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# Access to Education and Support for Children and Young People with Medical Needs



## Guidance

Welsh Assembly Government Circular No: 003/2010

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# Access to Education and Support for Children and Young People with Medical Needs

<b>Audience</b>	Local Authorities (education and social services functions); all maintained nursery, primary, secondary and special schools; Local Health Boards; parents and interested organisations.
<b>Overview</b>	This guidance is primarily to provide advice to schools and Local Authorities on meeting the educational needs of children and young people with medical needs. It emphasises the need for continuity in education and the impact medical conditions can have on a child or young person's education, health and well-being.
<b>Action required</b>	To be brought to the attention of Managers and staff.
<b>Further information</b>	Enquiries about this document should be directed by e-mail to: DCELLS.enquiries@wales.gsi.gov.uk Or in writing to: Additional Learning Needs Branch Support for Learners Division Welsh Assembly Government Cathays Park Cardiff CF10 3NQ
<b>Additional copies</b>	This document can be accessed from the Welsh Assembly Government website at: <a href="http://www.wales.gov.uk/educationandskills">www.wales.gov.uk/educationandskills</a>
<b>Related documents</b>	Consultation document No: 045/2007 - Consultation on 'Access to Education and Support for Pupils with Medical Needs' Welsh Office Circular 57/94 - The Education of Sick Children Welsh Office Circular 34/97 - Supporting Pupils with Medical Needs

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## Minister's Foreword

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 to meet their needs and allow them continuity in accessing educational opportunities at school, at home, in hospital, or another setting and in cooperation 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 their well being. 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 (NSF). The NSF has been cross-referenced throughout this guidance to ensure its standards are achieved in the support of children and young people with medical needs.



A handwritten signature in black ink that reads "Leighton Andrews".

**Leighton Andrews AM**

Minister for Children, Education,  
and Lifelong Learning and Skills



A handwritten signature in black ink that reads "Edwina Hart".

**Edwina Hart MBE AM**

Minister for Health and Social Services

Access to Education and  
Support for Children  
and Young People with  
Medical Needs

May 2010

Guidance Circular  
No: 003/2010

# Chapter 1: Support for children and young people with Medical Needs

## Chapter Summary

This chapter considers the varying degrees of a child or young person'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.

The aim is to minimise, as far as possible, the disruption to normal schooling. Enabling children and young people to access appropriate education is important to their future mental, social and physical development.

This guidance applies to children and young people 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 local authorities and schools in relation to relevant legislation regarding disability.

All local authorities, schools and governing bodies should formulate policies to educate children and young people who have medical needs in the light of their statutory responsibilities and their own assessment of local needs and resources.

1.1 Most children and young people will at some time have a medical condition, often only short term, which may affect their participation in school activities. Most are able to attend school regularly and with some support from the school can take part in most normal school activities.

1.2 Some medical conditions may have a significant impact. This may be direct and affect their cognitive abilities, physical abilities, behaviours or their emotional state, and/or indirect, for example by disrupting a child or young person'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 may be intermittent and impact on 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 child or young person and changes in their peer group.

1.3 Every year thousands of children and young people require education outside school as a result of longer term illnesses, injuries, or clinically defined mental health problems. Their situations will vary, but all run the risk of a reduction in self-confidence and educational achievement. Education can be provided in a variety of ways, for example through the provision of a hospital school or hospital tuition service; home tuition; an integrated hospital/home education service or 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 child or young person, their parents, the school, the school health service or their general practitioner, the community paediatrician and any specialist services providing treatment for them is 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. Parents and the child or young person, 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 and will help when it comes to making decisions about their education.

1.6 Parents should have access to information, advice and support during their child's illness and wherever possible parents and their children should be informed prior to admission to hospital of the education available. The involvement of parents with the school on the child's return 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 Whilst children and young people with medical needs may have additional learning needs, a medical diagnosis does not necessarily imply that they have special educational needs as defined within the Education Act 1996. It is possible that a medical condition may increase the likelihood that a child or young person will develop “a significantly greater learning difficulty than the majority of children of the same age,”<sup>1</sup> 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 they may have a special educational need and may require a statutory assessment of their needs.

1.8 The local authority, the designated medical officer and other professionals should consider in discussion with parents and the school, whether the child or young person has special educational needs and requires special educational provision to be made available. For further guidance please refer to the Special Educational Needs (SEN) Code of Practice for Wales.

### **The Role of the Local Authority**

1.9 Local authorities have a duty to provide education otherwise than at school (EOTAS) where it is necessary to do so to meet children and young people’s needs (see Chapter 4). The arrangements which an authority must make should be tailored to their individual circumstances and to the facilities available.

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<sup>1</sup> Special Educational Needs (SEN) Code of Practice for Wales 2002

### Good practice suggests that local authorities should ensure:

- clear lines of communication so that all concerned know who is responsible for identifying the child or young person's needs and how to activate the relevant services quickly;
- an individual education plan for every child or young person who is unable to attend school because of a long term or recurring medical condition. This should take effect as soon as they are admitted to hospital or are 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;
- children and young people are not at home without access to education for more than 15 working days and where the illness/diagnosis indicates prolonged or recurring periods of absence from school, at home or in hospital, access to education should begin so far as possible and appropriate, from day one;
- children and young people receive an education of similar quality to that available in school, including a broad and balanced curriculum;
- children and young people educated at home due to a medical condition should receive a **minimum entitlement** of 5 hours teaching per week. This should be increased where necessary to enable them to keep up with their studies, particularly when a child or young person is approaching public examinations;
- teachers have access to a range of in service training to support children and young people with medical needs; and
- their provision in schools and hospitals is kept under regular review; that the service they provide meets the needs of all children and young people; that children and young people's 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.

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

1.11 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 children and young people. 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 child or young person'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**

1.12 Schools should ensure that children and young people 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 local authority is necessary if good quality

education is to be provided. Local authorities and governing bodies should work together to ensure children and young people with medical needs and school staff have effective support in schools.

1.13 Schools should ensure that their own pastoral care arrangements allow children and young people, should they wish, 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 child or young person.

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

1.15 There is no legal duty which requires schools to administer medication; this is a voluntary role. However, there is a duty to ensure that members of 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 children and young people with medical needs;
- appoint a named member of staff who is responsible for children and young people with medical needs, liaising with parents, children and young people, the home tuition service, the local authority, the key worker and others involved in the child or young person's care;
- notify the local authority/EWO if a child or young person 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 child or young person'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 local authority and other professionals a school health care plan for individual child or young person's with medical needs;
- provide in service training for teachers supporting children and young people with medical needs;
- ensure that children and young people 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;
- encourage and facilitate liaison with peers, for example, through visits and videos; and
- when appropriate send work home to be completed in the interim period between absence and return to school or home tuition being implemented.

1.16 A child or young person who is unable to attend school because of medical needs must not be removed from the school roll 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.

1.17 School nursing is central to a range of services that promote and support the physical, emotional and social health of children and young people. With registration on the Specialist Community Public Health Nursing part of the Nursing and Midwifery Council register, school nurses are recognised as public health nurses who are key in promoting, improving and protecting the health and well-being of school-aged children and young people to ensure they achieve the best possible health.

1.18 The service encompasses:

- Assessment and health surveillance.
- Health promotion and health education.
- Immunisations and disease prevention.
- Safeguarding the health and welfare of children and young people.
- Supporting children with medical needs and addressing the needs of children and young people with complex health problems:
- Providing guidance, advice, support and training on medical conditions and the safe administration of medication to children and young people, parents/carers and school staff.
- Being involved in developing individual health care plans for children and young people who require them, including dealing with emergency situations and ongoing assessment.
- Working with schools to ensure the safe handling, storage and disposal of medicines.

***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.*

1.19 Other health professionals may also be involved in the care of children and young people 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's or on health problems generally.

1.20 Most NHS bodies have pharmacists who specialise in paediatrics or community health services. Some work closely with local authorities 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.*

1.21 Some children and young people with medical needs receive dedicated support from a specialist nurse or community paediatric nurse. These nurses often work as part of a Local Health Board and liaise closely with the primary health care team. They can provide advice on the medical needs of an individual, particularly when a medical condition has been recently diagnosed and the child or young person is adjusting to new routines. Schools can call upon Paediatric Diabetes Specialist Nurses (PDSNs) for practical support and advice.

## **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.*

1.22 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 child or young person to continue any course being taken on entry to hospital or whilst ill or injured at home.

1.23 Local authorities should normally arrange continuing education for young people over compulsory school age, but less than 18 years where, because of illness, he or she still needs to study further to complete examination courses, which they would otherwise have completed before they reached compulsory school leaving age.

1.24 It will be for the young person 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**

1.25 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.

1.26 Schools and local authorities 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 children and young people less favourably, to ensure reasonable adjustments are made in supporting them and to promote disability equality.

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



1.27 Since September 2002 schools and local authorities must:

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

1.28 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.

1.29 Detailed guidance has been published 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 Children and Young People's Needs

### Chapter Summary

Whatever provision is required for individual children and young people, each of the component elements should form 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 children and young people provides a sound basis for ensuring that children and young people 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 local authorities should have in place to ensure that; the medical needs of children and young people are met effectively; that where appropriate health care plans are in place; that offer advice and guidance on out of school activities, and that consider 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 parents to provide the child or young person with homework as soon as they become able to cope with it. Such liaison usually allows work and materials such as books and reference documents to be sent home. Where the absence relates to a chronic condition, local authorities should ensure that the child or young person is provided with education as soon as they are able to benefit from it.

2.2 The school should monitor work missed and plan, in liaison with the hospital/home tuition service, where involved, to help a child or young person “keep up rather than having to catch up”. A child or young person working towards public examinations needs special consideration and the arrangements should be stated in the local authority and school procedures.

### **Long Term Medical Needs**

2.3 The school should have sufficient information about the medical condition of any child or young person with long term medical needs. If a child or young person’s medical needs are inadequately supported this can have a significant impact on their 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 condition develops. For those 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 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 Where illness is unpredictable and changing, there should be review meetings in addition to planning and discharge meetings.

2.5 For those 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 local authorities officers do not follow up the absences of children and young people with medical needs as they are automatically considered authorised absences. It is important for the home school to inform the EWO and local authority of 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, local authorities have powers which can be used to provide support to young mothers and mothers to be. Local authorities should work together with 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 A local authority 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 school nurses, health visitors, midwives, GPs, 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 children are obliged to ensure that their child attends the provision arranged by the local authority. Local authorities will need to work closely with the child or young person 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 Government guidance "Inclusion and Pupil Support" (2006).

### **Children and young people with Degenerative Medical Conditions**

2.12 Some conditions are rapidly progressive and the child's health is in decline. This 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 Children and young people with a variety of progressive or degenerative medical conditions may require special consideration when educational support or intervention is considered. These children and young people 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 children and young people.

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

## Children and young people with Complex Health Needs

2.16 The policies in Wales toward the inclusion, wherever possible, of children and young people 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. This policy has resulted in the number of children and young people 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 children and young people 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 children and young people is essential.

2.18 A partnership approach is required to ensure effective collaboration between health and education to meet the needs of children and young people with health needs in school. The support of the identified senior officer in each LHB area with designated responsibility for commissioning services for children and young people, including school health services is essential. A strong focus on multi agency working improves training and support for teachers and education staff in the management of children and young people 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 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) requires close working between schools and the health services. These children and young people 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 also have children and young people 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 supports for the individual with complex needs and their families and is a link by which other services are accessed and used effectively. Key workers have responsibility for working with the family and with professionals, 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 children and young people 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 children and young people with complex needs and their parents. 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 important for children and young people 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 children and young people who are feeling unwell, recovering from an epileptic fit or treatment.
- have efficient heating, as severely disabled children and young people 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 children and young people 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 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 child or young person 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 child or young person'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.

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 child or young person. Those who may need to contribute to a health care plan are:

- The Headteacher.
- The parent or guardian.
- The child or young person (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 child or young person's GP, Social Services or other health care professionals (depending on the level of support the child needs).

2.27 If a child or young person's condition is degenerative or life threatening, the plan should reflect these additional needs and 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 them in the school, including preparing for an emergency situation. The plan should include details of their 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 those 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 children and young people 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 always involve the school health service in drawing up health plans.

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 a child or young person'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 parental responsibility for the child within the meaning of the Children Act 1989 - this may include the Local Authority for Looked After Children.

## **Resuscitation**

2.31 The question of resuscitation care is likely to become more common in education settings, not least because the management of children and young people with complex or degenerative conditions has changed. 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 them as for other children and young people.

2.32 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. Such plans tend to be prepared by a consultant paediatrician, a community paediatric

nurse together with parents, and are circulated to everyone within Health organisations. For children with a complex neuro disability, the school should still summon emergency services in the event of 'collapse', and decisions will then be taken within the health setting in consultation with parents.

2.33 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 child or young person's rights are respected and that misunderstanding and dissent is minimised.

2.34 Schools and other community facilities should have clear policies and procedures in relation to resuscitation care for children and young people with severe disabilities.

2.35 It is the employer's responsibility to make sure that correct procedures are followed and to 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**

2.36 The Headteacher and school staff should treat medical information confidentially. The Headteacher should agree with the child or young person (where he/she has the capacity) or the parent about who else should have access to records and other information about them. 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.

2.37 Co-ordinating and disseminating information on an individual 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.

2.38 Staff who may need to deal with an emergency need to know about a child or young person's medical needs. The Headteacher must make sure that supply teachers know about their 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. Children and young people 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**

2.39 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 child or young person's condition and how they should respond to day-to-day health care needs as well as emergencies. It is important that responsibility for children and young people's safety is clearly defined and that each person involved with children and young people and medical needs is aware of what is expected of them.

2.40 For children and young people 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 children and young people 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.

2.41 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. Current guidance for education settings is set out in Circular 37/98: The Use of Reasonable Force to Control or Restrain People. This is due to be replaced in 2010 by Behaviour in Schools: Safe and Effective Intervention.

2.42 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.

2.43 LHBs should lead (self-financing) training sessions for taxi and minibus drivers and escorts from the private sector used to transport children and young people 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**

2.44 Efficient and effective liaison is imperative when children and young people with medical needs are approaching public examinations, 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 they are unable to attend school. Liaison between the home school and the hospital teacher or home teacher is most important, especially where they are moving from school or home to the hospital on a regular basis. Some children and young people may need to monitor or treat their condition during an exam and arrangements should be made for this.

2.45 Awarding bodies may make special arrangements for children and young people 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.

2.46 Schools should be aware that some children and young people can find examination and assessments stressful which can exacerbate some conditions.

### **School Trips**

2.47 It is good practice for schools to encourage children and young people with medical needs to participate in school trips, wherever safety permits. Indeed a school may be unjustly discriminating against a disabled child 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 child or young person. If staff are concerned about whether they can provide for an individual's safety, or the safety of other children and young people on a trip, they should seek medical advice from the School Health Service or the child or young person's GP. A copy of their health plan and any emergency treatment or medication should be taken on trips.

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

### **Sporting Activities**

2.50 Most children and young people with medical conditions can participate in extra-curricular sport or in the PE curriculum which is sufficiently flexible for all children and young people 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 child or young person's ability to participate in PE must be included in their individual health care plan.

2.51 Some children and young people may need to take precautionary measures before, during, or after 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 Local Authorities arrange home to school transport where legally required to do so. They must make sure the children and young people are safe during the journey and where possible have school policies in place to encourage them to behave safely on their journeys to and from school. Most children and young people with medical needs do not require supervision on school transport, but local authorities should provide appropriately trained supervisors if they consider them necessary. A number of children and young people with profound and multiple difficulties are transported to school by various means, including taxi cabs.

2.53 An assessment of the child or young person'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 individual 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 children and young people 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 children and young people with medical needs who, as part of key stage 4 provisions, 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 children and young people 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 children and young people 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 local authority 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 children and young people 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 children and young people 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 children and young people 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 local authorities 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 child or young person's medical needs.

It should 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 children and young people with medical needs.

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

3.1 Many children and young people 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 them 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 34/97<sup>19</sup>.*

3.2 Local authorities, schools and governing bodies are responsible for the health and safety of children and young people in their care. The legal framework dealing with the health and safety of all children and young people 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 an individual with a medical condition, particularly if it is potentially life threatening. Teachers who have children and young people with medical needs in their class should understand the nature of the condition, and when and where they 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 children and young people 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 in making 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 Children and young people with medical needs have the same rights of admission to school as others, 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 children and young people in relation to notifiable infections, they 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 children and young people with 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 children and young people.

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 children and young people with medical needs. Employers should also ensure that there are appropriate systems for sharing information about child or young person'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 Authority**

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

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

3.18 Each LHB has responsibility for the health and well being of people who are usually resident in its area. LHBs, local authorities 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 paediatrician 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.

## **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 children and young people with medical needs. In local authority schools the governing body should follow the policies and procedures produced by the local authority as the employer.

3.21 The Headteacher is responsible for implementing the governing body's policy in practice and for developing detailed procedures. In local authority schools the Headteacher is responsible in line management terms to the local authority. When teachers volunteer to give children and young people 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 children and young people 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 children and young people 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 child or young person's needs, or where the parents' expectations appear unreasonable, the Headteacher should seek advice from the school nurse, the child or young person's GP or paediatrician and, if appropriate, the local authority. 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 children and young people. 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 effects 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 The Care and Social Services Inspectorate Wales (CSSIW) have statutory powers to inspect any premises on which day care is at any time provided and schools which provide accommodation for children for prescribed periods. The powers of inspection include the right to inspect records and other documents. These would include their having adequate policies and procedures in place regarding the safe 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
- Children and young people 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, unless agreed previously with parents and noted in the child or young person's individual healthcare plan.

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, although it is recognised that this will not always be appropriate, e.g. for some children and young people with diabetes.

### **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 children and young people, 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 children and young people are ready to take care of, and be responsible for, their own medicines, varies. As children and young people 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 children and young people can take their medicines themselves, staff may only need to supervise. The policy should say whether children and young people may carry, and administer (where appropriate), their own medicines, bearing in mind the safety of other children and young people 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 children and young people have been prescribed controlled drugs staff need to be aware that these should be kept in safe custody. However, children and young people 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 child or young person should check:

- Their 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 child or young person. 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 children and young people 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 child or young person 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 children and young people, 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.

### **Consent to treatment**

3.58 In many cases health care professionals will be present during the administration of treatment and will be familiar with requirements. However it is important that staff involved in the administration of treatment are familiar with the issue of consent.

3.59 It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care, for a patient. A children who has sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention or treatment, will have the capacity to give their consent.

3.60 The issue of consent should be considered carefully when developing policy on the administration of treatment. The Welsh Assembly Government has issued reference guide; Consent to Examination or Treatment. Chapter 5 sets out the legal requirements when treating a child, to which you are referred. ([www.wales.nhs.uk/sites3/page.cfm?orgid=465&pid=11930](http://www.wales.nhs.uk/sites3/page.cfm?orgid=465&pid=11930)).

## **Confidentiality**

3.61 Schools need to have a clear confidentiality policy that everyone (including children and young people, parents and carers) knows, understands and works within. This is a vital part of meeting children and young people' welfare needs, as required by the Education Act 2002.

3.62 Staff must be made aware of his need to respect, at all times, the child's right to confidentiality and understand the circumstances in which medical information may be shared. Seeking and consent of the child ought to be sought for the disclosure of medical information unless there are exceptional circumstances and it would be in the child's best interests to do so.

## **Dealing with Medicines Safely**

### **Safety Management**

3.63 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**

3.64 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.



3.65 Children and young people 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, adrenaline pens and glucogel, should be readily available to children and young people and should not be locked away. Many schools and settings allow children and young people to carry their own inhalers. Other non-emergency and insulin medicines should generally be kept in a secure place not accessible to children and young people. 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 children and young people.

3.66 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.

3.67 Local pharmacists can give advice about storing medicines.

### **Access to Medication**

3.68 Children and young people 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 children and young people carrying their own medication.

3.69 The school must ensure that teachers and staff know the child or young person or check the name and date of birth before handing over medicines.

### **Disposal of Medicines**

3.70 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.

3.71 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**

3.72 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 spillage's 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**

3.73 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.

3.74 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 child or young person, 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 child or young person as far as possible, even in emergencies.

## Chapter 4: Education Otherwise than at School (EOTAS)

### Chapter 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 children and young people 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 local authority is not expected to provide education at home for children and young people 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 child or young person’s condition permits. However, the local authority can provide teaching at home earlier at its own discretion if this would be best for the welfare of the child.

4.2 Few local authorities leave children and young people at home without any tuition for more than four weeks without justification and where the child or young person has already been in the hospital without access to education, the local authority should take this period into account when considering home tuition. If they have been in hospital for a longer period and have received tuition at the hospital, the education pattern has been curtailed and as much continuity as possible should be ensured. The local authority should give as many lessons as possible and as is beneficial, taking into account the available resources and their condition. It may be necessary to give particular consideration to a child or young person 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 children and young people to study and recognising when they are not well enough to benefit from teaching. This must be kept under regular review.

4.4 The local authority 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 Partnerships, and other planning tools, for example, the Children and young people's Plan.

4.5 Monitoring and evaluating of the out of school provision should form a key element in the local authorities 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 resourced 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 child or young person's home, in hospital or at a designated centre. Children and young people 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. Local authorities 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 children and young people 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 local authorities 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 local authority 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 children and young people 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 children and young people 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 children and young people. In the case of hospitalisation or prolonged absence at home, similar specialist teachers may not be available to provide continuing education while the child or young person is away from school. In these cases close liaison between the school, hospital, home tuition service and local authority is essential. In some situations it is possible for the local authority to make arrangements for specialist staff to visit them 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 children and young people.

### **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 a local authority and are specially organised to provide education for children and young people 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 children and young people with medical needs to cater exclusively for them. The local authority, with the management committee, sets the admission policy for a PRU. Children and young people should be admitted to a PRU based on clear criteria and each 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 local authority, 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 children and young people as a means of providing good quality education. Teaching children and young people 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 and Education (Pupil Registration) Regulations 1995 allow for dual registration of children and young people 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 aims of educating children and young people in hospital are the same as they are for other children and young people. Education remains crucially important to the child or young person's prospects; without it the child or young person'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 children and young people 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 local authority 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 Children and young people receiving support whilst in hospital in Wales will generally receive support from the local authority 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.

### **Admission to Hospital, Planning and Co-ordination of Support**

4.24 Admissions to hospital are generally unpredictable, but some are booked well in advance. Home/hospital teachers should have as much advance warning as possible of admissions with an indication of the date, or likely date, of admission and length of stay. 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 they are in hospital.

4.25 For long-stays, the planning of education should commence immediately and provision should start as soon as is practicable after the child is admitted, taking account of what he or she is currently learning. In cases of recurrent admission, for example where a child is having dialysis, education should be available on the day of admission. Liaison with the home/hospital teachers and home schools is particularly important as coverage of the curriculum is usually shared between them and to ensure continuity and progression. Home/hospital teachers should be kept aware of all relevant meetings held by the local authority in recurrent illness



cases. In other cases the judgment about when education should begin will need to take account of the length of stay and medical condition. The same level of planning and degree of provision is not required for short-stays, but to ensure that the period in hospital is not wasted, 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 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 Special Educational Needs 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.

4.27 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 child or young person who is in hospital. This should happen wherever possible.

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

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

4.30 Those who teach children and young people with long-term medical needs need not only to be professional teachers but must also be able to help the child back into education after trauma and illness. They need expertise in increasing the goals set to children and young people about to return to the mainstream; and, correspondingly, in decreasing the goals set to children and

young people who are physically deteriorating. This has implications for In Service Training (INSET) and should be addressed by the local authority or governing body.

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 Teachers in hospital can make a valuable contribution to the health care and rehabilitation of children and young people through, for example, communicating to the clinical team any anxieties which children and young people may express to them about pain or the effects of medication. They should liaise closely with nursing staff to ensure that children and young people 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.

4.33 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. There should be 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.

4.34 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 children and young people 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.*

4.35 It is part of the role of the teacher to re-establish learning and to keep education alive for the child or young person if any disruption to schooling is to be contained.

### **Statements of Special Educational Needs**

4.36 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-stays. The local authority should give or provide on request copies of the statement to the hospital school or service in the case of long-stay and the school must have regard to the requirements of the statement.

4.37 The local authority will need to consider proposing an amendment to the statement to name the hospital school in the case of some long-stays, if that is where the child or young person'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 the Education Act 1996.

4.38 Alternatively, it may be necessary for the local authority to undertake a statutory reassessment of a long-term child or young person'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. Local authorities are still required to carry

out the annual review of the statement notwithstanding a long-stay absence from the home school. For those 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**

4.39 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 local authority Home/Hospital Tuition Services or EOTAS service.

4.40 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 them 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. Children and young people placed in such units retain an entitlement to education. Private mental health units must plan with the home local authority to ensure that those who are mental health patients continue to access their entitlement to education.

4.41 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.

4.42 Children and young people admitted to psychiatric units all require an intensive educational input to restore self-esteem and enable a successful return to school and ordinary life, where possible. Without this, their prognosis for a full recovery may be diminished.

4.43 Educational programmes need to be designed to meet individual needs as their 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. Links to the National Curriculum are essential if there is to be any prospect of successful subsequent reintegration into mainstream education.

4.44 Teachers in psychiatric units need to be fully involved in planning admissions, assessments (including liaison with the child or young person'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'.

4.45 A minority will be admitted to hospital as a result of brain injury. Educational provision will in some cases be impracticable. Where it is not, and their abilities have been affected, the hospital teacher can contribute to an assessment of the impairment and the necessary provision to meet any learning difficulties.

4.46 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.

4.47 There can be no assumption that the teacher will have medical knowledge about head injury and 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.

4.48 Learning difficulties may emerge early in recovery or later, sometimes 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 child or young person's condition and treatment, while remaining professionally and independently responsible for what is taught.

4.49 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.

4.50 Local authorities must ensure that there is sufficient flexibility to meet an individual's needs. For example, some may attend the hospital unit on a part-time basis combined with attendance at the child or young person's home school.

4.51 To facilitate liaison and effective communication, every local authority 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.

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

4.53 Local authorities 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**

4.54 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 they collaborate with local authorities in the provision of education.

4.55 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.

4.56 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.

4.57 It is important to liaise with social services, where appropriate, as they have a duty to protect children and provide support to children in need. Some families in particular will struggle to support their children with medical needs and effective communication between all statutory agencies at this time is vital.

## **The Curriculum**

4.58 Temporary exceptions by Headteachers, under Section 114 of the Education Act, 2002 are not needed to authorise departures from the National Curriculum for children and young people who remain on their school's register but are, for the time being, absent from school due to illness. But, when they 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 them to adjust, co-operation well in advance between the hospital teachers and the home is necessary.

4.59 Hospital teachers generally seek to follow the National Curriculum as far as practicably possible. This benefits the child 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 children and young people's progress**

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

4.61 Dual registered or part-time children and young people, i.e. those registered with a mainstream school but attending 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 children and young people have achieved so that mainstream teachers can involve them in appropriate programmes of study on return to the home school; a portfolio of work done should be included for those in long-stay. Their 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 they may be able to achieve while in hospital. Those in short-stay should be encouraged to take back to their home school any of the work they have produced.

4.64 For those in long-stay, monitoring of progress will be achieved by establishing a pastoral support programme (PSP). This should focus on their individual needs, academic and social, and include plans for reintegration into mainstream school. The PSP should be reviewed at least every six weeks, and results shared with the main parties involved. The organisation where the child or young person spends the majority of their time should be responsible for carrying out the review. 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 child or young person'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 those who are sick and may already be under intense psychological or other pressure in that respect.

4.66 The basic requirements for efficient and cost-effective functioning of hospital schools, and tuition services, except those based essentially on bedside provision are sufficient classroom accommodation for the typical intake, and 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 specialism 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 local authority 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 Young People 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 local authority.

### **Information Communication Technology (ICT)**

4.70 ICT can be used in a variety of ways to support children and young people with medical needs once their learning needs have been assessed.

4.71 Anywhere children and young people 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 them in supporting individual needs. Assistive Technologies can also enable those with mobility problems or physical difficulties to access ICT.

4.72 Laptop computers offer a flexible solution as they can be used in the mainstream classroom, hospital or home. Portable devices e.g. WP, PDAs, EDAs can provide a convenient way for children and young people to record and make notes. Teachers can prepare tasks on CDs, Web20, Memory sticks, podcasts etc., which the child or young person can take with them and return when the tasks are completed.

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

4.74 The Internet or School Web site can be used to deliver distance learning packages. 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 whether children and young people 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 child or young person's peer group.

4.75 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 children and young people at home or in hospital provided they have a reasonable internet connection.

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

4.77 Inclusion is about ensuring that all children and young people 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 children and young people's 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 children and young people.

## 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, local authorities 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 children and young people 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 have:

- 'Access to Education and Support for Children and Young People with Medical Needs'

### **Long Term Absences**

5.5 Where children and young people 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 local authority and their 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 coordinate advice to the education services.

5.6 Common problems for a child or young person with an acquired brain injury are impairment of memory and concentration, fatigue, change in personality and behavioural problems. Some will have impaired or reduced IQ. Not all have a physical disability and as a result, many 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 child or young person is still in hospital, to commence statutory assessment of SEN, for example, following a head injury.

5.8 PRUs for children and young people with medical needs, which offer teaching in smaller groups, may offer a good "halfway house" before reintegration into the school. Some who appear to be able

to cope with a return to school, may well have a relapse sometime after their return. Schools should therefore be prepared to be flexible over issues such as time tabling where reintegration is not straightforward.

5.9 Children and young people 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 Local authorities are responsible for ensuring:

- That an individually tailored reintegration plan is in place for all children and young people 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;
  - 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 child or young person'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 children and young people 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 local authorities 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. Contact with a nurse specialising in the child’s specific condition may also be beneficial following any discharge from hospital.

## **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 children and young people into school as soon as possible and local authorities should ensure EWOs understand their role in relation to those with medical needs.

5.18 It is useful for the local authority to check on the result of post reintegration follow-up – an administrative task which is essential in determining effectiveness. Local authorities should be aware of the help that is available to reintegrate a child or young person 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 114 of the Education Act 2002 and SI 1999/1815 are not needed to authorise departures from the National Curriculum for children and young people who are absent from school due to illness. However, when they 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 individuals' 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.

# Guidance on Local Authority Policies for Supporting Children and young people with Medical Needs

Each local authority 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 Children and Young People's Plan. The policy should be freely accessible to all. A local authority's policy should encompass all aspects of arrangements for referral. These should be clear and publicised to all interested parties. A local authority's policy should encompass all aspects of the authority's provision, in hospital, at home and elsewhere, and set out clearly:

- How the local authority 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 child or young person is away from school as a result of medical needs, including procedures to support.
  - early identification;
  - medical referrals;
  - personal education plans;
  - reintegration into school;
  - children and young people working towards public examinations.
- For those 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 local authorities in which hospitals are situated and local and national hospitals, to ensure the continuity of education for children and young people 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.
- Links with other services.

# Guidance on School Policies for Supporting Children and young people with Medical Needs

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

- How the school will make educational provision for them as set out in this guidance.
- The school's responsibility to monitor pupil attendance and to mark registers so that they show if a child or young person 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 child or young person and the school.
- The provision of work and materials for those who are absent from school because of medical needs.
- Procedures for ensuring that those who are unable to attend school because of medical needs have access to public examinations, possibly as external candidates.
- Procedures for ensuring that they are reintegrated smoothly into the school.
- Issues related to those with statements of special educational needs.
- How the school's procedures will take account of the their views.
- The role of the school health service, which is to facilitate good assessment of the their 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 children and young people taking prescribed medication during the school day.
- The circumstances in which they may take non-prescription medication e.g. painkillers (analgesics).

- The school's policy on assisting children and young people 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 them carrying and taking their medication.
- Staff training in dealing with medical needs.
- Record keeping.
- Storage and access to medication.
- 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 children and young people 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.

# Model school policy for the Education of Children and Young People 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 Children and Young People with Medical Needs".

The school will continue to be responsible for all children and young people unable to attend school for medical reasons and they should be able to access education without stigma or exclusion.

Children and young people covered by this policy may:

- be recovering from an illness or injury keeping them away from school during recovery;
- have a long term or recurring illness;
- 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 children and young people 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 children and young people with medical needs whose role it is to facilitate communication with all parties and ensure that the school is meeting the needs of all those identified. Whether the headteacher accepts responsibility, in principle, for school staff

giving or supervising children and young people taking prescribed medication, they should ensure prior written agreement is obtained for any medication to be given.

Areas of general responsibility will include:

- maintaining a list of children and young people with medical conditions in the school.
- ensuring that contact is maintained with children and young people (and their families) who are away from school due to illness for a period of less than 15 working days, setting of work if they are well enough, forwarding of newsletters etc, welcoming them back to school, ensuring that all staff are aware of their up to date medical situation and ensuring that any adjustments to accommodation, curriculum are made, together with ongoing monitoring of the their situation and needs whilst in school.
- keeping the EWO informed of all attendance issues regarding children and young people 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 child or young person is (or is likely to be) away from school due to medical needs for more than 15 working days. This includes those with a recurring illness.
- ensuring that close contact is maintained with them (and their family) and that arrangements are in place for the setting and marking of work. This is particularly important for those for whom a support programme is being arranged.
- the school's policy on assisting children and young people with long term or complex medical needs.

## 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 children and young people 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 child or young person 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 child or young person'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 peers in the same set/group.
- passing on details of the child or young person's special educational needs and a copy of the current IEP.
- ensuring that children and young people 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.



- ensuring that all children and young people 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 Children and young people**

The policy should include a paragraph on how the school will work with parents/carers and the individual child or young person. 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. There should also be a policy on children and young people carrying their own medication.

## **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 child or young person'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. Emergency Arrangements**

The school's emergency procedures should be clearly identified.

## **9. Summary**

The school's policy for the education of children and young people 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.

### 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 5.

#### **ASTHMA - What is Asthma?**

One in ten children and young people 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 say that their tummy hurts or that it feels like someone is sitting on their chest. Not everyone will get all these symptoms, and some may only get symptoms from time to time.

Staff in early years settings 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 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.

**Children and young people 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 them to take charge of and use their inhaler from an early age, and many do.

Children and young people 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;
- 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 and parents 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;
- 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. Parents should be informed when their child has been given or taken their inhaler during the school day.

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. Children and young people should have a reliever inhaler with them when they are in school or in a setting.

Children and young people 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 children and young people with asthma in the same way as other children and young people. Some activities are more likely to bring on asthma symptoms. Some children and young people 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. Children and young people with asthma should not be forced to take part if they feel unwell. Children and young people should be encouraged to recognise when their symptoms inhibit their ability to participate.

Children and young people 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 children and young people 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 recognising 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.

Children and young people 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;
- 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 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).

There are currently around 1,300 children with diabetes in Wales. Around 97% of these have Type 1 diabetes, meaning that they are entirely dependent on injected insulin to live. There are also a small number of children with Type 2 diabetes and with other rarer forms of the condition, and the incidences of both Type 1 and Type 2 diabetes in children have been rising for a number of years.

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 blood glucose levels of the majority of children with diabetes are controlled by daily injections of insulin. Some children will be on a twice daily insulin regimen of a longer acting insulin and it is unlikely that these children will need to be given insulin during school hours. Increasingly, however, many children with diabetes are moving to a multiple daily injection (MDI) regimen in order to better stabilise their diabetes, and such children will often need injections during school hours. In the case of younger children, it may be necessary for an adult to administer the injection. Some children may control their diabetes by use of an insulin pump, and as in the case of MDI, this is an increasingly common treatment.

Most children and young people 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 regimen when they were confident that the child was competent.

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.

Children and young people 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 them if the school has staggered lunchtimes.

If a meal or snack is missed, or after strenuous activity, a child or young person 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 them 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;
- 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

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 but also relate specifically to the child's individual health care plan. Schools can call upon PDSNs for practical support and advice.

## **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 children and young people 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 children and young people 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 their 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;
- 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 minimize any risks to allergic children should be taken.

Children and young people who are at risk of severe allergic reactions are not ill in the usual sense. They are normal 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 they 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.

### 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://wales.gov.uk/?lang=en>

## **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
8. **Don't hang up until the information has been repeated back.**

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

Put a completed copy of this form by all the telephones in the school



## **FORM 2: Health Care Plan**

2.40 The health plan should specify:

- The child or young person's view where possible.
- Parental wishes for the child.
- The care co ordinator/key worker for the child.
- Any anticipated changes in the child or young person's care routine.
- The contact details of the paediatric healthcare team providing medical advice, care and support.
- 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 children and young people.
- The medication the child or young person takes both in and out of school hours.
- The permission of parents and the headteacher for the administration of medicines by staff or self administration by the child or young person (Form 3 and 4).
- 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 child or young person'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 child or young person'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** children and young people with complex health needs.
- The plan should also be made available to all staff coming into contact with the child or young person.
- Copies of any relevant forms should form part of the healthcare plan.

## Healthcare Plan

Name of school/setting

Child 's name

Group/class/form

Date of birth

Child 's address

Medical diagnosis or condition

Date

Review date

Contact member of staff

## Family Contact Information

Name

Phone no.(work)

(home)

(mobile)

Name

Phone no.(work)

(home)

(mobile)

## Clinic/Hospital Contact

Name

Phone no.

## G.P.

Name

Phone no.

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Describe medical needs and give details of child's symptoms

Daily care requirements (e.g. before sport/at lunchtime/home/school trips)

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

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

Daytime phone no. of parent	<input type="text"/>
<b>or,</b> adult contact	<input type="text"/>
Name and phone no. of GP	<input type="text"/>

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	<input type="text" value="/"/>	<input type="text" value="/"/>	<input type="text" value="/"/>
Time given	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dose given	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name of member of staff	<input type="text"/>	<input type="text"/>	<input type="text"/>
Staff initials	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date	<input type="text" value="/"/>	<input type="text" value="/"/>	<input type="text" value="/"/>
Time given	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dose given	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name of member of staff	<input type="text"/>	<input type="text"/>	<input type="text"/>
Staff initials	<input type="text"/>	<input type="text"/>	<input type="text"/>



## FORM 5: Continued

Date	<input type="text" value="/"/>	<input type="text" value="/"/>	<input type="text" value="/"/>	<input type="text" value="/"/>
Time given	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dose given	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name of member of staff	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Staff initials	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date	<input type="text" value="/"/>	<input type="text" value="/"/>	<input type="text" value="/"/>	<input type="text" value="/"/>
Time given	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dose given	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name of member of staff	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Staff initials	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date	<input type="text" value="/"/>	<input type="text" value="/"/>	<input type="text" value="/"/>	<input type="text" value="/"/>
Time given	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dose given	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name of member of staff	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Staff initials	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date	<input type="text" value="/"/>	<input type="text" value="/"/>	<input type="text" value="/"/>	<input type="text" value="/"/>
Time given	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dose given	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name of member of staff	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Staff initials	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## FORM 6: Record of medicines administered to all children and young people

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	<input type="text"/>
Child's name	<input type="text"/>
Date of birth	<input type="text" value="/"/> / <input type="text" value="/"/>
Home address	<input type="text"/>
G.P.	<input type="text"/>
Hospital consultant	<input type="text"/>

..... 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.

### 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 01 02 03 (Mon-Fri 9am to 5pm)

Tel: Cardiff (029) 2043 5400

<http://www.asthma.org.uk>

#### **Barnardos Cymru**

Tel: Cardiff (029) 2049 3387

<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) 2034 2434

<http://www.childreninwales.org.uk>

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**CLIC Sargent**

Tel: 0800 197 0068

<http://www.clicsargent.org.uk>

**Contact a Family**

Helpline: 0808 808 3555

Tel: Cardiff (029) 2039 6624

<http://www.cafamily.org.uk>

**Commission for Equality and Human Rights (CEHR)**

Tel: Cardiff (029) 2072 9229

<http://www.cehr.org.uk>

**Cystic Fibrosis Trust**

Helpline: 0845 859 1000

<http://www.cftrust.org.uk>

**Diabetes UK Cymru**

Helpline: 0845 1202960 (Weekdays 9am to 5pm)

Tel: Cardiff (029) 2066 8276

<http://www.diabetes.org.uk>

**Epilepsy Wales**

Helpline: 0845 741 3774

<http://www.epilepsy-wales.co.uk>

**Health and Safety Executive (HSE) Wales**

Infoline: 08701 545500 (Mon-Fri 8am-6pm)

Tel: Cardiff (029) 2026 3000

<http://www.hse.gov.uk>

**MENCAP Cymru**

Tel: Cardiff (029) 2074 7588

<http://www.mencap.org.uk/html/cymru>

**MIND Cymru**

Tel: Cardiff (029) 2039 5123

<http://www.mind.org.uk/About+Mind/Mind+Cymru/>

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**National Attention Deficit Disorder Information  
and Support Service**

Tel: Middlesex (02089) 522800

<http://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

<http://www.nhsdirect.wales>

**NCH Cymru, the Children's Charity**

Tel: Cardiff (029) 2021 27

<http://www.nch.org.uk>

**Special Needs Advisory Project (SNAP) Cymru**

Tel: 08451203730

<http://www.snapcymru.org.uk>

**Welsh Association of ME & CFS Support**

Tel: Cardiff (029) 2051 5061

<http://www.wames.org.uk>