

The Health Needs Of Primary School Age Children

Focus of the Working Party

The focus of the working party was children at primary school. The joint colleges working party on adolescent health will include children and young people at secondary school. A separate working party within Hall4 has focused on vulnerable children and children with special needs.

Recap on National Screening Committee Decisions.

Vision test/orthoptist screen at 4.5 to 5 years.

Height and weight at school entry.

Hearing test at school entry.

School Entry Health Assessment.

There are different models and methods of health assessment at school entry but little evidence on which to base any comparative analysis. Evaluation of benefits depends primarily on defining aims and objectives, which surprisingly is not always made clear. Aims and objectives are multiple and several may be combined at delivery.

These may include;

Ensuring the pre school health programme including immunisation is completed;

Detecting health problems of the individual child;

Delivery of school entry screening;

Building a health profile of the school population;

Introduction of the school health service and what it can offer to the child/parents;

Health promotion and health information.

School entry health assessment is currently delivered on a universal or selective basis (or both). Methods of delivery include;

Examination by a Dr. Current consensus is that a formal physical and developmental examination of all school entrants by a doctor is not a cost effective programme.

However neither the introduction nor the termination of this intervention rested on a secure evidence base.

Assessment by a school nurse. Currently this is delivered in a number of different ways. It may include an individual assessment of each child including a limited examination; contact with children and their parents in small groups; contact with teachers in the reception class; postal questionnaire to parents of school entrants; a review of pre school health records and selective assessment thereafter.

The ultimate aim of all these efforts is to improve the health of children. However comparative evaluation of all the alternatives and their permutations in implementation is extremely difficult for a number of reasons related to quality of research data and generalisations that can be made thereof, and the particular make-up of populations served by individual schools.

Key considerations in deciding how school entry health assessment is to be framed are;

Clearly defining the aims and objectives of assessment;

Information on the local population of the school which may vary widely across districts and even between adjacent schools; deprivation indices, and factors such as populations within which there is high mobility and/or refugees, asylum seekers and new immigrants are key.

Cost benefit analysis related to health outcome. Within this it must be remembered that school entry health assessment often represents a considerable proportion of the school nurse workload and time that may be spent on alternative health interventions.

School as a Health Promoting Environment.

A key purpose of the school health service is to promote and improve the health of children. However, again how this is done (and by whom) varies widely across the UK. Some programmes focus on single issues such as drugs, sexual behaviour, nutrition, and so on; whilst others aim to create an environment in which health in a holistic sense is facilitated across the whole school. Therefore programmes may be delivered through “one-off” health sessions either to the class or individual child/parent; or more subtly by working as a team with teachers on the delivery of PSE programmes and with the teaching staff and school governors in general on creating a healthy environment (for example, by looking at nutrition and school dinners, tuck shops, breakfast clubs, access to drinking water and so on). Surprisingly few programmes aim to actively engage parents in health promotion.

As with all health promotion initiatives, it is easier to increase knowledge than to change attitudes and practice. However the limited evidence available suggests that a whole school approach which aims to increase collective and community capacity is likely to be most effective. In particular in relation to improving the self esteem of children which is key in improvement of the capacity of children to make, and act upon, health decisions (also with the obvious spin off of improving mental health). Working as a team, rather than in isolation as a school health professional, is an important facet of this approach (see detailed discussion of this by David Hall regarding the pre school health programme).

The commitment of the headteacher and teaching staff is crucial to this approach. However teachers have many other commitments to fulfil, especially in relation to academic issues. Creation of appropriate levers to integrate and incorporate health into school life are needed, perhaps through the inclusion of health as an aspect of OFSTED inspections.

Reframing School Health Services.

The above discussion on school as a health promoting environment relies on school health services taking a public health approach to their work. We need to reframe school health services so that their focus is the child population which make up schools, within which school is an important locus for capturing that population, but not the only site of intervention. This would open up opportunities for working with local childrens groups such as brownies; working with local parents and communities on child health issues such as road safety in particular; and also provide opportunities to work with children who are infrequent school attenders and especially vulnerable, such as “looked after” children. It would not restrict school health services to a term-time, school hours only service, within which school is the only site of service delivery.

Equity of Access to Services and Service Provision.

One of the most obvious problems facing school health services and school children is inequity of access and provision across the UK. The inverse care law is clearly in operation here with some of the most deprived areas of the country receiving the least services. Service provision is often based on Trust establishment numbers and their traditional patterns of service delivery rather than the health needs of populations and sub-populations. National and local health inequality targets are an important pointer for commissioners to consider in school health service patterns.

In addition, there is the problem of inequity and difference between the provision of services to independent and state sector schools.