

PROMOTING THE HEALTH OF CHILDREN AND YOUNG PEOPLE THROUGH SCHOOLS: THE ROLE OF THE NURSE

Final Research Report
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Disclaimer

This is an independent report commissioned and funded by the Policy Research Programme in the Department of Health. The views expressed are not necessarily those of the Department

List of Acronyms

ADHD – Attention Deficit Hyperactivity Disorder
BME – Black and Minority Ethnic
CAF – Common Assessment Framework
CAMHS – Child and Adolescent Mental Health Services
CNO – Chief Nursing Officer
CPD – Continuing Professional Development
CPHVA – Community Practitioners and Health Visitors Association
CYP – Children and Young People’s Plan
DH – Department of Health
DCSF – Department for Children, Schools and Families
DIUS – Department of Innovation, Universities and Skills
ECM – Every Child Matters
ESP – Extended Schools Programme
FE- Further Education
FGD – Focus Group Discussion
FTE- Full Time Equivalent
HPV - Human Papilloma Virus
HSP – Healthy Schools Programme
IOE – Institute of Education
KPI - Key Performance Indicator
LA – Local Authority
NCMP- National Child Measurement Programme
NHSP – National Healthy Schools Programme
NMC – Nursing and Midwifery Council
NRES – National Research Ethics Service
PCT – Primary Care Trust
PDP – Professional Development Plan
PGD – Patient Group Direction
PAS – Public Service Agreement
PSHE – Personal, Social, Health and Economic
RCGP- Royal College of General Practitioners
RCN – Royal College of Nursing
SAPHNA – School and Public Health Nursing Association
SCPHN – Specialist Community Public Health Nursing
SCPHNs - Specialist Community Public Health Nurses
SHA – Strategic Health Authority
SLA – Service Level Agreement
SRE – Sex and Relationships Education
TCRU – Thomas Coram Research Unit
TCS – Transforming Community Services
WCC – World Class Commissioning

EXECUTIVE SUMMARY

1. Introduction

The present study examined the different ways in which nurses are enabled and supported to contribute to the promotion and safeguarding of children and young people's health and wellbeing within school settings. Through its various components, the study sought to identify the roles of nurses in schools, the sorts of challenges that nurses face in fulfilling the roles (and the expectations placed upon them), and the types of management, commissioning and strategic arrangements most likely to maximise the potential of nurses' contribution to children's and young people's health and wellbeing.

The study was commissioned by the Department of Health (DH) and conducted by a team of researchers from the Thomas Coram Research Unit (TCRU), Institute of Education (IOE). It took place between March 2008 and September 2009 and consisted of four main components: a preliminary review of key literature to inform the study; interviews with national and international stakeholders; a telephone survey about nursing practice in schools from a stratified sample of local authorities in England; and in-depth case studies in five local areas in England. An expert advisory group supported and advised the research team throughout the various phases of the study.

2. Research questions and methodology

The study aimed to offer new insights into the various roles and responsibilities which nurses were expected to assume with respect to promoting the health of children and young people and families in and through schools. As well as being concerned with what nurses were currently doing with respect to this agenda, the research sought to offer possibilities for how the role might be developed in the future. The following research questions guided the research throughout:

1. What types of commissioning, management and strategic arrangements are most likely to maximise the contribution of nurses to promoting the health and wellbeing of children, young people and their families through schools?
2. In what ways might nurses best be supported to assess and respond to the range of health and wellbeing-related needs of pupils in schools?
3. How do nurses review and evaluate their work for and with pupils and their families?
4. To what extent do nurses within school settings work in partnership with other professionals engaged in protecting and promoting the health and wellbeing of pupils and families?
5. What scope is there for extending the professional practice of nurses in schools and what can this study contribute to informing existing routes of registration/professional development for nurses?

A literature review was conducted to set the context for the wider study and to help inform subsequent phases of the work. The review included national as well as international literature published between 1997 and 2008.

Interviews were conducted with 28 key stakeholders with specific knowledge and expertise about the work of nurses within schools in local, national and international contexts. The telephone survey was conducted in a one-in-three stratified sample of all 150 local authorities in England, stratified according

to authority type: London Boroughs, Unitary authorities, Metropolitan District authorities and County Councils.

Case studies were carried out in five local authorities in England. In each of the five sites, case studies included interviews with primary care trust (PCT) and local authority (LA) stakeholders, as well as interviews and focus group discussions in one secondary school and one primary school with teachers, school staff, nurses, pupils and parents.

3. Key findings

All data collected through the various phases of the research were analysed in relation to the key research questions. It is important to note that there was wide variability in how nursing services were organised, commissioned and managed across the local authorities included in the research. While the findings presented here and the related recommendations are relevant to the majority of situations of nursing services included in the study, for each finding there were exceptions to the norm. In the following sections, findings are presented according to a number of substantive themes.

The nursing workforce in schools

- The numbers of nurses working in schools is still below the target of having one qualified school nurse to every secondary school and its feeder primary schools.
- New national agendas such as the National Child Measurement Programme (NCMP) and the Human Papilloma Virus (HPV) immunisation programme have had a major impact on the capacity¹ of nurses to fulfil their wider health promoting roles in schools.
- Service reviews conducted in many authorities are beginning to highlight the lack of capacity of nurses working in schools and to influence the commissioning agenda within PCTs and local authorities.
- There is clear evidence that nursing capacity in schools can be enhanced through appropriate mix of skills among nurses, nursing assistants and administrative staff.
- The skill mix of nursing teams working in schools varies widely across different authorities but, on the whole, is a dimension of workforce planning which is receiving increasing attention.
- The majority of nurses working at Band 6 and 7 within schools do not have a specialist community public health nursing (SCPHN) degree-level qualification.
- There are very few male nurses working in schools, although their numbers appear to be increasing.

What nurses do in schools

- National programmes such as the NCMP and HPV immunisations consumed substantial amounts of nursing time in the majority of authorities surveyed.
- Safeguarding and child protection work had increased significantly for nurses in the last couple of years and it was common in some areas for nurses to complete and be the lead professional for CAFs.
- There were widespread concerns that the expectations placed on nurses with respect to safeguarding issues were not always appropriate.

¹ Throughout this report 'capacity' is used to refer to all or a combination of: the numbers of nurses, the amount of time they have available; and the extent to which they have the relevant skills and competencies to fulfil the expectations on them.

- Nurses carry out limited sex and relationships education (SRE) and personal social, health and economic education (PSHE education) work, despite schools wanting more input and nurses wanting to do more.
- The numbers of young people experiencing emotional and mental health difficulties were reported to be increasing. There was some evidence of service innovations in this area within school settings.
- There is evidence that in some authorities the role of nurses is developing towards a more preventative, health promoting model. This is supported through increased investment in nursing services, a more appropriate skill mix and improved local intelligence with respect to the health needs and priorities of local populations.

The perceived profile and value of nurses in schools

- School nurses are highly valued when pupils, staff and parents are aware of who they are and what they do.
- Children and young people who have received one-to-one support from nurses in schools reported benefitting from their involvement and valued their input.
- Nurses make a unique contribution to addressing health issues relevant to children and young people in school.
- Nurses' clinical knowledge and the confidentiality of their service are particularly valued by children and young people.
- Young people valued the involvement of nurses in SRE and PSHE EDUCATION sessions in schools and often preferred discussing sensitive issues with a nurse rather than a teacher.

Professional development of nurses working in schools

- The telephone survey revealed that in most authorities nurses had access to a wide range of professional development opportunities, although many of these constituted mandatory training provided by the PCT.
- Access to non-mandatory training varied widely, with some PCTs supporting extensive professional development opportunities linked to professional development plans (PDP), while in others there was a lack of resources to enable such training to take place.
- In a number of local areas, and within some of the case study sites, PCT investment for nurses to complete an approved SCPHN degree-level qualification had increased over the past couple of years.
- There were some good examples of how the degree course was offered on a flexible, modular basis for nurses, thus facilitating access.
- In many areas, a shortage of suitably qualified community practice teachers was a barrier to nurses completing the degree course.
- Providing adequate support to nurses after completion of the SCPHN qualification was seen as essential if they were to implement what they had learned.
- There were examples of good partnership working between local PCTs and local universities to provide courses of relevance to the local workforce and to the needs of local communities.
- There was concern about the need to standardise training packages for some aspects of nurses' work to avoid local PCTs '*re-inventing the wheel*'.
- Nurses would benefit from training about recent organisational structures, (such as Children's Trusts), about new forms of integrated working and about the strategic direction of the local

children and young people's agenda, so as to contextualise their practice with children, young people and families.

Commissioning of nursing services

- Commissioning arrangements in most local areas are currently undergoing change as health and social care services move towards models of integrated working.
- In some PCTs the commissioner-provider split was complete, while in others the relationship between commissioner and provider services was described as unclear and at times ambiguous.
- Even though World Class Commissioning (WCC) stresses the commissioning of services based on local needs and in consultation with clinicians and health care providers, nurses' involvement in commissioning decisions was limited.
- The specifications and service level agreements between community nursing services and the PCT and other commissioners were generally handed down to nurses, although nursing services did have some say about how they would deliver services to meet specific outcomes and targets.
- Commissioners were said sometimes to lack knowledge about the front-line work of nurses, making their commissioning decisions less well informed than they might have been. They also lacked vision with respect to the potential of nurses' roles in promoting children and young people's health.
- The current split between commissioning and provider services led some respondents from nursing services to express a sense of vulnerability within the market economy and some anxiety that commissioners might look elsewhere to commission certain aspects of their work.
- There were examples from the telephone survey and within the research sites of commissioners increasing their investment in nursing services in schools as part of the wider children and young people's health agenda.
- There is a growing expectation that nurses should work with the 'school age population' in a range of community settings² in addition to schools.

Management and leadership arrangements

- Widespread restructuring of nursing services is taking place across the country as a result of service reviews and the need for better skill mixing and capacity building.
- Many nurses working in schools are moving into integrated teams with other health care providers. In some cases this involves physical relocation of services so that teams are on one site.
- Nurses are recognised as having a potentially significant role in coordinating children and young people's access to a wide range of health and social care services both within and outside of school settings.
- Integrated partnership arrangements in some areas involve locating nursing services for schools within the local authority rather than the PCT. There were concerns that such an

² Throughout this report, community settings refers to settings other than schools but which are accessed by young people, such as youth services, pupil referral units, youth offending services, colleges of Further Education, drug and alcohol services etc.

arrangement might negatively impact on clinical leadership and governance issues and therefore might not facilitate the timely development of school nursing services.

Evaluating what nurses do

- Most evaluation activities in schools focus on indicators which demonstrate the scale and quantity of specific activities, or the extent to which these are accessed by children, young people and families.
- Evaluation of health education activities is often conducted with young people through questionnaires, feedback forms or focus group discussions.
- Evaluating the outcomes of what nurses do is complex and there is a lack of clarity from commissioners, as well as among some nurses, about how the impact of nursing work can best be measured.
- In most cases, nurses lack adequate clerical and administrative support to enable them to evaluate what they do.
- In many areas inadequate computing systems, combined with a lack of appropriate information technology (IT) training for nurses and other members of nursing teams prevented nurses from effectively evaluating their work.

Partnership working with other agencies and schools

- Where there are adequate numbers of nurses and an appropriate skill mix, nurses in schools work effectively as part of multi-agency teams to promote children and young people's health.
- Recent reductions in nursing numbers have negatively impacted on the way nurses work in partnership with schools and with other agencies. These cuts have also adversely affected nurses' ability to influence other strategic developments such as healthy schools and extended schools programmes.
- There is evidence that the emphasis within the children's agenda on integrated working is having a positive impact on opportunities for nurses to work more closely with other partner agencies.
- Partnership working is facilitated by stability in the work force, a shared vision of integrated services for children and young people, and realistic expectations of the roles of nurses by other partner agencies.

The future of nursing services in schools

From the current study, the potential role of the nurse in promoting the health and wellbeing of children, young people and their families through schools and other community settings might best be described as follows:

- Working with the school-age population but not necessarily exclusively in schools.
- Working to support a social model of public health, offering services and support based on local health and wellbeing needs and priorities.

- Working at the prevention and early intervention stage with children, young people and families with more complex needs, and referring appropriately where safeguarding and other issues are beyond their remit.
- Working as a key service within 0-19 integrated partnerships, co-located with other community-based services such as health visiting, family support, youth services and workers and primary care mental health services.
- Working with year-round contracts which are full or part-time, configured both to the needs of individual employees and to the requirements of service level agreements with commissioners.
- Working as lead health professionals within schools, pupil referral units (PRUs), youth settings, children's centres and other community based settings and acting as a conduit between children, young people and their families, and other health and social care services.
- Working in teams which have a high profile within local school and other community settings.
- Working within appropriately skilled teams supported by administrative and clerical services.
- Commissioned to work in ways that foster appropriate levels of flexibility and innovation in professional practice in accordance with local needs and priorities.
- Commissioned to work against clearly defined outcomes and with guidance about what kind of evidence is needed for evaluative purposes.
- Having clear professional development pathways and access to relevant professional training opportunities.
- Being key partners in commissioning processes.

4. Conclusions

This study identified considerable variability with respect to what nurses do in schools to promote the health and wellbeing of pupils, the ways in which their services are commissioned and managed, the resources to which they have access, and the constraints they face in meeting the health-related needs of diverse populations.

Nurses continue to face significant challenges in promoting the health of children, young people and families in and through schools. These challenges include too few nurses working on part-time and/or term time only contracts; nurses being expected to carry out extensive child protection and safeguarding work; and the pressures of national public health campaigns. These factors militate against nurses engaging sufficiently in health promoting and preventative work in schools and often lead to the provision of reactive rather than proactive services.

Irrespective of these challenges, there is evidence that nurses working in school and community settings are enjoying increasing recognition and value. Commissioners are beginning to re-invest in school nursing services after many years of limited funding – although the extent to which this was possible in the current financial climate was sometimes questions. New structural arrangements are leading to more integrated ways of working, with nurses working in closer partnership with a wide range of other community health and social care providers.

Nurses have the potential to work on a number of levels in, with and through, schools including offering one-to-one support to children and families, as well as a generic health promoting service to whole school populations. Future nursing services for children and young people are likely to involve nurses being commissioned to work with the 'school age population'. The research indicates that it is no longer relevant to talk exclusively about nurses' work in schools, but rather their work with the school-age children and young people. It may be useful therefore to conceptualise nurses as providing a service

primarily in schools and, from there, working in a range of other community settings according to the needs of local communities.

5. Recommendations

The current study suggests there to be a number of implications at the national, local and service provision levels regarding the work of nurses in schools and other community settings.

At a national level

- There is a need to raise both the profile of nurses working in school settings and understanding about their potential for contributing to the health and wellbeing agenda for children and young people.
- There is a need for a greater clarity about the extent of (and limits to) nurses' legitimate involvement in safeguarding and child protection procedures.
- The DH and the Department for Children, Schools and Families (DCSF) (along with local commissioners) should carefully consider the impact of all national initiatives on the roles of nurses and other front-line health professionals working with school age children.
- There is a need for clearer guidance on how best to evaluate the public health function of nurses within schools and other community settings.
- Nurses should continue to be supported to complete the SCPHN degree-level qualification, and clearer national guidance is required as to whether this course should become mandatory.
- There should be a clearer career pathway for nurses working in schools and other community settings, with opportunities for progressing into senior management and leadership roles. This is likely to improve recruitment into, and retention of nurses within, the service.

At a local PCT/ LA level

- Commissioners need to ensure they are setting targets which are appropriate to the capacity of nursing services.
- Commissioners need to address the shortfall in the number of nurses required to meet the *Choosing Health* (DH, 2004) target of one qualified nurse to every secondary school and its feeder primary schools.
- In keeping with World Class Commissioning WCC, commissioning arrangements should provide scope for nurses, as key health care providers, to be central partners in informing commissioning decisions about health services for children and young people in schools and other community settings.
- Further investment in the professional development of nurses is required to enhance the core skills and competencies required to provide a public health service within schools and other community settings.
- Specialist community public health nurses require sound clinical and managerial support, after completion of the SCPHN qualification, if they are effectively to implement what they have learned.
- Commissioning arrangements should encourage nurses properly to assess the needs of local communities and to configure nursing provision according to identified needs.

- Commissioners should be clear about how nurses working in schools and other community settings can provide evidence of the impact of their work on the health and wellbeing of children and young people.

At nursing services level

- Greater emphasis should be placed on assessing the local needs of children, young people and families within schools and other community settings, and in achieving an appropriate skill mix to meet these needs.
- Building relationships with schools, children and young people, local communities and partner agencies, enables nurses to carry out their work effectively, so nurses need to be managed in such a way as to allow continuity of work in particular localities.
- Models of working which enable nurses to take leadership roles in coordinating health care and health promotion services in schools and other community settings should be encouraged.
- Adequate resources need to be allocated to clerical and administrative support for nurses working in schools and other community settings.
- Nurses need access to computers and relevant data systems to facilitate their working. Some nurses need training to make best use of information technology.
- Support for evaluation is needed to assist nurses to identify how their work might best be evaluated
- Additional training for nurses is required with respect to organisational structures, such as Children's Trusts and integrated working, as well as in relation to the strategic direction of the local children and young people's agenda.

INTRODUCTION

Evolving strategic, legislative and commissioning frameworks concerned with implementing the *Change for Children* agenda leave scope for flexibility in terms of how local services and structures are configured to provide services for children, young people and their families. The ways in which school and community nurses are organised, managed and located in relation to schools, and nursing contributions to the promotion and maintenance of health within schools vary enormously. The present study examined the different ways in which nurses are enabled and supported to contribute to the promotion and safeguarding of children and young people's health and wellbeing within school settings. Through its various components, the study sought to identify the types of management, commissioning and strategic arrangements most likely to maximise the potential of nurses' contribution to this agenda, and to highlight the sorts of challenges that nurses face in fulfilling the roles and expectations placed upon them.

The study was commissioned by the Department of Health (DH) and conducted by a team from the Thomas Coram Research Unit (TCRU), Institute of Education. It took place between March 2008 and September 2009 and consisted of four main components: a preliminary literature review to inform the study; interviews with national and international stakeholders; a telephone survey about nursing practice in schools from a stratified sample of local authorities in England; and in-depth case studies in five local areas in England.

An expert advisory group supported and advised the research team throughout the various phases of the study. This group was comprised of representatives from the DH, the Department for Children, Schools and Families (DCSF), the Royal College of Nursing (RCN); the Nursing and Midwifery Council (NMC) the Community Practitioners and Health Visitors Association (CPHVA); the School and Public Health Nurses Association (SAPHNA). It included several other nurse academics and senior nurse practitioners. The group met at regular intervals throughout the duration of the study and, in addition, provided support to the research team through email and telephone contact as necessary.

The following research report is organised into a number of chapters. The first chapter outlines the policy context to the current study before describing the research methodology. Subsequent chapters detail the main findings from the research according to a number of substantive themes. The key findings with respect to each of these themes are summarised at the end of each chapter. The final chapter highlights conclusions from the research as a whole, and offers some policy and practice recommendations for national government, for those commissioning nursing services in schools, and for those who directly manage nurses who work in schools and other community settings.

1. BACKGROUND AND METHODOLOGY

1.1. Background

Research in the UK over the past few years has highlighted widespread concern about a range of health issues for children and young people including, among others, the rising prevalence of mental health problems among young people between the ages of 5 and 16 years (Green et al, 2005), increasing levels of obesity (DIUS, 2007), high numbers of unplanned pregnancies and rising rates of sexually transmitted infections, including Chlamydia and Gonorrhoea (Brook et al, 2007). National policy and programme responses to these concerns have increasingly highlighted schools as key settings in which to address the health and wellbeing needs of young people. Nurses, working in and with schools, have the potential to promote the health and wellbeing of children and young people at a number of different levels through, for example, contributing to generic health promotion activities (including the development and implementation of health education and personal social, health and economic education (PSHE education) curricula), providing health services within schools, supporting public health initiatives and safeguarding the health and wellbeing of individual children and young people (Alcorn, 2007; RCN, 2005; Downie et al, 2002; Lightfoot and Bines, 2000; Clarke, 2000).

In the past few years and at national level, there has been an increasing emphasis on integrated and multi-agency approaches to promoting the health and wellbeing of children and young people. Equally, the importance of innovation and modernisation in health promotion practice has been highlighted, alongside a recognition that interventions can take place in many different settings. *Every Child Matters (ECM): Change for children* (DfES, 2004), identifies health as one of the five outcomes to be achieved for children and young people. The *National Service Framework for Children, Young People and Maternity Services* (DH, 2004c); *Youth Matters* (DfES, 2006) and *Aiming High* (HMT/DCSF, 2007) stress the need for partnership, multi-agency approaches and shared responsibility in promoting and safeguarding young people's health and wellbeing. Similarly, the government has placed the onus on local agencies working in partnership, to reduce health inequalities through steps such as the pooling of PCT and local authority (LA) budgets in order to prevent poor health outcomes (HMT/DCSF, 2007 pp. 71-72) and, as advocated by *Our NHS, Our Future* (DH, 2007), the provision of personalised services which are 'tailored' to individual needs (especially for the most vulnerable), accessible at times, and provided in places, chosen by service users.

There are many national level policy drivers, therefore, which advocate for schools as key settings for the promotion of young people's physical, emotional and social wellbeing. Indeed, schools have increasingly hosted a range of health and wellbeing-related agencies, services and initiatives including, the National Healthy Schools Programme (NHSP); the Connexions service; education welfare services; youth services; the extended schools programme (ESP); community safety partnerships and youth justice agencies. There is also an emphasis on extending health promotion activities in schools beyond health education, to include components of health-service delivery. *Aiming High* (HMT/DCSF, 2007), for example, stresses the importance of exploring the potential of 'innovative approaches to the provision of school-based health and wellbeing services' (5.31, p.73). Emphasis on services that are approachable and accessible to young people has led to initiatives such as the 'You're Welcome' quality criteria (DH, 2005), which encourage an assessment of where best to place, and how best to manage, health services that young people feel comfortable with and able to access. Situating health services within schools through drop-in services, 'clinic in a box'³ or other similar schemes is also

³ These are normally nurse-led mobile health drop-in services provided in school and other non-clinical community settings. They frequently offer contraceptive and sexual health services.

becoming increasingly common (Alcorn, 2007; Chase et al, 2005). At the time of finalising the report, the government introduced the Healthy Child Programme 5-19 (DH/DCSF, 2009) which provided further guidance on the commissioning and management of school-based health services.

Schools offer contexts within which both generic and targeted approaches to promoting the health of children and young people can be delivered. At a local level, Children's Trusts have the lead responsibility to provide leadership to Local Strategic Partnerships (LSPs) and involve all agencies in the development of Children and Young People's Plans (CYPs). These provide the local framework for the joint planning and delivery of common strategic objectives to improve the wellbeing of children and young people and they identify the appropriate pooling of resources across agencies to meet these objectives. In a recent review of a representative sample of CYPs within 75 local authorities, 72 of the plans identified schools at the centre of local partnership arrangements (Chamberlain et al., 2006). The government's Public Service Agreement (PSA) *Delivery Agreement 12: Improve the Health of Children and Young People* (HMSO, 2007) highlights the role of schools in improving the physical, mental and emotional health and wellbeing of children and young people, sets the target for schools to provide extended services by 2010, and advocates the use of school nursing services in the provision of 'front-line' advice on a range of health outcomes.

For many children and young people, access to information, advice and support about health-related issues (such as diet and nutrition, physical activity, sexual health and emotional wellbeing) may be sufficient to enable them to make informed choices about their health and to access the services they require. Other young people, however, will require more specialist and personalised forms of support as a result of chronic health conditions, learning difficulties or wider family and social pressures. A recent evaluation of full-service⁴ extended schools has demonstrated the potential of school settings for promoting the wellbeing of children and young people, and particularly those who are most disadvantaged (Cummings et al., 2007). Similarly, emerging findings from an evaluation of the Young People's Development Programme, working with schools to identify and provide targeted support to young people aged 13-15 and identified as 'at risk', have indicated that young people are able to recognise clear benefits from taking part in the programme. The development of the Common Assessment Framework (CAF)⁵ as a tool for identifying children, young people and families with more complex needs (including where there are safeguarding concerns), has implications for schools both in terms of assessment of needs and the appointment of an appropriate lead professional to offer a coordinated response to such needs.

The expanding health-promoting function of schools requires multi-agency professionals with an appropriate skills-base and with the capacity to respond effectively to the prevention, safeguarding and promotional aspects of this work. Nurses – both those with a school-specific remit (including school nurses/ health advisors) as well as those who work within the wider community (including practice nurses, nurse practitioners, and health visitors) – are all key professionals, uniquely placed to provide health expertise and knowledge within the school setting and in other settings relevant to children and young people. Research evidence shows that nurses within schools are able to foster positive relationships with children, their families and the school as a whole; can help increase the up-take of health services among young people; contribute substantially to the provision of PSHE Education; strengthen the links between education and health services; and, in some cases, have a direct impact

⁴ Full-service extended schools provide a comprehensive range of services on a single site including health services, adult learning and community activities, study support and 8:00am to 6:00pm wrap-around childcare.

⁵ CAF = Common Assessment Framework - a form for any professional to complete if they think a child might have additional needs. Lead professional is the person who agrees to coordinate multi-agency work when a child has been identified as having additional needs that require support from more than one agency

on specific health issues such as unplanned pregnancies, smoking cessation and immunisation uptake (RCN, 2005, 2006).

Previous research indicates that the role of the nurse within schools can include reviewing children's health at key stages, supporting the development of personal health guides, providing information, advice and support about health-related issues, and contributing to teaching and learning activities regarding health and the PSHE education curricula more generally (DH, 2004b). While the recently published school nurse practice development resource pack (DH, 2006) outlines a number of components of the modern 'school nurse' role, there is reportedly widespread confusion concerning the definition and balance of this role (RCN, 2005). Insufficient is known about the ways in which nurses adapt and develop their role when working with schools. The *Aiming High* strategy, for example, suggests a reshaping of the existing school nurse service and '*where appropriate*', its relocation within multi-agency teams being established as part of ECM reforms (HMT/DCSF, 2007, p.73). Excessive workloads, insufficient staffing and unmet training needs (RCN, 2005), are important concerns that have implications for the local management, planning and commissioning of nursing services. Such concerns will need to be addressed if nurses are to fulfil their potential in responding to the demands of the health agenda for children and young people within the school environment.

1.2 The study

The current study aimed to offer new insights into the various roles and responsibilities which nurses were expected to assume with respect to promoting children and young people's health in and through schools. As well as being concerned with what nurses were currently doing with respect to this agenda, the research sought to offer possibilities for how the role might be developed into the future.

Research Questions

The following research questions guided the study:

1. What types of commissioning, management and strategic arrangements are most likely to maximise the contribution of nurses to promoting the health and wellbeing of children, young people and their families through schools?
2. In what ways might nurses best be supported to assess and respond to the range of health and wellbeing-related needs of pupils in schools?
3. How do nurses review and evaluate their work for and with pupils and their families?
4. To what extent do nurses within school settings work in partnership with other professionals engaged in protecting and promoting the health and wellbeing of pupils and families?
5. What scope is there for extending the professional practice of nurses in schools and what can this study contribute to informing existing routes of registration/professional development for nurses?

1.3 Methodology

The study consisted of four phases: a review of key literature, interviews with national and international stakeholders, a survey of local authority areas in England, and case studies in five local areas in England.

Review of Literature

A literature review was conducted to set the context for the wider study and to help inform subsequent phases of the work. The review included key national as well as international literature published between 1997 and 2008. However, other policy, programme or legislative developments which have helped to define the role of nurses within schools before this time are also included.

The following databases, among others were used to identify relevant literature: *internurse* (providing the largest online archive of nursing articles); the *CINAHL database* (which includes literature on nursing, allied health, biomedicine, and healthcare); the *British Educational Internet Resource Catalogue* (BEIRC); the Australian Education Index (AEI); ERIC (the major US indexing service for education), the Educational Evidence Portal (EEP); *Applied Social Sciences Index of Abstracts (ASSIA)* Intute: Social Sciences; the *Cochrane* database of systematic reviews; and specific websites such as 'Wired for Health (the National Healthy Schools programme website); the Royal College of Nursing (RCN); the Health Development Agency; the Department of Health; the School and Public Health Nursing Association (SAPHNA) and the Community Practitioners and Health Visitors Association (CPHVA). Specialist nursing journals such as the *British Journal of School Nursing and Community Practitioner and Nursing Times* were searched on a year by year, issue by issue basis.

A range of search terms were employed in various combinations including:

- 'school nurses', 'school health advisors', 'school health nurses', 'nurses', 'health visitors'
- 'school', 'primary', 'secondary', 'education settings',
- 'school-based health service', 'school health drop-ins', 'youth friendly'
- 'pupil', 'student', 'Child(ren)', 'young people', 'adolescent', 'youth'
- 'health promotion', 'health education', 'personal, social and health education (PSHE)', 'personal, social, health education and citizenship' (PSHEC)
- 'mental health', 'emotional wellbeing', 'obesity', 'sexual health', 'alcohol', 'smoking', 'drug use', 'teenage pregnancy'

The review focused on examples of the range and types of services provided by nurses within a school context including the provision of a generic health promotion service (such as supporting PSHE education programmes and curricula); supporting the public health/prevention agenda (such as administering vaccination and immunisation programmes and carrying out health screening); the provision of targeted assessment and support for individual young people and their families; the role of nurses in school-based health facilities; the specialist nursing function with respect to children and young people living with particular health conditions (such as asthma, cystic fibrosis and diabetes mellitus). The review informed the background to the study and the subsequent phases of work (Appendix 2)

Interviews with national and international stakeholders

The second phase of the study involved a series of interviews with key stakeholders with specific knowledge and expertise about the work of nurses within schools in local, national and international contexts.

In total, twenty eight national and international stakeholder interviews were completed either by telephone or face-to-face. Twenty three interviews were with national stakeholders. These included professionals from within the DH and the DCSF known to have knowledge of specific areas of health and/or strategic policy development. These areas included healthy lifestyles and obesity; child and adolescent mental health services; teenage pregnancy; extended schools; children and young people programmes and partnerships; children and young people's public health; the NHSP; the children's workforce; and the healthy strategy team. Other interviewees were from a range of organisations including the RCN; the Sex Education Forum (SEF); the CPHVA; the Royal College of General Practitioners (RCGP); the NMC; the SAPHNA; senior nurses working in PCTs with a nation-wide knowledge of nursing practice; independent nurse consultants and nurse academics.

In addition, and to provide a wider context for the study, five stakeholders beyond England were interviewed from the Northern Ireland Department of Health, Social Services and Public Safety; the National Association of School Nurses in the USA; the Scottish Executive; the Ministry of Health, New Zealand; the Schools for Health in Europe Network.

Interviews were conducted using a semi-structured interview guide, and focused on current and emerging priorities in the ways in which nurses work to promote the health and wellbeing of children and young people; the perceived potential and vision of the role of nurses within schools; and the levers and barriers to such work. Interviews lasted an average of 60 minutes, were recorded (with the prior permission of the interviewees), partially transcribed and analysed thematically.

Survey of a sample of local authority areas in England

A one-in-three sample of all 150 local authorities in England was selected by means of a stratified sample, with authorities stratified by authority type: London Boroughs, Unitary authorities, Metropolitan District authorities and County Councils.

In each local authority area, the chosen survey respondent was the lead for school nursing services since they were considered most appropriate to provide an overview of nursing services in schools. Although the job titles, roles and responsibilities of survey respondents varied quite widely, all had a senior management role with respect to school nursing - either across the whole of an authority or for a specific locality or cluster area within an authority. Many respondents were lead managers for health visiting as well as school nursing services.

Respondents were initially contacted by letter and invited to participate in a telephone interview. Where no response was received, a follow-up telephone call was made. Telephone interviews were completed in a total of 34 (68%) of the sample of 50 local authorities. Participating authorities reflected a balance of authority types with eight London Boroughs, eight Unitary authorities, nine Metropolitan District authorities and nine County Councils. All ten Strategic Health Authority (SHA) regions were represented in the sample.

Semi-structured telephone interviews lasted between 45 minutes and an hour. Interviews were recorded, partially transcribed and analysed thematically. The findings from the survey are integrated into the relevant chapters of this report. .

Case studies in five local areas in England.

Information gathered from the literature review and interviews with national and international stakeholders was used to inform case studies carried out in five local areas in England. Research sites were selected in consultation with the expert advisory group and sought to reflect urban and rural settings and differences in geographic location; socio-economic profiles; and demographic characteristics. A decision was made to include at least one site where people from black and minority ethnic (BME) communities constituted a high proportion of the population.

Case studies aimed to identify how nurses contributed to the development, implementation and evaluation of health promotion programmes and activities for children and young people in the five local area sites. Attention focused on the types of local management arrangements, local strategic and commissioning structures, and the impact these had on how nurses worked. An initial visit was made to each case study site, primarily with leads managers of school nursing teams. During this visit, potential research participants were identified and a primary and secondary school were selected which could provide illustrative examples of how nurses were currently working in schools within the local area.

Within each of the case study sites, interviews were conducted with PCT and LA stakeholders. Interviews with local stakeholders focused on: current local strategic, commissioning and management arrangements for nurses in schools; roles and responsibilities of nurses within school (and other) settings; perceptions of the potential contribution of nurses to promoting young people's health; opportunities for continuing professional development for nurses; perceptions on the profile of nurses within schools; and the opportunities and challenges faced by nurses working in schools.

Two schools, one primary and one secondary school in each case study site, were identified to provide illustrative examples of how nurses worked with children and young people across different key stages of education. Interviews were conducted with nurses, head teachers, teachers, other school staff (described below), professionals from other agencies working in the school and parents. Questions focused on perceptions of how nurses contributed to the health promoting agenda in school; perceptions of the 'added value' of nurses within schools; nurse-led initiatives illustrative of innovative practice; the type and nature of professional relationships between nurses and others working in the school; and factors thought to enhance the role and profile of nurses in schools, as well as those that restricted what they did.

Focus group discussions (FGDs), of around six to children or young people, were held with pupils in Years 5 and 6 in primary schools and pupils in Years 7, 9 and 11 in secondary schools. In two secondary schools (in different research sites), Year 11 pupils were unable to participate in the study due to examinations, and in these schools Year 10 pupils participated instead. In each school, pupils were selected by members of the school staff in accordance with pre-set criteria, so as to achieve a balance in terms of gender and to reflect the economic, social and cultural backgrounds, and the range of academic ability within the school. When possible, one or two young people who had received personal one-to-one support from the school nurse were interviewed. This only took place when pupil participation was voluntary and when it was possible to guarantee confidentiality.

Discussions with pupils covered their perceptions of their health and wellbeing priorities; the profile and roles of nurses in school; the attitudes, skills and knowledge that pupils regard as important for nurses in school; the contribution that nurses can make; the positive aspects of nurses working in school, and suggestions for improvement in how nurses might work to promote pupil health and wellbeing in the future. FGDs with young people lasted for approximately 40 minutes. All interviews and discussions

were recorded (with the prior permission of participants), partially transcribed and analysed thematically in relation to the key research questions (see 1.5 below).

In addition, one FGD, and five individual interviews were conducted with a total of 12 parents in four of the five research sites.

1.4 Research participants

An overview of all research participants according to the different research sites is provided in Table 1.1. Within schools, participants included head teachers, deputy head teachers, learning mentors, learning for life programme workers, family support workers (employed by the school), inclusion officers, wellbeing coordinators, pastoral support tutors, re-integration and safeguarding managers, school administrators/first aiders, and parents. FGDs and interviews were held with a total of 71 pupils in Years 5 and 6 in primary schools and a total of 133 pupils in Years 7, 9 and 11 in secondary schools.

PCT and local authority interviewees included a range of professionals across the sites working at a strategic and/or commissioning level and who had an overview of how nurses worked in schools to promote children and young people's health and wellbeing. They included school nursing team leads, managers of integrated school nurse and health visiting teams (sometimes including other professionals), healthy schools coordinators, leads for public health and children's health commissioning, commissioners for sexual health services, teenage pregnancy coordinators and local authority lead officers for PSHE education, Child and Adolescent Mental Health Service (CAMHS) managers, coordinators of behaviour support teams and child protection leads.

Table 1.1 Research participants in each site

Case study site	PCT/LA professional	Nurses Working in participating schools	No. pupils primary		No. pupils secondary		No. school staff		No. parents
			Male	Female	Male	Female	Primary	Secondary	
1. (East Midlands)	7	2	9	9	6	9	3	6	1
2. (South West)	8	2	7	7	15	21	3	2	2
3. (London)	2	2	7	5	12	12	3	2	-
4. (North West)	9	2	5	10	18	18	4	8	2
5. (Yorkshire & Humber)	5	2	6	6	7	15	3	5	7
Total	31	10	34	37	58	75	16	23	12

1.5 Analysis

Interviews were partially transcribed and data analysed by means of successive approximation (Neuman, 2006). Applying this method, members of the study team used the research questions to guide initial readings of the interview data. A series of preliminary themes were agreed between members of the team (such as, the ways that nurses responded to the health needs of pupils, or perceptions of, and value placed on, the role of the nurse). These themes were used to guide further

readings of the transcripts. Successive readings identified a range of issues that were related to each theme (such as the different types of activities nurses carry out with pupils, the sorts of partnerships nurses formed to help them carry out their work, or the factors that helped or hindered a particular aspect of work – such as supporting health-related education). This enabled an approximate representation to be developed of the role of nurses in schools within and across case study sites.

1.6 Ethical issues

The research was conducted in accordance with TCRU's Ethical Code of Conduct and ethical approval was gained from an IOE Research Ethics Committee. Advice and guidance was additionally sought from the National Research Ethics Service (NRES) as to whether it was necessary to have NRES approval for the research, given that work involved some interviews with NHS employees. The research team were advised that NRES approval was not necessary since the research constituted a service evaluation activity and therefore approval from the relevant IoE Faculty Research Ethics Committee was adequate. A number of respondents asked for confirmation that NRES ethical approval was not necessary prior to them participating in the study. In these situations the response from NRES was made available to them.

TCRU research procedures are consistent with the highest standards of research practice, the safeguarding of all research participants (for example through Criminal Records Bureau checks for all research staff working with children, young people or vulnerable adults), as well as the principles of good practice set out in the Data Protection Act (1998). Careful attention was paid throughout the research to ensure that interviews were conducted with the freely given informed consent of all participants. Similarly, all participants were informed of their right to refuse to answer any questions, or to withdraw from the study at any time without explanation. All data were stored anonymously, and any quotes used in reports and publications arising from the research have been anonymised.

2. THE NURSING WORKFORCE IN SCHOOLS

In November 2004, the government published *Choosing Health: Making Healthy Choices Easier* (DH, 2004a). This White Paper stated that by 2010 each PCT would be funded to provide “at least one full time, year-round qualified school nurse working with each cluster or a group of primary schools and the related secondary school, taking account of health needs and school populations.” The 2007 National Health Service (NHS) Workforce Census (NHS, 2007) showed that there were 3,162 (2,232 full-time equivalent (FTE)) qualified nurses working in school health services across 3,300 state secondary schools - an increase of 753 (31.3%) since 2004. Of these, there were 1,227 (893 FTE) nurses with a recognised degree-level post-registration school nurse qualification, an increase of 371 (41%) since 2004. The latest National Health Service workforce Census (NHS, 2009) indicated that, as of September 2009, there were 1215 full-time equivalent qualified school nurses, compared to 1062 in September 2008, and that it would require 3,344 FTE qualified school nurses in order to meet the objective of having one qualified school nurse for every secondary school and its cluster of primary schools

2.1 Findings from national stakeholder interviews

The overall consensus among national stakeholders was that the number of nurses working in schools was far fewer than required for them to achieve everything that was expected of them by commissioners. Severe financial cuts in recent years had left many school nursing services reduced to a minimum number of nurses and they were expected to work with large numbers of primary and secondary schools. As a result, the majority of nurses' time, it was felt, was taken up with core services such as immunisations and school-entry health screening, and with meeting PCT targets for national initiatives such as the National Child Measurement Programme (NCMP). This work, while important, was considered by stakeholders to detract from the broader health promotion, public health and prevention work which nurses could otherwise be doing with children and young people through schools.

In order to meet this wider prevention agenda, it was felt that nurses needed to work at a local level in teams with a suitable skill mix. Such teams might comprise nurses with a recognised specialist community public health nursing (SCPHN) qualification, registered nurses, nursery nurses, nursing assistants and clerical and administrative support workers. This approach allowed nurses to work according to their skills and meant that the most highly qualified nurses were not spending time on more routine activities such as weighing and measuring children and uncomplicated health screening. Working in this way also allowed scope for nurses to work in partnership with other agencies concerned with children and young people's health and wellbeing in school settings, such as CAMHS, educational welfare officers, social workers and youth workers.

In practice however, it was believed that in most instances the available skill mix within school nursing teams was inadequate to allow nurses to work in accordance with their qualifications and experience. In addition, commissioning arrangements within PCTs did not always provide the necessary structures or resources for nurses to work effectively in partnership with other agencies.

A number of national stakeholders also discussed the importance of focusing less specifically on the role of the nurse in schools and more on the idea of children and young people's health services. These might be provided not only in schools, but in other community settings. In this way, the needs of the school-age population could be identified and responded to. This approach would offer services to

those children and young people not attending school but who might be accessed through other settings such as pupil referral units, (PRUs), colleges of Further Education (FE), youth services and youth offending teams (YOTs). Young people in out of school settings, it was felt, may be more likely to experience significant health issues which might not be identified. Although some national stakeholders knew of examples where nurses worked within these alternative settings, it was felt that this was unusual and that there were insufficient nurses to enable this to happen everywhere.

2.2 Findings from survey of local authorities

Survey respondents were asked to provide data on the numbers of school-age children for whom they provided a service, and the number of schools (primary, secondary, middle) they were expected to work with. They were also asked for the numbers of nurses working in schools (full and part-time) and for the level (band) at which they were employed⁶.

Table 2.1 provides data (for each authority type) about the school age population, the average skill mix of nurses working in schools, the average number of nurses in Band 6 and above, and the average proportion of these nurses with a recognised SCPHN degree level qualification. County Councils had, on average, the largest school age populations but nursing services in London Boroughs had the smallest ratio of Band 6 and above nurses to population size. Nurses in Metropolitan District authorities were more likely to have a recognised SCPHN degree level qualification (50%). Across the authorities surveyed, the majority of nurses in Band 6 and above did not have this degree level qualification.

Although the work of nurses in special schools was beyond the scope of this study, in many cases, nurses working in special schools were integrated into the school nursing teams for mainstream schools and therefore were included in the overall numbers of nurses in the service. In most cases the numbers of children and young people included those aged 5-16 years in mainstream (primary, secondary or middle) schools, although in a few areas, nurses also worked with young people over the age of 16 years in FE colleges. In some areas nurses were described as working within integrated 0-19 teams, which usually meant that they worked in a range of community settings in addition to schools.

In terms of the profile of nurses working in schools the majority were female⁷. Twelve authorities however had at least one male nurse working within their teams (two of these authorities had two male nurses and one authority had three). Fourteen respondents stated that they had members of staff who were from BME communities. The number of BME staff ranged from one to eleven. Two respondents stated that they did not know whether or not they had any members of their school nursing teams who were from BME communities.

The majority of nurses across all local authorities surveyed worked part-time. Part-time work was either term-time only or part-time during term-time. Very few nurses worked throughout the entire year, although in a number of authorities all new appointments were being made on year-round contracts. While some respondents felt that most nurses did not want to work all year round, others felt that they would be able to attract new and 'younger' members into the nursing team if they could offer full-time contracts.

⁶ Band 6 is normally allocated to nurses with qualifications and experience over and above a generic nursing qualification.

⁷ According to Ball and Pike (2005) only 19 of the 2211 school nurses registered with the RCN were men and only 4% of all nurses registered were from black and ethnic minority communities.

Table 2.1 Overview of number of nurses and skill mix for each type of authority participating in the survey

Type of Authority	Number of Authorities	Average school age population (Range in brackets)	Average number of nurses by band per local authority		Total and average number of Nurses Band 6 and above	Number (percentage) Nurses Band 6 and above with SCPHN (degree level) qualification
			Band	No.		
London	8	37,000 (8,600 -58,000)	Band	No.	82 (average 10 per authority)	29 (35%)
			2	1.5		
			3	1.3		
			4	1.6		
			5	4.9		
			6	8		
			7	3		
			8	0.25		
Unitary	8	22,000 (6,800-31,600)	Band	No.	88 (average 11 per authority)	30 (34%)
			2	0.25		
			3	1.4		
			4	1.4		
			5	7.6		
			6	9.4		
			7	1.4		
			8	0.25		
County	9	54,600 (25,000-114,500)	Band	No.	155 (average 17 per authority)	62 (40%)
			2	3.2		
			3	2.2		
			4	3.3		
			5	13.8		
			6	12.8		
			7	2.4		
			8	0.8		
Metropolitan District	9	43,600 (9,000-68,000)	Band	No.	178 (average 18 per authority)	50* (28%)
			2	0.2		
			3	7.5		
			4	5		
			5	8.5		
			6	14.3		
			7	5.4		
			8	0		

* In one Metropolitan District authority, the respondent did not know how many nurses had a degree level qualification

Factors influencing an increase in size of the nurse workforce

Respondents from 22 local authorities (65%) said that there had been at least some increase in the number of nurses working in schools over the last two years or in the number of nursing hours

commissioned. There was a wide variation in the amount of increase, which in some cases included the recruitment of additional staff, while in others it involved extending the hours of part-time nurses. A number of respondents described how services, after severe cuts over the past few years, were now witnessing a significant re-investment, resulting in substantial increases in the numbers of nurses available to work in schools.

The factors said to have influenced greater investment in nursing services were varied and included the following:

- Stakeholders, such as head teachers, governors and parents becoming more positive about the role of schools in promoting the health of children and young people and the PCT (or other commissioning bodies) being willing to listen to their requests for more resources.
- Nursing services being able to demonstrate what they were doing with respect to promoting the health of children and young people and what more they could do if they had increased numbers of nurses working locally.
- Reviews of nursing services showing commissioners that there was a strong case for additional funding.
- National policy initiatives such as *Choosing Health* (DH, 2004), the wider children and young people's agenda, the Chief Nursing Officer (CNO)'s requirement of one full-time qualified nurse for every state secondary school and its feeder primary schools, and, in some cases, specific funding such as the Healthy Community: Challenge Fund (DH, 2008).
- National programmes such as the National Child Measurement Programme (NCMP) and the Human Papilloma Virus (HPV) immunisation programme, for which additional posts were created in order for PCTs to meet their public health targets.
- Replacing part-time staff leaving the service with some full-time staff.
- Structural changes locally which resulted in an increase in the size of nursing services in schools.

The following examples illustrate some of the ways in which an increase in the numbers of nurses working in schools within the past two years impacted on what nurses within these authorities were able to achieve.

London Borough

In this local authority, in a single year, there had been an increase from nine full-time nurses to 20 full-time nurses. This included an additional two Band 7 nurses, two Band 6 nurses, six Band 5 nurses and one Band 3 school health technician.

We got to the stage where the schools were really fed up with us because I think we were about 60% capacity last year – we have been working really hard to build up the trust and support of the schools and I think it is really beginning to pay off now. (School Health Team Lead).

The additional investment in the service had meant an increase in the ratio of nurses to schools from one nurse to six or seven schools to one nurse for every three schools. The additional staff included a clinical lead for Healthy Choices and a clinical lead for immunisations. The impetus for the investment was said to have come from the integrated working agenda⁸ gaining a much higher profile within the authority. This had resulted in strengthened working links between the PCT and the LA and wider recognition of the role nurses in promoting health through schools. The additional nurses within the

⁸ The integrated working agenda has evolved out of the Laming Report (2009) *The Protection of Children in England: A Progress Report*. <http://publications.everychildmatters.gov.uk/eOrderingDownload/HC-330.pdf>

team meant that they were able to carry out more health education and health promoting work in schools.

Unitary Authority

In this authority, there had been an increase of two-30 hour posts in order to provide support and services to young people outside school time.

Commissioners wanted them (nurses) to be more accessible to vulnerable groups and to be able to increase their service provision during the school holidays. (Community School Nurse Team Leader).

Despite increases in the number of nurses and/or nursing hours in the majority of authorities, however, only in one or two local authorities did respondents feel that they were working with an adequate complement of nurses, and in most cases reported that the service was far from the target of having a degree-level qualified school nurse in every secondary school. Furthermore, the fact that increases in resources to employ more nurses were directly related to new demands on the service, such as the HPV immunisation programme or the NCMP, was a concern for respondents in a number of authorities. This meant that in real terms, over and above meeting these new targets, the capacity of nurses to take on more of a public health/ health promotion role had not increased at all.

We've got more Band 7s and four more Band 2s, so definitely an increase and that's come about through reorganisation, money we've had for the HPV vaccination and for the NCMP. But it's fair to say the extra resourcing has been proportionate to the extra workload, no more. It's balanced it out I would say. (Area Public Health Manager, County Council).

The full time equivalent number of nurses has increased because of the HPV vaccination programme. This increase has been proportionate to the extra workload. We got 50 hours nursing time of Band 5 and an additional admin person. We are trying to get assurance from the PCT that the funding will be recurring and with that I want to get a Band 6, 30-hour post and some admin support. (Deputy Directorate Manager Child Health, County Council).

Factors influencing a decrease in the size of the nursing workforce

Respondents in six local authorities (18%) reported that they had seen a drop in the numbers of nurses and nursing hours available to work in schools. This decrease was attributed to the following factors:

- Cost-improvement programmes within PCTs to redress financial overspends.
- Retired nurses not being replaced.
- Nurses becoming disillusioned and leaving the service.
- Difficulties recruiting suitably qualified nurses.

Over the last few years, posts have been frozen because of the (financial) difficulties of the health services, and yet expectations have increased, especially around immunisations. The small increase in funding for the immunisations has meant we could employ three health care assistants. (Team leader 0-19 Team, County Council).

We have lost four people over the last year and it is difficult to recruit despite recruitment drives. People went off for personal reasons, high stress levels. The numbers of referrals into the service have gone up. (Head of School Nursing, London Borough).

The problem is money, but also a national shortage of qualified school nurses. We can't fill our vacancies through traditional routes. (Lead for Health Visiting and School Nursing, County Council).

In four local authorities, respondents felt that there had been no change in the numbers of nurses working in schools over the past two years. However, in some cases, commissioners were said to be becoming increasingly aware of the shortfall in the number of nurses and were reviewing how they might redress this shortfall.

Whilst there has been a decrease in FTE nurses, the PCT has recently conducted a review of the service specification for school nursing using ACORN as a measuring tool. This took into account school nurse-pupil ratio and deprivation, ethnicity and free school meal allocations. This gave a score for how many school nurses are needed. So the Trust has now recognised that there is a need for more. (School Nurse Team Leader, Metropolitan District Authority).

Skill mix and qualifications within nursing teams

There was wide variation in the skill mix available within nursing teams. Some teams had Band 2 or Band 3 administrative support staff available. Other teams reported having no administrative support at all. Some authorities commissioned specialist immunisation teams to administer vaccination and immunisations programmes while in other authorities, the school nursing team provided these services directly. Similarly, while in some authorities Band 4 nursery nurses and/or Band 3 school health technicians/nursing assistants (or equivalent) were employed to work with school nurses, in other areas these roles did not exist. Banding of nurses also varied with some authorities categorising Band 2 staff as clerical, while in others, Band 2 staff were nursing assistants.

As can be seen from table 2.1 the majority of nurses in all authority types were in Bands 5 and 6. Proportionally, there were very few members of staff in Bands 2, 3 or 4. However, the average number of Band 3s in Metropolitan District authorities was substantially higher than in other authority types. Similarly Metropolitan District authorities and County Councils reported having a higher number of Band 4 nurses than either London Boroughs or Unitary authorities. Significantly, there were very few Band 8 nurses within teams and, where these did exist, they normally had management responsibility for services in addition to school nursing.

Improving the skill mix within nursing teams was reportedly high on the agenda for a number of authorities. Initiatives to achieve this included introducing administrative support where there had previously been none; using resources to employ nurses in lower bands to support the work of SCPHNs and extending hours worked into holidays and weekends.

We have increased by skill mixing. Rather than say employing a single Band 6, we've looked instead at having the Band 6 having overall responsibility for two comprehensive schools and feeders and looking at employing Band 5s or maybe a Band 3 to help with the other work. (Head of Service for School Nursing, County Council).

Additional money has uplifted the staff already in position from part-time to full-time and introduced more staff and more Band 3 and more Band 5 posts. This means that there is a better skill mix. (Senior Nurse Young People’s Services, Metropolitan District Authority).

Table 2.1 also indicates that a relatively small proportion of Band 6 and above nurses across all authority types had completed an NMC recognised SCPHN degree level qualification. In some cases, those who had completed the degree were about to retire from the service. This said, in many cases the PCT or other commissioning body had reportedly allocated additional funding to increase the number of nurses completing a recognised SCPHN degree level qualification. Despite this additional investment, difficulties arose where there were insufficient community practice teachers within the local area to mentor and support those studying for a degree.

Overall there was a wide variation in the numbers of nurses working in schools and the range of skill mix across different authorities. . The following example of two similarly sized local areas (with respect to school population size) provides a clear illustration of these differences:

London Borough (London Strategic Health Authority)

This area had a school age population of 8,600 across primary and secondary schools. The school nursing team comprised 13 FTE and five part-time staff with a skill mix across Bands 3 to 8a. Fifteen percent of nursing time in the Borough was said to be taken up with child protection and safeguarding work (taken as a comparative indicator of socio-economic deprivation). Staff retention was high, opportunities for professional development were described as extensive and nurses were reported to have a high degree of job satisfaction.

Table showing numbers of nurses and skill mix in London borough

Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a
2	3	3	4	5	1

Metropolitan District authority (Yorkshire and Humber Strategic Health Authority)

This area had a school age population of 9,000 across primary and secondary schools. The school nursing team comprised one FTE and 10 part-time staff with a very limited skill mix and an overall lower banding of nurses than in Site A. In this authority, child protection and safeguarding work was said to take up 50% of nursing time. Staff retention and recruitment were low and nurses were said to be frustrated by the fact that so little time could be allocated to their wider health promoting/public health roles within schools. All Band 5 nurses were currently being encouraged to complete the SCPHN degree level qualification and all new nurses were said to undergo an extensive induction programme and have access to a range of additional training opportunities.

Table showing numbers of nurses and skill mix in Metropolitan District authority

Band 3	Band 4	Band 5	Band 6	Band 7	Band 8
4	0	2	4	1	0

2.3 Findings from case study sites

Site 1: East Midlands

The school nursing service in this area had experienced extensive cuts in recent years, to the extent that one consultant public health nurse commented that, 'using the term decimated is not an understatement'. In April 2008, there were 35.87 FTE nurses working with a school (primary and secondary) population of 103,000 pupils, approximately one nurse for every 2,600 pupils. Of these nurses, nine had a recognised SCPHN degree level qualification (Council Health Scrutiny Commission, 2008).

More recently, there had been significant investment in the service by the PCT, enabling more nurses to be employed and a better skill mix to be achieved. In addition, some nurses were now employed all year round instead of in term time only. This allowed work, particularly with children with complex needs, to continue throughout holiday periods. As nurses left the service, their replacement was made on the basis of skill mix rather than on professional banding. For example, at times it was considered more appropriate to the skill mix of the team to replace a Band 5 nurse with two Band 2 clerical assistants or health care assistants. This attention to improving the skill mix was said to be making a significant difference to the nurses' work. A specialist consultant was working in this authority at the time of the research to develop a skill mix strategy. Where previously Band 5 and Band 6 nurses completed all screening of children, this work was now done by Band 2 nursery nurses, thus releasing higher Band nurses to complete other public health work such as health drop-ins, health promotion and safeguarding.

Ensuring an adequate skill mix across the nursing service was considered essential for maximising nursing capacity. Further work had also been carried out in this authority to clarify the distinction between the role of Band 5 and Band 6 nurses as this had been a controversial issue. Some Band 5 nurses felt they were fulfilling the same roles as Band 6 nurses despite being on lower salary scales.

A new assistant practitioner programme had recently been introduced in this authority. Trainee assistant practitioners were employed by the PCT on Band 3 contracts. They attended college one day a week for two years to complete a foundation degree in health and social care, after which they were promoted to Band 4 positions. Throughout their training, assistant practitioners needed to be mentored within the community in order to build up a portfolio of relevant practice. The school nursing service had taken on six trainee assistant practitioners to work within school nursing teams in the most deprived areas of the authority. The assistant practitioners had effectively increased the capacity of the teams to work in specific schools. Over the course of their two years of study, these assistant practitioners would also spend some of their time working with health visitors and, as a result, develop the skills and competencies to work with children and young people across the full 0-19 year age range.

Recruitment of qualified school nurses in what was essentially 'a rural economy' continued to be a challenge within this authority, but, on the whole, increased investment by commissioners had encouraged optimism for the future among nurses working in schools and a belief that recruitment and retention would become less of an issue over time.

Site 2: South West

This was a relatively small authority with 13 state secondary schools and a school nursing service made up of 20 qualified nurses (8 FTE) and eight school nurse assistants. Twelve of the qualified nurses were categorised as specialist community practitioners on part three of the nursing register, either because they had a degree or school nurse qualification or were experienced school nurses who had prepared a portfolio enabling them to upgrade to specialist community practitioners. The majority of nurses had a caseload which included work in one secondary school and its feeder primary schools. Nursing time was allocated to individual schools according to the number of pupils, the number on child protection plans, a review of the health and wellbeing needs, and the amount of PSHE education input individual schools were willing to accept (since a number of schools in the authority were resistant to this aspect of work). Some nurses also worked in special schools and one was responsible for work in FE colleges. At times, nurses provided certain services, particularly the 'clinic in a box', in other settings such as the youth offending team (YOT), youth clubs and at a local drug support project. Increased capacity for the service would reportedly enable work in more community settings, and facilitate the employment of nurses all year round rather than term-time only.

A nurse working in this authority discussed the frustration of trying to develop areas of specialism within the service but not having the time to do this. She also expressed discontent at the lack of time available for nurses to review and reflect on their practice. She was frequently faced with requests to take urgent referrals when her list for the following week was already full. Greater capacity and a year-round service were seen as ways to alleviate some of these difficulties.

I actually work more hours than I am contracted for. The things are thrown at us and we are expected to take them on. Sometimes we get temporary hours for a few months as new sources of income come in. (Nurse, Site 2, South West).

Site 3: London

The school nursing service in this borough comprised two Band 7 nurses, 14 Band 6 nurses and six Band 5 Nurses. In addition there were five Band 3 school nurse assistants and eight Band 3 administrative and clerical assistants. Two nurses (working at Band 7) currently held an NMC-approved degree-level SCPHN qualification.

The majority of staff worked during term time only and the team as a whole provided a service to mainstream and special schools. In total this included 60 primary schools, 15 secondary schools, five schools for children and young people with special needs, six education units for children and young people requiring sensory support and six alternative education facilities (including four PRUs).

This authority had experienced dramatic cuts to its nursing services in the past two years. There had previously been 18 qualified school nurses in the team but this number had been cut by a third. Consequently, no public health and health promotion work was carried out and the majority of nursing time was taken up with immunisations and safeguarding. Most nurses worked part-time during term

time only although some nurses had more recently had their hours extended to full-time throughout the school terms.

Site 4: North West

The number of nurses working in schools in this authority was particularly low with a total of 29 nurses (the majority working part-time), for 170 schools. Despite their limited numbers, school nurses were working in a wider range of settings than in any other research site. Settings included YOTs, the youth justice system, a special programme for young people at risk of prostitution and with children who go missing from their family homes or from care. Although 10 nurses had completed the SCPHN degree-level qualification, six of these were currently on maternity leave. Recruiting appropriately trained and experienced nurses was reportedly difficult and the current approach was to recruit registered nurses who had no SCPHN qualification or public health experience and train them in post.

Nurses working in an area of high socio-economic deprivation within this local authority described frustration with not having the capacity to address the needs of the wider school population. They were focusing primarily on safeguarding issues which they estimated accounted for 95% of their workload. One qualified nurse talked of how she and one other colleague worked in 15 schools including two PRUs and two secondary schools. In addition they provided support in some special schools where children were on a child protection plan.

People with normal needs are getting missed because we haven't got the service provision or capacity. We would like to focus more on the issues for teenage families, on emotional wellbeing and raising attainment, raising aspirations, breaking the cycle. (School Nurse 1, Site 4, North West)

I think there's a lot of preventative stuff that could take place. I mean, we did a lot of early prevention stuff within primary schools going back a couple of years, you know safe medication, and drugs and within the PSHE education curriculum, you know? Health, self esteem, domestic violence. Some of that worked and allowed children to be able to recognise that they can get support from other people and keep safe in some situations. But that's not done any more because of the lack of staff. (School Nurse 2, Site 4, North West)

At the time of the research, a new health needs assessment model of working was being introduced for nurses working in schools. This involved identifying the main health and wellbeing issues affecting the population in each school and comparing these to the range and type of services being delivered. Concurrent with the health needs assessment was a workforce development audit which involved examining the skills and competencies of the nursing workforce against the health and wellbeing needs of the school populations and considering how best to configure the workforce to maximise its effectiveness in addressing local health needs.

In addition to these measures, an extensive public consultation using a participatory rapid appraisal approach had recently been completed with over 2,000 people. One of the key issues identified by children and young people was that they wanted to have someone in school who was knowledgeable about health and with whom they could 'check things out'. As a result of the consultation process, a proposal had been put into the local strategic plan to have an additional 12 Band 5 nurses working in the 60 most deprived schools across the authority.

Site 5: Yorkshire and Humber

The school nursing team in this authority was comprised of seven Band 7 advanced practitioners (all with a degree level qualification), 26 Band 6 nurses (seven of whom had the specialist degree level qualification), Band 5 nurses and, in mainstream schools, Band 2 health support workers. The nursing service worked across 27 secondary schools and their feeder primary schools. Band 3 nurses worked in special schools. The majority of nurses had term-time only contracts with only two members of staff working full-time. At the time of the research, there was a lead team manager reviewing the education of nurses, including their access to the degree course provided by a local university. The PCT funded between one and three places for nurses to complete the SCPHN degree course each year.

Two PCT-commissioned reviews relevant to nursing services had just been completed but the findings had not been published at the time of the current study. One review had looked at the capacity and roles of nurses in schools so as to inform a revised specification for the work which they would be commissioned to do by the PCT. The second was a review of all commissioned services for children. Generally, as in other authorities, too few nurses and the heavy demands on the service in relation to safeguarding issues were said to limit the public health/ health promotion function in schools and local communities. Early indications from the nursing review were that some of these issues could be addressed through better skill mixing and better use of nursing time (for example through reducing the amount of time spent travelling across a large authority).

Key findings

- The numbers of nurses working in schools is still below the target of having one qualified school nurse to every secondary school and its feeder primary schools.
- New national agendas such as the National Child Measurement Programme (NCMP) and the Human Papilloma Virus (HPV) immunisation programme have had a major impact on the capacity of nurses to fulfil their wider health promoting roles in schools.
- Service reviews conducted in many authorities are beginning to highlight the lack of capacity of nurses working in schools and to influence the commissioning agenda within PCTs and local authorities.
- There is clear evidence that nursing capacity in schools can be enhanced through an appropriate mix of skills among nurses, nursing assistants and administrative staff.
- The skill mix in nursing teams working in schools varies widely across different authorities but, on the whole, is a dimension of workforce planning which is receiving increasing attention
- The majority of nurses working at Band 6 and Band 7 within schools do not have a specialist community public health nursing (SCPHN) degree level qualification.
- There are very few male nurses working in schools although their numbers appear to be increasing.

3. WHAT NURSES DO IN SCHOOLS

3.1 Findings from national stakeholder interviews

The majority of respondents felt there was considerable variation nationally in terms of what nurses did in schools to promote children and young people's health. The picture varied according to capacity, settings and contexts, demands of commissioners, school and other national programme priorities. While some respondents mentioned the amount of nursing time needed for safeguarding and child protection issues, others seemed less concerned about this. Individual care plans for children with complex needs and for looked-after children, one-to-one support to children, young people and families, school entry screening and health drop-ins in secondary schools were thought to account for most nursing time. Almost all national stakeholders felt that insufficient time was allocated to PSHE education and broader health promotion activities in most schools. One interviewee summarised the variation in what nurses do in schools as follows:

It is very hard to think of school nurses as a homogenous national service doing the same everywhere. In some schools nurses play an integral part of promoting health in the school, they have a leadership role in teaching PSHE education; they provide services and advice, counselling and referrals for pupils. And this work contrasts to where there is no clear nursing role or there is the typical role of dealing with head lice and inoculations - and there is a wide range in between. (National stakeholder).⁹

3.2 Findings from survey of local authorities

Even though not all respondents were able to provide estimations of time spent on specific activities in schools, there were some clear patterns about how nursing time was allocated.

Screening and the NCMP

In primary schools, substantial amounts of time were reported as being taken up with screening activities. These included school entry screening and the NCMP. The extent to which Band 5, 6 and 7 nurses were involved in these activities depended on the availability of a suitable skill mix allowing nursery nurses (usually Band 4) or nursing assistants (often Band 3) to carry out most of this work with support and supervision from more senior nurses. Overall the NCMP was said to take up a substantial amount of time. This programme had caused some frustration among nurses, particularly those without the opportunity or resources to develop interventions with those children and young people who most needed support with healthy eating and physical activity.

Immunisations and vaccinations

In secondary schools, a wide variety of nursing time (10 – 50%) was taken up with immunisations or vaccinations – mainly the administration of the HPV immunisation and, in some authorities, immunisation booster campaigns commissioned by the PCT. The approach to managing immunisation

⁹ To ensure that individual national stakeholders are not identified through their contribution to the study, quotes from national stakeholders are not attributed to individual professionals.

targets also varied locally. In some areas, specialist immunisation teams were responsible for meeting immunisation targets including HPV. However, even in these areas, other nurses in schools were said to support/help manage these teams and consequently still had to allocate time to this work. While the majority of immunisations/vaccinations were taking place in secondary schools, some services were also involved in immunisations in primary schools especially where there had been a low take-up of pre-school immunisation boosters. Swine flu had also impacted on nurses' work load with school nursing services in a number of authorities being required to administer Tamiflu.

Most respondents were highly critical of the way immunisation programmes such as HPV had been introduced. Programmes were seen to have been announced at short notice yet requiring extensive resources and as such had an adverse impact on other areas of work with children and young people.

The government decide to deliver these (immunisation) programmes at short notice and they are very destructive, absolutely destructive. I have been involved in two of these in the past however many years and I think they have the potential to bring school nurses and school nursing services to their knees. And they completely destroy relationships between schools and school nurses, because schools do not have nurses anymore, because all they are doing is mass immunisation programmes. And people leave, because that is not what they came into the job to do. (Lead Nurse Manager, Children's Nursing Team, London Borough)

PSHE education/SRE

In primary schools, a variable 5 - 40% of time was said to be allocated to health education activities. This was said to include talks about puberty, personal hygiene and nutrition for years 5 and 6. In most cases respondents felt that nurses would like to increase the amount of health education activity in primary schools. 5 - 30% of nursing time was said to be taken up with offering one-to-one support to children in primary schools – in a few places this took the form of a drop-in service, although this arrangement was unusual at primary level.

In secondary schools, PSHE education in schools was said to occupy 3 - 30% of nursing time. This was most commonly reported to include health promotion work in relation to SRE, contraception, smoking, alcohol and drug use, with some focus on mental health and emotional wellbeing. Other examples of PSHE education included nurses' involvement in enrichment/health days when the main school curriculum was suspended.

Despite the fact that most local areas surveyed had provided opportunities for nurses to access a PSHE education CPD programme, in many cases nurses did not have the time to offer support to PSHE education activities in schools. A large number of respondents described how other pressures on their time had limited what they were able to do with respect to PSHE education/SRE in schools.

Health drop-ins

Five per cent to 30% of nursing time was allocated to providing individual advice and support to young people, frequently through drop-in services. In total, 22 (65%) of respondents said that they provided some form of drop-in service in schools but this was only universally provided to secondary schools in a few authorities. More usually a pilot drop-in service was provided in one or more schools, usually in response to the level of needs of pupils within the school. Health drop-in services in primary settings were far less usual, although there were one or two examples described during the study.

Sexual health was an important focus for health drop-in work, especially in areas with high teenage pregnancy rates and where additional funding had been allocated to schools to offer confidential advice and support services to young people. Some services were said to be offered in certain schools only, and included distribution of condoms, the 'C' card scheme,¹⁰ Chlamydia screening, emergency contraception and pregnancy testing. Such drop-ins were either run by the school nurse alone or, more usually, in partnership with other professionals such as community sexual health nurses or youth workers. There were however, examples of a specialist sexual health team working in schools in parallel to school nurses with little coordination taking place between their activities.

While sexual health was a particular focus for many secondary school health drop-in services, a substantial amount of time was also said to be taken up with wider health issues including mental and emotional wellbeing. There were a number of examples where nurses in schools provided tier 1 triage for young people, referring them onto tier 2 or 3 CAMHS services as and when appropriate. There were also several initiatives described where nurses in schools were being trained in tier 2 interventions by local CAMHS services.

Safeguarding

Eighty per cent of survey respondents reported that safeguarding work took up a substantial amount of nursing time with an estimated range of 10 - 70%. Sometimes this degree of variation was seen within a single authority and was in response to the needs of children and young people in specific neighbourhoods. On the whole, the higher the level of socio-economic deprivation within a local area, the more time nurses were likely to spend on safeguarding issues. In almost all cases, it was senior nurses (Bands 6 and 7) who were responsible for this work.

In some areas of severe socio-economic deprivation, nurses were working with children and young people with significant health and wellbeing needs but who, nevertheless, did not reach the threshold for child protection intervention. One respondent in a Metropolitan District described these difficulties as follows:

And because of the way we have moved from Section 17, in order to have a social worker you need to be really well into the Section 47 – the real safeguarding, child abuse concerns. But we have lots of what I call 'high child in needs', you know, where there are lots of issues about neglect, drug and alcohol misuse, domestic violence, who might have had a social worker years ago but haven't anymore. So school nurses are much more involved with those children and families. (Community Public Health Nursing Locality Manager, Metropolitan District Authority).

Respondents in 17 (50%) authorities said that it was usual for nurses in schools to participate in the completion of CAFs for children and young people with additional physical, emotional or social needs. Two respondents (4%) indicated this would happen on the odd occasion; 12 (24%) said that it was not common for a nurse to complete a CAF but that it was becoming more common, and two respondents (4%) felt that it was unlikely nurses would complete a CAF.

Safeguarding is a huge part of their (nurses) work. They have to attend all case conferences for these children and all review conferences. After this, they prioritise children subject to child action and those for whom they are lead professional in the CAF. They are so focused on these vulnerable children that they have very little time to work with the wider population of children

¹⁰ The 'C' Card scheme facilitates young people's access to free condoms from other local services.

around things like smoking cessation and PSHE education. (Senior Nurse Manager, Metropolitan District Authority).

In another Metropolitan District authority, a community public health nurse manager reported that in addition to attending child protection conferences and child in need meetings, nurses in schools were responsible for triaging thousands of domestic violence referrals and for reviewing 9,000 child and young people attendances in accident and emergency departments to determine whether there were any child protection concerns.

Safeguarding issues were often complex, creating challenges for nurses about how best to respond and what role to take in a context where safeguarding had become *'everybody's business'*. A number of nursing services were reportedly grappling with the extent to which nurses needed to be present at safeguarding meetings and reviews. In most cases, the approach was to try and reduce the amount of time that nurses were involved, encouraging their input only when there was a significant health (requiring clinical input) issue. However, in one London Borough evidence from a recent review identified a lack of continuity in support to children and young people. In response to the review, a decision had been taken that nurses should resume their attendance at all review meetings.

The assignment of the lead professional in safeguarding issues was also an area of concern and an area showing variation between authorities. It was felt that under the new safeguarding arrangements the role of the lead professional was no longer falling to social workers but was being frequently assigned to other professionals in schools including nurses. Ten (30%) respondents said that it was common for nurses to be the lead professional in a CAF; nine (27%) said that nurses sometimes acted as the lead professional and the remainder of respondents felt that it was more usual for someone from another agency to act as the lead professional.

It is very common for nurses to be the lead professional. Often other services refuse to take on the role. But we need to start being stricter about when it's really appropriate for us to act as the lead professional. (Clinical Lead and Service Manager for School Nursing, Unitary Authority).

It is not that common at the moment (for nurses to be the lead professional) There is a pilot being rolled out to support GPs so that where a GP feels a CAF needs to be done for a school-aged child then they will contact the school nurse and she would be that link for the GP. And for pre-school age, the GP will link with the health visitor. We are also looking at setting up a pilot for a single point of access, particularly for young people going into CAMHS. (Head of Health and Wellbeing, Metropolitan District Authority).

School Nurses have had training and they are about to take on CAFs. This has ramifications for their caseload because across the city they have 4,100 children where there is a care plan allocated to them. (Community School Nurse Team Lead, Unitary Authority).

Other activities

A number of other activities were identified as taking up substantial amounts of school nursing time. These included annual health assessments for looked-after children and young people in school settings, and care plans for children and young people with complex medical conditions in mainstream education settings. Time was also taken up with partnership working and, for a few, conducting health needs assessments or school health profiles to inform programmes of work. Nurses also spent time training school staff about managing medical conditions such as anaphylaxis, diabetes mellitus, asthma

and epilepsy. Less common activities included offering domestic violence therapy and anger management groups (London Borough); supporting the ADHD pathway (Metropolitan District authority); organising a 'teens and toddler' group for teenage parents (London Borough); and a pilot project after school for children and young people with eating problems (London Borough).

Factors influencing the work of nurses

High teenage pregnancy rates and high numbers of local children and young people with obesity were the most frequently cited priorities which influenced the work of nurses in schools. A number of activities were described as targeted work to address these health issues. These included the extension and development of SRE work, improving access to emergency contraception, pregnancy testing and Chlamydia screening through schools, and specific interventions focusing on nutrition and exercise with individuals or groups of children who were considered to be over-weight. Other priorities included substance misuse, 'binge' drinking, poor dental health and smoking, all of which influenced the work that nurses felt they should be doing with young people. A further issue for nurses in three or four authorities was the relatively high number of looked-after children and young people and/or unaccompanied children and young people seeking asylum.

For a variety of reasons, setting local priorities for the work of nurses was complex. Fluctuating populations of young people was an issue for nurses in some authorities. In one authority 40% of pupils were said to travel into the authority for school and 45% travelled out. In another, 45% of pupils came into the authority for school and a further 45% from within the authority attended independent schools in which nurses were not commissioned to work. As a consequence, nurses had to work across different authorities in order to help children and young people with specific or additional needs access the services they required.

Furthermore, identifying health and wellbeing priorities depended on the availability of reliable data and/or local intelligence from different health and other professionals. One respondent described how quarterly local partnership meetings in each school cluster were used as fora in which to examine available information and identify priorities such as school non-attendance. She believed this approach was under-developed and that there was a consequent risk of introducing interventions based on anecdotal evidence and of using approaches which were not tried and tested.

Overall, and despite considerable variation in provision, what nurses did in schools was determined by the capacity of the service and by national and/or local demands.

We have developed a 3-tier service in face of the reality of our current capacity. If there are vacancies in the team they only do safeguarding, the NCMP and looked-after children. (Lead for Health Visiting and School Nursing, County Council).

3.3 Findings from case study sites

With the exception of Site 2 (South West), the majority of nursing time in school was said to be taken up with safeguarding, immunisations and the NCMP. There was an evident dilemma for nurses, managers and commissioners with respect to the safeguarding agenda, about how best to provide an effective, generic, preventative health service to children and young people in schools and local communities, while at the same time providing targeted support to those who were highly vulnerable. Moreover, there were concerns that if these roles were separated, the scope of what nurses could do would be jeopardised. For example, it was through PSHE education work and through talking openly

about sex, relationships and other sensitive health issues, that nurses built effective relationships with young people. Such relationship building encouraged those with greatest need to access the nursing service on an individual basis. The key, therefore, lay in the capacity of the service to offer both a generic and a targeted service.

Site 1: East Midlands

In this site, one cluster team lead for nursing services felt that the amount of safeguarding work nurses were undertaking was a direct result of the limited prevention work they had been able to do over the past few years, as a result of service cuts. The Healthy Schools Coordinator felt the lack of funding and the lack of clarity about their role had caused many nurses to leave the service, resulting in staff shortages. Prior to the teams across the north and south of the authority merging, there was said to be wide variation in what nurses did within different localities. The standardisation of the core service along with the introduction of the health needs assessment model were said to be influencing new patterns of working, more conducive to promoting health. While current capacity still limited the work to safeguarding and other 'must dos' in a lot of schools, re-investment in the service and a focus on achieving an appropriate skill mix meant there was a vision of nurses assuming a more proactive role in promoting health and an optimism that this would be realisable in the near future.

In the secondary school visited as part of the study, the nurse had a high profile among pupils and staff and was perceived as having multiple roles within the school. One behavioural support worker commented,

She does loads of the education of the young people, she does lessons, she does campaigns, awareness campaigns, works with schools to highlight other issues that come up in the clinics and things. So she does a lot of intervention, I would say, and a lot of early action stuff. And also a lot of working with other agencies. So through my work if there's an issue I've highlighted I go to X (Nurse) and vice versa. So she does a lot, a huge amount of multi-agency work.
(Behavioural Support Worker, Site 1, East Midlands).

Site 2: South West

In this authority, one-to-one work with children and young people took up the majority of nurses' time in schools. Children and young people were referred to the nurse by school staff, parents, other health professionals or, in the case of secondary schools, by young people self-referring through school drop-ins. Much of this work was said to centre on emotional wellbeing and constituted tier 1 mental health work. This work was complemented by a more universal preventative model of health promotion through the FRIENDS programme (described below), offered in all primary schools by nurses, and supported by the CAMHS service. Nurses in secondary schools were also involved in 'clinic in a box' sexual health services and a peer sign-posting programme. Under this intervention, young people in years 10 and 11 were trained to signpost others to young people friendly services. Whilst the one-to-one work was considered highly valuable, the current numbers of nursing staff meant that there was inadequate time to focus on broader public health initiatives such as healthy eating, smoking prevention/cessation and/or other activities. Nurses were said to make a considerable contribution to the provision of PSHE education in both primary and secondary schools. A common concern was that nurses in schools were providing support to young people with mental health issues but had limited referral options. However, the local CAMHS service was, at the time of the research, planning to employ some primary mental health workers, a development that was expected to widen access to more specialist intervention and relieve some of the pressure on school nurses.

Emotional Wellbeing: The FRIENDS programme

FRIENDS is a preventative, emotional wellbeing programme, based on cognitive behavioural therapy and universally provided to children aged nine and ten across the authority. Nurses, working in schools alongside teachers, are central to the programme. The intervention has reportedly provided an opportunity to enhance nurses' skills and develop a more evidenced-based approach to addressing the emotional wellbeing of children in primary (special and mainstream) schools. School nurse assistants support nurses in this work through providing administrative and organisational help to the programme. Standardised measures of emotional wellbeing are used before and after the programme and these, along with evidence from an external evaluation, have demonstrated some positive outcomes for children's mental health (See: Stallard et al, 2006; Barrett et al, 2006).

One nurse in this authority reported how a drop-in service had existed in one school for 10 years. This was provided twice a week, with one session for general health issues and the other for sexual health concerns. Young people could book 30 minute appointments by text. During an appointment, the nurse made an assessment to establish the nature of the health problem and whether the young person should be referred to another service. In addition to providing the drop-in service, she supported tutor group activities and contributed to the PSHE education programme. She was also able to administer emergency contraception. Despite this range of initiatives, the nurse concerned felt there was insufficient nurse involvement at a strategic level to influence the wider agenda of pupils' wellbeing.

I need more time to do the strategic work, so much of the work here is still about keeping young people in class, and attainment. The health issues in relation to disengagement are not considered enough. We need to get in earlier. The school doesn't have a panel to identify the most vulnerable students. (Nurse, Site 2, South West).

Site 3: London

As in other sites, the majority of nursing time in this area was said to be taken up with safeguarding work, child protection issues and work with looked-after children and other vulnerable groups. A clinical lead for school nursing described this approach as 'a reactive, rather than a pro-active service'. In this authority, the health and wellbeing needs of children and young people were diverse and, for many, English was their second or third language. Routine screening had been discontinued resulting in less opportunity to identify any additional needs children and young people might have. As in other authorities, nurses spoke of a time when they were more involved in PSHE education work and when they had a more regular presence in schools than currently. One nurse interviewed had a caseload of one secondary school and six primary schools. There were times when she would only visit the primary schools once a month. She tried to go to the secondary school at least once a week but as it was on a split site this was difficult to achieve. She tried to attend weekly student support group meetings where members of the school senior management team and support/pastoral staff would discuss pupils about whom there were particular concerns. If she was unable to attend these sessions, 'it is almost impossible for me to extract any information from the school about needs'.

Site 4: North West

This was an area of high socio-economic deprivation and LA, PCT and nurse interviewees felt that the vast majority of their time was taken up with safeguarding issues leaving little time for generic, school-

based prevention work. While the importance of safeguarding work was not questioned, there were concerns over whether nurses and other professionals were being appropriately deployed with respect to safeguarding work.

If you are talking about school-age children, we are in the middle of doing an audit and overwhelmingly, our practitioners for school-aged children are sat in safeguarding meetings. We are discovering through the audit that they are being used as health advisors for vulnerable children. There may not be any health input from the school nurse, this may come from the emotional wellbeing officer in the school or the CAMHS team or sexual health worker or GP – but the school nurse is being used as the health advisor and has to come out and act as a conduit through which all other health-related organisations get involved with that child. And so, effectively, their skills aren't being used for a fairly significant number of the cases they are attending. (Locality Services Manager, Site 4, North West).

There were plans within one area of the authority to have an integrated health centre to serve both primary and secondary schools and the local community. This integrated, one site, facility was likely to include sexual health services, CAMHS, housing providers, health visitors, and nurses, along with a range of other health and support agencies. It was hoped the service would be more responsive to the identified needs of the local community with easier, swifter access to the most appropriate agencies. A primary head teacher explained,

What we actually need is multi-agency teams working with families, rather than saying, 'I can do that', looking at a child or family and saying, 'what do they need?, right, who can help? What bit can you or you do?'. And when we find something that we can't do anything about, 'who can we call on to come and fill the gap?' I suppose, that's what we need. (Primary Head Teacher, Site 4, North West).

Site 5: Yorkshire and Humber

In this local authority, nurses, as part of universal services, were said to play an important role in public health and in promoting the wellbeing of 'school-age children'. The school nurse was said to be the key health link between health and education settings. Nurses also worked in out-of-schools settings and were said to be very much part of the '0-19 partnership'. In practice, given their current capacity, nurses were said to spend the majority of their time in health care planning, safeguarding, immunisations and working with vulnerable children and families, including one-to-one work. There was relatively little time for health promotion and generic prevention work, which nurses said they would like to be doing.

In one secondary school, for example, a health drop-in was run by two members of the school staff who had been trained to provide first line support to pupils with support from a central health clinic within the PCT. Staff were able to provide information around sexual health and condoms, conduct pregnancy testing and signpost young people to other, more mainstream services including for contraception. While the nurse in school supported this initiative when she could, she had no allocated time to do so. Similarly, there was no identified time for the nurse to support the PSHE education programme or the Preparation for Adult Life (PAL) programme which had been developed within the school.

One PSHE education coordinator commented on how she had asked for the nurse allocated to the school to set up a series of smoking cessation sessions for a small group of young people who wanted to give up smoking. She was told by the nurse that these young people should attend the general nurse drop-in but felt they were unlikely to do this, and consequently would not get the support they required.

The nurse only had two hours allocated to the school each week and was therefore unable to offer a more specialist service to these young people, despite having the necessary skills.

A professional advisory lead for school nursing in this authority believed that nurses in schools were adopting a more health promotion, preventative model than before. Nurses were doing less screening and were liaising with other services, such as speech and language, mental health and GPs, to facilitate children and young people's access to appropriate services.

Key Findings

- National programmes such as the NCMP and HPV immunisations consume substantial amounts of nursing time in the majority of authorities surveyed.
- Safeguarding and child protection work have increased significantly for nurses in the last couple of years and it is common for nurses to complete and be the lead professionals for CAFs.
- There is widespread concern that the expectations placed on nurses with respect to safeguarding issues are not always appropriate.
- Nurses carry out limited SRE and PSHE education despite schools wanting more input and nurses wanting to do more.
- The numbers of young people experiencing emotional, wellbeing and mental health difficulties is reportedly increasing. There was some evidence of service innovations in this area within school settings.
- There is evidence that in some authorities the role of nurses is developing towards a more preventative, health promoting model. This is supported through increased investment in nursing services, a more appropriate skill mix and improved local intelligence with respect to the health needs and priorities of local populations.

4. THE PROFILE AND THE PERCEIVED VALUE OF NURSES IN SCHOOL

In each of the five local areas where we spoke with children, young people, school staff and parents, the extent to which they were aware of who the nurse was within the school or what s/he did, varied widely. Where nurses had been working for some time in a school and had developed relationships within the school and community, there tended to be a clearer understanding of who they were, and what they did.

4.1 Perceptions of teachers and other school staff

The majority of schools visited during the study were in areas with substantial numbers of families experiencing socio-economic deprivation. Of all the case study sites, Site 4 (North West) was one with particularly high levels of poverty and need. The head teacher and school inclusion team (made up of learning mentors, family support workers etc) in one primary school described children in school requiring extensive support on a range of health and wellbeing issues. These included severe head lice infestation, scabies, malnutrition, drug and alcohol use within families and local communities, and domestic violence. The extent of malnutrition caused school staff to question the relevance, for their school, of the current anti-obesity strategy. Children and young people in both primary and secondary schools frequently described emotional wellbeing and mental health issues including self harm, anxiety, depression and eating disorders as well as conditions such as Asperger's syndrome and ADHD. Sexual health, pregnancy, alcohol, drugs and smoking concerns were primarily encountered among secondary school pupils, although some Year 6 pupils were known to be sexually active and to be experimenting with drugs.

Interviewer: *So you support any child where there are other issues getting in the way of learning?*

Learning mentor: *From showering, to cutting their toe nails, cleaning them, scrubbing their feet.*

Head teacher: *Finding clothes for them, washing their clothes.*

Learning mentor: *Washing their clothes, putting them back on, dressing them, finding winter coats, finding them shoes when they're coming into school with just the top of a trainer on with no sole. So we find them shoes and underwear.*

Family support worker: *It's totally Dickensian, it's ridiculous.*

Head teacher: *Partly the reason we don't get many level 4s. It's not 'cos we're rubbish really!*
(Interview primary school, Site 4)

Given the level of need within this authority, concerns were expressed by primary school staff about the lack of nursing time and the lack of continuity in nursing provision to the school. This meant that nurses did not have the time to build relationships with children and their families, nor, as one family support worker put it, '*get to know the context of the child and their difficulties*'.

In the secondary school in Site 4 (North West), members of staff talked about how their allocated school nurse had only recently been appointed, and that prior to this there had been a gap of several months when they had no nursing provision at all. As a result, they were unclear about when the nurse worked in school and what she was able to offer. At the same time, there were a range of other agencies working in the school including a teenage pregnancy nurse providing support around sexual health issues, a male sexual health worker, working specifically with young men, CAMHS, educational

psychologists and youth workers. While the range of services from different agencies was welcomed by members of staff, there was said to be a lack of coordination of these different initiatives.

A well-trained, dedicated PSHE education team coordinated PSHE education activities across the school and even though a school nurse had supported this work in the past, it had continued throughout the time there was no allocated nurse to the school. However, school staff felt pupils preferred to have professionals such as nurses from outside the school to talk to. A survey of students the previous year, for example, had shown that around 90% of young people in Years 9, 10 and 11 thought that having a nurse coming into the school to offer services was a good idea.

In Site 5, (Yorkshire and Humber) widespread alcohol and drug use within the local community, mental health problems and domestic violence were significant issues affecting the health and wellbeing of pupils. One member of staff in the secondary school who had responsibility for re-integration and safeguarding, worked primarily with young people and families around issues that kept young people out of school. These included teenage pregnancy and sexual exploitation. There were widespread concerns about alcohol and drug use and early sexual activity among pupils within the school. In particular, staff felt that young people's apparently easy access to pornography generated particular expectations around sex and put them at risk of sexual exploitation.

Within this same site, promoting school inclusion was a significant driver to the ways in which both primary and secondary schools worked. To support this agenda, some members of staff, including one deputy head teacher, worked across both primary and secondary schools. The deputy head teacher described the importance of building relationships with vulnerable families in order to offer the most appropriate support. She felt that continuity in working with these families was key and that the high turnover of nurses working in the school was counter-productive to nurturing effective relationships.

The nurse's time in the secondary school was perceived by members of school staff to be primarily taken up with care plans for pupils with complex medical conditions and with child protection cases. Overall, the profile of the nurse in the school was low and several members of staff did not know there was a school nurse allocated to the school, nor that she held regular drop-in sessions for pupils. One senior manager in the school felt that they received more input from the police and fire services than they did from the nurse. Ideally, school staff said they would like greater input from nurses into the PSHE education programme and more direct work with pupils, particularly those grappling with mental health issues.

I work with a lot of students that self-harm, eating disorders, that have got mental health issues but that aren't necessarily severe enough to be referred to CAMHS and even if they are referred to CAMHS it is not necessarily the most appropriate place. There's lots of times when X (nurse's) input would be really valuable but she wouldn't be able to justify it. (Reintegration Officer, secondary school, Site 5).

In Site 3 (London), teachers and staff in the primary school recognised the pressures that nurses were working under in trying to provide a service to a large number of schools with only a very skeleton service. They believed this was indicative of more general cutbacks in PCT commissioned services across the borough, such as speech and language services and CAMHS. The head teacher of the primary school explained how he increasingly had to find additional resources from within the school's budget to provide health and wellbeing services such as counselling for children, often with highly complex needs. In this school, members of staff reflected on a time when they had a nurse coming regularly into the school over a long period of time. This had resulted in an opportunity for the nurse to build relationships with pupils and staff and to have a significant presence in the school.

In the secondary school in Site 3 (London), there was a system of pastoral support tutors, one for each year group, who were available to pupils throughout the school day. Support tutors were often the first point of contact when pupils had a problem or difficulty, and two tutors interviewed described themselves as '*counsellors, mentors, parents, sisters, brothers – we're everything to the students*'. They also provided a point of contact for parents when they had concerns about a child or young person. If tutors identified issues which they felt required a health input, for example a young person losing weight and not eating, they would make a referral to the school nurse. The nurse came into the school as required and supported individual young people or families around specific issues. However, there was no health drop-in at the school where young people could self-refer, although this was considered something that would be very helpful to pupils.

Nurses in Site 3 (London) also felt that their profile in local schools was relatively low compared to what it had been prior to funding cuts two years previously. Schools, they reported, were frustrated by the lack of nursing input and at times had re-utilised rooms previously set aside exclusively for the nurse. This meant that when nurses did visit the schools, they had no private, allocated space in which to work with or see children and young people.

In Site 2 (South West), the profile of nurses was said to be improving. Initiatives such as the FRIENDS programme (described in Chapter 5) introduced in all primary schools had made nurses more visible and there was an increased emphasis on ensuring that schools involved nurses in the HSP action plan. A peer signposting initiative had also done much to raise the profile of what nurses did and a website for young people, and DVD promotional materials, also helped to generate a better understanding of their work.

In this same authority, professionals and young people in schools felt that nurses needed more time in school because of the complexities surrounding pupil and family health and wellbeing. Overall, nurses were said to have a higher profile in secondary than in primary schools where school staff felt that children would not know who the nurse was unless they had been to see her individually or had participated in the nurse-led SRE sessions in years 5 and 6.

Because of her wider role, she (nurse) can't develop an in-depth picture of all the children and the community which would have significant long-term benefits. (Head Teacher, primary school, Site 2).

Irrespective of the level of nursing service provided in specific schools, there was general consensus across all research sites concerning the unique contribution which nurses could make to the health and wellbeing of pupils in schools. Their clinical knowledge and skills were mentioned positively by school professionals almost universally. Several respondents across the research sites highlighted the importance of nurses' knowledge across the spectrum of health needs. Their work was also said to be contextualised by good theoretical frameworks with respect to child development and social models of health promotion. Other health professionals such as health visitors or CAMHS workers were not felt to have this same level of generic knowledge. In particular, their knowledge and their links to other services assisted the referral of pupils and families to more specialist support when this was necessary.

She (nurse) provides a bridge with the clinical psychologist which is very effective in increasing outcomes. Before, we didn't really know who they were. We filled in forms and sent them off. Now we have a single conversation and the needs of the family can be discussed. We can involve all the relevant agencies from the outset. Previously we had to refer from one agency to

another and the family withdraw from the process, they get fed up with having to repeat their story time and time again. (Head Teacher, primary school, Site 2, South West).

Nurses' ability to work alongside teachers in the classroom and support input into health education was also highly valued by school staff across the research sites. Nurses were also said to be in a position to support the work of the school but 'take the side of the child'. In particular, the independence they brought to a relationship with a child/young person and his/her family was highly valued. This was especially significant when there were complex needs and where the input of a nurse was perceived as less formal and prescriptive than that of, for example, an educational welfare officer or social worker. Practically, nurses' access to medical records made it possible to locate current issues faced by individual children and young people within broader health trajectories, allowing on-going needs or child protection concerns to be addressed.

Nurses were also seen as crucial in encouraging young people's access to health services outside school and in providing an entry point into school for other services for young people, such as CAMHS and 'clinic in a box'. They were also said to play an important role in normalising health-seeking behaviour for young people, such as Chlamydia screening and accessing contraception, and in contributing to broader teenage pregnancy, sexual health and obesity strategies. In addition nurses' enthusiasm, openness, flexibility, personality and personal attributes were widely cited as being important dimensions of what they could offer a school to complement the role of school staff.

All school nurses I have known are very proactive, they will get their hands dirty and will stand up for families and kids because they have that independence and will champion their needs to other agencies. They seem to be able to turn their hand to anything and they are quite practical...let's not analyse it too much, just get on with it kind of attitude. (Specialist Behaviour Support Worker, Site 2, South West).

4.2 Perceptions of children and young people

Young people in all sites talked about the factors that made them feel well and happy and the sorts of health and wellbeing issues that were important to them. While younger children in primary schools tended to start by focusing on the importance of eating healthily and exercising, they also touched on issues of emotional wellbeing and bullying and on wider issues affecting them and their families out of school. They commented on their environments outside school, whether they felt safe within them or not, whether neighbourhoods were clean or dirty, how far their homes were from school and whether they had friends who lived nearby. For instance, a girl in Year 5 in Site 1 (East Midlands) was very anxious because she had heard that a girl had been raped in the neighbourhood close to where she lived. Health issues affecting the young people's families included smoking, drinking alcohol, taking drugs, violence and anger and medical conditions such as asthma and diabetes mellitus.

In secondary schools, an extensive range of health and wellbeing issues relevant to young people, their friends and family were mentioned, from emotional issues including insomnia, depression, body image and self esteem concerns, to physical conditions such as epilepsy, diabetes mellitus, parental illness and broader health issues such as sexual health and relationships, drug use, alcohol use and smoking. There were also wellbeing concerns linked to being in school, such as bullying and the stress caused by examinations and assessments.

The profile of the nurse

The extent to which children and young people knew who the nurse in school was, varied widely across the research sites. Within the primary school in Site 2 (South West), Year 6 pupils all knew who the nurse was since she had provided PSHE education sessions on asthma, puberty and sex education. While children felt that she was not present very often in the school, they indicated feeling more comfortable going to see her than a teacher for help about more private things. They liked the fact that she was somewhat 'separate' from the school and was able to keep things confidential. They also valued the fact that nurses in general had special clinical knowledge and qualifications.

In Site 1 (East Midlands), a mixed group of Year 6 pupils recognised how the nurse came into school and took some children out of the classroom to talk about their health. Their perception was that the nurse worked more with girls than boys (because she had spoken to them about menstruation) and that she '*don't be around too much*'.

There was some confusion expressed by primary school pupils between the school nurse (who was more likely to visit the school) and the person in school who provided first aid and who was frequently referred to as 'the nurse'. In Site 3 (London), for example, children drew a distinction between the 'nurse' who was at the school all the time and the 'nurse who came to visit'. When asked what the visiting nurse did, a group of Year 5 pupils described how a nurse had been involved in some PSHE education work with them recently:

Girl: *She came to talk to us about puberty.*

Boy: *The girls had to be separate and the boys had to be separate because it would be a bit embarrassing.*

Interviewer: *Was that helpful?*

Girl: *Yes because the girls had like a bit different because the girls – we saw the same video but we talked about different things... how things were like in the girls' life and the boys'.*

Boy: *Yeh, it was good because.. if we don't see it (the video) and if we are worried that things are happening to our bodies and we thought it was something bad – we wouldn't know why it happened.*

Boy: *Before we didn't even know what puberty meant and that... we didn't even know the word - well some of us didn't, some of us might have...and like we learned about how our body grows and everything and how we can notice changes. So if we see something changing we can now notice it – so then we can just go to a Dr and say 'is this right or is this wrong'?*

Interviewer: *What difference did it make having a nurse talk to you about these issues rather than a teacher?*

Girl: *First of all the teacher wouldn't have much experience because she's a teacher and she would have more teacher experience. So the nurse would like know more about the things. And the teacher might be confused on some things because the teacher has more teacher experience. And the nurse, she have (sic) more experience, she will know more things about the life cycle.*

Boy: *The nurse would know what sort of questions people will ask and she will know the answers to them. But if someone asked a question that the teacher doesn't know, she won't know the answer but the nurse is more experienced and she will know the answer to more questions.*

(FGD, Year 5, Site 3, London).

Year 6 pupils in the London site also remembered the nurse coming to visit the school in the previous year to discuss puberty with them. They commented as follows:

Girl: *It was a new person, she was very kind to us.*

Boy: *She just said don't worry about it (puberty), it is going to happen to every boy. And then what's gonna happen to girls.*

Boy: *There is one girl in this class and she got her period, but she felt ok with it 'cos she was remembering what the nurse said to her.*

Interviewer: *Does the nurse bring something different to the school than the teachers do?*

Girl: *Yes, confidence...if it happens then she made it feel more comfortable. If it comes from a nurse you feel a bit more reassured instead of having a big shock. It's because she is a qualified person who knows these things more. Then you think yes, I know that will happen.*

Boy: *A nurse is more professional, it makes you feel more confident learning about it. (FGD, Year 6, Site 3, London).*

Nurses were frequently thought of as people who visited and did not spend very much time in school and young people across the research sites expressed concern that they would not necessarily know where to find the nurse if they wanted to talk to her. Overall, across the research sites, children in primary schools appeared less likely than young people in secondary schools to know who their school nurse was.

Interviewer: *Do you know who your school nurse is?*

Girl: *No, we've never met her.*

Boy: *Have you met her? (to interviewer)*

Girl: *I wish she could stay in school, be like one of them teachers who is like a teacher but a nurse. Who stays in school, so you can go and talk to her if you've got a problem. (FGD, Year 5, Site 4, North West).*

Focus group discussions in secondary schools revealed that unless young people had had direct contact with the nurse, they were not sure about what nurses did within the school and where they could be found.

In Site 5 (Yorkshire and Humber), a mixed group of 20 pupils, in small discussion groups, said that they would feel most comfortable accessing information about their health from the television and internet because these media were private, confidential and anonymous. The NHS helpline was also identified as somewhere they could get private and accurate information. Whilst some also said they might talk to parents or friends, the most important criteria for their sources of information were trust, confidentiality and that they would not be judged. Asking teachers or other members of staff for advice or support was not an option they would consider because of concerns about confidentiality. Within this group, the majority of pupils did not know who the school nurse was, the exception being a few year 7 and 8 girls who had been to the nurse to ask for individual advice and support. However, most did know that the nurse ran a drop-in service once a week in the school, since this was advertised on posters around the school.

Within the secondary school in Site 3 (London), pupils across Years 7, 9 and 10 who participated in the study were positive about their school and described its ethos as caring and supportive. They felt that they had access to support from many people within the school, mainly teachers, whom they got to know well and who they would feel comfortable talking to about various aspects of their health and wellbeing. On the whole, young people did not know who the nurse for their school was. They had, however, met several nurses in the school who had come to give injections and some pupils thought nurses had also been involved in enrichment days. Pupils were unsure about what the role of the nurse in school was or could be and consequently were uncertain about what s/he might offer to the school

over and above that provided by other members of staff. Several Year 9 pupils did think, however, that a health drop-in would be very helpful especially '*during their teenage years*'.

By contrast, in the secondary school in Site 1 (South West), the nurse had a relatively high profile. Young people spoken to in this school had all received some input from the nurse – either through her involvement in health education sessions, or through support for personal issues which they had accessed through attending drop-in sessions. They particularly valued the confidentiality of the service she offered, her specialist knowledge and skills and the practical support and advice which she gave them.

Many pupils across the research sites felt that nurses should be situated in an obvious place within the school where they could be easily accessed on a regular basis. Some pupils suggested that nurses should attend school assemblies more regularly and introduce themselves more widely in the school.

The school nurse is not advertised enough. She has a drop-in and it was mentioned at assembly once and there are posters around the school. (FGD, Year 9, Site 2, South West).

The nurse should have her own room somewhere in the school so everyone knows where to find her. The nurse should be at the school more than she is, she should be there more regularly. (FGD, Year 5, Site 1, East Midlands).

Young people receiving one-to-one support

Across the research sites, children and young people who had received one-to-one support from a nurse in school described these sessions very positively and had found them helpful. These young people were very clear about the role of the nurse and the specific support which nurses were able to offer them. One girl in Year 6 Site 1 (East Midlands) talked about how, in these private sessions, she was able to talk to the nurse about a range of issues in her life, and how she could also ask questions about health issues which she would be embarrassed to talk about in a big group.

Interviewer: How has the nurse helped you?

Girl: *Well she's helped me a lot. She's helped me with things that have gone on at home. But she also helped me how to understand. She gave me this booklet once and I have been reading it and it's been helping me how to understand....like how if I need something because my period is starting and what to do. (Girl, Year 6, Site 1, East Midlands).*

Another pupil in a primary school in Site 1 (East Midlands) had received support from the nurse because she had problems with anxiety and controlling her temper. Yet another in this same site had support from the nurse to build confidence about her body image. She described how she used to think she was fat and had a body image problem, thinking she needed to go on diets and was very worried about putting on weight. The school nurse had helped her through this and enabled her to see that her weight was acceptable. The nurse had given her lots of information about healthy eating. She described the nurse as being really helpful, someone that she could talk to without feeling scared or embarrassed.

I could talk to the nurse about anything and it is good to let your problems and worries out and not let them build up inside of you. If she hadn't been there I would still have problems and still be worried about my weight and trying to go on diets. (Girl, Year 6, Site 1, East Midlands).

While the following young people in a secondary school in Site 2 (South West) did not reveal the specific issues for which they received one-to-one support from the nurse, they articulated the quality of the support they received from the nurse.

I have been seeing her (nurse) most weeks since I was in Year 7. X (nurse) is really calm, nothing shocks her, she understands everything, she doesn't pretend she is something she is not'. (Young woman, Year 10).

I saw her first when I needed help in Year 10. I was about 13/14, I'd never encountered health professionals before. Through her links with the world of health it was less scary, she got me a referral to CAMHS. (Young woman, Year 13).

I have been seeing X (nurse) since Year 7. She has referred me onto other people, but she always wants to catch up with you, she is really interested in what you have to say. (Young woman, Year 9).

I was seeing the school nurse at my primary school in Year 6, so she introduced me to X (nurse) as my secondary school nurse. I see her on Mondays and then we set another appointment. She helps me with strategies for at home. (Young man, Year 7).

What else nurses could do in school

When children and young people were asked what else nurses could do if they were able to spend more time in schools, most felt they would be more available to talk to about health and wellbeing issues. Many had specific questions about health for which they wanted additional information. A girl in Year 6 in Site 1 (East Midlands) commented that she would like to know more about 'why we have to try and keep away from boys when we're on our period and why we get a bit ratty at people because of our bodies changing?'. Other concerns expressed related to the health of parents or other family members and there was a request for opportunities to discuss significant family health issues. Some Year 5 children in Site 4 (North West), for example, were concerned about their parents' intake of alcohol and about drug use locally. One particularly pressing issue for a group of Year 6 pupils in Site 1 (East Midlands) was smoking by family members:

Boy: *My dad smokes....My mum stopped and she did it without any help. But he has carried on and I am worried because if he carries on he might die.*

Girl: *I tried to stop my dad from smoking but he is a heavy smoker and won't stop.*

Boy: *The only person in my house that don't smoke is me...*

Girl: *My cousin is 10 and he smokes'.*

(FGD, Year 6, Site 1).

In both primary and secondary schools there was a close association between the nurse and clinical knowledge, and an ability to offer advice about medical conditions of relevance to the pupils,

My brother has like epilepsy and sometimes I am left with him on my own and I get scared because he could have like a seizure and so I want to know like how to put him in the recovery position properly and stuff like that. (Year, 6 pupil, FGD, Site 5, Yorkshire and Humber).

Occasionally pupils emphasised the fact that they would not necessarily feel comfortable talking to a nurse they did not know and that getting to know them first was very important. Only when they knew the nurse could they talk about private or sensitive issues.

If I were worried, I'd tell someone I know... because I don't know the nurse. Suddenly a woman walks in and she's like a nurse and I don't know her so I'll ask this teacher instead. (Pupil, FGD, Year 5, Site, 5, Yorkshire and Humber).

There was a strong consensus amongst pupils, particularly those in secondary schools, that they much preferred PSHE education lessons to be facilitated by the school nurse than by teachers. This was often, they said, because nurses were less embarrassed than teachers talking about more sensitive issues such as sex and relationships. Also, many young people felt that the quality of PHSE lessons was better when delivered by the school nurse. This was often attributed to nurses' more specialist clinical knowledge and skills.

Pupils in a secondary school in Site 5 (Yorkshire and Humber) had clear views about what the nurse could or should provide for pupils. Essentially, they felt this should be a combination of general information for everyone, and then one-to-one support for individuals who had particular concerns or worries about their health.

The benefits of a nurse over a teacher are that most pupils feel more comfortable and able to talk about things like sex with a nurse as this is her job and she has been specially trained. Nurses know much more information about medical and health issues than teachers. The school nurse should have more time in the school. It is a comforting thought knowing that the nurse is around. The nurse should have a special room or space that everyone knows is hers and that they can find her there. (Participant in FGD, mixed years, Site 5, Yorkshire and Humber).

An extensive public consultation exercise in Site 4 (North West) had included children and young people's perspectives on the role of nurses in schools. According to one Children and Families Partnership manager in this site, this had revealed insights including the following:

They want one point of contact, they don't want to see different people. I know the approach now is to have turnaround in health teams in schools, but children's problems don't come as neatly packaged. When I was a health visitor and we tended to be more involved with the school, we did 'stop smoking' sessions for year 9. But the problems that young people brought to that group were not just about smoking but more agony aunt type problems of quite a serious nature like 'I need the morning after pill' or bullying, or were from young people in care, or family care, and not getting on with relatives. (Children and Families Partnership Manager, Site 4, North West).

Important qualities of the nurse

Young people across the research sites were clear about the qualities they thought important for a nurse in school to have. Being friendly, approachable, sensitive, able to listen and non-judgemental were all qualities frequently mentioned. Vitally important for young people was the fact that nurses could take confidentiality seriously, more so than other members of school staff. Many young people also referred to the fact that they were 'comfortable' and 'not embarrassed' about discussing more sensitive aspects of health such as puberty, sex and relationships.

In FGDs in the primary school in Site 1 (East Midlands), young people had a clear sense of the qualities they would look for in a nurse. A group of year 5 pupils thought the nurse should be: *'friendly, chatty, being able to listen, have experience with children and be able to talk to children but not be patronising'*. One girl concluded, *'a good nurse needs to be an experienced social worker!'*

School nurses have got to be calm, caring and patient. They should make sure all the pupils know who they are. (FGD, Year 5, Site 1, East Midlands)

Two girls in Year 7 of a secondary school in Site 5 (Yorkshire and Humber) who had received individual support from the nurse described the characteristics and attributes of the nurse that were important to them.

Interviewer: *What is it about the nurse that you feel so comfortable about?*

Girl 1: *You can talk to her about anything and she'll listen. She's just really, really kind.*

Girl 2: *Anytime you walk in she's just 'hi' and all of that. I don't know, it's just psychological. She just makes you feel happy and welcome and makes you feel comfortable because you get to know her after just one or two times.*

Interviewer: *What if you had a different nurse coming in every week, how would that be?*

Girl 1: *It would be difficult because one, you'd forget the name, two you'd not really want to come and find them because you'd never know ...*

Girl 2: *We had different ones in sometimes and I never really liked 'em'.*

Girl 1: *I only like X (current nurse) because we have got to know her.*

Girl 2: *The odd occasion, that X (another nurse) comes around and she's a bit strange...*

Girl 1 *Horrible!*

Interviewer: *But, what is it that you don't like about her?*

Girl 2: *She is not as cheerie, and she shouts down corridors to see if you're coming in or not. And like say if I am like here with E (friend) and she's talking about her problem or something like that... E will get to some little bit and all of a sudden she (nurse)'ll stand up and go outside and say (mimics shouting) 'is anybody else wanting to come?' and it's like isn't E supposed to be speaking?.*

Girl 1: *That's why we like X (current nurse) isn't it? If she does need to step out and ask someone something, she'll like wait until we have finished speaking and just say 'just wait a minute girls, I'll be back in a minute' so she'll let us know...*

(FGD, Year 7, Site 5, Yorkshire & Humber).

4.3 Perceptions of parents

For those parents participating in the study, awareness of what nurses did in schools to promote children and young people's health varied. Parents who had had direct contact with the nurse, or who were involved in the management of the school as parent governors, were more likely to understand the roles and responsibilities of the nurse.

In site 5 (Yorkshire and Humber), a group of parents in a primary school had recently started to meet on a regular basis for a coffee morning which the school nurse also attended. This gave them an opportunity to discuss with the nurse any concerns they had about their children's health or wellbeing. In particular, parents in this group valued the confidentiality offered by the nurse, and believed that information was handled differently by a nurse than by school staff. In terms of the other services which

a nurse could offer, they discussed guidance on treating head lice and other health issues such as chicken pox. A number of parents also felt that a drop-in service for primary school pupils would be very helpful. They highlighted puberty, body image and anxieties related to eating as some of the issues about which the nurse could provide confidential advice and support to children. Prior to meeting the nurse through the coffee mornings, these parents had been unaware that a nurse visited the school regularly neither had they knowledge of what she did.

Parents participating in the study in other sites were aware of what nurses did in their local primary school but did not know who they were. One parent wanted nurses to have the time to support children in school in preference to bringing in outside agencies. This was a particular concern when staff from outside agencies changed frequently and yet children and young people wanted continuity with adults they could trust. In addition, parents perceived nurses to be different to teachers and found it more acceptable for nurses to discuss sensitive issues like SRE with children.

One mother in Site 1 (East Midlands) described the support that she had received from the nurse about her concerns about her daughter. The nurse had helped her access a more specialist service, had offered confidential support and had given her coping strategies.

I have told her (nurse) everything. She knows how to deal with things and she talks me through how to deal with my daughter. Otherwise I wouldn't have a clue to be honest with you. She has taught me a lot of things, how to make things easier, rather than harder for myself. I didn't know where to start. I could have gone straight to my doctor but I didn't really think it was.. you know? I knew it was different to I suppose other children ... but I suppose you don't like to think of your child being different do you? So it was nice to be able to see X (nurse). Otherwise I thought 'I can take her to the doctor, but they'll laugh at me'. Do you know what I mean? She was ever so nice. (Mother, Site 1, East Midlands).

Generally, there was some uncertainty expressed among parents across research sites about which aspects of health nurses should, and should not, offer advice. In a FGD in site 5 (Yorkshire and Humber), a heated debate took place among parents about whether children at primary school should be offered advice and guidance about sex and contraception.

Interviewer: *What else would you like to see offered to children in school by the nurse?*

Parent A: *Contraceptives, in Year 6.*

Interviewer: *Is that being discussed at school?*

Parent B: *They do start sex education in Year 6 don't they?*

Parent A: *I know they do, but it's mainly when they get to secondary school though isn't it? But 10 and 11 year olds they are a lot more mature, and when they get to secondary school sometimes it can be a bit too late. But at least if they were aware of contraceptives then...*

Interviewer: *So is it information about contraceptives or access to them that you are talking about?*

Parent A: *Both...the only reason is, to put across to younger kids these days.*

Interviewer: *And you see the nurse playing a role in that?*

Parent A: *I think it would actually help, yeh... at least if they were aware that you (to nurse) were there and able to offer with confidentiality (sic) about contraceptives or anything else like that, then it would probably help the kids.*

Parent C: *Now if I were a school nurse and I had a 10 year old come to me and ask me for contraception, I would ask why? And if a 9 or 10 year old is sexually active, then I am very sorry... I don't care how old fashioned anybody wants to say that I am ... I could not sit down on that.... I would have to tell the parents.*

(FGD, Parents, Site 5, Yorkshire & Humber).

Most parents and parent governors consulted during the study felt that nurses needed a higher profile in schools so that parents, pupils and staff knew who they were and what they offered. One parent commented,

I think the nurses suffer from no PR. They don't register on the radar. They are no longer the nit nurse and you won't know them if your child hasn't had a specific health problem such as epilepsy or asthma. (Parent governor, Site 2, South West).

Key Findings

- School nurses are highly valued when pupils, staff and parents are aware of who they are and what they do.
- Children and young people who have received one-to-one support from nurses in schools report benefiting from their involvement and valued their input.
- Nurses make a unique contribution to addressing health issues relevant to children and young people in school.
- Nurses' clinical knowledge and the confidentiality of their service are particularly valued by children and young people.
- Young people value the involvement of nurses in SRE and PSHE education sessions and often prefer discussing particularly sensitive issues with a nurse rather than a teacher.
- More needs to be done to raise the profile of nurses in schools and to increase awareness among pupils, school staff and parents of what they can offer.

5. PROFESSIONAL DEVELOPMENT OF NURSES WORKING IN SCHOOLS

5.1 Findings from national stakeholder interviews

National stakeholders indicated a varied picture with respect to the professional development of nurses working in schools. There was some consensus, however, that training needed to be more standardised and given a clearer direction at a national level.

Why does every PCT have to keep re-inventing the wheel developing training, patient group directions (PGDs) etc.? There should be a national standard of good school nursing practice and a standard package of training. This could be things like on-line subjects such as Chlamydia screening and treatment. (National Stakeholder).

There was also a perceived need among some stakeholders to consider whether the core SCPHN training programme available for nurses was providing them with the skills necessary to support children and young people in relation to specific aspects of health. For example, it was suggested that there could be more focus on working with groups of young people and group dynamics, and on 'mental and emotional health especially self harm, school refusal and risk-taking behaviour'. Despite evidence from this research that nationally SRE training is widely available, nurses were also said to require updated training on sex and relationships education (SRE). Nurses were also said to require further training on computer systems and the use of statistical data. Furthermore, there was a view that nurses required training with respect to evolving organisational structures and strategies such as Children's Trusts, integrated multi-agency working and local CYPs. This was because they were not always able to contextualise their work within the wider strategic agenda for children and young people's services.

I would welcome a cost effective analysis of what is the best use of the school nurse resource and once we have understood that a bit better we should make sure we are designing the school nurse career pathway appropriately. I am concerned that there is a mismatch between perhaps the tradition of the school nurse and the training provided and what is required in the here and now. (National Stakeholder).

Stakeholders felt that more funding was required to enable nurses to complete the SCPHN degree level qualification. Finally, national stakeholders wanted a clearer career progression for 'children and young people's nurses' working in community settings.

5.2 Findings from survey of local authorities

Pathways to degree qualification

Across the authorities included in the survey, there was wide variability with respect to nurses access to completing the degree-level SCPHN qualification. There was clear evidence of increased investment from some PCTs to enable more nurses to access an approved SCPHN degree course. Furthermore, local higher education providers were increasingly offering courses of study on a flexible, modular basis. In one authority, for example, a 'Band 5 Plus' programme had been introduced, providing a modular learning programme for Band 5 nurses to work towards a recognised SCPHN degree level

qualification. This had been developed with the local university and was felt to be a more cost-effective way of enabling nurses to complete the degree course than the previous approach of seconding nurses to a local university for either a year full-time or two year part-time course.

Now we can ensure they have the competencies to practice and they can progress through a modular route. It also means that previous qualifications and courses can be recognised. (Lead for Health Visiting and School Nursing, County Council).

There were also examples of nurses in lower Bands being offered opportunities to access a foundation degree in health and social care. In some areas such initiatives, coupled with the expectation that all registered nurses would eventually attain the SCPHN degree, were said to be proving successful in encouraging nurses to extend their qualifications and skills.

The benefits of completing the SCPHN degree level qualification were recognised widely. One respondent commented,

I did the course in 2006 and it had a completely transforming effect on the way I thought. Before this, I was going into schools and doing everything with the best intentions, but I didn't have that wider picture. First of all it's the context, what school nursing is and where it's come from and all the policies and how they affect us. But more importantly, it's about that more public health understanding and working within a social model of health. And you get a huge amount in that one year, if you are prepared to be motivated and pro-active. It gives you an incredible insight into public health working and you come out wanting to really make changes and you can make a difference. When you do the course you have a much better understanding of what evidence-based working is ... it professionalises you really I think' . (School Health Team Leader, London Borough).

In other authorities, however, there had not been the same level of investment in professional development, and some respondents described the frustration this caused. Furthermore, in some authorities, health visitors' access to training opportunities were said to take priority over training opportunities for nurses working in schools.

If you offered the other qualified nurses in the team the chance to do the school nurse training, they would bite your hand off. We haven't had anyone go through training since the last one finished in September 2007. The PCT won't fund places anymore. (But) I have just heard that three health visitors will be going this September for a degree, but no funding has been given to school nurses. (Team Leader 0-19 team, County Council).

An additional challenge faced by some services was that nurses on a SCPHN course had to have a qualified mentor from within the service for the duration of their course. Successful completion was therefore contingent on having suitably qualified community practice teachers in post.

We keep trying to train more people to be the practice teaches so that we can increase the amount of people we can put through (specialist training). We are trying to grow our own really because it is so hard to recruit community specialist practitioners. (Community Public Health Nursing Locality Manager, Metropolitan District Authority).

It's been incredibly difficult until this year (to get nurses to take up the degree course places) and I have had one of my clinical practice teachers retire, so replacing her was incredibly difficult. This means that at the moment we can only have one nurse completing the post registration degree. If I don't have someone with the practice educator's course to mentor them, then I am failing in my obligations to meet what I am asking for. (Service Manager for Children and Young People Services, London Borough).

In a number of authorities, nursing service reviews had identified nurses who in the past had transferred to Band 6 positions without having a degree-level SCPHN qualification. Whilst the review did not result in automatic re-banding of nurses (to the lower band), some local authorities were faced with the situation of wanting nurses to complete the degree in order for them to retain their Band 6 position. Some nurses were resistant to this, feeling that they had extensive experience and that a further qualification was not necessary. Service managers within these authorities were responding either by offering new Band 6 positions only to those with a specialist qualification, or by creating pathways for nurses within the service to take up these positions if they agreed to begin the SCPHN qualification within a year of their appointment. In one London Borough, the respondent said the latter approach had encouraged three nurses to volunteer to embark on the degree course.

Opportunities for other forms of continuing professional development

The majority of respondents surveyed felt that there were good professional development opportunities for nurses working within schools and that, in most cases, nurses were eager to access training. Training tended to be mandatory or linked to professional development plans (PDPs). Mandatory training was usually funded and provided by the PCT or by a commissioned training body. Mandatory training included areas such as safeguarding (including the CAF), immunisations, infection control, health and safety, equality and diversity and information governance/data protection.

Despite difficulties in accessing funding for non-mandatory training in some areas, only in one County Council was training described as '*ad hoc and not really a planned part of a work programme*'. In most areas, a combination of in-house and external training was available, with external courses more likely to be accredited. In some authorities, a service level agreement (SLA) had been developed with one or more local universities, and modular courses on topics such as public health and child-centred health were available. There were also a few examples of degree level nurses accessing additional post-graduate training, with one respondent in the process of completing a professional doctorate.

All nurses have professional development plans and training is linked to these. There is good in-house training on a wide range of things and short and longer courses. The trust is good at supporting individuals through the PDP and it is quite a formalised process. You can see and track development and people don't get that stuck feeling. (School Health Team Lead, London Borough).

There is lots of training available and we have good links with two major universities who run core training to meet statutory training requirements and will deliver tailor-made training packages. Currently we are about to start one on 'healthy weight, healthy lives', tailor-made between myself, the training department and the university. (Lead Nurse Manager for Community Children's Nursing Team, London Borough).

In almost all local areas, respondents identified the Personal Social and Health Education (PSHE education) Continuing Professional Development (CPD) course as being available to nurses. This

course was often mandatory for nurses entering school nursing teams and was said to support the health education work they undertook in both primary and secondary schools. In some areas, nurses could access additional training on, for example, facilitating drug and alcohol education. Family planning and sexual health training were also widely available to nurses working in schools. There were concerns in some authorities that while nurses were encouraged to complete the PSHE education CPD, and similar courses, they had little opportunity to practice what they had learned, due to other demands on their time.

A range of training opportunities about young people's emotional wellbeing and mental health were described by respondents. These included specialist training on assessing depression in teenagers (London Borough, provided by the Institute of Psychiatry); training on mental health with clinical supervision from a local voluntary organisation (London Borough); focussed therapy intervention for children and young people experiencing mental health difficulties (two London Boroughs); training provided directly by CAMHS with respect to tier one and tier two support in schools¹¹; and training on issues such as bereavement, self harm, eating disorders, behavioural difficulties and early intervention with children and families around emotional health issues. Other training programmes were evolving in line with new public health agendas such as MEND¹², linked to the National Child Measurement Programme (NCMP) and the Triple P¹³ parenting training programme.

The funding for non-mandatory training for nurses varied across authorities, with provision in some local areas described as limited. In some others nurses were expected to self-fund non-mandatory courses.

It can be difficult to find the money for non-mandatory training. The priority is always safeguarding, immunisations and family planning. (Clinical Director of School Health Services, Metropolitan District Authority).

5.3 Findings from case study sites

Site 1: East Midlands

In this authority, there were 30 Band 6 nurses. Thirteen of these held the SCPHN degree-level qualification and 17 nurses did not. It was expected that these 17 nurses would be supported to complete the SCPHN degree level qualification (in order to remain at Band 6), but there was reported resistance to this, primarily because nurses were not being offered additional remuneration for achieving the qualification.

There were good links with local universities and CPD curricula had been developed in response to local needs. For example, the PCT had worked with one local university to put together a Masters degree course with a focus on commissioning. In addition, registered nurse training at the local university was said to be highly relevant to community-based nursing (more so than the course offered by the main provider for nurse training in the region), and newly qualified nurses were reportedly

¹¹ Tier 1 services are provided by practitioners in universal settings (such as schools) who are not mental health workers. They include general advice and support, with referrals to specialist services as required.

Tier 2 services are provided by specialist mental health workers working in community and primary care settings. They include a consultation service to families and other practitioners, and outreach services to identify those with severe and complex needs.

¹² MEND is an intervention for families with children aged 7 to 13 whose weight is above the healthy range for their age and height

¹³ Triple P is the Positive Parenting Programme – a multi-level family intervention programme to support positive behaviour in children and young people.

emerging with health and social care degrees which made them '*much more prepared to work in the community than previous generations of nurses*'. The course had been devised with input from the PCT public health team, and was said to resonate with the local ethos to '*grow our own and develop the workforce from within*'.

Site 2: South West

All the nurses in this authority were encouraged to complete family planning training and the PSHE education CPD course. This latter course was offered jointly to teachers and other professionals by the local healthy schools programme. In addition, three accredited modules on young people's mental health could be accessed through a local university. In-house training included Patient Group Directions¹⁴ and basic mental health training provided via CAMHS. Despite adequate funding for professional development opportunities at the time of the research, there were concerns that funding might not be sustained into the future.

Site 3: London

Given the difficulties in recruiting qualified school nurses to this authority, the training emphasis was on '*growing our own*' specialist community public health practitioners. There were plans to support nurses to complete the SCPHN degree level qualification on a part-time basis soon after their recruitment into the service. Nevertheless, there was an on-going shortage of community practice teachers within the service to support this initiative.

Site 4: North West

In this authority, there was said to be increasing investment in nurses and health visitors completing an SCPHN degree level qualification. At the time of the research, four health visitors and two school nurses were completing a course and there were plans to include a further seven health visitors and three school nurses the following year.

There was an emphasis on providing on-going training and development for nurses working in different Bands. A Health Development Manager referred to this as a '*grow your own type of environment*'. It was hoped this approach would increase the skills of the workforce, encourage the development of a more appropriate skill mix within schools and help overcome some of the recruitment difficulties for qualified school nurses.

Site 5: Yorkshire and Humber

In this authority, approximately 40% of school nurses working in Bands 6 and 7 had completed a SCPHN degree level qualification. Nurses were able to complete the course at a local university, either full or part-time over one or two years. In the current year, three nurses were completing the degree, with places allocated according to individual PDPs. In addition, most nurses in Bands 6 and 7 had completed the PSHE education CPD module along with other mandatory training provided by the PCT. Band 5 nurses were increasingly completing this module and there were also plans to provide access for nurses in Band 5 to the degree course.

An education, training and development plan had been developed for the service in close consultation with nurses and reflecting their training needs. In addition, a clinical practice group for health visitors

¹⁴ A Patient Group Direction is a written instruction for the sale, supply and/or administration of a named medicine for a defined clinical condition. (www.portal.nelm.nhs.uk/PGD)

and schools nurses provided a forum for sharing information and updating practice on local and national developments.

Key Findings

- The telephone survey revealed that in most authorities nurses have access to a wide range of professional development opportunities, although many of these constitute mandatory training provided by the PCT.
- Access to non-mandatory training varies widely with some PCTs supporting extensive professional development opportunities linked to professional development plans, while in others there is a lack of resources to enable such training to take place.
- In a number of local areas, and within some of the case study sites, PCT investment for nurses to complete an approved SCPHN degree level qualification has increased over the past couple of years.
- There are some good examples of the SCPHN degree course being offered on a flexible, modular basis, thus facilitating access.
- In many areas, a shortage of suitably qualified community practice teachers is a barrier to nurses completing the SCPHN degree course.
- Adequate support to practitioners after completion of the SCPHN qualification is essential to enable them to effectively implement what they have learned.
- There are examples of good partnership working between local PCTs and local universities to provide courses of relevance to the local workforce and to the needs of local communities.
- There is concern about the need to further standardise training packages for some aspects of nurses' work to avoid local PCTs '*re-inventing the wheel*'.
- Nurses would benefit from training about recent organisational structures such as Children's Trusts, about new forms of integrated working and about the strategic direction of the local children and young people's agenda, so as to contextualise their practice with children and young people

6. COMMISSIONING OF NURSING SERVICES

PCTs and local commissioners are working towards meeting the criteria for World Class Commissioning (WCC) (DH, 2007, 2008a). The focus for commissioning is on integrated working, dynamic partnerships between PCTs, LAs, other commissioners, communities and health care providers. Services should aim to meet local needs and focus on promoting health and reducing inequalities. Central to the arrangements for WCC is the involvement of clinicians and providers of health care in commissioning decisions to meet the health care needs of local communities. Nurses, as key health care providers, have a key role to play in this process. The split between the commissioning and provider arms of PCTs – thus creating an internal market within the NHS - was being implemented during the current study. Under these arrangements, nursing services need to convince commissioners of their cost effectiveness and relevance to the health care needs of local communities. The RCN (2007) advises nurses to view commissioning as an opportunity to be proactive, to get involved and to use their skills to improve health services

6.1 Findings from national stakeholder interviews

National stakeholders described a varied and confused picture of how nurses were commissioned to work in schools, or with school-aged children and young people, across England. There was general agreement that the commissioning of nursing services should be based on local needs and priorities and should be guided by a health promoting model of service delivery. Thus nurses and other professionals would assess the needs of the local population and, on this basis, be commissioned to offer a suitably tailored service. Ideally, a nursing service should be provided through a team approach, using an appropriate skill mix, but maintaining scope for the 'familiar face', enabling trusting relationships to be built between nurses and young people.

In practice, the funding available to PCTs made it difficult for them to commission much more than a core service, resulting in limited scope for health promotion and preventative work. At a local level, a lack of 'joined up' commissioning decisions, a lack of integration between commissioning and budgeting arrangements, and limited consultation with nurses, meant that many commissioners were reported to lack information about how best to commission services and what might be the most effective use of nurses' time in schools. Too often, it was felt, PCTs commissioned according to national targets for which they were held accountable, such as immunisations, the NCMP and safeguarding. Furthermore, while nurses were normally funded on an annual cycle, their roles could change at any time throughout the year, often in response to new national agendas. There was a lack of flexibility in the numbers and skill mix of nursing services to respond to these new priorities and maintain a service within schools. Finally, SHAs, it was said, needed to exercise a more overview function for public health and needed to question individual PCTs about their investment in services for school-aged children, including nursing services.

6.2 Findings from survey of local authorities

Overall, the survey of local authorities revealed a complex mix of ways in which nursing services were commissioned for schools. The main drivers informing which services were commissioned included national government targets for health and education, local public health data, area needs assessments and local key performance indicators (KPIs). Most nursing services in schools had been commissioned

to provide a core service to schools with additional funding to address local health priorities, such as teenage pregnancy.

While respondents felt there were some robust commissioning processes in place in which nurses could participate to inform commissioning decisions, most arrangements were more fluid and at varying stages of development. A number of respondents felt that, as yet, nursing services in schools were not commissioned but, rather, took the form of a 'free core service' offered to schools. Others felt that the services they provided continued to be based on historical precedent.

While the commissioner-provider split was well established in a few authorities, in most cases this was something that was being worked towards and many commissioning arrangements were in a 'state of flux'. Some respondents indicated that commissioners might look to other providers for certain aspects of the work that nurses had traditionally offered to schools. Several respondents described how they had recently undergone service line reviews and were in the process of refining SLAs with commissioners about what they would provide to schools. In some areas, respondents felt that although nursing services in schools were currently commissioned by the PCT, there might be a shift to local authority commissioning in the near future. Despite these uncertainties, on-going developments in commissioning arrangements were frequently described as indicative of a re-investment in school nursing services and many respondents felt positive about the opportunities that such investment should provide.

The split between provider and commissioner is complete. NHS X is the commissioner and providers, including school nurses, went into community health services. So there is a very clear division of who commissions and who provides. The service is commissioned under an SLA and service specification developed between commissioners and providers. (Senior Nurse, Young People's Services, Metropolitan District Authority).

The service is not commissioned properly in the sense of responding to a needs assessment. It is only now, because we are moving towards Transforming Community Services, that they (nurses) are having to do needs assessments. At the moment it is really hit and miss, the service is not commissioned well in that they (nurses) have 42,000 school aged children in relatively poor socio-economic status and only 14 caseload holders in the team. (Senior Nurse Manager, Metropolitan District Authority).

I don't think there are any formal commissioning arrangements, it is based on historical practice and nurses are only commissioned for new areas of work such as NCMP and HPV. There might be an SLA somewhere but I've not seen it or been involved. We've been asked what we do and then just left to it. The focus has been on re-organisation, restructuring of the PCT and becoming financially solvent. We do meet with the commissioners and certainly I think we are fulfilling core expectations. (Deputy Directorate Manager, Child Health, County Council).

In some areas, PCTs reportedly commissioned nursing services to work in schools in close consultation with the local authority education department and other strategic partnerships such as the Healthy Schools and Extended Schools Programmes. In one authority, the PCT commissioner was said to spend time within the local authority in order to ensure consensus about health priorities and effective pooling of resources to meet these. In other areas, the PCT reportedly made unilateral decisions about what services to commission.

In several authorities, nursing services in schools were commissioned by two different arms of the PCT. Under this arrangement, while aspects of the core programme were commissioned by one section of

the PCT, all new initiatives, such as the HPV immunisation and the NCMP, came under Public Health. In one (Unitary) authority, the school nursing service was reportedly commissioned by the PCT but seconded to the authority's education department under the remit of the Children and Young People's Trust. So while funding came via the PCT, nurses were effectively employed by the education department

While commissioning arrangements were felt on the one hand to result in a more standardised service to schools, with nurses working to the same specification according to clear performance management targets, they were also felt to have a somewhat constraining effect on practice. At times, new arrangements were too inflexible to allow for specific needs within individual schools to be met.

I think it's quite restrictive on how practitioners work. If you need to work on a particular issue or with a certain family, you now have to ask if it is in the core programme. But it does mean more evidence-based working and encourages us to look at practice. (Locality Clinical Manager, County Council).

The school nursing service is still in its infancy in terms of addressing local needs. School nurses are generally working in the areas that they know best and tend to stay doing things that they've known for quite a long time. What we've got differently with the new commissioning arrangements is that we are asked for outcomes instead of just plodding on doing what we have always done. Commissioners are wanting a result on these, so we are being performance managed on our targets – that is a new thing for the service. (Public Health Nursing Services Manager, County Council).

In the majority of authorities surveyed, nursing services were commissioned to work in schools. However there were several examples where commissioning arrangements focused on the 'school age population', meaning that nurses had SLAs to work in community settings¹⁵ (in addition to schools) and all year round.

There were also examples of schools employing their own nurses. On the whole this arrangement was seen as problematic because such nurses did not have a nursing management structure and often had to work to different protocols regarding, for example, confidentiality and information sharing. There were also concerns about clinical governance and the risk of professional isolation.

The extent to which nurses were said to be able to influence commissioning decisions varied widely. The most frequently described arrangement was one in which the team leader for nursing services communicated the views and ideas of nurses back to commissioners. In practice, there was felt to be limited scope for negotiation on what nurses provided in schools due to the number of DH and local area targets influencing the commissioning agenda. So, while nurses might have some flexibility in how they delivered services, they had limited influence in terms of what they were commissioned to do.

Nurses are consulted and things discussed as far as 'this is what we have been commissioned to do, this is what they want, how can we provide it'. (Locality Clinical Manager, County Council).

¹⁵ Community settings throughout this report refer to settings other than schools but which are accessed by young people such as youth services, pupil referral units, youth offending services, colleges of Further Education, drug and alcohol services etc.

Nurses have very little input. It tends to come down from DH, such as obesity work, sexual health work, the government-set targets. Nurses have little say, but they do have some choice within this, for example whether they do smoking cessation or obesity work. (School Nurse Team Leader, London Borough).

Until recently, nurses have been able to participate in decisions, but their new service specification has been completed dictated by commissioners. (Clinical Lead for School Nursing and Health Visiting, Unitary Authority).

Commissioners were said to lack understanding about the precise nature of nurses' work in schools, although they were perceived to be relatively well informed about the work of health visitors. For this reason, several respondents felt that nurses needed to be more assertive in the commissioning process. However, many respondents recognised that nurses had limited training about involvement in commissioning processes and in most cases were unaware of how they might influence decisions.

I have always firmly believed that school nurses that deliver the service are the experts. And although they may not see how they contribute, they do contribute and have a huge influence in how we can purchase and how we can provide services. It's about those clinicians who have that sound knowledge and judgement bargaining for extra money and resources and meeting with the commissioners. I think historically those conversations and discussions took place in a darkened room somewhere and clinicians weren't aware of some of the dialogue for many reasons. At the end of the day knowledge and power is a great tool isn't it? You have to increase people's level of knowledge. (Health Improvement Services Coordinator, Metropolitan District Authority).

Nevertheless, several service leads described how they had started to adopt a more 'business-like' approach to working with commissioners, demanding more resources in order effectively to deliver what they were being asked to do. There were also a few examples where nursing team leads had been seconded to the commissioning process, a step which had facilitated communication between the service and commissioners. In some cases nursing teams had taken the lead in devising business plans and SLAs which were presented to commissioners for negotiation. Despite these developments, there appeared to be considerable scope for greater involvement of nurses in commissioning decisions. One respondent from a London Borough commented that because so many senior management posts (Band 8) tended to be health visitors rather than school nurses, it was harder for nurses working in schools to influence decisions.

6.3 Findings from case study sites

Site 1: East Midlands

In this authority, the commissioning structure took the form of a Children and Young People's Strategic Partnership. Because of its rural geographical location, the school nursing service had, until recently, experienced both under-investment and difficulties in recruitment. The past year, however, had seen a significant investment in health visiting and school nursing which was said to have 'pump-primed' the child health promotion strategy in areas of deprivation.

Commissioning of services was moving towards a universal core programme of work for all schools and an enhanced service in areas of higher socio-economic deprivation. These areas had been selected on the basis of public health data and annual assessment performance data within the local authority. At

the time of the research, the authority was introducing a health needs assessment model in all schools across seven districts. There was also a recognised shift from commissioning nurses to work only in schools, towards providing a service for the school age population, with nurses working in other community settings.

Within the authority, commissioning of services reflected the five main ECM outcomes, each overseen by one of five associate directors. The 'Be Healthy' lead was also the Children's Commissioner for the Children's Trust. Under this agenda, current commissioning decisions were being made so that nurses might support and extend health and social care provision through children's centres and extended schools.

Views about the extent to which nurses were engaged in commissioning decisions varied. One Head of Children's Services saw this as a result of the commissioning process still being developed and finalised.

The relationship between the provider arm and the commissioning arm is still finding its feet and finding its way, and so whether the frontline school nurse is fully engaged with that process, I don't know. But I do think at a strategic level there still seems to be some posturing.
(Head of Children's Services, Site 1, East Midlands).

Site 2: South West

In this authority the commissioner-provider split had only recently been introduced. This had resulted in a shift from previous arrangements under which the lead for the school nursing team was managed by the same person who commissioned the service. Under the new Children's Trust arrangements, the commissioner was due to provide a specification of what was required from the service. In the meantime, it was felt that commissioning arrangements for nursing were based largely on historical practice but in accordance with available funding streams and associated targets such as in mental health, extended services or the *Choosing Health* agenda. Envisaged changes included: freeing nurses from some of their more specialist clinical work, such as working with children with enuresis or with attention deficit hyperactivity disorder (ADHD), by introducing dedicated teams for these children; establishing integrated/co-located teams; and further developing local area multi-agency partnerships. These partnerships reportedly provided opportunities for geographically focused work and shared commissioning decision making across agencies.

Site 3: London

Nurses and nursing managers in this authority reported having '*no choice in the matter really*' about what they were commissioned to do by the PCT. Nurses felt that most of their time was taken up with child protection and immunisation work because such duties were statutory. They had limited resources. Too few nurses were working with a very large school population and they struggled to provide a core service to schools let alone influence commissioning decisions. Consequently, they felt that what they did in schools was driven by the commissioning arm of the PCT but without consultation with schools, the education department, nurses, pupils or parents. A healthy schools coordinator interviewed in this site felt that other outside agencies were being commissioned to work in schools independently of nurses and that such developments were uncoordinated and ran in parallel but were unconnected to the work of nurses. An example was the 'clinic in a box' project in secondary schools, provided by an outside agency and commissioned by the PCT with no discussion with, or involvement of, nurses.

Site 4: North West

Within this authority, the overall strategic framework which underpinned commissioning decisions focussed on addressing health inequalities. Specifically, this agenda focused on five key themes: geographical inequalities, alcohol use, tobacco use, infant mortality rates and cardio-vascular disease (CVD). Difficulties were said to arise because these five themes were of limited relevance to the health and well being of children and young people. One health development lead felt that as a result, *'there is no clear vision or strategy for young people and so work is piecemeal - there is no strategic lead'*.

There was also a sense that while the providers within the authority had a great deal of expertise relevant to the needs of local communities, the commissioners were still learning and developing their commissioning skills particularly with respect to children and young people. Commissioning was said to be happening at a very basic level with priority given to medical conditions and the service being *'GP-led'*. Little or no preventative work was being commissioned in schools. One professional said preventative work was limited to school entry screening, school drop-ins and immunisations. It was hoped that the adoption of the health needs assessment model would positively influence the commissioning agenda.

Example of successful commissioning arrangement – North West

Prior to the current commissioning arrangements in this area, the PCT had commissioned nursing services independently to work in primary and secondary schools. In addition, schools, through schools clusters, had part-financed an enhanced service in schools. This initiative had been evaluated very positively. It had enabled one full-time nurse to spend one day a week in each school. As a result, interventions had been tailored to meet the health, wellbeing and education needs of pupils. One example given was an initiative whereby if a young person had two health-related absences from school, a home visit from the nurse would be triggered to establish whether there were particular wellbeing issues affecting the child or young person's attendance at school. Pupils and parents were then reassured about the support available within the school to address specific issues, and appropriate support packages were put in place. The nurse worked collaboratively with others such as learning mentors, pastoral and behavioural support teams and CAMHS workers. This approach resulted in a reduction in health-related absences and improved attendance within the participating schools. The initiative also demonstrated how education and health targets could be met through addressing wider issues of pupils' wellbeing. While a lack of funding had meant that this needs-led approach had ceased, negotiations were underway with commissioners to see how funding might be allocated to support a similar approach in the future – particularly in the most deprived areas of the authority.

Site 5: Yorkshire and Humber

Within this authority, the work of nurses and other professionals in schools was commissioned under the Children and Young People's 0-19 Partnership Board, and in accordance with the national strategy for children and young people's health (*Healthy Lives: Brighter Futures*, DH 2009a). This framework was said to have helped define how health and social care professionals could work together to promote the health and wellbeing of children and young people locally, and according to local health priorities. The NHS arm of the partnership was the sole commissioner of these services but the

business plan for school nursing and health visiting required the support of the local 0-19 partnership in order for its implementation to be supported by schools and district managers of integrated services.

A recent review of the nursing service was said to be informing a re-specification of nursing services in schools rather than a re-commissioning of services. While, for example, the current capacity of school nurses meant that it was not possible to consider a designated nurse for every school, there was a commitment to re-modelling the service with a focus on locality-based areas, so that the same nurses would be known across the schools within a specific locality.

Teachers and other school staff interviewed in this same authority felt that they currently had no say about what nurses were commissioned to do in school. A senior manager in the secondary school commented, *'if you ask for something you are told it is taken out of your overall allocation'*.

Key Findings

- Commissioning arrangements in most local areas are currently undergoing change as health and social care services move towards models of integrated working.
- In some PCTs, the commissioner-provider split is complete, while in others, the relationship between commissioner and provider services was described as unclear and at times ambiguous.
- Even though World Class Commissioning (WCC) stresses the commissioning of services based on local needs and in consultation with clinicians and health care providers, nurses' involvement in commissioning decisions is limited.
- The service level agreements between community nursing services and the PCT and other commissioners are, on the whole, handed down to nurses, although nursing services do have some say about how they deliver services to meet specific outcomes and targets.
- Some commissioners were said to lack the necessary knowledge about the work of nurses, making their commissioning decisions less well-informed than they might be. They also lack vision about the potential value of nurses' roles in promoting children and young people's health.
- The current split between commissioning and provider services led respondents from nursing services to express a sense of vulnerability within the market economy and some anxiety that commissioners might look elsewhere to commission certain aspects of their work.
- There were many examples from the telephone survey and within the research sites of commissioners increasing their investment in nursing services in schools as part of the wider children and young people's health agenda.
- There is a growing expectation that nurses should work with the 'school age population' in a range of community settings in addition to schools.

7. MANAGEMENT AND LEADERSHIP ARRANGEMENTS

7.1 Findings from survey of local authorities

The survey showed that management arrangements for nursing services were frequently under review, with restructuring taking place, often as part of a wider re-configuring of community services. Some reviews had revealed how nurses in one Band were spending substantial amounts of time doing work that could be done effectively by either a nurse in a lower Band or by other team members.

A common organisational pattern was for nurses to be working in localities under locality managers who in turn were line-managed by one or more service leads for the authority as a whole. In several authorities, school nurses and health visitors were co-located in integrated teams, organised geographically according to extended school clusters or local area children's partnerships. In some cases, teams were diverse in terms of professional background and skill mix. For example, in one Metropolitan District authority there were 14 teams each comprising health visitors, school nurses, child health practitioners, assistant practitioners, nursery nurses and health care assistants. Team leaders were Band 7 health visitors or school nurses and there was a practice development mentor in each team. Another Metropolitan District authority had seven locality integrated teams made up of social care, health, education (such as educational welfare officers) and LA (including police) professionals. Each integrated team had a locality manager, from social care or from health, plus two clinical leads, one for health and one for social care. There were plans to have a single cross-disciplinary clinical lead for each team.

There were several examples of nurses working in multi-agency teams across a cluster of schools. In one London authority the multi-agency team included CAMHS, community nutritionists, and members of the HSP and the YOT. It also included a team working with young people with complex needs in PRUs. In other authorities, while partnerships had been developed with agencies such as CAMHS, youth workers, drug and alcohol agencies, sexual health services, educational welfare officers, educational psychologists and parenting support workers, the concept of a multi-agency team within the school was less developed.

In at least three County Councils, respondents highlighted how the majority of management positions were held by health visitors rather than school nurses. In one instance all 12 locality managers were health visitors and in another, only two out of nine team leaders were school nurses. The lack of school nurses in senior positions was felt to limit their influence with managers and with commissioning decisions.

In a number of authorities, advanced nurse practitioners provided clinical leadership for nurses in teams, although they did not have direct management responsibility for them. In some cases, each advanced nurse practitioner had developed an area of specialism, such as sexual health, immunisations or mental health. Their main role was to provide an expert voice to other nurses, communicate new health and clinical information to teams and help orientate new members of staff. It was common for Band 6 nurses to provide day to day management to those in Band 5.

In one Metropolitan District authority, a multi-agency health clinic was about to be launched in every secondary school. The PCT had allocated £20,000 to each school to offer an additional three hours each of school nursing, family planning nursing and youth worker time. A further £8,000 was available

for other services, based on the needs of the school population, such as CAMHS or substance misuse workers. Although nurses in schools had previously worked with these other services, additional funding was said to help establish more formalised and sustainable partnership arrangements.

In one London Borough, a 'virtual team around the school' had been developed. This included a named nurse for every school, working with the HSP, dietetic services, dental services, CAMHS, family support workers, education support workers, education welfare officers and learning mentors. This approach was part of the authority's early intervention strategy designed to support children, young people and families.

7.2 Findings from case study sites

Site 1: East Midlands

Recent structural changes in this authority had seen the merging of three PCTs into one. As a result, three nursing teams with very different historical practices of working in schools and with different styles and systems of management had been brought together at a strategic level. The focus of the new management structure was on ensuring that practitioners were supported equitably. It was recognised that the introduction of new management systems would take time and negotiation before they were fully embedded into local practice.

Within the single PCT, nurses worked in 15 teams across seven localities. In each locality, a health manager had responsibility for health visitors and school nurses. Although these two services were currently located separately, there were plans to look at how they could be co-located to enable them to respond more effectively and in a more integrated way to the children and young people's agenda.

Site 2: South West

Nurses in this area had one nursing team leader and had, on average, a case load of one secondary school and its feeder primary schools. Management arrangements, like commissioning arrangements, were said to be mainly based on historical practice. At the time of the research, however, there was a move towards local area multi-agency partnerships and integrated teams of health visitors, school nurses, speech and language therapists and educational psychologists. This, it was believed, would improve communication between these services and facilitate more effective partnership working.

Site 4: North West

Nurses in schools in this authority worked in 12 integrated teams. Each team comprised health visitors, school nurses, nursery nurses, assistant practitioners, primary care support workers and clerical assistants. Nurses working in schools were described as members of school health teams. These teams contained a range of workers including support workers, assistant practitioners, registered nurses and qualified school nurses.

In this authority, as in others, management and leadership of nurses working in schools was inextricably linked to the wider commissioning arrangements and to nursing capacity. However, there was a vision of how nursing services might best be organised to coordinate and support services for children and young people in schools and other community settings. One Associate Director for

Children's Services explained how this could work in a way similar to the model they had developed with health coordinators for local children's centres,

Nurses need to understand what the skill mix team is. This includes learning mentors, nursery nurses, CAMHS, extended services, people on site in the school. They are already there. You just need to sit together and design the package of what can be delivered in house. Nurses don't need to spend hours and hours in schools, they can deliver without that. So it's about nurses leading the services and providing the health angle on this. It's like the model we are using in children's centres. We've got four health coordinators who are Band 7 health visitors. They are providing coordination and support to all 35 children's centres across the PCT. So they don't deliver but work across all the centres and provide the connectivity between them. They sit between children's centres, health and integrated partnerships. They can look at governance issues in all centres, so you've got the right people delivering the right service in a safe way. I would like to employ the same tactics for our school nurses because we haven't got enough of them but you could have a function of coordinating what's already there, making sure that the governance issues are covered – make sure those delivering have the right skills, the level of training and know when to refer on. (Associate Director Children's Services, Site 4, North West).

Site 5: Yorkshire and Humber

Here, the local authority and PCT had been working towards a model of integrated multi-agency support teams for the past two years. The authority was divided into seven multi-agency teams, one in each local district area. These teams were comprised of school nurses, child development workers, a parenting support advisor, learning mentors, advanced practitioner social workers, educational welfare officers, family support workers and a youth strategy lead. School nurses within each of these teams were lead by a Band 7 advanced nurse practitioner responsible for local service delivery plans. At the time of the research, the integrated teams were at various stages of development. The view of one professional team lead for school nursing was that one advantage of working in integrated teams was the opportunity for nurses to become more knowledgeable about other disciplines.

Nurses like the fact that they can talk to someone in the next room or the same room, a sense of timeliness and that it speeds up communication. It helps in identifying needs and supporting family early intervention and preventive work. With the multi-agency approach, school staff like that everyone is there in the same place. (Professional Team Lead for School Nursing, Site 5, Yorkshire and Humber).

A commissioning lead for community nursing services in this same authority described how four managers for health visiting and school nursing had been transferred from the PCT to different geographical areas in the city and employed by the local authority. She expressed reservations about this move, and especially about how they might now be managed.

I am not convinced of the benefits or that there will be good outcomes in terms of delivering the new specification or about clinical leadership. From the NHS perspective, we want to take a more measured approach, we want to understand the benefits and consequences of such a move and take it more slowly. (Commissioning lead for community nursing services, Site 5, Yorkshire & Humber).

There was said to be pressure from the local authority to move all nurses out of the PCT and, instead, have them employed directly by the local authority. This change was spearheaded by the director of Children's Services who was in favour of full integration of services and combined budgets.

Key Findings

- Widespread restructuring of nursing services is taking place across the country as a result of service reviews and the need for better skill mixing and capacity building.
- Many nurses working in schools are moving into integrated teams with other health care providers. In some cases this involves physical relocation so that teams are on one site.
- Nurses are recognised as having a potentially significant role in co-ordinating children and young people's access to a wide range of health and social care services both within and outside school settings
- Integrated partnerships arrangements in some areas involve locating nursing services for schools within the local authority rather than the PCT. There were concerns that such an arrangement might negatively impact on clinical leadership and governance issues and might not be the best way for school nursing services to develop.

8. EVALUATION OF NURSES' WORK IN SCHOOLS

8.1 Findings from survey of local authorities

Finding ways to evaluate effectively what nurses do was identified by a number of respondents as a particular challenge. The need to measure performance against specific outcomes was increasingly felt to be part of the new commissioning processes.

School nurses tend to evaluate their own health education and health promotion work but we are looking at competency frameworks so we can monitor our work and get feedback, as we need to evidence what we do and why we do it for commissioners, certainly more robustly than we have done in the past. (Area Public Health Manager, County Council).

Most evaluation activities comprised numerical auditing of services, such as numbers of school drop-ins, uptake of immunisation programmes, numbers of children monitored through the NCMP or through school entry health assessments. Services were usually audited against key performance indicators (KPIs). In addition, the number of contacts made with children and families and how much time was allocated to particular public health and other health and wellbeing activities was monitored to some extent. Specific educational sessions such as PSHE education/SRE lessons or health enrichment days were variably evaluated through the use of feedback questionnaires or through FGDs with pupils and discussions with staff.

Other types of evaluation tools mentioned included patient satisfaction surveys, pupil questionnaires, workload management tools, and 'ask the patient' initiatives introduced by the PCT. 'Ask the patient' initiatives included consultation with children and young people in schools about their perceptions and experiences of nursing services. A number of respondents, however, identified the need for more consultation and feedback from young people, for example through assessing the work of nurses against the DH 'You're Welcome' criteria or through 'mystery shopping' exercises.

Generally, there was felt to be a paucity of robust evaluation of what nurses were doing in schools. Much nursing practice was thought to rely on historical patterns of work or to be limited to areas of work with which nurses felt most comfortable. One of the difficulties was the lack of outcome measures for nurses' work:

How do you quantify if a school nurse has a conversation with a young woman which means that she is sexually healthy rather than takes risks and becomes pregnant within the next four months? (School Nurse Team Lead, London Borough).

Within the Children and Young People's Plan we feed in data to meet primary and secondary indicators but how do you relate what we do to the broader health outcomes we are aiming for? We are struggling how best to do that. We are one of four pilot areas for adolescent health services but we have not done enough to sit down with the local authority to work out how best to evaluate which elements of different bits of work might contribute to overall targets. (Senior Manager for Children and Families, Unitary Authority).

Other difficulties included a lack of administrative support for evaluation work, a lack of time to carry out evaluation activities and inadequate computing systems (or the introduction of new computing packages, such as Rio and Lorenzo, which were not yet fully functional.) However, several respondents believed the new computing systems would eventually facilitate the evaluation of nurses' work.

Sharing of good nursing practice and opportunities for reflective practice tended to happen informally through team meetings, during professional development reviews or on away days. However, there were some examples of what were described as 'live' supervision sessions where nurses were shadowed and observed during practice, for example in drop-in clinics or when teaching about PSHE education. There was felt to be a lack of documentation of good practice and a reticence on the part of nurses to 'blow their own trumpet' or to broadcast effective or promising practice. While certain training opportunities, such as the PSHE education CPD programme and the SCPHN qualification, were said to help develop the critical skills necessary for evaluation, there remained a need for organisational and institutional structures to enable nurses to implement learned evaluative techniques.

Several respondents talked about how they were planning to draw on expertise within the wider PCT for evaluating work within schools, such as from the clinical effectiveness or public health teams. In a few cases, such as in the Metropolitan District authority where a school health clinic was being introduced into every secondary school, a local university had been commissioned to conduct an independent evaluation. More national guidance was said to be required on how the work of nursing services could best be evaluated, particularly in relation to the public health agenda.

8.2 Findings from case study sites

Site 1: East Midlands

There was consensus among interviewees in this authority that evaluation of nurses' work locally was not robust. It was thought that responsibility rested jointly on nurses (to develop a sound evidence base for their practice), and on commissioners (to be clear about what they felt constituted evidence and how this could best be demonstrated). One consultant public health nurse saw the responsibility as vested in performance management and the commissioning cycle.

Site 2: South West

Extensive auditing was conducted of nursing activities, aided by administrative support provided by nursing assistants. Data demonstrated effectiveness in meeting national and PCT targets and provided reliable data for commissioners on how nursing time had been allocated. In addition, PSHE education work was evaluated and reviewed with pupils and teachers. Some initiatives, including the ADHD and primary school emotional wellbeing projects were being evaluated through pre- and post-intervention measures. Evaluation activities were reportedly hampered by an inadequate computing system. Disaggregating the contribution of nurses to public health outcomes for the purposes of evaluation was seen as a particular challenge, especially as local commissioners were said to take an 'integrationist view' seeing all agencies contributing to overall outcomes.

It is difficult to evaluate our work as we don't see the long-term outcomes, we treat and are a signposting service – it's the same difficulty for all public health work. It's easier to measure outcomes for take-up of contraception or stopping smoking.
(School Nurse Team Lead, Site 2, South West).

Site 3: London

It was felt that the work of nurses in this authority was only partially evaluated and that the emphasis was on gathering numerical data to determine the level of funding the service should receive.

At the moment we're being told that the funding depends on figures basically. So they're using our computer system which is completely inadequate to try and pull up whatever contacts we have had to determine the funding we should be getting. But a lot of the work we do you can't actually put any numbers on it. We spend a lot of time in meetings and writing reports rather than having face-to-face contact with children or their families. So you spend a lot of time but haven't really got anything to show for it, which is part of the problem. (School Nurse, Site 3, London).

Site 4: North West

This site (along with site 1) was, at the time of the study, introducing a health needs assessment model within schools, which would provide the basis for future evaluation of the impact of health-related interventions. This was felt to represent a shift away from offering a core service to schools towards working with identified priorities, assessed primarily through the completion of a confidential, anonymised, pupil questionnaire. Once these priorities were established, it was felt, then the work of nurses could be evaluated against targets set in relation to these health needs.

Site 5: Yorkshire and Humber

In this authority, work was currently underway on a new audit of health care planning which had been supported by the PCT audit team. Records were kept of nursing activities and attendances at health drop-ins in schools. In addition, information was collected about key issues for young people. The multi-agency support team in this area had developed a series of evaluation letters for parents and carers, young people and school staff for feedback on the service they had received.

Key Findings

- Most evaluation activities in schools are numerical auditing exercises which provide indicators of the scale and quantity of specific activities or the extent to which these are accessed by children, young people and families.
- Evaluation of individual health education activity is often conducted with young people through questionnaires, feedback forms or focus group discussions.
- Evaluating the outcomes of what nurses do is complex and there is a lack of clarity from commissioners about how the impact of nursing work is, or should be, measured.
- In most cases, nurses lack adequate clerical and administrative support to enable them to evaluate what they do.
- In many areas inadequate computing systems, combined with a lack of appropriate information technology (IT) training for nurses and other members of nursing teams prevented nurses from effectively evaluating their work
- In order for nurses to effectively evaluate what they do, they require clerical and administrative support and access to appropriate computing systems.

9. PARTNERSHIP WORKING WITH OTHER AGENCIES AND SCHOOLS

9.1 Findings from survey of local authorities

Most survey interviewees felt that school nurses provided the main link between the PCT and schools. However a range of other nurses and allied professionals were identified as being commissioned to offer health-related services in schools, although these services were not universally provided. Many respondents stated that there was often little or no joint working between school nurses and other professionals in schools. However, some examples of collaborative working were given are outlined for each type of service in Table 9.1

Table 9.1: Examples of joint working between nurses and other external agencies in schools

Other agency/ professionals	Type of joint working with nurses in schools
CAMHS/ Mental Health workers	<ol style="list-style-type: none"> 1. CAMHS early intervention/link worker nominated for each school and working with school nurse 2. CAMHS (or similar) team providing training to school nurses 3. CAMHS providing clinical support and supervision to school nurses 4. Schools directly commissioning mental health services via CAMHS - nurses work alongside CAMHS workers 5. CAMHS assist nurses in mental health promotion curriculum development
Sexual Health Services/ SRE providers	<ol style="list-style-type: none"> 1. Nurses in schools supported by sexual health specialists to deliver sexual health services 2. Sexual health and school nurses working together to deliver a service e.g 'Clinic in a box' 3. SRE team in schools made up of youth workers, school nurses and health visitors 4. Integrated health visitor and school nursing team jointly deliver sexual health advice and support on health days 5. Assist nurses in curriculum development 6. Nurses work with SRE consultants employed by HSP
Community Children's Nurses/Continuing Care teams	<ol style="list-style-type: none"> 1. Work with nurses to develop care plans for individual children and young people 2. Provide training to nurses to enable them to support children with complex medical conditions
Nutritionists	<ol style="list-style-type: none"> 1. Work with nurses on targeted intervention for children over the 90th percentile 2. Provide advice and guidance to nurses about PSHE education curriculum for healthy eating and/or about individual children.
Range of external professionals	<ol style="list-style-type: none"> 1. Work together for enrichment/ health days in schools.

Through generic drops-ins in senior schools, the nurses worked with the sexual health young people's team and they helped develop a PGD so that we could offer emergency contraception, condoms and Chlamydia testing. So they worked alongside us but now we have enough expertise in the team and are able to run the service ourselves. (Deputy Directorate Manager Child Health, County Council).

As can be seen from Table 9.2, respondents from 19 (56%) authorities described the quality of partnership working between nurses and the HSP as either excellent or good; six (18%) described the relationship as adequate and three (9%) as poor or having no relationship with the HSP. Several respondents described how effective relationships between the HSP and nursing services were the result of HSP strategic leads having a background in nursing in schools or where a school nurse was seconded to the HSP strategic group.

Half of all respondents felt that robust partnerships had been developed between nurses working in schools and CAMHS. As identified in table 9.1 these partnerships tended to take the form of training for nurses and of clinical supervision and support to nurses. In some authorities CAMHS responded to specific training needs identified by nurses around issues such as self harm, eating disorders or behavioural issues. There were also examples of single points of contact for nurses to refer young people to CAMHS. However there were difficulties identified in some authorities where the threshold for CAMHS was so high that nurses had to support children and young people with complex mental health issues for which they did not feel adequately trained or prepared.

We have given a lot of the nurses some training in tier 1 and 2 mental health. But it is still- I think the school nurses feel that they hold CAMHS-type cases that they shouldn't because CAMHS are very quick to close cases. If they have a DNA (did not attend) or something, they close it. So they (nurses) do see children in drop-in who self harm or who have eating disorders and that sort of thing, and it's still difficult to get children in to CAMHS – the threshold is very high. (Community Public Health Nursing Manager, Metropolitan District Authority).

Relationships with the Extended Schools Programme (ESP) were mixed and some of the perceived inadequacies in local programmes were attributed to a lack of funding, a lack of continuity in ESP staff and/or a lack of capacity among nurses to be involved in the programme. Nursing leads involved at a strategic planning level for the ESP facilitated partnership working. A number of respondents felt that although the ESP had the potential to develop further and to integrate nurses into its activities outside school hours, the capacity of nursing services or the stage of development of the ESP, did not allow for this.

The quality of partnership working with Connexions was reportedly more mixed than with the ESP. with about a quarter (24%) of respondents describing the relationship as excellent or good, and a third (33%) describing it as adequate. Fewer respondents commented on the relationship with the youth service largely because it was less likely for nurses to work with youth workers in school. However, eight (27%) respondents felt the relationship between nursing services in schools and the youth service was excellent or good and 13 (38%) felt that it was adequate.

Survey respondents identified a range of other services with which nurses had developed excellent or good working relationships. These included young carers' forums, parenting forums, Brook, teenage pregnancy midwifery services, sports link programmes (and other initiatives designed to promote healthy activity and lifestyles), educational welfare officers, independent drug education and advice services and mental health services. One respondent identified excellent links with a support service for gay and lesbian young people.

Table 9.2: Perceived quality of partnership arrangements with other programmes and services

Service	Excellent	Good	Adequate	Poor	No response
Programme					
Healthy Schools Programme	10	9	6	3	6
Extended Schools Programme	2	6	12	9	5
CAMHS	5	12	8	2	5
Connexions Service	3	7	11	6	7
The Youth Service	1	7	13	4	9

Most respondents reflected on the importance of effective partnership working between schools and other agencies, and the factors which enabled or hampered these relationships. Effective partnership working was seen as contingent on a number of factors including funding to facilitate services working together and the personalities of the individuals involved.

The quality of relationships between nursing services and other agencies was reported as variable. There were tensions over the thresholds for intervention imposed, for example, by social services (children’s services) and CAMHS. A number of respondents identified the need for more joint training to understand better each other’s roles and responsibilities. Several respondents identified the lack of capacity within the nursing service as the reason why some nurses had to withdraw from strategic partnership meetings for the HSP or the ESP. They felt nurses were unfairly criticised for their lack of involvement in these initiatives.

I sense that the Healthy Schools Programme is very critical of nurses’ non-involvement, they don’t understand the other pressures. We have an advanced practitioner on their steering group but they can’t always attend and this sours relationships. If they employed one of our nurses, that would help. It is very teacher orientated and should have more health input at top level. (Senior Nurse, Young People’s Services, Metropolitan District Authority).

Strong relationships between nursing services and schools were said to centre around continuity of support, clear and realistic expectations of the nursing service on the part of the school and nurses having time to build relationships with teachers, school staff and pupils. A respondent from a London authority described how by working with the head teacher and governors in a Catholic secondary school, she had come to better understand the school’s reservations about HPV immunisation. Together, they had eventually reached a consensus on how best to promote and deliver the service within the school. Communication between nursing services and schools more generally was said to be facilitated by nurses attending governors’ and senior management team meetings on a regular basis.

A number of respondents discussed the importance of schools recognising that continuity of support did not necessarily mean the same nurse being in the school, but was more likely to be achieved through a team approach. Where there were examples of nurses being school-based, this was thought to foster good relationships with schools. In these cases, nurses were recognised as part of the school staff and were very visible within the school. The more common arrangement, however, was for a school to have

a named nurse who would be the first point of contact, even though other nurses might also work in the school.

In terms of identifying and addressing the specific needs of schools and their local communities, health profiling and or health needs assessments were models of working which were said to encourage partnerships with schools and other local agencies. These approaches, though not widely used, were said to support evidence-based practice and helped ensure that services were tailored to the needs of school communities.

9.2 Findings from case study sites

Site 1: East Midlands

Several respondents described how extensive structural and strategic changes in recent months had impacted on partnership arrangements between nurses, other agencies and schools. Once nurses had a clear specification of what their core service in schools would look like, it would be easier to define nurses' work in relation to that of other agencies. Overall, there was felt to be a sense of shared vision at a strategic level between the PCT and the LA about the direction of services to best promote the health and wellbeing of children, young people and families. A school nurse had been appointed to the healthy schools team and this was said to facilitate communication between the school nursing service and the HSP.

In terms of relationships between nursing services and other local services, the quality of partnerships was said to vary. While there was, for example, a close working partnership with CAMHS, educational welfare staff were considered to be more insular as a service and less likely to share information or work in collaboration with others. Similarly, at the school level, partnerships were said to vary but at their best *'there's a brilliant relationship between the school nurse and the schools and they are helping the school with all sorts of issues around policy and programmes and hands on one-to-one support around young people's health'* (Healthy Schools Coordinator).

Site 2: South West

Partnership working between nurses, schools and other agencies was said to be very effective within this authority. This was to some extent attributed to the relatively small size of the authority, the degree of stability of the workforce and the co-terminosity between the PCT and LA . There were said to be strong links between school nurses and CAMHS, the HSP, youth services, nutritionists and a number of voluntary sector agencies providing support to young people on issues such as bullying and drug use. Relationships within schools were said to be facilitated by stability and continuity in terms of the allocated nurse.

Schools are little cultural entities of their own, so you have to be there enough. It's really about building relationships
(Nurse, Site 2, South West).

Site 3: London

In this authority, partnership working was hampered by the limited numbers of nurses and the large number of schools within which they had to work. Nurses looked back to a time when partnerships with PSHE education coordinators had been very effective. More recently, however, these partnerships had

weakened because nurses had insufficient time for health promotion work within schools. School-based partnerships were now more likely to be based around safeguarding issues and included social services, designated child protection teachers, special needs coordinators and sometimes educational welfare officers or educational social workers.

Site 4: North West

Partnerships in this authority between nurses, schools and other agencies were hindered by the lack of continuity of nurses working in schools. In addition, the complexities of management structures across different districts within the authority made it very difficult to develop models of partnership working that could be transferred from one area to another. So while there was a recently developed, standardised model for school health, it had been introduced in five different Children's Trusts each with its own structure, and each with its own priorities for commissioning from school health services.

There was also a sense that the context within which nurses were working was constantly changing. In one secondary school, situated in an area of deprivation, a strong focus for the school was inclusion. This meant that any nurses in schools had to work alongside a plethora of other services. These included a wellbeing team, a comprehensive learning4life specialist PSHE education team, sexual health nurses commissioned to work in the school around the teenage pregnancy agenda, educational psychologists, behaviour support workers, learning mentors and other professionals. They were all drawn into the school periodically to meet the needs of pupils and to support them to attend school. In this context of evolving integrated working, policies and procedures around confidentiality and information sharing had been reviewed and the CAF had more recently become the framework for assessing needs of individual young people. A lack of continuity in the nurse allocated to the school meant that nursing risked being an add-on to these new developments rather than integral to them.

Importantly, however, planned developments within the authority such as the integrated health centre (servicing both primary and secondary schools in one locality) were expected to positively impact on how nurses could work within the local community and to help enhance partnership working between nurses, schools and other agencies.

Key Findings

- Where there are adequate numbers of nurses and an appropriate skill mix, nurses in schools work effectively as part of multi-agency teams to promote children and young people's health.
- Recent financial reductions to nursing services have negatively impacted on the way nurses work in partnership with schools and other agencies. These cuts have also adversely affected nurses' ability to influence other strategic developments such as Healthy Schools and Extended Schools Programmes.
- There is evidence that the emphasis within the children's agenda on integrated working is having a positive impact on opportunities for nurses to work more closely with other partner agencies.
- Partnership working is facilitated by stability in the work force, a shared vision of integrated services for children and young people, and realistic expectations of the roles of nurses by other partner agencies.

10. NURSING SERVICES IN SCHOOLS: LOOKING TO THE FUTURE

I want to go, knowing it's on a sound footing. I honestly believe that the health of the nation depends on a strong school nursing service. We can change the world. But we seem to take two steps forward and three steps back. However, we now have more of a momentum to move forward. (Clinical Team Leader for Children and Families, London Borough).

This study took place at a time of considerable change in policy development around the health of children, young people and their wider communities. Such changes have significant implications for the future role of nurses in schools. The NHS Next Stage Review conducted by Lord Darzi (DH, 2008b) emphasised six key goals for NHS activity with respect to prevention of poor health. These were: tackling obesity, reducing alcohol harm, treating drug 'addiction', reducing smoking rates, improving sexual health and improving mental health. To meet these goals, the review stated that every PCT should commission comprehensive wellbeing and preventive services, in partnership with local authorities, to meet the specific needs of their local populations. With respect to children and young people, the review emphasised the importance of designing and delivering services around the needs of children, young people and their families in settings other than health centres, including schools and children's centres.

At the same time, PCTs and local authorities are working towards meeting the criteria for World Class Commissioning (DH, 2008, 2009). These criteria see the focus for commissioning to be based on integrated working and dynamic partnerships between PCTs, local authorities, other commissioners, communities and providers of health care. Services should meet local needs and focus on promoting health and reducing inequalities. Central to WCC arrangements is the involvement of clinicians and providers of health care in commissioning decisions to meet the health care needs of local communities. Nurses, as key health care providers, should be central to informing these commissioning decisions.

Furthermore, *Transforming Community Services: enabling new patterns of provision* (DH, 2009) describes the 'transformational attributes of the future community practitioner which include: health promoting practitioners, clinical innovators, professional partners, entrepreneurial practitioners, leaders of service transformation and champions of clinical quality. At the time of writing, the *Healthy Child Programme* (DH, forthcoming) is about to be published. It is expected to have additional implications for the roles which nurses assume in school and community settings to promote children and young people's health.

These and other strategy and policy back-drops such as *ECM*, *Healthy Lives: Brighter Futures*, and *The National Service Framework for Children and Maternity Services* have ramifications for the roles of nurses in schools and point to high expectations about what they could and should do within these settings.

10.1 Findings from survey of local authorities

Some survey respondents felt very positive about the future of nursing services in schools and recognised real opportunities for expanding and extending the work. This optimism emanated from expectations of increased investment and a rise in the profile of nursing services and a better understanding, on the part of commissioners and stakeholders, about nurses' potential to more widely contribute to the preventative agenda. In some areas, rejuvenation of the service had already begun and was starting to attract younger nurses looking for full-time contracts and a fulfilling career in public

health nursing. In areas where such contracts were being routinely offered, more male nurses were being attracted to the service. Local re-structuring was also seen as a key opportunity for some as it enabled health visitors, school nurses and nursery nurses to work together in public health teams.

While some opportunities were perceived to be inspired by local factors and local decision making, others came from national policies and initiatives. These included the imminent mandatory provision of PSHE education; *Healthy Lives: Brighter Futures*, *Transforming Community Services*, *ECM* and *Choosing Health*. This latter policy document had helped to raise the profile of nurses and set the standard of one qualified nurse for every secondary school and its feeder primary schools. Other national initiatives were more controversial, seen by some as providing opportunities for nurses to raise their profile but by others as being detrimental to the development of the service. The NCMP, HPV immunisations and the CAF were examples of more controversial initiatives.

Other respondents were more uncertain, or even pessimistic, about the future. For them, a lack or reduction of investment in the school nursing service, a sense that nurses were becoming disillusioned with their work and were leaving the service and the amount of time being devoted to safeguarding work were negative factors. These factors were said to prevent nurses engaging in health promotion and prevention work which they nonetheless aspired to. There was a sense, too, that nurses sometimes experienced conflict between DH and DCSF targets. For example, children with complex health needs, missing school because of hospital appointments, might find an education department recommending attendance at a special rather than a mainstream school to limit their impact on attendance targets. Other national targets also restricted nurses' work in some areas and were felt to impact on recruitment and retention:

We run open days for recruitment. We recruit dynamic younger staff wanting to work with young people in a public health/preventative health model of service delivery. I wonder about when they have been flat out for several months delivering HPV, trying to achieve an uptake of 70%, what their level of disillusionment becomes. And when they say to you 'is this what you mean by the public health promotion for young people?', I ask the question, is this what we should be doing?'. (Lead Nurse Manager, London Borough).

10. 2 Findings from case study sites

Where schools considered the service they were provided with by nurses to be inadequate, respondents could normally draw on previous experience where there had been greater capacity, greater continuity and clearer roles and responsibilities for nurses in schools. When asked about how the role of nurses in schools could be developed, respondents often knew what they thought were the most appropriate responsibilities for nurses. Having more time in schools, building relationships with pupils and families, providing PSHE education and prevention work as well as one-to-one personalised support to more vulnerable children and families were all identified as appropriate roles. Several respondents also felt that nurses could provide a bridge between school and home, for example when children were not attending school or when there were significant concerns about their health and wellbeing. In these situations, the nurse could offer 'neutral' support to parents and, at the same time, encourage them to talk about the health and wellbeing needs of their children.

One approach suggested in Site 4 was to conceive nurses working in school as '*health coordinators who are the main point of contact*'. This would involve them being a familiar face to children in school, being available in a recognised space and at known times, thereby being in a good position to build relationships with pupils, school staff and outside agencies. In this model, nurses would essentially

work at two levels; the whole school level, where they would assess needs and coordinate appropriate health and wellbeing services for the school to meet these needs, and the individual level where young people (or professionals on their behalf) could come and talk about health issues and be referred as necessary to other services.

Several respondents felt that particular secondary schools, in areas of high deprivation, required a full-time nurse who could also link into the feeder primary schools. In this way, families could have access to the same nurse. Many respondents recognised a leadership and coordination role for nurses in schools. Coordinating integrated teams, providing clinical governance for health-related work in schools, and having a caseload manageable enough for establishing effective relationships with schools, school communities and partner agencies were seen as key elements of the role.

11. CONCLUSIONS AND RECOMMENDATIONS

11.1 Conclusions

This study has demonstrated considerable diversity with respect to what nurses do in schools to promote the health and wellbeing of pupils, the ways in which their services are commissioned and managed, the resources they have access to, and the constraints they face in meeting the health care needs of diverse populations. Importantly, this variability was evident from data gathered at national, local and school levels. Furthermore, evidence gathered through the interviews with five international stakeholders also reflected a very complex and variable picture with respect to the work of nurses in schools in the respective countries they worked in or had knowledge of.

Nurses continue to face extensive challenges in promoting the health of children and young people in schools. The study identified adequate capacity (in terms of numbers of nurses, the amount of allocated nursing time and nurses' skills and competencies) and resources as key in enabling them to work effectively within schools, in building relationships in school communities and in providing a service beyond the level of immunisations, screening and child protection. The majority of nurses worked on part-time and/or term time only contracts. National campaigns such as the HPV immunisation programme and the NCMP had had a significant impact on how nurses could use their allocated time to work in schools. In particular, a lack of consultation prior to the introduction of these initiatives and the limited time to plan them effectively had created particular challenges for nurses.

Increases in child protection work over recent months and years were widespread. In the majority of local authorities surveyed, and in four out of five of the case study sites, safeguarding work reportedly had a detrimental effect on the amount of time nurses could give to other more health promoting activities.

The effect of nurses having to focus on a restricted set of issues and activities was blamed for their sometimes low profile among schools and the wider community. Coupled with this, some schools and partner agencies were perceived to have little understanding of the contribution nurses could make to the health and wellbeing of children and young people. Many respondents also perceived commissioners to undervalue nurses compared with health visitors. In one County Council, for example, there were reportedly 26 FTE health visitors and only 1.6 FTE school nurses.

Nurses faced some significant institutional barriers to their work. The lack of physical space for them to work in was an issue in many schools and had not been adequately addressed in the *Building Schools for the Future* (DfES, 2004) initiative. In some schools, such as faith schools, nurses were restricted in what they could offer, in particular in relation to young people's sexual health.

In some local authorities there were marked difficulties in recruitment and retention of nurses. However, there were examples from this study of services having an adequate number of nurses and an appropriate skill mix to allow nurses to work in innovative ways. In these situations, there was reportedly greater stability in the nursing workforce and fewer difficulties with recruitment. Recruiting SCPHN qualified nurses was still a problem for many local areas and this was sometimes addressed by appointing registered nurses and by providing flexible opportunities for them to complete a SCPHN degree- level qualification.

Many participants in the study, including national stakeholders, survey respondents and participants in the case study sites, felt that the SCPHN degree level qualification should be mandatory for nurses working in schools. However, this expectation needed to be matched with clearer career pathways, particularly in a context where the majority of senior managers within community nursing services were those from a health visiting background. In addition, attention needed to be paid to ensuring there were adequate community practice teachers in place to act as mentors and support nurses through the course.

Despite the emphasis in WCC on the involvement of health care providers in commissioning decisions, nurses' involvement in this process was seen as minimal and there was a reported lack of awareness among nurses of ways in which they might influence commissioning. Furthermore, the evolving split between the commissioning and provider services within PCTs, meant that it was even more important for nurses to be able to make a strong case for their service. In some instances, the commissioning process left nursing teams feeling vulnerable to the workings of the NHS 'internal market' and concerned that commissioners might look elsewhere to commission the services which they had traditionally provided to schools.

Irrespective of these challenges, there was significant optimism in many areas that nurses working in school and community settings were enjoying greater recognition and feeling more valued than in recent years. Commissioners were beginning to re-invest in school nursing services. New structural arrangements were leading to more integrated ways of working, with nurses working in closer partnership arrangements with a wide range of other community health and social care providers, increasingly co-located in the same building. Despite some reservations about WCC, this approach appeared to be a framework for developing more tailored health services relevant to the needs of local communities. Furthermore, there were increasing opportunities for nurses to access CPD opportunities, including the SCPHN degree level qualification. Finally, there was a sense of innovation in nursing practice and clear evidence that, given adequate resources and structural support, nurses had the potential to make a significant contribution to the health and wellbeing of children, young people and their families.

This study suggests that it is less relevant to talk only about nurses' work in schools, than to highlight their work with school-age populations. It may be useful therefore to speak of nurses as providing a service primarily in schools and, from there, working in a range of other community settings according to the needs of children and young people in local communities. These settings may include, among others, pupil referral units, FE colleges, youth settings, children's centres, YOTs, and young offenders' institutions. This approach also involves nurses working alongside professionals offering more specialist services, for example to young parents, looked-after children and young people, care leavers, unaccompanied children and young people seeking asylum and young people not in education, employment or training (NEET).

Overall, the future direction of nurses' work in schools, as indicated by this study, appears clear. Nurses have the potential to work in a number of ways with schools including: one-to-one targeted interventions with children and families; supporting the generic provision of health education and health promotion in schools; co-ordinating health related interventions in schools; providing advisory/institutional support to schools to enable them to become health promoting environments; partnership working with other specialist services such as CAMHS and sexual health services to enable these services to be available in schools; supporting the wellbeing of the whole school, including staff, and identifying health care needs and coordinating responses to these within schools and other community settings.

The future of nursing services in schools

From the current study, the potential role of the nurse in promoting the health and wellbeing of children, young people and their families through schools and other community settings might best be described as follows:

- Working with the school-age population but not necessarily exclusively in schools.
- Working as a key service within 0-19 integrated partnerships, co-located with other community based services such as health visitors, family support workers, youth workers and primary care mental health workers.
- Working on year-round contracts which are full- or part-time, configured both to the needs of individual employees and to the requirements of service level agreements with commissioners.
- Working as lead health professionals within schools, pupil referral units (PRUs), youth settings, children's centres and other community based settings and acting as a conduit between children, young people, their families and other health and social care services.
- Working to support a social model of public health, offering services and support based on local health and wellbeing needs and priorities.
- Working in teams which have a high profile within local school communities.
- Working at the prevention and early intervention stage with children, young people and families with more complex needs, and referring appropriately where safeguarding and other issues are beyond their remit.
- Working within appropriately skilled teams supported by adequate administrative and clerical services.
- Commissioned to work in ways that foster flexibility and innovation in professional practice in accordance with local needs and priorities.
- Commissioned to work against clearly defined outcomes and with guidance about what kind of evidence is needed to evaluative practice.
- Having recognised professional development pathways and access to relevant professional training opportunities.
- Being key partners in commissioning processes.

11.2 Recommendations

The current study suggests there to be a number of implications at the national, local and service provision levels regarding the work of nurses in schools and other community settings.

At a national level

- There is a need to raise the both the profile of nurses working in school settings and understanding about their potential for contributing to the health and wellbeing agenda for children and young people.
- There is a need for a greater clarity about the extent of nurses' legitimate involvement in safeguarding and child protection procedures.
- The DH and the Department for Children, Schools and Families (DCSF) (along with local commissioners) should carefully consider the impact of all national initiatives on the roles of nurses and other front-line health professionals.

- There is a need for clearer guidance on how best to evaluate the public health function of nurses within schools and other community settings.
- Nurses should continue to be supported to complete the SCPHN degree-level qualification and clearer national guidance is required as to whether this course should become mandatory.
- There should be a clearer career pathway for nurses working in schools and other community settings, with opportunities for progressing into senior management and leadership roles. This is likely to improve recruitment into, and retention of nurses within, the service.

At a local PCT/ LA level

- Commissioners need to ensure they are setting targets which are appropriate to the capacity of nursing services.
- Commissioners need to address the shortfall in the number of nurses needed to meet the *Choosing Health* (DH, 2004) target of one qualified nurse to every secondary school and its feeder primary schools.
- In keeping with World Class Commissioning WCC, commissioning arrangements should provide scope for nurses, as key health care providers, to be central partners in informing commissioning decisions about health services for children and young people in schools and other community settings. .
- Further investment in the professional development of nurses is required to enhance the core skills and competencies required to provide a public health service within schools and other community settings.
- Specialist community public health nurses require sound clinical and managerial support, after completion of the SCPHN qualification, if they are to effectively implement what they have learned.
- Commissioning arrangements should encourage nurses to properly assess the needs of local communities and to configure nursing provision according to identified needs.
- Commissioners should be clear about how nurses working in schools and other community settings can provide evidence of the impact of their work on the health and wellbeing of children and young people.

At nursing services level

- Greater emphasis should be placed on assessing the local needs of children, young people and families within schools and other community settings and in achieving an appropriate skill mix to meet these needs.
- Nurses should be managed in such a way that continuity of working within specific localities is maximised so that they can build effective relationships with schools, children and young people, local communities and partner agencies.
- Models of working which enable nurses to take leadership roles in coordinating health care and health promotion services in schools and other community settings should be encouraged.
- Adequate resources need to be allocated to clerical and administrative support for nurses working in schools and other community settings.
- Nurses need access to computers and relevant data systems to facilitate their working. Some nurses need training to make best use of information technology.
- Additional training for nurses is required with respect to organisational structures, such as Children's Trusts and integrated working, as well as in relation to the strategic direction of the local children and young people's agenda.

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Appendix 1: Semi-structured interview guide

Promoting Children and Young People's Health through Schools: The roles of nurses

Discussion Guide – Key Informants

- Given your knowledge and expertise of work in this area, we welcome the opportunity to talk with you about your experiences.
- Your participation in the study is entirely voluntary and you need not answer any questions you do not wish to.
- Any information we receive from you in the course of the research will be held confidentially and reported anonymously (such as saying 'professional, [name of place])
- The findings from the study will form the basis of a report for the Department of Health
- Is there anything about the study you'd like to ask about?
- Is it ok to record what we talk about?
- Is it ok to start the interview?

Section One: About You

1. Name _____
2. Organisation _____
3. Job Title: _____
4. Could you say a little about the work that you do?

Section Two: What nurses currently do within school:

- 1.1 From your perspective, what role(s) do nurses currently play in promoting the health of children and young people through schools in (define the context)¹⁶?
 - What types of activities take up the majority of the time allocated to nurses to work within schools
 - What types of activities are less common for nurses to carry out within schools but which (in your opinion) would help promote young people's wellbeing.
 - In what ways (if at all) do these responsibilities differ between primary and secondary schools?
- 2.2 In what ways (if at all) have these roles and responsibilities changed over the past few years?
Prompt: In your opinion are these positive or negative changes?
- 2.3 In what ways do nurses currently assess and respond to the health and wellbeing-related needs of pupils in schools (and, where appropriate, their families) across different key stages and according to different health-related issues and topics?

Section Three: Commissioning, management and strategic arrangements

- 3.1 How are decisions made about what role nurses should play within schools in promoting young people's health and well-being?

¹⁶ Within stakeholder interviews this could be a UK national perspective, a UK local authority perspective or a national or regional perspective from another country.

- Who makes these decisions?
- What processes are in place to allow nurses to have a say in defining their roles within schools?

3.2 In what ways, if at all, have regional and local policy and strategic frameworks (such as Strategic Health Authority plans, local authority children and young people plans and/or school development plans) incorporated the role of the nurse within multi-agency approaches to promote health through schools?

Section Four: Working in partnership

4.1 What sort of relationships have been built between nurses in schools and other professionals such as education welfare officers, educational psychologists; CAMHS; Social workers etc

4.2 Are you able to provide examples of how nurses working in schools have worked effectively in partnership with other professionals to promote the health and well-being of pupils?

Section Five: Evaluating the work of nurses and identifying effective practice

5.1 From your experience, what types of activities (if any) are used by nurses to monitor and evaluate the work they do in schools?

5.2 What sort of support is available to nurses to assist them in monitoring and evaluation (such as particular guidance, training or evaluation forms or tools)?

5.3 How might nurses within schools better review and evaluate their work for and with pupils in relation to both health and education-related outcomes?

Section Six: The future of the role of the nurse in school:

6.1 In your view, in what ways might the role of the school nurse best be developed over the next five years?

6.2 To help achieve this, what would need to happen with respect to initial training and on-going professional development of nurses?

6.3 In your view, what, if any, changes need to be made to local decision making processes and contractual/ commissioning arrangements to ensure that this new role of nurses is achieved?

Is there anything else you would like to add?

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Promoting the Health and Wellbeing of Children
and Young People Through Schools: The Role
of the Nurse

A Review of Literature



Background and methodology

This review of literature was conducted as the first phase of a Department of Health-funded study entitled *Promoting the health and wellbeing of children and young people through schools: the role of the nurse*. The overall aim of the review was to set the context for the wider study and help to inform subsequent phases of the work: which include interviews with stakeholders; case study work in five local areas; and a telephone survey with key informants in a sample of local authorities.

The literature review includes key national as well as international literature published between 1997 and 2008. However, other policy, programme or legislative developments which have helped to define the role of nurses within schools before this time are also included. Following interviews with key national and international stakeholders, some additional material was later included - particularly new national policies that had evolved since the review began.

The following databases, among others were used to identify relevant literature: *internurse* (providing the largest online archive of nursing articles); the *CINAHL database* (which includes literature on nursing, allied health, biomedicine, and healthcare); the *British Educational Internet Resource Catalogue* (BEIRC); the Australian Education Index (AEI); ERIC (the major US indexing service for education), the Educational Evidence Portal (EEP); *Applied Social Sciences Index of Abstracts (ASSIA)* Intute: Social Sciences; the *Cochrane* database of systematic reviews; and specific websites such as 'Wired for Health (the National Healthy Schools programme website); the Royal College of Nursing (RCN); the Health Development Agency; the Department of Health; the School and Public Health Nursing Association (SAPHNA) and the Community Practitioners and Health Visitors Association (CPHVA). Specialist nursing journals such as the *British Journal of School Nursing* and *Community Practitioner and Nursing Times* were searched on a year by year, issue by issue basis.

A range of search terms were employed in various combinations including:

- 'school nurses', 'school health advisors', 'school health nurses', 'nurses', 'health visitors'
- 'school', 'primary', 'secondary', 'education settings',
- 'school-based health service', 'school health drop-ins', 'youth friendly'
- 'pupil', 'student', 'Child(ren)', 'young people', 'adolescent', 'youth'
- 'health promotion', 'health education', 'personal, social and health education (PSHE)', 'personal, social, health education and citizenship' (PSHEC)
- 'mental health', 'emotional wellbeing', 'obesity', 'sexual health', 'alcohol', 'smoking', 'drug use', 'teenage pregnancy'

The review focused on examples of the range and types of services provided by nurses within a school context ranging from the provision of a generic health promotion service (including supporting PSHE programmes and curricula); supporting the public health/prevention agenda (such as administering vaccination and immunisation programmes or health screening); the provision of targeted assessment and support for individual young people and their families; the role of nurses in school-based health facilities; and/or the specialist nursing function with respect to children and young people living with particular health conditions, such as asthma, cystic fibrosis and diabetes.

Introduction

Recent research in the UK has raised widespread concern regarding a range of health issues for children and young people. Such issues include a rising prevalence and recognition of mental health problems (Green *et al.* 2005), high numbers of unplanned pregnancies and rates of sexually transmitted infection (Brook, FPA, NAT/THT 2007) and increasing frequency of being overweight and/or obesity in children and young people (DUIS 2007).

Concurrently, and over the past decade, a range of national policy responses have acknowledged the importance of investing in the health and well-being of children and young people, and have identified schools as key settings in which this work should take place. Within this context, nurses working in or with schools are thought to be well placed to promote and deliver on a range of health and well-being initiatives for children and young people at a number of different levels (DH 2004a). This includes, for example, contributing to generic health promotion activities such as the development and implementation of personal, social and health education (PSHE), providing health services within schools, supporting public health initiatives and safeguarding the health and well-being of individual, and often vulnerable, children and young people (Alcorn 2007; RCN 2005; Clarke 2003; Lightfoot and Bines 2000).

The review offers an overview of recent government policy with respect to promoting the health and well-being of children and young people. In particular it focuses on the centrality of multi-agency and partnership working and the emergence of new roles for nurses working in and with schools. Drawing on the wide range of activities in which nurses are engaged, and examining the increased emphasis on integrated and partnership approaches, the review then draws out examples of good practice and raises ongoing concerns with respect to the successful implementation of multi-agency working and the role of the nurse in schools.

Policy developments

In response to the fragmented and under-prescribed development of services for children and young people (Lightfoot and Bines 2000), government policy in England has placed increasing emphasis on adopting a client-focused approach to enhancing the health and well-being of children and young people. Central to this has been an emphasis on integrated and multi-agency approaches, innovation and modernisation in health promotion and recognition that this work can take place in a variety of different settings (Brooks *et al.* 2007). *Every Child Matters: change for children* (DfES 2004) gives emphasis to health as one of the five outcomes to be achieved for children and young people while the *National Service Framework for Children, Young People and Maternity Services* (DH 2004b), *Youth Matters* (DfES 2006) and *Aiming High* (HMT/DCSF 2007) stress the need for partnership, inter-agency approaches and shared responsibility in promoting and safeguarding young people's health and well-being. Increasingly, the government has placed the onus on local agencies working in partnership to reduce health inequalities through steps such as the pooling of primary care trust (PCT) and local authority budgets in order to prevent poor health outcomes for young people (HMT/DCSF 2007) and, as advocated in *Our NHS, Our Future* (DH 2007), has emphasised the need to implement personalised services at times and places accessible to service users.

More recently, the NHS Next Stage Review conducted by Lord Darzi (DH, 2008) has emphasised six key goals for NHS activity with respect to prevention of poor health –tackling obesity, reducing alcohol harm, treating drug 'addiction', reducing smoking rates, improving sexual health and improving mental health. To meet these goals, the review stated that every primary care trust (PCT) should commission comprehensive wellbeing and preventive services, in partnership with local authorities, which meet the specific needs of their local populations. With respect to children and young people, the review emphasised the importance of designing and delivering services on the needs of children, young people and their families and in settings outside of health centres, including schools and children's centres.

In response to the Next Stage Review, all ten Strategic Health Authorities (SHAs) in England have developed visionary plans¹⁷ of how they will provide services – including how they will meet the health needs of local populations, ensure quality (defined as clinically effective, personal and safe), and develop and support a workforce that can effectively meet the health challenges met by the NHS in the 21st century. These SHA visionary plans reflect a strong-emphasis on increasing the investment in preventive services, diversifying the settings for health promotion and health service delivery, and reviewing and re-configuring the workforce to enable necessary changes in delivery to take place.

There are many national policy level drivers, therefore, making schools a primary focus for the promotion of young people's physical, emotional and social well-being, and which recognise the potential of schools to support the modernising of health promotion practice with regard to young people. Schools have increasingly become multi-agency settings for the promotion of health, hosting a range of health-related initiatives such as the Healthy Schools Programme, the Connexions service, youth services, the extended schools programmes, education welfare services, community safety partnerships and youth justice agencies. There has also been an emphasis on extending health promotion activities in schools to include components of health-service delivery through initiatives such as the DH/DfES National Five a Day Programme and the Food in Schools Programme.

Schools, as universal settings, offer contexts within which both generic and targeted approaches to promoting the health of children and young people can take place (Lightfoot and Bines 2000). At a local level, Children's Trusts have a major responsibility in providing leadership to Local Strategic Partnerships (LSPs) and involve a range of agencies in the development of Children and Young People's Plans (CYPPs). These in turn provide a framework for the joint planning and delivery of strategic objectives using pooled resources. A recent review of a representative sample of CYPPs in 75 local authorities revealed that 72 of these plans placed schools at the centre of partnership arrangements locally (Chamberlain *et al.* 2006). However, as Brooks *et al.* (2007) argue, health-related work in schools is diverse and competing demands on the education system may result in schools and teachers feeling ill-equipped to deliver public health programmes and initiatives. ,

The ever expanding health promoting function of schools requires a core of multi-agency professionals with appropriate capacity and resources to respond effectively to the prevention, safeguarding and promotional aspects of this work. Nurses – both those with a school-specific remit (including school nurses/health advisors), as well as those who work in the wider community (practice nurses, nurse practitioners and health visitors) – are core elements of this professional body and may be uniquely placed to provide health expertise and knowledge within the school setting.

A 'modern' role for school nurses

Despite an established history of health professionals working in schools, the role of nurses in UK schools has, until recent years, been limited to routine screening and surveillance tasks and short-term interventions such as one-off Personal, Health and Social Education (PHSE) classes. However, as Brooks *et al.* (2007) explain, nurses are professionals in a unique position to connect the school, home and wider environments of children and young people, to link clinical knowledge and expertise with understanding of the social determinants of health and to develop an in-depth knowledge of individual, family and community needs over time. In recognition of this new role, government targets specify that each primary care trust should be funded to resource one full time, year round, qualified school nurse per secondary school and its feeder primary schools (DH 2004a). In terms of contracting, school nurses can be employed either by the local health authority, PCT or community trust, or by the school directly. Although there is as yet a dearth of published information in this area, it is likely that these commissioning and management arrangements will be influential in determining the scope and focus of the future role of nurses in school.

¹⁷ These plans are available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085400

Evidence suggests that as part of this 'modern' role, nurses in schools can help increase the take-up of health services by young people, contribute substantially to the provision of PSHE, directly impact on specific health issues such as unplanned pregnancies (Larsson *et al.* 2006), smoking cessation (Pbert *et al.* 2006) and immunisation (Tung *et al.* 2005), provide individuals with key support in the management of conditions such as asthma (Hillemeier *et al.* 2006; Forbis *et al.* 2006), diabetes (Hellems and Clarke 2007; Nabors *et al.* 2005) and mental health disorders (Tylee *et al.* 2007) and, through targeted interventions, increase school attendance rates amongst minority ethnic children and vulnerable groups (Telljohan *et al.* 2004; Maughan 2003). In addition, research suggests that the presence of nurses in school may enable teachers to pass on concerns the latter have with regards to individual students (Lightfoot and Bines 2000) and provide parents with reassurance that their children are in safe hands should health-related problems arise (Maenpaa and Astedt-Kurki 2008).

Now considered pivotal to child-centred and proactive public health practice (Debell, 2006; Croghan *et al.* 2004; Hall and Elliman, 2003), nurses working in and with schools have recently been at the forefront of policy change in the UK. *Choosing Health: making healthy choices easier* (DH 2004a), *Every Child Matters* (DH 2004b) and more recently workforce changes promoted under the *NHS Next Stage Review* (DH, 2008), all stress the need for a new, modern and relevant workforce and identify a clearer and more substantial role for the nurse than in previous years. These developments have also been reflected in the growing numbers of school-based nurses and an increase in the take up of post-registration school nurse qualification. The 2007 Workforce Census showed that there were 3,162 (2,232 FTE) qualified nurses working in school health services across 3,300 state secondary schools - an increase of 753 (31.3%) since 2004. Of these, there were 1,227 (893 FTE) nurses with the post-registration school nurse qualification, an increase of 371 (41%) since 2004.

Although recent policy documents have called for a 'modern' role for school nursing, Coverdale (2006) argues that this rhetoric comes with an implied assumption that the service is stuck in the past, when in fact, research has found that many nurses are already delivering entrepreneurial programmes tackling some of the major issues faced by children, young people and their families. However, Colverdale argues that there are also many cases in which nurses find it difficult to move away from routine, task-based procedures, and that clear structures are needed to help ensure that they are able to embrace any necessary developments and changes.

While much of this review focuses on findings from work in state school contexts, it is important to recognise that nurses make a contribution to young people's health across a range of settings. Those working in independent schools or as part of a specialist team, for example, have been found to have very different working arrangements and priorities than those based in state schools (Ball and Pike 2005), and even within the state school context, it is recognised that nurses may need to adopt different approaches to enable individuals to maintain and improve their health (DH 2004a). Similarly, the age of the children and young people with whom the nurse is working will be influential in determining the reach and priorities of her/his role. There is as yet however, very little published information which makes clear and comparative distinctions between nurses' contribution at primary and secondary levels despite the fact that the focus in each setting is likely to require different kinds of skills and resources.

According to the Chief Nursing Officer's Review (DH 2004c), nurses' work in schools can include reviewing children's health, supporting the development of personal health guides, providing general information, advice and support about health issues such as diet and nutrition, physical activity, emotional well-being, puberty, smoking and sexual health, providing advice on where further support is available, and supporting learning which deals with healthy choices and managing risk. In addition, a growing body of research has identified an array of further activities in which nurses *could* take responsibility. These include issues as diverse as influencing traffic control policy around schools and residential areas (DH 2006), dealing with students taking performance enhancing supplements (Garzon *et al.* 2006) and responding to large-scale health emergencies such as bioterrorist attacks (Guillon 2004).

While the recently published *School Nurse: Practice Development Resource Pack* (DH 2006) outlines a number of aspects of the modern school nurse role, the 'catch all' approach suggested above is interpreted by some as an attempt to expand, mould or contract the role to fit a prevailing policy agenda (Brooks *et al.* 2007). This has not only led to a mismatch between expectations and what is delivered, but has also resulted in widespread confusion amongst nurses concerning the definition, structure and balance of their role (Madge and Franklin

2003; Croghan *et al.* 2004). This is supported by research which has found that a number of discrepancies exist between the contractual requirements of nurses in schools and requirements set out by government (Croghan 2007).

Paradoxically, it is reported that in many places, the increasing breadth of the work of nurses in schools combined with the under-resourcing of services has de-valued the expertise of nurses and either rendered them invisible or ineffective to young people, families, professionals and even line managers (Brook *et al.* 2007; Godson 2007; Croghan *et al.* 2004; Lightfoot and Bines 2000). Alternatively, through misunderstandings and lack of resources to fulfil these wider responsibilities, it has helped perpetuate stereotypes of school nurses as old-fashioned matrons or 'nit nurses' (Ball and Pike 2005). It is perhaps not surprising therefore, that some research has found that few young people would consider approaching the school nurse, and that those who would, would only turn to her with physical health problems rather than with family or other more socially-focused issues (Jones *et al.* 2000).

In addition, concerns regarding a lack of funding and resources, large disparities in payment and remuneration, heavy workloads, a lack of respect from other professionals, insufficient staffing and unmet training needs exist alongside issues of service accessibility, and effective partnership working, all of which have implications for the local planning, commissioning and management of nursing services.

Resource limitations and capacity building

Recent research reveals that nurses working with state sector schools are required to cover an average of eight schools – one secondary and six to seven primary schools (Ball and Pike 2005). This is irrespective of whether they work full or part-time – the latter being the case for up to 79% of nurses in the state sector. In addition, approximately one third of nurses have higher case loads than recommended (Merrell *et al.* 2007) suggesting that current staffing levels fall far short of those required to meet government targets (Ball and Pike 2005; Croghan 2008). Data cited above from the Workforce Census (2007) show that there were 893 nurses who had completed a specialist post-registration qualification in community nursing/public health while there are some 3300 secondary schools in England alone. Fears have been raised that at current levels of training, government targets will not be met until 2023 (Unite/CPHVA 2007). A major part of this problem lies in the fact that because Department of Health funding for school nursing is not ring-fenced, funding for the service is reliant on primary care trusts' decisions to invest in the school nurse service (Godson 2007).

While nurses working in schools are increasingly expected to take a more active role in on-going health promotion, PSHE and a range of other related areas, they are also expected to continue undertaking tasks associated with their more 'traditional' nursing role. Running large-scale vaccination programmes for example, has been highlighted as one area in which workload has increased, and is likely to do so even further with the introduction of the Human papilloma virus (HPV) immunisation programme, which began in the autumn of 2008 and will run as a permanent annual programme for the foreseeable future (Forbes 2008).

Lack of time and resources to develop new ways of working or acquire new training skills have been identified as areas requiring specific attention if school nurses are to effectively contribute to the health and well-being of children and young people (Godson 2007; Ball and Pike 2005.). In order to deliver services that respond to locally identified needs and priorities, training in undertaking local health needs assessments and in school health profiling has been identified as a key, yet under-resourced requirement (Croghan *et al.* 2004; Lightfoot and Bines 2000). Evidence from Huddersfield NHS School Nursing Service (cf. Madge and Franklin 2003), Airedale PCT (cf. NHS Networks 2008a) and Yorkshire (cf. Lancaster 2007), for example, has demonstrated that school health profiles can initiate proactive ways of identifying and monitoring key areas of need, ensure resources are appropriately targeted and inform multi-agency approaches to developments such as teenage pregnancy strategies and public health reports.

With an ever widening remit, there is also a clear need for nurses to be adequately trained in the more specialist areas in which they are now expected to work. One area in which further agreement and training is required is the delivery of PSHE curricula, and in particular, sex and relationships education (SRE). Since the OFSTED

report on SRE in schools in 2002, school nurses are now obliged to provide advice on sexual health to school aged children in educational settings (RCN 2006). In late October 2008, the government announced that SRE would become part of a compulsory PSHE curriculum for key stages 1-4 in all state secondary schools. This statement will have implications of how nurses work with other professionals in schools to effectively design and deliver this curriculum.

It is reported that nurses currently contribute to SRE programmes in one half of all secondary schools and one third of primary schools (Piercy and Hayter 2008). While a number of innovative and initiatives, such as the C-card scheme introduced in Leeds (cf. Wiles 2008), are reported to be effective, evidence suggests that education in this area in many schools remains inadequate (Harvey 2008) and tensions can exist between the nurse and teachers over the content of the information conveyed (Mason 2005; Cleaver and Rich 2005). Studies suggest for example, that while nurses, as relative 'outsiders', are in a unique position to promote more open discussion with young people about sex and sexuality, emphasis continues to be placed upon factual and physiological detail, with little attention given to acknowledging or advising on wider social factors such as sexual desire and satisfaction. While one study implies that this constraint is influenced by the traditional character of the school nurse role (cf. Piercy and Hayter 2008), others have reported that nurses feel monitored and regulated by teaching and management staff and that they risk being dismissed if they go beyond what are deemed as being acceptable boundaries (Lightfoot and Bines 2000; Hayter *et al.* 2007; Harvey 2008).

A further training need lies in meeting mental health and psychological well-being concerns, identified as priority areas in *Every Child Matters* and the *National Service Framework for Children, Young People and Maternity Services*. It is now well recognised that psychosocial issues can create considerable health problems for young people and include intentional and unintentional injuries, mental health difficulties, substance misuse and unprotected sex (Tylee *et al.* 2007). The following case study provides an overview of a programme currently being implemented to ensure that school nurses are adequately trained to respond to these issues.

King's College School Nurse Initiative

Since early 2007, the Institute of Psychiatry at King's College, University of London and the mental health charity Rethink have been developing training materials for school nurses within Sutton and Merton PCT. These materials are designed to enable school nurses to better recognise the early signs of mental health problems in young people, understand how to support young people within the school setting and understand when and how to refer them for additional support. As well as producing new materials such as video-based learning, the project aims to develop peer support networks for school nurses as a professional group. Central to the project, is the use of a multidisciplinary approach in the development of the materials. In addition, by working through the Royal College of Nursing and existing school nurse networks in London and the south east of England, it is hoped that there will be an active network of school nurses able to continue working together once the pilot scheme ends.

(Source: The Health Foundation 2008)

In addition to providing specialist training materials, the approach adopted by the King's College School Nurse Initiative attempts to foster information sharing networks so that individuals can provide support to one another within a particular specialist area. Other examples suggest that this supportive, networking role can have positive outcomes when a range of issues are involved. Reporting on a case from southern England, for example, Madge and Franklin (2000) describe how a multi-skilled team approach was adopted so that nurses working in schools would be able to call upon others within the team with specialist skills and expertise as and when required. While one nurse had special responsibility for vulnerable young people, for example, another took charge of special health needs. The study found that while the approach had considerable potential, in practice, nurses rarely had time to visit schools which were not part of their immediate case load, and within schools, they tended to focus on their own specialisms, resulting in some health concerns receiving significant attention at the expense of others (*ibid.*). However, a similar approach adopted by Airedale PCT has found that nurses working in such teams have had more time to focus on key problems, that their work is now more proactive than reactive, and that more initiatives have been introduced which have succeeded in eliciting possible changes in health behaviour. In addition, referrals made by health care support workers increased by 22%, the number of child protection issues dealt with increased by 23% and mental health issues by 6% (NHS Networks 2008a). Similar findings have been reported in Yorkshire, where this kind of team work has drawn upon the findings of a health needs assessment and resulted in an increase in both the number of reactive one-to-one interventions at primary

and secondary level and proactive interventions which develop innovative practice and evidence-based services (Lancaster 2007).

One innovative approach to providing on-the-job training and support to school nurses across a range of subject areas is evidenced in the Telekidcare project, a recent pilot study undertaken in the US.

Telemedicine in Kansas, USA

The Telekidcare project was launched by the Kansas University Medical Centre (KUMC) to provide health care services directly to students in 31 schools across the state of Kansas. Telekidcare makes use of interactive television systems as well as a digital otoscope and an electronic stethoscope located within the school health office to enable school nurses to interact with KUMC physicians to provide consultations for sick children. A major benefit of the programme has been the possibility for all those involved in the child's well-being (e.g. parents, school nurses, teachers, medical service providers) to talk together at the same time. As well as decreasing incidents of miscommunication, this was widely viewed to be of direct benefit to all involved in assisting the child. In addition, nurses have been able to use the technology to contact other school nurses for a second opinion, use the otoscope as a diagnostic aid to view things on the television screen in their office and to bring parents into school so that KUMC physicians can explain the importance of bringing their child to the hospital in cases which cannot be dealt with via the Telekidcare programme.

A number of factors have led to the success of the programme and its recognition as a Best Practice Initiative by the US Department of Health and Human Services. These include; 1) ensuring that school nurses received adequate training and were comfortable with the technology; 2) ensuring that Telekidcare could be built into the nurses' every day work to avoid burdening them with unnecessary extra workloads; 3) making a conscious effort to involve as many stakeholders as possible in the planning of the project, including KUMC practitioners, school nurses, technology centre staff, school boards and teachers; 4) the development of an effective, ongoing working relationship that emphasised mutual respect and partnership working between school nurses and physicians; 5) recognising that different schools and nurses would react to, and adopt the programme in different ways, a flexible approach was adopted in which it was made possible for individual sites to take ownership and customise protocols and procedures to be of most use in the varied situations they faced.

(Source: Mackert and Whitten 2007)

While the approach adopted in the Telekidcare project does not provide training in health related issues *per se*, it does enable nurses to gain specialist advice and perform their duties in an array of different health-related areas, as well as ensuring regular professional and peer support through ongoing access to physicians and other professional colleagues.

Meeting the needs of young people – dialogue and accessibility

Research suggests that the part-time and subsequently thinly-spread nature of their work not only results in frustration and fatigue for nurses working in and with schools (Madge and Franklin 2003), but can also result in low levels of student awareness of the role of the nurse, and a reluctance to approach the nurse when familiarity and trust have not been built (Lightfoot and Bines 2000; Chase *et al.* 2006). The nature of the interaction between student and nurse has therefore been identified as a key factor in influencing young people's health outcomes. Largely because of resource restrictions, school health check-ups in the UK and elsewhere in Europe have been criticised for being rather routinised, and lacking a personal approach which encourages children and young people to talk freely about their concerns (Tylee *et al.* 2007; Maenpaa and Astedt-Kurki 2008). As Pirskanen *et al.* (2007) make clear, spending time eliciting in-depth personal background data from young people and exploring the ways that they perceive and respond to their own needs and priorities is vital in ensuring that relevant and effective health promotion strategies are adopted. An effective, proactive and personal approach is evident in Denmark where open-ended *health dialogues* offered by school nurses on an individual and group basis have largely replaced routine screening procedures (Borup and Evald Holstein 2004). These dialogues focus not only on health but on the empowerment of children and young people by addressing problems that they themselves define as important. They have also been perceived as being particularly useful by students

from lower socio-economic backgrounds who reported that they had acted on the advice they received and were likely to return to the nurse when they felt they needed further information and support.

With a focus on exploring the wide range of underlying issues that can influence health and well-being, the following case study from New Zealand provides a similar example of the kind of holistic, student-centred approach that nurses may adopt to help students 'navigate' (cf. Brooks *et al.* 2007) health issues and strengthen their well-being.

VIBE: A model of community and school-based youth health service delivery, New Zealand

Although a variety of approaches to community-based youth health work exist in New Zealand, services such as VIBE have become models for the development of youth health services nationally. Seeking to complement care delivered by Primary Health Organisations, VIBE is a free, confidential and non-judgemental health service for young people aged 10-24. Adopting a youth-friendly approach to health and well-being, two youth board members participate on the VIBE trust board and peer workers (aged 17-24) are employed to liaise with staff and undertake community education and mentoring work. Ensuring that services are appropriate and responsive to the needs of Maori, Pacific and refugee communities is also reflected in the range of staff employed and a commitment to developing collaborative community partnerships. Since 2003, VIBE has worked in partnership with Regional Public Health and school management to establish school-based services and now oversees the Greater Wellington School Nurse Group.

With a commitment to providing a holistic 'whole of life', approach, VIBE addresses physical, social, mental, emotional and spiritual well-being by examining the underlying issues that influence the young person's health and well-being including; family relationships, school experience, study and employment, sexuality and relationship issues, substance use and exposure to violence and trauma. Rather than defining the young person as 'the problem', a positive, strength-based approach is adopted to help young people feel valued, connected and understood. Each consultation lasts in excess of 20 minutes, and is followed up by multidisciplinary review, referral and intervention with community partners such as GPs, mental health support services and counsellors. In addition, longer term help with personal development, goal setting and social support is made possible by the co-location of VIBE social support and youth transition service strands. Support is also available via an interactive website, and use is made of cell phone, text messaging and email to communicate with young people about appointments, test results and follow-up. The sixteen school nurses involved in VIBE meet twice a term for professional development, policy and practice updates and supportive liaison. (Source: Alcorn 2007)

While research has found that young people are generally willing to visit a doctor for physical complaints, there is widespread recognition that young people are not necessarily knowledgeable about accessing health services (Percy 2008) and that they may encounter difficulties in raising concerns about 'sensitive' or 'embarrassing' issues (Madge and Franklin 2003; Gleeson *et al.* 2002). In response, initiatives such as the DH and DfES supported *What School Nurse?* campaign have attempted to publicise the expanded role of the school nurse to children and young people, while the *You're Welcome* (DH 2005) criteria encourage the development and provision of services that are accessible and approachable for young people.

Studies have shown that what many children and young people most want from health services is an informal and non-judgemental approach; (Gleeson *et al.* 2002); accessible language and terminology (Kelsey and Abelson-Mitchell 2007); and assurance of confidentiality (Day 2007; Chase *et al.* 2006; Lightfoot and Bines 2000). Achieving such aims requires not only the investment of adequate time and resources such as appropriately located office accommodation, private phone, fax and email, but also a sustained and flexible service and the willingness to use a variety of approaches that reflect the needs of each individual school (NHS Networks 2008a). The TIC TAC programme offers an example of a successful 'one-stop-shop' response to meeting these needs.

TIC TAC, Paignton Community and Sports College

The Teenage Information Centre and Teenage Advice Centres (TIC TAC) were set up in 1998 and have since received praise from the Government Select Health Committee and OFSTED. The TIC TAC daily lunchtime drop in centres were initiated following consultation with students concerning ways to improve their health and well-being. With approval of all the GP practices in the area and with initial funding from the local health authority, the

multidisciplinary service is co-ordinated by the school nurse and offers individual or group consultations as well as information leaflets and group work activities. It is staffed on a rota basis by GPs, practice nurses, health visitors and school nurses, helping ensure that the team are fully informed of the range of locally available services. Focus is placed on responding to teenagers' needs in a welcoming and a non-judgemental way and the school hopes to try to link the work of the TIC TAC centres to their sixth form peer mentoring programme. (Source: Paignton Community College 2008; Gleeson et al. 2002)

In recent years, attempts to work effectively with young people have also involved engaging with a range of 'youth friendly' technologies such as text messaging and emailing (Haste 2005). According to the RCN (2006), a major benefit of such approaches is that they reach out to those who may not feel comfortable accessing face-to-face services. Although as yet under-developed in many areas, such services can be used in a variety of ways. Sending reminders about appointments or medications, for example, is an approach that has been tested in Birmingham where a service exists to remind 15-25 years olds to take the oral contraceptive pill. A client initiated approach such as that adopted at Cardigan Secondary School as part of Ceredigion School Nurse Service, and that adopted by school nurses in East Kent also reported successful outcomes when students were able to text the nurse anonymously with their health concerns which were then either dealt with via consultation or via referral to other service providers (Ceredigion and Mid Wales NHS Trust 2004; Kent and Medway NHS 2007). Given that research has found that boys are more likely to use services where a high level of anonymity is maintained (Madge and Franklin 2003), it is important that the effective use of such services is followed up.

While all of these initiatives have been praised for facilitating service accessibility, a number of outstanding issues remain. Data show that the vast majority of nurses working in and with schools continue to be white women¹⁸. While some research has found that many boys are more comfortable talking with female nurses (cf. Gleeson *et al.* 2002), other studies suggest that many boys and young men prefer discussions about health issues, in particular, sex and relationships education and advice, to be facilitated by men (Watson 2007; Carruthers 2008). Recent studies have recommended that a recruitment drive for school health teams is developed which focuses on recruiting male and black and minority ethnic nurses to the service (Croghan 2007) and it is likely that such a move would facilitate the development of communication not only with pupils, but also between nurses and a wider array of parents than is currently the case.

Another issue lies in the fact that the majority of nurses working in and with schools are only contracted on a term time basis and only work during school hours, creating a gap in service provision during school holidays and during evenings and weekends (Ball and Pike 2005; Croghan 2007). Given adequate resources and effective partnership working, it is worth considering the use of an extended schools approach in overcome these constraints. Services such as those provided at Eltham Green Specialist Sports College have shown that extended schools can provide a useful opportunity for developing partnership working and community links, with the school nurse there now involved in weekly inter-agency meetings with the special educational needs coordinator, the school's community police officer, Connexions staff and an attendance advisor amongst others (cf. Coverdale 2007).

A further issue lies in the location of the school nursing service. At present, the majority of services and resources are targeted at children and young people *in school*, and as such, place little focus on those who are excluded from or unable to access mainstream education, or those who would prefer to access services outside of a school environment. It may be advantageous to examine ways in which school-based health services form part of a broader strategic response to meeting the health needs of children and young people, and to ensure that effective identification and referral systems are in place between partner agencies.

Partnership working

Working with parents

¹⁸ According to Ball and Pike (2005) only 19 of the 2211 school nurses registered with the RCN were men and only 4% of all nurses registered were from black and ethnic minority communities.

Policy documents such as *Every Child Matters* (DfES 2004) highlight the need for opportunities to be developed to increase the involvement of parents in school-based activities and family learning programmes. The need for such involvement has been supported by research in England which found that most children interviewed (aged 7-11) wanted their parents to talk with them about health issues (Jarvis and Stark 2005). However, a number of constraints limit the development of partnership working with parents. Jarvis and Stark (2005), for example, found that while many parents did talk to their children about subjects such as healthy eating and exercise, far fewer discussed more sensitive issues such as substance misuse and risk-taking. They suggest that this was likely to be because many parents felt themselves under-qualified to provide this kind of information and were reluctant to interfere with the advice being put forward by teachers and nurses particularly when they did not fully understand the latter's role. At the same time, other research has found that not all nurses were prepared to offer family support owing to a lack of training in family focused work (Lightfoot and Bines 2000). Despite these constraints, a number of initiatives have been established in which partnership working between parents, nurses and other service providers has had positive outcomes. As with the food education programme set up in Birmingham PCT (cf. Hagues 2007), and the MEND scheme which now has the involvement of several hundred local authorities, PCTs, schools and other organisations (cf. Sacher 2007) the Archbishop Sumner School in Lambeth provides a useful example of a successful family-based initiative to improve children's health and well-being.

Archbishop Sumner School, Lambeth:

This Full Service Extended Primary school developed its programme of study support activities in order to provide opportunities and increase participation amongst pupils and involve and encourage commitment from parents and the wider community. Using excellent working relationships with the Lambeth PCT, The Early Years Development and Childcare Partnership and Guy's and St Thomas Hospital Trust to develop programmes, over twenty clubs were established. One such club was the PCT's healthy lifestyles club Fit4Kids which was led by the School Nurse Team. This aimed to provide exciting and fun after-school activities such as exercise, gardening and cooking and, encouraging parents to participate promoted a whole family approach to understanding healthy living. The school feels that an excellent relationship has been built between itself and Lambeth PCT, especially through the School Nurse team. Lambeth PCT has been particularly supportive and has covered the majority of staffing costs (Source: Quality in Study Support 2006).

The need for parents to have a variety of means by which they can contact school nurses (e.g text, email) has also been identified as an issue (Maenpaa and Astedt-Kurki 2008) although it is clear that care must also be taken to adhere to issues of confidentiality as set out in the Fraser Guidelines (Day 2007). It is also worth noting that mothers and fathers have been found to have different priorities and concerns regarding their children's health, and that this may also be a contributing factor in the success of any family health-based initiatives (Baggens 2001). In cases where such work has been successful, Brooks *et al.* (2007) report that parents and teachers have particularly valued the ability of the nurse to work across agencies, and to navigate the various forms of service provision that can work together to support children and young people.

Inter-agency working

It is increasingly recognised that the effectiveness of nurses in schools is contingent on the capacity and resources available to them to work across the wide spectrum of agencies that provide specialist advice and support to children and young people. A major factor hindering this process is an ongoing reluctance amongst some professionals and service providers to give nurses adequate recognition. Croghan *et al.* (2004) for example, found that 95% of nurses interviewed in a study in the West Midlands claimed to feel a lack of professional respect from their peers within the nursing field as well as from their line managers, while Coverdale (2006) reports that in some areas there has been considerable resistance to skill-mixing and the sharing of roles and responsibilities, resulting in a lack of collaboration in multi-agency working. Similarly, Ball and Pike (2005) found that nurses working in schools were relatively isolated from other staff in the health field and had less contact with other agencies and services than other types of health professionals, whilst the RCN (2004) has reported that nurses can be isolated from much of school life because their busiest time with pupils is often in breaks when other staff get to meet.

The lack of a standardised job description and the pressures of high workloads which can render them invisible on the ground and 'voiceless' in the policy making process (Brooks *et al.* 2007) has also led many school-based

nurses to recognise that they may not be seen as effective partners by health agencies such as teenage pregnancy teams and child and adolescent mental health services (CAMHS), even though they may have considerable skills in these areas (Godson 2007). The approach adopted by Haydon Bridge High School provides one example of how recognition and respect can be transferred across those involved in partnership working.

Partnership training in Northumberland

Recognising that rural schools are ideally placed to provide a key community focus and meet local need, Haydon Bridge High School established a community team to develop and run a youth club and drop-in service which enables young people to access support by self-referral at an early stage. This drop-in provides weekly sessions by the school nurse and a Connexions Personal Advisor, as well as hosting an array of services concerned with health and well-being such as SORTED (substance misuse), the Youth Offending Service and the Child and Adolescent Mental Health Service (CAMHS). In order to help establish trust, young people have been closely involved in the development of this service. Key to the success of this project is the way that the team has, through training together, developed an understanding and appreciation of each others' skills and roles, acknowledged and supported the professional self-confidence of team members such as the school nurse, have drawn up Partnership Agreements which establish roles and responsibilities and had the commitment of senior management in the school. (Source: Northumberland Families and Children's Trust, 2004)

One major benefit of inter-agency working can be the decrease in waiting times for children and young people to be referred to relevant specialists and consultants. Through a reconfiguration of existing services and funding from Woolwich Development Agency, *Teen Talk* at Kidbrooke School in London is an example of partnership working between different service agencies such as the PCT, family planning, GUM services, youth service and the school nursing service. This service provides access to mainstream services which students may not previously have known about or felt able to access (Chase *et al.* 06). Similarly, Bradford CAMHS provides specialist training to nurses in school who are now able to support the majority of children concerned, cutting waiting lists for CAMHS and thus enabling the most troubled children more direct and speedier access to specialist support services (NHS Networks 2008b).

A further area for development for nurses working in and with schools is in influencing and informing practice-led commissioning. Research in Ireland reports a widespread perception amongst GPs, community nurses and the public that community-based nurses do not have the skills to take a lead in the commissioning of services and that they require intensive training and possibly remuneration to take on such roles (McKenna *et al.* 04). The RCN (2007) however, advises nurses to view commissioning as an opportunity to be proactive, get involved and use their skills to improve health services. While no firm guidelines have been developed, the RCN (2007) suggests that opportunities for community-based nurses to have indicative budgets will enhance their role in improving services and as such, will encourage them to seek out their local commissioning arrangements and have the confidence to find ways of getting involved.

This review of literature suggests that the role of the nurse in promoting the health and wellbeing of children and young people through schools is potentially extensive. Currently, however, from the work that is written about and in the public domain, there is a wide variation in what nurses do in school, from leadership and involvement in more traditional activities such as health screening and immunisations, to comprehensive public health interventions working in close collaboration with other agencies.

Several factors appear to influence the activities that nurses working in and with schools currently carry out. These include the commissioning arrangements in place and the extent to which nurses play a role in informing commissioning decisions; the current capacity of nurses (both in terms of numbers and professional training) to move beyond the more traditional nursing roles in schools; and the extent to which they are able to work in partnership with a range of other agencies to meet the needs of local communities.

While evidence suggests that such inter-agency working can result in positive health outcomes for both children and young people, there is still much to be done with respect to developing a more detailed understanding of the ways in which multi-agency teams should be established, funded and managed to meet this agenda most effectively (Coverdale 2007). The current policy agenda in England indicates that partnership working across

agencies needs be at the heart of public health and prevention work. It is also supportive of moving health initiatives away from health settings into more accessible and convenient community settings. There are a number of examples cited in this review of projects where such inter-agency working in school settings appears to have some positive effect for young people's health and wellbeing.

The next step therefore lies in how best to move beyond the rather 'ad hoc' nature of existing initiatives where nurses have a strong leadership role, to consider how such projects and approaches can become more mainstream in the work that nurses do in and with schools.

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Appendix 3: Proposed dissemination plan

- 2- 3 papers in peer-reviewed journals – British Journal of School Nursing and Children and Society
- Presentation at School and Public Health Nurses Association (SAPHNA) conference (September 2010)
- Short practitioner pieces in Nursing Times and Times Educational Supplement
- Dissemination of executive summary to local authorities
- If permitted, a link to the final report on the TCRU website could be widely disseminated to all relevant organisations.