FOREWORD

Most children and young people will become ill at some time in their lives but fortunately they are for the most part resilient and bounce back to good health very quickly. However, for those who suffer serious or chronic illness, the effects on them and their whole family can be devastating.

Medical conditions can have a lasting effect on children and young people's social development, ability and confidence in educational attainment. It is important to ensure seamless support services are available that meet the needs of individual pupils and allow them continuity in accessing educational opportunities. In recognising this we all have a role to play to support children and young people to access education by whatever means their medical condition allows.

This guidance stresses the need for continuity in education for pupils with medical needs, whether provision is made at school, at home, in hospital, or another setting and the importance of effective liaison with parents and the school the child normally attends.

The Welsh Assembly Government is committed to promoting equal access to education for all children and young people and recognises the important part that health, education and social care play in the well being of all children and young people. Our commitment to children and young people is set out in Children and Young People: Rights to action and the National Service Framework for Children and Young People and Maternity Services, more commonly known as the NSF. The standards within the NSF have been cross-referenced throughout this guidance to ensure standards are achieved in the support of children and young people with medical needs.

We hope that this guidance will offer schools, parents and practitioners useful advice in meeting the needs of pupils with medical needs effectively and ensure their continued access to education as an important part of their continuing development and to ensure better outcomes for learners.

Jane Hutt
Minister for Children, Education, Lifelong Learning and Skills

Edwina Hart
Minister for Health and Social Services

CONTENTS

Chapter 1: Support for Pupils with Medical Needs

Chapter Summary

The primary aim of educating children and young people who have medical needs is to minimise, as far as possible, the disruption to normal schooling by continuing education as normally as the incapacity allows. Enabling children and young people to access appropriate education despite their medical condition is important to their future mental, social and physical development. It is vital that arrangements are in place in all local education authorities (LEAs) to enable continuance of the learning process, to keep education alive in the pupil's life, and where possible maintain progress. The emphasis on continuing learning applies equally to those with physical or mental health problems and pupils with life threatening or terminal illnesses, all of whom have the right to education suited to their age, ability, needs and health at the time.

This chapter considers the varying degrees of a pupil's medical needs, the impact on their education, health and well being and the respective roles and responsibilities of all those providing support to ensure continued access to educational opportunities. There is also an emphasis on the important role that parents play in supporting their child's continuing education.

This guidance applies equally to all those pupils who are unable to attend school because of medical needs: those who are physically ill or injured and those with mental health problems. It outlines the duties of LEAs and schools in relation to relevant legislation regarding disability. Particular care is needed to ensure that there is adequate provision for pupils suffering from mental illness. Pupils with mental illness, anxieties, depression and/or school phobia, including separation anxiety and school refusal associated with depression, which prevent them from attending school, may need support from specialist mental health services. The Assembly will shortly issue specific guidance for schools and LEAs on promoting emotional health and well-being, including supporting children and young people with mental health needs.

It is for authorities, schools and governing bodies to formulate their own policies in the light of their statutory responsibilities and their own assessment of local needs and resources, but it is hoped that when doing so they will find this guidance helpful.

1.1 Most pupils will at some time have a medical condition often only short term that may affect their participation in school activities. Such pupils are regarded as having medical needs. Most are able to attend school regularly and with some support from the school can take part in most normal school activities.

1.2 In some cases, medical conditions may have a significant impact on the pupils' experiences and the way they function at school. The impact may be a direct one in that the medical condition may affect the pupil's cognitive abilities, physical abilities, behaviours or their emotional state. The impact of a medical condition may

also be indirect, for example: by disrupting a pupil's access to education; through unwanted effects of treatment; and through the psychological effects which serious or chronic illness or disability can have on them and their family. The effects of a medical condition may be intermittent and its impact on the pupil's functioning in school can vary at different stages of their school career. This may be so particularly at times of changes in the school curriculum, changes in the individual pupil and changes in the peer group.

1.3 In any given year there are also thousands of children and young people who require education outside school as a result of: longer term illnesses; injuries or; clinically defined mental health problems. The situations of these children and young people will vary widely but they all run the risk of a reduction in self-confidence and educational achievement. Education for pupils who are unable to attend school because of medical needs can be provided in a variety of ways, for example through the provision of a hospital school or hospital tuition service; home tuition; or an integrated hospital/home education service or in a designated pupil referral unit.

NSF Standard Access to Services: Key Action 7.7

An appropriate amount of on-going education, in a suitable environment, is provided to all children and young people who are well enough to receive it, including those in hospital. Education is provided in liaison with each child's school, and is appropriate to their age and stage of development.

1.4 Consultation and open discussion between the pupil, their parents, the school, the school health service or the pupil's general practitioner, the community paediatrician and any specialist services providing treatment for the pupil will be essential to ensure that they are not unnecessarily excluded from any part of the curriculum or school activity because of anxiety about their care and treatment.

1.5 Parents have prime responsibility for their child's health and should provide schools with information if their child has a medical condition. Parents and the pupil (if they have the capacity to do so), should provide details from the General Practitioner (GP) or paediatrician, as appropriate. Parents can provide information on their child's educational achievements and on a range of other matters, which will affect his/her educational progress. Such perspectives will help when it comes to making decisions about the pupil's education.

1.6 Parents should have access to information, advice and support during their child's illness and wherever possible, when they are to be admitted to hospital, parents and their children should be informed of the education available prior to admission. The positive involvement of parents with the school once their child has returned to school can often reassure them, their child and teachers.

NSF Standard – Child and Family Centred Services

Children, young people and their families receive services that meet their particular needs. They are treated with respect by service providers and are provided with information and support appropriate to their needs and ability that assists them in making decisions about the care that they receive.

1.7 It should be noted that whilst pupils with medical needs may have additional learning needs, a medical diagnosis does not necessarily imply that a pupil has special educational needs as defined within the Education Act 1996. However, it is possible that a medical condition may increase the likelihood that a pupil will develop "a significantly greater learning difficulty than the majority of children of the same age,"[1] or that their condition may amount to a disability which prevents or hinders them from making use of educational facilities generally provided for children of their age in their local area. If this is the case, then the pupil may have a special educational need and may require a statutory assessment of their needs. The LEA, the designated medical officer and other professionals will need to consider in discussion with parents and the school, whether the pupil also has special educational needs and requires special educational provision to be made available. For further guidance please refer to the SEN Code of Practice for Wales and the SEN Handbook for schools.

The Role of the Local Education Authority (LEA)

Section 19 of the Education Act 1996 provides that, "Each local education authority shall make arrangements for the provision of suitable education at school or otherwise than at school for those children of compulsory school age who, by reason of illness, exclusion from school or otherwise, may not for any period receive suitable education unless such arrangements are made for them." Local education authorities (LEAs) also have the power to provide suitable education otherwise than at school for young people over compulsory school age but under the age of 19.

1.8 LEAs have a duty to provide education otherwise than at school (EOTAS) where it is necessary to do so to meet pupils' needs (see Chapter 4).
The arrangements which an authority must make should be tailored to the circumstances of each pupil and to the facilities available.

[1] SEN Code of Practice for Wales 2002

Good practice suggests that LEAs should ensure:-

- there are clear lines of communication so that all concerned know who is responsible for identifying the pupil's needs and how to activate the relevant services quickly;
- every pupil who is unable to attend school because of a long term or recurring medical condition, has an individual education plan. This should take effect as soon as a pupil is admitted to hospital or is unable to attend school. Education should begin as soon as the medical condition allows;
- that parents are informed about whom to contact to request the provision of education otherwise than at school;
- medical advice is sought and acted upon without delay;
- pupils are not at home without access to education for more than 15 working days and where pupils have an illness/diagnosis which indicates prolonged or recurring periods of absence from school, whether at home or in hospital, have access to education, so far as possible, from day one;
- pupils receive an education of similar quality to that available in school, including a broad and balanced curriculum;
- pupils educated at home receive a **minimum entitlement** of 5 hours teaching per week. This is a minimum and should be increased where necessary to enable a pupil to keep up with their studies. This is particularly important when a pupil is approaching public examinations;
- teachers have access to a range of in service training to support pupils with medical needs; and
- their provision for pupils with medical needs in schools and hospitals is kept under regular review; that the service they provide meets the needs of all pupils; that pupils' progress is tracked and monitored throughout; that provision is run cost-effectively, and that it is in accordance with the requirements of the Education Act 1996.

1.9 Regular analysis of medical absences, by the school or Education Welfare Officers (EWOs), can be used to develop regular monitoring of pupils with medical needs, including those referred to the home and hospital tuition service.

1.10 EWOs play an important role in liaising between home and school and in resolving attendance issues, including cases of medical need. Each school should have a named EWO responsible for helping that school to manage school attendance for all its pupils. In some areas, EWOs are based in and managed directly by the school. Shared policies and operational practices between the Education Welfare Services (EWS) and schools are vital, as are clearly defined roles of school staff and EWOs. It is good practice to appoint a senior member of staff to co-ordinate attendance as part of a whole school approach to inclusion. Schools should make use of administrative staff to check registers and to contact a pupil's parents promptly on the first day of any absence.

NSF Standard Access to Services: Key Action 6.6

All school-aged pupils in special circumstances (such as those with medical needs) should be offered an allocated school place in the locality in which they are living whenever possible and appropriate. The young person's choice of school should also be taken into consideration. Their attendance and requirements for additional support at school should be monitored, and actions taken to ensure their needs are met.

The Role of the School

1.11 Schools have a vital role to play in ensuring that pupils who are absent from school because of their medical needs have the educational support they need to maintain their education. Good communication and co-operation between the school, parents and the LEA is necessary if good quality education is to be provided. LEAs and governing bodies should work together to ensure pupils with medical needs and school staff have effective support in schools.

1.12 Schools should ensure that their own pastoral care arrangements allow children and young people to discuss any health related and other problems with a relevant health professional, educational psychologist, education welfare officer, counsellor or other professional. The school and family should liaise in providing maximum support for the pupil.

1.13 Schools should have a written policy and procedures for dealing with the education of pupils with medical needs. These might also be usefully included in the schools' prospectus (see Annex 2).

1.14 There is no legal duty which requires schools to administer medication; this is a voluntary role. However there is a duty to ensure that staff who volunteer to administer medication have support from the Headteacher and parents, access to information and training, and reassurance about their legal liability.

Good practice suggests that schools should:-

- have a policy in place for meeting the needs of pupils with medical needs;
- appoint a named member of staff who is responsible for pupils with medical needs, liaising with parents, pupils, the home tuition service, the LEA, the key worker and others involved in the pupil's care;
- notify the LEA/EWO if a pupil is, or is likely to be, away from school due to medical needs for more than 15 working days;
- supply the appropriate education providers with information about a pupil's capabilities, educational progress, and programmes of work;
- be active in the monitoring of progress and in the reintegration into school, liaising with other agencies, as necessary;
- develop in liaison with parents, the LEA and other professionals a school health care plan for individual pupil's with medical needs;
- provide in service training for teachers supporting pupils with medical needs;
- ensure that pupils who are unable to attend school because of medical needs are kept informed about school social events and are able to participate, for example, in homework clubs, study support and other activities; and
- encourage and facilitate liaison with peers, for example, through visits and videos.

1.15 A pupil who is unable to attend school because of medical needs must **not** be removed from the school register without parental consent, even during a long period of ill health, unless the school medical officer certifies him or her as unlikely to be in a fit state to attend school before ceasing to be of compulsory school age. Parents should not be persuaded to allow removal of their children from the school roll.

School Health Service

1.16 School nurses are part of the school health service. They provide advice, guidance and support to school staff, parents and pupils on caring for children and young people with medical needs and the safe administration of medicines. This includes:-

- Liaising with parents to provide guidance, advice and support on medical conditions and the safe administration of medication.
- Providing guidance, advice, and training to school staff on how to care for pupils with identified medical conditions.
- Providing guidance, advice and training to school staff on the safe administration of medicines.
- Educating pupils about their medical condition and the safe administration of medicines.
- Being involved in developing individual health care plans for pupils who require them including dealing with emergency situations.

- Working with schools to ensure the safe handling, storage and disposal of medicines.
- Working with schools to ensure that hygiene/infection guidelines are in place.

NSF Standard Quality of Services: Key Action 5.23

*Children with **complex healthcare needs** who attend mainstream or **special schools** have access to school nurses, who are employed by the NHS. Children in special schools have access to nurses at all times when children are on the premises and these school nurses also act as an expert resource for **disabled children** in mainstream schools.*

1.17 Other health professionals may also be involved in the care of pupils with medical needs in schools. The community paediatrician is a specialist doctor with an interest in disability, chronic illness and the impact of ill health on children and young people. He/she may give advice to the school on individual pupils or on health problems generally.

1.18 Most NHS Trusts with School Health Services have pharmacists who specialise in paediatrics or community health services. Some work closely with LEAs and give advice on the management of medicines within schools. This can involve helping to prepare policies relating to medicines in schools and training school staff. In particular, they can advise on the storage, handling and disposal of medicines.

NSF Standard Quality of Services: Key Action 2.27

LHBs and NHS trusts have a medicines strategy that includes:-

- *A named pharmacist with expertise in paediatric medicine.*
- *Access to a standard and regularly updated information source on children's medicines for all practitioners who prescribe, administer or dispense medicines for children, available both as hard copy and electronically, e.g. Children's BNF.*

1.19 Some pupils with medical needs will receive dedicated support from a specialist nurse or community paediatric nurse. These nurses often work as part of an NHS Trust and liaise closely with the primary health care team. They can provide advice on the medical needs of an individual pupil, particularly when a medical condition has been recently diagnosed and the pupil is adjusting to new routines.

Post 16 Education

NSF Standard: Transitions

Young people who require continuing services, such as those who are disabled or chronically ill, young people with persistent mental illness or disorders, vulnerable young people and their families and carers, and care leavers, are offered a range of co-ordinated multi-agency services, according to assessed need, in order to make effective transitions from childhood to adulthood.

1.20 A young person's educational needs post-16 should be carefully considered, particularly where he or she has made slow progress up to the age of 16 because of interruptions in educational provision. All agencies should try to enable a pupil to continue any course being taken on entry to hospital or whilst ill or injured at home.

1.21 LEAs should normally arrange continuing education for a young person over compulsory school age but under 18 where, because of illness, he or she still needs to study further in order to complete examination courses, which they would in normal circumstances, have completed before they reached compulsory school leaving age.

1.22 It will be for the young people themselves to decide which route best suits them. Careers Wales advisers can play a vital role in advising young people about their learning options.

Disability Discrimination

1.23 The Welsh Assembly Government has adopted the 'social model' of disability, which uses the term disability not to refer to impairment but rather to describe the effects of prejudice and discrimination, the social factors which create barriers, deny opportunities, and thereby exclude and disable people.

A person is regarded as being disabled if he/she has "a physical or mental impairment which has a substantial and long term adverse effect on his/her ability to carry out normal day to day activities." DDA 1995.

1.24 Schools and LEAs have specific duties under the Disability Discrimination Act 1995 as amended by the SEN and Disability Act 2001 and the Disability Act 2005 to not treat disabled pupils less favourably, to ensure reasonable adjustments are made in supporting pupils with a disability and promote disability equality.

1.25 The definition **may** include pupils/students with cerebral palsy, cancer, HIV, asthma, diabetes, epilepsy, muscular dystrophy, autism, depression, and Chronic Fatigue Syndrome. This list is not exhaustive.

1.26 Since September 2002 schools and LEAs must:-

- not treat disabled pupils less favorably, without justification, for a reason which relates to their disability;
- take reasonable steps to ensure that disabled pupils are not placed at a substantial disadvantage compared to other pupils who are not disabled; and
- plan strategically for and make progress in:-
  - improving the physical environment of schools for disabled children and young people;
  - increasing disabled pupils 'participation in the curriculum; and
  - improving the ways in which written information is provided to pupils who are not disabled is as opposed to those disabled pupils.

1.27 Claims of disability discrimination may, in certain circumstances, be made by parents against responsible bodies. These may be heard by the SEN Tribunal for Wales.

1.28 The DDA 2005 introduces a duty on all public bodies to promote equality of opportunity for disabled people. This means that they must take account of the needs of disabled people as an integral part of their policies, practices and procedures, and not as something separate or as an add-on. They will have to have due regard to the need to:-

- eliminate unlawful discrimination and disability-related harassment;
- promote equality of opportunity and positive attitudes to disabled people; and
- encourage disabled people to participate in public life.

1.29 These duties apply to anyone carrying out functions of a public nature. If a public body was perceived as failing to comply with these duties then anyone, including the DRC, could apply to the High Court for judicial review.

1.30 In addition to this, many public bodies, including Government departments, local authorities and schools, will be subject to specific duties, which will include having to produce a Disability Equality Scheme explaining how they intend to fulfil the duty to promote equality.

1.31 Detailed guidance will shortly be published by the Welsh Assembly Government on "Awareness of Disability Discrimination Duties for Schools (2007)". Further information is also available from the Commission for Equality and Human Rights which was established from October 2007.

Chapter 2: Planning to Meet Pupil's Needs

Chapter Summary

Whatever mode of provision is required for individual pupils, it is important that each of the component elements forms part of a strategic planning framework which ensures a continuum of education provision and establishes effective mechanisms for liaison between home, schools, pupil referral units and hospitals.

A clear policy, understood and accepted by staff, parents and pupils provides a sound basis for ensuring that pupils with medical needs receive proper care and support at school. Policies should, as far as possible, enable regular school attendance. Formal systems and procedures, drawn up in partnership with parents and staff should back up the policy.

This chapter aims to identify the appropriate planning mechanisms that schools and LEAs should have in place to ensure that the needs of pupils with medical needs are met effectively, that where appropriate health care plans are in place and further offers advice and guidance on out of school activities. It also considers the training needs of school support staff and the importance of information sharing.

Short Term Medical Needs

2.1 For absences that are expected to last for 15 working days or less and are not part of a pattern of a recurring illness, arrangements should be made in liaison with the child's parents to provide the child with homework as soon as they become able to cope with it. Liaison between the school and parents usually allows work and materials such as books and reference documents to be sent home. However, where the absence relates to a chronic condition, LEAs should ensure that the child is provided with education as soon as they are able to benefit from it.

2.2 The school should monitor work missed and develop a strategy, in liaison with the hospital/home tuition service, where involved, to help a pupil "*keep up rather than having to catch up"*. A pupil working towards public examinations needs special consideration and the arrangements should be stated in the LEA and school procedures.

Long Term Medical Needs

2.3 It is important for the school to have sufficient information about the medical condition of any pupil with long term medical needs. If a pupil's medical needs are inadequately supported this can have a significant impact on a pupil's academic attainments and/or lead to social, emotional and behavioural problems. The school therefore needs to know about any medical needs before a child starts school, or when a pupil develops a condition. For pupils who attend hospital appointments on a regular basis, special arrangements may also be necessary. It is often helpful for a school to draw up a written health care plan for such pupils, involving the parents and relevant health professionals. Please see Annex 4, Form 3.

NSF Standards Child and Family Centred Services and Quality of Services: Key Actions 2.2 and 5.29

Emphasises the importance of schools having a 'school health care plan' which should be specifically designed for every child who has complex needs. Children and young people who receive services from any agency are to be fully involved in regular reviews that allow them to express a view about how their needs are met.

2.4 There may be problems with the unpredictable and changing pattern of the illness. Review meetings should be as integral to the identification and intervention arrangements as the planning and discharge meetings.

2.5 For pupils who are not at school and require teaching but have not been admitted to hospital or who are between periods in hospital, the most frequent source of notification is the EWO. In some LEAs, however, officers do not follow up the absences of pupils with medical needs as they are automatically considered authorised absences. It is important for the home school to inform the EWO and LEA when a pupil has an authorised absence due to long term illness. **Permission from parents must always be obtained before medical information is sought.**

2.6 A resumption of education, in whatever form, should be planned in a way which ensures that children and young people do not feel under pressure to study but are encouraged to do so in a way which is likely to be sustainable.

Teenage Pregnancy

2.7 In fulfilling their statutory obligations under section 13 and 19 of the Education Act 1996, LEAs have powers which can be used to provide support to young mothers and mothers to be. LEAs should work together with social services, schools and wider partnerships to provide support for the mother, both during pregnancy and after the baby is born.

NSF Standard Access to Services: Key Action 3.11

There are specialist services available for young, pregnant teenage girls, such as peer parent education and support groups.

2.8 An LEA officer should be nominated to be responsible for young parents in school. This will be the specialist reintegration officer in areas that have them.

2.9 Schools should promote the services of the school nurse, health visitors, local clinics and other medical facilities as far as possible as the first port of call for all advice on medical matters, including pregnancy.

2.10 Parents of school-age parents are obliged to ensure that their child attends the provision arranged by the LEA. LEAs will need to work closely with the pupil and their wider family to ensure that they benefit from the continued learning opportunities available.

2.11 Further information on young parents and teenage pregnancy, can be found in Welsh Assembly Guidance “Inclusion and Pupil Support” (2006).

Pupils with Degenerative Medical Conditions

2.12 Some conditions are rapidly progressive. This means that the child’s health is in decline and raises particular issues of curriculum accessibility and appropriate activities for the child and young person’s age and ability. In such circumstances a rapid response is required by the various agencies contributing to any statutory assessment and provision at school. Maintaining educational input, even when a condition is progressing rapidly, is important to the child and family.

2.13 Pupils with a variety of progressive or degenerative medical conditions may require special consideration when educational support or intervention is considered. These pupils will have greater medical needs than many others. Close liaison between health professionals, hospital schools and other schools will be necessary, particularly where medication and medical equipment are provided.

2.14 Although regression may occur with varying degrees of rapidity, reviews of educational and other provision may need to occur more frequently and more rapidly for this group of pupils.

2.15 From September 2002, degenerative conditions have been covered by the provisions of Part IV of the Disability Discrimination Act 1995.

Pupils with Complex Health Needs

2.16 The policies in Wales toward the inclusion, wherever possible, of pupils with complex health needs into mainstream schools, mean that schools are becoming increasingly responsible for meeting the health needs in education settings of growing numbers of pupils with complex needs. As a consequence this policy has resulted in the number of pupils that remain in special schools being likely to have higher levels of need than was previously the case.

2.17 The primary objective in delivering an educational curriculum remains the need to maximise the potential of all the pupils in the school, regardless of their health care needs. A positive commitment to a rights-based approach to the care and education of severely disabled pupils is essential.

2.18 A partnership approach is required to ensure effective collaboration between health and education to meet the needs of pupils with health needs in school. The identified senior officer in each LHB area with designated responsibility for commissioning services for children and young people, including school health services, is an essential component of this process. Strong focus on multi-agency working improves training and support for teachers and education staff in the

management of pupils with complex health care needs, as well as in the preparation, implementation, monitoring and evaluation of care plans.

NSF Standard Child and Family Centred Services: Key Action 5.28

There are clear protocols on the early referral to education for children below the age of 2 years who have severe, long-term and ***complex needs.*** *Health, social services and education jointly agree on each child's assessed needs and how those will be met, so that no child is delayed from starting school.*

2.19 The pressures on schools and health agencies to provide a collaborative and comprehensive service for pupils with special health care needs will be further increased by the growing number, in a mainstream school, of children and young people with conditions such as asthma, diabetes, anaphylactic shock, epilepsy or cystic fibrosis (see Annex 3 – Common Conditions). These conditions may not be associated with learning difficulties, but the pupils concerned are likely to require periodic additional support with the management of a health condition (sometimes potentially life-threatening) in education or other community settings. Schools may have pupils with significant health care needs returning to school, possibly during courses of treatment.

2.20 All children and young people with complex health needs should have an identified key worker or care co-ordinator. A key worker is a named person who is both a source of support for children and young people with complex needs and their families, and a link by which other services are accessed and used effectively. Key workers have responsibility for working together with the family and with professionals from services, and for ensuring delivery of an inter-agency care plan for the child and family.

NSF Standard Child and Family Centred Services: Key Action 2.14

Children and young people, who require more than two ongoing services in addition to the universal services, have their services co-ordinated by a commissioned ***key worker****. The name of the* ***key worker*** *is made known to the child and is recorded in the child's care plan.*

2.21 Parents of pupils with medical needs may also be able to provide schools with a copy of the relevant sections contained in their child's "Orange Book". The Orange Book is a Welsh Assembly Government-backed initiative that supports pupils and parents with complex needs. It enables parents to collate important information about their child in one easily accessible place and to share this information with practitioners.

2.22 The quality of the physical environment of a school is of vital importance for pupils with complex needs. They are more likely to need health interventions which:-

- require areas that can be maintained as sterile;
- offer sufficient space for the safe storage, retrieval, servicing and deployment of equipment, wheelchairs etc;
- ensure privacy for the provision of intimate care or medical treatment or therapy;
- have safe storage arrangements for medication;
- provide quiet places for pupils who are feeling unwell, recovering from an epileptic fit or treatment;
- have efficient heating, as severely disabled pupils are unlikely to be sufficiently mobile to keep warm and are likely to spend periods of time on the floor or in fixed equipment or wheelchairs. Cleanliness and warmth are essential to their well-being; and
- have safe access arrangements for wheelchairs and mobility aids, transport vehicles and outside play areas.

Health Care Plans

2.23 An individual health care plan can help schools identify the necessary safety measures to support pupils with medical needs and ensure that they and others are not put at risk. The main purpose of an individual plan is to identify the level of support that is needed at school. **Not all pupils who have medical needs will require an individual plan.** A short written agreement with parents may be all that is necessary. Guidance on what should be included in a health care plan can be found at Annex 4 – form 3.

2.24 An individual health care plan can clarify for staff, parents and the pupil the help that the school can provide and receive. Schools should agree with parents how often they should jointly review the health care plan. It should be normal practice to do this at least once a year.

2.25 The school should judge each pupil's needs individually as children and young people vary in their ability to cope with poor health or a particular medical condition. However, the school's medication policy must be applied consistently. The Headteacher should **not** make value judgements about the type of medication prescribed by a registered medical or dental practitioner.

2.26 Drawing up a school health care plan should not be onerous, although each plan will contain different levels of detail according to the needs of the individual pupil. Those who may need to contribute to a health care plan are:-

- The Headteacher.
- The parent or guardian.
- The pupil (where possible).

- Class teacher (primary schools)/Form Tutor/Head of Year (secondary schools).
- Care assistant or support staff (if applicable).
- School staff who have agreed to administer medication or be trained in emergency procedures.
- The school health service, the pupil's GP, Social Services or other health care professionals (depending on the level of support the child needs).

2.27 If a pupil's condition is thought to be degenerative or life threatening the plan should reflect these additional needs. Such plans should provide sufficient information to school staff. They should be drawn up in conjunction with the child (where possible), the parent, health care professionals, and social services where appropriate, and should set out in detail the measures needed to support a pupil in the school, including preparing for an emergency situation. The plan should include details of a pupil's condition and what to do and who to contact in an emergency. The plan identifies the level of support needed and clarifies the help to be provided and should be reviewed at least once a year for children and young people with relatively stable medical conditions. More frequent review will be required for those with conditions that are technologically dependent or potentially life-limiting.

2.28 Pre-admission meetings for planning and induction arrangements should always be held for pupils with complex health care needs whom the school is seeing for the first time. The pre-admission meeting should involve the family and relevant health education and social services representation. Headteachers considering the admission of a child with complex health needs should regard the involvement of the school health service in drawing up health plans as essential, not optional.

2.29 Parents, if necessary, with the help of health care professionals should provide the Headteacher with sufficient information about their child's medical condition and the treatment or special care needed at school. They should, jointly with the Headteacher and other agencies, reach agreement on the school's role in helping with their child's medical needs. Staff noticing deterioration in pupil's health over time should inform the Headteacher who should inform the parents.

2.30 It is also essential at this stage that it is clearly understood who has legal parental rights to give consent, including the responsibility of the Local Authority for Looked After Children, if relevant. The Children Act 1989 and 2005 defines the nature of parental responsibility.

Resuscitation

2.31 The issue of resuscitation care for pupils in education settings is of comparatively recent concern. However, it is now very relevant in the light of growing numbers of pupils with exceptional health care needs. Many of these pupils have severe impairments and high levels of need. They are usually fragile, with unknown life-expectancy and many appear to be living longer than anticipated because of improved quality of health care.

2.32 The question of resuscitation care is likely to become more common in education settings, not least because the management of pupils with complex or degenerative conditions has changed. Whereas historically they were likely to spend long periods of time in hospital care, the presumption now is that they will use community facilities such as schools on a regular basis. Schools have the same responsibility to seek emergency medical help for pupils with complex health needs as for their wider groups of pupils.

2.33 When the application of a “Do Not Resuscitate” notice is under consideration the decision should always be taken by an appropriate multi-disciplinary team with the full involvement of parents and those with clinical responsibility.

2.34 These decisions must be clearly written into the individual health care plan for the child. Good communication is absolutely necessary in these circumstances and is key to ensuring that the pupil’s rights are respected and that misunderstanding and dissent is minimised.

2.35 Schools and other community facilities should have clear policies and procedures in relation to resuscitation care for such pupils with severe disabilities.

2.36 It is the employer’s responsibility to make sure that correct procedures are followed and must ensure that all staff are fully aware as appropriate, of the particular policies and procedures that have been agreed for the child. Staff are expected to use their best endeavours at all times, particularly in emergencies. In general the consequences of taking no action are likely to be more serious than those of trying to assist in an emergency. If there is uncertainty, treatment should be started until a clearer assessment can be made.

Co-ordinating Information

2.37 The Headteacher and school staff should treat medical information confidentially. The Headteacher should agree with the pupil (where he/she has the capacity) or the parent about who else should have access to records and other information about the pupil. If information is withheld from staff they should not generally be held responsible if they act incorrectly in giving medical assistance but otherwise in good faith.

2.38 Co-ordinating and disseminating information on an individual pupil with medical needs, particularly in secondary schools, can be difficult. The Headteacher may give a member of staff specific responsibility for this role. This person can be a first contact for parents and staff, and liaise with external agencies. A Key Worker can take on this role.

2.39 Staff who may need to deal with an emergency need to know about a pupil’s medical needs. The Headteacher must make sure that supply teachers know about pupil’s medical needs. When a secondary school arranges work experience, the Headteacher should ensure that the placement is suitable for a student with a particular medical condition. Pupils should be encouraged to share relevant medical information with employers.

NSF Standard Child and Family Centred Services: Key Action 2.59

There are clear protocols on sharing of information to facilitate co-operative working between organisations. These protocols take account of and make reference to Government guidance and legislation.

Training

2.40 Schools will need to assess their training requirements on a regular basis and work with health partners to ensure that these are maintained and met. School staff will require full and up-to-date knowledge of a pupil's condition and how they should respond to day-to-day health care needs as well as emergencies. It is important that responsibility for pupils' safety is clearly defined and that each person involved with pupils and medical needs is aware of what is expected of them.

2.41 For pupils with health care plans, the plans may identify the need for further training. Health care professionals should confirm proficiency in medical procedures ranging from the administration of medication by various means to the handling of technological equipment. All staff require basic first aid training as well as knowledge about the proper arrangements for moving and handling a child. More specialised training would include resuscitation training. For some pupils with learning disabilities and associated mental health needs there would need to be addressed concerns relating both to the administration of medication and to policies and procedures around the use of physical restraint. Health and safety issues, with special reference to risk management, and personal hygiene measures would also be necessary.

2.42 The Framework for Restrictive Physical Intervention Policy and Practice was issued by the Welsh Assembly Government in March 2005 and set out the principles that should govern the use of restrictive physical intervention. The Welsh Assembly Government is currently in discussion with Department for Children, Schools and Families (DCSF) on options for joint consultation on a draft document on good practice on Permissible Restrictive Physical Interventions with Children who Live Away from Home. The document has a focus on risk management and agreed intervention techniques.

2.43 All staff working with children and young people should be trained to fully understand children's rights and have an appropriate level of awareness of their needs, in that they should be required by the employers, as a matter of specific contractual obligation, to respect and apply those rights vigorously. All staff should also receive child protection training.

2.44 LHBs should lead (self-financing) training sessions for taxi and minibus drivers and escorts from the private sector used to transport pupils to school.

NSF standards Quality of Services and Child and Family Centred Services: Key Actions 2.21, 5.30 and 5.31

All organisations have in place agreed core joint education and training programmes for staff who deal with children and young people and specific training for those working with disabled young people.

Public Examinations and National Curriculum Assessments

2.45 Efficient and effective liaison is imperative when pupils with medical needs are approaching public examinations. For such pupils, including those undertaking examinations in hospital, the course work element may help them to keep up with their peers in schools. The home and hospital teachers may be able to arrange for a concentration on this element to minimise the time lost while the pupil is unable to attend school. Liaison between the home school and the hospital teacher or home teacher is most important, especially where a pupil is moving from school or home to the hospital on a regular basis.

2.46 Awarding bodies may make special arrangements for pupils with permanent or long term disabilities and learning difficulties and with temporary disabilities, illness and indispositions, taking public examinations, such as GCSEs or A levels. Applications for special arrangements should be submitted by schools to the awarding bodies as early as possible. Full guidance on the range of special arrangements available and the procedures for making applications is given in the Joint Council for General Qualifications' circular, "Regulations and Guidance Relating to Candidates with Particular Requirements" which is available from the awarding bodies.

School Trips

2.47 It is good practice for schools to encourage pupils with medical needs to participate in school trips, wherever safety permits. Indeed a school may be unjustly discriminating against a disabled pupil should they refuse to allow them to participate in such activities.

2.48 The school may need to take additional safety measures for outside visits. Arrangements for taking any necessary medication will also need to be taken into consideration. Staff supervising excursions should always be aware of any medical needs, and relevant emergency procedures. Sometimes an additional supervisor or parent may be required to accompany a particular pupil. If staff are concerned about whether they can provide for a pupil's safety, or the safety of other pupils on a trip, they should seek medical advice from the School Health Service or the pupil's GP.

2.49 Schools should advise outward bound centres and other such suppliers of services of a pupil's medical needs or disability so that a risk assessment can be prepared and suitable planning undertaken.

Sporting Activities

2.50 Most pupils with medical conditions can participate in extra-curricular sport or in the PE curriculum which is sufficiently flexible for all pupils to follow in ways appropriate to their own abilities. For many, physical activity can benefit their overall social, mental and physical well-being. Any restrictions on a pupil's ability to participate in PE must be included in their individual health care plan.

2.51 Some pupils may need to take precautionary measures before or during exercise, and/or need to be allowed immediate access to their medication if necessary. Teachers and others supervising sporting activities should be aware of relevant medical conditions and emergency procedures.

School Transport

2.52 LEAs arrange home to school transport where legally required to do so. They must make sure the pupils are safe during the journey and where possible have school policies in place to encourage pupils to behave safely on their journeys to and from school. Most pupils with medical needs do not require supervision on school transport, but LEAs should provide appropriately trained supervisors if they consider them necessary. A number of pupils with profound and multiple difficulties are transported to school by various means, including taxi cabs.

2.53 An assessment of the pupil's transport requirements should be made and clearly written in the personal health care plan for the child. The care plan should specify the steps to be taken to support the normal care of the pupil as well as the appropriate responses to emergency situations. All drivers and escorts should have basic first aid training and should know what to do in case of a medical emergency. They should be clear about roles, responsibilities and liabilities. Additionally, trained escorts may be required to support some pupils with complex medical needs. They must receive training and support and fully understand the procedures and protocols to be followed, including the administration of medicines in an emergency, if necessary.

2.54 It is essential that drivers and escorts provided by private organisations are safe to work with children and young people by the production of a satisfactory Criminal Records Bureau (CRB) check.

Off-Site Education or Work Experience

2.55 Schools are responsible for ensuring, under an employer's overall policy, that work experience placements are suitable for students with a particular medical condition. Schools themselves are also responsible for pupils with medical needs who, as part of key stage 4 provision, are educated off-site through another provider such as the voluntary sector, training provider or further education college. Schools should consider whether it is necessary to carry out a risk assessment before a young person is educated off-site or has work experience and whether it is necessary to provide information to enable receiving parties to carry out a risk assessment of their own.

2.56 Schools have a primary duty of care for pupils and have a responsibility to assess the general suitability of all off-site provision including college and work placements. This includes responsibility for an overall risk assessment of the activity, including issues such as travel to and from the placement and supervision during non-teaching time or breaks and lunch hours. This does not conflict with the responsibility of the college or employer to undertake a risk assessment to identify significant risks and necessary control measures when pupils below the minimum school leaving age are on site.

2.57 Generally schools should undertake an overall risk assessment of the whole activity and schools or LEA placement organisers should visit the workplace to assess its general suitability. Responsibility for risk assessments remain with the employer or the college. Where students have special medical needs the school will need to ensure that such risk assessments take into account those needs. Parents and pupils must give their permission before relevant medical information is shared on a confidential basis with employers.

Emergency Procedures

2.58 As part of the general risk management processes, all schools and other education settings should have arrangements in place for dealing with emergency situations. This could be part of the school's first aid policy and provision. Other pupils should know what to do in the event of an emergency, such as telling a member of staff. All staff should know how to call the emergency services. Guidance on calling an ambulance is provided at Form 1.

2.59 All staff should also know who is responsible for carrying out emergency procedures in the event of need. A member of staff should always accompany a child taken to hospital by ambulance, and should stay until the parent arrives. Health professionals are responsible for any decisions on medical treatment when parents are not available.

2.60 Staff should never take pupils to hospital in their own car; it is safer to call an ambulance. In remote areas a school might wish to make arrangements with a local health professional for emergency cover.

2.61 Individual health care plans should include instructions as to how to manage a child in an emergency, and identify who has the responsibility in an emergency. For example if there is an incident in the playground a lunchtime supervisor would need to be very clear of their role.

Chapter 3: Access to Medication

Chapter Summary

This chapter outlines the legal framework for schools and LEAs in the management of medicines in schools. It summarises, the main legal provisions that affect the responsibilities of Local Authorities and schools in managing a pupil's medical needs.

It should to be noted that this does not constitute an authoritative legal interpretation of the provisions of any enactments, regulations or common law – that is exclusively a matter for the courts. It remains for Local Authorities and schools to develop their policies in the light of their statutory responsibilities and their own assessment of local needs and resources.

Secondly this chapter also aims to help schools in drawing up policies on managing medication in schools, and to put in place effective management systems to support individual pupils with medical needs.

It is important that responsibility for pupils' safety is clearly defined and that each person involved with pupils with medical needs is aware of what is expected of them. Again, close co-operation between schools, parents, health professionals and other agencies will help provide a suitably supportive environment for pupils with medical needs.

3.1 Many pupils will need to take medication (or be given it) at school at some time in their school life. Mostly this will be for a short period only; for example to finish a course of antibiotics or apply a lotion. To allow pupils to do this will minimise the time they need to be off school. Medication should only be taken to school when essential.

NSF Standard Quality of Services: Key Action 2.30

Service providers ensure safe and effective administration of medicines to children and young people in education settings by adherence to guidelines recommended in the Welsh Office Circular 34/9719. New guidance will be issued for consultation in 2006.

3.2 LEAs, schools and governing bodies are responsible for the health and safety of pupils in their care. The legal framework dealing with the health and safety of all pupils in schools derives from health and safety legislation. The law imposes duties on employers. LHBs and NHS Trusts have legal responsibilities for the health of residents in their area.

3.3 There is no legal or contractual duty on staff to administer medicine or supervise a child taking it. Support staff may have specific duties to provide medical assistance as part of their contract. Of course, swift action needs to be taken by any

member of staff to assist any child in an emergency. Employers should ensure that their insurance policies provide appropriate cover.

3.4 Some school staff are naturally concerned about their ability to support a pupil with a medical condition, particularly if it is potentially life threatening. Teachers who have pupils with medical needs in their class should understand the nature of the condition, and when and where the pupil may need extra attention.

3.5 Staff should be aware of the likelihood of an emergency arising and what action to take if one occurs. Back up cover should be arranged for times when the member of staff responsible is absent or unavailable. At different times of the school day other staff (e.g. learning support assistants) may be responsible for pupils it is important that they are also provided with training and advice. Form 8 provides an example of confirmation that any necessary training has been completed.

3.6 Anyone caring for children and young people including teachers, other school staff and day care staff in charge of children have a common law duty of care to act like any reasonably prudent parent. Staff need to make sure that children are healthy and safe. In exceptional circumstances the duty of care could extend to administering medicine and/or taking action in an emergency. This duty also extends to staff leading activities taking place off site, such as visits, outings or field trips.

3.7 Pupils with medical needs have the same rights of admission to school as other pupils, and cannot generally be excluded from school for medical reasons. In certain circumstances, e.g. where there is a risk to health and safety of staff or other pupils in relation to notifiable infections, pupils can be removed from school for medical reasons (see paragraph 3.23).

3.8 Legislation, notably the Education Act 1996, the Disability Discrimination Act 1995, the Care Standards Act 2000, the Misuse of Drugs Act 1972 and the Medicines Act 1968 are also relevant to schools and settings in dealing with pupils medical needs.

The Employer

3.9 Under the Health and Safety at Work etc Act 1974, employers, including Local Authorities and school governing bodies, must have a health and safety policy. This should incorporate managing the handling of medicines which includes administration by staff, storage, self-administration and carrying of medicines by pupils.

3.10 With the exception of Local Authorities, employers must take out Employers Liability Insurance to provide cover for injury to staff acting within the scope of their employment.

3.11 Local Authorities may choose instead to ‘self-insure’ although in practice most take out Employers Liability Insurance. Employers should make sure that their insurance arrangements provide full cover in respect of actions which could be taken by staff in the course of their employment. It is the employer’s responsibility to make sure that proper procedures are in place; and that staff are aware of the procedures

and are fully trained. Keeping accurate records is helpful in such cases. Employers should support staff to use their best endeavors at all times, particularly in emergencies. In general, the consequences of taking no action are likely to be more serious than those of trying to assist in an emergency.

3.12 In most instances, the Local Authority, a school or an early years setting will directly employ staff. However, some care or health staff may be employed by a LHB or Social Services department, or possibly through the voluntary sector. In such circumstances, appropriate shared governance arrangements should be agreed between the relevant agencies.

3.13 The employer is responsible for making sure that staff have appropriate training to support pupils with medical needs. Employers should also ensure that there are appropriate systems for sharing information about pupil's medical needs in each school or setting for which they are responsible. Employers should satisfy themselves that training has given staff sufficient understanding, confidence and expertise and that arrangements are in place to up-date training on a regular basis. A health care professional should provide written confirmation of proficiency in any medical procedure.

3.14 If staff follow the school's documented procedures, they will normally be fully covered by their employer's public liability insurance should a parent make a complaint. The Headteacher should ask the employer to provide written confirmation of the insurance cover for staff who provide specific medical support.

3.15 LHBs have the discretion to make resources available for any necessary training. Employers should also consider arranging training for staff in the management of medicines and policies about administration of medicines. This should be arranged in conjunction with local health services or other health professionals. Managing medicines training could be provided by Local Authorities, pharmacists and other training providers.

The Local Education Authority

3.16 In LEA maintained schools the LEA, as the employer, is responsible for all health and safety matters.

3.17 The LEA can provide a general policy framework of good practice to guide their schools in drawing up their own policies on supporting pupils with medical needs. Many LEAs find it useful to work closely with their LHB when drawing up such a policy. The LEA may also arrange training for staff in conjunction with health professionals.

3.18 LHBs have a statutory duty to purchase services to meet local needs. National Health Service (NHS) Trusts provide these services. LHBs, LEAs and school governing bodies should work in co-operation with the multi-disciplinary teams to determine need and plan and co-ordinate effective local provision within the resources available.

3.19 LHBs normally designate a medical officer with specific responsibility for children and young people with special educational needs (SEN). Children and young people with complex healthcare needs who attend special schools should have access to school nurses, who are employed by the NHS. NHS Trusts, usually through the School Health Service, may provide advice and training for school staff in providing for a pupil's medical needs.

Schools and Governing Bodies

3.20 Individual schools develop their own policies to cover the needs of their own school. The governing body has general responsibility for all the school's policies even when it is not the employer. The governing body will generally want to take account of the views of the Headteacher, staff and parents in developing a policy on assisting pupils with medical needs. In LEA schools the governing body should follow the policies and procedures produced by the LEA as the employer.

3.21 The Headteacher is responsible for implementing the governing body's policy in practice and for developing detailed procedures. In LEA schools the Headteacher is responsible in line management terms to the LEA. When teachers volunteer to give pupils help with their medical needs, the Headteacher should agree to their doing this, and must ensure that teachers receive proper support and training where necessary. Day to day decisions about administering medication will normally fall to the Headteacher.

3.22 The Headteacher should make sure all parents are aware of the school's policy and procedures for dealing with medical needs. The school's policy should make it clear that parents should keep pupils at home when they are acutely unwell. The policy should also cover the school's approach to taking medication at school.

3.23 The Local Public Health Service Consultant in Communicable Disease Control (CCDC) can advise on the circumstances in which pupils with infectious diseases should not be in school, and the action to be taken following an outbreak of an infectious disease.

3.24 For a child with special medical needs, the Headteacher will need to agree with the parents exactly what support the school can provide. Where there is concern about whether the school can meet a pupil's needs, or where the parents' expectations appear unreasonable, the Headteacher should seek advice from the school nurse or doctor, the pupil's GP or other medical advisers and, if appropriate, the LEA. Complex medical assistance is likely to mean that the staff who volunteer will need special training.

3.25 Many voluntary organisations specialising in particular medical conditions produce school packs advising teachers on how to support pupils. Annex 4 lists contact names and addresses.

3.26 Teachers' conditions of employment do not include giving or supervising a pupil taking medicines. Schools should ensure that they have sufficient members of support staff who are employed and appropriately trained to manage medicines as part of their duties.

3.27 Any member of staff who agrees to accept responsibility for administering prescribed medicines to a child should have appropriate training and guidance. They should also be aware of possible side affects of the medicines and what to do if they occur. The type of training necessary will depend on the individual case.

3.28 The nurse or community paediatrician may also be able to advise on training for school staff willing to administer medication, or take responsibility for other aspects of support. The school nurse or community paediatrician may attend school open days or parents' evenings to give advice to parents and staff.

NSF Standard Quality of Services: Key Action 2.29

*All settings including **children's homes**, residential care homes, residential schools, **foster care**, **hospices** and **secure units** implement guidance on the safe use of medicines that complies with the relevant legislation and Welsh Assembly Government Minimum Standards for the relevant service setting, and have a pre-agreed contact point for pharmaceutical advice.*

Inspection

3.29 During an inspection the Care standards and Social Services Inspectorate for Wales (CSSIW) inspectors will check that day care providers and schools that provide accommodation to pupils have adequate policies and procedures in place regarding the administration and storage of medicines.

3.30 The CSSIW already has a regular programme of inspections for care homes and other types of residential establishment such as special residential and boarding schools. Specialist pharmacy inspectors assist where necessary.

3.31 In inspections of schools that are conducted according to the Common Inspection Framework, Estyn inspectors evaluate and report on how well learners are cared for, guided and supported.

3.32 When inspecting the work of local authorities in the field of additional learning needs (ALN), Estyn and Wales Audit Office inspectors evaluate and report on the effectiveness of services for children and young people who have physical, medical and/or mental health difficulties. This evaluation includes consideration of whether:-

- there is effective training for staff in early years settings and in schools to enable them to meet the needs of children and young people with ALN; and
- pupils with difficulties in physical or mental health who are unable to attend school receive as much education as possible and maintain good links with their schools.

Prescribed Medicines

3.33 Regulations require that parents give their consent to medicines being given to their child and that the provider keeps written records.

3.34 Medicines should only be taken to school or settings when essential; that is where it would be detrimental to a child's health if the medicine were not administered during the school or setting 'day '.Schools and settings should only accept medicines that have been prescribed by a doctor, dentist, nurse prescriber or pharmacist prescriber. Medicines should always be provided in the original container as dispensed by a pharmacist or dispensing doctor and include the prescriber's instructions for administration.

3.35 Schools and settings should never accept medicines that have been taken out of the container as originally dispensed nor make changes to dosages on parental instructions.

3.36 It is helpful, where clinically appropriate, if medicines are prescribed in dose frequencies which enable it to be taken outside school hours. Parents could be encouraged to ask the prescriber about this. It is to be noted that medicines that need to be taken three times a day could be taken in the morning, after school hours and at bedtime.

Controlled Drugs

3.37 The supply, possession and administration of some medicines are controlled by the Misuse of Drugs Act 1972 and its associated regulations. Some may be prescribed as medication for use by children, e.g. methylphenidate.

3.38 Any member of staff may administer a controlled drug to the child for whom it has been prescribed. Staff administering medicine should do so in accordance with the prescriber's instructions.

3.39 A child who has been prescribed a controlled drug may legally have it in their possession. It is permissible for schools and settings to look after a controlled drug, where it is agreed that it will be administered to the child for whom it has been prescribed.

3.40 Schools and settings should keep controlled drugs in a locked non-portable container to which only named staff should have access. A record should be kept for audit and safety purposes.

3.41 A controlled drug, as with all medicines, should be returned to the parent when no longer required to arrange for safe disposal (by returning the unwanted supply to the local pharmacy). If this is not possible, it should be returned to the dispensing pharmacist/doctor (details should be on the label).

3.42 Misuse of a controlled drug, such as passing it to another child for use, is an offence. Schools should have a policy in place for dealing with drug misuse.

Non-Prescription Medication

3.43 Staff should **never** give a non-prescribed medicine to a child unless there is specific prior written permission from the parents. Where the Headteacher agrees to administer a non- prescribed medicine it **must** be in accordance with the employer's

policy. The employer's policy should set out the circumstances under which staff may administer non-prescribed medicines. Where a non-prescribed medicine is administered to a child it should be recorded on a form such as Form 5 or 6 (see Annex 3) and the parents informed. If a child suffers regularly from frequent or acute pain the parents should be encouraged to refer the matter to the child's GP.

A child under 16 should never be given aspirin unless prescribed.

Self Management

3.44 It is good practice to support and encourage pupils, who are able, to take responsibility to manage their own medicines from a relatively early age and schools should encourage this. The age at which pupils are ready to take care of, and be responsible for, their own medicines, varies. As pupils grow and develop they should be encouraged to participate in decisions about their medicines and to take responsibility.

3.45 Older children with a long-term illness should, whenever possible, assume complete responsibility under the supervision of their parent. Children develop at different rates and so the ability to take responsibility for their own medicines varies. This should be borne in mind when making a decision about transferring responsibility to a child or young person. There is no set age when this transition should be made. There may be circumstances where it is not appropriate for a child of any age to self-manage. Health professionals need to assess, with parents and children, the appropriate time to make this transition.

3.46 If pupils can take their medicines themselves, staff may only need to supervise. The policy should say whether pupils may carry, and administer (where appropriate), their own medicines, bearing in mind the safety of other pupils and medical advice from the prescriber in respect of the individual child. A suggested parental consent form is provided in Form 7.

3.47 Where pupils have been prescribed controlled drugs staff need to be aware that these should be kept in safe custody. However, pupils could access them for self-medication if it is agreed that it is appropriate.

Administering Medicines

3.48 Any member of staff giving medicines to a pupil should check:-

- the pupil's name and date of birth;
- written instructions provided by parents or prescriber;
- prescribed dose; and
- expiry date if stated.

3.49 If in doubt about any of the procedures the member of staff should check with the parents or a health professional before taking further action.

3.50 It is good practice for staff to complete and sign record cards each time they give medicines to a pupil. In some circumstances, it is good practice to have the dosage and administration witnessed by a second adult. Form 5 can be used for this purpose.

3.51 Staff should provide a quiet, private area for pupils when giving and receiving medicines.

NSF Standard Quality of Services; Key Action 2.31

Service providers ensure that staff receive the appropriate training to develop relevant competencies in dosage calculation, prescribing, dispensing and administration of medicines for children.

Refusing Medication

3.52 If a pupil refuses to take medicine, staff should not force them to do so, but should note this in the records and follow agreed procedures. The procedures may either be set out in the policy or in an individual child's health care plan. Parents should be informed of the refusal on the same day. If a refusal to take medicines results in an emergency, the school or setting's emergency procedures should be followed.

Record Keeping

3.53 Parents should tell the school or setting about the medicines that their child needs to take and provide details of any changes to the prescription or the support required. However, staff should make sure that this information is the same as that provided by the prescriber.

3.54 Medicines should always be provided in the original container as dispensed by a pharmacist or dispensing doctor and include the prescriber's instructions. In all cases it is necessary to check that written details include:-

- name of child;
- name of medicine;
- dose;
- method of administration;
- time/frequency of administration;
- any side effects; and
- expiry date if stated.

3.55 It may be helpful to give parents a form similar to Form 3A or 3B to record details of medicines in a standard format. Staff should check that any details provided by parents, or in particular cases by a paediatrician or specialist nurse, are consistent with the instructions on the container.

3.56 Form 4 could be used to confirm, with the parents, that a member of staff will administer medicine to their child.

3.57 While there are no legal requirements for schools to keep records of medicines given to pupils, nor to give details of the staff involved, it is good practice to do so. Records offer protection to staff and proof that they have followed agreed procedures. Some schools keep a logbook for this. Forms 5 and 6 provide example record sheets.

Dealing with Medicines Safely

Safety Management

3.58 All medicines may be harmful to anyone for whom they are not prescribed. Where a school or setting agrees to administer any medicine the employer must ensure that the risks to the health of others are properly controlled. This duty derives from the Control of Substances Hazardous to Health Regulations 2002 (COSHH).

Storing Medication

3.59 Large volumes of medicines should not be stored. Staff should only store, supervise and administer medicine that has been prescribed for an individual child. Medicines should be stored strictly in accordance with product instructions (paying particular note to temperature) and in the original container in which dispensed. Staff should ensure that the supplied container is clearly labeled with the name of the child, the name and dose of the medicine and the frequency of administration. This should be easy if medicines are only accepted in the original container as dispensed by a pharmacist in accordance with the prescriber‘s instructions. Where a child needs two or more prescribed medicines, each should be in a separate container. Non-healthcare staff should never transfer medicines from their original containers.

3.60 Pupils should know where their own medicines are stored and who holds the key. The Headteacher is responsible for making sure that medicines are stored safely. All emergency medicines, such as asthma inhalers and adrenaline pens, should be readily available to pupils and should not be locked away. Many schools and settings allow pupils to carry their own inhalers. Other non-emergency medicines should generally be kept in a secure place not accessible to pupils. Criteria under the national standards for under 8s day care and schools that provide accommodation require medicines to be stored in their original containers, clearly labeled and inaccessible to pupils.

3.61 A few medicines need to be refrigerated. They can be kept in a refrigerator containing food but should be in an airtight container and clearly labeled. There should be restricted access to a refrigerator holding medicines.

3.62 Local pharmacists can give advice about storing medicines.

Access to Medication

3.63 Pupils must have immediate access to their medicine when required. The school or setting may need to make special access arrangements for emergency medication that it keeps. However, it is also important to make sure that medicines are only accessible to those for whom they are prescribed. This should be considered as part of the school's policy about pupils carrying their own medication.

3.64 The school must ensure that teachers and staff know the pupil or check the name and date of birth before handing over medicines.

Disposal of Medicines

3.65 Staff should not dispose of medicines. Parents are responsible for ensuring that date-expired medicines are returned to a pharmacy for safe disposal. They should also collect medicines held at the end of each term. If parents do not collect all medicines, they should be taken to a local pharmacy for safe disposal.

3.66 Sharp boxes should always be used for the disposal of needles. Sharps boxes can be obtained by parents on prescription from the child's GP or paediatrician. Collection and disposal of the boxes should be arranged with the Local Authority 's environmental services.

Hygiene/Infection Control

3.67 All staff should be familiar with normal precautions for avoiding infection and must follow basic hygiene procedures. Staff should have access to protective disposable gloves and take care when dealing with spillages of blood or other body fluids and disposing of dressings or equipment. Further guidance is available in the DfTE publication HIV and Aids: A Guide for the Education Service and Welsh Office Circular 54/95 – Drug Misuse: Prevention and Schools.

Intimate or Invasive Treatment

3.68 Some school staff are understandably reluctant to volunteer to administer intimate or invasive treatment because of the nature of the treatment, or fears of accusations of abuse. Parents and Headteachers must respect such concerns and should not put any pressure on staff to assist in treatment unless they are entirely willing.

3.69 Each LHB will have a school nurse or community paediatrician to whom schools can refer for advice. The Headteacher or governing body should arrange appropriate training for school staff willing to give medical assistance. If the school can arrange for two adults, ideally one of the same gender as the pupil, to be present for the administration of intimate or invasive treatment, this minimises the potential for accusations of abuse. Two adults often ease practical administration of treatment too. Staff should protect the dignity of the pupil as far as possible, even in emergencies.

Chapter 4: Education Otherwise Than At School (EOTAS)

Summary

A child or young person who is unable to attend school because of medical needs should have their educational needs identified, receive educational support quickly and effectively and be able to access suitable and flexible education appropriate to their needs. The nature of the provision must be responsive to the demands of what can be a changing medical status.

This chapter describes the support available to pupils educated otherwise than at school either at home, in hospital, in a designated pupil referral unit, or other setting.

4.1 In fulfilling its duty to provide “education otherwise than at school", the LEA is not expected to provide education at home for pupils who are only ill for very short periods of time; however, they should take into account the way in which the absence is likely to effect the child on his/her return to education. In the case of a short absence, for example those which are likely to last for less than four weeks, the regular school is expected to provide work to be done at home if the pupil’s condition permits. However, the LEA can provide teaching at home earlier at its own discretion if this would be best for the welfare of the child.

4.2 Few LEAs leave pupils at home without any tuition for more than four weeks without justification. In cases where the child has already been in the hospital without access to education, the LEA will be eager to take this period into account when considering home tuition. If the pupil has been in hospital for a longer period and has received tuition at the hospital, the LEA will realise that the pupil’s education pattern has been curtailed and that as much continuity as possible should be ensured. The LEA will be eager to give him/her as many lessons as possible and as is beneficial, taking into account the available resources and the condition of the pupil. It may be necessary to give particular consideration to a pupil who is working for public examinations.

4.3 Whether the child or young person is able to access this entitlement will depend on medical advice and, perhaps more importantly, when they feel able to cope with it. The right balance must be struck between encouraging pupils to study and recognising when they are not well enough to benefit from teaching. This must be kept under regular review.

4.4 The LEA should have a written policy regarding lessons at home and or in another setting. Policies should include arrangements for the service and the way it is staffed; the timing of the provision; and a named person that parents, teachers at the hospital and others should contact (see annex 1). The policy should make links with related services in the local authority such as those for special educational needs and other local authority support services, educational psychologists, the Education Welfare Service and pupil referral units. It should also take account of other provision such as the Children and Young People’s Framework Partnerships,

and other planning tools, for example, the Single Education Plan (to Children and Young People's Plan 2008).

4.5 Monitoring and evaluating of the out of school provision should form a key element in the LEAs strategies. They need to ensure that new developments are taken on board, that levels of education are of a sufficient standard and that provision represents good value for money.

4.6 Hospital and home tuition services, or discrete parts of a service which provide education in a resource based school setting must either be established as a hospital school or registered as a Pupil Referral Unit (PRU).

The Home/Hospital Tuition Service

4.7 Home/hospital tuition can be described as education either on an individual basis or in a small group and delivered either in the pupil's home, in hospital or at a designated centre. Pupils generally do better educationally and socially when taught in groups; this also helps reintegration into schools. However, home tuition should be available on a one to one basis for those who need it. LEAs should ensure that they fulfil all statutory duties and that criteria for access to hospital/home education provision are clear, fair and consistent

4.8 Most of the children and young people for whom hospital schools or hospital tuition services provide are hospital in-patients, although a few chronically ill pupils may attend daily from home. Some may be admitted for only a few days, while others may remain on wards or in units for longer. Others may attend the hospital school regularly for a few days a week, returning home or to school for the rest of the week.

4.9 In Wales, hospital/home tuition services are usually part of an integrated service whereby LEAs employ the tutors to work either in a hospital or home setting as part of one service. Where this is not the case they should establish strong links between the hospital and the home tuition service.

4.10 The LEA should inform home/hospital tutors of the resources and support available to them in their work. Home tutors should have a wide range of books, equipment and materials for lessons at home. Home tuition should follow the National Curriculum wherever possible. It is important that the full records of long term stay pupils are transferred from the usual school to the hospital and then to the home tutor. When the child returns to school the home tutor should note the work done and the progress made.

NSF Standard Acute and Chronic Illness or Injury: Key Action 7.7

An appropriate amount of ongoing education, in a suitable environment, is provided for all children and young people who are well enough to receive it, including those in hospital. Education is provided in liaison with each child's school and is appropriate to their age and stage of development.

4.11 Some pupils have particular needs which require input from specially trained teachers, such as those with the mandatory qualification to teach hearing impaired, visually impaired or multi-sensory impaired pupils. In the case of hospitalisation or prolonged absence at home, similar specialist teachers may not be available to provide continuing education while the pupil is away from school. In these cases close liaison between the school, hospital, home tuition service and LEA is essential. In some situations it is possible for the LEA to make arrangements for specialist staff to visit the pupil in hospital on a regular basis. It may also be possible to provide training of hospital staff for example, to aid communication with sensory impaired pupils.

Pupil Referral Units (PRUs)

4.12 PRUs are legally both a type of school and education otherwise than at school. They are schools established and maintained by an LEA and are specially organised to provide education for pupils of compulsory school age who, by reason of illness, exclusion from school or otherwise, would not receive suitable education.

4.13 It is good practice for PRUs that provide for pupils with medical needs to cater exclusively for them. The LEA, with the management committee, sets the admission policy for a PRU. Pupils should be admitted to a PRU based on clear criteria and each pupil should have targets for reintegration into mainstream or special schooling, further education or employment. Day-to-day decisions on admissions to the Unit may be handled by the LEA, or delegated to the management committee or teacher in charge.

4.14 The development of resource based provision can provide an excellent way of bringing together small groups of ill and injured pupils as a means of providing good quality education. Teaching pupils in groups, where possible, can offer a more rounded educational and social experience and a way back into school.

4.15 Dual placements can support effective inclusion, by helping to prepare children and young people for mainstream education and schools to meet their needs. The Education Act 1996 allows for dual registration of pupils at both a Pupil Referral Unit (PRU) or special school and another local school. This process can assist in a phased return to mainstream education.

4.16 Further guidance on PRUs can be found in the Welsh Assembly Guidance Document “Inclusion and Pupil Support” (2006).

Education in Hospital

4.17 The aim of educating children and young people in hospital are the same as they are for other pupils. Education remains crucially important to the pupil’s prospects; without it the pupil’s personal happiness, life and career chances as an adult may be irretrievably disadvantaged.

4.18 Education in hospital can provide continuity and help children and young people (and their families) cope with hospital treatment, assist rehabilitation and raise their morale.

4.19 Most of the children and young people for whom hospital schools or hospital tuition services provide are hospital in-patients, although a few chronically ill pupils may attend daily from home. Some may be admitted for only a few days, while others may remain on wards or in units for longer. Others may attend the hospital school regularly for a few days a week, returning home or to school for the rest of the week.

4.20 Children and young people with life-threatening or terminal illness, have a right to education suited to their age, ability, needs and health at the time.

4.21 There are currently no hospital schools established in Wales as defined within the Schools Standard and Framework Act 1998. Hospital schools as defined in the Act should be registered within the premises of a hospital as special schools, with maintained or non maintained status, i.e. maintained by the LEA or independent schools. They are subject to the procedures laid down in Section 31 and Schedule 6 of the School Standards and Framework Act 1998 in relation to establishment, discontinuance or making prescribed alterations. It should be noted that Children and young people from Wales may attend hospital schools outside Wales.

4.22 Pupils receiving support whilst in hospital in Wales will generally receive support from the LEA managed hospital/home tuition service.

4.23 Education law reflects the special nature and variable circumstances of hospital schools by providing, in some areas of legislation, more flexible arrangements than those applying to other special schools. Hospital schools are under no legal obligation to offer the National Curriculum. All hospital schools have local management and delegated responsibility for their budgets.

Admission to Hospital, Planning and Co-ordination of Support

4.24 Admissions to hospital are generally unpredictable but some are booked well in advance. It is essential for home/hospital teachers to have as much advance warning as possible of admissions.

4.25 Education provision should start as soon as is practicable after the child is admitted; for long-stay pupils the planning of education should commence immediately. The level of planning and degree of provision needed for long-stay pupils is not required for short-stay pupils. However, to ensure that the period which short-stay pupils spend in hospital is not wasted educational time, some hospital teachers have designed specific work programmes, in the context of the National Curriculum, which represent worthwhile educational experiences but can be completed in short periods.

4.26 For pupils undertaking GCSEs in hospital, liaison between the home, school and the hospital teachers is most important to ensure that pupils keep up with their peers in mainstream schools.

4.27 A young person’s educational needs post 16 should be carefully considered. As a matter of good practice, and where appropriate and practicable, all parties should try to enable a pupil to continue a course being taken on entry to hospital.

4.28 Those who teach pupils with long-term medical needs need not only to be professional teachers in the ordinary sense; they must also be able to help the child back into education after trauma and illness. They need expertise in increasing the goals set to pupils about to return to the mainstream; and, correspondingly, in decreasing the goals set to pupils who are physically deteriorating. This has implications for INSET and should be addressed by the LEA or governing body.

4.29 Home/hospital teachers should be provided with an indication of the date, or likely date, of admission and length of stay as soon as possible. Such advance warning will provide an opportunity for teachers to liaise with the parents and home school about the educational programme to be followed whilst the pupil is in hospital.

4.30 The planning of education should begin as soon as it is known that a child is to be admitted to hospital. This should take account of what he or she is currently learning. Education should be available on the day of admission in recurrent illness cases, for example where a child is having dialysis. In other cases the judgment about when education should begin will need to take account of the length of stay and medical condition.

4.31 Co-operation between education, medical and administrative staff within the hospital is also essential. The aim should be to achieve the greatest possible benefit for the child's education and health, which should include the creation of an atmosphere conducive to effective learning. It is crucial that hospital teaching staff establish a clear profile within the hospital setting. Service managers need to be proactive in establishing a multi-disciplinary perspective.

4.32 In cases of recurrent admission to hospital, liaison with the home/hospital teachers and home schools is particularly important as coverage of the curriculum is usually shared between them. Liaison is essential to ensure continuity and progression. Home/hospital teachers should be kept aware of all relevant meetings held by the LEA.

4.33 Teachers in hospital can make a valuable contribution to the health care and rehabilitation of pupils through, for example, communicating to the clinical team any anxieties which pupils may express to them about pain or the effects of medication. They should liaise closely with nursing staff to ensure that pupils are able to gain the most from their education hours, by ensuring that routine and other procedures are completed before teaching is due to start. Hospital teachers may need to attend ward rounds, case conferences and multi-disciplinary meetings to cover the educational perspective. Parents should also be involved in the admissions process and informed of educational programmes and hospital routine.

4.34 Close liaison between home/hospital teachers and mainstream teachers underpins the provision of an effective educational programme for the child; parents can also act as a valuable link. However, home/hospital teachers need a named contact in the ordinary school, which might be the SEN co-ordinator, or the year tutor at secondary schools and the Headteacher at primary schools.

4.35 Visits by the home/hospital school teachers to home schools should be made where other pressures permit. Some school teachers might also try to make time for pastoral visits to the hospital to see their pupils and their teaching situations.

NSF Standard Child and Family Services: Key Action 7.27

Children with complex health needs are not discharged from hospital without a written care plan. Systems are in place between health, social services and education to ensure that equipment suitable to the child's needs, and follow-up care, is provided in a timely fashion.

4.36 It is part of the role of the teacher to re-establish learning and to keep education alive for the pupil if any disruption to schooling is to be contained.

Statements of Special Educational Needs

4.37 A number of children and young people being taught in hospital are likely to have statements specifying certain special educational and/or non-educational provision. Hospital teachers are not likely to have the time or opportunity to contribute significantly towards provision, which is essentially long-term, in respect of short-stay pupils. However, the LEA should give or provide on request copies of the statement to the hospital school or service in the case of long-stay pupils and the school who must have regard to the requirements of the statement.

4.38 The LEA will need to consider proposing an amendment to the statement to name the hospital school in the case of some long-stay pupils, if that is where the pupil's special educational needs are to be met for the foreseeable future. Parents would have a right to comment on any such amendment in accordance with the statutory process set out in Schedule 10 to the Education Act 1993.

4.39 Alternatively, it may be necessary for the LEA to undertake a statutory reassessment of a long-term pupil's needs if his or her circumstances and special educational needs have changed by reason of long term illness or deterioration in condition. The Code of Practice gives guidance on the criteria for statutory assessment. LEAs are still required to carry out the annual review of the statement notwithstanding a long-stay pupil's absence from the home school. For pupils with statements who have regular periodic stays in hospital, the home school (if still named on the statement) should lead the review but should seek to involve the hospital school, and possibly the SSD. The hospital school should lead the review if it is named in part 4 of the statement.

Hospital Tuition Units

4.40 The majority of children and young people accessing education in hospital will be within a hospital tuition unit with support and tuition delivered by the LEA Home/Hospital Tuition Services or EOTAS service.

4.41 A small number of young people develop severe emotional and behavioural disorders, which require care and treatment beyond that which can be found in school, or sometimes even local health care. Some of these young people need special boarding schools while others need to be treated in hospital. Some are placed in NHS or private mental health units or hospitals often at a considerable distance from home. Pupils placed in such units retain an entitlement to education. Private mental health units must plan with the home LEA to ensure that pupils who are mental health patients continue to access their entitlement to education.

4.42 Children and young people may be admitted to a mental health setting under the Mental Health Act 1983 or, more usually, on a voluntary or informal basis. The criteria for admission laid down in the Act are that, first, the patient must be suffering from a mental disorder as defined by the Act; secondly, that the disorder must be of a nature or degree which makes admission to hospital appropriate; and, thirdly, that medical treatment must be necessary for the health or safety of the patient or the protection of others.

4.43 Although the majority of adolescents and children admitted to psychiatric units have already had difficulties with their education, they all require an intensive educational input to restore self-esteem and enable a successful return to school and ordinary life, where possible. Without effective education their prognosis for a full recovery may be diminished.

4.44 Educational programmes need to be designed to meet the individual needs of youngsters whose requirements and difficulties will vary widely. There is no legal requirement to provide the National Curriculum, but psychiatric unit teachers should nonetheless aim to provide a broad and balanced curriculum within which the young person's needs may be. Links to the National Curriculum are essential if there is to be any prospect of successful subsequent reintegration into mainstream education.

4.45 Teachers in psychiatric units need to be fully involved in planning admissions, assessments (including liaison with the pupil’s home school), and in establishing and managing a reintegration programme. The demands on teachers, and their requirements, are similar in many ways to those on the staff in pupil referral units, as described in Welsh Office Circular 61/94 ‘The Education by LEAs of Children otherwise than at school’.

4.46 A minority of children and young people will be admitted to hospital as a result of brain injury. Educational provision will in some cases be impracticable. But where it is not, and the pupil’s abilities have been affected, the hospital teacher can contribute to an assessment of the impairment and the necessary provision to meet any learning difficulties.

4.47 Very close co-operation between medical and teaching staff is needed. The hospital teacher should be an integral part of the hospital-based multi-disciplinary teams, who should be trained for the purpose, to deliver all in-patient assessments, care and treatment. However, there can be no assumption that the teacher will have medical knowledge about head injury.

4.48 Medical staff should give the teacher clear and early information about the severity of the injury and about the main areas of concern regarding recovery. Medical terminology should be interpreted with care: neuro-surgical categories of mild, moderate and severe head-injury may not equate to the learning difficulties likely to follow.

4.49 Learning difficulties may emerge early in recovery or later, sometimes even after the return to school. The pace of change in brain injury recovery places special demands for flexibility on the hospital teacher, and calls for close liaison between the teacher and others in the education system. The hospital teacher needs to be aware of the pupil's condition and treatment, while remaining professionally and independently responsible for what is taught.

4.50 Physiotherapists, occupational, speech and play therapists, and nursing staff can all help to regain access to the curriculum. Clinical psychologists may need to be involved before the child leaves hospital; links with the Educational Psychology Service may be helpful.

4.51 LEAs must ensure that there is sufficient flexibility to meet an individual pupil's needs. For example, some pupils may attend the hospital unit on a part-time basis combined with attendance at the pupil's home school.

4.52 To facilitate liaison and effective communication, every LEA should have at least one named educational psychologist within the Educational Psychology Service, designated to work with home/hospital tuition services or to liaise within the Educational Psychology and other support services as necessary.

4.53 The occupational therapist may need to assess the home and school environments, with a view to recommending physical adaptations or the provision of equipment.

4.54 LEAs also have to ensure that the provision follows health and safety guidelines and the appropriate child protection policies and procedures are in place.

Working Together

4.55 The Department for Health issued guidance in December 1991 on the "Welfare of Children and Young People in Hospital". Section 4.17 of that document advises LHBs/Trusts that they have duties to ensure that provider hospitals collaborate with LEAs in the provision of education.

4.56 A large number of agents can be involved in supporting a young person for whom hospital education needs to be provided. Liaison between education, medical and administrative staff within the hospital is essential.

4.57 Informal links are best developed through joint meetings and combined In-Service Training (INSET). With their responsibility for teaching all ages and all abilities, hospital and home teachers need access to relevant INSET if they are to maintain their professional expertise and status and are not to be isolated from their colleagues in mainstream and other special schools.

The Curriculum

4.58 Temporary exceptions by Headteachers, under Section 19 of the Education Reform Act, are not needed to authorise departures from the National Curriculum for pupils who remain on their school's register but are, for the time being, absent from school due to illness. But, when pupils return to mainstream school, Headteachers should use the inherent flexibility provided by the National Curriculum access statement to make suitable modifications to the curriculum. To enable pupils to adjust, co-operation well in advance between the hospital teachers and the home is necessary.

4.59 However, hospital teachers generally seek to follow the National Curriculum as far as practicably possible. This benefits the child, not least in easing the return to mainstream school and in providing continuity within a commonly accepted framework with the home tuition service. Where appropriate, hospital schools and tuition services should observe terms and holidays of the schools in whose area they are situated.

Monitoring and Evaluating Pupils' Progress

4.60 Recording academic progress (or otherwise) of long-stay pupils during periods of hospitalisation should as a matter of good practice reflect National Curriculum terminology and requirements.

4.61 Dual registered or part-time pupils, i.e. those pupils that are registered with a mainstream school but attend a hospital education unit or pupil referral unit or special school for some or all of the week, should continue to be monitored by their home school. The school should monitor attendance and education and chase up regular reviews of progress.

4.62 Mainstream and hospital teachers need to agree exactly how information on academic progress will be exchanged, including Records of Achievement (ROA).

4.63 Hospital teachers should keep evidence of what pupils have achieved so that mainstream teachers can involve the pupil in appropriate programmes of study on return to the home school; a portfolio of work done should be included for long-stay pupils. Pupil involvement is needed in producing ROA so that they can comment on their own experiences of being in hospital. Home schoolteachers should take care not to underestimate what pupils may be able to achieve while in hospital. Short-stay pupils should be encouraged to take back to their home school any of the work they have produced.

4.64 For long-stay pupils the monitoring of progress will be achieved by establishing a pastoral support programme (PSP). The PSP should focus on the individual needs of the pupil, academic and social and would include plans for reintegration into mainstream school. The review of the PSP should take place at least every six weeks with results being shared with the main parties involved. The responsibility of carrying out the review should be with the organisation where the pupil spends the majority of their time. Further guidance on PSPs can be found in the Welsh Assembly Government Circular 'Inclusion and Pupil Support'.

4.65 Some hospital schools and units act as Examination Centres for public examinations. Statutory assessments (if the pupil's condition permits and if the child is attending both hospital school and the home school) remain the home school's responsibility, but other regular testing should continue at the hospital teacher's discretion. Care is needed to ensure that this does not add to the stress for pupils who are sick and may already be under intense psychological or other pressure in that respect.

4.66 Hospital schools, and tuition services except those based essentially on bedside provision, have certain basic requirements in order to function efficiently and cost-effectively. Sufficient classroom accommodation for the typical intake is needed, along with appropriate storage and office space perhaps in a multi-purpose base. The accommodation should be reasonably close to the children's wards. It will not generally be possible within a hospital to provide the full range of other resources (for example current books and equipment for the entire compulsory school age range and beyond, embracing all abilities). Home schools should co-operate in the provision or loan of books and other resources.

Staffing

4.67 Staffing requirements vary considerably with the nature of the medical specialisms of particular hospitals, and with the conditions for which children and young people are admitted; organisation of staffing requires considerable flexibility. It is therefore not practicable to determine general staffing ratios centrally. The pupil teacher ratio is generally higher where there is a more predictable number and where there are more opportunities for grouping for teaching purposes. However, the educational requirements of some children and young people may be highly individual and thus be more demanding of teacher time. Where the school caters for the entire compulsory school age range with a small full-time permanent staff, it is helpful to have an appropriate balance between primary and secondary trained teachers. Access to teacher specialisms may be necessary.

4.68 Teachers should discuss their roles with nursing and medical staff where a child or young person is attending a hospital. The LEA should ensure that teachers in hospitals receive information about every opportunity for local INSET sessions. Teachers in hospital and home tutors may wish to form links with local schools to arrange visits and join INSET sessions where appropriate and relevant, the Social Services Department may be able to contribute under these circumstances.

Children and Adolescents in Hospitals

4.69 Unless it is unavoidable, children and young people should not be placed on adult wards. Where they are, information reaching teachers about the child may be haphazard. Administrative, medical and teaching staff need to be alert to this potential difficulty. Adolescents are more frequently admitted to adult wards and scattered throughout the hospital. Hospital teachers do not usually teach in adult wards, where the routines will often in any event make teaching difficult. Many adolescents will be working towards or have imminent public examinations and their needs will be particularly acute and specific. The provision of education and the maintenance of standards are therefore particularly important. The young people

concerned may experience considerable anxiety over the impact of their illness on their future qualifications. Hospitals should offer hospital teachers ready access to data about the admission and discharge of children and adolescents to adult wards and inform the LEA.

4.70 As a matter of good practice, teachers in hospital settings should offer tuition to recurrent admissions as early as possible during each period in hospital. In cases of cystic fibrosis, renal and complex cardiac conditions and cancer the liaison between hospital teacher, home tutor and home school is particularly important to ensure continuity and progression. The guidance given in the SEN Code of Practice for Wales applies here. Educational advice forming part of a statutory assessment must be sought from any school the child has attended in the prior 18 months.

4.71 Some specialist hospital schools providing for children and young people who require long term care, also make or help to arrange provision for well siblings where the whole family has moved to the area temporarily to be close to the pupil who is in hospital. This should happen wherever possible.

Information Communication Technology (ICT)

4.72 ICT can be used in a variety of ways to support pupils with medical needs once their learning needs have been assessed.

4.73 Anywhere pupils are educated (other than at schools) computers can offer a flexible solution to continuing education as they can be used in a variety of settings and in a number of ways to assist pupils in supporting individual needs. Assistive Technologies can also enable pupils with mobility problems or physical difficulties to access ICT.

4.73 Laptop computers offer a much needed flexible solution as they can be used in the mainstream classroom, hospital or home. The storage of information is compact and easily accessed wherever the teaching takes place. Portable devices e.g. WP, PDAs, EDAs etc. can also provide a convenient way for pupils to record and make notes. Teachers can prepare tasks on CDs, Web20, Memory sticks, podcasts etc., which the pupil can take with them and return when the tasks are completed.

4.74 When a pupil is educated other than at school it is vital that communication is maintained between the pupil and the school. ICT enables this to happen in a virtual context which can reduce a pupil’s feelings of isolation and allows them to continue with their education as far as their illness allows. Implications for staff preparing those resources should be considered.

4.75 The Internet or School Web site can be used to deliver distance learning packages and this may be managed by a local authority teaching service, a private organisation or by the mainstream school. It can also be used to support research tasks regardless of whether pupils are at home, in hospital or in a mainstream environment. E-mail (podcasting, blogs etc.) can be used to exchange information and assignments details or problems. It can also be useful for social interaction with staff and the pupil's peer group.

4.76 School web sites created by mainstream schools or hospital schools can be used to post details of lessons missed and homework to be done. All local authorities are investigating the use of Learning Platforms which could be accessed by all education establishments in their local authorities, as well as by pupils at home or in hospital provided they have a reasonable internet connection.

4.77 The use of web cameras for video conferencing can enable pupils in hospital or at home to link to mainstream lessons. Video conferencing can also link teaching areas within a hospital and enable pupils to make contact with education establishments world wide.

4.78 Inclusion is about ensuring that all pupils are able to participate fully in the learning and life of the school. ICT can provide a valuable support to achieve inclusive practice through helping teachers overcome potential barriers to learning in response to pupils' diverse needs and setting appropriate learning challenges. Teachers need to plan their management of ICT in the classroom together with the availability of particular technologies to support the individual needs of pupils.

Chapter 5: Reintegration

Chapter Summary

Returning to school after a period of illness can be an emotional hurdle for a child or young person. Skills such as learning the routine of the school day and developing and maintaining friendships can be damaged by a long absence.

This chapter considers how schools, LEAs and others can assist to ensure a seamless transition on return to school. It considers the assessment of the child's immediate and future needs and provides practical advice on systems to support the process of re-integration.

5.1 School policies and practices need to be as positive and proactive as possible in order to welcome the child or young person back into school and to assist successful reintegration. Consultation with the child and parents about concerns, medical issues, timing and pace of return is important. Key staff such as a class teacher, head of year, pastoral teacher, home and/or hospital tutor, and careers adviser could meet to discuss the case. Friends and other pupils can help a child settle back in school. Extra support should be provided when it is clear what has been missed – diagnostic testing is a good way to assess any gaps.

5.2 Continuous involvement of the home school throughout a period of illness aids the successful return to school. Peer group contact during an absence, for example cards, letters, videos and invitations to school events, are as important as formal contact.

5.3 For some, reintegration is likely to be a gradual process over a period of time. Initially some children and young people will benefit from flexible arrangements which may include attending school part-time while retaining some other support. Others may require alternative provision to allow them to cope with peer relationships and a school environment, before a gradual return to school is possible. Support may need to continue to be available on return to school.

5.4 Schools have a key role to play in ensuring successful re-integration. Schools should:-

- ensure that their part in any re-integration plan is carried out;
- be pro-active in working with all agencies to support smooth transition;
- ensure that the pupil's educational needs are met;
- ensure that peers are involved in supporting the pupil's re-integration; and
- ensure compliance with the DDA (Chapter 1).

Long Term Absences

5.5 Where pupils have illnesses such as cancer or other conditions or trauma resulting in a long time away from school, or have acquired brain injury there is a need for good links between the hospital, the hospital school, the home LEA and the pupil's school. Acute hospital services should liaise closely with community health services. There may sometimes be a need for the child's paediatrician to seek advice from colleagues to cover cognitive and emotional and behavioural issues that may affect learning. The paediatrician should liaise with the designated medical officer so as to decide who is best to take the lead and co-ordinate advice to the education services.

5.6 Common problems for a child with an acquired brain injury are impairment of memory and concentration, fatigue, change in personality and behavioural problems. Some pupils will have impaired or reduced IQ. Not all have a physical disability and as a result, many pupils with a brain injury are not perceived as being disabled. The interruption and alteration to a normal progression of development may result in preservation of some skills but loss of others, leading to complex and unusual profiles. For example, a preserved word reading age but the inability to progress further. Sometimes problems do not manifest themselves until years after the injury is sustained.

5.7 Educational psychologists can play a valuable role, particularly where it becomes necessary whilst the pupil is still in hospital, to commence statutory assessment of SEN, for example, following a head injury.

5.8 PRUs for pupils with medical needs, which offer teaching in smaller groups, may offer a good "halfway house" before reintegration into the school. Pupils, who appear to be able to cope with a return to school, may well have a relapse some time after their return. Schools should therefore be prepared to be flexible over issues such as time-tabling where reintegration is not straightforward.

5.9 Pupils with long term medical needs should have an assessment of their situation and the provision of well structured support from the home and school in liaison with the hospital and home tuition service and other agencies as necessary, to assist reintegration to school, wherever possible.

5.10 LEAs are responsible for ensuring:-

- that an individually tailored reintegration plan is in place for all pupils before they return to school. The plan should have multi-agency approval. It might include:
  - details of regular meetings to discuss potential reintegration;
  - clearly stated responsibilities and rights of all those involved;
  - appropriate social contacts – possibly including mentors;
  - a programme of negotiated small goals; and
  - reintegration follow-up procedures.

5.11 Where reintegration is a gradual process and the child or young person is only able because of their medical condition to attend school part-time, educational support should continue to be available to help them to keep up with their studies.

Discharge from Hospital

5.12 After discharge from hospital, the hospital teacher should liaise with the home tuition service, the school or the next hospital's tuition service, as appropriate. The hospital teacher should be available to give advice as necessary on potential changes in a pupil's language, memory and organisational skills (which may be misunderstood or mishandled) and on ways of dealing with the child.

5.13 It is easy for pupils to get lost in the system, especially when they are discharged from hospital to "out of county" provision. In these cases it is even more important that there is effective communication between hospital provision and home LEAs and schools.

5.14 Hospitals should give as much notice of discharge as possible to all those involved in a child's education, together with information about his or her achievements and educational progress.

5.15 Larger hospitals which act as regional centres will often have a liaison nurse who can prepare the child's school on how best to manage their return. A short information session with a liaison nurse often enables teachers with no experience of dealing with a particular condition or disease to handle reintegration effectively. It can also promote understanding that some illnesses or treatments can create behaviour problems or cognitive difficulties.

Post Reintegration

5.16 A continued outreach service after discharge is sometimes essential to prevent early relapse.

5.17 Hospital and home teachers should be aware of their role in reintegrating pupils into school as soon as possible and LEAs should ensure EWOs understand their role in relation to pupils with medical needs.

5.18 It is useful for the LEA to check on the result of post reintegration follow-up – an administrative task which is essential in determining effectiveness. LEAs should be aware of the help that is available to reintegrate a pupil locally not only from health and other public agencies but also private and voluntary organisations.

Disapplication of the National Curriculum

5.19 Formal exceptions by Headteachers under section 365 of the Education Act 1996 and SI 1989/1181 are not needed to authorise departures from the National Curriculum for pupils who are absent from school due to illness. However, when pupils return to school, it may be helpful for Headteachers to consider, in special circumstances and perhaps for a short time (subject to the normal legal procedures and consultation with parents), making more use of the

flexibility afforded by the National Curriculum access statement to meet individual pupil's needs at the point of transition back to school.

5.20 In appropriate cases, co-operation well in advance between the hospital teachers and home teachers and the school is necessary. The former ACCAC publication *Disapplication of the National Curriculum* gives guidance on all types of disapplication.

Annex 1

Guidance on LEA Policies for Supporting Pupils with Medical Needs

Each LEA should have a written policy statement on the implementation of its legal duty to provide education for children and young people who are unable to attend school because of their medical needs and this should be referred to in the authority's Single Education Plan (to become Children and Young People's Plan 2008). The policy should be freely accessible to all. An LEA's policy should encompass all aspects of arrangements for referral. These should be clear and publicised to all interested parties. An LEA's policy should encompass all aspects of the authority's provision, in hospital, at home and elsewhere, and set out clearly:-

- how the LEA will meet the standards of educational provision set out in this guidance;
- what range and standard of educational provision will be provided;
- how responsibility for that service is shared between schools and other elements, such as the hospital and home teaching service(s) and EWOs;
- the procedures to be followed when a pupil is away from school as a result of medical needs, including procedures to support:
  - early identification;
  - medical referrals;
  - personal education plans;
  - reintegration into school;
  - pupils working towards public examinations;
- for those pupils who may be school refusers, clear procedures for ensuring early and accurate identification and access, as necessary, to specialist mental health services;
- main collaboration arrangements with other agencies, including LEAs in which hospitals are situated and local and national hospitals, to ensure the continuity of education for pupils in hospital;
- the annual budget, management structure, organisation and staffing and training needs of the service;
- how the service can be accessed by parents and details of advice and support available to them, including a named contact point;
- how the service will take account of the child or young person's views;
- how the service will be monitored and evaluated; and
- links with other services.

Annex 2

a. Guidance on School Policies for Supporting Pupils with Medical Needs

All schools should have a written policy for dealing with the education of pupils with medical needs (an example policy is included below). The policy should include information such as:-

- how the school will make educational provision for pupils as set out in this guidance;
- the school's responsibility to monitor pupil attendance and to mark registers so that they show if a pupil is, or ought to be, receiving education otherwise than at school;
- management structures and staff responsibilities;
- strategies for ensuring support in cases of long-term absence, including the provision of assessment and curriculum plans within 5 working days and work programmes on a termly basis;
- a named contact within the school to aid communication with other parties, to attend reviews, and to facilitate communication generally between the pupil and the school;
- the provision of work and materials for pupils who are absent from school because of medical needs;
- procedures for ensuring that pupils who are unable to attend school because of medical needs have access to public examinations, possibly as external candidates;
- procedures for ensuring that pupils are reintegrated smoothly into the school;
- issues related to pupils with statements of special educational needs;
- how the school's procedures will take account of the pupil's views;
- the role of the school health service, which is to facilitate good assessment of the pupil's health care needs and enabling them to be helped through effective multi-agency/disciplinary team work;
- whether the headteacher accepts responsibility, in principle, for school staff giving or supervising pupils taking prescribed medication during the school day;
- the circumstances in which pupils may take non-prescription medication e.g. painkillers (analgesics);
- the school's policy on assisting pupils with long term or complex medical needs;

- the need for prior written agreement from parents or guardians for any medication, prescribed or non-prescription, to be given to a child. policy on pupils carrying and taking their medication;
- staff training in dealing with medical needs;
- record keeping;
- storage and access to medication; and
- the school's emergency procedures.

The policy statement should be reviewed each year, revised as necessary and used as a tool for improving provision. Schools might, for example, want to include a report on the implementation of their policy for pupils with medical needs in the governors' annual report, alongside information about the school's policy on providing for children with additional learning needs and any changes to the policy in the last year.

b. Model school policy for the Education of Pupils with Medical Needs

Name of school ……..

1. Introduction

This policy is written in response to the guidance contained in the Welsh Assembly Government circular “Access to Education and Support for Pupils with Medical Needs (2007)”.

The school will continue to be responsible for all pupils unable to attend school for medical reasons. Students should be able to access education without stigma or exclusion.

Pupils covered by this policy may:-

- be recovering from an illness or injury keeping the pupil away from school during recovery;
- have a long term or recurring illness; or
- have an illness or clinically defined mental health disorder which causes them to be absent for a period in excess of 15 days where medical opinion states they are still unable to access mainstream school.

2. Aim

Our aim is to ensure that all pupils in our school continue to have access to as much education as their medical condition allows so that they are able to maintain the momentum of their education and to keep up with their studies. The nature of the provision will be responsive to the demands of medical conditions that can sometimes be changeable.

3. Responsibilities

The school has a designated contact responsible for the education of pupils with medical needs whose role it is to facilitate communication with all parties and ensure that the school is meeting the needs of all pupils in the school with a medical condition.

Areas of general responsibility will include:-

- maintaining a list of pupils with medical conditions in the school;
- ensuring that contact is maintained with pupils (and their families) who are away from school due to illness for a period of less than 15 working days, setting of work if the pupil is well enough, forwarding of newsletters etc, welcoming pupils back to school, ensuring that all staff are aware of the up to date medical situation of the pupil and ensuring that any adjustments to

accommodation, curriculum are made, together with ongoing monitoring of the pupil's situation and needs whilst in school;

- keeping the EWO informed of all attendance issues regarding pupils where there may be medical needs, either physical or mental;
- ensuring that the school register is marked appropriately;
- maintaining contact with the school nurse;
- notifying the Medical Needs Team if a pupil is (or is likely to be) away from school due to medical needs for more than 15 working days. This includes those pupils with a recurring illness; and
- ensuring that close contact is maintained with the pupil (and their family) and that arrangements are in place for the setting and marking of work. This is particularly important for pupils for whom a support programme is being arranged.

4. Referral to the Medical Needs Team

Children who will be absent from school for 15 working days trigger intervention.

Educational provision will be made in collaboration with the service providing alternative education.

The school will hold, chair and document a planning meeting.

The designated school contact for pupils with medical needs will be responsible for:-

- ensuring that Medical Needs referral forms (Request for Involvement and Request for Medical Information forms) are completed and passed to the relevant agencies as quickly as possible;
- drawing up an Individual Education Plan (IEP) and ensuring that the pupil is on School Action Plus of the SEN Code of Practice;
- arranging for a member of the school staff to attend an initial meeting with the Medical Needs team to plan a way forward;
- ensuring that regular half termly review meetings are in place;
- ensuring the prompt provision (as agreed with the Medical Needs Team) of information about a pupil's capabilities programmes of work, and resources. Work provided by school will be relevant, appropriate and of comparable level to work being done in school by pupils in the same set/group;
- passing on details of the pupil's special educational needs and a copy of the current IEP;
- ensuring that pupils who are unable to attend school because of medical needs are kept informed about parents evening and are able to participate, for example, in homework clubs, study support and other activities;

- encouraging and facilitating liaison with peers - for example, through visits, emails, letter, and telephone calls; and
- ensuring that all pupils covered by this policy have access to statutory assessment, including guidance on the completion of appropriate coursework. The school will also be responsible for requesting special arrangements where necessary.

5. Parents/Carers and Pupils

The policy should include a paragraph on how the school will work with parents/carers and the individual pupil. It will need to outline how parents will be full collaborative partners and how they will have access to information, advice and support during their child's illness. Opportunities to allow the individual child to be involved in making decisions and choices will also need to be addressed.

6. Reintegration

The school will have a key role to play in successful reintegration and will be proactive in working with all agencies to support a smooth transition and in ensuring that peers are involved in supporting pupil's reintegration. The plan will always have multi-agency approval.

7. Involvement of Governors

There should be a short statement on Governor involvement and the monitoring of this policy.

8. Summary

The school's policy for the education of pupils with medical needs will form part of the Inclusion or SEN policy and will be included in the prospectus.

This policy will be reviewed annually.

Annex 3

Medical Advice on Common Conditions

The medical conditions in children and young people that most commonly cause concern in schools and settings are asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis). This chapter provides some basic information about these conditions but it is beyond its scope to provide more detailed medical advice and it is important that the needs of children are assessed on an individual basis.

Further information, including advice specifically for schools and settings, is available from leading charities listed in Annex 4.

ASTHMA - What is Asthma?

Asthma is common and appears to be increasingly prevalent in children and young people. One in ten children in the UK has asthma.

The most common symptoms of asthma are coughing, wheezing or whistling noise in the chest, tight feelings in the chest or getting short of breath. Younger children may verbalise this by saying that their tummy hurts or that it feels like someone is sitting on their chest. Not everyone will get all these symptoms, and some children may only get symptoms from time to time.

In early years settings, however, staff may not be able to rely on younger children being able to identify or verbalise when their symptoms are getting worse, or what medicines they should take and when. It is therefore imperative that early years and primary school staff, who have younger children in their classes, know how to identify when symptoms are getting worse and what to do for children with asthma when this happens. This should be supported by written asthma plans, asthma school cards provided by parents, and regular training and support for staff. Children with significant asthma should have an individual health care plan.

Medicine and Control

There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child will only need a reliever during the school day. Relievers (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are taken during an asthma attack. They are sometimes taken before exercise. Preventers (brown, red, orange inhalers, sometimes tablets) are usually used out of school hours.

Pupils with asthma need to have immediate access to their reliever inhalers when they need them. Inhaler devices usually deliver asthma medicines. A spacer device may be used with the inhaler, particularly for a young child, and the child may need some help to use this. It is good practice to support pupils with asthma to take charge of and use their inhaler from an early age, and many do.

Pupils who are able to use their inhalers themselves should be allowed to carry them with them. If the child is too young or immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name. Inhalers should always be available during physical education, sports activities and educational visits.

For a child with severe asthma, the health care professional may prescribe a spare inhaler to be kept in the school or setting.

The signs of an asthma attack include:-

coughing;

being short of breath;

wheezy breathing;

feeling of tight chest; and

being unusually quiet.

When a child has an attack they should be treated according to their individual health care plan or asthma card as previously agreed. An ambulance should be called if:-

the symptoms do not improve sufficiently in 5-10 minutes;

the child is too breathless to speak;

the child is becoming exhausted; and

the child looks blue.

It is important to agree with parents of children with asthma how to recognise when their child's asthma gets worse and what action will be taken. An Asthma School Card (available from Asthma UK) is a useful way to store written information about the child 's asthma and should include details about asthma medicines, triggers, individual symptoms and emergency contact numbers for the parent and the child's doctor.

A child with asthma should have a regular review with his/her GP or other relevant healthcare professional. Parents should arrange the review and make sure that a copy of their child's management plan is available to the school or setting. Pupils should have a reliever inhaler with them when they are in school or in a setting.

Pupils with asthma should participate in all aspects of the school or setting 'day' including physical activities. They need to take their reliever inhaler with them on all off-site activities. Physical activity benefits pupils with asthma in the same way as other pupils. Swimming is particularly beneficial, although endurance work should be avoided. Some pupils may need to take their reliever asthma medicines before any physical exertion. Warm-up activities are essential before any sudden activity especially in cold weather. Particular care may be necessary in cold or wet weather.

Reluctance to participate in physical activities should be discussed with parents, staff and the child. Pupils with asthma should not be forced to take part if they feel unwell. Pupils should be encouraged to recognise when their symptoms inhibit their ability to participate.

Pupils with asthma may not attend on some days due to their condition, and may also at times have some sleep disturbances due to night symptoms. This may affect their concentration. Such issues should be discussed with the child's parents or attendance officers as appropriate.

All schools and settings should have an asthma policy that is an integral part of the whole-school or setting policy on medicines and medical needs. The asthma section should include key information and set out specific actions to be taken (a model policy is available from Asthma UK). The school environment should be asthma friendly, by removing as many potential triggers for pupils with asthma as possible.

All staff, particularly PE teachers, should have training or be provided with information about asthma once a year. This should support them to feel confident about recognizing worsening symptoms of asthma, knowing about asthma medicines and their delivery and what to do if a child has an asthma attack.

EPILEPSY - What is Epilepsy?

Children and young people with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time.

Seizures can happen for many reasons. At least one in 200 children has epilepsy and around 80 per cent of such children attend mainstream school. Most children and young people with diagnosed epilepsy never have a seizure during the school day. Epilepsy is a very individual condition.

Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children and young people experience. Parents and health care professionals should provide information to schools, to be incorporated into the individual health care plan, setting out the particular pattern of an individual child's epilepsy. If a child does experience a seizure in a school or setting, details should be recorded and communicated to parents including: any factors which might possibly have acted as a trigger to the seizure – e.g. visual/auditory stimulation, emotion (anxiety, upset) any unusual 'feelings ' reported by the child prior to the seizure parts of the body demonstrating seizure activity e.g. limbs or facial muscles the timing of the seizure – when it happened and how long it lasted, whether the child lost consciousness, whether the child was incontinent. This will help parents to give more accurate information on seizures and seizure frequency to the child's specialist.

What the child experiences depends whether all or which part of the brain is affected. Not all seizures involve loss of consciousness. When only a part of the brain is affected, a child will remain conscious with symptoms ranging from the twitching or jerking of a limb to experiencing strange tastes or sensations such as

pins and needles. Where consciousness is affected; a child may appear confused, wander around and be unaware of their surroundings. They could also behave in unusual ways such as plucking at clothes, fiddling with objects or making mumbling sounds and chewing movements. They may not respond if spoken to. Afterwards, they may have little or no memory of the seizure.

In some cases, such seizures go on to affect all of the brain and the child loses consciousness. Such seizures might start with the child crying out, then the muscles becoming stiff and rigid. The child may fall down. Then there are jerking movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some children may bite their tongue or cheek and may wet themselves. After a seizure a child may feel tired, be confused, have a headache and need time to rest or sleep. Recovery times vary. Some children feel better after a few minutes while others may need to sleep for several hours.

Another type of seizure affecting all of the brain involves a loss of consciousness for a few seconds. A child may appear 'blank' or 'staring ', sometimes with fluttering of the eyelids. Such absence seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class. If such seizures happen frequently they could be a cause of deteriorating academic performance.

Medicine and Control

Most children and young people with epilepsy take anti-epileptic medicines to stop or reduce their seizures. Regular medicine should not need to be given during school hours.

Triggers such as anxiety, stress, tiredness or being unwell may increase a child's chance of having a seizure. Flashing or flickering lights and some geometric shapes or patterns can also trigger seizures. This is called photosensitivity. It is very rare. Most children with epilepsy can use computers and watch television without any problem.

Pupils with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or working in science laboratories. Concerns about safety should be discussed with the child and parents as part of the health care plan.

During a seizure it is important to make sure the child is in a safe position, not to restrict a child's movements and to allow the seizure to take its course. In a convulsive seizure putting something soft under the child's head will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the child should be placed in the recovery position and stayed with, until they are fully recovered.

An ambulance should be called during a convulsive seizure if:-

- it is the child's first seizure;
- the child has injured themselves so badly they have problems breathing after a seizure;
- a seizure lasts longer than the period set out in the child's health care plan;
- a seizure lasts for five minutes;
- if you do not know how long they usually last for that child; and
- there are repeated seizures, unless this is usual for the child as set out in the child's health care plan.

Such information should be an integral part of the school or setting's emergency procedures as discussed at paragraphs 115-117 but also relate specifically to the child's individual health care plan. The health care plan should clearly identify the type or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required.

Most seizures last for a few seconds or minutes, and stop of their own accord. Some children who have longer seizures may be prescribed diazepam for rectal administration. This is an effective emergency treatment for prolonged seizures. The epilepsy nurse or a paediatrician should provide guidance as to when to administer it and why.

Training in the administration of rectal diazepam is needed and will be available from local health services. Staying with the child afterwards is important as diazepam may cause drowsiness. Where it is considered clinically appropriate, a liquid solution midazolam, given into the mouth or intra-nasally, may be prescribed as an alternative to rectal diazepam. Instructions for use must come from the prescribing doctor. For more information on administration of rectal diazepam, see Form 9.

Children and young people requiring rectal diazepam will vary in age, background and ethnicity, and will have differing levels of need, ability and communication skills.

If arrangements can be made for two adults, at least one of the same gender as the child, to be present for such treatment, this minimises the potential for accusations of abuse. Two adults can also often ease practical administration of treatment. Staff should protect the dignity of the child as far as possible, even in emergencies.

DIABETES - What is Diabetes?

Diabetes is a condition where the level of glucose in the blood rises. This is either due to the lack of insulin (Type 1 diabetes) or because there is insufficient insulin for the child's needs or the insulin is not working properly (Type 2 diabetes).

About one in 550 school-age children has diabetes. The majority of children have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their

blood glucose level and to eat regularly according to their personal dietary plan. Children with Type 2 diabetes are usually treated by diet and exercise alone. Each child may experience different symptoms and this should be discussed when drawing up the health care plan. Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention.

Medicine and Control

The diabetes of the majority of children is controlled by injections of insulin each day. Most younger children will be on a twice a day insulin regime of a longer acting insulin and it is unlikely that these will need to be given during school hours, although for those who do it may be necessary for an adult to administer the injection. Older children may be on multiple injections and others may be controlled on an insulin pump.

Most pupils can manage their own injections, but if doses are required at school supervision may be required, and also a suitable, private place to carry it out.

Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime; and then insulin with breakfast, lunch and the evening meal, and before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. They may or may not need to test blood sugar prior to the meal and to decide how much insulin to give. Diabetic specialists would only implement this type of regime when they were confident that the child was competent. The child is then responsible for the injections and the regime would be set out in the individual health care plan.

Children with diabetes need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs adjusting. Most older children will be able to do this themselves and will simply need a suitable place to do so. However, younger children may need adult supervision to carry out the test and/or interpret test results.

When staff agree to administer blood glucose tests or insulin injections, they should be trained by an appropriate health professional.

Pupils with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. Schools may need to make special arrangements for pupils with diabetes if the school has staggered lunchtimes.

If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode (a hypo) during which blood glucose levels fall too low. Staff in charge of physical education or other physical activity sessions should be aware of the need for pupils with diabetes to have glucose tablets or a sugary drink to hand.

Staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar – a hypoglycaemic reaction (hypo) in a child with diabetes:-

hunger;

sweating;

drowsiness;

pallor;

glazed eyes;

shaking or trembling;

lack of concentration;

irritability;

headache; and

mood changes, especially angry or aggressive behaviour.

Each child may experience different symptoms and this should be discussed when drawing up a health care plan.

If a child has a hypo, it is very important that the child is not left alone and that a fast acting sugar, such as glucose tablets, a glucose rich gel, or a sugary drink is brought to the child and given immediately. Slower acting starchy food, such as a sandwich or two biscuits and a glass of milk, should be given once the child has recovered, some 10-15 minutes later.

An ambulance should be called if:-

the child's recovery takes longer than 10-15 minutes; and/or

the child becomes unconscious.

Some pupils may experience hyperglycaemia (high glucose level) and have a greater than usual need to go to the toilet or to drink. Tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention. If the child is unwell, vomiting or has diarrhoea this can lead to dehydration. If the child is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and the child will need urgent medical attention.

Such information should be an integral part of the school or setting's emergency procedures as discussed at paragraphs 115-117 but also relate specifically to the child's individual health care plan.

ANAPHYLAXIS - What is Anaphylaxis?

Anaphylaxis is an acute, severe allergic reaction requiring immediate medical attention. It usually occurs within seconds or minutes of exposure to a certain food or substance, but on rare occasions may happen after a few hours.

Common triggers include peanuts, tree nuts, sesame, eggs, cow's milk, fish, certain fruits such as kiwifruit, and also penicillin, latex and the venom of stinging insects (such as bees, wasps or hornets).

The most severe form of allergic reaction is anaphylactic shock, when the blood pressure falls dramatically and the patient loses consciousness. Fortunately this is rare among young children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply, or severe asthma. Any symptoms affecting the breathing are serious.

Less severe symptoms may include tingling or itching in the mouth, hives anywhere on the body, generalised flushing of the skin or abdominal cramps, nausea and vomiting.

Even where mild symptoms are present, the child should be watched carefully. They may be heralding the start of a more serious reaction.

Medicine and Control

The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine). Pre-loaded injection devices containing one measured dose of adrenaline are available on prescription. The devices are available in two strengths – adult and junior.

Should a severe allergic reaction occur, the adrenaline injection should be administered into the muscle of the upper outer thigh. An ambulance should always be called.

Staff that volunteer to be trained in the use of these devices can be reassured that they are simple to administer. Adrenaline injectors, given in accordance with the manufacturer 's instructions, are a well-understood and safe delivery mechanism. It is not possible to give too large a dose using this device. The needle is not seen until after it has been withdrawn from the child's leg. In cases of doubt it is better to give the injection than to hold back.

The decision on how many adrenaline devices the school or setting should hold, and where to store them, has to be decided on an individual basis between the head, the child 's parents and medical staff involved.

Where pupils are considered to be sufficiently responsible to carry their emergency treatment on their person, there should always be a spare set kept safely which is not locked away and is accessible to all staff. In large schools or split sites, it is often quicker for staff to use an injector that is with the child rather than taking time to collect one from a central location.

Studies have shown that the risks for allergic pupils are reduced where an individual health care plan is in place. Reactions become rarer and when they occur they are mostly mild. The plan will need to be agreed by the child's parents, the school and the treating doctor.

Important issues specific to anaphylaxis to be covered include:-

anaphylaxis – what may trigger it;

what to do in an emergency;

prescribed medicine;

food management; and

precautionary measures.

Once staff have agreed to administer medicine to an allergic child in an emergency, a training session will need to be provided by local health services. Staff should have the opportunity to practice with trainer injection devices.

Day-to-day policy measures are needed for food management, awareness of the child ’s needs in relation to the menu, individual meal requirements and snacks in school.

When kitchen staff are employed by a separate organisation, it is important to ensure that the catering supervisor is fully aware of the child ’s particular requirements. A ‘kitchen code of practice’ could be put in place.

Parents often ask for the Headteacher to exclude from the premises the food to which their child is allergic. This is not always feasible, although appropriate steps to minimise any risks to allergic children should be taken.

Pupils who are at risk of severe allergic reactions are not ill in the usual sense. They are normal pupils in every respect – except that if they come into contact with a certain food or substance, they may become very unwell. It is important that these pupils are not stigmatised or made to feel different. It is important, too, to allay parents’ fears by reassuring them that prompt and efficient action will be taken in accordance with medical advice and guidance.

Anaphylaxis is manageable. With sound precautionary measures and support from the staff, school life may continue as normal for all concerned.

Annex 4 - Forms

To assist schools with the administration for their support of children with medical needs we have prepared a number of examples of forms which are set out below.

Schools and settings may wish to use or adapt these according to their particular policies on administering medicines.

Form 1	Contacting Emergency Services
Form 2	Health Care Plan
Form 3A	Parental agreement for school/setting to administer medicine
Form 3B	Parental agreement for school/setting to administer medicine
Form 4	Headteacher/Head of setting agreement to administer medicine
Form 5	Record of medicine administered to an individual child
Form 6	Record of medicines administered to all children
Form 7	Request for child to carry his/her own medicine
Form 8	Staff training record – administration of medicines
Form 9	Authorisation for the administration of rectal diazepam

These forms are downloadable as WORD documents, so that it is possible to personalise for a particular school or setting, at:-

http://www.wales.gov.uk**.**

FORM 1: Contacting Emergency Services

Request for an Ambulance

Dial 999, ask for ambulance and be ready with the following information

1. Your telephone number

2. Give your location as follows *(insert school/setting address)*

3. State that the postcode is

4. Give exact location in the school/setting *(insert brief description)*

5. Give your name

6. Give name of child and a brief description of child ’s symptoms

7. Inform Ambulance Control of the best entrance and state that the crew will be met and taken to

Speak clearly and slowly and be ready to repeat information if asked.

Put a completed copy of this form by the telephone.

FORM 2: Health Care Plan

2.40 The health plan should specify:-

- The pupil's view where possible.
- Parental wishes for the child.
- The care co-ordinator/key worker for the child.
- Any anticipated changes in the pupil's care routine.
- Protocols for exchanging information between education and health services (with clearly defined lines of responsibility and named contacts) including the provision of accurate and regularly updated information about the needs of individual pupils.
- Arrangements for any emergency or invasive care, or for the administration of medication. Emergency procedures should be set out in conjunction with health care professionals. Risk assessment should be carried out and would include the identification of potential emergency situations in relation to the health needs of that particular child – better planning leads to fewer real emergencies.
- Any special health care needs which may affect the pupil's use of services such as transport or play activities at the school, implementation of therapy programmes etc.
- The use, storage and maintenance of any equipment.
- Any arrangements for the provision of education or associated services when the child is too unwell to attend school or is in hospital or another appropriate health care setting.
- Health care plans should be jointly written by health professionals and parents. Completed plans should be signed by the parents, Headteacher and health professionals. A copy of the plan should also be available to all the above and to accompany the child on out of school trips.
- Health care plans should be reviewed annually at the pupil's annual school review. If the plan needs revising the school health professionals should meet with parents and the plan would then be written again and signed by all parties. If the plan needs to be altered between reviews this should always take place with parents and be signed.
- The importance of very clear procedures for emergency treatment for **all** pupils with complex health needs.

Name of school/setting	
Child ’s name	
Group/class/form	
Date of birth	/ /
Child ’s address	
Medical diagnosis or condition	
Date	_____
Review date	_____

Family Contact Information

Name	
Phone no.(work)	
(home)	
(mobile)	
Name	
Phone no.(work)	
(home)	
(mobile)	

Clinic/Hospital Contact

Name	
Phone no.	

GP

Name	
Phone no.	

Describe medical needs and give details of child's symptoms

Daily care requirements *(e.g. before sport/at lunchtime)*

Describe what constitutes an emergency for the child, and the action to take if this occurs

Who is responsible in an emergency *(state if different for off-site activities)*

Form copied to

FORM 3A: Parental agreement for school/setting to administer medicine

The school/setting will not give your child medicine unless you complete and sign this form and the school or setting has a policy that staff can administer medicine.

Name of school/setting

Name of child

Date of birth / /

Group/class/form

Medical condition or illness

Medicine
Name/type of medicine
(as described on the container)

Date dispensed ____/____/____ Expiry date ____/____/____

Agreed review date to be initiated by *[name of member of staff]*

Dosage and method

Timing

Special precautions

Are there any side effects that the school/setting needs to know about?

Self administration Yes/No *(delete as appropriate)* **Yes/No**

Procedures to take in an emergency

Contact Details
Name

Daytime telephone no.

Relationship to child

Address

I understand that I must deliver the medicine personally to *[agreed member of staff]*

I accept that this is a service that the school/setting is not obliged to undertake.

I understand that I must notify the school/setting of any changes in writing.

Date _____ Signature(s) _____

FORM 3B: Parental agreement for school/setting to administer medicine

The school/setting will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that staff can administer medicine.

Name of school/setting	
Date	/ /
Child 's name	
Group/class/form	
Name and strength of medicine	
Expiry date	/ /
How much to give *(i.e. dose to be given)*	
When to be given	
Any other instructions	
Number of tablets/quantity to be given to school/setting	

Note: Medicines must be in the original container as dispensed by the pharmacy

Daytime phone no. of parent or	
adult contact	
Name and phone no. of GP	

Agreed review date to be initiated by *[name of member of staff]*

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Print name _____ Parent's signature _____

Date _____

If more than one medicine is to be given a separate form should be completed for each one.

FORM 4: Headteacher/Head of setting agreement to administer medicine

Name of school/setting

It is agreed that *[name of child]* _____will receive

[quantity and name of medicine] _____ every day at

[time medicine to be administered e.g. lunchtime or afternoon break] _____.

*[Name of child]*_____will be given/supervised whilst he/she

takes their medication by *[name of member of staff]* _____.

This arrangement will continue until *[either end date of course of medicine or until instructed by parents]*
_____.

Date _____

Signed _____

(The Headteacher/Head of setting/named member of staff)

FORM 5: Record of medicine administered to an individual child

Name of school/setting	
Name of child	
Date medicine provided by parent	/ /
Group/class/form	
Quantity received	
Name and strength of medicine	
Expiry date	/ /
Quantity returned	
Dose and frequency of medicine	

Staff signature _____

Signature of parent _____

Date	/ /	/ /	/ /
Time given	/ /	/ /	/ /
Dose given	/ /	/ /	/ /
Name of member of staff	/ /	/ /	/ /
Staff initials	/ /	/ /	/ /

Date	/ /	/ /	/ /
Time given	/ /	/ /	/ /
Dose given	/ /	/ /	/ /
Name of member of staff	/ /	/ /	/ /
Staff initials	/ /	/ /	/ /

Form 5 Continued

Date	/ /	/ /	/ /
Time given	/ /	/ /	/ /
Dose given	/ /	/ /	/ /
Name of member of staff	/ /	/ /	/ /
Staff initials	/ /	/ /	/ /

Date	/ /	/ /	/ /
Time given	/ /	/ /	/ /
Dose given	/ /	/ /	/ /
Name of member of staff	/ /	/ /	/ /
Staff initials	/ /	/ /	/ /

Date	/ /	/ /	/ /
Time given	/ /	/ /	/ /
Dose given	/ /	/ /	/ /
Name of member of staff	/ /	/ /	/ /
Staff initials	/ /	/ /	/ /

Date	/ /	/ /	/ /
Time given	/ /	/ /	/ /
Dose given	/ /	/ /	/ /
Name of member of staff	/ /	/ /	/ /
Staff initials	/ /	/ /	/ /

FORM 6: Record of medicines administered to all pupils

Name of school/ setting

Date	Child 's name	Time	Name of medicine	Dose given	Any reactions	Signature of staff	Print name
/ /							
/ /							
/ /							
/ /							
/ /							
/ /							
/ /							
/ /							
/ /							
/ /							
/ /							
/ /							

FORM 7: Request for child to carry his/her own medicine

This form must be completed by parents/guardian

If staff have any concerns discuss this request with healthcare professionals

Name of school/setting	
Child 's name	
Group/class/form	
Address	
Name of medicine	
Procedures to be taken in an emergency	

Contact Information

Name	
Daytime phone no.	
Relationship to child	

I would like my son/daughter to keep his/her medicine on him/her for use as necessary.

Signed _____ Date _____

FORM 8: Staff training record – administration of medicines

Name of school/setting	
Name	
Type of training received	
Date of training completed	/ /
Training provided by	
Profession and title	

I confirm that *[name of member of staff]* _____ has received the training detailed above and is competent to carry out any necessary treatment.

I recommend that the training is updated *[please state how often]* _____

Trainer 's signature _____ Date _____

I confirm that I have received the training detailed above.

Staff signature _____ Date _____

Suggested review date _____

FORM 9: Authorisation for the administration of rectal diazepam

Name of school/setting

Child 's name

Date of birth / /

Home address

GP

Hospital consultant

_____ should be given Rectal Diazepam _____mg.

If he/she has a *prolonged epileptic seizure lasting over minutes.

OR

*serial seizures lasting over _____ minutes.

An Ambulance should be called for *at the beginning of the seizure.

OR

If the seizure has not resolved *after _____ minutes.

(*please delete as appropriate)

Doctor's signature _____ Date _____

Parent's signature _____ Date _____

NB: Authorisation for the administration of rectal diazepam

As the indications of when to administer the diazepam vary, an individual authorisation is required for each child. This should be completed by the child's GP, Consultant and/or Epilepsy Specialist Nurse and reviewed regularly. This ensures the medicine is administered appropriately. The Authorisation should clearly state:-

- when the diazepam is to be given e.g. after 5 minutes; and
- how much medicine should be given.

Included on the Authorisation Form should be an indication of when an ambulance is to be summoned.

Records of administration should be maintained using Form 5 or similar.

Annex 5: Useful Contacts

Action for Sick Children
Freephone: 0800 744519
http://www.actionforsickchildren.org/

Allergy UK
Helpline: (01322) 619898
http://www.allergyuk.org/

The Anaphylaxis Campaign
Helpline: (01252) 542029
http://www.anaphylaxis.org.uk/

Association for Spina Bifida and Hydrocephalus
Tel :(01733) 555988 (9am to 5pm)
North Wales ASBH Tel. (01248) 671345
http://www.asbah.org/

Association for the Welfare of Children in Hospital (AWCH)
Tel. Swansea (01792) 205227
http://www.awchwales.org.uk/

Asthma UK Cymru
Advice line: 08457 010203 (Mon-Fri 9am to 5pm)
Tel. Cardiff 029 20435400
http://www.asthma.org.uk

Barnardos Cymru
Tel. Cardiff: 029 20493387
http://www.barnardos.org.uk/wales

Cerebra – for Brain Injured Children and Young People
Tel. Carmarthen: 01267 244200
http://www.cerebra.org.uk/

Children in Wales
Tel. Cardiff: 029 20342434
http://www.childreninwales.org.uk

CLIC Sargent
Tel. 0800 1970068
http://www.clicsargent.org.uk

Contact a Family
Helpline: 0808 808 3555
Tel. Cardiff: 029 20396624
http://www.cafamily.org.uk

Commission for Equality and Human Rights (CEHR)
Tel. Cardiff: 029 20729229
http://www.cehr.org.uk

Cystic Fibrosis Trust
Helpline: 0845 8591000
http://www.cftrust.org.uk

Diabetes UK Cymru
Helpline: 0845 1202960 (Weekdays 9am to 5pm)
Tel. Cardiff: 029 20668276
http://www.diabetes.org.uk

Epilepsy Wales
Helpline: 0845 7413774
http://www.epilepsy-wales.co.uk

Health and Safety Executive (HSE) Wales
Infoline: 08701 545500 (Mon-Fri 8am-6pm)
Tel. Cardiff: 029 20263000
http://www.hse.gov.uk

MENCAP Cymru
Tel. Cardiff: 029 20747588
http://www.mencap.org.uk/html/cymru

MIND Cymru
Tel. Cardiff: 029 20395123
http://www.mind.org.uk/About+Mind/Mind+Cymru/

National Attention Deficit Disorder Information and Support Service
Tel. Middlesex: 02089 522800
www.addiss.co.uk

National Children's Bureau Council for Disabled Children
Tel. London: (020) 78436000
http://www.ncb.org.uk

National Eczema Society
Helpline: 0870 241 3604 (Mon-Fri 8am to 8pm)
http://www.eczema.org

National Health Service Direct Cymru
Tel. 0845 46 47
www.nhsdirect.wales

NCH Cymru, the Children's Charity
Tel. Cardiff: 029 20222127
www.nch.org.uk

Special Needs Advisory Project (SNAP) Cymru
Tel. Cardiff: 0845 1203730
www.snapcymru.org.uk