Royal College of Nursing

RCN School Nurse Survey 2016

Introduction

An RCN survey of school nursing in 2009 revealed a range of issues. The survey in 2016 sought to get up to date evidence on school nursing, including the impact of service delivery changes and new models of provision

School nursing is a universally accessible service that is non-stigmatising and accepted by most families and school communities, with school nurses having a key role in promoting the health and wellbeing of children and young people. Today's school nurse is a specialist practitioner working across education and health, providing a link between school, home and the community to benefit the health and wellbeing of children and young people. Essentially, the school nurse functions as both health promoter and health educator, and works in collaboration with teachers, youth workers and counsellors.

Background

England

The Health and Social Care Act 2012 gave local authorities statutory responsibility for commissioning public health services for children and young people aged 5-19 years, including the school nursing service. School nurses are identified as the leaders of the second stage of the Government's Healthy Child Programme (a public health programme for children, young people and families) focused on those aged 5-19 years.

In 2012 the Department of Health published 'Getting it Right for Children, Young People and Families – Maximising the contribution of school nursing', setting out a new vision and guidance for school nursing. The aim was to highlight the role and contribution of school nurses and refresh the service model, focusing on the needs of more vulnerable children and young people including excluded children, young carers, and those with mental health needs. Such guidance was also timely given the new commissioning environment. Although key areas of knowledge and skills were identified, no numbers or targets were set for the future school nursing workforce either nationally or locally. Further guidance for local commissioners and providers setting out the core school nurse offer and supporting the development of locally determined service specifications was published in 2014.

In contrast, national projections of student numbers by the Department for Education demonstrate that there has been a steady rise in the number of pupils in state schools in England, with numbers projected to reach 8.02m by 2023.

Scotland

The Chief Nursing Officer in Scotland has recognised there are issues and challenges facing the school nursing workforce and has carried out on-going work to refresh and refocus the role of school nursing. National working groups have developed new pathways to refocus the role of school nurses in Scotland. The new pathways focus

on nine priority areas: emotional health and wellbeing; substance misuse; child protection; domestic abuse; looked after children; homelessness; youth justice; young carers and transitions.

The new pathways are being tested in two health boards. These early implementer sites are also looking at the education and training needs for school nurses in each of the priority areas. Currently in Scotland many school nurses do not have a specialist qualification for the role. However, no funding has yet been agreed to support essential continuing professional development for those who do not currently hold a specialist qualification.

Northern Ireland

In Northern Ireland's integrated health and social care system, services for children and young people are commissioned by the Health and Social Care Board and the Public Health Agency and delivered by five Health and Social Care Trusts. The Northern Ireland Executive's ten year strategy and action plan for children and young people (2006-2016) set out a number of high level outcomes, the first of which is that all children and young people are healthy. Despite some progress in recent years, it is estimated that 22% of children in Northern Ireland still live in poverty.

In its campaigning for the recent Northern Ireland Assembly elections, the RCN called for public health priorities, including early intervention and preventative measures aimed at children and young people, to be included in the Northern Ireland Executive's Programme for Government for 2016-2021. The RCN has continued to highlight the need to support the delivery of health care services for children and young people by appropriate investment in the school nursing workforce in particular, pointing out how staff shortages and an ageing demographic profile in these areas of practice are affecting the capacity of the HSC to tackle health inequalities amongst children and young people in Northern Ireland.

Workforce figures published by the DHSSPS illustrate that, during 2014-2015, there was one whole time equivalent school nurse for every 3219 schoolchildren in Northern Ireland. Furthermore, the percentage of school nurses aged 45 and over has increased from 51% in 2010 to 63% in 2015. The RCN believes that, until the numerical under-representation and ageing demographic profile of the school nursing workforce is addressed through robust workforce planning, the capacity of school nurses to promote the health and well-being of children and young people in Northern Ireland will not be maximised.

Wales

In 2009 the Welsh Government published A School Nursing Framework for Wales. This can be viewed at http://gov.wales/topics/health/publications/health/reports/nursing/?lang=en and was the result of an RCN campaign.

This set out a clear strategic direction for school nurses. The Health Board was to deploy school nurses in teams to support the health of school-aged children in their locality on a year round basis. The team would include specialist skill sets (e.g. sexual

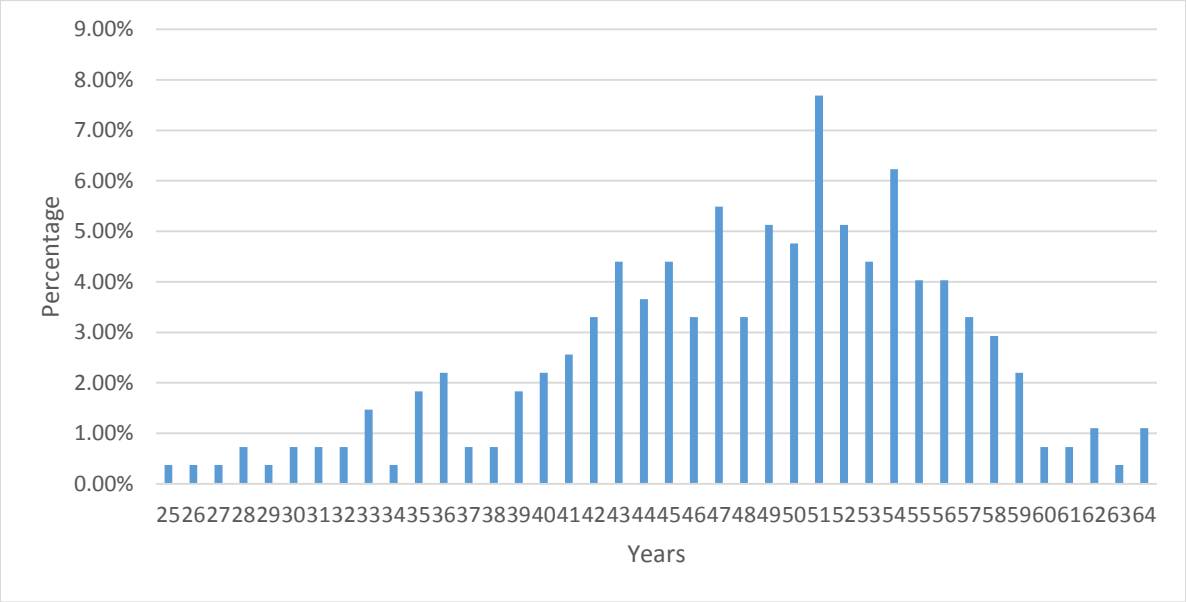
health) but there would be an emphasis on the specialist school nurse qualification. Each secondary school in Wales would have a named school nurse. At the same time £4.7 million was set aside to boost the health boards recruitment to these posts. This aim was achieved and indeed the drop in teenage conceptions in Wales in 2011 was attributed by the Welsh Government to the success of the school nurse network. However the strategy has not been refreshed since 2009 and current figures on the number of nurses working with schools have not been published in Wales. 98 assignments with a school nurse qualification are listed in the NHS statistics (Statistics Wales). This is a sharp jump from 2009 when only 59 such assignments were listed. However there are 207 secondary school in Wales.

The RCN in Wales is calling on the new Welsh Government (elected in May 2016) to refresh the school nursing strategy for Wales and renew their commitment to school nursing

About the respondents

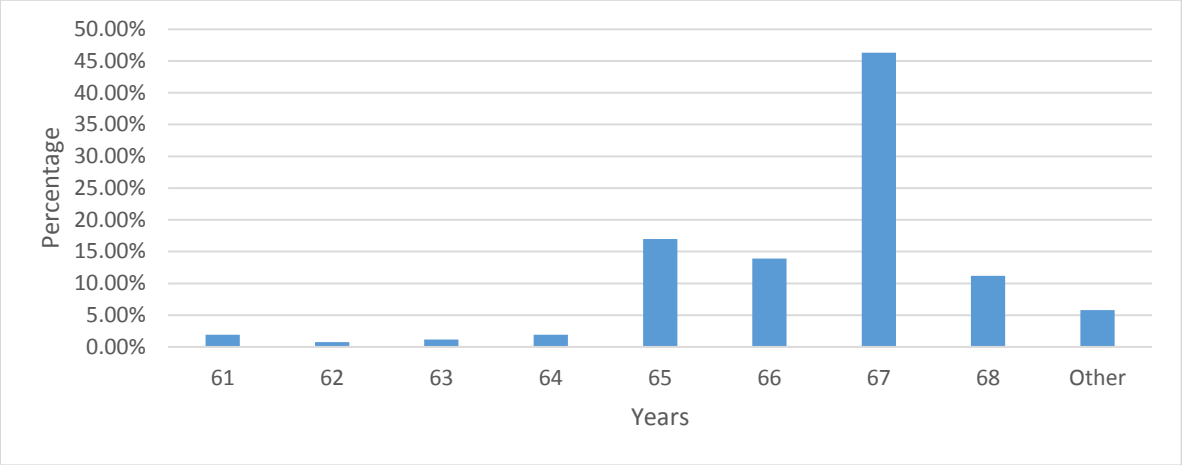
277 members responded to the survey advising they worked in school nursing. The vast majority were female (97.45%). Respondents were between 25-64 years of age (see Figure 1).

Figure 1: *Age of respondents*



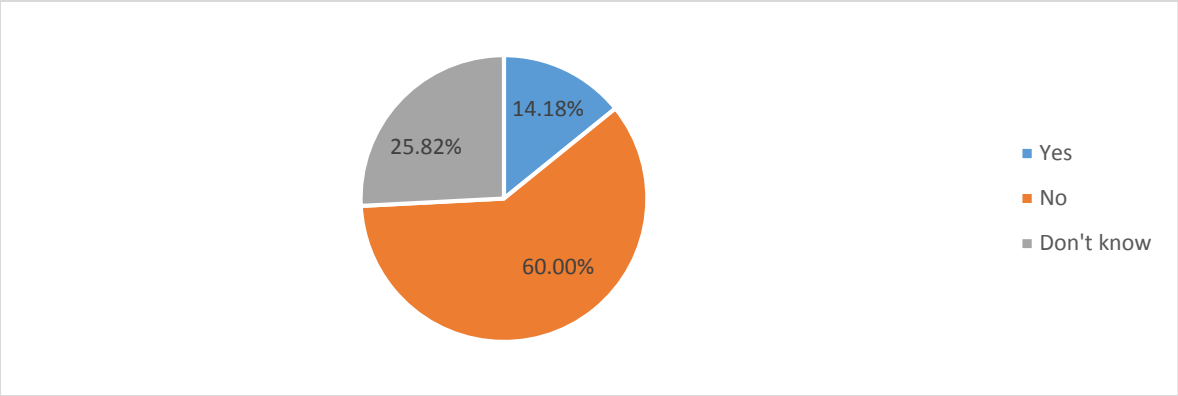
The majority of respondents reported their state pension age as being between 65-68 years of age (see Figure 2). The 'other' category encompassed individuals who either did not know or who had already passed their state pension age.

Figure 2: *State pension age*



The majority of respondents reported that they did not plan to continue to work after reaching retirement age (see Figure 3).

Figure 3: *Plan to continue to work after reaching retirement age*



Almost ninety percent of respondents reported that they lived with a partner/spouse (see Figure 4), with over sixty percent reporting they had children/young people still in full-time education living with them (see Figure 5) and over twenty percent stating they had regular caring responsibilities for an elderly relative or other adult with care needs (see Figure 6).

Figure 4: *Live with partner/spouse*

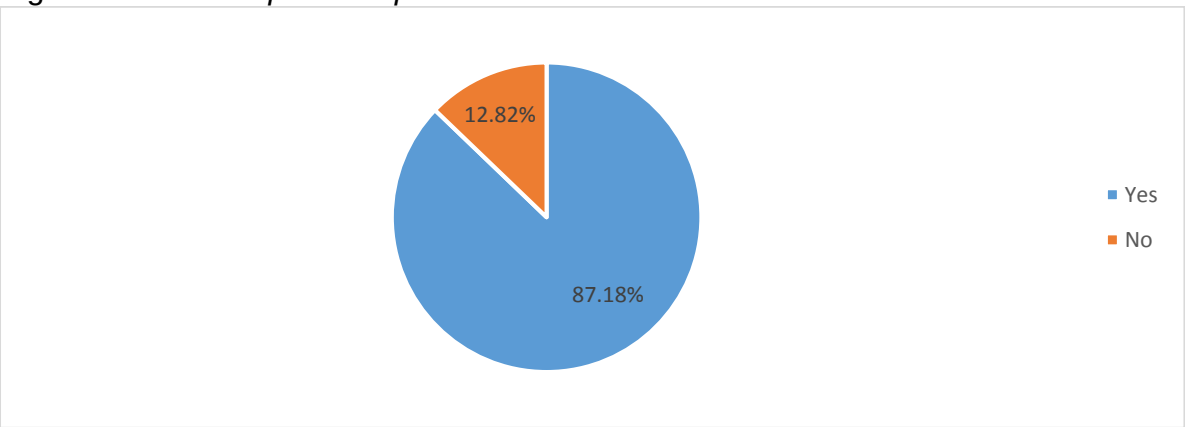


Figure 5: *Children/young people still in full-time education*

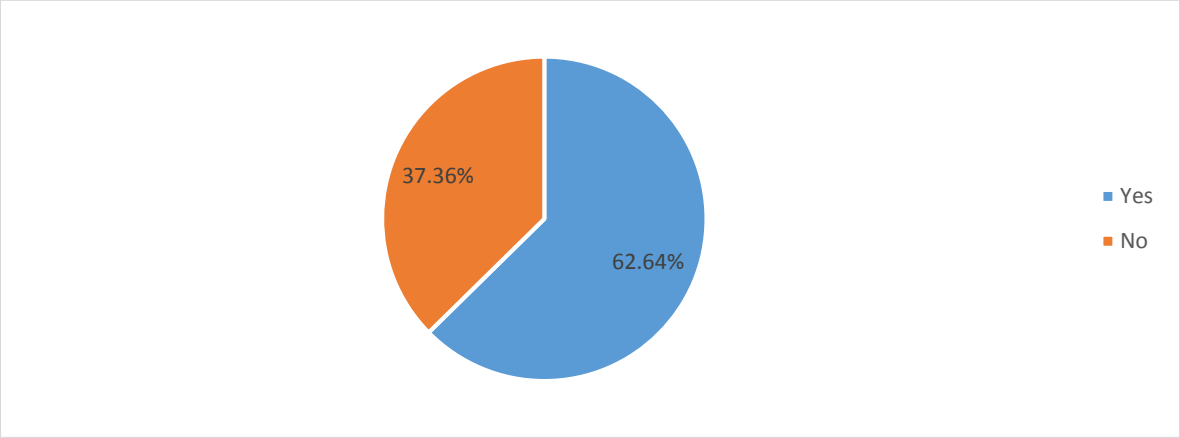
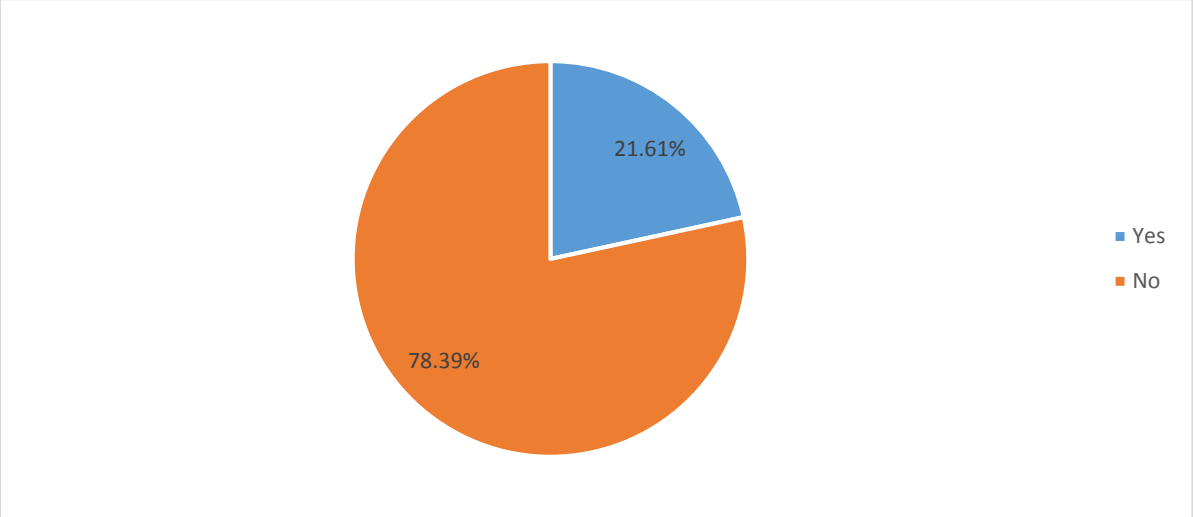
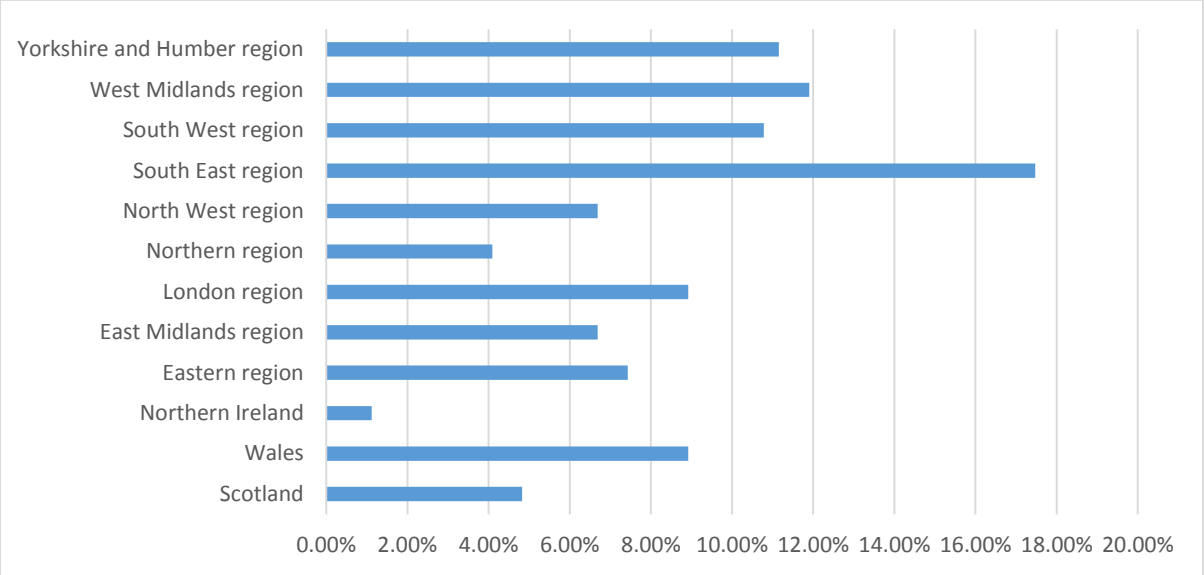


Figure 6: *Regular caring responsibilities for an elderly relative or other adult with care needs*



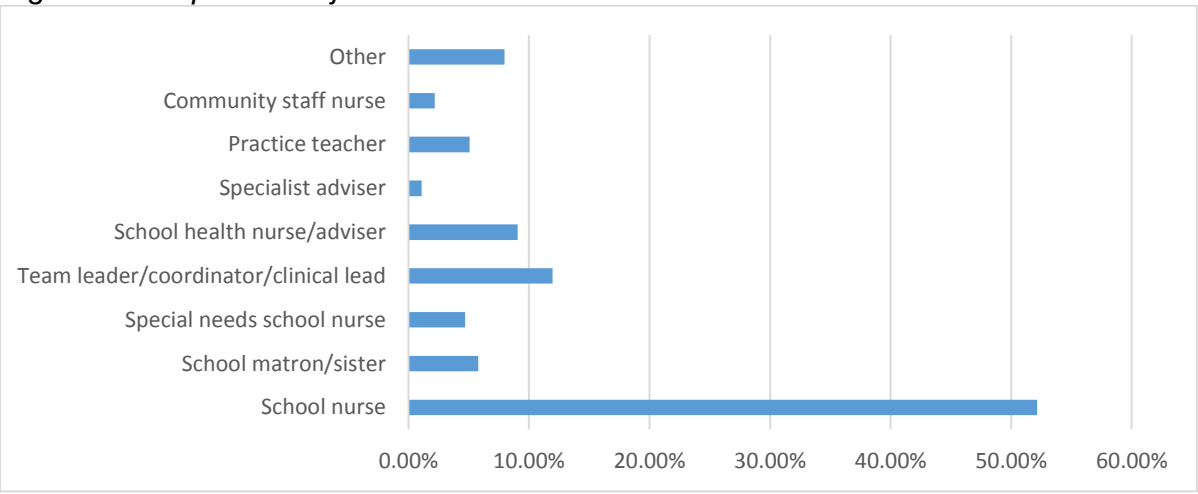
Respondents were from all Countries and RCN regions, although there was a greater proportion from the South East (see Figure 7).

Figure 7: *Country/RCN region of respondents*



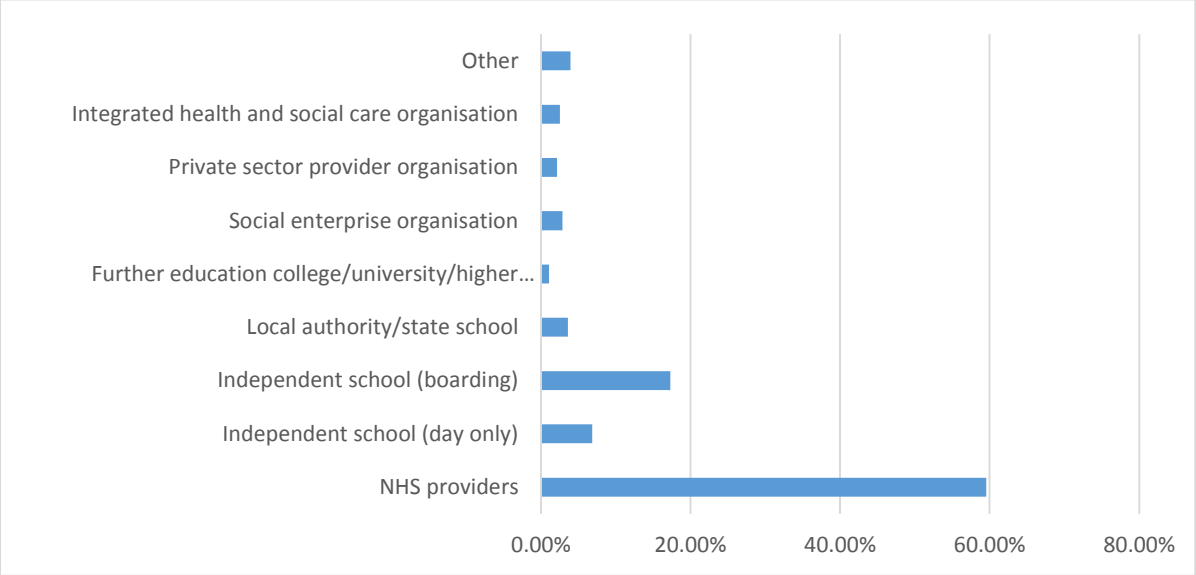
144 (52.17%) advised 'school nurse' was their job title, while other respondents indicated a range of role titles (see Figure 8). The category 'other' included role titles such as SCPHN student school nurse, immunisation staff nurse, professional lead and team manager.

Figure 8: *Respondents job titles*



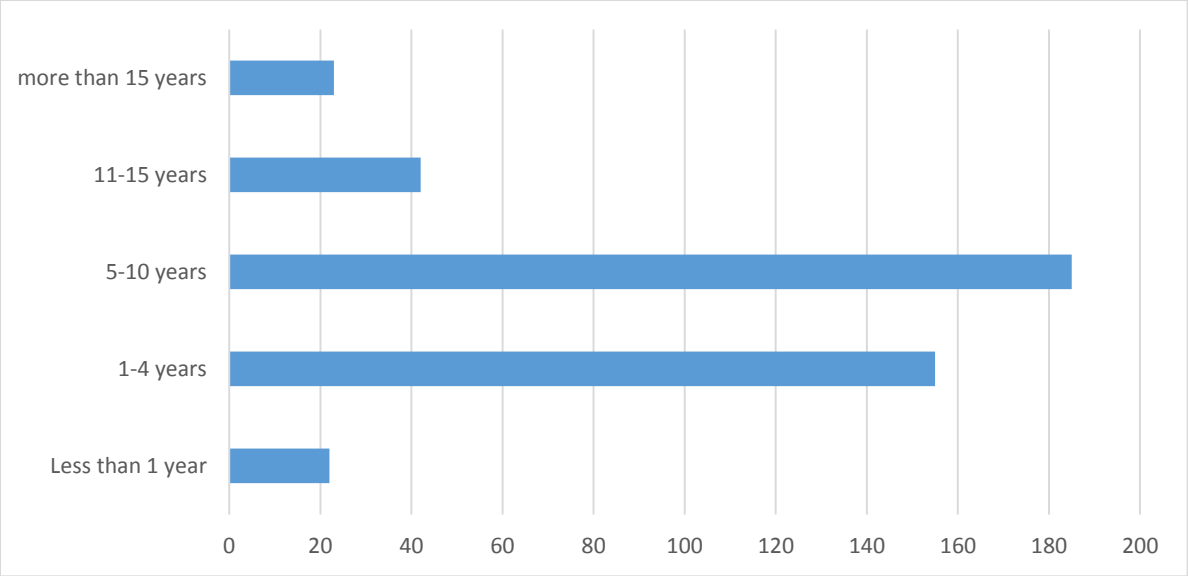
The majority of respondents indicated their NHS providers were their employer, although a significant number were employed in independent day and boarding schools (see Figure 9). A number reported their employer as being the local authority or a social enterprise. The category 'other' included respondents employed by SSAFA in Germany, private school overseas and state boarding school.

Figure 9: *Respondents employer for main job*



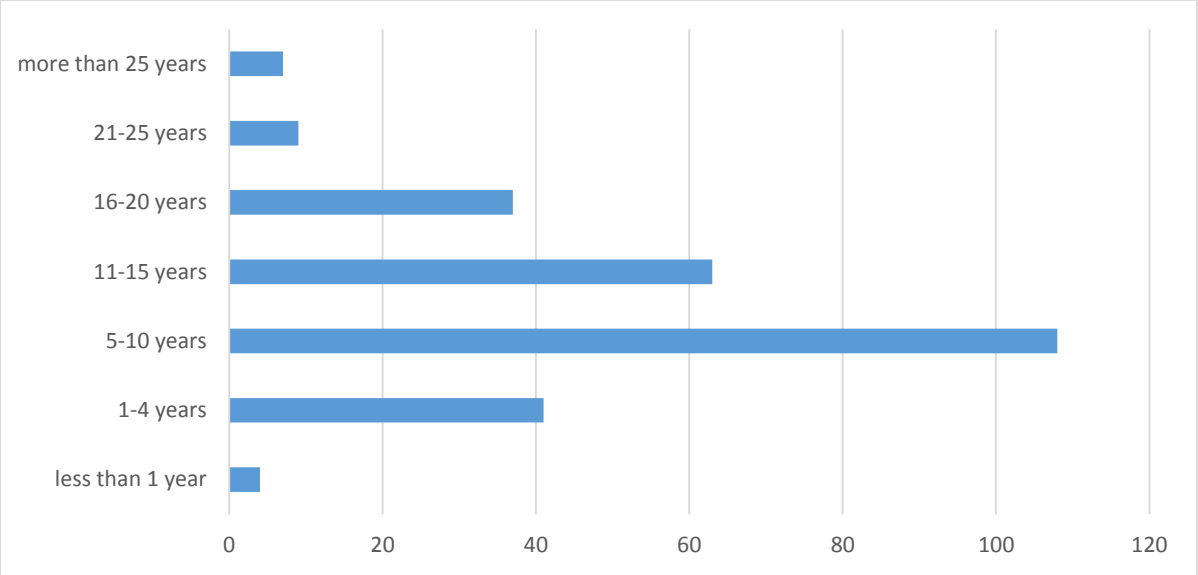
The majority of respondents had been in their current post for between 1-4 years or 5-10 years. Some respondents had been in post for 25 years, while some had been in post for less than 12 months (see Figure 10).

Figure 10: Length of time in current post



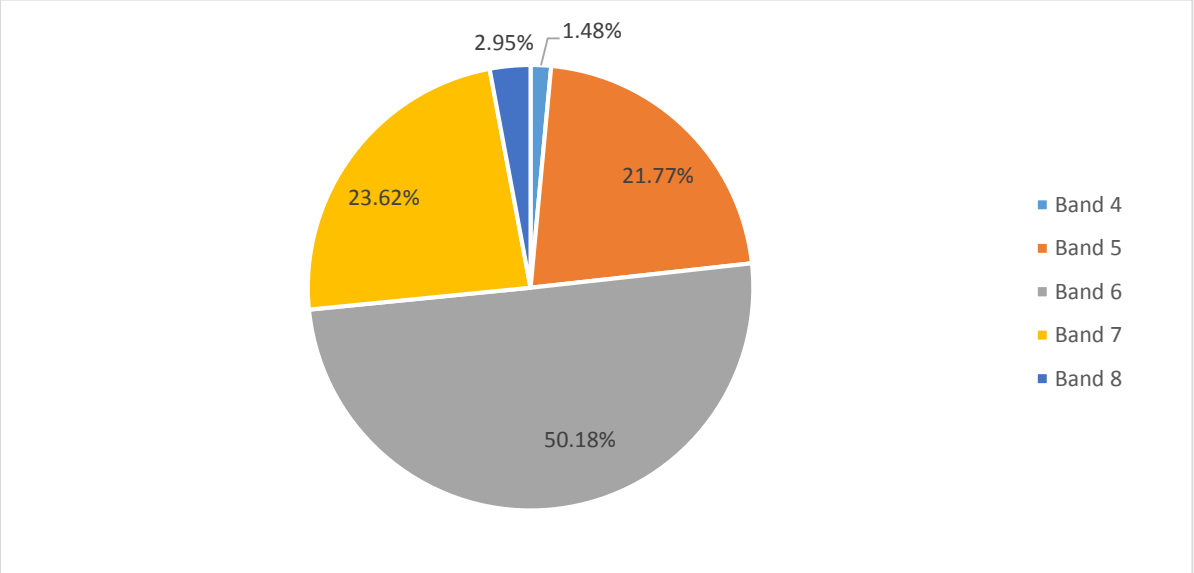
Several respondents had been working in school nursing for more than 25 years, while the majority had worked in school nursing between 5 and 15 years (see Figure 11)

Figure 11: Length of time in school nursing



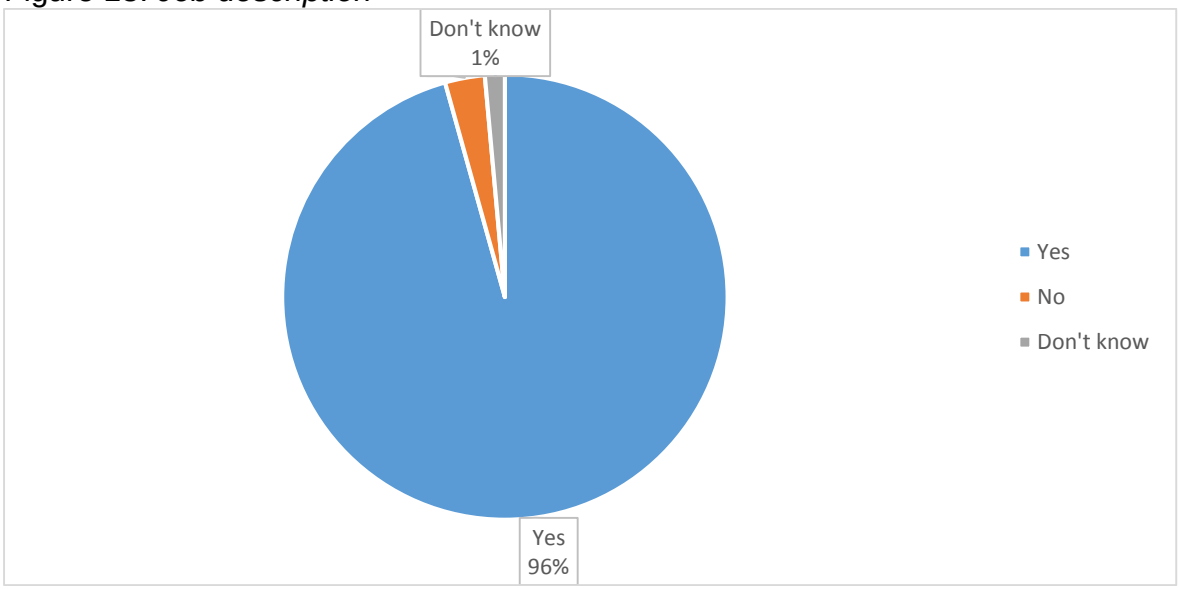
The Majority of respondents indicated that their pay scale was Agenda for Change Band 6 (or its equivalent) (see Figure 12).

Figure 12: *Agenda for Change pay band*



While the vast majority of respondents reported that they had a job description, several did not (see Figure 13).

Figure 13: *Job description*



Of those that indicated they had a job description the majority reported that this was an accurate description of their role (see Figure 14). A significant number however reported that the job description was not an accurate description of their role, indicating that role descriptions need revision along with changes in service provision and role development.

Figure 14: *Job description accurate for role*

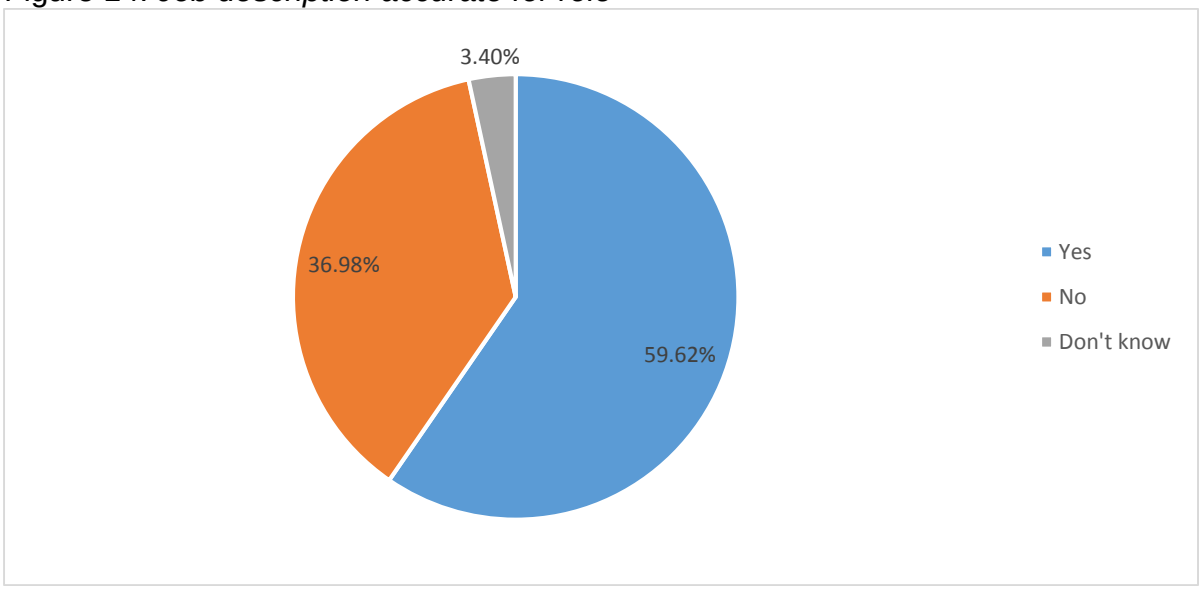
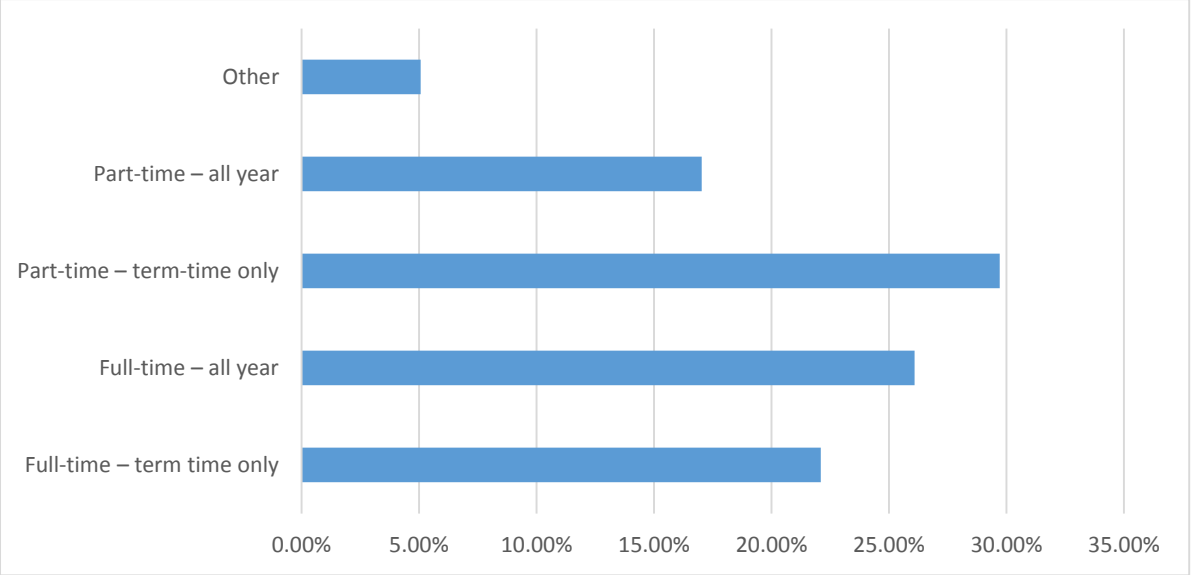


Figure 15 highlights the hours respondents are contracted to work, depicting the increase in number of full-time all year contracts for school nurses. The 'other'

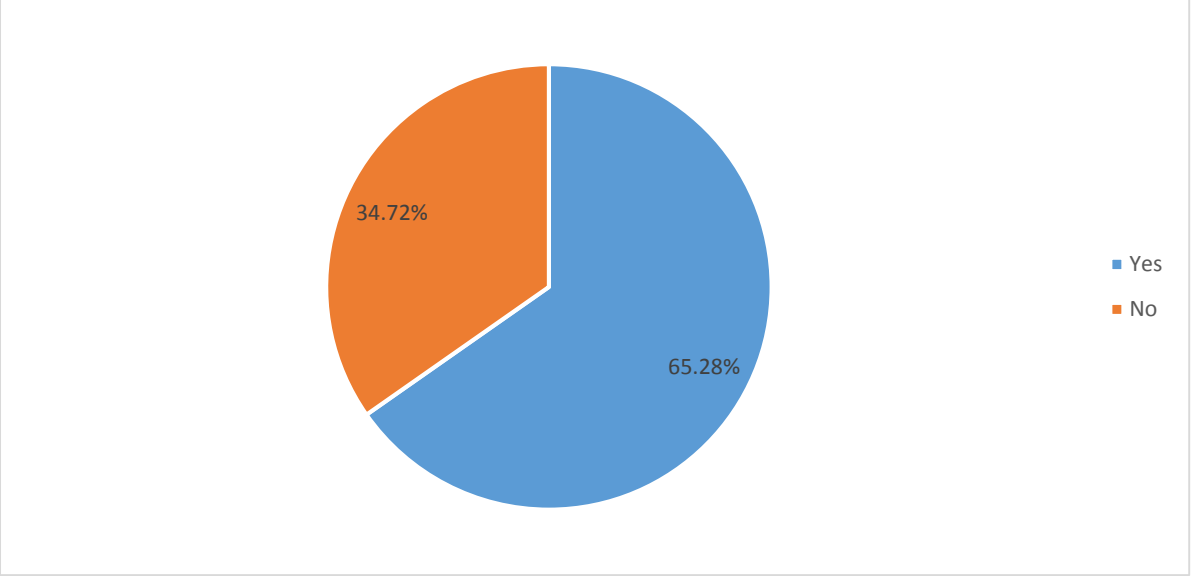
category included nurses that worked bank shifts, as well as those that covered some but not all school holiday periods

Figure 15: *Hours contracted to work*



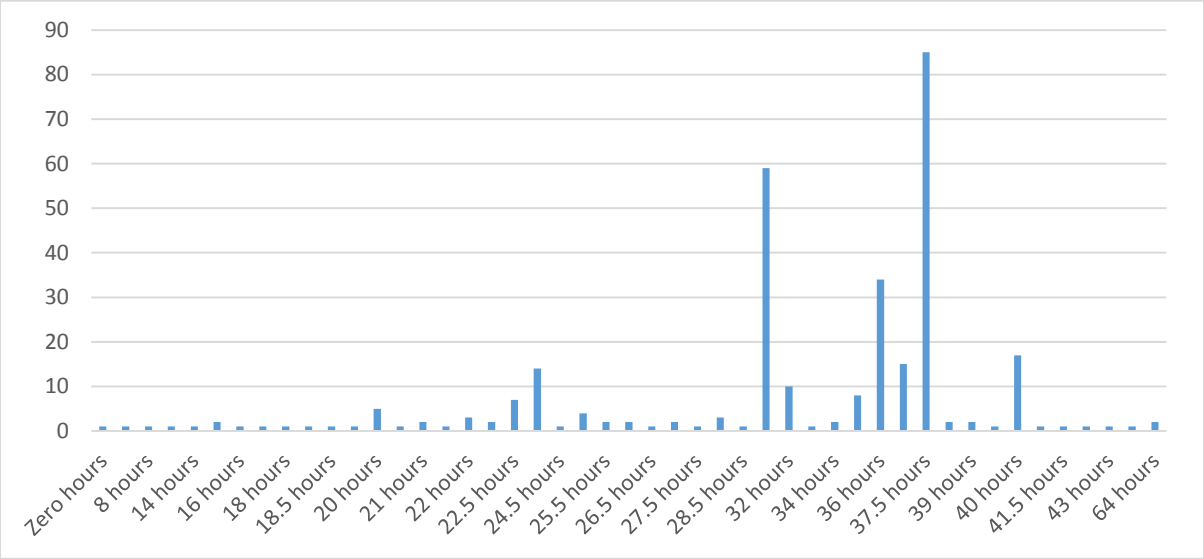
The majority of those that worked term-time only had chosen to do so, although a significant number had not done so (see Figure 16).

Figure 16: *Chose to work term-time only*



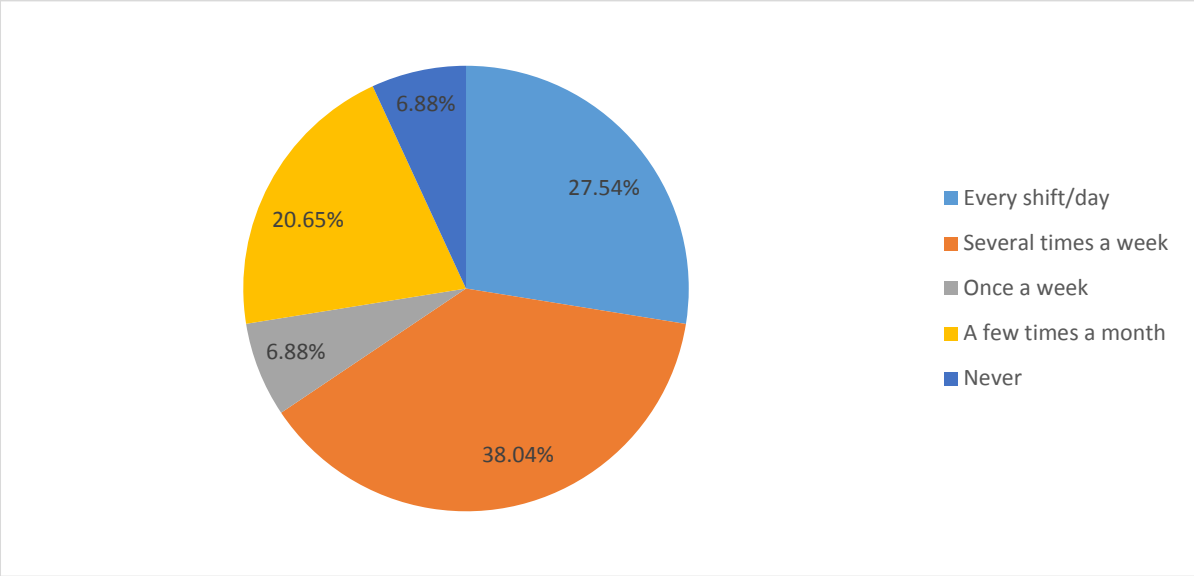
The vast majority of respondents were contracted to work between 30-40 hours per week (see Figure 17). Two respondents indicated that they were contracted to work 64 hours per week.

Figure 17: *Contracted hours per week*



The majority of respondents indicated that they worked in excess of their contracted hours (see Figure 18). For some this was a few times a month but for others this was every shift/day.

Figure 18: *Work in excess of contracted hours*



The school nursing service

The majority of nurses reported that they covered 4/5-18/19 years of age. Although a number worked with pre-school aged children (see Figure 19 and 20).

Figure 19: *Youngest age of child*

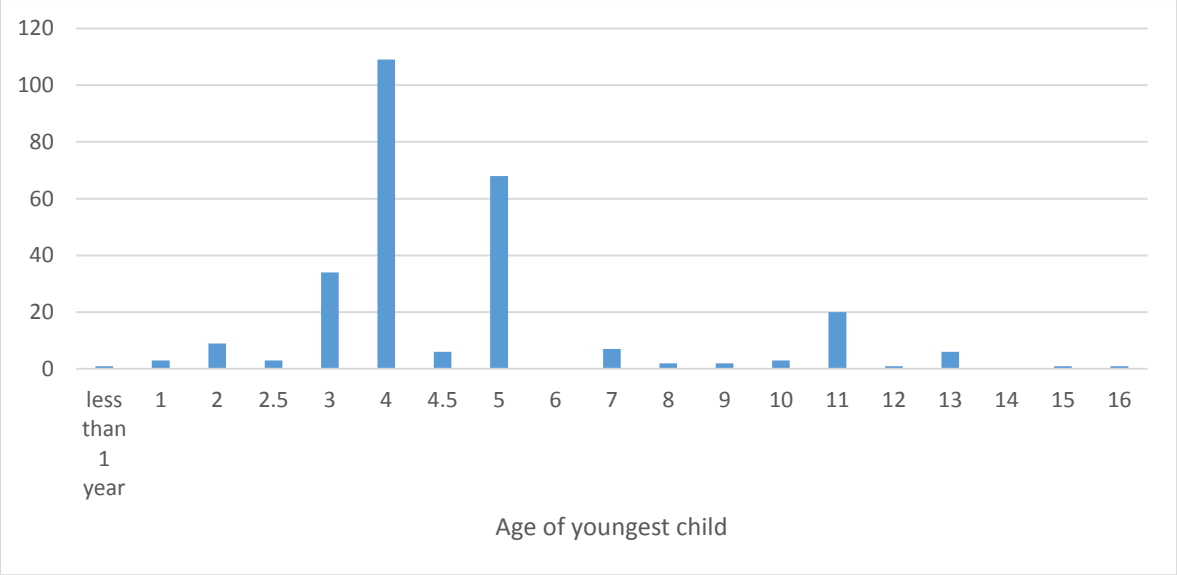
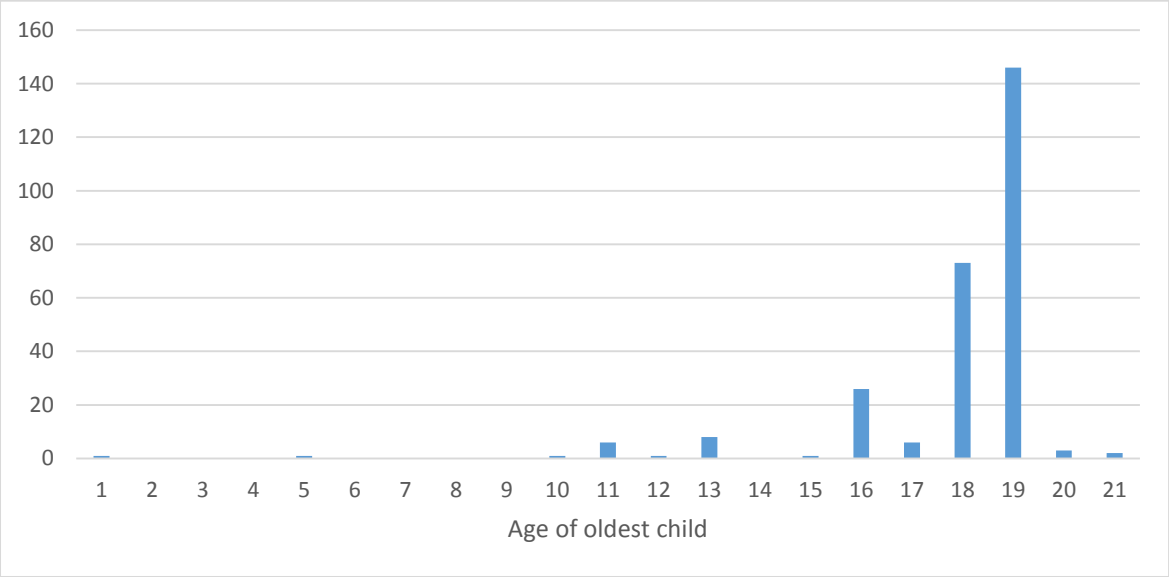
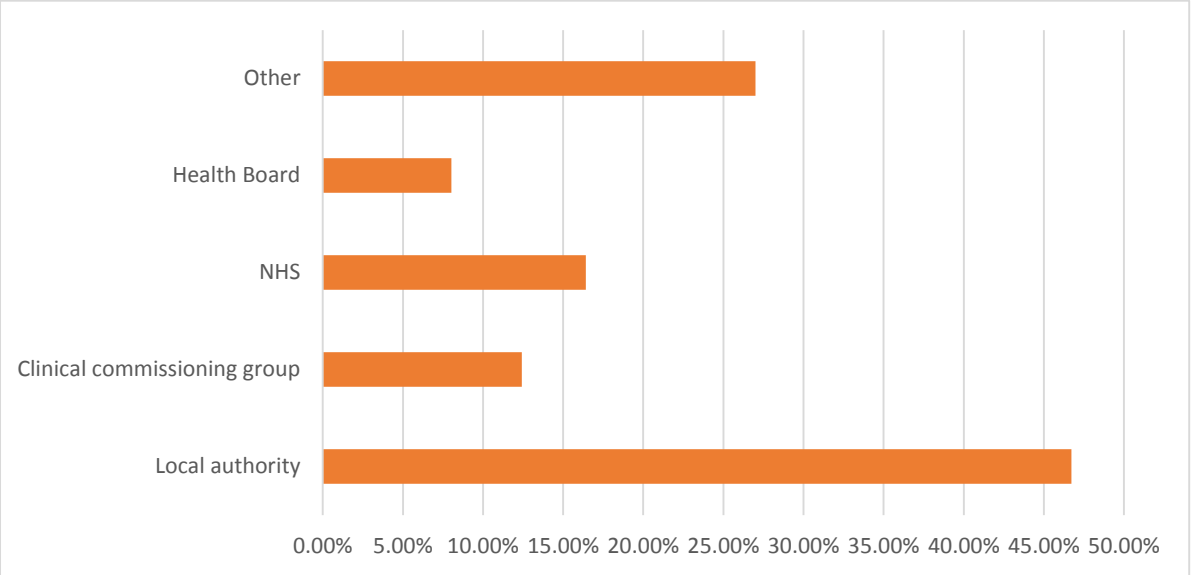


Figure 20: *Oldest age of child*



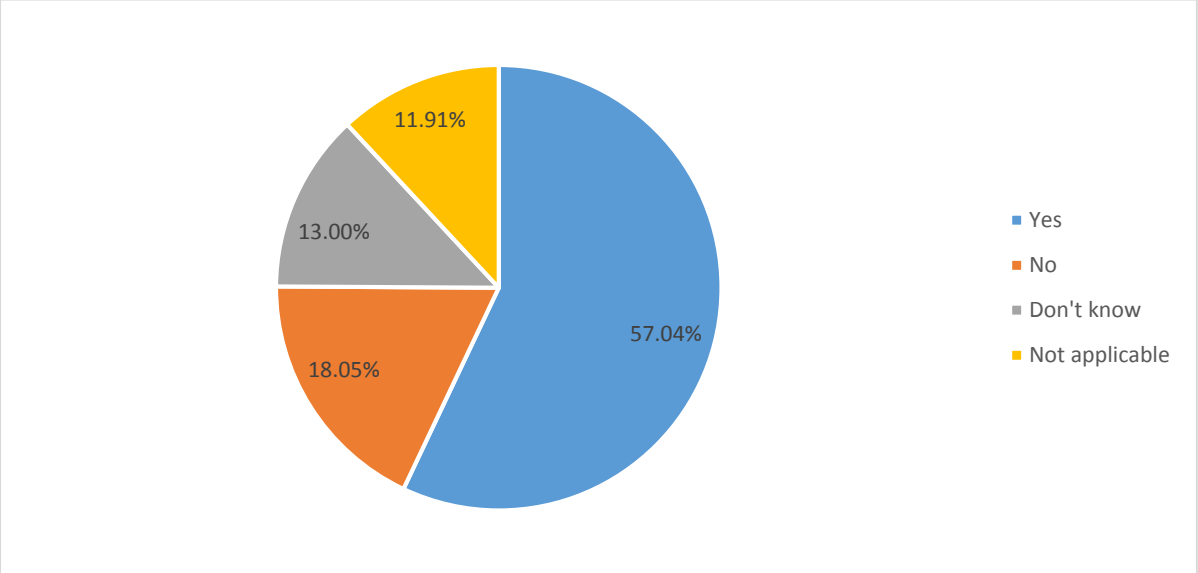
The majority of respondents reported that their service was commissioned by the local authority (see Figure 21). The 'other' category included a significant number of respondents from independent/private schools and therefore reported that their service was commissioned by the school. Interestingly one respondent cited the local GP practice as the commissioner of their service. The latter may be due to the fact that a local GP is often contracted by an independent school to act as their medical officer.

Figure 21: *Commissioner of school nursing service*



Over fifty percent of respondents reported that changes to commissioning of school services locally had impacted on the school nursing service (see Figure 22).

Figure 22: *Changes to commissioning impacted on service*



A number of respondents highlighted positive experiences as a result of changes to commissioning:

"More specific care"

"More time in school, working towards less safeguarding"

"At the end of 2014 the school health contract was awarded to a social enterprise by our commissioners and

we transferred in May 2015. The service specification has remained the same and was written with input from the team, our stakeholders and service users prior to the transfer. In terms of delivery of the spec this has remained the same".

"Revision of the service, streamlining of the service, more robust processes in place and additional supervision, support and learning opportunities"

"New service delivery, more public health focus, more partnership working"

"We have been fortunate to have been invested in and this has had a positive impact. We have more staff, better resources ….and ….a voice!!"

"I believe young people are getting a far better service as they have access to a school nurse in every secondary school 5 days a week. This can however take a toll on the school nurse as they are now very much lone working – we do have a weekly team meeting but that isn't the same support wise as being based in a single office"

"Each secondary school has its own designated school nurse, as a result more children and young people have used the service as accessibility has improved"

"We continue to do a lot of child protection but we now have a greater focus on health promotion and education"

Some respondents highlighted a mixed picture:

"Agreed pathways between mainstream and specialist school nursing team. More parent workshops and group interventions around public health. Assisting multi-professional clinic no longer in our service unless working with specific child"

"Commissioners are more descriptive on delivery of sex and relationship programme and reduce the number of sessions from last year to the schools I cover and teaching plan on healthy behaviour and relationships with particular focus on increasing awareness of child sexual exploitation and domestic abuse. The schools are very clear what they would like i.e. school nurse to cover puberty for year 5 and 6 and contraception and STIs plus relationship discussions for years 9 and 10"

"Specific targets, some inappropriate like chlamydia tests for 70% of all young people who come to drop in. less time

for PSHE now, as this is not one of the targets. Despite this they are supportive and they do listen sometimes. They have invested in school nursing in XXXX, whereas in XXXX they lost sight of the aims of the service, so I moved counties!"

Others however highlighted negative experiences:

"40% service cuts since the local authority started to commission us – much less contact with children and young people"

"Service delivery directed by local authority priorities not priorities of local population and individual children"

"Ridiculous handover to local authority. Budget and funds not assessed or transferred. Loss of posts and increase in workload resulting in red risk register"

"Following a consultation in December 2014 our team lost a full-time Band 6 and a full time Band 4. Replaced by 2 Band 3 health care assistants"

"For approximately the last 2 years there has been no school health board nurse visiting due to staffing sickness/shortages, no drop in service provided, minimal contact with school health colleagues which has impacted on delivering health promotion lessons"

"Confusion! More than one 'boss'. Lack of understanding from local authority and NHS about staffing and role"

"Less time to be present at schools. Less time to work with children, their parents and teacher. There are some services that I can't no longer do, like I used to do unlimited health promotion sessions. Now there has to be a few a year"

"No longer screen at school entry. Less health promotion. No longer able to deliver as much PSHE. Less one to one work for emotional health and wellbeing"

"There has been a split in provider services, so the public health side is commissioned for one team and the CCG is commissioned differently and immunisations also are separately commissioned. It has fragmented the service and led to a loss of qualified school nurses, and cuts to service provision"

"Feels like 2 masters i.e. Public Health England for vaccination programme and local authority for providing healthy child input. Both impact on capacity and both insist they are the most important"
"Decommissioning of key school nursing services such as sexual health, teenage pregnancy, health promotion, PHSE"

"No longer give health promotion/education input. Main role is safeguarding and fire-fighting issues with reduced resources to refer to. No longer able to provide full enuresis clinic/service. Health visitors under different provider so not easy to liaise about same families - have to get written permission to liaise! Also strict guidelines about who looks after who – school nurses cannot deal with 4 year old reception children even though they are in full time school and even if 4 years 11 months – has to be health visitor – makes for inconsistent care if issue then needs to be passed on a month later"

"Change in NHS provider, take over. Now not run by my local NHS provider. Unable to access local health centres"

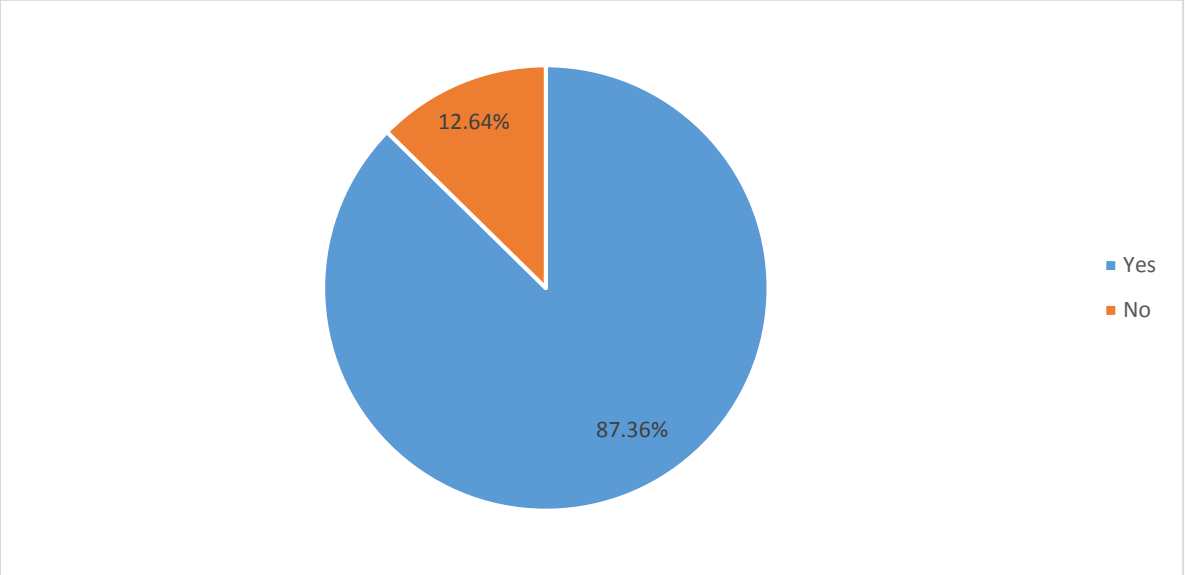
"Confusion! We are commissioned by three different places CCG, NHS England and local authority for immunisations, healthy child programme and enuresis and they don't talk to each other. Therefore we end up with competing priorities and unmanageable workloads. Uncertainty over the long term future of the service and our jobs as it is going out to tender this year. Staff are worried about jobs and continuity of care for patients. Priorities are set by commissioners that don't fully understand the service or listen to the staff on the ground. They come up with ideas and we have to change what we do and what our schools are requesting to fit in with the new ideas flowing from above"

"Lack of paediatric incontinence clinics. Withdrawal of sight /hearing screening. Changes in immunisation provision – changing from GP to school based clinics"

"Less staff, workload increase, less opportunity to see children and young people, no longer offer the comprehensive service we used to provide"

The vast majority of respondents indicated that other than themselves, other school nurses were employed by their employer as part of the school nursing team (see Figure 23).

Figure 23: Other school nurses employed as part of the school nursing team



The number of other school nurses employed on a full-time or part-time basis in the organisation varied, with some employed on a variable and occasional basis (see Figure 24, 25 and 26).

Figure 24: *Number of school nurses employed full-time in the organisation*

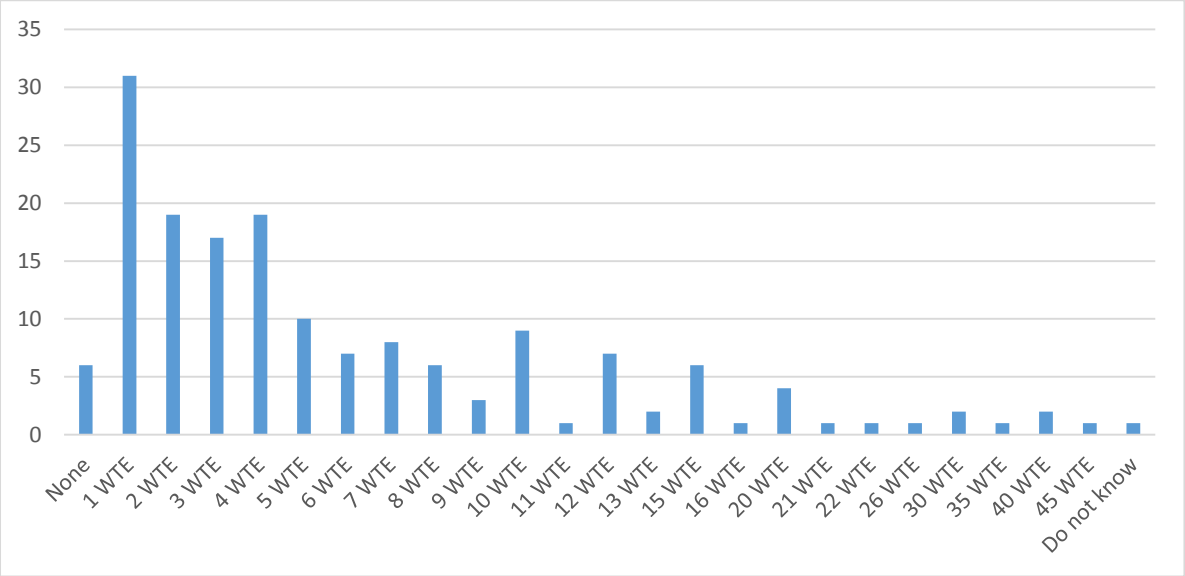


Figure 25: *Number of school nurses employed part-time in the organisation*

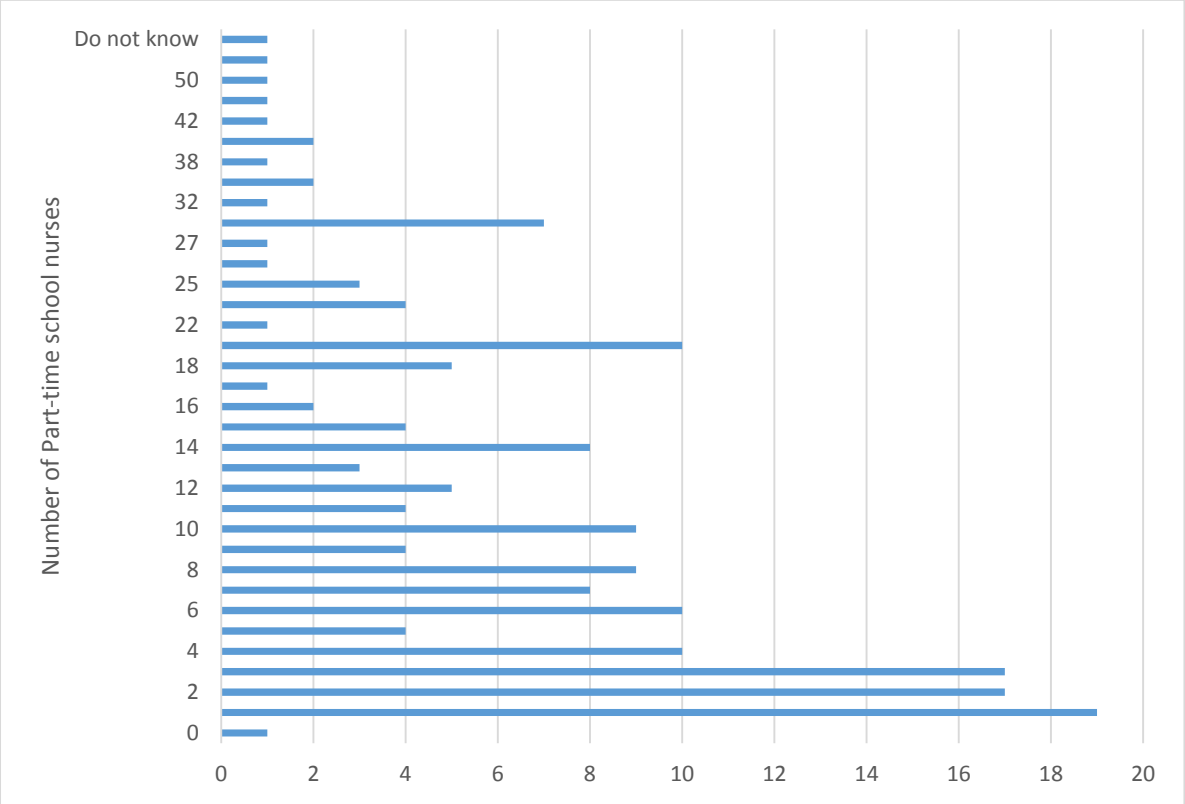
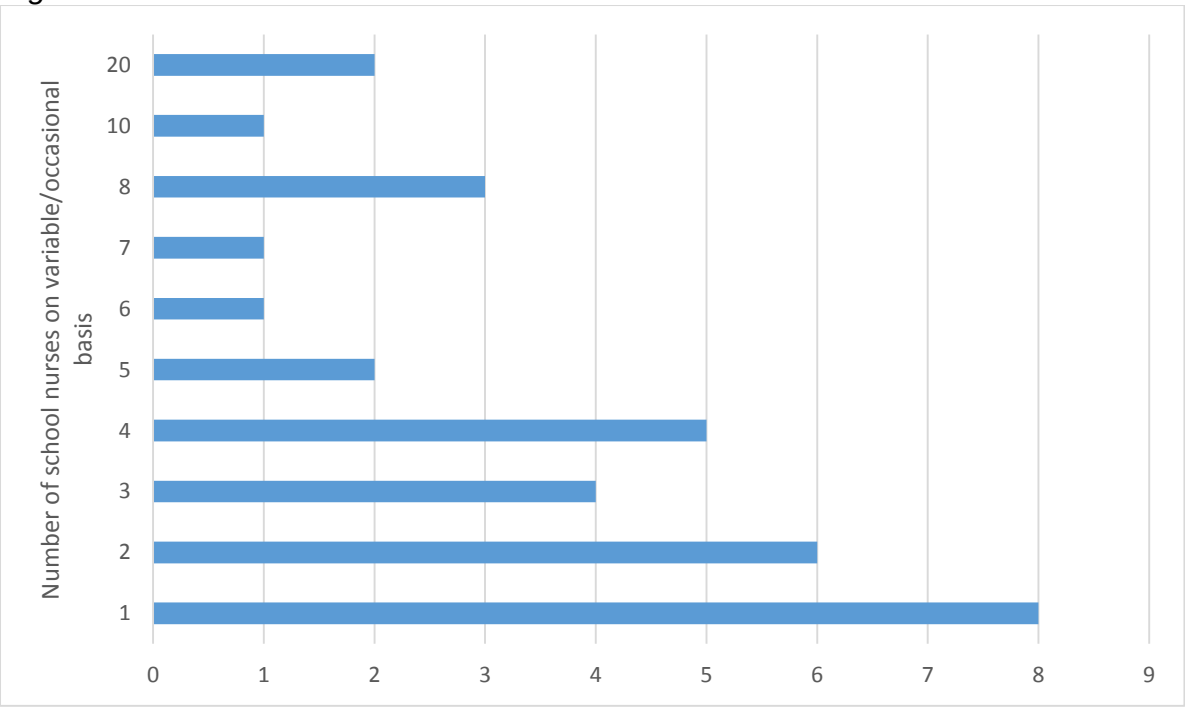


Figure 26: *Number of school nurses employed on variable/occasional basis in the organisation*



The number of other school nurses employed on a full-time or part-time basis in the cluster/locality/team varied, with some employed on a variable and occasional basis (see Figure 27, 28 and 29).

Figure 27: *Number of school nurses employed full-time in the cluster/locality/team*

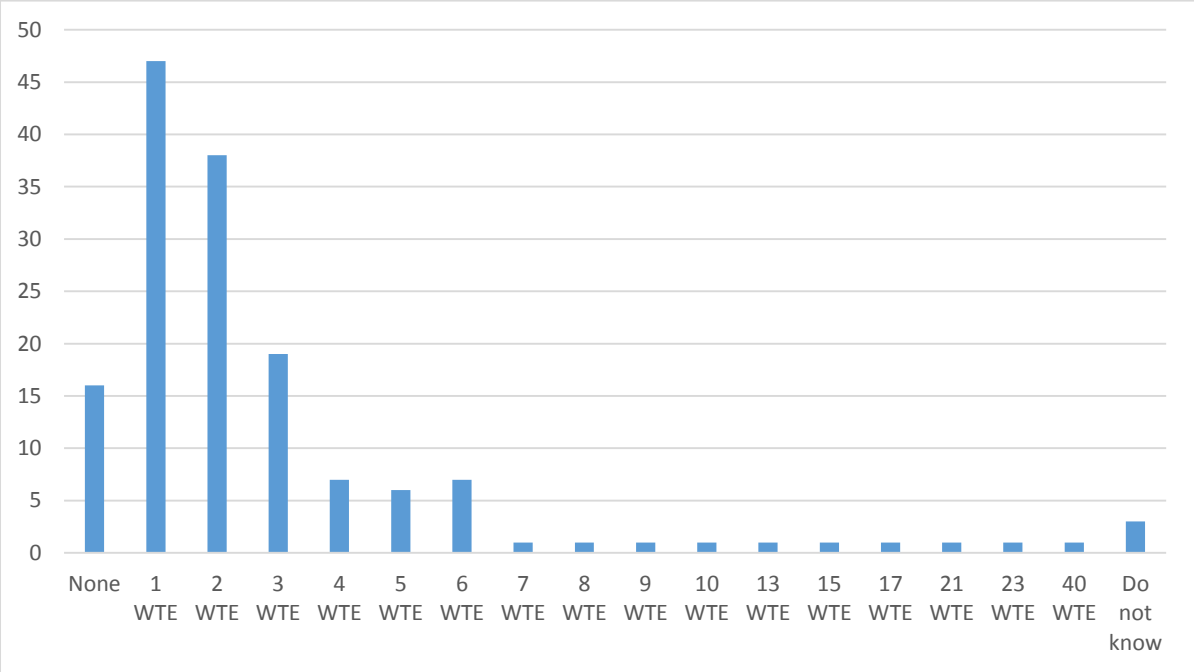


Figure 28: *Number of school nurses employed part-time in the cluster/locality/team*

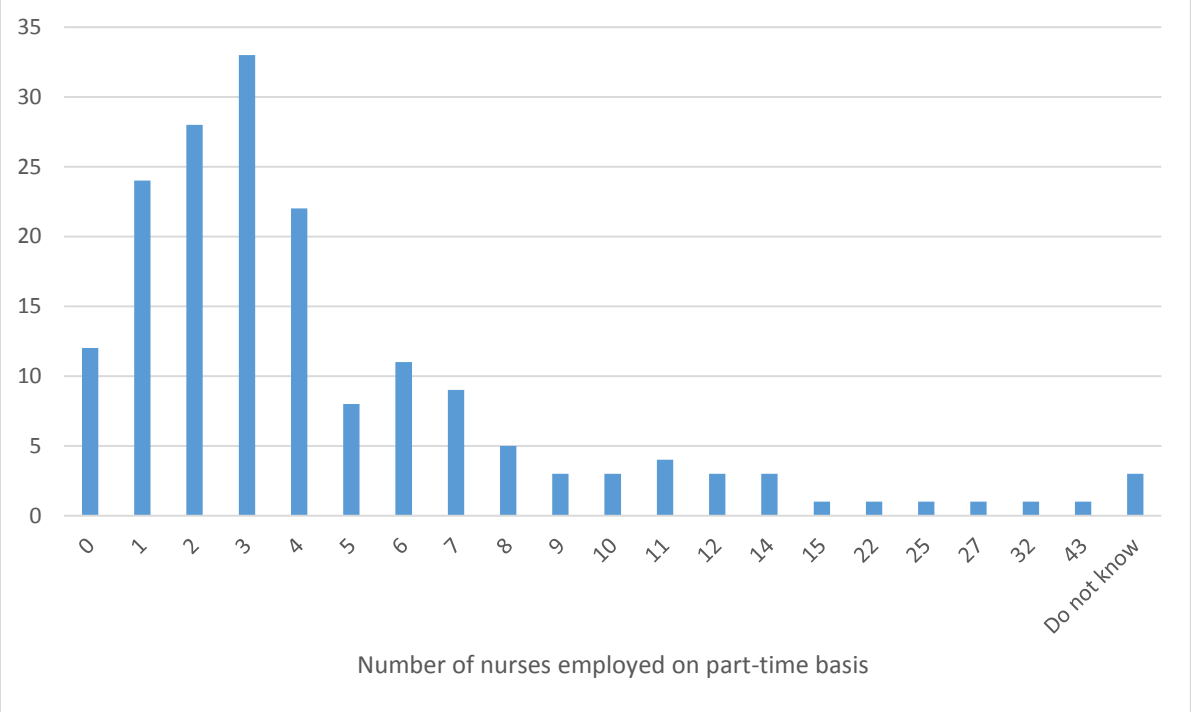


Figure 29: *Number of school nurses employed on a variable/occasional basis in the cluster/locality/team*

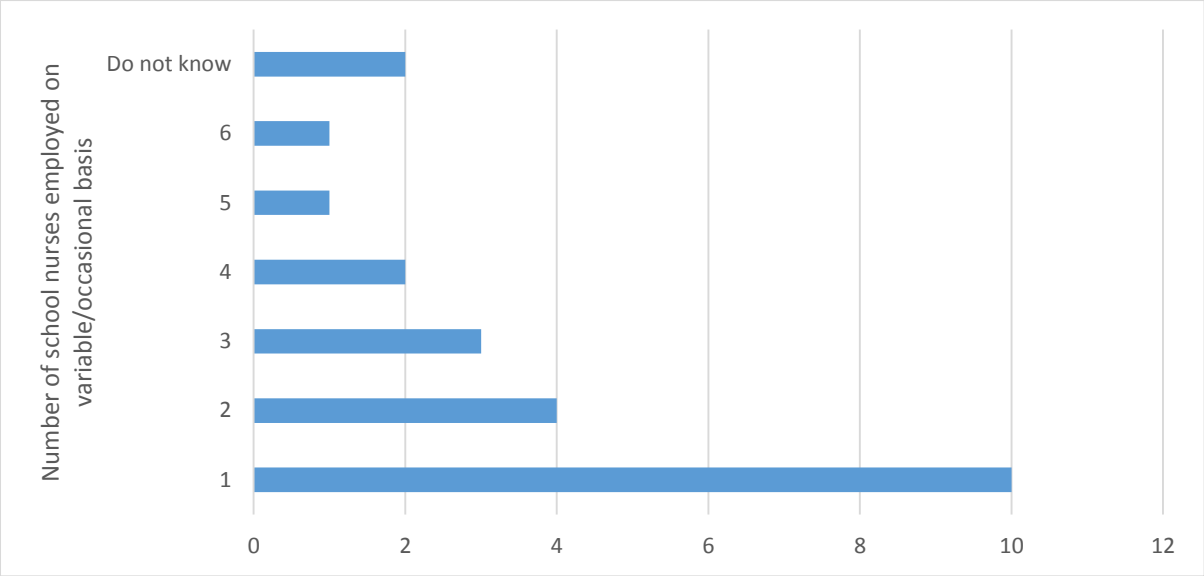
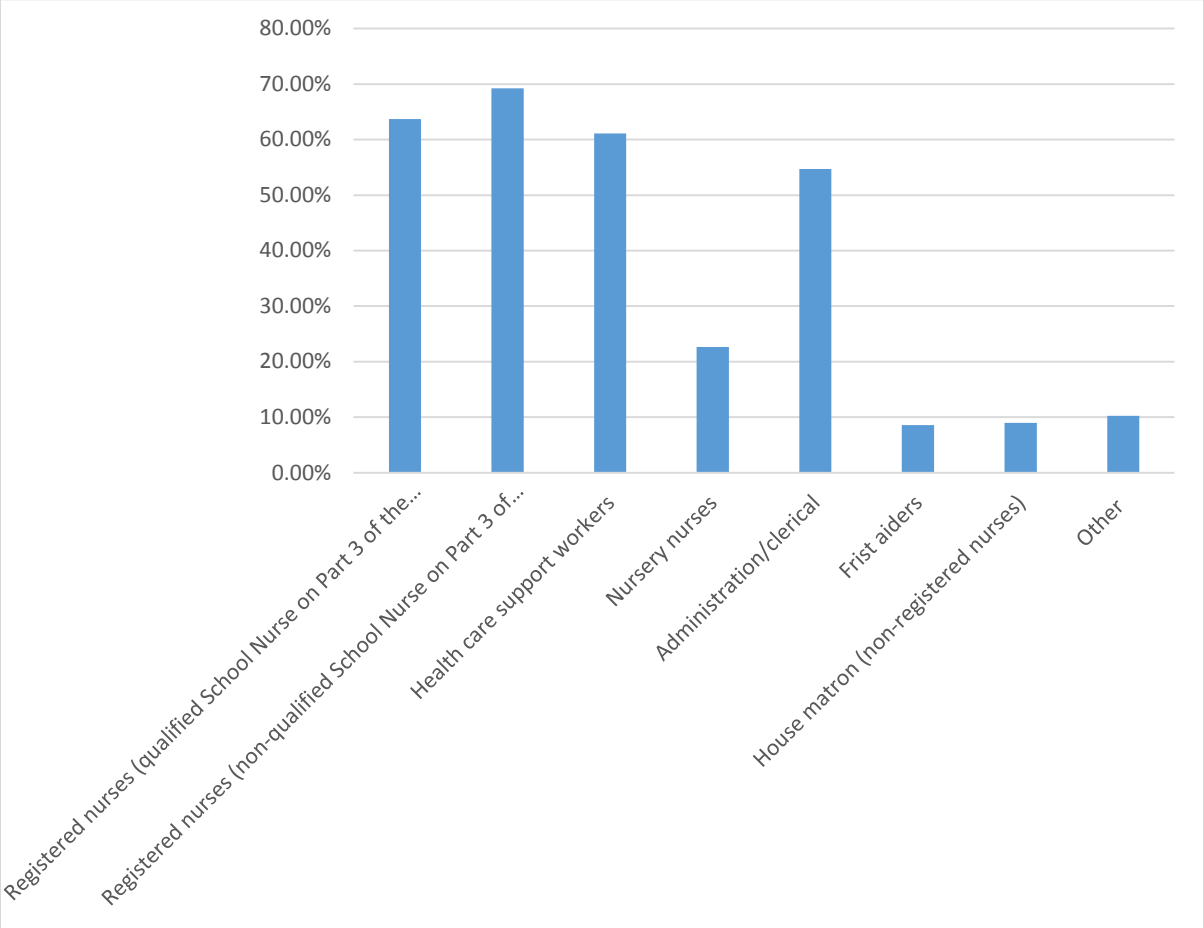


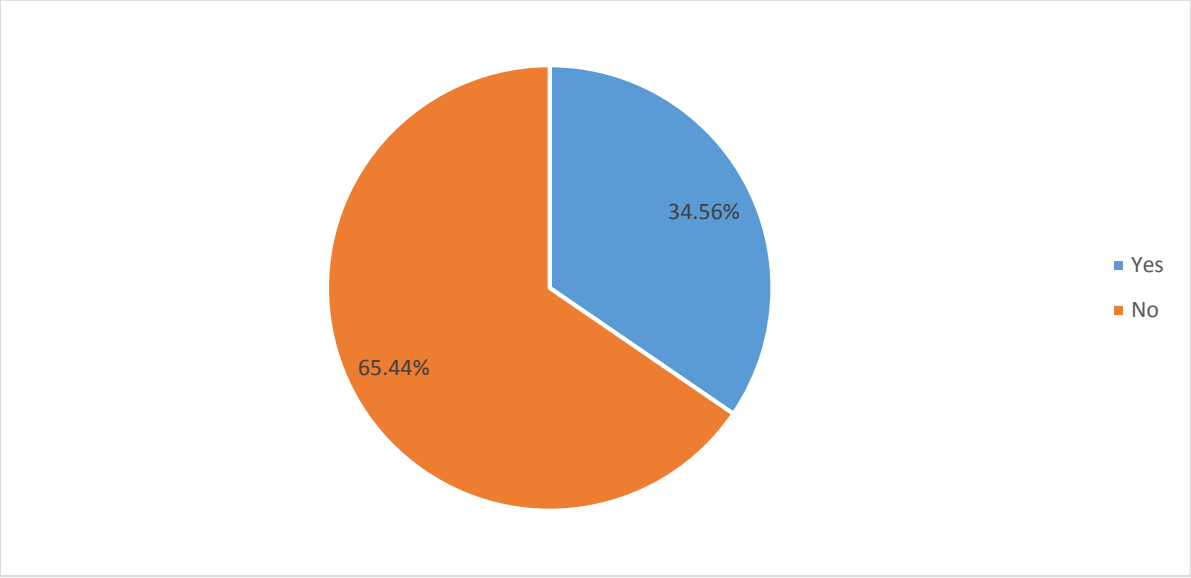
Figure 30 highlights the range of staff employed as part of their cluster/locality/team, including registered nurses with the Specialist Community and Public Health Nursing qualification, as well as House Matron's in independent/private boarding schools. The 'other' category includes registered leading disability nurses, school nurse assistants, youth workers and housekeepers.

Figure 30: *Staff employed as part of the cluster/locality/team*



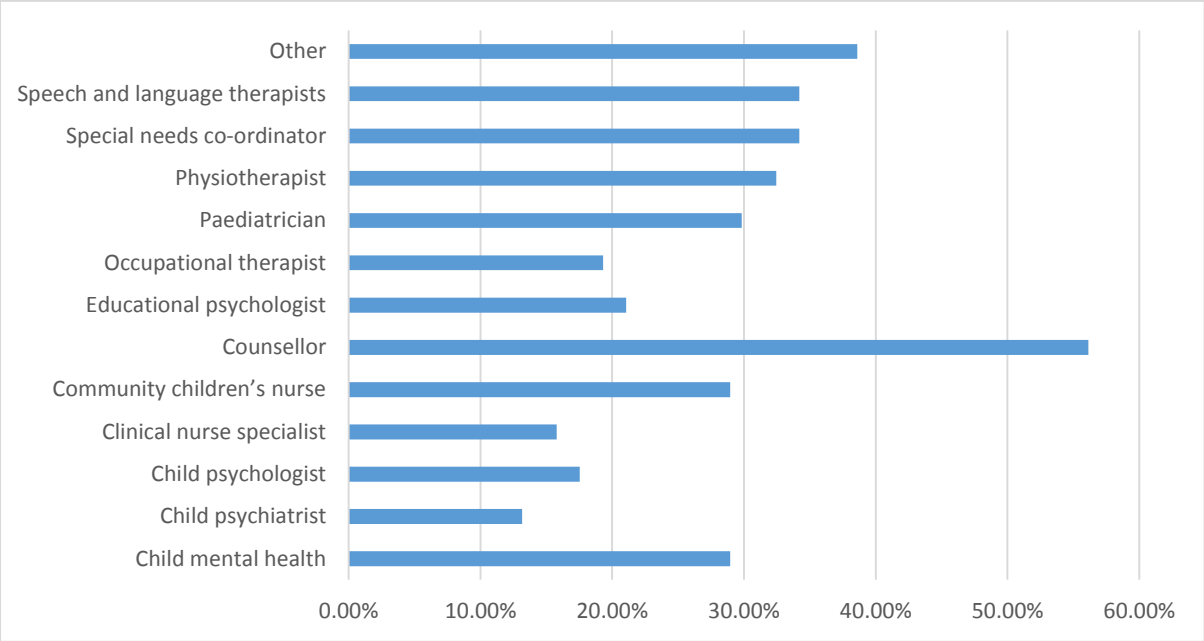
Only thirty five percent of respondents indicated their school nursing service was part of an integrated multidisciplinary team (see Figure 31).

Figure 31: *School nursing service is part of a multi-disciplinary team*



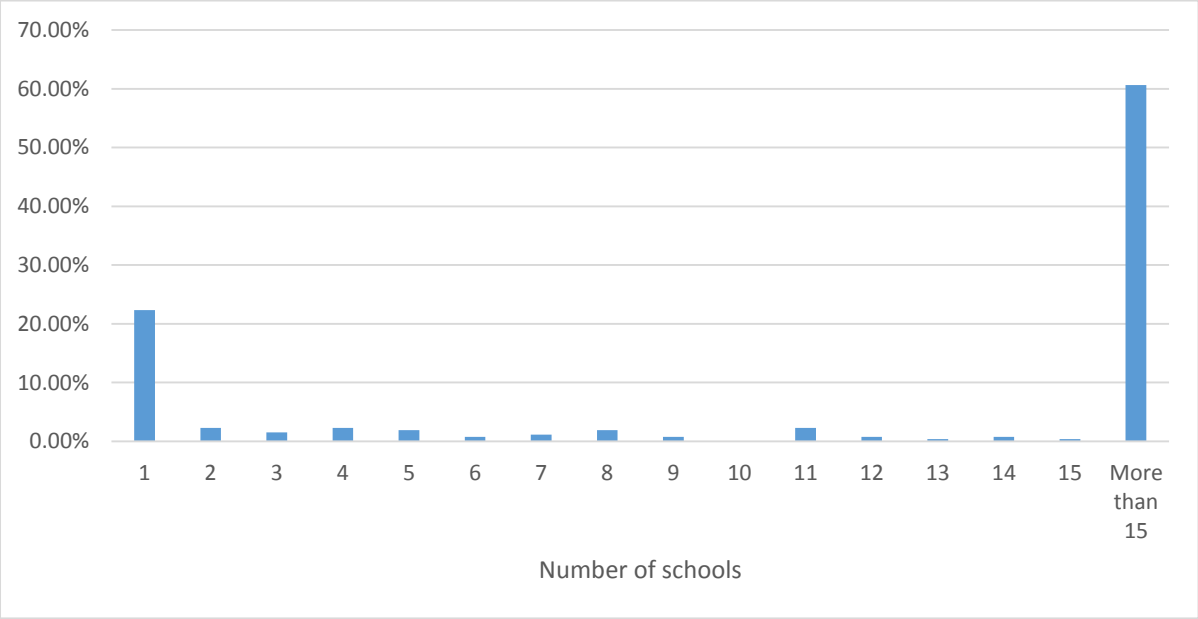
Respondents indicated a wide range of professionals within their multi-disciplinary team (see Figure 32). The category 'other' included GP, dietician, social worker, pastoral care, PSE teacher and immunisation nurses

Figure 32: *Range of professionals within the multi-disciplinary team*



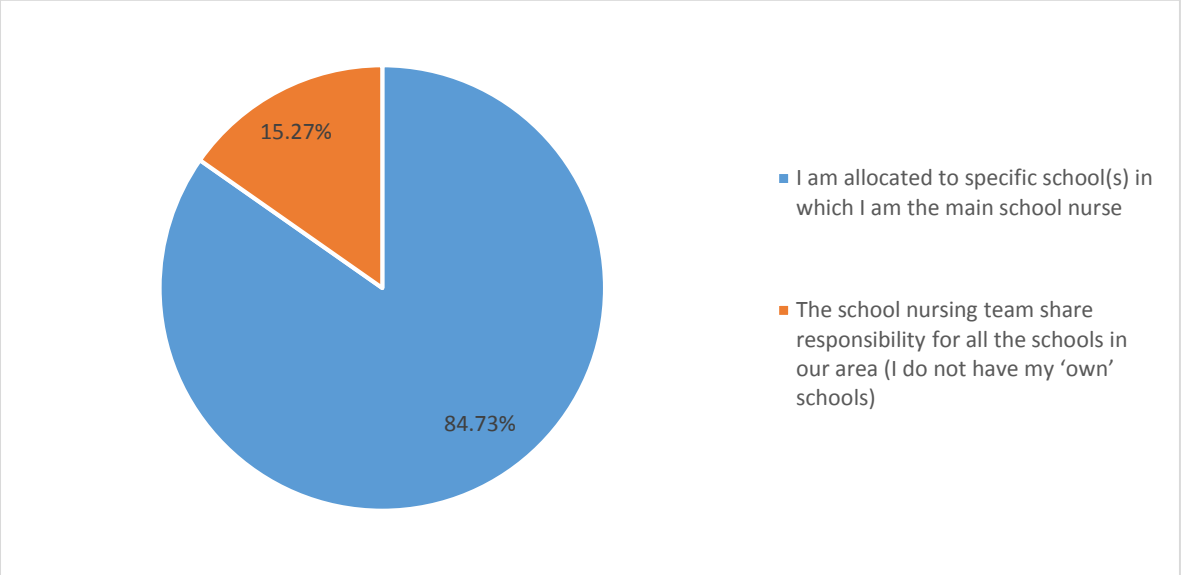
Respondents highlighted that the number of schools the school nursing cluster/locality/team covered varied considerably, with the majority reporting that they covered more than 15 schools (see Figure 33).

Figure 33: *Number of schools the school nursing cluster/locality/team covers*



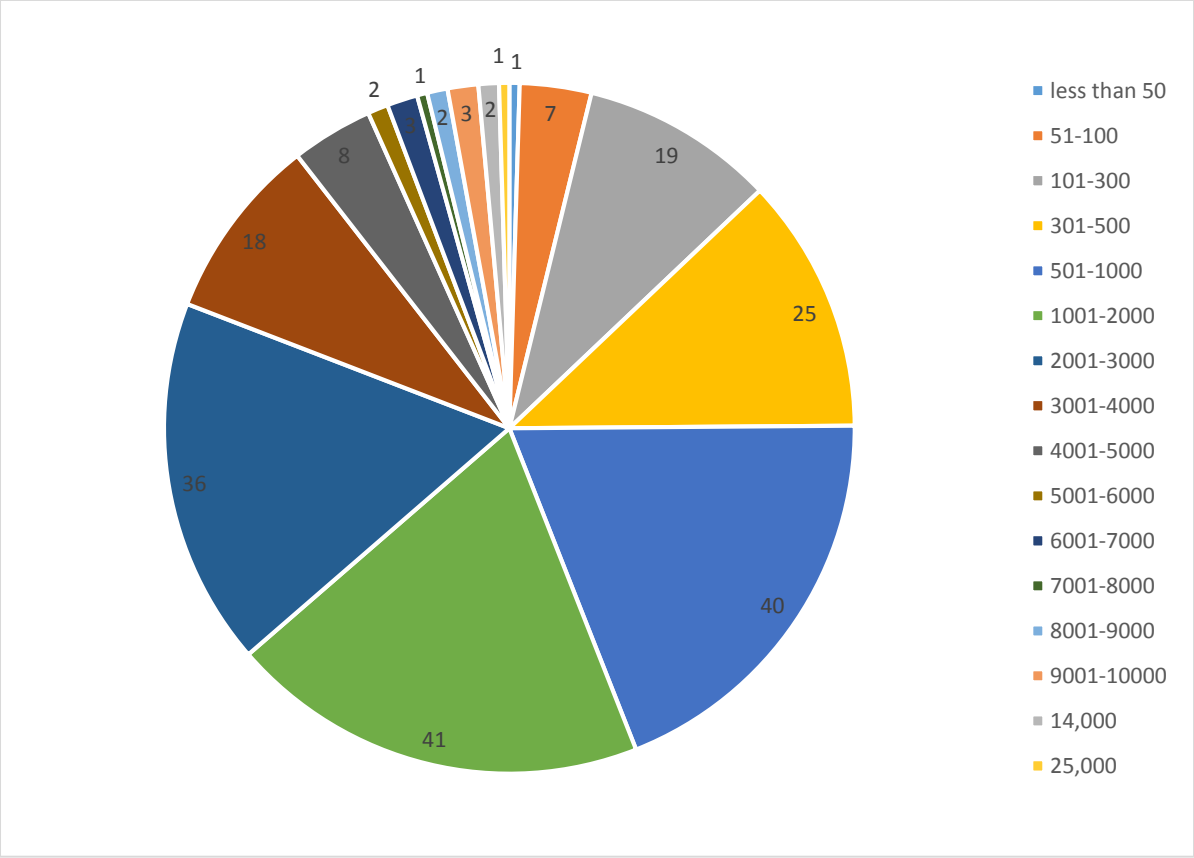
The majority of respondents reported that they are allocated specific schools for which they are the main school nurse (see Figure 34).

Figure 34: *Allocation of schools*



The total number of children/young people in the schools/colleges where respondents are the main school nurse varied considerably, from less than 50 to twenty five thousand (see Figure 35)

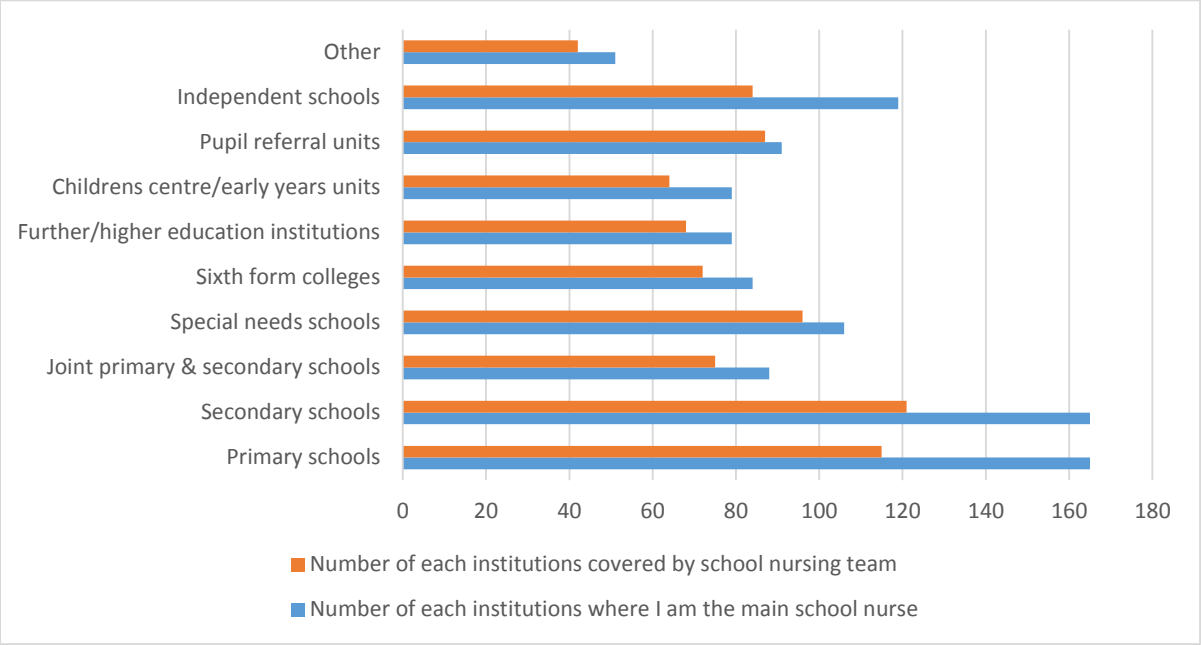
Figure 35: *Total number of children in the schools/colleges*



As the main school nurse the number and range of institutions covered as an individual and as a school nursing team varies considerably as can be seen in Figure 36. Other

includes home schooled children, youth offending team, special needs pre-school, day nursery and local authority children's homes.

Figure 36: *Number and range of institutions covered*



Over sixty six percent of respondents undertake home visiting as part of their role as a school nurse (see Figure 37), with 41.4% seeing children who are educated at home/have been removed from school for home education (see Figure 38).

Figure 37: *Undertake home visiting as a school nurse*

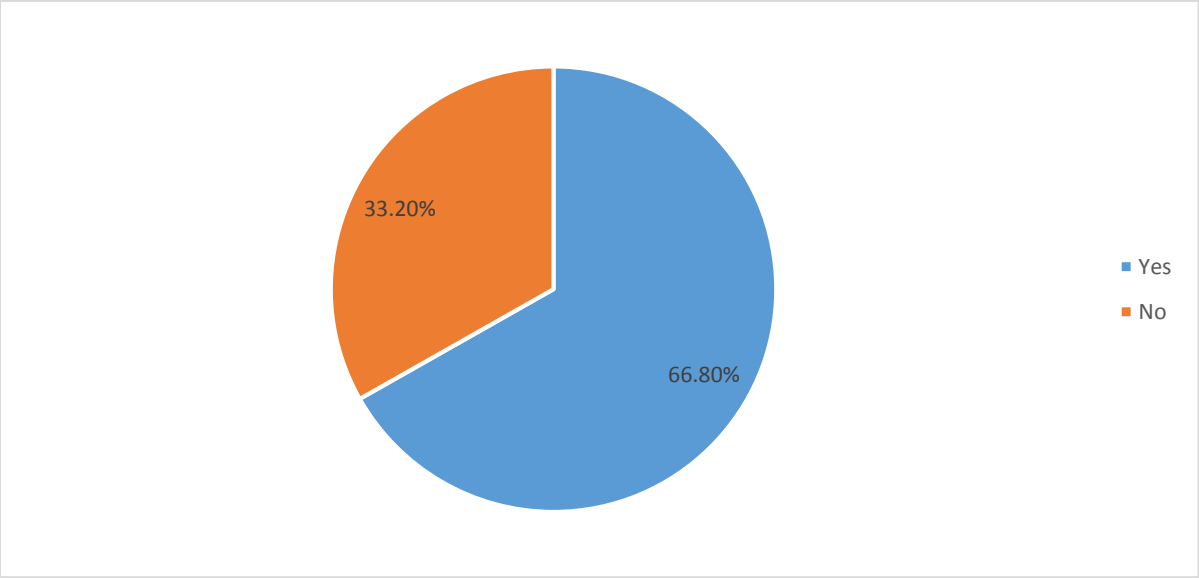
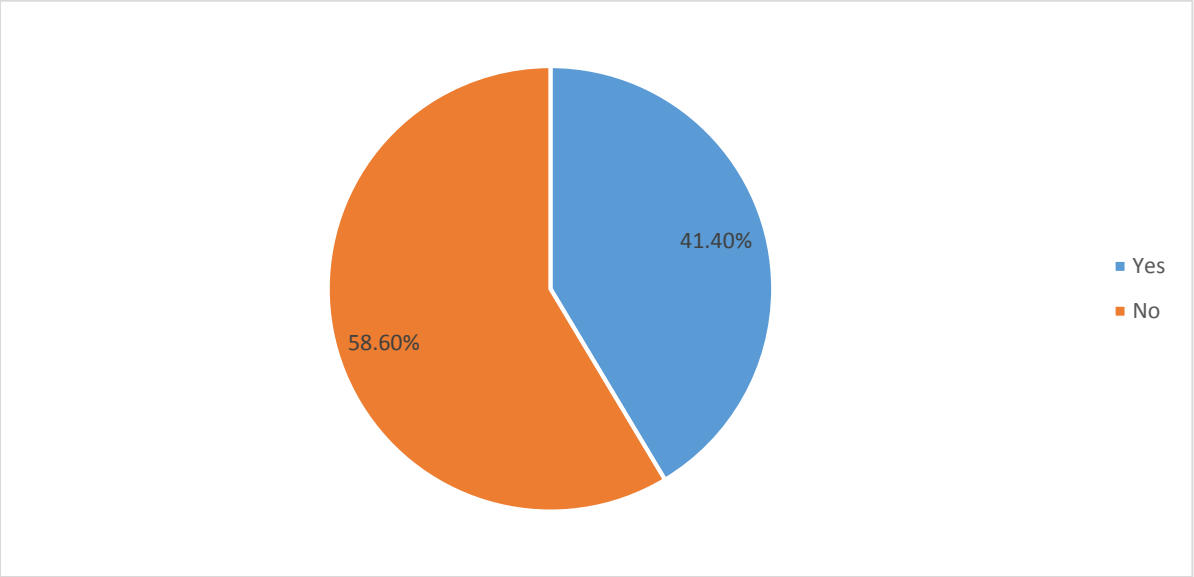


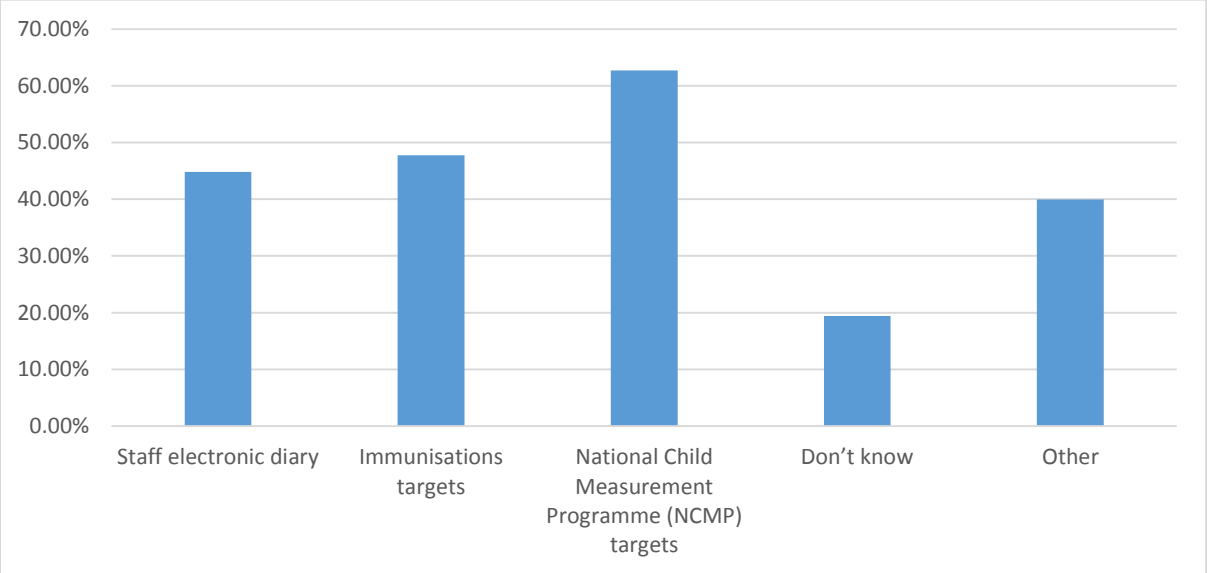
Figure 38: *See children who are educated at home or been removed from school for home education*



Monitoring school nursing performance

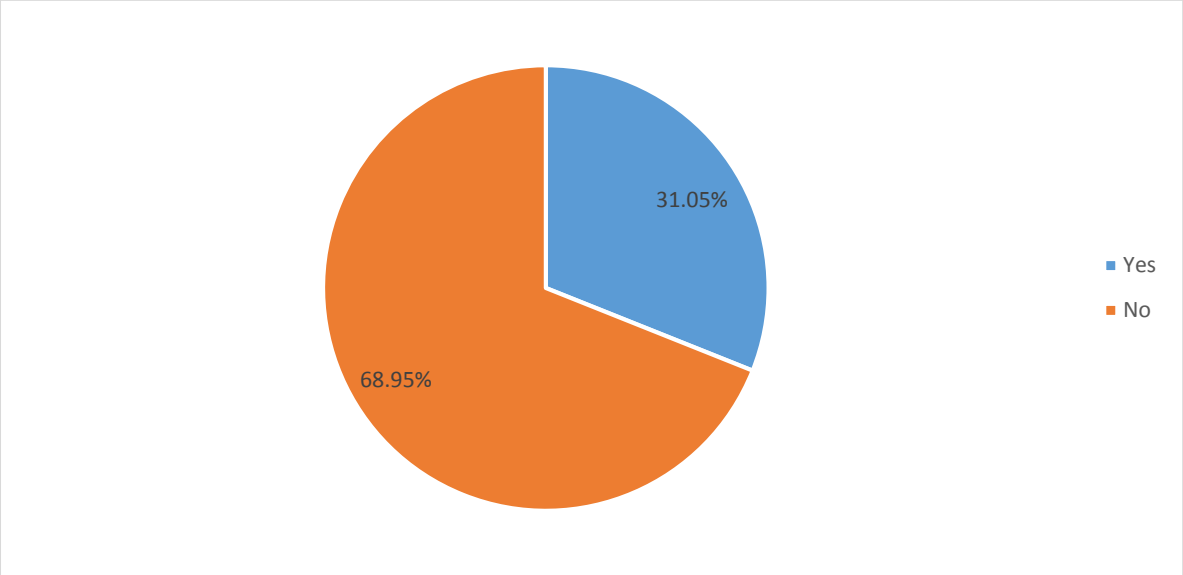
Respondents highlighted a range of mechanisms by which school nursing performance is recorded and measured (see Figure 39). The 'other' category includes key performance indicators set by the local authority, audit of practice, parent/pupil and teacher feedback.

Figure 39: *Mechanisms by which school nursing performance is recorded and measured*



The vast majority of respondents do not feel that the mechanisms in Figure 39 are effective ways to monitor and measure school nursing performance (see Figure 40).

Figure 40: *Effective ways to monitor and measure school nursing performance*



Some of the challenges with monitoring and measuring identified by survey respondents included:

> Lack of clarity around what exactly to enter on the Lorenzo system. Lack of access to IT. Lack of time to complete the data collection

> Staff find it difficult, to find time to record in electronic diaries and it is very hard to capture the breadth of work that school nurses undertake using electronic coding

> The job is so varied not everything can be monitored. We are also employed by NHS England and the local authority therefore priorities differ

> Trying to fit in what we actually do into computer recording data set up primarily for mainstream nursing team. Cannot always find the 'right code' to click

> Isolation from mainstream school makes it hard to know what and how they monitor

> Management understanding of the job unrealistic expectations

> The above [Figure 40] captures some of the tasks we do but it is hard to capture the hours that go into safeguarding and support for children with complex needs and teaching education staff to care for them

Measuring effectiveness of interventions is difficult as no nationally agreed or evidenced based wellbeing assessment tools

A lot of public health work can't be measured as outcomes won't be known for many years! Safeguarding takes a lot of time but is not measured or accounted for

It is hard to define what we achieve in a day's work. Immunisations targets are good but we see children and young people and perform good quality Public Health Service that cannot be measured on targets

I am the only school nurse and so it's hard for the non-medical management to know if I am doing a good job or not. This is also difficult in terms of meeting the revalidation requirements

Some referrals for children with complex health needs require significant support and multiple referrals that are time consuming, they require multiple telephone contacts - how can you measure this?

Incorrect data entry, incomplete questionnaires. Time required for staff to accurately record the vast work they do

None of the systems seem to have been built with school nursing in mind, they don't really capture what we do. I have been busy all today but my recorded work on the spread sheet shows I wrote a care plan, did a hearing test and made a referral. The face-to-face and telephone contacts do not count whether to parent, student or professional. Nor do I have any way to record my admin work - someone should be asking why a Band 6 is being paid to do Band 2 work

The electronic system is not set to provide the data hence we have to collect this manually which is time consuming and not very cost effective. Due to the preventative nature of the service it is difficult to measure outcomes straight away hence the data collected very often does not reflect the work being done on the front line. Key Performance Targets have been set by professionals with no experience of school nursing and set at 100% which means they are unachievable at best of times. With hardly any staff to do the work this makes it very stressful for the front line staff

Every child is different, arguably there is a lot of disparity between children so who is to say what is right for one child is right for another

Not able to evidence that the work we do has significant benefits and impact on the children and young people s health in adult life

Role is too diverse & unpredictable to capture all activity. No two contacts require the same amount of time - what appears to be a simple contact turns out to be a complex piece of work whilst another can be a five minute activity

Challenges for monitoring School Nursing performance is that a lot of our outcomes are qualitative not quantitative

When you are giving support in a difficult situation it is not appropriate to then ask for the client to complete a feedback form

A lot of the work is safeguarding and so to measure the impact school nursing has in this is very difficult. To attend meetings and undertake health reviews is fine but to know what impact this is having and to evidence this to commissioners is very challenging

To provide evidence that the health information given is helpful and valid. Especially as sometimes people use this information for later on in life e.g. breast awareness talks and may find a lump as a result of checking her breasts as the school nurse mentioned the importance of doing so many years before

My appraiser has no medical experience and does not really comprehend the pay structure, how we register or our full roll

Individual children and young people develop at differing rates according to their own circumstances, so improvement cannot be given a definitive time span

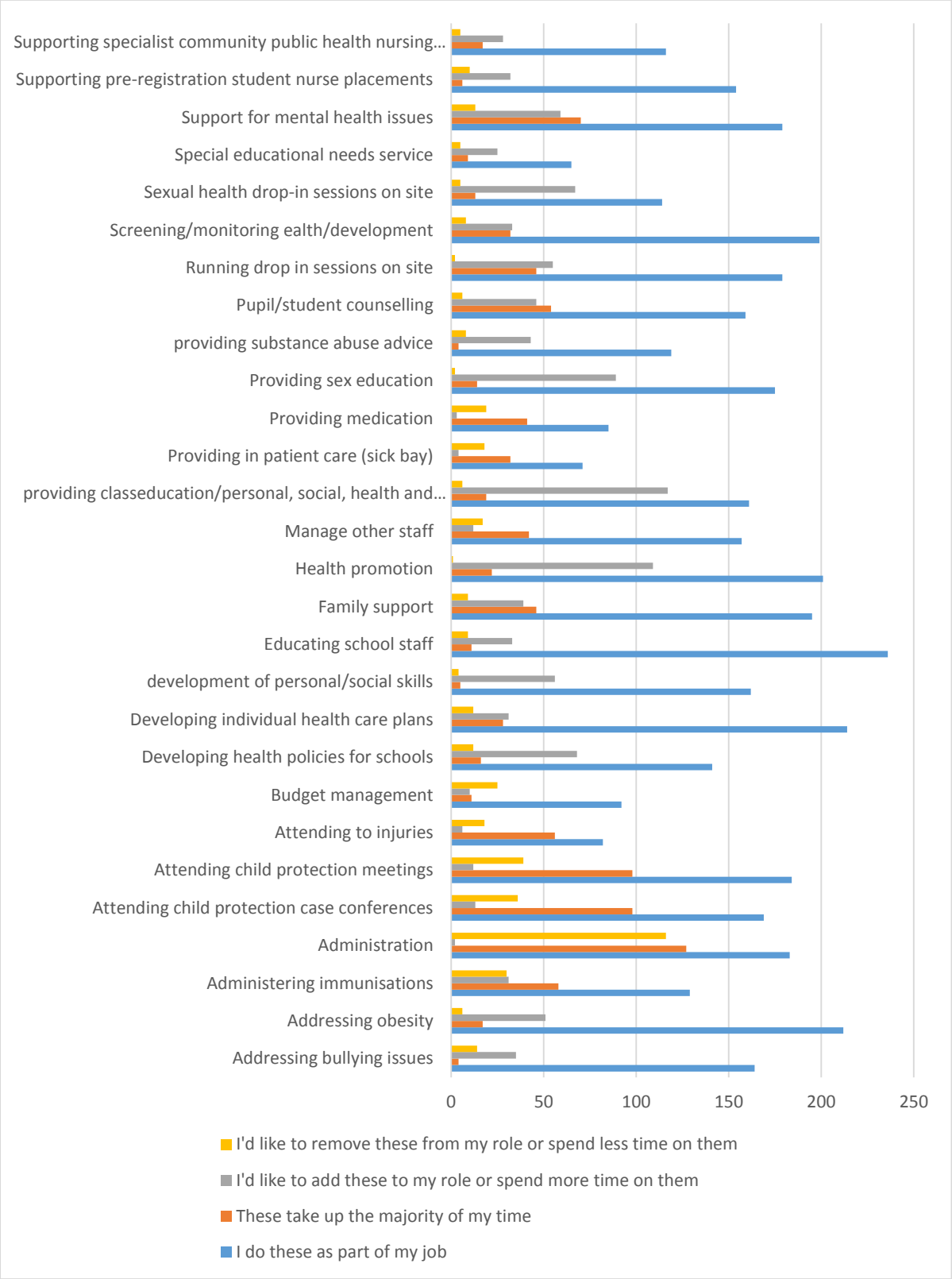
Ineffective IT is a huge issue which equates to time wasted

Hard to have the time to consider it as your every day job, you are just too pressured

Role and activities

Respondents were asked to identify activities that were part of their role, those activities that took up the majority of their time, as well as to identify up to 5 activities they would like to do less and which activities they would like to spend more time on (see Figure 41).

Figure 41: Activities of the school nurse role



The most commonly shared aspect of the school nursing role was educating school staff (81.7%). The tasks which take up the majority of respondents' time include attending to injuries (34.6%), attending child protection case conferences (31%),

administration (29.7%), attending child protection meetings and providing medication (27.7%).

Respondents clearly indicated that they would most prefer to spend more time on educational activities i.e. providing class education (PSHE) (38.6%), health promotion (32.7%) providing sex education (31.8%) as well as running sexual health drop-in sessions on site (33.7%) and developing health policies (28.7%).

The survey results indicated that respondents would most like to remove or spend less time on administration (27.1%) and budget management (18%) in their roles.

When asked what other tasks not represented in Figure. 42 they undertake as part of their school nursing role, respondents commented:

> We test hearing and measure children, provide emergency department visit follow ups, provide anaphylaxis and buccal midazolam awareness sessions for school staff, promote School Nursing in the community in the events like Roma Day. Develop policies and practice in practice development groups
>
> Research opportunities should be added
>
> Pregnancy health checks for staff
> Staff counselling
>
> Coordination of the counselling service
>
> Supporting carers
>
> Parenting support, parenting classes, safeguarding
>
> Eating disorders management
> Asthma reviews
>
> Peer reviews take a great deal of time, I recognise their value, but this reduces the time I have to use my skills to support children
>
> We are expected to complete Common Assessment Frameworks with families which takes up a lot of time completing the paperwork sending this out to agencies, arranging meeting, minuting the meeting typing them up sending paperwork on again to the families and professionals. (We have no admin staff for support). This process can be made less time consuming without the paperwork, and may have the families more on board if the paperwork didn't exist there appears to be a stigma against it

I carry out lots of health needs assessments and behaviour management support

I carry out clinical care such as enteral feeding, epilepsy management. Emergency care, respiratory support such as tracheostomy care, oxygen therapy and Naso-pharyngeal airway management

Providing advice around continence issues. We have an Enuresis team but nothing for soiling issues and a lot of our team feel we lack skills (collectively) in this area

I would like more administrative support especially around preparation, ordering and data inputting of immunisations

Huge amount of time reviewing domestic violence notifications from the police, which doesn't help the children in this situation. I would like to remove this from role and spend time running groups for children living in households where there is DV

Running more groups for young people such as LGBT group

Working with commissioners
Working on tenders
Implementing quality standards

Education, Health and Care Plans (EHCPs) are a massive job for special school nurses

Risk assessing

The majority of respondents identified lack of time and capacity as the key factors which prevent them from dedicating more of their role to preferred activities:

Time constraints

Time, always having to prioritise the priorities

As a lone worker, I have to manage the minor injuries/illnesses at the same time as giving time to pupils that have mental health issues. I'm spread too thinly and the school won't employ a counsellor

Time and increased paper work/records management

Documentation, data collection requirements and very high level of safeguarding & vulnerability within my active

caseload which requires lots of meeting attendances, home visits and liaison / referrals

Caseload especially child protection

Being the sole School Nurse for my cohort and there just not being enough time

Time and the amount of children who use the service on a daily basis

Time limit associated with number of staff to schools ratio

Time and availability of resources

Never enough hours in the day

Lack of time

Other factors included funding, staff shortages, job description / remit and management buy in:

Money as budgeted have been cut significantly with the fragmented commissioning arrangements

Staffing shortages

Not having enough staff to carry out the regular care of the children

I am the only qualified nurse on site. No budget for additional support staff

Not in our School Nurse specification & capacity

We are not allowed to do anything outside of our five key roles: immunisations, screening, drop in, safeguarding, health care plans

Constraints imposed by management

Management putting up red tape

Working in a Catholic school stops all sexual health education

The identified key tasks set out by management, who do not understand the variety of activities of our role

Respondents highlighted a wide range of professionals they work with on a regular basis and who refer pupils/students to them (see Figure 42). Parents and teachers are the groups which respondents advised more often refer children and young people to them. This was followed closely by health and social care professionals including GPs and health visitors.

Respondents indicated that they work with Children and young people, parents and teachers most regularly. Again, this was followed closely by health and social care professionals such as GPs, health visitors, social workers, special educational needs coordinators. Careers advisory agencies, pregnancy advisors, youth justice and the police do not appear to work with survey respondents on a regular basis of at least once a month.

Almost twenty four percent of respondents reported that their service did not have explicit pathways and processes in place to deal with referrals and just over twenty one percent indicated that pathways and processes were partly in place (see Figure 43).

Comments regarding inexplicit pathways and processes included the following:

> Referral forms- staff often object to completing these opting for verbal or email instead. When completing them they are usually filled in incorrectly

> With regards to child protection there are clear pathways. Direct referrals are self-explanatory and I have an open door policy. If I am concerned about an incident with a child at school I will also give parents my contact number- it is also available on the school website / information sheet

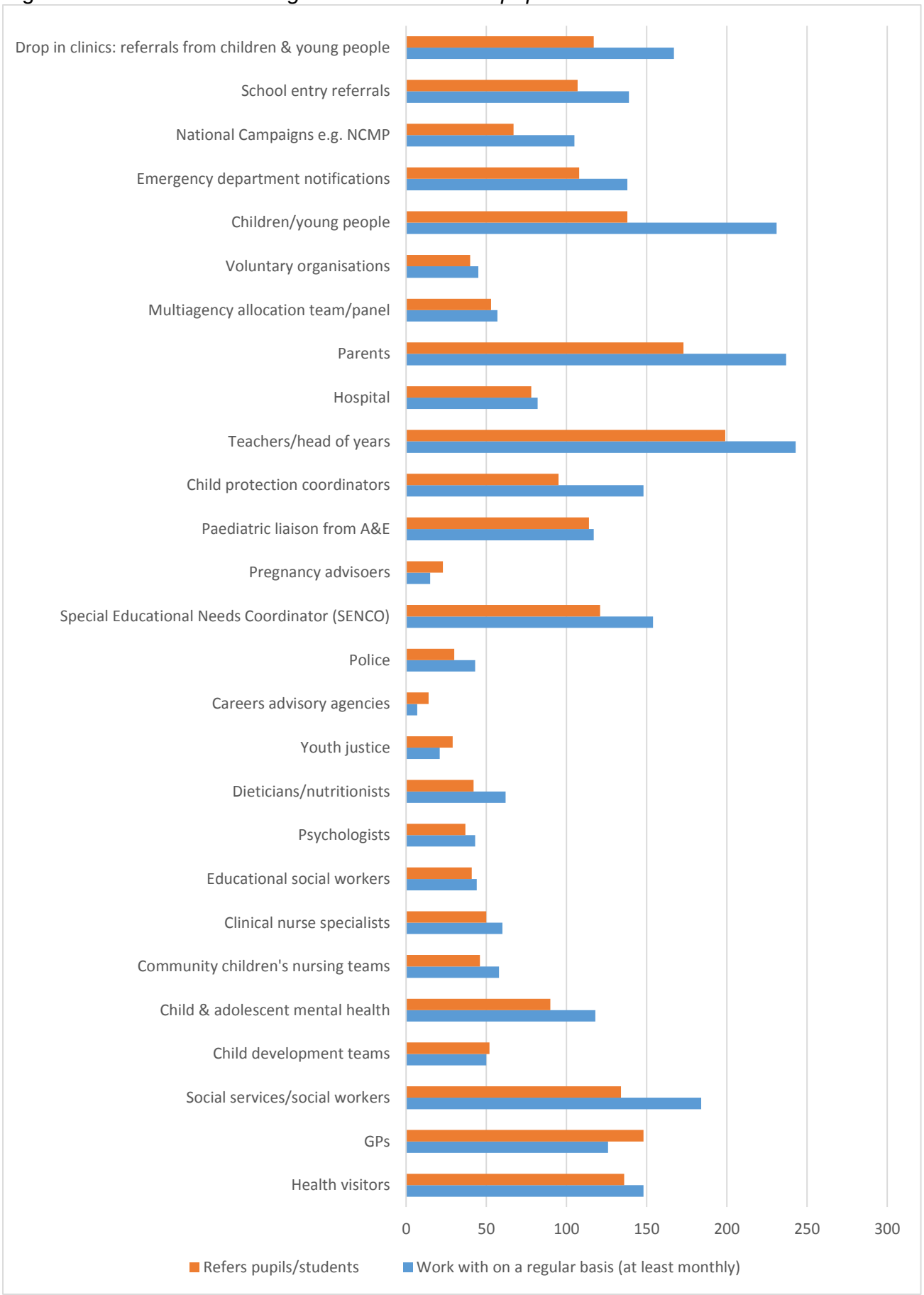
> The processes in place are not always used, and often referrals are made informally. This is not ideal and individual nurses like myself usually request a basic written referral which includes specific information, before we will consider accepting it

> Referral form used for professional referrals, parents/carers & children/young people can self-refer by telephone or face to face. Referrals reviewed by myself and decision made re acceptance. Letter sent to referrer and parent/carer acknowledging referral and outcome.
> Where referral accepted name added to waiting list then allocated when appropriate staffing capacity allows. All referrals taken in date order with exception of safeguarding ones that have to be prioritised. When intervention complete discharge report sent to parent/carer and referrer

> Single point of entry and then each nurse collects daily referrals from all different areas. These have to be put onto a spread sheet but this is new and no one remembers to record it as too busy

> We have a referral form but the vast majority of referrals are verbal. Where they are written they are hardly ever submitted on the referral form. We have no policy of pathway and as a result

Figure 42: *Work with on a regular basis and refer pupils/students*



there can be a grey area of things we accept. Some people will do some things while others will not

Pathways are still being formulated

There is a formal pathway but to maintain relationships with schools and pupils I tend to take them informally

They were rushed out just days before the CQC inspection

We have standard operational procedures that are new, these cover some of the pathways but not all

We have referral forms but we often get calls from schools with queries that we pick up, we also have regular head teacher meeting & safeguarding meetings at GP meetings where info is shared & referrals get picked up. CYP also self-refer & attend drop ins or their parents call, request appointment through GP

Sadly the biggest referral we need is mental health.....and the pathways are muddy and also no early intervention. Unless young people suicidal there is very little help

Have a referral form - in practice this doesn't always work. They tell students to self-refer

Often ad hoc, some pathways in place, for example continence and also self-harm

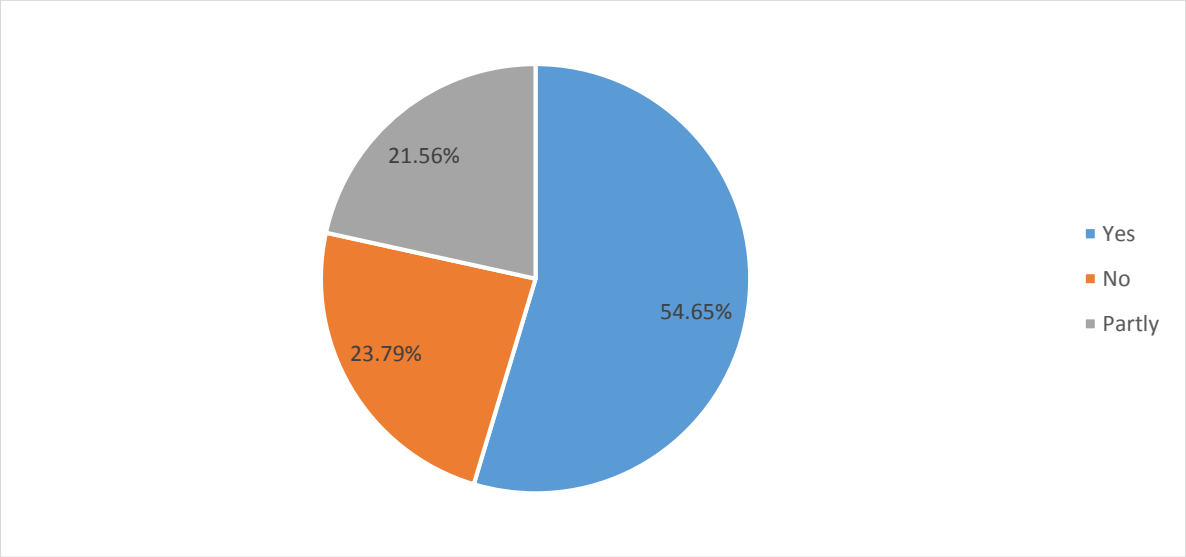
We have the GIRFEC child's planning process but no formal referral criteria or paperwork. Tends to be that we get referrals from other agencies to 'fix things'

Staff and parents usually email or call us to refer a child. Frequently the child comes themselves as we are available at school from 8-4 each day for children to drop in

Referrers have to complete a request for school nurse support that has to be actioned within a time frame. The referrer then gets feedback

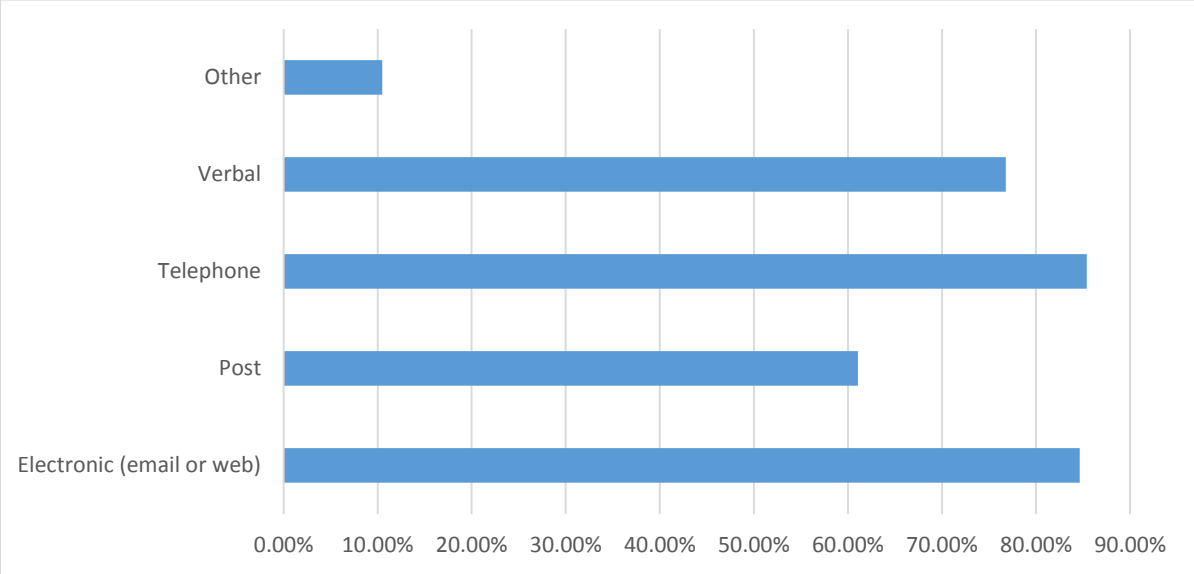
We have to acknowledge all referrals within a set time. Prioritise the referrals and action within a set time

Figure 43: *Explicit pathways and processes in place to deal with referrals*



Referrals are received by telephone, email, post and verbally (see Figure 44). In addition many respondents highlighted that they had referral forms in place and received texts.

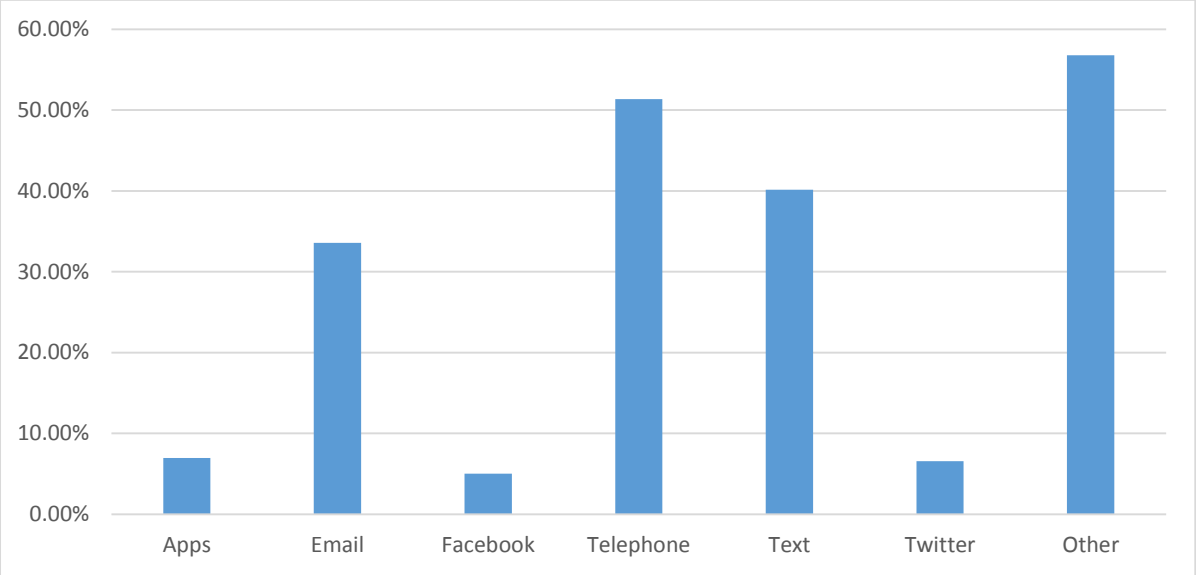
Figure 44: *Mode of referrals to the service*



Communication with children and young people

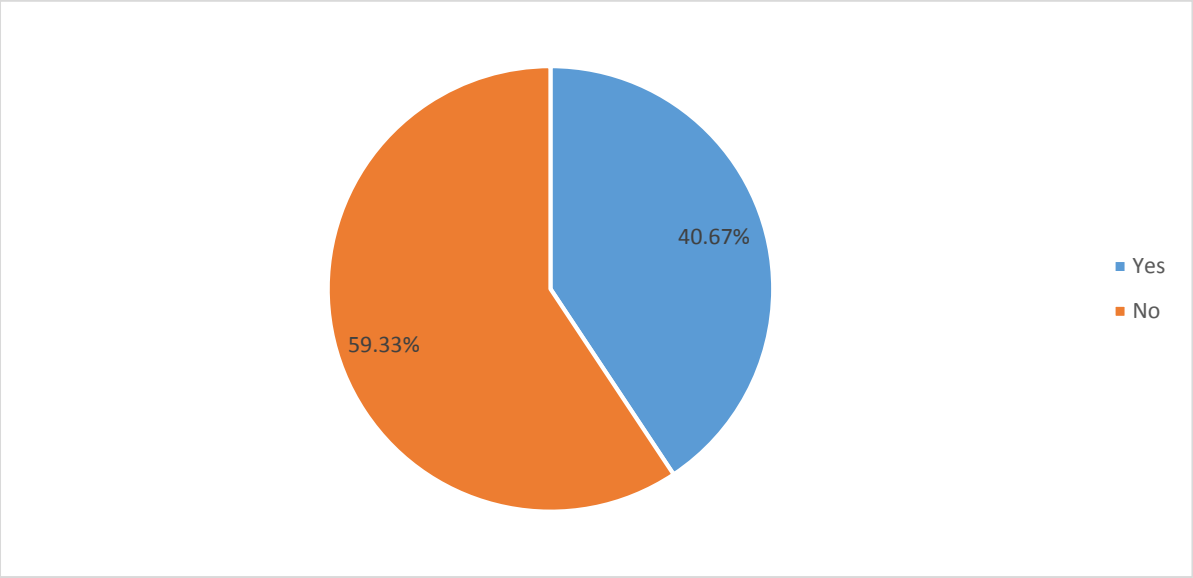
Respondents highlighted the range of mechanisms by which they communicated with children and young people (see Figure 45). The category 'other' included face to face, one to one meetings, posters, assemblies, health promotion boards, letters and appointment cards

Figure 45: Communication mechanisms



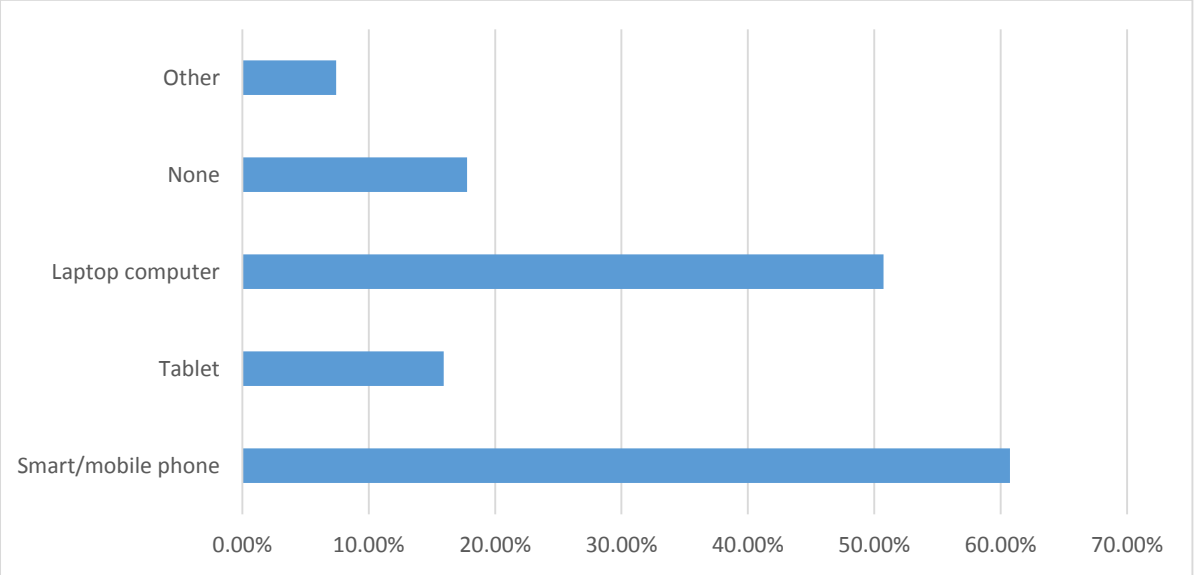
Forty percent of respondents highlighted that their service had either a webpage or app (see Figure 46). Other respondents reported that apps were currently being designed and developed.

Figure 46: Service webpage or app



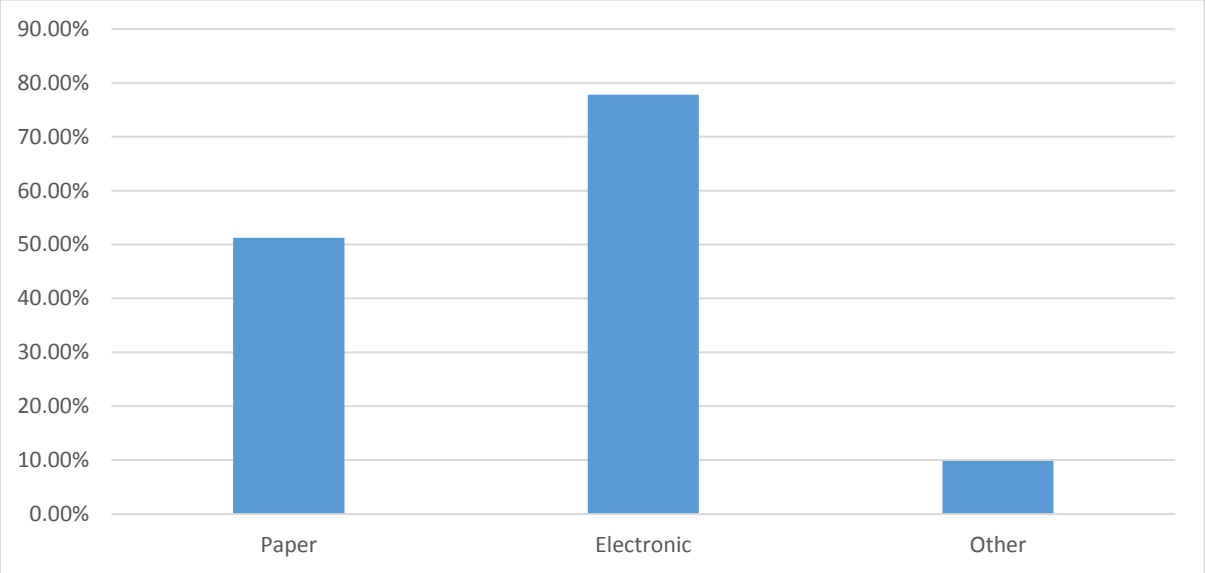
Respondents reported that they used a range of mobile devices (see Figure 47). While many stated they used a mobile/smart phone or laptop, many reported that it was difficult to access IT systems out of the office as they were only provided with desktop computers.

Figure 47: Mobile working devices



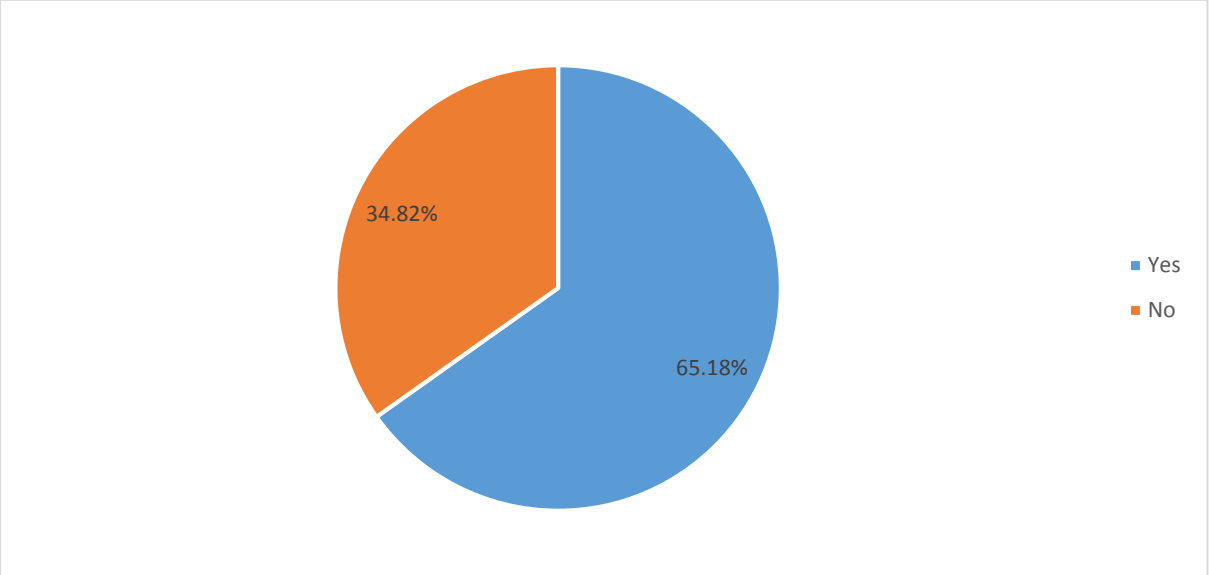
Respondents reported that their organisation used a mixture of paper and electronic systems for health records (see Figure 48). Electronic systems included Emis, System one, PARIS, Rio and Care notes

Figure 48: Mechanism used for health records



Over sixty five percent reported that they could access electronic health records via mobile working devices (see Figure 49).

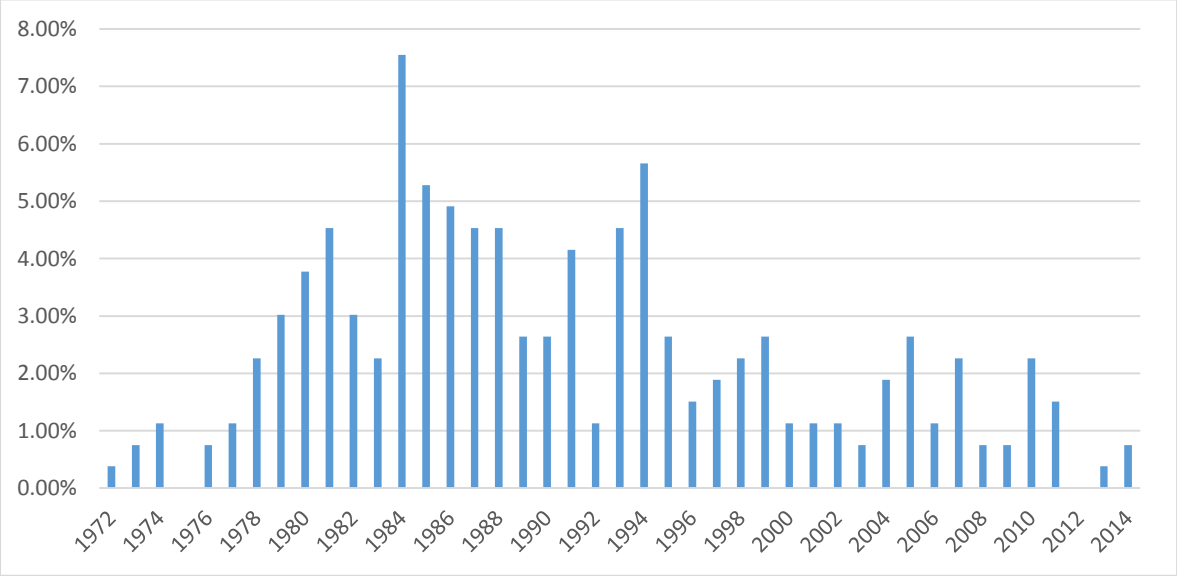
Figure 49: Access electronic health records via mobile working devices



Preparation for current role, CPD and revalidation

The majority of respondents had first registered as a qualified nurse over twenty years ago (see Figure 50).

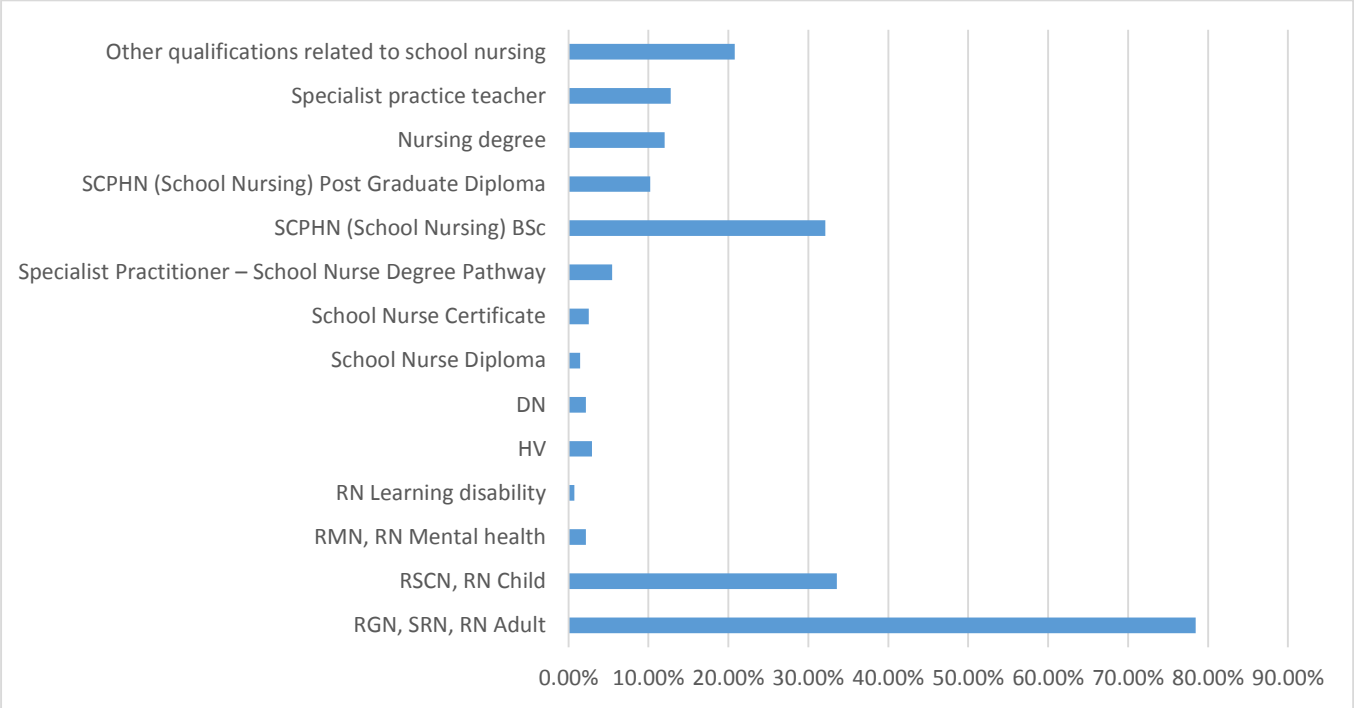
Figure 50: Year of registration as a qualified nurse



The majority of respondents were either Registered General Nurses, State Registered Nurses or Registered Nurse – Adult, with forty-two percent indicating that they had a Specialist Community and Public Health Nursing qualification at degree or diploma level (see Figure 51). The category 'other' encompassed Registered Midwife, MSc Advanced Practice, nurse prescribing, post graduate certificate in Health Education,

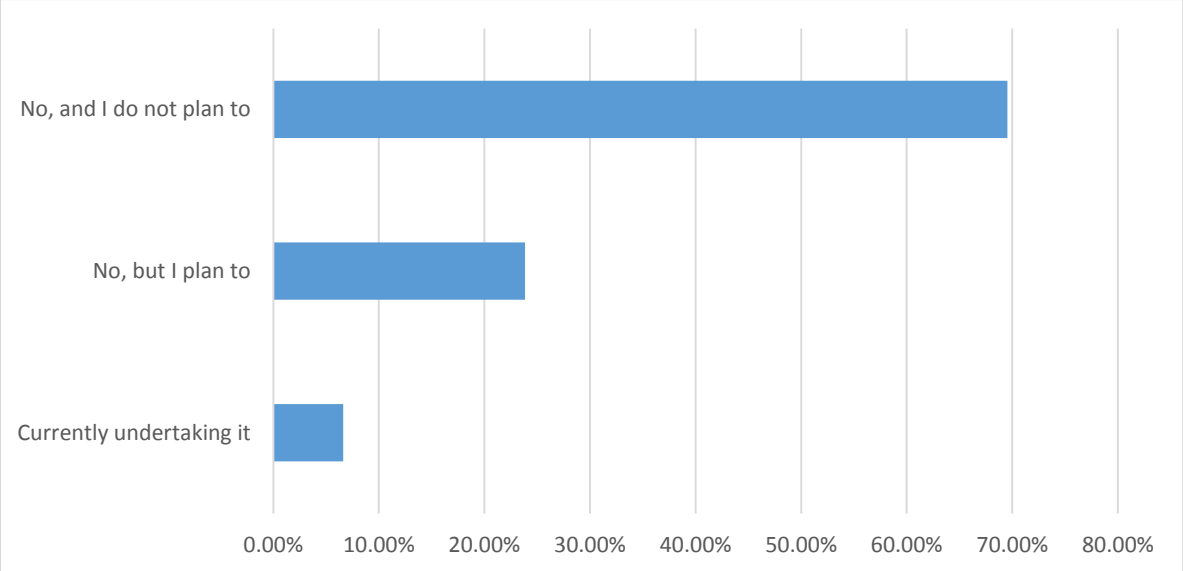
advanced diploma in child development, first aid, teaching and assessing, minor illnesses/injuries, family planning, contraception and sexual health.

Figure 51: Nursing qualifications held



Of those that did not have a specialist practitioner degree/diploma related to school nursing at the current time 6.62 percent (10) were currently undertaking and 23.84 percent (36) planned to do so in the future. The majority did not plan to undertake (see Figure 52).

Figure 52: Plans to undertake specialist practitioner degree related to school nursing

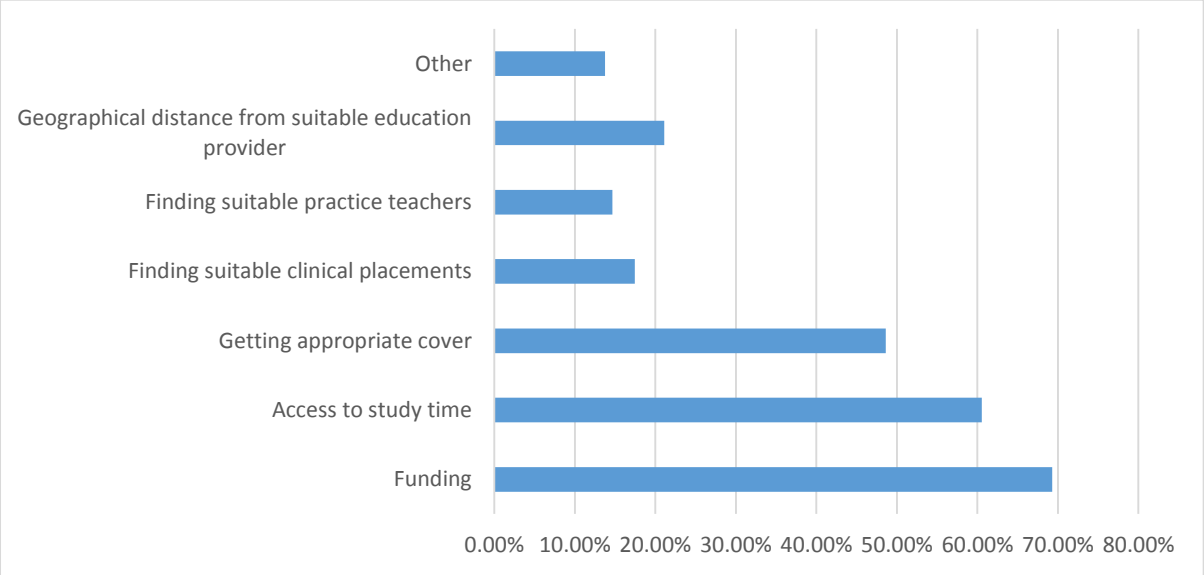


Respondents reported a range of barriers to undertaking further training and education. The greatest barriers were funding, access to study time and getting

appropriate cover for their duties (see Figure 53). The 'other' category included nearing retirement, a lack of opportunities, funding, child care and family commitments:

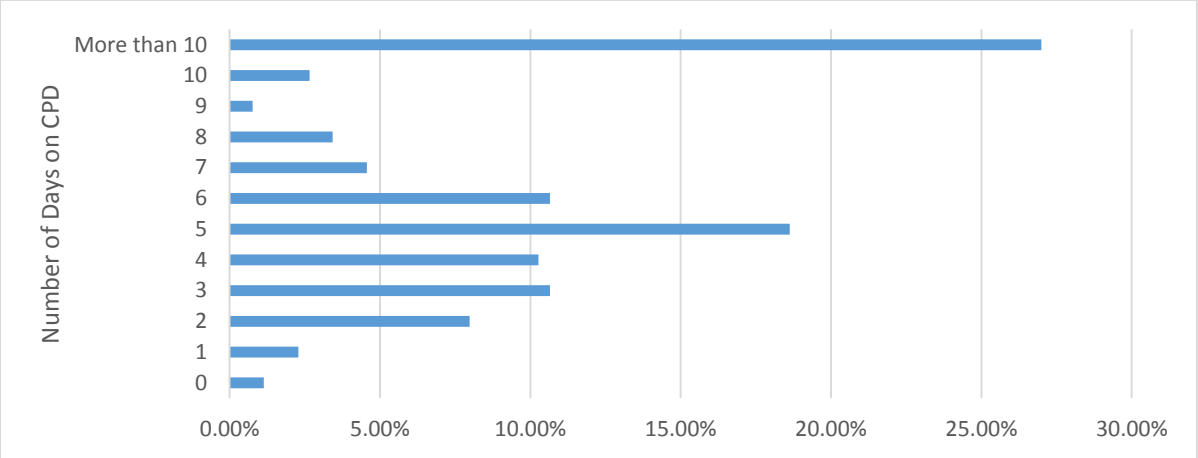
> I retire in 5 months!!
>
> Only plan to work another 2 years
>
> Age, near to retirement
>
> Lack of funding. I would have to undertake the degree over 2y and run my caseload at the same time. Which is very hard. The opportunities to take the degree are very limited. I would also have to travel a considerable distance
>
> Not being NHS made it difficult to get on to an appropriate training programme
>
> The school would not fund me, so it would have to be self-funded, I cannot afford to do that. I would also need placements outside the school and a mentor. I couldn't take time off work to do that
>
> Child care
>
> Managing your own family needs
>
> As a single parent sometimes the time required for training and fitting this in around own family needs
>
> Work life balance and leaving my case load

Figure 53: Barriers to undertaking further training and education



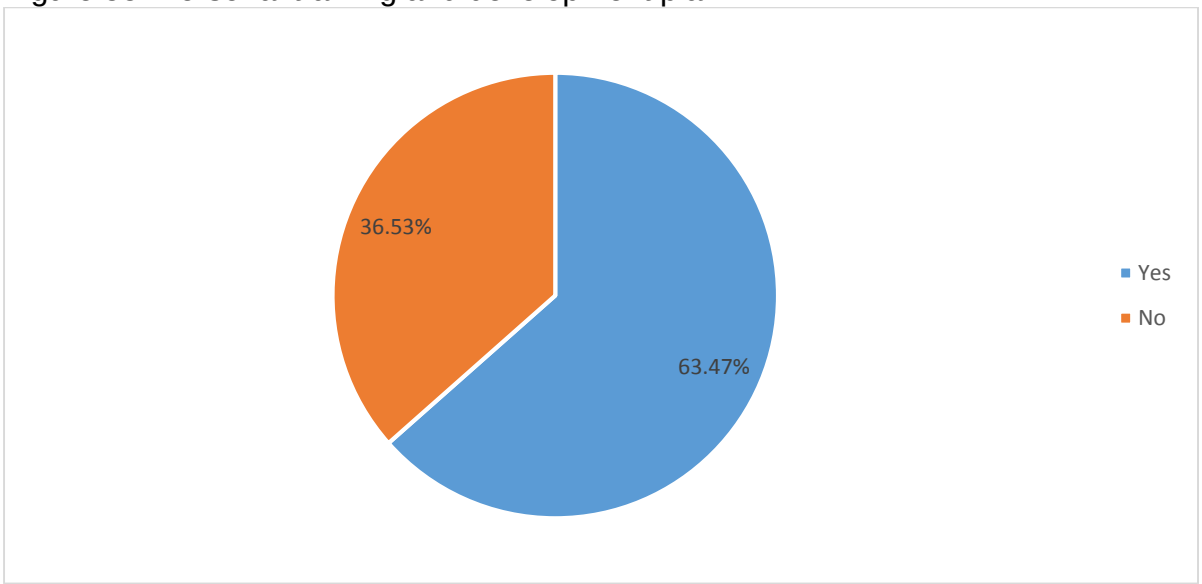
The majority of respondents had spent 2-6 days on CPD activities over the last twelve months, although twenty seven percent indicated they had spent more than ten days on CPD during this time (see Figure 54)

Figure 54: Days spent on CPD activities in the last 12 months



Over sixty percent of respondents stated they had a personal training and development plan (see Figure 55). This included statutory in house training, epilepsy training, asthma and anaphylaxis, first aid, child bereavement, safeguarding, preparation for revalidation and completing degree programme.

Figure 55: Personal training and development plan



Respondents provided the following details regarding their training and development plans:

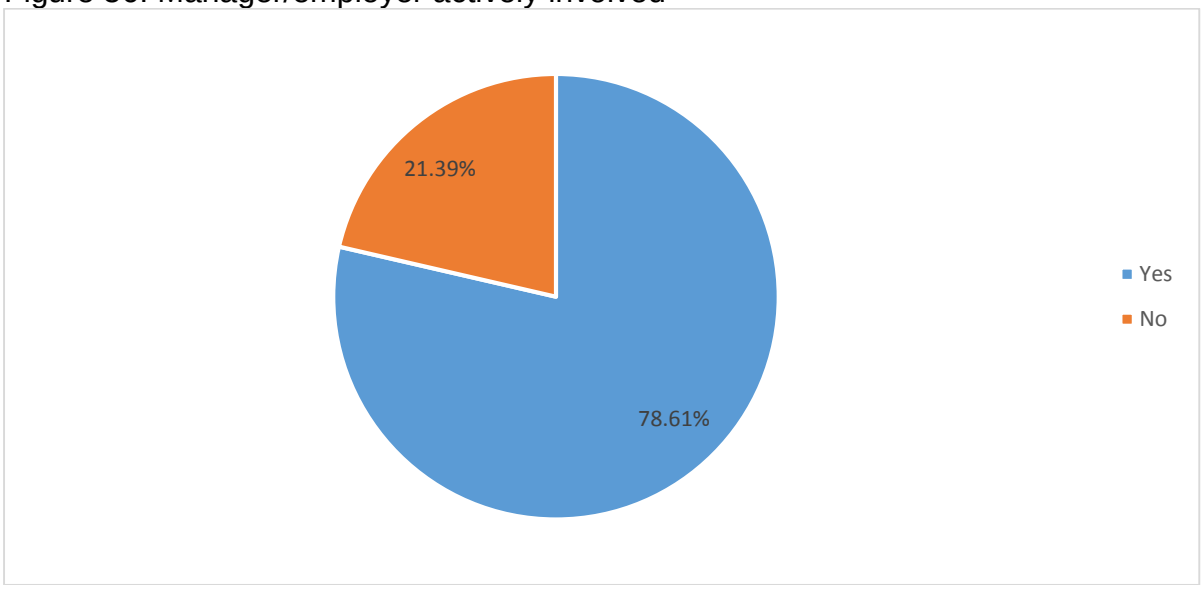
> Our management are excellent at making sure we have our annual Practice Development Reviews. This outlines our aspirations for personal development in the short term (over the next year) and the long term (over the next 2-5 years) and includes how our manager will support/assist us with achieving these

> Annual Resuscitation and AED training which we do yearly at the school where I work following an incident when I was involved in nursing a very drunk pupil overnight I am planning on attending a few hours training at a local hospitals A and E department to gain further training and knowledge. Level 3 child protection renewal update next year

> Short courses to keep me updated. I have to find these myself as working in an independent school means I don't get notified of relevant courses as state school (NHS) nurses do

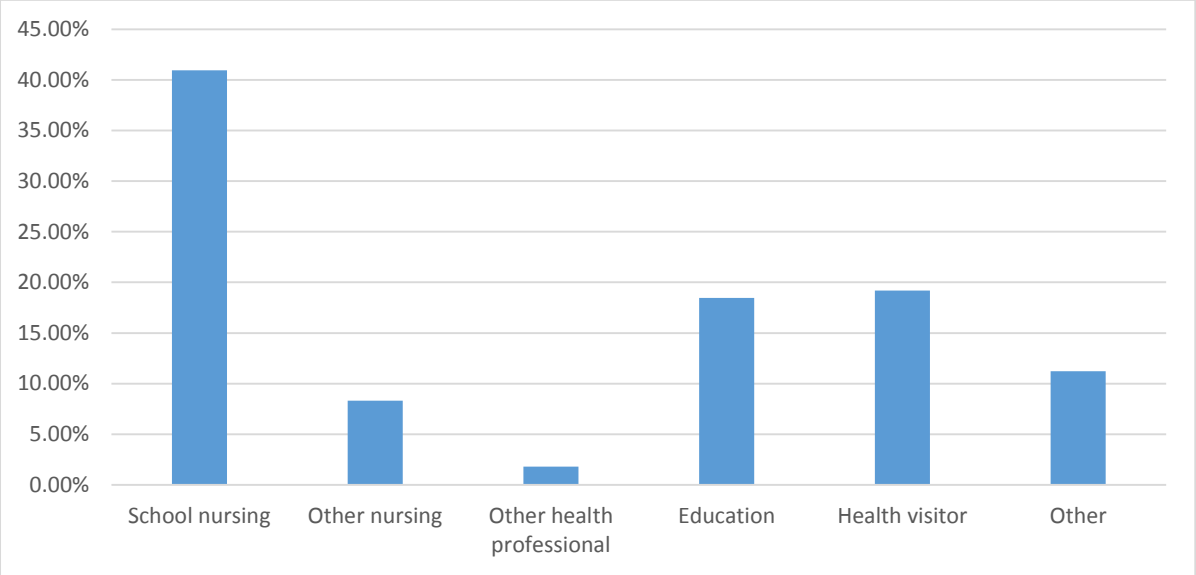
The majority of respondents reported that their manager/employer had been actively involved in drawing up their personal training and development plan (see Figure 56).

Figure 56: Manager/employer actively involved



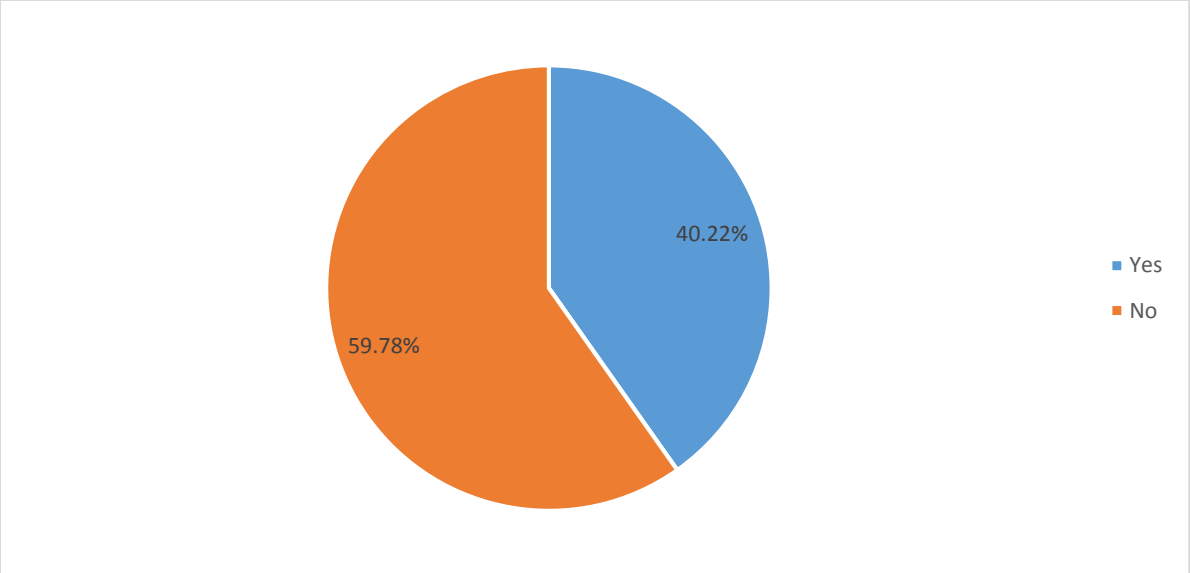
Only forty percent of respondents were line managed by someone from a school nursing background (see Figure 57). The 'other' category included school bursar, head of boarding, head teacher, social worker, midwife and HR director.

Figure 57: Professional background of line manager



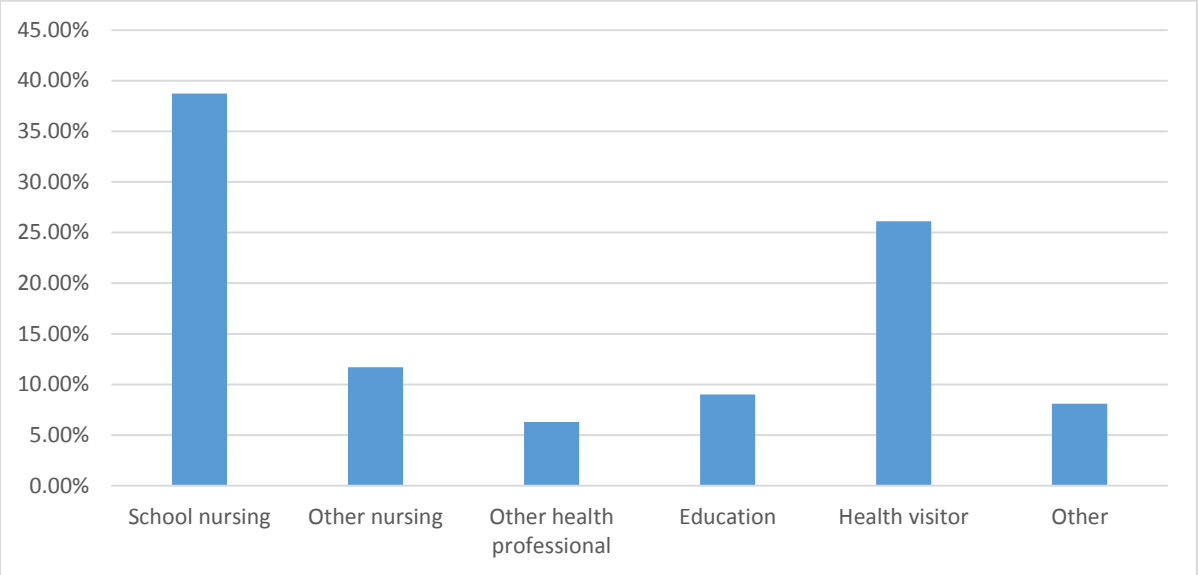
Forty percent of respondents reported that they have access to another manager who has responsibility for professional support (see Figure 58).

Figure 58: Access to another manager for professional support



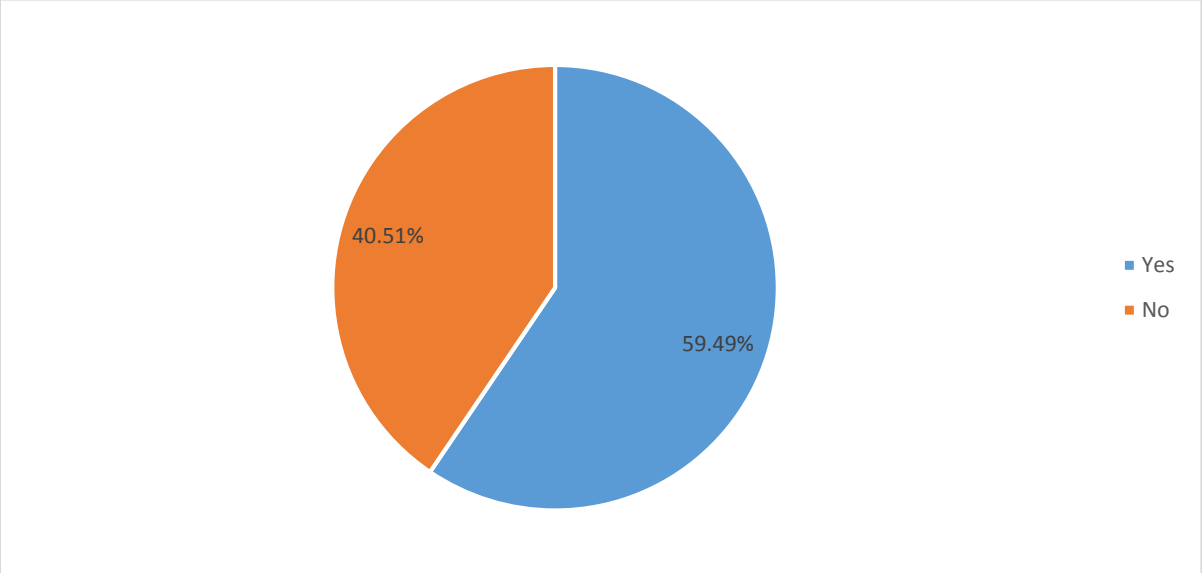
Thirty eight percent of respondents reported that school nursing was the professional background of the manager responsible for professional support (see Figure 59). The 'other' category included GP, deputy head teacher, social worker and office manager.

Figure 59: Professional background of the manager responsible for professional support



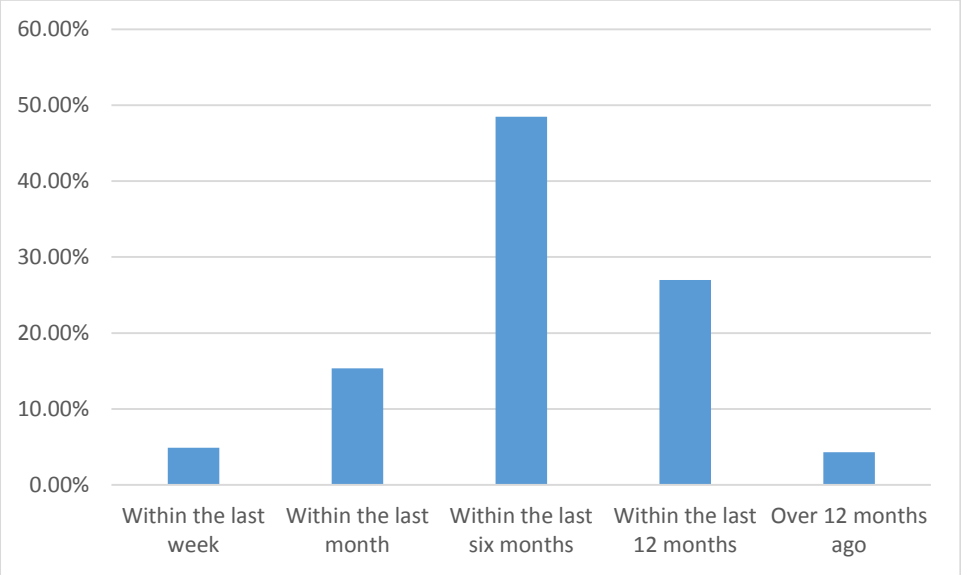
Almost sixty percent of respondents reported that they had met with their manager to review their personal development plan (see Figure 60).

Figure 60: Met with manager to review personal development plan



The majority of respondents reported that this meeting had taken place within the last 6-12 months (see Figure 61).

Figure 61: Meeting with manager held to review personal development plan



Respondents were asked about their views working as a school nurse by responding to a number of statements to indicate the extent to which they agreed or disagreed (see Figure 62).

Figure 62 shows that the vast majority of respondents strongly agreed that a high level of autonomy is required for a school nurse role. A significant number also either agreed or strongly agreed that their workload was too heavy, that they felt overstretched in their role and that it will be difficult to progress from their current grade. A large proportion of respondents strongly disagreed or disagreed that there are sufficient nurses school nurses in their area.

Respondents expanded on these options by offering additional comments some of which are captured below:

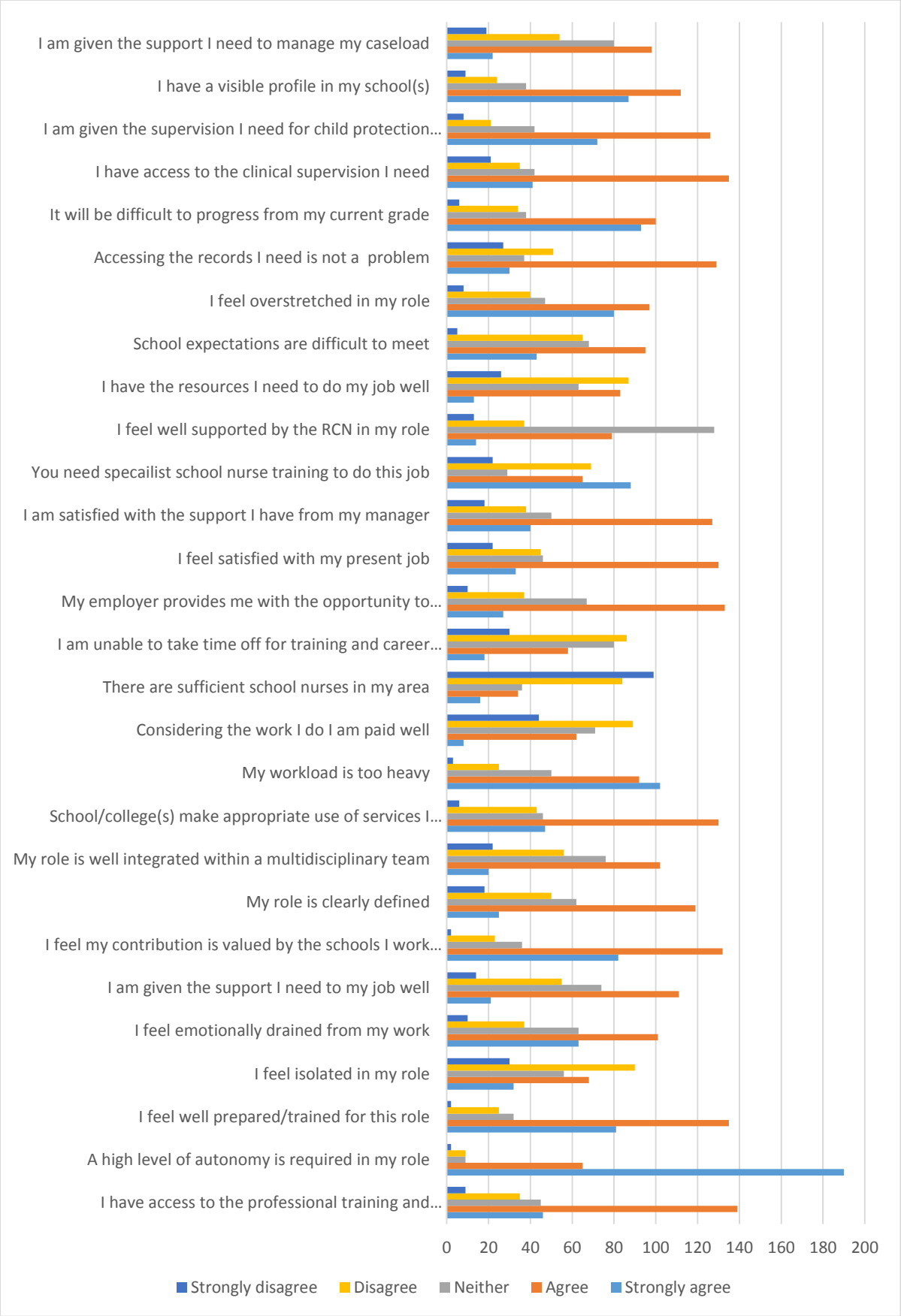
> Accessibility to appropriate related professional development is very limited in the environment I work in

> I think only child qualified nurses should look after any child including school children. It is desirable to have School Nursing, ICU and or A&E experience and preferable to have an appropriate age School Nurse qualification

> I started this post with a background of general, mental health, midwifery and district nursing (& first aid & a degree). I would have added school nurse training too, but it was not available at the time so I learned on the job

> Because of the massive flu vaccination programme, and this academic year the extra HPV cohort and the new MenACWY vaccine, I find that a large amount of my time and effort is spent in sifting through consent forms, dealing

Figure 62: *Views about working as a school nurse*



with the issues contained in these forms, planning the vaccination sessions, and delivering them. The school nurses in my area have little time left to do the Child Protection, Looked After Children, vulnerable children and families

I only have a visible role in my schools because I have worked at it. When we establish allocations visibility will drop - erosion due to RHA / PSHE / immunisations being removed from our role

Not sure if you want to hear this but school nurses in my area feel people are trying to get rid of them to replace with lower grades

Accessing records is fine when I am at base but not when I actually need it during a consultation with a student in school. Very often managers are too busy adding numbers and not be bothered about the health and wellbeing of their staff. The culture and hierarchy between health visitors and school nurses mean, school nurses are not offered any opportunity to progress beyond Band 7. This is a national phenomenon where school nurses are being managed by health visitors. There are some very good school nurses who deserve the chance to have the opportunity to move up the ladder and manage their own teams

Due to the recent changes and corporate working, there is limited time for collaborative working with the partner agencies and schools, the job has become very task focused with referrals being opened and closed and where longer pieces of work are identified passing this onto the clinical commissioned team

Staff recruitment and retention is a big problem in the trust I work. This impacts upon workloads. Also majority of managers are health visitors therefore lack of understanding of role is frustrating

I am close to burn out and do not feel my employer cares that I have been understaffed for months

I work in isolation for much of the time, especially as I work in a rural area. I feel that many of the skills that I have acquired have been as a result of my own motivation and desire to provide as good a service as I possibly can, rather than what has been available from management

> Although I am very positive about my role this is due to the people I work with on the ground level and the staff in schools. I do feel that school nursing takes a back seat compared to Health Visiting yet it is as important. I am often called to help out the HV team due to staffing problems yet no one comes to help our team. We are under resourced and for the first time in my career I am looking forward to retirement and it is not because I don't love my job, I just don't love all the politics and red tape that surround it

> The team I'm in is well led and is very friendly and supportive and we've had positive feedbacks but also a few blips which we have supported each other and learned from

> Work is increasingly difficult to manage. Caseload pressures being juggled with innovation and being proactive plus high levels of safeguarding mean I work over most days, take work home with me and am seriously considering a career change which is really sad because I actually love my job

> I work alone and have to make all my own decisions in all areas of Health so the RCN conferences have been invaluable for me. I attend the Independent School nurses conference every year and RCN congress most years. I fund them myself if necessary

> Our work is unpredictable and chaotic - when quiet it is manageable when busy it can be frantic and at times unsafe. We have no bank cover and so have to cover sickness etc. amongst ourselves

> Recently qualified as a SCPHN in September 2015 and in July 2015 our trust announced they were cutting the numbers of SCPHN. This means those that studied the course will lose their qualification, and pressures on existing staff increased threefold. Therefore we are seeing more sickness, staff leaving, more errors, less contact with public health and increased CP, and less supervision, and told every day we just have to get on with it

When asked what they found most satisfying about working in school nursing, respondents' comments overwhelming cited working with children and young people. Other responses included working with families, being part of a team and the variety of the day to day work:

> The kids, who look for you, they come back, they ask questions they develop a relationship with you they trust you, they are the ones who keep me coming to work

Working with young people and making a difference

I love working with young people and seeing a change in them

Seeing children with profound disabilities make progress

When the children recognise me and want just to say hello. When patents/carers say thank you and i have made a difference

I love the daily contact with young people, building relationships, providing them with health information and watching them grow and develop in knowledge to take important health decisions for themselves

Working with young people can be fun and rewarding. I love being able to give them a positive experience of accessing health care without a parent for the first time

Working with the pupils, the variety and energy

Love the children. As an independent school nurse I have watched children enter at 11 years old and leave grown up at 18

Working with the special needs children is so rewarding

Relationship building and effecting behaviour change, making a difference for young people

I find working with children, young people and their families most rewarding, to help turn round behaviours which are causing difficulties e.g. behaviour problems, sleep problems, anxiety

Having a parent/carer (and sometimes a young person) saying thank you as you have made a difference

The variety of the work and the ability to impact positively on families

Helping to meet goals for families. Support in school for families by liaison with all agencies

That no days are the same and I can make a difference to children young people and their families

The surprising variety of cases, making a difference, building relationships

> No day is ever the same! Helping children and Young people, emotionally and physically, as they grow and develop, helping them to manage their health / medical conditions, gain an understanding of personal/health issues, learn to make informed choices regarding their health and well being

> It is honestly a privilege & very varied. Just wish I had more time to do it to the best of my ability

Respondents overwhelming identified lack of time and resources as well as understaffing as being their biggest frustrations with working in school nursing. Issues with management were also identified:

> The work load has increased enormously with no extra help. The expectations have not changed, and this makes our work challenging. The extra stress felt by school nursing staff does not seem to be recognised by our managers

> Lack of time, funds and amount of safeguarding

> Not enough time to do the job well. There needs to be more funding put into school nursing. The job is being cut into pieces that are given to unqualified staff

> Case load management, never enough time to do health promotion work which potentially relieves the crises that we spend our time dealing with

> Always chasing your tail and not having enough time to offer the service you would like to.

> Everyone being over stretched - not able to meet all the needs of the children and young people in our area

> Too much to do and too little time leading to stress and fear that you may forget something or let someone down

> Time allocation, expectations from employer to make savings when we are already cut to the bone

> Our vacant post have been cut meaning that it is only possible to meet the day to day care needs of the children and child protection

> Training new recruits only for them to leave in 6 months to a year

> Lack of staff resources - no cover for long term absences/maternity

> High turnover of staff. Low numbers of SCPHN nurses so difficult to recruit to band 6 posts

> Not having an adequately resourced all year round service. Many of my team are still on 20 hours per week TTO contracts of 39 weeks per year… Local authority commissioning not understanding the role and trying to reduce already inadequate budgets

> Restrictions due to funding and therefore provision of a gold standard service that I feel should be expected in an Independent School

> Working in an environment that doesn't understand professional needs of nurses and being paid only for the hours we work and not for the holidays as teachers are

> Lack of understanding from school re job role and lack of support from manager

> Not being listened to by managers. Being told 'you can only do what you can do' but expected to priorities your priorities. Managers no knowing what you do, agencies not knowing what you do

> Management and other staff they don't /don't want to understand about our work load and responsibilities

> Poor leadership, poor management, unclear work priorities, working in a prevention team who do not respect my role and being commissioned by local authority who clearly do not have the best interests of the children as their priority

> Lack of co-ordinated views of service managers makes it difficult to implement changes and consistent messages to staff

Respondents identified increased staffing and better management as being the most important types of support needed to do their job better. Administration assistance, better technology and improved communication with external agencies were also identified as desirable support**:**

> More staff to ensure that we are meeting the needs of the children and their families. An extra school nurse and HCA/admin provision would be beneficial for this purpose

> More staff on all levels in the school nursing team

Having a full time School nurse for very secondary school and feeder primary schools

Sufficient staff at SCPHN level

More school nurses in post and in training

Adequate number of school nurses to cover the amount of schools and children

Management to understand the role of the school nurse and how it differs from health visiting

Team work supported by a manager who has school health experience

Good line management, supervision and recognition of the high quality work we do and the difficulties and challenges we face daily

Interest from line manager and a better understanding of the role
Management understanding the school nurse role and spending time with them so they have an insight into the complexity of the role

Administrative support to enable me to care rather than get tied down with paperwork

In our area we need clerical/administrative support, to do the filing which is required to keep our records up to date

Electronic records and better communication between our service leads and other agencies to improve our profile

Technology- certain aspects of the role are still not time efficient due to the lack of technology in our area

If commissioners want everything recorded and boxes ticked online, we need more computers that are up to date and work

Suitable electronic record system that is built for school nursing not district nursing

Teaming up with other agencies to do workshops and open days

> We need clear well written pathways that are communicated with the multidisciplinary team so that people's expectations can be realistic

When asked if they would like to make any further comments about life as a school nurse, the majority of respondents used the opportunity to express their dedication to the role and their desire to fulfil the role to the best of their ability. Repeatedly the need to value school nursing on par with health visiting was raised. Many respondents stressed their love for the job but that they felt they are being held back by lack of capacity, lack of resources, understaffing and poor management:

> School nursing is a rewarding and satisfying role. It is misunderstood by many in health and does not always get the recognition it deserves. I hope to develop and enhance the role as I believe in the current social climate the role will become increasingly significant and would like to see school nurses to be highly valued and recognised by the stakeholders for the difficult job they do

> School nursing is an amazing, varied job but it does feel as though you are used as a sticking plaster to gap the holes left by services that no longer exist, but we can only stretch so far

> Love my job as a school nurse but I am finding it increasingly difficult to balance my home life with the amount of emotional effort I put into my job

> I love my job but feel undervalued by staff within school as they still consider our role to be one of first-aider and "nit Nurse"

> Undervalued by the government and unable to reach the full potential without significant investment in school nurse numbers or schools, purchasing school nurse hours

> I love my job the contact and the difference I make to young people and families and appreciate that the listening ear the understanding the signposting on are often not measurable outcomes but would be devastated if the service failed because it is difficult to measure and ultimately cost

> The job is great when we have a full complement of staff who are fully trained and we can deliver a quality, consistent service but this has not been the case since I started in the service 6 years ago… Our service is in crisis

> I love my job, but the pressure and covering huge amounts of school for absent colleagues is very wearing. As a band 6, i do 7 SADRS, recruitment and selection, lead on

Enuresis for the county and lead a working party, mentor and support colleagues and students, performance management, sickness management, with no additional time to do my own caseload

In general working as a school nurse in an independent school is an isolated role with the associated problems of clinical supervision, peer feedback etc. However, despite that working as part of the whole school community provides a different kind of support. All in all very satisfying developing long term professional relationships with pupils

I have enjoyed my role as an independent school nurse. It has a high level of autonomy and variation every day. It is a privilege to support young people as they grow and develop. I am lucky to be well supported by my work colleagues

I love the job and will not give up on it, but it is getting more stressful with each year that goes by. There is not enough funding allocated to support the governments vision for school nursing

Although I enjoy the element of my role of working with children and young people, I feel overstretched, burnt out, not supported, or appreciated, nor listened to by managers or commissioners… The pay is not worth the stress either. I am doing a full time job on part time hours.

HVs wherever I work always appear to be superior to SNs we have the same training and I find it most frustrating when GPs won't talk to me but will a HV

School nursing is a rewarding role and I loved being a school nurse and now love educating the school nurses of the future, however, this is tagged onto health visiting and is still seen and the poor relation

It is a fantastic job but too pressured to stay long-term. I am stressed on a daily basis & regularly go without breaks and stay late just to try and keep up. A Band 5 pay is not enough for the stress. If I do my SCPHN, I will still be a band 5, whereas Health Visitors automatically go back on a Band 6. It is double standards & they only have children from 0-5

I truly wish that commissioners had co commissioned our services and that the role had value and we could continue to deliver high quality services to our children and families, at best I feel we are winging it, I fear commissioners pulling the contracts at any time and I am sick of shielding my staff

> from complaints and not having the numbers for any slack in the system… There were 12 SCPHN and now we have the equivalent of 6 WTE SCPHN, it is not difficult to see that this will reduce your capacity to deliver and being effective at preventing ill health and maximising the school nurse contributions. Sadly, I fear I can't stay in this role, I feel I am losing a battle and delivering on key performance indicators that are both unrealistic and unachievable.

> I am still a passionate school nurse and only do the job because I believe in the young people I serve to help. I have no respect for the management especially as there is more of them than actual school nurses and not one holds a qualification in school nursing

> The rationale for world class commissioning is to drive up standards and improve client care. This has absolutely not been my experience as the service has suffered heavily reduced resources, increasing staff shortages and our SCPHN training for SN has ceased.

Concluding statement

The 2016 survey reinforced many of the findings of the 'RCN School Nursing in 2009 Survey', highlighting school nurses today continue to have heavy workloads, with a considerable proportion of time being spent on safeguarding activities and administration. The range and breadth of the role of the school nurse in meeting the needs of school aged children and young people is clearly evident.

Comments made by respondents clearly indicated school nurses dedication and commitment to improve the health and wellbeing of children, with supporting families recognised as a key priority. Many felt they are being held back by a lack of capacity, lack of resources, understaffing and poor management. In particular many respondents reported a lack of understanding when managed by someone who lacked a background in school nursing, with isolation and loneliness highlighted by nurses working in independent schools.

Overall many school nurses felt undervalued and unappreciated, calling for investment and for school nursing to be valued on a par with health visiting. Key issues to be addressed included time and funding for continuing professional development, as well as clear job descriptions which match the actual role and activities being undertaken. The survey highlighted real concerns about the ageing profile of the school nursing workforce and service specifications. Respondents reported the importance of financial reward and the recognition of experience, as well as specialist qualifications.