The Queen's Nursing Institute

Transition to the School Nursing Service

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Introduction

Safeguarding children and young people is everyone's responsibility but the specific role that you play within that agenda will vary between different areas. Safeguarding is not just about child protection but describes an agenda which helps to identify vulnerable children, young people and families who are in need of extra help and support. They may not always ask for that help but you will be in contact with children, young people and families in a variety of different ways and settings and this means that they may disclose information to you that indicates that they are in need of help or that they are at risk of harm. You will need to know the processes that are in place for you to escalate any concerns that you have to the appropriate people and who the named child protection leads are in your area.

The aim of this Chapter is to:

- Encourage you to consider what your knowledge and skills are with regard to the safeguarding agenda
- Raise awareness of systems that protect vulnerable people and how to 'raise concerns'
- Discuss current issues that are impacting on children, young people and family's health and wellbeing.

Discussion point: Using this adapted SWOT analysis, identify your current knowledge about the safeguarding agenda and think about what your concerns are about this part of the school nursing role. Discuss this with your mentor.

STRENGTHS - what do I already know?	WEAKNESSES- What do I need to find out?
OPPORTUNITIES - where can I find out information?	THREATS - what are my main worries or concerns about safeguarding?

'Safeguarding children and young people is everyone's responsibility.'

The principles of safeguarding

Safeguarding is about promoting the welfare of children, young people and families and protecting vulnerable groups from harm. The underlying principles of safeguarding children, young people and their families are that professionals who come into contact them are alert to their needs and know how to act to help protect them from harm. The Working Together to Safeguard Children document (DH 2013) identifies safeguarding as:

1. Protecting children from maltreatment;
2. Preventing impairment of children's health or development
3. Ensuring that children grow up in circumstances consistent with the provision of safe and effective care
4. Taking action to enable all children to have the best outcomes.

There is guidance for school nurses on safeguarding at the following website for you to get more information:

www.gov.uk/government/publications/working-together-to-safeguard-children--2

You may be aware of serious case reviews (SCR's) that follow any tragic deaths of children or young people and there have been some high profile cases that have prompted attention on the child protection agenda. You can find some of these SCR's on the following websites:

Serious case reviews at a glance: www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/2014/

SCR - Daniel Pelka:
www.coventrylscb.org.uk/dpelka.html

SCR – Hamzah Khan:
https://www.saferbradford.co.uk/children/

Discussion point: Think about any commonalities that exist across these SCR's and how they may have informed your local child protection policies.

You will need to be aware of key documents in relation to safeguarding children, young people and their families as well as familiarising yourself with local policies and procedures. These are four of the key reports and documents:

1. **The Children Act (1989 and 2004)** www.legislation.gov.uk/ukpga/2004/31/contents

2. **Working Together to Safeguard Children (2013)** A guide to inter-agency working to safeguard and promote the welfare of children www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf

3. **The Children and Families Act** www.legislation.gov.uk/ukpga/2014/6/contents/enacted

4. **The Munro review on child protection** www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf

Working in the school nursing team (SNT) as a qualified nurse you will be governed by The Code: Professional standards of practice and behaviour for nurses and midwives (NMC (2015) which gives guidance on the key principles in protecting individuals at risk and harm.

Here is what the NMC says about safeguarding:

- Safeguarding = protecting people from abuse, neglect as well as actively promoting their welfare
- All members of health and social care teams are required to work together to take action to address actual or potential concerns

Reporting concerns

Your SHT will have procedures in place and there will be specialist child protection nurses in the organisation. The duty to investigate lies with social services and there will be a specific number to ring to the duty officer in children and families locally. See the NSPCC guidance below:

www.nspcc.org.uk/preventing-abuse/child-protection-system/england/reporting-your-concerns/

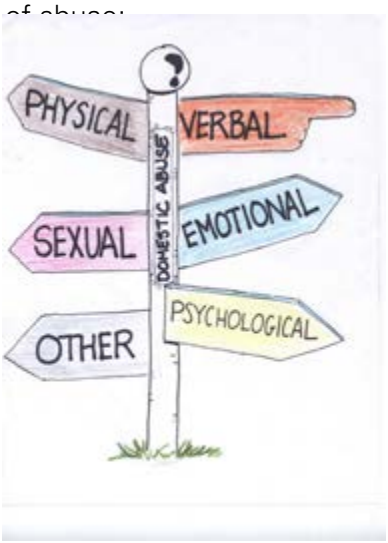
Vulnerability

Vulnerability can be defined in different ways but there is an acceptance that in terms of safeguarding, it refers to individuals who are susceptible to harm. It is linked to being dependent on others for care, security or support and this provides an opportunity for abusers to take advantage of the situation. Safeguarding is about acting in the best interest of the child or young person and putting them at the centre of decisions that are made about them. Children may be open to abusive situations either

directly or indirectly.
For example, they may be witnessing domestic abuse or they may be being physically or sexually abused. There will be an emotional impact on children or young people from any type of abuse and this may have long term consequences. Early identification and intervention is very important therefore and there is a role for everyone in this respect.

What is Abuse?

It is important to have some understanding of how to recognise forms of abuse:



Safeguarding children is everyone's responsibility and to ensure that services are available to children in need or at risk of harm, every professional and organisation must be mindful of their responsibilities and process of appropriate referral (HM Govt 2013). Categories of abuse as defined by the National Society for the Prevention of Cruelty to Children (NSPCC) (2010) are listed as:

- Physical
- Sexual
- Emotional
- Neglect

It is important to consider what behaviours happening within a family could be seen to be causing or likely to cause significant harm to any child within that family.

Nice Guidelines 'When to Suspect Child Maltreatment' (NICE 2013) provides guidance for recognition of both physical and psychological symptoms. It is important to remember that the impact of abusive behaviours and neglect will be dependant on age, resilience and other support networks available.

It has been recognised that early intervention is extremely important to reduce the negative long term effects of child abuse (Munro 2011). This means that prompt referral to appropriate agencies is essential. Nurses are often concerned that by discussing clients they might be breaching confidentiality, but the safety of the child is paramount. You may have disclosures from older children and an understanding of confidential responsibilities is important here. Complete confidentiality can never be promised and any concerns that a young person is at risk of significant harm should be shared with the appropriate agencies.
http://cks.nice.org.uk/child-maltreatment-recognition-and-

‘Early intervention is extremely important to reduce the negative long term effects of child abuse.’

management#!topicsummary

Assessing need

It might be helpful to look at levels or thresholds of need; how can you judge when a child is in need of extra help or in need of protection from significant harm. The four levels below will help to identify how you might assess this.

1. **No additional needs** – these are children or young person (YP) with no additional needs; all their health and developmental needs will be met by universal services. The majority of children living in each local authority area require support from universal services alone.

2. **Early help** – these are children or YP with additional needs who may be vulnerable and showing early signs of abuse and/or neglect; their needs are not clear, not known or not being met. This is the threshold for a multi- agency early help assessment to begin.

3. **Children in Need** – these are children or YP who are unlikely to achieve or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services; or children who are disabled. They may require longer term intervention from statutory and specialist services. This is the threshold for an assessment led by children’s social care under s.17 Children Act 1989;

4. **Child Protection** - these children or YP are suffering or are likely to suffer significant harm. They will require intensive support under s.47 Children Act 1989. This is the threshold for child protection.

Reflection point - Think about the two case scenarios below and these levels of need. Where do you think Sam and Charli might be, based on these criteria? Discuss with your mentor.

1. Case study - Sam

Sam is 7 years old and is an only child. He lives with his father (Rob) who is unemployed and is an alcoholic. Sam’s mother died two years ago of breast cancer. Rob has a sister, Hannah who lives nearby. She works full time and has three children of her own. Sam’s maternal grandparents live some distance away and his paternal grandparents have both died since the death of Sam’s mother. Sam had disclosed to a teacher that he was often waiting in the car in a car park for his father (Rob) while he was drinking in the local pub. When the concerns were first raised with this disclosure, the child protection thresholds were not met. New concerns were raised, shortly afterwards, by the school due to visible head lice on Sam’s head. There were also concerns about Sam’s school work and attitude in class which had gradually deteriorated since his mother had died. Sam had started school as a lively and enthusiastic student who made friends easily but he had become withdrawn and anxious and lacked concentration, often falling asleep in class. There had also been a social care referral due to Rob’s persistent lateness in picking him up from school.

2. Case study - Charli

Charli was 13 at the time of the referral to the school nurse drop in. She attended the local secondary school where the school nurse ran a drop- in. Charli lived at home with her mother (Emma) and two younger siblings, Freya aged 9 and Oscar aged 6. When Charli was 11, her parents separated and her father left the country to live in Australia with his new partner and so Charli rarely sees him. Charli attended the drop in at the time of the divorce for support from the school nurse and school counsellor as she was struggling to deal with her father not only leaving the home but also moving so far away. She had found the support at the drop- in very helpful. Charli’s mother (Emma) started a new relationship with Ryan six months after the divorce from Charli’s father, which Charli found very difficult to cope with. Ryan then moved into the family home about three months after the relationship began. Having established a good relationship with the school nurse, Charli continued to have regular contact and attended the drop in regularly for support. Charli began to come more frequently to the drop in and displayed signs of anxiety which gradually increased. At one of the drop-in sessions, Charli disclosed that when they are alone, Ryan made inappropriate comments to her and that he had tried to fondle her breasts. She was clearly very upset but did not want to tell her mother as they had been rowing frequently and Emma had called her a trouble maker who resented her being happy with Ryan. Emma had also just started working at the local supermarket in the evenings and left the children with Ryan. Charli was worried that both Oscar and Freya would be vulnerable if she went out and left them alone with Ryan.

Now think about Sam and Charli’s situations in relation to doing a more detailed assessment. Local assessment frameworks have evolved out of the idea of a Common Assessment Framework (CAF) that was developed to gather relevant information for

children in need and children in need of protection. This was to identify which relevant services would be needed to support vulnerable children, young people and their families. Although it may not be called a CAF in some areas, the principles are still applicable. Using the triangle below, consider the individual needs of Sam and Charli in relation to their developmental needs, the parenting capacity and their family and environmental circumstances. Discuss these with your mentor and think about what services would be appropriate and what is available in your local area.

Multi-agency approaches/working together

There is general agreement that there needs to be a team approach to address the needs of vulnerable children and young people. Criticisms of safeguarding processes in the past have highlighted that agencies don't always work together for the welfare of the child or young person in a co-ordinated way. Good integration hinges on good communication strategies between professionals as well as with the child, young person and their families. A team around the child approach should enable them to be placed at the centre with clearly identified needs and how those needs are going to be met.

Current issues relating to safeguarding

Domestic abuse and violence

See the school nurse pathway on domestic violence at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/211018/9576-TSO-Health_Visiting_Domestic_Violence_A3_Posters_WEB.pdf

When children and young people are witnessing or involved in abusive situations, their social, emotional and cognitive development may be affected. This may become evident in various ways, which could be identified in school or elsewhere and the SHT may be alerted to changes in children or young people's behaviours by education staff or other members of the community. A range of emotions and behaviours might be displayed; they may become anxious, withdrawn, nervous, sad, angry, aggressive or sexually inappropriate. They may also become less interested in school work or begin bullying others; they could be acting out behaviours that they are witnessing at home.

There is also growing evidence to suggest that abusive relationships can

‘When children are witnessing or involved in abusive situations, their social, emotional and cognitive development may be affected.’

develop between young people themselves. You may be involved in contributing to sex and relationships education and also supporting individuals as part of Children in Need (CIN) or Child Protection (CP) plans. Guidance on developing healthy relationships which promote self-respect and a positive self-image are important in tackling the issues of sexual exploitation in the future. You will need to talk to your mentor about your responsibility and be aware of the policies and procedures in relation to these issues.

You can find some more information on the following websites: The last statutory guidance on Sex and Relationships Education (SRE) was in 2000: www.gov.uk/government/publications/sex-and-relationship-education

This is supplementary advice which came out in 2014: www.sexeducationforum.org.uk/media/17706/sreadvice.pdf

The Personal, Social Health and Economic Association provides this guidance: www.pshe-association.org.uk/content.aspx?CategoryID=1172

Improving the local response to young people experiencing relationship abuse www.caada.org.uk/Young_People/The_Young_Persons_Violence_Advocacy_Programme.html

Social Media

The internet has enabled young people to communicate in a wide variety of ways. While in many situations this is a positive development, it has also created a platform for abuse. This can be between young people where a different form of cyber bullying or sexual exploitation has grown or between adults and young people. Adults can portray themselves through the internet as anything they want to be without a child knowing who they really are. The internet also gives more opportunity to view inappropriate images such as pornography. Young people are also influenced by celebrities as role models that are not always positive on social media sites.

Here is some guidance about using digital technology: Guidance for nursing staff working with children and young people www.rcn.org.uk/__data/assets/pdf_file/0008/586988/004_534_web.pdf

Child Sexual Exploitation (CSE)

Your role in CSE, as with other safeguarding issues is to be aware of the risks, be alert to reports of any changing behaviours in young people, be confident in reporting your concerns and listen and believe what young people may tell you.

Types of child sexual exploitation include, but are not limited to:

Inappropriate relationships: often involving a sole perpetrator who has inappropriate power or control over a child or young person, and uses this to sexually exploit them. The victim may believe they are in a consensual loving relationship. The perpetrator may be known to the child and may be a family member.

‘Boyfriend’ model of exploitation: the perpetrator befriends and grooms a child or young person into a ‘relationship’. Once trust is gained they may then coerce or force them to have sex with friends or associates. Often, the victim believes they are in a consensual, loving relationship.

Peer exploitation model: a child or young person is invited (often by same sex friends) or forced by peers or associates to engage in sexual activity. They may then be rewarded in many ways, including participating in the abuse of other victims.

Organised/networked sexual exploitation: victims (often connected) are passed through networks, possibly over geographical distances between towns and cities where they may be forced or coerced into sexual activity with multiple men and women, often at ‘sex parties’ involving drugs and alcohol before sexual abuse occurs. The victims may be used to recruit others into the network. This activity can entail serious organised crime involving the planned exchange of victims.

See ‘If only someone had listened’: Office of the Children’s Commissioner’s inquiry into child sexual exploitation in gangs and groups: Final report, Children’s Commissioner, 2013 www.gov.uk/government/publications/helping-school-nurses-to-tackle-child-sexual-exploitation

As part of your role, you will need to have some understanding about consent and how the law can protect children and young people from sexual exploitation.

The Sexual Offences Act 2003, introduced a new series of laws to protect children under 16 from sexual abuse. However, the law is not intended to prosecute mutually agreed teenage sexual activity between two young people of a similar age, unless

it involves abuse or exploitation. (FPA, 2011).
Specific laws protect children under 13, who cannot legally give their consent to any form of sexual activity. There is a maximum sentence of life imprisonment for rape, assault by penetration, and causing or inciting a child to engage in sexual activity. There is no defence of mistaken belief about the age of the child, as there is in cases involving 13–15 year olds. (FPA, 2011).

The following websites provide further information about child sexual exploitation

- Child Exploitation and online protection: www.ceop.police.uk
- Family Online Safety Institute: www.fosi.org
- The Anna Freud Institute: www.annafreud.org/corc.htm
- Preventing sexual exploitation: www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-exploitation/what-is-child-sexual-exploitation
- How to recognise sexual exploitation: www.nhs.uk/livewell/abuse/pages/child-sexual-exploitation-signs.aspx

Female Genital Mutilation

Female genital mutilation (sometimes referred to as female circumcision) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. The practice is illegal in the UK but it remains a cultural tradition in some communities. You may be working in multi-cultural communities, so talk to your mentor and others in the team about this and any particularly risky groups that might be in your area. It has been estimated that over 20,000 girls under the age of 15 are at risk of female genital mutilation (FGM) in the UK each year, and that 66,000 women in the UK are living with the consequences of FGM. However, the true extent is unknown, due to the "hidden" nature of the crime. Girls are often returned to their country of origin for the procedure but it is believed that it is also done in this country although it is illegal. Schools and SHT's need to be aware of young girls missing school, although it is often done during holiday time. Reporting procedures need to be in place and a multi-agency practice guideline is available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf

Other information can be found at:

- www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm
- www.gov.uk/government/publications/services-for-women-and-girls-with-fgm
- www.e-lfh.org.uk/programmes/female-genital-mutilation/
- www.hscic.gov.uk/isce/publication/scci2026.

Young carers as a vulnerable group

Young carers could be classified as a vulnerable group and in need of safeguarding, and they may be children in need of extra support. They may be at risk for a number of reasons:

- They be carrying out inappropriate caring and domestic duties in relation to their age and stage of development
- They may be missing school
- They may not be able to complete homework because of their caring responsibilities
- They often hide what is happening at home
- It may be difficult for them to sustain friendships.

'Over 20,000 girls under the age of 15 are at risk of FGM in the UK each year.'

The number of young carers in the UK is growing and they may spend up to 50 hours a week caring for parents or other family members. The impact on their social life and educational achievement can be considerable. They will often be reluctant to relinquish their caring role or discuss with their teachers but they need help to access services and organisations who can provide them with appropriate support and respite.

Case scenario - Mary

Mary has multiple sclerosis and her condition has been gradually deteriorating since she was widowed 12 months ago. She has one child, Jack who is 7 years of age. Jack has been taking the odd day off school to look after Mary. Teachers are noting that Jack is falling asleep during class on occasions and his overall appearance has declined. For example Jack has been coming to school with a stained uniform for the past two weeks and his body odour is causing him to be excluded from group games at school. Jack's class teacher speaks to you about Jack and asks for your help – in the first instance this is because of his unkempt appearance, falling asleep in class and he is being teased by his class mates.

What is your first action?

Possible actions:

- You would need to discuss this with the SHT
- A home visit may be arranged or Mary may be invited to the school for a meeting if she is well enough
- A joint visit would be useful with the integrated health and social care team at home if possible
- Both Jack and Mary will need an assessment. Mary to assess her health and social needs and Jack to assess his needs according to local assessment need guidelines
- A Referral to local MS Society might be useful
- A referral also to Young Carers for Jack http://qni.org.uk/supporting_carers/school_nurse_resources

Discussion point: What help and services would be available to Jack and Mary? Discuss with the SHT and also what your role might be.

Children in Care

A child who is being looked after by the local authority is known as a child in care (CIC) or a looked after child (LAC). In some cases, parents will have placed their children in care voluntarily but in other cases, children's services will have intervened because of a risk of significant harm.

Children in care can be:

- living with foster parents
- at home with their parents under the supervision of social services
- in residential children's homes
- Other residential settings like schools or secure units.

School nurses may play a part in assessing the health needs of looked after children. There may be specialist CIC nurses in your area. Find out what their responsibility is and what your involvement as part of the SHT is in undertaking health assessments. Children or young people (YP) in care have the same overall needs as other children and YP but they may also have additional needs, in particular, their emotional health and wellbeing. An accurate and up to date personal health record is important for children and YP to ensure that they understand their own health history as well as making sure that the right decisions are made. You may also be involved in supporting CIC as they leave the care system: discuss this with your mentor.

Reflection trigger point

These reflection triggers are for you to get together with your mentor and if appropriate other team members to debate possible solutions. They could be used as a basis for a discussion or even a teaching session. Consider these in relation to referral routes locally.

- A young girl (11 years old) comes to a drop in and appears thin and pale and seems to be cutting herself. There are marks on her arms and she also discloses that she is cutting herself. She says that she is very scared at home of her older brother Liam who is 17 and that her mum is often out, leaving Liam in charge. What would you do?

- You are doing a routine screening on school entry and a child has a large bruise on their eye. What would you do?

- You do a home visit to see a 9 year old boy who is not attending school. The house is untidy and chaotic but he is happily playing with his young sister who is 3. Mum also has a new baby and looks very tired. What would you do?

- You are made aware by a primary school that a young African girl who is about to go to secondary school has been taken out of school for two weeks in term time without permission from the school. There are concerns by the school that there may be an issue of Female Genital Mutilation. They are unsure whether she left the country or not during this time. What are your responsibilities in this case? And what action would you take?

Below is a list of common Acronyms used in safeguarding. Although it can be confusing using acronyms and they are not recommended, they do exist. They will vary and change but here are some common ones in use:

- **CIN** – Child/Ren in need
- **DV/A** - Domestic Violence/abuse
- **EOTAS** - Education Other Than At School
- **ICS** Integrated Children's Services
- **MASH** Multi-Agency Safeguarding Hub
- **TAC** Team Around the Child TAF Team Around the Funds
- **CP** review – Child Protection Review
- **CSC** – Children's Social Care
- **CSE** – Child Sexual Exploitation
- **SEN** – Special Educational Needs
- **SW** – Social Worker
- **CIC** – Child in Care
- **LAC** – Looked After Child
- **LADO** – Local Authority Designated Officer
- **MAPPA** – Multi Agency Public Protection Arrangements
- **LASCB** – Local Area safeguarding Children's Board
- **MARAC** – Multi Agency Risk Assessment Conferencing

Chapter summary

This chapter has given an overview of the safeguarding agenda and what your role may be within that. It has encouraged you to reflect on any gaps in your knowledge and also to think about the concerns that you may have when you come into contact with child protection issues. It has highlighted some of the current issues in safeguarding such as FGM and CSE. You have also had the opportunity to look at some case scenario's to help assess the needs of children, young people and their families.

References/resources

www.chimat.org.uk/schoolhealth/safeguarding

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‘The number of young carers in the UK is growing and they may spend up to 50 hours a week caring for parents or other family members.’

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