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PROVIDING HEALTH CARE DURING SCHOOL DAYS

Report of a Conference held at the King's Fund Centre
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PROVIDING HEALTH CARE DURING SCHOOL DAYS

(Chairman: Miss Winifred Frost)

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1. INTRODUCTION

The conference delegates were welcomed by Miss Hazel O Allen, Assistant Director, King's Fund Centre, and introduced by the Chairman, Miss Winifred Frost, Area Nursing Officer, Bedfordshire Area Health Authority. Miss Frost started by introducing members of the Panel: Mrs Jean Watts, a school nurse in South Lincolnshire, Mrs Gaynor Simpson, who, although a teacher by profession was present in her capacity as a parent, and her daughter Helen, a pupil, and therefore described by Miss Frost as being at 'the receiving end of the Service'. Miss Frost then introduced Miss Patricia Slack, Area Nursing Officer Kensington, Chelsea and Westminster. She said that Miss Slack was well known for her publications and mentioned that those who had read her editorial in one of the Nursing papers a fortnight ago would know that it was a very well-balanced article and indeed very stimulating from the point of view of the conference. Miss Frost next introduced Dr Esther Simpson as a former Senior Principal Medical Officer at the DHSS and also the DES, and although Dr Simpson had retired (not so long ago!) she thought the audience would receive from her a lot of help and stimulating ideas in their discussion. Finally Miss Frost introduced Mr John Tomlinson, a member of the Court Committee, the Director of Education for Cheshire Education Authority, and Chairman of the Schools Council. The fact that he was also a parent she felt sure would add weight to his contribution. Miss Frost said that she had readily agreed some months ago to chair the proceedings and 'brave the sound of distant drums', but

when the time came nearer, not only had the sound of those drums got very much louder, but during the past few weeks they had been accompanied by a whole orchestra of contributions referring to school health, whether these were nursing, education or social services and thus she felt the conference itself was timely. She also felt the Panel of Speakers would be a rock of strength to help her through the day's activities. As Area Nursing Officer she had learnt a lot about co-ordination since 1974 and as a result would try to chair the day's proceedings in order to keep to the time-table.

Her job, continued Miss Frost, was to set the scene and to paint the backcloth, and in looking at the provision of the Service and the evolution of school nursing, there were some very interesting facets indeed. She quoted from the initial communication sent to members in July that the conference 'aims to give an opportunity for school nurses to discuss their part as members of the School Health team, working closely with the Primary Health Care Team, the contribution the nurse can make to the health needs of school children and their relationships with teachers and parents.' All this was the essence of school nursing, and much enlightenment would come from the Panel of Speakers.

2. SETTING THE SCENE - EVOLUTION OF SCHOOL NURSING

The Chairman said there seemed to be little or no need at this conference to dwell on such things as management, accountability and salaries, and that personally she would avoid them. She felt everyone was here today with a common

purpose because they were committed to the necessity for school health, and one of the important things she had to do was to dispel any idea that the School Health Service began on 1st April 1974; indeed the present position was reached by a long process of evolution - a fact that could not be stressed too much. As in so many fields of human endeavour provision for the health and education of this country's children was first made many years ago by the pioneering efforts of private individuals, singly or in association. Religious bodies played also a great part. They established many Church schools, which remained a very effective force in education until well into this century. The Poor Law too made a contribution by its workhouse schools, which again continued into the 19th century. Some nursing support was provided even in the year 1700. Thus at one workhouse it was ordered that 'the nurse shall cause all children under their care above three years of age, to be up, have their hands and faces washed and their heads combed with small tooth combs every morning, so as to get to school at 7 o'clock.'

In 1880 Elementary Education was made compulsory. Mainly as a result of this millions more children attended school. Between 1870 and 1890 the number increased from 1¼ million to 4½ million. Many of the children were in such poor health that their education was adversely affected. Gradually steps were taken to remedy this. School doctors began to be appointed and this can perhaps be regarded as the first step towards a school health service, but it fell very short

of actual requirements. However by 1905 there were 85 school doctors and if we look at the population of school children they were serving then today's development gives room for thought. In addition, interest in handicapped children increased and by 1905 there were about 300 special schools with 17,000 handicapped children.

Soon afterwards, following reports by a Royal Commission and two Interdepartmental Committees, the decision was taken to establish a School Medical Service organised on a national basis. In 1907 Local Education Authorities were given the duty to provide for the medical inspection of children in public elementary schools, and the power, subject to approval, to provide school clinics, and meals for children attending elementary schools who were unable to take full advantage of the education provided owing to lack of food. There is no doubt that the poor state of health of recruits for the South African War was instrumental in prompting some of this activity.

In 1918 the Local Education Authorities' duties were extended to include the treatment of children in elementary schools and power was given to inspect in secondary schools. With the development of the service came the need to provide adequate medical and nursing services.

In 1944 yet more steps were taken. A duty was placed on Local Education Authorities to provide school meals and milk for pupils at schools maintained by them, to provide medical and dental treatment in all types of maintained primary and secondary schools and the duty to provide or secure for

children all forms of medical and dental care without cost to the parent.

The Service had travelled a long way since 1907, when medical inspection was first imposed as a duty. The State may have appeared slow in providing care, but from the beginning there has been some vision of future needs. Thus, one of the stated objects of the 1907 legislation was 'to stimulate a sense of duty in matters affecting health in the homes of the people, to enlist the best services and interests of parents.... It is in the home, in fact, that both the seed and the fruit of public health are to be found'.

The team concept of health supervision of school children was formed in the Medical Branch of the Board of Education almost 70 years ago, so the Briggs Committee did not invent the team concept, it developed it, but it did not invent it.

The School Health Service has always concerned itself with handicapped children and especially so during the last 25 years, and a lot of historical fact supported this. Well defined categories and District Handicap teams have developed but there are not nearly enough of them.

In all that had been mentioned the school nurse had played a vital part, working in close association with the school doctor from the very outset. The character of the work had changed with changing needs. In the early days it was mainly clinical, but as the health of the children improved the school nurse began to undertake more work of a medical social kind and to become involved in the early ascertainment of handicap, and with health education. In

recent years, however, an extended role, e.g. in screening and immunisation, had taken up much of her time.

Miss Frost said one must remember that the school nurse was a member of a team which included the school doctor, teacher and parent at all times; and as the need arose, educational psychologist, speech therapist, audiologist, and other professionals. There was now a suggestion that there existed a case for including the school nurse in the Primary Health Care Team. This suggestion and also the matter of Team Concept would be discussed later.

Miss Frost repeated that she would not like the conference to get 'bogged down' by questions of accountability and management. That, however, did not prevent us looking at the roles of health visitor and school nurse in school nursing.

The 1945 Regulations said that all school nurses (except existing school nurses and those employed solely in school clinics, in boarding special schools or in specialist duties) should be qualified health visitors, but there were saving clauses then, because it was recognised that there were manpower problems and all kinds of difficulties.

In 1977 the Chief Nursing Officer of the Department of Health and Social Security stated that the health visitor was the leader of the team which may include S.R.N.s etc. working in schools and clinics. She added that the school nurse was involved in the health surveillance of school children of all ages, and in some cases she would work direct with the health visitor; and what Miss Frost was hoping to stress was the flexibility of that particular statement. Nevertheless

as Chairman she had to be totally unbiased.

In the editorial in this month's 'Health Visitor' it was pointed out that working relationships, responsibilities, and practices of the community nursing team (that is health visitors and school nurses) for infants, young children and school children, varied throughout the country and the question was asked if the time had not come to consider the identification of the individual responsibility for each professional with each age group. Should the health visitor, in addition to her unquestioned commitment to children under five years of age, aided by untrained staff, resume total responsibility for the health of school children or should the school nurse, with her state registration, be given a recognised training and opportunity to pursue a career in a field where she can become expert? The demands on the health visitors were such that there was a need to determine how much time would be left for school health. The editorial added that 'there is room for the school nurse and her career, alongside her health visitor colleagues and she should be welcomed.'

Miss Frost said she did not think she could do any better than quote or end her talk with some words from the Court Report which were: 'it is the mark of the human species that our young are born incomparably more immature than the young of other species'. It continues 'that is why the quality and philosophy of health, education and other care available to the child and his family are so important.' The Court Report also says 'we have found no better way to

raise a child than to reinforce the ability of his parents to do so... parents need to be made aware of learning (in the widest sense) that goes on day by day through experience and their part in it. Future improvements in the health of children will depend as much on the beliefs and behaviour of parents as on the services provided.' Those were very telling words and we at this conference could do very well to remember them in relation to school health. Just one more point that was made in the Court Report and one more quotation which again was an important one - 'many parents have to contend with circumstances which grossly hamper their natural and acquired ability to be good parents, and many children are crippled by circumstances.... We now know that the effects of early disadvantage can be much diluted... and it is especially worth making this corrective effort because early disadvantage tends to lead to later disadvantage.' Words which were part of a philosophy on which the whole of the Report was based. It was the Chairman's firm belief that these words would, in her view, have an important place in the continued evolution of the School Health Service.

Furthermore she hoped she had succeeded in just giving the audience a backcloth because the real pictures were now going to be painted on that backcloth by her colleagues round the table.

3. A SCHOOL NURSE'S VIEW OF THE SERVICE

The third speaker was Mrs Jean Watts, School Nurse, South Lincolnshire.

Mrs Watts said she was very glad to have this opportunity to speak to the delegates at the conference, as it was her experience that very few people outside the Service itself knew exactly what was the School Health Service. She believed that only school nurses themselves knew precisely what school nurses actually did, so she would try to make the most of her time to relate what she thought were the main failings of the School Nursing Service at the present time and what was being done to try to improve it.

In South Lincolnshire it had become apparent that for some time there was discontent and lack of job satisfaction amongst school nurses. They had become aware also that the service they were offering to the school child was falling far short of the ideal, so they decided to do something about it. In June 1979 she and her colleagues in the Boston area of Lincolnshire organised the first National Conference for school nurses, which was attended by 300 nurses and managers from all over the country. From this conference and from talking with colleagues they gained two outstanding impressions of the School Health Service:

First, despite the fact that they all had the same aim, which was the welfare and wellbeing of the school child, in respect of the role of the school nurse there was complete lack of uniformity throughout the country. Each area had its own standard of child care and nurses had a bewildering variety of titles and qualifications and even two salary scales.

Second, the school nurse had gained the impression that some education authorities, head teachers and teachers were unaware and consequently disinterested in the part played by the

school nurse, and the very important role she should be playing in ensuring that none of the children in her care suffered educationally because of any physical or emotional shortcomings. Nothing should be too good for the children in their care. Children were an investment in the future and they could not function if they were unhappy. Thus from these observations Mrs Watts and her colleagues concluded, that in order to improve the School Health Service there was a dire need for a nationally recognised training for the school nurse, thus encouraging career-minded and highly qualified nurses to enter the Service, and to put an end to the employment of nurses who regarded the School Nursing Service post as an easy option with convenient hours. (They did not know how much, if any, insight student teachers were given into the value and role of the school nurse and School Health Service, but they suspected that many teachers were under the impression that school nurses still functioned only as 'nit nurses'.)

Mrs Watts would like to think that in the future the function of the School Health Service and the role of the school nurse would make a significant appearance in the Student Teachers' curriculum. There were, of course, many agencies involved enabling us to offer the service we felt the school child deserved.

In South Lincolnshire she and her colleagues were very fortunate in the backing they received from their managers, hospital staff, specialist agencies and all members of the Primary Health Care Team with whom they worked very closely. Over the past two years they had been taking a long hard look

at the service they were giving to the school child and as a result had set up working parties to examine all aspects of child care. The school nurses had been closely involved in all discussions, and ideas had very largely been implemented resulting, they felt, in a steadily improving service.
Their first contact with the children for whom they would be responsible came at the age of four and a half years with a pre-school assessment. This was a continuation of the developmental assessments carried out by the health visitors from the child's birth. The meeting allowed the children to get to know the school nurse and for her to introduce the mother to the School Health Service and what it had to offer. From then until the child left school the school nurse visited the schools frequently, either for Health Education sessions, hygiene and general health inspections, vision testing or selective medicals with the school doctor and for immunisation sessions in the Senior Schools. Mrs Watts mentioned that they had only recently changed over from the routine medical inspections for the 10 to 11 year-olds, when all children in this age group were examined, to what they felt was a more valuable procedure, namely, the Selective Medical.
Instead of examining hundreds of healthy children, the nurses' time was more profitably spent on children with problems. In this they involved the parent, the teacher and any other specialist agency they thought necessary. At the same time surveillance checks were carried out on selected age groups. Reappraisal of the value of the school-leaver's medical was also made, and it was anticipated that in the future

this could be replaced by an interview with perhaps the school nurse, the school doctor and the career's officer, bearing in mind their future employment, and with the aim of trying to fit square pegs into square holes. Mrs Watts said that she personally did a great deal of home visiting on behalf of children with problems, partly so that she could remain in friendly contact with parents and also to gain an insight into the home background. These visits also provided valuable liaison between school and home when the parents were reluctant to visit. In some of their Infant Schools, the school nurse was a welcome visitor at Parents' Afternoon when new entrants were introduced to their teacher and classrooms. During this session Mrs Watts said she chatted with parents, heard of any health problem which was likely to affect the child's performance in school and talked to the mother about her job as school nurse and her availability in the future. Head teachers were also glad to see the school nurse at school concerts, plays, and Parent-Teacher Meetings. By being involved in the social life of the school, she and her colleagues liked to think they were accepted as a friend of the school and the school child. As education for parenthood starts early in life they hoped they were playing their part in helping the children to become in their turn happy and caring parents.

4. A CONSUMER VIEW OF THE SERVICE

The fourth speaker was Mrs Gaynor Simpson, a parent and teacher.

Mrs Simpson said that as a parent she felt that the School

Medical Service appeared to be somewhat impersonal, although it provided an excellent screening service for the children. She continued by stating that although she might be rather out of touch as it was three years since she had taken her youngest child to be medically examined. She said that often one felt a trespasser on those occasions, due to the attitude of the school concerned and not the medical staff. One felt rather a nuisance having to enter the school, and was often shunted into a rather small, poky room, climbing over gym equipment or interweaving with clothes hanging from coat pegs! The children, she added, became quite apprehensive, not the children whose parents were there, but the children whose parents were not there. Here she felt, the fault lay, not with the school but with those particular parents.
Mrs Simpson realised that the doctors and nurses were extremely busy. Nevertheless they did their utmost to make the examinations enjoyable, but she still felt it was a pity the schools were not more welcoming in providing facilities and time.
She would like to see a meeting of children and mothers with the school nurse who could explain how the Service functioned and what facilities were provided. Mrs Simpson was also concerned that during a child's stay at the Infant and Junior School, the teachers were not more familiar with problems that could arise. They should become more involved, not simply leaving it to the school nurses to pick up the needy children. The teachers themselves would perhaps refer children with disabilities to the nurse, but she knew of cases

where this had not happened. For instance when a child had impaired hearing (because of the informal teaching methods in Junior Schools at the present time, for example, not sitting in rows looking at a blackboard) it was often difficult for the teachers to pick out a child not now sitting at the back of the class who could not hear.

During the last two years from observations made in the Junior School, Mrs Simpson went on to say that she would like to see Health Education introduced into the curriculum. As a teacher she realised that the curriculum was ever-expanding, covering new topics, but with the early development of children it was often too late to start this topic in Secondary Schools. Mrs Simpson said she was trained as a Home Economics teacher, doing a small amount of Health Education which she taught in Secondary Schools. This was fifteen years ago, and she now understood that if she were to teach in secondary schools it would be too late for her to start introducing Health Education perhaps in the second and third year.

She related how her children attended a school where one afternoon a week they had Creative Studies. The year was divided up into groups and the children enjoyed informal lessons in several of the crafts; she felt this would be an excellent field in which the school nurse could participate, with small groups and the use of illustrative material, in worthwhile discussions and talks with the pupils.

The fifth speaker was Mrs Simpson's daughter Helen, a pupil. Helen said she felt that the school nurses and dentists did

a good job because if any child needed to visit the optician or dentist they were then sent for treatment. She thought, however, that it would be a good idea if the child could be told what was to be done and what they were looking for. It would also be interesting if they could be told what the chart meant on the dental card when they went to see the dentist for their teeth.

5. WORKING IN AN EDUCATION SETTING

The sixth speaker was Mr John Tomlinson, Director of Education, Cheshire Education Authority.

Mr Tomlinson said that if he had any right to be present at all, which he doubted, it was only because being on the Court Committee had taught him a great deal, and as the Chairman had already made it 'fashionable' to quote from Court, he hoped to be allowed to do so in the same way. There was no statement anywhere of what doctors and nurses should be trying to do in educational work, so Court had created a classic definition, he thought the only one, and he would remind the audience of it:

> 'Educational medicine is the study and practice of child health and paediatrics in relation to the processes of learning. It requires an understanding of child development, the educational environment, the child's response to schooling, the disorders which interfere with a child's capacity to learn and the special needs of the handicapped. Its practitioners need to work co-operatively with the teachers, psychologists and others who may be involved with

the child and to understand the influences of family and social environment.'

Mr Tomlinson explained to the delegates that Court went on to say quite firmly it was their belief as a Committee and his as an educationalist that 'Every school needs to have a doctor and a nurse nominated as their school doctor and their school nurse who are suitably qualified and knowledgeable about educational medicine and nursing and have sufficient time to get to know their schools and meet the teachers regularly.'

Mr Tomlinson said that was where he stood and that he did not feel in the least defensive. He was not present to defend education practice, he agreed with all that had been said about the problems that occur and he would not be speaking today if he thought there was not room for improvement.

He referred to a remark made by the Chairman that the School Health Service did not start on April 1st 1974. He thought many people in Education considered it stopped then! Therefore he was delighted that this seminar was being held, and that he was able to contribute to some extent.

His belief was that schools have very little contact with their doctors, and that the School Health Service was the front line. Indeed often the only line of the Health Service that was operational was the school nurse so far as the ordinary practising head or school teacher was concerned. It seemed to him that there was need to recognise, strengthen, and organise the school nursing service according to known

principles and to acknowledge the good practice which had been accumulated.

Mr Tomlinson then said that there were three essential activities which were really key from an educationalist's point of view for the school nursing service:

1. A proper kind of interaction with Head and staff, so that each side deepened and extended their understanding of each child by ensuring that health aspects of emotional and physical development were recognised so that their education could be improved.

2. A continuing health surveillance of individual children. He had no idea of the situation over the whole of England but his impression was that since health visiting typically finishes when the children reached the age of five, the only involvement of community health workers with the family these days was through the child's school, and that was an enormously important link which must be recognised and developed. There was a need to give personal health counselling to children too.

3. The encouragement and support of parental involvement; helping teachers to be more confident in the way they worked with parents because teachers on the whole felt threatened by parents, just as parents felt threatened by teachers. Another adult who was trained coming in, helping and working in the school environment might very well be able to do much to create that good relationship.

Mr Tomlinson had asked himself what were the conditions that would be needed if his listeners were to fulfil the kinds of

objectives about which he had talked, and it seemed to him that they consisted of three categories:

1. There must be an understanding among the nurses as to how schools were working and why they were trying to work that way.

2. In addition there should be an understanding by the school teachers and the schools in general, as to what it was that the health workers, particularly the nurse, could best contribute and the methods to use to make that contribution.

3. The creation of an organisation for implementing the first and second points which brings health and education workers into regular and mutually supportive contact.

Mr Tomlinson then went on to consider these categories in more detail:

It seemed to him that there had been such a change in the way that teachers tried to work and organise their schools that there was a very strong need for some kind of generic and continuing training of the caring professions working with children and parents so that they understood each other's approaches to children better.

Without really trying very hard, Mr Tomlinson found himself stating, for example, that teachers now tried to obtain more understanding of how the environment affects the acquisition of intelligence. We had abandoned the notion that intelligence was fixed and innate, so that meant avoiding early judgement, and avoiding premature specialisation.

Appreciation of the individuality of children and how their

personal rhythms of maturation - emotionally and physically as much as intellectually affects their capacity to learn. The importance of differences in temperament in children for their span of concentration and their style of learning. The importance of the adult-child interaction and the way in which we now tried to vary the experience the children had of different adults, so that all did not depend on one relationship which might not be a good one for that particular child. Mr Tomlinson stressed the importance of the level of expectation which we set as adults. Set it too high and we created a sense of failure and rejection; set it too low and we created over-easy success and apathy. The great art of being either a parent or a teacher was to make children reach just that little bit further than they thought they could, but which you knew they could.

Mr Tomlinson then referred to the slower rate of maturation of boys compared with girls - he said they had sinned against boys again and again in the educational system. One had only to look at the remedial classes in schools, which were overloaded with boys, just as the penal establishments in this country were filled with men.

Mr Tomlinson continued on the theme of the impact the school's attitude and values had on the children; how they saw the way in which they were being treated, whatever the teachers pretended to be saying to them or doing with them. It was the way the school was organised which created the values and the experiences which came through to the children, what was known as 'the hidden curriculum', and if

those at the conference wished to read more about it, he suggested Michael Rutter's marvellous book 15000 Hours which analysed why some schools were good for children and some were bad. Parents on the whole chose the bad schools because it was the bad characteristics which were traditionally thought to be the good ones. Thus there was an enormous amount to learn about how to help children, to learn what teachers were trying to do, and how it interacted with their kind of work.

Mr Tomlinson then referred to the understanding teachers need of the contribution health workers can make, what the Health Service could do, and here he agreed entirely with what Mrs Jean Watts had just said. His experience was that teachers on the whole were understanding about specific matters such as impaired hearing, eyesight, surveillance of health, courses of drugs, and so on, but weak on understanding or insight into the problems that were really intractable and loomed very large for all teachers, namely emotional, psychological, social, and family problems. Those in fact which really oppressed teachers and prevented children learning. So Mr Tomlinson emphasised that he felt family problems played an extremely important part in the caring professions. He quoted from a document that had come into his hands from a school in his own Authority, a school that was not an educational priority school, but was an 'ordinary' primary school where the Head was recently moved to write and say 'I have found that 39% of my children have got ghastly social and personal problems'. Teachers need and want help. Mr Tomlinson illustrated his point

by reading several case histories, because he felt that the delegates needed to share with him the memory of this morning, just as they needed to remember the backcloth which others had given.

Children in the first year of the school (a primary school): 'Attending school afternoons only at the special request of the Health Authorities (the child was too young to go to school). Father has a nervous breakdown, is an outpatient at the local mental hospital, drinks heavily, mother an alcoholic, not registered. Mother withdrawing, child not mixing.'

Next child: 'Only child of a second marriage, mother older, father very young. Six children by a previous marriage. Only one child opted to live with mother. Mother drinks heavily and is involved with her racing greyhounds spending a long time at the dog track. Brian is showing signs of extreme nervousness and disturbance; then an extra note: Brian involved in a road accident, broken leg, mother adds to distress.'

'Damon and Paul. Mother unmarried. Three boys in the family, middle subnormal attending special school. Known to have been involved in drugs and to hurt children when in difficulties or under stress. Different fathers for each child and mother still associates with a number of men. Paul fantasises (who blames the poor little child?). Light-fingered and hoards treasures.

Next case history: 'Father constantly in and out of prison, involved in brutal assaults, mother now refusing to live with him.'

And lastly: 'Nicola born during the break-up of her father's

previous marriage. Very disturbed, severe disturbance from the beginning of this marriage. Father a heavy drinker and extremely aggressive, mother therefore very short of money. She, herself, is the child of a disturbed family with no father. Grandmother has a history of mental illness. The whole family are involved in black magic, which has a terrifying effect on the mother. She impulsively leaves home at times. The school was instrumental in bringing her back the last time. The two children have nervous asthma.'

Mr Tomlinson continued that obviously his listeners would need to have greater insight and the need to relate to teachers if they were going to be successful. He then referred to organisation.

First of all within the school, he felt the idea of nominated nurses absolutely essential. It was only stable relationships which achieved anything in his experience. Constant changes of people were counter productive. There must be a total acceptance of a nurse as a professional colleague in the staffroom - where this occurred and it happened a great deal - it was a positive step. The knowledge which some of those present had was needed especially since the advent of Special Schools, and even more so in the ordinary school.

Mr Tomlinson referred to the Warnock Report which showed that 20% of children had special needs, of those only 2% of the total were in Special Schools, the rest were in ordinary schools. These children were not being dealt with properly by the teachers, who were not adequately trained. Yet again the nurse's contribution was paramount.

Health education in the curriculum had been mentioned. Of

course it must start young, the Schools' Council, of which he was chairman, had two marvellous projects which were now in 35% of Primary Schools - Thinking Well and All About Me. They were creating a demand and that demand had got to be met, otherwise the teachers would be turned off because they could not gain the knowledge and ideas they wanted. There was an enormous area of out-of-school contacts, the penumbra of working with parents in an informal relaxed supportive way between nursery, free school, play group, health visitors, school nurse, GPs, if one could get them to take part, and social workers, was on the increase. The Open University programmes were beginning to form a centre for that and the Health Education system in Cheshire, said Mr Tomlinson, was such that mothers would attend, even the most deprived mothers, providing the project was held in somebody's home and was not called Child Development. (It was called About Bringing up the Kids), also that teachers and nurses did not talk didactically to them. In this way parents began to think about what the real issues were; thus a whole range of new techniques of relationship was involved.

There was a need for an operational management base whether it was a district office in a big county or an area office, or even the Centre in a Metropolitan district which had contact with general administrators and school advisers. At the planning level, which was the Educational Authority of the Area Health Authority, there was a need to have some kind of Standing Group, said Mr Tomlinson, which deal with

interdisciplinary health thinking; education and the social services.

Now how to achieve all this? There was a great deal being done already. Much of it had been heard this morning, but it seemed to vary across the country and good practice was rare.

Mr Tomlinson said it was good to learn for oneself and that to some extent everybody had to go through a process of learning so as to understand why they must work that way. Nevertheless, he thought, there was nothing like success to encourage people and urge them towards a greater fulfilment in their work, thereby benefiting both children and their parents. He thought some kind of continuity was important, particularly in the period of contraction which we were now all facing; there was a grave danger of slippage unless a conscious effort was made to resist it, and stick to certain principles and to pursue them.

(a) Firstly there should be more planned interdisciplinary training both in the initial stages and the in-service stages. Mr Tomlinson would like to see school nurses and teachers participating in joint training, thus helping to teach one another.

(b) As to <u>organisation</u>, Mr Tomlinson did not think it mattered to the Education Authority of the schools how one chose to organise one's School Nursing Service. He realised there were different ways of doing it. He found some that had been very satisfactory, others had found different ones equally satisfactory. Mr Tomlinson said he was unbiased as it was

not his business as a Director of Education to express a view. What he wanted to achieve was an efficient Service; but regular contact and shared experiences of training and working together were essential. However, if the nurse could not participate in curriculum planning and training within the school, then failure would ensue.

At Management Level, Mr Tomlinson continued, the Local Education Authority, the Area Health Authority, still an imperfect connection in most places, must recognise the need for regularly linking their planning and training schemes. Where these schemes were carried out properly, interdisciplinary training planned and where there were Standing Meetings of Primary Health Care Teams and so on, an enormous amount could be achieved.

Mr Tomlinson concluded on an optimistic note that the professionals were now much clearer about what children needed and how these needs could be met; also the necessity to work with and through parents far more than hitherto. This would have to be done in a non-authoritarian way combined with discreet guidance. We as professionals were more confident in our abilities and thus through our efforts Mr Tomlinson believed we could learn the art of co-operation (people find co-operation difficult if they feel threatened. They feel threatened if they have not acquired the self-confidence of their own position and their own discipline.) Ironically it is first necessary to obtain co-operation by ensuring that professionals themselves are very well trained and confident of their role. In this way

knowledge was formulated of where the boundaries lay and when they should reach across them for others to come and help. It was this kind of approach which involved both authorities - Health and Education - and in addition the Social Services. It would be necessary to use this method of work in order to obtain their own personnel, and from trained first-class practitioners create first-rate professionals.

6. CO-OPERATION WITHIN THE SCHOOL HEALTH SERVICE

The final speaker of the morning was Dr Esther Simpson, formerly Senior Principal Medical Officer, Department of Health and Social Security.

Dr Simpson said that first of all she would like to endorse much of what Miss Frost, the Chairman, had said. She thought people did not know the long and honourable history of the School Health Service, and because they did not understand it, they tended to disparage it. In many ways the School Health Service was the forerunner of a national Health Service, though such provision was limited at first to children in elementary schools. This was 40 years before the National Health Service Act of 1946 was implemented.

It had always been a mystery, that despite the fact that the 1946 National Health Service Act was being discussed at the same time as the 1944 Education Act, why the opportunity was not taken then to integrate the School Health Service. Dr Simpson gathered there was considerable debate at the time, but it was decided that the School Health Service should

remain where it was, in an educational setting; integration was not attempted until 1974, and the fact that the School Health Service had developed independently for more than 70 years explained some of the present difficulties and misunderstandings.

The fact that the time of its integration into the National Health Service coincided with a period of considerable financial constraint, made the School Health Service an easy target for economies, ill-considered comment and criticism.

One of the provisions of the many Collaboration Working Parties at the time of the transfer of the School Health Service was that there should be a doctor and nurse jointly appointed by the Area Health Authority and Local Education Authority to ensure as far as possible the adequate staffing and operation of the School Health Service. However, both the Specialist in Community Medicine(CH) and the Area Nurse(CH) have experienced considerable difficulty since 1974 in making their needs known at the various operational and management levels of the re-organised National Health Service, particularly ib obtaining resources to run the School Health Service and to provide the essential continuity. Dr Simpson felt that perhaps now was the time more than ever to take stock. Certainly co-operation had never been more necessary than at the present time in order to make the best use of existing resources. Different aspects of co-operation could perhaps be considered as follows:

1. Pre-School. The health visitor at this stage had an important responsibility not only in advising mothers of young

children but also inspiring them with a degree of confidence in their ability to look after their own children. She was in an ideal position to know which children were likely to have problems and to need special consideration when they went to school. These would include not only the obvious ones, mental, physical or sensory handicap, but the less obvious ones like behavioural and emotional problems, and over-dependence on mother. The health visitor could advise her colleagues (if she was not the school nurse herself) about these children and both health visitors and school nurses could act as a very welcome link between home and school.

For many children even those without special needs and for many parents school entry was traumatic. The trauma could be considerably reduced if the health visitor and school nurse were able to prepare the child, parent and school staff for their eventual meeting. The health visitor would present a friendly welcoming known face amongst so many strangers and possibly be able to attend that very important medical examination at or just before school entry. It was not just her personal human presence in both camps, but her insight into the family background (i.e. the kind of things that happen in the children's homes, as mentioned by Mr Tomlinson) which would be vital. Regarding the child's personal medical history, both school nurse and health visitor would have the opportunity possibly to prevent the development of new problems or the aggravation of existing ones by offering advice to teachers about the management of a particular child and assisting his parent where necessary.

2. <u>The Entrant Medical Examination or Pre-Entrant Medical</u>.

Dr Simpson said she thought there was general agreement now that this was of fundamental importance.

(a) The medical assessment of all children, either just before they went to school or soon after they started school is designed not only to review the child's growth (with special attention to sensory and neurological development) so that any problems could be tackled prior to the child starting school but also, (b) the assessment of any special needs the child might have from an educational point of view, and to inform his teachers, not forgetting the need to ask for parental permission to divulge what might be regarded as confidential information. There should rarely be any difficulty about this if parents realised that this information could be helpful to the child.

With regard to those parents who do not easily keep appointments for pre-school examinations or for those children who belonged to the more mobile families, the captive nature of the school population ensures that all children over the age of five years - in maintained schools - are under surveillance. It should also be borne in mind that this might be the first systematic developmental examination they had had since early babyhood.

Dr Simpson thought it had been clear from what other speakers had said that parents did not always understand how the School Health Service functioned. All too frequently the response to an invitation to attend a school-entrant medical examination or a pre-school medical was 'But my GP looks after my children.' Parents did not realise that relatively

few general practitioners undertook the kind of assessment of hearing, vision, speech development and mental ability which mattered in school, and which might affect learning profoundly. This illustrated the need for additional education on the purpose of the School Health Service. Dr Simpson referred to the time 20 years ago when she was a School Doctor. She was also Medical Officer to the local Child Health Clinic and held clinics in the children's hospital. In addition she looked after the Primary and Secondary Schools to which her children transferred, and several Special Schools. Her school nurse colleagues worked with her in the Child Health Clinic and they knew all the parents. She had very co-operative and interested head teachers, although not all the local GPs were as helpful. Dr Simpson felt that some of this continuity and community spirit had been lost over the years. She considered it very important that this should be regained and the school nurse was one of the key people involved within the community to achieve this end.

3. Post-entry Medical Examinations. Mrs Watts had already spoken about more selective medical examinations. Dr Simpson thought that once the child had undergone an entrant medical and transferred incoming children had had a similar comprehensive assessment, a selective procedure was desirable. The selection depended very much on the school nurse. If she was able to visit her schools regularly and be recognised as a member of the school team (as well as being a member of the Primary Health Care Team), then her work would be at its most valuable. This did not always happen, but when it

did, it was extremely useful, so that teachers, school welfare officers, caretakers, catering staffs, psychologists, physiotherapists, social workers, speech therapists and so on, as well as parents and grandparents, regarded a good school nurse as their contact in whom to confide their anxieties about children, parents and families. From all her sources of information the school nurse would be able to assess the need for further investigation, and would know to which speciality the child or family should be referred. She would be able to look at attendance records and follow up any unexplained or inadequately explained absences. These records might reveal inadequately treated asthma, behavioural and emotional problems, demands of the family particularly on girl pupils for support of younger members of the family, refusal to attend school, true truancy and delinquency. To achieve this however the school nurses must have good supportive services. For example it was absolutely no use if they reported problems to their medical colleagues only to be told they 'were just making a fuss about nothing' and 'there is nothing you can do anyway.' In Dr Simpson's experience this happened only too frequently, but she thought many doctors were now becoming much more aware of the importance of regular surveillance of the development of children, although there was still a long way to go.

Dr Simpson continued that school nurses also had an important role to play in educating their medical colleagues. This required considerable diplomacy and persistence. Furthermore she thought all they had heard that morning stressed the need for more information and better communication. Further

information was needed about the purpose of the various services. As Helen had said, pupils needed to know the reason why things were being done. It was not just courtesy that they should, but it was an important part of health education. We required more information about what other professions could offer and their limitations, particularly if we worked in teams, and above all we needed continuity, which in itself was an important contributor to better communication.

7. SCHOOL NURSING - TRENDS AND INNOVATIONS

The speaker of the afternoon was Miss Patricia Slack, Area Nurse (Child Health) Kensington and Chelsea and Westminster Area Health Authority (Teaching).

Miss Slack said she was astonished to see that the title of her talk appeared on the programme as 'Trends and Innovations.' Before talking about trends Miss Slack always liked to remind herself of what she considered was needed to achieve a good School Health Service, and this was a healthy child who leaves school with a basis for a healthy life. A great deal had been heard recently about prevention; that it was impossible to continue owing to lack of finance; that people could not be ill or away from work, and Mr Tomlinson during the morning had given in excellent detail the difficult problems facing some parents and children. If this state of affairs was to be altered it would have to be done in school, and an ideal combination would be a School Health Service, the members of which 'knew what they were about' and an Education Service to teach the children a healthy life style with involvement

of the School Health Team.

How to achieve this? Miss Slack thought it was necessary to work with the child and one of the most important points was Helen's remark, when she said she would like to know what the charts meant and what was happening when the tests were carried out on her. Miss Slack then went on to say that vision testing and other interviews were carried out on many children who had no interest in the reason why. The first time children encountered the Preventive Service was at Primary School, where they could make their own decisions and whether they felt a Preventive Service was useful or not. Miss Slack said readers would find at the back of the Court Report that in a survey on Secondary School children, the majority had no idea what prevention meant. Therefore if genetic counselling services and early ante-natal care were to be developed, the children must leave school fully informed as to the Preventive Health Service and how it functioned. And where better to start educating them except in the School Health Service in conjunction with the teachers? Teacher colleagues were doing project work with the children all the time in schools, and Miss Slack felt that if the School Health Service was included as part of the project work, it would benefit all concerned. She then referred to parents, how that morning they had heard from a parent that she felt nervous about going to school, and reluctant to ask questions. She had called it a 'screening service'; and this was true. What was being provided at the moment was not a Health Service. Referring to handicapped children in ordinary schools,

Miss Slack quoted a head teacher who had stated that 'teachers go into a job to teach normal children', and it was clear that teacher colleagues should understand the implications of the handicapped children's health problems, not only for the sake of the child but also for the teaching staff. An example of this is a child with a fine motor control problem which might affect his writing.

A delegate speaking during the morning had referred to the problem of nits, and Miss Slack suggested that parents and children could be taught about prevention. This would obviate the need for repeated visits having to be made by the school nurse to treat children.

With regard to health problems in a primary and a secondary school, she listed the following illnesses:

Primary school: Respiratory disease, chronic ear nose and throat infections (with a probable outcome such as deafness), dental caries, bed-wetting, accidents; infectious and contagious diseases and major chronic conditions such as asthma and epilepsy.

Secondary school: Respiratory diseases again, headaches, menstrual pains, and all the problems associated with adolescence and the acceptance and understanding of sexual development. (An interesting note was that one per cent of 16 year-olds were still wetting the bed.)

The existence of the Occupational Health Service had not yet been mentioned.

Reverting to the aim to equip all children with a healthy life style, Miss Slack wondered how many nurses referred to

the Infectious Diseases Notification Book, or if a first aid book was kept in every school. She felt that in the case of a child with recurrent infectious disease returning frequently to his general practitioner for antibiotics (often leaving a course of drugs unfinished), it might be more profitable if parents and teachers were to understand the importance of the development of immunity in a child, by correct nutrition and the protection this gave. Perhaps this subject could be included in the health education programme.

With regard to trends, Miss Slack felt the most important development had been the selective medical examination, which meant that the child would have a major medical examination at four and a half to five years of age on school entry. If there was no problem necessitating a further interview with the school doctor it was then the responsibility of the school nurse to identify from these normal children which of them needed to be referred back to the doctor later on in their school life. The Court Report had suggested an annual health interview, but it seemed to be a common occurrence, at least in her experience that the children were suddenly taken out of class, for example to have their hearing tested or to attend a hygiene interview, which she felt was a 'task-orientated approach'.

The nurses in the audience would know that for the last two years there have been many articles in the nursing press concerning the Nursing Process, which for the benefit of those delegates who were not nurses, was a means whereby the nurse would make a health assessment of the patient (this being

nursing in a hospital context) and a plan of action drawn up, which included teaching over a period of time. Miss Slack felt that this nursing process was never so applicable as in school health because it provided an opportunity to see the child as an individual and from that point consider the teaching needs of the parent, the teacher and the child.

If the school nurse found a group of children who had a similar need she should talk to teachers in that particular school, and if there happened to be a Schools' Council Health Education project going on in a primary school, then it would be an ideal opportunity to incorporate this subject so that a comprehensive view could be taken of each individual child.

Since the introduction of the selective medicals, school nurses were probably spending far too much time on administrative work and less time on the actual health interview. Decisions would have to be taken on the priorities; whether expensive nursing time could be spent in this way, when it was the nurse's responsibility to select the children with problems necessitating a selective medical examination. Miss Slack knew that some members of the audience would consider this impossible to achieve because of the school organisation, but if the head teacher understood the purpose and how this was going to contribute to the curricula, then it should be possible.

The question of accommodation had been raised that morning, and Miss Slack agreed that to provide a good service a nurse must have a 'patch' in which to work. In primary schools particularly, the nurse's accommodation was often

unsuitable, such as the back of an assembly room for hearing testing when there was a music lesson going on. It was complete lack of understanding. One head teacher stated that the children needed 'language tuition' not 'hearing testing', regardless of the fact that their hearing might be impaired. There was a great deal of work to be done. Regarding the secondary school child, Miss Slack said things had changed considerably from the point of view of the Education Service, probably since the introduction of the Health and Safety at Work Act 1974, and she agreed with Mr Tomlinson that a full-time school nurse was needed in every large secondary school. However this was a very different service from the one needed in a primary school, and since the introduction of this Act, the education authorities should re-think their policies in secondary schools. It would be a pity if school nurses were not involved in this because the job description of the occupational health nurse and the school nurse employed by the National Health Service showed considerable similarity, except in respect of accidents and first aid, and no doubt the school nurse's occupational health responsibility would increase if the existing services were developed rather than new ones being brought in as the 1974 Health and Safety at Work Act progressed. (At management level how many nursing officers and GPs, for that matter, had ever visited a school?) Mentioning again the handicapped child, Miss Slack referred to the 1976 Education Act, this amended the 1944 Education Act in relation to children requiring special educational treatment in that provision must now be made for this in

county or voluntary schools. If this were not possible owing to the incompatibility of a particular child, because of incurring unreasonable public expenditure, the child would then attend a Special School. The Warnock Committee were considering the whole question of special education. Not all children with a similar handicap would respond to the same circumstances. Some would adapt easily to ordinary school life while others would need the protection and extra facilities of a special school.

8. The delegates then divided into groups for syndicate work on four questions relating to the subject under discussion. Their conclusions were as follows:

1. Do you think the School Nurse should be a member of the Primary Health Care Team? She is a member of the Primary Health Care Service and is involved in the health surveillance and health education of a large number of children.

   (CNO's letter (77) 8. para 4.2) Much of the School Nurse's work is done in the homes of children, particularly socially deprived homes.

   By School Nurse is meant - a visiting School Nurse and one who is <u>school based</u>.

There appeared to be some division of opinion among the discussion groups as to whether or not the school nurse should be a member of the Primary Health Care Team. Difficulties were seen because of the large number of Primary Health Care Teams in an urban school area and often there were general practitioners working in Health Centres, many of whom had little idea of the children's problems in school. In a rural area

the school nurse would find it easier to be part of a Primary Health Care Team, therefore much depended on the environment. Again opinions were divided about the amount of home visiting a school nurse actually did and how often visits should be made. It was felt that there should be close liaison with the health visitor so that a link could be forged between school nurse and health visitor. On the whole, particularly where the home was classed as 'deprived', the health visitor with her training was best suited for this task.
It was stressed that a national training scheme should be implemented for the school nurse which would make her a member of the school health team.

2. 'Court' said (page 2.) 'We have found no better way to raise a child than to raise the ability of his parents to do so.'

The need to develop a closer partnership between parents and the professional staff is very real - can success be achieved where the life style of the parents is a hindrance and where, often, the mother goes out to work?

Often difficulty in communicating with parents might be resolved by educating the present generation of school children in school health. One faction felt that the school nurse or health visitor should go to parents when a problem arose. Different life styles generated their own particular difficulties. Parents often found school nurses incomprehensible and frightening; communication both with children and parents should begin at an early age starting with the health visitor and graduating to the school nurse. It was also thought that

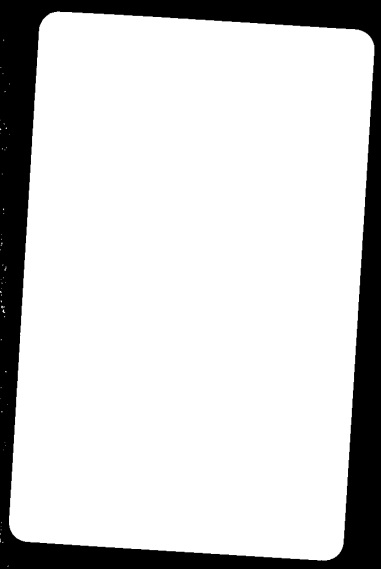
parents should be persuaded to join in school activities to achieve greater understanding of what happened in school. Some of the delegates stressed the problems associated with the working mother. It would be useful to introduce some kind of flexibility into an arrangement of clinics and their timing. For example, evening clinics and evening home visits. Nevertheless it was felt that the nub of the matter lay in better liaison with parents and the foundation of a pattern of health education in school.

3. The Health Visitor/School Nurse system which was the vogue, some decades ago, was regarded as ideal because it gave continuity. Is it still regarded as the ideal but one which is not now realisable?

Most of the members of the groups thought that with the growth in population, what was the ideal of yesterday did not apply today because it was impracticable particularly in urban areas. Nevertheless in rural areas it probably was feasible. Some delegates thought the continuity of health visitor/school nurse care still existed. Where possible health visitor and school nurse should share offices for close linkage. Other members felt there was a place for a separate School Nursing Service with its own structure run in conjunction with the Health Visitor.

4. Court's system of Child Health Visitors, to whom trained school nurses would look for guidance is not to be. In the absence of such an ad hoc system, what are the practicable

ways of providing the necessary guidance?
It was suggested by some delegates that practical guidance would come from a nursing officer who would have responsibility for community Child Health. This would replace the Court system of Child Health Visitors. The school nurse nationally trained, particularly where there is a greater need for support and counselling in the senior schools, would be in direct contact with the Department of Health and the Education Department, and also have access to guidance from the nursing officer. There was some dissension over the approach to be made; others considered that in the absence of such an ad hoc system health visitors and school nurses should both be trained in school work because of the necessity that nursing officers (on the presumption that these would be health visitors) should have an adequate knowledge of the School Health Service. This did not follow that the nursing officer need be a trained health visitor. Other delegates thought that the above was not practicable because of the pressure of work on the health visitor. Therefore it would be more sensible to raise the professional status of the nurse who should have a mandatory national training.

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