Royal College of Nursing's response to the Department for Education's consultation on SEND reform: putting children and young people first

**All responses are expected within the online survey format. All questions are optional. Free text boxes are included for all questions and limited to 1500 characters, including spaces & has been used to save character count*

**Given the document is the SEND Reform guidance, a presumed understanding of what SEND means has been made and therefore not expanded.*

1. We want children, young people and their families to be involved in making better, evidence-based decisions about SEND, both in their local area and across the country. How can we make sure children, young people and their families have a genuine say in these decisions?

The experiences of Children & Young People (CYP) & families must be valued alongside clinical & education records when considering decisions. CYP should be involved from the outset in designing, commissioning & reviewing policies & services, not consulted after decisions are made. For those with communication accessibility needs, age-appropriate & accessible approaches such as play-based methods, visual & digital tools & peer-led groups are essential

Available support for CYP & families to articulate their wishes include:

Health Visitors (HV): longitudinal knowledge of family dynamics, developmental course & emerging complexities for under 5s

School Nurses: in-school perspectives on CYP mental wellbeing & social factors that affect functioning at school

Learning Disability (LD) Nurses: clinical insight into SEND, particularly those described as 'invisible'. This includes adjustments & rights-based care & workplace transitions. This ensures decisions reflect realistic functional need, safety & equity into adulthood

Clinical Nurse Specialists (CNS): support CYP with medical conditions that sit alongside SEND; many are outlined in the Department for Education's *Medical Conditions in Schools & Allergy* consultation

Community & voluntary sector partners: support legal advocacy, wellbeing & provide in-school therapies

Decision-makers must build trust in the process, showing how views have shaped outcomes & rationalise when views have not been utilised so families understand options given

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2. How can we make sure that high-quality evidence and best practice inform decisions about SEND?

National frameworks such as the SEND Code of Practice, National Inclusion Standards & multidisciplinary processes must be grounded in evidence rather than relying on individual discretion or local custom to ensure inclusion is not at the expense of health needs & families are not negatively impacted by decisions

Best Start Family Hubs offer sizable opportunities to strengthen the SEND evidence base, bringing together education, health & early years services to act as local sites where evidence is generated, shared, interpreted & applied collaboratively

There are, however, workforce implications. Nurses routinely undertake acute & longitudinal assessment of CYP, holding deep contextual knowledge of communities & circumstances which impact wellbeing at school. This positions them as a rich source of practice-based data & contributors to SEND research across health & education. To realise this, systems must enable research through protected time, leadership sponsorship & organisational pathways for governance, ethics approval & funding, so learning systematically informs practice & policy. If evidence-informed decision-making is expected without corresponding recognition in workforce modelling, there is a risk that nurses will be required to generate data or undertake research activity without protected time, further affecting workload pressures. The RCN has recently published data on this: *Prevention Starts Here: Health Visitors, School Nurses and children's health in England*

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3. How can we ensure that children are best supported by the Universal offer?

4. How can we ensure that children in the Targeted layer are best supported?

Not commented: all children will have access to these layers and is education-led

5. How can we ensure that children in the Targeted Plus layer are best supported?

The core purpose of Targeted Plus should be to prevent escalation to Specialist Provision by bringing the right expertise into mainstream or inclusive settings early in a coordinated way. The Targeted Plus offer must provide rapid access to multidisciplinary expertise, with clear plans & accountability. This includes clearly defined thresholds based on functional impact & complexity, not diagnosis alone, yet the need for appropriate diagnoses to access the right support must not be lost. A named coordinator linked to the Individual Support Plan, who can interpret time-limited goals, agree review points & understands escalation routes, resource streams & accountability, is necessary.

The Targeted Plus layer will significantly increase reliance on nursing expertise, particularly:

School Nurses: for risk management, health needs & transition planning

LD Nurses: for behaviour of distress/communication & reasonable adjustments

CNS & Community Nurses: for condition-specific complexity & monitoring

This could be highly positive, enabling earlier intervention & preventing crisis escalation. However, there is a risk that nurses become default coordinators while waiting for education or commissioning decisions. Nursing input must be formally commissioned & time-limited & caseloads must reflect the intensity & complexity of Targeted Plus work. Visible escalation routes are needed so nurses & other health professionals can trigger review or movement into the Specialist layer

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6. How can we ensure that children in the Specialist layer are best supported

The Specialist layer should be reserved for CYP with enduring, high-risk/low-incidence needs that cannot be met safely or effectively without statutory protection, Specialist Provision Packages (SPP) and/or specialist placements

Learning Disability (LD) Nurses should be central to this work. They bring specialist expertise in behaviour as communication, reasonable adjustments, trauma-informed care, mental capacity & health inequality. LD Nurses could help design & review SPP so placements are safe & sustainable, particularly for children with profound or overlapping needs & ensure work experience placements reflect realistic expectations. LD Nursing input is critical in evidencing when need exceeds what a placement can safely deliver, triggering system-level action. However, LD nursing numbers continue to decline nationally, by around 44% since 2009 (RCN Press Release 2024), resulting in persistent workforce shortages that directly limit access to specialist clinical expertise & negatively impacts equity of care for CYP in education settings

CNS & School Nurses must also contribute by managing clinical risk, care planning & training staff for co-existing medical conditions, providing the information commissioners require to make informed decisions about placement sufficiency & quality

Specialist layer support must include formal escalation routes from nursing & education settings caring for CYP with this level of need when specialist provision is unavailable or unsafe

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7. How do you think early years settings, schools, and colleges can best support the mental health and wellbeing of children and young people?

Learning Disability, School & Mental Health Nurses are critical to addressing this, yet members repeatedly report workload impacts their ability to provide sufficient support.

Workforce modelling for caseloads using population-based need are essential for this relationship-based & preventative work, but the RCN highlights this is lacking: *Prevention Starts Here: Health Visitors, School Nurses & children's health in England*

Mental Health Support Teams in schools will not provide SEND children with the skills they need because they lack specialist SEND expertise & have limited capacity to address complex, co-occurring or enduring needs that require coordinated, multidisciplinary support. Members want to work with Mental Health Nurses to identify changes to student mental wellbeing early & must be supported to coordinate timely referrals to CAMHS with ongoing oversight while CYP with SEND wait for specialist care

Nurses should also be contributing clinical expertise to behaviour policies, attendance strategies & wellbeing initiatives given they are well placed to identify & mitigate the impact of SEND, health inequalities & the social impact of SEND with/without medical complexity on mental wellbeing. Members have expressed concern about the expectations placed on CYP regarding attendance, attainment & behaviour, particularly for those with 'invisible' disabilities who show behaviours of distress, misunderstood as 'bad' behaviour & impacting negatively on attendance & wellbeing

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8. Do you agree that the refreshed 'areas of development' will support educators to understand and address barriers to learning and participation?

The RCN agrees that a shared language around children's development could support educators to better understand barriers to learning & participation. However, on its own, the refreshed "areas of development" will not address longstanding challenges in the SEND system & risks oversimplifying complex needs.

There is a danger that focusing on broad developmental areas, without sufficient specialist input, could obscure the health-related, neurodevelopmental & social factors that underpin many children's difficulties. Learning difficulties, disability & developmental delay do not exist in isolation from health, family circumstances or inequality. Children from disadvantaged backgrounds could be disproportionately affected as they have greater health & development needs which can compound over time.

Without clear guidance, joint working with specialists across healthcare & sufficient workforce capacity, educators may struggle to translate these areas into effective, evidence-based support. Members have raised particular concern that this approach could be used to delay or replace access to specialist assessment & intervention, rather than complement it.

There is a risk that variability in interpretation will increase, rather than reduce, inequity for children with SEND. It is important to Identify that this is a starting point for early identification, not a substitute for diagnosis where clinically appropriate.

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9. What arrangements would best support effective joint working between early years providers, Best Start Family Hubs, health, local authorities, and parents for children with SEND in the early years?

Members report current arrangements lead to delayed identification, repeated assessments & families being left to coordinate care themselves. Effective joint working depends on sufficient staffing & mandated roles for HV, Learning Disability & School Nurses, whose expertise in child development, family context & health determinants is under-utilised. Early, proactive nursing input is essential: HV could involve LD Nurses & other professionals from infancy where a learning disability is probable, to prevent escalation of unmet need. Clear transition oversight, led by Clinical Specialist, School & LD Nursing teams, is also essential to prevent loss of support at key stages, including post-16 education, particularly where medical conditions co-exist & expectations may need to be managed

A single, shared plan, co-produced with CYP, parents & professionals across health, education, local authority & community services is needed to improve continuity & reduce repeated information gathering; this must be the intended function of the Individual Support Plan

Family Hubs will operate under non-statutory guidance, while the SEND reform raises national expectations, risking families being directed to services without assured capacity or access to specialist intervention. This tension between national consistency & local flexibility risks postcode variability. Without workforce planning & system alignment, early identification may simply shift pressure upstream rather than improve outcomes

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10. How can the early years foundation stage (EYFS) two-year old progress check and the Healthy Child Programme development review be improved so that children's needs are identified and supported more quickly? Please share examples

These reviews are critical opportunities for early identification of SEND. However, longstanding misalignment between systems & sustained pressures on the HV workforce means they are not realising their full potential.

RCN workforce evidence shows high caseloads, vacancies & reduced capacity limit HV ability to provide continuity & relationship-based practice, particularly in areas of greatest deprivation. Over half of respondents in the RCN Report: *Prevention Starts Here: Health Visitors, School Nurses & children's health in England*. indicate that understaffing prevents them from undertaking preventative or early intervention work. Without sustained investment to restore safe staffing levels & protect the universal health visiting offer, earlier identification of SEND will not be achievable

Areas with adequate HV capacity & shared reviews demonstrate quicker identification of developmental needs, improved parental confidence & faster access to support, but

around 25% of the most vulnerable CYP do not receive a 2-1/2 yr check (Fraser *et al. 2022. Variation in health visiting contacts for children in England. BMJ Open*)

Strengthening HV leadership & workforce capacity is therefore a necessary foundation for SEND reform. Clear, time-bound escalation pathways & information sharing across services are essential to prevent CYP remaining in repeated 'monitoring' cycles. Where concerns are identified, HV must be able to initiate timely referral to specialist services & ensure follow-up

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11. What should the top three priority areas be for building and sharing evidence within the National Inclusion Standards?

Capacity & investment must match deliverable expectations: standards should clearly set out what inclusive practice looks like in mainstream settings, with expectations matched to adequate workforce capacity, training & access to specialists. Without this, early identification may expose unmet need rather than improve outcomes, increasing frustration for families. National standards must be accompanied by sustained investment across education, health & early years services to ensure inclusion is achievable

The accountability & interfaces across systems for HV, School Nurses & LD Nurses mean the standards are likely to increase expectations around early identification, family support & coordination of care. This could strengthen prevention & family-centred practice if nursing roles are explicitly recognised, appropriately resourced & supported through workforce planning. Clear interfaces between education, health & early years services are essential to avoid responsibility being shifted onto individual professionals without capacity

There is a risk that non-statutory standards drive a 'checklist culture' focused on compliance rather than meaningful inclusion. The standards should prioritise child-centred practice, professional judgement & continuity as core enablers of inclusion & judged by the lived experiences & outcomes for CYP & families, which currently demonstrate adverse mental health/wellbeing & employment impacts for families & attendance for CYP. This must improve

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12. What are the most important issues for national training to cover, to help support children and young people with SEND?

13. What practical actions can help teachers, educators and leaders manage workload whilst implementing these changes?

14. How should the Special Educational Needs Coordinator (SENCO) role evolve to better meet the needs of children and young people with SEND?

Not commented on as focus is on teachers

15. What would provide assurance for families that an Individual Support Plan (ISP) is high quality and contains the essential information?

To do this, consider the principles of family-centred care that underpin nursing practice: partnership, choice, accountability & transparency. Partnership working builds trust, improves adherence to support & leads to better outcomes.

Families & CYP should be able to see their voice woven throughout the plan, not confined to a consultation section. Simple but visible indicators such as "what matters to me" written in the family's words help families recognise the plan as *their* plan, not a document about them

Accountability is equally critical. Families need to know who is responsible for what & who to contact if things are not working. A high-quality ISP should name a coordinator, set out roles of those delivering support & explain escalation routes. Clarity about who carries responsibility is essential to prevent families carrying the burden of coordination themselves

Families should be able to understand how decisions were made, what evidence informed the support given & how success will be measured. ISPs should include clear outcomes, review dates & criteria for change. Transparency is central to partnership working & reduces anxiety, conflict & the need for adversarial challenge

Nationally consistent, minimum standards for ISPs would help families recognise completeness & fairness across settings, with room for personalisation. Final documents must be clear, jargon-free & available in formats CYP & families can use, including Easy Read or digital versions

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16. How can we ensure Individual Support Plans are clear, concise and practical for professionals to use?

Members report plans become ineffective when they are over-long, duplicated, or unclear about responsibility, so must be designed for real-world use. CYP & families should help prioritise what truly matters day to day, reducing unnecessary content & improving professional adherence

Members want a nationally consistent structure with a short set of mandatory fields including what the CYP needs to access learning safely & successfully; the day to day support that is needed; who is responsible for delivering it & what staff should do if things are not working. ISPs must be function-focused, not report-heavy. Long narrative sections reduce usability: evidence should be synthesised into clear statements of need

& the impact on learning & participation, with supporting detail available elsewhere if required

ISP must have a clear & deliberate interface with Individual Healthcare Plans (IHP), as duplication could create confusion & unsafe practice. The ISP should reference the IHP explicitly where health or allergy needs affect access to education; the implications for medical needs (e.g. fatigue, sensory impact, risk management) & clearly direct staff to the IHP for clinical procedures, medication & emergency response. If the plan is to hold information digitally, access to infrastructures to support this across all professions is also needed

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17. How can we best support transition for young people with SEND, so that they are well supported into post-16 provision and further education, training or employment?

Transition support should begin by Year 9 & be anticipatory, with nurses contributing to a single, co-produced transition plan aligned across health, education & social care. The support for education & employment must be realistic & sustainable

Nurses, alongside other professions, can best support transition by:

Providing holistic, functional assessment of how health, neurodisability & emotional wellbeing affect learning, independence & employability

Ensuring continuity of care with named professionals, structured handover to adult services & no gaps in provision

Enabling the CYP voice, capacity & self-management, including preparation for decision-making & managing health needs as an adult in school settings

Defining & supporting reasonable adjustments & risk management in post-16, training & employment environments. This may include supporting employer placements to facilitate the adjustments needed & honesty about what the young person can reasonably achieve. Plans should be practical, outcome-focused & relevant beyond school

LD Nurses, CNS & School Nurses will be critical in addressing communication needs, behaviour linked to unmet health need & preparation for adulthood, particularly where complexity or reduced self-advocacy is present

Delivery must be underpinned by system accountability, including transition leadership, timelines & escalation where provision is not in place. Nurses must have protected time, access to specialist advice & authority to influence decisions

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18. How can we make sure that every area can meet the full range of the needs of children and young people through Inclusion Bases?

19. How can we make sure that Inclusion Bases help children and young people succeed in mainstream settings?

Not commented on as focus is on education

20. Through the Experts at Hand offer, we want to ensure that mainstream settings can get quick specialist support for children and young people. What arrangements are needed between local area partners (education, health, social care) to deliver this Experts at Hand offer effectively?

To deliver the *Experts at Hand* offer effectively, local area partners need shared arrangements & accountability across education, health & social care. This requires a single, agreed governance framework with collective ownership of outcomes for inclusion, early support & reduced escalation, rather than parallel service responsibility. Mainstream settings must be able to access timely specialist input & direct support, not solely advice or signposting. Clear thresholds, response times & escalation routes should be agreed locally to build confidence in the model. Community & voluntary sectors should be included

Nursing capacity must be intentionally built into the *Experts at Hand* model. The recognition of Speech & Language Therapy & Educational Psychologists is valid, but members report that the reforms fail to recognise the roles of CNS, School & LD Nurses in making schools successful for CYP & bridging home/school life. Nurses are critical to early identification, risk management, staff training, reasonable adjustments & family-centred coordination, particularly for CYP whose needs span health, communication & behaviour. Workforce modelling with job plans that include consultation time & follow-up rather than reactive involvement is needed. Joint workforce development, governance & shared learning between education & health are essential. Without it, the *Experts at Hand* model risks becoming a referral management service than the preventative support model intended

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21. What needs to be in place so that children and young people with low incidence, highly complex needs can always access the right specialist placement?

Nursing expertise is essential to securing safe, appropriate specialist placements for CYP with rare & highly complex needs. Effective systems must be anticipatory & clinically led, not crisis-driven. Early identification pathways should be jointly led by LD Nurses, CNS & School Nursing services, recognising complexity beyond diagnostic or educational thresholds, to plan placement needs before breakdown occurs.

LD Nurses should lead on reasonable adjustments, interpretation of behaviour linked to unmet health need, mental capacity & family advocacy

CNS should coordinate condition-specific expertise, clinical risk management & links with tertiary services.

School Nurses should ensure continuity across education, health & safeguarding, with insight into day-to-day functioning & placement sustainability.

Local areas must have jointly agreed placement criteria that explicitly recognise low-incidence & medically complex presentations, articulated in EHCP packages. Nursing leadership must inform these criteria to ensure they reflect real clinical risk. Nursing leadership must be matched with authority, escalation routes, funding & decision-making power. There must be explicit accountability when appropriate placements are unavailable, including risks associated with workforce scarcity, geographic inequity & distance from home. Where agencies disagree, final decision-making responsibility must be clearly defined at system level, not held by individual professionals

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22. How can Specialist Provision Packages be designed to effectively support the main types of need we currently recognise?

Specialist Provision Packages (SPPs) must design around functional need, clinical complexity & intensity of support, rather than rigid diagnosis-led packages. Each SPP should specify training, commissioning responsibility & review points to prevent aspirational descriptors rather than actionable plans

Members indicate that fragmented planning & lack of clinical oversight are major drivers of placement breakdown, particularly for medically complex CYP. SPPs should include: clear learning, wellbeing & participation outcomes; integrated education & health planning; structured communication support; continuity planning through transitions; staffing needs & therapeutic input

For learning disability & autism, SPPs must prioritise communication, reasonable adjustments, sensory-regulatory environments & behaviour which could indicate an unmet need. LD Nurses play a critical role in shaping these packages by translating clinical risk, health needs & rights-based adjustments into everyday educational practice, reducing reliance on restrictive or punitive responses

For additional medical complexity, SPPs must be genuinely integrated. CNS & School Nurses are essential to ensure that education provision is built around Individual Healthcare Plans indicating what is safe care delivery, staff training & rapid response to deterioration involves. When integration is absent, increased exclusion, attendance failure & emergency escalation to parents is likely, already exists & must reduce

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23. We propose that EHCPs will guarantee educational provision set out in a Specialist Provision Package, with day-to-day provision captured in Individual Support Plans. What is needed to make these proposals work effectively?

Not commented on: how schools function

24. We propose creating a more direct route to Specialist Provision Packages and EHCP assessments for children under 5 with complex needs. How can we make sure this works in practice?

A more direct route to Specialist Provision Packages (SPPs) & EHCP assessment for children under 5 could improve early outcomes, but only if aligned with the Healthy Child Programme (HCP) & supported by Health Visitors

Family Hubs should act as trusted, non-stigmatising access points for early identification & coordinated escalation. HV are often the first to recognise developmental & contextual complexity. Members express concerns that proposed thresholds may exclude CYP with learning disabilities from future EHCP eligibility if they are not deemed “most complex”. Learning disabilities are often invisible, poorly understood & confused with learning difficulties. Furthermore, complexity frequently arises from the interaction between health need, family circumstances & environment, particularly social deprivation. This is compounded by a lack of clear diagnostic pathways, which requires urgent attention

HV assessments should be recognised as valid triggers for access to SPPs & EHCP assessment, rather than reliance on education-led thresholds. HV must be formally recognised as a decision-making partner in under-five SEND pathways, be able to access specialist advice via Family Hubs, avoiding repeated referral cycles & have clear escalation pathways to reduce variability in access to support. However, the workforce impact must also be addressed. Earlier routes will increase case volume & complexity & drive expectations on HV to evidence need, support families & manage risk

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25. What would you expect to be considered as part of the needs assessment, for example evidence and expert or professional input?

From a nursing perspective, early assessment is vital to enable timely intervention, support CYP to thrive & reduce avoidable escalation of need across the life course. Needs assessments must recognise the educational impact, even where diagnoses are unconfirmed

HV, School & LD Nurses & CNS each bring distinct but complementary expertise to understanding CYP needs. HV contribute evidence on early development; School Nurses provide insight into day-to-day functioning, wellbeing & safeguarding concerns; LD Nurses bring specialist assessment of functional impact & behaviour linked to unmet needs & CNS add condition-specific expertise around medical conditions

The term ‘neurodisabilities’ in health settings makes clear that neurological disabilities affecting the child will impact their educational experience. Impairments of the brain and/or neuromuscular system result in functional limitations & therefore needs assessments of longitudinal health & development should include cognition, communication, mobility, sensory processing, emotional regulation, behaviour, sleep, nutrition & continence, alongside relevant medical history & safety needs. Assessments

must also capture how needs affect learning, participation, stamina, regulation & safety in real environments

Family circumstance, trauma, social deprivation & environmental demand must also be explored, recognising that complexity is relational. Of course, the voice of CYP & families must be treated as valid evidence too

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26. What factors should LAs take into account in proposing to parents and young people a list of potential settings to name on a plan?

Not commented on: focus on local authorities

27. What information and support do parents need to make a decision about which setting will be best for their child?

Parents need shared understanding of their child's strengths, needs & likely trajectory, including learning, communication, health, sensory & emotional wellbeing needs & how these may change over time. They must be able to see what support is guaranteed & what is discretionary, including clarity on thresholds, funding arrangements & legal entitlements

Members indicate parents require clear, comparable information about what different settings can realistically provide across mainstream, mainstream with specialist support & specialist provision. This should cover staffing expertise, class size, therapeutic input, inclusion practices & how distress or behavioural presentation is supported

Health & safety information is critical, particularly where medical needs or learning disabilities co-exist. Parents need assurance about clinical oversight, staff training, care planning & safeguarding

Decisions must be supported by trusted, impartial professional guidance. HV, School Nurses, LD Nurses & SENCOs play a key role in helping families interpret information, weigh options, understand trade-offs & avoid crisis-driven decisions

Parents need transparency about how placements will be monitored, how concerns can be raised & reassurance that decisions are not fixed if a setting cannot meet need. Without consistent, accessible information & professional support, parents are forced to rely on personal persistent advocacy, damaging their collective wellbeing. This must stop in any new system

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28. What do you think is the right maximum length of time for a temporary placement in Alternative Provision (AP) schools? Please explain your rationale.

29. We have set out our plans to regulate Independent Special Schools (ISS) sector. Do you agree that these proposed changes will lead to suitable placements being available at a fair cost?

30. How should settings be held accountable for how they spend their Inclusive Mainstream funding?

31. Do you agree that more SEND funding should sit directly within mainstream budgets?

32. In relation to pooled funding, we propose that every school becomes part of a local SEND group. Do you agree that this proposal aligns with our aim for all schools to be part of high-quality, community-based trusts?

33. How should disagreements about membership, provision, or funding in groups of schools for SEND be resolved?

34. How can we ensure the most effective use of these local partnership groups?

Not commented on: nursing will not be involved/relates to funding

35. Which stakeholders are important for the success of local partnership groups, and why?

The SEND reform will only be realised when national standards which have authority to implement & local partnership groups bring together those who can decide (Local Authority & ICB commissioners), those who deliver (education, nursing & allied health professionals), & those who live with the consequences (children & families) of decisions, with clear shared accountability

Children, young people & families must be central, not peripheral. The SEND reform documents are explicit that co-production, transparency & trust are essential to reducing adversarial processes & impact & improving confidence in the system

Health partners with commissioning power, particularly Integrated Care Boards & community health providers, are critical. SEND is explicitly framed as a shared education, health & care responsibility. Health involvement must enable action. To that end, nursing leadership across HV, School & LD Nursing is vital to achieve the reform's ambition for earlier, preventative & integrated responses. These roles underpin early identification, provide clinical insight into complexity & support continuity across transitions, aligning the emphasis on early & local support

Social care & safeguarding partners would reflect the reform's focus on whole-family context, vulnerability & reducing crisis escalation. Lastly, voluntary & community partners can provide the independent bridges that empower families through legal advocacy, peer support & options for therapeutic interventions

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36. How can we build stronger collaboration and a culture of through local SEND strategic plans?

Not commented on: education focus

37. What information, advice and guidance can best support children, young people and their families to ensure greater fairness across the system?

RCN members report inequity arises when families are expected to navigate complex SEND systems based on capacity or persistence. Families must receive the right information with active support to understand & act on it to prevent some of the negative health & wellbeing impacts families bear under the current system

Information should be set by nationally consistent standards so families can understand, in plain language, what support is available at each layer of the SEND system. Clear explanations of thresholds, decision-making criteria & timescales, would reduce reliance on professional advocacy to secure support

Information must be accessible & inclusive: Easy Read formats, community languages, alternative communication & non-digital routes. Best Start Family Hubs, early years settings & schools offer trusted, practical locations for sharing guidance

Families should be able to see how decisions are made, what evidence is used, & how to review or challenge decisions safely. Advice & guidance should be proactive & staged, not crisis-driven, with anticipatory information at predictable points so families understand options before difficulties escalate

HV, School & LD Nurses play a vital role across early identification, relational working & navigation. They can support families less able to advocate by explaining developmental, health & learning information, help families prepare questions, articulate concerns, & reinforce consistent messages about pathways & review points

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38. Do you agree that a SEND specialist (e.g. a SENCO) should sit on the school complaint panel, when the complaint relates to SEND support and provision?

Not commented on: education decision

39. This consultation outlines a series of measures intended to reform the SEND system. Some of these measures have already been finalised, and this is clearly indicated within the document. With this in mind, is there anything further you would like to contribute to help inform the remaining proposals that are still under consideration?

The SEND reform proposals & statutory guidance on *Medical Conditions & Allergy in Schools* are insufficiently connected: inclusion & attainment must not be at the expense of health. The former introduces Individual Support Plans (ISPs) as the main record of

day-to-day support, while statutory guidance requires Individual Healthcare Plans (IHPs) to ensure the safe management of medical conditions. Neither clearly set out how IHPs will be integrated within ISPs & EHCPs. For CYP with both SEND & medical conditions, this alignment is critical for safe inclusion: IHPs provide clinical detail on medical risk, medication, emergency planning & staff training, ISPs & EHCPs should build on this to address learning, participation, reasonable adjustments & outcomes

Without definitive national guidance, there is a risk of fragmented or duplicated planning, with medical safety being treated as secondary to education-led processes. This disproportionately affects CYP with learning disabilities, who are more likely to have complex health needs, reduced self-advocacy & reliance on reasonable adjustments to stay safe in education settings

School & LD nurses are central to effective delivery. School nurses & CNS support IHP development, training & safeguarding, while LD nurses bring expertise in reasonable adjustments, communication support & health-related risk. The SEND reform increases expectations without explicitly addressing nursing capacity, leadership or accountability to do this

1495