

Meeting the Health Care Needs of Children and Young People in Cardiff

A toolkit for Early Years Settings and **Schools**

This document is available in Welsh / Mae'r ddogfen hon ar gael yn Gymraeg

April 2017-version 1

Summary

About this toolkit

This toolkit has been written to provide educational settings with practical help in supporting learners' health care needs while at setting. The document is designed to be read alongside the Welsh Government guidance; **Supporting learners with healthcare needs (March 2016)**¹. This guidance emphasises the need for a collaborative approach from education and health professionals, placing the learner at the centre of decision making. It provides advice on ensuring learners have full access to education including trips and physical education. This new Welsh Government guidance will replace the Welsh Government Guidance: **Access to Education and Support for Children and Young People with Medical Needs (2010)**². The new statutory guidance requires all maintained nursery, primary, secondary and special schools, pupil referral units (PRUs) and local authorities in Wales to implement a healthcare needs policy and to publish it online at the earliest opportunity.

The purpose of the toolkit is to ensure that all children with healthcare needs are successfully supported in settings across Cardiff so that they are afforded their right to play a full and active role in setting life, to remain healthy and achieve their academic potential.

The toolkit should be read and referred to alongside the current Welsh Government guidance and in conjunction with the **Equality Act, 2010**. An outline of the legal framework can be found in Appendix 3 of this document and stated in the Welsh Government Guidance.

This toolkit has been developed and written by the Disability Team with advice and information from a range of services/teams from Education and Health.

Thank you to all who have contributed to this document.

N.B Throughout the document '**settings**' refers to both Early Years settings and schools.

¹ http://dera.ioe.ac.uk/25558/3/160224-draft-guidance-en_Redacted.pdf

² <http://learning.gov.wales/docs/learningwales/publications/131016-access-to-education-for-children-with-medical-needs-en.pdf>

INTRODUCTION

Local Authorities, settings and governing bodies in Wales are responsible for the health and safety of children and young people in their care.

The City of Cardiff Council is committed to the provision of high quality care that meets the individual needs of all children and young people in Cardiff. As a local authority we embrace the **Every Child Matters** document, the **United Nations Convention on the Rights of the Child, 1992** and we adhere to the **Equality Act 2010** (see Appendix 3 for more details of these documents).

In Cardiff, settings are successful at including children and young people with needs of increasing complexity so each setting will inevitably at some time, have a child or young person on roll with a significant healthcare need. There is an expectation that these children and young people are able to, and can safely attend their local mainstream setting.

A child or young person with medical conditions may be considered as disabled under the definition set out in the Equality Act and/or have a statement of special educational needs (SEN). For children and young people with SEN, this guidance should be read in conjunction with the **Special Educational Needs Code of Practice (Wales), 2002**.

Settings must have a knowledge and understanding of how to routinely manage any child or young person with a chronic condition, and also of any relevant emergency management procedures required. There will be occasions where setting staff may be asked to facilitate a child or young person's attendance or administer medication regularly or in an emergency situation.

A child or young person with a long-term, complex medical condition may require on-going support, medicines or care with interventions. It is also the case that a child or young person's healthcare needs may change over time, in ways that cannot always be predicted, sometimes resulting in extended absences. It is therefore important that parents feel confident that settings will provide effective support for their child or young person's medical condition and that they feel safe and happy.

Settings should:

- **Establish relationships** with relevant local health service. It is crucial that settings receive and fully consider advice from healthcare professionals and listen to and value the views of parents and the child or young person.
- **Consider social and emotional implications** associated with medical conditions. Children and young people may be, or become, self-conscious about their condition and some may experience bullying or develop emotional disorders such as anxiety or depression around their medical condition.
- **Consider the impact of short term and frequent absences**, including those appointments connected with a child's medical condition; they need to be effectively managed and appropriate support put in place to limit the impact on the child's educational attainment and emotional and general well-being.
- **Consider the impact of long-term absences** due to health problems a child or young person's educational attainment may be affected, impacting on their ability to integrate with their peers and affect their general wellbeing and emotional health. Reintegration back into a setting should be properly supported so that the child or young person with a medical condition can fully engage with learning and do not fall behind when they are unable to attend.

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PART 1

SECTION 1: Principles that need to be included in a policy regarding the management of healthcare needs in settings

All settings should have a written policy for the education of children and young people with healthcare needs. Governing bodies should ensure that these policies are in place. Policies should be reviewed regularly, at a minimum of every 12 months and should be used as a tool for guiding improvements.

A Policy should include:

- The responsibility of the setting for monitoring attendance in order to highlight any potential difficulties in attendance for children and young people who have medical needs so that alternative plans can be made to support education as necessary
- Management structures and staff responsibilities, including arranging and monitoring that suitable staff are competently trained
- How the setting will assist children and young people with long term or complex needs, and monitor impact on their mental health and wellbeing
- A system of record keeping including an authorised staff list, health care plans, risk assessments, records of parental consent and the administration of medicines
- Reference to the setting's first aid procedures
- Arrangements for the implementation and review of Health Care Plans
- Reference to the Health and Safety Policy
- Arrangements for liaison with the setting health nurse or health visitor (with parent's consent) as necessary
- A commitment that all relevant staff will be made aware of the child or young person's condition
- Briefing for supply teachers
- Arrangements in case of staff absence or staff turnover to ensure someone is always available to carry out identified procedures/give agreed medications.
- Risk Assessments for setting visits, residential trips, and other setting activities outside of the normal timetable
- Whether the Head teacher accepts responsibility, in principle, for setting staff giving, or supervising a child or young person taking, prescribed medication during the setting day
- The circumstances in which a child or young person may take non-prescription medication (e.g. painkillers)
- The need for a prior written agreement from parents/carers for any medication, prescribed or not prescribed, to be given to a child or young person
- Storage and arrangements for access to medication

Procedures should also be in place to cover any transitional arrangements between settings, the process to be followed upon reintegration or when the child or young person's needs change, and arrangements for any staff training or support. For children starting at a new setting, arrangements should be in place in time for the start of the relevant setting term. In other cases, such as a new diagnosis or children moving to a new setting mid-term, every effort should be made to ensure that arrangements are put in place within two weeks.

SECTION 2: Training for Staff

Suitable training should be identified during the development and review of individual health care plans. Some staff may already have some knowledge of the specific support needed by a child or young person with a medical condition and so extensive training may not be required. Settings that provide support to a child or young person with a medical condition should be included in meetings where this is discussed.

Training should be sufficient to ensure that staff members are competent, have confidence in their ability to support children and young people with medical conditions, and to fulfil the requirements as set out in individual health care plans. They will need an understanding of the specific medical condition they are being asked to deal with, their implications and preventative measures.

The family of the child or young person will often be key in providing relevant information to staff about how their child's needs can be met, and parents should be asked for their view. They should provide advice but should not be the sole trainer.

A first aid certificate does not constitute appropriate training in supporting children with medical conditions. For specific conditions settings should be aware that training and health care plans will be written for an individual child or young person, and should not be duplicated for a child or young person with the same condition.

The Royal College of Nursing in 2005 provided the following advisory list of procedures for the document **Including Me, 2005**¹ which may be safely taught and delegated to non-health qualified staff. This has been subsequently updated in 2008². This is intended to allow carers to care for a child or young person who is medically stable, recognise signs that the child or young person is becoming unwell and know how to seek appropriate help.

The following procedures can be safely taught and delegated to non-health qualified staff:

- Administering prescribed medicine in pre measured dose via nasogastric tube or gastrostomy tube
- Giving bolus or continuous feeds via a nasogastric or gastrostomy tube
- Injections with pre filled syringe/pen device
- Intermittent catheterisation and catheter care
- Stoma care
- Administration of buccal or intra nasal midazolam
- Emergency treatments covered in basic first aid training
- Assistance with inhalers, insufflation cartridges and nebulisers
- Basic life support/resuscitation

These procedures can be covered by County Insurance – see Part 1, SECTION 6, for further information.

¹ Council for Disabled Children, Department for education and skills (2005) Including Me, London, Council for Disabled Children

² Managing Children with healthcare needs, delegation of clinical procedures, training and accountability issues (2008)

www.ncb.org.uk/rcn_guidance_april_08

The Royal College of Nursing has also advised the following tasks **should not be** undertaken by non-health qualified carers:

- Re insertion of nasogastric tube
- Re insertion of gastrostomy tube
- Injections involving: drawing up injection fluid from a vial/bottle into a syringe; administering intravenous drugs; giving controlled drugs
- Programming of syringe drivers
- Filling oxygen cylinders

These procedures are not covered by County Insurance – see Part 1, Section 6, for further information.

These lists are provided as a general guide only and it is important to acknowledge that children and young people with complex health needs may require creative and innovative solutions.

It is imperative that any delegation of medical tasks to non-health qualified staff is undertaken within a robust framework including arrangements for:

- Initial training (ideally prior to the child or young person starting or reintegration)
- Assessment and confirmation of competency of staff
- Confirmation of arrangements for on-going support, training updates and reassessment of staff competency

Training should take place at two levels:

- General training about the child or young person's medical condition (s). This may be applicable for all staff
- Training regarding specific procedures or care that the child or young person will be required for the staff that will need to perform them and a plan for occasions when these staff maybe absent.

A competency assessment should be completed and signed by both trainee and trainer. The setting nurse and specialist health outreach teams are able to deliver training to settings.

SECTION 3: Individual Health Care Plans

Governing bodies should ensure that the setting's policy covers the role of individual health care plans, and who is responsible for their development in supporting children or young people at a setting with medical conditions.

An Individual Health Care Plan (See Form 2, in Appendix 1) can help settings identify the necessary safety measures to support the child or young person with a medical need and ensure that they and others are not put at risk. They will often be essential, such as cases where conditions fluctuate or where there is a high risk that emergency intervention will be needed. They are likely to be helpful in the majority of cases, especially where the medical condition is long term and complex. However, not all children and young people will require one.

An Individual Health Care Plan can clarify for settings, parents and the child or young person the help that the setting can both provide and receive. There should be a level of flexibility to account for any unexpected changes in the child or young person's needs.

The setting should judge each child or young person's needs individually as each will vary on their ability to cope with poor health or a particular medical condition. However, the setting's medication policy must be applied consistently.

The format of individual health care plans may vary. They should be easily accessible to all who need to refer to them, while preserving confidentiality. Drawing up a 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.

A health professional must take a lead role in writing a Health Care Plan; this could be the school nurse, specialist nurse, special needs health visitor or consultant. Their knowledge of the condition, medication, emergency procedures and the child or young person is paramount. This should be completed involving the:

- ✓ Child or young person (where possible)
- ✓ Parent/carer
- ✓ Head teacher/ Senior Management
- ✓ Class teacher/ Form Tutor/ Head of Year
- ✓ Support Staff (if applicable)
- ✓ Setting staff who have agreed to administer medication or be trained in emergency procedures
- ✓ School nurse or a health professional – this will depend on the area of need

If the plan needs revising the setting and health professional should meet with the parents and a new plan written and signed by all parties.

The plan should also be made available to **all staff** coming into contact with the child or young person.

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 setting staff. The plan should include details of the condition, what to do and who to contact in an emergency. More frequent reviews will be required for those with conditions that are technologically dependent or potentially life limiting.

A Health Care Plan should include:

- ✓ The medical condition: its triggers, signs, symptoms and treatments and how it is managed on a day to day basis, in particular during setting hours
- ✓ The child or young person's needs: including medication (dose, side effects and storage) and other treatments; time; facilities; equipment; testing; access to food and drink where this is used to manage their condition; dietary requirements; and environmental issues e.g. crowded corridors, travel time between lessons
- ✓ Specific support for the child or young person's educational, social and emotional needs
- ✓ The level of support needed (some children will be able to take responsibility for their own health needs) including in an emergency
- ✓ Who will provide this support, their training needs and expectations of their role
- ✓ Who in the setting needs to be aware of the child or young person's medical condition and the support they require
- ✓ Protocol for exchanging information between education and health (if necessary)
- ✓ Written permission from parents and the Head Teacher for the administration of medicines by staff or self-administration by the child or young person during setting hours
- ✓ Separate arrangements or procedures required for setting trips or other setting activities outside of the normal setting timetable that will ensure the child or young person can participate e.g. risk assessments
- ✓ Where confidentiality issues are raised by the parent/child/young person, the designated individuals to be entrusted with information about the child's condition
- ✓ Emergency Procedures including whom to contact, and contingency arrangements. Some children may have an emergency health care plan prepared by their lead clinician that could be used to inform the development of their individual health care plan.

The aim of the Individual Health Care Plan is to capture the steps which a setting should take to help the child or young person manage their condition and overcome any potential barriers to getting the most from their education and how they might work with other services.

SECTION 4: Administering Medicines in Settings

For some children and young people regular, prescribed medication is required to keep them healthy and this often means that they will require medication during setting hours. It is important that settings are aware that under the **Equality Act 2010**¹ the child or young person has a right to have their health needs met at a setting, particularly if the administration of medication is the only barrier to their accessing the environment, and that without this the consequence may result in having a detrimental effect on their health. Settings must be mindful and consistent about what is considered as reasonable steps under this Act. Guidance can also be found in the document **Managing Medicines in Schools and Early Years Settings, 2010**². The main points of this guidance have since been incorporated into **Supporting learners with healthcare needs, Draft 2016**³.

Children and young people may require medication at setting for many reasons and this should only be administered with prior agreement and consent given by the parent/legal guardian. Medicines should only be given if prescribed by the GP. No child under 16 should be given medicines containing Aspirin.

A child or young person requiring medication will require a health care plan which must be written by the school nurse/ health visitor and/or other health professionals.

Arrangements to give medication in setting

- A parental request form should be completed each time there is a request for medication to be administered (Form 3A and 3B in Appendix 1) by setting staff, or for a child or young person to self-administer their own medication. This arrangement must be agreed, documented and dated by the Head Teacher. A copy must be kept on file.
- In the case where medication maybe a long term arrangement, a letter must accompany the request from the child or young person's GP or consultant explaining this.
- Amendments to the medication should only be accepted in writing from a health professional and this should again be kept on file. **Verbal messages should not be accepted.**

Receiving medication in Setting

No medication should be accepted into a setting unless it is clearly labelled with the:

- Child or young person's name
- Name and strength of medication
- Dosage, frequency and time the medication should be given
- Expiry date
- Advice about storage

¹ <http://www.legislation.gov.uk/ukpga/2010/15/contents>

² Managing Medicines in School and Early Years Settings (2005), Department for Education and Skills /Department of Health.

³ Supporting Learners with Healthcare Needs (2016) Draft Guidance, www.gov.wales

Storage of medication

- Medication should be stored in a locked cupboard away from other children and young people. The key should be kept in an accessible place known to the designated members of staff. Some medications require refrigeration. If storage in a refrigerator is required this should be in a sealed container that is clearly labelled. All medicines must be clearly labelled. Further advice can be obtained from the **COSHH guidelines, Control of Substances Hazardous to Health, 2002**¹.
- In the case of older children or young people it may be appropriate for them to carry emergency medication with them – settings should make such decisions based on individual circumstances in liaison with the family and setting health team. The Individual Health Care plan should reflect this agreed decision
- In most cases children and young people should be allowed to carry asthma inhalers with them to ensure easy access. Again this should be reflected in the child or young person's Individual Health Care plan.
- Local pharmacists can give advice about storing medicines.

Administering medication

- Any staff willing to administer medication must receive appropriate training and guidance, and be aware of any possible side effects of the medication. This can be found in the information leaflet.
- Parents must not send the medication to setting in pre-drawn doses/syringes (unless this is how it is dispensed by the pharmacist) or in drinks. It must come in the original packaging with a pharmacy label intact. There must be a syringe provided to help in the measurement of the correct dose.
- Medicines must only be given according to the prescription given by the GP. Parents should ensure a copy of this is available for the setting. Settings require written notification from the GP should doses change or medications change.
- Medicines should not be given if they are out of date. Parents will need to replace the medicines immediately and it is the parent's responsibility to dispose of any unwanted medicines.
- It is best practice that there should be two members of staff to check the medication when it is time to administer it. The following details should be checked:
 - **Right Child or young person** (name and date of birth)
 - **Right Medicine** (staff should be aware of the purpose of the medication)
 - **Right Dose** (measured using a syringe)
 - **Right Route** (orally/gastrostomy/nasogastric)
 - **Right Time**
- The child or young person may self-administer some medications e.g. asthma inhalers. It should be clear in the forms relating to medications in setting whether the child or young person needs supervision or not. It is good practice to record when a child or young person has medication even if self-administering.
- Appropriate measures should be put in place or alternative arrangements if named staff are unavailable or absent.

¹ Control of Substances Hazardous to Health (COSHH) Regulations (2002) amended as required www.hse.gov.uk

- There should be a completed form (Form 5 & 6 in Appendix 1) to show the child or young person's name and DOB, the date, time and medication name and dose and two staff should sign this. Accurate recording is of the utmost importance.
- Staff should not give any medication if a medical judgement is required to determine the need unless an emergency but this should be in accordance with the agreed health care plan.

Hygiene and Infection Control

- All staff should be familiar with normal procedures for avoiding infection and follow basic hygiene procedures. Staff should have access to protective disposable gloves and take care when dealing with spillages of blood or other body fluids and disposing of dressing or equipment.

Disposal of medications

- Medications should always be returned to the parent to be disposed of. If this is not possible any unused medications should be returned to a local pharmacy
- Medications should not be disposed of in sinks or toilets
- Some medications (i.e. for diabetes) are pre-assembled and contain a needle. Sharps boxes are essential for the disposal of needles and these can be obtained by contacting your local pharmacy or speaking to the setting nurse.

Emergency Medications

- Emergency medications (i.e. epi pen, buccal midazolam) must have a Health Care Plan detailing how to administer it and what to do in the event of an emergency
- The location of emergency medications should be easily known and accessible to all staff but not accessible to other children and young people
- Emergency medications must not be used for another child or young person displaying the same symptoms. If there are concerns an ambulance must be called. Medication can only be given to the child or young person it is intended for
- Staff should receive training in how to administer any emergency medications. If a child or young person forgets their emergency medications the parent must either bring it in immediately or the child or young person must go home
- Parents and GP must always be informed if emergency medications have been given and records should be retained at the setting.

Points to Consider:

- **If the child or young person refuses to take the medication:** we cannot force a child or young person to take medication so if the child or young person refuses, and reasonable steps have been taken to encourage them parents must be called. If the refusal to take the medication results in an emergency then emergency procedures should be followed.
- **If the child or young person spits out or vomits after taking medication:** staff should not re-administer medication as there is no way of knowing if any has already been absorbed into the body. There may be individual cases where this is appropriate but these should be clearly documented in the Health Care Plan. Parental advice should be sought.
- **If the parent has changed the dose on the bottle by hand:** the reason for this may be acceptable, some medication doses increase as the child or young person gets used to them, or doctors may be trying to find the correct dose but under no circumstances should staff accept the parent's authority to change the dose. Advice should be sought from the GP. Any planned increases /decreases in medication should be clearly written in a plan signed by the GP/ consultant.
- **If the parent has said to hide the medicine in food/drink:** As a general rule food should not be mixed with medications as this can change how they work or be seen as a covert administration without the child or young person's consent. However on occasion and if the need for the medicine to be given is in the child or young person's best interests, certain strategies can be used to ensure it is given. If this is the case this must be clearly documented and agreed with both parent and GP.
- **If staff forget to give the dose:** The medication should be given immediately when the error is detected. Parents should be informed immediately. Advice should also be sought from the GP or NHS Direct on how to proceed with the next dose. This should be documented. It may be useful to set an alarm or an alert to remind staff that the medication is due.
- **If the wrong dose/medicine is given:** Immediate medical advice should be sought from the GP or NHS Direct. If the child or young person is showing signs of distress then an ambulance should be called and emergency procedures followed. Parents should be informed immediately and the incident documented.

SECTION 5: Managing Medical Procedures in Settings

At times settings may be asked to carry out medical procedures in order to meet children's health care needs within the setting day. Training, support and advice will be provided by relevant health professionals for staff who are willing to be involved in carrying out these medical procedures.

Any child or young person who requires a medical procedure to be able to access and attend a setting will require a detailed Health Care Plan. This should be written by the most appropriate medical professional and signed by the setting, health and parents. The head teacher will have the responsibility of agreeing for their member of staff to undertake this medical procedure.

The following procedures are becoming more common in our mainstream settings:

Feeding Tubes

There are different types of feeding tube that children may have:

- **Naso-gastric tube** - this is a tube that runs from the nose, down through the oesophagus and into the stomach. Naso-gastric tubes are usually in place as a short term procedure intended to boost nutritional intake or are in place for children who have difficulty swallowing and may have a risk of choking. They can be needed for a variety reasons.
You may see other versions of a nasal tube; the second letter usually refers to the part of the digestive system where the lower half sits e.g. NJ, ND
- **Gastrostomy tube** (PEG-Percutaneous Endoscopic Gastrostomy) - if it is the case that a child or young person requires a feeding tube for a longer period of time then it is normally the case that they will then have a gastrostomy fitted. This is a permanent tube from the inside of the stomach through the skin to the outside where there is a tube fixed in place. Fluids and nutritional feeds are then given through this tube.
- **MIC-KEY button** - once the PEG is established and healed it is usually changed to a MIC-KEY button which is much more practical and discreet as it sits flat against the skin and is more easily covered by clothing.

Tracheostomy

A tracheostomy is an opening into the trachea in order to allow breathing. Children and young people who require active management of the tracheostomy, or at significant risk if it were to become displaced, are usually supported by a health care worker. Please contact the Disability Team if this is the case as you will need further advice regarding this.

On a practical basis, settings need to be aware that some activities may not be appropriate such as glitter/sand or anything with small breathable particles as this may interfere with the function of the tracheostomy.

Settings will also need to consider the emotional well-being of children or young people as tracheostomy tubes are visible.

Catheterisation

Children or young people may require catheterisation for a number of reasons; they may have a condition such as Spina Bifida which impairs nerve sensation in the genital area preventing the child from being able to control the bladder voluntarily or there may be damage to the urethra preventing normal drainage of the urine.

Most children or young people who are catheterised have intermittent catheterisation. This involves a catheter being inserted into the urethra and into the bladder to drain the urine. This is usually done several times a day.

Most children are taught to catheterise themselves at some point and may only require supervision but for young children settings may be asked to help with this. Please seek further advice from the Disability Team if this is the case.

Stomas

A stoma is where an opening is made in the abdomen to allow waste to pass out of the body. Children can require stomas for a variety of reasons; to correct congenital abnormalities or if children have experienced significant bowel/bladder disease and damage. These can be permanent or in some cases temporary to allow the bowel/bladder to heal after an operation or to treat certain bowel/bladder conditions.

Stomas are in place to divert either the flow of faeces or urine.

The most common stomas that settings are most likely to see in children with medical conditions are the colostomy and ileostomy. This is where an opening is made into either the colon or the ileum to allow the passing of faeces from the body.

In some cases there may be an opening needed to allow urine to pass from the body. These are vesicostomy or an ureterostomy depending on the position of the opening.

Children with a stoma receive ongoing care from a Stoma nurse. Staff should contact the Stoma care team for advice as necessary.

VP Shunts

In order to avoid damaging the brain from a build-up of fluid children and young people with hydrocephalus usually have a shunt fitted. This is a tube that is sited in the brain to allow the fluid to drain away either into the heart or the stomach where it is reabsorbed by the body. In most cases they are intended to stay in place for life although on occasion they may block. Shunt Alert Cards are available from the Shine Charity.

Signs to look for:

Vomiting, Headache Dizziness, Visual disturbances, Drowsiness, Seizures

If any of these are suspected then an ambulance must be called.

SECTION 6: Insurance – for Schools and Funded Non Maintained Settings only

Before carrying out any medical procedures City of Cardiff County employed staff must be trained and assessed by appropriately trained health professional and are deemed competent in the relevant procedures. There needs to be written evidence via a risk assessment and/or appropriate training and/or competency assessment.

On the basis that the training has been completed and assessed, all employees of City of Cardiff County are protected by Public Liability insurance (subject to its terms, conditions and exclusions). This may not include supply staff if they are employed by an independent supply agency.

Procedure/Activity/ Use of	Requirements for Cover
Administration of Medicines	Subject to being pre-prescribed by a medical practitioner and written guidelines. Via nasogastric tube, gastrostomy tube or orally Wherever possible parents should provide the medication prior to the child or young person leaving home. A written consent form will be required from the parent, and this should be in accordance with LA procedure on administering medicines in settings
Bathing	Following training and in accordance with written guidelines
Blood Samples	Only by glucometer following written guidelines
Buccal midazolam	Following written guidelines, training and a health care plan
Catheters	Following written guidelines for changing of bags and the cleaning of tubes There is no cover available for the insertion of tubes – this can be arranged if necessary and requires training and competency assessment
Colostomy/Stoma Care	Following written guidelines in respect of both cleaning and changing of bags
Dressings	Following written health care plan for both application and replacement of dressings
Defibrillators/ First Aid only	Following written guidelines and appropriate documented training
Epi pen/Medi pens	Following written guidelines with training and a preassembled epi pen
Gastrostomy – peg feeding	Feeding and cleaning following written guidelines, training and a detailed health care plan. No cover available for tube insertion
Inhalers, cartridges and nebulisers	Both mechanical and hand held following written guidelines
Injections	Only for the administering of pre-packaged dose on a regular basis pre prescribed by a medical practitioner and written guidelines/health care plan
Insulin Injections	These should be self-administered but can be undertaken by trained staff in

	accordance with a written health care plan. Cover will operate in respect of the administration of doses that need to be determined due to individual needs of the child or young person as long as this is set out in their care plan and has parental approval
Nasogastric tube feeding	Following written guidelines, training and a detailed care plan. This cover is only available for feeding and cleaning of the tube. A competency assessment is essential. There is no cover for tube insertion or reinsertion which should be carried out by a medical practitioner
Oxygen	Following written guidelines and training in the use of the equipment including oxygen saturation monitoring where required. No cover for filling oxygen cylinders from a main tank

On occasion a separate insurance policy may be required to insure a particular health procedure which is not listed on this table above. If your setting is currently undertaking, or has been asked to undertake a procedure that is not listed on the table above, contact the Disability Team (Education Inclusion), or the Risk and Insurance Department for further advice or information.

Insurance and Risk Management Section 029 2087 2257

Inclusion and Disability Team 029 2067 1479

PART 2

SECTION 1: Adapting the Physical Environment

Points to consider:

General:

- Parking arrangements – space may be needed for a taxi or parents' car to drop the child or young person off. Location of this must be considered
- General accessibility of external setting site e.g. are the playground/outdoor area flat or sloped?
- Entrances to setting – steps, doors and handles, security systems. Are ramps required or could an alternative entrance be used?
- General accessibility of internal setting site – width of corridor, storage obstructing access, door size and how they are opened and closed, clearly labelled rooms, signage at appropriate level
- Distances between different areas of the setting – this can be very tiring for a disabled child or young person
- Fire exits – can they be accessed by a child or young person in a wheelchair?
- Stair safety – provision of handrails, visual markers

Classrooms:

- Position of the child or young person's classroom – if the classroom is upstairs consideration needs to be given to relocating downstairs
- Organisation of rooms to allow free movement around with minimum obstructions
- Tables and work surfaces – can they be accessed by a wheelchair, is there space for specialist/personal equipment?
- Is there space for specialist equipment e.g. chairs, standing frames, mobile hoist?
- Use of interactive whiteboard may have to be adapted

Toilet Areas:

- Size is important and so is accessibility – can a wheelchair user/ child or young person with a walking aid, get in and turn around?
- Is there space for a carer?
- Toilet area may have to accommodate a variety of different needs – a child or young person with incontinence problems, catheter users, or who need moving from chair to toilet by means of a hoist
- Can the child or young person access the sink and taps independently?
- Can the child or young person dry his hands, use the mirror independently?
- Is the room organised to allow supervision with privacy?

Dining Area:

- Is it accessible to all – can the child or young person using a walker or a wheelchair access the room and get around easily?
- Can the child or young person using wheelchair/walkers reach the hatch area and carry food to the table?
- Can the wheelchair go under the dining tables?

Computer, Art, DT, Library Areas:

- Consider the accessibility of these areas – often the working benches are at a higher level – adjustable tables can be useful here
- Can the sinks be accessed by a wheelchair user?
- How is the library organised for accessibility and visual accessibility?

Playground/Outside Areas:

- Physical terrain – is the site sloped, stepped or flat?
- Outside exits – are they accessible to a wheelchair user?
- Condition of outside surfaces – crumbling tarmac, uneven concrete, gravel
- Icy weather – salting and gritting policy
- Is there a quiet area? – some children and young people find it difficult to cope with noise and busy activities
- Is there outside seating? – a child or young person with physical difficulties can tire easily
- Are there areas in the shade? – a child or young person with physical difficulties may be very sensitive to light

SECTION 2: Manual Handling Guidelines

Manual Handling involves moving or supporting a load by hand or bodily force, including lifting, lowering, carrying, pushing and pulling. This may involve animate or inanimate loads. The **Manual Handling Operations Regulations 1992¹**, amended 2002, say that all staff involved in Manual Handling need to have training to allow them to carry out their jobs safely. Incorrect Manual Handling is one of the most common causes of injuries at work causing musculo-skeletal disorders in the workplace.

What to do about it?

- Assess – What are the risks and who is affected by them? How likely are they to happen, and what are the levels of risk?
- Avoid – Employers should avoid employees doing hazardous manual handling
- Reduce – We MUST reduce risks to the lowest reasonably practicable level. This may include training, provision of equipment, adaptations to buildings etc.

Training is provided for the handling of a child or young person with physical difficulties by Cardiff's Manual Handling Trainer. In Cardiff we follow the **All Wales Passport in Manual Handling²** along with **Cardiff's Manual Handling Policy**. There are 6 modules in the **All Wales Passport** for moving and handling:

- A Introduction & Theory
- B Inanimate Loads (including lifting of small child or young person and young people)
- C Sitting to standing
- D Couch Mobility
- E Lateral Transfers
- F Hoisting

The passport allows staff to be trained in the modules that are relevant to their individual jobs.

Risk Assessments

Some children and young people with more complex handling needs will require a Risk Assessment and a Handling Plan. In these we need to consider:

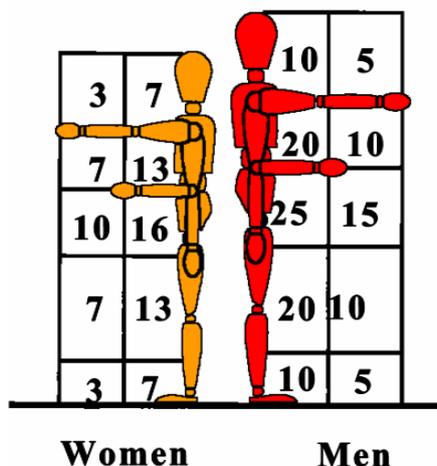
- Task
- Individual Capability
- Load
- Environment

¹ <http://www.hse.gov.uk/pUbns/priced/l23.pdf>

² <http://www.wales.nhs.uk/documents/All-Wales-NHS-Manual-Handling-Training-Passport-and-Information-Scheme-V2-final.pdf>

The aim of completing the assessment is to provide safe systems of work. The assessment must be reviewed annually or when a contributing factor changes i.e. significant weight gain making lifting more difficult.

There is no law preventing lifting; lowering, carrying and pushing, however, please note the following guidelines which show the recommended weights in kilograms:



Equipment

Equipment may be recommended by the Manual Handling Trainer often following joint visits with Physiotherapist and/or Occupational Therapist. Small pieces of handling equipment may be recommended, encouraging as much independent movement as possible, or it may be hoists for child or young person with complex physical difficulties. Mobile hoists and slings are provided through the Manual Handling Trainer and can be issued quickly as and when needed. Overhead tracking is often used in accessible toilets and this can be arranged through the School Organisation Access and Planning Team following joint visits with the Manual handling trainer.

Ongoing support is given to settings depending on the needs of the individual child or young person, enabling staff to feel comfortable and confident with any handling necessary to fulfil their roles allowing the child or young person to access setting environment/activities.

SECTION 3: Writing a Risk Assessment for a child or young person with health care and/or physical needs

Why do you need to carry out a risk assessment?

- Settings have a duty of care for the health and safety of those in their care. A risk assessment will help the setting to plan and make suitable arrangements to make sure a child or young person's needs are being met safely
- There are legal reasons for having a risk assessment. **The Management of Health and Safety at Work Regulations, 1999¹**, requires a risk assessment to be carried out for all work related activities
- If there is an accident involving a child or young person, the setting and where appropriate The City of Cardiff Council will need to show that it has taken all 'reasonable steps' to prevent harm. A copy of the Risk Assessment will need to be kept on file for reference
- As part of ESTYN, inspectors consider a range of evidence to judge the safety of particular groups of children and young people, including those with a disability. They are likely to ask to see your risk assessment.

When do you carry out a Risk Assessment?

- It is advisable to establish policies and safety procedures in advance of a new child or young person
- For a child or young person with significant physical or medical needs, you should complete a risk assessment as soon as possible. The assessment will need to be reviewed on a regular basis and updated in response to any significant change, or in the event of an incident or as the child or young person moves to a new year group.

How do you carry out a risk assessment?

You need to:

- Identify potential hazards in the environment or planned activities
- Consider how those hazards will affect the child or young person concerned and others who may be affected (directly and indirectly)
- Evaluate the potential risks and look at existing arrangements. Are they adequate or could more be done?
- Record and inform others of the significant findings of the assessment
- Review the assessment regularly, following changes or if it is believed to be no longer valid.

Areas to consider when writing a risk assessment:

¹ <http://www.legislation.gov.uk/uksi/1999/3242/made>

- ✓ Arrival and departure arrangements e.g. identify adult and procedure, transport transfer, adverse weather conditions
- ✓ Setting entrance e.g. always uses most accessible entrance
- ✓ Mobility around setting e.g. corridors, cloakrooms, upper floor levels
- ✓ Access to the curriculum e.g. practical subjects and physical education
- ✓ Possible absence of staff or key workers
- ✓ Specialised equipment (purchase, storage, use, maintenance, disposal)
- ✓ Toileting – see the **City of Cardiff Council Toileting Guidelines**
- ✓ Lifting and moving the child or young person through specific Manual Handling Training
- ✓ Illness events e.g. Norovirus, Flu, Chickenpox (for those with reduced immune systems)
- ✓ Medical Procedures – see Health Care Plan Section
- ✓ Fire drill and emergency evacuation of the premises e.g. Personal Emergency Evacuation Plan (PEEPS)
- ✓ Trips need to be planned well in advance to book accessible transport e.g. coaches
- ✓ Swimming needs to be planned well in advance especially if the child or young person has physical difficulties

What next?

- Having identified potential hazards, who is affected, considered consequences and possible solutions, you may need to discuss the issues with other professionals before deciding on the most practical solutions
- The Risk Assessment may identify training needs and potential hazards for staff and helpers. Steps must be taken to protect staff and child or young person and young people from injury or exposure to excessive risk
- Any person involved in lifting must receive Manual Handling Training
- Training must be up to date and refreshed every two years, unless circumstances change
- If a hoist is used for lifting child or young person and young people, staff must have training in its use. Training is available from a Manual Handler Trainer (see above). Staff must adhere to the safe system of working with regard to using a hoist safely
- Once suitable arrangements have been agreed, share the Risk Assessment with parents/carers and child or young person and also the relevant staff
- After an initial period, review the risk assessment to check that the arrangements are working and then review regularly, perhaps as an Individual Development Plan meeting or Individual Education Plan meeting

Personnel Issues

The job description of Learning Support Assistant (LSA) needs to reflect all aspects of the duties required e.g. intimate care, manual handling. Staff should be suitably trained to carry out their duties in reasonable safety.

- Arrangements must be in place for when the designated LSA is absent
- It is not acceptable to send a child or young person home if the LSA is absent. This could be a contravention of the **Equality Act**. Therefore contingency plans need to be in place.

SECTION 4: Specialist Equipment for children and young people with Physical difficulties

Wheelchairs

- These are normally supplied by ALAC (Artificial Limb and Appliance Centre); there is usually a waiting list to be assessed
- Referral by Occupational Therapist or Physiotherapist required
- Wheelchairs are sometimes funded by private or charitable means e.g. Whizz Kids. These organisations can also provide training

Manual Wheelchairs

- These can be self-propelled by the child or young person or pushed by a carer
- They may be fairly basic, or have more individualised support/straps
- A child or young person with greater postural and support needs may use spinal moulds to accommodate the shape of the child or young person and prevent deformity
- Some chairs may be quite heavy to push

Powered Chairs

- There is a strict criteria for provision of these chairs
- They are sometimes provided to assist a child or young person with severe mobility difficulties to access a setting site more easily
- They should only be used in setting if staff have been shown the basic workings i.e. brakes, emergency stop, speed changing mechanism

Specialist Seating

- Good seating is essential to facilitate support and comfort and therefore enable attention, concentration and learning
- Correct seating can help correct poor posture
- It can maintain optimum posture for child or young person who have abnormal muscle tone or cannot support themselves
- It can help prevent deformity
- It can improve heart and lung capacity
- It can often help to accommodate different height working surfaces
- It can usually only be used indoors

Standing Frames

- Standing frames enable a child or young person who cannot/ have difficulty standing unaided to attain an upright position without much effort
- Standing frames are usually used daily for up to an hour at a time, during lessons
- Standing frames may be upright or leaning forward or backwards. The child or young person's physiotherapist will advise on the most appropriate standing frame and the best way to get the child or young person in and out.

Walking Frames

- Walking frames enable a child or young person with poor control/movement of the legs to walk. They offer improved balance and allow the child or young person to use his/her arms to help support their legs during standing and walking
- Most walking frames have 2 wheels and 2 legs, or 4 wheels. A walking frame may be used in front of the child or young person (rollator) or behind the child or young person (K walker)
- A child or young person with a walking frame will need extra room in and around the classroom and may have difficulty turning in small spaces as the wheels usually do not swivel and the child or young person has to lift the walker to turn
- Walking frames are funded by the health service; assessment is by the physiotherapist

SECTION 5: Use of ICT

ICT can be used in a variety of ways to support a child or young person with physical needs once their learning needs have been assessed. Inclusion is ensuring that all children and young people are able to participate fully in the learning and life of the setting. ICT can provide valuable support to achieve inclusive practice through helping staff overcome potential barriers to learning in response to a child or young person's diverse need and setting appropriate learning challenges.

When using ICT with a child or young person with physical difficulties, it is important that there are regular assessments of their needs and the provision of training and support for both the child/young person and their helpers. This will ensure that the equipment offered is suitable and appropriate for their needs. ICT resources can include computer access devices such as switches, adapted mice and key guards, communication aids and specialised software.

Consideration should be made for a child or young person with visual impairment in terms of their position in relation to a computer screen, the size of the computer monitor and the clarity of the display. Where possible, colours should be adjusted to meet the specific needs of the child or young person. Large and clear fonts and speech feedback should also be used where possible.

For children and young people who struggle to form letters, who tire easily or have limited motor control, computers may be the only way of recording their thoughts. Most find it easier to use word processors and press keys to complete text than forming letters. Using a keyboard or specific applications can help a child or young person with motor difficulties to gain confidence. If you have concerns about a child or young person in this area, please look at the **Handwriting Motorway**¹ in conjunction with the Graduated Response and **Cardiff's Expectation** document.

There are many software/ hardware providers and products but here are a few we would recommend as a starting point; these support learners with various physical disabilities.

Support for:	
Writing	Desktop PC Laptop iPad
Keyboards	Miniature Keyboards Keyboards with built in tracker balls Jumbo boards Standard size with coloured keys, lower case Keyboard angle rests Most alternative keyboards can be used with an iPad through a camera connector
Mice	Mini mice/tiny mice Track balls Touch pads Joysticks

¹ <http://www.nhswalesawards.wales.nhs.uk/sitesplus/documents/1086/Handwriting%20Motorway.pdf>

	Switches Head pointer
Software	Clicker Write Online; this requires a yearly subscription Co:Writer Penfriend XP, This is still the version used for prediction just in English. It has been around a long time. Voice Recognition
iPad apps	There are a wide range of apps for Early Years, Primary, and Year 7 and 8.

ICT assessments for learners with significant physical needs can be accessed through direct referral to the Disability Team or via a PARM referral.

SECTION 6: Safety in a Fire

The introduction of **The Regulatory Reform (Fire Safety) Order, 2005¹**, requires that employers or organisations providing services to the public, take responsibility for all people, including disabled people evacuating buildings safely. When an employer or a service provider does not make provisions for the safe evacuation of disabled people from its premises, this may be viewed as discrimination. It is a general requirement that emergency procedures are pre-planned and that planning should have regard to the needs of all occupants. It is therefore essential to identify the needs of disabled people and, where necessary, to make proper arrangements for their assistance in the event of an emergency evacuation.

All settings will have in place procedures to be followed in the event of a fire and will ensure that evacuation procedures are practised frequently. The procedures in place should cover the practice that will also apply to children and young people with physical difficulties.

In an event of a fire it is the responsibility of the building user to ensure the safe evaluation of all children and young people from the building. Also to ensure that all evacuation plans (SEEPs and PEEPs) are up to date, accurate and are accessible in an event of a fire. **Please note that the Fire Service role is to put the fire out not to evacuate people.**

Safe Emergency Evacuation Plan (SEEP), see Appendix 2

A SEEP refers to the standard safe emergency evacuation procedures that are in place in a setting for the evacuation of staff/students and visitors who do not need any extra help to escape in an emergency situation.

If a child or young person or staff member requires assistance to escape from the building safely in an emergency situation then they will need an individual plan in place. This is known as a PEEP.

Personal Emergency Evacuation Plan (PEEP), see Appendix 2

The purpose of a PEEP is firstly to secure the safety of the named individual in the event of a building evacuation. The PEEP will also record the safety plan e.g. routes, corridors, stairs or refuges etc, identify those persons who will assist carrying out the evacuation and training or practice needs.

Where identified within the PEEP that assistance is required to carry out the evacuation, faculties, settings or departments must be assured that the people identified within the plan are in place.

Considerations should be given to timetabling and room location of the disabled person. Room location as near to the ground floor as possible for quick evacuation should be considered.

Faculties, Settings or Departments must construct a PEEP when aware that staff, students or visitors may experience difficulties in responding to a building emergency evacuation alarm.

Practice drills:

In the event of a fire drill you do not have to evacuate a child with physical disabilities but need to have processes in place to inform the adult responsible for the child that it is a fire drill. The reason for not practicing is that hazardous manual handling may be involved and putting someone at risk for a drill is not good practice. However that person should have clear knowledge of expectations in a real emergency which is referred to in a Personal Emergency Evacuation Plan (PEEP).

¹ <http://www.firesafe.org.uk/regulatory-reform-fire-safety-order-2005/>

Essential for settings:

- A SEEP is in place for all users of the premises
- A PEEP is in place for each of those people needing help to escape in an emergency situation.

Points to consider: this will vary from site to site

- Identify the number of disabled staff and students and where they will be in the building at different times of the day
- How to implement Personal Emergency Evacuation Plans
- Consult with relevant staff and students to look at individual preferences and requirements
- The evacuation plan should not rely upon the intervention of the Fire and Rescue Services to make it work.
- Consider the characteristics of the building e.g. Are there lifts suitable for use in an emergency? Does the building have safe holding spaces?
- Assess if evacuation equipment is needed for disabled children and young people e.g. Albac Mat or Evacuation chair
- Staff will need training to deal with emergency evacuations
- A Plan for Practice Drills and Emergency situations to include what needs to be done when it is not possible to evacuate disabled people.

Further information can be found at:

- Fire Safety Risk Assessment: Means of Escape of a Disabled Person (WG Guidance)
- For more information or specific queries about Fire Safety and Evacuation Plans please contact the School Organisation Access and Planning Team who are based at County Hall.

Section 7: Information for day trips, residential visits and sporting activities

Additional safety measures to those already in place in the setting may be necessary to support child or young person with health care needs during visits or activities outside of the normal school timetable. Arrangements for taking medication and ensuring sufficient supplies for residential visits may be required.

All staff supervising visits should be aware of a young person's health care needs and any medical emergency procedures. Summary sheets held by all staff, containing details of each young person's needs and any other relevant information provided by parents, is one way of achieving this. If appropriate, a volunteer staff member should be trained in administering medication, if they have not already been so trained, and should take responsibility in a medical emergency.

Parents should be asked to supply:

- Details of medical conditions
- Emergency contact numbers
- The child or young person's GP's name, address and phone number
- Information on whether the child or young person has spent a night away from home before and their ability to cope effectively
- Written details of any medication required (including instructions on dosage/times)
- Parental permission if the young people needs to administer their own medication or agreement for a volunteer staff member to administer
- Information on any allergies/phobias
- Information on any special dietary requirements
- Information on any toileting difficulties, special equipment or aids to daily living
- Special transport needs for child or young person and young people who require help with mobility
- 'Fit to travel' certificate written by the GP/consultant if the child has a significant medical need (without this the insurance maybe invalid)

Settings should consider what reasonable adjustments they might make to enable children with health care needs to participate fully and safely on visits. A thorough risk assessment should be written so that planning arrangements take account of any steps needed to ensure that children or young people with health care needs are included. This will require consultation with parents, child or young person and relevant health care professional to ensure that the child or young person can participate safely.

Some areas that should be considered prior to any off site visit:

- Transport e.g. coach companies have facilities to store or secure specialist equipment
- Access to Emergency facilities e.g. hospital
- Access to places e.g. ramps, lifts
- Accommodation
- Food/menus e.g. allergies, diabetes, coeliac
- Airlines e.g. notification if a child/young person has a severe allergy

PART 3

SECTION 1: Supporting Parents and Carers

When a child or young person has been diagnosed with an illness, disability or sensory impairment which requires additional support for them to live day to day they may be described as having 'complex needs'. A child or young person may have complex needs from birth, or following an illness, or injury.

Although everyone's experience will be different; it can be reassuring for parents to speak to other parents who have a child or young person with the same disability or condition as they're likely to have been through the same emotions and processes.

Support for Parents/Carers

The first place a parent/carer could access support and advice would be through their local GP surgery, or through the health visitor/ school nurse. Health professionals will be able to offer support and guidance specifically about the condition and will be able to liaise with experts in the particular field. They will also have information to be able to signpost the parent/carer to local organisations, support groups and carers services that may benefit both the parent/carer and the child or young person now and in the future.

Having a clear diagnosis means parents/carers will probably want to find out as much about the condition as they can. When researching online, it is important to look out for the Information Standard Mark, which confirms that the information is reliable.

As a setting it is important to be mindful that parents/carers will be on different pathways after a diagnosis; some may be in denial where as others may be fully accepting. All conversations should be dealt with in a sensitive manner and settings must use their own judgement about how to handle a situation based on the individual and the pathway that the family are on.

Health and education staff involved in the child or young person's care should be available to talk to parents/carers. Encouraging the writing down of questions or concerns is always helpful for families before meeting professionals. This helps in building trusted relationships with professionals who work closely with the child or young person in hospital, at home and in setting and can be a valuable source of support.

Many of the children and young people with significant and/or complex needs will be assigned a Special Needs Health Visitor who will support the family until they move into High School. Often these children or young people will transfer over to a worker from the Child Health and Disability Services.

If the child or young person needs regular healthcare treatment at home, the family may be supported by the Community Children's Nursing Service (CCNS). These nurses can also help with any treatment that needs to be carried out for the child or young person at home and are able to give advice to settings.

The child or young person may receive a 'continuing care package' if they have needs arising from disability, accident or illness that can't be met by existing specialist services alone. The package could include a range of services commissioned by the local authority. Once the child or young person is eligible for nursery and school placement these services will include education. This is regarded as a multi-disciplinary approach with agencies working together in the best interests of the child or young person. 'Team around the Child' (TAC) meetings convene regularly for child and young people with complex needs. It is important that settings are

invited, attend and participate in the discussions about what is working or not working from the perspective of education, and plans for the future.

There are a number of health outreach services which provide support and practical help/training for the families of children or young people diagnosed with a significant health need. These services will provide training and advice for setting about the individual needs of children or young people with these conditions. They will also either write or contribute to the Health Care Plan. Contact details for these specialist services can be found on page 60.

SECTION 2: Health Visiting Service

The Health and Social Wellbeing Strategy identifies the importance of improving health and well-being outcomes for children, particularly those children who are disadvantaged. The purpose of the Health Visiting Service is to improve the quality of life for children and families within Cardiff and the Vale of Glamorgan – adding not just years to life but, life to years.

The Health Visiting service will provide a universal service for all families with children under the age of 4 years. The service will consist of comprehensive health assessments resulting in service provision based on individual and local need and will support Cardiff and Vale University Health Board in meeting health improvement targets.

Health Visiting is predominately a preventative public health service based on the following principles:

- the search for health needs
- the stimulation of an awareness of health needs
- the influence on policies affecting health
- the facilitation of health enhancing activities.

All Health Visitors are qualified nurses, who go on to do additional specialist Health Visitor training.

All Health Visitors are Community based with some located in GP practices while others are based in UHB premises.

The Senior team is based at:

Health Visitor & Flying Start Headquarters

Lansdowne Site

Cardiff

CF11 8PL

Tel: 029 2093 2604 / 2952

Special Needs Health Visiting

The Special Needs Health Visitors act as key workers for children from birth until 11 years of age who have a severe learning disability and complex health and social care needs. The teams work closely with the child's paediatrician, GP, generic health visitor, therapists and other specialist teams. In addition, they have excellent multi-agency links with Child Health and Disability social workers, education and the voluntary sector.

The teams have received much recognition for their work with families of disabled children, not only within health but across all agencies. The caseloads that this group hold are high and this is increasingly challenging not only due to the increasing numbers of children referred but due to the increasing complexity of their health needs.

The SNHV Team is based at: St David's Children Centre. Tel: 029 2053 6789

School Nursing

The School Nursing Service offers support and advice to children, young people and their families or carers to help ensure that they reach their full potential during their school aged years and beyond.

The age range covered is 4 up to 18. Children and young people can access the service whether they attend school or not.

What does this service do/provide?

All School Nurses in the School Nursing Team are qualified nurses.

School Nurses become involved in the health and wellbeing needs of children once they become 4 years old taking over the care from the Health Visitor.

Advice and support can be offered for a wide range of issues:

- Promoting healthy lifestyles for primary setting aged children
- Promoting healthy lifestyles and lifestyle choices for adolescents and young adults hopefully with the aim of reducing risky behaviour
- Parental worries about their child
- Emotional health and well being
- Immunisations
- General advice about health conditions
- Helping to ensure that children and young people with complex health needs can access education
- Bedwetting and constipation
- Relationship difficulties
- The support of children and young people in need or at risk of harm
- Healthy growth and development

School Nurses carry out the Child Measurement Programme and a vision and hearing test for children in their first year of school. Immunisations in High School are also delivered by the School Nursing Service.

There is a School Nurse allocated to each high school in Cardiff. Generally the same nurse covers the primary schools that feed into that high school.

School Nurses are based in a variety of settings including hospitals, GP surgeries and Children's Centres.

School Nurses provide Drop In Clinics in high schools that young people can access independently whilst in school. If children or young people do not attend mainstream high schools they are still entitled to access the School Nurse that covers their area.

Parents and carers of children and young people can contact the School Nurse for their area.

SECTION 3: Self Esteem

In addition to the educational implications, there are social and emotional implications associated with medical conditions. Children and young people may be self-conscious about their condition and some may experience bullying, or develop emotional disorders such as anxiety or depression around their medical condition.

In particular, long term absences due to health problems can affect the child or young person's educational attainment, impact on their ability to integrate with their peers and affect their general well-being and emotional health. Reintegration back into setting should be properly supported so that the child or young person with medical conditions fully engages with learning and does not fall behind when they are unable to attend. Short term and frequent absences, including those for appointments connected with a child or young person's medical condition also need to be effectively managed and appropriate support put in place to limit the impact on the child or young person's educational attainment, emotional and general well-being.

Self Esteem and Learning:

- It is important not to make assumptions about strengths and weaknesses based on a child or young person's perceived difficulties
- Allow a degree of risk taking and support failures – we tend to shield children and young people with physical difficulties
- Give lots of varied experiences and opportunities
- Involve the child and young person in target setting and ask what they would like to improve and prioritise
- Don't try for perfection
- Praise carefully – unrealistic praise is demeaning and a child or young person will lose credibility with peers if they are overvalued – children and young people know!

Self Esteem and Friendship:

- Some children and young people may require a teaching assistant (TA) who is assigned for a certain number of hours a day to support physical and learning needs. Staff need to be sensitive to the implications and risks of this and be mindful that the TA does not become the total supporter, carer, advocate and best friend for the child. Children and young people need a variety of people in these roles the same as their peers
- No child or young person should have a TA 'velcroed' to their side during lessons – there should always be daily occasions when the TA physically moves away, allowing peers to interact and support each other.
- Buddy systems, talking partners and small group work can all help to facilitate friendships and increase the confidence of those children who may need encouragement to make friends.

Self Esteem and Wellbeing

- Children and young people with complex medical needs may lack confidence especially if their difficulties require them to be 'singled out' or miss parts of lessons.
- Quite often children and young people's needs are visible to others making other children nervous to approach. It will be especially important in these circumstances for awareness of the child's condition (within reason) to be shared between staff and other children to increase acceptance and inclusion.
- Children and young people who have complex physical/medical needs may find it difficult to join in with games in the playground and staff will need to be aware of these restrictions and provide fun alternatives/adaptations to allow children to feel included and part of the group.
- Increased absences and medical appointments may also mean that the child or young person is feeling anxious due to the other children having more established friendships or that they have missed important work in lessons and feel like they cannot keep up with the rest of the class. It will be important for setting to plan for any absences to make sure that the child has the opportunity to keep up with their work.

SECTION 4: Practice to avoid

Whilst these are guidelines, settings have a responsibility to ensure that the requirements of the **Equality Act** are fully met.

The **Equality Act** (2010)¹ states that:

- Disabled children or young people **must not** be subject to discrimination, harassment or victimisation because of their disability
- Reasonable adjustments **must be** made to ensure that they are not substantially disadvantaged compared to their peers
- This duty is anticipatory; adjustments **must be** planned and put in place in advance, to prevent that disadvantage

It is imperative that all reasonable steps are made to ensure that settings adhere to the **Equality Act**. A head teacher, with the support of their governing body should take responsibility to make informed decisions to ensure that this happens. Each case must be considered on an individual basis. This informed decision should make reference to the child's individual health care plan, risk assessment and advice from health/education professionals.

It is not acceptable for the following practice to occur in our Cardiff Settings/Schools.

Settings must not:

- Prevent child or young people from attending education or reduce hours due to their health care needs, unless this would be likely to cause harm to the child or young person or others.
- Prevent children or young people from easily accessing their inhalers, medication and administering of their medication when and where necessary (if they are self-medicating)
- Assume that every child with the same condition requires the same treatment
- Send children with medical conditions home frequently for reasons associated with their medical condition or prevent them from staying for normal setting activities, including lunch, unless this is specified in their individual health care plan or risk assessment
- Send a child that becomes ill to the setting office or medical room unaccompanied or with someone who is unaware of the child or young person's needs
- Penalise children or young people for their attendance record if their absences are related to their medical condition e.g. hospital appointments
- Prevent children or young people from drinking, eating or taking toilet or other breaks whenever they need to in order to manage their medical condition effectively
- Require parents, or otherwise make them feel obliged, to attend setting to administer medication or provide medical support to their child, including with toileting issues
- Prevent, or create unnecessary barriers for children or young people from participating in any aspect of setting life, including setting trips e.g. by requiring parents to accompany the child

All of the above are actions by settings which have been known to lead to challenges under the **Equality Act**.

¹ <http://www.legislation.gov.uk/ukpga/2010/15/contents>

PART 4

Quick Reference guide to common conditions

The knowledge and understanding of a condition is essential when planning to meet the needs of a child or young person with a medical condition.

There are a wide variety of conditions that settings may encounter, and medicine is advancing so quickly that new conditions and syndromes are being diagnosed on almost a daily basis. The medical conditions which are the most common cause for concern in settings are asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis).

This section provides some basic information about these conditions and others but it is beyond the scope of this document to provide more detailed medical advice. It is important that the needs of a child or young person are assessed on an individual basis, as the severity and possible implications of a particular condition can vary greatly between individuals.

QUICK REFERENCE GUIDE to Anaphylaxis

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

Common triggers include peanuts, tree nuts, sesame, eggs, cow's milk, fish, certain fruits, 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. This is rare among children below teenage years. Children and young people with this form will need to have access to their emergency medication (epi pen).

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.

Essential for settings:

- Epi pen training
- A Health Care Plan

Points to consider:

- Potential triggers
- Food and classroom activity/management (precautionary measures)
- Cross contamination of food/resources (playdoh)
- Location of emergency medication
- Liaison with the Education Catering Department

The City of Cardiff Council has an in house catering department, Education Catering (see Appendix 3:5), which delivers catering services to the majority of maintained and voluntary aided settings in Cardiff. In December 2014 the **Food Information for Consumers (Regulation (EU) 1169/2011)**¹ came into force obliging food manufacturers and caterers to make information on 14 allergens readily available to consumers. The Education Catering department manages compliance with the legislation on behalf of the settings it operates within by producing an allergen matrix for each of its primary, secondary setting and sixth form sectors. These matrices list all the food items produced and served onsite and highlight the 14 main allergens that may be present. The matrices are available from the Education Catering Section of the City of Cardiff Council website or the CIS system (reference 5.SC.CA438/9). See Appendix 3 for further details of legislation.

Further information can be found from:

The Anaphylaxis Campaign

www.anaphylaxis.org.uk

Allergy UK

www.allergyuk.org

Food Standards Agency

www.food.gov.uk

¹ <https://www.food.gov.uk/enforcement/regulation/fir>

QUICK REFERENCE GUIDE to Asthma

One in ten children or young people in the UK have Asthma. The most common symptoms of asthma are coughing, wheezing, and a whistling noise in the chest, a tight feeling in the chest or getting short of breath. Younger children may verbalise this by saying that their tummy hurts or that it feels like someone is sitting on their chest, and some children or young people may only get symptoms from time to time.

There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child will only need a reliever during the setting 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 outside of setting 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 too immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe place but readily accessible, and clearly marked with the child's name. For a child with severe asthma, the health care plan professional may prescribe a spare inhaler to be kept at setting.

Essential for settings:

- A Health Care Plan
- Training for staff in the use of inhalers/spacer devices
- An awareness of triggers and signs and symptoms of an asthma attack.
- All staff to be aware of the location of Emergency Medications

Points to consider:

- An 'Asthma Friendly' Environment in order to remove as many potential triggers as possible
- Children and young people with asthma should participate in all aspects of the setting day including physical activities. Inhalers should always be available during physical education, sports activities and educational visits.
- 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 medications before any physical exertion.
- Warm up activities are essential before any sudden activities especially in cold weather. Particular care may be necessary in cold or wet weather.
- A Risk Assessment should be considered

Further Information can be found from:

Asthma UK Cymru

www.asthma.org.uk

QUICK REFERENCE GUIDE to Brittle Bone Disease

It is difficult to estimate the amount of people in the UK with this condition as it cannot be identified by a single test. The best estimate would suggest that approximately 1 in every 15,000 people will have the condition.

It is known as Osteogenesis Imperfecta (OI) and is a disorder of the collagen which provides the framework for bone structure. This weakens the joints and makes them liable to fracture even without trauma. As the composition of the bone is not correct this puts further stress on the joints and muscle groups causing hypermobility and muscle fatigue. This can result in aches and pains and can compromise the quality of life for the child/young person. The severity of the condition can vary greatly.

Essential for settings:

- A Health Care Plan/ Fracture Management Plan
- A Risk Assessment

Points to consider:

- Gaps and loss of learning due to frequent absences. Children may need time off due to frequent fractures or health appointments/hospital stays and this will need to be planned ahead of time if possible with a plan in place for any missed work. Children should be encouraged to return to setting as soon as possible. Home schooling may be an option in extreme circumstances
- The possibility of hearing loss- this is a medical complication of OI which can occur at any time.
- The need for additional training /advice regarding manual handling at certain periods when children may be in plaster or recovering from a fracture
- The flow of people through high traffic areas during the setting day, children/young people may need to leave earlier or later to move around the setting safely
- The effect on drawing/writing skills. Children and young people tend to have lax joints which make it very difficult to sustain this activity to an acceptable standard. Alternative assisted technology may need to be considered as the child or young person progresses through the key stages
- Additional support during playtimes and unstructured hours due to the increased risk of fractures occurring
- The management of the condition during setting trips and physical activity

Further Information can be found from:

Brittle Bones Society

www.brittlebone.org.uk

This website has various downloadable factsheets giving information and advice for primary and secondary settings and ideas for including children in PE successfully.

QUICK REFERENCE GUIDE to Cerebral Palsy

Cerebral Palsy is damage to the brain either before, or during birth, or as a result of injury or infection during the early years. It is a non-progressive condition but functional ability may deteriorate over time. It leads to variable impairment of the co-ordination of muscle action, with a resulting inability to maintain 'normal' movements.

Some children or young people with cerebral palsy may be of average or above average cognitive ability, but this maybe masked by a physical impairment affecting mobility and co-ordination, speech, swallowing and sensory impairments such as vision and hearing difficulties. These can often be accompanied by epilepsy. The term 'cerebral palsy' covers a wide range of ability and need.

Spastic Cerebral Palsy – the muscles are stiff and difficult to control and there is a decreased range of movements in the joints. Within the definition there are 3 types of cerebral palsy:

- Hemiplegia – either the right or the left side of the body affected
- Diplegia – legs are affected, there may be some or no effect to the arms
- Quadriplegia – all four limbs affected

Frequent associated difficulties may include:

- Visual perceptual difficulties
- Spatial awareness/motor planning issues
- Epilepsy

Athetoid cerebral palsy – the muscles rapidly change from floppy to tense in an involuntary way. A child or young person finds movements hard to control, and it may take a great deal of effort to achieve any activity. Speech may be hard to understand due to difficulty controlling the tongue, vocal chords and breathing. There are also likely to be difficulties with eating and drinking.

Ataxic cerebral palsy – the child or young person may have unsteadiness of movement and poor balance, walking may be jerky, hands shaky and speech may be slow, spatial awareness maybe impaired.

Essential for setting:

- A Risk Assessment

Points to consider:

- More time between activities and lessons, and at meal times
- Alternative means of recording information (assistive technology)
- Ensure appropriate equipment are in place and are fully accessible to the child or young person
- Flexibility in uniform requirements to promote independence
- Visual perception for a child or young person in a wheelchair (at a lower level)
- Manual Handling Training is essential if the child or young person requires handling

Further information can be found from:

Bobath

www.bobathwales.org

QUICK REFERENCE GUIDE to Cystic Fibrosis

Cystic Fibrosis is a life-limiting inherited condition caused by a faulty gene that controls the movement of salt and water between cells. This causes mucus to gather in the lungs and digestive system. There is currently no cure for cystic fibrosis but the condition can be managed by physiotherapy and exercise, medication and nutrition. The severity of the condition varies greatly between children. People who have cystic fibrosis should not meet face to face as although bacteria is not harmful to people without the condition people may have bacteria which is harmful to each other

Lungs

People who have cystic fibrosis are susceptible to a range of infections and reduced lung function. Infections need to be treated with antibiotics and may mean that the child or young person may miss periods of education. In some cases a lung transplant is the only way to effectively manage the condition and will mean a long period of recovery away from setting and continued medications.

Digestive System

Mucus produced by the condition can block the ducts in the pancreas halting the flow of digestive enzymes. This can cause malnutrition, poor growth, physical weakness and delayed puberty. Children and young people may need to take enzyme supplements at mealtimes to help digestion and may require a high fat, high calorie diet.

Essential for settings

- A Health Care Plan
- A Risk Assessment
- Awareness training for staff
- Close liaison with medical professionals

Points to consider

- The child or young person may require a small amount of physiotherapy exercises to be carried out in setting
- The child or young person may require additional supervision at lunchtimes to ensure that supplements are taken and to try to encourage eating well
- Treatments for the condition need to be prioritised which may mean that children and young people have less time available to complete homework or coursework
- Children and young people should be encouraged to participate fully in PE lessons but must be mindful at times where the child is unwell or feeling unusually tired
- As adolescence approaches young people may struggle emotionally and may benefit from setting counselling

Further information can be found from:

NHS Direct

www.nhs.uk

The Cystic Fibrosis Trust

www.cysticfibrosis.org.uk

QUICK REFERENCE GUIDE to 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 or young person may experience different symptoms and this should be discussed when drawing up the health care plan. The majority of children and young people with this condition will require injections of insulin each day. Children or young people with diabetes need to ensure that their blood glucose levels remain stable. They may check their levels by taking a small sample of blood and using a monitor at regular intervals.

Staff should be aware that the following symptoms, either individually or combined may be indicative of low blood sugar- a hypoglycaemic reaction 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

Settings will need to have a plan in place to respond and all staff will need to be aware of how to manage this.

Essential for setting:

- A Health Care Plan
- Staff training when Insulin Injections are needed

Points to consider:

- Regularly breaks to monitor blood glucose, or to eat/drink
- Food and classroom activity/ management (precautionary measures)
- Location of emergency medication/ alternative foods
- A Risk Assessment should be considered

Further information can be found from:

Diabetes UK

www.diabetes.org.uk

JDRF

www.jdrf.org.uk/setting-resources

QUICK REFERENCE GUIDE to Restricted Growth (dwarfism)

Restricted growth, sometimes known as dwarfism, is a condition characterised by short stature, resulting from a medical condition causing slow growth. It can be caused by more than 300 distinct medical conditions such that the symptoms and characteristics of individuals with dwarfism vary greatly.

There are two types:

Disproportionate dwarfism is characterised by one or more body parts being relatively large or small in comparison to those of an average sized individual, with growth variations in specific areas being apparent. The trunk is usually of average size with limbs being proportionately shorter, the head usually larger and a prominent forehead. Orthopaedic problems can result in multiple conditions.

Proportionate dwarfism, the body appears normally proportioned, but is usually small. Height is significantly below average and there may be long periods without significant growth. Sexual development is often delayed or impaired into adulthood. In some cases intellectual disability may be part of proportionate dwarfism unlike disproportionate dwarfism.

Physical difficulties vary according to the specific underlying syndrome. Many involve joint pain caused by abnormal bone alignment or nerve compression that can cause pain and disability. Reduced thoracic size can restrict lung growth and reduce pulmonary function and some forms of dwarfism are associated with disordered function of other organs.

Mental effects also vary depending on specific underlying syndromes. In most cases such as achondroplasia mental function is not impaired. The social and emotional implications may be more disabling than the physical symptoms.

Essential for setting:

- A Risk Assessment

Points to consider:

- More time to move around setting between lessons /activities
- More time to complete tests/exams if manual dexterity is an issue
- A step (portable or permanent) in the bathrooms and at water fountains
- Modifications to the environment eg: lowered mirrors/ hand dryers
- Modified requirements for PE
- Emotional wellbeing, there may be an increased risk of bullying or children may be lacking in confidence to participate in setting life.

Further information can be found from:

Restricted Growth Association

www.restrictedgrowth.co.uk

QUICK REFERENCE GUIDE to 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 setting. Most children and young people with diagnosed epilepsy never have a seizure during the setting 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. Children with epilepsy may also experience behavioural changes. Parents and health care professional should provide information to settings, 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 setting/setting, details should be recorded and communicated to parents including any factors which might possibly have acted as a trigger to the seizure.

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 a child's head will help to protect it. Nothing should be placed in their mouth. After the 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
- The seizure lasts longer than is set out in the child's health care plan.
- A seizure lasts for 5 minutes
- If you do not know how long a seizure usually lasts for the child
- There are repeated seizures, unless this is usual for the child as set out in the child's health care plan.

Essential for setting:

- A Health Care Plan to include the location of emergency medication
- A Risk Assessment
- Training for Staff

Points to consider:

- Medication can affect alertness, attention and memory (tiredness)
- Information missed due to absences
- Individual triggers for seizures
- Identification of a quiet, safe, calm zone for recovery
- How to manage the other children in the classroom

Further Information can be obtained from

Epilepsy Wales

www.epilepsy-wales.org.uk

QUICK REFERENCE GUIDE to Haemophilia

Haemophilia is a genetic condition passed down through families. It affects the clotting factors in the blood and the body's ability to manage bleeding. A child or young person with haemophilia may bleed for longer than a person without the condition when injured.

Children or young people with severe haemophilia may also experience bleeding in the joints of the body and excessive bruising when injured. Most people who have haemophilia are boys due to the way that the condition is inherited.

The two most common types are Haemophilia A and Haemophilia B. Both have the same symptoms but are caused by different factors in the blood and have slightly different treatments. Haemophilia is a treatable condition and children born with the condition are likely to have a normal life expectancy and an excellent quality of life.

Treatments are usually in the form of preventative medications given by regular injections. Sometimes to minimise the need for continuous injections children/young people are given an implantable port which is placed surgically into a blood vessel and allows easy access for treatments. If this is the case there will be a specialist nurse involved who can provide staff with any information needed. Injections can usually be given outside of setting hours.

In mild and moderate cases treatment may only be needed on an on-demand basis in periods of injury/bleeding. Each child's case will be individual and advice can be sought from the child's doctors.

Minor cuts and scrapes/nose bleeds should be managed with normal first aid procedures and only are a cause for concern if bleeding continues for longer than is normal for that child. If staff are concerned then medical advice should be sought immediately.

Any physical trauma should be checked by a doctor.

Essential for settings:

- A Health Care Plan
- A Risk Assessment

Points to consider:

- Supervision and safety during high risk activities, contact sports in particular should be avoided
- Mobility issues due to pain or bleeding in joint
- The amount of staff who are First Aid trained, there may need to be more staff readily available to respond to emergencies particularly in a busy secondary setting.

Further information can be found from:

The Haemophilia Society

www.haemophiliawales.org

The Haemophilia Society

www.haemophilia.org.uk

NHS Choices

www.nhs.uk

QUICK REFERENCE GUIDE to Head injuries: Brain Injury, Meningitis, Brain tumour, Stroke

An Acquired Brain Injury (ABI) is an injury caused to the brain since birth. Injuries resulting from trauma are known as Traumatic Brain Injuries but an Acquired Brain Injury also covers situations such as tumours, strokes and encephalitis among others.

Children and young people who have a Traumatic Brain Injury may initially experience a period of unconsciousness and post traumatic amnesia. If unconsciousness lasts for 6 hours or more with post traumatic amnesia lasting for 24 hours or more, the injury is classed as severe and children /young people with these injuries may have long term physical needs and emotional and behavioural effects. These may include balance problems, headaches, dizziness, memory problems and difficulty controlling their emotions.

A stroke happens when the supply of blood to an area of brain tissue is interrupted either by a blood clot or a bleed in the brain. Children/young people who experience a stroke will experience different effects and severity according to which areas of the brain were starved of oxygen. Children will need a period of rehabilitation and recovery will be varied.

Brain Tumours are rare in children and the cause usually remains unknown. Children/young people will experience different treatments, the side effects of which can be very tiring, may cause the child to feel sick, may cause hair loss and throughout treatment the child will be at a greater risk of catching an infection. Children will not usually attend setting during treatments but the side effects can continue for some time afterwards and need to be planned for when children return to setting.

Meningitis is an infection of the protective membranes which surround the brain and spinal column. It can be life threatening if not treated quickly and can result in permanent damage to the brain or nerves. Symptoms can include: high temperature, vomiting, headache, blotchy rash that doesn't fade when a glass is rolled over it, dislike of bright lights, drowsiness and fits. Medical attention should be sought immediately.

Points to consider:

- Carefully planned re-integration to setting
- After effects of the conditions i.e. epilepsy, reduced stamina, short and long term memory problems, emotional and behavioural problems, physical difficulties
- Absences due to therapies or follow up appointments
- Training for staff if handling is required or if health care needs are present.
- A Risk Assessment and Health Care Plan will be necessary
- Robust liaison with the relevant health professionals and family will be of utmost importance

Further information can be obtained from:

Headway	www.headway.org.uk
SCOPE	www.scope.org.uk
NHS choices	www.nhs.uk

QUICK REFERENCE GUIDE to HIV positive

Human Immunodeficiency Virus damages or destroys cells in the immune system leaving them unable to fight infections and certain cancers. The most common route for infection is from mother to child during pregnancy, labour and delivery or breastfeeding and is spread through infected blood or body fluids. Other causes of infection may be through blood transfusions although due to extensive testing in western countries this has become more and more infrequent. More infrequently the virus can be spread through sexual abuse or sexual relationships and drug use using infected needles.

HIV usually leads onto AIDS (Auto Immune Deficiency Syndrome) but not all people who are HIV+ have AIDS.

HIV is managed by antiviral drug treatments intended to stop the virus becoming resistant to any one drug. Children may be taking a drug regime even if they are showing no symptoms as a preventative measure and to improve general health and long term survival.

Symptoms that may be seen are frequent childhood infections, failure to thrive and achieve developmental milestones, brain or nervous system problems characterised by seizures, difficulty walking or poor performance in setting.

Essential for setting:

- A Health Care Plan
- A Risk Assessment
- Clear procedures and policy for managing first aid incidences in particular dealing with any bleeding

Points to consider:

- Staff awareness of the condition
- How to manage any incidences of bleeding
- Self Esteem and confidence may be affected due to any stigmas surrounding the condition or lack of awareness of other children and young people.
- Children and Young people have the right to have their status kept confidential
- Family bereavement may be more common as it is likely that caregivers are infected too.

Further information can be found from:

WebMD

www.webmd.com

NHS Choices

www.nhs.org.uk

AVERTing HIV and AIDS, Global Information and advice

www.avert.org

QUICK REFERENCE GUIDE to Juvenile Arthritis

“Arthritis is caused by inflammation of the joints. It causes pain, swelling stiffness and loss of motion. Juvenile arthritis is the term used to describe arthritis in children. The most common type that children get is juvenile idiopathic arthritis (from unknown causes)” (www.niams.nih.gov)

Children with this condition may complain of pain in situations where it would not normally be expected such as on waking and this may lessen throughout the day. Joints in the hands, feet, neck or jaw may be painful. Children may also experience stiff joints and may struggle to perform normal movements and activities. They may complain that a joint feels hot, which is a sign of inflammation. Children may also experience fevers that can be at any time and are very transient in nature. Children may also experience weight loss. It can also cause sleep disturbances so at times children and young people may be very tired during the day and struggle to concentrate.

Flare ups in the condition can occur due to infections, in times of stress or due to changes in medication.

Other forms of the condition are Juvenile Lupus, (an auto-immune disease which affects the joints, skin, kidneys, blood and other areas of the body) Juvenile Scleroderma, (a condition which causes the skin to tighten and harden) and Fibromyalgia (causes stiffness and aching, along with fatigue and other disrupted sleep).

Essential for settings:

- A Risk Assessment
- If medication is required for pain relief a Health Care Plan will be needed

Points to consider:

- Fluctuating condition will have good days and bad days where fatigue is overwhelming
- Depleted energy levels resulting in lack of motivation
- Reduced self-care skills, children and young people may need extra time to dress and undress
- Regular breaks and places to rest, children and young people may need extra time to move between lessons
- Alternative means of recording information (assistive technology) or more chunky implements for writing and mark making
- Children may need regular prescribed medication throughout the setting day to manage pain and the condition
- PE lessons may need to be adapted to include more low impact sports and activities

Further Information can be found from:

Arthritis Care	www.arthritiscare.org.uk
Children’s Chronic Arthritis Association	www.ccaa.org.uk
Kids get arthritis too	www.kidsgetarthritisoo.org
Arthritis Foundation	www.arthritis.org

QUICK REFERENCE GUIDE to ME/CFS (Chronic Fatigue Syndrome)

Chronic Fatigue Syndrome causes persistent fatigue (exhaustion) that affects everyday life and doesn't go away with sleep or rest. It is also known as ME (myalgic encephalomyelitis).

This usually occurs following a viral infection and is characterised by persistent fatigue and muscle pain. The fatigue is made worse by even minimal physical and mental exertion and there is a prolonged recovery period. There is no specific treatment for the condition but the condition is managed by drug therapy for pain, and a slow programme of graded activities to build up stamina. A hormone imbalance can also cause the condition or problems within the immune system. Stress and emotional trauma is also thought to be a consideration. It is a serious condition that can cause long term illnesses and disability but for most people, in particular children and young people, it will improve over time.

There are varying degrees of severity:

- Mild - People are able to carry out their daily activities but may need to take days off to rest
- Moderate - People may experience reduced mobility, sleep disturbances and may need rest in the afternoons on a daily basis
- Severe - People struggle to carry out simple daily tasks and may have difficulty concentrating. Some people may be unable to leave their house

It usually affects people in their early 20's but can develop in young people as young as 13.

Essential for setting:

- Risk Assessment
- If medication is needed a Health Care Plan will be required
- A plan in place to address any absences and missed work
- Training for staff in Manual Handling if the child/young person is a wheelchair user

Points to consider:

- Regular breaks and places to rest
- Opportunities to revisit and consolidate skills
- Learning may be affected due to poor concentration levels
- Depression due to a restricted social life and isolation
- Flexible timetable
- Consideration of home tutoring when necessary
- Staff awareness of the condition so that symptoms are understood and responded to appropriately
- Physical exercise will cause an increase in the symptoms in the hours that follow

Further information is available from:

NHS Choices

www.nhs.org.uk

ME Association

www.meassociation.org.uk

Association of Young People with ME

www.ayme.org.uk (Education factsheet-England)

QUICK REFERENCE GUIDE to Muscular Dystrophy

Muscular Dystrophy is a group of progressive neuromuscular disorders. It is caused by a faulty gene so can be inherited although the fault can be spontaneous. There are different types depending on where the fault lies on the gene. The term 'dystrophy' refers to a progressive weakness of the muscles due to the breakdown of the muscle fibre. Some conditions are life limiting and others are milder.

Main types of Muscular Dystrophy

Duchenne (this is the most common and severe) – This condition mainly affects boys and is diagnosed when the child or young person is still young and begins to have difficulty with mobility. Between ages 6 – 11 mobility will start to deteriorate, and in their teens they will experience problems with respiratory muscles affecting breathing. Life expectancy is shortened. Children and young people with this condition may need a wheelchair by the time they are 8-14 years old. Gross motor skills are mainly affected but during the teenage years the heart muscles may become affected and children and young people may need regular medical appointments.

Becker – This is very similar to Duchenne's but is a milder form of dystrophy which progresses at a slower rate, also affecting boys. Symptoms usually start in the teenage years.

Myotonic – This type mainly affects the smaller muscles first including those in the face, jaw and neck. As well as this, people can experience muscle stiffness, excessive sleepiness, difficulty swallowing and learning and behavioural difficulties in children.

Essential for setting:

- A Risk Assessment
- Training for staff in Manual Handling
- An awareness of the progression of the condition so changes can be monitored.

Points to consider:

- Appropriate accessibility arrangements during lessons and outside
- Low stamina and physical fatigue
- Susceptibility to changes in temperature
- Eating and swallowing difficulties
- Alternative arrangements for recording information
- Assistance with toileting and self-care (this may increase as the condition progresses)

Further information can be found from:

Muscular Dystrophy

www.muscular dystrophyuk.org

NHS Choices

www.nhs.uk

KidsHealth

www.kidshealth.org

QUICK REFERENCE GUIDE to Neurofibromatosis

Neurofibromatosis is a group of genetic conditions which affect the nervous system and the skin. Although the condition is genetic, it is not always passed through families, as the genetic mutation can occur spontaneously. It occurs in all races and between males and females.

NF1 - This is more common and varies widely in its severity. This type causes pale coffee coloured patches on the skin and small, soft, non-cancerous bumps on or under the skin. Children and young people may be easily distracted and be restless and fidgety. They may have a poor short term memory and struggle to recall things that have just been learnt. They may forget homework tasks and need frequent reminders to do things. Their co-ordination may be affected and they may be clumsy and accident prone. They may have difficulty transferring skills and processing tasks. They may misinterpret facial cues and may not understand social rules and may seem immature for their years preferring the company of younger children to their peers.

NF2 - This type is far less common. Symptoms usually occur in the teenage years and usually begin with gradual hearing loss, tinnitus and unsteadiness, particularly when walking on uneven ground or in the dark. This is due to benign tumours which grow on the hearing nerves. Over time these tumours are likely to cause deafness. The tumours are very slow growing and may not cause issues for many years.

In addition to this tumours may also grow on other parts of the nervous system such as the lining of the brain, the spine and the skin. Although they are not cancerous the position and size of the tumours can be a problem.

Schwannomatosis - This is very similar to that of NF2 but with the absence of the vestibular (hearing nerve) tumours. Symptoms only start to appear in adulthood although the mutation in the gene is present from birth.

Essential for settings:

- A risk assessment
- An awareness of the characteristics of the condition so that difficulties are not misinterpreted
- Training for staff if difficulties affect children and young people's mobility

Points to consider:

- Safety and accessibility to equipment and areas of the setting.
- Adjustments to allow for progressive hearing loss, liaison with specialist teams
- Strategies to address the learning difficulties that may be present, these will benefit all children
- Wellbeing and self-esteem if tumours are visible
- Children and young people may require careful monitoring to ensure any changes are noted and passed on to parents and medics

Further information can be found from:

The Childrens' Tumour Foundation

www.ctf.org.uk

The Neuro Foundation

www.nfauk.org

QUICK REFERENCE GUIDE to Sickle Cell Anaemia/disorder

This disorder affects the red blood cells which contain a special protein called haemoglobin (Hb). The function of haemoglobin is to carry oxygen from the lungs to all parts of the body. It is an inherited condition from both parents. If the gene is inherited from one parent then the Child or young person will be a sickle cell carrier and have enough normal shaped cells to carry out daily living activities. They do however need to be cautious when doing activities where there is less oxygen.

Children and young people with sickle cell disorders have haemoglobin which is a different shape to normal haemoglobin. This occurs when the blood cells gives up it's oxygen to the tissues of the body it sticks together causing the haemoglobin to have a sickle shape.

This means that because of their shape they cannot squeeze through small blood vessels and this stops the oxygen from getting to certain parts of the body. This in turn can lead to severe pain and damage to organs. When this occurs it is called a Crisis and hospital treatment may be required. Sickle cells do not live as well as normal shaped cells and therefore this causes a constant state of anaemia.

Complications can include jaundice, crisis within the chest area which can cause breathing difficulties, stroke, priapism (painful, persistent erection-this needs medical attention if it continues longer than 2 hours) and bedwetting even into teenage years.

It is more common in children of African and Caribbean descent and those from the Eastern Mediterranean, Middle East and Asia. Children are usually diagnosed in pregnancy or through family history.

Essential for Settings

- A Health Care Plan
- Awareness Training for Staff

Points to consider

- Settings need to be aware that the following things can increase the risk of a crisis:
 - Exercise which over exerts the child or is in cold weather
 - Stress
 - Infections
 - Not enough water to drink -children and young people will need to be encouraged to drink sufficient amounts of fluids to keep the cells moving and free access to the toilet.
- Children may need painkillers and regular medications
- Children may be embarrassed if they are having bedwetting episodes or episodes of priapism.
- Children may experience frequent absences from setting due to treatment during crisis and will need a plan in place to keep up with their school work.

Further information can be found from:

The Sickle Cell Society

www.sicklecellsociety.org.uk

This website contains information booklets aimed at children aged 5-10 and 11-16 and an information guide for settings.

QUICK REFERENCE GUIDE to Spina Bifida

This condition is a fault in the spinal column in which the neural tube fails to form correctly around the spine and a section of the vertebrae is also affected. This leaves a gap in which the spinal cord is exposed. There are 3 main types of spina bifida and an associated condition is often hydrocephalus (excess cerebral fluid).

Spina Bifida Cystica- This is characterised by a cyst on the back, rather like a large blister covered by a thin layer of skin. Myelomeningocele is the most serious and most common form of this type of spina bifida. The spinal cord is damaged and not properly developed so, as a result, there is always some paralysis and loss of sensation below the damaged region. Bladder and bowel problems occur in most people with this type and they may require interventions to maintain function. Menigocele is less severe and in this type the sac only contains meninges which are the tissues that cover the brain and spinal cord and cerebro-spinal fluid.

Spina Bifida Occulta – This is a mild form of spina bifida estimated to occur in 5-10% of the population and is only usually identified when being x-rayed for an unrelated problem.

Hydrocephalus - This condition is where there is additional fluid around the brain which can cause pressure on the brain. It is common in children and young people with Spina Bifida due to the imbalance in the nervous system from the lesion in the spine, but can also be present for other reasons and can occur during pregnancy or after birth.

In order to avoid damaging the brain from a build up of fluid, children and young people with hydrocephalus usually have a **Shunt** fitted. This is a tube that is sited in the brain to allow the fluid to drain away. Shunt Alert Cards are available from Shine Charity.

Essential for setting:

- A Health Care Plan
- A Risk Assessment
- Training for staff in carrying out any medical procedures
- Staff awareness training if the child has a Shunt in situ.

Points to consider:

- Safety and accessibility to equipment and areas of the setting
- Alternative seating or places to sit during lessons
- Assistance with continence and personal care

Further information can be found from:

The Shine Charity

www.shinecharity.org.uk

Contact List

Specialist Area (Health	Team	Telephone
Asthma, Eczema & Allergies	Paediatric Allergy, Asthma & Eczema Service	029 2071 5580
Haemophilia	Paediatric Clinical Nurse Specialist	029 2074 3403
Respiratory	Paediatric Respiratory Team	029 2074 2116
Cardiac Conditions	Paediatric Nurse Specialist	029 2074 5184
Sickle Cell, Thalassaemia	Paediatric Haematology UHW	029 2047 1055
Epilepsy	Children's Epilepsy Nurse	029 2074 3460
Diabetes	Paediatric Specialist Team	029 2074 5435
Oncology	Oncology Outreach Team	029 2074 5026
Renal Failure	Renal Team UHW	029 2074 4844
Continence	Continence Specialist Nurse	029 2074 4627
CCNS	Children's Community Nursing Service	029 2071 6617
VP Shunts	SHINE	029 20752922/ 20748268
Gastrostomy	Children's Community Nutrition Nurse	07970614530
Tracheotomy/ Suction	Children's Community Nursing Service	029 2071 6617
Colostomy	Children's Stoma Nurse	029 2074 4627
Catheterisation	Childrens Incontinence Nurse	029 2074 4627
Stomas OR Nurse	Stoma Outreach Nursing service	07966977915
Endocrine Nurse	Specialist Endocrine Nurse	029 2074 3478
School Nursing Service		2046 2160/ 2093 2604
Acute Team		029 2074 8392
Team (Education)		Telephone
Education Catering Department		029 2233 0924
Disability Team (including Manual Handling)		029 2067 1479/ 1466
Health & Safety Department		029 2087 3714
Risk and Insurance Management		029 20 87 2287

SECTION 5

Appendices

Appendix 1:	Form 1	Contacting Emergency Services*
	Form 2	Individual Health Care Plan*
	Form 3A	Parental agreement for setting/setting to administer medicine*
	Form 3B	Parental agreement for setting/setting to administer medicine*
	Form 4	Head teacher/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*
	Form 10	Risk Assessment

Appendix 2:	2:1	Information gathering questionnaire
	2:2	Template for Personal Emergency Evacuation Plan (PEEP)
	2:3	Sample Personal Emergency Evacuation Plan (PEEP)

Appendix 3:	3:1	Outline of Legal Framework
	3:2	Useful relevant legislation for England and Wales
	3:3	Useful relevant legislation specific to Wales
	3:4	Food allergy legislation
	3:5	Education Catering

*These forms are downloadable as Word documents, so that it is possible to personalise for a particular school or setting, from Access to Education and Support for Children and Young People with Medical Needs May 2010 Guidance Circular

Appendix 3:1

Outline of legal framework

There are various duties on schools and local authorities which are relevant to safeguarding the welfare of children and young people with healthcare needs in the educational context. The main provisions are outlined below.

This is not an exhaustive list of the law relevant to this subject. Nor is it an authoritative statement or description of the law, which only courts can give. The descriptions below are summaries of the main relevant provisions. For any particular duty, there will be further statutory provisions and there may be case law (and possibly such developments after the issue of this guidance), affecting the meaning of the provisions (e.g. defining terms), or how a function is to be exercised (e.g. matters to which the person exercising the function must have regard). It should not be relied upon as a substitute for seeking legal advice or reading the actual provisions. Legislation can be found at www.legislation.gov.uk though it is not all in revised and up to date form.

General

As part of the common law, those responsible for the care and supervision of children and young people, including teachers, and other staff in charge of children, owe a duty of care to act as any reasonably prudent parent would in relation to their own children.

A person without parental responsibility for a child or young person, but with the care of that child, may do what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare. This is subject, for example, to a court order prohibiting certain steps being taken in relation to that child or young person without the Court's consent (**Section 3(5) of the Children Act, 1989**)¹.

Statutory duties on governing bodies of maintained schools

- In discharging their functions relating to the conduct of the school, governing bodies of maintained schools (including maintained nursery schools) must promote the well-being of pupils at the school (**Section 21(5) of the Education Act, 2002**)².
- Governing bodies of maintained schools (including maintained nursery schools) must make arrangements for ensuring that their functions relating to the conduct of the school are exercised with a view to safeguarding and promoting the welfare of children and young people (i.e. those under 18) who are pupils at the school (**Section 175(2) of the Education Act, 2002**). In considering what arrangements are required, the governing body is to have regard to any guidance by the Welsh ministers³ (**Section 175(4) of the Education Act, 2002**). Governing bodies are also subject to duties under the **Equality Act, 2010**⁴ – see the section below for more details.

¹ **Children Act, 1989** - <http://www.legislation.gov.uk/ukpga/1989/41/contents/enacted>

² **Education Act, 2002** - <http://www.legislation.gov.uk/ukpga/2002/32/contents>

³ This power is now vested in the Welsh Ministers, rather than the National Assembly for Wales, by virtue of paragraph 30 of Schedule 11 to the **Government of Wales Act, 2006** - <http://www.legislation.gov.uk/ukpga/2006/32/contents>

⁴ **Equality Act, 2010** - <http://www.legislation.gov.uk/ukpga/2010/15/contents>

Statutory duties on local authorities

- Local authorities have general functions in relation to providing education for their area (*in particular sections 13 to 14, 15A, 15B of the **Education Act, 1996***)¹.
- A local authority must make arrangements for the provision of suitable education (at school or otherwise), for children of compulsory school age who may now otherwise receive it for any period due to illness, exclusion from school or otherwise (*Section 19(1) of the **Education Act, 1996***). For young persons (i.e. those who are over compulsory school age but under the age of 18), local authorities have a power (rather than a duty), to make such arrangements in those circumstances (*Section (4) of the **Education Act, 1996***). In determining what arrangements to make under *Section 19(1) or 19(4)*, in the case of any child or young person, the local authority must have regard to any guidance given by the Welsh ministers.
- A local authority must make arrangements for ensuring that their education functions are exercised with a view to safeguarding and promoting the welfare of children and young people (i.e. under 18 years old), (*Section 175(1) of the **Education Act, 2002***).

In considering what arrangements are required, the local authority is to have regard to any guidance given by the Welsh Ministers (see footnote 3 on previous page), (*Section 175 (4) of the **Education Act, 2002***). Some of this guidance is issued under *Section 175(4)* –it is marked in bold font.

- Local authorities have general duty to safeguard and promote the welfare of children and young people in need within their area (and so far as consistent with that, to promote the upbringing of those children by their families) by providing a range and level of services appropriate to those children's needs (*Section 17 of the **Children Act 1989***).
- Local authorities must make arrangements to promote cooperation between various persons and bodies, including a local health board for an area within the local authority's area and an NHS Trust providing services in the area. The arrangements are to be made with a view to:
 - Improving the well-being of children and young people within the area;
 - Improving the quality of care and support for children and young people provided in the area (when amendments made by the **Social Services and Well-Being (Wales) Act, 2014** come into force)².
 - Protecting children and young people who are experiencing or at risk of, abuse and other harm (when those amendments come into force), (*Section 25 of the **Children Act, 2004***)³.
- **The Education (School Premises) Regulations, 1999, S.I. 1999/2**⁴ set out requirements (for which local authorities are responsible) regarding facilities at maintained schools. These include requirements regarding accommodation for medical examination and treatment of pupils and the care of sick or injured pupils (*Regulation 5*).
- Local authorities also have duties under the **Equality Act, 2010** – see below.

The Equality Act, 2010

¹ **Education Act, 1996** - <http://www.legislation.gov.uk/ukpga/1996/56/contents>

² **Social Services and Well-Being (Wales) Act, 2014** - <http://www.legislation.gov.uk/anaw/2014/4/contents/enacted>

³ **Children Act, 2004** - <http://www.legislation.gov.uk/ukpga/2004/31/contents>

⁴ **Education (School Premises) Regulations, 1999, S.I. 1999/2** - <http://www.legislation.gov.uk/uksi/1999/2/contents/made>

Disability is a protected characteristic under the **Equality Act, 2010**¹. Some learners with healthcare needs may be disabled for the purposes of that Act; others may not be. There are various duties under the **Equality Act, 2010** which are relevant in the context of learners with healthcare needs who are disabled.

The responsible body of a school must not discriminate, harass nor victimise disabled pupils and in some cases, other particular persons. The responsible body is also subject to a duty to make reasonable adjustments (*Section 85 of the Equality Act, 2010*).

Local authorities must prepare and implement an accessibility strategy in relation to schools for which they are the responsible body. This is a strategy for (over a particular period):

- a) Increasing the extent to which disabled pupils can participate in the schools' curriculums;
- b) Improving the physical environment of the schools for the purpose of increasing the extent to which disabled pupils are able to take advantage of education and benefits, facilities or services provided or offered by the schools;
- c) Improving the delivery to disabled pupils of information which is readily accessible to pupils who are not disabled (*paragraph 1 of Schedule 10 to the Equality Act, 2010*).

The responsible body of a school must prepare and implement an accessibility plan. Such a plan involves the same content as an accessibility strategy except that it relates to the particular school (*Paragraph 3 of Schedule 10 to the Equality Act, 2010*).

In relation to a maintained school and maintained nursery, the responsible body is the local authority or the governing body. In relation to a pupil referral unit, it is the local authority.

Local authorities and the governing body of local authority maintained educational establishments (e.g. maintained schools) are subject to the public sector equality duty. This requires them, in the exercise of their functions, to have due regard to particular matters related to equality (*Section 149*). They are also under specific duties for the purpose of enabling better performance of the public sector equality duty (**Equality Act, 2010, (Statutory Duties) (Wales) Regulations, 2011 S.I. 2011/1064**).

Other relevant provisions

The **Learner Travel (Wales) Measure, 2008**² places duties on local authorities and governing bodies in relation to home-school transport.

The **Data Protection Act, 1998**³ regulates the processing of personal data, which includes the holding and disclosure of it.

The **Misuse of Drugs Act, 1971**⁴ and regulations made, deal with restrictions (for example, concerned with supply and possession), on drugs which are controlled. Learners may be prescribed controlled drugs.

Appendix 3:2

¹ **Equality Act, 2010** - <http://www.legislation.gov.uk/ukpga/2010/15/contents>

² **Learner Travel (Wales) Measure, 2008** - <http://www.legislation.gov.uk/mwa/2008/2/contents>

³ **Data Protection Act, 1998** - <http://www.legislation.gov.uk/ukpga/1998/29/contents>

⁴ **Misuse of Drugs Act, 1971** - <http://www.legislation.gov.uk/ukpga/1971/38/contents>

Useful relevant legislation for England and Wales

The legislation listed below can be referred to clarify the main provisions relevant to children and young people with healthcare needs.

- ❖ **Children and Families Act, 2014 (Section 100)**¹ - places a duty on governing bodies of maintained schools, proprietors of academies and management committees of PRUs to make arrangements for supporting pupils at their school with medical conditions.
- ❖ **Section 21 of the Education Act, 2002**² – provides that governing bodies of maintained schools must, in discharging their functions in relation to the conduct of the school, promote the wellbeing of pupils at the school.
- ❖ **Section 175 of the Education Act, 2002** – provides that governing bodies of maintained schools must make arrangements for ensuring that their functions relating to the conduct of the school are exercised with a view to safeguarding and promoting the welfare of children who are pupils at the school. Paragraph 7 of Schedule 1 to the Independent School Standards (England) Regulations 2010 set this out in relation to academy schools and alternative provision academies.
- ❖ **Section 3 of the Children Act, 1989**³ – provides a duty on a person with the care of a child (who does not have parental responsibility for the child) to do all that is reasonable in all the circumstances for the purposes of safeguarding or promoting the welfare of the child.
- ❖ **Section 17 of the Children Act, 1989** – gives local authorities a general duty to safeguard and promote the welfare of children in need in their area.
- ❖ **Section 10 of the Children Act, 2004**⁴ – provides that the local authority must make arrangements to promote cooperation between the authority and relevant partners (including the governing body of a maintained school, the proprietor of an academy, clinical commissioning groups and the NHS Commissioning Board, with a view to improving the wellbeing of children, including their physical and mental health, protection from harm and neglect, and education. Relevant partners are under a duty to cooperate in the making of these arrangements.
- ❖ **Equality Act, 2010**⁵ – the key elements are as follows:
 - They **must not** discriminate against, harass or victimise disabled children and young people
 - They **must** make reasonable adjustments to ensure that disabled children and young people are not at a substantial disadvantage compared with their peers. This duty is anticipatory: adjustments must be planned and put in place in advance, to prevent that disadvantage
- ❖ **Education Act, 1996, Chapter 1 (Special Educational Needs)**⁶
- ❖ **Care Standard Act, 2000**⁷
- ❖ **Health and Safety at Work Act, 1974, Section 2**⁸ - and the associated regulations, provides that it is the duty of the employer (local authority, governing body or academy trust) to take reasonable steps to ensure that staff and pupils are not exposed to risks to their health and safety.

¹ <http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted>

² <http://www.legislation.gov.uk/ukpga/2002/32/contents>

³ <http://www.legislation.gov.uk/ukpga/1989/41/contents>

⁴ <http://www.legislation.gov.uk/ukpga/2004/31/contents>

⁵ <http://www.legislation.gov.uk/ukpga/2010/15/contents>

⁶ <http://www.legislation.gov.uk/ukpga/1996/56/part/IV>

⁷ <http://www.legislation.gov.uk/ukpga/2000/14/contents>

⁸ <http://www.legislation.gov.uk/ukpga/1974/37/section/2>

- ❖ **Misuse of Drugs Act, 1971¹** – and associated regulations the supply, administration; possession and storage of certain drugs are controlled. Schools may have a child who has been prescribed a controlled drug.
- ❖ **Medicines Act, 1968²** – specifies the way that medicines are prescribed, supplied and administered within UK and places restrictions on dealings with medicinal products, including their administration.

Other relevant legislation

- ❖ **Every Child Matters, 2003³**
- ❖ **UN Convention on the Rights of the Child, 1989⁴**
- ❖ **Management of Health and Safety at Work Regulations, 1999⁵**
- ❖ **Control of Substances Hazardous to Health Regulations, 2002⁶**
- ❖ **The Regulatory Reform (fire safety) Order, 2005⁷**
- ❖ **Chronically Sick and Disabled Persons Act, 1970⁸**

¹ <http://www.legislation.gov.uk/ukpga/1971/38/contents>

² <http://www.legislation.gov.uk/ukpga/1968/67>

³ <https://www.education.gov.uk/consultations/downloadableDocs/EveryChildMatters.pdf>

⁴ http://www.unicef.org.uk/Documents/Publication-pdfs/UNCRC_PRESS200910web.pdf

⁵ <http://www.legislation.gov.uk/uksi/1999/3242/regulation/1/made>

⁶ <http://www.legislation.gov.uk/uksi/2002/2677/contents/made>

⁷ <http://www.legislation.gov.uk/uksi/2005/1541/contents/made>

⁸ <http://www.legislation.gov.uk/ukpga/1970/44/contents/enacted>

Appendix 3:3

Useful relevant legislation specific to Wales

Below are some references/acts/legislations relevant specifically to Wales:

- ❖ **Special Educational Needs Code of Practice, 2002¹**
- ❖ **Welsh Government Guidance, 2010² - Access to Education and Support for Children Young People with Medical Needs**
- ❖ **Children and Young People’s Continuing Care Guidance, (Welsh Government), 2012³**
- ❖ **Continuing NHS Healthcare: The National Framework for Implementation in Wales, (Welsh Government), 2014⁴**
- ❖ **Safeguarding Children – Working together under the Children’s Act 2004, April 2007⁵**
- ❖ **The Food Information (Wales) Regulations 2014⁶ came into operation on 19 September 2014 and enables local authorities in Wales to enforce the European Food Information to Consumers Regulation No 1169/2011 (FIC)**

Useful relevant documents specific to Cardiff

- ❖ **Handwriting Motorway, 2013⁷**
- ❖ **Toilet Training – A Resource Pack, 3rd Edition, 2013**
- ❖ **Excellent Practice in Managing Inclusion – The Expectation of Mainstream Schools, 2012**

¹ <http://www.legislation.gov.uk/wsi/2002/156/contents/made>

² <http://gov.wales/docs/dcells/publications/100603medguideanceen.pdf>

³ <http://gov.wales/docs/phhs/publications/121127careen.pdf>

⁴ <http://gov.wales/docs/dhss/publications/140630frameworken.pdf>

⁵ <http://gov.wales/pubs/circulars/2007/nafwc1207en.pdf?lang=en>

⁶ http://www.legislation.gov.uk/uksi/2014/1855/pdfs/uksi_20141855_en.pdf

⁷ <http://www.nhswalesawards.wales.nhs.uk/sitesplus/documents/1086/Handwriting%20Motorway.pdf>

Appendix 3:4

Food allergy legislation

On 13th December 2014 the **Food information for Consumers Regulation (Regulation (EU) No 1169/2011)**¹ came into force obliging food manufacturers and caterers to make information on 14 allergens readily available to consumers. The 14 main allergens stipulated in the legislation are:

- Cereals (containing gluten)
- Crustaceans
- Eggs (and all derivatives)
- Fish
- Peanuts
- Soybeans (and all derivatives)
- Milk (and all derivatives)
- Nuts (typically almonds, hazelnuts, brazil nuts, macadamia, walnuts, pecan nuts, pistachio nuts and cashew)
- Celery (and all derivatives)
- Mustard
- Sesame
- Sulphur dioxide
- Lupin
- Molluscs

Food manufacturers must display any allergen within their food stuff by highlighting it in **bold**, putting it in *italics*, or highlighting the allergen in a distinctive colour within the ingredients list on the packaging. In this way, consumers can easily identify the allergen contained in the foodstuff and make informed decisions based on their personal circumstances.

Caterers/catering companies must make available details on the 14 listed allergens to consumers which are contained in the foodstuffs that they produce on site, which are not packaged. This information can be provided in a variety of ways and the individual caterer/company can choose as to how they relay this information; either in written or verbal formats, or both. However, signposting must be provided in order to direct the consumer to where they can obtain this information. Again, this will allow consumers to make informed decisions based on their personal circumstances.

Further information can be found on this from the Food Standards Agency website <https://www.food.gov.uk/business-industry/allergy-guide>

¹ <https://www.food.gov.uk/enforcement/regulation/fir>

Appendix 3:5

Education Catering

The City of Cardiff Council has an in house catering department, Education Catering, which delivers catering services to the majority of the maintained and voluntary aided schools in Cardiff, with the exception of Greenhill School, Cardiff High School and Bishop of Llandaff High School (as from 6th June, 2016).

As commercial caterers, Education Catering must comply with Regulation (EU) 1169/2011. Education Catering manages compliance with the legislation on behalf of the schools it operates within by producing an allergen matrix for each of its primary school, secondary school and sixth form sectors. These matrices list all the food items produced and served onsite and highlight the 14 main allergens that may be present. These matrices are available at a variety of touch points; each school administration team has been provided with a copy and every kitchen management team also has a copy. Parents may contact the school directly to obtain the information contained on the matrices and pupils may ask both the school and kitchen management teams directly to obtain the information. The matrices are also available from the Education Catering section of the City of Cardiff Council website:

www.cardiff.gov.uk/ENG/resident/Schools-and-learning/schools/school-catering-services/pages/default.aspx

Education Catering also has a process in place in partnership with Cardiff and the Vale UHB Community Dietitians to potentially provide a “therapeutic” diet to a pupil of a Cardiff school that has been assessed by a Community Dietician as having a specific dietary requirement. Further information on this process can be found through contacting Jackie Bennett (Area Catering Manager) at the Education Catering department on 029 2233 0924 or alternatively emailing at jbennett@cardiff.gov.uk