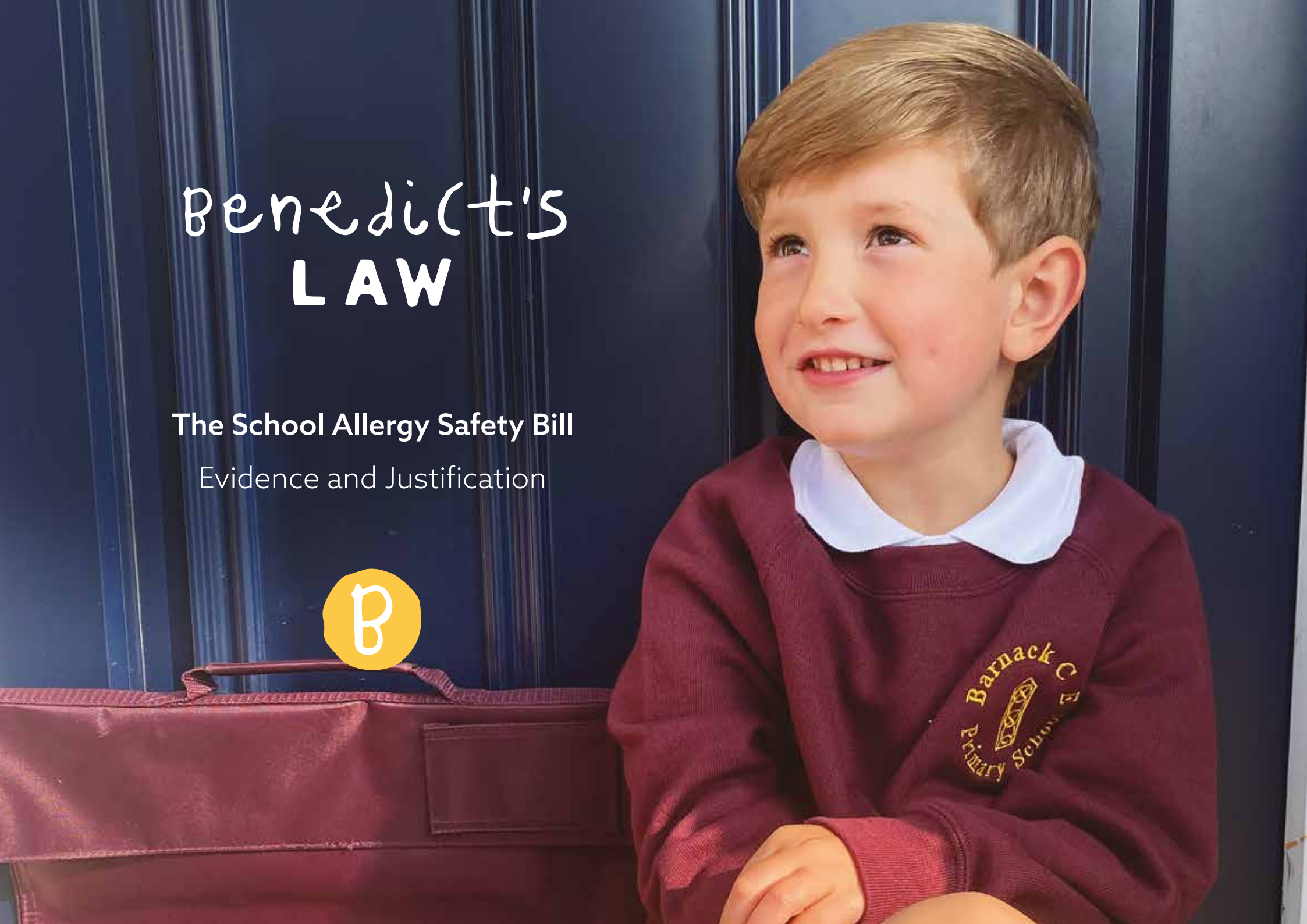
Benedict's LAW

The School Allergy Safety Bill

Evidence and Justification



Executive Summary:
Benedict's LAW — The School Allergy Safety Bill

Benedict's Law is a proposed piece of legislation that addresses critical gaps in school-based allergy safety.

Named in memory of five-year-old Benedict Blythe, who tragically died from anaphylaxis at school, the Bill introduces a simple, nationally consistent framework to ensure every child is protected — regardless of diagnosis, postcode, or income. Benedict's Law is a preventative, cost-efficient, inclusive measure that fulfils clinical recommendations, public health priorities, and public demand — without adding pressure to school or NHS budgets. It is the right law, at the right time, for the right reason: to keep children safe.

What the Bill Does

Benedict's Law would make three key safety measures mandatory in all state-funded schools:

- **Spare adrenaline auto-injectors (AAIs)** centrally funded and distributed
- **Allergy awareness and emergency response training** for all school staff
- **A national model allergy policy**, tailored and implemented by each school

Why It's Needed

Despite allergy being the most common chronic childhood condition in the UK:

- **Over 69%** of schools lack basic allergy safeguards
- **Almost half** do not stock spare AAIs
- **One-third** have no allergy policy at all
- **30%** of school-based allergic reactions happen in children with no previous diagnosis

With no statutory allergy protections currently in place, English legislation lags behind global comparators. Children face daily, avoidable risks — particularly in deprived areas.

The Cost Model

Rather than costing extra, Benedict's Law **reallocates existing spend** on individual AAI prescriptions into a more efficient, school-based model:

- **Current spend on additional AAIs to children:** £9,000,640 annually
- **Proposed model cost:**
  - £4,967,002 for national rollout of spare AAIs
  - £2,901,488 for annual training
  - **Total: £7,968,490**

Annual saving to the system: £1,032,150

These savings could be reinvested to support high-need areas or further strengthen allergy response capacity.

Expected additional benefits

- **306,000 school days** regained annually through improved attendance
- **Over £1.5 million** saved in A&E and hospital admissions
- Reduction in emergency response times from **up to 20 minutes to under 5**
- Economic gains through improved parental workforce participation
- A fairer, safer school experience for all children — not just the lucky ones

About Benedict

On a typical Sunday morning, Benedict would wake up at 5.30am, tap his parents on the shoulder and say 'can we play numbers?' He would happily line up blocks and learn shapes, numbers falling into place in his quick little mind. It wasn't surprising when an assessment just before he started school in September 2021 found him to be in the top 1% and automatically gave him membership to MENSA.

Aside from numbers, trains were his constant love. He never tired of watching *Thomas the Tank Engine*, and the floor of the house would often be given over to elaborate train tracks, where he raced his trains and squealed in glee.

With known food allergies, and a history of anaphylactic reactions, Benedict started school in September 2021. Just a few short months later on 1st December, he went off to school happy and healthy after opening his advent calendar. A couple of hours later he experienced a fatal anaphylactic reaction, and died with his family holding his hand. His mother said 'Benedict didn't just lose his life. It's all the future moments stolen from him. Every birthday uncelebrated, every laugh unheard, every dream unfulfilled. This wasn't just a tragedy; it was a theft of everything he was meant to become'.

For his family, it was his kindness and curiosity they remember most. Someone once asked him 'what's your superpower? What's the most important thing you can do that others can't?'. After thinking deeply, he said, 'it's when I open the door for my little sister because she can't reach'. His superpower was his kind heart, and his desire to look out for others. It was in that spirit that the Benedict Blythe Foundation was formed, and why the proposed legislation is named in his memory – an act of kindness and protection for other children with allergies.

Allergies in classrooms are on the rise

The prevalence and impact of allergies is on the rise. In less than half a century, allergy, originally perceived as a rare disease, has become a major public health threat.

It currently affects more than 680,000 children in England and close to one people billion worldwide, heavily impacting their daily lives and the health budgets that support them.

Disturbingly, its prevalence and impact are on the rise, with a rapid increase in the number of hospitalisations due to allergy in the last 20 years.

There is a need for schools to be better prepared to manage the increasing number of children with allergies entering the classroom.

Currently between 5% and 8% of children in the UK are believed to have a food allergy. With children spending 20% of their waking hours in schools, it's perhaps unsurprising that 18% of allergic reactions take place there – more than in any other setting outside the home.

Allergic disease is the most common chronic condition among children in England, and an estimated 45,000 children born in 2022 will go on to develop allergies. Current measures are failing students. For pupils with allergies currently in the education system, over 3 million school days are lost annually for allergy related reasons, and there are increasing numbers of children opting out of the school system entirely – choosing to remain safe by home educating. Benedict Blythe Foundation's proprietary research in 2024 found 70% of schools did not have the recommended allergy safeguards in place.

There is a need to better support pupils with allergies in order to break down barriers to opportunity and ensure students have the same chance to learn as their peers.

Allergy related child fatalities happen more in school than any other setting

There have been several high-profile fatalities in recent years as a result of anaphylaxis in English schools. In 2017 alone, three children died following allergic reactions at school:

13-year-old **Karanbir Cheema** died after a pupil flicked cheese at him, knowing he had a dairy allergy. 14-year-old **Nasar Ahmed** died after an allergic reaction to milk in his tandoori chicken lunch. 9-year-old **Mohammed Ismaell Ashraf** died following an anaphylactic reaction to an unknown allergen. In all these cases, the coroner pointed out that there were failings in how the school responded and outlined key recommendations to be put in place to prevent future fatalities from anaphylaxis in school in the shape of access to allergy adrenaline pens, staff training, and clearer policies.

Recently 5-year old **Benedict Blythe** collapsed at school and died from anaphylaxis, prompting his family to establish Benedict Blythe Foundation to campaign on behalf of other families for increased allergy safety. The proposed Benedict's Law is named in his memory.

The current legislation doesn't go far enough

Schools in England must adhere to two pieces of statutory guidance: Supporting Pupils with Medical Conditions at School, and Early Years Foundation Stage. Neither of these make explicit mention of specific safeguards for pupils with allergies. The Department for Education's belief is that the statutory guidance is proportionate, however evidence shows that the vagueness of the guidance, and the possibility of its delivery being open to interpretation, has created a worrying gap in allergy safeguard provision.

The current English legislation falls well short of other western countries, where examples like Sabrina's law in Canada, and Elija's Law in New York have seen protection for pupils with allergies through legislation for almost two decades, while in England the Children and Families Act 2014 makes no explicit mention of allergy. *See Appendix: International School Allergy Laws*.

We know this is the case, because Benedict Blythe Foundation's 2024 proprietary research, conducted with The Institute of Clever Stuff, found in an freedom of information analysis of 2,198 UK schools that:

70% of schools did not have the basic recommended allergy safeguards in place

almost half of UK schools did not have a stock of 'spare pens' for use when a child suffers an allergic reaction

1/4 did not provide any training on allergy symptoms and emergency response

1/3 did not have any kind of allergy policy

Benedict Blythe Foundation believes the lack of explicit expectations set out in legislation mean safeguarding pupils with allergies in school is open to interpretation, causing allergy safety to fall between the cracks in English schools.

Combined with the fact that no budget is made available to schools to deliver the recommended protections, it is unsurprising the evidence shows that 70% of schools do not have even basic allergy safeguards in place.

Allergy safety is falling between the cracks in English schools because vague guidance and absent legislation leave protections open to interpretation and dangerously inconsistent.

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

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**

Attending an allergy safe school should not be a matter of chance

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

Between **61-54%** chance **no training** has been given in managing allergies in school or on trips/visits

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 grown-up 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 grown-up running, they don't normally run! It was just annoying though because I did tell them I didn't feel ok.

Preventable
Allergy Fatalities in English Schools

In the space of one year alone, three children died in English schools from anaphylaxis.

Benedict's Law seeks to address the recommendations made by multiple coroners in response to school-based allergy fatalities, including:

- Every pupil with allergies or asthma must have an accurate, up-to-date care plan shared with staff.
- All staff should be trained to recognise allergic reactions and confidently administer emergency medication.
- Emergency medication must be in-date, clearly labelled, and easily accessible, including inhaler spacers.
- Schools should stock spare (generic) adrenaline auto-injectors for use in any emergency.
- Adrenaline should be given immediately if breathing problems or anaphylaxis are suspected.
- Families, schools, and healthcare providers must coordinate closely on care plans and medication.
- Schools must regularly review health procedures, training, and emergency readiness.

2016

14 year old Nasar Ahmed suffered a fatal anaphylactic reaction to milk in his lunch at school. Staff did not use the EpiPen he had with him.

2017

13 year old Karanbir Cheema died after another pupil threw a piece of cheese that contacted his skin. The inquest criticised the school's inadequate awareness and care plans for managing his allergies.

2017

9 year old Mohammed Ismaeel Ashraf collapsed less than two hours after consuming fish fingers and chips. An inquest revealed that lack of action and delays administering his AAI and poor allergy management contributed to his death.

What is Benedict's LAW?

Benedict's Law closes the gaps and makes school safer

It's universally accepted that protecting the health and wellbeing of children is a good thing. Benedict's Law closes the gaps created in current legislation that allow for poor practice in schools – creating safer environments, a more educated teaching workforce, reduces the postcode lottery that most impacts children in deprived areas, and does so without costing the government one extra penny in delivery.

The School Allergy Safety Bill, known as Benedict's Law, is named in memory of 5 year old Benedict, who died from anaphylaxis at school in 2021. This targeted legislation seeks to make adrenaline auto-injectors (AAIs) mandatory in all schools, alongside compulsory training in allergy awareness and emergency response, and a requirement for every school to have a clear, effective allergy policy to ensure these measures are implemented safely.

The three components are:

- Spare allergy pens
- Allergy training
- School allergy policy

The intention is that while this is legislated at a national level, delivery would be at a local level where the costs released by prescribing into schools rather than extra pens to all pupils would cover the cost of allergy training. This document sets out the components of Benedict's Law, its delivery, and the expected financial and benefits model.

What makes up the components of Benedict's LAW?

Benedict's law comprises three components – allergy pens, allergy training, and a school allergy policy.

Spare Allergy Pens

Benedict's Law would make it a legal requirement for all schools to hold spare adrenaline auto-injectors (AAIs)—expanding on current MHRA guidance, which only permits this on an optional basis.

The law would require that:

- **Spare AAIs are provided free of charge to all schools**
- **They are legally mandated and not reliant on discretionary uptake**
- **They can be used as an equal or first-line response in any suspected anaphylaxis—without delay to locate a child's personal device**
- **AAIs must be in date, readily accessible, and stored in an unlocked, clearly marked location**
- **Staff must be trained to use any brand confidently and without hesitation**

This change would close critical safety gaps, reduce emergency response time, and ensure every child at risk is protected—diagnosed or not.

Allergy Awareness and Emergency Response Training

Benedict's Law would require that all school staff must complete structured allergy training online, with key staff attending training delivered face to face. This training must go beyond passive access to materials and include:

- **Allergy awareness**
- **Management in school settings**
- **Emergency response, including anaphylaxis**

A minimum number of staff must also receive certified face-to-face training, including practical experience of holding and administering an adrenaline auto-injector (AAI) although this must be an opt-in for teaching staff. This group must include the school's designated first aider.

Training will be centrally funded, but schools will be expected to cover the cost of staff time to attend. All training must be based on a nationally agreed framework. These measures are in addition to EYFS paediatric first aid requirements, ensuring schools are equipped to respond swiftly and safely to allergic emergencies.

Allergy Policy

Under Benedict's Law, all schools would be required to have a clear, up-to-date allergy policy, based on the BSACI Model Allergy Policy for Schools.

This policy must be:

- **Tailored to each school's setting and pupil population**
- **Developed in consultation with parents, pupils, and healthcare professionals**
- **Published and regularly reviewed**
- **Aligned with national clinical guidance and safeguarding standards**

It must clearly outline roles and responsibilities, risk reduction measures (including lunch, classroom, and trip management), Emergency response procedures, Staff training and communication protocols

Schools must test their policy annually with an Anaphylaxis Drill.

Teachers with allergies

Staff with allergies face similar risks as pupils—yet are often overlooked in policy.

This bill ensures that school environments are safer and more inclusive for allergic adults too, by mandating accessible emergency medication, raising awareness, and embedding allergy safety in school culture.

Pupils with known allergies

Only 64% of children with a history of anaphylaxis are prescribed AAIs. That means that a reliance on children having their own medication is flawed when we are in the knowledge that 46% of children will not have allergy pens on prescription.

Pupils without known allergies

Around 30% of allergic reactions in schools occur in children who were previously undiagnosed with a food allergy. Having spare pens protects children who are having their first allergic reaction in school and wouldn't otherwise have access to medication.

Who does this bill help, and how?

Teachers and school staff

Teachers want to help—but many feel underprepared or anxious about managing allergy risks.

Benedict's Law ensures all staff are trained, supported, and protected with clear protocols and access to spare AAIs.

It reduces fear of getting it wrong, clarifies responsibilities, and improves emergency response confidence across the school.

Parents and carers of pupils with allergies

2/3 parents described worrying about their child's safety at school every day due to their allergies. Benedict's Law gives parents peace of mind that schools are properly prepared to protect their children. When all staff are trained, emergency medication is accessible, and clear policies are in place, families no longer have to rely solely on their own vigilance.

This can reduce anxiety, prevent unnecessary withdrawals from school, and restore trust in the education system.

How Benedict's Law is delivered without any extra spend

Benedict's Law proposes that spare adrenaline auto-injectors (AAIs) are provided directly to schools, rather than relying on individual prescriptions for pupils. This shift ensures a more consistent, equitable, and manageable supply of emergency medication.

In primary schools—where individual prescription volumes are currently high—this change would significantly reduce the need for multiple spare AAIs to be issued per child. The resulting cost savings released within each local health system (ICB) can then be reinvested to fully fund allergy training for school staff.

This model ensures that both safety equipment and staff preparedness are delivered efficiently, equitably, and sustainably, without increasing overall system costs. An illustration based on ICB averages is outlined below, with a more detailed cost profile per ICB later in this document.

Current model – to the child

£9,000,640 total annual spend on **additional** AAIs that can be reallocated into a new model

Current model description

- No legal requirement for allergy training after children leave early years
- Half of schools rely on a child having their own AAIs – this model costs an additional £9million to the NHS
- No mandated allergy policies
- Where schools have spare AAIs they're privately prescribed and taken out of donations or school budgets

Proposed model – to the school

£4,967,002	£2,901,488	£100,000
total cost of rolling out spare AAIs in all schools nationally	cost of annual online learning for all staff plus	cost of allergy policy programme support

Total costs £7,968,490

Model under Benedict's Law

- **Allergy pens in every school** – ICBs deliver 4x AAIs to all state primary and secondary schools, reallocating the £9million to benefit all schoolchildren
- **Key school staff face to face trained once every two years** – ICBs fund one Band 3 allergy nurse (or alternative) to provide face to face training to schools and support with creating individual healthcare plans and offer advice
- **All school staff complete annual accredited allergy training** – Annual licences for e-learning funded by ICB
- **Allergy policies in every school** – All schools are supported by nationally funded programme manager to amend their own version of an allergy policy based on recognise national standard template
- Secondary school pupils would still be encouraged to carry their own AAIs, while primary school pupils would use their personal AAIs for school trips and off-site activities

*N.B. This is one proposed funding model that illustrates how more comprehensive support can be delivered while achieving cost savings, rather than incurring additional costs. Other delivery models may achieve similar outcomes.

That suggests a **cost saving** of Benedict's Law of £1,032,150

Implementing Benedict's Law does require additional cost—in fact, by rethinking AAI distribution, it frees up enough budget to fully fund the new measures and release over £1 million back into the system. That surplus can be seen as a genuine cost saving, or reinvested to support higher-need pupils, schools, or ICBs that may not see immediate savings under current prescribing models.

Benedict's LAW

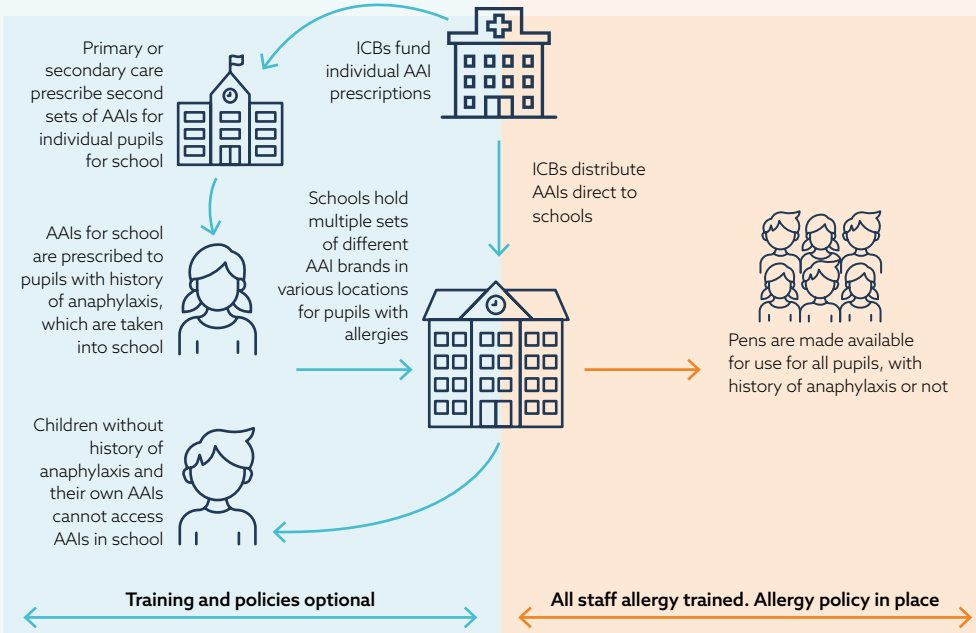
the model for distributing Spare Allergy Pens into all English Schools

Current Model: To the Child

- MHRA guidance is for children to be prescribed 2 x AAIs for home use. Data show 50% children are then **prescribed an additional set of 2 pens for school use**.
- AAIs are prescribed by GPs or consultants to around half of children at risk of anaphylaxis.
- These are individually labelled and stored, and are **not transferable** – they can't be used on another child, even in an emergency.
- Classrooms may **store multiple pens**, creating waste and confusion.

Key Issues With This Model

- Only 6.5% children are seen in secondary care for their allergy, and many at risk do not have their own AAI so reliance on a child 'having their own' puts them at greater risk.
- Around **25% of first-time anaphylaxis** episodes happen in **school settings** – these children would not have their own AAI to treat the reaction and **are not protected by the current model.**
- **High cost and inefficiency**:
  - Duplication across classrooms and schools.
  - Wastage due to expired pens.
  - Administrative burden on schools and families.



Allergy Training and Policies

Schools have no legal requirement to deliver allergy training beyond anaphylaxis first aid in early years.

Around half of schools do not have a functional allergy policy.

Allergy Training and Policies

All staff would receive online training on allergy awareness and emergency response, a percentage would **attend face to face allergy training** aligned to school allergy standards.

Delivery options include nationally commissioned e-learning, supplemented by ICB-funded face-to-face regional training, or school-led training selection with ICB funding.

All schools have **an allergy policy** aligned to BSACI model allergy policy

Proposed Model: Benedict's Law

Shift from a 'child-focused' to a 'school-focused' model.

Schools would receive **4 centrally funded, generic AAIs**, distributed at ICB level.

Secondary students may still carry personal AAIs if they have them.

Parents can still send **pens for travel** to and from school and for trips when required.

Allergy pens can be used on any student, reducing delays and **protecting all pupils**.

All staff receive allergy training.

Simpler for staff training, and emergency protocols.

Key Benefits of This Model

Greater protection: emergency AAIs available for all children, including those undiagnosed.

Simplified logistics: central stock means fewer pens stored and less admin.

Cost-effective: fewer prescriptions, less wastage, and longer shelf life.

Supports better training: cost savings can fund essential staff training.

Aligned with Benedict's Law: improves safety at scale with a practical delivery model.

ICBs: Leading Cost-Neutral Implementation of Benedict's Law

Integrated Care Boards (ICBs) can drive the safe, cost-neutral implementation of Benedict's Law by aligning AAI prescribing with MHRA guidance and shifting from a "to the child" to a "to the school" model. Children would still carry two pens, but schools wouldn't require excess prescriptions—cutting waste while maintaining safety.

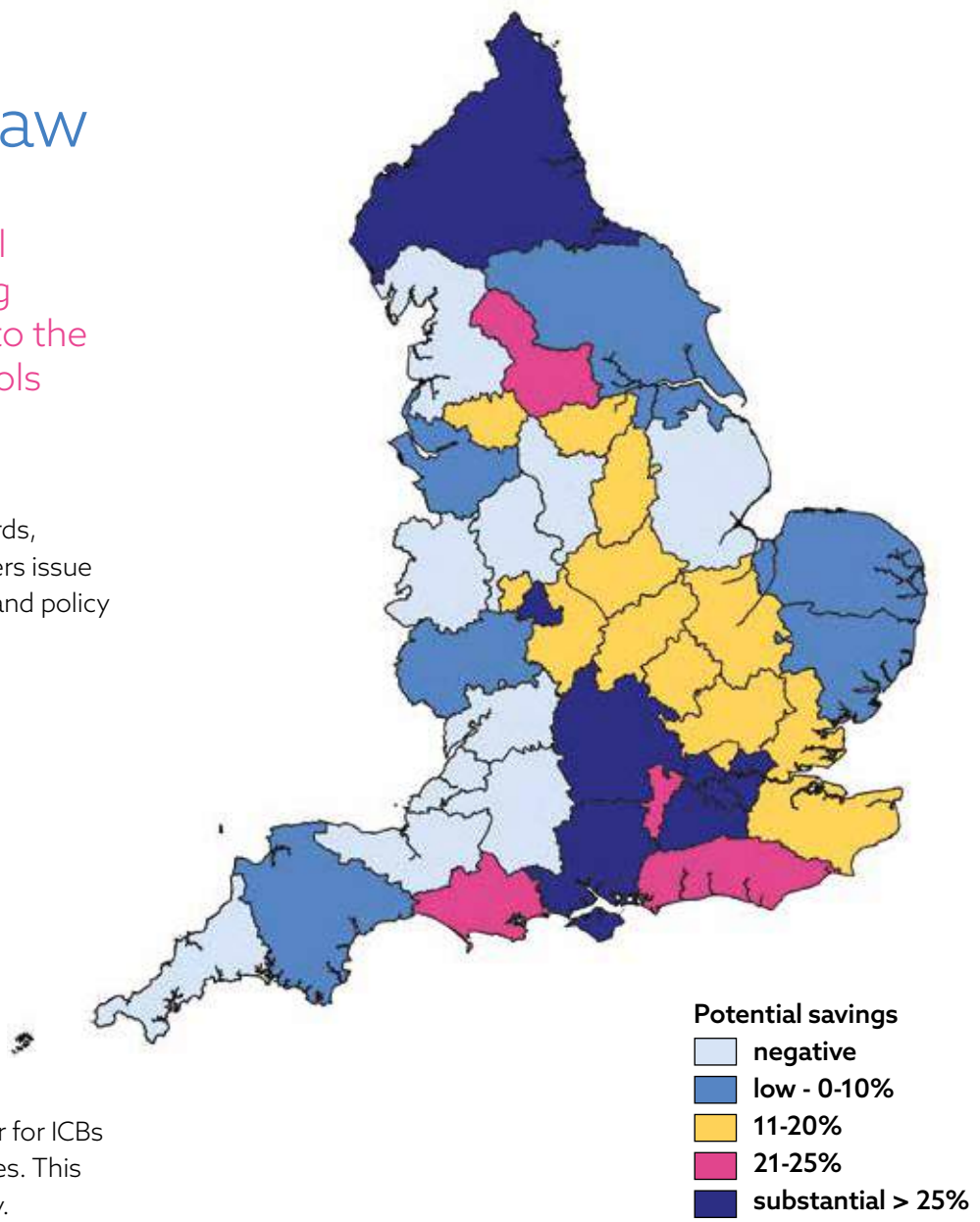
Prescribing data from the NHS Business Services Authority (BSA), linked to HES records, shows wide variation between ICBs. Some prescribe in line with guidance, while others issue significantly more. The mapped savings show that most ICBs can fully fund training and policy requirements through reduced prescribing alone.

Savings can cover:

- Annual virtual training for all school staff
- Biennial, in-person training with hands-on elements for key staff
- Programme coordination and policy development

Delivery can be tailored locally—via direct funding to schools, commissioning allergy nurses, or licensing verified providers like The Allergy Team (endorsed by Prof Adam Fox OBE and Dr Paul Turner). The model used in our costing is illustrative; ICBs can choose what works best locally.

Crucially, the approach is fully funded from existing prescribing budgets, with a buffer for ICBs with minimal or negative savings, ensuring no added pressure on staffing or resources. This enables a national improvement in allergy safety, led locally and delivered sustainably.



Delivery model case studies

Leicester's School Emergency Medicines Scheme

In Leicester City and Leicestershire County, a programme has equipped all 458 schools with spare adrenaline auto-injectors (AAIs), salbutamol inhalers, and single-use spacers — safeguarding thousands of children with asthma and severe allergies.

Initially launched in 2021/22 across 76 secondary schools using charitable donations, the scheme expanded significantly by 2023/24, reaching over 200 primary and secondary schools. By 2025, every school in the region received a one-year supply of emergency medicines, backed by £49,145 in funding — with AAIs representing the largest cost.

The scheme's impact is already clear. In 2023, four emergency AAI uses were reported — two in children who had no access to their own device, making the availability of spares potentially life-saving. At least eight schools reported using generic salbutamol inhalers, often when students' personal inhalers were expired or unavailable.

Success has been driven not only by removing cost barriers, but also through dedicated online training and awareness resources to boost school staff confidence in recognising and treating anaphylaxis. In a recent case from March 2025, a teenager experiencing anaphylaxis was successfully treated with a school's spare AAI after their personal device had expired.

While the initiative aligns with MHRA guidance and has strong public health value, its long-term future depends on sustainable funding from Integrated Care Boards. This model shows that with minimal investment and the right support, schools can be empowered to deliver fast, effective care in life-threatening emergencies.

Emergency Allergy Bag Scheme – A Life-Saving School Safety Model

Launched in 2020 by St George's University Hospitals NHS Foundation Trust, the Emergency Allergy Bag Scheme has equipped over 140 schools in Wandsworth and Merton with life-saving resources to respond to anaphylaxis. Prompted by two allergy-related deaths in London schools, the initiative ensures that all participating schools hold emergency kits containing two adrenaline auto-injectors (AAIs), a usage log, instructions, and an allergy register.

The programme was made possible through a business case supported by local GPs, school nurses, pharmacists, and Wandsworth and Merton CCGs. Each school receives annual training for staff, with both in-person and online formats. In September 2024 alone, more than 100 staff were trained, with 98% reporting improved understanding of anaphylaxis, and 94% feeling confident to use an AAI in an emergency.

Crucially, the spare AAIs have already been used in at least five incidents, including for a student with expired devices and another with no known allergy. Both recovered fully thanks to timely intervention.

Parents have welcomed the scheme, with one saying, "It's a great reassurance that schools are prepared. This will save lives."

Now in its fifth year, the scheme is a clear, replicable model combining emergency preparedness with education. It demonstrates how health bodies, schools, and local partners can collaborate to deliver rapid, safe care — setting a strong precedent for regional or national adoption to protect children with allergies across the UK.

case study

ICB-led community setting prescription distribution

Summary

Integrated Care Boards (ICBs) fund and support the distribution of naloxone — a prescription-only, life-saving medicine — into community settings like hostels, pharmacies, and outreach services. This shows a clear precedent for ICBs to also fund and distribute spare adrenaline auto-injectors (AAIs) in schools to protect children at risk of anaphylaxis.

What ICBs Are Doing with Naloxone

- **Funding: ICBs commission naloxone supply via local drug treatment services and community pharmacies.**
- **Distribution: Naloxone is placed in non-clinical settings — hostels, outreach vans, and even distributed peer-to-peer.**
- **Training: Quick training is provided to non-clinicians on overdose recognition and naloxone use.**
- **Legal Workarounds: Despite being prescription-only, naloxone is distributed under exemptions and PGDs due to its public health importance.**

What This Shows

- **ICBs can legally and practically fund access to prescription-only emergency medicines in community settings.**
- **Non-clinical staff (like teachers) can be trained in basic emergency use, just as with naloxone.**
- **The goal is the same: fast access, reduced risk, saved lives.**

Applying the Same Model to Schools

- **Need: Schools face growing anaphylaxis risks, but spare AAIs aren't routinely funded.**
- **Solution: ICBs could commission AAIs for schools, using a naloxone-style model — bulk purchase, training, legal clarity.**
- **Impact: Safe, scalable, and life-saving — just like naloxone has been.**

Conclusion

ICBs already fund the community rollout of one life-saving prescription medicine. They can — and should — do the same for adrenaline pens in schools.

How Benedict's LAW increases safety for pupils

Faster Emergency Response

Spare AAIs are immediately accessible and don't require locating a pupil's personal device — reducing critical delays in treatment.

Increased Staff Awareness and Confidence

All staff complete certified training, so more adults in the school are alert to allergy risks and know what to do.

Inclusion of Staff with Allergies

Allergy protections apply to all — including teachers — making the school environment safer and more inclusive for everyone.

Improved Use of Adrenaline Auto-Injectors (AAIs)

Standardised, in-date AAIs are stored in clear, unlocked locations — no confusion over brand or access in an emergency.

Better Recognition of Early Symptoms

Training includes recognising subtle signs of an allergic reaction, leading to faster escalation before symptoms become severe.

Improved Communication with Parents and Pupils

Clear allergy policies and training foster a culture of openness, inclusion, and partnership with families.

Consistent Risk Management Across All Settings

A national allergy policy standard ensures safe practices not just in the classroom, but also on trips, in canteens, and during clubs.

Protection for Undiagnosed Pupils

Up to 30% of school reactions happen in pupils with no known allergy — spare pens and trained staff ensure these pupils aren't left unprotected.

Luca's story – Benedict's LAW in practice

Luca, age 9, sits down for lunch with friends at school. He's never had an allergic reaction before.

No allergy policy required. Staff unaware of potential risks.

Staff trained to watch for signs. Clear policy in place – allergy emergency plan for staff

Luca eats a bite of a classmate's snack — a homemade cookie.

No food allergy awareness among pupils or supervision at lunch.

School staff educated to supervise risky food-sharing situations.

Within minutes, Luca starts to itch and cough. He feels funny.

Staff unsure if it's an allergic reaction or anxiety.

Staff trained to recognise early signs of anaphylaxis.

Luca begins to swell around his face and struggles to breathe.

Staff panic. No allergy plan or point of reference.

Staff consult allergy action plan posters and respond quickly.

Luca is now wheezing and grabbing at his throat.

No clear allergy policy. Teacher unsure what to do or who's responsible. His teacher, panicked, runs to school office to get help — leaving him alone.

Teacher follows a rehearsed allergy plan. A second trained adult stays with Luca at all times.

Luca sits slumped at his desk hoping for medication to make him better.

No trained staff immediately present. No emergency medication available.

Every class has at least one trained adult. Teacher knows to lay Luca down on his back with feet raised.

Teacher goes to the office and speaks to a couple of senior team members.

No clear Allergy Policy or Allergy Lead so staff scramble, unsure who should take charge. No standard emergency procedure. No spare pens.

Allergy lead is alerted. They grab the emergency AAI kit and rush to Luca.

They call 999. The operator suspects anaphylaxis and says adrenaline is needed now.

Staff hesitate. Luca isn't diagnosed. Do they have a spare pen? Can they use another child's AAI?

Clear legal authority to use the spare AAI under 999 guidance, even if the child has no diagnosis.

The trained TA arrives with the spare pen. She gives Luca the adrenaline.

Pen is in-date, clearly labelled, and regularly checked. Staff act with confidence.

Paramedics arrive and praise the staff's quick thinking. Luca is taken to hospital.

Incident logged. Parents informed. Policy reviewed and AAI replaced.

Amira's story – Benedict's LAW in practice

				
Amira, age 6, is in class after lunch when she starts to feel sick. She tells her teacher her throat feels funny.	**Amira starts coughing . She's had allergic reactions before — her AAI is in a box in her classroom.**	**The teacher hesitates. Is it too soon to give the pen? Could it make things worse?**	**A trained teaching assistant arrives, checks Amira's allergy action plan, and prepares the AAI.**	**The TA administers the AAI calmly. Amira begins to feel better. 999 is called. Staff stay with her until help arrives.**
Teacher isn't trained. Unsure if it's a real allergy symptom or anxiety.	No system in place for rapid access. Staff scramble to find the pen.	No allergy training. Staff afraid of "getting it wrong."	Plan may not be accessible. Staff disagree on next steps.	Staff unsure whether to stay with Amira or call parents. Uncoordinated.
Teacher recognises symptoms from training. Acts quickly and calmly.	AAI stored in a clearly labelled emergency kit in the classroom.	Staff trained to follow Amira's allergy action plan and act without fear. They lay Amira down with her feet raised.	Plan is printed, easy to access, and staff know how to follow it.	Staff follow a rehearsed procedure. Everyone knows their role.

Luca's story – The Impact of Benedict's Law

BEFORE BENEDICT'S LAW

Staff uncertainty: No clear allergy guidance. Adults aren't sure if symptoms are serious.

Delay in care: No spare pen available. Precious time is lost trying to find help.

Increased anxiety: Luca becomes more unwell while staff try to work out what to do.

Lasting worry: The experience leaves staff shaken, and Luca more nervous at school.

AFTER BENEDICT'S LAW

Clear protocol: Staff follow a known allergy plan with confidence.

Immediate action: A spare pen is on hand and used without delay.

Reassurance for all: Luca is supported quickly and calmly.

Learning and trust: The incident is reviewed, and Luca's family feel reassured.

Amira's story – The Impact of Benedict's Law

BEFORE BENEDICT'S LAW

Hesitation: Staff worry about acting too soon or getting it wrong.

Access issues: Her pen is hard to find; her care plan isn't up to date.

Mixed messages: No agreed process means staff are unsure who takes the lead.

Parental concern: Amira's parents lose confidence in the school's ability to keep her safe.

AFTER BENEDICT'S LAW

Staff confidence: Allergy training means symptoms are recognised early.

Smooth response: Medication is easy to access and given quickly.

Consistent approach: Everyone knows their role and follows the plan.

Improved trust: Amira's family feel supported, not sidelined.

How Benedict's Law can positively impact health and education

Implementing Benedict's Law isn't just about saving lives — it delivers measurable savings and tangible benefits to improve inclusion in education, prevention and equitable access to healthcare, and support for working families.

£1.01 million saved in A&E and ambulance costs

£580,000 saved in paediatric hospital admissions

£420,000 saved in GP prescribing time

306,000 school days regained annually

£1.6 million in benefits to families (e.g. reduced missed income, less anxiety)

£5.6 million million in system-level benefits (NHS, education, local government)

£132,000 saved through targeted allergy support in high-risk schools

£252 million in potential regained workforce productivity (if just 10% of parents retain full working hours)

£628,000 in potential economic gain by reducing allergy-related anxiety disruption at work

469 children potentially returned to mainstream school from home education

Educational Equity and Inclusion

Benedict's Law removes financial and systemic barriers that currently disadvantage allergic children, ensuring consistent access to life-saving support and inclusive school environments.

Core Argument

Children with allergies are faced with a real postcode lottery. Some schools provide funded AAIs, trained staff, robust policies. For 69% schools though, the basic allergy safeguards aren't in place. Where schools do have spare AAIs in place for example, these are often funded by donations – or by PTAs shaking buckets to raise pennies for lifesaving allergy medication.

Collectively, pupils with allergies miss over 3million school days per year, undermining their long-term attainment. In some recorded cases, children have lost up to 100 days due to their allergy.

The burden isn't shared equally. Children from more deprived areas are more likely to be affected, and less likely to be protected – with increased rates of A&E attendance, and higher rates of schools without spare allergy pens and policies. This combination directly affects around 79,500 pupils and is an entirely avoidable driver of educational inequality.

Accounts of families having to sell homes to fund private school places for children with allergies solely because maintained schools cannot safely accommodate their child tell the story of this inequality.

Beyond safety, the lack of education among school staff sees 60% pupils with allergies having to avoid daily school activities – a clear lack of inclusion.

How Benedict's Law helps

By funding spare pens, training and policies into every school, the lottery disappears. Safety doesn't only come to pupils with allergies that get lucky with school placements, or come from higher income families or areas.

Expected benefits

Benedict's Law would contribute to over 306,000 school days being gained across the population of pupils with allergies, and medication made available to the most at-risk groups in deprived areas.

		Current picture	Predicted improvement
Reducing absence linked to a school-based allergic reaction.	Children with poorly managed allergies miss more school days, affecting academic performance – an indirect but long-term economic cost to productivity.	Currently **336,000 children have to leave school early due to an allergic reaction**. 148,000 of these have had to leave early multiple times.	By reducing school-based allergic reactions by 1/3, **111,078 partial school days are restored**.
Closing the allergy-related attendance gap.	Children with allergies miss 4.5 days each per year. Each missed day lowers attainment, and long-term absence can cut lifetime earnings by up to 20%. Each school day missed correlates with a measurable drop in attainment, particularly in Key stage 2 and GCSE results.	**3 million school days lost to allergy per year.**	Based on affecting a modest 10% reduction in absence due to activity avoidance, school-based allergic reaction etc this would return **300,000 days of education.**
Shutting down the postcode lottery.	Children in more deprived areas account for nearly twice as many A&E visits. They're also more likely to attend underperforming schools, which we know from a 2024 FOI have the lowest rates of allergy safeguards – particularly spare AAIs – protecting the most vulnerable children last.	An estimated **79,500 pupils** are at greater health risk due to combined limited primary care access, health education, higher A&E attendance and lower access to school-held medication and education.	**Benedict's Law would reduce the number of pupils unprotected by medication to zero.**
Allowing children to remain in mainstream education.	Data show 4.95% of allergy parents have already made the choice to home educate their child due to their allergy- an impossible choice that may not be the right thing educationally for a child, or a positive choice for families where parents have to step away from work.	Based on the number of pupils with allergies, and estimates of home educating children, **approx. 33.4k children are home educated because of their allergies**.	**Reduction of number of children who are home educating because of allergies** rather than because it is the right thing for the child.
Schools will be better able to accommodate children with allergies on trips and at school lunchtimes.	We know access to healthy school meals boosts attainment by up to 4.5 percentage points – but many families report being the 'jacket potato kids' – either unable to eat at school or with limited options. Families also report being excluded from school trips. Bridget Philipson emphasised making schools 'welcoming, engaging and inclusive spaces' which is not always the case for allergic pupils.	**Some children with allergies have limited access to healthy school meals**.	**4.5 percentage point improvement in academic progress**, particularly at Key Stage 2-3 for pupils able to access allergy-safe lunch environments following allergy training and policy.

Child Health and Wellbeing (Preventative Healthcare)

By mandating spare AAIs and standardised training, the policy directly contributes to Labour's goal of reducing avoidable harm and improving children's health outcomes through prevention.

Core Argument

Allergic reactions happen more than anywhere else. 30% of these occur in children with no known allergy diagnosis.

With half of schools not stocked with allergy medication, these children are reliant on timely identification of their symptoms, and the fast attendance of an ambulance. With some regions recording category 1 calls taking over 20 minutes, this puts children needlessly at risk where a model with trained staff and on-site medication could see it administered in minutes.

Emergency response aside, the lack of staff awareness and prevention sees almost 27,000 schooltime emergency department admissions annually due to allergic reaction, costing the NHS over £15million – a figure that the simple introduction of training and policy can reduce.

With 76% of child allergy deaths having modifiable factors, such as delayed adrenaline, the case for making this readily available has been made consistently by coroners – delays cost lives, and the current system allows for unnecessary delays.

How Benedict's Law helps

Not only does the approach of improving staff knowledge to prevent allergic reactions, as well as medication to treat early and improve outcomes, it also reduces a financial and care burden on the NHS while delivering the right thing from both a moral and policy perspective.

Expected benefits

Benedict's Law would contribute to over 306,000 school days being gained across the population of pupils with allergies, and medication made available to the most at-risk groups in deprived areas.

		Current picture	Predicted improvement
Reducing delays leads to a reduction in fatalities.	In 76% of allergy fatalities there were modifiable factors including delays administering AAIs. The NCMD report highlights inadequate training among professionals was a significant factor in preventable anaphylaxis deaths – something Benedict's Law would solve.	Fatalities in children from anaphylaxis happen more in school than in any other setting.	Predicted improvement in emergency response, **reducing instances of fatal anaphylaxis**.
Speeding up administration of medication to improve outcomes.	Currently average wait times for category 1 ambulance callouts are 12 minutes 19 seconds. Combined with time for making the call and paramedics assessing and treating, time from recognising allergic reaction to treatment can be up to 20 minutes. Having trained staff with medication on-site can reduce that to just a few minutes – reducing distress and improving outcomes.	Estimated time to treat is up to 20 minutes.	**Improved time to treat, just a few minutes.**
Reduction in NHS spend on A&E access.	Annually there are 26,600 schooltime attendances in A&E per year due to allergic reactions, and 2,240 pupils are conveyed to hospital from school by ambulance due to allergic reactions. The total cost of this over £10million, and is at least partially preventable with better management and education in school.	Almost **29,000 pupils attend A&E** per year with schooltime allergic reactions, **costing the NHS £10million**.	Predicting a modest 10% reduction in these reactions would **save the NHS over £1million.**
Reduced paediatric admissions.	A 2020 IACI study found 20% of emergency department visits result in admission, which equates to a minimum of 5768 paediatric bed days, a cost of £5,195,368 to the NHS and taxpayer.	**Over £5million annually spent** on hospital admissions following schooltime allergic reactions.	Predicting a modest 10% reduction in these admissions would **save the NHS over £500,000.**
Training school staff reduces allergic reactions.	While prevention metrics are tricky, studies show school staff consistently have increased confidence and knowledge after training, with 100% in some research correctly understanding how and when to administer AAIs up from as low as 13%.	**Only 13% school staff** know how and when to administer AAIs.	**AAI knowledge up 87%** following training.
Reducing GP costs and workload.	The current model is a 'to the child' distribution model, with GPs being pressured to make additional prescriptions. A more efficient distribution model direct from ICB to schools would save the demands on GPs time, and associated costs.	**Up to £600,000 of GP time** spent on reviewing and issuing AAI prescriptions.	**Reduction of £420,000** based on new ICB- delivery model.

Supporting Working Parents

A safer, more reliable school system for children with allergies reduces the care burden on families — particularly mothers — enabling greater workforce participation and reducing inequality.

Core Argument

When systems aren't set up to support pupils with allergies, the burden of allergy management falls heavily on families – often mothers – reducing their ability to work, earn and plan with confidence, and keeping them out of the workplace entirely in some cases.

Over half of parents of children with allergies have changed or quit jobs due to allergy risk in school. 5% families moved to home educate due to poorly managed allergy risk, with one parent needing to step out of work in these cases to support the child's education.

The economic cost of these working parents forced to step back from their careers sits in excess of £500million, as well as creating significant holes in the pockets of many hardworking families.

For those who remain in work, adaptations like moving to be within reach of their child's school, having to pick a child up following reactions, or the 60% who say they have to 'constantly remind or educate school staff' carving out time to do so, the burden placed on them takes a significant toll.

How Benedict's Law helps

Benedict's Law raises the bar of knowledge among school staff by ensuring they're sufficiently trained to understand and manage allergies in the school environment, have processes and protocols outlined in policy and understood, and through access to medication. These combined create safer, more reliable school settings taking the burden off families to educate staff and manage the condition at a distance.

By increasing parental trust in schools, it reduces care burdens, supports working families, and promotes economic participation — particularly among women.

Expected benefits

Benedict's Law would contribute to over 306,000 school days being gained across the population of pupils with allergies, and medication made available to the most at-risk groups in deprived areas.

		Current picture	Predicted improvement
Improving safeguards allows parents to step back and progress their careers.	Over half of working parents with school aged children with allergies changed jobs, reduced hours, or left work entirely due to managing their child's allergies. As well as the personal and economic toll, there's impact of missed promotions, reduced pension contributions and lower lifetime earning. Across the 300k+ parents this affects, reducing salaries by 1 day per week equates to a whopping £2.5billion per year. The tax implications being £506 equate to £506 million per year of lost income to the government.	A **parent will lose £7,020 per year** by reducing their work hours. **Costing the economy £506million** per year.	If just 10% retain their full time earning productivity, this equates to **£252 million/year** in regained productivity.
Reducing the economic cost of school-based allergic reactions.	An estimated 336,600 pupils with allergies have had to leave school early at least once due to an allergic reaction. If only 1/3 of these require a day to be taken off work after a reaction, the 111k missed work days equates to £1.7million per year of economic cost.	**£1.7million economic cost** due to absences following school-based reactions.	**£170,837.96 could be restored to the economy** based on just 10% of those absences not being required.
Improving the impact of anxiety on families and the economy.	Many parents of children with allergies report frequent anxiety about their child's safety at school, resulting in disrupted work: early pickups, calls, reduced focus, and occasional absences. Based on national estimates, just 10% of families affected in this way could account for over £6.28 million in lost productivity each year.	**£6.28 million economic cost** due to anxiety-related work disruption among allergy parents.	**£628,000 could be regained** annually if **just 10%** of this disruption were prevented through better school allergy safeguards.
Returning pupils to mainstream education who home educate due to allergy alone.	Each year, an estimated 2,346 children are home-schooled due to allergies. If 5% of these families reflect cases where allergy was the sole factor, and a parent had to leave work to provide care, that's 117 parents. Assuming only 25% of those parents were in the workforce, that's 29 working parents leaving employment due to lack of safe allergy support at school—resulting in an estimated £1.08 million/ year in missed income.	**£1.08 million in lost earnings** annually due to parents exiting the workforce to home-school allergic children.	If just **6 parents** (20% of those impacted) returned to work due to improved in-school allergy safety, the economy could gain **~£225k per year**. Additionally **469 children would be able to return to mainstream education**.

Safeguarding and Children's Welfare

Embedding allergy management into statutory school policies enhances safeguarding practices and supports the drive to improve attendance and wellbeing across the system.

Core Argument

Children with severe allergies are at daily risk in schools — yet there is no statutory requirement to track incidents, fund emergency medication, or standardise safeguarding practices. The result is a postcode lottery in allergy care, with serious consequences for children, families, and the wider system.

Schools are not required to centrally report AAI (Adrenaline Auto-Injector) use, meaning high-risk patterns go unnoticed, and around 50% of state schools purchase AAIs from their own limited budgets, creating unequal protection. Current safeguarding frameworks do not consistently account for allergy risk, leaving gaps in preparedness and accountability with at least 1/3 schools having no allergy policy at all, and 1/3 having one that isn't suitable.

How Benedict's Law helps

Centralising distribution of AAIs makes tracking usage a side benefit. This has been something that has been carried out in regional models such as South West London for almost 8 years, with the act of replacing used pens allowing for easy analysis of how often, and in what locations, AAIs are being used.

By including the mandatory requirement for a school allergy policy based on the existing, freely available BSACI model allergy policy template, it ends the postcode lottery, ensuring all schools have clear responsibilities for staff training, care planning, and emergency preparedness. One core component that Benedict's Law would stipulate is the requirement of an annual allergy drill, similar to a fire drill.

Expected benefits

Benedict's Law would improve consistency of safeguarding, policies, and tracking of school allergy incidents while also releasing over £1.5million in school budgets that can be spent elsewhere.

		Current picture	Predicted improvement
Improving emergency response through data tracking.	Centralised reporting of Adrenaline Auto-Injector (AAI) use helps identify high-risk schools, enabling proactive support and reducing preventable emergency incidents. With ICBs replacing used pens, a method of data capture will automatically exist without a new system needing to be set up nationally.	**AAI incidents are under-reported due to poor central tracking**, leading to missed opportunities for early intervention and inconsistent care.	**By tracking Adrenaline Auto-Injector (AAI) use in schools**, we could identify the top 2% of schools with high-risk profiles (400 schools). Targeted training and care planning could reduce A&E visits by 400 annually, saving **£132,000/year**, and preventing trauma.
Creating consistent safeguarding across all schools.	Embedding allergy care into statutory safeguarding structures like policies ensures uniform, accountable standards across school settings, improving pupil safety and wellbeing and reducing inequity and a variable 'postcode lottery'.	**Inconsistent school policies** lead to **variable safeguarding standards**. Some schools lack formal allergy management policies or fail to integrate allergy care into broader safeguarding.	**Embedding allergy care in statutory safeguarding policy** would standardise school responses, improving safety and reducing preventable emergencies. Early interventions (e.g., staff training, care planning, audits) would reduce risk and increase attendance.
Ensuring equitable access to life-saving medication.	State-funded provision of AAIs relieves financial pressure on individual schools, particularly those in deprived areas, ensuring consistent emergency preparedness.	**Half of schools fund AAIs from their own budgets**, diverting limited resources from other pupil needs. The estimated cost schools are spending on **2 EpiPens (0.3 mg)** is approximately **£1,490,115.**	Almost **£1.5million in school budgets saved** as the burden of paying for pens is removed from their budgets.
Strengthening local coordination between health and education.	Better collaboration between schools, local authorities, and ICBs improves early identification of needs, reduces duplicated effort, and targets support more effectively.	**Neighbourhood-level coordination between health and education is patchy**, limiting data sharing and proactive planning.	Improved integration between schools, ICBs, and councils would enable smarter resource targeting and support **early identification of health needs** — reducing emergency incidents and improving equity.

Who supports Benedict's LAW?

Benedict's Law has unanimous support from clinicians and clinical institutes, politicians and peers, unions, charities and industry.

Crucially though, it has the support of the public. A petition reached the 10,000 required for government response in under two weeks, stopping at 13,000 due to the government's response.

Politically, Benedict's Law is supported by 90 MPs and Peers from across parties and across the devolved nations who have taken action to raise the cause in parliament through debates, PMQs and presentations.

You can see the supportive MPs to the right here.

Supporting organisations

The following organisations backed an open letter in 2024 which was sent to Secretary of State for Education, Bridget Phillipson.

Clinicians and clinical institutes support this proposed bill

Clinicians working in specialist allergy are acutely aware of the financial restraint currently in the NHS and are very keen to support initiatives where access to better care can also create cost efficiency. Mandatory provision of AAIs in schools is an excellent example of this – the release of funds otherwise spent on the large number of devices held for individual pupils in schools would be better spent on anaphylaxis training and other initiatives whilst also improving the safety of all children with allergy in school. This approach has broad support amongst prescribing clinicians. I would also, on behalf of the NASG, like to be clear of our full support of the work of the Benedict Blythe Foundation and the urgent need for Benedict's Law.

Prof Adam Fox OBE, Chair of National Allergy Strategy Group for Allergy

I whole-heartedly support the initiate for there to be a Benedict's Law. One in 5 deaths due to food-anaphylaxis happen in schools, and plenty of near misses which is what scares me. These measures will make our schools so much safer and better support our wonderful teachers to look after our children to the best of their ability.

Paul Turner

References

Pg **Source/ reference/ further detail**

2 *69% schools lack allergy safeguards* – REACT Report 2024, Benedict Blythe Foundation based on FOI data.

Half schools do not stock spare AAIs – REACT Report 2024, Benedict Blythe Foundation based on FOI data.

1/3 no allergy policy – REACT Report 2024, Benedict Blythe Foundation based on FOI data.

Current spend on additional AAIs to children: £9,000,640 annually based on BSA data for 2023/24 and calculated to show number of children prescribed 4+ AAIs where 2 would be in excess of the MHRA prescribing requirement per child of 2 pens, so for school use. Costings are based on the list price per AAI at the time of prescribing. Referenced in 2025 paper Turner et al.

306,600 regained days - A 2025 BBF survey estimated that children with allergies miss an average of 4.5 school days per year. Applied to the estimated 680,000 school-aged children with allergies in the UK, this amounts to 3,060,000 school days lost annually (680,000 x 4.5 = 3,060,000). Rounded, this gives a total of 3,066,000 when accounting for partial days and survey variation. A 10% improvement in allergy management—for example, through better staff training and access to emergency medication—would prevent approximately 306,600 of these absences. All figures refer to full school days missed.

1.5 million saved - There were approximately 26,600 school-time A&E attendances in 2023/24 due to allergic reactions, with 2,240 ambulance conveyances, based on FOI hospital data from 15 Acute NHS Trusts with A&E Departments gathered by Benedict Blythe Foundation in 2024 and referenced in the REACT report. The average cost of an A&E attendance including ambulance transport is estimated at £385 per case. 26,600 attendances x £385 = £10.24 million total NHS cost annually. If 15% of these attendances were avoided through improved allergy preparedness (e.g. stock AAIs, trained staff), then 15% x £10.24 million = approx. £1.54 million saved annually. This 15% assumption is a conservative estimate, consistent with other models for reduced emergency visits through preventative measures. If £1.54 million is saved nationally through reduced allergy-related A&E attendances, this equates to an average saving of £11,000 per acute hospital with an A&E department.

Reduction in emergency response times – Average time for an ambulance to arrive (Cat 1) = 8 mins. Time and motion studies by Benedict Blythe Foundation calculated a 2-3 minute interval for a member of staff to access central AAIs, with seconds from location to injection. The national target for these calls is an average response time of 7 minutes, with 90% of ambulances expected to arrive within 15 minutes. However, actual response times can vary significantly based on factors like location and service demand. For instance, data from December 2024 indicates that the mean waiting time for Category 1 callouts was 12 minutes and 19 seconds, exceeding the target with some regional averages being over 15-16 mins or 20+ minutes. Turner et al 2017 states ''The majority of fatal food-induced anaphylaxis cases occurred when epinephrine was not administered within the first 20 minutes'. Once you factor in the time for paramedics to gain access to the school, assess before administering, it's clear accessing on-site epinephrine is faster which in turn contributes to reducing risk of fatalities.

4 *Allergies affect more than 680,000 children in England and close to one people billion worldwide*: REACT Report 2024 Benedict Blythe Foundation, 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.

Children spend 20% of their waking hours in schools, and 18% of allergic reactions take place there – more than in any other setting outside the home: Higgs et al, 2021.

An estimated 45,000 children born in 2022 will go on to develop allergies: Calculated based on 7.5% of the 605,479 births in the UK in 2022.

Over 3 million school days are lost annually for allergy related reasons - Children with allergies miss an average of 4.5 school days per year according to a BBF Survey, February 2025.

Deaths of students 2016-17 - Inquests into the deaths of three pupils between 2016 -17, Prevention of future deaths reports, Courts and Tribunals Judiciary.

6 These statistics are highlighted in the REACT Report by the BBF in 2024 and based on data gathered from an FOI sent out to 20,000 English schools.

7 See further lived experiences from the perspectives of teachers, children and parents in the Benedict Blythe Foundation's Allergy Stories, research carried out in 2023 in collaboration with Sheffield Hallam University.

10 *Only 64% of children with a history of anaphylaxis are prescribed AAIs and 46% of children will not have allergy pens on prescription* – Turner et al 2024.

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

2/3 parents described worrying about their child's safety at school every day due to their allergies – Survey to 250 parents of primary aged pupils with allergies in UK carried out by Benedict Blythe Foundation in Feb 2025.

11 *Half of schools rely on a child having their own AAIs* – REACT Report 2024, Benedict Blythe Foundation - based on half of schools in 2024 FOI not having any spare AAIs.

12 Individually labelled and stored, and are not transferable DHSC Guidance - Guidance on the use of adrenaline auto-injectors in schools.

Data show 50% children are then prescribed an additional set of 2 pens for school use – based on average proportion of school aged children, (5-16) between 23/24 and cross-referenced with partial data from 24/25 provided by BSA, who are prescribed 3+ or 4+ AAIs in addition to the 2 per child.

Only 6.5% children are seen in secondary care for their allergy – Turner et al 2024.

Around 25% of first-time anaphylaxis episodes happen in school settings (Raptis 2020).

16 *Up to 30% of school reactions happen in pupils with no known allergy* (Santos et al 2022).

19 *£1.01m Saved in A&E and ambulance costs:* The estimated annual cost to the NHS for allergy-related A&E attendances among school-aged children during school time is approximately £10.1 million. This figure is based on an analysis assuming that most of the 190 recorded cases per trust are standard A&E attendances, each costing around £330, resulting in £62,700 per year. An additional 16 cases per trust involve ambulance conveyance, estimated at £600 each (covering both the ambulance and A&E attendance), adding a further £9,600 annually. Together, this gives a conservative lower-bound estimate of £72,300 per hospital trust. With around 140 NHS hospital trusts in England operating Type 1 consultant-led A&E departments, the total annual national cost is calculated as £72,300 multiplied by 140, equalling approximately £10,122,000. It is important to note that this estimate does not include the cost of follow-up care, such as GP or specialist appointments, nor does it account for any inpatient admissions that may result from more severe allergic reactions. The figure of £1.01m reflects an assumption that 10% attendances can be avoided by better knowledge in school.

£580,000 Saved in paediatric hospital admissions: Based on 2024 FOI data collected from 15 acute NHS trusts with A&E departments—representing over 10% of Type 1 A&E trusts in England—an estimated 206 children per trust attended emergency departments following allergic reactions occurring at school. Using findings from a 2020 study published in the Journal of Allergy and Clinical Immunology (JACI), which reported that approximately 20% of anaphylaxis-related ED visits result in hospital admission, this equates to around 41.2 admissions per trust. When extrapolated across all 140 Type 1 A&E hospital trusts in England, this results in approximately 5,768 paediatric admissions per year. Assuming a conservative estimate of a one-night hospital stay per admission, and an average paediatric bed-day cost of £1,000 the resulting annual cost to the NHS is approximately £5.8 million for these admissions alone. Applying the 10% reduction equally to admissions, this results in the £580k saving.

£420,000 saved in GP prescribing time: From a per-child perspective, the administrative burden and cost of issuing prescriptions for additional adrenaline auto-injectors (AAIs) for school use is significant. GP time is typically costed at £150–£200 per hour, meaning that a single prescription taking five minutes to complete costs approximately £14. FOI data shows that around 30,000 prescriptions were issued over a six-month period specifically for school-use AAIs, resulting in an estimated £420,000 in GP time alone. When taking into account the wider system costs—including the pens themselves, pharmacy dispensing fees, and administrative processing—the total expenditure is considerably higher.

306,000 School days regained annually: 306,600 regained days - A 2025 BBF survey estimated that children with allergies miss an average of 4.5 school days per year. Applied to the estimated 680,000 school-aged children with allergies in the UK, this amounts to 3,060,000 school days lost annually (680,000 × 4.5 = 3,060,000). Rounded, this gives a total of 3,066,000 when accounting for partial days and survey variation. A 10% improvement in allergy management—for example, through better staff training and access to emergency medication—would prevent approximately 306,600 of these absences. All figures refer to full school days missed.

£628,000 in potential economic gain: Around 2,346 children are home-schooled each year due to allergy-related concerns. If 5% of these cases (around 117 families) involve a parent missing work, and 25% of those parents would otherwise be employed (approx. 29 individuals), the resulting lost income—based on the average UK salary of £37,430—totals an estimated £1.08 million annually. This highlights the wider economic impact of inadequate allergy support in schools.

20 *For 69% schools though, the basic allergy safeguards aren't in place:* BBF REACT Report, 2024.

This combination directly affects around 79,500 pupils and is an entirely avoidable driver of educational inequality: In August 2024, 2,200 schools were rated poorly by Ofsted, serving an estimated 79,500 pupils. These children, already at higher health risk due to limited access to primary care and health education, are also the least likely to benefit from school-held emergency medication—leaving those most in need with the lowest level of protection.

References continued

21 *Each school day missed correlates with a measurable drop in attainment, particularly in Key stage 2 and GCSE results*: Poor educational outcomes linked to chronic absence can reduce lifetime earnings by 10–20% (Social Mobility Commission).

336,000 children have to leave school early due to an allergic reaction. 148,000 of these have had to leave early multiple times: BBF Survey, 2025 showed the number of pupils who left school early because of an allergic reaction. Scaled up to school population, it means over 300,000 children had to leave school because of an allergic reaction. Some of these may be mild, but some may be more severe, but if only 1/3 of these pupils took an additional day off school following the reaction that equates to 336,600 lost school days.

3 million school days lost to allergy per year: Children with allergies miss an average of 4.5 school days per year according to a BBF Survey, February 2025.

Children in more deprived areas account for nearly twice as many A&E visits: An estimated 79,500 pupils are at greater health risk due to combined limited primary care access, health education, higher A&E attendance and lower access to school-held medication and education:

Approx. 33.4k children are home educated because of their allergies: Recent figures show c. 92,000 children are currently home educated in the UK, with 7,820 of them living with allergies. A 2025 BBF survey found that 4.95% of families had already chosen to home educate or move schools due to allergy. When applied nationally, this suggests up to 33,400 children may be affected—accounting for over a quarter of all home educated pupils. Even with conservative assumptions, around 3,366 children are likely being home educated solely due to allergy concerns rather than educational preference.

Access to healthy school meals boosts attainment by up to 4.5 percentage points: A study in Public Health Nutrition found that healthier school lunches were linked to a 4.5 percentage point improvement in academic progress at secondary level, along with reductions in exclusions and absenteeism—especially among lower-income students. It's reasonable to assume that improving allergy awareness and support in schools could yield similar benefits for pupils with allergies, by reducing absences and supporting academic progress.

22 *Allergic reactions happen more than anywhere else. 30% of these occur in children with no known allergy diagnosis:* Santos 2022.

76% of child allergy deaths having modifiable factors: National Child Mortality Database (NCMD) report titled Child deaths due to Asthma or Anaphylaxis (December 2024).The NCMD report highlights inadequate training among professionals was a significant factor in preventable anaphylaxis deaths.

23 *26,600 schooltime attendances in A&E per year due to allergic reactions, and 2,240 pupils are conveyed to hospital from school by ambulance due to allergic reactions. The total cost of this over £10million:* Based on NHS reference costs, a standard A&E attendance is estimated at approximately £330, while ambulance conveyance with A&E attendance is around £600 per case. According to 2024 FOI data obtained by the Benedict Blythe Foundation and published in the REACT report, NHS trusts reported an average of 190 allergy-related A&E attendances annually among school-aged children, along with 16 cases involving ambulance conveyance. Assuming the majority are non-admitted cases at £330 each, this results in a cost of £62,700 per trust. The 16 ambulance cases, at £600 each, add a further £9,600, giving a total conservative lower-bound cost of £72,300 per trust per year. With approximately 140 NHS hospital trusts in England operating Type 1 A&E departments, the projected national cost is £72,300 × 140 = £10,122,000 annually. This estimate does not include the cost of follow-up care or inpatient admissions, suggesting the true figure is likely higher.

Up to £420,000 of GP time spent on reviewing and issuing AAI prescriptions: £420,000 saved in GP prescribing time: From a per-child perspective, the administrative burden and cost of issuing prescriptions for additional adrenaline auto-injectors (AAIs) for school use is significant. GP time is typically costed at £150–£200 per hour, meaning that a single prescription taking five minutes to complete costs approximately £14. FOI data shows that around 30,000 prescriptions were issued over a six-month period specifically for school-use AAIs, resulting in an estimated £420,000 in GP time alone. When taking into account the wider system costs—including the pens themselves, pharmacy dispensing fees, and administrative processing—the total expenditure is considerably higher.

100% correctly understands how and when to administer AAIs following training, up from as low as 13%: Santos Food Allergy Education and Management in Schools: A Scoping Review on Current Practices and Gaps.

24 *Over half of parents of children with allergies have changed or quit jobs due to allergy risk in school:* A 2025 Benedict Blythe Foundation survey of families of children with allergies found 53% of their parents—approximately 360,400 individuals—have changed jobs, reduced hours, or left work entirely to manage their child's condition.

5% families moved to home educate due to poorly managed allergy risk, with one parent needing to step out of work in these cases to support the child's education: Benedict Blythe Foundation Survey 2025.

The economic cost of these working parents forced to step back from their careers sits in excess of £500million, as well as creating significant holes in the pockets of many hardworking families: The estimated tax revenue loss resulting from allergy-related parental work reduction is based on national prevalence and earnings data. With approximately 680,000 children in the UK living with allergies, survey data shows that 53% of their parents—around 360,400 individuals—have changed jobs, reduced hours, or left employment entirely to manage their child's condition. Assuming each affected parent loses one working day per week, this equates to a 20% reduction in income from a typical £35,000 full-time salary, or £7,020 per parent annually. The total estimated earnings loss across this group is £2.53 billion per year. Applying a conservative flat income tax rate of 20%—representing the basic UK tax band—this results in an estimated annual tax revenue loss of approximately £506 million.

60% who say they have to 'constantly remind or educate school staff' carving out time to do so, the burden placed on them takes a significant toll: Benedict Blythe Foundation 2025 Survey.

25 *Over 306,000 school days being gained across the population of pupils with allergies, and medication made available to the most at-risk groups in deprived areas:* NHS Digital data shows nearly double the A&E attendance rates compared to the least deprived areas (3.1 million vs. 1.6 million). In August 2024, around 2,200 schools with lower Ofsted ratings served approximately 79,500 pupils—many already disadvantaged by limited access to primary care and health education. These pupils are also the least likely to attend schools with access to life-saving emergency medication.

A parent will lose £7,020 per year by reducing their work hours. Costing the economy £506million per year: In the UK, an estimated 680,000 children live with allergies. Survey data from a 2025 Benedict Blythe Foundation survey shows that 53% of their parents—approximately 360,400 individuals—have changed jobs, reduced hours, or left work entirely to manage their child's condition. Assuming each parent reduces work by one day per week, and using an average full-time salary of £35,000, the annual income loss per parent is £7,020. This results in a total annual productivity loss of approximately £2.53 billion. Applying a 20% tax rate, lost tax revenue is estimated at £506 million. With a 5% pension contribution rate, this also equates to £126.5 million in lost pension contributions annually. These figures underscore the wider economic impact of allergy management and the potential gains from improving in-school allergy policies such as Benedict's Law.

£1.7million economic cost due to absences following school-based reactions: An estimated 336,600 pupils with allergies have had to leave school early at least once due to an allergic reaction, with over 148,000 experiencing this multiple times based on applying data from Benedict Blythe Foundation's 2025 survey to the figure of 680,000 pupils with allergies. If 1/3 take a day off after a reaction, that's 111,078 days. Based on government calculations of economic cost of £15.38 per lost day of adult working, that equates to £1,708,379.64.

£6.28 million economic cost due to anxiety-related work disruption among allergy parents: A 2025 survey of parents of school aged children with allergies by Benedict Blythe Foundation found 65% parents worry daily about their child while at school. According to Carers UK, one in six working adults caring for someone with a chronic condition lose 1–2 days per month due to anxiety, medical appointments, or crisis-related support. Applying this to allergy care, with an estimated 680,000 children in the UK living with allergies, and conservatively assuming 10% of their parents are significantly affected, around 68,000 parents may be losing work time each year. At a rate of 0.5 lost days per month, this results in 6 lost working days per parent annually, or a total of 408,000 workdays lost across this group. Based on a government-estimated cost of £15.38 per lost working day, the total annual productivity loss is approximately £6.28 million. Additionally, research shows that 65% of parents worry daily about their child's allergy safety at school, contributing to workplace disruption through early pickups, phone calls, or distraction. If a policy such as Benedict's Law could improve school preparedness and reduce just 10% of this anxiety-driven disruption, it would generate an estimated £628,000 in annual productivity gains—highlighting the economic as well as emotional impact of allergy management in school settings.

References continued

25 *£1.08 million in lost earnings annually due to parents exiting the workforce to home- school allergic children* A small but significant proportion of parents may experience lost income due to home-schooling their children as a result of severe allergies. Data suggests that approximately 2,346 children are home-schooled each year in the UK due to allergy-related concerns. Using a conservative estimate that 4–6% of this population reflects cases where parents face financial implications, this equates to around 117 parents (5% of the total). Assuming that 25% of these parents would otherwise be in employment, approximately 29 parents may be missing out on earnings. With the average UK salary at £37,430, the total estimated missed income across this group is approximately £1.08 million annually. This figure highlights the wider socioeconomic impact of unmanaged or unsupported allergy care on families.

26 *Around 50% of state schools purchase AAIs from their own limited budgets, creating unequal protection:* REACT Report 2024, Benedict Blythe Foundation.

At least 1/3 schools having no allergy policy at all, and 1/3 having one that isn't suitable: REACT Report 2024, Benedict Blythe Foundation.

27 *Releasing over £1.5million in school budgets that can be spent elsewhere:* See cost model on page 11 for new prescribing model. Assuming a private prescription cost of £76.95 per adrenaline auto-injector (AAI), and that 50% of state schools (12,000 out of 24,000) each have 2 pens, the total current spend in education on AAIs is approximately £1,846,800.The private prescription cost is approximately £646,800 higher than the NHS price for the same number of adrenaline auto-injectors. This represents a 53.9% increase over what the cost would be at NHS rates. This figure is rounded down to allow for a proportion of schools that may have received donations for their AAIs so that we do not give an over-estimate of the saving.

Tracking Adrenaline Auto- Injector (AAI) use in schools could identify the top 2% of schools with high-risk profiles (400 schools). Targeted training and care planning could reduce A&E visits by 400 annually, saving £132,000/ year, and preventing trauma: Calculation based on the proportion of visits per school * 400. Bias as we know high-risk profile schools may have a higher rate of A&E attendance, however this cannot be proved through existing research.

Helen, Pete and Etta Blythe, Benedict's family campaigning for Benedict's Law at 10 Downing St, alongside Prof Adam Fox OBE, Chair of National Allergy Strategy Group (NASG)

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