would greatly support usability and implementation.

The draft guidance is difficult to navigate due to its length and poor flow, which is compounded by the substantial annex placed mid-document. The annex, which provides information on specific medical conditions, is likely to include content which will date in a relatively short space of time. A more useful approach would be to streamline the document and replace detailed condition-specific content with links to authoritative external resources. This would help to futureproof the guidance, ensuring schools have access to accurate, up-to-date information and improve the clarity and usability of the guidance overall.

#### Equality Impact Assessment

The Equality Impact Assessment (EqIA) concludes that the revised guidance will have positive or neutral impacts across all protected characteristics, with particular benefits for disabled pupils and those with long-term or complex medical conditions. These benefits are linked to clearer expectations, more consistent planning and improved emergency preparedness. No adverse impacts were identified. However, while some proposals may strengthen arrangements within schools, this does not apply where schools would be expected to take on responsibilities for the clinical support that currently sits with the NHS.

The assessment relating to disability is largely framed around schools making reasonable adjustments and strengthening emergency responses. In the current guidance, it is clear that

the NHS is responsible for providing clinical support for children and young people, including those who meet the definition of disabled, but this is not reflected in the draft guidance. Instead, the draft guidance places the responsibility for providing planned clinical support for pupils with long-term conditions, including asthma, diabetes and epilepsy, on schools.

The EqIA does not acknowledge this shift or its implications for standards of care and risk, and therefore, lacks balance and transparency. The draft guidance references the Equality and Human Rights Commission (EHRC) [Technical Guidance](#) for schools. However, the EHRC has previously removed examples of schools providing clinical support, including management of long-term conditions. The EqIA refers to legal input to ensure alignment with statutory duties, but greater clarity is needed in this area, including how a positive impact has been concluded for children and young people with disabilities, particularly where their entitlement to NHS services appears to have been removed.

### **Draft guidance – Consultation**

Finally, ESC would like to note concerns regarding the structure and framing of this consultation. The questions are confined to areas identified by the DfE, with limited ability to raise wider issues. This is established by the DfE's strong preference towards online submissions, which does not readily allow feedback beyond the predetermined questions, and alternative routes referred to as being used in "*exceptional cases*". As a result, respondents are directed towards a format that restricts broader views.

In addition, several questions are framed in a way that is likely to elicit positive responses. It is also notable that the draft guidance is structured across four key sections, yet the consultation questions only cover three sections. There are no questions relating to Section 4, "*Roles, responsibilities and statutory duties*", despite its central importance to the overall framework.

The issues identified throughout this response, including gaps in clarity and rationale, unresolved issues relating to delegation, wider issues around governance and accountability, unexplained disparities in standards compared to other sectors, and the absence of impact assessments in key areas, raise concerns regarding the overall robustness of the consultation. It is not clear that respondents are being provided with sufficient information to fully understand and assess the implications of the proposals and to give informed views.

In this respect, the approach may not fully align with the [HM Government Consultation Principles \(2018\)](#), particularly the expectation that consultations should be informative and supported by adequate evidence. This is consistent with established consultation principles, such as those set out in *R v Brent LBC ex parte Gunning*, which also emphasise the need for sufficient information to enable intelligent consideration and response. If respondents are unable to fully assess the potential impact of the proposals, this may lead to unsafe and insecure arrangements for children and young people, schools and staff.