Implementing Wrap-Around Health Initiatives for Disadvantaged Children

Jade Hunter - Deputy Head Teacher/SENDCo/EYFS lead

West Earlham Infant and Nursery school

Norwich

Norfolk

- Outlining the barriers to education faced by disadvantaged children caused by poor health and nutrition
- Strategies to support disadvantaged children to have healthy lifestyles in school and at home
- Initiating and developing strategies to support disadvantaged families to access dental care and treatments
- Using data to measure the impact of school health and nutrition initiatives: key tips and advice

Context of WEINS

We have 3 nursery classes 2 year old provision and 3-4 year old provision.

We are a 2 form entry Infant and Nursery school with an in house alternative provision for children with significant Social, Emotional and Mental health needs who are at risk of permanent exclusion.

We employ our own Speech and Language therapy team as 100% of our two year olds and 80% + of our 3 and 4 year olds join us with significant speech delay.

We have a full time Family support worker who attends child protection conferences, leads EHAPS and supports the families on a daily basis with providing parenting courses, cooking courses, sourcing clothing, food bank deliveries, Christmas hampers, onward referrals for financial support, legal aid, domestic abuse support.

- We have a high level of Pupil Premium in school approx. 57%
- IDACI index of deprivation report shows we are in the top 10% most deprived areas in the UK for education, crime and health along with income, employment and living barriers.
- Average age of male deaths within West Earlham is 54 years old.
- High levels of parent illiteracy
- High levels of deprivation including education, multi generational unemployment, poor parental mental health, high levels of safeguarding, alcohol and drug abuse and domestic violence.

Outlining the barriers to education faced by disadvantaged children caused by poor health and nutrition on the ground floor

- Children come to school often without breakfast
- Often come inadequately clothed
- Many children are often unwell – glue ear, coughs and colds due to living in cold and damp or smokey houses – poor quality housing, further worsened by the cost of living crisis. Our families are literally choosing between eating and heating.
- Attendance started to decline due to children experiencing dental pain and not being able to get into dentist. This is where our initiative was born.
- Poor hygiene and diet - many of our children do not brush teeth at home, high sugar and carbs diet.
- Health is not viewed as a priority
- Lack of understanding of health this is a generational issue - they are repeating what their parents did for them.
- Access to support - many parents do not have reliable internet access or phones so accessing

Strategies to support disadvantaged children to have healthy lifestyles in school and at home.

Providing breakfast for all children, supported by a charity but subsidised by school.

Free toothbrushes and toothpaste in school

Healthy snacks and parenting courses - healthy cooking, slow cooker course.

Our own chef who is flexible

Regularl deliveries from foodbank

Regular vouchers issued for foodbank - we collect and deliver this.

All children have a school cooked meal every day - we don’t have packed lunches sent in.

Signpost parents when they should be seeking medical advice – even taken children to GP’s due to lack of appointments available

Supporting conversations with Norwich city council re: housing suitability, mould issues

Providing referrals to welfare rights and financial advice.

Buy in sports coaches to ensure the children are active at lunch time.

Staff plan this into their curriculum and share resources, recipes and signposting for families.

Initiating and developing strategies to support disadvantaged families to access dental care and treatments.

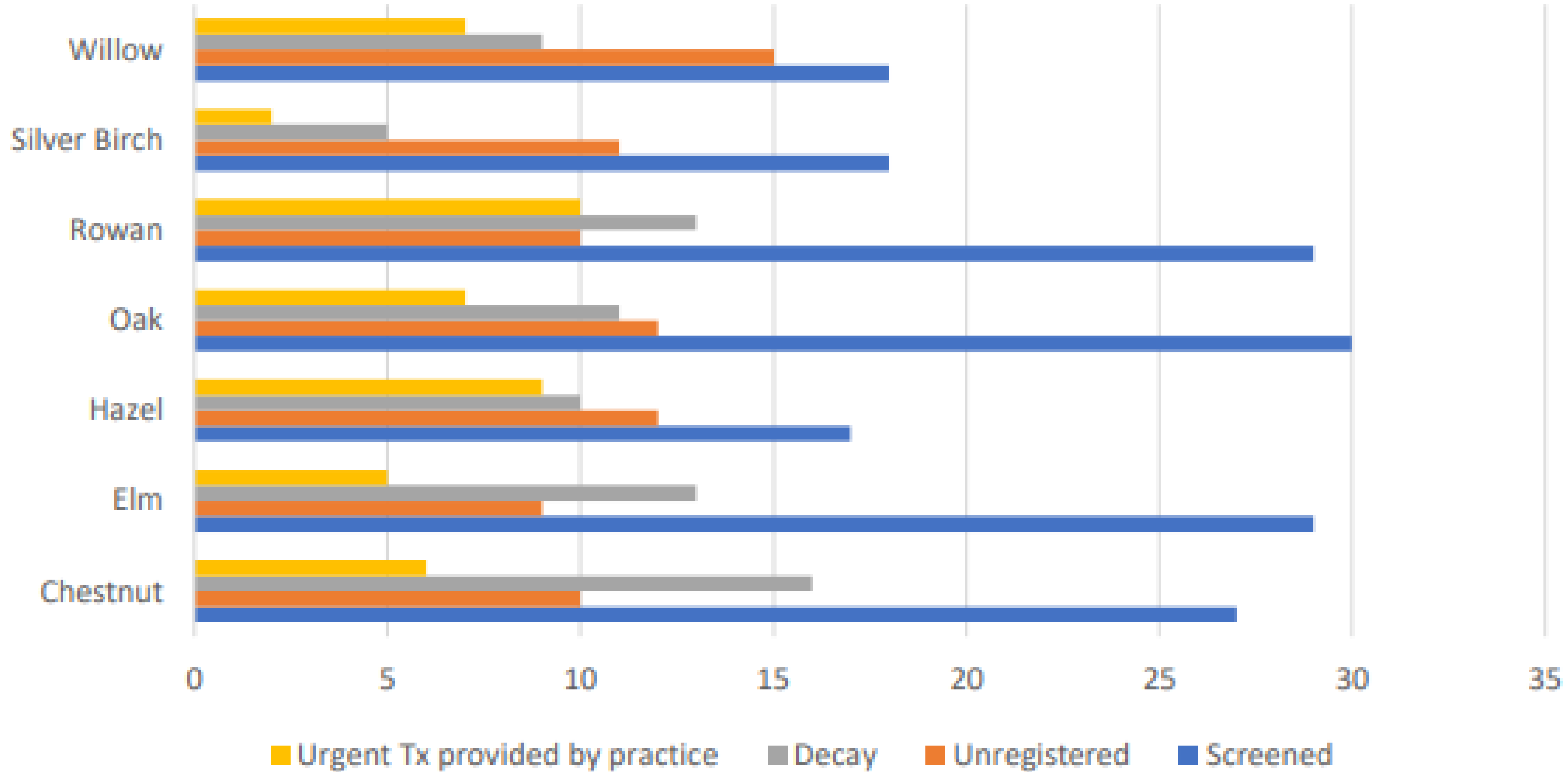
- ➢ Attendance dropped by 20% for a number of children due to pain from poor dental health.
- ➢ Started by contacting the education department of a couple of local dentists, one of whom were able to provide education sessions for each class. This work was then woven into the curriculum and followed up in planning by teachers.
- ➢ Having spoken to a number of parent, I learnt that a vast majority of our children throughout the school were both not registered and had never seen a dentist in their life (pandemic and lack of availability were cited as the reasons)
- ➢ Spoke to the dentist and I delivered a Dragons Den style pitch about the ‘dream’ provision I would like to be able to deliver in school.
- ➢ Dentist were able to support this and the programme has grown from there.

The delivery of the initiative

- Consent was sought from parents. 169 children were invited into the screening programme and 100% of our parents gave consent.
- A programme was set up in school and the session included disclosure tablets, education session and screening by a dentist supported by a dental nurse.
- Every parent was given feedback on the findings of the screening which included: poor oral hygiene, needs follow up treatment in dental surgery, needs follow up treatment in hospital under general anesthetic or no action needed - check up in 9/12 months.

The impact

- We had no child refuse - environment was more natural for the children.
- Parents report children are more engaged with oral hygiene at home *“I personally think it's good to show the children about teeth health. Since she has done the blue tablet and seen the dentist she is much more willing to clean her teeth twice at home and not just a little brush,we do 2 mins with a timer. Also really reassuring as so hard to get a dentist thanks to them coming into school I now both have them in a dentist as the last one just took them of their books. I'm sure you already do but explaining that sweets are particularly bad for teeth as she is a sweet monster lol.”*
- Attendance which was our primary indicator has improved - average attendance improved by 5 - 10% for children who were absent due to dental pain.



Individual Classes
Willow
Silver Birch
Rowan
Oak
Hazel
Elm
Chestnut
0
5
10
15
20
25
30
35
Urgent Tx provided by practice
Decay
Unregistered
Screened

What have we learnt

We have learnt that this model could work with funding for a mobile team that goes into schools.

We have learnt that parents from deprived areas face barriers to accessing dental care that parents from non-deprived backgrounds don't face so often - primarily transport to travel and funds to pay for private treatment where necessary.

We learnt that parents are concerned about the lack of dental care and have tried to source this for their child with no success and were therefore very much on board with this project and willing to engage.

What next in school

- We are now in the process of organising the new cohort to be screened (reception) and a drop in for nursery parents.
- We are looking at the possibility of a fluoride programme in school to effectively halt any decay that a child may have.
- We are looking at whether we could offer fillings in school - we are currently looking at logistics and funding.

Conclusion

Context plays a major factor

Parents are open to learning and accessing treatment for children but require support with this. Relationships must be in place for this to be achieved.

Children more compliant in screening and treatment in familiar environments.

Ultimately for us attendance improved, learning was not lost and children were orally healthy and pain free.