SAFE AND SOUND
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CLEAR THE AIRWAYS
How increased asthma awareness saves lives

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MOVICOL® Paediatric Plain and MOVICOL® Paediatric Chocolate are the only oral treatments licensed for chronic constipation in children aged 2 to 11 years old and for faecal impaction in children aged 5 to 11 years old.

**NEW**

MOVICOL® Paediatric Plain and MOVICOL® Paediatric Chocolate are the only oral treatments licensed for chronic constipation in children aged 2 to 11 years old and for faecal impaction in children aged 5 to 11 years old.

References
2. MOVICOL® Paediatric Plain Summary of Product Characteristics.
3. MOVICOL® Paediatric Chocolate Summary of Product Characteristics.
Symptoms indicating shifts of fluids/electrolytes treatment should be stopped for use: Diagnosis of impaction should be confirmed. If patients develop any hypersensitivity to macrogol or any of the excipients. Intestinal tract, such as Crohn’s disease, ulcerative colitis and toxic megacolon. Functional disorders of the gut wall, ileus, severe inflammatory conditions of the intestinal tract or obstruction due to structural or impaction in children with cardiovascular impairment or renal insufficiency. Doses (SmPC) for full dosing recommendations. Not recommended for treating faecal impaction in children aged 5 to 11 years old. Treatment needs to be for a prolonged period (at least 6 months). The maximum dose needed does not normally exceed 4 sachets a day. Treatment escalation: Faecal impaction: Escalating dose regimen starting with 4 sachets/d for the treatment of chronic constipation in children aged 2 to 11 years old and MOVICOL® Paediatric Plain and MOVICOL® Paediatric Chocolate are the only oral treatments licensed for chronic constipation in children aged 2 to 11 years old. Movicol Paediatric Choc JSPHN advert. 210 x 297mm. CMYK. May 2013.

Presentation: MOVICOL® Paediatric Plain and MOVICOL® Paediatric Chocolate are the only oral treatments licensed for chronic constipation in children aged 2 to 11 years old. The usual starting dose is 1 sachet twice daily to treat faecal impaction, use with caution in patients with impaired gag reflex, reflux oesophagitis or diminished levels of consciousness. The dose should be adjusted up or down as required to produce an effective laxative effect. The dose for children aged 7-11 years. The dose should be adjusted up or down as required to produce an effective laxative effect. The dose for children aged 7-11 years.

Dosage and administration: The dose for children aged 7-11 years. The dose should be adjusted up or down as required to produce an effective laxative effect. The dose for children aged 7-11 years.

Dose for children aged 5-11 years: The dose should be adjusted up or down as required to produce an effective laxative effect. The dose for children aged 7-11 years.

For the treatment of chronic constipation in children aged 5-11 years. The dose should be adjusted up or down as required to produce an effective laxative effect. The dose for children aged 7-11 years.

The doses (SmPC) for full dosing recommendations. Not recommended for treating faecal impaction in children aged 5 to 11 years old. Treatment needs to be for a prolonged period (at least 6 months). The maximum dose needed does not normally exceed 4 sachets a day.

Uses: For the treatment of chronic constipation in children aged 2 to 11 years old and MOVICOL® Paediatric Plain and MOVICOL® Paediatric Chocolate are the only oral treatments licensed for chronic constipation in children aged 2 to 11 years old. The usual starting dose is 1 sachet twice daily to treat faecal impaction, use with caution in patients with impaired gag reflex, reflux oesophagitis or diminished levels of consciousness. The dose should be adjusted up or down as required to produce an effective laxative effect. The dose for children aged 7-11 years.

Movicol Paediatric Choc JSPHN advert. 210 x 297mm. CMYK. May 2013.

Pharmaceutical Particulars: Do not store sachet above and peripheral oedema.

Interactions:

Adverse events should be reported. Reporting forms and data on use in pregnancy and lactation, and should only be used if considered essential.

Reactions related to the gastrointestinal tract are the most common and include vomiting, dyspepsia, diarrhoea, flatulence, borborygmi and anal discomfort. Allergic reactions, including anaphylactic reaction, angioedema, dyspnoea and skin reactions can occur. Other effects can include electrolyte disturbances, headache, dizziness, malaise, myalgia, nausea, abdominal pain, abdominal distension, oedema, hyperkalaemia and hypokalaemia. A minority of patients may experience changes in renal function, e.g. renal impairment, renal failure, hypertension, increased blood urea and/ or creatinine.

References

1. Now with 2. MOVICOL

Legal Category: POM. Cost: 30

Licensing and legal category: MOVICOL Paediatric Plain  PL 20011/0005, MOVICOL Paediatric Chocolate PL 20011/0004.

Diary dates & Noticeboard

Norgine Hospital admissions for asthma treatment peak every autumn. Angela Jones from Asthma UK explains how school nurses can help to reverse this worrying trend.

Meet some of the talented young carers who recently won a prize for their designs. Simon Blake also introduces you to the Children and Young People’s Health Outcomes Forum.

Strategic planning can help to provide a more efficient and effective school nurse workforce. Michael McGechie believes the School Nursing Service Planner can assist.

SAPHNA’s professional officer Sharon White details some of the key actions implemented by the organisation recently.

The Children and Young People’s Health Outcomes Forum also introduces you to up and coming young carers who recently won a prize for their designs.

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Time flies when you’re having fun, so they say, and I have to agree. It’s hard to believe that I’m already introducing the second edition of our journal to you! Our first issue was received so positively, with wonderful comments, encouragement and, as you will read, amazing contributions coming our way. Thank you and please do keep them coming.

The role of school and public health nursing is itself multi-faceted and our aim is to continue responding to this by featuring a broad array of contemporaneous and reflective articles.

As such, our leader article on page 10 focuses on the recent and numerous child sexual exploitation cases and also considers the potential role of multi-agency safeguarding hubs (MASH) in helping professionals protect children and young people. Alongside this we remind ourselves of the paramount importance of providing children and young people with quality sex and relationship education (SRE) so that they too are equipped with the knowledge and skills to help empower them to protect themselves (p20).

Recognition is finally being given to the rising challenge of young people’s emotional health and well-being, which can be a real cause of concern. We explore this further by exploring the best ways to manage individuals displaying self-harm behaviours (p14).

SAPHNA regularly receives requests for help and guidance in commissioning and designing services, so we have responded to this with an introduction to the School Nursing Service Planner and in this issue we explore its impact to date (p30). We’ve also always been extremely active on our members’ behalf and so in our regular “You said, we did” feature, we outline some of the positive outcomes of this work, which has included connecting with some amazingly talented young carers (p29 & p33).

Our new membership joining fee offer of £50/year will soon expire so please do sign up soon. Don’t forget, this is then deducted from the fee for our annual conference on October 8th; take a look at our programme on page 5 and you can see for yourself what a great line up we have.

Finally, with the school holidays almost upon us, Asthma UK reminds us how a lack of medication compliance over the summer break results in increased hospital admissions and, tragically, in death. It calls upon parents and healthcare professionals, including school nurses, to help raise awareness of its new campaign by distributing My Asthma packs. The aim of these packs is to help children improve self-management of their asthma over the summer months. We hope the campaign is successful and the new figures released later in the year show a downward trend.

Enjoy the summer break – we hope the sun shines on you in more ways than one!

sharon@saphna-professionals.org
Twitter: @SaphnaSharon

Executive board members

Helen Ross
Chairperson
Lead for school nursing and the National Child Measurement Programme for Central Essex Community Services

Sharon White
UK professional officer for the School and Public Health Nurses Association (SAPHNA)
Formerly consultant nurse for looked after children, Leeds Community Healthcare

Jill Beswick
Healthy child pathway manager
Stockport Foundation Trust

Babs Young
Secretary
Health visitor, Kent

Sally Norfolk
Treasurer
Retired school nursing manager

Betsy Allen
Professional lead for school nursing and nurse for children
Integrated Children’s Services, Virgin Healthcare, Devon

Penny Greenwood
Nurse consultant public health
Barnsley Metropolitan Borough Council

Elaine Davies
Public health school nurse
Northumbria Healthcare NHS Foundation Trust, North Shields team

Veronica Hetherington
SAPHNA website editor
Lead public health school nurse, Northumbria Healthcare NHS Trust

Jane Walton
Immunisation and screening coordinator
Public Health England

All of these people come from a variety of nursing backgrounds and currently work across a broad spectrum of public health nursing roles and are committed to the success of the association.

Further information
Please contact Sharon White, Babs Young or any other board member if you require any further information about the association or wish to become active.

Email SAPHNA at:
info@saphna-professionals.org
The School and Public Health Nurses Association Annual Conference:

Enabling School and Public Health Nurses to rise to the changing needs of children and young people

Date: Tuesday 8th October 2013
Venue: Austin Court, Birmingham

£50 off delegates rates for SAPHNA members

Speakers include:
Sharon White Professional Officer, School and Public Health Nurses Association
Jo Yarwood Programme Manager for Immunisations, Department of Health
Jenny Rankin and Sandra Williamson School Health Nurses, Virgin Care
Jess Streeting SCPHN QN Nurse and Practice Lecturer, Central London Community Health Care Trust
Jimmy Endicott Mobile Media Development Manager, and Maggie Clark Senior School Nurse, Leicestershire Partnership NHS Trust
Betsy Allen School Nursing Lead, NHS Devon
Jill Beswick Healthy Child Pathway Manager, Child and Family Business Group, Stockport NHS Foundation Trust
Wendi Murphy Managing Director, Children & Young People First
Wendy Nicholson Professional Officer for Nursing (School Nursing), Department of Health

For full programme details and booking options visit www.pavpub.com
More than 60% of parents believe their child’s primary school does not provide water throughout the day, new research by the National Hydration Council (NHC) and Netmums has revealed.

Additionally, 64% of parents of the 1,000 surveyed said that water is banned from the classroom and 73% said there is no access to water via water fountains. This goes against Department of Education guidelines, which state local authorities must ensure pupils have access at all times to free, fresh drinking water on school premises.

Parents also said that their children were thirsty when they got home from school in 69% of cases, while just under half (43%) said they noticed signs of dehydration in their children, such as tiredness and irritability.

Nutritionist and advisor to the NHC, Dr Emma Derbyshire, said: “It is concerning that so many parents have said they don’t think their children are drinking enough fluid throughout the day. However it was reassuring to learn that 80% of parents said they would like their children to drink more water, as this is the ideal choice for regular hydration as it contains zero sugar, calories, preservatives or additives.”

Despite the findings, 91% of parents accept chief responsibility for their children’s hydration habits. However, almost two-thirds (63%) didn’t know how much fluid their child should be drinking.

Recent research by Dr Caroline Edmonds, senior lecturer at the School of Psychology, The University of East London, suggests that children who receive additional water could improve their ability in key classroom activities such as handwriting and copying text, as well as maintaining their attention.

The National Hydration Council and the British Nutrition Foundation (BNF) last year produced guidelines on healthy hydration called a ‘Children’s Hydration Glass’. This is available to download from www.naturalhydrationcouncil.org.uk

YoungMinds to kick start mass movement for change in mental health

Charity YoungMinds is looking to improve the mental health of children and young people in the UK by starting a mass movement for change.

This is the charity’s most ambitious campaign to date, and is supported by Comic Relief and the Big Lottery Fund. The new funding will allow YoungMinds to improve the mental health of young people by establishing a number of new initiatives, including:

- the creation of a national charter for change for children and young people’s mental health which will be backed by thousands of young people and hundreds of health, children and young people’s organisations
- the formation of a young activists network, which will do everything from delivering training to healthcare and childcare professionals, to running local mental health task groups
- allow young people to directly influence local structures and influence how mental health services are run where they live and effect real substantive change.

Sarah Brennan, chief executive of YoungMinds said: “This is our most ambitious campaign ever and will build on our ever-expanding online and social media networks.

“Over the last few years the barriers around talking about mental health have started to be broken down. Now people are starting to talk about mental health the time is right to deliver the change that is so badly needed for children and young people across the UK.

“Every day we hear about the unprecedented toxic climate children and young people face in a 24/7 online culture where they can never switch off. Cyber bullying and sexting, bleak employment prospects and a society obsessed with body image are creating a negative environment around children and young people.

“YoungMind’s ambition is to create a movement among children and young people that champions their voice and seeks to deliver change that improves the support for their mental health and emotional well-being.”

The campaign follows on from recent research by the National Union of Students, which found that a fifth of students in higher education consider themselves to have a mental health problem, while 13% have suicidal thoughts.

Development work is currently underway with young people across the UK taking part in online surveys and focus groups. To register your interest in the campaign email YMcampaigns@youngminds.org.uk
Government launches looked after children consultation

The government has launched a consultation on amendments to the Care Planning, Placement and Case Review (England) Regulations (2010), with the aim of improving safeguarding of looked-after children placed out of authority.

The proposals take on board recommendations made in the report of the Expert Group on Children’s Homes Quality, published earlier this year. These include ensuring that all agencies in the area where a child will be living have an awareness of the child’s needs and, where appropriate, understand their contribution to supporting the child.

Additionally, the government wants to ensure that children are only placed at a distance once there has been sufficient scrutiny to establish that this option represents an appropriate response to their needs.

The consultation also seeks views on the proposal on ceasing to provide care for 16- and 17-year-old looked-after children, but not until it has been approved and signed off by the director of children’s services.


Supermarkets urged to adopt new food labelling system

The government is urging all supermarkets and food companies to adopt a new food labelling system, which will make it easier for consumers to know what they are eating in line with guideline daily amounts (GDAs).

The traffic light system being adopted has already proved popular as it allows consumers to know the dietary levels of foods at a glance. It will now be on the front of packs and be consistent, ensuring consumers know where to look and what to look for when purchasing food. The system provides data on how much fat, saturated fat, salt, sugar and calories are in the food.

The food labelling system is currently voluntary and has a 60% take up of users, including major supermarkets such as Tesco and Waitrose and large companies including Nestle and Pepsico food manufacturers.

It is hoped that the new guidelines will be beneficial to parents wishing to choose healthier food options for their children. High levels of obesity in schoolchildren have been linked to the consumption of processed foods and a lack of exercise.

Siân Burton, honorary chairman of the British Dietetic Association, said: “The British Dietetic Association wants consumers to have access to clear, consistent, at glance information to help them to make informed choices about the food they buy and eat. Consumers need a quick understanding of the relative healthiness of a product. We welcome today’s development by the government about front of pack labelling. This is a significant step forward.”

New board game on health issues launched

A new free board game has been created by Public Health England (PHE) to teach young people about health issues.

The game, called Zones, encourages children to think and talk about health issues that affect them growing up, and help them to make informed decisions.

Zones can be played by three teams with up to four young people (aged 11+) per team and is facilitated by a youth leader or youth worker. Teams race around the board and back to their home zone by completing a number of challenges and battles against other teams.

The challenges range from fun team building activities, through to myth busting and serious discussions about smoking, drinking alcohol, drugs and sex and relationships. The game encourages players to think about the consequences behind the choices they make, without normalising or glamourising the issues.

Helen Antoniou, senior youth worker, Zone Youth Project, said: “Zones enables young people to discuss sensitive subjects without feeling embarrassed … it teaches valuable life skills in an informal way, making it both unique and fun!”

To order a copy of Zones call the PHE order line on 0300 123 1002 and quote product number 2900915.
The National Children’s Bureau (NCB) is encouraging young people to help shape health and social care services by sharing their experiences of the systems.

To encourage young people to do so, the NCB has published a new resource for local Healthwatch bodies called *Bringing Children and Young People to the Heart of Healthwatch* (2013). This presents the lessons learned from a three-year project that worked with 75 Healthwatch Pathfinders and LINKs (the patient involvement scheme that preceded Healthwatch) to find effective ways of involving children and young people in local health and social care services.

The resource presents creative ways to engage with children and young people and effective ways of getting their views, such as making meetings more interactive than the traditional table-bound gatherings, and using a variety of communication tools from social media to face-to-face chats.

Dr Hilary Emery, chief executive of the National Children’s Bureau said: “By listening to children and young people we can improve health and social care services for them, but all too often there is a failure to provide an engaging and relevant way for them to give their views. Through working with children and young people this resource has been developed to provide local Healthwatch bodies with inspirational ideas and practical suggestions on effective communication and working together. We hope it will encourage these new patient involvement bodies to listen to and respond creatively to the needs of their local children and young people.”

*Bringing Children and Young People to the Heart of Healthwatch* is available from: www.ncb.org.uk/healthwatch

**Peanut allergy breakthrough, claim scientists**

Scientists believe a patch could save the lives of people with peanut allergies – and potentially allow them to eat the food in the future.

The patch, which is worn on the back or arm, allows miniscule amounts of peanut protein to seep through the top layers of skin. As the amount of protein is small, it is not enough to trigger an allergic reaction when it reaches the immune system.

Instead, the immune system learns to recognise the protein, meaning tolerance can be built up over a period of time.

Trials are currently taking place with more than 200 patients with a severe peanut allergy. Early results have indicated that even those aged five to 17 with a severe allergy can build up a tolerance after wearing a patch for 12 to 18 months. After 12 months, 20% of children were consuming more than ten times the amount of peanut protein they were able to tolerate at the start of the study. By 18 months, this had risen to 40%.

Researcher professor Christophe Dupont, from the Necker Hospital in Paris, said: “The change in peanut consumption represents an important improvement in the quality of life of these patients.”

The Anaphylaxis Campaign provides information on anaphylaxis to health professionals at www.anaphylaxis.org.uk/healthcare

**Female genital mutilation advice line launched**

After discovering that more than 70 women and girls as young as seven seek treatment every month, the NSPCC has launched a helpline to protect UK children from female genital mutilation (FGM).

FGM is a form of child abuse common to some African, Asian and Middle Eastern communities in the UK. This illegal and life-threatening initiation ritual can leave young victims in agony and with physical and psychological problems that can continue into adulthood.

Carried out in secret and often without anaesthetic it involves the partial or total removal of the external female genital organs. Victims are usually aged between four and 10, but some are babies.

Anyone who is worried about a child being or has been a victim of FGM can contact 0800 028 3550 for information and support.
Youth Self-harm and Suicide Awareness

A reflective practice training pack

By Jude Sellen

Key features
Piloted training programme; written by an expert trainer; includes two full-day modules and three optional workshops; underpinned by a framework of reflective practice and Transactional Analysis; DVD-rom with all the course materials

About the resource
Research shows that while staff find training courses that provide facts and figures about self-harm and suicide useful, such training does little to build their confidence when working with young people. In addition to exploring key facts and research, Youth Self-harm and Suicide Awareness seeks to recognise the importance of acknowledging attitudes and encourage workers to understand how their attitudinal stance impacts their work with young people who self-harm or feel suicidal.

The core training comprises two full-day modules: module one introduces self-harm in young people and module two expands on this learning by examining more closely working with young people who self-harm. Both modules are underpinned by a framework of reflective practice and a basic application of theories from Transactional Analysis.

The training manual also includes three optional youth suicide awareness workshops, which can be run together as a full day’s training. The purpose of the workshops is to increase participants’ knowledge and understanding about youth suicide and to look at developing local youth suicide prevention guidelines and support within local areas and organisations.

Contents include
- About the author and acknowledgements
- Introduction
- Module 1: An introduction to self-harm and young people
- Module 2: Working with young people who self-harm
- Three workshops on suicide awareness
- Resources

Vital information for
- Trainers
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- Therapists and counsellors
- Anyone working with children and young people

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Time to act

Victims of child sexual exploitation and street grooming are still being failed, despite a series of high-profile prosecutions. School nurses play a crucial role in identifying children at risk, but are sometimes overwhelmed by the lack of time and resources. However we believe it is everyone’s collective responsibility, not just designated professionals, to help protect children.

Child protection isn’t the preserve of specialists; it’s the duty of every individual and of society in general,” said Peter Davies, chief executive of the Child Exploitation and Online Protection Centre (CEOP) at the recent launch of its annual Threat Assessment of Child Sexual Exploitation and Abuse.

His message was a timely one given last month’s Home Affairs Committee report (2013) that reinforced the perception among health professionals and the public that child sexual exploitation and street grooming are increasingly a “large-scale nationwide problem”, and that victims are still being failed by the services that are supposed to protect them. The recent publication of the Jillings report has only served to highlight this further.

The committee laid the responsibility for these failings squarely with police forces, social services and the Crown Prosecution Service (CPS).

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Dan Parton, editor of Mental Health Today & Penny Hosie, editor of JSPHN

Following the Home Affairs Committee report, the NSPCC called for “a culture change among the police, CPS, judiciary, and all child protection professionals”. However this journal believes it should go even further and that the public should also share in the collective responsibility and awareness of abuse – and have the courage to report it.

The Savile effect

Child sexual abuse now has a higher public profile than it’s arguably ever had, and this is partly down to the Jimmy Savile case. The details of the alleged extent of his abuse may have been shocking but many felt it was a “watershed moment”.

Indeed, one result of the publicity generated by the case is that it has given more victims the courage to come forward to testify. In early June, it was reported that...
there has been a nine per cent surge in victims reporting child abuse since the Savile case broke (BBC, 2013).

Since then revelations about children's care homes have also come to light. Tom Watkins, the Labour MP for West Bromwich East, bravely came forward in Parliament to ask questions that helped reopen the criminal investigation into historic abuse in care homes in north Wales, which subsequently led to more revelations of systematic abuse all around the country. Unfortunately, the abuse appears to have continued in some places.

**North Wales – the evidence comes to light**

Earlier this month the Jillings report (2013) into the abuse in north Wales care homes, was published, 17 years after the original report was compiled. Never published at the time, the report has only been released following a freedom of information request by the BBC.

Currently 140 people have come forward to say they were victims of serious abuse, which ranged the gamut from physical and emotional to violent sexual abuse. There are some unnerving parallels with the child protection failures we are witnessing today.

“[John] Jillings [the report’s author] comments that the interests of children were often sacrificed by the very professionals who should have been looking after them. And when the young victims tried to raise the alarm people turned a deaf ear to their pleas for help. He recently told the BBC that: “They didn’t have regular supervisory visits from headquarters staff, as I understand it. Or if they did, they weren’t very searching.

“So the staff for 99% of their time were on their own with the children, could treat them as they wished. “They regarded them as children who were out of control and they thought the way of dealing with that is by severely treating them.

“The treatment of children was bestial really; they weren’t treated like human beings, by some members of staff at any rate.

“I mean some children died, 10 children died. Some of them committed suicide.”

Speaking of the report Peter Wanless, the NSPCC’s chief executive, said: “This report comments on appalling child protection failures that took place nearly 40 years ago but could just so easily be commenting on dreadful events happening today.

“While some things have improved – particularly for those in care – there is a depressing realisation that in some areas nothing has moved on.

“The same mistakes have been highlighted in recent grooming cases where young girls were abused in sickening ways for many years while those who could and should have helped stood by, leaving them to their awful fate.

“While Jillings is concerned with what went on from 1974 to 1993, we have to ensure this kind of abuse does not cast its long shadow over children today. We can only prevent it by giving children confidence to speak out, paying attention when they tell us they need protection and moving swiftly to justice – so 40 years down the line we do not find ourselves in this invidious situation again.”

**Serious safeguarding failures**

Aside from Jillings, the recent criminal investigations into grooming cases in Oxford and Rotherham have grabbed the headlines – because of the horrendous details of the children's experience, and importantly because the victims gave testimonies. These cases highlighted serious safeguarding failures by the authorities, who again effectively turned a blind eye to the abuse. This abuse was allowed to continue, despite persistent alarms being raised by members of the public and worried parents, and also by the victims themselves (some of whom were as young as nine years old).

This failure to prevent the abuse is again one of the most disturbing aspects of these cases. It appears the health professionals were also guilty of not listening because they had dismissed the girls as ‘troublemakers’, rather than vulnerable victims. (NSPCC)

They had fundamentally failed to recognise this simple fact, voiced by Anne Marie Carrie, Barnardo’s chief executive: “Everyone coming into contact with vulnerable teenagers needs to remember they are children too, and cannot consent to their own abuse.”

Indeed, the recent case in Oxford, where seven men were convicted of involvement in a major sex trafficking ring, showed just how vulnerable children can be. Some girls as young as 11 were groomed with gifts before being subjected to horrific abuse by the men who they thought were their friends.
**Could MASH improve methods of integrated working?**

Two common themes running through the recent high-profile cases is the failure of services to communicate with one another about concerns over the young people involved, or to intervene early enough.

One potential answer to these problems is the multi-agency safeguarding team (MASH). In these, professionals from a range of services involved in child protection, including social care, school nurses, GPs and police, among others, come together to provide advice and information on safeguarding matters, deal with referrals, identify current information on vulnerable children, and provide an initial rating on assessed levels of risk. The team can then decide appropriate action and allocate cases accordingly. This process includes providing “pertinent information” and guidance to operational staff, but means that some of the detail may remain confidential within the MASH team.

This was trialled in Devon County Council, but has since been rolled out across many other local authorities, including a pan-London MASH project involving 32 boroughs.

While integrated approaches to child protection have been tried before – and failed – there are hopes that MASH could provide an effective way forward because of the way that it brings people from different agencies together.

“We shouldn’t just do what we did before,” said Briony Ladbury, who runs Safeguarding First and is an independent health consultant for the NHS. “We should be thinking about doing the right thing this time. To health professionals this does not threaten existing NHS systems. It’s not a takeover. It’s there to get a quicker reaction to the children’s needs coming through the MASH. If a health professional has a query about whether there is a risk to a child or a need to a child that has to go through the multi-agency risk assessment planning process, then they can exercise their own professional judgment; use their designated and named professionals for the advice they would normally have and then it goes into the MASH system.”

Detective superintendent Richard Henson of the Metropolitan Police, who is leading on a pan-London MASH involving 32 boroughs, added: “Analysis allows us to identify repeat victims and have proper interventions and profiling. Who is that person who seems to be moving around the place? Allows us to identify repeat victims and have proper interventions and profiling.”

Analysis of where the child/young person is living. They would discuss the quality, safety and suitability of where the child/young person is living. They would consider any risk factors, behaviours and indicative/worrying signs regarding the child, such as going missing or staying out beyond agreed times.

The failures in Rochdale were widespread. Indeed, the trial had only gone ahead because the chief prosecutor for Northwest England, Nazir Afzal, had overturned a previous decision to drop the case.

But Labour MP Keith Vaz, chairman of the committee, was adamant that those who fail to take action must be held to account: “Officials who fail to act, for example in places like Rotherham or Rochdale, must not be allowed to evade responsibility through early retirement or resignation for other reasons and should not be paid compensation of any kind.”

The MPs also backed the introduction of video-recorded cross examination of child victims to make it easier for them to give evidence without being distressed by appearing before a live court session.

A few of the victims were brave enough to speak up in court, only to have their evidence ridiculed by top barristers representing the abusers. One of them was so traumatised by the ordeal that she subsequently committed suicide.

Sadly, the Home Affairs Committee’s report added that these scandals may not be the last: “Despite recent criminal cases laying bare the appalling cost paid by victims for past catastrophic multi-agency failures, we believe that there are still places in the UK where victims of child sexual exploitation are being failed by statutory agencies.”

‘Failed twice’

The report also said that social services directors around the country must take direct responsibility for properly investigating allegations. This must include ensuring that their staff treat exploited girls as victims, rather than collaborators who had given their consent to enter a life of sex trafficking and prostitution.

Rochdale and Rotherham councils were singled out by the committee for criticism, saying both had failed to grasp the seriousness of the problem and had been “inexcusably slow” to realise what had been going on in their areas, thanks “in large part to a woeful lack of professional curiosity”.

Barnado’s Carrie summed this up neatly: “Victims of child sexual exploitation are being failed twice, once by the failure to prevent them becoming victims in the first place and again by the failure to take swift action once that abuse has come to light.”

**Looked after children are vulnerable**

Many of these children were ‘Looked after children and young people’ under the care of the local authority. Looked after children are known to be even more vulnerable to child sexual exploitation and, due to their desired need for love, affection and a sense of belonging, they are easy victims for child ‘groomers’ often responding naively to being showered with gifts, attention and praise – known tactics of those who exploit (Barn et al, 2005).

Looked after children, are, by law, required to have six monthly in-care reviews. This involves meeting a number of multi-agency professionals, who would discuss the quality, safety and suitability of where the child/young person is living. They would consider any risk factors, behaviours and indicative/worrying signs regarding the child, such as going missing or staying out beyond agreed times.

The failures in Rochdale were widespread. Indeed, the trial had only gone ahead because the chief prosecutor for Northwest England, Nazir Afzal, had overturned a previous decision to drop the case.

But Labour MP Keith Vaz, chairman of the committee, was adamant that those who fail to take action must be held to account: “Officials who fail to act, for example in places like Rotherham or Rochdale, must not be allowed to evade responsibility through early retirement or resignation for other reasons and should not be paid compensation of any kind.”

The MPs also backed the introduction of video-recorded cross examination of child victims to make it easier for them to give evidence without being distressed by appearing before a live court session.
‘Patterns of abuse’
The MPs said also there was a public perception that abusers were Asian and the victims were white – but emphasised that the full picture was more complicated.

“There is no simple link between race and child sexual exploitation,” the report said. “It is a vile crime that is perpetrated by a small number of individuals, and abhorred by the vast majority, from every ethnic group.

“Authorities should not focus on just one model of child sexual exploitation to the exclusion of others or they will become blinded to other patterns of abuse taking place.

“Stereotyping offenders as all coming from a particular background is as likely to perpetuate the problem as is a refusal to acknowledge that a particular group of offenders share a common ethnicity.”

‘Culture change’ needed
Labour’s shadow crime and security minister, Diana Johnson, said no one who read the committee’s “truly shocking” report could be “in denial about the extent or horrific nature of child sexual exploitation in the UK”.

“What is vital now is that these recommendations are not lost;” she added, calling for “an expert-led review to produce clear and co-ordinated recommendations across government”.

David Tucker, NSPCC head of policy, added that there needs to be a “culture change” among child protection services: “The victims in recent child sexual exploitation cases were too often ignored or treated as troublemakers.

“There now needs to be a culture change among police, CPS, the judiciary, and all child protection professionals, so they better understand how grooming gangs operate, and how young people’s behaviour could be a sign they are at risk of, or suffering, sexual exploitation.”

He also called for “tougher action against predatory sex offenders who target the most vulnerable children, including sentences that reflect the seriousness of the crimes committed and act as a strong deterrent.”

Government needs to act
There are hopes that these cases may lead to some lasting change. Peter Saunders, of the National Association of People Abused in Childhood, said:

“This report does give me a bit of hope because it is actually insisting that the government act to make things happen.

“The other thing that struck me very very powerfully in the report was that they consider and they know that children are still in huge danger today and that some of these areas and the local authorities in these certain areas are not acting to protect our little ones and it’s got to stop.”

Saunders is right: it has to stop. Everyone – not just those involved in providing services to children but the general public – has to take responsibility and act when they suspect vulnerable children and young people are in danger. Scandals such as Oxford and Rotherham should never be allowed to happen again.

References


One shoe...
In our next issue, we will launch our “One shoe” safeguarding campaign in association with the Journal of Family Healthcare. “One shoe” is about speaking up for children, giving them a right to be heard, to be listened to and to be looked after properly. So they feel safe and sound, always. Without that feeling of security children are damaged, childhoods are lost. The aim of this campaign is for everyone to be collectively responsible for safeguarding children, but we need school nurses to to be instrumental in driving this campaign for school aged children and young people forward. The campaign will be supported not just by SAPHNA, but several leading charities.
Out of harm’s way?

The number of self-harm cases reported to the authorities has nearly doubled in 10 years. Yet school nurses are often in an ideal place to identify and work with young people who self-harm, reports Robert Mair.

Approximately 180,000 young people aged 15 and older attend hospital due to self-harm every year (YoungMinds, 2013a), while in December 2012, ChildLine reported a near 70% rise in calls on the issue of self-harm over the previous 12 months (YoungMinds, 2012). This led the charity YoungMinds to label self-harm as the fastest rising risk to young people’s physical and mental health and call for greater support for parents, teachers, carers, school nurses and GPs. Self-harm usually starts in the early to mid teenage years (13-19) with girls having greater self-harm tendencies, although in recent years more boys have adopted these behaviours (Meltzer et al 2002).

New NICE guidelines

The National Institute for Health and Care Excellence (NICE) responded in July by guidance to ensure services selected by commissioners meet the needs of people who self harm. (NICE, 2013).

Robert Mair, Deputy editor, JSPHN

This goes some way to addressing the issue, meaning children identified can seek help and will know where to turn to for advice, but there are still underlying issues that this guidance may not answer.

A poll by YouGov for charity Mindful found that nearly one in 3 young person self-harms, while on average, if someone approached a health professional for help, if they spoke to more than one person, they ended up speaking to people 22 times before they got help (MindFull 2013).

A report carried out late last year by YoungMinds and Cell Group (2013b) found that:

- Three in four young people don’t know where to turn to talk about self-harm
- A third of parents would not seek professional help if their child was self-harming
- Almost half of GPs feel that they don’t understand young people who self-harm and their motivations
- Two in three teachers don’t know what to say to young people who self-harm (2013b).
Case history: Chris’s story*

Chris came to see the school nurse at a drop-in session at the school. A member of staff had referred Chris to the drop-in as she had been cutting herself.

After talking to Chris on a one-to-one basis, the school nurse made a referral to CAMHS. While Chris was waiting for an appointment to come through, she was seen by the school nurse on several occasions where she was able to talk about the self-harming and about her feelings. The discussions that Chris and the school nurse had were in relation to the self-harming, duration, type and frequency. This was done in a ‘safe’ environment of the drop-in, where she was given time and space to work out some practical solutions to her feelings and patterns of self-harming. It was an important part of the sessions to let Chris know that she was not a failure and that she may have setbacks. It was necessary for her to realise that the self-harming was her coping strategy and she couldn’t expect to solve it overnight, but that any discussion about it hopefully would help and give her encouragement to go on.

She was a very angry young woman who had some feelings of paranoia and felt everyone was talking about her behind her back and finding fault with her.

The school nurse avoided rushing in with ‘advice’ and asked open ended questions to try and encourage Chris to discuss things; for example ‘And how did that make you feel?’ or ‘What do you think about that?’

When Chris found it difficult to talk, the school nurse mirrored Chris’s body posture and voice tone to show empathy with her and also tried to encourage Chris with plenty of head nods, gestures and words of encouragement.

Eye contact is also important and although this was difficult on the initial session it got easier on subsequent sessions.

The school nurse, on bringing the session(s) to a close, arranged another appointment and also said that she would think about what they had discussed before the next meeting and that if Chris wanted to think about what they had discussed before the next meeting as well that was all right. Depending on how the session had gone, the school nurse would suggest small tasks for Chris to do before the next meeting; for example, taking a long hot bath or massage for relaxation, and pampering herself. She suggested keeping a diary of feelings or writing things down in the form of a letter, story or poem if that would help.

*(NHS Solihull Care Trust, 2004)

A school nurse’s perspective

For a young person, self-harm may be a strategy to cope with whatever it is making them feel down (Wood 2009). Self-harming is a distraction from the real world, and may bring comfort to the individual by detaching their feelings from their body - so they can be separate from what has happened. It is a way of self punishment but also allows the person to have a level of control over their life. It is a physical act of expressing emotional pain and may relieve the pressure for a short time. It is also a way of asking for help although self-harmers are notoriously secretive and do not show off their injuries readily.

A young person may not ask for help because they may think it will only happen once or twice, they may think that they are not taken seriously or that their injuries are not serious enough to warrant help. Some may not have anyone they feel able to confide in or know how to contact the school nurse or professional. They may be worried about what others may think, that it might affect future choices or once their secret became public knowledge they would lose their only bit of control over their lives.

A school nurse can help the young person by listening to them. You don’t need answers, just give them time to talk. You cannot force them to talk; respect their feelings. Be clear and honest about the behaviour and express your concern; don’t make promises that can’t be kept, particularly about confidentiality or offer services which may no longer be available. Discuss harm minimisation and prevention of infection, and make sure they aren’t sharing cutting tools. If a wound looks infected, they should see their GP.

Barbara Richardson Todd (2013)
SELF-HARM

says Richard Pacitti from Mind in Croydon (Pacitti, 2013). In fact, school nurses should seek appropriate training to work effectively with young people who self-harm, as the situation can be challenging for both the student and professional [see box on page 17 for training opportunities].

Writing in Mental Health Today, Pacitti says that, although on the face of it, the new guidelines are dense and intimidating (they’re 414 pages long), there is plenty of good information within, considering self-harm is not a clinical condition.

He also highlights two clauses in particular which should provide practical help for health professionals:

- 10.4.8 Consider offering 3 to 12 sessions of psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm
- 10.4.9 Do not offer drug treatment as a specific intervention to reduce self-harm. (Pacitti, 2013)

The challenge, says Pacitti, is to find ways to effectively use the information put out by NICE to work with young people who self-harm, and not to look at them as a group who can’t be helped, or for which there are very few effective interventions. He also believes that a concrete definition of what is, or isn’t, classed as self-harm could help practitioners when devising treatment plans.

What is self-harm?

NICE defines self-harm as "self-poisoning or self-injury carried out by an individual irrespective of motivation" (NICE, 2013).

A concrete definition might help professionals, however. One of the past problems Pacitti argues is that self-harm has often been used as a catch-all term to include attempted suicide, which can be less helpful than it first appears as interventions aimed at reducing suicide can be conflated with interventions aimed at helping non-suicidal people who self-harm (Pacitti, 2013). This traditional view is very much at odds with many service user-led definitions of self-harm or self-injury. Here, the individual may not focus on the purpose of the act, while for others the purpose of the act is central – but it is often used as a coping mechanism – or, as Mr Pacitti says “attempted suicide is about wanting to die, whereas self-harm is about wanting to stay alive and trying to find methods to cope with life. Approaches that do not take these two different states of mind into account are unlikely to be effective.” (Pacitti, 2013)

Why do young people self-harm?

There may be a number of reasons why a young person harms: it could be academic pressure of either under or over achieving, peer group pressures, family difficulties such as family breakdown, entering into care, lack of social support, physical or mental illness, issues around sexuality, rape, abuse, issues with sexuality, arguing with family or friends, bullying, bereavement, domestic abuse, parental illness or poverty. (NICE 2004; Bancroft et al 1977).

Young people who deliberately self-harm have usually experienced four times as many stressful life problems in the six months before the act. The events may vary but recent quarrel with a girlfriend or boyfriend are common (NSFT http://www.

Box 1: Labels for self-harm

Self-harm can include:

- self-abuse
- self-inflicted violence
- parasuicide
- self-mutilation
- delicate cutting

(NHS Solihull Care Trust, 2004)

Box 2: Self-harm behaviours

Self-harm can include a number of different behaviours:

- burning
- hitting own body with fists or objects
- pulling hair
- picking at skin
- taking tablets.

Other activities which could be classed as self-harm are:

- abuse of alcohol, solvents or drugs
- smoking
- participation in unwanted or dangerous sex
- compulsive eating, starving, bingeing, etc.

(NHS Solihull Care Trust, 2004)
Harm-minimisation

Although clinical interventions might be somewhat limited, the NICE guideline does provide information on the ideas of harm-reduction and harm-minimisation – which might be much more achievable goals in the short term. The guidance says that staff should “consider strategies aimed at harm reduction; reinforce existing coping strategies and develop new strategies as an alternative to self-harm where possible; consider discussing less destructive or harmful methods of self-harm with the service user, their family” (NICE, 2013).

The benefits of this are two-fold. Firstly, it allows for incremental gains and ensures professionals feel like they are making a difference, rather than giving up on the young person. Secondly, it provides a focus on different outcomes, rather than simply stopping the behaviour, such as improved resilience, increased self-esteem or reducing the feelings of shame, guilt, hopelessness or isolation. Again, school nurses are ideally placed here to support young people, and can be seen as a dependable, discreet and accessible person who they can talk to.

Further information

http://www.youngminds.org.uk/training_services/training_calendar.

YoungMinds offers training to school nurses and health professionals on the topic of self-harm. The next self-harm training session is scheduled for October.

http://www.youngminds.org.uk/for_children_young_people/whats_worrying_you/self-harm/further_info

The YoungMinds website also has information on self-harm for young people.

References


NHS Norfolk and Suffolk, What’s the deal with deliberate self-harm? Available at http://www.whatsthedealwith.co.uk/great-yarmouth/teaching-material/deliberate-self-harm


This poem is by a young self-harmer called Rhian

Points of view

You think if you stitch me without anaesthetic it might put me off self-harming.

I think there are better ways of teaching me to respect my own body.

You think self-harm is a big problem.

I think if I didn’t self-harm I might kill myself.

You think I’m a waste of time.

I don’t feel like people have wasted much time trying.

You think I should stop self-harming.

I wish you would just listen to me.

You think I’m manipulating you.

Today you said you couldn’t manage me.

You think if you talk to me when I self-harm, I’ll stop.

I think ‘So what’s new?’

You think if you don’t talk to me when I self-harm, I’ll stop.

I think ‘What do you want from me?’

You think I’m attention-seeking.

You think I shouldn’t self-harm.

You think I’m a waste of time.

You think self-harm is not coping.

You think if I self-harm I might kill myself.

You think if you stayed with me, I wouldn’t have to.

You think if I didn’t self-harm I might kill myself.

You think if I didn’t self-harm I might kill myself.

You think I’m a waste of time.

I think if I didn’t self-harm I might kill myself.

You think if you stitch me without anaesthetic it might put me off self-harming.

I think if I didn’t self-harm I might kill myself.

You think if I self-harm I might kill myself.

You think if you didn’t stay with me, I wouldn’t have to.

You think if I didn’t self-harm I might kill myself.

You think if I didn’t self-harm I might kill myself.

You think if I self-harm I might kill myself.
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Let’s talk about sex

Although the policy makers recently voted against the new Clause 20, Brook continues with its vital task, highlighting the importance of sex and relationships education (SRE) in schools to safeguard children. Brook’s chief executive Simon Blake explains why SRE matters and highlights how the charity’s Traffic Light Tool can help professionals working with young people to identify child sexual abuse and exploitation.

We all want children and young people to have the best start in life, and to develop and grow with confidence, self-esteem and a strong and positive sense of their developing identity.

Helping young people to have safe and healthy lives

Providing children and young people with a comprehensive programme of sex and relationships education (SRE) which includes consent and contraception, together with easy access to sexual health services they trust provides the foundations for all children and young people, and is central to their health, well-being and identity.

Universal access provides the foundations for more targeted work to take place with those young people such as young people in care who are often more vulnerable to abuse, exploitation and harm outside of the classroom. School nurses or a member of the school health can play a key role here.

This article provides an overview of sex and relationships education, and then introduces Brook’s Traffic Light Safeguarding Tool for sexual behaviours.

I think of all the sex education lessons I’ve had, probably 60–70% of them have been about STIs. Young person, 15

The role of Brook

Brook is the UK’s leading provider of sexual health services and advice for young people under 25, with nearly 50 years’ experience of working with young people. This puts us in a powerful position to ensure that young people’s voices are heard both in and outside of Brook, by the people who make decisions about what services and education should be made available for them and by the people who provide those services.

Young people, sex and relationships education

Young people have been saying for decades that sex and relationships education in schools needs to be drastically improved and made more relevant to their lives (Sex and Relationships Education Fit for the 21st Century, 2011), specifically including more information about relationships. Currently SRE is patchy.

The coalition government consistently says that personal, social, health and economic education (PSHE) (and SRE as part of that) is important. Yet PSHE remains a non-statutory curriculum subject and official statutory guidance from government was last published in 2000.

This means that too often SRE is delivered by teachers who are not trained or who may feel embarrassed, and who don’t have any information about who or what resources are available to help them to plan, deliver and evaluate the quality of provision we all, including young people, want to be taking place as a normal and routine part of everyday school life.

What do young people tell us?

A report by the UK Youth Parliament found that young people felt that neither parents nor teachers were good at talking to them about sex and relationships. They wanted opportunities to talk about feelings and relationships, not just biology (SRE – Are you getting it? 2007).

What do parents tell us?

The majority of parents and carers support SRE in schools as this supports what many of them are already doing at home. Some however may not understand what SRE in schools is, and need to be helped to understand it is much more than contraception and sex.

Parents and carers might also be worried that they don’t have the most up-to-date information to pass on to their children and not all parents feel comfortable talking about sex and relationships with them.

What do teachers tell us?

Teachers who are trained and confident enjoy delivering SRE and see it as a vital part of their role. Those who are not feel embarrassed, unsure and can therefore lack confidence about what they can and cannot talk about in the classroom, or indeed how best to approach relationships and sex.

What does Ofsted tell us?

The recent Ofsted report (Not Yet Good Enough: Personal, social, health and economic education
in schools, 2013) also found PSHE education, and within that sex and relationships education, still isn’t good enough in many schools and sets out the key characteristics of outstanding PSHE education.

In addition to the benefits of protecting young people from harm and enabling them to have healthy relationships, the Ofsted report also highlights that outstanding PSHE education is linked to academic performance. PSHE education provides a strong foundation for pupils’ health, well-being and their wider lives and is why Brook would urge the Department for Education to provide strong leadership on this issue, and would encourage schools to follow the guidelines set out by Ofsted for delivering PSHE education.

My school didn’t offer SRE classes until Year 11, when I was 15 going on 16, by which time I was pregnant so it was too late. I wasn’t allowed to take part in lessons as the teacher said it wouldn’t be relevant for me, so I had to look elsewhere for information, which was often incorrect. I do not blame school for my decisions … but if I was taught SRE sooner and had honest, accurate information when I needed it, I would have made different choices. Young person, 18

Everyone has a role in supporting young people’s rights

Young people’s right to good quality education, information and health services is enshrined in the UN Convention on the Rights of the Child.

SRE is part of their wider rights and entitlements. The evidence shows us that comprehensive education about sex and relationships, both at home, at school and in the community; a more open attitude towards sex; and access to confidential young people friendly advice services are key to reducing teenage pregnancy and sexually transmitted infections (STIs).

School nurses have a key role in educating young people about sex and relationships. When this
SExUAL HEALTH

education takes place in a classroom setting you are working within the SRE policy of the school and a classroom is not confidential and young people need to know and understand this.

It is therefore crucial to signpost children and young people to the school nurse, counsellors, any on-site facilities and other sexual health clinics such as Brook so that young people know where they can go if they would like further information or to speak to someone in confidence.

Outside of the classroom school nurses often play a vital role in supporting children and young people through puberty, adolescence and into adulthood through one to one advice, signposting and support for all young people, as well as identifying, assessing and supporting those who may be at greater risk.

Identifying healthy and unhealthy sexual behaviours

With heightened awareness of risk of harm, abuse and exploitation increasingly Brook understood that professionals would like advice and guidance on the range of healthy and unhealthy sexual behaviours.

That is why Brook developed the Traffic Light Tool, an online resource for professionals to help them in identifying, assessing and responding to healthy and unhealthy behaviours.

My sex ed was really awful. The first time I had sex ed, we watched about half way through the video and our teacher said it was just too rude and fast-forwarded it. And then my teacher didn’t know how to put a condom on to a dildo. He messed up about three of them, and it was really awkward. Young person, 16

The Traffic Light Tool

This resource uses a ‘traffic light’ system of green, amber, or red to:

- categorise sexual behaviours
- increase understanding of healthy sexual development
- and distinguish this from harmful behaviour.

By using the Traffic Light Tool professionals can assess and respond appropriately to sexual behaviours and increase confidence in their decision making about whether behaviour is healthy and when action is needed. For children and young people who are displaying worrying behaviours professionals can help them get the support they need. For children and young people who are displaying ‘normal’ or healthy behaviours this can ensure they are given the correct messages to support the development of healthy sexuality.

Brook is working with multidisciplinary groups to deliver training including police, social workers, healthcare professionals, youth workers and teachers. By increasing understanding for all professionals working with children and young people we can ensure everyone is working to the same criteria and a unified approach is taken to safeguarding.

Further information

For further information about Brook please visit www.brook.org.uk or contact 020 7284 6040. Twitter @BrookCharity

The Traffic Light Tool is available free online at www.brook.org.uk/traffic-lights – we recommend training for all practitioners to help them use the tool most effectively. This can be provided for professionals and teachers in one school or across an area. Contact traffilights@brook.org.uk or call 0870 750 3082 for further information.

References


Exploring Children’s Rights

A participative exercise to introduce the issues around children’s rights in England and Wales

Key features:
Extensively revised and updated second edition; written by an expert with experience of leading training sessions on children’s rights; handbook with heading cards and multi-coloured flashcards.

About the resource:
Exploring Children’s Rights introduces key ideas about children’s rights in England and Wales by means of a participative activity, or exercise, that can be used for groups or individuals. This has been created using the author’s own experience of leading training sessions on children’s rights. Exploring Children’s Rights equips a group facilitator to lead sessions in:

- types of children’s rights
- power issues in relation to children’s rights
- the historical development of children’s rights
- current and past law on children’s rights.

The training guide offers three versions of the exercise: a group discussion version (1 hour 20 mins), a case histories version (1 hour 50 mins) and an individual activity (1 hour).

The training will be of interest to anyone who wishes to introduce the complex issue of children’s rights in an informative and challenging way. It is particularly relevant to teachers and trainers in the fields of education, health and social work, but is designed for use by anyone who works with children and young people and who has a real concern for promoting their rights.

Format:
A5 handbook (126pp) in polyprop presentation box with heading cards and multi-coloured flashcards and a CD-rom


Non-photocopiable

Children’s Rights and Counselling

A training exercise exploring children’s rights to counselling, current law, types of children’s rights and power issues relating to them

Key features:
Companion resource; written by an expert with experience of leading training sessions on children’s rights and counselling; wirobound book with printable flashcards

About the resource:
Children’s Rights and Counselling introduces key ideas about the rights of children and young people to access counselling in a range of settings. It identifies key rights held by children and young people in England and Wales to confidentiality and to access therapy alongside court proceedings. It links these rights to crucial ethical values and principles held by therapists, such as respect for client welfare, participation and autonomy.

This training pack equips a group facilitator to lead sessions in:

- types of children’s rights to counselling
- power issues in relation to children’s rights to counselling
- the historical development of children’s rights to counselling
- current law on children’s rights to counselling.

The pack can be used as a stand-alone training resource, or can follow on with preparatory training for participants on children’s rights, delivered using Exploring Children’s Rights. The latter covers important developments such as the Children Act (1989), the United Nations Convention on the Rights of the Child (CRC) (1989) and the Human Rights Act (1998).

The training offers two versions of the exercise: a group activity version (runs for 1 hour 30 mins) and an individual/pair activity (1 hour 30 mins).

Format:
A4 wirobound manual with CD-rom

Price: £35.00      Order code: E130     ISBN: 978-1-908993-40-3

Non-photocopiable

Vital resources for: Trainers, counsellors and therapists, health care professionals, social care staff, teachers, all those working with children and young people.

OFFER: Get both Children’s Rights titles by Peter Jenkins for only £75.00 quote REF: CR20
“These child asthma deaths are preventable”

With child asthma attacks peaking every September and several preventable deaths every year, school nurses are urged to act now to help prevent an asthma attack epidemic. Angela Jones explains how

There are 1.1 million children living with asthma in the UK, an average of two children in every classroom, making it the most common long-term condition for children.

Living with asthma can be a frightening experience for children and young people, worsened by a lack of understanding around the seriousness of the condition. A report called Missing Out by Asthma UK, the UK’s leading asthma charity, revealed how asthmatic children felt their condition meant they were ‘missing out’ or excluded from normal everyday activities, particularly at school (Asthma UK, 2009).

Asthma UK believes that, if well-controlled, asthma shouldn’t stop each child fulfilling their potential. However, every year, more than 25,000 children are rushed to hospital with an asthma attack¹, and in 2010, 16 children died as a direct result of asthma². Asthma UK estimates that 75% of these hospital admissions are preventable.

Hospital admissions can be especially distressing for a child, leading to missed school time and often with the child being accused by their peers of ‘skiving’ on their return.

Asthma UK aims to halve hospital admissions in the next five years, and we want to see a world where no child dies of asthma within the next 10 years. School nurses are integral to helping to make our plans a reality.

Asthma cases peak in the autumn

Every autumn when children return to school, there is an alarming peak in hospital admissions for children with asthma. This occurs in several countries, not just the UK, and typically peaks around two to three weeks after the school return. Studies show that children aged around six to seven years old appear to be the earliest and the most seriously affected (Sears & Johnston, 2007).

Some key risk factors

It is thought that a combination of risk factors may be responsible for the September spike in children’s hospital admissions for asthma. For example, the...
spread of colds and viruses, increased levels of stress, and exposure to triggers such as food allergies, dust and cleaning products can all exacerbate asthma symptoms when children re-enter the school environment. These can trigger symptoms such as coughing, wheezing, tight chest and breathlessness. Some children also describe their symptoms as having a ‘tummy ache’.

**Routines get out of synch...**

A key factor which Asthma UK is aiming to address this summer is a lack of adherence to medicines over the summer holidays. Families may fall out of their normal routines during the long summer break, which can mean that preventer medicines are neglected. For example, the child’s routine during term time might be to take their inhaler before breakfast every morning, but during the school holidays the child might skip breakfast altogether so their asthma routine is affected.

Children who have forgotten to take their regular preventer inhalers as prescribed over the summer will be at greater risk of having an asthma attack when they return to school. It is therefore vital that children are encouraged to take their preventer inhalers regularly, particularly in the run-up to the school return, so that their asthma routine is unaffected.

### What is asthma?

Asthma is a long-term medical condition that affects the airways – the small tubes that carry air in and out of the lungs. The most common asthma symptoms are coughing, wheezing, shortness of breath and a feeling of tightness in the chest. Children and young people with asthma have airways that are sensitive and can become inflamed and irritated when they come into contact with ‘asthma triggers’.

Everyone’s asthma is different and a child may have several triggers. Some of the most common triggers include cold and flu, dust, cigarette smoke, pollen, paint fumes, exercise, cold air and stress. In some cases, certain foods can trigger asthma by way of an allergic reaction, including peanuts, nuts, sesame, fish, shellfish, dairy products and eggs.

When a child or young person with asthma comes into contact with an asthma trigger, the muscles around the walls of the airways tighten so that the airways become narrower. The lining of the airways becomes inflamed and starts to swell. Often sticky mucus or phlegm is produced. These reactions lead to the symptoms of asthma.

### How to respond when a child has an asthma attack

**Step 1** Help the child to take their usual dose of reliever inhaler (usually blue) immediately, preferably through a spacer.

**Step 2**
- Sit the child upright and loosen any tight clothing
- Get them to take slow steady breaths
- Keep calm and reassure them
- Do not leave them alone

If their symptoms improve sit with them until they are completely well and can go back to their previous activity.

If their symptoms have not improved move on to step 3.

**Step 3** Continue to give two puffs of their reliever inhaler (one puff at a time) every two minutes, up to 10 puffs.

**Step 4** If the child does not start to feel any better after taking their reliever inhaler as above, or if you are worried at any time, call 999. Do not wait, treat it as an emergency.

**Step 5** If an ambulance does not arrive within 10 minutes repeat step 3 while you wait.

### My Asthma pack

To help improve self-management in children aged six to 12 years, Asthma UK has developed an innovative and award-winning resource for parents and healthcare professionals to use together with children called My Asthma. The free My Asthma pack aims to help children understand and engage in their asthma, using interactive calendars, stickers and postcards.

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3 Asthma UK surveyed 226 children aged between 5 and 18 years of age from across the UK. The questionnaire was completed online between 4–17 November 2011.
Case history: Valerie Smith and her son Thomas, 11

“Thomas’ asthma has affected his school life a lot. It was particularly bad when he first started school and he had to take a lot of time off. It didn’t help that the staff didn’t seem to know what they were doing. The secretary that organised the medication said she understood how to administer Ventolin but she clearly didn’t have a clue – it wasn’t going in properly when she gave it to him. Initially it wasn’t such a problem as I was still off work so could go into the school and give him his medication myself but once I returned to work it became a major issue as I had to take so much time off. In the end my employers actually told me to leave because I’d had to take so much time off.

“I believe schools need more education on how to administer basic asthma drugs. I also think children should be made more aware of asthma in general. Thomas has had problems with his peers in the past – I think they just assume he’s ‘a bit weak’ when he can’t do certain things. All of a sudden they’ve started having camping parties and they look at Thomas strangely when I have to pick him up early because he can’t stay overnight.”

Asthma UK say:

School nurses can support children like Thomas, and create a culture of asthma awareness at school, by supporting school staff to receive training so they know the school’s asthma policy and what to do in an asthma attack, as well as keeping details of each child’s medicines and triggers.

Support Asthma UK’s inhaler campaign

Children with asthma face an increased health risk because schools cannot keep spare inhalers for emergencies on site. Asthma UK is calling for a change in the law so that school children will have access to life-saving medicine in school emergencies. An Asthma UK survey of 200 children with asthma from across the UK found that nearly two-thirds have had an asthma attack at school, but regulations mean that schools are not allowed to have a spare asthma inhaler in their first aid kit. One in five children claimed they had put them in key places (by their bed, in the kitchen, in the bathroom) so that it would remind them to take their inhaler.

The blue reliever inhalers most commonly used to treat asthma attacks are prescription-only medicines, which means that schools are not allowed to keep an inhaler for emergencies. The survey also found that 64% of children with asthma have at some point been unable to access a working inhaler in school, having either forgotten, lost, broken or run out of their own inhaler. Emily Humphreys, head of policy and public affairs at Asthma UK said: “These medicines are very safe but going without them can be very dangerous. The majority of children know to find a teacher if they don’t have their own inhaler when having an asthma attack at school but the reality is that there is very little that staff can legally do to help in this situation. This puts children at risk.”

The campaign is supported by professional bodies such as the Royal College of General Practitioners (RCGP) and the Primary Care Respiratory Society (PCRS UK) and charities including Education for Health and the George Coller Memorial Fund. Stephen McPartland MP, Chair of the All Party Group on Respiratory Health is championing the campaign in Westminster and it has received the support of a broad range of MPs from the Conservative, Labour and Liberal Democrat parties.

You can find more information about this issue and Asthma UK’s other campaigns at www.asthma.org.uk/campaign.

The pack, which won the British Medical Association Award for best self-management resource in 2011, essentially acts as a child-friendly and interactive version of a written asthma action plan. Using a written personal asthma action plan is one of the most effective ways of managing asthma, and it is recommended in the British Thoracic Society Guidelines for Asthma Management.

A child with asthma might only have one annual review with their GP or nurse, but the My Asthma resource puts the parents and child in control of their asthma on a day to day basis, so they know how well the asthma is under control and can take appropriate action to avoid asthma attacks.

In addition to an asthma action plan, listing the child’s medicines and what to do if their asthma gets worse, the My Asthma pack also includes a colourful wall calendar, where children can add stickers to show if they have coughed, wheezed, had a tight chest or felt breathless that day. They also get reward stickers for taking their preventer inhalers each day. The ‘Don’t forget to take your inhaler’ sticker is particularly popular with children and parents, who have told us that they had put them in key places (by their bed, in the kitchen, in the bathroom) so that it would remind them to take their inhaler.

I’ve had to miss up to half of the school year due to my asthma and have been bullied because of my inhalers and the effects of steroids. May, 18

Improved asthma management

The majority of parents using the pack saw an effect on their child’s self-management within just two to three weeks (Asthma UK, 2013). By turning asthma management into a fun activity, the pack instils good asthma management practices in children at a young age, increasing the likelihood that their asthma is well controlled throughout life.

Useful resource

In an in-depth evaluation of the My Asthma pack, more than half of children using the pack saw an improvement in their symptoms as a result of the resource (Asthma UK, 2013). The findings also revealed that:

- 97% of healthcare professionals said it was a useful resource for children
- 68% of parents said that their child’s attitude towards taking their medicines has improved since using My Asthma
- 95% of children said that using the plan helped them to learn about what medicines to take
- 65% of children found using the calendar fun
- all children said that since using the pack they know what to do if their symptoms get worse.

Results from longitudinal surveys also showed improvements in symptoms, use of inhalers and lower emergency hospital admission rates among the children who used My Asthma.
**500 school nurses complete their vital asthma training**

Since January 2012 at least three children in the north west have died due to asthma, so in Spring 2013 asthma awareness training was offered to 500 school nurses across the north west of England as part of a joint initiative between Asthma UK, NHS North West and Respiratory Education UK. Gill Hall, chief executive officer from Respiratory Education UK who has developed the Wize up to Wheezing programme, said: "Only small numbers of children die from asthma each year – but many if not all of these deaths are thought to be preventable. Having a structured policy for the management of asthma in schools is essential.”

Sue Hunter, project manager for Asthma UK added: "Asthma is a very common condition but that can sometimes cause complacency and sadly we know that it is all too possible for a child to have an asthma attack whilst at school. It is vital that every school understands how important their role is in reducing the number of child asthma deaths.”

Paul and Karen Linton whose son, Sam, tragically died following an asthma attack whilst at school in Stockport in 2007 welcome the training: "It’s an amazing legacy for Samuel that all school nurses in the north west will be trained in asthma. Tragically we know just how important it is that school staff know what to do if a child has an attack at school. Hopefully this training will have a real impact and ensure that no other parent has to experience what we have been through.”

**How school nurses can help**

School nurses are well-placed not only to help prevent hospital admissions by distributing these My Asthma packs before the summer holidays, but also to improve the school’s attitudes and practices relating to asthma during term-time. We strongly encourage school nurses to work with their school to promote and distribute the free packs to parents before the end of term in July, so that children can develop a fun routine to manage their asthma over the summer and, as a result, reduce their risk of an asthma attack in September.

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**My asthma gets really bad and it does annoy me as I have to miss out on things like sport and school trips. Louis, 14**

Asthma UK’s Adviceline takes frequent calls from school nurses who are looking for advice on how best to support the care and well-being of pupils with asthma. We welcome these calls and would recommend these life-saving tips for schools.

- Have an asthma school register. Use Asthma UK’s school cards with the details of each child’s medicines, when to take them and contact details.
- Ensure the relevant teachers and staff members know children’s triggers so they can help pupils avoid them.
- Appropriate support and training should be given to school staff so they know the school’s asthma policy and what to do when a child is having an asthma attack (see box on page 26).
- Ensure that all children with asthma have access to their reliever inhalers quickly and without difficulty. Reliever inhalers should never be kept in a locked room or drawer, and should also be kept on hand during PE lessons, school trips and other activities outside the classroom.

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**Further information**

Order your free My Asthma packs and school cards today at [www.asthma.org.uk/myasthmapack](http://www.asthma.org.uk/myasthmapack)

Call the Asthma UK Adviceline on 0800 121 6244 (9am to 5pm, Monday to Friday).

People over the age of 12 can use Asthma UK’s new Your Asthma pack. Much like the children’s My Asthma pack, ‘Your Asthma’ can help adults and older children to stay in control of their condition and avoid asthma attacks. The pack includes a personalised asthma action plan, a peak flow diary and advice on making the most of your asthma review.

Asthma UK is also developing an online game aimed at teenagers to encourage them to think about their usual routine and to remember to take their brown inhaler with them over the summer holidays.

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**References**


We share a determination to get it right for children and young people

Although still in its infancy, members of the Children and Young People’s Health Outcomes Forum believe it has the potential to make a positive difference to young people’s lives. Simon Blake from Brook and Sharon White describe some of the Forum’s key aims.

The Children and Young People’s Health Outcomes Forum (CYPHOF) was established by Andrew Lansley then secretary of state for health in January 2012. The Forum was tasked with responding to Sir Ian Kennedy’s 2010 report Getting It Right for Children: Overcoming Cultural Barriers in the NHS so as to Meet Their Needs by developing a strategy for the new health system.

The Forum is chaired jointly by Christine Lenehan OBE, director, Council for Disabled Children and professor Ian Lewis. The Forum published its report which set out a number of recommendations for key players in the new health system in July 2012.


SAPHNA’s very own professional officer Sharon White, is now a member of the Forum which is tasked with being relentless on results and has the following purpose:

To be an independent expert in child health and maintain the momentum for improvement in outcomes for children and young people. It will provide expertise in child health and constructive criticism; review children and young people’s health outcomes and make recommendations as to their improvement. It will be a critical friend to the wider health system.

The Forum aims to be influenced by and act on the voices of children and young people and will publish an annual report for the Secretary of State and the wider health system. It is really clear there is strong commitment from government - the co-chairs are honorary members of the chief medical officer’s newly established Children and Young People’s Health Outcomes Board.

The Forum has established a series of sub-committees to develop specific programmes of work. Sharon White is a member of the public health 5–19 group. The work priorities of the group are currently being established and will definitely include a focus on school as a site for promoting and improving health, and more immediately advising on the new DH survey of 15 year olds which will be piloted from the autumn.

It’s an important Forum and has high level commitment from across government and the wider health system. It is really still early days of the new Forum and we commit to keeping you up-to-date with developments as the work progresses.

Sharon White, professional officer for SAPHNA, says:

“SAPHNA are delighted to be part of the membership of the CYPHOF forum. This offers a huge opportunity to improve the health outcomes for children and young people. It is heartening and tangible to feel the passion, drive and commitment of the Forum members who, indeed, want to make a difference and are, alongside you, the workforce, charged with making this happen. You will get the opportunity to share your expertise, views and opinions via the journal, website and newsletters. Make sure you check for regular updates and requests. In the meantime, do email me with any thoughts or concerns at sharon@saphna-professionals.org”
Young carers receive accolades for their caring designs

Every picture tells a story and this was certainly the case for each entry to the SAPHNA/DH Design a Pin Badge competition. The standard was exceptionally high and JSPHN was honoured to attend the moving Central London ceremony to meet some of the talented winners.

You’re all winners in my eyes,” said Viv Bennett, chief nursing officer from the Department of Health (DH) as she presented prizes to winners of SAPHNA’s Design a Pin Badge competition at the Young Carer’s Ceremony at Skipton House, central London alongside Flora Goldhill, Director for Children, Families & Maternity and Health Inequalities.

This was the culmination of an idea Sharon White from SAPHNA and Wendy Nicholson, professional lead (school nursing) from the DH had, that school nurse champions be easily identifiable by wearing these pin badges. The DH are currently co-ordinating training for school nurses who have come forward to receive expert training on their school nurse champion role. To date, over 50 have been trained with a similar number anticipated in the autumn.

The entries were outstanding and it was a hard task to choose a winner in both the 5–10 and 11–19 years categories. All the final and winning entries were proudly displayed at the DH before the ceremony in April.

The overall winner was Lucy Davies whose badge design was selected for its slogan, which summed up the intention of the project: “I’m a champ of young carers”. Lucy was thrilled to receive an iPad for her winning design.

The youngest prize winner Georgie Threlkeld, aged 7, won for her striking heart design. Her baby sister has health problems and Georgie’s mum proudly explained how Georgie helps her to care for the baby.

James Garity, 14 and, a runner up in the 11–19 category said that although he was shocked, it was “Excellent to win”. James’s story illustrates the sacrifice many of these children and young people make. He willingly stays at home over the weekend to do household chores and look after both his mum and nana. He also regularly takes his nana for walks to ensure she gets fresh air and exercise. This follows a period of temporary foster care, where he was separated from his own siblings, and felt very unhappy, a feeling compounded even more when he didn’t bond with one particular foster family.

James and all the other runners up were delighted to be presented with their very own Kindles.

Sharon White said after the ceremony: “We were completely staggered at the response to this competition and the calibre of the entries. The judging panel, which included myself, Wendy, Viv and Flora, all agreed that it was very difficult to identify winners as, by definition, they all were! Many of the designs represented their personal stories, journeys and the caring role they provided. This gave insight and reminded us all why we need to further raise the profile of this vulnerable and inspiring group of children and young people and give them and their families the support they need and deserve.”

The Society believes that the estimated number of young carers (166,000) is just the tip of the iceberg and that many young carers remain hidden from society because of bullying, stigma and a lack of identification of children taking on these roles. This is up by a fifth from when the last census was conducted in 2001.

From left to right: Megan Cook, Sharon White (SAPHNA), James Gantry, Jessica Gless, Flora Goldhill, Mia Fletcher, Viv Bennett, Georgie Threlkand, Lucy Davies (overall winner)
Planning for the future

The School Nursing Service Planner has been designed to help improve the strategy and decision-making processes, thereby delivering a more effective and efficient service. Michael McGechie explains how it works.

Michael McGechie, Director of health and social care, Benson Wintere

With the health landscape in a state of flux, the current environment requires school nursing services to demonstrate efficiency, whilst also ensuring sufficient workforce capacity to fulfi l the demands of the local caseload. The School Nursing Service Planner (SNSP) was set up to help facilitate a more dynamic approach to service planning. It enables demands to be more accurately predicted across each locality, and provokes a response to ensure the workforce is able to meet this demand adequately in the future.

Project background

Developed by Benson Wintere in 2009 the planner offers an accessible, central resource which communicates each organisation’s future service programme needs, and assists in the allocation of workforce across each area.

In recent years we have implemented service planning tools in children’s health environments, initially in health visiting, and more recently in school nursing. Our first school nursing project commenced in 2012 in Liverpool (see the case study section on page 29). The project process is important in ensuring tools become integrated and used in the long term. Our approach ensures the buy-in and ongoing involvement of the working group throughout the project, and ensures continuous support so tools remain optimised. New users are supported with in-tool guidance and other support documents as required to ensure tools can be understood quickly. Here I will explain how the planner works and then will summarise the lessons learnt from implementing service planning processes and reviewing existing tools.

Meeting the challenges of service planning

With the right approach, investment of time and shared ownership, a robust process will inform decision making, and align with the performance system to drive improved analysis, for example it can help to identify deviations in delivery across localities. It can also articulate future strategy plans in an open and transparent way, which is a benefi cial way of communicating how a future service will look to commissioners and other stakeholders. This effectively could pay dividends in the future.

The principles of planning

A service plan will commonly be a spreadsheet based model, which is used to allocate and sensitize caseloads for workforce teams. These vary in complexity, and are often developed by one person in the organisation to provide a more structured basis to workforce analysis.

“Dynamic” is the word used to describes the key ethos behind the planning structure. The definition of the word itself indicates “a force that stimulates constant change or progress within a system or process”. Set in this context, planning is considered dynamic if it leads to change by informing decision making, and is able to adapt and improve to remain relevant over time.

Albeit the process is dynamically evolving, it also requires a formal process that reinforces ongoing information refresh, collective ownership, and strategic application. As a predictive tool it must not only concentrate on the workforce supply, but also adopt a diverse approach to demand incorporating local deprivation, safeguarding and additional needs. As a live process it should adapt and improve over time to refl ect changing needs, improved information and feedback.

Areas where the planner can assist

- **Workforce**: assessment and allocation
- **Caseloads**: sensitize for safeguarding and deprivation
- **Service development**: service planning and profiling
- **Compliance**: alignment with the Healthy Child Programme
- **Operations**: target greater efficiency and harmonisation of delivery across localities

How the dynamic service planning tool works

- **Simplicity, transparency and objectivity** Planning tools and models can very quickly become encumbered by excessive detail, complicated functionality, volatile workings and an over-
engineered update process. Even the most accurate predictive model may not gain sufficient traction or trust where it is not understood sufficiently or not communicating core messages clearly.

Reports should present key messages quickly and effectively. Flexible reporting ensures where detail is required, it can be presented as an additional view to summary reports.

Transparency is equally important in building trust – the user of the tool or reports should be able to understand how the process works, based not just on assumptions but the flow of information.

Traditionally, updates demand significant time to assimilate and validate historical and ad-hoc data, as tools are often neglected or become one person’s responsibility. The SNSP can speed this process up.

Modelling demand and demographics

Services we talk to have perceived a lack of available dynamic planning tools in the children’s health environment. Most have performed caseload sensitisation exercises, focusing on the supply of workforce time or head count in each area, but in many cases not profiling the underlying demand for services from the child population.

To address this the model focuses on the demand for services from the child population, which is profiled by defining a target group defined either by deprivation or other defined need. This ensures that caseloads are appropriately sensitised and delivered in each locality.

Case study

We recently worked in partnership with Liverpool Community Health (LCH) in Sefton, Liverpool to implement our School Nursing Service Planner. The planner aims to improve outcomes for our children through identifying and managing risks within the service, identifying recruitment needs, assisting with business continuity planning and identifying potential cost savings.

Due to PCT reconfigurations, the service has recently merged two previously separate organisations of Sefton and Liverpool into one. The project was overseen by a steering group consisting of school nurse practitioners and managers, HR, public health analysts, business and performance intelligence team, workforce development team and the public health team. A series of workshops were undertaken with front line staff to drive the work forward and involve them in the process.

Given the reconfiguration, harmonising services and workforce profiles were key outcomes of the workshops and collaboration was imperative to ensure buy-in of the new service from all those involved. Collective area, workforce and service profiles were developed and variations in the existing service were discussed, prompting ideas around best practice and plans for future service provision. Where there were clear differences in practice and staff configuration, the service planner was instrumental in focusing discussion.

Following the successful completion of the pilot, the rollout is being extended across the rest of LCH. The service planner has provided an overview of the current workforce capacity to deliver the new programme in each locality, providing a consistent overview of the service to help inform the new service redesign. As well as workforce evaluation, LCH intend to use the planner to assist future change, refine service delivery, and assess new ways of managing performance.

Doreen Porter, Leader of the Project team, says “Working on the development of the school nurse planner will continue to help us deliver on the QIPP agenda through ensuring we have the right staff with the right skills to deliver the Health Child Programme. The tool also supports managers with key decisions around staff deployment to meet the needs of our diverse population. This helps us to ensure we have an equitable service with optimum staffing levels to improve the outcomes for our children, young people and their families.

As well as being able to consider current service provision it also allows us the opportunity for some visionary thinking by enabling us to test hypotheses in an objective and safe way. It provides us with a clear picture of what that may look like in terms of costs to deliver the service, identifying roles and responsibilities including training and development needs.”

Leverage off intelligence

The service plan can act as a central intelligence repository, and drive improved and enhanced analysis and data collection. Information analysts can contribute throughout the process.

A lack of available or sufficiently granular data should not prevent incorporating intelligent estimates or assumptions in the service planner. Provided these are arrived at collaboratively and prudently, they can add significant value and dynamism. In our workshops, the average travel time taken by practitioners to visits is often a subject of debate and uncertainty. Often credible data is lacking, but time is a key component in
Effective service planning will inform decision making in the follow areas:

i. **Workforce improvement**
A service planner should provide analysis around the adequacy of the existing workforce to deliver the required service programme, identifying those with the largest "support deficit." This allows the exploration of alternative workforce structures to deliver the full programme, and supports decisions around allocation of new practitioners and rebalancing of the existing workforce. Services may also choose to address the role of skill mix in the future service.

ii. **Service change**
The service planner can help assess service offer, balancing overall service demand with the available workforce. It can also forecast change in services delivery. Changing the profile may involve changing delivery or administrative procedures to reflect best practice or national guidance, targeting basis, redefining responsibilities, or venue. Services may also reflect the requirements of the Healthy Child Programme.

iii. **Operational improvement**
Services may wish to identify levels of variation from the service plan by comparing contacts and contact time with planned measures. This analysis will depend on the quality and granularity of information from the performance system. This is a useful sensor check of assumptions underpinning the service profile, and can highlight localities with the most deviation from the service plan. This could include exceeding the average time to deliver the service, or variation in number of sessions delivered. Once variances are identified, action can be taken to understand and act to target operational improvements.

Standardised service planning approaches also raise the potential for comparison of service information. This may allow services to share service information to help identify the potential for improving delivery and efficiency.

- **Collaborate and share**
  Involving more people helps to arrive at collective assumptions about the service, add credibility to the assumptions, and establish buy-in across the organisation.
  In our workshops we involve team leaders, school nurses, skill mix, service management, analysts and commissioners. This ensures assumptions and information are subjected to the kinds of organisational debate and sensor checking that would otherwise need to occur after its release for the tool to earn credibility and buy-in.
  Future update and ownership should continue as a cross section of views and experience helps maximise available intelligence and draw best practice to ensure we develop a collective, rigorous view of the future service.

- **Refresh and review**
  For service planning to become ingrained in service strategy, a structured process should be in place determining frequency of review and responsibility. Each information component should be considered taking into account volatility and materiality.
  For instance, the safeguarding population and workforce composition vary both critical to the service plan, should be updated regularly. School roll data is important, but less volatile and might be updated less frequently.

- **Informing decision making**
  Reports and functionality in the service planner should be engineered towards decision making. Project planning ensures key variables and outputs are identified, and reports designed to facilitate strategy. Our service planners focus specifically on the effectiveness of the existing team to deliver the service programme. It also allows alternative team structures to be built for each locality to enable “what-if” analysis. These are themes that resonate with users of the tool and quickly communicate the relationship between demand for services and potential of workforce to deliver.

**Delivering a new way forward**
The service plan can become a central strategic tool which not only reflects strategy but helps to develop it. One of its strengths is that it can be adapted over time with an organisation and be transparent as well as accessible, providing a process for discussion around future service delivery and workforce responsibilities. In the future services may use the service plan to target greater harmonisation, operational efficiency and sharing of best practice internally and with other services.

**Further information**
Michael McGechie, Director of health and social care, Benson Wintere e: michael@bensonwintere.com
SAPHNA’s Professional Officer Sharon White brings you up to speed on some key actions the organisation has undertaken on behalf of its members to help push the school nursing agenda forward.

1 YOU SAID...  
‘We need to do more to support young carers.’

WE LISTENED  
We worked alongside the Department of Health (DH), Carers Trust (CT), and the Children’s Society (CS), to develop and deliver School Nurse Young Carers (YC) Champions training. We also held a competition with YC to design a pin badge for school nurse (SN) champions to wear so that they could be easily recognised by Young Carers. (N.B: See pages 29 and 34 for more details and to view a selection of winning and short listed entries.)

OUTCOME  
Fifty SN champs have now been trained and it’s anticipated that an additional 50 will receive the training this autumn. We held a YC badge winners ceremony and prize-giving which was well attended by the Young Carers and their families. There is to be continued work on this alongside with the Royal College of Nursing (RCN), Royal College of General Practitioners (RCGP) and Queen’s Nursing Institute (QNI).

2 YOU SAID...  
‘The proposed PSHE curriculum for schools is weak on sex and relationship education (SRE).’

WE LISTENED  
We raised our concern with the Department of Education (DfE) and the DH and contributed to the consultation. Subsequently we joined forces with numerous other organisations, including Brook (the UK’s largest young people’s sexual health charity) and petitioned Parliament to make SRE a mandatory part of the curriculum.

OUTCOME  
Unfortunately it was not accepted this time, although there is ongoing work via the alliance and ongoing dialogue with government and departments. Simon Brook sums up the determination of the alliance to continue fighting when he said: “I believe that this campaign’s time has come as people realise that not only can SRE prepare and develop young people, it can protect them from harm. It is exciting to be part of the Coalition for Consent, and I look forward to working closely with them in future.” See pages 20–22 for further details and an update.

3 YOU SAID...  
‘We need a professional conference that responds to our needs but also recognises the capacity demand on our resources.’

WE LISTENED  
We worked with you to design and develop a programme to reflect your needs.

OUTCOME  
The programme is now finalised with presentations including child sexual exploitation, the new immunisation programme, tried and tested tools to maximise capacity and service delivery, and much more. Recognising the limitations on study budgets we have also managed to offer a very competitive price and a discount of £50 off if you are a member of SAPHNA. For further information on the programme line up and details on how to book please turn to page 5.

4 YOU SAID...  
‘I’m fed up to the back teeth of no one knowing what school nurses do!’

WE LISTENED  
We have worked with NHS careers to develop new information and resources to promote and recruit to school nursing. These will be available in late July. We will inform you via our website www.saphna-professionals.org.

OUTCOME  
We have also worked with the Department of Health and produced a suite of promotional materials to educate parents, local government associations, head teachers and others. Visit http://www.chimat.org.uk/schoolhealth/schoolnurses for further details.
In July…

We’re looking forward to sharing ideas with our international nursing friends including Mary Henley (a sprightly 85 years young) at the SNI in Slovenia at the end of the month.

Congratulations SAPHNA,
your inaugural journal is off to a great start. Kudos to your board members, two of whom we count among our friends so far. May SAPHNA be blessed for all the hard work and spirit you have achieved, your friendship and help with School Nurses International (SNI).

Mary Henley, founder member of SNI committee

In July…

It’s sickle cell month. Access the sickle cell society’s vast array of info, resources and support here: http://www.sicklecellsociety.org/

Young carers have got talent…

The new flu vaccination programme, starting this September, will be administered to all two year olds in the form of a nasal spray called Fluenz. A small number of areas are also set to pilot vaccination of primary and preschool aged children this year, with a view to rolling out the programme to all children in those age groups in 2014, while pilots for secondary schoolchildren will be run in 2014 ready for full roll-out in 2015.

August diary dates

1st–7th WABA World Breastfeeding Week
12th International Youth Day

Youth in health care
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On the count of three...

Because it’s so important that eligible girls receive all three doses of the HPV vaccine, we’ve developed a range of materials to help you maximise their attendance at your school-based HPV vaccination clinics, including an exclusive wristband for you to give girls after their third injection!

To find out more or to order support materials, visit www.spmsd.co.uk and click on ‘healthcare professionals’.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard

Adverse events should also be reported to Sanofi Pasteur MSD, telephone number 01628 785291.

Adverse events should also be reported to Sanofi Pasteur MSD, telephone number 01628 785291.

ABRIDGED PRESCRIBING INFORMATION

GARDASIL® (Human Papillomavirus Vaccine [Types 6, 11, 16, 18]) (Recombinant, adsorbed).

Refer to Summary of Product Characteristics for full product information.

Presentation: Gardasil is supplied as a single dose prefilled syringe containing 0.5 millilitres of suspension. Each dose of the quadrivalent vaccine contains highly purified virus-like particles (VLPs) of the major capsid L1 protein of Human Papillomavirus (HPV). These are type 6 (20 µg), type 11 (40 µg), type 16 (40 µg) and type 18 (50 µg).

Indications: Gardasil is a vaccine for use from the age of 9 years for the prevention of pre-malignant genital lesions (cervical, vulvar and vaginal) and cervical cancer causally related to certain oncogenic Human Papillomaviruses (HPV) types and genital warts (condyloma acuminata) causally related to specific HPV types. The indication is based on the demonstration of efficacy of Gardasil in females 16 to 45 years of age and in males 16 to 26 years of age and on the demonstration of immunogenicity of Gardasil in 9 to 15-year old children and adolescents. Dosage and administration: The primary vaccination series consists of 3 separate 0.5 millitre doses administered according to the following schedule: 0, 2, 6 months. If an alternate schedule is necessary the second dose should be administered at least one month after the first and the third dose at least three months after the second. All three doses should be given within a 1 year period. The need for a booster dose has not been established. The vaccine should be administered by intramuscular injection.

Contraindications: Hypersensitivity to any component of the vaccine. Hypersensitivity after previous administration of Gardasil. Acute feverish illness. Warnings and precautions: The decision to vaccinate an individual should take into account the risk for previous HPV exposure and potential benefit from vaccination. As with all vaccines, appropriate medical treatment should always be available in case of severe anaphylactic reactions. The vaccine should be given with caution to individuals with thrombocytopenia or any coagulation disorder because bleeding may occur following an intramuscular administration in these individuals. Syncope, sometimes associated with falling, can occur before or after vaccination with Gardasil as a psychogenic response to the needle injection. Vaccination should be observed for approximately 15 minutes after vaccination; procedures should be in place to avoid injury from faints. There is insufficient data to recommend use of Gardasil during pregnancy therefore the vaccination should be postponed until after completion of the pregnancy. The vaccine can be given to breastfeeding women. Gardasil will only protect against diseases that are caused by HPV types 6, 11, 16 and 18 and to some limited extent against diseases caused by certain related HPV types. Vaccination is not a substitute for routine cervical screening. Individuals with impaired immune responsiveness, due to either the use of potent immunosuppressive therapy, a genetic disorder because bleeding may occur following an intramuscular administration in these individuals. Syncope, sometimes associated with falling, can occur before or after vaccination with Gardasil as a psychogenic response to the needle injection. Vaccination should be observed for approximately 15 minutes after vaccination; procedures should be in place to avoid injury from faints. There is insufficient data to recommend use of Gardasil during pregnancy therefore the vaccination should be postponed until after completion of the pregnancy. The vaccine can be given to breastfeeding women. Gardasil will only protect against diseases that are caused by HPV types 6, 11, 16 and 18 and to some limited extent against diseases caused by certain related HPV types. Vaccination is not a substitute for routine cervical screening. Individuals with impaired immune responsiveness, due to either the use of potent immunosuppressive therapy, a genetic defect, or other causes, may not respond to the vaccine. As with any vaccine, vaccination with Gardasil may not result in protection in all vaccine recipients. There are no safety, immunogenicity or efficacy data to support interchangeability of Gardasil with other HPV vaccines. Undesirable effects: Very common side effects include: headache and at the injection site, erythema, pain and swelling. Common side effects include bruising and pruritus at the injection site, pyrexia, nausea, and pain in the extremity. Rarely urticaria and very rarely anaphylactic reactions have also been reported. Idiopathic thrombocytopenic purpura, Guillain-Barré Syndrome and hypersensitivity reactions including, anaphylactic/ anaphylactoid reactions have also been reported. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. Package quantities and basic NHS cost: Single pack containing one 0.5 millitre dose prefilled syringe with two separate needles. NHS cost: £86.50 per dose. Marketing authorisation holder: Sanofi Pasteur MSD SNC, 8 rue Jonas Salk, F-69007, Lyon, France. Marketing authorisation number: EU/1/06/357/007 (prefilled syringe with two separate needles) Legal category: POM R Registered trademark Date of last review: Nov 2012

PROTECTION AGAINST HPV RELATED DISEASES

GARDASIL® Human Papillomavirus Vaccine Types 6, 11, 16, 18 Recombinant, adsorbed

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