INDEPENDENT HIGHER EDUCATION

IHE response to the DfE call for evidence on improving non-medical help for disabled students in higher education

July 2024

Introduction

For IHE and its members, student choice and equality of opportunity are paramount. We feel that all students with disabilities must be assured that wherever they choose to study they will get the support they need. We believe this means that the individual entitlement for specialist non-medical help (NMH) should remain in place, and improvements made to the experience of students in applying for and accessing this support.

We are supportive of a social model of disability, and the development of inclusive approaches. IHE members demonstrate the strengths of small and specialist institutions in this area. They are making significant efforts to develop learning and living environments and experiences that are supportive of the success of all students. They also demonstrate their strengths in providing personalised, course-tailored support for students with disabilities, including playing a key role in ensuring their students can successfully access their Disabled Students' Allowance (DSA) entitlement.

However, we feel strongly that in an environment of increasing demand but reduced funding for student support, a move to higher education provider (HEP) responsibility for NMH will have a detrimental effect on the experience and outcomes of disabled students. Despite the efforts of providers to develop inclusive approaches, the sector as a whole is not where it needs to be. Furthermore, there will always remain a need for specialist one-to-one support for those students with complex needs. Removing the individual entitlement to this will lead to a disparity of provision, limiting student choice. It will put further pressure on already stretched support staff, risking quality and ultimately disadvantaging students.

We also feel that a model of HEP responsibility would have a disproportionate impact on small providers, like those in our membership. These providers have high proportions of students with

disabilities coupled with small staff teams. The range of student needs and level of expertise required means that providers would need to outsource specialist NMH support and put internal systems and processes in place to assure the quality of this provision. This would be a disproportionately more expensive model, with administrative costs that would ultimately take funding away from the student. Even if assisted by funding, we are concerned that this would not go far enough or enable the level and quality of provision that is required. Providers are already stretched and insufficiently funded to meet demand for non-specialist support. For those eligible, public grant funding (the Disabled Student Premium in particular) has been cut in real terms. There is even greater challenge for those providers not in the fee cap category of Office for Students (OfS) registration, who do not receive any of this funding and so are relying solely on income from student fees to fund student support.

Our Student Advisory Board were clear that whilst, in principle, integrated support managed by HEPs would create a better experience and outcomes for students, this is entirely dependent on there being sufficient funding and expertise. In reality, the risk of a reduction in provision and an unequal experience across institutions is too great.

What do you consider is working well for students in the current NMH system?

The experience of IHE members has been that where students have been able to access NMH support, it has had significant benefits. Having one-to-one personalised support from a dedicated specialist has been what some of their students have needed to be able to access and succeed in their studies. IHE members have a high prevalence of students with additional needs due to the nature of programmes – for example, many offer creative courses which are known to have a higher proportion of students with disabilities or those with a strong practical element – as well as more flexible modes of study. There is a high prevalence of students with Specific Learning Difficulties (for example Dyslexia) and mental health conditions. For these students, being able to meet with a specialist, especially in-person on campus, to develop specific strategies to support their individual needs has been invaluable as complementary to the support their institution provides. The benefits of this can extend beyond their time in higher education, learning strategies to help them to transition into the workplace and be able to confidently articulate their needs to employers.

What do you consider is working well for HEPs in the current NMH system?

IHE members rely on the provision of individual NMH to provide the specialist, one-to-one support that their students with disabilities need. As detailed later in our response, our members make significant efforts to provide personalised support to high proportions of students with disabilities, drawing on small staff teams of sometimes just one or two people to do this. They demonstrate the strength of small and specialist providers in being able to develop good relationships with their student cohorts – to facilitate early disclosure and engagement with support – as well as to tailor provision to course requirements. However, they rely on students with specific and complex needs being able to access specialist support alongside this. The diversity of the needs of their students with disabilities can only be met through access

to central provision, as individual providers do not have the resource, or the expertise, to provide specialist support effectively for every student.

For some of our members, there has been effective integration of DSA-funded NMH with their own provision. The small size of the student cohort means that support teams are able to have a rapport and relationship with individual students and are therefore more likely to know about students' needs and the support they are receiving through DSA. TASO's latest research evidences the strengths of smaller providers in being able to identify and respond to the needs of students with disabilities and to build relationships that encourage early disclosure.

In many cases, staff at our member institutions have been involved in actively supporting students with the process of applying for and accessing DSA. One example of effective integration is of one provider using a supplier that provides mentoring to their students with DSA entitlement to offer their own extended in-house provision, leading to greater continuity for individuals and integration of support. However, we would stress that where there has been such integration this is due to the efforts of providers and not the NMH system as it currently is.

What aspects of the current NMH system do you consider are not working well for students?

Our members report that many students eligible for NMH support are missing out due to significant barriers in the application and assessment process.

Firstly, many do not apply as they are not aware of what they are entitled to, or how to access it. There is confusion amongst both students and staff as to what support is DSA-fundable, and what falls under reasonable adjustments that are the responsibility of the provider. There is a need for much clearer student and provider-facing information and communication that enables students to understand their eligibility and apply.

Secondly, the application process is lengthy and complex. Our Student Advisory Board highlighted in particular that this places significant stress and burden on students who already face additional challenges in accessing their studies. The length of the process means that students often do not have support in place at the outset. This is problematic for all students, as it means they will face even greater challenges as they transition into higher education, but is especially so for postgraduate students and those on accelerated programmes (offered by many IHE members). The shorter course duration and increased academic pressure from the start means that a delay in getting support could result in them not meeting the requirements of their programme and being unable to progress.

One notable issue is the evidence requirements and assessment of this. For students who do not have a diagnosis before entering higher education, getting the evidence required can be extremely challenging as they are subject to NHS waiting times to receive their diagnosis. We feel that there needs to be an alternative route for these students, for example evidence of need from their provider. Members also noted cases where evidence has been rejected but this has not been communicated with the student, causing even greater delays in them getting the support they need. Our work as part of the Many Hands project showed a trend amongst our membership that over half of students who accessed DSA were assessed during their first year

of study, in part related to the high number of mature learners and those from underrepresented groups who might not have sought a diagnosis or accessed support before.

IHE members have only been able to manage these barriers in the application and assessment process through the proactive and resource intensive support they are providing to students, for example speaking to the Student Loans Company (SLC) on their behalf or helping them source the evidence they need, and by funding additional in-house provision such as study skills tutors to provide a stopgap whilst students are assessed.

Other issues raised by our members and our Student Advisory Board are the lack of choice and flexibility for students. The two-quotes system introduced in 2016/17 means that the lower cost supplier is chosen irrespective of student preference. We do not agree with this or think that value for money should be prioritised above all else, not least student need and choice. This is particularly problematic in those few instances whereby there is an option for the HEP to provide the support (if they have a member of staff or existing contractual arrangement with a supplier with the relevant expertise). This can result in students receiving support from a new external supplier, where they have the option for continuity and integration of support from their provider or a third party that they have existing links with.

We also call for policies on cancellations of booked sessions to be reviewed to ensure that there is sufficient flexibility for students where missing sessions is not within their control. This is most often due to ill-health, or the cancellation of a teaching session by their provider. In these instances it is not always possible to give 24 hours' notice, and so it is unfair that they are charged for this from their funding, reducing the amount of support they can receive overall. We feel there should be provision to ensure that students are not penalised when missing booked sessions as a result of circumstances outside of their control.

What aspects of the current NMH system do you consider are not working well for HEPs?

There is currently no effective information sharing from the SLC. This creates a barrier and extra work for providers seeking to integrate DSA-funded support with their own provision and ensure that there is no duplication. It also creates a barrier to supporting individual students with applying for and accessing their NMH support. As noted above, where providers are doing this effectively it is due to the proactivity and effort of individual members of staff, taking up much needed resource that could be otherwise directed into the provision of non-specialist support.

Do you have any suggestions for how the current NMH system could be improved?

We call for systems and processes that enable the SLC, with the appropriate student consent, to share information about students' applications, assessment statuses and outcomes. This would enable providers to better support students with their applications, and to join up the support they can offer internally. It would also reduce the time and resource currently spent seeking this information as well as the risk of duplicating provision, meaning staff in institutions can focus efforts on the provision of non-specialist support.

We also call for the review of evidence requirements to make sure these are proportionate, flexible and do not cause unnecessary delays in students accessing support. For example, allowing a statement of support from the provider in instances where students are waiting for medical evidence so that their application can be progressed. There also needs to be much clearer communication with students and providers about evidence requirements, especially where evidence is submitted and not deemed sufficient.

Thirdly, the SLC should prioritise plans to make it easier for students to track the progress of the application. We understand that an accessible student dashboard is planned and urge for this to be expedited. This will make the student journey through their DSA application and assessment clearer, resulting in less stress for those already facing additional challenges in higher education.

Do you consider it more important for a student to have an individual entitlement for more specialist NMH support or for a HEP to have overall responsibility for the whole of a student's NMH support?

Individual entitlement is more important.

Student choice and equality of opportunity are paramount: all students with disabilities must be assured that wherever they choose to study they will get the support they need.

We are, of course, supportive of a social model of disability and the development of inclusive approaches, and note the strengths of providers like those in the IHE membership in advancing this. However, we feel that in an environment of increased pressure and reduced funding for student services, a shift to HEP responsibility for specialist NMH will not result in all students receiving the personalised, individual support that they need to access and succeed in their studies. Such a model would have a disproportionate impact on small and specialist universities, with high proportions of students with disabilities and small staff teams, ultimately creating a negative impact on the experience and success of disabled students.

Our Student Advisory Board were clear that whilst, in principle, integrated support managed by HEPs will create a better experience and outcomes for students, this would be entirely dependent on there being sufficient funding and expertise. In reality, the risk of a reduction in provision and an unequal experience across institutions is too great because no provider could offer the specialist provision that a centralised service could. We have provided further explanation, and evidence from our members, below.

IHE is supportive of a social model of disability, and the development of inclusive practices that meet the needs of all students. The last reform of NMH in 2017 already gave responsibility for non-specialist support to providers and tasked them with a focus on inclusive practices and anticipatory duties under the Equality Act. Our members have been making significant efforts in this area. Small student cohorts enable them to understand the needs of individual students and adapt teaching and learning approaches to meet these needs, as well as being able to tailor support to specific course requirements. Many courses are practical in nature, allowing for alternative assessments that are more inclusive. The close working relationship between staff and students aids early disclosure, and the development of tailored Study Support Plans and reasonable adjustments.

However, our members recognise that there will always be cases where specialist, personalised individual support is needed, in particular for those with the most complex needs. As an example, many of our members have a high prevalence of students with specific learning difficulties. A particular challenge for some of these students is learning in group environments, and to seek the support they need to access and succeed in their studies. In these instances, a specialist support worker or mentor is crucial. Furthermore, it is widely accepted that the sector as a whole is not there yet in achieving the level of inclusive practice that a truly social model of disability support requires. For example, TASO's latest research shows the variability in the effectiveness of transition support and reasonable adjustments across the sector, and that evaluation of this provision is still in its infancy.

A move to HEP responsibility for this provision would create an unrealistic and disproportionate expectation for smaller providers who are already stretched delivering the non-specialist support described above. IHE members have high proportions of students with additional needs, due to the nature of programmes and modes of study. A number are specialist creative institutions, and there is evidence that students with disabilities are more likely to study these courses. The practical nature of programmes offered by our members also attracts students with disabilities, in particular those with specific learning difficulties, such as Dylsexia, and mental health needs. The intersectionality of disability and personal circumstance is also a reason for this. Most of our members have high proportions of mature learners, who are more likely to declare a mental health condition than their younger peers, or have other underrepresented characteristics, choosing to study with providers who offer flexible modes of delivery to fit around their lives. As an example, one of our members, a theatre education provider, has a core mission to reach students from underrepresented groups; as such, 60-65% of students have Education Health and Care Plans or DSA eligibility. Another example is a specialist provider in psychotherapy and counselling, which attracts predominantly mature students and first-time adult learners; as such, there is a higher propensity of students who are neuro-diverse or who have mental health needs.

Due to their small size and limited resources, most IHE members have small teams, and in some cases just one member of support staff. They often do not have a specialist role working with students with disabilities. As outlined above, these teams are already stretched in providing non-specialist support (including to manage the increasing demand for mental health support) and in providing hands-on support to get students through the DSA process. Our members are concerned that even if assisted by funding, this would not be sufficient to provide the level of specialist NMH support that students currently receive and need.

Firstly, funding for non-specialist support (the Disabled Student Premium) has already decreased in real terms, despite services needing to extend their provision in line with changes made in 2016 and a parallel increase in the numbers of students disclosing a disability. We are concerned that any funding allocated to bring specialist NMH provision in-house would similarly not rise with inflation or increasing student demand, requiring already scarce resources to be stretched even further. Secondly, and significantly, there are a number of providers who are not even eligible for this funding due to their category of OfS registration, and so rely on student fee income to fund their support, meaning they are even more stretched.

For smaller providers, a model of HEP responsibility would be disproportionately more costly. In most cases their provision would need to be outsourced, as it is unrealistic to expect a small

provider to have sufficient staff with the appropriate training to meet all the complex and diverse needs of their student cohort. Such a model is more expensive and resource intensive to operate. It would require significant staff time to administer and manage (for example sourcing suppliers, managing contracts, and quality assurance). Ultimately, there would be less spent per student and funding for this would need to come from existing budgets or the allocation for NMH support, in both instances taking funding away from students. This is not in the student interest.

Our members are already at a disadvantage as they have not received the same level of support and assurance that other parts of the sector are receiving in this area. For example, The Higher Education Mental Health Implementation Taskforce has a stream of work looking at mental health and transitions, but this is focused on 18 to 21-year-olds transitioning from school to college and into higher education – not mature students who make up a large proportion of our members' intakes. A further example is the Mental Health Charter, where the cost of engaging with it is prohibitive for small providers. Moving responsibility for the provision of specialist NMH would create further disadvantage for our members, and therefore their students.

A further issue is how challenging it would be for providers to plan and put in place support for incoming students. In many cases they do not know even at admission stage how many students they have with disabilities. This means that it would be extremely difficult to ensure they have appropriate and sufficient specialist support in place in time to be of benefit to students from the beginning of their studies. This would be a particular issue for providers with large cohorts of mature students, who may not have previously accessed support for their disability and therefore may not be as likely to disclose this on their application or in the transition period. It is also not clear how funding allocations would be calculated, given that other student grant funding (for example the Disabled Student Premium) is calculated using HESES data, which is not a requirement for providers who are not in the Approved (fee cap) category of OfS registration. Further clarity is needed on how, in such a model of provider responsibility, funding allocations would be calculated to ensure that these fairly reflect student numbers and the costs of supporting them, which will be higher for smaller providers.

Finally, the implications of the Lifelong Learning Entitlement (LLE) need to be considered. This could result in greater numbers of students moving between providers as they progress their learning. There is a risk that, without their individual entitlement to NMH, they could experience disjointed support or risk losing it entirely if they move to an institution which does not have the same provision in place. Modular delivery will also have an impact, as there will be a higher cost of support relative to the length of study. These changes to the ways that students will access learning need to be considered in designing any model of funding and support, to protect student choice and equality of opportunity.

How do you think giving HEPs overall responsibility for the whole of a student's NMH support would affect the provision offered?

We feel that giving responsibility to HEPs for the whole of a student's NMH support would create a risk to the availability and quality of provision in some institutions, and lead to a

widening disparity between what is offered by providers who can afford to resource it properly and those who cannot.

Our members recognise that there are, in principle, benefits to this model for the provider and the students in creating more integrated support that is more closely tailored to a student's programme of study. However, as we have set out above, we are concerned that smaller providers in particular would struggle to resource the level and quality of provision needed by their students with disabilities. Even assisted by funding, the additional resource and costs to manage this provision risk both a decrease in the amount and quality of specialist NMH that can be offered to students, and a consequential impact too on the amount of non-specialist support that a provider can resource. There is a risk that existing pressure on resources will see an over emphasis on 'one-size-fits-all' adjustments rather than making sure that students have support that meets their particular challenges. Providers might be forced to adopt less expensive solutions, such as group sessions or online resources or support; such approaches would not provide the personalised support that individual NMH currently does, to the detriment of the student's experience and outcomes.

It is not realistic to assume that small providers would have the staff with the relevant expertise to support all of their students with disabilities, recognising that their needs are often diverse and complex. This would likely result in a model of outsourced support which is more expensive and delivers less benefit per student for smaller providers than larger ones. In our OfS-funded Many Hands project, a key issue identified was that outsourced services are not scaled to small providers. For example, if they want to provide 24/7 mental health support they need to invest in systems like Togetherall, which are designed for large student cohorts and are therefore an expensive solution. This will be the same scenario for the provision of NMH as suppliers are not motivated to create cost-effective packages for small providers, leading to disproportionate costs. Support will cost more per student for smaller providers, placing increased pressure on their already stretched resources. This will lead to a reduction in the amount of support that can be provided, ultimately having a negative impact on students.

Do you think a single approach will work for all providers and students?

A key principle for IHE is that student choice and equality of opportunity should be preserved above all. In this case that means that funding should follow the student, and any model of support for those with disabilities should ensure that wherever a student chooses to study they will get the support they need. Because of this, parity and consistency across the sector is important to ensure that if a student transfers to another provider, they continue to receive the same level of support and their experience of accessing it does not place unnecessary stress on them. However, as we have made clear, we feel that there is a risk of unfair disadvantage for smaller providers in the proposed model of HEP responsibility. The approach should seek to address this, by recognising the higher costs and resource burden for these providers of supporting disabled students – as well as the lengths to which they are already going to maintain quality provision for increasing numbers with diverse and complex needs on already stretched budgets.

What do you think the potential equality impacts are of the individual entitlement model compared to the HEP overall responsibility model?

We feel that there is a risk of a negative equality impact for students with disabilities due to the likely disparity in the specialist NMH support offered by different institutions. The nature and level of support could vary depending on where a student studies, causing a differential experience and outcomes, and limiting student choice.

There is also a risk that removing individual funding could lead to providers seeing disabled students as unaffordable and resource intensive, leading to behaviour changes of not actively encouraging (or even discouraging) some applicants for fear of the cost of supporting them. This could be especially true for individuals with high -ost NMH support needs, creating significant inequality of opportunity for students with certain disabilities. This will reinforce ableism as opposed to supporting providers on their journey to being inclusive.

There is also the risk that the higher costs of providing specialist NMH support would result in institutions reducing other non-specialist support (such as specialist study skills provision), resulting in a negative equality impact for other students in receipt of this support. We also note that HEP responsibility would require students to declare their disability in order to receive support. Those that do not do this would then miss out on the NMH support they would have received under the individual entitlement model.

Are there any DSA-funded NMH roles that you consider are no longer needed, or should be adapted?

We feel it would be useful for there to be a review of the support currently offered to students in work-based learning models. This would ensure that responsibilities are shared effectively between teaching providers and employers, and reduce the risk of duplication.

Have you experienced any issues with specific NMH roles, and if so what are those?

Issues highlighted by IHE members include a shortage of available workers for particular roles in certain regions, resulting in students being unable to engage with teaching and learning activities. A further issue raised was DSA funding not being sufficient to cover high-cost NMH support needs, for example specialist support professionals for students with visual or hearing impairments.

Do you have any other comments on DSA-funded NMH support?

We feel that there has not yet been sufficient time for the reform to other aspects of DSA (assessment and Assistive Technology) to bed in and be evaluated and that it would be unwise to introduce further changes to the DSA model until this has happened. There is a risk of causing significant disruption for students and providers who advise and support them.

Contact IHE

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