REACT

Is the education sector protecting pupils with allergies, and what more can be done?

Report created by

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‘WE WELCOME FEEDBACK ON HOW WE CAN BETTER SUPPORT SCHOOLS’ IMPLEMENTATION AND AWARENESS OF THESE POLICIES, PARTICULARLY TO TRY TO REMEDY ANY INCONSISTENCIES BETWEEN WHAT WE REQUIRE FROM THEM AND WHAT IS HAPPENING’.

David Johnston MP – Under Secretary of State for Education at a debate discussing Pupils with Allergies in School brought by Benedict Blythe Foundation in November 2023.

**‘THIS REPORT HIGHLIGHTS A SYSTEMIC FAILING IN SAFE ALLERGY PROVISION FOR PUPILS WITH ALLERGIES. GAPS IN ALLERGY COMMUNICATION, MEDICATION AND EDUCATION ARE PUTTING CHILDREN AT RISK OF SEVERE ILLNESS OR DEATH.
MEASURES NEED TO BE PUT IN PLACE TO KEEP CHILDREN WITH ALLERGIES IN ENGLAND SAFE – WHAT IS IN PLACE NOW IS NOT GOOD ENOUGH. PUPILS AND THEIR FAMILIES DESERVE BETTER’.**

Helen Blythe – Founder and Director, Benedict Blythe Foundation

EXEC SUMMARY

THERE IS A MOUNTING NEED FOR POLICYMAKERS AND SCHOOLS TO REACT QUICKLY AND BE PREPARED FOR A GREATER NUMBER OF PUPILS WITH ALLERGIES THAN EVER BEFORE. THERE HAS BEEN A RAPID INCREASE IN THE NUMBER OF CHILDREN WITH ALLERGIES IN THE LAST 20 YEARS AND THIS HAS LED TO HOSPITALISATIONS DUE TO ALLERGY NEARLY DOUBLING IN THAT PERIOD.

Despite this knowledge, current legislation makes only modest requests of schools, falling far below the recommended good practice outlined by clinicians, allergy charities and coroners following inquests into fatal anaphylaxis reactions in children during school. The UK lags behind international legislation, with many measures recommended in this report having been common practice in USA, Canada and Australia for almost two decades, putting the estimated 680,000 pupils in England with allergies at unnecessary risk.

This report is the largest research of its kind, analysing data from 2,198 individual settings - almost 10% of England's schools. Our findings show that schools aren't given the direction and support needed to make them adequately safe for pupils with allergies. Communication of each school's approach through a clear policy was absent in one third of schools, and individual healthcare plans were not universally adopted for children with allergies - with schools often being forced to make clinical decisions without having the level of knowledge to do so.

There is huge variation in the quantity and quality of allergy training and education for school staff. Parents would find it impossible to know whether their children were being cared for by adults with sufficient knowledge in prevention, management, and emergency response. Medication was available in only around half of schools, with the rates being slightly higher in secondary than primary.

1-2
CHILDREN IN EVERY AVERAGE-SIZED CLASSROOM WILL HAVE A FOOD ALLERGY

AN ESTIMATED
680,000
PUPILS IN ENGLISH SCHOOLS HAVE ONE OR MORE ALLERGIES

CHILDREN MISS
HALF A MILLION
DAYS OF EDUCATION DUE TO ALLERGY EACH YEAR

It is particularly concerning that 69% of schools do not have all of the recommended safeguards in place: an allergy policy, individual healthcare plans, medication and training.

This report also highlights the lack of reliable data available on the number of allergic reactions that take place in schools. It makes it impossible to see the true scale of the challenge schools face, and to identify where the number of incidents may be higher due to school failings.

PARENTS WOULD FIND IT IMPOSSIBLE TO KNOW WHETHER THEIR CHILDREN WERE BEING CARED FOR BY ADULTS WITH SUFFICIENT KNOWLEDGE IN PREVENTION, MANAGEMENT, AND EMERGENCY RESPONSE.

While these findings may be worrying for parents, it actually highlights the proactive measures schools have taken to follow good practice despite a seeming lack of guidance, training and funding in this area from government - often going above and beyond to implement examples of good practice. It is crucial schools continue to interrogate and improve their own processes to make education environments safe for children with allergies.

What is clear is the need for policymakers and schools to react quickly to implement the recommendations outlined in this report, to better protect pupils with allergies in English schools. For government, this means helping schools to prioritise allergy management through clear safeguards, for the £5 million funding to be made available to them, and for there to be adequate checks to ensure measures are in place to keep children with allergies safe.

18% OF ALLERGIC REACTIONS TO FOOD TAKE PLACE IN SCHOOL

AN ESTIMATED **45,000** CHILDREN BORN IN 2022 WILL DEVELOP ALLERGIES

ANAPHYLAXIS HAPPENS **MORE IN SCHOOL** THAN IN ANY OTHER SETTING OUTSIDE THE HOME

KEY FINDINGS

Rates of **staff training on basic allergy knowledge was poor**, particularly around understanding allergy and daily management.

Schools are typically only delivering on their statutory responsibilities, and **not always doing the right things to keep children with allergies safe**.

Recording allergy incidents is either **not happening or is inaccurate**, meaning schools and government have no awareness of the scale of allergy risk in English schools.

Communication of how the school manages allergies and emergency response through policy individual healthcare plans **wasn't universal and not always accessible** to all staff.

Almost half of schools **don't hold their own life-saving allergy medication**, relying on a child having their own medication, which they often don't.

Allergy management in schools varies widely, and it is down to chance whether a child's school has recommended allergy safeguards in place.

RECOMMENDATIONS

1. Policymakers and government need to **react to the findings** by **implementing new safeguards to protect pupils with allergies.**
2. Schools, Headteachers and Governors need to **recognise the gaps in the ways they manage allergies** and to take **proactive steps** to close them to **keep children with allergies safe.**
3. Department for Education needs to provide the £5 million of funding **needed for schools to implement safety measures**, and also organise checks to ensure statutory requirements are in place.

Our beautiful son, Benedict, collapsed at school and died from anaphylaxis in December 2021 aged 5 years old. We don't yet have answers about what happened to him, but it did lead to families generously sharing their experiences of having a child with allergies in schools and where things had gone right - and wrong.

This report shows the staggering variance between schools, with the patchwork of approaches meaning it really is a postcode lottery for families with a child with allergy. Some have robust processes, others none at all. The fact it's pot-luck whether your local school has medication, communication and education relating to allergy made available to teachers, puts children needlessly at risk.

Our campaign to Protect Pupils with Allergies launched in 2022, with 13,000 people backing a request to government to make recommended safeguards mandatory. Their belief was that the current guidance was sufficient, with schools given the freedom and flexibility to access the right tools voluntarily. This report shows that this system isn't working - schools are not taking up those voluntary measures, the fact 70% of schools don't goes to show more leadership is needed at national level.

We know that changes to legislation and funding take time, but there is action that can be taken in the meantime. We would urge schools to react to the findings in this report and to put their own measures in place. For parents concerned by the findings, there is action they too can take, raising helpful guides like the Schools Allergy Code, which is backed by Department for Education, to the attention of schools and raising money to implement some of the more costly measures.

THIS REPORT SHOWS THAT THIS SYSTEM ISN'T WORKING - SCHOOLS ARE NOT TAKING UP THOSE VOLUNTARY MEASURES, THE FACT 70% OF SCHOOLS DON'T GOES TO SHOW MORE LEADERSHIP IS NEEDED AT NATIONAL LEVEL.

This is something that needs to be achieved by a united effort, taking a whole-sector approach to allergy safety in schools. The findings in this report demonstrate that there is much more to be done to ensure our children with allergies are safe in school - and we all have a role to play in making that happen.

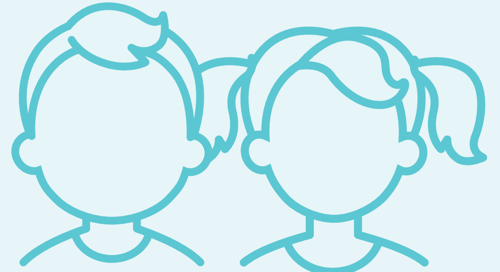
Helen – Benedict's mother, and Director of Benedict Blythe Foundation

WHAT A CHILD WITH ALLERGIES SHOULD BE ABLE TO EXPECT AT SCHOOL...

An **understanding** of how many allergic reactions and near-miss incidents take place and **lessons learnt** to address this.

Teachers and school staff who are **trained** in **understanding** allergy, **managing** allergy, and **emergency response**.

An **environment** where allergy is **taken seriously** and measures are put in place to **protect pupils**.



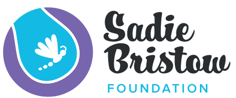
Access to life-saving medication including spare adrenaline auto-injector pens and adults **trained to administer them.**

Reassurance that there are **checks in place** to make sure schools **adhere to their statutory responsibilities**.

A plan for each child that explains their unique allergies, **how to manage them**, and **what to do in an emergency**.

A school that clearly communicates its allergy management **approach and procedures** to staff, parents and pupils.

This ask is backed by:



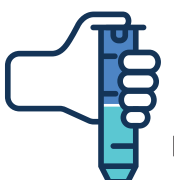
A CHILD WITH AN ALLERGY, ATTENDING A SCHOOL IN ENGLAND CURRENTLY HAS:

A **1 in 6** CHANCE OF ATTENDING A SCHOOL THAT **DOES NOT** HAVE INDIVIDUAL HEALTHCARE PLANS (IHPs) FOR PUPILS WITH ALLERGY

Although the remaining **86%** may be making clinical decisions about whether your child's allergy is 'severe enough' to have an IHP

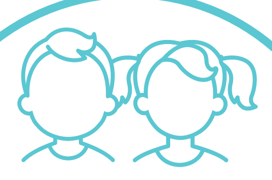
A **1 in 3** CHANCE OF ATTENDING A SCHOOL THAT **DOES NOT** HAVE AN ALLERGY POLICY

and if they attend one of the 2/3 it **may not yet be completed or accessible** outside an IHP



ALMOST **50/50** CHANCE OF WHETHER THEIR SCHOOL WILL HAVE A SPARE AUTOINJECTOR PEN

And an **11%** chance of being in a school where training **is not** provided on administering an autoinjector pen



ATTENDING AN ALLERGY SAFE SCHOOL SHOULD **NOT BE** A MATTER OF CHANCE

BETWEEN **61-54%** CHANCE **NO TRAINING** HAS BEEN GIVEN IN MANAGING ALLERGIES IN SCHOOL OR ON TRIPS/VISITS

HAVE A **1 in 3** CHANCE OF ATTENDING A SCHOOL THAT DOES NOT KEEP TRACK OF 'NEAR MISSES'

Although **90%** of the 2/3 who say they do record said they had **zero instances** in **6 years**

1 in 4 CHANCE OF ATTENDING A SCHOOL THAT **DOES NOT** PROVIDE TRAINING IN IDENTIFYING ALLERGY SYMPTOMS AND ANAPHYLAXIS, OR WHAT TO DO IN AN ALLERGY EMERGENCY

A **69%** **CHANCE** THEIR SCHOOL **DOES NOT** HAVE THE RECOMMENDED MEASURES OF SPARE PENS, TRAINING, ALLERGY POLICIES AND IHPs IN PLACE

BETWEEN 70-80% CHANCE THE SCHOOL **DOES NOT TRAIN** ON WHAT FOOD ALLERGY IS, INCLUSION OR THE IMPACT OF ALLERGY ON PUPILS

LIVED EXPERIENCES

In the June I got the call which is every parent's nightmare. It makes me tear up thinking about it every time. **I was told the Autoinjector (AAI) had been given and the ambulance was on its way.** I didn't know whether she was alive or dead. I arrived and the ambulance was outside – I didn't know what we were going into. Flora was crying amid absolute chaos. There was just the caretaker and the receptionists there. Flora was distraught.

I just remember hugging her...I got in the ambulance and he told me that **the first aider had held the AAI upside down and injected herself**...no one rang to see if she was OK. There wasn't one member of teaching staff around and no one followed up. I rang the next morning... I asked for a meeting because I wanted to know what happened. **There was no report done or record of this anaphylaxis**.

I rang the school saying we need to know what happened and they basically wiped the floor with me and didn't want to listen to us. [The receptionist said] "we've been told not to speak to you. You want to hear what they say about you."

I asked school for **the care plan and the one they had on file was out of date**.

We had about 17 care plans in the end. I kept querying why **the AAIs were in a locked cupboard**, but this was met with the headteacher saying, "it's not locked, look, you just turn the key".

When we asked about who was AAI trained – they said **we don't like AAI training**. I put in a Subject Access Request as they still didn't admit that day happened. I was told not to talk about this, that we've got to move forward. So I went in and asked, **can you get me the spare AAI? They couldn't find it**. The School nurse told them they should have got it.

There are no records of around 13 allergic reactions at school. Flora's had uncontrollable anxiety, meetings unearthed out of date Epipens.

Allergy plans I created with the nurse had been copied and pasted incorrectly. **Policies disappeared** when I tried to point to how they should be caring for her at school. I kept asking, "how can I help you put the things in place that we need to make all children with severe allergies feel safe?" You'd always fight for your child.

Allergy Stories, from a parent of a child with allergies

I told my teacher that I felt a bit poorly one time after lunch. A girl in my class had been sick with a tummy bug that week, so she told me if I was going to be sick to let her know but she let me go outside to play.

I started to feel really poorly and my friend ran to get another grownup but couldn't find anyone, the teacher watching the playground was behind a wall. So she had to go into the school. When the lady from the office came, I was all wobbly and then I had to be on my own while she ran to get my pens. It was scary, but I'm ok now. It was funny seeing the grownup running, they don't normally run! It was just annoying though because I did tell them I didn't feel ok.

NUMBERS & RECORDING

THE IMPORTANCE OF RECORDING

'The autoinjector had been given and the ambulance was on its way, but there was no report done or record of this anaphylaxis'

WE ASKED

How many allergic reactions took place between 2016 – 2023

How many 'near miss' incidents took place between 2016 – 2023

How many incidents took place where an ambulance was called in response to a child's allergic reaction since 2016

Our aim was to understand the prevalence of school allergic reactions. Was it as predicted in existing research, or could the figure be higher?

We also wanted to understand the range of less severe reactions or 'near misses', through to those that require emergency services.

In 2023 we asked those three questions, but realised quite soon that schools don't have this information readily available in a spreadsheet or on an incident management system.

That prompted us to learn more about what they do have in place, so we went back out with a subsequent FOI request to ask:

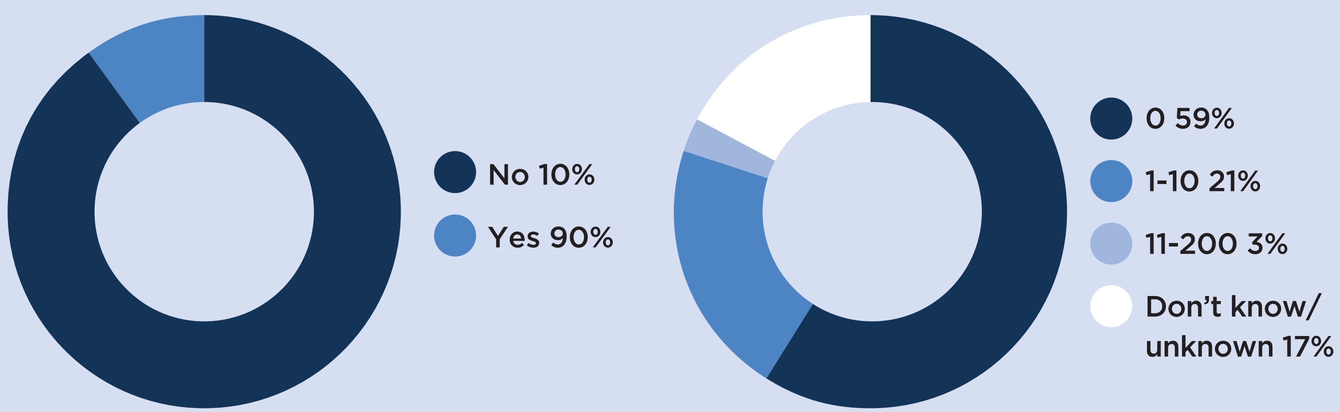
DO YOU ROUTINELY RECORD INSTANCES OF ALLERGIC REACTION, NEAR MISSES AND AMBULANCES CALLED AS A RESULT OF AN ALLERGIC REACTION?

In 2023, Lee Owston Director of Education at Ofsted said, *'Inspectors gather a wide range of evidence to make their judgements, including an evaluation of the experience of particular individuals and groups, such as pupils with medical needs...Ofsted does make a judgement about the effectiveness of a school's safeguarding culture during each inspection. This includes the extent to which pupils with specific needs and vulnerabilities are kept safe.'*

We were keen to understand how far instances like this were recorded and how, so that we could understand the type of 'evidence' Ofsted are currently able to review.

90% of schools routinely record instances of allergic reactions…

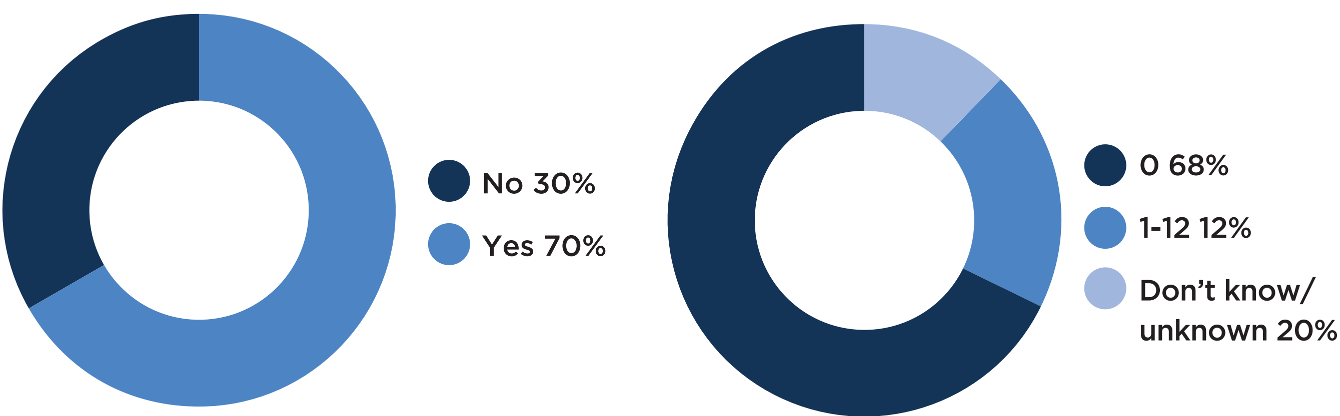
…however, almost 80% have recorded zero instances of allergic reaction since 2016 or don’t know.



One or two children within an average class size of 30 pupils have a food allergy and they would have at least one accidental reaction every 2-3 years. This suggests that **the data collected is not accurately captured or recorded.**

One-third of schools do not record near misses

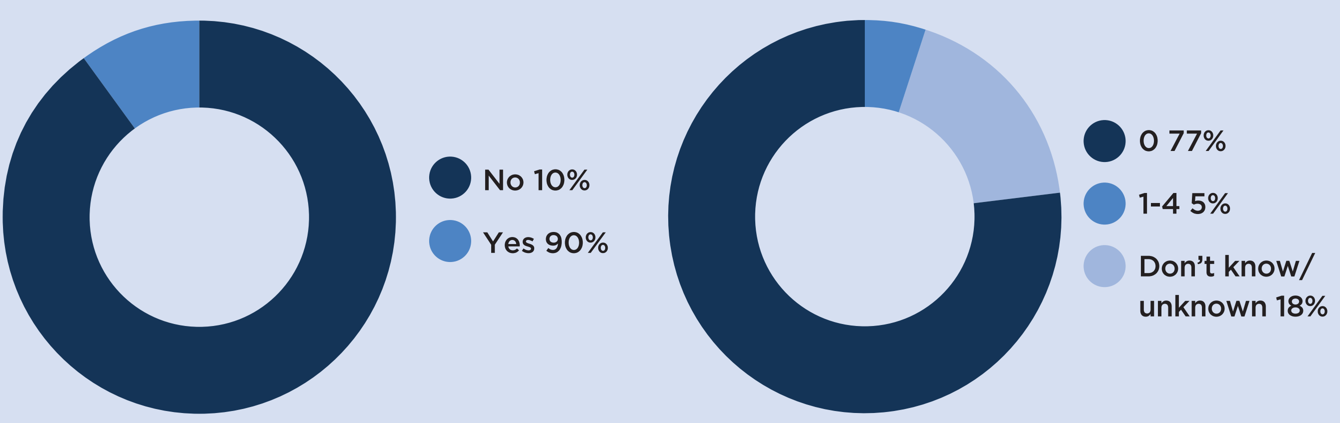
Almost 90% of school have recorded zero near misses since 2016 or don’t know



One or two children within an average class size of 30 pupils have a food allergy and they would have at least one accidental reaction every 2-3 years. This suggests that **the data collected is not accurately captured or recorded.**

90% routinely record instance of ambulances being called

Of which, almost 20% either didn't respond or didn't know



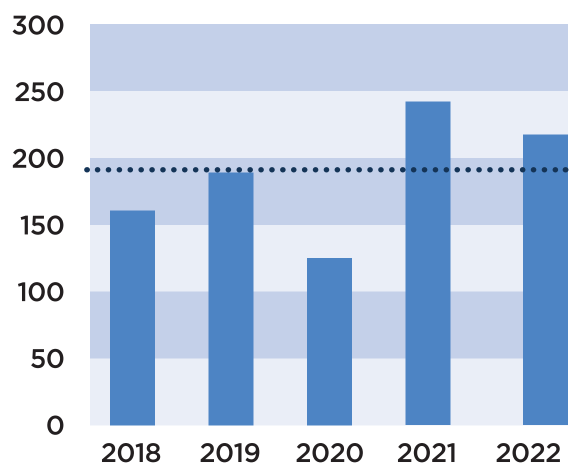
These figures suggest that on average, hospitals receive five under 18 y/o each year who have been conveyed by ambulance with an allergic reaction from schools. This suggests that there is a **discrepancy between the data collected from schools**.

An average of 16 children each year who have been conveyed by ambulance

20
18
16
14
12
10
8
6
4
2
0

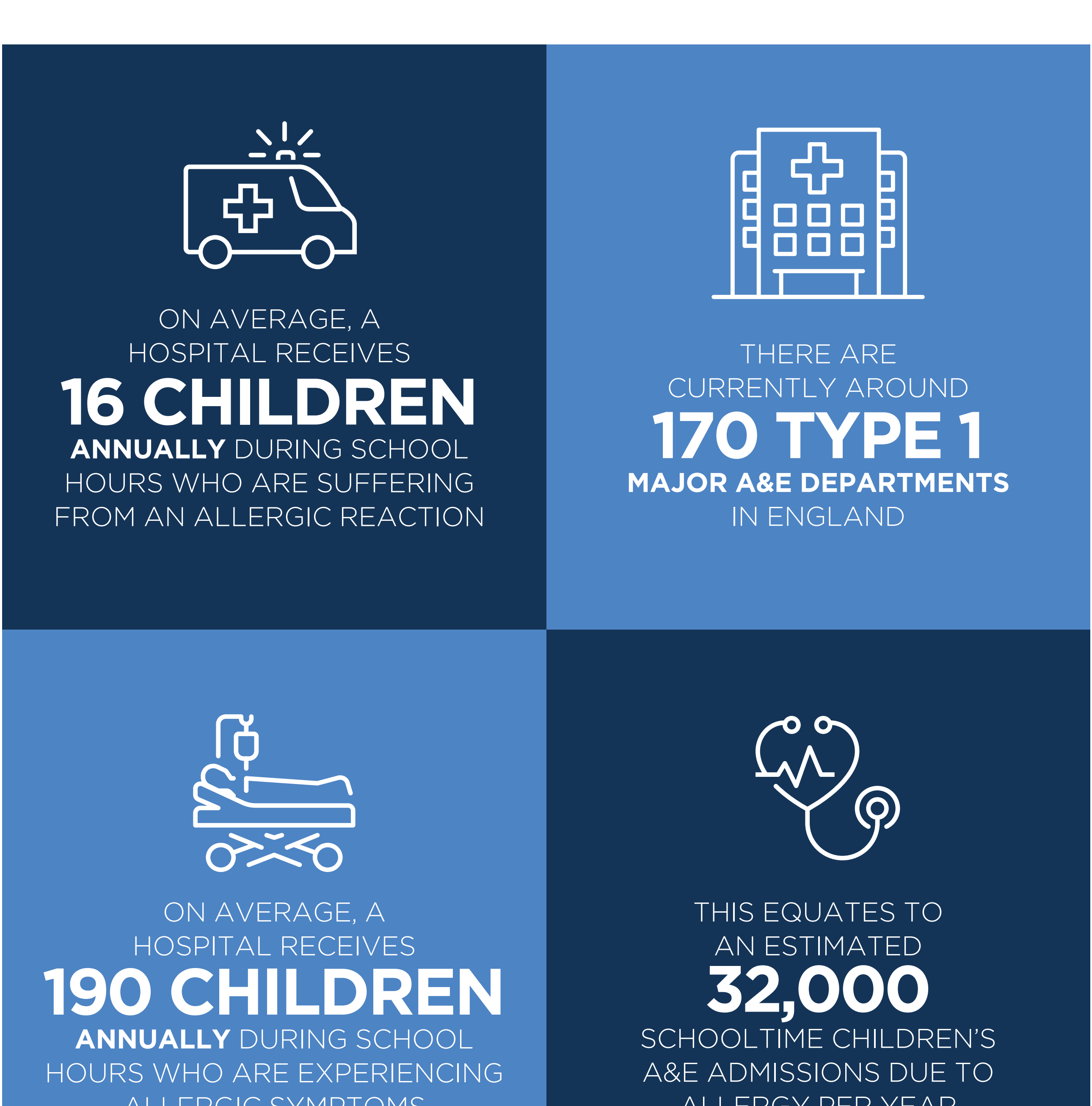
2018 2019 2020 2021 2022

An average of 190 children have been admitted during school hours with an allergy



SEVERE REACTIONS

While this data is based on a modest sample size of 10%, it gives us an indication of what the real figures may look like



WHAT GOOD LOOKS LIKE

THE LEGAL PICTURE

Schools have a responsibility to track and record health and safety incidents as outlined in 2022 Department for Education Guidance Health and safety: responsibilities and duties for school and Headteachers have a role in managing school safety under Management Regulations.

Section 175 of the Education Act 2002 places a duty on local authorities (in relation to their education functions and governing bodies of maintained schools) to exercise their functions with a view to safeguarding and promoting the welfare of children who are pupils at a school.

Severe allergic reactions where a child is taken from school to hospital should be reported under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 either by the NHS trust or following a recommendation to a school. The most serious incidents can be referred to the Health and Safety Executive (HSE) who may investigate where it is in the public interest and is life threatening or uncommon.

WHAT GOOD LOOKS LIKE

All food businesses (including school caterers) must follow the Food Information Regulations 2014 which states that allergen information relating to the 'Top 14' allergens must be available for all food products. The school menu should be made available for parents to view in advance with all ingredients listed and allergens highlighted. Schools will also need to consider how to keep food-allergic pupils safe during lessons and activities that involve food. Ideally, the curriculum should include education on food allergies for all pupils.

Guidance from the Department of Health recommends that schools keep a register of food-allergic children as part of their medical conditions policy. The register could include:

- Known allergens
- Whether a pupil has been prescribed AAIs, and if so, what type and dose
- Whether parental consent has been given for use of the spare AAI

Ideally, this Register should also form part of a system to ensure catering staff can identify pupils with food allergies, to reduce the risk of a pupil being given a meal containing something they are allergic to.

Use of any AAI device (whether a pupil's own device or a "spare" pen") must be recorded. This should include:

- Where and when the reaction took place (e.g. PE lesson, playground, classroom).
- How much medication was given, and by whom
- What happened after the AAI was given, e.g. ambulance called, taken to XX hospital.

The pupil's parents should be contacted at the earliest opportunity, and this documented.

CASE STUDY

The New South Wales Anaphylaxis Education Program (NSWAEP) was established in Australia in 2004 to improve and support state-wide anaphylaxis education in schools. The public education system in NSW educates 810,000 school students. All staff receive regular training to recognise and manage anaphylaxis. Since 2017, NSWAEP has collected data on all episodes of anaphylaxis and/or adrenaline autoinjector (AAI) use in NSW public schools. This has demonstrated that:

- Around 2 anaphylaxis events happen per year, per school
- 12% of all episodes use occurred in students with intellectual or physical disabilities
- 15% of students required a second dose of adrenaline, but 99% responded to 1-2 doses
- Over 20% of students had no previous known allergies
- No student had anaphylaxis from casual contact (smell/touch) with a food

Collecting these data have informed subsequent education and policy, and made NSW schools safer for students with food allergies.

Dr Paul Turner, Consultant & Clinician scientist in Paediatric Allergy and Immunology, Imperial College London

KEY FINDINGS

In our survey we asked several stats-based questions. Our aim was to to be able to better understand the prevalence of allergic reactions taking place in English schools, with the first substantial sample of recorded data on reactions year by year since 2016.

In our 2023 FOI request, we asked for quantities of allergic reactions, situations where an AAI had been used, and instances where an ambulance had been called. When we reviewed the responses, we felt it was important to dig a bit deeper into how these figures were recorded, and how. So in 2024 we made a subsequent request for information that asked exactly that - do you record instances of allergic reaction, near miss and ambulance calls due to allergy, and how?

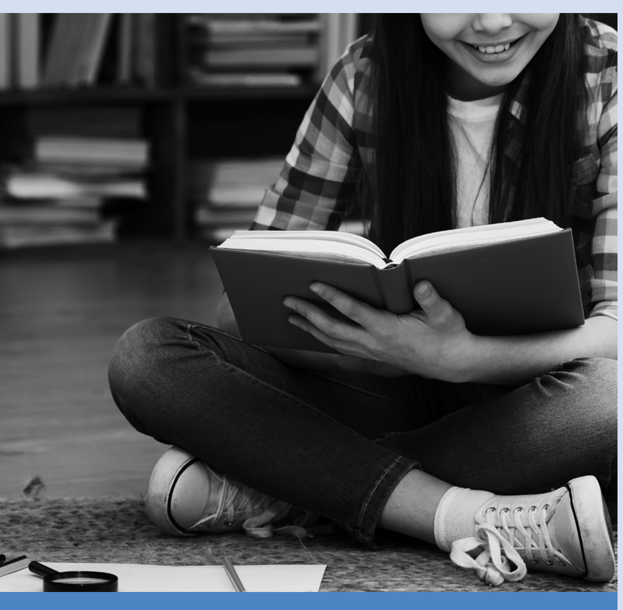
When we began to analyse the findings, it became clear from what we know about the prevalence of allergy, the likelihood of a child with allergy having some sort of allergic reaction, and the body of research that describes volumes and experiences of school-based allergic reactions, that it simply wasn't possible for the figures we received to be accurate.

Because the disparities between what an expected reasonable response would look like and the figures we received, we're unable to report the answers to these questions. Our assumption is not that these figures are deliberately incorrect, and instead that it shows that schools either 1) do not know or, 2) report data incorrectly/ inaccurately.

In a 2024 survey, 58% of respondents said their child has had an allergic reaction or experienced a near miss at school, or 394,400 children. In the same survey, just over 4% of parents reported their child having a reaction where emergency services were called.

And yet 72% of schools responding to our freedom of information request either did not record these instances, or claimed that zero instances had taken place within the last six years.

THE FIGURES DON'T ADD UP



SCHOOLS DON'T ROUTINELY AND ACCURATELY RECORD INSTANCES OF ALLERGIC REACTION OR NEAR MISS.

HOW IS IT POSSIBLE TO KNOW THE SCALE OF ALLERGIC REACTIONS TAKING PLACE IN SCHOOLS IF THIS DATA ISN'T RECORDED?

RECOMMENDATIONS

RECOMMENDATION 1.

SCHOOLS SHOULD REPORT ALL KNOWN INSTANCES OF ALLERGIC REACTION AND NEAR MISS.

Allergic reactions will happen, and not all are preventable. Keeping track of this is not intended to put blame onto schools, but to identify those with a higher prevalence of allergic reactions and therefore a need for greater support.

Measurement helps to light our path. When we track, measure, and evaluate we can continue to learn.

Without having an accurate understanding of the challenge schools and pupils are facing when it comes to allergy management and safety, it is hard to proactively seek improvements.

BSACI is working with Imperial College London to establish a prospective UK Anaphylaxis Registry, supported by UK Food Standards Agency (FSA) and Food Standards Scotland (FSS), to collect data relating to unintended allergic reactions. It is our belief that a similar model that collects data in schools about:

- Near miss incidents
- Allergic reactions
- AAI administration
- Emergency service involvement

The aim would be to improve student experience and to help guide public policy.

We believe that schools should report all known instances of allergic reaction and near miss through a **Schools Allergy Reaction Register**.

ALLERGY POLICIES

WHY DO POLICIES MATTER?

Policies are more than pieces of paper that live in a file or on a computer system. They are important pieces of guidance and information that cover all aspects of school life.

Depending on the topic, policies can be directed towards teachers, governors, parents or wider school staff. They describe what a school's approach, values and expectations are on a given topic and help provide a framework for employees. They usually fall into three categories:

- **Statutory policies** - Schools and academies are required by law to have these policies and documents in place.
- **Discretionary policies** - Additional policies a school or may wish to have in place but are not required to by law.
- **Curriculum policies** - Policies that relate to specific areas of the curriculum. They are mostly discretionary but some are statutory, such as a relationships and sex education policy.

Due to the fact that Allergy Policy is a discretionary, rather than a statutory policy, we wanted to understand how many schools were adhering to the basic legislation and how many were adopting good practice.

WE ASKED

Does your school have an allergy policy in place?

If you responded stating your school does have an allergy policy in place, please describe where the policy is located, who it is intended for and who can access it.

We asked this question to better understand whether the fact allergy is not specified in medical conditions policies meant it wasn't universally addressed through allergy policy. We were also interested in understanding the approaches schools might take to its storage, location, visibility and audience.

My daughter's class teacher takes it extremely seriously...What has baffled me is the wider school's response. The senior leadership team's position is that they are 'very used to dealing with allergies'' however they do not have a policy, they do not use IHPs (Individual Healthcare Plan)... and they are almost avoidant when I try to raise my concerns when things have gone wrong.

I had a case in an after school situation where the parent didn't actually tell us that she was allergic to kiwi. They'd told the school but they hadn't told us. Luckily it was home time for her so her parent arrived and said right away.

They don't get it. The staff have little understanding about allergies. The allergy policy they have is inadequate and does not follow best practice.

POLICIES

Not all schools selected 'yes' or 'no'. 422 schools responded 'other' in response to this question, providing additional detail about the policies they had in place. Observational themes from the open-ended responses included:

ALLERGY INFORMATION IN INDIVIDUAL CARE PLANS

Schools mention that allergy information is included within individual care or health plans for children with allergies. This approach is problematic because it is not widely and visibly available to existing or supply staff. Allergy information held within an IHP doesn't amount to being an allergy policy.

DEDICATED ALLERGY POLICY IN PROGRESS

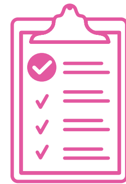
Schools responded than an allergy policy is in progress, being reviewed and approved. While it's positive a significant number of schools are using prompts such as this review as a catalyst for developing an allergy policy, for our purposes these do not count as having an allergy policy in place.

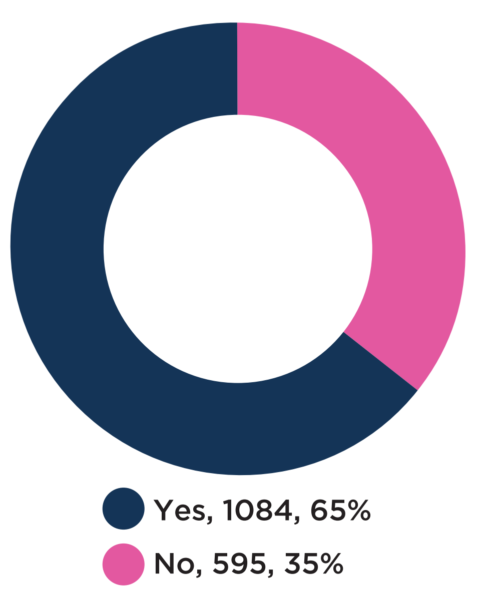
ALLERGY INFORMATION INCLUDED IN OTHER POLICIES

Schools mention that allergy information is included in broader policies such as First Aid, Medical Conditions Policy, Medicines Policy, or Food and Catering Company Policies. Good practice means having an explicit section focussed on allergies, but whether that is included within another policy is up to each school. In these instances we would say these schools do have a policy.

1 in 3

of schools do not have an allergy policy in place





Some schools also describe not having an allergy policy, but having a specific 'Nut Allergy Policy' as part of their position as a no nut school

LOCATION AND ACCESSIBILITY

Schools were asked to provide information about where their allergy policies are located, who they are intended for, and who can access it.

The majority of respondents describe a central location such as a website, shared drive or physical policy folder. Many give locations within other policies, eg First Aid policy.

COWS MILK ALLERGY IS RESPONSIBLE FOR 26% OF FOOD ALLERGY DEATHS IN SCHOOL-AGED CHILDREN, MAKING IT THE MOST COMMON CAUSE OF FATAL FOOD ANAPHYLAXIS AMONG THIS GROUP.

Schools also specified that the policies are held in the catering department, by a catering provider, or 'in the unit manual in the catering manager's office', or otherwise held in a medical room or on a medical noticeboard. Both of these approaches fall short because they aren't accessible to everyone and there's no way to predict if a member of catering or medical teams will be the person with a student having an allergic reaction.

NO NUT POLICIES

Some schools pointed towards 'no nut policies' in place of an allergy policy. Dr Adrian Sie, Consultant in Paediatrics at NHS Lanarkshire says 'a temporary safe bubble in school doesn't reflect day to day life...a child will go to secondary school and there's no way a secondary school can be totally nut free, it's not possible. It's much more sensible to encourage skills and practice them every day'. The largest allergy charities also warn against nut-free schools as they build complacency and less vigilance. While tree and peanut allergies remain one of the top allergies among children, with the potential for severe allergic reactions, Cows Milk Allergy (CMA) is the most common cause of food allergy in the paediatric population. Cows milk allergy is responsible for 26% of food allergy deaths in school-aged children, making it the most common cause of fatal food anaphylaxis among this group. We were unable to identify any example of 'no milk policies'.

PREVIOUS RESEARCH

In a 2022 survey, 39% of teachers didn't know how many pupils had food allergies, and over a third (38%) didn't know how many of their pupils carried adrenaline pens.

In a 2023 survey, 36% either didn't know, or said their school did not have an allergy policy.

15% did not know how many pupils had food allergies in their own class, and 25% weren't sure how many children in the school had allergies, equating to 243,465 teachers.

THE LARGEST ALLERGY CHARITIES ALSO WARN AGAINST NUT-FREE SCHOOLS AS THEY BUILD COMPLACENCY AND LESS VIGILANCE.

WHAT GOOD LOOKS LIKE

THE LEGAL PICTURE

- Accurate information sharing in a school setting is crucial.
- Allergy management relies on up-to-date information on the severity of each child's allergy and the medicines required.
- Policies need to facilitate effective first aid responses.

The Department for Education published guidance for schools, outlining steps they should take to support any pupil with medical conditions (2017). A key aspect was to develop, implement and regularly review a medical support policy. This should contain details regarding the development of individual healthcare plans (IHPs) for pupils with a medical condition, along with clear roles and responsibilities of those supporting them.

In 2019, British Society for Allergy and Clinical Immunology (BSACI) and the Medical Conditions in Schools Alliance, Allergy UK and Anaphylaxis UK, supported by the Department for Education (DfE), produced a Model Allergy Policy for schools, recognising the need for a standalone policy given the prevalence and potential severity of allergic disease.

Requirement 3.46 in the Early Years Framework Stage states: 'Providers must have and implement a policy, and procedures, for administering medicines. It must include systems for obtaining information about a child's needs for medicines, and for keeping this information up-to-date.'

WHAT GOOD LOOKS LIKE

“Schools have a legal duty to support pupils with medical conditions, including allergy. Schools must adhere to legislation and statutory guidance on caring for pupils with medical conditions. Allergy policies and Individual Healthcare Plans are not just pieces of paper. They are important documents for considering and communicating risk, and a school’s process and approach to ensuring a safe environment for a student with an allergy, and how to respond in an allergy emergency.

In 2019, Department for Education backed the creation of a Model Policy for Allergy at School, which was created by several groups including Allergy UK and Anaphylaxis UK. This template policy was designed to support schools to develop a ‘Gold Standard’ policy to manage children’s allergies safely, explicitly focussing on allergy. The policy can be included within a Medical Conditions Policy, or as a standalone policy. It should be read in conjunction with the schools’ Health and Safety Policy as the management of anaphylaxis is integral within the management of First Aid. Designated first aiders will need to have specific training on anaphylaxis and understand their responsibilities in this regard.

In terms of roles and responsibilities, the governing body is required to develop policies to cover their own school. This should be based on a suitable and sufficient risk assessment

carried out by a competent person. The head teacher is responsible for putting the governing body’s policy into practice and for developing detailed procedures. The head teacher should also make sure that parents are aware of the school’s health and safety policy, including arrangements for managing children with allergies and at risk of anaphylaxis.

In 2014, the Children and Families Act 2014 made it a legal duty for schools to make arrangements for pupils with medical conditions to have an Individual Healthcare Plan agreed between the parents and the school. Good practice would be to have an IHP in place for all children with allergies, not only those with a history of anaphylaxis. Alongside these, Allergy Action Plans have been designed to facilitate first aid treatment of anaphylaxis, by either the allergic person or someone else (e.g., parent, teacher, friend) without any special medical training nor equipment apart from access to an AAI. They have been developed following an extensive consultation period with health professionals, support organisations, parents of allergic children and teachers, and the British Society for Allergy & Clinical Immunology (BSACI).”

Simone Miles, Allergy UK

GOOD PRACTICE WOULD BE TO HAVE AN IHP IN PLACE FOR ALL CHILDREN WITH ALLERGIES, NOT ONLY THOSE WITH A HISTORY OF ANAPHYLAXIS.

KEY FINDINGS

1 IN 3 DON'T HAVE A DEDICATED ALLERGY POLICY

In our findings, despite a Department for Education backed Model Allergy Policy being freely available, 1 in 3 schools do not have a standalone allergy policy.

A LACK OF SPECIFIC ALLERGY PLANS

The 2 in 3 schools who said they do have a policy may be referring to a more generic medical conditions policy or first aid policy that may mention allergy, rather than having a standalone allergy section.

LACK OF CLARITY AROUND POLICIES AND GUIDANCE

Allergy policies are crucial documents for the explanation of a school's approach to allergy management and emergency response. As we've heard, it's important these are clear and centrally accessible to all staff.

INCONSISTENT APPROACHES

Schools describe varying approaches to how these policies are published and shared. Some have these on websites, central databases and as part of staff training, others may keep information inside IHPs, with catering teams or medical offices which makes it difficult for the wider school staff to understand what a school's expectations of allergy management are.

PLANS NEED TO BE ACCESSIBLE AND GENUINELY SUPPORT PRACTITIONERS

It's clear there are gaps to increase the number of schools with policies up to 100%, but also for the quality of those policies and visibility of them to be addressed.

1 IN 3 SCHOOLS DON'T HAVE AN ALLERGY POLICY, AND THERE IS VARYING QUALITY AND ACCESSIBILITY FOR THE REMAINING 2 IN 3.

SCHOOLS ARE SOMETIMES KEEPING POLICIES INSIDE INDIVIDUAL HEALTHCARE PLANS, WITH CATERING OR MEDICAL TEAMS, AND NOT IN CENTRAL LOCATIONS.

RECOMMENDATIONS

RECOMMENDATION 2.

ALL SCHOOLS SHOULD HAVE A SPECIFIC ALLERGY POLICY WHICH INCLUDES AN ANAPHYLAXIS PLAN

Allergy is so prevalent, unpredictable and potentially life-threatening that it should be elevated above other conditions for explicit mention in policies, either through a standalone policy or a section within an existing one.

POLICIES SHOULD NOT BE VAGUE

Schools must all develop and publish statutory policies, of which Medical Conditions and Schools is the policy umbrella for all conditions. Historically there has been no explicit mention of any condition, with a fear that it may 'open the floodgates'.

SPECIFIC GUIDANCE IS NEEDED TO ACCOMMODATE ALLERGY RISKS IN SCHOOLS

Allergy is different. It is the most common chronic condition among children, and is one of a only a couple of conditions with the potential to become life threatening or fatal within minutes. The combination of prevalence and risk to life, means it should automatically be elevated above other conditions and pulled out for an explicit mention.

ACCESSIBLE PLANS THAT TRULY SUPPORT TEACHERS AND MAKE PUPILS FEEL SAFE

In 2019, Department for Education recognised the need for allergy policies to be in place, backing a Model Allergy Policy for Schools developed by a group of allergy charities. Despite this, the adoption is not mandatory and our figures show one in three, or almost eight thousand schools, do not have these in place. Of those that do, they are not always accessible or based on good practice.

ALLERGY POLICIES SHOULD BE MANDATORY

This variation is worrying for parents and children, meaning it is a postcode lottery whether a school has this important information available to staff. This should no longer be down to luck, and should be made mandatory as an explicit mention either in a standalone policy or mention within an existing one.

INDIVIDUAL HEALTHCARE PLANS

WHY DO INDIVIDUAL HEALTHCARE PLANS MATTER?

Individual healthcare plans provide a unique opportunity to set out a child's medical condition, their needs, risks and medication in a place that those providing care for them at school can access. In many ways it is the 'download' of knowledge from parent and clinician to the school, so that in their role in loco parentis, they are able to effectively care for that child.

IHPS HELP PROACTIVELY MANAGE ALLERGIES

Allergies are unpredictable in nature, a child who experiences a mild reaction to an allergen on one occasion may experience severe anaphylaxis on another. It's why documents like this that describe what a child's allergies are, how to manage those, and the medication they have been prescribed can be incredibly helpful in those situations. It is particularly important to have an IHP where a child has a history of airborne or contact reactions to an allergen, where their presence in the school can cause harm.

A COLLABORATIVE APPROACH

The co-creation of IHPs is almost as important as the document themselves. It allows a chance for a parent to discuss school scenarios and situations, processes and procedures, and to identify where risk feels appropriate and where it is not. Good practice published in the 'Supporting Pupils with Medical Conditions' suggests that these documents be developed with clinician input, however with wait times for allergy appointments in England at a record high it's often pragmatic to develop plans with the best available information at that time.

THE DECISION-MAKING PROCESS BEHIND THE CREATION OF IHPS

IHPs for medical conditions are covered in the statutory guidance, however schools are given control over which children should have one and those that don't. We wanted to understand the decision making that was taking place in English schools.

WE ASKED

Does your school have an IHP for children with allergies?

We did not ask whether an IHP was in place for every child with allergies.

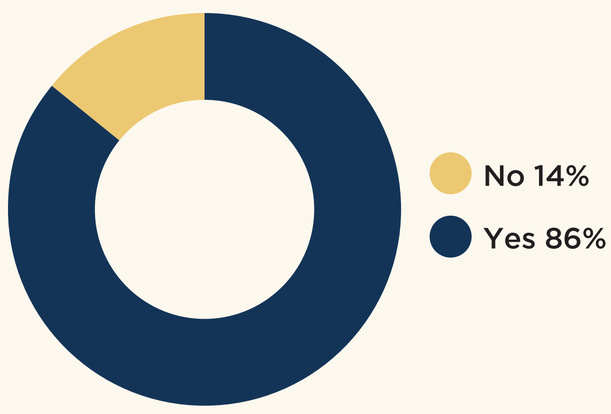
Our objective was to get a reading of how common it was for schools to give IHPs to children with allergies, as opposed to other conditions. We also wanted to see in the qualitative data how IHPs were being created and who for, to give us an awareness of whether schools that did have IHPs for children with allergies were providing them for all children, or only a select few.

We don't have IHPs, there are forms filled out by parents with specific details such as how they react to their allergy, what to do should they have a reaction such as when to contact emergency services etc

Every student within autoinjector has a care plan written by the school nurse with parental consultation kept in their red box

INDIVIDUAL HEALTHCARE PLANS (IHPS)

86% of schools have an IHP for children with a recorded allergy



Typically, IHPs only exist for children with severe allergies

SEVERITY BASED IHPS

Schools will often have IHPs for children with severe allergic reactions, those who have experienced anaphylaxis or those prescribed auto-injectors. This often excludes children without a history of these things, despite these being poor predictors of future allergic reactions.

DIGGING INTO THE DETAIL

Below are comments shared in the responses to the question 'Does your school have an IHP for every child with a recorded allergy?'

We have no children attending school with an IHP and never have done.

IHP for those with epipens. Recorded and highlighted for all allergies however severe.

Depends on severity.

We would put an IHP in place if the allergy was at high risk of being triggered in school.

When we have had children with severe allergies they have had IHPs.

If severe - if low level, then no.

Any child identified with a health issue will have one.

IHPs for those who have medical practitioner input only.

WHAT GOOD LOOKS LIKE

THE LEGAL PICTURE

- **The governing body should develop, implement and regularly review a medical support policy.**
- **A child's mental and physical health should be properly supported in school.**
- **Information about special dietary requirements and food allergies must be obtained before children being admitted to schools so they can put in place safeguards, given that 16% of deaths due to food in UK school children happen in school (Turner et al, JACI 2014).**

In 2017, The Department for Education has issued Statutory Guidance and Departmental Advice (best practice) on "Supporting pupils at school with medical conditions". The governing body of a maintained school, proprietor of an academy and management committee of a pupil referral unit must have regard to the Statutory Guidance in this document. This means that they must follow it unless there is a good reason not to. A key aspect was to develop, implement and regularly review a medical support policy. Contained therein, should be details regarding the development of individual healthcare plans (IHPs) for pupils with a medical condition, along with clear roles and responsibilities of those supporting them.

Section 100 Children and Families Act 2014 places a statutory duty on governing bodies of maintained schools, academies and pupil referral units to make arrangements at school to support pupils with medical conditions. A child's mental and physical health should be properly supported in school, so that the pupil can play a full and active role in school life, remain healthy and achieve their academic potential. Individual healthcare plans provide clarity about what needs to be done, when and by whom, in order to support a child's medical condition. An individual healthcare plan might be appropriate if a medical condition:

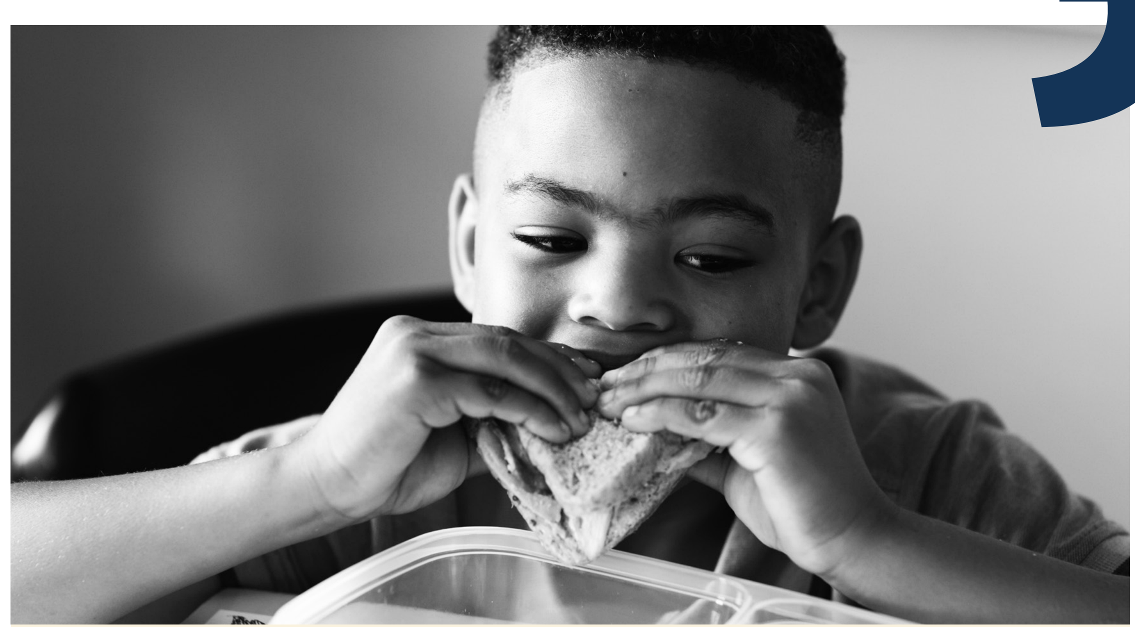
- is long-term and complex;
- fluctuates;
- is a recurring condition; or
- there is a high risk that emergency intervention will be required.

The nature of allergies are that they meet all of those four criteria. Prevention of future deaths reports consistently call for care plans to be made available and updated for each child. One report states '[it's a matter of concern that] care plans are not in place for pupils that require them...That there are delays in issuing care plans. Care plans need to be issued quickly where a child has an allergy.' (Report to Prevent Future Deaths 2017).

For Early Years settings, The Early Years Foundation Stage (EYFS) framework sets out in requirement 3.48 that: Before a child is admitted to the setting the provider must obtain information about any special dietary requirements, preferences and food allergies that the child has, and any special health requirements.

In a 2023 article in The Guardian, Dr Paul Turner, allergy researcher at Imperial, is asked whether someone's food allergies could be either mild or serious, he says, "That's rubbish. Allergy is allergy. 'The unsettling thing is that every food allergy has the potential to cause an anaphylactic reaction even if someone's symptoms are currently not too bothersome'". Turner's research has shown it is extremely difficult to predict who will suffer fatal or near fatal anaphylaxis. Most people who suffer a severe anaphylaxis have had only milder reactions in the past. One of the very few predictors of severe anaphylaxis is that it is more likely to take place after someone has exercised, but no one is suggesting people with allergies should give up exercising.

Bee Wilson, The Guardian



Good practice should mean that every child with an allergy has their own individual healthcare plan. These documents contain vital information about a student's history, allergens, individual needs and risks, and day to day management. his is the most important tool to keep each pupil safe from their known allergies.

Teachers are not clinicians, and it is not reasonable for them to make decisions about whose allergy meets the threshold for an IHP.

If a child has an allergy, they have the potential for a severe reaction and should be treated as such. Allergy meets all four of the criteria for an IHP.

All schools should recognise allergies as medical, not dietary, and implement an IHP for all children regardless of previous severity of reaction. These should be ideally co-created with parents and clinicians, but where clinical information isn't available they should be developed from available information.

KEY FINDINGS

Overall, we would have hoped to see 100% of schools applying IHPs to children with allergy. The 14% who do not may seem low, but represents 3,421 schools serving over a million children.

What became clear from the responses received, is that the 86% of schools providing IHPs were not providing them for every child in the school with a known allergy. They listed several criteria, including:

- Children with medical practitioner input
- Children who have experienced an anaphylactic reaction
- Children prescribed an AAI
- Children with severe allergy

This is a well-meaning approach schools have adopted to follow the Department for Education's guidance about who should have an IHP, and would work for many other conditions. The problem with allergies is that they are unpredictable, and their trajectory is not linear.

A child with an allergy may be waiting for a referral to a clinician - wait times can be very long. They may have been diagnosed with an allergy from a blood test and avoided the allergen from birth, meaning they have no history of anaphylactic reactions. They may also have a clinician that is reluctant to prescribe an AAI. These factors would mean they were potentially not given an IHP, despite allergy in itself meeting the criteria of an IHP for its long term complexity, ability to fluctuate, recurring nature and potential for emergency intervention.

THE PROBLEM WITH ALLERGIES IS THAT THEY ARE UNPREDICTABLE, AND THEIR TRAJECTORY IS NOT LINEAR.

The qualitative data kept coming up with the same sentence, the concept of the 'severe allergy'. We debunked this myth in our 'what good looks like' section, where Dr Paul Turner describes this notion as 'rubbish'. However many schools clearly use the idea of the severe or non-severe reaction as way of deciding whether a child should have an IHP.

Given what we know about allergy, and about the role of individual healthcare plans, there appear to be relatively few scenarios where a child with an allergy would not qualify. These might be in the instances of mild seasonal allergic rhinitis, which schools mention in their responses, '*Children with hayfever for example do not require an IHP*'.

NOT EVERY CHILD WITH AN ALLERGY RECEIVES AN IHP.

SCHOOLS OFTEN MAKE MISGUIDED DECISIONS ABOUT ABOUT WHETHER AN ALLERGY IS 'SEVERE', MEANING PUPILS MISS OUT.

THOSE PUPILS WHO DON'T TICK THE RIGHT BOXES MAY BE PUT AT RISK.

RECOMMENDATIONS

RECOMMENDATION 3.

ALL SCHOOLS SHOULD HAVE AN IHP IN PLACE FOR EVERY CHILD WITH ALLERGY

Children should not be put at risk because they have not historically experienced anaphylaxis, are not currently under secondary care, or have not yet been prescribed an autoinjector. Schools should not have to make clinical decisions due to the misguided idea of 'allergy severity'. Therefore every child with allergy should have an IHP as standard.

STEP AWAY FROM GIVING SCHOOLS DISCRETION IN CREATING IHPs

Department for Education statutory guidance makes it clear how to develop an IHP, and their usefulness. Where this guidance currently falls short is in leaving it open to schools and headteachers to make choices about which pupils do or do not qualify.

ALL CHILDREN WITH ALLERGIES SHOULD HAVE AN IHP

The recommendation is that, to avoid scenarios that have been described where allergy can be seen as 'dietary' or misguided beliefs of 'severe or non-severe' allergy, all children with allergy be provided with an IHP that is co-created.

SCHOOLS SHOULD NOT HAVE TO MAKE CLINICAL DECISIONS

Arbitrary measures such as the medication they've been prescribed, whether they have pediatrician input into their care, or recorded history of anaphylaxis cannot be relied on for making a judgement.

IHPS SHOULD NOT BE LINKED TO 'ALLERGY SEVERITY'

The recommendation is that an IHP should be created for every child with a known allergy using the format outlined by Department for Education.

SPARE ADRENALINE AUTO-INJECTOR PENS (AAIs)

WHY SPARE ADRENALINE AUTO-INJECTOR PENS MATTER

AAIs ARE NEEDED FOR EMERGENCIES

In schools, 30% of allergic reactions take place in children with no diagnosed history of allergy. It's therefore not always possible to rely on a child's own adrenaline auto-injector pen (AAI). Almost 8000 deaths in 2018 mentioned anaphylaxis on their death certificate, showing how significant allergy is. It is now recognised that delays in administering adrenaline arising from problems accessing the child's AAI device can lead to fatalities.

SPARE AAIs SAVE TIME

Currently children may have AAIs held in tupperware boxes in classrooms, or may carry themselves in their bags. Spare AAIs have an important role for these children too. Rummaging for a pen in a child's rucksack and being unable to find one quickly means having a viable, accessible back-up is crucial. It's also important where a child may bring one set from home to school daily, but could then forget.

THE RISK OF DELAYS IN ADMINISTERING ADRENALINE

A survey of schools in the Severn NHS Trust in 2020 found only 36% children had medication available in school. In this study, 44% with an allergic child had no staff trained to administer AAIs.

Following the 2017 legislation in England that allows schools to purchase their own spare pens, it was believed that the majority of schools would seize that opportunity. We want to find out if that's the case.

WE ASKED

Does your school have spare autoinjector pens?

Does your school provide training on administration of an autoinjector / AAI / EpiPen and other allergy medication?

I went in and asked, can you get me the spare AAI? They couldn't find it. The school nurse told them they should have got it. There are no records of around 13 allergic reactions at school.

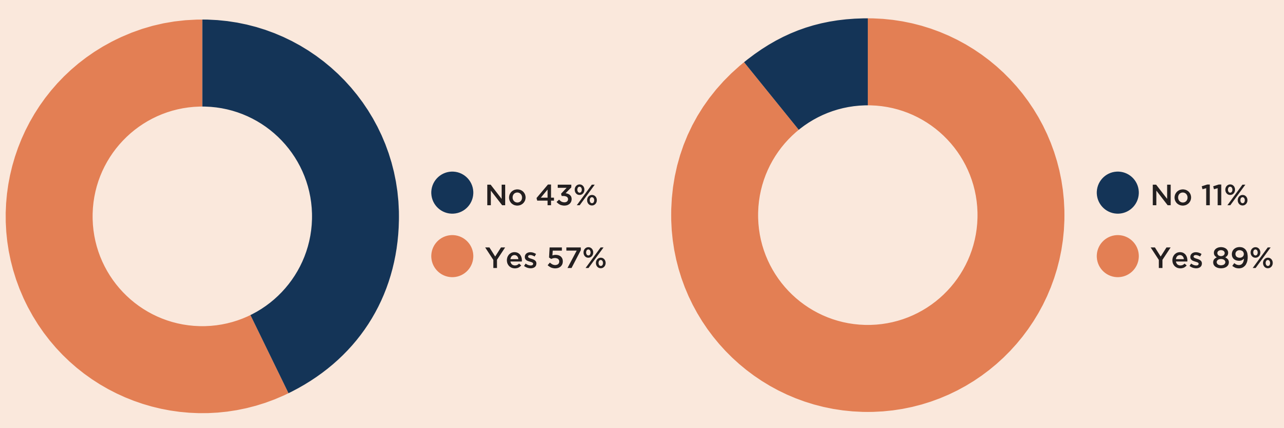
He left his epipen at home that day. Fortunately the school had a spare, if not I dread to think what would have happened.

The first aider had held the AAI upside down and injected herself. I kept querying why the AAIs were in a locked cupboard. My worry was always that someone would misplace the key to lifesaving medicine when a child needed it most.

SPARE PENS

Almost half of schools don't have spare AAIs. For those that do...

...11% don't provide training on administering AAIs



95% of schools with AAIs have either a Good or Outstanding Ofsted rating.

Of Primary schools, 56% have spare AAIs.

Of Secondary schools, 74% have spare AAIs.

WHAT GOOD LOOKS LIKE

COUNTRIES' OUTLOOKS ON MANAGING ALLERGIES

Many countries internationally have mandated AAIs in schools and childcare settings. England still lags behind, in many western countries it is no longer optional to stock AAIs. That's despite England having the highest rate of allergies in the western world.

- Amarria's law requires Virginia public schools to stock AAI auto-injectors for use on any child having a severe allergic reaction by a school nurse or any employee.
- House Bills 4352 and 4353 laws mandate epinephrine auto-injectors in schools for use on any student suffering an allergic reaction and requires staff training.
- Epinephrine Accessibility in MN Schools law ensures Minnesota students have access to epinephrine & individual health plans to keep allergic students safe.
- Elijah's Law requires the education and training of New York day care employees in recognising anaphylaxis and in the proper administration of epinephrine.
- Michigan - bills to provide free AAI training, purchase and administration to prevent deaths like that of a Michigan student who passed away after a reaction on a school bus in 2015.

OUT OF DATE OR MISSING AAIs HAVE BEEN ATTRIBUTED TO FATALITIES

Inquests into the deaths of three pupils between 2016 -17 blamed in part AAIs being out of date and not readily available. Since 2017, new legislation under the Human Medicines (Amendment) Regulations 2017 allows schools to buy two of their own AAI devices, without a prescription. However, guidance explains that these can only be used in an emergency and when the child's own device is unavailable (Department of Health, 2017).

Although schools can now keep their own emergency supply of AAIs, this is not mandatory. Ideally, all pupils should have an Allergy Action Plan which includes consent from a parent/guardian, but this is not required by law "for the purposes of saving a life". Spare AAIs are not intended to replace the need for pupils at risk of anaphylaxis to have their own AAI devices, accompanied by an Allergy Action Plan.

To support schools, the Department of Health and key stakeholders developed non-statutory guidance, which is also available at www.sparepensinschools.uk. This website has been set-up to support schools, parents, pupils/students and healthcare professionals in implementing the guidance to support children with food allergies in schools, and, where appropriate, the use of emergency "spare" AAIs.

ALL PUPILS SHOULD HAVE AN ALLERGY ACTION PLAN WHICH INCLUDES CONSENT FROM A PARENT/GUARDIAN, BUT THIS IS NOT REQUIRED BY LAW "FOR THE PURPOSES OF SAVING A LIFE".

The rise in food allergy among young people is posing a significant risk for schools who can be faced with a life threatening situation requiring urgent action.

One in five fatal food-allergic reactions in children happen at school. Schools can now purchase the first line treatment for an anaphylactic reaction, without a prescription. While not compulsory, we are sure that many schools will take advantage of this change in the interests of their duty of care for those children who are at risk of anaphylaxis. The change is likely to increase awareness and staff training to recognise and treat anaphylaxis in school."

A statement from Anaphylaxis Campaign, Allergy UK, the British Society for Allergy & Clinical Immunology (BSACI), the British Paediatric Allergy Immunity and Infection Group (BPAIIG), and the Royal College of Paediatrics and Child Health (RCPCH) following the passing of legislation in 2017 allowing schools to purchase AAIs.

Spare AAI devices should be stored in an emergency anaphylaxis kit which could also contain an "emergency asthma inhaler kit" (containing a salbutamol inhaler device and spacer)

Many food-allergic children also have asthma, and asthma is a common symptom during food-induced anaphylaxis. Schools should keep a register of pupils at risk of anaphylaxis. It may be helpful to keep this in the Emergency Anaphylaxis kit. Severe anaphylaxis is a time-critical situation: delays in giving adrenaline have been associated with fatal reactions. All AAI devices – including those prescribed to the pupil themselves – must:

- Be accessible at all times, in a safe and central location at room temperature (not in a 'fridge) e.g. school office or staff room. They must NOT be locked away or kept in an office where access is restricted.
- Spare AAIs should not be kept more than 5 minutes away from where they may be needed. In larger schools, more than one kit may be needed.
- In primary schools, keep "spare" AAI separate from any AAIs prescribed to pupils. In secondary schools, pupils should be encouraged to be independent and have their own AAIs with them at all times.
- AAIs should be kept at room temperature (not in a 'fridge) and away from direct sunlight

All AAIs held by the school should be checked on a monthly basis, that they are in date and replaced if needed.

The Department of Health has stated that it is reasonable for ALL staff to:

- be trained to recognise the signs and symptoms of an allergic reaction;
- understand that anaphylaxis can rapidly progress to a life-threatening reaction, so AAI should be given without delay as soon as anaphylaxis occurs;
- know how to access the AAIs, which staff members have received training to administer them and how to contact them in an emergency

Dr Paul Turner, Consultant & Clinician scientist in Paediatric Allergy and Immunology, Imperial College London

KEY FINDINGS

SCHOOLS SHOULD ADOPT THE SPARE PENS SCHEME

Schools have been able to buy spare AAIs for the past six years, with work having gone into providing information and guidance to make this simple for Headteachers and Governors to arrange. It was hoped that the change in legislation would see schools voluntarily adopt the spare pens scheme.

The data show this has not been the case, with almost half of schools still without this lifesaving allergy medication.

Alongside this, 1 in 10 schools does not provide training on administering AAIs.

ALL SCHOOLS NEED RELIABLE EMERGENCY MEDICATION

Because anaphylactic reactions do not always happen in children with a history of anaphylaxis, or those who have been prescribed an AAI, and because AAIs a child brings to and from school can be hard to find (particularly in secondary schools) or out of date, having a reliable back up on the school site is crucial. It's why these figures are so surprising.

The rates of schools with spare AAIs was significantly higher in secondary rather than primary schools.

SPARE AAIs SHOULD BE PART OF THE PICTURE OF GOOD GOVERNANCE IN SCHOOLS

Interestingly, 95% of schools with spare AAIs were rated Ofsted Good or Outstanding. This may be indicative of the difficulty in prioritising allergies when struggling in other areas, and why government taking a role in elevating it up the priority list and allocating funding is so important.

ALMOST HALF OF SCHOOLS DO NOT HAVE SPARE LIFE-SAVING ALLERGY MEDICATION

1 IN 10 SCHOOLS DO NOT PROVIDE TRAINING ON HOW TO ADMINISTER AAIs

SECONDARY SCHOOLS, AND OFSTED GOOD OR OUTSTANDING SCHOOLS ARE MORE LIKELY TO HAVE SPARE PENS

RECOMMENDATIONS

RECOMMENDATION 4.

ALL SCHOOLS SHOULD BE FUNDED TO HOLD AN IN-DATE SPARE AAI WITH ALL STAFF TRAINED IN THEIR USE.

We recommend that in addition, schools have a spare asthma inhaler and antihistamine to create an 'Allergy First Aid Kit' to use in an instance of allergic reaction.

SPARE AAIs SHOULD BE MANDATORY

The 2017 legislation that allows schools to purchase AAIs was in response to two child deaths in school from anaphylaxis. The hope was that schools would grasp this opportunity, however the combination of low awareness and high cost has meant uptake has never moved too far beyond 50/50.

Because voluntary uptake has been slow, it seems pragmatic to move towards mandatory AAIs in English schools to ensure consistent safeguards are in place for all pupils, not only those in more affluent schools.

SCHOOLS SHOULD RECEIVE FUNDING AND TRAINING

In 2023, Department for Education funded the roll-out of defibrillators to all English schools following the death of Oliver King, an investment of £18 million. There have been four high profile child fatalities due to anaphylaxis in English schools. The cost of a similar programme funding the rollout of AAIs using the £90 cost point would be just over £2 million, with an 18 month manufacturer shelf life.

The recommendation is that it should be mandatory for all schools to hold an in-date spare set of adrenaline auto injector pens, with all staff trained in their use and for this to be fully funded.

TRAINING

WHY TRAINING IS IMPORTANT

Allergy policies and individual healthcare plans can describe actions and protocols for various predictable scenarios and situations, however the school environment is not predictable. Giving school staff the knowledge that they can apply to a variety of environments, children and situations is likely to provide the best chance for identifying and preventing an allergic reaction and also being ready to react when one occurs.

THE CONFIDENCE TO RESPOND IN EMERGENCIES

As the number of children with allergies increases, the volume of children in different parts of the school site with allergies means it's not longer viable for one or two members of staff to understand and be confident in preventing and responding to an allergic reaction.

It's important that adults can recognise and respond to allergies in an emergency, which is why we asked questions to understand whether schools provided training in these areas, but also to know more about the prevention training they offer.

SAFEGUARDING CHILDREN WITH ALLERGIES

The reason training is so important is that it provides the knowledge of how to interpret and uses other safeguards, such as AAIs, allergy policies and IHPs, as well as how to respond in any situation.

GIVING SCHOOL STAFF THE KNOWLEDGE THAT THEY CAN APPLY TO A VARIETY OF ENVIRONMENTS, CHILDREN AND SITUATIONS IS LIKELY TO PROVIDE THE BEST CHANCE FOR IDENTIFYING AND PREVENTING AN ALLERGIC REACTION AND ALSO BEING READY TO REACT WHEN ONE OCCURS.

WE ASKED

Do you provide allergy training to your staff?

What topics does your allergy training cover?

Laura Squire, the MHRA's chief officer for healthcare quality and access, said:
"These figures [about increases in hospital admissions due to allergy] highlight just how serious the consequences of allergies can be, and the rising numbers of hospitalisations highlight the need to know how to act in an emergency."

The teacher waved the AAI in the air and said, "if you need a bit of this love, come and find me.

I would really like proper training, but they won't do anything for us.

It was near home time and a staff member ran across the playground when she saw me and exclaimed, 'quick, he is having an allergic reaction and we don't know what to do!

25% OF SCHOOLS DON'T TRAIN THEIR STAFF ON IDENTIFYING ALLERGY SYMPTOMS AND ANAPHYLAXIS AND WHAT TO IN AN EMERGENCY

75% Identifying allergy symptoms and anaphylaxis

73% What to do in an allergy emergency

63% The medication students might be carrying and how to use it (JextPen, Emerade, Certirizine et al)

50% Communicating allergies with parents, other teachers, caterers

46% How to manage off-site activities like school trips and sports fixtures

39% How to manage in-school activities like cooking lessons, science lessons or bringing animals etc into the classroom

37% Supporting pupil well-being through inclusion

28% The impact of a food allergy on a pupil's day-to-day life

21% Understanding the science of food allergy

WHO RECEIVES TRAINING?

We did not ask all schools this question, however many provided information in comments. For schools where they did not train all of their staff, those they chose to fund training for were:

- First aiders
- Catering staff
- SEN staff
- Food technology staff

4 IN 10 ARE NOT CONFIDENT IN THEIR ABILITY TO RESPOND IN AN EMERGENCY

This correlates with a 2023 survey that found 1 in 3 teachers had never received any allergy or anaphylaxis training. This is not surprising as a school may provide training to a select number of staff, not always those providing direct care for a child with allergies. In the same survey, 4 in 10 teachers would not describe themselves as confident in their ability to respond to a situation where a child was displaying signs of allergic reaction or anaphylaxis. There is a need to support teachers to feel more confident. In survey carried out across 157 teachers in Cumbria, 81% believed further training was needed.

VARIATION IN TRAINING

There were different approaches taken to the frequency of training, one school commented 'a large group are due for the 3 year refresher training in Summer 24', indicating a 3 year training cycle.

KEEPING CHILDREN SAFE

It is a statutory requirement that all schools that are monitored by Ofsted and provide early years education have at least one member of staff that is paediatric first aid trained which must include anaphylaxis treatment and medication administration. However data shows that 11% and 15% of schools do not provide training on identifying allergy symptoms and anaphylaxis, and administration of AAI medication respectively. Ofsted's role in keeping children safe in education means that they would be best placed to ensure adherence to statutory guidance.

WHAT GOOD LOOKS LIKE

ENGLAND LAGS BEHIND OTHER COUNTRIES' OUTLOOKS ON MANAGING ALLERGIES

- The governing body ensures arrangements give parents and pupils the confidence to know they are in safe hands.
- These arrangements should reflect an understanding of how medical conditions impact a child's ability to learn. In order to increase confidence, staff should be properly trained to provide this support.

Section 100 Medical Supporting Pupils at School with Medical Conditions states 'The governing body should ensure that its arrangements give parents and pupils confidence in the school's ability to provide effective support for medical conditions in school. The arrangements should show an understanding of how medical conditions impact on a child's ability to learn, as well as increase confidence and promote self-care. They should ensure that staff are properly trained to provide the support that pupils need'.

There are national minimum standards that early years providers must meet, such as the Early Years Foundation Stage statutory framework in England. Requirement 3.46 in the EYFS states: Training must be provided for staff where the administration of medicine requires medical or technical knowledge. The EYFS also states that 'at least one person who has a current paediatric first aid (PFA) certificate must be on the premises and available at all times when children are present, and must accompany children on outings. The certificate must be for a full course consistent with the criteria set out in Annex on contents of a PFA certificate including being able to help a baby or child suffering from anaphylactic shock.

All schools and Ofsted-registered early years providers must follow the EYFS, including childminders, preschools, nurseries and school reception classes, however once a child joins KS1 this statutory requirement does not apply.

Legislation to mandate allergy training has been implemented in USA and Canada for 18 years. Examples include:

- The Allison Rose Suhy Act incentivises Ohio schools to train staff and students on food allergies by qualifying teachers to receive continuing education.
- Sabrina's Law requires Canadian schools to provide allergy and adrenaline auto-injector training for teachers and staff.
- Elijah's Law requires the education and training of New York day care employees in recognising anaphylaxis and in the proper administration of adrenaline.

WHAT GOOD LOOKS LIKE

The School and Public Health Nurses Association (SAPHNA) recognises the importance of staff in schools and education settings having the knowledge to confidently manage medical conditions, in particular allergy. Schools have seen a surge in pupils with non-IGE and IGE allergies over the past decade. School nurses have a key role in supporting education in their mandatory functions, including meeting the needs of pupils with medical needs. They may work in collaboration with other health professionals to ensure that the child or young person, their parents and school staff have access to the appropriate advice and support whilst in school or engaged in school activities.

Schools have a statutory responsibility to support children with medical conditions in schools, however the way this legal requirement is interpreted and put into practice varies from school to school. It is our belief that robust knowledge about emergency response, including recognising symptoms of an allergic reaction and anaphylaxis, and the administration of allergy medication including AAIs should be universally delivered to all school staff. Allergic reactions are not reliable, and the likelihood is that a child or young person will not be with the one or two trained staff members at the time of a reaction.

Beyond that, the statutory guidance states governors should make provision for staff to understand how medical conditions may affect a child's ability to learn. Training and education should therefore be provided on this subject, giving school staff knowledge of the day to day impact of allergies on a child or young person's life.

In a school environment, children have various scenarios where they may come into contact with an allergen. The dining hall, school trips, science experiments, food lessons, and classroom activities are all rich experiences for a child or young person but also a source of potential risk. School nurses may work with schools to help them consider how to manage different situations based on our knowledge of how allergies work and manifest, and so training and education on these points and the day to day management of allergies in the classroom and on school trips must be available to staff to enable them to apply the knowledge to all new events as they arise. It is also important for schools to ensure that they have Individual Health Care Plans and emergency medications that are available and current to support the child or young person if an allergic reaction should occur.

In Early Years, the statutory requirements on schools are more rigorous - requiring that at least one person with paediatric first aid training is available at all times and trained to administer medication. Sadly this isn't the case for the wider school population, although the risk of allergic reaction remains the same.

Sharon White, SAPHNA (School And Public Health Nurses Association)

KEY FINDINGS

ONLY AROUND ONE THIRD OF SCHOOLS EDUCATE STAFF ON THE IMPACT OF ALLERGIES ON PUPILS

Statutory guidance states that schools must make arrangement for school staff to understand 'how medical conditions impact on a child's ability to learn' however, when asked, only 28% of schools provided training on the impact of allergy on a pupil's life.

GREATER UPTAKE OF ALLERGY AND ANAPHYLAXIS TRAINING IS NEEDED

Schools are expected to provide training on paediatric first aid to at least one member of staff which covers allergy and anaphylaxis training as part of the EYFS Framework. We would expect any school with reception aged children to therefore be reporting 100% rates of training in order to adhere to statutory guidance. It's surprising therefore that the equivalent of 1,500 English schools said they did not provide any allergy training and of those that did, 25% did not provide training on recognising allergic reaction symptoms.

TEACHERS NEED GREATER CONFIDENCE IN IDENTIFYING AND MANAGING ALLERGIC REACTIONS

The striking finding was how little education and training is provided to members of school staff charged with keeping children with allergies safe. It's no surprise that two in five of teachers when surveyed said they didn't feel confident managing an allergic reaction. It's also surprising how low the figures are for schools providing any training on what allergy is, what it feels like to have one, and how to manage allergies in a variety of situations.

PREVENTION NEEDS TO BE PRIORITISED

The most obvious observation is that energy is focussed far more on emergency response than on prevention, and increasing prevention training may be the best way of reducing the volume of allergic reactions in school.

TOTAL NUMBER OF SCHOOL STAFF TRAINED IN ALLERGY IS LOW.

THAT NUMBER DROPS FURTHER WHEN LOOKING AT ALLERGY MANAGEMENT AND PREVENTION.

SCHOOLS AREN'T ALWAYS FULFILLING THEIR STATUTORY RESPONSIBILITIES, LET ALONE ADHERING TO GOOD PRACTICE.

RECOMMENDATIONS

RECOMMENDATION 5.

ALL SCHOOL STAFF SHOULD BE TRAINED IN ALLERGY AWARENESS, MANAGEMENT AND EMERGENCY RESPONSE

However a framework should be developed by key allergy stakeholders to define 'what good looks like' to enable schools to make informed choices about the training they choose.

THE IMPACT OF ALLERGIES ON PUPILS SHOULD BE UNDERSTOOD BY STAFF

Education and training gives us an understanding that we can apply to various situations. Without that understanding, people fill in the gaps.

EMERGENCY RESPONSES MUST BE PRE-DEFINED AND UNDERSTOOD

This is when we hear of stories where schools take a child's set of two AAI pens and split them across two locations in the school.

They feel that they're managing risk, because they're not educated in the reasons why both are kept together (in the case of the first jamming, but also because a second may be given just 5 minutes after the first). Had those individuals been properly trained, they would have been able to make more informed decisions.

ALL SCHOOL STAFF BE TRAINED IN EMERGENCY RESPONSE

Allergic reactions can take place anywhere at any time, and while we advocate for every member of staff to be trained in emergency response, we also know that every adult and pupil has a role in prevention and management. It's therefore crucial that best practice is established, understood and widely shared.

FURTHER RECOMMENDATIONS

National and international guidelines all contend that schools should implement staff training in the prevention, recognition, and treatment of allergic reactions to food. However, the extent and quality of research evidence supporting the recommendations remains low. Most of the research evidence comes from the USA and Europe.

ALLERGY AWARENESS TOOLKITS RAISE AWARENESS AND CONFIDENCE

Two studies have been conducted in UK schools that investigate staff training and education. A follow-up study by Raptis and colleagues in 18 of the schools in Cumbria investigated the impact of a face-to-face training intervention on food allergy preparedness and found it enhanced staff preparedness in managing pupils with food allergy.In London and South-West England, allergy awareness toolkits were piloted in secondary schools. Findings were positive, and raised awareness in pupils with and without allergies.

A WHOLE SCHOOL APPROACH

The researchers suggest training staff in emergency AAI administration alone is insufficient and a whole-school approach to training and education is necessary to reduce risk of reactions and foster a more accepting societal attitude.

TRAINING SHOULD BE ROBUST TO GIVE EVERYONE PEACE OF MIND

The data show that schools are commissioning training of varying lengths and content. When a parent asks a school 'are your staff trained in allergy?' they may receive a 'yes', but not know what that training has covered and how prepared the staff are to prevent an allergic reaction or know how to manage it in a variety of situations.

IMPROVE PUPIL SAFETY THROUGH FURTHER RESEARCH

Two key recommendations are therefore that an evidence base be established to demonstrate the efficacy of allergy training as a way of increasing knowledge, and competence in managing allergic reactions. Also for the allergy community collaborate to develop a set of School Allergy Education Standards to help schools navigate the training available, and parents to be reassured schools have received comprehensive education.

THE RESEARCHERS SUGGEST TRAINING STAFF IN EMERGENCY AAI ADMINISTRATION ALONE IS INSUFFICIENT AND A WHOLE-SCHOOL APPROACH TO TRAINING AND EDUCATION IS NECESSARY

1. **A CONTROLLED STUDY INTO THE EFFICACY OF ALLERGY EDUCATION AS A TOOL FOR IMPROVING PUPIL SAFETY**
2. **DEVELOPMENT OF A SET OF SCHOOL ALLERGY EDUCATION STANDARDS**

RECOMMENDATIONS

PRIORITIES FOR CHANGE

As a result of the findings from this report, we would like to see:

1. **Policymakers and government react to the findings by implementing new safeguards to protect pupils with allergies**

2. **Schools, Headteachers and Governors recognise the gaps in their allergy-safe provision and to take proactive steps to close them to keep children with allergies safe**

3. **Funding for schools to implement measures, and checks to ensure statutory requirements are in place**

These priorities for change see a shift at central government level as well as individual school level, with the funding to make it possible.

Following Sabrina's Law in 2021, research showed significantly better consistency of policies and better technique in administering medication. Implementing new safeguards along similar lines would address some of the variance or 'postcode lottery' outlined in this report. These are outlined on pg 53.

There does though need to be change at all levels, with schools being properly funded and supported to proactively recognise and address gaps in their allergy management. Parents too have a role to play in keeping their own child, and others, protected from allergic reactions.

Successfully keeping a child with allergies safe goes beyond a 'whole school approach' and must be a priority of the whole education system.

RECOMMENDATIONS FOR POLICYMAKERS

LONG TERM

Take proactive steps to safeguard children with allergies by implementing a range of protective measures

Implement measures outlined in page 53 of this report, including amendments to legislation to explicitly mention allergy policies and IHPs for all children with allergy. Fully fund the roll-out of allergy training and spare pens. Establish a Schools Allergy Reaction Register.

MID TERM

Provide targeted support to improve culture and awareness of allergy across education

Provide communications to schools that demonstrate the importance of allergy safety and keeping pupils with allergy safe in schools to support a wider culture change in schools.

SHORT TERM

Ensure schools are aware of their statutory responsibilities and highlight good practice

Share examples of good practice with schools via targeted comms, including reminding Governors, Headteachers and school staff of their statutory responsibilities.

RECOMMENDATIONS OF SPECIFIC SAFEGUARDS TO IMPLEMENT

SCHOOLS SHOULD REPORT ALL KNOWN INSTANCES OF ALLERGIC REACTION AND NEAR MISS	Allergic reactions will happen, and not all are preventable. Keeping track of this is not intended to put blame onto schools, but to identify those with a higher prevalence of allergic reactions and therefore a need for greater support.
ALL SCHOOLS SHOULD HAVE A SPECIFIC ALLERGY POLICY WHICH INCLUDES AN ANAPHYLAXIS PLAN	Allergy is so prevalent, unpredictable and potentially life-threatening that it should be elevated above other conditions for explicit mention in policies, either through a standalone policy or a section within an existing one.
ALL SCHOOLS SHOULD HAVE AN IHP IN PLACE FOR EVERY CHILD WITH ALLERGY	Children should not be put at risk because they have not historically experienced anaphylaxis, are not currently under secondary care, or have not yet been prescribed an autoinjector. Schools should not have to make clinical decisions due to the misguided idea of 'allergy severity'. Every child with allergy should have an IHP as standard.
ALL SCHOOLS SHOULD BE FUNDED TO HOLD AN IN-DATE SPARE AAI WITH ALL STAFF TRAINED IN THEIR USE	We recommend that in addition, schools have a spare asthma inhaler and antihistamine to create an 'Allergy First Aid Kit' to use in an instance of allergic reaction.
ALL SCHOOL STAFF SHOULD BE TRAINED IN ALLERGY AWARENESS, MANAGEMENT AND EMERGENCY RESPONSE	A framework should be developed by key allergy stakeholders to define 'what good looks like' to enable schools to make informed choices about the training they choose.

RECOMMENDATIONS FOR SCHOOLS, HEADTEACHERS AND GOVERNORS

Familiarise yourself with your legal responsibilities and outlined good practice. The Schools Allergy Code is backed by Department for Education and provides a helpful checklist.

- **Where budgets allow, make a school 'Allergy Kit'** by buying your own spare AAIs, inhalers and antihistamines. Details on how, including template letters for pharmacies and roles and responsibilities can be found at www.sparepensinschools.uk.
- **At your next inset day, or your next training, put allergy on the agenda** - focus on emergency response and administering an AAI, alongside the fundamental principles of prevention.
- **Review your current system for parents communicating an allergic reaction** or near miss, and your way of logging these. Find a central location and begin recording this information.
- **If you do not have an allergy policy, create one now.** Also review one if you have one. BSACI's Model Allergy Policy gives you a template to work from.
- **If you are aware of children in the school with an allergy** not covered by an IHP, work with their family to put one in place.
- **To make this manageable, it can be helpful to nominate a designated 'Allergy Lead'.** Although it's a whole school approach that keeps children with allergies safe, it can be helpful to have one point of contact with an eye always on allergy safety.

RECOMMENDATIONS FOR PARENTS

The contents of this report may feel worrying. However you can use the findings to communicate with your child's school the ways that they can implement allergy-safe policies and processes. We suggest sharing a copy of this report with your child's school.

- **Draw the school's attention to examples of good practice** outlined in this report, but also The Schools Allergy Code which is backed by Department for Education. This document gives clear guidance as well as a helpful checklist for them to identify any gaps they have.
- **If your school is unable to afford some of the measures outlined in this report, speak to the PTA** (Parent Teacher Association) and other parents to explore the fundraising options open to you and the school for raising the money.
- **Ensure you communicate clearly in writing your child's allergies, allergy medication and how to manage it on a daily basis** - ask your school if they have a template for producing an individual healthcare plan. If your child is under a clinician, ask if they can provide an Allergy Action Plan for the school to hold.
- **Ensure any instances of allergic reactions are logged** by the school and request that any near-misses are also recorded.

WE SUGGEST SHARING A COPY OF THIS REPORT WITH YOUR CHILD'S SCHOOL.

APPROACH, REFERENCES & DEFINITIONS

METHODOLOGY

Freedom of information (FOI) requests were submitted to 20,653 English schools in two requests – one in October 2023, one in January 2024.

Schools analysed as part of this research are: primary and secondary state schools including community, voluntary, foundation, free, grammar schools and academies.

The findings relate to English schools only, with no data submitted from schools across Scotland, Wales and Northern Ireland.

Schools were asked quantitative and qualitative questions intended to improve understanding of allergy management measures they have in place, the prevalence of allergic reactions, and near misses. Their responses were gathered using a combination of email and via an online survey link. These were extracted and cleansed to provide a clean data set.

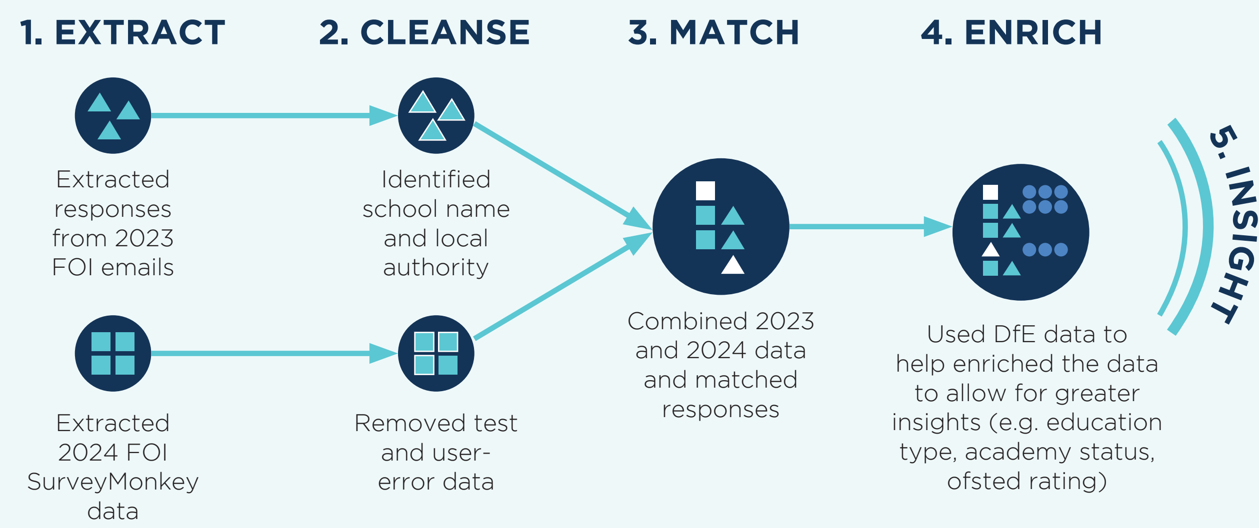
To enrich the data, information provided by the Department for Education about a school's education type, Ofsted rating, academy status, etc, was factored in to enhance the findings.

This complete enriched data set of findings were then analysed and compared against published 'good practice' and minimum requirements laid out in this document.

To add context to the findings from the FOI responses, they have been compared against available research that has taken place within the same time period as this review.

Correlations and contradictions have been identified and raised throughout the report, and brought to life through qualitative input.

Incomplete or partial responses from schools may produce certain biases within the data.



KEY TERMS IN THE REACT REPORT

Adrenaline Auto-Injector Pens (AAIs)
Adrenaline is a hormone released in response to stress. The pen injects adrenaline to reverse the effect of a severe allergic reaction.

Airborne allergy
Where an allergic reaction can occur when the allergen is inhaled through the airways.

Allergen
A substance which can cause an allergic reaction. You can be exposed to allergens by inhaling (airborne allergens); eating (food allergens); or injecting (through medicines or insect stings).

Allergy
An allergy can be caused by a wide range of allergens. Symptoms vary from mild to potentially life threatening.

Allergy UK
A charity engaging with all people affected by allergic disease, campaigning that it is time to take allergies seriously.

Anaphylaxis
A severe allergic reaction involving throat swelling, closing of the airways, and risks to heart function and high blood pressure, which requires an emergency response.

Anaphylaxis UK
A charity dedicated to supporting people living with serious allergies for 30 years, offering evidence-based information for individuals and their families, for businesses and for schools and other places of education.

BSACI
British Society for Allergy & Clinical Immunology

Certirizine
An anti-histamine medication that is used by some to control their allergies.

Emerade
A type of auto-injector pen.

EpiPens
A type of auto-injector pen.

EYFS Framework
The Early Years Foundation Stage Framework provides the standards that school and childcare providers must meet for the learning, development and care of children from birth to 5.

IGE allergies
An IgE food allergy is where your immune system overreacts to an allergen by producing antibodies called Immunoglobulin E (IgE), often characterised by the rapid onset of symptoms following ingestion (such as anaphylaxis).

Individual Healthcare Plan (IHPs)
Independent healthcare plans are developed in partnership between the school, parents, pupils and relevant healthcare professional. This agrees how to support your child effectively and provides clarity about what needs to be done, when and by whom.

ISBA
A national association representing school bursars and business managers of independent schools, providing them with the professional support they need to manage their schools successfully and provide a world class education to their pupils.

JextPen
A type of auto-injector pen.

Near miss
A near miss is an unplanned event that does not cause injury or damage, but could do so. Suitable information and training should be given to all personnel regarding accident management, emergency response and incident reporting. All accidents should be reported, recorded and reviewed. Unless the school is informed of incidents, it will be unable to identify what is wrong and take remedial action.

Non-IGE allergies

These are allergies where reactions may not appear immediately after the ingestion of food and usually relate to reactions in the gastrointestinal tract, such as vomiting, bloating and diarrhoea.

PFA

Paediatric first aid

School and Public Health Nurses Association (SAPHNA)

School and Public Health Nurses Association works towards its vision of enhancing the profession through professional growth and development, therefore, improving the health and well-being of children and young people.

The British Paediatric Allergy Immunity and Infection Group (BPAIIG)

The British Paediatric Allergy, Immunity and Infection Group (BPAIIG) is an affiliated speciality group of the Royal College of Paediatrics and Child Health (RCPCH) . Members of the BPAIIG are actively involved in the clinical care of children as well as in research and development of new methods of investigation and treatment of allergic, immune and infectious conditions.

The British Society for Allergy & Clinical Immunology (BSACI)

An organisation of healthcare professionals dedicated to improving allergy care through education, training and research.

The Royal College of Paediatrics and Child Health (RCPCH)

The Royal College of Paediatrics and Child Health, the membership body for paediatricians in the UK and around the world.

The Schools Allergy Code

Backed by the Department for Education, this Code sets out best practice and should be implemented by every school. Developed by Benedict Blythe Foundation, The Allergy Team and ISBA.

REFERENCES

Pg	Source/ reference/ further detail
4	*The last 20 years and this has led to hospitalisations due to allergy nearly doubling in that period* – Turner et al, Food anaphylaxis in the United Kingdom: analysis of national data, 1998-2018.
	1-2 children in every class size have an allergy - Based on stat of 7-8% children worldwide, and an average class size of 25-27 in England. (Santos et al., 2022).
	Children miss half a million days of school – In a 2024 survey of parents by The Allergy Team, 48% said their child had missed at least one day of school due to their allergies. 28 (10%) said their child had missed more than six days of school due to their allergies, 59 (21%) had missed 3 or more days. Calculated based on 680,000 children having an allergy.
	680,000 – 2022/23 government figures state there are 9,073,832 pupils in English schools. Based on 7.5% pupils having an allergy (Santos et al., 2022)., this gives us 680,537.4, we have chosen to use a rounded figure in this report.
5	*18% of allergic reactions take place in school* – Higgs et al., 2021.
	An estimated 45,000 children were born with allergy in 2022 – Calculated based on 7.5% of the 605,479 births in the UK in 2022.
	Anaphylaxis happens more in school than in any other setting outside the home - Muraro et al., 2014.
12	*Would at least have one accidental reaction every 2-3 years* – Spare Pens in Schools.
14	NHS Trusts (acute hospital and ambulance trusts) were asked to provide information on the number of school aged children either conveyed to hospital via ambulance, or self-presenting in A&E, exhibiting allergic symptoms during school hours.
	32,000 admissions - 170 Type 1 Major A&E Departments x 190 average children admitted with an allergy during school time = 32,300.
	38,000 admissions - 170 A&E Departments x 223 = 37,910.
	Based on this, the estimated schooltime A&E admissions due to allergy per year would be c. 32,000 (170 Type 1 Major A&E Departments x 190 average children admitted with an allergy during school time = 32,300)
	The lowest year was still 2020 for admissions. The average A&E admissions per hospital post-pandemic (based on 2022 only) was 223. Based on this, this would give an annual figure of c.38,000 (170 A&E Departments x 223 = 37,910).
15	Health and Safety at Work etc Act 1974.
	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR 2013).
17	*In a 2024 survey* – The Allergy Team Parents Survey 2024.
	Cows Milk Allergy (CMA) is the most common cause of food allergy in the paediatric population - (Schoemaker et al 2015, Meyer 2018).

REFERENCES CONTINUED

Pg **Source/ reference/ further detail**

17 *Cows milk allergy is responsible for 26% of food allergy deaths in school-aged children* (Turner et al 2021 - Food anaphylaxis in the United Kingdom: analysis of national data).

In a 2022 survey, 39% of teachers didn't know how many pupils had food allergies – Teacher Survey, The Allergy Team.

In a 2023 survey, 36% either didn't know, or said their school did not have an allergy policy - Teacher Survey 2023, Benedict Blythe Foundation.

23 *Supporting Pupils at School with Medical Conditions* – Department for Education.

Model Allergy Policy for Schools 2019, British Society for Allergy and Clinical Immunology (BSACI) and the Medical Conditions in Schools Alliance, Allergy UK and Anaphylaxis UK, supported by the Department for Education (DfE).

Early Years Framework Stage Requirement 3.46, Department for Education.

26 *Most common chronic condition among children* – (EAACI, 2016).

8000 schools -1/3 as a figure of 24,442 schools, Department for Education Headline facts and figures –2022/23.

32 3,421 schools serving over a million children – (9,073,832 / 24,442 = 371 average, x 3,421 = 1,270,009 calculations are based on stats provided by DfE 2022/23.

33 *Misguided idea of 'allergy severity'.* – Dr Paul Turner Guardian 'It's one of the great mysteries of our time' July 15, 2023

Where this guidance currently falls short - Supporting Pupils at School with Medical Conditions – Department for Education

35 *In schools 30% of allergic reactions take place in children with no diagnosed history of allergy* - (Santos et al., 2022)

Almost 8000 deaths in 2018 mentioned anaphylaxis on their death certificate – figures provided by Mortality team, Health Analysis and Life Events Division, Office for National Statistics

Now recognised that delays in administering adrenaline arising from problems accessing the child's AAI device can lead to fatalities – Dr Turner & MHRA Guidance 2017

A survey of schools in the Severn NHS Trust in 2020 found only 36% children had medication available in school. In this study, 44% with an allergic child had no staff trained to administer AAIs. - Watura JC Nut allergy in schoolchildren: a survey of schools in the Severn NHS Trust

36 *95% of schools with AAIs have either a Good or Outstanding Ofsted rating* – Institute of Clever Stuff comparison of Freedom of Information data collated by Benedict Blythe Foundation 2024, with Department for Education published data on school Ofsted ratings.

Of Primary schools, 56% have spare AAIs – Data analysed by Institute of Clever Stuff taken from FOI data collected by Benedict Blythe Foundation 2024

Of Secondary schools, 74% have spare AAIs – Data analysed by Institute of Clever Stuff taken from FOI data collected by Benedict Blythe Foundation 2024

37 *Inquests into the deaths of three pupils between 2016 -17*, Prevention of future deaths reports, Courts and Tribunals Judiciary

38 *One in five fatal food-allergic reactions in children happen at school* – Turner et Al 2020, Keeping food-allergic children safe in our schools—Time for urgent action

39 *Almost half of schools do not have spare life-saving allergy medication, 1 in 10 schools do not provide training on how to administer AAIs* - Benedict Blythe Foundation Freedom of Information data 2024

Secondary schools, and ofsted good or outstanding schools are more likely to have spare pens – comparison of FOI data and DfE Ofsted ratings

40 *The 2017 legislation* - Human Medicines (Amendment) Regulations 2017

Roll out of defibrillators - Automated External Defibrillators Bill 2022

The number of children with allergies increases - NHS Digital figures 2019

43 *4 in 10 are not confident in their ability to respond in an emergency*-Teacher Survey 2023, Benedict Blythe Foundation

This correlates with a 2023 survey that found 1 in 3 teachers had never received any allergy or anaphylaxis training. – Teacher Survey 2023, Benedict Blythe Foundation

157 teachers in Cumbria, 81% believed further training was needed- Raptis et al, 2019, A survey of school's preparedness for managing anaphylaxis in pupils with food allergy

It is a statutory requirement that all schools that are monitored by Ofsted - Early Years Foundation Stage (EYFS) Statutory Framework

48 *A follow up study by Raptis* - Raptis et al, 2019, A survey of school's preparedness for managing anaphylaxis in pupils with food allergy

Following Sabrina's Law in 2021, research showed, Cicutto 2012, Comparing School Environments With and Without Legislation for the Prevention and Management of Anaphylaxis

RESPONSE

Total responses and response rate per question

Question	2023 FOI emails (FOI1)	2024 FOI emails (FOI2)
Have you completed the FOI questions about allergy management sent by Benedict Blythe Foundation in 2023?	N/A	100% (1,812)
Number of recorded instances of allergic reaction that took place in your pupils during school time	90% (348)	78% (1,420)
Recorded number of 'near misses' where children came into contact with an allergen without reaction	86% (332)	79% (1,425)
Number of instances where an ambulance was called in response to a child's allergic reaction	92% (355)	79% (1,439)
Does your school have an allergy policy in place?	99% (381)	72% (1,298)
Does your school have an allergy policy in place? Other (please specify)	N/A	23% (422)
Does your school have an IHP for every child with a recorded allergy?	97% (375)	77% (1,391)
Does your school have an IHP for every child with a recorded allergy? Other (please specify)	N/A	10% (182)
Does your school have spare autoinjector pens?	98% (379)	80% (1,455)
Does your school provide allergy training to staff?	99% (382)	80% (1,448)
Do you routinely record instances of allergic reactions?	N/A	87% (1,570)
Do you routinely record instances of allergic reactions? Other (please specify)	N/A	17% (312)
Do you routinely record near misses?	N/A	87% (1,569)
Do you routinely record near misses? Other (please specify)	N/A	19% (343)
Do you routinely record instances of ambulances being called in response to a child's allergic reaction?	N/A	87% (1,569)
Do you routinely record instances of ambulances being called in response to a child's allergic reaction? Other (please specify)	N/A	20% (363)
If you responded to FOI1 stating your school does have an allergy policy in place, please describe where the policy is located, who it is intended for and who can access it. If your school does not have an allergy policy, respond NA to this question	N/A	87% (1,569)
If you responded to FOI1 stating your school does provide allergy training to teachers and school staff, please select from the list below what the training covers:		
Identifying allergy symptoms and anaphylaxis	N/A	75% (1,350)
Administration of an autoinjector/ AAI/ EpiPen and other allergy medication	N/A	77% (1,398)
Understanding the science of food allergy	N/A	21% (388)
How to manage in-school activities like cooking lessons, science lessons or bringing animals etc into the classroom	N/A	38% (694)
How to manage off-site activities like school trips and sports fixtures	N/A	45% (824)
The impact of a food allergy on a pupil's day-to-day life	N/A	30% (551)
The medication students might be carrying and how to use it (JextPen, Emerade, Certirizine et al)	N/A	63% (1,142)
Supporting pupil well-being through inclusion	N/A	37% (676)
Communicating allergies with parents, other teachers, caterers	N/A	50% (909)
What to do in an allergy emergency	N/A	72% (1,311)
NA - responded 'no' to FOI1	N/A	7% (133)
If you responded to FOI1 stating that your school provides allergy training, please indicate the number of teachers in your school that have received this training within the last 18 months. If you responded no to FOI1, please type NA	N/A	87% (1,569)

Note: There were a total of 1,964 survey responses (FOI2), however 152 responses were removed due to either duplicate entries from schools, test responses or user-error related. For duplications, those with the least number of responses removed.

Disclaimer: Incomplete or partial responses from schools may produce certain biases within the data.

THE FINDINGS OF YOUR RESEARCH ARE CONCERNING AND SO SAD TO SEE FOR MANY REASONS. WHEN SCHOOL NURSING SERVICES WERE ADEQUATELY STAFFED WE HAD MUCH, MUCH BETTER PRACTICE THAN THIS; MUST BE SO WORRYING FOR PARENTS AND THE PUPILS THEMSELVES TO HAVE SUCH MINIMAL SUPPORT IN MANY AREAS.

Sharon White OBE, CEO School And Public Health Nurses Association

‘SCHOOL STAFF WANT TO DO THEIR BEST TO PROVIDE A SAFE AND INCLUSIVE LEARNING ENVIRONMENT FOR ALL CHILDREN, INCLUDING THE INCREASING NUMBER WITH ALLERGIES. HOWEVER SCHOOLS NEED MUCH GREATER SUPPORT AND FUNDING FROM GOVERNMENT IN ORDER TO IMPLEMENT THE BEST PRACTICES THAT ARE IDENTIFIED IN THE REPORT.’

Daniel Kebede, NEU General Secretary

THE SAFETY OF TEACHERS AND PUPILS IN SCHOOLS MUST BE PARAMOUNT AT ALL TIMES. THIS REPORT LAYS BARE THE DEFICIENCIES IN SOME SCHOOLS’ APPROACHES TO SAFEGUARDING PEOPLE WITH ALLERGIES, AND HIGHLIGHTS THE ISSUES THOSE PEOPLE WILL FACE AS A RESULT . NASUWT STRONGLY SUPPORTS THE RECOMMENDATIONS IN THIS REPORT TO ENSURE ALL STAFF AND PUPILS WITH ALLERGIES ARE SAFE IN SCHOOLS AND COLLEGES.

Wayne Bates, National Negotiating Official

THE KEY FINDINGS FROM THE DOCUMENT REVEAL THAT A SIGNIFICANT NUMBER OF SCHOOLS IN ENGLAND DO NOT PROVIDE ADEQUATE EDUCATION AND TRAINING ON ALLERGIES, RESULTING IN A LACK OF STAFF CONFIDENCE IN MANAGING ALLERGIC REACTIONS. THERE IS A NEED FOR GREATER UPTAKE OF ALLERGY AND ANAPHYLAXIS TRAINING, AS WELL AS A FOCUS ON PREVENTION. THE UK MUST TAKE ALLERGY MORE SERIOUSLY TO ENSURE THAT CHILDREN ARE, AND FEEL SAFE AND SCHOOLS ARE SUPPORTED TO FULFIL THEIR STATUTORY RESPONSIBILITIES IN THIS AREA.

Simone Miles, CEO Allergy UK

THIS DOCUMENT PLAINLY LAYS OUT THE EVIDENCE THAT WE ARE FAILING SCHOOL CHILDREN WITH ALLERGIES. THIS IS SOMETHING THAT ALLERGY SUFFERERS AND THEIR ADVOCATES HAVE BEEN SAYING FOR YEARS, BACKED UP BY THE EVIDENCE OF CORONER'S INQUESTS FROM AVOIDABLE TRAGEDIES. THIS RELEASE OF THIS REPORT MUST BECOME A WATERSHED MOMENT FOR POLICY MAKERS TO ACTIVELY ENGAGE WITH THE ALLERGY COMMUNITY TO MAKE THE CHANGE THAT IS NEEDED. THE ALTERNATIVE IS TO ALLOW FURTHER TRAGEDIES TO HAPPEN AND WE CANNOT ALLOW THIS.

Prof Adam Fox, Chair of National Allergy Strategy Group,
Trustee and Past President of BSACI

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