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The Role of Nursing in Reducing Health Inequalities for Children and Young People with Special Educational Needs: Towards Sustainable, Safe, and Needs-Based Support

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Abstract

Children and young people with special educational needs (SEN) face multiple layers of health inequality, compounded by socioeconomic disadvantage, family stress, and fragmented care systems. This practice-based review explores the significant role of nursing in tackling these inequalities through cost effective, evidence-based, and person-centred approaches. It argues that nurses are uniquely positioned to bridge gaps between education, health, and social care, and must be empowered to influence policy and practice to ensure sustainable, safe, and appropriate support for this vulnerable population.

Keywords

Special Educational Needs (SEN), Health Inequality, Nursing Leadership, EHCP, Integrated Care, Clinical Judgement, Needs-Based Care

1. Introduction

In the face of growing health inequality, constrained resources, and increasing parental legal challenges, nurses are the best-positioned professionals to lead the transformation of care for children with special educational needs (SEN). This practiced based review argues that placing nurses at the centre of clinically grounded, needs-led, and integrated care models can ensure safety, sustainability, and trust, while mitigating the risks associated with reactive, tribunal driven or politically influenced or biased laden decisions which does not necessarily result in acceptable outcomes of children or the services.

This reactive and adversarial model of decision-making, often driven by tribu-

nals, service preservation, or political optics, rarely results in outcomes that are acceptable for children and young people. Instead, it tends to produce a cycle in which families feel let down, services feel under attack, and staff experience moral injury and exhaustion. The cumulative effect is a vicious cycle of poor outcomes for children, deteriorating trust, and a burned-out workforce, further destabilizing an already fragile system.

Children and young people with SEN experience multiple and persistent disadvantages in health [1]. Their needs are increasing in complexity, and they often fall through the gaps between systems. Simultaneously, families face immense pressure navigating fragmented services.

The system is increasingly under strain. NHS resources are stretched. Tribunals challenging health provision in EHCPs are rising. Parental expectations are shaped by desire to get the best possible outcomes for their children sometimes clash with clinical judgement. Health professionals feel their expertise is being undermined, while the risk of inappropriate interventions grows.

Nursing profession can reduce health inequalities for children and young people with SEN in a way that is clinically sound, cost-effective, and sustainable, while also preserving trust and supporting families. Nurses are central to improving outcomes in the SEND system, not only as clinicians but also as educators, supervisors, and strategic leaders. Their contribution strengthens the quality and timeliness of EHCPs, supports cross-sector workforce development, and enables health-informed commissioning. Investment in SEND nursing capacity and leadership is therefore critical to achieving integrated, person-centred, and equitable services for children and young people with SEND.

The role of nurses as strategic leaders within the Special Educational Needs and Disabilities (SEND) system in England, with a focus on influencing the Education, Health, and Care Plan (EHCP) process, commissioning, preparation for adulthood, and addressing health inequalities. Drawing on evidence from national policy, audit reports, and peer-reviewed studies, the review highlights the risks of fragmented, delayed, or tokenistic health advice and presents a framework for embedding nursing expertise as a lever for long-term outcomes.

Nurses must be placed at the centre of integrated, needs-led care for children with SEN, leading early intervention, shaping EHCP processes, and safeguarding the integrity of clinical decision-making across systems.

As the system struggles to meet increasing need with finite resources, nurses offer a clinically grounded, cost-effective, and family-aware solution to the growing challenge of SEN inequality. The profession must be supported to lead, not just follow, policy, commissioning, and practice design. Only then can we provide the care children need, without undermining clinical integrity or fragmenting trust.

2. Methodology

This review employs a practice-based critical inquiry approach, is a research ap-

proach that positions professional practice both as the site and the source of knowledge creation. It involves systematically examining one's own or others' professional actions, decisions, and contexts using critical, reflective, and evidence-informed methods. Rather than separating theory from practice, it seeks to interrogate practice in situations and identifying patterns, questioning assumptions, and uncovering the underlying social, organisational, and policy influences on outcomes.

Practice-based critical inquiry is the methodology integrates professional experience with critical reflection, enabling an examination not only of how services are delivered, but also of the systemic, policy, and socio-economic factors that sustain or exacerbate inequalities. Drawing on nursing's values of safety, equity, and person-centred care, the approach interrogates the mechanisms by which health needs are assessed, recorded, and translated into Education, Health and Care Plans (EHCPs), and how these processes can either enable or obstruct needs-based, sustainable support.

This enquiry is grounded in the author's professional lived experience and role as a Designated Clinical Officer (DCO) within an Integrated Care Board (ICB) and past working with operational manager and children safeguarding nurse. This is focus on the how the nursing leadership and practice can address health inequalities experienced by children and young people with Special Educational Needs, ensuring that provision is sustainable, safe, and responsive to individual needs.

Narrative literature review, a purposive review of policy documents, NHS England guidance (including the SEND Improvement Plan, the NHS Long Term Plan, and the SEND Champion Programme evaluation), and relevant academic literature on nursing leadership, health inequalities, and SEND.

Experiential and practice-derived learning, the review draws extensively on real-world experiences and service improvement initiatives led or co-facilitated by the author, including:

1) Supervision and consultation models are embedded in schools and local authorities.

2) Training and capacity-building for non-health professionals involved in EHCP writing.

3) Participation in NHS England's SEND nursing development programmes.

4) Case-informed reflection, illustrative examples are used from local practice in North Yorkshire, where nurse led training, pilot projects, and feedback mechanisms have been implemented to improve EHCP quality and workforce confidence.

This methodology adopts a practice-based critical inquiry approach, positioning nursing practice within the SEN system as both the source of research questions and the site of knowledge generation. The inquiry begins from the lived realities of nurses working with children and young people with SEN, where health inequalities intersect with educational, social, and policy challenges. Recognising

that nurses often operate at the interface of health, education, and social care, the approach captures the unique insights that arise from their frontline experiences and their role in coordinating needs-based support.

2.1. Findings

The findings are presented as key thematic insights generated through the triangulation of national policy, local practice, and evaluation data.

2.2. Enhancing the Quality and Timeliness of EHCPs

Nurse-led advice writing and quality assurance processes have led to demonstrable improvements in the clarity, specificity, and relevance of health information in EHCPs. Pilot projects in North Yorkshire show that training education professionals in health literacy and co-producing advice with health professionals reduces EHCP delays and improves their educational and clinical utility.

2.3. Developing the Wider Workforce

Training and supervision delivered by nurses has significantly improved confidence among EHCP writers (e.g. SENCOs, education officers) in recognising and describing complex needs such as neurodivergence, emotional regulation issues, and long-term conditions like asthma or epilepsy. An evaluation from the NHS England SEND Champion Programme [2] found that staff trained by nurses felt more equipped to recognise and respond to health needs.

2.4. Preparation for Adulthood

Nurses contribute to preparation for adulthood by supporting transition planning that addresses ongoing health needs, medication management, and access to employment or apprenticeships. They also help families and services understand the role of health in post-16 and adult settings, influencing outcomes beyond school age.

2.5. Influencing Commissioning through Data and Insight

Nurses use their clinical knowledge and population health awareness to support more targeted commissioning. Rather than solely focusing on EHCP compliance, nursing input supports early intervention planning, service design, and tackling social determinants of health. This includes identifying gaps in provision, co-producing outcome measures, and ensuring funding is directed toward reducing preventable health inequities.

2.6. Strengthening Interagency Practice and System Integration

Through supervision models, multi-agency working groups, and SEND Champion roles, nurses function as critical connectors between health, education, and care. Their contribution facilitates more coordinated pathways, clearer communication, and shared responsibility for outcomes.

3. State of the Affairs

Health inequality among children and young people with special educational needs (SEN) remains a persistent and growing challenge in the UK. These children face a dual burden: increased risk of ill health due to their underlying needs, and additional structural barriers to care caused by socioeconomic disadvantages, fragmented services, and under-resourced systems. The rise in demand, for EHCP and needs (See Figure 1) support, particularly following the COVID-19 pandemic and increasing complexity of presentations, has collided with financial constraints, workforce shortages, and policy uncertainty.

Nursing, as a profession rooted in clinical expertise, advocacy, and person-centred care, must be central in meeting this challenge. This review explores how nurses can lead and influence across care systems to reduce health inequality for children with SEN, delivering care that is not just safe and cost-effective, but tailored to the unique and diverse needs of this population.

The landscape of SEND in England as in 2025

How many children	Just over 1 in 5 pupils (19.5%) have SEND in 2024/25
	5.3% with an EHCP and 14.2% on SEN Support.
	That's >1.7 million pupils and still rising.
	The most common primary need with an EHCP is autism (33–34%); on SEN Support it is speech, language and communication needs (26%).
	FSM eligibility is far higher among SEND pupils (44% EHCP, 39% SEN Support) than among pupils without SEN (22%).
EHCP system pressure / delays	Children and young people with EHCPs rose to 638,700 in Jan 2025 (+10.8% year-on-year).
	New EHCPs in 2024 hit 97,700 (+15.8%)
	Only 46.4% of new plans were issued within 20 weeks (down from 50.3% in 2023).
	Primary needs within EHCPs: ASD 31.5%, SLCN 21.3%, SEMH 20.7%.
Health & complexity	NHS England's Core20PLUS5 (Children & Young People) framework flags asthma, diabetes, epilepsy, oral health and mental health as priority inequality conditions, highly relevant for many CYP with SEND.
	For autistic and/or learning-disabled CYP at risk of admission, the NHS Keyworking model and Care (Education) and Treatment Reviews are now embedded to prevent avoidable in-patient care.

Figure 1. The landscape of SEND in England 2025.

3.1. The Burden of Inequality in SEN Populations

According to Public Health England, the health inequalities faced by children with learning disabilities begin early in life and continue to widen over time without targeted intervention [3]. A significant number of children and young people require an Education, Health and Care Plan (EHCP) due to their health needs, which has a substantial impact on their daily lives and future opportunities (see Figure 2). However, this trend may also reflect a lack of accessibility and inclusivity within mainstream education for young people with health needs, to the extent that an EHCP becomes the only viable route to secure the necessary adjustments and support. Equally, it may signal the increasing complexity of health needs among the

school-aged population. Future research is needed to explore whether EHCP allocation is primarily a response to the growth in medical complexity, or whether it also highlights systemic barriers that prevent young people with health conditions from fully accessing education without statutory intervention. These challenges are often made worse by a lack of timely assessments, long waiting lists for therapy or specialist care, and a disjointed system that places responsibility on families to coordinate services themselves.

SEND Needs	Prevalence	Impact on Child and young person
Neurodevelopmental	Autism- 33% of EHCPs ADHD- often co-occurring with other needs SLCN- 20-25% across SEND tiers	These link to high needs around communication, sensory regulation, anxiety, and executive functioning.
Social Emotional Mental Health	Roughly 20% EHCPs list social, emotional and mental health as the primary need	Closely tied to exclusion risk, alternative provision placement, and poor attendance.
Long-term conditions & complexity	Physical health about 14% Epilepsy, asthma, diabetes, feeding/continence	Risk of admission into hospital and missing education while attending medical appointments.

Figure 2. Prevalence and SEND needs in children and young people.

3.3. Safe, Cost-Effective, and Sustainable Care Models

In the context of rising demand and constrained public finances, care models for children with SEN must deliver maximum value without compromising safety or individual need. Nursing-led approaches contribute significantly to:

1) Early intervention, reducing escalation to crisis or specialist care.

2) Community-based models, improving access while reducing reliance on hospital care.

3) Holistic care planning, ensuring that interventions reflect the whole child, not just diagnostic labels.

4) Efficient use of resources, through joint working, integrated reviews, and digital tools.

Examples such as keyworker models for children with autism and learning disabilities, or early support hubs, demonstrate that multi-agency working led by nursing professionals can improve outcomes while managing costs.

4. Nurses as Policy Influencers and System Leaders

The SEND Code of Practice [4] mandates that children and young people with special educational needs and disabilities receive integrated, outcome-focused support across education, health, and care. The EHCP is the statutory instrument for achieving this, with clinical professionals expected to contribute specific, time-sensitive, and needs-lead advice.

Despite structural reforms, health input into the EHCP process remains incon-

sistent. Reviews by the Local Government Association [5], Ofsted/CQC SEND inspections, and judicial outcomes (e.g. Upper Tribunal rulings on inadequate advice) suggest systemic gaps in both the timeliness and clinical depth of input. This weakens not only the individual plan but also impairs commissioning, transitions into adulthood, and the broader strategic use of clinical intelligence.

Nurses, particularly those in Designated Clinical Officer (DCO) or strategic roles, be positioned as system leaders who actively shape SEND processes, improve interagency outcomes, and address the structural health inequalities faced by CYP with complex needs. Nurses not only deliver care, but they also have the insight and expertise to shape systems.

The 2021 SEND Review: Right Support, Right Place, Right Time acknowledged ongoing weaknesses in how health advice is integrated into EHCPs. Audit data from NHS England [6] shows that only 64% of health advice met statutory timelines in some regions. Moreover, a thematic review by the Council for Disabled Children [7] found that over 50% of plans sampled included advice that was non-specific or lacked outcomes.

Inadequate clinical advice leads to vague plans, poor intervention targeting, and increased tribunal challenges. Nationally, tribunal appeals have increased by 29% between 2020 and 2023 [8], with a significant proportion citing inadequate health contributions. This legal recourse is costly and further erodes family trust.

Preparation for adulthood is a statutory EHCP domain, yet research by the National Development Team for Inclusion [9] found that only 34% of plans addressed meaningful health transitions. Young people with chronic conditions often face fragmented support at age 18 - 19, leading to disengagement from services and deteriorating health management (RCPCH, 2021).

Nurses can play a pivotal role in co-producing health transition plans aligned with educational/employment goals. Bridging CAMHS and adult mental health services. Supporting self-management of long-term conditions (e.g. asthma, diabetes, epilepsy) to prevent crisis-led care.

A longitudinal cohort study Macaulay L, Saxton J, Ford T [10], found that structured health transition planning was associated with a 22% reduction in unscheduled admissions among 18 - 25-year-olds with neurodevelopmental conditions. This finding offers compelling evidence for the effectiveness of structured, anticipatory care in bridging the often-fractured gap between paediatric and adult services. For nursing, this highlights the pivotal role of skilled, holistic needs assessment, not only as a clinical tool but as a means of identifying transition readiness, safeguarding continuity of care, and reducing reliance on crisis-driven interventions.

From a governance perspective, the findings support the case for embedding nursing leadership within service development and commissioning structures, such as through Designated Clinical Officer (DCO) roles. Nurses are uniquely positioned to lead on the governance of transition processes, ensuring that assessment frameworks are developmentally appropriate, that care is co-produced with families, and that accountability for health outcomes is maintained across organ-

isational boundaries. Structured transition planning, underpinned by robust governance and nursing oversight, can serve as a lever for quality improvement, patient safety, and efficiency within integrated care systems.

The implications of this study suggest that structured transitions to adulthood must become a systemic, measurable improvement priority. Nursing involvement in the design and evaluation of transition pathways, especially for young people with neurodevelopmental needs, can ensure that services are equitable, sustainable, and tailored to avoid the escalation of unmet needs into emergency presentations. This reinforces the nursing profession's dual role as both a care provider and a system leader, one that shapes services not only around the needs of young people but around the principles of prevention, partnership, and long-term impact. Role such as Designated Clinical Offers and their associates exemplify the contribution of senior nurses in governance, accountability and improving the outcomes of children with SEND.

4.1. Clinical Integrity, Parental Advocacy, and the Rise in EHCP Tribunals

The SEND system in England is increasingly adversarial, with a sharp rise in tribunal cases particularly around health and therapy provision (see **Figure 3**) Data from the Ministry of Justice Gov.uk 2025. Families often resort to tribunals as they perceive that the care planning and assessment processes lack transparency, robustness, and responsiveness.

The current arbitrary reliance on tribunals, often bypassing established health complaint pathways such as PALS, and mirrored within education processes, risks eroding the integrity of professional departments. When individual cases are routinely escalated to legal forums, it implies that the clinical and educational assessment processes for children and young people are not robust or trustworthy enough to stand on their own merit. While legal judgments have a vital role in addressing systemic failings, their use in the day-to-day management of individual cases introduces significant risks. This adversarial pattern undermines confidence in frontline services, positioning them as dependent on judicial oversight rather than being capable of delivering reliable, safe, and holistic assessments.

In addition, tribunal escalation bypasses the therapeutic dialogue between families and practitioners. This dialogue, where young people and parents can tell practitioners what is working, what side effects they may be experiencing, or where support is insufficient, is critical for safe, responsive care. When this relational process is replaced by legal arbitration, families lose opportunities to build trust and co-produce solutions with those directly responsible for their child's care. For the young person, these risks fragmented interventions, delayed responses, and reduced confidence in practitioners' capacity to help.

Nursing leadership provides a practical mechanism for mediating between families, education, and health, thereby reducing the need for tribunal escalation. Nurses are uniquely skilled at:

1) Formulating clear, rational care plans that integrate physical, psychological, and social dimensions of health.

2) Facilitating therapeutic conversations with families and young people, ensuring their voices are heard and embedded in care planning.

3) Working across disciplines, education, social care, local authority, thus avoiding siloed approaches to assessment and planning.

4) Providing ongoing monitoring and review, ensuring that care remains flexible and responsive to a child's changing needs rather than fixed provision named in EHCP.

One emerging area of concern is the increasing number of special educational needs tribunals, particularly extended tribunals where parents challenge or seek to secure health provision through the EHCP process. While it is entirely understandable that families want the best support for their child, and often feel they have no alternative, this trend presents risks:

1) Clinical judgement may be overridden by legal arguments, potentially resulting in services being directed without appropriate assessment or justification.

2) Children may receive interventions not tailored to their individual needs, or before they have been assessed by qualified professionals.

3) Trust between families and clinicians may be eroded, with health services perceived as barriers rather than partners.

4) Social media and anecdotal evidence increasingly influence parental expectations, which can create pressure for care models that may not be appropriate or effective in every case.

Indicator	2022→2023	2023→2024	Latest point 2025
EHCPs in place	517,048 → 576,474 (+11.5%)	576,474 → 638,745 (+10.8%)	Jan 2025: 638,745
% new plans within 20 weeks	49.2% (2022 activity	50.3% (2023)	50.3% → 46.4% (2024)2024 activity reported in 2025 release
SEND appeals registered	-	21,000 (2023/24, +55% y/y)	Backlog up +57% YoY to
Mediation (refusal-to-assess)	-	-	10,500 mediations; 1,500 proceeded

Figure 3. EHCP trends and timeless in 2025.

Nurses, positioned between systems and families, are often tasked with navigating this tension. Their role in ensuring that care remains grounded in clinical evidence and assessed need, while also listening deeply to family experience, is more critical than ever.

1) To address this, nurses need to provide clear, timely clinical assessments that

are communicated in accessible ways.

2) Contribute to multi-agency early dispute resolution, avoiding escalation to tribunal where possible.

3) Support parents in understanding what good care looks like, and why it may differ from case to case.

4) Ensure the health section of the EHCP is defensible, person-centred, and aligned to real world practice.

By doing so, the nursing profession upholds both its duty of care and its commitment to relational, family-informed practice.

4.2. Commissioning Influence through Clinical Insight and Data Use

EHCPs are often viewed as administrative tools, rather than strategic datasets. Aggregated health trends (e.g. rising neurodevelopmental diagnoses, co-morbid physical health needs) are under-analysed in commissioning cycles.

Lack of data-informed commissioning leads to reactive service models and over-reliance on high-cost interventions (e.g. out-of-area placements, unplanned admissions).

Nursing skills are effective in identifying trends across EHCPs to forecast future service needs. Translate case-level insight into population commissioning strategies (e.g. the need for specialist continence services or ADHD pathways).

Champion value-based funding, where the outcome per pound spent guides resource allocation. This approach is logically sound, as it directly aligns investment with impact. Nevertheless, a significant challenge arises from the absence of a consistent and clear definition of "value" in health. This ambiguity leads to uncertainty regarding which outcomes should be prioritised and evaluated. Further work is therefore required to establish reasonable definitions of both "health" and "value", not only within healthcare at large but specifically in the context of SEND. Doing so will help ensure that funding models achieve improved results while also guaranteeing that national health services provide value for taxpayers.

4.3. Case Example: The Transition Nurse Role at York and Scarborough Teaching Hospitals

The Transition Nurse role at York and Scarborough Teaching Hospitals NHS Foundation Trust provides [1] a strong example of nurse-led practice that reduces health inequalities for young people with long-term conditions and special educational needs and disabilities (SEND). Transition is a vulnerable stage in healthcare where poor planning can lead to disengagement, missed needs, and widening inequalities [11].

The Transition Nurse Co-ordinator ensures consistent oversight of young people moving from child-centred to adult services. This includes ensuring hospital passports are created and flagged on clinical systems so that reasonable adjustments are recognised at every hospital encounter. The role also supports families,

supervises staff, and coordinates across health, education, and social care services to guarantee continuity. The impact of the role of Transition Nurse Co-ordinator:

1) Reducing Inequalities: CYP with SEND are made visible within the hospital system, preventing unsafe care and ensuring equitable access.

2) Cost-effectiveness: The tiered approach avoids duplication of assessments, reduces unplanned admissions, and promotes engagement with adult services.

3) Leadership in Collaboration: Transition Nurse provides a bridge across agencies, ensuring CYP and families are supported toward Preparing for Adulthood outcomes.

Crucially, the Transition Nurse role provides real-time data on the needs of young people. This evidence informs local commissioning, ensuring that decisions are grounded in lived experience rather than assumptions. By reporting directly to commissioners and working closely with providers and local authorities, the Transition Nurse creates a continuous feedback loop that aligns services with the actual needs of CYP year by year.

The York and Scarborough model demonstrates how nurse leadership can deliver measurable improvements, generate live data for commissioners, and embed system-wide equity. It is a replicable approach that other hospital trusts could adopt without creating new professional roles, drawing on nursing's established expertise in holistic care, advocacy, and multi-agency coordination.

4.4. Structural Inequities

Children with SEND experience higher rates of poverty, poor housing, and reduced access to preventive healthcare [12]. Young people with SEND are three times more likely to be NEET (Not in Education, Employment or Training) post-16 ONS [13]. This disparity often widens at transition points, especially for those with long-term conditions or mental health needs.

However, these narrative risks reinforcing the false assumption that such outcomes are inevitable. These disparities often result not from the nature of the child's condition, but from insufficient systemic support for the families who care for them. For example, where a child exhibits significant behavioural challenges, the absence of timely, coordinated interventions can leave families isolated, unsupported, and unable to participate in the labour market. This functional exclusion from economic life, combined with gaps in respite, housing adaptations, and accessible local services, leads to financial precarity. This is therefore not a clinical inevitability, but a policy failure rooted in service fragmentation and underinvestment.

Policy and practice can be reshaped to treat poverty and marginalisation among families of CYP with SEND as preventable outcomes of structural neglect, rather than inherent consequences of disability. There is need for service improvement frameworks and targeted investment strategies that would enable local systems to build protective support, such as flexible respite, employment safeguards for carers, and better integrated care pathways, to reduce long-term socioeconomic harm.

That will require a degree of willingness for across government, society, health system and families to engage in difficult and often uncomfortable thinking about structural neglect and systemic failures. These outcomes are not random, nor are they inevitable; they are the product of policies, practices, and social norms that have consistently failed to respond to complexity with the nuance it requires.

A more dynamic and multilayered understanding of these challenges is needed, one that recognises the intersecting influences of poverty, exclusion, under-resourcing, and disjointed service systems. Improving outcomes will require health professionals, educators, commissioners, businesses, and community systems to do things differently, including adopting more collaborative, anticipatory, and family-centred approaches. It also requires society to rethink how it values caregiving, inclusion, and the long-term sustainability of families raising children with complex needs.

This reframing demands a shift from reactive service provision to proactive, system-level planning that addresses both the social determinants of health and the economic impacts of unsupported care. For example, nursing professionals embedded within SEND systems, such as Designated Clinical Officers, can play a critical leadership role in identifying systemic risk factors, shaping joint commissioning, and advocating for cross-sector investment that sustains families, not just manages clinical presentations. Such an approach aligns with current NHS Long Term Plan goals by DHSC [14] around reducing health inequalities, improving outcomes, and embedding person-centred, integrated care.

5. Addressing the Knowledge Gap in Non-Health Professionals through Nursing Leadership

A recurring barrier to effective multi-agency working in the SEND system is the limited health-specific knowledge among non-health professionals, such as Special Educational Needs Coordinators (SENCos) and those responsible for drafting and reviewing Education, Health, and Care Plans (EHCPs). Many of these professionals receive minimal formal training in areas such as long-term health conditions (e.g., asthma and epilepsy), neurodevelopmental diversity (e.g., autism, ADHD), and emotional regulation difficulties, all of which are highly relevant to the everyday functioning and educational access of children with SEND.

While it is encouraging that education services are increasingly offering awareness-level training, this alone does not equip practitioners to interpret complex health needs accurately or to write EHCP advice that meets legal and clinical standards. There remains a clear need for ongoing input and leadership from nursing professionals, particularly those in Designated Clinical Officer (DCO) roles, to bridge this knowledge gap.

Nurses bring a unique blend of clinical expertise and system-level insight, making them well-placed to offer structured training, supervision, and consultation models that support the workforce beyond health. This includes contributing to statutory strategies such as the National Asthma Training for Schools and the im-

plementation of the National Autism Strategy at local level. For example, nurses are increasingly delivering consultation sessions for schools and local authority officers, improving the consistency and quality of advice submitted for EHCPs and annual reviews.

In North Yorkshire, the DCO-led training and quality assurance initiative for EHCP health advice has demonstrated measurable service improvement. Evaluation of the pilot phase showed a marked improvement in the clarity, clinical accuracy, and timeliness of health input into EHCPs, and early feedback from local authority staff suggested greater confidence in engaging with health information and interpreting clinical language for educational planning.

Further evidence of nursing impact can be seen in the evaluation of NHS England's SEND Champion Programme [15]. Findings indicated that non-health professionals trained or supervised by nursing staff reported significantly improved confidence in identifying neurodevelopmental needs, understanding associated health impacts, and translating these into effective educational and social care responses. This suggests that nursing leadership can play a transformative role in building system-wide health literacy and improving the quality of support offered to children and young people with complex needs.

These developments underscore the critical contribution of nurses not only as clinical advisers, but as educators, influencers, and capacity-builders within the wider SEND system.

Responding to Need in a Resource-Constrained System

The broader challenge facing all health professionals is the growing gap between need and capacity. While NHS budgets continue to rise in headline terms, the complexity and volume of need, particularly in child development, neurodiversity, and long-term conditions, outpaces, resources workforce and infrastructure growth.

Rather than pursuing equal service provision, what is needed is:

1) Responsive care based on clinical need and local context.

2) Streamlined systems that reduce duplication and improve access.

3) Better data to inform resource allocation.

4) Skilled, empowered nursing leadership to shape services around those who use them.

This requires long-term investment in the children's workforce, particularly specialist nurses who can lead on integration and complexity across health and education.

6. Discussion

This discussion presents a critical practice-based analysis of the leadership role nurses play in influencing the SEND system, particularly within the Education, Health, and Care Plan (EHCP) process and broader system reform. The findings reinforce the growing recognition that health professionals, and nurses in particular, possess unique insight and skills that can drive improved outcomes for chil-

dren and young people with special educational needs and disabilities (SEND). However, it also reveals the structural and operational barriers that hinder optimal impact, requiring a fundamental rethinking of policy assumptions, workforce development, and interagency responsibilities.

6.1. Challenging Policy Assumptions and Structural Neglect

A recurring tension within the SEND system is the perception that poor outcomes for children with additional needs are inevitable or biologically determined. Yet, evidence from this review, and from broader policy and health equity literature, suggests that such outcomes are more accurately understood as the consequence of systemic neglect, under-resourcing, and fragmented responses across services. Families facing complex health and behavioural challenges often encounter unmet needs, reduced access to support, and social isolation, which in turn contribute to poverty, housing instability, and worsening health conditions. This is not inevitable, it is preventable, and failure to prevent it is a structural failure.

Nurses, particularly in roles such as Designated Clinical Officers (DCOs) and Designated Medical Officers (DMOs), are positioned to surface these inequities and advocate for a policy approach that prioritises prevention, early intervention, and life course planning. However, for nurses to act effectively as system leaders, their insight must be integrated earlier in the policy and commissioning cycle, not just at the point of statutory EHCP advice.

6.2. Workforce Capability and Interprofessional Learning

One of the most consistent findings from practice is the knowledge gap among non-health professionals, particularly EHCP writers and SEN case officers, when it comes to complex health conditions, neurodivergence, emotional regulation, and long-term physical health needs. Although the education system has invested in general training, this often lacks clinical specificity and fails to support confident application in real-world casework.

Nurses fill this gap by leading consultation, supervision, and training across services. For instance, nurse-led EHCP advice training and co-production models have shown measurable improvements in both timeliness and quality. More significantly, evaluations such as the NHS England SEND Champion Programme show that nurse-delivered training has a sustained impact on confidence and accuracy in recognising neurodevelopmental conditions, resulting in more appropriate support and reduced risk of misdiagnosis or exclusion.

This represents a form of transformational leadership that extends beyond traditional clinical roles. Nurses function as educators, collaborators, and enablers within a complex policy system, helping to operationalise abstract principles like "person-centred care" and "reasonable adjustments" in concrete, actionable terms

6.3. Using Data for Commissioning and Health Equity

Another area where nursing leadership demonstrates system-level value is in the

use of clinical data to influence commissioning and reduce health inequalities. While the current system often focuses narrowly on compliance with EHCP processes, nurse leaders are increasingly calling for a shift towards outcomes-based commissioning; where decisions are informed not just by volume and need, but by a nuanced understanding of avoidable health inequalities.

For example, nurses can highlight trends such as high asthma admissions or poor diabetes management in children with EHCPs, prompting investment in targeted interventions and early support. This aligns with the NHS England direction of travel, but also requires brave commissioning, willing to focus on reducing preventable illness rather than simply meeting statutory minimums. Nurses are often among the few professionals who can bridge the clinical, public health, and operational domains to influence this shift.

6.4. System Leadership and Service Improvement

Overall, this practice-based review highlights that nurses are already performing many of the functions described in NHS policy documents as essential to transformation: improving outcomes, reducing inequalities, strengthening multi-agency collaboration, and building a capable workforce. However, many of these contributions are undervalued or poorly recognised in formal policy and workforce structures. There is a need for explicit recognition of nursing as a system leadership profession within SEND reform, with clear investment in role development, protected time for training delivery, and integrated leadership pathways.

In addition, current performance metrics for SEND often fail to capture the preventative or enabling impact of nursing work. A more sophisticated evaluation framework, including patient and family-reported outcomes, workforce confidence, and system readiness, could help illuminate the full value of nurse-led interventions.

Policy makers and commissioners therefore need to integrate nursing leadership into SEND commissioning frameworks to complement financial and operational planning with holistic population health insights. Embedding a nurse-led perspective within commissioning and service frameworks does not represent a novel innovation, but rather a strategic recognition of nursing's longstanding expertise in holistic care, coordination, and equity. By formally integrating these established skills, proven effective across generations of health practice commissioners can strengthen system sustainability, reduce fragmentation, and ensure that services respond more directly to the lived realities of children, young people, and families and achieve the following outcomes:

1) Enable dynamic, community-focused provision that responds to shifting demand rather than relying on static, long-term models.

2) Strengthen joint planning across education, health, social care, and the voluntary sector, with nurses leading on coherence and coordination.

3) Recognise nursing's established expertise in multidisciplinary collaboration, positioning the profession as a mediator across systems and as a safeguard against

fragmented or unsafe care.

Embedding nurse-led perspectives into SEND commissioning, services would not only achieve greater coherence but also ensure equity, reduce adversarial disputes, and secure better long-term outcomes for children and young people with SEND. Nursing's holistic and integrative strengths provide the foundation for a future service model that is both sustainable and responsive to the real-world needs of families.

6.5. Impact of Nursing Workforce Sustainability

The sustainability of the SEND nursing workforce is closely tied to retention. With adversarial processes, such as tribunals, contributing to professional stress, and increase cost of becoming nurse with limited structural opportunities for career progression in clinical roles, nurses in SEND are at high risk of burnout. This weakens the system's ability to deliver consistent, trusted care and exacerbates existing gaps in provision.

Policy-level recognition of the need for clinical advancement without managerial displacement could help address this. Nurse consultants in SEND should be enabled to remain in direct practice, similar to consultants in medicine or senior psychologists, thereby retaining expertise where it has the most impact.

Nursing's ability to remain close to children and families while progressing into advanced roles is limited, unlike in other professions. This both reduces the visibility of nursing's impact and contributes to workforce attrition. Addressing this imbalance is not about diminishing other professions but about ensuring that nursing expertise remains at the frontline, where it can most directly reduce health inequalities. By contrast, advanced nursing progression often depends on moving into managerial or strategic posts. While these roles are vital, they result in:

1) Loss of clinical expertise at the point of care, as highly skilled nurses are removed from the very environments where their expertise is most needed.

2) Reduced incentive for specialist training, as investment in advanced education does not translate into sustained opportunities to remain in practice.

3) Workforce attrition and burnout, as nurses experience frustration at being unable to use their training fully, or at having to choose between career advancement and patient contact.

This anomaly is particularly significant in SEND, where long-term, relational, and holistic care is essential to improving outcomes for children and young people. Removing experienced nurses from frontline roles risks widening existing inequalities, as families may not have access to professionals who can coordinate and translate complex health needs into accessible, practical care plans.

Reforming nursing career pathways is not only a workforce issue but also a matter of equity and sustainability in SEND. Enabling nurses to remain in advanced clinical practice ensures that the children with the most complex needs are supported by highly skilled practitioners. This strengthens family confidence, reduces conflict, and contributes to more cost-effective and equitable outcomes.

7. Conclusions

This analysis argues that nursing professionals are vital policy influencers and system leaders within the SEND system. Their ability to translate clinical knowledge into policy-relevant advice, build capacity across the non-health workforce, and shape commissioning decisions places them at the heart of effective and equitable SEND provision.

Importantly, this work reframes nurses not as passive responders to statutory duties, but as active agents of system improvement, capable of shaping how health needs are identified, supported, and sustained across the life course.

To maximise impact, there is a need to invest in structured nursing roles within SEND systems, support ongoing development in supervision and training delivery, and embed formal evaluation into nurse-led service improvement initiatives. Only by leveraging nursing leadership at all levels, from the consultation room to the commissioning board, can the system deliver timely, inclusive, and sustainable outcomes for children and young people with SEND.

Children with special educational needs face both clinical vulnerability and structural disadvantages. Nurses, through their unique positioning, clinical judgement, and family-centred values, must be central to addressing these inequalities.

As pressures on the system grow, it is vital that we do not allow legal processes, online trends, or resource constraints to dictate care. Instead, we must champion care that is timely, proportionate, clinically sound, and person specific.

Nurses have the knowledge, strategic position, and public trust required to function as change agents within the SEND system. Their role must move beyond reactive care and statutory compliance into active policy influence, commissioning leadership, and system transformation. By embedding themselves across pathways, from EHCP quality assurance to data-driven commissioning and transition planning, nurses can play a significant role in improving outcomes and reducing inequality for a population often overlooked by traditional healthcare models.

Nursing brings a distinctive population health perspective to SEND, positioning the profession as a vital contributor to future commissioning and service design. Unlike static commissioning models, which often struggle to adapt to the rapidly changing needs of young people and their families, nursing practice emphasises responsiveness, holistic assessment, and dynamic care planning. This enables provision to be re-shaped in real time, reflecting the growing shift towards community and home-based support.

Critically, nursing practice also recognises the interdependence of the child and their family, acknowledging the stressors associated with raising a child with SEND and the ways in which family resilience directly influences outcomes. Embedding this holistic approach into SEND commissioning could reduce the adversarial nature of current processes, ensuring safer and more person-centred pathways that align health, education, and social care perspectives.

To secure a more equitable SEND system, nursing leadership as resources should be positioned as system leaders whose expertise directly shapes commissioning,

policy, and service design. Structured roles, supported by investment in supervision, training, and evaluation, enable nurses to translate clinical knowledge into actionable strategies that strengthen EHCP quality, build workforce capacity, and reduce adversarial processes. The effect is a system that shifts from fragmented, compliance-driven provision to one that is anticipatory, accountable, and aligned with population needs. Embedding nursing leadership into decision-making structures, policymakers will ensure that children and young people with SEND receive sustainable, person-centred support that reduces inequality and delivers measurable improvements in outcomes.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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