

2017

Guidance for Paediatric Physiotherapists Writing Advice for Education, Health and Care Plans (EHCP)



Association of Paediatric
Chartered Physiotherapists

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The child or young person is referred to as CYP throughout.

Objectives

This guidance is focussed on the CYP's needs and best interests and promotes that as key to paediatric physiotherapists working together with other health colleagues, education and social care.

The guidance will promote good professional standards for writing advice for an EHCP within the legal structure required.

The guidance will enable paediatric physiotherapists to explore co-working boundaries when writing for an EHCP.

This guidance is linked to current legislation and standards.

The information contained within this document gives an overview which is accurate at time of writing. However the fine detail and application of legal guidelines is continually evolving. For this reason it is recommended that for updated information readers use the links to relevant websites included within this document.

Introduction

The origin of identifying special educational needs goes back as far as the [Education Act 1921](#), the first attempt to classify need by an impairment model. (Johnston 1996, Marks 1997).

In the 1940s, [The Education Act 1944](#) gave Local Education Authorities (LEAs) the duty to “ascertain” children who required “special educational treatment” based on an examination by a “medical officer of the authority” to see if the child was “suffering from any disability of mind or body”. The special educational treatment provided depended essentially on the category into which the child had been placed, rather than on any specific assessment of his/her individual needs. Parents had no right to be involved in the process or to see any of the reports.

There were then many changes in legislation governing special educational needs including the [Education \(Handicapped Children\) Act 1970](#) , the [Education Act 1976](#) , the [1978 Warnock Report](#) which formed the basis of the [Education Act 1981](#), at last giving parents a role to play in decision making regarding the educational placement of their child. [The Education Act 1993](#) sought to address specific issues by introducing a Code of Practice, and an independent Special Educational Needs Tribunal to resolve disagreements between parents and local authorities.

A wide range of much amended, but still current, education law was consolidated into the [Education Act 1996](#), including the section of the 1993 Act relating to ‘Children with Special Educational Needs’. (Appendix I). Following a consultation of almost two years, the [SEN Code of Practice was published in 2001](#).

In September 2014 a very big legislative change happened with the [Children and Families Act](#) introduced in England and Part 3 included clauses on:

- The local offer
- Personal budgets
- [Education Health and Care Plans](#) (EHCP)

The [SEND Code of Practice 2015](#) (Special Educational Needs and Disability) is a statutory guidance document for organisations which work with and support CYP who have SEND in England.

United Nations Convention on the Rights of the Child 1989

In the wider context of SEN across the UK, all four governments should also have regard to the provisions contained in the [United Nations Convention on the Rights of the Child](#). The Convention protects children's rights by setting standards in health care, education, legal, civil and social services.

Understanding Roles and Responsibilities

All paediatric physiotherapists should be aware of their statutory duties in relation to the special educational needs and disability (SEND) reforms. You must also work within the [standards](#) set out by the Chartered Society of Physiotherapy (CSP) and the [Health and Care Professions Council](#) (HCPC).

The SEND reforms are set out in part 3 of the [Children and Families Act 2014](#). It applies to England only. There is also the [Special Educational Needs and Disability Code of Practice: 0 to 25 years](#). The Code tells local authorities, schools and others how they must carry out their duties under the law. In particular Section 42 of the Children and Families Act states:

‘Duty to secure special educational provision and health care provision in accordance with EHC Plan’.

(1) This section applies where a local authority maintains an EHCP for a child or young person.

(2) The local authority must secure the specified special educational provision for the child or young person.

(3) If the plan specifies health care provision, the responsible commissioning body must arrange the specified health care provision for the child or young person.

(4) “The responsible commissioning body”, in relation to any specified health care provision, means the body (or each body) that is under a duty to arrange health care provision of that kind in respect of the child or young person.

(5) Subsections (2) and (3) do not apply if the child’s parent or the young person has made suitable alternative arrangements.

(6) “Specified”, in relation to an EHCP, means specified in the plan.

Paediatric physiotherapists along with all other clinicians working with children and young people (CYP) with SEND have the responsibility of early identification of need, and must inform the appropriate local authority of any CYP identified under compulsory school age who has or probably has SEND (section 23 of the Children and Family Act 2014). The clinician **MUST** give the CYP’s parents/ carers the opportunity to discuss their opinion on potential SEND before informing the local authority.

Key Principles of SEND

The law aims to improve the system by giving more importance to the views, wishes and feelings of CYP and their families. It is based on these principles:

Participation

Local authorities (LA) and health partners must work with parents/ carers and CYP to improve services in their area, for example through their local parent carer forum.

Outcomes

LA's must offer support in a way that enables CYP with SEND to achieve the best possible educational progress, and helps them do what they want in their lives as they grow up.

Joint decisions

LA's must make sure that CYP and their parents/ carers are fully informed and supported to take part in decisions which affect them. Therapists must make sure that CYP and their parents/ carers are involved in discussions about their individual support and about the local provision and take into account their views.

Joint working

Education, health and social care services must work more closely together when they are deciding on the support available for CYP with SEND in their area.

Many CYP with SEND will not need an EHCP, this is determined by the matrix funding arrangements for each educational setting and will vary in each area. SEN support at their nursery, school or college should be able to provide all the extra help they need.

A Joint Strategic Needs Assessment (JSNA) pulls together information about local health, care and support and is a tool used to help plan future services. A small number of CYP will need an EHCP if they need more support than is normally available in mainstream nurseries, schools or further education colleges, or through the 'local offer'. [Current statistics](#) show that 19.5% of CYP with SEND have an EHCP which is 2.8% of the total pupil population.

The Local Offer

LA's in England have a duty to publish a [Local Offer](#), setting out in one place information about the provision they expect to be available in their area across education, health and social care for CYP in their area who have SEND, including those who **do not** have EHCP's. This would also be a straightforward way to find information about other areas if you have a CYP moving to another area and clinicians should be signposting families to this as a matter of course. **It is vital clinicians know details about their area's Local Offer before commencing to write advice for an EHCP.** Ideally clinicians will proactively contribute to their area's Local Offer, ensuring it is a thorough and accurate reflection of their service. These will vary from one area to another but the Local Offer has two key purposes:

- To provide clear, comprehensive, accessible and up-to-date information about the available provision and how to access it although it is not a guarantee that a particular service would be available.
- To make provision more responsive to local needs and aspirations by directly involving CYP with SEND and their parents/ carers, and service providers in its development and review.

It should also include:

- Universal, preventative services and specialist services.

- Therapy services including physiotherapy, speech and language therapy, and occupational therapy and services relating to mental health, such as arts therapies (these must be treated as special educational provision where they educate or train a CYP).
- Wheelchair services and community equipment providers, children's community nursing, continence services.
- Palliative and respite care and other provision for children with complex health needs
- Other services, such as emergency care provision.
- Provision for CYP's continuing care arrangements (including information on how these are aligned with the local process for developing EHCP's).
- Support for young people when moving between healthcare services for children to healthcare services for adults.

Personal Budgets

[Personal health budgets](#) are a new and evolving tool to increase individual choice and control within the NHS as part of the mandate to increase the role of patients as partners in the management of long-term conditions.

A personal health budget is an allocation of NHS resources that individuals can use to meet their health and well-being goals in new and innovative ways that do not rely on commissioned services. It does not cover an individual's entire NHS care. Certain services, such as GP services, A&E, and inpatient care, are excluded. The organisation who commissions services in each area needs to be satisfied that the requested service is effective and appropriate before they agree to allocate a personal budget for it. For example payment used for a specialist sports club may be appropriate. Payment for private therapy may or may not be covered depending on services available locally.

The personal budget for education is included in an EHCP and will only include the funds needed to buy more specialist or individual support than the school or college is expected to provide. Health professionals will have to work with the LA to describe the services they offer which lend themselves to the use of Personal Budgets. There are clear overlaps between Personal Budgets for CYP with SEND and Personal Health Budgets and consideration should be given to how these can be aligned to ensure that the process is as smooth and as manageable as possible for families.

Information, Advice and Support Services (IASS)

Formerly known as Parent Partnership Services, Information, Advice and Support Services (IASS) are available nationally and fulfil the extended duty upon local authorities under section 32 of the Children and Families Act 2014. IASS are for CYP with SEND (0-25) and their parents/ carers. In some areas, the IASS is known as SENDIASS.

IASS offer free, impartial and confidential information, advice and support on matters relating to a child or young person's special educational needs or disability such as:

- Education, health and social care matters and relevant law.
- Rights and entitlements.
- Support available in schools, early years and post 16 settings.
- Funding arrangements.
- How needs are identified and met.
- Disagreement resolution and moving forward.

IASS have staff who have undergone significant training to offer individual support which may include:

- Support at and preparing for meetings.
- Help to understand and navigate processes and procedures (such as the EHCP process).
- Help to participate in discussions and decision making.
- Liaising with services and organisations.
- Ensuring the views, wishes and feelings of the CYP and their parents/ carers remain at the heart of discussions and decisions.

The IASS network is funded by the Department for Education and is based within the Council for Disabled Children.

Each area operates slightly differently and services will differ in size and capacity but the key feature is impartiality from the LA and statutory services.

The requirements of an IAS Service are set out in Chapter 2 of the [SEND Code of Practice](#). The standards expected of IAS Services can be found in the [IASSN Quality Standards](#)

This link is to the [Wolverhampton service](#) as an example so please access your local service as well. It is extremely helpful when working with CYP and their families to refer them to your local IASS for support regarding their provision within education settings.

Understanding Outcomes, Aspirations and Targets- the Language of EHCP

Aspiration- an ambition or hope, these may not be realistic but are the wishes of the CYP, unlike outcomes they have no legal duty. It may give clues as to what motivates them. Families may have aspirations which seem unrealistic to professionals, services are not responsible for people's dreams but it is helpful to know what they are and to have honest and open conversations about them. Sometimes there is confusion between aspirations and outcomes.

Need- essential or very important rather than just desirable.

Outcome- the SEND Code of Practice describes outcomes in the following way:

'An outcome can be defined as the benefit or difference made to an individual as a result of an intervention. It should be personal and not expressed from a service perspective; it should be something that those involved have control and influence over, and it should be [Specific, Measurable, Achievable, Realistic, Time bound \(SMART\)](#).

When agreeing outcomes it is important to consider both what is important to the CYP – what they themselves want to be able to achieve – and what is important for them as judged by others with the CYP's best interests at heart' Code of practice 2015; Chapter 9.

A good outcome can be described as:

- Building on something that is working well.
- Changing something that doesn't work well.
- Moving the CYP towards their future aspirations.

If the outcome being considered doesn't address any of these issues, then it probably isn't a good one. It should be personal and not expressed from a service perspective. Consider what will success look like? How will you know it has been achieved? Words to avoid are potential (what), opportunity (how), regular (when), support (what/who), may (must/will).

Apart from confusing outcomes with aspirations, there are two further common mistakes often made when developing outcomes.

The first is embedding the solution or provision into the outcome, often you will see outcomes that describe the solution for achieving the outcome as part of the outcome or they are describing the provision that will help the outcome be achieved e.g. *To have 1 hour of physiotherapy every week.* This is a provision, not an outcome.

The second is not being specific enough to be able to measure whether an outcome has been successfully achieved and has made a difference in the CYP's life e.g. *To improve my fitness and stamina.* This outcome is not specific to the individual and there is no way of measuring if it has been achieved. We don't know what to be fit looks or feels like to this person or what is important to them about improving their fitness and stamina.

Provision- the action of providing or supplying a service or resource. This may include training, equipment and direct therapy. This should be based on available evidence and best practice. It should not specify the service available, but should focus on the CYP's needs and outcomes. It should also include time required to attend meetings regarding the CYP, write reports, review the evidence base and measure outcomes as well as any direct therapy time.

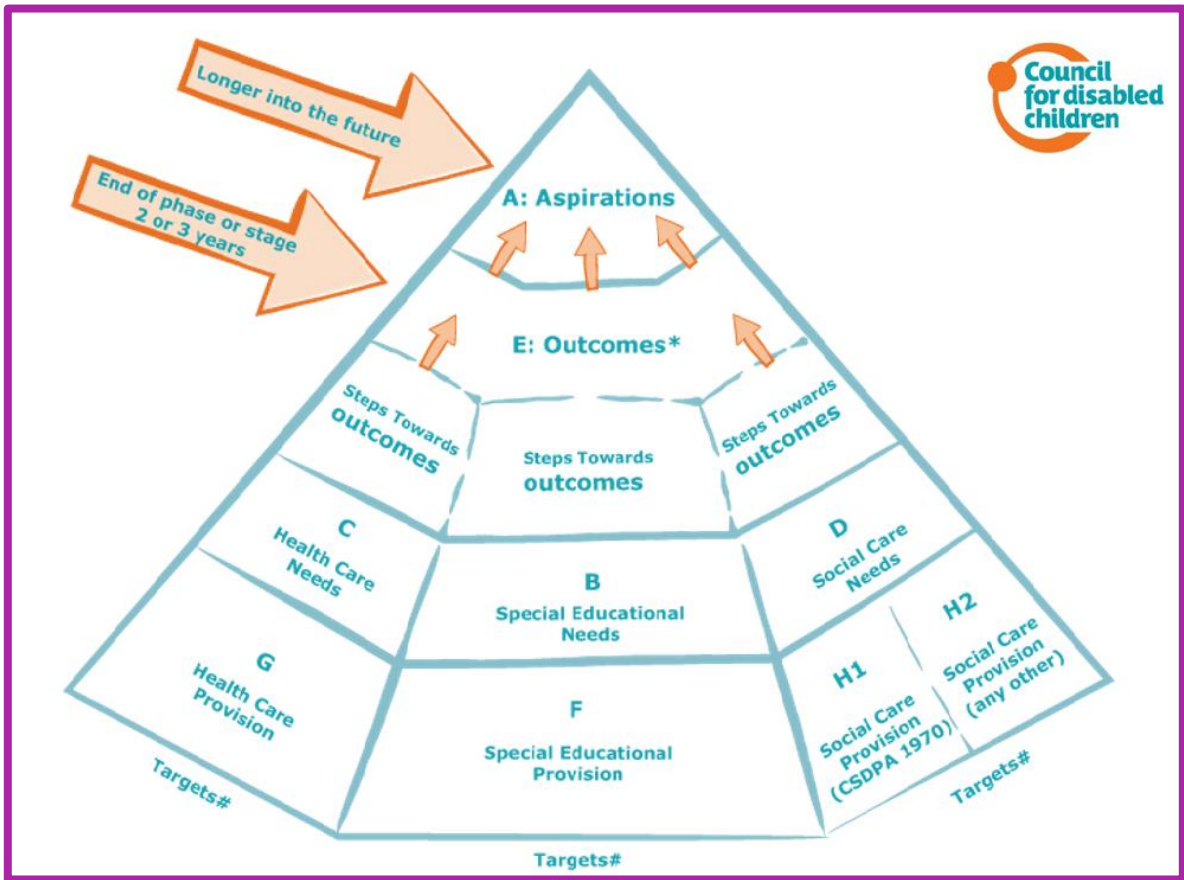
Long term outcome (goal/ target) - A long term outcome for the CYP, suggested timescale may be by the end of next key stage, next transition point or within the next three years. Some areas may choose different timescales.

Short term outcome (goal/ target) - a short term outcome or step towards long term outcomes, a suggested timescale could be something that can be realistically achieved within the next 12 months.

Aspiration	Need	Long term outcome	Short term outcome	Provision
		To be able to move around school independently by the time I go to secondary school	Unable to move between classes	
Six visits from a physiotherapist in the next 12 months to teach school staff a programme of mobility skills				
		To be able to go out to the playground on my walker every day	I want to get a good job as a computer games designer	

Which is which?

Aspiration	I want to get a good job as a computer games designer
Need	Unable to move between classes
Long term outcome	To be able to move around school independently by the time I go to secondary school
Short term outcome	To be able to go out to the playground on my walker every day
Provision	Six visits from a physiotherapist in the next 12 months to teach school staff a programme of mobility skills



About the EHCP

An EHC assessment is an assessment of the education, health care and social care needs of a CYP (Section 36(2)). LA's are required to gather evidence from the CYP, parents/ carers and also from a range of professionals across education, health and social care.

EHC assessments should be built on an understanding of the aspirations of the CYP, parents/ carers and the outcomes they want to achieve.

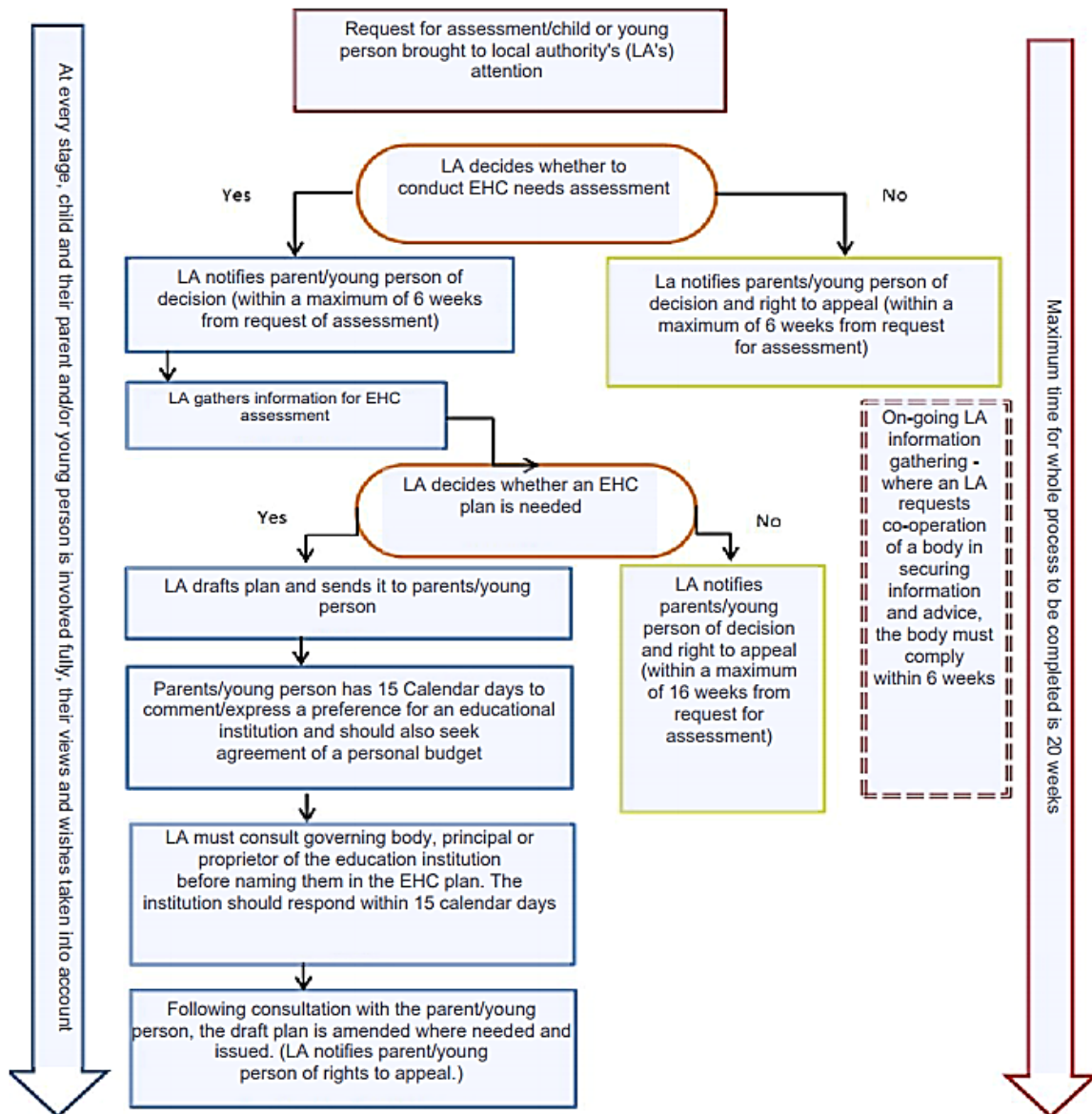
Following an EHC assessment, the LA must decide whether it is necessary for special educational provision to be made in accordance with an EHCP. This decision will be based on whether the education institution can be reasonably expected to provide the special educational provision that a CYP needs.

According to the SEND Code of Practice, when a LA agrees to initiate an EHCP it must complete it within 20 weeks of the initial request for an EHC needs assessment. This means that requests for information from paediatric physiotherapists **must** be dealt with in a timely manner and within **six weeks** of the request.

Health professionals asked to contribute to the EHCP often find their reports listed in section G of the plan: *Any health provision reasonably required by the learning difficulties or disabilities which result in the CYP having SEND. (See section on legal issues as to why you may want to encourage your advice to be included in section F)*

- Health provision should be detailed and specific and should be quantified, for example, in terms of the type of support and who will provide it.
- It should be clear how the provision will support the outcomes, including the health needs to be met and the outcomes to be achieved through provision.
- Clarity as to how advice and information gathered has informed the provision specified.
- Health care provision reasonably required may include universal services, specialist support and therapies, a range of nursing support, specialist equipment, wheelchairs and continence supplies. It could include highly specialist services needed by only a small number of CYP which are commissioned centrally by NHS England (for example therapeutic provision for young offenders in the secure estate).
- The local authority and CCG may choose to specify other health provision reasonably required by the CYP, which is not linked to their learning difficulties or disabilities, but which should sensibly be co-ordinated with other services in the plan.

Statutory timescales for EHC needs assessment and EHC plan Development



An EHCP is separated into 12 parts. These parts detail the education, health and social care needs and provision necessary to cater for a CYP's SEND.

Education, Health & Care Plan outline

Section A	• Views, interests and aspirations of the child or young person, and their parents
Section B	• The child or young person's special educational needs (SEN)
Section C	• The child or young person's health needs which relate to their SEN
Section D	• The child or young person's social care needs which relate to SEN
Section E	• The outcomes sought for the child or young person
Section F	• The special educational provision required by the child or young person
Section G	• Any health provision required by the child or young person
Section H	• Social care provision
Section I	• Placement
Section J	• Personal budget (including arrangements for direct payments)
Section K	• Advice and information

- A-** This should include: history, future goals, play, health, schooling, friendships, how to communicate with the CYP and involve them in decision making.
- B-** The description of the CYP's SEND. Some health or social care needs may be treated as SEND.
- C-** Health needs identified by the ENC assessment which may relate to SEND.
- D-** Social care needs related to SEND, for example personal care needs, travel.
- E-** Outcomes can be education, health or social care related. Should include steps to achieve outcomes, how progress will be checked and arrangements for review. Physiotherapy outcomes may be included here.
- F-** The Special Educational Provision required to meet those needs identified in section B and outcomes identified in section E. **The local authority is responsible for delivering (including funding) the support in Section F of the EHCP. This is why you may wish to ensure physiotherapy requirements come into this section, as provision for activities which need to be embedded into the daily life of the CYP, such as postural management. This will secure the correct support for the CYP regardless of local arrangements on therapy provider organisations.**
- G-** Health provision is where physiotherapy and other therapies have typically sat, alongside medication, medical, nursing and equipment.
- H-** Social care provision includes use of direct payments, help in the home and socialisation outside of school.
- I-** Type and name of school, college or other setting.

- J- Details of personal budget and direct payment arrangements, specifying the SEND outcomes which are to be met by direct payments.
- K- Advice and information gathered during the EHC assessment.

The LA will then have the legal duty to secure the educational provision specified in the EHC plan, that is, to ensure that the provision is delivered. The EHCP can be continued until the age of 25 so a young person aged between 19 and 25 can have a plan if they still need more time to finish their education or training.

Where there is a health provision in an EHCP, the local health commissioning body, usually the Clinical Commissioning Group (CCG), has the duty to provide. The CCG may also choose to specify other health care needs which are not related to the CYP's SEND (for example, a long-term condition which might need management in a special educational setting).

Role of the Designated Medical/ Clinical Officer

The Designated Medical Officer (DMO) or Designated Clinical Officer (DCO) play a key role in implementing the Children and Families Act reforms and supporting joined up working between the CCG, health providers, LA's and education.

While DMO/DCO roles may have some elements in common with the previous Designated Doctor for Special Educational Needs role, there are also significant differences as a result of the recent reforms. The DMO/DCO provides a point of contact for local authorities, schools and colleges seeking health advice on CYP who may have SEND. They would also be the point of contact for CCG's or health providers so that the appropriate notification can be given to the LA about CYP who they believe may have SEND who are of school age, or under the age for statutory schooling.

The DMO should have an appropriate level of clinical expertise to enable them to exercise these functions effectively, and should be designated as the DMO in their job description. There may be one DMO for several CCGs and LA's, where there are joint arrangements or shared commissioning responsibilities, and given the age range of EHCP's from birth to 25, the DMO may need to liaise with colleagues outside paediatrics.

Providing written advice for the EHC assessment or plan

Physiotherapists should write detailed reports to support the CYP. All physiotherapy reports should comply with CSP quality assurance standards and [APCP Working with Children - Guide to Good Practice \(2016\)](#).

Reports should be written in collaboration with the CYP, parents/ carers and relevant stake holders, taking into account the views of the CYP.

Physiotherapists should be providing clear advice for all CYP who have additional physical needs impacting on their education. This should be in relation to access to the curriculum or in being able to participate in every day school life; in order to maximise function, participation and inclusion.

This advice should provide clear and concise information and guidance on the CYP's current and potential physical development and abilities, and their relevance to the CYP's functioning and participation within the school environment, home and community. They should set clear aims and expected outcomes for intervention.

The focus should be on outcomes in relation to school, home and community. These should be based on the CYP's needs and aspirations. These should be SMART (specific, measurable, achievable, realistic, and timed).

Services work differently in different areas as to the specific roles within educational settings of the physiotherapist, occupational therapist and the speech and language therapist. The report may need to reflect this and collaborative report writing is good practice where possible.

The reports may be read by CYP, parents/ carers and by practitioners who work in education services, and should:

- Make sense to them.
- Include a summary of the CYP's strengths and needs.
- Be written in the third person.

The report should not:

- Be considered as a clinical report.
- Contain any jargon.
- Contain any ambiguous statements or words.
- Contain any non-specific advice.

The following section suggests a format for writing advice for an EHCP and guidance on what to include in the report. The actual EHCP template will be different in every area and may require different information.

It may be helpful to include the following two sentences at the beginning of the report:

'This report is written for the sole purpose of this CYP's special educational needs and cannot be reproduced or altered without consent from the clinician.'

'Physiotherapy recommendations are based on the level of need as it is assessed at the current time.'

The report should list the following details, relating to the CYP, at the beginning:

- Name.
- Date of birth.
- NHS number.
- Address.
- Parent / carers names.
- Current educational placement.
- GP / medical consultant.

Introduction

This should be a general and positive paragraph giving a pen picture of the CYP.

It should include:

- A brief sentence as to the nature of difficulty/diagnosis and its effect.
- Relevant background information.
- CYP's first / main language.
- Their behaviour and co-operation.
- How long the CYP has been known to the physiotherapy service, and nature of input and location.

Description of the CYP's strengths and needs

This section should focus on the CYP's abilities and difficulties that are likely to affect them in the educational setting, home and social environments, providing a clear description of the CYP.

Functional abilities / difficulties may include:

- Floor mobility.
- Ability to move between positions.
- Abilities in the sitting and standing positions, including with the use of equipment.
- Dependence on assistance for moving and transfers.
- Mobility and mobility aids.
- Patterns of movement and tone- *beware of medical jargon.*
- Balance and co-ordination- *beware of medical jargon.*
- Posture and implications of immobility on pain, discomfort and deformity.
- Motor planning and organisation.

- Body and spatial awareness.
- Upper limb function (or refer to the Occupational Therapy Report).
- Self-help and personal care (or refer to the Occupational Therapy Report).
- Aids, orthotics and appliances.
- Ability to communicate (or refer to Speech and Language Therapy Report).
- Ability to participate in age appropriate social interactions.
- Independence e.g. toileting, transfers.
- Leisure activities.
- Think about all aspects of the CYP's day:
 - Arriving at school, morning routine, book bag, and coat.
 - In the classroom, completing written work, completing craft/practical work, playing sport/ PE, following directions for activities, packing up/tidying desk.
 - In the playground, level access, safety, vulnerability, socialising.
 - Self-care, toileting, managing menstruation, changing for PE.
 - Moving around school, going to lunch, managing tray/cutlery/packed lunch, drinking, snacks in class.
 - Participation, assembly, school clubs, concerts, school play, trips out of school, public transport, school coach.

Summary of Needs

This should be a brief summary of the section above stating where the CYP may have difficulties and the consequences of these on their function and participation in relation to their education, social and community environments.

Outcomes

Outcomes should enable CYP to move towards their long term aspirations of employment, higher education, independent living and community participation. The precise interpretation of these terms including the length of time, should be determined locally. They will normally set out what needs to be achieved by the end of a phase or stage of education in order to enable the CYP to progress successfully to the next stage. This will likely include short and long term suggestions.

Outcomes should be discussed and agreed with all CYP and their parents/ carers as part of their care.

Provision required to meet CYP needs and desired outcomes

This section should clearly identify provisions required to meet the CYP needs and desired outcomes.

This may include:

- School staff training needs/experience/knowledge.
- Manual handling training.
- Time to deliver specific physiotherapy programmes.
- Physical environment.
- Additional adult support.
- Need for specialist equipment within school, and the space to use and store the equipment - details such as storage, and battery charging where motorised equipment is a means of mobility should be included.

- Parental support.

The school will also need to know how much support the CYP requires to be able to do any additional activities that the physiotherapist has identified as being important to maximise learning, function and participation within the school setting.

Recommended Provision by the Physiotherapy Service

The advice should be **detailed** and **specific** and **quantified** and include the type of provision, who will provide this and where this will be provided. This should relate directly to the CYP's needs and not the service level available, **never modify provision to suit capacity**. The advice about 'how much physiotherapy' remains an individual decision, dependent on many factors and needs. Advice should be as clear as possible e.g. how long a CYP should stand in a standing frame. Emphasis should be on a more holistic approach to physical development and management, involving not only specific strategies but also activities that can be incorporated into school, home and social activities.

Recommendations for physiotherapy provision must be reasonable and in line with what is considered sound ethical practice, and where possible, evidence based. If there comes a time that this will go to tribunal, a judge will always be most interested in how the provision will enable the CYP to meet the outcomes so use as much evidence base as possible. Local authorities and CCG's have to agree how to achieve the outcomes for CYP who have SEND. Therefore it is important that each practitioner understands their service and their commissioning agreements.

When detailing provision time, remember to include specified time for direct treatment, to measure outcomes and attend meetings regarding the CYP. The time specified for the physiotherapy provision should also realistically take into account non- contact responsibilities and duties such as safety checks and monitoring of equipment, provision of equipment, report writing, liaison with parents and other professionals, devising postural management and exercise programs where needed, as well as quantified time to supervise and oversee competence of teaching support staff if they deliver indirect physiotherapy programs and monitoring. Recommendations for provision should also consider the time required to review the evidence base for the management of the CYP's condition.

We risk selling ourselves short when we overlook aspects of our role, or underestimate how much time a CYP may need from us, in order for us to adhere to our own robust guidance documents and standards.

If recommendations to achieve outcomes are outside local offer currently commissioned this should be acknowledged within the report.

It is important that a degree of flexibility is built into this if the CYP is starting a new school, has changing needs, or is due to undergo surgery. It is acceptable to write *'this is based on the level of need as it is assessed at the current time'* and then explain why it may change.

It may be necessary to include the time required to enable close collaboration with those who are providing risk assessment and advice about manual handling. There may be conflicts to

be resolved around staff safety versus developing independence skills such as standing transfers, or working together to achieve a specified physical function.

The report could conclude with the following statement:

'This advice will be subject to review in line with the EHC review process, but may be altered by the therapist at any time to reflect the changing needs of the CYP'.

Reports should end with the title, name, profession and place of work of the therapist, and be signed and dated.

The content of the advice **must** be discussed with the CYP and the parents/ carers before sending to the LA and any areas of disagreement noted.

The local authority will seek advice from involved professionals and use this to draft a plan

Legal issues

There is still quite a lot of confusion about how therapeutic provision should be provided to a CYP who has an EHCP.

It is worrying that many LA's are claiming that therapists are employed by the NHS so their support is medical, not educational.

Why does this matter?

When a provision is recognised as a Special Educational Provision it is placed into Section F of the EHCP. The LA, not health, is responsible for Section F. This is important for two reasons:

- It is the LA that is responsible for, and funds, the provision in Section F.
- If the provision is not made available, discussion should take place with the LA.

The first point is likely to have the most significant practical effect for parents/ carers. If there is a disagreement about the content of an EHCP, it may proceed to a tribunal.

A tribunal currently only considers the Special Educational Provision – i.e. the provision, and cost of that provision, in Section F. As such, it is important that any and all provision that is Special Educational Provision is in Section F so that it is included in that cost. **However from March 2018 a national trial of the single route of redress for the First-tier Tribunal SEND will be introduced.**

The single route of redress national trial will expand the powers of the First-tier Tribunal SEND to enable it to make non-binding recommendations on the health and social care aspects of Education, Health and Care (EHC) plans alongside the educational aspects.

This will reinforce the person-centred nature of the Children and Families Act 2014 by enabling the Tribunal to take a more holistic view of the child or young person's needs.

This will have a significant effect on the EHC process, enabling wider scrutiny, and legal direction relating to Health provision

If parents accept the LA's position that therapies should be in Section G, rather than Section F, the following issues can arise:

- The provision contained in Section G cannot (currently) be appealed to the Special Educational Needs and Disability Tribunal (SENDIST), however a pilot expected in 2018 may change this.
- It will lead to an inaccurate calculation of costs of the provision to the local authority.
- This could significantly impact on prospects of success to an appeal to SENDIST/negotiations with the local authority.
- If parents/ carers are asking for a Personal Budget, the funding for the therapies needs to be correctly allocated from the correct agency.

The 'lawful' way to write your provision in the EHCP is to ensure that advice is specified and quantified, including who will deliver it.

Case Law

EB V ISLE OF WIGHT COUNCIL [1997] ELR 279

This is one of few cases to reach the High Court on the issue of whether physiotherapy and occupational therapy can be special educational provision, as opposed to medical provision. In giving his decision, the judge made the following comment:

"All that anyone can do when judging whether a 'provision' is educational or 'non-educational' is to recognise that there is an obvious spectrum from the clearly educational (in the ordinary sense of that word) at one end to the clearly medical at the other, take all the relevant facts into account, apply common sense and do one's best."

The Code of Practice at paragraph 9.74 does make clear that decisions about whether a therapy is education or health provision must be taken on an individual basis. That means that general policies from local authorities that state physiotherapy is a health need only, as suggested by the above quote, must be wrong in law.

IPSEA (Independent Parental Special Education Advice) also had reason recently to disagree with the CDC (Council for Disabled Children) over wording in an EHCP document. CDC recently released a document 'Education, Health and Care Plans- Examples of Good Practice' to support the development of skills in writing good quality EHCP's. There is a detailed explanation of what must go into each section, plus two exemplars for 'Jay' and 'Jessica'. IPSEA felt that it perpetuated the myth that health services should remain as health provision in an EHCP.

'We then considered 'Jessica's' EHC Plan. Section B of the EHC Plan describes Jessica having to change position at least every two hours. There is some provision in Section F to

match this need in that a member of staff will be available at all times during the day to move and transfer her. However, the physiotherapy sessions Jessica requires and the physiotherapy training to school staff is detailed in Section G of the EHC Plan. Again, in IPSEA's view this is incorrect; the physiotherapy and staff training should be should be in Section F and we were disappointed to see this in an exemplar EHC Plan which is likely to influence those drafting EHC Plans.'

So it would seem that there are still several issues that are not completely clear yet.

Mediation and Tribunals

When parents or CYP disagree with a LA's decisions on whether they will carry out an EHC needs assessment, or disagree with the content of a final EHCP, they have the right to go to mediation about the education, health and social care elements of the plan. If parents/ carers or CYP want to go to mediation about the health or social care elements of an EHCP the relevant CCG and/or the LA respectively must attend. Under the Children and Families Act section 53, health professionals must also participate in mediation when asked to do so.

Mediation means involving an independent professional whose job it is to negotiate between two parties in the hopes of getting an agreement. Mediation seeks to resolve matters through agreement between parents/ carers or CYP and LA's rather than through a judicial decision. Mediation is an opportunity for the CYP and family to meet with the LA and have an open discussion, supported by a mediator, about their concerns and why they disagree with the LA. A mediator is someone who is trained in the area of law and is able to best facilitate this discussion so that both the family and the LA are able to explain their points of view. The mediator must be independent (e.g. not an employee of the LA).

Parents/ carers or CYP are obliged to go to mediation before they bring an appeal to the First-tier (SEND) Tribunal. Where they decide against mediation, they will be able to go straight to appeal after receiving a certificate stating that they have considered and declined mediation. The Special Educational Needs and Disability Tribunal (SENDIST) can allow presentation of an appeal without having first considered mediation but that power is discretionary and it may be difficult to convince the Tribunal to use it.

Where physiotherapists have been asked to contribute to an appeal, they should be clear that their role is not as a mediator or advocate; they are acting as either a factual witness or an expert witness, or potentially both. For example, reporting on what a CYP can do, or the results of a test, is factual; explaining what conclusions to be drawn and what response should arise is a matter of expertise. **The focus is on the needs of the CYP and response to intervention and provision. As in written advice for the process, their identification of the CYP's needs should not be influenced by pressures such as the desires of the CYP, parents/ carers, school or resource constraints.**

In preparation for the tribunal, physiotherapists should consult with peers and take legal advice, usually available from the LA. In large teams a lead therapist may take responsibility within each locality for ensuring effective communication with the LA with regard to SEND appeals. This therapist will in most cases be a clinical lead, who fully understands the process and has experience with complex cases within an educational context but may not necessarily be a physiotherapist. They would need to work in partnership with the physiotherapist who is attending the tribunal. This should be someone who has recent detailed first-hand experience of the CYP and their management and care. If this therapist is inexperienced, it is strongly recommended that they are supported by an experienced colleague in preparing for the tribunal hearing.

The tribunal does not have strict rules of evidence, but the following key points are important and apply to all appeals or claims:

- Opinion evidence will be accorded little weight unless provided by a witness who has expertise in the relevant area.
- Experts are witnesses with particular qualifications, knowledge and/or skills, which enable them to give an opinion within their area of expertise. They do not need to be medically or scientifically qualified but must have specialist knowledge acquired by education or experience. They should avoid expressing opinions on matters beyond their expertise.
- All witnesses should assist the tribunal in accordance with the overriding objective of enabling the tribunal to deal with appeals justly and fairly.

These points come from a [publication](#) about giving evidence at appeals and tribunals that is very useful and should be read if you are called to attend.

Dealing with Disagreements

Communication is an essential skill of physiotherapists. This should be open and honest, regular and in the CYP's best interests. When working in paediatrics, physiotherapists will often be part of a multi-disciplinary team (MDT). It is expected that physiotherapists will work closely and maintain positive working relationships with the MDT, parents/ carers as well as with other physiotherapy colleagues, regardless of the sector of employment.

When working as part of an MDT there is always a need to maintain positive working relationships and pre-empt any disagreements with openness. This may well be most relevant when there is more than one paediatric physiotherapist working with the same family. The guiding principles here should be around explicit discussions of roles, responsibilities and joint working practices. **See APCP 'Putting the Child First'**

For example, a potential arrangement might be that a NHS/school-based paediatric physiotherapist may work within school, training teachers and classroom assistants and in close liaison with an independent paediatric physiotherapist, who may be offering therapy outside of school.

Establishing explicit and sustained collaboration is the responsibility of each therapist irrespective of the sector in which they operate and the identification of who takes responsibility for specific areas will hopefully reduce any conflicting therapy outcomes/programmes.

Both NHS and independent physiotherapists may be asked to contribute to the EHCP and it is helpful if they can work together to produce a collaborative document/ report. The Code of Practice 2015 states in section 9.184 'Information sharing is vital to support an effective assessment and planning process which fully identifies needs and outcomes and the education, health and care provision needed by the child or young person.'

Where there are disagreements the physiotherapist should try to resolve the situation through good communication. It is the responsibility of the physiotherapist to communicate fully with all other professionals involved in the CYP's care. Consent is required from the parent/ carers before you can contact the other professional. If the family are reluctant to provide consent, it is essential that you explain the reasons fully to the family, and that this is your professional duty.

Differences in opinion with families

When outcomes and targets have been agreed with families from the earliest stages in intervention, it is hoped that differences in opinion at the statutory assessment stage will be minimised. It will be particularly important for paediatric physiotherapists to attend planning meetings when differences in opinion are anticipated.

Parents/ carers are not able to change the recommendations made by professionals contributing to the process, but can suggest amendments to the plan at the draft stage and request a meeting with the LA to discuss them. Where an agreement cannot be reached, parent/ carers views should be documented and attached as an addendum to the therapy advice.

The LA may not agree to these amendments and proceed with issuing the plan, in which case parents may appeal.

Differences in opinion with the Local Authority

The EHCP sets out the result of the LA's assessment of need and may occasionally take a differing view to that of the paediatric physiotherapist. In such instances the LA cannot misrepresent the views of the therapist (e.g. by claiming its view is that of the physiotherapist), and should include all reports received as appendices to the plan.

If the EHCP is then subject to an appeal, the paediatric physiotherapist giving evidence should clearly distinguish between their view and that of the LA, ensuring that their first duty is always to the CYP.

Annual (EHC) Reviews

An annual review (AR) is a review of a CYP's EHCP.

The EHCP must be reviewed within 12 months of the initial plan being finalised and at least once every 12 months to check on the child's progress and the EHCP's continuing relevance. It may be more frequent than this, especially in the younger child.

Reviews must focus on the CYP's progress to achieving their outcomes.

An AR will not always lead to changes in the EHCP.

The AR is arranged by the education setting and usually takes place here.

The views of the CYP should always be sought and they may be invited to attend part or all of the meeting.

What is the purpose of an AR?

- To assess the CYP's progress over the last 12 months in terms of targets set at the last AR and record if the EHCP has been successful in meeting their needs.
- Collate and record information for planning future support for the CYP.
- Consider continuing appropriateness of the EHCP in light of performance over last 12 months and whether the EHCP needs continuing, amending or ceasing.
- Consider any additional or new educational needs.
- Set goals and outcomes for next 12 months.
- To bring together the views of everyone involved in CYP's care and record any change in circumstances.

What happens before the meeting?

- An invitation to attend the AR is sent by the education setting to the CYP and parents/ carers and also anyone else involved in the CYP's care which could be therapists, educational psychologist, social services, doctor etc.
- It is good practice to encourage your education settings to give six weeks' notice to enable timely and comprehensive report writing. It is not always necessary to attend the AR, especially if provision is not changing. It is recommended to attend at key transition points and where provision may be changing.
- Written reports from each invitee should be sent two weeks prior to meeting. All attending should have access to others reports ideally before the meeting. It is **essential** to be open and honest in the review report and to share with the CYP and parents/ carers before the AR. There should be no surprises that you are recommending a reduction in therapy provision for instance.

What happens during the meeting?

- There will be consideration of progress made to achieve targets/ outcomes.
- The meeting will consider views of CYP, parents/ carers and all involved in fulfilment of the EHCP.
- National curriculum requirements and targets will be discussed.
- Any further needs or actions will be discussed and who will be responsible for those actions.
- Review of existing personal budget if relevant.
- Recommendation on continuing, amending or ceasing the EHCP.

What happens after meeting?

- A report from the education setting will be sent to the LA recommending any changes required to the EHCP or if it will be ceasing or continuing.
- A copy of the report should be sent to all those involved in the meeting or those submitting information to the meeting within 2 weeks of meeting.
- The LA will decide on any actions needed to cease, amend or continue the EHCP and notify parents/ carers within 4 weeks.

Young People 16-25 with an EHCP

All reviews or EHC needs assessments (EHCNA) taking place from Year 9 and onwards must include a focus on preparing for adulthood, including employment, independent living and participation in society.

This transition planning must be built into the EHCP and where relevant should include effective planning for young people moving from children's to adult social care and health services.

It is particularly important in these reviews to seek and to record the views, wishes and feelings of the CYP. The review meeting organiser should invite representatives of post-16 institutions to these review meetings, particularly where the CYP has expressed a desire to attend a particular institution. The EHCP will cover further education such as colleges but not higher education at university. Students who choose to go to university should look at their chosen university's provision and access the disabled student allowance. Review meetings taking place in Year 9 should have a particular focus on considering options and choices for the next phase of education.

There is a new SCIE (Social Care Institute for Excellence) document published in June 2017 called [Building Independence through Planning for Transition](#) that was developed jointly by SCIE and NICE based on NICE guidelines and quality standards.

CQC Inspections of SEND

A five year programme of local area inspections started in May 2016 and is intended to inspect all settings for CYP, carried out jointly by CQC and OFSTED. This joint programme evaluates implementation of the reforms introduced by the Children and Families Act 2014. Inspections will look at:

- How well education, social care and health services work together in partnership to identify those CYP (aged 0 – 25) who have SEND.
- How they assess their needs.
- How they meet their needs.

The [handbook](#) and [inspection framework](#) have been published and inspections started in May 2016.

The CQC inspectors will be part of a national team who aim to drive forward good practice and improve outcomes. It is very important for paediatric teams to be aware of these inspections and prepare to engage with them. Many Trusts will have appointed a CQC Specialist Advisor who will be able to support your team. One of the main principles will be ensuring that commissioners respond to the level of support which is needed for CYP who have SEND, and to signpost areas to resources which are already in place. Inspections

include focus group discussions where therapists participating may need to demonstrate evidence of their role.

A full report is then prepared after the inspection, highlighting the strengths and weaknesses. It is helpful to read these reports which are in the public domain, to learn from the inspections which have already taken place, in order to better prepare for your own. There may be findings relevant to the provision of physiotherapy or the writing of reports as noted in the actual examples below.

'It is unclear whether the timeliness of health reports is a key factor in delaying assessment for EHC plans, as this analysis has not been done by the area. Parents and schools report that the necessary health disciplines and specialists are not regularly included in planning meetings. The result is that children's plans are not consistently, fully and comprehensively informed by these disciplines.'

'A single EHC plan template is firmly in place across the county, supporting consistency in planning and review. However, the quality of plans varies greatly. Where EHC planning is effective, intended outcomes and precise strategies are set out clearly. This supports speech and language therapists, occupational therapists and physiotherapists, to work effectively with parents and schools. However, in many cases seen by inspectors, plans set out very broad aims, lacking clear measures of success. Plans frequently list the number of sessions to be provided by therapists, rather than the expected outcome of the therapy. This broad approach limits the precision of provision and effective review.'

Frequently Asked Questions

Q1- Can I have advice as to what we should be putting on EHCP's. Are we supposed to be prescriptive and say "to meet health needs, a child needs fortnightly physio", or can we say a child needs regular physio?

One of the challenges to producing this is that case law around SEND is continually evolving and changing. You do need to be prescriptive to identify the CYP's needs and provision to meet their outcomes. Regular means nothing, the suggestion is that you write something like 'A physical management programme will be integrated into the school day. Therapy staff will provide 6 contacts within the next 6 months for training of school staff and specific advice on promoting independence and integrating the programme into the CYP's timetable'. **Any advice should be based on sound clinical reasoning rather than an ad hoc number of contacts in a package of care.**

Q2- My team is very short-staffed, what do I do if the physiotherapy recommendation is greater than that which we can provide?

If a child's SEND are identified in the EHCP, the section it is contained in is the key. The only relevant issue is meeting the CYP's needs (not whether resources are locally available).

You also need to be aware of what has been published as your area local offer, as this should give some information about the service you are supposed to offer. If you can't fulfil the

provision identified you will need to discuss that further- I would suggest with the CCG. Your manager should be able to help with allocation of resources etc. I definitely would anticipate that your team would be building therapy into the school daily programme- not expecting that a physio does it all.

Q3- Is 'half termly' review by a physiotherapist sufficient to write on an EHCP?

It is suggested six contacts per year would allow more flexibility in tailoring management for the CYP's needs e.g. increased visits at the start of the school year or at time of transition.

Q4- Working with private providers, they sometimes seem to recommend input only from senior therapists, or are prescriptive about aspects such as aquatic therapy. How do I manage this?

The skill mix in every department is different and it is not helpful to be prescriptive over staff bandings. It is up to the lead physiotherapist to decide if their staff are competent to carry out any procedure. Communication is the key here, make contact with the private provider, ideally all reports should be co-produced to common goals and outcomes. It is not therefore recommended to write 'from senior physiotherapists only.' **See the APCP 'Putting the Child First' document.**

Q5- How do I write SMART goals for children who have deteriorating conditions?

The outcomes should relate to the aspects which are important for the CYP and parents/ carers. For example, if the CYP wants to remain at school and participating in the classroom activities, then that would be the outcome. How this is achieved would change as the condition changes. If the outcome was for the child to engage in sport during PE at school, the strategies may change, they could still achieve the outcome, for example participating in their wheelchair or adapting the environment.

e.g...Aspiration-A CYP with Duchenne Muscular Dystrophy (DMD) wishes to continue to go out at playtime, Need- playground must be level and accessible to wheelchairs, Outcome- to enable child to socialise at playtime, Provision- classroom assistant to ensure safe exit/ entrance at playtime when walking, to assist with wheelchair access when no longer independently mobile. SMART- specific- CYP to go out at playtime, measurable- CYP goes out at playground, achievable- yes, if the playground can be accessed via wheelchair, reasonable- it is CYP's wishes and socially acceptable, timed- will need classroom assistant help to use manual wheelchair when the CYP is no longer safe to walk, within this school year.

Q6- What if the child no longer requires therapy part way through school year?

You should write a discharge report for the annual review and send to all those involved in the CYP's care. There must be clear communication with parents/ carers and staff and a request for therapy to be removed from the educational/health provision at the next annual review.

Q7- What do I do when the case officer cuts and pastes sections of my report, which now appear out of context?

It is recommended in this guidance document to always put a sentence at the beginning of your report stating what it is for and that it should not be cut or changed without the clinician's permission. Then always ask for a draft of the EHCP as some areas do not send them routinely to everyone. Make time to check what has been written, there is usually a very short timeframe and the case officer can't be responsible if you didn't check it in a timely manner. It may be worth telephoning the case officer to discuss it if you notice it is a recurring problem.

Q8- A child has been referred for an EHCP but they are new to us and currently on our waiting list. What do I do?

Firstly you need to look at your service specification, is there a local agreement for the CYP to be prioritised for assessment? Are they part of a multi-disciplinary meeting or assessment? This may be a judgement call by your manager as to whether to prioritise them or not, and that may depend on their needs. For instance you may need to see a CYP who has moved into the area from overseas who has no assessments or paperwork and needs a place at a special school, so the assessment and report is crucial. Otherwise you could consider notifying education that the CYP is not going to be prioritised for assessment as some LA's may procure an independent practitioner to assess instead.

Q9-What should I do if I have to dispute another physiotherapist's opinion in my advice?

See the section on 'Dealing with Disagreements'. When there is conflicting written evidence in two different physiotherapy reports, the best route is communication between the physiotherapists before you send your EHCP advice.

Q9- What should I do if a school is unwilling to provide extra medical support for a child, for example in giving medication?

Schools have a duty of care to support a CYP with medical needs. Prescription medication can only be administered in school when it would be detrimental to a child's health or school attendance not to administer it. The document [Supporting Pupils at School with Medical Conditions](#) is a very useful read to understand duty of care.

Q10- Am I allowed to write advice in an EHCP which uses the resources of a different team? For example- school staff carrying out exercises

Yes- the EHCP encompasses anything which 'educates and trains the child'. You must specify what the CYP needs regardless of who is going to perform that. For example, advice on embedding a postural management programme into the school day with frequent changes of position will need to be supported by education staff. A classroom assistant's role is look after the CYP's physical, social and emotional welfare. When a CYP has a physical problem which impacts on their access to the curriculum your advice will be to teachers and classroom assistants on the kinds of activities which will be helpful, e.g. exercise routines or use of equipment that improve their ability to access the environment, that they would not be able to do without this input.

Under the Equality Act schools are required to make 'reasonable adjustments' so that CYP with SEND can participate equally in the curriculum and receive the same quality of education as their peers. So as long as the advice you are giving will enhance the CYP's ability to participate and to meet their needs and desired outcomes as outlined in the EHCP, then it is expected that the education staff and parents would work with you to support the needs of the CYP by following your advice.

Q11- We have had a couple of tribunals lately which have centred on a therapist's report being unlawfully worded. How do we avoid this?

Read carefully the section on 'Writing the EHCP' and 'Legal Issues'. There are terms which are considered more acceptable as wording than others. Do not use 'regular' or 'frequent' but quantify time. It's helpful if you refer to contacts i.e. six contacts a year, rather than one session

half termly. Unfortunately the detailed specificity of the SEN code of practice does not go hand-in-hand with the changeable nature of our CYP and their conditions, therefore we are trying to find wording that will satisfy both sides. Always try and get a colleague, who maybe does not know the CYP, to read your report and critically appraise it, does it make sense to them? Do they know what you are asking for? If it is not crystal clear to another physiotherapist, it will be less clear to an educationalist or other members of the MDT.

Q12- I'm treating a child with physical needs who does not have an EHCP but is requiring considerable additional help and support? How do I ensure the school meets his needs?

This actual case study from the IASS may help.

<p>What was the CYP/family situation when they came to the IAS Service?</p> <p>Sara has Spinal Muscular Atrophy (SMA) 3 - a rare, genetically inherited neuromuscular condition. When Sara's family were first referred to IASS she was in year 5 and experiencing difficulties with mobilisation, having undergone some spinal surgery and waiting for further surgery. Sara used a wheelchair and required support to help her mobilise to a standing position, and physiotherapy during school day and could often be in pain. Sara always had a smile on her face and was a very high achiever. School had made a request for statutory assessment but this had been refused due to Sara's academic ability. Although school had made some reasonable adjustments the lack of space was proving quite a problem and Sara was having difficulty accessing toilet facilities. Mum was frustrated at times when she was called to accompany Sara on school trips or told Sara couldn't go swimming with her class because school had not got enough staff to support her.</p>
<p>What support did the IAS Service provide?</p> <p>A Team Around the Child (TAC) meeting was established bringing occupational therapy, physiotherapy, outreach services, school and mum together to discuss Sara's condition and agree an action plan on how best to support Sara in school. The IASS supported mum at the meeting and subsequent meetings so that mum felt empowered to get her views across. As Sara went into year 6 IASS arranged and accompanied mum on visits to local secondary schools so she could make an informed decision. When the secondary school place was allocated IASS ensured the SENCo from secondary school was invited to the next TAC meeting and a transition plan for Sara was agreed and put in place. This included visits to school to meet various staff, access visits to school by occupational therapy and physiotherapy to ensure facilities were in place and the school purchasing specialist equipment e.g. hoist.</p>
<p>What was the impact of IAS support on the CYP/family?</p> <p>In primary school daily effective support was provided to ensure Sara could access all areas of the curriculum. A named member of staff and contingency staff were fully aware of Sara's needs and how best to support her e.g. year 6 classroom changed so Sara has access to playground to enable her to join in with all school activities.</p> <p>Transition to secondary school went very well. Continued TAC meetings means that Sara and her family are supported by all professionals as Sara's health condition deteriorates. Sara has started to use assistive technology to access her learning and continues to achieve academic success.</p>

Examples of Communication Surrounding EHCP

1. Parental permission was already in place for communication between private and NHS providers and established at the outset of physiotherapy provision.

Susie who has a genetic abnormality resulting in delayed gross motor skills is in mainstream nursery provision although at the time of entry was not walking independently and nor could she stand herself up from the floor. She was crawling.

Susie was being seen by an independent practitioner for physiotherapy provision addressing core strength, balance and coordination and having regular reviews within the NHS. A joint nursery visit was made to observe Susie within the setting and for the two therapists to discuss their provision for Susie.

The NHS physio drafted the contribution for the EHCP and shared it with the independent provider. A discussion ensued regarding targets that were being set, some amendments were made and the document finalized.

2. Simon has leg deformities and scoliosis. The NHS therapist was unable to produce the draft EHCP in the necessary timescale due to resource issues, she suggested that the independent therapist took the lead with drafting the report. The NHS therapist read the draft report and agreed it before it was submitted. Unfortunately in this case the local authority put the information in section H only. This is being appealed.

3. Steffi was a 6 year old girl with coordination and balance difficulties and had received her physiotherapy provision within the independent sector as this had been the parental choice. Steffi initially attended a private school although this placement proved inappropriate for her. Steffi transferred to a state school and the school, in view of the scope of her needs, requested an EHCP report from the local physiotherapy department.

Steffi attended the local physiotherapy department for an assessment of her needs. A plan was made to carry out a standardized assessment at the beginning of the school term and provision of a block of sessions in school. The independent physio was not informed of this NHS provision and the mother was not made aware of the need to communicate this additional provision to the independent physio.

When the draft EHCP was issued the mother asked the independent physio to look at it for her, the independent therapist noted that the targets needed updating as they had already been achieved or were non-specific. The independent physio contacted the NHS therapist and in discussion it was agreed that the EHCP outcomes needed rewriting. This led to additional time being needed to ensure the EHCP was up to date and clear when it was finalized to ensure Steffi's needs were met.

4. Sam who had a spinal injury as a teenager, required intensive input following spinal surgery. The NHS physio would not accept collaboration from the independent therapist and

provided a report that did not quantify her input or list smart goals. The independent therapist provided a more detailed separate report that the NHS therapist disagreed with as “she was unable to provide this level of input or had the knowledge to do so”. The case had to go to mediation and it was determined the independent therapist’s report was included in the EHCP. Although this was successful for the child in the long term, it meant there was a lot of additional work needed and cost to the family.

Examples of EHCP Templates

Every organisation is likely to have different templates but this is just an example of some in use. The first two plans are multidisciplinary, the third is not. Both varieties are in common use.

These are examples only and not prescriptive of the amount of therapy any child should have. All names have been changed.

MULTIDISCIPLINARY THERAPY ADVICE FOR EDUCATION HEALTH AND CARE NEEDS ASSESSMENT

NHS NUMBER:
HOSPITAL NO:
NAME:
ADDRESS:
DATE OF BIRTH:
SCHOOL: No Placement
CONSULTANT:
GP:
DATE OF REPORT:

This report is written for the purpose described in the title and should not be circulated for any other reason without the prior consent of the author.

INTRODUCTION:

Satvi is a 4 year old girl has been receiving physiotherapy input since March 2013 and has been known to the current physiotherapist since September 2014. Satvi has been receiving occupational therapy since December 2013 and been known to the current therapist since October 2015.

Satvi receives her therapy input at a district general hospital and is also under the care of a tertiary centre. Satvi's response to therapy is impacted upon by her medical condition, for example when Satvi sustains a fracture, she will miss direct therapy for long periods.

Satvi has a diagnosis of Osteogenesis Imperfecta, type IV (OI) which is a genetic condition that is present from birth. OI is a defect where collagen (the protein that is responsible for bone structure) is missing, low or of low quality, which is not enough to support the minerals in the bone. This makes the bone weak, which in turn makes the bones easy to fracture and impacts on Satvi's physical development. Satvi presents with muscle tone that is within normal limits. Satvi's joint range of movement is only restricted in her feet and this is due to positioning from where her bones have healed post fractures and is not related to her muscle tone.

Satvi has regular orthopaedic reviews and has undergone surgery to insert rods into her bones. These reviews will be required yearly until growth has stopped.

SENSORY AND PHYSICAL NEEDS:

Sensory/ Perceptual Skills:

Satvi has age appropriate perceptual skills. She is able to identify and match colours and shapes and complete basic threading sequences. Satvi does not display any sensory behaviour.

Fine Motor Skills:

Satvi has established a right hand preference and uses this hand consistently during all fine motor skills. Satvi has age appropriate fine motor skills and can form and apply a range of refined hand grasps. For example a pincer grasp (thumb and index finger) and a tripod grasp (thumb, index and middle finger). Satvi's bilateral hand skill, that is using two hands together, is age appropriate. During fine motor activities, Satvi is able to manipulate small objects skilfully within her hand.

Satvi holds a range of tools with appropriate grasps. She is able to hold a pencil a tripod grasps and maintain the grasp throughout drawing and colouring activities. Satvi is at the pre-writing stage of writing. She is able to form a number of pre-writing forms and her writing skills are age appropriate.

Posture:

Satvi presents with an upright posture and is able to sit independently on the floor in cross legged sitting. She will sit in her wheelchair to access her schoolwork in the nursery/ school environment. She is unable to stand independently due her leg posture. She presents with severe bowing (curve in bone) of her legs and is unable to stand supported for long periods until she has further surgery to insert longer rods into her femurs (long bone in thigh). She will however pull herself into supported standing at a low bench for shorts periods.

Mobility:

Satvi uses crawling and bunny hopping to mobilise around on the floor. She is able to move herself into high kneeling and will support herself at a surface to play in this position. She was issued with a Rifton Pacer gait trainer, in January this year but due to fractures she has sustained, she has not been using this regularly. Her walker will be need to be reviewed in the near future once Satvi has recovered from her most recent injury and able to use it. Satvi is able to propel herself in her wheelchair and this is likely to be her main form of mobility in school. Satvi is currently lifted for all her transfers. The physiotherapist and occupational therapist have discussed hoisting with Satvi's parents as it is anticipated that she will require hoisting in her school setting as this is deemed safest for Satvi and staff working with her. The therapists will need to arrange sling assessments and the school will need to provide a hoist to be used with the sling for all transfers.

Balance and Co-ordination:

Satvi is able adjust her body in sitting to sustain her balance by using her hands to support herself. Satvi loses her balance in other positions for example when attempting to stand at a surface, she will tire quickly due to lack of stamina having not stood for long periods of time. Satvi requires an adult to closely monitor her position and respond appropriately especially in more challenging positions such as high kneeling and standing. Satvi will need to access an adapted P.E curriculum.

Motor Planning and Organisation:

Satvi will need adult support to get around her environment and respond to sudden changes e.g. moving around other children or obstacles when using her wheelchair. When completing her physiotherapy programme, Satvi will need to have a dedicated matted area and adult support and supervision to maintain her safety as her medical condition makes her more vulnerable to fractures.

INDEPENDENCE AND COMMUNITY:

Dressing:

Satvi requires adult assistance with dressing due to positioning and to support her to dress her lower half without weight bearing.

In an educational setting Satvi will require adult assistance to help her with changing for PE and to manage her clothing at break time. Satvi will require a matted space on the floor to change.

Eating/ Drinking:

Satvi is able to feed herself using a spoon or fork. She is able to drink out of a normal cup.

In an educational setting Satvi will require adult support to carry a tray to and from the table. She will also require a height adjustable table in order to sit at the table in her wheelchair.

Play/Social Development:

Satvi displays age appropriate plays skills.

Toileting:

Satvi requires adult support with accessing the toilet and to manage her personal care. In an educational setting Satvi will require adult support to access the toilet and to manage her personal care.

Moving & Handling and Transfers:

Satvi is mobile on the floor but requires a soft surface to crawl on. For example: mats on the floor. Satvi is dependent on adults for all other aspects of moving and handling and is lifted by her parents for all transfers. For example from the chair to the floor and chair to the toilet.

In an educational setting Satvi will need to be hoisted for all transfers during the school day. Two adults will need to be present for all hoist transfers and these staff will need to have manual handling training provided by a qualified manual handling trainer.

SUMMARY

Satvi is a 4 year old girl with a diagnosis of Osteogenesis Imperfecta, type IV (OI). Due to a history of recurrent fractures in her femurs, mobility and therapy has been slow. Satvi is quite confident at moving herself on the floor and she is keen to use her new walker. Satvi displays age appropriate fine motor skills. She requires support with self-care skills and to access her environment.

OUTCOMES : these will be subject to change due to Satvi's medical status.

SENSORY AND PHYSICAL NEEDS:

Long Term Outcome (s):

- To cruise along the furniture indoors.

Short Term Outcome (s):

- To complete fine motor activities in high kneeling for 8-10 minutes.
- To pull to stand independently.

INDEPENDENCE AND COMMUNITY:

Long Term Outcome(s):

- To use her walker to participate at breaktime.
- To propel herself in her wheelchair within the school environment.
- To independently manage her clothing when changing for PE.

Short Term Outcome(s)

- To use her walker within her home environment.
- To dress and undress the lower half of her body with minimal support.

PROVISION REQUIRED TO MEET NEED AND ACHIEVE OUTCOMES:

Educational Environment:

Satvi requires an educational environment which:

- Has staff with experience in working with children with a physical disability.
- Has dedicated space for school staff and therapists to carry out therapy programmes.
- Has a level access environment with adequate storage for her specialist equipment, she will require use of hoists, appropriate slings, self-propelled wheelchair, and accessible toileting facilities.
- Has an appropriate height table with the school environment e.g. classroom and dining room that XX will be able to position her wheelchair under.
- Has appropriate toileting facilities including access for a wheelchair and hoist.

Support from physiotherapy/ occupational therapy

Staff:

- Key staff will have generic manual handling training provided by school.
- Key staff will have knowledge and training in the use of specialist equipment.
- Key staff will have knowledge of working with CYP with physical disability.

In order to support Satvi's needs school staff will need support or advice from physiotherapy/ occupational therapy to:

- Be able to carry out gross and fine motor programmes as directed by the physiotherapist/ occupational therapist for the CYP.
- To be able to incorporate physiotherapy strategies into the PE curriculum.
- To be able to incorporate self-help strategies into the curriculum.
- To carry out physiotherapy/occupational therapy programme 3x times per week.
- To be able to provide personal care for toileting and dressing activities.

Equipment

- Rifton gait trainer.
- Manual propelled wheelchair.
- Hoist and sling.

PARENTAL SUPPORT:

Therapy services will work closely with parents. Parental support is required to attend meetings/sessions with therapists as required; implement programmes/strategies out of school to ensure that skills are generalised in to all settings and situations.

THERAPY REQUIREMENTS:

Occupational Therapy

Satvi will require 6 contacts per year from an occupational therapist. At least 5 of these contacts will involve working directly with Satvi and her parents/ member of staff through 1:1/ group sessions. These sessions will focus on developing self-care skills, manual handling and accessing the environment.

The remaining contact will involve working indirectly with Satvi to produce relevant resources/ reports/ or attending meetings.

Physiotherapy

Satvi will require 6 contacts per year from a physiotherapist to support her physical status and development within her educational environment.

A minimum of 5 contacts will involve working directly with Satvi; these will include ongoing assessment of her gross motor development to inform her physiotherapy programme, and monitoring and adjustment of her walker. Direct contacts will also include assessment of her manual handling needs and providing specific support to staff to implement her therapy programme and postural management.

The remaining contact will include setting Satvi's termly physical targets within the curriculum and attending review meetings.

Prior to attending full time education, therapy contacts may take place within the CDC with input to the pre-school educational environment as indicated. These may take the form of individual or group contacts, liaison with education staff and/or health professionals in order to set out specific targets and provide appropriate strategies. Specific training to staff in the education environment may also be provided.

These recommendations are subject to review and may be altered at any time by the therapists to reflect Satvi's abilities and needs.

CONFIDENTIAL

MULTIDISCIPLINARY THERAPY ADVICE FOR EDUCATION HEALTH AND CARE NEEDS ASSESSMENT

NHS NUMBER:
HOSPITAL NO:
NAME:
ADDRESS:
DATE OF BIRTH:
CONSULTANT:
GP:
THERAPISTS:
DATE OF REPORT:

This report is written for the purpose described in the title and should not be circulated for any other reason without the prior consent of the author.

INTRODUCTION:

Soraya has been known to the physiotherapy and the occupational therapy service since February 2013. Soraya has been known to speech and language therapy since August 2013. The current speech and language therapist has known Soraya since June 2016. The current occupational therapist has known Soraya intermittently since February 2013. The current physiotherapist has known Soraya since May 2015.

Soraya was born in London and English is spoken at home.

Soraya is a 4 year 3 months old girl with a diagnosis of whole body cerebral palsy secondary to her premature birth. She also has epilepsy, global developmental delay and mild visual impairment. Soraya presents with reduced muscle tone (floppiness) in her body and increased muscle tone (stiffness) in her arms and legs which mean she has difficulties maintaining postures and coordination movements and difficulties eating and drinking.

Soraya's physiotherapy, speech and language therapy and occupational therapy contacts have consisted of review sessions and blocks of therapy input. Contacts include individual sessions, liaison and joint planning with parents. Soraya demonstrates slow progress towards her therapy targets.

Soraya is an intentional communicator who uses a combination of eye pointing, vocalisations and body movements to communicate her needs. Her vocalisations are unclear and her body movements inconsistent as a result of her physical disability. She therefore has difficulty indicating her needs and requests and relies heavily on familiar adults around her to interpret her needs.

Soraya is at high risk of aspiration (food and drink entering the airway) when eating and drinking. She requires a modified diet and a high level of adult support during meal times to maximise her safety when eating and drinking.

COMMUNICATION AND INTERACTION:

Attention and Listening Skills: Soraya presents with single channelled attention skills. She is able to watch and attend to activities of her choice for prolonged periods. Soraya requires an adult to prompt her in order to focus her attention to structured activities. She demonstrates a preference for visually or auditory stimulating activities and enjoys watching colourful lights and listening to singing or to music. Soraya is able to share her attention and enjoyment with an adult when she is enjoying an activity, for example, through looking at an adult and looking back at the activity. Soraya finds structured learning activities challenging and rejects activities requiring a high level of attention through turning her head away or vocalising “bye”. Soraya requires support to focus her attention when required to access learning activities. This will impact on her ability to access activities alongside peers without support in a classroom environment and she will require support to focus her attention.

Comprehension of Language: Soraya demonstrates an understanding of the routine of the day at home and follows contextual instructions with familiar adults, for example, she will look towards the door and vocalise “bye” when told it is time to go home. Soraya responds to her name and recognises the names of familiar people in her environment, for example, her siblings. She is able to find everyday objects and photographs of everyday objects on request from a choice of two through eye pointing. Soraya is also demonstrating recognition of familiar symbols, for example, crisps and singing. Soraya’s understanding of language is significantly delayed for her age.

Soraya presents with significant difficulty understanding verbal language expected for her age. This will impact her ability to follow individual and whole group instructions, learn rules and access core curriculum vocabulary and concepts. She will require additional adult support to develop her understanding of language through routines, using photographs, a visual timetable, simplifying language used in the classroom, pre-teaching and repetition of key vocabulary and concepts and by supporting spoken language using visual and kinaesthetic materials.

Expressive Language: Soraya communicates using a combination of means. She expresses her likes through smiling and laughing and dislikes through facial expression. Soraya vocalises when she is happy and uses vocalisations alongside non-verbal eye pointing when indicating requests. Soraya vocalises “no” to reject items/activities. She vocalises to request “more”, however, her vocalisations are not consistently clear. Soraya vocalises “bye”. Soraya’s physical difficulties impact on her ability to communicate verbally. She is developing her ability to use alternative and augmentative communication means such as eye pointing alongside her current vocalisations. Soraya has been introduced to an e-Tran frame and is currently developing her ability to scan two photograph options prior to fixing her eye contact on the option of her choice. Soraya is able to activate a switch positioned to her left hand side. She has shown an ability to use a switch to intentionally turn battery operated toys/devices such as fans on and off. Soraya’s expressive language skills are severely delayed for her age and she will require ongoing alternative communication support to enable her to access learning and peer relationships in an educational and home environment.

Social Interaction: Soraya shows a keen interest in interacting with adults and peers. She enjoys activities with others and shows enjoyment through eye contact and smiling. She demonstrates appropriate shared attention and shared enjoyment for her age. Soraya’s communication difficulties impact on her ability to interact with those around her and she

requires heavily on adult's interpreting her needs. This will impact on her ability to form relationships with her peers and she will require adult support to enable her to communicate effectively.

SENSORY AND PHYSICAL NEEDS:

Sensory/Perceptual Skills: Visual perception is the ability of the brain to make sense of visual information, e.g. colour, shape and size discrimination, spatial orientation of objects (in/on/under), etc. Soraya is not able to complete simple noisy shape sorters or basic form boards. Soraya's visual impairment and physical impairment impact on the progress of her skills in this area.

Soraya will require a high level of adult support for promoting her visual perceptual skills through carrying out therapy programmes, in addition to helping to focus and maintain her attention to table top activities and providing hand over hand assistance as required.

Sensory processing is the ability to register (take in), process and organise sensory information from various sensory systems (e.g. touch, vision, hearing and movement) in order to appropriately attend to and participate in daily activities at home and nursery/school. Soraya enjoys engaging in sensory based play. She shows a preference for toys with lights and sounds.

Soraya will require access to a multi-sensory environment with a high level of adult support to explore her environment appropriately and engage in various sensory activities.

Posture: Soraya presents with hypotonia (floppiness) in her body and increased muscle tone (stiffness) in her arms and legs. Soraya's hypotonia affects her ability to hold her head up when in an upright position (e.g. sitting) for more than a few minutes.

When Soraya is positioned in cross leg sitting and is fully supported by an adult, she is able to hold her head up without support for 30 seconds. Soraya will then rest her head back to the adult or her head will fall forward, she can lift her head up again when prompted. When a motivating switch toy is held in front of her she is able to use her left arm to activate it using a raking movement with her hand. Soraya's muscle tone in her arms and legs increases with effort especially through the right side of her body, this affects her sitting posture and she needs increased adult support.

When Soraya is placed in prone (on her tummy) with a support under her chest she is able to prop on her forearms and hold her head up to look towards a book.

Soraya's floppiness in her trunk and stiffness in her arms and legs means she requires supportive equipment to allow her to maintain postures and to optimise the use of her upper limbs and hands for play. Soraya uses supportive seating to maintain an upright sitting position and a standing frame to maintain a standing posture. Soraya has supportive boots which maintain her ankle position when in specialist equipment.

Fine Motor Skills: Soraya enjoys engaging in simple cause and effect play involving pushing large buttons. She demonstrates basic grasp and release patterns using her left hand. Her

accuracy is significantly impacted by her physical difficulties and requires hand over hand assistance for more accurate tasks.

Soraya presents with hypertonia (stiffness) in her upper limbs with her right hand more affected than her left hand. Soraya keeps her hands in a fist posture with her thumbs adducting into her palm. This posture impacts on her ability to use her hands effectively to engage in play. Soraya wears Bennis Splints on both hands to enable her to open her hand to allow her to use her hands more effectively. Soraya's physical impairment alongside her reduced hand strength impacts on her ability to engage in basic symmetrical bilateral tasks such as pulling apart Velcro vegetables.

Soraya presents with hypotonia (floppiness) in her trunk which also impact on the effectiveness of her fine motor skills. She requires a supportive seating system to provide appropriate support to enable her to participate in fine motor activities to the best of her ability.

Soraya will require a high level of adult assistance during fine motor tasks to access her curriculum and to implement therapy advice/strategies to promote her fine motor development and increase her ability to participate in self-care routines.

Mobility: When placed on the floor lying on her back, Soraya is able to start the movement to roll to her right side but needs assistance to move fully onto her side. When on her side Soraya can use her left hand to hold a musical toy and purposefully shake it using a large movement. She is able to roll from her side to her back. Soraya needs assistance to roll onto her left side and move into prone.

Soraya is unable to move from lying into cross leg sitting and will need adult support to move between floor positions as part of her therapy programme. Soraya is not able to transfer from the floor into her seating or her postural equipment and will need to be hoisted for all transfers with the assistance of two adults. Soraya is unable to mobilise and will require an adult propelled wheelchair to allow her to access her environment both inside and outside of school.

Balance and Co-ordination: Soraya has limited awareness of her balance and her increased muscle tone (stiffness) in her limbs and reduced muscle tone (floppiness) in her body mean she has difficulties adjusting her body position when needed. This is because it takes more time for her to initiate movement of her arms and legs and her movement range in her limbs is reduced. When in challenging positions e.g. sitting, Soraya needs adult support that that can respond to her changing need for support, to maintain her safety. Soraya will need an adapted P.E curriculum so she is able to access this area with her peers.

Motor Planning and Organisation: Soraya requires the use of an adult propelled wheelchair to access her environment. She is unable to transfer independently and will need to be hoisted by two adults when moving between floor and her postural equipment. Soraya's manual handling needs will be assessed and monitored by the occupational therapist and the physiotherapist.

INDEPENDENCE AND COMMUNITY:

Dressing: Soraya is fully dependent on adult support for all her dressing needs.

In her educational environment Soraya will require a high level of adult support for dressing tasks, including promoting her participation with dressing.

Eating/ Drinking: Soraya uses her left hand to feed herself crisps. She is dependent on adult to spoon feed. Soraya drinks from a straw when an adult holds the cup or carton.

Soraya presents with reduced oral skills which means she has difficulty chewing and controlling food and drink in her mouth. This puts her at risk of aspiration (food entering the airway). Speech and language therapy and occupational therapy have provided a mealtime management plan for Soraya to mum which outlines modified textures and drinks as well as positioning advice in order to maximise Soraya's safety when eating and drinking.

In her educational environment Soraya will require adult assistance for feeding including cutlery use, cutting food into pieces, opening containers and packages and pouring drinks. Adults working with Soraya require training on how Soraya's skills and difficulties and how to support her to eat and drink safely.

Toileting: Soraya wears nappies full time. She becomes upset when her nappy is dirty. She shows no awareness when her nappy is wet.

In her educational environment Soraya will require adult support with nappy changes and access to a height adjustable changing table.

Transfers/ Moving & Handling: Soraya requires the use of an adult propelled wheelchair to access her environment. Soraya is unable to transfer independently and will need to be hoisted by two adults when moving between floor and her postural equipment. Soraya's manual handling needs will be assessed and monitored by the occupational therapist and the physiotherapist.

SUMMARY

Soraya is a 4 year 3 months old girl with significant difficulties in all areas of development. Soraya's movement disorder means she needs adult support to access different positions through the day, including floor time and access to her postural equipment. Soraya is dependent on adults to provide opportunities for communication and interaction throughout the day and requires adults to interpret her behaviours as communication. Soraya is fed orally.

Soraya will require a high level of adult support in order to allow her to access all aspects of her educational environment.

OUTCOMES

COMMUNICATION AND INTERACTION:

Long Term Outcomes:

- Soraya will communicate a 2 part request to a familiar adult in structured activities, for example, to request "more crisps", "car for mummy" using alternative communication systems.

- Soraya will demonstrate an understanding of a wide range of vocabulary including nouns, verbs and concepts in classroom activities.

Short Term Outcomes:

- Soraya will indicate her choice of activity to a familiar adult from a choice of four.
- Soraya will follow instructions containing two key words (familiar nouns and verbs) in structured activities with an adult.

SENSORY AND PHYSICAL NEEDS:

Long Term Outcome (s):

- Soraya will be able to hold her head in midline whilst activating a switch toy with her left hand when using a variety of sitting positions (long sitting/bench sitting)
- Soraya to use her hands purposefully in play

Short Term Outcome (s):

- Soraya will be able to hold her head to look at a motivating toy for 20 seconds, when in supported cross-legged position
- When in a prone position (on her tummy) on a wedge, Soraya will be able to hold her head in midline to look at a motivating toy for 20 seconds, with the aim of developing her head control
- Soraya will purposefully release a small toy with her left hand

INDEPENDENCE AND COMMUNITY:

Long Term Outcomes:

- Soraya will tolerate using her postural equipment to allow her to access all areas of the school environment for play, learning and self-care tasks.
- Soraya will have safe and enjoyable mealtime experiences in her educational environment in accordance with speech and language therapy and occupational therapy feeding recommendations.
- Soraya will increase her participation in self-care activities such as feeding and dressing

Short Term Outcomes:

- Soraya will tolerate her standing frame for one hour to access part of her school curriculum in a standing position
- Soraya will safely participate and enjoy her snack time at school in accordance with her mealtime management plan as recommended by Speech and Language Therapy and Occupational Therapy.
- Soraya will use a spoon to feed herself with adult support

PROVISION REQUIRED TO MEET NEED AND ACHIEVE OUTCOMES:

Educational Environment:

Soraya requires an educational environment which:

- Has staff with experience in working with children who have complex physical, learning and sensory needs

- Provides a high ratio of adult to children
- Has access to multi-sensory activities and equipment
- Has dedicated space for school staff and therapists to carry out therapy programmes
- Provides integration of therapy advice within the school curriculum
- Provides a consistent, structured environment with minimal distractions
- Provides a differentiated curriculum to meet Soraya's speech, language and communication needs
- Uses strategies to support speech, language and communication across the school day, including modelling simple language, allow thinking time, break down instructions and using multi-sensory support across the curriculum.
- Acknowledgement and facilitation of total communication approaches to ensure all forms of communication are accepted and responded to appropriately through the school day.
- Provides access to alternative and augmentative communication such as e-Tran frames and switches and the ability to explore further high tech communication systems.
- A level access environment with adequate storage for her specialist equipment, she will require use of hoists, appropriate slings, attendant propelled wheelchair, and a height adjustable changing table.
- Access to equipment to meet her postural needs including a specialist seating, standing frame, orthotics.

In order to support Soraya's development, school staff will need to

- Follow feeding advice devised by a speech and language therapist (staff will need training in working with children with eating and drinking difficulties)
- Interpret her communication needs/wants
- Support her to interact with her peers
- Support to communicate her needs using alternative communication systems.
- Carry out therapy programmes
- Assist with toileting/dressing and feeding needs
- Assist her to access the environment in her adult propelled wheelchair
- Utilise specialist supportive equipment for seating and standing
- Have generic manual handling training provided by the educational setting, as well as specific training regarding Soraya's needs and equipment.
- Have knowledge of working with children with physical disabilities.
- Have knowledge and training in the use of specialist equipment
- Assisting to apply and remove her specialist footwear
- Supervision/assistance when moving around the educational environment
- Adapting the P.E curriculum to ensure full integration
- Putting on and taking off her piedro boots.

Soraya will require additional adult support with her **equipment** including:

- A specialist supportive seating system
- A supine standing frame – to be assessed for once in school.
- Moving and handling equipment including hoist and slings.
- Ankle boots

PARENTAL SUPPORT:

Therapy services will work closely with parents. Parental support is required to attend meetings/sessions with therapists as required; implement programmes/strategies out of school to ensure that skills are generalised in to all settings and situations.

THERAPY REQUIREMENTS:

Speech and Language Therapy

Soraya will require a total of 22 contacts of speech and language therapy per year - 12 contacts per year for communication and 10 contacts per year for feeding as outlined below:

Communication

9 of the 12 contacts will involve working directly with Soraya to develop her understanding of language and increase her ability to communicate using non-verbal communication and alternative and augmentative communication systems.

The remaining contacts will involve working with staff supporting Soraya to

- Provide specific advice and training on the impact of Soraya's communication needs and strategies for managing these in the new setting
- Jointly set goals and plan how to generalise communication goals and strategies in to everyday situations
- Attend planning and review meetings as required
- Advise staff on approaches to facilitate Soraya's access to school's curriculum in relation to her SCLN including her use of alternative communication systems as appropriate.

Eating & Drinking

Soraya will also require 10 contacts per year of speech and language therapy to focus on her feeding development. This will involve 3 direct contacts to review feeding programmes and feedback/demonstrate to staff. Other contacts will be made up from individual training sessions with staff, indirect liaison with parents regarding changes to recommendations, and liaison with other professionals such as gastroenterology, dietician, community agencies and paediatricians.

Soraya's needs will be reviewed at the end of the academic year.

Occupational Therapy

Soraya will require 12 contacts per year from the occupational therapist. 8 contacts will involve working directly with Soraya; this will include ongoing assessment of her fine motor development, and monitoring and adjustment of her postural equipment. Direct contacts will also include assessment of her manual handling needs and providing specific support to staff to implement her therapy programme and postural management.

The additional 4 contacts will be indirect contacts; including setting Soraya's termly targets within the curriculum and attending review meetings.

Physiotherapy

Soraya will require 12 contacts per year from a physiotherapist. 8 contacts will involve working directly with Soraya; these will include ongoing assessment of her gross motor development to inform her physiotherapy programme, and monitoring and adjustment of her postural equipment. Direct contacts will also include assessment of her manual handling needs and providing specific support to staff to implement her therapy programme and postural management. The additional 4 contacts will be indirect contacts, including setting Soraya's termly physical targets within the curriculum and attending review meetings.

Prior to attending full time education, therapy contacts may take place within the CDC with input to the pre-school educational environment as indicated. These may take the form of individual or group contacts, liaison with education staff and/or health professionals in order to set out specific targets and provide appropriate strategies. Specific training to staff in the education environment may also be provided.

These recommendations are subject to review and may be altered at any time by the therapists to reflect Soraya's abilities and needs.



Physiotherapy Advice for Education Health and Care Plan

Name	Seth	School	Pre-school
Dob		Year group	-1
C. A.	3.5		
Address		Date of report	110116

Background information

Seth has been known to the physiotherapy department since the age of four months. He had a difficult start in life and it was evident from an early age he had four limb cerebral palsy.

Seth has progressed very well with his motor skills, he is now independent walking with a walking frame, able to mobilise around the floor and is showing determination in achieving physical skills.

Although he is non-verbal, he follows instructions well within therapy.

Summary of Seth strengths and needs

Physical strengths & achievements

- Seth can roll or crawl on the floor and lately has been getting around by walking on his knees.
- Seth can sit independently on the floor although this is challenging for him, he prefers to W-sit and he can sit unaided on a box or bench.
- Seth can pull to stand with some supervision for safety and he is working on standing supported at a table.

- Seth is independent walking with a walking frame on level ground, without too many obstacles. He can stand up from the floor and return to the floor independently.

Identified needs.

- Seth has difficulty using his arms and finds pulling to stand difficult as he cannot support himself well, so needs one person to closely supervise.
- Seth has difficulty standing at a table due to poor weight bearing through his arms and poor balance. He needs one person to be with him whilst in any standing activity.
- Seth is working towards being able to seat himself in a chair; he needs supervision to do this.
- Seth's dystonia (uncontrolled movements) makes his abilities very variable and therefore he will need supervision for most activities.
- Seth is at an early stage of learning to drive a power wheelchair (using a Whizzybug) and he will need space and time to practice this skill as self-propelling a manual chair would not be an option.
- Seth would be very vulnerable walking outside, on uneven surfaces or in crowded places. He will need support outside.

Person centred outcomes for physical activity

Aspirations:

Although Seth is non-verbal he demonstrates his desire to stand and walk alone by constantly trying to do so. His family would like him to be safe in his physical abilities and to maximise his independence.

Support arrangements (what needs to happen)

Staff knowledge and skills

Classroom staff will need to be trained to carry out a daily physical activity programme focussing on Seth's targets. Seth will need a very high level of supervision for his safety as he does not always understand his limitations.

Seth will need assistance to participate in PE and any other physical activities and this may need to be differentiated for him. Seth will need to be assessed in school by the manual handling team and a risk assessment recorded.

He will need to have a fire evacuation plan, especially if upstairs in a building. SENCO to identify staff training needs and liaise with relevant professionals.

Classroom organisation / environment

Seth will need level access to all parts of a building to use his walking frame. He will need a lift for any upstairs classrooms. Level playing areas would be required outside and level access to them.

Seth has special seating currently and he would need a height appropriate table so as not to exclude him from his peer group.

Seth will need help with all aspects of feeding and personal care. Seth will need assistance to participate in PE and any other physical activities and this may need to be differentiated for him.

Seth will need to be following a physiotherapy programme within school and a suitable area to carry this out may be needed if too disruptive to the class.

Seth will need access to a wheelchair for long distances or off-site visits and therefore will need storage and transportation for this considered.

Role of physiotherapist

Seth will need five contacts each term- one review of his progress and targets and a block of four weeks of therapy each term. In addition one contact for reports/meetings and annual review per year. This should be accommodated within the school day as Seth, in common with most children with severe cerebral palsy, will find the school day very tiring and therapy after school would not be appropriate.

The main aims of intervention are to focus on key targets to maximise physical independence and accessing the curriculum.

Short term targets:

Seth learning to seat himself independently in a chair (for the classroom) within one term

Seth learning to pull to stand from the floor safely within two terms

Seth standing to play at a table whilst using his arms for support within one term

Long term targets (12 months):

Seth reaching down to the floor from a small bench in order to remove shoes/socks

Seth stepping sideways around furniture (to better access environment)

Seth being able to drive a power chair in a straight line in an unobstructed environment

Signed:

Paediatric Physiotherapist:

Resources

[SEND Code of Practice: 0-25 years](#)

[United Nations Convention on the Rights of the Child](#)

[Contact a Family- EHCP](#)

[NHS England](#)

[Information, Advice and Support Services \(IASS\)](#)

[APCP Working with Children](#)

[Supporting pupils with medical conditions at school](#)

[Building independence through planning for transition- SCIE/ NICE](#)

[Council for Disabled Children](#)

[Securing good quality health advice for education, health and care \(EHC\) plans-](#) Council for Disabled Children

[IPSEA](#)

[Care Quality Commission/ Ofsted handbook](#)

[Extra Help in Education for 19-25 year olds](#)

Acknowledgements

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Written and compiled by Sam Bishopp, Kerry McGarrity, Jane Sellar and Michelle Baylis on behalf of the Association of Paediatric Chartered Physiotherapists.

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