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A Realist Evaluation of the Refocused School Nurse Programme within Early Adopter Sites in Scotland: Summary Report

HEALTH AND SOCIAL CARE

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A Realist Evaluation of the Refocused School Nurse Role within Early Adopter Sites in Scotland: Summary Report

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1. Background

The school health service is a universally accessible service provided to children and young people, aged 5-19 years and their families. Historically the school nursing role has played a significant part within this service. Models, roles and skill mix have varied greatly across Scotland and have encompassed; direct interventions with pupils in schools, a teaching and education focused role and a wider public health and community function. The publication of CEL 13 (2013)[1] aimed to redefine this role to focus on delivering consistent and more efficient services to meet current needs of the 5-19 Scottish population. The work to re-focus the School Nurse (SN) role has been undertaken by a national Steering Group commissioned by CNO/SEND. As part of this work detailed consideration was given to the epidemiology and wider needs of the 5-19 population across Scotland. It was then proposed what the unique and specific contribution and potential contribution could and should be of a nursing role supporting school aged children

Since September 2015, two health boards, Dumfries and Galloway (D&G) and Perth and Kinross (P&K) in Tayside have been piloting the refocused role, including the role of the wider school health team, and associated re-design requirements. These early adopter sites are seeking to provide learning and guidance to support further roll out of the service.

The overarching aim of the refocus is to ensure that the SN role and service going forward delivers safe, effective and person-centred care based on the principles of Getting It Right for Every Child (GIRFEC) national practice model.

It is proposed the future SN role will comprise two main elements:

1. Responsibility/leadership for children and families with additional healthcare needs:

Following pre-school review of children with an additional Health Plan Indicator (HPI) at four years of age and handover from the Health Visitor, the SN will re-assess those families and children requiring on-going support. Following re-assessment, SNs will agree those children and families requiring additional support, intervention or home visit in discussion with the Named Person.

2. Focused and targeted interventions with vulnerable population groups:

It is proposed that the wider school health service remains a universally accessible service but the SN role will be more focused and targeted. School Nurses will be required to adopt the Getting It Right for Every Child National Practice Model to assess the health and well-being needs of children and young people in conjunction with the Named Person (education) role and other partners providing the health assessment component to the Child's Plan. The future role will have greater emphasis on home visiting and addressing wider policy and public health priorities,

[1] Chief Executive Letter 13 available at http://www.sehd.scot.nhs.uk/mels/CEL2013_13.pdf

interagency working and partnerships with education and justice. In response to the available evidence base, policy direction and priorities, it was proposed that the role will be focused on nine priority areas:

- Mental health and well-being
- Substance misuse
- Child protection
- Domestic abuse
- Looked After Children
- Homeless children and families
- Children known to or at risk of involvement in the Youth Justice System
- Young Carers
- Transition points

As part of the review, it is proposed that some previous duties of school nurses may be more appropriately addressed through existing health improvement services and through the delivery of the health and well-being component of the Curriculum for Excellence.

Role of the wider school health team

The composition of the wider school health teams consisting of staff nurses, support workers, health improvement leads, social work and education link workers are likely to differ in individual Boards. However, it is proposed that they provide the universal service for all school aged children and families. This will consist of four main elements:

- Immunisation
- Screening such as height, weight, BMI. At present this takes place at P1 and sometimes P7. Following introduction of the Health Visitor review at 4 years of age the P1 screening will be reviewed. In the early adopter sites P1 assessment will be done by the wider school health team.
- Additional work commissioned by the SN
- Weekly Health Zones

2. Aims of the Evaluation

The aim of the evaluation was to assess how the refocused school nursing role worked in both D&G and P&K, in order to provide learning and guidance to support SN training and any further roll out and evaluation of the service.

The objectives were:

- to assess the implementation of the refocused school nursing role in the early adopter sites and identify the key facilitators and barriers to implementation.
- to explore whether the assumed mechanisms of action for the new school nurse role and wider team appear to be operating as planned, thus indicating likely future effectiveness on outcomes.
- to assess the degree to which both implementation and potential effectiveness of the school nursing role may be dependent on unique local contexts, and make recommendations for tailoring it to help inform school nursing training in future.

3. Evaluation design

A realist framework informed this evaluation, combining both qualitative and quantitative data analysis. Realist evaluation uses a theory-driven approach to evaluate healthcare programmes and public health interventions. Interviews were held with staff from the SN teams and managers, both on an individual level and in groups and the information gathered was analysed in accordance with realist evaluation methodology. Secondary data from the first 6 months of the pilot was also collected and analysed in order to capture patterns of referral both in and out of the school nursing service and the pathways being used for children.

4. Setting

Table 1: Demographic Factors for two Early Adopter Sites

	Total Population	Area	Population of main town	Primary Schools	Secondary Schools
Dumfries and Galloway	149,670	6426 km^2	38,900	99	16
Perth and Kinross	149,930	5286 km^2	44,820	69	11

In terms of the proportion of their populations that are in the most deprived 20% (SIMD quintile 1), Dumfries and Galloway is ranked 19th and Perth and Kinross 24th out of the 32 local councils. In other words both areas have lower populations of SIMD 1 (most deprived) and higher of SIMD 5 (least deprived) than many other areas and this should be borne in mind when interpreting the findings.

At the time of interviews the composition of the School Nurse Teams in the two areas was as follows. However staffing has fluctuated during the course of the pilot:

Table 2: Staffing

Role/Band	**Dumfries and Galloway**	**Perth and Kinross**
Manager	3	3
Band 6	9 (4 with SPQ; 1 with PHN)	11 (1 with SPQ)
Band 5	3	0
Band 4	4	0
Band 3	1	5

5. Findings

5.1 Overview of Referrals from November 2015 to end of May 2016

The two early adopter sites had received different numbers of referrals from November 2015 up till May 2016. D&G recorded 299 children and young people who had been seen by the School Nurse service. P&K recorded 107 for the same period. However, the team in P&K had had to continue with their immunisation work in schools in addition to adopting the new role.

Gender

In both areas more girls were referred into the School Nurse services than boys, although a slightly higher percentage of girls were seen in D&G than P&K.

Table 3: Numbers and percent of children seen by School Nurse by gender

	Perth and Kinross (n=107)	Dumfries and Galloway (n=299)
Female	53.3%	63.7%
Male	46.7%	36.3%
	100%	100%

Age/Year Group

Overall a higher proportion of secondary school children were referred into the School Nurse service in D&G than in P&K who had a higher proportion of primary school children referred in.

Table 4: Percent of children seen by School Nurse by Year Group

	Perth and Kinross (%)	Dumfries and Galloway (%)
Nursery	2	0
P1	14	6
P2	14	4
P3	12	2
P4	7	7
P5	4	2

P6	4	3
P7	4	4
S1	4	9
S2	10	16
S3	8	14
S4	12	18
S5	3	12
S6	1	3
Total	101%	100%

SIMD

P&K appear to have had a lower proportion of children from SIMD quintiles 1 and 2 referred into the School Nurse service than D&G. However it should be noted that there were a high number of children in D&G where the postcode had not been fully reported and so it was not possible to ascertain in which quintile they resided. In addition, both D&G and P&K have a higher proportion of children living in quintiles 4 and 5 than the national average so a higher number of referrals from these groups would be expected for these areas. However, as can be seen from the table, a higher proportion of the children from the more deprived SIMD quintiles were referred to the SN.

Table 5: Percent of Children referred to School Nurse by SIMD – Perth and Kinross

	Perth and Kinross			
	No. children referred to SN	% of total referrals to SN	Population of SIMD aged 5-19 in P&K	% of SIMD population 5-19 referred to SN
SIMD 1 (most deprived)	11	11%	1355	0.8%
SIMD 2	23	23%	2550	0.9%
SIMD 3	19	19%	5060	0.4%

SIMD 4	35	35%	10357	0.3%
SIMD 5 (least deprived)	13	12%	4833	0.3%
Total	101	100%	24,155	0.4%
No postcode given	6	6%		

Note: The populations used to derive the proportions are weighted according to ISD weighting schedule.

Table 6: Percent of Children referred to School Nurse by SIMD – Dumfries and Galloway

	Dumfries and Galloway			
	No. children referred to SN	% of total referrals to SN	Population of SIMD aged 5-19 in D&G	% of SIMD population 5-19 referred to SN
SIMD 1 (most deprived)	56	26%	2243	2.5%
SIMD 2	45	21%	6135	0.7%
SIMD 3	73	34%	8884	0.9%
SIMD 4	34	16%	3919	0.9%
SIMD 5 (least deprived)	6	3%	2076	0.3%
Total	214	100%	23,257	0.9%
No postcode given	84	28%		

Note: The populations used to derive the proportions are weighted according to ISD weighting schedule.

Children's Status on and after Referral to School Nurse

On the whole HPI status was not an accurate predictor of the need for referral. Both areas took referrals from children on Core and Additional HPIs although P&K had

fewer children referred on additional HPIs than D&G. This is despite proportionately more children from primary school being seen by the P&K nurses.

Table 7: Percent of Children by HPI status on referral

	Perth and Kinross	Dumfries and Galloway
Additional	21	77
Core	69	16
Pending	4	
Unknown	7	7

A certain proportion of children also were referred in because they were subject to a Child's Plan, they were on the Child Protection register or they were Looked After (often in kinship care). However, the figures below also refer to children's status after intervention by the School Nurse, so they represent children who had a Child's Plan in place on referral plus those who were assigned a plan as a result of being referred to the School Nurse.

Table 8: Percent children referred to School Nurse by status

	Perth and Kinross	Dumfries and Galloway
Child's Plan (after SN intervention)	24	29
Child Protection	1	6
LAC	3	15

Note: The three columns represent separate groups of children although any one child could be LAC, on the Child Protection Register and have a Child's Plan in place.

5.2 Main themes from the Evaluation

Programme Implementation and the Nine Priority Areas (Pathways)

It was felt the nine priority areas and pathways provided a clear framework which ensured only the relevant cases were referred to the School Nurse. However concern was expressed that there were some gaps in the priority areas, such as sexual health and physical health (eg obesity and enuresis) which were not covered.

Some pathways were used far more than others with Mental Health and Well Being being widely used and pathways such as those for homelessness and Youth Justice being very little used. This may be because these early adopter areas experienced lower levels of child/young person homelessness and involvement in the youth justice system than is prevalent nationally. However, it was felt by the SNs that the Mental Health and Well Being pathway was sometimes used as a 'catch all' for occasions when there did not seem to be an appropriate pathway.

Whilst many of the pathways were seen as providing useful guidance, other pathways, in particular the Mental Health and Well-being and Substance Abuse were seen as needing further development.

According to the records, the majority of children were referred in to the service for mental health and well-being issues. As can be seen, 68% of those from both P&K and D&G were referred in to the service because of concerns around a child's mental health and well-being. There was quite limited representation on the other pathways, except those children who were Looked After in D&G. It should be noted, however, that a high proportion of children in P&K had not been referred into the service on any particular pathway.

Dumfries and Galloway also reported on the pathways children were assigned to after meeting with the School Nurse, when School Nurses might change the pathway following more in-depth assessment. In this case some 50.5% of children were not given a pathway presumably because the referral had been declined or the children had received one episode of care before being discharged.

Table 9 Percent of Children on Pathways at Referral and after SN intervention

	Perth and Kinross	Dumfries and Galloway	
		Before SN intervention	After SN intervention
Mental Health and Well-Being	68	68	37
Substance Misuse	0	0.3	
Child Protection	0	4	3.3
Domestic Abuse	3	2	2
Looked After Children	0	12	8.4
Homelessness	5	1	0
Youth Justice	3	0	0.3
Young Carers	5	0.3	2.7
Transitions	0	4	2.7
Unknown/Discharged	32	9	50.5

Please note: children could be on more than one pathway, hence the percentage add up to more than 100%

Referral

Both D&G and P&K developed new referral systems. These took some time to embed and referrals were slow at the start of the pilot. In addition IT issues affected whether referrals could be made electronically or not. However, referrals have increased over the period and the demand for specificity around the needs of the child/young person means that School Nurses felt that more thought was being given to referrals. This also helped clarify the role of the School Nurse.

As can be seen from the table below, school was the main source of referral, particularly in P&K but Social Work, other health services and other agencies also referred.

Table 10: Percent of Children referred to School Nurse Service by referrer

	Perth and Kinross	Dumfries and Galloway
Health Services incl GPs, HVs and A&E, CAMHS	7	6
School	92	68
Parent	1	3
Self referral	1	1
Other eg LAC, Child Plan Meeting, SACRO	0	4
Social Work	0	11
Missing	0	8

In terms of referrals that were declined by the School Nurse team there was some variation between the two areas. School Nurses in P&K declined nearly 20% of the referrals to them, 65% were accepted and data is missing on the remaining 16%. In D&G only 5% of referrals were declined. However, there were many cases where the School Nurse had only seen the child once suggesting that the School Nurse was in some cases declining the referrals after making their own assessment.

Table 11: Reasons for Declining Referral (numbers)

	Perth and Kinross (N)	Dumfries and Galloway (N)
Already being seen by another professional (health or other)	9	2
Parent refused	1	1
Referral did not fit criteria	1	2
School Nurse felt another service was more appropriate	6	
Child did not attend	2	
Inadequate Information was given	1	
Child did not want support	1	

There is confusion as to whether referrals are in fact referrals or are 'Requests for Assistance' under the 2014 Children's Act. This needs to be clarified at national level. There is also some confusion as to the role of the HPI status of the child. In one area all children with an Additional HPI were placed on the School Nurses' caseload. In another area the School Nurses' caseload comprised only those children referred in regardless of HPI status.

Role Clarity and Standardisation

The intention was that several school nurses' duties would be discontinued to create additional capacity for implementing the nine priority areas. However, this was not always possible and in P&K, in particular, School Nurses had to continue to undertake immunisations. This meant that they could not fully implement the refocused role. In D&G a team had been created specifically to undertake immunisations from the SN budget and this appeared to work better.

Whilst the refocused role had been designed in some detail and School Nurses knew what was expected from them there was some lack of clarity as to the role of members of the wider team.

School Nurses broadly welcomed the more clearly defined role in terms of validation for their work and clear lines of responsibility when engaging with other

services. However some nurses felt that the new role was not for them and several staff resigned, were re-deployed or retired during the course of the early adoption.

Due to shortage of staff therefore, Band 5 nurses were employed during the pilot with a view to training them up to undertake the refocused School Nurse role, but delays in implementing the training courses and the temporary nature of their contracts meant that the first round of recruited nurses left for other posts. Additional Band 5 nurses have since been recruited with a view to them being trained up as fully qualified School Nurses.

Engagement and Accessibility

It was perceived that the diversity of the priority areas facilitated engagement with partner agencies in a more positive way. This has also meant that School Nurses' visibility to other agencies had improved. Both areas developed Steering Groups which brought partners together and this was seen as a useful way of engaging partners. The refocused role has meant that School Nurses are having more engagement with certain agencies for example, Youth Justice than previously and this is regarded as a positive development.

In addition staff at the schools understood the role of the School Nurse better. However, the refocused role has meant that School Nurses are less visible to children and young people in the schools. Increased home visits has meant that some families are more aware of their role but many children may not meet the School Nurse unless referred. There was some concern that because School Nurses were less visible in the schools, children and young people, especially those who did not wish to go through Pupil Support, were not able to access the service. D&G have suggested overcoming this by utilizing a text message service where children can directly access school nurses, but this may require careful evaluation.

Training and Support

In P&K only one School Nurse out of 13 held a Specialist Public Health Qualification (SPQ) and in D&G four out of the nine School Nurses held SPQs and one member of staff held a Certificate in School Nursing.

It was recognized that adoption of the nine priority areas would also mean additional training was necessary, over and above that contained in the SPQ. Masters level modules were therefore developed by three Higher Education Institutes (Robert Gordon University, Queen Margaret University and University of the West of Scotland) but these had not come on line during the course of the pilot.

To fill this gap NES delivered a 2 day Master Class in the pilot areas and this was followed by a variety of day courses offered locally covering the priority areas. The training was widely welcomed. However staff expressed the view that they needed more in-depth training in the more commonly used pathways, in particular Mental Health and Well Being, and regular refresher training in the less well used pathways, such as Homelessness and Youth Justice where local conditions could change quite regularly.

The provision of training to staff from local resources proved very time consuming and stressful for managers but it was recognized that this was not likely to be a permanent need as staff undertook more training provided nationally. However the issue of the provision of CPD for qualified nurses in the future may need to be addressed.

Concern was expressed that taking staff away to pursue training was likely to have a detrimental effect on existing staff capacity and this would need additional consideration. In addition some staff need to upgrade their academic skills before undertaking Masters level modules and this also needs to be factored in to planning for staff training.

Status of Cases at End of the Early Adoption period

By the end of May 2016 P&K had closed/discharged 50 (47%) of its cases and D&G 79 (26%). The difference may have been caused by D&G Nurses sometimes keeping cases open but on reduced intervention. Many of the children had been referred on elsewhere, particularly in the case of P&K. This may indicate a need for further training in order to build confidence in the skills in the School Nurse workforce.

Table 12: Percent children with certain Outcomes of Intervention for Closed Cases

	P&K % Outcomes	D&G % Outcomes
Child Development Team	31	
Elsewhere in NHS	2	4
Patient Declined (or DNAs)	13	1
CAMHS	24	8
GP	7	
YPHT	4	
Central due to Immunisation	7	
Incontinence	2	1
Intervention Completed	11	68
Left school		8
Foster Care		3
Educational Psychology		1

Physiotherapy		1
Social Work		1
Other		3

By the end of the early adoption period around two thirds of cases were open in D&G and a third in P&K (there was a relatively high proportion where the outcome was unknown). However this does not take into account the complexity of cases in the respective areas, nor whether the term ‘open’ meant the same in both areas (in discussion it became apparent that some School Nurse were keeping cases open so that they could keep a watching brief over certain children but this did not necessarily entail a high level of intervention).

6. Conclusion

What worked well?

1. The nine priority areas have undoubtedly made the school nurse role more focused and standardised. It has added value to the service by providing clear priority areas and pathways to school nurses.

2. The referral system formalises practice and ensures that school nurses receive mainly relevant referrals.

3. The role is now clearer to the nurses themselves and to all relevant agencies, including education.

4. Other agencies are increasingly aware of the contribution school nurses make to children's assessment and support process.

5. The priority areas have extended working relationships with agencies (e.g. youth justice) that school nurses did not previously engage with.

6. Extensive and mandatory training appears helpful for delivering the pathways.

What did not work so well and may require further consideration?

1. The nine selected priority areas generated divided opinions amongst both managers and nurses, especially in terms of what qualifies to be included or excluded. However it was recognised that children and young people could move between priority areas and could also be on several pathways at once.

2. The mental health and wellbeing pathway was the most frequently used pathway. Whereas nurses referred complex mental health cases to CAMHS, they felt less equipped to deal with low to moderate cases. As there are no nationally agreed guidelines on the assessment and treatment of mental health issues in young people, it is difficult to know what kind of training would be most appropriate for School Nurses.

3. Some members of the wider school health team felt alienated and excluded from the refocussing of the SN role. Whilst the development of the priority areas and pathways gave increased clarity and structure to the School Nurse role the role of the wider School Health team still needs further clarification.

4. Accessing the service through pupil support teachers was considered as a barrier in some cases.

5. Although school nurses perceived that they are now in a position to build stronger trusting relationships with the limited number of children who

access their services, it was generally recognised that they are now less accessible to the wider school population.

6. Targeted skill-based training would be required to equip nurses on some specific pathways e.g. mental health and wellbeing.

Recommendations for school nurse training and further implementation

Priority areas and Pathways

1. There needs to be greater clarity around the pathways. It may be beneficial to amend some e.g. the substance misuse pathway could be widened to include all risk taking behaviour.

2. Health Boards should be encouraged to adopt the nine priority areas but develop their own pathways as referral mechanisms and resources differ locally.

3. Additional training on the mental health and wellbeing pathway is required. It might be useful to involve CAMHS in any such training.

Training

4. Nurses would benefit from training approaches that seek to build practical skills within the parameters of the priority areas. This would ensure that aside from identifying risks, nurses would also be equipped with skills to deliver interventions or support where necessary.

5. When training school nurses, the rationale for the selected nine priority areas may need to be clarified and the reasons for omitting some of the obvious ones, for instance sexual health (if it is to be omitted) need to be clearly articulated. This would promote consistency across the workforce regarding the rationale for the selected priority areas.

6. Whilst it is encouraging to see staff taking up opportunities for full time training backfilling their posts is necessary. This will be particularly pertinent over the next 5 years or so whilst most staff are receiving training.

Referral

7. The current referral procedure through the pupil support teachers may exclude some groups of children who may find it uncomfortable to approach such teachers with their issues. Exploration of other means of accessing school nurses (e.g. text message service) without going through pupil support teachers would be useful.

8. Clarification is needed around whether the School Nurses use referrals or Requests for Assistance and the role of the HPI.

Wider School Health Team

9. The role of the band fives should be consistent and clear career development/progression opportunities could be incorporated within the role.

10. Clearly articulating the specific role within the priority areas of members of the wider school health team would be useful.

11. A dedicated immunisation team is required if school nurses are to focus on the priority areas.

Recording and Record Keeping

12. Data needs to be consistently gathered using an agreed format. This data should be analysed nationally and fed back to school nurse teams for management purposes as well as being used to show the patterns of usage across Scotland.

13. The evaluation of the pilot was unable to measure any kind of impact. It is recommended that if the refocused school nurse role is rolled out nationally that some sort of outcome/impact study is undertaken.

How to access background or source data

☒ cannot be made available by Scottish Government for further analysis as Scottish Government is not the data controller.

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The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

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