Nursing services in specialist schools for children and young people with 'severe complex needs'.

A shared point of reference for many colleagues in public service is the disability rights campaigns of the 20th Century, including the ongoing battle to establish a 'social model' of disability, rather than accepting a mindset of deficit based on medical description and diagnosis.

This right-minded intent is often detectable in discussions with LA SEND officers, Designated Medical Officers and NHS commissioners in well-meaning comments such as "parents have to do this now, so schools should too", when describing delegated nursing tasks such as tracheostomy care. This thinking fails to recognise the fundamental difference between parental care and the provision of a publicly-funded service that has incrementally acquired 'quasi-clinical' characteristics, in terms of the cumulative effect of both the risk and complexity of the service that is being provided in many specialist school settings.

What are the key issues and how do they inter-relate?

1) Analysis by Emma Smith has shown that an interpretation has been placed on the Children and Families Act 2014 by some CCGs and LAs that runs counter to the spirit of the law and the intent of the SEND Code of Practice, because the C&F Act is wrongly believed to have 'over-written' the NHS Act 2006 and thus allowed some medical services to be transferred out of NHS responsibility through the inclusion of delegated nursing tasks within Education Health and Care plans. This interpretation persists despite clear case law that has clarified the position beyond doubt (Haringey 2015), because the proliferation of locally commissioned arrangements sits outside the direct oversight and control of the departments of central government, where understanding of the law is secure, but influence over local commissioning decisions is limited.

2) A resultant national pattern of reductions in, and increasingly, withdrawal of nursing and medical services provided in special schools, has led to unsafe provision and incidents of harm to children, that are not properly recorded in a systematic way and therefore not collected as a discrete data set.

3) No national metric enables the DfE or DH to understand the scale of the problem, but recent research (conducted by a consortium of special schools and school nursing services in response to DfE's request for data) has demonstrated that this is a substantial new area of need, which corresponds closely with a 'clinical' model of service provision.

4) Innovations in public service delivery for this group of **'children and young people with severe complex needs'** (*NICE guideline in development 2019-21*) has run out in front of the frameworks of governance and accountability, the level of risk is not properly understood, and hence often not well managed at local level, because there is no national framework to guide commissioners of services.

5) Some health sector national bodies such as the Royal College of Nursing have issued guidance to their members about how to respond to these issues, but there is no corresponding

national guidance for Directors of Children's Services or governing bodies of schools, which has led to an incoherent divergence of practice across the country, colloquially a 'post code lottery'.

6) Widespread misunderstanding of Part 5 of Schedule 2 of the School Funding Regulations that allows for ("*Expenditure on the provision of special medical support for individual children and young people in so far as such expenditure is not met by an NHS Trust, NHS foundation trust, Clinical Commissioning Group or Local Health Board.*") exists because of the imprecise wording used. Our understanding is that this provision is intended as an enabling statement for "therapies" (cf High Needs Block Operational Guidance 2019-20) when they are jointly funded in line with educational aims and outcomes.

This means that public funds are now being mis-applied, and the Designated Schools Grant is increasingly being used to fill gaps in NHS service provision, where this is delivered in schools. In turn this contributes to the risk of LAs running up deficits in their High Needs Block budgets, as unplanned stop-gap measures accrete and re-direct funds intended for educational purposes.

Combined with a widespread misunderstanding by CCG, and sometimes LA, commissioners that the 2013 transfer of public health duty School Nursing to local authorities included specialist school nursing services (where they existed), this has driven a resource-led practice of unilateral withdrawal of CCG-commissioned services from specialist schools, which is the under-lying driver for the current build up of 'noise in the system' from special school leaders and governors for example:

https://planetradio.co.uk/viking/local/news/hundreds-of-parents-back-campaign-to-save-nurses-at-hull-special-schools/

7) There is a proliferation of training providers for medicines management in schools, but no standards against which school governors can evaluate their suitability, whereas in the parallel adult social care environment NICE has developed clear guidelines for the sector.

The current statutory guidance 'Supporting pupils at school with medical conditions' (DfE 2015) responded to equalities discrimination in mainstream schools and was not designed to provide guidance for 'quasi-clinical' arrangements in specialist settings. Despite containing a clear statement that "For pupils who have medical conditions that require EHC plans, compliance with the SEND code of practice will ensure compliance with this guidance with respect to those children", this document has been interpreted by some CCGs to suggest that schools must become providers of medical support to students with disabilities, using their own resources.

8) The accountability framework in which the CQC and Ofsted keep an overview of education, health and care services provided to children in schools, has not kept pace with these developments, and so nursing/medical services commissioned by schools (or families using personal budgets, but delivered in schools), are often not reviewed or held to account by either regulatory body, and as a result when there are critical incidents, no clear pathway exists for lessons to be learned or accountability to be applied, apart from the local safeguarding board arrangements, which usually approach the problem as a safeguarding failure, and so do not examine the surrounding infrastructure of service design and delivery, instead focussing on individual performance and compliance with established routines.

What does 'good' look like, and where are there examples of good practice?

The most widely recognised exemplar of good practice is the Chailey Heritage Foundation in West Sussex where, for historical reasons, the county council and corresponding CCG have aligned services for children with "severe complex needs" and co-located a clinical service centre with an independent non-maintained special school. As a result all delegated tasks undertaken by school staff are clinically managed and supervised within shared protocols that have been signed off by education, health and social care commissioners. This means that agreed pathways exist for managing risk and investigating incidents, so that lessons are learned and practice improved.

Perhaps out of this existing good practice, in 2016/17 the West Sussex LA and Sussex Community NHS Trust created a pooled budget to respond to a growth in demand for special school nursing services elsewhere in the county, and the clinical lead for Children's Complex Care nursing (Trudy Ward) developed an assessment tool for assessing the level and pattern of need across the county authority. This was later recognised by the Royal College of Nursing as a highly effective innovation and has been awarded a RCN Institute's Child Health Award in 2018.

https://www.sussexcommunity.nhs.uk/news/NHS-in-Sussex-wins-prestigious-national-award.htm

This tool has been used by the Bradford DAP research project to review service provision across Bradford, Kent, Sheffield and West Sussex, and reported on by Carol Williams in a research report presented at the Royal College of Nursing in October 2019.

There are some other examples of effective local joint commissioning which has led to pooling of budgets and alignment of services, for example at St Hugh's special school in North East Lincs LA, when the LA and CCG areas are contiguous and there is a ready mapping of need on to service delivery in a single setting.

At Perseid School (community special school in Merton), following a tragic fatality that led to a serious case review, the headteacher and chair of governors (also coincidentally a CCG commissioner in professional life) led a fundamental review of clinical need within the pupil population and were able to have NHS direct service delivery in the school re-commissioned. The school's leaders and their NHS counterparts are now working to develop a shared governance and accountability model, though discovering that this is not without problems when moving from shared intent to implementation.

In the United States the Individuals with Disabilities Education Act 2004 (IDEA) is a foundational federal law that sets out to "improve early childhood, educational and employment outcomes and raise expectations for all people with disabilities, their families, their communities and the nation."

As an outcome of this mission, a national body the Office for Special Education and Rehabilitative Services (OSERS) exists to support families, local school districts and individual states to implement services effectively, and to hold them to account for outcomes. Within this infrastructure there is a federal template for each state to implement, that aligns the education, health and social care services required to achieve these goals, under a unitary budget and management arrangement. Each state has delegated authority to make ensure that local arrangements at district level are suitable and responsive to local need, but they have to ensure sufficiency and compliance with the

national requirements set out by OSERS. In this model special educators, therapists and school nurses all work in the same structures, share management lines and even join the same trade unions (source 'The medically fragile child: caring for children with special healthcare needs in the school setting' - American Federation of Teachers 2009).

What would need to happen to drive change?

- Clarification of the meaning of the statutory instrument para. 39 of Part 5 of Schedule 2 of the School Funding Regs. so that CCGs are no longer able to propose the withdrawal of clinical services (ie medical/nursing as opposed to 'therapies') that are delivered in school settings.
- For NHS England to clarify that nursing and medical services continue to be a NHS service when delivered in specialist schools and settings, and that locally agreed joint funding does not absolve NHS providers from ongoing clinical supervision, scrutiny and shared accountability for these services.
- For the Nursing and Midwifery Council and Royal College of Nursing to review the guidance for registrants on delegation of nursing tasks, so that minimum standards are described for nurses and medical professionals when providing training to staff in publicly-funded settings such as specialist schools, as opposed to informal family, voluntary or community settings.
- For the DfE to issue further statutory guidance supplemental to 'Supporting pupils at school with medical conditions', that specifies the minimum standards for school governing bodies to apply when accepting the delegation of nursing tasks to their staff and managing large volumes of medicines in schools.
- Consultation with the education trade unions via the SEND working group and RCN to develop an understanding of the interrelationships of: school staff as **support workers**, nursing/medical professionals as **training providers** and **clinical supervisors**, and school leaders as **line managers** and governing bodies as **employers** who must ensure that insurance and liability is properly managed and roles and responsibilities fully consulted and agreed, before tasks are delegated.
- Use the review of the SEND Code of Practice to give clear specifications for locally commissioned nursing/medical services where they are provided to the sub-population of "children and young people with severe complex needs" in specialist settings.
- Ofsted and Care Quality Commission to develop clear inspection and accountability criteria for all specialist providers in settings where nursing/medical care and delegated tasks are undertaken in a 'quasi-clinical' model of service such as a special school ie where 'cumulative risk' has a multiplier effect.

Submitted on behalf of the Medicines in Specialist Schools steering group, 13th February 2020

by

Dominic Wall – National Leader of Education and Regional SEND Lead – North (Whole School SEND)