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Dear Colleagues,

As we move from spring into summer term, our role in school nursing is far reaching and places constant demands on our expertise and resources as we juggle supporting young people through exams and hay fever season, mental health struggles and relationship worries, promote sun safety and farm visit hygiene, outdoor play and exercise…

And so we welcome with open arms the clarity offered by the long-awaited Department of Health national school nursing service specification, which provides a clear framework to support commissioning of school nursing services. Viv Bennett discusses the vital views of children and young people that must be used to inform such policy and guidance whilst Wendy Nicholson shares how this will help maximise our contribution to children and young people’s public health (see p10).

The impact of domestic violence on children and young people, whether directly or indirectly, is considered in the article from CAADA and discusses the partnership opportunities for school nursing to work with their young people violence advisors (p13).

We also analyse the recently published Supporting Children with Medical Conditions in Schools guidance, which aims to improve the support offered to those with additional health needs in schools so that they may achieve their optimum potential and well-being (p17).

Elsewhere, the National Deaf Children’s Society outlines some of the struggles faced by children with hearing difficulties and proposes some practical solutions which enable these to be minimised (p20). The impact of eczema is also explored (p24) as families share with us their rich experiences so we may deliver services accordingly.

Building on children and young people’s involvement we also feature an article on obesity, its impact, our role and innovative approaches which are having positive outcomes (p29).

Our regular features from Lauren our young carer (p22) and Paul Watson, as he finishes his SCPHN course (p33), offer valuable insight into personal experiences which we are privileged to know and utilise in our practice.

Working “smarter” not “harder” is a current buzz phrase which can, at times, feel less than helpful. However, the launch of the @WeSchoolNurses Twitter chat group is already proving beneficial for school nurses by providing social media opportunities for sharing, learning and developing together and, as we move from spring into summer term, our role in school nursing is far reaching and places constant demands on our expertise and resources as we juggle supporting young people through exams and hay fever season, mental health struggles and relationship worries, promote sun safety and farm visit hygiene, outdoor play and exercise…

Working “smarter” not “harder” is a current buzz phrase which can, at times, feel less than helpful. However, the launch of the @WeSchoolNurses Twitter chat group is already providing valuable opportunities for sharing, learning and developing together and, the school nursing community of 500+ strong agrees with me that this is one sure way of achieving this (see p7 for further details). I look forward to virtually chatting with you!

sharon@saphna-professionals.org

PS You can purchase extra copies of the journal for £15 each (£90 p.a) by calling 01273 434943.
Protect families with Australia’s No.1 sunscreen

Even on cloudy and cool days, UV radiation in sunlight can cause damage to skin, including pigmentation, premature ageing and even skin cancers. And children’s delicate skin is especially at risk, as damage in childhood can cause skin problems in later life.2,3

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All change for vaccinations

School and community health nurses will face a range of changes to the immunisation programme, it has been revealed

From September 2014 the number of doses of the HPV vaccine given to teenage girls will decrease from three to two. This is because of a continuing evidence base supporting the effectiveness of the two-vaccine course, which will last for around 20 years.

As is currently standard, the first injection should still be administered in year 8, provided the girl is aged 12–13 years old. The second dose can be given at any point between six months and 24 months after the first injection. Public Health England (PHE) is undertaking discussions with local area teams to decide upon the best approach. This could result in the first injection being given while girls are in year 8 and the second dose when the girls are in year 9.

Girls who have already started the three-dose schedule should complete this course, and any girl over the age of 14 should also be offered the three-dose vaccination due to its improved effectiveness in this age group.

An updated timetable for the flu vaccination has also been released:

2014–2015. Childhood flu immunisations to children aged 2–4, while pilot areas to continue delivery to Y7 and Y8 in specific area teams.

2015–2016. Continued flu immunisation of children aged 2–4, as well as the roll out of immunisation to reception, Y1 and Y2 children. The primary pilot areas roll out to Y3, Y4, Y5, Y6 to be confirmed.

2016–2017. Continued flu immunisation of children aged 2–4. All areas to roll out to all primary school age children (reception – Y6) to be confirmed.


An updated immunisation chart can be viewed at: http://www.chimat.org.uk/resource/view.aspx?RID=201021&src=KU

Government to report on PSHE

A Parliamentary inquiry is under way into personal, social, health and economic education and sex and relationships education, led by the House of Commons Education Committee.

The Committee plans to investigate:

● Whether PSHE ought to be statutory, either as part of the National Curriculum or through some other means of entitlement;
● Whether the current accountability system is sufficient to ensure that schools focus on PSHE;
● The overall provision and quality of teaching of SRE in schools, including in primary schools and academies;
● Whether enough guidelines are in place on the teaching of SRE, including issues of consent, abuse between teenagers and cyber-bullying;
● Measuring the effectiveness of SRE.

PSHE Association Chief Executive Joe Hayman said: ‘The Committee is asking all the right questions about PSHE education and at the right time, so we look forward to working with our members and colleagues across the PSHE community over the coming weeks on our response to the inquiry. Ofsted said last year that PSHE education was ‘not yet good enough’; we hope the Committee will help us to improve that position.’

The PHSE website describes PSHE education as a ‘planned programme of learning through which children and young people acquire the knowledge, understanding and skills they need to manage their lives. As part of a whole school approach, PSHE develops the qualities and attributes pupils need to thrive as individuals, family members and members of society.’

If you would like to find out more visit https://www.pshe-association.org.uk/content.aspx?CategoryID=335
Digitally-savvy school nurses will now be able to get extra support thanks to the launch of #WeScNs and the @WeSchoolNurses Twitter handle.

The launch follows exploratory work by the Department of Health's (DH) school nurse development programme which, last year, gathered a small number of interested school nurses together with experienced tweeters to explore if social media would be useful for school nurses to network, share and support one another. The result of the workshop was #SNSOME, which is now an established point for conversation between school nurses and other professionals who have an interest in the health and well-being of children and young people.

Now, with the plan to build on this success Wendy Nicholson from the DH has partnered with @agencynurse to pilot a #wenurses school nurse focussed chat – an hour-long discussion on school nurse-related issues.

The new Twitter chat called #WeScNs will be run fortnightly by the Twitter handle @WeSchoolNurses. Details will be released in advance and published post chat for those that either couldn’t make that chat or would like to reference it later and connect with the participants.

Nicholson said: ‘Clearly there was an appetite to formalise regular Twitter chats aimed at school nurses and the requests to take this forward have filled my inbox. ’The community will welcome and support school nurses, their teams and the wider workforce who have an interest in the health and well-being of school-aged children. So a great opportunity for multi-disciplinary sharing!’

The chat is facilitated by a number of skilled volunteers including: @Jo_France, @maggieclarkelpt, @HeidiPouney, @Paul_RMHN, @School_NurseUK and @wendyjnicholson. The first chat took place on 3rd of June at 8pm was aptly titled ‘How technology is changing school nursing’.

Autism link to vaccine ruled out by large scale study

Scientists have ruled out the link between autism and childhood vaccines, following a large scale study which looked at more than one million children.

Researchers from the University of Sydney, Australia, pooled the results of numerous studies together to look to find if there was any link between autism and childhood vaccines. Following the study, the researchers said that there were no significant links to be found between the vaccinations and the development of the condition. The findings were reported in the peer-reviewed journal, Vaccine.

The scientists looked at the results of studies into a range of vaccines including measles, mumps and rubella (MMR) vaccination, cumulative mercury, or cumulative thimerosal dosage from vaccinations. Overall, five cohort studies were examined, totalling 1,256,407 children from the UK, Japan and Denmark.

Additionally, no link was found in five other cohort studies. When the results of the five cohort studies were combined, there was no increased risk of developing autism or autism spectrum disorder after MMR, mercury or thimerosal exposure.

Professor Guy Eslick, who led the research, said: “The findings were saying nothing. The odds ratio came up null, null, null. That means there’s no connection. You can’t get better than that.”

“I hope it reaches a lot of parents who are sitting on the fence about whether to vaccinate their kids. I hope it helps to change their minds.”

Charity optimistic over changes to inhaler guidance in schools

Asthma UK is optimistic that children will soon be able to keep spare asthma inhalers in schools, following the closure of a public consultation.

Campaigners believe the move would reduce the risk of emergency hospital admission or even death for more than a million pupils who live with asthma. Currently, schools are not allowed to keep spares of the blue reliever inhalers as they are a prescribed medicine. However, the consultation, which closed on May 30th, could see them stored in first-aid kits.

If passed, the new legislation could be in place next year. The consultation will also look at providing further guidance to schools on the use of the devices, the Healthcare Products Regulatory Agency (MHRA) said.

Dr Samantha Walker, Deputy Chief Executive of Asthma UK, said: “Tragically the equivalent of a classroom of children die every year because of asthma so it is absolutely vital that children have access to this life-saving medicine when they really need it.”
Shropshire school nurses pick up national award

Shropshire Community Health NHS Trust’s school nurses had cause for celebration after being awarded the title of School Nursing Team of the Year 2014 in the prestigious Nursing Standard awards.

The award was presented at a gala ceremony in May, and picked up by school nurses Kirsten Ellmore and Gayle Fitzpatrick. The award recognised the team’s outstanding work in partnership with local schools to support children and young people with asthma.

As a result of their work, all schools in Shropshire now have a member of staff who has in-depth knowledge about asthma, as well as special equipment to help children breathe easier during an acute asthma attack. Teachers and parents now say they feel more confident about the care of children with asthma at school, knowing that staff members with specialist knowledge are on hand.

The award was presented by Wendy Nicholson, professional lead for community and school nursing at the Department of Health and Viv Bennett, director of nursing at Public Health England.

Jo France, school nurse manager and professional lead at the Community Trust said: ‘I am very proud of the whole team whose hard work and dedication have contributed to Kirsten and the team winning this award. The awards ceremony was an emotional evening with lots of very worthy winners across all areas of nursing and we felt very honoured to be part of the celebration. It was great to see that promoting good health and preventing illness featured strongly.’

Government launches initiative to drive out homophobic bullying

A new project aimed at driving out homophobic, biphobic and transphobic bullying in schools has been launched.

The government-led project is being taken forward by the National Centre for Social Research (NatCen), and follows an initial announcement made in November 2013 which set out the need for the project. The aim of the initiative aims to understand the most effective ways to reduce bullying of this nature as well as find out what sort of impact it has on school age children and young people.

The first phase of the initiative will look at the existing evidence available in the field as well as looking at measures schools tackling such issues already have in place. NatCen will report back on this first phase later in the summer.

Minister for women and equalities Jenny Willott, said: ‘Homophobic, biphobic and transphobic taunts and teasing in the school playground may seem harmless but it can seriously affect children’s health and well-being, lead to poor educational performance and prevent them getting ahead in life.

‘Young people should be able to go to school without fear of bullying or discrimination. We expect schools to take a strong stand against all forms of bullying and to deal with incidents quickly when they occur.

‘This project will help us to understand all the issues, what works best in tackling this type of bullying, and to develop effective, evidence-based tools and best practice that will help schools and others to stamp out this harmful behaviour.’

Michelle Gray, project research director at NatCen, said: ‘We are delighted to be carrying out this important and well-needed piece of research and have put together a team who fully understand and have experience in the areas of equalities and LGBT research. We have designed a mixed methods programme of work which we hope will really get to the bottom of what works and why to eventually help all of those working with children and young people to eradicate homophobic, biphobic and transphobic bullying.’
Making a difference

In our regular feature Sharon White, professional officer for SAPHNA, shows how feedback from school nurses is helping to transform the profession

1 YOU SAID...
We need a national framework for school nursing.

WE LISTENED
We lobbied and worked arduously with the Department of Health (DH) School Nurse Development Programme and key partners to develop and produce an updated school nursing service specification called Maximising the School Nursing Team Contribution to the Public Health of School-aged Children (April 2014). This document provides guidance to support the commissioning of public health provision for school-aged children 5–19. We are also involved in the development of the supporting products and pathways.


WE DID
This provides robust guidance for both providers and commissioners of school nursing services, assisting all parties in agreeing service specifications underpinned by the JSNA, and provides evidence-based practice with which to deliver it.

2 YOU SAID...
I want to become a member of SAPHNA, but I can’t afford it!

WE LISTENED
We are now offering FREE membership to all working to promote the health and well-being of school-aged children. See http://www.jhfc.co.uk/saphna/saphna_membership.aspx to join up and encourage others to do the same!

WE DID
As our membership grows, so does our voice and influence. Therefore we can champion and represent the voice of school nurses and the health of children, young people and their families even more effectively. Our publications, events and website offer you the opportunity for ongoing professional development and all to have your say in the future of the profession.

3 YOU SAID...
We need tools to understand and screen for child sexual exploitation.

WE LISTENED
We worked with key partners who, underpinned by what the young people told us, have developed the recently published document called: Spotting the Signs: A national proforma for identifying risk of child sexual exploitation in sexual health services by Dr Karen Rogstad and Karen Johnston:


WE DID
This provides a national evidence based tool for those working with children and young people which, will, in turn, assist us all in better protecting children and young people from child sexual exploitation

Please contact Sharon White at Sharon@saphna-professionals.org if there are any school nursing issues you would like advice on.
Mission accomplished

The new national school nursing service specification launched recently outlines to health commissioners the vital and effective role school nurses can play in improving the health outcomes of children and young people. Wendy Nicholson and Viv Bennett from the Department of Health acknowledge that progress couldn’t have been made without the help and support of young people themselves.

Local authorities and directors of public health have the key roles and responsibilities in improving health outcomes for local people, including children and young people. The way public health services are commissioned has changed. Local authorities now commission a range of services for school-aged children and young people including the school nursing service. Following a number of requests the Department of Health (DH) developed new guidance to support local commissioning of school nursing services called Maximising the School Nursing Team Contribution to the Public Health of School-Aged Children (DH & PHE, 2014).

Wendy Nicholson
Professional officer, school nursing at the Department of Health
Viv Bennett
Director of nursing at DH and Public Health England

Commissioning school nursing services and supporting delivery locally

We worked with partners including Public Health England, the Local Government Association, the Society of Local Authority Chief Executives, the Association of Directors of Public Health, professional bodies including SAPHNA, and other stakeholders drawn from commissioning in local authorities and providers to develop the guidance to support local commissioning of school nursing services. This small working group who supported the development were so passionate, offering positive challenge and as you can imagine differing perspectives – which proved to
be incredibly helpful and added richness to the whole development phase.

The guidance builds on good practice drawn from across England and draws on the user voice by encapsulating the key messages from children, young people and parents. The guidance offers a framework for local commissioners and providers. It sets out the core school nurse offer and has been developed to meet local need to ensure effective, seamless delivery of public health for school-aged children and young people. It aims to:

- ensure a consistent and equitable approach across England (this guidance can be used to benchmark and monitor provision)
- outline services and provide quality indicators related to the health and well-being of school-aged children
- provide clarity on the vital role of school nursing services and how the public health skills of the profession can be used most effectively.

**Promoting intelligent commissioning**

The guidance promotes intelligent commissioning and commissioning for improved outcomes for children and young people. In health and well-being, the starting point is that outcomes are the results of supported activity or interventions, not the activity itself. Clearly, commissioners and school nursing teams need to work together to develop robust plans to improve outcomes for children and young people – commissioning is not a one-way linear process, there needs to be open, on-going, transparent dialogue which supports flexible and innovative approaches to delivery underpinned by evidence. School nurses are leaders for delivery of the Healthy Child programme (5–19) and as such they need to use their specialist public health skills to identify population health needs, whilst harnessing their negotiation and influencing skills.

Commissioners need quality data to assist their decision making and service providers need to understand why data is required, and how it will be used – this includes robust feedback from children and young people. Practitioners often report they are collecting endless data but are not advised of the rationale or indeed how this may affect future commissioning, likewise commissioners advise data quality could be improved – so there is a conversation to be had! Understanding and clarifying each other’s respective roles will support increased effective, collaboration.

**You’re Welcome Criteria**

Clearly commissioning is not just about commissioners and providers; children, young people and families must be central to the whole process. Understanding their needs and developing services to meet needs is complex and means there has to be local variation. There will of course be overarching public health issues that are common across regions and nationally including obesity, teen conceptions and emotional health issues. Commissioners seek to help children and young people to achieve planned and positive outcomes. The You’re Welcome Criteria – quality standards for young people’s health services are well established and a robust tool for use locally.

Commissioning does not have to be complex; however it does require commissioners, providers and service users to work together, to determine local need. Perhaps it’s worth reflecting on local priorities within the premise of “thinking like a service user and acting like tax payers” – the two components need to be intertwined and considered at all stages of the commissioning cycle.

**Pathways to support practice**

We also published three new pathways to support practice which include sexual health and emotional health and support for young carers. These are:

- **Sexual health.** The recent under 18 conception rates published in March illustrate just what can be achieved by pooling expertise, listening to young people, meeting their needs locally – and most importantly shear determination from professionals to make a difference. (http://www.ons.gov.uk/ons/rel/vsob1/quart-conc-to-women-und-18/q4-2012/index.html)
- **Emotional health,** young people told us they wanted support before they got to crisis and this is the central concept of the emotional health and well-being pathway. (http://www.byc.org.uk/media/75447/byc_school_nurse_report_web.pdf)
- **A focus on young carers** – supporting the health and well-being needs of young carers has been a real focus of our work – with approximately 164,000 identified young carers we know there needs to be more support and school nurses are well placed to offer this. The pathway clearly articulates the contribution school nursing teams can make. (http://www.carers.org/key-facts-about-carers)

We hope the new guidance and pathways will help to support you in local delivery and make a difference to the outcomes for school-aged children. Finally, a huge thanks to those who supported the development, particularly the children and young people whose life experiences keep us grounded and provided the motivation to ensure they were fit for purpose.

**References**

‘Nothing about us without us’
Viv Bennett wrote this blog recently on why listening to children and young people makes for good public health

What do young people think are the big public health messages? The best way to find out is to ask them!

Listening to children and young people is core to PHE and Department of Health values and both organisations have put this into practice in the last year. This blog gives a brief insight into what we have done and learnt.

Learning good habits and building emotional resilience during the school years is vital for life chances and school nurses are a key part of the public health workforce giving support to make this happen. To help make this happen locally we have produced a range of documents which local areas will find helpful — including the School Nurse Development Programme, produced with key partners and, most importantly, children and young people themselves. Indeed, our wide range of documents for school health is shaped by the voices of pupils as well as professionals. These documents cover, amongst others, emotional health and wellbeing and sexual health, and fact sheets for services and local government.

In the work between DH and the British Youth Council (BYC) we have learnt directly from children and young people about how best we can meet their needs. The BYC report in 2011 is still an important guide for us, including needing to ‘be in sync’ … ‘be understanding’ … ‘be approachable’, including in our use of social media. Our joint work over the last 12 months has shown that children and young people live amazing and sometimes challenging lives, and this was especially true in our work with young carers.

Throughout 2013/14 more than 40 young carers shared with us the things that matter in their lives, their strengths and where they do and don’t want us to help. A group of young carers have also been central to the training of school nurses at national events and we now have 150 school nurse young carer champions across England. The programme has proved to be successful and demand for the places has been high, with rollout requests in Wales.

We learn much when we listen to the experience of young people as service users. DH supported BYC to pilot the training of young people as ‘health champions’ to peer review school nursing services locally. Young people work with providers to identify service improvements and ideas for taking these forward. It provides a platform for their views to shape service re-design and this has been so well received locally. More recently PHE, supported by the National Children’s Bureau, met a group of young people ranging from 12–18 years of age who took time out from homework and precious leisure time to think about what matters to them about health and well-being. A week later four of them met PHE’s leaders on young people’s health.

The discussion was wide-ranging and challenging at times because young people want and need so much more than what is currently being offered. Topics included:

- Information: the need for clear, accessible, age appropriate and reliable health information, making more use of digital media, but not to neglect other forms of communicating.
- Personal, social, health and economic education: interestingly, at a time when the Parliamentary Education Select Committee is consulting about PSHE, there was frustration that the subject is not taught to the same standard as other subjects such as maths and English. Young people told us that teachers need specialist training and qualifications to deal with sensitive issues and for PSHE to be recognised and valued.
- Physical activity: there was equal frustration that more should be done to encourage older pupils to stick with physical activity — not just the traditional sports but also activities such as dance. Girls’ abilities at excelling in all sorts of sports should be recognised, valued and supported more, not just by schools but society in general, as this would help stop so many dropping out of physical activity as they get older.
- Fast food: this was another concern. Many outlets near schools offer very affordable food and can be addictive. Having healthier choices would be welcomed, but these have be able to compete on price with the ‘fried chicken takeaways’.

As public health advocates we also have to be more sensitive to the pressures young people are under around drugs and alcohol, from their peers as well as the media. It can be hard to say no to trying drugs and alcohol, especially when they are sometimes seen as not a problem and ‘everyone does it’. More reliable information about the risks and the realities would help young people make more informed decisions.

Looking ahead to this year, 2014/15, across PHE and DH we will continue to work directly with children and young people. This is being shaped in discussions with the National Children’s Bureau, British Youth Council and other leading organisations — and of course with young people themselves.

All of us involved in this work are overwhelmed by the energy and thoughtfulness that the young people have brought, not to mention the generosity and commitment by which they have engaged with us. We, in turn, are committed to embedding an approach of ‘nothing about us without us’ in all that we do.

My thanks to Wendy Nicholson (professional lead, school nursing DH) and Eustace de Sousa (Deputy director – children, young people and families, PHE) for their leadership in this work and for kindly sharing their knowledge for this blog and to all the children and young people who advise us.
A cry for help

School and public health nurses are in a unique position to identify children who may be exposed to parental domestic abuse. Equally, they have a vital role in supporting young people experiencing relationship abuse, explains Diana Barran from CAADA

Domestic abuse has a grave impact on the health and well-being of children who are exposed to this behaviour within the family. 130,000 children live in households where there is serious violence and abuse between parents, and hundreds of thousands more are exposed to it at lower risk levels. It is a factor in the background of two-thirds of serious case reviews; a number of these have made the headlines recently, including the tragic cases of Daniel Pelka and Hamzah Khan. Such cases act as a stark reminder that we all need to recognise the risks faced by children exposed to domestic abuse if we are to prevent further needless deaths in the future.

Children exposed to abuse

Our latest national policy report, In Plain Sight: Effective help for children exposed to domestic abuse (CAADA, 2014) reflects these facts. It reveals a troubling picture of the harm experienced by children who witness violence between parents. Analysing a sample of 877 children receiving support from four specialist domestic abuse services in Blackpool and Devon, the report found a clear link between domestic abuse between adults and direct harm to children. 62% of children in the research had experienced direct abuse, for example emotional abuse, physical assault and/or neglect, in addition to witnessing the abuse of a parent. A staggering 28% of the total sample had experienced direct physical abuse.

The report also found that:
- Children are suffering multiple physical and mental health consequences as a result of witnessing domestic abuse: 52% of the children had behavioural problems, 39% had difficulties adjusting to school and 60% felt responsible for what was happening at home.
- A quarter of the children displayed abusive behaviour: this usually occurred once their exposure to adult domestic abuse had stopped. This behaviour was frequently directed towards their mother, sibling or friend, and rarely towards the main perpetrator of the domestic abuse.
- Children's health and well-being outcomes significantly improved after support from specialist children's domestic abuse services, and abusive behaviour also dropped from 25% to 7%.
- Children were less likely to experience direct harm if the parental domestic abuse had ended.
- Only half (54%) of the children exposed to domestic abuse, and two-thirds (63%) of those living with severe domestic abuse were known to local authority children's social care. 80% of the children were known to at least one public agency.
- Many families in the study were very vulnerable, which meant the child was exposed to other risks: there were substantial rates of disclosed mental ill-health and drug/alcohol misuse among both parents.

Teenage abuse

In addition to children who witness abuse between parents, we frequently hear about young people who have been exploited or abused within their own relationships. These experiences include intimate partner violence and abuse, sexual violence, sexual exploitation, cyber-stalking and abuse, gang-related violence, forced marriage, and ‘honour’-based violence. Some victims suffer multiple forms of related abuse. Our research report, A Place of Greater Safety (CAADA, 2012), estimates there are 3,500 16 and 17 year olds at risk of severe domestic abuse in the UK today. The report also shows that...
these victims experience at least the same level of violence as adult victims, and many endure additional problems which increase their vulnerability:

- 67% of the young people in our research experienced at least one severe abuse incident, for example: threats to kill, stalking, rape, serious sexual assault, broken bones, or strangulation.
- Nearly a third (32%) had attended A&E due to injuries, compared with 21% of adults.
- 21% were suicidal.
- 26% had self-harmed.
- 26% were experiencing financial problems — an identified barrier to leaving abusive relationships (Bell & Kober, 2008).

How do children describe the impact of domestic abuse on their health and well-being? Anonymised quotes from *In Plain Sight*

‘Every time I felt scared I wanted to go into my room, curl up into a ball and start screaming.’ **Chloe***

‘I don’t feel safe at school ’cos my dad says he’s going to come and take me away. I just try and stay with friends, near teachers and near buildings where teachers are.’ **Peter***

‘There was physical violence twice a week [during contact sessions] in front of him, it was not pleasant for him and not pleasant for me…. My son was in tears…. He was seeing the case worker then and she was vital for him.’ **Daniel’s mum***

‘If my dad would be angry and everything, I would copy him, that’s how I got angry…. he used to shout at me all the time and I thought that was a good thing.’ **Hassan***

‘Things are better than they were. But I’m still waking up scared and having nightmares, but they’ll go away won’t they?’ **Alfie*, aged 11**

‘I never invite my friends home. I never know if dad’s gonna kick off.’ **Alyssa*, aged 15**

‘I worry about school phoning home when I’ve been in trouble, because then dad takes it out on mum. It’s my fault.’ **David*, aged 13**

*To protect identities, names have been changed.

Pregnancy is a critical time for victims. Our data indicates that girls under 18 who experience domestic abuse are three times more likely to be pregnant than their older counterparts. Information on the referral routes taken by these younger victims demonstrates that they are more likely to be identified by the police, children’s safeguarding and health agencies, and that only four per cent would self-refer to a specialist domestic abuse service.

In recognition of the prevalence of abuse experienced by young people, last year the government updated the definition of domestic abuse to include victims of 16 and 17 years old. We welcomed the change as we believe it will help improve the response to this particularly vulnerable group. To help local areas meet the change and better support teenage victims CAADA has developed the Young People’s Programme, where nominated professionals are trained to act as local champions. These Young People’s Violence Advisors are building partnerships with local agencies to create an effective care pathway for young people - both victims and those who cause harm to others. Some of them will also hold a caseload of young people.

**How can school nurses help?**

Firmly established within the school community, school nurses can play a special role in providing confidential support to vulnerable children and young people. These are often children and young people experiencing a range of health and social inequalities, including domestic abuse at home or interpersonal violence within their own relationship.

In addition to arranged support meetings and drop-in sessions, school nurses come into contact with children and young people on other occasions, such as provision of immunisation or routine health surveillance.
Christine Etheridge, Policy Advisor at CAADA for the Young People’s Programme and a former school nurse, explains: ‘It’s so important to make every contact you have with a child or a young person count. Being extra vigilant for signs of domestic abuse and interpersonal violence and taking time to talk to pupils will help you identify children and young people at risk at an early stage.’ To effectively support a young person who might be experiencing abuse at home or within their own relationship, it’s important that you are familiar with the school’s child protection policy and referral procedures.

The unique role of school nurses means that they are vital in providing early intervention and prevention education. Acting as a champion to ensure that domestic and relationship abuse is included in the school’s personal, social, health and economic education (PSHE) or sex and relationships education (SRE) curriculum is one area where school nurses can really take the lead,” adds Jo Morrish, learning and quality services manager at CAADA. ‘If it’s not currently included, approach the headteacher to raise awareness of these issues. You don’t need to deliver the training yourself, you can for example invite the local domestic violence co-ordinator to talk to school staff.’

Strong partnerships such as these form the cornerstone of a good response. ‘As the majority of school nurse services transfer to the local authority in 2015, working with strategic partners, such as your local Director of Public Health, to ensure the issues of domestic and relationship abuse among children and young people are high on the agenda will be crucial,’ adds Etheridge. For specialist advice, find out what local domestic abuse services are around. In many areas, there will also be a Young People’s Violence Advisor available. They can help you to improve the response to those young people who are experiencing domestic abuse in their own relationship by providing practical recommendations and sharing information about new tools and research. For those aged 16 and over, there will also be a Multi-Agency Risk Assessment Conference (MARAC), a meeting where representatives from a range of agencies support the highest risk cases, and thus ensure effective action and safety planning.

The subtle signs of abuse – what should nurses look out for?

**IN CHILDREN WHO MAY BE EXPOSED TO DOMESTIC VIOLENCE AND ABUSE AT HOME:**
- Fear of getting hurt and of someone else getting hurt.
- Withdrawal.
- Bed wetting.
- Problems with social development and relationships; delayed development.
- Aggressive and abusive behaviour towards mother/siblings and friends/partner.
- Anxiety; difficulties in sleeping.
- Difficulties adjusting at school.

**IN YOUNG PEOPLE WHO MAY BE EXPERIENCING RELATIONSHIP ABUSE:**
- Not achieving at school.
- Poor concentration and attendance.
- Eating disorders
- Alcohol and drug use.
- Repeated sexually transmitted infections.
- Early pregnancy.
- Mental health issues.
- Self-harm.

**Health policies addressing domestic abuse**

In February 2014 the National Institute for Health and Care Excellence (NICE) published new guidance: Domestic Violence and Abuse: How health services, social care and the organisations they work with can respond effectively. The guidance is aimed at health and social care commissioners, practitioners and others whose work may bring them into contact with people who experience or perpetrate domestic abuse.

In addition to advice for health commissioners, the guidance includes a range of practical recommendations which health professionals can embed in their practice:
- Participate in a local strategic multi-agency partnership to prevent domestic abuse.
- Create an appropriate environment for disclosure.
- Access training which focuses on how to ‘ask the question’ and establish a local referral pathway.
- Adopt clear protocols and methods for information sharing.
- Tailor support to meet people’s needs.
- Provide people who experience domestic abuse and have a mental health condition with evidence-based treatment for that condition.

Recommendations 10 and 11 in the guidance are particularly relevant to providing support for children and young people, and outline best practice around identifying and, where necessary, referring children and young people affected by domestic abuse to relevant local agencies.

**Further reading**

To learn more about the Young People’s Programme and how to link up with a Young People’s Violence Advisor in your area, visit www.caada.org.uk/youngpeople

To download In Plain Sight: Effective help for children exposed to domestic abuse report, visit: www.caada.org.uk.

To download a free MARAC toolkit for health visitors, school nurses and community midwives, visit www.caada.org.uk/marac/Toolkit-Health-Feb-2012.pdf.

To access the National Institute for Health and Care Excellence guidance: Domestic Violence and Abuse: How health services, social care and the organisations they work with can respond effectively, visit: guidance.nice.org.uk/PH50.

**References**


**Further information**

To learn more about the Young People’s Programme and how to link up with a Young People’s Violence Advisor in your area, visit www.caada.org.uk/youngpeople

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SAPHNA is the leading professional organisation representing the voice of school and public health nurses across the UK.

Our growing community of more than 2,500 professionals are dedicated to promoting excellence in practice and improving the health and well-being of the communities in which we work.

Benefits of SAPHNA membership include:

• A professional officer
• Free subscriptions to The Journal of School and Public Health Nursing and The Journal of Family Health Care
• Dedicated enquiry and support line
• ‘Members-only’ website content
• Free and member-only discounts for events and publications

For more information, contact Sharon White, professional officer on 07702 871 922 or email her at: sharon@saphna-professionals.org

www.saphna-professionals.org
## Safety first

Last year we detailed the vital role the Health Conditions in Schools Alliance had played in influencing the Children and Families Bill to provide schools with a statutory requirement to support children with long-term medical conditions. School nurses will return to work this September secure in the knowledge that they helped bring about a small revolution. Bibi Berki explains how it will work.

### The new legislation

The School and Public Health Nurses Association (SAPHNA) was among 30 charities and organisations making up the Health Conditions in Schools Alliance, whose successful lobbying of the government has brought about new statutory measures aimed at levelling the playing field for all English school children who require medication during school hours.

The new legislation, which comes under the Children and Families Act 2014, kicks in at the start of the new school year. Governors and head teachers will be tasked with introducing a system of tailored, individual healthcare plans. These will not only detail the conditions and needs of the pupils with long-term health issues but also outline which staff members are responsible for their care. The plans must be regularly reviewed and be accessible to both parents and staff.

### Establishing a need for training or recruitment

In addition, schools may have to recruit new staff to carry out these statutory functions and, at the very least, train their existing staff to tend to children with confidence and dedication.

It is on this issue of training that the Alliance members say they will do everything they can to make the transition easier for school staff.

Jill Beswick, a member of the SAPHNA executive, explained: ‘Teaching assistants will need appropriate training so that they are able to provide high quality care. The school might also have to recruit a support worker for the giving of medicines and provision of care clearly stated in the job description.’

The emphasis, she says, will be on a high level of training which goes beyond basic first aid.

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‘The schools themselves will have to take responsibility so there will be a need to be accountable now.’

Charities to provide support
Alliance member Diabetes UK is also promising to be there for schools. The charity launched its schools campaign Type 1 Diabetes: Make the grade, last month (Thursday, 29th May), with packs for parents, schools and health care professionals and a brand new schools information page on its website aimed at spreading expertise in dealing with the condition. Later in the year it will unveil its volunteer advocacy service which will help parents get the care their children need in school.

Luke Thorne, public affairs officer for Diabetes UK, says the charities are only too willing to lend their expertise to schools.

‘What we’ve always said is that we know of lots of schools who look after children with Type 1 diabetes really well. It can be done. It’s having the will and the know-how to do it. We will now be working with schools, families and healthcare professionals to make sure they know how to provide brilliant care for children with Type 1 diabetes.’

This level of support, mirrored by the other Alliance charities, reveals a degree of sympathy for schools, which will unquestionably have a new layer of administration to cope with.

But there is simply no other way, says Thorne, if we are to provide all children with equal access to education, regardless of their health. Too often, he points out, children needlessly miss out on activities and opportunities because of their medical condition while a lack of understanding of their condition can mean their academic work and even their health can suffer.

Tightening up the system
Under the legislation, a named person in each school will have overall responsibility for the implementation of the policy and will make sure staff are properly trained, are aware of a child’s condition, will arrange cover for teacher absence, brief supply teachers, make risk assessments for school visits and outside activities and monitor individual healthcare plans.

And this all kicks in as soon as the school is notified of a pupil’s medical condition, or in some cases, even before: ‘Schools do not have to wait for a formal diagnosis before providing support to pupils,’ says the guidance.

‘In cases where a pupil’s medical condition is unclear or where there is a difference of opinion, judgements will be needed about what support to provide based on the available evidence. This would normally involve some form of medical evidence and consultation with parents. Where evidence conflicts, some degree of challenge may be necessary to ensure that the right support can be put in place.’

Tailoring a healthcare plan
So what kind of information should go into a healthcare plan? The guidance suggests it should include:

- The pupil’s medical condition, its triggers, signs, symptoms and treatments.
- The pupil’s needs, including medication (with information on dosage, side-effects and storage), facilities, equipment, dietary requirements and environmental issues, for example problems with overcrowded corridors.
- Support for the pupil’s educational, social and emotional needs, for example how the staff should allow for the pupil’s protracted absences.
- The level of support needed. Some children will be able to take responsibility for their own health needs.
- Who will provide this support and cover arrangements for their absence.
- Who in school needs to know about the child’s condition.
- Arrangements made for written permission from parents for staff to administer medication or for the pupil to do it him- or herself.
- Arrangements in place for school medication or for the pupil to do it him- or herself.
- Designated individuals to be entrusted with information if there are confidentiality issues.
- What to do in case of an emergency. Some pupils may have an emergency plan prepared by a clinician that could inform the school plan.

The formats of healthcare plans can vary and the plans should be easily accessible to all who need to refer to them, while preserving confidentiality. They should be initiated in consultation with the parents and drawn up in partnership with the school, parents and relevant healthcare professionals.
‘Plans should not be a burden on a school, but should capture the key information and actions required to support the child effectively.’

Staff training is vital, says the document, and must be organised by governing bodies. ‘Training should be sufficient to ensure that staff are competent and have confidence in their ability to support pupils with medical conditions and to fulfil the requirements as set out by the individual healthcare plans.’

The National Union of Teachers, which represents 388,000 teachers in England and Wales, took part in the consultation process and made it clear that ‘it is imperative that staff receive suitable training’.

An NUT spokesperson told the Journal of School and Public Health Nursing: ‘We believe the vast majority of schools do an excellent job supporting pupils in this situation. Schools should be able to access support and advice as necessary in order to meet the new statutory duty.’

And of course the parents will have a role and are described as a ‘key partner’. Their side of the bargain is the supply of medicines and equipment and the willingness to be contactable at all times.

**Rules to minimise risk**

The guidance recognises the risks of poor practice and provides a list of rules that all schools must follow to eliminate risk. These range from ensuring that medicines are not out of date to their safe storage. Pupils who need to know the whereabouts of their medication should be aware of who holds the keys. Asthma inhalers, blood glucose testing pens and adrenaline pens should always be available and not locked away and this particularly applies to school trips. Records must be kept of who gets what.

The school’s healthcare policy should clearly set out emergency procedures and a member of staff must always accompany a child who is being taken to hospital from school.

The guidance also suggests that each school purchases a defibrillator and notifies the local NHS ambulance service that they hold one. First aid-trained staff, it advises, should also be trained in CPR.

Children should never be penalised if their poor attendance is as a result of their illness. They should not be prevented from drinking, eating or taking toilet breaks if these are needed to manage their conditions.

Parents, say the guidelines, should never be forced to attend school to administer medication.

It makes no bones of the fact that, ‘no parent should have to give up working because the school is failing to support their child’s medical needs’.

The Health Conditions in Schools Alliance was formed to lobby the government to bring about improved conditions for children with long-term illnesses at schools. Details of their membership and of their lobbying work can be found at http://www.publications.parliament.uk/pa/cm201213/cmpublic/childrenandfamilies/memo/cl26.htm

SAPHNA welcomes the revised guidance and its underpinning intention to enable all children and young people, regardless of any health condition, to achieve and enjoy in their school lives. School nurses are well versed in supporting children, young people, families and schools and, alongside this more robust guidance, will continue to work in partnership to further promote improved health and wellbeing of the whole school population.

Sharon White, professional officer for SAPHNA

**Further information**

The Supporting Pupils at School with Medical Conditions: Statutory guidance for governing bodies of maintained schools and proprietors of academies in England was published by the Department for Education in April 2014 and has recently been updated. The consultation on the new statutory guidance ran for six weeks from February 3 to March 14 2014. There were 265 responses to the consultation. (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/3069935/Statutory_guidance_on_supporting_pupils_at_school_with_medical_conditions.pdf)

Listen up

My life, My health is the name of a new campaign launched by the National Deaf Children’s Society which calls upon health professionals, deaf young people and their parents to work together to ensure deaf teens get the health support they need. Krishna Maroo explains how school nurses can help

The My life, My health campaign and resources highlight the issues affecting deaf young people when accessing healthcare. It has been developed with the help of the charity’s Young People’s Advisory Board – a group of 17 deaf young people from around the UK.

Challenges in health care

More than 200 deaf young people from across the UK were contacted by the National Deaf Children’s Society (NDCS) and shared their experiences through focus groups and an online survey. Those consulted with had different levels of hearing loss and communicated using sign language, spoken language or a combination of both.

The charity found that deaf young people often face many barriers before they even meet a health professional – lack of basic deaf awareness in health settings is a key issue, impacting on their confidence, as well as their experience and trust in the service. Young people said that staff not looking at them when speaking to them, appointments taking place in rooms with background noise and poor acoustics all made their visit to a health professional difficult.

Deaf young people said that the information they receive from health professionals is often complex and hard to understand. As a result they are missing important information or relying on friends and family to tell them information about their own health. Surgeries do not always provide deaf friendly services, such as the option to book appointments by text message or visual display screens to announce appointments. It is vital all staff communicate clearly and that sign language interpreters are available to those who require one.

Most deaf young people said they would not consider going to their health care appointments alone because of a lack of confidence, and worries about deaf awareness and inaccessible information. Some deaf young people believed that their future partner or children would support them in the future. Others

Krishna Maroo
Senior participation manager, National Deaf Children’s Society

Top tips for school nurses

- Prior to an appointment with a deaf child or young person, ask them if there is anything they need you to do to help them understand you.
- Keep background noise to a minimum.
- Don’t stand with your face in the shadow or with a window behind you, as this makes it hard to read your lips.
- Keep still, it is hard to lip-read someone who is moving around.
- If you are not sure a child has understood something, don’t give up. Try writing it down.
- Encourage a deaf young person to ask questions, ask if they have understood or if they would like you to write down a summary of what you have said.
said they thought that their parents would continue to support them, however old they might be.

**How can school nurses provide support?**

As a result of the focus group, the charity has created a practical range of resources for parents, professionals and young people: a campaign video, factsheets, top tips and a wallet-sized card for deaf teenagers to write down their communication needs for health professionals. The charity has also created top tips for health professionals on how to become more deaf aware (see Top tips box), which are ideal for school nurses. There is information and guidance for parents too.

It is key for school nurses to establish good communication with parents/carers of deaf children and other professionals involved in a deaf pupil’s support, for example, teachers of the deaf and audiologists. As a school nurse, you may face some challenges, especially if you have not been provided with information about the child in advance, or are a visiting school nurse who might not have access to information about the child and their deafness until you meet them.

**How you can help:**

1. Find out if there are deaf children and young people in your school by speaking to your local specialist education support service for hearing impaired pupils.
2. Download or order the My life, My health campaign resources from ndcs.org.uk/mylifemyhealth.
3. Share the My life, My health campaign resources with others in the school nursing team and consider signing up to deaf awareness training.
4. Share the resources with your colleagues and any deaf children you support.
5. Become a National Deaf Children’s Society professional member and have access to hundreds of free resources, including our professional’s newsletter. Visit ndcs.org.uk to become a member.

**Key contact: teacher of the deaf**

A Teacher of the Deaf is a qualified teacher, who is additionally qualified to teach deaf children. They provide support to deaf children, their parents and family, and to other professionals who are involved with a child’s education. They should be able to help you with more information on the issues highlighted above. You can find out who a particular teacher of the deaf is by speaking to your school’s special educational needs co-ordinator (SENCO).

**What does the National Deaf Children’s Society mean by the term ‘deaf’?**

The National Deaf Children’s Society uses the term deaf to refer to all types of hearing loss from mild to profound. The term includes deafness in one ear or temporary deafness such as glue ear. It includes all children and young people that health professionals may identify as having a ‘hearing impairment’.

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**Case study**

Lesley Messenger-Jones is a school nurse who is also the parent of a deaf child, Zanna aged 17. Here she explains why this campaign is so beneficial.

Lesley has been a school nurse for over 13 years and previously worked in the community as a district nurse. She is also a busy working mother to four children, including Zanna who is profoundly deaf and lip-reads to communicate. Zanna uses a cochlear implant in one ear, a hearing aid in the other and uses a Radio Aid at school.

Lesley says: ‘I feel as a parent of a deaf child I have a unique insight into a deaf child’s needs – but every child is different. I understand about the benefits of equipment like Radio Aids, and I know what questions to ask. I would say a lack of deaf awareness and training for school nurses could have an impact on deaf children accessing the school nurse.’

As school nurses we face practical challenges, for example, the public health resources that we use, such as DVDs, can sometimes be outdated and do not have subtitles. This can impact on a deaf child. During an immunisation session, we ask many questions in an often noisy area and if we are not aware a deaf child is present, some information may not be understood or heard correctly, or heard at all. This concerns me as I know that my daughter would struggle in the same situation.

‘Following the simple steps from My life, My health can benefit school nurses and other health professionals, and most importantly can make a huge difference to deaf young people and their health experience, now and in the future.’

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**Further information**

National Deaf Children’s Society

http://www.ndcs.org.uk/professional_support/index.html

The National Deaf Children’s Society is the leading charity dedicated to creating a world without barriers for deaf children and young people. It helps deaf children, young people and their families, and professionals by providing practical advice and support. It’s important to remember that every deaf young person is different: some might use sign language, lip-read, or use speech – some might use a combination of communication methods. The best way to find out what a child needs is to ask them and also the other professionals who support them.

More information about My life, My health, including a campaign video and resources, can be found at ndcs.org.uk/mylifemyhealth.
The start of the career

I started at Basingstoke Voluntary Services (BVS) back in March. I first found out about the job through an email that was forwarded to me. I looked through the job details and thought it would be the perfect opportunity to show what I can do, so I applied for it and got an interview. About two days later I received a phone call to say I had been offered the 10-hour a week position. I was over the moon. I had wanted to be a youth worker for a while, so I was pleased all my hard work over the previous few months had paid off. I was so proud I rang everyone I could possibly think of!

The job

The job consists of two separate parts; detached work and hub-based work.

Detached work is initially quite daunting. You have to walk around certain areas of Basingstoke and act as a point of contact for young people. You are unable to approach them, so you have to wait for them to come to you. By repeatedly going back to the same places, they start to wonder why you’re there and ask questions – but that allows you to build trust and respect. It can take a long time to reach that level of trust, which can be quite frustrating at times, but it is also hugely rewarding when it does pay off.

The second part of the role is hub-based. The hubs are in areas such as Buckskin and South Ham in Basingstoke, and provide activities such as football, music and graffiti. The focus is on mental health and well-being and it gives the young people a chance to express themselves through their hobbies. It’s not all fun though. There’s a lot of paper work involved, which we use to measure how well we’re doing and the progress that we’re making.

The best part of the job though is the young people. We get to see the difference we’re making every time they attend. Every child is different – different hobbies, social skills and personalities – so it can be a big challenge as each child responds differently. But that is what being a youth worker is all about – showing young people about life, especially when things can get hard at times, so you need to be open. We are there to support them in the best way that we can.

A typical day

A typical day would depend on if we were in a hub or if we were detached. In a hub I’d turn up with my colleague and make sure we had everything we needed – leaflets, paper, pens and such. We would set up before the young people would arrive. If it was a planned hub we would sit down and talk about the subjects that are necessary. As I only work 10 hours a week, the shifts can seem very short and sweet!

When we’re working detached, because we’re on the streets, we would need things such as a football or a rugby ball. At the start of the day we’d set out a route, walk around and find a decent spot in which to wait and see who turns up. Sometimes no young people would turn up so we would then go somewhere else. It’s trial and error and can take three– to four weeks to find a group that we can stick to in that area.

Next steps

This job has definitely changed me. I feel more professional, and I think my passion and commitment to the job is evident – especially with the young people. You can’t be scared to open up to people, and they appreciate your honesty, which in turn helps build trust and respect. Of course, I think there’s room for improvement – just as there is in any job – but that will come with time, patience and virtue.

I’ve met some fantastic people since I left the Children’s Society, and I’ve been lucky with the opportunities that I’ve had. But this job has made me realise how important the work is that we do. We pull together as a team when things get tough, and working in such a fantastic charity really does open your eyes to see just how amazing people really are.

Previously, I’ve never had the patience to be able to stick to one thing for a long period of time – but I enjoy every moment that I spend there, on the ground, even when things get tough.

I don’t know what the future holds, but I’ve found that taking it just one day at a time works for me.
Parents always tell their children to ‘eat your vegetables’, but do they really ever listen?

The health benefits of eating vegetables are widely-publicised and now help is at hand for all parents and health professionals to overcome those well-trodden words “I don’t like vegetables”.

Mrs C! and her heroic team ‘The Vegetable Pack’ from the ‘Vegetable rack’ will help raise awareness of the benefits of eating vegetables through a series of beautiful illustrations, fun tales of adventure and interactive activities to engage children in.

“Using the book as a starting point for our topics and our writing created a real buzz in the school, the feedback from parents was overwhelming and the children are still talking about our ‘Vegeta-Ball’ disco weeks after the event ran. I cannot recommend this book highly enough!”

Kate Masters
Deputy Head – Stanley Green 1st School, Dorset

“This is a great fun book that brings vegetables alive. It is a well written rhyming story with wonderful characters that engages the children’s interest from the very first page. It is destined to become a firm favourite in our pre-school book box and will be a valuable resource to start topics such as healthy eating and growing etc.”

Verwood Pre-School

Price: £7.95
Order code: E149
Starting school is a huge milestone for every child and parent, but for a child with eczema this can be even more of a wrench. Dermatology nurse Julie Van Onselen and primary school teacher Kirstin Fraser offer advice to school nurses on the challenges a child with eczema can face and how to help them to overcome them.

The challenge of eczema

Part of the challenge is the fact that although eczema is common it is not a one-size-fits-all condition. Symptoms can vary enormously in severity in each individual child, and from time to time. Although it is likely that school nurses, teachers and teaching staff will have experience of children with eczema the experience of a child with mild eczema will be quite different to a child with severe eczema. Also, perceptions can cloud reality. A child with eczema which at first glance looks relatively mild may have more discomfort than a child with eczema which looks more severe and therefore is (incorrectly) perceived as such.

The other challenge with eczema is that triggers (and responses) to different things in the school environment really do vary with each individual child. The school nurse’s role is to offer guidance and advice to teaching staff but also reassure parents that there are systems in place to ease the transition.

Historically, there have been legitimate reasons for parental anxiety as levels of care have been variable in nature.

However, this will change from September, when Department of Health legislation comes into play (DH, 2014), and the revised guidance, Supporting Children with Medical Needs in Schools, will become mandatory (NB: see p17 for our article, which covers more detail).

Forward planning is key

It may take time until new procedures demanded by the new legislation come fully into effect, so many parents will find that planning and thinking ahead can still be useful in helping to allay their levels of anxiety.

When parents choose a school, asking relevant questions about how the school will be able to help their child with eczema, can be revealing and show how seriously the school considers medical issues.

Although parents will have filled in a medical form as part of the school admission procedure, meeting the head teacher and child’s reception teacher face-to-face in the term before the child starts school can be vital in building an understanding between the parent and the school about the child and their eczema.

This meeting is useful for parents to assess how the school will support their child with emollient application, and emphasise that the school health plan is communicated with all the school staff, including any temporary ones.

Eczema treatments at school

A child with eczema will need to have access to emollients at school. If the child has a skin infection, they will need oral antibiotics administered at school. Treatments for ‘eczema flares’, topical corticosteroids or topical calcineurin inhibitors are applied once or twice a day, so will be applied outside the school day. Emollients are prescribed therapies for eczema, so should be treated as medicines.

Parents may worry that their child’s needs may not be supported fully. However, they can be reassured that the new legislation Supporting Children With Medical Conditions in Schools (DfE, 2014), mandatory from September 2014, places the medical needs of the child at the forefront and expects schools to fully support them. This document will replace previous guidance on managing medicines in schools and early years settings, published in March 2005 by the Department of Education and the Department of Health.

The new legislation offers guidance on drawing up a suitable health plan saying it should be done in partnership between the school, parents, and a
relevant healthcare professional, eg. school, specialist or children’s community nurse, who can best advise on the particular needs of the child. Pupils should also be involved whenever appropriate.’

Crucially, for a child with eczema, it also acknowledges the need for ‘specific support for the pupil’s educational, social and emotional needs – for example, how absences will be managed, requirements for extra time to complete exams, use of rest periods or additional support in catching up with lessons, counselling sessions.’

**Medical and eczema history**

When school nurses take a child’s health history it can be useful to find out the following:

- Ask when the child’s eczema developed
- Ask if there are any patterns of eczema such as:
  - How often does the eczema flare?
  - Can it become infected?
  - Is their eczema better/or worst depending on the season?
- How often do they need to visit healthcare professionals?
- Ask if the child attends regular hospital appointments
- Predict the time off school due to appointments
- Does the child have any other relevant medical history?
- Allergies related to eczema?
- Any other medical history?

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**Friendships and other children**

Friendships and learning to be in a class with other children is part of becoming a school child and growing up. Some children with eczema may experience teasing, although typically this usually happens when a child is older, not in the reception class. By and large the other children are too young to be knowingly malicious. It is part of peer pressure at any age to ‘pick’ on someone who is or looks different.

There may be times when a child with eczema feels different, self-conscious, or anxious about fitting in at school. They may find it hard to make new friends, or find that other children are reluctant to touch them because they have eczema, or this may not be a problem at all. Signs that a child may be feeling anxious about their eczema include reluctance or refusal to go to school, or becoming irritable or upset when they get there. Being singled out for special treatment may make things more stressful for a child, so the teacher should be discreet. They might need additional help to deal with their feelings, or work on some coping strategies.

There are some delightful stories about eczema (which are often animal or cartoon characters), which could be read to the class in circle time, to help other children understand more about eczema.

**Stay positive**

Preparing a child for school is a worrying time for any parent, as it is a big milestone for both. However, it is important for the parent of a child with eczema to stay...
positive and think of ways in which their child can join in everything at school, rather than not taking part in activities. Most children with eczema cope well at school, as long as common sense is applied and special attention is paid to their physical comfort and they are helped to avoid triggers.

Although it won’t be possible for a school to give a child the one-to-one attention they may have at home or nursery, good communication by parents and an understanding of their condition by teaching staff, with support from the school nurse, can help them settle in.

**Parents can help by listing all their child’s normal routines and daily eczema treatments, such as:**
- Estimating how much time is spent every day treating their child’s eczema
- Writing all their child’s treatment down in a list
- Personally taking in their child’s emollients to school, to show the treatments that will need to be applied during the school day

**A parent’s view**

“My son, Stanley is now nine years old and has had severe atopic eczema since birth. I remember well his days at playschool. As we lived in the village, it was easy for me to pop in at lunchtimes and apply his emollients. When Stanley started school, I met with the teacher and head teacher and the school was excellent. They listened and tried their best to understand Stanley’s eczema needs. However, Stanley was in a busy reception class and sometimes it was difficult; on one occasion his arms flared badly, as he did not wash the paint off, after an art class. There were other occasions when the teachers were fantastic. One teacher recognised when Stanley became overheated and would take him out of the classroom and walk him around the playground until he cooled down. Stanley was expected to apply his own emollients, but he had to remember to ask his teachers for his creams, which were kept in a safe place at school. We did help Stanley prepare for applying his own creams at home, building up his confidence and using sticker charts. In his early school years, one big problem for Stanley was tiredness and even exhaustion at the end of the school day. His eczema was particularly severe during year 1 (He was in hospital for a week with eczema herpeticum), and he had very restless nights. However, school was very understanding and if he was in a deep sleep and could not wake, I was able to take him in later. Stanley was also allowed to wear 100% cotton at school, wearing a sweatshirt the same colour as the synthetic regulation school uniform; again this was very helpful. Stanley is now nine years old and copes extremely well with his eczema at school. He understands when he needs to moisturise, and is allowed to shower after PE and swimming, and knows his own triggers. I feel very proud of my son and also am very grateful to his school for being so understanding.

Emma Deeley, mother of Stanley

**Impact of eczema on sleep**
- Explaining how their child’s sleep is affected by their eczema
- Discuss, if their child has very restless nights, whether they can come into school late, on these occasions

**What triggers a child’s eczema?**
- Describe their child’s eczema triggers
- Explain that eczema will be triggered by your child getting too hot and with some school activities (especially messy play with paint, sand, water and clay)
- Discuss how triggers may be recognised and avoided in school

**How the child copes with their eczema?**
- Explain how their child feels about their eczema
- Tell them about the times when their child does not cope so well
- Discuss how they will help their child cope with their eczema at school and how they will also help other children understand the condition

**Common triggers at school**

A child’s eczema will be triggered by some things that are difficult to avoid anywhere. However, there may also be some new triggers, which are school related. These include:
- **Circle or carpet time** – Sitting directly on a carpet can irritate eczema.
  **Tip:** A cotton sitter can be a useful aid to prevent skin directly touching the carpet, especially in the summer term, when a child wears shorts or dresses.
- **Classroom pets** – Furry and feathered animals and birds may irritate eczema.
  **Tip:** It is best not to handle the classroom pet at all, or volunteer to look after it for the weekend or on the holidays.
- **Games, PE and playtime** – As well as getting hot running around, sweat can be a trigger. Dust may also be problematic, especially when limbs are exposed in PE kits (school halls tend to be dusty.
Sunscreens and eczema

- **Tip:** Wearing long sleeved cotton t-shirts and maybe leggings/track suit bottoms for PE, can reduce dust exposure.

- **Getting too hot** – This can happen in the classroom or during PE and playtime, and can provoke a scratching frenzy.
  - **Tip:** Make sure the child is not seated by the radiator or a sunny window in the classroom.

- **Messy play, art and cookery** – In the early years, messy play, art and cookery are regular learning activities and eczema may be triggered by the materials used, such as sand, water, paint, clay and some foods. Plants may also be problematic.
  - **Tip:** It may be beneficial to wear PVC gloves with a cotton liner for these activities and request if hands can be washed with an emollient after activities, rather than soap.

- **School trips** – May be a source similar and different triggers, for example farmyard or zoo visits; being outside with high pollen counts or in the hot sun
  - **Tips:** Consider any factors or things specific to the trip environment that may trigger the eczema.

- **School uniform** – Wool and synthetic fibres make the itch worst.
  - **Tip:** Invest in good quality 100% cotton, or alternatively, wear cotton layers under regulation synthetic uniform. Thin layers of uniform are better, as layers can be removed, if your child gets hot.

- **Sunscreens and eczema** – Children with eczema will need to apply sunscreens around their emollients at school. It is important that sunscreens are applied after emollients and gap is of approximately 15–30 minutes, (depending on how thick the cream or ointment is) before applying sunscreen on top of the emollient. It is important to apply emollient then sunscreen, as an emollient on top of a sunscreen could create a ‘frying effect’ and actually cause burning and skin irritation.
  - **Tip:** Do advise parents to use sunscreens that block rather than reflect, as they tend to be more eczema-friendly.

- **Swimming** – Chlorine will irritate eczema but it is also very important that children learn to swim
  - **Tip:** A layer of oily emollient should be applied before getting into the pool. Additional time should be allowed for an emollient shower after swimming and emollient application (this may mean getting out of the pool early).

**Further information**

This article first appeared in the National Eczema Society’s (NES) magazine Exchange, which is available to members.

Visit http://www.eczema.org/ to keep up with management and treatment of eczema – there is a section for health professionals.

The NES is also currently updating its packs for school nurses and these will be available from September 2014. However, the following are useful resources:


NES School Packs – Designed with activities for teachers to use with children (available for Reception to year 3; year 4 to year 7; year 8 to year 11).

**References**


**A nursery view – Transition from nursery to school**

‘I run a family centered nursery school where we place great emphasis on nurturing and cherishing each individual child in a kind and loving environment. I am also a mother and my son had atopic eczema as a child. So my staff and I completely understand the needs of a child with eczema and we work closely with parents to ensure that each child’s eczema and skin care needs are fully met at nursery. The transition from nursery to school begins in the nursery environment itself, as we proactively and sensitively support children to augment their confidence along with their personal and social life skills, thereby preparing them effectively for school. This is even more essential for a child with a long-term condition, such as eczema. A child with eczema requires a conscientious approach to the application of emollients, but it is important that the older child, in readiness for school, is helped to understand how to apply emollients themselves. Thus, when the child starts school and needs to be independent in looking after their skin, we would hope that the loving support and gentle encouragement given at nursery will not only support the care of the child’s skin but also promote the child’s independence and dignity, thereby protecting the child’s heart.’

Sandy Enjily, nursery manager, Oxford

**A primary school teacher’s view**

‘I am Kirstin Fraser, a primary school teacher. My current class is year 1 but I have also taught the reception year. I have atopic eczema and can still remember what it was like to cope with eczema when I was at primary school. The key to making school life easier for a child with eczema starting school is for the parents to prepare early, before the child starts school and clearly communicate their child’s eczema issues and triggers. It is the parent’s responsibility to make this contact and give as much information as possible to the school; the level of information needed and practical issues, do not necessarily feature on a school medical form.

As a primary school teacher, I would do my best to support a child with eczema in my class and understand how their eczema affects them and how to avoid triggers at school. It is important for parents to understand that teachers do have to follow policy, one example relating to eczema care is, at school we can only supervise and support a child with moisturising at school, as school staff are not allowed to physically apply creams and ointments. Schools always want to do their best for each individual child. Your child’s happiness is paramount, a happy child is one who will learn and get the best from school.’
Carers, who provide vital support to millions of people at home in the UK every year, are to receive more support from community nurses, thanks to funding received by The Queen’s Nursing Institute (QNI) from the Department of Health. The project, initially funded for one year, has a full-time project manager and aims to engage 300 community nurses. School nurses are a very important group that will be an integral part of the project, because of the extensive contact they have with young carers.

**Developing a network of community nurses**

The 12-month project will:
- develop a network of community nurses dedicated to supporting the needs of carers
- recruit and support carers nurse champions across all specialities
- develop resource materials online and other media, and convene learning events
- carry out a national survey to identify areas of greatest need and potential for improvement.

Community nurses, including school nurses, general practice nurses and district nurses, have always worked closely with carers, young and old, helping them to give the best care to friends and family in need. It is in the interests of patients, carers, and nurses themselves if all can co-operate to the best of their ability. Carers who are well-supported by nursing teams are less likely to suffer ill health themselves, and are more able to give effective care, reducing the need for health service interventions.

Anne Pearson, practice development manager for the QNI said: ‘This is a vitally important project – we know that community nurses are more than willing to support carers. What they are asking for is tailored information to enable them to advise and signpost carers in the most appropriate way.’

**School nurses will enhance the development**

The QNI has already developed an online resource, to support nurses who visit patients at home to work more effectively with carers. The resource has been reviewed and has received encouraging endorsement as an intensive introduction to the importance of working effectively with carers, including young carers. The next stage of the development is to include new material relevant to school nurses, who are at the forefront of public health. It is hoped that the involvement of school nurses in this work will enhance the development of the resource; thereby supporting them in the excellent work they already do.

The QNI will also be working closely with SAPHNA and the Children’s Society over the coming year to bring together nurses from across the community nursing workforce.

School nurses already make a huge difference to the lives of young people; and it is hoped that by engaging with this project, we can help support them to continue their work with young carers. We would encourage all school nurses to get involved at this key stage in the project’s development.

‘School nurses are an integral part of the project because of the extensive contact they have with young carers’

Anne Pearson Practice development manager, QNI

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Further information

The online carers resource can be accessed at: www.qni.org.uk/for_nurses/supporting_carers and the latest project e-newsletter can be downloaded from the QNI’s website here: www.qni.org.uk/for_nurses/supporting_carers/carers_project_resources
Obesity in children is still one of the single biggest challenges facing healthcare professionals today, says Ian A McMillan, despite some recent encouraging news. We also bring school nurses news of some anti-obesity projects being run in schools.

Speaking at the Arthritis and Musculoskeletal Association's (ARMA) fifth annual lecture in London held in late November last year, Charles Greenough, NHS England’s national clinical director for spinal disorders, didn’t mince words. He blamed healthcare problems on obesity and the related lack of fitness among many young people in the UK. His view is that healthcare staff are battling against huge social change which is playing havoc with the well-being of children and their parents.

Professor Greenough, who continues to practise in orthopaedics at South Tees Hospital NHS Foundation NHS Trust in addition to his clinical director role, explained how the average 15-year-old girl’s waist size has increased by 7cm over the past decade.

‘If the average 15-year-old schoolchild was put into a race with his contemporary of 20 years ago he would lose by almost a lap in a four-lap race,’ he said.

His view tallies with findings published at the tail end of last year when the latest Health Survey for England (HSCIC, 2013), which monitors trends in the nation’s health, was published.

The findings are based on information collated by nurses who visited individuals and families across England who agreed to take part after more than 9,000 households were randomly selected. It is often used as a tool to monitor progress towards selected health targets.

It emerged that a relatively low proportion of children aged from five to 16 years old engage in at least one hour of ‘moderately intensive physical activity’ on a daily basis – the level set by the current guidelines. Just 21% of boys and 16% for girls fell into this category.

Among both genders, older children were less likely to meet the guidelines. While the proportion of boys aged from five to seven who met the guidelines stood at 24%, this fell to 14% among their counterparts aged from 13 to 15. Among girls in these age groups the decrease was even sharper – from 23% to eight per cent.
Most crucially, 14% of children aged two to 15 were found to be obese, with 28% of children classed as obese or overweight. Children aged from 11 to 15 were more likely to be obese (19% of both boys and girls) than those aged from two to 10 years (11% and 10% respectively).

Public Health England further contributed to this grim picture by publishing the latest National Child Measurement Programme statistics for the school year 2012–13 (NCMP 2013). The heartening news that obesity levels have ‘stabilised’ was almost instantly diluted with statistics showing obesity levels doubling in children between the ages of 4–5 and 10–11 years (from 9.3% to 18.9%).

The report also highlighted no positive move away from the strong links between obesity and deprivation, with the prevalence among children living in the 10% most deprived areas of the country nearly twice that of children living in the 10% least deprived areas (and greater still for those living in urban areas, compared to towns or villages).

Additionally obesity levels are significantly higher than the national average for children in both school years in the ethnic groups ‘Black or Black British’, ‘Asian or Asian British’, ‘Any Other Ethnic Group’ and ‘Mixed’ (14% of records were returned without an ethnicity classification).

Overall the report proved health inequalities continue, with children born in lower socio-economic circumstances today having vastly lower life expectancy, and higher rates of heart disease, diabetes, and certain cancers – all because of the circumstances they were born into.

The picture is similar in Scotland, and even worse in Wales. Almost three in 10 (28%) reception children in Wales were obese or overweight in 2011/12, according to the first report of the Child Measurement Programme for Wales (Public Health Wales, 2013). 22% of Primary 1 children were overweight or obese in 2011/12 in Scotland.

Our children deserve better...

This is something which concerns Professor Dame Sally Davies, England’s chief medical officer. In her annual report Our Children Deserve Better: Prevention Pays, (DH, 2013), she made it clear that there is a strong financial as well as a sound ethical case, for improving the health and well-being of children and young people.

She said: ‘What happens early in life affects health and well-being in later life.

‘There is increasing evidence that, in England, we are not doing as well as we should to achieve good health and well-being outcomes for our children and young people – when we compare both historically and within and between countries for mortality, morbidity, well-being, social determinants and key indicators of health service provision.

‘While our economic future may be challenging, there is a growing business case for improving the lives of children and young people. Improving health has the potential to benefit our nation economically.’

A practical approach

The report also points to evidence, from the National Institute for Health and Care Excellence guidance among others, that structured parenting programmes can help assist parents in providing a supportive and caring relationship and a structured environment at home. One example given in the report is the ‘Incredible Years’ group programme, based on social learning theory, that aims to improve child–parent interaction.

Another example is the Department of Health’s Change4Life initiative which aims to promote healthy lifestyles and well-being amongst children and their families, a practical attempt to bring levels of obesity down.
The information on the Change4Life website is presented in a down-to-earth way but still conveys vital health messages. For example, it states: ‘These days, ‘modern life’ can mean that we’re a lot less active. With so many opportunities to watch TV or play computer games, and with so much convenience and fast food available, we don’t move about as much, or eat as well as we used to.’

‘Nine out of 10 of our kids today could grow up with dangerous amounts of fat in their bodies. This can cause life-threatening diseases like cancer, Type 2 diabetes and heart disease.’

Families can register at: https://registration.change4life.co.uk

Further information


The WHO report on ending childhood obesity gives an interesting global perspective: http://www.who.int/dietphysicalactivity/end-childhood-obesity/en/

References


Healthy Heroes

Healthy Heroes is a scheme developed last year by the Lancashire Healthy Schools Programme, with the aim to raise awareness in primary schools of the importance of healthy eating and physical activity among families.

Four Healthy Heroes and their sidekick ‘Freddie’ are used to introduce and reinforce healthy eating and physical activity key messages through a range of activity cards which school pupils select to take home and work on together with their family. Once families complete the challenge a suitable reward, such as a family pass to use at their local leisure facilities, is given.

To find out more about ‘Healthy Heroes’, visit: www.nhs.uk/change4life/pages/schools-case-studies.aspx

Ideas for creating an ‘active school’

The Phunky Foods Programme has a full curriculum for physical activity, including ideas for small spaces, which can be accessed by our registered schools at www.phunkyfoods.co.uk/dashboard/curriculumoverview/area/physical/. Additional hands-on support is available in the growing number of areas where the programme has recruited energetic community support workers. These are some of their ideas for creating an active school:

1. Continuing professional development (CPD) of teachers to understand how to build physical activity into lessons across all areas of the curriculum.
2. Creating school ‘active travel’ plans to encourage more young people to cycle/walk to school. This could include anything from a walking bus, to cycle training, to inter-school competitions.
3. Encourage the sharing of facilities such as through letting community sports clubs use school facilities to provide the after school opportunities for students in schools in the area.
4. Provide allowances to teachers running after school clubs.
5. Breakfast fitness clubs.
6. Short activity breaks between or during lessons.

Visit www.phunkyfoods.co.uk/communitysupport/ for more information

Further information


The WHO report on ending childhood obesity gives an interesting global perspective: http://www.who.int/dietphysicalactivity/end-childhood-obesity/en/
For more than 20 years the Journal of Family Health Care has been providing the latest research and up-to-date information on a huge range of topics concerning the health and well-being of infants and young children. These exciting new books bring together a selection of articles from the Journal’s recent archives for the first time to provide comprehensive, informative and convenient reference tools for community health professionals, including health visitors and their teams, midwives, school nurses, practice nurses, dietitians, practice teachers, tutors and students, as well as community paediatric nurses.

The CD-roms that accompany the books supply a number of factsheets that cover many of the issues discussed, which can be printed out and left with parents, schools or anyone else affected by the issues covered, enabling community health professionals to easily provide reassurance and advice.

Volume I turns its attention to food, nutrition and some diet-related issues, and provides some of the best articles, written by leading experts in their fields, to have been published in the Journal of Family Health Care over the last few years.

Volume 2 explores the ever growing problem of allergies, including asthma, and the causes and management of allergic conditions. Carefully selected from the archives of the Journal of Family Health Care, this book provides some of the best articles to have been published by the journal in recent years, written by some of the leading experts in the field.
In his final diary piece Paul Watson reflects on how his year of studying has resulted in him putting theory into good practice.

Welcome to my final diary entry. Gosh, this last year has gone by so quickly! Last September, during the SCPHN course induction I remember sitting quietly in class with around 40 strangers (all experienced nurses) consisting of health visitors, school nurses and district nursing students, and there was me... straight out of the pre-reg factory; smiling on the outside but petrified on the inside.

One thing that sticks out to this day was the video presentation from last year’s course students. The previous cohort gave us some really good tips to prepare for the year ahead, but the sticking moment was when they said how hard it was, and that it left them in tears at times! To be honest, I felt a bit blasé at that point, thinking they were just being dramatic. How hard could it really be for someone like myself, who had just completed their degree?

Well, time would provide an answer and put all of this into context. At the start of the course there were nine bright-eyed and eager students doing the SCPHN PgDip, but then the nine became four. Even I questioned during the early weeks whether the fact I had only started my own journey in education four years previously, meant that perhaps writing and learning at masters level was simply a bridge too far. But I stuck with it and took a leap of faith in myself.

However, the run up to last Christmas would test me again, both personally as well as academically. Regular readers of this column will know that this was the point when I seriously contemplated dropping out of the course. It started when my first essay came back with a fail, which was absolutely devastating. When it became clear that I had failed some of the other exams that I had taken, my confidence took a further knock. But with a good shake off I re-sat them and passed. It helped that my family and the academic staff were fantastic and gave me the hugs I needed in order to summon up the strength to move on and face another challenge.

As the course progressed into the new year I still found it really hard and challenging, but I also knew I was there for a reason. I was being given an opportunity many before me had not had, and I had to grab it with both hands. I started to see with more clarity what this course and my future role as a SCPHN school nurse could provide for me, both personally and professionally.

The theoretical process was sinking in, and my clinical practice started to take shape; I was moulding into a school nurse. In practice I was still being supported closely by my CPT, as I had not been a nurse before, having just left pre-reg training. There came a point around Easter time that I had a very deep and meaningful conversation with my CPT; it was time for me to fly the nest, become a practising nurse and make my own decisions. Thankfully my CPT was fully supportive and agreed that I was now competent and able to practise more freely.

Out in practice I was asked questions about children and young people’s physical issues. I also faced child protection issues, but I met these challenges and by doing it gave me more confidence in my own practice. I am not implying that I have reached my destination of being an established SCPHN school nurse, but acknowledging these first baby steps means I am on the way to assuring both myself and my colleagues of my potential to become, over time, a very good school nurse.

Along the way I have had some very tough times but these have been balanced by amazing ones too. I have presented to the National School Nurse Advisory Group and the RCN interviewed me for an article on supporting military children and young people’s health and well-being. I have been contacted by other professionals for advice on supporting children and young people in military families. This population is dear to my heart, I know them well and it is a deep-rooted passion of mine to work and advocate for this unique community. I have been very fortunate to have been given this opportunity, by being offered a role as a SCPHN school nurse in Catterick Garrison, North Yorkshire.

I would like to thank everyone at SAPHNA (especially Sharon White), my tutors, especially Michelle Sobande, my CPT (Michelle MacMurray) and Wendy Nicholson (from the Department of Health) for supporting me through my journey. I would also like to thank you, the readers, for taking the time to read my journey through my course. I hope I will meet and connect with some of you on the other side.

As we went to press it was announced that the Twitter feed #WeScNs will run a designated school nurse chat forum every two weeks called @WeSchoolNurses. Paul has volunteered to help be one of the forum’s moderators and will bring his enthusiasm and knowledge of mental health issues to the fore. See p7 for more details.
Recognising abuse

Child Safety Week
Child Safety Week runs from 23–29 June. Led by the Child Accident Prevention Trust, it aims to raise awareness of the risks of child accidents and how they can be prevented. http://www.childsafetyweek.org.uk/

Join SAPHNA for FREE!
For a limited time only you can join SAPHNA for FREE. http://www.jfhc.co.uk/saphna/saphna_membership.aspx

SEN bullying guidelines launched

Hold the date
The School nurse INTERNATIONAL conference, which will be hosted by SAPHNA in partnership with the DH and Public Health England will take place on July 27th–31st 2015.

Inside view
@WeSchoolNurses tweeted this cute Department of Health (DH) poster, designed by young people, to describe how they see the supportive role of a school nurse. You can download your own poster here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216938/School-Nurse-publicity-YP-version-final-aug-2014.pdf

Sharon White is pictured here with Wendy Nicholson (centre, DH Professional Officer for School Nursing) and Penny Greenwood (right, SAPHNA exec) prior to the recent Nursing Awards ceremony.

Someone you know and can trust...
Healthy eating made easy
Teaching children to make healthy food choices using a colourful and fun approach

A classic tale of heroes vs. villains using food heroes and food villains

It is often a struggle to persuade children to eat healthily, but research shows that there is a very simple solution: give healthy foods superhero names and personalities to inspire kids’ imaginations.

The Food Fight is a fun, educational children’s book and CD-rom about healthy foods (food heroes) and unhealthy foods (food villains).

“provides a great basis for a discussion on what constitutes a healthy diet in any educational setting, or could just as easily be read at home. It is good to see a children’s book that is fun and educational, and based on sound nutritional principles.”

Reviewed by Beatrice Cutler
The Nutrition Practitioner – Spring/Summer 2013

“A must have for your book collection as so clear and informative for parents and great fun for children too. My daughter loves telling us what we should be eating now. It is worth every penny without a doubt.”

Reviewed by Deborah Broughton
Amazon – August 2013

Price: £12.95
Order code: E133
Order online at: www.pavpub.com/the-food-fight
Because HPV is the last thing on a girl’s mind

- In 2010/11, over 10% of eligible girls did not start their course of HPV vaccination
- You have an opportunity to change this. Gardasil® is available at no cost for GP practices through ImmForm, for all previously unvaccinated girls aged 12–17

FIND THEM. REMIND THEM. HELP PROTECT THEM.

For further information, contact your local Sanofi Pasteur MSD representative or visit www.123againstHPV.co.uk

ABRIDGED PRESCRIBING INFORMATION

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

Refer to Summary of Product Characteristics for full product information.

Presentations: Gardasil is supplied as a single dose pre-filled syringe containing 0.5 millilitre 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). There are type 6 (20 µg), type 11 (40 µg), type 16 (40 µg) and type 18 (20 µg).

Indications: Gardasil is a vaccine for use from the age of 9 years for the prevention of premalignant genital lesions (condyloma acuminata) and cervical cancer causally related to certain oncogenic Human Papillomavirus (HPV) types and genital warts (condyloma acuminata) causally related to certain oncogenic Human Papillomavirus (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 years old children and adolescents. The use of Gardasil should be in accordance with official recommendations. Dosage and administration: The primary vaccination series consists of 3 separate 0.5 millilitre 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 dose and the third dose at least three months after the second dose. All three doses should be given within 1 year period. The need for a booster dose has not been established. The vaccine should be administered by intramuscular injection. Gardasil must not be injected intradermally. Neither subcutaneous nor intradermal administration has been studied. These methods of administration are not recommended. Contraindications: Hypersensitivity to any component of the vaccine. Hypersensitivity after previous administration of Gardasil, Austin serotype 16 Vaccine, Warts 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 rare anaphylactic reactions. The vaccine should be given with caution to individuals with thrombocytopenia or any coagulation 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: pyrexia, pruritus at the injection site, nausea, and pain in the extremity. Rarely urticaria and very rarely bronchospasm has 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 millilitre dose pre-filled 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 (pre-filled authorisation number). Package quantities and basic NHS cost: Single pack containing one 0.5 millilitre dose pre-filled 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 (pre-filled authorisation number). Find them. Remind them. Help protect them.

For further information, contact your local Sanofi Pasteur MSD representative or visit www.123againstHPV.co.uk