Department
for Education

Supporting children and young people with medical conditions and allergy

Draft statutory guidance for governing bodies of maintained schools and proprietors of academies in England

March 2026

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Summary

This document is a draft of statutory guidance issued under section 100 of the Children and Families Act 2014 setting out how LA-maintained schools, Academies and PRUs should fulfil their statutory duty to make arrangements for supporting pupils with medical conditions and allergies.

This draft has been issued for consultation. It is intended to replace the current statutory guidance on Supporting pupils with medical conditions at school, published in December 2015.

When published following consultation, the governing bodies of maintained schools, proprietors of academies and management committees of pupil referral units (PRUs) must “have regard to” this guidance when carrying out their statutory duty to make arrangements to support pupils at school with medical conditions. The guidance also applies to activities taking place off-site as part of normal educational activities.

To “have regard to” means to take account of the guidance and to carefully consider it. Having done so, there would need to be a good reason to justify not complying with it. Further advice, where provided, is based on good practice but is non-statutory.

Early years settings and schools which offer provision for “young children” (from birth until the 1st of September following their fifth birthday) should continue to apply the Statutory Framework for the Early Years Foundation Stage.

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Who this publication is for

This is **statutory** guidance for the following education providers (i.e. they must “have regard” to it in fulfilling their statutory duties):

- governing bodies of maintained schools, including special schools but excluding maintained nursery schools
- management committees of PRUs
- proprietors of academies, including free schools and alternative provision academies (but excluding 16–19 academies)

In addition to this being statutory guidance for maintained schools, it will also be of assistance to other education providers as they fulfil their wider statutory duties, including:

- early years settings
- FE colleges and post-16 institutions (including 16-19 academies)
- independent schools
- non-school alternative provision

This guidance is also provided to assist and guide:

- local authorities

- home to school transport providers
- children, young people and their parents/carers
- Integrated Care Boards (ICBs), including executive leads for SEND
- Designated clinical officers / designated medical officers
- Staff working for NHS providers
- School nursing teams delivering the Healthy Child Programme

Definitions

In this guidance:

- references to “schools” includes academies and pupil referral units;
- references to “schools, colleges and early years settings” means any institution where this guidance may be of relevance;
- references to “governing bodies” includes the governing bodies of maintained schools, proprietors of academies and management committees of pupil referral units (PRUs), together with the governing bodies of non-maintained special schools and the governing body or proprietor of post-16 institutions;
- references to “parents” includes anyone with parental responsibility, including carers.

A medical condition is a specific physical or mental health issue or illness that can be diagnosed by healthcare professionals based on symptoms, tests, or examination. These conditions, which include chronic diseases, require management or treatment and can affect an individual's functioning. A medical condition is in scope of this guidance if a school, college or early years setting needs to put arrangements in place to support children and young people with the condition (whether as part of institution-wide policies or specific arrangements for an individual).

Legislation this publication refers to

Section 100 of the Children and Families Act 2014 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 (excepting those who are “young children” from birth until the 1st of September following their fifth birthday and subject to the requirements of the EYFS). In meeting the duty, the governing body, proprietor or management committee must have regard to guidance issued by the Secretary of State under this section.

In addition, a wider range of statutory duties is of relevance to children and young people with medical conditions (including allergy), including:

- The duty of care under section 3 of the Children Act 1989 for any person with the care of a child to do all that is reasonable for the purposes of safeguarding or promoting the welfare of the child;

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- The duties to safeguard and promote the welfare of pupils and students under sections 20 and 175 of the Education Act 2002, the Education (Independent School Standards) Regulations 2014 (and associated statutory guidance Keeping Children Safe in Education) and the Non-Maintained Special Schools (England) Regulations 2015;
- The duty of the employer under section 2 of the Health and Safety at Work etc Act 1974 to take reasonable steps to ensure that employees are not exposed to risks to their health and safety;
- The duties under the Equality Act 2010 to provide equality of opportunity for all, including those who are disabled.
- The Special Educational Needs and Disability (SEND) SEND code of practice: 0 to 25 years.
- The Early Years Foundation Stage (EYFS) statutory framework.

We therefore recommend that early years settings, post-16 institutions and independent schools should have policies for supporting children and young people with medical conditions and allergy safety to assist them in complying with these statutory duties. This guidance will therefore be of relevance to early years settings, post-16 institutions and independent schools.

Scope of the draft statutory guidance

Delegation of healthcare activities is not covered by this consultation or this draft guidance.

This statutory guidance focuses only on the support that schools, colleges and early years settings provide for children and young people with medical conditions. It does not cover delegation of healthcare activities from a regulated healthcare professional to a non-healthcare professional working in the education sector (where it is safe and reasonable to do so).

The Department for Education and the Department of Health and Social Care will jointly publish separate non-statutory guidance on delegation of healthcare activities for healthcare professionals and education settings.

Expiry or review date

This guidance will be kept under review and updated as necessary.

Key points

Children and young people with medical conditions have the same right to education as their peers. They should be able to attend regularly, be safe, feel fully included and welcome and enjoy their life in their school, college or early years setting. Schools, colleges and early years settings should set out to be fully inclusive, able to recognise and respond to a wide range of medical conditions not just as a response to specific diagnoses, but as a

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proactive approach towards creating environments where all children can access learning, feel valued and safe, and succeed. Children and young people with medical conditions have higher rates of absence than their peers as a result of their medical condition. The ambition for them to attend should be the same for all children and young people, but those with medical conditions may need additional support and flexibility.

Schools, colleges and early years settings should set out their arrangements for supporting children and young people with medical conditions (including allergy) in a **medical conditions policy**, which should be published on the school, college or setting's website. A named member of the governing body and named senior leader should be responsible for the policy, which should be reviewed at least annually.

The medical conditions policy should set out how the school, college or setting will ensure children and young people with medical conditions (including allergy) are **identified** and fully **included**, including in **visits and trips**; how **Individual Healthcare Plans** will be developed; how staff (whether teaching staff, support staff or supply staff) will be **trained** in awareness of medical conditions; how the school, college or setting will respond in an **emergency**; how the school, college or setting will put **reasonable adjustments** where a medical condition constitutes a disability; how **medication** will be managed; how **concerns** should be raised; and how the **wellbeing** of children and young people with medical conditions will be promoted.

Any child or young person whose medical condition will require the school, college or early years setting to put supportive arrangements in place should have them captured through an **Individual Healthcare Plan**. Individual Healthcare Plans set out what needs to be done to support a specific child or young person with a medical condition, how, when and by whom, including in an emergency. Individual Healthcare Plans should be developed in collaboration with the child or young person and their parents, taking account of any advice received from healthcare professionals.

Where **serious incidents or "near misses"** occur involving a child or young person with a medical condition (including allergy), the incident should be recorded. It should be reported to the child or young person's parents and the governing body alongside any statutory reporting. Lessons should be learned from any serious incident or "near miss", prompting a review of the relevant policies and arrangements.

In addition, schools, colleges and early years settings should have a dedicated **allergy safety policy**, separate to their medical conditions policy, given the specific risk to life which anaphylaxis can pose. A named member of the governing body and named senior leader should be responsible for the policy, which should be reviewed at least annually and published. The allergy safety policy should set out how the school, college or setting will **identify** children and young people staff with allergy and **minimise the risks of exposure** to known allergens, including **managing the risk of food allergy**; how staff will be **trained** in allergy awareness and emergency response; how individuals at risk of anaphylaxis will have **access** to their prescribed adrenaline devices, alongside **"spare" adrenaline devices**; and how children and young people with allergy will be able to participate in **visits**

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and trips; how **Individual Healthcare Plans** will capture specific arrangements (including any Allergy Action Plan and/or Asthma Plan); and how the **wellbeing** of children and young people with allergies will be promoted.

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Principles: inclusive education for children and young people with medical conditions

Under Article 28 of the United Nations Convention on the Rights of the Child every child has a right to education. Our vision is that every child or young person attending a school, college or early years setting will be able to thrive and succeed, achieving well academically, receiving an effective preparation for adulthood and playing a full part in the life of the school, college or setting. Where a child or young person has a medical condition that presents a barrier to that, the school, college or setting – working as appropriate with its health and other partners – should seek to remove that barrier. We want children and young people with medical conditions – just like their peers – to be able to attend regularly, be safe, to feel welcome and to enjoy their life at school, in college or their early years setting. In truly inclusive settings, all staff are **able to recognise and respond to** a wide range of additional needs, not just as a response to specific diagnoses, but as a proactive approach towards creating environments where all children can access learning, feel valued and safe, and succeed.

Statutory duties are of course one element in achieving these aims, but good practice is based on much more than compliance. Drawing on good practice in schools, colleges and early years settings, we have identified that some of the key factors in supporting children with medical conditions are:

- the school, college or setting being committed to do all it can to remove barriers and provide appropriate support. Strong leadership with a ‘can do’ attitude to find solutions to removing barriers is crucial. Wherever possible, needs should be met by planning to be inclusive; specific adaptations for individuals will be supplementary (and may be unnecessary if there has been inclusion by design);
- close cooperation between the school, college or setting and the child or young person and their parents, to reach a shared understanding of the range of ways in which that condition might affect the child or young person while in education and over how to provide support. The school, college or setting should work with relevant health partners in doing so;
- the school, college or setting having a good understanding of the impact of a child’s medical condition while in education, including impacts that go broader than directly on learning such as on friendships, wellbeing and participation in extra-curricular activities.
- the school, college or setting should recognise that medical conditions may not be visible, may fluctuate or evolve, and that children and young people may downplay or mask those conditions or their effects, or attempt to manage them privately;

- any risks to the child or others relating to the child's medical condition being managed effectively, including for example when staff with usual responsibilities over those arrangements are temporarily absent;
- the protection of the child or young person's dignity and human rights being central to all of the actions of the school, college or setting;
- a "whole school" approach, so that everyone plays their part in supporting children and young people with health needs. The actions and attitude of a lunchtime supervisor or receptionist can be just as important as those of teachers;
- a celebration of diversity and effective arrangements to prevent stigmatising or other bullying relating to medical conditions. Inclusion benefits all children and young people and the life of the whole school, college or setting;
- policies and practice that reflect the potential impact of medical conditions. For example, attendance management arrangements should be both sensitive to medical conditions and reflect high ambitions as to the level of attendance that suitable support can enable. Uniform policies should take into account that as a result of a medical condition some children and young people may be sensitive to particular fabrics, struggle with fastenings, have sensory issues. Some children and young people will need to carry emergency medication or have it close at hand at all times; and
- the school, college or setting having robust arrangements to keep the effectiveness of its support under regular review, adapting its approach as appropriate in the light of experience. The culture of continuous improvement will cover both institution-wide policies and the way individual children and young people are supported. The governing body will have appropriate strategic oversight, underpinned by meaningful data and access to appropriate training.

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Medical conditions and their impact on children and young people

Many medical conditions can impact on children and young people and their access to learning. A medical condition is in scope of this guidance if a school, college or early years setting needs to put arrangements in place to support children and young people with their condition (whether as part of institution-wide policies or specific arrangements for an individual).

Some medical conditions will have no effect on a child or young person's participation in the life of their school, college or setting and will not require any additional arrangements. Similarly, short-term illnesses (not linked to a medical condition) will have a limited impact and are unlikely to require additional arrangements.

Some medical conditions will be long-term. Some will be fluctuating, with irregular or unpredictable onset. Many will be “invisible”, without immediately obvious signs or symptoms. The same medical condition can have very different impacts on different children and young people.

Schools, colleges and early years settings should not wait for a formal diagnosis of a medical condition before providing support. The absence of visible symptoms in a school, college or early years setting does not mean that a condition is not present or its management in or by the setting is not having an impact. Whenever it is clear that a child or young person has medical needs which impact on their life in the school, college or setting (including their learning), arrangements should be put in place to support them, ensure they can engage effectively in education and be fully included in the life of the school, college or setting.

While all children and young people with allergies should be supported under the medical conditions policy, a separate allergy safety policy is required because of the specific risk posed by anaphylaxis (a serious allergic reaction which can be life-threatening). Schools, colleges and early years settings should have an allergy safety policy in place even if no children and young people have a known history of anaphylaxis.

Children and young people with medical conditions (including allergy) are vulnerable to a number of risks which need to be managed and mitigated. Ensuring these do not become barriers to accessing and being included in education is essential to children and young people’s wellbeing and attainment and a key priority for the Government.

- **Risk to health and life**: poor management of medical conditions can pose risks – potentially to life itself. One scenario where this is especially acute is in the case of anaphylaxis: children and young people with no previous history of a reaction can have a severe reaction for the first time in school.
- **Risk to learning**: we know that children and young people with medical conditions have poorer school attendance than their peers, whether as a result of the condition itself or absence due to medical appointments. This brings the risk of lost learning or additional pressure through the need to catch up. However, pressure to attend school when the child or young person is not well enough can also pose risks to their health and wellbeing.
- **Risk to wellbeing**: children and young people with medical conditions often report feeling different to their peers. They can often feel isolated – or exposed to bullying. There are risks to the child or young person’s mental

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wellbeing, for example if they are coming to terms with a new diagnosis or as they get older and begin to appreciate its implications for their identity and life. Serious incidents(or the risk of them) will clearly affect the wellbeing of the individual and their family, often causing considerable anxiety. Equally, we cannot overlook the emotional impact an incident will have on those around them – whether staff or other children and young people.

Supporting children and young people to manage their own medical conditions

Children and young people should be able to access their medication quickly and easily at all times. This is essential in the case of medication which may be needed in an emergency or to relieve pain. Wherever possible and appropriate, children and young people should be allowed and encouraged to carry their own medicines and relevant devices for self-medication.

Where children and young people have medical conditions, part of the role of their school, college or setting is to help them understand how to manage their medical condition and ultimately how to take responsibility for doing so themselves. However, it will not always be appropriate for the child or young person to manage their own medical condition unaided, for example because of their age, confidence, learning difficulty, the fluctuating nature of a condition or the complexity or risk.

Schools, colleges and early years settings should consider how they can help children and young people to practice management of their medical condition in a safe and supported environment, where it is safe and appropriate to do so. Older children and young people may be able to do so with little or no external support. Decisions about self-management should be made on an individual basis, in discussion with the child or young person, their parents or carers and, where appropriate, relevant healthcare professionals. The child or young person's competence, understanding of their condition, level of risk and the school, college or setting's safeguarding responsibilities should all be considered. Where there is disagreement, the decision and its rationale should be clearly recorded and further medical advice sought if necessary. The child or young person's safety and best interests should always remain the primary consideration.

Children and young people who can take their medicines or manage procedures themselves may nevertheless require an appropriate level of supervision and support. If it is not appropriate for a child or young person to self-manage, staff will need to help or step in to ensure the child or young person receives the medical intervention they need. Arrangements for self-management, including support,

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supervision and alternative arrangements, should be reflected in an Individual Healthcare Plan.

Communication and language

Schools, colleges and early years settings should take particular care with the way they communicate with children, young people and their families about medical conditions, because this helps set the tone for the support they provide. Standard processes, such as automated text messages to parents when attendance dips below 90%, absence warning letters or formal attendance and legal notices, can feel threatening or hurtful when a family is already under pressure, especially if the health context is not recognised. Where a medical condition may be contributing to absence or difficulty engaging in the life of the school, college or setting, communications should be timely, supportive and should clearly signpost the help available.

The language used to talk about a child or young person’s medical conditions also matters in everyday interactions. The words used by staff can have a profound impact on how children, young people and families experience a condition day to day, and can help to reduce anxiety, build confidence and support engagement. Equally, the choice of language can be stigmatising and undermining, contributing to increased anxiety, poor wellbeing and the risk that a child or young person will seek to “mask” their condition rather than seek the support they need, potentially with severe consequences for their health.

For example, when describing blood glucose management, healthcare professionals try to avoid terms that imply blame, such as “good” or “bad” blood glucose "control”. Blood glucose levels are influenced by many factors outside a child or young person’s control. Instead, it is good practice to use neutral descriptive wording (for example “higher” or “lower”) and focus on their practical implications.

Unacceptable practice

Governing bodies should ensure that a school, college or early years setting’s medical conditions and allergy safety policies are explicit about what practice is not acceptable. Examples of unacceptable practice include (but are not limited to):

- preventing children and young people from easily accessing and administering their medication in line with what is agreed in their Individual Healthcare Plan (for example prescribed adrenaline devices and asthma reliever inhalers) when and where necessary;
- assuming that every child with the same condition requires the same support;

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- assuming that older children and young people do not require support related to their medical condition, even if they are able to take increasing responsibility for its management;
- ignoring the views of the child or young person or their parents or carer;
- ignoring medical evidence or the opinion and advice of healthcare professionals;
- assuming that a child or young person does not have a medical condition because they do not yet have a diagnosis, for example while medical investigation is under way;
- unreasonably requesting further medical evidence (e.g. from specialists);
- discriminating against children or young people with medical conditions by sending them home frequently for reasons associated with their medical condition or prevent them from staying for normal school activities or extracurricular activities, including lunch;
- sending a child or young person who becomes unwell to a school office or medical room without suitable supervision. In the case of an emergency or suspected emergency (for example anaphylaxis) help should come to the child or young person;
- penalising children or young people for their attendance record if their absences are related to their medical condition, e.g. hospital appointments and health management. This includes excluding children and young people from rewards for 100% attendance where their non-attendance is the result of a medical condition. This should be reflected in attendance policies;
- setting lower attendance ambitions for children or young people with medical conditions, for example by implementing sustained part-time timetables without review;
- preventing children and young people from drinking, eating or taking toilet or other breaks whenever they need to, in order to manage their medical condition effectively;
- preventing children and young people from resting or engaging in sustained physical activity where they have conditions which cause chronic pain or fatigue;
- requiring parents / carers (or otherwise making them feel obliged) to attend the school, college or setting to administer medication or provide medical support to their child, including with toileting issues. Parents and carers should not have their work or other responsibilities impacted because the school, college or setting is failing to support their child's medical needs; or
- preventing children and young people from participating, or creating unnecessary barriers to them participating in any aspect of school, college or setting life, including external visits and trips, e.g. by requiring parents to accompany the child.

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1) Policies for supporting medical conditions

The governing body of an LA-maintained school, the proprietor of an Academy and the management committee of a PRU must make arrangements to support pupils with medical conditions. In doing so it should ensure that such children can access and enjoy the same opportunities at school as any other child or young person.

A school, college or early years setting should set out these arrangements in a medical conditions policy, which should be published on the school, college or setting's website.

In making their arrangements, governing bodies should take into account that:

- Some medical conditions may be life-threatening. The school, college or setting should ensure the relevant staff have the necessary training and awareness to understand warning signs and are able to respond quickly and effectively.
- Some medical conditions will affect the child or young person's quality of life, potentially requiring intimate care. Support should be arranged in a way which preserves the child or young person's dignity.
- Some medical conditions will impact the child or young person's attendance. This can be a result of the medical condition itself, side effects of medication and treatment or a higher susceptibility to other illnesses (including longer recovery times).
- Some medical conditions will impact the child or young person's energy levels or may cause chronic pain. This may require active support or management within the school, college or setting so that the child or young person derives the greatest benefit from their time in education.
- Some medical conditions will not be immediately obvious. Less visible or "invisible" conditions should not be dismissed or overlooked. "Masking" of a medical condition while in school can cause significant harm, both to the individual's wellbeing and through potential worsening of their symptoms.
- Some medical conditions are fluctuating or recurring. The child or young person's support requirements and capacity to engage with learning may therefore vary considerably (and in some cases change abruptly). Schools, colleges and settings will need to adapt their support arrangements depending on the child or young person's immediate needs. Periods of stress (for example examinations or changes of school, college or setting) can exacerbate medical conditions.
- Children and young people may have multiple medical conditions. The cumulative or combined effect may be much greater than might be expected of any of the conditions on its own.

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- Schools, colleges and settings should not make assumptions about the needs of children and young people with medical conditions. Support arrangements should always be discussed with the child or young person and their parents. Some children and young people will want the support they receive to be seen, which promotes the normalising of medical conditions. Others may prefer for it to remain unobtrusive.
- Many medical conditions will affect the child or young person's wellbeing. Children and young people with chronic (long-term) medical conditions are around twice as likely as their healthy peers to have a mental health disorder at ages 10, 13 and 15. Children and young people who have repeated absences are more likely to suffer mental ill health. Where appropriate, active support should be provided for the mental health and wellbeing of children and young people with medical conditions.
- The risk of children and young people (including siblings) being bullied as a consequence of a medical condition should be actively managed and avoided.

A school, college or early years setting's attitude to medical conditions (including allergies) sets an important example which children and young people will carry forward into their lives. It is therefore essential to establish a culture whereby all children and young people – and indeed staff and visitors – with medical conditions are actively supported and included. A culture which assumes and expects flexibility and adjustments to be made *in anticipation of an individual requiring them* will be well placed to respond to the specific needs of a child, young person, member of staff or visitor. In many cases a medical condition may also constitute a disability; a school, college or early years setting must comply with its duties under the Equality Act 2010, including making "reasonable adjustments" (both anticipatory adjustments and those made for specific individuals).

Medical condition policies should therefore set the tone for how children and young people with medical conditions are supported; kept safe; and included. Specific arrangements for individual children and young people and the adjustments that the school, college or setting will make should be developed with the child or young person and their parents and set out in an Individual Healthcare Plan, based on how their medical condition impacts on their education.

The governing body should ensure that its arrangements give children, young people and parents confidence in the school's ability to provide effective support for medical conditions in school. The arrangements should show an understanding of how medical conditions impact on a child's ability to learn, as well as increase confidence and promote self-care. They should ensure that staff are properly trained to provide the support that children and young people need, using support and guidance from the relevant associated healthcare professional, including school nurses.

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Which medical conditions are in scope

Governing bodies should ensure the school, college or early years setting's medical condition policy covers the arrangements which need to be in place to support children and young people with medical conditions. Some medical conditions will have no effect on a child or young person's participation in the life of their school, college or setting and so do not require any additional arrangements. Similarly, short-term illnesses will have a limited impact and are unlikely to require additional arrangements. Examples of medical conditions which may impact on children and young people while in education are provided in the annex.

The medical conditions policy should cover the arrangements made at a school, college or setting level. It should provide for individual arrangements to be made for specific children and young people. These arrangements should be detailed separately and captured in an Individual Healthcare Plan, to reflect the child or young person's circumstances and the support or arrangements they require to be able to thrive in school.

While all children and young people with allergies should be supported under the medical conditions policy, a separate allergy safety policy is required because of the specific risk which anaphylaxis can pose. Further information is available in the section on Anaphylaxis and emergency situations.

Schools, colleges and early years settings should not wait for a formal diagnosis of a medical condition before providing support. Whenever it is clear that arrangements are needed to support a child or young person with a medical condition, they should be put in place to ensure they can engage effectively in education and be fully included in the life of the school, college or setting. The absence of a confirmed diagnosis or the fact that symptoms are not consistently observed within the setting, should not in itself be a barrier to support. Many medical conditions are fluctuating, internally experienced or masked, and may not be immediately visible to staff. Decisions should be based on the child or young person's reported needs, available evidence and the potential risk of harm if support is not provided, with arrangements reviewed as further information becomes available. In some cases the process of securing a formal diagnosis may not be in the child or young person's best interests. For example, if it is clear that a child or young person is benefiting from a gluten free diet, then the educational setting should support provision of this even in the absence of a formal diagnosis of coeliac disease.

Where a child or young person's medical needs are complex, evolving or where healthcare professionals have differing opinions about how to provide support, the school college or setting may need to seek further advice. The child or young person and their parents or carers should always be involved, since they will have a crucial

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understanding of the medical condition and its implications. The school, college or setting may also need to seek advice from the clinicians involved in the child or young person's care. School nursing services may be able to provide advice. Appropriate and proportionate support should remain in place so that the child or young person is not left without reasonable adjustments or access to education while further advice is sought.

Managing medical conditions policies

Governing bodies are responsible for ensuring the school, college or setting has a medical condition policy setting out the arrangements in place to support children and young people with medical conditions. There should be a named governor and a named member of the senior leadership team with responsibility for the school, college or setting's arrangements for supporting children and young people with medical conditions. Risks relating to children and young people with medical conditions should be included on the school, college or setting's risk register and be actively managed by the governing body.

Governing bodies should ensure that medical conditions policies are readily accessible to parents and school staff. Policies should be published on the school, college or setting's website and be made available in hard copy on request.

Governing bodies should ensure that medical conditions policies are reviewed at least annually. Policies can be reviewed more frequently, particularly where incidents or "near misses" suggest areas for improvement. Any review should take account of any incidents and "near misses" and should seek to learn lessons from them. This is essential where incidents suggest that policies or procedures may leave children and young people with medical conditions at risk (whether risk to life, wellbeing or learning).

Medical conditions policies and inspection

As part of its inspection arrangements, Ofsted will consider the effectiveness of a school, college or early years setting's arrangements for **safeguarding** and for **inclusion**. Inspectors will consider medical conditions and allergy safety policies and the effectiveness of their implementation as part of the inspection process.

What medical conditions policies should contain

A medical conditions policy should set out the school, college or setting's commitment to being inclusive for all children, young people, staff and visitors with medical conditions. It should set out how policies and procedures will discharge

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duties under the Equality Act to make anticipatory arrangements to avoid discrimination. It should set out how the school intends to be proactive in managing risks to children and young people with medical conditions – risks to their health, their wellbeing or their learning. A template medical conditions policy will be made available shortly.

Medical conditions policies should set out:

- How the school, college or setting will ensure children and young people with medical conditions (including allergy) are both enabled and supported to **attend** as fully as possible, and to **participate as fully as possible** in all aspects of life in the school, college or setting, including trips and extracurricular activities, and the role played by all staff in doing so;
- How children and young people with medical conditions will be identified;
- How staff (whether teaching staff, support staff or supply staff) will be **trained** in awareness of medical conditions;
    - Where children and young people have Individual Healthcare Plans, how relevant staff will be made aware of the arrangements and where necessary trained to provide the required support;
- How the school, college or setting will respond in an **emergency**;
- How the school, college or setting will put **reasonable adjustments** in place for children and young people whose medical condition constitutes a disability;
- What arrangements and adjustments will be put in place to ensure children and young people are able to participate in **visits, trips and extracurricular activities**, and do so safely;
- How **Individual Healthcare Plans** will be developed in consultation with the child or young person and their parents to document specific support arrangements, and how the effectiveness of the arrangements will be reviewed and (where necessary) amended);
- How **medication** will be managed, including safe storage and disposal;
- How **concerns** should be raised and disagreements resolved;
- How the **wellbeing** of children and young people with medical conditions will be promoted.

The remainder of this section provides further guidance.

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Identifying children and young people with medical conditions

The medical conditions policy should set out clear arrangements for identifying children and young people (and, where appropriate, members of staff and visitors) who have medical conditions which may require additional support. The school, college or setting should keep a record of all individuals with medical conditions which may require support, including whether they have an Individual Healthcare Plan.

The medical conditions policy should set out arrangements for gathering information about medical conditions before a child or young person is admitted to the school, college or early years setting. This may include asking their previous setting for relevant information, such as an Individual Healthcare Plan (if one was in place). Parents (and, where appropriate, the young person themselves) should always be asked for information on medical conditions and their impact.

For children and young people starting at a new school, college or setting, arrangements should be in place in time for the start of the relevant school term. In other cases, such as children and young people moving to a new school, college or setting mid-term or children and young people on roll who receive a new medical diagnosis, every effort should be made to ensure that arrangements are put in place as quickly as possible.

The medical conditions policy should set out how new arrangements will be put in place where a child or young person already on roll is diagnosed with a medical condition, develops medical needs (for example as a result of accident or illness) or where their medical condition changes in such a way that existing arrangements need to be reviewed.

Staff training

Governing bodies should ensure that the school, college or setting's policy sets out clearly how staff will be supported in carrying out their role to support children and young people with medical conditions, and how this will be reviewed. This should specify how training needs are assessed, and how and by whom training will be commissioned and provided.

Governing bodies should ensure that all staff are aware of the school, college or setting's policy for supporting children and young people with medical conditions and that each member of staff understands their role in implementing the policy. Induction arrangements for new staff should be included. The policy should set out arrangements for all staff, including support staff, supply and cover staff. It also

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includes staff or volunteers responsible for before-school provision, free breakfast clubs and afterschool clubs, whether delivered directly or through third-party providers operating on or in the vicinity of the school site.

Where children and young people in the school, college or setting have specific medical conditions, the governing body will need to consider what training and awareness may be needed to ensure the members of staff who are likely to be involved in supporting them have the knowledge to enable them to do so appropriately. This will be particularly important in the case of less common conditions. Governing bodies should keep in mind that any member of staff may be called upon to provide support in an emergency situation.

For example, where a medical condition is likely to impact on a child or young person's energy levels, it will be important that their teachers understand and can recognise when adjustments specified in their Individual Healthcare Plan may be required.

Training for staff supporting children and young people with Individual Healthcare Plans

Any child or young person with a medical condition who requires support from their school, college or early years setting should have an Individual Healthcare Plan which specifies the arrangements which will be put in place. The governing body will need to ensure that the staff who are likely to be involved in supporting the child or young person know that they have an Individual Healthcare Plan and understand the arrangements it sets out, which they are likely to be called upon to provide.

Where a child or young person has an Individual Healthcare Plan, it may identify specific training needs for staff who are likely to be involved in supporting the child or young person. In some cases relevant healthcare professionals may provide advice on the type and level of training required, how this can be obtained and whether any assessment of competency is required. Staff who provide support to children and young people with medical conditions should be included in meetings where this is discussed and developed.

The medical conditions policy should set out arrangements for the training of staff whose role is intended to include providing support to a child or young person with specific medical needs. The policy should set out the frequency of training; this will typically mean annual training, unless the healthcare professionals involved in an individual's care advise otherwise. The policy should be clear that such staff should receive suitable training to ensure:

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- They can provide the necessary support safely (which may include giving prescription medicines or undertaking healthcare procedures in accordance with an Individual Healthcare Plan);
- They understand any risks associated with providing support;
- They can recognise symptoms of the medical condition, what can trigger them, appreciate their effects and know what preventative and emergency measures to take. They should be able to recognise if the child or young person may be at risk and take the required action (for example as set out in the child or young person's Individual Healthcare Plan).

Training should be sufficient to ensure that staff are competent and have confidence in their ability to support children and young people with medical conditions, and to fulfil the requirements as set out in individual healthcare plans. They will need an understanding of the specific medical conditions they are being asked to deal with, their implications and the preventative and emergency measures they may need to take. A first-aid certificate does not constitute appropriate training in supporting children with medical conditions.

Where children and young people have specific medical support needs requiring named members of staff to be trained and/or assessed as competent, the medical conditions policy should set out sufficient supply or cover arrangements. Children and young people should not be prevented from attending and receiving education because of staffing issues. Parents or carers should not be expected to act as substitutes in these circumstances.

Emergency situations

As part of their general risk management processes, all schools, colleges and early years settings should have arrangements in place for dealing with emergencies for all activities wherever they take place, including on school trips within and outside the UK.

Governing bodies should ensure that the medical conditions policy sets out what should happen in an emergency situation. This may include considering the role of other children and young people, for example in informing members of staff if they think help is needed.

Teachers and other staff working with children and young people are expected to use their best endeavours at all times to secure the welfare of the pupils and students in education in the same way that parents might be expected to act towards their children. This is particularly important in emergency situations. In general, the

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consequences of taking no action are likely to be more serious than those of trying to assist in an emergency.

Where a child or young person has an Individual Healthcare Plan, it should clearly define what constitutes an emergency and explain what to do, including ensuring that all relevant staff are aware of emergency symptoms and procedures, and ensuring access to emergency medication. It is good practice to consider:

- Who will identify a potential emergency situation? Can the child or young person do so? What signs or symptoms need to be watched for? How will the child or young person let an adult know that they are feeling unwell (for example if they are having difficulty speaking)?
- Who will support the individual? Who will seek medical help or bring emergency medication (remembering not to move individuals during a serious incident unless absolutely necessary)?
- Who will call for emergency services? Who will let an ambulance onto the premises and at what access point?
- Who will contact the individual's family?
- Who will manage other children and young people or onlookers?

If a child or young person needs to be taken to hospital, staff should stay with them until their parent arrives, or accompany them to hospital if taken by ambulance. Schools, colleges and early years settings need to ensure they understand the local emergency services' cover arrangements and that the correct information is provided for navigation systems.

The medical conditions policy should be clear that, if a child or young person experiences a life-threatening medical emergency, anyone – staff, volunteers or bystanders – may take reasonable action to save their life. The law recognises that rescuers act under extreme pressure. People who attempt to save a life in good faith are protected, even if an injury occurs while giving emergency care (for example, broken ribs during CPR are common and not a sign of wrongdoing). This includes administering adrenaline when an individual is suffering anaphylaxis.

School trips and external visits

Governing bodies must ensure that their arrangements are clear and unambiguous about the need for proactive support so that children and young people with medical conditions can participate in school trips and visits, or in sporting and extracurricular activities, and not prevent them from doing so.

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Schools, colleges and early years settings should consider what arrangements they need to make to enable children with medical conditions to participate fully and safely on trips and visits. A risk assessment should be carried out so that planning arrangements take account of any steps needed to ensure that children and young people with medical conditions are included. This will require consultation with children, young people and parents and advice from the relevant healthcare professional to ensure that children and young people can participate safely. Further guidance is available on Health and safety on educational visits, together with guidance by the Health and Safety Executive on School trips.

Staff should be aware of how a child or young person's medical condition will impact on their participation in trips and visits, but there should be enough flexibility for all children and young people to participate according to their own abilities and with any reasonable adjustments if they are disabled. The medical conditions policy should set an expectation that the school, college or early year setting should make arrangements for the inclusion of children and young people in trips and visits (making any adjustments as required) unless evidence from a clinician (for example a GP) states that this is not possible.

The statutory Early Years Foundation Stage framework states that at least one person who has a current paediatric first aid certificate must accompany children in the early years (including Reception classes) on outings.

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Breakfast clubs and after school clubs

Governing bodies must ensure that arrangements to support children and young people with medical conditions apply at all times when the child or young person is in the care of the school. This includes during before-school provision, free breakfast clubs and afterschool clubs, whether delivered directly by the school or through a third-party provider operating on or in the vicinity of the school site.

Children and young people with medical conditions (including allergies, intolerances and coeliac disease) should not be prevented from accessing free breakfast clubs or other extended school provision as a result of their medical condition. Appropriate arrangements must be in place to ensure they can participate safely and inclusively, including:

- suitable training for staff or volunteers delivering breakfast or after-school provision;
- access to medication and emergency treatment plans during the club session;
- staff awareness of Individual Healthcare Plans, including Allergy and/or Asthma Action Plans, where relevant;

- safe food handling and allergen risk management during food preparation and service;
- reasonable provision of alternative food options for children and young people with allergies, intolerances and coeliac disease.

All of the statutory duties and requirements concerning school food apply to breakfast clubs and after-school provision. Further information can be found in the section on Food Allergy.

In addition, the safeguarding and welfare requirements in the statutory Early Years Foundation Stage framework will apply to children aged from birth to until the 31 August after their 5th birthday who attend breakfast clubs and after school clubs.

Individual Healthcare Plans

The medical conditions policy should set out how children and young people with specific medical conditions will be supported through Individual Healthcare Plans. The policy will set out the circumstances in which the school, college or setting expects to provide an Individual Healthcare Plan and the frequency with which IHPs will be reviewed. Further information on Individual Healthcare Plans is provided below.

Medication

The medical conditions policy should be clear about the procedures to be followed for managing medicines, including prescription medication and controlled drugs. It should also set out arrangements for the storage of medication. Further guidance on medication is provided below.

Wellbeing of children and young people with medical conditions

Children and young people with medical conditions are disproportionately likely to experience poor mental wellbeing. This can arise from anxiety over the support they will receive for their medical condition and the impact of poor care or serious incidents. It can arise from social isolation, where the medical condition means they cannot be fully included in the life of the school, college or setting or engage with their peers. Lack of understanding or sympathy from peers or staff, or active bullying on the basis of the medical condition is a particular concern. Office for National Statistics research on Child mental ill health and absence from school shows that the more times a child or young person is absent from school, the greater the probability that they will experience mental ill health, increasing with the frequency of absence.

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The medical conditions policy should set out how the welfare of children and young people with medical conditions (including allergy) will be supported. This should include arrangements to promote the mental health and wellbeing of children and young people and to prevent children and young people being bullied on account of their medical condition. The medical conditions policy should also set out measures to prevent and respond to bullying related to children and young people with medical conditions (including allergy).

Arrangements for supporting the wellbeing of children and young people with medical conditions should be appropriate and proportionate to the age and circumstances of the individual, including the nature and severity of the medical condition. This is particularly important in the case of life-limiting or degenerative conditions and progressive neurological conditions. The siblings and friends of children and young people with such conditions should also be supported actively.

Schools, colleges and early years settings should involve children and young people with medical conditions and their families in developing and reviewing these arrangements, since they will have a direct understanding of the consequences for their wellbeing and will know what support would be most effective.

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Individual Healthcare Plans

Individual Healthcare Plans are documents which a school, college or education provider produces and owns, setting out the support which a specific child or young person may require in respect of their medical condition, and the steps which the education provider will take to support them. They provide clarity about what needs to be done by the staff in a school, college or early years setting, how, when and by whom, to support a specific child or young person with a medical condition. They should be developed in collaboration with the child or young person and their parents, and should take account of any advice received from healthcare professionals.

Individual Healthcare Plans are “owned” by the school, college or early years setting which the child or young person attends. While they may be informed by advice from healthcare professionals (and may incorporate care or action plans provided by healthcare professionals), they are not clinical documents. They describe the arrangements to support the specific child or young person at the specific school, college or setting. If the child or young person moves, their new school, college or setting will need to draw up a new Individual Healthcare Plan. While it might be very similar, it needs to reflect the arrangements the new school, college or setting will put in place.

Individual Healthcare Plans are essential communication tools. They set out the arrangements the school, college or setting will put in place to support a specific child or young person’s medical condition. This will provide the child or young person and their parents with clarity about the arrangements which will be in place and how they will ensure the child or young person is as fully included in the life of the school, college or setting as possible. The Individual Healthcare Plan will provide staff in the school, college or setting with clarity about what they need to do. It will also include information which will be essential in managing an emergency situation.

Individual Healthcare Plans in the long term

As part of our consultation on SEND reform: putting children and young people first we propose that schools, colleges and settings should create digital Individual Support Plans for any child or young person with identified special educational needs or disability, capturing barriers to learning, day-to-day provision, any reasonable adjustments required and intended outcomes. In developing Individual Support Plans, we will ensure that they incorporate Individual Healthcare Plans so that children and young people do not need two separate documents, reducing the burden on schools, colleges and early years settings and ensuring support is delivered holistically.

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Who may need an Individual Healthcare Plan

Schools, colleges and early years settings should seek to identify any children and young people with medical conditions so they can consider whether an Individual Healthcare Plan is required. The school, college or setting should discuss the circumstances with the child or young person and their parents. If it is clear that the medical condition will require the school, college or early years setting to put supportive arrangements in place, an Individual Healthcare Plan should be drawn up which specifies these arrangements. This includes children and young people whose medical conditions require flexibility and “reasonable adjustments”, as well as those who require medication (either proactively or in an emergency situation). Individual Healthcare Plans are particularly important in cases where conditions fluctuate or where there is a high risk that emergency intervention will be needed.

It is not necessary for a child or young person to have a formal diagnosis for them to have an Individual Healthcare Plan. Whenever it is clear that a child or young person has medical needs, arrangements should be put in place to support the child or young person, ensure they can engage effectively in education and be fully included in the life of the school, college or setting wherever they are needed. These should be recorded in an Individual Healthcare Plan.

Individual Healthcare Plans will be particularly important in certain cases:

- **Prescribed medication**: Individual Healthcare Plans should be put in place for any child or young person who requires medication while in school, college or the early years setting. The IHP should set out arrangements for administering the medication, contact details of the relevant healthcare professional and procedures in the event of any complications or side-effects. The IHP should record parental consent for the medication to be administered to a child (other than in the exceptional circumstances where medication is prescribed without a parent’s knowledge). Where specific members of staff have been trained to administer medication or deliver personalised care plans (for example diabetes care or plans seizure plans), they should be named on the IHP, together with cover arrangements in their absence.
- **Personalised care plans**: for many medical conditions, healthcare professionals will issue personalised care and/or action plans. These should be sought and included in the IHP. This includes allergy and asthma action plans, diabetes care plans and seizure plans.
- **Allergy**: Individual Healthcare Plans should be put in place for any child or young person who has a known allergy which requires active management, together with their Allergy and/or Asthma Action Plan. The IHP should specify their known allergens, what risk reduction measures are necessary and

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whether they have been prescribed adrenaline (including medical and parental consent to use “spare” adrenaline devices where appropriate).

- **“Reasonable adjustments”**: Individual Healthcare Plans should be put in place where a child or young person’s medical condition constitutes a disability and requires the school, college or early years setting to make adjustments to its policies or practices. The IHP should set out what these adjustments are and how or when they might be required.

Not all children with a medical condition will require an Individual Healthcare Plan. Some medical conditions will have little or no impact on the child or young person while they are at school, college or in an early years setting, or arrangements can be made under the medical conditions policy. The following examples are illustrative only: schools, colleges and settings will need to consider the specific context of any individual child or young person, such as the cumulative effect of co-occurring medical conditions):

- Hay fever (allergic rhinitis) may not require specific arrangements through an Individual Healthcare Plan provided the medical conditions policy permits them to receive or use non-prescription medication to manage the condition.
- Eczema may not require specific arrangements through an Individual Healthcare Plan provided the medical conditions policy permits them to receive or use medication to manage the condition. Schools, colleges and early years settings should note that activities such as sandpits and swimming can trigger eczema flares.
- Intolerance to specific foods which can be self-managed by avoiding them may not require specific arrangements through an Individual Healthcare Plan.
- Mild asthma might be managed through the child or young person’s Asthma Action Plan and access to their asthma medication. However, children and young people with complex or severe asthma will require an Individual Healthcare Plan.

It is ultimately for head or principal of the school, college or early years setting to decide (in discussion with the parents and any relevant healthcare professionals) whether the medical condition can be managed through the adjustments made under the school’s medical conditions policy or whether an Individual Healthcare Plan is required to specify arrangements that reflect the child or young person’s condition and circumstances.

EHC plans which specify health provision

Some children and young people will have an Education, Health and Care (EHC) plan which specifies that they require health provision in section G. Section G of an

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EHC plan typically describes health provision at a strategic level and may not contain the practical, supervisory or emergency information required for safe implementation within the school, college or early years setting. Where medication, monitoring, environmental adjustments or emergency response arrangements are required, these should be clearly set out in an Individual Healthcare Plan.

Content of Individual Healthcare Plans

Individual Healthcare Plans should capture key information about the child or young person's medical condition and record the arrangements which the school, college or early years setting will put in place to keep them safe, included and supported. The level of detail within plans will depend on the complexity of the child's condition and the degree of support needed. Different children with the same health condition may require very different support. Individual Healthcare Plans should be easily accessible to all who need to refer to them, while preserving confidentiality.

A template Individual Healthcare Plan is available *and will be revised following the consultation process*. The Health Conditions in Schools Alliance has produced Resources to support the development of Individual Healthcare Plans.

Individual Healthcare Plans should include:

- The child or young person's name, date of birth and a current photo.
- Contact details for the child or young person's parents or carer. Where confidentiality issues are raised by the parent/child, the designated individuals to be entrusted with information about the child's condition should be specified.
- Who needs to be aware of the child or young person's medical condition and the support required.
- A brief summary of the medical condition, its triggers, signs, symptoms and treatments.
- The child or young person's needs arising from their medical condition, including any 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.
- An indication of how the medical condition may impact on the child or young person's learning and emotional wellbeing.
- The extent to which the child or young person is able to take responsibility for their own health needs including in emergencies. If a child or young person is self-managing their medication, this should be clearly stated, with appropriate arrangements for monitoring.

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- Details of the specific support or adaptations which the school, college or early years setting will put in place – for example, how absences will be managed, requirements for extra time to complete exams, use of rest periods or additional support in catching up with lessons, counselling sessions and how the child or young person can access food.
- Clear arrangements for maintaining educational progress where absence or missed learning occurs due to medical conditions. This should include how missed work will be communicated and supported, what assistance will be provided to help the child or young person catch up, expectations regarding workload on return, and how the child or young person will be supported as they return (which may include flexibility or part-time attendance to prevent relapse or deterioration).
- Details of any arrangements or procedures which may be required for school trips or other activities outside of the normal timetable that will ensure the child can participate. This may include the requirement for a risk assessment and prompts for specific issues which should be considered.
- Information about what to do in an emergency, including whom to contact, and contingency arrangements. Where children and young people have an emergency healthcare plan prepared by their lead clinician, this should be attached to their Individual Healthcare Plan.
- Where a child or young person has a personalised care and/or action plan issued by a healthcare professionals, it should be attached to their Individual Healthcare Plan. This may include allergy and asthma action plans, diabetes care plans and seizure plans.

Where the child or young person will or is likely to require medication to be administered while at school, college or in an early years setting, the Individual Healthcare Plan should include:

- Details of any medication (dose, side effects and storage, and any arrangements for checking that it is in date) and how and when it should be administered.
- Instructions on how to identify the symptoms of complications or side-effects and how to respond.
- Written permission from parents and/or healthcare professionals for medication to be administered by a member of staff, or self-administered by the pupil during school hours.
- Where necessary, the names of specific members of staff who have been trained to administer the medication, together with cover arrangements in their absence.

An Individual Healthcare Plan may require specific members of staff to administer medication or deliver personalised care plans (for example diabetes care or seizure

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plans) for the child or young person. The school, college or young person must ensure that the named members of staff have received the training they require to undertake the role safely and competently. Further information is provided in the section on Training for staff supporting children and young people with Individual Healthcare Plans. Where named members of staff have been trained to provide support to a child or young person, their Individual Healthcare Plan should set out arrangements for cover in their absence. Any member of staff providing cover must have received appropriate training and have up-to-date knowledge of the child or young person's medical needs and Individual Healthcare Plan, including current triggers, warning signs, medication requirements and emergency procedures. Cover arrangements should ensure continuity of knowledge as well as continuity of staffing. Where specific members of staff have been trained to provide support, this responsibility should be reflected in their role and job description.

Drawing up an Individual Healthcare Plan

Schools, colleges and early years settings should be active in seeking information about whether children and young people on their roll have medical conditions. This is most obvious when children and young people join the school, college or setting. It is equally important where a child or young person already on roll is diagnosed with a medical condition, develops medical needs (for example as a result of accident or illness) or where their medical condition changes in such a way that existing arrangements need to be reviewed.

The school, college or setting should discuss the circumstances with the child or young person and their parents so they can consider whether an Individual Healthcare Plan is required. They should take on board any advice from any relevant healthcare professionals involved in providing care to the child or young person (for example a GP, consultant or community nurse). They may also wish to seek advice from school nursing teams on how best to support children and young people with specific medical conditions. In some cases (especially rare, complex or multi-system conditions), advice should also be sought from clinicians with relevant specialist knowledge.

Drawing up an Individual Healthcare Plan is the responsibility of the school, college or early years setting. While it may be helpful to consider the arrangements put in place in a child or young person's previous school, college or setting, a new Individual Healthcare Plan will need to be drawn up when they move to a new school, college or setting since different arrangements will be put in place. Where a child is returning to school following a period of hospital education or alternative provision (including home tuition), schools should work with the local authority and

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education provider to ensure that the Individual Healthcare Plan identifies the support the child will need to reintegrate effectively.

A flow chart for identifying and agreeing the support a child or young person needs and developing an Individual Healthcare Plan is provided below.

Figure 1: flow chart for creating and reviewing Individual Healthcare Plans

CYP comes onto roll of school, college or EY setting. Parents or YP identify they have a medical condition.

or

CYP on roll of school, college or EY setting is identified by parents, YP or healthcare professional as having a medical condition (including new diagnosis) or develops medical needs.

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School, college or setting meets the CYP and their parents to discuss the circumstances and consider whether an Individual Healthcare Plan is required, taking account of any advice from relevant healthcare professionals.

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If the medical condition will require the school, college or EY setting to put supportive arrangements in place, an Individual Healthcare Plan should be drawn up which specifies these arrangements. The school, college or setting will discuss what arrangements may be required with the CYP and their parents. If the CYP has an Allergy or Asthma Action Plan, it will be attached to their IHP.

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IHP is shared with the CYP, their parents and those staff who need to be aware of its contents.

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School, college or setting delivers the arrangements set out in the IHP. Arrangements may require staff to be trained and/or signed off as competent to carry out procedures, with agreed review and reassessment date.

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IHP is reviewed at least annually.

and

Any serious incident, “near miss” or change in circumstances (including changes in medication) triggers an automatic review of the IHP.

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Amended IHP is shared with the CYP, their parents and those staff who need to be aware of its contents. School, college or setting delivers the revised arrangements.

Reviewing and updating Individual Healthcare Plans

The school, college or early years setting should ensure that Individual Healthcare Plans are reviewed at least annually. They can be reviewed more frequently if the child or young person’s needs have changed. A significant incident or a “near miss” should always be a trigger that the arrangements in an Individual Healthcare Plan should be reviewed. The child or young person and their parents should be involved in reviewing the Individual Healthcare Plan. The school, college or setting may need to ask parents or the young person to confirm whether there has been any change in circumstances or medical advice.

Where an Individual Healthcare Plan includes details of medication (for example timings and dosages), the IHP will need to be kept updated to reflect any changes to medication.

Action plans (for example allergy or asthma action plans) will be updated by healthcare professionals at regular intervals. An Individual Healthcare Plan should be reviewed and updated whenever a revised action plan becomes available.

As children and young people get older, they may be able to take increasing responsibility for managing their medical condition. Where this is safe and possible it should be encouraged, to help prepare the child or young person for managing their condition in adult life. It is important that children and young people remain actively supported by their school, college or setting; the child or young person should be closely involved in discussions about the extent to which they feel able to take ownership and what support they might need.

In other cases, children and young people may find that they require more or different support over time, for example in the case of progressive or degenerative conditions, or conditions such as Acquired Brain Injury where additional needs may emerge over time. The Individual Healthcare Plan will need to be reviewed and amended as necessary to ensure the arrangements put in place by the school,

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college or setting remain appropriate and relevant for the needs of the child or young person.

Transition between education phases

Where a child or young person moves on to a new school, college or setting, their Individual Healthcare Plan should be shared as part of the transition. The new school, college or setting will need to draw up a new Individual Healthcare Plan since different arrangements will be put in place.

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Serious incidents

Children and young people who have medical conditions and allergies may be at heightened risk as a result of their medical condition or allergy. Mistakes in responding to a medical condition can have very serious consequences which can result in a short- or long-term deterioration in their health, hospitalisation or, in very rare cases, death. This is why it is so important for schools, colleges and early years settings to be active and conscious in managing the risks associated with medical conditions and allergy. The most effective settings are self-reflective, regularly challenging and testing their own arrangements and seeking to improve them wherever possible.

However effective a setting's policies are, they can never remove the risk of a serious incident involving a child, young person, member of staff or visitor with a medical condition or allergy. Medical conditions and allergies are not always predictable. Incidents may occur for reasons which are wholly beyond the control of the setting. Children and young people with no prior history of allergy may come into contact with and have a severe reaction to an allergen for the first time while in an education setting. In such cases the response by the school, college or early years setting will be critical: prompt recognition and effective emergency response action may be essential to saving a life.

If a child or young person experiences a life-threatening medical emergency, anyone – staff, volunteers or bystanders – may take reasonable action to save their life. The law recognises that rescuers act under extreme pressure. People who attempt to save a life in good faith are protected, even if an injury occurs while giving emergency care (for example, broken ribs during CPR are common and not a sign of wrongdoing). This includes administering adrenaline when an individual is suffering anaphylaxis. Schools, colleges and early years settings should be reassured that mistakes, hesitation, or imperfect technique do not amount to serious and wilful misconduct. The expectation is simply that staff act reasonably, to the best of their ability, in an emergency.

The frequency or rarity of serious incidents or "near misses" involving medical conditions or allergy will depend on the circumstances of the school, college or early years setting. Specialist settings (for example special schools and special post-16 institutions) may experience a higher rate of incidents where a significant proportion of the children and young people they support have complex medical conditions.

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What are serious incidents?

- A **serious incident** is any event relating directly to a medical condition (including allergy) in which a child, young person, member of staff or visitor with a medical condition or allergy is harmed or is placed at an immediate and significant risk of harm, including situations requiring emergency medication, urgent clinical intervention or attendance by emergency services.
- A “**near miss**” is an event relating directly to a medical condition (including allergy) that did not result in harm but had the clear potential to do so, for example, where an error, omission, or system failure could reasonably have led to a serious incident had circumstances been only slightly different.

“Near misses” are as important as actual incidents, since they may highlight weaknesses in a school, college or early years setting’s policies, procedures, training or communication and arrangements which, if not addressed, might have serious consequences in the future. While the “near miss” may not have led to harm on this occasion, they are a warning that, if circumstances had been different, serious harm could have occurred.

Not all serious incidents and “near misses” will result in an immediate emergency situation. In some cases the impact may be delayed. The consequences might not become apparent until the child or young person is back at home – and in some cases might not be seen for several days. It is therefore important that incident reporting is not limited to staff in the school, college or setting. The child or young person, their parents or others (for example healthcare professionals) may be the ones to identify that there has been an incident.

Following any serious incident or “near miss” involving a child, young person, member of staff or visitor with a medical condition or allergy, the school, college or early years setting should record what happened; report it as appropriate; and consider what lessons can be learned.

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Incident recording

Schools, colleges and early years settings should ensure any serious incident or near miss involving a child, young person, member of staff or visitor with a medical condition or allergy is recorded as soon as is feasible. A report should set out:

- **Who** was affected;
- **What** happened, **when** and **where**;
- **Why** the incident occurred (as far as is known);
- **How** staff and students responded; **what** was done to support the individual; whether **emergency services** were called;

- **How** the incident concluded.

Incident reporting

The report should be shared with the child's parents, the young person or the individual involved. They should be given the opportunity to discuss what happened and to contribute their views to the consequent lessons learned review.

The report should always be shared with the governing body, since the governor responsible for medical conditions and/or allergy will need to consider what lessons to learn and whether changes are required to the school, college or setting's medical conditions and/or allergy safety policies. Any learning should be shared appropriately with staff so they can act on them, reducing the chance of an incident reoccurring.

It may also be necessary to share the report with other agencies.

- Schools acting as food businesses must report any allergen-related food safety incidents to their local authority (Report a food safety issue).
- Schools, colleges and early years settings must report incidents which arose directly from the way they undertook a work activity and which resulted in death or immediate hospitalisation to the Health and Safety Executive (Incident reporting in schools (accidents, diseases and dangerous occurrences)).

Further information on these reporting requirements is provided below.

Reporting allergen-related food safety incidents

Schools, colleges and early years settings that operate as food businesses should record and review all allergen incidents and near-misses and, where appropriate, seek advice from their local authority environmental health team or Primary Authority. A legal duty to notify external authorities applies only when unsafe food has been supplied. Where a child or young person has been supplied unsafe food (for example, food containing an undeclared allergen), the food business must follow the Food Standards Agency's incident procedures, which may include withdrawing the food and, where necessary, recalling it. Near-misses and incidents that do not involve unsafe food being supplied are not subject to statutory notification, but should be recorded and used for learning and improvement.

Incorrect allergen information or near-misses that do not result in unsafe food being supplied are not subject to any statutory notification duty. These events should, however, be recorded and reviewed, and, where proportionate, discussed with the local authority environmental health team or Primary Authority as part of good

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practice and continuous improvement. Larger catering providers may handle this through their Primary Authority arrangements, while smaller in-house or local operators may seek advice from their local authority environmental health team.

Further information can be found at Report a food safety issue.

Investigating serious incidents: HSE

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) require employers such as schools, colleges and early years settings to report certain accidents, diseases and dangerous occurrences (near misses) arising out of or in connection with work to the HSE. This also applies to education settings, regardless of whether an accident happens to a child or young person, member of staff or visitor.

Schools, colleges and early years settings are only required to report incidents which arose directly from the way they undertook a work activity and which resulted in death or being taken directly to hospital.

Many of the common incidents that cause injuries to children and young people in a school, college or early years setting will not be reportable under RIDDOR, as they do not arise directly from the way the school, college or setting undertakes a work activity. Schools, colleges or settings only need to consider reporting where an accident results in a death or where an individual is taken directly from the scene of the accident to hospital for treatment. There is no need to report incidents where individuals are taken to hospital purely as a precaution, when no injury is apparent.

HSE's guidance on Incident reporting in schools (accidents, diseases and dangerous occurrences) is clear that a child or young person being taken to hospital because of a medical condition (e.g. an asthma attack or epileptic seizure) this would not be reportable, as it did not result from a work activity.

Medical conditions and safeguarding

The statutory guidance on Working together to safeguard children is clear that preventing the impairment of children's mental and physical health or development forms part of safeguarding and promoting the welfare of children.

The primary focus of DfE's statutory guidance (Keeping children safe in education) on safeguarding children in schools and colleges is to provide guidance on the policies and procedures they should or must have in place to respond to incidents of neglect, abuse and the exploitation of children posed by intra or extra familial harms, rather than health and safety or the management of child medical conditions.

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The fact that there has been an incident relating to the management of a child or young person's medical condition (including allergies) would not in and of itself warrant a referral to local safeguarding partners. A safeguarding referral would only be needed where an incident highlighted concern that the child or young person might be at an increased risk of being neglected, abused or exploited by persons inside or outside of their family unit because of their medical condition. This might occur where relevant information about a child or young person's medical condition is not provided to a school, college or setting, or where they are repeatedly sent without essential medication, thereby putting the individual at risk.

Learning lessons from incidents and "near misses"

We recommend that the report should be submitted to the designated member of the governing body responsible for medical conditions and/or allergy. The child or young person and their parents should be involved in reviewing the arrangements made (for example in the Individual Healthcare Plan) to ensure they are robust and appropriate.

The designated governor and designated senior leader should consider:

- Could the school, college or setting reasonably have foreseen an incident of this nature?
- Did the school, college or setting have policies (for example a medical conditions policy, allergy safety policy or Individual Healthcare Plan) which set out how to respond to an incident of this nature?
- Were the school, college or setting's policies followed? If not, are there staff training, capability or even disciplinary issues to consider?
- Were the school, college or setting's policies adequate? If not, what changes might be required?
- Might the incident or near miss have been avoided through reasonable preventative steps? If so, what steps might have been taken? Should the school, college or setting's policies be changed as a consequence?

The governing body and the designated senior leader of the school, college or early years setting should consider whether the incident or near miss indicates that any statutory duties may have been breached, or at significant risk of being breached, and whether there were weaknesses in the relevant policies and/or Individual Healthcare Plan. If so, they will need to ensure steps are taken to review and where necessary amend the relevant policies or practice.

"Near misses" are particularly important in this respect, since they highlight weaknesses or risks and offer an opportunity to learn lessons without causing actual

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harm to a child, young person, member of staff or visitor. Some settings have used simulated drills, active training and role play to test out how staff would respond to a medical emergency or case of anaphylaxis, without putting individuals at risk.

When the governing body, proprietor or management committee of the school, college or early years setting reviews its medical condition and allergy safety policies, all recent serious incidents and “near misses” which have occurred should be considered, since they will indicate potential areas for improvement.

Supporting wellbeing following a serious incident

An incident or a “near miss” with the potential to put a child or young person’s life at risk is a serious event. The school, college or early years setting should consider its impact not only on the individual and their family, but also on those involved in responding and any children or young people who may have witnessed it.

The school, college or setting should take time to review the incident or near miss with the child or young person and their parents, since they may be understandably concerned that the environment may not be safe. The child or young person and their parents should be involved in reviewing the arrangements made (for example in the Individual Healthcare Plan) to ensure they are robust and appropriate. This is essential to retaining confidence that the school, college or setting is safe for the child or young person.

The school, college or setting should consider how it supports the staff involved. This might involve giving them time to reflect on what happened, in a constructive spirit. Carelessness, inadvertence or a simple mistake do not amount to serious and wilful misconduct.

The school, college or setting should consider how it communicates the incident or near miss internally. This can provide a valuable opportunity to remind all members of the community of the importance of supporting those with medical conditions and of the school, college or setting’s medical conditions and/or allergy safety policies. However, care should be taken to respect the privacy of the child or young person involved.

Complaints

The governing body, proprietor or management committee of the school, college or early years setting should ensure that their complaints processes permit complaints to be raised and investigated following a serious incident or near miss relating to a child or young person’s medical condition.

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Child deaths

The death of a child or young person with a medical condition while in school, college or an early years setting is a rare and tragic event. Further information on child death reviews can be found in the statutory guidance Working together to safeguard children. Schools, colleges and early years settings should be aware of the Child death review: statutory and operational guidance (England).

The unexplained death of a child or young person may be subject to investigation by the police and a Coroner’s inquest. Schools, colleges and early years settings should be aware that materials such as residues of food consumed or handled or samples of fluids may constitute evidence, which may need to be seized and retained.

Schools, colleges and early years settings should consider how to support children and young people and their own staff following a child’s death. They should also consider how they can support the grieving family, and in particular any siblings. Support can be found through organisations such as Child Bereavement UK and the Child Death Helpline.

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Annex: Specific medical conditions

Medical conditions frequently found in schools

Children and young people may present with many medication conditions. We have provided short summary information about a number of common or significant conditions, indicating how schools, colleges or early years settings might need to respond.

Acquired brain injury

Acquired brain injury (ABI) is an umbrella term for any illness or injury to the brain that happens after a period of expected development, both via traumatic causes (e.g. falls, assaults, road traffic accidents) and non-traumatic causes (e.g. illnesses/infections, strokes, brain tumours, lack of oxygen). An ABI can impact on all aspects of a child or young person's functioning: physical, cognitive, emotional, behavioural, communication and social. Neuro-fatigue is also highly prevalent. ABI is a common but often under-recognised condition in schools. In 2018 over 40,000 children presented to hospital with an ABI of some kind. By age 18, an estimated 0.85-2.73% of children and young people will have experienced a hospital admission for a condition associated with an ABI.

ABIs can range from mild (e.g. concussion) to severe. Concussions are typically short-term medical conditions. ABIs can require support ranging from simple adaptations in the weeks after an injury to long-term individual support or even changes in school placement. All ABIs need to be monitored throughout a child or young person's time in education, as new needs can emerge or evolve as the brain develops.

When returning to school after an ABI, a child or young person will require a timely and flexible response to their acquired needs. They are likely to need an Individual Healthcare Plan and may require support to address any special educational needs, as well as training for staff and peers, adaptations to the environment, curriculum and teaching methods, and coordination of multi-professional meetings. This should be planned alongside health professionals and should utilise advice from specialist services and organisations.

The United Kingdom Acquired Brain Injury Forum provides information about supporting and maintaining a child's return after ABI, concussion guidance for schools, and signposts to key resources and supporting organisations.

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Arthritis and related musculoskeletal and rheumatic conditions

Around 5% of children and young people aged 0–19 in the UK live with a musculoskeletal (MSK) condition, meaning many children and young people may face daily challenges related to joint pain, fatigue, or mobility. Rheumatic conditions affect the soft tissues, joints, bones, cartilage, tendons, ligaments and muscles.

Juvenile Idiopathic Arthritis (JIA) is a chronic autoimmune condition, diagnosed before the age of 16, in which the immune system mistakenly attacks the body's own joints. This causes inflammation, leading to symptoms such as pain, stiffness and fatigue; the emotional toll can also be high. There is no cure. Almost one in five children and young people with JIA have uveitis, a type of inflammation that affects the eye.

These conditions can affect movement around school, writing, concentration, participation in PE and stamina. Symptoms often fluctuate unpredictably. Children and young people also have to also manage the side effects of medications they take. Some children and young people will be absent to attend treatment, appointments and to manage their condition. Reasonable adjustments such as extra time to move between lessons, adapted seating, writing support, flexible PE activities, or rest breaks can make all the difference to a pupil's wellbeing, outcomes and participation. Furthermore, children and young people face misconceptions that arthritis only affects older adults. Understanding, inclusion and wellbeing support are vital.

Good communication between school staff, the young person, and their family is essential. A regularly updated Individual Healthcare Plan helps ensure needs around symptom management, wellbeing and medication are met. Musculoskeletal conditions vary dramatically for each individual and so education providers need to meet with the child or young person and their family to gain an understanding of the individual impact and how best to support them.

Information, IHP templates, training, tools and specialist support are available from Arthritis UK, Children's Chronic Arthritis Association, Lupus UK Youth and NRAS | Rheumatoid arthritis charity.

Asthma

Asthma is the most common long-term condition among children and young people and one of the leading causes of school absence. On average, there are two children with asthma in every classroom in the UK, and 1.1 million children are currently receiving asthma treatment. Asthma remains among the top 10 causes of emergency hospital admissions among children and young people in the UK.

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There were 54 child deaths due to asthma and 19 from anaphylaxis between April 2019 and March 2023, as set out in the National Child Mortality Database Report on Asthma and Anaphylaxis. All of the children who died from anaphylaxis and had known allergies were also diagnosed with asthma. Further, 87% of schools are in neighbourhoods with air pollution above WHO guidelines, while 1654 schools are exposed to air pollution more than double the WHO guidelines. All of the children who died due to asthma were exposed to air pollution above WHO guidelines.

Asthma exacerbations are typically precipitated by identifiable triggers. In individuals with allergic asthma, exposure to airborne allergens such as pollen, house dust mite debris, pet dander and mould spores is a common trigger of worsening symptoms and exacerbations in sensitised people. Viral respiratory infections (such as rhinovirus, flu, RSV, and COVID-19), allergen exposure, and air pollution are recognised as among the most common contributors to acute asthma exacerbations, with evidence of synergistic interactions that can increase severity in sensitised children. Exercise and cold air can also cause symptoms. Common symptoms include coughing, wheezing and breathlessness out of proportion to effort, and a tight chest. An asthma attack occurs when symptoms are severe, and breathing becomes difficult.

Poor air quality worsens asthma and increases asthma attacks, and those in deprived areas with poorer nutrition suffer increased negative health effects from poor air quality. Clean air is a core asthma control measure. Good ventilation, air quality monitoring and supplemental HEPA air filtration are essential, especially when ventilation is limited and outdoor air is polluted. Systematically integrating and embedding clean indoor air into legal health and safety duties, policies, procedures and practices will reduce pressure on staff and ensure consistency and support without too much extra work.

Children and young people known to have asthma should have their own reliever inhaler at school to treat symptoms and for use in the event of an asthma attack. Schools may also stock “spare” asthma reliever inhalers for use in an emergency if an individual’s prescribed device is unavailable. If they are able to manage their asthma themselves they should keep their inhaler on them, and if not, it should be easily accessible to them. In some cases children and young people with suspected asthma will be prescribed a reliever inhaler before they receive a formal diagnosis.

Where children and young people travel long distances to their school, college or early years setting, consideration should be given to how the risks of asthma should be managed.

Further information is available through Asthma friendly schools.

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“Spare emergency asthma reliever inhalers

The Human Medicines (Amendment) (No. 2) Regulations 2014 permits schools to buy salbutamol inhalers, without a prescription, for use in emergencies. The emergency salbutamol inhaler should only be used by children, for whom written parental consent for use of the emergency inhaler has been given, who have either been diagnosed with asthma and prescribed an inhaler, or who have been prescribed an inhaler as reliever medication. The inhaler can be used if the pupil’s prescribed inhaler is not available (for example, because it is broken, or empty). Guidance is available on Emergency asthma inhalers for use in schools.

Keeping an inhaler for emergency use could prevent an unnecessary and traumatic trip to hospital for a child, and potentially save their life. Parents are likely to have greater peace of mind about sending their child to school. Having a clear policy on how and when the inhaler should be used will ensure staff know what to do in the event of a child having an asthma attack.

Schools which choose to keep an emergency inhaler should establish a policy or protocol for the use of the emergency inhaler as part of their medical conditions policy. The policy should cover:

- arrangements for the supply, storage, care, and disposal of the inhaler and spacers, including checking that they are in-date and in working order;
- how children and young people who have been diagnosed with asthma or prescribed a reliever inhaler are identified;
- securing written parental consent for use of the emergency inhaler, to be recorded on their Individual Healthcare Plan;
- ensuring that the emergency inhaler is only used by children with asthma with written parental consent for its use;
- training for staff in the use of the emergency inhaler;
- keeping a record of use of the emergency inhaler and informing parents or carers that their child has used the emergency inhaler.

Bladder and bowel (continence) conditions

It is estimated that bladder and bowel (continence) problems affect more than 1.5 million children and young people in the UK. These issues include but are not limited to: constipation, soiling, daytime wetting accidents, delayed toilet training and bedwetting. For many children and young people their continence problem will be chronic, meaning it could persist for many years or keep recurring. Other children and young people may have an underlying condition that requires lifelong management.

These conditions can have a devastating impact on a child’s learning, development and wellbeing. Children and young people with continence issues are at high risk of bullying and withdrawing from social situations. Most suffer embarrassment and stigma. Furthermore, continence difficulties may also be associated with behavioural or psychological problems, poor self-image and peer victimisation.

Children spend a significant proportion of their day at school, college or early years. Education settings need to manage continence issues effectively by supporting and promoting the principles of good bowel and bladder health. This includes providing access to drinks, clean and safe toilets and toileting support.

Guidance on Managing continence problems in schools provides a framework to help education, health and social care professionals understand bladder and bowel difficulties and issues faced by children and young people in educational settings. For further information on bladder and bowel conditions in children visit www.eric.org.uk and www.bbuk.org.uk.

Cancer

Around 4,200 children and young people under 25 are diagnosed with cancer every year in the UK. Undergoing treatment for cancer can often result in significant missed time from education, in long, continuous periods or intermittently throughout treatment. This can be due to many factors, including:

- being admitted to hospital;
- intensive treatment requiring frequent hospital attendance;
- being treated in specialist hospitals far from home;
- treatment side effects, such as sickness, pain, and fatigue;
- being immunocompromised and needing to stay out of public settings, such as following chemotherapy or a stem cell transplant;
- generally feeling too unwell to engage in education.

After treatment ends, children and young people can suffer from “late effects” (or “long-term effects”), side effects of having cancer and its treatment which begin or persist after treatment ends. There are many kinds of late effects, but some which might have a greater impact on education are, for example:

- mobility changes;
- concentration and learning changes or impairment;
- hearing loss;

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- fatigue;
- pain.

There may be particular neurological or cognitive impacts for children and young people impacted by brain tumours.

Cancer treatment can be traumatic and also have a significant impact on children and young people’s mental and emotional health which can persist long after treatment ends. They may also be dealing with other physical changes such as hair loss, weight changes, scarring and changes to the onset of puberty (either accelerated or delayed) which may impact on their self-esteem and socially. They may have other anxieties about having fallen behind, having been isolated from friends for long periods or other health anxieties such as worrying about cancer coming back. This can cause anxiety and trauma around returning to education.

Cancer treatments such as chemotherapy and stem cell transplants can impact the immune system, so infection risk can be a concern when returning to education, especially for younger children who may be susceptible to childhood illnesses such as measles, chicken pox and other infections. Schools, colleges and early years settings need to be vigilant and inform families of children and young people with cancer immediately of outbreaks or incidences of illnesses amongst children and young people.

During treatment, children and young people may be absent from their usual education provider for long periods. Most specialist children’s cancer hospitals have education departments to help patients keep up with school work as much as possible, and facilitate taking exams where necessary. A keyworker (e.g. clinical nurse specialist or social worker) will support communication and coordination with education providers and the hospital, so that an education plan can be put in place, work can be in line with their usual class and learning materials can be shared to support educational progression.

Keyworkers will also help coordinate Individual Healthcare Plans and education plans so that after treatment, the “home” school, college or setting is aware of the child or young person’s health and educational needs after treatment.

In some instances, home tuition may be appropriate or required, for example if the child or young person is required to isolate due to being immunocompromised. The hospital clinical and education teams, key workers, and education provider should support referrals to the local authority to put alternative provision in place where the child or young person cannot attend school on the advice of a medical practitioner (Education for children with health needs who cannot attend school).

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Other actions which may support children and young people with cancer returning to education are:

- Planning and coordination between all parties - hospital teachers, school, college or university staff, clinicians, social workers and the family;
- Short visits before formal return to education;
- Phased returns or part-time schedules;
- Regular communication with designated staff or support workers;
- Flexibility in attendance and support to take time off for appointments;
- Extra time for coursework and extensions to deadlines;
- Access arrangements or special considerations for exams;
- Access to notetakers;
- Extra help from teachers or learning support assistants;
- Access to specialist/supportive equipment;
- Help for food needs (e.g. access to storage for chilled food/specialist food, or being able to eat extra snacks in class);
- Staff awareness of cancer and its impact.

Further information can be found through Education - Young Lives vs Cancer and Dealing with school - The Children & Young People's Cancer Association.

Childhood Liver Disease

There are over 100 different childhood liver diseases. Most are life threatening and the reason why they occur is often unknown. Although rare, childhood liver disease will be diagnosed in over 400 children per year. There are only three specialist centres in the UK for childhood liver disease and these are Leeds General Hospital, Birmingham Children's Hospital and Kings College Hospital, London.

Treatment is often centred on dealing with the consequences of liver disease – increased liver damage, ascites, portal hypertension, vitamin deficiencies and failure to thrive. Treatments vary with the nature of the disease and include dietary management, medication and surgery, including transplant. Ongoing medical monitoring is essential. Liver transplantation may be necessary if liver damage is substantial and, following surgery, will mean a lifetime of immunosuppressant medication and higher susceptibility to infection.

Childhood liver disease can be invisible and the condition will affect children and young people in different ways. It is a chronic condition which will have acute periods which necessitate hospital admissions. Schools, colleges and early years settings should put in place Individual Healthcare Plan recognising the child or young person's signs and symptoms and supporting necessary absence related to their

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condition. Childhood liver disease can impair cognitive development in some children so may result in special educational needs.

Further information can be found at Liver Information and Advice | Children's Liver Disease Foundation and Children – British Liver Trust & Children's Liver Disease Foundation Publications including an Education Pack for educational settings.

Clinically Vulnerable children and young people

Some children and young people are clinically vulnerable. This means they have an underlying health condition, or combination of conditions, that places them at higher risk of becoming seriously unwell than their peers from infections and other factors, such as environmental factors, or that can negatively influence a child or young person's health and result in complications or a longer recovery period. Clinical vulnerability is associated with long-term conditions, fluctuating conditions and treatments or “invisible” conditions. The level of risk may change over time. Children and young people who are immunocompromised or immunosuppressed will be clinically vulnerable.

Schools, colleges and early years settings should work in partnership with the child or young person (where appropriate), their parents and any healthcare professionals involved in their care to understand how the child or young person’s condition affects them and what support will enable them to attend, learn and participate safely. Where arrangements are required, these should be set out in an Individual Healthcare Plan, including how to respond in an emergency.

Schools, colleges and early years settings should have regard to relevant current public health guidance in supporting clinically vulnerable children and young people, alongside their existing infection prevention and control arrangements. This may include, where appropriate, supporting good respiratory and hand hygiene; ensuring good ventilation of indoor spaces (Ventilation and air quality in education and childcare settings); cleaning and environmental hygiene practices; reducing avoidable close contact during periods of increased infection risk; and supporting children and young people to follow any individual clinical advice provided to them, so that they are able to access education safely alongside their peers. Where a child or young person chooses to wear a protective mask for health reasons, schools, colleges and settings should support this choice and ensure that they are not discouraged or treated unfavourably for taking proportionate steps to protect their health.

Further information can be found at Clinically Vulnerable Families | Work School & Lives.

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Coeliac disease

Coeliac disease is a serious autoimmune condition triggered by the consumption of gluten. Exposure to gluten causes damage to the small intestine and can result in significant symptoms including abdominal pain, fatigue, nutritional deficiency and impaired growth, as well as longer-term health risks if not properly managed.

Children and young people with coeliac disease require safe meal provision, and awareness among staff of how exposure to gluten can occur and how it affects the child's health, attendance and wellbeing.

Coeliac UK supports those with coeliac disease for which the only treatment is a gluten free diet for life. The Coeliac UK website offers guidance and advice to everyone involved with supporting a child with coeliac disease in school, including training resources for caterers and parents, as well as templates to support the appropriate care plans and safe food provisions.

Congenital heart disease

Congenital heart disease (CHD) refers to structural or functional problems of the heart present from birth. CHD manifests symptoms such as breathlessness, fatigue, chest pain, dizziness, or fainting. This often limits a child or young person's ability for physical exertion, affecting participation in the full school day. After cardiac treatment, including surgery or interventional procedures, children and young people may experience ongoing or long-term effects, either from their underlying heart condition or from the treatment itself. This can include: fatigue and reduced tolerance of physical exertion or exercise; motor skill delays or reduced stamina; reduced concentration or slower processing speed (sometimes associated with reduced oxygenation); feeding or nutritional challenges; and ongoing pain or discomfort.

Depending on the severity of their condition and any interventions required, children and young people with CHD may need to miss significant periods of education. Absence may occur in long consecutive periods or intermittently. It may be caused by being admitted to hospital for planned or emergency cardiac surgery; recovery periods following surgery or cardiac catheterisation procedures; ongoing outpatient appointments, monitoring, and diagnostic tests; and treatment in specialist cardiac centres far from home. Collaborative planning between hospital school teams, clinical teams, school or college staff, and families is important. Where the child or young person has been absent due to surgery and recovery, short pre-return visits can be helpful to prepare them for routines and minimise anxiety.

Children and young people with complex CHD, including single-ventricle physiology or those who have undergone staged surgeries, may have neurodevelopmental or

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cognitive vulnerabilities. These can include challenges with attention, working memory, executive function, and social communication, which may affect learning and classroom engagement.

Experiences of cardiac surgery, repeated hospital admissions, or living with a long-term cardiac condition can be emotionally and psychologically challenging. Children and young people with CHD may experience anxiety about their health, fear of overexertion, concerns about visible scars, or worries about being seen as “different” by their peers.

Some children and young people with CHD may be at increased risk of infection, especially those with cyanotic heart disease, those recovering from surgery, or those taking certain medications (e.g. immunosuppressants following transplantation). Viral illnesses such as flu, RSV, or measles can be particularly serious. Schools, colleges, and early years settings should promptly inform families of any relevant outbreaks so that appropriate precautions can be taken. During periods of treatment or recovery, children and young people with CHD may be absent from their usual education provider for extended periods. Specialist cardiac centres often have hospital school provision that supports continuity of learning and ensures curriculum alignment. Clinical nurse specialists, cardiac liaison nurses, or designated keyworkers typically coordinate communication between health teams and education providers so that an appropriate education plan can be developed, and learning materials shared.

Other actions which may support children and young people with congenital heart disease returning to education include:

- Regular communication with designated staff members and staff awareness and training on CHD and its impact on daily functioning;
- Flexibility around attendance and medical appointments;
- Phased returns or reduced timetables where fatigue is an issue;
- Careful planning for meals, hydration, and medication access;
- Access to supportive seating, temperature control, or adapted equipment;
- Support for handwriting speed, notetaking, or motor challenges where relevant;
- Reasonable adjustments for PE and physically demanding school activities;
- Provision of rest breaks or access to quiet spaces when fatigued;
- Special consideration for exams, including rest breaks or extra time.

Further information can be found at Education Resources | Little Hearts Matter.

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Cystic fibrosis

Cystic fibrosis (CF) is a genetic condition affecting over 11,000 people in the UK which causes a build-up of mucus in the lungs, digestive system and other organs, causing a wide range of challenging symptoms affecting the entire body. CF is a varied condition and every child and young person will have individual support needs to ensure they can access a full educational experience. Specialist clinical teams provide care for those with CF and can advise on how to support them in education settings. This guidance should be key in developing Individual Healthcare Plans.

Children and young people with CF will require daily treatment, mainly at home, often including physiotherapy, nebulisers, and complex medication regimes. Many will need to take pancreatic enzymes with every meal and snack; they should be supported with this in school and be able to access these easily or carry them with them to self-administer when they are capable of doing so. Some children and young people with CF will also have diabetes, which is likely to require management during the school day. Attendance at regular specialist NHS clinics is vital for management of the condition.

Children and young people with CF frequently struggle with energy levels. It can be helpful for a school, college or setting to have a designated private, quiet area which would support those with CF if they are exhausted and need to rest due to their condition. A healthy environment is important; this can include minimising damp, mould and dusty environments, considering infection risk from coughs and colds in other students and staff, and ensuring students with CF are not exposed to second-hand smoking/vaping (including in school toilets, in spite of clear rules). The risk of cross-infection means people with CF are advised not to meet face to face with each other, which can have implications for schools with more than one pupil with CF, or with a pupil and a staff member with CF. Specialist NHS CF teams can advise on risk assessment and management.

As well as affecting the lungs, CF also affects the digestive system, which may mean that students with CF need to eat different things or eat at different times, or may need quick and discrete access to a toilet throughout the day.

CF is often covered as part of the secondary school curriculum, and students with CF (or with a family member/friend with CF) may need support through this. Treatment for the condition is changing rapidly, and text books and online resources can often be out of date. Children and young people will have differing levels of awareness of their condition and its effects, and may or may not have shared their diagnosis with their peers. Those affected by CF and their families should be made aware in advance when CF will be taught in their lessons, and supportive

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discussions should be held (and documented on the child or young person's IHP) to establish how they will be supported.

The charity Cystic Fibrosis Trust provides resources for teachers and schools: Cystic fibrosis information for teachers and other resources including information packs, class passes and a IHP template.

Diabetes

Diabetes is a serious condition with two main types: type 1 and type 2 diabetes. Both are serious conditions where the blood glucose level is too high either because the body is unable to produce a hormone called insulin (type 1) or doesn't produce enough of it (type 2). Most children and young people with diabetes will have type 1, but cases of type 2 are rising amongst children and young people.

Diabetes can affect a child or young person's learning because it can cause difficulties with attention, memory, processing speed and perceptual skills if blood glucose levels are not managed. On average, children with type 1 diabetes miss nine extra school sessions per year, but have similar GCSE attainment to their peers without diabetes. Many children and young people with diabetes use medical technology like continuous glucose monitors (CGMs) to enable them to do so with greater ease and accuracy. CGMs help people with diabetes avoid dangerous high (hyper) or low (hypo) blood glucose levels and are connected to mobile phone or smartwatch apps that display glucose readings, send hypo alerts and allow parents and carers to follow a children or young person's levels remotely.

All children and young people with type 1 diabetes need to administer insulin. Some children and young people with type 2 diabetes will administer insulin, though they may be treated with other medications. Insulin can be administered with an insulin "pen" but many children and young people with type 1 diabetes will use an insulin pump that is attached to the body and releases insulin regularly. Insulin pumps can be connected to CGMs to create a hybrid closed loop (HCL) system that automatically adjust insulin delivery based on glucose readings from a CGM. Insulin pumps and HCL systems require some manual input which is typically done with a mobile phone via an app.

It is vital that children and young people with diabetes are supported to keep their blood glucose levels in a healthy target range to avoid hypos and hypers. Exercise and food intake impact blood glucose levels alongside other factors like stress and illness. It is important that schools, colleges and early years settings agree measures to support children and young people to monitor glucose levels closely, interpret them and take steps to mitigate any negative effects. This should not be a barrier to being included in school activities. For example, a child or young person with

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diabetes should be able to enjoy all kinds of physical activity but will need support to plan in advance as exercise can lower glucose levels and risk hypos. Because of this, they might need to have an extra snack before, during and after physical activity, alter their insulin dose and check their blood glucose more regularly. In many cases older children and young people may be able to manage their own blood glucose levels. They should be encouraged to take increasing levels of responsibility in doing so, where it is safe and appropriate – but this process will still require ongoing support from staff in the school or college.

Further information about managing diabetes in schools can be found at Diabetes in Schools | Diabetes UK .

Eczema

Atopic eczema (also called atopic dermatitis) is a common, relapsing inflammatory skin condition that affects up to 20% of children. It presents with dry, itchy, red/inflamed skin with patches that can ooze or crust during flares. It typically involves the skin creases (behind knees, inside elbows), hands, wrists, neck and around the eyes but can be so severe that the whole body is affected.

Triggers can include irritants (soaps, detergents, fragrances), heat/sweating, stress, illness, exposure to allergens, rough fabrics, and environmental factors. The mainstay of treatment is regular application of moisturisers and anti-inflammatory creams such as steroids. In more severe cases, oral or injected medicines are needed.

Eczema can affect sleep, concentration, mood, self-esteem and participation in sport; visible eczema may contribute to stigma or bullying, and frequent flares can increase absence for appointments or infections.

Schools, colleges and early years settings should have a simple, child-centred plan agreed with parents/carers (and the young person where appropriate). This should encompass:

- The need to apply skin creams such as moisturisers and steroid creams (including permission, privacy and hand-hygiene);
- correct use and safe storage of prescribed creams such as topical steroids
- identification and avoidance of known triggers (e.g. swapping soaps for emollient substitutes, managing heat/sweat, accommodating cotton uniforms)
- any reasonable adjustments that are needed (extra time to apply emollients, letting students carry moisturisers, access to cool rooms, non-punitive responses to scratching, support for sleep-related fatigue).

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Staff should be able to recognise red flags that need same-day parental contact/clinical advice (rapidly worsening redness, weeping/crusting of the skin, pain, fever, spreading rash, eye involvement), and should actively support wellbeing (anti-bullying, inclusive adaptations for PE and sport, and exam/support measures if sleep disruption is significant).

Further information can be found through the NHS overview of atopic eczema and the National Eczema Society.

Epilepsy

Epilepsy is one of the most common long-term conditions for children and young people (affecting around one in 220 children), but it affects each person differently and there are many types of seizure. Some seizures are more noticeable than others and they may happen quickly or continue for a few minutes. Signs of a possible seizure include:

- Uncontrollable jerking or shaking;
- Losing awareness and staring blankly into space;
- Becoming rigid or collapsing;
- Changes in vision;
- Strange sensations.

Epilepsy can have a significant impact on a child or young person's education, even if seizures are controlled or do not occur during the day.

Individual Healthcare Plans are essential to help staff in a school, college or setting understand each child or young person's epilepsy so they can be kept safe and included. The IHP should include a description of their seizure types, impact on learning and emotional wellbeing, what to do when a seizure happens and what constitutes an emergency. This may be different for each child or young person and will need to reflect any care plan or emergency plan issued by their healthcare team.

When a seizure occurs, it is important to time the seizure, stay with the young person, reassure them and keep them safe. Most seizures stop by themselves without the need for treatment, but some young people may need access to emergency epilepsy medication. Seizures that go on too long can cause damage to the brain or may lead to death.

Staff will need to be trained in how to give emergency medication safely. Training should meet the standards set out in the Epilepsy Nurses Association (ESNA) guidelines on emergency medication training.

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The charity Young Epilepsy has free information and resources for professionals working in education: For educators | Young Epilepsy.

Fluctuating conditions

Conditions which have a substantial effect but fluctuate or recur will be considered to have a long-term impact if the substantial effect is likely to recur. Further information is provided in section C5 of in Guidance on matters to be taken into account in determining questions relating to the definition of disability.

Hypermobility spectrum disorder

Some people may be able to extend their joints further than is usual – this is known as being hypermobile or double-jointed. Hypermobility is quite common in the general population, especially in children and, on its own, is not necessarily a problem. However, hypermobility can be associated with long-term, widespread pain, frequent dislocations, damage to the tissues surrounding joints and fatigue. When hypermobility comes with these problems it is called symptomatic hypermobility. People who are hypermobile may also struggle to sense the position of their joints (this is called having poor proprioception). This can make them appear clumsy and can lead to falls and other injuries.

There are 13 types of Ehlers-Danlos syndrome (EDS), a group of genetic (heritable) conditions affecting the connective tissue which is found throughout the body. Connective tissue holds joints and internal organs in place and is an important structural component of skin, blood vessels and other tissues. In EDS, a certain kind of connective tissue (collagen) is fragile and stretchy. This can cause symptoms throughout the body. The most common type is hypermobile EDS. The remainder are relatively rare, though vascular EDS (vEDS) can be life-threatening.

Symptoms can vary widely between children and young people with hypermobility and EDS, even in those from within the same family. The same individual may experience huge variation in how their condition affects them day by day and over their time.

- Children and young people with joint hypermobility (JHS) or EDS may present as being distracted, fidgety and uncooperative in class. This could be caused by a range of factors including pain, the need to move for joints to be comfortable and/or to stop muscle spasms, difficulty writing, tiredness or anxiety.
- Tiredness caused by JHS or EDS may present as slowness in the body and in thinking, gradually getting worse through the day. Sometimes bouts of extreme tiredness might cause the pupil to fall asleep. Those who have

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postural tachycardia syndrome (PoTS), which can be associated with JHS and EDS, may experience worse tiredness in the morning but this may also be prolonged after a PoTS flare.

- Children and young people may experience a general persistent pain, muscle spasms or sensory pain. At times they may appear “brain fogged”, with difficulty thinking or concentrating.
- Children and young people may not be able to keep up with their peers in the playground, may be less able to participate in social activities outside of school and may experience anxiety, making maintaining friendships challenging. They may need extra emotional understanding and support.
- Particularly severe symptoms may affect attendance, as will the frequent medical appointments which often come with having the conditions. Most children and young people with JHS or EDS want to fully participate in school life but find it too challenging physically and mentally in the school environment.

Further information and resources on hypermobility and EDS can be found at School toolkit for JHS and EDS.

Immunocompromise and Immunosuppression

Some children and young people may have conditions or treatments making them Immunocompromised (IC) or Immunosuppressed (IS). This means their immune system is less able to fight infections. This may be due to an underlying condition affecting immune function or as a result of medical treatment, such as chemotherapy, organ transplant medication, high-dose steroids, or other immune-modifying therapies. The level of immune suppression may vary over time depending on treatment or recovery. Immunocompromised or immunosuppressed individuals are at increased risk of infection and serious illness, including those transmitted through close contact and through the air in indoor environments.

Schools, colleges and early years settings should work in partnership with parents and, where appropriate, the child or young person’s clinical team to understand any specific precautions which may be required. They should consider what support will enable safe attendance and participation, including remote education where attendance is not possible for health reasons. These arrangements should be set out clearly in an Individual Healthcare Plan, including how to respond if the child or young person becomes unwell or is exposed to infection.

Schools, colleges and early years settings should have regard to relevant current public health guidance in supporting immunocompromised or immunosuppressed children and young people, as well as their existing infection prevention and control

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arrangements. This includes measures to reduce transmission of infections spread by respiratory droplets and aerosols, such as maintaining good respiratory and hand hygiene, ensuring adequate ventilation of indoor spaces, following cleaning and environmental hygiene practices, and implementing reasonable adjustments. Arrangements should be designed to enable the pupil to access education safely alongside their peers, while maintaining confidentiality and preventing stigma.

Inflammatory bowel disease (IBD)

Inflammatory bowel disease (IBD) includes Crohn's disease and Ulcerative Colitis. These are lifelong conditions caused by inflammation in the gut, which can make children and young people feel unwell at times (flare-ups), with periods when symptoms are better controlled (remission). Symptoms can include urgent and frequent diarrhoea, tiredness, pain, difficulty concentrating, weight loss, delayed growth or puberty, and some children and young people may also experience symptoms affecting their joints, skin or eyes; treatment can include medicines, nutritional support, hospital procedures or surgery.

Crohn's and Ulcerative Colitis are often unpredictable and can vary from day to day. Schools, colleges and early years settings may need to make reasonable adjustments to help children and young people manage their condition and take part fully in education. This may include unrestricted access to toilets, flexibility around attendance (including attending hospital appointments), timetables, physical activity and assessments, access to medication, rest breaks, and support for emotional wellbeing.

For further resources on how to support children with IBD visit Crohn's & Colitis UK, NICE guidance on Ulcerative colitis and NICE guidance on Crohn's disease.

Long Covid

Long Covid is a condition involving persistent symptoms following SARS-CoV-2 infection. Presentation varies and may include fatigue, cognitive impairment, breathlessness, autonomic dysfunction, pain, mobility impairment, and exacerbation of pre-existing respiratory, allergic, neurological or immune-related conditions.

Children and young people with Long Covid may experience fluctuating and unpredictable capacity. Schools, colleges and early years settings should therefore be flexible and responsive, with adjustments that may include reduced or flexible timetables, rest breaks, environmental adaptations and examination adjustments where appropriate. For some children and young people, periods of reduced attendance, home-based learning, or sustained rest may be necessary in line with the known fluctuating nature of the condition.

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Emerging evidence indicates that some children and young people with Long Covid may have increased respiratory sensitivity or exacerbation of allergic or asthmatic conditions. Environmental factors such as poor air quality and inadequate ventilation may therefore have heightened impact. Schools, colleges and early years settings should consider both infection prevention and environmental health measures.

Further information, resources and educational materials are available from Long Covid Kids, including an educational toolkit and a IHP template.

Mast Cell Activation Syndrome (MCAS) and Mast Cell disorders

Mast Cell Activation Syndrome (MCAS) is a complex, multi-system condition involving inappropriate activation of mast cells - cells which play an important role in immune defence and allergic responses. When activated, mast cells release chemical mediators (such as histamine) which can affect multiple body systems. Symptoms can be episodic, fluctuating and unpredictable. MCAS affects multiple body systems including the skin, gastrointestinal system, cardiovascular system, respiratory system and neurological functioning. Symptoms vary between individuals and can include flushing, hives, abdominal pain, nausea, diarrhoea, headaches, dizziness, faintness, rapid heart rate, fatigue, cognitive difficulties ("brain fog"), joint pain and, in some cases, anaphylaxis. Some children and young people may also have associated conditions such as hypermobility spectrum disorders, Postural Tachycardia Syndrome (PoTS), asthma or migraine. Triggers vary significantly between individuals and may include foods, temperature change, infection, stress, exercise, medication, insect bites or stings, environmental exposures (including fragrances, aerosols or cleaning products), or sometimes no clearly identifiable trigger.

MCAS can have a substantial impact on attendance, stamina and participation. Symptoms may fluctuate daily or even within the same day. Fatigue can be significant and may worsen after exertion. Cognitive symptoms may affect concentration, processing speed, memory and communication. Some children and young people may experience repeated absences due to flares, hospital appointments or emergency care. Others may struggle to tolerate aspects of the physical school environment, particularly where airborne triggers such as fragranced products, poor ventilation or cleaning chemicals provoke symptoms. The unpredictable nature of the condition can cause anxiety, social isolation and reduced confidence, particularly if peers or staff do not understand the condition.

MCAS will require an Individual Healthcare Plan. This should set out: known triggers and preventative strategies (including environmental adjustments where required), early warning signs of a flare or systemic reaction, medication requirements and arrangements for access to medication and emergency procedures where

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anaphylaxis risk exists. Children and young people with MCAS are likely to need access to rest breaks and a quiet space, flexible timetabling and phased returns after absence, adjustments to physical education (where exertion triggers symptoms) and examination access arrangements to reflect physical health difficulties, fatigue or cognitive impact.

Depending on the triggers for an individual child or young person, schools, colleges and early years settings may need to consider fragrance-aware or low-chemical classroom practices, careful selection of cleaning products and attention to ventilation.

Where a child or young person has been prescribed an adrenaline auto-injector, staff should be trained in its use and clear emergency protocols must be in place. As symptoms can fluctuate significantly, support arrangements should be reviewed regularly and adapted as needed. Schools, colleges and early years settings should work collaboratively with parents or carers and relevant healthcare professionals, recognising that families often develop detailed expertise in managing the condition.

Further information and resources are available at www.mastcellaction.org.

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ME/Chronic fatigue syndrome

Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) and Long Covid are recognised as the leading causes of medically-related persistent and prolonged school absence and long term educational loss for children and young people. ME/CFS is a complex, chronic medical condition affecting multiple body systems Children and young people with ME/CFS experience post exertional malaise disproportionate to the activity which caused it, debilitating pain and fatigue and unrefreshing sleep, among other symptoms. Some children and young people will experience related cognitive difficulties (sometimes described as “brain fog”), which may include problems finding words or numbers, difficulty in speaking, slowed responsiveness, short-term memory problems and difficulty concentrating or multitasking. The NICE guideline for ME/CFS provides further information. Long COVID shares many similarities with ME/CFS.

To support a child or young person with ME/CFS, their education needs to be paced, flexible and, depending on the level of severity, often part time. Schools, colleges and early years settings should adopt flexible practices that ensure that participation in education does not exacerbate symptoms or cause long term deterioration.

Some children and young people can remain in a school, college or early years setting with the support of reasonable adjustments including rest breaks and flexible timetables. They may also need wellbeing support, a quiet room, hall and/or lift pass, extra time between lessons and exam adjustments. Others may be unable to sustain participation, even in home-based learning, due to the profound impact of their symptoms.

Children and young people with ME/CFS can move between levels of severity with very little warning. Their capacity to engage in education can change markedly over time with Post Exertional Malaise, Post Exertional Symptom Exacerbation, Orthostatic Intolerance, pain and often extreme, debilitating fatigue unrelieved by sleep, directly limiting what they can manage.

For a minority of young people with ME/CFS, their symptoms are so debilitating that they are unable to participate in any form of education unless and until they experience sufficient health improvements. Where health needs are so severe that they prevent participation in the medium to long term, individualised planning is necessary to protect long term educational outcomes and life chances.

Further information and resources are available through Action for ME's Guide for Educators together with an Action for ME Individual Healthcare Plan template.

PANS / PANDAS

Paediatric Acute-onset Neuropsychiatric Syndrome (PANS) and Paediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) are uncommon acute-onset conditions that can cause a sudden deterioration in emotional, cognitive and functional abilities. Symptoms such as abrupt obsessive-compulsive behaviours, tics, restricted eating, severe anxiety, tics, sensory sensitivities and slowed processing can lead to the acute onset of SEND, with immediate impact on learning, wellbeing, participation and attendance. Early recognition and a prompt, supportive response from education settings are vital, especially as "flares" can make some children too unwell to attend school or tolerate typical classroom demands.

Flexible, low-demand approaches such as reduced cognitive load, rest breaks, alternatives to handwriting, quiet spaces and paced expectations may be required to support access to education. For some children and young people, periods of part-time attendance or home-based learning may be needed. Where the level of support required amounts to special educational provision, it may be appropriate to request an Education, Health and Care (EHC) needs assessment

Further information about UK clinical guidelines endorsed by the Royal College of Paediatrics and Child Health (RCPCH) and Local Authority Advisory Principles of Support is available at the PANS PANDAS UK Steering Group website.

Further information can be found at PANS PANDAS UK.

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Postural tachycardia syndrome (PoTS)

Postural Tachycardia Syndrome (PoTS) is a chronic autonomic condition characterised by an abnormal increase in heart rate upon standing, accompanied by a range of debilitating symptoms. The condition is variable and fluctuating in nature. Symptom severity may change significantly over time and from day to day, and may be exacerbated by intercurrent illness, temperature, dehydration, stress, or prolonged upright posture. It is common for people with PoTS to have other associated medical conditions that compounds their disability. PoTS is often under diagnosed and misdiagnosed. There are estimates that it affects up to 1 in 100 children and young people. Over half of children and young people with PoTS have lost over three months of schooling.

PoTS has a number of impacts which can have a significant effect on a child or young person's ability to participate in education. These include:

- **Orthostatic intolerance:** Prolonged standing (e.g. assemblies, queues, practical lessons) may provoke dizziness, pre-syncope, or syncope. Sudden positional changes can trigger symptom escalation.
- **Severe and fluctuating fatigue:** Fatigue may be disproportionate to activity levels and can significantly impair both physical stamina and cognitive function. Some children and young people experience more severe symptoms in the morning, while others deteriorate as the day progresses.
- **Cognitive dysfunction ("brain fog"):** Reduced processing speed, impaired working memory, word-finding difficulty, and reduced concentration are frequently reported. Academic performance may fluctuate accordingly.
- **Autonomic symptoms:** Palpitations, chest discomfort, nausea, abdominal pain, headache, visual disturbance, tremor and temperature dysregulation may affect classroom participation. These physiological symptoms may be misinterpreted as anxiety.
- **Attendance:** Symptom flares, recovery following illness and frequent medical appointments may impact attendance.
- **Wellbeing:** Unpredictable symptoms and fear of fainting in public settings may contribute to distress or social withdrawal.

Children and young people with PoTS need appropriate recognition and reasonable adjustments to ensure they can participate as well as possible in education. These arrangements should be set out in an Individual Healthcare Plan, which should also set out emergency response procedures. Appropriate adjustments may include:

- Provision of seating as an alternative to activities involving prolonged standing;

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- Access to fluids (including electrolyte supplementation) and snacks during the school day;
- Access to rest spaces to allow symptom stabilisation when required;
- Flexible timetabling, including consideration of reduced or phased attendance during periods of instability;
- Environmental adjustments to reduce heat exposure and overcrowding where possible and uniform adjustments to avoid overheating;
- Adjusted expectations regarding written output, processing speed, and deadlines during symptomatic periods;
- Access to lesson materials in alternative formats (e.g. digital resources, recorded content) to mitigate the impact of cognitive fatigue or absence;
- Training for staff to improve understanding of autonomic conditions and reduce misinterpretation of symptoms as behavioural or anxiety-related issues. Education of peers should also be considered, where appropriate.

Further information can be found at Managing PoTS.

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2) Policies for managing allergy safety

Allergy is a medical condition in which the body reacts to normally harmless substances such as food, insect stings, contact allergens and airborne allergens. Many individuals with allergies to food or insect stings are at risk of anaphylaxis, a serious and potentially fatal allergic reaction affecting the whole body – and in particular the Airway/Breathing/Circulation (“ABC”).

Therefore schools, colleges and early years settings should have a dedicated allergy safety policy, separate to their medical conditions policy, given the specific risk to life which anaphylaxis can pose. The school, college or early years setting’s medical conditions policy will also apply to children and young people with allergy.

Schools, colleges and settings must be proactive in mitigating the risk of exposure to allergens known to have the potential to cause anaphylaxis in any given person. However, it is not sufficient to organise allergy safety measures around children and young people with known allergies. Around one in five children and young people with allergies have their first allergic reaction while in their school, college or early years setting. Anaphylaxis is a medical emergency which can be fatal. All staff in schools, colleges and early years settings must therefore be able to recognise anaphylaxis and understand how to treat it. Schools, colleges and early years settings must also have robust plans to respond in an emergency i.e. administer adrenaline by autoinjector “pen” or equivalent device while awaiting the arrival of emergency services.

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Allergy and the Equality Act

The Equality Act 2010 places statutory duties on local authorities and education providers, intended to provide equality of opportunity for all including those who are disabled. Under the Act a person is considered disabled if they have a physical or mental impairment that has a substantial and long-term negative effect on their ability to carry out normal daily activities. Case-law[1] has established that that severe allergies can fall within this definition. Seasonal rhinitis (such as hay fever) is explicitly excluded from the definition of disability, unless it aggravates the effect of another health condition.

What forms of allergy are in scope

Allergy is a spectrum of different allergic diseases. Reactions occur when a susceptible person is exposed to something (an “allergen”) they are allergic to. Asthma, food allergy, eczema and seasonal rhinitis (hay fever) are all forms of

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[1] Wheeldon v Marston’s plc ET/1313364/2012.

allergy. Coeliac disease and intolerance can present symptoms which are similar to those of food allergy.

Common allergic conditions include:

- **Hay Fever (Allergic Rhinitis)**: triggered by allergens that can be carried in the air ("aeroallergens"), such as pollen, house dust mite, animal fur/feathers, or mould. Symptoms include sneezing, a runny or stuffed nose and itchy or watery eyes.
- **Skin allergies** (eczema, contact dermatitis, contact urticaria/hives) caused by contact with allergens including house dust mite, pollen and substances like nickel, latex, and some chemicals. Symptoms include itching, hives and dry, flaky skin. Reactions can be delayed (i.e. occur many hours after contact).
- **Food allergy** (see below), which can cause symptoms ranging from mild itching in the mouth to "whole body" reactions including anaphylaxis (i.e. allergic reactions which affect the **A**irway/**B**reathing/**C**irculation (“ABC”)).
- **Asthma** in children is usually allergic in nature, meaning that it may be triggered by airborne allergens such as e.g. dust mite or pollen. On average, there are two children with asthma in every classroom in the UK.

Less common allergic conditions in children include allergy to **insect stings** (e.g. bee, wasp) and **medicines**.

There is a spectrum of severity, from mild local reactions (as is common in mild hay fever) to "whole body" reactions (common with food allergy) to more serious reactions like anaphylaxis. In general, most allergic reactions are not severe. Even for food allergy, there is a spectrum of severity ranging from just mild itchy mouth/throat to whole body (but mild) skin rashes through to anaphylaxis.

Most allergic reactions do not affect the Airway/Breathing/Circulation (“ABC”) and can be treated with a non-drowsy oral antihistamine (typically available over-the-counter for those aged over 6 years) or local treatments such as nose sprays or eye drops. However, some children and young people are at risk of anaphylaxis and require emergency medication (e.g. self-administered adrenaline).

The most common causes of "whole body" reactions – including anaphylaxis – are:

- foods (e.g. peanuts, tree nuts, cow’s milk/dairy foods, egg, wheat, fish/shellfish and sesame);
- insect stings (e.g. bee, wasp);
- medication (e.g. antibiotics, pain medicines such as ibuprofen);
- latex (e.g. rubber gloves, balloons, swimming caps).

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Even for food allergy, the vast majority of anaphylaxis reactions require the person to have eaten the food, although less severe allergic reactions can happen through skin or other contact. Anaphylaxis reactions due to skin contact are very rare.

Schools, colleges and early years settings will need to consider arrangements to support children and young people with allergic conditions including:

- Children and young people with food allergy
- Children and young people at risk of anaphylaxis (usually allergic to food or bee/wasp sting)
- Children and young people with allergic rhinitis or allergic eye disease or eczema, who may need to be given treatments for their condition in school (e.g. eczema creams, nasal sprays, eye drops), particularly if they have more severe allergic disease or need adaptations e.g. with sport.
- Children and young people with eczema or asthma, who may need additional precautions (e.g. avoiding sand pits, some swimming pools)
- Children and young people with more severe allergies to animal fur, who may need to take avoidance measures (e.g. exposure to pets in school, visits to petting zoos)

Schools, colleges and early years settings will need to consider what arrangements should be put in place to support children and young people with allergy. If the school, college or setting needs to put specific arrangements in place, they should be recorded through an Individual Healthcare Plan

The management of allergy safety should not be limited to formally diagnosed IgE-mediated allergies. Some children and young people have medically recognised sensitivities or triggers which may not meet the clinical definition of allergy but may nonetheless result in serious or potentially life-threatening reactions (for example mast cell disorders or other systemic hypersensitivity conditions). Any known trigger with the potential to cause significant harm should be identified and managed.

Transplant-acquired food allergy (TAFA) is a rare phenomenon where a previously non-allergic recipient develops food allergies (commonly to eggs, soy, wheat, or peanuts) after receiving an organ (often liver) or bone marrow transplant. It typically develops within the first year, driven by the transfer of allergen-specific immune cells or IgE antibodies from the donor.

Food intolerance and coeliac disease

Food intolerance is a non-immune system reaction where the body struggles to digest specific foods, causing symptoms like abdominal pain, bloating, diarrhoea and headaches hours or days after eating. Unlike food allergies, intolerances cannot

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cause anaphylaxis. They are usually managed by identifying specific triggers, for example lactose intolerance or gluten sensitivity.

Coeliac disease is an autoimmune condition where the small intestine is hypersensitive to gluten. Consuming gluten can cause significant illness and may result in absence from school for several days. Repeated exposure to gluten carries serious long term health risks.

Food intolerance and coeliac disease are also managed through dietary avoidance. Children and young people with these conditions should therefore have an Individual Healthcare Plan specifying the arrangements the school, college or setting will put in place. This will include setting out the dietary restrictions established for the individual.

Managing allergy safety policies

Governing bodies are responsible for ensuring the school, college or setting has an allergy safety policy which sets out the arrangements to reduce the risk of individuals coming into contact with their known allergens (e.g. food or contact allergens), and sets out emergency response plans for cases of anaphylaxis. There should be a named governor and a named member of the senior leadership team with responsibility for allergy safety, since they will need to drive setting-wide policies. Responsibility for allergy safety should not be left with a catering manager. Risks relating to children and young people with medical conditions should be included on the school, college or setting's risk register and actively managed by the governing body.

Governing bodies should ensure that allergy safety policies are readily accessible to parents and staff. Policies should be published on the school, college or setting's website and be made available in hard copy on request.

Allergy safety policies should be reviewed at least annually. Policies can be reviewed more frequently, particularly where incidents or "near misses" suggest areas for improvement. Any review should take account of any incidents and "near misses" and should seek to learn lessons from them. This is essential where incidents suggest that policies or procedures may leave individuals with allergy at risk.

We will make available a template allergy safety policy shortly.

It is good practice for schools, colleges and early years settings to conduct allergy safety drills, in the same way as fire drills or in an active training exercise. A simulated case of anaphylaxis can be used to test out how staff respond, without risk to any individual. The results of the drill should be recorded in a similar way to an

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incident or “near miss” and used to inform the ongoing review of the allergy safety policy. In some cases it may be appropriate to include children and young people in such tests, for example where one of their peers has a high risk of anaphylaxis. If so, the child or young person should be involved in the planning of the drill to avoid a negative impact on their wellbeing. This can support the person at risk of anaphylaxis and provide reassurance to them and their family.

Allergy safety policies and inspection

As part of its inspection arrangements, Ofsted will consider the effectiveness of a school, college or early years setting’s arrangements for **safeguarding** and for **inclusion**. Inspectors will consider allergy safety policies and the effectiveness of their implementation as part of the inspection process.

What an allergy safety policy should contain

Allergy safety policies should set out:

- How the school, college or setting will **identify** children and young people staff and visitors with allergy (in particular food allergy and/or asthma);
- How the school, college or setting will **minimise the risks of exposure** to known allergens;
- How the school, college or setting will **manage the risk of food allergy** and provide clear information on allergens in food provided;
- How staff will be **trained** in allergy awareness and emergency response, for both anaphylaxis and acute asthma;
- How individuals at risk of anaphylaxis and/or asthma will have **access** to their prescribed adrenaline and/or asthma inhalers;
- How the school, college or setting will stock, store and use **“spare” adrenaline devices** and asthma inhalers, ensuring they remain in date;
- What arrangements and adjustments will be put in place to ensure children and young people with allergy are able to participate in **visits and trips**, and do so safely (including access to adrenaline where required);
- How children and young people with allergy who require specific support arrangements will have them documented through an **Individual Healthcare Plan**;
- How the **wellbeing** of children and young people with allergy will be promoted.

Further guidance is provided below.

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Identifying children, young people, staff and visitors with allergy

The allergy policy should set out clear arrangements for identifying individuals with allergy (not just children and young people but also members of staff and visitors), their known allergens and whether they carry medication (for example adrenaline autoinjector (AAI) devices). The school, college or setting should keep a record of all individuals with allergies, including whether they have an Individual Healthcare Plans and/or an Allergy Action Plan.

The school, college or setting should capture key information about the child or young person with allergy, which should be recorded in their Individual Healthcare Plan:

- Emergency contact details for the individual’s parents, carers or family;
- An up-to-date photograph of the individual;
- What the individual’s known allergens are and whether the allergen is ingested, inhaled or absorbed;
- Whether the individual has an Allergy Action Plan; if so, it should be attached to the Individual Healthcare Plan;
- Whether the individual has been prescribed adrenaline devices and, if so, what make and dosage it is;
- Whether there is prior medical and parental consent for a “spare” adrenaline device or emergency asthma reliever inhaler to be used (notwithstanding that in an emergency situation that could not be foreseen, a spare adrenaline device can be used without prior parental consent).
- Whether the individual also has asthma; if so, there should be an Asthma Plan attached to the Individual Healthcare Plan; this should include whether there is parental consent to use an emergency asthma reliever inhaler (if available) in an emergency (see paragraph 281).

The allergy safety policy should set out arrangements for gathering information about known allergies. This may include asking a child or young person’s previous setting for relevant information, such as an Individual Healthcare Plan and Allergy Action Plan. The child or young person and their parents should always be asked to provide information.

For children and young people starting at a new school, college or setting, arrangements should be in place in time for the start of the relevant school term. In other cases, such as children and young people moving to a new school, college or setting mid-term, every effort should be made to ensure that arrangements are put in place within two weeks. For members of staff, arrangements should be in place

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when they commence work. For visitors, information on allergy should be sought in advance of their visit wherever possible.

It is good practice to keep a list of individuals with known allergies (including up to date photos and lists of their known allergens) in places where food may be served or handled (including food technology, science, craft and art classrooms). Such lists should be kept in areas accessible to staff only.

Individual Healthcare Plans

The allergy safety policy should set out how children and young people with known allergies will be supported through Individual Healthcare Plans and the frequency with which IHPs will be reviewed. Where a child or young person has been issued with an Allergy and/or an Asthma Action Plan by a healthcare professional, it should be attached to their Individual Healthcare Plan. Further information on Individual Healthcare Plans is provided in the guidance below.

Allergy Action Plans

Where individual children and young people have a known allergy to a food or insect stings, they must be issued with an appropriate Allergy Action Plan (for example that available from the British Society for Allergy and Clinical Immunology (BSACI) at Spare Pens in Schools) by their healthcare professional. Allergy Action Plans are designed to facilitate first aid treatment of reactions including anaphylaxis, by people without any special medical training or equipment other than access to an adrenaline device (e.g. AAI “pen”).

Children and young people with asthma should be provided with an Asthma Action Plan. This provides everything staff need to know about a child or young person’s asthma in one place, including information about their triggers, symptoms, medicines to be used if they have asthma symptoms and when to seek emergency help when they have an asthma attack

These Action Plans should be attached to the child or young person’s Individual Healthcare Plan. The plans include medical and parental consent for staff to administer medicines such as adrenaline in the event of an allergic reaction or the emergency reliever inhaler in the event of an asthma attack. Action Plans are reviewed and updated by healthcare professionals at regular intervals. Whenever an updated Action Plan becomes available, the child or young person’s Individual Healthcare Plan should be reviewed to incorporate it.

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Allergy awareness and training

An allergy safety policy should set out arrangements for whole-school allergy awareness training, so that all staff receive regular (at least annual) allergy awareness training. This training should cover all staff, including teaching staff, support staff, catering staff and others who may oversee children and young people at breakfast or after school clubs. It should ensure all staff:

- Have an awareness of allergy, the risks it poses, how allergic reactions can occur and how to manage it;
- Understand that allergy includes multiple conditions (food allergy, asthma, eczema, hay fever, others), which can co-exist;
- Understand and can identify the main food allergens, and understand the difference between food allergy, intolerance and coeliac disease;
- Can identify the range of symptoms of allergic reactions;
- Understand and can recognise anaphylaxis;
- Know how to respond in an emergency, including calling emergency services and how to locate and administer adrenaline in a case of anaphylaxis or an asthma reliever inhaler during an asthma attack. This should include training on how to use the adrenaline devices prescribed to children and young people at the school, college or setting and/or the “spare” adrenaline devices which are stocked;
- Understand the impact which allergy can have on a child or young person’s wellbeing;
- Understand the school, college or setting’s allergy safety policy;
- Know how to check whether an individual is on the record of those with known allergies and how to use an Allergy or Asthma Action Plan;
- Understand their responsibilities in reducing the risk of individuals with known allergy coming into contact with their known allergens;
- Understand how to report an allergic reaction or case of anaphylaxis (whether an incident or a “near miss”).

The allergy safety policy should set out induction arrangements for new staff, as well as arrangements for supply and cover staff.

Minimising risks of exposure to known allergens

An allergy safety policy should set out how the school, college or setting will minimise the risk of individuals (whether children, young people, staff or visitors) coming into contact with their known allergens.

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Some schools, colleges or early years settings adopt policies such as “nut-free” environments. This is not the most effective approach as they can create a false sense of security. Nuts are only one of a number of food allergens, all of which can have serious consequences for individuals. UK and European legislation https://www.food.gov.uk/business-guidance/allergen-guidance-for-food-businessesidentifies fourteen key food allergens which cause over 90% of reactions, but any food can cause an allergic reaction. Many foods do not contain nuts as an ingredient, but are labelled “may contain nuts”, which causes confusion and can make such policies difficult to implement. For this reason, we recommend an “allergy aware” (e.g. “nut-aware”) environment rather than a “nut-free” policy.

While schools, colleges or early years settings may wish to discourage certain foods being brought on site, it is more important to remain actively aware of the risk posed by allergens, take steps to minimise the risk of exposure and to have robust emergency response plans in place.

Managing the risk of exposure to allergen

The allergy safety policy should set out how the school, college or setting will manage the risk of children, young people, staff and visitors coming into contact with their known allergens.

This should include:

- Measures to manage the risks of exposure to a food allergen through food provided by the school, college or setting;
- Measures to manage the risks of exposure to a food allergen through food brought in by others (for example parents, children and young people or staff);
- Where children and young people have known allergies to airborne or contact allergens, how the school, college or setting will put reasonable measures in place to manage the risk of the child or young person being exposed to such allergens;
- An expectation that staff planning any activity should consider the risk of exposure to allergens, for example in craft, science, musical or cooking activities, or where activities involve animals;
- Specific risk assessments to manage the risks of exposure to allergens in individuals with an allergy when planning external visits or trips.

Children and young people should not be prevented from taking part in activities alongside their peers simply because of a risk of coming into contact with one of their allergens. Where an activity would involve most children and young people using a material which might contain an allergen known to affect one of the group (for

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example), alternatives will need to be found for the whole group which do not exclude individuals. Staff should consider:

- old food boxes or packaging may contain traces of allergens;
- some products contain wheat flour, including ”play dough”;
- some glues contain milk, wheat or soya;
- bird feed may contain nuts and sesame.

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Reducing the risk of allergen exposure in children with food allergy

- Bottles, other drinks and lunch boxes provided by parents or the school for children with food allergies should be clearly labelled with the name of the child for whom they are intended.
- **School caterers** must provide information on food allergens to parent/carers, and have this available for the child to be able to check independently. Catering staff should be available to meet with parents/carers to discuss provision of allergen safe meals.
- **Leaders** need to be aware of and engage with caterers to understand the controls in place to ensure that food service conforms with legislation.
- Where food is provided by the school, **school staff** should be educated about how to read labels for food allergens and instructed about measures to prevent cross-contamination during the handling, preparation and serving of food. Examples include: preparing food for children with food allergies first; careful cleaning (using warm soapy water) of food preparation areas and utensils.
- Where food is not directly provided by the school (for example brought in as treats or to celebrate birthdays) parental engagement and permission should be sought in advance to ensure inclusion and safety for children with allergies
- Implement policies to avoid trading and sharing of food, food utensils or food containers.
- Unlabelled food poses a potentially greater risk of allergen exposure than packaged food with precautionary (“may contain”) labelling suggesting a risk of contamination with allergen. This applies to foods used within the classroom curriculum (e.g. cooking) as well that from the school kitchen or canteen.
- Use of food in crafts, cooking classes, science experiments and special events (e.g. fetes, assemblies, cultural events) needs to be considered and alternatives used when needed.
- In arts/craft, an appropriate alternative ingredient should be substituted (e.g. wheat-free flour for play dough or cooking). Food containers (egg cartons, yoghurt pots etc) can also be contaminated with food: use alternative, non-food containers for craft activities, where possible. If essential to the activity, e.g. junk modelling, ensure that all materials used are free from any allergens that might pose a risk for a specific child.
- When planning out-of-school activities such as sporting events, excursions (e.g. restaurants and food processing plants), school outings or camps, think early about the catering requirements of the child with food allergies and emergency planning (including access to emergency medication and medical care).

Air quality

Air pollutants, both outdoors and indoors, can trigger allergies, asthma, and other respiratory illnesses. An explanation of air pollution and the associated health impacts can be found at Air pollution: applying All Our Health. Schools, colleges and early years settings should consider both environmental air quality and infection prevention measures as part of their wider health and safety responsibilities.

Further information is provided in the section on Air quality.

Food provision

The School Food Standards regulates the food and drink provided at both lunchtime and at other times of the school day. Beyond this we believe that head teachers, school governors and caterers are best placed to make decisions about their school food policies, taking into account local circumstances and the needs of their pupils. In doing so, we expect schools to make reasonable adjustments for pupils with medical conditions including allergy.

Children and young people with allergy and food hypersensitivities should be able to enjoy school meals alongside their peers, with any risks managed effectively. Schools and colleges are expected to make reasonable efforts to cater for pupils with particular requirements that reflect their medical and dietary needs. Schools and colleges must ensure that food provided to children and young people with food allergies and hypersensitivities is safe and should aim to serve food that is appropriate and inclusive. They should work with caterers, parents and children and young people to ensure risks are identified, minimised and managed effectively so that individuals with allergies and medical conditions can be fully included in meals. Similarly, where a child or young person’s needs present additional considerations for participation in practical subjects (for example food technology), the school or college should make reasonable adjustments to enable safe and inclusive access wherever possible, rather than excluding them from the subject.

This applies to all food supplied by a school, including school meals, grab-and-go items, snacks, breakfast clubs and after-school provision and food provided for trips, visits or special events. Other on-site catering will only be covered by allergen law if it constitutes a “food business”, i.e. it provides food on a regular and organised basis. A parents’ association which provides food at events or an occasional cake sale is unlikely to be in scope. It is nevertheless good practice to provide clear information about potential allergens in food brought in by others.

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Food brought from home, such as packed lunches or food used in food technology lessons, should also be considered when developing approaches to allergy safety. Clear expectations should be set for children, young people and parents on ensuring lunchboxes and classroom ingredients are clearly labelled, prepared and stored safely.

Individual Healthcare Plans can help schools and colleges to support children and young people with reasonable adjustments relating to food.

Food allergy

It is important to balance safety and inclusion. It is good practice to have at least two robust methods of identifying children and young people with known allergies at mealtimes to ensure they receive a safe meal, for example a member of staff checking who the children or young people with allergies are, or children and young people wearing coloured lanyards or photographs alongside details of their allergy in the kitchen or serving area. The identification methods chosen will depend on the size of the school, college or setting and the age of the children and young people. Children and young people with food allergies should not be segregated from their peers at mealtimes (e.g. by being required to sit at a separate table).

- The Food Information Regulations 2014 require all food businesses, including school and college caterers, to show allergen ingredients information for the food they serve. This makes it easier for schools, colleges and early years settings to identify the food that children and young people with allergies can and cannot eat. An amendment in 2021 (“Natasha’s Law”) requires that any food which is pre-packed for direct sale (PPDS), i.e. freshly prepared and then packaged and displayed before being sold, must have a label on it listing all the ingredients and highlighting any of the 14 mandated allergens it contains.

- **EU Regulation 828/2014** (retained in UK law) mandates that food labelled "gluten-free" must contain 20 parts per million (ppm) or less, while "very low gluten" is restricted to 100ppm or less. These standards apply to all pre-packaged and, in many cases, loose/catered foods and are relevant for the safe provision of food for individuals with gluten intolerance and coeliac disease.

- Schools, colleges and early years settings that operate as food businesses should record and review all allergen incidents and near-misses and seek advice from their local authority environmental health team or Primary Authority where appropriate. A legal duty to notify external authorities applies only when unsafe food has been supplied; otherwise, reporting near-misses or administrative errors is good practice rather than a statutory requirement.

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> Where unsafe food has been supplied (for example, food containing an undeclared allergen), the food business must act without delay in line with the Food Standards Agency's incident procedures (including withdrawal and, where necessary, recall). Further information can be found at Report a food safety incident and Food incidents, product withdrawals and recalls.

Schools, colleges and early years settings are considered "food businesses" for this purpose. The requirements therefore apply to all food which schools, colleges and early years settings make on site and package, such as sandwiches, salads and baked goods and any grab-and-go items selected by children and young people. Dishes and menus must be clearly labelled emphasising food allergen by highlighting the words rather than using abbreviations or symbols. Schools, colleges and early years settings will also need to ensure that the parents/carers of children with food allergies or intolerances are given information about the allergenic ingredients used in the foods available.

The standards for school food in England allow schools to substitute items from their usual menus if certain items are in short supply. When making changes to menus or substituting food products due to supply changes or for religious and cultural reasons, schools, colleges and early years settings must make sure they can continue to meet any special dietary needs. This includes children and young people who cannot eat certain ingredients due to an allergy or other medical condition. If menus need to be adapted at short notice, the needs of these children and young people must still be met.

Further guidance is available from the Food Standards Agency on Allergen Information for Non-Prepacked Foods, Allergen guidance for food businesses and Prepacked for direct sale (PPDS) allergen labelling. Providers may also find the FSA allergen checklist for food businesses helpful, as it is widely used in education catering to support day-to-day allergen management, cross-contact controls and staff training.

With regards to packed lunch policies, while schools, colleges or settings may wish to discourage certain allergens (for example, nuts) being brought on site it is more important to remain actively aware of the risk posed by allergens and to have robust emergency response plans.

Free school meals

Pupils may be eligible to receive free meals under DfE's benefits-based and universal infant free school meals policies.

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For pupils entitled to benefits-based Free School Meals, schools are required to make reasonable adjustments to enable pupils with allergy to access their free school meal entitlement, under section 100 of the Children and Families Act 2014 to "*make arrangements for supporting pupils at their school with medical conditions*".

Schools are best placed to determine the exact nature of a reasonable adjustment in relation to food provision, taking into account the individual circumstances of the child and their family, as well as the school's obligations under the School Food Standards. Schools should work with their caterer, the pupil and their family, and any other professionals involved, to agree the necessary support.

Safer eating and the EYFS

Whilst children are eating there should always be a member of staff in the room with a valid paediatric first aid certificate for a full course consistent with the criteria set out in Annex A of the EYFS.

Before a child is admitted to the setting the provider must obtain information about any special dietary requirements, preferences, food allergies and intolerances that the child has, and any special health requirements. This information must be shared by the provider with all staff involved in the preparing and handling of food. At each mealtime and snack time providers must be clear about who is responsible for checking that the food being provided meets all the requirements for each child.

Providers must have ongoing discussions with parents and/or carers and, where appropriate, health professionals to develop Individual Healthcare Plans for managing any known allergies and intolerances. This information must be kept up to date by the provider and shared with all staff. Providers should refer to the child's Allergy Action Plan. Providers must ensure that all staff are aware of the symptoms and treatments for allergies and anaphylaxis, the differences between allergies and intolerances and that children can develop allergies at any time, especially during the introduction of solid foods which is sometimes called complementary feeding or weaning. Providers should refer to the NHS advice on Food allergy and treatment of Anaphylaxis.

Providers must have ongoing discussions with parents and/or carers about the stage their child is at in regard to introducing solid foods, including to understand the textures the child is familiar with. Assumptions must not be made based on age. Providers must prepare food in a suitable way for each child's individual developmental needs, working with parents and/or carers to help children move on to the next stage at a pace right for the child. The NHS has some advice providers should refer to: Weaning - Best Start in Life.

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Providers must prepare food in a way to prevent choking. Guidance on Help for early years providers: Food safety includes advice on food and drink to avoid, how to reduce the risk of choking and links to other useful resources for early years providers.

Babies and young children should be seated safely in a highchair or appropriately sized low chair while eating. Where possible there should be a designated eating space where distractions are minimised.

Children must always be within sight and hearing of a member of staff whilst eating. Choking can be completely silent, therefore, it is important for providers to be alert to when a child may be starting to choke. Where possible, providers should sit facing children whilst they eat, so they can make sure children are eating in a way to prevent choking and so they can prevent food sharing and be aware of any unexpected allergic reactions.

When a child experiences a choking incident that requires intervention, providers should record details of where and how the child choked and ensure parents and/or carers are made aware. The records should be reviewed periodically to identify if there are trends or common features of incidents that could be addressed to reduce the risk of choking. Appropriate action should be taken to address any identified concerns.

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Allergic reactions

However effective a school, college or early years setting's measures to reduce exposure to allergens, a risk remains that an individual (whether a child, young person, member of staff or visitor) will suffer an allergic reaction. It is therefore essential that the allergy safety policy provides robust and effective measures for emergency response.

Allergic reactions occur when a susceptible person is exposed to something (an "allergen") they are allergic to. Most allergic reactions do not affect the **A**irway/**B**reathing/ **C**irculation ("ABC") and can be treated with an oral antihistamine. The features of an allergic reaction are shown in Figure 2.

Allergic reactions are unpredictable. Most reactions do not result in anaphylaxis. However, when anaphylaxis occurs, reactions usually start off as less severe (e.g. skin rash, vomiting) but then become anaphylaxis – so someone having a reaction should always be monitored (e.g. in a first aid room) for at least 60 minutes afterwards, just in case the reaction gets worse. In other people, anaphylaxis develops within minutes after exposure to the allergen.

Features of an allergic reaction and anaphylaxis

Mild-moderate reaction (not anaphylaxis)

- Swollen lips, face or eyes
- Itchy or tingling mouth
- Mild throat tightness
- Hives or itchy skin rash
- Abdominal pain or vomiting
- Sudden change in behaviour

Figure 2: SIGNS OF ANAPHYLAXIS
(a potentially life-threatening allergic reaction)

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A: Airways: Swelling in the throat, tongue or upper airways (tightening in the throat, hoarse voice, difficulty swallowing)

B: Breathing: Sudden onset wheezing, breathing difficulty, noisy breathing

C: Circulation: Dizziness, feeling faint, sudden sleepiness, tiredness, confusion, pale clammy skin, loss of consciousness

Mild reactions can worsen and become anaphylaxis:

- Always stay with someone having an allergic reaction for at least one hour
- **If in doubt, always treat for anaphylaxis**
- Treatment of anaphylaxis is with a dose of adrenaline (e.g. using an auto-injector “pen”)

Children and young people at risk of an allergic reaction to food or insect stings should be provided with an Allergy Action Plan by a healthcare professional (for example that available at Spare Pens in Schools). These documents include parental consent to administer medications such as antihistamine to treat mild-moderate reactions. For those people assessed as not being at risk of anaphylaxis, the Allergy Action Plan also includes medical authorisation and parental consent to administer emergency adrenaline in the event of an anaphylaxis emergency.

Other allergies such as asthma, hay fever or eczema can also affect a pupil's health and school performance. Children and young people may need to bring both prescription and non-prescription medication (such as oral antihistamines, steroid nasal sprays and eye drops) to school, which they should be able to access if needed.

Children and young people with asthma should have an Asthma Action Plan. Asthma+Lung UK also provides a poster to help school staff help children and young people if they have an asthma attack.

Anaphylaxis and emergency situations

Anaphylaxis reactions involve the **A**irway/**B**reathing/**C**irculation ("ABC"). Reactions usually progress quickly and can be life-threatening – so anaphylaxis **always** requires an immediate emergency response. The features of an anaphylaxis reaction are shown in Figure 3.

The vast majority of anaphylaxis reactions require the person to have eaten the food, although less severe allergic reactions can happen through skin or other contact. Anaphylaxis reactions due to skin contact are very rare. In some medical conditions such as mast cell disorders, anaphylaxis may occur without a clearly identified allergen or without ingestion of a food trigger. Emergency planning should therefore be based on the individual child or young person's documented triggers and clinical history, rather than assuming ingestion of food is required.

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Anaphylaxis

Anaphylaxis reactions to food usually begin within 30 minutes of eating the trigger food, but can sometimes occur 4-6 hours later (e.g. allergy to mammalian meat). They typically affect the breathing (**A** and **B**, i.e. mimic an asthma attack) rather than the **C**irculation (blood pressure).

Once started, anaphylaxis reactions progress quickly. Investigations into fatal anaphylaxis show that there is only a 20-30 minute window of opportunity during which steps can be taken to prevent death – therefore giving emergency adrenaline **immediately** and calling Emergency Services (999) is so important. **Anaphylaxis always requires an emergency response**.

Anaphylaxis can occur without any other signs (such as a skin rash) being present. **Always consider anaphylaxis in someone with a known food allergy who has sudden difficulty in breathing.** Giving adrenaline in this context is very safe and may be lifesaving.

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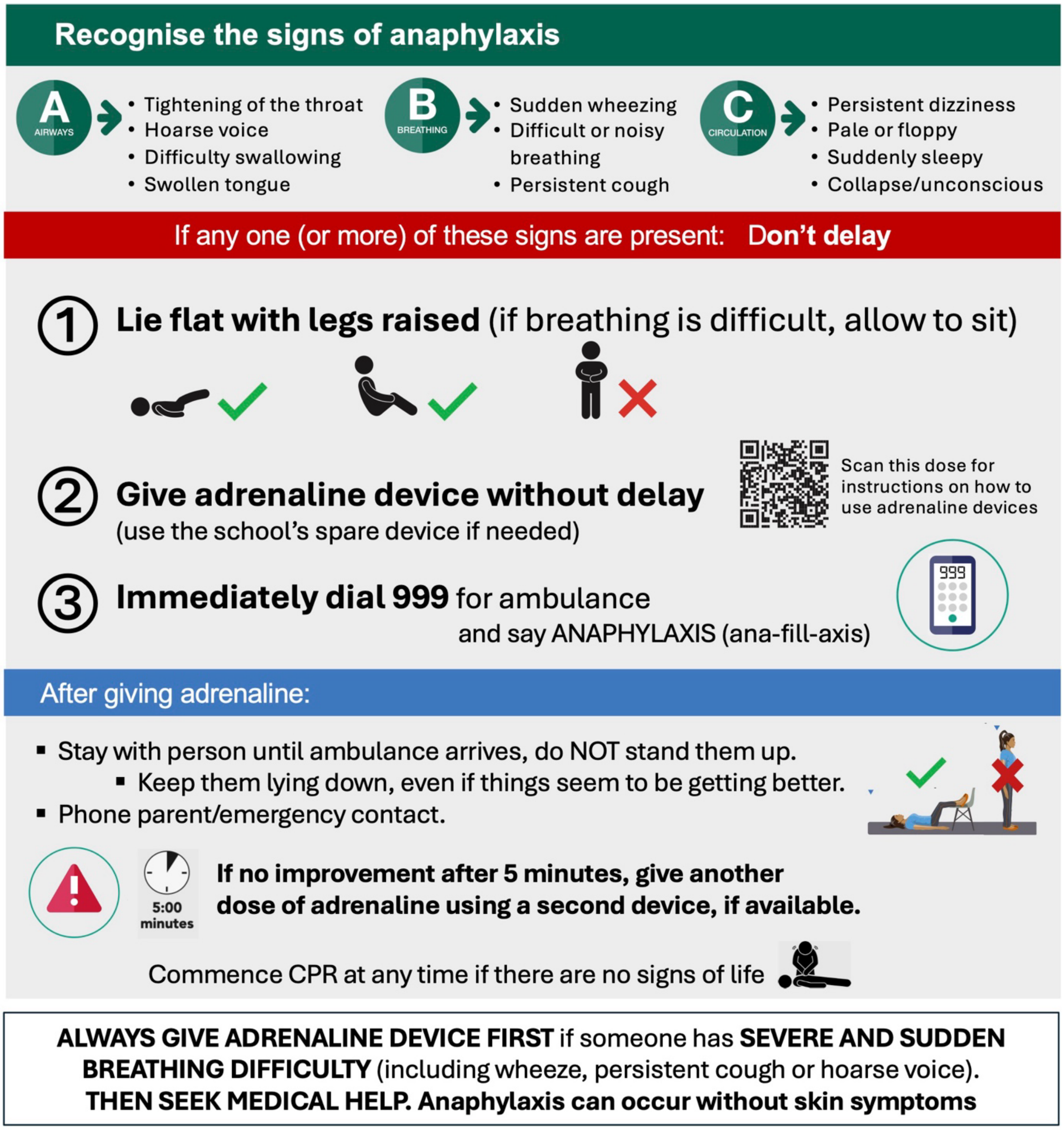
Responding to an allergic reaction and anaphylaxis

Mild to moderate reactions which do not involve the **A**irway/**B**reathing/**C**irculation can be treated with oral antihistamines. For a child or young person, telephone their parent or emergency contact to tell them about the reaction. Do not leave them unattended. The child or young person does not normally need to be sent home or require urgent medical attention. They should be observed in a safe place for at least 60 minutes after reaction, as mild reactions can sometimes develop into anaphylaxis.

Anaphylaxis commonly occurs alongside mild symptoms or signs, such as an itchy mouth or skin rash. Anaphylaxis can also occur on its own, without a skin rash or other mild signs being present.

Anaphylaxis (i.e. any reactions which involve the **A**irway/**B**reathing/**C**irculation) must be treated promptly with emergency adrenaline (see figure 3). The individual's prescribed adrenaline device (for example an AAI or nasal adrenaline device) should be used if it is available; if not, a "spare" adrenaline device can be used (see below). If in doubt whether the reaction is anaphylaxis, treat with adrenaline. Always dial 999 to request an ambulance if someone is experiencing anaphylaxis. The Emergency ('999') Operator can provide advice over the telephone if needed.

Figure 3: Management of anaphylaxis



Recognise the signs of anaphylaxis

A AIRWAYS
- Tightening of the throat
- Hoarse voice
- Difficulty swallowing
- Swollen tongue

B BREATHING
- Sudden wheezing
- Difficult or noisy breathing
- Persistent cough

C CIRCULATION
- Persistent dizziness
- Pale or floppy
- Suddenly sleepy
- Collapse/unconscious

If any one (or more) of these signs are present: **Don’t delay**

① **Lie flat with legs raised** (if breathing is difficult, allow to sit)

② **Give adrenaline device without delay**
(use the school’s spare device if needed)

Scan this dose for instructions on how to use adrenaline devices

③ **Immediately dial 999** for ambulance
and say ANAPHYLAXIS (ana-fill-axis)

After giving adrenaline:

- Stay with person until ambulance arrives, do NOT stand them up.
  - Keep them lying down, even if things seem to be getting better.
- Phone parent/emergency contact.

If no improvement after 5 minutes, give another dose of adrenaline using a second device, if available.

Commence CPR at any time if there are no signs of life

ALWAYS GIVE ADRENALINE DEVICE FIRST if someone has **SEVERE AND SUDDEN BREATHING DIFFICULTY** (including wheeze, persistent cough or hoarse voice).
THEN SEEK MEDICAL HELP. Anaphylaxis can occur without skin symptoms

Recognise the signs of anaphylaxis

A: Airways

- Tightening in the throat
- Hoarse voice
- Difficulty swallowing
- Swollen tongue

B: Breathing

- Sudden wheezing

- Difficult or noisy breathing
- Persistent cough

C: Circulation

- Persistent dizziness
- Pale or floppy
- Suddenly sleepy
- Collapse/unconscious

Management of anaphylaxis

If one or more of these signs are present: **don't delay**.

1. **Lie flat with legs raised** (if breathing is difficult, allow to sit)
2. **Give adrenaline device without delay** (use the school's spare device if needed)
3. **Immediately dial 999** for ambulance and say ANAPHYLAXIS (ana-fill-axis)

After giving adrenaline:

- Stay with the person until ambulance arrives, do NOT stand them up
- Keep them lying down even if things seem to be getting better
- Phone parent or emergency contact

If no improvement after 5 minutes, give another dose of adrenaline using a second device, if available.

Commence CPR at any time if there are no signs of life.

Always give adrenaline device first if someone has severe and sudden breathing difficulty (including wheeze, persistent cough or hoarse voice). Then seek medical help. Anaphylaxis can occur without skin symptoms.

Many food-allergic children also have asthma. "Wheeze" is a common symptom of asthma and also happens during food-induced anaphylaxis. The Allergy Action Plan may include instructions to give a reliever medicine (e.g. using a salbutamol inhaler) after giving a dose of adrenaline if the person is still wheezing. Many schools keep an emergency asthma reliever inhaler containing a salbutamol inhaler device and spacer (see paragraph 282). DHSC has published guidance on Emergency asthma inhalers for use in schools. **Never give the reliever inhaler instead of adrenaline to treat anaphylaxis.**

One in five anaphylaxis deaths among school-aged children in the UK happen in school. Key learnings from these events are listed below. Accordingly, the allergy

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safety policy should consider how to safely manage anaphylaxis reactions to reduce the risk of a severe outcome.

Learning from anaphylaxis deaths in schools

- Always give adrenaline immediately to treat anaphylaxis. **If in doubt, give adrenaline.** Delays in giving adrenaline are associated with fatal outcomes.
- NEVER let a person having anaphylaxis stand or walk around: always bring help and medicines to the person, and not the other way round.
- Always dial 999.
- Give a further dose of adrenaline if there is no improvement after 5 minutes.
- If someone known to have asthma and food allergy suddenly gets difficulty in breathing, always consider anaphylaxis. Giving adrenaline in this context is very safe and may be lifesaving.
- Children and young people may be at risk of anaphylaxis while travelling to or from school, college or their early years settings. If they have been prescribed an adrenaline device, they should carry these devices with them at all times, including while travelling to or from school.

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Adrenaline devices

People at risk of anaphylaxis are usually prescribed self-administered adrenaline for use in an emergency. Adrenaline devices (ADs) may be in the form of an adrenaline auto-injector (AAI) or a nasal adrenaline device. DHSC has published guidance on Using emergency adrenaline auto-injectors in schools.

The allergy safety policy should set out how the school, college or setting will ensure that children and young people who are prescribed ADs have rapid access to their devices **at all times**. This includes in the lunch area, playground and sports fields. The Medicines and Healthcare products Regulatory Agency (MHRA) recommends that people at risk of anaphylaxis carry two devices with them at all times.

- Children and young people (even in primary school) should be encouraged to keep their ADs with them in their school bags, and thus also have access to them when travelling to or from the school, college or setting;
- If a child or young person cannot keep their ADs with them in the classroom (due to age or other considerations), then the devices should be stored in an appropriate central location that is unlocked and accessible at all times;

- The school, college or early years setting should also stock “spare” ADs for use in an emergency, in the event a child or young person’s own devices are not available or misfire;
- In a case of anaphylaxis, adrenaline should be administered within five minutes. If a child or young person does not have their prescribed ADs with them, they should be close enough to hand that they can be used within five minutes. If necessary, “spare” ADs should be used instead;
- It is good practice to keep a copy of the individual’s Allergy Action Plan together with their medication, since it will include instructions on how it should be used in an emergency situation.

The allergy safety plan should set out:

- Arrangements for children, young people and parents to take individually prescribed ADs home (for example, during holidays) and for checking that they remain in date;
- Arrangements to keep a register logging all children and young people known to be at risk of anaphylaxis, and whether they have been provided with self-administered adrenaline (and an Allergy Action Plan);
- Arrangements for the storage and use of “spare” ADs which can be used in an emergency for the treatment of anaphylaxis (see below).
- Arrangements for disposing of ADs safely when they have been used, following requirements for the safe disposal of medicines.

Guidance is available on Using emergency adrenaline auto-injectors in schools, issued by DHSC. Adrenaline auto-injectors (AAIs): guidance and resources for safe use is issued by the Medicines and Healthcare products Regulatory Agency (MHRA).

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Storage of adrenaline devices

Severe anaphylaxis is a time-critical situation: delays in administering adrenaline have been associated with fatal reactions. All adrenaline devices – including those prescribed to the pupil themselves, as well as any spare ADs – must

- Be stored at room temperature (in line with manufacturer’s guidelines) and not be exposed to extremes of heat. They should not be refrigerated or left in direct sunlight.
- Not be locked away or kept in an office where access is restricted.
- “Spare” adrenaline devices should be accessible at all times in a safe and central location (e.g. school office or staff room).

“Spare” adrenaline devices

Anaphylaxis reactions are unpredictable. In addition, up to 20% of anaphylaxis reactions in schools happen in children without a pre-existing diagnosis of food allergy. **We therefore expect that all schools will stock “spare” adrenaline devices for emergency situations**.

The Human Medicines (Amendment) Regulations 2017 permit schools in England to purchase “spare” AAI devices without a prescription for emergency use to treat anaphylaxis. The Regulations only apply to schools and not to early years setting or FE colleges. Similarly, the Regulations currently only apply to AAIs and not to the newly-licensed nasal spray.

Any ADs held by a school in this way should be considered a “spare” device and not a replacement for a pupil’s own AD. Children and young people at risk of anaphylaxis should have their prescribed ADs with them at school for use in an emergency and should have access to both of their two prescribed ADs at all times.

The school’s spare ADs can be used in children and young people:

- who have been prescribed ADs but whose own devices are not available (for example because they are broken, out of date, cannot be accessed or have misfired). These individuals should have an Allergy Action Plan which includes both medical authorisation and written parental consent for the use of a spare ADs in an emergency
- with food allergies who have been assessed as being at lower risk of anaphylaxis and therefore not prescribed their own ADs. Medical authorisation and parental consent must have been obtained. The easiest way for this to happen is by their healthcare professional providing an appropriate Allergy Action Plan.

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Using “spare” ADs in an emergency situation without prior consent

The MHRA has clarified that a legal exemption under Regulation 238 of the Human Medicines (Amendment) Regulations 2017 permits a school’s “spare” ADs to be used for the purpose of saving a life for a pupil or other person not known by the school to be at risk of anaphylaxis (i.e. who does not have medical authorisation/consent in place for the spare device).

This might be, for example, a child presenting for the first time with anaphylaxis due to an unrecognised allergy, or an adult visiting the school premises. This provision should be reserved for exceptional circumstances only, that could not have been foreseen.

Therefore, the spare AD can be used with **anyone** experiencing anaphylaxis in an emergency, for the purpose of saving their life.

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Schools can purchase AAIs from a pharmaceutical supplier, such as a local pharmacy, without a prescription. A supplier will need a request signed by the principal or head teacher (ideally on appropriate headed paper) stating the name of the school for which the product is required; the purpose for which that product is required, and the total quantity required. A template letter which can be used for this purpose can be downloaded at Spare Pens in Schools.

Guidance in terms of how many AAIs (and which doses) should be purchased can be found in guidance published by the DHSC on Using emergency adrenaline auto-injectors in schools. In general, schools should obtain 4 “spare” AAIs:

School type	**AAI for children under age 6 years** (150 micrograms) e.g. EpiPen Junior, Jext 150	**AAI for individuals over 6 years of age** (300 micrograms) e.g. EpiPen, Jext 300
State-funded nursery school	Two “spare” devices	n/a
Primary school	Two “spare” devices	Two “spare” devices
Secondary school	n/a	Two to four “spare” devices*
Special school	Two “spare” devices**	Two “spare” devices**

* Secondary schools should consider having two pairs of “spare” devices, so that the “spare” ADs are not located more than five minutes aways from where they may be needed.

** Where special schools operate across more than one site, they should ensure there are spare ADs of the appropriate dosage on each site as required.

A school which purchases “spare” ADs should set out its policy for their use as part of its allergy safety policy. This includes the following considerations:

- How and when “spare” ADs should be used (see above);
- How “spare” ADs will be stored, noting that:
    - “Spare” ADs must be readily accessible and not locked away;
    - “Spare” ADs should not be located more than 5 minutes away from where they may be needed. In larger schools, more than one set may be needed e.g. one near the central dining area, another near the playground;
    - “Spare” ADs should be stored in pairs, so that if a second one is necessary it is on hand rather than needing to be obtained from elsewhere on site; “Spare” ADs should be brought to the person having anaphylaxis in an emergency, as adrenaline should be given as soon as possible and certainly within 5 minutes;
    - “Spare” ADs should be clearly labelled, to avoid any confusion with ADs prescribed to a named person. Schools may choose to have an “Emergency Anaphylaxis kit” clearly marked as such (e.g. in a red plastic box) containing the spare ADs (± emergency asthma reliever inhaler and spacers) and instructions as to their use;
- Arrangements for checking that “spare” ADs and salbutamol inhalers are in date;
- Processes for replacing “spare” ADs when they are used (this includes safe disposal of autoinjectors as they contain a needle) or go out of date.

The Human Medicines (Amendment) (No. 2) Regulations 2014 also permit schools to buy an emergency asthma reliever inhaler (salbutamol inhaler device and spacer), without a prescription, for use in emergencies. The inhaler can be used if the pupil’s prescribed inhaler is not available (for example, because it is broken or empty). Guidance is available on Emergency asthma inhalers for use in schools. It is recommended that schools keep emergency asthma reliever inhalers alongside “spare” adrenaline devices.

School trips and external visits

Schools, colleges and early years settings should conduct a risk assessment for any child or young person at risk of anaphylaxis taking part in a trip off the premises. Children and young people at risk of anaphylaxis should have their own adrenaline device with them, and there should be staff trained to administer adrenaline in an

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emergency. Schools, colleges and settings may wish to consider whether it may be appropriate, under some circumstances, to take “spare” adrenaline devices in case of emergency use on some trips.

Wellbeing of children and young people with allergy

The allergy safety policy should set out how the wellbeing of children and young people with allergies should be supported. Many children and young people with allergy become anxious as a result of the risk of exposure to allergens and the potential for anaphylaxis , which may be compounded by living with difficult-to-control asthma or eczema. The school, college or setting should be active in providing support, both in providing reassurance that steps are taken to minimise the risks of exposure to allergen and that robust measures are in place in the event of anaphylaxis. The allergy safety policy should also set out measures to prevent and respond to bullying related to allergy.

Examples of good practice include:

- Regular communication to children, young people, parents and staff about allergies, ensuring ongoing awareness and appreciation of the severity of the potential risks.
- Proactive engagement with new joiners with known allergies, setting out the school, college or setting’s policies and the support available.
- Inviting new joiners with allergies to have a tour of the kitchen and canteen so they can meet staff and get used to the mealtime environment. This may reduce anxiety and helps everyone to get to know one another, which will support staff to identify children and young people with allergies, intolerances and coeliac disease in the dining hall.
- Introducing “allergy champion” roles for staff and children and young people (not just within the catering team). Acting as a point of contact for children, young people and staff with allergies, they can share feedback and support new joiners or anxious children and young people.

It is good practice for schools, colleges and early years settings to involve individuals with allergies (whether children, young people or staff) in developing and reviewing these arrangements.

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3) Specific considerations arising from medical conditions and allergy

A number of considerations apply to children and young people with medical conditions. This section provides further information and points to relevant guidance.

Admission

Children and young people with medical conditions are entitled to a full education and have the same rights of admission to school as other children and young people.

Mainstream LA-maintained schools and academies are subject to the Admissions Code. Schools may not ask for prohibited information such as information about a child’s disabilities or medical conditions during the school application process or before admission. This means that no child with a medical condition can be denied admission or prevented from taking up a place in school because arrangements for their medical condition have not been made.

Other education settings (special schools, alternative provision schools, early years settings, FE and post-16 institutions and independent schools) are subject to a duty not to discriminate under section 85 of the Equality Act 2010. Their admissions criteria must not treat applicants who may be considered to be disabled less favourably than others who are not. A decision whether or not to admit a child or young person with a medical condition which constitutes a disability must be carefully considered and consulted upon.

Colleges and post-16 providers should recognise that some medical conditions can have a significant and sustained impact on a young person’s academic attainment, attendance, examination performance or the number of qualifications they are able to complete. This may occur even where the student has the underlying academic ability and potential to succeed. Admission criteria and entry requirements should therefore be applied flexibly where there is credible evidence that a young person’s performance has been affected by a medical condition. Admissions policies should make clear that reasonable adjustments may extend to entry processes and that disability-related disadvantage will be considered. Decisions should focus on the student’s capacity to meet course demands with appropriate support in place, rather than solely on historic attainment. Transparent communication with applicants and families about how medical circumstances will be considered can reduce uncertainty and promote equitable access to further education.

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Attendance

Some children and young people with medical conditions face complex barriers to attendance. Schools, local authorities, health professionals, commissioners and other support services should work together to ensure that children with medical conditions receive as full an education as their condition allows.

The guidance Working together to improve school attendance is clear that the ambitions for children and young people with medical conditions to attend school should be the same as for any other pupil – but that additional support may need to be provided. It sets a clear expectation that schools, colleges and early years settings should have sensitive and non-judgmental conversations with children and young people and their families and work with them to put support in place for their individual needs. This support could include reasonable adjustments for children and young people with disabilities or support where mental health issues affect attendance. Schools, colleges and settings should take a ‘support first’ approach when considering strategies to increase attendance. This can include:

- Where school transport is regularly being missed, working in partnership with families to develop or support routines.
- Addressing in-school barriers, including considering support or reasonable adjustments for uniform, transport, routines, access to support and lunchtime arrangements.
- Ensuring joined up pastoral care is in place where needed
- Considering whether time-limited phased returns may be appropriate.

Where children and young people require frequent medical appointments or additional support interventions, these should be scheduled outside of the main school day wherever possible. The school, college or early years setting should work with the child or young person’s parents and the relevant healthcare professionals to the understand frequency, likely timings and length of medical appointments so that advance planning can help to minimise the impact on the child or young person’s education or assist in catching up where needed.

In addition, children and young people with long-term medical conditions may be more susceptible to short-term illnesses or may find that they take longer to recuperate from short-term illness. Similarly, a short-term illness can make managing a long-term more difficult. For example a cold or flu can make it harder for those with diabetes to manage blood glucose.

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Attendance and wellbeing

Schools, colleges and early years settings should carefully consider how attendance policies and messaging affect children and young people with medical conditions, and their families. Attendance approaches should distinguish clearly between absence arising from medical incapacity and absence linked to behavioural or engagement concerns. Children, young people and families should not be characterised as non-compliant, lacking effort, or disengaged where absence is directly related to a medical condition. Health-related absence should be managed within a supportive and inclusive framework rather than through punitive or pressure-based approaches. This is particularly important where a medical condition is fluctuating or beyond the child or young person's control. Excessive pressure to return before a child or young person is medically ready may worsen symptoms, delay recovery and undermine longer-term attendance. Where appropriate, reintegration plans should be flexible, phased and responsive to the individual's health needs, with the aim of supporting sustainable participation in education.

It is equally important that children and young people should not be excluded from attendance rewards where their absence was due to a medical condition. Where a medical condition constitutes a disability, such exclusion could be considered discrimination.

Schools, colleges and settings should carefully consider how the child or young person is supported in their return to education, particularly after a prolonged absence or repeated periods of absence. Arrangements should take account of the impact that illness may have had not only on learning, but also on energy levels, confidence, peer relationships and emotional wellbeing. For some children and young people, fatigue may be significant and recovery non-linear, meaning that stamina is reduced and can fluctuate. Reintegration plans should therefore be flexible, phased and responsive to the child or young person's health needs. Academic catch-up expectations should be proportionate and should not prevent the child or young person from participating in enrichment activities, social time or opportunities to reconnect with peers. Schools, colleges and early years settings should also recognise that social reintegration can be as challenging as academic return. Planned, low-pressure opportunities to visit the setting before a full return (such as attending for a short social meeting, shared lunchtime, tutor time, or a brief wellbeing check-in) may help rebuild confidence and peer connections. These visits can form part of a graduated reintegration plan and should prioritise safety, belonging and emotional readiness alongside academic progression.

Where children and young people are unable to attend, it is important to ensure they remain connected to their school, college or setting. Sending messages and updates from friends, peers and staff can have a very positive impact on wellbeing. In some

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cases children and young people may be able to join lessons or activities through virtual presence devices. Where children or young people are receiving support through hospital education services, their “home” school, college or setting should provide work.

Part-time school attendance

All children must receive a full-time education, unless this would not be in their best interests because of their health needs. Some children and young people with medical conditions will require flexibility and involve programmes of study that rely on part-time attendance in combination with alternative provision arranged by the local authority. Consideration may also be given to how children will be reintegrated into school after periods of absence, using appropriate Individual Healthcare Plans.

The aim should always be that any child or young person should have full-time attendance. The flexibility of part-time attendance can be very important (for example in the case of fluctuating conditions and those which affect energy levels). However, any sustained use of part-time attendance should be kept under review by the school, college or setting, in discussion with the child or young person and their parents, to establish whether it continues to be in the best interests of the individual.

Further information is provided in Working together to improve school attendance.

Education where a pupil cannot attend school because of a medical condition

Under section 19 of the Education Act 1996, local authorities should ensure children who are not attending school due to their health needs are offered good quality education equivalent to that provided in mainstream schools (or special schools if relevant), as far as the child’s health needs allow. This means that, where a child cannot attend school because of a physical or mental health need and cannot access suitable full-time education, the local authority is responsible for arranging suitable alternative provision, suitable to the pupil’s age, ability and aptitude, and any special educational needs they have.

Statutory guidance for local authorities on Education for children with health needs who cannot attend school sets out that they should be ready to make arrangements under this duty when it is clear that a child will be away from school for 15 days or more because of health needs (whether consecutive or cumulative across the school year). There is no absolute legal deadline by which local authorities must provide education for children with additional health needs. However, as soon as the local authority have been informed by the home school that the child will be absent for 15 days or more they should begin the process of arranging suitable alternative provision.

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Where an absence is planned, for example for a stay or recurrent stays in hospital, local authorities must make suitable, timely arrangements, in advance to allow provision to begin from day one, unless exceptional circumstances apply.

Where possible, the child’s health needs should be managed by the home school so that they can continue to be educated there with support, and without the need for the intervention of the local authority. However, as soon as it is clear that the home school can no longer support the child’s health needs and provide suitable education, the school should speak to the local authority about putting alternative provision in place.

With planned hospital admissions, conversations between the home school, and the local authority’s hospital education provider should take place as early as possible to discuss likely admission date and expected length. This will give the provider time to liaise with the child’s school and, where applicable, with the local authority about the educational programme to be followed while the child is in hospital. In such circumstances, local authorities should set up a personal education plan setting out how the child’s home school, the local authority and the hospital school or other provider will work together.

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Assessment and examinations

Schools and colleges should consider examination access arrangements as part of drawing up an Individual Healthcare Plan. They should ensure that children, young people and their parents are informed, at the earliest possible stage, about the special consideration and access arrangements process, the range of adjustments that may be available, the evidence required, and the timelines involved. This ensures the right arrangements are established well ahead of public examinations.

The Standards and Testing Agency publish Key stage 2 tests: special consideration guidance and the Joint Council for Qualifications publishes further information on Access arrangements, reasonable adjustments and special consideration.

Clean air

Air quality, both indoors and outdoors, can significantly affect children and young people’s health, for example through exposure to pollutants, airborne viruses, allergens such as pollen, and inadequate ventilation. Poor ventilation, indoor air pollution, indoor airborne allergens and irritants can worsen symptoms, trigger medical emergencies, compromise learning due to sickness absence and the reduced ability to concentrate and learn effectively, impact quality of life and wellbeing, and increase the risk of hospital admission with potentially severe consequences.

Poor air quality can exacerbate asthma, allergic conditions and other respiratory illnesses. Emerging evidence indicates that some children and young people with Long Covid may experience increased respiratory sensitivity or exacerbation of pre-existing respiratory or immune-related conditions, which may impact attendance and participation. Air quality can also significantly affect children and young people with other medical conditions, including mast cell disorders and other systemic hypersensitivity conditions. For some individuals, airborne triggers such as fragrances, air fresheners, cleaning products, aerosols, scented personal care products or other volatile compounds may provoke symptoms that are systemic rather than purely respiratory, including headaches, dizziness, flushing, fatigue or, in rare cases, severe reactions.

Air quality management should therefore be considered as part of the arrangements to support a wide range of medical conditions. Where a child or young person has medically documented sensitivities to airborne triggers, these should be considered within risk assessments and Individual Healthcare Plans.

Schools, colleges and early years settings should consider both environmental air quality and infection prevention measures as part of their wider health and safety, equality and accessibility duties. Clear, proportionate policies to minimise non-essential fragranced products, alongside practical measures such as effective ventilation, careful selection of cleaning products, and use of appropriate air purification systems where necessary, can reduce health risks and support inclusive access to education. Consideration of fragrance-aware or low-chemical approaches may form part of reasonable adjustments for individual children and young people whose medical conditions are triggered by airborne exposures.

Continuous or routine monitoring of CO2 and indoor pollutant levels, especially particulate matter, nitrogen dioxide and specific known pollutants and allergens, should inform ongoing mitigation and safeguarding efforts and support continuous improvement in the school environment's safety. Transparency is recommended to improve compliance, increase public awareness and confidence and aid identification of hotspots in need of remediation.

Further information can be found at Ventilation and air quality in education and childcare settings and coschools.org.uk/facts.

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Complaints

Governing bodies should ensure that the medical conditions policy sets out how complaints concerning the support provided to children and young people with medical conditions (including allergy) may be made and will be handled.

Should children, young people or parents be dissatisfied with the support provided they should discuss their concerns directly with the school. If for whatever reason this does not resolve the issue, they may make a formal complaint via the school's complaints procedure.

Data protection

Information concerning a child or young person's medical conditions can be deeply personal. Nevertheless school, colleges and early years settings will need to hold, use and share this information in order to ensure the child or young person receives the support they need to stay safe and be included in education.

A child or young person's health information is considered special category data under UK GDPR, which means it is highly sensitive and has additional legal protections. Schools have a lawful basis to hold, use and share a child's special category health data when this is necessary, but it should always be done in a controlled and respectful way, because unnecessary sharing can reduce children's confidence in practitioners and can be embarrassing for children and young people who may not want to be singled out.

Further information is provided by the Department through Information sharing advice for safeguarding practitioners.

Defibrillators

Sudden cardiac arrest occurs when the heart stops beating. It can happen to people of any age and without warning. If this does happen, quick action (in the form of early CPR and defibrillation) can help save lives. A defibrillator is a machine used to give an electric shock to restart a patient's heart when they are in cardiac arrest. Modern defibrillators are easy to use, inexpensive and safe. Schools, colleges and early years settings are advised to consider purchasing a defibrillator as part of their first-aid equipment.

The Department has put arrangements in place to assist schools in purchasing defibrillators at reduced cost. Further information can be found at Automated external defibrillators (AEDs) in schools.

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If a school, college or early years setting installs a defibrillator, they should notify the local NHS ambulance service of its location. Staff members appointed as first-aiders should already be trained in the use of CPR and may wish to promote these techniques more widely in the school, amongst both teachers and children and young people alike.

First aid

First aid at work does not include giving tablets or medicines. The only exception is when aspirin is used as first aid to a casualty with a suspected heart attack for those 16 and over. Never give aspirin to a child younger than 16, unless it has been prescribed by a doctor.

Separate guidance is available on First aid in schools, early years and further education.

Food provision

The School Food Standards regulates the food and drink provided at both lunchtime and at other times of the school day. Beyond this, we believe that head teachers, school governors and caterers are best placed to make decisions about their school food policies, taking into account local circumstances and the needs of their pupils. In doing so, we expect schools to make reasonable efforts to accommodate for children and young people with particular requirements, for example to reflect dietary, medical, SEND and sensory needs

Children and young people may have sensory processing differences which may impact their experience of eating at school. This can stem from the food choices available and/or the environment in which food is consumed. These differences may arise from medical conditions or SEND, either diagnosed, awaiting diagnosis or undiagnosed.

Children and young people with allergies, food hypersensitivities, SEND, medical conditions and sensory needs should be able to enjoy school meals alongside their peers, with any risks or adjustments managed effectively. Schools should work with caterers, parents and children and young people to ensure safety risks are identified, minimised and managed effectively so that individuals can eat safely at school and that barriers to enjoying food at school are minimised. Individual Healthcare Plans can be used to document risks, how children and young people will be supported and what needs to be done, when and by whom.

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Food brought from home should also be considered when developing approaches to managing a child's dietary, medical, SEND or sensory needs. This could include packed lunches, or food used in food technology lessons or other classroom activities. Clear expectations should be set for children, young people and parents.

Duty to make reasonable adjustments for disabled children with regards to Free School Meals

Schools are required to make reasonable adjustments for disabled pupils on roll at a school to ensure they are not put at a substantial disadvantage in relation to accessing meals where appropriate. This includes disabled pupils who are eligible for free school meals.

Schools are required to make such adjustments as are reasonable to enable such pupils to access their free school meal entitlement. Schools should work with the pupil, their family and any other professionals involved, to agree the necessary support.

Schools are best placed to determine the exact nature of a reasonable adjustment in relation to food provision, taking into account the individual circumstances of the child and their family, as well as schools' obligations under the School Food Standards. It is good practice for the school to make a record of what reasonable adjustments have been agreed and ensure that all staff who work with the individual pupil are aware. It is also recommended that the reasonable adjustments are regularly reviewed to make sure that they are effectively helping individual pupils while at school. The support should be adjusted if the individual pupil's needs change.

Where a child has Special Educational Needs (SEN) and is either in receipt of SEN Support or has an education, health and care plan (EHCP), the disadvantage they experience may be overcome by support received under the SEN framework. In other cases, a disabled pupil may need reasonable adjustments to be made in addition to their special educational provision. It may be appropriate to review such adjustments with the parent either through the regular SEN Support meetings or the formal EHCP reviews.

Making alternative arrangements for non-disabled children

Schools are not obliged to make reasonable adjustments for children who are not disabled. However, section 100 of the Children and Families Act 2014 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 – which may be food-related, for example a pupil

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may have a food allergy. Schools should similarly therefore take appropriate action in supporting such children and young people to access food provision.

Home to school transport

Local authorities are responsible for providing free home-to-school travel for eligible children of compulsory school age. They may also make travel arrangements for other children and for some young people in post-16 education. When they arrange travel for a child or young person with medical needs, they may need to put in place proportionate arrangements to manage those needs. They will need to work with the NHS and transport operators to do this. The Department has produced guidance about how NHS professionals and local authority school travel teams should work together

The Department provides guidance on Home-to-school travel.

Insurance and indemnity

The DfE's Risk Protection Arrangement (RPA) provides insurance for public sector schools. It will offer indemnity insurance (during the membership year and within the territorial limits) for schools which are part of the scheme in connection with the provision of medicines or medical procedures, provided they can demonstrate that they have followed this statutory guidance in making arrangements to support children and young people with medical conditions. Indemnity will also be provided to any member of staff (other than any doctor, surgeon or dentist while working in a professional capacity) who is providing support to children and young people with medical conditions and has received sufficient and suitable training.

Where an RPA member has not followed the statutory guidance and can demonstrate mitigating circumstances for not doing so, the RPA administrator will consider the circumstances on a case-by-case basis to determine whether cover can be provided. The only exception will be where the actions of the employee amount to serious and wilful misconduct. Carelessness, inadvertence or a simple mistake do not amount to serious and wilful misconduct.

The RPA cover does not extend to medical negligence or medical malpractice indemnity. If a school requires medical negligence/malpractice cover then they will need to seek commercial insurance.

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Managing infectious diseases in schools

Guidance on Managing specific infectious diseases: A to Z is available for staff in children and young people settings, including education, those working in children and young people's social care and across the secure estate. This guidance should be used alongside the emergency planning and response for education, childcare, and children's social care settings published in April 2022. It is not intended to be used as a tool for the diagnosis of infections. The information is designed for use by staff members in children and young people settings (for example teachers, managers, teaching assistants, and cleaners) to prevent and respond to infection, incidents and outbreaks.

Managing medicines

Where clinically possible, medicines (including controlled drugs) should be prescribed in dose frequencies which enable them to be taken outside school hours. Medicines should only be administered while the child or young person is at a school, college or early years setting when it would be detrimental to their health or school attendance not to do so.

The governing body should ensure that the medical conditions policy is clear about the procedures to be followed for managing medicines, including:

- Children and young people should not be prevented from taking prescription or non-prescription medication.
- Children under 16 should not be given prescription or non-prescription medicines without written consent from their parent (or someone with parental responsibility) – except in exceptional circumstances where the medicine has been prescribed to the child without the knowledge of the parents.
- A child under 16 should never be given medicine containing aspirin unless prescribed by a doctor.
- Medication (for example for pain relief) should never be administered without first checking maximum dosages and when the previous dose was taken. Parents should be informed.

An Individual Healthcare Plan may require specific members of staff to administer medication to the child or young person. Any member of staff in a school, college or early years setting may be asked to provide support to children and young people with administering of medicines, but they cannot be required to do so. Where named members of staff have been trained to provide support to a child or young person, this should be reflected in their role and job description. The school, college or young

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person must ensure that the named members of staff have received the training they require to undertake the role safely and competently.

Non-prescription medication

Non-prescription or over-the-counter medication is licensed by the Medicines and Healthcare products Regulatory Agency (MHRA) as safe for use without a GP prescription. Schools, colleges and early years settings should not expect or require the authorisation of a GP in order for children and young people to take non-prescription medication. It is a misuse of NHS resources to take up a GP appointment to get a prescription just to satisfy the needs of a school, college or early years setting.

It is appropriate for non-prescription or over-the-counter medicines to be administered by a member of staff in the school, college or setting, or be self-administered by the child or young person, following written permission by the parents. Any member of school staff may be asked to provide support to children and young people with administering of medicines, but they cannot be required to do so.

Controlled drugs

Schools, colleges, early years settings and other education settings (and home to school transport staff) may administer controlled drugs where they have been prescribed to a child or young person. This is permitted by Regulations 7(1) and 7(3) of the Misuse of Drugs Regulations 2001. Since the controlled drugs will have been prescribed to the child or young person on the basis that they need to be administered by the education provider or transport team (or during normal school hours), there are no specific requirements for their storage under the Misuse of Drugs (Safe Custody) Regulations 1973.

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Storage of medication

The medical conditions policy should set out arrangements for the storage of medication:

- All medicines and devices should be stored safely and in accordance with the manufacturer's instructions (noting that medication may need to be stored at room temperature or be refrigerated).
- Children and young people should know where their medicines are at all times and be able to access them immediately, including when outside the premises.
- Children and young people should be able to carry appropriate medication to self-administer if deemed suitable by a healthcare professional or required

due to their condition, for example asthma reliever inhalers, insulin pumps or pancreatic enzymes needed whilst eating.
- Medicines and devices which may be required in an emergency situation, such as adrenaline devices, asthma reliever inhalers and spacers, blood glucose testing meters and monitors and emergency epilepsy medication should be always readily available. They should never be locked away. This is particularly important to consider, including on external visits and trips.
- Medication should not be kept in a first aid container.
- There should be processes for disposing of medication safely.

Schools, colleges and early years settings should only accept prescribed medicines if these are in-date, labelled, provided in the original container as dispensed by a pharmacist and include instructions for administration, dosage and storage. Insulin is an exception; while it must still be in date, it will generally be available inside an insulin pen or a pump rather than in its original container.

Disposal of medicines

Medicines and products associated with them (such as needles, injectors and inhalers) should be disposed of safely. Schools, colleges and early years settings are subject to regulations designed to protect public health and the environment, including:

- The Controlled Waste Regulations (England and Wales) 2012 which governs how different types of waste, including pharmaceutical waste, must be managed and disposed of.
- The Environmental Protection Act 1990 which requires businesses to ensure that all waste is stored, transported, and disposed of safely, without harming the environment.
- The Hazardous Waste Regulations (England and Wales) 2005 which covers hazardous medications such as certain chemotherapy drugs.
- The Misuse of Drugs Regulations 2001 which covers the disposal of controlled substances, to prevent misuse or diversion.

Medications contain active ingredients that, if not disposed of correctly, can have harmful effects on people, animals, and the environment. Medications should be separated from other types of waste, such as general rubbish or clinical waste. This ensures that they are handled and disposed of correctly.

- **Over-the-counter medicines** are typically classified as non-hazardous pharmaceutical waste and can often be returned to pharmacies for safe disposal.

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- **Prescription medicines** must be disposed of through licensed facilities to ensure their active ingredients are neutralised and do not pose a threat to the environment or public health.
- **Controlled drugs** such as morphine or methadone are subject to additional controls and must be rendered irretrievable before disposal to prevent misuse.
- **Adrenaline auto-injectors** (AAIs): once an AAI has been used it cannot be reused and must be disposed of according to manufacturer's guidelines. Used AAIs can be given to the ambulance paramedics on arrival, taken to a pharmacy or can be disposed of in a pre-ordered sharps bin for collection by the local council. AAIs which have expired without being used should be disposed of in the same way.
- **Asthma reliever inhalers**: manufacturers' guidelines usually recommend that spent asthma reliever inhalers are returned to the pharmacy to be recycled, rather than being thrown away.

Medicines for disposal should be stored securely in a tamper-proof container within a cupboard until they are collected or taken to the pharmacy. Schools, colleges and early years settings should be aware that, to comply with their duties they should register as a lower-tier waste carrier. Registration only takes a few minutes online, and is free, and does not usually need to be renewed in future years. Further information can be found at Waste carrier registration.

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Mental health

Good mental health and wellbeing improves standards in schools and helps children and young people achieve and thrive in education, setting them up well for life and work. Guidance is available on Promoting and supporting mental health and wellbeing in schools and colleges.

Mental health support teams (MHSTs) provide additional capacity to promote and support mental health and wellbeing in primary, secondary and further education settings. MHSTs include a new workforce of education mental health practitioners who work alongside senior clinicians and other professionals. They integrate with the existing mental health and wellbeing support in and around schools and colleges provided by a range of practitioners including counsellors, educational psychologists, school nurses, school and college pastoral care teams, educational welfare officers, the voluntary and community sector, local authorities and NHS children and young people's mental health services. Further information is available on Mental health support in schools and colleges.

Mobile phone policies

Whilst all schools should be mobile phone-free environments by default, as outlined in the Mobile Phones in Schools guidance, they must comply with their other legal duties such as the duty to make reasonable adjustments for disabled children and young people where necessary. Where school leaders need to make additional exceptions or flexibilities to their policies based on a child's individual needs, we trust them to do so.

Schools, colleges and early years settings have a duty under the Equality Act 2010 to take such steps as is reasonable to avoid substantial disadvantage to a disabled child or young person caused by the school, college or setting's policies or practices. In some cases a child or young person's medical condition may constitute a disability. Allowing a disabled child or young person access to their mobile phone during the day, where it is necessary due to the nature of their disability, may be considered a reasonable adjustment and a failure to do so may be a breach of the school, college or setting's duty. For example, children and young people with diabetes might use continuous glucose monitoring with a sensor linked to their mobile phone (which needs to be in close physical proximity) to monitor blood sugar levels. Where mobile phone use allows children and young people to manage their medical condition effectively, it would not be reasonable for a school to prevent this.

Allowing flexibility for individual children and young people does not mean that they should be exempt from all restrictions on the use of their mobile phone. Schools, colleges and early years settings should develop practices which enable children and young people to use their mobile phone for a specific purpose at specific times and locations.

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4) Roles, responsibilities and statutory duties

Children and young people with medical conditions will be supported by a range of medical and healthcare professionals with different areas of specialism. Effective co-operation between schools, colleges and early years settings; local authorities; and healthcare professionals in the NHS is essential to provide coherent support which ensures children and young people have their medical needs met with the minimum necessary impact on their education.

The primary purpose of schools, colleges and early years settings is to educate children and young people.

Children and young people with medical conditions have the same right to education as any others, and so staff in education settings and on home-to-school transport will frequently be involved in supporting them so they can be as fully integrated into the life of the school, college or setting as possible. Education settings have responsibilities to keep children and young people safe and to ensure those with disabilities (which may arise from a medical condition) are not discriminated against. However, staff in education settings and on home-to-school transport will not usually be professionally trained or regulated as healthcare professionals and there are therefore limits to their ability to meet the medical needs of the children and young people attending the setting.

Local authorities commission public health services (including school nursing services) to promote the health and wellbeing of children and young people as a whole. They typically provide support, training and monitoring for children and young people across an area as a whole rather than delivering healthcare provision to individuals.

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Statutory duties – all education providers

As children and young people will spend much of their time in schools or other education provision, their school, college, or early years setting will necessarily be involved in meeting some of their healthcare needs. For some, their home-to-school transport provider may also need to be involved. Children and young people should not be denied the right to participate in education because of a medical condition.

Many health conditions can be managed without specialist intervention. Wherever possible, children and young people should be supported to learn how to manage health conditions with increasing autonomy, as they ultimately will in adult life. The policies of schools, colleges and early years settings should therefore create an environment where health needs can be met within the education setting without the need for external support and care, where it is safe and appropriate to do so. Where children and young people require greater support (for example because of their age or the nature of their condition), it should be provided as part of the school, college or setting's arrangements.

Saving life

If a child or young person experiences a life-threatening medical emergency, anyone—staff, volunteers or bystanders, may take reasonable action to save their life. The law recognises that rescuers act under extreme pressure. People who attempt to save a life in good faith are protected, even if an injury occurs while giving emergency care (for example, broken ribs during CPR are common and not a sign of wrongdoing). This includes administering adrenaline when an individual is suffering anaphylaxis.

Schools, colleges and early years settings should be reassured that mistakes, hesitation, or imperfect technique do not amount to serious and wilful misconduct. The expectation is simply that staff act reasonably, to the best of their ability, in an emergency.

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Duty of care

All education providers owe a common law duty (i.e. duty derived from past court decisions but not written in legislation) to take reasonable steps to protect children left in their care from foreseeable risk of harm and to act in their best interests. Breach of such a duty can lead to serious legal consequences if a court deems that the harm caused by a breach of duty was foreseeable and preventable.

Furthermore, under section 3 of the Children Act 1989, any person with the care of a child who does not have parental responsibility for them is subject to a duty to do all that is reasonable in all the circumstances for the purposes of safeguarding or promoting the welfare of the child.

The principal duties and powers relating to safeguarding or well-being of children within schools are set out in school-type specific legislation including sections 20 and 175 of the Education Act 2002 (as amended), the Education (Independent School Standards) Regulations 2014 and the Non-Maintained Special Schools (England) Regulations 2015. This legislation places a duty on the relevant educational institutions to safeguard and promote the welfare of pupils and students.

First aid

Under the Health and Safety (First-Aid) Regulations 1981 employers are responsible for providing adequate and appropriate equipment, facilities and personnel to ensure their employees receive immediate attention if they are injured or taken ill at work. While the regulations do not require employers to provide first aid for anyone other than their own employees, it is strongly recommended that all schools and colleges consider the needs of non-employees such as children, young people and visitors when making provision for first aid.

First aid provision must be available while people are on school or college premises. It must also be available when children, young people and staff are working elsewhere on school, college or early years setting activities, including any off-site activity such as educational visits. The regulations require employers to provide adequate and appropriate equipment, facilities and personnel based on a first aid needs assessment. This does not apply to work placements as work experience students are employed by the placement provider.

Any member of staff in a school, college or early years setting may be asked to undertake first aid tasks, though they cannot be required to do so. Teachers and other staff working with children and young people are expected to use their best endeavours at all times, particularly in emergencies, to secure the welfare of the children and young people in education in the same way that parents might be expected to act towards their children. In general, the consequences of taking no action are likely to be more serious than those of trying to assist in an emergency.

The DfE has published guidance on First aid in schools, early years and further education. HSE has published detailed first aid guidance to help employers comply with the regulations and offers practical advice on what they need to do.

For early years settings (including Reception year in schools), the Early Years Foundation Stage statutory framework has specific paediatric first aid requirements which must be followed.

Safeguarding duties

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. The statutory guidance on Working together to safeguard children is clear that preventing the impairment of children’s mental and physical health or development forms part of safeguarding and promoting the welfare of children.

Section 10 of the Children Act 2004 provides that the local authority must make arrangements to promote co-operation between the authority and relevant partners (including the governing body of a maintained school, the proprietor of an academy, Integrated Care Boards and NHS England) with a view to improving the wellbeing of children, including their physical and mental health, protection from harm and

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neglect, and education. Relevant partners are under a duty to co-operate in making these arrangements.

Other relevant statutory duties

Section 2 of the Health and Safety at Work etc Act 1974 and the associated regulations provide that it is the duty of the employer (for example the local authority, governing body or academy trust) to take reasonable steps to ensure that employees are not exposed to risks to their health and safety.

Under the Misuse of Drugs Act 1971 and associated Misuse of Drugs Regulations 2001 the supply, administration, possession and storage of certain drugs are controlled. Education providers may have children and young people who have been prescribed a controlled drug.

The Medicines Act 1968 specifies the way that medicines are prescribed, supplied and administered within the UK and places restrictions on dealings with medicinal products, including their administration.

“Reasonable adjustment” duties in relation to disabled children

The Equality Act 2010 places statutory duties on local authorities and schools, colleges and early years settings intended to provide equality of opportunity for all including those who are disabled.

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Medical conditions and disability

Children and young people with medical conditions may have a disability and, if so, will be protected by the Equality Act 2010.

A child or young person is deemed to have a disability if they have a physical or mental impairment and the adverse effect on the carrying out of normal day-to-day activities is “substantial” and “long term” (i.e. it has lasted or is likely to last for at least 12 months). A child under the age of six who has an impairment which does not have a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities is included in the definition of disability where the adverse effects would be considered “substantial” and “long term” in a child over six.

Certain health conditions are automatically deemed to meet the definition of disability. Schedule 1 to the Equality Act states that a person who has cancer, HIV infection or multiple sclerosis is always a disabled person. In addition section 4 of the Equality Act 2010 (Disability) Regulations 2010 state that a person who is certified as blind, severely sight impaired, sight impaired or partially sighted by a consultant ophthalmologist is deemed to have a disability.

If an impairment would have a substantial adverse effect without treatment or correction, it will be in scope of the Act even if treatment or correction is provided (for example through medical treatment). Similarly, conditions which have a substantial effect but fluctuate or recur will be considered to have a long-term impact if the substantial effect is likely to recur.

The definition of disability is set out further in Guidance on matters to be taken into account in determining questions relating to the definition of disability.

All education providers (including early years settings, LA-maintained schools, Academies and independent schools, FE colleges and sixth form colleges) and local authorities are subject to the duty in section 20 of the Equality Act “*to take such steps as it is reasonable to have to take to avoid the substantial disadvantage*” to a disabled person caused by a provision, criterion or practice applied by or on behalf of the education provider, or by the absence of an auxiliary aid or service. The duty to make “reasonable adjustments” requires an education provider or local authority to take positive steps to ensure that disabled children and young people can fully participate in the education provided, and that they can enjoy the other benefits, facilities and services that the school, college or setting provides.

Reasonable adjustments

The Equality and Human Rights Commission's technical guidance for schools in England and technical guidance for further and higher education in England on "reasonable adjustments" (which reflects duties in the Equality Act 2010 which apply to all education providers) is intended to help schools and colleges comply with the law. The guidance for schools sets out:

> "*The duty to make reasonable adjustments requires schools to take what are referred to in the Act as 'reasonable steps' to make adjustments.*
> *The Act does not say what is 'reasonable'. This allows flexibility for different sets of circumstances so that, for example, what is reasonable in one set of circumstances may not be reasonable in another.*
>
> *The crux of the reasonable adjustments duty is not whether something is an auxiliary aid or whether it is an adjustment to a practice, but whether it is something that is* ***reasonable*** *for the school to have to do. It is not possible for a school to justify a failure to make a reasonable adjustment; the question is only whether or not the adjustment is reasonable.*"

Factors to be taken into account

"*Without intending to be exhaustive, the following are some of the factors that are likely to be taken into account when considering what adjustments it is reasonable for a school to have to make:*

1. *The extent to which special educational provision will be provided to the disabled pupil under Part 3 of the Children and Families Act 2014*
2. *The resources of the school and the availability of financial or other assistance*
3. *The financial and other costs of making the adjustment*
4. *The extent to which taking any particular step would be effective in overcoming the substantial disadvantage suffered by a disabled pupil*
5. *The practicability of the adjustment*

- *The effect of the disability on the individual*
- *Health and safety requirements*
- *The need to maintain academic, musical, sporting and other standards*
- *The interests of other pupils and prospective pupils*".

Health, safety and risk

“If making a particular adjustment would increase the risks to the health and safety of any person (including the disabled pupil in question), then this is a relevant factor in deciding whether it is reasonable to make that adjustment. However, as with the approach to any question of health and safety, and risk assessment, schools are not required to eliminate all risk. Suitable and sufficient risk assessments should be used to help the school to determine where risks are likely to arise and what action can be taken to minimise those risks.
Risk assessments should be specific to the individual pupil and the activities in question. Proportionate risk management relevant to the disability should be an ongoing process throughout a disabled pupil’s time at the school.”

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In addition, section 149 of the Equality Act 2010 sets out the public sector equality duty. Local authorities and education providers funded by the state (not only maintained schools, maintained nursery schools, academies and free schools, further education institutions, but also providers of early years providers, non-maintained special schools, independent specialist providers and others making provision that is funded from the public purse) are subject to this general duty. This means that, when carrying out their functions, they must have regard to the need to eliminate discrimination, promote equality of opportunity and foster good relations between disabled and non-disabled children and young people. They should consider health inequalities, ensuring that healthcare support is accessible and appropriate for children and young people from diverse backgrounds.

Section 85 of the Equality Act 2010 prohibits schools (maintained schools, Academies, non-maintained special schools and independent schools) from discriminating against pupils with certain protected characteristics, including disability. This includes a requirement that schools must not discriminate in the way they provide education for pupils; the way they afford pupils access to benefits, facilities or services; or by not providing education for pupils. Schools might find themselves in breach of this duty if they refuse to provide education or offer reduced educational provision to a pupil with a disability.

Section 88 of the Equality Act and Schedule 10 require schools to have an accessibility plan. An accessibility plan is a plan that, over time, increases access for disabled pupils. The school’s accessibility plan must be run for a three-year period, from 1 April of specific years. It must be set out in writing, implemented and reviewed during the three-year period to which it relates and revised as necessary. There are three key strands that must be addressed in an accessibility plan: increased access to the curriculum for disabled pupils; improvements to the physical environment of the school to increase access to education and associated services at the school; and improvements in the provision of information for disabled pupils where it is provided in writing for pupils who are not disabled. The accessibility planning duties apply both to disabled pupils currently at the school and to disabled children and young people who might be admitted to the school as a pupil. This means that schools need to think ahead, consider potentially changing patterns of admission and be alert to early information about pupils coming through the admissions or transition processes. This can help schools to be ready to welcome disabled pupils and reduce any concerns that they may feel unable to meet need'.

A number of resources are available to help education settings understand their responsibilities towards disabled children and young people. DfE has published guidance for schools on the Equality Act 2010. The Equality and Human Rights Commission has also published various guidance documents, including technical guidance for schools in England (and a range of other guidance on the Act for schools) and guidance for FE colleges. The Council for Disabled Children has published guidance for early years settings and guidance for schools and guidance for FE colleges on the disability provisions as well as Accessibility plans and the Equality Act 2010: A handbook for schools. The Health and Safety Executive has published guidance on supporting pupils with disabilities, special educational needs, and additional support needs for educational institutions.

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Statutory duties – specific types of school, colleges and early years settings

LA-maintained schools, Academies and PRUs

LA-maintained schools (including Pupil Referral Units) and academies (excepting 16-19 academies) have a specific duty under section 100 of the Children and Families Act 2014 to "*make arrangements for supporting pupils at the school with medical conditions*". In doing so they should ensure that children and young people with medical conditions can access and enjoy the same opportunities at school as any other child or young person. This is also important in fulfilling the separate duties under the Equality Act 2010 to promote equality of opportunity and to avoid discrimination.

Early Years Foundation Stage

The Early Years Foundation Stage (EYFS) framework sets the standards that all registered early years providers must meet for the learning, development and care of children from birth until the 31 August after their 5th birthday. The EYFS will apply to children in schools with a Reception class.

The EYFS requires that

- Providers must promote the good health, including the oral health, of the children they look after.
- Providers must have and implement a policy, and procedures, for administering medicines to children.
- Medicine (both prescription and non-prescription) must only be administered to a child where written permission for that particular medicine has been obtained from the child's parent and/or carer.
- Providers must keep a written record each time a medicine is administered to a child and inform the child's parents and/or carers on the same day the medicine has been taken, or as soon as reasonably practicable.

In addition, since September 2025 the safeguarding requirements of the EYFS include a new "safer eating" section. Within the safer eating section are a number of requirements related to allergies and a requirement that, there should always be a member of staff in the room with a valid paediatric first aid certificate whilst children are eating.

The EYFS requires providers to have and implement a policy and procedures, for administering medicines. It must include systems for obtaining information about a child's needs for medicines, and for keeping this information up to date. Staff must have training if the administration of medicine requires medical or technical knowledge.

Independent schools

Part 3 of the Education (Independent School Standards) Regulations 2014 sets standards about the welfare, health and safety of pupils at the school. In Part 5, section 24 requires the proprietor to ensure “suitable accommodation is provided in order to cater for the medical and therapy needs of pupils”.

Residential schools

The Boarding schools: national minimum standards requires boarding schools to have appropriate policies for the care of boarders who have medical conditions and to implement them effectively. This includes requirements that:

- all medication should be stored safely and securely, and accurate records are kept of its administration;
- staff are properly trained to provide the support that pupils need when administering medicines;
- prescribed medicines are given only to the boarders to whom they are prescribed;
- boarders allowed to self-medicate are assessed as being sufficiently responsible to do so.

The Residential special schools: national minimum standards set the same requirements, together with the further requirements that:

- Where school staff carry out medical or nursing procedures, or may need to administer emergency medication, for a disabled child (e.g. PEG (percutaneous endoscopic gastrostomy) feeding, catheter care, administration of oxygen, administration of rectal diazepam, management of prostheses), these are only carried out on the written authorisation of the prescribing doctor or the responsible qualified nurse in relation to the individual child concerned and following the correct medication protocol.
- Staff carrying out these procedures are authorised to do so and have the correct knowledge, skills, up-to-date training, and necessary external support. There are clear arrangements in place to access medical support at all times, and for when clinicians are not available.
- Timely records are kept of all such tasks carried out.

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Statutory duties – Local authorities

Home-to-school transport

Local authorities have statutory responsibilities (under section 508B of the Education Act 1996) to arrange free home-to-school travel for eligible children of compulsory school age. They have the discretion to arrange travel for other children (under section 508C of the Education Act 1996). Local authorities may also make travel arrangements to support young people of sixth form age to attend post-16 education. They must also comply with their duties under the Equality Act 2010 as outlined above. The DfE has published statutory guidance on Travel to school for children of compulsory school age, and on Post-16 transport and travel support to education and training.

Children not attending school for medical reasons

Under section 19 of the Education Act 1996, local authorities are statutorily responsible for arranging suitable and (normally) full-time education at school or otherwise than at school for children of compulsory school age who, because of exclusion, illness or other reasons, would not receive suitable education without such provision. This means that, where a child cannot attend school because of a physical or mental health need and cannot access suitable full-time education, the local authority is responsible for arranging suitable alternative provision.

Local authorities should ensure children who are not attending school due to their health needs are offered good quality education equivalent to that provided in mainstream schools (or special schools if relevant), as far as the child's health needs allow. Alternative provision must be suitable to the child's age, ability and aptitude, and any special educational needs they have.

Hospital education is provided where a child is admitted to hospital by a medical practitioner. Hospital education can be provided at a special school established in a hospital, or through other arrangements made by the local authority under section 19 of the Education Act 1996. The local authority is not generally involved in decisions about admission to hospital – as admission is often as an emergency, the home-base school and local authority may only be notified after admission has occurred.

The legal duty to put alternative provision in place applies to children of compulsory school age. It does not apply to children and young people under and over compulsory school age, but local authorities and schools should have clear policies in place to support these children and young people to access education.

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Local authorities should have a named officer who is responsible for the education of children with health needs, working closely with schools, relevant agencies, medical and nursing professionals and parents or carers.

The DfE has published statutory guidance on Education for children with health needs who cannot attend school.

Medical conditions and special educational needs

Under the Children and Families Act 2014 a child or young person is considered to have special educational needs if they have a learning difficulty or a disability which calls for special educational provision (i.e. educational or training provision that is additional to, or different from, that made generally for others of the same age).

Where a child or young person has special educational needs and undergoes a statutory education, health and care (EHC) needs assessment, any health and/or social care needs which relate to their special educational needs must be included in the EHC plan. A child or young person will therefore only receive an EHC plan if they require special educational provision – EHC plans will not be issued where there are health and/or social care needs but no special educational need. Many children and young people who require clinical healthcare tasks will not have special educational needs and so would not have or be eligible for an EHC plan.

Where an EHC plan identifies needs (whether education, health or social care) it must also set long-term outcomes and specify provision which will secure those outcomes. The local authority is statutorily responsible for securing the special educational provision specified in section F of an EHC plan. Where healthcare provision is specified in section G of an EHC plan, the relevant health commissioner (normally the ICB) is statutorily responsible for arranging the provision. The local authority and the ICB must work together to jointly commission education, health and social care provision for those with and without EHC plans. They must present that provision publicly through the local authority's published SEND Local Offer.

Health or social care provision which educates or trains a child or young person must be treated as special educational provision (that is, "deemed" special educational provision). It will therefore be specified in section F of an EHC plan. This particularly applies to therapies such as speech and language therapy, physiotherapy and occupational therapy, that are often written into section F rather than section G. All decisions about whether health care provision or social care provision should be treated as special educational provision must be made on an individual basis by the local authority and its health or social care partners, as set out in paragraph 9.74 of the SEND Code of Practice.

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High needs funding and special educational needs

The high needs block of the Dedicated Schools Grant (DSG) is intended to meet the educational costs of children and young people with SEN or who require alternative provision. The DSG may only be used for the purposes specified in the DSG: conditions of grant and School and Early Years Finance (England) Regulations. This means that the high needs block may not be used to meet non-educational costs, except where specifically permitted.

The costs of securing health provision (specified in section G of an EHC plan) should be met by either the ICB or NHS England depending on the type of provision. The costs of securing social care provision (specified in sections H1 and H2 of an EHC plan) should be met by the local authority from their social care budgets.

Care provision for disabled children

Section 17 of the Children Act 1989 places a statutory duty on local authorities to safeguard and promote the welfare of “children in need” in their area, including disabled children, by providing appropriate services to them. If a local authority determines that a disabled child needs support under section 17, it must consider whether such support is of the type outlined in section 2 of the Chronically Sick and Disabled Persons Act 1970. Where it is, the local authority must provide that support. Services for disabled children provided under section 17 may include short breaks, equipment or adaptations to the home, support at home and support for parents from social workers, for example in support of parenting capacity.

For all children who have social care plans the social worker should co-ordinate the plan with other relevant professionals as required. Where there is an EHC needs assessment, it should be an holistic assessment of the child or young person’s education, health and social care needs. Where there are child protection concerns resulting in action under section 47 of the Children Act 1989, careful consideration should be given to how closely the assessment processes across education, health and care can be integrated, in order to ensure that the needs of vulnerable children are put first.

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