Guidance

Pupil Support & Access

Access to Education

for children and young people
with Medical needs

LEAs, Headteachers & Governors

Status: Statutory

Action by: Nov 2001

Date of issue: Nov 2001

Ref: DfES 0732/2001

DoH HSC 2001/019

LAC (2001) 27

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Acknowledgment

The DfES is extremely grateful to the members of the Steering Group on Access to Education for Children and Young People with Medical Needs for their help in preparing this guidance and to those who provided case studies. We are also grateful to The Leicester Royal Infirmary Children's Hospital School, Coventry Hospital & Home Tuition Service, Sutton Hospital & Individual Tuition Service and the Association of Young People with ME who kindly provided us with the photographs used in this guidance.

Access to education for children and young people with Medical needs

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Access to education for children and young people with Medical needs

Audience	LEAs, headteachers, governors, hospital and home teaching services. Hospital and health trust managers, chief executives of prinary care trusts, and social service departments.
Date of issue	Nov 2001
Ref	DfES 0732/2001 DoH HSC 2001/019 LAC (2001) 27
Superseded documents	DES Circular 12/94 The Education of Sick Children, DH LAC(94)10, NHSE HSG (94)24
Related documents	DfE Circular 9/94 DH LAC (94) 9: The Education of Children with Emotional and Behavioural Difficulties DfEE Circular 14/96: Supporting Pupils with Medical Needs in School DfEE PPY19: Supporting Pupils with Medical Needs – A good practice guide DfEE Circular 10/99: Social Inclusion: Pupil Support DfEE Circular 11/99: Social Inclusion: the LEA role in Pupil Support DfEE/DH joint Guidance – Guidance on the Education of Children and Young People in Public Care (May 2000) DfEE 0121/2001 – Promoting Children's Mental Health within Early Years and School Settings DfES/0629/2001 – Guidance on the education of school age parents DfEE 0068/2001 – Good practice guidance, home to school transport for children with special educational needs
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This Circular gives statutory and good practice guidance. It should not be treated as a complete and authoritative guide to the law.

Introduction

1. This guidance sets out minimum national standards for the education of children who are unable to attend school because of medical needs.

2. In any given year there are some 100,000 children and young people who require education outside school because of illness or injury. In addition there are a significant number of children and young people who experience clinically defined mental health problems. The situations of these children and young people will vary widely but they all run the risk of a reduction in self-confidence and educational achievement.

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

4. This guidance contributes to the Government's strategy to promote equal access to education for all children and young people. This strategy is being developed through the amendments made to the Disability Discrimination Act 1995 and the Education Act 1996 by the Special Educational Needs and Disability Act 2001.

5. It also forms part of a joint approach by the DfES/Department of Health, which recognises the important part that both health and education play in the well being of children and young people. For pupils recovering from trauma or illness, a teacher can play a vital part in the recovery process because education is seen as a normal childhood activity.

6. This guidance takes account of views gathered through the consultation, which strongly endorsed the key principles. These are covered in the following chapters.

Chapter 1 Access to education
Chapter 2 Clear policies, procedures and standards of provision
Chapter 3 Early identification and intervention
Chapter 4 Continuity of educational provision
Chapter 5 Working together
Chapter 6 Successful reintegration into school
Chapter 7 Partnership with parents[1] and pupils
Chapter 8 High quality educational provision
Chapter 9 Accountability

7. Despite the overwhelming support for the key principles, a high proportion of respondents considered that there were barriers, which arose in respect of access to education for pupils who are unable to attend school because of medical needs. However, respondents also pointed to much good practice in overcoming those barriers and enabling pupils to achieve their potential. This guidance is designed to build on examples of good practice and to make these principles a reality.

1 Throughout this document the term "parent" includes all those who have parental responsibilities.

Chapter 1
Access to education

All pupils should 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 statutory framework

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

Suitable education is defined as efficient education suitable to the age, ability, and aptitude and to any special educational needs the child (or young person) may have. In determining what arrangements to make under subsections 19(1) or (4) in the case of any child or pupil, an LEA must have regard to guidance given from time to time by the Secretary of State.

This is such guidance.

The Learning and Skills Council (LSC) has duties to secure the provision of proper facilities for the education and training for 16-19 year olds, and to encourage those young people to undergo such education and training. In performing those duties, the LSC must take account of provision, which might reasonably be secured by other persons.

Groups covered by this guidance

1.1 This guidance applies equally to all those pupils who are unable to attend school because of medical needs, both those who are physically ill or injured and those with mental health problems. Particular care is needed to ensure that there is adequate provision for pupils suffering from mental illness. Pupils with mental illness, anxieties, depression and/or school phobia, including separation anxiety and school refusal associated with depression, which prevent them from attending school, may need support from specialist mental health services.

1.2 There is separate guidance relating to the education of pregnant school girls contained in DfEE Circular 11/99. Joint DfES/Department of Health guidance on the education of school age parents, which builds on Circular 11/99, will be published shortly.

Type and range of provision

1.3 Education for pupils who are unable to attend school because of medical needs can be provided in a variety of ways, for example through the provision of a hospital school or hospital teaching service; home teaching; or an integrated hospital/home education service.

1.4 Whatever mode of provision is chosen by the LEA it is important that each of the component elements forms part of a strategic planning framework which ensures a continuum of education provision and establishes effective mechanisms for liaison between hospital, home, pupil referral units and school.

1.5 With changes to the way the education and health services are managed and a move towards shorter stays in hospital, the development of more unit provision can provide an excellent way of bringing together small groups of ill and injured pupils as a means of providing good quality education. Teaching children in groups, where possible, is more cost effective and can offer a more rounded educational and social experience and a way back into school.

1.6 Hospital and home teaching services, or discrete parts of a service which provide education in a unit or school type setting must either be established as a hospital school or registered with the DfES as a Pupil Referral Unit (PRU). This would also apply to such education provision within NHS Psychiatric units, which is provided and maintained by an LEA. It would be open to the LEA to:

- register a hospital and home teaching service as one PRU where there is one head of an integrated service, for example, a hospital or tuition centre which also organises home teaching; or

- to make arrangements for a "confederation" of PRUs in their area grouped under one teacher in charge, with one management committee.

1.7 Another possible model would be for a hospital school to manage hospital and home teaching.

Case study
Unified Service
There is clear evidence that the provision of education via a unified service reduces the likelihood of a youngster remaining without education upon discharge from a hospital.

A 13 year old pupil recovering from a road traffic accident required only a relatively short stay in hospital but her recuperation period at home was in excess of eight weeks. Hospital teachers were able to liaise directly with the home tutor, thereby ensuring continuity of educational provision. This example typifies the current trend in paediatric care with hospital admissions becoming shorter with recuperation at home being a major part of the rehabilitation process.

Case study
Hospital, Home and Young Mothers' Education Service
A referral mechanism is in place, which enables a swift response to the child or young person requiring a period of home tuition after being discharged from hospital. The amalgamation of previously separate hospital and home tuition services in 1995 has ensured that the transition is achieved seamlessly.

Hospital schools

1.8 Hospital schools for the purposes of this guidance, are special schools, maintained by LEAs, within the premises of a hospital. 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. 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 not under a legal obligation to offer the National Curriculum. All hospital schools have local management and delegated responsibility for their budgets.

1.9 Most of the children for whom hospital schools or hospital teaching services provide are hospital in-patients, although a few chronically ill children 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.

Pupil Referral Units (PRUs)

1.10 PRUs are legally both a type of school and education otherwise than at school. They are schools established and maintained by an LEA which are specially organised to provide education for pupils of compulsory school age who, by reason of illness, exclusion from school or otherwise, would not otherwise receive suitable education. Legislation and guidance on PRUs is set out in chapter 6 of DfES Circular 11/99 Social Inclusion: Pupil Support.

1.11 It is good practice for PRUs that provide for pupils with medical needs to cater exclusively for them.

1.12 The LEA, with the management committee, sets the admission policy for a PRU. The LEA should also consult the management committee about proposed changes. Pupils should be admitted to a PRU based on clear criteria and each pupil should have targets for reintegration into mainstream or special schooling, further education or employment. Day-to-day decisions on admissions to the Unit may be handled by the LEA, or delegated to the management committee or teacher in charge.

Psychiatric units and hospitals

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

Home teaching

1.14 Home teaching is education on a one-to-one basis in the child's home, perhaps with occasional attendance at a teaching centre. Electronic provision can be an invaluable aid to home teaching. Home teaching services are usually part of an integrated service. Children generally do better educationally and socially when taught in groups; this also helps reintegration into schools. However, home teaching should be available for those who need it.

Suitable education

1.15 Pupils who are unable to attend school because of medical needs should 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.

LEAs' responsibilities towards pupils who are unable to attend school because of their medical needs should ensure that:

- Pupils are not at home without access to education for more than 15 working days.
- Pupils who have an illness/diagnosis which indicates prolonged or recurring periods of absence from school, whether at home or in hospital, have access to education, so far as possible, from day one.
- Pupils receive an education of similar quality to that available in school, including a broad and balanced curriculum.
- Pupils educated at home receive a *minimum entitlement* of 5 hours teaching per week This is a minimum and should be increased where that is necessary to enable a pupil to keep up with their studies. This is particularly important when a pupil is approaching public examinations.

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

Well siblings

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

The role of the mainstream/special school

1.17 Schools have a vital part to play in ensuring that pupils who are absent from school because of their medical needs have the educational support they need to maintain their education. Good communication and co-operation between the home school, the home and the hospital and home teaching service is necessary if good quality education is to be provided.

Schools should:

- Have a policy and a named person responsible for dealing with pupils who are unable to attend school because of medical needs.
- Notify the LEA/EWO if a pupil is, or is likely to be, away from school due to medical needs for more than 15 working days.
- Supply the appropriate education provider with information about a pupil's capabilities, educational progress, and programmes of work.
- Be active in the monitoring of progress and in the reintegration into school, liaising with other agencies, as necessary.
- Ensure that pupils who are unable to attend school because of medical needs are kept informed about school social events, 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.

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

1.19 The pastoral support system operated in secondary schools can be an integral part of the structures for ensuring the provision of education for pupils who are unable to attend school because of medical needs, either at home or in hospital.

The Education Welfare Service (EWS)

1.20 Educational Welfare Officers (EWOs) play an important role in resolving attendance issues, including cases of medical need, and can play a vital role in tracking pupils who have "slipped through the net". Each school should have a named EWO responsible for helping that school to manage school attendance for all its pupils. In some areas, EWOs are based in and managed directly by the school. Shared policies and operational practices between the 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 work as part of a whole school approach to inclusion. Schools should make use of administrative staff to check registers and to contact a child's parents or carers promptly on the first day of any absence.

Transport

1.21 The provision of transport to and from school by the LEA can sometimes enable a pupil to re-adapt to school, for example by travelling outside the rush hour. An LEA is only under a statutory duty to provide transport if the nearest suitable school is not within statutory walking distance of the child's home by the nearest available route (section 444(5) of the Education Act 1996 refers). Otherwise the provision of transport is at the LEA's discretion (section 509 of the Education Act 1996 refers). LEAs can use this discretion to provide an effective and efficient means of reintegration. It is generally more cost effective and educationally and socially sound for children to be transported to a centre for tuition or to the home school, rather than to provide tuition at home.

Connexions

1.22 The Connexions Service[2] provides information, guidance, referral and support for all young people aged 13 to 19 in England, including giving more in-depth support to those who are at greatest risk of not making a successful transition to adulthood. It has a remit to increase participation in learning up to 19 and beyond, promote social inclusion and provide coherent support and guidance for young people when and where they need it. There are currently 15 Connexions Partnerships operating in different parts of the country, bringing together a wide range of providers of services to young people. The service will be available across England by 2003.

1.23 As the service comes on stream, pupils aged 13 and over will have access to a Connexions personal adviser to help them find ways to overcome barriers to achieving their potential. The personal adviser, working closely with the school, will need to assess the young person's needs and help broker access to, and monitor the support given by, specialist services. Connexions Partnerships will be developing tracking systems, in conjunction with other agencies, to help stop young people from "slipping through the net".

1.24 Working with schools and others, personal advisers over time will also call on networks of voluntary and community mentors being developed to provide extra support and role models for young people. Advisers will also broker specialist support for the young person where needed, for example, Child and Adolescent Mental Health Services.

2 The Connexions Service and Schools 2000 (DfEE Circular 0078/2000).

Chapter 2
Clear policies, procedures, standards and responsibilities

All parties should be aware of their roles and responsibilities and be clear about the standards of service that are expected of them. Policies should be clear, transparent and easily accessible to all.

Local education authority policy statements

2.1 Each LEA should have a named senior officer with responsibility for the provision of education for children or young people who are unable to attend school because of medical needs.

2.2 Each LEA should also 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 its place in the authority's Education Development Plan. The policy should be freely accessible to all.

An LEA's policy should encompass all aspects of the authority's provision, in hospital, at home and elsewhere, and set out clearly:

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

2.3 LEA policies should feed down to operational plans and to the job descriptions of individual officers and teachers. The policy statement should be used to help monitor the authority's educational provision for pupils. The existence of that policy statement should be made known to all relevant staff in the authority, to every school within that LEA, to parents and all relevant agencies and voluntary bodies. Head teachers should know who to turn to for

advice and be aware of the support mechanisms available.

2.4 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 Early Years Development and Childcare Partnership, and other planning tools such as the Behaviour Support Plan and the Asset Management Plan.

2.5 For 13-19 year olds it will be important to have strong links with Connexions Partnerships. LEAs will need to agree protocols with the Connexions Service so that Connexions is informed about those young people who are ill and being educated otherwise than at school, in order that Connexions personal advisers can contact and support these young people where appropriate.

2.6 LEA policies on provision for those children and young people over and under compulsory school age should be clear. Particularly, policies should include what provision or options are available to post 16s.

Case study

LEA policy statement

Havering Tuition Service provides tuition for pupils with long-term sickness, pregnant school girls and for pupils with emotional difficulties such as school phobia. Tuition in hospital is provided quickly to those pupils who need it. The LEA policy statement is attached as an annex to this document.

School policy statements

2.7 Similarly, all schools need to have a written policy and procedures for dealing with the education of pupils with medical needs, which may stand alone or be incorporated into the schools' SEN policy. These might also usefully be included in the school's prospectus.

The policy should include information such as:

- How the school will make educational provision for pupils as set out in this guidance.
- The school's responsibility to monitor pupil attendance and to mark registers so that they show if a pupil is, or ought to be, receiving education otherwise than at school.
- Management structures and staff responsibilities.
- Strategies for ensuring support in cases of long-term absence, including the provision of assessment and curriculum plans within 5 working days and work programmes on a termly basis.
- A named contact within the school to aid communication with other parties, to attend reviews, and to facilitate communication generally between the pupil and the school.
- The provision of work and materials for pupils who are absent from school because of medical needs.
- Procedures for ensuring that pupils who are unable to attend school because of medical needs have access to public examinations, possibly as external candidates.
- Procedures for ensuring that pupils are reintegrated smoothly into the school.
- Issues related to pupils with statements of special educational needs.
- How the school's procedures will take account of the pupil's views.

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

Health authorities/hospital trusts

2.9 Health authorities/primary care groups and primary care trusts/hospital trusts should facilitate arrangements for the education of children with medical needs to take account of this guidance and that of earlier guidance on the Welfare of Children and Young People in Hospital published by the Department of Health through HMSO in 1991.

This should cover:

- The holistic approach to the welfare of the child and any particular need identified within the local health improvement programme.
- Procedures for enabling children to participate in education.
- Co-operation and strategic planning between the health authority/PCT/hospital trust and the education service.
- Protocols for sharing information between health and education. Clearly defined lines of responsibility and named contacts.
- Arrangements for publicising provision.

Information about children's health-development of local protocols

2.10 In March 2001 the Cabinet Office published a report, "Making a Difference, reducing GP paperwork". One aspect of this work was to encourage the development of local protocols on child health and education to recognise the most appropriate role for GPs.

2.11 Protocols provide an opportunity for LEAs and Health Authorities to meet and agree procedures such as who should be approached for particular advice and information. The overriding principle is that the best use is made of the expertise of the relevant health professionals. The protocols should not be complicated documents – they should simply set out transparent arrangements for the provision and sharing of information between LEAs, local health professionals and others.

2.12 Introducing protocols will benefit both seekers and providers of information and ultimately best serve the needs of children.

Chapter 3
Early identification and intervention

A child or young person who is unable to attend school because of medical needs should have their educational needs identified and receive educational support quickly and effectively.

Early identification of pupils' needs

LEAs are responsible for ensuring that:

- There are clear lines of communication so that all concerned know who is responsible for identifying the pupil's needs and how to activate the relevant services quickly.
- Every pupil, who is unable to attend school because of a long term or recurring medical condition, has a personal education plan. This should take effect as soon as a pupil is admitted to hospital or is unable to attend school. Education should begin as soon as the medical condition allows.
- 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.

3.1 For children and young people's needs to be identified early, cross-agency working and liaison between health services, social services, and learning services is essential. This cannot be achieved without the support of the National Health Service. There should be close liaison between hospital consultants, GPs, schools and LEAs so that ill pupils can be provided with educational support quickly and effectively and ongoing monitoring can be facilitated. Ideally, an early diagnosis should be made by a consultant paediatrician. The co-ordinating clinician might then be responsible for referral to the Education Welfare Service to ensure that education is minimally disrupted. School nurses, and for older children, their Connexions personal adviser, can play a pivotal role in linking agencies and supporting a child or young person.

3.2 LEAs must have arrangements to ensure that a pupil with medical needs who is away from school for any period has access to education. If a pupil is expected to be away from school for more than 15 working days, education, in whatever form, should begin immediately the pupil is absent from school. It is the total time of predicted absence from school that is important, not merely the hospital stay. Regular analysis of medical absences, by the school or EWO, can be used to develop regular monitoring of pupils with medical needs, including those referred to the home and hospital teaching service.

Case study

Nottinghamshire Hospital and Home Education Service

The Referral Process

To ensure continuity of educational provision, Nottinghamshire has an effective referral system and mechanisms for ensuring a prompt response.

Unless a pupil has previously been receiving education in hospital, the head teacher or a delegated member of teaching staff is responsible for making referral for home education. Nottinghamshire Home Education Service has a standard form for this purpose.

A letter from the child's consultant or community paediatrician should accompany the request for home education.

On receipt of a referral, and subject to complying with the criteria to receive home education, Nottinghamshire Home Education Service immediately send the relevant letters and forms to the home school requesting curricular information to be returned within one week.

Where children have been in hospital, there is a 'direct referral system' for pupils who receive education at hospitals within the area. This is referred on a specific form, which incorporates the medical recommendation and curricular details of work undertaken in hospital.

The referral system ensures a speedy referral and curricular continuity between home school, hospital education base and home education service.

Mental health

3.3 The survey of 10,000 children published in March 2000 by the Office for National Statistics found that around 10 per cent of children aged 5-15 had clinically defined mental health disorders.[3] Within this definition are included conduct and hyperactivity disorders, emotional disorders such as depression and anxiety or more rarely psychosis. Presenting problems can range from separation anxiety and sleep problems in young children to panic attacks, aggressive and irritable behaviour or self-harming behaviour in older pupils.

3.4 Some mental health problems, such as eating disorders, can involve frequent or long absences from school. At times it may not be clear whether a child or young person's behaviour, for example truancy or school refusal, or non-attendance is indicative of an underlying emotional difficulty. Close and early collaboration between LEAs and health, particularly the Child and Adolescent Mental Health Services (CAMHS) and other agencies is essential when the nature of an illness and its effects are not clear. Community paediatricians/consultants can often help with the identification of pupils with chronic or long-term conditions.

3.5 There is a commitment by the Department of Health, first set out in the National Priorities Guidance for Health and Social Services (published September 1998), to improve the provision of appropriate, high quality care and treatment for children and young people by building up locally based Child and Adolescent Mental Health Services.

3.6 Obtaining the medical evidence for securing eligibility for educational support can be a serious problem, particularly for mental health where there may be no medical note. In some areas there may be a long waiting list for pupils being seen by a child mental health professional, in order to have their difficulties diagnosed. Procedures need to be in place to ensure that this does not leave a pupil without education. In some cases, consideration should be given to beginning the process of identification and assessment of a pupil to determine any special educational needs, to aid early intervention and effective monitoring. LEAs might consider setting up an inter-agency "rapid response panel", to quickly consider referrals for pupils who are unable to attend school because of medical needs.

3.7 Further guidance on mental health issues can be found in the DfES guidance document "Promoting Children's Mental Health within Early Years and School Settings". This can be ordered from DfES publications, telephone: 0845 60 222 60 – fax 0845 60 555 60 – email dfes@prolog.uk.com asking for product code 0112/2001.

[3] Mental Health of children and adolescents in Great Britain (Office of National Statistics).

Case study

Pupils with Mental Health Problems

The following case histories illustrate the need for a range or continuation of provision for pupils unable to attend mainstream school because of mental health problems.

1 Following the closure of the local private school, the pupil transferred to a comprehensive school in Year 9. He could not cope with the different regime and ethos, and was bullied on his journeys to and from school. The pupil was polite and quiet but extremely anxious. His family life was unstable.

After nine months of non-attendance and unsuccessful efforts by the school to support him, the pupil was referred for a short period of home education prior to being introduced into a small group in a PRU, where he made good educational progress and was supported through many personal and family problems. Staff soon became aware of his many phobias and obsessions, especially with cleanliness. A referral to a clinical psychologist began to help with these problems.

2 An accident involving violence resulted in admission of a young person to a hospital adolescent psychiatric unit that he attended for four months. He was then able to return to the PRU until his school leaving date.

Intensive support was needed to support him through this time as he continued to face many personal and family problems. He developed a facade of a different "tough" behaviour, getting involved in drinking, drugs, forming undesirable relationships with local boys but underneath he was still very anxious and fearful, needing constant reassurance to help counteract his often morbid fears.

The high level of joint support and flexibility of provision available enabled him to achieve success, including 4 GCSE's, in spite of his mental health problems.

Long-term problems

3.8 With some illness there may be problems with the unpredictable and changing pattern of the illness. Review meetings should be as integral to the identification and intervention arrangements as the planning and discharge meetings.

3.9 The Government has undertaken a review of management and practice in the field of CFS/ME with the aim of providing best practice guidance for professionals, patients, and carers to improve the quality of care and treatment for those with CFS/ME. Some young people will be too severely affected by their illness to participate in any form of education. 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.

Provision at home

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

3.11 ICT has growing potential in the education of pupils including those at home or in hospital. (See chapter 8).

An LEA should ensure that a pupil is not at home without access to teaching for more than 15 working days. That period should include any period that the pupil has spent in hospital. Where a pupil has been in hospital for a longer period and has received teaching whilst in hospital, LEAs should be aware of the disrupted pattern of education for that pupil and the need for the maximum possible continuity, and will wish to make some teaching available as soon as possible.

3.12 The home school should monitor work missed and develop a strategy, in liaison with the hospital and home teaching service, for helping a pupil to keep up rather than having to catch up. A pupil working towards public examinations needs special consideration and the arrangements should be stated in the LEA and school procedures.

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

Provision in hospitals

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

3.15 Admissions are generally unpredictable but some are booked well in advance. It is essential for hospital teachers to have as much advance warning as possible of admissions. They need an indication of the date, or likely date, of admission and length of stay as soon as the hospital administration can provide this. Computerised administrative systems and the use of e-mail can be of considerable assistance. Such advance warning will provide an opportunity for teachers to liaise with the home school about the educational programme to be followed whilst the pupil is in hospital.

3.16 Parents and other carers should also be involved in the admissions process, consulted about educational programmes and informed of hospital routine. They have a key role to play.

Chapter 4
Continuity of educational provision

The aim of any provision should be to provide continuity of education similar to that provided at the pupil's home school.

The importance of liaison

4.1 Effective liaison between the key partners minimises disruption caused by illness to a pupil's education. It is essential that there is good liaison between the school, parents, hospital and home teaching service.

LEAs and schools should designate someone with specific responsibility for the education of children and young people who are unable to attend school because of medical needs.

4.2 Partnership between the school, agencies and parents makes possible the establishment of appropriate provision. There may be a number of different ways in which a pupil's education can be maintained but they should take into account often unforeseen changes of circumstance that require amendment to its provision.

Case study

Continuation of Provision for Children with Mental Health Problems

From an early age, the pupil felt uneasy and different at school. He worked hard and learned quickly, but often seemed out of touch with his peers, occasionally erupting into challenging and frightening behaviour. His relationships with teachers were fraught with misunderstandings and confrontation, and help was sought from CAMHS.

At secondary transfer, it soon became apparent that he was not able to cope unaided with mainstream school life and he was taught on Outreach by a member of the Pupil Referral Service (PRS), who gradually tried to reintegrate him. However, as his mental state became more precarious, he was referred to the Adolescent Unit as an inpatient and received education there. The PRS staff maintained individual contact during the next three years which he spent out-of-city for a period of assessment. He returned to the service, and attended a small group. When he again became too unstable, he was taught on Outreach until at the end of Year 10, he was admitted into hospital out-of-city and spent three months there before returning to be sectioned to an adult acute psychiatric ward.

He spent his Year 11 accommodated on the ward, and was taught on Outreach, during which time he took and passed GCSE Maths, and prepared to attend college in Year 12.

Throughout his secondary schooling, the pupil received the care and concern of the PRS, whether or not the Service was actively teaching him for periods of time. The continuity and linking together of professionals involved in the his education has been a major factor in his treatment as a whole, and facilitated the continuation of the work each time he returned from being away.

Tracking

4.3 It is easy for pupils to get lost in the system, especially when they are discharged from hospital to "out borough" provision. In these cases it is even

more important that there is effective communication between hospital provision and home LEAs, schools and where appropriate, Connexions partnerships. 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.

Home school

Schools should:

- Liaise with home and hospital teaching services to enable them to draw up a personal education plan to cover the complete education for a pupil who is likely to be at home for more than 15 working days and pupils with chronic illnesses who regularly miss some school. This plan should be agreed with appropriate health service personnel.
- Consider the need for assessment under the Code of Practice on the Identification and Assessment of Pupils with Special Educational Needs, of pupils with a medical need.
- Provide information about records of achievement and curriculum for individual pupils as promptly as possible to facilitate continuity and enable suitable education to continue.

4.4 Learning mentors in some schools are proving to be a valuable added resource to help facilitate this, as they can speed up the flow of work, aid continuity and enable quality co-ordination between the agencies involved. Connexions personal advisers will also play an important role for pupils aged 13 and over. Where a young person is already working with a Connexions personal adviser, the development of the personal education plan should take into consideration and seek to utilise any assessment or personal action planning that may have been undertaken through Connexions.

4.5 A medical diagnosis does not necessarily imply that a pupil has a special educational need. However, it is possible that a medical condition may increase the likelihood that a pupil has a significantly greater learning difficulty than the majority of children of the same age, or that his or her 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 the area of the LEA. If this is the case, then the pupil will have a special educational need within the meaning of the Education Act 1996 and this may require a statutory assessment. Therefore, the designated medical officer and other health professionals may need to consider when discussing medical conditions with parents and the school, whether the pupil also has a special educational need. Further guidance will be available in the SEN Code of Practice and the SEN Toolkit.

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

Recurrent admissions

4.7 Pupils who are admitted to hospital on a recurring basis experience particular educational disruption. These pupils should have access to education from day one. Arrangements should be

in place to ensure that such pupils have work packs prepared in advance to bring into hospital with them.

Pupils with degenerative medical conditions

4.8 Pupils with a variety of progressive or degenerative medical conditions may require special consideration when educational support or intervention is considered. In particular:

- Some conditions are rapidly progressive. This means that the direction of their progress runs counter to that of their peer group and raises particular issues of curriculum accessibility and appropriate activities for the child and young person's age and ability. They require rapid responses from the various agencies contributing to SEN statutory assessment and provision at school.
- Maintaining educational input, even when a condition is progressing rapidly, is important to the child and family.
- Although regression may occur with varying degrees of rapidity, reviews of educational and other provision may need to occur more frequently and more rapidly for this group of pupils.
- These pupils will have greater medical needs than many others with SEN. Close liaison between health professionals, hospital schools and other schools will be necessary, particularly where medications and medical equipment are provided.

4.9 From September 2002, degenerative conditions will be covered by the provisions of Part IV of the Disability Discrimination Act 1995.

Public examinations and National Curriculum tests

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

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

Post-16 transition

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

Case study

The Hospital and Individual Tuition Service, Sutton, Surrey

The Tuition and Reintegration Officer works with the Education Department to identify pupils requiring specialised support.

After attempts on the young person's own life following permanent exclusion from secondary school, she was allocated one-to-one tuition for her Year 11 studies with the Tuition Service, following a negotiated course of four GCSEs. The tutor worked hard with support agency information to develop self-esteem and confidence in all that the young person did.

After a successful first term, she asked to join the Drama GCSE group that ran on a non-tuition day. This, in turn, led to joining groups in other subjects, and the hours offered for tuition were therefore improved.

She passed five GCSEs and subsequently joined an Intermediate NVQ group in Travel & Tourism at the local college, obviating any major disruption to her education from her earlier trauma.

4.13 An LEA should normally arrange continuing education for a young person over compulsory school age but under 18 where, because of illness, he or she is a "year behind" so that they still need to study for a further year to complete examination courses, which they would in normal circumstances, have completed before they reached compulsory school leaving age.[4] Where a young person has a Connexions personal adviser, they will play a key role in drawing up the transition plan and in helping to identify and co-ordinate access to appropriate post-16 provision.

4.14 The Learning and Skills Council (LSC) also has a duty to young people aged 16-19 who have missed out on education due to prolonged illness, as part of its overall duty to encourage increased participation and achievement within this age group. This is to ensure that they have the best possible start to their working lives, including progression to higher education.

4.15 The LSC also has a duty to secure the entitlement of all 16-19 year olds to stay in learning and to fund the continuing education of young people up to age 19.

4.16 It will be for young people themselves to decide which route best suits them. For example, some young people who have missed out on the last stage of compulsory education might well choose not to complete their GCSEs, but decide to follow a more vocational route. Connexions advisers can play a vital role in advising young people about their learning options.

4.17 From April 2002 the LSC has the responsibility for funding of sixth form provision in maintained schools and maintained special schools. Only that funding which was delegated previously to those schools will transfer to the LSC. Funding for central services provided by LEAs in respect of 16-19 year olds will not, therefore, transfer. LEAs will retain the central funding and the responsibilities they have currently to secure access to education for 16-19 year olds enrolled in schools.

4.18 For young people aged 13-19, Connexions Partnerships will build up a map of the services that are available to young people locally, as well as working to establish clear referral and information-sharing protocols between agencies. In doing this, they will draw on the information and

4 Social Inclusion: the LEA role in Pupil Support (DfEE Circular 11/99, para 4.6).

systems that already exist. Partnerships will also be establishing tracking systems to help stop young people slipping through the net. Connexions works with the LSC at local and national levels, advocating on behalf of the young person for the supply of appropriate educational provision in the case of medical need.

ICT

4.19 ICT will play an increasingly important part in ensuring the quality and continuity of out-of-school education. New technology is already allowing some children and young people with medical needs to access their own virtual school. The medium of computer can vastly improve access to learning at home, in hospital and other venues outside school. LEAs are increasingly using CD-ROMs, e-mail and the Internet to extend the variety of educational materials available to children and young people with medical needs and their teachers. It is also a speedy and effective way of sending homework during a short period of absence. Good liaison is essential so that optimum benefit can be obtained from ICT, whether at home, in hospital or elsewhere. ICT should supplement rather than replace individual teaching.