Exploring risk assessment in school nursing and safeguarding practice: A mixed methods study

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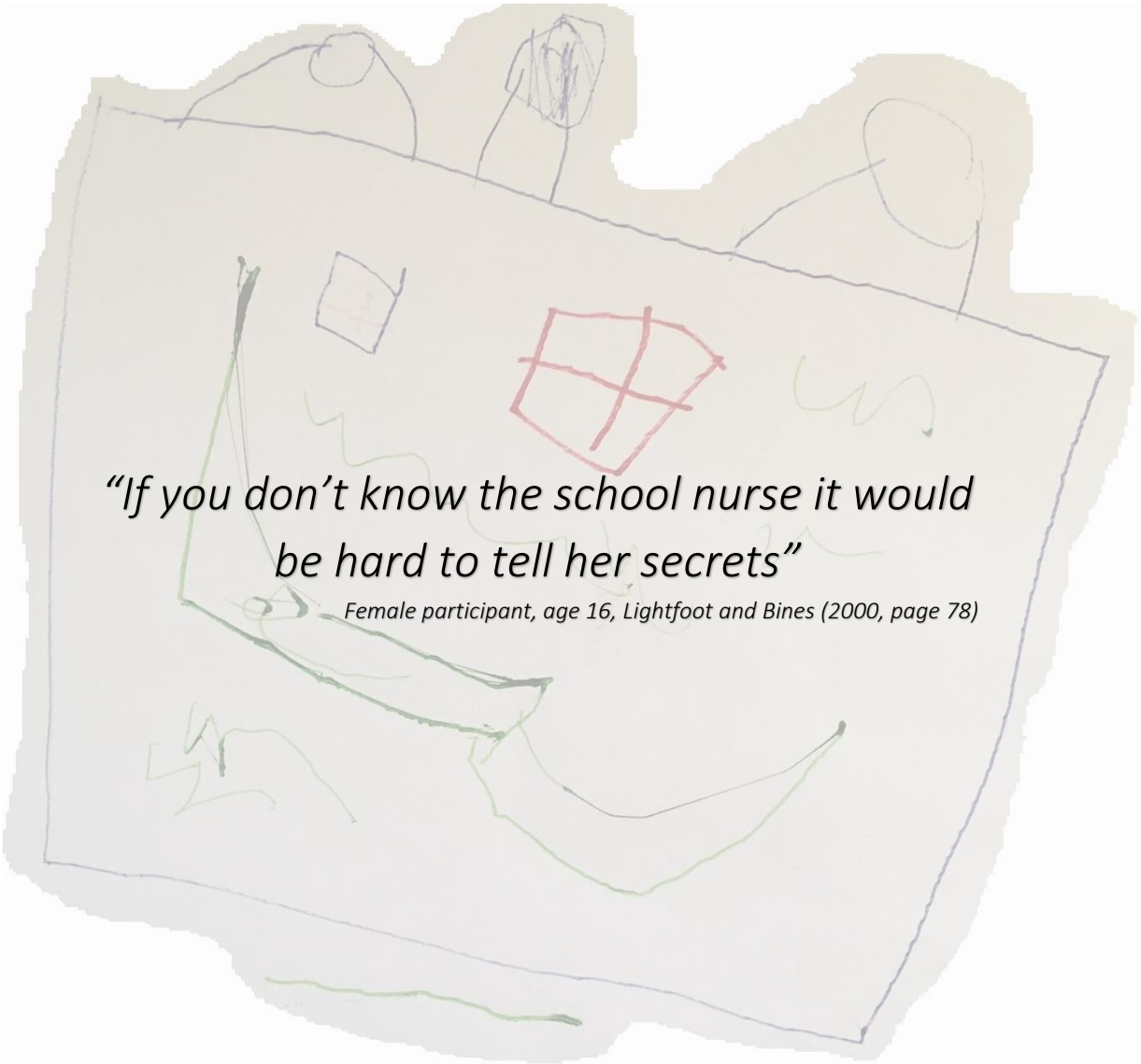

“If you don’t know the school nurse it would be hard to tell her secrets”

Female participant, age 16, Lightfoot and Bines (2000, page 78)

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Abstract

School nurses in the UK have a unique position to recognise and respond to suspected abuse and neglect through their universal contact with the school population (HM Government, 2018) although a dearth of in-depth research exists to understand their role.

The aim of this research study is to understand how school nurses identify and work with school children aged 5-19 years at risk of child abuse and neglect. Three research objectives informed the study; (1) to explore the processes through which school nurses identify school children aged 5-19 years at risk of child abuse and neglect (2) to explore how school nurses make assessments of school children aged 5-19 years at risk of child abuse and neglect, and the types of school nursing interventions offered to them, and (3) to explore the experiences of school nurses in identifying and working with school children aged 5-19 years at risk of child abuse and neglect: including the perceived challenges and opportunities of their role.

A mixed-methods approach was taken to the study, underpinned by the epistemological stance of pragmatism (Creswell and Plano Clark, 2007; Teddlie and Tashakkori, 2009). A sequential design was conducted in two stages; Stage One explored the context of school nursing caseloads and appointments with children and young people using secondary data from electronic diaries and caseloads, and Stage Two explored in-depth the experiences of school nurses through semi-structured interviews, informed by a constructivist Grounded Theory approach (Charmaz, 2014).

A process model of risk assessment in school nursing practice, developed from the findings of this study, is presented in three key stages; *'becoming aware of safeguarding concerns', 'detective work'* and *'managing risk'*. Key concepts of risk, trust and communication are explored, which form the foundations of a school nursing safety net of care for vulnerable children and young people who may otherwise fall through the gaps of current service provision.

Much greater clarity is needed at a local and national level as to the remit of school nurses in safeguarding and child protection. School nurses are expected to operate at any given point along the spectrum of preventative to reactive care; they must not *only* be regarded as an expanding catch-all service in this way, but rather a speciality with focus.

Acknowledgements

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Thank you to my family and wider circle of friends, and to my husband Craig for his continued patience. A mention to my nephews, Jude and Louie- thank you for 'drawing the picture for Aunty La La's book' (see third page).

Finally, I recognise the children and young people who sadly have or will suffer child abuse, neglect, exploitation, and mental health crisis, for whom this research hopes to inform the practice and organisation of those professionals available to support them.

Chapter One: Introducing Safeguarding, Child Protection and School Nursing in England

Chapter one sets the context of the study in the current literature on safeguarding and child protection, including risk factors and symptoms of child abuse and neglect. A brief overview of the policy landscape for safeguarding children and young people in England is given, as well as an introduction to national guidance concerning the role and remit of the school nurse.

Chapter Two: The Role of the School Nurse in Safeguarding -An Integrative Review of the Literature

A systematic, integrative review of primary research studies was conducted to understand the international role of the school nurse in protecting children and young people from child abuse and neglect. Thematic analysis uncovered the themes of *'supporting the child and family', 'detective work', 'working with other professionals', 'training and supervision', 'barriers to protecting children from abuse and neglect'*, and *'trust'.*

Chapter Three: Methodology and Research Design

In chapter three, an overview of the epistemological stance of pragmatism is given, as well as the key concepts of mixed-methods research. The research question is posed: '*how do school nurses in England identify and work with school children aged 5-19 years at risk of child abuse and neglect?'.* For the qualitative stage of the research, an introduction to Grounded Theory is presented and a brief history of the approach is given. Key stages of Grounded Theory methods are explored; including coding techniques, constant comparative analysis and memos.

Chapter Four: Methods

An in-depth description of the methods for both Stage One and Stage Two of the research study is given. Stage One used descriptive statistics to understand school nursing caseloads and interventions with vulnerable children and young people, according to their diaries and caseloads held on Electronic Clinical Records (ECRs). Stage Two employed Grounded Theory methods to analyse 25 semi-structured interviews with school nurses, to understand their experiences of working with children and young people at risk of abuse and neglect.

Chapter Five: Stage One Results

Findings from school nurses' ECRs explored the size and complexity of school nursing caseloads (in relation to children and young people at risk of abuse and neglect) across three study sites in England. Key findings highlighted the involvement of school nurses, through scheduled health appointments, with vulnerable children and young people with mental health concerns and children and young people who are categorised as 'in need'.

Chapter Six: Stage Two Results

Interviews with 25 school nurses from across the three study sites highlighted the process of risk assessment in safeguarding practice. A model of risk assessment was developed following an analysis of study data, and this is presented in three stages;

'becoming aware of safeguarding concerns', *'detective work'* and *'managing risk'*. Key concepts of risk (and pre-conceptions of risk), trust and communication are introduced.

Chapter Seven: Becoming Aware of Safeguarding Concerns

School nurses first became aware of safeguarding concerns through the child's disclosures, checking records or by referral from other professionals or family members. Key tensions on this process are explored, including the emerging concept of building trust and using objective assessment tools.

Chapter Eight: Detective Work

Detective work, an 'in-vivo' term from the interview data itself, explores the role of the school nurse in gathering further information to support or refute initial concerns. Thresholds and definitions of risk become a key concept, as well as the influence of time pressure, perceptions of objective risk assessment tools, and relationships with other stakeholders in the information sharing process.

Chapter Nine: Managing Risk

Managing risk was a contentious issue for school nurses, and this chapter explores the tensions of navigating concepts of risk, uncertainty and professional decision-making. Influences of trust, experience and time continue, and the influence of emotion (anxiety) is introduced.

Chapter Ten: Discussion

This chapter discusses the key concepts of the risk assessment model in school nursing and safeguarding practice. Throughout the model, '*risk*', *'trust'* and *'communication'* work together to create a safety net of school nursing practice; identifying vulnerable children and young people who may otherwise be without support from health and social care agencies. In this study, risk assessment and trust are closely tied, as trust is the foundation for talking to vulnerable children, families and other professionals.

The safety net of school nursing is explored in-depth, focusing on the challenges and opportunities of this unique role bridging health and education. Implications for children and young people are highlighted, and arguments for and against 'safety nets' in practice are explored.

Chapter Eleven: Conclusion and Recommendations for Practice

The final chapter in this thesis considers the future direction of school nursing and safeguarding practice. Considering the complexity of caseloads in Stage One, and the risk assessment model in Stage Two, recommendations are made for better risk education, opportunities for experiential learning, and role clarity for school nurses within the wider safeguarding system. School nurses must be regarded as the experts when setting a new direction for the profession.

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Glossary of Key Terms

Term	Description
A 'One-to-One'	A term commonly used by school nurses to describe a pre-booked, individual appointment with a child or young person.
Child and Adolescent Mental Health Services (CAMHS)	Specialist services for children and young people with mental, emotional and behavioural concerns.[1]
Child in Need Plan	A plan or register that records details of children and young people who are at on-going risk of harm from abuse or neglect.[2]
Child Neglect	An ongoing failure by a caregiver to meet the basic needs of a child, such as providing food and shelter.[3]
Child Protection Plan	A written action plan for children and young people at risk of child abuse, developed my multiple professionals and managed by the local authority.[4]
Child Sexual Abuse	A child (under 18 years of age) forced to engage in sexual activity, either through contact or remotely (e.g. online).[5]
Child Sexual Exploitation (CSE)	Coercion of a person under the age of 18 years to engage in sexual activity, in exchange for gifts, money, drugs, affection or similar.[6]
Clinical Supervision	A scheduled meeting for practitioners and trained supervisors to reflect on practice.[7]
Children and Young People	Children or 'child' is a legal term in the UK referring to people under 18 years of age. 'Young people' is a preferred term for older children in UK literature, to reflect their ability to take a great responsibility in

[1] NHS (2018) *Child and adolescent mental health services (CAMHS),* Available at: https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/child-and-adolescent-mental-health-services-camhs/(Accessed: 29.12.2018).
[2] Bentley, H., Burrows, A., Clarke, L., Gillgan, A., Glen, J., Hafizi, M., Letendrie, F., Miller, P., O'Hagan, O., Patel, P., Peppiate, J., Stanley, K., Starr, E., Vasco, N. and Walker, J. (2018) *How safe are our children: an overview of data on child abuse online.* London: NSPCC.
[3] NSPCC (2018) *Neglect,* Available at: https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/neglect/ (Accessed: 05.01.2019).
[4] Social Care Institute for Excellence (2018) *Child protection procedures,* Available at: https://www.scie.org.uk (Accessed: 15.12.2018).
[5] NSPCC (2018) *Sexual abuse,* Available at: https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-abuse/ (Accessed: 05.01.2019).
[6] NSPCC (2018) *Child sexual exploitation,* Available at: www.nspcc.org.uk (Accessed: 14.12.2018).
[7] Royal College of Nursing (2018) *Clinical supervision,* London: RCN.

	decision-making.[8]
Designated Safeguarding Lead	A member of staff within an education setting who is responsible for supporting other team members to fulfil their safeguarding duties. A contact for liaison between other safeguarding agencies. [9]
Named Professional	An identified person within any organisation who is responsible for safeguarding and child protection training, supervision and practice advice.[10]
Education, Health and Care Plan (EHCP)	An education, health and care plan for children and young people aged up to 25 years, who need additional support above traditional school provision.[11]
Genogram	A way of drawing a 'family tree' to explore the bio-psycho-social history of a group of related individuals.[12]
Health Assessment	A school nurse health assessment commonly compromises a health questionnaire, and encompasses an assessment of physical, mental, social and sexual health.[13]
Health Visitor	A registered nurse with additional training in public health, who provides a universal health service to children aged 0-5 years and their families. [14]
Initial Child Protection Conference	A meeting of multiple professionals to decide a plan of care, for a child who has been deemed at significant harm from child abuse or neglect. This meeting is usually chaired by children's social care under the Local Authority.[15]
Looked After Child (LAC)	Children and young people looked after by the government (local authority) due to a care order. This may be on a long-term or short-term

[8] General Medical Council (2019) *Definitions of children, young people and parents.* Available at: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people/definitions-of-children-young-people-and-parents (Accessed: 31.10.2019).
[9] Department for Education (2018) *Keeping children safe in education: statutory guidance for schools and colleges,* London: HMSO.
[10] Steele, A. and Shabde, N. (2014) 'Safeguarding Children: Understanding the Role of Named and Designate Professionals', *Paediatrics and Child Health,* 24 (12), pp. 531-535.
[11] UK Government (2018) *Children with special educational needs and disabilities,* Available at: https://www.gov.uk/children-with-special-educational-needs/print (Accessed: 16.12.2018).
[12] Waters, I., Watson, W., and Wetzel, W. (1994) 'Genograms; practical tools for family physicians', *Canadian Family Physician,* 40 (1), pp. 282-287.
[13] Royal College of Nursing (2017) *An RCN toolkit for school nurses.* London: RCN.
[14] Institute of Health Visiting (2018) *What is a health visitor?* Available at: https://ihv.org.uk/families/what-is-a-hv/ (Accessed: 06.12.2018).
[15] Greater Manchester Safeguarding Partnership (2018) *Initial child protection conference,* Available at: www.greatermanchesterscb.proceduresonline.com (Accessed: 03.01.2019).

	basis. [16]
Local Authority	Local governments in the UK responsible for making community-orientated decisions; most commonly these are county or city councils.[17]
Multi-Agency Safeguarding Hub (MASH)	A team of professionals (e.g. police, education and health) that triage and co-ordinate referrals to children's social care.[18]
Safeguarding	Protecting children and young people against abuse, preventing impairment to health and wellbeing, and promoting safe and supportive environments. A population approach. [19]
Self-Harm	Behaviours involving the infliction of deliberate physical harm to the self, including (but not limited to) cutting, burning, poisoning, disordered eating and seeking violence/fighting with others.[20]
Standard Operating Procedure (SOP)	A document that provides detailed guidance on a set of actions to take when a specific circumstance arises.[21]
Suicidal Ideation	A person who is thinking about suicide, or who wishes to take their own life. Sometimes differentiated as 'passive ideation' (thinking but not planning) and 'active ideation' (planning a suicide attempt).[22]
Team Around the Family (TAF)	Coordination of services to support a child or family in need, usually facilitated by a TAF meeting.[23]
Threshold of Needs Matrix	A document implemented across England that defines a child's level of need, by mapping vulnerabilities against categories of risk. [24]

[16] Bentley, H., Burrows, A., Clarke, L., Gillgan, A., Glen, J., Hafizi, M., Letendrie, F., Miller, P., O'Hagan, O., Patel, P., Peppiate, J., Stanley, K., Starr, E., Vasco, N. and Walker, J. (2018) *How safe are our children: an overview of data on child abuse online.* London: NSPCC.

[17] Local Government Association (2018), *What is local government?* Available at: https://www.local.gov.uk/about/what-local-government (Accessed: 16.12.2018).

[18] Barnet London Borough (2018) *Multi-agency safeguarding hub (MASH),* Available at: https://www.barnet.gov.uk/wwc-home/practitioner-guidance/multi-agency-safeguarding-hub-mash.html (Accessed: 13.12.2018).

[19] HM Government (2018) *Working together to safeguard children*. London: The Stationery Office.

[20] Mental Health Foundation (2016) *The truth about self-harm.* London: Mental Health Foundation.

[21] Rao, T, S., Radhakrishnan, R., and Andrade, C. (2011) 'Standard operating procedures for clinical practice'. *Indian Journal of Psychiatry*, *53* (1), pp. 1-3.

[22] Barry, L C., Wakefield, D B., Trestman, R L. and Conwell, Y. (2015) 'Active and Passive Suicidal Ideation in Older Prisoners', *Crisis,* 37 (1), pp. 88-94.

[23] Oxfordshire County Council (2017) *Early Help Assessment and Team Around the Family,* Available at: www.oxfordshire.gov.uk/cms/content/early-help-assessment-and-team-around-family (Accessed:15/02/2018)

[24] Barlow, J., Fischer, J D. and Jones, D. (2012) *Systematic review of models analysing significant harm,* London: Department for Education.

Chapter One: Introducing Safeguarding, Child Protection and School Nursing in England

1.1 Chapter Overview

This thesis presents a research study to understand the role of the school nurse in safeguarding in England, the motivations for which stem from the author's experience of the unique challenges and tensions of safeguarding practice in school nursing. The aims and objectives of the study are first defined here, and later justified through an exploration of the literature. This chapter sets the research study in the context of current safeguarding legislation, policy and guidance in England, to highlight the legal, political and professional issues that impact school nursing today and to understand the environment within which the health organisations involved in this study operate. The role of the school nursing team as part of a continuum of public health practice in England is introduced, and concepts of health needs assessment defined. The chronological development of the school nurse's role in safeguarding over time is mapped (as far as possible), reviewing national guidance. Finally, key definitions in relation to child abuse and neglect are given, as well as a brief exploration of the impact of child abuse over the life course.

1.2 Aims and Objectives

The aim of this research study was to address the question: 'How do school nurses in England identify and work with school children aged 5-19 years at risk of child abuse and neglect?'

This question was informed by a dearth of research in school nursing, yet, from the small body of literature that does exist, it is suggested that school nurses have a challenging role in safeguarding.

The three research objectives were:

- To explore the processes through which school nurses identify school children aged 5-19 years at risk of child abuse and neglect.

- To explore how school nurses make assessments of school children aged 5-19 years at risk of child abuse and neglect, and the types of school nursing interventions offered to them.

- To explore the experiences of school nurses in identifying and working with school children aged 5-19 years at risk of child abuse and neglect: including the perceived challenges and opportunities of their role.

1.3 The Role of the School Nurse in England

School nursing in the public health context first developed in the Edwardian era, following a report by the British Army about the poor health of young men joining the armed forces (Inter-Departmental Committee on Physical Deterioration, 1903). The school nursing role during these early years focused on gathering health information about the school population and intervening to prevent the detrimental consequences of poverty on children such as malnutrition and poor growth (The Queen's Nursing Institute, QNI, 2015). Today, schools remain an important asset in the community approach to improving health and health inequalities (Caan *et al.* 2015).

The development of school nursing services over time in the UK is poorly documented, although many elements of the role today remain public health focused, including surveillance of heights and weights in the school-aged population (QNI, 2015). Public health policy published in the 1990s and early 2000s called for public health nursing services in the UK to become more targeted in order to focus limited resources on those most in need, such as children and families living in poverty or at risk of abuse and neglect (Blair *et al.* 2003). It is argued that the result of this was a narrowing of public health nursing services (including school nursing) over time, with a gradual shift away from being a predominantly preventative universal service (Elkan *et al.* 2000). Where some elements of the preventative role remained, such as health screening programmes, a tension developed between time spent on

reactive (targeted) versus proactive practices (Elkan *et al.* 2000; Hoekstra *et al.* 2016).

As a result of this evolution of the school nurse, today, their roles are manifold and vary according to setting. The term 'school nurse' in the UK can apply to nurses working across state (local authority) schools, private (fee paying) schools and special needs schools (for children with complex learning disabilities). School nurses working in the state school context differ slightly from other nurses working in private and special needs schools. School nurses in private and special needs schools have a greater role in first aid and physical health care of children, although their safeguarding role is likely to be similar (Ball and Pike, 2005; Public Health England, PHE, 2014a). In England, special needs school nurses are often commissioned by the local Clinical Commissioning Group (CCG), as opposed to the local authority, as their remit often involves the care of children with complex medical conditions (PHE, 2014a).

A school nursing team commissioned by the local authority will usually provide a public health service to all state secondary and primary schools in a geographical county, including academy and free schools, and may provide some immunisation provision to independent and special schools. Models of school nursing vary across England, and consequently there exists national disparity in the number of schools a school nurse may cover, ranging from one to several (QNI, 2015). It is arguable that such disparity makes it

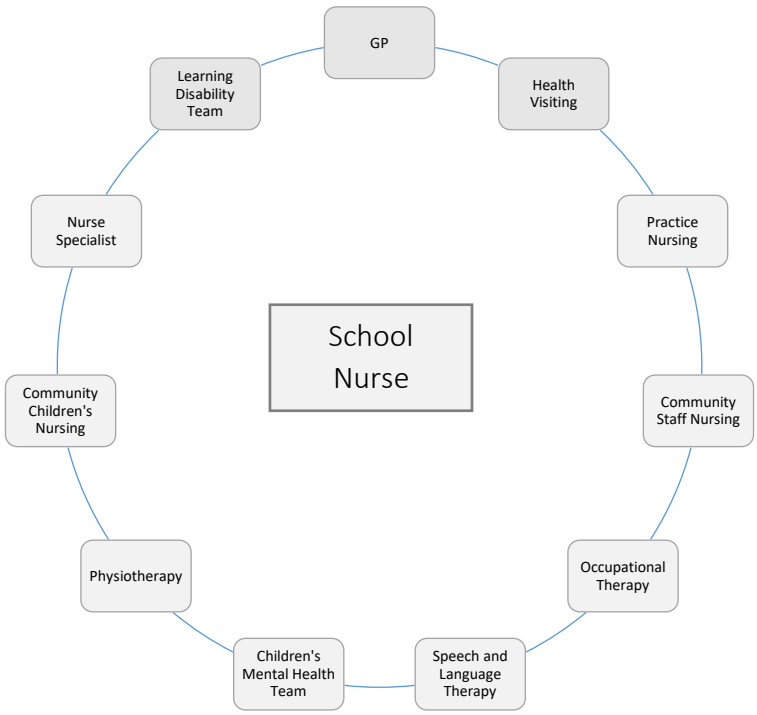
challenging to compare school nursing services, as well as affords children and young people little consistency in service provision between counties (becoming a 'post-code lottery'). More schools in England are choosing to become academies and free schools, meaning they have greater financial and operational control independent of local authority and may buy-in their own school nurse to work as a direct school employee (Roberts and Denachi, 2019).

There are approximately 1,013 qualified school nurses working in England for 24,372 schools, although this latter figure includes nurseries and independent school which are not always covered by local authority school health teams (Department for Education, DfE, 2014; NHS, 2018); this still highlights school nursing as a small workforce supporting a large population of children and young people. School nurses can work part-time, full-time or term-time only, meaning provision can vary between areas, teams and during the school holidays (QNI, 2015).

Many school nurses hold an additional registration in 'specialist community public health nursing' (SCPHN), a status and set of related standards introduced in 2004 to recognise the specialist role of school nurses and to inform training (NMC, 2004). The Nursing and Midwifery Council (NMC) standards for registration of SCPHN status (NMC, 2015) defines this as a first-level registered nurse or midwife who has completed a postgraduate course incorporating ten essential public health competencies and who is working in

a public health nursing role (NMC, 2015). SCPHN nurses often work alongside first-level registered nurses (staff nurses) who may not hold additional qualifications, as well as healthcare assistants and administrative staff. In addition, school nurses work closely with other health professionals within the community, as represented in Figure 1.1.

Figure 1.1. The school nursing role within the multi-disciplinary team (MDT)



Adapted from the Queen's Nursing Institute (QNI, 2015)

Five years after the SCPHN standards were published (NMC, 2004) the 'Healthy Child Programme' (Department of Health and Social Care, 2009) was introduced in England to provide a collaborative schedule of health promotion interventions for children and young people. These included routine screening and early identification of additional needs, and subsequently guided much of the school nurses developing remit. In 2012, 'Getting it right for children, young people and families…' (DH, 2012) was published, which introduced grades of school nursing intervention (from *'Community'* to individualised *'Universal Partnership Plus'*) and this sought to delineate the school nursing role and raise the profile of the profession.

The commissioning of school nursing services in England moved from NHS England to local authority public health departments in April 2014, and the document 'Maximising the school nursing team contribution to the public health of school-aged children: guidance to support the commissioning of public health provision for school aged children 5-19' (PHE, 2014a) was produced. This sought to support the commissioning of school health services and the development of local service specifications, and continued to have a health promotion focus. Examples of more targeted support remained health-centric, stating; *"a swift response from your school nurse service when you need specific expert help which might be identified through a health check or through providing accessible services…managing long term health needs and additional health needs, reassurance about a health worry, advice on*

sexual health, and support for emotional and mental wellbeing" (PHE, 2014a, page 17).

To further define the nature of targeted school nursing work, a framework for service delivery for school nursing, called the '4-5-6' model, was introduced (PHE, 2014b). This model remains based on four levels of service (ranging from universal population interventions to targeted interventions for highly vulnerable children), five health reviews (ranging from 4-16 years) and six key impact areas. The six key impact areas include resilience, managing risk and supporting additional needs (PHE, 2014b).

Despite the good intentions of such guidance to promote the influence of school nursing, surveys of school nurses and school pupils have highlighted some disconnect between the ideal service provision and the reality of practice. A survey of 277 UK school nurses with membership to the Royal College of Nursing (RCN, 2016) identified that meeting the demands of a widening range of responsibilities could leave school nurses feeling over-burdened and stressed, and reduce face-to-face contact time with children and young people. A survey of 1,599 UK teenagers in 2011 identified that 69% did not know how to access their school nurse, and felt school nurses were decreasingly visibly in the school community (British Youth Council, BYC, 2011).

The focus of this thesis is on school nursing teams in England who are funded by the local authority to deliver the public health and targeted agenda to children aged 5-19 years, to understand how they balance a population-based approach with individual work with school pupils. These school nursing services, commissioned by the local authority, are provided by both private and NHS organisations. The job role and remit of a school nursing service is to some extent decided by the local authority and service provider but is guided by a national public health agenda. This includes, for example, reducing chlamydia rates in 16-24 year olds, improving school readiness, decreasing childhood obesity, and providing *"public health interventions to reduce risk"* in safeguarding (PHE, 2014a, page 18; Department of Health, DH, 2015). The sometimes nebulous terms such as 'reducing risk' create challenges for school nurses when interpreting their role, as explored in chapter nine of this thesis.

Safeguarding, and the involvement of school nurses in child protection procedures, has become a larger part of the school nurse role in recent years, although some school nurses have expressed feeling forced to attend child protection meetings in the absence of another suitable health representative (Children's Commissioner for England, 2016).The evolution of the school nurse's involvement in more formal child protection procedures, such as child protection meetings, is more challenging to identify in the literature. Some publications suggest that this change may have progressed through the late 1980s and early 1990s, with school nursing moving from an invisible service,

somehow failing to establish itself as a key workforce, to a more cohesive group of nurses who took on greater contributions to child protection planning (Harrison and Gretton, 1986; Clarke, 2000; Appleton, 2008a). In the broader definition of safeguarding as protecting the safety and wellbeing of a specific population, school nurses have consistently had a role in promoting the health of children and keeping them safe from harm (Hackett, 2014).

Safeguarding and child protection has been promoted as a multi-professional responsibility and not just the remit of social workers, who are often unable to have universal contact with children (DfE, 2016). As part of a move for safeguarding to become everyone's responsibility, the school nurse became included in guidance regarding the identification and prevention of child abuse in the context of both community nursing and the school setting (DH, 1991; HM Government, 2003; HM Government, 2018).

In the early 1990s, a UK government green paper 'Our Healthier Nation' reinforced school as a key setting for multi-disciplinary health work, although this was far from mandatory and at the time many local authorities were cutting funding to school nursing (HM Government, 1998). This is still very much the case, and there has been a loss of approximately 550 school nurses in England since 2010, meaning the widening remit of school nurses does not correlate with an increase in workforce numbers, and may force them to prioritise the most urgent work with individual children (RCN, 2017a). As school nurses seek to find a role in this changing landscape of practice, and

where they often must allocate shrinking resources to those most in need, assessment becomes an increasingly important part of the school nursing approach (NMC, 2015). The health needs assessment is introduced next in this chapter as a means of seeking vulnerabilities and planning targeted interventions of care.

1.4 Health Needs Assessment

In safeguarding practice, a health needs assessment tool might be used by a school nurse to understand the un-met needs and vulnerabilities of a child or young person (Lancaster, 2007; Lancaster, 2019). This is closely related to identifying signs and symptoms of child abuse which may present through the assessment process and require the school nurse to make judgements on the risk and impact of these indicators (Engh Kraft and Eriksson, 2015; Calder, 2016). Children may already be known to be at risk or suffering from abuse and neglect and be supported by specialist agencies (e.g. children's social care) or may be unknown at the point of assessment (Calder, 2016). Children *not* meeting the threshold for social care intervention can create the most self-reported anxiety amongst professionals during assessment, and these families are often defined as being in the 'grey' (Appleton, 1994; Rooke, 2015; Wallbank and Woollacott, 2015) which is explored later in the results and discussion of the thesis.

Health needs assessment is a central tenet of public health practice, in the belief that in order to deliver effective public health interventions planners and practioners must first understand the needs of the people and community they serve (World Health Organisation, WHO, 2001; RCN, 2017b). Needs assessment in school nursing is important to understand the health and social issues surrounding a school population or concerning an individual child (Lancaster, 2007; Lancaster, 2019). Identification and assessment of those in need by public health nurses often draws on several types of knowledge and skill, including the ability to build trust and process intuition (Appleton and Cowley, 2008a). In the '4-5-6' model (PHE, 2014b) routine health reviews by school nurses are prescribed for pupils aged 4-5 years, 10-11 years, 12-13 years, post-16 (school leaver) and at the transition point to adult services.

1.5 Current Safeguarding Legislation, Policy and Guidance in England

Following an exploration of the history and remit of school nursing, consideration will be given to wider legal and political influences on school nursing services in England, as their role exists and operates in the current context of safeguarding legislation, policy and guidance.

The *Children Act 1989* is the legislative safeguarding framework for services that are provided to children and young people in the UK, including school nursing and other health and social care agencies. It defines the

responsibilities of the local authority to act to protect children from harm. The act promotes the safety and wellbeing of the child as a priority in child protection procedures, and several sections of the act are regularly invoked by local authorities, including:

Section 17: The local authority must safeguard children and young people who are 'in need' by providing appropriate services. Children in need are unlikely to meet a reasonable level of health and development without professional support, such as those with a complex disability. Where possible, children should remain in the family home.

Section 47: When the local authority has cause to suspect a child or young person is at risk of significant harm, they should make the enquiries considered necessary to protect that child.

The *Children Act 1989* was introduced to promote a more cohesive law around child rights and the ability of the courts to intervene to protect vulnerable children, as previous laws regarding child protection were disparate. The act was updated in 2004 following a landmark investigative report by Lord Laming (2003) into the death of 8-year-old Victoria Climbié, and the importance of all agencies taking responsibility to share information and work together in safeguarding was reinforced. In England, the local authority may request an order through the courts to take action without parental consent when a child is deemed at risk of serious harm (National

Society for the Prevention of Cruelty to Children, NSPCC, 2017a); these include a child assessment order, emergency protection order, female genital mutilation (FGM) protection order and an exclusion order. In addition to this, the police have powers to remove children and young people from an unsafe home environment for up to 72 hours without permission from the courts (NSPCC, 2017a).

The definition of what constitutes 'significant harm' is generally thought to be decided through thorough multi-agency assessment of the child and family's individual situation, although Section 31 of the *Children Act 1989* offers a definition of 'harm' as *"ill-treatment or the impairment of health or development; including, for example, impairment suffered from seeing or hearing the ill-treatment of another; ill-treatment includes sexual abuse and forms of ill-treatment which are not physical"*. School nurses have an increasing role in identifying signs and symptoms of harm and are likely to be guided by such definitions as well as local training and development. The extent to which definitions of harm can be truly objective is contested (Feng and Levine, 2005) and the influences of subjective decision-making are explored in the results and discussion chapters of this thesis.

In the era of the New Labour government in the UK, the *Education Act 2002* required schools and colleges to make formal arrangements to actively safeguard children and young people, and in the same year the *Adoption and Children Act 2002* expanded the definition of harm to include the witnessing

of violence in the home. The *Children and Young Person's Act 2008* called for improvements in quality of care placements for children who are taken out of the home, and the *Children and Families Act 2014* made further improvements by allowing more long-term foster care arrangements so children and young people experienced greater stability and less frequent movement between homes. The *Children and Families Act 2014* also replaced the Statement of Educational Needs (SEN) for children with learning disabilities and additional complex needs, with a new Education, Health and Care (EHC) Plan which can include contributions from the school nurse. Working within a legislative framework in this way has defined some of the responsibilities of the school nurse, yet, as discussed in chapter ten, has repercussions on the freedom of school nurses to self-define where their influence is most valuable.

Further legislative changes that moved school nursing towards a more investigatory remit came in 2015, when an amendment to the *FGM Act 2003* made it a mandatory responsibility for health professionals, social care staff and teachers to report cases of FGM in children and young people less than 18 years of age to the police. At the same time, the remit of school nurses in a health promotion/public health capacity has been influenced by legislation such as the *Children and Social Care Act 2017*, which made several changes relevant to school nursing practice; better transitions and aspirations for care leavers and mandatory Personal Social and Health Education (PSHE) for all

primary and secondary schools, including relationship education for secondary schools.

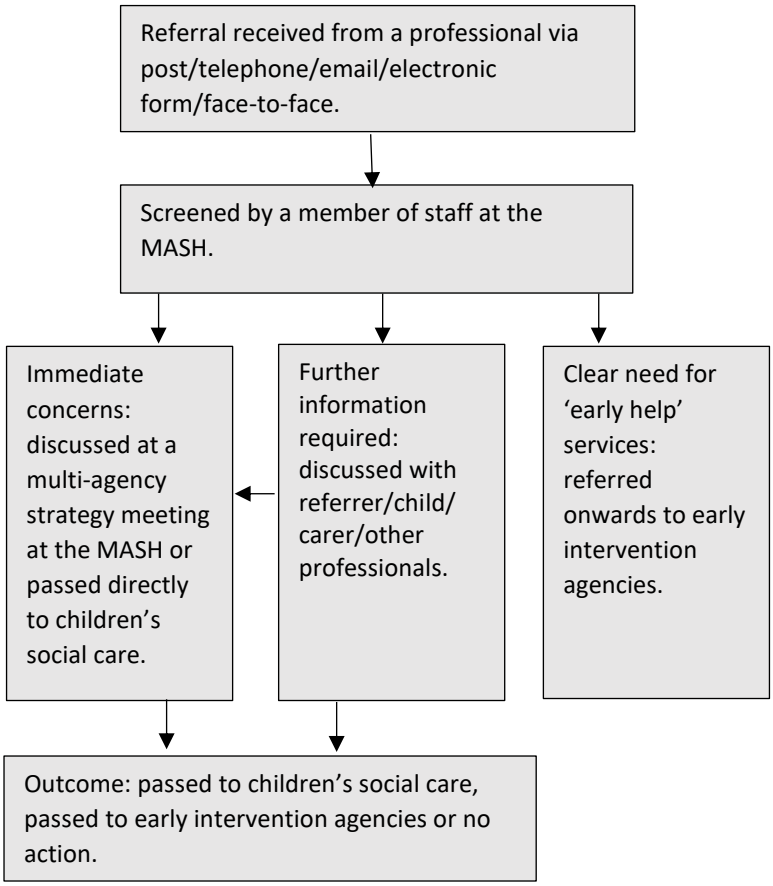
These 'frameworks' continue to be refined in ongoing procedural reviews, with school nurses increasingly visible on this stage, and within which they need to continually reassess their role. In England, serious case reviews (SCRs) are conducted by Local Safeguarding Children's Board (LSCB) when a child or young person is seriously harmed or dies from abuse or neglect, with similar systems in Northern Ireland, Scotland and Wales. This process seeks to review the role of professionals involved with the child and family to identify future learning (DfE, 2015). Wood (2016) reviewed the operational model of LSCBs, SCRs and Child Death Overview Panels (CDOPs) and made recommendations for reform, based on the notion that current approaches were too prescriptive (concerned mainly with procedure), inconsistent and not focused enough on outcomes for children and young people. In summary, Wood (2016, page 4) called for better definitions of *"child protection, safeguarding and wellbeing"* and argued a new statutory framework to ensure health, police and social care co-operate (rather than relying on moral duty). In addition, SCRs were to be replaced by National Serious Case Inquiries (NSCIs) and Local Learning Inquiries (LLIs). Many of these changes remain in transition (to date, December 2019). In 2019, issues brought to light in SCRs included the need for quality of information sharing between professionals and gaps in training around self-harm and suicidal ideation, particularly for

those working with young people of secondary school age, such as school nurses (Doherty, 2018).

The DfE (2018) and Care Quality Commission (2016) identify school nurses as part of a key group of health professionals who can play a critical role in the identification, assessment and intervention of safeguarding concerns. They also promote the importance of timely information sharing between agencies and putting the child's needs at the centre of decision making. Recent amendments to key safeguarding guidance 'Working Together to Safeguard Children' call for local authorities, local safeguarding boards and their partners to set up services for children and young people at risk of child sexual exploitation (CSE), FGM and radicalisation (HM Government, 2018). Professional referral mechanisms for safeguarding concerns relating to children and young people may vary slightly between local authorities across England, but many have opted for a version of the 'Multi-Agency Safeguarding Hub' (MASH) (Home Office, 2014). A professional, such as a school nurse, may refer children and families into the MASH via a written or verbal referral, and these concerns would be screened and/or discussed at a multi-professional meeting with representation from health, social care and law enforcement agencies (Home Office, 2014). An example of this process is shown in Figure 1.2 as referrals to social care and the 'MASH' are frequently discussed in the results chapter of this thesis. Of course, a professional might also refer children and families to other services, such as early intervention

family support, if they felt safeguarding concerns were not immediate or at a significant threshold of risk.

Figure 1.2. Example model of a MASH referral in England



Adapted from Torbay MASH (2016)

1.6 Defining Child Abuse and Neglect

Current processes in safeguarding are influenced by the development in national understanding of child abuse and neglect over time. In the UK, there were notable shifts in public focus on safeguarding practice following the tragic deaths of Maria Colwell (1973), Victoria Climbié (2000), Peter Connelly (2007) and Shanay Walker (2014) at the hands of their carers, which were reported widely in the media (Laming, 2003; Shoesmith, 2016; Wiffin, 2017). This resulted in publications of new practice guidance and changes to legislation to improve multi-agency practice, notably the *Children Act 1989* and 'Working Together to Safeguard Children' (HM Government, 2018). A shift in approaches to investigating child abuse (from paternalistic to partnership) occurred in the 1980s, following the wrongful diagnosis of multiple cases of child sexual abuse in Middlesbrough/UK, and the public backlash against the authoritarian approach taken by social workers (Butler-Sloss, 1988). Paternalist and seemingly invasive approaches to investigating allegations of child abuse evolved to become a partnership approach, attempting to balance the need for a thorough investigation with transparency and involvement of the parents and family (Alaszewski *et al.* 2000). The impact of such legislative and practice frameworks on the ability of school nurses to truly remain in partnership with the family is largely unknown, but it could be argued that such frameworks have the potential to override some freedom of professional judgement by predetermining practice. Partnership working also presents a new dilemma of whom to

believe, and how much to believe them, and has at times taken the professional focus away from the child's story to that of the parents (Bruce, 2014).

To understand the signs and symptoms of child abuse and neglect that school nurses are likely to assess in practice, definitions and risk factors of abuse and neglect are explored in the following section. WHO (2014) define child abuse as harm experienced by those less than 18 years of age, and categorise the types of abuse as physical, emotional, sexual, negligent or exploitative. Physical abuse is defined as any act of violence that causes physical harm to a child, including unreasonable chastisement (Lindon and Webb, 2016). Emotional abuse, sometimes called psychological abuse, can include ridiculing, humiliating and isolating a child or having unrealistic and non-age appropriate expectations of them (Lindon and Webb, 2016). Sexual abuse is when a child is forced or coerced into sexual activity (Lindon and Webb, 2016), and neglect can be defined as a deprivation of a child's basic care needs through acts of omission by the child's caregivers (Lewin and Herron, 2007). Neglect, as an act of omission rather than commission, is often written and considered separately from other types of abuse in the literature (Lewin and Herron, 2007; Bentley *et al.* 2018). Exploitation can encompass sexual exploitation, drug exploitation and child labour; forcing or coercing a child to participate in often illegal activities that are extremely detrimental to health, wellbeing and development (Lindon and Webb, 2016).

Terms for child abuse can vary in the literature, being referred to as child maltreatment, violence against children, and child exploitation, thus definitions in practice are constantly evolving in line with the latest research. Specific issues that constitute abuse include FGM and fabricated illness. Furthermore, there exists some difference in use of the terms 'safeguarding children' and 'child protection', although safeguarding is commonly considered as any action to promote the safety and welfare of *all* children and young people, and child protection concerned with the identification and protection of individual, highly vulnerable children (Parton, 2011; Appleton and Peckover, 2015).

The NSPCC produce annual reports on the prevalence of established child abuse and neglect in the UK and acknowledge that a true understanding of the extent of abuse is lacking without further research into the area (Bentley *et al.* 2018). The most recent report (Bentley *et al.* 2019) only focuses on online abuse, rather than all types of abuse and neglect, highlighting the evolving landscape of safeguarding. In 2017 the NSPCC added a new definition of 'online abuse' involving the use of technology, social media and online gaming, to target and victimise children and young people (NSPCC, 2017a). Across the UK during the years 2017/18 there were 55,902 children on a child protection plan; meaning the local authority and a team of professionals have put forward a formal schedule of interventions to protect the child from significant risk of harm (Bentley *et al.* 2018). Child protection planning has steadily increased over the past decade. In the same time

period, the number of recorded sexual offences against children increased, as well as a continued year-on-year increase in the number of children going into care, although this is also likely to be influenced by changes in knowledge of abuse, public attitudes and media attention (Bentley *et al.* 2018). In recent years, gang violence and drug exploitation in the UK have come to the forefront of discussions around child protection and involve the recruitment of young people to sell and transport drugs (PHE Crime Agency, 2016).

The United Nations International Children's Emergency Fund (UNICEF, 2014) identifies child abuse and neglect as a global problem although acknowledge that data regarding the prevalence of child abuse and neglect is weak, influenced by underreporting and poor record keeping in many countries. In addition, cultural and societal perceptions of what constitutes child abuse and neglect can differ. Anthropologists have long been interested in cultural influences on issues such as infanticide, parenting styles and neglect, and the lack of a universal definition of child abuse and neglect means international comparisons of child protection practice can be difficult to make (Korbin, 1987).

Definitions of child abuse and neglect in the UK are influenced by a 'Euro-American' perspective on childhood and child-rearing, for example, child-centred practices and the general dislike of physical chastisement (Korbin, 1987) and child abuse research developed at the greatest pace after the term 'battered child syndrome' first entered Western medical language in the

1960s (Kempe *et al.* 1962). Although it is widely agreed by researchers across epistemological paradigms that child abuse exists, understanding child abuse through a socially deconstructive approach (breaking down a belief to discover how it was built in the first place) may help particularly understand more about safeguarding practice and thresholds for intervention in any chosen society (Alaszewski *et al.* 2000). For example, increasing restrictions in the freedom of Western children to play alone outside over the past 50 years have been attributed to increased parental and societal fears of perceived community dangers, i.e. road traffic accidents or abduction by a stranger (Lee *et al.* 2015). However, there is little evidence to suggest similar dangers were not there in the past (aside from modern phenomena such as road traffic), and yet children who are allowed more freedom outside can sometimes be categorised as at risk or poorly supervised (Lee *et al.* 2015). In addition, there are now new fears of the negative implications for allowing children to stay indoors, and especially play computer games which can be violent or open to contact from strangers over the internet (NSPCC, 2017a). This highlights the ever fluctuating and evolving ideas about risk, which are further explored in chapter six of this thesis. Understanding social beliefs behind safeguarding practice, including in school nursing practice, may shed light on how such socio-cultural pre-conceptions colour decision-making and pre-determine the markers of harm that a school nurse seeks to find; as discussed in chapter six.

1.7 Impact of Child Abuse and Neglect on the Life Course

As well as an understanding of the history and developing concept of child abuse and neglect, the impact of abuse and neglect on children influences the manifold signs and symptoms professionals (and school nurses) are seeking to assess and report. The impact of child abuse and neglect on child development and life outcomes is well documented, and children who suffer from abuse are known to be at a higher risk of poor mental and emotional health, risk-taking behaviours and turbulent future relationships (Maguire *et al.* 2015). In the worst cases, significant child abuse and neglect can lead to serious harm or death (Laming, 2003; DfE, 2008). This highlights the weight and seriousness of practising in the realm of safeguarding and child protection for the school nurse, and the impact of this is explored in chapters seven to nine of this thesis.

The impacts of child abuse and neglect on the child can vary widely depending on the experiences of the individual, and can be discussed in terms of immediate impact (such as physical injury) and long-term impact (such as emotional trauma). Published data on the impact of child abuse and neglect is often considered in terms of type of abuse and will be discussed in this way. It is important to note that children and young people will frequently suffer multiple types of abuse and neglect at the same time, and the impacts are not confined to one category; for example, physical abuse will likely have a significant emotional impact (Teicher *et al.* 2006).

Physical abuse, which involves the deliberate harm of a child, can cause broken bones, bruises, burns, scars and other serious injuries (NSPCC, 2017b). Considering long-term impact, a US study by Cicchetti *et al.* (2010) found a link between experiencing physical and sexual abuse before the age of five years and displaying depressive and internalising behavioural features in later childhood. Additionally, the study sought a relationship between early experiences of abuse and chronic stress by measuring cortisol levels, although the correlation was more tenuous. The sample compared 265 maltreated children with 288 non-maltreated children in a summer camp context, and it could be considered that cortisol and stress may be impacted by the children attending an unfamiliar environment (Cicchetti *et al.* 2010). Holmes and Sammel (2005) surveyed 289 men in the USA and identified a link between adult male incarceration, depression and violence with experiencing childhood physical abuse, although it was acknowledged that the variables affecting outcomes in adulthood are multiple and complex. Additionally, it was not possible to understand a link between length of exposure of childhood abuse and outcomes in adult life (Holmes and Sammel, 2005).

A study by Shapero *et al.* (2014) sought to understand the link between early childhood emotional abuse and sensitivity to life stressors in a sample of 281 university students, using a set of self-reporting questionnaires. Students who reported experiencing a greater severity of early childhood emotional abuse seemed to be highly sensitive to depressive symptoms when

encountering stressful life events, although data relied on self-report and retrospective descriptions of childhood events which may not be recalled accurately (Shapero *et al.* 2014). A study by Weiss (2011) considered the particular impact of emotional abuse on the psychological distress of adolescents with a learning disability, comparing 48 young people with a learning disability with 117 peers without a learning disability using a number of self-reporting tools and observation. Although the study did not find a link between having a learning disability and suffering a greater *severity* of emotional abuse, it was found that children and young people with a learning disability reported greater distress to their mental health as a *result* of emotional abuse compared to their peers (Weiss, 2011). Children with a learning disability can be at greater risk of child abuse, particularly if they use non-verbal forms of communication and are unable to talk about their experiences; however more research is needed to understand the unique interactions between different types of disability, abuse and disclosure (Stalker and McArthur, 2012).

As a public health service, school nurses are to keep in mind the long-term impacts of adverse life events for children and must manage the challenges of intervening for both immediate safety and long-term wellbeing (NMC, 2015). An example of such a tension might involve endorsing a recommendation for a child to go into care, when children in care often have poor physical and emotional health outcomes (National Institute of Care Excellence, NICE, 2013). That is not to say that children who are at risk of

harm should not be removed into a safer environment, but that such decisions are nearly always complex, and reliant on a certain number of unknown possibilities about the future. The complexity of making decisions about risk factors of child abuse and neglect for the school nurse are highlighted in chapter ten. School nurses are responsible for an entire school population, and sometimes multiple school populations, which encompass children and young people experiencing emotional distress, and those with varying levels of learning needs (and sometimes disabilities) (RCN, 2016).

As well as the challenges of assessing abuse and neglect, the results and discussion chapters (seven to nine) of this thesis explore some challenges for the school nurse of working with concepts of neglect, where indicators may be non-tangible. Neglect involves the deprivation of a child's basic care needs and can have an impact on brain development, future relationships and attachment (Child Welfare Information Gateway, 2009; Howe, 2011). Symptoms of neglect include poor appearance, under-nourishment and a decline in physical health (NSPCC, 2017c). Research on chronic neglect has gained traction in recent years and neglect is recognised as significantly detrimental to a child reaching their potential, although deep seated beliefs that neglect is complex and difficult to untangle may fuel an avoidance of addressing it more directly and routinely in child protection practice (Taylor and Daniel, 2005; Daniel, 2013). A report by Action for Children (2010) discussed the difficulties with identifying neglect due to professional bias in what constitutes deprivation of a child's care needs and states the severity

and impact of neglect has historically been taken less seriously than other types of abuse. Despite this, neglect is the most common category for child protection plans in the UK (Bentley *et al*. 2018). A recent focus on neglect may be in line with an attempt to shift child protection practice towards better multi-agency working and early intervention; these professionals (and school nurses) must face emerging and predictive signs of neglect which can be subtle in nature or deliberately concealed (Taylor and Daniel, 2005; Daniel, 2013).

New challenges for school nursing in the last decade have included the increased awareness of child exploitation. Exploitation in the UK has predominantly been discussed in terms of child sexual exploitation (CSE), with high profile cases of CSE in England including 'Operation Bullfinch' in Oxford and 'Operation Central' in Rotherham (Jay, 2014; Bedford, 2015). In these cases, predominantly young females were groomed by gangs of adult males and coerced into drug abuse and sexual activity with multiple gang members. CSE does not always involve gangs and can occur between peers as well as involve male victims and female perpetrators; a fact that can sometimes be overlooked by professionals (Barnados, 2014). A US study by Edinburgh *et al.* (2015) analysed interviews of 62 victims of CSE aged 12-17 years (girls=55, boys=7) about their experiences; the self-reported impacts included self-harm (71%), suicidal intent (78%), traumatic genital injury (37%) and disengagement from education (40%). Many of these signs of CSE were

historically not conceptualised as abuse, and victims could feel unheard and unseen (Berelowitz *et al.* 2013).

Criminal exploitation in England, particularly in relation to drug dealing, gangs, and modern slavery, has come to the fore in recent years (Home Office, 2018). Vulnerable young people are frequently targeted to deal in drugs and become initiated into associated gangs, and this chain of command across areas of England is coined 'county lines' (Home Office, 2018). As school nurses seek to identify safeguarding concerns and promote safeguarding, they must acknowledge these evolving social and community challenges, which are explored in chapters seven to nine. Assessing safeguarding concerns beyond the scope of the family in this way, has been identified as 'contextual safeguarding' (Firmin, 2017).

1.8 Risk Factors for Child Abuse and Neglect

Risk factors for child abuse and neglect can be varied and complex, and such variables can mean casual inferences are difficult to make (Feng and Levine, 2005; Fleming, Biggart and Beckett, 2009; Hogg *et al.* 2012). The National Institute of Care Excellence (NICE) published two guidance documents; 'Child maltreatment; when to suspect maltreatment in under 18s' (2017) and 'Domestic violence and abuse: multi-agency working' (2014), which guide definitions of maltreatment/abuse within health care and school nursing. NICE (2017) distinguish between 'suspecting' and 'considering' child abuse;

suspecting is defined as a practitioner having significant concerns about child abuse but no proof and considering is defined as thinking about child abuse as one possible explanation about a set of symptoms. Symptoms of child abuse and neglect can depend on the type and severity of abuse experienced, but may include unexplained physical trauma to the body, ano-genital symptoms, fabricated illnesses, malnutrition and a change in emotional state (NICE, 2017).

Research has attempted to study factors that may heighten the risk of a child experiencing abuse although these can only be approached with caution as the presence of a risk factor is not always concrete evidence of abuse or neglect (Lewin and Herron, 2007). Children can become vulnerable to abuse in different ways and at different ages, with the nature of dependency in childhood being a universal factor (Sidebotham *et al.* 2016). Common risk factors for all types of child abuse and neglect include violence in the home, parental substance abuse and significant parental mental health concerns, particularly when these are present in combination (Sidebotham *et al.* 2016).

Poverty causes additional pressure on the responsibilities of parenthood and it can become difficult to provide for children in the home; financial issues are often present in households involving neglect although not always, and those with financial abundance are equally capable of neglecting children (Jütte *et al.* 2014). Children who have a disability, have experienced abuse in the past, or who live in foster care may be at heightened risk of exploitation;

disabled children may be less able to express what is happening to them, and emotionally vulnerable children who have been abused and live in care can be targeted by groomers (Finkelhorn *et al.* 2007; Jones *et al.* 2012).

The assessment of risk in safeguarding work remains a debated issue in health, education and social care, and such debates impact on the uncertainty of safeguarding assessment in school nursing practice (Appleton and Cowley, 2004; Akehurst, 2015; Taylor, Baldwin and Spencer 2008). The subjective nature of risk assessment, and the arguments regarding the reliability of objective measurements of child abuse and neglect, makes this a complex topic interwoven with aspects of culture, psychology and professional practice (Feng and Levine, 2005; Fleming, Biggart and Beckett, 2009; Hogg *et al.* 2012). Some of the literature discusses the abstract nature of concepts often described in child abuse cases such as vulnerability (Appleton, 1994), which may contribute to the subjective nature of risk assessment. This can be particularly true of neglect and emotional abuse assessment as found in a study by Fraser *et al.* (2009), whose quantitative survey of 930 registered nurses in Australia utilised the 'Child Abuse and Neglect Nurses' Questionnaire'. Nurses were less likely to escalate concerns in the hypothetical case vignettes that predominantly included descriptors of emotional abuse and neglect and their judgements varied (Fraser *et al.* 2009).

Several studies consider the assessment of vulnerable children and families in community nursing and social care practice, and arguments regarding the

relative importance of subjective and objective risk assessment (Appleton and Cowley, 2004; Adams, 2005; Taylor, Baldwin and Spencer 2008). Research studies testing measurement tools for assessing vulnerable families found that most practitioners' used tools to contribute to an assessment, but most used a holistic approach incorporating subjective judgement. Influences on this process included emotional experience (judgements clouded by anxiety), human error, forced mental short-cuts, experience (gaining confidence in time), intuition (gut feelings) and blame culture (fear of getting it wrong) (Fraser *et al.* 2009; Fleming, Biggart and Beckett, 2009; Hogg *et al.* 2012). In forced mental short-cuts, practitioners sometimes felt that assessment tools hampered their natural thought processes, which included time to reflect, by forcing quick decisions based on objective markers (Fraser *et al.* 2009; Fleming, Biggart and Beckett, 2009; Hogg *et al.* 2012). Issues such as concepts of intuition and fear of blame are highlighted in the results of this thesis.

Risk is difficult to conceptualise although an overview of this follows in chapter six. The presence of risk factors does not always equate to the associated catastrophy, therefore risk factors and indicators cannot be treated as the same and yet are commonly confused (Lewin and Herron, 2007). Some argue this does not matter and that early intervention is intended to support families before any harm occurs to the child (Munro, 2011) thus it may be better to have too many false positives than false negatives. This may of course leave some families open to stigma. In many

countries (including the UK and USA), resources for public health nursing are scarce meaning that the most at-risk families need to be prioritised and decisions need to be accurate (Seigart *et al.* 2013). Taylor (2017) looks at risk assessment in social work and child protection practice, and highlights some common themes including the entanglement of risk factors in child abuse, high frequency of overestimation and underestimation (false positives and false negatives) in statistical testing of objective measures and the importance of a context-specific assessment. The concepts of assessment and information gathering (detective work) in safeguarding and school nursing are explored later in chapter eight.

1.9 Chapter Summary

This chapter has set the context for the research study, to highlight the challenging world of safeguarding in which the school nurse must operate, as well as the weight of importance of 'getting it right' to keep children and young people safe from abuse and neglect. This chapter has introduced the remit of the school nurse in relation to protecting children from harm and has explored the development of the school nursing role over time, as well as some of the tensions of managing both a proactive and reactive role that will be explored further throughout this thesis. Next, this thesis will explore in greater depth the available research focusing on the school nurse's role in safeguarding and child protection internationally.

CHAPTER TWO: THE ROLE OF THE SCHOOL NURSE IN SAFEGUARDING: AN INTEGRATIVE REVIEW OF THE LITERATURE

2.1 Chapter Overview

This chapter presents the findings from an integrative, systematic literature review to understand the role of the school nurse in safeguarding, setting out what is already known about the topic, acknowledging existing research and providing a context for the research study. This literature review was peer-reviewed and published in the *International Journal of Nursing Studies* in January 2019 (Appendix 1). This literature review is broadened out from a UK to an international context, partly owing to a dearth of research but also to explore international comparisons of school nursing and safeguarding practice, as child abuse is a global issue (UNICEF, 2014). The design of the literature review is first described, followed by the methods for analysis. Findings are discussed in six main themes identified in the literature; *'supporting the child and family', 'detective work', 'working with other professionals', 'training and supervision', 'trust',* and *'barriers to protecting children and young people from abuse and neglect'*.

2.2 Integrative Design

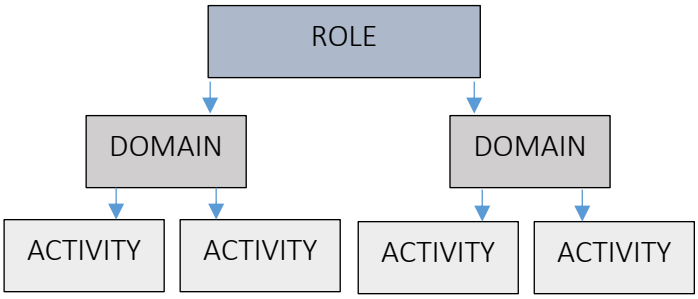
The methods for this integrative literature review followed the steps outlined by Whittemore and Knafl (2005) who defined an integrative literature review as incorporating research that employs both qualitative and quantitative methods and a range of study designs, including mixed-methods studies. This approach was chosen as it allowed for a broader range of studies (in terms of methodology and research design) to be included; studies that provided a large-scale overview of school nursing services as well as an in-depth exploration of processes and nuances of experience. Furthermore, Whittemore and Knafl (2005) argue that an integrative approach can build a knowledge base about complex phenomenon that are often studied from multiple perspectives. An initial scoping exercise identified that evidence pertaining to the role of the school nurse in safeguarding included a variety of qualitative, quantitative mixed-method designs, thus an integrative approach seemed suitable.

The stages of the literature search were systematic and used clearly defined search terms, as well as the adoption of inclusion and exclusion criteria (Aveyard *et al.* 2016). Studies were appraised using a critical appraisal tool; the Critical Appraisal Skills Programme tool (CASP, 2017) for qualitative studies and the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) tool (University of Bern, 2009) for mixed- methods and quantitative studies. These tools were chosen as they were perceived by

the researcher as clear and comprehensive. Thematic analysis was undertaken to identify key themes across the studies; an approach that allowed for the consolidation of multiple perspectives and to highlight similarities and differences (Braun and Clarke, 2006).

Integrative literature reviews are not without their challenges as Whittemore and Knafl (2005) discussed; the inclusion of such diverse evidence means that the final stages of analysis, synthesis and reporting are at risk from lack of rigour owning to sometimes confused attempts to synthesise different types of data. To support these latter stages, the work of Poitras *et al*. (2016) was used to structure the reporting of professional practice. Poitras *et al.* (2016) identified a lack of consensus on how best to rigorously compare and describe evidence about nursing practice and suggested a model for reporting using the concepts of *'role'*, *'domain'* and '*activity'* (Figure 2.1). Sorting the final data (following thematic analysis) in this way supported comparisons of practice across the literature and particularly aided the writing of the literature review. It is acknowledged that this approach might not always reflect the complexity and nuance of professional practice, as it attempts to 'sort' a role into orderly categories.

Figure 2.1. A model for reporting professional practice



KEY
ROLE: A function assumed by the nurse and modulated by professional norms, a legislative framework, a scope of practice and a social system.
DOMAIN: Set of activities of the same nature requiring specific knowledge and expertise.
ACTIVITY: An action undertaken by the nurse in a corresponding domain, to help a patient move towards an expected outcome.

Adapted from Poitras et al. (2016)

2.3 Problem Identification

According to Whittemore and Knafl (2005), the primary stage of an integrative review is to define the problem to be addressed and the purpose of collecting evidence from the literature. The importance of a well-specified question or topic to guide literature searching and data extraction is common amongst most literature reviews, regardless of the specific methods chosen (Aveyard *et al*. 2016). The problem addressed in this literature review was the lack of clarity regarding the role of the school nurse in safeguarding in the UK, as practice tends to be variable and insular (unknown to those outside of the organisation) (RCN, 2012; PHE, 2014a). In addition, international comparisons

of school nursing and safeguarding practice were deemed useful as child abuse and neglect are global issues (UNICEF, 2016). This literature review formed the basis of the subsequent PhD study, and the objectives included an overview of the methods other researchers have used to explore school nursing practice (to inform planning). The purpose of collecting evidence was to bring together what is already known about the work of school nurses in safeguarding and attempt to provide a description of practice conceptualised as roles, domains and activities. In addition, the literature review sought to locate subsequent PhD research within the existing knowledge base and identify gaps for further exploration. This process intended to answer the following questions:

- What roles do school nurses take on in safeguarding in the UK and internationally?

- How do these safeguarding roles translate into school nursing activities?

- What methods have other researchers used to explore school nurses' professional practice in safeguarding?

- What gaps in the knowledge base warrant further research?

2.4 Literature Search and Critical Appraisal

A search was conducted in six healthcare databases chosen for their scope and relevance to school nursing practice; *British Nursing Database, Cumulative Index of Nursing and Allied Health Literature, Medline, and PsycInfo.* A search of the *Cochrane Library Database for Systematic Reviews* and *Cochrane Central Register of Controlled Trials (CENTRAL)* returned 0 relevant results. No date limit was set on the searches to capture, as far as possible, all studies focusing on school nursing practice in this small area of research. Search terms and Boolean operators were chosen to promote a comprehensive search, capturing primary research involving school nurses and their role in protecting children from physical, sexual, emotional and exploitative abuse and neglect (Table 2.1). These are international categories and therefore relevant to international literature.

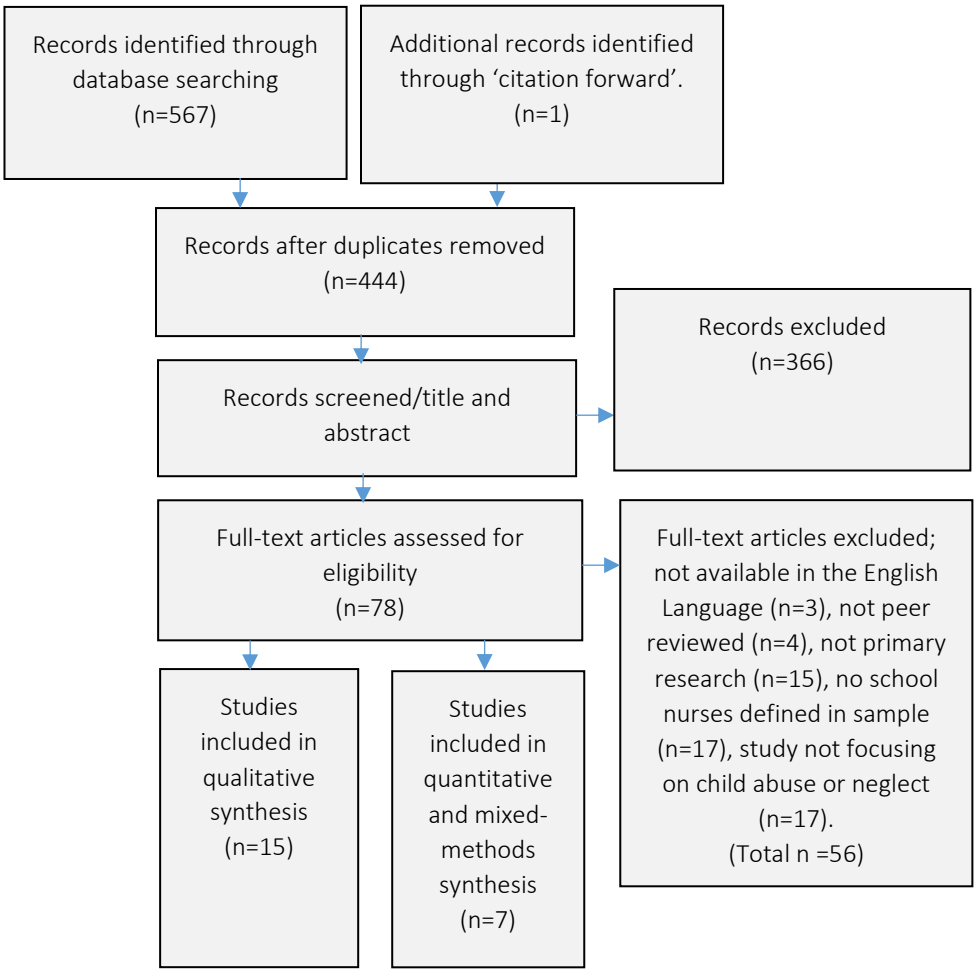
Table 2.1. Search terms and Boolean operators

Search Line 1	Search Line 2	Search Line 3
Role AND	School nurs* AND	Child Protection
Role*OR	School nurs* OR	Child* N3 protect* OR
Contribut* OR	School health nurs* OR	Safeguard* N3 child* OR
Participat* OR	Specialist community public health nurs* OR	Child abuse OR
Responsibilit* OR	Public health nurs* OR	Child* N3 maltreat* OR
Involv* OR	Community practitioner*	Neglect OR
Engag*		Child* N3 welfare OR
		Physical abuse OR
		Emotional abuse OR
		Sexual abuse OR
		Exploitation OR
		Fabricat* Illness OR
		Induced Illness
Mesh Terms/thesaurus	Mesh Terms/thesaurus	Mesh Terms/thesaurus

Additional search strategies were employed by scanning reference lists of all 22 studies in the final sample, and conducting forward citation searching with the Google Scholar search engine. No other search strategies were employed. Search terms for databases were developed with support from a university healthcare librarian and the supervisory team, increasing the expert knowledge regarding the search strategy and supporting rigour. Studies were stored and organised in *EndNote* software, and abstracts read applying the following inclusion criteria; (1) study available in the English Language, (2) peer reviewed, (3) primary research, (4) school nurses defined in sample and (5) study focusing on child abuse and neglect. Studies that included other professionals within the sample (as well as school nurses) were still deemed

important to the review as there is a dearth of research looking at the role of school nurses in safeguarding, therefore all relevant material was included. It was mostly possible from reading these studies which findings related to each professional group, defined in the results or discussion. Figure 2.2 presents a PRISMA diagram outlining the screening process.

Figure 2.2. Flow diagram of screening process



Adapted from PRISMA (Moher et al. 2009)

Whittemore and Knafl (2005) identified critical appraisal as a central tenet of 'data evaluation'. Studies were appraised using the CASP tool (2017) for qualitative studies and the STROBE tool (University of Bern, 2009) for mixed-methods and quantitative studies. This was to assess the quality of the studies, for example, ensuring the validity of measurement tools had been considered and the approach to methods justified. Appraisal of the studies was initially conducted by the researcher, and the notes made during the appraisal of each study were included in a data summary table of study characteristics; the data summary table was developed by the student in collaboration with a member of the supervisory team. Appraisal of studies and the data summary table were then checked by two supervisors, and notes on studies were compared and discussed as a team to achieve some consensus on quality. No studies were excluded at the appraisal stage as all met a level of quality in accordance with the appraisal tools; it was also considered that few studies exist in this subject area, so each study brought important insights to the review. Critical appraisal of the 15 qualitative studies using the CASP tool (2017) identified that all authors sufficiently explained the research methods used to collect interview and focus group data. Critical appraisal of four quantitative studies and three mixed-methods studies using the STROBE tool (University of Bern, 2009) identified a sufficiently rigorous and transparent approach in all cases.

2.5 Data Analysis

2.5.1 Data Reduction

Following Whittemore and Knafl (2005), each study was read several times to become familiar with the content, and key statements relevant to the review objectives were highlighted. Notes were made on each paper before they were summarised into a table (Table 2.2). Direct quotations of findings were summarised, and the studies ordered according to study classification as quantitative, qualitative or mixed methods. This was to aid the data comparison stage, particularly considering the question: 'what methods have other researchers used to explore school nursing professional practice in safeguarding?' As far as possible data were extracted relating to the views and experiences of school nurses.

Table 2.2. Worked example of data summary

Research Study	Summary of Findings
Alizadeh, V., Tornkvist, L. and Hylander, I. (2011) *Counselling teenage girls on problems related to the 'protection of family honour' from the perspective of school nurses and counsellors.*	Staff wanted to empower the girls to make changes in their lives. Staff helped the girls to find ways out of their situations-with or without family involvement. Staff were sometimes passive listeners, hearing the girls' problems but not directly intervening. Staff sometimes felt powerless in this role. Staff sometimes hesitated making referrals to social care due to previous negative experiences. Staff sometimes felt unsure about when to take the final step and report a family, balancing protection from harm vs. protection from a harmful intervention. Staff felt confused when they had no feedback from the girls, and unsure if they had helped. Staff found it difficult to manage cases where the girls had hidden expectations. Staff were frightened that girls who did not accept interventions would become depressed and this was a dilemma; should they intervene anyway?

These findings were further summarised into a framework of studies, ordered in the same way (presented later in this chapter). Data for the framework were extracted using an extraction sheet adapted from the CASP (2017) and STROBE tool (University of Bern, 2009) and included sample, methods, findings and limitations of the study. It was felt defining the number of school

nurses participating in the study was important as many studies had a mixed sample of professionals.

2.5.2 Data Display and Comparison

According to Whittemore and Knafl (2005) the next stage of an integrative review is to use the data frameworks, along with notes on the research studies, to identify patterns and themes. This was a systematic and organised process employing thematic analysis (Braun and Clarke, 2006) and later reported using the reporting model by Poitras *et al.* (2016). Research studies were read and re-read, and along with the literature framework, summary table and extraction sheets, themes were identified and organised into a thematic matrix (Table 2.3). In this way, themes could then be compared for frequency and any outliers identified for discussion, acknowledging the importance of outliers to highlighting differences, anomalies of practice and possible issues for expansion in subsequent research (Braun and Clarke, 2006).

Both quantitative and qualitative findings were combined (into frameworks and discussion) during this process, as well as through the final stage of developing a synthesised summary and conclusion of the phenomenon (Whittemore and Knafl, 2005). Generally, quantitative and qualitative findings supported each other, therefore results from quantitative studies were summarised and grouped with qualitative data, rather than combined

separately in a meta-analysis. Quantitative results that contributed to the review objective of understanding school nursing activity and remit (for example, from surveys) were highlighted and transposed. Thematic categories were constantly compared with each other and to the original studies to ensure that they accurately reflected the study findings. Development of themes were checked and compared by a member of the supervisory team, discussing any differences. During this process some changes were made, as upon re-reading and discussion some categories were deemed similar and able to merge, such as *'supporting the child and family'* and the previous *'child-centred care'*.

Table 2.3. Summary table of themes

	Supporting the child and family	Detective work	Working with other professionals	Training and supervision	Barriers to protecting children and young people from abuse and neglect	Trust
1.Alizadeh, Tornkvist and Hylander. (2011)	✓	✓	✓		✓	✓
2. Chase *et al.* (2010)	✓				✓	
3.Clarke. (2000)	✓		✓			
4.Coates. (2011)					✓	
5.Eisbach & Driessnack. (2010)	✓	✓	✓	✓	✓	✓
6.Engh-Kraft & Eriksson. (2015)	✓	✓	✓	✓	✓	✓
7.Engh-Kraft, Eriksson and Rahm. (2016)	✓	✓	✓	✓	✓	✓
8.Fraley, Aronowitz and Jones. (2018)	✓	✓	✓	✓	✓	✓
9.Hackett. (2013)	✓	✓		✓	✓	
10.Jordan, MacKay and Woods. (2017)	✓	✓	✓	✓	✓	
11.Joyner. (2012)	✓	✓	✓	✓	✓	
12.Land & Barclay. (2008)	✓	✓	✓		✓	✓
13.Lightfoot & Bines. (2000)	✓	✓	✓	✓	✓	✓
14.O'Toole *et al.* (1996)		✓				
15.Paavilainen, Ästedt-Kurki and Paunonen. (2000)	✓	✓	✓	✓		✓
16.Paavilainen & Tarkka. (2003)	✓	✓	✓			
17.Paavilainen *et al*. (2014)	✓	✓	✓	✓		
18.Pakieser, Starr and Le Baugh. (1998)		✓		✓		
19.Peckover &Trotter. (2014)	✓	✓	✓	✓		✓
20.Ramos *et al.* (2013)	✓		✓	✓		
21.Schols, De Ruiter and Öry. (2013)	✓	✓	✓	✓	✓	✓
22.Sekhara *et al.* (2018)	✓	✓				✓
TOTAL	18	17	15	13	12	10

The themes were organised as domains according to the reporting model proposed by Poitras *et al.* (2016) and studies were read for a final time to confirm accuracy and understanding regarding how these domains were performed (thus defining the activities). Poitras *et al.* (2016) was one of few comprehensive models found to assist in the reporting of professional practice and was chosen for its pragmatic and evidence-based approach. Poitras *et al.* (2016) conducted a review of 49 studies specific to nursing practice in order to develop their reporting model. A mind map display was used to organise the data around the domains (Figure 2.3) and a flow chart display was used to show the relationship between the role, domains and activities (Figure 2.4). This was chosen specifically by the researcher (as a visual learner) to support the writing of the review.

Figure 2.3. Worked example of conceptualising a theme into domain/activity

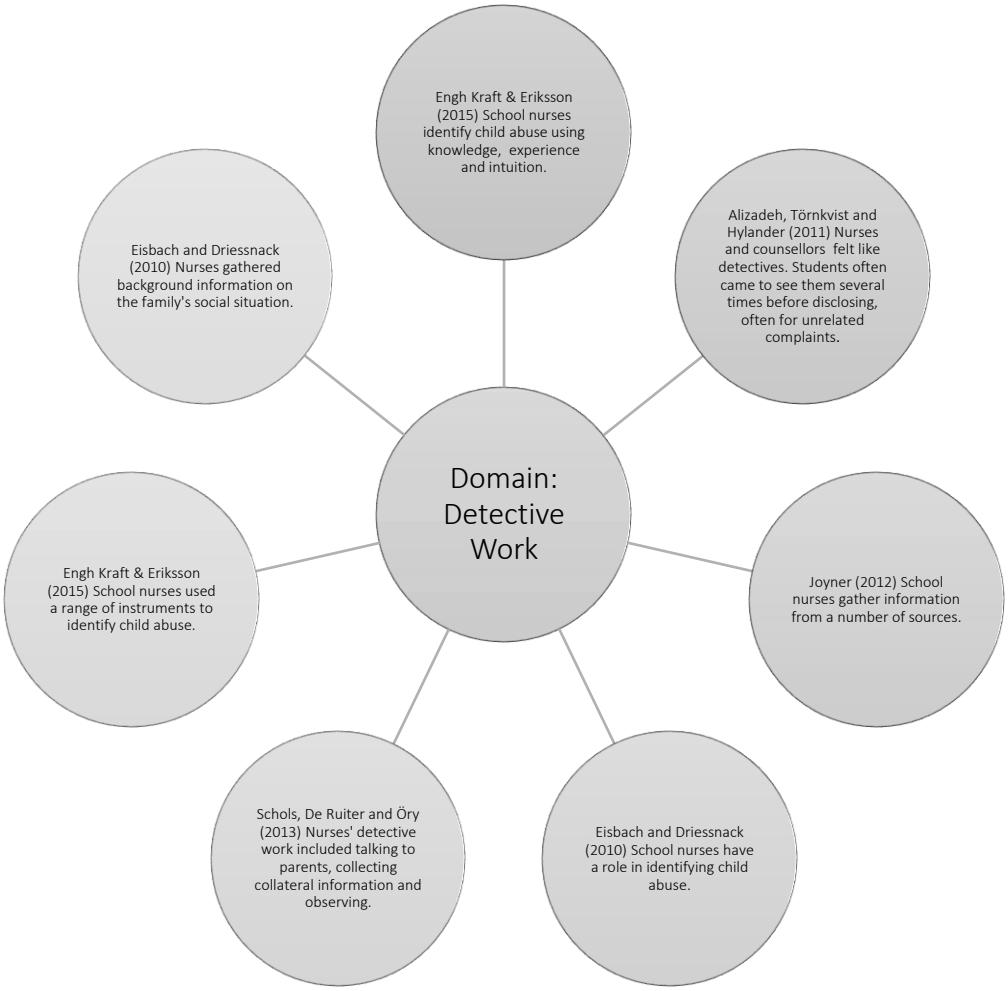
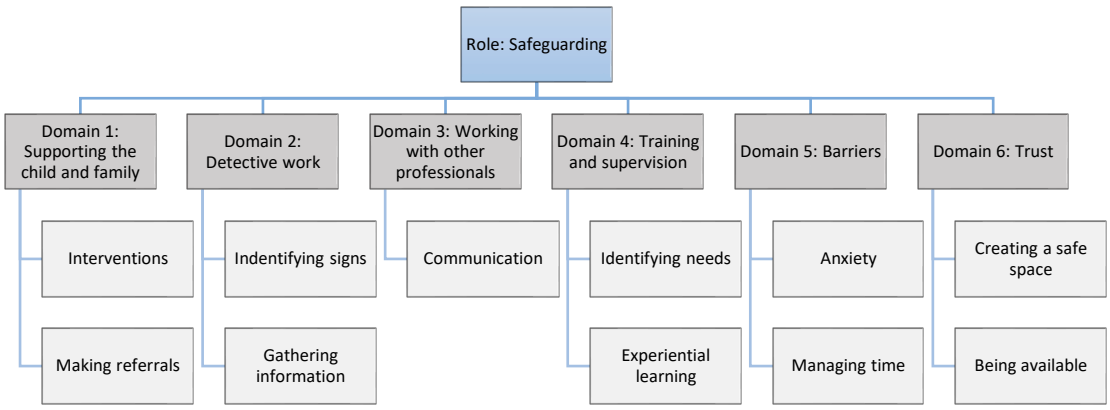


Figure 2.4. Roles, domains and activities of the school nurse in safeguarding



2.6 Results

A total of 444 studies were found for initial screening of the title and abstract for relevance, after which 78 studies remained for full text review. Inclusion and exclusion criteria were applied leaving 21 studies. Forward citation searching identified one study for inclusion, taking the total number of studies to 22. The framework of studies is presented in Table 2.4. Of the 22 studies included in the review, eight were from the USA, six from the UK, three from Sweden, three from Finland, one from Australia and one from The Netherlands. It is acknowledged in the limitations that this encompasses entirely Western literature. Studies were conducted in a range of countries where health care systems vary in structure and organisation. Nine studies included solely school nurses (or equivalent job role internationally) in the sample, with the remainder involving mixed samples of school nurses with other professionals; these were doctors, counsellors, other nurses and educational staff. Where possible the findings relevant to school nurses were extracted or otherwise indicated in the results and discussion.

Table 2.4. Framework of studies

Qualitative Studies								
Author/s	Year	Country	Title	Participants	Study Design	Methods	Key Finding/s	Limitations
1. Alizadeh, Tornkvist, and Hylander.	2011	Sweden	*Counselling teenage girls on problems relating to the protection of family honour from the perspective of school nurses and school counsellors.*	School nurses (n=4). School counsellors (n=6). From across six secondary schools.	Qualitative.	Individual interviews at two time-points (2006 and 2007).	Staff felt professionally hampered as they could not always help the girls in ways they would like.	Small sample of school nurses. It isn't always clear how many participants contributed to the development of each theme. Perspective of teenage girls not included.
2. Clarke.	2000	UK	*Out of the wilderness and into the fold: the school nurse and child protection.*	Mixed sample: health, education and social care professionals (n=84). School nurses (n=31).	Qualitative. Longitudinal.	1984: Headteachers (n=23). Educational welfare officers (n=23). Social workers (n=22).	Headteachers and social workers recognise the role of the school nurse in child protection more so in 1993/4 than in 1984. School nurses always felt their role was important.	Small sample site; one English shire county. Ten year time gap between interviews; many landmark reports published and changes to local

						School nurses (n=23). 1993/4: Headteachers (n=13) Educational welfare officers (n=9). Social workers (n=14). School nurses (n=16).		and national child protection procedures during this time. Analysis applied to qualitative data; method could be described in more detail.
3. Eisbach and Driessnack.	2010	USA	*Am I sure I want to go down this road? Hesitations in the reporting of child abuse by nurses.*	Paediatric nurse practitioners (n=7). School nurses (n=10). Paediatric mental health nurses (n=6).	Qualitative descriptive design. Cross-sectional.	Individual interviews. Face-to-face or over the telephone. Incentives used.	Nurses identified three stages to reporting child maltreatment; becoming aware, intervening and reporting. Many moderating points influenced how quickly nurses moved through the stages, and two major themes identified were; easy reporting decisions and complex reporting decisions.	Novice nurses were not included in the sample. Only nurses belonging to the professional organisations were recruited. Only nurses who have experience of reporting abuse were included; therefore, nurses who do not report are not

								involved in the sample.
4. Engh-Kraft and Eriksson.	2015	Sweden	*The school nurse's ability to detect and support abused children: a trust creating process.*	School nurses (n=23).	Qualitative. Cross-sectional.	Focus groups; four groups with 4-6 participants per group. Each focus group was held twice.	School nurses felt that abused children receiving support was the most important aspect of care. This was done by creating trust, and four themes emerged (1) knowledge and experience, (2) building relations, (3) talk about sensitive issues, and (4) preventive measures.	School nurses in the sample were only included if they had two years minimum experience; excluding novice nurses. One of the researchers was known to school health services having previously been in a management role. Results based solely on school nurse opinion.
5. Engh-Kraft, Rahm and Eriksson.	2016	Sweden	*School nurses avoid addressing sexual abuse.*	School nurses (n=23).	Qualitative. Cross-sectional.	Focus groups; four groups with 4-6 participants per group. Each focus group was held twice.	The main theme that emerged in the analysis was avoidance, which also permeated other themes. The following three themes were developed in the analysis: (1) arousal of strong emotions, (2) disclosure process, and (3) ambivalence of the school nurse. Each theme consists of 2-3 subthemes.	Secondary analysis of data from a previous study looking at the wider role of the school nurse.

								Novice nurses excluded from sample.
6. Hackett.	2013	UK	*The role of the school nurse in child protection.*	School nurses (n=6).	Qualitative. Cross-sectional.	Semi-structured interviews. Face-to-face.	Themes and subthemes were identified using thematic analysis. These were (1) 'role confusion' (lack of clarity/variation in practice/competing demands), (2) 'learning in practice' (importance of experience/learning from experience/learning from others) and (3) 'moving forward' (self-development/supporting child and young person/practice development).	Time constraints meant final sample had to be purposefully selected. Methodological approach could be explored in greater depth. Small scale study undertaken in one health board area; limits transferability of findings.
7. Joyner.	2012	UK	*What are the lived experiences of school health nurses working with children and their families subject*	School nurses (n=11).	Qualitative. Cross-sectional.	Semi-structured interviews.	School nurses must meet a wide range of needs of vulnerable children and offer a variety of interventions. Pressure of time, caseload size and public health work influences safeguarding and child protection work. Other roles of the school nurse in safeguarding include liaison, detective work, advocating and signposting.	Small sample in one locality limits transferability. Time constraints meant the author could not complete all steps of the chosen data analysis

			to a child protection plan?				Barriers to safeguarding work centred on parental engagement with the service and child protection recommendations.	method 'Colaizzi's framework for data analysis'.
8. Land and Barclay.	2008	Australia	*Nurses contribution to child protection.*	Mixed sample (n=10), including school health nurses.	Qualitative. Cross-sectional. Exploratory.	Interviews using semi-structured and open-ended questions.	All nurses recognised their legal and professional duty to safeguard children but identified many barriers to completing this work. The three main themes identified were: (1) 'drawing a line in the sand', (2) 'mushrooms in the dark' and (3) 'fear factor'.	Novice nurses excluded from sample. Legislation, service models and population demographics varied widely. Nurses in Australia are mandated reporters of child abuse.
9. Lightfoot and Bines.	2000	UK	*Working to keep school children healthy: the complementary roles of school staff and school nurses.*	Teachers (n=27). Commissioners (n=15). NHS managers (n=13). School nurses (n=23). Pupils (n=8). 7 parent focus groups with 2-5 attendees.	Qualitative. Cross-sectional.	Semi-structured interviews with health and education staff. Focus groups with parents and school pupils.	Safeguarding was one of four key roles of the school nurse, as well as health promotion, being a pupil's confidante and providing family support.	Not looking specifically at child protection and safeguarding work, although safeguarding a major theme (thus included). Context and time may influence applicability of results to modern

								child protection work (data collected 1995-1996).
10. O'Toole, O'Toole, Webster and Lucal.	1996	USA	*Nurses diagnostic work on possible physical child abuse.*	Mixed sample (n=1,036) including school nurses (38.9%). Community nurses (13.6%). Paediatric nurses (8.3%). A and E nurses (31.6%).	Qualitative.	Questionnaire with open questions and case vignettes.	Nurses undertake diagnostic work in child protection. This included 'error work' and searching for information. School nurses relied more on physical symptoms of child abuse and neglect. School nurses are important links in schools.	Data from a previous study using the same questionnaire (but a different vignette) was incorporated into the analysis, although there was a two year time gap between collections.
11. Paavilainen, Ästedt-Kurki. and Paunonen.	2000	Finland	*School nurses' operational modes and ways of collaborating in caring for child abusing families in Finland.*	School nurses (n=20).	Qualitative. Cross-sectional.	One-to-one interviews.	School nurses work predominantly one-to-one with children in child protection, rather than the wider family. They often saw a child multiple times before receiving a disclosure. Nurses could be categorised as 'active' or 'passive' workers.	Numbers of school nurses who were 'active' and 'passive' not defined. Findings may be confined to cultural context.
12. Paavilainen and Tarkka.	2003	Finland	*Definition and identification of child abuse by*	Finnish public health nurses who worked in child welfare clinics and	Qualitative. Cross-sectional.	Focused interviews.	School nurses under-recognised emotional abuse and there was a non-consensus in child abuse definitions. School nurses have a role in	Findings limited to one specific urban area.

			Finnish public health nurses.	school health services (n=20).			the identification of abuse and use several objective and subjective tools.	
13. Peckover, S. and Trotter, F.	2014	UK	*Keeping the focus on children: the challenges of safeguarding children affected by domestic abuse.*	Mixed sample (n=23), including school health nurses, midwifes, health visitors, educational staff, family support and early years workers, and specialist support staff.	Qualitative. Cross-sectional.	Focus groups (n=5 in total).	Universal services are well placed to see families who may otherwise not be seen. School nurses discussed both direct and preventative work with children in schools. Generally, professionals conceptualised domestic violence work as referring to other agencies and were not child-focused.	No information was collected about the domestic abuse training experiences of those who attended the focus groups. Findings could be limited by individual's understanding of the term 'safeguarding children'. Participants had an *a priori* interest. Study held in one local authority area.
14. Schols, De Ruiter and Öry.	2013	The Netherlands	*How do public child healthcare professionals and primary school teachers identify and handle child*	Mixed sample: (teachers n=15, school principal n=1, public child healthcare nurses n=11, school public	Qualitative. Cross-sectional.	Focus groups (n=6), three involving health professionals, three involving educational staff.	School nurses identified with a range of responsibilities within child protection, which were influenced by social, attitudinal and internal factors. Risk perception may be influenced by nursing values.	Change in reporting laws during the study period.

			abuse cases? a qualitative study.	child healthcare doctors n=6).			Intuition featured in nurses' responses.	
15. Sekhara, Kraschnewskia, Stuckey, Witta, Francisa, Mooree, Paul, Morgan and Noll.	2018	USA	*Opportunities and challenges in screening for childhood sexual abuse.*	Mixed sample: 2 groups of school nurses (n = 19), 2 groups of schoolteachers, counsellors and administrators (n = 14), 2 groups of paediatric providers (n = 14), and 2 parent groups (n = 15).	Qualitative. Cross-sectional.	Focus groups (n=8) using an interview guide.	Most participants in the focus groups had considered CSA either professionally or personally. They were aware of the consequences of CSA and discussed the barriers to reporting. Three overarching themes were identified: (1) early screening and identification is preferred. (2) maintaining confidentiality. (3) the identification process needs refinement to be successful.	May not be generalisable to other states in the USA (or internationally). No perspectives of children and young people were included.
Mixed-methods Studies								
16. Chase, Chalmers, Warwick, Thomas, Hollingworth and Aggleton.	2010	UK	*Shifting policies and enduring themes in school nursing.*	Strategic stakeholders (n=23). School nursing leads (n=34). School nursing case studies (n=5). Parents (n=12). Pupils (n=204).	Mixed methods. Cross-sectional.	Four stages (1) Literature review. (2) Interviews with 23 national stakeholders. (3) Telephone survey of nurse managers.	School nursing practice varied across England, and much time was spent on activities relating to safeguarding and child protection.	Wide scope of report. Small sample of school nurses. Information on time and caseloads taken from managers and local authority

						(4) Five in-depth case studies; interviews with PCT/LA stakeholders (n=31), school nurses (n=10) and school staff (n=39). Focus groups with school pupils (n=204). Focus groups and interviews parents (n=12).		stakeholders (rather than school nurses).
17. Fraley, Aronowitz and Jones.	2018	USA	*School nurses' awareness and attitudes toward commercial sexual exploitation of children.*	School nurses (n=112).	Mixed methods.	Surveys (n=112). Focus groups (n=3). In-depth interview (n=1).	Four themes were identified: (1) 'exposure/knowledge', (2) 'collaboration', (3) 'role boundaries', and (4) 'creating respite space'. There was some awareness of commercial exploitation but this could be improved. Trust and safe spaces for children were important. Barriers to understanding and intervention included training and information sharing.	Small, convenience sample. School nurses responding to survey may have an *a priori* interest,

18. Jordan, Mackay and Woods.	2017	USA	*Child maltreatment; optimizing recognition and reporting by school nurses.*	School nurses (n=174).	Mixed methods. Pre and post-test design.	Face-to-face educational intervention with pre and post-test written questionnaires. Focus groups (n=not specified) using a semi-structured guide.	Four key elements of the school nurse role were identified: (1) safeguarding the health and welfare of children, (2) health promotion, (3) being a pupil's confidante, and (4) providing family support.	Post-test questionnaires were administered immediately after educational intervention, and not followed-up later. Small results/discussion section. A more open structure to the focus groups may have collected a greater variety of opinions and information.
Quantitative Studies								
19. Coates.	2011	UK	*School nursing: a priority for child-centred public health.*	Public health advisors (n=13). School nurses (n=42). School health assistants (n=3). Not declared (n=4).	Quantitative with open comments. Cross-sectional.	Questionnaires sent to six local school nursing organisations (108 sent, 62 returned, response rate 58%).	The author had experience of the disparity between proposed and actual school nursing role. Safeguarding became a major theme and identified role by questionnaire respondents.	The author of the study worked in the area as a SCPHN programme lead. Questionnaires can make it difficult to confirm accuracy of responses.

								Findings may be region specific.
20. Paavilainen, Helminen, Flinck and Lehtomaki.	2014	Finland	*How public health nurses identify and intervene in child maltreatment based on the national clinical guideline.*	Finnish public health nurses (n= 367); 30% in school health.	Quantitative. Cross-sectional.	E-surveys.	School nurses scored highest on ability to identify child abuse- as well as nurses who worked in other settings but had a background in school nursing.	Some participants were unaware of the guideline, but still completed these survey questions. Results rely on self-report of public health nurses.
21. Pakieser, Starr, and Le Baugh.	1998	USA	*Nebraska school nurses identify emotional maltreatment of school-age children: a replication of an Ohio study.*	School nurses (n=121).	Quantitative. Cross-sectional.	Questionnaire. Case vignettes.	High numbers of school nurses had been involved in the identification and reporting of child abuse and neglect. Identification was a crucial step that triggers on-going care. No demographic factors influenced the ability to detect emotional abuse.	Larger sample need to explore statistically significant relationships. Authors changed the terms 'black' with 'minority' within the case vignettes. Case vignettes are not 'real life' situations. Using referral as the only indication of intervention may not

								be appropriate; in real life the school nurse may provide their own interventions depending on the threshold of need.
22. Ramos, Greenberg, Sapien, Bauer-Creegan, Hine and Geary.	2013	USA	*Behavioural health emergencies managed by school nurses working with adolescents.*	School nurses working in a secondary school (n=186).	Quantitative. Cross-sectional.	Statewide workforce survey (New Mexico). Online or paper options available.	Two thirds of the sample had provided support for behavioural emergencies in relation to child abuse/neglect, mental health and violence. 40% had managed suicide risk. Current education may not prepare them for this role.	A mixed-methods approach may have enriched the data further. Sample did not include nurses working in private or parochial schools. Survey was developed by an expert team but not validated. Findings may be limited to the state of New Mexico.

Following thematic data analysis, six main themes were identified. These were; *'supporting the child and family', 'detective work', 'working with other professionals', 'training and supervision', 'barriers to protecting children and young people from abuse and neglect'* and *'trust'*. The most common theme was *'supporting the child and family'*, with 19 studies reporting this role. This was followed in descending order by *'detective work'* (18 studies), *'working with other professionals'* (16 studies), *'training and supervision'* (14 studies), *'barriers to protecting children and young people from abuse and neglect'* (13 studies) and *'trust'* (11 studies). As evident, there was not a large difference in occurrence of themes, and most studies reported a combination of themes. Themes are presented in the discussion by order of frequency, to understand how often school nurses spoke about these concepts in the research. All themes except *'barriers to protecting children from abuse and neglect'* seek to describe the activity and remit of nurses as posed in the objectives of the review.

2.6.1 Supporting the Child and Family

A range of examples were given across the literature of how the school nurse might deliver support to children and young people at risk of abuse and their families, and this theme occurred in studies originating from all six countries. On a descriptive level, school nurses might provide direct interventions relating to mental and emotional health support, physical health needs (for example enuresis advice), preventative health promotion and immunisations

(Peckover and Trotter, 2014; Jordan, MacKay and Woods, 2017; Sekhara *et al.* 2018; Fraley, Aronowitz and Jones, 2018). School nurses in one study were providing emergency (rather than planned) interventions, such as intervening in breakdowns of behaviour, for children at risk of abuse, acute mental health episodes and violence; 40% of the sample had intervened in school for a suicidal student (Ramos *et al.* 2013). More indirect support of children and families was achieved in three studies by providing a link role across services, monitoring the child and family and communicating between different agencies (Clarke, 2000; Lightfoot and Bines, 2000; Joyner, 2012; Schols, De Ruiter and Öry, 2013).

Another aspect of the school nursing role involved referring families to social care and writing official reports. Social care can be defined internationally as a service for vulnerable children and adults who require additional support from the local government for reasons such as ill-health, disability or homelessness, and are usually central to the assessment of risk in cases of child abuse and neglect (Robertson, Gregory and Jabbal, 2014). It was described in three studies that referring parents to social care, or similar specialist services, could feel challenging as nurses often feared parental retribution (Lightfoot and Bines, 2000; Engh Kraft and Eriksson, 2015; Engh Kraft, Eriksson and Rahm, 2016). School nurses' involvement in making referrals to specialist services was represented well in one study, with one third of 11,000 children's visits to school nurses in New Mexico between

2011-2012 resulting in a referral to school or community behavioural services (Ramos *et al.* 2013).

The importance of school nurses' communication skills and confidence in this referral process were apparent (Hackett, 2013). School nurses in one research study were divided as to whether their role was to provide parents with support, with some school nurses reporting they were not trained to provide such family interventions (Lightfoot and Bines, 2000). Nevertheless, in another study 88% of 367 public health nurses (including an unknown number of school nurses) indicated they would help families to seek support (Paavilainen *et al.* 2014).

A proactive approach to supporting children and families at risk of abuse involved school nurses and colleagues seeking to empower children and young people and be an advocate for them (Eisbach and Driessnack, 2010; Alizadeh, Törnkvist and Hylander, 2011; Engh Kraft, Eriksson and Rahm, 2016). In five studies school nurses supported families to access other agencies and make appointments for their children, and sometimes acted as a lead for child abuse cases (Chase e*t al.* 2010; Joyner, 2012; Schols, De Ruiter and Öry, 2013; Engh Kraft and Eriksson, 2015; Jordan, MacKay and Woods, 2017). In one study, school nurses who took a proactive approach seemed to involve the family more readily by conducting home visits, although these visits remained firmly child-centred and the school nurses worked less with

the family when the child was older (Paavilainen, Ästedt-Kurki and Paunonen, 2000).

In the results chapters (seven to nine) of this thesis, an exploration of some of the practical ways in which school nurses support children and families is given. These echo some of the findings of the literature review, including the tensions of locating a role in practice between reacting to events and being proactive.

2.6.2 Detective Work

Signs and symptoms of child abuse and neglect could be identified through what has been defined in the review as detective work, and activities relating to detective work were apparent in studies from all six countries. Detective work encompassed strategies to identify (or 'detect') concerns regarding child abuse and gather information to support or refute these concerns. In four studies, school nurses showed an awareness of a range of signs and symptoms of child abuse and neglect including frequent visits to the school nurse with no apparent cause, evidence of physical harm, parental rejection, family secrecy, withholding medication, missing appointments, a change in behaviour or appearance, and neglect of basic care needs (Paavilainen, Ästedt-Kurki and Paunonen, 2000; Paavilainen and Tarkka, 2003; Peckover and Trotter, 2014; Engh Kraft and Eriksson, 2015; Fraley, Aronowitz and Jones, 2018). Objective signs that could indicate child abuse, such as burns or

bruising, were often cited as easier to identify than less overt signs such as emotional maltreatment, neglect or cases that felt 'borderline' (Land and Barclay, 2008; Eisbach and Driessnack, 2010). In one study, school nurses indicated physical injuries, oedema and abrasions as most important in initial assessments of case vignettes describing child abuse, compared to other nurse specialities (O'Toole *et al.* 1996). A second study focusing specifically on the identification of emotional abuse found school nurses were most likely to hypothetically refer case vignettes to other agencies when they involved criminal activity, sexual exploitation and physical punishment (Pakieser, Starr and Le Baugh, 1998). School nurses used several methods for detecting these signs and symptoms of abuse and neglect including health assessments, problem solving, information in school records, talking to other professionals, conducting home visits and traditional health screening (Lightfoot and Bines, 2000; Paavilainen and Tarkka, 2003; Engh Kraft and Eriksson, 2015; Joyner, 2012; Jordan, MacKay and Woods, 2017).

When school nurses and their colleagues in two studies felt less sure about cases of abuse, they would seek to gather further information to understand the situation better (Eisbach and Driessnack, 2010; Alizadeh, Törnkvist and Hylander, 2011; Fraley, Aronowitz and Jones, 2018). This was achieved by monitoring and questioning the family at school, arranging additional home visits, talking to teachers, counsellors and school friends, and organising a one-to-one appointment with the child (Paavilainen, Ästedt-Kurki and Paunonen, 2000, Paavilainen and Tarkka, 2003; Eisbach and Driessnack,

2010; Schols, De Ruiter and Öry, 2013; Jordan, MacKay and Woods, 2017). Four studies described how the method of questioning a child or young person to obtain sensitive information was important, particularly considering age-appropriate communication. This involved asking children to talk about their secrets, being open, enquiring about safety at home, listening intently, making assessments non-threatening and interpreting non-verbal communication (Hackett, 2013; Engh Kraft and Eriksson, 2015; Engh Kraft, Eriksson and Rahm, 2016; Sekhara *et al.* 2018). In five studies, children's situations were difficult to interpret and in the absence of signs and symptoms of abuse a school nurse might rely on intuition to make professional decisions (Paavilainen and Tarkka 2003; Schols, De Ruiter and Öry, 2013; Engh Kraft and Eriksson 2015; Engh Kraft, Eriksson and Rahm, 2016; Fraley, Aronowitz and Jones, 2018).

In the results of this study and the relating chapter (eight) of this thesis, the theme of detective work continues. School nurses perform many of the activities identified in this review, but additional focus is given to how they gather information, and the pre-requisites for this to be successful, such as building trust and utilising intuition.

2.6.3 Working with Other Professionals

School nurses in all six countries represented by the literature reported working with several different professionals in their role to protect children and young people from child abuse and neglect. Examples given in four studies were social services, teachers, head teachers, school counsellors, psychologists, local police and general practitioners (Clarke, 2000; Paavilainen, Ästedt-Kurki and Paunonen, 2000; Schols, De Ruiter and Öry, 2013; Engh Kraft and Eriksson, 2015). School nurses in three studies collaborated particularly closely with schools by liaising with teachers about concerns, making joint referrals, providing training and supervision and developing joint health promotion activities (Lightfoot and Bines, 2000; Paavilainen, Ästedt-Kurki and Paunonen, 2000; Engh Kraft and Eriksson, 2015). In relation to other professionals' awareness of the school nurse, one longitudinal study conducted between 1984 and 1993 found that social workers and teachers saw school nurses as having a more active role in the protection of children from abuse over time, with a 53% increase in participants expecting a school nurse manager to be present at a child protection conference (Clarke, 2000). In one study, working with other professionals was sometimes influenced by the professional style and attitude of school nurses, as nurses who took an 'active and firm' approach in safeguarding (as opposed to a 'passive and uninvolved' one) seemed to actively seek out opportunities to collaborate with others and share information (Paavilainen, Ästedt-Kurki and Paunonen, 2000). This is explored

further in chapter ten of this thesis, seeking to understand how school nurses manage this unique role working across professional boundaries.

The 16 studies that described work with other professionals were published between 2000-2018, and problematic issues regarding multi-professional communication were repeatedly reported, particularly relating to referring children and young people to social services. This of course could be influenced by policy, and thus direct participants to discuss the concerns already highlighted by publications of the time. School nurses in one study could be hesitant to report suspicions of child abuse to social services because they worried it would leave the child in a state of uncertainty (Engh Kraft and Eriksson, 2015). In two studies, these reporting decisions were influenced by previous negative experiences with referral to social services (Alizadeh, Törnkvist and Hylander, 2011; Engh Kraft, Eriksson and Rahm, 2016). In four studies, nurses felt that the social care system was overburdened, and they would receive inadequate feedback (Land and Barclay, 2008; Eisbach and Driessnack, 2010; Joyner 2012; Engh Kraft and Eriksson, 2015). Good communication between agencies was self-reported as important to school nurses, as this helped to create a safe network of professionals around a child at risk of abuse and neglect and supported different agencies to understand the role of the other, which was sometimes lacking (Land and Barclay, 2008; Schols, De Ruiter and Öry, 2013; Jordan, MacKay and Woods, 2017; Fraley, Aronowitz and Jones, 2018). The tensions of inter-disciplinary working are addressed in chapters seven to nine of this

thesis, where the boundaries and thresholds between services are sometimes perceived by school nurses as a barrier to accessing specialist support.

2.6.4 Training and Supervision

School nurses in 14 studies (representing five countries) identified involvement in training and supervision to support their work relating to protecting children and young people from abuse and reported mixed experiences of this. School nurses valued training that was multi-agency, useful and regular; and suggested topics for training included subjective measures of child abuse, legal issues, policy changes, difficult conversations, needs of the Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ+) community, normative psycho-sexual development and parenting (Eisbach and Driessnack, 2010; Joyner, 2012; Hackett, 2013; Ramos *et al.* 2013; Schols, De Ruiter and Öry, 2013; Fraley, Aronowitz and Jones, 2018). Mental health was discussed in terms of training needs, with 75% of school nurses in one study identifying neglect, violence, depression and suicide as 'very important' training topics (Ramos *et al.* 2013). A small number of school nurses in three other studies expressed feeling under-confident in providing mental and emotional health counselling to vulnerable children and young people, although this was not the focus of the respective studies (Lightfoot and Bines, 2000; Peckover and Trotter, 2014; Engh Kraft and Eriksson, 2015). Identified training issues may be reflective of the wide remit of school nurses, as well as

the legislative, policy and guidance documents of the time (e.g. FGM, CSE) as previously discussed in chapter one.

School nurses often felt they could benefit from more training and supervision in matters relating to child abuse and neglect but barriers to taking this up were defined as time, workload and lack of staff (Joyner, 2012; Hackett, 2013; Engh Kraft, Eriksson and Rahm, 2016; Jordan, MacKay and Woods, 2017). Another important method of learning in five studies, besides training and supervision, was described as experiential or 'on the job', and nurses who had more experience of child abuse and neglect often expressed greater confidence in identifying concerns and acting on their gut instinct (Paavilainen, Ästedt-Kurki and Paunonen, 2000; Hackett 2013; Paavilainen *et al.* 2014; Engh Kraft, Eriksson and Rahm, 2016; Fraley, Aronowitz and Jones, 2018).

2.6.5 Barriers to Protecting Children and Young People from Abuse and Neglect

The studies highlighted a range of barriers to protecting children and young people from child abuse and neglect, and this was discussed in 12 studies from five countries. The first barrier involved reporting children and families to social care or other agencies, which nurses in six studies felt was difficult when the child, young person or family may disengage, be at seemingly greater risk than before, or if the concerns were found to be incorrect (Land

and Barclay 2008; Eisbach and Driessnack, 2010; Alizadeh, Törnkvist and Hylander, 2011; Schols, De Ruiter and Öry, 2013; Engh Kraft and Eriksson, 2015; Engh Kraft, Eriksson and Rahm, 2016). Creating and breaking trust became an important concern for school nurses in the literature, and this concept continues in the results of this thesis.

School nurses in one study found sexual abuse particularly difficult to address as it was 'private' and 'taboo' and reflected how this might impact on their identification of such concerns (Engh Kraft, Eriksson and Rahm, 2016). As reported in four studies, work involving child abuse and neglect cases, including making referrals, could cause feelings of discomfort, fear and anxiety for school nurses and other professionals, sometimes creating avoidance of addressing concerns (Land and Barclay 2008; Schols, De Ruiter and Öry, 2013; Engh Kraft and Eriksson, 2015; Fraley, Aronowitz and Jones, 2018). One study dubbed this *"the power of fear"* (Fraley, Aronowitz and Jones, 2018, page 120).

A second frequently reported barrier to work relating to the protection of children from abuse and neglect was lack of time and conflicting priorities. School nurses in four studies had a varied role that included other public health activities, and time spent on 'core' activities such as attending meetings relating to child protection could take away from other aspects of their role (Chase *et al.* 2010; Coates, 2011; Joyner, 2012; Fraley, Aronowitz and Jones, 2018). This was demonstrated clearly in one study, where school

nurses reported large and complex caseloads; with 23% identifying work relating to child protection as taking 20-30% of their time and 16% identifying this work as taking up over 70% of their time (Coates, 2011). A study of school nurse managers from 34 health authority areas found that 80% of the sample identified work relating to safeguarding as taking up a large amount of school nursing time, and school nurses and managers sometimes felt there was a lack of clarity around the school nursing remit (Chase *et al*. 2010). School nurses in four studies from the UK agreed, and wanted more clarity on their role in safeguarding, and worried that other professionals and parents might not have an understanding of their role (Lightfoot and Bines, 2000; Coates, 2011; Joyner, 2012; Hackett, 2013).

2.6.6 Trust

For children and young people to talk about sensitive issues with the school nurse including child abuse and neglect, it was felt by nurses in four studies that a safe, calm and trustful environment was important (Alizadeh, Törnkvist and Hylander, 2011; Engh Kraft and Eriksson, 2015; Engh Kraft, Eriksson and Rahm, 2016; Fraley, Aronowitz and Jones, 2018). Trust was a central theme represented in research studies from five countries. Building trust was influenced by the school nurse discussing confidentiality, being visible and regularly available around the school, offering drop-ins, sharing their own experiences, avoiding serious questions too soon, making time to listen, seeming confident and capable, and making active efforts to build

relationships with their most vulnerable children and young people (Lightfoot and Bines, 2000; Alizadeh, Törnkvist and Hylander, 2011; Peckover and Trotter, 2014; Engh Kraft and Eriksson 2015; Engh Kraft, Eriksson and Rahm, 2016). A mixed professional group in one research study highlighted school as an ideal place to conduct sexual abuse screening as it provided the platform to build trusting relationships (Sekhara *et al.* 2018).

Trust was often dependent on confidentiality, and school nurses in three studies were able to offer professional privacy and be an independent alternative for children and young people who did not want to talk to parents or teachers (Lightfoot and Bines, 2000; Land and Barclay, 2008; Fraley, Aronowitz and Jones, 2018). In this PhD study, school nurses commissioned by the local authority worked to different information sharing policies than the educational establishments in which they work, such as providing confidential advice regarding sexual health and mental health. The tensions of this are discussed in chapter seven; encouraging school pupils to access confidential school nursing support yet creating a barrier between school nursing and other school staff.

Children and young people in one study agreed that confidential support was important, but they wanted the school nurse to be more visible to them, although school nurses reported their level of visibility was affected by workload and time pressures (Lightfoot and Bines, 2000). Availability was important in four studies because it was often felt that children visited the

school nurse (and colleagues) multiple times for unrelated issues before disclosing child abuse or neglect, seeming protective of their family and almost 'testing the waters' to see how confidential the service might be (Eisbach and Driessnack 2010; Alizadeh, Törnkvist and Hylander, 2011; Engh Kraft and Eriksson 2015; Fraley, Aronowitz and Jones, 2018). Some studies reported that it was sometimes a difficult decision for school nurses to escalate concerns regarding child abuse and neglect as this risked breaking the trust and contact between the child and family (Eisbach and Driessnack 2010; Alizadeh, Törnkvist and Hylander, 2011; Schols, De Ruiter and Öry, 2013).

Some school nurses felt age might moderate trust and disclosures, and two studies described younger children as more open, but older children as particularly protective of their parents and could use deflective strategies to avoid talking about their problems (Paavilainen, Ästedt-Kurki and Paunonen, 2000; Engh Kraft and Eriksson, 2015). School nurses in one study overcame this by trying to see children without parents; helping the child open-up through health dialogue and open questions (Engh Kraft, Eriksson and Rahm, 2016). In the results and discussion of this thesis, the concept of trust continues and appears as a central tenet of practice. The nuances of building and breaking trust, and the tensions of this, are explored.

2.7 Discussion

The review highlights a breadth of key domains of practice that the school nurse must navigate in their safeguarding role. Although the domains of *'supporting the child and family', 'detective work'* and *'working with other professionals'* occurred most frequently in the literature, all domains explored important elements of practice that contributed to protecting children and young people from abuse. Domains and encompassed activities did not occur in silo, but rather were related to each other; for example, school nurses felt trust was important to identify child abuse and neglect and engage the child and family with support, making this an underpinning value. However, this trust could be threatened by the nurse's duty of care (or mandatory duty in some countries) to report safeguarding concerns and initiate detective work. Although the latter were important activities to protect the safety of the child it could be a difficult and emotional path to navigate for the school nurse. It is important to note that it is a professional duty of nurses in countries such as the UK to report a child at risk and mandated in law in other countries such as the USA and Australia (Child Welfare Information Gateway, 2016). School nurses were sometimes unsure if making referrals to other agencies would damage trusting relationships with children and families or have negative outcomes (Land and Barclay, 2008; Eisbach and Driessnack, 2010; Alizadeh, Törnkvist and Hylander, 2011; Schols, De Ruiter and Öry, 2013; Engh Kraft and Eriksson, 2015; Engh Kraft, Eriksson and Rahm, 2016).

Activities to build trust with school pupils were supported by the school nurse being visible and available amongst the school community, as well as taking an active approach in reaching out to other professionals (Lightfoot and Bines, 2000; Paavilainen, Ästedt-Kurki and Paunonen, 2000). A service evaluation of school nursing services conducted by the Children's Commissioner for England (2016) found that school nurses needed to spend a significant amount of time on paperwork alongside the challenges of a busy clinical workload. This suggested that the impact of administrative work on the ability of the school nurse to be present in school should be considered, and whether current service models are allowing time for being visible and meeting regularly with children and young people. A clear understanding of the remit of the school nurse in safeguarding was important for managing a complex workload, and school nurses and school nurse managers felt this remit was sometimes confused (Lightfoot and Bines, 2000; Chase *et al.* 2010; Joyner, 2012; Hackett, 2013). Role confusion is defined as feelings of uncertainty around role scope, identity and expectations, and can result in reduced job satisfaction, frustration and difficulties with collaboration (Redekopp, 1997).

A barrier to work relating to protecting children and young people from child abuse and neglect was communication between agencies. Communication between services was deemed to be important and issues with this were consistently reported, particularly when discussing referrals to other

agencies (Land and Barclay, 2008; Eisbach and Driessnack, 2010; Joyner, 2012; Engh Kraft and Eriksson, 2015). In the UK, formal reviews of practice are conducted when a child or young person comes to significant harm or death due to abuse and neglect, and poor communication between services is frequently found to be a contributory factor (Munro, 2011; Munro, 2019). Prior to referring to other agencies, school nurses might identify child abuse through detecting signs and symptoms and gathering information to substantiate their concerns. It was suggested that objective signs of abuse such as physical injury are easier to detect than issues such as emotional harm, which are more subjective in nature (O'Toole *et al.* 1996; Land and Barclay, 2008; Pakieser, Starr and Le Baugh, 1998; Eisbach and Driessnack, 2010). The assessment of vulnerable children and families in other areas of community nursing and social care practice is well researched, and professionals are likely to be influenced by intuition, professional experience, emotions and the environment in which they worked (Fleming *et al.* 2009; Fraser *et al.* 2009; Hogg *et al.* 2012).

Revisiting the aims of this integrative review, within the context of this thesis and wider research study, an international overview of the role of the school nurse in safeguarding has been achieved. In addition, the translation of this role into tangible activities has been introduced, however further research is needed to develop an in-depth understanding of some of these processes (i.e. building trust, dealing with conflict). There is a dearth of recent research to understand the tensions of safeguarding and child protection practice

against the public health remit for school nurses in England, which will be explored in chapters seven to ten. Methods used in the studies included in the review were both quantitative and qualitative, and a mixed-methods study seemed to best combine an overview of the context of professional practice as well as capturing in-depth stories regarding the school nurses' experiences in working with vulnerable children and families. This has informed the design of this study, as described in the methods sections of this thesis.

2.8 Limitations

Only studies published in the English language were included in this review, meaning relevant studies (and any data regarding the role of the school nurse) published in other languages may have been missed or have been excluded. Studies were conducted in a range of countries where healthcare systems vary in structure and organisation which may impact on the findings. No date limit was set on the search, although it is acknowledged that changes in legislation for some or all of the countries represented in the review may have impacted the role of the school nurse over time. Efforts were made to create a comprehensive set of search terms although the indexing of the studies within the databases may affect the ability to recover them. Only two studies included the views of children and young people, therefore recommendations may lack the voice of the child. Thirteen studies included other professionals within the sample and as far as possible the findings

relevant to school nurses were extracted, or otherwise indicated in the results and discussion of findings. This highlighted the need for more research to be led by school nurses and focus on school nursing issues alone. Two studies included data from 1995-1996 (O'Toole *et al.* 1996; Lightfoot and Bines, 2000), and changes to service models of school nursing have since developed, however school nurses' involvement in identifying child abuse and neglect and multi-agency working remain key today and so these studies were included.

2.9 Chapter Summary

This systematically conducted, integrative review included research evidence from the UK, USA, Finland, Sweden, Australia and The Netherlands, and highlighted the variety of activities undertaken by school nurses that contribute to the protection of children and young people from abuse and neglect. In terms of primary research, studies focusing solely on school nursing are few, and further research would help to develop a deeper understanding of current practice. This PhD study seeks to explore the gaps within this literature review, to develop an in-depth understanding of school nursing processes in safeguarding in England, and make recommendations focused on school nursing practice alone.

Conclusions from this literature review suggest the importance of identifying barriers to protecting children and young people from abuse and neglect so

supportive strategies might be put in place, and more support may be needed to manage the size and complexity of the school nursing role. In practice, this might be achieved by ensuring the remit and responsibilities of school nurses are clear in in-service guidelines, and training addresses the complex and evolving nature of child abuse and neglect. The remit of school nursing in safeguarding should be clear at both service planning and front-line levels. Training for school nurses might not just cover policy and processes, but also less-tangible elements such as communication skills and managing relationships with both the child and family. Day-to-day demands should still allow school nurses to access training and development to meet their identified learning needs. The next chapter of this thesis will explore the methodological background to the study and introduce the research design.

CHAPTER THREE: METHODOLOGY AND RESEARCH DESIGN

3.1 Chapter Overview

This chapter will introduce the methodology of the study, the epistemological influences, and how this translated into a set of methods to explore school nurses' safeguarding practice. Deciding on the philosophical principles that will inform a research study is an important stage of planning, as this guides the approaches to data collection, ethical considerations and encourages thinking about the strengths and weaknesses of an approach (Dawson, 2009). An overview of mixed-methods research will be given, including a justification of its use and the influence of pragmatism. The choice to conduct semi-structured interviews influenced by constructivist Grounded Theory will be explored, including a reflection on the researcher's own stance and how this may have informed the approach to the research process.

3.2 Aims and Objectives Revisited

It is encouraged that the decisions made during a research study should be guided by the research aims and objectives (Dawson, 2009) and thus they have been presented again here to provide a basis for further discussion. A

dearth of school nursing research highlights the need to develop an understanding of the work of school nurses in safeguarding practice, particularly considering recent reports on the increasing complexity and vulnerability of the children school nurses care for (Children's Commissioner for England, 2016; Hoekstra *et al.* 2016). The study aim was to address the research question: *'How do school nurses in England identify and work with school children aged 5-19 years at risk of child abuse and neglect?'.*

The three research objectives were:

- To explore the processes through which school nurses identify school children aged 5-19 years at risk of child abuse and neglect.

- To explore how school nurses make assessments of school children aged 5-19 years at risk of child abuse and neglect, and the types of school nursing interventions offered to them.

- To explore the experiences of school nurses in identifying and working with school children aged 5-19 years at risk of child abuse and neglect: including the perceived challenges and opportunities of their role.

The latter objective promoted research recommendations that were led by the voice of the school nurses themselves, adhering to the belief that they

are the experts in their own experiences and practice (Thomas, Seifert and Joyner, 2016).

3.3 Introducing Mixed-Methods

This study adopted a two-stage approach defined as mixed-methods; combining an analysis of quantitative data in Stage One, with qualitative interview data in Stage Two (Walker, 2009). According to Creswell and Plano-Clark (2007), qualitative and quantitative data are best used together in a research study when a combination of approaches will help to understand a research problem more completely than either one alone. Mixed-methods research can be described as a combination of data collection techniques within a single study, meaning the term mixed-methods can be applied to a variety of research designs (Walker, 2009; Robson and McCartan, 2014). According to Creswell and Plano-Clark (2007), mixed-methods research has developed over the last 50 years, transitioning through several name changes including 'multi-trait' research and 'hybrid research'. The modern term mixed-methods became most widely recognised following the publication of a handbook for mixed-methods research by Tashakkori and Teddlie (2003). Interest in using more than one method in research was sparked in the 1950s by Campbell and Fiske (1959), who promoted the use of multiple quantitative methods in psychology research. Publications that proposed ways of combining qualitative and quantitative data were sparse (Sieber, 1973; Cook and Reichardt, 1979) until processes of designing a mixed-methods study

were refined in the 1990s (Creswell, 1994; Tashakkori and Teddlie, 1998). The main criticism of using quantitative data (alone) to understand a social research problem is the lack of rich understanding about human experiences that quantitative studies bring, although they can provide a broad overview of a social problem (Robson and McCartan, 2014). The main criticism of qualitative data in social research is that the focus is often narrow, and concerned with a specific group of experiences (not always transferable to different cultures, times, spaces); therefore by combining quantitative and qualitative data it was intended to achieve both an understanding of school nursing practice across multiple areas, and an in-depth cross-section of experiences (Robson and McCartan, 2014). In this study, the main challenge of a mixed-methods approach was the time needed to set up two distinct stages and learn the methods for each, within the time and resource limitations of a PhD.

3.3.1 Justification for Using Mixed-Methods

It has been argued that the rationale for choosing a mixed-methods research design should be led by the research question (Brouwer, Policastri and Moga, 2015; Halcomb and Hickman, 2015). Considering the research question for this study *'how do school nurses in England identify and work with school children aged 5-19 years at risk of child abuse and neglect?'* and the objectives of exploring the processes of identification, assessment and intervention, the decision to take a mixed-methods approach was twofold. Firstly, to achieve a

wider overview of the activity and context of school nursing practice with children and young people at risk of child abuse and neglect across multiple sites and in a timely manner. This was achieved using secondary, administrative data in Stage One. Secondly, to include the experiences of school nurses and provide a richer qualitative insight into the decision-making processes behind identification and assessment of vulnerable children and young people, achieved through interviews in Stage Two. This data provided a level of detail that could not be achieved with quantitative data alone.

Mixed methods approaches to research can help nurses to address research issues in increasingly complex healthcare systems (Halcomb and Hickman, 2015). It can be ideal for understanding a complex world where people often describe their experiences in both words and numbers (Creswell and Plano-Clark, 2007). It is known that safeguarding practice is similarly complex and often involves an interplay of factors, such as practitioner knowledge, type of abuse and familial risk factors (Fleming *et al.* 2009; Fraser *et al.* 2009; Hogg *et al.* 2012). In this study, utilising more than one approach to data collection to understand the complexities of school nursing practice has supported a wider understanding of the different factors that may influence the assessments made by school nurses and the interventions they offer.

3.3.2 Application of Mixed-Methods

A multi-level research design was chosen for this study, where data were collected at more than one level to understand a research problem (Creswell and Plano-Clark, 2007; Tashakkori and Teddlie, 1998). Again, this was to achieve both an overview of current practice across multiple areas, and an in-depth understanding of practice on the ground. The quantitative data in Stage One was collected at the organisational level, through electronic clinical diaries and caseloads of all school nurses working in the service. School nurses record patient appointments and interventions in diaries stored on electronic clinical records (ECRs), and this information was collected by running system reports. The qualitative data in Stage Two was collected at the individual level, with semi-structured interviews with school nurses.

Six main mixed-methods designs are discussed by Creswell and Plano Clark (2007), which are convergent, explanatory, exploratory, embedded, transformative and multiphase. Data from Stage One provided the contextual foundations for the semi-structured interviews in Stage Two (and informed the interview schedule), making it sequential explanatory in nature (Ivankova, Creswell and Stick, 2006). As discussed in the limitations of this thesis (chapter eleven) the emphasis of the quantitative stage became less important than initially planned due to the availability and quality of the administrative data. In a multi-level research design, findings from each of the levels are merged into one interpretation (Tashakkori and Teddlie, 1998);

in this study the interpretation is presented in chapter ten, with a theoretical exploration of how school nurses identify and work with children at risk of abuse and neglect.

3.3.3 Critical Commentary on Mixed- Methods

The choice of mixed methods in this study, to understand the complexities of two distinct phenomena 'school nursing practice' and 'safeguarding', has allowed the researcher to experience two distinct types of data collection and analysis. This had, of course, meant that additional time was spent learning both quantitative and qualitative analysis skills. As previously discussed in this chapter (section 3.3) a mixed-methods approach promoted a richer understanding of school nursing practice from more than one perspective but created challenges for the researcher when considering her own beliefs about the usefulness of each type of data. This is illustrated by an extract from the researcher's personal research journal, which formed part of the methods for qualitative analysis (discussed later in this chapter). The research journal was maintained throughout all stages of the research study.

"Child protection and nursing practice itself often relies on two types of data, both 'numbers' data (such as clinical measurements) and 'spoken' data (such as how the child is feeling). In research, combining the two types of data makes you consider how you really feel about the reliability of each. For example, are people's spoken 'truths' just a subjective interpretation of a

hidden reality that we could probably measure, or is it more relevant to make recommendations based on research that measures the truth as they see it? Nurses are, however, adept at taking both these approaches and making situational judgements"

This reflection, and others like it, formed part of the motivation to explore a pragmatic basis for the research study, making the research question the catalyst for decision-making (making a situational judgement). It also informed a constructivist approach to the qualitative stage, seeking recommendations based on the perspectives of the school nurses themselves.

3.4 Ontology, Epistemology and Methodological Approach

3.4.1 Ontology and Post-Positivism: Gathering Qualitative Data

The philosophical study concerned with the nature of being is ontology. It is concerned with the most fundamental features of knowing, such as influences on the mind and the reliability of proof (Blackburn, 1994). A researcher's ontological position will influence how they view the nature of reality and choose to develop knowledge (Dawson, 2009). Grounded Theory and other qualitative enquiry is often associated with an interpretivist stance; the researcher is concerned with reality being subjective to each participant and therefore likely to change (Charmaz, 2014). In contrast, a positivist

worldview will define reality as separate from social perspectives, and possible to measure in a controlled and objective environment (Robson and McCartan, 2014). Traditionally, quantitative and qualitative approaches to research were seen as coming from distinctly different philosophical paradigms, although recent authors on research design promote a more flexible approach particularly when studying the complexities of society and human behaviour (Robson and McCartan, 2014). The researcher in this study aligns with a post-positivist world view. Post-positivism accepts that we can understand knowledge but only imperfectly as the researcher will act as a filter and bring their own set of pre-conceptions. This is true in much social science research as *"imperfect humans researching imperfect humans"* (Clark, 1998, page 4). A post-positivist will not reject the notion of qualitative inquiry and will largely respect the idea of different perspectives on a phenomenon still holding truth (Clark, 1998). Bronowski (1956) writes that the truths found in both art and science, although distinctly different, can still hold validity. This example of art versus science mirrors literature regarding the art and science of nursing; as practice is not just guided by clinical tasks, but framed in concepts of caring, compassion and human interaction (Jasmine, 2009). The purpose of this study is not just to understand the tasks of the school nurse in safeguarding work, but to understand their relationship with children and young people, hence seeking to understand both the science of intervention and the art of interaction.

3.4.2 Introducing Pragmatism

This study adopted an epistemological stance of pragmatism. Ormerod (2006) defines the word pragmatic to mean a practical approach, a considered approach and a multi-dimensional approach, although notes it may also be construed as lacking theoretical underpinning. Pragmatism is synonymous with an opinion that reality can be viewed from multiple perspectives, both external and internal, and these perspectives can be combined to produce a richer understanding of a problem (Halcomb and Hickman, 2015). This relates to the ontological position of the researcher in this study, as previously discussed in section 3.4.1; an understanding of a problem cannot claim to be truly complete as there may always be another perspective. A pragmatist researcher may consider themselves outside of the traditional philosophical position of research paradigms and primarily be concerned with producing research that is relevant in a real-world context, using a variety of methods to answer a research question (Ormerod, 2006; Feilzer, 2010). On the other hand (and more synonymous with the type of pragmatic approach in this study), research claiming to sit outside of traditional paradigms may simply be less purist, and therefore pull different aspects of design from different paradigms (therefore still having some influence from philosophical beliefs) (Halcomb and Hickman, 2015). This has sometimes been called 'bricolage'; with traditionalist researchers arguing it marks a loss of discipline in the application of methodology and methods,

versus other academic groups arguing it represents an evolution of modern design (Yee and Bremner, 2011).

Pragmatism assumes that the world operates on multiple levels, where some aspects can be viewed objectively and others subjectively as they are more unstable and susceptible to human influence (Creswell and Plano Clark, 2007; Teddlie and Tashakkori, 2009). In this study, the nature of the phenomenon of school nursing practice and safeguarding are concepts greatly influenced by human behaviour, and therefore perspectives from these multiple levels are sought.

In recent years, some have argued for nurses to take a pragmatic approach to study by using the perceived best methods, both quantitative and qualitative, to address a problem (Garrett, 2007; Fawcett, 2015; Florczak, 2014). This moves away from a traditional medical (and typically positivist) model of research (Clark, 1998). Some medical academics do focus on the narrative and art of applying evidence (rather than the evidence itself) (Greenhalgh, 1999). It is argued that problems frequently studied by nurses (e.g. patient health, challenges to practice) are complex as they tend to centre on human factors, and pragmatism can promote a flexible approach to understanding (Garrett, 2007; Nowell, 2015). Pragmatism can be reflected in nursing practice itself; nurses will collect, record and make judgements on objective measures of health, such as vital signs and pain scores, but will also rely on qualitative descriptions of health from the patients they care for

(Fawcett, 2015; Romero-Brufau *et al.* 2019). School nurses in this study worked in a similar way, using objective measures of health and wellbeing in tandem with children's spoken stories about their lives.

Many research studies in the context of safeguarding and child protection have highlighted this subject as complex and multi-factorial and both qualitative and quantitative methods are used to understand the problem (Fleming *et al.* 2009; Fraser *et al.* 2009; Hogg *et al.* 2012). Houston (2014) discusses the child protection practice of social care professionals in relation to risk. He argues that the approach taken by social care professionals to risk assessment and risk management can exist in an objectivist paradigm (e.g. reliance on risk assessment tools), subjectivist paradigm (e.g. value given to personal accounts) or a critical paradigm (e.g. testing causes of abuse). Houston (2014) argues a pragmatic approach is ideal to understand complex social issues, as it encourages the researcher to be open to seeking knowledge in different ways. School nurses in this study worked within a similar environment of safeguarding, and it was anticipated that they may operate in different paradigms as described above.

3.4.3 Critical Commentary on Tensions in Pragmatism

As the researcher aligns best with a pragmatic approach to research, a tension was noted when operating in a type of paradigm that is often described as outside of traditional and intensive philosophical concerns,

although perhaps more of a shift away from purism than devoid of any philosophical influence (Ormerod, 2006; Feilzer, 2010; Halcomb and Hickman, 2015). That is, it was still deemed necessary to choose methods for the qualitative stage and the best fit for the research question was determined to be a social constructivist approach to Ground Theory, which is explored later in this chapter. Constructivism is its own paradigm with an associated set of beliefs about how the world is understood, including how understandings are built on social interactions with others (Given, 2008). The tensions are illustrated by an extract from the researcher's personal research journal:

"Pragmatism encourages a focus on the real-world context of inquiry and seeks the 'best way' to answer a research question. Tensions have been found when choosing particular methods with their own underpinning philosophies. This calls into question whether anyone can really consider themselves 'outside' of traditional epistemological arguments and "sidestep the contentious issues of truth and reality" (Feilzer 2010, page 8) because there is always some influence in how you decide the 'best way' to answer a question"

This reflection prompted the researcher to realise the importance of acknowledging the reasons for answering research objectives (in a pragmatic study) in a particular way. If pragmatism is taken as seeking an approach for the real-world context under study (Creswell and Plano Clark, 2007; Teddlie and Tashakkori, 2009) then the qualitative methods chosen, and any

associated beliefs, must suit the research question but acknowledge how the philosophical under-pinning of the said approach are in synergy with how the problem seeks to be understood. The view was taken in this study, that to understand how school nurses make assessments of vulnerable children and young people and deliver interventions, was to understand how they operate in a particular social world. The social world in question was that of school nursing and safeguarding practice, encompassing school nurses, other professionals, children and their families, and focussing on the interactions between these actors. In this way, an approach grounded in constructivism seemed appropriate and this will now be explored in the remainder of this thesis chapter.

3.5 Qualitative Phase

3.5.1 Introducing Grounded Theory

Due to a mixed-methods approach and some practical constraints explored in chapter four, this research study only claims to use an approach *informed* by Grounded Theory (rather than being a purist version of Grounded Theory research). Despite this, the history and background of the approach is introduced, to understand the essential elements of it. Grounded Theory is an approach to research that is inductive; where the results of the study must be grounded in the data and any concluding theory built from this (Charmaz, 2014). In contrast to Grounded Theory, a different approach to study may be

deductive and concerned with testing an existing hypothesis or theory (Charmaz, 2014). Stage Two of the research study involved qualitative, semi-structured interviews that were collected and analysed using Grounded Theory methods. Grounded Theory was founded in the 1960s in response to a perceived lack of structure and guidance for qualitative research at the time (Glaser and Strauss, 1967). The early work on Grounded Theory focused on the idea that new knowledge and theory in social research could emerge solely from the data itself, rather than constructing a theory and testing it with data. Practical concepts such as constant comparative analysis and theoretical sampling were introduced, which allowed for ideas to emerge rather than already being hypothesised (Glaser and Strauss, 1967).

Grounded Theory has evolved significantly since the 1960s, with so-called second and third-generation grounded theorists bringing their own approaches to Grounded Theory study (Birks and Mills, 2011; Charmaz, 2014). These variations occurred as the wider research community adopted the approach. Much of the second-generation methodological approaches to Grounded Theory were a result of researchers attempting to apply a different philosophical underpinning to the methods, such as constructivism (Charmaz, 2014). The founding grounded theorists, often dismissed the application of a philosophical stance to Grounded Theory as they argued this limited the potential of it to be an approach free from pre-conceptions, although as previously discussed in this chapter (section 3.4.3) it is debatable if true objectivity is possible (Glaser, 1998). Third-generation grounded theorists

(for example, Birks and Mills, 2011), argue that the variety of Grounded Theory approaches available to researchers today, positively contributes to a tool kit of methods for use in qualitative data analysis.

3.5.2 Justification for Using Grounded Theory

Grounded Theory can be an ideal approach to an exploratory study into novel social processes as it asks open questions to participants that do not pre-conceive how or why they make decisions (Birks and Mills, 2011). One challenge to Grounded Theory is that many researchers fall short of producing a robust theory at the end of the study; some blame the natural intuitive ability of the individual researcher, misunderstanding of the methods, or the lack of a clear and 'testable' question at the outset of study (Suddaby, 2006; Charmaz, 2014). Others argue that modern Grounded Theory *approaches*, acknowledging the practical requirements of many research studies today (e.g. background knowledge, ethical approval, research protocol), can be defined as a core set of principles, as discussed in this chapter (Timonen, Foley and Conlon, 2018).

The aims and objectives of this PhD study particularly focus on the processes of identification and assessment of child abuse and neglect by school nurses. Little previous research exists into how school nurses are working with children at risk of child abuse and neglect therefore the search for this knowledge is exploratory in nature. Some pre-conceptions are acknowledged

through the researcher's own practice as a school nurse and previous exploration of the literature (see section 'Positionality and Reflexivity'). Furthermore, optimising Grounded Theory methods can support the rigour of the qualitative element of a mixed-methods study by providing the researcher with a set of steps to follow that promote submersion in the data through constant analysis and memo keeping (Birks and Mills, 2011; Charmaz, 2014). This was appealing as a novice researcher. Grounded Theory seeks to inductively develop knowledge to explain a phenomenon (Glaser and Strauss, 1967), and from scoping the literature, models of assessment and practice in safeguarding and child protection commonly existed in the domain of social work, and less commonly in healthcare and nursing (Sullivan *et al.* 2007; Parton, 2011; Houston, 2014).

Alternative methodologies in qualitative research seek to explore participants' experiences and feelings towards a concept (phenomenology), analyse an event (case study), understand a person's in-depth story (narrative) or embed in a social group or context (ethnography) (Astalin, 2013). The different and appealing element of Grounded Theory was the focus on studying processes; it was considered that to understand school nurses' perceptions on processes it was first essential to uncover what these processes were, which is largely missing in research accounts pertaining to school nursing in England.

3.5.3 A Constructivist Approach to Grounded Theory

Stage Two of the study is guided by the constructivist work of one of the original second-generation grounded theorists, Charmaz (2014), to understand the interactions of school nurses with children, families and other professionals in the world of safeguarding and nursing practice. Constructivism promotes the idea that individuals construct their own subjective understanding of a reality, and learn through experience and social interaction (Charmaz, 2014). This approach to Grounded Theory was accepted (and thus alternative theories rejected) by the researcher through a process of reading, and the constructivist approach aligned best with the objectives of the study. In this study, the researcher sought to understand school nursing processes through the perceptions, and past and present experiences of participants; to understand what influenced a school nurse's subjective assessment of risk and decision-making. Opposing theories of behaviourism and cognitivism suggest that behavioural processes are instead learnt through positive and negative feedback from the environment, or explicable by measurable cognitive events (Lopes, 2010).

The constructivist version of Grounded Theory (Charmaz, 2014) as with other approaches (Corbin and Strauss, 2008) focuses on exploring meanings and actions with fluidity and creativity (Chamberlain-Salaun, Mills and Usher, 2013). It is argued that a constructivist approach takes the researcher one step further than fundamental pragmatic concepts, by further exploring tacit

meanings behind actions (Charmaz, 2014). Constructivist Grounded Theory can be criticised for becoming too removed from original Grounded Theory methodology by forcing the researcher to view data through a constructivist lens (Glaser, 2002), although the researcher could equally be drawn to the approach through their personal ontological understanding (rejecting the notion of being 'outside' paradigms) making the prior argument contestable.

In this study, the researcher takes a post-positivist stance in the pursuit of knowledge, which respects both quantitative and qualitative enquiry. The move in Grounded Theory development, from seeking the absolute truth (some place the original Glaserian Grounded Theory in the positivist paradigm) to understanding participants' role in constructing the truth, aligns with the researcher's stance (Age, 2011). As well as understanding some of the fundamental processes in school nursing practice, the study seeks to understand the human influence and modifications on these processes.

3.6 Positionality and Reflexivity

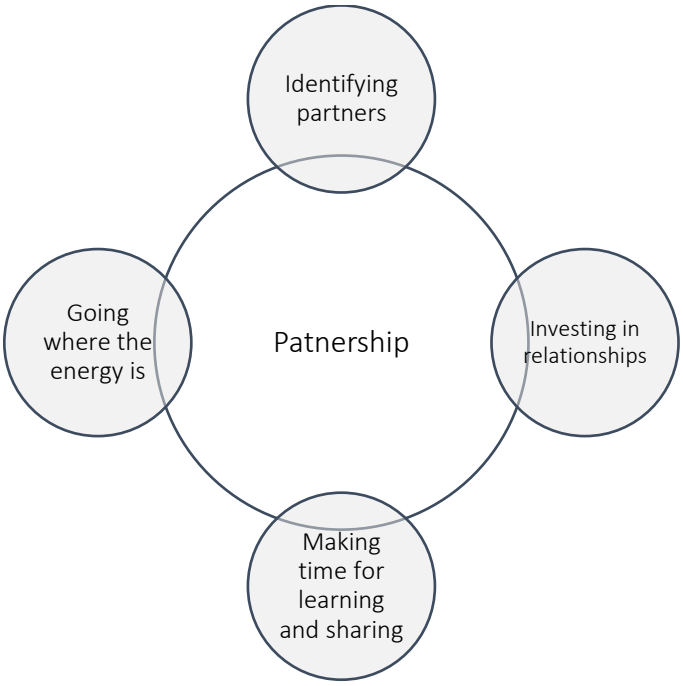
The choice to use Grounded Theory to inform this study was not without challenges, namely the ability to come to the topic without previous knowledge of school nursing practice; the researcher being a practising school nurse. It was acknowledged throughout the research process that this study could not claim to be without any bias or pre-conception. In relation to this, a literature search (which is discouraged in early versions of Grounded

Theory) was still undertaken as it would seek to affirm existing practice-based knowledge of the researcher. The reality of conducting a research study in a current healthcare setting meant some elements of the purist Grounded Theory study had to be modified, for example, an interview schedule had to be submitted to ethical review boards with some idea of sample size. Despite this, there was still some flexibility to explore the emphasis of questions regarding developing themes and gaps in knowledge, as detailed in the methods chapter (four) of this thesis.

A constructivist approach to Grounded Theory seeks to explore why research participants may hold certain perceptions, rather than simply describing what those perceptions are (Charmaz, 2014; Taghipour, 2014). Alternative, objectivist approaches to Grounded Theory that relate to a more positivist tradition view research participants and data from an outside perspective to understand patterns of behaviour (Glaser and Strauss, 1967). Objectivist Grounded Theory therefore seeks to retain a distance from the research participant, rather than working closely in partnership with participants to discover socially constructed beliefs (Taghipour, 2014). The researcher in this study sought to develop an understanding of school nurse processes in partnership with the participants. Despite not always explicitly introducing herself as a school nurse to avoid participants assuming knowledge when discussing their experiences (e.g. using jargon), participants inevitably found out through managers or colleagues. Thus, they became aware that the researcher shared a profession and a common body of experiences with

them, and to ignore or dismiss this felt inappropriate. In nursing, a partnership model is well understood to foster trust between patients and health-care professionals and promote patient engagement and empowerment (Splaine, 2008). It includes elements such as providing choice, respecting decisions and using common language (Splaine, 2008). In this study, the core concepts of partnership working were used according to Seale (2016). That is '*identifying partners', 'investing in relationships', 'making time for learning and sharing'* and *'going where the energy is'* (Figure 3.1). It is contested, however, if partnership models are ever truly equal as professionals ultimately hold behind them the power of their organisation and/or status (Dinç and Chris Gastmans, 2012; Rutherford, 2014). A feminist researcher Phoenix (2008) suggested research participants may align the way they share their stories and experiences with what they assume the interviewer would like to hear. For example, school nurse participants might have assumed the researcher was seeking to promote the beneficial contribution of the school nurse to safeguarding, or conversely highlight problems within the system, and thus frame their chosen answers accordingly.

Figure 3.1. A partnership model in health care and nursing



Adapted from Seale (2016)

The partners in this study were the participants, and investment in relationships involved respecting their choice of interview location, showing interest in their lives and asking about their day-to-day activities. For example, one participant was keen to give the researcher a tour of the school building in which they worked. Making time involved protecting the interview appointment as well as offering to attend team away days to share learning from the study and feedback to the participating organisations. "*Going where the energy is"* (Seale, 2016, page 12) meant respecting what a participant may feel passionate about and allowing them to explore this during the interview, rather than applying the interview schedule in too much of a regimented fashion.

A constructivist approach to Grounded Theory understands that the process of collecting and analysing data is influenced by the shared experiences of researcher and participant, and interactions with other sources of information (Mills, Bonner and Francis, 2006; Charmaz, 2014). Constructivism belongs to an interpretive tradition of research and acknowledges that findings will depend on the researcher's viewpoint (Given, 2008). This makes it important to examine and clarify the researcher's viewpoint, acknowledge the possibility of multiple truths and justify the conclusions of the study. Different researchers may produce similar findings, but how they theorise about them may depend on their own unique experiences and interactions (Given, 2008). To be aware of one's own beliefs is encouraged in later iterations of Grounded Theory through the writing of memos that reflect on both the process of data collection and on data analysis (Birks and Mills, 2011; Charmaz, 2014). During data collection objective memos may be kept in relation to the interviews, such as observations of the environment, research participants and the initial reactions of the researcher to data collection processes. In addition, this creates an audit trail of the research process that can be useful during later stages of writing and describing the methods of the study (aiding transparency) (Birks and Mills, 2011; Charmaz, 2014). In the data analysis phase memos are kept recording emerging ideas (any 'light bulb' moments), including ideas for categories and codes to explore in further interviews (Birks and Mills 2011; Charmaz 2014). During the course of this study, memos evolved over time, and so the interpretation of data changed as the researcher recognised what biases they may have from their own

school nursing practice (e.g. what situations cause the most anxiety, what school nurses 'should' do in any particular situation). In this way, some memos felt as if they caused the researcher to step back from the data (to acknowledge bias), and others brought the researcher closer (when break-through moments occurred). In reality, repeated cycles of this process made memos feel simultaneously helpful and frustrating.

Memos may be kept separately from a reflective journal or be incorporated, although both aid the development of reflexivity and emerging ideas. A reflective journal is a record of the researcher's personal reflections in relation to the research process and usually includes subjective thoughts and feelings. A reflective journal is a tool that can facilitate insight into the researcher's position within the study and any life experiences or inherent perceptions that may influence how data is interpreted (Charmaz, 2014). A researcher may reject the use of written reflections and the wider concepts of reflexive practice as poor evidence of self-insight in relation to a research study (Cutcliffe, 2003). However, Charmaz (2014) discusses this operationalisation of reflexivity is essential to keeping an open and honest approach to Grounded Theory research and considering the position and impact of the researcher on the process. The views of Cutcliffe (2003), and to some extent in the Grounded Theory literature, present memo-keeping and reflective writing as a linear process and confine it to a set of steps that belie the true complex nature of reflexivity. In the experience of this study, reflexivity was a combination of memos, reflective writing (in a journal) and

many other factors (e.g. time away from the thesis, space to rest and think) and insight did not come instantaneously.

In this study regular reflections (in a journal) were kept in relation to a variety of issues, including any influences of the researcher's personal and professional background, positive experiences, or unforeseen events during the life of the study. Reflections were kept in addition and separately to memos regarding thought processes during initial and focused coding. The majority of issues that felt worthy of reflection related to the researcher's professional background as a school nurse. This meant the researcher had prior knowledge of school nursing practices, guidelines and experiences, and written reflections served as an outlet for considering these factors in relation to the emerging data. For example, one of the main challenges of being a school nurse was the risk of not questioning threads of information that seemed common knowledge. In more positive ways, the existence of this prior school nursing experience was considered a benefit for the engagement of participants, empathy with their challenges in practice and an understanding and sympathy with the resulting data.

3.7 Chapter Summary

This chapter has set out the ontological and epistemological perspectives of the researcher and how these have led to the choice of research design and methodological approach of Grounded Theory. Consideration has been given

to the researcher's own position in the research process, through an exploration of positionality and reflexivity. The thesis will now explore the application of more tangible methods to collect data for Stage One and Stage Two of the research study.

CHAPTER FOUR: METHODS

4.1 Chapter Overview

This chapter will present the methods for both Stage One and Stage Two of the research study. An overview and justification of each stage will be given, before a discussion on site recruitment and ethical approval. Data collection and data analysis will be presented consecutively for Stage One and Two, to understand how each stage was undertaken as well as how they worked in sequence. Some of the limitations of the chosen methods, as identified in the literature, will be introduced and discussed, including attempts to overcome these.

4.1.2 Summary of Stage One

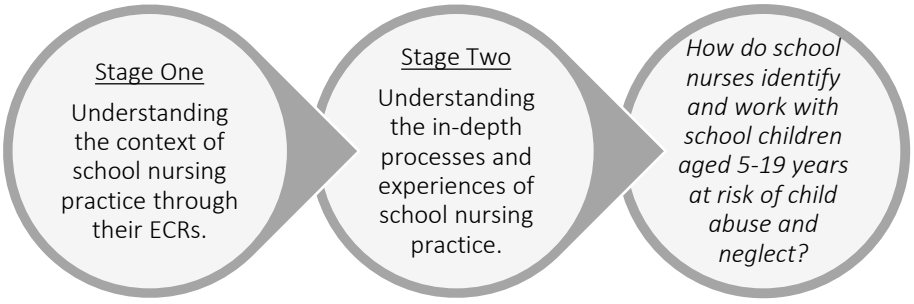
Stage One of the research study addressed part of the second objective: *'to explore the types of interventions offered by school nurses to school children aged 5-19 years at risk of child abuse and neglect'*. Analytical insights from Stage One informed the interview schedule for Stage Two (Figure 4.1), by gaining an overview of the type, range and amount of safeguarding work school nurses were recording on a daily basis. School nursing activity data

were collected from electronic clinical records (ECRs) at three study sites in England and analysed using descriptive statistics.

4.1.3 Summary of Stage Two

Stage Two of the research study addressed objectives one, two and three: to explore how school nurses identified and made assessments of school children aged 5-19 years at risk of child abuse and neglect, and to understand their experiences of this role. Semi-structured interviews with 25 school nurses were conducted across three study sites, and data were analysed using Grounded Theory methods.

Figure 4.1. An overview model of the research study



4.2 Site Recruitment

Three county-wide school nursing services in England agreed to participate in the study, after a total of six were initially approached. The three study sites that declined to take part in the study cited lack of staff, low morale and lack of time, which meant the final sample was one of convenience (those willing to take part within reasonable travelling distance). In addition, the research team had some existing contacts within the final sample of study sites. It was anticipated that more study sites might be interested in the study, although their reasons for not taking part were understandable within the context of the time (2016-2017) where school nurse numbers were in continued decline and pressure on existing staff was increasing.

As regular travel would be necessary to visit each study site and collect data, the time burden of this was considered within the context of the PhD timeline, and considering the researcher still worked part-time in a clinical role as a school nurse. A limitation of this was, of course, that potential study sites in further corners of the country were not approached. Initially, an existing network of school nursing contacts were gathered, representing six sites across England. These contacts were available through the researcher's own work as a school nurse and the knowledge of the supervisory team. Information about the study was emailed to service leads for school nursing in each potential study site, as well as the lead for research and development in each organisation. Study sites were offered a telephone call or in-person

visit to discuss the study in further detail; one study site accepted the invitation of an in-person visit to the area managers for school nursing.

Although the final sample was one of convenience, demographic variation of the local population was still considered as the study hoped to explore the perceptions of school nurses who had experience of working with children and young people at risk of child abuse and neglect. It has been suggested that safeguarding concerns are more likely to be identified for families in lower socio-economic groups, both through the impact of issues such as poverty and unemployment, and greater official scrutiny by agencies (Bywaters *et al.* 2016).

Some geographical variation of the sites was considered important to explore the perceptions of school nurses working in a range of practice environments, for example an industrial city in comparison to a rural setting. Knowledge of geographical and demographic variation was gained through a search on the UK Child and Maternal Health information observatory (ChiMat, 2019) (see Table 4.1). A brief overview is given only, to protect the anonymity of the study sites. Each of the three study sites covered one county and terminated at local authority county boundaries; each county contained both rural and semi-urban/urban populations. All three sites contained at least one city or large town, and therefore represented school nursing practice in busier, urban areas.

Table 4.1. An overview of study site characteristics

	Study Site One	Study Site Two	Study Site Three
Geography	Urban and rural	Urban and rural	Semi-urban and rural
Population Size	Circa 700,000	Circa 800,000	Circa 1.5 million
Children Living in Poverty	12%	16%	15%
Unemployed	3.1%	2.9%	3.8%
Population of 0-15 Year Olds	Circa 140, 000	Circa 140,000	Circa 320,000
Local Issues	Substance misuse and mental health	School readiness, substance misuse and mental health	Childhood obesity and mental health

(ChiMat, 2019)

4.3 Ethics

This research study received ethical approval from the Faculty Research Ethics Committee (FREC) of the Faculty of Health and Life Sciences at Oxford Brookes University on 14/12/2016 (Appendix 2). The FREC at Oxford Brookes University requested additional wording on the participant information sheet regarding confidentiality and data protection. Approval from the UK Health Research Authority (HRA) was obtained on 20/02/2017 (Appendix 3). Application to the HRA was completed via the UK Integrated Research Application System (IRAS). Some additional information on the interview schedule and wording of email study invitations was requested by the HRA before approval was sent. One study site was a private healthcare provider, and as the HRA only provided approvals for NHS study sites, the private

provider conducted their own internal approval process, led by the business innovation team. Following these initial approvals, each of the three study sites conducted a review of the research study to confirm they had the capacity to host it. The process of obtaining all of the above approvals took 13 months, as the study involved three sites and each site had slightly different arrangements for reviewing applications. For example, one study site requested the researcher attend in-person to present the project to the ethical review board.

Careful attention was given to ethical considerations for the study, as child abuse and neglect is a sensitive and difficult topic to discuss. Although most school nurses were trained and experienced in safeguarding work, many participants commented that the interviews were a chance to reflect on their most challenging cases. In addition, several participants chose to speak about the stresses of their role and job satisfaction within their organisation. Ashton (2014) advises that the boundaries between nurse and researcher can become blurred in nursing research concerning sensitive topics, and the researcher should be prepared to provide reassurance and support for participants, whilst retaining some distance to be able to navigate the conversation. Valentine (2007) called this empathetic listening. In this study, this distance was maintained by taking notes and being mindful of the interview schedule, although as discussed in the methodology chapter the reality of conducting research can differ from an idealistic approach. Keeping the school nurses as partners in the conversation whilst maintaining a certain

level of control of the interview process was not always a clearly defined boundary. For example, participants described different pre-conceptions of the interview including formal, therapeutic, informal, or a chance to 'vent' and this resulted in varying levels of familiarity. In some ways, the presence of the recording device (as a reminder of the purpose of meeting for interview) sometimes acted as a barrier to the conversation diverting into a 'friendly chat', although many participants remarked that they forgot about its existence in the end. One participant became upset about their lack of job satisfaction and was offered a break from the interview, although this offer was subsequently declined, and the interview continued. In accordance with Fahie (2014), who conducted research on workplace bullying, self-reflection of the researcher was maintained through a reflective diary, and any difficulties were discussed with the supervisory team. For example, one discussion centred on how to continue an interview and be mindful of the interview schedule if participants have spoken at length about un-related topics, such as their personal life or previous jobs.

As the subject of interviews was safeguarding, it was necessary to plan for any sensitive dilemmas arising. That included any unresolved safeguarding concerns that the school nurse had not taken forward to appropriate agencies, although this was felt to be unlikely. Participants were directed to re-read the statements on the participant information sheet before commencing the interview, and these stated that in the event of unresolved safeguarding issues being highlighted, the participant and the researcher

would together take this forward to the area manager for school nursing. It was not necessary to do this during the study.

This study was selected for an ethics audit at the university on 22/03/2018 and ethical compliance was reviewed positively.

4.4 Stage One

4.4.1 Secondary Data Collection: Electronic Clinical Records

In all three study sites, school nurses recorded appointments with children and young people on electronic diaries on ECR systems. School nurses also kept electronic caseloads of all children and young people with whom they had direct involvement. These two areas of ECRs were the focus for data collection. A data request sheet (Appendix 4) was developed according to the research team's knowledge of ECRs and the information that might best address the research objective of understanding the types of interventions offered by school nurses. The data request sheet contained a list of information to be obtained by a designated member of the Internet Technology (IT) or service management team, by running reports on school nursing activity from the ECRs. This was securely emailed to an identified contact (as above) for each organisation. Data were requested for the previous two academic years, 2015/6 and 2016/7, although most items of data could only be provided for the 2016/7 academic year. Reasons given for

this were in relation to time constraints of the parties involved in collating the data, a recent changeover of health provider in one study site (meaning they could not access data owned by the previous provider) and the persons collating the data only having permission to view the latest information (i.e. for the last reporting year). The member of the service management or IT team returned the final data set on Microsoft Excel spreadsheets or the complete data request sheet, and by means of a secure, encrypted email.

To comply with the ethical approval of the study, all names of school nursing staff, patients and any other identifiable information were removed by the service manager or a member of the IT team before being sent to the researcher. The data request sheet contained generic (and transferable) questions as each school nursing service used a different ECR system to record their daily activity. An example was the data request: *'What is the total number of contacts/interventions with children and young people with a safeguarding or child protection alert (on their clinical records) by the school nursing team in the last two academic years?'*

It was anticipated by the researcher that each service may also use different labels for indicators and interventions. In one organisation, an alert on a child's clinical records to say a child protection plan was in place was labelled as '*child protection'*, and in a different organisation was labelled as *'section 47'*. Such discrepancies were explored, as later described in this chapter, by comparing in-service record keeping guidance for definitions of labels.

Each member of the IT or service management team responsible for running these reports was offered a telephone call or face-to-face visit to talk through the data request sheet and raise any issues or concerns. Each study site accepted an initial visit to discuss data collection and the data request sheet. In addition, telephone and email support was provided for approximately 3 months (February-May 2017) to the person responsible for collating the data in study site three. Working with a third party to collect data had benefits and challenges; working with someone who was an expert in their own organisation's ECR system was a valuable source of knowledge, but the researcher was one step removed from the process of directly collecting the data.

4.4.2 Advantages and Disadvantages of ECRs in Research

A number of ECR systems are used within health in the UK, following a move towards paperless patient records within the NHS by 2020 (National Information Board, 2014). ECR systems are usually designed and supported by a sub-contractor who bids to provide such services to a health provider through a tendering process. Although ECR systems are considered efficient, timely and cost effective (Ozair *et al.* 2015), the tendering process means systems used across the country and between local health services are often different and information held about a patient can be fragmented. Using data from ECR systems has advantages in research, as it allows for the collection of large amounts of information on a population (Castillo *et al.* 2015; Cowie

et al. 2017) and does not rely on participant responses to other methods of primary data collection (Connelly *et al.* 2016). Collecting data from readily available electronic databases can be more cost-effective than attempting to collect similar data through primary data collection methods and reduces the burden on potential participants (Administrative Data Liaison Service, 2010). Additionally, the recording of administrative data in practice usually follows consistent pro-forma and is subject to audit, as is true of the school nursing data in this study (Administrative Data Liaison Service, 2010). Clinical record keeping in nursing is expected to be contemporaneous and accurate, as it forms a legal document that provides evidence of care (NMC, 2015).

Using ECRs as a secondary data source in research has several limitations. Firstly, clinicians may mis-classify interventions at the point of selecting pre-set options; distractions in the clinical environment may impact on the time and concentration required for record keeping (Castillo *et al.* 2015). Clinicians may mis-interpret the meaning of pre-set options through inadequate training or unclear guidance. Comparing data across different services may be a challenge if they use different ECR systems, and different labels for interventions (Castillo *et al.* 2015; Connelly *et al.* 2016). These limitations exist because most ECR systems were not designed with research in mind and are primarily for supporting clinical care and providing evidence for commissioners about the performance of a service against financial targets (Castillo *et al.* 2015; Connelly *et al.* 2016; Cowie *et al.* 2017). The use of clinical records by health providers for evidence of care provision against

organisational targets may be in conflict with the perspective of some nurses, who find the amount of record keeping activities increasingly overwhelming and distracting from direct time with patients (Cunningham *et al.* 2012).

These limitations were addressed in this study by following recommendations in the literature on increasing validity in ECRs research. A working knowledge of ECRs has been suggested to achieve an understanding of the content and how information is recorded (Castillo *et al.* 2015; Connelly *et al.* 2016), and as the researcher used ECRs in their own school nursing practice this recommendation was achieved. Each organisation in the study used a different ECR system, so any knowledge deficit (of the researcher) around individual systems was addressed by liaising with the coordinating IT department. Additionally, record keeping guidance from each organisation was obtained to understand the meaning of different labels used within the systems, such as *'safeguarding event'* or *'child protection'*.

4.4.3 Data Analysis

Data were managed on Microsoft Excel, to produce descriptive statistics on school nursing caseloads and school nursing interventions. Organisational data were transferred onto one single master spreadsheet, as this aided comparisons between each service. Additionally, each organisation sent two to three spreadsheets or templates each in answer to the data request, and one used a pivot table (an interactive table that generates specific data from

the spreadsheet), so it was necessary to extract the required data and combine this into a cohesive format. The master spreadsheet contained tabs for each school nursing service, and a tab to present comparable data between the services. All data provided by the organisations was count data presented in table format, for example, 'total number of children on a caseload' or 'total frequency of a specific intervention in the academic year 2016/7'. Data to describe school nursing caseloads and school nursing interventions remained as count data in table format and was subsequently converted to percentage values using Microsoft Excel commands. Percentage values were calculated in order to present the weighting of each intervention within the total annual school nursing activity.

The meaning of individual labels used in the data, such as '*child protection'* or *'health promotion intervention'* were confirmed by reading the local service guidance on record keeping, thus obtaining documents that helped to interpret labels was an important process of this method. The local record keeping guide for each service was obtained from the lead for school nursing, and this helped to understand how school nurses might categorise their interventions and to compare similar interventions across the different services. Interventions that showed a frequency of '0', or interventions that used a label not recommended in the record keeping guidance, were removed as anomalies. For example, one data set had recorded a '*new birth visit'* which is not offered by school nursing, as it is a service solely for children and young people aged 5-19 years. This again highlighted that data from ECRs

is only as accurate as the practitioners recording it. Additionally, the intervention '*chlamydia treatment accepted'* was an outcome of *'chlamydia treatment offered'* so the latter was counted as the intervention.

As the total list of different interventions for school nursing was long, some interventions were grouped together when forming data displays (i.e. pie charts and bar graphs) to ensure they were clear and legible. For example, all interventions relating to sexual health in one service were combined under the heading '*sexual health'* and count data added together. A colour-coded diagram of this process is provided in Appendix 5, and this was reviewed independently by two supervisors. Grouping interventions in this way was driven by the professional knowledge of the researcher (as a school nurse) and by reading the record keeping guidance. Professional knowledge was therefore an asset to this stage of data collection, both to understanding ECRs (as mentioned in section 4.4.2) and to the interpretation of data. It is important to note that a school nurse might record more than one intervention for the same child, as an appointment may address more than one issue, for example, providing emotional support at a sexual health contact. Therefore, frequency of interventions did not represent individual appointments with children and young people but rather the number of times the intervention was offered.

4.4.4 Critical Commentary on using ECRs in Research

A reflection on the process of working with ECRs deemed it to be an important learning activity, especially as there is increasing interest in this type of research. Health research using existing large data sets, sometimes referred to as 'Big Data Research', is thought to provide the potential to understand research questions at a population level (Bates *et al.* 2014). This interest is driven in part by the increasing implementation of ECRs internationally and the general improvements in computing technology (Bates *et al.* 2014, Jin *et al.* 2015). Although a volume of health data exists, ways to harness it for the purposes of research are in somewhat of an infancy (Bates *et al.* 2014, Jin *et al.* 2015). In this study, the realities of obtaining data from ECRs required patience and the ability to navigate complicated permission processes. The process of obtaining the data from all three study sites took approximately 13 months from start to finish, including waiting for data sets to be anonymised. The frustrations are reflected below, in an extract from the researcher's personal research journal:

"It has taken much longer than anticipated to obtain the data requested from electronic clinical records, which has delayed my proposed time-schedule. I do feel this is reflective of researching in the 'real-world', and in particular the NHS, and navigating the processes of obtaining the correct permissions has felt confusing. Although this has been frustrating and time intensive, I hope it might provide a useful case study to those thinking of journeying into research

with existing data, which is perhaps an outcome of this stage of data collection that is just as useful as the data itself."

A case study of this stage of data collection has been accepted to the journal *Nurse Researcher* and is pending publication at the time of writing.

4.5 Stage Two: Interviews

In Stage Two of the research study, 25 semi-structured interviews with school nurses were undertaken across the three study sites. As previously described in section 4.2, study sites were selected by means of convenience sampling and were all located in England. One-to-one interviews were chosen as a means of gaining individual stories in a format that promoted an honest exploration of a (possibly sensitive) set of topics (i.e. experiences in safeguarding practice, and beliefs about the challenges of school nursing) (Ashton, 2014). This was in comparison to alternatives such as focus groups, where school nurses might have felt unable to express their thoughts freely due to the dynamics or presence of others in the group (Farquhar, 1999). A semi-structured approach (as opposed to an un-structured approach) was used to guide the conversation, making the most of a finite amount of time with the participant (Jamshed, 2014). In addition, open-ended questions prompted participants to discuss core ideas, based on the research questions (Jamshed, 2014). Despite the presence of a semi-structured interview guide, participants were still given time to speak about the issues within the topic

area that were most pertinent to them, to promote partnership in the interview process, as discussed in the methodology chapter (three) (Seale, 2016). In addition, the focus of questions changed depending on developing Grounded Theory data analysis, which is explored in the remainder of this chapter.

4.5.1 Participant Recruitment

Participants were invited to interview by means of an electronic information pack sent to their work email addresses by the area manager for school nursing services in each site, making this person an important collaborator and gatekeeper to recruitment. The main benefit of this approach was the manager's knowledge of the individual study site, for example, what point in the school term should interviews be held (i.e. near the end of a term and when workload was a little less busy). In a similar way to the third-party contact obtaining data from ECRs, the researcher had little direct control over when email invitations were sent out and could only make a request. The email included an electronic invitation letter (Appendix 6), participant information sheet (Appendix 7) and consent form (Appendix 8). Potential participants were instructed to respond directly to the researcher if they were interested in taking part or wanted further information about the study. Six weeks from the initial invitation email, a second reminder email regarding the study was sent by the area manager in the same format. The area manager was asked to send invitation emails to all nurses working in school

nursing services using the manager's existing electronic mailing list, and no email addresses were shared with the researcher. As time had been invested by the researcher to provide study sites with information, in addition to offering a visit or telephone call, the area managers for school nursing were already knowledgeable and encouraging of the research. A visit was accepted by all three study sites, who invited the researcher to attend their annual school nurse study days held in May 2017 (study site one), September 2017 (study site two) and July 2018 (study site three) and this provided the school nurses with an opportunity to ask questions about the study. Many participants reflected that this aided their decision to take part in the study, as they could 'put a face to the name' of the researcher.

25 participants agreed to take part in the study and were offered a telephone call to discuss the research further, which 12 agreed to. The remaining 13 participants preferred to set up an interview via email communications. Of the final sample, ten participants worked in study site one, 12 participants worked in study site two, and three participants worked in study site three. Each site had between 30-50 school nurses working there, and it is acknowledged that school nurses who came forward likely had a prior interest in safeguarding practice and/or research (please see limitations of results in chapter ten). Participant recruitment at study site three was paused for four months between June 2017 and October 2017 as the health provider was taken over by a different organisation. The researcher had to reapply for permission through the new organisation's Research and Development (R

and D) department which caused a delay. This also influenced the lower number of participants who came forward for interview. Following re-approval of the study by R and D, a reminder study invitation email was sent to school nurses in October 2017 by the area manager.

4.5.2 Key Processes in Grounded Theory

According to literature on Grounded Theory (Glaser and Strauss, 1967; Birks and Mills, 2011; Charmaz, 2014) there are several key stages in a Grounded Theory study. These are theoretical sampling, stages of coding, constant comparison and theoretical saturation. An overview of these stages is given below, and a further discussion of how, and to what extent, these methods were applied to Stage Two of the research study. As previously discussed in chapter three (section 3.5.2) the research study was influenced by Grounded Theory and does not claim to be a purist version. This study draws on Grounded Theory principles yet is applied and operationalised in a pragmatic paradigm (Age, 2011).

4.5.2.1 Sampling

Key authors of Grounded Theory propose a concept known as 'theoretical sampling', although define this in slightly different ways (Glaser and Strauss, 1967; Birks and Mills, 2011; Charmaz, 2014). In theoretical sampling, an initial and purposive sample of participants is selected to represent a range of

characteristics appropriate to the study; such as age, gender or professional role. Thereafter, further sampling is conducted based on the needs of the data as perceived by the research team. This may include targeting apparent gaps in the data and unknown explanatory factors relating to emerging theoretical ideas. Interview participants who may contribute to solving these needs are then invited to take part in the research study (Glaser and Strauss, 1967; Birks and Mills, 2011; Charmaz, 2014).

In more traditional Grounded Theory texts, Glaser and Strauss (1967) encouraged the researcher to approach a study with little idea of who the final sample of participants might be, as this leaves the search for knowledge truly open and non-anticipatory. However, this approach was not compatible with current requirements for ethical approval and approvals from the NHS study sites, who wanted prior information about the study sample and an estimated number of participants. Indeed, the concept of 'no prior knowledge' was already challenging as the researcher had school nursing experience, had conducted a literature review and had already begun analysing data from ECRs. Instead, an approach inspired by Birks and Mills (2011) and Charmaz (2014) was taken. Gaps in the data were instead addressed by modifying the focus of the interview schedule, as explored later in this chapter. As previously discussed in section 4.2, school nursing services were initially invited to take part based on existing contacts within the research team (a convenience sample), and the final three study sites were the only organisations that felt they had the capacity to host the study. There

was on-going national re-structuring of school nursing services and some services approached at the time cited un-certainty, low morale and staffing issues.

4.5.2.2 Stages of Coding

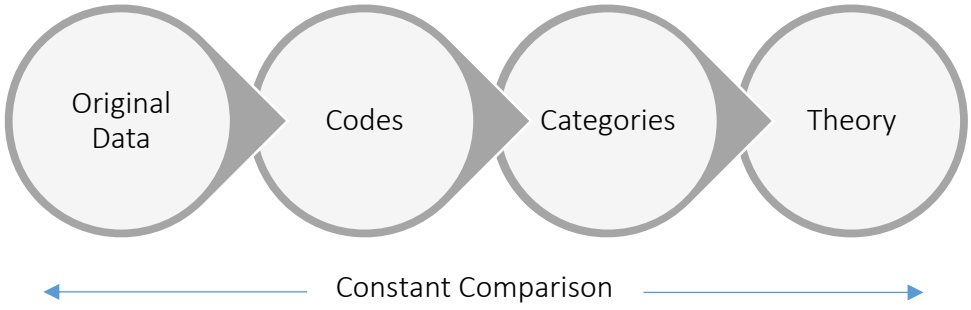
The coding technique used in Grounded Theory can be defined in two stages; initial/open coding at the beginning of the data analysis period, and focused coding for subsequent development of categories (Glaser and Strauss 1967; Birks and Mills 2011; Charmaz 2014). Initial codes are usually descriptive in nature, and can be assigned to each word, line or incident of practice (Charmaz, 2014). Focused codes use the most frequent initial codes, or those with perceived analytical potential, to synthesize ideas and present explanations for larger sections of data (Charmaz, 2014).

In this study, these distinct stages of coding were applied. There were natural breaks in data collection as the researcher was required to travel between three different areas of England, and this allowed for data analysis to take place between sets of interviews and inform the focus of the next round of interviews (for example, further exploring concepts of building trust).

4.5.2.3 Constant Comparison

In Grounded Theory, categories of data are developed by assigning codes to words, lines or incidences within the data, and then grouping similar codes together (Charmaz, 2014). During constant comparative analysis, codes are compared with each other and to the category in which they are placed, as well as to the practice incident or phenomenon they are describing in the original data (Glaser and Strauss, 1967; Birks and Mills, 2011; Charmaz, 2014). Categories are then compared to each other and this process is repeated to explore the relationships between concepts and anticipating the induction and emergence of a theory or an over-arching idea (e.g. tensions in public health versus reactive practice) (Figure 4.2).

Figure 4.2. Visual representation of constant comparison



In this way, data collection and data analysis occur concurrently and new directions for data collection can emerge (Charmaz, 2014). Later in this process, a core category may be identified which has overwhelming

explanatory power (as perceived by the research team) in relation to the phenomenon under study, and further data collection may focus on fully developing this category and related issues only (Birks and Mills, 2011). In this study, the core concepts of risk, trust and communication started to become apparent during focused coding, but moreover the tensions of working with these concepts in a reactive safeguarding and child protection role versus a public health role. A re-analysis of the data highlighted consistent tensions in decision-making on risk (to take responsibility for monitoring a child at risk versus letting go), building trust (building more intensive relationships with vulnerable children versus spending time on population prevention approaches) and building a network with other professionals (taking the lead on safeguarding cases versus protecting the public health role). These are explored in the results and discussion chapter (ten) of this thesis.

In this study, the process of constant comparison was lengthy and at times felt complex. It required complete immersion in the data for a period of 12-18 months, in tandem with ongoing interviews. The researcher went back and forth between original data, codes and categories before emergent concepts could be justified. A worked example of this process is provided later in this chapter (section 4.7.1). The first stage of coding was particularly challenging and time intensive, as there was a large amount of data from 25 interviews. This was managed by coding in stages and allowing for some periods of distance from the data to reflect on emerging ideas.

4.5.2.4 Theoretical Saturation

Theoretical saturation in a study is achieved when no new categories can be created, and existing categories are deemed to be full and rich, thus enough information exists to support the emerging theory or idea (Breckenridge and Jones, 2009; Charmaz, 2014). In this way, saturation focuses on the central theory or idea by saturating categories with the best potential for explanatory power, and fitting these into and around the core finding of the study (Breckenridge and Jones, 2009; Glaser and Holton, 2004). In contrast, Dey (1999, page 21) prefers the term *"theoretical sufficiency"* as it more accurately reflects how Grounded Theory researchers code selectively and follow one core emerging theory or idea, rather than code completely to cover all descriptive possibilities.

Interestingly, outside of research the term saturation can be defined as a state that is full beyond necessity or desirability; a saturated ground is at risk of flooding from further rainfall (Oxford English Dictionary, 2019). As theoretical sampling was not employed fully in this study, and study sites and participants were recruited in a more controlled and predicted way, the term 'theoretical saturation' was not deemed an accurate reflection of the final study process. For example, the focus was school nursing practice, but a category of 'multi-professional working' might not be fully saturated without perspectives from other professionals. Instead, the idea of theoretical sufficiency was applied (Dey, 1999), and as previously discussed (section

4.5.2.3) the later stages of coding identified the core concepts of '*risk, 'trust'* and *'communication'*. These concepts became the focus of later coding and subsequent data collection, until sufficient explanations could be found regarding the relationships, tensions and moderating factors between them. Saunders *et al.* (2018) identifies this type of approach as *"inductive saturation"* (where no new codes are appearing). Outlying opinions (of participants) relevant to these core concepts were still included, as they formed interesting comparisons to what seemed the most common ideas or practices of the school nurses involved in the study. These are incorporated in chapters seven to ten.

4.5.2.5 Data Collection

25 interviews were conducted between March 2017-January 2018. Time and date of interviews were arranged with the participant via email or telephone. Venues for interviews were booked at a location chosen by the participant, although this needed to be a local health centre to comply with lone worker safety and ethical approval of the study. All 25 interviews took place at a health centre local to the school nurses, and rooms were booked by the researcher via a telephone call with the main reception of each building. Rooms were booked in a different part of the health centre than the school nursing offices, to allow the participant to maintain anonymity from their colleagues (i.e. they didn't have to tell their colleagues they were taking part, and their colleagues wouldn't accidentally see them being interviewed). In

this study, these locations were generally quiet although they were often still in a busy health centre with some level of noise distraction. Participants often requested an interview at the end of their working day, so they were not pressured to return to work. Participants were given as much choice of time and venue as possible, in line with building good rapport (Seale, 2016). All interview locations were unfamiliar to the researcher, but it was felt this helped to level the playing field in terms of control and gave the interviewee some sense that the interview was taking place on their terms (Seale, 2016). In this way, the researcher sought to acknowledge the impression (or perhaps presence) of power imbalance that may come with an invitation to 'be interviewed' and reassure the participant of the equality of the encounter.

Prior to the commencement of interviews, participants were given time to read the participant information sheet again, sign the consent form and ask questions about the study. Interviews lasted between 40 minutes and 1 hour. The interviews were audio-taped using a digital recording device and transcribed verbatim by the researcher. At the point of transcription, all identifiable information was removed and the participant was given a code name i.e. 'P001'. Transcribing the interviews helped the researcher to become immersed in the data and set a foundation of familiarity for later coding. It was, however, an inevitably lengthy and time-consuming process.

A topic guide, developed with the supervisory team and informed by the literature review, was used to direct the interview (Appendix 9). As data were

collected from ECRs and initial interviews, the focus of the interview questions changed, for example, discussing mental health in the context of safeguarding and child protection. According to the initial topic guide, participants were first asked about their experience, background and training in school nursing. Questions were then structured in accordance with the research objectives, grouped under three broad themes; '*how school nurses identify vulnerable children and young people in school*', '*how school nurses make assessments of risk and vulnerability in safeguarding*', and '*the experiences and perceptions of school nurses regarding their role in safeguarding'*. During the interviews, notes were made by the researcher on participant responses to aid the transcription process e.g. key words and meanings. At times the speed of participant speech and noise disturbance on the audio recording could make a small number of responses more challenging to interpret in retrospect.

Between 2-7 interviews were scheduled at one time and held over a period of 2-3 days. A time period of at least two months was left between each set of interviews, allowing time for initial analysis between each group in accordance with Grounded Theory methods. Interviews were undertaken in March-April 2017, June-July 2017, November 2017 and January 2018. Organising interviews in small groups was also convenient for the researcher who travelled approximately 3 hours to the furthest study site.

4.6 Data Storage

Following each interview, the audio recording was uploaded into a secure Google Drive folder following information security recommendations at Oxford Brookes University. This allowed the researcher to check back for the original context and meaning of a participant's quote during the transcription phase. The audio was then deleted on the Dictaphone device. All audio recordings were deleted at the end of the study. Anonymous transcripts were typed on Microsoft Word and given a password to protect the file. One copy of each transcript was stored in a secure Google Drive folder, and one printed copy stored in a locked filing cabinet, along with any anonymised notes taken during the interview session. No personal information about participants was stored, apart from the correspondence emails kept on the researcher's secure university Google Mail account (later deleted). Confidentiality was discussed with participants and detailed on the participant information sheet i.e. that all information was confidential except if there was a safeguarding concern that needed raising (as described earlier in this chapter, section 4.3). Confidentiality is important in research to maintain trust, ethical processes and allow participants to express their opinions honestly; the latter point was considered particularly important for school nurses considering the current climate of low morale in the profession (Kaiser, 2009; RCN, 2016). However, advanced warnings about the parameters of confidentiality might enable the participant to censor their responses and limit the depth of findings (Yanos and Hopper, 2008).

4.7 Data Analysis

Anonymised transcripts of interviews were uploaded and managed in NVIVO 12 software. The advantages of qualitative data management software can include saving time, auditability of coding processes and the ability to sort large amounts of data (St John and Johnson, 2000). In contrast, data management software may distract the researcher from focusing on depth and meaning of data (instead, being pressured to focus on breadth and volume) and lose time spent to learn how to use relevant software (St John and Johnson, 2000). In this study, data management software was particularly useful for the initial stages of line-by-line coding, which created a large number of codes to be sorted. Transcripts were read, and then re-read, for familiarisation. Stages of data analysis (open coding and focused coding) followed the recommendations of Charmaz (2014) and her constructivist approach to Grounded Theory analysis (as below). This section on data analysis and stages of coding will follow a worked example, to present how the sub-category '*working in the grey areas'* was developed.

4.7.1 Initial/Open Coding

Once uploaded to NVIVO 12, transcripts were initially coded line-by-line using descriptive words and gerunds (verbs that act as nouns) where possible e.g. "*liaising*…" and "*perceiving*…" (Table 4.2). According to Charmaz (2014), using gerunds to code can help the researcher to remain focused on processes, and

maintaining initial codes at the descriptive level keeps the researcher close to the original meaning of the participant. A number of 'in vivo' codes were also used at the initial coding phase; where codes included the language used by the participant e.g. "*the grey area"*. Initial coding was conducted on NVIVO 12, and lines of data were highlighted before codes were stored electronically within the programme. Initial (hand-written) coding of two selected transcripts was performed by the researcher and two other members of the supervisory team and codes were discussed in a meeting. Interestingly, although slightly different approaches to coding were evident in the comparison transcripts, the core meanings extracted from the data were similar. For example, identifying tensions between the safeguarding role and other (public health) expectations in school nursing practice. Additionally, one member of the supervisory team reviewed a random selection of ten transcripts and the related initial coding in NVIVO 12. Specific training in coding for a Grounded Theory study was undertaken by the researcher with the Social Research Association (SRA) in June 2017.

Table 4.2. Initial/open coding of interview 006 participant 006

Transcript	Initial Codes
P= Err, I think that would be a good opportunity if there was further liaising with schools as to how we work, and maybe like a, you know, flow charts or a SOP [standard operating procedure], you know, something really, really clear as to *"this is what you do with these things",* clarity I suppose yeah, because it's all that grey area stuff that you find the most difficult. I= Hmm, why do you think that is? P= Well the grey area stuff, it's always grey area. I= Hmm, why do you think people find this a grey area, how would you describe that I suppose and why do you think it's challenging? P= Because safeguarding and things, some of it can be very subjective? Depending on how you view the situation, one nurse can interpret a child's views and opinions in one way, and another person in another, and it's, it's, you're assessing risk and you can have assessment tools, and you can have questionnaires, and you know, tools like that, but also it's down to your…opinion?	*Liaising with schools.* *Communicating how we work.* *Wanting written guidance.* *Wanting clear guidance.* *Finding the grey area difficult.* *Finding grey stuff always grey.* *Perceiving safeguarding as subjective.* *Viewing situations.* *Interpreting children's views.* *Having different views.* *Using assessment tools.* *Relying on opinion to assess risk.*

4.7.2 Focused Coding

The second stage of data analysis moved to focused coding, where initial codes were re-read, compared with each other and compared with the original data (Charmaz, 2014). Comparing coding in this way allowed for the

researcher to identify any tentative relationships between codes and seek codes that occurred most frequently or had more perceived analytical reach (the ability to relate to other codes in a meaningful and explanatory way) (Charmaz, 2014). Focused coding continued on NVIVO 12, and initial codes were combined under category headings. An example of focused coding is presented in Table 4.3, relating to *'working in the grey areas'.*

Table 4.3. Focused coding of interview 006 participant 006

Transcript	Initial Codes	Focused Codes	Summary	Memos
P= Err, I think that would be a good opportunity if there was further liaising with schools as to how we work, and maybe like a, you know, flow charts or a SOP [standard operating procedure], you know, something really, really clear as to *"this is what you do with these things",* clarity I suppose yeah, because it's all that grey area stuff that you find the most difficult. I= Hmm, why do you think that is? P= Well the grey area stuff, it's always grey area.	*Liaising with schools.* *Communicating how we work.* *Wanting written guidance.* *Wanting clear guidance.* *Finding the grey area difficult.* *Finding grey stuff always grey.*	*Wanting better mutual understanding.* *Seeking clarity of role.* *Needing help to navigate the grey.*	"something really, really clear as to '*this is what you do with these things',* clarity I suppose yeah, because it's all that grey area stuff that you find the most difficult." P006 "because safeguarding and things, some of it can be very subjective? Depending on how you view the situation" P006 "you're assessing risk and you can have assessment tools, and you can have questionnaires, and you know, tools like that, but also it's down to your…opinion?" P006	School nurses defined risk assessment as a grey area of practice. This encompassed the children whose level of risk was difficult to define, and those not known to specialist services. This work could also feel grey because school nurses were uncertain of their own role. Why does working with this group create professional anxiety? How do school nurses manage this sense of uncertainty?

I= Hmm, why do you think people find this a grey area, how would you describe that I suppose and why do you think it's challenging? P= Because safeguarding and things, some of it can be very subjective? Depending on how you view the situation, one nurse can interpret a child's views and opinions in one way, and another person in another, and it's, it's, you're assessing risk and you can have assessment tools, and you can have questionnaires, and you know, tools like that, but also it's down to your…opinion?	*Perceiving safeguarding as subjective.* *Viewing situations.* *Interpreting children's views.* *Having different views.* *Using assessment tools* *Relying on opinion to assess risk.*	*Relying on subjectivity to make risk assessments.*		

Focused codes were shared and discussed with the supervisory team. Focused coding occurred following periods of initial coding using constant comparison methods, as defined below. Focus codes were subsequently compared with initial codes, with other focused codes, with developing categories and with the original quotes within the transcripts. This was to ensure the focused codes remained true to the words of the participant and were refined enough to reflect the main issues surrounding the phenomenon (Charmaz, 2014). Focused coding sought to address the research objectives of the study, and therefore focused on identifying risk, assessment of vulnerable children and young people, and types of interventions. Initially, it was hoped that Stage One would provide enough detail to fully understand the interventions offered by school nurses for children at risk of abuse and neglect, however as explored later in the thesis (chapter five) this was not the case and it was necessary to examine interventions in the qualitative data. Stage One produced a generic list of interventions provided by school nursing services, and far more interventions were revealed in the narratives of participants in Stage Two, as well as the nuances behind deciding what intervention to provide and why. School nurses' experiences and perceptions of their role were integrated within the categories, including perceived challenges and opportunities. At this stage of coding, memos were recorded on emerging categories and how they might relate to each other, as well as areas that could benefit from exploration in further interviews (for example,

tensions in the school nursing role). Memos were kept electronically on the NVIVO 12 platform and in hand-written journals.

4.7.3 Constant Comparison in Application

Between each set of interviews, initial coding took place to identify gaps for exploration in further interviews. Examples of some of the main gaps identified as initial codes developed were 'thought processes behind the assessment of vulnerable children', 'conceptualising mental health as a safeguarding concern', 'dealing with emotional aspects of safeguarding work' and 'visiting children and families outside of the school environment'. These gaps were accommodated in subsequent interviews by adapting the focus of some interview questions, for example, spending a greater length of time on the topic guide section relating to the assessment of children and young people. The original interview schedule was not changed, but rather the order of questions, how questions were asked and the time spent exploring them.

In October 2017, and after the first nine interviews had been conducted, the majority of data from ECRs had been collected from Stage One of the research study (excluding some data from study site three due to time delays and a change of provider). This data from ECRs was analysed concurrently with subsequent interviews and provided a useful contextual background for further in-depth qualitative exploration within the interviews. In particular,

findings from ECRs relating to mental health interventions, interventions relating to children and young people in the 'grey' areas of vulnerability, recording of non-face-to-face tasks and evidence of collaboration with other professionals contributed to a change in focus of several subsequent interviews, to capture the experiences of school nurses around these issues in practice. This is explored further in the discussion of Stage One results (chapter five).

4.7.4 Theoretical Coding

In Grounded Theory, the third stage of data analysis is theoretical/conceptual coding, where the main concentration becomes the relationships between focused codes and how these might explain the processes or phenomenon under study (Charmaz, 2014). This has been called *"weaving the fractured story back together"* Glaser (1978, page 72). Charmaz (2014) described theoretical/conceptual coding as most challenging for the novice researcher as it raises the data to a conceptual level. She suggested looking at theories from the same discipline (i.e. nursing) and similar concepts from other fields. However, concepts such as risk assessment in the literature tended to focus on the acute nurse (in the hospital environment) or on social work practice (with a different professional remit). Instead, the researcher explored literature on conceptual coding families presented in the earlier work of Glaser (2005) as inspiration for seeking conceptual codes; a second approach endorsed by Charmaz (2014). The list of coding families, which are by no

means exhaustive, suggest different perspectives from which to view the data. An example is presented in Table 4.4, continuing the sub-category of *'working in the grey areas'*.

Table 4.4. Example application of coding families

Conceptual Family	Description	Working in the Grey Areas
Six Cs	Causes, contexts, contingencies, consequences, conditions, covariance.	Children who don't meet thresholds for specialist services; drifting, woolly, confusion and anxiety.
Process	Stages or sequences of the event.	Identifying, assessing, managing risk, and managing own anxieties.
Degree	The extent, intensity or range of the phenomenon.	Children in the grey take the most energy and focus.
Type	Different types or classifications.	*"grey is all grey"*; no significant distinctions.
Strategies	Management techniques.	Monitoring the child.
Interactive	Interactions or interdependence with another phenomenon.	Dependent on perceptions of the social care system.
Identity-Self	Identity, self-image or social worth.	These children are perceived as lost in society, hopeless.
Cutting-Point	The boundaries, thresholds or tolerance levels.	Tangible boundaries: thresholds for specialist services. Also dependent on workload, experience, emotional tolerance.
Cultural	Social norms, values and beliefs.	Many school nurses believed more children should be in care.
Consensus	Definitions; agreements or conflicts.	Mostly negative perceptions of this role, also some nurses were more active and determined to challenge thresholds.

Adapted from Glaser (2005)

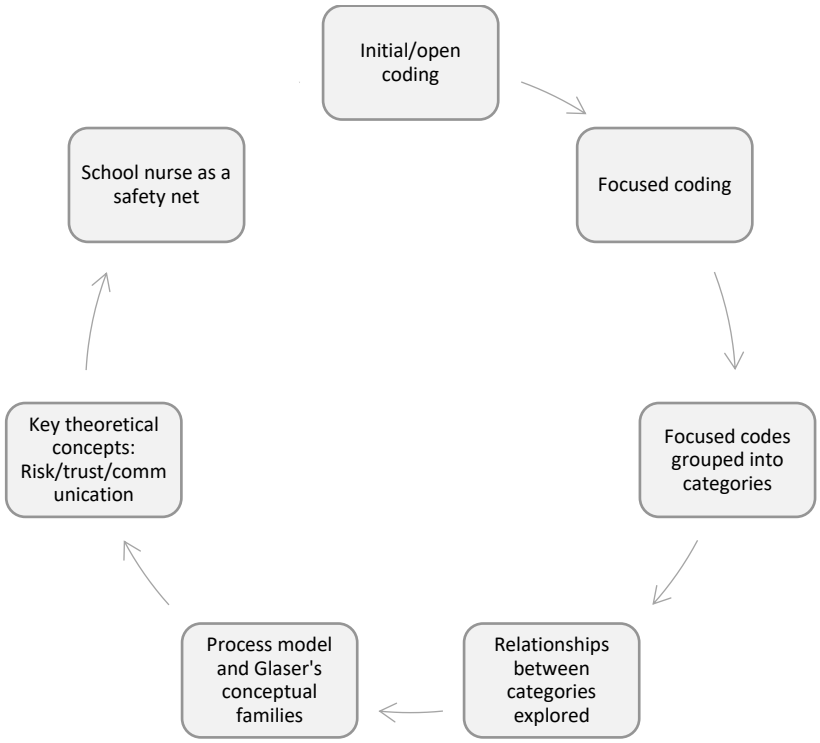
To visualise how key categories worked together, a process model of the school nurse's self-perceived journey, from identifying safeguarding concerns to creating a plan of care, was created using visual, creative methods (Appendix 10). The tensions and influences on this process were explored using Glaser's coding families (Glaser, 2005) as well as memos kept throughout the focused coding stage. The use of this creative data visualisation was in line with the researcher's visual learning style. It allowed for categories, and tensions and influences on categories, to be moved around, changed and discussed. Table 4.5 presents the final categories, and their tensions and influencing factors. This model was discussed with the supervisory team, and when finalised became the basis upon which to organise and explore the data in chapters six to ten.

Table 4.5. Final categories and tensions/influences

Main Categories	Subcategories	Tensions and Influences
Becoming aware of safeguarding concerns	Receiving referrals Receiving disclosures Checking records	Pre-conceptions of vulnerability and risk Trust Using tools and guidance
Detective work	Asking questions Requesting information Making observations Promoting holism	Time Intuition and risk Sharing information (trust) Using tools and guidance
Managing risk	Making judgements on risk Working in the grey areas Monitoring the child Challenging practice	Remote decision-making Anxiety Desensitisation Sharing information (trust)

It became apparent in this stage of data analysis that the main, over-arching concepts that weaved through the processes of identifying, assessing and working with children and young people at risk of abuse and neglect, and seemed to relate to nearly all categories, were *'risk', 'trust'* and *'communication'*. In addition, the core issue was the tensions between the school nurse being in a reactive safeguarding role and being able to take a preventative, public health approach. These key findings are discussed in the results and discussion of this thesis. A summary of the stages of data analysis are presented in Figure 4.3.

Figure 4.3. Summary of data analysis process



4.8 Critical Commentary on Improving Quality

Some qualitative research can be criticised for lacking rigour and not attending to issues of reliability and validity, although the application of such terms to qualitative research is contested (Noble and Smith, 2015; Brigette, 2017). Some (including the researcher in this study) believe that the epistemological underpinnings of many qualitative pursuits reject the notion of an objectifiable truth and embrace the potential for different perspectives on a phenomenon (Seale, 1999). This is true of constructivist approaches to Grounded Theory that are concerned with the formation of a social world and

it's encompassed truths (Charmaz, 2014). Despite this, issues of quality were considered in this study to improve the confidence with which the final results might be presented.

Lincoln and Guba (1985) proposed four types of quality in qualitative research: credibility (confidence in results), transferability (extent to which findings can be related to other contexts), dependability (the scope to repeat findings) and confirmability (neutrality of findings). The researcher, as previously discussed in chapter three, generally rejected the notion of complete 'neutrality' of research findings in favour of acknowledging positionality through reflection. Within the methods of this study, some strategies were employed to strengthen the justification of results through the development of an audit trail of NVIVO 12 data analysis files and keeping memos. In addition, the supervisory team were regularly involved in checking and comparing coding and discussing the developing categories and theoretical concepts. Discussion with the research team created opportunities to highlight previously unexamined assumptions of the researcher, such as meanings behind participant responses. Supervision of the research study took place approximately every month.

Some level of external audit (Lincoln and Guba, 1985) to address dependability was achieved through presenting the research process to the university 'Children and Families Research Group', at conferences and at school nurse training days. Member-checking was not employed (where

participants check their own transcribed interviews for meaning and accuracy), as constant comparative analysis allowed for checking of developing categories with further data collection from different groups (Elliott and Lazenbatt, 2005). In addition, some believe member-checking might introduce yet another layer of data, that can itself introduce a bias of thought and push the researcher away from any abstract overview of the phenomenon (Morse, 1998). It is possible, of course, that individual participants may not have agreed with some interpretations of their transcribed story.

Transferability is considered in the limitations of this thesis (chapter eleven), and it was acknowledged that findings were mostly relevant to school nursing practice and originated from three school nursing teams in England, selected through convenience sampling. Despite this, efforts were made in the writing of this thesis to produce in-depth descriptions of the research process, and each stage of the risk assessment model as presented in the results (chapters six to nine). As Anney (2015) writes, a 'thick' description can help the reader determine the relevancy of research findings to their own area of study or professional practice; for this study this might include other community nurses or safeguarding practitioners.

4.9 Chapter Summary

This chapter has presented the methods for Stage One and Stage Two of the research study. Stage One involved collecting data from school nurses' ECRs and provided a context for subsequent interviews. Stage Two involved semi-structured interviews with 25 school nurses, looking at issues relating to the identification and assessment of children at risk of abuse and neglect. Insights into some of the challenges of collecting and analysing secondary data from ECRs have been given, as well as the tensions of adopting an approach influenced by Grounded Theory in the current research and healthcare environment. Continuing from the application of methods this thesis will next present the results of the study.

CHAPTER FIVE: STAGE ONE RESULTS

5.1 Chapter Overview

This chapter will present the results from Stage One of the research study, which sought to understand the context of school nursing practice by collecting and analysing school nurses' ECRs. In particular, data collection focused on school nurses' electronic diaries and caseloads. School nursing caseloads across the three study sites are first compared, followed by a description of type of interventions, time spent on interventions and referrals. Limitations of the data and recommendations for Stage Two of the research study are given. Not all study sites could provide all the data requested, and a comparison of data provided by each study site is presented in Table 5.1. This is explored further in the limitations and discussion of this chapter.

The data presented in this chapter will provide an overview of the type of work school nurses were participating in across the three study sites, in relation to vulnerable children and young people. As subsequently described, the availability and quality of the data on ECRs was limited and thus comprehensive comparisons between study sites were not possible. Arguably, the most interesting finding of Stage One is how poorly this data represents the nuance and complexity of school nursing work explored in

Stage Two qualitative data, and this will become the focus of later discussions in this chapter and the thesis. This chapter becomes important as an example of collecting data from ECRs for the purposes of research study.

Table 5.1. Comparison of data request items by study site

Date Request Number	Description	Data Request Met		
		Site One	Site Two	Site Three
1	School nurse caseload	✓	✓	✓
2	Child protection caseload	✓	✓	✓
3	Child in need caseload	✓	✓	✓
4	Team around the child/family/ CAF caseload	✓	✓	X
5	Total no. of interventions	✓	✓	✓ (non/ face-to-face)
6	Total no. of safeguarding and CP interventions	✓	✓	X
7	Time spent on all interventions	✓ (average appointments)	✓	X
8	Time spent on safeguarding and CP interventions	✓	✓	X
9	Referrals	✓	X	✓ (social care)
10	Use of risk assessment tools	✓ (Child Sexual Exploitation)	X	X
11	Type and range of interventions; All	✓	✓	✓ (non/ face-to-face)
12	Type and range of	✓	✓	X

	interventions; Safeguarding and CP			

5.2 School Nursing Caseloads: Providing a Context for the Study

Data were requested from three study sites using a data request sheet (Appendix 4) sent to the IT/service management team in each organisation. The first questions on the data request sheet asked: *'what is the total school nursing caseload?*' and '*what is the total caseload for children and young people with a team around the family/child in need/child protection alert?*' This was to provide a context to the study and understand the caseload (group of children) that school nurses were responsible for in each of the three study sites. A team around the family, child in need, or child protection alert is usually displayed as an icon or a small description on the main page of a child's clinical records, to indicate that the viewing health professional should take note of an additional need. All three alerts are indicative of a multi-professional care plan being in place due to additional family safeguarding needs.

A difference in the definition of 'caseload' was found across the three study sites, as study site one held only children and young people on their caseload with whom they had direct involvement, and study site two and three held all children and young people of school-age within the county regardless of direct involvement. This created some challenges for the researcher when comparing the data from the study sites, although some key issues are

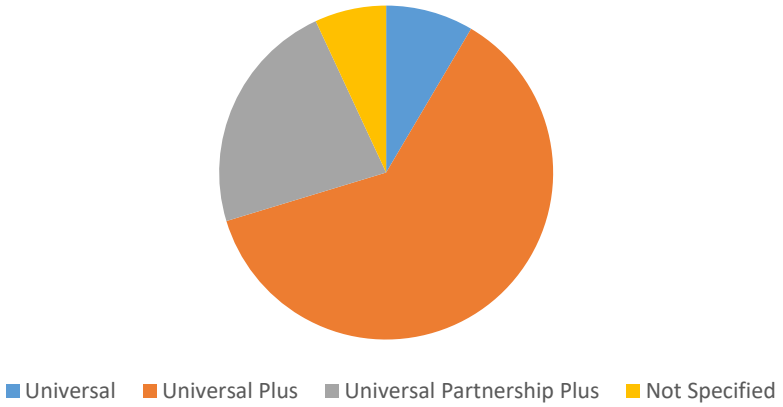
highlighted below around complexity of caseloads within study sites, and the challenges of using indicators of vulnerability within ECRs.

5.2.1 Study Site One

The total school nursing caseload for study site one was 5,813 children, of which 57% of children (n=3,303) were in Key Stage 3 (11-14 years) or Key Stage 4 (14-16 years), focusing the majority of work on young people in secondary school. The caseload was further broken down by an indicator known as universal rating (Figure 5.1). Universal rating is defined as the level of school nursing service offered to a child: *'Universal'* indicates routine activities such as immunisations or health screening, *'Universal Plus'* indicates the provision of specific interventions relating to a health need such as continence advice/emotional support/sexual health advice, and *'Universal Partnership Plus'* relates to interventions for children and young people with either a complex health need, disability or child protection planning (Department of Health and Social Care, 2009; DH, 2012). These definitions are set out in the service specification for school nursing (PHE, 2014a), and indicate the type of work school nurses may perform in relation to each level of need. In this study, much of the health education and preventative work of school nursing teams targeting whole populations of school children was defined as *'Universal'*, and one-to-one interventions with children and young people through health appointments were defined as *'Universal Plus'* or *'Universal Partnership Plus'*.

In study site one, 62% (n=3,593) of children and young people on the school nursing caseload were defined as *'Universal Plus'* and 23% (n=1,323) were defined as *'Universal Partnership Plus'*. It is important to note that the majority of children receiving routine health screening or immunisations were not kept on the caseload in this site, explaining the lack of universal representation in comparison to the above figures. There was a difference in weight within the caseload of those defined as in need of support ('*Universal Plus'*) compared to those defined as needing the *most* support ('*Universal Partnership Plus'*). This likely meant that the majority of children working with school nurses would need support, but not have a complex need such as a child protection plan or long-term health condition/disability. The idea of early intervention and working with children and young people in safeguarding before their needs became complex was raised by participants in later qualitative interviews; these children needing support, although not always defined as the most complex (PHE, 2014a), could create the greatest sense of professional anxiety.

Figure 5.1. Study site one: total school nursing caseload by universal rating



KEY

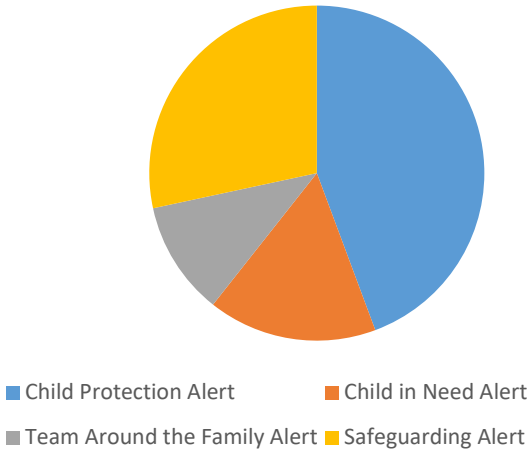
Universal: interventions provided for a population e.g. screening programme.

Universal Plus: interventions provided for individuals with an additional need e.g. health advice.

Universal Partnership Plus: interventions provided for children with a high level of need e.g. safeguarding.

Of the total school nursing service caseload in study site one, 19% (n=1,128) had a safeguarding or child protection alert (Figure 5.2). The most frequent safeguarding or child protection alert in study site one was '*child protection'*, indicating a child protection plan was in place, and 44% (n=500) of children and young people had this alert. 16% of this group of children had a child in need alert, and 12% had a team around the family alert.

Figure 5.2. Study site one: total safeguarding caseload by alert



KEY

Child Protection Alert: significant risk of child abuse/neglect.

Child in Need Alert: additional need that impacts on a child's wellbeing.

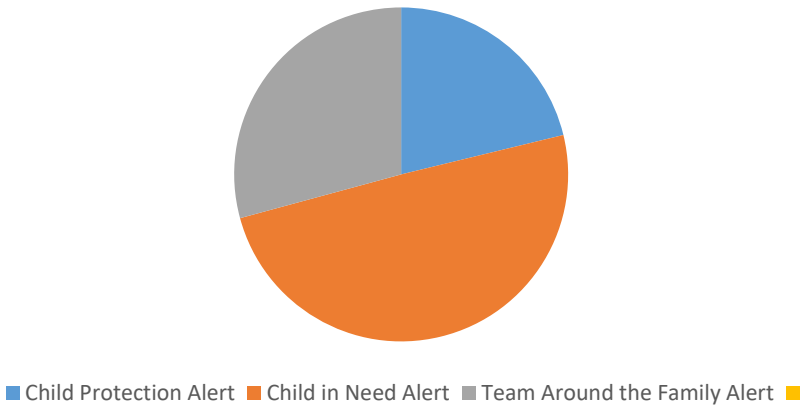
Team Around the Family Alert: family in need of multi-professional support.

The term '*safeguarding*', which 28% (n=320) of children had as an alert on their clinical records, could not be clearly defined in the record keeping guidance, and it was possible that this term could indicate children and young people on all levels of child protection planning. No other sites used this alert, but it continued to highlight the challenges of non-specific labels in data from ECRs. Despite this, a broad idea of the school nursing caseload somewhat justified that school nurses indeed had involvement with children and families of varying levels of need (as well as their public health role), and it was of interest to explore how school nurses balanced this in later interviews.

5.2.2 Study Site Two

Study site two had a total recorded school nurse caseload of 112,744 children and young people, with a range of 15,581 to 21,949 children per locality. A locality related to an individual school nursing team, usually covering the schools in one large town/city or several smaller villages. 3% (n=3,494) of the total caseload in study site two (considering this caseload related to all children and young people at school in the county) had a safeguarding or child protection alert, and of this group 21% (n=741) had a 'S47' (child protection) alert, 50% (n=1,732) had a 'S17' (child in need) alert and 29% (n=1, 021) had a 'TAF' (team around the family) alert in place (Figure 5.3).

Figure 5.3. Study site two: total safeguarding caseload by alert

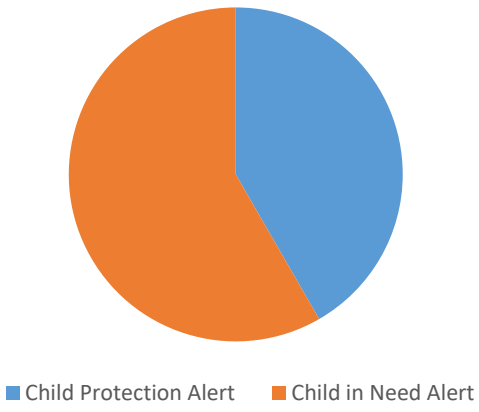


5.2.3 Study Site Three

In study site three, there were a total of 144,545 children and young people on the school nursing service caseload, with a range of 12,079 to 21,152

children per area (defined as a town and surrounding villages). A total of 1,099 children had a safeguarding alert; of which 42% (n=458) of children had a '*child protection*' alert and 58% (n=641) of children had a '*child in need'* alert (Figure 5.4). Data for children with a '*team around the child/family'* alert was not available as the site did not routinely collect this data. This was another example of the challenges of comparing data from ECRs across sites, when computer systems and ways of recording data differed. Although some alerts and labels used between study sites were similar in definition (as described in the local record keeping guidance), some alerts used in one study site were not used at all in others (such as team around the family alert) meaning there was no way to capture this data in the first place.

Figure 5.4. Study site three: total safeguarding caseload by alert



The number of children with a safeguarding or child protection alert varied between locality caseloads in study site three, as presented in Table 5.2. This was interesting to understand how a school nurse working in one locality might have a more complex caseload than a colleague working in another, such as locality 3 having less children with a '*child protection'* alert or '*child in*

need' alert than localities 1 and 2. In later interviews, and presented in the results chapters (seven to nine) of this thesis, the influence of exposure to different practice environments and how this impacted on a school nurse's belief about risk is addressed.

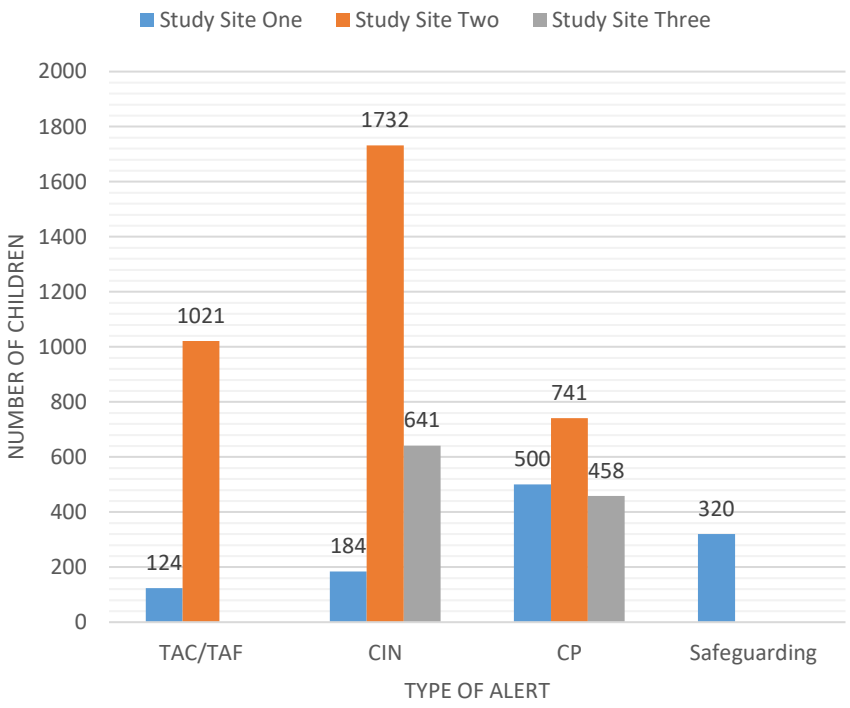
Table 5.2. Study site three: safeguarding caseload by locality

Locality	No. of Children with a Child Protection Alert	No. of Children with a Child in Need Alert
1	140	262
2	232	214
3	86	165
TOTAL	458	641

5.2.4 Study Site Comparison of Caseloads

Study site three had the highest recorded caseload number, although study site one only recorded children with whom school nurses were actively working and study sites two and three maintained all children of school-age within the locality on their caseload. This made comparing total caseloads between study sites difficult. A direct comparison of safeguarding caseloads for all three study sites is presented in Figure 5.5.

Figure 5.5. Total number of safeguarding alerts on caseload



KEY

Team Around the Child/Family (TAC/TAF): Coordination of services to support a child or family in need, usually facilitated by a multi-professional meeting.

Child in Need (CIN): A child or young person who is unlikely to have a reasonable standard of wellbeing without intervention from local agencies.

Child Protection (CP): A child or young person who is at significant risk of harm and requires support from the local authority and other services.

Safeguarding: Undefined.

As presented by the data, study site one had the greatest proportion of safeguarding and child protection alerts recorded as '*child protection*', and study site two and three had the greatest proportion of safeguarding and child protection alerts recorded as '*child in need*'.

Overall, study site one had more children and young people on their caseload needing '*Universal Plus*' support, compared to '*Universal Partnership Plus*'

(including those with a child protection alert). Whether, therefore, school nurses kept some vulnerable children on their caseload but had minimal involvement, e.g. children with a child protection plan, was an issue highlighted in subsequent qualitative interviews. Furthermore, it was interesting to explore how school nurses in some areas were shifting focus to the type of preventative work definable as '*Universal Plus*' (PHE, 2014a) in an attempt to re-claim their public health role, and to understand the tensions of this against the requirements to partake in child protection processes (such as writing reports, referring to children's social care and telephoning social workers).

Alerts and labels used on ECRs across the three study sites attempted to define vulnerability under pre-set categories, and it was interesting to compare these with much wider and dynamic definitions of vulnerability explored by the school nurses in later interviews. This supported the notion, as discussed in the methodology chapter of this thesis, that qualitative data explores the meanings and ideas behind statistics and promotes a richer understanding of the problem (Halcomb and Hickman, 2015). The following section in this chapter explores how school nursing interventions were distributed across these groups of children and young people and the type of interventions school nurses were providing as recorded on their ECRs.

5.3 What School Nursing Interventions are Offered to Children and Young People at Risk of Child Abuse and Neglect?

Questions 5, 11 and 12 of the data request sheet related to school nursing interventions, asking how many contacts school nurses provided to all children and young people, and children with a safeguarding and child protection alert (in the last academic year), and what the range and frequency of these interventions were. A school nursing intervention in this study was defined as any activity undertaken by a school nurse with a child or in relation to a child; including non-face-to-face contact such as attending a multi-professional meeting about a child's wellbeing.

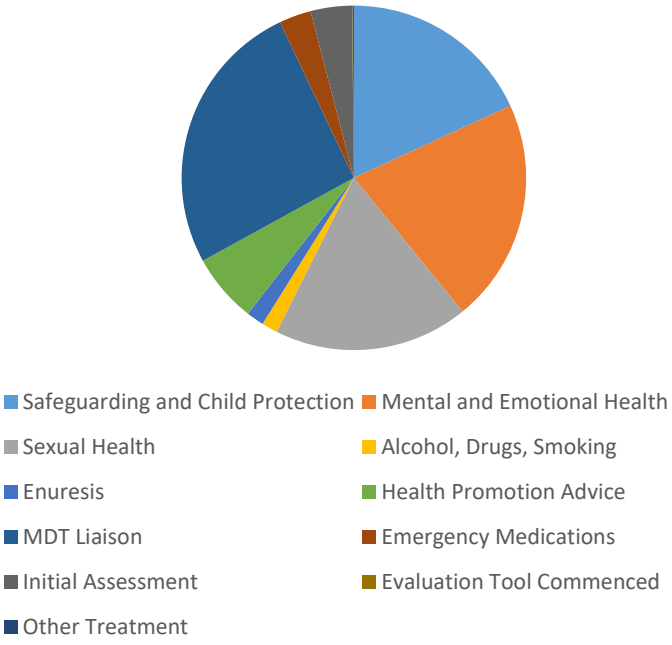
Only study site one and two could provide data on type of school nursing interventions, and the interventions were confined to those that were recorded on the school nurses' ECRs. Interventions relating to all children and young people are discussed first, to understand the remit of the service, before interventions relating to safeguarding and child protection are described. The intention of collecting this data had been to better explore the latter part of objective two of the overall research study: *'to explore how school nurses make assessments of school children aged 5-19 years at risk of child abuse and neglect, and the types of school nursing interventions offered to them'*, as well as further develop an idea of the areas of practice to explore in subsequent qualitative interviews in Stage Two.

5.3.1 Study Site One

There were 136,424 recorded interventions provided for children and young people in total during the academic year 2016/17. Interventions in study site one could be grouped into the categories: *'safeguarding and child protection', 'drugs/alcohol/smoking', 'multi-disciplinary team (MDT) liaison', 'evaluating care', 'mental/emotional health', 'enuresis (bed-wetting)', 'emergency medication', 'sexual health', 'health promotion', 'initial health assessment'* and '*other'* (Figure 5.6). The largest number of interventions related to multi-disciplinary liaison (26%, n=35,376), mental and emotional health (21%, n=28,648), sexual health (18%, n=24,928) and safeguarding and child protection (18%, n=24,740). 41% of all interventions in study site one were recorded as '*non-face-to-face'* meaning the child was not present, for example, when the school nurse attended professional meetings or wrote reports. This was perhaps not surprisingly given recent surveys on school nursing practice highlighting the burden of administrative work (Children's Commissioner for England, 2016; RCN, 2016). This also highlighted that school nurses were frequently working with other professionals as discussed in the literature review (Clarke, 2000; Paavilainen, Ästedt-Kurki and Paunonen, 2000; Schols, De Ruiter and Öry, 2013; Engh Kraft and Eriksson, 2015) and the researcher subsequently explored perceptions of multi-disciplinary working in relation to safeguarding and child protection in Stage Two of the study.

Although recorded interventions did not equate to individual appointments with children and young people (as more than one intervention could be provided at an appointment), school nurses in study site one did record more total appointments in the academic year 2016/17 (n=11,871) than in the academic year 2015/16 (n=9,524), which suggested an increase in workload. 56% (n=6,613) of these appointments in 2016/17 were for children receiving a '*Universal Plus'* service and 35% (n=4,205) of appointments were for children receiving a '*Universal Partnership Plus'* service. This reflected the caseload and concentration of work for children in need of support, but not defined (in accordance with the definition of these alerts) as in need of the *most* support (PHE, 2014a). The issue with such labels (and practice related jargon) creating *"received ideas"* and assumed meanings about vulnerability is not a new concept (Rojeck, Peacock and Collins, 1989, page 17), and thus the school nurses in Stage Two of this study discussed the tensions of their own personal ideas about children at risk in comparison to organisational thresholds.

Figure 5.6. Study site one: frequency of all school nursing interventions by type (2016/17)



KEY

Child Protection and Safeguarding: attending meetings, undertaking assessment and intervention.

Mental and Emotional Health: counselling.

Sexual Health: providing contraceptive advice, sexual health screening and pregnancy testing.

Alcohol, Drugs, Smoking: providing smoking cessation advice, alcohol and drug awareness.

Enuresis: advising on bed-wetting and providing bed-wetting alarms.

Health Promotion Advice: advice to promote health choices, for example, diet and exercise.

MDT liaison: telephoning, emailing or speaking with another professional.

Emergency Medication: training on anaphylaxis and use of adrenaline, training on buccal midazolam.

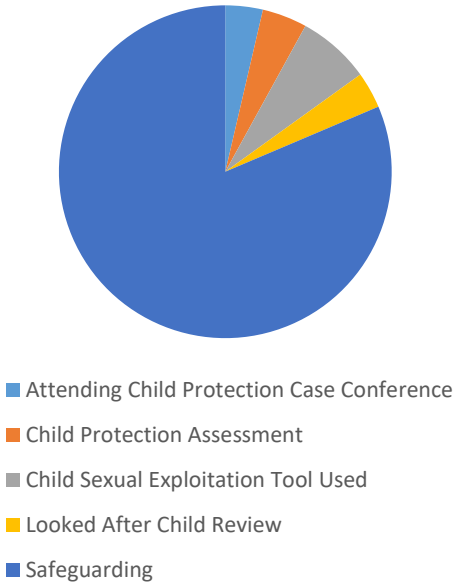
Initial Assessment: first assessment with a child or young person, for a range of health needs.

Other Treatment: other intervention not listed.

Focusing on safeguarding and child protection interventions in study site one further (Figure 5.7) it was evident that most of the interventions in this category were recorded as *'safeguarding'* (81%, n=20, 136) and this meaning was not specified in detail in the record keeping guidance. Unpacking what *'safeguarding'* really meant to school nurses was important in the Stage Two interviews. In the literature, and as discussed in the chapter one of this thesis,

safeguarding generally encompasses population-based approaches to protecting the welfare of all children and young people rather than individual children undergoing child protection processes, but is often used inter-changeably in either context (HM Government, 2018).

Figure 5.7. Study site one: frequency of safeguarding interventions by type (2016/17)



In study site one, interventions relating to undertaking health assessments for child protection (n=1,080) and looked after children (n=876), and attending conferences (meetings) for child protection planning (n=900), all equated to approximately 4% of total activity each. Again, the non-descript label of '*child protection assessment*' needed further exploration in Stage Two interviews, however, it did highlight that school nurses in this study had a role in the assessment of vulnerable children and young people. School nurses in previous research studies have discussed their role in safeguarding

assessment (Peckover and Trotter, 2014; Engh Kraft and Eriksson, 2015; Fraley, Aronowitz and Jones, 2018). The nuances of this assessment process for school nurses, as explored in Stage Two of this study, are largely not explored in published research.

The only risk assessment tool recorded on school nurses' ECRs in this study site, due to the reporting duties to commissioners in this organisation, was a child sexual exploitation (CSE) risk assessment tool which was used in 7% of all interventions (n=1,748). It was mandatory to report the use of this tool as its use was being monitored against performance indicators and surveillance of CSE work at a county level. This may suggest that the monitoring of activities on ECRs was somewhat dictated by local and national socio-political issues. This went a little way to address question 10 of the data request: *'what is the range of risk assessment tools used by school nurses to safeguard children and young people?'* which was consequently explored in interview questions in Stage Two of the study. In Stage Two interviews, school nurses were able to describe a range of risk assessment tools, both specific (i.e. designed specifically for risk assessment) and adapted (i.e. changing other tools and applying them to risk), which highlighted a large amount of unseen work not recorded on ECRs. This is explored fully in the results chapters (seven to nine) of this thesis.

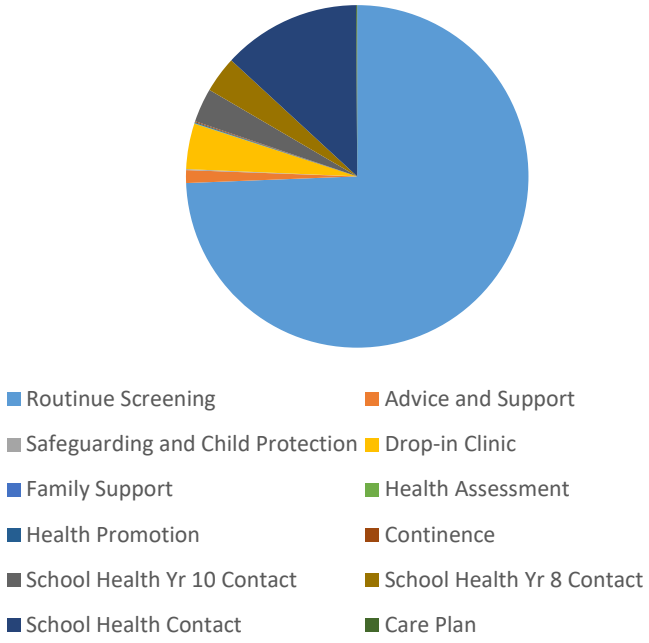
5.3.2 Study Site Two

In study site two, there were 63,550 recorded interventions in total for all children and young people during the 2016/17 academic year, with a higher total caseload number on record than study site one. Study site two had a total of 30 labels to record interventions and study site one had 31 (Appendix 5). Labels for interventions differed slightly from study site one as they used a different ECR system, but the majority of recorded interventions were for *'routine screening'* (74%, n=47,265) and '*school health contact'* (13%, n=8,289) (Figure 5.8).

According to the record keeping guidance for study site two, the label *'school health contact'* was used when a child or young person attended a one-to-one appointment with a school nurse and is another generic label that provided little detail on the content of the intervention. Routine screening can include activities such as the measurement of hearing, vision and weight (PHE, 2014a). Of the 63,550 total school nursing interventions, 4% (n=2,803) related to a child with a '*team around the family'*, '*S17'* (child in need), '*S47*' (child protection) or '*looked after child'* alert on their clinical notes. Of this group, the majority of interventions (40%, n=1,117) were provided for children with a '*S17*' (child in need) alert. This again highlighted the need to explore the focus of school nursing interventions further in Stage Two interviews, including how school nurses decided to provide an intervention for a child and how they defined vulnerability. This is discussed in chapter ten

of this thesis, and voiced definitions of vulnerability went far beyond prescriptive safeguarding labels.

Figure 5.8. Study site two: frequency of all school nursing interventions by type (2016/17)



KEY

Routine Screening: height, weight and hearing.

Advice and Support: providing advice on a range of health issues, to carers and other professionals.

Safeguarding and Child Protection: attending meetings, undertaking assessment and intervention.

Drop-in Clinic: children can attend with no prior appointment.

Family Support: providing advice to parents/carers/guardians.

Health Promotion Advice: advice to promote healthy choices, for example, diet and exercise.

Continence: advising on daytime and night-time wetting.

School Year 10 Contact: pupils aged 14-15 years.

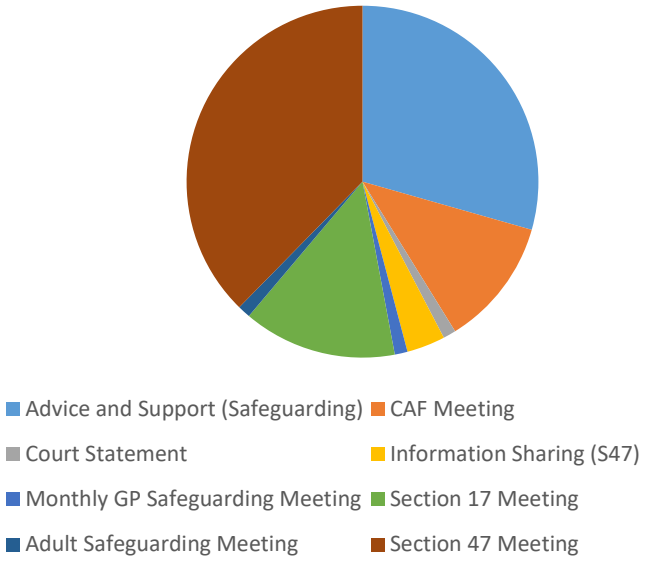
School Year 8 Contact: pupils aged 12-13 years.

School Health Contact: unspecified face-to face intervention with the school nurse.

Care Plan: a written document to support children and young people with a medical condition in school.

Focusing on the safeguarding and child protection processes in study site two (Figure 5.9), the recorded data presents a surprisingly low amount of this type of work compared to other study sites, however the majority related to attending conferences for child protection planning (38%, n=32) and providing follow-up advice and support for safeguarding concerns (29%, n=25).

Figure 5.9. Study site two: frequency of involvement in child protection processes (2016/17)



The total number of activities for this period was n=85. After discussion with a service manager for school nursing within the organisation, no reason for this low representation of safeguarding work could be given except, tentatively, recording error i.e. nurses were recording these interventions with the wrong labels that were not routinely collected to form school nursing activity reports. It is important to note that several of the less frequent

interventions, for example '*adult safeguarding meeting'* had an occurrence of '1' during the 2016/17 academic year, but it was not possible from the record keeping guidance to discern if this was a recording error that could be excluded. Relying on a third party to run system reports, as discussed in the methods chapter (four) of this thesis, made it particularly challenging to identify if seemingly unusual results in the data were attributable to an error at the point of record keeping, or even an error at the point of running the data collection reports on ECRs (Castillo *et al.* 2015; Connelly *et al.* 2016). This was because the researcher was not collecting this secondary data first-hand and relied on remote liaison with a key contact in the IT/service management team.

5.3.3 Study Site Three

Study site three provided data on the number of contacts school nurses had with all children and young people in the previous three months from February-April 2018 and compared figures for face-to-face contacts (directly seeing the child) with non-face-to-face activities (defined as record keeping, administrative work or attending a professional meeting). There were 2,627 face-to-face contacts (26%) with children in this period, and 7,619 non-face-to-face activities (74%) (Table 5.3).

Table 5.3. Study site three: comparison of contact type February-April 2018

Type of Contact	Number of Contacts
Face-to-Face	2,627
Non-Face-to-Face	7,619
TOTAL	10,246

As in study site one, where non-face-to-face interventions made up a large proportion of annual workload in 2016/17, school nurses in study site three were involved in administrative tasks such as writing reports and record keeping. How they balanced this with direct contact with vulnerable children and young people was explored in later qualitative interviews, addressing issues such as the importance of visibility versus the importance of completing organisational tasks in safeguarding practice.

5.4 How Much Time Do School Nurses Spend on Interventions?

In relation to time spent on interventions this was asked in question 7 and 8 of the data request sheet, to understand the average total time spent on interventions relating to all children, and children with a safeguarding or child protection alert, by the school nursing team in the previous academic year. The intent was to understand how school nurses focused their time between vulnerable children and the wider school population. Only study sites one and two could provide data relating to this request, although comparisons across

the sites were challenging due to the difference in caseloads (i.e. study site one only had children with whom school nurses had direct involvement, study site two had the whole school population).

Study site one was able to provide the average time spent on appointments relating to levels of service, with the longest appointments (average 51 minutes) provided for children in '*Universal Partnership Plus'*, compared to 37 minutes for '*Universal Plus*' interventions and 34 minutes for any *'Universal'* interventions. This suggested, despite the higher number of interventions offered to children in need of *'Universal Plus'* support, that interventions with children in need of a (higher) '*Universal Partnership Plus'* support (including children with a child protection plan) were, on average, more time intensive. In study site two, approximately 8,600 hours were spent in total on interventions with all children and young people during the 2016/17 academic year; 4% of this time (approximately 350 hours) was spent on children with a '*S17*' (child in need) alert, 4% (approximately 320 hours) with a '*S47'* (child protection) alert, and 2% (approximately 140 hours) with a *'Team Around the Family'* alert. The time intensity of working with the most vulnerable children was reflected in qualitative interviews in Stage Two, where school nurses discussed the time-intensity of child safeguarding assessments and related interventions, and the idea of unseen *"shadow work"* (work not collected by administrative systems) is explored (John and Parsons, 2006, page 266).

5.5 What Referrals to Other Services Might School Nurses Make Within Their Safeguarding Work?

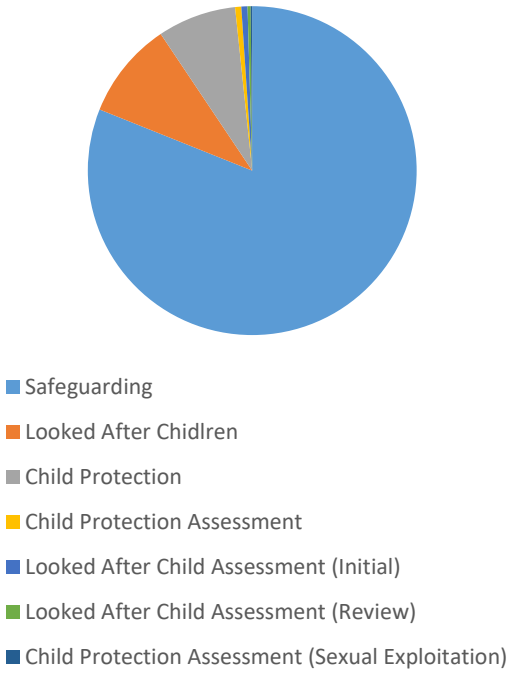
Some school nursing activity related to making referrals to other agencies, and this information was requested in question 9 of the data request: '*What is the total number of referrals made to social care by school nurses in the last academic year?*'. Although the original data request sheet only asked for referrals relating to social care, referrals to other agencies were included in the results that were returned from study site one and two, due to the way in which the ECR systems ran reports. Additionally, some results included information on referrals made *to* school nursing services. Study site three only provided information relating to school nurses' referrals to children's social care.

5.5.1 Study Site One

In study site one, school nurses had a total of 5,813 children on their caseload. Most children and young people were referred to school nursing for routine services such as '*screening*' *(*35%, n=2,062), for '*advice and information'* (21%, n=1,221) and for '*safeguarding and child protection'* (21%, n=1,236). Focusing on the n=649 referrals made to school nursing for safeguarding from other services (other referral made by the school nurse themselves or from the child's self-referral) during the 2016/17 academic year, 82% (n=535) were referred for unspecified *'safeguarding'* input, 8% (n=51) for input

relating to *'child protection'* processes, and 10% (n=63) for input relating to being '*looked after'* by the local authority (Figure 5.1.0).

Figure 5.1.0. Study site one: frequency of safeguarding referrals by type from other agencies (2016/17)



Study site one was the only organisation that provided data on onwards referrals made by school nurses to agencies other than children's social care. In the 2016/17 reporting year school nurses made a total of 1,182 referrals to other agencies which had decreased from 1,748 in 2015/16. It was not possible from quantitative data to ascertain the cause of this, but school nurses in Stage Two discussed increasingly negative perceptions of thresholds for specialist agencies. Most referrals in 2016/17 were made to GPs (29%, n=346), sexual health services (18%, n=208) and mental health services (18%,

n=208). In 2016/17 7% (n=87) of referrals related to safeguarding and child protection, and this was made up of referrals to the multi-agency safeguarding hub (MASH), social care, early intervention services, the local trust safeguarding board and the CSE service. This percentage had decreased from 10% (n=179 referrals) in 2015/16. This data provided a broad indication of some of the professionals with whom school nurses were working on a regular basis; how school nurses worked with other professionals in relation to managing risk and gathering information was explored in Stage Two interviews. Previous literature suggests that relationships with other professionals are important in safeguarding process, although tensions can exist when inter-agency ideas about risk differ (Alizadeh, Törnkvist and Hylander, 2011; Engh Kraft, Eriksson and Rahm, 2016).

5.5.2 Study Site Two

In study site two, there were 28,049 interventions during 2016/17 for children and young people who had not been seen previously by school nursing services (defined as '*new contacts*'), with 96% (n=26,867) of these interventions resulting from referrals for routine school health services. The second largest categories of referral were children moving in from another area (2%, n=492) and children under child and family services e.g. children's social care (1%, n=284). Study site two also provided information on the source of referrals to school nursing by profession. It was evident that most interventions for children seen for the first time in 2016/17 resulted from

referrals from the '*child health'* department (91%, n=25, 407) for routine services such as screening and immunisations, and from '*educational establishments'* (8%, n=2, 308). Study site two did not collect data on referrals to social care, presenting a challenge when comparing their involvement in making referrals with other study sites. It was interesting that study site two seemed to hold much more data on routine screening contacts on ECRs (although this screening data were stored elsewhere in study site one), yet they held little detail on safeguarding and child protection interventions. This highlighted the design of ECRs for administrative purposes rather than to answer in-depth research questions (Castillo *et al.* 2015; Connelly *et al.* 2016; Cowie *et al.* 2017).

5.5.3 Study Site Three

School nurses in study site three had a role in referring children and young people at a perceived risk of abuse or neglect. In study site three, there were 111 referrals made to children's social care in the previous reporting year 2016/17. This equated to approximately nine referrals per month, on average. How school nurses made these referrals, and their experiences of referring to other safeguarding agencies, is explored in the results chapters (seven to nine) of this thesis

5.6 Limitations of the Data

Obtaining data from ECRs had several anticipated limitations and despite attempting to plan for these, some of the results highlighted the challenges of using a system not designed for research purposes. Arguably, if school nursing services are going to be examined and compared nationally, and want to evidence what they do, consistent and comparable ECR systems may be important. In this study, each study site used a different ECR system and the researcher relied on the IT/service management team to interpret the data request and find the 'best fit' item of data to collect. There was a difference in the size and definition of the term '*school nurse caseload'*, with study site one only holding children and young people with whom they had direct involvement, and study sites two and three holding all children and young people within the locality. This made comparisons somewhat challenging.

The data presented a presence of possible recording errors, such as interventions having a frequency of '1' during the academic year. In addition, the ECRs data used many non-descript labels, which included the term '*safeguarding'* used to define caseload alerts, interventions and referrals in study site one. In study site two, the general term '*school health contact*' equated to a significant number of interventions and could cover a whole range of activities from emotional support to sexual health advice. This highlighted the importance of the qualitative data collected through school

nurse interviews in Stage Two, to explore the content and meaning of such interventions in greater depth.

Despite offering several consultations to the IT/service management teams, not all organisations could provide the full data set on the original request as the ECR system was not sensitive enough. The system either did not record the level of detail needed to answer the specific item in the data request, or it was not possible to run a report on the system to collate the information required. This was particularly an issue in study site three, where it was not possible to collate data on the type of school nursing interventions in much detail, such as sexual health or mental health contact. In addition to lack of sensitivity of the ECR system, the organisation felt it was too time consuming to work out how they may alter the ECR system in order to run these reports, due to long-term staff sickness. Issues with staffing and resources is not unusual in a busy healthcare organisation (RCN, 2016).

5.7 Discussion and Summary of Recommendations for Stage Two

Stage One has provided some overview of the activity of school nurses with vulnerable children and young people across the three study sites and data collected from ECRs highlighted a number of contextual factors that were explored in subsequent interviews in Stage Two of the research study. Importantly, the process of collection and analysis also raised issues regarding the quality of ECR data when used for research purposes, despite

arguments for its use apparent in the literature (Castillo *et al.* 2015; Connelly *et al.* 2016; Cowie *et al.* 2017). Inconsistencies in the data (i.e. from recording error, or use of different ECR systems) meant comparisons between study sites were not possible, and in many cases comprehensive understanding of any one issue, such as time spent on different school nursing activities, was limited in scope. The consequences of these limitations for the current study meant Stage One developed into a smaller, supplementary chapter for later qualitative findings. In the wider scope of school nursing practice and service development, this has consequences for the representation of complex safeguarding work to both commissioners (who often rely on administrative data from ECRs to evaluate services) (PHE, 2014a) and for school nursing research with ECRs.

With a focus on interventions that were highlighted in the data, mental health interventions formed a significant proportion of total interventions in study site one, perhaps reflecting the county-wide trend of increased requests for mental health services for children and young people. Considering also the national trend in increasing demand for child and adolescent mental health services (Earle, 2016), it was important to explore with school nurses in subsequent Stage Two interviews, how they feel mental health care fits into the wider safeguarding role. In chapter seven of this thesis, mental health concerns are a key indicator of a child's vulnerability, particularly considering self-harm and suicidal ideation.

In study site one, just under half of all appointments during the 2017/18 academic year were for *'non-face-to-face'* activities, meaning the child or young person was not present, and these included professional meetings and record keeping. In study site three, the majority of recorded activities in the period February-April 2018 were '*non-face-to-face'*, encompassing record keeping, administrative work and professional meetings. Recent surveys by the Children's Commissioner for England (2016) and the RCN (2016) found that participating school nurses spent a significant amount of time on record keeping and other *'non-face-to-face'* activities relating to safeguarding and child protection work. It was therefore of interest to explore time-management and the balance of direct contact with children with school nurses in subsequent Stage Two interviews, as previous research highlighted the importance of being visible and accessible in school for children and young people to make safeguarding disclosures (Engh Kraft and Eriksson, 2015).

The most frequent destinations for school nursing onward referrals in study site one were GPs, sexual health services, mental health services, and children's social care. Study site one and study site three recorded total number of referrals made to social care which confirmed that school nurses had a role in making referrals for safeguarding concerns; this data provided little information about the experience of making these referrals. Exploring the relationships with other agencies in safeguarding in Stage Two highlighted how these relationships were built and how communication was

achieved, which is an important priority to support safe practice (HM Government, 2018).

In study site one, a greater number of total interventions and total appointments were provided for children and young people with a *'Universal Plus'* service level, which indicated a child had an additional health or safeguarding need, but was not as complex as '*Universal Partnership Plus'* (including children and young people with a child protection plan). This was perhaps due to the smaller number of children requiring '*Universal Partnership Plus'* interventions; one would hope that early intervention professionals could support these children well and their need would not escalate to such a level (DH, 2012; HM Government, 2018). Yet there were more children and young people with a '*child protection'* alert, compared to *'child in need'* or *'team around the family'* alert in this study site; '*Universal Partnership Plus'* encompassed children undergoing child protection planning, but also other children with complex health needs (PHE, 2014a). Alternatively, it is known from the literature that professionals (such as nurses) may find those children and young people below a certain threshold of need more worrying and may concentrate their interventions on this group, who are often without a social worker or other specialists (Appleton, 1994; Rooke, 2015; Wallbank and Woollacott, 2015). Despite a lower frequency of interventions, individual appointments with children with a *'Universal Partnership Plus'* level of service took (on average) 14 minutes longer than appointments with children under '*Universal Plus'*. This perhaps

suggested that appointments with this group (which could encompass more than one intervention) were more complex and time-intensive in nature. School nurses' perceptions and experiences of working with children on different levels of child protection planning, as well as those not known to social care, were explored in qualitative interviews with school nurses in Stage Two of the study.

In study site two, the greatest number of safeguarding and child protection alerts and interventions related to children under '*S17*' (child in need), rather than the higher risk '*S47*' (child protection). In study site three, there were also more safeguarding and child protection alerts in relation to children who were '*child in need*' compared to children who were on '*child protection*' plans. In study site two and three it was possible these figures simply reflected actual child protection plans ongoing in the county at the time and did not indicate the level of involvement of the school nurse. However, it is known from research with health visitors and other nurses in community settings, that health professionals may feel a greater responsibility to monitor children and young people who do not meet the threshold for high-level social care involvement (Appleton, 1996; Rooke, 2015; Wallbank and Wonnacott, 2015).

In study site two, the presence of ECR data on universal screening activities, versus the presence of some data to describe safeguarding activities, suggested a school nursing role that encompassed a broad range of care

activities. For example, a role that had to record data on national screening programmes for a whole population of children and young people, and at the same time record data on complex work completed with the individual child, such as referring to specialist services and undertaking CSE screening. How school nurses managed a role that seemed to expect such proactivity and reactivity simultaneously was explored in later qualitative interviews, considering issues around role clarity and defining the role of the school nurse (Redekopp, 1997; Hackett, 2013).

5.8 Chapter Summary

This chapter presented a challenging yet illuminating process of collecting ECR data for the purpose of research, and the implications of the limitations of this data for school nursing research and service development have been emphasised. The collection of data from ECRs went some way to address research objective two: '*to explore how school nurses make assessments of vulnerable children and young people, and the types of school nursing interventions offered to them'*. This was achieved by identifying the range and frequency of interventions school nurses undertook in one academic year according to their clinical diaries and caseloads on ECRs. Data from ECRs also provided some contextual understanding of the school nurse practice environment, particularly regarding the size and complexity of caseloads. Data from ECRs informed some of the later interviews, addressing research objective three: '*to explore the experiences of school nurses in identifying and*

working with school children aged 5-19 years at risk of child abuse and neglect: including the perceived challenges and opportunities of their role'. Use of risk assessment tools for identifying vulnerable children were not routinely recorded on ECRs, and thus qualitative interviews addressed research objective one in greater depth: *'to explore the processes through which school nurses identify school children aged 5-19 years at risk of child abuse and neglect'.*

CHAPTER SIX: STAGE TWO RESULTS

6.1 Chapter Overview

This chapter will introduce the results of semi-structured interviews conducted with 25 school nurses in Stage Two of the study, in relation to the core process of assessment of children and young people at risk of child abuse and neglect. As discussed in the methods chapter (four) of this thesis, the focus on processes (including social transactions and relationships) is congruent with a Grounded Theory approach (Charmaz, 2014). The presentation of this core assessment process sets the context for later chapters (seven to nine) which look at each stage in-depth. In addition, this chapter will introduce concepts of risk, trust and communication that became apparent in interviews and are referred to in the discussion of findings.

The results from all three study sites are presented together as school nurses shared similar experiences in the identification of possible safeguarding concerns, and their actions to gather further information following this. As highlighted in the methods chapter (four), data were analysed together and comparisons between study sites were not conducted as the sample of nurses between study sites one, two and three were different (10, 12 and 3 participants respectively). The qualitative results of this study addressed all three research objectives: *'to explore the process through which school nurses*

identify school children aged 5-19 years at risk of child abuse and neglect', *'to explore how school nurses make assessments of school children aged 5-19 years at risk of child abuse and neglect'*, and *'to explore the experiences of school nurses in identifying and working with school children aged 5-19 years at risk of child abuse and neglect: including the perceived challenges and opportunities of their role'*.

6.2 Sample Characteristics

Questions were asked at the beginning of the interviews about the training and background experience of participants, their description of their geographical area of practice, any specialist roles in safeguarding (such as involvement in SIGs or as named champion for a safeguarding issue) and their self-identified involvement in supervision. These initial questions served as 'ice-breakers' but also helped the researcher to understand the variation of these factors within the sample. It is important to note that data were not analysed in comparison to these factors, but it was hoped that variation in school nurses' skills, knowledge and experience would create different stories from practice. Participants working in different geographical areas would bring contrasting narratives of working with children, families and the wider community.

25 school nurses agreed to participate in the study, all of whom were female. This of course meant that no views of male school nurses were captured in

the research, although there were in fact no male school nurses employed in any of the three study sites. The school nurses' experience of working in a school nursing service ranged from three months to 27 years, and the impact of experience is highlighted in later discussions on risk sensitivity (section 6.6). Two participants were team managers and two were practice educators, responsible for training nurses undertaking the year-long postgraduate diploma in Specialist Community Public Health Nursing (SCPHN). 14 participants were working at (NHS) agenda for change band 6 as school nurses, having undertaken the diploma. Seven nurses were working at (NHS) agenda for change band 5 as school staff nurses. Both grades of nurses were included as they shared a professional duty to identify and report child abuse and neglect and were involved in child protection processes.

Nine school nurses described their entry-level nursing qualification as adult nursing, ten described this as paediatric nursing, two as general nursing, one as prison nursing, one as learning disability nursing and two had initially trained as midwives. This meant that participants came from different backgrounds and training experiences, and consequently had their own specialist areas of interest. All participants reported taking part in clinical supervision on a regular basis. This was an opportunity to discuss any complex safeguarding or child protection issues with colleagues and a trained clinical supervisor or specialist safeguarding nurse (Wallbank and Wonnacott, 2015). The format of supervision sessions differed slightly, ranging from individual to group supervision, meaning that school nurses in some areas had a more

intensive, one-to-one supervision and review of their safeguarding work. Most participants had supervision every 6-8 weeks, which is discussed in relation to support mechanisms in later chapters (seven to nine). Four participants were trained to be clinical supervisors and delivered group supervision sessions themselves, meaning they had a particular vested interest in this topic. Five participants sat on special interest groups (SIGs) around safeguarding issues, such as domestic violence, to develop resources and pathways of care with nursing colleagues from the community. Three participants were individual champions in their organisation for specified safeguarding issues, such as FGM; the main purpose of this role was to represent school nursing at training events and disseminate learning. These varying levels of experience, clinical background and specialist interests contributed to a rich data set.

6.3 School Nursing Practice Across the Three Study Sites

School nurses across the three study sites worked in teams, mainly consisting of school nurses (band 6), school staff nurses (band 5) and school nursing administrative assistants. There were two distinct types of working noted. School nurses in study sites two and three were assigned to a group of schools, usually 1-2 secondary schools and the surrounding primary schools, and shared the workload between them as a 'corporate caseload' i.e. one band 6 school nurse and one band 5 school staff nurse per group of schools. In study site one, band 6 school nurses were assigned to one secondary

school each, and a smaller group of band 6 school nurses managed the primary schools alongside the band 5 school staff nurses. This meant school nurses had slightly different challenges when discussing issues in Stage Two interviews, including managing time and building relationships (across multiple schools). The role of the school nursing administrative assistants ranged from office management to clinical tasks such as weighing and measuring children, but their role did not include child protection work (i.e. attending child protection meetings or writing reports).

In all study sites, the reported remit of school nursing work was similar, and included immunisations, sexual health advice, mental health support, diet and exercise advice, smoking cessation, drug and alcohol awareness and safeguarding/child protection. This was in-keeping with the government directed health promotion and public health remit discussed in chapter one (PHE, 2014a; DH, 2015). School nurses who looked after a group of schools managed many of these tasks by running set drop-in sessions within schools each week, for example, every Tuesday and Thursday lunchtime. School nurses who only looked after one school were based there almost daily. This highlighted how some school nurses were able to be more visible and available to school pupils, and thus discussed different challenges in later results chapters (seven to nine) in relation to building trusting relationships (rather than not physically being in school).

Most school nurses maintained an office base as well as a working room in school and were often required to travel around the county for training and child protection meetings. In all three study sites, each group of school nurses divided within a county had an area team leader without a clinical caseload, and an operations or service manager. All three study sites were impacted by staff sickness, maternity leave, and vacant posts, so there were many deviations from the norms described above, with several school nurses covering additional schools to bridge the gap. This was likely to have influenced their perceptions of the pressures of school nursing and how they felt about their caseload.

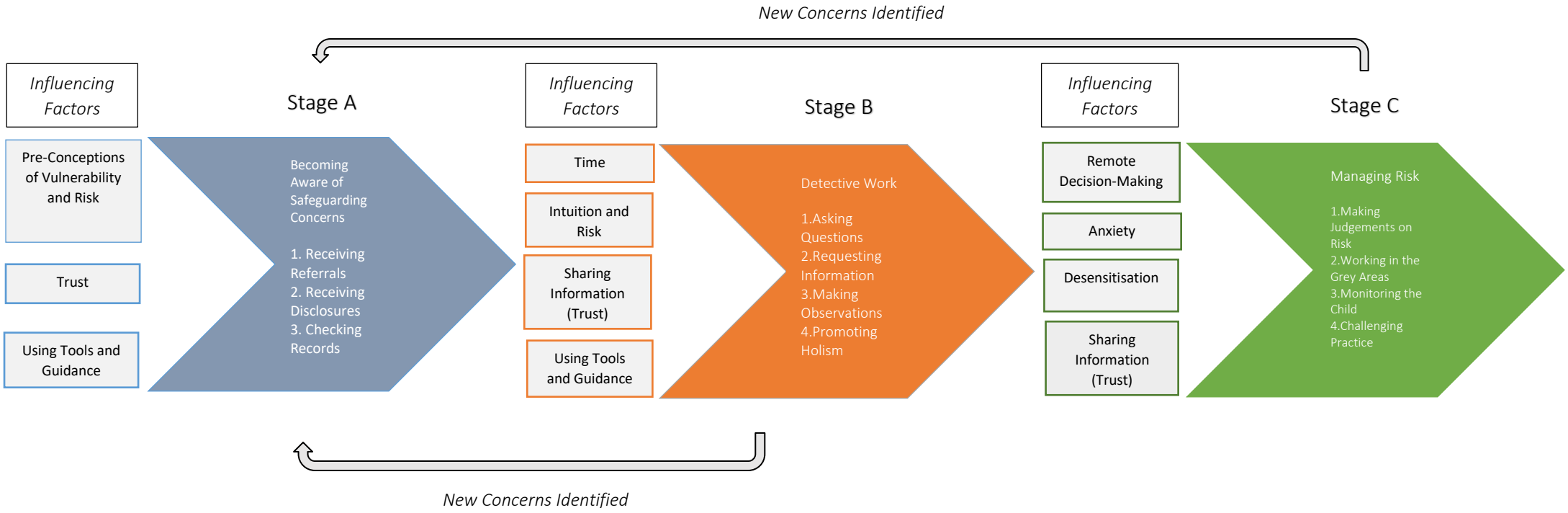
6.4 Modelling the Process of Risk Assessment

Analysis of qualitative data from 25 semi-structured interviews in Stage Two of the research study identified the following *'process model of risk assessment in school nursing practice'*. The process model maps the stages of identifying and working with children at risk of child abuse and neglect, as described by the participants. This shapes the presentation of findings within which the threads of risk, trust and communication emerged as important. It serves to present the findings of this study in a way that common ideas (such as *'working in the grey areas'*) and challenges (such as communication) are highlighted and recommendations can be directed towards specific processes within school nursing practice. The model presented here is a formalised version of the creative 'mapping' exercise described in chapter

three and included in Appendix 10. This was completed following focused coding (Charmaz, 2014) to visualise how key categories worked together and to understand the school nurse's self-perceived journey, from identifying safeguarding concerns to creating a plan of care. In this way, the identified model was developed from constant comparison analysis of the data.

The identified process model is presented in Figure 6.1, with three key stages: *'becoming aware of safeguarding concerns', 'detective work'* and *'managing risk'*, which are written as three subsequent chapters (seven to nine) in this thesis. Presenting this model before the data in findings chapters guides later in-depth explorations of each stage and how they relate to school nursing practice. This also sets the context for chapter ten, which discusses the school nurse as a 'safety net' and the tensions of fulfilling this role against a remit of public health expectations.

Figure 6.1. The identified process model of risk assessment in school nursing practice



School nurses first became aware of safeguarding concerns either through direct contact with the child or young person, a professional or parent raising a concern, or through checking electronic and paper records (for example, hospital letters). A consequential process of gathering additional information regarding the history and context of the safeguarding concern has been termed *'detective work'*, borrowing the 'in vivo' term used by several of the school nurses interviewed. The final stage of the model is concerned with the processes of risk analysis and decision-making, with a decision about a safeguarding concern normally resulting in a referral to social care, a referral to another agency and/or the provision of a school nursing intervention.

Each stage of the process model has several influencing and moderating factors that will be explored in chapters seven to nine. Influencing factors were issues that formed a pre-requisite to the main process taking place or changed how the nuances of the process might work. The three main stages of the model are the central foundation upon which these deviations or variations to the process occur. For example, each stage could be moderated by the strength of relationships with key stakeholders (i.e. the child, the family and other professionals), previous knowledge, experience and beliefs of the school nurse, and access to an outlet for professional anxiety, such as peer support and clinical supervision.

For the purposes of the thesis the model has been discussed as if it were a linear process, with school nurses always moving through stages A, B and C

in order. This enabled each stage to be described in-depth. In the reality of school nursing practice as described by participants, this process was often more complex, as new concerns emerged during detective work and existing concerns about risk were alleviated or perpetuated with additional knowledge. During any of the core activities involved in *'detective work'*, school nurses might identify new safeguarding concerns which would lead them back to the first stage of the model: *'becoming aware of safeguarding concerns'*. New concerns might be identified through asking questions of the child, family and other professionals, or through observation of the child at school or in the home environment. During the management of risk over time in Stage C, particularly in cases where school nurses were monitoring vulnerable children and young people, an escalation of concerns might occur, or new information revealed, which would trigger a repeat cycle of becoming aware, conducting detective work, and managing risk in the light of refreshed knowledge.

Despite some differences in school nursing caseloads (i.e. looking after one school versus looking after many), and differences in experience and nursing background, most school nurses within the sample followed this risk assessment process with little variation. There were some small differences in the way individual school nurses took part in each stage, dependent on influencing factors such as *'time'* and *'anxiety'*. In addition, the extent to which individual school nurses became immersed in each stage was dependent on how they saw their role generally, and this is explored in

chapter ten discussions on the tensions between their safeguarding/child protection and public health role. For example, some participants felt that the school nursing role was becoming more akin to a social worker, and thus felt that monitoring (beyond the occasional contact with a child or young person) was not always appropriate.

6.5 Concepts of Risk

Definitions of risk in this thesis are drawn from bodies of literature that discuss risk in safeguarding as dealing with multiple chances; the chance of abuse or neglect, the chance of abuse or neglect re-occurring, the chance of parents not taking action and the chance of long-term negative impacts to the child or young person (Daniel, 2010). Another broad definition of risk by Alberg *et al.* (1996) highlighted two components; (1) the weighing up of a perceived positive or negative outcome attached to a specific event, and (2) the likelihood of either happening. Findings from this PhD study generally support a continued move from neutral definitions of risk to negative definitions of risk that might contribute to anxiety and defensive practice within safeguarding culture (Lupton, 1999; Munro, 2007).

"Policing boundaries" was a term coined by Lupton (1993, page 425) to discuss the ways in which individuals and groups deflected risk to themselves; but school nurses also police boundaries on behalf of children and young people, and in doing so sometimes intrude on the private sphere of family

life. School nurses, as employees of a health organisation commissioned by local government, might not be in a position to act outside of socio-political definitions of risk (Perron, Fluet and Holmes, 2005). Despite their school nursing practice being structured and supported by their wider organisation, participants in this study felt the nuances of decision-making about risk were often managed alone, as explored in chapter nine.

The term *"risk society"* defined by Beck (1992, page 40) was concerned with a shift in global societal attitudes about risk. Whereby communities were once focused on the sharing of social good, such as financial capital and other resources, a shift occurred in modern civilisation to become obsessed with the study and distribution of dangers (Beck, 1992). Therefore, communal decisions became calculated on the basis of risk and danger. Globalisation, although bringing many benefits, opened up societies to new fears, including pollution, terrorism, and a loss of local tradition (Beck, 1992). With the erosion of traditional, close-knit communities, managing risk moved from being a collective community responsibility, to an individual responsibility; the individual must make daily decisions based on a wider range of chances (Beck, 1992; Tulloch and Lupton, 2003). A common critique of Beck's theory is the lack of empirical evidence (Tulloch and Lupton, 2003; Olofsson and Öhman, 2007); moreover the decisions made by the individuals in this study (i.e. the school nurses) were not only dealing with a risk to themselves, but a risk to another person (the child) for whom they were professionally responsible.

The fear attached to making decisions about chances in safeguarding can be influenced by anxieties about blame culture and a fear of making mistakes; an idea that seems to persist across the sphere of research into professional practice, despite major reviews attempting to encourage confidence in judgement and supportive organisational structures (Munro, 2011; Munro, 2019). Child protection can be highly charged with emotion; cases where children are tragically killed or seriously injured by their abusers often reach the media and gain public attention, and the role of the professionals who were involved with the child or young person are scrutinised (Parton, Thorpe and Wattam, 1997; Alaszewski *et al.* 2000; Shoesmith, 2016). This might mean professionals need to simultaneously manage both risk to the child and to themselves.

In terms of the what is defined as a risk factor, the author of this thesis subscribes to a socially constructed idea of risk indicators (Lupton, 1999; Burgess, 2014). Risk factors of child abuse and neglect are presented in chapter one (section 1.8) to provide an overview of current evidence. Risk factors, in the view of social constructivism, can be less to do with the objective study of what is actually most dangerous to life, and more to do with what risk is important to a society (Lupton, 1999). Ideas about risk can be used to identify self and other; to categorise those at risk, those who pose a risk, and where to assign blame, which of course can be open to bias and stigma (Lupton, 1993). Within this thesis, some focus is given to the process

of managing risk and how school nurses conceptualise it (section 6.6). The management of risk, especially when risk factors are perhaps organisationally defined, can become tensive when personal (socially constructed) beliefs differ (Alaszewski *et al.* 2000).

Nurses, and school nurses, can face additional dilemmas when they must weigh-up decisions between two undesirable outcomes (e.g. risk of breeching confidentiality vs. risk of not protecting the child or young person), and the time pressures of nursing practice can make it difficult to partake in the type of regular self-reflection to understand one's own pre-conceptions of risk (Luker and Kendrick, 1992). Some nursing literature has discussed the importance of a reflexive nursing approach (over years of experience) as a means to develop internal resilience against uncertainty in practice (Offredy, 1998; Netto, Silva and Santos-Rua, 2018), and such protective factors are highlighted in the results chapter (nine).

'Vulnerability' can be a much-used term in safeguarding literature, but often is poorly defined and somewhat ambiguous (Brown, 2015). As discussed in chapter one, safeguarding concern in the UK has moved from a focus on 'actual' harm, to 'possible' risk and the identification of vulnerable groups (Kempe *et al.* 1962; Maguire *et al.* 2015). For the purposes of this study, vulnerability is defined as a person's diminished (physical and/or mental) capacity to protect themselves from harm, for example, young children or the elderly (Keay and Kirby, 2017). Concepts of vulnerability can be contextual,

and be influenced by the environment, social beliefs and an individual's own experiences and subsequent perspectives on vulnerable groups (Keay and Kirby, 2017). Some literature has expressed that anyone might be considered vulnerable at different stages of life, including childhood, during illness or as defined by demographics such as gender (Virokannas, Liuski and Kuronen, 2018). In this way, school nurses in the current study might perceive any child or young person to be vulnerable, yet specific factors (identified or suspected) might define an individual child as 'at risk'.

6.6 Pre-conceptions of Vulnerability and Risk

An influencing factor, or a 'pre-determining' factor, on the identified *'process model of risk assessment in school nursing practice'* was school nurses own personal and professional ideas about vulnerability and risk. During interviews in Stage Two, school nurses were asked to discuss their professional experiences of safeguarding work and consider how they might define a vulnerable child or young person. These perceptions of vulnerability were often shared by participants without prompting and can be presented in the following categories; 'socio-economic status', 'risk-taking behaviours', 'family history', 'the isolated child', 'mental health', 'un-met needs' and 'child protection labels'. It is presented in this section of the thesis as a natural progression from the introduction of concepts of risk. It is also an influencing factor that, unlike many others, was not part of the practical processes of 'becoming aware' (i.e. there was no tangible way to build pre-conceptions, as

with building trust). Pre-conceptions of vulnerability and risk were concepts forecasting the vulnerable groups school nurses might seek in the first place.

School nurses' perceptions of vulnerability and risk were often rooted in their training/education, nursing experience, cultural background and personal childhood and child-rearing experiences. In this way they were mostly subjective, but nevertheless provided an interesting insight into how school nurses' distinguished vulnerable children, including those at risk, from the wider school population. These perceptions might influence the environments in which school nurses chose to see the child (i.e. home, school, or the community) and what questions they may ask of the child.

School nurses' definitions of vulnerability were broad and by no means confined to children and young people undergoing child protection planning. These broad definitions might have contributed to the number of 'non-specific' and 'unboundaried' referrals and subsequent work that school nurses took on, as explored in chapter seven. Indeed, elsewhere in the literature school nurses have been described as *"a jack of all trades"* (Ball and Pike, 2005, page 4). This highlights some of the challenges of being a universal service, where key school nursing guidance uses terms such as 'vulnerability' frequently and often without comprehensive definition.

The *'4-5-6'* model for school nursing and the school nursing *'Universal'* to *'Universal Partnership Plus'* levels of service (as described in Stage One of this

study), call for the highest level of school nursing intervention to *"improve early and ongoing help for vulnerable children and families"* and *"deal with complex issues over time"* (PHE, 2014b, page 2). However, these recommendations are made without breaking down what 'vulnerable children' or 'complex issues' really mean. This may be because such concepts are not static and there is no single definition of a vulnerable or complex situation (Rojeck, Peacock and Collins, 1989; Appleton, 1994), or perhaps there is an element of assumed knowledge (by the producers of such guidance), but this may leave the school nurse to self-define which children and young people to prioritise. The tensions of school nurses assuming a proactive versus a reactive response to vulnerability and risk (i.e. at which stage they choose to intervene) is explored in the discussion chapter (ten) and forms part of the over-arching arguments of this thesis.

Child Protection Labels

When asked about prioritising work with vulnerable children and young people, many school nurses would discuss children who were defined by the local authority as meeting a category of need. This included children and young people on a child protection plan, child in need plan, team around the family plan, a looked after child (LAC), or a child with an education, health and care plan (EHCP). Some school nurses presumed children and young people who were on some sort of plan would have a health need, either at the point of assessment or in the future. These school nurses often felt the need to

prioritise working with these children and seeking health needs because of these labels.

> *"I think everyone on a child protection plan is going to have some health needs, it just might not be emerging yet"*
>
> P006

Ideas about vulnerable groups might be invisible to the school nurses themselves and this is sometimes called an implicit bias (Munro, 1999). For example, organisational child protection labels could create pre-conceptions about family functioning and poor parenting, despite there being a multitude of factors that might lead to child protection planning outside of the family home (Alaszewski *et al.* 2000).

Socio-Economic Status

A major focus in school nurses' examples of vulnerability was socio-economic status (both familial and geographical). School nurses would often use socio-economic markers, such as poverty, unemployment and lack of community services (such as green spaces, shops and medical centres) to define a child or young person who was vulnerable to a decline in health, wellbeing and happiness. This could even contribute to school nursing teams marking out 'postcodes of need', i.e. residential areas that would become stigmatised as vulnerable. For example, this might be the road or city quarter that contained

most of the social housing. In places where these smaller areas of socio-economic deprivation existed amongst predominantly privately-owned housing with high levels of employment and household income, they would become defined as the 'pockets' of need and vulnerability. These areas were where school nurses anticipated much of their safeguarding work would originate, even describing them as a 'breeding ground' for problems.

> *"I don't get a massive community feel from that area; they breed problems"*
>
> P011

> *"across the road you have [name of area], that's your poverty area"*
>
> P023

Whilst this is not accusing school nurses of being consciously discriminatory, the over-representation of children and young people from lower socio-economic backgrounds in child protection procedures is a highly contentious issue in current, international (Western) literature (Johnson-Reid, Drake and Kohl, 2009; Enosh and Topilsky, 2014). It has been debated if this representation is due to the association between poverty and higher need, or if it is in fact an artificial representation resulting from implicit bias and over-scrutinisation (Johnson-Reid, Drake and Kohl, 2009; Enosh and Topilsky, 2014). In a quantitative UK study of social care interventions for children in

13 local authority areas, it was suggested that in places with greater economic variation (i.e. the very poor living next to the very rich), professionals can begin to over-scrutinise families of lower socio-economic status and contribute to feelings of shame in these communities (Bywaters *et al.* 2015).

A small number of school nurses who described working in areas with predominantly high unemployment, social housing and low family income, defined 'pockets of affluence'. School nurses felt these pockets of affluence could mask hidden harm around emotional stress and domestic violence. They described how local socio-economic statistics could contradict the reality of what happened behind closed doors, and school nurses were often privy to this reality. Some evidence suggests that safeguarding professionals work differently with affluent families, as they often expect to be questioned and tested by (highly educated) parents (Bernard and Greenwood, 2018). Training for social workers may too often over-emphasise risk factors associated with poverty, meaning that signs of issues such as domestic violence and alcoholism in affluent families are not challenged (Bernard and Greenwood, 2018). Perhaps for similar reasons, in this study school nurses would not usually seek out safeguarding concerns in these areas, but rather receive information about unexpected incidences through the police or other agencies.

"it's a really lovely area, and it is a bit of a hidden thing because it is a nice area, but drug use is apparently quite prolific"

P013

Some school nurses described feeling surprised and challenged when safeguarding concerns were raised for families they perceived as affluent and well-educated, perhaps suggesting that internal stereotypes persist.

"parents who are very clever, you need to have your facts in front of you, to challenge"

P012

"[on affluent families] they don't recognise themselves as needing to be in that position"

P018

They felt these families were often in conflict with the stereotypical image of a family needing involvement from children's social care and were therefore unlikely to recognise themselves as being of parallel need to that stereotype. Some school nurses might approach these families in a particular way, citing the need to present a more robust evidence base for their opinions.

Risk-Taking Behaviours

School nurses were alerted to risk if a child or young person was known to engage in what they defined as 'risky behaviours'. These included smoking, using drugs, drinking alcohol and un-protected sexual activity (without contraception). Although these activities were accepted as a predictable part of adolescence, it was the dis-connect between the young person's knowledge of associated risks and their level of use that caused the most concern.

> *"I've got a child who's on a plan with a disconnect between what she knows and putting herself at risk"*
>
> P012

Behaviours such as substance misuse and un-protected sex were often perceived as risky because there was an associated (and evidenced) threat to health; for example, unprotected sex leading to a sexually transmitted infection (NHS, 2018). Professionals might also feel that risky behaviours threaten the innocence of childhood, for which they are responsible (in the absence of risk-aware parents) for protecting (Jackson and Scott, 1999).

In this study, most school nurses felt they worked in partnership with children and young people, but some respondents described a more paternalistic approach to keeping children safe, as explored in later discussions in this

thesis on the concept of trust (section 6.7). In Lupton's sociocultural theory of risk in childhood, socially defined risks to childhood subsequently shape childhood itself and set the boundaries over which this construct is threatened (Lupton, 1999). Whether young people acknowledge the same definitions of risk is not a guarantee, as adolescent brain development (of the pre-frontal cortex) can impede risk awareness (Blakemore, 2018). This might explain the inherent tensions described by the school nurses above, who had to negotiate definitions of risk with young people who may not be able to implement safety advice in the moment.

Family History

School nurses described risk factors relating to familial culture to define vulnerable groups. These included large families, domestic violence, child-rearing practices and parental substance misuse. Safeguarding concerns were often described as 'inter-generational', and children and young people with a family name associated with previous child protection cases were sometimes automatically presumed by some school nurses to be vulnerable. Parenting and family environment has been established as one of the greatest influences on child development and achievement (Frome and Eccles, 1998; Ary *et al.* 1999). Family history and vulnerability were most commonly discussed by school nurses who worked in smaller communities with less movement of people in or out of the local area.

"some of the small old mining communities, the problems have just been perpetuated over time, so because granny did it…so nothing was corrected way back and so it's carried on, and to try and break that cycle I think it's even harder"

P022

Evidence that parents who were abused or neglected in childhood will replicate these behaviours with their own children is contentious (Widom, Czaja and DuMont, 2015). It is known that the trauma of child abuse and neglect can have a negative impact on social and emotional development in later years, including forming attachments, relationships and a person's ideas about parenting (Maguire *et al.* 2015). The social influences on abuse and neglect, such as poverty and unemployment, may have an inter-generational impact on families who stay living in the same area as they attempt to break from stigma and expected norms (Widom, Czaja and DuMont, 2015).

The Isolated Child

Some school nurses defined children and young people who were isolated from traditional school-based services as additionally vulnerable to those who appeared to engage well in the school system. This included children who were excluded or who were in school but not visiting school nursing services, such as drop-in clinics or scheduled appointments. School nurses described how this group of children could be socially vulnerable, have few

friends, become 'lost in the community' and struggle to have their voices heard. Some participants argued that the current models of school nursing, where most contact occurred on the school site, were no longer fit to serve these isolated groups.

> *"there are a lot of children and young people who are excluded from school, and they don't necessarily go anywhere, just out there in the community…they can just get lost"*
>
> P008

The responsibility of the local authority and related professional services towards children and young people who are home-schooled in the UK has historically been unclear, and it has only been this year (2019) that the DfE announced the development of a compulsory register for children receiving their education at home (DfE, 2019). Resistance to this register has centred on the over-intrusion of the 'state' to monitor families, although as the number of home-schooled children in the UK rises (an increase of 40% since 2016) these measures are likely to continue (Foster, 2019). In the current study, the involvement of school nurses with this cohort of children and young people was mixed, owing to the absence of guidance on what the role of school nursing services with home-schooled children should be. For example, some school nurses in study site two might provide one-to-one health interventions for home-schooled children at the request of parents. In contrast, school nurses in study sites one and three has minimal involvement

with home-schooled children and only sent a reminder letter to the home address for immunisations. The support of this group of children and young people was another important factor in the argument for better clarity around the school nursing role, as presented in the discussion chapter (ten).

Mental Health

Mental and emotional health, as an issue on the national UK agenda (DH, 2017), was universally identified by school nurses as an area of vulnerability for most children and young people. This interest was also influenced by a recent increase in mental health awareness through school nurse training events. Children and young people with diagnosed mental health conditions were described by school nurses as vulnerable, but mental health and emotional vulnerability was also expected for all children who had additional safeguarding needs regardless of diagnosis. This could be a conflict for school nurses when trying to define their role and decide where to invest their time for meaningful impact.

> *"we're supposed to cover emotional health, and every child going through that kind of thing is going to have an emotional health impact"*
>
> P018

School nurses, as a universal service, have a role in supporting the mental health needs of children and young people through health promotion and signposting (Pryjmachuk *et al.* 2011; Jönsson *et al.* 2019). Prevention is the focus of current UK parliamentary strategies for issues such as suicide in young people (Caan, 2019). However, as child and adolescent mental health services (CAMHS) have come under pressure in the UK from funding cuts and growing demand, teachers, support staff and nurses in schools have had to become increasingly involved in crisis management of mental health issues (Pryjmachuk *et al.* 2011; Shelemy, Harvey and Waite, 2019). Consequently, in the current study, many school nurses felt the line between universal and specialist services had moved in relation to mental health support of school children, with school nurses having to increasingly provide mental health 'first aid' (Atkins, 2017).

In 2017, a green paper published by the DH and DfE presented new plans for investment in school mental health teams and stated *"school nurses already provide valuable support and early help on a number of issues that may affect children and young people's mental health"* (DH, 2017, page 22). In the current study, school nurses felt that less of their mental health support was now definable as 'early help' but more at the crisis point of mental health intervention, when young people had begun to regularly self-harm or express suicidal ideation.

"the waiting lists [for CAMHS] are horrendous, they are unacceptable is the bottom line, I've had students that have been referred in the June, they've been seen in the October…so they've not had any proactive involvement apart from what I'm offering"

P012

"last year there was a young person who disclosed to me that he had actually attempted suicide, but his Mum had interrupted him"

P021

This is one of several examples of tensions between the proactive and the reactive role of the school nurse as explored in chapter ten; where time to prevent poor health outcomes (using a public health approach) is often taken up by supporting children and young people at the most acute point of need.

Un-Met Needs

School nurses could identify children and young people who were vulnerable by the presence of un-resolved health needs, including health conditions, illnesses and injuries. This vulnerability was often negated if another service was already involved to meet this health need, or if the child and their family had a plan of care. School nurses were mostly concerned with health needs that were un-met; meaning no services were currently involved or no plan was in place to seek a professional assessment of those needs. These un-met

needs could also be more fundamental, such as clothing, food or a safe home environment, as in classifications of neglect (NSPCC, 2017c).

> *"it's safeguarding because of the child's obesity and her lack of support to remedy his obesity"*
>
> P021

Although identifying these un-met needs is an example of the early intervention work for which school nursing is recommended (HM Government, 2018), school nurses in this study felt it was a role that they had to take by default due to an increasing demand on specialist services. The pressure of this type of surveillance work can go unseen by organisations as it is difficult to quantify, and the broad definitions of who might be vulnerable can mean nurses are taking on a diverse range of roles to fill perceived gaps in safeguarding and child protection services (Appleton, 1996).

6.7 Concepts of Trust

Trust, as a core concept, presents in all three stages of the identified *'process model of risk assessment in school nursing practice'* and supported the relationships upon which the process relied; mutual trusting relationships with children, families and other professionals (see chapters seven to nine). Trust is widely mentioned in literature from different sectors, including finance, business (e.g. customer satisfaction) and healthcare, yet little focus

is given to the philosophical concept of trust and how it might be defined (Blomqvist, 1997).

It has been argued that trust is important in nursing care because the patient, often in a state of vulnerability, is reliant on the nurse to provide care; thus the nurse holds a certain degree of responsibility and power (Rutherford, 2014). In gaining trust the nurse attempts to address this imbalance of power, through language, shared space and patient empowerment (Dinç and Gastmans, 2013). These strategies are explored further in chapter seven, as ways in which the school nurse created a 'safe space' for disclosures.

Patient trust of the nursing profession can be influenced by the image of nursing in the media and the qualities society expects; nurses are commonly depicted as caring, compassionate and trustworthy (Hayward, 1975). Conversely, social workers in child protection can often be mistrusted by families as their work may intrude on the private sphere of the family home, and stereotypes about the role of the social worker in the removal of children endure (Gallagher *et al.* 2011). Additionally, children and families are not always willing participants in the social care process (Gallagher *et al.* 2011). Despite these challenges, there is little research attention given to the experiences of practitioners at the point of contact (and building trust) with children and families, when compared with the large body of research on organisational processes in safeguarding (Ferguson, 2009).

A seminal theory on trust in nursing was presented by Johns (1996), who defined four key elements to the concept of trust: (1) the risk attached to trusting a person, (2) the decision made to trust a person, (3) the willingness of the patient (in a vulnerable state) to rely on someone else, and (4) the outcome of the trust-based scenario. In light of the complexity and high emotion involved in safeguarding work this 'trust' model might be tested (Johns, 1996; Alaszewski *et al.* 2000); the risk attached to trusting a professional with a disclosure is likely high for vulnerable children and young people, who have sometimes lost trust in adult (and parental) figures to keep them safe (Adams, 2005). Decisions to trust a professional can take time, which is again of high demand in school nursing, and families may not yet be willing to rely on a 'figure of authority' to intrude into the private sphere of family life (Paavilainen, Ästedt-Kurki and Paunonen, 2000; Gallagher *et al.* 2011; Fraley, Aronowitz and Jones, 2018). Despite this, some key examples of how trust was created (and sometimes broken) as described by the school nurses in this study are explored in chapters seven to nine.

According to Giddens (1990) and Beck (1992) the decline of small, traditional communities and local knowledge in past decades has meant citizens need to increasingly rely on governments, systems, and people with whom they might never meet to protect them from harm. Generally, everyday life can continue in this perceived cocoon of trusted others, however significant moments can happen when uncontrollable events, such as violence, abuse and failure of trusted others, occur (Giddens, 1990). The person (in the context of this

study, the child or young person) can be left open to the fears associated with risk and danger, and the cocoon of safety must be re-built once again (Giddens, 1990). In these instances, individuals might turn back to seek the personal connections of traditional community and ask professionals to prove their reliability before trust can be handed over (Lupton, 1999). In the discussion chapter (ten), the conflict between school nurses' attempts to build personal connections with vulnerable children and young people, and an increasingly remote, corporate working model, is explored.

6.8 Communication in Multi-Agency Environments

As discussed in chapter one, major reviews of UK child protection systems and serious case reviews (SCRs) of abuse and neglect consistently highlighted good communication between agencies (such as health, education, police and social care) as central to safety and efficiency (Munro, 2011; HM Government, 2018). Despite this, failures of communication between agencies still occur; Hudson *et al.* (1999) identified key barriers to collaboration between agencies as (1) different patterns of accountability, (2) different approaches to decision-making, (3) different standards for distributing resources and, (4) different professional cultures. In the results of this study (chapter eight) school nurses identified hot-spots of inter-agency conflict, particularly at the point of referring to specialist services, managing 'thresholds' and approaching 'gate-keepers' (where professional ideas on risk can differ).

The ability of the professional to work across boundaries, and in particular articulate knowledge about how and where resources (in the form of expertise) are held, is a concept known as 'reticulism' (Power, 1973; Challis *et al.* 1988; Williams, 2011). A 'reticulist' is a person who can manipulate communication networks for a desired outcome (e.g. school nurses requesting services on behalf of a child or young person), by understanding where relevant decisions are made and how to influence them (Power, 1973; Challis *et al.* 1988). Examples of this are explored in the results chapters (seven to nine) of this thesis, including how school nurses use common language and trust-building strategies.

It has been argued that reticulist behaviour is of greater value in systems that are highly complex and fragmented, such as the UK child protection system (Williams, 2011). Some suggest instead of continuing to re-structure systems and hoping to see an improvement in collaboration, investment should be concentrated on the skills of the 'reticulist' (Challis *et al.* 1988; Williams, 2011). As health and social care services become increasingly divided, through fears of privatisation and selling off sub-sections of public services, the reticulist will likely become of increasing importance (Williams, 2012). The future role of the school nurse, considering such skills of communication, building trust, and managing risk, are discussed in chapter ten of this thesis.

6.9 Chapter Summary

This chapter provided an overview of the participants involved in this study, to present the variation of factors such as training, experience and special interests in the final sample of 25 school nurses. Furthermore, the identified *'process model of risk assessment in school nursing practice'* has been introduced, as well as the conceptual understanding of risk, trust and communication. This model, developed following focused coding (Charmaz, 2014), provides a way to organise the qualitative findings and identify key emergent concepts, practice issues and recommendations. It is based on the experiences and stories of the school nurses who took part. An overview of the school nurses' *'Pre-conceptions of vulnerability and risk'* presented personal and professional ideas about vulnerable groups and where safeguarding concerns might be 'sought'. An in-depth exploration of each stage of the model will continue in the following chapters.

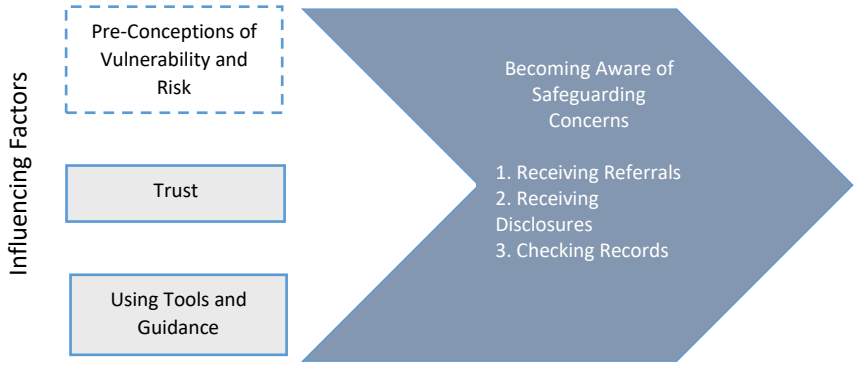
CHAPTER SEVEN: BECOMING AWARE OF SAFEGUARDING CONCERNS

7.1 Chapter Overview

This section will present the initial stage of the model: *'becoming aware of safeguarding concerns'* (Figure 7.1). The results of this stage, and subsequent stages, are based on findings in the data. Results are presented alongside discussions of relevant theory and other research, to continue signposting the reader to key concepts (i.e. risk trust and communication) and later discussions on the school nurse as a 'safety net' (chapter ten, section 10.3).

This stage encompasses several ways in which the school nurse might first become aware of children and young people at risk of child abuse and neglect. The three main sub-processes are *'receiving referrals'*, *'receiving disclosures'* and '*checking records'*. In addition, several influences on these sub-processes exist which involve fostering trust with children and young people and using tools and guidance. *'Pre-conceptions of vulnerability and risk'* has already been addressed in chapter six.

Figure 7.1. Becoming aware of safeguarding concerns (Stage A)



7.2 Becoming Aware of Safeguarding Concerns (Stage A)

7.2.1 Receiving Referrals

School nurses spoke about becoming aware of children and young people with safeguarding concerns through referrals from other professionals, and sometimes parents/carers. Professionals making these referrals were often based in school, but other examples included social workers, GPs and health visitors. These referrals came through both formal and informal routes. Informal routes could include ad-hoc conversations with other school staff. Formal routes included existing referral processes in place within the organisation, such as school nurse referral forms (a standard template detailing the nature of the referral), letters (including discharge letters from the hospital) and telephone calls. In these cases, the referring professional

had already identified the concern, and this gave the school nurse a pre-existing idea of issues to explore in their first contact with the child or young person.

> *"you have an idea, from the students that have been referred in, what concerns have been raised already by school"*
>
> P003

> *"the student manager fills out the referral form, which is really helpful, then you've got a good idea of what's coming"*
>
> P008

In this way, referrals created an anticipation of needs. Although school nurses usually agreed to see the child in the first instance (and thus accepted the referral) they would normally undertake their own additional assessment of concerns from the 'school nurse perspective'. This additional assessment might include small-scale activities such as scanning the referral form for health-related issues, inviting the child or young person for a brief contact to gather additional information, or matching the identified needs with other professionals (i.e. the 'best fit') who may have more specialised knowledge (for example, in mental health).

"we rarely ever say that's an inappropriate referral, we might do one contact that allows us to review"

P011

"someone from each team looks at the referrals and decides who it best fits, and picks up through there"

P015

School nurses spoke of relying on other professionals, particularly in school, to highlight safeguarding concerns to them. Many school nurses managed large caseloads (up to 150 pupils per nurse), sometimes across multiple schools, and support from other professionals meant there were additional people looking for early signs of need in the school population. School nurses felt that, overwhelmingly, safeguarding concerns had already been identified by the time a referral had been sent to the school nurse. As explored in chapter one of this thesis, school nurses are cited in UK guidance as being in an ideal position to identify safeguarding concerns (HM Government, 2018), which suggests they are receiving first-hand information; however, this seems to be in tension with managing such a varied and complex workload.

One participant described that relying on others to flag-up concerns was a gap in the current safeguarding system, and that school nurses should focus on identifying concerns first-hand. As discussed in chapter one, the evolution of the school nursing role to include safeguarding and child protection work

has developed over time (Harrison and Gretton, 1986; Clarke, 2000; Hackett, 2014). The question as to whether school nurses should indeed be part of a primary response to safeguarding concerns (including those not identified first-hand) or be a specialist agency for other services to refer to for specified health work, receives little consensus amongst participants. These tensions are explored in the results and discussed in chapter ten.

> *"there's a bit of a gap in that you're relying on the parent, GP or someone else to flag them up to us"*
>
> P015

Another key partner in identifying safeguarding concerns were health visitors, who are public health nurses responsible for children aged 0-5 years (PHE, 2016). Health visitors in all three study sites would routinely refer children who were starting school on to school nursing services, by means of a referral form, email or telephone call. The suggestion that many safeguarding concerns were already ongoing by the time children started school may speak to the chronic nature of some safeguarding work, and the length of time some professionals stay involved (Widom, Czaja and DuMont, 2015). Therefore, it may not be so easy for school nurses to identify a brief health intervention, or even fulfil a preventative role when most of the current referrals they received were almost 'beyond' early intervention.

"they tend to be electronic; we tend to get tasks from them [health visitors] and also from the GP as well"

P016

"quite a few families will come through with concerns already identified from the health visiting side of things...I'd say a good proportion of children get identified after referral into safeguarding"

P024

Professionals passing on identified concerns to the school nurses was not always seen as a positive activity. Conversely, it could lead to feelings of frustration voiced by the school nurses regarding other professionals referring to them in a non-specific way and 'passing on' safeguarding issues. Non-specific referrals could include referrals for broad issues such as poor behaviour or school avoidance. The process of passing on ownership of worries or concerns from one professional to another has been defined in the literature as *"off-handing"* or *"passing the buck"* (Malek, 1994, page 7). In this study, discussions regarding inappropriate referrals introduced the idea (as perceived by the school nurses) that other professionals seemed to mis-understand their remit of care. Despite this, few participants felt able to resist such non-specific or informal referrals as they sought to define their school nursing role between a proactive and reactive approach. This was despite the

perception that other specialist agencies seemingly rejected referrals on a regular basis.

> *"I get frustrated by some of the things we get asked to do because I feel we are asked to do things that aren't our role, they just tick someone's box"*
>
> P011

> *"we get referrals from anywhere and everywhere, we get them from schools, health visitors, parents, GPs"*
>
> P021

Interestingly, a few school nurses described ways in which they might pass on issues themselves, for example, when considering the process for communicating about transfers of children and young people between schools. They felt that once they had referred a child to another professional, there was a certain relief that they were no longer responsible. This suggests that school nurses, as with other members of the multi-disciplinary team, could be at risk of working in silos; where looking beyond the boundaries of the school or service in which they worked was a challenge (Williams, 2011). However, this seemed to be the minority of participants and later results highlight how school nurses were central in many multi-agency liaisons about children and young people.

"I feel more and more it's coming back to education and health, so that's batted back"

P003

"I think we get quite pigeon-holed into thinking-this is my school…you sort of think-well they've been discharged and gone off somewhere else…and you can forget about it, because it's not your issue"

P010

Informal routes to referring vulnerable children and young people to the school nurse were those that did not follow the prescribed route in school nursing guidance, namely completing a written referral form or making a phone call. Informal routes were defined as non-traditional and included ad-hoc conversations with other professionals and receiving information that was 'third-hand'. Most school nurses across the three study sites felt these informal referral routes were common, but often more chaotic and difficult to manage. Ad-hoc conversations were sometimes more convenient as they saved time for the professional who did not have to write a formal referral form.

"I often hear through word of mouth really, I don't necessarily know every child"

P005

"quite often we get word of mouth referrals rather than written, which can be hard to keep track of"

P006

Many school nurses found it difficult not to see the child or young person imminently, and to delay contact by asking professionals to send 'ad hoc' information via formalised routes. This speaks of the school nurse seeking to build relationships at the cost of their own workload and time pressure.

As discussed in chapters one and six of this thesis, it has been continually illustrated in the literature (including SCRs) that better communication between professionals strengthens safeguarding processes (Banner, 2012; Doherty, 2018; Munro, 2019). In this study, a tension is presented between allowing informal referrals ('easy communication') and the need for an audit trail. This is the first of many examples of school nurses balancing direct care and time with people, with administrative workload seen as important (organisationally) for evidence of adherence to policies and guidance.

Despite the chaotic nature of informal referrals, some school nurses saw the benefit of these ad-hoc conversations in terms of relationship building and

the accessibility of the school nurse to other professionals, as promoted in key government guidance (HM Government, 2018).

> *"they can just physically pop by and see me, or email me, and sometimes they bring students to me"*
>
> P007

School nurses described school staff as signposting to them following the identification of a concern. School staff might encourage the child or young person to visit the school nurse drop-in, or even take them in person. This was sometimes, but not always, preceded with a brief conversation with the school nurse. Again, in these instances, the safeguarding concern was primarily identified by another professional. Encouraging young people in secondary schools to attend drop-in was another way in which formal referral routes might be bypassed.

> *"you can even get, walking through school, a teacher stopping you…they might just say to the young person, go and drop-in or knock on the door"*
>
> P010

This process was undeniably easier in schools where the nurse was present daily, and in a survey of young people in the UK this school nurse visibility has

been identified as important for building relationships with the pupil population (BYC, 2011).

7.2.2 Receiving Disclosures

School nurses in all three study sites worked within the boundaries of patient confidentiality and this was recognised and reported by participants as a professional duty (NMC, 2018). According to professional guidance, contacts with children and young people are confidential unless there is a risk to their safety, or the safety of others, and in these circumstances, information may be shared (NMC, 2018). In all study sites, children and young people were made aware of these boundaries of confidentiality at the start of a consultation.

To maintain confidentiality, for example, in sexual health contacts, young people must have capacity to understand their decisions and the advice given to them (General Medical Council, GMC, 2019). This is termed 'Gillick Competency' or meeting 'Fraser Guidelines', which were terms from a 1986 legal case involving a young female obtaining the oral hormonal contraceptive pill without her parent's consent (*Gillick v West Norfolk & Wisbeck Area Health Authority 1986*). In the example of sexual health, children in the UK cannot consent to sexual activity under the age of 13 years, and a breach of confidentiality would be necessary to protect children younger than this (GMC, 2019).

Across the sites in this study, parents and carers were almost always involved in health contacts with primary school-aged children. School nurses in all study sites (as employees of a health organisation) worked to different safeguarding and information sharing policies and procedures than school staff, although they often liaised with the key school contacts such as pastoral managers. School nurses would not necessarily have to inform the school if they referred a young person to another agency if they felt this would breach patient confidentiality, for example, to mental health or sexual health services. In addition, contacts with adolescents might not always involve parents. Sometimes, as previously discussed (section 7.2.1) the concept of "off-handing" un-resolved concerns (Malek, 1994, page 7) meant school staff requested the school nurse to explore issues in the knowledge that initial conversations might remain confidential from parents.

School nurses could receive disclosures of sensitive information from children and young people, particularly in secondary schools where they could be accessed independently. This was another important way in which school nurses became aware of safeguarding concerns. Disclosures could occur at both planned appointments and during drop-in clinics, which were held at least once weekly in all schools where participants worked and allowed young people to seek school nursing advice without needing a prior appointment. The school nurses' experiences of receiving disclosures could be defined in

three categories; *'un-expected disclosures', 'expected disclosures'* and *'in-direct disclosures'*.

'Un-expected disclosures' predominantly occurred during drop-in clinics when the school nurse had little prior knowledge of any significant safeguarding concerns. Examples of un-expected disclosures at drop-in, as reported by participants, included a young female victim of sexual assault, and a young suicidal male (who had not shared his mental health issues with a health professional before). Although many school nurses felt they were made aware of safeguarding concerns through other people, this seemed to be different in cases with older children who accessed the school nurse independently for issues surrounding mental health and sexual harm.

> *"I had one disclosure recently regarding a rape allegation, so that was just somebody who had turned up at drop-in and disclosed that…so I think we are the first port of call for some"*
>
> P018

> *"well I've recently had a 17-year old come to me, and he's never spoken to a nurse, and he told me he drank bleach and he doesn't think he can stop himself next time"*
>
> P023

This drop-in model may be important for a cohort of young people who would not otherwise engage in health services, sometimes called *"hard-to-reach"* (Nelson and Taberrer, 2017, page 428). The term 'hard-to-reach' has been contested as children and young people might not be so difficult to engage, but rather models of health and social care fail to reach them (Cortis, Katz and Patulny, 2009). This makes the universality of the school nursing role important, as acknowledged in this study, but difficult to manage when universality means an open door for the whole school population.

School nurses felt it was important to have regular opportunities for children and young people to access them on an ad-hoc basis, by attending drop-in clinics or passing by the school nursing office. This was not always easy, as school nurses felt it took time and effort to maintain a profile in school, and this conflicted with a growing amount of administrative work they faced (Children's Commissioner for England, 2016). School nurses reflected that children and young people needed to see a school nurse in-person in order to disclose, as the personal connection was important (BYC, 2011).

> *"we have a room where if they [children] want to talk about health issues they can, or if they want to talk about anything going on in their lives"*
>
> P011

"I think we should be in our schools every week, capacity or no capacity, that's the main way we are going to be accessed"

P023

Young people might request to see the school nurse for a planned appointment, and through this make a disclosure. In these cases, the school nurse was usually prepared to address the anticipated issues on the referral form or appointment-request slip, and safeguarding disclosures that diverted from this came 'out of the blue'. Children and young people might also be referred by another professional for concerns such as changes to emotional health and behaviour, and through contact with the school nurse a safeguarding disclosure would be made.

"sometimes they come in for emotional health needs, and then we unpick things and realise there is cause for concern"

P018

"it can be that they've been referred initially for another reason and during that they disclose"

P020

'Expected disclosures' were usually anticipated by the school nurse as they had some prior knowledge of potential safeguarding concerns from the referring professional i.e. they already had some idea of what a child wished

to discuss during an appointment. These children might have previously been known to specialist services such as children's social care, or the school nurse might have had an informal conversation about them with the school safeguarding team.

> *"sometimes we do a one-to-one with the child in response to something, say we've heard [from school] that they've been talking to older men on Facebook"*
>
> P016

> *"most of the students that come [to drop-in] are on safeguarding, or from safeguarding backgrounds, and I do know them"*
>
> P017

School nurses often described children and young people making disclosures after several visits to the school nurse for un-related reasons, such as emotional health or just for a 'chat'. In these instances, school nurses often had a suspicion that a disclosure may eventually be made, based on observations of the child's body language, behaviour and way of talking (explored in chapter eight, section 8.2.3). These types of informal and non-specific visits are found in other research studies into the work of school nurses with vulnerable children and young people, and are seen as a way of the child testing the boundaries of trust and confidentiality (Eisbach and

Driessnack 2010; Alizadeh, Törnkvist and Hylander, 2011; Engh Kraft and Eriksson 2015; Fraley, Aronowitz and Jones, 2018).

> *"[I ask myself] why are they coming back for that, when we've already spoken about it? there's more to it than they're telling me…and logging that, and saying you're concerned but you're not sure why"*
>
> P013

> *"sometimes it's the first time they've seen me, and sometimes it will take a while, it's varied, it depends on the person, more often than not it's a good while after you've seen them, they'll say…well actually this happened"*
>
> P017

'In-direct disclosures' were commonly described by school nurses when reflecting on their work with younger children in primary schools, although a small number of examples also involved adolescents. *'In-direct disclosures'* occurred when a child spoke freely about their life and highlighted an issue without knowing it might be perceived by the school nurse as a safeguarding concern. Finkel (2012, page 4) called this concept *"accidental disclosure"* and theorised it to be more likely in younger victims of sexual abuse, who may not understand that the behaviours inflicted on them constitute abuse.

"the boys were quite openly talking about what they did at home…in terms of helping mum and physical chastisement"

P009

"it depends on what stage in that child's life, I suppose sometimes, especially younger children, just talk away and say something inadvertently"

P014

The school nurse role can vary in accordance with age and developmental stage of the child, and communication skills must reflect an ability to adapt to this (Destefano Lewis and Bear, 2008).

"I've even gone for a walk around the field, walked and talked, because they find it difficult to sit in an office, and I've got a box with fiddle toys, sand, colouring…"

P003

"For the younger ones we do a lot of creative activities, like making shoe boxes where they can put worries and things in it and then look at it"

P013

All 25 school nurses put measures in place to encourage children and young people to feel safe enough to talk about private issues. School nurses might also use these approaches if they felt a child or young person was building-up to making a disclosure, as described above. The first measure defined by the school nurses was practising openness and honesty and asking children directly if something bad had happened, or if they were at risk of harm.

> *"I'm quite open and honest with children, I would ask them outright…if you're honest and you ask them, quite often they will tell you"*
>
> P002

> *"we ask pupils…what are your concerns? what do you find difficult? what would you like help with?"*
>
> P003

School nurses from across the three study sites shared examples of using 'ice-breaking' activities, to provide distraction and encourage the child or young person to talk about non-threatening issues, before talking about more sensitive/private issues. These ice-breaking activities included using a health questionnaire or completing a genogram. A genogram is a way of mapping a person's family tree, to understand their family structure and dynamics (Beauchesne, Kelley and Gauthier, 1997). It can therefore serve as an 'ice-breaker' and as an assessment of the home environment.

"I always do a genogram with them, pictures of who they are and how they fit into the family, get to know them a bit, and they're more willing to share information"

P003

"because some people can't verbalise how they feel, but the tool gives you nice points to encourage people to think about how they feel and give them indicators…so if people aren't quite ready to talk"

P007

The child's agenda was often discussed by participants in relation to encouraging disclosures. School nurses acknowledged children and young people might not be ready to talk about private issues at the point of seeing a school nurse, but the contact was still valuable in terms of 'planting a seed' of thought that they could one day come back and disclose. This was especially true if children had been referred by another professional, rather than attended a school nurse drop-in of their own volition.

"the ones that come through the door are choosing to come and see me"

P004

"but pupils do know where we are if they need you, I think on the whole kids will turn up when they think they need you"

P018

Some school nurses felt that children and young people seemed to fear the consequences of disclosing a safeguarding concern, particularly if it involved a family member or if they knew their family would need to be involved. It has been suggested that victims of abuse often know their abuser and may even view them as an important figure in their life; therefore, disentangling this relationship from the harm is complex and emotive (Middleton, Sachs and Dorahy, 2017). School nurses were aware that children and young people might need reassurance that any disclosure they made would be dealt with, and information would be shared on a need to know basis. Many school nurses felt that children made a disclosure because they wanted a professional to take it further, rather than with the intention for it to remain indefinitely confidential.

"they're too scared to disclose, so whilst we know the signs and symptoms, and feel it could be going on possibly, it can be very difficult"

P003

"*they're not telling us because they don't want us to tell anybody, they're telling us because they do"*

P025

This type of disclosure, where the child's decision to share information is conscious and deliberate, has been called a *"purposeful disclosure"* (Finkel, 2012, page 5). It is acknowledged that 'purposeful disclosures' in this study are described from the viewpoint of the school nurses, rather than the child. It might be argued that assuming a child wants a disclosure acted upon (even if there exists a duty to act upon it) is influenced by professional agenda (La Valle, Payne and Jelicic, 2012). In addition, school nurses in this study highlighted numerous tensions between maintaining confidentiality, building good relationships with children, young people and families, and the need to break this trust to take 'professional control' of safeguarding concerns. In a study of school health and counselling support for girls at risk of harm from practices of family honour, this conflict was called *"professional dilemma"* and even *"professional hampering"* (Alizadeh, Törnkvist and Hylander, 2011, page 477). The consequences of disclosing for the child or young person, perhaps, are somewhat lost amongst this focus on the consequences for the professional; albeit driven by genuine concerns about mis-handling the situation and receiving blame from the child's family and other professionals (Fraser *et al.* 2009; Fleming, Biggart and Beckett, 2009; Hogg *et al.* 2012). The experiences of school nurses in this study around professional anxiety are discussed in chapter nine, section 9.2.7.

7.2.3 Checking Records

School nurses might first become aware of children and young people for whom there are safeguarding concerns by checking patient electronic clinical records (ECRs). These records could highlight a child's past involvement with child protection services such as children's social care. School nurse's might be checking records during a general review of their caseload, or before seeing a child for the first time. They might also check patient records on behalf of another professional who has discussed preliminary concerns about a child, within the boundaries of their information sharing policies.

> *"school might say, we're worried, mum says they are having all these appointments, so we could look that up, and it might flag a concern"*
>
> P001

> "*we might go back and check the record, and then there might be other things, other little things"*
>
> P012

As highlighted in Stage One of this study, ECRs were rarely completely contemporaneous. Despite this, ECRs could either initiate concerns or fill in gaps in a school nurse's knowledge about a child or young person. One school nurse spoke of 'reading between the lines' of disparate pieces of information

on clinical records regarding a child's multiple visits to the local Accident and Emergency (A and E) department. This started to create a feeling of concern as the school nurse questioned why the child might had attended so frequently. Health visitors in a study by Appleton and Cowley (2008b) also used patient records to gather further information, but some felt this could create pre-conceptions about family circumstances.

> *"when you look at the reports…why has the child been in hospital so many times? and there's lots of that coming up, or say the child keeps coming back to you for something, so read between the lines"*
>
> P013

> *"we take a social care history, check with A & E to see if there has been any recent and any 'not brought to appointments"*
>
> P019

'Reading between the lines' and making assumptions are closely related (Gough and Lynch, 2002), and some school nurses in this study often had to rely on disparate pieces of information in this way. School nurses relying on disparate information was partly because their role was not just dedicated to the most vulnerable children and any related safeguarding processes, and balancing this with wider (public health) aspects of their role meant school

nurses sometimes had to make quick assessments of risk (Munro, 1999). This was particularly the case for school nurses who cared for multiple schools.

In addition to checking ECRs, school nurses would also routinely receive notifications about referrals to social care from other agencies, discharge summaries about children and young people who had attended the local A and E department, and notifications about children who had recently moved to the school from out-of-area. These notifications might come via email or letter and were a routine part of information sharing between health organisations. School nurses would check these notifications to identify any safeguarding concerns and act accordingly.

> *"that can be really useful if you have a young person come from another area, or from primary school, or who has changed schools, you can identify straight away if there's been other professionals involved"*
>
> P003

> *"we get a lot of A and Es with intentional self-harm, so it's quite useful in that way, because we'll get to see them in school and talk about it"*
>
> P016

An issue for participants was that new administrative processes were added without reviewing and removing any old processes; thus, administrative work built upwards and consistently increased.

> *"I think the difficulties come with other admin-type things that we're expected to do from management that aren't necessarily linked"*
>
> P015

> *"A&E forms are discharge summaries, they all go on the computer then you have to look and document on it. But for 15,500 children!"*
>
> P017

As explored in chapter one of this thesis, following major reviews of UK safeguarding practice by Munro (2011) there has been a drive to focus more on professional development and effective practice (including communication between health, education and social care agencies). This attempts to move away from a defensive system overly obsessed with organisational targets, procedural work and record keeping (Munro, 2011; Munro, 2019). Although school nurses categorised checking records as procedural work, it still created opportunities to learn about children and young people, thus the distinctions between 'helpful' and 'unhelpful' procedural work become less clear. Although school nurses in this study spoke about the burden of administrative work, they still saw the benefit of

having clear record keeping processes.

7.2.4 Influencing Factor: Trust

The second main influence on the process of *'becoming aware of safeguarding concerns'* was the concept of trust. Trust was a core factor that enabled school nurses to build relationships with children and young people and create a safe space for them to talk about private issues. In many cases, trust was seen as a pre-requisite to children and young people feeling able to talk about their worries and concerns in the first place. Trust features in all three stages of the identified *'process model of risk assessment in school nursing practice'* but is first discussed here.

As introduced in chapter six of this thesis, trust in healthcare can be seen as a safeguard against the fears associated with risk (i.e. risk of illness or death) and nurses often have to emulate certain qualities to engender trust quickly with a patient, such as openness, warmth and expertise (Alaszewski *et al.* 2000). Furthermore, trust often needs to be tested by fulfilling promises (Alaszewski *et al.* 2000). In safeguarding work, there can be a certain pressure to ensure this trust is built successfully with children and families as it is key to engagement (Warner, 2015). Safeguarding and child protection work can be highly emotional and cases where children are harmed due to professional failures to intervene often reach the media (Warner, 2015). These tensions are conceptualised by Warner (2015, page 1) as *"the emotional politics of*

social work and child protection". School nurses in the current study commonly discussed working on the very edge of what they considered to be the nurse's role, with a move away from clinical work to social and emotional work.

> *"I also find it, kind of, quite frustrating sometimes because we are classed as school nurses, I think our job is very misconstrued…I'm not allowed to be clinical"*
>
> P002

> *"I think that's probably where we are, the role of the school nurse strikes me as something between mental health and social work"*
>
> P012

> *"I think the role at the moment is a lot of filling in for social care, because they're really struggling, so I feel we are having to pick up a lot of slack"*
>
> P016

In this study, school nurses in study sites one and three commonly spent most of their time in schools and did less work in the community (e.g. visiting children in the home), influenced by both the service model within the organisation and their personal view on the scope of the school nursing role. In study site two, where working in the local area (including home visits) was

more commonplace, trust was an important aspect of gaining access to the community. This was especially true of communities that were defined as *"close-knit*", *"static"* and "*deeply in-grained*"; where little movement of families in or out of the local area occurred, and generations of the same family tended to live closely together. Some school nurses felt specific communities that had been historically stigmatised as troublesome could be resistant to input from school nurses, as residents often associated them with a demonised view of the social worker (Gallagher *et al.* 2011). A school nurse's decision to bring their work into the community could be led by a 'professional curiosity' (Burton and Revell, 2018), particularly for children and young people who had poor school attendance and seemed to be unknown. In addition, school nurses who had worked in the same locality for several years felt protective of their community relationships, perceiving the trust between the school nurse and the local people as precious and an important preservation of more traditional models of community nursing.

> *"in that deprived estate I work on, they also had a lot of problems, but they had a strong community feel, they closed ranks, but actually included me in that once I'd been there for a number of years…people would say-I can't believe you went down there on your own?...and I was like-oh it's alright!"*
>
> P011

The remit of school nursing in school versus working in the community relied on a decision between an early intervention (proactive) approach and a reactive approach, as discussed in chapter ten. For example, school nurses who were based in a school often reacted to more immediate issues and thus had less availability to be outside of the school environment; working in a more preventative role and building relationships with the local community. Despite some difficulties in engaging with communities some school nurses felt that, with time, parents tended to trust the school nurse as an ally due to their unique position bridging social care, education and the home (QNI, 2015). School nurses could take on a mediating role and become a source of support for parents.

> *"for parents, it's just listening if they're worried, being a link person between them and school, we can be mediators if things have broken down"*
>
> P001

> *"so another job in safeguarding is to actually try and build-up a parent's belief in themselves"*
>
> P023

School nurses acknowledged that whilst they were always an advocate for the voice of the child or young person, if the child was not at immediate risk of harm they were likely to remain in the home; therefore building trust with

parents was important to effect real change. Professional relationships with parents were described as a delicate balance between ally and protector of the child, and school nurses were aware of the importance of remaining objective.

> *"if you can't get the parents or carers to engage with you, it's really difficult to carry out any work or to implement any changes, especially with the very young ones"*
>
> P004

> *"our role in health isn't to collude, but to build better relationships to get better outcomes for children…some children are removed, but your presumption is that the child will stay with the family"*
>
> P023

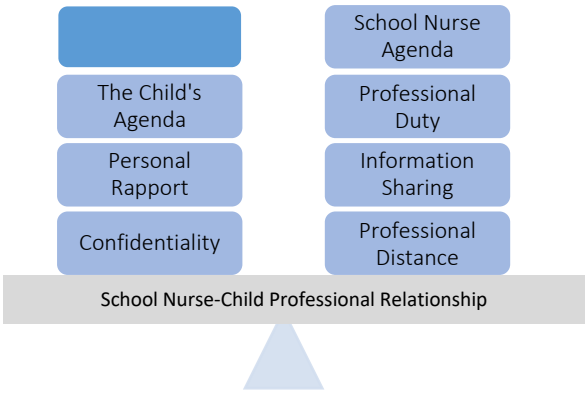
Hennessy (2011) has described this role balance as important, as safeguarding work hinges on these human networks, and professionals must have good self-awareness to understand how they are positioned within this network. In this study, school nurses felt children often perceived them as a trustworthy nursing figure who was not associated with parents/carers or teachers and had some small distance from the school or home environment. In chapter six of this thesis, the image of the 'trustworthy' nurse was defined as a long-standing concept (Hayward, 1975).

School nurses felt trust was a delicate balance between building rapport and maintaining a professional distance to enable information sharing, and it was this balance that was important to manage the tensions of safeguarding work. The need to build rapport and keep the promise of privacy with the child or young person was balanced against the duty of the school nurse to share information and make a professional assessment of risk. A visual representation of the factors school nurses felt were important to balance in relation to trusting relationships with children and young people is presented in Figure 7.2.

> *"you want to be friendly, but you don't want them to think that they're your friend, because you don't want them to think you're not going to take something further if you need to"*
>
> P018

> *"it's about having those skills to empathise, but not making them feel uncomfortable with that empathy"*
>
> P022

Figure 7.2. Balancing the school nurse-child professional relationship



Not all school nurses subscribed to the idea of professional distance and described a position that was nearer to a personal connection with the child or young person, such as the role of parent, mentor or friend.

> *"pupils will tell you things to keep you involved…keep you worried about them, hold them in mind"*
>
> P008

> *"a lot of the time, they are grateful to have someone to talk to, it's just listening, and giving them basic advice, it's quite simple what they need, a bit like a parent"*
>
> P016

Again, this role could be defined as a balance between professional and personal rapport, and school nurses acknowledged that children and young people could not become dependent on the school nurse to see them

informally and on-demand, as the school nursing service was only available during school-time. Although some school nurses sought these closer connections with children, it was often hindered by their lack of time and availability caused by managing multiple schools. School nurses felt that building trust was closely linked to their visibility in school, and the amount of face-to-face contact time they had. They felt that if they visited the school site more frequently, children might become more familiar with who they were and school nurses could become a consistent, professional confidant (BYC, 2011).

> *"it's a really good model, the way it works in secondary schools, to have that connection, that more physical connection"*
>
> P007

> *"in senior schools we try to keep that consistent person if we can…because then you get to build that relationship and they keep coming back"*
>
> P017

One school nurse spoke of visibility and a good general knowledge of the character of a child helping her to identify a-typical behaviours in referral information and notifications from other agencies (such as the hospital).

"I had a hospital admission notification which on its own looked really innocuous, but because I'm in school I know him…it said he had fallen when he was running, but I knew there's no way he'd be running anywhere unless he was chased"

P007

As explored in chapter six of this thesis, trust can become more complex when related to safeguarding and child protection; children often gain their first experiences of trust from their caregiving relationships in the home, yet in cases where abuse and neglect starts in the home this trust is broken, as the 'promise' of a safe childhood is denied (Alaszewski *et al.* 2000). The need to put trust in a professional often increases when the risk to a person increases during times of crisis (Adams, 1995), and school nurses often built trust with children and young people during a child's crisis period. In the current study, the investment by school nurses in building rapport could occur most intensely during the period leading up to a child or young person's disclosure of abuse or neglect, but maintaining trust would continue beyond this.

A key aspect of building rapport for school nurses was scheduling an initial, informal appointment with the child or young person that would focus on general introductions and a broad discussion about health, rather than dealing immediately with sensitive issues. This was not for child protection concerns that posed an immediate risk to a child or young person (as these

would be dealt with urgently), but rather for suspected safeguarding concerns via referral from other professionals or third-hand information shared in an informal way. Again, tensions existed between rapid trust-building strategies to address imminent concerns in a timely manner, and developing stable trusting relationships with children over time (Alaszewski *et al.* 2000).

> *"just treating them like normal people, in our first appointment, just to get to know each other, and then next time I'll be like-okay now talk to me"*
>
> P015

> *"Once you've seen them and you're like 'that's it you're all right you're ok but I'm here if you want me', they'll then start coming back again."*
>
> P017

These informal contacts included using 'soft skills' of communication; loosely defined as a collection of strategies such as showing interest, being positive, empathising, being welcoming and using active listening (Jelphs, 2006). There may be a false belief in healthcare that soft skills of communication are inherent and 'un-teachable' and the disregard of the importance of this has led to many failures in information sharing (Jelphs, 2006).

In the current study, situations where concerns were more immediate (such as risk of serious harm) necessitated school nurses to share relevant information with children's social care, the school safeguarding lead and parents/carers. Although school nurses often felt children and young people who made disclosures did so in order to seek help, some children could be unhappy at the idea of private issues being shared with other people. School nurses universally acknowledged that breaking confidentiality was sometimes important in order to keep a child or young person safe, but described feelings of discomfort and anxiety at how this could affect their ongoing professional relationship with the child. This dilemma has been discussed in previous research, where nurses described feeling hesitant to escalate concerns and reflected on the complexity of re-building professional relationships with children and young people when confidentiality had been broken (Eisbach and Driessnack 2010; Alizadeh, Törnkvist and Hylander, 2011).

In the current study, all school nurses (from across the study sites) would routinely define the boundaries of confidentiality with children and young people at an initial appointment; acting as both a disclaimer and a protection of the professional need to share information. School nurses did not feel this hindered open discussion all the time, but it is known that children and young people value this confidentiality highly (BYC, 2011) and a breach of this might affect future contact.

"[on working with a young person] social care then looked at my notes, and shared that information with her family, then she felt the relationship was lost, I'm losing trust now, between me and her"

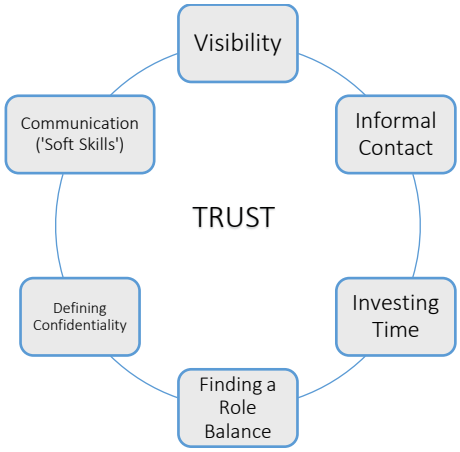
P007

"my issue working with [the young person] was finding the balance between maintaining her confidentiality and keeping her safe in the community, and maintaining a therapeutic relationship"

P008

A summary of factors that contributed to trust-building exercises in school nursing is presented in Figure 7.3. It represents the often unseen and unrecognised work in school nurses' safeguarding practice. This type of work contrasted with the 'visible' work of school nurses in child protection processes (e.g. attending meetings and submitting reports), which involved interaction with children already known to children's social care and a more active recognition by other professionals. An ethnographic study of midwifes by John and Parsons (2006, page 266) explored the unseen emotional work of creating a safe environment for expectant mothers and called this *"shadow work".* Unrecognised 'shadow work' often contributed to the midwives' stress and anxiety, and these impacts are looked at in relation to school nurses in chapter nine of this thesis.

Figure 7.3. School nursing contributions to building trust with children and young people



In addition to building a rapport with children and young people, trust between the school nurse and other professionals was also described by participants as important for *'becoming aware of safeguarding concerns'*. This particularly applied to schools, where school nurses invested time in interactions with school staff who were responsible for safeguarding (such as pastoral managers). Making introductions, scheduling meetings and informal social interactions all supported the school nurse to become part of the school community and the 'inner circle' of information sharing. Hennessy (2011) described the creation of professional support networks as an active and involved process. Building relationships with other professionals was described by school nurses as *"forging", "building"* and *"creating",* and always relied on conscious effort and action.

"it's forging links with all the different agencies, so you've got really good links with them, and you're kept involved"

P018

"if you lose the relationships with schools, you're not privy to information…it was very easy for me to phone the pastoral lead and say-I've got this mum…"

P023

As explored in chapter six of this thesis, this process may not always be easy when working between different agencies, particularly where boundaries meet (such as health and education); this can create issues such as organisational culture clash and power struggle (Williams, 2011). Building professional relationships was a challenge for school nurses who were responsible for multiple schools, as they could feel dis-connected from the school community due to lack of capacity to invest time.

7.2.5 Influencing Factor: Using Tools and Guidance

A final influence on how school nurses might identify safeguarding concerns was their use of printed or electronic assessment tools. Using assessment tools influenced the first two stages of the identified *'process model of risk assessment in school nursing practice'* but is first discussed here. In *'becoming aware of safeguarding concerns'* assessment tools were used by some school

nurses as a pragmatic way to estimate risk, and thus decide how concerned they should be about a child or young person. These assessment tools and checklists would usually take the form of questionnaires based on general health and wellbeing, or a specific aspect of health, such as sexual health. In addition to estimating risk, using checklists to complete a 'general health assessment' at an initial contact with a child or young person might uncover new safeguarding concerns.

School nurses found checklists particularly useful for children and young people who they felt were building-up to a disclosure or were frequently appearing at the school nurse drop-in for non-specific issues. Checklists were usually described as an aid to professional interaction; providing ideas of questions to ask children and young people, creating a focus away from sensitive issues and initiating collaboration between the school nurse and the child. School nurses were not only using tools to identify professional concerns, but also to identify what was most concerning from the child or young person's perspective. In this way, they sought to include the child's voice and agenda in the safeguarding process.

> *"you know, they wouldn't disclose fully, but you pick things up using the tools, I use the child sexual exploitation tools"*
>
> P005

"it can be woolly, but understanding what the child's thoughts and wishes are, if there are any changes"

P009

As previously highlighted in chapters one and six of this thesis, working with relatively broad definitions of safeguarding, child protection, risk and vulnerability (Wood, 2016) meant some school nurses sought more structured and tangible ways to prioritise their work, and the 'catch-all' nature of the school nursing service perhaps promoted such actions (Ball and Pike, 2005). The use of assessment tools by school nurses in this study was by no means universal, and many participants did not routinely use them in practice. Appleton and Cowley (2004) identified a similar feature in groups of health visitors who relied more on professional judgement than formal practice guidance when assessing the needs of children and families in the home. In the current study, some school nurses explained how they no longer used formal assessment tools as they had memorised and internalised these frameworks.

"I found that the more I've done, the more experienced I've become, I don't like to have a piece of paper there that I write on and tick through, I like to engage with that young person, sometimes I do make notes, but it's trying to put a picture together"

P004

In this way, nursing experience played some part in deciding what approaches to use when identifying safeguarding concerns, and when to use them. Although this had some advantages for school nurses in terms of making them feel confident in decision-making, it has been argued that relying wholly on internal skills (and rejecting organisational guidance) can suggest a resistance to new ways of working (Williams, 2011). The influence of practice experience is continued in the second stage of the assessment model (chapter eight).

7.3 Chapter Summary

The first stage of an identified *'process model of risk assessment in school nursing practice'* has been explored in *'becoming aware of safeguarding concerns'*. Safeguarding concerns could be identified by the school nurse through various routes of referral, disclosure and assessment. This stage of the model hinted at the inherent tensions between proactivity and reactivity in school nursing practice, and the challenges of practising at the perceived boundaries with specialist services. Trust was introduced as a central concept to facilitate the identification of risk, as well as strengthen networks of information sharing between children, young people and professionals. The role of trust and information sharing is continued in the next stage of the model, which focuses on the role of the school nurse as a 'detective'.

CHAPTER EIGHT: DETECTIVE WORK

8.1 Chapter Overview

The second stage of the identified *'process model for risk assessment in school nursing practice'* is *'detective work'*, and this stage encompasses *'asking questions', 'requesting information from others', 'making observations'* and *'promoting holism'* (Figure 8.1). Following the identification of safeguarding concerns school nurses would begin to gather additional information from children and young people, family members and other professionals in order to understand the context of concerns, build a body of knowledge to support risk assessment, and seek evidence to support a referral to specialist services (if required). This stage is influenced by four key factors; *'time', 'risk and intuition', 'sharing information'* and *'using tools and guidance'*.

Figure 8.1. Detective work (Stage B)

8.2 Detective Work (Stage B)

8.2.1 Asking Questions of Children and Young People

Asking questions of children and young people was a common feature of school nursing practice, with the purpose of gathering additional information about a safeguarding concern. Despite challenges with managing a busy caseload and increasing administrative tasks (Children's Commissioner for England, 2016), school nurses felt able to approach potentially vulnerable children and young people for an assessment with more ease than health professionals in specialist (outside) settings, as they were a universal service frequently present in school. In secondary schools, young people could see the school nurse without parental permission, meaning the nurse was in a privileged position to be able to hear the child's authentic voice in a private space away from the influences of the home environment (La Valle, Payne and Jelicic, 2012).

School nurses would ask questions of children and young people at a scheduled appointment regardless of how they first became aware of possible safeguarding concerns; through disclosure, referral or third-party information. There was some challenge in finding a way to see a young person for whom concerns had been raised by a third party, and some school nurses spoke of 'making excuses' to see them, as discussed in section 8.2.6. Questions could broadly be categorised as baseline questions or probing

questions. As discussed in chapter seven, some questions might be more direct (by asking openly about safeguarding concerns) or less direct (by talking around sensitive issues so as not to 'scare off' the child).

> *"I just tend to gently probe, if it's an immediate concern that's slightly different, I would be more direct with my questioning…if it's an emerging concern I've got that time to gently probe around, and to understand a little bit"*
>
> P009

Rather than being seen as covert questioning that took away from an honest relationship with the child or young person, school nurses felt that in-direct approaches were gentler and allowed for trust to develop before more direct issues might be discussed. In contrast to these ideas (as presented in chapter two), some school nursing literature has suggested that nurses might avoid addressing difficult conversations, particularly concerning childhood sexual abuse, as they feel unsure how to broach emotive and taboo issues (Engh Kraft and Eriksson, 2015; Engh Kraft, Eriksson and Rahm, 2016). In chapter nine of this thesis, school nurses' perceptions of addressing different categories of abuse and neglect are explored, with many identifying childhood sexual abuse as particularly challenging.

Baseline questions usually preceded probing questions and were concerned with general health and wellbeing. These questions laid a foundation and

framework of knowledge to understand which areas of a child or young person's life might be affected by the safeguarding concerns and sought possible signs and symptoms of abuse or neglect (such as anxiety and poor school attendance). This questioning recognised that safeguarding concerns could have multiple impacts that inter-connected through several areas of a child's life, not just confined to their immediate presentation, as in bio-psycho-social models of health (Zittel, Lawrence and Wodarski, 2002).

> *"you're using those topics aren't you, and saying-how's school? tell me about your family? who do you talk to if you're sad? who do you talk to if you're happy? are you sleeping and eating alright? just using those as trigger points"*
>
> P007

> *"so our health assessment, it looks at domains of health history, physical health and emotional health"*
>
> P009

Baseline questions were also used as an introductory 'ice-breaker' to prepare children and young people for more probing questions. Probing questions were concerned with focusing in on the safeguarding concern (or additional concerns picked up during baseline questions); to dig deeper and broach difficult subjects. Probing questions often asked the child about their thoughts, feelings and perceptions on their situation using an open-ended

format, however most school nurses acknowledged it was important to recognise when asking probing questions was causing emotional discomfort. They felt it was important to remain sensitive to the experience of the child or young person and maintain a balance between ethical questioning (avoiding distress) and needing information in order to make a strong assessment of risk.

> *"it's a tricky one, because we're not there to probe too much…you'd be doing an initial assessment"*
>
> P004

> *"asking appropriate questions and being sensitive to how that young person is at that particular time…knowing when not to rock the boat and when to push things a bit further"*
>
> P019

Some school nurses felt more comfortable with asking probing questions than others, influenced (in this study) by their level of experience and beliefs about the school nurse's participation in *"fringe work"* (De La Cuesta, 1993, page 665) at the boundaries with specialist services. 'Fringe work' encompasses additional activities carried out by a professional for which they are not usually expected to perform, or to take part in, often compensating for perceived deficiencies in other services (De La Cuesta, 1993). Other school nurses felt asking probing questions was too investigatory and crossed-over

with the role of the social worker, who would also make a risk assessment of suspected safeguarding or child protection concerns following a referral to children's social care (HM Government, 2018). By avoiding probing questions, some school nurses sought to preserve their partnership with children and young people, and to distance themselves from processes that felt too forensic. Asking in-depth questions created a feeling of discomfort and a perceived loss of their supportive and non-threatening image.

> *"it feels a little bit in this role like you're an investigator, that wasn't something I was expecting, it feels like you're trying to catch people out rather than look after this child's health"*
>
> P014

> *"it's a very in-depth questionnaire, and it looks at the home situation…some school nurses do argue that it does cross-over to social care too much"*
>
> P021

It could be argued that despite feelings of discomfort, school nurses (as employees of a government-funded health service) remain agents of their organisation and cannot distance themselves entirely from pre-defined duties and policies (Perron, Fluet and Holmes, 2005). In smaller ways, such as choosing how and when to ask questions of children and young people, school nurses had some freedom to regain control over how they worked

(Lipsky, 1980), albeit in response to some uncertainty regarding the school nursing remit.

In a counter argument to the negative perceptions of the school nursing role becoming blurred with that of social care, Edwards (2011) said working at the boundaries where professional practice intersects is important for building a common body of knowledge around complex issues. However, this inevitably means professionals must stretch beyond practice that is familiar and comfortable. In response to this, some school nurses seemed to embrace this position, whilst others tried to move away from it and reclaim the proactive public health/health promotion activities they felt were lost (as explored in chapter ten of this thesis). Nearly all school nurses in this study sought the support of colleagues and other professionals to explore any discomfort they might feel through clinical supervision (Wallbank and Wonnacott, 2015). The tension at this boundary between social care and school nursing practice, particularly when a safeguarding concern approached the threshold for social care referral, is evident throughout the final two stages of this identified *'process model of risk assessment in school nursing practice'*.

Crossing this perceived boundary into more 'investigatory questioning' took courage, particularly if school nurses felt uncomfortable about being outside of their apparent role scope. Some school nurses, as the quotes (below) demonstrate, felt more comfortable to use their power as an 'investigatory questioner'. These differences are an example of a disparity between

perceived and actual role (where and if documented/defined), arising from influences such as background experience and pre-conceptions of the school nursing profession. As discussed in chapter one of this thesis school nursing, as part of public health nursing, has increasingly become involved in more safeguarding and child protection processes (such as writing reports and monitoring children and young people) since services became targeted and subsequently narrowed to those most 'in need' (Elkan *et al.* 2000; Blair *et al*. 2003).

> *"it's the same thing in school nursing, not being afraid to ask the questions…not in a blunt way…but a clear enough way to get the information you need"*
>
> P007

> *"but then if I don't feel satisfied, I keep questioning them until I get what I need…that's what our strength is, being curious we don't let go, we're quite tenacious"*
>
> P009

School nurses who felt confident about asking these probing questions often perceived greater value in gathering information in order to protect the child or young person; this represented an area of school nursing practice that was sometimes individualised at the point of delivery (Lipsky, 1980). It related to the use of tools and guidance, with some less experienced nurses relying on

a pre-set proforma and feeling less comfortable going 'off-piste'. At times, many school nurses felt they were expected (by other professionals) to take on work that, given their own interpretation of the expectations of their role, they may not ordinarily take on (Malek, 1994). In the later discussion chapter ten, these two different approaches are explored as a response to role uncertainty (Redekopp, 1997; Hackett, 2013). Although school nurses, as universal health professionals, seemed in an ideal position to be curious and gather information, the question as to whether they should take on this role has been little debated in the literature. This rests on a decision to focus on proactivity versus reactivity, within the current levels of service (PHE, 2014a; PHE, 2016), to avoid tension and polarisation between role expectations.

8.2.2 Requesting Information from Others

In addition to asking questions of children and young people, school nurses would seek information from other people in the child's life; namely family members and health, education and social care professionals. The purpose of this information was to fill any gaps in the school nurse's knowledge regarding the context of a safeguarding concern, and to corroborate issues raised during an appointment with the child. School nurses commonly sought information from school staff (including teachers and those taking a lead role for safeguarding), social workers, GPs, hospital consultants, specialist mental health nurses and health visitors. This was part of building a 'human network' of trust and support for both the school nurse (gathering information) and

for subsequent support of the child and family, as introduced in chapter six (Hennessy, 2011).

> *"so, I would try to speak to anyone else who's been working with that person, try to just get a view"*
>
> P003

> *"I would be liaising with the pastoral team if something comes up, and they have been secretive, I'd be going and saying-is anything going on? or, what background can you give me?"*
>
> P010

The above quote suggested the child was actively concealing a safeguarding issue, although, as previously discussed in chapter seven (section 7.2.2) some children may not consciously be aware that their situation is harmful, abusive or neglectful (Finkel, 2012). School nurses felt that other professionals within a network of support offered a different perspective on potential safeguarding concerns, an opinion within their field of expertise and some level of reassurance. Reassurance was sought by school nurses to validate their concerns and share the burden of decision-making.

"me and the safeguarding lead [in school], we meet weekly, we're always in contact and working on cases together"

P005

"other professionals, safeguarding line, consultation line, I've used that, sometimes manager, and other colleagues because you sort of know don't you, but sometimes you think…I just want, I want someone else to say, yeah, you're doing the right thing"

P006

In a safeguarding system that has arguably become defensive in its approach to risk, some suggest that skills of professional decision-making have become overshadowed by assessment tools and 'box-ticking'; there is a certain anxiety in safeguarding about relying on one's own judgement and subsequently getting it wrong (Gillingham, 2011; Munro, 2011). As discussed in chapter one, safeguarding practice in the UK has moved from 'diagnosing' abuse to identifying risk factors of abuse and neglect, ensuring *potential* safeguarding concerns are not overlooked (Lupton, 1999; Munro, 2007). Many specialist services have increasingly become targeted in their service delivery and similarly defined their boundaries and thresholds for referral (Gillies, Edwards and Horsley, 2017). In the current study, school nurses seem to have the potential to remain somewhat unboundaried as a universal service. However, this seems to mean they work with children and young

people who do not meet other service thresholds, rather than have the opportunity for much proactive and preventative safeguarding work.

Some school nurses would routinely involve parents or carers in the assessment process by seeking their perspective on any problems raised during conversations with the child (either in person or via telephone); this was normally routine for younger children at primary school who could not see the school nurse without parental consent. Many school nurses in secondary schools preferred to protect the initial assessment appointment with the young person as confidential, and therefore did not invite parents or carers to attend. Contact with parents or carers would usually occur afterwards via telephone, as a way of comparing the young person's and the parent's perspectives of family life at home.

> *"with safeguarding, when I've done the health assessment, I will have seen them in confidence, so then I'll also contact the parents and ask for the parent's side"*
>
> P014

> *"if they're younger children, I always invite the parents to be there during the health needs assessment…sometimes they do, sometimes they don't"*
>
> P018

Working with parents and carers could sometimes create tension when school nurses needed to raise difficult issues, such as the perceived poor state of the home or disclosures of physical chastisement. According to Henderson (2018) these difficult conversations in safeguarding are contentious and balance issues of care and control. Professionals often must adhere to certain frameworks of assessment and referral and thus 'control' the situation whilst maintaining a therapeutic and trusting relationship, as addressed in chapter six (Henderson, 2018). In this study, school nurses spoke of exercising courage to resist regressing into avoidance when tensions with parents and carers heightened above their own thresholds of comfort.

> *"[on concerns about fabricated illness] well I've got to challenge this mum this afternoon, or I need to make an appointment because I don't want to do it over the phone, I need to have a one-to-one , and I need to arrange to see her, because I need to have that conversation that is, you know, 'this is slightly misleading', I've got to work out in my head how to put it"*
>
> P012

Gathering information from others was perceived to be particularly helpful in assessments of younger children, whom school nurses felt were less able to answer questions about their personal health and wellbeing. Parents or carers might be invited formally for a meeting in school with the school nurse or contacted via telephone. This seemed to be common practice across all

three study sites. Some school nurses adopted a more informal approach to seeking information from parents and carers, by disguising the assessment process as a general introductory conversation or visit.

> *"I've done a home visit, met the family, and seen what's going on at home"*
>
> P002

> *"I've had students where I've had bits of information from GPs, hospital, school staff…so I have to ring the parents and say-just checking in, I'm the school nurse, is there anything you're worried about?"*
>
> P007

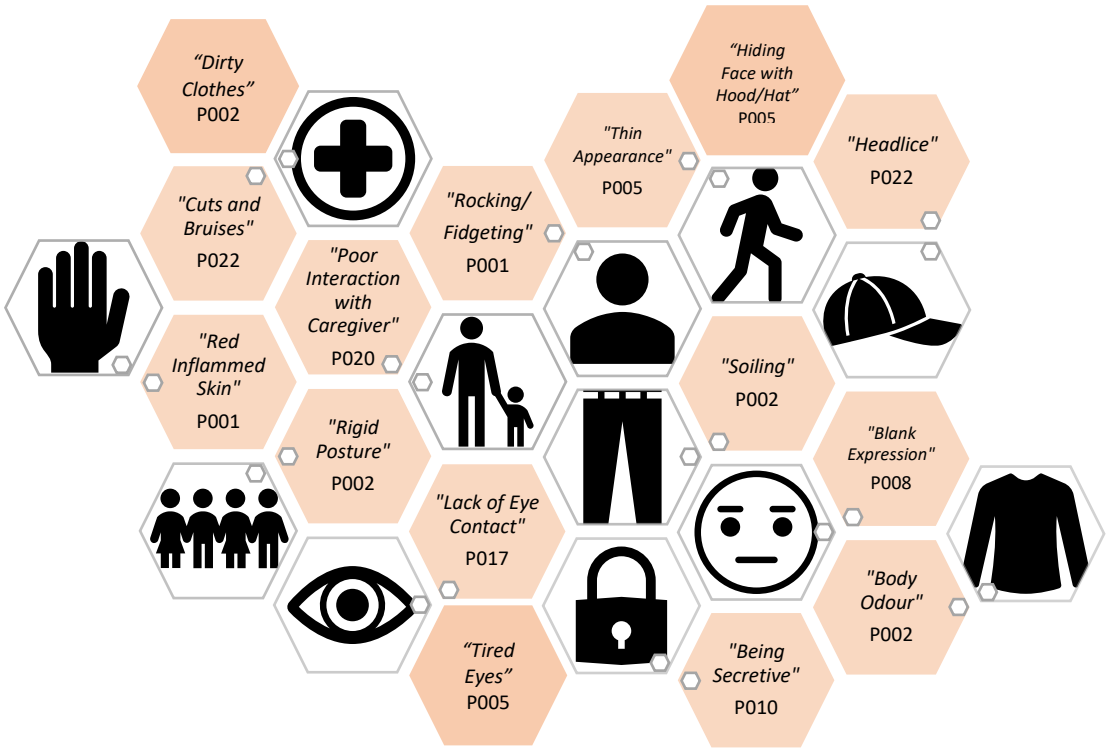
This type of approach could be considered duplicitous in nature, and tips the power balance away from the family, however it is another example of where conversations in safeguarding must manage the fine balance between care and control, trust and professional duty to protect children (Alaszewski *et al.* 2000; Henderson, 2018).

8.2.3 Making Observations

School nurses not only relied on verbal communication to gather additional information about a safeguarding concern, but also recognised and

responded to non-verbal cues from children and young people. Making observations of a child's body language was common practice for many school nurses during one-to-one appointments, and cues for concern included poor visible hygiene and evasive behaviour. The descriptors of signs and symptoms given by school nurses across all three study sites are presented in Figure 8.2. Most factors were evidence-based indicators from previous research and school nurse training; acknowledging the impact of neglect on personal hygiene, possible signs of physical harm (e.g. unexplained cuts and bruises), emotional distress (e.g. soiling) and the relationship between emotional abuse and caregiver behaviour (NICE, 2017). Other signs and symptoms for concern related to a child or young person's mannerisms, such as sitting uncomfortably, hiding their face, avoiding eye contact and having a blank expression. These signs relied more on the concept of intuition and an unquantifiable sense of unease (Appleton and Cowley, 2008b). As with risk factors of child abuse and neglect, signs and symptoms of harm were not in themselves evidence of abuse (Lewin and Herron, 2007), and it was more likely that school nurses would identify an accumulation of factors before feeling concerned. This made the school nurses threshold for referral to specialist services a combination of evidence and subjective interpretation.

Figure 8.2. Non-verbal cues for concern as identified by school nurses



Some school nurses described how previous experiences of dealing with child abuse and neglect, as well as relevant training, might create a mental template by which to identify future safeguarding concerns. They felt that these previous experiences and memories (both conscious and unconscious) could manifest as intuitive feelings (explored in section 8.2.6 of this chapter). For example, if a school nurse had previously worked with a child who was very withdrawn and later found out they were self-harming, the school nurse might subsequently be concerned about other withdrawn children. Making observations of non-verbal cues was a smaller part of the wider assessment and information gathering process, and often occurred quickly on immediate visual contact with the child or young person during a school nurse

appointment. Despite this, the power of these first impressions could still be influential on the school nurse's final evaluation. As later discussed in section 8.2.5 rapid assessments were often performed in response to a perceived lack of time to spend with children.

> *"so, you'd be looking…taking all of that into account, you'd be looking for their eye contact, are they withdrawn? um, so that's even before you've opened your mouth"*
>
> P001

> *"you pick up fairly quickly, don't you, body language, about how willing they are to talk to you, often that comes with experience doesn't it? the more you do, it's not always right but it does help"*
>
> P003

In studies of human reasoning in safeguarding practice, these first impressions have been called *"rapid assessments"* and are often needed to make quick judgements about complex situations (Munro, 1999, page 746). In a content analysis of child abuse enquiry reports between 1973-1994, Munro (1999) argued that intuitive thought is often overlooked for evidence that is readily available and concrete. In earlier work, Munro (1995) discussed the power of first impressions, and whilst they may be useful, safeguarding professionals might bias further information towards validating theses initial beliefs. In this PhD study, school nurse's initial concerns (for example, about

withdrawn behaviour relating to mental health) determined the type of information sought and the places it might be sought in, suggesting that initial impressions may indeed colour the rest of the assessment process.

8.2.4 Promoting Holism in Assessment

Most school nurses defined their approach to gathering additional information as holistic. This encompassed asking questions of children and young people, as well as requesting information from family and other professionals in order to build a picture of the child's life. Holistic approaches broaden the focus of assessment wider than one singular issue (Appleton and Cowley, 2008c). In the current study, a holistic approach was defined as understanding the context of the safeguarding concern, seeking different perspectives and understanding why a risk-associated event might have happened. School nurses attributed value in seeking sources of information to illuminate each aspect of a child's life, assigning a broadly ecological and holistic framework of physical, mental, emotional, social and sexual health (Bronfenbrenner, 1994; Lancaster, 2007).

> *"look at their history, what the issues are now, what has been done in school, what needs to be done, try and look at them holistically"*
>
> P008

"we look at physical health, emotional health, sexual health, family…what's important to them? anything that's a risk?"

P010

Although some school nurses felt that gathering information was a process to validate their own initial judgements, others felt taking a holistic approach could protect them from individual subjectivism and being narrow-minded in their opinions. Differences in practice between participants might be attributed to their experience and beliefs about the remit of school nursing. A study by Paavilainen, Ästedt-Kurki and Paunonen (2000) identified different active and passive approaches to school nursing practice dependent on individual school nurse's confidence and ideas. In this PhD study, school nurses' opinions on safeguarding practice could broadly be categorised in two; those who embraced *'detective work'*, and those who felt it was their role to identify safeguarding concerns but refer on to other specialist agencies to perform these in-depth assessments. In chapter ten of this thesis, this is discussed in relation to the wider arguments about the remit of school nursing practice in safeguarding and the gradual shift away from prevention (Elkan *et al.* 2000; Ball and Pike, 2005; RCN, 2016).

School nurses described their own perspective on safeguarding concerns as a small piece of a larger puzzle but believed they could also act as the central figure to pull together pieces of information and build a more complete assessment. Although school nurses have been identified as forming part of

a team of professionals who can lead on addressing safeguarding concerns, this more 'unofficial' central role in gathering pieces of information together is poorly documented in UK safeguarding and child protection guidance, often presumed to be the role of the social worker (DH, 2017; HM Government, 2018). In this study, this suggested changing roles and boundaries for the school nurse, which some resisted, towards a leadership role within safeguarding processes.

> *"if you're thinking about child protection, we are just a small part of a big puzzle"*
>
> P004

> *"school nurses have got all those links to the external agencies, and they are the lynch pin that links them all together, often school nurses are the ones that each agency is liaising with separately, and they can be the one to join the dots"*
>
> P018

As discussed in chapter seven, this aspect of the school nursing role (i.e. bringing together different pieces of information) was often facilitated by trusting relationships with children, families and other professionals. School nurses frequently conceptualised assessment in safeguarding as a puzzle, owing to the complexities of family engagement, truthfulness and barriers to communication between professionals. These three issues particularly could

create knowledge gaps and areas of uncertainty in relation to the holistic picture of a child or young person's life.

8.2.5 Influencing Factor: Time

Time was a commonly explored constraint in relation to gathering information about a safeguarding concern. School nurses acknowledged that there might be a 'perfect' scenario for conducting a comprehensive assessment of a child or young person, but in reality this was often constrained by a finite time slot for the appointment. This forced school nurses to make 'rapid assessments' (Munro, 1999) despite their perceptions on the importance of time and building trust with children, young people and their families, and to prioritise more direct questioning about safeguarding concerns. As with other studies into public health nursing, school nurses felt they had so many competing priorities that they had become a 'jack of all trades' and were unable to give special attention to just one area (Appleton, 1996; Nic Philbin *et al.* 2010).

> *"it's trying to gather as much information in…literally we have ten minutes…thinking about the threshold of need trying to tick as many of those boxes"*
>
> P004

"it would be a very robust assessment if it was completed every time, but it's very time consuming"

P023

Lack of time was largely dictated by large caseloads and the competing priorities of record keeping and other administrative tasks, as highlighted in chapters one and five of this thesis (Children's Commissioner for England, 2016). School nurses in this study were responsible for large school cohorts (commonly, at least one secondary school of circa 1000 pupils), and sometimes multiple school cohorts, and school nurses felt this created tension between spending direct time with children and completing mandatory administrative work such as maintaining clinical notes.

"should your caseload be busy and heavy, it's about prioritising those needs"

P003

"I'd say direct contact is a lot less, predominantly because you have to come back and type it all up, so if you come back and make the calls, it takes longer"

P015

In this way, school nurses felt they had to work in a reactive way; prioritising appointments with children and young people they felt were at the most risk

and for whom they were most concerned. With the central tenet of public health being proactivity, it could be frustrating for some school nurses to shift to reactivity; respondents to previous surveys of school nursing practice have labelled this concept 'fire-fighting' (Ball and Pike, 2005; RCN, 2016).

8.2.6 Influencing Factor: Intuition and Risk

Intuition has been discussed in relation to making observations of children and young people and was a key influencing factor in this second stage of the identified *'process model of risk assessment in school nursing practice'*. Intuition can be defined as a state of 'knowing' without evidence for rational reasoning and is often overlooked as a valid form of evidence in nursing practice, which largely still favours countable information (Hassani, Abdi and Jalali, 2016). In the current study, most school nurses were frequently influenced by intuition, or a gut feeling, to guide them in following-up concerns. As previously explored in chapter seven, intuition may be related to prior professional and personal experiences, however this might also invite inherent bias (Munro, 1999; Johnson-Reid, Drake and Kohl, 2009; Enosh and Topilsky, 2014). Participants in the current study defined intuitive feelings as doubting thoughts, feelings of anxiety, acting instinctively or experiencing discomfort regarding the truthfulness of a child's response to a question.

"[on intuition] it's just a bell that rings, you meet a child and there's a deep sadness behind their eyes…something's not right"

P001

"I think you acquire knowledge and experience of being with people, you just get to know, that sounds like you're working intuitively, it's a collection of training and different things you pull together"

P018

As highlighted in section 8.2.3, some school nurses described how previous professional experiences of safeguarding often created a mental template by which to identify and investigate future concerns, and they felt this could manifest as intuition (Appleton and Cowley, 2008b). A similar concept was found in a qualitative study by King (2016), where participants relied on intuition (based on experience) to make judgements with little concrete information. In the current study, these contributing professional experiences included working with different children, young people and families in varying environments over time, observing the practice of other school nurses and engaging in training. Some school nurses still spoke of intuition even though they were newly qualified; one participant had only been qualified as a school nurse for one year. This suggested that intuition was based on more than an accumulation of experience, or perhaps relied on other types of experience beyond the scope of professional practice. It has

been suggested by Hassani, Abdi and Jalali (2016) that intuition relies more on knowledge of the individual patient and their norms and is facilitated by a strong bond of trust; perhaps a further case for the visibility of nurses in school.

Intuitive feelings (including anxiety, nervousness, a sense of un-ease) could present a dilemma for the school nurse when these feelings contradicted the verbal responses of a child or young person, or the outcomes of a health questionnaire. School nurses might feel that there was still an underlying safeguarding concern for that child, even if the outcome of their assessment found no evidence of this. This tension could be created by a sense of duty to protect children and a fear of missing something important. A defensive approach to risk seems to permeate the culture of safeguarding practice in the UK, although not always consciously, and anxieties persist regarding *"sins of commission"* (accidentally doing harm with an intervention) and *"sins of omission"* (not intervening well enough); this sometimes leaves professionals walking a tight rope of decision-making (Munro, 2011; Whittaker and Havard, 2016, page 1158). School nurses' perceptions of these anxieties are explored in chapters nine and ten of this thesis.

Despite many school nurses describing intuition as being rooted in experience, some school nurses conceptualised intuitive thoughts as subjective and personal. This meant it was challenging to present them as adequate proof of a child or young person's vulnerability to specialised

services (such as children's social care) who seemingly relied on objective evidence.

> *"but sometimes it's a gut feeling, it's very difficult to challenge what is being presented"*
>
> P012

> *"you have your intuition; you have your own ways"*
>
> P024

Other school nurses expressed some confidence in following intuitive feelings to guide their actions, including decisions to conduct further assessments of the child and family and involve other professionals, as they felt more driven to satisfy their own gut feeling than worry about referrals to specialist services being rejected. These school nurses seemed to reject (in part) the perceived rigidity of organisational processes in safeguarding, which they sometimes felt pushed them away from nursing intuition and autonomy, to 'flow-charts' and 'checklists' that dictated procedure (Munro, 2019).

> *"[on intuition] I think if you truly care about what you do, you care about the wellbeing of the child, even if it comes to nothing you've not caused any harm, so listen to it, I think"*
>
> P013

"[on truthfulness of parental explanations of safeguarding events] challenge it, don't take that as gospel, because it isn't always, that comes from confidence, sometimes you get a gut feeling"

P017

Maintaining this professional curiosity (a recommended stance in safeguarding) is a way of promoting openness and transparency; opportunities for professionals to voice these feelings can have an important impact on patient safety (Francis, 2010). Professional curiosity is defined in the literature as having the sensitivity, courage and communication skills to see past assumptions (Burton and Revell, 2018).

8.2.7 Influencing Factor: Sharing Information (Trust)

The ease of gathering information during the process of *'detective work'* was influenced by the mechanisms of communication and sharing information with other professionals (Munro, 2011). The methods by which information was shared could be described in terms of formal ways (e.g. a referral form) and informal ways (e.g. an impromptu conversation) as previously discussed in *'receiving referrals'* (chapter seven, section 7.2.1). Each of these processes followed a different approach to how information was handled and passed from one professional to another. In this study, sharing information was hampered by breakdowns in communication, which were commonly caused by systems that were complex to navigate and contrasting perspectives

regarding the ownership of information. A tension was thus created between the desire to share information and build human networks, and managing complex systems (Hennessey, 2011; HM Government, 2018). In addition, the constraints of working in professional 'silos' meant a focus on internal processes could neglect the need to build a shared knowledge at inter-agency boundaries (Williams, 2011). As previously explored in chapter one, the increase in targeted, reactive work for school nurses meant their role became increasingly about working with social workers and other safeguarding professionals within child protection processes, thus needing to increasingly confront these inter-agency boundaries (Clarke, 2000; Ball and Pike, 2005; RCN, 2016).

> *"safeguarding sharing with another GP centre within that location is horrendous, they just say -no, it's need to know…and they won't share"*
>
> P009

> *"sometimes there's a bit of a rub, we have this mantra that it's health information and we can't share without permission"*
>
> P012

Although all school nurses were aware of formal routes of sharing information with other agencies, such as sending a secure email or booking a telephone appointment, some school nurses held value in being able to share

information in informal ways, including dropping-in on school staff at ad-hoc opportunities. This has been highlighted in chapter seven of this thesis. These school nurses often felt that waiting to contact professionals through formal routes caused delays, such as leaving a telephone message and waiting for a response, only to miss the subsequent call and repeat the process; one school nurse named this "*telephone ping-pong"*. School nurses who valued informal approaches were often proactive and creative in seeking out opportunities for information sharing outside of formal routes. This pro-active approach has been defined as a *"confident and firm"* in a qualitative study of school nurses and their work with vulnerable children in Finland, by Paavilainen, Ästedt-Kurki and Paunonen (2000, page 742). In the current study, these participants who sought informal routes of information sharing were often the same school nurses who invested in building relationships of trust with other professionals.

> *"they were really good at involving me in the school ethos, [the headteacher] will come and see me on a Monday, and say-I've got a concern about this, so we liaise and communicate quite well"*
>
> P013

> *"we have a good relationship with the social workers, we go to their building and say-let's catch up on this"*
>
> P017

School nurses who felt their trust and relationship with other agencies was not consistent perceived themselves as being 'left out of the loop' of information sharing, as highlighted in chapter seven. They described receiving notifications for safeguarding events at a later stage in the escalation process, such as when another professional had referred a child or young person into children's social care. Information sharing could be described by school nurses as *"hit and miss"* or *"sporadic".* This mirrored some school nursing perceptions in previous research (Land and Barclay, 2008; Schols, De Ruiter and Öry, 2013; Jordan, MacKay and Woods, 2017; Fraley, Aronowitz and Jones, 2018). In particular, school nurses in this study felt that information sent to children's social care, either in the form of a referral or in a request for further information, became seemingly 'lost in the ether' when a response about the outcome was not received. In cases such as these, school nurses described a process of chasing information; spending time on repeated attempts to contact the named professional. This again formed part of the unseen and uncountable work of school nurses to build and maintain networks of information (John and Parsons, 2006).

> *"it's a bit ad-hoc, so I might get a telephone call and get asked to come to the office because something is kicking off, it's something immediate…and other times I won't be aware a MASH referral has gone in"*
>
> P006

"…it's difficult to contact social care and get a response back from them, I find that difficult sometimes, as you find yourself telephoning more than once and that's a barrier"

P014

Most school nurses acknowledged that these barriers to communication were not the fault of social workers in particular, but a wider symptom of the complex nature of safeguarding work (Munro, 2011; Whittaker and Havard, 2016). Multiple professionals were often involved in child protection cases, and it could be challenging to keep up with the names and current contact details of named professionals from different agencies. The chronic nature of some safeguarding work meant that children, young people and their families might have professional involvement over longer periods of time (Widom, Czaja and DuMont, 2015) meaning school nurses sought to keep up-to-date with multiple, challenging cases against competing (public health) demands of their role (i.e. screening). Many school nurses felt information sharing in safeguarding could feel chaotic, as agencies still largely operated as separate entities, and co-ordination outside of formal processes (such as child protection meetings) was largely taken on informally by school nurses or school staff as a universal service.

Some physical barriers to communication were influenced by incompatible systems. For example, school nurses in one study site were unable to send secure emails to several different agencies in their area, which was often the

most convenient and mobile method of information sharing with the provision of iPads and smart phones to the work force. In another area, school nurses hoping to speak to a GP via telephone had to call through to the patient reception at the GP surgery and book an urgent telephone appointment.

> *"but then I also need to contact the GP surgery regarding child protection issues, at the moment we're still having to go through their main reception, so it can take nearly an hour to get through"*
>
> P014

> *"it's a bit difficult to email, I'd prefer to email but emails aren't secure, I think that's a real barrier to good communication in child protection"*
>
> P015

Some school nurses blamed a lack of awareness of their role amongst other professionals for the tendency to be left out of safeguarding communications. School nurses across all three study sites felt some progress was still needed to raise their profile and build those contacts with other agencies to strengthen communication pathways, as identified in previous school nursing literature (Lightfoot and Bines, 2000; Chase *et al.* 2010; Joyner, 2012; Hackett, 2013). Many school nurses described experiencing frustration and uncertainty when requests for information (from other agencies) for the

purposes of *'detective work'* were left unanswered. They could feel un-supported in their assessment of the child, and feel they were not respected as equal in their role and influence as a safeguarding professional.

> *"it can be really infuriating when you ring…and they don't get back to you, and you're making those decisions"*
>
> P010

> *"I do get cross sometimes at social care, because we don't always get that response…and we're always playing catch-up"*
>
> P019

Despite this, school nurses were often still expected to take on this work by other professionals which felt, at times, unboundaried and unspecified (Malek, 1994). In chapter ten of this thesis, these issues are considered in light of the simultaneous proactive and reactive expectations of the school nursing role, and how this might present to other professional groups.

8.2.8 Influencing Factor: Using Tools and Guidance

The way in which school nurses asked questions of children and young people, and subsequently conducted the assessment process, was influenced by their use of tools and guidance (as introduced in chapter seven). Tools included general health questionnaires and checklists on specialist issues

such as sexual health and substance misuse. Guidelines included local standard operating procedures (SOPs) for the school nursing service and national guidance on best practice in safeguarding (HM Government, 2018).

In *'detective work'*, the use of tools and guidance might continue following the identification of a possible safeguarding concern, to support a further in-depth assessment. The use of tools and guidance (particularly checklists) to make further assessments of children and young people could be in response to a focus on objective 'evidence' of harm in safeguarding practice (Fraser *et al.* 2009; Fleming, Biggart and Beckett, 2009; Hogg *et al.* 2012. Despite this, school nurses across all three study sites did not tend to use tools and guidance in isolation but rather to support areas of practice they felt less familiar with. Tools and guidance were perceived as an aid to the school nurse's existing knowledge and experience (as well as advice from other professionals), which formed the foundation to most decision-making. Checklists, screening tools and questionnaires could act as an aide-memoire to assessment, reassuring the school nurse that they had conducted a comprehensive assessment about all areas of a child's life; this was complementary to their holistic approach discussed in section 8.2.4. At times, school nurses felt tools could support with asking uncomfortable and probing questions by creating a distance between themselves and the child.

"so, we've got all our standard SOPs and things for child protection, but what I find helpful is things in those specialist areas, you sort of know your bread and butter"

P005

"the threshold of needs matrix, its's that sort of stuff that doesn't necessarily frame the whole conversation…it's not a stand-alone tool, it's just something to be mindful of"

P009

Conversely, using checklists and tools to create this distance between the school nurse and the child might impact on the transparency needed to build trust (BYC, 2011), as introduced in chapter seven. According to Cash (2001) there is a distinct 'art' and 'science' to risk assessment in safeguarding. The art of risk assessment relates to personal rapport and experience and the science relies on tools and guidance; each alone can create difficulties, but harmony can be found when the use of both are combined within a consultation (Cash, 2001).

School nurses who described themselves as being experienced in safeguarding and child protection, and had worked in school nursing for several years, began to adapt tools to meet their own needs. These school nurses were openly aware of areas of assessment in which they felt less confident and wanted to address. Adapting tools involved making them more

user-friendly, taking the best-bits of previous assessment tools and creating a personal version. School nurses might also choose tools that were popular within the practice of their team or with previous mentors, or tools that they had used in other nursing roles within the hospital and community. School nurses argued that most assessment tools were a one-size-fits-all approach, and the reality of assessing children and young people in safeguarding was far more complex and idiosyncratic. In chapter ten of this thesis, the use of tools and guidance by some school nurses to seek structure in an uncertain role is explored.

> *"we all come to the same thing at the end, arrive at the same destination, but we've all got different ways of doing an assessment"*
>
> P005

> *"it's not generic throughout, it depends who you work with, who you've worked with in the past, what your team likes"*
>
> P013

Despite some school nurses feeling that they eventually *"arrived at the same destination"*, others expressed concern regarding the ambiguity of standard questions and the time taken to complete tools and checklists. This was most significant when the completion of a questionnaire was requested by another agency, for example, a drug and alcohol assessment for a young person to

accompany a referral to children's social care. School nurses felt that ambiguous questions often led to a subjective interpretation of the information needed, and different professionals could produce different results. It is known that objective tools can falsely identify risk, or not identify enough of a risk, and the purpose of a tool to *supplement* an assessment should be made clear to professionals (Cash, 2001).

> *"we all came up with different answers, even though we were asking the same things"*
>
> P003

> *"sometimes the questions on that assessment are very vague, and they don't necessarily draw-out the real problems, the issues you're seeing for that young person"*
>
> P008

School nurses feared over reliance on these tools could brush over the significant issues for the child, by having to ask too many unrelated questions. Such tools also imposed an organisational agenda on the assessment process, as discussed by Cowley, Mitchenson and Houston (2004) who studied ten health visitor-patient interactions and the use of risk assessment tools. Here, Cowley, Mitchenson and Houston (2004) argued that structured assessment tools created abrupt conversations, impeded the natural relationship building process and un-necessarily medicalised the assessment process.

8.3 Chapter Summary

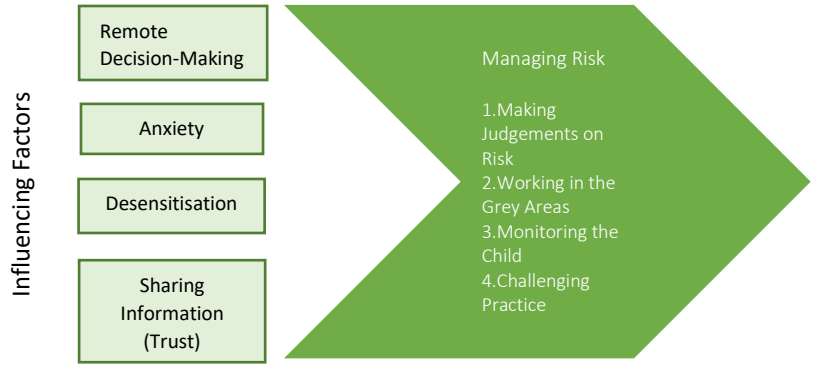
This chapter has presented the process of *'detective work'* which formed the second stage of the identified *'process model of risk assessment in school nursing practice'*. *'Detective work'* encompassed strategies to gather information and this continued to rely on trust between the school nurse, the child or young person, the family and other professionals. Tensions were apparent when managing these relationships against the need to take action and the use of structured assessment tools. The idea of the school nurse as a central figure in the co-ordination of information comes to light. The continuation of this leadership role, and the decision-making processes surrounding use of evidence and judgement of risk are explored in the next chapter.

CHAPTER NINE: MANAGING RISK

9.1 Chapter Overview

The third stage of the identified *'process model of risk assessment in school nursing practice'* is titled *'managing risk'* (Figure 9.1). Following the identification of a safeguarding concern and the gathering of additional knowledge, school nurses reported having to make a judgement regarding the level of risk to a child or young person. This stage encompasses *'making judgements on risk', 'working in the grey areas', 'monitoring the child'* and *'challenging practice'*. The four influencing factors *are 'remote decision-making', 'anxiety', 'desensitisation'* and *'sharing information (trust)'*. Risk was defined as a complex phenomenon, and school nurses often felt they were working in a 'grey area' of practice when a level of potential risk (for a child) could not be easily defined. As explored in chapter six of this thesis, concepts of risk are drawn from bodies of literature that discuss risk in safeguarding as socially constructed and dealing with multiple chances (Lupton, 1999; Daniel, 2010; Burgess, 2014). Findings, in relation to school nurse participants, also support a move away from broader definitions of risk, to negative definitions of that might contribute to feelings of uncertainty and defensive practice within safeguarding culture (Lupton, 1999; Munro, 2007).

Figure 9.1. Managing risk (Stage C)



9.2 Managing Risk (Stage C)

9.2.1 Making Judgements on Risk

School nurses defined risk as the likelihood of abuse or neglect occurring, or the child or young person coming to harm as a result of the identified safeguarding concern; in this way they subscribed to the notion of risk in safeguarding dealing with chance (Daniel, 2010). In this study, ideas about risk (as presented by participants) related closely to a constructionist view, with thresholds of risk being heavily influenced by individual pre-judgement and shared beliefs between members of the same 'school nursing' group (Burgess, 2014). In some ways, this may be a response to the widening definitions of child abuse from obvious physical harm (i.e. 'the battered child syndrome') to the (sometimes) less overt signs of emotional abuse and neglect (Kempe *et al.* 1962; Maguire *et al.* 2015). In the current study, school

nurses formed ideas about risk, and risky situations, and looked to their colleagues and peers for advice in situations of uncertainty (explored in section 9.2.7).

As explored in chapter six, standpoints on risk in the current study were affected by pre-conceptions about the nature of vulnerability (and vulnerable groups) and the presence of risk factors. Vulnerability has been conceptualised as people who may not be able to protect themselves from harm (e.g. through age, circumstance, illness, disability) (Keay and Kirby, 2017; Virokannas, Liuski and Kuronen, 2018) and risk often involves the presence of specific 'risk factors' (Lewin and Herron, 2007). In the UK, safeguarding and child protection practitioners also work to wider legal frameworks such as the UN Convention on the Rights of the Child (UNCRC, 1989). UNCRC is a legal framework of children's rights to which a country subscribes and includes 'the right to life', 'the right to protection' and 'the right to play'. As with statements about vulnerability in some UK safeguarding guidance, there remains an element of interpretation by the professional as to who is most vulnerable, why they are vulnerable and how best to protect them (Rojeck, Peacock and Collins, 1989; PHE, 2017).

School nurses overwhelmingly spoke about estimating risk in terms of a spectrum and a hypothetical threshold above which the likelihood of harm was too great to not act. Sometimes these thresholds were the result of internalised knowledge and experience, and at other times these thresholds

were created in a more tangible form by other agencies, such as the referral criteria for children's social care. In addition, thresholds of risk were influenced by organisational agendas and the perceived defensive nature of the safeguarding system within which school nurses operated; essentially, school nurses felt it was safer to over-estimate risk and get things wrong, than under-estimate and be accountable for harm (Munro, 2011; Whittaker and Havard, 2016). In this study, school nursing discourse on communicating about risk between agencies commonly spoke of "*rejection*", "*bouncing back"* and *"pushing away",* particularly in relation to sending a referral to specialist agencies (e.g. mental health or children's social care). At times, this could prompt acts of resistance by the school nurse, as described in the first quote below.

> *"[on making a referral to social care] MASH then said, 'no, call the named social worker', and I'm being batted back and forth, in the end I just thought…I'm just going to put it as an online referral, then they can deal with it"*
>
> P010

> *"my personal response is to make the referral because I'm worried about the accountability routes, so if I was worried, I would put the referral in so that we know that we've asked the other services, does that make sense?"*
>
> P012

"if you refer them, they just bounce back…or it's not picked up at all"

P018

Challenges could occur when the school nurse's own personal or professional perceptions of a risk threshold conflicted with the thresholds set by external agencies (Williams, 2011). There was a consensus that school nurses' thresholds of risk were often lower than the referral criteria set by specialist agencies; higher agency thresholds were often blamed on financial cuts to children's services and an increase in the narrowing of community interventions to be re-branded as 'targeted' (Gillies, Edwards and Horsley, 2017). Managing these thresholds was another aspect of the unseen work of school nurse's safeguarding practice. In the discussion chapter (ten) of this thesis, the burden of this unseen work is explored in relation to managing a proactive role (pre-empting risk) versus a reactive role (caring for children and young people already experiencing harm).

"in the ideal world, we would like to look at a risk assessment at our level, not a CAMHS assessment, a risk assessment at our level"

P023

"I will continue to refer under my thresholds, and continue to challenge those thresholds…because you can feel very disillusioned when you feel this young person is being abused, and social care don't care"

P025

Most school nurses gathered information during *'detective work'* (chapter eight) with the agency threshold (for acceptance of referrals into specialist services) in mind and this would frame the way in which information was sought; seeking evidence that would meet the referral criteria. As with intuition (chapter eight, section 8.2.6), many school nurses felt that physical signs of harm were easier to present in terms of evidence for referral, and it was the less concrete signs, such as emotional harm, that were more difficult to put into words. This has been similar belief expressed elsewhere in nursing and safeguarding research (O'Toole *et al.* 1996; Hassani, Abdi and Jalali, 2016).

"the referrals I have done have been very clear-cut, black and white, it's been instances of physical abuse…I haven't had to think twice about that"

P004

"I think we've got to be really clear on what our threshold is, and what the risk is…we can't just say-that's awful that's child protection…because what is child protection? what's not being done?"

P022

School nurses frequently applied their own spectrum of risk to each assessment with a child or young person, placing them on a hypothetical gradient of likelihood of harm. Some children might progress to becoming more at risk over time; they might have had an initial concern perceived as low risk to the school nurse, or below the referral threshold for specialist agencies, but remained stagnant, unchanging and thus increasingly concerning.

"[on a child protection case] headlice continued and continued, and I'd been phoning and phoning mum, and nothing was changing"

P009

"I think it's a worry that they're just under the threshold and they sort of bubble along, there's such a lot of damage being done during those months"

P018

Despite challenges of administrative work and busy caseloads, most school nurses that were visible in the school environment on a regular basis felt able to see a child or young person more than once, and over a period of time, to identify such changes. As discussed previously in chapters two, seven, and eight of this thesis, this visibility has been identified as a key factor in building trusting relationships (Engh Kraft, Eriksson and Rahm, 2016; Sekhara *et al.* 2018).

Some school nurses felt confident in applying their own perceptions of how 'at risk' a child or young person might be, whereas other school nurses discussed their reluctance to apply their own thresholds of risk to a safeguarding situation. The latter group of participants felt more confident gathering information and discussing this with a specialist agency (such as children's social care) to receive an opinion, as they feared over-estimating or under-estimating the level of harm to a child (Whittaker and Havard, 2016).

> *"it's very easy to bring your own background into it, and judge, and working round here, you can't do that because people just live very different lives"*
>
> P001

"it's really answering the questions and giving your opinion, rather than me trying to interpret what [the children] are saying"

P003

These school nurses felt less comfortable with their role as a 'risk assessor' in safeguarding, and felt it pushed the boundaries of what it meant to be a school nurse rooted in health. They expressed concern at the blurring of the school nurse role with that of a social worker, or specialist mental health worker, and feared what this meant for the direction of the profession in the future. This perception of boundary blurring between universal and specialist services is not new; in a study of UK health visiting practice, health visitors expressed frustration at bridging the expanse of vacant services (Appleton, 1996).

"you're finding more and more safeguarding issues within work, and you risk taking on more of a social worker role rather than a school nurse role"

P018

As previously explored in chapters seven and eight, the involvement of school nurses at the boundaries with other services (including children's social care) and the unseen complexity of this is arguably under-represented in current commissioning guidance for school health services in the UK, which talks widely of health promotion, health prevention and universal screening (PHE,

2016). The two main categories of ideas about where the school nurse role should be located (according to participants) are explored in chapter ten of this thesis.

9.2.2 Working in the Grey Areas

School nurses defined working with some groups of children and young people in safeguarding as a 'grey' area of practice. This encompassed the children whose level of risk was difficult to define, or the children and families who were not accepted into specialist services. This area of practice felt 'grey' because there may be no concrete evidence of immediate danger to the child, but still concerns for their health and wellbeing, and school nurses often described feeling left to hold this knowledge. Practising in the 'grey areas' of safeguarding has been defined elsewhere in the literature as areas of unknown, areas of dispute or concerns that don't fit the rules of the system in which they sit (Appleton, 1996; Jowitt, 2003).

In the current study, many school nurses felt responsible for making decisions and continuing to monitor the level of risk to a child (section 9.2.3) and perceived this process as being open to subjectivity. Many school nurses took on this role despite feeling it should not be in their remit, as the boundaries with social care and mental health services continues to blur. School nurses further described children and families in the 'grey area' of practice as being in a *"void"* or *"on hold"*, as their level of need was somewhere between early

intervention services and specialist agencies. Whether school nurses should indeed take on a monitoring role, and the implications of it, are discussed in chapter ten.

> *"so, there does tend to be a void, a gap for a period of time where this family are left in limbo, and in many cases social care don't pick up, and then it's left for schools"*
>
> P004

> *"safeguarding and child protection is always grey, some of it can be very subjective, depending on how you view the situation, one nurse can interpret a child's views and opinions in one way, and another person in another"*
>
> P006

School nurses felt they acted as one of few universal service professionals (along with education) who could 'catch' these children and young people, and there seemed an ever-shrinking availability of multi-disciplinary support at this community level (Gillies, Edwards and Horsley, 2017). There have, of course, been real cuts to spending in the UK, with the 2008 financial crisis acting as a *"critical juncture"* in austerity (Gray and Barford, 2018, page 4). Between 2010-2016, the budget for children's social services in the UK reduced in real terms by £2.4 billion (with some reallocation), yet the demand increased in the form of 108% more referrals (Gray and Barford, 2018). In the

community sector, cuts to youth services (e.g. youth centres, youth workers and related services) were approximately £60 million between 2012-2014 (UNISON, 2014).

> *"there seems to be less and less for the in-betweens…so child protection is here [indicates]…and non-child protection is here [indicates]…but it's the in-between bit"*
>
> P007

> *"I keep getting invites to initial child protection conferences, because everything is going to child protection, because they have taken away all the support at that bottom level"*
>
> P011

Several school nurses felt that, whilst children and young people who were picked up by children's social care were more obviously 'at risk' of harm, it was the children in this 'grey area' of need that caused the greatest sense of professional burden and anxiety (Appleton, 1994; Rooke, 2015; Wallbank and Woollacott, 2015). This was because children known to social services usually had several other professionals involved as part of a local authority plan of care, and this shared the responsibility for managing risk and making decisions (between professionals).

"sometimes it's not the ones that are on a [child protection] plan we're worried about, it's the ones that aren't"

P017

School nurses often expressed feeling uncertain as to how to manage the burden of offering a consistent level of contact to children, young people and their families below the radar of children's social care. As highlighted in chapter one and five, school nurses were often responsible for a large secondary school, or multiple secondary and primary schools, and many children came under this category of need. It was described by participants in the current study, how these children and families could often 'drift' and lose contact with services, until a significant event would bring it back into the safeguarding 'spotlight' within school. This somewhat contradicts the early intervention agenda, focused on early identification and response to signs of child abuse and neglect (Gillies, Edwards and Horsley, 2017).

"do we jump on things when we know there's a vulnerable child? do we need to get involved? Because we would be doing that for all children, it's that grey stuff"

P006

"it drifts for a bit, and suddenly someone thinks-oh actually things aren't happening as they should be…and there's this scramble to get things back"

P012

School nurses defined two types of abuse that they found most challenging to manage in terms of risk assessment in the 'grey areas' of practice, and these were child sexual abuse and child neglect. Child sexual abuse was discussed as a hidden issue, as school nurses felt few children and young people came forward willingly to disclose. This was attributed to sexual abuse being a taboo issue in society, and young children being unaware of what might constitute sexual abuse of their bodies (Engh Kraft, Eriksson and Rahm, 2016; Fraley, Aronowitz and Jones, 2018). In addition, one nurse discussed the difficulties in making a clear risk assessment in disclosures of peer sexual abuse, where the lines of sexual consent could be complex (Jackson and Scott, 1999). When children did disclose sexual abuse, school nurses found it emotionally distressing, and could find it difficult to know how best to support the child through the child protection process, as explored in section 9.2.7 of this chapter. This finding is congruent with other studies of school nursing perspectives of child sexual abuse (Engh Kraft, Eriksson and Rahm, 2016).

"[on suspected sexual abuse] it's showing in the child's behaviour, but she's yet to admit it, so that's very hard"

P002

"it's those blurred lines between what is consent and what isn't, so it's the sexual health, or the sexual assault side of child protection, it's really difficult"

P009

School nurses expressed uncertainty and frustration regarding suspected cases of child neglect. They felt it was difficult to assess the risk to the child or young person as neglect was often an accumulation of neglectful caregiving over time, and it could be challenging to present tangible evidence that matched the thresholds for referral into children's social care (Dubowitz, 2013).

"the other one I find really difficult is neglect, because it's difficult to pin down"

P009

"neglect, where things don't change, and you can see, for that young person, nothing is changing…it's just 'good enough parenting' isn't it?"

P010

School nurses perceived that an inability to present such 'tangible' evidence created a longer, more drawn out experience of professional anxiety, where they felt increasingly disillusioned about the possibility of positive change.

Boundaries, thresholds and referral criteria within safeguarding processes became a common feature of practice described by many school nurses in the current study, as highlighted throughout chapters seven and eight.

9.2.3 Monitoring the Child

Many school nurses employed several activities termed 'monitoring' to manage situations where a level of risk for a child or young person was undefined. This included monitoring children and young people who were waiting to hear the outcome of a referral to specialist services, and children who had yet to disclose or display significant signs of a safeguarding concern (but for whom there were professional suspicions of child abuse or neglect). School nurses felt a level of responsibility to 'hold' these children and identifying any detrimental changes over time, particularly if no other professionals were involved. In this way, school nurses described their role in universal services as a 'safety net' for children and young people whose vulnerabilities may not otherwise be recognised, and this is explored further in chapter ten. Monitoring might involve gathering information as in *'detective work'* (chapter eight), but the focus of this chapter is on the repeated re-assessment of risk over time.

"I'd have more appointments with the children, keeping a closer eye on things because there aren't any other professionals involved in terms of social services…so it's continuing to monitor and just keep an eye on them, find out if things are changing"

P006

"the reason I'm still visiting, because he's seventeen now, so he's nearly ready to go into adult services, but his weight was very low so we're continuing to monitor that…"

P012

For social workers, this holding activity has been identified as creating uncertainty, often underpinned by a negative concept of risk constructed by governments, media and the public (Littlechild, 2008). Categories of child protection (e.g. a child protection plan, a child in need plan) can create separate categories of practice that don't account for gradients of need, and the significant resources often required to support those children and families that don't meet constructed thresholds for higher level intervention (Kirk and Duschinksy, 2016). In the current study, some school nurses described monitoring as facilitating a 'ticking time bomb' approach to safeguarding, where professionals were seemingly waiting for the next bad thing to happen and hope it met the threshold for specialist intervention.

"it does feel a bit like a waiting game, for me to refer [to children's social care] in the first place means I think there is significant harm, so then it feels like a ticking time bomb waiting for another bad thing to occur before they will hear the referral…it's treatment not prevention"

P015

In this study, practical ways in which school nurses monitored children and young people included regular short and informal appointments and observing how a child interacted with others in the school environment (e.g. the classroom or the playground). They might also monitor the child or young person's school attendance, as well as attendance at other routine health appointments. School nurses felt perceived 'at risk' children valued the informal contacts with them, particularly if they were waiting for an assessment appointment with specialist services (such as CAMHS or children's social care), as it provided a point of communication and reassurance. This meant the role of monitoring had a therapeutic element to it, as well as being used as a form of surveillance. This process was frequently defined as *"containment"* by the school nurses interviewed in the study; in relation to containing both the emotions of the child and any escalating risk. 'Emotional containment' is a term borrowed from psychotherapeutic counselling, and relates to the preservation of a safe therapeutic space by the counsellor (Miller, 2018), as reflected in chapter seven of this thesis in relation to the school nurse creating safe spaces for children and young

people to disclose abuse or neglect. Monitoring was described most commonly by school nurses who were based permanently in one school, as they had the advantage of a daily presence amongst the school population.

> *"it's just a case of holding them, containing them, reviewing their situation…they're given an appointment to come and see me, just so they know they've not spilled and someone's gone-okay, we'll deal with that…and then nothing's happened"*
>
> P001

> *"I think we get to see those children in school every day, we're the eyes, aren't we? we can protect every child we see, can't we?"*
>
> P013

In contrast to school nurses who felt they could *"protect every child they see"*, some school nurses felt these monitoring activities went beyond the remit of their role and stemmed from a school nurse's own need to feel reassured. In addition, consistent monitoring activities could be hampered by large caseloads and the pressures of time (Children's Commissioner for England, 2016; RCN, 2016). This hesitancy to participate in monitoring children and young people at risk of child abuse and neglect, or from significant mental health concerns (discussed below), might be justified. Although many argue that safeguarding activities (such as 'surveillance') should be shared between agencies (i.e. not just the responsibility of children's social care) (DH, 1991;

HM Government, 2003; HM Government, 2018), a recent report by The King's Fund (Charles *et al.* 2018) highlighted the struggle of UK universal and community health services (including school nursing) to meet the needs of the population owing to chronic under-funding and an over-burden of work.

In the current study, it was common for school nurses to be monitoring safeguarding risks that related to mental health, such as suicidal ideation and self-harm. Although this PhD study set out to understand risk in relation to child abuse and neglect, self-harm and suicidal ideation were commonly cited by school nurses as safeguarding risks in practice (as explored in chapter seven, section 7.2.4). School nurses were commonly monitoring children and young people who were experiencing serious mental health concerns and waiting for an appointment with CAMHS, and participants did not always feel comfortable with this role. The rise in demand for child and adolescent mental health services in the UK is known; between 2012-2015 referrals to national child and adolescent mental health services (CAMHS) rose by 64% (Earle, 2016) with school nurses being on the front-line to deal with new and existing mental health concerns arising in school.

For some school nurses in this study, they felt they became the default health professional to 'monitor' children and young people with mental health conditions in school whilst they waited for CAMHS involvement. These school nurses did not necessarily feel that addressing mental health needs should form no part of their role, but rather they felt less equipped to provide mental

health interventions above a certain level of perceived seriousness (namely suicidal thoughts and significant self-harm).

> *"I think school nurses get very panicking about suicide risk, and I think if you haven't got that background in mental health, or dealing with suicide, I imagine it can be quite scary, what to do, you're left holding that"*
>
> P005

> *"the worry is when you invite them, and they don't come…there's a possibility you could lose touch with that person and wonder what they're up to"*
>
> P018

Decisions to commence with a period of monitoring were in themselves complex, sometimes forced by professional anxiety and sometimes part of a defined therapeutic 'package of care'. School nurses often questioned if something was safe for them to monitor; reflecting on their knowledge, experience and limits as a practitioner.

> *"at what point can you hold? thinking about suicide risk, what's safe for you to hold or not?"*
>
> P023

For example, one school nurse who had a background in mental health felt confident in monitoring a young person with a mental health risk, but not confident monitoring a situation involving substance misuse.

> *"if you sent me someone with drugs, I'm less experienced in that because of the school I cover, whereas some of my colleagues would hold it longer…equally, for emotional wellbeing I would perhaps hold the child longer than others, while they wait for CAMHS"*
>
> P012

School nurses felt that risk was often a hypothetical (socio-cultural) construct particularly when there was no evidence of harm being caused. This was influenced by a largely constructionist view of risk and risk thresholds, as explored in chapter one (section 1.7) (Lupton, 1999; Burgess, 2014). In addition, school nurses could label risk (in the absence of evidence) as a gamble between protecting the child, and unnecessarily intruding into family life (Daniel, 2010). In theory, school nurses could not really know if their judgements of risk were accurate unless there was a catastrophic outcome (such as serious harm) in which case they would likely realise they had under-valued the level of risk (Munro, 2011). For this reason, and despite some criticism of the monitoring role, most school nurses tended to 'err on the side of caution' and commence some level of monitoring.

9.2.4 Challenging Practice

When perceptions of risk between professionals conflicted, some school nurses often fulfilled a role of challenging practice. These school nurses did not always accept an outcome of a risk assessment by another agency and continue to 'hold' the child or young person, as discussed in the previous section. They were sometimes inclined to push against the perceived mandatory thresholds set by specialist agencies and would do this in several ways. Firstly, they might seek alternative pathways of escalation, such as speaking to a senior manager or approaching a different agency. They would often try to verbally justify the referral by re-iterating the safeguarding concerns and discussing the evidence base, such as the detrimental impacts on health and wellbeing.

> *"I guess if I'm not happy with the outcome then I speak to my manager, and speak to the named nurse, find out if there's another way of escalating it"*
>
> P001

> *"I'm often battling against the red tape, so the social care processes are constantly changing"*
>
> P009

In the literature on challenging practice and ethical decision-making, Savage (2017, page 12) discusses the concept of *"school nurse grit"* necessary to work successfully in a role that bridges multiple agencies (i.e. health, education and social care). In the current study, some school nurses might challenge practice that they perceived to be an injustice of social wellbeing; wanting more for a child than could be offered by the family, school nursing or other services (Jameton, 1984; Shi and Singh, 2012; Savage 2017). This feeling of injustice was demonstrated well in one quote, from a school nurse speaking up at a child protection conference.

> *"and in meetings you can get the feeling that the emphasis is on the parents and the parent's needs and if you can help the parents that will benefit the child, but we sometimes get a little bit lost, but you know, we are there to speak up"*
>
> P020

School nurses were divided in their opinions on challenging practice. As in *'detective work'* (chapter eight), some school nurses (as above) felt confident in taking a lead role in safeguarding and child protection, and felt they had equal weight (within the multi-disciplinary team) in decision-making regarding risk. These school nurses were more inclined to challenge other perspectives and were protective of their own expertise in health and wellbeing. In contrast, other school nurses felt that children's social care had the ultimate responsibility for making judgements about a child risk of harm

regarding abuse and neglect, and held the opinion of social care in the highest esteem. These school nurses were more likely to pass on their expertise but step-back from challenging apparent un-satisfactory outcomes.

> *"I do try not to judge, because at the end of the day it's not our decision"*
>
> P019

> *"we work closely with early intervention [social] workers, because they have a lot of contact with the children"*
>
> P021

Many school nurses felt challenging practice could be a lonely task, as they often worked in isolation as an autonomous employee of health within the school environment. In the current study, challenging practice was a tension between what the school nurse felt was right and maintaining trusting relationships with other professionals, creating a professional and moral dilemma (Jameton, 1984; Savage, 2017). Previous school nursing research has identified different approaches to working with children, families and other professionals; some school nurses may be more task-orientated and others may seek more flexible and creative ways to engage with others (Paavilainen, Ästedt-Kurki and Paunonen, 2000). The importance of trusting relationships with other professionals has previously been highlighted in chapters seven and eight, yet these relationships seem to so easily tip-over

into a state of overwhelming, unboundaried work for the school nurse and a reluctance to say *'no'*.

> *"schools also place referrals, as well as the early intervention team, social care team, and anyone else who knows about us"*
>
> P013

> *"[on challenging practice] it can be quite awkward, because you know you have to say these things but as soon as you've said something, you can hear the complaints coming"*
>
> P017

School nurses felt challenging practice was a skill best learnt through experience, as it was only through navigating these complex scenarios in real life that a school nurse could learn about their own boundaries of confidence and the boundaries of others. This was, of course, difficult in a safeguarding system where the changeover of staff and changes to escalation processes were frequent (Bowyer and Roe, 2015), which contributed further to the uncertainty and complexity of safeguarding work apparent in the stories of school nurses in this study.

9.2.5 Influencing Factor: Remote Decision-Making

The first influencing factor on the process of *'managing risk'* was that of *'remote decision-making'*. In the current study many school nurses, particularly those who held a caseload of multiple schools, frequently wrote reports, gave telephone advice (e.g. to the social worker) and attended child protection meetings for children and young people they did not know very well (yet needed to give a professional opinion about). In this way, school nurses felt they were asked to make remote judgements about risk for children and families they had perhaps only met once, or not at all. The main reason given for this way of working, according to the school nurses in this study, was a lack of time. Time was a commonly discussed constraint in relation to the ability of the school nurse to take part in *'detective work'* (chapter eight) and time pressures detracted from building enduring and trusting relationships with children and families (Munro, 1999; Children's Commissioner for England, 2016).

> *"as I say we don't actually see the children, that's one of the things I find very difficult, literally you might see the child once or twice but you're continuing to make decisions about them without actually seeing them"*
>
> P014

"the safeguarding aspects of writing reports, meetings, and the admin side of our role…the actual work with the children is quite limited"

P024

Remote decision-making became a common example for school nurses when considering where their role should sit within safeguarding and child protection (as explored in chapter ten). Some school nurses felt comfortable giving remote professional advice in this way but others felt it had become 'tokenistic' for them to be involved in some child protection processes to tick the box of quoracy (for social care) (Powell, 2007). A quorate child protection meeting is deemed to be one that had at least three professional agencies represented (Powell, 2007), but the latest guidance on working together in safeguarding in the UK states *"all involved professionals"* are to be invited to such events (HM Government, 2018, page 46). This was another example, as explored in chapters one and seven, where school nurses seemed to work with somewhat vague definitions in safeguarding guidance as they attempted to define what 'involved' meant and to manage the enduring ideas of quoracy expressed by other agencies.

For some school nurses, *'remote decision-making'* created a moral dilemma between what they knew to be best practice (involving the child) and the reality of practice (Jameton, 1984; Savage, 2017). They found it challenging to find the voice of the child (having only minimal interaction with them) as

recommended in safeguarding processes (Bruce, 2014). Some school nurses felt that not having time to see a child or young person before contributing at a meeting or via a written report, made them lose confidence and credibility in their judgements regarding risk.

> *"you can feel you don't know the family as well as others, sometimes you feel almost guilty about that because we don't see them as much as the social worker, or the early intervention worker, or school, sometimes you don't have a lot to say"*
>
> P016

> *"that's a real challenge turning up to a conference that you know nothing about; I hate turning up with no credibility"*
>
> P023

As well as providing a professional opinion remotely, some school nurses were also involved in monitoring remotely. Monitoring was previously explored in section 9.2.5 of this chapter. These school nurses might complete activities such as checking a child's attendance at health appointments and asking school staff if the child was engaging in classes well, without having much direct contact with them.

> *"often it's just monitoring if they're not attending appointments"*
>
> P001

"I was monitoring, when I say monitoring, I had not even met the child at that point…I also hear a lot of third-party information, I think as a nurse we should be more hands on"

P002

As discussed in section 9.2.5 this monitoring activity was a strategy used by school nurses to manage caseloads of multiple schools, and to evaluate children and young people's ongoing needs. In other ways, remote monitoring and decision-making seemed a symptom of the school nurse's need to stay involved, to be aware of any changes in a child's circumstances and to protect themselves (as professionals) from missing anything (Lupton, 1999; Munro, 2007; Whittaker and Harvard, 2016). Despite this, nearly all school nurses recognised that remote strategies, as well as the requirements to attend child protection meetings and submit reports, diluted direct time with children and young people (RCN, 2016). This seemed to create a cycle of reactive working that was difficult to break.

9.2.6 Influencing Factor: Anxiety

The way in which many school nurses approached *'managing risk'* could depend on their emotional experience of safeguarding. In particular, school nurses frequently defined feelings of anxiety in relation to recognising and making judgements about possible child abuse and neglect. The responsibility

of making an independent assessment of a child or young person and carrying out monitoring activities led to examples of stress and rumination described by many of the school nurses in the current study. Rumination was defined as thinking about safeguarding concerns beyond the end of the working day. These responsibilities were commonly defined as *"heavy"*, "*burdensome"* or "*weighty"*.

> *"it feels quite heavy on our shoulders, it feels bigger than it should sometimes, it can be quite overwhelming"*
>
> P009

> *"once you get that information you start owning it whether you mean to or not"*
>
> P011

> *"so personally, I find that difficult because you worry about where [the young person] is, and what she's doing, and then your mind overruns"*
>
> P013

Considering professional anxiety in relation to safeguarding practice is important, as emotional burnout is detrimental to nursing retention, and repeated cycles of anxiety and burnout may reduce the effectiveness of *"emotional buffering"* in future practice (Trifiletti *et al*. 2017, page 5). In

addition, un-examined fears can lead to defensive practices (Whittaker and Harvard, 2016).

Some school nurses described worrying about the outcome of their decision-making or the emotional impact of possible child abuse and neglect concerns on the child. These experiences of anxiety might influence future decision-making, as school nurses sometimes struggled to feel confident in their judgements. They might make immediate referrals to other services (i.e. children's social care) to help lessen the burden of anxiety put upon them, despite sometimes feeling their concerns were (at that time) below the threshold of referral.

> *"I've taken it home and really found it difficult to be confident that the decisions were the right decisions"*
>
> P008

> *"I think you're always wondering if your interpretation of things is not quite how it should be. There's always a possibility you could be saying the wrong thing or making things worse."*
>
> P018

In addition to feeling a burden of responsibility, many school nurses in this study defined the emotional challenge of dealing with difficult disclosures. Children and young people were often distressed when making a disclosure

of abuse or neglect, and school nurses discussed concepts of empathy and 'taking on' another person's emotions. School nurses who felt it was important to lower their own emotional barriers in order to build a trusting relationship with the child described this most keenly. They might feel emotionally drained or experience heightened emotions for the rest of the working day and seek outlets for this in the form of colleague support or clinical supervision (discussed later in this section).

> *"obviously you hear stuff that really upsets you, children don't ask for that to happen, and you can't help but take it personally"*
>
> P010

> *"it can be really overlooked, the emotional impact on school nurses, because we take on that person's trauma, so you can take it on board, and it can have a huge impact"*
>
> P021

In counselling therapies, the concept of creating a safe space for patients to disclose difficult or (perceived) shameful information is called *"containment"*, "*holding*", or "*boundarying"* (Gravell, 2010, page 29; Miller, 2018), as introduced in section 9.2.3. Most school nurses in this study, especially newly qualified school nurses, had no formal counselling training and navigated difficult, emotional conversations with experience more akin to the clinical assessment of patients in the hospital. Although school nurses were

undoubtedly adept at this, it could mean they sometimes faced children's complex emotions, mental health and trauma with a sense of uncertainty.

Feelings of anxiety could be perpetuated by feelings of isolation, as school nurses from across the three study sites often worked alone (as the only member from a health organisation) in school or travelling between appointments in the community. This lone working was one of a few aspects of the current service delivery model of school nursing that contributed to feelings of anxiety. In addition, the perceived rise in the size and complexity of caseloads that necessitated a remote working style, left school nurses in the current study feeling helpless and guilty about not having more direct contact with children and young people, as previously discussed in section 9.2.6.

> *"I actually felt a bit helpless, I had to sit in my office chair…as a school nurse I have that information on my shoulders"*
>
> P002

> *"when you're supporting young people, you have a lot going on with them, it can take its toll when you are working in isolation"*
>
> P008

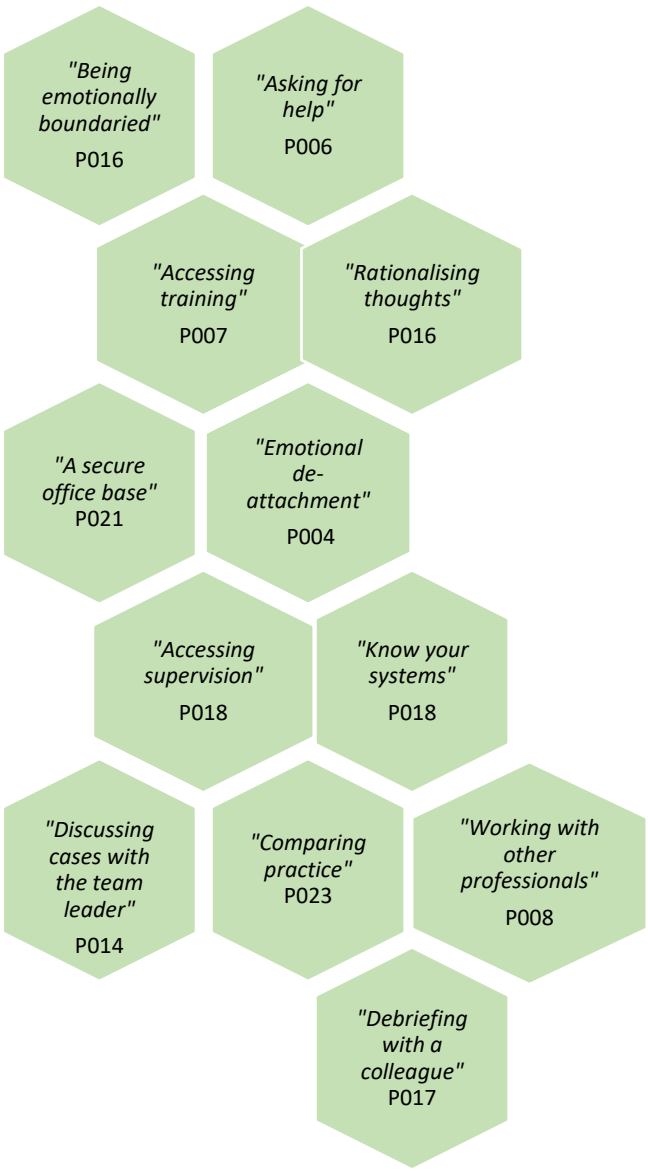
In this study, it was perhaps not surprising that school nurses (especially those recently qualified) felt some anxiety and uncertainty about complex decisions

and this has been discussed elsewhere in the school nursing literature (Land and Barclay 2008; Schols, De Ruiter and Öry, 2013; Engh Kraft and Eriksson, 2015; Fraley, Aronowitz and Jones, 2018). It was therefore important to discuss strategies (in Stage Two interviews) for exploring and addressing these shared emotions, and school nurses in the current study offered several solutions. These are collated and summarised in Figure 9.2.

Solutions were centred on maintaining a connection with the wider school nursing team and having the opportunity to meet and discuss difficulties in relation to safeguarding cases (e.g. clinical supervision, visiting the central school nursing team office and debriefing). Access to training in order to feel confident with safeguarding systems was valued, and training was on offer in both online and face-to-face formats in all three study sites. Mandatory clinical supervision was provided across all services involved in the study, and this was also highly valued by the school nurses, as it is by professionals in other research studies (Edwards *et al.* 2006; Jarett and Barlow, 2014). Maintaining emotional boundaries was practised by attempting to rationalise ruminative thinking, although emotional boundaries, as with creating distance in professional assessment, could create a tension with building trust and making meaningful connections with children and young people (Cash, 2001; Alizadeh, Törnkvist and Hylander, 2011). Creating a peaceful and comforting space at home or in a central office base allowed school nurse's emotions to de-escalate away from the school environment, highlighting the

importance of maintaining such spaces even if school nurses should become more present in school.

Figure 9.2. Solutions for managing professional anxiety in safeguarding



9.2.7 Influencing Factor: De-sensitisation

Desensitisation in safeguarding can occur when risk factors (such as substance misuse or domestic violence) occur so frequently within a community that they become culturally normalised by professionals (Rawlings *et al.* 2014; Sidebotham *et al.* 2016). At times, safeguarding professionals may become desensitised subconsciously to cope with increasing complexity and demand of concerns (Rawlings *et al.* 2014; Sidebotham *et al.* 2016). In this study, a school nurse's assessment of a child or young person could be influenced by their professional sensitivity to risk. Some school nurses discussed that, over time, their perceptions of risk might change as they become exposed to a greater variety of safeguarding concerns.

> *"it feels like every family has a violent relationship, and they all use drugs at some point, it almost becomes the norm. I have to pull myself back every now and again and think…this isn't acceptable"*
>
> P011

> *"I still try to be as open as when I started, it's quite difficult when you've been here a long time because you tend to get quite cynical and that is something as a nurse I will speak to myself about"*
>
> P019

Most commonly, school nurses were aware that they might become less sensitised to the risk associated with vulnerable situations, such as underage sexual activity, and often used regular self-reflection to contemplate this. In other ways, school nurses described becoming *"cynical"* about the outcome of risk assessment and were more inclined to seek a higher level of intervention to avoid periods of waiting for early intervention services to have an impact (section 9.2.6). In this way, school nurses could manipulate the perceptions of risk across agencies to promote acceptance of referrals; learning what other agencies perceived as high risk and collecting information to meet this threshold. This was perhaps a response to the systematised safeguarding processes that seemingly relied on objective evidence over subjective concern, as referenced in chapter eight (Cash, 2001).

Sensitivity to risk might also be influenced by the environment in which the school nurse practised. This was highlighted when school nurses discussed working across several different geographical areas, which allowed them to compare their perceptions of risk with others. One school nurse discussed the difficulties of making a risk assessment when safeguarding concerns were so commonplace within the communities; it became challenging to 'see the wood from the trees' and differentiate those children and families that needed a higher level of health and social care intervention (Sidebotham *et al.* 2016).

"I mean chaotic home life…there's loads of chaotic home lives around here, and bad conditions people are living in"

P001

Another school nurse spoke of undertaking a rural community placement during her school nursing degree and discovered her ideas about risk had been formed and influenced by the inner-city environment in which she normally practised.

"I did an alternative placement with this school nurse, and she took me to see this family who was on a child protection plan, and when we left the home she did her little chat to me 'so obviously he's on street corners and drinking every night'…and I thought-oh god, if that was in the city that would be the whole population on a child protection plan"

P022

In this way, school nurses in the current study felt their estimations of risk could not be independent of their background, training and experience, as this knowledge provided a template against which to compare safeguarding concerns. Acknowledging sensitivity to risk seemed to be an increasing demand of school nurses as they took part in safeguarding processes; whereby it perhaps used to be acceptable to voice a concern and refer immediately to a specialist agency, school nurses were now taking a

leadership role in monitoring children and young people in school and making more judgements about risk on a daily basis.

9.2.8 Sharing Information (Trust)

The final influencing factor on this stage of the identified *'process model of risk assessment in school nursing practice'* was information sharing between professionals, as in *'detective work'* explored in chapter eight. In *'managing risk'*, school nurses relied on a network of professionals to compare their concerns regarding child abuse and neglect, and to build community support around a child or young person for the purposes of ongoing monitoring. This has previously been conceptualised as a human network hinged on trust (Hennessy, 2011).

Creating this 'safety net' of professionals was most commonly discussed by participants in relation to children, young people and their families who were not yet known to children's social care, or who were apparently below the threshold for referral. Many school nurses felt that if they initiated this circle of professional support around a child and family, it was less likely that new concerns could *"slip through the net"* (Appleton, 1994; NSPCC, 2018, page 2). This was, in part, driven by the professional anxiety of missing new or changing signs and symptoms of abuse and neglect, as defined in section 9.2.3 (Lupton, 1999; Munro, 2007; Whittaker and Harvard, 2016). Some school nurses in the current study were particularly motivated to liaise with

professionals in the community, where they felt they had less of a presence outside of the school environment and during the school holidays (as most school nurses worked term-time only). Examples from practice included asking a GP to see a child for a health review and arranging a home visit from a health visiting colleague.

> *"I use the community to support me…so I used the GP to follow-up with an asthma review, and the travelling education champion to visit"* P002

> *"we can do that real team around the family…so we're grouping all the time, our knowledge around that family"*
> P019

In some cases, when a young person may be at risk to themselves (for example, from self-harm or suicidal ideation), a school nurse might share information with parents and ask them to monitor the young person closely in the home environment.

> *"immediately you would contact the family, make sure everything was in place for that young person, to be in school, to be cared for in a safe way"*
> P008

This was again facilitated by trusting relationships with children, young people and their families, which allowed school nurses to gain access to the private sphere of the family home. It has been suggested that trust holds a certain weight of power in contexts such as these, and the ethical considerations of using such power in nursing is under-researched (Dinç and Chris Gastmans, 2012), as discussed in chapter six. In this study, the trust nurtured by the school nurse to encourage a young person's disclosure of self-harm or suicidal ideation might quickly be broken by sharing information with parents. As identified in chapter seven, trust (and confidentiality) between the school nurse, child and their family might often be broken in this way due to the school nurse's professional duty to escalate child protection concerns, thus this 'network' was more fragile than those built with professionals.

9.3 Chapter Summary

This chapter presented the final stage of the identified *'process model of risk assessment in school nursing practice'.* Making an analysis and managing risk, were complex processes that involved uncertainty, challenging practice and professional anxiety. Managing risk was discussed in terms of child abuse, neglect and specific mental health concerns constituting a risk to 'self' for the young person. This stage could be moderated by the strength of relationships with key stakeholders, knowledge, experience and beliefs of the school nurse, and access to an outlet for professional anxiety. The key concepts of risk, trust

and communication continued in this stage, as well as school nurses' increasing involvement in reactive work, and these will be explored in-depth in the following chapter.

10.1 Chapter Overview

Chapter ten first brings together the key concepts from the identified *'process model of risk assessment in school nursing practice'*; risk, trust and communication. As defined in chapters seven to nine, and set out in the research objectives of this study, safeguarding 'risk' related to child abuse and neglect, and for some school nurses included children and young people who self-harmed or expressed suicidal ideation. The objectives of the current study were: *'to explore the processes through which school nurses identify school children aged 5-19 years at risk of child abuse and neglect'*, '*to explore how school nurses make assessments of school children aged 5-19 years at risk of child abuse and neglect, and the types of school nursing interventions offered to them'*, and *'to explore the experiences of school nurses in identifying and working with school children aged 5-19 years at risk of child abuse and neglect: including the perceived challenges and opportunities of their role'.*

Definitions of risk, trust and communication as introduced in chapter six are discussed in relation to the research data from Stage One and Stage Two, including the processes through which these concepts became interdependent in school nursing practice. Following this, an exploration of

the current role of the school nurse in safeguarding is given, considering their increasing involvement in risk management and the tensions of this reactive work within the wider public health remit. This sets the scene for the final chapter (eleven) of this thesis where recommendations are made for the future of the school nursing role.

10.2 Risk, Trust and Communication in School Nurses' Safeguarding Practice

In this study, school nurses discussed increasingly becoming involved in risk work including making judgements about risk to a child or young person, and monitoring/re-evaluating this risk over time. In the wider definitions of safeguarding school populations, school nurses have always had a role in protecting the welfare of children and young people, but changes to universal services over time and an increase in targeted work have contributed to school nursing becoming a more reactive service (Blair *et al.* 2003; RCN, 2016). In the current study, school nurses' involvement in risk management meant they had to confront their own ideas and sensitivities to risk; questioning their own perceptions of what made a child vulnerable and who might need their support most urgently. This prioritisation was often a direct result of limited time and the constraints of providing services across a whole spectrum of interventional levels (from organising mass-screening and immunisation programmes to individual health counselling for school pupils) (PHE, 2017).

In Stage One of this study, definitions of vulnerability on electronic clinical records (ECRs) were confined to pre-set labels, such as '*child protection'*, '*child in need*' or '*Universal Partnership Plus'*. Conversely in Stage Two, school nurses' definitions of vulnerability (including vulnerable groups) and risk were broad, and the greatest concerns were often for those children and young people who were below the threshold for specialist agency intervention (e.g. children's social care). In this way, the children who were framed as most vulnerable on ECRs were not always the children the school nurses were most worried about. The school nurses' pre-conceptions of vulnerability and risk were described beyond just child protection labels (although these were included) and encompassed socio-economic factors, isolation and un-met needs. Mental health was a common example given relating to how school nurses monitored the risk to children and young people (from self-harm and suicidal ideation) whilst waiting for specialist intervention (i.e. CAMHS) and substantial waiting lists. The high provision of school nursing interventions for mental health was highlighted on ECRs in chapter five of this thesis. Working with young people who were perceived as a risk to 'self' from self-harm and suicidal ideation was described as an emerging role for the school nurses, away from traditional ideas about children being at risk from others.

It is possible that school nurses seeking their own definitions of risk, or categories of risk, was a result of sometimes broad and un-specified concepts of vulnerability seen in safeguarding guidance. Key guidance often advises school nurses to identify vulnerable children and young people needing

additional support, or provide a health assessment for vulnerable children, without detailed specification of vulnerability, health need or length/style/frequency of assessment (PHE, 2014a; PHE, 2016; PHE, 2017). School nurses in this study had additional in-service guidance (such as school nursing standard operating procedures/SOPs) but many participants discussed the broad nature of this guidance also. Beyond the categories of child protection, or children and young people with a recorded status of need such as homelessness or being in care (LAC), concepts of vulnerability and risk assessment were, to some extent, left open to interpretation. This, of course, might have been a deliberate action by those preparing such guidance in order to give the school nurse enough freedom to make their own judgements, and to acknowledge that risk factors of abuse, neglect and other types of harm do not always equate to actual harm (Lewin and Herron, 2007). However, some school nurses described the result of this as being a sense of uncertainty, and an unboundaried remit of care that left school nurses taking on more intensive (one-to-one) work with children and young people.

Intensive work tended to generate more record keeping and administrative tasks, and this meant that many school nurses found it challenging to focus on preventative, population-based work to prevent abuse and neglect (and self-harm); this might include classroom workshops or school campaigns to encourage children and young people to disclose their worries and concerns. In Stage One of this study, the average time spent by school nurses in two study sites on interventions relating to children with a higher category of

need (i.e. '*Universal Partnership Plus', 'child protection', 'child in need'*), was greater than time spent with children in a lower category of need (i.e. *'team around the family'*). This suggested a more time-intensive interaction with this group of children and young people.

With somewhat uncertain definitions of vulnerability and interpretations of the school nursing remit in safeguarding, many school nurses sought to confirm their definitions of vulnerability and risk with their colleagues and peers. Many of their ideas about vulnerable groups and their gradings of risk therefore developed as social constructs within the 'social group' of school nurses (Lupton, 1999; Burgess, 2014). For example, newly qualified school nurses tended to look to their practice mentors for advice and guidance on issues such as risk assessment and prioritisation of caseload.

When searching for information (*'detective work'*) regarding an identified potential risk to a child or young person, many school nurses discussed intuition. More specifically, they described how intuition remained an integral part of their nursing assessment of children, yet it seemed to be de-valued in the current system of referral to children's social care (and similar specialist agencies). Organisational guidance on referrals to other agencies seemed to favour 'tangible' evidence and whilst this may support a fair and objective assessment process (Macdonald *et al.* 2017), school nurses in the current study felt this type of evidence (e.g. verbal disclosures) was not always present. This forced some school nurses to seek information that

could meet these constructed thresholds (often using tools and checklists). For example, some school nurses felt it was not enough to simply express that they intuitively felt a young person was self-harming, but they needed to see evidence of physical harm, or receive a verbal disclosure from the young person, before a referral to specialist services would be accepted. For some school nurses, this need to seek evidence of risk imminently (rather than waiting for a child or young person to disclose in their own time) was driven in part by the fear of 'missing something' or 'getting it wrong'. This was likely influenced by the development of defensive practice in safeguarding, and a consequence of public backlash in high profile cases of child abuse and neglect (Munro, 2019).

The *identification* of risk seemed a less contentious issue for the school nurses in terms of their remit. There was little disagreement that school nurses should have a role in identifying safeguarding concerns, and referring to social care, as they were talented in observing the subtle signs and symptoms of abuse and neglect and had universal contact with a whole population of children and young people (Hackett, 2013; Jordan, MacKay and Woods, 2017). This universal contact was, of course, reduced for school nurses who had to cover multiple schools. The *monitoring* of risk was a more contentious issue; whilst some school nurses felt comfortable with 'holding' children and young people who were waiting for specialist services and for whom a concern had been identified, the majority felt this had become their default role in the chasm between sparse early intervention services and specialist

agencies (Gillies, Edwards and Horsley, 2017). Some school nurses felt it took away from their availability to provide preventative work around safeguarding issues and was a type of surveillance work outside of the public health remit for which they initially trained (NMC, 2015); this may rob school nurses of their unique 'speciality' as a universal service and early intervention health practitioners.

When specialist agencies did begin to support vulnerable children, young people and their families, most school nurses were still encouraged (by their own and other agencies) to remain involved in the child protection process, including attending child protection conferences and writing reports. Whilst other professionals present at such meetings, including social workers and pastoral staff at school, might have worked closely with the child and family, school nurses had sometimes only had minimal involvement. This was because school nurses in this study were responsible for at least one large secondary school, and often multiple schools, and were increasingly making remote judgements about risk to manage large caseloads of children. In this study, it seemed a model designed for public health intervention on the population level (NMC, 2015) was, at times, attempting to also encompass more intensive child protection work focused on the individual child/family and the result was not always compatible.

The concepts of risk and trust, as introduced in chapter six and explored by school nurses in Stage Two interviews, were somewhat dependent on each

other. To identify risk and gather further information about safeguarding concerns, school nurses needed to be trusted by children, young people and families in order to be mutual partners in information exchange. It has been argued that children cannot be expected to make disclosures without professionals investing time in building trusting relationships, and children exposed to the most fearful situations (such as abuse or neglect) often need to put the most trust in the expert professional (Alaszewski *et al.* 2000). In many ways, some school nurses in the current study could act as a 'trusted other', being dissociated from the role of teacher or social worker, and gain access to the private space of the family home, or the private sphere of the child's thoughts, feelings and experiences. Through school nurse drop-ins, they were uniquely available to children and young people, unlike professionals such as social workers and GPs who could only be accessed via appointment or referral. In this role, school nurses were perhaps unique in a world where there has been a general decline in public trust of the professional or state to manage risk, and the importance of such ability to partner with vulnerable children, young people and their families in a non-threatening way should not be undervalued (Beck, 1992). This has been called being *"the personal face of an impersonal system"* (Adams, 2005, page 54).

Two key tensions were present in the examples of trust-creating processes given by the school nurses in this study. Participants knew well how to build trust with children and young people (e.g. preserving a confidential space) despite the complexity and high emotion of some safeguarding work; in this

way, creating trust was relatively easy. Yet, there was little resource to invest in building trust with the school population, owing to the demands of administrative work and large caseloads, meaning building trust naturally and incrementally was difficult. In the current study, school nurses commonly relied on rapid assessment and rapid trust-building techniques (Munro, 1999; Alaszewski *et al.* 2000). School nurses described building trust through testing promises (doing what they said they would) and informal conversations with children (showing an interest in their life). These types of skill have been called *"intangible assets"* (Rutherford, 2014, page 284) or *"shadow work"* (John and Parsons, 2006, page 226) and were part of a growing sphere of un-countable skills and time-intensive work by school nurses in this study. Indeed, much of the nuance and intensity of school nursing activities relating to building trust, risk assessment and communication with other agencies were poorly represented on ECR systems in Stage One of this study.

The increase in targeted and reactive work for school nurses meant their role had increasingly become about working with social workers and other professionals within safeguarding systems (HM Government, 2018). Therefore, they needed to confront inter-agency boundaries on a regular basis and communicate with professionals outside of their own organisation (Williams, 2011). Despite safeguarding literature calling for a move away from defensive and fragmented systems (Munro, 2011; HM Government, 2018), school nurses in the current study frequently described boundaries,

communication barriers and conflicting thresholds of risk between agencies. Many barriers to communication identified by participants were still very much practical in nature; for example, the inability to send a confidential email, the need to ring a GP via the main surgery reception or the back and forth exchange of mobile phone voicemail messages with a social worker.

School nurses were in a unique position as a health agency working across the boundaries of education and social care (Hennessy, 2011) and they described fulfilling a central role of bringing together information from different agencies. School nurses in this study seemed to meet much of the criteria of a good 'reticulist', including a foundation of trust, knowledge of other stakeholders and their technical language, an understanding of the 'jigsaw' of services and a knowledge of the shared purpose (i.e. safeguarding children) (Challis *et al.* 1988).

In the current study, examples of 'reticulism' included using language of another agency (e.g. children's social care) to encourage acceptance of referrals or making in-person visits (and crossing boundaries) to social workers to share information about safeguarding concerns. As explored in chapter six, reticulist behaviour may be of particular value in fragmented safeguarding and child protection systems, yet research on reticulism is mostly focused on professionals who have a dedicated job description as such (a 'link worker' or similar) (Challis *et al.* 1988; Williams, 2011; Williams, 2012).

The reticulist work of the school nurse, at present, seems mostly un-counted and un-acknowledged (John and Parsons, 2006).

As Edwards (2011) suggested, working at the boundaries of practice takes courage, not least because professionals can become accustomed to staying within their own remit and be protective of this. In this study, the increasing involvement of the school nurse in safeguarding work seemed to push their role to the edge of what it meant to be a 'health' nurse; as some school nurses described feeling more like a social worker or mental health counsellor, than a nurse. Working at the very edge of comfort for some, a concept previously introduced as *"fringe work"* (De La Cuesta, 1993, page 665) seemed to create two types of practice; those school nurses that felt more defensive of the perceived boundaries of their role, and school nurses who actively sought to create shared knowledge with others as a means of support, occasionally crossing over boundaries to take on new skills. In part, these different approaches were a response to a sense of uncertainty about the remit of school nursing, and a lack of guidance on how far a school nurse should be involved with children and young people at risk of abuse, neglect, and other types of harm.

10.3 School Nursing as a Safety Net

Overwhelmingly, school nurses described their experiences in safeguarding as compensating for 'missing' intensive services, particularly mental health

services and children's social care. This was mainly performed through monitoring, re-evaluating risk and working in the grey areas (for children, young people and their families below specialist thresholds). Whether deliberately or through a default position as a universal service working amongst the school population, school nurses took on roles that historically were more in the realm of a social worker or mental health counsellor (Ball and Pike, 2005; RCN, 2016). School nurses felt agencies often wanted them to stay involved with vulnerable children, young people and families to fill gaps in the wider body of children's services (Gillies, Edwards and Horsley, 2017), and for the school nurse, put simplistically, it was hard to say 'no'. School nurses also discussed their perceptions on the rise of mental health issues, and exploitation, which might suggest that so called 'gaps' in children's services are the result of agencies attempting to catch-up with emergent and evolving safeguarding issues.

The importance of trusting relationships with other professionals has been highlighted throughout this thesis; yet this seemed to so easily tip-over into a state of overwhelming, unboundaried work evident in school nurses' descriptions of non-specific referrals and 'passing on' problems (Malek, 1994). Some argue that government re-branding of community services as 'targeted' in fact attempted to divert the public eye away from gross, chronic under-funding and subsequent cuts (Gillies, Edwards and Horsley, 2017; Gray and Barford, 2018; Charles *et al.* 2018). Of course, demand is not changing, and more children, young people and families are requesting support for

financial and social needs (Earle, 2016; Gray and Barford, 2018) so inevitably it must fall to someone to ensure these individuals are not left without professional support. In a society where it is largely agreed that children are precious, and should be protected from harm, this may drive a sense of moral duty, as well as a professional duty, for school nurses to intervene (Jackson and Scott, 1999; Lupton, 1999). It is important to note that the idea of the school nurse as a 'safety net' is not implying they are the only service that can support children and young people over time, as Stage One of this study highlighted consistent recording of referrals both to and from other front-line services (e.g. GPs, health visitors and education). It is acknowledged that part of the ability of the school nurse to be a safety net for children was the active building of networks of other professionals (Appleton, 1994; Hennessey, 2011; NSPCC, 2018). However, unlike other primary healthcare services such as the GP, where appointments are usually booked for a specified health need, school nurses had the potential to be accessed by children and young people in a more unrestricted way.

The potential for such unrestricted contact has benefits for children and young people in terms of their accessibility to health advice, as forms part of the *'4-5-6'* model for school nursing and surveys of young people's own recommendations for youth-friendly services (BYC, 2011; PHE, 2014b). A major challenge in taking on such a role for school nurses in the current study was that much of the work involved in monitoring children, building trusting relationships and making complex decisions about risk was largely

uncountable (by ECRs) and not represented in much in-service guidance. Despite this, it formed a significant amount of unseen work (John and Parsons, 2006). This was a finding that was as important as the data itself; in an organisational climate where health services need to increasingly prove their worth through robust evidence due to higher competition between potential providers (Ham, 2014), services might consider how the reality of practice is reflected in the tangible documents, guidance and statistics of 'what is known' about school nursing.

Some school nurses felt that a lack of representation of the complexity of their safeguarding role meant new responsibilities were added into their remit without service providers fully considering if school nurses could, or should, meet these demands. This seemed to stretch school nursing services to a point where they perceived their role to be 'fire-fighting' or 'ticking boxes', without the time or resources for more meaningful work with children and young people, or the opportunity to reflect on the future direction of the profession (Children's Commissioner, 2016; RCN, 2016). Even school nurses who were only responsible for one school (rather than multiple schools) described elements of this phenomenon; some felt strongly that their potential to do so much as a universal service meant they could become over-burdened with miscellaneous requests.

If school nurses were indeed compensating for other missing early intervention services for vulnerable children and young people, a question is

raised as to the ethical dimensions of this. Elsewhere in nursing research, professionals and services acting as a 'safety net' is generally considered a positive and beneficial concept; for example, school health services in the USA acting as a safety net for families without health insurance (Joel, 1994; Runton and Hudak, 2016). There is a smaller body of literature that discusses social safety nets and dependency; that is, when a person or group becomes so accustomed to measures that are meant to be temporary, that the underlying, fundamental problems are forgotten (Holmes and Jones, 2013; Carcillo *et al.* 2014). For example, if school nurses continue to compensate for lacking mental health and social services, the root cause of the problem might seemingly diminish in some small area; that problem being the under-funded, and under-resourced children's service provision.

In this study, school nurses' opinions on moving away from prevention (i.e. population-based approaches and pre-empting risk) to reactive and intensive work with vulnerable children and young people could broadly be categorised in two. One group embraced asking in-depth questions of children at risk of abuse or neglect and becoming involved in *'detective work'*, whereas the other group felt it was their role to identify but refer on to other specialist agencies to perform these in-depth assessments. In response to perceived unclear boundaries and limits of practice, school nurses expressed ideas relating to role confusion; a feeling of uncertainty surrounding the scope and purpose of their role (Redekopp, 1997; Hackett, 2013). Consequently, most school nurses felt unable to mirror a template of the ideal school nurse, so

far removed from the clinical duties of a traditional hospital nurse and embodied their own ideas of what a modern school nurse in safeguarding practice should be (Benner, 2000).

In light of evolving responsibilities, school nurses commonly faced dilemmas over how far their involvement in child protection processes should reach, when to hand over to social care and when to retreat from child protection meetings. As previously discussed, taking on too many duties perceived as the realm of social care took some school nurses to the apparent 'fringes' of their professional role and comfort (De La Cuesta, 1993). In addition, they needed to identify an image of themselves (as the school nurse) to present to children and young people, families and professionals to attempt to set a precedent for future collaboration. Some school nurses sought to embody the idea of the nurse as a non-threatening, compassionate 'other' as described in previous discussions on trust; one nurse defined *"being warm, friendly, trusting…all the things you would expect a nurse to do"* (P012). These school nurses particularly sought to reject any association with the negative image of the intrusive social worker (Gallagher *et al.* 2011). Other school nurses were comfortable with embodying a firm and more direct safeguarding role (Paavilainen, Ästedt-Kurki and Paunonen, 2000), seeking (and sometimes struggling) to be an equal counterpart with that of the social worker. These school nurses felt that, although needing to provide this role in a depleted safeguarding system, they did not seem to be given the same credibility and felt they needed to justify their expertise to other agencies.

These two differing opinions on the safeguarding and child protection remit of school nursing services might be justified. For the group of participants who attempted to reclaim their 'lost' public health role, through challenging other agencies to take on more complex interventions, it was argued that initial school nurse training (for those completing the post-graduate course) was still largely focused on health promotion and population-based work (NMC, 2015). Although they acknowledged universal school nursing drop-ins as an ideal place for children and young people to disclose safeguarding issues; this was difficult when school nurses often had to hold and monitor these children and young people for a period of time. School nurses who embraced their safeguarding role argued that safeguarding was indeed the responsibility of everyone who worked with children (HM Government, 2018). In this way, the concept of 'universality' (PHE, 2017) had been interpreted in different ways; either to focus public health interventions on a universal population of children, or to be an open-door for any vulnerable child.

National commissioning guidance for school nursing in England, the *'4-5-6'* model and related documents, specify the 6 high impact areas for school nursing as *'resilience and wellbeing', 'reducing risky behaviours', 'healthy lifestyles', 'maximising learning and achievement', 'supporting complex needs'* and '*transition'*. In a banner encompassing all these, is the word '*safeguarding*' and the tagline *"visible, accessible, confidential"* (PHE, 2014b,

page 3; PHE, 2017). Additional documents expand (yet only make suggestions) for the remit of school nurses in these impact areas (PHE, 2018). In addition, the concepts of visibility and accessibility have been challenged in this study by those school nurses managing multiple schools. The actual meaning and the remit of 'safeguarding' for school nurses requires much further exploration ideally led by school nurses, to provide clearer guidance for school nurses and other practitioners on the consistent expectations of school nurses' involvement in monitoring children and young people, prevention strategies to safeguard the school population and engagement in child protection processes.

The current study has highlighted a simultaneous expectation for school nurses to manage screening/health promotion/health prevention and perform intensive work with individuals, as evident in recorded interventions on ECRs in Stage One. Therefore, school nurses performed at multiple points along the proactive to reactive 'spectrum' of care. This thesis further argues that the gap between 'expected' and 'actual' role of the school nurse seems to be widening, as the burden and complexity of unseen work was mostly underrepresented in administrative data and service guidance. It has been suggested that the school nurse is in an ideal position to recognise and respond early to safeguarding concerns, yet this position will remain under-threat if the expectations of monitoring and record keeping remain unchanged (Children's Commissioner, 2016; HM Government, 2018).

A response to evolving and sometimes uncertain expectations for school nurses in this study has been to seek their own definitions of risk, to prioritise and to challenge boundaries. The numerous descriptions of boundaries and thresholds by participants suggests a defensive and fragmented safeguarding system endures, and it is possible the desire for some school nurses to embrace monitoring as a central role is out of a fear of blame and a need to ensure nothing is missed (Munro, 2011; Munro, 2019).

The findings of this thesis are considered in light of wider societal concepts of child abuse and neglect, and safeguarding practice in the UK. In the last few decades, a shift has been evident away from child abuse as a medical (diagnosable) condition (Kempe *et al.* 1962) to child abuse and neglect as a social issue (Jütte *et al.* 2014; Featherstone *et al.* 2018). It has been argued that these earlier concepts of child abuse and child protection practice took predominantly legalistic approaches, where legal frameworks made the basis of investigation and intervention (Luckock, Vogler and Keating, 1996; Saleebey, 1996). Conversely, many believe current safeguarding and child protection practice to predominantly take a holistic and partnership approach; considering the strengths of the family and the availability of wider community (and multi-agency) support for the child or young person (Bronfenbrenner, 1994; Social Care Institute for Excellence, SCIE, 2018).

There is a strong argument for this holistic approach, and indeed for the involvement of school nurses. No single problem occurs in isolation and the

ripple effects of abuse and neglect, directly impacting on a child's health imminently and in the future, are known in research (Laming, 2003; DfE, 2008; Maguire *et al.* 2015). By framing child abuse and neglect as a health issue, an emotional issue and a social issue, it avoids rigid solutions for the child or young person that simply enact legal frameworks, remove them to care and then move on (Oliver and Charles, 2015). The roles and responsibilities of each agency should be clear in this model of intervention, to avoid duplication of work or indeed 'gaps' in the plan of care for a child, where one agency might presume an intervention is the responsibility of another (Munro, 2011; HM Government, 2018). In the current study, many school nurses felt their role was still misunderstood by other agencies, as evident in seemingly inappropriate or non-specific referrals, and being 'left out' of important communications regarding children and young people on child protection planning.

Findings from this study may suggest that some legalistic ideas endure, as described elsewhere in research (Featherstone, Morris and White, 2013). Symptoms of this appeared in school nurses' descriptions of gathering evidence to meet defensive referral boundaries and fearing the legal and professional consequences of making mistakes. This thesis has argued that legal frameworks have their role in child protection, to prevent serious cases of harm and death, but society and professional services must attempt to shift away from the fear they create for those responsible for making front-line decisions (Fraley, Aronowitz and Jones, 2018; Munro, 2019).

In this study, school nurses appeared to be practising against a backdrop of these conflicting approaches to safeguarding, which had not yet fully transitioned to the 'therapeutic' and 'holistic' realm (Featherstone, Morris and White, 2013). This was evident in the school nurses desire to make intuitive judgements and build enduring trust with children, young people and families, yet still enact some level of professional power to gather intelligence and test suspicions of abuse or neglect (Perron, Fluet and Holmes, 2005). Concepts of child abuse and neglect are fluid, and ever changing, represented in the recent definition of 'online abuse' by the NSPCC which recognised the exploitation of children via technology (Bentley *et al.* 2019). This definition was first published in 2018, despite the online world being established for at least two decades, highlighting the difficulties of attempting to contain and label child abuse and neglect as society evolves. In addition, school nurses in this study were increasingly supporting young people with mental health issues and risk to 'self', rather than working with parents on issues in the home. Considering this, multiple perspectives on child abuse and neglect may be beneficial, as well as the role of the school nurse to offer their own unique 'health-based' approach, as defined in the conclusion and recommendations in chapter eleven.

10.4 Reflexivity

The ideas discussed in this chapter are an interpretation of the study results by the researcher (with support from the supervisory team) and it is acknowledged that the researcher's own beliefs about child abuse and neglect, safeguarding and professional practice may have influenced this (Cutcliffe, 2003). For example, the original objectives of the study sought somewhat pragmatic answers to questions that became increasingly complex as time went on, and the researcher's more black and white ideas about the 'right' and 'wrong' in safeguarding practice had to be challenged. The researcher brought a pragmatic approach to research, as a nurse used to solving practical problems on a daily basis, although acknowledged different perspectives on an issue could still hold value and truth. Safeguarding and child protection, it seemed, became more shades of grey in this study and there was often not one, certain truth.

Prior to undertaking the study the researcher might have been inclined to agree with participants who felt more children and young people should be removed into care; yet discovering the long-term outcomes for children in care are often poor, and the experiences traumatic (NICE, 2013), this highlighted a need to increase engagement with other ideas and world views. This was achieved through regular supervision, attendance at conferences and reading other literature. In addition, the researcher undertook a Florence Nightingale Travel Scholarship to Tokyo/Japan in March 2018, to understand

the role and experiences of Japanese public health nurses in safeguarding, and this again encouraged the researcher to think wider than Western-centric views on child-rearing.

The researcher, as a qualified school nurse and safeguarding professional, was somewhat shaped by organisational ideas about practice received through training and development and was therefore conscious of not being biased to the most popular opinion of the time. In addition, the researcher worked as a school nurse alongside the completion of this study and was concurrently involved in child protection cases whilst analysing interview data regarding others' experiences of this type of work. By maintaining a reflective journal, the researcher acknowledged the times when the emotion of a working day might have influenced data analysis; whether feeling frustrated about a particular issue or anxious about a specific case.

The benefits of being a school nurse researcher and undertaking this study included building trust with participants and being perceived as someone who understood their challenges. As highlighted in chapter four of this thesis, the researcher did not purposefully tell participants of her job role but most became aware through other colleagues or by asking directly. It was a deliberate decision, therefore, to request participants to elaborate on certain discussion points as if they were talking for a non-expert audience. In this way, it was ensured as much of the depth and meaning of their experiences were captured.

The approach to the study developed and changed as time went on. For example, information from ECRs in Stage One was initially a larger anticipated data set that would be able to answer questions such as '*what are the type and range of interventions offered by school nurses to vulnerable children?'.* This was another example of the pragmatic ideas of the researcher, who hoped to answer specific questions in specific ways, and then move on when one stage had been 'neatly' completed. When data were unable to answer such questions, the researcher relied more on qualitative data in Stage Two to provide insight.

As qualitative data analysis continued, some participants' opinions regarding safeguarding and the school nurse's role could feel surprising. Although the researcher took a pragmatic approach to the study, they also subscribed to the idea of the social construction of beliefs, i.e. that the social group of school nurses constructed a system of ideas based on common knowledge and experience. The somewhat divided opinions of participants regarding the school nurse's remit in safeguarding were therefore surprising, as initially the researcher might have expected participants to share the same belief. That is, that the burden of safeguarding work was growing and that this was only a negative influence on school nursing practice. Conversely, a group of school nurses did embrace this role, and the researcher had to be conscious not to be too quick to disregard this idea. These conflicts were acknowledged in supervision and written reflection.

For this reason, this thesis does not argue for a particular future service model for school nursing, as findings highlight the potential of school nurses to be knowledgeable and expert at both preventative work and intensive work with vulnerable children and young people. Rather, the need to better define an approach (informed by front-line school nurses and actual experience) that focuses on either prevention or reaction is expressed. The following chapter (eleven) presents the conclusion and recommendations that may inform this change.

10.5 Limitations of the Study

These recommendations for practice and the findings of the study are presented in acknowledgement of the limitations of the research. Many of these limitations have been highlighted throughout this thesis, in the reflective and critical commentary necessary of Grounded Theory, but are summarised here. Firstly, this was a small, mixed methods study and qualitative interviews represented the experiences of 25 school nurses across three areas in England. It is possible that school nurses working in different parts of England (or the UK) would have a different set of beliefs and experiences of safeguarding practice. Despite this, the three study sites involved in the research included rural and urban areas, and recurring ideas discussed by school nurses from different sites (and with various nursing backgrounds) suggested shared challenges.

As this study was an in-depth exploration of the role and experiences of the school nurse, for which there is a paucity of research, the views and experiences of other professionals (e.g. teachers and social workers) and school children were not sought in the scope of this study. Including such views might have presented an interesting comparison between ideas about the role of the school nurse. Due to the timeframe for the current PhD study, widening the scope of participants in this way was not considered, however this could be a recommendation for future research.

As previously discussed in chapter five, it was not possible to obtain all data requests from ECR systems, owing to time and staffing issues in the respective organisations and the sensitivity of the systems for running reports. Despite this, some valuable insights were gained regarding obtaining administrative, readily available data for research purposes. Many data labels on ECRs were non-descript and could encompass a variety of nuanced work, for example the intervention label *'safeguarding'*. Exploring the types of interventions school nurses offered to vulnerable children and young people in Stage Two of the study resulted in verbal descriptions of interventions such as *"mental health counselling*", "*sexual health advice"* and "*healthy eating advice*". These were standard interventions indicated in local standard operating procedures (SOPs), so this thread of investigation was not continued. As data analysis developed, it became clear that the richest data concerned the ways in which school nurses worked with children and young

people, through processes of risk assessment and risk management. This highlighted the importance of combining numerical data with experiential data, to understand services and how they work for children, young people and families.

The sample of study sites was a convenience sample, and it was likely that school nurses who came forward for interview already had an interest in research and safeguarding practice. This may have influenced the strength of opinions captured in the data, and perhaps excluded the voices of school nurses who had less involvement in safeguarding (and why that might have been so). In addition, there were periods of service restructure occurring in some study sites during the life of the data collection phase, which may have influenced how school nurses felt about the organisation and their job satisfaction at the time. A different approach to the research, such as the distribution of an electronic survey, might have encouraged wider representation although the depth of findings may have been lost.

Although Grounded Theory methods were adopted in the qualitative stage of this research study, it was not claimed that the researcher had no prior assumptions or knowledge about school nursing (as a practising school nurse), as sometimes recommended in Grounded Theory approaches (Glaser and Strauss, 1967). Although attempts were made to remain reflexive, through memo-keeping and regular supervision, it is possible that data analysis could have been biased by the researcher's own opinions on

safeguarding work (as discussed in section 10.4). In addition, the need to submit applications for ethical and capacity approval at the university and study sites, meant theoretical sampling (a Grounded Theory approach) was not possible. Such applications usually requested an indication of sample group, size, and expected duration of the research study. Instead, the focus of interview schedules were developed in line with evolving codes, categories and concepts.

10.6 Novel Contribution

The novel contribution of this thesis has been to explore, in-depth, the role of the school nurse in assessing and working with children and young people at risk of abuse and neglect across multiple study sites in England. This is an area of research that has previously received a paucity of attention. Prior research has sought an overview of the school nursing role through quantitative methods or predominantly focused qualitative research in one study site. It is known from national guidance in the UK that school nurses have a role in safeguarding and child protection, as well as a role in public health, but little consideration has been given to how these two roles work together in the realities of daily practice. This study has provided relevant insight into the unseen work of school nursing in England, in a climate of financial cuts to children's services and a decline in school nursing numbers. In addition, this study has given specific insight into the school nurse's

safeguarding role against the backdrop of a changing safeguarding landscape; considering issues such as mental health and defensive practice.

The methods of data collection in Stage One of this study explored a relatively recent approach of using existing data from ECRs for research purposes (as the storage of patient information moves towards an entirely 'paperless' system). Although there were some challenges with regards to the quality of the data and the lengthy process to obtain it, this stage provided insight into the reality of engaging with administrative data in research, and how current ECR systems may not be as sensitive or compatible as they potentially could be.

This thesis has explored a number of concepts regarding risk, trust and communication (e.g. 'reticulism') in relation to school nursing and presented the school nursing role as a 'safety net' for children, young people and their families. These concepts have been widely considered in other areas of practice, such as social care and nursing (in general), but bodies of research applying these concepts to school nursing remain small.

An identified '*process model of risk assessment in school nursing practice'* was presented to gain new understanding of decision-making and risk management in school nursing. Safeguarding practice involved an inter-play of gaining trust, estimating risk and building networks of communication to support relationships and information sharing. Knowledge of these processes

has further highlighted perceived barriers in current safeguarding systems for school nurses, including thresholds of referral to other agencies and role uncertainty. Several recommendations are made in chapter eleven of this thesis to inform direct school nursing practice, such as training and development opportunities, as well as recommendations for a more unified philosophy and mission statement for school nursing services.

10.7 Chapter Summary

This chapter has summarised and discussed the over-arching concepts of the identified '*process model of risk assessment in school nursing practice'*; *'risk', 'trust'* and '*communication'*. Consideration has been given to the working dynamics of these concepts within the complexities of safeguarding practice and theory. The current role of the school nurse in creating a safety net for vulnerable children, young people and families has been explored, including the tensions of reactive work, substituting for (social) early intervention services and the school nursing perceptions on this role. The main influences of the researcher's position (as a practising school nurse) on the research process have been reflexively explored, and the limitations and novel contributions of this study have been stated. Chapter eleven presents the final conclusion and recommendations of this thesis.

11.1 Chapter Overview

The final chapter of this thesis considers the future direction for school nursing and their safeguarding practice. A summary and set of recommendations are first given, followed by a concluding statement. Recommendations are made for dispelling the fears associated with defensive practice in safeguarding and child protection and to secure the continued development of therapeutic interventions with children, young people and their families. The position of the school nurse within this system is considered, suggesting redefining their expert 'health' role either at the proactive or reactive level, or as a split role.

It is posed that school nurses must be consulted as front-line experts when setting a new direction for the profession. Practical recommendations are made relating to school nurse education and development, based on the findings from the identified '*process model for risk assessment in school nursing practice'*. These are displayed in an infographic (Appendix 11) that has the potential to be shared within practice and at academic events. An infographic is designed to be simple yet engaging and is an increasingly popular way to share information on web-based platforms (Dunlap and

Lowenthal, 2016). This type of graphic may be an ideal way to share recommendations of the study with school nurses and other professionals, who are pressured by time and busy workloads.

11.2 Summary

School nurses have a central role in safeguarding and are one of few universal health services that can identify and support vulnerable children and young people in school who may be without other (specialist) services (Gillies, Edwards and Horsley, 2017; Gray and Barford, 2018). The future remit of the school nurse and how this relates to specialist safeguarding and child protection services (including children's social care and children's mental health services) must be clear, and decisions between the preventative and reactive dimensions of the role considered, as school nurses currently practise in a complex and sometimes uncertain environment, creating elements of defensiveness and competing expectations.

In response to objectives one and two of this study, to understand how school nurses identify and make assessments of vulnerable children and young people, a '*process model of risk assessment in school nursing practice'* was identified. This highlighted some of the issues for school nurses in responding to child abuse, neglect and mental health risk, as well as explored concepts such as pre-conceptions of vulnerability and risk, and the influence of

intuition on decision-making, which may be relevant to other professionals working in child protection.

Most current service models of school nursing seem designed for predominantly population-based work, with large caseloads and multiple schools allocated per nurse (RCN, 2016). Current beliefs around intervention for children, young people and families in need of additional support (discounting deliberate and serious harm) generally advocate for a therapeutic, holistic and partnership approach (Oliver and Charles, 2015; SCIE, 2018), yet this may be under threat when school nursing services are stretched to the point of stark prioritisation and 'ticking boxes'.

In response to objective three of this study, to explore the experiences of school nurses in identifying and working with children at risk of abuse and neglect, it seems school nurses are somewhat passive recipients of their current role in the wider safeguarding and child protection systems. In the stories heard from school nurses in this study, they sometimes struggled to have their voices heard when challenging practice. This was evident in the unboundaried work and non-specific referrals they received from other agencies. School nurses have described skills of both prevention and in-depth assessment/intervention with vulnerable children and young people, yet they can feel unable to practice at either end of this care spectrum with the level of intensity, time and efficiency they hope for.

11.3 Recommendations for Service Development

The identified *'process model of risk assessment in school nursing practice'* has provided a novel and in-depth look at school nurse's decision-making processes in safeguarding, as well as highlighted challenges and opportunities for school nurses in their safeguarding work. These novel findings might inform consultations on school nursing service development at the local and national level, as well as inform re-validation of school nurse training (i.e. the Specialist Community Public Health Nursing 'SCPHN' post-graduate diploma). For example, a better understanding of the school nurse experience in working with vulnerable children and young people, including advantages such as visibility, accessibility and universality, might persuade a more careful consideration of de-commissioning school nursing services. An understanding of the challenges of safeguarding work within current school nursing service models (e.g. managing time, administration, balancing trust) could inform safeguarding modules on SCPHN curriculum (discussed further in section 11.4).

Although the focus of this thesis has been the role and experiences of the school nurse, the findings inform practice that directly impacts the care of children and young people at risk of child abuse and neglect. The school nursing 'safety net' appears to play an important role in keeping children and young people safe, and previous surveys of school children have indicated that they want accessible and confidential health and wellbeing support in

school (BYC, 2011). There has been a steady decline in school nursing numbers in England (a 16% fall between 2010-2017) with some areas de-commissioning their school nursing services entirely, seemingly without considering what impact this may have on universal safeguarding support for children (Fagan *et al.* 2017). It is also known that a large section of the school nursing workforce in England is close to retirement age (Edwards, 2016; Fagan *et al.* 2017). Arguably, if there is little evidence of the unseen work of school nurses, commissioners may not be aware of the totality of what they might lose (in part, due to poor representation of the complexity of school nursing work on current data available for research on ECRs). In the literature on safety nets and dependency, there needs to be a certain awareness of what services are equipped to step into the emerging gaps for any real drive for change to be created (Holmes and Jones, 2013; Carcillo *et al.* 2014). This thesis argues that much of the work of school nurses remains invisible and dis-jointed from the knowledge of policy makers, therefore further research in school nursing might build a knowledge base to which policy makers can refer when organising care.

Elsewhere in research, children and young people have indicated they respond to a firm and confident approach from professionals, particularly when they rely on them to make important decisions (Edwards, 2016). The experiences of children and young people in safeguarding and child protection systems are of high importance to ensure they feel safe, protected and heard (CQC, 2016). Findings from this study indicate that school nurses

are highly considerate of the child's experience, including how they feel welcomed into a therapeutic space and how they feel respected. They are knowledgeable of children and young people's development and can tailor their practice accordingly. School nurses who are being overwhelmed by child protection process work (i.e. attending meetings and writing reports), are not always being afforded enough time and space to nurture such skills, and this is perhaps indicative of a need for commissioners to re-address this balance.

This thesis has called for a focus on either a preventative or reactive approach to school nursing and safeguarding. A preventative approach, in line with the wider responsibilities of school nurses in health promotion, centres on the prevention of child abuse and neglect (and other risks, such as self-harm and suicidal ideation) through population-based early intervention (e.g. universal classroom workshops) (Featherstone, Morris and White, 2013; Gillies, Edwards and Horsley, 2017). As identified in this research study, school nurses have a key position in the identification of child abuse and neglect through their routine contact with the school population, but the intensive and ongoing monitoring of children and young people can create the most tension with their public health remit. A preventative approach would mean a shift away from intensive monitoring, and in some ways, this might be hard to maintain with pressure from other safeguarding and child protection services on the front-line.

The role and remit of the school nurse, as defined now and in the future, should be well communicated to the multi-disciplinary team. Many school nurses in this study were making remote decisions about children and young people and attending child protection meetings for families they had only minimal contact with, and thus the benefit of this type of involvement for all parties is questioned. School nurses are indeed trained in health promotion and prevention and are commissioned by public health departments, who are not always aware how far the school nursing role may have drifted from a predominantly population-based approach (Chase *et al.* 2010).

In some areas of the UK, there has been the development of more focused and specialist safeguarding/school nursing roles, to work alongside other nurses responsible for the wider public health work such as screening and immunisations (Chief Nursing Officer Directorate, 2018). This has allowed school nurses to focus on either type of intervention, without having to manage the inherent conflict between maintaining both levels of intervention. There is some caution in splitting the spectrum of care in this way, as it may create two distinct services who do not communicate fluidly with each other, even when working with the same group of children and young people (Clarke, 1997). As previously highlighted in chapter ten, this thesis does not advocate for one model over the other, but rather promotes for a change in the current way of working that does not seem compatible with school nurse satisfaction and their own perceived ability to enact meaningful work or child focused outcomes.

For some school nurses in this study, their caseload amounted to only one secondary school. These nurses felt slightly better able to manage preventative and reactive work simultaneously, but their physical presence in school seemed to equate to an increase in expectations (from their own organisation and other agencies) and more non-specific referrals from school. In these cases, the school nurses could feel like a 'jack of all trades' and uncertain about their specific approach and contribution. If school nurses are to become more focused on individualised interventions, and thus practice towards the reactive sphere of care, a reclamation of their status as a 'health' expert might be considered.

Child abuse and neglect impacts on multiple areas of a child's life, and thus the assessment of vulnerable children and young people by school nurses cannot be constrained to one aspect (Bronfenbrenner, 1994). However, in terms of ongoing intervention, the unique position of the school nurse is one of a universal health professional (NMC, 2015). Although sparse in number and greatly impacted by funding cuts (Gray and Barford, 2018), education and social services at the early intervention level do exist in many areas (for example, pastoral staff in school) and therefore have the potential to be developed also. As highlighted earlier in this section, school nursing numbers are declining consistently and many school nurses in England are due for retirement in the next decade, so an increase in workforce would be needed to support a specialist safeguarding/school nurse role.

For school nurses, and possibly other safeguarding and child protection professionals (e.g. social workers and school pastoral staff), a need to continue to dispel fears associated with 'getting it wrong' in safeguarding has been highlighted in chapter ten of this thesis. Although many examples of therapeutic and partnership working with children, young people and their families (for whom there were safeguarding concerns) were discussed by school nurses in interviews (i.e. building trust), there was some continued conflict with a need to perform surveillance and evidence concerns over intuition. It is of course important to ask questions and refer concerns of abuse and neglect to children's social services, to avoid serious harm and work in the best interests of children and young people (Laming, 2003; DfE, 2008). However, this approach can sometimes create a loss of meaningful and long-term therapeutic support for children and families, in favour of over-emphasis on documentation, surveillance, and the legal 'audit trail' of actions (Lupton, 1999; Munro, 2007). Recognising aspects of defensive practice in the wider context of safeguarding systems is often considered to be the first step in creating change (Whittaker and Havard, 2016). Solutions might include regular case supervision for safeguarding professionals (i.e. discussing decision-making with a colleague or manager) and better education on defensive practice at the under-graduate level.

11.4 Recommendations for Practice, Education and Future Research

Recommendations for school nursing practice, based on the findings of this study, have been categorised in this thesis as 'role clarity', 'risk education', 'experiential learning', 'support networks', 'visibility' and 'communication pathways'. A description of each is given below, as presented on the infographic in Appendix 11. These recommendations are based on the barriers to safeguarding identified in the *'process model of risk assessment in school nursing practice'* and discussed in chapters seven to nine.

Role Clarity

School nurses should have clear in-practice guidance (such as standard operating procedures/SOPs) regarding the remit of their safeguarding role within the multi-agency team, however this is decided in future. This is in response to participants in the current study identifying with aspects of 'role confusion', which is a concept previously discussed in literature regarding school nursing and other clinical nurse specialist roles (Redekopp, 1997; Hackett, 2013). In addition, seemingly 'woolly' terminology in practice guidance should be avoided, for example by defining more specifically the meaning of 'health assessment' or 'health need'.

Data collection systems (including ECRs) should accurately reflect the scope and complexity of school nursing work, as highlighted in the poor

comparisons of data in Stage One and Stage Two of this study. A review of the burden of administrative work could identify processes that might be simplified or eliminated. This review could be achieved in partnership with practising school nurses, school nurse managers, and those responsible for maintaining ECR systems, in the format of a specialist interest group or similar. School nurses should be present to give insight into the impact of administrative work on their daily practice.

More research is needed into the role of the school nurse in safeguarding, including the perceptions of other agencies and the views of children and young people. The current study has highlighted the experiences of school nurses, but further exploring the experiences of children, young people, families and other agencies would help to better understand the tensions that exist in the evolving safeguarding systems in England. Opportunities and funding for school nurses to become involved in research are needed, in the form of clinical-academic roles. Clinical-academic roles currently exist in the UK and other parts of the world and would allow school nurses to undertake research whilst simultaneously maintaining a clinical role. This would bring more research knowledge into practice, whilst also promoting research that is informed by current practice issues.

Risk Education

School nursing curricula should consider, if not already available, education on concepts of risk and risk perception in safeguarding; giving student school nurses the opportunity to explore how thresholds of risk are constructed and how these might be encountered in practice. In the current study, school nurses discussed the influence of pre-conceptions of vulnerability and risk on their practice (chapter six), including issues such as desensitisation. Participants in this study indicated that SCPHN training programmes (NMC, 2015) did not always prepare them for the reality of complex work involving cases of abuse and neglect, and mental health issues such as self-harm and suicidal ideation.

The identified *'process model of risk assessment in school nursing practice'* might be used by school nurses (and other safeguarding professionals) as a tool to reflect on their own decision-making practices and challenges they face when working with vulnerable children and young people. For example, reviewing *'pre-conceptions of vulnerability and risk'* might encourage the practitioner to reflect on their own presumptions about vulnerable groups and how these might pre-determine their approach to assessment. The model might also encourage reflection on issues such as intuition, use of assessment check-lists and the availability of trust-building spaces. The model does not claim to be the 'ideal' approach to risk assessment but highlights a common set of steps that a group of school nurses described, deviations to

this process and inherent conflicts. By using the model in reflective discussions before safeguarding events are met, school nurses, student nurses or other safeguarding professionals might feel better prepared for the complexities of decision-making that often occurs in a short space of time.

Experiential Learning

As well as theoretical study, regular and varied 'on-the-job' learning experiences can be important for school nurses (especially those who are newly qualified) to put safeguarding theory into practice, and feel better prepared for the complexity of safeguarding systems. This could continue post-qualification in the form of peer review. Examples of good experiential learning provided by participants in the current study included opportunities to spend time in different geographical areas to ensure exposure to a variety of community groups. In addition, this allowed school nurses to compare their own thresholds of risk with that of their colleagues and engage in peer-learning.

Support Networks

School nurses in this study valued both informal and formal networks to support the emotional aspects of their safeguarding practice, as well as the anxiety associated with making difficult decisions and facing dilemmas. Examples provided by participants included group supervision, one-to-one

supervision with a mentor or specialist safeguarding nurse and having their own ‘safe space’ in a central office location in which to meet regularly with colleagues. The benefits of support networks included the opportunity for peer review of practice and the promotion of a cohesive team environment, considering many school nurses were lone working in school. These support networks could be encouraged further by school nurse managers offering protected time, which only specified ‘essential’ work might interrupt.

Visibility

Creative ways to maintain visibility of the school nurse to children and young people would support the development of trust and safe spaces for disclosure. In the current study, school nurses described the importance of trusting relationships with children and young people as a foundation for conversations about child abuse, neglect and other sensitive issues. However, the impact of administrative work and caseload size reduced visibility. A safe and private space for school nurses to meet with children in the school environment would be essential. In addition, creative ways in which school nurses could maintain visibility include the use of school websites, posters, e-newsletters, lunch-time events and pupil text message systems (with related training available) (QNI, 2015; RCN, 2017b).

Communication Pathways

A review of multi-agency communication pathways in safeguarding would better support liaison between services. This review could be set-up locally, inviting representatives from different agencies, in the format of a steering group or similar. School nurses should be represented in this group, considering the findings of the current study in which some school nurses described being 'left out' of important safeguarding and child protection communications. Common communication issues for school nurses in this study included the availability of secure email and direct telephone lines to GPs.

Awareness of the role of the school nurse amongst the multi-agency team, including communication about remit and expectations, would support boundary work and knowledge of agency thresholds. In this study, most school nurses described sending referrals to social care and mental health services into an unknown 'void', where feedback on the outcome of referrals could seem inconsistent and expectations about thresholds, waiting times and what to do in the holding period were not clear. In the opposite flow of information, many school nurses described receiving non-specific and vague referrals from other professionals. Raising the profile and representation of school nurses on multi-agency panels and special interest groups (for example, local forums on mental health and child protection issues) would support a better awareness of their role. School nurses should be supported by school nurse managers and commissioners to feel confident at delineating the boundaries of their remit through clear in-

service guidance and referral criteria, as well as protected time to attend multi-agency events.

11.5 Conclusion

To conclude, this research study has addressed the initial question *'how do school nurses in England identify and work with school children aged 5-19 years at risk of child abuse and neglect?'* and has offered in-depth insight into the vital contribution of school nurses to safeguarding. As both universal services and educational establishments increasingly become principal sites for safeguarding work and the identification of safeguarding concerns, so too do school nurses become integral to supporting those most in need. This includes children, young people and families affected by child abuse and neglect, but also young people in mental health crisis, as identified by the findings of this study. This thesis has moved forward with knowledge regarding the complexities of risk assessment and decision-making in school nursing practice, and highlighted significant challenges to address with specific recommendations, including risk education, peer support and school nurse visibility. A review of the position of school nursing within safeguarding systems is essential to ensure their remit is delineated, valued by the multi-agency team and protected from further cuts to funding and de-commissioning. School nurses possess valuable skills, including the ability to build rapport and manage communication in highly sensitive situations, and perhaps most importantly school nurses can be a knowledgeable,

compassionate and trusted other for children and young people who most desperately need to confide.

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Appendix 1: Published Literature Review

A journal article has been removed from this version of the thesis due to copyright restrictions.

Harding, L., Davison-Fischer, J., Bekaert, S., Appleton, J.V., *The role of the school nurse in protecting children and young people from maltreatment: An integrative review of the literature*, International Journal of Nursing Studies, 92, 60-72
doi: 10.1016/j.ijnurstu.2018.12.017

Appendix 2: FREC Approval Faculty of Health and Life Sciences/Oxford Brookes University

Oxford Brookes University

Faculty of Health and Life Sciences

Decision on application for ethics approval

The Departmental Research Ethics Officer (DREO) / Faculty Research Ethics Committee (FREC) has considered the application for ethics approval for the following project:

Project Title: How do school nurses identify and work with children at risk of abuse?

FREC Study Number: 2016/12

Name of Applicant: Lauren Harding

Name of Supervisor: Professor Jane Appleton

Please tick one box

1. The Faculty Research Ethics Committee gives ethical approval for the research project. [√]

   Please note that the research protocol as laid down in the application and hereby approved must not be changed without the approval of the DREO / FREC

2. The Departmental Research Ethics Officer / Faculty Research Ethics Committee gives ethical approval for the research project, subject to the following: [ ]

3. The Departmental Research Officer / Faculty Research Ethics Committee cannot give ethical approval for the research project. The reasons for this and the action required are as follows: [ ]

Signed: …Hazel Abbott … ……

Approval Date: ……14 December 2016 ..……..

Designation: Departmental Research Ethics Officer

(Signed on behalf of the Faculty Research Ethics Committee)

Date when application reviewed (*office use only*): 18 October 2016 ……..

Oxford Brookes University

Faculty of Health and Life Sciences

Research Ethics Committee

Scientific Peer Review Form

The Research Ethics Committee (REC) of the Faculty of Health and Life Sciences has undertaken an independent scientific peer review of the following research proposal:

Project Title: How do school nurses identify and work with children at risk of abuse?

Name of Researcher: Lauren Harding

Name of Research Supervisor: Professor Jane Appleton

Faculty REC Application Number: 2016/12

Following review on 18/10/2016 the above research is considered to be both ethically and scientifically sound.

Signed: …Hazel Abbott……

Designation: Departmental Research Ethics Officer

(Signed on behalf of the Faculty of Health and Life Sciences Research Ethics Committee)

Date: …14th December 2016 ……

Independent scientific peer review and ethics review undertaken by the following members of the Faculty REC:	
Mrs Hazel Abbott (Chair)	Mr Ben Ellis
Dr Magali Chohan	Ms Kellie Tune
Dr Roger Dalrymple	

Appendix 3: HRA Approval Letter

Mrs Lauren Ruth Harding
PhD student
Email: hra.approval@nhs.net
Oxford Brookes University
Marston Road
Oxford
OX3 0BP

03 February 2017
Amended and Reissued 20 February 2017

Dear Mrs Harding,

Letter of HRA Approval

Study title:	**How Do School Nurses Identify and Work with Children at Risk of Child Abuse and Neglect?**
IRAS project ID:	**212783**
Sponsor	**Oxford Brookes University**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England
The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices
The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators",* issued with your REC The attached document "After HRA Approval – guidance for sponsors and investigators" gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net. Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **212783**. Please quote this on all correspondence.

Yours sincerely

Thomas Fairman

HRA Assessor

Email: hra.approval@nhs.net

Copy to: *Ms. Hazel Abbott, Oxford Brookes University, (Sponsor Contact)*

Ms. Natalia Jastrzebska, Oxford Health NHS Foundation Trust, Research and Development, (Lead NHS R&D Contact)

Appendix 4: Data Request Sheet

Contextual Data
1.What is the total school nursing caseload?
2. What is the total **child protection** (CP) caseload?
3. What is the total **child in need** (CIN) caseload?
4. What is the total **team around the child/family** (TAC/F) and **common assessment** (CAF) caseload?
5. What is the total number of contacts/interventions with **all children and young people** by the school nursing team in the last two academic years?
6. What is the total number of contacts/interventions with children and young people with a **safeguarding** or **child protection** alert (on their clinical records) by the school nursing team in the last two academic years?
7. What is the average total time spent on interventions relating to **all children and young people** by the school nursing team in the last two academic years?
8. What is the average total time spent on interventions relating to children and young people with a **safeguarding** or **child protection** alert (on their clinical records) by the school nursing team in the last two academic years?
Data: How do school nurses identify children at risk of child abuse?
9. What is the total number of referrals made to social care by school nurses in the last two academic years?
10. What is the range of risk assessment tools used by school nurses to safeguard children and young people?
Data: How do school nurses work with children at risk of child abuse?
11. What is the range and type of interventions provided by school nurses relating to **all children and young people** in the last two academic years?
12. What is the range and type of interventions provided by school nurses relating to children and young people with a **safeguarding** or **child protection** alert in the last two academic years?

Appendix 5: Chart to Present the Grouping of Interventions

Step 1. Similar interventions in 'full intervention list' colour coded.
Step 2. Colour coded interventions grouped, and data combined.

Study Site One:

Full Intervention List
Attending Child Protection Case Conference
Child Protection Assessment
Chlamydia Test Offered
Combined Hormonal Contraceptive Dispensed
Condoms Given
Contraceptive Advice
CSE Tool Used
Drug and Alcohol Misuse
Emergency Contraception Follow Up
Emergency Contraception Given
Emotional and Psychological Support
Enuresis Assessment
Enuresis Review
Health Promotion Advice
Initial Assessment
Implant Fitted
LAC Review
Liaison
Medication Review Emergency Medication
Multidisciplinary Meeting
Nutritional Advice
Obesity Advice
Evaluation Tool Commenced
Pregnancy Advice
Pregnancy Test Done
Progesterone Only Pill Dispensed
Safeguarding
Sexual Health and Related Subject
Smoking Cessation
Treatment
Worries Emotional well being

Grouped Interventions
Child Protection and Safeguarding
Mental and Emotional Health
Sexual Health
Drugs, Alcohol, Smoking
Enuresis
Health Promotion Advice
MDT Liaison
Emergency Medication
Initial Assessment
Evaluation Tool Commenced
Other Treatment

Study Site Two:

Full Intervention List
Adult Safeguarding Meeting
Advice & Support
Advice & Support - Follow Up (Safeguarding Only)
CAF Meeting
Child Health Clinic
Court Statement
Family Support
Health Needs Assessments
Health Promotion
Information Sharing - S47
MDT Discussion
Monthly GP Safeguarding Meeting
NCMP Reception
NCMP Year 6
School Health - Continence
School Health - Drop-in Clinic
School Health - Year 10 Contact
School Health - Year 8 Contact
School Health Contact
School Nurse Hearing
School Nurse Screening
Screening Care Plan
Screening Hearing
Screening School Entry
Screening Vision
Screening Yr6
Section 17 Meeting
Section 47 Meeting
Smoking Prevention
Transition Meeting

Grouped Interventions
Routine Screening
Advice & Support
Safeguarding and Child Protection
Drop-in Clinic
Family Support
Health needs assessments
Health Promotion
Continence
MDT Discussion
School Health - Year 10 Contact
School Health - Year 8 Contact
School Health Contact
Care Plan
Smoking
Transition

Lauren Harding
Clinical Academic PhD Student
Department of Psychology, Social Work and Public Health
Faculty of Health and Life Science
Oxford Brookes University
Jack Straw's Lane
Oxford
OX3 0FL
Email: 15123233@brookes.ac.uk
Telephone: 01865 482814

Reference: *Exploring how school nurses identify and work with children at risk of child abuse and neglect.*

Dear school nurse,

You are being invited to participate in the above research study because your area manager has identified you as a school nurse or school staff nurse, who is involved in child protection work on a regular basis. The aim of the study is to understand how school health nurses identify and work with children at risk of child abuse and neglect in daily practice.

The chief investigator is PhD student Lauren Harding at Oxford Brookes University, and the research study is part of a PhD programme. The supervisory team overseeing the project are Professor Jane Appleton and Dr. Jan Davison-Fischer.

Please find enclosed a participant information sheet, which provides further details about what the study involves and what to do if you would like to participate. Participation is voluntary and you can withdraw at any time without giving a reason. The chief investigator (Lauren Harding) may be contacted to request further information using the above details.

Thank you for your time,

Yours sincerely,

Lauren Harding
Clinical Academic PhD Student
Oxford Brookes University

Appendix 7: Participant Information Sheet

Participant Information Sheet

Study Title:
How do School Nurses Identify and work with Children at Risk of Child Abuse and Neglect?

You are being invited to take part in a research study to explore how school nurses identify and work with children at risk of child abuse and neglect. It is important that you read the following information before deciding to take part, so that your involvement is informed and you have the opportunity to ask further questions. Please don't hesitate to contact Lauren Harding, the chief investigator on the contact details below:

Lauren Harding
Clinical Academic PhD Student
Department of Psychology, Social Work and Public Health
Faculty of Health and Life Sciences
Oxford Brookes University
Jack Straw's Lane
Oxford
OX3 0FL
Email: 15123233@brookes.ac.uk
Telephone: 01865 482814

If you have any concerns about the conduct of this research project, please contact the Chair of the Oxford Brookes University Research Ethics Committee, Hazel Abbott on ethics@brookes.ac.uk.

The contact details of the supervisory team are:

Professor Jane Appleton
Department of Psychology, Social Work and Public Health
Faculty of Health and Life Sciences
Oxford Brookes University
OX30FL
Email: jvappleton@brookes.ac.uk
Telephone: 01865 482606

Dr. Jan Davison-Fischer
Department of Applied Health and Professional Development
Faculty of Health and Life Sciences
Oxford Brookes University
OX30FL
Email: j.fischer@brookes.ac.uk
Telephone: 01865 482740

What is the purpose of the study?

The aim of this research project is to explore how school nurses identify and work with children who they think are at risk of child abuse and neglect. These may be children already suffering abuse, or children who have a number of issues going on in their lives which means they are at increased risk of child abuse and neglect. The definition of child

abuse and neglect is taken from the World Health Organisation (2014) *"…all forms of physical and emotional ill-treatment, sexual abuse, neglect, and exploitation that results in actual or potential harm to the child's health, development or dignity. Within this broad definition, five subtypes can be distinguished – physical abuse; sexual abuse; neglect and negligent treatment; emotional abuse; and exploitation".*

The research project is a mixed-methods design, exploring what school nurses record about their child protection activity in electronic clinical records and interviewing school nurses to understand their experiences of identifying and working with children at risk of abuse. Activity data will be collected separately and be an anonymised summary. Participants will be invited to an interview once, and this data will be used to look for themes and trends in school nurses' experiences. The study is part of a PhD that will run over 3-4 years.

Why have I been invited to participate?

You have been invited to participate because you have been identified by your area manager as a school nurse or school staff nurse, who is involved in child protection work on a regular basis. Invitations will be sent to all nurses in the school nursing service in your area who fulfil this criterion. The overall research project will involve 3 study sites in different locations in England. School nurses and school staff nurses with whom Lauren Harding (chief investigator) has previously worked closely with will not be eligible to take part.

Do I have to take part?

Participation is entirely voluntary. It is your decision whether or not to take part, and you are free to withdraw at any time without giving a reason along with withdrawing any unprocessed data. If you do decide to take part you will be provided with a copy of this information sheet to keep and will be asked to sign a consent form prior to participating in the interview.

What will happen to me if I take part?

Participants will be invited to an interview at a suitable location, and this will last approximately 1 hour. You will be asked about the day-to-day work you do with children at risk of child abuse and neglect, and to share your experiences of identifying abuse in practice. The location will be a booked room at the nearest community hospital or school nursing base, but not be in or near the office where you directly work to avoid interruptions and protect your confidentiality as a research participant. Interviews will be audio taped using a Dictaphone. Interviews will take place at a time most convenient for you, and can take place during working hours as prior approval by the management team has been sought for this to happen.

Involvement in the study will cost the time to participate in the interview, and you may need to travel a short distance to the interview location.

What are the possible benefits of taking part?

Involvement in the study will help to shape our understanding of the role of the school nurse in identifying and working with children at risk of child abuse and neglect, of which there is little previous research. It will be an opportunity to share your experiences and opinions about the daily involvement of the school nurse in child protection.

What are the possible disadvantages of taking part?

Participation will involve taking time away from your daily work to be interviewed, and this will take approximately 1 hour plus travel time. Discussing work with vulnerable children may bring up a number of emotions, and support would be offered for this. The interview would be stopped if you were to become upset, and you may be referred to your named nurse for safeguarding children to access supervision.

Will what I say in this study be kept confidential?
All information collected about you during the interviews will be kept strictly confidential (subject to legal limitations). It is important to understand that any information disclosed in an interview that causes concern for a child or young person's immediate safety (i.e. they are currently at risk of experiencing significant harm or abuse) and where the participant has not acted on this concern themselves, may have to be shared with the participant's organisation (usually a line manager or safeguarding nurse) in a sensitive and collaborative way after full discussion with the participant. This study will have a small sample size of school nurses and school staff nurses, and where every effort to maintain anonymity is preserved and identifiable information censored, it cannot be guaranteed in a small sample that someone will not recognise your quotes in the final reporting of results.

Interviews will be audiotaped and transcribed. All identifiable information will be removed at the transcription stage and you will be given a code name e.g. 'nurse A'. The audiotaped interview will then be destroyed. The transcripts will only be viewed by the chief investigator and members of the PhD supervisory team. Data will be stored securely in a locked cabinet or on an encrypted computer device, in accordance with the Data Protection Act 1998. Following Oxford Brookes University policy, data will be kept securely in paper or electronic form for ten years after the completion of the research project. Anonymous quotations from the interviews may be used in future publications.

What should I do if I want to take part?
If you would like to participate in the research study, or to request further information, please email the chief investigator (Lauren Harding) directly on 15123233@brookes.ac.uk.

What will happen to the results of the research study?
The results of this research will be presented in a PhD thesis, which will be accessible once published through online dissertation search engines and at the Oxford Brookes University library by request. Publications may be sought via appropriate professional journals. Participants may obtain a summary of the research findings via their area manager at the end of the study.

Who is organising and funding the research?
The research is part of a PhD study at Oxford Brookes University. It is funded by Oxford Brookes University as part of a PhD Clinical Academic Studentship. The chief investigator and PhD student (Lauren Harding) is attached to the *Department of Psychology, Social Work and Public Health* in the Faculty of Health and Life Sciences.

Who has reviewed the study?
The research project has been approved by Oxford Brookes University, Faculty Research Ethics Committee (Faculty of Health and Life Sciences). The study has also been approved by the Research and Development department at the NHS Trust or Provider who employs you.

Thank you for the taking the time to read this information sheet. Please don't hesitate to contact the chief investigator (Lauren Harding) on the above contact details if you would like to participate, or would like any further information.

Date
Feb 2017

Appendix 8: Study Consent Form

CONSENT FORM

How do School Nurses Identify and work with Children at Risk of Child Abuse and Neglect?

Contact Details of Chief Investigator:
Lauren Ruth Harding
PhD Research Student
Department of Psychology, Social Work and Public Health
Faculty of Health and Life Sciences
Oxford Brookes University
Jack Straw's Lane
Oxford
OX3 0FL
15123233@brookes.ac.uk
01865 482814

Contact Details of the Supervisory Team:

Professor Jane Appleton

Department of Psychology, Social Work and Public Health

Faculty of Health and Life Sciences

Oxford Brookes University

OX30FL

Email: jvappleton@brookes.ac.uk

Telephone: 01865 482606

		Please initial box
1.	I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	☐
3.	I understand that the interview will be audio-recorded.	☐
4.	I agree to take part in the above study.	☐
5.	I understand that relevant sections of my data collected during the study, may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.	☐

		Yes	No
6.	I agree to the use of anonymised qoutes in publications.	☐	☐
7.	I agree that my data gathered in this study may be stored (after it has been anonymised) in a specialist data centre and may be used for future research.	☐	☐

Name of Participant	Date	Signature

Name of Chief Investigator	Date	Signature

Appendix 9: Interview Topic Guide

How do School Nurses Identify and Work with Children and Young People at Risk of Child Abuse and Neglect?

Interview Guide for Semi-Structured Interviews with School Nurses and School Staff Nurses

Aim of the study:

- To explore how school nurses identify and work with school children aged 5-19 years at risk of child abuse and neglect.

Objectives of the study:

- To explore the processes through which school nurses identify school-aged children at risk of child abuse and neglect.
- To explore how school nurses make assessments of vulnerable children, and the types of school nursing interventions offered to them.
- To explore the experiences of school nurses in identifying and working with school-aged children at risk of child abuse and neglect; including the perceived challenges and opportunities of their role.

1. Introduce self and the research study.
2. Present information sheet and consent form.
3. Remind the participants about confidentiality in accordance with the *NMC Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (2015).*
4. Allow time for reading and questions.

Background information

5. School nurse's training, qualifications, length of service and experience of child protection work.
   Q. When did you train as a school nurse?
   Q. Did you undertake any qualifications to work in school nursing?
   Q. How long have you worked as a school nurse?
   Q. How many years of experience do you have working with vulnerable children and young people, undertaking a safeguarding or child protection role?

How school nurses identify and assess children at risk of child abuse and neglect.

6. School nurses' experiences of identifying the signs and symptoms of child abuse and neglect.
   Q. Can you describe a time when you have identified or suspected child abuse or neglect in practice?
   Q. How might you become aware of actual or suspected child abuse in practice?
   Q. How would you describe the experience of identifying the signs and symptoms of child abuse and neglect?

7. School nurses' experiences of referring children to social care.
   Q. Can you describe a time when you have referred a child and/or family to children's social care in practice?

Q. How would you describe the experience of making referrals to social care?

8. School nurses' experiences of working with other professionals to identify child abuse and neglect.
   Q. Can you describe how you might work with other professionals to identify cases of child abuse or neglect?

9. School nurses' experiences of assessing and managing risk in child protection.
   Q. How might you assess if a child or young person is at risk of child abuse and/or neglect in practice?
   Q. What are your experiences of assessing risk of child abuse and/or neglect in practice?
   Q. Can you describe any ways in which you might manage this risk?

<u>Define the type and range of intervention offered by school nurses to children at risk of child abuse and neglect.</u>

10. School nurses' experiences of the type of interventions they offer to children at risk of child abuse and neglect.
    Q. What is your experience of working with children and young people at risk of child abuse and neglect?
    Q. How might you work with these children?

11. Explore how school nurses decide when and how to intervene with children at risk of child abuse and neglect.
    Q*. Can you describe how you make decisions about the care and support a child at risk of abuse may need?*

<u>Further exploration of school nurses' experiences.</u>

12. Explore school nurses' perceptions of the opportunities and challenges of their role in child protection.

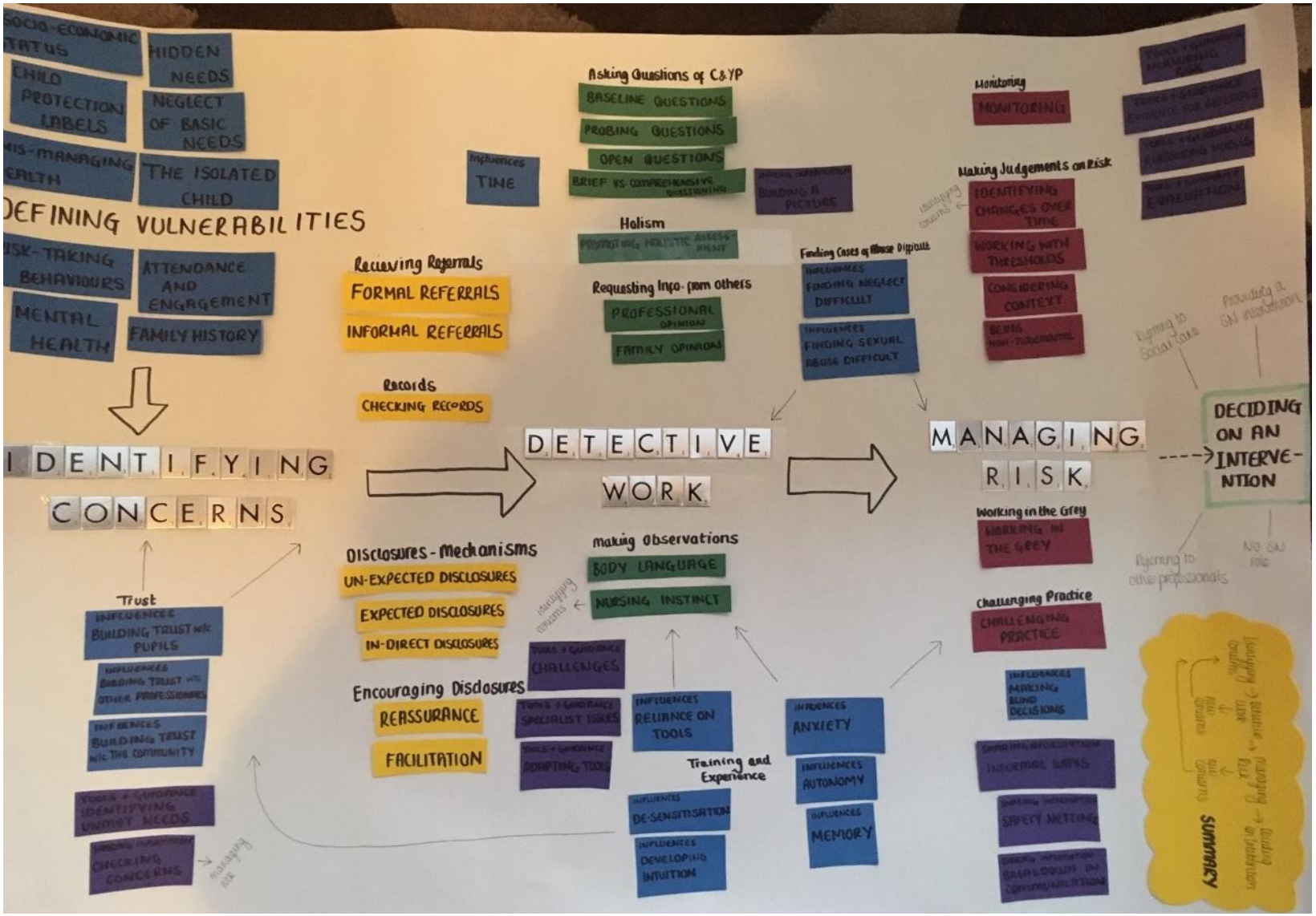
Q. What, in your opinion, are the opportunities for school nurses to contribute to child protection?

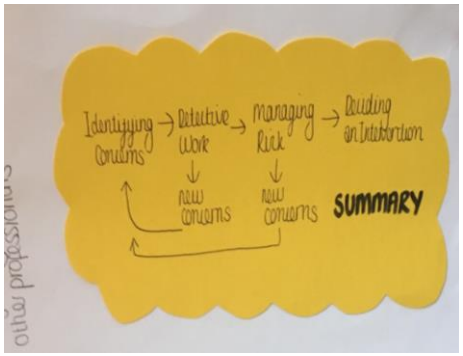
Q. What, in your opinion, are the challenges for school nurses working in child protection?

13. Explore school nurses' perceptions of the knowledge and skills they use in child protection.
    Q. What knowledge do you draw on when working in child protection?

Q. What do you think are the important skills to have as a school nurse working in child protection?

Appendix 10: Data Visualisation of Categories and Relationships





Appendix 11: Infographic and Recommendations for Practice