DON’T WORRY, BE HAPPY
How to boost children’s self-esteem

THE LAST TABOO
Empowering the brave victims of FGM

EMBARRASSING BODIES
Positive ways of coping with IBD
Measure precisely, transport comfortably. seca makes it easy for school nurses.

A child’s height and weight are important indicators of overall health and nutrition. So it’s all the more important that these measurements be taken at school. A scale for this purpose has to fulfill some critical criteria— it has to be easy to use, light to carry and requires small dimensions. Like the flat scales from seca you see here. Used together with the portable stadiometer seca 217 they all fit into the tailor made carry case seca 414 with handle and shoulder strap, it’s the perfect measuring system for the school nurse.

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www.seca.com
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Welcome back to work to those of you who had time off during the summer. While I was fortunate enough to have a week away in Spain, I also worked for much of the time. One high point for me was joining colleagues from around the globe at the School Nurse International Conference in Slovenia.

It was an event bringing together like-minded souls with a shared passion, vision and commitment to improving the health and well-being of children and young people worldwide. Spearheaded by inspirational school nurse leaders, it was a powerful experience and a reminder of our value. Wendy Nicholson, the School Nurse Professional Lead at the Department of Health, shares her experiences of the conference in her regular policy update article.

Our leader considers self-esteem and proposes that it should be considered a vital life tool for children and young people. One great way of boosting self-esteem for younger children is peer-to-peer massage and you can read all about this on p12.

Elsewhere in the journal the Association of Young People's Health share with us their recent, poignant work with those who have experienced sexual exploitation and the resources the young people have developed to enable us to support others.

Staying on the safeguarding theme, Shelagh Willis discusses female genital mutilation and the role of the school nurse in identification and ongoing care. Meanwhile, the debilitating effect of inflammatory bowel disease is explored by Crohn's and Colitis UK, whose campaign this year has a revised focus on young people. They share with us the interesting findings of their recent research.

A further example of technological development is outlined by Michael Thomson, who presents the School Screener, an innovative programme that can assist school nurses and other professionals in vision and hearing screening along with height and weight monitoring.

The diverse role of school nursing is somewhat reflected in the breadth of the articles in our Journal and, indeed, much more will be shared and showcased at our forthcoming conference to be held in Birmingham on October 8th. Speakers from the Department of Health, Public Health England as well as courageous young people themselves, will make for an extremely informative and exciting event. See p18/19 for details of how to become a member and save £50 on your conference place (p5).

I look forward to meeting many of you there and sharing in your news and developments.

sharon@saphna-professionals.org
Twitter: @SaphnaSharon

PS. You can purchase extra copies of the journal for £15 each (£90 p.a) by calling 01273 434943
The School and Public Health Nurses Association Annual Conference:

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

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

£50 off delegates rates for SAPHNA members

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

For full programme details and booking options visit www.pavpub.com
Government issues new NCMP guidance

New guidance for 2013/14 has been issued by Public Health England (PHE) designed to ensure local authorities meet their statutory duty to deliver the NCMP, which monitors the growth of children in reception and Year 6 annually.

Until March 2013, primary care trusts were responsible for delivering the programme, but on 1 April 2013 local authorities became responsible for the NCMP. PHE is working with local authorities to support them in delivering the programme.

Professor Kevin Fenton, National Director for Health and Wellbeing, said: “The real benefit of this programme is that it supports local authorities to understand their local population and also helps parents identify whether or not their child is maintaining a healthy weight.”

The government will spend more than £5 million to encourage children to play outside and get more exercise, it has been announced. About £1.1 million of the fund has been set aside for a scheme called Playing Out run by Street Play England, which aims to make streets a safer place for children to play, as well as providing practical tools and training, and creating opportunities for social connection.

This is part of a three-year Department of Health-funded project to get children playing out regularly, including in areas of deprivation. The University of Bristol will evaluate the health impact of the project.

Information seminar on nasal vaccine launched

A new web-based information seminar on the use of the Fluenz nasal vaccine has been launched. The resource is designed to ensure health practitioners, including school nurses, feel confident in administering Fluenz, the Department of Health’s vaccine of choice for the childhood influenza vaccination programme.

For more information, or to view the seminar, visit http://www.nasalspraylearning.co.uk/1-0.html
Families encouraged to make a ‘Smart Restart’

A new Change4Life campaign has been launched to coincide with the start of the new school year encouraging families to introduce healthy changes to their school-time routines. The ‘Smart Restart’ campaign, run by Public Health England (PHE), will encourage families to capitalise on the fresh start presented by the new school year as an opportunity to establish healthier habits – such as walking to school, incorporating short bursts of extra activity into the day, and making sure children eat a healthy lunch at school – in order to get parents and children moving more and eating more healthily.

Families who sign up to the campaign will be supported through a six-week engagement and incentive programme to help them to stick to their chosen healthy change all the way through to half term.

Ann Hoskins, director for children, young people and families, Public Health England, said: “Families tell us that they sometimes slip into unhealthier habits during the summer holidays, such as spending too much time in front of the TV or computer, or indulging in too many treats. The new school year is an opportunity for them to press the restart button and choose and sustain healthier habits for the year ahead. People are much more likely to establish a healthy new routine if they make one small change at a time – and ‘Smart Restart’ will make this simple, fun and easy to achieve.”

‘Smart Restart’ is backed by a range of Change4Life partners, including supermarket chains Asda and Aldi; the leisure sector’s representative body UK Active; Unilever’s low-fat spread Flora; and Disney, which is providing content for the children’s microsite and a range of free activities to reward families once their ‘Smart Restart’ changes are achieved. For more info visit: http://www.nhs.uk/Change4Life/Pages/smart-restart.aspx?gclid=CPC23YjAyLkCFSGWtAodkWgAsA

New course reveals why fathers matter

Healthcare professionals are being offered the chance to understand why fathers are important for the health, wellbeing and outcomes of their children through a new course run by the Fatherhood Institute.

The Institute is calling for a ‘father-inclusive’ service and for healthcare professionals to actively involve fathers in the services they offer as it is beneficial to the children to do so.

The course aims to help commissioners, managers and practitioners understand why fathers matter as well as getting them to think about what a father-inclusive service would look like. The course will also allow professionals to learn more about the interventions and methods that work for fathers and mothers.

The course is free, for more information and to find out how to register, visit http://www.fatherhoodinstitute.org/training-and-consultancy/dads-included-free-online-course/

RCN calls for professionals to have their say on children’s services

The Royal College of Nursing (RCN) is urging healthcare professionals, including school nurses and health visitors, to have their say on the key issues facing children’s health services.

It is hoped the thoughts and views will help inform discussions about future workforce, education and training. It also represents an opportunity for healthcare professionals to highlight examples of initiatives and services for children and young people that are working well locally.

To facilitate the discussion, the RCN has produced a set of questions:

1. What do you think are the top five short-term workforce factors/education and training issues for children and child health services?
2. What do you think are the top five longer-term workforce factors/education and training issues for children and child health services?
3. What might potential solutions be for the factors/issues you have highlighted?
4. What are the current gaps locally (roles, skills, education etc)?
5. What are the current pressures locally (roles, skills, education etc)?

Respondents are urged to email their thoughts to Fiona.smith@rcn.org.uk
Next stop: UK

Following on from the successful 2013 conference, SAPHNA is delighted to announce it will host the next biennial School Nurse International Conference (SNIC) in 2015.

The School Nurses International Conference (SNIC) is a biennial event hosted around the world. I am proud to be co-chair of the SNIC Committee alongside my colleague, Karen Farrell from New Jersey, USA.

School Nurses International provides a forum for nurses around the world working with school children to come together in a stimulating intellectual and happy environment to share their knowledge and understanding of the emotional, social and physical needs of the school-aged child.

Slovenia welcomes delegates

This year it was a delight to go to the beautiful city of Ljubljana in Slovenia alongside over 100 school nursing colleagues from around the globe representing 17 countries. A shared passion, vision and commitment to improving the health and well-being of children and young people the world over, spearheaded by inspirational school nurse leaders is a powerful experience and a reminder of our value and great work. As you’d expect, the presentations were very varied, with some exceptional research and practice shared.

I am delighted that the conference voted for SAPHNA to host the next SNIC here in the UK in 2015. This will enable more of us to showcase our excellent work and experience with the School Nurse International community. This has full support from the Department of Health (DH), Public Health England (PHE) and all four chief nursing officers (CNO), and is a huge demonstration of the on-going commitment to the advancement of the school nursing profession across the UK. Professor Viv Bennett, director of nursing at Public Health England (PHE) and director of nursing at the Department of Health, did not hesitate when I approached her to support SAPHNA in hosting the next SNIC. She said: “Getting the best start in life is key to life chances later on and thus supporting good health and wellbeing of our children and young people is vital for them and for society.

“School nursing services and school nurse leadership has a major contribution in improving and protecting the health of school age children and understanding of the educational, emotional, social, and physical needs of the school aged child in a stimulating intellectual and happy environment.

“There is no official membership as committees or individuals in each country volunteer their time to jointly plan and implement the programmes. If we have a philosophy, it would be to continue sharing as we care for the children we come in contact on a daily basis in our individual educational and cultural systems, knowing that it will make a difference in his or her life.”

Mary Henley, now aged 85, is one of the SNIC’s founding members. Here she shares an historical perspective of the SNIC

“In 1979, I was invited to talk to two groups of nurses, which included school nurses and public health nurses in Oxford and Southampton, England. The meeting with the Hampshire School Nurses Association (HSNA) in Southampton was the “spark” that ignited our fire and brought us to our present status. We discussed many things about school nursing, but the HSNA members were most interested in building a national organisation of school nurses for the United Kingdom (UK). Pamela Rees and Kay Fletcher were the lead members of the HSNA and they suggested that if we could get a group of California school nurses and British school nurses together, we could share our programmes and ideas together.

“And so it was that in 1981 a group of 28 California school nurses met with an equal number of British school nurses at St. Hilda’s college in Oxford, England under sponsorship of the Hampshire School Nurses Association and the Los Angeles County Superintendent of Schools. We all paid our own expenses and there was no intent to hold another workshop, simply to share ideas and to encourage our British counterparts to join together and develop their own national organisation. However, many friendships were formed and before leaving Oxford an invitation was extended to hold a second conference in California in 1983.

“Beginning in 1983, a host program was added as an attraction. School nurses and their families were, and continue to be, welcomed into families in the host country after the conference.

“The use of universities and residential schools for our conferences has given us inexpensive living space and academic backing. This provides a forum for school nurses around the world to come together and share their knowledge and understanding of the educational, emotional, social, and physical needs of the school aged child in a stimulating intellectual and happy environment.

“Sharing Knowledge, Making a Difference”
young people. I am absolutely delighted on behalf of DH and PHE that the UK has been successful in securing the next School Nurse International Conference and to be working with SAPHNA to make this an opportunity to work with our colleagues from other countries to achieve the best outcomes for our young people.”

This year myself, Betsy Allen (SAPHNA), Wendy Nicholson (DH) and Ros Godson (CPVHV) were privileged to be chosen to present to the conference. It was heartening to see two other school nurses from Birmingham and a SCPHN course leader amongst the delegates.

The mission of the SNIC is to:

To share knowledge in the caring of children in our individual educational systems, knowing that it will make a difference in his or her life.

Get involved

SAPHNA are honoured to have the opportunity to host the next SNIC and feel the timing will be right in terms of demonstrating the implementation of the Department of Health School Nurse Development Programme and to highlight the amazing work from the school nursing workforce across the UK.

You can now visit the SNIC’s website (http://www.schoolnursesinternational.com/) which is a great source of global expertise and offers links to a range of differing School Nursing practice full of rich experiences, knowledge, research and evidence. SAPHNA will post details of the 2015 conference on here as well as on our own website as they emerge, and there is a Facebook community which you are more than welcome to join; https://www.facebook.com/pages/International-School-Nurses/113037168753112

A happy gathering of school nurse delegates from all around the world

A number of the current SAPHNA Exec formed part of the organising committee when we hosted the successful SNIC in Edinburgh. It is hard but rewarding work. We will be calling on our members for support in designing and developing the programme as well as speaker and poster presentations. Visit our website for regular updates and opportunities.

### Previous School Nurses International Conferences:

1983 UCL, California, USA
1985 Derwent College, York, UK
1987 UCSD, California, USA
1989 Jönköping, Sweden
1991 Chester College, UK
1993 UCSB, California, USA
1995 Eindhoven, The Netherlands
1997 University of Alaska, USA
1999 University Hall Conference Centre, Cardiff, Wales, UK
2001 Brandbjerg Hojskole, Jelling, Denmark
2003 University of Colorado, Colorado Springs, Colorado, USA
2005 Edinburgh, Scotland, UK
2007 Singapore
2009 Monmouth University, New Jersey, USA
2011 Hong Kong Polytechnic University, Hong Kong, China
2013 Ljubljana, Slovenia

### School Nurse

**Required:** November 2013

**Salary:** AfC Band 6, points 21–25
(£12,248 - £14,137 actual salary)

**Location:** St John’s Catholic School for the Deaf
Church Street, Boston Spa, Wetherby, LS23 6DF

**Contract:**
- **Type:** 20 hours per week, school term times only
- **Form:** Permanent

St John’s Catholic School for the Deaf is a non maintained residential and day school for deaf pupils aged 4–19, many of whom have additional special educational needs. Our school uses an oral approach to develop pupils’ spoken and written language skills, and knowledge of sign language is not required.

We are seeking to appoint a suitably qualified and experienced nurse to join our team. You will be responsible for the routine health care of our pupils, and will provide support and guidance to school colleagues on medical and health related matters.

Duties of the post include:
- Responsibility for the administration of medication, including the training of staff
- Responsibility for medical records
- Ensuring colleagues are aware of relevant guidance and emerging trends in relation to health care
- Develop and deliver programmes to promote healthy lifestyles amongst the pupils
- Monitoring the effectiveness of health care in the school

The successful candidate will have a relevant, up to date nursing qualification and be highly motivated and enthusiastic. They will have excellent communication and organisational skills, and work effectively both in a multi-disciplinary team, and independently.

We can offer opportunities for professional development and the chance to have a real impact on the overall care and well being of our young people.

For further details and an application pack, please contact Miss M Dowson mdowson@bostonspa.org.uk, or phone 01937 842144.

- **Closing date for applications – 11 October 2013**
- **Start date November 2013** (subject to DBS clearance and pre employment checks)

*St John’s School for the Deaf is committed to safeguarding and promoting the welfare of children and young people, and expects all staff to share this commitment. An enhanced CRB check from the Disclosure and Barring service and references regarding your suitability to work with children are an essential requirement for this post.*

www.stjohns.org.uk – Charity reg 5290319

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**SNIC CONFERENCE**

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The Be Healthy project aims to highlight and address the barriers to health services experienced by young people affected by sexual exploitation. It is a partnership between The Association for Young People’s Health (AYPH) and The International Centre: Researching Child Sexual Exploitation, Violence and Trafficking at University of Bedfordshire. The Be Healthy team worked with three specialist sexual exploitation projects across England; Barnardo’s in London, Safe and Sound in Derby and Isis in Leeds to identify 10 young people who were interested in becoming Health Advocates. The Be Healthy project has been working with this group of young people for over two years.

The first stage involved the young people taking part in a series of workshops and discussions about different health topics. They thought about how different health issues (such as body image, mental health and sexual health) relate to sexual exploitation and also developed a more holistic view of health seeing how different health concerns can impact on one other.

The Health Advocates identified the opportunity to talk with their peers about sexual exploitation issues as a way of developing empathy. Lucy*, 19, said, “Before I came to the project I thought people were responsible for what happened to them. Now I can think and understand more about why it happens to people. Some people need more help than others. I’m more aware of the barriers people face to getting help. It sounds weird but you can actually start seeing things in a different light when you meet people who have been through similar experiences.”

The second stage of the project was to put this learning into action using creative media. The Health Advocates decided to make a series of short animated films and a booklet to get what they felt were the most important messages out to other young people and professionals. They focused on healthy relationships, low self-esteem and how professionals manage confidentiality. They also decided to use a low-tech, low budget animation technique so that they were in control of the look and the final outcome. Each animation was filmed in a single day at each of the local projects. Then the young people came together in a recording studio in London to record the narration and character voices, improvising the script in their own words.

It was agreed that the Health Advocates would write their own case studies, allowing them control over the way they and their experiences were represented. They also serve as inspiring examples of young people increasing their resilience as a result of working together. In her case study, Maisy, 18, wrote, “I’ve gone from the person who is coming here to ask for help for me, to someone who’s coming to help other young people.”

An important part of building resilience came from understanding their rights. A major concern expressed by many group members was the way confidentiality is handled by professionals – often in insensitive ways that break down trust between young people and support services. From these discussions, the “You Get Me?” leaflet was born, a free resource for professionals and young people to clarify expectations around confidentiality and address concerns young people often have when first accessing a service. Sharing information about rights with other young people and promoting best practice by professionals has been a strong motivation for involvement from the start of the project. 15 year old Florence wrote, “Before I started I didn’t really know about any health services – but now if I was ever in a situation I’d know where to go or where to tell someone else to go.”

We are currently disseminating the work of the Health Advocates and supporting them to present it to groups of young people and professionals. They have shared their work at a series of conferences and specialist events and two of the Health Advocates will be travelling to Milan in November to present their work at the Eurochild conference as an example of good practice in participation of marginalised young people. We are also working with the Department of Health and others to look at how the resources and key messages can be embedded in ongoing work in this area.

The project demonstrates why young people’s participation in a health context is so important. It also highlights the importance of ensuring that all young people including those who are vulnerable and marginalised have their voices heard so that we can develop services and professional responses to better meet their needs.

All of the resources created by the Health Advocates are available free of charge to both professionals and young people on the project website: http://www.ayph-behealthy.org.uk/

*Names have been changed to protect the young people’s identities.
Always look on the bright side of life

Although the headline is slightly tongue in cheek, we should encourage our children and young people to have a strong sense of resilience and self-esteem, says JSPHN editor Penny Hosie, to cope with life’s varied challenges. At the beginning of a new school year it is vital that we equip them with the tools to help make a positive difference to their own mental health and wellbeing.

Ten years ago Every Child Matters (2003) was introduced into the policy framework as a blueprint for how healthcare professionals should approach their work. At the time it was described as ‘a positive vision of the outcomes we want to achieve’.

The outcomes were on the surface a fantastic vision, with healthy living and enjoying life two of the five key points. But detractors argued that the paper was biased towards younger children and insufficiently youth focused. They also believed that there was too much of an emphasis on protection, with an absence of any reference to encouraging autonomy and participation. The National Youth Agency was among these critics and one of its own key criticisms was that ‘the green paper generally reflects children and young people as passive recipients of adult care, rather than as partners and active citizens with a full range of human rights and a need for encouragement and support to take increasing responsibility for their own lives’ (National Youth Agency, 2003, p.1).

Ten years on...

A decade on, were the concerns legitimate? On healthcare the focus certainly seems to have shifted,
The power of touch

One innovative and effective way of promoting self-esteem to younger kids is peer-to-peer massage in schools. JSPHN's deputy editor Rob Mair reports

Peer-to-peer massage has been in primary schools for more than a decade, but it is only now gaining traction thanks to an increasing body of evidence to support the wellbeing claims.

The Massage in School Programme (MISP) was first introduced into UK schools in 2001. Since then several studies have been carried out about the validity and effectiveness of the initiative, which is essentially a clothed peer massage programme for children aged 4–12 and their parents.

The Massage in Schools Association has published the results of studies on their website, which point to a number of key consistent findings. These include:

- Making pupils calmer and improving their concentration
- Improving students' self-esteem and self-confidence
- Reducing aggressive behaviour and bullying
- Increasing the ability to recognise signs of stress in the body.

The clothed peer massage usually lasts for 10–15 minutes each day and starts with the children asking permission from each other and saying “thank you” to their partner at the end. The massage is given on the back, head, arms and hands, and the children remain clothed at all times.

Parents are consulted before the school implements the programme, and it is then linked to aspects of the school curriculum. The initiative is the brainchild of two mothers, Canadian Sylvie Hétu, who has been the international president of the International Association of Infant Massage (IAIM) for 12 years, and Swede Mia Elmaster, who has worked tirelessly to spread the discipline throughout Europe, including in Romania, Germany, the UK and her native Sweden. As a result of the work of this duo, MISP is now taught in schools in more than 30 countries around the globe, including the United States, Australia and Italy.

To find out more about massage in schools visit: http://www.misa.org.uk/index.php?massageinschools

I like doing the massage because it is calm and gentle.”

Unrealistic expectations?

So, is society making children unhappy or are a child’s expectations simply off kilter, whether they be too high or too low? This may seem a contradictory statement in itself, but then happiness is often measured as an extreme emotional state, just as depression is.

Today, in our praise culture, some of the traditional rules appear subverted. While the children who typically ‘act up’ or don’t perform well academically are highly praised if they behave well or achieve beyond expectations, it’s often the bright children who diligently get on with their work without disrupting the classroom who ironically feel ignored and end up with low feelings of self-worth and self-esteem.

Both are victims of this dichotomy – and perhaps that is why many of today’s children seemingly struggle with a sense of being ‘grounded’.

Parents have noticed this rule shift in the playground too. I can’t be the only parent who wishes that when my child falls over or is upset by school bullies that they can turn to a kind adult who will treat them with respect, rather than be held at arm’s length for fear of being accused of over familiarity or abuse. Yet today this shift of emphasis appears to be heightening professionals’ fears, as well as increasing parental concern.

If it’s confusing for the adults to interpret these ‘rules’ at times, no wonder our children are left feeling confused and ‘out of synch’ with the world.

Focus on self-esteem

Sharon White, SAPHNAs professional officer, says that when she first entered the school nursing profession there was much more of a focus on building a child’s sense of resilience and self-esteem rather than troubleshooting child protection issues, which inevitably necessitate a great deal of time and resources and are reactive rather than proactive in nature.

Perhaps we need to shift our thinking and refocus collectively to work together and try to foster our children’s self-esteem as well as protect them?

Imagine a society where instead of competitive hot-housing parenting our collective aim is to nurture children to be accepting and forgiving of differences, recognise that working to the best of their abilities is ‘good enough’ and that being kind, caring and polite to
Steps to improving self-esteem for young people

Children and young people can themselves play a huge part in raising their own self-esteem, although this sometimes needs to be harnessed. Here are some tips school nurses and others can share to help young people start empowering themselves:

- Accept that everyone makes mistakes and view them as a learning opportunity. Everyone excels at different things – it’s what makes people interesting.
- Try to stop thinking negative thoughts about yourself and instead start thinking about your most positive qualities. To get out of the habit of negative critical thinking, write down three positive things about yourself that make you feel happy.
- Sometimes experimenting with different activities or trying out something new can help you develop a skill you may not have realised you had. This in itself can be empowering, giving you the confidence to widen your horizons further.
- Don’t continually strive for perfection, aim for realistic accomplishments.
- Instead of procrastinating or obsessing over what you can’t do, focus instead on what you can do, then relax and enjoy doing it.
- Recognise what you can change and what you can’t. If you’re unhappy with something about yourself that you can change, then start today. If it’s something you can’t change (like your height), then start to work toward loving yourself the way you are.
- Set realistic goals. Think about what you’d like to accomplish, then make a plan and stick to it.
- Take pride in your opinions and ideas and don’t be afraid to voice them.
- Be kind and make a contribution. Help a friend who’s struggling with their homework, or volunteer your spare time for a good cause. Feeling like you’re making a difference and that your help is valued can do wonders for your self-esteem.
- Exercise! You’ll not only relieve stress levels that can build up, but you’ll also feel healthier as well as happier.
- Life’s not a dress rehearsal so remember to have fun. Enjoy spending time with the people you care about and doing the things you love. Relax and have a good time.

When I give massage I feel good because I feel like I have helped someone relax.”

Further information

MindFull: www.mindfull.org/

MindFull is a brilliant new service for 11–17 year olds, providing support, information and advice about mental health and emotional wellbeing.

YoungMinds: www.youngminds.org.uk/

YoungMinds is the UK’s leading charity committed to improving the emotional wellbeing and mental health of children and young people.

References


Technology makes school nurses more approachable...

School nurses are increasingly finding that technology is helping them to reach out quicker to young people experiencing emotional distress. This is because the private 24–7 nature of technology means school nurses are viewed as being more approachable and accessible. Often just listening is good enough, but those whose hurt appears more entrenched may still require the help of an experienced mental health professional.

When you give massage I feel good because I feel like I have helped someone relax.”

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References


Introduction

Vaccination is the single most effective way to prevent the morbidity and mortality associated with influenza. However, only 73.4% of people aged 65 years or over in England were vaccinated during the 2012/13 season. Vaccine uptake among patients aged 6 months to less than 65 years in a clinical risk group was just 51.3%. Both figures are below the World Health Organisation’s (WHO) recommended coverage of 75% and neither has changed markedly in recent years. So, in July 2012 the Joint Committee on Vaccination and Immunisation (JCVI) recommended the routine annual influenza vaccination of children aged two to less than 17 years. The JCVI suggested that the change would avoid many influenza cases in children. In addition, vaccination would indirectly prevent influenza in unvaccinated younger children, people in clinical risk groups and older adults. Immunising children will be “highly cost effective” by “substantially” reducing flu-related illnesses, GP consultations, hospital admissions and deaths, and will raise public awareness of vaccination’s benefits. Initially, NHS England will offer routine vaccination to two and three year olds and plan pilots for four to ten year olds to ascertain the most effective way to implement the new programme. Most children will receive Fluenz® live attenuated influenza vaccine (LAIV), a nasal spray vaccine.

Fluenz has been used in clinical practice since 2003 in the U.S and at-risk children in Northern Ireland have received Fluenz since 2012.

What is Fluenz?

Fluenz delivers a suspension of LAIV strains that are genetically altered in three ways to maximise efficacy:

- Cold-adapted – the LAIV strains in Fluenz stimulate the immune system in the nose, where cooler temperatures are found.
- Temperature-sensitive – the LAIV cannot infect the lungs or other areas that are warmer than the nasal passages.
- Attenuated – the LAIV replicates to provoke a full immune response but does not cause clinical symptoms.

Fluenz indication

Fluenz is indicated for influenza prophylaxis in children aged 24 months to less than 18 years. Patients receive 0.1 ml of the suspension in each nostril (see Figure 1). According to the approved schedule, children who were not previously vaccinated against seasonal influenza should receive a second dose after at least 4 weeks.

Fluenz: A highly efficacious vaccine

Eight randomised clinical trials, including children and adolescents aged between 2 and 17 years, compared LAIV against placebo or the standard trivalent inactivated vaccine (TIV). Compared with placebo, year 1 efficacy of 2 doses of LAIV was 83% (95% CI: 78, 87) (absolute change in efficacy 13.3%) against antigenically similar strains. Classifying B variants as dissimilar, efficacy against all similar strains was 87% (95% CI: 63, 91) (absolute change in efficacy 12.7%).

Compared with TIV, LAIV recipients experienced 44% (95% CI: 28, 56) (absolute change in efficacy 1.8%) and 48% (95% CI: 38, 57) (absolute change in efficacy 3.9%) fewer cases of influenza illness caused by similar strains and all strains, respectively.

How is Fluenz administered?

Before administration, you should complete the check list (overleaf). Fluenz is administered as a divided dose to eligible patients, one actuation in each nostril (Figure 1). Patient can breathe normally during administration and does not need to actively inhale or sniff. Health care professionals can reassure parents that LAIV is very quickly absorbed and so remains effective even if the child’s nose dripped or the child sneezed or blew their nose after administration.

LAIV can be given at the same time as other live and attenuated vaccines. Recipients with a heavily blocked or runny nose should receive the vaccine once this is resolved.

How should Fluenz be stored and what is the shelf life?

Fluenz should be stored in a refrigerator between 2 and 8°C. Before use, the vaccine may be taken out of the refrigerator, without being replaced, for a maximum period of 12 hours at a temperature not above 25°C. If the vaccine has not been used after this 12-hour period, it should be disposed of.

Fluenz has a shelf life of 18 weeks, which is shorter than other influenza vaccines. Healthcare professionals should check the expiry date on the applicator before use.

What are the contraindications for Fluenz?

Fluenz should not be given to children or adolescents who are clinically severely immunodeficient, including those:

- with acute and chronic leukaemias
- with lymphomas
- with HIV infection who are not taking highly active antiretroviral therapy (HAART)
- with cellular immune deficiencies
- taking high-dose corticosteroids.

In addition, Fluenz is contraindicated in children and adolescents:

- younger than 24 months of age
- receiving aspirin or another salicylate: Reye’s syndrome is associated with salicylates and wild-type influenza infection
- with egg allergy
- pregnant.

Fluenz is not recommended for children who are actively wheezing at the time of vaccination or those with severe asthma (BTS SIGN step 4 or above). Safety data is limited in these groups.

Fluenz is not contraindicated for children or adolescents:

- with asymptomatic HIV infection who are receiving stable antiretroviral therapy
- who are receiving topical/inhaled corticosteroids or low-dose systemic corticosteroids
- who are receiving corticosteroids as replacement therapy, e.g. for adrenal insufficiency.

The small proportion of children for whom Fluenz is contraindicated should be offered an inactivated injectable flu vaccine. If you have any queries regarding a patient’s eligibility please contact AstraZeneca’s Medical Information department: 0800 783 0033.
Can Jess receive Fluenz?

Jess, who is 13 years old, has moderate asthma that is well controlled with a combination of inhaled corticosteroid and long-acting beta-agonist. Jess is generally in good health but takes aspirin to treat period pain. Can Jess receive Fluenz?

Is there a risk of transmitting influenza to immunocompromised contacts?

LAIV contains live viruses. Therefore, there is a small risk of transmitting the LAIV to contacts for between one and two weeks following vaccination. However, as LAIV is attenuated, transmission is unlikely to result in influenza symptoms. Nevertheless, where close contact with very severely immunocompromised patients (e.g. bone marrow transplant patients requiring isolation) is likely or unavoidable (e.g. household members) healthcare professionals should offer children inactivated influenza vaccine (IIV).

Can Tommy receive Fluenz?

Tommy is 4 years old. His older sister has leukaemia and is currently in hospital recovering from a bone marrow transplant. In the past, he has had an anaphylactic reaction after eating eggs. Can Tommy receive Fluenz?

What are the side-effects with Fluenz?

Safety data collected from more than 28,500 people aged 2 to 17 years of age from clinical studies and more than 52,500 children and adolescents from post-authorisation safety studies suggest that Fluenz is generally well tolerated. Over the 10 years LAIV has been available across the world no unexpected tolerability risks have been identified when used according to its approved indication.1,2,3,4

In clinical trials, nasal congestion/rhinitis was the most common adverse reaction. Other adverse events that were very commonly (≥ 1/10) or commonly (1/100 to < 1/10) associated with LAIV were: reduced appetite, headache, fever or myalgia (Figure 2). Please refer to the SmPC for further information about side effects and report any suspected adverse events to AstraZeneca’s Medical Information department: 0800 783 0033, or by using the yellow card system.

Learn more about Fluenz

You can learn more about Fluenz by completing an e-learning module. The module also offers practical resources for your clinic. You can access the e-learning module at www.nasalspraylearning.co.uk.

FLUENZ® nasal spray suspension Influenza vaccine (live attenuated, nasal)

PRESCRIBING INFORMATION Consult Summary of Product Characteristics before prescribing. Use with caution in children: LAIV should not be used in children under 6 months of age. LAIV should not be used in children aged 24 months to less than 18 years of age. Presentation Nasal spray, suspension. Dosage and administration 0.2mL (administered as 0.1mL per nostril). Children not previously vaccinated against influenza may receive a second dose at least 4 weeks apart. Do not inject FLUENZ. FLUENZ should be used in children who are currently immunocompromised due to conditions or immunosuppressive therapy. Do not inject FLUENZ. Contraindications Hyperreactivity to the active substances, any of the recipients (e.g. gelatin), gentamicin (a possible trace residue), eggs or egg protein products (e.g. ovalbumin). Children and adolescents who are clinically immunocompromised due to conditions or immunosuppressive therapy. (acute and chronic leukaemias; lymphoma; symptomatic HIV infection; cellular immune deficiencies; and high-dose corticosteroids). Not contraindicated for use in children with asymptomatic HIV infection; or individuals who are receiving topical/nasal corticosteroids or low-dose systemic corticosteroids or those receiving corticosteroids as replacement therapy, e.g. for adrenal insufficiency. Contraindicated in children and adolescents younger than 18 years of age receiving salicylate therapy because of the association of Reyes’ syndrome with salicylates and wild-type influenza infection. Precautions Medical treatment and supervision should always be readily available in case of an anaphylactic event following administration. FLUENZ should not be administered to children and adolescents with severe asthma or active wheezing because these individuals have not been adequately studied in clinical studies. Do not administer to infants and toddlers younger than 12 months. Do not administer to infants and toddlers 12–23 months of age. In a clinical study in children hospitalised with influenza in infants and toddlers younger than 12 months after vaccination and an increased rate of wheezing was observed in infants and toddlers 12–23 months of age after vaccination. Vaccine recipients should be informed that Fluenz is an attenuated live virus vaccine and has the potential for transmission to immunocompromised contacts. Therefore anyone who is likely or unavoidable (e.g. household members) to have close contact with severely immunocompromised individuals (e.g. bone marrow transplant recipients requiring isolation) for 1–2 weeks following vaccination. Where contact is unavoidable, the potential risk of transmission of the influenza vaccine virus should be weighed against the risk of acquiring and transmitting wild-type influenza virus. No data exists regarding the safety in children with uncontrolled cranial malformations. Interactions Sodium citrate must not be used for 4 weeks following vaccination unless medically indicated. Co-administration of FLUENZ with the live attenuated vaccines: No clinically meaningful changes in immune responses to measles, mumps, varicella, orally administered poliovirus and Haemophilus influenzae B vaccines have been observed. Immune response to rubella vaccine was significantly altered. This might not be of clinical relevance with the two dose immunisation schedule of the rubella vaccine. Co-administration of FLUENZ with inactivated vaccines has not been studied. Concurrent use of FLUENZ with antiviral agents active against influenza A and/or B viruses has not been evaluated. However, based upon the potential for influenza antiviral agents to reduce the effectiveness of FLUENZ, it is recommended not to administer the vaccine until 48 hours after the cessation of influenza antiviral therapy.

Administration of influenza antiviral agents within two weeks of vaccination may affect the response of the vaccine. If influenza antiviral agents and FLUENZ are administered concurrently, vaccination should be considered when appropriate. Pregnancy and Lactation: Not recommended during pregnancy. Should not be used during breastfeeding. Un foreseeable effects: Very common: decreased appetite, headache, nasal congestion/rhinitis, malaise. Common: myalgia, pyrexia. Uncommon: hyperamylasaemia reactions (including facial oedema, urticaria and very rare anaphylactic reactions), epistaxis, rash. Very rare reports of Guillain-Barré syndrome and exacerbation of symptoms of Leigh syndrome (mitochondrial encephalomyopathy) have also been observed in the post-marketing setting. Consult SmPC for a full list of adverse events. Legal category POM. Marketing authorisation number EU/1/10/661/001-002 Very common: decreased appetite, headache, nasal congestion/rhinitis, malaise. Common: myalgia, pyrexia. Uncommon: hyperamylasaemia reactions (including facial oedema, urticaria and very rare anaphylactic reactions), epistaxis, rash. Very rare reports of Guillain-Barré syndrome and exacerbation of symptoms of Leigh syndrome (mitochondrial encephalomyopathy) have also been observed in the post-marketing setting. Consult SmPC for a full list of adverse events. Further information is available from AstraZeneca on behalf of AstraZeneca UK Limited, 600 Capability Green, Luton, LU4 9LJ, UK. Information on the global biologics business for AstraZeneca FLUENZ is a trade mark of the AstraZeneca group of companies. 02/2012

References

Helping school nurses to achieve more

Often school nurses may have great ideas to develop a service or reach more people, yet find their creativity constrained by budgetary or time pressures. That’s where the Queen’s Nursing Institute (QNI) can help, says their practice development manager Anne Pearson.

The Queen’s Nursing Institute (QNI) was established in 1887 by philanthropist William Rathbone, with advice from his friend Florence Nightingale. It was started because there was an absence of suitably qualified community nurses with the requisite knowledge and skills to deliver care to individuals and families in their own homes and communities.

The Institute was created to provide education and training to prepare nurses to work outside of the hospital environment. Nurses who undertook additional training with the Institute were prepared to work in clinics, schools and homes. They provided what we know today as many specialist practice areas of community nursing – midwifery, health visiting, school nursing, general practice nursing and district nursing services.

The original Queen’s Nurses (QNs) worked with the whole community in a defined geographical area known in those days as the ‘district’ (hence the use of the term ‘district nurse’) and once qualified to work in the community, they were often employed by the local authority of that district as a QN. They maintained an enviable and national reputation for the highest standards of training and care.

The QNI archives include evocative black and white photographs depicting the QNs of the early 20th century working in all of these roles. The QNI was responsible for setting the educational standards, planning and delivering the education of all QNs in England, Wales and Northern Ireland until the late 1960s, when community nurse education was moved into higher education.

The QNI has maintained its independence and our mission today is to promote high quality nursing care in the home and community. In 2007 we reintroduced the title of Queen’s Nurse, and community nurses across all specialties are welcome to submit an application for...
this prestigious title. The application includes written validation by patients, peers and managers. Our QNs are shining examples of community nurses who have made a commitment to excellence in patient care and they work in the name of the QNI to enhance and improve the care of patients, families and carers in the community. Currently we have nine school nurses who are QNs.

‘Right Nurse, Right Skills’
For the last two years we have run our ‘Right Nurse, Right Skills’ campaign as part of our mission to ensure that patients cared for in the community have care delivered by a nurse with the right knowledge and skills. Our report on district nurse education, published in June 2013, provided evidence of the low numbers of nurses on specialist practice programmes and has been the catalyst for a number of actions at the Department of Health.

We are also concerned about the low numbers of school nurses who have the specialist community public health nursing practice qualification, particularly when it is crucial to improve the health of the school age population in the face of myriad health issues caused by today’s unhealthy life-styles. The shocking statistics around obesity in school aged children should be evidence enough that more investment needs to be done to promote a healthy adult population of the future.

The QNI has also focused on improving practice through the support of innovation projects. Every year we fund and support 10 frontline projects which are aimed at improving care in the community. Applications come from nurses across all specialties including district nurses, health visitors, school nurses and practice nurses. The QNI has supported school nurses working in mainstream schools and those who work with children with learning difficulties.

One most recent project was the development of a texting service for young people. Those who work with young people will recognise their preference to communicate via new technology rather than face-to-face.

In a six month period, 202 texts were received from young people with 81% of these relating to sexual or emotional health concerns. Forty-five texts led to a face-to-face appointment being arranged, and most importantly this project also enabled more effective use of school nurse time by reminding young people of their appointments by text, reducing the amount of non-attendance.

Another project aimed at improving the dental health, diet and physical activity of children with autistic spectrum disorders was very successful in achieving its aims with the children and their families. This project was led by a school nurse and was influential in changing the way professionals from all of the involved disciplines worked together. This methodology has now been adopted as the blueprint for future projects to enable more families to be helped in the future.

For many applicants this may be the first time they have run a project, which is why professional development workshops run in tandem to support nurses to deliver the project and to improve their confidence and belief in themselves.

Many nurses, when invited to apply for the Fund for Innovation and Leadership programme, say they can’t think of a project but very often these same nurses know that they do not reach all their clients because of the limitations of how a particular service or intervention is delivered. A small amount of funding may enable you to work on this area and deliver services that meet the needs of your clients in a more effective way.

Have a look at the innovation section of our website for further information about school nurse projects and how to make an application.
http://www.qni.org.uk/innovation_centre
SAPHNA is the leading professional organisation representing the voice of school and public health nurses across the UK.

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Reflections and moving forward

Wendy Nicholson, the Department of Health’s Professional Lead for School Nursing, talks about her experiences at the recent School Nurse International Conference. She reflects on the fact exceptional work is carried out daily by school nurses to improve the health of children worldwide.

I was fortunate to attend the 17th biennial School Nurse International Conference (SNIC), held in Slovenia this July. The conference brought together 17 nations, all with a shared passion and commitment to improving the health and well-being of school-aged children worldwide. The conference was a fantastic opportunity to network, learn and reflect. It was fascinating to spend time with school nurses, school nurse leaders and educationalists from across the globe. The hunger for more data and evidence to illustrate the impact of school health services was thoroughly debated and accepted as a key area for development.

Interestingly, yet not surprisingly, a number of reoccurring themes resonated across the nations represented at the SNIC including: the increasing challenges of childhood obesity; the need for better support to improve emotional health and well-being; increasing vulnerability and complexity of needs locally; and the need for evidence to support interventions. The social determinants of health and well-being among young people (HBSC, 2012) also highlights these issues as key challenges.

The Health Behaviour in School-aged Children (HBSC) is a World Health Organization collaborative cross-national study which examines the physical and mental health of children and teenagers from a sociological perspective. It provides a wealth of information and analysis, presenting findings on patterns of health among young people aged 11, 13 and 15 years in 43 countries across the WHO European Region and North America. The HBSC approach looks at young people in the context of the social circumstances and developmental processes that influence their health. It draws attention to the effects of age, gender, socioeconomic status and geography on health, thus focusing policy on social and economic determinants.

The HBSC is an invaluable study and provides a national health check and benchmark for participating countries.

Vision for the future

Despite the similarities, school nursing services varied across the 17 nations at the SNIC and I was honoured to be asked to present England’s vision and model for school nursing (https://www.gov.uk/government/publications/getting-it-right-for-children-young-people-and-families). The approach taken by the Department of Health, particularly the professional engagement undertaken to develop the model, was extremely well received. The delegates were keen to discover more about the government commitment to support school nursing teams to address the challenges and issues facing school-aged children and their families.

The emphasis on the leadership role of the school nurse and tailored support for school-aged children through partnership approaches, with a clear offer of early help within the model, was met with much enthusiasm. I was interested in the almost stunned silence when I shared the recently published census figures (http://www.guardian.co.uk/society/2013/...
may/16/thousands-children-caregivers-family-data) regarding young carers. Data, compiled from the 2011
census, shows that nearly a quarter of a million people
aged 19 and under in England and Wales were caring for
parents, siblings and other family members. Often these
young carers may remain hidden due to the fear of being
identified, not realising they are a young carer, or through
professionals not acknowledging their role and therefore
failing to identify and support them.

As I outlined our work to support the health and
well-being of young carers, it was evident for many in
the audience that the needs of young carers hadn’t been
a priority for some of the nations represented at the
conference. There seemed little or no support (or even
a process to identify young carers. So, the school nurse
champions for young carers work stream developed
alongside School and Public Health Nurses Association
(SAPHNA) was not only thought-provoking but received
overwhelming interest throughout the presentation and
subsequent days. On reflection, our 45 school nurse
champions for young carers are not only trailblazing here
at home but possibly across the world.

Sharing best practice
The School Nurse Development Programme,
particularly professional engagement and the emphasis
on children and young people, sparked much debate
over the course of the event. This positive engagement
with children and young people which helped shape
the model, design new products and to train school
nurses to be champions, might have seemed routine to
us – but our colleagues in other nations wanted to learn
how this was achieved. Delegates were intrigued by
the Department of Health’s commitment and positive
partnership working with expert organisations including
the British Youth Council, North West Regional Youth
Work Unit and National Children’s Bureau (NCB) to
make this happen.

The SNIC also gave us an opportunity to reflect on
the progress made since we first began working on the
programme in 2011. While we still have some way to go,
it’s fair to say there have been significant developments to
support the profession and local delivery.

We have worked to increase the profile of school
nursing: the recently launched NHS Careers materials
and fact sheets are two examples.

The fact sheets and briefings are proving
popular in engaging stakeholders and ensuring the
communication of a consistent message, and are
enabling school nursing teams to articulate their
contribution in improving health and well-being. We
know from engagement with our partners – sadly
school nursing still seems to be a mystery for some –
however the current high focus on public health means
school nurses can re-affirm their leadership role in the
delivery of public health for school-aged children and
clearly they are a crucial workforce in terms of both
health promotion and health protection!

Embracing technology
As technology and social media advance, school
nurses have risen to the challenge and embraced new
approaches. More than 200 school nurses are using
Twitter to network, share, learn and support each other –
and #SNSoMe is an extremely vibrant and active
twitter community, which is connecting, galvanising
new relationships and supporting new ways of working.
I’d urge you to take a look if you haven’t already.

As we move into the next phase of the School Nurse
Development Programme our commitment will be to
continue to work in partnership with the profession
and key stakeholders, whilst providing a platform to
ensure the voice of children, young people and their
families is not only heard but acted upon. There are new
opportunities ahead to strengthen the school nurse offer
and workforce – but we can only make a real impact if
school nurses are ready to provide strong public health
leadership locally. School nurses have so much to be
proud of and need to share their innovation and passion.

SAPHNA has already secured the hosting of the next
SNIC (2015) in the UK and will be supported by Public
Health England, the Department of Health and partners.
This will provide a fantastic opportunity to unite school
nursing and to showcase the incredible contribution
school nurses and their teams make in improving the
health and well-being of children and young people.

Resources
NHS Careers materials: http://www.nhscareers.nhs.uk/explore-by-
career/nursing/careers-in-nursing/school-nursing/ and fact sheets
(http://media.dh.gov.uk/network/SNDP/files/2012/11/SNDP-Fact-sheet-
HSCPpdf, http://media.dh.gov.uk/network/SNDP/files/2012/11/Head-
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The School Screener system is an innovative new way for school nurses to carry out vision and hearing tests. Professor David Thomson from City University London explains how it works.

"Can you read the letters on the chart?", I inquired of the five year old. The rather blank look and shake of her head suggested she could not. "What about these larger letters?" Still no response. Eventually, with some difficulty she read the largest letters on the screen.

This child was one of approximately 18% of five year olds who have poor vision in one or both eyes. The child, her teacher and her parents were apparently unaware that her vision was poor and without school vision screening, it is likely to have been several years before the problem was detected. While it is difficult to predict exactly what effect this may have had on her social and educational development, there is little doubt that it would have been detrimental to some degree.

Three weeks later she was proudly wearing her new glasses and already interacting more in the classroom and showing increased enthusiasm for reading.

Learning has been defined as the "acquisition of understanding through the senses" (Dictionary, 2012). While all of the senses are important conduits of information, vision and hearing are particularly important in this respect.

Professor David Thomson, Department of Optometry and Visual Science, City University London

The importance of good vision during the formative years led to the introduction of routine vision screening in schools in the UK more than 100 years ago. While the school screening programme has been less than perfect, there is no doubt it has provided a useful safety net, detecting children with significant vision problems at an early stage before it impacted on their educational development.

Screening policy

General policy on vision screening is set by the National Screening Committee (NSC) and guidance is provided in a related publication known as Health for All Children (Hall, 2003). In 2003, the NSC recommended that vision screening was limited to a single screening on school entry at the age of four to five years and that screening at the age of seven and 11 should cease (Hall, 2003).

While some localities have implemented good screening programmes, surveys carried out by the RNIB (McLaughlin, 2009) and Which? (Pearl, 2011) suggest that at least a third of authorities have no screening programme in place at all. Even where screening programmes are in place, in many cases the programmes lack proper mechanisms for audit or
adequate pathways to manage the children who “fail” the screening.

Since 1995, a team from City University London has been investigating ways of improving the sensitivity, specificity, efficiency and cost-effectiveness of screening in schools. One of the outcomes of this work is a computer system known as the School Screener. This system offers a radical new solution for providing an efficient and effective vision and hearing screening programme.

This article gives a brief overview of the School Screener system and the evidence for its effectiveness. The article is focused on vision screening although the system can also be used for hearing screening and collecting height and weight data.

The target conditions for vision screening

The first few years of life are a time of radical development for the human visual system. While the eyes themselves are fully formed at birth, the complex network of cells in the brain which interprets the information received from the eyes is immature. As a result, a newborn infant has very limited visual perception (Daw, 2006).

The brain matures rapidly over the first few months of life and by the age of one year most attributes of vision are present, although the visual system does not reach full maturity until the age of approximately seven years.

In order for the cells in the brain to develop normally, the two eyes must be well co-ordinated and focused. If a child has a squint (where the two eyes are misaligned) or a focusing problem (refractive error), vision in the affected eye(s) may not develop normally and the child will develop a condition known as amblyopia, or ‘lazy eye’.

Amblyopia results in visual impairment in the affected eye and means there is a reduced or absent 3D vision (stereopsis).

If the condition is detected before the age of approximately seven, vision in the amblyopic eye can often be improved by prescribing spectacles and/or patching the good eye for a few hours each day. Treatment becomes less effective after the age of seven as the brain loses its plasticity.

Another challenge for the developing eye is the change in focal length as the eye grows. In order to keep the image in focus on the retina as the focal length of the eye changes, the shape of the cornea has to change in exact proportion. This process, known as emmetropisation, works well in most cases and the majority of children retain good focus throughout the growth period.

However, in some cases the process fails and this results in the child developing a focusing error (refractive error). If the eyeball grows too long for the shape of the cornea a child becomes short-sighted (myopic). If the eyeball is relatively short, the child will be long-sighted (hypermetropic). If the cornea develops an egg-shape rather than being spherical, the child will become astigmatismic.

In general, short-sightedness results in poor distance vision while long-sightedness tends to cause problems with near vision. Astigmatism tends to affect both distance and near vision. All of these conditions can be corrected using glasses or contact lenses.

Therefore, the primary target conditions for vision screening are amblyopia and significant refractive error. While there are many other problems and conditions that can affect a child’s eyes, they are not common enough or serious enough to justify being included as target conditions for universal screening.

Amblyopia, myopia and astigmatism can be detected by simply measuring the visual acuity in each eye. Hypermetropia can be detected by including a blur test in the protocol.

The School Screener software

The School Screener system consists of software which runs on a standard laptop (running Windows XP or later) and a secure cloud-based server. The software is fully compliant with NHS information governance standards.
A screening cycle begins by uploading a list of the children to be screened. It is recognised that these lists are subject to change and children can be added or removed from the list at any stage throughout the year.

Each school nurse or team member is then registered on the system and required to generate a password. Nurses can be allocated all the schools in the locality or a subset.

Before attending a school, the nurse synchronises the laptop software with the server by connecting to the internet and clicking on Sync. This downloads a list of all the children at the schools that the nurse has been allocated. This information is stored locally so that internet access is not required when the nurse visits the school (figure 1).

How does it work in practice

The nurse or team member then visits the school and sets up the laptop in a suitable room. As each child is called, the nurse simply selects the child’s name from the list and selects vision or hearing screening (figure 2).

For vision screening, a cartoon character gives the child exact instructions about when to cover each eye and put on the “special” glasses. Instructions can be spoken in 27 different languages or muted so that the nurse or team member gives the instructions. The software uses the gold standard tests for vision screening as recommended by the NSC. Visual acuity is measured with the child standing at three metres from the laptop screen and viewing letters displayed in a crowded LogMAR format (figure 3).

Displaying the letters on a laptop screen rather than using printed charts provides better control over the luminance and contrast of the charts and allows the letter size to be scaled to accommodate different viewing distances. Matching cards may be used with children who are not yet able to name letters.

To progress the test, the nurse simply clicks on the Next button using the mouse or uses the wireless remote control. For the visual acuity test, letter size is varied automatically according to the recommended protocol and all scoring and recording of results.
happens automatically. A vision screening can usually be completed in less than three minutes.

For hearing screening, an audiometer device (the size of a spectacle case), developed specifically for the system, is plugged into the laptop. This device is used to generate test tones under computer-control through the calibrated headphones. The child is seated in front of the laptop screen and watches three cartoon characters appear on the screen. The child is asked to report which of the characters “squeaks.” The tones are presented to each ear at the predetermined frequencies and following the recommended protocols.

For height and weight screening, the measurements are simply entered into the system. The software automatically determines the BMI and the corresponding centile for a child of the corresponding gender and age and places the child into one of four categories: underweight, healthy weight, overweight or obese (figure 4). Personalised letters with appropriate wording can then be generated automatically and the final dataset exported to a spreadsheet for submission to the NCMP.

The tests are usually very well received by the children who are often so absorbed in the "game" they do not realise they are being screened. The results are all securely stored on the laptop removing the risks associated with paper-based records.

**The results process**

On completion of the screening the laptop is once again connected to the internet and with the click of a button, the results are synced with the server. The server then automatically analyses the results and generates personalised letters for the parents or carers of each child. The letters follow templates which are customised for each locality.

The nurse or an administrator can then log-in to the server using a secure code and view the results of the screening and any comments recorded by the nurse (figure 5). They are also asked to record if the screening result was correct (true positive), i.e. did the child turn out to have one of the target conditions. They may also record additional clinical information such as visual acuity, spectacle prescription and treatment/intervention prescribed.

Thus, at any moment in time, the system can provide information on the number of children screened, the number who have tested positive, the number of screen positives who have attended for a secondary examination and the number of these children who were true positives. This powerful audit information allows the programme director to constantly monitor the progress and effectiveness of the overall screening programme. Issues with over or under-referral rates can be readily identified and appropriate measures taken.

While most parents and carers tend to comply with the initial request to arrange a secondary examination, a minority often require further encouragement. To address this issue, an automated reminder

**Referral pathways**

Screening on its own is of little value without a robust pathway to ensure that those with vision or hearing problems receive the appropriate treatment or intervention. In the past, following children through the referral pathway has been a time-consuming and difficult process requiring the transfer of referral letters to the secondary clinic and the return of examination reports. In practice, most authorities do not track children beyond the initial letter to parents and therefore have no way of ensuring that those who test positive receive the tests and intervention they may require.

The School Screener provides an elegant and efficient solution to this problem. Parents of children who test positive at the screening receive letters giving clear and precise instructions about how to book the secondary examination. For vision screening, the examination might be with an optometrist, a secondary clinic or a hospital, depending on the local policy.

When the child attends the secondary clinic, the clinician can log-in to the server using a secure code and view the results of the screening and any comments recorded by the nurse (figure 5). They are also asked to record if the screening result was correct (true positive), i.e. did the child turn out to have one of the target conditions. They may also record additional clinical information such as visual acuity, spectacle prescription and treatment/intervention prescribed.

Thus, at any moment in time, the system can provide information on the number of children screened, the number who have tested positive, the number of screen positives who have attended for a secondary examination and the number of these children who were true positives. This powerful audit information allows the programme director to constantly monitor the progress and effectiveness of the overall screening programme. Issues with over or under-referral rates can be readily identified and appropriate measures taken.

While most parents and carers tend to comply with the initial request to arrange a secondary examination, a minority often require further encouragement. To address this issue, an automated reminder
protocol can be set up so that the School Screener automatically generates reminder letters for all children who test positive but have not yet attended the secondary clinic. Up to three reminder letters can be sent at prescribed intervals following the screening.

**Pilots show promising results**

The system was first developed over 10 years ago and has been subject to extensive clinical and field trials. In a clinical trial involving more than 3,000 children in inner-London schools, all children were screened using the system and then examined by an optometrist and an orthoptist (Thomson, 1999).

Using the outcome of the clinical assessment as the gold standard, the program was found to have a sensitivity of 96.9% and a specificity of 96.1%; i.e. the program correctly identified 96.9% of the children with the target conditions and 96.1% of the children with “normal” vision.

The children responded very well to the screening tests, perceiving the whole process as a “computer game.” The personalised reports generated for the parents and carers of the children were also very well received.

With appropriate organisation within the schools it was possible to screen between 10 and 15 children per hour using a single computer. Coupled with administration time savings, by virtue of the automated system, this allows school nurses to work more efficiently and offers Community Health Trusts opportunities to use time released on the many other pressing demands on school nursing.

Since large scale pilots ended in March 2013, areas covering more than 30,000 children have started screening using the new system and many more areas are in discussions to start using either later in 2013 or early 2014.

In the pilots, overall, 18% “failed” the vision screening, compared to between 3% and 33% with traditional methods. Of these, approximately 10% of those who have received secondary tests were false positives, 17% required treatment for amblyopia and the remainder (73%) had a refractive error. 62% of those tested were given spectacles.

**Summary**

The School Screener provides a radical new solution for managing screening in schools. The system oversees the entire process including obtaining parental consent, testing vision and hearing, generating letters and reports, tracking through the referral pathway and collating audit statistics.

At a time when school nurses are under increasing pressure to take on new responsibilities, the School Screener removes a huge administrative burden (which is often borne at least partly by nurses).

Vision and hearing screening in schools is an extremely important safety net, without which many children with vision and hearing problems are disadvantaged at school. By making appropriate use of technology, the School Screener allows localities to provide a high quality, efficient screening programme while actually reducing the demands on school nurses.

**School Screener users say:**

“Many children with vision and hearing problems go undiagnosed. The pilots of the School Screener software demonstrate that screening effectiveness can be substantially improved with benefits for children’s development and cost savings for special needs.”

John Brown of the Institute of Education, University of London

“We have recently piloted School Screener. The benefits identified for patients, staff and the Sussex Community Trust quality agenda has led to the decision to now roll out School Screener across the West Sussex County.”

West Sussex Healthy Child Programme team

“Implementing School Screener has demonstrated improvements to the standard of screening provision.”

Sabeen Saeed, specialist orthoptist in Barnet

**Further information**

Thomson Screening Solutions, a spin-out company of City University London, has been set up by the university to implement and support School Screener. Further details about the School Screener are available at www.thomsonscreening.com or by contacting the author at w.d.thomson@city.ac.uk

**References**


Barbaric rite of passage

The number of cases of female genital mutilation is on the rise in the UK, especially in ethnic communities where the practice remains a cultural tradition. Independent safeguarding consultant Shelagh Willis looks at the issues surrounding the controversial topic.

Some young school girls in the UK are being forced to undergo the barbaric mutilation of their genitalia as part of family and cultural tradition. The practice can leave children in extreme pain and at risk of potentially life threatening conditions including psychological problems, which can go on into adulthood.

About 20,000 under 15s in England and Wales mostly from African, Middle Eastern and Asian communities are thought to be at risk of female genital mutilation (FGM) (Forward UK, 2007). These figures could possibly be higher due to the growth of the UK population and immigration from countries that practice FGM.

Health consequences of FGM
FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic purposes. The practice (often carried out in an unsterile environment with dirty and blunt tools) is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life (DH, 2011).

The terms ‘FGM’ or ‘cut’ are used at a community level although ‘FGM’ is not always understood fully as it is an English term. In Egyptian FGM might be called ‘Thara’ or ‘Khitan’, in Somali it might be called ‘Guidiniin’, ‘Halalays’ or ‘Qodiin’ (DH, 2011). FGM is often also referred to as ‘female genital cutting’, ‘circumcision’ or ‘initiation’.

When do the procedures typically take place?
The procedure may be carried out on a child at birth, during childhood or adolescence, and sometimes just before marriage or during first pregnancy. The age can vary depending on community practices, but most cases of FGM are thought to take place for girls between five and eight years old. FGM is thought to be happening in the UK as well as abroad. Schoolgirls are often taken to their home countries during the long summer holiday to allow healing time. The World Health Organization (WHO) estimates that between 100 and 140 million girls and women have experienced FGM and around three million girls undergo some form of the procedure each year in Africa alone.

FGM prosecutions are imminent
FGM is illegal in the UK and is a form of child abuse. The law is very clear under the Female Genital Mutilation Act 2003 (England, Wales and Northern Ireland) and The Prohibition of Female Genital Mutilation Act 2005 (Scotland). The law specifies that it is an offence for a person to excise, infibulate or otherwise mutilate the whole or any part of a girl’s or woman’s labia majora, labia minora or clitoris except for clinically necessary surgical operations and operations carried out in connection with childbirth. It is also an offence to assist a girl to mutilate her own genitalia or to take a girl outside the UK for the purpose of carrying out FGM. Any person found guilty of any offence under the 2003 FGM Act could face a fine but also the possibility of 14 years in prison. To date there have been no convictions in the UK under the 2003 law. However, as we went to press Keir Starmer, the director of public prosecutions, encouragingly announced that the first conviction for FGM is just around the corner and that the Crown Prosecution Service is currently considering whether to proceed with five cases, which would see charges brought against the perpetrators.
The physical pain is one thing — but the psychological torment of living with FGM is also ruining the lives of so many girls in London.”

Writer, polemicist, ex-Muslim and former Dutch MP Aayan Hirsi Ali

In May 2012 the Department of Health along with the Royal College of Nursing and Royal College of Physicians asked GPs, practice nurses, health visitors and school nurses to recognise the role they play in the recognition of and prevention of FGM. In March 2013 the NSPCC asked school teachers to improve their knowledge around the prevention and recognition of FGM in our UK schools. Lisa Harker, head of strategy at NSPCC, said: “There are young girls in British classrooms who will be subjected to the agony and trauma of FGM and a life of pain. Teachers are on the frontline in the fight against FGM yet clearly feel unprepared for this role.”

Different methods of FGM

- **Type 1 – Clitoridectomy:** partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and in very rare cases only the prepuce (the fold of skin surrounding the clitoris).
- **Type 2 – Excision:** partial or total removal of the clitoris and labia minora, with or without excision of the labia majora (the labia are the lips that surround the vagina).
- **Type 3 – Infibulation:** narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
- **Type 4 – Other:** all other harmful procedures to the genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area.

**(WHO, 2008)**

**Why is FGM practised?**

Families and individuals will cite a variety of reasons why FGM is practiced. These often include:

- It brings status and respect to the girl, is a rite of passage, and preserves virginity/chastity.
- It cleanses the girl, upholds family honour, and makes a girl socially acceptable especially for marriage.
- It is more hygienic, cosmetically desirable, and often wrongly thought to be safer for childbirth.

These beliefs are deeply embedded in communities’ everyday lives, and are rarely thought of as abusive in any way. In fact the opposite is true, families believe they are doing the right thing for their daughters. It often comes from a place of love for their daughters. Children may not come forward and ask for help because they don’t know it’s wrong, and they may want to protect their families. Families who might refuse or avoid FGM may experience being ostracised in their communities; girls may experience bullying within their communities and be considered unsuitable for marriage.

Religion is often the reason given to justify FGM, but this is not supported in the Bible, the Torah or the Koran or any other religious texts. Clerics have spoken out against FGM in the hope of reducing its prevalence.

**Prevalence of FGM and implications**

In 2010 UNICEF published the results of a number of surveys carried out between 1997 and 2009 which revealed the prevalence of FGM in Africa. It revealed that FGM had a prevalence of more than 90% in places such as Sierra Leone and Egypt, while Somalia had 97.9% prevalence. Meanwhile,
Uganda only had a prevalence of 0.6%. FGM is also practiced among Muslim populations in parts of Malaysia, Pakistan, Indonesia, the Philippines and Iraq. This information is vital when considering the preventative role that a school nurse might play, and knowing the ethnicity of your school population is part of that prevention.

The short-term implications of FGM can include severe pain, haemorrhage, infection including HIV and Hepatitis B and C, urinary retention, fractures or damage to other organs, emotional trauma and death.

The longer term implications of FGM can include chronic vaginal infections leading to infertility, reproductive organ damage, menstrual problems, long-term pain, sexual problems, mental health issues, scarring, and complications during childbirth including death of mother or child.

Some years ago I met a young Somali interpreter who told me that she had been ‘cut’ as a child and accepted it, but now she was living in London and living a new Western life and being ‘cut’ was causing her problems when she tried to form relationships with men. ‘It does not work to have been ‘cut’ if you live in England’ were her words.”

Shelagh Willis

How can a school nurse act to help prevent FGM?


FGM is a serious child protection issue; so all practitioners should be aware of their safeguarding responsibilities and respond appropriately by getting advice from their safeguarding advisors and their local safeguarding children board. Following their child protection policy is part of their duty of care to children and young people.

FGM is also considered a domestic violence and abuse issue, the new definition of domestic violence and abuse was introduced in April 2013 by the Home Office. While it has been widened to include 16 and 17 year olds and reflect coercive control, it includes FGM as a harmful traditional practice (Home Office, 2013).

In 2011 the government introduced ‘Multi-agency Practice Guidelines: Female genital mutilation’. It is expected that these guidelines are used by all agencies when dealing with cases of suspected FGM but also in the prevention of FGM.

Professionals need to be able to identify girls who may be at risk of FGM and they also need to recognise when FGM may have already occurred. School nurses will be well placed to fulfil this role; they can also support their schools in the recognition and prevention including understanding their safeguarding responsibilities.

Multi-agency guidelines for all professionals

School nurses can raise awareness among school staff through training sessions and by sharing resources. They can also provide an advisory or support role to teaching staff. They should:

- Inform and raise awareness among their colleagues about the issues surrounding FGM. This includes FGM in domestic violence training and ensuring copies of FGM leaflets are on display (www.fco.gov.uk/fgm provides access to a great leaflet for girls to read).
- Deal with FGM in a sensitive and professional manner and avoid showing signs of shock, confusion, horror or revulsion when dealing with someone who has undergone FGM. A common complaint of women who disclose FGM is the response of the person they have told.
- Consider other family members who may be at risk of FGM and consider mental health issues of any person affected by FGM.

The guidelines also suggest that FGM should be part of a variety of curriculum subjects, mainly PSHE but also drama, history, religious studies, citizenship and sociology. Schools and their school nurse can join forces to plan effective awareness-raising classes and provide support and advice on FGM among their school population.

Part of that plan should include what action should be taken if there is suspicion that FGM has taken place or is about to. Clear referral pathways for counselling and safeguarding advice should be identified within the plan.

School health nurses and health visitors who may be working closely with families need to be skilled and confident in talking about FGM with mothers and girls. The family view on FGM should be explored and the illegal aspect of FGM should be conveyed to families.
Local safeguarding children boards also need to plan community wide education that includes boys, male partners and leaders in the community in order to try and end the practice of FGM.

Some practitioners fear complaints of racism or prejudice if they ask questions about FGM, and it is vital these fears are ignored and professional responsibility is the driving force behind questioning.

School nurses or health visitors should ensure they are able to direct the family to the right kind of support to break the traditions. They may be required to provide counselling to a young person affected by FGM.

The NSPCC FGM helpline (see FGM helpline box) is also a great source of information and advice. Just two weeks after their launch earlier this summer, they had received 41 calls.

John Cameron from the NSPCC said: “Health professionals need to understand that those who have suffered FGM often don’t know it is abusive and harmful because they have been told by their own family that it is in their best interest. There is also huge pressure from their community to keep quiet with some people even being threatened with violence if they speak out.

“This is why professionals who come into contact with these communities have such a vital role to play in reporting cases of FGM.”

It is important when dealing with issues of FGM, or any other safeguarding-related issue to always use independent interpreters. We must not use family members to interpret for a child or adult who is not fluent in English.

As a school nurse I had arranged the new entry medicals for four Somali children who had recently arrived at the school. I had organised an interpreter to assist me with this. The four girls aged between six and 11 years has spent time in a refugee camp in Ethiopia on their way to the UK. I had asked routine questions about previous medical history and operations, with FGM in mind. Culturally this was not considered a medical practice or a form of operation. The family of four girls and their mother answered ‘no’. The interpreter suggested that they may have been circumcised, the answer was a resounding ‘yes’. My questioning had been ineffective and a big lesson for me that day. Luckily thanks to the interpreter we were able to know that FGM had happened to all the girls in a refugee camp in Ethiopia with poor hygiene conditions and we were able to organise for all the girls to receive further medical checks to ensure they were no underlying health problems as a result.”

Some women may request ‘deinfibulation’ (this is the procedure to re-open the vaginal opening) before marrying or because they find penetration very painful. There are specialist FGM clinics around the UK to support women with this.

A midwife colleague explained that she often delivers babies from mothers who have undergone FGM; these mothers tend to tear much more and lose more blood but also require extensive suturing post-delivery.

Just to clarify though, doctors in the UK are not allowed to re-suture to form the original infibulations and excisions, they will only suture the tears caused by the vaginal delivery.

FGM helpline:
If you are concerned that a child may be at risk of FGM, contact the NSPCC’s FGM (24 hour) helpline anonymously on 0800 028 3350 or email fgmhelp@nsppcc.org.uk

Further information


References


Not just growing pains

School nurses can play a key role in helping pupils manage debilitating digestive conditions collectively known as IBD. Helen Terry from Crohn’s and Colitis UK explains the impact of these serious bowel diseases on a child’s life and offers advice on managing them effectively.

Earlier this year Crohn’s and Colitis UK, a national medical charity, released the findings of a new survey of 1,081 teenagers and young adults. Although the Me and IBD survey (2013) was designed to assess how education professionals are supporting their pupils with Crohn’s disease and ulcerative colitis, the results were revealing, exposing flaws in the understanding and awareness of serious inflammatory bowel diseases (IBD) amongst teaching staff and others assigned to care for children young people.

Over 50% of the young respondents who were still at school, believed their teachers were ignorant of their often unseen or embarrassing symptoms.

Pupils and young people with IBD want greater recognition of these lifelong chronic conditions, which cause severe stomach pains, urgency for the toilet, relentless diarrhoea, extreme fatigue, nausea and loss of appetite. These symptoms can cause immense distress and embarrassment to sufferers, especially as often there is no prior warning of the onset of symptoms, and ‘flares’ can strike at any time. These ‘flare-ups’ can be especially difficult for children and young people to manage on a daily basis, but especially so during exam time or when attending university or job interviews.

How common is inflammatory bowel disease (IBD)?

The survey findings are all the more significant, as the two inflammatory bowel diseases (IBD) Crohn’s disease and ulcerative colitis are known to be on the increase. Every year, 10,000 young people are diagnosed with IBD which is often more aggressive in this young age group (Molodecky et al, 2012; Henderson et al, 2012).

Although rare in young children under the age of two, the incidence of these diseases increases substantially from the age of 10 and increases further...
Nobody is sure, but researchers and experts think both Crohn’s and UC are caused by a combination of factors, including:

- the genes you are born with
- an abnormal reaction of the digestive system to bacteria in the intestine
- an unknown ‘trigger’ or set of triggers which could include viruses, other bacteria, diet, stress, or something else in the environment.

If one parent has IBD, the risk of their child developing IBD is about 2% for ulcerative colitis and 5% for Crohn’s disease, although it may be higher in some population groups.

**TREATMENT OPTIONS**

Because of the nature of the symptoms and the treatments, IBD symptoms can be a painful experience for a child or young person, both physically and psychologically.

There isn’t a cure at the moment but a lot can be done with medication and surgery to help keep symptoms under control and reduce the chance of a flare-up.

Treatment for IBD often includes courses of drugs which can cause excessive weight gain, a moon-face, spottiness and mood swings. Some children are treated by being put on exclusive liquid diets, and they may need a feeding tube.

Sensitivity should be shown towards young people with IBD and their desire for privacy be fully respected. Some children prefer to keep their condition private, but others may prefer to explain to their peers how their condition affects them. Whatever their preference, school nurses and teachers should offer support, whilst remaining vigilant to possible signs of bullying from their peers.

**SYMPTOMS AT A GLANCE**

Although these may vary from patient to patient, these can include:

- diarrhoea (sometimes relentless) and urgency for the toilet
- dramatic weight loss or weight gain (although the latter can be linked to medication)
- extreme fatigue
- growth delay in children
- loss of appetite
- nausea
- rectal bleeding and severe abdominal pain
- skin, joint and eye problems.

**How to best provide help and support**

- Keep in touch with parents about their child’s ongoing or changing needs. If possible, draw up an individual health care plan, which can be passed on as they move up the school.
- Arrange for a liaison teacher to be assigned, someone the child/young person, their parents and other teachers can talk to should any problems arise.
- Understand that they may arrive late at school or for lessons because of an urgent need to use a toilet or because joint pains have slowed them down.
- Let the child/young person leave and return to the classroom discreetly without having to get permission whenever they need the toilet. If toilets are locked or some distance away, let the pupil use a staff toilet.
- Be aware that a child/young person with IBD may need to take medication during school hours and/or need extra meal breaks.
- If a child/young person with IBD is unwell at school, don’t rush to send them home – sometimes they may be able to continue after a rest.
- If they have to have time off, either at home or in hospital, encourage the class to keep in touch, for example with cards and phone calls or by email.
- Do not automatically wait for them to return to school before offering schoolwork. They may be able to do some work at home and would like to keep up with others in their class. For example, provide notes on lessons and arrange for work to be set by email. Let them judge for themselves how much sport/PE or after-school activities they can join in – but don’t stop them trying whatever they want to try.
- Don’t exclude pupils with IBD from school trips: talk to them about their needs and try and arrange to meet these, eg. with an aisle seat at the theatre or cinema and using a coach with a toilet.
in young adults. There are approximately five new cases per 100,000 children under the age of 16 each year. Although a primary school teacher may occasionally have a child with IBD in their school, secondary school teachers are quite likely to have at least one pupil in the school with the disease.

Commenting on the survey findings David Barker, chief executive of Crohn's and Colitis UK, said: “The implications for teaching staff are clear, they need to improve their recognition of these serious diseases and make more reasonable adjustments for their pupils with hidden impairments. Increased communications with the parents and ideally the pupil; unlimited access to toilets; time off for hospital appointments and sending work assignments home for pupils recovering from surgery or a disease flare, would all be a great start.”

He added, “Teachers and school nursing staff have a duty of care to all pupils including those with IBD. The starting point has to be greater awareness of these painful, embarrassing conditions and we urge all teachers to encourage and help pupils to discuss what they are going through, if the young person wants to talk. Needless to say creating a supportive environment and promoting positive attitudes towards pupils with these lifelong conditions is a critical part of fulfilling this duty of care. With the rising incidence of IBD in children and teenagers, every school is now likely to have pupils with IBD and improved communications must be a priority.”

Case study: coping with a new diagnosis in the classroom

Just before Ryan Alderson was 12-years-old, he became seriously ill with stomach pains, sickness and exhaustion for no apparent reason. Adding to his discomfort further, Ryan was suffering with urgent diarrhoea which meant that he needed to be near a toilet at all times. As a result of these debilitating symptoms, he lost a great deal of weight and after three months, he was diagnosed with Crohn’s disease, one of the two main inflammatory bowel diseases (IBD).

Ryan’s mum Catherine considers that he is very lucky, as Garforth Academy in Leeds has provided him with excellent support in coping with the pressures of the classroom, school work and Crohn’s disease.

Catherine explains, “Ryan was diagnosed in the first year of attending the school and the Academy staff should be applauded for providing a good example to others. Ryan has a card he carries around school that allows him to go straight to the school toilets, first aid or the excellence centre, which is a place where there are a few children who are working to catch up.

Ryan needs a reduced timetable to allow him to keep up with his core subjects. Also the school are keen for Ryan to attend even if it’s only for a small part of the school day, which has encouraged him to go even when he feels poorly knowing that he doesn’t have to keep going all day long. He is doing well at school and we have a close relationship with the staff and feel able to contact them with any concerns and they always endeavour to help us.”

Further information

Visit www.crohnsandcolitis.org.uk or contact the Crohn’s and Colitis UK Information Line: 0845 130 2233, open Monday–Friday 10am–1pm. There is an answerphone service outside these hours or please email info@crohnsandcolitis.org.uk

The charity also has a dedicated micro-site for young people and children packed with useful tips, information and the Blog Roll at www.MeandIBD.org (see the campaign logo, top left).

Crohn’s and Colitis UK’s 2013 campaign aims to ensure that every school and teacher is aware of IBD and the needs of children and young people who are living with these conditions. School nurses can contribute by acting as ‘champions’ for pupils with IBD, offering their understanding and support to pupils and ensuring that school staff are aware of the potential impact and needs of children and young people suffering from Crohn’s and colitis. Increased awareness, understanding and support will serve to help children and young people cope better with these conditions to get the best that they can from their years in education.

References


Hands of friendship – Local children hold hands during the opening ceremony at this year’s School Nurse International Conference (SNIC)

School nurses attending this year’s international conference were treated to a feast of Slovenian food and wine.

‘Appy students in Leicestershire
Students in Leicestershire will soon benefit from the launch of a new App which will allow them to contact their school nurses. This follows on from an SMS service which was launched in the summer term.
Visit http://www.leicspart.nhs.uk/Library/MyHealthApplicationProjectUpdateSeptember2013.pdf for more information.

Inject some knowledge
Jo Yarwood, the Department of Health Programme Manager for Immunisations, will present to SAPHNA conference delegates on the multiple changes and additions to the childhood immunisation programme. For more information visit http://www.pavpub.com/p-641-saphna-conference-2013.aspx speakers.

Calling all independent school nurses (including free/academies)
We are conducting some work to support independent school nurses in their practice. Contact me for details of how to ‘Have your say’ and become involved: Sharon@saphna-professionals.org


8 October
Don’t miss out!

14 November
World Diabetes Day
Visit http://www.diabetes.co.uk/World-Diabetes-Day.html for more information on events in your local area.

Jo Yarwood, Department of Health Programme Manager for Immunisations.
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