CHANGING SCHOOL HEALTH SERVICES

Primary Health Care Group
King's Fund Centre for Health Services Development
126 Albert Street
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CHANGING SCHOOL HEALTH SERVICES

This information pack has been compiled for managers who are reviewing and developing school health services:

1.

CURRENT DEBATES

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The group's current interests include strengthening the management of primary care services; collaboration between district health authorities and family practitioner committees; decentralising community health services; and services for disadvantaged groups. The work is financed by the King's Fund and the Department of Health and Social Security.

This series of working papers is intended to make material from work in progress readily available to a wider audience. Each paper records the experience of testing a new idea and draws out the lessons learned.

CHANGING SCHOOL HEALTH SERVICES

1. Current debates

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The workshops highlighted the issues and problems that school health service managers need to tackle. It quickly became clear that they had few 'models' on which to draw to help them assess the quality of services provided for school children. Like us, most of them believed that school health service resources could be used more effectively and efficiently than at present. However, without precedents to quote to clinical colleagues and feasible alternatives to offer them, managers often lacked confidence to challenge traditional practices and methods of service delivery.

When it came to preparing a report on the workshops, we felt that the presentations and discussion should be put into the wider context of the debate about child health services. This information pack has therefore grown from the workshops and other material has been added to enhance its value to managers who are reviewing and improving school health services. It was compiled and edited by Jane Hughes, Pearl Brown and Pat Gordon, who gratefully acknowledge the contributions of the workshop speakers and participants, and the assistance of colleagues at the King's Fund Centre. Alex Cattell and Kate Cattell supplied the illustrations.

The information pack has five sections, each of which is intended to complement the others but also to stand on its own. The first section summarises the current debates on policy and practice in community child health services. The second presents two case studies which offer some clear indications of what to look for when assessing the quality of service. The third section examines the process of developing and reviewing policies for the school health service. The fourth is a rererence section, which describes the origins and organisation of school health services and gives a summary of available statistics and performance indicators. The fifth and final section is an annotated bibliography containing references selected for their usefulness to managers and policymakers.

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The selective screening debate

School health services have been criticised for being slow to respond to changing patterns of mortality and morbidity among school children[5]. For many years, routine medical examinations were regularly carried out on all school children to screen them for developmental problems, disease or disability. Today doctors and nurses still use many of the same basic procedures for screening and surveillance, although their effectiveness has never been properly tested[6]. Doubts have been cast on the value of routine school medical examinations and in most districts children are now only routinely examined once or twice in their school career. The majority of children still have a 'school entry medical' soon after they begin their primary education[7]. At other times medical attention is selectively focussed on children with previously recognised 'special needs' or with new problems identified by teachers, nurses or parents. It is now generally accepted that although comprehensive coverage is appropriate and necessary for the success of some preventive programmes, notably immunisation, selection may be preferable in other programmes, where intervention by health professionals is not needed by the majority of children.

The current debate is whether *any* routine medical examinations should be carried out in the school years, since pre-school health services involve comprehensive screening and surveillance, which should provide a sound basis for selecting children for special attention. In some districts the school entry medical has been abandoned and replaced with surveillance by nurses, parents and teachers, who decide which children should be seen by the doctor. Evidence suggests that selective services may be a more effective way of improving the health status of a population, as well as being an efficient use of scarce resources[8,9].

The Black report[10] recommended that school health services should operate more selectively to tackle inequalities in health, by finding methods of 'positive discrimination' that would concentrate resources on the most needy children. As well as identifying children most 'at risk' in all schools, it was envisaged that schools in the most deprived areas would be allocated a larger share of health resources. Although in recent years some additional resources appear to have been found to expand and improve services for children with special needs, these developments have usually left the organisation and distribution of generalist school health services unchanged and unchallenged.

The reluctance of school health services to abandon comprehensive screening stems in part from lack of integration with pre-school child health services. School health staff may lack confidence in the effectiveness of pre-school screening to identify children with developmental problems. In a properly integrated child health system, the school health service would build on, rather than duplicate, screening that has been carried out in the pre-school years. This kind of flexible approach has already been introduced in services to many secondary schools. Staff appear to have confidence in the screening carried out in primary schools and see no need for it to be repeated. It is now quite common to find that the routine medical on entry to secondary school has been replaced by a health interview with the school nurse[11].

Many health authorities, particularly in inner city areas, justify continuing with comprehensive screening programmes because of poor use of pre-school services and high levels of mobility among families with children, which cause concern that children with problems may be 'missed'. However, replacing routine medicals for pre-school children with a more selective system in a deprived area of Nottingham was found to be effective[12]. More experimentation is needed with selective systems that would accommodate high rates of 'turnover' among school children.

Many of the anxieties and difficulties with selective screening would be alleviated by the adoption of clear policies and procedures, cooperation between pre-school and school health staff, and good information systems. All these features are found in the Riverside Project in Newcastle which is successfully using a selective screening system[13].

The policy and planning vacuum

For many aspects of child and school health services there are no national policy guidelines. National policy guidance could help to rationalise child health services and would provide a framework on which districts could build. This policy vacuum was one of the key problems highlighted in the Court report in 1976. Macfarlane ascribes the vacuum to an absence of information and lack of sound research on which to base policy, particularly for screening procedures[14]. However, if he is right about the relationship between research and policy, the prospects are poor that guidance on school health services will be formulated in the near future. Districts seem likely to make most headway by developing, with education authorities, their own aims, objectives and policies.

Collaboration, however, has not always been a feature of school health services. Typically, services have been provided to schools by the health authority rather than being planned and delivered in partnership with the LEA, schools, teachers, parents and children. To ensure that there is close cooperation in policymaking, the establishment of 'liaison committees' across health, education and social services to consider children's needs has been suggested in a recent review by the National Children's Bureau[15].

The introduction of selective screening of school children means that 'partnership' is an important ideal to aim for, as more reliance is placed on parents and teachers recognising problems and referring children to school health staff. There is growing recognition that to make their full contribution parents and teachers need to know what school health services can offer and how they work. Published material, however, suggests that information does not flow as freely as it might, and that school health staff need to put much more effort into establishing good communication and consultation with parents and teachers. A recent survey found that most health authorities gave head teachers minimal written information about children seen by school health staff, and some did not inform them in writing at all[16]. Informal communication between school health staff and teachers has also been shown to be very variable; and teachers may not appreciate the importance of their role in health surveillance[17].

All health authorities make some attempt to inform parents about school health services and to encourage them to attend when children are being examined. Unfortunately this is often done by letters or leaflets that are poorly designed and difficult to understand[18]. Parents are rarely given a simple statement of the aims of the service and a clear description of when and how their children will come into contact with school health staff.

Where objectives for school health services have been set, the information that is routinely available is of little use for monitoring performance and for allowing managers or staff to assess how fast they are moving towards their goals. As usual in community health services, good information systems lag some way behind good practice. The lack of useful information about the health of school children was noted in the Black report, which suggested that resources should be put into improving school health statistics. To enable monitoring of health inequalities, the working group recommended that "... school health statistics routinely provide, in relation to occupational class, the results of tests of hearing, vision, and measures of height and weight". Some health authorities already collect information on parents' occupation, but we know of none which routinely use this in analysis of information about children's health and development.

As well as being starved of useful information, school health staff have been given little autonomy to respond to needs they may have identified in particular areas or schools. School nurses, who have most contact with school children, may respond in ad hoc ways but few will have the skills and support necessary to monitor and assess a new initiative. Although most districts have now allocated to each school a named school doctor and school nurse, little more may have been done to foster the notion of a 'school health team' working together to improve the health of a defined child population. In a few places teamwork has become a reality, but most school health staff still find themselves isolated from colleagues, often overstretched by routine work, and rarely encouraged to think critically about the services they are providing[19]. The professional isolation of school nurses is one reason why the Cumberlege report recommended that they should be brought into the neighbourhood nursing team with health visitors and district nurses[20].

Professional roles and relationships

Child health services generally are an arena for professional rivalry and dispute about roles, responsibilities and boundaries, and this has slowed the development of teamwork and contributed to low morale. In recent years, nurses in particular have challenged doctors' control over developmental surveillance and screening procedures, especially at school entry and in secondary schools. In some districts they have been successful, and the traditional picture of the doctor assisted by the nurse is changing to a more thoroughly trained nurse carrying out surveillance with medical back-up where necessary.

While school nurses may have gained some ground from their medical colleagues, they have recently found themselves in competition with health visitors, especially for health promotion work with older school children. The nursing journals have carried a number of articles about what the health visitor can do better than the school nurse and vice versa, which are often followed by a lengthy correspondence from both camps. This renewed rivalry is ironic, since it is only just over ten years ago that responsibility for nursing services to schools was passed, without protest, from health visitors to school nurses.

Between doctors there are arguments about whether the main responsibility for child health services should lie with general practitioners (GPs) or clinical medical officers (CMOs). In some areas GPs are, and have been for many years, the mainstay of these services, usually playing a larger role in work with pre-school children than in the school health services. Recent policy documents envisage GPs taking on more child health work[21]. GPs are keen to do this for pre-school children, but school health services seem to hold less attraction for them. Indeed, the GP contribution to school health fell between 1974 and 1983[22].

The appropriate division of labour between CMO and GP and the separation of prevention and treatment remain issues for debate, the temperature of which has increased with threats to the future of CMOs. Both parties argue that it would be better to have closer links between treatment and prevention, but this is difficult to achieve, given established professional roles. The separation between school health services and primary health care is particularly wide in inner city areas, and the potential for involving members of the primary health care team in routine school health work is rarely explored. Even where GPs are employed by the school health service no attempt may be made to use them in schools near their practices, where they would see at least some of the children on their own lists.

Hopes for better integration of the medical aspects of community child health services have been pinned on the creation of consultant community paediatrician posts, as described in the Court report. Growing numbers of districts are appointing consultant community paediatricians to lead community paediatric teams; to take responsibility for planning child health services; and to train more GPs in child surveillance and preventive procedures. Nottingham Health Authority pioneered the development of community paediatric teams and claims that they have given a sense of purpose and direction to child health services in the district[23]. It is too soon to say whether similar

developments elsewhere will be as successful in filling the policy and planning vacuum and achieving integration between generalist and specialist medical staff.

Children with special educational needs

Introduction of the 1981 Education Act has had important implications for school health services. The policy of integrating children with physical or mental disabilities into mainstream schooling, and the formal procedures laid down in the Act for multidisciplinary assessment and provision of a 'statement' of special needs for each child, have increased the priority, and the amount of time, given to children with special needs.

Multidisciplinary child development (special needs) teams play a major role in making assessments and providing specialist services to children with disabilities or health and developmental problems. Establishment of these teams was recommended by the Court report, but not all health authorities have followed its guidance. In 1985, two-thirds of districts had child development teams[24] (including only 6 of the 13 health authorities covered by the Inner London Education Authority)[25] and there was great variation in their size and composition. All of them had, as core members, a clinical medical officer, a nurse and a psychologist. Other members might include health visitor, physiotherapist, occupational therapist, speech therapist, social worker and psychiatrist. Where they exist, these teams seem to have improved the coordination of services between agencies (especially where they are jointly provided by health, education and social services) and are a much-needed resource for generalist school health staff.

Special schools have generally been provided with high quality health services. In some districts, however, as the Education Act is gradually implemented, there seem to be difficulties reorienting health services away from a focus on special schools towards the needs of individual children in mainstream schools. Part of the problem may be the need this creates to rethink the roles and relationships of generalist and specialist staff, but a more pressing constraint may be lack of resources for developing a more flexible and responsive service.

A recent review by the Education Select Committee of progress on implementing the 1981 Act found considerable variation between LEAs in the numbers of children with 'statements' and their integration into ordinary schools[26]. The committee concluded that progress was being impeded by lack of specific resources, including health resources. Formal assessment procedures were delayed by the slow response of health and social services; and where statements of needs had been agreed "it is not possible for the LEA to ensure the delivery of many of the means of meeting these needs". Shortage of health resources, including speech and other therapists, was identified as a particular problem. The Fish report, a review of Inner London Education Authority services, also found that some parents opted to keep their children in special schools because this guaranteed access to therapy which might not be available in ordinary schools[27].

Both education and health authorities have much more to do to ensure that children's special needs are met. Successful implementation of the 1981 Education Act depends on health and education authorities formulating joint policies and plans; making adequate resources available; and ensuring that close cooperation is developed between all those working with children with special needs.

Conclusion

This account portrays school health services as beset by problems, but these are similar to and no more severe than those faced by other primary care and community health services. School health services have for too long been without clear policy direction, and have been ignored by managers and planners. The performance of the 'invisible service' deserves closer scrutiny, and the current opportunities for debate and change should not be missed.

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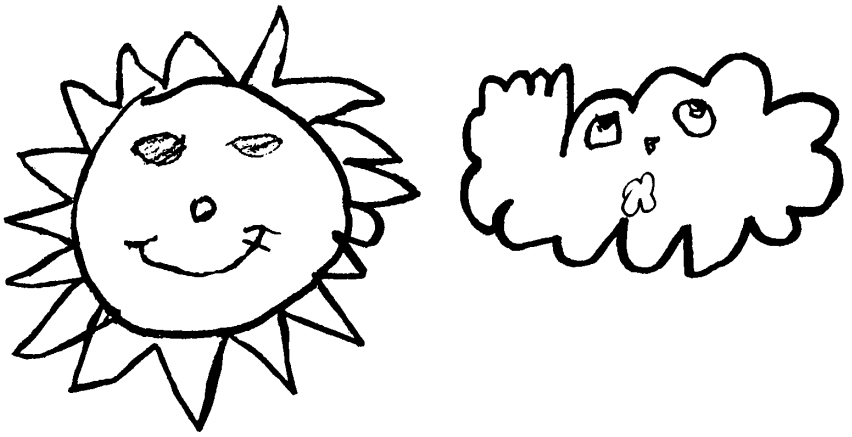

2.
TWO CASE STUDIES

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2. Two case studies

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TWO CASE STUDIES

In this section accounts are given of two case studies which were presented at workshops on school health services held at the King's Fund in 1986. Each in its own way moves the focus from professionals to children as the starting point for planning services.

Chris Wilson, School Nursing Sister and **Paddy Halse**, Medical Officer, describe the Riverside Child Health Project in Newcastle and, in particular, the project's work with school children.

Diane Plamping, Senior Lecturer in Community Dental Health at the London Hospital Medical College, describes community health projects involving children in London and discusses what can be learned from working in settings where the children's concerns rather than the professionals' form the focus for activities.

Riverside Child Health Project

In his preface to the evaluation report of the Riverside project, Professor J Walker says: "Patterns of health and of health services in Britain are so well established that change in either is difficult to achieve. Health services for children in particular owe their basic structure to decisions taken almost eighty years ago. Despite a variety of suggestions, the most significant of which are those of the Committee chaired by Professor Donald Court, there have been few developments and even fewer experiments designed to provide services for children which more clearly match their needs .... One exception has been the Riverside Child Health Project which has attempted in a variety of ways to enhance the services for children living in the Riverside Wards, a part of the City of Newcastle upon Tyne known to have particular social, environmental and health problems"[1].

By taking the needs of the child as the starting point and remodelling services with this clearly in mind, the outcome in Riverside is a continuum of care from pre-school to young adulthood rather than separate, compart- mentalised services which reflect the needs of professionals and not children. The underlying principles and the aims of the project are set out in detail in the evaluation report, but the main features of the work with school children were described in the workshops by Paddy Halse and Chris Wilson as:

- an integrated approach to community child health both within health services and general practice, and between health, social and educational services;

- interdisciplinary working and information sharing;
- written policies for the school health services with clear objectives and priorities for each school, which in turn are related to the needs of each neighbourhood;
- routine medicals replaced by a multidisciplinary review of children to determine who might require medical examination or other support;
- greater accessibility for parents and teachers to medical and nursing staff, especially for informal health advice.

Starting with the pre-school child

There are 6,000 school age children in Riverside and the health services they receive are part of an integrated service whose emphasis is placed firmly on the pre-school child. The health visitor is the key worker for developmental assessment and for family support. Input from doctors is limited to contributing specific skills at certain times. Health visitor assessments take place at four weeks, three months, six months, nine months, one and a half years, and at two and a half years. Medical examinations take place at six weeks and one year. At three and a half to four there is a selective review system involving both the nurse and doctor for those children causing concern to parents or teachers.

The gap between medical examination at one year and selective screening before starting school may seem large, but it reflects the role and contribution of the health visitor during these years. Also, children most in need tend to visit clinics infrequently, therefore home visits by the health visitor are particularly important.

Informing parents

Direct contact with parents is seen as important. Parents of children about to start primary school are invited by the head teacher to meet the school doctor and nurse in the previous summer term. About 40% of parents attend and the school health system of class reviews and routine screening programmes is explained to them. A simple booklet on health services in Newcastle is also provided, and is sent to parents unable to attend. Parents are encouraged to seek help at any time. The meeting, as well as providing practical information on the school health service, helps parents to see themselves and health and teaching staff as part of a team.

Pre-school handover

Effective transfer of information to school health staff is essential if children with problems are to be helped. Health visitors identify children they consider to be at risk of reduced school performance and meetings between the health visitor, school nurse

and doctor are arranged by the project health visitor. The criteria used to identify children at risk include: behaviour difficulties, speech and language problems, family and social problems, cultural problems, child abuse and family violence, physical, sensory or emotional problems, incomplete immunology, poor use of services, general anxiety and special educational needs. The same criteria are used later when children transfer from junior to comprehensive school. A recording sheet, prepared by the school nurse, acts as a bridging record until the health visitor record arrives. A summary sheet of basic information, including a nursing care plan, is inserted into the IOM (the school health record).

For those children not selected by the health visitor, pre-school records are transferred to the school nurse by the nursing officer.

School entry screening

Assessment and screening by the school nurse is usually completed for all children in the first term at primary school. Vision screening, audiometry, height and weight monitoring are included. Parents are immediately informed of the results of vision and hearing tests, and results are recorded on the IOM and inserted into the medical records.

Class reviews

In their second term at school, all children are reviewed by teachers and the school health team at a 'class review' meeting, but only those whose health is causing concern are medically examined. This selective system of medicals on entry to primary school is an important feature of the Riverside project.

The class review has four aims:

- to identify medical, learning, emotional, social or attendance problems;
- to decide on appropriate intervention;
- to improve understanding and cooperation between professionals;
- to focus the work of school health staff on children with special needs.

This system has liberated the school health team from traditional routine approaches and opened up interdisciplinary learning and cooperation. Service inputs are focused on the minority of 'children with special needs' who are socially disadvantaged and moderate under-achievers.

Gathering information for the class review

One month before the class review, parents are sent a questionnaire and given the opportunity to discuss with school health staff any worries about their child's health, including hospital treatment. At the same time professionals who will attend the review are sent class lists. This includes the Director of Social Services, and a social worker is delegated to attend with records and information on the children being reviewed. A class review record sheet is prepared for each child by the school nurse and doctor. It includes responses from parents; whether a nursery check was done; information on handover. Any problems are identified.

Data collected by the Riverside project show that information from child health clinics is available for 83% of children; health visitors can provide information on 86% of children; and the selective nursery review procedure includes 40% of children. 73% of parents respond to the questionnaire and of these 37% report no problems. The Riverside staff believe that the key to a good service lies in trust and exchange of information between the professionals involved. However, confidentiality between different disciplines is important too; and only information relevant to present and potential need should be shared.

The class review meeting

By the second term in primary school, school nursing assessments are available for all children and teachers have had time to get to know their pupils. The class review meeting is organised and managed by the class teacher and head teacher. Present at each meeting are the head teacher, class teacher, school nurse and school doctor. As necessary other professionals attend, such as the education welfare officer, educational psychologist, social worker, community paediatrician, speech therapist. The central role of teachers is vital. It is the teacher and not the doctor who takes the lead and this ensures that the focus is not on medical problems alone. As the majority of problems experienced by children are social in origin this is particularly important. One of the advantages of this multidisciplinary approach is that the responsibilities of individual professionals for the management of specific problems can be identified and coordinated with those of other professionals. To make the system work commitment is needed from all agencies: health, education and local authority.

Selective medicals

Selective medicals follow the class review. One example given during the workshop was of a teacher who said at a review that she was worried about three children with coughs. This prompted medicals and one child was found to have whooping cough, another asthma and the third bronchiectasis. When medicals are carried out a list is prepared of all children examined, giving information about problems found and action initiated. This is discussed with the head teacher who liaises with the class teacher.

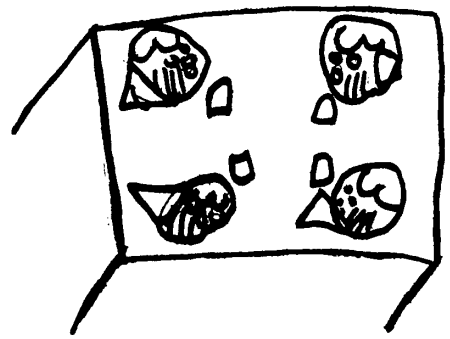
Parental involvement

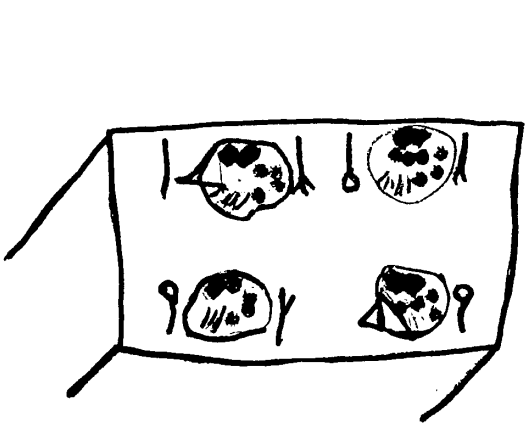
One of the principles on which the Riverside project is based is that of greater accessibility of the school medical service to parents as well as teachers and pupils. One way of doing this is to establish a regular pattern of visits to schools and to make sure that parents know the days and times when the doctor or nurse attends. The move away from a service based on routine medicals to one where the doctor and nurse are available more often and informally seems to have succeeded in changing the nature of the contact with parents. An evaluation of the project shows that parents see the school doctor as an appropriate source of informal advice and that the selective medical is also seen as an opportunity to raise problems and seek advice[2]. This may be particularly important where parents have low expectations of their own GP's interest in their child's health and development. Parents also want to know the results of investigations, such as hearing tests, whatever the outcome. In the case of children not selected for medical examination, these results are now passed on via the class teacher.

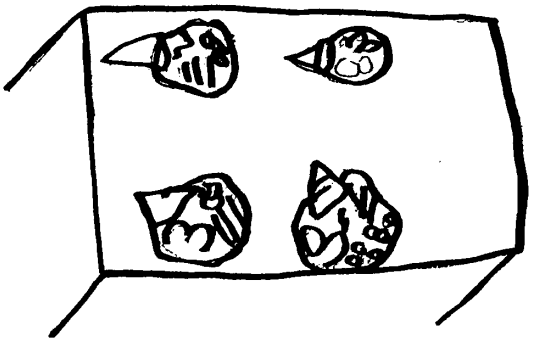
The role of the school nurse

In Riverside the role of school nurse has changed dramatically from the 'nit nurse' to a pivotal role in the mobilisation of resources to promote child health. She is seen as having a professional responsibility to identify unmet needs in the schools she covers; to subject all procedures she undertakes to critical review; and to identify where redeployment of resources might be possible. Changes from routine to selective screening free her time for advising teaching colleagues, parents and children and for health education activities.

The effectiveness of the system used by the Riverside project depends on having a named school nurse; efficient and effective health surveillance programmes; the vigilance of teachers and other professionals; a school nurse/pupil ratio based not on national averages but on the recognition that schools have varying and changing levels of need for health services; effective management; adequate resources and equipment; clear relationships and understanding between professionals; and shared responsibility for children's health and well-being.







Taking children seriously

Diane Plamping began her presentation by asking professionals to face up to the fact that however highly trained and skilled they are, their impact on health status is limited. Prevention is often hailed as a solution, but it is not a simple one. Professionals cannot be taught how to prevent ill health effectively — prevention often implies changes at a political level. The sugar industry, for example, has greater impact on dental health than the professional activity of dentists.

Questions are now being asked about which professional skills are most relevant to improving health status. Educating patients, or telling them to change their habits, has been tried with little success. More attention needs to be given to the obvious communication gap between professionals and their clients, a distance that is based on differences in class, language, culture and power, and reinforced by attitudes that are established during professional training. Patients, too, learn how to be 'good patients' and let professionals take over treatment of their illnesses. Finding ways of bridging the communication gap was the impetus for the projects Dr Plamping went on to describe, in which children are active participants not just passive learners.

In health education it is now quite widely accepted that traditional approaches, based on the assumption that information leads to changes in attitudes which in turn leads to behaviour change, need to be replaced by techniques of *empowerment.* Where children are the 'clients', empowerment is a difficult concept. It is not widely recognised that children are an oppressed group deprived of power. They are statutorily dispossessed, as are criminals and mentally ill people, and they are rarely taken seriously by adults. This works against children's belief in their own power. Imparting information is of little value if children do not believe they have the power to do something with it. Information is a necessary but insufficient condition for change.

Empowering children: children's health club

One approach to giving children both information and power was tested in practice by the St Thomas's (now West Lambeth) Community Health Council. A group of children aged 4 to 16 wanted to do useful work at the CHC. They started a Tooth Club, meeting at the CHC one evening a week for one hour. Dr Plamping asked the children to help her teach other children about teeth. The club members developed their own teaching materials, including posters, dental snakes and ladders and dental bingo. The project soon extended into other areas, such as road safety, environmental hazards and child development.

The children showed great enterprise. Once they became engaged in a topic, they would read and prepare materials that would surprise their teachers. For example, one 13 year old designed a questionnaire on road safety and did a pilot study with children in her block of flats before using it at a pre-school centre. Various places were chosen for

health teaching — swimming pools, a baker's shop, a hospital, health centres, schools. The children used role play to improve their teaching. Because the children chose their topics, controlled the pace of working, and decided how and where to teach, a significant shift in power took place. They saw what they were doing as real work and defined themselves as 'voluntary workers'.

This project represents a shift from traditional goals of health education — health consciousness, personal knowledge, self-awareness and attitude change — to decisionmaking, choices, behaviour change and social change. This means accepting that children choose to take risks, as do adults, and that this is done knowingly.

Health education as a pleasurable activity

To engage children, talking about health had to be fun. They said that they came to the club because they enjoyed it and learnt things: it was an integral part of their lives, they wanted more club activities. Attendance at the club was purely voluntary and when the children came they exercised some control over their learning by choosing topics and selecting activities. The club members were from a variety of cultural backgrounds and there was a wide age range. They came after working at school all day. Asked why they came, their responses were:

> *"I enjoy it", "to learn things", "I enjoy it, it's good, we do things. I think more people should come to learn about health. Because it is interesting and we learn things ... it's better than a youth club where we'd just eat crisps and play records, at our club we can learn and enjoy ourselves."*

Perceptions of health

A main aim in the club was to develop the children's self-confidence rather than to change their behaviour. However, the children's perceptions of health changed and there were some behavioural changes, too. The children said that they did not smoke and ate fewer sweets as a result of coming to the club.

> *"Health club is healthy ... it teaches us things about health ... so we think more about health, you know, like if I forget to clean my teeth, Sarah says, remember what Diane used to say to us at club and I'll say 'Oh yeh' and I'd go and brush them."*

> *"... 'cos if you didn't have a club, how to wash yourself, clean your teeth, come and ask and they'll tell you ... it helps with information and things."*

At an early stage in the club's development the children were asked to define health and illness: at first the 'illness' list was much longer than the 'health' list. It included not only common illnesses but also anorexia, depression and hydrophobia. Two months later the 'health' list was longer and included 'being happy', showing a wider

conception of health than before. When asked 'what things around here affect your health?' the children related health to the environment — they suggested:

"fumes, noise, cars";

"cars, factories — we just live behind a factory — a paper factory. People shouldn't stay out all day, all the fumes from the cars they breathe in".

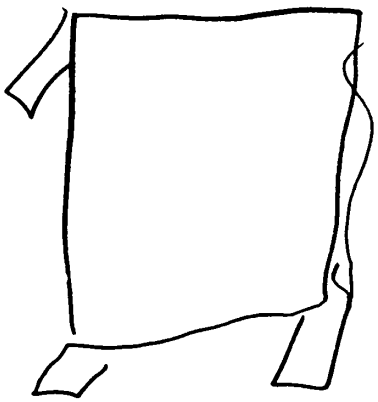
Competence and responsibility

Both parents and teachers recognised that the children's level of self- confidence increased through teaching other children. The responsibility they were able to take in teaching was also of great interest to other children. Two boys (aged 11 and 12) taught 15 year olds about foetal development, using a 'script' we had prepared jointly. They were met with a silent, respectful attention by their pupils who were possibly embarrassed at being less able to talk about this topic than the health club members.

"How old are you to know so much?" asked one pupil.

"Old enough," replied Darren.

They came to see their teaching as a normal activity which could be done by anyone and developed their own teaching activities outside the club, e.g. a 'learning club' in a block of flats. They also expressed confidence in the abilities of fellow club members. They were keen to be seen as useful and productive and liked to join in with general work at the CHC: giving leaflets to people making enquiries, answering the telephone and directing people to meetings. Of all the labels attached to their activities they liked 'voluntary worker' best. This signified real work valued in the world and contrasted with creative but unreal project work at school and in other clubs.



Empowering children: medical in the classroom

Another project in which children took the lead was started by a health education department and involved a range of local professionals — teachers, doctors, probation officer and health education officers. The children chose which professional they wished to meet and took control of the session, introducing the visitor and asking questions. Part of this project was the 'medical in the classroom' series. With the school doctor present, children did tests on each other, familiarising themselves with the instruments. The doctor gave explanations.

Some of the workshop participants also had experience of using role play to prepare children for medical and dental examinations. School nurses and teachers were involved and sometimes took the part of the patient. This had the effect of making children feel more relaxed about examinations. Role play can uncover previously unrecognised skills in children, and can provide insights into their fears, preoccupations and family dynamics. In a dental health project, as children lost teeth a graph was filled in and there were discussions about why the tooth had come out and when the new one would emerge.

Learning from children

In all this work, the most important condition is for the adults involved to regard children as people first. Adults tend to underestimate what children know, what they can learn and their capacity for taking appropriate responsibilities. Children are still often seen as the passive recipients of adults' knowledge. Peer teaching provides a way of building on children's own experiences [3,4].

In most settings, some people's knowledge is more highly valued than that of others. When a professional, an expert, is imported into a group it may have the effect of confirming the sense of inadequacy of members of the group. 'Sitting at the foot of the master' may incline people to rely even more on experts to do the job. Children need to be active in the learning process if health education is to be effective. Peer teaching appears to be a relatively expert-proof approach. In both the projects described in the workshop the children were in control and the professional role was to *offer* information. Doctors, nurses and dentists were deprofessionalised, often in spite of themselves.

Dr Plamping emphasised the need for professionals to take seriously children's concerns and recognise their potential for learning in any health education initiative. Professionals could also learn from children: through her involvement with the children's club she had gained a great deal.

Workshop participants agreed that it was of great importance to enhance children's self-images and this was the aim of teaching life skills. One participant described how a girl's self-esteem had improved when she learned how to plait her hair and improve her appearance. Unfortunately, this kind of work is often seen as an 'extra' in the NHS and

does not command resources. Managers, however, are unlikely to respond if this work is not brought to their attention and its value underlined. Another participant described her experiences in South Australia where health education using active learning is an integral part of the school curriculum. Health issues are linked to decisionmaking and information-gathering skills.

School health teams are well placed to forge the links between health and education. Information needs to be shared between professionals and joint working developed. Participants described workshops held for ILEA health education advisers and school nurses. These had clarified the roles and expectations of professionals and children; and had resulted in teachers and school nurses responding to children's requests for information.

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The Riverside Child Health Project produces an annual report which describes the work of the project. Copies are available from Riverside Office, Atkinson Road Clinic, Atkinson Road, Benwell, Newcastle upon Tyne, NE4 8XS. Tel: 091-273 9730/4463.

3.

DEVELOPING POLICIES

CHANGING SCHOOL HEALTH SERVICES

The **Primary Health Care Group** is a multidisciplinary team based at the King's Fund Centre for Health Services Development. Its aims are to improve primary and community health services, particularly in inner London; to encourage experiments with new ways of working; to disseminate 'good practice'; and to contribute to debates about primary health care policy. The group provides information and advice about primary care developments; works with NHS managers to establish and evaluate demonstration projects; organises workshops and conferences; and publishes papers and reports.

The group's current interests include strengthening the management of primary care services; collaboration between district health authorities and family practitioner committees; decentralising community health services; and services for disadvantaged groups. The work is financed by the King's Fund and the Department of Health and Social Security.

This series of working papers is intended to make material from work in progress readily available to a wider audience. Each paper records the experience of testing a new idea and draws out the lessons learned.

CHANGING SCHOOL HEALTH SERVICES

3. Developing policies

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January 1988
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CHANGING SCHOOL HEALTH SERVICES

A series of workshops on school health services was held at the King's Fund Centre during 1986 with the aim of helping the managers who took part in them to think critically about school health services. We were encouraged by the response to a topic that is definitely not fashionable and usually takes second place to services for under fives. With hindsight, however, the enthusiasm for the workshops may have had more to do with the lack of opportunities to meet to discuss school health in its own right than a sign that priorities were changing.

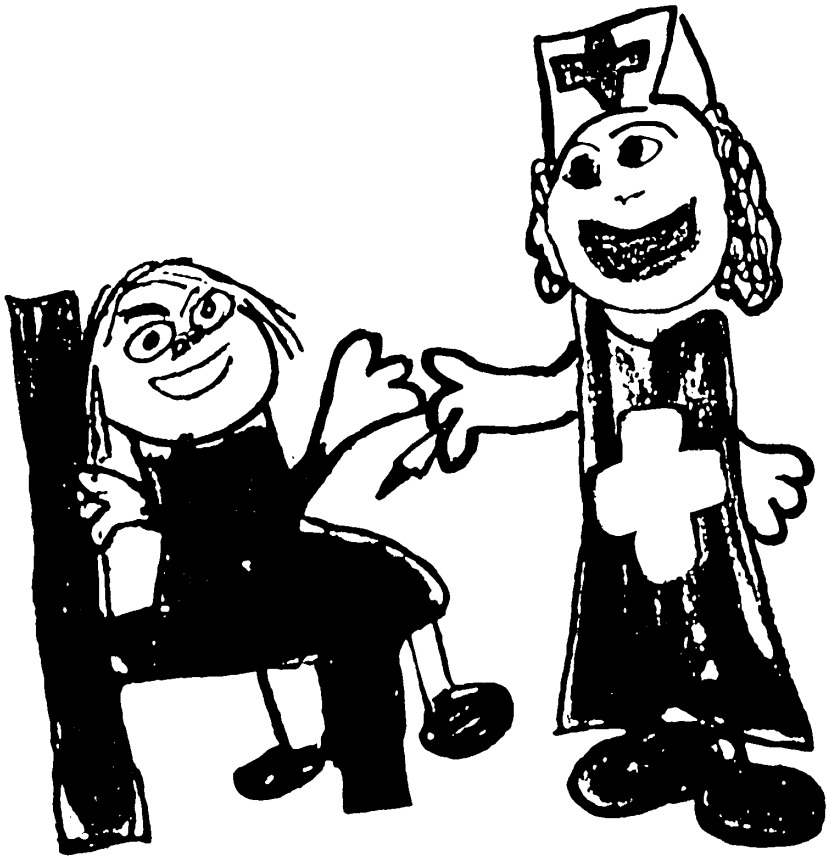
The workshops highlighted the issues and problems that school health service managers need to tackle. It quickly became clear that they had few 'models' on which to draw to help them assess the quality of services provided for school children. Like us, most of them believed that school health service resources could be used more effectively and efficiently than at present. However, without precedents to quote to clinical colleagues and feasible alternatives to offer them, managers often lacked confidence to challenge traditional practices and methods of service delivery.

When it came to preparing a report on the workshops, we felt that the presentations and discussion should be put into the wider context of the debate about child health services. This information pack has therefore grown from the workshops and other material has been added to enhance its value to managers who are reviewing and improving school health services. It was compiled and edited by Jane Hughes, Pearl Brown and Pat Gordon, who gratefully acknowledge the contributions of the workshop speakers and participants, and the assistance of colleagues at the King's Fund Centre. Alex Cattell and Kate Cattell supplied the illustrations.

The information pack has five sections, each of which is intended to complement the others but also to stand on its own. The first section summarises the current debates on policy and practice in community child health services. The second presents two case studies which offer some clear indications of what to look for when assessing the quality of service. The third section examines the process of developing and reviewing policies for the school health service. The fourth is a rererence section, which describes the origins and organisation of school health services and gives a summary of available statistics and performance indicators. The fifth and final section is an annotated bibliography containing references selected for their usefulness to managers and policymakers.

Jane Hughes
Pearl Brown
Pat Gordon

Primary Health Care Group
King's Fund Centre for Health Services Development
January 1988



DEVELOPING POLICIES

One of the main points to emerge from the King's Fund workshops was the importance of having a written policy, with clear objectives and priorities, which is known and understood by all school health staff. Without this the prospects for a revitalised service seem remote.

Only a few participants in the workshops said that their district had a written policy. Some were unsure, which would indicate that even if a policy does exist it is not known to those whose job it is to put policy into practice. As a result of the work done in the meetings, the following elements were identified as important in constructing or reviewing a school health policy. They are divided here into eleven sections to make an ordered presentation; but since real life does not follow a rational course, it is not intended that managers work from start to finish but use the ideas in any way they find helpful.

Defining principles

A school health policy would begin with a statement of the values and principles on which it is based, for example:

Positive health:	each child should be enabled and encouraged to develop to his or her optimum potential.
Shared responsibility:	the family and the school are important influences on a child's health. Children, parents and teachers are active participants in ensuring and maintaining health. Safeguarding the health of school children is therefore a shared responsibility between children, parents and professionals.
Continuity:	the health of the school child cannot be separated from health in the pre-school years. School health services therefore need to be closely integrated with pre-school services.
Special needs:	the child with special needs or learning difficulties needs special consideration.
Integration with primary care:	the work of the school health team (school nurse and school doctor) should complement that of the primary health care team.

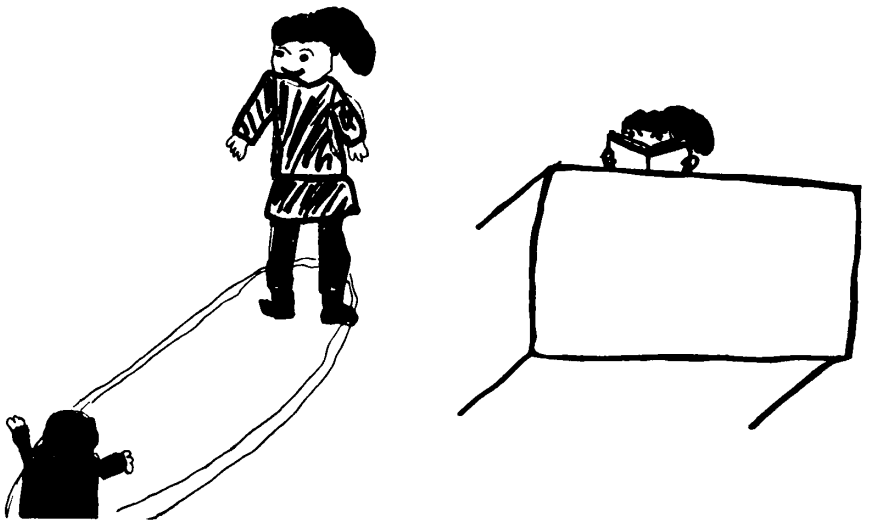
Setting priorities

Priorities are broad and general statements of aims. They form a useful framework for managers and professional staff to assess current practice and to develop their own objectives. Priorities need to be translated into practice in ways that suit particular local circumstances. Examples of priorities in a school health policy are:

- to increase immunisation rates;
- to improve cooperation with class teachers;
- to ensure that every child entering secondary school has a health review;
- to reduce health inequalities between children in different social classes;
- to direct resources to meet the needs of children from black and ethnic minority groups;

- to provide adequate specialist services for children with learning difficulties and special needs.

Setting priorities usually has resource implications and is of little value unless managers have the power to redirect resources to reflect their priorities. Priorities need to be kept under review by policy and planning groups.



Sharing responsibility

If shared responsibility for the health of school children is to mean anything in practice, then policies and priorities must be hammered out as a joint venture. The usual forum for doing this is a multidisciplinary planning group with professional input from health and educational agencies and users represented by school governors, PTA members or CHC members.

Districts vary greatly in the extent to which they consult more widely on policy matters. Field staff, for example, will have valuable insights into how services could be improved and need clear channels of communication with policymakers. Management structures should facilitate rather than impede their views being heard. Parents and children, too, will have ideas about school health services, and older children in particular may have preferences for certain ways of organising and delivering the service. A service which children help to design may be more acceptable and therefore more effective.

Setting objectives

A school health policy with a statement of principles and priorities would then need a set of objectives both for the district and for each school. Realistic objectives for a district can only be decided with reference to the needs of the district's school children and information about the school health service's current performance. Examples are given below of the kind of objectives a district might set itself for a year.

- To achieve a 10% increase in completed immunisation schedules for school leavers.
- To increase uptake in rubella immunisation to 95%.
- To establish a pilot scheme in one secondary school offering a personal health advisory service with open access to advice and counselling by nurse and doctor.
- To review the need for interpreters and linkworkers to help school health staff improve communication with parents.
- To review the success of the child development team in identifying children with special needs who could be placed in ordinary schools and in helping them to integrate.
- To discuss with the Family Practitioner Committee ways of informing GPs of the activities of the school health service, with a view to closer cooperation.
- As well as contributing to the achievement of district-wide objectives, school health teams should be encouraged to set their own objectives relevant to the needs of their schools and neighbourhood. For these to be realistic, the team would need information about the circumstances and needs of children in their school, and about their own performance in relation to other school health teams, for example, in referral rates to specialist services, or the uptake of immunisation. In most districts there is insufficient information of this sort, and managers may need to help teams seek out information for themselves.

Information is needed not only for setting objectives, but for measuring progress towards those objectives. School health teams can be encouraged to collect relevant data themselves in order to evaluate their performance, but they also need regular feedback from managers. Examples are given below of the kind of objectives a school health team might set for itself for one year.

- To decide the information they want to collect about the health status of the children in their school and how to go about collecting it. This could entail discussions with community health services managers, community physicians,

teachers and GPs. The purpose of the information would be to form a basis for setting the next year's objectives.

- To link into the Health Education Department's campaign on solvent abuse and work intensively with the school's children, parents and teachers as well as local shopkeepers and community groups.

- To find ways of giving practical support to a local organisation which has started a campaign to reduce road accidents to children.

- To introduce a class review system for new entrants and to work out ways in which teachers, parents, school doctor and nurse can each play a full part.

- To achieve 100% rubella immunisation among 13 year old girls.

Managers should help teams set realistic objectives and ensure they are in line with district-wide priorities and objectives. Resources also have to be taken into account — one or two clear objectives that are likely to be achieved are preferable to a longer list of vague aims.

Making plans

Having set objectives, a plan has to be made for achieving them. Most districts do have operational plans for providing routine services but these are usually set out as professional tasks rather than as steps towards achieving specific objectives. Typically the tasks and responsibilities of the school nurse will be set out in some detail: procedures to be followed, criteria for referral, channels of communication. These in turn will be related to the tasks and responsibilities of the doctor or other professionals.

Another kind of action plan may be needed to achieve a specific objective as the following example shows. In Hampstead Health Authority a short-term planning group was formed to meet the district-wide objective of increasing the uptake of rubella immunisation. It was decided to mount a special campaign with a coordinator appointed to run it and to ensure maximum publicity to both professionals and the public. The *target group* was to be girls in their final year of primary school and first year of secondary school. The *timing* was to be over a period of three weeks. The *place* was to be in schools. The crucial *personnel* were to be school nurses who would contact teachers, pupils and parents, provide school rolls, prepare for the visit of the vaccination team, and follow up defaulters. The mobile vaccination team would consist of a school doctor, nurse and clerical officer. The whole campaign was part of a planned health education programme. The action plan on page 7 shows how the campaign was operationalised and further details are given in the report from Hampstead Community Health Services[1].

This example shows that setting objectives and making the plans to achieve them requires clear thinking and careful preparation. The same principles apply to planning to meet less specific objectives such as taking action to reduce inequalities in health. Choices have to be made about which aspects of health inequalities are appropriate targets for school health services; which children, schools or areas will be selected for special attention; what interventions will be made; who will make them; where and when.

If school health teams are to be encouraged to identify and respond to local needs, they will also require help with drawing up feasible plans to meet their objectives. Senior managers can help by suggesting effective approaches to tackling problems, such as solvent abuse; where to direct effort; where resources may be found. Discussions with parents, teachers and children may also be important to check that plans are realistic and to gain their support.

ACTION PLAN FOR RUBELLA CAMPAIGN
Autumn 1984

Hampstead Community Health Unit

Juliet Oerton
Rubella Campaign Coordinator
Community Health Unit
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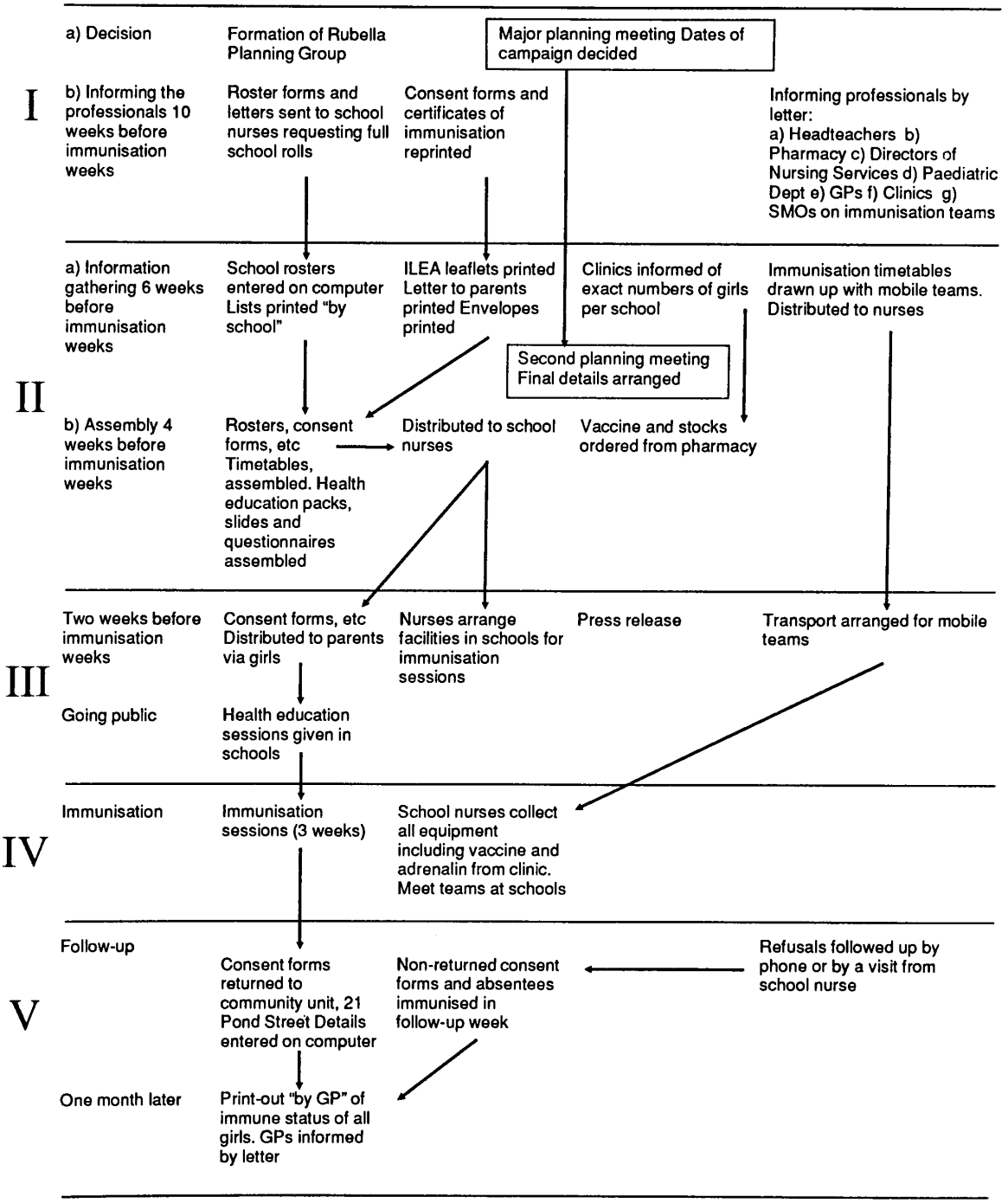
Stages



Disseminating policies

A written policy statement with clear objectives for school health services should be disseminated widely to school health staff and those with whom they work.

The first step must be for managers to make sure that all field staff are aware of the school health policies and meetings will have to be devoted to discussing them. Written policy statements can be displayed in schools and given to teachers and parents, but it is the members of the school health team who are in a position to explain how the service works and what it can offer. One way is for the team to arrange a meeting with teachers at the beginning of each school year, to introduce themselves, explain their policies, the sort of help that can be expected of them, and where and when they can be contacted.

Parents also want to know about school health policies. Some authorities favour explanatory booklets, and there is evidence that where these are prepared with the assistance of parents they are more readable and effective than those written by professionals[2]. They are more effective still when backed up by personal contact. Some schools invite parents of all new pupils to meet school health staff and learn about the service.

The other professionals with whom school health staff work also need to know about their policies and procedures. These include social workers, education welfare officers, child development teams, GPs and primary care teams.

Reviewing existing services and resources

A good policy will include a robust system of review. Arrangements for reviewing and planning school health services vary between districts. Some have a district-wide children's services planning team; others have a child or school health forum within the community unit. These groups are usually multidisciplinary and should include the managers responsible for staff in school health teams. Introducing new initiatives is often a higher priority for these groups than the possibly more difficult task of reviewing the appropriateness of current provision. It may be easier initially to bring in an 'outsider' to help managers assess how well a service is meeting its objectives and whether its organisation and efficiency could be improved. Newham Health Authority in East London recently employed an independent consultant to review its school health services and to make recommendations for change[3].

Discussions with parents, teachers and children and with school health staff are another way of highlighting areas of practice that need to be reexamined by managers.

Clinical practice in school health services is particularly difficult to review because there is a dearth of published information on evaluation of the effectiveness of methods of screening and surveillance. A review of the literature, however, can alert managers to the questions they should be asking when reviewing services. For example, recent studies have found that facilities for testing hearing need to be good to make screening worthwhile[4]; that children with asthma and their teachers may need continuing help to make sure treatment is carried out effectively[5]; and that the British Scoliosis Society and the British Orthopaedic Society have concluded that children should not be routinely screened for scoliosis[6].

Monitoring and evaluation

Policies should be evaluated and service quality regularly monitored. Senior managers need information that allows them to judge whether priorities and objectives are being met in the district as a whole.

Evaluation of procedures is also important but rarely attempted locally. Most districts do not collect the kind of information that would allow judgements to be made about the effectiveness or efficiency of screening programmes. Given the limited resources of a district, this kind of evaluation is probably most appropriately undertaken on a larger scale by a specialist research unit. However, where new schemes or procedures are introduced, simple evaluation measures should be built in from the beginning to give managers sufficient information to assess whether objectives are being achieved.

School health teams require regular feedback of detailed information about their performance and how it compares with that of other teams. They should also be given information that allows assessments to be made about whether their own objectives have been achieved. Given the current state of information systems, school health teams may need to set up for themselves simple ways of checking whether they are meeting their targets.

More effective use could be made of information about the health of school children that is collected routinely by school nurses and doctors. Simple summary information from surveillance and screening could alert managers and school health teams to increased prevalence of illnesses or conditions and allow them to initiate appropriate action.

Teachers, school governors and PTAs should be given simple aggregate information about the health of children in their school. The information should allow them to assess whether objectives have been met successfully.

Ensuring confidentiality

Procedures for safeguarding confidentiality must be laid down and policy statements should include assurances about confidentiality. Older children in particular need to know that the problems they choose to discuss with school health staff will not be revealed without their permission.

While the question of who should have access to medical records is part of the current national debate surrounding data protection, it is hoped that professionals are working towards a more open form of recordkeeping and will in future feel confident to share with parents (and children) what is being written in the child's record. Patient-held records from birth to adolescence have been recommended in a recent policy review by the National Children's Bureau[7].

Codes of practice may need to be drawn up locally giving clear guidance about which other professionals have access to medical information. The Fish report on services for children with special educational needs recommends that consistent procedures are agreed to ensure that teachers receive adequate information about the educational implications of children's medical conditions[8].

Training

A school health policy will have built into it regular training and updating for staff. When new procedures are introduced special instruction and support may be needed — training in counselling skills, for example, before offering a counselling service for adolescents. Training may also be required to help staff meet specific local objectives. An example from Nottingham illustrates the need for training. Following two cases of diphtheria, vaccination targets were set for the uptake of pertussis, measles and DPT. At the same time a survey of staff was undertaken which revealed uncertainty about vaccination policy and practice. It also revealed the variety of messages and myths that were being communicated to the public. To overcome this, a special training scheme was devised to build staff knowledge and confidence about immunisation. Following the training period, immunisation uptake increased[9].

Multidisciplinary training has many advantages and some authorities have found joint finance a useful way of doing this. For example, Tower Hamlets Health Authority in East London is coterminous with its local authority and ILEA division, and uses joint finance money for multidisciplinary training on child abuse. Having this budget has encouraged health, social services and education to plan training together.

Finding resources for experiments

Developing policies agreed by all those concerned with the health of school children is a relatively slow process. Experimenting with new ways of working is part of that process. This may or may not require extra resources and these resources may or may not be financial. By definition, small scale pilot schemes to try out a new idea should not be costly, and one criterion for judging success and applicability would almost certainly be financial. Rather than money staff may need help with organising, monitoring and evaluating a trial and this kind of resource may be readily available within the district from, for example, community physicians, polytechnics, the CHC.

Most districts do experiment and ideas are often spread by word of mouth. Before putting an idea into practice it is therefore worth tapping the grapevine to see if it can yield worthwhile tips and help avoid pitfalls. Published accounts of experiments in school health services are quite difficult to find, especially those which are not wholly successful, although they may be just as valuable as the successes. Two which have been published describe improvements in Nottingham and in Oxford. In Nottingham a decision to involve teachers and parents more closely in selecting children in junior school for medicals resulted in more children being identified with educationally significant health problems, greater uptake of immunisation, higher parental attendance at medicals and improved school/health liaison[10]. In Oxford a specially trained nurse visited children in their homes to increase immunisation uptake, and this was found to be an effective and fairly inexpensive way of achieving the objective[11].

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4.

ORIGINS AND ORGANISATION

CHANGING SCHOOL HEALTH SERVICES

The **Primary Health Care Group** is a multidisciplinary team based at the King's Fund Centre for Health Services Development. Its aims are to improve primary and community health services, particularly in inner London; to encourage experiments with new ways of working; to disseminate 'good practice'; and to contribute to debates about primary health care policy. The group provides information and advice about primary care developments; works with NHS managers to establish and evaluate demonstration projects; organises workshops and conferences; and publishes papers and reports.

The group's current interests include strengthening the management of primary care services; collaboration between district health authorities and family practitioner committees; decentralising community health services; and services for disadvantaged groups. The work is financed by the King's Fund and the Department of Health and Social Security.

This series of working papers is intended to make material from work in progress readily available to a wider audience. Each paper records the experience of testing a new idea and draws out the lessons learned.

CHANGING SCHOOL HEALTH SERVICES

4. Origins and organisation

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CHANGING SCHOOL HEALTH SERVICES

A series of workshops on school health services was held at the King's Fund Centre during 1986 with the aim of helping the managers who took part in them to think critically about school health services. We were encouraged by the response to a topic that is definitely not fashionable and usually takes second place to services for under fives. With hindsight, however, the enthusiasm for the workshops may have had more to do with the lack of opportunities to meet to discuss school health in its own right than a sign that priorities were changing.

The workshops highlighted the issues and problems that school health service managers need to tackle. It quickly became clear that they had few 'models' on which to draw to help them assess the quality of services provided for school children. Like us, most of them believed that school health service resources could be used more effectively and efficiently than at present. However, without precedents to quote to clinical colleagues and feasible alternatives to offer them, managers often lacked confidence to challenge traditional practices and methods of service delivery.

When it came to preparing a report on the workshops, we felt that the presentations and discussion should be put into the wider context of the debate about child health services. This information pack has therefore grown from the workshops and other material has been added to enhance its value to managers who are reviewing and improving school health services. It was compiled and edited by Jane Hughes, Pearl Brown and Pat Gordon, who gratefully acknowledge the contributions of the workshop speakers and participants, and the assistance of colleagues at the King's Fund Centre. Alex Cattell and Kate Cattell supplied the illustrations.

The information pack has five sections, each of which is intended to complement the others but also to stand on its own. The first section summarises the current debates on policy and practice in community child health services. The second presents two case studies which offer some clear indications of what to look for when assessing the quality of service. The third section examines the process of developing and reviewing policies for the school health service. The fourth is a rererence section, which describes the origins and organisation of school health services and gives a summary of available statistics and performance indicators. The fifth and final section is an annotated bibliography containing references selected for their usefulness to managers and policymakers.

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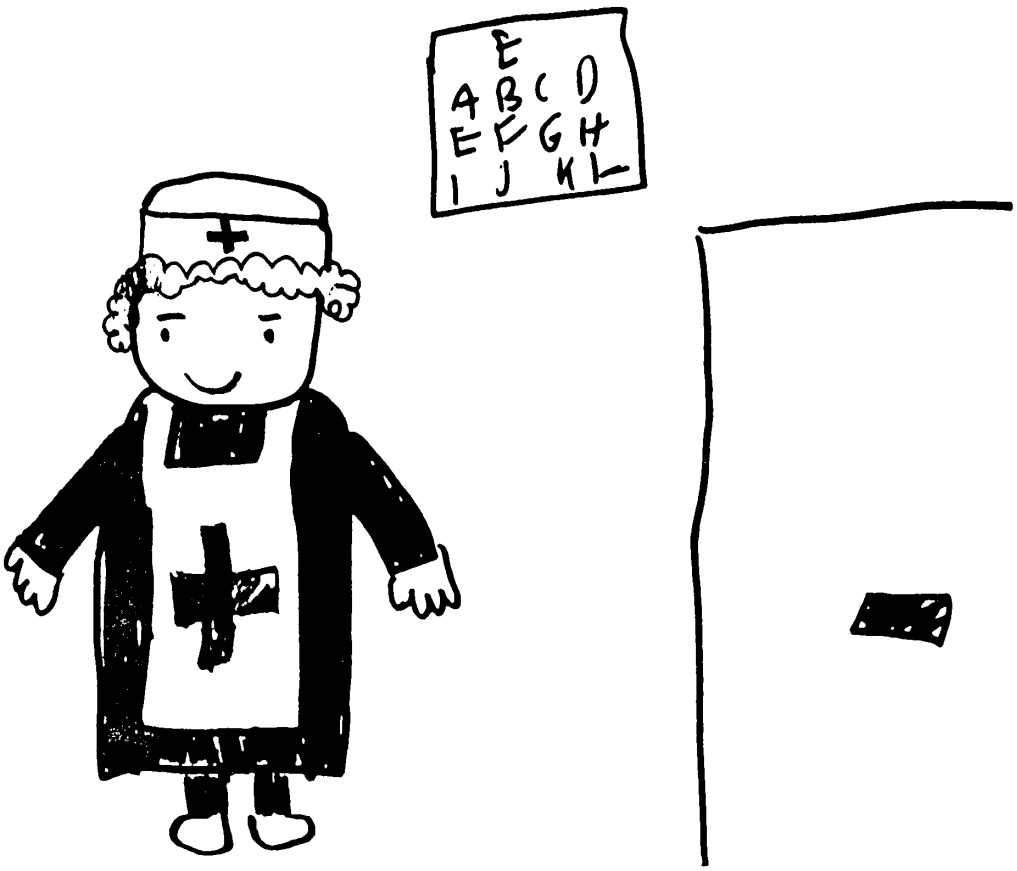
King's Fund Centre for Health Services Development
January 1988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ORIGINS AND ORGANISATION

This is a brief descriptive account of the school health service for those who are not familiar with how it is organised, its staff and how they work. It is intended for reference. The material is divided into four parts: the first outlines the origins of the school health service and relevant legislation; the second describes the work of the school health service; the third the organisation and staffing of the service; and the fourth gives details of relevant statistics, performance indicators and management information. As far as possible 'typical' procedures and structures are described but readers should not assume that these are the same as the structures and procedures that have been adopted in their own districts. A hallmark of the school health service is its local diversity and it is often difficult to generalise. The intention here is to give an overview of the service that will help clarify its important elements and enable readers to ask relevant questions about the organisation and delivery of local services.

Origins and legislation

The school health service has its origins in the public health movement and the legislation that was introduced during the nineteenth century to improve living and working conditions and the health of the population. By the turn of the century, environmental measures such as adequate drains and sewers and the provision of clean water supplies had greatly improved conditions in urban areas, but poverty, malnutrition and disease were still taking a high toll on people's health. Nearly 40% of Boer War recruits were found to be medically unfit for service, a public scandal that was investigated in 1903 by the Interdepartmental Committee on Physical Deterioration. The committee's recommendations, published in 1904, focused on child welfare and led directly to the creation of the school medical service. They included introducing systematic periodic medical examination of children and young people in schools, mines and factories; hygiene instruction for school children; the provision of school meals for needy children; and the appointment of medical officers of health in all areas.

Some school boards already had school doctors who examined children and this development was consolidated by the 1907 Education Act which placed a duty on all local education authorities (LEAs) to provide systematic medical inspections of elementary (primary) school children. These inspections confirmed an unacceptable level of ill-health among school children and subsequently the local education authorities were required to provide treatment, too. This included treatment of minor ailments, dental treatment, supply of spectacles and payment for operations like tonsillectomy. Statutory medical inspection of secondary school children was also introduced.

The provisions of the 1944 Education Act laid the foundations for the school health service as we know it today, giving LEAs the responsibility to seek the advice of a medical officer in discovering children requiring special education or with mental handicaps; and to provide regular medical inspection and free treatment and cleansing of verminous pupils.

In most local authorities the school health service was run by the Medical Officer of Health, who was also the Principal School Medical Officer, and who was accountable to the local education authority for the services provided. Each PSMO produced an annual report and, until 1974, the Chief Medical Officer to the Department of Education and Science published a report every other year about the organisation and work of the school health service. Since 1974 the role and functions of PSMOs have been assumed by specialists in community medicine.

The introduction of the National Health Service in 1948 appears to have had little immediate impact on school health services, because local authorities retained responsibility for providing all community health services, including services to schools. Treatment continued to be provided as part of the service, some areas establishing a range of specialist clinics for children. However, since 1948 treatment

of illness in school children has gradually passed to GPs and the hospital service, while the school health service has developed its preventive and advisory roles.

It was not until the 1974 NHS reorganisation that school health services were incorporated into the National Health Service. Medical inspection of pupils ceased to be a statutory requirement but area health authorities were given responsibility for providing facilities for the medical examination of any school child, especially those who might need special education, and for any necessary treatment. This responsibility passed to district health authorities in 1982. Since then, following the introduction of general management in the NHS, school health services have been incorporated into the unit management structures of district health authorities. They are usually within the community health services unit, and are the responsibility of the unit general manager.

The work of the school health service has been influenced by the 1981 Education Act which came into force on 1 April 1983 and provides a new legal framework for the assessment and placement in school of children with disabilities. The Act is based on the recommendations of the Warnock Committee (1978) and aims to allow children with special educational needs to be taught wherever possible in ordinary rather than special schools.

Up to one in five children requires some form of special provision at some time in their school career. Within this large group are a minority of children who require special arrangements because of severe, complex or long-term disabilities. The 1981 Act provides a legal framework for the assessment and placement of these children. It places an obligation on local education authorities to ensure that adequate provision is made for them. The emphasis is on early identification of special needs, multidisciplinary assessment, improved coordination between health and education authorities, and greater parental involvement.

The implementation of the 1981 Act is posing challenges for education and health staff, as it places on them new responsibilities for supporting children with special needs in mainstream schools and for coordinating services to enable them to get maximum benefit from their education.

At the examination, the school nurse measures each child's height and weight and tests vision. Hearing may be tested by the nurse or separately by an audiometrician. Teachers provide information about behaviour at school. With this information the doctor carries out a general physical examination of all children or, in a selective system, only those about whom there is cause for concern. Those needing follow-up are seen again for review. Those needing treatment are referred to their GP or to the appropriate specialist. Vaccination is encouraged for those who are unprotected.

The timing of subsequent routine medical examinations (all children in a class or year) or selective examinations (involving only children referred by parents, teachers or the school nurse) depend on local policies and these vary greatly between health authorities. Where further routine examinations are carried out they are organised in a similar manner. For selective examinations, the nurse collates information from parents, teachers and her own screening and refers to the school doctor only those children about whom there is concern.

After the school entry medical, screening and surveillance are carried out mainly by the school nurse. The most recent DHSS paper on prevention in the school health services (1980) states that:

"Health surveillance during the school period should be based on serial screening of vision, hearing and growth, on regular dental inspection and on annual health care interviews with the school nurse especially for children over the age of 11 years, ie those receiving secondary education. Visual acuity should be tested at least in alternate years throughout school and further screening of hearing should be carried out on children after school entry, particularly during the later primary school period at about age 8-9 years. Colour vision should also be tested at about age 8-9 years; the proportion of boys affected by anomalies of colour vision is much greater than girls but if resources permit both sexes should be tested."

An example of a system for health and developmental surveillance of school children with a selective examination at school entry is given on page 7.

The advisory role of school health staff is also emphasised by DHSS:

"During the school years the school doctor should be regularly available to provide medical advice on the implications of any handicapping condition for a child's participation in classroom and other activities, and to see any child about whom parents, teachers or school nurses may express concern. Health visiting and school nursing services will provide advice both to teachers and parents on the management and care of children with handicapping conditions and those with chronic illness."

A school health programme

AGE	EXAMINER	EXAMINATION — IN SCHOOL
4-5 years *(1st year infants)*	School Nurse	Entrants Screening Examination: a) Information from: Health Visitor report and pre-school records Health questionnaire from parent Class teacher report b) Hearing and vision test c) Parent interview/examination of child: Denver developmental screening test Height and weight measurement Physical condition
	School Nurse	Follow-up of problems including growth checks and re-tests of hearing/vision If immunisation not completed, refer child to GP
	School Doctor	Referral to School Doctor of selected children for medical examination
7-8 years *(lst year juniors)*	School Nurse	Hearing and vision test (inc colour vision) Height and weight measurements Physical condition
11-12 years *(1st year secondary)*	School Nurse	a) Health questionnaire (inc details of arrangements for rubella immunisation) Class teacher report b) Hearing and vision test c) Height and weight measurement Physical condition
	School Doctor	Rubella immunisation — girls (if not done by GP)
13-14 years *(3rd year secondary)*	School Nurse and School Doctor	BCG (TB) immunisation
	School Nurse	Informal health interview
14-16 years *(4th/5th year secondary)*	School Nurse	Vision test Reminder of polio/tetanus booster — refer to GP .

Immunisation

In the United States, legislation ensures that children are vaccinated against measles, rubella, polio and diphtheria before entering school in all States, and for tetanus, pertussis and mumps in most States. In this country there is no compulsion to have children immunised and each child's immunisation record is checked at school entry and vaccination is offered to children unprotected against diphtheria, pertussis, tetanus (DPT), polio and measles. Booster doses of diphtheria, tetanus and poliomyelitis vaccines are also given at this time. 10-13 year olds are currently screened by skin test with tuberculin and BCG immunisation is given to those found to be negative. The DHSS, however, plans to introduce a selective BCG immunisation programme before 1990, as TB is now a relatively rare disease. Rubella vaccine is offered to girls aged 11-13 years. The Chief Medical Officer recently announced that a combined measles, mumps and rubella vaccine will shortly be introduced in Britain for immunising all children in the second year of life, so in future the focus for immunisation will be firmly with the pre-school services.

Without legislation it seems unlikely that Britain will meet the World Health Organisation's target of a 90% uptake rate for DPT, polio, rubella and measles. Current uptake rates are 85% for DPT and polio, 68% for measles and 86% (among school girls) for rubella. In an attempt to achieve improved uptake of immunisation, the DHSS has asked each health authority to nominate an officer responsible for immunisation performance. DHAs will be accountable for their performance through the regional review system.

Dental services

School dentists visit each school regularly to examine children's teeth, give treatment where necessary and educate about prevention. Dentistry is free to school children up to age 16 and parents may elect to send a child to the family dentist for treatment or to use the school dental service. Dental clinics are usually sited in large secondary schools, health centres or child health clinics.

In London, for example, all ILEA primary and secondary schools are visited annually by the school dentist. A form is sent to parents informing them of the visit and unless they send it back refusing inspection, the child is examined. If treatment is necessary a form is sent home with the child who may be seen at the school clinic or by their own dentist. Treatment is not given at the school clinics without parental consent. Referrals to the school dental service may also be made by the school nurse or doctor following a health check.

Nationally, school dentists inspect the teeth of an increasing proportion of the school population each year. In 1985, 5.274 million children were seen (71% of the school population) compared with 4.725 million in 1975 (54.7%). Although more children's teeth were examined, fewer were found to require treatment, which reflects the overall trend towards improved dental health.

Staffing and organisation

The school health service is staffed by clinical medical officers, school nurses, auxiliary nurses, and community dentists, with administrative and clerical support. Some GPs work as school doctors on a sessional basis. In England in 1985 more than 4,000 whole-time equivalent (wte) staff were employed in the school health service (Table 1).

Table 1

School health staff in England, 1985*

	wte
Medical officers	944
Senior nurses	38
School nurses	2,819
Other nursing staff	248
	4,049

** Source: DHSS. Health and Personal Social Services Statistics for England 1987 edition. London, HMSO 1987.*

Most of these staff, however, work part-time or, in the case of doctors, on a sessional basis, so the numbers of people involved are more than double the whole-time equivalent figures. Around 1,500 wte dentists work in the community dental service.

As well as generalist school health staff, most districts also have a multidisciplinary child development or special needs team which may work from an assessment centre offering specialist expertise and supportive therapy to children with special needs. There is, however, enormous variation between teams but most have, as core members, a clinical medical officer, nurse and psychologist. Other professionals involved may be child psychiatrist, paediatrician, speech therapist, educational and clinical psychologist, social worker, health visitor, physiotherapist, occupational therapist. The aims of these teams are to coordinate care for children with handicaps, act as a source of information for parents and others, and to contribute to training. The education welfare service, educational psychologists, child guidance clinics and local authority social work teams may also work closely with school health teams and the special needs team.

Professional training

No special qualifications are required for doctors to become clinical medical officers, or for registered nurses to become school nurses, but both groups receive in-service training. 'Educational' medicine and nursing are becoming increasingly well established as specialisms as a result of improved professional training.

Before 1974 most *school nurses* were trained health visitors, but this requirement was waived by most health authorities when community health services became part of the

NHS. Since then, school nursing has developed an identity as a specialism distinct from health visiting. Following publication of the Court Report in 1976, a school nurse training course (lasting twelve weeks and run by polytechnics and colleges of further education) was developed. Twenty courses have now been validated by the English National Board and eighteen are currently running. The proportion of staff who have had training is increasing, although training is not yet mandatory for practice.

Some *clinical medical officers and GPs* who take on child health work have the diploma in child health, a postgraduate qualification. Others usually have some post-registration experience in paediatrics, but in the past this involved only treating sick children in hospital. Developmental assessment was a skill learnt 'on the job' or on short training courses. Many more posts now exist that combine hospital paediatrics with community child health work and are open to junior hospital staff and child health doctors. However, postgraduate training in child health still poses many problems and a high proportion of trainee GPs are unable to obtain any kind of paediatric post.

The British Paediatric Association recommend that eventually all doctors working in 'generalist' or 'primary' school health services should have completed a three year basic vocational training, which could lead them to become eventually either consultant paediatricians or general practitioners. This would also need to be supplemented by further in-service training on taking up the post of school doctor.

The BPA also argues that the school health service needs a 'secondary' tier of more experienced medical staff to deal with statements, special schools, comprehensive assessments and management, child abuse and problems of adolescence. This tier should be headed by consultant community paediatricians, supported by district handicap teams and junior community paediatric staff (as in the Nottingham model described later).

How the service is organised in a district health authority

In most districts, school nurses and school doctors work regularly with the same schools, so that each school has its own 'school health team'. The organisational connections between the school health team and other health authority services are shown in the diagram. Its main purpose is to illustrate the complex web of managerial and professional accountability, referral pathways and flows of information that surround and support the school doctor and school nurse and which characterise this multidisciplinary service.

Starting at the top of the diagram, at field level, the school health team maintains close links with parents, children and their teachers, GPs, health visitors and opticians. The school dentists work alongside staff in the schools and clinics. The health education department provides information directly to parents, teachers and children and involves the school health team in special campaigns. All routine work in schools is

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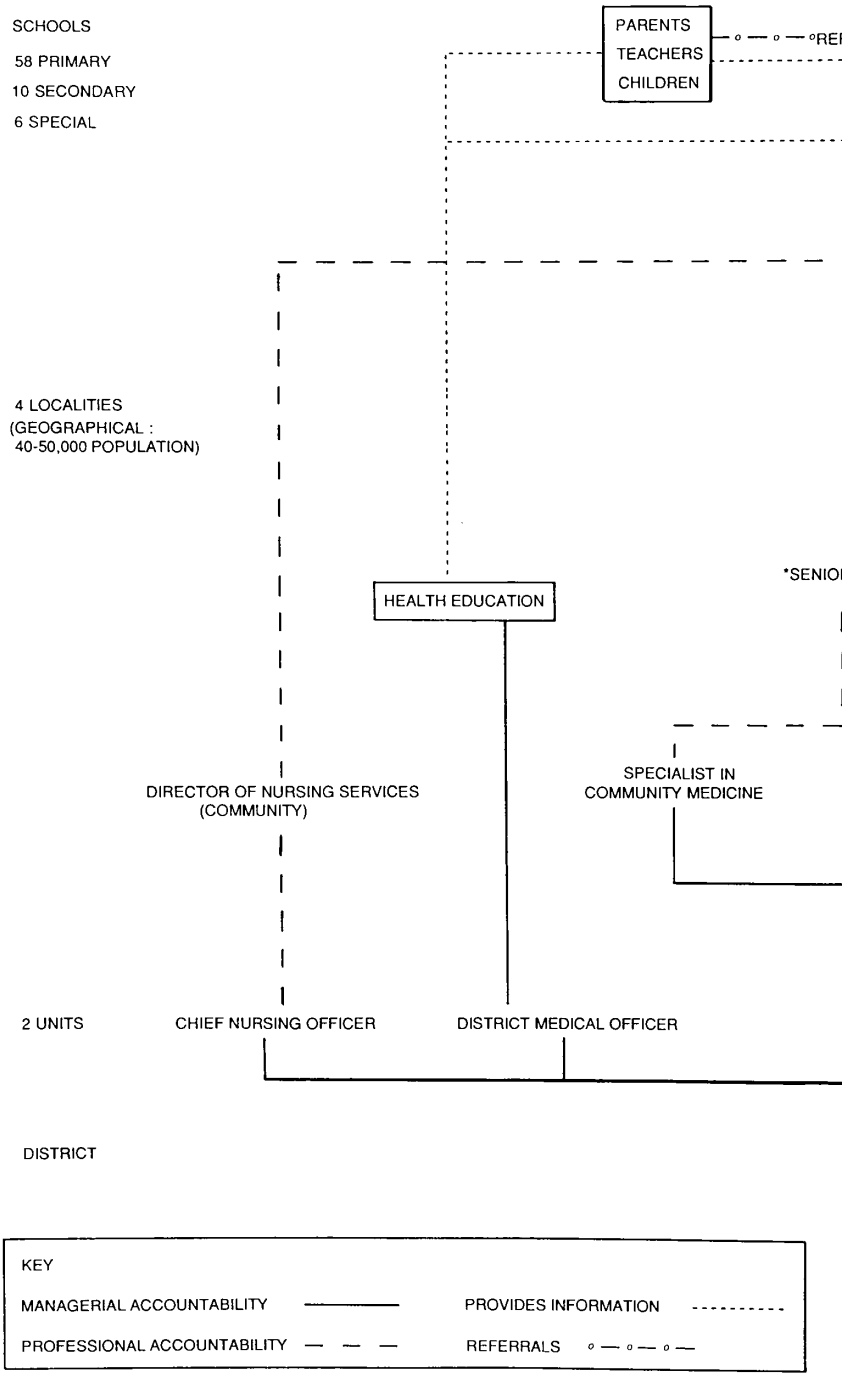
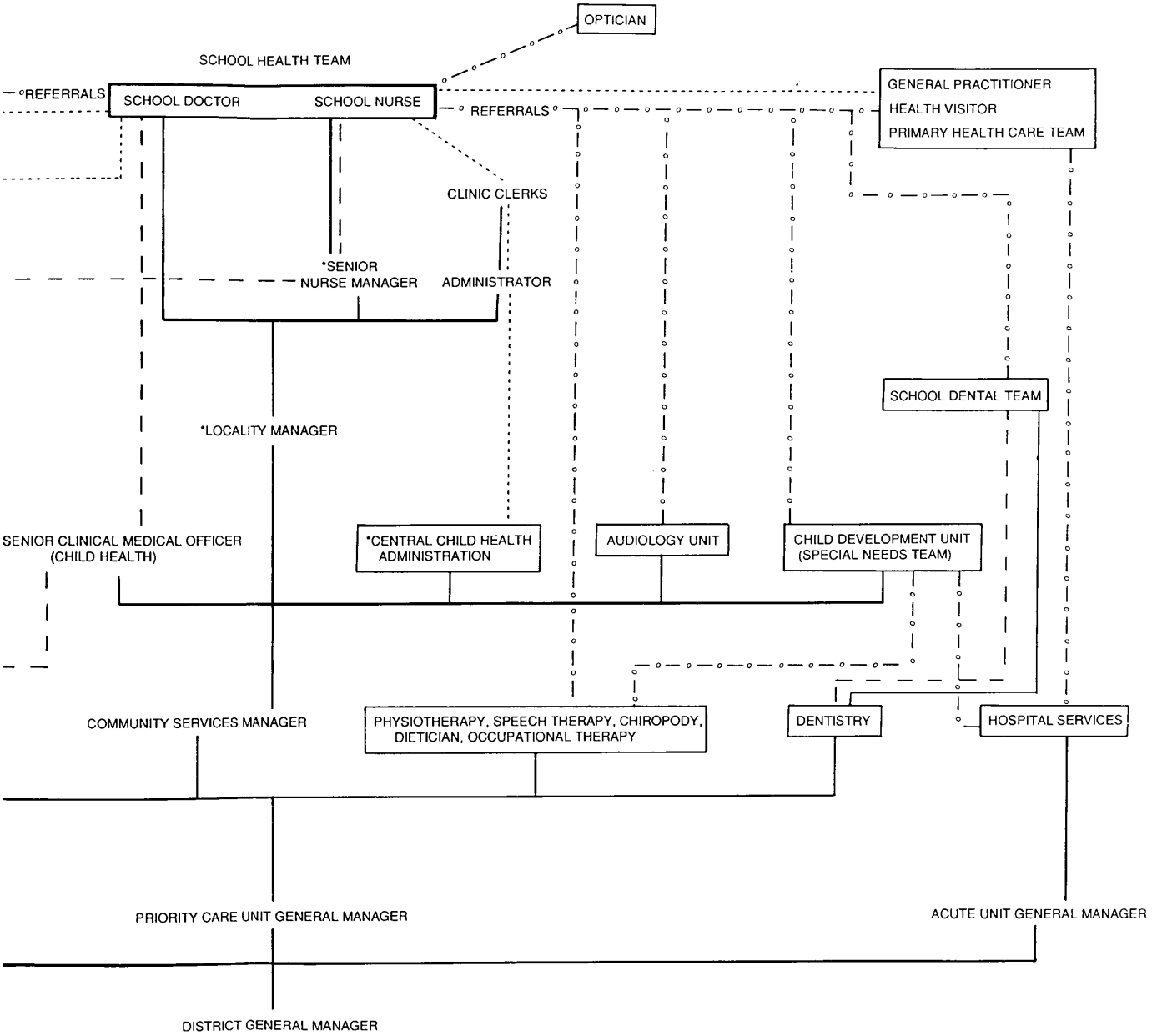


ON AND MANAGEMENT OF SCHOOL HEALTH SERVICES IN A LONDON HEALTH AUTHORITY WITH LOCALITY MANAGEMENT



*MEMBERS OF THE COMMUNITY CHILD HEALTH MANAGEMENT ADVISORY GROUP, WHICH REPORTS TO THE COMMUNITY SERVICES MANAGER

supported by administrative staff who make appointments, ensure that records are maintained and information is collated and channelled to the appropriate place in the system. The child development unit and special needs team provide staff in schools with more specialised support and information, and a referral point for children who may have special educational or health needs. Other children with problems or abnormalities are referred for further investigation or treatment to a range of specialist services in the community, such as audiology, occupational therapy, physiotherapy, speech therapy, chiropody, community paediatrics. As well as holding special clinics, staff from these services also work with children in schools. Access to hospital-based specialist services is most often via these community-based services, or a child's GP, rather than directly from the school health team.

The school doctor and school nurse have separate lines of professional accountability. A senior clinical medical officer usually takes responsibility for the professional aspects of medical work in schools, and is in turn accountable to a specialist in community medicine. School nurses are professionally and managerially accountable to a senior nurse manager. She is in turn professionally accountable to the director of nursing services (community) and through her, to the chief nursing officer. In a district with locality management, in which generic locality managers are responsible for all community health services in a defined geographical area, managerial accountability of all field staff is either directly, or through their first-line manager, to the locality manager. In the example shown in the diagram, the four locality managers are accountable to the community services manager. Community health services (with elderly services, mental health services and mental handicap services) are part of the priority care unit, whose general manager is accountable to the district general manager (at the bottom of the diagram).

In this district questions of operational policy and planning for school health services are dealt with by the Community Child Health Management Advisory Group, which reports to the community services manager. Members of the group are a locality manager, senior clinical medical officer (child health), senior nurse manager, child health administrator and, on occasions, a representative from the child development unit and a paediatrician.

Some health authorities have adopted different organisational arrangements to those shown in the diagram, especially for school medical services. As consultant community paediatrician posts become more numerous, the model pioneered by Nottingham Health Authority is becoming popular. Patch-based community paediatric teams provide a 'second-level' child and school health service supporting and complementing the 'first-level' of care and surveillance carried out by GPs and school health staff. Each team is led by a consultant community paediatrician (CCP) who is responsible for all child health services in the patch. Each CCP also has responsibility at district level for specialist services, eg children with speech and language problems, children with mental handicaps. The teams also include 'junior' doctors in training at registrar and senior house officer level.

Statistics, performance indicators and management information

Information about school health services that is useful for management and planning purposes is difficult to come by. The purpose of this section is to list the information which is currently available and its sources. The performance indicators that have been suggested for school health services are described, and a summary is given of the relevant Korner recommendations.

Not all districts are yet producing the 'minimum data set' suggested by the Korner group. However, for those reviewing the management and planning of school health services, the report of the working group also gives clear guidance on a broader range of information that managers may wish to compile for these purposes.

Routine statistics

Information about staff employed in the school health services and the work they do is collected routinely by all district health authorities. Some of this information is recorded on official 'returns' which are submitted to regional health authorities and to DHSS. Summaries of this national information collated by DHSS are published each year in "Health and Personal Social Services Statistics for England" (HMSO).

The following checklists include all the current routine sources of information about school health services and the staff who provide them. They are taken from "A Guide to Health and Social Services Statistics 1987 edition", DHSS, 1987.

Information about services

All district health authorities are required to complete the following forms annually, for the year ending 31 December. The information is then submitted to regional health authorities where it may be aggregated and summarised and regional returns made to DHSS.

Form number	Title	Information on return
8M(1)	School Health Services	By age groups: — number of pupils examined fully — number of pupils found not to warrant examination — year of birth Number of special inspections/re-inspections Pupils seen and referred by nurses for examinations. Policy on staffing, frequency and typeof surveillance service for non-maintained schools. Number of children verminous. Policy on hygiene inspections; number of pupils examined; number found to be infested.
SBL 607	Vaccination (other than smallpox) of persons aged 16 and under. Rubella: school girls aged 10-15.	Number of persons vaccinated, by type of vaccine or dose, and age, completed primary courses, reinforcing doses.
SBL 655	Tuberculin test and BCG vaccinations	1. School children (excluding those already vaccinated) skin tested, found positive, found negative, vaccinated. 2. Contacts. 3. Babies in high risk groups. Number of persons in other groups vaccinated; babies; contacts.
SBL 618	Chiropody service	Number and category of patients treated by health authorities or voluntary organisations in the community and schools. Number of treatments by place of treatment.
28M1	Dental inspection and treatment	School dental clinics. Number of fixed clinics available/ in use Number of mobile clinics available/ in use. Total number of hours worked. For mother and child service, school service for handicapped adults: — number of clinic hours worked — number of inspections — number of visits — courses of treatmen — type of treatment — orthodontics — dentures fitted — anaesthetics administered by dental officers.
28M2	Dental treatment	Dental therapists — by mother and child service, pupil age groups, handicapped adults, and total community service: number of first and subsequent visits and courses of treatment. Number of specified treatments.
28M3	Dental treatment	Dental hygienists: by mother and child service, pupil age groups, handicapped adults, and total community service: number of first and subsequent visits and courses of treatment. Specified treatment.

Information about staff

Information about all *non-medical* staff employed in the NHS is now collected automatically from health authorities' computerised payroll information. Previously, this information was collected manually when health authorities carried out an annual 'census' of staff in post at 30 September each year. As well as the annual census, quarterly counts are now made at 31 December, 31 March and 30 June each year. However, a detailed analysis is only carried out of the 30 September census data and from this is derived the information about school health staff that is published each year in "Health and Personal Social Services Statistics".

The data collected for each staff member are:

- Authority identification
- Unit identification
- Unit type
- National Insurance number
- Salary scale and point
- Occupation code
- Sex
- Date commenced at authority
- Whole-time/part-time
- Date of birth
- Contract hours/sessions
- Payroll identification
- Date of leaving authority

For bank and agency nursing staff, manual staffing returns are completed at 30 September each year (SBH2C (Agency) and SBH2 (Bank)).

For *medical and dental* staff the annual census is still completed manually at 30 September each year. The information on school health staff is as follows:

Form number	Title	Information on return
SBH 50(A) and 50(A)(1)	Medical and dental staff in posts	Medical and dental staff (including school health services). Full name, National Insurance number, date and place of birth, sex, grade, nature of contract and number of hours worked.

Performance indicators

Performance indicators (PIs) for all aspects of health service provision have been identified by the DHSS Joint Group on Performance Indicators. The DHSS produces performance indicators for all health authorities in a form that can be used on microcomputers or as computer printout. A guide to their use is also available, which offers the following advice about PIs:

"PIs are intended to be practical and useful tools for management. They are indicators and not measures, as the name states. They provide pointers and signals to areas which appear to merit further investigation. They enable managers to make comparisons between the performance of their services and that of others throughout England. No PI should be used in isolation. No single PI, or group of PIs, will reveal conclusively whether performance is satisfactory or unsatisfactory.

Average PI values should not be used as 'norms' or 'standards'. PIs provide a starting point for investigation. Local information, knowledge and experience are essential to assess the validity of inferences drawn from PIs."

PIs identified for school health services are as follows:

PI no. and title	***Explanation***	***Source***	***Definition***
C46 school health Nur/ 1000 sch pop	The number of school health nurses (WTE) related to the school population of the DHA	Non-medical man-power census at 30.9/CHS cost form 040 (s/c 010)	All nurses (except learners) working in school health. Agency, bank, managerial and tutorial staff excluded
C47 Periodic med exam rate	The annual number of children aged under 16 years who have received periodic medical examinations at school as a %age of the school population of the DHA	8m(i) Table A col2/CHS cost form 040 (s/c 010)	A periodic medical exam-ination is a routine examination carried out under the health policy of the DHA
C48 Special med inspections rate	The annual number of children aged under 16 years who have received special medical inspections at school as a %age of the school population of the DHA	8m(i) Table B item B1/ CHS Cost Form 040 (s/c 010)	A special inspection is one that is carried out at the special request of a parent, doctor, nurse, teacher or other person
M55A M55B M55C % School health nurses HV, trained, auxil	The total number (WTE) of health visitors, trained nurses and auxiliary nurses employed in school health services in the DHA, each shown as a %age of the total no. (WTE) of nursing staff employed in school health services in the DHA	Non-medical manpower census at 30.9	Total school health services, includes all nursing staff *except* bank and agency nurses. Trained nurses includes all qualified nurses (SRNs and SENs) not included in M55A. Auxiliary nurses includes all other unqualified staff working in school health services.

Currently, because of the limitations of routinely available information about the school health service, PIs represent the 'lowest common denominator' in comparative information. For the most part they only reveal what has gone into the service and not what it achieves. They tell us little about the quality of service being offered or the extent to which needs are being met. Most districts are trying to identify better measures of 'performance' that can be used to chart their movement towards policy goals and targets.

Korner information

The recommendations of the NHS/DHSS Steering Group on Health Services Information, usually known as the Korner group in honour of its chairwoman, are currently being implemented by all district health authorities. In the early 1980s, the group undertook the first comprehensive and detailed review of the statistics available for health service management since the inception of the NHS.

The aim was to identify basic information which should be routinely collected by all district health authorities to:

- enable decisions to be made about priorities and resource allocation by setting objectives and monitoring their achievement;
- allow comparisons to be made between health authorities;
- monitor costs.

Korner set out to do this in a way that is reliable and makes collection reasonably cheap and convenient. The intention was to provide information for ***management***, not for the clinical care of patients. Working groups were set up to look at specific health service activities; and the working group on community health services considered school health services information. Its recommendations were published in January 1983 and a subsequent circular (DA(84)23) made it clear that districts would be required to collect the 'minimum data sets' it had identified by 1 April 1988.

The report of the working group gives a clear picture of the kinds of information that should be gathered for planning and management purposes. Not all the information specified is available from routine data collection in all districts and may need special enquiries at intervals.

The working group recommended that district management should be aware of the proportion of time school medical and nursing staff spend on the following activities:

- participation in interdisciplinary and interprofessional teamwork, related to individual children;
- general advice on health matters within the school;
- health education;
- contact with individual children at a) health care interviews; and b) examinations.

This analysis would need to be specially carried out.

In its consideration of school health services, the working group made a distinction between work which continues child immunisation, surveillance and screening programmes in a school setting; and the work of school health staff which is explicitly related to learning.

Immunisation and surveillance in schools

Vaccination and immunisation

Information is currently required on immunisation against pertussis, diphtheria, tetanus, polio, measles, rubella and TB. For the planning and monitoring of vaccination and immunisation programmes, the following items of information are recommended to be produced at least annually for each programme:

- a statement of objectives, specifying target level of coverage and budgeted expenditure;
- estimated target population;
- target level of immunisation (%) in relation to age;
- population cover: estimated actual percentage immunised in relation to age;
- estimated cost of disease programme, for comparision with budgeted expenditure;
- reported current incidence of the disease.

The *minimum data set* recommended is based on a record for each child and includes not only data to enable the items listed above to be produced but also data for scheduling and administration of immunisation. The recommended minimum content of the individual record is set out below:

A. name, address, date of birth and sex;

B. for each condition for which immunisation is offered:

(i) date and result of any tests carried out to assess the need for the course;

(ii) courses which are deemed complete:
— date of completion;

(iii) other courses:
— date of termination of the course;
— reason for non-completion:
- unnecessary
- side effects or contraindications
- refusal
- contact lost - transferred
other;

(iv) whether the course was administered within general practice;

(v) data on the vaccine (see recommendation in paragraph 2.13 below):
- manufacturer
- batch identifier.

Health surveillance

For each child health and developmental surveillance programme, the following items of information are recommended to be produced annually:

- a statement of local policy, setting out the objectives of the programme and its budgeted expenditure;

- statistical information, as follows, in respect of children at locally determined key ages:

— estimated target population;
— the percentage (for comparison with target 100%) of the target population covered:
- within general practice
- otherwise;
— the number of children examined who required further action, distinguishing: those requiring
- further investigation or treatment
- recall for further surveillance-
- others;
— estimated expenditure on district services (for comparison with budget).

The minimum data set recommended is again based on a record for each child and includes data on each relevant surveillance contact, wherever and by whomever it may be conducted. A 'contact' is to be counted as 'surveillance' only when it occurs as part of a structured surveillance programme. Such a contact may involve a number of 'tests', e.g. measurements of sight, hearing, height and weight. These are not separately identified within the statistical minimum data set, but will, of course, appear in clinical records. It is recommended that the following data be obtained on each stage of the local surveillance programme:

A. the number of children seen, distinguishing those seen:

- within general practice
- otherwise.

B. the number of other children requiring follow-up action, distinguishing those requiring:
- further investigation, or treatment
- recall for a special surveillance check
- continuing observation.

Work of the school health service related to learning

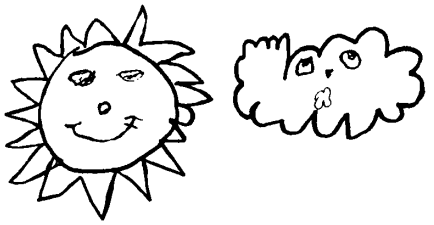
The working group recommended that district managers receive the following minimum information, at least annually, on the school health service:

- a statement of policy on the provision of health services in relation to learning, including target coverage and budgeted expenditure;
- the school population (including children in non-maintained schools), by age and sex;
- the number of school-based assessments in relation to special educational need;
- the number of referrals for a multidisciplinary assessment;
- the number of children, formally identified as having a special education need, who require continuing health service support in the school service;
- estimated expenditure for comparison with budget.

The recommended *minimum data set* includes:
- the school population, by age and sex;
- the number of school-based assessments in relation to special educational need, by age and sex of the child;
- the number of referrals for multidisciplinary assessments, by age and sex of the child;
- the number of children, formally identified as having a special educational need, who require continuing support from the school health service, by age and sex of the child.

The working group also recommended that additional information about special educational needs be collected, indicating the level of a child's special needs and whether a statement has been issued. These data can be routinely obtained from the school health module of the National Child Health Computer System.

The working group felt that the school medical record (form 10M) which is completed for each child in a maintained school, was potentially a valuable source of management information. However, the standard version of the form was not considered an entirely suitable data source and the group recommended its revision by DHSS.



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Appendix 1

JOB DESCRIPTION

1.	**Title of post**	School Nurse
2.	**Grade**	Deputy Sister/Charge Nurse
3.	**Minimal qualifications**	SRN
4.	**Job summary**	Working as a member of the School Health Team in designated schools. Undertaking regular health surveillance, working with school medical officers and facilitating health care
5.	**Responsible to**	Senior Health Visitor

6. **Principle responsibilies**

1. **Clinical responsibilities**

1.1 Visiting homes to introduce the aims of the health service to families of all children due to enter school the following term.

1.2 Liaising with the appropriate Health Visitor.

1.3 Undertaking regular health surveillance according to agreed procedure.

1.4 Participating in medical examinations and immunisation sessions.

1.5 Organising and providing a professional health advisory service.

1.6 Initiating and participating in health education programmes.

1.7 Referring school children and families to other agencies as appropriate.

1.8 Writing reports relating to children's special educational needs.

1.9 Participating in the integration of children with special educational needs into school.

1.10 Taking opportunities to initiate and participate in community nursing development.

1.11 Ensuring safe use of equipment.

2. Education

2.1 Teaching school children, families and other professional staff.

2.2 Acting as a resource person for other professional staff.

2.3 Participating in in-service training and working when required.

2.4 Being aware of up-to-date trends in community nursing and taking advantage of opportunities for professional development.

2.5 Participating in new educational methods in agreement with other professional staff.

2.6 Participating in approved research projects as required.

3. Communications and Public Relations

3.1 Reporting regularly to Senior Nurses.

3.2 Keeping appropriate agencies/colleagues informed re clients/ school children.

3.3 Keeping accurate records and providing written reports as required.

3.4 Submitting reports and statistical information.

3.5 Maintaining contact with other appropriate organisations.

3.6 Ensuring confidentiality is maintained.

3.7 Carrying out agreed health authority policies and procedure.

3.8 Working in accordance with Health and Safety at Work Act, ensuring that hazards are identified and reported promptly.

3.9 Cooperating with other staff to ensure the security of premises in which they work and the property of the public and fellow members of staff according to Health Security Policy.

3.10 Reporting all incidents to the Senior Nurse according to agreed procedures.

N.B.: This job description is a reflection of the current situation and details may be changed in full consultation with the postholder.

TERMS AND CONDITIONS OF SERVICE

Salary	£7,270-9,095 pa plus £930 pa London Weighting Allowance (Part-timers will be paid on a pro-rata basis.)
Hours	36 per week
Annual leave	25 days pa plus bank and public holidays
Superannuation	Currently 6% of annual salary
Notification of leaving	One month in writing on either side

All other terms and conditions of service are in accordance with the Nurses and Midwives and General Whitley Councils.

Every opportunity for professional and career development will be given.

The health authority is an equal opportunity employer.

November 1986

5.
BIBLIOGRAPHY

CHANGING SCHOOL HEALTH SERVICES

The **Primary Health Care Group** is a multidisciplinary team based at the King's Fund Centre for Health Services Development. Its aims are to improve primary and community health services, particularly in inner London; to encourage experiments with new ways of working; to disseminate 'good practice'; and to contribute to debates about primary health care policy. The group provides information and advice about primary care developments; works with NHS managers to establish and evaluate demonstration projects; organises workshops and conferences; and publishes papers and reports.

The group's current interests include strengthening the management of primary care services; collaboration between district health authorities and family practitioner committees; decentralising community health services; and services for disadvantaged groups. The work is financed by the King's Fund and the Department of Health and Social Security.

This series of working papers is intended to make material from work in progress readily available to a wider audience. Each paper records the experience of testing a new idea and draws out the lessons learned.

CHANGING SCHOOL HEALTH SERVICES

5. Bibliography

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January 1988
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CHANGING SCHOOL HEALTH SERVICES

A series of workshops on school health services was held at the King's Fund Centre during 1986 with the aim of helping the managers who took part in them to think critically about school health services. We were encouraged by the response to a topic that is definitely not fashionable and usually takes second place to services for under fives. With hindsight, however, the enthusiasm for the workshops may have had more to do with the lack of opportunities to meet to discuss school health in its own right than a sign that priorities were changing.

The workshops highlighted the issues and problems that school health service managers need to tackle. It quickly became clear that they had few 'models' on which to draw to help them assess the quality of services provided for school children. Like us, most of them believed that school health service resources could be used more effectively and efficiently than at present. However, without precedents to quote to clinical colleagues and feasible alternatives to offer them, managers often lacked confidence to challenge traditional practices and methods of service delivery.

When it came to preparing a report on the workshops, we felt that the presentations and discussion should be put into the wider context of the debate about child health services. This information pack has therefore grown from the workshops and other material has been added to enhance its value to managers who are reviewing and improving school health services. It was compiled and edited by Jane Hughes, Pearl Brown and Pat Gordon, who gratefully acknowledge the contributions of the workshop speakers and participants, and the assistance of colleagues at the King's Fund Centre. Alex Cattell and Kate Cattell supplied the illustrations.

The information pack has five sections, each of which is intended to complement the others but also to stand on its own. The first section summarises the current debates on policy and practice in community child health services. The second presents two case studies which offer some clear indications of what to look for when assessing the quality of service. The third section examines the process of developing and reviewing policies for the school health service. The fourth is a rererence section, which describes the origins and organisation of school health services and gives a summary of available statistics and performance indicators. The fifth and final section is an annotated bibliography containing references selected for their usefulness to managers and policymakers.

Jane Hughes
Pearl Brown
Pat Gordon

Primary Health Care Group
King's Fund Centre for Health Services Development
January 1988


PARK TO PLAY
Book

BIBLIOGRAPHY

The publications included in this bibliography are drawn from a wide range of sources and were selected for their usefulness to managers and policy-makers. The brief summary of each document is intended as a guide to the main points or arguments and the relevance to school health services.

All the publications are in the library at the King's Fund Centre, which is open for reference purposes from 9.30am - 5.30pm Monday-Friday and 10.00am - 4.30pm on Saturdays.

The bibliography is divided into ten sections, and there is a simple cross-referencing system.

1 Reviews of policy and practice in child and school health services

1.1 School health: the invisible service in Harrison A and Gretton J (eds). **Health Care UK: An economic, social and policy audit.** London, CIPFA, 1986.

Managers who need basic information about school health services and how they are organised will find this a useful article. It presents data from a survey of 130 health authorities in the UK on service provision, organisation and delivery.

The variation in practice shown by the survey results *'reflects an uncertainty within district heath authorities about what a school health service should be doing and how it should be organised. And this in turn reflects central indecision.'*

1.2 Fit for the Future. Report of the Committee on Child Health Services. (Court Report) London, HMSO, 1976. Cmnd 6684.

A benchmark in child health policy in Britain; the foundation for the debate on child health services in the 80s; and now a historical document. It reviews all health services for children and proposes a new, integrated child health service. It also provides a compendium of detailed information about children, child health, and the historical development of child health services.

The problem of the school health service is diagnosed as its separation from primary care and from GP services in particular. *'Parents and teachers have found themselves faced with a school health service which knew something of the child's health at school and had skills in educational medicine — but could rarely provide treatment and had no firsthand knowledge of the child's behaviour or development out of school; and a general practitioner service which could provide treatment but had no opportunity to study the child's behaviour in school and to discuss problems of health and adjustment with teaching staff concerned, and had no experience of educational medicine.'* The policy vacuum in school health is also noted: *'There is still a striking lack of any national or local policy aimed at achieving rational, efficient cooperation between general practitioners and school doctors or resolution of the underlying dichotomy between promoting health and treating illness.'*

The report sets objectives for the future *'...we want to see a child and family centred service; in which skilled help is readily available and accessible; which is integrated in as much as it sees the child as a whole, and as a continuously developing person. We want to see a service which ensures that this paediatric skill and knowledge are applied in the care of every child whatever his age or disability, and wherever he lives, and we want a service which is increasingly oriented to prevention.'*

It proposes creation of a general practitioner paediatrician, who would have special responsibilities and training in child health. GPPs would work in the school health service. Working with each GPP would be a child health nurse. In schools, a specially trained school nurse would continue to carry out nursing duties. These primary health care workers would be supported by consultant paediatricians and the district handicap team (now generally known as child development teams).

There is a separate chapter on educational medicine and the work of doctors and nurses in schools. In terms of health surveillance, the report recommends that this should be part of a continuum with preschool work; that every child should have a routine medical examination before school entry, and that this should be statutory. *'Further routine examinations are unnecessary and should be discontinued.'* Annual screening by the school nurse to check on health and development is recommended during school years. Views have changed since the report was written and selective surveillance is now thought to be more valuable.

At 13, the report recommends that every boy and girl should have a private interview with the school doctor. The main recommendations on organising and staffing the school health service are that schools should have a named school doctor and

school nurse to achieve continuity of care and interprofessional collaboration; that school doctors and nurses should be fully trained; that health records be maintained for every pupil; and that parents' and pupils' views should be taken into consideration. There are chapters on dental health; handicap and the role of the district handicap team; and psychiatric disorder. The report is particularly strong on the rights of children and includes a chapter entitled 'a voice for children'. *'Children are full citizens with an equal right to health and health services, whatever their age and wherever they live.' '..we believe that children have a right to basic health care which comprehends not only treatment at times of illness or injury but also continuing surveillance to promote health and detect disability or handicap.'*

The report looks at the training implications of the proposed new system.

1.3 Scottish Home and Health Department and Scottish Education Department. **Towards better health care for school children in Scotland.** A report by the Child Health Programme Planning Group of the Scottish Health Service Planning Council. Edinburgh, HMSO, 1980.

This very thorough report is divided into four sections on health surveillance, children with handicap, staffing the school health service and school health records. Each section has useful summary of recommendations.

I Health surveillance: This section reviews existing guidance by SHHD on medical examinations. *'Traditionally, the school health service has been organised as a separate entity providing a largely self-contained service. The general extent and content of this service has derived, in the past, from advice issued periodically by the Scottish Home and Health Department to local health authorities, and, since the reorganisation of the Health Service in 1974, to health boards. There is, however, an increasing acceptance of the view that health services in schools should be provided as an integral part of primary health care. There is also a growing emphasis on the need for early identification of disabilities of whatever kind and for close collaboration between the health, educational, social work and other services directed towards children.'* The main recommendation is that surveillance in schools should be linked to a comprehensive system of preschool developmental screening. This section also covers the content and timing of examinations, coverage of the population, involvement of parents, exchange of information between school health staff and other professionals, resource implications.

II Children with handicap: This section reviews information on the prevalence of disability, the wider context of assessment, the handicapped child at home and at school, establishing a flexible framework for assessment, the district assessment team (similar to Court's district handicap team) and its accommodation, cooperation between health boards and local authorities, resource implications.

III Staffing the school health service: 'If a school health service were to be created within the educational setting, there is no doubt that such a service would differ significantly from the present one. Many of the differences would depend on the organisation of the child health services as a whole. It seems probable that the continuance of existing constraints must be accepted and hence the staffing of the school health service may need to remain substantially as it is. Nevertheless, clarification of the objectives of the school health service should enable the career structure and training of the health professionals involved to be planned within the existing constraints in order to make these objectives more readily attainable.' This section considers medical, nursing and paramedical staffing; and accommodation.

IV Child health records: This section looks at the functions of a child health record system and the implications for record keeping of other recommendations in this report. *'...every effort should be made to achieve integration of records.'*

1.4 Inequalities in Health: Report of a Research Working Group (The Black Report). London, DHSS, 1980.

The working group set out to investigate the gap in

health status and life chances between the social classes in Britain. It documents the differences between social classes in morbidity and mortality during childhood. The group takes the view that *'early childhood is the period of life at which intervention could most hopefully break the continuing association between health and class'*. The report includes a discussion of policies to reduce inequalities in health and many of these focus on improving child health: *'giving children a better start in life'*, through better health services and by measures to reduce poverty.

Amongst other recommendations, the group suggests that emphasis should be on child accident prevention programmes (the highest cause of death in children aged 1-14 years) and that school health statistics should routinely be analysed by occupational class. A district action programme is suggested which recommends that *'every opportunity should be taken to link revitalised school health care with general practice and intensify surveillance and follow-up both in areas of special need and for certain types of family.'*

1.5 DHSS. **Prevention in the child health services.** London, DHSS, 1980.

This paper outlines the main objectives and content of preventive child health services in the light of government decisions on the report of the Committee on Child Health Services (the Court report); and suggests a basic programme of child health surveillance.

DHSS circular HC(78)5 was the government's immediate response to the Court report and it gave general guidance on the development of child health services. This paper was prepared 'following consultations with health authorities and interested professional organisations', and it gives more detailed guidance about the nature, content and timing of child health surveillance.

For school children, it recommends comprehensive medical assessment at school entry, but no routine medicals in subsequent years. *'health surveillance during the school period should be based on serial screening of vision, hearing and growth, regular dental inspection and an annual health care interviews with the school nurse, especially for children over the age of 11 years.'*

1.6 Macfarlane A. **Child health services in the community: making them work.** British Medical Journal, 26 July 1986, **293**, 222-223.

This pithy BMJ leader describes the current confusion in community child health services — there is no uniformity in child health surveillance programmes adopted by health authorities; the health status of children gives cause for concern; and there are disputes between professionals over who should be responsible for the various aspects of child health services. Macfarlane calls for agreed national guidelines and targets for screening and surveillance; training for the professionals undertaking screening; more research into the effectiveness of screening; better monitoring of child health services; and more involvement of parents, including parent-held records.

1.7 Whitmore K and Bax M. **School health in the wilderness.** Health Trends, August 1982, **14**, 3, 52-55.

'Concern is expressed for the school health service which has been overlooked in the current controversy about child health services. Reference is made to a study of health services in 15 primary schools in London demonstrating the objectives and value of the school health service. The study also shows the need for a combination of preventive and therapeutic roles on the part of doctors practising primary child health care, and for community child health services (which include health services in schools) to be planned as supplementary rather than complementary to the family doctor services.'

The complementary/supplementary distinction is quite difficult to grasp, but the essence seems to be that community child health services don't just cater for those who choose not to go to the GP — they are providing an additional (and superior?) service to children. There needs to be overlap between the two services.

1.8 Whitmore K. **Health Services in Schools — A New Look.** London, Blackwell, 1985.

This book gives a useful overview of the health of school children, school health services and how they are organised, and the current controversies about the delivery of school health services. In chapters 10-12, 'What's wrong with the school health service?' and 'Putting the services right', Kingsley Whitmore gives his diagnosis of the problems and his prescription for the survival and strengthening of school health services. These mainly concern the medical aspects of school health and he makes the case for maintaining specialist medical input to schools. The central arguments can also be found in earlier papers by the author.

1.9 Issues for London DHAs: Policies for child health. A report of a conference held at the King's Fund Centre on 23/9/82. Available form King's Fund Centre, 126 Albert Street, London NW1 7NF. KFC 82/218.

This conference report dips into the various issues facing London in 1982 following the NHS reorganisation. It highlights the complexities of delivering child health care in the inner city where there is high mobility of families and often poor take-up of services. Practitioners describe small research projects and use them to illustrate how child health services might be improved. There has been little change in the 5 years since the report was written. These projects, together with a background paper written for the conference, give a valuable overview for managers in London.

1.10 Roche K and Stacey M. **Overview of research on the provision and utilisation of child health services.** University of Warwick, September 1984. Update I, March 1986.

This review of research was commissioned by DHSS. The first document covers reports published up to 1984 and the second document is an update to early 1986. The aim of the review was to identify areas for further research and the resulting annotated bibliographies are therefore likely to be of limited use to managers and practitioners.

The gaps identified by the authors are, however, significant. The first report includes over 300 publications but the authors found few of these were based on good, systematic research. Most of the work was descriptive rather than explanatory. A relatively high level of research attention has been given to the pre-school child; little to the school child; and even less to young people. Work on school health is 'extremely sparse'. Other gaps noted are research into collaboration between DGH paediatric departments and GPs; and reports on the benefits of concentrating services on localities, schools or high-risk groups.

In the second report the authors identify an increase in the number of papers on professional roles, particularly those of health visitors and GPs in child health surveillance. On inter-professional collaboration, however, they found surprisingly little. Different approaches to practice are not being systematically evaluated; there is little interdisciplinary research; and few studies are child-focussed. The authors recommend that these gaps should be filled and that 'state of the art' papers would be an economical way of forwarding understanding of problems areas.

1.11 Investing in the future. Child health ten years after the Court report. A report of the Policy and Practice Review Group, National Children's Bureau. London, National Children's Bureau, 1987.

This review of child health services ten years after Court concentrates on three areas: the preventative services, the school health service, and services for adolescents. It gives a useful summary of the social and medical characteristics of the child population and describes how child health services have developed since the Court report was published.

The report places great faith in the creation of consultant community paediatrician posts as a way of solving the problems of child health services. Inter-professional 'disagreements' about child health are referred to politely. Involving parents is a general theme and the report recommends that parents should hold *'a standardised health record for each of their children, throughout the period from infancy to adolescence'*.

The Review Group envisage that primary health care teams will eventually take over complete

responsibility for surveillance and preventive procedures. It is acknowledged that health visitors and school nurses currently undertake a major proportion of this workload, and that this should continue is recommended. More research is called for into the effectiveness of screening and surveillance procedures — *'many of the screening procedures recommended by the Court Committee are of unproven value insofar as findings often do not lead to effective treatment'*. A trial of 'demand led' surveillance is suggested, with screening applied only to those who do not come forward.

It is also recommended that child development teams be established in every health district by 1990 and that there should be easy access to the professionals in the team for children seen in primary health care settings.

The section on school health services does not make many advances on the Court report; for example recommending that each school should have a named school doctor and school nurse, both appropriately trained. The Review Group also came out in favour of retaining a comprehensive examination of all primary school entrants by a doctor and a nurse with parents present. 'Thereafter the school doctor should see children at teacher or parent request rather than routinely.'

For secondary school children they recommend *'a personal health advisory service with confidential counselling ... with an 'open door' arrangement allowing pupils independence in their access to the nurse and doctor'*. Both nurses and doctors require training in counselling skills.

'We suggest that nurses should undertake most of the school health screening examinations in ordinary schools to provide advice to nurses on children with special needs and on problems they have encountered, and to provide information directly to teachers on children at school with specific handicap such as may arise from hearing loss, epilepsy, diabetes or asthma.'

'There should be an agreed code of conduct concerning the health care of school children that should guide the professional activity of family doctors, school nurses and school doctors. We suggest that the primary health care team should continue to be the main source of health care for school children.....If children are thought by the school doctor to require further paediatric, psychiatric or multi-disciplinary assessment, the referral should be made directly or through the GP according to parental wishes. If the referral is made directly, the GP should be asked to comment on the referral and provide information relevant to the referral at the time it is made.'

1.12 British Paediatric Association. The School Health Services, BPA, 5 St. Andrew's Place, London NW1 4LB, 1987.

This useful booklet prepared by a committee of the BPA gives a clear and concise statement of the current consensus on the provision of medical services to schools. It also contains a paper by the National Association of Head Teachers on the future requirements for school health service provision.

The BPA reinforce many of the recommendations of the Court report: every school should have an identified school doctor and school nurse; the school nurse is the key worker; parent-held records. In the absence of an 'integrated' child health service, with continuity between pre-school and school health services, the BPA recommends continuing school entry medicals for all children, to identify medical and neurodevelopmental problems likely to affect education. *'If there was efficient transmission of medical information between the pre-school and school health services then a school entrance examination (at or around five years) on all children would be unnecessary.'*

On the content of this examination, the BPA is cautious. *'The majority of children who have had adequate pre-school surveillance, including routine screening for abnormalities of vision and hearing, will not have medical problems and for them the examination should be limited. It should include (a) measurement of height and weight; (b) a check for undescended testes; (c) auscultation of the heart for murmurs.'* Hearing and vision should be checked at school entry or in the first term at school. No recommendation is made on neurodevelopmental screening, because its value is still being assessed.

The booklet includes recommendations on all

aspects of school health services, including services for children with special needs. The 2% of children with more serious special needs, who are mainly in special schools or units, should be cared for by the consultant paediatrician and local special needs team. The 18% of children with less severe special needs, including those with asthma, diabetes, epilepsy and emotional problems, would normally be kept under observation by liaison between the teacher, school nurse, school doctor and general practitioner, with referral to the paediatrician when necessary. *'Each health authority should ensure that it has a system that informs the school health services one term in advance of any child with special needs entering a primary school or special school, so as to ensure adequate consultation between the various disciplines involved.'*

See also: 2.1, 2.3, 7.2, 7.3, 7.5, 8.2, 8.3, 8.4, 8.6, 8.7, 10.3, 10.4.

2 School nursing

2.1 Neighbourhood Nursing — A focus for care: Report of the Community Nursing Review (The Cumberlege Report). London, DHSS, 1986.

This report of an enquiry into the future of community nursing in England suggests the formation of combined nursing teams of district nurses, health visitors and school nurses to serve neighbourhoods of 10-25,000 population. This recommendation is based on the finding that community nurses, with their separate management structures, worked with different age groups. This division of labour may be inefficient because of duplication of effort; ineffective because problems may be missed; and makes it difficult to achieve a cohesive approach to individual, family and neighbourhood care. *'...the neighbourhood nursing service would bring school nursing in from the periphery of primary care; it would mean that the needs of the neighbourhood's children would be brought into much sharper focus and would make it easier to take a more integrated, family-based approach to the health care of children and young people'.*

The report's training recommendations suggest that all community nurses (including school nurses) should take a diploma course in community nursing and health care followed by specialist modules. For nurses planning to go into school nursing as a career there would be modules on the health of young children and adolescents. This would give school nurses, for the first time, equal status with health visitors and district nurses.

As well as being a policy document that is likely to shape the future of community nursing in England, the report outlines where school nurses fit into the broader context of community nursing. At the end of the report there are checklists for working with care groups, including children aged 5-16 years; adolescents and young adults. These are useful both for managers and professionals involved in school health.

2.2 RCN Society of Primary Health Care Nursing. **Recommended guidelines for the basic role of the school nurse.** 1981. Available from The Royal College of Nursing, Henrietta Place, London W1.

These guidelines were produced in 1981 by the RCN and take the form of a standard job description for a school nurse. Most school nurse managers would be familiar with the contents. Some of the responsibilities listed are already outdated, for

example those concerning infestations and personal hygiene, as many schools have moved away from regular 'hygiene' inspections. However, the rest of the guidelines apply to services offered today.

2.3 Whitmore K, Bax M and Jepson A. **Health services in primary schools: the nurse's role 1 and 2.** Nursing Times, 1 September 1982, **78**, 35, 97-100; 8 September 1982, **78**, 36, 103-104.

These two papers present the findings of a project set up in 1977 to assess health services provided to 15 primary schools in North Paddington, London. A large proportion of five year olds (44%) were found to have health problems, and the prevalence of problems did not diminish until the children reached age seven to eight. Services were deficient in that some children did not receive treatment as advised by the school doctor; there was delay in reassessing some children with problems; and there was poor liaison between the school nurses and doctors and other professional staff, particularly GPs, speech therapists, educational psychologists and the staff of child psychiatric units. The paper particularly explores the role of the school nurse in health surveillance. The project also evaluated the effectiveness of selective medical examination of seven year old children, based on a parental questionnaire and teachers' comments.

The authors recommend that school nurse and doctors should

- be appointed to named schools;
- organise their own work in the schools to which they are appointed;
- agree the manner on which they work together in schools;
- decide their own programme of surveillance in each of their schools;
- be responsible for the health records in their schools.

2.4 Latham A. **Health appraisal/surveillance by school nurses.** Health Visitor, January 1981, **51**, 1, 25-27.

This article describes a health appraisal scheme for school children carried out by school nurses in Nottingham. It describes the interview, how long it took and assesses its contribution to the health maintenance of the children. The interview enabled nurses to identify children who should be referred to other professionals for more detailed examination. The effectiveness of the scheme was evaluated and manpower requirements were estimated.

This is a useful article for anyone wanting to introduce health surveillance interviews for secondary school children by school nurses.

2.5 Collins J. **Why educate school nurses?** Health Visitor. May 1985, **58**, 123-124.

This article describes the role that school nurses can play in educating parents, teachers and children and discusses the pros and cons of training courses aiming to achieve this.

In the first part of the paper the author looks at the arguments for educating school nurses and in the second part she suggests that the original arguments for education perhaps need rethinking. The author discusses whether it is right to encourage the process of selfdetermination, to sometimes unsettle and distress students in this process, just to return them to work which gives little opportunity for them to step outside prescribed roles that have been adhered to for many years. *'Having exposed them to an environment where creative ideas and critical thought are encouraged, only to return then to an environment which requires and encourages neither right results in dissonance, arguably a factor in burnout and discontented staff.'* One possible solution is for the educators to work more closely with managers of staff attending courses, involving them more in the preparation of staff for the course. Another, more radical, approach is an enquiry into school nursing.

The article is useful reading for nurse managers and general managers who are reviewing school health services. So often reviews revolve around tasks, screening activities and clinical matters, and may not question whether school health staff are used to their full potential or could be developed further.

2.6 Staunton P. **In a class of their own?** Nursing Times, Community Outlook, September 1985, 6-8.

This is a useful overview of school nurse education since the introduction of nationally recognised courses for school nurses in 1980. It gives the background to the structure of the courses, their length and content. Extension and development of the courses appear to be limited by the willingness of health authorities to finance the courses.

2.7 Staunton P. **Separate compartments?** Occupational Health, June 1984, **36**, 6, 251-253.

This article looks at the links and common boundaries between school health nursing and occupational health nursing. The author observes that many school nurses advise school staff, not just the children, and many occupational health nurses work in student health services provided in universities, polytechnics and some colleges of further education. A common training for these two groups of nurses would extend career opportunities, allowing them to move between the NHS, local authorities and industry. This short article raises issues that should not be missed in the current debate surrounding the future of nurse training following the UKCC's Project 2000 proposals.

2.8 Pearson P. **Health reviews in nursery school.** Health Visitor, October 1985, **58**, 10, 291-292.

This article describes a pilot scheme carried out in Newcastle-upon-Tyne to evaluate health visitor involvement in the surveillance of 3-4 year old pre-school children attending nursery school. The control group had school nurses doing in the surveillance. There appeared to be little difference between the two groups in the ages at which problems were detected. Altogether the differences between the groups were not marked, although the pilot scheme using health visitors showed positive gains in professional understanding and parental involvement.

2.9 Health Visitor's Association. **The health visitor's role in child health surveillance. A policy statement.** HVA, January 1985.

A useful summary of the health visitor's contribution to child health surveillance, the document sets out a minimum programme of health visiting activities in surveillance and the key ages at which children should be seen by child health staff.

The HVA recommends that at age four to five years the child should be screened by the doctor in conjunction with the health visitor and/or school nurse (depending on which has the current relationship with the family). If the child is already in school, this assessment should take place there, and with appropriate input from the teaching and other school staff. The Association proposes the involvement of doctor, health visitor and school nurse in order to draw together all the available information about the child's health and development hitherto, and so that the health visitor is in a position to transfer a comprehensive account of the child's progress to the school nurse who will then continue child health surveillance on into the school age years.

The Association recommends that every health authority should have a stated philosophy (general rationale and aim) and a policy (containing detailed objectives) for the child health surveillance programme. The health authority's policy should be available for consultation and dissemination both to the providers and consumers of the service, and parents should be provided with full details of the programme's purpose, structure and content.

The implications of the programme recommended by the HVA are spelled out in terms of professional responsibilities; training; resources; record keeping and information systems; legislation; and research.

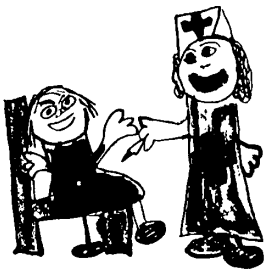
2.10 Hanson L. **No longer the nit lady.** Nursing Times, 3 June 1987, **83**, 22, 30-32.

This article describes a survey of school teachers in the south west of England to find out how they saw the role of the school nurse. The author concludes that many teachers continue to be influenced by an outdated image of the school nurse as the 'nit lady' and as a handmaiden to the doctor. Her role in

relation to handicapped and chronically sick children in schoool was not fully understood. Few teachers used school nurses as a source of information about these children and rarely were they involved in school meetings about children with problems.

The survey findings indicate that the potential of the school nurse is still not being recognised or used and this is in part due to teachers' lack of awareness of the current role of the school nurse.

See also: section 1, 4.1, 5.1, 5.4, 6.1, 7.4, 7.6, 7.9, 7.10, 8.4, 8.8, 8.10, 8.11, 10.1, 10.4.



3 School doctors

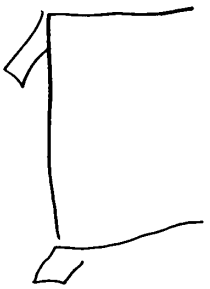
3.1 Davies L M and Bretman M D. **What do community doctors do? Survey of their work in the child health service in Nottinghamshire.** British Medical Journal, 25 May 1985, **290,** 1604-1606.

This paper describes a one-week survey in October 1983 of the work of all community health doctors in Nottinghamshire. Information was collected from all pre-school and school health sessions about each child seen. The paper presents analyses of sources of referral, problems identified, action taken, work in special schools and proportion of time spent on different activities.

It shows that community child health services are not just 'screening' services; community health doctors are being used by parents, teachers and other professionals as a source of assessment, treatment and advice. They also play an important role as coordinators of services for individual children and have a key role in the regular review of children attending special schools. The authors, however, question whether they communicate sufficiently with GPs about individual children, and comment that a *'positive attempt to establish close working relationships with local medical practitioners may bear dividends in increasing awareness of, and confidence in, the activities and skills of the community health doctor'*.

This paper usefully demonstrates the range of activities undertaken by community health doctors and offers a simple technique for assessing their activity that could be used in other districts.

See also: section 1, 2.3, 4.1, 5.1, 5.4, 6.1, 7.10, 8.4, 8.8, 8.12, 9.1.



4 Involving general practitioners

4.1 Bowie C and Parry Jones A. **Court come true — for better or for worse?** British Medical Journal, 1985, **298**, 1322-1324.

The Court report (1976) proposed that primary care teams take over child health surveillance. In 1966 Somerset started a scheme to incorporate GPs in the school health service and this paper reports the degree of integration that has been achieved. It attempts to evaluate the success of the venture.

There are two schemes in operation, one in urban and one in rural areas. In rural areas GPs act as school doctors and are paid on a capitation basis for this work. In urban areas the school entrance medical examination is brought forward and held in GP premises, when children are four years old. GPs hold special clinics in their own surgeries, attended by health visitors, exclusively for children registered with them. This 'preschool' medical examination is linked with five other routine child health examinations in the preschool period that form part of the surveillance programme. At the examination of four year olds a short report for the head teacher of the school the child will be attending is completed by the GP and HV. The report is the last routine medical that the child receives.

All but one of the urban GPs take part in this scheme. They are paid on a capitation basis for this work, with an item of service payment for each preschool medical report received, which also has to be signed by the health visitor.

This system was evaluated by comparing rate and timing of orchidopexy operations in Somerset and in the rest of the South Western Region. No significant difference was found.

Discussion looks at the pros and cons of the scheme, in relation to the Court proposals. The main negative point is that head teachers feel they have lost direct access to medical advice.

4.2 Colver A F and Steiner H. **Health surveillance of preschool children.** British Medical Journal, 26 July 1986, **293**, 258-260.

Although this article is about preschool health surveillance, it describes a model for working with GPs to agree policy and monitor its implementation.

Discussions with every general practice, health visitor and clinical medical officer in Northumberland Health Authority led to agreement about the content of preschool health surveillance, the ages at which it should be done, and referral pathways after a failed screening test. Each primary health care team now undertakes to do a basic minimum set of screening tests, and each team decides who in the team will do each test. The screening system agreed on should enable time to become available for the equally important aspects of surveillance — namely developmental guidance, health education, and assessment and follow-up of problems. The discussions also led to agreement about how the health authority should evaluate the effect of the surveillance programme on the health of children.

4.3 Syed I and Leach J. **Walk in surgery for children.** British Medical Journal, 3 August 1985, **291**, 318.

This letter from a GP and health visitor describes a walk-in surgery for children aged up to 16 years in a general practice in Burnley. In a five month period in 1983 418 children attended 520 consultations, averaging 6.5 children per session. The majority of children attending were under 5 years but 15% of the practice population aged 5-16 attended the sessions. Apart from benefits to parents and children, health visitors saw 25% of the children and found valuable opportunities for health education and gained confidence in dealing with minor illnesses. The three GPs involved tried to standardise care and changed their prescribing patterns.

Monitoring and evaluation of schemes like this may well help members of primary health care teams reassess their work and the services they offer.

4.4 Donovan C. **Practising prevention: children aged 5-15.** British Medical Journal, 9 October

1982, **285**, 1018-20.

This article discusses the areas in which GPs can 'think prevention' when working with children aged 5-15. When working with this age group the important issues are nutrition, contraception, smoking, alcohol and drug abuse, immunisation and emotional, behavioural and learning problems. This may provide a useful agenda for managers who are negotiating with GPs about provision of services.

4.5 Healthier Children— thinking prevention. Report of a working party appointed by the Council of the Royal College of GPs. London, RCGP, 1983.

Although there is little discussion of school health services in this report, it analyses the current involvement of GPs in preventive work with children and suggests that their role should increase.

See also: 1.2, 1.3, 1.4, 1.7, 1.8, 1.11, 1.12, 2.1, 2.3, 3.1, 6.5, 7.10.

5 Involving parents, teachers and children

5.1 Fitzherbert K. **Communication with teachers in the health surveillance of school children.** Maternal and Child Health, March 1982, **7**, 3, 100-103.

The effectiveness of selective screening and surveillance of school children depends on information about children's needs and problems being passed from teachers to school health staff. This article reports on the findings of interviews with 35 junior school teachers in 3 schools about their knowledge and experience of school health services.

Most had little knowledge of health services linked to schools and none of the teachers appreciated their key role in the health surveillance of children. Some teachers made referrals to the school doctor but this was often via the head teacher and they rarely received feedback.

The author recommends that teacher training should include information about how the school health service operates. School health teams should visit schools specifically to meet the staff and explain their policy and practice. After medicals the doctor should communicate directly with the class teacher.

5.2 Newby A and Nicoll A. **Selection of children for school medicals by a pastoral care system in an inner city junior school.** Public Health, London, 1985, **99**, 331-337.

'The selection of children for medicals in a junior school was altered from being purely a medical decision to one involving teachers and parents. Particular attention was paid to the health of children on a pastoral care scheme. The change resulted in more children with educationally significant health problems being identified and treated. There were other advantages in better uptake of immunisation, higher parental attendance at medicals and improved teacher/medical training liaison.'

5.3 Storr J, Barrell E and Lenney W. **Asthma in primary schools.** British Medical Journal, 1987, **295**, 251-252.

A survey was carried out of all primary schools in the town of Lewes to discover the attitudes of parents and teachers to asthma in children and to identify problems in the use of inhalational treatment at school.

Most schools coped well with giving bronchodilators, though there was little understanding of the nature of the disease or

treatment. *'Teachers realised that their knowledge about asthma was poor, and they were keen to learn more about common medical conditions that they might encounter. Their main worry was that they might get into trouble for allowing children to use their inhalers too often, and some teachers were surprised that children might be allowed to request treatment when they felt like it.'*

Most children who had been given pressurised inhalers could not use them satisfactorily. Only 2 of the 67 children studied were being followed up regularly at a hospital outpatient clinic. The report concludes that children and teachers need to be taught inhalation techniques and advice given to partents and children. *'Because children spend so much time at school it is important that teachers understand asthma and are instructed on when and how to give inhalation treatment.'*

5.4 Nicoll A. **Written material concerning health for parents and children** in Macfarlane J A (ed). **Progress in child health.** London, Churchill Livingstone, 1985.

A stimulating paper on the usefulness and problems of producing written material about child health. Common problems with existing pamphlets are that they are produced by professionals for parents; are difficult to read; are unrealistic because they counsel perfection; over-emphasise dangers to health; encourage dependency on professinals and thereby de-skill parents; give conflicting information, all of which is legitimised by reference to scientific findings; and emphasise individual control over health.

The author advocates producing information in cooperation with those it is designed for and evaluating its effectiveness.

5.5 Levane L, Beattie A, Plamping D, Thorne S. **Children's Health Club.** A report from St Thomas' Community Health Council. King's Fund Centre, 1981.

This report describes the development of the club and the methods used to evaluate it. The club was a health education project that used peer teaching as a way of promoting understanding of health and sickness and of developing children's self-confidence. The approach to evaluation focussed on the children's experiences of the club and their contacts with other children and adults. The methods used included participant observation and analysis of critical incidents. The report also identifies some wider dilemmas in health teaching that are relevant to all health educators. There is an extensive bibliography.

5.6 Plamping D. **Learning from children learning:** peer tutoring in health education. Radical Community Medicine, Summer 1986, **26**, 31-40.

A personal account of working with children in the St Thomas' Health Club and of developing methods of evaluation. Diane Plamping describes the principles on which the work of the club was based and assesses the personal benefits of her involvement with the project.

See also: 1.2, 1.3, 1.5, 1.6, 1.8, 1.11, 2.4, 2.8, 2.9, 2.10, 3.1, 4.1, 7.3, 7.10, 8.1, 8.2, 8.3, 8.4, 8.8, 8.9, 8.10, 8.11, 8.12, 9.2, 10.1, 10.4.

6 School health information systems

Computerised information systems are being developed for the whole range of community health services and they can broadly be divided into those which collect activity-based data and those which collect patient-based data. In the developments that are taking place, collecting information about the work of school health staff or on the health of the school child are not usually given high priority. Most systems have started with either under-fives and health visiting activity or elderly people and district nursing caseloads, and have then been extended into other areas of community health work.

While some districts and regions are experimenting with their own systems, the national child health computing system has been in operation for some years and is used by many health authorities. The latest addition to this system is the school health module.

6.1 Winn E and King C. **Making use of community health services information.** Report of a workshop on 3.7.86. King's Fund Centre, 1986.

This is a useful report describing the 'state of the art' of community health services information and the uses to which it is being put. The report includes case-studies from Greater Glasgow Health Board and Newham Health Authority; a discussion on how to ensure that information is useful and usable; and a section of the important factors in establishing information systems. There is also an annotated bibliography with 32 references covering all aspects of information systems.

6.2 Scrivens E. **Management information in the national health service: the use of the child health computer system.** Community Medicine, 1984, **6**, 4, 299-305.

A description of the way the information generated by the national child health computing system can be used for management purposes, for example, by drawing out some of the factors which determine the uptake of immunisation by certain parents and not others. By examining measles immunisation uptake in one district the author highlights areas for further investigation by managers and demonstrates that the information system could have been put to better use.

6.3 Rigby M. **Computing school health information. School care goes hi-tech.** Health and Social Service Journal, 18 April 1985, 486-87.

Michael Rigby (Chairman of the National Child Computing Committee) describes the school health module, the last and largest service delivery element of the child health system. A report on this system was sent to all health and education authorities in 1985. The module, designed by the child health computing committee, consists of a series of sub-routines for medical examination, screening, dental inspection, immunisation and surveillance. In addition there are facilities for arranging re-examination after any interval by staff other than the doctor; and to specify a different location for the recall. A very useful aspect of the system is that the outcome of medical and screening examinations can be communicated to GPs. Each child's GP can receive a simple summary of the key information from each medical examination on a print-out designed to slip into the record wallet. There is also scope for hospitals and GPs to contribute key information to the school health system. A record card for the school can be printed out. The whole system provides a wide range of management and evaluation data including the minimum data sets specified by the Korner committee. This article should be read in conjunction with the following reference.

6.4 Rigby M. **Child Health Comes of Age.** British Journal of Health Care Computing, July 1985, **2**, 3, 13-15.

This article also describes the final module of the national child health computer system, which became available in 1985. It is useful for giving the background to the development of the whole system and its important characteristics.

6.5 Atkins C and Greenslade B. **A local nose on a national face.** Health Service Journal, 7 August 1986, 1053.

South Western RHA has developed a local data base using the National Child Health Computer System as a foundation. The authors list some of the features of the system which include rapid recall of records by a search of name, year, month or day of birth, sex, or school; rapid recording/updating; storage of reference files for vaccination/immunisation etc; workload/performance indicators. It is suggested that there are revenue savings of £10,000 per year net.

Eighty per cent of eligible GPs within the district are now using the system and the authors say that this will eventually lead to reductions in the number of child health clinics provided by the district.

Confidentiality is maintained by using passwords and 'logon' names which are controlled by the child health services manager, and transfer to the regional mainframe computer is done on magnetic tape.

See also: 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.8, 1.11, 4.1, 7.2.

7 Effective practice

7.1 Harding N and Nietupska O. **Auditory screening of school children: fact or fallacy?** British Medical Journal, 6 March 1982, **184**, 717-720.

This article describes research carried out on a single class of 30 primary school children in south London to evaluate the information in school medical records on hearing test results. A high incidence of hearing loss was found. The authors conclude that auditory screening by the school health service (including school medical examination) is ineffective and unreliable.

The authors do not suggest that every service is so poor, but much of what they report may well be typical, eg an excess of ambient noise in the testing room; poor communication between the health professionals. What emerges is a picture that many health professionals in school health will recognise.

7.2 Stuart-Brown S and Haslum M. **Screening for hearing loss in childhood: a study of national practice.** British Medical Journal, 30 May 1987, **294**, 1386-1388.

'A questionnaire survey of all health districts in England and Wales was carried out at the end of 1984 to document screening programmes for identifying hearing loss in childhood. The response rate was 81.3%. all districts performed distraction testing, all but nine aiming to do so at 7-9 months of age. All districts tested children's hearing at school, generally before 7 years of age. The number of times that children were screened both before school and at school varied considerably, from one to six times before school and one to six times at school. Few districts collected information that would allow them to make judgements about the efficiency or effectiveness of their screening programmes.'

'Very few districts were collecting the sort of data that would allow them to make even the most rudimentary assessment of their screening programmes; far less any evaluation of cost consequences or benefits.'

7.3 British Orthopaedic Association and British Scoliosis Society. **School screening for scoliosis.** British Medical Journal, 1 October 1983, **287**, 963-964.

In September 1982 the Council of the British Orthopaedic Association discussed the question of whether to screen for scoloisis. Whilst acknowledging that detection and treatment of the condition are important, after a national survey of practice the association came to the conclusion that it should not be national policy at present to screen children routinely. There is currently disagreement about who should be screened, how and when; because screening has not been properly evaluated.

7.4 Maunder J. **Head lice — a different future.** Midwife, Health Visitor and Community Nurse, 20, 10, 366-367.

This article takes a refreshing look at the problem of head lice and the school nurse's role in helping to control it. The author suggests that 'head inspections' are rarely worth the time and expense involved. Head inspections are continued partly because they are traditional and partly because insufficient consideration has been given to the alternatives. The main burden of both detection and treatment of lice should lie with parents and that nurses should not try to be parent substitutes. The author sees the nurse's role as activating teachers, parents, pharmacists and doctors to tackle the problem and to encourage and sustain them.

7.5 Zeilhuis G A. **Are periodic school health examinations worthwhile?** Health Policy, 1985, **5**, 3, 241-253.

'A review of the literature on periodic health examinations of school children indicates that no proof is available on the effectiveness of PHE. Also the value of other activities such as health education and health counselling, which have been grafted on to school health check ups, is debatable. Health policy makers must make a choice between an entrenched tradition of unproven effectiveness combined with vested interests in PHE in schools, and potential savings which could be reallocated to neglected areas for which more cost-effective interventions are available and feasible.'

Interesting and provocative paper from the Netherlands which looks at the evidence for effectiveness of PHE and discusses the alternatives for safeguarding the health of school children. Targeting is clearly one but this is not explored in any detail. 58 references to international literature.

7.6 Jefferson N, Sleight G and Macfarlane A. **Immunisation of children by a nurse without a doctor present.** British Medical Journal, 14 February 1987, **294**, 423-424.

This article describes a scheme recently set up in Oxford to improve immunisation uptake using a specially trained nurse who visited children in their homes.

Over 16 months 148 children who had failed to complete courses of immunisation were referred by health visitors and GPs. A further 91 children of Travellers' families were also identified as needing immunisation. The nurse carried out 810 immunisations on 237 children in their homes without a doctor being present. The age range was three months to eighteen years. The cost per immunisation, in nurse's salary and travel expenses, was £8.

The risk of anaphylatic reaction has been the main reason why nurses have been discouraged from giving immunisations without a doctor present. The authors argue that a well-trained nurse is just as competent in dealing with anaphylatic reaction as a well-trained doctor.

They conclude that this is an effective and fairly inexpensive way of achieving immunisation for certain groups of children. The scheme shows the possibilities for raising immunisation uptake rates in pre-school and school age children.

7.7 Anderson M. **Preventing rubella in Edinburgh and Lothian schools.** Health at School, 1986, 2, no 2, 40-41.

This article describes a scheme in which all thirteen year old girls had their blood tested to see whether they had rubella antibodies. Those without them were immunised. Parental acceptance of blood testing in Edinburgh in 1984/85 was 99.6%. Of those requiring vaccination 97.5% received it. This method of achieving protection against rubella appears to have been very successful.

7.8 Rubella 85 — Prevention and Protection. Hampstead Health Authority, Summer 1985. Available from Community Health Services, Hampstead HA, 21 Pond Street, London NW3.

This report describes a campaign that aimed to immunise against rubella all girls in their final year at primary school and older girls who had missed earlier campaigns. Uptake rates were successfully increased. There is a useful account of how the campaign was carried out and this could be a model for others to follow. It includes a planned health education programme for schools involved in the campaign.

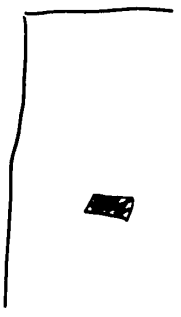
7.9 Davies S. **Children's growth — how and why schools should measure it.** Health at School, 1985, 1, no 1, 28-29.

This article gives the reasons for measuring children's growth and suggests methods which might be used. Some of the disorders which cause unusually short stature are treatable if discovered early enough. To successfully detect abnormalities the author emphasises the need to plot growth measurements on centile charts at least yearly. A summary is given of what makes children grow and of normal growth expectations.

7.10 Turner S. **The Riverside Child Health Project Evaluation Report.** Department of Family and Community Medicine, University of Newcastle-upon-Tyne, 1983.

This report gives a full description and assessment of the work of the Riverside Project. It is divided into 4 parts. **Part I** describes the aims, principles, structures and method of the project; the characteristics of the area; and how the work was evaluated. **Part II** takes each of the four aims of the project and explores how far they have been achieved. Briefly, the aims are to encourage more involvement of parents, improve teamwork, to increase medical care for children most in need, and to use the experience of the project to improve professional training. **Part III** looks at the impact of the project on child health and children's health services. Most of the material is about under-fives, but chapter 11 describes the project's work in schools and nurseries and assesses the effect the the project has had on schools. **Part IV** is a summary and discussion of the evaluation. Suggestions are made for further evaluative work and for changes in the information on child health routinely collected by the health authority and others.

See also: 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.11, 1.12, section 5, 8.8, 8.12, 10.4.



8 Children with special needs

8.1 Education Act 1981 An Act to make provision with respect to children with special educational needs. London, HMSO, 1981.

The Act provides guidance on the assessment of needs by local education authorities and lays emphasis on a multidisciplinary approach to children with learning difficulties. It moves the focus from categories of handicap to meeting the speical needs of individual children.

The emphasis of the Act is on integrating children with special needs into ordinary schools wherever possible and gives parents extensive rights to consultation and access to the appeal committees set up under the Education Act 1980.

In Section 10 the Act states that *'if an area or district health authority, in the course of exercising any of its functions in relation to a child who is under the age of five years, forms the opinion that he has, or probably has special educational needs, the authority shall —*

a) inform his parents of its opinion and of its duty under this section; and

b) after giving the parents an opportunity to discuss that opinion with an officer of the authority, bring it to the attention of the appropriate local education authority.'

It also says that *'If the authority are of the opinion that a particular voluntary organisation is likely to be able to give the parent advice or assistance in connection with any special edcuational needs that the child may have, they shall inform the parent accordingly.'*

8.2 Special educational needs. Report of the Committee of Enquiry into the Education of Handicapped Children and Young People. (Warnock Report). London, HMSO, 1978.

Terms of reference:

'To review educational provision in England, Scotland and Wales for children and young people handicapped by disabilities of body or mind, taking account of the medical aspects of their needs, together with arrangements to prepare them for entry into employment; to consider the most effective use of resources for these purposes; and to make recommendations.'

The Warnock report recommends a unified approach to the education of children with special needs. Up to one-in-five children require some form of special provision at some time in their school careers. A minority of children require special arrangements because of severe, complex or long term difficulties. Recommends that health authorities make adequate resources available to promote effective child health services in ordinary and special schools; and that there should be a named doctor and nurse for every school. Many of the recommendations in this report formed the basis for the 1981 Education Act.

'...we hope that no time will be lost in strengthening health services to schools. We regard a properly structured school health service as essential for all children and particularly for those with special educational needs.'

'The school nurse in both ordinary and special schools can play an important part in the discovery and support of children with special needs. In ordinary schools, part of the school nurse's task is both to inform the health service of needs detected by the school and to ensure that teachers have the necessary information about individual children. Her function in providing health care for children in ordinary schools is particularly important as far as children with special needs are concerned, and will assume greater importance as section 10 of the Education Act 1976 is progressively implemented. Similarly her contribution to health education may be expected to increase in future. For these reasons we see the provision of adequate nursing services to ordinary schools as essential.'

8.3 Special Education Needs: Implementation of the Education Act 1981 Third Report from the Education, Science and Arts Committee, Session 1986-87. London, HMSO, 1987.

The Committee undertook a review of the way in which the 1981 Education Act had been implemented, and found that lack of specific resources had restricted progress.

Wide variation was found among LEAs in the percentage of pupils who are the subject of statements, and in the percentage of children who have their needs met in the mainstream primary and scecondary schools.

'Having arrived at an agreed statement of needs it is not possible for the LEA to ensure the delivery of many of the means of meeting these needs.'

Problems identified by the Committee include

- time taken by health and social services personnel to respond to during formal assessment procedures;
- the relatively low priority given to services for children and schools by the health services;
- a shortage of speech and other therapists in general and of therapeutic time allocated to the education service in particular.

The Committee felt that implementation of the Act should be more effectively monitored and guidance given to authorities. Extra resources are needed, but

'... successful implementation of the 1981 Act is very much dependent on the development by an LEA of a clear and coherent policy, arrived at in a way which enables it to command the support of those-parents, teachers and voluntary organistations - who are most affected by it.'

8.4 ILEA. **Educational opportunities for all? The report of the committee reviewing provision to meet speicial education needs.** (The Fish Report). London, ILEA, 1985.

This lengthy report, which thoroughly reviews the range, quality and coherence of provision to meet special educational needs in ILEA schools, gives an excellent background to how services have developed in the 1980s since the Warnock report and the 1981 Education Act. It is divided into three sections, the Committee's approach, current provision, and future developments and recommendations.

There is a chapter on voluntary agencies, health and social services and the emphasis is on improving interprofessional collaboration; clarifying for parents the distinction between medical and educational assessments; and developing clear lines of communication between agencies and with parents. The chapter includes a review of parents' experience of child health services. Some parents felt they received too little information about their child's medical needs and that the picture they were given of their child was too pessimistic. Others, however, had received considerable personal support from child health serivces.

'Most special schools in the ILEA have adequate health services provision although there is uneven provsision of some paramedical services. ....However, the main issues brought to the Committee's notice are related to services in primary and secondary schools. These include the relatively infrequent follow up of individuals with medical conditions identified in the examination made on entry and the lack of information about the educational implications of these conditions made available to schools.'

There are many recommendations for future developments which have implications for school health services. This report is well worth reading to get an overview of services for children with special education needs. Also includes examples of good practice.

8.5 Education Act 1981. The law on special education. Advisory Centre for Education, (undated). ACE, 18 Victoria Park Square, London E2 9PB Tel: 01-980 4596.

This is a well-presented short guide to the 1981 Education Act and would be useful to have for reference purposes if a copy of the Act is not available. It gives information on where to find out more and gives the historical landmarks behind the development of special education in Britain since the 1960s.

8.6 The flaws in the 1981 Act. Childright, 1985, October 15-18.

This article, written four years after the implementation of the Act, suggests that it has so far failed to end discrimination against children with disabilities and other significant difficulties. It examines the current law covering 'children with

special educational needs' measures up to principles of human rights; and at problems raised by the interpretation and implementation of the law.

8.7 Wilson M. **The Education Act 1981: Progressing Education.** Midwife Health Visitor and Community Nurse, 1986, **22,** 218-221.

This article written by a director of community nursing services describes a survey of the 14 english regional health authorities and Wales to to find out how the Act was being implemented. The results showed great variations throughout the regions.

8.8 Watkins B. **Pulling down the barricades on Broadwater Farm.** Special Children, July 1986, 18-20.

This short article is written by a principal educational psychologist in Haringey in London and describes a research project to integrate Down's Syndrome children into mainstream schools. It is useful for those who are involved in such projects as it highlights good and bad practice. The analysis shows that there was a tendency for the children to do better in mainstream schooling than their friends who were placed in special schools. This is heartening for those trying to integrate children with special needs into mainstream schooling.

8.9 **Across the field.** Special Children, August 1986, 8-9.

A neighbouring primary school and special school in Coventry, which had had little contact in the past, started sharing activities and exchanging experiences. The article describes how.

8.10 Waldron S. **Integration of handicapped pupils.** Nursing times, 1983, April 13, 54-56.

This article is written by a school nurse and describes the integration of two children with spina bifida into mainstream schooling. The author discusses the practicalities of this; what arrangements were made in the school; what further education she needed; and how the girls had an influence on general attitudes towards those with special needs.

8.11 Pratt L. **Integrating the child with spina bifida into school.** Health Visitor, 1984, **57,** 242-243.

A school nurse describes spina bifida and hydrocephalus, their incidence and the special learning difficulties they give rise to. The role of the school nurse is discussed. The article also looks at the health risks to children with spina bifida and hydrocephalus in ordinary schools.

8.12 Trend U and Nicoll A. **Disabled children in a comprehensive school.** Health at School, January 1987, **2,** 4, 102-105.

This article by two doctors looks at the integration of five physically handicapped children into a mainstream secondary school. To look at both the successes and weaknesses of the integration process, information and opinions were sought from the five pupils, their teachers and parents. The study found that the 'helper' and school nurse played a key role in good integration, and that the children were making good friends with the able-bodied children. Many lessons were learnt from the study.

See also: 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.11, 1.12, 5.2, 7.1, 7.2.

9 Health services to secondary schools

9.1 Crouchman M R. **The role of the school medical officer in secondary schools.** Journal of the Royal College of General Practitioners, 1986, **36**, 322-324.

'This paper describes the children seen during a typical morning session in a London girls' comprehensive school. Although many of the problems are similar to those encountered in general practice, it is argued that these children, who give rise to considerable anxiety among teaching staff, would not present to their family doctors. The way in which they are managed requires particular skills in understanding of the complicated interaction between adolescents, their families, and their educational environment. With the move towards primary care child health surveillance, and the appointment of consultant community paediatricians, the future of the school health service is under debate.'

9.2 Cherry N, Gear R and Walden H. **Occupational health and the school leaver.** Community Medicine 1983, **5**, 1, 3-10.

This article looks at the important but rarely discussed area of health child on leaving school and entering employment. It describes the present system of identifying young people with health problems, the role of the Employment Medical Advisory Service, and gives a good background to the legislation surrounding this area. The problems are examined and possible solutions discussed. The authors suggest that there should be a more broadly-based approach to occupational health problems in school and that all young people should be better informed about health and safety at work, and the structures such as the Health and Safety Executive.

The authors suggest four steps that can be taken by policy makers and professionals in order to remedy the problems they found in their research. The steps are: introducing occupational health as a module within the school careers education programme; the identification of young people at risk through the development of a specifically designed questionnaire; improved medical screening of those identified at risk by teachers, with more training in occupational medicine; and the provision by the Employment Medical Service of individual advice to the young people referred from the screening service (very few children identified are followed up at present).

See also: 1.2, 1.3, 1.5, 1.8, 1.11, 2.1, 2.4, 4.4, 5.4, 7.10, 8.4, 8.12, 10.3, 10.4.

10 Health promotion in schools

As this is a specialised field, the papers listed below are a limited selection of review articles that raise questions about the focus, organisation and effectiveness of health education in schools. Those who need to know more about health education programmes and materials for use in schools should contact the Health Education Authority, which provides a free list of publications on health education and young people and a guide to HEA projects and resources, or the local health education unit. The Health Education Authority is at 78 New Oxford Street, London WC1A 1AH.

Good sources of information on current practice in health promotion in schools are the *Health Education Journal* and the monthly journal *Health at School.* Recent issues have included papers on healthy eating; teaching about Aids; drug and solvent abuse; and cigarette smoking. Some of the

papers describe special projects and these would be particularly useful for school health staff who are searching for ways of improving practice.

10.1 Moon A. **Pictures of health.** Nursing Times, 7 January 1987, 49-50.

An interesting short article describing how the Health Education Council's primary schools project discovered which health issues primary school children wanted to learn more about. The results didn't always match what teachers and others felt they should learn about.

'The primary schools project is unique because it aims to start with the child, making sure that the health messages it promotes are relevant to his or her experience, age, ability and stage of development.'

The project team is preparing information about school-based health education, including handbooks that will be useful for school nurses.

10.2 Turner R. **Healthcare goes back to school.** Health Service Journal, 24 July 1986, 992.

Describes South Birmingham Health Authority's health education centre and the appointment of a schools health education adviser, jointly funded by the LEA and HA.

10.3 Williams T. **School health education 15 years on.** Health Education Journal, 1986, **45**, 1, 3-6.

'The publication of three major reports on education during the 1960s coincided with the creation of the Health Education Council, and the appointment of health education officers. The schools health education project, the Teachers Advisory Council on Alcohol and Drug Education, and the HEC my body project stimulated the further advancement of school health education during the 1970s. The role of the school coordinator of health education, and the use of lifeskills training and tutorial based methods, were strengthened during the early 1980s. If this success is to be sustained, coordination and planning need to be improved.'

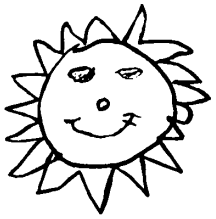
10.4 Reid D and Massey D. **Can school health education be more effective?** Health Education Journal, 1986, **45**, 1, 7-13.

'This paper reviews the evidence for the effects of health education on health related behaviour, with special reference to NHS support for schools. It concludes that effectiveness has considerably increased, especially in relation to smoking, dental health, rubella immunisation, sex education, and even family health as a whole. Schools may also have a significant role to play in education concerning nutrition and exercise, but positive results from alcohol and drug abuse programmes remain hard to find.'

Further improvements are possible if greater attention is paid to in-service training; support from peers; cooperation with services; parental involvement; timing of appropriate lessons; school policies; and teacher attitudes to health education. Of these seven factors, particular importance is attached to cooperation between schools and local services, and to timing, especially in relation to better provision for the 11-14 age group. Finally, health programmes for teachers themselves might prove a particularly valuable investment of scarce resources.'

This article has 66 references.

See also: 1.2, 1.3, 1.5, 1.11, 2.4, 4.4, 4.5, 5.4, 7.8, 9.2.



CHANGING SCHOOL HEALTH SERVICES

This information pack has been compiled for managers who are reviewing and developing school health services: