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Provision of academic support to children who have a prolonged absence due to a physical condition in mainstream primary schools in Wales and England

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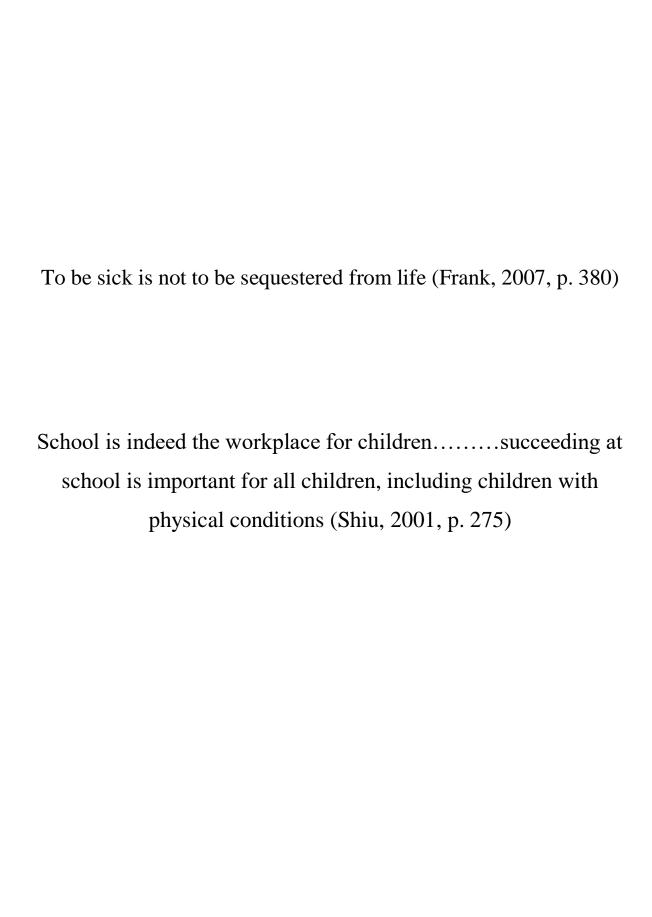
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To be sick is not to be sequestered from life (Frank, 2007, p. 380)

School is indeed the workplace for children………succeeding at school is important for all children, including children with physical conditions (Shiu, 2001, p. 275)

ABSTRACT

Being a child and going to school is taken as a parcel of the same thing by most people but this is not the same for children with physical conditions, who cannot avoid absence from school for significant periods of time rather prolonged or recurrent/intermittent. What matters in this context is not primarily the seriousness of the child's condition but how much and in what way schooling affects his or her ability to fully benefit from the provided opportunities. Participation in school activities promotes children's interaction and collaboration educationally and socially. Their involvement and sense of belonging can be affected considerably owing to a physical condition, not least because of prolonged absence. Staying connected to school contributes to their sense of normality towards daily life routine, increase hope and distract their attention from the invasion of medical treatment (Wilkie & Jones, 2010). Additionally, keeping children connected to school and learning during absence from school is very important to ensure that these children do not prematurely disengage from their expected educational journeys (Hopkins *et al*., 2014). These children may have many individual requirements but like their healthy peers, they share the desire for equal access to the same educational outcomes, both academically and socially. If their needs are not timely taken care of, the school can become a place of failure, both academically and socially, in no time.

Considering mainstream primary schools, my research has studied the opinions of teachers and other educators about the provision available for children who miss more than 50% of school over a 3 months' period due to a physical condition. The research question for this proposal originated from my own experience as a mother of a precious child with a physical condition. The current research has 52 research participants, 45 questionnaire respondents and 7 interviewees, having different roles as educational professionals. Using a mixed methods approach, this research aims to provide a more comprehensive description of the ways in which teachers and educational professionals in Wales and England provide academic continuity to the children in Key Stage 2 (age 7–11) with physical conditions during their prolonged absence.

Since similar themes cut across the two sets of data, I have combined the findings from questionnaires and semi-structured interviews that suggest that teachers and other professionals are aware of the impact of physical conditions on children's school life. Also,

they focus on the main barriers in Wales and England which hinder the appropriate academic continuity of this group of children, including issues such as: muddled understanding of accepting roles and responsibility among professionals, limited awareness and professional training for teachers, compromised quality education at home and in mainstream schools and the absence of clear guidelines on medication, first aid procedures and prolonged absence in schools. The findings also suggest that the four means of supporting academic continuity, considered in this research i.e. using technology, individualized instruction, bed-side teaching in hospital and home tutoring for children's academic continuity are not regularly practiced in the schools in Wales and England.

Based on the findings of my research, it is recommended that teachers should be provided regular trainings to support the academic continuity of these children. Further, it is important for every primary school to develop a personalized policy statement for this group of children that is accessible to every staff member and is referred in full when dealing with issues in this area.

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ACKNOWLEDGEMENT

I offer my most humble gratitude to God almighty for blessing me with His wisdom and strength to complete this piece of research successfully.

I wish to express my appreciation to my first supervisor Dr. Anne Marie Smith. I gratefully acknowledge and appreciate her insight, dedication, valuable guidance, concern and enthusiasm for my research which was a motivation for me to work even harder. I would also like to express my sincere gratitude to my second supervisor Dr. Marguerite Hoerger. I acknowledge her patience, motivation and immense knowledge. Their guidance helped me in all the time of research and writing of this thesis. I could not have imagined having better supervisors for my EdD study.

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This project was not possible without the love and care of my parents, I thank them for being such an inspiration in my life.

A profound gratitude goes to my husband Frank, as his love and confidence in my ability to complete this project has been a tremendous source of strength throughout my years of studies. He and Joanna, our daughter has been there from the beginning of this project. Joanna's little innocent life, with a physical condition was the inspiration for me to choose this topic for my research and she has been a special part of the whole project. Also, I am thankful to our son Jaden, for bearing with me during this season of life and being such a joy and blessing to us. They are the most important people in my world and I dedicate this thesis to them.

DECLARATION

I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

CHAPTER 1 INTRODUCTION TO THE RESEARCH

Being a child and going to school is taken as a parcel of the same thing by most people. Schools generally prepare children for future life, a place to form friendships, develop skills and experience discovery, achievement and creative expression (Jeffrey, 1990). Some children are born with physical conditions, others are diagnosed in infancy, childhood or adolescence. Children with physical conditions, whose condition may deteriorate and may not survive into later life can still have the valuable and essential experience of schooling (Williams, 2013). What matters in this context is not primarily the seriousness of the child's condition but how much and in what way schooling affects his or her ability to fully benefit from the provided opportunities. According to Shiu (2004a), the school may represent the only place where a child with physical conditions can be viewed as a child and a pupil rather than a patient. Therefore, children with physical conditions have the same right to education as those children who do not have such conditions.

1.1 Context and research background

Being a mother of a precious child who had physical conditions as well as being very smart cognitively inspired me to explore this present topic of my research. Being with my daughter in different children's wards in the UK, I often used to think about the schooling of the children who were born with physical conditions or had them later in their lives, and their needs for a supportive environment. Gradually I became interested in considering their academic continuity, support from school during their absence and policies available for children with physical conditions and the process of implementation of these policies.

I chose to focus the context of my research within Key Stage 2 (age 7–11) because I have experience of teaching children at Key Stage 2 in the UK and in Pakistan.

I am also strongly influenced and inspired by the work of Alison Close such as '*Education for children with a poor prognosis: Reflections on parental wishes and on an appropriate curriculum*' (1995); '*Outlook uncertain: Enabling the education of children with chronic and/or deteriorating conditions*' (1997) and '*Quality of life of children and young people with serious medical conditions*' (1998). In particular, in '*The education of children with medical conditions*' (2000), her contribution towards the education of children with medical conditions is encouraging. Her research provided structure to my thesis as she argues that it

is crucial to discuss how to achieve maximum inclusion for all children with health care needs. In her view, it requires strategic partnerships between education and health services, teachers, children and families to understand the emotional and practical impact of physical conditions on education and development (Closs, 2000). Her research has helped to recognize the capability and entitlements of this minority group of children to educational opportunities to live as valued individuals in family and community.

When children are first diagnosed with a physical condition, their and their family's focus is directed towards necessary medical intervention and the child's physical welfare. The initial shock of diagnosis, prognosis, symptoms, treatment and adaptations to daily routines and financial pressure all contribute to the stress and trauma faced by the child and his/her family. Children with physical conditions cannot avoid periods of absence which can be prolonged or recurrent/intermittent. Participation in school activities promotes children's interaction and collaboration educationally and socially. Their involvement and sense of belonging can be affected considerably owing to a physical condition, not least because of prolonged absence. There is an increased rate of survival for physical conditions (Shaw & McCabe, 2008; and Hinton & Kirk, 2015), consequently schools are more liable to have pupils who are enrolled but are absent for considerable period of time due to their physical conditions. Therefore, it is important for them to stay connected to their schools to minimize their educational disadvantage and apprehension about disruptive friendships (Charlton, Pearson & Morris-Jones, 1986; and Sullivan, Fulmer & Zigmond, 2001). The longer the child is absent from school, the higher the risk of his/her school drop-out. As the absence itself might be unavoidable, strategies must be employed to overcome the effects of such prolonged or repeated absence (Hopkins *et al.*, 2014).

Staying connected to school is defined as pupils' beliefs of being accepted by their school and recognising themselves as being part of their school (Wilkie, 2010). Staying connected to school contributes to their sense of normality towards daily life routine, increase hope and distract their attention from the invasion of medical treatment (Wilkie & Jones, 2010). Addressing these children's social and academic needs and interests, minimises the educational disadvantage, provides reinforcement to return to full-time schooling, improves future quality of life and employment prospects (Lightfoot, Wright & Sloper, 1999) and (Wilkie, 2010). Additionally, keeping children connected to school and learning during absence from school is very important to ensure that these children do not prematurely disengage from their expected educational journeys (Hopkins *et al.*, 2014). These children

may have many individual requirements but like their healthy peers, they share the desire for equal access to the same educational outcomes, both academically and socially. If their needs are not catered in time, the school can become a place of failure, both academically and socially, in no time at all.

School attendance is required for two basic reasons, it prepares a person with the educational skills which are important for successful transition into the adult work force and it also provides opportunities for socialization (Shiu, 2004a). There are many factors that influence school attendance such as diagnosis of the conditions, severity of the illness, parental response to the illness, parental educational level and ability of the child to participate in physical activities (Shaw & McCabe, 2008).

Children with physical conditions are challenged to access education, opportunities for personal achievements, friendships and help to plan for adult life which is a cornerstone of everyday living for children without physical conditions. As Capurso (2014) states that children with medical needs (physical and mental) still face the challenge of less engagement in learning, increased experiences of bullying, social difficulties and lower academic achievement. Schools and teachers may worry about the implications of including children with physical conditions in mainstream schools especially when they are not equipped to address their specific educational and medical needs. Teachers fear discussing the child's perception of his or her condition and needs whilst they should be able to address serious health issues positively and sensitively with all the children including children with physical conditions. Nabors *et al*., (2008) state that though teachers are aware of some medical conditions yet their knowledge regarding physical illness could be improved. Teachers do not have high confidence in their ability to meet the social and academic needs of children with physical conditions which could make a critical difference in the children's lives in educational and social contexts.

Since an individual teacher cannot support the children with physical conditions, who cannot avoid absence, there is a need for strategies to be employed by a team of professionals to overcome the effects of such prolonged or repeated absence (Hopkins *et al*., 2014).

1.2 Research aims

The primary and broader research aim of this project is to investigate what provision is available to children in Key Stage 2, who miss more than 50% of school over a three month period due to a physical condition in mainstream schools in Wales and England. Whereas, the specific questions of this research are listed in the following section.

1.2.1 Research questions

1. What are teachers' perceptions about their interactions with children during their absence from full-time school attendance owing to a physical condition?

2. What having a physical condition may mean educationally and psychosocially and how does it impact the education of children with prolonged absence?

3. What are the available means to provide academic continuity during the children's absence period?

4. How consistent is policy and practice and to what extent are they implemented in the mainstream schools in Wales and England?

5. What are the barriers and facilitators faced by teachers and educational professionals in Wales and England to provide academic continuity to these children?

6. What are teachers' concerns and recommendations for providing academic support for this group of children by mainstream primary schools in Wales and England?

7. How academic continuity can be maximized and sustained to maintain connections with the school with the help of multidisciplinary teams including parents, educators, policy makers, health and social care professionals and the child her/himself?

1.3 Definition of the terms

The definition of the terms particularly 'prolonged absence' and 'physical condition' was self-generated or agreed by a supervision team. I was interested in children with a physical condition and how that impact their schooling. My supervisory team was concerned that the category was too broad i.e. if I will ask teachers about how a 'physical condition' impact students and teaching. One teacher may consider a child with well managed Type 1 Diabetes who never missed school and another who had cancer and missed a great deal of school, suffered physical changes and took medication that temporarily altered their

cognitive state. The category was so large, that I might get such a range of responses that the data would be hard to interpret. Therefore, my supervisory suggested me to focus on students with significant absence to identify a sub-group of children with physical conditions so the teachers would be speaking of a more homogenous group. Absence was chosen because it did not depend on limiting my population to specific diagnosis.

Hence, in this research 'prolonged absence' is taken as children who have missed school approximately 50% of time over the past six months (about three months) as a result of a physical condition.

The term 'physical condition' initially came from a paper by Payne *et al*., (2013), however to provide a clear and manageable parameter to my research, it's definition is self-generated. Therefore 'physical condition' is taken as an incapacity of an individual's body to function normally, affecting and individual's ability to move, co-ordinate and/or control, caused by a bodily defect or injury.

Academic continuity: a child's access to, and utilization of, opportunities to learn effectively so that academic progress is made despite disruption to full-time schooling (Wilkie, 2012).

SENCO: special educational needs co-ordinator.

Medical conditions: includes all kinds of mental and physical conditions. Although children with physical and mental conditions both have educational needs my research is focused on children with physical conditions. However, some of the literature cited in this thesis covers both physical and mental conditions in which case the children are described as having medical conditions (physical and mental).

1.4   The current 'state of play'

Due to the reduced hospital stays and greater use of outpatient medical care, there is a growing burden on schools to accommodate the educational needs of children with medical conditions (physical and mental). Though children are provided with academic support in some hospitals and at homes as well, they miss their peer relationships, support friendship and overall routine of school life.

Teachers, SENCOs and principals are expected to provide effective academic support for these children but there is an ambiguity among school staff to accept their roles and responsibilities to contact these children during their absence. Communication between

healthcare professionals and schools is another issue for some parents. This lack of communication creates barriers to the effective support of children during absence (Asprey & Nash, 2006). These principal issues will be discussed in the further chapters, in detail.

Schools have a significant role to play in ensuring successful reintegration of the children with prolonged absence owing to medical conditions (physical and mental), which is the ultimate goal of an inclusive education. School systems may ensure that teachers understand physical conditions and the effects associated with their conditions to provide effective interventions. There exists little by way of legislation and policy that is relevant specifically to children with physical conditions, in both settings i.e. in Wales and England. Their needs are addressed to some extent in generic legislation and policies (Dewis, 2007). According to Closs (2000), at present the Codes of Practice of Wales and England give significant emphasis on the merit of a statutory assessment to provide equal opportunities to children with physical conditions.

However, the limited amount of research towards the educational needs of children with medical conditions (physical and mental) is in line with the scarce attention given to determine present practice to deliver services to this group of children (Hinton & Kirk, 2015). Moreover, despite significant policy interventions designed to provide flexible, individual and comprehensive support plans for children with medical conditions (physical and mental) implementation of the policy remains unclear, and poorly communicated.

1.5   Overview of the chapters

Chapter 1 presents the introduction to the research, its context and background, research questions, definition of the terms and aims of the research emphasizing the importance of providing academic continuity for children with prolonged absence owing to a physical condition.

Chapter 2 will be the engagement with the literature and research debates regarding physical conditions, their effects on the children particularly focusing on their academic achievement along with the academic continuity provided by the mainstream schools in Wales and England.

Chapter 3 will describe the details about methodology and methods that underpin the justification of this research, the research instruments and a discussion of ethical issues which were considered during this research.

Chapter 4 will present the analysed findings of the research data, along with the descriptions of the themes that resulted from the research findings, linking them to the original research questions.

Chapter 5 will discuss the findings related with the information presented in the literature to synthesise and analysise the findings related to current knowledge, the main research questions and the professional practice of the participants.

Chapter 6 will conclude the summary of the main findings briefly and will discuss the implications for practice, limitations and strengths of the study along with the final reflections.

CHAPTER 2   LITERATURE REVIEW

2.1   Introduction

As discussed in the introduction chapter, understanding of physical conditions and the role of academic continuity to enable the children with prolonged absence to fully benefit from the provided opportunities by schooling is fundamental.

This literature review has, therefore, adopted an approach that gives a critical account of the literature about physical conditions, its effects on the academic achievement of the children and academic continuity provided by the mainstream schools in Wales and England.

This literature review was conducted using a broad range of literature using manual searches and computerised databases by entering search terms in search engines and then followed leads from those papers. These reference lists were followed to retrieve studies published in different parts of the world regarding the said topic. The key studies that informed the research undertaken includes Closs's work (2000) which has an acknowledged influence. However, studies by Bolton, Closs, and Norris (2000), Eiser (1990, 1993 & 2000), Mukherjee, Sloper and Lightfoot (2000), Shiu (2004 & 2005), Shaw and McCabe (2008), Jones and McDougall (2010), Wilkie (2010, 2011 & 2012), Nisselle *et al*., (2012), Hainault (2013), Capurso (2014), Wadley *et al*., (2014), Hopkins *et al*., (2014), Filce and LaVergne (2015) and Hinton and Kirk (2015) added significant impact to this piece of research.

The review has been written with clear purposes, taking the key issues into consideration, for instance, research questions, the participants who took part in the research and the research context, to identify a suitable framework for the research study. The review begins by drawing on the phenomenon of physical conditions and their occurrence. This is followed by an exploration of the literature relating to physical conditions and school absence and issues regarding their impact on different spheres of a child's school life with particular focus on their educational achievement. Then the academic continuity and its means are discussed, followed by the concept of teacher training and research on teachers' knowledge about physical conditions. A revision on research regarding the Welsh Assembly Government (WAG) 2017 and Department for Education (DfE) guidelines 2015 are discussed in the context of developing the school's policy, roles and responsibilities of professionals and managing medicines and emergency procedures on school premises.

Finally, this review presents a discussion that has emerged from my research about re-integrating the children with physical conditions in routine school life and different approaches practiced by mainstream primary schools.

2.2   Physical conditions and their occurrence

In this current research, physical condition is a dysfunction of the musculoskeletal and/or neurological body, which affects the functional ability of a person to move or coordinate movement. For example, muscular dystrophy, juvenile arthritis and other rheumatic diseases, Parkinson's disease, thyroid disorders, cerebral palsy, developmental co-ordination disorder (Dyspraxia), spina bifida, severe asthma, diabetes, epilepsy, certain types of cancer and mobility issues caused by road accidents. All these physical conditions can be permanent, temporary or intermittent.

It is important to mention here that in my research, physical conditions are considered as the diseases that affect physical growth but particularly have effect on mobility and coordination of limbs. Whereas, children whose physical condition is associated with a cognitive deficit (e.g. a head injury) are taken as outliers to avoid respondents' potential confusion.

It is estimated that about 10–15 percent of the child population in the UK have considerable health needs in the UK (Eiser, 1993 and Bolton, Closs & Norris, 2000). According to Hinton and Kirk (2015), in the UK, approximately 10% of children aged 0–9 years and 12% of children aged 10–19 years have medical conditions (physical and mental) (DH 2012). The most common physical conditions in childhood are asthma, diabetes and epilepsy affecting an estimated 1.1 million (Asthma UK 2012), 29,000 (Diabetes UK 2012) and 1 in 240 children and young people under age of 16 in the UK (Epilepsy Action 2013), respectively (Hinton & Kirk, 2015).

Though there is advancement of medical care toward increasing outpatient service yet it makes transition programming from hospital to school more complicated. For example, rather than a two to four weeks' hospital stay, a child with cancer may have a 1 day admission followed by 6 to 10 outpatient doctors' visits over that 2 to 4-week period (Blank & Burau, 2004). The illnesses are still severe, yet a share of the burden of care has shifted from hospitals to parents, schools and outpatient clinics (Weller, Minkovitz & Anderson, 2003 and Shaw & McCabe, 2008). Due to medical advancement and decentralized

approaches, children with physical conditions spend less time in hospital and often during convalescence, receive outpatient care and treatment at home instead (Shaw *et al*., 2010). However, being sent home does not mean being able to attend school (Capurso, 2014). Home visits by tutors or visiting teachers may be prescribed in some programs but eligibility and availability vary across educational sectors (Shaw & McCabe, 2008). Tutors often visit them at homes for a few hours a week but education of the pupils with recurrent absence as compared to prolonged absence are at risk, as they receive no interim educational provision. According to Hinton and Kirk (2015), although educational support is often provided during lengthy hospital stays, concern about those who are in and out of hospital repeatedly or who spend considerable time recovering at home, remains.

Consequently, there is increased pressure on schools to effectively communicate with families and healthcare services to meet the needs of pupils with physical conditions who are absent from school for a prolonged period owing to their illness.

2.3   Physical conditions and school absence

Children with physical conditions experience difficulties with school attendance, academic performance and social adjustment owing to symptoms, result of treatment and misconception about their particular condition (Vitulano 2003; Sandstrom & Schanberg, 2004; Logan *et al*., 2008; Maslow *et al*., 2011; Jackson, 2012; Singh *et al*., 2012 and Filce & LaVergne, 2015). In general, children with physical conditions are absent 16 days in a year as compared to 5 days absence for children without physical conditions (Gracey & Ward, 2012). According to Capurso (2014), 58% of children with physical conditions routinely miss school. This prolonged absence can be continuous absence from school i.e. for weeks, months and in some cases even for years. It can also be recurrent or intermittent absence which means that children with physical conditions may attend school for less than five days per week. For example, children with asthma or allergies may require hospitalization for a short time period or waiting for lengthy hours in waiting rooms to attend appointments with medical specialists that requires intermittent absence from school. For the purpose of this study, prolonged absence is taken as, children who have missed school approximately 50% of time over the past six months (three months roughly) as a result of a physical condition.

According to Kabbouche and Linder (2005), children with migraine missed an average of 4.5 days of school per month. Of children who completed cancer treatment, 50% were considered "frequently absent" as compared to 20% of well peers (Gerhardt *et al*., 2007).

However, children with physical conditions have different patterns of absenteeism depending on their nature of illness. This variable pattern of absenteeism, at times, makes it impossible to estimate an 'average' number of days missed from school.

Jones and McDougall (2010) state that there are four patterns/forms of extended absence from school. Firstly, intermittent but regular prolonged absence, where a child attends school for example, every three days a week e.g. Wednesday to Friday but is absent on Monday and Tuesday. The second form of extended absence is intermittent but irregular prolonged absence where a child is absent from school due to his/her physical condition but the absence period cannot be planned for ahead of time, hence his/her absence is unpredictable depending on the physical condition.

The third pattern, explained by Jones and McDougall (2010), is known as intermittent then none, which is explained by providing an example that the pattern of absence of child was intermittent and regular but due to worsening condition the pattern changed to intermittent and irregular. When the child was well enough he/she was attending school but due to the worsening condition of the illness, he/she is absent for several months. At the same time, there is no indication the child wants to abandon the connection from school/learning. For example, a child in isolation due to chemotherapy wanted to stay connected to the school/classroom by making contact to the class using technology.

The fourth category of school absence is called None, where the chronic illness creates physical or psychological issues that prevent the children from attending school. For example, in Jones and McDougall (2010) a boy is described whose physical appearance has been changed to such an extent that he did not want his peers to see him. Due to his illness, he was not physically able to go to school but he kept social communication with a small group of peers using web-based video conferencing, where he had control of the camera on his computer so he could determine how much his peers could see of him. These four patterns/forms of extended absence from school are also indicated by various participants of my research and will be discussed later in this study.

According to Jones and McDougall (2010), each of the categories of school attendance has its specific problems and implications for a teacher as well as for a pupil. Vetere *et al.*, (2012) added that children with different patterns of absenteeism may also have completely different educational support needs. As for a teacher, it is important to be aware of the learning requirement and level of success of a child being absent owing to physical

condition. Also, she/he can develop a routine of connection with a child whose attendance is intermittent and regular, based on weekly or fortnightly cycles of a school timetable. Here the problem is that sometimes school timetables do not allow an ongoing routine to be established due to public holidays or certain events. To tackle this situation, some teachers introduce new concepts or topics when the child is expected to be at school only so that he/she can have a chance to ask questions. Unfortunately, not many schools and teachers embrace this practice due to one reason or another.

It is significant for a teacher to have a close contact with parents and medical advisor so that the child's daily state of health can be considered. As what the child can do one day he/she may not be able to do the next day or if an ability is lost once, it is unlikely to return but possibly the child's interest is still there to learn and keep connected to the school (Shiu, 2004b). Therefore, the teachers need to keep the balance between encouraging the child to achieve his/her potential, whilst at the same time considering the imposed obvious limitations of his/her physical condition.

According to Closs (2000), the British Paediatric Association proposes that about ten percent of the under–15 population has physical conditions that decreases their functional capacity and most likely, their education. These children may suffer from one or a combination of two or possibly more conditions. They may be diagnosed with a rare medical condition and, in some instances, have another more common long-term illness as well. So why is there little study about the education of the children with physical conditions? Is it assumed that health and illness belong 'elsewhere' and are not the business of school but only of family and medical personnel? Closs further explains that the reasons for the lack of significant educational research may possibly include the teachers and educational psychologists being inconsiderate about the health-related issues of children with physical conditions. Another reason is the lack of correlational studies between educational, medical and social policy research, which is not the focus of this project but is discussed briefly in this thesis.

Long term absences due to health problems affect children's educational attainment and impact on their ability to integrate with their peers which effect on their general wellbeing and emotional health. In addition to the educational impacts, there are social and emotional implications associated with medical conditions. Children may be self-conscious about their condition and some may be bullied or develop emotional disorders such as anxiety or

depression connected with their medical condition. These concerns and issues related to them are discussed in the following section in detail.

2.4   Impact of prolonged absence and physical conditions on the educational experience

According to Martinez and Ercikan (2008), prolonged absence from school can cause severe barriers to learning. Additionally, it causes high anxiety and stress to the child who may be worried about keeping up with coursework and they fail to take and fulfil school expectations towards them. Missing face-to-face teaching interaction and being away from his/her peer group while in the hospital, can create additional barriers to learning and further anxiety. School provides opportunities for social connection and friendship likewise, group work provides opportunities for social interaction; hence, it is hard to separate the educational and social implications of children's absence from school (Mukherjee, Sloper & Lightfoot, 2000; Shaw & McCabe, 2008; Wadley *et al*., 2014 and Filce & LaVergne, 2015).

There is a strong relationship between absenteeism and underachievement (Gottfried, 2011; Krenitsky-Korn, 2011; Hancock *et al*., 2013 and Arthurs, Patterson & Bentley, 2014). Conversely one study by Schmitt, Balles and Venesky (2013), found no statistically significant relationship between number of absence days and reading scores on a standardised test. However, the sample size in their study was very small (n=106). Whereas, in the same year, Gottfried's (2013) study of over 20,000 children in Philadelphia found a strongly negative effect of absence on reading skills and mathematics. Similarly, a large scale study of children (n=415,000) in Australia found low achievement in tests due to absence, which continued to decline as absence rate increased (Hancock *et al*., 2013). Likewise, in the UK a systematic review by Hinton and Kirk (2015) suggest that prolonged absence effects the children's academic performance adversely, which can lead to further complications such as difficulties in reintegration. A strong connection between absenteeism and underachievement is indicated by the participants of the current study as well. This study has explored a number of other related issues which are presented and discussed later in this thesis.

Physical conditions, as mentioned earlier, have a significant impact on many areas of the educational experience. Children with physical conditions usually miss more school than their healthy peers and are expected to have up to 50 percent more absences and underachieve academically (Shiu, 2004a). However, Hainault (2013) states that children

who are absent from school more than 30% of term underachieve academically. Yet he concluded that neither the number of days of the child's absence from school directly relate to the academic achievement, nor does his/her severity of condition. It is the 'pattern of absence and the chronicity of condition that together affect the children with physical condition in achieving their potential. Burke and Cigno (2000) added that children with physical conditions are vulnerable to being absent from school not only because of their specific condition but also due to the consequential affects of their illness on their family routine life and their self-development. They further state that school absence may possibly be an indicator of social maladjustment or depression as they find themselves different from the other children of their age. According to Close (2000), the fear of under-achieving and rejection of being 'different', requirement of medical treatment in school that lead to interference in school routine and social time with peers and living with general anxiety about the uncertainty of the course of their condition are some other factors that place the education of children with physical conditions at risk. Extended absence, teasing and sometimes extreme cases of school phobia have all been reported in her research. Eiser (1980) found that school absence among the children in the first six months following cancer diagnosis was very high, but improved steadily over longer periods of time. Children with cancer were described as lower in energy levels and were reported to have more difficulty in concentrating and completing projects than other children in the class. They were also rated as emotionally inhibited and less likely to express their feelings. Physical problems, especially nausea, tiredness and lack of mobility was reported that indeed create more difficulties than being behind the school work (Eiser, 1993).

It is difficult to access the academic achievement of children who receive educational support in a hospital setting as each child has a unique personal plan. There is a correlation between the health of an individual and his or her academic success (Duggan, Medway & Bunke, 2004 and Taras & Potts-Datema, 2005). For example, children with muscular dystrophy may not attend school regularly over long periods of time in comparison to children with other physical conditions or healthy children, therefore some may show poor school performance. Similarly, the complications, particularly pain experienced by children with juvenile arthritis, affect their attendance and performance at school. According to McCarthy *et al.*, (2003), after having mild episodes of hypoglycaemia, children's cognitive recovery rate concerning memory and attention is slower than their physical recovery rate, which should be addressed with particular attention by the teachers and school.

In addition, Roberts and Whiting-Mackinnon (2012) state that a physical condition such as epilepsy has considerable implications for children's general development and daily routine functions. Following a seizure, they can also experience memory impairments, attention and concentration difficulties, and cognitive impairments as well as difficulties in mathematics, spelling, writing and reading comprehension. Further, Eiser (1993) notes, physical conditions such as leukaemia have adverse effects on intellectual development as chemotherapy and radiation treatment have been linked to retarded cognitive development and academic difficulties in children. According to a study by Taras and Potts-Datema (2005), 51% of children with leukaemia and 41% with epilepsy, whereas 17% and 14% of those with diabetes and asthma respectively, experience academic difficulty. Interestingly their teachers do not have issues based on their academic difficulties but on their perceptions, that they themselves lack both time and medical expertise to care for these children adequately, which is another area of discussion presented later in the present study.

The fact is that modern medicines can control pain effectively and limit the intensity of symptoms and long-term complications but cannot always offer a cure. As a result, children may face a life-time of hospital appointments, diagnostic procedures and painful medical treatments (Eiser, 1993). This situation makes the individuals dependent on others and requires special care in areas like medications, special diet, medical technology, assistive devices and personal assistance (Nabors & Lehmkuhl, 2004). According to Dewis (2007), besides the unpleasant side-effects of medication and/or invasive and usually painful medical procedures, some children with physical conditions have delayed or difficult developmental progress. In fact, the negative effect of a physical condition can be direct or indirect, on a child's development. For example, it is considered direct if the condition affects the brain and other parts of the nervous systems, resulting in impaired cognitive functioning. Whereas, the indirect effect is when secondary factors hinder the achievement of development tasks such as frequent or prolonged absence from school or chronic fatigue may obstruct a child's learning (Wadley *et al*., 2014). Moreover, many children with physical conditions are prescribed a combination of medications to combat ongoing conditions, reduce the effect of their symptoms and minimize related side effects. The side effects from these medications vary from child to child but can have a severe influence on the child's executive functioning and learning. For example, medications to treat seizures may cause sedation, whereas those that treat asthma or cancer may lead to irritability and difficulty in focusing on tasks (Sexson & Madan-Swain, 1993).

An illness or its treatment may result in pain, fatigue, nausea or lethargy and may seriously limit the child's ability to concentrate on academics. In additions there could be some behavioural symptoms such as inattention, hyperactivity or emotional liability resulting from the prescribed medication. Now as the medical professionals are not in the school to observe the cumulative effects of multiple medications, it is essential that school staff observe the child's academic functioning and report back to the medical team in a timely fashion. The medical team may perform further assessment by involving the school multidisciplinary team to adjust medications, modify treatment schedules or may advice a change of school day so that the child's academic performance is maximized (Shaw & McCabe, 2008).

Apart from having adverse effects on academic achievement and social life, physical conditions and prolonged absence from school can produce lower self-esteem and evident psychological pressure on these children. Frances (2004) asserts that the self-esteem of any child affected by an injury or a condition can be an issue, particularly the way they look. However, it is also a possibility that a child with no disfigurement can have painfully low self-esteem and a child with a severe facial disfigurement can have very good self-esteem. A child's repeated failure to achieve his/her desired level of social interaction as well as his/her appearance can deteriorate one's self-esteem.

Considering the effects of physical conditions on self-esteem, Orton (1979) asserts that possibly disfigurement of the face causes most problems more than any other part of the body, as it is the face that holds ones' individual identity and so we most often look at when we communicate with other people. To help this out, the teachers may speak to classmates about the child's particular problem, but this has to be done with great caution, as it may draw more attention to something the children might not even have noticed. Frances (2004) states that recognizing and understanding symptoms of children' low self-esteem can help to avoid further lowering it. Teachers can help to improve the children' self-esteem by integrating measures to manage unacceptable behaviours into a more radical programme to raise self-esteem such as to teach the child strategies for dealing with unwanted attention and by setting achievable targets for alternative behaviours. Ainsa (2000) added that teachers can also play an important role in prompting peer assistance of a sick child and help them to communicate, make decisions and solve problems to promote good self-esteem.

It is important to understand what it is that children with a physical condition find stressful (Pretzlik, 1997). Wadley *et al*., (2014) state that besides distress, children with physical conditions meet certain challenges when hospitalised for significant periods of time. As they are at the risk of experiencing social dislocation from family especially from their mother, community and school. This leads to their isolation from friends and learning at school, which eventually effects their future achievements. It is equally important to address the educational and social needs of children with physical conditions so that they are not disadvantaged in their classroom but are able to integrate with their peers and achieve their full academic potential (Maslow *et al*., 2011).

Children with physical conditions may experience constant or intermittent pain, discomfort and fatigue, painful procedures, missing out on daily activities, being separated from family and friends during periods of hospitalization, feeling different and being disfigured, disabled and/or terminally ill (Dewis, 2007). Though all these factors are not unique to children with physical conditions they are experienced frequently and with greater severity, last longer and overlap in these children. Dewis (2007) asserts that the severity of condition that affect children varies both across and within conditions as individual children have different experience of the same condition and some conditions have more severe effects on the child whereas others do not.

Many children with physical conditions have the cognitive capabilities to be academically successful, nonetheless having unique educational needs. For this they often require close cooperation of family, medical professionals and educators to support them and accommodate their needs (Duggan, Medway & Bunke, 2004). Education can likely influence children's health by influencing their ability to support themselves, manage physical conditions and navigate complex medical and social service systems during childhood and later in life (Aron & Loprest, 2012). The prospects of children's future employment are influenced by their level of educational achievement; therefore, it is important to minimize the impact of physical conditions and prolonged or recurrent absence on academic attainment by supporting their academic continuity (Wilkie & Jones, 2008).

2.5   Prolonged absence and academic continuity

The long-term nature of physical conditions and subsequent absence from school mean that these children need academic continuity. Academic continuity is defined as pupil's access to and utilization of, opportunities to learn effectively so that academic progress is made

despite disruption to full-time schooling (Wilkie, 2012). Wilkie (2012) further states that this academic continuity should be considered vigilantly as not only the type of interaction with the children is important but also the frequency and regularity of these connections is vital for continuous reinforcement. Carter (1989) added that continuing education is not only necessary for a child's future, in fact it also provides stimulus and gives a structure to the day and can bring some normality into hospital life as legally, children who stay in hospital for a long time have a right to education provision according to their abilities.

In addition, Dewis (2007) asserts that developmental theorists, including Piaget, Vygotsky, Erickson and others, have suggested that daily routines encourage the development of independence and competence, facilitate developing fine motor skills and build muscle control to practice new skills among the pre-school children. Unfortunately, some medical conditions can compromise the achievement of all these skills. Whereas, the primary school children with physical conditions are predominantly vulnerable to behavioural and emotional difficulties. Eiser (1990) concluded that the problems this age group face include the emotional effects of separation and hospitalization; depressive symptoms; anxiety and behaviour problems.

Therefore, children with prolonged absence from school require educational continuity and a variety of adaptations can be put in place to support them (Lehr, 1990; Lynch, Lewis & Murphy, 1992; Shiu, 2001; Geist, Grdisa & Otley, 2003; Kaffenberger, 2006 and Filce & LaVergne, 2015). In my research, four means of supporting academic continuity have been considered which are commonly practiced in Wales and England. These means of academic continuity are: use of technology (telephone chats, videoed lessons, videoconferencing, live online interaction, using Skype, Facetime etc), individualized instruction e.g. using Individualized Education Plans (IEPs) and Individualized Health Care Plans (IHCPs), bed-side teaching in hospital and home tutoring for children's academic continuity. These means are reviewed separately in the following section.

2.5.1   Information Technology as a means of academic continuity

Research shows that technology makes it possible to take learning beyond classrooms and timetabled periods, enabling autonomy and individualized learning for children who are unable to attend school regularly (Waddell, 2000; Jones & McDougall, 2010; Wilkie, 2011; Nisselle *et al*., 2012; Wadley *et al*., 2014 and Hopkins *et al*., 2014).

Children's communication with their schoolmates is vital, as learning is a social process and not an isolated event that takes place only within an individual (Capurso 2014). The use of technology can bridge the instructional gaps such as providing access to online modules on content missed, allowing pupils to attend class via a distance using real-time video conferencing, or other strategies (Filce & LaVergne, 2015). For example, it is most difficult for children with physical conditions to learn and progress independently in all subjects particularly in mathematics. As children being absent from school for a prolonged period miss instructional learning opportunities and may suffer from gaps in their understanding which hinders further learning, therefore, collaborative learning and frequent interaction between teachers and pupils are required (Wilkie, 2012). Using technology i.e. webcams, email and distance education programs include children with physical conditions into the classroom. Jones and McDougall (2010) state that the development of digital communication networks has made it possible to extend teaching and learning beyond the traditional classroom environment, which has provided an individualized learning opportunity for children in hospitals.

There is, however, an increasingly large range of off-the-shelf communication mobile Internet-based technologies such as laptops, tablets and smart-phones. Research found evidence that families and schools were making significant use of commercially available communication technologies to maintain connection with a hospitalized child (Nisselle *et al*., 2012; Hopkins *et al*., 2014 and Wadley *et al*., 2014). Research by Jones and McDougall (2010), Nisselle *et al*., (2012) and Hopkins *et al*., (2014) show that children like to stay connected to their school and learning as they feel 'normal' despite hospitalization. They may connect with their classroom using technologies such as email, blogs and teleconferencing. The health and educational lives of children with physical conditions are continually interwoven at hospital (Hainault, 2013). While these studies found that videoconferencing was an effective tool for keeping the absent child connected to the class, concerns were raised over the privacy and security of information transmitted in this way (Hopkins *et al*., 2014). Similar apprehension was also indicated by the participants of the current research (presented in Chapter 4), as information and communication technologies are usually not adequately sensitive to the context of neither the classroom nor the hospital. There are also the potential risks of children seeing a sick or injured friend or classmate without being prepared for the medical condition which may traumatize them (Hopkins *et al*., 2014). To overcome these issues in a busy classroom, the teacher needs to have control

over the video connection so that it could be switched on at pre-arranged times (Wadley *et al.*, 2014).

Given the complex nature of issues associated with the hospital and school setting careful thinking about the design of technology that supports connection and non-disruptive presence at the same time is required. Few researchers have considered using ambient technology on trial to connect children in hospital with their classroom, while taking account of the very specific needs of both hospital and classroom settings for minimizing risk, protecting privacy and reducing potential disruption to both health care and classroom learning (Hopkins *et al.*, 2014 and Wadley *et al.*, 2014). The purpose of ambient technology is to suggest social presence rather than sustained rich communication and to represent information visually in an abstract form that invites interpretation. Ambient technologies are lightweight and do not demand attention but function in the background of primary activities without being disruptive. This technology establishes, maintains and nurtures human relationships, for example, sharing a photo may communicate information about a certain activity but also works to strengthen social ties among the children and their classmates (Wadley *et al.*, 2014). However, Vetere *et al.*, (2012) claim that ambient technologies stress the superficial interaction between the child and the teacher, whereas in primary and secondary school interaction is crucial in the classroom setting where attention is frequently shifting between teacher, child and activity.

Children with physical conditions need frequent connections with their home school of origin to stay involved with the academic life. These connections are certainly achievable, but sustaining connection over time remains a challenge. However, if these connections are regular and sustained even in the child's unpredictable medical routines and the teacher's busy timetable and workload at school, this can facilitate child's learning immensely (Wilkie & Jones, 2010). Research conducted in different countries and backgrounds with children being absent from school owing to their conditions has shown children's connection with their school using technology is effective and manageable. In Sweden, for example, Berkoff's (1998) research using technology to connect a pupil with cancer to his school and classmates showed that it has reduced the child's fear of falling behind academically and access to recorded lessons allowed him to work at any time of the day or night when he felt well enough (cited in Wilkie & Jones). This significant research has similar findings to my research as I have discussed this frequently that staying connected to

school provided an opportunity to a child to stay in touch with the class curriculum, which in turns will make the reintegration process much easier.

Similarly, use of hardware such as the robots, in a study in the Netherlands allowed pupils to be immersed in the actual classroom (Hopkins *et al*., 2014). In the 1990s, a Canadian project developed a robot named PEBBLES (Providing Education by Bringing Learning Environments to Students). This robot was in the classroom but was controlled remotely by a hospitalized child, where the classmates could communicate with the child via the screen of the robot. These projects highlighted the benefits of group discussion, presentations and participation in classroom activities for the hospitalized children (Fels *at el*., 1999; Hopkins *et al*., 2014). Whereas, later research by White (2003) found that conventional desktop videoconferencing was just as effective and significantly less expensive. It is essential to mention these researches here as my study has suggested that the use of laptops and smart phones is very common to connect children at homes or in hospitals with their peers moreover, they serve the same purpose. Therefore, being economic and convenient the same gadgets can be used for teaching purposes as well.

In the UK, an educational technology event in London in February 2013 (the British Education and Training Technology exhibition: BETT), involving contributions from teachers, policymakers, researchers and commercial organizations suggested that unlike other forms of educational technology, the integration of videoconferencing in UK schools was neither uniform nor widespread (Lawson & Comber, 2014). Research conducted by Lawson and Comber (2014), using videoconferencing in schools in England, over a span of approximately eight years (2003–2011) concluded that there are examples of using videoconferencing for distance learning at a school level to provide education to pupils in remote or rural locations and for children who are absent due to different health conditions. The current study shows that most schools in Wales and England tend to focus on accessing expertise beyond their school walls, rather than being proficient to develop programmes for these children by themselves. For example, the use of TUTE teaching service, a virtual school system in Wrexham used by different schools is provided by a specific company, situated in the UK. In this service, a teacher would be online at a specified time on a webcam and deliver an hour of Maths or Science or Science, Maths and English lesson to an individual pupil or a group of pupils. It is fundamental to consider; would it have a significant influence on the academic achievement of these children if video teaching was to be provided by a child's own school on the similar lines to TUTE.

Videoconferencing, despite its proven educational value, is far from being widely adopted in UK schools. Considering the importance of using information communication technology (ICT), at times the provision of ICT for schools was on the agenda of UK government and it was assumed that videoconferencing would become an integral element contributing substantial weight in national and local educational policies. As it was suggested in the Welsh Assembly Government (WAG) 2010 guidelines that using web cameras for videoconferencing enables children in hospital or at home to link to mainstream lessons. Therefore, use of videoconferencing was encouraged as it links teaching areas within a hospital and enable children to contact education establishments worldwide. Though ICT is integrated into curricular planning and practice in schools yet videoconferencing gained marginal importance. It was used by some teachers in some schools but it never become a regular means of technology.

ICT can be used in a variety of ways to support children with medical conditions (physical and mental), once their learning needs have been assessed. Lap computers offer a flexible solution as they can be used in the mainstream classroom, hospital or home. The internet or school website can be used to post details of lessons missed and homework to be done. The use of web cameras for videoconferencing can also be used to enable children in hospitals or at homes to link to mainstream lessons. The use of ICT can reduce the feelings of isolation in children with medical conditions and allow them to continue with their education as far as their illness allows. It enables the achievement of inclusive practice where all children can participate fully in the learning and life of school despite of having diverse needs (WAG, 2010).

According to Maor and Mitchemt (2015), during periods of absence the use of technology also helps children to overcome isolation and promote social well-being but unfortunately to date, no reviews of literature has been located that have explored these aspects. Disengaged and de-motivated pupils can be re-engaged through online learning and can also improve independent access for these children to people and learning materials (Jones, McDougall & Robertson, 2009). This practice can increase their technological confidence, motivating them to use online technology for both educational and leisure purposes (Waddell, 2000 and Jones & McDougall, 2010). But to maintain one successful connection between a child with physical condition and their teacher at school, several conditions have to be fulfilled first (Wilkie & Jones, 2010). For example, to make a simple telephone conversation, the teacher should feel confident enough that his/her call will not be taken as interference in the child's

daily routine. The child should also be well enough and to be available at that time to take the call. Similarly, videoconferencing also involves several conditions, any of which, if not met, will affect the success of the actual connection. Such as will the child be available at that time and his/her sleep or medical appointment not be disturbed? Will he/she be well enough to discuss the schoolwork with the teacher? Will the appropriate equipment be available to use? Will the teacher be free at that time and so on? Even if all these conditions are met and the child and the school agree a time or day, technical issues may interfere at times for example, technical issues with an audio headset or poor wireless network coverage.

However schools and families do use telephone and video calls to stay in touch with the child an exchange of email is another popular link to communicate between hospital and school (Wilkie, 2011). Whereas, hand-written letters and handmade gifts are a preferred way for classmates to stay in touch, signifying that personalized physical objects are more important to maintain this connection with children with physical conditions at hospitals or at home (Wadley *et al*., 2014). Another way of continuing the school connection with the children with physical conditions at home is providing home tutoring to these children.

2.5.2 Home tutoring as a means of academic continuity

Home tutoring is a system of educating children who are unable to attend school due to mental or physical illness or any injury (Telzrow, 2001). A qualified teacher visits the pupil's home to provide them with individual instruction in a comfortable environment. Home tutoring comprises instruction that is developed considering educational policies, statutory law and local education authorities to provide educational instruction for these children in the safety and comfort of their own homes (Shaw & McCabe, 2008). The aim of home tuition is to maintain the child's academic continuity, chiefly by providing lessons in the main subjects (like mathematics and languages) and by assessing the knowledge and skills of the child. The home tutor can be very flexible in organizing the lessons at home, considering the needs and health condition of the child by providing social-emotional support to the child and by keeping the parents informed about the progress of their child (Boonen & Petry, 2012).

Capurso (2014) asserts that in some countries home tutoring is provided either by one of the child's own teachers, if that teacher is allowed extra time to visit the pupil or by a hospital teacher, extending his/her range of action to the child's home and continuing the work

previously started at the hospital. Whereas, in Wales and England, local authorities have a legal obligation to work with schools to support pupils with medical conditions (physical and mental) to attend full-time. These local authorities assign a trained professional to teach this group of children at their homes. Regarding this, the guidelines provided by WAG (2017) and the DfE (2015) state that local authorities should make arrangement under this duty for a child if he/she will be away from school for 15 or more days (consecutive or cumulative across the school year) due to the child's health condition. If the children in mainstream schools are not able to attend school due to their health conditions, the local authority has a duty to make other arrangements of education for children of compulsory school age, such as home tuition. For example, the Wrexham County Borough Council, home tuition policy November (2016) states that children and young people educated at home should receive a minimum entitlement of 3 hours' teaching per week in the years up to and including Key Stage 3 (Year 9) while, 5 hours' teaching per week in Key Stage 4 (Years 10 and 11). However, the North Yorkshire County Council (NYCC) guidance (2015) states a child receives a minimum of 5 hours of home tuition a week across all key stages, in other words 1 hour of instruction everyday, Monday to Friday or 2 hours of tuition on one day and 3 hours of tuition on any other day of the week. Also, depending on the need and condition of a child, the hours of home tuition can be maximised to assure full support by the available provision.

The provision of home tutoring in Wales and England is similar to few other countries, for example, in Belgium home tuition is organized by the school in which the child is enrolled and can be provided tuition at home or at the hospital. There is a legislative distinction in Belgium between children who are chronically ill and children who have long-term illness. The latter group has a right to 4 hours' home tuition a week after being continuously absent from school for 21 calendar days. Whereas, the former group is entitled to 4 hours' home tuition every time they are absent from school up to nine half days (Boonen & Petry, 2012). However, unlike Belgium there are no clear guidelines available in Wales and England for the academic provision for children with chronic illness and those with long-term illness. This is not studied in this thesis but is recommended for future studies.

Nonetheless, Wilkie and Jones (2010) state that children who receive home tuition have less involvement with and receive less support from hospital schools, which will be explored in section 2.5.4. According to their research, there appeared to be no specific arrangements for pupils regarding their school work while in the hospital, neither any additional academic

support when these children returned to school. Some children have contact neither with their peers nor with their teachers. Their parents have accepted responsibility for coping with their children's absence from school by collecting work and catching up on their work after hospitalization (Bailey & Barton, 1999). Similar findings are indicated by the participants of my research, which will be discussed later in this thesis.

Moreover, Bessell's (2001) study discovered that home tuition was perceived to be academically inadequate and socially isolating for children who have medical conditions (physical and mental). This finding contrasts with Boonen and Petry's findings (2012) that indicated most children felt part of their class and that the home tutor tried to involve them with their home school. Also, due to the growing use of the internet to keep in touch with their peers, home tuition is no longer perceived as being socially isolated (Straker, Pollock & Maslen, 2009). Additionally, Blakeney (1994 cited in Shaw *et al*.,) affirm that home tutoring can be an excellent source to assist in the transition of children with physical conditions from hospital to school.

However, one of the difficulties with home tutoring is that because children receive 1 hour instruction per day, they are expected to keep pace with their peers with extensive individual work. To help them out, their parents do provide instruction, support and supervision of academic work which puts additional stress on parents and families on a whole. Whereas, another difficulty with home tutoring is lack of flexibility in the delivery of this service (Shaw & McCabe, 2008). For example, due to the administrative challenges local authorities (LAs) in Wales and England consider having a qualified teacher visit the home at least 1 to 3 hours per week after a minimum of 15 days child's absence from his/her school is not sufficient. This lack of flexibility may hinder the transition to school and may lead to academic demotivation (Shaw *et al*., 2010). There is little research available on the academic motivation in children with physical conditions. However, there is also little evidence to suggest that children with physical conditions would differ significantly from those without physical conditions in their motivation to succeed academically. Yet pain, fatigue or other physiological symptoms they experience might affect their motivation over time (Shaw & McCabe, 2008).

While the responsibilities of school to provide specialized educational services, reintegration and accommodation for children with illness (physical and mental) are broadly described in the literature, home tutoring is rarely addressed in the literature and

national/school policies (Shaw *et al*., 2010). Moreover, there are significant barriers to home tutoring becoming an effective service such as lack of consistent eligibility criteria, low academic motivation of children with physical conditions, the requirement of significant parent involvement, challenges of cooperation with medical professionals, high cost to school and LAs, liaising with the child's home school and the pedagogic difficulties of teaching children at home (Shaw *et al*., 2010 and Capurso, 2014). Therefore, the arrangements provided by the local authorities can be tailored to the child's individual circumstances and to the facilities available to provide them optimum chances to receive education (WAG, 2017 and DfE, 2015).

Two methods of instructional strategies used to address individual differences are differentiated and individualized instruction. In the former group, pupils are taught in the classroom by having shared interest, topic or ability for assignments and is an especially valuable approach to organize the teaching of children with medical conditions (physical and mental). This approach is not the focus of my research but the latter individualized instruction is, as it is a very precise plan for an individual child and besides the classroom, can be used in any environment such as in hospital or at home by the teachers.

2.5.3   Individualized instruction as a means of academic continuity

Individualized instruction focuses on the needs of an individual pupil as teaching is specific and targets a child's need individually (Feeley & Skilling, 2000). In the Individualized instruction method of teaching, Individualized Education Plans/programmes (IEPs) are developed through which the school can accommodate the needs of children with special needs. IEPs are necessary for children who may underachieve academically while at school or have significant absence. Closs (2000) states that IEPs are everyday working documents which are used to support the education of children with medical needs and which should be based on continuity assessment of ordinary and special needs. It should not only record gaps in learning but also should include plans for overtaking these gaps as far as reasonably possible.

Another programme to support children with health conditions in Wales and England is the Individualized Health Care Plan (IHCP) which is used to achieve educational equality for pupils with health management needs, whether the pupil is classified as eligible for special education (Jackson, 2000). WAG (2017) guidelines suggest that IHCPs are essential where healthcare needs are complex, fluctuating, long term or where there is a high risk that an

emergency intervention will be needed however, not all children with healthcare needs require an IHCP. These IHCP should be developed and agreed between the school, family and healthcare professionals and should be reviewed at least annually. It should also be easily available within school to all the staff members who support the child with physical conditions. An individual healthcare plan (IHCP) should include details of the medical condition (physical and mental), their symptoms and the effect it has on the child. It should also include any relevant information about medication or support required by the child including the instructions specifying how to respond in case of emergency intervention (Jackson, 2000).

According to their guidelines/policy for having IHCP, WAG (2017) and DfE (2015) state that children with medical conditions (physical and mental) should have an IHCP, even for the conditions which children can manage well in their day to day life, such as asthma or diabetes. Moreover, these guidance documents emphasize that where a child has a special education need, their IHCP can be linked or attached to any individual education plan, Statement of SEN or learning and skills plan. The school governing bodies should specify who is responsible for developing the plans. Healthcare professionals can play an important role in developing IHCPs to meet children's individual requirements and can make sure that teachers have a clear plan of action for the everyday management of their pupils' long-term conditions and are knowledgeable about the proper action to take in an emergency (DfES, 2005 and Hinton & Kirk, 2015).

Schools in Wales and England are using IHCPs to provide academic support to children with medical conditions (physical and mental). For example, schools in North Yorkshire share the guidelines by the North Yorkshire County Council (NYCC), which explain that the purpose of the IHCP is to provide the necessary information that clarifies procedure for support, signifying who is responsible for a specific task in the staff. It also focuses the compulsory resources and training and describe who will undertake the training. These guidelines have declared that Individualized Health Care Plans (IHCP) are written plans that explains all the details of a child's health care needs such as when additional members of staff are involved, suggest who is responsible for each task, contains parental consent and is essential to be put in place by the school's insurers before an employee can commence a health care procedure. A group of people need to work thoroughly to develop an IHCP and provide support, advice, information and training. The group may include, the child him/herself where appropriate, parents, school, health professional, child health service,

advisory support teacher for physical/medical needs and early years advisory teacher. It stresses the fact that the overall responsibility to develop and implement IHCP lies with the head teacher. He/she should acquire information from the parents, and health care professionals as well as the child to make appropriate decisions. Also, the governing bodies should make sure that their school has an appropriate policy for children with physical conditions which is reviewed on a regular basis and available to parents and staff. WAG (2017) has considered the importance of IHCP on similar lines but has advised governing bodies to annually review these plans or more frequently in case the needs of the child has changed, particularly for those children who are technologically dependent or have potentially life-limiting conditions.

Though educational support is often provided to children during their prolonged hospital stays, yet concern remains about those who are in and out of hospital repeatedly as unpredictable and irregular patterns of hospitalization decrease the prospect of ongoing academic support from either a hospital school or a child's own school (Wilkie, 2012), which should be carefully considered by the child's school of origin and LAs.

In Wales and England, IHCPs are written in conjunction with healthcare professionals to keep teachers informed about a child's symptoms, medical requirements and support needs in school. However, a recent survey suggests that IHCPs are not routinely used in all schools in the UK and teachers may not be aware of the specific medical needs of an individual child (Hinton & Kirk, 2015). The children and their parents may not be satisfied with the care they receive at school as parents may feel that teachers have not received appropriate training and lack knowledge about the specific condition of their child (Shiu, 2005). Whereas, for children teachers' attitude and lack of knowledge limit their capacity to manage their conditions on their own (Roberts & Whiting-Mackinnon, 2011 and Nurmi & Stieber-Roger, 2012). Therefore, in mainstream primary schools, multidisciplinary teams in particular, can be more flexible in designing individualized health care plans that adjust to the child's medical regimen as well as aim to cater for the child's academic, socioemotional and physical needs (Shaw & McCabe, 2008).

Where IHCPs are helpful to all the teaching staff of a school who are responsible to educate a child with physical conditions, they are also used by hospital teachers to support the academic continuity of this group of children.

2.5.4 Bed-side teaching in hospital as a means of academic continuity

The most common form of educational provision in the UK is in on-site hospital schools that offer bedside teaching or lessons in a classroom within the hospital for children who are hospitalized for extended periods of time (Wilkie, 2012). According to Capurso (2014), bedside teaching is provided in a hospital by hospital teachers who are assigned to work in the medical setting to teach children who stay in the hospital for a length of time.

A hospital teacher ensures continuity of education and communication with the child's own school. In previous years, hospital schools had little to do with these children's school of origin (Fels, Shrimpton & Robertson, 2003). However, Wilkie (2012) states that in recent years, hospital schools have gradually increased liaising with them to develop learning plans consistent with the child's school curriculum programs. They liaised with school teachers and passed on to children the required learning materials and school work using email, videoconferencing and telephone. This also is helpful for parents as instead of being relied upon to courier materials from school for their child's academic continuity, they can focus on their health issues. Moreover, usually the hospital teachers are included in the multidisciplinary team by some schools to better coordinate their effort with the different routines of the hospital and because they can provide essential psychological and sociological insights about the children being admitted to the hospital, who liked to keep connected with their own regular schoolwork as it has many positive psychosocial benefits for them (Capurso, 2014).

Hospital teachers exhibit competencies to work with children from preschool through high school levels in a hospital setting while coordinating educational services with medical personnel and staff from the child's home school (St Leger & Campbell, 2006). They demonstrate flexibility, understanding and compassion when working with children experiencing serious physical conditions. There is a policy statement followed by hospital school services that set out the principles that elucidate how education of the children with physical conditions should be supported. This guidance is provided by the Department for Education, to assist and guide schools, local authorities, NHS and anyone who has an interest in promoting the academic attainment of children with medical conditions (DfE, 2015). As without this, decisions may lack consistency and focus can be made on an ad hoc basis, consequently the service will be invalid and unreliable (Feeley & Skilling, 2000).

In Wales, hospital/home tuition services are usually part of an integrated service and the local authorities employ a tutor who teach children either in a hospital or home setting as part of one service. In a hospital setting, the tutor provides one to one teaching on the child's bedside as there are currently no hospital schools established in Wales as defined within the Schools Standard and Framework Act 1998. This Act defines hospital schools as schools registered within the premises of a hospital as special schools with maintained status i.e. maintained by the local authorities or non-maintained status as independent schools. In that case, children with medical conditions (physical and mental) may attend hospital schools outside Wales (WAG, 2017).

However, there are several hospital schools in England that often offer multiple sessions every day for pupils of different ages and grade levels. For example, Royal Manchester children's hospital has 40 members of staff who sometimes also teach children in their own homes. Any child aged between 3 and 19 admitted to RMCH can be referred to the hospital school which adheres to the National Curriculum just like any primary or secondary school. Each morning a member of staff visits each ward where medical teams will determine if a child is well enough to attend the school. Then the teaching staff collects each child from every ward, but if any child is not well enough to leave the ward but is able to participate in some lessons, he/she is provided with bed-side teaching by one of the experienced teaching staff. The NHS teaching staff also meet with the parents of these children to go over the lesson plans and activities for the day. Similarly, a Sheffield City Council service based in the hospital provide educational support to school aged children who have been in hospital for more than three days. This service aims to offer at least one teaching session per day. Depending on the child's circumstances more sessions may be offered and lengths of sessions may vary. The school teaching team liaises with the child's school of origin in all educational matters and provide advice, assistance and support in reintegrating the child with physical conditions back into his/her regular school.

Hospital teachers have more professional development needs than others as they not only deliver the curriculum as fully as possible but teach at the bed-side taking in account all of the assorted distractions of families, visitors, physical and emotional state of the sick child. Therefore, they need to be familiar with developments in both the educational and medical fields related to their pupils' progress and treatment. They also liaise with the child's home school regularly so that there is a shared awareness of progress and gaps in their learning (Feeley & Skilling, 2000).

The pressure for teachers whether teaching in class, home or hospital to take on duties relating to the health needs of children has continued to grow. This results in situations where they may be providing medical care without a suitable policy in place or adequate training. At the present time, the role of a teacher is clearly more than planning and executing lesson plans as it is quite multifaceted. The following section reviews the role of teachers to support academic continuity of children with physical conditions.

2.6   Academic continuity and teachers

To manage a prolonged absence of children with physical conditions while providing a realistic learning program, arranging part-time school attendance as appropriate, additional tuition as well as supporting the pupil emotionally considering their context of classes full of other pupils, a significant teaching workload, and the expectations of anxious parents, can surely be overwhelming for a teacher (Wilkie & Jones, 2010). Within the school context, teachers are a major source of support for children, therefore it is important that teachers feel well equipped to respond to their specific needs. However, a few studies have found that teachers are ill-informed about a range of conditions and have particular difficulty knowing how to deal with emergencies, which may put the safety of pupils at risk (Close, 2000; Neuharth-Pritchett & Getch, 2001; Thacker *et al*., 2008 and Hinton & Kirk, 2015). They feel worried about dealing with the reactions of other pupils, the time involved in helping the child to keep up with school work, knowing how to discipline a child with a physical condition and dealing with the child's emotional reaction to their condition (Mukherjee, Sloper & Lightfoot, 2000).

Teachers are unclear about their involvement in medical care, though the DfE guidance (2015) states that teachers' conditions of employment do not include giving medication or supervising a pupil taking it, staff may volunteer to do this and should be given proper training and guidance. National guidelines developed to assist UK educational authorities to meet pupils' medical needs in schools (DfES, 2001; Scottish Executive, 2001; DfEs, 2005 and WAG, 2017), are ambiguous both in the guidance and in its interpretation (Mukherjee, Sloper & Lightfoot, 2001). Additionally, there is limited guidance from the Department of Health that suggest teachers may experience confusion about whether and how to include children and young people with health needs into the framework of the special education needs register (Mukherjee, Sloper & Lightfoot, 2001).

Hainault, (2013) asserts that unfortunately, there are no standard educational programmes and policies to support the academic continuity of children with physical conditions. Moreover, to have maximum attendance to ensure children' educational growth, if teachers do not offer help, this may lead to failure and frustration among these children. Therefore, it is vital for teachers to have awareness and appropriate training to support children' academic continuity.

2.6.1   Teacher training and information

To teach children with physical conditions teachers require training, for instance Initial Teacher Education (ITE) courses or In-Service Education and Training (INSET) to identify, assess and meet a child's individual needs (Hinton & Kirk, 2015). The official guidance on duties and good practice in schools related to pupils with physical conditions issued jointly by the DFEE and DoH in England has emphasised training of teachers to address minor and major medical situations for example, to give rectal valium to counteract and an epileptic seizure or to use a 'histostab' to reduce anaphylactic responses to acute allergies (Alcott, 2002). Despite this, in practice, training teachers in the special needs of children with serious medical conditions is a neglected area, both in initial training and in-service courses. Norris and Closs (1999) noted that teachers are poorly trained and ill-informed in terms of childhood diseases and in understanding the likelihood of medical emergencies arising in school. They suggest raising general awareness among teachers to examine their own presumptions, approach and fears about illness.

As a result of the changing status of educating children with physical conditions, school personnel particularly classroom teachers have a huge responsibility to provide specialized care, disease management and individualized instruction to these children (Duggan, Medway & Bunke, 2004). Prevalence rate estimations of physical illnesses among school aged children is difficult to determine accurately due to the differences in the types of conditions defined as physical conditions, variation in the severity of condition over time and because records are only kept on those in special schools (Duggan, Medway & Bunke, 2004). Neuharth-Pritchett and Getch (2001) have estimated that in any given year, a teacher is likely to have two children with asthma in his or her class. Becker, Johnson and Greek's (1996) research added that nearly three in four teachers feel unprepared to teach children with physical conditions. They do not have sufficient knowledge and expertise to handle healthcare procedures for diabetic children to do glucose monitoring or provide asthma

management, prosthesis care and mechanical ventilation to children with specific physical conditions in the classroom environment. Eiser (2000) states that almost all teachers have a child with a chronic condition in their class at some point during their careers. Few feel comfortable with the situation, younger teachers especially are unlikely to have any personal contact with sick children, and even less likely to have experienced any formal training about their needs. Children with chronic diseases require varying degrees of practical help during the school day. For example, at the simplest level, children with asthma may need to have access to their inhaler occasionally.

According to Duggan, Medway and Bunke (2004), presently there is substantial body of literature, especially that include studies conducted within the last 20 years, on how physical conditions impacts personal, family and school life and on how these conditions are best treated in home and medical environment. Whereas, up to early 1990s there was very limited research on physical conditions and school adaptations for children who attended school mainly because this research was not circulated to educators effectively as not many children with physical conditions attended school regularly. On the other hand, though the number of publications on physical conditions and its educational implications have increased the last decade (e.g. Power *et al.*, 1995; Worchel-Prevatt *et al.*, 1998; Closs, 2000 and Nabors & Lehmkuhl, 2004), yet these articles were not written for educational personnel and thus not read by them. Consequently, teachers are not prepared to deal with the challenges of children with physical conditions in the classroom (Frieman & Settel, 1994; Becker, Johnson & Greek, 1996; Johnson, 1998 and Mukherjee, Sloper & Lightfoot, 2000). Moreover, they may find it difficult to accept that for some children continual improvement may not take place, which may reduce their life expectancy and due to their progressive disease, they may eventually die. Teachers need to be able to address these challenges positively and sensitively, to be able to listen and work with children with life-threatening conditions and their healthy pupils (Leaman, 1995). The death of a classmate or a pupil is obviously a distressing experience, yet an experienced and trained teacher may discuss this issue wisely with the deceased child's classmates as they may have certain questions.

Wilkie's (2010) research has suggested that teachers show their concern about needing information about their pupils' health status. Mukherjee, Sloper and Lightfoot (2000) have indicated that teachers in the UK prefer to receive information and advice about pupils with special health needs by healthcare professionals but at the same time there is evidence that

contact between teachers and health professionals is low. Duggan, Medway and Bunke (2004) state that studies have shown that teachers want practical information, additional training in teacher education programs and specific information about working with the children with physical conditions, their families and medical personnel. They are also interested to get training to recognize early warning signs of illness, understanding the impact of a physical condition on growth, development, classroom instruction, to provide the best practice to these children.

To provide these specific skills to the class teachers, two approaches were described by Duggan, Medway and Bunke (2004). The first approach involves using external medical personnel as trainers, depending on school nurses or connecting professionals inside and outside the school. Whereas, the second approach involves training coordinated by the educators who work for the school districts. The later approach is recognized as a potential role for school psychologists based on their expertise in assessment, ability to diagnose and treat disorders and teacher consultation. Parkins (2012) affirms that the school psychologists can support the teacher training regarding physical conditions by providing educational material and consultation to teachers as required to meet the needs of their classroom, which helps to develop specific interventions for teachers who work with children with physical conditions. School psychologists can also provide useful information to teachers by working in close liaison with health care professionals. However, to date, no articles have appeared in which school psychologists have practised this on a reasonably large scale in their local districts, and therefore no models of practice exists. Whereas, research by Brown *et al.*, (2011) and Hinton and Kirk (2015) suggests that another source to provide educational training to increase teachers' knowledge of and confidence in dealing with medical conditions (physical and mental) could be the healthcare professionals such as school nurses, clinical nurse specialists and community paediatricians. As they have the relevant knowledge and expertise about these conditions and can work with schools and families on a one-to-one basis. The role of the healthcare professionals to provide information regarding a child's health is significantly important, which is repeatedly highlighted throughout this thesis considering the guidelines provided by WAG (2017) and DfE (2015).

Teachers may change their beliefs for sick children and redefine the purpose of school for them so that academic achievements are seen to be less important, as they are for healthy children. Dewis (2007) states that the more a teacher knows about a physical condition is affecting a child, the better equipped she/he will be to support that child and to empathize

with him/her. Parkins (2012) added that teachers who have formal knowledge and appropriate training about physical conditions can be an asset to these children and their families. As the teachers have an opportunity to spend extended time with these children in the classroom, they can encourage the family to focus on all the areas of their child's development rather than just their specific conditions and help their children to excel at the tasks they are good at. Their child's achievement in certain tasks will encourage families to have normality in their lives to some extent and see the success of their child instead of being limited by physical condition, merely. Therefore, schools should provide appropriate training to equip teachers to support education of children with physical conditions. Dewis (2007) emphasises another dimension stating that in fact, it is essential that all professionals who care for and educate children with physical condition develop sound knowledge and understanding of conditions affecting children for whom they have responsibility. He believed that every now and again the professionals caring for a child with a physical condition should reflect on what it must be like to live with that condition, as they should not overlook the extent to which the child's life may be affected by that condition.

Hinton and Kirk (2015) also underlined the importance of formal training programmes for all school staff who support children with physical conditions, so that they all have a precise understanding of their conditions, can identify the key signs and symptoms and know what action to take in an emergency. In addition, teachers also need to complete refresher training on a regular basis to ensure that they have an up-to-date knowledge. This training should be in accordance with the development of school policies and procedures which should be clearly communicated and agreed with school staff. This is because it is a statutory responsibility of a governing body of all the mainstream schools in Wales and England to ensure that their school has developed a policy for supporting children with medical conditions (physical and mental) that is reviewed regularly and is readily accessible to parents and school staff. In developing their policy, schools can take advice from any relevant healthcare professionals (DfE, 2015).

According to their guidelines regarding staff training, WAG (2017) and DfE (2015) state that the governing bodies should be responsible to commission and provide the staff training and how these training needs are assessed. Healthcare professionals can be a helpful source to identify to the school what type and level of training is required, how this can be obtained and confirm the proficiency of staff in a timely manner. School nurses can provide useful information on medical procedures or in providing medication. These training should focus

on enhancing the staff's confidence to support the children with medical conditions even in an emergency. All staff are required to participate in this training as a first aid certificate is not adequate to support this group of children. There are no widely available teacher professional development guidelines for teaching in online learning environments. Online professional development for teachers is one approach that was considered and trialed in the United Kingdom (DfES 2004) and was found most effective if it is tailored to teachers' specific needs (OFSTED 2002) (Jones, McDougall & Robertson, 2009).

It is discernible that failing to provide teachers with ongoing professional training and support in long-term condition management, including the correct procedures to follow in the event of a medical emergency, may have negative effects on the sick child (Hinton & Kirk, 2015). Thus, the immediate priority is to ensure that teachers can identify and respond quickly to medical emergencies because a delay in providing appropriate medical support can result in serious harm to or the death of a child. Affirming this Boden *et al.*, (2012) added that this confidence about their ability to deal with a potential medical emergency will enable teachers to encourage children with physical conditions to participate in extracurricular activities, such as school outings. The children's participation in extracurricular activities was emphasized in the past in the UN Convention on the Rights of the Child (UNCRC) (1989) and the Education Acts of 1944, 1981 and Equality Act 2000. That declared that all children have a right to be educated, including those with physical conditions. Further, the 1981 Act outlines that children with disabilities may attend school from aged 2 to 19 years (Noyes, 1999). The present guidelines by WAG (2017) and DfE (2015) have stressed that all the schools are legally liable to support children with medical conditions (physical and mental) so that they have full access to education, including school trips and physical education. These guidelines state that children with medical conditions (physical and mental) have the same rights of admission to school and to full-time education as other children. Therefore, the schools have a statutory responsibility to make arrangement for these children to accommodate their specific needs and ensure that implementation of policies, plans, procedures and systems are effective to support their wider safeguarding duties.

However, in mainstream schools, there is confusion among the educational professionals between differentiating the children with physical conditions and those with having special education needs, which leads to misconceptions as briefly reviewed in the following section.

2.7   Physical conditions and special education needs

Most children with physical conditions are educated in their local mainstream schools because usually their conditions are such that they can access the full curriculum if their individual needs are considered (Nabors *et al*., 2008). A small number of children with physical conditions may be educated in a special school but their physical condition is not generally their primary special educational need (SEN). Some children have long-term, persistent or deteriorating overt symptoms rather having shorter-term or inconsistent symptoms. Therefore, are considered as having special educational needs by some professionals, due to their lack of awareness about physical conditions and their impact on education. This is complemented by narrow and rigid understanding of the concept of special educational needs and its associated terminology (Closs, 2000).

Although physical conditions and SEN are conceptually different issues, in practice there is often overlap between them. SEN is defined as extra support required by a child or young person due to difficulty in learning by comparison with the majority of other children or young people of the same age for example speech, language and communication needs, behavioural, emotional and social difficulties and Autistic spectrum conditions (Williams, 2013). SEN also include specific learning difficulties such as Dyslexia and attention deficit hyperactivity disorder (ADHD), moderate learning difficulties, profound and multiple learning difficulties and multi-sensory impairment (Alcott, 2002). According to Jackson (2000), children are considered to have SEN if they are suffering from physical or sensory impairments and some may have medical needs arising from these impairments.

According to Closs (2000), educational professionals will consider children with physical condition and children with constant or deteriorating overt cognitive and physical impairments having SEN as for many of these professionals both belong to the same category. Closs (2000) claims, by contrast, that apart from a child's overt cognitive or physical impairment, his or her medical conditions are often not the same as SEN. This is because people have narrow views of SEN and its related terminology which also creates confusion in areas of overlap between illness and disability. Children with physical conditions are expected to experience identified difficulties such as fatigue, extensive absence from school and poor prognosis. This may reduce their functional capacity such as accessing educational provision as reported by the British Paediatric Association (1995) but does not indicate that the child's illness will lead to any disability or special educational

needs (Norris & Closs, 1999). According to Closs (2000), the key cause of confusion is in the varied understandings of 'learning difficulties' and 'learning disabilities'. This confusion does not leave room for educationists to give the appropriate consideration to the marginalized children with physical conditions. My thesis is not about this topic but it is important to recognize overlap and indicate the difference between learning difficulties and learning disabilities to highlight the widespread unawareness among education professionals about physical conditions and their impact on education.

Jackson (2000) and Alcott (2002) state that some professionals understand learning difficulties as some degree of cognitive impairment resulting in globally and constantly lowered performance. An example of this is William's argument (2013) that children have a learning difficulty if they have considerably greater difficulty in learning than the majority of children of the same age and which requires special educational provision. According to Burke and Cigno (2000), 'learning difficulties' is used in the UK policy document instead of the previous term 'mental handicap'. This term is considered so offensive by adults with learning disabilities that they regard it as a term of abuse. In the UK, children with disabilities are provided with special educational provision and by law have right to inclusive education (depending on the severity of their condition).

Whereas, learning disability is explained as a significant reduced ability to understand new or complex information and a reduced ability to cope independently (Burke & Cigno, 2000). Section 1(1), Disability Discrimination Act 1995 states that a person is considered to have a disability if he/she has a physical and mental impairment that has a considerable and long-term adverse effect on his/her capability to carry out usual day-to-day activities. According to Williams (2013), learning disability is not a medical condition but people with learning disabilities do have health care needs on occasion. It refers to a broad variety of individuals such as people with highest support needs who are unable to manage the basics of their life and need support round-the-clock people with 'profound or multiple learning disability' (PMLD), the individuals who have a series of impairments as well as profound learning disability and communication impairments and may also have complex medical needs. Another category, according to Williams (2013), is of the individuals who have 'moderate' or 'mild' learning disabilities who do not receive specific services and find some of the tasks of independent living difficult. Including all the above mentioned categories, there are over one million people with learning disabilities in the UK aged 15 and over and this

number is predicted to increase in coming years, presuming many with learning difficulties will not have physical conditions (Burke & Cigno, 2000).

A central question is whether children with learning disabilities are delayed in their development or do they present a different developmental pattern? Generally, children with learning disabilities display a slower rate of learning and it is important to recognize that aggressive and potentially damaging medical treatment of physical conditions affect children's academic abilities. Though educational interventions offer general approaches for children with different learning disabilities, they are not tailored for children with physical conditions, needing repeated hospitalizations (Eiser, 1993). The Special Educational Needs and Disability Act 2001 (SENDA 2001, DFES 2001) covers the children with a physical condition within its remit when their condition 'has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities'. All children do not fall within this description; still, schools have a duty to meet the needs of children with a physical condition (Closs, 2000). The child's physical impairment does not necessarily mean that he/she has special educational needs, in fact it is the child's educational needs rather than diagnosis that must be considered.

All children in the UK are entitled to school education, since education authorities are required to provide 'adequate and efficient' school education (Closs, 2000). For instance, the guidelines issued by WAG (2017) state that although the children with medical needs may have additional learning needs, a medical diagnosis does not necessarily imply that they have special educational needs as mentioned in the Education Act 1996. There is a possibility that a medical condition may increase the chance of developing a significant learning difficulty or sometimes a certain disability among these children, yet they should not be discriminated. If they may develop a special educational need, they may require a statutory assessment of their needs and appropriate academic arrangement should be made for them.

However, the existing policies do not define the specific nature of support to be provided as well as they lack an adequate framework to help teachers to provide academic continuity for children who are absent from school owing to physical conditions (Wilkie, 2012). Here, the available policies and guidance by Welsh and English governments are discussed briefly, in the light of issues raised in my research.

2.8   Available Acts and guidelines for supporting children at school with physical conditions

The WAG guidance 'Supporting learners with healthcare needs' March 2017 explains the support to be provided to children with medical conditions (physical and mental) in school. This guidance is for Local Authorities (education and social services functions); governing bodies of all maintained nursery, primary, secondary and special schools and pupil referral units (PRUs), parents and interested organisations. The heart of this guidance is to emphasise the need for continuity in education and the impact medical conditions can have on a child's education, health and well-being.

The DfE has also produced the statutory and non-statutory guidance for 'Supporting pupils at school with medical conditions' in England on 1 September 2015 to support schools in implementing their duties in respect to Section 100 of the Children and Families Act 2014. The guidance is for maintained schools, Pupil Referral Units (PRUs) and academies in England but does not apply to Early Years settings and independent schools. Based on good practice and in meeting the duties under section 175 of the Education Act 2002, these guidelines have placed a duty on the governing bodies in schools in Wales and England to arrange support for children at school with medical conditions (physical and mental) that affect the pupil's quality of life and may be life-threatening. The focus is to assure that the needs of each individual child are met and the impact of their condition on their school life is well-thought-out (WAG, 2017 and DfE, 2015).

2.8.1   Developing the school's policy

As stated in the guidelines issued by WAG (2017) and DfE (2015), individual schools should develop their own policies to cover the needs of their own school. It is the responsibility of governing bodies to ensure that all schools have developed a written policy for supporting children with medical conditions which is regularly reviewed and is accessible to parents and school staff. It is helpful to seek relevant healthcare professionals while developing this policy. Moreover, the head teacher has an overall responsibility to implement the policy such as arranging suitable training for staff, necessary equipment and space provision, and funding for appropriate effective implementation of the guidance (WAG, 2017 and DfE, 2015). The guidelines by WAG (2017) further suggest this policy is not expected to be lengthy or complex or cover every possible medical condition, but it should have a broad and relevant approach to the local authority or individual education

setting. It will need to be available in the schools' prospectus or online for parents and learners to read but not contain any personal or confidential information. This is interesting to note that WAG (2017) guidelines has emphasised an overall well-being of a learner as the governing bodies have a statutory duty to meet the needs of a child with physical conditions, including providing them access to information and material aimed at promoting spiritual and moral well-being and physical and mental health. The schools are advised to intervene in line with the education setting's policy in case of bullying issues and emotional well-being.

Accordingly, it is encouraging to view personalized policies for supporting pupils with medical conditions, tailored according to their pupils' needs and the support available for them. These policies are available for all the staff members, parents and other education professionals. As according to the guidelines issued by WAG (2017) and DfE (2015), schools, local authorities, health professionals and other support services should work together to provide effective education within and outside the school to children with medical conditions and consider their reintegration back into school after periods of absence.

According to the WAG (2017) and DfE (2015) guidance, supporting children at school with medical conditions (physical and mental) is the responsibility of a team of experts, whose roles are briefly presented in the following section.

2.8.2   Roles and responsibilities

Schools are under a safeguarding duty, under section 175 of the Education Act 2002 to investigate any unexplained absences by their pupils. According to the guidelines/policy regarding the role of governing bodies, WAG (2017) and DfE (2015) state that the governing bodies should ensure that the roles and responsibilities of all those staff supporting children with medical conditions are identified as it is not a responsibility of one individual but requires collaborative work by school staff, healthcare professionals, local authorities, parents, children and social care professionals. These guidelines emphasized having multi-agency arrangements made between education settings, healthcare professionals, social care professionals, local authorities, parents and learners. Healthcare needs policies and procedures should identify the collaborative working arrangements and demonstrate how they will work in partnership to meet the needs of children with physical conditions. Whereas, the head teacher is legally responsible to ensure trained staff are

available to deliver IHCPs, handle emergency situations and administer medicines of children with medical conditions. They should also make sure that information and other support materials are accessible to all the staff members as any member of staff may be asked to provide support to children with medical conditions, although they cannot be required to do so.

The guidance by WAG (2017) and DfE (2015) emphasized that local authorities and governing bodies can work together to ensure children with physical conditions and school staff has effective support in school. Local authorities (LAs) must make arrangements to promote cooperation between different bodies to improve the well-being of children in relation to their physical and mental health, their education, training and recreation. This influenced my thinking on this matter about taking extra precautions by developing agreements between the concerned stakeholders. WAG (2017) has made it clear that local authorities can ensure appropriate agreements are in place for data sharing, while making such arrangements. This could be through working within the Wales Accord on Sharing Personal Information (WASPI) Information Sharing Protocols or Data Disclosure Agreements. Local authorities and health boards have WASPI coordinators who can support service providers to develop appropriate agreements.

Subject to this point, there is no legal or contractual duty on staff to administer medicine or supervise a pupil taking it as this is a voluntary role. Support staff may have specific duties to provide medical assistance as part of their contract. However, Circular 14/96, para 14, DfEE (1996a) gives the following advice that teachers and other school staff have a common-law duty to act as any reasonably prudent parent to ensure children are healthy and safe on school premises and in some circumstances, they are expected to administer medicine and act in emergency (Coutler *et al*., 2016).

The role of the Local Authority is to provide education otherwise than at school (EOTAS) i.e. to provide tuition of 5 hours per week, at home or in hospitals, where the illness of the child indicates prolonged or reoccurring periods of absence from school (WAG, 2017). The provided education should be of a similar quality to that available in school, including a broad and balanced curriculum. The statutory role of the LA is also to ensure that teachers have access to a range of in-service training to support children with medical conditions (physical and mental). The LA should also closely liaise with the Education Welfare Officers (EWOs), who are the named responsible individual by the school to analyse

medical absences regularly as well as local authority support services, education psychologists and PRUs (WAG, 2017).

Similarly, according to the statutory guidance from DfE (Statutory guidance for local authorities, January 2013) local authorities (LAs) must arrange suitable full-time or part-time education (depending on the child's needs) for children who are unable to attend a mainstream or special school due to their health conditions. This duty is applied to all children who would normally attend mainstream schools, including academies, free schools, independent schools, special schools and where a child is not on the roll of a school. Moreover, this duty is applied to LAs even if a child cannot attend school at all or can only attend intermittently. This means that where a child cannot attend school because of health issues and would not otherwise receive a suitable full-time education, the LA is responsible for arranging provision and must have regard to this guidance.

The guidance by WAG (2017) and DfE (2015) have underlined that LAs should set up a personal education plan for these children that ensures that the child's school of origin, the LA and the hospital school can work together as a team. This plan declares how much education will be appropriate for a child after he/she is discharged from the hospital, when that child is ready to return to school and initially whether he/she should attend school on a part-time basis only.

Section 7 of the Education Act (1996a) places a duty on parents to ensure that their child of compulsory school age receives a suitable education either by regular attendance at school or otherwise. In other words, the parents have a statutory duty to inform school about their child's absence owing to a physical condition but they are not responsible either in the Education Act nor in guidance statements for teaching their sick child or to collect work from school to teach the child by themselves at home.

WAG (2017) and DfE (2015) guidance state explicitly about the managing of medicines and emergency procedures in school to support children with medical conditions (physical and mental), as briefly discussed below.

2.8.3   Managing medicines and emergency procedures on school premises

The guidelines by WAG (2017) suggest governing bodies to be ensured that every education setting is clear regarding its policy and procedures to follow for managing medicines and devices. Storage, access and administration procedures will always be contextual to each

education setting and the requirements of children with physical conditions. However, they shall reflect following general principles such as they must not store surplus medication as parents should be asked to provide appropriate supplies of medication. These medications should be in their original container, labelled with the name of the child, medicine name, dosage and frequency along with the expiry date.

The guidance provided by WAG (2017) suggests that there is no legal or contractual duty on staff to administer medication of children with physical needs, as it is a voluntary role. However, the staff members who voluntarily administer medication should be supported by the head teacher and have been provided with suitable training regularly. These guidelines underlined that the supply, possession and administration of some medicines are controlled by the Misuse of Drugs Act 1972 and its associated regulations. WAG (2017) and DfE (2015) guidance emphasized that no child under 16 should be given prescription or non-prescription medicines without their parents' written consent. Children should know where their medicines are stored and be able to access them immediately or otherwise should know who holds the key to the storage facility. The staff should monitor a child who has been prescribed a controlled drug and have it in their possession, so that they should not pass it to another child for use, as this is an offence.

The schools should have clear individualized policies and procedures for resuscitation care of children with medical conditions (physical and mental). All staff members should know who is responsible for carrying out emergency procedures in the event of need which should be included in the individual health care plans (WAG, 2017). The IHCPs should clearly outline what constitutes an emergency and explain what procedure to follow in that case. If a child is taken to hospital, staff should stay with the child until the parent arrives or accompany a child in an ambulance while the child is being taken to hospital (WAG, 2017 and DfE, 2015). In case of emergency an ambulance should be called but staff should never take an ill child to hospital in their own car, as it may put the child's life at stake (WAG, 2010). Moreover, should the staff voluntarily go with the child in an ambulance to hospital, his/her personal circumstances should be considered. Staff should only be expected to commit their time outside of normal working hours to stay with a child if they are willing and able to do so.

Governing bodies should ensure that their schools have kept written records of all medicines administered to children (DfE, 2015). It is important to keep records not just for the child

with medical conditions but also for the member of staff who is administering the medicine or providing medical support. As staff can be accused of negligence for failing to follow the school policy, carry out procedures correctly or breaking confidentiality, which authorize the employer to take disciplinary action against that staff member. According to the guidelines regarding record keeping, WAG (2017) state that it is a good practice for staff to complete and sign record cards each time they give medicines to a child as it is safe practice to have the dosage administration witnessed by a second adult.

After children's prolonged absence from school, it is important to consider their reintegration by taking advice from school staff, health professionals, parents and the children themselves. Here the real challenge for the professionals is to make their reintegration process as smooth as possible because these children may have experienced physical and emotional trauma and may not be ready for a change in their hospital/home routine. Therefore, coming back to school may be stressful for them due to all sorts of reasons however, being unique individuals every child copes differently with their school re-entry, which is discussed in the following final section.

2.9   School re-integration

Attending school regularly has far more benefits than receiving education at home or in hospital as school provides opportunities for peer relationships, support, friendship and a source of normality and functioning both in parents and in children (Capurso, 2014). Indeed, the incidence of school refusal among children who have medical conditions (physical and mental) is up to five times greater than the rate among the general population (Shiu, 2001).

There is empirical evidence that children can find the return to school difficult after diagnosis or long absences (Eiser, 2000; Closs, 2000; Coutler *et al*., 2016 and Boonen & Petry, 2012). The moment of re-entering school is critical to determine the future quality of school life of children with medical conditions (physical and mental). Yet these children may be reluctant to return to school due to school phobia, physical changes, depression or anxiety and may be worried about teasing and social rejection due to mis-conceptions among peers concerning the conditions that they are contagious and anxiety over physical changes intimidating their body image and self-esteem (Madan-Swain, Katz & LaGory, 2004).

Children are accounted for by school absences, creating difficulties with school work and slowing academic progress. Despite the growing awareness of the necessity of education for children with physical conditions and the barriers that they face regarding school re-entry, there is still little empirical research available addressing programmes that facilitate smooth school re-entry. Boonen and Petry (2012) state that much attention has been paid to school reintegration programmes in the literature, to remove these barriers such as meeting the unique needs of the individual child, extra explanations during the lessons or assistance with assignments and homework, given by the class teacher or classmate, and ensuring continuing academic and social skill development by adapting the school environment and encouraging parents to effectively promote their children.

Eiser's (2000) research with parents of children with prolonged absence owing to medical conditions (physical and mental) indicated that most parents felt that the school staff had been helpful in re-integrating their child into classroom, the remainder had experienced unhelpful behaviour from school staff. Teachers' behaviour that was judged to be helpful included caring, treating the child as normal, giving special academic help and keeping parents well informed about what was happening in the classroom. Unhelpful behaviours included insensitivity, over protectiveness and refusing to acknowledge the reality of the situation, (telling parents that everything was fine). Differences between teachers in terms of the extent to which they were judged to be helpful were unrelated to the age of the children (Eiser, 2000). However, the staff that undertake training in the more straightforward procedures become experienced and accept an additional role for the child's well-being in the school (Closs, 2000).

Schools have a key role to play in ensuring successful reintegration of the children with prolonged absence owing to medical conditions (physical and mental). According to Shiu (2004b), some of the positive strategies and best practices in schools are to make major physical adjustments and modification on a larger scale to enable the child to access the classroom or school easily such as installing lifts in the school. Physical support for children with physical conditions may involve significant structural and material adaptations, including physical therapy equipment, assistive mobility and improved accessibility for children with disabilities and life support equipment (Shaw & McCabe, 2008). However, some supports are relatively minor in terms of cost and inconvenience, such as provision of specialist equipment for seating, computers and other material to aid learning, additional quiet space to complete work, cot availability for brief naps to overcome the fatigue of a

long school day, use of partitions to reduce distractions and potentially embarrassing situations from classmates and delivering medications to the classroom/or outside the classroom to minimize out-of-class time. Moreover, provision of facilities or private areas within the school for medication or changing with dignity, flexible school timetable to provide alternative activities to accommodate physical needs during sport, recess and lunch breaks, dietary support by canteen staff and availability of more time to complete work and assignments are some other approaches a school can adopt. Even common disorders such as allergies and asthma may require some physical and academic accommodations such as reduced activity in physical education classes or late or extended school day to overcome the fatigue and other complications associated with those conditions (Shaw & McCabe, 2008).

It is important for school staff to understand that the assistive devices and medical technologies that may prolong a child's life can significantly affect the lifestyle of that child and operate as a repeated reminder that the child is different from his or her peers (Shaw & McCabe, 2008). School re-entry for some children may be delayed or constrained due to the inability of the school to provide necessary daily health care, efficient emergency procedures and dependable medication administration. The knowledge and attitude of school staff and the availability of health care resources are significant factors that influence the ability of children to cope successfully and overcome challenges in the school. Consequently, if they do not return to school in the early stages of their illness, they may find reintegration more perplexing (Shiu, 2004b). However, Shiu (2001) further states that most children with physical conditions return to their classrooms without any program medication to enable them to catch up with their peers. Still, for many children, falling behind and needing to catch up on missed work will result in anxiety, placing additional strain on an already physically and emotionally fragile body, which may further interfere with their cognitive skills and their ability to concentrate. School can support the educational continuity of children with physical conditions by designing programs that integrate their health and educational needs. This practice will be helpful to give rise to an educational community that will have financial, physical and human resources to meet their academic, social, emotional and physical needs (Hainault, 2013).

According to Coutler *et al*., (2016), depending on the condition and ability of a child, he/she should be encouraged to self-manage in Key Stage 2. The children should be encouraged to implement their cleansing and changing routines independently, with oversight for

emotional support and guidance. Some children respond well to using an alarm on their wrist-watch, to alert them to the time to go to the toilet. It is hoped that independence will have been achieved well before secondary school transfer. Peer pressure plays an important role with older children, who become anxious if anybody knows about their condition. It is significant to maintain the dignity of the children all times to help them achieve their academic ambitions to the best of their abilities.

However, Capurso (2014) suggests the best way to cope with such problems is to arrange a school reintegration programme that considers several aspects. For example, a doctor or a hospital teacher may accompany the child back to class and meet schoolmates and teachers to listen to their concerns to share proper information with them. Another way could be using mediators such as photographs, medical equipment and puppets to convey a message to the staff or schoolmates. Nevertheless, it should always be taken care of that every child is different so may have to share different amounts of information at school. It is recommended that parents should be actively involved in all the steps of the reintegration process (Capurso, 2014).

Provision of academic continuity is important to assist children to keep connected to their peers and education. This could be managed by helping them catch up with missed school work through tutoring and peer programs, returning work to school for marking during absence, assistance with preparation for exams, ongoing monitoring of pupil's progress including assessment of learning needs and individualized instructional programs (Shiu, 2001, 2004b). The school should create an ongoing caring environment in the classroom, encouraging children to maintain friendships with diverse children and enrich their social skills through cooperative learning structures. It should facilitate and enhance children's self-esteem and empathy toward others and should also facilitate ongoing communication between the home, school and medical personnel. Contact by friends during absence, for example, cards, letter, videos and invitations to school events are as important as formal contact. For some children reintegration is a gradual process over a period therefore, they should be provided with flexible arrangements such as attending school part-time while retaining some other support (WAG, 2017). Home tuition also helps in a smooth school re-entry as it keeps children in touch with their classmates during absence. Moreover, it is important for teaching staff providing home tuition to be aware of their role in reintegrating these children as soon as possible. The guidelines by (WAG 2017) also emphasized that

local authorities should ensure education welfare officers understand their role in relation to facilitating reintegration for children with physical needs.

However, it is significant to highlight here that the statutory guidance for local authorities (DfE, 2013) specified that when a child's reintegration into school is probable, LAs should work with the school, hospital school and home tuition service to plan for constant provision during and after the period of education outside school. LAs should make sure that children during absence are in touch with the school continuously and can access the curriculum and materials that he/she would have used in school such as receiving school newsletters, emails, invitations to school events or internet links to lessons from their school. LAs should coordinate with schools to set up an individually tailored reintegration plan for each child. When the child is likely to be absent for a lengthy period, this reintegration plan may only be outlined nearer to the likely date of return so that an unsuitable pressure on the child can be avoided. Though most children want to return to their previous school routine at once, yet some need gradual reintegration over a longer period (DfE, 2013).

Summary

This chapter has considered the literature on physical conditions, its effects on the academic achievement of the children and academic continuity provided by the mainstream schools in Wales and England. It has also discussed issues around teachers training to provide academic continuity as well as reintegration of children with physical conditions in relation to the Welsh Assembly Government (WAG) 2017 and Department for Education (DfE) guidelines 2015.

This literature review has led to the formulation of the aim and the research questions of the current study and to the identification of data collection and analysis methods all of which will be discussed in the next chapter.

CHAPTER 3   RESEARCH METHODOLOGY

3.1   Introduction

In the previous chapter a review of the relevant literature was presented. This chapter gives details of the rationale, which guided me to formulate the research questions and methods to collect data which would respond to these questions. Firstly, it explains the ontological and epistemological positions which underpin this research, followed by the justification of data collection techniques, incorporating developing and piloting the research instruments and later explains the data analysis methods. It also includes a discussion of ethical issues which were considered during this research.

3.2   Research Questions

School is an environment that provides pupils with opportunities to learn, interact with peers and adults and experience success. At the same time, it is a place where these children are confined by their illness. For instance, children with a hip replacement may undergo numerous operations or may be hospitalized repeatedly, which may lead to lower self-esteem as well as feelings of rejection and isolation (Belgrave, 1998). According to Roberts *et al*., (2005), children with physical conditions experience extensive psychological difficulties, which impact their development and functioning negatively. For example, many of them may experience embarrassment, low self-confidence, anxiety, medical fear, regression, school phobia and behavioural maladjustment.

Presently there is substantial body of literature, especially that included studies conducted within last 20 years, on how physical conditions impacts personal, family and school life and on how these conditions are best treated in home and medical environments. Whereas, up to early 1990s there was very limited research on physical conditions and school adaptations for children who attended school mainly because this research was not circulated to educators effectively as not many children with physical conditions attended school regularly (Duggan, Medway & Bunke, 2004).

In 1997, two separate but parallel research studies by Angela Bolton in England and Wales '*Losing the thread: Pupils' and parents' voices about education for sick children*' and Alison Close with Claire Norris research in Scotland '*Outlook uncertain: Enabling the education of children with chronic and/or deteriorating conditions*', emphasized educating

children with physical conditions in mainstream schools (Bolton, Closs & Norris, 2000). Both studies used qualitative methods, using case studies and loosely structured interviews with parents, children and health professionals. These studies shifted the scope of attention much more towards education authorities and additional specialist services, providing education to these children in mainstream schools rather than in special schools, for which they have a right to.

Considering mainstream primary school, my research has studied the opinions of teachers and other educators about the provision available for children who miss more than 50% of school over a three months' period due to a physical condition. The research question for this thesis originated from my own experience as a mother of a precious child with a physical condition. As outlined in the introductory chapter, this study aims to provide a more comprehensive description of the ways in which teachers and educational professionals in Wales and England provide academic continuity to the children in Key Stage 2 with physical conditions during their prolonged absence.

All research is based on some underlying philosophical assumptions that constitutes appropriate research methods for the development of knowledge in each study. To conduct and evaluate any research, it is therefore important to know what these assumptions are. The next section discusses the philosophical assumptions and the design strategies underpinning this research study. Ontological and epistemological paradigms were reviewed and presented, the post positivist approach was identified for the framework of the study.

3.3   Research paradigms and approach

Research paradigms guide the researcher to make significant decisions to carry out the research. According to Kuhn (1962), a research paradigm is an agreed set of common beliefs which is shared by all scientists about how problems should be understood and addressed. According to Guba (1990), research paradigms can be characterised as ontology, epistemology, theoretical perspective, methodology and sources. Crotty (1998) states that a researcher can choose which phase to begin at, ontological, epistemological, or methodology. Whereas, other authors like Grix stress that research is best conducted by identifying one's ontological assumptions first. Grix (2004) states that thinking carefully what a researcher believes can be researched (one's ontological position), combining it with what he knows about it (one's epistemological position) and how to attain it (one's methodological position), a researcher can begin to understand the impact his ontological

position can have on what and how he decides to study. In other words, one's view of reality and being is called ontology and the view of how to acquire knowledge is called epistemology (Mack, 2010).

3.3.1   Ontological position

Grix (2004) defines ontology as the study of "claims and assumptions that are made about the nature of social reality, claims about what exists, what it looks like, what units make it up and how these units interact with each other" (p. 59). Simply if a researcher studies ontology they study what we mean when we say something exists.

In terms of education, ontology is the philosophical study of the nature of educational reality and different perceptions of what is known. The researcher's ontological position therefore shapes decisions about the research approach, depending on whether he perceives an external independent reality (positivist) or an experienced, constructed reality based on social or individual conception (interpretivist/constructivist) (Mack, 2010). The perspective I have taken has guided me to consider a post-positivist approach which tends to incorporate interpretivist methods; using mixed methods i.e. applying a quantitative method to conduct objective and measurable study and a qualitative method to incorporate a subjective and interpretative study. Therefore, as Oliver (2010) states the researcher's ontological perspectives is 'closely related to issues of how we decide to collect our research data…they are intimately linked to the basis upon which we think we know something to be true' (p.34).

From this ontological perspective, therefore, the focus of this research is not research participants' perceptions, nor indeed the children with physical conditions, but the relationship between the two. In other words, considering physical conditions as reality and investigating educators' perceptions about their interactions with children during their absence from full-time school attendance owing to a physical condition.

3.3.2   Epistemological position

Epistemological and ontological questions are related since former claims about what exists in the world and latter claims about how what exists may be known (Usher, 1996). The ontological assumptions inform the epistemological assumptions which inform the methodology and these all give rise to the methods employed to collect data for this research.

According to Gall, Borg and Gall (1996), "epistemology is the branch of philosophy that studies the nature of knowledge and the process by which knowledge is acquired and validated". It studies the relationship between the researcher and the known phenomena as deals with the significant question how do someone knows the reality? In this research, I came across this reality through my personal experience (as mentioned above), reading literature and asking research participant's opinions about their interactions with children during their absence from full-time school attendance owing to a physical condition. King and Kitchener (1994) state that epistemology helps to understand how individuals evaluate new information, make important decisions and solve problems that affect their lives and the lives of others.

Epistemology is one's perceived relationship with the knowledge that one discovers rather being a part of it or independently. The researcher's view will frame his/her interaction with what he/she is researching and will depend on his/her ontological view. My approach, for example, is objective as I see knowledge governed by the law of nature (physical conditions) and subjective as I see knowledge as something interpreted by individuals (research participants), which in turn has affected the methodology of this research.

3.3.3 Research approach

Initially a positivist approach was considered to be suitable for my study as it leads to meaningful and in-depth understanding of the research questions. According to Morehouse (2012, p.9), Positivism argues that 'we construct our realities from our tacit understanding and tangible experience'. Hence this philosophical approach prevents the researcher from involving individuals' own ideologies and values. Moreover, it requires a research methodology that must be objective and scientific.

Cohen, Manion and Morrison (2000) state that a positivist approach does not consider one's unique ability to interpret one's experiences and represent them to him or herself, despite being the one himself who assimilated the knowledge. Subsequently it misses the whole point of significance of values, informed opinion, moral judgements and principle. Consequently, this approach is not suitable for my research as my research considers the opinions of teachers and interviewees where their responses would be subjective and it is unlikely that any participant could be entirely objective.

I therefore decided to opt for a post-positivist approach with my study, as it claims that, though the object of inquiry is outside and independent of the human mind yet it cannot be perceived with total accuracy by one's observations (Philips, 1990 cited in Greene). Therefore, complete objectivity is nearly impossible to achieve. Post positivist focus on experimental and quantitative methods which can be complemented by qualitative methods to gather information in broader perspective (Gephart, 1999). This research has used the generic post-positivist approach which has incorporated interpretivist methods. These methods comprised both quantitative and qualitative techniques (questionnaire and semi-structured interviews), to address any question from different perspectives, by combining their strengths (Johnson, Onwuegbuzie & Turner, 2007).

3.4 Research Methodology

Kennedy and Lingard (2006) state that post positivism acknowledges that truth is gained gradually through the research process, using a variety of research methods. My approach in this research was using broadly mixed methods incorporating qualitative and quantitative tools for gathering my data.

In the first phase I began the research by collecting and analysing quantitative data from questionnaires. The specific results connect to the second phase, i.e. qualitative phase which describes additional information such as what is happening, particularly in the little-understood situations, to seek new insights, to ask questions and to access phenomena in a new light to assess trends and relationships with quantitative data (Creswell & Clark, 2011).

I have used a mixed methods approach as qualitative methods consider both breadth and depth whereas quantitative focus on both causality and meaning. The quantitative research focus on deduction, prediction, standardized data collection and statistical analysis and the heart of qualitative research is induction, discovery, theory generation, data collection and qualitative analysis (Johnson & Onwuegbuzie, 2007). Mixed methods research (MMR) is a third research paradigm which does not replace qualitative and quantitative research but achieves more by combining the strengths of both methods and minimising their weaknesses (Johnson & Onwuegbuzie, 2004). According to Creswell and Clark (2011), in MMR the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study. Due to this reason MMR approach is particularly suited to this piece of research as the use of qualitative and quantitative techniques provide a better understanding of the problems addressed in this research than

either approach alone. For example, regarding the question about the effects of prolonged absence on children's learning, the respondents only agree or disagree to the statement which does not explain the reason to their response. But when the same question was asked to the interviewees, besides their agreement or disagreement, they explained their responses and shared their experiences with this group of children.

According to Morehouse (2012), the inclusion of qualitative and quantitative methods in the same study is important but how these methods of data collection and analysis are combined is even more significant. Yanchar and Williams (2006) have provided some important parameters for combining data from quantitative and qualitative sources. According to them the researcher should be sensitive to the context as well as creative to formulate questions and solve problems. The researcher should also be informed about theoretical and historical sources about their area of interest to combine qualitative and quantitative data coherently. Therefore, "questions, methods, practices and interpretations should fit strategically within some larger purpose" (Yanchar & Williams, 2006, p.9). By combining these two methods I was conscious that they might be contradictory and finally the critical reflection is well integrated to present qualitative and quantitative data with coherence.

This study used two data collecting techniques i.e. questionnaire and semi-structured interviews. The different sources of information were used to compare and integrate qualitative and quantitative methods, thus to enhance the validity of a study (Patton, 2002 and Creswell & Clark, 2011). The details of these two data collecting techniques are provided in section 3.7.

Being a post-positivist researcher, the information I collected from research participants was related to their personal experiences, which certainly involves their subjectivity (Ryan, 2006). Subjectivity and researcher's positionality is briefly elaborated in the following section.

3.4.1 Subjectivity

Subjectivity is an essential part of a researcher's thinking that is 'conditioned' by his/her educational background, personal feelings, assumptions, interpretations, beliefs, experiences and skills rather than on external facts (Kumar, 2014, p.7). Clark (1994) states that in a qualitative study personal, judgement-based nature of inquiry is inevitable' (p.88) as one's subjectivity and perspective of how he/she views reality is reflected in one's study.

A sound methodological framework of qualitative research develops an understanding of the implicit subjectivity (Morgan & Drury, 2003). In this research, using qualitative research methods (semi-structured interview) has provided me an access to the lived reality of research participants to know their individual opinions. This is referred as 'conscious partiality' by Mies and Vandana (1997, p.34), that brings the researcher closer to the actual reality of participants' experiences. This interaction between me as a researcher and interviewees was fundamental element for data generation as it is means of getting closer to the experiences of interviewees in different schools of Wales and England, to view reality in their individual context and from their own perspectives (Morgan & Drury, 2003).

3.4.2 Positionality

Positionality provides a relationship between the context and the potential research population (Burton, Brundrett & Jones, 2008). A researcher's positionality not only shapes his own research but also influences his interception, acceptance and understanding about the literature he reads for that particular research (Bourke, 2014). As Smith (1999) states "…objectivity, authority and validity of knowledge is challenged as the researcher's positionality…is inseparable from the research findings" (p. 436).

Positionality also defines the researcher's opinion regarding the research he/she is conducting. The researcher's opinion is influenced by his values and beliefs such as religious faith, gender, geographical location, culture, experiences and so on (Burton, Brundrett & Jones, 2008). For example, being an international student from Pakistan, I always observed different cultural perspectives for education in the UK and in Pakistan. In the former country (UK) children with disabilities are provided with special educational provisions and have a right to inclusive education (depending on the severity of their condition). Whereas, in the latter (Pakistan), ironically the concept of inclusion is not taken as its literal meaning rather is taken as integration as the focus is on keeping children with physical conditions within mainstream school but in separate classrooms (UNICEF Report, 2003). My experience, values and beliefs may affect my point of view which does not mean that they lead to a specific perspective (Bourke, 2014) that the whole meaning of inclusion is what I know through my experience.

Examining one's positionality in the research process is called reflexivity. Reflexivity is a continuous means of self-analysis (Callaway, 1992) as the researcher is consciously aware of the relationship between himself and the truth. As a researcher, I must acknowledge who

I am as an individual, as a member of a group and as I exchange social positions (being a researcher or a mother). Reflecting on the research process in the context of positionality, I realized that my positionality is not a limitation. But this research is shaped by who I am and if I remain reflective throughout the process, I will be shaped by it and voices of those who has participated in this research.

The research methodology guided me to design this research, which is presented in the following section.

3.5   Research Design

The research design was non-experimental as it did not involve a manipulation of the situation and experience of the participants but focused on interpretations of descriptive questions and was complemented by qualitative analysis (Johnson & Onwuegbuzie, 2004). The identified variables in this research are prolonged school absence, communication with children during prolonged absence, means of support to provide academic continuity, communication with health professionals and barriers to education of children with physical conditions. I have taken into consideration the relationships in/between these variables but have not manipulated them (Ary *et al*., 2014).

3.5.1   Participants

Using stratified sampling technique, (Cohen, Manion & Morrison, 2000) the sample of the study was drawn from mainstream primary school teachers who teach Key Stage 2 across Wales and England. Teachers identified the pupils of Key Stage 2, who have had a prolonged absence as a result of a physical condition. In this study, prolonged absence is taken as the children who have missed school approximately 50% of time over the past six months (three months roughly). Whereas, children whose physical condition is associated with a cognitive deficit (e.g. a head injury) and emotional conditions are taken as outliers, hence excluded from the study to avoid respondents' potential confusion.

The variety of research participants from Wales and England, performing variable responsibilities in their unique roles participated in this research. The questionnaire respondents' demographic information and the role of the questionnaire respondents in their school is presented in the table 3.5.1 (a), however 06 respondents did not indicate their roles in this section.

Role of the participants	Number of the participants	Percentage
Class teacher	15	33%
SENCO	10	22%
Principal/Head teacher	8	18%
Teaching assistant	6	13%

Table 3.5.1 (a): Results of the question "What is your role within the school?" (n=39)

Whereas, the details of the interviewees, their roles, the date of their interviews and their geographical areas are briefly described in the following table.

	Original roles	Areas
Interview 1 16.09.2016	Primary school SENCO	South Wales
Interview 2 23.09.2016	Acting teacher in-charge Enhanced mainstream primary schools (EMS)	North England
Interview 3 23.09.2016	Primary school SENCO	North England
Interview 4 30.09.2016	Primary school SENCO	South East England
Interview 5 09.12.2016	Primary school SENCO	North Wales
Interview 6 10.10.2016	Education social work team manager	North Wales
Interview 7 24.09.2016	Advisory support teacher (physical medical team and inclusive education service)	North East England

Table 3.5.1 (b): Details of interviewees

Hence there were 52 research participants, 45 questionnaire respondents and 7 interviewees. These professionals had experience of teaching the children with physical conditions and most indicated their willingness to be contacted again in the near future.

Biesta (2012) states that the origin of mixed methods research is developed from the notion 'Triangulation' that merges the evidence collected by two or more methods to enhance the strength and validity of research findings (Burton, Brundrett & Jones, 2008).

3.5.2   Triangulation

Triangulation is a strategy used to establish concurrent validity in research by using multiple methods, theories and data and by looking at the same issue from different perspectives (Basit, 2010). It combines methods from both the approaches i.e. quantitative and qualitative and uses them to explain the complexity of human behavior in depth (Cohen, Manion & Morrison, 2000).

To Basit (2010) the two main types of triangulation that concern an individual small-scale piece of research are methodological and sample. Sample triangulation comprises collecting data from several different individuals or groups. Whereas, methodological triangulation is defined as the use of two or more methods of data collection in the study of some aspect of human behavior (Cohen, Manion & Morrison, 2000).

In this research, I have used both sample triangulation as I requested information from both teachers and educational professionals (please see Table 3.5.1a). In addition, I also used methodological triangulation as I utilized two different methods to obtain my data i.e. questionnaire and semi-structured interview. Biesta (2012) state that using sample/data and methodological triangulation together increase the chances of reliable and valid results. For example, when respondents and interviewees produce the same description of effects of physical conditions on academic outcomes and respond similarly to a question asked on three different occasions, one has evidence of creditability (Ary *et al*., 2014). Mathison (1988) argues that the challenge using triangulation is how it can produce results which are consistent or inconsistent. Being a post-positivist researcher, using different methods I have considered this an opportunity to study the "unpredictable and contradictory nature of human experience" (Giddings & Grant, 2007) to produce valid conclusions (Mathison, 1988).

3.5.3   Credibility in qualitative research

Validity and reliability both can be applied to quantitative and qualitative research, though it varies how they are addressed in the two different research approaches (Cohen, Manion & Morrison, 2000). To explain validity and reliability and in response to the criticism by positivists, qualitative researchers such as Guba has used different philosophical/paradigm approaches for example a) credibility is used (in preference to internal validity); b) transferability (in preference to external validity/generalisability); c) dependability (in preference to reliability); d) confirmability (in preference to objectivity) (Shenton, 2004). Qualitative researchers are not only aware of the criticisms typically made by its sceptical but they are also aware of the requirements which can be made to address matters such as credibility, transferability, dependability and confirmability. Being a researcher I can then assess the extent to which I am able to apply these generic strategies to my particular investigation.

In this research, I am considering credibility (in preference to internal validity) as it deals with the question 'how congruent are the findings with reality'? (Shenton, 2004 p. 64) as well as it is the foremost important factor in determining trustworthiness of a research. The use of Mixed methods research provided enriched data to this current study, which also added to the credibility to it as the same methods were employed by other researchers in similar type of researches, for example Wilkie (2010), Wilkie and Jones (2010), Boonen and Petry (2012) and Wadley *et al*., (2014).

To ensure credibility of the current research, I incorporated certain strategies to uncover deliberate lies, for example I used probes in semi-structured interview to elicit data and often repeated questions to return to matters previously raised by the interviewee. In case where contradiction emerged, falsehood can be detected which helped the researcher to decide to discard the suspected data in the current research. However, few other considerations that attributed to the credibility of this research were the diverse background of the participants as explained briefly in the previous section 3.5.2 triangulation as well as informing them about their right to withdraw at any point without disclosing explanation to the researcher. Moreover, discussions in frequent and regular supervisory meetings with my supervisors helped me to widened my vision as their experiences and perceptions bought different dimensions to this research and challenged the researcher's own biases and preferences.

Prudently considering the above-mentioned factors, data for this research was collected. The details are briefly presented in the following section.

3.6 Data Collection

In study 1, I carried out a formal pilot survey in 20 schools in Wales and England, as I intended to acquire 100-150 teachers' opinions. This informed the first phase of research in which quantitative methods i.e. a semi-structured questionnaire was used. This online questionnaire was sent to the teachers of Key Stage 2 in mainstream primary schools across Wales and England using Bristol online survey. Ary *et al*., (2014) state there are number of advantages using online survey for example, they are available to respondents 24 hours a day and they can reply when and where they choose. Moreover, online questionnaire has the potential to reach larger populations and collect larger amount of data than is possible using traditional survey methods.

I conducted the pilot study and sent 100 questionnaires to primary school teachers across Wales and England. I received 29 responses which helped me to improve the actual questionnaire as it highlighted some questions which were unclear for the participants and helped to identify the importance of adding few more questions to it (see appendix I).

3.6.1 Questionnaire

By sending the online questionnaires to over 2000 primary schools in Wales and England I intended to get 100 responses from each country but I received only 45 questionnaires altogether. This low number of questionnaire return influenced the next step of the research therefore, in the second phase of data collection I planned to conduct face-to-face interviews. According to Kumar (2014), a limitation of using online questionnaire is that not all the population has access to technology. Also as Ary *et al*., (2014) state that online survey cannot avoid the problem of sampling error, so the researcher must make sure that their survey is reaching the desired respondents.

The quantitative research was able to use analytical and inferential statistics (Cohen, Manion & Morrison, 2000) by the data I collected from the part A of the questionnaire (see appendix II) which included distinctly information, such as

1. Are the teachers currently teaching or have they supported a child who has had a prolonged absence as a result of a physical condition?

2. What is their role in the school?

3. Do they agree that children who have a prolonged absence are at greater risk of underachievement and miss out mastery of core skills? and so on.

Part B of the questionnaire included semi-structured questions requiring a qualitative approach to allow more detailed information to be obtained. As a follow up to the questionnaires, semi-structured interviews were used to acquire a deeper insight into the attitudes and perceptions of participants, especially about the areas which were not elicited in the questionnaires.

3.6.2   Semi-structured interview

Semi-structured interviews are in-depth explorations of a topic engaging one person at a time with an interviewer. They are conducted with an open framework which allow for focused, conversational, two-way communication (Morehouse, 2012). According to Burns (1990), in semi structured interviews rather than having a specific interview schedule or none, an interview guide is developed to provide a direction to the interview so that the content focuses on the crucial issues of the study.

I interviewed each participant face-to-face and individually in their contexts. Each interview was average 45-50 minutes in length and the interviewees were informed about the current research and its purpose before starting the interview. All interviews were audio-taped using an encrypted device provided by the university and then were individually transcribed. To comply with the Data Protection Act 1998 requirements, the audio files were downloaded and saved onto the Bangor University password encrypted computer immediately or as soon as possible post interviews. The portable device that stored data was also locked encrypted to secure data during in-between school visits.

Basit (2010) states that by using semi structured interviews for data collection researchers are usually aware of the construct that need to be addressed in the interview. They frame various questions and probe questions to ask in the interview which would be linked to the interviewees' responses to earlier, pre-formulated, questions for achieving a more elaborate, in-depth response (Morehouse, 2012). In this research, under various themes the questions and probe questions were developed to request interviewee's opinions about the continuing study during children's absence from school owing to a physical condition, their interactions with children during their absence from school, barriers to pupils' access to and utilization

of opportunities and recommendations to support academic continuity and so on. According to the different roles of the professionals, as mentioned in the table 3.5.1. (b), different interview schedules were used for the SENCOs of the primary mainstream schools in Wales and England (see appendix III) and for the advisory support teacher in England and Education social work team manager in Wales (see appendix IV).

To investigate the research questions, I have used both quantitative and qualitative data analysis tools, here I will discuss each in turn.

3.7   Data analysis methods

I have used Interpretivist approach for data analysis in this research because it emphasize the importance of understanding and exploring participants' views and experiences from their point of view (Ritchie *et al*., 2014). According to Grbich (2013), this approach focus on how people interpret and make sense of their experiences in the worlds in which they live and what impact their contexts of social environments to construct understandings, which can be correlated to the previous studies. For example, in the current study teachers were asked about their perceptions about their interactions with children during their absence from full-time school attendance owing to a physical condition. The findings of this question are put back into the context of other theories or existing knowledge (mentioned as key studies in chapter 2), supported by the data I collected as a researcher.

For analyzing quantitative data that is part A of the questionnaire, I read the responses of teachers repeatedly and highlighted the pattern among the responses manually. Then I used SPSS statistics software (version 22) and after looking for obvious trends and relationships among variables, I have represented and displayed research data in forms of tables. The data shown in these tables presents the number of responses associated with different values of one variable and expresses these counts in percentage terms (Malhotra, 2005).

Whereas, for analyzing qualitative data, i.e. part B of the questionnaire and interview transcripts NVIVO 10.6 software coding was used as a process of analysis. I followed the five-step process recommended by Ezzy (2002) and Krauss and Ismail (2010). After reading thoroughly the responses of the participants for part B of the questionnaire, data was organized in specific categories. On the other hand, for analyzing, semi-structured interviews I transcribed all the taped interviews and read them carefully. In step 1, I manually highlighted the commonalities and discords among the respondents' responses and

came up with categories which mainly were guided by predetermined categories of the interview schedules.

At step 2, after line-by-line coding and pattern searching I categorized information by assigning abbreviated codes of a few letters, words or symbols and place them next to the themes and ideas I found, which enabled me to identify the subcategories of relevant themes and those themes that emerged from this data.

Using drag and drop method in the computer analysis NVIVO 10.6 software, at step 3, I categorized the descriptive data. This software was utilised for interpretive coding, pattern searching, grouping of codes into conceptual sets, memo writing and graphical modelling using transcribed text from the participants' questionnaires and interview transcripts (Bazeley, 2007). Coding was undertaken throughout the data analysis to reshape perspective. I focused the analysis on how participants in Wales and England responded to each question or topic to explore the connections and relationships between asked questions in questionnaires and interviews.

At step 4 I identified patterns and connections within and between categories i.e. I looked for similarities and differences in teachers' responses within mainstream schools in Wales and England. This relationship across these two or more categories is shown in the next chapter. At the final step 5, by bringing all the themes and connections together, interception is done to explain meaning and significance of the findings. This data analysis revealed gaps in this investigation and connections that remain unclear which are the areas where I can suggest further study.

Research ethics were carefully considered while conducting this research and is briefly discussed in the following section.

3.8   Research Ethics

There are no fundamental or distinctive ethical issues related to this research, despite the nature of the subject. Particular attention was given to the research ethics regarding confidentiality, as information about the health issues of vulnerable children was discussed by the teachers. The participants were provided with appropriate information, including an introduction to the objectives of the questionnaire and interviews stating the nature and aim of the research (Walliman, 2011). I informed the participants about the nature of the

research and any possible risks, indicating that their participation is voluntary and they have right to withdraw at any stage of the research (BERA, 2011).

The participants' confidentiality and anonymity was respected as the questionnaire and interview transcripts were coded and were used to analyse and generate themes and conclusions but not to identify individuals (Howe & Moses, 1999). During interview transcription confidentiality was strictly maintained as participants' real names and location was not disclosed and the researcher used their fictional names.

I also ensured that the confidential information such as the health records of children, performance data and personal information, whether written or verbal is protected (BERA, 2011). This research data was kept strictly confidential in a locked file and all electronic information was coded and secured using password protected file and encrypted devices.

Summary

In this chapter, the aim and the research questions were developed based on the previous chapter, the literature review. The various research methods were reviewed and the research paradigms and approach were explained. Following this was the presentation of the design of the study with the description of the questionnaire, semi-structured interview, its validity and reliability, data collection and analysis.

The demographic descriptions of the study, along with the descriptions of the themes that resulted from the research findings will be presented in the next chapter.

CHAPTER 4   FINDINGS

4.1   Introduction

The previous chapter described the details about methodology and methods that underpin the justification of this research, the research instrument and ethical issues considered to conduct this research.

This chapter presents the analysed findings of the research data taken from 45 questionnaire respondents and seven hours of recorded interviews with 07 interviewees. A total of 45 of the 2000 questionnaires sent online to the mainstream primary schools across Wales and England were returned, which represents a response rate of 2.25%. Hence, it is unlikely to be representative as I was aiming for at least 100 questionnaires. As per its design, the questionnaire was designed to identify points for follow-up discussions with the interviewees during semi-structured interview.

Since similar themes cut across the two sets of data, I have combined the findings from questionnaires and interviews in this chapter. Although there was variability in the roles of the participants, urban versus rural schools and number of pupils enrolled in participants' schools, findings were similar across Wales and England. The presented data shows the pre-determined themes as well as those that emerged through careful analysis using SPSS statistics software (version 22) and doing detailed and systematic coding using NVIVO 10.6 software. The results shown in percentage are from the findings of the quantitative part of the questionnaire whereas, the results from the qualitative study i.e. part B of the questionnaire and semi structured interviews are presented thematically.

Six themes (predetermined and those that emerged from the data) identified during the synthesis of the data were: participants' experience; impact of prolonged absence on children's academic achievement, self-esteem, psychological and social life; importance of provision for academic continuity; roles and responsibilities to contact children; practices and policies in school; and participants' recommendations. These themes are graphically represented where relevant describing the data underpinned with quoted extracts from the questionnaire respondents and interviewees. Due to ethical considerations, the identity of the interviewees is not disclosed but these interviewees are given numbers from 1 to 7 and their original roles are shown in brackets along with their citations.

Identified themes are discussed below that highlight participants' perceptions of the key barriers and facilitators to provide academic continuity to the children with prolonged absence due to a physical condition in mainstream primary schools.

4.2   Participant's experience

The interviewees and questionnaire respondents were asked about their experiences of teaching children with prolonged absence due to physical conditions. All the interviewees had an experience of teaching these children however, out of 45, 27 (60%) questionnaire respondents were currently teaching or had recently supported this group of children. The questionnaire respondents and interviewees indicated their roles, shown in the table 3.5.1(a) and (b) in the Chapter 3.

In the participants' various capacities and experiences these children had variety of conditions such as kidney transplant, gastrostomy, road accidents, spina bifida, muscle dystrophy, heart conditions/surgery and other degenerative conditions. There is not much difference in the opinions of the questionnaire respondents who teach children with physical conditions and those who do not, as all reported that children's attendance in school is affected by their physical conditions as well as the treatment they receive in hospital or at homes.

As one of the interviewees said "*we had a boy who had a heart surgery, so he was off for significant period of time. He spent a couple of weeks in hospital but then went home because of pain and positioning…he gonna* (sic) *be in home for a period of time while still with the plaster so up to six to eight weeks probably if not longer*" (Interviewee 1, SENCO).

During convalescing these children with different physical conditions spend most of their time at their homes but if feeling much strengthened, they occasionally attend school. As the interviewees also indicated the pattern of absence of these children varied from one day to a few days, a week or months. They also specified that depending on the physical condition they experience, sometimes they are absent for continuous days, or sometimes it is an intermittent absence.

As one SENCO shared that "*there was a reduced timetable as sometimes he was three days a week in school and sometimes less but it's a maximum of three days a week. Sometimes he was off three consecutive weeks and his absence was increasing due to the progress of his condition*" (Interviewee 3, SENCO). Another stated that "*so he was absent from day to day*

because he needed to visit the hospital. When we knew he was going to have the kidney transplant, I think he was absent for possibly six months" (Interviewee 5, SENCO).

Moreover, it was indicated that teachers are apprehensive of teaching the children with physical conditions in their class as they are not aware of the various conditions and feel anxious if in case any emergency arises. As indicated "*teachers are not aware of the diversity of disease in the school…they feel nervous if they have to meet any emergency*" (Interviewee 7, Advisory support teacher).

Discussion around the teacher's lack of confidence and training will be presented in the next chapter. However, in the research participant's experience children's prolonged absence owing to physical conditions has definite effects on their learning and school life. These findings are presented in the next section.

4.3 Impact of prolonged absence on children's academic, self-esteem, psychological and social life

The participants suggested that children who have a prolonged absence are at greater risk for underachievement in school, as indicated by all interviewees and 44(98%) questionnaire respondents as shown in the table 4.3(a).

Children are at greater risk of underachievement	Frequency and percentage of response
Agree	44 (98%)
Disagree	1 (2%)

Table 4.3(a): Results of the question 'Do you agree children who have a prolonged absence are at greater risk for under-achievement in school?' (n=45)

Moreover, all the participants i.e. 7 interviewees and all the 45 questionnaire respondents indicated that they agree that during prolonged absence these children miss out mastery of core skills that are required to progress on to more advanced skills. This is the only statement to which everyone agrees and the response rate is 100% as shown in the following table 4.3(b).

Children may miss out on mastery of core skills	Frequency and percentage of response
Agree	45 (100%)

Table 4.3(b): Results of the question 'Do you agree children who have a prolonged absence may miss out on mastery of core skills that are required to progress on to more advanced skills?' (n=45)

The participants highlighted that children who miss actual teaching in the classroom become out of routine, miss core aspects of the taught curriculum and important explanation by the teachers. This leads to gaps in their learning that have definite effects on their future learning, as indicated in some responses:

"*time away from the classroom means they miss learning opportunities which are then difficult to make up at another time*" (Questionnaire respondent 9).

"*they have gaps in their learning which, if missed, can cause knock on effects in future education*" (Questionnaire respondent 29).

Literacy and numeracy were the areas of concerns being the key part of curriculum and where children miss core teaching, as signified by a few participants that

"*…the bits are important but literacy and numeracy are the bits you really want to tackle. Because literacy all full of repetition you know and again maths, there are certain aspects you may miss out…this impact all other subjects*" (Interviewee 1, SENCO).

"*there are certain academic topics that are not repeated throughout the year e.g. fractions in Math's, so if the child is absent for a long period they miss that coverage*" (Questionnaire respondent 6).

"*those who miss whole chunks of the curriculum particularly English and Maths do struggle if the class has moved on*" (Questionnaire respondent 36).

One respondent being particular about the direct impact of anxiety on learning said that "*when the routine of school and learning is not as familiar, it can make a child feel less secure and affect anxiety levels and therefore the learning they do at school*". (Respondent 6).

Prolonged absence may also affect the self-confidence and self-esteem of the children with physical conditions, as specified in Chapter 2. The unfamiliar routines in school, feeling of being different from others and receiving medical treatment in school when their peers are involved with other activities may lead to have poor confidence. As one SENCO shared that "*he said he doesn't want to use his wheelchair in school as he doesn't want anybody to see him in it………he is not using his chair, he needs to be pushed in for his lessons but would rather crawl along floor. So obviously, it is affecting him emotionally, he doesn't like anybody to know what is wrong with him*" (Interviewee 3, SENCO).

Moreover, self-esteem may be or become an issue for a child who has an injury or condition that affects the way they look. Sharing her experience one interviewee said that "*coming back to school after fifteen months, this child with cancer was quite anxious about her appearance because she still had no hair, as soon as she saw me, she hid herself behind her mother*" (Interviewee 2, EMS).

From her experience, one interviewee firmly believed that children's self-esteem is affected if they are not provided educational support according to their cognitive abilities. She stated that '*because he was missing school, he was put in a lower ability group…his self-esteem was really badly affected, he was crying and mentioned he couldn't write as much as everybody else, having condition affecting his motor skills*' (Interviewee 3, SENCO).

The children who are not born with physical conditions but face physical condition resulting from an accident or sudden illness are also at risk of low self-esteem, as indicated here "*if they come back to school possibly with broken leg and they being sporting before, they can't do sport they used to do……especially with the boys if they play football this can cause low self-esteem*" (Interviewee 5, SENCO).

Rejection by peer group may cause certain physiological pressures on children which adds additional challenges for them to cope with their education. As one opinion was "*he can go through peer pressure as other kids would learn and move forward. The peer pressure can cause emotional strain on the child who is sick or recovering*" (Questionnaire respondent 3). *In confirmation, another said that "……children feel the pressure as their classmates move on*" (Questionnaire respondent 15).

Prolonged absence not only hinders learning but also influences social life and friendships of children as indicated by participants as "*children found it hard to integrate back into*

class, make strong friendships, lacking in fine and gross motor skills and confidence with most activities in comparison to classmates" (Questionnaire respondent 21).

In addition, one said that "*mostly children miss real interaction with other class mates especially soft skills like taking turns, handling disagreement etc*". (Questionnaire respondent 18). Another view was "*if they are out of school, they are not part of that social group anymore. There would be impact, coming back and trying to be a part of the social group might be hard and very difficult*" (Interviewee 4, SENCO).

On the other hand, one participant gave commentary information saying that children's friendship groups are not affected by them being away as for them it is easy to "*slot back in as they find new friends…Kids are flexible*" (Interviewee 1, SENCO).

As reviewed in Chapter 2, prolonged absence affects all the areas of a child's life including friendships. The effects of prolonged absences on children's leaning with physical conditions is integral to this research, which is further discussed in the next chapter. However, the following results present the opinions of the participants regarding the importance of children's academic continuity during prolonged absence.

4.4   Importance of provision for academic continuity

The participants were asked whether they think that it is important to provide appropriate academic support for children with a physical condition during prolonged absence in the questionnaire as well as in the interview. The participants indicated that providing appropriate academic support during prolonged absence is essential for keeping children's academic continuity, which is discussed further in Chapter 5. The findings show that some teachers/educational professionals perceive this to be the case that providing academic support keeps children connected to their class/school as it avoids gaps in learning, boost their self-esteem and confidence and eases the process of reintegration after prolonged absence for these children. As one participant said that "*academic support helps to keep them in touch with their class, peers, and to help keep their learning moving forward, even if it is small steps at a time*" (Questionnaire respondent 8).

The participants stressed the importance of continuous education as indicated that "*they need continuity in academic support, it is important for them to be appropriately challenged…they should be given the same attention and the range of learning opportunities that children in class are given*" (Questionnaire respondent 34).

Similarly, many participants were apprehensive about the quality of education this group of children receive in mainstream school. As one strongly stated that "*there should be different not easy level of difficulty for these children. They should not be expected for the length of curriculum to cover as their peers but at the same time they shouldn't be given 'drawings to colour' as they are enable…they are sick not with SEN*" (Interviewee 3, SENCO). Consequently, many join SEN school at later stage, as it was indicated that "*these children can be behind as compared to mainstream children anyway. We have had children that have had so much time off they have had to leave a mainstream school and come to our SEN school in order to get specialised help as they were lost in the mainstream system*" (Questionnaire respondent 21). Children with physical conditions are often considered having special educational needs by professionals, which is briefly explored in Chapter 2.

The participants suggested that academic support should be provided at hospital through hospitals teachers and at homes through home tuition. As one opinion was "*access to schooling within hospitals if the child is having a long stay must be provided, also this must continue when the children are at home recovering*" (Questionnaire respondent 6). As mentioned in the literature review, hospital teachers provide bed-side teaching or sometimes teach in groups, following the national curriculum or else these children are provided home tuition service, which is further discussed in the Chapter 5.

Considering the importance of academic support therefore, the participants indicated various means of support to provide academic continuity to this group of children. But as in this research only four means of supporting academic continuity are discussed i.e. using technology (telephone chats, videoed lessons, videoconferencing, live online interaction, using Skype, Facetime etc), individualized instruction e.g. Individualized Education Plans (IEPs), bed-side teaching in hospital and home tutoring for children's academic continuity; the participants were asked to indicate the means their schools use to contact children with physical conditions.

A few of the questionnaire respondents indicated that they use technology to teach children during prolonged absence, as shown in the table 4.4(a)

Using technology for teaching purpose	Frequency and percentage of response
YES	9 (20%)
NO	28 (62%)
NOT APPLICABLE	8 (18%)

Table 4.4(a): Results of the question 'Have you ever used technology to teach children during their prolonged period of absence?' (telephone chats, videoed lessons, videoconferencing, live online interaction, using Skype, Facetime etc. (n=45)

Whereas, the interviewees indicated that they have not used technology (Skype) for teaching children while they are absent from school. The class teacher might talk to children on phone or use Skype only for social communication but not for teaching purpose, as is indicated "*we might use Skype for chatting with the child but we haven't done it for teaching, I haven't seen it done*" (Interviewee 1, SENCO). While, another important consideration was "*teaching time is bit trickier and often teachers are a bit reluctant to do that, some teachers aren't confident enough to have their sessions recorded*". She further stated that "*they might use YouTube where you have got a very confident teacher who is happy to put on lesson on whatever topic……but it isn't the same as to be able to ask questions and things there and then*" (Interviewee 7, Advisory support teacher).

Nonetheless, one SENCO said that "*but that's quite a good idea for him to Skype during lesson time……he would like that, he would want to see them but don't want them to see him*" (Interviewee 3, SENCO). Children's reluctance to use video chatting or conferencing due to change in their appearance was also indicated by another interviewee who stated that as "*if they lost hair they might not feel comfortable in front of camera*" (Interviewee 2, EMS).

Moreover, concerns regarding parents' keeping their and their children's confidentiality was expressed by one participant "*sometimes the parents are not happy about its use…if others knowing looking after the child they can be doing that sort of thing or in case people hacking and find out where they are…in complicated family situations*" (Interviewee 7, Advisory support teacher). Therefore, schools have to be extra vigilant using video conferencing with children being absent due to physical conditions.

The findings regarding the second means of support show that the children with physical conditions do have IEPs to assist their learning in school, as indicated by most of the questionnaire respondents in the table 4.4(b).

Using IEPs to assist learning	Frequency and percentage of response
YES	27 (60%)
NO	11 (24%)
NOT APPLICABLE	7 (16%)

Table 4.4(b): Results of the question 'Have you ever used individualized instruction (teaching focused on the needs of an individual pupil using IEPs) to compensate for the effects of prolonged absence?' (n=45)

The interviewees also indicated using IEPs for these children stating that "*if they been off three months, they are falling behind, we might need an IEP to address part of the curriculum to give them extra time in school when they come back*" (Interviewee 6). During the process of designing an IEP, a group of professionals are concerned so that everyone is aware of child's condition and precautionary measures to take in case of emergency (Norris & Closs, 1999). As a SENCO stated "*the health care plan is signed by the health care professionals, the SENCO, the parents as well as the class teacher....so that's for what to happen, what to watch for, who to call in emergency*" (Interviewee 3, SENCO). Therefore, these IEPs are used for their health purposes as well as for providing education according to the individual needs of the child. As one interviewee said that "*some of the children have IEP for literacy reason, some have for speech and language difficulty, some have for physical disability...if they need a posture cushion to sit on or hand writing tools, slope to write on...*". To strengthen her view she quoted an example from her school "*we have got one girl with hyper mobility problems...in her IEP we will see when this child needs to lay down, rest in the afternoon for five to ten minutes*" (Interviewee 5, SENCO). Another interviewee said that "*we call individual educational plan as learning support plan...we have them as we need to talk about moving and handling, how they gonna cope in the playground*" (Interviewee 4, SENCO).

The third means of academic support considered in this research was home tuition and the questionnaire respondents indicated that very few have taught children in their homes, as shown in the following table.

Home tutoring	Frequency and percentage of response
YES	5 (11%)
NO	37 (82%)
NOT APPLICABLE	3 (7%)

Table 4.4(c): Results of the question 'Have you ever taught children in their homes (home tutoring) during their prolonged period of absence?'

However, the interviewees suggested that children with prolonged absence from school due to physical conditions are provided with home tuition by assigned staff to continue their education. It is the schools' responsibility to raise this need for a child, as one SENCO said "*the local authority provides home tuition but it would be up to the school to apply for that*". She also indicated that the support in the form of home tuition is received after certain period of time "*it's usually after six weeks they will get support in South Wales*" (Interviewee 1, SENCO). Affirming this another interviewee expressed that "*if they been off for four consecutive weeks, they will get tuition three hours a week*". He added that "*As far as home tuition, the law requires us to provide tuition to the young pupils who are not in school regularly. The home tuition policy is up to Key Stage 3 so that's up to year nine, so fourteen years old we would give it*" (Interviewee 6, Education social work team manager).

The duration of home tuition depends on the well-being of a child and the stamina he/she has to focus on study being in the recovery period but "*it is government policy which is statutory that we have to deliver home medical tuition a minimum of five hours a week, on local authority level*" (Interviewee 2, EMS). On the other hand, concerning home tuition one interviewee stated that "*I don't think we have done a young person a favour by keeping them at home with a tutor five hours a week*" (Interviewee 6, Education social work team manager).

None of the participants have ever had an experience of bed-side teaching in hospital, as the responses of the questionnaire respondents indicated in the table 4.4(d).

Bed-side teaching	Frequency and percentage of response
NO	37 (82%)
NOT APPLICABLE	8 (18%)

Table 4.4(d): Results of the question 'Have you ever taught children while they are in hospital (bed-side teaching) during their prolonged period of absence?' (n=45)

According to some research participants, parents should collect the work from their child's school and deliver it to the hospital teachers, to continue education of their sick child. For example "*it would be the parents to come and get stuff to take over to the child in hospital, but there are I believe tutors in hospital who may well liaise with the school or parents might liaise with them and let us know*" (Interviewee 1, SENCO).

Another SENCO suggested that the school cannot provide academic support in hospital unless parents request for that. She said "*no we can't do that but if the parents request coming to school and say 'oh please can you do this' especially when the NHS teachers are not involved or where the hospital do not provide that kind of support, then we are happy to do that*" (Interviewee 4, SENCO).

The hospital or NHS based teachers are assigned to work in the medical setting to teach children who stay in the hospital for a length of time. As mentioned in the literature review, the hospital teachers liaise with the child's school and provide advice, assistance and support in reintegration (Feeley & Skilling, 2000). Moreover, hospital teachers work with LA in Wales and England, following national curriculum they provide bed-side teaching or offer teaching in a group of same age children, under statutory guidelines.

These findings lead to one of the pre-determined themes of this research that is the responsibilities of different professionals for providing academic continuity to children during their prolonged absence owing to physical conditions. The few roles emerged from the research findings are discussed in the following section.

4.5 Roles and responsibilities to contact children

The participants were asked whom they considered had the responsibility to communicate with children or their families during children' prolonged absence from school owing to a

physical condition, in questionnaire as well as in the interview. One of the obvious role indicated by 23(52%) questionnaire respondents was the role of the parents being responsible to find out their children's missing work from school. The participants indicated that it is the parent's responsibility at the first place to inform the school about their child's physical condition and that he/she would be absent from school for certain period. As was stated "*but it is the expectation that the parents sort of keep us up to date about anything about their child*" (Interviewee 4, SENCO). Another opinion was "*the parents would usually come and pick up work from school but sometimes the work wasn't returned to us to supply him with more work*" (Interviewee 5, SENCO).

Some participants indicated that their schools do not contact parents during their child's stay in hospital as it might disturb them, as one said "*we leave it up to the parents to get us...you would expect them to ring us up and say 'well he is doing fine' or 'we are ready to bring him back school' and all that stuff*" (Interviewee 1, SENCO).

The participants who disagree parent's involvement to complete their children's school work hold different view stating that "*parents who are already caring for a physically ill child often struggle to do the additional work with them because they have the high demands of the child's personal care*" (Questionnaire respondent 6). Whereas, another said, "*I won't say parents can't teach, probably it is not the best role for them but for teachers*" (Interviewee 1, SENCO).

The findings show that most interviewees indicated that it is mainly the class teachers' responsibility to contact children during their prolonged absence owing to a physical condition as they are more familiar to the child and the family and are in regular contact with them than SENCOs. According to one SENCO, "*the class teacher would liaise better because they have better relationship and know their parents...they see them everyday*" (Interviewee 5, SENCO). Similarly, majority of the questionnaire respondents i.e. 20 (45%) indicated it is class teacher's responsibility to contact children during their absence, their responses are shown in the table 4.5.

Responsibility to contact children/families	Frequency and percentage of response
Class mates	0
Class teacher	20 (45%)
SENCO	13 (29%)
Principal/Head teacher	6 (13%)
Local education authority	5 (11%)

Table 4.5: Results of the question 'Who do you think has the responsibility to contact children and their families with a physical condition during prolonged absence?' (n=44)

Explaining the responsibility of a teacher one of the SENCO's view was "*if the child is not well the class teacher would phone the parents in hospital and probably will say 'how is he doing' and things like that*" (Interviewee 1, SENCO). On the other hand, one participant indicated that this is mainly the SENCO's responsibility rather than the class teacher, as she said that "*the class teacher needs pressure off, she is informed about the child's coming back to school but it is the SENCO who actually liaise with everyone*" (Interviewee 2, EMS).

It was indicated that the SENCO is responsible to liaise with families, class teacher and other health services and know when is the child coming back to the school. As was mentioned "*the SENCO would have that overall responsibility of special needs, monitoring and coordinating within the school...she makes the referral...she liaises with everybody, families, home tutors and inclusive education services*" (Interviewee 2, EMS).

Two interviewees stated that

"*yes it is only me obviously I have to closely liaises between the teachers here and the child*" (Interviewee 3, SENCO).

"*yes it would be my responsibility to sort of contact the family*". She admits that "*I must confess we don't really do, we would may be call once in a while to say 'hi' but it's not in the practice...I am actually trying to think that 'oh God it's something we should be doing'*" (Interviewee 4, SENCO).

Some participants believe that providing academic continuity to children is the responsibility of the hospital schools and teachers who contact the children's schools to get information to plan lessons accordingly. It was indicated that "*when the children are away it doesn't seem to be the school's responsibility, it becomes hospital responsibility to contact school and plan suitable lessons and activities for these children*". She added "*what we can do is to send work to child at home but to support the child in hospital, no we can't do that. I have seen NHS teachers involved contacting schools asking for information about child, how do we support the child, what level is that child in*" (Interviewee 4, SENCO).

Another interviewee said that "*most hospitals do provide a service and then they liaise with school, as the child comes back home with the medical outreach teaching team*" (Interviewee 7, Advisory support teacher).

Given these points about the opinions of the participants about the role of hospital staff for children's academic continuity, I must present here the findings regarding the opinions of participants about the information given by health professionals to schools to assist their learning.

The participants indicated that during children' prolonged absence from school owing to a physical condition, they receive information about their health from the health professionals. As indicated by a SENCO "*we have a direct access to the physio therapist and occupational therapist in South of Wales who discuss with us needs and manoeuvring of the child before he returns to the school*" (Interviewee 1, SENCO). Whereas, some receive this information from the school nurse "*I think in North of Wales our school nurse would be a link for us……….I will always seek advice from her*" (Interviewee 5, SENCO).

Similarly, the information about children's physical condition is received in schools in England too, as was indicated "*yes around North of England they are very good about giving the information like the child development centre*" (Interviewee 7, Advisory support teacher). Another commented, "*we have input from a number of multi agencies like physio therapist, occupational therapist, school nurse, expert nurses as well as dietician*" (Interviewee 4, SENCO). Moreover, this information is in written version as stated here "*yes we do receive, if it's being on the phone it would be followed up in writing always*" (Interviewee 3, SENCO).

Further, the participants shared that this helps teachers to plan their lessons according to the needs of the child as asserted by an interviewee "*I think it is important to get information so*

that I make sure that I deliver teaching in an appropriate way" (Interviewee 2, EMS). This useful information also helps to design a reintegration plan in relation to children's health and education, as stated that "*it is helpful in order to enable them to keep pace with the curriculum and ease the reintegration back into the classroom*" (Questionnaire respondent 32). As discussed earlier in the literature review, reintegration plan does not only involve the academic area but also requires some physical adaptations regarding the child getting access to the school building or help for toileting. "*sometimes we get referral from the health team………so we can get some ramps build…providing hygiene room with high adjustable change bed and other equipment so they can be changed discreetly and safely*" (Interviewee 7, Advisory support teacher).

Pondering on its importance another said that "*massively, its very crucial…keeping everything up to date and constantly speaking to different people who can suggest different ideas that would help things*". She added that "*medical people can give such a take on things that from educational side a class teacher might not see it that way*" (Interviewee 3, SENCO).

Also, this valuable information prepares the school and its staff for the future occurring as was believed "*information from health side help us to be prepared what they can actually do when they come back………they won't be same as everybody else immediately*" (Interviewee 5, SENCO). Another important opinion was "*…we had children who had car accidents they came with mobility issues that they didn't had before… the physio therapist would advise about the physical access to the building and the occupational therapist would advise about any special seating and that kind of things*" (Interviewee 7, Advisory support teacher).

This exchange of information about the children's health adds additional responsibility for the school to cater for educational as well as the health needs of the children. Thus, it was an evident finding that most of the participants are of the view that children being absent from school are still the school's responsibility, while school being the foremost caretaker of academic provision. As one home tutor stated that "*the work they do at home is set by the school…the child is still school's responsibility as he is still on roll of their school…I would have a meeting weekly with the teacher to go through what work they would like me to do with the child at home. I will take that work back to the school and the class teacher will mark it*" (Interviewee 2, EMS). Yet contradictorily another interviewee specified that "*it is*

extra work for teachers, so when the children are away from school it doesn't seems to be the school's responsibility but of the hospital to find that kind of input" (Interviewee 4, SENCO). This view is in line with the findings of the questionnaire where 17(37.8%) questionnaire respondents indicated that contacting children during their prolonged absence from school does add to their work significantly, which is discussed briefly in the following chapter.

Emphasizing on the role and responsibility of the school interviewee 2 highlighted that "*it's still their child and the school still have responsibility for the progress of that child, it helps to facilitate gaps in learning as it sets the work and the activities and will provide the resources in theory*" (Interviewee 2, EMS). This was supported with this opinion that "*the schools have the responsibility and it's up to individual teachers that liaise with the families to form a plan in school in an agreement with the family…the school provides work and make sure that they have the best chance possible to continue with their learning*" (Interviewee 6, Education social work team manager).

Moreover, one indicated that "*schools should make extra effort by providing extra teacher who can help children to catch up on their returning back to school*" (Questionnaire respondent 15). Disagreeing with that, one interviewee stated that "*we probably get one child compare to many thousand children in school, therefore, a school can't employ another teacher…we have to think about other children………the only way we can support is by providing input, educational information whenever it is required*" (Interviewee 4, SENCO). Affirming this another said that "*each school is only likely to encounter this issue infrequently…maintaining any expertise in the area of difficulty*" (Questionnaire respondent 33).

Whereas, a noticeable opinion was "*It's not us who supply the work it would be the LEA that would step in and suggest that work*" (Interviewee 5, SENCO). It was suggested that LA is responsible to provide home tutors and appropriate educational resources as the school informs the LA which arranges for the home tuitions. As one of the SENCOs said that "*we notify the local authority and request support, its LEA's duty*" (Interviewee 1, SENCO).

In response, the Education social work team manager shared the view that "*The government of Wales say we (*sic*) got a statutory duty to provide home tuition. Therefore, we have one council based home tuition policy and we require the school to keep the ownership of that pupil because they are on their roll. So just because they are not attending doesn't mean*

that oh ya we don't need to worry about them, the council will sort it out". He furthered stressed that "*We are saying this is the policy, you got a duty to provide work and liaise with these young people*" (Interviewee 6, Education social work team manager).

The findings regarding the roles and responsibilities of different professionals to contact children during prolonged absence is very interesting, and will be further discussed in the next chapter. However, in their specified roles the participants shared the best practice their schools use to support the children's education. This leads to the fourth theme of this study and is presented in the following section.

4.6   Practices and policies in school

There was a mixed response from the participants about having the written policy in their schools regarding this group of children. For some there exists a policy for these children as indicated by one participant "*ya we have the document supporting children with medical needs in mainstream schools in North of England. The original document is much bigger which was printed and sent off to schools in a folder. The updates versions have to be sent in an email web link which is called the_____, where an email is flagged up for all the head teachers and is also accessible for parents*" (Interviewee 7, Advisory support teacher).

Contradictorily one said "*there is no specific policy for this group of children, it starts with not attending school, then assessment and the support would be down to the individual from the school*" (Interviewee 6, Education social work team manager).

Yet another does not consider the importance of having a particular policy for these children in school as affirmed that "*we don't do as a policy thing, we sort of contact home out of personal interest….no it is not in the SEN practice, there is nothing anything like that at all. We don't do policy any more, we send information, special education needs information and it is on the school website*" (Interviewee 4, SENCO).

The participants who indicated that they receive a general policy from LA stated that they modify it according to the needs of individual schools. As one SENCO in Wales specified that "*we kind of tweak them and personalize a little more…they give us bare bones of the policy and we kind of fit in the bits but the legal bits. The school adapts it according to its situation, the head will look at the policy and then get verified by the school governing body*" (Interviewee 1, SENCO). Whereas, one of the SENCOs in England said that "*I am*

not sure, I need to check if we adapt LEA's policies in the form of guidelines" (Interviewee 3, SENCO).

Whatever adjustments the schools make to the LA policy, they have certain referral systems in place in their individual set ups to support the academic continuity to children with physical needs. As one of the interviewee indicated that "*we now have got a single point of access referral system, which is under the local education authority and it goes to a panel of various teachers, SENCOs and myself and we look at what the school has put as child needs and we decide which team to refer*". She further stated that "*sometimes we get referral from the health team, so from the occupational therapist or the physio therapist and that's usually because they got concerns about the child assessing the building*" (Interviewee 7, Advisory support teacher).

For some the referral system is quite intensive so they follow a different pattern, as a participant mentioned that "*we don't go by_____ referral as it is very intense…so we have discussions at pastoral meetings usually about once a week………a member of our team visit every primary and secondary school once in a half term*" (Interviewee 6, Education social work team manager).

This referral system also caters for home tuition for children who are unable to attend mainstream school regularly due to their physical conditions. As one interviewee said that "*generally schools are adapting guidelines in North of England and they got a support of different teams working under LEA, such as home tutors*" (Interviewee 7, Advisory support teacher). There is a designated staff which in practice is the connection between home and school in Wales and England. One of the interviewees in North of England being enhanced mainstream school as teacher in charge (EMS) for social, emotional and mental health indicated that "*contacting children during their illness is my responsibility as the home medical teacher…I am responsible for the tuition, the educational tuition of those home medical children*" (Interviewee 2, EMS). While, in Wales one interviewee indicated that "*the Education Welfare Officer (EWO) arranges for home tuition, they visit children at home just to reassure parents their support to access the outside agencies/social services in South of Wales*" (Interviewee 1, SENCO).

Whereas, "*in North of Wales, Educational social worker (ESW) is the link between school and home. ESW is based in school but she comes out of school as she works under LEA. She comes here every month, every five six weeks*" (Interviewee 5, SENCO). Affirming this one

interviewee stated that "*the ESW (education social worker) is based in school, who knows the sick child…… in North Wales schools we have ESAP which is additional extended school action plus, teachers and schools can apply for that*" (Interviewee 6, Education social work team manager).

It was an interesting finding that the participants were not sure if their schools have a separate policy for children with physical conditions and where exactly it is in their schools. As a few of the responses were

"*I imagine this would be in the attendance policy", later in the interview she said "I am involved in making this policy at school*" (Interviewee 1, SENCO).

"*It might be there in the policy of attendance or in the SEN policy*" (Interviewee 3, SENCO),

"*It comes under additional needs policy, the class teachers are responsible for this*" (Interviewee 5, SENCO).

"*This is a statutory government policy and I think the school would have that as part of their own policy, it would be included in their written policy*" (Interviewee 2, EMS).

Whereas, some of the participants being aware of having a policy for these children considered sending work at home and to hospital teachers as a good practice by their schools. As a few stated that "*providing work for children at home is a good practice, clearly depending on how well the child is and the parents' ability to work through the work with the child*" (Questionnaire respondent 19). Another stated that "*we will send work home to the parents, for them to complete with the pupil*" (Questionnaire respondent 32).

While, an important finding about a gap in government policy and guidelines was shared by a participant who mentioned that "*One of the shortfall with the government guidelines say children over five should receive educational support because five is the age in which children have to be in school. We had a bit of a problem with a child who was off school for a prolonged period having had a double kidney transplant and she wasn't five at that time……there doesn't seems any system to provide them a bit of support. We did try to query that but we didn't get a good response*" (Interviewee 7, Advisory support teacher).

The data highlights a lack of consistency in relation to policy and practice, which will be discussed in the Chapter 5. As indicated by the participants that children with prolonged

absence owing to physical conditions are at risk of educational disadvantage therefore, professionals should take protective measures to nurture their educational needs. The following section presents the participants' recommendations for improving academic continuity for these children.

4.7   Participant's recommendations

It was indicated by 27(60%) questionnaire respondents that their school can provide appropriate academic support to children with prolonged absence. Therefore, some participants recommended that schools can use technology is an effective way to keep children connected with it while they are in hospital or at homes and when most schools already have the IT facilities. It was recommended that "*they should have Skype sessions, online lessons…we have all the necessary technologies at school*" (Questionnaire respondent 32) and (Questionnaire respondent 19). Another view also highlighted the need of using IT for teaching purpose as was "*using Skype not only for social interaction but for teaching……online lessons would be helpful*" (Interviewee 1, SENCO). Affirming this another recommended that "*online teaching facilities should be provided by the school*" (Questionnaire respondent 11).

Whereas, for some participants good communication with the parents is very helpful as they are the foremost and immediate source of information for the school, therefore "*ensure that communication is effective and works for both the school and family*" (Questionnaire respondent 28). It was recommended that "*frequent and regular contact is fundamental, weekly is just not enough*" (Interviewee 3, SENCO). Also, "*family should be involved in focused IEPs which needs careful planning*" (Questionnaire respondent 21).

Regular contact with the health professionals was suggested as one of the important recommendations to support children's academic continuity without any delays. As it was indicated that "*the part of the process that slows everything down is communication with health professionals. Referrals cannot be made unless there is a doctors' note explaining the medical need. Parents are often more concerned about the health of their child to chase after doctor's letter and this all impacts on the child's education*" (Questionnaire respondent 8).

The participants recommended keenly that children would be provided quality and creative work at home that may not only keep them 'busy' but they should learn new concepts from

those activities. One of the strong recommendations was "*because at home the work might be a little bit dry…no worksheets…she did about some games and things which were lovely……but she should be creative to practice what you do in the classroom*" (Interviewee 3, SENCO). In addition, another participant said that "*home tutor should put in equal planning effort as for classroom teaching so that the pupil is engaged in the work and is not simply completing a worksheet*" (Questionnaire respondent 7).

While, another important recommendation by the participants was to provide funding for the class teachers and enable them to teach children at homes and in hospitals. For example, few mentioned that "*teachers should visit children out of schools on a regular basis and that funding would be available to release them*" (Questionnaire respondent 38). For some "*funding for teachers should be there to teach at home*" (Questionnaire respondent 21).

Summary

This chapter presents the findings of the participants' experience of teaching children with prolonged absence due to physical conditions in mainstream schools. The participants acknowledge that prolonged absence affects the academic as well as the other areas of a child's life. They noted the importance of academic continuity of children with prolonged absence due to a physical condition but were concerned about different pressures within school, such as increased workload on teachers, taking their focus away. They are optimistic that using different proactive means for children's academic continuity and following good practice they can enhance their chances to have best possible learning opportunities. The data reveals a wide range of approaches i.e. some inconsistency, in response to who deals with the issue and how it is dealt with variety of perspective. The participants also recommended practical suggestions to schools and professionals in their specific roles, for preparing schools to receive children with physical conditions within the life of an educational community.

This chapter summarizes the findings briefly and presents the descriptions of the six themes and sub-themes that resulted from synthesis of the collected data, linking them to the original research questions. These identified themes will be discussed in the next chapter in the light of literature, in detail.

CHAPTER 5   ANALYSIS AND DISCUSSION

5.1   Introduction

Chapter 4 provides the results of data gathering using a mixed-methods approach with consecutive phases to gain a better understanding of the research problem or questions posed. According to Creswell *et al*., (2003), firstly the quantitative phase begins which then is followed by the qualitative phase; quantitative study provides a general understanding of the research problem which can be refined by exploring the participants' views in more depth within the qualitative phase.

In this chapter, results have been integrated from the quantitative and qualitative phases of the research and are discussed in relation to the literature review, the main research questions and the professional practice of the participants. The questionnaire and interviews provided worthwhile results and a valuable insight into the academic support that is available and how is it considered among professionals in Wales and England.

The six identified themes indicated in Chapter 4, along with the relevant literature and the participants' opinions are discussed here in this chapter. These themes emphasise the participants' perceptions of facilitators to support academic provision for these children, that is (i) Participants' knowledge of impact of physical conditions on children's school life. They also focus on the main barriers in Wales and England that hinder the appropriate academic continuity of this group of children, including issues as:

(ii) muddled understanding of accepting roles and responsibility among professionals (iii) limited awareness and professional training for teachers (iv) compromised quality education at home and in mainstream schools and (v) the absence of clear guidelines on medication, first-aid procedures and prolonged absence in schools.

5.2   Thematic presentation

5.2.1   Participants' knowledge of impact of physical conditions on children's school life

As the findings in the previous chapter have indicated a significant number of participants i.e. 60% of this research were currently teaching or had recently supported a child who has had prolonged absence as a result of a physical condition. This is in line with this view that

due to the development in the diagnosis, treatment and management of physical conditions most children attend mainstream school (Mukherjee, Sloper & Lightfoot, 2000; Mukherjee, Sloper & Lightfoot, 2001; Shiu, 2001 and Shaw & McCabe, 2008). Therefore, inclusion is important for the holistic development of all the children, including children with physical conditions. Booth and Ainscow (2000) define inclusion as a target for mainstream schools since inclusive education is the process of increasing the involvement of all children in the curricula and other school activities, in such a way that they learn effectively in a safe and happy environment.

Furthermore, as the participants in this research have an experience of teaching such children, the impact of physical conditions on children's school life was strongly emphasised both in the literature (Eiser, 1993; Ainsa, 2000; Kabbouche & Linder, 2005; Gottfried, 2011; Krenitsky-Korn, 2011; Gracey & Ward, 2012; Roberts & Whiting-Mackinnon, 2012; Hancock *et al*., 2013; Arthurs, Patterson & Bentley, 2014; Capurso, 2014; Wadley *et al*., 2014; Hinton & Kirk, 2015 and Filce & LaVergne, 2015) and in the findings of this present study. The findings presented in the Chapter 4 indicate that children who have prolonged absences are at greater risk of under-achievement in school. These results support the view that children with physical conditions often experience difficulty with school attendance, academic performance and social integration owing to symptoms, effects of treatment and misconceptions about their conditions (Vitulano, 2003; Sandstrom & Schanberg, 2004; Logan *et al*., 2008; Maslow *et al*., 2011; Jackson, 2012 and Singh *et al*., 2012). For example, one of the misconceptions highlighted by the data is that children with physical conditions are considered having special educational needs, which is further discussed in the next section, in this chapter.

However, Shiu (2001) states that school attendance is difficult to maintain for the children with physical conditions hence, they underachieve academically compared to their healthy peers. The findings of this research also show that It is no wonder that children with physical conditions may not perform to their optimum academically as their physical condition may undermine their self-esteem. Participants in this research were also convinced that prolonged absence from school affected their self-esteem. Deteriorating self-esteem has been associated with their repeated failure to achieve their desired level of social interaction with their peers (Frances, 2004). In other words, lower self-esteem, low levels of self-confidence and poor social skills all overlap and affect a child who is already struggling with his/her physical condition in their desire to thrive educationally.

In addition, one of the important observations made by the participants indicates a greater concern for children missing their English and Mathematics lessons compared to other core skills. From their experience, participants were of the firm belief that literacy and numeracy skills are the heart of the primary school curriculum, due to the emphasis on regular testing in these subjects. These significant results are in line with the findings of Wilkie (2010) who claims that studying Mathematics in isolation is not usually effective as cooperative learning and regular interaction between teachers and pupils is essential. As previous research has indicated that to learn and progress independently in Mathematics, is one of the most difficult domains during absence from lessons. Since these children miss instructional learning opportunities at school, there will be some gaps in their understanding of the subject when they are required to learn new information built on previous knowledge and skills, which consequently hinders further learning.

In response to the effects of prolonged absence, participants have a strong opinion that it causes certain psychological pressures on children such as peer pressure when their classmates have moved on and emotional strain involving separation from parents and siblings during their long stay in hospital. These results are affirmed by Roberts *et al*., (2005) and Duggan, Medway and Bunke (2004) that children with physical conditions experience extensive psychological difficulties, which impact their development and functioning as they may experience embarrassment, low self-confidence, anxiety, medical fear, regression, school phobia and behavioural maladjustment. In addition, Dewis (2007) maintains that this age group (age 7–11) is particularly vulnerable to the effects of intermittent or prolonged separation from their main caregivers. They may also have more problems related to their long stay in hospital such as night terrors, irritability, feeding problems, behaviour regression and separation anxiety especially intolerance of their separation from mother.

These issues add even greater weight on the importance of providing continual academic support in order to keep these children connected to the normality of school life. This was also expressed by one of the participants whose concern was that owing to a physical condition these children are disconnected to the school. This result is in line with the findings of Wilkie (2012) who asserts that children should be provided with an access to the opportunities to learn successfully so that academic progress is made despite interference to full-time schooling. The participants firmly believe that it is important to provide academic support at home and in hospital for the child's academic development. Their responses

presented the shared confidence that academic continuity reinforces the children's learning as well as enable them to learn the required skills of their age group. The guidelines provided by WAG (2017) also emphasize on providing flexible delivery of the curriculum during children' absence e.g. through part time study or providing education at home by the local authority, which also help them to reintegrate. Thus, such children should be given the appropriate educational support, keeping in view their health constraints wherever they might be, in hospital, hospice, respite or most commonly, at home.

In the light of the data, and with the view to maintaining the importance of providing academic continuity, participants firmly believe that it helps the school staff to design a reintegration plan for these children. It was encouraging to find that participants think that children should return to school as early as their health would allow them, given its importance in their lives. These results are affirmed by Shiu (2001) who maintains that the longer the period of absence, the more difficult it is for the child to integrate. As the research indicates, children who return to school in the early stages following their illness, will find the challenges of reintegration far easier. As a few interviewees in the research noted that children are reluctant to return to school after their prolonged period of absence as they develop school phobia. This finding of my research relates to previous studies as to prevent the onset of school phobia at the thought or returning to school, Boonen and Petry (2012); Wadley *et al.*, (2014); Hinton and Kirk (2015) and Filce and LaVergne (2015) recommended that it is important for children to have social contact with friends and teachers during their absence from school. The importance of social contact for absent children with physical conditions with their peers and school is highlighted in Chapter 4 and will also be discussed below.

Due to the increased incidence of physical conditions schools are expected to enrol more children, and consequently, teachers face increased challenges (Shiu, 2004). In turn, the school including teachers, SENCOs, head teachers and other professionals appear to lack sufficient clarity about their role in managing these children's academic provision and feel apprehensive about the additional risks and responsibility which this demands (Hinton & Kirk, 2015). This is discussed briefly in the following section.

5.2.2   Muddled understanding of accepting roles and responsibility among professionals

A recurring topic which appears throughout the data collection process was the overarching theme that parents are responsible for their child's education and its continuity. Though the current research did not involve interviewing parents yet occasionally teachers mentioned that their primary source of information about the condition of their pupils were their parents. On the other hand, for parents, class teachers were the prime source of contact to collect their children's work from school, as indicated by many participants in the previous chapter. According to the guidelines concerning parental role and responsibility provided by WAG (2017) and DfE (2015), parents are required to inform the school concerning their child's absence due to illness. Whereas, the data indicates that the overall communication between parents, school authorities, teachers, health and social care services appears to be poor and a major obstacle in providing sufficient support to children with physical conditions. Teachers might use the internet, leaflets, personal experience and conversations with parents to collect information about the child's health conditions (Thacker *et al*., 2008) but participants of this research suggested that there should be an open and frequent communication between parents, the health care team and school personnel, to increase the positive adaptation of children with physical conditions in the classroom which may also increase the level of support a school provides to a child (Clay *et al*., 2004).

While relying on parents to communicate their child's needs may be difficult, teachers may also feel uncomfortable discussing concerns about their (in)capacity to meet the needs of that child (Robinson & Summers, 2012). A survey of teachers in Australia suggests that they prefer to receive information about a child's physical condition from a health care professional (Shiu, 2004). This is also included in my data and the school is in regular contact with the healthcare professionals, including the school nurse, physiotherapist and occupational therapist, in Wales and England to offer the best academic opportunities and take direct information from them to provide positive, inclusive educational experiences.

The findings of this current research relate to previous studies as indicate that health professionals can educate teachers having the relevant knowledge and expertise regarding a certain physical condition and can work with schools and families on a one-to-one basis. Healthcare professionals have an important role to play as educational programmes developed in conjunction with them have the potential to increase a teacher's knowledge and confidence (Hinton & Kirk, 2015). They can play a key role in developing

Individualized Health Care Plans (IHCPs) to meet the child's specific requirements and to ensure that teachers are well-informed about the suitable action to take in an emergency and have a clear plan of action for the day-to-day management of children's physical conditions (DfES, 2005; Epilepsy Action, 2012; UNISON & RCN, 2012a and Hinton & Kirk, 2015). The WAG (2017) guidelines added that specialist health professionals such as GPs, paediatricians, speech and language therapists, occupational therapists, physiotherapists, dieticians and diabetes specialist nurses can provide health advice and support developing and implementing IHCPs to support learners with healthcare needs.

Nevertheless, as it is indicated in Chapter 4, the findings of this research show that most participants believe that it is the teachers' responsibility to contact children during their prolonged absence. The class teachers know their pupils better and meet their parents daily to provide work for their children as interviewee 3 and 5 said in the previous chapter. However, teachers are often not sure of owning this responsibility. One possible explanation for the teachers' lack of awareness of their role and responsibilities, according to Hinton and Kirk's (2015) research, is that while teachers in the UK can volunteer to support children with healthcare needs, there is no legal obligation for individual members of staff to manage or supervise a pupil's health care needs (DfES, 2001). It is clearly specified in the WAG (2017) guidelines that any staff member within the education setting may be asked to provide support to learners with medical needs, including assisting or supervising the administration of medicines. However, this role is entirely voluntary as they must achieve the necessary level of competence before they take on the responsibility. No staff member can be required to administer or supervise medication unless it forms part of their contract, terms and conditions or a mutually agreed job plan.

Yet Teachers are uncertain about their role and responsibilities in relation to providing medication and meeting a child's health needs as they lack appropriate training and support to perform a healthcare role that obviously does not help the child with a physical condition who spend a lot of time in school. Teachers may also feel uncertain about their responsibility as these children are no longer attending full-time school and whether it is appropriate or practical for them to maintain contact (Wilkie, 2012). They may worry about the risk of crossing the line between professional and personal involvement. The findings of this current research show a reluctant among the participants to accept the responsibility to contact children during their prolonged absence and cater for their academic continuity. According to Clay et al., (2004), this reluctance to accept responsibility reflects a lack of

professional preparation regarding the impact of physical conditions in the educational environment.

Research conducted by Mukherjee, Sloper and Lightfoot, (2001) in the United Kingdom recognises that children with chronic illness wish their teachers to know their condition and how their everyday school life is affected by it as it is important for the child to have 'a teacher who understands' (p. 61). Yet in the same study, teachers emphasized their struggle to communicate appropriately with a child with physical conditions and reported feelings of distress, anxiety and ambiguity. Such feelings were also expressed by the teachers in my data, particularly with regard to their response to a pupil affected by a physical condition and how to be supportive towards their academic continuity. The participants in my study, as indicated in the Chapter 4, were hesitant to initiate contact with children during their prolonged absence. This is supported by Wilkie's (2012) findings that teachers acknowledge to support their pupils' academic continuity yet the majority appear noticeably hesitant to initiate contact. As indicated by interviewee 4 in the previous chapter, teachers can provide input or support for a child during a prolonged absence if requested by the hospital teacher or the parents. This finding again concurs with Wilkie's (2012) findings that although not always, teachers do provide academic support if asked by the hospital education advisor, e.g. they might telephone the pupil, e-mail a scheme of work, or inform the parents what they are teaching during that term. The findings of the current research therefore show that it is not merely because of time pressure, but also teachers' involvement that counts more being keen for their children' academic continuity.

Further, in Chapter 4, interviewee 2 indicates that contacting children during prolonged absence adds to the teachers' workload. This was also affirmed by interviewee 1, that teachers find it difficult to provide additional time for children in order to bridge the gap. These significant results are in line with the findings of Hinton and Kirk (2015) that children with long-term health conditions are regarded as 'risky' pupils by primary and secondary teachers as their health care needs set additional responsibilities on teaching staff. In addition, Wilkie (2010) asserts that teachers have concerns about their additional workload pressures and that schools do not provide time or resources to help them achieve the extra effort involved in supporting such pupils. Teachers' time pressure is also highlighted in the researches by Mukherjee, Sloper and Lightfoot (2000); St Leger and Campbell (2008); Wilkie and Jones (2010) and Wilkie (2012) as another possible reason for a teacher's lack of contact with children absent from school for a prolonged period. This extra workload

included maintaining contact with their pupils, preparing personalised educational plans, marking work received from children and writing extra contextual information about classroom activities and set work. Wilkie (2012) states that an individual teacher cannot manage responsibilities for additional educational provision, workload and time pressures that limits his/her ability to support children with physical conditions. The findings of the current research relate Wilkie's research as indicate that children with physical conditions requires an involvement and infrastructure within the school and related services to acknowledge and maintain the commitment required by those teachers. While the teachers approve to offer support in principle, but in practice, their participation is limited due to the demands of a busy school environment.

The participants in the data held various opinions regarding who should communicate with children in their professional roles, as shown in Chapter 4. For some, SENCOs are the key professionals who would cater for the educational needs of children with physical needs, and therefore, they should be required to take responsibility for appropriate academic provision.

As the SENCOs who participated in this research have indicated, they are responsible for coordinating SEN policies and overall provision for SEN within mainstream schools in Wales and England. This is supported by the literature as among the areas of responsibility outlined as the most SENCOs are expected to perform are operating the school's SEN policy on a daily basis, coordinating provision for children with SEN and liaising with external agencies (Crowther, Dyson & Millward, 2001). In other words, as SENCOs rarely teach the children with physical conditions they are therefore not responsible for their academic continuity. Moreover, SENCOs are responsible for making the necessary arrangements for children with SEN though not specifically for children with physical conditions, as they cover different regime of areas related to SEN rather physical conditions. This adds to further complicate the issue of who is responsible to cater for the education continuity of children with physical conditions? This important finding, points out to the fact that children with physical conditions are often considered as having special educational needs, as they may have reduced functional capacity such as accessing educational provision but that does not indicate they have special needs (Closs, 2000). Physical conditions and SEN are conceptually different, in practice there is often an overlap between them. This detailed topic was presented in Chapter 2.

Further, the data gathered in the current research project indicates that some children with physical conditions, who encounter academic difficulties are moved from mainstream to special education schools. Closs (2000) asserts that most children with physical conditions attend mainstream schools, and although national and local authorities' policies of inclusion have been widely disseminated, yet a striking number of children still attend special education schools. Although, guidance issued by WAG (2017) and DfE (2015) have declared that children with serious medical conditions should be educated alongside their peers in mainstream schools as in the past these children are often educated in special schools. Children with conditions such as asthma, epilepsy, cystic fibrosis were educated in segregated provision, having access to all the medical and para-medical facilities but not necessarily to a wide-ranging and motivating education, hence were often educated in a 'disabled' environment. The data also suggest that many other children attend special units with some amount of time spent being educated in mainstream school with their peers. Educated in a special provision means that they have a condition affecting severely their cognitive health or physical/mobility or both. This topic is also considered in detail in Chapter 2.

The participants in the current research also indicate that children being absent from school remain the school's responsibility, with the school being the foremost caretaker of academic provision. Wilkie (2012) maintains that some schools regard pupils that are absent from school no longer their responsibility. The longer a pupil is absent, the less likely he/she will receive academic support from the school as schools do not support pupils during lengthier absences (Shiu, 2005). School is an environment that provides pupils with opportunities to learn, interact with peers and adults and experience success, simultaneously it is a place where these children are confined of their illness. Among other support providers, the school will inform the Local Authority (LA) that arranges home tuition for these children and as suggested by the current research participants that LA is responsible for providing tutors and appropriate educational resources for these children's education. WAG (2017) provides clear guidance that the local authorities have a duty (sections 19(1) and 19(4) of the Education Act 1996) to arrange the provision of suitable Education other than at school (EOTAS) for all children and young people of compulsory school age. This provision can be provided in hospital or at home by a named member of staff who is responsible for a child's healthcare needs, liaising with parents, the local authority and others involved in the child's care. As explored in Chapter 4 according to the interviewees, the Welsh and English

Governments have got a statutory duty to provide home tuition for children with prolonged absence from school but the overall responsibility to provide work for the child rests with the school because the child remains on the school roll.

Therefore, while it is anticipated that the challenges of maintaining academic continuity for the children with physical conditions may change, the problems and dilemmas for those responsible for coordinating and supporting their education will remain (Crowther, Dyson & Millward, 2001). One of the main difficulties in facilitating a pupil's academic continuity is often the teacher's lack of information and understanding of a pupil's physical condition that can affect his/her academic and social skills, which is discussed briefly in the following section.

5.2.3   Limited awareness and professional training for teachers

The basic need for professional training and education for teachers to support the academic continuity of a child's education, is a key finding of this research and is underpinned by the work of Norris and Closs (1999); Wilkie (2010) and Hinton and Kirk (2015). My data shows that teachers often meet with parents to discuss issues relating to their child's physical condition but report a lack of professional information regarding physical conditions and their implications for the classroom. This is in line with Mukherjee, Sloper and Lightfoot's (2000) finding that the majority of teachers in the UK reported a need to increase the awareness of physical conditions and issues related to them among staff which would be helpful to increase the pupils' understanding as well.

Some research participants indicated in Chapter 4 that teachers are often unsure how to deal with any medical emergency relating to the child. The current research findings show that due to a lack of knowledge and confidence, teachers may be unsure as to whether to encourage the child to participate in all activities or exclude the child from activities altogether. They may be anxious and concerned about how best to treat the child if they become ill in school and lack confidence in dealing with the unexpected medical emergencies arising in school (Eiser, 2000). This is affirmed by Parkins (2012) that teachers are often poorly trained and ill-informed regarding childhood diseases. Interviewee 7 also indicated that teachers are apprehensive of teaching such children as they are not aware of the various conditions and will be anxious. Teachers may experience worry, ambiguity and frustration when they face a newly diagnosed condition for a child under their care and are unsure how to manage or approach the child (Shiu, 2004b and Wilkie, 2012), which can

inevitably be a stressful experience for them. Equally, there is a wide range of physical conditions, and it is unlikely that a teacher will have had the experience of teaching a child with the same condition previously, except for some very common illnesses such as asthma (Shiu, 2004a). Research by Mukherjee, Sloper and Lightfoot, (2000); Brook and Galili (2001) and Clay *et al*., (2004) suggest that school personnel may not be fully aware of the educational needs of children with physical conditions, placing them at further risk for academic and social difficulties. Norris and Closs, (1999) added that most teachers will respond to their pupil's illness or death as lay people rather than as trained professionals. Occasionally they are not sure whether to treat their pupils with physical conditions in the same way as their peers. Instead, their knowledge and confidence about their ability to deal with a potential medical emergency can encourage these children to participate in extracurricular activities, such as excursion trips. According to Wilkie (2012), keeping things as normal as possible for the child reduces the teacher's worry instead it increases the children's sense of control and helps them cope better with treatment.

Moreover, it was an interesting comment by a participant in Chapter 4 that teachers are often not aware of their pupil's condition, which reduces their confidence in welcoming that child into their classroom. This finding relates Closs's (2000) study as she stated that teachers should raise their awareness of the needs of the children and should also acquire the skills and knowledge to provide equal learning opportunities for all their pupils (Closs, 2000). Adequate information about a child's condition and its effect on his/her learning may increase a teacher's ability to accommodate his/her health and academic needs in the classroom (Hinton & Kirk, 2015). Teachers can also play an important role in supporting the children to manage symptoms, integrate with peers and achieve their academic potential. The current research's findings also show that school environment greatly affects the development of a child with physical conditions as well as the attitude, behaviour and actions of their teachers. For example, by assisting play, learning and peer relationships, teachers are able to support children in experiencing mastery and optimizing their development. Therefore, teachers and school professionals must be prepared to respond to the needs of children who live with physical conditions as they are better able to deal with the situation if they have adequate information and support from parents and medical professionals. This information should focus not only on the condition, diagnosis and treatments but also on the likely warning signs and management of medical emergencies. They should also be aware of the behavioural and psychological problems the child may

experience because of medication, treatment and the illness itself (Roberts *et al.*, 2000). Under these circumstances, health professionals such as GPs, paediatricians, speech and language therapists, occupational therapists, physiotherapists and dieticians can provide health advice and support to the staff in schools. In addition, according to the WAG (2017) guidelines, third sector voluntary bodies can also provide advice and practical support for example, practical help when writing and implementing IHCPs, counselling sessions and training and awareness-raising resources, including video links.

Thus, the work of training teachers to cope with the special needs of children with physical conditions is often a neglected area, both in initial teacher training and in-service courses. It is of utmost importance that teachers are professionally trained to address academic and psychological needs of children with physical conditions as they would be able to provide appropriate learning opportunities according to the individual's health-related limitations (Clay *et al.*, 2004). They may further help to inform classmates who may be worried about 'catching' the illness which will improve social acceptance and peer relationships. In the United Kingdom, much of the responsibility for the everyday management of the child's condition is monitored by the trained health professionals including school nurses (Shiu, 2004a). However, Neuharth-Pritchett and Getch (2001) suggest that schools should also provide health care training for teachers and teaching assistants for situations when the school nurse is not available or unable to manage health care at the appropriate time. If they received specific guidance on how to assist children with physical conditions, they would be more consistent, tolerant, considerate and involved in providing support to these pupils (Thompson *et al.*, 2015).

In the absence of formal and ongoing professional training, teachers rely on various informal sources of information concerning physical conditions, including the internet, personal experience and discussions with others (Thacker *et al.*, 2008). This can lead to receiving inaccurate information giving rise to harmful practices such as placing an object in a child's mouth during an epileptic seizure (Eyong *et al.*, 2012). The guidelines provided by WAG (2017) underline that the governing bodies must ensure that the staff with responsibility for supporting children with medical conditions are appropriately trained. Therefore, the findings of the current study show that there should be formal training programmes to ensure that all school staff who support children with physical conditions have an accurate understanding of their conditions. The staff can often recognise the key signs and symptoms for which they need to watch and know what action to take in an

emergency. Additionally, every local school should arrange for refresher training on a regular basis to ensure that the teachers have the latest information concerning the child's condition. There emerges an immediate need for the development of school policies and procedures about these children' academic requirements, which should be clearly communicated and agreed with school staff during such professional trainings.

Among other academic requirements, providing quality education at home and in mainstream school holds significant importance, as indicated by the participants of this research and is discussed in the following section.

5.2.4 Compromised quality education at home and in mainstream school

One of the participants' concern was the quality of academic continuity children with physical conditions receive at homes or in hospital during their absence period. Their apprehensiveness about providing the same curriculum for this particular group of children as to others in the classroom is genuine. This finding is supported by Wilkie (2012), who states that the academic support should be provided prudently as not merely providing access to the right and uniform curriculum is important but also the quality of learning for continuous reinforcement.

Although teachers are sometimes reluctant to contact the children during their prolonged hospital stays, yet on the other hand, most children, are eager to maintain contact with their school. This finding of the current study relates Wilkie's (2010) research which indicates that children with physical conditions wish to continue their school studies and keep connected to their schools during their prolonged absence. Due to advancement in their medical treatments, they are often not regarded as in-patients and consequently, spend less time in hospital. They therefore have reduced access to the educational support provided by on-site hospital schools, yet they are still too unwell to attend school and consequently will require home tuition. This service is provided to the children only if they have been absent from school for an extended period, usually after six weeks as indicated by interviewee 1. Those whose absence from school is recurrent or intermittent are likely to receive no provisional educational support at all (Shaw & McCabe, 2008).

Moreover, as indicated by interviewee 6 in the previous chapter that in Wales a pupil may receive 3 hours' teaching per week by the home tutors whereas, in England a child may receive a minimum of 5 hours of home tuition a week. Home tutors are assigned their

responsibilities by the local councils but they occasionally liaise with the child's home school. If they liaise, they sometimes take the work completed by the child at home to their class teachers to mark, as indicated by interviewee 2. Occasionally, however, they are not able to teach them even for the 3 or 5 hours that have been assigned due to several reasons, for instance, if the child is having a rough day or is poorly and has been admitted into hospital. This may result in no teaching during that week or following few weeks, which evidently leaves gaps in the child's learning. In either case, there is clearly some inequality in the provision of receiving only 3 or 5 hours of teaching, compared to 30 hours (per week) of education received by a child without physical condition. A noteworthy comment by interviewee 3 in Chapter 4 was that this group of children are not expected to cover the complete curriculum due to their illness and related issues but neither should they be given drawing or colouring or other, non-challenging activities to complete during their home tuition period. In other words, the whole purpose should not be merely to entertain the child but rather for the individual to learn from such activities and cover as much as possible of the required curriculum. When the child returns to school, they will then be familiar with the work and can understand what is going on around them.

Considering the gap between the full-time school experience and the provision available to children with physical conditions, it is imperative that such children are given appropriate academic continuity. If resources are accessible, the connection between school and hospital may assist in bridging the gap in communication and improve the coordination of efforts across systems and stakeholders (Thompson *et al*., 2015). As indicated by several participants in the current research, children use mobile phones and laptops (*via* internet facilities) to maintain contact with their peers and teachers but such communication is often used for social rather than for educational purposes. The development of digital communication networks has made it possible to extend teaching and learning beyond the traditional classroom environment, which has provided and individualized learning opportunity for the children in hospitals and at home (Jones & McDougall, 2010). My data suggests that practitioners are considering using technology such as video conferencing, Skype etc. to maintain contact with children during their prolonged absence, as indicated in Chapter 4.

According to Wilkie (2011 and 2012), much ambiguity exists concerning educational responsibilities for children away from school owing to their medical/physical conditions, including contacting them in order to maintain their academic continuity. This is discussed

above together with teachers' hesitance to initiate contact with children during their absence from school. Teachers in my research expressed concern about using video conferencing as a method of teaching as it often lacks interactivity. On the other hand, children long to remain in contact with their school, as they would prefer watching videos of lessons rather than reading a textbook on their own (Wilkie & Jones, 2010). Wilkie and Jones also considered online collaboration, for example the use of online 'white boarding' as an effective approach to maintaining contact with children absent due to physical conditions. The use of such technology for 'distance' leaning and for maintaining a child's academic continuity however requires certain resources, supportive infrastructure and trained teacher support.

Research by St Leger and Campbell (2008) suggests that, even with resources, trained teachers found the delivery of live, online lessons to children as time-consuming as it involved additional work including the reliance on information and communication technology to set up and run certain software. This corresponds to the concerns expressed by teachers in my research, who said they were concerned about workload pressures and not having sufficient time to maintain contact with their pupil. This is also in line with Wilkie's (2010) study where the teachers reported that their workloads were too considerable for them that they do not have time to master the technological skills required to contact only one child (learning away from school) with a physical condition. Workload issues for teachers supporting such pupils have also been described in the literature (Fels, Shrimpton & Robertson, 2003; Cook, 2005 and St Leger & Campbell, 2006) and have been discussed earlier in this research.

Bed-side teaching is considered as another means of maintaining academic continuity, among the four means of supporting education in my research. On-site hospital schools provide educational support and bedside teaching to children who are hospitalized for prolonged periods. Hospital schools rarely contact the patient's schools of origin (Shaw & McCabe, 2008), which is another major weakness, as ideally such schools should develop plans and resources consistent with the child's original education provision. According to one interviewee in my research, the hospital schools did liaise with the child's own school and as SENCO provided work for them via email or by telephone.

However, as mentioned in Chapter 2, that there is a different mode of operation for bed-side teaching in Wales and England. In Wales, the LA has a statutory responsibility to provide

education to children at home as well as in the hospital as part of one service. Whereas, in England though it is the duty of the LA to arrange for education in hospital, there are many hospital schools where children of different ages and grades are offered multiple daily sessions. In such hospitals, bed-side teaching is only provided if the child is not well enough to attend the group sessions. Due to the geographical difference in practice, this is a significant omission amongst the participants of the current study, and although this is not a common strategy yet none of the participants had ever an experience of bed-side teaching in hospital.

Shaw and McCabe (2008) assert that when the child is ready to attend school, flexible school days are important for a smooth transition. Mukherjee, Sloper and Lightfoot (2000) recommend that attending school for half days are beneficial for such children as they have varying levels of fatigue, pain, alertness, stamina and attention that vary from day to day, depending on their condition. Shaw and Brown (2007, cited in Shaw and McCabe) added that this burden on the schools can also be reduced using technology e.g. use of telephone consultation, e-mail, fax, instant messaging, text messaging and delivery of classwork, *via* e-mail all can improve instructional flexibility. The guidelines provided by WAG (2017) highlight that education settings have a key role to play in the successful reintegration of child with medical needs, considering parents and reflected in the IHCP. The finding of the current study also show that although it is challenging for the school administration, it may provide, for example, home tuition services on one day, one-half day at school the next and a full day at school on the third day etc as it supports successful reintegration. School re-entry support should also be provided to children with physical conditions, which may include verbal/written communication with the school, guidance for parents around resources and procedures, workshops for teachers and an individualized education plan (Thompson *et al*., 2015).

In Chapter 4, one of the interviewees stated that in England IEPs are written with the help of parents and health care professionals, and would consist of useful information to assist a child's learning. IEP is no longer a legal requirement in England, therefore the findings of this research show that not all schools use IEPs and as this is not a legal document, LAs does not have to produce a plan or make sure that a child receives any support that is outlined in the plan. According to Close (2000), IEPs are practical working documents that are utilised to support the education and training of children with physical conditions. They are useful to monitor progress and provide a bridge during their stay in hospital or at homes,

working with hospital teachers or home tutors. She also states that IEPs should be based on constant assessment of regular and special educational needs, including those related with the child's medical requirements. Such documents should be simple and brief and would facilitate the altering of strategies and modifying of targets as changes occur, record gaps in learning, planning for covering these gaps and allowing clear monitoring of progress. Most importantly, IEPs should be working documents and available to teachers, parents and children where they all may contribute and suggest realistic targets.

Children with physical conditions will experience an obvious decline in performance either because of their condition itself or due to the medical treatment. Therefore, it is important to have individualised educational programs for them to enable them to access the curriculum (Shiu, 2001). When learning problems are not identified in good, the pupil is likely to experience academic failure, further obstructing his/her self-esteem and regular school attendance. Shaw and McCabe (2008) state that teachers should be aware of current literature regarding a child's condition in order to alter the teaching and learning environment based on daily formative assessment of the children to best meet their educational needs. Children with physical conditions face academic challenges depending on their individual case and condition, which require a personal, tailor-made approach. Differentiating instruction is a valuable approach for such children as it provides room for adapting instruction according to the day to day needs of the child (Wilkie, 2012).

Individualized Health Care Plans (IHCPs) are compulsory for the children with physical conditions as indicated by interviewee 3 in Chapter 4. IHCPs are compiled in conjunction with healthcare professionals in the UK and aim to keep teachers informed of a pupil's symptoms, medical requirements and the support they require in school (Scottish Executive, 2001; DfES, 2005; WAG, 2010 and UNISON & RCN, 2012a). However, the finding of the current research show that all teachers may not be aware of the specific medical neds of each pupils as IHCPs are not routinely used in all schools throughout the UK. There is an indication that children and parents are often dissatisfied with the care receive at school (Nurmi & Stieber-Roger, 2012). Parents believe that teachers should have received sufficient training in understanding physical conditions and require greater knowledge and experience. Similarly, children often feel disappointed and discouraged by a teacher's lack of medical understanding and attitude that limit their capacity to self-manage their condition (Hinton & Kirk, 2015). However, the guidance by WAG (2017) emphasize that where possible, the children should be supported and encouraged to self-manage their healthcare

needs, depending on their ability to do so. This is sometimes referred to as 'Gillick competence'. This encouragement to self-manage their medical needs will not only give them confidence but as the current research shows that it will enable them to be independent individual as many may have to live with their physical conditions for life.

The factors discussed here highlight that there are no specific policies for managing medication, first-aid procedures and prolonged absence (Closs, 2000). The current research findings show that the guidance by WAG (2017) and DfE (2015) is available but it is not used precisely. which adds to the complexity of providing appropriate academic support to this particular group of children, which is discussed briefly in the following section.

5.2.5 The absence of clear guidelines on medication, first aid procedures and prolonged absence in school

As discussed above, the issue of educational responsibility for a child during prolonged absence from school is a complex. Similarly, the research participants indicated in Chapter 4 that there appears to be no specific guidelines for teachers, particularly regarding children's medication and first-aid procedures. These issues related to the educational continuity of the child with physical conditions seem best addressed by clearer governmental policies and the educational professionals' involvement rather than efforts made by an individual teacher or school (Wilkie, 2012). This research shows that policy guidelines to accommodate children with physical conditions is not sufficient as current policies lack a suitable framework and do not define the specific nature of academic support to be given to children absent for a prolonged period. Mukherjee, Sloper and Lightfoot (2001) added that national guidelines have been created to support UK educational authorities to meet all pupils' medical needs in schools (DfES, 2001; Scottish Executive, 2001; DfES, 2005 and WAG, 2017), however the findings of the current research show that there is evidence of confusion and uncertainty both in the guideline and in its interpretation.

Consequently, teachers are naturally concerned about how to identify and deal with medical emergencies, such as an asthma attack or an epileptic fit. General first-aid training does not prepare them to deal with an individual child's needs. Homan (1997) asserts that better understanding of most of the conditions as well as the management of medication have enabled the inclusion of many children with serious and sometimes life-threatening, conditions in mainstream classes. Therefore, it is crucial that teachers and other school staff are trained to deal with situations that might arise because of a specific medical condition

e.g. to give rectal Valium to stabilise an epileptic seizure. Inadequate ongoing professional training and support for teachers in managing physical conditions, including the correct procedures to follow in the event of a medical emergency, may place the safety of pupils at risk. Even a delay in providing appropriate medical assistance could result in serious harm to or the death of a child (Hinton & Kirk, 2015). However, guidance on medication and medical treatment in school is contained in DfES circular 14/96 (1996b) and Welsh Office Circular 34/97 (1997b) (cited in Closs) and currently in WAG (2017) and DfE (2015) has made it plain that school staff are not under any statutory or contractual duty to be involved in managing medical emergencies. Nevertheless, teachers are expected as part of their 'duty of care' towards pupils to volunteer or undertake realistic responsibilities after being trained by qualified medical staff.

For effective learning, school staff and local education authorities must have positive educational responses to the issues related to the education of children with physical conditions. However, there are only few examples of individual teachers and schools that have developed good practice for such children, though most schools are ill-prepared in terms of experience, professional training, knowledge, skills and attitudes to cater for the educational needs of children with physical conditions (Closs, 2000). For example, in my data the participants shared that one of the good practices exercised in few schools in North Yorkshire that the medical procedures have been written in consultation with the main health care professionals who are involved in the child's care and are signed by them e.g. levels of medication and administration of medication.

On the other hand, most participants believe that informing parents about schoolwork is good practice. They view of explaining schoolwork to the parents when they come to collect it from the teacher is an example of the school supporting the child's academic progress. One possible explanation for this result could be that parents are regarded as a foremost figure to provide information about the child as well as responsible for teaching children in case other agencies are not involved. However, guidance issued by WAG (2017) and DfE (2015) indicate a different position that schools, as part of good practice should work in partnership with parents and health professionals. Such guidance indicates that schools should develop a well-defined written policy and procedures within its medical policy for the education of children with prolonged absence due to their medical reasons. Schools are responsible for identifying and monitoring absences for medical reasons, maintain contact with children during their absence period and plan their reintegration to school. If the child

is absent for less than 15 working days, the school is responsible for providing homework once the child is well enough to manage it.

In defining 'good practice' Noyes (1999), states that a good practice enables the child to attend the right school for them, without facing any problems with unnecessary bureaucracy. Good practice also means listening to the child's views that may be contrary to the parents or teachers' views and to be able to participate in and enjoy education. The schools with good practice are welcoming and accommodating, have an Equality Act 2010, promote positive images of disability, with trained staff meeting the individual's needs and providing support such as installing additional information technology, toilet facilities and accommodate wheelchairs.

The official guidance on duties and good practice in schools issued by WAG (2017) and DfE (2015) address meeting the medical needs of pupils in schools. Likewise, education authorities in the UK were legally required to provide education to children with prolonged absence but it become a statutory duty in Wales and England under section 19 of the Education Act 1996 (Closs, 2000). Occasionally, even legislation and guidance is not sufficient to determine suitable and effective education, possibly because no national criteria of quantity or quality of education out of school has been specified in law or guidance. However, it is difficult to determine what such criteria should be because of the variety of circumstances and periods of absence, which would depend on the independent decision of education authorities, to a certain degree.

Participants in the current research also indicated their concern about the child's reintegration. The findings of this research show that children with physical conditions find it difficult to reintegrate and continue their previous school routine life. Though local education authorities are advised that 'school policies and practices need to be as positive and proactive as possible to welcome the child or young person back into school and to assist successful reintegration' (DfES, 2001, p. 29 and WAG 2017), there is nonetheless limited guidance on how schools should manage absenteeism and school re-entry for pupils with long-term conditions (Hinton & Kirk, 2015).

However, it was encouraging to find that some schools have their personalized policy as indicated by interviewee 1, that they individualized the policy document received from the LA and structure them according to their institutional needs and requirement. This finding is in line with Homan's (1997) conclusion that each school should have its precise policy

according to its own needs, which would be discussed with school staff, governors and parents. In principle, schools should develop a clear policy on medication and first-aid procedures for supporting children with physical conditions that is agreed and known by staff, parents and children. Therefore, this policy can be included in the school's prospectus so that it is available to the parents and should include supporting pupils with long-term or complex medical needs, written agreement from parents for any medication for the child, training staff to deal with medical needs, record keeping, storing and accessing to medication and the emergency procedures of a school.

Summary

In this chapter, the findings relating to the information presented in the literature have been synthesised and analysed in accordance with current knowledge. The six identified themes from Chapter 4 that emphasise participants' perceptions of facilitators in supporting academic provision for children as well as the main barriers in Wales and England which hinder the appropriate academic continuity for this group. The limited research available, that addresses the educational needs of children with physical conditions, is in line with the minimal attention given to determine present practice to deliver such services to this group of children (Shiu, 2001).

The research questions posed for my study have also been discussed together with the aims of the study. The study's contribution to knowledge and how it relates to practice has also been considered here, to enable future researchers to draw conclusions and make recommendations in Chapter 6.

CHAPTER 6   CONCLUSION

Given today's medical advances, more children are surviving physical conditions and managing their health day-to-day. For them, the concern may not be about getting better but rather about how to live a good life while being not well. There are multiple issues and concerns when a child with physical conditions is unwell and absent from school. However, a complexed intersection of medical and educational domains has made it even more complicated (Wilkie, 2011). Children with physical conditions receive their treatment at home as they are more likely to be in and out of hospital and experience prolonged or accumulative absence from school. Yet many of them want to remain a part of their school's academic and social life. The intent of the current research has been to consider if and how academic continuity can be maximised for children with prolonged absence owing to physical conditions by helping them maintain connections with their teachers, peers and schools. The main findings of this research are summarized in the following section.

6.1   Summary of the main findings

Results of this study revealed that more than 60% of participants reported having an experience of teaching children with physical conditions or had recently supported such children. The most frequently reported physical conditions were kidney transplant, gastrostomy, road accidents, spina bifida, muscular dystrophy, heart conditions/surgery and other degenerative conditions, all of them have a significant impact on children's social and academic functioning at school. Despite the prevalence of children with a physical condition in primary schools (which is 10% of children aged 0–9, Hinton & Kirk, 2015), these results are consistent with previous literature suggesting a lack of information among professionals regarding issues associated with physical conditions in children in Wales and England (Miller, 1995; Spencer, Fife & Rabinovich, 1995 and Hinton & Kirk, 2015). Furthermore, teachers are apprehensive about teaching such children in their class as they are unaware of the various conditions; thereby feel anxious in emergency situations.

It is difficult for children with physical conditions to maintain regular school attendance, achieve good academic grades and to adjust socially because of their condition, its consequential affects and treatment they receive. The findings of the current research show that the children with prolonged absence miss actual teaching in the classroom, become out of routine, miss core aspects of the taught curriculum and important explanation by the

teachers. This consequently leads to gap in their learning, having definite effects on their future learning and difficulties in reintegration. Missing face-to-face teaching interaction and being away from peer group while in the hospital, can create additional barriers to learning and further anxiety. School provides opportunities for social connection and friendship and group work provides opportunities for social interaction; hence, it is hard to separate the educational and social implications of children's absence from school (Mukherjee, Sloper and Lightfoot, 2000; Shaw & McCabe, 2008; Wadley *et al*., 2014 and Filce & LaVergne, 2015).

Therefore, the participants of the current research stressed the importance of minimizing the impact of physical conditions and prolonged or recurrent absence on academic attainment by supporting their academic continuity. However, there is a muddled understanding and acceptance of roles and responsibilities among professionals to contact these children during their absence from school. Most of the participants considered parents to be the foremost caregiver of their children and therefore are responsible to find out their children's missing work from school and help children continue their education. However, this shows a lack of consistency in relation to policy and practice as the guidance provided by WAG (2017) and DfE (2015) suggests that the parents' foremost responsibility is to inform school about their child's absence and medical condition but not to educate him/her. Another opinion by the research participants was that class teachers and SENCOs are responsible for contacting and providing academic continuity to these children while they are in hospital or at home. However, according to WAG (2017) and DfE (2015) guidance, teaching staff including SENCOs do not have a professional duty to administer medicines but they should consider the needs of pupils with medical conditions (physically and mental) under their care. They should receive adequate training and should be capable to take the responsibility to support such children.

There were only few research participants who indicated that it is the responsibility of the head teacher and the LA to arrange education of these children. This however, is in line with the guidance issued by WAG (2017) and DfE (2015) as these documents state that governing bodies should develop policies according to the individual needs of their school taking advice from teaching staff, health professionals, parents and children. The head teacher has a statutory responsibility to implement the policy for these children in their school. They should designate their responsibility to a named person as well as make sure that all the staff are provided with appropriate training to cater for the needs of children with

physical conditions. According to these guidance, in Wales and England LA has the main responsibility to provide education other than school, that is in hospital and/or in the comfort of the child's own home. With planned hospital admissions, LAs are responsible to provide information to the teacher who will be teaching the child including the likely admission date and expected length of stay, which will enable her/him to liaise with the child's school of origin and develop a programme to be followed while the child is in hospital. This set personal education plan will ensure that the child's school, the LAs and the hospital school or other provider can work together. Moreover, it is the duty of LAs to make sure children can remain in touch with their school while they are away and set up an individually tailored reintegration plan for each child, for his/her successful reintegration.

The use of information communication technology (ICT), home tuitions, Individualized Education plans (IEPs) and Individualized Health Care Plans (IHCP) were considered important means to provide academic continuity by the participants of this research. However, the findings and the review has indicated a difference in policy and practice in the schools in Wales and England. Therefore, the present research recommends the following implications for practice to mainstream primary schools, in order to provide effective academic support to children with physical conditions.

6.2   Implications for practice

The prospect for academic continuity for children with physical conditions involves many multifaced issues such as social, educational and medical domains. However, a few adjustments to people's perspectives, changes to current programs and practices, or even broad policy may increase that possibility for many children who seek it (Wilkie, 2012).

The following suggestions relate to the themes and issues about academic continuity that emerged from this research. They are not intended to prescribe what must be done but rather to suggest what could be, perhaps to encourage the educational outcomes for children with prolonged absence owing to physical conditions.

i)   Schools need to be more flexible in designing Individualized Health Care Plans (IHCPs) that are modified to the child's medical condition and that target the child's academic, socioemotional and physical needs. These plans should also include strategies for everyday management as well as emergency treatment procedures and details of a named responsible staff whose advice should be taken into account at the

time of need. Most importantly, these plans should be developed by considering health professionals (including physiotherapist, occupational therapist, school nurse), teaching staff (class teacher, SENCO, head teacher), parents and the child (if appropriate). These multidisciplinary teams should regularly evaluate their plans to ensure that children with physical conditions do not fall further behind in their academic development and are provided appropriate social and emotional support. These monitoring and evaluation strategies should seek to ensure new developments are taken on board and levels of education are of a sufficient standard (WAG 2017).

All members of interdisciplinary teams can bring different skills, experiences and unique responsibilities to the table. They may also differ in their approach to problems which may make their collaboration increasingly challenging. However, such diversity amongst team members makes it important for all individuals to be open to the advice and guidance of their colleagues (Boutilier & King, 2013). Boutilier and King (2013) assert that challenging interdisciplinary collaboration often results in the most effective outcomes for children, considering that all members present their recommendations in a collaborative rather than in an authoritative or expert manner.

ii) Creating a safe school environment promotes respect for all unique pupils despite their individual differences. Moreover, by providing an open and knowledgeable classroom environment, by encouraging children with physical conditions a chance to share their stories, can be a part of health curriculum. Some children enjoy educating teachers and peers about their conditions, which can be therapeutic for the child and educational for the classmates. However, other children with physical conditions do not want to discuss their conditions, so their privacy/wishes need to be respected. Also, bringing health professionals for discussion and facilitating peer learning can contribute to healthy classroom climate and may help to resist absenteeism.

iii) There is a need for a system in school whereby new teachers or supply teachers are provided with an up-to-date information about pupils with physical condition throughout their school career. This will enable them to be informed about the health condition of the child they are looking after and be prepared for any emergency situation, in case. However, as the WAG (2017) guidelines suggest the right to privacy of a child with physical condition must always take into account.

iv) There is an urgent need for more initial and in-service staff development to enable the inclusive education of children with physical conditions and to allow teachers to respond in an informed manner to the needs of these pupils. This training should be provided regularly however, refresher training should be provided at least once a year and should specifically focus on the different conditions the children of their school have, its treatment, medical emergency procedures, the impact of medications and treatments on learning, memory and overall health of a child.

v) The participants of this research have recommended good communication with the parents which is very helpful as they are the foremost and immediate source of information for the school. Also, regular contact with the health professionals was suggested as one of the important recommendations to support children's academic continuity without any delays. To receive effective support, frequent communication with relevant health professionals is also highly recommended by WAG (2017) guidance. There must be considerable improvement in communication between healthcare, educational and social care services and families to share information about the specific needs of an individual child. This practice is useful to identify people within the education and medical professions to provide ongoing management of the child's condition, particularly being aware of the likely side effects of medication and/or treatments for educators when adapting material to individual pupil's learning styles and the management of his/her behaviour. Moreover, healthcare professionals can provide educational programmes to the teaching staff as the participants of my research appear to be keen to receive advice and support from them. It is suggested that if teachers have limited time to attend training programmes or if they are teaching in geographically remote settings, there is a scope to use IT facilities to deliver training programmes remotely, quickly and cost-effectively to them.

vi) IT facilities should be used for teaching children with prolonged absence and not merely for maintaining social contact. The schools should offer clear guidance on the educational advantages of videoconferencing in an age of rapidly developing technology, including the emergence of social media tools. Externally determined education policy is of course facilitated at the level of the school by its leadership's decision as to whether to incorporate educational strategies or not such as videoconferencing. As a continuous use of videoconferencing for teaching purpose is strongly associated with a school leader who demonstrates support for and

understanding of the educational potential of videoconferencing. As a result, it can lead to investment in technology, in relevant professional development opportunities for their teachers and can be a significant part of their school curriculum.

Moreover, the school website can provide generic guidance about physical conditions to encourage their staffs' ongoing involvement with their pupils during absence from school. Content might include importance of their contact with children during their absence, advice from pupils and teachers who have experienced similar situations, strategies for managing study during absence, suggested wording for e-mails and information about schoolwork.

vii) The provision of minimum entitlement of home tutoring for 3 hours' teaching per week in Wales, in the years up to and including Key Stage 3 (Year 9) and a minimum of 5 hours of home tuition a week in England, is possibly too limited for some children. Furthermore, there should be suitable measures to evaluate home tutoring so that children are provided rightful access to national curriculum, which will enable their smooth reintegration.

viii) This piece of research suggests providing funding for the additional/assistant teachers to enable them to teach children at home or in hospital, to help children catch up and may liaise between school and home. This approach requires certain resources, supportive infrastructure and trained teacher support. Likewise, Education sectors can provide funding for schools so that teachers can be given extra time while they support a child with physical conditions. This could for example mean eliminating their yard duty or minimizing their teaching responsibilities or co-curricular commitments. Moreover, there should to be a commitment from central and local government to provide ongoing support to fund specialist child healthcare services such as local clinical commissioning groups comprising a range of professionals who work in partnership to deliver a range of services to local inhabitants.

ix) By providing an emotional support to the children with physical conditions, the school will enable them to know people around them who can empathize them at times when they undergo challenging treatments, separation from family and peers, social rejection, changes in their appearance and academic performance. Also as WAG (2017) guidelines suggest, school can also take health advice from third sector voluntary bodies for practical support. Moreover, school can also provide emotional support by

implementing different strategies to maintain social contact with the child's classmates for example, by arranging and encouraging the child to attend social get together at school. In case the child with a physical condition is reluctant to attend big gathering, the school can arrange for small peer groups where they all can talk using a telephone, a laptop or a computer.

x) To ensure inclusive provision and access for all pupils, all schools are required to provide children using wheelchairs an access to all parts of the school including playground and indoor activity areas. The school must provide them an appropriate sitting arrangement or ample space for moving their wheelchairs freely and arrange for their classes on the ground floor only. They should also be provided facilities of a supervised, hygienic, private room to receive medication in privacy or can change with dignity.

xi) Above all, it is important for every primary school to develop a personalized policy statement for this group of children that is accessible to every staff member. This policy should be referred in full when dealing with issues in this area, as advised by the WAG (2017) and DfE (2015) guidance. Moreover, it should have named personnel for certain responsibilities for these children e.g. administering medication, clear guidelines on storing medication, practicing first-aid procedures and prolonged absence in school.

6.3   Further research

Further research can build on the findings from this study. In this study, teachers reported that they do not have sufficient knowledge or training to work with children with physical conditions. Therefore, additional research might assess interventions to increase teachers' knowledge and understanding of this topic. Additionally, future research might assess if such trainings have an impact on the attitudes and behaviours of teachers in a manner that benefits the child with a physical condition. Similarly, further research can focus on school systems whether they provide formal training to identify children with physical conditions and assess if this training is feasible and acceptable to healthcare professionals and school staff. However, it should also examine if increased education and training for teachers results in better educational programming, better academic and social outcomes, child and parent satisfaction and more efficient use of already limited school resources. These research areas can bridge the foundation of increasing knowledge about physical conditions

so school systems can identify, intervene and properly assist children with physical conditions.

The evaluation of home tuition is an additional area that warrants further research. In addition, more children at secondary school level than children at primary school level receive such support. This is not surprising, given the fact that home tuition is limited to 3–5 hours of teaching a week in Wales and England, consequently, only the main subjects can be included. For future research, it would be interesting to further examine the differences in educational needs between primary and secondary school age children.

Despite the growing awareness of the necessity of education for children with medical conditions (physical and mental), and the barriers that they face regarding school re-entry, there is still little empirical research available addressing programmes that facilitate school re-entry.

Another area to be considered by the future research is to conduct a study with children with physical conditions, their parents, health professionals and hospital based teachers/Hospital Education Services. My research mainly focused on the role of schools and education professionals but it would surely be a motivating investigation to take view point of other stakeholders about the said topic, using case studies or other qualitative measures.

6.4 Limitations of the study

Although not all areas were discussed with the same depth and description, the participants provided rich descriptions of the meaning and management of supporting academic continuity of children with physical conditions. Yet there are some limitations to this study that must be acknowledged.

One of the limitations of this research for me as a researcher was to narrow down my research topic as it was very challenging to thin down to a simple definition of physical conditions considering a vast knowledge of medical conditions and disabilities.

Another limitation was that it was difficult to find literature directly dealing with this research topic particularly in the United Kingdom context. I therefore studied broad range of literature around the research topic published in different parts of the world and followed their reference lists to retrieve further studies.

Due to the constraints of time in this EdD research, my research lacked cultural diversity. Moreover, the study sample was limited with respect to conditions represented and professional's experiences with children with physical conditions in mainstream primary schools in Wales and England. However, such small samples can provide rich, informative data as mixed methods research relies upon depth rather than breadth (Wengraf, 2001).

Also, being a parent of a child with a physical condition, I wanted to include parents who have children with physical conditions in my study. I asked for the permission from the ethical board which was denied. This was frustrating for me at that time but further down the road researching this topic, I realized how wise this decision was. As the university's ethical board protected my emotional stability, I remembered clearly many times I cried reading parents' cries in words, their anxieties and fears about their children's future. I therefore have mentioned in the recommendations of this study, the future researchers must explore this topic with the parents, particularly those who do not have any emotional attachment to such area of research.

Although using questionnaire for data collection is subject to social desirability bias, one would expect that if such bias existed here it would have resulted in an overestimate of how prepared teachers and other professionals feel to deal with issues regarding physical conditions. This was clearly not the case as I received only 45 questionnaires out of the 2000 that I sent online to different schools. It was also limited in the type of analyses that could be conducted based on the observations or case study data.

Despite these limitations, the results are similar to the findings gained from previous research conducted in the UK and in other different countries, as presented in Chapter 2.

6.5   Strengths of the study

My study has a potential to inform educational policy in Wales and England for additional learning needs (ALN) to strengthened relationship between school and health services. The findings and recommendations can also be helpful for governing bodies, principals, SENCOs and teachers to modify classroom activities and school routines to accommodate the individual needs of children with physical conditions.

This study has reviewed and synthesized evidence about the barriers and facilitators to teachers' supporting academic continuity of children with physical conditions. It has

highlighted that healthcare professionals have an important role to play in training and supporting teachers to meet children's health needs.

Primarily, this study has identified the potential of educational interventions to increase teachers' knowledge and confidence in meeting the needs of this group of children. In addition, it was intended to give direction to parents, educators and policy makers wishing to understand and deal with the concerns of teachers and other education professionals in the education of children with physical needs.

6.6   Concluding reflections

As mentioned in Chapter 1, I have a genuine interest exploring this topic being a parent, who could only see her beautiful daughter, neither her physical condition nor its affects. Like other parents with children having physical conditions, I just not loved my first born but also embraced her cruel and life-threatening condition. While considering issues regarding academic continuity of children with physical conditions, certain ideas overlapped throughout this research journey, being a researcher and a mother at the same time.

In given circumstances, it is difficult to avoid subjectivity but by using reflexivity, I found that subjectivity in research can be transformed from problem to opportunity (Bonner, 2001). Therefore, subjectivity about this precise topic provided me an opportunity to explore these issues in a broader context of school in Wales and England. As discussed in Chapter 3, reflexivity requires critical self-reflection of the ways in which researchers' social background, assumptions, positioning and behaviour impact on the research process. Considering this at times I felt sorry for the parents of the children with physical conditions, the trauma they go through along with their child, with an additional pressure to be responsible of their child's academic continuity (as some research participants strongly emphasized this).

Moreover, I was very keen to explore the available policies and their process of implementation in mainstream primary schools in Wales and England, as well as the connections between different professionals to encourage children's education during absence. In research reflexivity can be translated as thoughtful, self-aware analysis of the intersubjective dynamics between researcher and the studied phenomena (Lynch, 2000). The findings and implications shared in this research have highlighted the value that many professionals place on providing academic continuity to children with physical conditions

during their prolonged absence from school. Children with physical conditions can be at risk of school failure and developing long-term problems in psychological adjustment if their individual needs are not considered (Shiu, 2001). Ambiguity about responsibility for the academic support of children absent from school was highlighted as an issue best addressed by educational sectors and schools. Most teachers struggle to manage time to contact children due to their workload and are unfamiliar with their physical conditions hence, lack confidence to provide appropriate educational support. However, during prolonged absence children desire to maintain contact with their schools as it helps them to maintain a daily routine, stay up-to-date with their studies, keep in touch with peers and keep an important non-medical aspect of their lives.

It is the legal mandate for all primary schools in Wales and England to be responsible for the academic continuity of the children with medical conditions (physical and mental) (WAG, 2017 and DfE 2015). As per the definition of academic continuity the notion of access the opportunities to learn, it is important for schools to find ways to build regular means of interaction, schools' and teachers' knowledge, confidence and ability to support the increasing numbers of children with physical conditions. Schools can make a difference to help children to cope with a physical condition and can facilitate their academic and social growth by providing appropriate support, resources and encouraging attitudes by school communities, to ensure that all pupils receive access to equity in educational outcomes (Shiu, 2004). Children with physical conditions may require teachers to modify classroom activities and school routines to accommodate their needs, such as flexible school attendance or different/individualized instruction (Kliebenstein & Broome, 2000 and Shaw & McCabe, 2008). It is imperative to develop strategies that can be managed practically and to be persistent in the use of technology to support their ongoing learning. Such strategies are worth practicing as good education will ensure that maximum number of children are able to function effectively within society tomorrow and live longer and happier lives (Capurso, 2014).

Finally, my research has identified a few gaps in the current literature. Most of the studies has chiefly included teachers' knowledge and perceptions of the most common childhood long-term conditions, e.g. asthma, diabetes and epilepsy and not much focus has been given to the other physical conditions and their effects on a child's education. Secondly, most of the studies included in my research, have been conducted in different parts of the world and not much literature is available in the UK context. It is significant to emphasize this area of

research as the number of children with physical conditions is growing in the UK each year. Lastly, the limited research available in the UK context regarding medical conditions (physical and mental) has included opinions and attitudes of trained teachers, school personals or parents. However, the research has not involved professionals from health care services, social services, LAs and hospital school teachers' beliefs, which holds significant importance as supporting children is not the responsibility of an individual school or a teacher but of an efficient multidisciplinary team.

APPENDIX I (Pilot study questionnaire)

Survey of teachers' opinions to provide academic support to children with physical conditions for academic continuity during prolonged absence.

For the purpose of this study the terms physical conditions, prolonged absence and academic continuity are defined as follows

Physical condition: incapacity of an individual's body to function normally, affecting individuals' ability to move, co-ordinate and/or control, caused by a bodily defect or injury.

Prolonged absence: children who have missed school approximately 50% of time over the past six months (about 3 months) as a result of a physical condition.

Academic continuity: students' access to, and utilization of, opportunities to learn effectively so that academic progress is made despite disruption to full-time schooling (wilkie, 2012).

Part A

Consider one child in your class and answer the following questions. Please reply to all the questions by tick marking the appropriate box.

1. Are you currently teaching a child who has had a prolonged absence as a result of a physical condition?

    Yes ☐   No ☐   Not sure ☐

   School absence

2. Children who have a prolonged absence are at greater risk for under-achievement in school.

    Yes ☐   No ☐   Not sure ☐

3. Parents are responsible to find out missing work during their child's absence from school.

    Yes ☐   No ☐   Not sure ☐

4. Children who have a prolonged absence may miss out on mastery of core skills that are required to progress on to more advanced skills.

Yes ☐   No ☐   Not sure ☐

Means of support to provide academic continuity

5. How often do you use these different means of academic support for children with prolonged absence?

	Daily	Once in a week	A couple of times a week	Once in a month	A couple of times a month	Two or three times during entire absence period	Never	Any other? Please specify
Flexible attendance (children attending school for 1 to 4 hours)								
Technology (telephone chats, videoed lessons, videoconferencing, live online interaction, using Skype, Facetime etc.)								

Differentiated instruction (teaching designed around the needs of a specific group)								
Individualized instruction (teaching focused on the needs of an individual student using IEPs)								
Bed-side teaching (while the child is in hospital)								
Home tutoring (teaching in child's home)								

Communication with children during prolonged absence

6. Who do you think has the responsibility to contact children with a physical condition during prolonged absence?

Classmates		SENCOs		Local Education Authorities	
Class teacher		Principal/Head teacher			

7. How often do contacting children during absence adds to your work load significantly?

Always		Sometimes	
Often		Never	

Communication with health professionals

8. Do you know whom to contact in health sector to take information about children with a prolonged absence due to a physical condition?

   Yes ☐   No ☐   Not sure ☐

9. Do you receive information and advice directly from health professionals about children with a physical condition?

   Yes ☐   No ☐   Not sure ☐

10. Do you receive prompt information from health professionals to help you plan appropriate programmes for children with a physical condition?

    Yes ☐   No ☐   Not sure ☐

Part B – Open questions

11. In general, do you believe that prolonged absence from school can cause severe barriers to children's learning? Please explain the reasons for your answer.

    _____
    _____
    _____

12. Do you think it is important to provide appropriate academic support for children with physical condition during prolonged absence? Please explain your answer.

    _____
    _____
    _____

13. What good practice does your school use to support children with a physical condition during prolonged absence? Please give an example.

_____

_____

_____

14. What do you recommend to primary schools to improve their academic support for this group of children's academic continuity?

_____

_____

_____

15. May we contact you again in the near future?

_____

_____

_____

Thank you for taking the time to fill in this survey.

APPENDIX II (Revised/actual questionnaire)

Survey of teachers' opinions to provide academic support to children in Key Stage 2 who have a prolonged absence due to a physical condition.

Dear teachers,

While filling in this questionnaire, please make sure you must observe Data Protection Act 1998, requirements by not identifying a pupil by name, school marks nor exams results, SEN assessments or medical diagnosis.

For the purpose of this study the terms physical conditions, prolonged absence and academic continuity are defined as follows

Prolonged absence: children who have missed school approximately 50% of time over the past six months (about 3 months) as a result of a physical condition.

Physical condition: incapacity of an individual's body to function normally, affecting individuals' ability to move, co-ordinate and/or control, caused by a bodily defect or injury.

Academic continuity: students access to, and utilization of, opportunities to learn effectively so that academic progress is made despite disruption to full-time schooling.

Part A

Consider one child in your class and answer the following questions. Please reply to all the questions by tick marking the appropriate box.

1. Are you currently teaching or have you recently supported a child who has had a prolonged absence as a result of a physical condition?

    Yes ☐   No ☐   Not sure ☐

2. What is your role within the school?

Class teacher		Principal/Head teacher	
SENCOs		Teaching assistant	

School absence

3.   Do you agree children who have a prolonged absence are at greater risk for under-achievement in school?

    Yes ☐   No ☐   Not sure ☐

4.   Do you agree parents are responsible to find out about missing work during their child's absence from school?

    Yes ☐   No ☐   Not sure ☐

5.   Do you agree children who have a prolonged absence may miss out on mastery of core skills that are required to progress on to more advanced skills?

    Yes ☐   No ☐   Not sure ☐

Communication with children/families during prolonged absence

6.   Who do you think has the responsibility to contact children and their families with a physical condition during prolonged absence?

Classmates		SENCOs		Local Education Authorities	
Class teacher		Principal/Head teacher			

7.   Does someone in your school contact the children and their families during their prolonged absence from school?

    Yes ☐   No ☐   Not applicable ☐

8.   If so, does it add significantly to your workload?

    Yes ☐   No ☐   Not applicable ☐

9.   How often do you contact the children/families during prolonged absence?

Daily		Once in a week	
A couple of times a week		Once in a month	
A couple of times a month		Never	
Any other? Please specify			

Means of support to provide academic continuity

10.   Have you ever used technology to teach children during their prolonged period of absence? (telephone, chats, videoed lessons, videoconferencing, live online interaction, using Skype, Facetime etc.)

      Yes ☐   No ☐   Not applicable ☐

11.   Have you ever used individualized instruction (teaching focused on the needs of an individual student using IEPs) to compensate for the affects of prolonged absence?

      Yes ☐   No ☐   Not applicable ☐

12.   Have you ever taught children while they are in hospital (bed-side teaching) during their prolonged period of absence?

      Yes ☐   No ☐   Not applicable ☐

13.   Have you ever taught children in their homes (home tutoring) during their prolonged period of absence?

      Yes ☐   No ☐   Not applicable ☐

14.   Do you think your school is able to provide appropriate academic support to children with prolonged absence?

      Yes ☐   No ☐   Not applicable ☐

Communication with health professionals

15. Do you know whom to contact in health sector to take information about children with a prolonged absence due to a physical condition?

    Yes ☐   No ☐   Not Sure ☐

16. Do you receive information and advice directly from health professionals about children with a physical condition?

    Yes ☐   No ☐   Not Sure ☐

17. Do you receive prompt information from health professionals to help you plan appropriate programmes for children with a physical condition?

    Yes ☐   No ☐   Not Sure ☐

18. Approximately how many students are enrolled in your school>

    _____

Part B – Open questions

19. In general, do you believe that prolonged absence from school can cause severe barriers to children's learning? Please explain the reasons for your answer.

    _____
    _____
    _____
    _____

20. Do you think it is important to provide appropriate academic support for children with a physical condition during prolonged absence? Please explain your answer.

    _____
    _____
    _____
    _____

21. What good practice does your school use to support children with a physical condition during prolonged absence? Please give an example.

_____

_____

_____

_____

22. What do you recommend to primary schools to improve their academic support for this group of children' academic continuity?

_____

_____

_____

_____

23. May we contact you again in the near future? If yes, can you please give your name and e-mail address.

_____

_____

_____

_____

Thank you for taking the time to fill in this survey.

APPENDIX III (Interview schedule for the SENCOs of the primary mainstream schools in Wales and England)

1. Are you currently teaching or have you recently supported a child who has had a prolonged absence as a result of a physical condition?

    Prompt-If yes, could you please tell me a bit about your experience?

2. Do you think it is important to provide appropriate academic support for children with a physical condition during prolonged absence?

    Prompts-What good practice does your school use to support children with a physical condition during prolonged absence? Please give an example.

School absence

3. In general, do you believe that prolonged absence from school can cause severe barriers to children's learning?

    Prompts-Could you please explain your answer by giving an example?

4. Do you think prolonged absence only affects on these children's academic life?

    Prompts-Which other areas of the children's lives are affected? How?

Communication with children/families during prolonged absence

5. As a SENCO are you the key person with responsibility to contact children and their families with a physical condition during prolonged absence?

    Prompts-Is there anyone else who liaises between school and hospital/homes for these children's academic continuity? -If so, how often?

6. Is this responsibility dictated by school policy or by the local authority policy?

    Prompts-How is this policy dictated? Do you receive the written version of this policy as well? Why/why not?

Means of support to provide academic continuity

7.   Which means of support do you use to provide academic continuity to this group of children?

Prompts-technology, Individualized instruction using IEPs, home tutoring or bed-side teaching in hospital-how often?

Communication with the health professional

8.   Do you receive information and advice directly from health professionals about children with a physical condition?

Prompts-Do you wish so? How will it help you to contribute towards these children's academic continuity?

Last question

9.   What do you recommend to primary schools to improve their academic support for this group of children' academic continuity?

APPENDIX IV (Interview schedule for the Advisory Support Teacher in England and Education Social Work Team Manager in Wales)

1. What are your duties and responsibilities to support a child who has had a prolonged absence as a result of a physical condition?

    Prompts-Could you please tell me what other teams work with you to support this group of children? Please elaborate a bit about your experience.

2. Do you think it is important to provide appropriate academic support for children with a physical condition during prolonged absence?

    Prompts-What good practice does your county/LEA use to support children with a physical condition during prolonged absence? Please elaborate.

School absence

3. In general, do you believe that prolonged absence from school can cause severe barriers to children's learning?

    Prompts-Could you please explain your answer by giving an example?

4. Do you think prolonged absence only affects on these children's academic life?

    Prompts-Which other areas of the children's lives are affected? How?

Education guidelines and policy

5. What guidelines are available to support the education of these children?

    Prompts-What are your county/LEA's guidelines about who should liaise between school and hospital/homes for these children's academic continuity? How often?

6. Is there any specific policy for this group of children? Why/why not?

    Prompts-Whose responsibility is to draw policy from the National Guidelines? Please explain.

7. Do you think schools effectively implement these guidelines? Why/why not? Please give an example.

   Prompts-In your view, what is the role of a SENCO and a class teacher to put this policy into practice? Please elaborate your answer.

Means of support to provide academic continuity

8. What do the guidelines say about using means of support to provide academic continuity to this group of children?

   Prompts-technology, Individualized instruction using IEPs, home tutoring or bed-side teaching in hospital-how often?

Communication with the health professional

9. Do you receive information and advice from health professionals about children with a physical condition?

   Prompts-Do you wish so? How will it help you to contribute towards these children's academic continuity?

Last question

10. What do you recommend to primary schools to improve their academic support for this group of children' academic continuity?

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