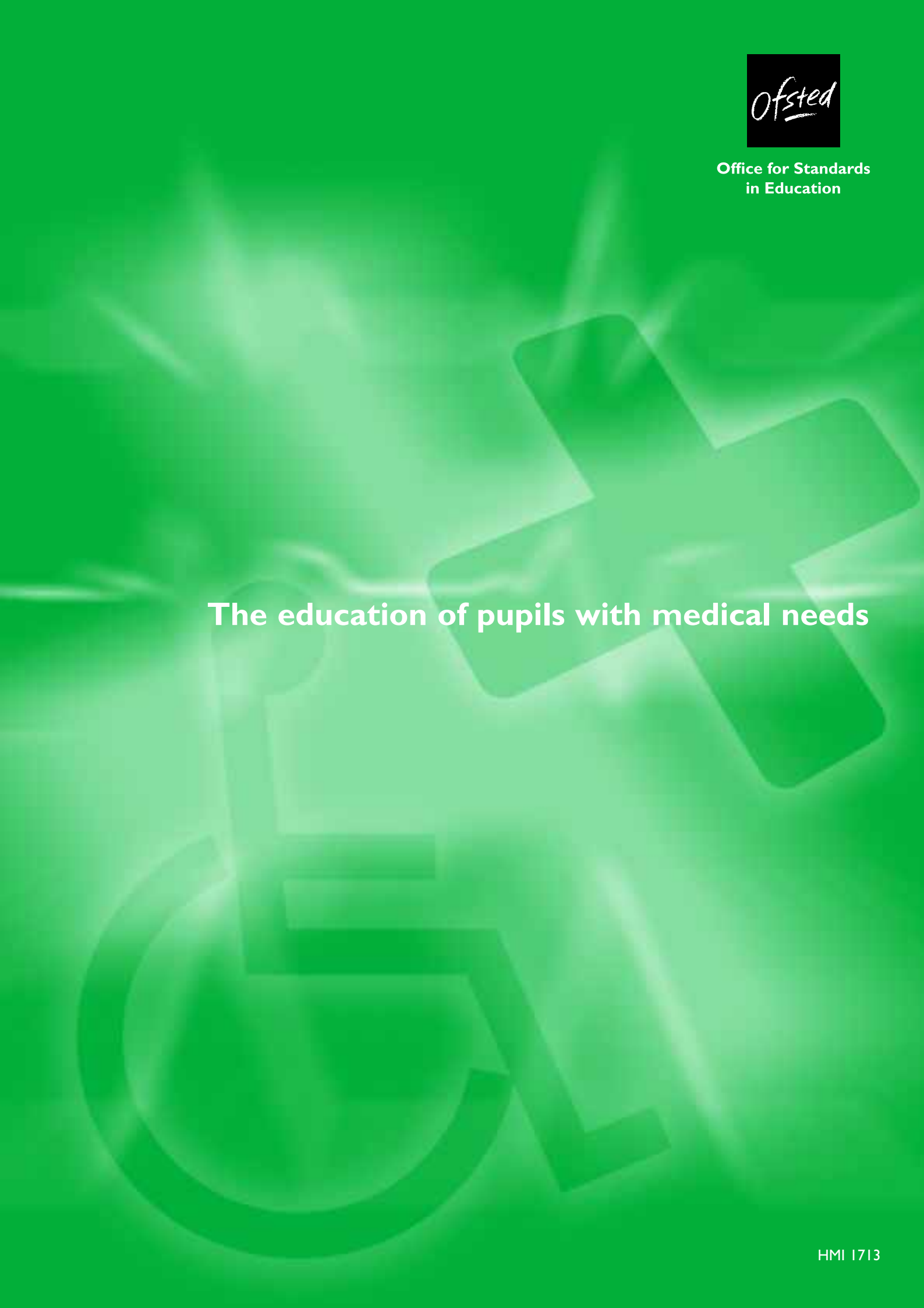

Office for Standards in Education

The education of pupils with medical needs

HMI 1713

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in Education

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Introduction

1 This report outlines the findings from inspections of provision for pupils with medical needs carried out by Her Majesty's Inspectors (HMI) in 12 local education authorities (LEAs) between September 2002 and March 2003.

2 Little overall evaluation of the provision for this group of pupils has been carried out for some time, although hospital special schools and pupil referral units are inspected regularly by Ofsted teams. In 1989 HMI published a report which drew on evidence accumulated between 1983 and 1988. This publication highlighted the variations in quality of provision, the difficult situations in which teaching often has to take place, the relative isolation of the work, and the challenge of meeting the needs across the curriculum of children varying widely in age and ability.

3 In 1996 the then Department for Education and Employment (DfEE) published *Supporting pupils with medical needs in school*: *a good practice guide*. The purpose was to help schools draw up policies on the administration and management of medication and to put into place effective systems to support pupils with medical needs.

4 In November 2001, the government issued statutory guidance, *Access to education for children and young people with medical needs*. This guidance was the result of a joint approach by the Department for Education and Skills (DfES) and the Department of Health. It was the first time that national standards had been introduced. The purpose of these standards was to minimise the disruption to education for pupils with medical needs, and to provide continuity of learning for those with both physical and mental health difficulties. The guidance contributed to the government's strategy to promote equal access to education for all children and young people.

5 The purpose of this Ofsted survey was to evaluate the effectiveness of the existing provision. The twelve LEAs inspected were: Bury, Coventry, Dorset, East Riding, Essex, Hertfordshire, Kent, Kingston upon Thames, Leicester, Southwark, Swindon and Wirral. HMI held meetings with heads of service and scrutinised documentation. They made visits to over 50 different providers, which included hospital special schools, adolescent psychiatric units, pupil referral units, hospital wards, home tuition services, mainstream schools and other units. They observed lessons and examined work in schools, pupil referral units, hospitals, adolescent and other units and in pupils' homes. They obtained additional evidence from discussions with staff, parents, pupils, some health professionals (mostly in adolescent psychiatric units), and teachers in mainstream and special schools.

Main findings

LEAs

- In almost all the LEAs visited, the DfES guidance, *Access to education*, has helped LEAs to improve parts of their service, but in over half policies and procedures do not yet reflect all aspects of the guidance. Providers, schools, parents and outside agencies are unclear about the service available and their respective roles and responsibilities within it.
- Most LEAs ensure that pupils receive at least the minimum amount of teaching each week, but the curriculum for many pupils is limited because teaching time is short or the accommodation is inadequate for the teaching of practical subjects.
- In a third of LEAs, there are too few opportunities for pupils, especially those with anxiety, depression and phobia, to work together in group settings. In some LEAs, pupils with medical needs are educated alongside those with emotional, behavioural and social difficulties (EBSD) and other complex special educational needs. In some pupil referral units this works well but in others it is inappropriate for the pupils with physical and mental health illnesses.
- In most LEAs little, if any, monitoring is carried out to determine the effectiveness of each part of the service and LEAs have insufficient data on costs and numbers to be able to evaluate the cost-effectiveness of the service.

Providers

- In all settings the quality of teaching and learning is generally good, pupils have very positive attitudes towards their work, their behaviour is good and, as a result, they learn well.
- Few pupils have personal education plans that detail all aspects of their education. This has a negative impact on the continuity of learning.
- In some hospital special schools, pupil referral units and hospitals there are good opportunities for pupils to improve their skills in information and communication technology (ICT), but in most settings, and in particular in home tuition, pupils have too few such opportunities.
- Most providers have stable staff teams but professional development opportunities for many teachers and tutors are limited in breadth and depth. Some lack knowledge and experience in working with pupils with more complex special educational needs.
- In three quarters of cases, the leadership and management of often complex organisations are good. A positive ethos is created in which staff work together to form strong teams. This has a positive effect on pupils' progress in their academic, social and behavioural development. However, in most schools and units there is insufficient monitoring of the quality of education provided and the collection and analysis of data are weak.

- Where hospital and home tuition services are located on sites with health professionals there is almost always good collaboration between them. However, in about one quarter of LEAs, links with Child and Adolescent Mental Health Services (CAMHS) are weak and, in half, providers have inadequate contact with social services.

Schools

- Most schools do not yet have the procedures in place to fulfil their role as detailed in the 2001 DfES guidance. Some schools take responsibility for pupils' learning whilst they are absent from school but in too many cases this does not happen, so that pupils are entirely dependent on tutors in the service for continuity in their learning.
- Pupils with anxiety, depression and phobia are sometimes not easily identified by schools. As a result, these pupils can be absent for considerable periods of time before they are referred to the appropriate service.
- Many schools and colleges lack confidence in providing for pupils with more complex medical needs and few are well supported by nurses or other health professionals in this respect.

Parents

- Almost all parents appreciate the good quality of education their children receive in hospital schools, units and at home. They are satisfied with the quality of teaching and the committed and understanding approach of staff which enables their children to make significant progress, both academically and socially.
- Some parents were critical of the delay in time before their children received support from the service and a significant number of parents of pupils who have anxiety, depression and phobia were critical of the time taken for schools to identify their child's illness and the ineffectiveness of pastoral arrangements.

Pupils

- Almost all pupils are pleased with the education they receive within the settings in which they are working. They enjoy small-group teaching and form close relationships with staff. A significant number of pupils with anxiety, depression and phobia were concerned about the time they spent at home before they received any real help.

Recommendations

- To improve the provision made for pupils with medical needs:

LEAs should:

- clarify the roles of the LEA, the providers, schools and other agencies in a policy which reflects the requirements set out in *Access to education for children and young people with medical needs*

- ensure that all parts of the service which provide education in a unit or school setting and are provided and maintained by the LEA are established as hospital schools or registered as pupil referral units
- develop a system for establishing stronger links between different parts of the service and between schools and the service, so that expertise can be shared
- improve joint work with health and social services
- improve the procedures for monitoring the quality of education provided and evaluating the cost-effectiveness of each part of the service.

Providers should:

- liaise closely with the LEA, schools and other agencies in drawing up personal education plans
- increase the opportunities for pupils to use ICT in their learning, and in communicating with their schools, by improving resources and by ensuring teachers have the skills and confidence to use ICT in their teaching
- increase the opportunities for staff to take part in training, in particular to improve their knowledge and understanding of working with pupils with more complex special educational needs
- improve the monitoring of the quality of education and use the information obtained to develop the provision further.

Schools should:

- ensure that there is a named person who is responsible for pupils who cannot attend school as a result of their medical needs
- establish a written policy and clear procedures which meet the recommendations in *Access to education for children and young people with medical needs*
- ensure that pupils are referred promptly to the appropriate service so that alternative education can be provided within 15 working days
- work closely with the hospital and home tuition service and, in particular:
  - take responsibility for drawing up personal education plans which outline all aspects of pupils' education and the person responsible for each aspect
  - provide the hospital and home tuition service with information about the pupils' curriculum, their achievements and any special educational needs
  - provide appropriate work and materials promptly and regularly
  - ensure pupils are re-integrated into their own schools smoothly.

Pupils with medical needs

6 The pupils receiving education from hospital and home tuition services include those who are physically ill or injured, pupils with anxieties, depression and phobia, and those who require support from specialist mental health services. In a small number of LEAs there are a few pupils with complex special educational needs (SEN), but not primarily medical needs, who are being educated within the service because LEAs are unable to find alternative suitable placements for them. By far the largest group of pupils are those with anxiety, depression and phobia. In all 12 LEAs, the number of pupils with such medical needs is increasing.

7 The age of pupils educated in the services ranged from 6 to over 16. By far the largest numbers are of secondary school age, in particular amongst those with anxiety, depression and phobia. However, the incidence of younger pupils suffering from anxiety and phobia is increasing. Adolescent psychiatric units mostly support pupils aged 13 to 19. Across all providers there was little difference in numbers of boys and girls, although more girls than boys with eating disorders were receiving support. About a quarter of pupils had statements of SEN.

8 The length of time pupils remain within the hospital service varies considerably. Some pupils receive short periods of support, recover and return quickly to their own schools, others have longer-term illnesses and receive extended periods of support or regular short-term support. Those with anxiety, depression and phobia often remain within the service for long periods. In all LEAs there are pupils who have been within the home and hospital school service for periods of more than a year, and sometimes as long as four years. Pupils usually stay in hospitals for short periods. Home tuition is provided for periods from six weeks to over two years. Pupils remain in hospital special schools and pupil referral units for varying periods of time, but for those with anxiety, depression and phobia, and those with more complex needs, this is often for periods in excess of two years. Stays within adolescent psychiatric units are on average between four and six months. In some of these units the pressure on budgets and the demand for places have resulted in shorter placements than those in the past.

9 Most pupils remain on the roll of their school while they are being educated within the hospital and home tuition service but a small, but significant, number of secondary-aged pupils are not on the roll of any school. These are generally pupils with anxiety, depression and phobia who have not been attending their own school for long periods.

10 The challenge facing providers is how to provide effective education for pupils who may differ considerably in terms of their age, ability, length of stay, medical condition and the setting within which they require education. Providers may be teaching pupils as young as four or working with 18 year olds; some pupils may be working towards Advanced Level (A-level) qualifications whilst others have severe learning difficulties. Some pupils may require education in hospitals for only one or two days, but others may remain in units for over two years as a result of their mental health difficulties. Some may have illnesses that result in regular support from providers; others might require short-term support while recovering from operations or accidents. Pupils may require home tuition as a result of their physical or mental illnesses, some may attend schools and units every day, while others may require regular teaching in their hospital beds while they receive treatment for recurring illnesses. A wide range of provision and well-qualified, adaptable staff are needed to meet the needs of this diverse group.

Local education authorities

Provision

11 In two thirds of LEAs there is a satisfactory range of provision. In the best examples this includes hospital special schools or units, a home tuition service, hospital teaching, adolescent psychiatric units and additional opportunities to meet the needs of the growing number of pupils with anxiety and depression, such as smaller units within other schools and part-time courses at colleges of further education (FE).

One of the key challenges facing almost all LEAs is the increase in the number of pupils with mental health difficulties who are unable to cope in secondary schools.

12 In at least a quarter of LEAs, there are units that are not yet established as hospital schools or pupil referral units. These are mostly National Health Service (NHS) psychiatric units which provide education that is funded and maintained by the LEA. LEAs should ensure that these are established as hospital schools or registered with the DfES as pupil referral units.

13 The provision in three LEAs is not entirely appropriate for the whole range of pupils with medical needs, as there is a lack of any provision between home tuition and a return to school. This means that pupils, especially those with anxiety, depression and phobia, are educated at home for too long.

14 In another third of LEAs, insufficient provision exists for these pupils to work together in group settings. This results in teaching pupils in isolation at home for too long. Some have no peer contact as they seldom leave home, and the tutor becomes the only point of contact between the young person and life outside the family home.

> *In Kent a small unit has been established in a spare classroom in a special school, to cater mainly for pupils who have anxiety, phobia and depression. The parent of a secondary-aged pupil described this new provision as 'a lifesaver'. For almost three years her child was unable to attend school or leave the house as a result of his anxiety. Sensitive support and encouragement by his home tutor have enabled him to leave home, travel to the centre and work within a group setting for a few hours each week. The centre itself and the flexible, encouraging approach offered by all the staff have made all the difference to this pupil and given him the confidence to begin to think about the future.*

15 Some pupil referral units cater for pupils with medical needs alongside those with other difficulties, in particular emotional, behavioural and social difficulties (EBSD) and other complex special educational needs. In two units this works well as a result of very careful timetabling and grouping of pupils. However, in others it is unsatisfactory, as the needs of pupils with physical injuries or illnesses, anxiety, phobia and depression are not always compatible with those who have EBSD. In one LEA there is inequality in provision: in one area there is good provision for all pupils within pupil referral units, while in another those with medical needs receive home tuition only. There are insufficient places in the local pupil referral unit as a result of the recent requirement to offer all permanently excluded pupils full-time education.

A major task is to establish and keep an appropriate balance of pupils with different needs, including special educational needs, in each hospital special school, pupil referral unit, and adolescent psychiatric unit.

16 In at least one LEA the lack of provision for pupils with more complex special educational needs and serious psychiatric disorders is leading to a risk that a specialist adolescent unit may become a placement centre rather than a treatment unit. This is of concern to health and education professionals as pupils may stay in the unit longer than is necessary and others are therefore prevented from obtaining the treatment they require.

> *A Year 10 pupil who has psychiatric difficulties is unable to attend his own school. He was refusing to attend for almost a year and became very anxious about being close to other people. He attended a psychiatric unit for a year; he still attends the unit in the mornings, where he has counselling and therapeutic provision, and in the afternoons he attends the hospital special school where he works in a larger group and follows General Certificate of Secondary Education (GCSE) courses. He still finds being with larger groups difficult but feels he is being given the support he needs and has developed a more positive outlook.*

17 The quality and extent of accommodation vary considerably between LEAs and between types of provider. While some hospitals are very well equipped with school rooms, small group rooms and social areas, others have no teaching area and little, if any, storage space. Some hospital special schools and pupil referral units have very good accommodation, with specialist teaching areas, whilst others are cramped and inadequate to teach all subjects. Adolescent psychiatric units generally have few specialist facilities and the quality of the buildings varies considerably. Not all types of provision are fully accessible to wheelchair users. LEAs need to do more to ensure that suitable accommodation, resources and learning environments are available to meet the needs of all pupils, including those who are physically ill or injured and those with mental health problems.

Hours of education

18 The hours of education provided vary between LEAs and between providers, but almost all provide at least the minimum requirement of five hours a week. Hours of home tuition are generally shorter than in any other type of provision. However, in some LEAs, for example Hertfordshire, most pupils receive ten hours of home tuition a week. Most home tuition services try to give additional hours to Key Stage 4 pupils so that they can keep up with some examination courses. Hospital teaching tends to take place in the mornings and hours are appropriate to the pupils' medical needs.

19 Most hospital special schools and pupil referral units provide full-time education, but there are exceptions. One provides only 10 hours a week because of the high demand for places and the inadequate accommodation. This is achieved only as a result of careful timetabling by senior managers. Some pupil referral units offer fewer hours because of the pressure for places resulting from the requirement to offer full-time education to permanently excluded pupils. Adolescent psychiatric units provide fewer than 25 hours, but part of the week is used very appropriately for therapy and other treatment. The curriculum for many pupils with medical needs in almost all LEAs is limited because teaching time is short.

Policies and procedures

20 In all but one LEA, the DfES guidance has had some impact on the LEA's provision. In half of LEAs the heads of service believe that the guidance has helped them to improve their service, in over half it has been used as a means to bring about change, and in one third it has made schools more aware of their responsibilities. More than half have reviewed their policies or are in the process of reviewing them. In two, the length of time before education begins has decreased and the hours of education have increased. Training, based on the national standards, has been provided in three LEAs. In Kent, the headteachers of the hospital schools have provided training opportunities for all schools, at which common formats for review and referral were introduced. In Swindon, new premises have been established as a result of the guidance and the subsequent review of the whole provision.

21 However, in over half of the LEAs, policies do not include all the aspects set out in the guidance. The lack of a clear policy means that staff within the service, as well as schools, parents, pupils and outside agencies, are unclear about both the service available and their respective roles and responsibilities within it.

22 In most LEAs, schools show little awareness of the guidance, although special schools are better informed than mainstream. Few secondary schools have a named person who takes responsibility across the school for pupils with medical needs. A third of LEAs provide very little information about the service for parents. They do not promote the service, and parents only find out what is available if they actively seek information. In contrast, a few LEAs produce detailed information for parents which is easily accessible through providers, schools and doctors' surgeries.

> *A Year 6 pupil has a medical need that means he has to return to hospital frequently. His mother is pleased with the education he receives in the hospital but until recently she was unaware of the other support he is entitled to, for example home tuition when he is too ill to attend school. She was unaware that he is allowed special arrangements for taking examinations to fit in with his complex pattern of medication. This is a weakness on the part of the service and the school.*

> *In one LEA some schools are not aware of their role and responsibilities in referring pupils to the service. A few schools have very good systems in place but there are others which fail to ensure parents and pupils are given the details they need about the service. The LEA has not established whether or not schools have named persons responsible for pupils with medical needs, or that they have systems in place to respond quickly to the needs of these pupils. One consequence of this has been that a Year 10 pupil suffering from chronic fatigue syndrome has not attended his school for any length of time since Year 8. Although his parents have attempted to secure work from the school, they have not been referred to the home tuition service.*

23 Two thirds of LEAs have satisfactory procedures for dealing with referrals but in one third of LEAs some pupils had to wait too long before they received tuition either at home or within a school or unit. In a few LEAs, pupils who become ill during the summer holidays often remain without education for some time. Where referral by schools is slow and the LEA's response is also slow, pupils miss considerable periods of education. This is most

common for those with anxiety, depression and phobia. In a few cases pupils do not receive education for periods of up to two years. However, if appropriate, those in hospital receive education from day one either on the ward or in the schoolroom.

24 In most LEAs personal education plans are not established and, although individual plans are drawn up by most providers, these do not bring together all aspects of pupils' education, including liaison strategies and plans for re-integration to school. The lack of a clear policy in some LEAs means that outside agencies may be uncertain about their role and responsibilities. In over half of LEAs regular review meetings are organised between the provider, schools and sometimes the LEA. However, there is generally little input into these meetings from other agencies such as CAMHS and social services. In adolescent psychiatric units all review meetings include multi-disciplinary representatives, and in Kingston upon Thames there is very good involvement of CAMHS professionals in regular review meetings.

25 When LEAs are not sufficiently involved in the re-integration of pupils into their own or other schools, some pupils receive home tuition for long periods, which may not be appropriate. In two LEAs, budget constraints prevent providers from employing teaching assistants to support pupils as they re-integrate into their own or another school. This results in less successful re-integration programmes and sometimes extended placements within the hospital and home tuition service.

26 In contrast, at an adolescent psychiatric unit in Essex, pupils are very well supported by a nursing team as they re-integrate gradually into their own schools. This continues for several months after they have returned and provides both the individual and the school with the support needed to make the re-integration successful.

27 Adolescent units are facing other challenges on re-integration. LEAs do not influence referrals to these units but it is important that they are involved in re-integration. Many of the young people who attend these units are not able to return to their own school once they are discharged because of their previous experiences or behaviour. It is often very difficult to place these young people back into schools. As a result, there is a danger that these specialised units, for which demand is constantly rising, are being expected to provide longer-term placements for pupils with severe mental health problems, complex special educational needs, such as autistic spectrum disorders and challenging behaviour, because there is no suitable provision within the LEA. Some pupils are discharged and remain at home for some time.

28 Pupils at the end of Year 9 or beginning of Year 10 in hospital special schools, pupil referral units, other units and those on home tuition, who have anxiety or other conditions, are very difficult to re-integrate into their own or other schools. As a result they remain in the school or unit or continue home tuition until the end of Year 11. This is true for some pupils in all LEAs. It is not a result of ineffective re-integration procedures on the part of LEAs but of the pupils' inability to consider a return to mainstream schooling because of their previous experiences. This is also occasionally true for primary-aged pupils.

A Year 5 pupil with learning difficulties and complex emotional, behavioural and communication needs was out of school for five months prior to admission to a specialised hospital school. It took her several months to settle in, during which time her behaviour was very unpredictable. She then started to make gradual progress in her ability to remain calm, to listen and eventually to communicate with her peers. She began to join in small group activities and her interest in learning began to develop. She was discharged four months later.

A suitable school had been identified but a place was not immediately available. Despite the best efforts of school staff a time lag was unavoidable. Her mother was anxious that all the progress made during her time at school would gradually be lost and that once more she would regress whilst she remained at home without peer contact.

Monitoring the provision

29 In over half of LEAs, little monitoring is carried out to assess the quality of the provision in different parts of the service. This means that LEA line managers have little information about the effectiveness of the service as a whole and the aspects requiring improvement.

30 Providers receive little advice from LEA inspection and advisory services or SEN departments. Often this is a result of the organisation of LEA services. Home and hospital services are frequently managed by LEA departments other than those which deal with schools. In one LEA an adolescent unit is managed by a different team from the remainder of the service. The lack of support and advice from SEN departments is, quite rightly, of concern to some providers, especially as more pupils with increasingly complex needs are referred to the service. In at least two LEAs the lack of monitoring and the lack of involvement of SEN staff in the provision of education for pupils with medical needs adversely affects the appropriateness of the education offered to some pupils.

A Year 9 pupil with a statement of SEN and showing extremely challenging behaviour as a result of a psychiatric disorder was excluded from school but no alternative placement was provided. She remained at home for six months before her five hours of home tuition per week started. The objectives on her statement are not being met. The LEA's special needs department has not been involved in monitoring the appropriateness of a placement within the home tuition service.

A Year 3 pupil has been out of school for nine months as a result of anxiety and phobia. He was thought by home tutors to have both language and learning difficulties. There has been no follow up by his school since he stopped attending; no assessment has been made of his special needs by an educational psychologist and no review meeting has been held.

31 Over half of LEAs collect little data about the numbers of pupils receiving support during the course of the year and their length of stay in different types of provision. Accurate information on numbers was difficult to obtain in a third of LEAs. It was most difficult in LEAs where no distinction was made between pupils with medical needs and those who have been permanently excluded. However, in Bury, data is used well to analyse and support the service's performance indicators. In Kingston upon Thames, the East Riding of Yorkshire, Hertfordshire and Bury, parental and school questionnaires are sent out regularly by the LEA to evaluate users' satisfaction with the service. This information is used to improve the provision.

Funding

32 In five LEAs, accurate figures showing budget expenditure were not available. No LEAs provided a breakdown of cost according to types of need and length of placement. In some LEAs, budgets are based on historical costs rather than current information. The paucity of detailed data on numbers and costs means it is difficult for LEAs to judge the cost-effectiveness of different parts of the service for different groups of pupils.

33 All LEAs find this a difficult service to budget for because numbers likely to use the service are difficult to predict. Budgets are under pressure in all LEAs and as the number of pupils with medical needs increases, so does pressure on budgets.

Almost all LEAs find difficulty in funding a service for which numbers are growing but hard to predict.

34 Average costs per pupil in the seven LEAs that provided figures varied from £1,100 to over £4,000. This cost varies according to the length and type of placement and the hours of education provided. Comparisons between LEAs are difficult as the provision differs considerably, and comparisons between the different types of providers, for example hospital schools, are also of little value as the medical needs of pupils in each one differ.

Promoting links with providers, schools and agencies

35 Most LEAs could do more to promote links between providers and schools. Only two LEAs initiated training in the national standards for all schools and, where policies are unclear and LEAs do not publicise their services, schools are not fully aware of the services available or their responsibilities within the service. As a result, providers do not receive the information they require from schools, and schools do not take responsibility for ensuring continuity of learning for pupils whilst they are being educated within the hospital service.

36 In almost all LEAs there are some examples of effective provision. However, LEAs do not do enough to encourage links between these providers and other schools and units; the good practice is therefore unlikely to spread. For example, very little use is made of staff from the hospital schools, units and hospital teaching services to provide training in schools. Training and reassurance from experienced teachers could ease the concern evident, in mainstream schools in particular, about meeting the needs of those with more complex physical and mental conditions.

37 In LEAs with adolescent psychiatric units which are financed mostly by the health service, there is generally little contact between these and other parts of the service. This means that opportunities are missed to use the knowledge and experience of staff at these units to develop the skills of others, both within the service itself and in schools. In addition, these smaller units can become isolated from other parts of the service and other schools. Staff within units are not always included in training opportunities, especially in relation to new developments and initiatives, and in some LEAs these units have not received any additional funding from the Standards Fund.

38 Links with health and social services at LEA level are satisfactory in most cases, but in a number of LEAs they are less effective at provider level. Links between health professionals and the service are strong within hospitals and in adolescent psychiatric units and in some other schools and units. However, in other LEAs some referrals to CAMHS take a long

time, and there are long waiting lists for all counselling services. In most LEAs, links with social services departments are less effective than those with health professionals. While there were some examples of good links with health professionals – for example in Kingston upon Thames – there were very few examples of sustained, effective links with social services.

Providers

The quality of education

39 Most schools, units, hospital teaching and home tuition services are well led and managed; teaching in them is good and pupils achieve well. However, for some pupils in schools, units and on home tuition, achievement is limited to a narrow range of subjects, as the hours of education are short or the accommodation and resources are inadequate.

40 Pupils with the most severe physical and mental health illnesses are at times able to manage only a few hours of education a week, but there are a significant number, including many who have anxiety, depression and phobia, who are well enough to receive more teaching each week. Even though home tutors set a good amount of work for pupils to complete independently, this does not compensate for the short hours.

41 Some pupil referral units and schools have good accommodation which allows a range of subjects to be taught.

> *One hospital school ensures that all pupils follow a physical education (PE) course unless their medical condition at the time prevents participation. The hospital gym or an outdoor space is used for the weekly hour of PE. Younger pupils develop their skills of catching, throwing and striking while older pupils are challenged by problem-solving tasks which encourage co-operative learning. Meanwhile, on the wards, pupils are taught in small groups according to their abilities. Two Year 11 pupils were completing a GCSE assignment on how to prepare and recover from exercise safely and effectively; two other pupils with extreme mobility difficulties were thoroughly enjoying playing a game of bowls, using specially adapted equipment.*

42 However, many providers are unable to offer design and technology, science and PE because of inadequate facilities. This means that pupils on long-term placements do not experience a sufficiently broad curriculum. Many hospitals do not have a school room, which means small-group teaching is difficult.

43 Many pupils achieve the examination grades predicted by their school, and some, particularly those whose attendance at school had been poor, achieve above the expected level. Most hospital schools and pupil referral units offer a good number of entry-level and GCSE courses. They adopt a flexible approach and teach courses which meet individual or small group need. Leicester Hospital School has recently introduced the Award Scheme Development and Accreditation Network (ASDAN) scheme to meet the needs of some of its pupils who are on long-term placements. East Kent Hospital School has introduced the General National Vocational Qualification (GNVQ) in information technology for pupils on long-term placement at the school and for some on home tuition.

> *The manager of an adolescent psychiatric unit is trying to provide Key Stage 4 pupils with an appropriate individual curriculum. A Year 11 pupil was working towards a GCSE in childcare based on work sent in by her school. She continued this while she was attending*

social skills groups and other therapy which developed her confidence and self-esteem. She reached a part of her course where she needed to attend school for a practical session. With support and encouragement she managed to attend and now has the confidence to attend all childcare lessons in her school. She is now following a work-related learning course and is looking forward to full-time employment at the end of this year.

44 In many centres and units for pupils with mental health difficulties there is a strong emphasis on creative development. For example, at Bethlem Hospital School there is a focus on creative poetry, art and music, and pupils take part in a regular production. Pupils in many centres and units achieve well in these areas. These experiences help them to gain confidence and improve their self-esteem.

45 In many centres, work experience is provided for pupils on long-term placements. In one in three LEAs, some pupils attend college part-time to follow vocational courses. In the East Riding of Yorkshire, money from the Standards Fund has been used to develop this further. In Bury, links with the youth service have been established and youth workers support pupils with medical needs in college. Some pupils achieve well in these courses and move on to full-time college courses at the end of Year 11.

46 Some schools and units, in particular adolescent psychiatric units, offer a good range of additional activities. Regular use is made of leisure and other facilities in the local community. These activities contribute to pupils' physical, social and personal development. Pupils who receive home tuition seldom have the chance to take part in any additional activities. However, the commitment and dedication of a number of tutors mean that they give up their own time to take pupils out in the community, for example to the local library.

47 Amongst all providers there is a shared understanding of the importance of academic achievement to pupils' self-esteem, regardless of whether they have a physical or mental illness. In adolescent psychiatric units, short periods of education are part of pupils' treatment from the first day. Complex arrangements are made by providers to ensure that pupils are entered for the appropriate examinations and take them in the most suitable location for the individual, which might be at home, in hospital, in a small room in school or in a unit or hospital special school. In schools and units where pupils often remain for longer periods of time, there is strong focus on recognising and celebrating achievement in many different areas of the curriculum.

A secondary-aged pupil has to spend considerable periods in hospital to stabilise a serious condition which has also led to periods of severe anxiety and depression. She has received support matched to her physical and mental condition at any one time. Initially she received support at school from a home tutor. She has also benefited from hospital teaching and most recently she has been able to attend a unit. This pupil is making excellent progress, and she is gradually increasing her hours of attendance. She is following GCSE courses in four subjects and benefiting from the opportunities to mix with other young people on a regular basis. The most striking aspect of progress has been in her social development, both in the centre and in her recreation time.

48 Most pupils achieve well because the quality of teaching and learning is good and pupils have positive attitudes towards their work. During the inspections, the quality of teaching

and learning was at least good in over three quarters of lessons in schools, homes, units, hospitals and adolescent psychiatric units, and in one third it was very good. In over two thirds of lessons pupils' attitudes towards learning and their behaviour were very good. The only setting in which attitudes were less positive was in a pupil referral unit where pupils with medical needs worked alongside those with EBSD.

49 Teachers prepare carefully for lessons so that work is challenging for all ages and abilities. A good variety of tasks is included, and in schools and units imaginative use is often made of a good range of resources. However, in some hospitals, particularly those without school rooms, resources are limited and teachers often have to spend considerable amounts of time adapting and making resources to meet individuals' needs. In almost all lessons, clear explanations are given and questioning is appropriately matched to pupils' levels of understanding, used well to assess learning, to encourage participation and to develop pupils' confidence in speaking aloud.

50 In most adolescent psychiatric units, thorough, four-weekly assessments of pupils' learning and behaviour are made by a multi-disciplinary team. These assessments are used well to plan appropriate lessons for pupils. A good emphasis is placed on pupil self-assessment, in particular in relation to their behaviour and self-image.

51 Baseline assessment is carried out on entry to almost all providers. This is especially important when pupils have been out of school for some time and schools' records of pupils' achievement may no longer be accurate, sometimes because pupils have regressed as a result of their illness. Some providers are beginning to use an electronic tracking system to monitor pupils' progress. West Kent Hospital School uses an online assessment system to measure performance in a range of subjects. This provides useful information for teachers in the hospital school and those in other schools when pupils re-integrate. Many home tutors and teachers in schools and units make detailed recordings of pupils' academic and social achievements which, for those on longer-term placements, are used to compile half-termly or termly reports. However, the comments recorded are in some cases more about activities covered than what had actually been learned.

> *A range of different professionals are brought in by the service to help assess pupils' needs and to shape the teaching strategies. After three weeks, an initial review is carried out with a member of staff from the school, the relevant health professionals and the educational psychologist responsible for children with medical needs. The psychiatrist from CAMHS is involved in monthly reviews with staff in the service. Staff make detailed records of pupils' achievements and difficulties in their academic and personal development. The whole assessment and recording process ensures that all pupils' needs are properly identified and the provision is matched accordingly.*

52 Few pupils have detailed personal education plans which outline all aspects of their education over the longer term. Although lesson planning in the short term is mostly good, there are some weaknesses in longer term planning because teachers in some schools, centres and home tuition services do not have an overall plan to guide them in their teaching. This is more evident in Key Stage 3 than in Key Stage 4, where teaching is in almost all cases based on the requirements of examination courses. In a few providers, good use is made of the primary national strategies to guide teachers in their planning. The impact of the Key Stage 3 Strategy is less evident, as most teachers in smaller units have not had access to the strategy training.

53 In almost all providers there is a suitably experienced staff team. Although current teacher recruitment difficulties are affecting some schools and units, most providers have a stable staff. A significant number of home tutors are retired teachers from secondary schools. They form a good core of experienced staff but part-time, temporary tutors, who are often required at short notice, are difficult to appoint. Home tutors, hospital teachers and teachers in small units often teach a range of subjects to primary and secondary pupils who have varied abilities and differing medical needs.

54 Staff in some settings have good opportunities for professional development which ensure they are well informed. Generally home tutors are paid only for the hours they work so any training has to take place in their own time. This is unsatisfactory and results in some tutors lacking knowledge and understanding in some areas, for example, SEN, ICT and the national strategies.

A problem for LEAs and providers is to ensure that staff have the skills they need to teach pupils who have increasingly complex needs, and that schools have support from a full range of professionals, including SEN experts, nurses, counsellors and youth workers.

55 In hospitals and adolescent psychiatric units, training in health-related issues is usually good. In Kingston upon Thames, staff receive good training in curriculum, health and work-related learning areas. In hospital schools and pupil referral units, headteachers ensure staff have the opportunity to keep up-to-date with examination requirements, either by attending courses, or in a few cases, by liaising closely with other schools. However, training for many staff is limited in breadth and depth.

56 Some schools and pupil referral units use their own or other subject specialists well and this makes an important contribution to pupils' learning. In Leicester Hospital School, Key Stage 4 pupils receive home tuition from subject specialists wherever possible. Guys Evelina hospital school buys in peripatetic music and art teachers. In East Kent, some teachers from pupils' schools provide lessons at home after school hours. In Longview adolescent psychiatric unit in Essex, an advanced skills teacher from a local secondary school gives pupils practical science lessons after school hours and offers advice and support to unit staff. Although most non-specialists conscientiously ensure they are briefed in the topics they teach and many pay particular attention to subject-specific vocabulary, a lack of subject knowledge is evident in some lessons.

Year 11 pupils with anxiety, depression and phobia in a hospital special school were preparing for a GCSE assignment. The abilities within the group varied from those with learning difficulties to those likely to achieve high grades at GCSE. The teacher was a subject specialist who used her knowledge and understanding of the pupils to select a text that would be of interest to all and allow each pupil to contribute to the group discussion.

Expectations for work and behaviour were very high and pupils showed a mature, interested approach to the tasks. The teacher created a positive atmosphere, and learning was fun. Pupils were confident to express their opinions in both small, ability-based groups, in which they were well supported by a teaching assistant, and whole group discussions. Thoughtful questioning by the teacher ensured pupils were discussing the text in a depth appropriate to their abilities. All pupils made good progress in both their

understanding and interpretation of the text and also in their ability to work co-operatively.

57 In some hospital special schools and hospitals, for example, the Guys Evelina School and East Kent Hospital School, there are good opportunities for pupils to develop their ICT skills. In other parts of the provision, in particular home tuition services, pupils have few opportunities to build on their existing knowledge and skills. Equipment is limited and few tutors have received New Opportunities Fund training in ICT. In East Kent, the Standards Fund is being used to develop a virtual classroom and video-conferencing facilities. Across all providers very little use is made of ICT to allow pupils to keep in contact with their peers or to receive their work from schools.

An issue for LEAs and providers is to improve ICT resources in hospital and home tuition services and increase staff understanding and confidence in using technology.

58 Some teachers in schools and units and some home tutors lack knowledge and experience in working with pupils with more complex SEN. In one third of LEAs, staff have too few opportunities to develop their knowledge and skills in this area. Some schools provide only limited information about pupils, and where individual education plans are made available they are at times inappropriate or ineffective in guiding teachers in the strategies that should be employed to enable progress to be made. As a result, these pupils' learning is not as effective as it could be.

59 Relationships between staff and pupils are very good. Pupils develop confidence in the relaxed and encouraging atmosphere in schools, units, hospitals and homes. Handover briefings in adolescent units and hospitals are thorough, and teachers are well informed about pupils' current difficulties and are mindful of their illnesses. Teachers have a calm, sensitive approach. Pupils are offered choices and, although there is a flexible approach, expectations are high and tasks are challenging. Teachers use persuasive skills very well to engage pupils, especially primary pupils, and praise their work appropriately. Lessons are generally enjoyed by all and in this positive learning environment pupils work well independently, their levels of concentration are good, they are eager to learn and they offer their opinions willingly. The pride pupils take in their work is evident in their attitudes in lessons and in the presentation of much of their written work.

For two years a pupil has had chronic fatigue syndrome and, despite her determination, she has been unable to manage a day in school. Her teachers were concerned because they knew she had the potential to achieve top grades in a wide range of GCSEs. The home tuition service suggested that she reduce the number of subjects she was studying as her condition seemed to be deteriorating.

The pupil was involved in all decisions about her education and was adamant that she would not give up any subjects. Now, with the regular support of two tutors, she is completing nine GCSEs, two of which she is doing with support directly from teachers at her school. She is producing work of a high standard in all subjects.

60 In schools and units where pupils are taught in small groups, a strong and appropriate emphasis is placed on developing pupils' skills of collaborative lear-ning. Pupils, particularly those with anxiety, depression and phobia, make good progress in this respect. Some pupils in long-term placements develop close circles of friends, and happily take part in group activities during and after school hours, often for the first time in their secondary schooling.

In LEAs where there is very little provision for pupils to work together in group settings pupils make, at best, only slow progress in developing their independence and social skills. This is of particular concern for pupils with mental health problems.

Leadership and management

61 In three quarters of schools, centres, home tuition and hospital services, leadership and management are good. Headteachers or heads of centre give clear direction and organisation to what is often complex provision. A positive ethos is created in which staff work together to form strong, and in some cases multi-disciplinary, teams. This has a positive impact on pupils' academic, social and behavioural development.

62 Overall, staff are deployed well; there is appropriate delegation of responsibility, and in most cases effective systems have been established to ensure regular communication with home tutors, most of whom are employed for only short periods. Daily routines are clear to all and, in some settings, for example in Leicester and in parts of Essex, the careful grouping of pupils ensures that teaching time is used as well as possible and pupils are taught in groups appropriate to their needs.

63 Leaders and managers are generally less effective at monitoring the quality of education provided by their school, unit or service. Although performance management systems have been introduced in most settings, there is little monitoring of the quality of teaching, in particular of home tuition and hospital teaching. Little evaluation of strengths and weaknesses takes place and only a few providers have established clear development plans for improving their practice.

64 The collection and analysis of data are weak. Some centres have recently started to track pupils' performance and use value-added information but very few analyse financial data to measure the cost-effectiveness of different parts of the provision. As a result it is difficult to make judgements about the value for money that each school, centre or unit provides.

Links between providers and other agencies

65 Where hospital and home tuition services are located on sites with health professionals there is almost always good collaboration between them. Links between all professionals, including health, education and social services, are good in specialist units for pupils with psychiatric illnesses. Links between hospital teachers, health professionals and other hospital staff, for example play therapists, are generally good. In these settings, multi-disciplinary teams respect the importance of each other's contributions. They have a shared understanding of the importance education plays in pupils' recovery and in the development of their self-esteem. Regular meetings, in particular in adolescent units, are held to discuss each pupil. These are attended by all the agencies involved. As a result, joint planning and monitoring of pupils' progress in their health and education takes place. These professionals remain involved during the re-integration process and often beyond. However, links with other providers are not as good. In about one quarter of providers, links with CAMHS are weak and, in at least one half, providers have little contact with social services departments.

66 Some schools and units have, however, developed strong links with CAMHS. This is partly because some LEAs have worked with other agencies in developing clear policies and procedures in which roles and responsibilities are clear.

67 In LEAs where policies, procedures and responsibilities have not been made clear, links with health and social services departments are often inadequate. Personal education plans are not established at the time of referral to the service, which means that the role of different professionals is not clearly established from the beginning. This, combined with the pressure on health services and social services departments, results in less effective partnerships and less comprehensive support for pupils.

A key task for almost all LEAs and providers is to improve links with health and social services departments so that all pupils receive effective multi-disciplinary support.

68 Where links are good, joint termly meetings are held and decisions are made about placements and strategies to support pupils. At a school in Dorset, a multi-disciplinary meeting is held each half term, chaired by the head of in-school learning and attended by the SEN co-ordinator (SENCO), the teacher responsible for children in public care and representatives from health, social services and Connexions. A small number of high-priority pupils are discussed. This is an efficient arrangement for different professionals to share a response together.

69 In about one third of LEAs, pupils on home tuition benefit from support from CAMHS professionals. In one LEA, pupils with chronic fatigue syndrome have daily management plans which are overseen by specialists and reviewed every two weeks. Psychiatric teams advise on strategies to help overcome anxiety and depression. Home tutors play an important role from the beginning. As pupils progress, teaching time increases and a programme for gradual re-integration to school starts. Throughout, regular review meetings are held with the school and health professionals to monitor progress and plan the next step.

> *A Year 10 pupil with a mental health problem which resulted in a pattern of challenging behaviour, was admitted to a pupil referral unit. Staff at the centre were unsure how to approach and manage the behaviour in the best way for both the pupil and the rest of the group. A consultant psychiatrist came into the unit and discussed the problems from the child's perspective. As a consequence there was a review of the arrangements for his lessons, break times and groupings. The pupil was temporarily given individual support and a programme of limited, specific targets was agreed with the consultant. The pupil is slowly being given opportunities to work with his peers, starting with spending break with one other pupil. There has been some progress and staff now understand the process will be slow.*

70 However, in many other LEAs, pupils, particularly those with anxiety, depression and phobia, remain at home for long periods without any support from health professionals. Some providers report that, as a result of the demand on the services, some pupils wait 10 months for individual appointments, in particular for counselling. At least two providers have trained members of their staff in counselling skills, or appointed their own part-time counsellors.

71 About two thirds of schools, units and home tuition services have developed partnerships with Connexions services; personal advisers support individual pupils in developing their career plans, or, in a few units, they contribute to the teaching of careers education. Some providers have good links with youth services. In Hertfordshire and Bury youth workers support pupils when they attend alternative Key Stage 4 provision.

A Year 11 pupil, suffering from anxiety and a fear of crowds, was permanently excluded from school and subsequently attended a pupil referral unit. An individual curriculum was designed for her, which included part-time college attendance. A youth worker collects the pupil from home each morning, and if the pupil is unable to leave the house, works with her to try and help her overcome the fear and leave the home. The youth worker also attends college with her. This support is most beneficial, but the pupil is not receiving any other specialist support from health services to help her overcome her anxiety and phobia.

Links with parents

72 In most LEAs, providers have developed at least good links with parents. Providers ensure that parents are involved from the beginning. Initial meetings are organised quickly and providers aim to establish effective working relationships with parents in a short space of time. Providers recognise the difficulties parents are likely to be experiencing, are understanding of their needs and try to offer effective support for both them and their children. Some strong relationships have been established with parents of pupils who have recurring medical conditions. Home tutors play a vital role in linking parents to the service; they often form close relationships with pupils and the rest of family.

73 Regular telephone calls are made to parents, review meetings are held, and in some units, in particular adolescent psychiatric units, individual education plans and weekly diaries are sent to parents. These are particularly important for pupils who return home at weekends. Some schools and units who have pupils on long-term placements provide progress reports for parents and hold regular open evenings for them. However, some providers do not involve parents fully in discussions about a pupil's curriculum or individual targets.

Schools

74 Pupils achieve most when there is close liaison between schools and the providers. Sometimes schools are too slow in referring pupils to the appropriate service. This results in having pupils at home for too long before alternative education begins.

A challenge facing almost all LEAs is to ensure that all schools take full responsibility for their pupils, whatever the length of absence, throughout the time they remain on the school roll.

75 Some schools continue to take responsibility for pupils' learning: providers are sent information about pupils' abilities and difficulties, including any special educational needs, and work is set and marked thoroughly and regularly. However, in too many cases this does not happen and it is mainly the hard work of the dedicated teachers and home tutors that enables pupils to achieve some continuity in their learning.

A Year 8 pupil needed dialysis three times each week. This involved a lengthy return journey as well as the treatment. The school's SENCO took responsibility for the overall planning of his education; a member of staff from the hospital school visited the main school to share information about the pupil's treatment and a joint educational programme was established. The school set work to be completed during treatment and, on return to school, swimming and PE time (in which the pupil was unable to participate) were used to catch up on missed work. This pupil continued to make good progress whilst attending hospital because the main school took responsibility for planning his educational programme and liaising with hospital staff and parents. The school and parents had the expectation that he should do as well as his peers.

A Year 11 pupil had chronic fatigue syndrome and had not attended school for two years. Hospital school staff motivated her to study. Good links were established with her school. Work sheets and curriculum ideas were provided by them. This pupil had a particular interest in science and was entered for the double science GCSE. She was very nervous about returning to mainstream school because of her fragile physical condition, so the school offered support by opening the science laboratories after the end of the normal school day to enable her to complete the necessary experiments.

At the time of admission into this specialist provision for pupils with emotional and psychiatric difficulties, a target is set for re-integration into school. This target date is regularly reviewed but the aim is to ensure that pupils, parents and schools realise that this specialist provision is for a short time only. To reinforce this, regular contact is kept with schools. After the first four weeks a review meeting is held and from this point most pupils begin to visit their school every fortnight, dressed in their uniform and accompanied by their key teacher. To begin with, pupils meet with the liaison teacher to exchange completed work and collect new assignments. As confidence increases they meet subject teachers to discuss any difficulties with work. Meetings are arranged for a quiet time of the

day in a room near the front of the building. This system keeps both the provider and pupil in contact with the school.

This secondary school has a base for pupils who have physical disabilities. The SENCO has responsibility for the base which is staffed by teachers and support assistants who know the pupils well. A Year 10 pupil was in hospital following an operation in the summer holidays. There was close liaison with the hospital staff from the beginning, work was sent up to the hospital, and staff from school visited the pupil. The whole ethos of the school is supportive of pupils with difficulties and this helps to ease pupils' re-integration after absence.

76 When schools are slow, do not send providers information about pupils or do not set regular work for them, pupils' achievement is affected in the short term and for some pupils over the longer term as well. If information is not received from schools or is too slow arriving, pupils are at best consolidating rather than extending their learning. Some schools initially provide information and work, but as the length of absence increases the school's involvement in the pupils' learning decreases. This includes the setting of work and attendance at review meetings.

A Year 10 pupil has not attended school regularly since Year 8. His presenting symptoms have been diagnosed but since primary school he has had underlying psychological problems. His school took time to recognise his problems and, as a result, he has only just been referred to the home tuition service. The school has not provided continuous or adequate work while he has been at home or attending part-time. When work has been set it has been of an inappropriate level and has shown little continuity and progression over time.

77 In LEAs where procedures are unclear to schools, schools are less likely to take full responsibility for the education of pupils while they receive support from home and hospital services. Personal education plans are not drawn up at initial meetings and schools are slow to organise review meetings. The lack of partnership between the LEA, schools and the service affects pupils' continuity of learning and often their subsequent re-integration into school.

78 Secondary schools are faced with some difficulties when pupils are receiving education from services for long periods. If a pupil's absence spans the summer holiday period it may be that subject teachers change, the form tutor or class teacher changes and new teachers are expected to set work for pupils they have never taught, or perhaps even met. Similar problems arise in schools where a large number of short term temporary teachers are employed.

79 The symptoms of pupils with anxiety, depression and phobia are sometimes not easily recognised by schools. As a result, these pupils can be away from school for considerable periods before they are referred to the appropriate service. For some pupils, this affects their continuity of learning not just in the short term but sometimes for the remainder of their schooling and beyond.

80 Many schools and colleges lack confidence in providing for pupils with more complex medical needs. Few schools are well supported by nurses or other health professionals and without this input they feel they lack the expertise to provide for some pupils. Many pupils

with medical needs do not have statements of special educational need and do not generate additional funding. Therefore additional support cannot usually be provided when the pupil returns to school.

> *A 16 year old gained five higher-grade GCSEs and was offered a place at a sixth-form college. A few weeks before the start of term she was suffering from depression and was admitted to a adolescent psychiatric unit for three weeks. She was unable to attend college on enrolment day and her mother rang to explain the situation. The college was sympathetic and said they would hold her place. Unit staff invited college staff to a discharge review meeting but they did not attend. The pupil's place was subsequently withdrawn as the college said it was its policy to admit only students who attended personally for enrolment and that places had now been filled. Staff in the hospital service felt the college was anxious because the pupil had attended a psychiatric unit and that it was unfortunate that the college had not been able to find out more about her needs.*

> *A pupil was involved in a serious car accident and was left with slight brain damage, which caused some difficulty with certain motor skills. His school was reluctant to accept him back because of the risk of accidents such as falling down stairs. The LEA felt that looking for another school was the best option, one which was willing to accommodate his disability. However, this took time and as a result the pupil was out of school for longer than he should have been. The pupil successfully transferred to another school and subsequently went on to further education.*

81 In a few LEAs there is a good flow of information between schools and providers. For example, in the East Riding of Yorkshire, home tutors are organised into regions and develop strong relationships with schools in their area. In Wirral and Leicester, some schools describe the hospital school as giving excellent support to them in terms of speed of response and the information they provide. In Essex, some very useful advice is given to schools about working with pupils who are withdrawn or have anxiety, depression and phobia. These links have developed more as a result of individual efforts than of deliberate policy.

Views of parents and pupils

Parents

82 Almost all parents interviewed were pleased with the quality of education provided by the schools, units, hospitals and home tuition services. Parents were particularly satisfied with the quality of teaching and the understanding approach of staff, which resulted in significant academic and social progress for some pupils, in particular those with mental health difficulties.

83 The range of GCSEs that pupils were able to take was thought to be at least satisfactory by most parents. Some, especially parents of pupils who had poor attendance in their previous schools because of anxiety, depression and phobia, were pleased with the results pupils achieved in their examinations. They felt pupils would not have achieved this success without the intervention of the hospital and home tuition services. However, some parents were unhappy that their children had not been able to continue all subjects to examination level as a result of a lack of subject specialists.

> *Parents described how their child suffered from anxiety attacks after he had started at secondary school. These became more severe until he could no longer attend. They were very concerned that he would lose contact with the school, but their fears were unfounded. They described the work of the home tutor as wholly beneficial and a vital link between home and the teachers at his school. The home tuition service prevented their son from falling further behind, and helped him to progress academically as well as boosting his self-confidence.*

84 Many parents of pupils who have been educated within the service for some time, for example parents of those with mental health problems, described how, in their schools, pupils had lacked the confidence to ask or answer questions. In the small schools and units they had since attended these pupils developed their confidence and took a full part in discussions. As a result they made good progress both academically and socially.

85 A few parents noted the flexible and supportive approach of staff at their children's school, and the way in which the school had continued to take an active part in their child's education throughout the period of absence. They felt this helped significantly when pupils went back to their schools. However, a significant number of parents of pupils with mental health difficulties were critical of schools. They referred to the slowness with which their child's illness was identified, ineffective pastoral arrangements, the inflexibility shown by some staff and the fact that insufficient work had been provided, in particular when their child was at home.

86 Many parents found it difficult initially to obtain information about the service, such as who to contact and what services were available. In half of the LEAs some parents spoke of a considerable delay before their child started to receive support from hospital and home tuition services. A small number of parents said that they had received little or no support in dealing with their children who had mental health difficulties prior to their referral to a specialist provider. The lack of support networks made parents feel isolated. Support was only forthcoming when the situation became acute. Parents of a few pupils who had attended adolescent psychiatric units reported a lengthy time at home after their child was discharged because of the difficulties of finding suitable placements.

A parent described how the home tutor was very flexible, making sure that any hours lost when her child was too ill were made up when he felt better. Without this understanding approach he would not have obtained three GCSEs. The parent described how the tutor adjusted the level and quantity of work and homework so that he never felt under pressure; consequently, when he was well he was eager to do as much as he could – and more eager than he had been at school. The tutor helped him to keep in touch with school by writing newsletters to let the staff and his form tutor group know how he was. This encouraged them to write back. When the first part of his treatment was over she helped him to re-integrate into school part-time. Returning was daunting for him but she helped to boost his confidence and make the transition easier. Home tuition worked well and the tutor became an important part of this family's life.

Pupils

87 Almost all pupils, whether they are in schools, units or being educated at home, were pleased with the education they received. They enjoyed lessons, established strong relationships with staff who, they said, always had time to listen, and they liked the less formal learning atmosphere. Many described how they liked the small-group teaching, found it easy to concentrate and were not afraid to speak aloud in class. Pupils felt that staff had a good understanding of their illness and were flexible: for example, home tutors changed lesson times when pupils were too ill to concentrate. Pupils on long-term placements in particular felt that appropriate work was set for them and that teachers and tutors helped them to achieve a number of GCSE results.

88 A small number of pupils were disappointed that they were not able to continue all their subjects to GCSE, for example German, Spanish and religious education, because schools and centres lacked subject specialists. Specialist facilities, for example for design and technology, were not available and resources were described as limited, in particular for ICT. A number of pupils in adolescent psychiatric units really enjoyed the range of additional activities offered, such as sailing, canoeing, swimming, art therapy and music. They felt these activities helped them stop thinking about their problems.

89 In at least one third of LEAs, some pupils who have anxiety, depression and phobia described how they had wanted to learn whilst at school but they found school too difficult to cope with. A significant number said that the large numbers of pupils and the frightening behaviour of others made them anxious. Others described how they felt bullied by other pupils. They said that if attempts were made to get them back into school they could not deal with it and would not attend. Some described how they had now made close friendships, whereas at school they did not really have any friends. These pupils were attending their small centres regularly and achieving well.

90 Almost all pupils said they felt involved in decisions about their education. They established targets with teachers and were involved in all aspects of planning for their future. A number of pupils, particularly those with anxiety, depression and phobia, were critical of the time they spent at home before they received any help or support, which was sometimes over one year. They described how they were at home feeling anxious about everything; they wanted to be at school but just could not go.

Conclusions

91 Over the last year, in response to the DfES *Access to education* guidance, LEAs have focused more attention on the provision of education for pupils with medical needs. This has resulted in improvements in practice. However, there is still much for the LEAs visited to do to ensure that minimum standards are met and that pupils who are physically ill, injured or have mental health difficulties, receive an appropriate education. LEAs have a major role to play in ensuring that disruption to education is minimised and that there is continuity in pupils' learning so that, wherever possible, pupils continue to make progress.

92 The quality of education provided in hospital special schools, units and at home is good; there is clear leadership and efficient management of what is often a complex provision; the quality of teaching is good and pupils achieve well. Managers have welcomed the statutory guidance and worked hard to implement the requirements, especially in terms of working with schools. However, more support is needed from LEAs to develop and strengthen these links further.

93 *Access to education* has had least impact in schools. Although some schools covered in the survey take responsibility for pupils' learning whilst they are absent, the majority do not. These schools do not comply with the standards set out in the guidance.

94 A strong partnership between LEAs, schools, providers and other agencies is necessary if the education for these pupils is to be more effective. As the best practice seen in this survey demonstrated, when there is joint assessment and planning, on-going dialogue and the sharing of resources it proves possible to maintain effectively the momentum of learning for pupils whose lives are disrupted by serious injury or illness.

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