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Integrated working: School nursing in Suffolk

Since I last wrote on integration in 2005, (Richardson-Todd, 2005), Suffolk has edged nearer to inter-agency working. In May 2011, by leaving the NHS and coming under the auspices of the local authority, health visitors and school nurses joined the integrated children's service teams within the county council, which also consisted of social workers, family support practitioners and youth support workers education, early years support and wider services to support children and families.

Integration could be defined as a single system of service provision and it is not the same as coordinating separate systems but integrating services for young people. A national policy, is being interpreted differently in different parts of the country. There is a long continuum which ranges from co-location and better links between those delivering services to young people, right through to the delivery of all services to young people through wholly integrated locality-based teams.

According to my local authority, integrated service delivery is "a way of working alongside children, young people, their families and communities where everyone shares responsibility for promoting safety, well-being and learning. All recognize their role in identifying need, meeting challenge and building resilience and will have the confidence and skills to secure best outcomes and opportunities for children and young people" (Suffolk County Council, 2011).

Practitioners should be enabled and encouraged to work together in more integrated front-line services, built around the needs of children and young people, using common processes which are designed to create and underpin joint working and at the heart a child-centered, outcome-led vision.

The local vision is for Children and Young People's Service to enable all children and young people "to aspire to, and achieve, their full potential, giving them a basis for a successful life as active members of their community" (Suffolk County Council, 2011), and to guide staff, children, young people and their families/carers to realising this vision are the values of empowerment, respect, innovation, collaboration and commitment.

Drivers

Some of the national drivers for change have been the economic climate with a reduction in funding for public services; localism, with the concept of the 'Big Society' and building partnerships with communities as well as the growth of Academies and Free Schools.

The following documents (Suffolk County Council, 2010), are also impacting on services for children, young people and families:

- Child Poverty Strategy: "A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives" This includes removing financial disincentives to work, encouraging early targeted work with needy families, improving health outcomes and tackling disadvantage.
- Munro review of child protection emphasis on reduction of bureaucracy and reforming social work education, changing the way Serious Case Reviews are undertaken.
- Wolf Review of vocational education including changing the nature and improving the quality of some vocational qualifications pre-16 and allowing FE lecturers and professional to teach in schools.
- SEN and Disabilities Green Paper including proposals to replace the current statements with a single assessment process and a combined Education, Health and Care Plan.

- The Review “Early Intervention: the next steps” independent report to Her Majesty’s Government” by Graham Allen highlights evidence-based early intervention programmes and strategies to provide a ‘social and emotional bedrock’ for children and young people before the problems arise.
- Education Bill including amongst other elements the removal of the duty on schools and colleges to cooperate with Children’s Trusts and for schools to have regard to the area’s Children and Young People’s Plan
- Health and Social Care Bill including proposals that:
 - make consortia of GPs responsible for commissioning services
 - establish HealthWatch as the national voice of patients and the public
 - give Local Authorities responsibility for public health improvement (currently resting with PCTs)
 - create Health and Wellbeing Boards (HWBs) bringing together GP consortia, Departments for Public Health, children’s services, adult social services and others and will have a statutory responsibility to develop a ‘joint health and wellbeing strategy’
 - abolish Primary Care Trusts (PCTs) (2012) and Strategic Health Authorities (SHAs) (2013)
 - create Public Health England

Common Assessment Framework

A vehicle to ensure swift and easy access to services is the Common Assessment Framework (CAF). This is a national initiative to develop common methods and processes for conducting an assessment of the needs of a child or young person and deciding how they should be met. It is designed for use by practitioners in all agencies so they can communicate and work more effectively together and there is less need for the family to repeat their story. As part of this process, appointing a lead professional will support children and young people who have a range of additional support needs. Better service co-ordination and increased communication and information sharing is encouraged where appropriate and more clarity given as to what professionals can share with whom.

The benefits for children, young people and families are the “No wrong door” policy which

is a single point of contact giving easier access to the appropriate services, and information to ‘navigate’ services, early identification and resolution to difficulties, faster more co-ordinated and appropriate response and a better service experience for families.

The core professional purpose is to ensure safety, well-being and learning for all children, young people and families. The national expansion of the Health Visiting Service is to ensure, amongst other elements, the delivery of the Healthy Child Programme. By 2015 there should be an extra 1268 health visitors in the East of England and large numbers are being trained over a three year period. The Department of Health document on health visiting, “*A Call for Action*” (DH, 2011) has a new model for health visiting consisting of community, universal, universal plus, universal partnership plus, safeguarding. This model is also being adopted by school nursing.

The Healthy Child Programme

The Healthy Child Programme (HCP) is for children and young people aged 0-19 and supports a model of progressive universalism – a core programme for all children, with additional services for children and families with particular needs and risks and provide greater emphasis on promoting the health and wellbeing of children in the early stages – pregnancy and the first five years of life.

It focuses services on changing public health priorities by supporting the establishment of healthy lifestyles: reducing obesity by healthy eating and exercise; breast feeding; smoking cessation; parenting groups and support; harm reduction from drinking and substance misuse; sexual health – increase the proportion of 16-25 year olds screened for chlamydia; safeguarding children and their families through early identification and intervention; increasing detection and support for women with mental health needs; social and emotional development; supporting children with additional needs and improving the emotional wellbeing and support for children and young people within schools to reduce absences and improve behaviour.

Working within an inter-agency and multi-skilled team is not without its challenges: there are diverse cultural and working practices

which can impact on information sharing/development of common protocols. This is compounded by geographical distance and fragmentation of services. There may be a lack of knowledge of each others services and roles and how/when to refer and the need to align priorities/resources to address common needs made more challenging at a time of re-organisation/restructuring within partner organisations. On a more basic level, issues such as co-location, work space and hot desking can bring their own problems. It is a new mind set for staff.

We need to appreciate different ways of working and understand different use of language/jargon; we have to establish role boundaries and deal with any power issues. Team members are coming from different backgrounds and the integrated teams will be multi-disciplinary and inter-organisational in their make-up. If workers from different professional backgrounds are to work well together successfully, they need to make an effort to understand others' professional cultures and be clear about their own role and responsibilities and that of the other members of the team.

Although working in an integrated team, it is vital to establish clear lines of accountability wherein those responsible for tasks, milestones, actions and intended outcomes are visible presences within the team. If there is no ultimate responsibility, individuals are left in a vulnerable position. If the integrated team is to be a success, team members need to have a clear, shared purpose and vision.

Our promise to children and young people

Integrated Services provide early help to enable children, families and young people to make things better for themselves. Our promise to children and young people -

We will:

- listen to you
- treat you with respect
- treat information confidentially unless we have to share it to keep you or someone else safe
- be honest with you
- do what we say

- keep you informed
- ask you before taking any action
- give you one main person to speak to
- not ask you to repeat basic information
- with your agreement, link with other services to support you
- reply to any messages from you promptly
- ask you whether or not we've helped

Case Study 1

The school nurse was invited to be part of the Team Around the Child (TAC) meeting which also consisted of parents, teacher, education welfare officer (EWO), outreach worker from the county inclusion support, behaviour support worker and family support worker from children and young people's services (social care). The issues were around an 11-year old autistic girl in her first term at high school having poor school attendance. Because of her autism spectrum disorder, she did not like change and the transition to high school had been traumatic alongside the added onset of puberty. The school nurse was asked to intervene to give health education, advice and support in order for the girl to deal with, and accept, her changing body and emotions. The girl was very bright but uncommunicative to many staff and even to her mother about personal things. The girl was invited to attend the drop-in or to see the school nurse by appointment but because it takes her a long time to build trusting relationships, she refused to see the nurse. Having looked at the register, there appeared to be a pattern of school absences, and the school nurse realised that the absences were when the young girl had her period.

The nurse gathered relevant information and resources which were age and cognitively appropriate and offered them to the girl's mother, advising her to place them under her daughter's pillow. The daughter found them and read them and took on board the information, which she might not have done if it had been offered verbally. Her autistic condition suggested that this was the best way forward. Young people learn in different ways and if one method fails, try another approach. If a young person won't engage, then support can be offered via the family (with young person's consent if appropriate) Mother, school and

EWO were extremely pleased and grateful as the girl is now attending school when she is menstruating and has accepted the changes in her body.

Case Study 2

Working closely with the student managers at a high school, a referral was made concerning a 13 year old girl with complex emotional needs resulting in self-harming. She had older siblings and younger half-siblings and there were unpredictable family routines adding to child's emotional stability. The intended outcome was to assess the immediate risk to the child, ensure her safety and identify any support systems that are available to her.

The school nurse met the girl in school during a lunch time and the aim of the first meeting was to build trust and develop rapport to enable her to disclose her feelings. It was evident that she found it difficult to vocalise her emotional needs. There was discussion around the past history of her social background and reasons contributing to her self-harming. During this meeting the school nurse discussed with the girl the issues of confidentiality and consent to share information disclosed.

Established practice was to discuss with a person responsible for the child's wellbeing the events that had occurred. The girl was aware of this and consent was given by her for the school nurse to speak to her parents. This was quite positive as she felt unable to discuss these feelings directly herself and at all stages the child was aware of the actions of the school nurse.

During the discussion with the parent, mother was advised to contact the GP to make an appointment to discuss events as this was highlighted as being of high priority. The school nurse wrote a supporting letter to the GP highlighting the concerns.

The school nurse also spoke to her safeguarding named nurse and she agreed the appropriate action had been taken. The school nurse then discussed the case with the primary mental health worker who re-iterated that the appropriate course of action had been taken. The health professionals were in agreement that a referral to social care via *Customer First* must be the first intervention taken.

A week later, there was a follow up meeting and the school nurse found the child to be more at ease to discuss the situation. She disclosed she had stopped self-harming and was more able to cope and to talk to parents.

Benefits

The school nurse was able to give support via the student manager and close links with the school. The child was invited to the drop-in to provide ongoing support. The school nurse had open discussions with the parent as to how best to address the child's needs and was available to talk further if they felt the need. The way was open for closer child/parent communication

Risks

The child and parent could become over dependant on the support of the school nursing service. When services are withdrawn the child could feel vulnerable again but with the ongoing support of the student manager and school nursing team we will aim for her to maintain emotional wellbeing and equilibrium.

The initial assessment commenced in September and completed in November. The parent felt positive and we had provided a beneficial and supportive service to her daughter. The child said she felt much better in herself and able to cope and would know she can access the school nursing service should she need further advice or support in the future.

The child felt more positive which in turn had a good effect on her social and family relationships.

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