Special Needs School Nursing Project:

Assessment of Nursing Needs of Children in Special Needs Schools in Four Areas of England & Wales

Commissioned by

The Bradford District Achievement Partnership

Supported by

The Royal College of Nursing

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1. Introduction

1.1. This report provides an overview of the nursing and health needs of children in special needs schools in four areas of England and Wales. The report was commissioned by the Bradford District Achievement Partnership (DAP), which is a partnership representing special needs schools in Bradford[1]. The DAP funded this project following an initial 'Review of Special School Nursing' in Bradford (Williams, March 2018[2]) and concerns raised via Special School Voice (SSV)[3] in 2016, which identified that the issues experienced in Bradford existed more widely across the country. These issues included considerable differences in nursing provision and variation in the quality and safety of health services provided.

1.2. A decision was taken to commission a wider study of health needs in special schools. Four areas were identified from discussion at SSV and from working with Trudy Ward from West Sussex: Bradford, Kent, Sheffield and West Sussex. The Project Lead discussed the work with the Professional Lead for Children's & Young People's Nursing at the Royal College of Nursing. The Professional Lead agreed to hold a round table discussion at the RCN with a representative from the Children's Continuing Care and Community Nursing Forum present, as their guidance covers special needs school nursing. This resulted in a nurse manager and head teacher from South Wales becoming involved in the project.

1.3. The West Sussex team had developed a tool to assess health needs of children in special schools[4] (Appendix 1). This tool had been developed and revised over a number of years to produce a tool which could be used to identify nursing needs and form the basis for discussion of service needs with commissioners. This tool has enabled commissioners to better understand the role of the Special Needs School Nurse and has enabled to team to grow from one to 10. In 2018, the team were awarded the RCN Children's Nursing Award in 2018, highlighting the value of nursing in special schools.

1.4. The aim of the project was to establish the health needs of children in special schools in order to make recommendations for a model of special school nursing and health provision which would reduce the inconsistencies across the country and raise the standard of care provided in special needs schools.

[1] https://deliusspecialschool.co.uk/about/the-district-achievement-partnership-dap/
[2] Williams C (2018) Review of Special School Nursing, Bradford (unpublished, for the Bradford District Achievement Partnership)
[3] http://specialschoolsvoice.org/about-us/
[4] https://rcni.com/nursing-children-and-young-people/features/rcni-child-health-award-win-will-enhance-nursing-visibility-special-schools-135026#1

2. Background

2.1. Children with disabilities and complex health needs will require the same health services as every child, although often accessing services more frequently. In addition, they need a range of specialist services not required by non-disabled children[5]. This group of children will need to access these services in all settings where care is provided, including schools and short break services.

2.2. The current policy framework for the provision of health requirements of children with special needs in schools is unclear. Despite a Government pledge in 2017 to 'improve standards of care for those with learning disabilities and autism' and to include local authority health services in Care Quality Commissions inspections[6], there has been little change in Government policy for children with special needs in school.

2.3. Current legislation and guidance for schools outlines roles and responsibilities in service provision, placing a duty on schools to make reasonable adjustments, prior to school admission, to ensure that children with disability have access to the range of activities and facilities provided for all children[7,8]. However, much of this guidance largely relates to mainstream schools.

2.4. In England, The Health and Social Care Act 2012 places a statutory responsibility on local authorities to commission public health services for children and young people and to ensure cooperation with healthcare commissioners, where additional needs are identified[9]. Public Health commissioning is the responsibility of the Local Authority and for school age children school health services are led by School Nurses. The responsibilities are described in the Healthy Child Programme (HCP)[10] which was reviewed in 2018. The Children and Families Act 2014 sections 19 to 26 place the duty on local authorities, to identify and make provision for children with special educational needs and disabilities. For those children with health needs it is the responsibility of the local authority and clinical commissioning groups to jointly commission services to address health needs outlined in the Education, Health and Care Plan (EHCP) (S26). Section 42 further clarifies commissioning responsibilities with Local Authorities being responsible for education and health commissioners having a duty for health care

[5] https://www.nap.edu/read/25028/chapter/6

[6] Conservative and Unionist Party (2017) Forward Together: Our Plan for a Stronger Britain and a Prosperous Future.

[7] Department for Education/Department of Health (2015) Special education needs and disability code of practice: 0 – 25 years: statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities.

[8] HM Government (2010) The Equality Act 2010

[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/686928/best_start_in_life_and_beyond_commissioning_guidance_1.pdf

[10] https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning

provision included in the EHCP[11]. Health and Wellbeing Boards (HWB) have a statutory duty to work with CCGs to develop a Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy to address the needs of children with special educational and complex needs[12],[13]. This should provide a forum for joint commissioning based on local need.

2.5. The SEND Code[14] outlines the role of health commissioners, defined under section 3 of the NHS Act 2006[15], who '*must put arrangements in place*' where health needs are identified and agreed in the EHCP (p55, 3.65). For most children, these needs would be funded by the CCG, but for children who have highly specialised health needs, these may be catered for by wider NHS England commissioning. The SEND Code also outlines role of the Community Child Health Team, providing guidance relating to joint working, and supporting children and young people through transitions, including to adult services. The Community team have a role in supporting schools to manage health needs such as therapies, tube feeding and respiratory technologies, including provision of training (3.61 – 3.63). The Children's Community Nursing team may be part of the Community Child Health Team and may include Special School Nurses, as well as other specialist nurses including Epilepsy, Palliative Care and Respiratory Nurses. These teams will be largely responsible for monitoring the development and health needs of children with disability and complex needs and are likely to work closely with special needs schools and may provide clinics within some schools. Variation in models of provision mean that in some areas, these services are provided from the acute hospital children's services. Despite the location of the services, these teams would be expected to contribute to the health element of the EHCP, reviewing and updating specific elements of the care plan as indicated.

2.6. The SEND Code[14] outlines the process Local Authorities must follow when agreeing and publishing the 'Local Offer', which includes consultation with children, young people and parents as well as schools and health services. The Local Offer must also include information on assessment for education, health and care plans (EHCP) and an outline of services for children with special educational needs and disabilities within the local area and in a wider area, where services are not available e.g. specialist colleges. A summary of commissioning arrangements outlined in the SEND Code is provided at Appendix 2.

[11] http://www.legislation.gov.uk/ukpga/2014/6/section/42/enacted
[12] https://www.kingsfund.org.uk/publications/health-wellbeing-boards-explained
[13] Department of Health (2014) Children with special educational and complex needs: Guidance for Health and Wellbeing Boards.
[14] Department for Education/Department of Health (2015) Special education needs and disability code of practice: 0 – 25 years: statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities.
[15] http://www.legislation.gov.uk/ukpga/2006/41/section/3

2.7. The revised National Framework for Children and Young People's Continuing Care[16] provides a national framework for CCGs to lead the assessment and provision of continuing care packages. Whilst the above legislation and guidance outlines roles and responsibilities, it allows for flexibility in local joint working arrangements. This allows for differences in local needs but may result in inconsistency in funding arrangements across the country and regional variations in care provided.

2.8. The Children and Families Act 2014 (S100) places a duty on governing bodies of maintained schools and academies to support the needs of children with medical needs in school. The Department for Education published statutory guidance and advice for maintained schools and academies[17] to assist all organisations involved in making appropriate provision for children with health needs. This places a responsibility on school governing bodies to make arrangements to support pupils with medical conditions. It provides a range of advice relating to the roles of health and social care bodies and individual professionals, including school nurses and school staff who may need additional training to support individual healthcare plans. This guidance places a responsibility on local authorities and schools to 'provide support, advice and guidance, including suitable training for school staff', to ensure provision of individual healthcare plans. Where children have special educational needs or disability, this guidance alone does not provide clarity regarding provision for health needs. It refers to the SEND Code and the need for schools to work with local authorities and health bodies to ensure the needs, including medical needs, of children are met.

2.9. The RCPCH *State of Child Health Report 2017* reports the numbers of children and young people with special educational need across the UK. In England, this was at 14% in 2016 with a fall from 23% in 2010. This is against the trend of increasing numbers in Scotland (10% to 23%), Wales (21% to 23%) and Northern Ireland (19% to 23%), which may relate to differing definitions across the four countries. The report identified a UK wide link between low income and special or additional educational need, which is supported by a review of services in Bradford[18]. In Wales and England, the percentage of children with a statement or education, health and care plan (EHCP) is similar at 2.7% and 2.8%. However, the report states lack of consistency across the UK regarding definitions and thresholds for provision of support for these children. The RCPCH recommends

[16] Department of Health (2016) National Framework for Children and Young People's Continuing Care, 2016
[17] Department for Education (2015) Supporting pupils at school with medical conditions: Statutory guidance for governing bodies of maintained schools and proprietors of academies in England.
[18] City of Bradford Metropolitan District Council (2016) Service Review and Recommendations: Bradford Special Needs School Nursing Service

implementation of the 'Disability Matters'[19] e-learning programme across all health, education and social care settings to support education and multiagency working.

2.10. The lack of consistency described by the RCPCH in relation to thresholds for provision can be seen in the variation of special school nursing provision across the areas involved in this study. In South Wales, Special Needs School Nurses are based in special needs schools, providing continuity of care during school hours. In other areas, named nurses are allocated and visit schools during the school day or specialist nurses visit for specific health needs and in some schools, there is no school nursing provision. In these schools, the school staff must provide for healthcare needs, without school nursing support or training in health interventions, which should have been appropriately delegated by registered nurses[20]. One school headteacher reported employing an agency nurse, with no continuity of care and variation in the knowledge and skills of the individual nurses. Further information about special needs school nursing provision by area can be found in section 4 below.

2.11. Similarly, there are varied funding models to address health needs in special schools across these four areas. Children with a continuing care package will often have all health needs funded by the CCG. Where no care package is in place, funding may vary from very limited funding to 50% funding from health commissioners, despite the duty under section 3 of the NHS Act 2006 to provide services (such as nursing), or facilities for children with special educational needs and disability[21]. The responsibility for public health provision lies with the local authority whilst health commissioning lies with NHS Commissioners. This requires a multiagency commissioning model across education, health and social care to ensure that both public health and specialist health needs are met.

2.12. The new NHS 'Long Term Plan'[22] encourages Integrated Care Systems to include Local Authorities and Voluntary Organisations to provide care based on local needs. It states a commitment to implement national learning disability improvement standards, applicable to NHS funded services. These will include workforce and specialist care, with a commitment to work with the Department for Education and Local Authorities '*to improve their awareness of, and support for, children and young people with learning disability, autism or both*' (NHS 2019, p 52). The plan refers to the 'keyworker' role for children who are the most vulnerable or those with the most complex needs. The special needs school nurse would be ideally placed to co-ordinate the care of children in

[19] https://www.disabilitymatters.org.uk/
[20] RCN (2018) Meeting Health Needs in Educational and other Community Settings; a guide for nurses caring for children and young people
[21] Smith E (2019) The Provision of Nursing Services in Special Schools: Statutory Duties (A Discussion Paper)
[22] (NHS 2019, p52) https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

special schools if there was consistency of provision across all schools and special school nurse posts were filled 52 weeks per year.

2.13. The National Institute for Health and Care Excellence (NICE) are in the early stages of developing a NICE service guideline for children with complex needs and disability where the definition of complex needs identifies the child requiring services from health, social care and education services [23]. The process for developing this guidance is lengthy and it is not expected that the final guidance will be published until February 2021. However, this work involves expert topic advisers from all three public services, and committee members with specialist nursing and paediatric medical experience as well as health commissioners, education experts and expertise by experience. Therefore, it is well placed to make significant recommendations which could, in time, lead to service re-alignment and improvement.

3. Methodology

3.1. The methodology for this study was considered and drafted following a review of special school nursing needs in Bradford. This earlier review made recommendations for provision of nursing in the special schools in Bradford and led to discussion about development of a model for provision of health needs. To develop a useful model, the team felt it would need to be based on a larger sample than Bradford special schools and be applicable to special schools in other areas of the country. Therefore, it was proposed to develop a study to explore the health needs of children in different areas of the country. The Bradford DAP worked closely with schools in Sheffield and had contact with the Lead Nurse from West Sussex who had developed a nursing needs assessment tool (appendix 1), used in Bradford to assess the health needs of children in Bradford's special schools. Representatives from these areas were interested in taking part in this study. Through Special School Voice, the Executive Principle from Co-op Academy Southfield had discussed concerns regarding school nurse provision with a Head Teacher from Kent. The project lead attended a meeting of special school Head Teachers in Kent to discuss early proposals for a study and explore their willingness to be involved. Some of the Kent staff were familiar with the West Sussex nursing needs tool. Local Authority representatives were at this meeting and were willing to be involved in further discussions. It was agreed that a roundtable meeting would be arranged in July 2018 and a proposal was drafted for discussion at that meeting.

3.2. Round Table

3.2.1. The proposal was discussed with the Professional Lead for Children's & Young People's Nursing at the Royal College of Nursing. It was agreed that the RCN would co-host the

[23] https://www.nice.org.uk/guidance/indevelopment/gid-ng10113/documents

meeting at RCN Headquarters with attendance from a representative from Children's Community Nursing, as the college was in the process of revising its guidance for children's community nurses. This guidance includes a section on special needs school nursing, and it was agreed that the findings of the study would be included in the revised guidance.

3.2.2. Invitations were sent out to the Local Authority Lead for children with children with special educational needs and disability, the CCG commissioner for children's services and Head Teachers representing each of the four areas. A Head Teacher from South Wales attended with the RCN representative for Children's Community Nursing. In addition, invites were sent to individuals at Department for Education, Department of Health, NHS England and NHS Improvement (who accepted the invitation, but was unable to attend on the day), the Care Quality Commission and the Council for Disabled Children. A telephone discussion was held following the round table to provide an update on the proposed study.

3.2.3. The focus of the round table discussion was to explore the proposal to undertake a study to collect anonymised data on all children in special schools in the four areas. The background and reasons for undertaking the study were provided by a Head Teacher from Bradford DAP and information about the tool were provided by the Lead Nurse for West Sussex. All teams were either using the tool or expressed a desire to use the tool to inform discussions about commissioning. Each area team provided a brief overview of provision and concerns in their area. This was followed by a discussion of key questions in each area team to explore how the data would be collected in each area, what the group wanted to achieve and how the results might be used to influence policy makers (appendix 3). This was fed back to the wider group and the issue of resources required to collect the data appeared to be the biggest obstacle to involvement in the study. It was important that those collecting data were able to apply the tool based on a knowledge of children's nursing and specifically, care of children with long term and complex health needs. It was agreed that to ensure consistency of data collection a limited number of nurses should collect data in each area. For each school, a representative from the school should be involved in data collection and all data should be anonymised.

3.2.4. Teams were asked to reflect on the meeting and contact the Project Lead with further questions if there were outstanding issues or provide a decision regarding involvement. It was agreed that the data would be collected in the Autumn term, as there was not time prior to the end of summer term and many nurses had term-time contracts. The data was to be used to inform individual local area discussions with commissioners, which would take place prior to completion of the project.

3.2.5. Following the round table, the Children's Community Nurse and Head Teacher from South Wales asked to be involved in the study, providing a fifth area. This was agreed. Discussion with individuals in Kent highlighted a problem with identifying the nursing resource required to collect the data, based on the limited number of nurses in post. It was decided that the schools in Kent would not be part of the study as they had some work to do on ensuring all schools had nursing provision prior to looking at the individual profile of health needs in each school.

Case Study 1: Special Needs School Nursing in Kent

Due to the lack of and considerable variation in special needs nursing resource in Kent, it was not possible to assess every child in each school. Therefore, the CCG did a detailed assessment on the most complex children in each school as identified by the school staff. In addition, they allocated all children to the tiers outlined in the nursing needs assessment tool to get 'a flavour' of the needs across all 13 special needs schools.

There were various models of health provision in the county with six schools directly employing nurses and providing for all heath needs. In the schools in West Kent, they had taken an 'educator model', with nurses providing a 'hands off' service and delegating all aspects of care. The work in progress is aiming at somewhere between these models, with one governance framework and agreed policies used by all nurses.

Routine medicines are being delegated to school staff following a programme of training and assessment, which will free up nurses to undertake the more complex interventions, requiring nursing skills. They are developing a list of interventions that nurses are responsible for, to ensure that where clinical reasoning is required to modify interventions to meet the needs of specific children, nurses are available.

The Health Commissioners have accepted responsibility for commissioning health services. They are looking at both the role of nurses and developing an education and healthcare role within schools to support health needs within the child's educational programme. They aim to keep classroom environments as normal as possible, without disrupting the education setting or turning it into a clinical setting.

3.3. Training in use of the tool

3.3.1. The Project Lead was familiar with the nursing needs assessment tool but was aware that changes had been made following further use on West Sussex, where it was developed. A visit was made to West Sussex to discuss the changes, how the tool was being used to populate the health section of EHCPs and to explore the complexity tool, which had been developed to work alongside this tool. It was agreed that the areas would not use the complexity tool as this was used on a day to day basis to assess acuity and workload in individual schools.

3.3.2. The Project Lead arranged dates to train the teams in Sheffield (two nurses) and Wales (three nurses), who were not familiar with the tool. This training was undertaken in October 2018, when the children and staff had settled back into school after the summer. It was decided to train teams individually to reduce the need for clinical staff to travel and to enable clinical teams to discuss anonymised cases to learn how to use the tool in practice. The teams were asked to select several children of varying complexity in advance of the training, to enable the training to be focused on real examples. The team were able to raise questions and explore how they would apply the tool in their area.

3.3.3. Contact details were provided for the Project Lead to enable follow up questions where required. Nurses raised questions when they first started using the tool, but quickly became confident in collecting the data. Questions identified that there were children with special educational needs who did not have additional health needs above the need for health assessments and normal public health provision (see section 5).

3.4. Data collection

3.4.1. Data collection was planned between July 2018 and January 2019, for children in school in the 2018/19 school year. However, the final complete data was not received until May 2019, due to staff numbers in one area. Data was collected by two people using each child's records and with at least one nurse having knowledge of the child's care plan and health needs.

3.4.2. One nursing needs assessment form was completed for each child, recording all health and partnership plus needs. This was then collated locally with anonymised totals provided for each section of the tool for individual schools.

3.4.3. The original timescale for submission of data was by the end of the Autumn Term, but in one area, maternity leave and sickness meant that this was significantly delayed due to the number of schools in the area.

3.5. Collate, review and clarify information

3.5.1. Once all data was received, it was collated onto a spreadsheet by school in each area and then the totals for each area were collated onto another sheet to show the total number of children in each category by area (appendix 4).

3.5.2. Data was reviewed by the Project Lead and the Lead Nurse for West Sussex, who developed the tool. Potential discrepancies were identified and clarified by the Project Lead with the area teams as required.

3.5.3. Data analysis was undertaken to identify the health interventions required that should be delivered by nurses and those which could eb delegated to non-registered school or health staff. The findings are provided in section 5 below.

4. Overview of five areas

4.1. During the early stages of this project there were five areas, which were reduced to four early in the prior to data collection commencing. This was due to lack of resources to collect data and the more immediate need to review special needs nursing provision in some areas of Kent. However, the background information relating to Kent is provided here to illustrate the similarities and differences in the populations of children with special needs and the range of provision in place in special schools to meet these health needs.

4.2. Bradford

4.2.1. Public Health data for 2018[24] indicated that 16.4% or 16,275 children have a special educational need, which is higher than average for the region or England as a whole (14.3%/14.4%, range 9.3% to 19.8%). This figure had fallen since 2017. The percentage of children with a long-term illness, disability or medical condition diagnosed by a doctor was reported as 12.5% (range 9.2 to 18.6%, 2,035 children), which is lower than the regional average (13%) and the average across England (14.1%).

4.2.2. As the fourth largest Metropolitan Authority in England, with a population of 531,000, Bradford has a young and diverse population. Bradford has the highest percentage of young people in UK with 23.7% of the total population being under 16 years of age, compared with the national average of 18.8%[25]. The Bradford area is ethnically diverse and has the largest proportion of people of Pakistani origin in England (20.3%). It was noted that there was a high prevalence of specific disabilities and complex needs in the South Asian population including, with almost twice as many children with congenital abnormalities and more children with severe learning difficulties including profound and multiple learning and physical difficulties. In addition, higher rates of sensory problems, complex needs and rare congenital anomalies are seen in this group.

4.2.3. There are eight special schools in Bradford, two of which provide for children with social, emotional and mental health or communication and interaction problems. The number of children with an educational statement or EHCP has risen from 2,145 to 3,530 over the last four years. The Bradford Special School population was reported as a total of 1,230 children and young people in special school placements (32%

[24] https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133231/pat/6/par/E12000003/ati/102/are/E08000032/iid/10101/age/169/sex/4

[25] https://www.bradford.gov.uk/business/bradford-economy/about-bradfords-economy/

population)[26], including those in transition. The remaining children are in mainstream schools or are home educated. 190 new placements have been created by repatriating children previously educated out of area. The Local Authority Plan suggests that an additional 354 special needs places will be needed by 2021, half of which will be in special needs schools. Services are commissioned by three CCGs from four health care providers. Special school resources have been challenged by a 30% increase in the number of pupils in special schools with increasingly complex needs between 2013 and 2018.

4.2.4. The Special School Nursing team is made up of 13 nurses and four healthcare support workers, who are based off-site. Their school nursing role involves child health assessments, training school staff, provision of clinics in schools, immunisation, safeguarding and respite care. This last responsibility takes special school nurses off site, but other off-site work includes home assessments, attending complex care clinics, supporting parents in hospital, discharge planning meetings in hospital, strategy meetings and supporting immunisation sessions. The work undertaken around immunisation has been recognised as innovative to by Public Health England and prevents children with special needs being unimmunised.

4.2.5. The team reported not being commissioned to provide nursing care in schools throughout the day but provide gastrotomy care and change naso-gastric tubes when on-site. The team works closely with Children's Community Nurses, Dieticians, the Continence Team and Physiotherapists. These teams have been involved in developing new pathways to avoid duplication of provision and to enhance the experience for children and families. One example is Southfield School, which has 1.4 WTE nurses and 0.25 WTE Healthcare Support Worker allocated to the school with 253 pupils with a current total of 214 care plans, which is increasing year on year. Between 2016 and 2017, the school saw an increase from 91 to 152 in NHS care plans plus increases in manual handling, physiotherapy, feeding and speech and language care plans. The care being provided by school staff is becoming increasingly more complex, requiring additional training, supervision and assessment of school staff by nurses. However, use of the 'nursing needs assessment tool' has resulted in more informed discussions with commissioners and increased funding and nursing numbers.

4.2.6. The issues and challenges faced include increasing levels of risk faced by school staff providing care for children, due to the high number of children with everyday complex needs with health care interventions delegated to the school workforce. School governance structures must address risk management issues including incidents,

[26] https://bradford.moderngov.co.uk/documents/s21592/SEND%20Strategy%202018-22%20draft%20for%20consultation.pdf

medicines management, training and competency assessment, requiring review of staff contracts. School staff feel they are left to fill gaps in NHS funding and provision. The Special School Nursing team are unable to meet the current need with existing resources, due to the number of school staff who require training and assessment and competing priorities from areas such as safeguarding and clinical services.

4.3. Kent

4.3.1. The Public Health data for 2018 indicates that Kent has 28, 767 (12.4%) children and young people with special educational needs, compared with the regional average of 14.1% and national average of 14.4% (range 9.3 to 19.8%). There is a higher percentage of children with long-term illness, disability or medical conditions diagnosed by a doctor than in other areas: 18.3%, compared with an average of 15.2% regionally and 14.1 in England (range 9.2 to 18.6%). The number of children with a continuing care package was reported to be low.

4.3.2. Kent is a large county, which has seven CCGs (and often works with Medway CCG) and 12 district councils, with Medway as a unitary authority. The area is populated by small towns and rural communities and has areas of both high deprivation and low deprivation with the west of the county being largely more affluent than the east[27]. There are more than 1.5 million people of which more than 200,000 were of school age. The percentage of people from ethnic minority group was 11.4% at last census in 2011, with variation between coastal areas (2.7-3.7%) and the Dartford (33.3 – 48.2%) and Canterbury (34%) areas[28]. The population of Kent has grown more than both national and regional rates and is predicted to grow further in future years based on planned development

4.3.3. There are 13 schools for children with profound, severe and complex needs or physical disability, with a total of 2,642 designated places for children with profound, severe and complex needs or physical disability across the country. A further 368 places are planned for 2021. Between 2016 and 2017 there was a 16.1% increase in EHCPs (national 12.1%) and a total of 9,111 children and young people with an EHCP or statement. 45% of these children receive their education in special schools with 48% in mainstream schools and 7% in other provision.

4.3.4. At the time of the round table, only four of the 13 schools had NHS nursing or physio provision commissioned by the local CCGs. The remaining nine schools directly employed a permanent nurse or agency nurse on a full or part-time basis, or they employed therapists or they relied on school staff trained to manage the children in-

[27] KCC (2018) Commissioning plan for Education Provision in Kent 2018 – 2022.
[28] https://www.kpho.org.uk/__data/assets/pdf_file/0010/43579/Ethnicity-in-Kent-and-Medway-2011.pdf

house, with reliance on the '999' ambulance service if required. In these nine schools a total of 403 pupils were reported to need daily support with health needs, with many pupils moving from stable to unstable without warning. Work has been undertaken since the round table to develop a network of Special Needs School Nurses across the county. This has involved the lead CCG working with schools to spread resources and effectively delegate care to school staff using the RCN guidance as a framework[29].

4.3.5. The concerns raised by Head Teachers included the responsibility placed on schools for issues which were outside their knowledge and competency, the number of incidents arising, the lack of an agreed tool to assess need and identify provision, education funds taken for health provision, increasing levels of staff stress and CCN provision not meeting training needs. However, steps were being made with joint working following allocation of a lead CCG commissioning services and a plan to provide equitable healthcare provision based on pupil needs.

4.4. Sheffield

4.4.1. Public health data[30] shows that Sheffield has 13,151 (16.4%) children with special educational needs, compared to a regional average of 14.3% and national average of 14.4% (range 9.3 to 19.8%). 13.6% of all children in Sheffield have a long-term illness, disability or medical conditions diagnosed by a doctor, compared with 13% across the region and 14.1% nationally (range 9.2 to 18.6%).

4.4.2. The population of the City of Sheffield is around 575,000 with a high proportion of young adults between 20 and 24, due to a high number of students at the city's two universities. The population is growing as there are now more births than deaths in the city[31]. Around 19% of the population come from ethnic minorities, with the largest group being of Pakistani origin, but there are also large groups of Chinese, Caribbean, Indian and Somalian origin.

4.4.3. There are 10 Special Needs Schools in Sheffield with more than 1,000 pupils in total. These children are reported to have a wide range of increasingly complex needs with an increasing number of clinical interventions required, with many children having multiple health problems. In addition to increasing complexity of need the population of children with mental health problems is increasing.

[29] RCN (2018) Meeting Health Needs in Educational and other Community Settings; a guide for nurses caring for children and young people

[30] https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133231/pat/6/par/E12000003/ati/102/are/E08000019/iid/91816/age/44/sex/4

[31] https://www.sheffield.gov.uk/home/your-city-council/population-in-sheffield

4.4.4. There is no special needs school nurse provision in Sheffield, with specialist health support provided by a broad range of nurses and therapists. There is no co-ordinated provision of in-reach provided by the Children's Community Nursing team, although a scoping exercise is taking place to provide in-reach support and training to school staff. Sheffield Children's NHS Foundation Trust have undertaken a full review of training provision. Sheffield Clinical Commissioning Group provide pharmacy support in schools. Due to the limited resources available, two of the 10 schools were included in this project to determine nursing need in these schools.

4.4.5. There are a range of issues of concern for the special schools management teams including the lack of co-ordination or case management, the lack of quality assurance relating to non-health practitioners providing healthcare interventions, the lack of training and competency assessment, the lack of a national framework or guidance, lack of consistency of care in special schools and the lack of standards for both school and healthcare staff to ensure quality and safety of provision are maintained.

4.5. South Wales, Abertawe Bro Morgannwg University Health Board,

4.5.1. The Congenital Anomaly Register and Information Service for Wales[32] reports 34,353 cases of congenital anomaly on the CARIS database in 2017. There are about 4.4% of all live births with a congenital anomaly, with 97% surviving to one year old. However, it does not state how many survive to school age and how many have complex education and health needs. In the Swansea area 24.7% children have a special educational need, including both physical health needs and behavioural and learning difficulties.

4.5.2. The total child population is around 520,000[33] within the health board area of which 14.9% are from ethnic minority groups. Nationally around 200,00 children in Wales live in poverty[34] with around 21% receiving free school meals in the Swansea area. The Welsh Index of Multiple Deprivation indicates high levels of deprivation in some areas of Swansea with deprivation levels varying between 1.5% and 99.3%, with an average around 35% across the Swansea area.

4.5.3. There are three special needs schools in the South Wales area providing education for children from 3 or 4 years of age to 19 with complex care needs. One of these schools has a stream for children with autistic spectrum disorder, but the school largely provides for children with learning disability and complex care needs.

4.5.4. Nursing provision in the three special needs schools in South Wales is provided by 4.6 WTE nurses based in the schools during school opening hours. Nurse to child ratios are

[32] http://www.caris.wales.nhs.uk/home
[33] http://www.publichealthwalesobservatory.wales.nhs.uk/information-about-the-interactive-map
[34] https://www.rcpch.ac.uk/resources/policy-response-wales-state-child-health-report-2017

between 1:80 and 1:123 children. These nurses work term-time only and are line managed by the Community Children's Nursing Team Leader. The nurses provide most medications and deliver care for children with continuing care packages. There is an integrated community model with CCNs providing in-reach into schools when Special School Nurses require cover or to meet health requirements in school. Safeguarding supervision is provided by the Clinical Nurse Specialist for safeguarding after school hours.

4.5.5. The term-time model is well established and historical. The team would like to have 52 week contracts to enable them to undertake assessments for new children and safeguarding activity during the school holidays. Additional resources are required as the service is stretched when staff are sick or on study leave.

4.6. West Sussex

4.6.1. Public health data indicates that West Sussex has 18,230 (16.2%) of pupils with special educational needs, which has fallen on previous years, but remains higher than both the regional (14.1%) and national (14.4%) averages. 14.3% of children have a long-term illness, disability or medical conditions diagnosed by a doctor, which is below the regional average of 15.2% and slightly above the national average (14.1%).

4.6.2. Like Kent, the county is largely made up of small towns and rural communities, with much of the county falling within one of three areas of outstanding natural beauty. The population of West Sussex estimated in 2016 is around 843,760 people, with around 11% of the population being from minority ethnic groups.

4.6.3. West Sussex has 12 special schools of which nine have an allocated Special School Nurse. School nursing in the other three schools is through the Local Authority HCP. School nursing services are currently joint funded by the CCG and schools on a 50:50 basis. Standard Operating Procedures are in place governing delegated duties and service provision, which emphasises the nursing role as advisor to staff with trouble shooting responsibilities in relation to medicines management. Medicines administration currently sits with the schools and local authority with the school nurses offering trouble shooting advice only. Training in medicines management is provided by the Local Authority, using a pharmacist with no nurse involvement.

4.6.4. The special school nursing service in West Sussex falls under the county-wide comprehensive children's community nursing service within a community NHS provider. This includes locality based teams, an end of life care team and a continence service. This model enables joint working where children are seen by both community and special school nursing teams and shared safeguarding and clinical supervision for staff. The nurses are primarily based in the schools but also work from the base for the

community nursing team. Schools also have access to the CCN team throughout the school week where required such as for end of life care. The model is described as hybrid and holistic in that it promotes health, wellbeing and learning, through the provision of public health, child development and disability and community nursing pathways. The team is comprised of 10 nurses (7.1 WTE), led by a Band 7 who works closely with the Local Authority SEND team. All these nurses are children's nurses and all Band 6s must hold a specialist practice qualification in public health, health visiting, school nursing or community nursing or be a nurse practitioner or graduate with relevant knowledge and experience. The model builds in four full year contracts to cover transition, EHCPs and safeguarding during school holidays. However, there is flexibility built in the recruitment plan agreed by Sussex Community Foundation Trust and Head Teachers to appoint term time applicants with the right skill set. In April 2019 the team increased to 8.1 WTE. The team works closely with the HCP and Children, with Disabilities teams for service delivery and training and the audiology service who provide a pathway for hearing screening in special schools.

4.6.5. The volume of training and competency assessment place a significant pressure on special school nursing time. In addition, there has been an increase in complexity with children with rare diseases living longer than in previous years. Some of these children require nursing presence in school throughout the school day. Therefore, the most recent review of nursing needs identified a shortfall of 3.56 WTE to meet the demand on the nursing service.

4.7. Summary of Issues

4.7.1. Review of these areas provides evidence of between 12.4 and 16.4% of children having a special educational need and between 12.5 and 18.3% of children having a long-term illness, disability or medical conditions diagnosed by a doctor. Whilst many of these children will be in mainstream schools e.g. 48% in Kent, many will require special educational settings to meet their learning needs. This group will often be the children with the most complex needs, which often cannot be met in mainstream education. One of the concerns of special needs school staff is that the complexity of health need within this pupil population is increasing, which has resulted in a higher number of incidents and increased risks and stress for school staff who feel inadequately trained and supported (see Case Study 1).

4.7.2. There are a range of models of nursing provision from school-based nursing services, to in-reach special school nursing from a community base, community nursing and therapy service in-reach and, in some areas, no dedicated special school nursing service. Where there are special school nurses, the numbers seem to vary with the pupil population, although this was not true of Kent, where nursing provision was limited to

four schools initially. This lack of consistency of nursing provision is likely to be replicated across England and Wales. In those areas where nursing need has been assessed using the 'nursing needs assessment tool' they have been able to provide evidence of need and the nursing team has secured increased staffing based on this information.

4.7.3. The lack of a framework, guidance or standards relating to managing the healthcare needs of these children in schools is an issue for schools. There is a need for a clear and consistent governance structure which involves commissioners and providers to address issues such as care co-ordination, risk management, delegation and training, employment policies and funding sources. Addressing these concerns may enable Head Teachers, school staff and special school nursing teams to assure the quality and safety of the services provided to some of the most vulnerable children in society.

Case study 2

John (pseudonym) is at senior school. He has a moderate learning disability and epilepsy. He has rescue medication with a clear protocol which indicates when it is to be given. Parents inform school that he is most likely to have a seizure when he starts eating. There is no clinical guidance or recommendations as to how to risk assess this situation and ensure his nutritional needs are met in the safest way. The school report that neither Speech and Language Therapy nor the Neurology service has felt able to give this guidance and there has been a near miss where his airway has been at risk. Since the change in the school nursing role there is now no Special School Nurse for the school who would previously have helped to resolve this. This school also raised concerns about 13 other children they feel are at risk of choking (see Table 1).

The following issues have been raised by the school staff who are looking after this young man for large parts of the day and by the Children's Community Nursing team, who support the school staff as required. There are no school nurses in this setting. This case study and the issues arising are common issues and questions raised by school staff and point to the need for clear joint commissioning and governance arrangements in special schools.

Table 1: Issues arising from Case Study 1

Risks to the child	• is there additional health advice which could help prevent choking? • Is it more a case of preventing seizure onset with careful monitoring and medication management and where is the health documentation to communicate this? • Is this a longstanding condition and is there information which should have followed him from transition from primary school or is this a relatively new health issue?

	• The School report they are often unaware of admissions and discharges from hospital, Changes in health needs are not always communicated, resulting in very outdated documentation. When children are in hospital for a long time then there is no health professional who keeps the school updated this makes it difficult to know when and how to support/contact the family • What is the emergency advice for his airway? Should oxygen be available? • If he should choke how can school know they have done everything possible/ everything right? • who should provide a care plan for this child's need? And is advice from parents alone enough? (without guidance from a health professional) • Are the other 13 children perceived to be at a greater risk because of the near miss? How can we help schools 'risk assess'?
Roles and responsibilities	• Whose role is it within school for working with parents to develop the child's school health care plan? • For children with complex/multiple needs who is responsible for assessing the ongoing health and wellbeing of the whole child (not just gathering a compendium of single care plans) i.e.: impact of multiple appointments, respite, liaison re admissions and discharges to hospital • What is the essential health information needed in school before a child attends? And who checks it's in place for starting and follows up on missing info? • Who links with other Health MDT professionals in acute and community services (shared meetings/forums where issues can be raised)? • The health role of the school HCA appears to vary considerably between schools. In this school they have a full schedule of health tasks within the day and a responsibility for responding to emergencies which has had a big impact on their ability to address some of the organisational/ administrative/health information needs which are outstanding. This is frustrating for them and they will need support to make the changes needed. Support may include a better system to store and gather health information, which potentially could be admin support. Would a standardised role be helpful? Clear lines of responsibility and an understanding of how this role fits in with the communication of health needs between primary and secondary care are required.
Legalities/liabilities	• Who is accountable in the event of permanent injury or death? What systems/ evidence is needed to show best care given?

	• Do school insurers need to know about individual risks? Should there be clearer guidance for schools and health professionals about this?

5. Findings: Identified nursing needs of children in special schools

5.1. The findings are based on the assessed needs of 3,151 children from 22 schools across 4 areas of England and South Wales (Table 2). The results are structured based on the areas for assessment on the 'nursing needs assessment tool' (appendix 1).

Table 2: Total Schools, Pupils and Nurses by area

	Bradford	Sheffield	South Wales	West Sussex	Total
Number of schools	8	2*	3	9	22
Number of Pupils	1111	269	404	1367	3151
Number of Special Need School Nurses	13 nurses and 4 HCAs	0 dedicated SNSNs	4.6 Nurses	10 Nurses	27.6 Nurses & 4 HCAs

* 2 of 10 schools were included in the study, with a total population of over 1,000 children across the 10 schools.

5.2. Complex and fluctuating health needs likely during the school day

5.2.1. This category of need is described on the tool as indicating '*children's nursing priority input required & shows the need for nursing assessment during the school day likely*'. Therefore, where children in special needs schools fall into this category of need, a nurse will always be required in school to support symptom management following assessment of changing condition. One Senior Nurse stated that it was important that this nurse was experienced to prevent pain and suffering for children with dystonia or autonomic storming, as this can reduce the need for admission to hospital.

5.2.2. Table 3 shows the number of children requiring nursing input in each category by area. The fourth column labelled 'nursing needs' is for those children with everyday complex needs whose care cannot be delegated to a non-registered person. The section 'other' is for additional categories added by teams, which did not fit into the four categories stipulated. These include management of steroid replacement therapy and advanced care plans. The latter might have been recorded under life limiting condition in other areas.

Table 3: Children with complex and fluctuation health needs during the school day					
	Continuing Care Support	Life limiting condition	Unstable health	Nursing needs	Other
Bradford	12	93	60	0	0
Sheffield	3	4	12	0	0
South Wales	12	60	13	4	2
West Sussex	59	213	147	5	0
Total	***86***	**370**	**232**	**9**	**2**

5.2.3. Only one school in Bradford of the total 22 schools did not have one or more children with continuing healthcare packages. The total number of children with a continuing care package in these 21 schools was 86 or 2.7% of the total school population. In view of the introduction of the Framework for Children's and Young People's Continuing Care in 2010, it was surprising that more children in these special schools were not in receipt of a care package when the complexity of health needs are considered. This may be due to adjustments to the framework since 2010, with the most recent change in 2016, since when anecdotal information from Children's Continuing Care Nurses has indicated that the threshold for health care packages has increased as funding has become more restricted. There is also some evidence that access to continuing care assessments differs in different areas of the country[35].

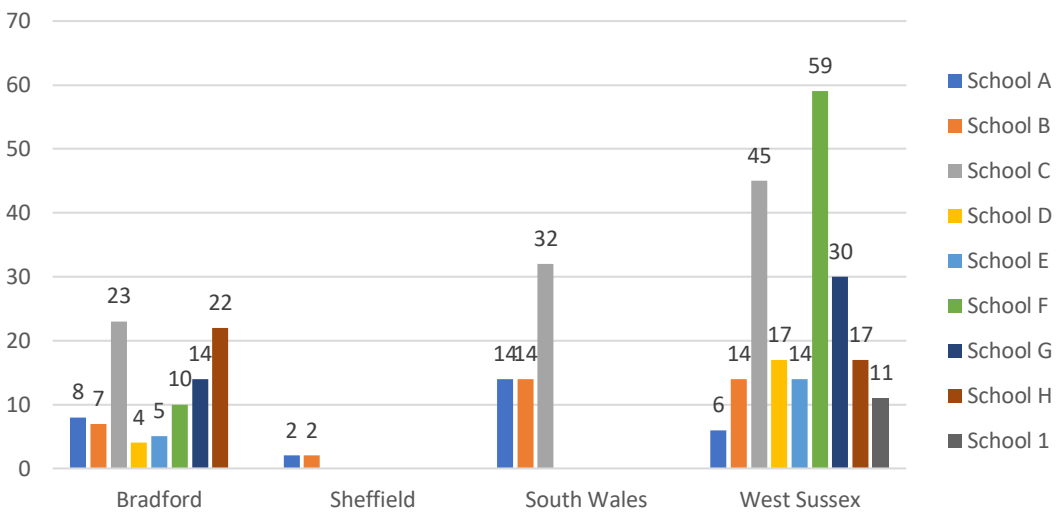
5.2.4. Discussion with nurses indicated that few children with a care package had a carer accompany them into school. The reasons cited were lack of allocation for care during school hours and difficulty overcoming the governance issues of having someone in school employed by another organisation or the family. However, it appears that the team in Sheffield have addressed this by training and employing the carers at Sheffield Children's Hospital. In South Wales, the Special Needs School Nurses support the care packages in school time. In West Sussex, a mix of school staff and continuing care NHS funded nurses are providing the care for these care packages. The higher number of children with care packages in West Sussex is possibly due to the way the continuing care assessment tool has been applied in this area, as it was reported that numbers had always been high.

5.2.5. The number of children with life limiting conditions includes those children with life threatening conditions such as complex epilepsy. All schools had children with life limiting conditions (Figure 1), with support for children's palliative care and end of life care being provided by specialist nurses from the Children's Community Nursing Team.

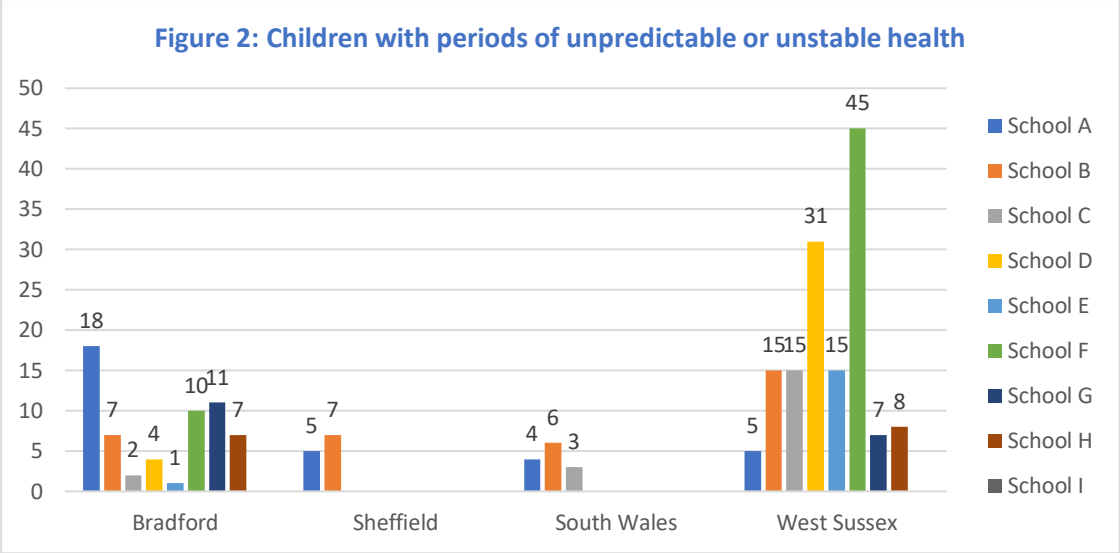
[35] http://www.lukeclements.co.uk/2018/09/

These nurses contribute to care planning for this group of children in some schools, although care plans may be provided by specialist children's hospice or hospital services.

Figure 1: Number of children with life limiting illness in schools in each area



5.2.6. All 22 schools had children with periods of unpredictable or unstable health, with between 1 and 45 children per school (Figure 2). This is one of the groups of children that cause the most stress for school staff who are providing interventions, as the children can become unstable quickly, requiring emergency intervention and ambulance transfer to hospital. Emergency nursing intervention might be required at short notice, which would require a nurse to be present in school in order to provide appropriate intervention for the child and support for the staff. Currently, where nurses are not present in school all children becoming unwell would be transferred to hospital via an emergency ambulance. It was also reported that most children who become unstable are transferred to hospital, regardless of assessment by a nurse, as most required medical intervention.



5.2.7. Not all schools are routinely collecting the data relating to the number of children requiring emergency transfer to hospital. However, in Bradford the DAP commenced data collection from January 2018. Audit of 999 calls for the Autumn term 2018/19 showed 42 emergency calls, with 25 of these coming from two schools (Table 4).

Table 4: Number of children requiring 999 call in Bradford, Autumn Term 2018/19

School	P	B	C	D	H	HP	O	S	**Total**
	5	1	5	12	3	3	0	13	**42**

An example from one school in Bradford which has been collecting this information since autumn 2017/18, with the number of calls collated by term (see Table 5).

Table 5: Number of children from one school requiring 999 call in 2017/18 and 2018/19

	Autumn	**Spring**	**Summer**	**Total**
2017/18	21	13	7	**41**
2018/19	12	13	7 (to 17 June 2019)	**32**

The Special Needs School Nurse is often called to see these children and supported the need for the child to be transferred to hospital by ambulance.

5.2.8. There were few children reported who had everyday health needs, where that care could not be delegated to non-registered staff. In total there were nine children in 5 schools, with four children in one school in South Wales and 5 children in 4 West Sussex schools. Examples of children falling into this group include:

1. a young person with complex respiratory needs including a cough assist device,
2. a child with neuromuscular problems requiring 24 hour assisted ventilation and total care needs which fluctuate throughout the day
3. a child with fluctuating dystonic epilepsy and respiratory problems of undiagnosed origin
4. a child with fluctuating respiratory problems
5. a child with complex epilepsy requiring oxygen and vagal nerve stimulation
6. a child on complex medication.

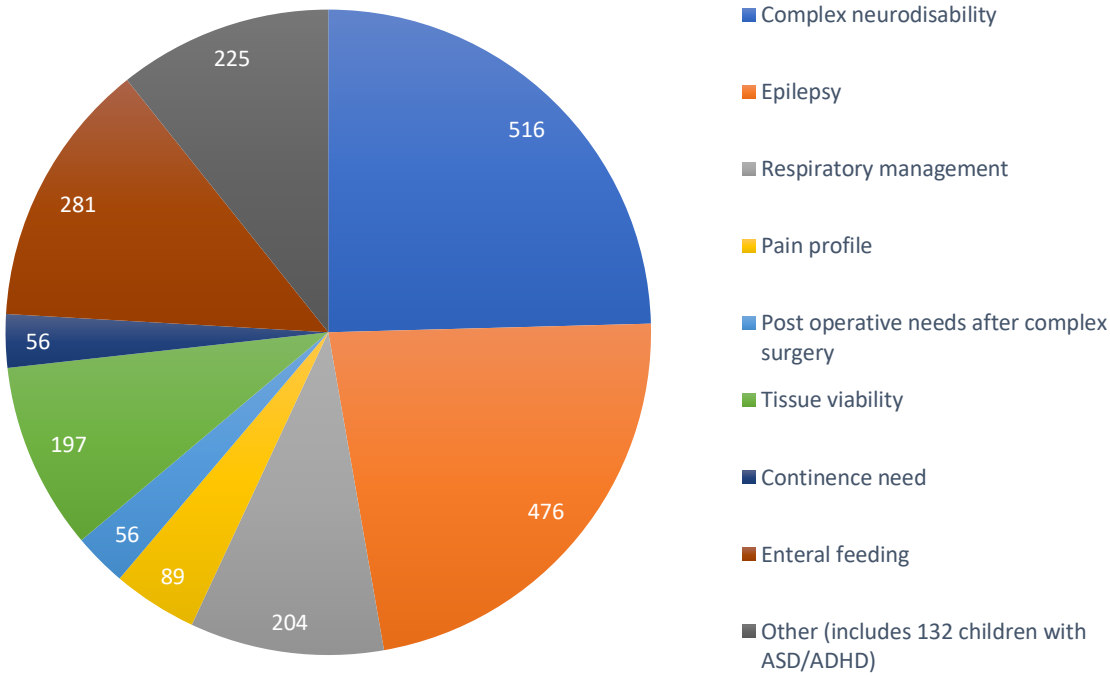
Most of these children had a nurse allocated to their care on a 1:1 or 1:2 basis whilst in school. When looking at the assessment tool, cases 1-5 could have been included under 'fluctuating, unpredictable health needs' (Cases 2, & 4) or 'complex long-term health conditions (Cases 1, 3 & 5) based on the descriptors on the tool.

5.2.9. Overall, for children with complex and fluctuating health needs, there was evidence that nursing intervention is required by children in all schools within this study. The number of children with life limiting conditions and unstable health are not insignificant. In Bradford alone there were 42 emergency 999 calls in one school term, representing children who were able to attend school but whose health needs changed whilst in school. Whilst in some areas, work has been undertaken with health commissioners to agree funding for nursing, further work is required in this area for those children who do not have a continuing care package. Where there are children with complex and fluctuating health needs, the responsibility placed on school staff causes severe stress which impacts on staff wellbeing and retention. In addition, the children may be at risk from lack of knowledge and training in their care needs. Therefore, the findings indicate that where '*children's nursing priority input'* is required *and the 'need for nursing assessment during the school day* (is) *likely*', a school nurse is required to be present on-site during school opening hours to meet these needs.

5.3. Complex long term health conditions

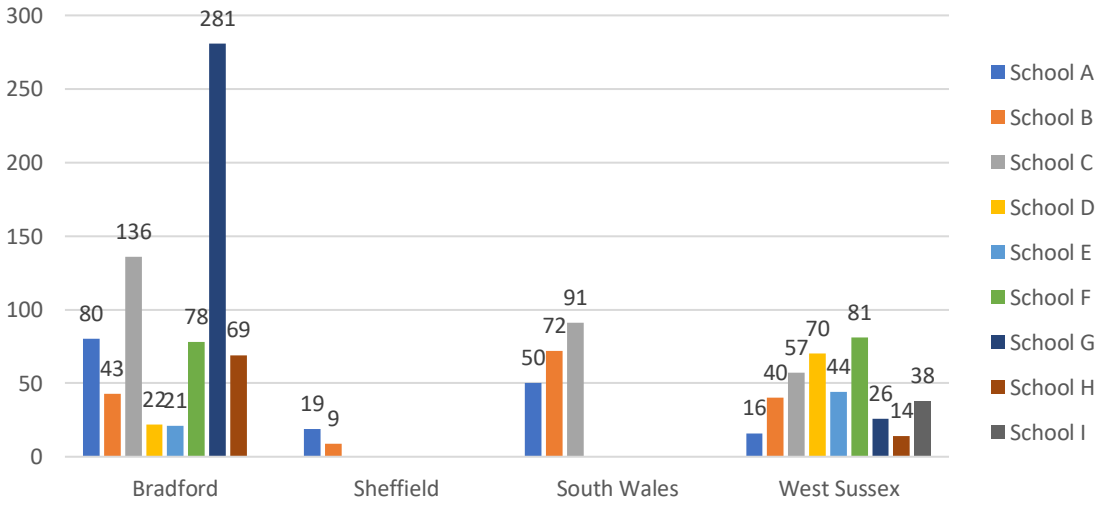
5.3.1. The nursing needs tool states that children in this group have care needs that require '*children's nursing advice and interventions regarding long term condition management during the school day*'. This may require assessment of a child by a nurse or direct nursing intervention to meet care needs. The types of health need included in this group can be seen in Figure 3, with complex neurodisability and epilepsy making up almost half of the total number of needs in the complex long term group with enteral feeding being the next largest need.

Figure 3: Number of children with complex long term conditions by health needs



5.3.2. When broken down by schools in each area (Figure 4), the number of children with these three health needs varies considerably between schools with a range of 9 to 281. However, it should be noted that some children may have all three needs, which is true of the high numbers of needs noted in one of the Bradford schools where the figure of 281, represents the high number of children with complex needs in this school.

Figure 4: Total number of children with complex neurodisability, epilepsy and/or enteral feeding by school



5.3.2. When complex needs are reviewed by individual school in each area, the level of complex long term health need is variable both across schools in each area and between areas (Table 6). However, the data indicates that, in all 22 schools, there are a significant number of children (minimum 21) in each school who would require '*children's nursing advice and interventions regarding long term condition management during the school day*'. This would suggest that, in all schools where children with complex long term health needs are placed, nursing advice and skills will be required throughout the day. This will require a school nurse to be on-site when the school is open to pupils.

Table 6: Complex long term health needs by school and area

	Complex neuro	Epilepsy	Respiratory	Pain profile	Post-op	Tissue viability	Continence	Enteral feed	Other	**Total**
Bradford Schools										**790**
A	37	21	5	1	1	2	0	22	0	**89**
B	6	24	4	0	0	0	0	11	0	**45**
C	55	41	21	1	1	1	0	40	0	**160**
D	6	8	4	2	2	0	0	8	0	**30**
E	0	19	0	0	0	1	0	2	0	**22**
F	14	36	8	1	3	1	1	28	0	**92**
G	172*	80	12	0	3	2	2	29	0	**300**
H	14	13	8	1	0	2	2	12	0	**52**
Sheffield Schools										**51**
A	16	2	2	2	2	0	2	1	3	**30**
B	5	3	3	2	2	1	3	1	1	**21**
South Wales Schools										**513**
A	19	22	7	2	2	1	0	9	29	**91**
B	31	25	17	2	2	26	8	16	7	**134**
C	23	44	31	0	2	14	1	24	149	**288**
West Sussex Schools										**809**
A	3	11	4	4	0	5	1	2	32	**62**
B	7	19	7	3	0	18	2	14	0	**70**
C	30	21	2	5	9	19	4	6	0	**96**
D	14	37	10	13	4	28	0	19	3	**128**
E	13	25	11	9	5	10	1	6	1	**81**
F	21	46	18	28	15	40	7	14	4	**193**
G	10	12	18	11	3	10	4	4	5	**77**
H	6	8	0	1	0	4	1	0	1	**21**
I	14	11	12	1	0	12	17	13	1	**81**

* Refer to 6.2 below

5.3.3. For some children with complex long term needs, advice may be required from a specialist nurse such as a Children's Nurse Specialist for pain or tissue viability. The small number of children with complex continence needs may require input from a Specialist Bladder and Bowel Nurse, although a significant number of children will require support to promote continence. For children with an established need, a care plan is likely to have been provided by the Specialist Nurse e.g. Epilepsy Nurse Specialist, with specific instructions for individuals providing care. However, where new needs arise, specialist nurses may be accessed via the Children's Community Nursing Service or the local Children's Hospital Service, following assessment and referral by the Special Needs School Nurse. Where possible specialist nursing assessment could take place during school hours although the child may need referral to a clinic for medical assessment. Assessment in school is likely to reduce the amount of time the child is out of school attending clinic appointments, which can be frequent in this group of children. In many schools, community paediatric clinics take place within the school with support from the school nurse.

5.3.4. Children with complex long term problems will often have more than one health need, requiring varying amounts of time to support healthcare needs. For those children requiring naso-gastric or gastrostomy feeds during the day, one feed can take between 20 and 30 minutes, unless feeds are administered via a pump. If a child also has complex neurodisability including dystonia and spasms or a complex seizure disorder, additional medication and other health interventions may be required during the school day. Therefore, some children can require considerable time in support of health needs. Those children with complex respiratory needs are likely to need regular support throughout the day from both an education or health support worker and special needs nurse. Where these health needs are delegated to education or health support staff, there will be a requirement for nursing staff to train, supervise and assess education staff and then provide ongoing support and update training[36],[37]. However, this group of children will often require direct nursing input to enable support staff to meet health needs.

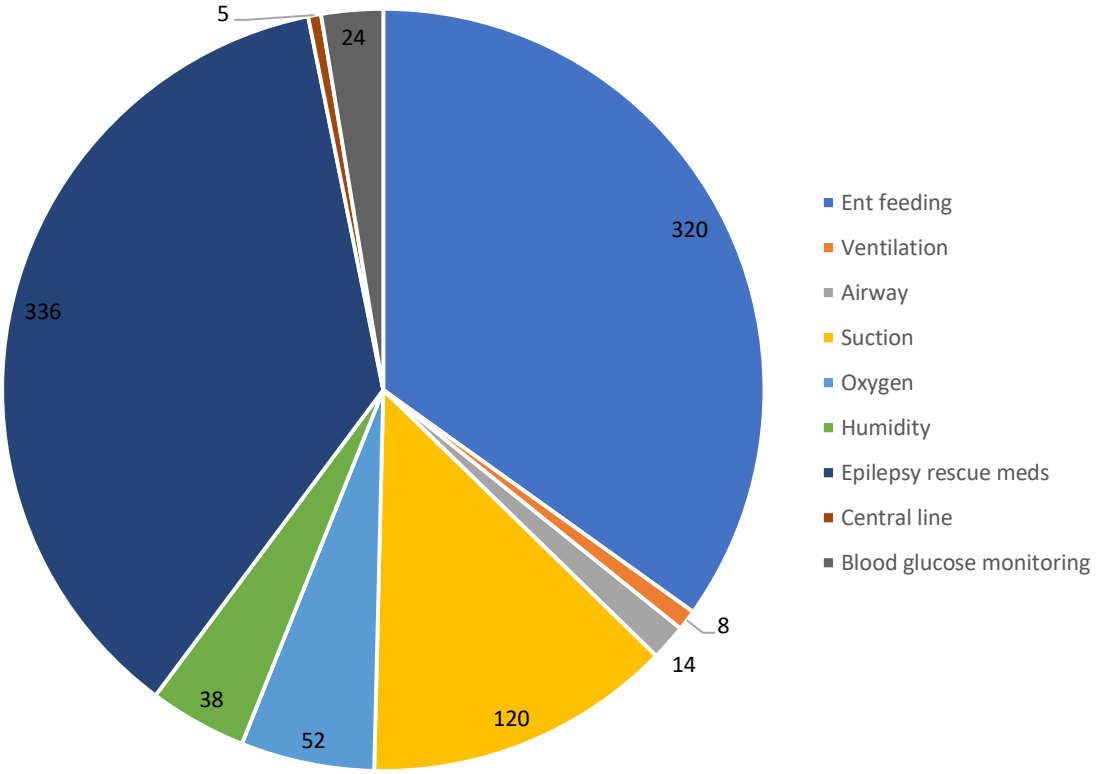
5.4. Everyday complex health care needs

5.4.1. The total number of the individual everyday complex needs (*a children's nurse is required to train under delegated duties, to an adult, specific skills)* is shown in Table 7 by area and as totals for each health need in Figure 5. As with complex long term needs some children have more than one need in this category, especially when respiratory needs are considered, as a child requiring ventilation might have an artificial airway, is likely to require suction and humidity and may require oxygen. Therefore, respiratory needs are likely to relate to a smaller number of children except in the case of the need for suction. A

[36] RCN (2018) Meeting Health Needs in Educational and other Community Settings; a guide for nurses caring for children and young people
[37] RCN (2017) Accountability and Delegation: a guide for the nursing team

larger number of children require enteral feeding and epilepsy rescue medication, which will relate to the number of children in school with complex neurodisability and epilepsy.

Figure 5: Total number Everyday Complex Health Needs



5.4.2. The number of everyday complex needs is lower than complex long term health needs in three of the four areas (Figure 6). In the two schools in Sheffield a higher number of everyday complex needs is seen, rather than complex long term health needs. The reason for this is unclear, although it could be due to the selection of two of the 10 special needs schools in Sheffield with a less complex caseload. However, this could only be determined by undertaking the health needs assessment across all special needs schools in Sheffield.

Figure 6: Number of children by area with complex long term and everyday complex needs

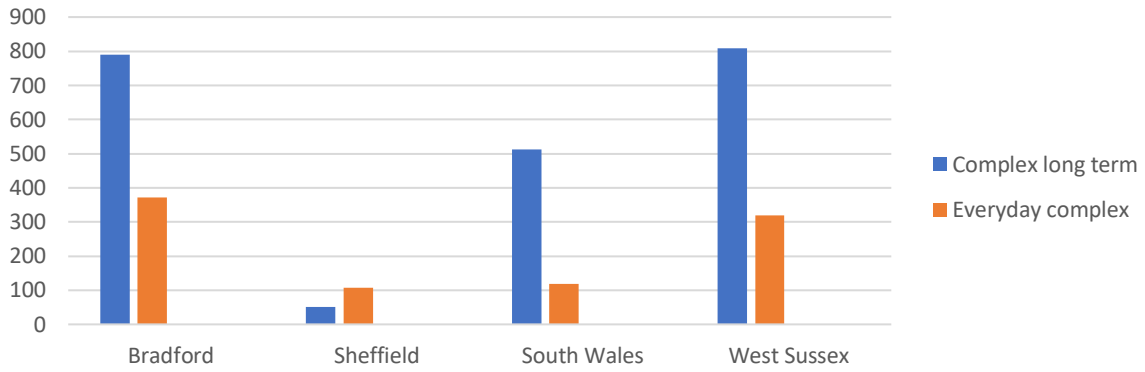


Table 7: Total children with complex everyday healthcare needs

	Enteral feeding	Resp: ventilation	Resp: airway	Resp: suction	Resp: oxygen	Resp: humidity	Epilepsy rescue meds	Central line	Blood glucose	Total
Bradford	159	2	3	50	19	16	118	1	4	372
Sheffield	36	2	2	4	2	0	58	1	2	107
South Wales	47	0	2	6	5	3	51	0	5	119
West Sussex	78	4	7	60	26	19	109	3	13	319

5.4.3. In schools where Special School Nurses are available, it is often the everyday health needs that are delegated to education support staff, although in some schools most health needs are delegated, with nursing support available on request. Head Teachers in Special Needs Schools are concerned that these health needs are often delegated without appropriate governance arrangements and with no additional funding to provide this increased activity. This takes education support workers away from educational activities for which they are trained. Many school staff find this extremely stressful but undertake health interventions because they feel they have no choice but to meet the child's needs. The Department for Education guidance[38] states that they do not have to provide medical support and medications. Whilst job descriptions have been amended in some areas to include specified health interventions, in some cases, the need to provide health interventions is not specified in the job role.

[38] Department for Education (2015) Supporting pupils at school with medical conditions: Statutory guidance for governing bodies of maintained schools and proprietors of academies in England.

5.4.4. The Assessment of Nursing Needs includes an assessment of the number of support staff who need training to meet the specific health needs of individual children (Table 8). RCN guidance states that '*support workers should only undertake delegated tasks relating to the named children in their care and particular to the care setting in which they are employed*'[39]. This requires training of multiple school staff to ensure enough support is available for individual children. The high number of children requiring enteral feeds, requires a high number of school staff to be trained to meet this need. Similarly, a higher number of school staff are required to provide suction and epilepsy rescue medication, as delays in these interventions can have adverse effects on the individual child. In contrast no school staff required training in ventilation, and few are trained in airway management, which reflects the smaller population of children, who are likely to have allocated carers.

Table 8: number of school staff requiring training per annum

	Enteral feeding	Resp: ventilation	Resp: airway	Resp: suction	Resp: oxygen	Resp: humidity	Epilepsy rescue meds	Central line	Blood glucose
Bradford	122	0	3	94	77	39	287	0	18
Sheffield	72	0	0	12	6	0	116	0	6
South Wales	126	0	8	18	8	3	166	0	14
West Sussex	136	0	11	124	91	42	196	3	30

5.4.5. Discussion with School Nursing staff indicated that different methods were used for identifying the number of staff to be trained. In Wales, all staff are trained in emergency interventions such as suction and rescue medications and common procedures such as enteral feeding. However, as a nurse is based in the schools, smaller numbers are trained for other interventions depending on the level of need and the distribution of the children within the school.

5.4.6. In Bradford 4,495 teaching hours per year are commissioned for training education staff in special needs schools and respite services, including competency assessment. This includes the training sessions, four observations of each member of staff and sign off. They have one trainer in each of the three clusters and reported training more staff than necessary, due to turnover of staff and the need to cover children or staff changing classes. In addition, schools have made requests for additional training that is not currently commissioned, which it is difficult to consistently provide.

[39] RCN (2018) Meeting Health Needs in Educational and other Community Settings; a guide for nurses caring for children and young people

5.5. Medicines Safety

5.5.1. A proportion of children will require medicines to be administered during the school day either on a regular or 'as required' basis (Table 9). In West Sussex the number of children requiring medication every day is higher than Bradford, where there are a similar number of schools. However, Bradford have more children requiring medicines occasionally. When divided by the number of schools there are approximately 10 – 24 children requiring daily medication or between 8.7% and 17.8% of the total school population in each area.

Table 9: Medicines administration in school

	Every day	Occasionally	Boarding
Bradford	97	527	6
Sheffield	48	23	0
South Wales	44	120	0
West Sussex	212	292	28

5.5.2. The needs assessment tool refers to the nurse providing 'advice and support' to promote medicine safety, with school staff administering medication. Whilst this is the model used in West Sussex, this is not the model used in all schools: in Wales the Special School Nurses administer medicines and, until recently, a similar system operated in Bradford. However, in Bradford, this has now been delegated to the healthcare support workers and education support staff, which has involved Special Needs Nurses and school staff in considerable training over the last school year, whilst this was being introduced. In West Sussex, training in medicines management is commissioned from the Local Authority who use a pharmacist to provide the training, with a nurse supervising practice and undertaking assessments. To ensure consistency of training, it will be important for the school nurses to attend the training session.

5.5.3. Incidents occurring in schools relating to health needs often involve medication. Evidence provided from Bradford indicates that in the past there had been two methods of managing incidents depending on whether the school or the nursing team investigated the incident. Following discussions about the need for joint learning and consistency in the approach to managing incidents, there is now a joint investigation procedure, with meetings to discuss action required and learning from incidents. There is a similar approach in West Sussex.

5.5.4. To reduce the pressure on staff from medicines administration and to reduce the associated risks, those children requiring once daily medicines, should be given these at home either before or after school, unless required at a specific time in the day. Where medicines are administered in school parents should provide these in pre-prepared doses, where possible to reduce the risk of errors[40].

5.6. Partnership Plus

5.6.1. Partnership plus refers to areas of work that involve multiagency working where statutory guidance exists to provide a framework such as in the case of safeguarding activity. In this case the nurse works with educations, social care and mental health providers to address the needs of the individual child. This work can be time consuming, involve report writing and attendance at meetings.

5.6.2. Table 10 provides a summary of the number of children with specific partnership needs by area. Information provided by Bradford suggests that the special needs nursing team attended 504 meetings relating to partnership plus in the first quarter of 2018, without EHC plan activity. These include child protection meetings, child protection reviews, core groups, child in need meetings, strategy meetings and looked after children reviews. In addition, they attend a range of multiagency meetings including EHC planning meetings and clinics involving paediatricians, dieticians and CAMHS. This work can take up a considerable portion of a nurses' time with attendance at meetings, report writing and liaison with other organisations.

5.6.3. The three schools in South Wales have a higher workload in the Children in Need and Looked after Children group, than in the other areas, when the number of children is divided by the number of schools. This may be reflective of the high levels of deprivation seen in the Swansea area, but is likely to place considerable pressure on nursing time.

Table 10: Children with Partnership Plus needs

	CIN/LAC	CP Plan	MH needs	Transition	EHCP
Bradford	206	10	122	166	659
Sheffield	9	3	30	47	0
South Wales	138	10	47	37	162
West Sussex	145	25	81	75	256

[40] RCN (2018) Meeting Health Needs in Educational and other Community Settings; a guide for nurses caring for children and young people

6. Discussion and recommendations

6.1. The Nursing Needs Assessment Tool and issues arising

6.1.1. The tool used to assess nursing needs across these schools has proven effective in individual areas such as West Sussex and Bradford at providing a clear picture of needs and how they change over time. In both areas the tool has been used in consecutive years to provide evidence to commissioners of the health needs in school. Evidence from Bradford and West Sussex indicates that where the tool is used effectively, it has led to increases in resources in both these areas.

6.1.2. When used across the four areas, the tool is effective at identifying health needs across a larger number of schools, with differing models of service provision. This is particularly true when comparing Sheffield and Wales, where Sheffield had no dedicated special needs school nurses and South Wales has five nurses based in three schools. When using the tool, the model of care does not affect the results because it is the individual health needs that are collected. However, questions raised by nurses using the tool indicates that there needs to be some further clarification between some areas of the tool, such as the respiratory management in complex long term conditions and the respiratory needs included under everyday healthcare needs. The lack of clarity could make it difficult for nurses unfamiliar with the tool to allocate children's needs to the correct category. In the Bradford data a high number of children were allocated to the complex neurodisability category (Table 6, School G, 172) which was thought to be related to a member of the team with less experience of the tool than others. Expansion of the guidance document would promote greater consistency in application of the tool between nurses collecting data across a group of schools.

6.1.3. Review of the findings from the nursing needs assessment and additional information provided by the teams about the services in each area, has raised issues that need to be addressed to ensure safe and effective health provision for children in special needs schools:

- There is a need to have a clear commissioning framework for this group of children to ensure that health needs are commissioned alongside educational provision. Commissioning should also include all areas of health provision including public health, the local offer for children with disability and the additional health needs of children.
- A joint governance framework is required to incorporate health, social care and education services, ensuring consistency of approach and shared learning
- A model for healthcare provision is required to ensure that children receive care that is appropriate for their needs, provided by individuals with the appropriate knowledge and skills.

6.2. Multiagency approach

6.2.1. Children in special needs schools with complex health and educational needs are some of the most vulnerable in our society. Like all children in schools, they should have access to services provided by public health teams, but in addition may need services provided under the local offer and from the children with disability team as well as more targeted health provision based on individual needs. This requires health providers, public health teams, social care and education to work together to meet the health and other needs of children in special needs schools. A multiagency approach to all aspects of the service from commissioning and provision, to governance arrangements and evaluation of services provided is required to ensure that needs are met.

6.3. Current guidance

6.3.1. Current guidance underpinning service provision is sector specific. Department for Education guidance relating to support for children in school with medical needs[41] places a responsibility on schools to ensure health needs are provided for. This document outlines the roles of individual professionals and bodies in relation to meeting health needs. It clearly states that CCGs are responsible for commissioning services to meet long term conditions and disabilities:

Children in special schools in particular may need care which falls outside the remit of local authority commissioned school nurses, such as gastrostomy and tracheostomy care, or postural support. CCGs should ensure their commissioning arrangements are adequate to provide the ongoing support essential to the safety of these vulnerable children whilst in school (DfE [2015], p16).

Similarly, the SEND Code[42] also describes health commissioners' responsibilities (3.65, p 55) in the provision of services to meet health needs. However, the application of this guidance appears to vary between the areas included in this study. In Sheffield schools are providing for health needs with advice from Children's Community Nurses and no special school nursing services, whilst in West Sussex the CCG funds 50% of the health resource in special schools. There appears to be local variation in the application of policy and guidance relating to commissioning for health needs.

6.3.2. Guidance, provided by the Department of Health relating to school nursing, identifies School Nurses as leaders of healthcare provision for children with complex and long term health needs and contributors to provision as part of a multiagency team[43]. Subsequent guidance from Public Health England supports this position but does not

[41] Department for Education (2015) Supporting pupils at school with medical conditions
[42] Department for Education (2015) special educational needs and disability code of practice: 0 to 25 years
[43] Department of Health (2012) Getting it right for children, young people and families

provide detail about models of provision. There is commissioning guidance relating to health visiting and school nursing services, but this focuses on provision of the Healthy Child Programme[44] and is not specific to children with special needs. Public health school nurses work mainly in mainstream schools and are often not commissioned to provide services to special needs schools. Therefore, this group of children often miss out on public health provision. The guidance available refers to children with complex needs but lacks specific clarity regarding the responsibilities for health provision. There is a requirement for Government Departments to produce joint guidance that specifically relates to this vulnerable group of children. Commissioners and providers of services for children with special needs in special needs schools should lobby the Departments for Education and Health to jointly publish relevant guidance to ensure consistency and equity in service provision.

6.4. Commissioning arrangements

6.4.1. Commissioning arrangement across the four areas are varied, with a shared responsibility in West Sussex where there is a 50:50 split in funding between health and education for health needs provision. In contrast, in Sheffield, the service is commissioned as part of the Children's Community Nursing Service, where nurses provide advice to schools when requested. Bradford Schools have seen a change in commissioning arrangements over the last year. Previously, despite increasing numbers of children in special schools, there had been no increase in nursing numbers since 2013, when the ratio of nurses to students was 1:65. Using the data from use of the nursing needs assessment tool, they have assessed the number of nurses required in 2018/19 and projected this forward to 2021, based on the projected increase in special school population. This projection has aimed to maintain the special needs nurse to child ratio at 65 children per nurse across the school population, but it is currently 1:88. It is difficult to extrapolate this ratio to other areas, because it is calculated on the complexity in Bradford. However, by reviewing the case mix in each category of need, individual areas should be able to determine the nursing team requirement for the local special school population. West Sussex have also developed a complexity matrix[45], which can be used alongside the nursing needs tool. The complexity matrix tool demonstrates caseload dependency and can be used to highlight fluctuating dependency and complexity over time.

[44] https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning

[45] Mulcahy, J (2018) *Special School Nursing Complexity Matrix* Available from author by agreement jane.mulcahy@nhs.net

6.4.2. There is a need for a national commissioning framework and specific guidance as existing guidance does not include all aspects of provision for children in special schools and is spread across a range of policy and guidance documents. This framework and guidance should bring together existing policy and guidance into one document to promote effective joint commissioning arrangements between CCGs, the local authority and schools to ensure all organisations are meeting their statutory duties. The Department for Education has provided guidance relating to the Director of Children's Services' role in leading on joined up local commissioning to include health, public health, social care and education[46]. This leadership role should ensure that all areas of required commissioning are included, to meet the health and care needs of children with complex and long term conditions, incorporating:

- public health provision
- the local offer and children with disability services
- additional health needs.

6.4.5. The commissioning framework needs to be sufficiently flexible to enable strategic commissioning across a wide area and between health, local authorities and other providers, with a focus on local requirements. It also needs to be clear about the number of children with complex or life-limiting conditions within the local area, but the Council for Disabled Children has highlighted the problem of the lack of data collected regarding this group of children[47]. There needs to be good data collection from both health and education to ensure the data available accurately reflects the number of children with complex needs.

6.4.6. The pooling of budgets could allow for improved use of resources by removing duplication and enabling specialist services to work across a wider area. Section 75 of the NHS Act 2006 allows for the pooling of budgets between the NHS and local authority where this would lead to improvements in provision[48]. This may produce varied models of service provision across the country, as services will be based on the needs of the local special school population. The NHS Long Term Plan may make this easier to implement within the local area, as this plan is based on local population health needs and states a commitment to improve services for individuals with special educational needs and disability. Integrated service provision is also key to this plan and is also central to providing services for children with complex needs in schools. Children with complex needs could need a range of services during their school day including

[46] Department for Education (2013) Statutory guidance on the roles and responsibilities of the Director of Children's Services and the Lead Member for Children's Services. (For local authorities)
[47] https://councilfordisabledchildren.org.uk/help-resources/resources/understanding-needs-disabled-children-complex-needs-or-life-limiting-conditions
[48] http://www.legislation.gov.uk/ukpga/2006/41/section/75

therapies, continence care, medications, nursing interventions and educational input. Collaboration is essential to ensure these needs are met without turning the classroom into a medicalised setting, as this could interfere with learning and development.

6.5. Governance framework

6.5.1. Where interagency working is required, a joint governance framework is essential to ensure shared processes are in place covering all providers and based on standard operating procedures. In West Sussex there is a draft service specification for the special school nursing service, based on national and local guidance, with specified outcomes and baseline performance targets, reported quarterly to the commissioners. This specification includes clear aims and objectives, items for inclusion in the care pathway, workforce and risk management arrangements. This provides some clarity regarding commissioning and provision of health services for children in special schools.

6.5.2. Governance arrangements in other areas were reported to be less well developed, although in Bradford, agreements have been reached on managing and reviewing incidents to ensure consistency in approach and shared learning across all providers. In Kent, they are agreeing shared policies across all 13 schools to promote equality of provision and agreed standards for health care interventions. In Wales, a school nursing framework is in place with the introduction of the 'Nursing in Special Schools' element in November 2018[49]. This provides a national framework providing standards for both emotional and mental health as well as physical health needs, workforce priorities and guidance on providing all three levels of the Healthy Child Wales programme. In addition to these issues, a governance framework must include issues relating to accountability and vicarious liability for staff undertaking additional roles not covered in their normal role. For example, where classroom assistants are supporting health interventions such as enteral feeding, this should be included in their job descriptions and only undertaken following a period of training, supervision and competence assessment[50].

6.5.3. One area where governance arrangements are particularly important is in medicines management. Teams reported that medicine errors were one of the most frequently reported incidents. In Bradford there were historical reports of differing management of incidents depending on whether these involved health or education teams. More recently the Special School Nursing team and the education staff have worked to agree a joint process for investigating and sharing learning. This has provided a more consistent approach to the management of incidents and implementation of improvements in practice.

[49] Welsh Government (2018) A School Nursing Framework for Wales – part 2, Nursing in Special Schools
[50] RCN (2018) Meeting Health Needs in Educational and other Community Settings; a guide for nurses caring for children and young people

6.5.4. Training for school staff in medicines management varies between areas, with the Local Authority commissioning pharmacists to provide training to school staff in West Sussex and special school nurses providing the training to school staff in other areas. The governance arrangements in place need to consider all aspects of this training to ensure that all risks are identified. Medicines management is often considered to be the role of the nurse. Where this is delegated to support staff, the process of delegation must meet guidance provided by the nursing regulator[51],[52] and professional bodies[48]. Where nurses are training, supervising and assessing support workers there is likely to be consistency in the training and guidance given. However, where training is provided by pharmacists and supervised practice and assessment undertaken by nurses, the risks that inconsistent messages may be given to support staff must be mitigated.

6.6. Continuing care packages

6.6.1. It was surprising that only 2.7% of the children were in receipt of a continuing care package, given the complexity of need of many children in this study. Continuing care packages were introduced in 2010 for those children whose needs could not be met by existing universal or specialist health services and where additional health support was required. However, where children have special educational needs and disability, their needs should be addressed under the SEND guidance[53], [54] through an education, health and care plan (EHCP)[55]. The number of children with an EHCP varies with area, so not all children with additional needs have either a continuing care package or a plan in place to agree how their needs will be met.

6.6.2. The framework for continuing care packages was amended in 2016 in light of the Children and Families Act 2014. This increased the threshold for qualifying for a continuing care package, although it applies to those children whose care cannot be met by universal or specialist services. Where a child is subject to a continuing care package and has been assessed as requiring support in school, their carer often cannot accompany them to school. This was reported to be due to difficulties associated with having a carer employed by another organisation in school. Whilst in school, the carer cannot get involved with other children in the class and it has been difficult to agree governance arrangements in terms of policies and cover for breaks. In Sheffield, they have overcome some of these problems by the children's hospital team training the carers, but in other areas the carers are employed by an agency and work to different policies and guidelines. There is a need for Continuing Care Panels to consider this issue

[51] Nursing & Midwifery Council (2018) The Code

[52] Nursing & Midwifery Council (2018) Delegation and accountability; Supplementary information to the NMC Code

[53] Department for Education/Department of Health (2015) Special education needs and disability code of practice: 0 – 25 years: statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities.

[54] http://www.legislation.gov.uk/uksi/2014/1530/pdfs/uksi_20141530_en.pdf

[55] https://www.gov.uk/children-with-special-educational-needs/extra-SEN-help

and decide whether health care needs in school can be met by commissioning school support staff or whether carers should be trained alongside school and/or health staff.

6.7. Proposed model of Special Needs School Nursing Provision

6.7.1. It could be argued that it is appropriate to delegate these needs, so that health needs are met as part of the child's normal school day and are incorporated into activities to have minimum impact on the child's learning. However, if the demands on education support staff are increased without an associated increase in staffing, they will have less time to support children with their learning needs. There is an urgent need to agree a funding formula for the provision of health services in special schools, as currently the guidance relating to delegation is leading to the widespread handing over of health interventions to school staff with no health background. It is often argued that school staff should be able to undertake any interventions that parents take on, but parents have a personal interest in ensuring that their child has the right care. Children are not discharged home until their parents can manage their care, which involves being assessed as competent and able to deal with emergencies. For some children, it can take parents several months to become confident in their child's care and they will often go home with daily visits from a Community or Specialist Children's Nurse. This is compared with a teaching model in Bradford of a teaching session, four supervised observations and final signoff as competent for most education support staff. Despite the same level of risk to the child if a mistake is made, when made by the parents it is unlikely to result in a complaint or legal action, but if a member of school staff is involved either of these scenarios is likely. Therefore, the model of healthcare provision should be appropriate to the health needs in question.

6.7.2. There is considerable variation in the models of provision across the areas, with some schools employing health support workers to work across the school. These teams also provide for hygiene needs and physiotherapy, often taking children out of the classroom for periods of time. However, interventions such as suction and administration of medication could be provided in the classroom, although a child requiring epilepsy rescue medication may need to be removed from the classroom and be supported in the first aid room or a quiet room until assistance arrives and plan is made for ongoing treatment. The Health Support Worker team provides a flexible solution to provision of health and care needs but may not be helpful where children are spread across many classrooms. With no additional funding to meet health needs, the size of the team is limited by available school financial resources.

6.7.3. Some schools have developed the Education and Health Care Assistant role, with staff trained to support both education and health needs in special schools. This is like the model being developed in many special schools since the publication of the RCN

guidance on meeting health needs in educational and community settings in 2018. This guidance appears to recommend delegating health interventions to school staff, providing a framework for delegation through training and competence assessment. Whilst this framework is helpful, in clarifying nursing interventions which can and should not be delegated, it appears to recommend delegation without addressing the commissioning aspects of health care provision, which has resulted in an increased burden on schools without any financial support.

6.7.4. At the opposite end of the spectrum, in South Wales, care is provided by Special Needs School Nurses, who support children and education staff in the classroom. These nurses are all children's nurses with additional training for their role, including the BSc in Community Children's Nursing, an MSc in Public Child Health and additional training in the fundamentals of community nursing practice. These nurses support continuing care packages in the classroom and give medication as required. In England, some health services have moved away from the 'nurses do it all' approach to 'an empowerment' model, which has perhaps gone too far. In West Kent, in 2016 they moved to an empowerment model of health provision, training school staff to provide care. In 2017, it was noted that a skills gap had appeared, as the SNSNs could not oversee the nursing care. This required retraining to ensure that the nurses could deal with emergencies or support children during carer's breaks. They are now developing a model where nurses are placed in schools with the highest levels of needs, supported by school nursing clinical assistants and enteral feeding assistants (Appendix 5). This model will be used across Kent and Medway to provide consistency and equality in care provision.

6.7.5. In West Sussex they are also considering a different skill mix within the nursing team, including teaching assistant posts jointly funded by health and education and Band 4 roles such as the Nursing Associate role to support the Special Needs School Nursing Team (subject to commissioning review). Bradford currently use healthcare support workers in some schools, but care is largely provided by teaching support staff, which is causing increasing stress among this group of staff, due to increasing demands placed upon them.

6.7.6. The model chosen will depend on local needs but should include a mixture of special needs school nurses and healthcare support staff as well as education support staff with additional health roles. Training of support staff should not be based on a formula but should relate to development of competence. Whilst commissioners might commission training hours based on an average for each intervention, the amount of time each staff member takes to become competent will vary and allowance should be made for this.

6.7.7. Where there are children on site who fall into the 'fluctuating and complex care' or 'complex long term care' where nursing intervention is likely to be required during each

school day, a special needs school nurse should be on-site during school hours. This will mean that one nurse is required as a minimum for schools with children in these categories who do not have a continuing care package or a trained carer in school. There may be periods of time that the nurse is required to attend team meetings or 'partnership plus' activity and it is recommended that these periods are covered by a member of the health team with the required competencies to meet the needs of the children in school. This may be a Children's Community Nurse or a senior healthcare support worker. Where 'partnership plus' requirements are high, additional nursing hours may need to be allocated to the school to ensure appropriate skills are available in school. Figure 7 provides a model outlining the role of the nurse in special needs schools moving from provision of care at the centre to supporting and teaching others to provide the care. The model shows 'everyday complex needs' delegated to teaching and healthcare support staff and recognises that time needs to be allocated for team meetings and professional development.

6.7.8. There has been some criticism of having a nurse based on site in schools, with concerns raised that they 'go native' and relate to school staff rather than health colleagues and that they can lose their skills. However, this will depend on how posts are set up, the requirements to attend team meetings and to undertake update training in core skills required, as necessary. Ensuring appraisal remains with health but school staff have input into this can contribute to effective joint working.

6.7.9. The qualifications of special needs nurses to be considered. This post carries considerable responsibility for health provision in schools and requires the post holder to have experience of working with children and young people with special and complex needs. This will also require the nurse to be competent in a range of practical skills with the knowledge required to teach others. Therefore, these roles are not suitable for newly qualified nurses or for adult nurses with no experience of managing care of children with complex needs. Ideally, most nurses would be children's nurses, although where there is a large team of nurses a learning disability nurse or CAMHS nurse may contribute well to the team and skill mix. The exact composition of the team will depend on local needs.

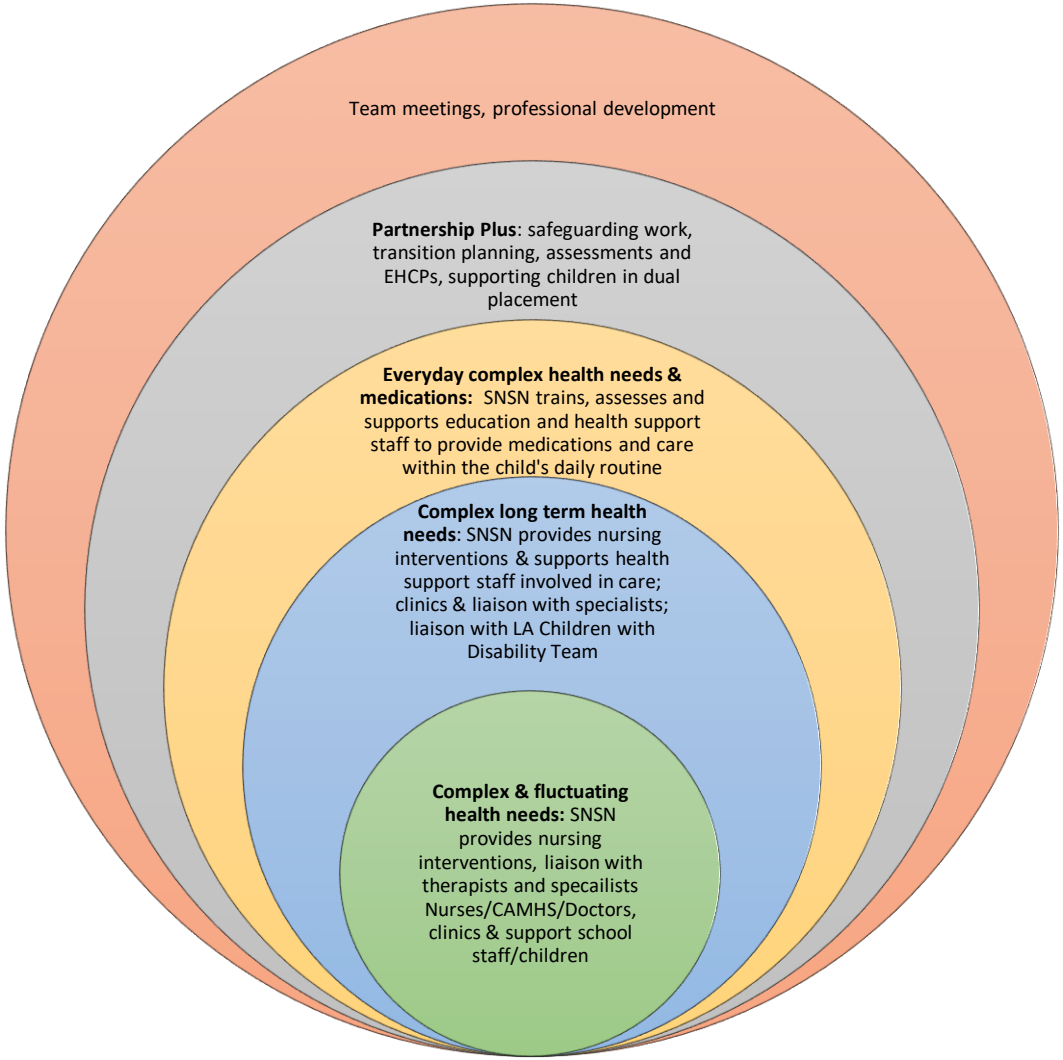
6.7.10. Coordination of the care for children with complex needs[56] is important and includes assessment and planning of needs, specialist and emotional support and logistical issues associated with care. The special needs school nurse is ideally placed to co-ordinate the care for this group of children as they are assessing needs and planning care, as well as liaising with other professionals. However, if they have a term time rather than full year

[56] Hillis R et al (2016) The Role of Care Coordinator for Children with Complex Care Needs: a systematic review, International Journal of Integrated Care, 16(2):12

contract the coordinator role could become impractical. Public Health England recognise the importance of school nurses in leading care for children[57] , but if nurses are not available during school holidays, this potentially leaves gaps in availability for advice and support during school holidays.

[57] https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning

Figure 7: Model for Special Needs School Nursing



7. Conclusion and recommendations

7.1. There are limitations to this study, in that it did not include all schools in Sheffield and can therefore only be a representative example rather than a comprehensive sample of the four areas. However, this work has not previously been undertaken to illustrate nursing needs and compare these across several areas. What has been possible is to provide a suggested model of nursing based on the needs of children in special needs schools and the range of interventions required. For the more complex children, direct nursing intervention and supervision is required, whilst for those children with everyday complex needs, nurses are required to train and supervise support staff.

7.2. Clear governance structures underpinning provision of healthcare in schools are essential to ensure that health and education providers are working to common policies and procedures and staff are adequately trained and insured to undertake the required activities.

7.3. Further work is required to identify the ratios of nurses and support workers depending on category, using the West Sussex complexity matrix. Use of the complexity matrix at the same time the health needs assessment tool is used would provide more detail enabling nursing numbers to be calculated. Where this has been undertaken in Bradford a ratio of 1 nurse to 62 or 1 to 65 children is in place.

7.4. Review of the background to each area, health needs data, current policy and guidance has resulted in the following recommendations:

- A model for healthcare provision is offered to ensure that children receive care that is appropriate for their needs and provided by people with appropriate knowledge and skills
- A minimum of one SNSN should be based in every school where there are children with complex fluctuating and complex long term health needs during school hours
- The SNSN should be care coordinator for those children with nursing needs
- There is a requirement for interdepartmental Government policy that specifically addresses the needs of this vulnerable group of children.
- A national, interdepartmental commissioning framework, based on current policy, is required to provide clarity and greater equality of health needs provision in special schools.
- The commissioning framework for this group of children should ensure that health needs are commissioned alongside educational provision.
- The commissioning framework should also include public health provision and take into account the local offer for children with disability in the local area.
- The Director of Children's Services should provide leadership in joint commissioning to ensure that public health, specialist health, social care and education needs are met.

- A multiagency approach to all aspects of the service, from commissioning to evaluation of services provided, is required to ensure that all needs are met.
- A joint governance framework is required to incorporate health, social care and education services, ensuring consistency of approach and shared learning
- Joint governance arrangements should be agreed to promote consistency in provision of health services
- There is a need for Continuing Care Panels to consider how health needs will be met in school

Appendix 1: Sussex Community NHS Trust Tool:

Assessing Nursing Needs in School tool
Nursing Advice for a Child's EHCP
Commissioning & Workforce Planning tool

Complex and fluctuating health needs likely during the school day ***Indicates children's nursing priority input required & shows the need for nursing assessment during the school day likely***	
The child receives CYP continuing care support (National Framework Department of Heath England)	
The child is identified as having a life limiting/life threatening condition- Together for Short Lives definition- includes complex epilepsy	
The child has frequent and/or intensive periods of unpredictable or unstable health	
The child has everyday health needs that cannot be delegated to unregistered staff – [insert health need]* includes children who must have a nurse available during school day/on outings	
Complex long term health conditions *Indicates children's nursing advice and interventions regarding LTC management during the school day*	
Child with complex neuro-disability: autonomic storming; dystonia; severe spasms; VP shunt.	
Child with epilepsy – seizure profile and protocol inc ketogenic diet; VNS	
Child with respiratory management: ventilation, artificial airway; oxygen; suction; choking risk	
Child who needs a tailored pain profile protocol in school	
Child has post- operative needs following complex surgery e.g. spinal surgery, hip surgery, bilateral tendon release	
Child who has tissue viability and/or pressure management needs e.g. wound dressings/regular risk assessment; moisture lesions	
Child requires continence programmes in school eg complex bladder & bowel management/CIC/ACE/Mitroffinoff.	
Child requires enteral feeding nursing intervention inc changing jejunostomy/gastrostomy tubes	
Child with ……	

***Everyday* complex healthcare needs** *Indicates that a children's nurse is required to train under delegated duties to an adult specific skills*	
The child is fed enterally everyday- gastrostomy, nasogastric, jejunostomy.	
Number of support staff who need to be trained per annum	
The child has complex respiratory everyday needs –VENTILATION eg BiPAP; 24/7	
Number of support staff who need to be trained per annum	
The child has complex respiratory everyday needs –AIRWAY eg tracheostomy; nasopharyngeal airway.	
Number of support staff who need to be trained per annum	
The child has complex respiratory everyday needs –SUCTION eg oral; nasal & oral; artificial airway; deep suctioning.	
Number of support staff who need to be trained per annum	
The child has complex respiratory everyday needs –OXYGEN eg PRN; night time; most of day & night; 24/7.	
Number of support staff who need to be trained per annum	
The child has complex respiratory everyday needs- humidification eg HME; night time; day time; nebulisers	
Number of support staff who need to be trained per annum	
The child has epilepsy requiring rescue medicine protocol eg buccal midazolam	
Number of support staff who need to be trained per annum	
The child requires medicines or interventions via an Intravenous central line e.g. Hickman line, TPN	
Number of support staff who need to be trained per annum	
The child requires blood glucose monitoring	
Number of support staff who need to be trained at school per annum	
Medicine Safety	
The child needs medicines given at school everyday	
The child needs medicines given at school some days/occasionally	
The child needs medicines given for short breaks/boarding	
Total number of medicines administered during a school day or if boarder over 24hrs	
Number of support staff who need to be trained in medicines administration per annum	

Partnership plus: Safeguarding, Looked After Children, Transitions and Education Health care Plan.	
The child is a CIN with specific nursing input in school **and/or** The child is a Looked After Child- school nurse reviewing health LAC nursing assessment.	
The child has a CP plan with specific nursing input **and/or** active high safeguarding input	
The child needs targeted mental health nursing eg mood assessments/ongoing advice and support for behaviour that challenges	
Transition planning requiring nursing: school entry/to secondary/transition to adult services	
Nursing assessment and report for EHCP	
Child in dual placement – mainstream/special school- requiring nursing advice and/or training	
Nursing Complexity Matrix tool **Caseload management & monitoring tool, which assesses clinical risk; demand and capacity.** **Dark red; Red; Amber;** **Yellow; Green & Grey - plus number**	

Name of person completing this assessment:

Designation: **Date:**

Appendix 2: Roles and Responsibilities for Joint Commissioning

Reference: Department for Education/Department of Health (2015) Special education needs and disability code of practice: 0 – 25 years, p 56-58.

Agency	Key responsibilities for SEN or Disability	Accountability
Local authority	Leading integration arrangements for Children and Young People with SEN or disabilities	Lead Member for Children's Services and Director for Children's Services (DCS)
Children's and adult social care	Children's and adult social care services must co-operate with those leading the integration arrangements for children and young people with SEN or disabilities to ensure the delivery of care and support is effectively integrated in the SEN system.	Lead Member for Children and Adult Social Care, and Director for Children's Services (DCS), Director for Adult Social Services (DASS).
Health and Wellbeing Board	The Health and Wellbeing Board must ensure a joint strategic needs assessment (JSNA) of the current and future needs of the whole local population is developed. The JSNA will form the basis of NHS and local authorities' own commissioning plans, across health, social care, public health and children's services. This is likely to include specific needs of children and young people with SEN or disabilities.	Membership of the Health and Wellbeing Board must include at least one local elected councillor, as well as a representative of the local Healthwatch organisation. It must also include the local DCS, DASS, and a senior CCG representative and the Director of Public Health. In practice, most Health and Wellbeing Boards include more local councillors, and many are chaired by cabinet members
Clinical Commissioning Group	To co-operate with the local authority in jointly commissioning services, ensuring there is sufficient capacity contracted to deliver necessary services, drawing the attention of the local authority to groups and individual children and young people with SEN or disabilities, supporting diagnosis and assessment, and delivering interventions and review.	CCGs will be held to account by NHS England. CCGs are also subject to local accountability, for example, to the Health and Wellbeing Board for how well they contribute to delivering the local Health and Wellbeing Strategy. Each CCG has a governing body and an Accountable Officer who are responsible for ensuring that the CCG fulfils its duties to exercise its functions effectively, efficiently and economically and to improve the quality of services and the health of the local population whilst maintaining value for money.

NHS England	NHS England commissions specialist services which need to be reflected in local joint commissioning arrangements (for example augmentative and alternative communication systems, or provision for detained children and young people in relevant youth accommodation).	Secretary of State for Health
Healthwatch	Local Healthwatch organisations are a key mechanism for enabling people to share their views and concerns – to ensure that commissioners have a clear picture of local communities' needs and that this is represented in the planning and delivery of local services. This can include supporting children and young people with SEN or disabilities.	Local Healthwatch organisations represent the voice of people who use health and social care on the Health and Wellbeing Board. They are independent but funded by local authorities.
Maintained nurseries and schools (including academies)	Mainstream schools have duties to use best endeavours to make the provision required to meet the SEN of children and young people. All schools must publish details of what SEN provision is available through the information report and co-operate with the local authority in drawing up and reviewing the Local Offer. Schools also have duties to make reasonable adjustments for disabled children and young people, to support medical conditions and to inform parents and young people if SEN provision is made for them. More information about the role of early years settings, schools and post-16 institutions is given in Chapters 5 to 7 of the SEND Code.	Accountability is through Ofsted and the annual report that schools must provide to parents on their children's progress.
Colleges	Mainstream colleges have duties to use best endeavours to make the provision required to meet the SEN of children and young people. Mainstream and special colleges must also co-operate with the local authority in drawing up and reviewing the Local Offer. All colleges have duties to make reasonable adjustments for disabled children and young people. (see Chapter 7, SEND Code)	Accountable through Ofsted and performance tables such as destination and progress measures.

Appendix 3: Round Table Group Work Questions

Special Need School Nursing – Partnership for Change Roundtable

13th July 2018, 11.30 to 14.30

Royal College of Nursing, Cavendish Square, London

The proposal using the West Sussex Tool involves undertaking a needs assessment of all children in special schools in your area, which is not an insignificant piece of work. It requires nursing experience, so is best undertaken by a Special Needs School Nurse or Community Children's Nurse.

Questions for Groupwork:

Q1. How will the needs assessment be undertaken in your area? What are the practical considerations including:

- Who will undertake the needs assessment?
- When will this be completed?
- How will it be completed (work with School Nurse, Head Teacher, records, care plans etc)

Q2. What are the potential benefits and perceived challenges for your area?

Q3. Who do you want to influence?

What do we want to achieve?

How will we achieve this?

Appendix 4: Collated data

Academic Year					
Name of School					
Post Code					
ASSESSING NURSING NEEDS IN SCHOOL TOOL; COMMISSIONING & WORKFORCE PLANNING TOOL		Bradford	Sheffield	South Wales	West Sussex
NURSING ADVICE FOR A CHILD'S EHCP		1111	269	404	1367
Complex and fluctuating health needs likely during the school day *Indicates children's nursing priority input required & shows the need for nursing assessment during the school day likely*					
The child receives CYP continuing care support (National Framework department of Health England)		22	3	12	59
The child is identified as having a life limiting/life threatening condition - Together for Short Lives definition - includes complex epilepsy		93	4	60	213
The child has frequent and/or intensive periods of unpredictable or unstable health		60	12	13	147
The child has everyday health needs that cannot be delegated to unregistered staff - (insert health need)* includes children who must have a nurse available during school day/on outings		0	0	4	5
Management of Steroid Replacement Therapy				*1*	
Advanced Care Plan				*1*	
Complex long term health conditions I*ndicates children's nursing advice and interventions regarding LTC management during the school day*					
Child with complex neuro-disability: automatic storming; dystonia; severe spasms; VP Shunt		304	21	73	118

Child with epilepsy - seizure profile and protocol inc ketogenic diet; VNS		272	5	91	190
Child with respiratory management: ventilation, artificial airway; oxygen; suction; choking risk		62	5	55	82
Child who needs a tailored pain profile protocol in school		6	4	4	75
Child has post-operative needs following complex surgery: e.g. spinal surgery; hip surgery; bilateral tendon release		10	4	6	36
Child who has tissue viability and/or pressure management needs: e.g. wound dressings; regular risk assessment; moisture lesions		9	1	41	146
Child requires continence programmes in school: e.g. complex bladder & bowel management/CIC/ACE/Mitroffinoff		5	5	9	37
Child requires enteral feeding nursing intervention inc changing jejunostomy/gastrostomy tubes		152	2	49	78
Child with ….*includes 106 children with autism & 16 with ADHD			4	*175	46
Everyday complex healthcare needs *Indicates that a children's nurse is required to train under delegated duties to an adult specific skills*					
The child is fed enterally everyday - gastrostomy, nasogastric, jejunostomy		159	36	47	78
Number of support staff who need to be trained per annum		122	72	126	136
The child has complex respiratory everyday needs - **ventilation** e.g. BiPAP; 24/7		2	2	0	**4**
Number of support staff who need to be trained per annum		0		0	**0**
The child has complex respiratory everyday needs - **Airway** e.g. tracheostomy; nasopharyngeal airway		3	2	2	**7**
Number of support staff who need to be trained per annum		3		8	**11**
The child has complex respiratory everyday needs - **Suction** e.g. oral; nasal & oral; artificial airway; deep suctioning		50	4	6	**60**
Number of support staff who need to be trained per annum		94	12	18	**124**
The child has complex respiratory everyday needs - **Oxygen** e.g. PRN; nighttime; most of day & night; 24/7		19	2	5	**26**
Number of support staff who need to be trained per annum		77	6	8	**91**

The child has complex respiratory everyday needs - **humidification** e.g. HME; nighttime; day time; nebulisers		16	0	3	**19**
Number of support staff who need to be trained per annum		39	0	3	**42**
The child has epilepsy requiring rescue medicine protocol e.g. buccal midazolam		118	58	51	**109**
Number of support staff who need to be trained per annum		287	116	166	**196**
The child requires medicines or interventions via an Intravenous central line e.g. Hickman Line, TPN		1	1	0	**3**
Number of support staff who need to be trained per annum		0	0	0	**3**
The child requires blood glucose monitoring		4	2	5	**13**
Number of support staff who need to be trained at school per annum		18	6	14	**30**
Other			7		50
Medicine Safety					
The child needs medicines given at school everyday		97	48	44	212
The child needs medicines given at school some days/occasionally		527	23	120	292
The child needs medicines given for short breaks/boarding		6	0	0	28
Total number of medicines administered during a school day or if boarder over 24 hours		186	0	66	34
Number of support staff who need to be trained in medicines administration per annum		144	8	37	447
Number of support staff who need to be trained in medicines administration per annum (Buccal, rectal, IM, SC etc)				18	44
Partnership Plus: Safeguarding, Looked After Children; Transitions and Education Health Care Plan					
The child is a CIN with specific nursing input in school a**nd/or** The child is a Looked after Child - school nurse reviewing health LAC nursing assessment		206	9	138	145
the child has a CP plan with specific nursing input **and/o**r active high safeguarding input		10	3	10	25
The child needs targeted mental health nursing e.g. mood assessments/ ongoing advice and support for behaviour that challenges		122	30	47	81

Transition planning requiring nursing: school entry/to secondary/transition to adult services		166	47	37	75
Nursing assessment and report for EHCP		659	0	162	256
Child in dual placement - mainstream/special school - requiring nursing advice and/or training		0	0	0	48
Annual Reviews of Statement for Health Care Plan review (EHCP) per annum					
Consultant clinics per annum - 4 pupils per clinic 30-45 minutes per slot					
Education Reviews, consultant clinics, dental therapy, supporting allied health professionals, social services, therapists, wheelchair assessment				57	
Children with ADHD 3/12 height, weight & BP				18	
Early help development support - sleep					35
Early help development support - continence					79
Early help development support - nutrition					60
Healthy child programme - anxiety / self esteem					4
Nursing input required to support pupil with mental health assessment					3
Intensive liaison by SSN with other health professional/social care					32
Name of person completing this assessment					
Designation					
Date					

Appendix 5: Transforming Health & Social Care in Kent & Medway

Special School Nursing Draft Proposal

March 2019

Background and aim

The overall aim is to facilitate on-going care and management of children with disabilities and/or complex health conditions by establishing the health needs of individual children in school.

The service will be provided by a health network across Kent and Medway consisting of registered and non- registered health care professionals.

The service will work within the school setting to support the health and development of children with special needs. Not all schools require on-site registered nurses and the provision of registered nurses will be driven by both the complexity of health needs and the volume of children with those needs. In very complex cases it may be that continuing health care packages are also required around individual children to support their on-going access to education.

The role of special school nursing

Many tasks, as outlined by the Royal College of Nursing, can be delegated to non-health qualified staff so long as appropriate training and competency sign off is assured and the task(s) are performed on a frequent basis. There remain some health related tasks that should only be undertaken by a qualified and competent health care professional. Examples of these are attached at Appendix A. This guidance will be the basis of the work to clearly define which health tasks in schools must be undertaken by a registered nurse.

Specialist school nurses will work with families and other professionals to ensure that children have individual health care plans and protocols in place to support their ongoing and emergency care needs in school. This may also include supporting a multi-disciplinary response to planning end of life care where needed.

Specialist nurses will also work with school staff to ensure they have the required skills and competencies to care for individual children and young people and work, in a consultative role, to ensure schools are able to fulfil their responsibilities with regards to medicines management.

Responsibilities for the Specialist School nursing service	Not the Responsibilities of the Specialist School Nursing service
Health task competency development	Medicines management
Delivery of registered nurse health tasks in school	Delivery of non-registered nurse health tasks in school
Training staff for the delivery of tasks to be undertaken by non-registered health care staff	Personal care tasks including feeding
Day to day advice for educational staff	Writing EHCPs
Health input into EHCPs	
Health input into local health plans	
Referrals to other health care professionals	
Advise the school with respect to reviewing new student admissions with complex health needs	
To work alongside continuing health care (CHC) staff in schools	

Current provision of special school nursing

The schools where nurses are health funded and currently based are:

- Five Acre Wood;
- Valence;
- Meadowfield;
- Nexus and
- Abbey Court;

Reviews of a select sample of children with the most complex health needs have been undertaken in some of the following schools and therefore it is proposed that a desk top review of the volume of children and young people with these needs is undertaken to assess the need/level of registered nursing provision in the following schools:

- St Nicholas;

- Wyvern;
- Ifield;
- Aspen;
- Foreland;
- Milestone (self-funded with agency); and
- The Beacon (self-funded with agency)

Determining the total workforce

There is no national model or agreed children to staff ratio for providing specialist school nursing.

This requires local design with the two existing community providers of special school nursing which are Kent Community Health NHS Foundation Trust and Medway Community Healthcare.

There are other areas in the country that have county wide special school nursing teams, for example Birmingham Community Trust special school nursing team, who we can work with to finalise the number and skill mix of the nursing team.

However, it is proposed that K&M have 3 locality teams who are part of a single network of special school nursing. This will ensure that a geographical area can be covered appropriately. It is proposed the 3 locality teams are:

- East Kent covering
    - St Nicholas
    - Wyvern
    - Aspen
    - Foreland
    - The Beacon
- North Kent and Medway (including Swale) covering
    - Meadow Field
    - Milestone
    - Ifield
    - Abbey Court
- West Kent covering
    - Valence
    - Five Acre Wood
    - Nexus

Whilst not all schools will require registered children's nurses on site every day, each locality will provide support and advice to all schools.

It is proposed that the information required to undertake the desk top review is quickly collated across the 7 schools, specifically focussing on east Kent where no school nursing

provision currently exists, as soon as possible and reviewed by the end of April, recognising schools will be closed for 2 weeks over the Easter Break.

This review will clarify how many of the reviewed schools require on site provision of registered nursing support to finalise the network numbers and ratio of registered to unregistered staff. It is envisaged that the staffing model will include:

- A team leader or leader(s)
- Registered children's nurses
- Enteral feeding assistants
- School nursing clinical assistants

Given the specialist nature of this work and specifically recognising the identified potential safety issues around the current variation in provision, it is not proposed to go to procurement, rather work with existing providers to rapidly develop the network irrespective of employer.

When the desk top review is complete and the total number of registered and non-registered staff finalised, a short paper for funding will be submitted and it is proposed costs of this service are met by health from 1st April 2019.

As outlined above, a number of schools already have on-site school nursing support and there are no plans to alter this provision in the first phase of implementation. The provision of school nursing will be reviewed each year to review the level of medical needs recognising that children and young people are living longer with significant and more complex medical conditions.

Next Steps

- to collate the information required to support the desk top review for the 7 schools listed above;
- to undertake the desk top review to determine onsite registered nurse provision requirements of the 7 schools by end April latest;
- to prepare jointly agreed protocols and standard operating procedures across the two community providers for a single special school nursing service by end May;
- to prepare the funding paper for health commissioners' agreement as soon as possible and in time for the May Joint Committee meeting;
- to jointly consider the next phase of implementation and related issues such as blended diets, paediatrician recommendations for in school care, more formal links the ambulance provider and hospices.