The BOW GROUP

Target Paper

Putting the Health Back in Education

The Bow Group Health & Education Policy Committee

(Tracey Bleakley, Stuart Carroll and Ross Carroll)

with a foreword from Charlotte Leslie MP

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Charlotte Leslie MP

Charlotte Leslie is the MP for Bristol North West having been elected at the 2010 General Election. She has previously worked for the National Autistic Society as their public affairs officer, helping with their Autism Bill. She is the former editor of the Bow Group magazine Crossbow, and has written for a number of publications, including The Guardian's candidate blog, Prospect Magazine, The Spectator, The Daily Mail blog, and the Daily Telegraph. Before getting selected for Bristol North West, she was Special Adviser to the then Shadow Education Secretary, David Willetts. In 2005, Charlotte co-authored the report 'More Good School Places' for the think-tank Policy Exchange, and has worked with The Centre for Social Justice. She is also a member of the Education Select Committee.

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The Bow Group was founded in February 1951 as an association of Conservative graduates, set up by a number of students who wanted to carry on discussing policy and ideas after they had left university. They were also concerned by the monopoly which socialist ideas had in intellectual university circles. It originally met at Bow, East London, from which it takes its name.

Geoffrey Howe, William Rees-Mogg and Norman St John Stevas were among those attending the first meeting. From the start, the Group attracted top-flight graduates and quickly drew the attention of a number of Government ministers, notably Harold Macmillan. In the intervening time, Michael Howard, Norman Lamont and Peter Lilley have all held the Bow Group chairmanship. Christopher Bland, the current Chairman of BT, was Bow Group chairman in 1969. In the recent General Election five recent members of the Bow Group Council were elected to the Commons.

Since its foundation the Bow Group has been a great source of policy ideas, and many of its papers have had a direct influence on Government policy and the life of the nation. Although it has no corporate view, it has at times been associated with views both of left and right - always within the broad beliefs of the Conservative Party.

The Bow Group (BG) has four clear objectives:
To contribute to the formation of Conservative Party policy
To publish members' work and policy committee research
To arrange meetings, debates and conferences
To stimulate and promote fresh thinking in the Conservative Party

Recent publications include (all available at www.bowgroup.org):

'Delivering Enhanced Pharmacy Services in a Modern NHS: Improving Outcomes in Public Health'
Ross Carroll, Mike Hewitson & Stuart Carroll with a foreword from Baroness Cumberlege (BG Health Committee) **September 2010**

'Equity and Excellence: Liberating the NHS' – Opportunities and Challenges
Stuart Carroll & Gary Jones (BG Health Committee) **August 2010**

The Case for Energy Crops:How Developing Countries can Help Themselves & Boost UK Energy Security
Tony Lodge (BG Transport & Energy Committee) **July 2010**

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The Right Track – Delivering the Conservatives' Vision for High Speed Rail
Tony Lodge with a foreword by Lord Heseltine (BG Transport & Energy Committee) **January 2010**

"People Power: Reforming QUANGOs" – Is this Applicable to Health Agencies?
Stuart Carroll & Nick Hoile (BG Health Committee) including contributions from Sir Andrew Dillon, Dr. Richard Barker and Dr. Bill Moyes **November 2009**

More for Less: Cutting Public Spending, Protecting Public Services
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Ross Carroll, Stuart Carroll and Julien Rey (BG Health Committee) including contributions from Simon Weston OBE and Captain Surgeon Morgan O'Connell **June 2009**

A Report by the Health & Education Policy Committee of the Bow Group

(3rd February 2011)

Tracey Bleakley, Stuart Carroll and Ross Carroll

with a foreword from

Charlotte Leslie MP

Bow Group Health & Education Policy Committee

The Health & Education Policy Committee is committed to researching and analysing the issues and challenges facing the NHS and wider healthcare sector, and the education system, as a result of Government policies. The Committee regularly meets to discuss new research projects and how it can support viable, sustainable and effective policies to improve the provision and delivery of healthcare and education services.

Chairman – Stuart Carroll

For more information, please contact Stuart Carroll on health.policy@thebowgroup.org.

FOREWORD

Charlotte Leslie MP

My former swimming coach, who trained Olympians (of whom, alas, I was never one) swore by the mantra “No pain, no gain.”

It is one of my perennial complaints that in the celebration of British Olympic victories, the ‘pain’ bit of the equation, that is the gruelling training, the early mornings, the cold, the lack of any kind of social life, and all the physical pain that goes into achieving that glittering gain of an Olympic Podium moment, is so seldom shown.

Showing both sides of the equation is important. Not least in a world where technological advances mean that in so many walks of life we can get what we want far quicker and with far less effort. The simple equation of sport reminds us that the ‘real world’ rule that says ‘no pain, no gain’, or translated into more everyday situations, ‘no result without hard work’, still holds. It is a rule that explains that actions have consequences – you choose your actions and the consequences will follow.

So how does all this relate to public health, and this timely paper by the Bow Group? It relates because the recognition that daily personal choices have far-reaching personal consequences is at the heart of the issue of public health.

Public health is about far more than simply initiatives, which, despite the best of intentions have not delivered the results over the last decade.

Public health is about ensuring everyone, regardless of background, have the information they need to make informed personal choices – that is, they are informed about the results of actions. And it is about ensuring that everyone is able to grow up in an environment where choosing to act in interest of long-term benefit as opposed to succumbing to the charms of the short-term is encouraged and celebrated (most of us know by experience that it is not always easy to buck the trend to choose what is good in the long-term as opposed to what is pleasant in the short-term!).

There is a long way to go, and the challenge spans all generations. Child obesity is at record levels with almost one in four children either overweight or obese at reception age. Teenage pregnancies are the highest in Europe, and drinking amongst secondary school children is a real issue. The challenge this poses an already stretched NHS has been well reported and is alarmingly clear.

Moreover, it is often easy for a vicious circle of unhealthy habits, a resulting decreasing quality of lifestyle, depression and a sense of powerlessness to develop. And in cases where physical health suffers, it is often the case that life-chances and personal ambitions suffer as well.

But there is hope: where there are vicious circles, there can be virtuous circles. Initiatives such as the social enterprise MEND have shown that helping children tackle their weight issues can lead to improvements in every part of their life, as they take actions to tackle their obesity, see a result, feel empowered and transfer that sense of achievement and empowerment to other parts of their life.

Bleakley, Carroll and Carroll have targeted an absolutely fundamental issue in this comprehensive and stimulating paper, which tackles head on some of the crucial issues and barriers to a healthier, happier, and more active nation. This is an extremely valuable contribution to a debate that gets to the heart of the challenges of our future.

Charlotte Leslie
Member of Parliament for Bristol North West
Member of Education Select Committee

January 2011

From the Research Secretary

If the Government is to achieve its ambitious objectives – including keeping a tight lid on public spending in an effort to reduce the yawning budget deficit – it is going to have to find novel ways of extracting as much value as possible from public spending. Health education is undoubtedly one area in which the potential gains from a more focussed approach could be enormous.

This report calls for health education to take its rightful place at the centre of health and education policy. With its focus on preventative action and on raising the overall health of the nation, health education could play a crucial role in enhancing the quality of life of millions of people. Moreover, it would not just be the individual who would benefit from this; society as a whole would gain by having a healthier, and therefore more productive, workforce. This could also have the added benefit of reducing the long-term burden on the NHS.

As a former teacher, I know firsthand that health education can help provide people with the information they require to make informed choices. In that respect, it is consistent with the Conservative core belief in empowering the individual. By calling for the active engagement of community partnerships and other grassroots organisations in health education – including, naturally, the family – this report supports the wider aims of the current Government to create a 'Big Society' in which non-State actors are more active in helping to overcome society's problems.

With its detailed dissection of the plethora of policies and initiatives launched in the period 1997-2010, this report also highlights one of principal flaws of the previous Labour Government: the vast gap between its lofty rhetoric and the results it signally failed to achieve. While there was a great deal of activity in the field of health education, the effectiveness of the numerous policies and initiatives was undermined by the lack of a coherent and overarching strategy. Ambitious aims were trumpeted without any meaningful follow-through to ensure that objectives were reached. This report rightly calls for results and positive outcomes to play a far more important role in the future. It should not be considered enough to make a great deal of noise about the potential of health education. Positive outcomes must be achieved. Policies and initiatives in this area must make a real difference to people's lives.

With an approach that emphasises the importance of adding value in public policy, greater personal responsibility and the increased involvement of a wider range of non-State actors to solve the country's problems, this report is entirely consistent with the Bow Group's objective to produce relevant research that can influence the policy-making process.

It is time for health education to come out of the shadows and take its place at the centre of health policy.

Luke Powell
Bow Group Research Secretary

January 2011

Executive Summary

- Health education can play a crucial role in introducing children to a healthy, equitable, and inclusive psychological and physical environment, delivering benefits that cross-cut Government departments and wider societal imperatives.

- Health education is closely linked to public health, equipping people with the knowledge and education to live healthy lives; reducing reliance on the NHS and ensuring economic productivity is not undermined by unhealthy lifestyles and illness. It is an issue that should be of amplified interest and importance to a wide range of different stakeholders – not just Government or the public sector, but also the private and voluntary sectors and, of course, individuals and families. Health education is therefore inescapably a societal issue.

- This report examines the plethora of health education policies and initiatives launched by the last Labour Government, alongside the clear absence of sustainable progress and improved outcomes. Lacking much-needed strategic focus and political leadership, the health education debate has badly lost policy momentum at a time when its significance has arguably never been higher. This is not least the case given the stated aims and priorities of the new Government's Coalition agreement. These include:

    1) the unequivocal commitment to advance public health, reduce health inequalities, and move the NHS away from reactive healthcare to a more preventative model as outlined in the Government's recently published Public Health White Paper *'Healthy lives, healthy people: our strategy for public health in England'*;

    2) the pledge to ring-fence the NHS budget with real term spending increases over lifetime of the current Parliament with a strong emphasis placed on *'Equity and Excellence'* to improve patient health outcomes and healthy across the UK;

    3) the Government's overriding theme of the "Big Society" and in turn the need for a "responsibility revolution" where individuals are empowered to improve their own health and lifestyle choices; and,

    4) the Prime Minister's, David Cameron, own personal assertion that the NHS is his number one priority and his ambition to see better public health.

- It is from this perspective that a key challenge, and indeed policy imperative, for the new Liberal-Conservative Coalition Government is to reshape the terms of reference of this critical policy debate, and push forward a real programme of reform to address the inadequacies of the prevailing approach to health education.

- As the Government has recently said in its Public Health White Paper, "this is a new era of public health". It is clear a new model for health education is now needed where competitive sport, healthy eating and better lifestyle education are at the heart of the Government's approach.

- This paper outlines a number of options to revolutionise the way in which future generations approach daily and healthy living. Specifically, we propose a **three-phase model**:

  1) national campaigns targeted at specific groups, particularly those most in need, to encourage behaviour change as aligned with wider public health policy;

  2) health education to form part of the core curriculum and wider societal initiatives to ensure children, families and communities have sufficient information to make informed choices and take responsibility for their health and wellness; and,

  3) targeted health management as part of Extended Schools, developed nationally and delivered locally, utilising community partnerships, families and specialist providers at every possible opportunity.

- We believe the above three-phase model would put outcomes and results at the heart of health education policy, equipping society with the skills and knowledge to take responsibility for their health and well-being in the long-term.
- This is seminal to tackling perennial health inequalities; seriously advancing any meaningful public health policy; shaping a more affordable and sustainable NHS; and reducing productivity losses and other indirect costs at a time of economic peril.
- It would also go some way to implement the “Big Society” the current Government rightly aspires to and which has been emphasised as a policy imperative.

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1.0 Introduction

In December 2009, the Macdonald Report that looked at health education concluded "*it is essential for all children and young people to have an entitlement to a common core of knowledge, skills and understanding in PSHE [Personal, Social, Health and Economic] education. The depth and range of this learning experience should no longer be determined solely by individual schools and teachers*"[I].

Health education is a highly topical issue not least because it can play a central role in introducing children to a healthy, equitable, and inclusive psychological and physical environment. When implemented properly, health education can deliver benefits that cross-cut government departments and, more broadly, wider societal imperatives. This is particularly the case in terms of improving public health; equipping people with the knowledge and education to live healthy lives; and ensuring economic productivity is not undermined by unhealthy lifestyles. It is therefore an issue that should be of interest and importance to a wide range of different stakeholders.

Moreover, the issue, and policy imperative, that is healthy living and public health is a stated priority of the new Coalition Government's health and education policy, and something both the Conservative Party and Liberal Democrats have paid significant attention to over recent years. As is stated in **The Coalition: Our Agreement for Government** document: *"The Government believes that we need action to promote public health, and encourage behaviour change to help people live healthier lives. We need an ambitious strategy to prevent ill-health which harnesses innovative techniques to help people take responsibility for their own health"*[1].

This has been reaffirmed in the Government's recently published **Public Health White Paper**, *'Healthy lives, healthy people: our strategy for public health in England'*, which states: *"This is a new era for public health, with a higher priority and dedicated resources"*.[2]

However, the current economic climate and new "Age of Austerity" means that an increasing emphasis is now being placed on the cost-effectiveness and the sustainability of all departmental budgets and therefore health education programmes. This is most notably exemplified by the terms of reference of the new Office for Budget Responsibility and the provisions laid down by the Chancellor, George Osborne MP, and Chief Secretary to the Treasury, Danny Alexander MP, in the recent Comprehensive Spending Review. Allied to this point is the fact that children's education is under growing public scrutiny. It therefore follows that teaching in this area must be underpinned by evidence and results delivering outcomes that are clear, accountable and measurable.

The most recent National Child Measurement Programme (NCMP) results show that in

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[I] "Independent Review of the proposal to make Personal, Social, Health and Economic (PSHE) education statutory", Sir Alasdair Macdonald, December 2009 for the then Department of Children, Schools and Families.

Reception almost one in four children is either overweight or obese. By Year 6[II], this rises to nearly one in three[3]. More than 50% of pupils aged between 11 and 15 years have experimented with alcohol, and in 2008 the average amount of alcohol consumed by pupils who had drunk in the last week was 14.6 units[4].

In 2008, 22% of pupils admitted to taking drugs, with 15% reporting drug use in the last year and 8% in the last month[5]. In 2007, the number of pregnancies recorded in women under the age of 18 rose from 41,768 in 2006 to 42,918. In 2007, there were 8,196 pregnancies among girls under 16, compared with 7,826 in 2006 (three-quarters of the girls were aged 15 when they fell pregnant)[6].

2.0 Why Health Education?

It is from this perspective that increasing political attention is being paid to the issue of health education and how this can better foster better preventative healthcare, public health and healthy living. Prior to the general election, the Conservative Party made clear the need for a new approach as outlined in the Conservative Green Paper on public health, which stated:

"Obesity, binge-drinking, smoking and drug addiction are putting millions of lives at risk and costing our health service billions a year. So getting to grips with them requires an altogether different approach to the one we've seen before. We need to promote more responsible behaviour and encourage people to make the right choices about what they eat, drink and do in their leisure time"[7] (**Conservative Public Health Policy Green Paper, January 2010**)[8].

Addressing the recent Association of Teachers and Lecturers' annual conference in Liverpool, The Hon **Michael Gove MP**, the new Secretary of State for Education, highlighted the pressure placed on schools by health education demands and called for a more cohesive and societal response: "*The curriculum has become festooned with examples of politically motivated interventions where we use the classroom to correct the broader social ills many of us are concerned with...What we need is to take a step back and say 'why is it we as a country have a problem with children's nutrition and obesity?' These are things we can all solve rather than suggesting that teachers solve them for us*."[9]

Although health education is incorporated into the current PSHE curriculum (which became compulsory with the Children, Schools and Families Bill), a societal response would go far wider, involving and including some of the following key players:

- The entire education sector, from Sure-Start centres[III] and nursery/ pre-school clubs to schools, followed by further, higher and continuing education. Delivery staff would

[II] Year 6 covers 10-11 year old pupils.
[III] Sure Start is a Labour Government initiative, with the aim of "giving children the best possible start in life" through improvement of childcare, early education, health and family support, with an emphasis on outreach and community development. The programme was originally intended to support families from pregnancy until children were four years old but the brand was extended to cover an undefined responsibility up to age fourteen, or sixteen for those with disabilities.

include teachers, ancillary and support staff, school nurses and industry and subject experts.

- The health sector, which includes public health initiatives (such as lifestyle change promotions), primary care trusts, local GP's surgeries, health and medical centres, and hospitals and clinics.
- The social sector, including social services and agencies for children and young people.
- The voluntary/social enterprise sector, including agencies offering services to improve the wellbeing of children and families.
- The community, including youth clubs, sport initiatives, community groups and after school-clubs.
- The family and the extended family.
- The private sector, many of whom have large resource levels and may have corporate responsibility and community engagement written into their operational goals.

Guidelines from the National Institute for Health and Clinical Excellence[IV] (NICE) encourage schools to *"...work in partnership to identify other education institutions willing to deliver physical activity programmes involving the school, family and community"* [10]. NICE identified the benefits of this approach[11] to include a reduction in health problems such as obesity, heart disease and cancer, improvements in children and young people's cognitive ability and academic achievement, and improved social cohesion and a reduced risk of criminal behaviour. Similarly, the recently published Marmot review into health equalities[12] accentuated and emphasised the need for a more cross-functional and collaborative approach to dealing with the above health problems if real and sustainable success is to be achieved moving forward.

It is the aim of this research paper to describe how these benefits can be extended by using an innovative approach to delivering health education through schools, families and the community. For the purposes of this paper, our research focus primarily concerns the delivery of health education with a particular emphasis placed on obesity, alcohol and drugs, and sex education. As part of our analysis, we assess the relative advantages and disadvantages associated with both prevention and treatment approaches.

Stakeholders consulted and impacted by this research include children, families, teaching staff, ancillary staff, community workers, health workers and close influencers on children (such as the media, celebrities and peers). It is the intention of this paper to reach out to this wider target audience and provoke further thought on what health education should look like and how it can best be delivered.

3.0 Research Objectives and Methods

There are five main objectives of our research:

1. To establish the baseline health education entitlement for all children;

[IV] The National Institute for Health and Clinical Excellence (NICE) provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health.

2. To establish how these subjects should be taught and by whom;
3. To promote continuity and coherence across the subject, incorporating related disciplines such as physical education and community activities;
4. To recommend a scalable approach to delivering consistency and quality across these subjects; and,
5. To predict clear benefits and value from the investment in these disciplines.

In tackling these objectives, we aim to cover prevention approaches through standardised curriculum education combined with behaviour change delivered through smaller groups. We provide a definition of minimum standards and outcomes, and highlight how cost effectiveness can be achieved. Finally, we quantify the desired long-term results and outcomes, and examine how health education can be made interesting, engaging and relevant.

In addition to quantitative and qualitative analysis of current policies, our research methods included personal communications and interviews with healthcare and industry experts, and a structured literature review of published papers and viewpoints expressed by leading writers on this wider subject area.

4.0 All these Initiatives and all this Legislation BUT no Outcomes

The following section describes the plethora of current policies aimed at tackling childhood overweight and obesity; reducing drug and alcohol use; and reducing teenage pregnancies or occurrences of sexually transmitted diseases. Each of these policies has each been implemented in isolation without the benefit of an overarching public health policy framework.

A recent Health Select Committee (HSC) report on health inequalities argues that the number of sporadic and expensive public health initiatives launched over the past ten years has been irresponsible: "*Such wanton large-scale experimentation is unethical, and needs to be superseded by a more rigorous culture of piloting, evaluating* and using the results to inform policy"[13].

Despite the huge number of initiatives and pieces of legislation, the section below illustrates that there has been a complete lack of progress on the issue of health education since 1997. We have analysed all the previous Labour Government initiatives, but have been unable to identify any truly positive policies or sustainable outcomes despite at times best intentions to the contrary. Instead, we have found a cloud of confusion – something the current coalition Government should seek to reverse.

4.1 Healthy Schools (1999 - Present)

The Healthy Schools Programme (NHSP) was formed in 1999 as part of a joint initiative between the Department for Children, Schools and families (DCSF) and Department of Health (DH). The scheme was designed to promote a whole school/whole child approach to health, to improve health in schoolchildren and reduce health inequalities; to increase pupil achievement, to deliver closer social inclusion; and to implement closer working relationships between health promotion providers and education establishments. It is identified as a key

delivery mechanism in two key policy papers: 1) the Children's Plan (DCSF 2007)[14] and 2) Healthy Weight, Healthy Lives (DH 2008)[15].

To achieve National Healthy School Status, schools were asked to meet criteria set over four core themes[16] of Personal, Social and Health Education (PSHE), healthy eating, physical activity, and emotional health and wellbeing. The outcomes measured included:

- Use of the PSHE framework to deliver a planned programme of PSHE in line with relevant DCSF/QCA guidance
- Identification of a member of the Senior Leadership Team to oversee all aspects of food in schools
- Establishment of clear leadership and management to develop and monitor physical activity policy
- Identification of vulnerable individuals and groups and the formulation of appropriate strategies to support such individuals and their families

All outcomes were self-validated by the schools by filling in a form. These outcomes were accepted (and Healthy Schools Status was confirmed) unless the DCSF National Healthy Schools Quality Assurance Group felt that the school had not provided 'minimum evidence'[17]. There was no external measurement, audit or validation of these outcomes.

In 2009 (ten years on from the original policy), the former Education Secretary, **Ed Balls MP**, announced that the programme would exceed the Government targets for 75% of schools to have achieved National Healthy School Status by December 2009, and announced plans to extend the programme. Richard Sangster, Head of Healthy Schools added: *"Schools that have achieved National Healthy School Status are acknowledged as already contributing to the wider role which schools will play in the future"*[18].

However, a report commissioned by the DH in May 2009 found that the results of NHSP were inconsistent[19]. The NHSP outcomes were found to be unhelpful as they merely reflected current good practice. Nonetheless, where schools embraced the programme and went beyond the prescriptive recommendations, some positive outcomes were recorded. Examples include influencing the development of healthy eating policies through introducing lunchbox guidelines; promoting healthy eating in schools; investing in increased staff training; and selling healthy snacks and foods.

Conversely, schools that demonstrated a lack of engagement with the programme reported little effect. The report recommended that NHSP needs to focus further on being a "framework of delivery" rather than an "award", and that "the process of judging whether a school has achieved NHSS needs to be more rigorously monitored". This is supported by the fact that the data detailing how schools met the criteria in each theme shows a substantial variation. In Tower Hamlets, figures show that nearly 40% of primary schools had not met healthy school standards by May 2008[20].

Despite these problems, the role of NHSP in agreeing widely accepted standards has been important in helping schools implement positive change, and the programme has shown a

positive increase in the knowledge of staff and other stakeholders regarding health and wellbeing issues[21].

In order to address these weaknesses, the NHSP now asks schools to reflect and build upon the existing 41 criteria to make plans to meet additional proposed pupil wellbeing indicators, and to develop a three-year plan that embeds an outcomes based model for both universal and targeted health interventions.

These interventions will be prioritised by assessing school, local and national targets, and would be flexibly developed by schools with key partners including Children's and Young People's Services, Primary Care Trusts (PCTs), parents/carers and children and young people themselves[22]. The partnership approach and structured framework are excellent additions to the programme. However, schools are still being asked to design health education offerings on an individual basis to fit with the scheme, rather than being given proper national advice and guidance on how to do so effectively. This is of concern, and runs the risk of embedding existing problems associated with highlighted discrepancies in the quality of health education provision.

4.2 National Healthy Schools Standard (1999-2002)

The NHSS was the main delivery mechanism of the healthy schools programme and was introduced in 1999 to provide content for the Personal, Social and Health Education (PSHE) curriculum. The NHSS and PSHE framework were designed to work together to improve educational achievement; health and emotional wellbeing; and make schools a safe, secure and healthy environment in which young people can learn and develop. From a health education perspective, NHSS covered personal, social and health education, drug education (including tobacco and alcohol), emotional health and wellbeing, healthy eating, physical activity, and sex and relationship education

The development of the NHSS was a cross-departmental initiative between the DH and DfES (now the Department of Education), and set criteria for the accreditation and quality assurance of partnerships between LEAs and health authorities to deliver the content.

Schools could choose between three levels of NHSS participation starting from awareness through to involvement, auditing, target setting and action planning.

Measurement of the initiative was limited to the most advanced schools, and was supposed to comprise school monitoring and evaluation, fulfilment of specific criteria drawn from the NHSS, and evidence that social inclusion and health inequalities inform the development and implementation of activities. Evaluation covered the effectiveness of teacher training, coverage of the national curriculum, and finally the views of all pupils (including those with special educational needs and specific health conditions, disaffected pupils, young carers and teenage parents).

The NHSS programme was considered complete in April 2002. Success was measured on the number of schools signing up to the scheme (which by that point was 100%, with 8000

schools achieving the top level. However, signing up to the scheme and achieving accreditation was not one and the same, and it was reported that the majority of schools did not achieve the full standard[23].

The National Healthy Schools Standard report prepared by NICE in 2007[24] reported that schools involved in the NHSS were more likely to be improving at a faster rate than the national average with regards to the behaviour of pupils, the standards of work in the classroom, the quality of the PSHE programme, and the management and support of the pupils.

However, the research report "The Impact of the National Healthy School Standard on School Effectiveness and Improvement"[25] carried out by the Scottish Council for Research in Education in 2003 found that whilst NHSS is successfully meeting its objectives of encouraging schools with deprived communities to participate in the standard, there was no overall difference between the attainment rates of fully participating and non-participating establishments.

What is not in dispute is that the scheme was successful in proving the value of partnership working to deliver PSHE education in schools. Quotes from local programme coordinators support this view: "*The NHSS way of working via partnerships has brought together people across the LEAs and health authorities and relationships between them are now strengthened*"[26], and "*If you get your partnership working right the rest follows*."

One teacher went on to say : "*...the healthy schools programme is so useful for joined-up working.*"[27] Finally, a head teacher was quoted as saying: "*The reason why I think the NHSS is one of the most powerful Standards is because however good a teacher is they cannot be the font of all wisdom and the NHSS asks other professionals to play their part and bring their expertise, their skills and knowledge into the teaching and learning environment of the children to help them to make healthy life choices for the future*."[28]

This chimes with the view of Michael Gove, who has spoken out about the need for teachers not to be overburdened with the expectations to deliver all of these different subjects: "*Staff are being turned into social workers with requirements to cut obesity, promote community cohesion and ensure children become good citizens*"[29].

The next steps of the programme were reported in 2002 as the need to make an explicit contribution towards the discussion of health inequalities; to promote social inclusion; and to encourage high standards in schools through improvement activities.

4.3 Every Child Matters (2003)/ The Children's Act (2004)

In 2003, the Government published a Green Paper called Every Child Matters setting out the Government's approach to the wellbeing of children and young people from birth to age 19. This was released in conjunction with the response to the report into the death of Victoria Climbié. Following this, the Children Act 2004 became law.

The aim of the Every Child Matters programme is to give all children the support they need to be healthy, stay safe, enjoy and achieve, make a positive contribution, and achieve economic wellbeing. The Every Child Matters was further developed through publication of The Children's Plan in December 2007[30]. Health education plays a major role in schools' contribution to the five Every Child Matters outcomes, but again in the absence of a clear structure, the curriculum must be designed by individual schools to match the framework.

4.4 The Children's Plan (2007)

The Children's plan is the ten-year strategy for the DCSF, launched in December 2007. The plan includes an original pledge to spend £30 million over three years to provide family learning to help parents and carers develop skills and learn with their children in schools, and a promise to tackle behaviour that puts young people at risk.

The initiative included the publication of a youth alcohol action plan in spring 2008, plans to tackle parental alcohol misuse; and consideration of further action on alcohol advertising.

In addition, the plan included pledges to encourage all young people to participate in positive activities to develop personal and social skills, to promote wellbeing and reduce behaviour that puts young people at risk, and to improve child health, with the proportion of obese and overweight children reduced to 2000 levels.

The Plan aimed to improve educational outcomes for children, improve children's health, reduce offending rates among young people and eradicate child poverty by 2020, thereby contributing to the achievement of the five Every Child Matters outcomes.

However, the Children's Plan gives substantial responsibility for the most complicated issues (i.e. child consumerism, primary curriculum, child alcoholism etc) to newly formed independent review groups appointed by DCMS. So far, this has resulted in a plethora of vague statements showing how well the plan is progressing, but no concrete policies. In addition, the plan does not address how to engage parents in children's education. Such engagement is essential to achieve the shared goals and incentives for parents as outlined in the plan, especially for hard to reach groups.

4.5 Extended Schools (2007)

This policy started out as a delivery mechanism for Every Child Matters (ECM), arguing that schools are located at the heart of the community and are therefore well placed to be the forum to disseminate the ECM outcomes to children, young people and related stakeholders. The publication '*Extended Schools: Building on Experience*'[31] set out a core offer of services that all children and parents should be able to access through schools by 2010.

The core offer includes a variety of after school of activities including study support, sport and music clubs, childcare in primary schools, parenting and family support interventions, and targeted and specialist services. In addition, it promised community access to facilities available in schools such as adult and family learning, ICT and sports grounds.

The policy requires schools to work closely with parents, children and community stakeholders to define the activities offered around the needs of the local community. Schools were given the option to provide extra services in response to demand.

The Government committed funding of £840m over 2003-2008 for the Extended Schools initiative[32]. This funding is made available through each LA alongside funding streams sent directly to schools. Additional funding was made available (albeit at lower levels) in 2009/2010 as schools were expected to develop a sustainable model and overcome potential barriers to developing extended services.

In addition, £1.3 billion was made available in 2006-08 for schools to support personalised learning during and beyond the school day. This funding was designed to support access to extended services, especially for children from disadvantaged areas. Over 8,000 schools (one in three) now provide access to extended services in partnership with voluntary, private and independent providers.

However, once again this is an example of a Labour policy that has been heavily funded without a clear and agreed operating model. In this case, it is still unclear how such community-oriented schooling should operate, and therefore the services will vary according to how the policy is understood by the people who have to make it work in practice. Indeed a study comprising interviews with over 350 professionals reported a range of different assumptions about the fundamental social and educational issues within Extended Schools and argues for a more open debate around these issues[33]. Such widespread delivery will necessarily result in a wide range of outcomes once again.

4.6 Healthy Weight, Healthy Lives (2008)

The £372 million Healthy Weight, Healthy Lives[V] strategy includes[34] a £75 million budget for a marketing campaign to persuade parents to improve their children's diet and encourage physical activity, a code of practice to be agreed with the food and drink industry, and a £30 million budget for "healthy towns" to encourage walking, cycling and other activities

It also promised increased funding over three years for personalised weight-loss programmes and competitions in workplaces and the community, a pledge for cookery lessons to become compulsory in all secondary schools by 2011, and an Ofcom review into junk-food advertising to children.

Alan Johnson MP, the then Health Secretary in 2008, and Ed Balls MP, the former Secretary of State for Children, Schools and Families, announced the policy with the message that England would become the first country to reverse the trend for expanding waistlines, with a

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[V] The resources provided by Healthy Weight, Healthy Lives can be found at the following link: http://www.fphm.org.uk/resources/AtoZ/toolkit_obesity/default.asp, Accessed 25th November 2010.

focus on children. Alan Johnson went on to say, "*The core of the problem is simple — we eat too much and we do too little exercise. The solution is more complex*." Ed Balls went on to pledge an increase in sport and exercise in and out of school, supported by more play and sports facilities[35].

The £75 million social marketing campaign was designed to focus on health education messaging things such as fruit-tasting sessions, compulsory cookery lessons in schools and walking buses (where an adult leads a group of children walking to school). Schools were advised to monitor pupils eating habits and parents were given guidelines showing how to make use of available technology to limit the time children spent on the internet, watching television or playing computer games.

Andrew Lansley MP, the new Health Secretary, commented on the policy, stating: *"Labour have failed to make public health a priority. Under Gordon Brown public health budgets have been raided, specialist staff cut and obesity targets missed and scrapped."* [36]

4.7 The Obesity Improvement Programme (2009 – 2010)

As an extension to Healthy Weight, Healthy Lives, and in recognition that tackling obesity requires partnership working with schools, strategic health authorities, primary care trusts, third parties and local authorities, the Labour Government pledged to provide £69 million to NHS PCTs in 2009/10 to combat overweight and obesity.

The policy included a pledge to encourage local authorities to use their power to promote or improve the economic, social or environmental wellbeing of their area, and to create an Obesity Improvement Programme to strengthen local capabilities to both prevent and treat obesity.

Harry MacMillan, **CEO of MEND**[VI] believes that the majority of this funding has been wasted. Mr. Macmillan told us: "*I believe that significantly less than 10% of the unallocated Healthy Weight Healthy Lives budget has been used to fund frontline child obesity treatment programmes and obesity-related training - a significant (but not the only) objective of the strategy - especially for these first two years. This is due to a number of factors including poor central direction, poor understanding of services to be commissioned (locally and centrally), NHS structural changes, a limited understanding of cost-effectiveness or appreciation of how to improve this, and inefficient, poor quality local commissioning*"[37].

This further demonstrates how substantial funds have been poured into a programme with little thought given to the operational framework, local guidance and skills needed to realise value from the investment.

[VI] MEND is a social enterprise running community based programmes for children and their families, based on behaviour change, nutrition and exercise.

4.8 Change4Life (2009)

Change4Life is a national marketing campaign costing £75M over three years. It was launched in January 2009 as part of Healthy Weight, Healthy Lives. The Labour Government is using the Change for Life programme to educate the public about healthy lifestyle choices, and is designed to help people eat better, be more active and as a result live longer. Government research has shown that, although parents realise that obesity is a growing problem, they do not recognise it as a problem they face.

Change4Life was initiated to inspire 200,000 families to change their behaviour through a dedicated social marketing campaign in 2009. The marketing programme is complex, spanning several audiences who are being asked to change eight separate behaviours through multiple activity strands backed by a range of partners and stakeholders. There are a range of related spin-off campaigns including Start4Life and Dance4Life. Future plans include a new phase of Change4Life targeted at at-risk adult groups[38].

An early Change4Life general monitoring survey (carried out in November 2009) concluded:

- Advertising awareness reached 85% in May 2009, with logo recognition at 86% (compared to a baseline recognition level of 9%).
- 85% of mothers agreed that Change4Life "made me think about my children's health in the long term", 81% agreed it "made me think about the link between eating healthily and disease" and 83% "made me think about the link between physical activity and disease".
- 71% of general practitioners and practice managers are aware of the campaign.
- Over 320,000 families have joined Change4Life. 260,000 families completed 'How Are The Kids? Questionnaires'.

However, Professor Hunter, Head of Durham University Public Policy and Health Centre, commented that Change4Life will fail to stop rising levels of obesity unless it commits to a strategy to change long-term behaviour[39]. Once again, a short-term initiative has been launched without a long-term framework, meaning that positive outcomes will be short-lived at best.

4.9 The PE and Sport Strategy for Young People (2008)

The new PE and Sport Strategy for Young People (PESSYP) launched in January 2008 aimed at improving the quantity and quality of PE and sport undertaken by young people aged 5 - 19 in England. PESSYP involves an investment of £755 million over three years and now forms part of Public Service Agreement target 22. The policy is the next phase of the PE, School Sport and Club Links (PESSCL) Strategy for 5 –16 year olds, launched in April 2003[40].

The five-hour offer is aimed as a contribution to a number of national indicators including preventing childhood obesity and providing positive activities for young people. The specific targets are as follows:

- By the end of academic year 2010-2011, 40% of young people should take part in five hours per week of physical activity (3 hours for 16-19 year olds).

- By the end of academic year 2012-2013, 60% of young people to take part in five hours per week of physical activity (3 hours for 16-19 year olds).

- By the end of academic year 2010-2011, 80% of five to 16 year olds in every School Sport Partnership (SSP) to take part in three hours per week of PE and sport organised by schools.

For five to 16 year olds, the expectation is that schools will provide three hours of sport (two within the curriculum and an hour delivered after school), with community providers providing the additional two hours[41].

Given such a significant funding stream, and the fact that the benefits of physical education cover policy areas in education, sport and health, it might be expected that this is a policy area that would produce sustained and positive outcomes. However, Margaret Talbot, PhD OBE Chief Executive, Association for Physical Education (afPE) disagrees, saying "*the overlapping policy agenda has so far not resulted in joined-up policy which would support Government investment. Hence, in late 2008, afPE issued a Manifesto for Physical Education, which outlined some of the ways in which the existing system could be improved to ensure better use of resources and more effective delivery*"[42].

4.10 The Healthy Community Challenge Fund (2008)

The Labour Government wanted to create an environment that is conducive to physical activity. Therefore, the Government set up the Healthy Community Challenge fund (HCCf). This provided funding to a small number of local areas to test and evaluate their ideas on how to make activity and healthier food choices easier for local communities. Nine towns were chosen to share a £30 million investment over three years:

- Tower Hamlets
- Manchester
- Dudley
- Halifax
- Sheffield
- Thetford
- Middlesborough
- Tewkesbury
- Portsmouth.

The policy promised that lessons from these pilot projects would be shared across the country. This study has found no such lessons or outcomes. Indeed, although there was an initial flurry of press releases from local authorities that had received grants under this scheme in 2008, no further communications can be found.

4.11 The Youth Alcohol Action Plan (2008)

The Youth Alcohol Action plan was a joint strategy launched by DCSF, the Home Office, and DH aimed at reducing the occurrence of young people drinking in public; helping young people make the right decisions about alcohol; and providing clear information to parents and young people about the risks of early drinking.[43].

The Action Plan had four main aims, which are:

1. To work with police and the courts to prevent teenage drinking in public
2. To provide clearer health information for parents and young people about how consumption of alcohol can affect children and young people
3. To liaise with the alcohol industry to reduce the sale of alcohol to under-18s
4. To target the marketing and promoting alcohol in a more responsible way.

The strategy included new laws to stop young people drinking in public places, including a new offence to tackle persistent possession of alcohol, new authoritative guidelines about young people, alcohol and health from the Chief Medical Officer, clear information to guide children towards low risk drinking, and publicity campaigns and education in schools to enable children to make the right decisions about alcohol.

However, by February 2010 no outcomes had been published from this policy, and the Government decided to move on to another initiative. Launching the 'Why Let Drink Decide?' campaign and the Kickz Cup 2010, former Schools Minister Vernon Coaker MP said: "*Today's research shows that parents underestimate their influence over their child's drinking and attitudes to alcohol, yet a quarter of young people have never spoken to their parents about the issue. That's why through the 'Why Let Drink Decide?' campaign we are giving parents and young people the confidence to have open conversations about alcohol, to ultimately delay the age at which young people start drinking. We are determined to do all we can to prevent alcohol ruining the lives of children, young people and their families*."[44]

The then Home Office Minister Alan Campbell MP added: "*We recently introduced new powers to tackle underage drinking, including making it easier for police to confiscate alcohol, move on groups of teenagers causing trouble and stop retailers selling to underage children. We are also supporting young people in partnership with the Department for Children, Schools and Families, through the Positive Futures programme which targets vulnerable young people aged 10-19 and supports them through sport and arts based activities to steer them clear of alcohol misuse and its associated anti-social behaviour*."[45]

The quiet replacement of the Youth Alcohol Action plan two years on with this remarkably similar policy would suggest that little was achieved.

4.12 Frank (2003)

FRANK is a campaign aimed at reducing drug use of teenagers. The campaign aims to ensure that young people understand the risks and dangers of drugs (and their use) and know where to go for advice or help. It also aims to give parents the confidence and knowledge to talk to their children about drugs, and ensure that professionals who work with young people (especially vulnerable groups), are supported.

FRANK uses a variety of channels including advertising and local campaigns, a helpline, and website called 'Talk to FRANK'[46]. FRANK was designed as an umbrella campaign, allowing local communities to use resources to promote their own drug communications and campaigns with young people, parents and the wider community.

In 2007/08, FRANK launched a strategy called 'Experience FRANK' to bring about increased interaction and access to information. The helpline received 413,921 calls (53% of callers rated their experience excellent and 35% very good), responded to 31,715 emails and received over 5 million visits to the FRANK website[47].

However, FRANK has been accused of presenting misleading, or in some cases entirely false, information about drugs. For example in 2007, the website site was forced to remove an article entitled "Cannabis Explained" after several groups pointed out glaring errors in the information presented[48].

In addition, figures released by the National Treatment Agency in England in March 2010 highlighted that growing numbers of children in the UK are being treated for cocaine addiction. A previous report, by the European Monitoring Centre for Drugs and Addiction, revealed that the UK has the highest proportion of cocaine use amongst adults and 15 and 16 year olds. James Brokenshire MP, then the Shadow Home Office Minister, said: "*This depressing report bears out the evidence of the UK being the cocaine capital of Europe; it is particularly disturbing that so many young people are in need of treatment for their addiction. It highlights that the current system just isn't working. We simply can't go on with the same approach.*"[49]

4.13 The Teenage Pregnancy Policy (2007)

The Labour government's Teenage Pregnancy Strategy was an attempt to tackle both the causes and the consequences of teenage pregnancy. The strategy set out to halve the under-18 conception rate by 2010; to establish a continued reduction in the under-16 rate; and to increase the proportion of teenage parents in education, training or employment to 60% by 2010 to reduce their risk of long-term social exclusion.

The strategy engaged delivery partners in partnership working arrangements (including health, education, social services, youth support services, and the voluntary sector), and focused on targeted interventions for young people at greatest risk of teenage pregnancy, in particular with looked-after children. It also provided training on SRE for partner

organisations and developed a youth service with a focus on addressing key social issues affecting young people, such as sexual health and substance misuse.

In addition, local delivery was supplemented by two national media campaigns: 'RU Thinking' and 'Want Respect? Use a Condom'. Support for parents is also provided through the 'Time to Talk' initiative delivered by Parentline Plus[50]. Teenage Parents Next Steps[51], published in July 2007, set out what action local areas need to take to drive improvements in outcomes for teenage parents and their children.

In 2009, the Government pledged an additional £20.5 million to help young people get better access to contraception, to provide support for teenagers and to raise awareness of the risks of unprotected sex[52]. However, in February 2010, Ed Balls conceded that it was going to be "*really hard*" to achieve the pledged target of a 50% decline on 1998 figures by 2010[53].

Furthermore, serious questions have to be raised regarding the effectiveness of contemporary sex education in terms of conveying a moral message of personal responsibility and communicating the importance of stable relationships for wider society. Although it can be cogently argued that significant advances have been made on a "mechanical" level, namely teaching young people what contraception is and how it should be used, it would seem that sex education has been devoid of a moral message and teaching the importance of responsibility in a society that has arguably lost its way in that respect.

4.14 Summary

This section has covered the plethora of policies launched under the previous Government aimed at tackling childhood overweight and obesity; reducing drug and alcohol use; and reducing teenage pregnancies or occurrences of sexually transmitted diseases. The list included:

- Healthy Schools
- National Healthy Schools Standard
- Every Child Matters / The Children's Act
- The Children's Plan
- Extended Schools
- Healthy Weight, Healthy Lives
- The Obesity Improvement Programme
- Change4Life
- The PE and Sport Strategy for Young People
- The Healthy Community Challenge Fund
- The Youth Alcohol Action Plan
- FRANK
- The Teenage Pregnancy Policy.

Each of these policies has each been implemented in isolation without the benefit of an overarching public health policy framework and systemic coordination. Despite the huge

number of initiatives and pieces of legislation, this section has illustrated that there has been a marked lack of progress on the issue of health education since 1997.

Despite the list of Government initiatives above, we have been unable to identify any truly positive policies or sustainable outcomes despite at times best intentions to the contrary.

5.0 PSHE Curriculum Overview

PSHE education is a part of the school curriculum designed to educate children and young people on a wide range issues that they face as they grow up[54]. From a health education perspective, it covers drug and alcohol education, emotional health and wellbeing, sex and relationship education (SRE), and nutrition and physical activity.

In October 2008, the Labour Government announced its intent to make PSHE education statutory in primary and secondary schools. An independent review, undertaken by Sir Alasdair Macdonald[55], identified three areas of concern among schools and parents. These were that statutory PSHE education would increase pressure on the curriculum; that it would reduce the rights of school governing bodies to decide their own approach in areas such as SRE; and that the rights of parents to withdraw their children from SRE must be taken into account.

DCSF accepted all the recommendations of the Macdonald Review on these key issues, and as part of the Children and Families Bill set out a core curriculum of PSHE education, which is set to become mandatory in September 2011. Whilst the curriculum will be flexible enough for schools to ensure that topics are taught in line with the views of parents, pupils and local communities, school policies must include the core entitlement of PSHE education.

Although the Children and Families Bill has brought the subject of PSHE under national scrutiny, most schools already provide a broad PSHE education programme and therefore the introduction of statutory PSHE education is unlikely to result in significant changes to the way in which they teach the subject now.

Whilst the DCSF advised that all such initiatives should be ‘planned, coordinated, assessed, monitored and evaluated’, they did not issue guidance or support on how to do so, nor were there any plans for a single results database to coordinate the provision of national results and evaluations. DCSF also advised that children and young people should be involved in defining the curriculum process, influencing what is taught from the start and being consulted as learning develops.

If the Children and Families Bill is passed, and before PSHE education becomes statutory, DCSF have pledged to work with the Training and Development Agency for Schools (TDA) to investigate and establish a dedicated route for initial teacher training (ITT) which will, in time, create a group of specialist PSHE education teachers. However, this will not be in place in time for September 2011.

DCSF also agreed to work with the Qualifications and Curriculum Development Agency (QCDA) and the PSHE Association before September 2011 to provide research on models of

teaching and their effectiveness in improving outcomes, (informing the development of a workforce strategy), to recommend appropriate ways of assessing pupil progress, to provide support for schools and teachers, including resources, guidance, examples of good practice, and to give advice on how schools can involve people and organisations from outside the school.

The PSHE Health Curriculum is detailed in **Appendix B**.

5.1 The Children, Schools and Families Bill

The Children, Schools and Families Bill was written in order to clearly define what children and parents are entitled to expect from the schools system. The Bill was passed on the 8th April 2010 and will purportedly reform the curriculum and introduce a new licensing scheme for teachers. The changes to the primary curriculum follow a review by Sir Jim Rose in 2009, making Personal, Social and Health Education (PHSE) mandatory for the first time.

In the primary curriculum review led by Sir Jim Rose, the section entitled 'Understanding physical development, health and wellbeing component', stated that "*children should build secure knowledge [that]...healthy living depends upon a balance of physical activity, nutrition, leisure, work and rest to promote wellbeing.*"[56]

6.0 Political Commentary

In direct response to the proposed Children and Families Bill, **Michael Gove MP**, said the shift away from subjects meant a dilution of learning: "*The government's changes to the primary curriculum will lead to children learning less not more. The move away from traditional subject areas will lead to a further erosion of standards*"[57].

The former Liberal Democrat Children's spokesman **David Laws MP** commented that schools should have greater freedom to set their own teaching priorities, rather than a new set of Government directives[58]. In April 2010, he commented, "Labour wanted to impose mountains of extra bureaucracy on schools which wouldn't have raised standards. We are pleased that we managed to kick much of it out… Sex and relationships education is vitally important in tackling this country's high teenage pregnancy rate"[59]. At the 2009 Liberal Democrat conference, a motion was passed to provide age-appropriate lessons on body image and media literacy as part of Personal, Social and Health Education (PSHE) in schools[60].

The National Association of Head Teachers welcomed the bill, particularly the emphasis on wellbeing, adding that such an "*ethos of holistic education*" is a key component of primary school[61]. However, the NASUWT general secretary Chris Keates was sceptical of schools ability to realise beneficial outcomes from this curriculum when tests and league tables at the end of primary school remain a priority. "*The Rose Review presents an opportunity to remove this outdated, divisive method of school accountability*," she said[62].

Since compulsory PSHE is not due until September 2011, it is currently unclear how far the Coalition Government would go in implementing the proposals. Secretary of State for Education, **Michael Gove MP** has spoken publically about his concern around sex education

for very young children; and a spokesman for his office confirmed that Conservative policy did not propose any more compulsion in the curriculum[63].

Going further, Mr Gove has expressed the view that teachers are being turned into social workers with the introduction of requirements to cut obesity, promote community cohesion and ensure children become good citizens[64]. He further pledged to strip down the "*politically motivated*" curriculum to allow staff to focus on teaching.

However, at the Conservative Party Conference in 2009, Parliamentary Under-Secretary of State for Children and Families, **Tim Loughton MP** announced that PSHE **would** be made statutory under a Conservative government. He stated that it was important that personal, social and health education (PSHE) became part of the national curriculum, as current teaching was a "*postcode lottery*". He went on to suggest "*Clearly what needs to be done is to have a trained pool of specialists, probably not teachers, maybe outside organisations such as Brook, to give more sensitive and sensible messages to young people*"[65] [VII]

The PSHE Association agree that well trained specialist staff from organisations like Brook (see section 9.6.2) can make a significant contribution to the health and wellness component of PSHE. They also point out that the existing PSHE CPD programme has extended the role of school nurses in providing additional delivery support for teachers and young people[66].

Finally, young people themselves have had their say. A report released by the UK Youth Parliament following a survey of 11-18 year olds (in which 21,602 responses were received) advocated that SRE, including relationships, should be '*an entitlement for all children and young people and taught as part of statutory provision of PSHE*'. They went further to state that '*schools should employ more trained staff and specialist personnel, and that all young people should be able to access a confidential Sexual Health Service*'[67].

7.0 Current Delivery of PSHE/ Health Education

We have seen that health education is crucial in safeguarding children, and gives young people the skills to ask for help[68], contributing to a reduction in childhood abuse and neglect[69]. Evidence also shows that health education is an important intervention for preventing bullying[70]. But how should it be delivered to maximise its effect?

Ofsted and the DCSF both advise that there should be a weekly PSHE session in the curriculum and that a dedicated team should deliver it. Dr John Lloyd, policy adviser to the PSHE Association, commented[71]: "*Schools should endeavour to provide a full PSHE education programme for all pupils, co-ordinated and delivered by trained teachers in discrete curriculum time as opposed to 'drop-down, off- timetable days' or 'inadequate tutorial time'*".

[VII] Brook is an organisation that currently provides information to around 200,000 young people each year through specially trained doctors, nurses, counsellors and outreach and information workers. Brook, MEND and DAES are highlighted later in this report as potential national partners for the health and wellness component of PSHE.

A key stakeholder with strong views on health education delivery is the **National Health Education Group (NHEG)**[72]. Founded in 1986, the group meets regularly with, and has representation on, a wide variety of national organisations including the Drug Education Forum, the Sex Education Forum and the PSHE Advisory Group. The NHEG agrees that effective health education equips young people with the knowledge, skills and understanding to make informed choices about their lives, build self-esteem and contributes to their academic and social achievements.

They also argue that the National Healthy School Standard provides the ideal framework for the delivery of the PSHE curriculum and of whole school issues relating to health, and that youth services can be used as a vehicle to deliver education within both formal and informal settings particularly to young people who are 'disaffected'. They also advocate that whole school staff training must be undertaken continually in order for staff to build the confidence and competence necessary to meet new challenges and opportunities.

7.1 Current Training/ Qualifications Available to Teachers

The PSHE Association[73] exists to analyse PSHE resources and professional development opportunities to ensure they are appropriate and beneficial. The association tries to make sense of the large number of Continuing Professional Development (CPD) providers in the field of PSHE. One training programme they recommend is the National PSHE CPD Programme.

The National PSHE CPD Programme is jointly funded by DCSF (the former Department for Children Schools & Families) and DH (Department of Health), and offers a PSHE certification for Community Nurses and Teachers[74]. The programme has been running for six years and around 8,000 teachers, community nurses and other professionals have completed this study route.

The CPD Programme runs across one academic year and the majority of participants access the training through locally organised provision by PSHE Leads (normally based within the Local Authority). The programme can also be completed via e-learning. Participants gain accreditation on completion from Roehampton University London (30 credits at HE3)[75]. The programme is widely praised by teachers as being highly effective and should be rolled out and promoted nationally. However this is only part of the story. Teachers also need to be trained in how to facilitate PSHE classes – a skill that can only be taught through classroom training and workshops, and should be subject to assessment to ensure that skills have become embedded.

However, other than accredited courses, the PSHE Association[76] reports that there are no current teacher qualifications that specifically cover the programmes of study for PSHE education. The only related course available is the Personal and Social Development Qualification (PSD) from ASDAN, which offers ways of supporting young people in becoming confident individuals who are physically, emotionally and socially healthy; being responsible citizens who make a positive contribution to society and embrace change; and

managing risk together with their own wellbeing. PSD Levels 1 & 2 is used by mainstream establishments for students aged 14 – 19, and also for adults[77].

7.2 Current Teacher Training – Is it Adequate?

The current provision of PHSE/Health Education training for teachers is widely considered to be inadequate. The NSPCC has warned that there is a vital need for more teacher training in PSHE for both primary and secondary schools. In 2009, NSPCC focus groups revealed that young people did not feel that health education was taken seriously by teachers and felt that staff had not been trained to teach the subject. In addition, youngsters revealed that the content of the lessons was not very interesting and often failed to engage them in the issues discussed[78].

Teachers responsible for delivering health education must be properly trained in both the content and delivery of the subject, and must be fully supported by the school. The NSPCC argues that form tutors should be exempted from teaching PSHE/ health education because the relationship of tutor and pupil changes when it becomes that of teacher and class, which then conflicts with the important role of the form tutor as confidant or mentor[79]. An NSPCC schools consultation in 2009[80] revealed that children specifically asked for a named individual to turn to for help when required (for example a mentor) as distinct from their usual teachers. It also noted that students feel that PSHE lessons currently do not work in schools and that more information should be communicated on the young person's level.

A 2007 Ofsted study observed that many otherwise good teachers do not have either the knowledge or access to appropriate teaching methods for many PSHE topics, including health education. In addition, there is often reluctance to teach some topics. Where a teacher has a lack of knowledge or enthusiasm, or displays embarrassment, this is quickly recognised by students who will then react negatively or become embarrassed themselves[81].

Teachers should also be equipped for a situation where a child or young person discloses abuse, confides about a health issue, or describes related problems at home. Teachers must be skilled to deal with disclosures and sensitive issues in an appropriate and timely manner[82].

7.3 Current PSHE Outcomes/ Qualifications Available to Students

The NSPCC argue that there should be no PSHE education attainment targets as "*we would be very concerned that defining and measuring what children and young people have attained would in effect require the creation of an objective concept of a 'normative person'*"[83]. However, they do believe that PSHE should be assessed on the effectiveness of teaching, recommending that children and young people's views and experiences should be part of the assessment process.

There are a number of external qualifications available to students that fall under the banner of health education. These are effective and useful qualifications that can support new career paths, such as Community Health Worker. The GCSE in health and social care (double award) provides opportunities for students to develop knowledge and understanding of the

health, social care and early years sectors in a vocational context and prepares them for progression to employment and/or further training in this sector. Students study health, social care and early years provision; promoting health and wellbeing, and understanding personal development and relationships[84].

The certificate of personal effectiveness (CoPE) is offered by ASDAN and is available at levels 1, 2 and 3 of the National Qualifications Framework for students in years 10, 11 and post-16. Students complete challenges based on key skills and activities, and receive credits once they have completed a set of challenges. These challenges include sport and leisure, health and fitness, and beliefs and ethics[85].

The Sex and Relationships Education Award offered by ASDAN provides 30 hours of activity aimed at increasing young people's awareness of, and confidence to deal with, relationships and sexual health. The award is aimed at 13-19 year olds, and provides a standalone certificate of achievement[86]. The St John Ambulance Young first aider course provides a basic introduction to first aid for 7- to 16-year-olds in schools and youth organisations. In addition, the Youth first aid course provides comprehensive training for 11- to 16-year-olds[87].

7.4 Current PSHE/ Health Education Teaching Resources

Current PSHE teaching techniques rely heavily on SEAL (a curriculum resource comprising of booklets, posters and pictures) aimed at improving the social and emotional aspects of learning. The pack is designed to overcome barriers such children’s difficulties in understanding and managing their feelings, working co-operatively in groups, helping young people to motivate themselves and demonstrating resilience when faced with setbacks.

The resource is designed to help develop young people as effective learners, and was developed through a pilot scheme in over 500 schools[88]. It comprises of a whole-school pack for the staffroom, a year-group pack with the same materials organised into a set of booklets for each year group from early Foundation Stage through to Year 6, and a resource file of photographs and posters.

However, SEAL focuses on how health education can be delivered, and not what is being delivered (i.e. the curriculum content). The resources are no longer available to schools in hard copy (resources are now only available on-line), and it does not cover elements of citizenship or healthy, safer lifestyles, such as sex education and drug education[89].

External organisations such as the Schools Food Trust and MEND have developed additional resources to help in the delivery of PSHE; however there is no standard set curriculum for the subject, and no set standard for the training of PSHE teachers.

7.5 Current Links between Health Education (in PSHE) and Physical Education (PE)

In a QCA Conference in 2009[90], delegates called for an explanation of the links between PSHE education, physical education, science and personal development. They argued that the different components of the subjects could be simplified and that this area of the curriculum could become more structured (for example SEAL should ideally be recognised as a component of Understanding Personal Development, Health and Wellbeing). "*Help is needed to pull PSHE and wellbeing together, clearer threads are required for leaders*."

At Swindon Academy[91], Sport and Health Education has been created as a single subject on the curriculum, comprising Physical Education and PSHE to create an innovative teaching model. Students are given the opportunity to participate in traditional sports and experience 'alternative sports' alongside lessons in personal health and wellbeing. All students are encouraged to participate in inter-house competitions and attend extracurricular clubs and activities to progress the subject.

Healthy Schools Cornwall[92] has also found innovative ways to link the subjects. St Issey VA CE School makes increased use of SEAL material in PSHE. They found that following a review of the PHSE syllabus and SEAL materials they were able to improve the existing teaching plans. The outcome was that the children's knowledge and involvement in this area of the curriculum greatly increased. St Neot Primary School created a display for PSHE and PE, showing the ten learning objectives, backed up by regular open assemblies to send the message and school ethos to the community. Finally, St John's Catholic Primary School developed after-school clubs supporting the Healthy School focus, contributing to the children's health education and sense of staying safe.

7.6 Case Studies – Health Education Resources

The lack of centralised resources for teaching PSHE or health education was highlighted in Sheffield, when the Sheffield Healthy Schools Programme, supported by Sheffield City Council and Sheffield Primary Care Trust (PCT), created their own toolkit in 2008 to assist local teaching in the subject. The toolkit was designed to support health education through to year six[VIII].

The toolkit provides local schools with health and well-being evidence for school improvements plans and the Ofsted self-evaluation form (SEF). A dedicated website -based tool was designed to help schools to maintain their National Healthy School Status (NHSS), and ensure that the benefits are being embedded through the whole school approach. Finally, the health and well-being improvement tool (HWIT) takes schools step-by-step through the planning and recording of their work as part of the Healthy Schools enhancement model.

[VIII] Year 6 covers the ages 10 – 11.

The benefit of the model is that it helps schools prioritise better outcomes around health and well-being for children and young people, with a particular focus on providing targeted support for those who are most at risk.

Giles Ratcliffe from the Sheffield Healthy Schools Programme said at the time: "*The toolkit was designed to enable schools to develop their own policy and practice for teaching these issues. The ideas in the toolkit are designed to be adapted according to the needs and values of each individual school, but through a citywide Sheffield Healthy Schools approach. It's important that teachers can talk about these issues with knowledge and confidence and that they can help children make sense of what they see by providing effective and early PSHE. The toolkit was made to act as a support and a resource to help and enable all teachers and schools in Sheffield achieve this.*"[93]

Healthy Schools Nottingham[94] recommends that outcomes that should be expected from well delivered PSHE content include an increase in the number of pupils involved in the development of the PSHE curriculum, an increase in the number of pupils and staff who describe the school council as effective, a reduction in the number of teenage pregnancies, a reduction in the number of drug-related exclusions, an increase in the number of staff who feel confident in delivering PSHE, and an increase in the number of pupils who know how to access specialist services.

7.7 Case Study – Health Education Delivery

At the Stoke Damerel Community College in Plymouth, the health education team replaced traditional classroom teaching with a new emphasis on active techniques (including drama and discussion), to explore issues and dilemmas. These techniques draw out students' feelings, emotions and opinions. Key concepts and issues are introduced using videos or case studies, followed up by drama techniques such as role-play to develop pupils' knowledge, skills and understanding.

Whilst specific outcomes were not measured, staff report that these techniques help to establish a safe environment in which difficult issues and situations, such as sex and relationships, can be discussed openly. The college now integrates health education lessons, through collaborations between related subjects (such as PE) and through out-of-school activities. An example is when the PSHE, English and PE departments collaborated on a project to raise boys' sporting aspirations and social and emotional skills by combining poetry and football training with the local team. In addition, pupils have the opportunity each year to take on leadership roles to raise their confidence and social skills[95].

7.8 Expert Opinion on Current Policy

Experts agree on one thing – the sheer number of Government initiatives that now affect the health and wellness component of the PSHE curriculum is staggering and becoming difficult, if not outright impossible, to manage[96].

As a direct result, schools without dedicated PSHE teaching staff may struggle. Mick Waters (the Director of Curriculum at the Qualifications and Curriculum Authority) commented: "*The subject is a challenge for the successful organisation and management of the school… Making drug and alcohol education, along with sex and relationship education, an integral part of a statutory programme of study for PSHE will be an important change for all schools*."[97]

Des Flood (lead regional subject advisor for PSHE in the West Midlands) believes that this is an area of the curriculum that has always been '*weak*', and therefore schools will face difficulties in recruiting the right staff to deliver these elements. "*Schools have to invest in a lot of training, especially for new teachers... Because it has not been compulsory up to now, teacher training institutions haven't bothered to offer it*."[98]

Studies show that many schools, particularly primaries, do not have dedicated responsibility posts for PSHE, relying on tutorial time and short courses carried out in citizenship slots. This approach has been criticised in inspectors' reports. In fact Ofsted and DCSF both advocate a dedicated team teaching a weekly lesson. "*Schools should endeavour to provide a full PSHE education programme for all pupils, co-ordinated and delivered by trained teachers in discrete curriculum time as opposed to 'drop-down, off- timetable days' or 'inadequate tutorial time*'," Dr John Lloyd, policy adviser to the PSHE Association[99].

Sarah Smart, Chief Executive of the PSHE association (set up by the Department for Children, Schools and Families in 2006) added: "*We expect so much of our teachers in this sensitive area of the curriculum, but provide little training for new teachers*." Des Flood agrees. He goes on to argue "*Schools need to think deeply and model good personal and social behaviours in the culture of the school, not just in PSHE … It has to be seen in a wider context. How do children reach out to others outside schools? What economic challenges do they face outside school*?"[100]

But should teachers even be responsible for delivering these subjects?

A 2007 Ofsted report, found that pupils react negatively, or are embarrassed if they notice a teacher's lack of knowledge or enthusiasm for the subject. Alice Hoyle, head of PSHE at Highlands School in Enfield, believes this is a hugely important area: "*SRE is not an option; it is an imperative for all our children and young people who are growing up in an ever-sexualised environment fuelled by cynical marketing and the media. We have a duty to help our children to develop positive relationships and learn how to be safe*.[101]"

Finally, there is the issue of assessment. As Des Flood commented: "*Assessment needs to look at the whole child, in the community as well as the school. The more a teacher knows about a child, the better. One size doesn't fit all*." Some schools use an individual assessment with their teacher supported by the end of term assessment booklets linked to the key concepts and process[102]. What is missing completely is the tracking of outcomes at a national level so that the different schemes (or at least the combination of initiatives) can be measured and continually improved.

7.9 Summary

This section has concentrated on how best to deliver Health Education to maximise its effect. The main points can be summarised as follows:

- There is currently no standard set curriculum for the subject, and no set standard for the training of PSHE teachers
- The current provision of PHSE/Health Education training for teachers is widely considered to be inadequate
- Ofsted and the DCSF both advise that there should be a weekly PSHE session in the curriculum and that a dedicated team should deliver it.
- The National Healthy School Standard provides a useful framework for the delivery of the PSHE curriculum and of whole school issues relating to health,
- Youth services can be used as a vehicle to deliver education within both formal and informal settings particularly to young people who are 'disaffected'.
- Teachers responsible for delivering health education must be properly trained in both the content and delivery of the subject, and must be fully supported by the school.
- Form tutors should ideally be exempted from teaching PSHE/ health education
- All teachers should be equipped for a situation where a child or young person discloses abuse, confides about a health issue, or describes related problems at home.
- PSHE should ideally be assessed on the effectiveness of teaching, and children and young people's views and experiences should be part of the assessment process.
- There are a number of external qualifications available to students that fall under the banner of health education. These are effective and useful qualifications that can support new career paths.
- Sport and Health Education can be merged into a single subject on the curriculum to create an innovative teaching model.
- Increased use of SEAL material in PSHE can improve existing teaching plans.
- Traditional classroom teaching can be replaced with a new emphasis on active techniques (including drama and discussion), to explore issues and dilemmas.

A well-designed Health Education programme can help schools prioritise better outcomes around health and well-being for children and young people, with a particular focus on providing targeted support for those who are most at risk. It is therefore, well worth putting effort into supporting the development of teacher training, teaching resources and curricular assessment for health education.

8.0 Literature Review – Best Practice

Health education offers a unique opportunity to positively impact the health of young people by reducing their susceptibility to poor health behaviours and poor health outcomes in later life[103]. As the cost burden placed on the NHS becomes increasingly prohibitive due to poor health choices, health education is likely to become the determining factor in the overall health of the nation and the sustainability and affordability of the NHS itself[104]. This is particularly the case against the backdrop of the UK's parlous public finances and eye-watering budget deficit.

8.1 Teacher Training for Health Education

Teachers are seen by many[105,106,107] as being the central delivery team necessary for a successful expansion of health education[108]. This view has already led to a number of healthy schools initiatives in the UK as a way of supporting health education prior to a formal PSHE curriculum being put in place[109,110]. However, a number of studies have identified a lack of training and preparatory time available to teachers in the health education arena[111,112,113,114,115,116]. It is critical for teachers to receive appropriate training in order to effectively deliver health education in such a way that it is effective[117]. Indeed, the need for continuing professional development in health education is now widely recognised in many countries[118,119,120].

Initial PSHE teacher training is viewed by some as a crucial stage in the provision of professional development[121,122]; however there is clear evidence that health education has become marginalised in initial teacher education courses in recent years[123,124]. This is firstly because less status and priority is given to health education within initial training institutions, and secondly because insufficient attention is devoted to the mentoring of trainee teachers to teach health education in schools[125]. Critics argue that "*further Government support is necessary to elevate the status of health education within initial teacher training, through the provision of a more explicit statutory foundation and more-institution-based time for training*"[126].

In England, there is currently a reference that trainee teachers need to "demonstrate and promote the positive values, attitudes and behaviour that they expect from pupils" and "be familiar with the National Curriculum Framework for personal, social and health education" as a requirement of the key standards of Professional Values and Practice (Standard 1) and Knowledge and Understanding (Standard 2)[127]. However, there is no requirement that trainees demonstrate a secure knowledge or understanding of health education in order to gain Qualified Teacher Status (QTS), nor is there an expectation that all trainees should be trained to teach PSHE[128].

This lack of training could be a contributory factor to the lack of monitoring and evaluation of classroom health education (particularly relating to drug education) on factors such as students' knowledge, skill development and attitude change[129,130]. Studies have shown that trainee teachers require greater classroom experience and guidance to acquire confidence in certain skills, including evaluation and helping students make informed choices[131].

Moreover, these skills can only be acquired and embedded through collaboration between the initial teacher training establishment and schools in the monitoring of the ability of new teachers to effectively deliver the PHSE curriculum. This would require that all trainee teachers be assessed on their ability to deliver and evaluate PSHE lessons as part of Qualified Teacher award. It is also recommended that new teachers receive specific life skills training as part of their continuing professional development[132]. These changes would raise the status and importance of health education within teacher training institutions[133].

In a study of group learning, the development of a partnership intervention to train student teachers to deliver health education was assessed. The results demonstrated a significant

improvement in staff confidence across all the key health education related skills. Trainee teachers were subsequently able to employ role-play strategies, were better able to measure the outcomes of sessions, and understood how strategies can be employed to empower pupils to make informed choices about their health[134]. It is recommended that all trainee teachers be assessed on their ability to deliver and evaluate health education and that trainee teachers receive specific life skills training as part of their initial and continuing professional development[135].

8.2 The Delivery of Preventative Health Education in Schools

Studies show that schools provide the optimum mechanism for delivering health education based on factors such as nutrition and increased physical activity, promoting lifelong healthy living[136]. Schall (1994)[137] has long argued that school health education is vital to improving the overall health of the nation, citing hundreds of studies demonstrating the positive effects of health education in (for example) reducing teenage pregnancy rates, smoking rates and adoption rates of one or more high-risk behaviours.

In order to be effective, studies show that school-based education must cover multiple disciplines, and be broad-based and continuous[138,139]. There is compelling evidence to show that where school health education programs for children have been a permanent part of the curriculum through reception to year 11[IX] health behaviours have improved significantly and become more embedded than with ad-hoc lessons delivered on different health topics[140], therefore it is recommended that health education programs should cover a wide spectrum of subjects and continue through all developmental stages.

A health education curriculum should deliver information, foster motivation, and provide the necessary skills to make effective health choices. Subjects such as sexual health and nutrition must also include messages that are inclusive of all children, cultures and religions, and must take into account the values of the parents or carers. The content must be updated constantly to improve and enhance the overall health knowledge, attitudes, and practices of children and young people[141].

Adequate teacher training and the provision of sufficient, planned classroom instruction time are also proven to be critical success factors as is the involvement of families and the need to secure wider community support[142,143]. Research studies have shown higher incidence of behaviour change when parents are involved, when class sizes are limited and community partnerships are used to supplement the resources of schools[144].

In addition to improved outcomes, the significant involvement of other community members is also recommended for increasing public awareness and preventing issues such as overweight and obesity in childhood. Recent obesity studies have recommended a socio-ecological approach to understanding and preventing excessive weight gain among children[145]. Studies show that youth behaviours are influenced by children's interrelationships with family, schools, and the wider community to which they are exposed;

[IX] Year 11 covers ages 15 - 16

therefore a health education curriculum that can integrate multiple influences on children is ideal[146].

It is not surprising therefore that most of the research studies investigated argue that classroom health education programmes need to involve or be accompanied by parent outreach efforts[147,148]. This view has delivered positive outcomes in the context of abstinence and sexual attitudes of adolescent females[149], in the context of children's fruit and vegetable consumption[150], in the context of childhood overweight and obesity[151], and from the parents' perspective[152] in the context of tobacco use prevention for youth.

The health of school-age children is also directly associated with their school achievement. However, with increasing prioritisation being given to core curriculum areas such as reading, writing, and mathematics, subject areas such as health education often receive inadequate time in the school curriculum (especially as PSHE is not currently a compulsory subject). This means that groups that are disadvantaged due to social factors, chronic illness or loss, or specific needs, are often ignored.

It is also important to recognise that a skills-based school health curriculum can and should be highly interactive, engaging[153], and inclusive. Research shows that enlightened policies to support school-based health education are likely to have far reaching social and economic impacts[154].

In conclusion, active participation in school-based health education can foster the knowledge, skills, motivation, and support young people need to make good health-choices, reducing the future risk of health and social problems. This report does not claim that health education is a panacea. However it is critical to ensure that all children are given the best, equal chance of achieving optimal health through experiencing high quality, consistent learning opportunities in safe and supportive environments. An active role of parents, teachers, support staff, and community groups is critical in achieving this[155]. In addition, the incorporation of culturally sensitive practices and learning approaches; adequate teacher training; consistent, proven teaching resources; and interactive departmental and community-based collaborations are all essential[156].

8.3 The Delivery of Health Management in Schools

Health management (i.e. the provision of services for those youngsters already facing a health related issue) is a service area that can be delivered very effectively by schools through the extended schools scheme. Such services have clear and positive outcomes, and are recognised as being essential to improving the health of young people[157].

A critical factor in delivery of such services is the creation of safe and confidential spaces in which young people can go for advice and support[158]. Another critical factor is the involvement of families and the local community in sharing and demonstrating health enhancing behaviours and values[159].

However, current barriers to young people accessing such services include locality and times of opening, staff attitudes and young people's anxieties about confidentiality and trust[160].

The facilitation of access to high quality health education support services should be a central component of Government strategies to address teenage pregnancy, promote mental health and respond to drug and alcohol-related concerns[161,162], indeed it is increasingly recognised that school-based health provision for young people has the potential to provide comprehensive, easily accessible and confidential services within a familiar environment[163].

Ideally, such services would create a link between health education as a preventative element of the core curriculum and the practical support needed to assist young people in taking responsibility for their own health and wellbeing once an issue has been identified[164].

Some (albeit limited) evaluation of school-based health facilities has been conducted, and the initial evidence demonstrate clear benefits of this form of provision for children and young people[165,166]. These initial studies have provided important information about the impact of the accessibility of services, how well they are used in practice, and the extent to which they provide value for money[167].

8.4 Case Study: The Delivery of Health Management in Schools

Community based delivery through the extended schools framework is fully integrated into the delivery of health education services at the City School in Sheffield. The school has a full-time nurse on site who assists with classroom delivery as well as providing confidential health appointments to students after school. Michelle Bridges has been a school nurse for nine years, finds that the biggest challenge is trying to get pupils to engage. "*Building relationships with young people is difficult - they have to see you as a safe person," she says. "You have to get students on-side so they can trust you*."

The school also uses an online NHS questionnaire to get information across to students in a less intrusive way. The Teen LifeCheck website[168] covers a range of issues affecting young people, including alcohol, sexual relationships, eating disorders, mental health and healthy lifestyles.

"*The beauty of the Teen LifeCheck is that it addresses a rainbow of issues. It's appropriate to use with any students, but it doesn't single them out as having a particular problem*," says Mrs Bridges. The website has a light-hearted editorial tone and appealing design, developed in conjunction with teenagers.

The site directs youngsters to answer questions as they would advise a friend with a particular problem, this teasing out attitudes and encouraging pupils to reflect. At the end of the survey, pupils are encouraged to set their own goals, and signposting to specialist services, either in schools or externally is available[169].

The evaluation of the pilot phase of Teen LifeCheck found that a total of 8,716 young people aged 11-14 years accessed the site between February and July 2007. Young people and other stakeholders were positive about the concept, with most users expressing the view that the site had the potential for impact on knowledge, attitudes and behaviour[170].

8.5 Case Study: The Delivery of PE in Schools – the Youth Sport Trust

School Sport Partnerships (SSPs) are groups of schools working together and with the community to develop PE and sport opportunities for all young people. A typical partnership consists of a partnership development manager, up to eight school sport co-coordinators, and up to 45 primary and special school link teachers. The partnership development manager is a full-time role that develops the partnerships and develops links with key partners in sport and the wider community.

Schools sport coordinators are based in secondary schools and concentrate on improving school sport opportunities including out of hours school learning, intra and inter-school competition and club links, across a family of schools. Link teachers are based in primary and special schools and aim to improve the quantity and quality of PE and sport in their own schools.

These partnerships are designed to improve the take-up of sport in schools, tackle health inequalities and issues in young people, and maximise the use of existing knowledge and resources to improve the health and wellbeing of children. An example of a successful programme run under this framework is the Westfield MEND programme in Sheffield.

Sainsbury's, Westfield Sports College, Westfield SSP and Westfield sports centre worked in partnership to deliver a nine-week after-school project to promote physical activity and healthy lifestyles to targeted local families. Eleven families self-referred themselves onto the programme, which consisted of nine weeks of two, 2-hour sessions per week, one hour focusing on healthy lifestyles and one hour of physical activity. The Sainsbury's food advisors and a volunteer (a participant from a previous course) ran the healthy lifestyle sessions which included activities such as creating a balanced meal, baking and a visit to the supermarket for a 'healthy shop'. These activities were presented to both the students and their parents.

Coaches from the community and the Westfield SSP ran the physical activities for the students while the parents continued with their healthy lifestyle sessions. Participants were able to assist in the planning of the activities and older participants were encouraged to lead aspects of the session (for example warm-up activities) using their own ideas and with assistance from the coaches. In addition, free family swim sessions were provided by the Sports Centre to encourage activity outside the programme.

At the end of the nine weeks, participants had lost around four inches from their waist measurement, students' confidence had improved, and reluctant participants had been motivated to participate in the physical activities. At the 'graduation', following the end of the nine weeks, the increase in confidence and self-esteem was demonstrated in the participants' short presentations about each other[171]. Following this initiative, students are enrolled in a 2-year 'graduates' programme involving signposting to local sports/activities,

access to an interactive health and wellbeing website, quarterly magazines (with activities and recipes), and ongoing measurements to ensure continued weight-loss.

8.6 Summary

This section has examined teacher training, the delivery of preventative health education, and the delivery of health management. The key points can be summarised as follows:

Teacher Training:

- Healthy schools initiatives in the UK have supported health education prior to a formal PSHE curriculum being put in place
- There is a lack of training and preparatory time available to teachers in the health education arena
- There is an outstanding need for continuing professional development in health education
- There is clear evidence that health education has become marginalised in initial teacher education courses in recent years
- There is no requirement that trainees demonstrate a secure knowledge or understanding of health education in order to gain Qualified Teacher Status (QTS
- There is a lack of monitoring and evaluation of classroom health education
- Trainee teachers require greater classroom experience and guidance to acquire confidence in certain skills, including evaluation and helping students make informed choices
- The development of a partnership intervention to train student teachers in role-play strategies would help empower pupils to make informed choices about their health

It is therefore recommended that all trainee teachers be assessed on their ability to deliver and evaluate health education and that trainee teachers receive specific life skills training as part of their initial and continuing professional development.

The Delivery of Preventative Health Education in Schools:

- Schools provide the optimum mechanism for delivering health education
- School health education is vital to improving the overall health of the nation
- Health education should cover multiple disciplines, and be broad-based and continuous
- Subjects must include messages that are inclusive of all children, cultures and religions, and must take into account the values of the parents or carers.
- Content should be updated constantly to align with the attitudes, and practices of children and young people
- Adequate teacher training and the provision of sufficient, planned classroom instruction time are critical success factors

- There is a higher incidence of behaviour change when parents are involved, when class sizes are limited and community partnerships are used to supplement the resources of schools
- Involvement of other community members can increase public awareness and preventing issues such as overweight and obesity in childhood.
- Classroom health education should be accompanied by parent outreach efforts
- The health of school-age children is directly associated with their school achievement.

The Delivery of Health Management in Schools

- Health management (i.e. the provision of services for those youngsters already facing a health related issue) can be delivered by schools through the extended schools scheme
- The creation of safe and confidential spaces and the involvement of families and the local community are critical success factors
- Current barriers include locality and times of opening, staff attitudes and young people's anxieties about confidentiality and trust.

9.0 Assessment

Over the past decade, concerns about the health and well-being of young people has risen up the national policy agenda due to some shocking statistics. England has the highest rates of teenage conceptions in Western Europe (United Nations Children's Fund (UNICEF), 2001), and in 2007, the number of pregnancies recorded in women under the age of 18 rose from 41,768 in 2006 to 42,918. In 2007, there were 8,196 pregnancies among girls under 16, compared with 7,826 in 2006 (three-quarters of the girls were aged 15 when they fell pregnant)[172]. In addition, there has been a significant rise in recent years in sexually transmitted infections such as Chlamydia (Department of Health, 2001).

The most recent National Child Measurement Programme (NCMP) results show that in Reception almost one in four children are either overweight or obese. By Year 6[X], this rises to nearly one in three[173]. Obesity is linked to many serious health risks in children and young people as well as adults. These include cardiovascular problems, Type-2 diabetes, respiratory illnesses, sleep apnoea and certain types of cancer. In addition, overweight or obese children are particularity susceptible to psychological disorders, such as depression and low self-esteem that can lead to lowered academic achievement. Furthermore, evidence shows that overweight and obesity in childhood often leads to being an obese or overweight adult[174].

Finally more than 50% of pupils aged between 11 and 15 years have experimented with alcohol, and in 2008, the average amount of alcohol consumed by pupils who had drunk in the last week was 14.6 units[175]. In 2008, 22% of pupils admitted to taking drugs, with 15% reporting drug use in the last year and 8% in the last month[176].

[X] Year 6 covers 10-11 year olds.

The Government responded by launching a plethora of short-term policies aimed at tackling each different element of the problem, from childhood overweight and obesity, to reducing drug and alcohol use, reducing teenage pregnancies or occurrences of sexually transmitted diseases. Each of these policies was implemented in isolation without the benefit of an overarching public health policy framework.

The White Paper Choosing Health (2004)[177] committed the Government to building health into all future legislation and all national policy. However, there is no current mechanism for establishing how health is being taken into account in policy making, or whether Health Impact Analysis (HIA) is being used. There is a consistent trend for policies to be launched without operating models, outcome targets or agreed measurement and reporting frameworks[178].

The HSC report on Health Inequalities agrees that the number of sporadic and expensive public health initiatives launched over the past ten years has been irresponsible, "*Such wanton large-scale experimentation is unethical, and needs to be superseded by a more rigorous culture of piloting, evaluating and using the results to inform policy*"[179].

10.0 Detailed Recommendations

Our recommendations are based on the five main objectives of this research each of which is dealt with in turn below.

10.1 Baseline Health Education Entitlement

- We support the content outlined in the PSHE curriculum (described in **Appendix B**).
- We recommend the urgent creation of a national set of resources and minimum standards, a national level of training for those delivering health education, and a way of measuring outcomes of health education.
- We also recommend the design of a continuous improvement process to ensure that lessons are learned. This should incorporate real time student feedback and ensure new developments in health are incorporated into the curriculum.

10.2 Teaching Health Education

10.2.1 Content

- Health education should be made interesting, engaging and relevant. We recommend the use of "young ambassadors" in a decentralised delivery model.
    - By deploying young people to teach young people, influence, engagement and understanding is increased.

- National voluntary organisations and social enterprises in the health sector should become suppliers of curriculum materials.

    - These organisations have invested decades in understanding the best way of educating individuals and communities
    - Their resources should be leveraged to provide varied content for a national health education curriculum.

- We recommend that curriculum content be designed in conjunction with complimentary after school/community initiatives and focused interventions (such as camps for the severely affected).
    - Such services could be procured nationally (to take advantage of scale, volume discount and national collection of outcome data), but customised and delivered locally through community teams and health workers.
    - This initiative would provide a number of volunteering and skills building opportunities, which would be ideal vehicles to be included in the proposed National Voluntary Service Scheme.
    - Private sector partnerships should be encouraged, such as leveraging the spare capacity in the health and fitness sector to deliver after school services.

10.2.2 Delivery

- Health Education teachers should undertake the National CPD Programme, should undertake classroom facilitation training, and should be subject to ongoing assessment

- We recommend that Form Tutors are not used to deliver Health Education, but rather are trained to become 'Health mentors'.

- A team of health ambassadors should be trained and gain practical experience to enable them to follow a career path as a Health Visitor or Health Trainer.

- A dedicated qualification should be designed (for which funding should be made available) for health ambassadors.

- Volunteer options for young people should be created to assist with specialist areas of the curriculum.

- Active participation from the local community is essential to give context to the messages.
    - This could be in the form of guest speakers or outings.
    - Evidence suggests that this approach embeds learning as the students associate the messages with the visitor experience[180].

10.2.3 Assessment

- Once a national set of health education resources has been designed, there will be a consistent and wide range of understanding, knowledge and skills within the subject, which can and should be assessed.
    - Both the Qualifications and Curriculum Authority (QCA) and Ofsted have reported that "assessment remains the weakest aspect of PSHE provision in schools"[181].
    - It is important to ensure that health improvements from this investment are measured, and continuous improvement occurs as a result.

- We recommend that a combination of qualitative and quantitative outcome surveys be implemented across pupils, parents and teaching staff
    - We recommend that the outcomes be captured, measured, benchmarked and reported on nationally.

- We also recommend that a vocational health education qualification be designed to give young people a career path into a 'Young Health Ambassador' role leading to a career as a health visitor or health trainer.

- We recommend that students should be encouraged to pursue a Health Education Qualification where relevant, such as the GCSE in Health and Social Care, and signposted to careers in the community wellbeing sector.

- We also recommend the CoPE Qualification (Certificate of Personal Effectiveness), which is an excellent basis for careers in Sport, Leisure, Health and Fitness.

10.2.4 Sustainability

- We recommend that the health education curriculum should be backed up with an inexpensive, national social media campaign, which would reinforce the curriculum and collect feedback data (which in turn would be used for continuous improvement).

- We recommend that the health and wellness component of PSHE is more closely integrated into the PE curriculum and community sport initiatives, including the PE and Sport Strategy for Young People (PESSYP) 5-hour offer.

- We would like to see a 'sustainable outcomes' model whereby children and families can access additional information and be signposted to appropriate services or activities in the local community.
    - This could be provided on a national level through a community website, which would combine centralised health messages and content with local

activities and services. A good example of this is MENDWorld https://www.mendworld.org.

10.2.5 Consistency

- A national strategy will be critical if we are to ensure consistent quality across the country.

- National partnerships with specialist providers will ensure consistency across the curricula.
  - Providers must prove they have programmes of study that can be delivered locally, using the local community, tailored to local needs.
  - Partners would deliver standardised curricula in partnership with the local community and stakeholders such as Health Trainers, School Nurses and Community Health Ambassadors.

10.3 Promoting Continuity and Coherence

- We recommend that health education in schools and communities is part of a wider public health strategy incorporating:
  - Legal and tax incentives to reinforce behaviours
  - Wider community services aimed at adults and workplace wellness
  - National behaviour change campaigns
  - Coordination between departments such as DCOMS, DH, DE and DBIS.

- We also recommend that health education policy is aligned to the outcomes, strategies and policies adopted by the NHS and local government.

10.4 A Scalable Approach

- A national curriculum pack for health education (and indeed PSHE) should be developed with a range of resources from which teachers can choose the most appropriate lesson plans for their school, culture and community.
  - This will save time and money in sourcing lesson content and will ensure consistency of standards and reliable, measurable outcomes.

- It is unlikely that there will be a cohort of trained PSHE teachers able to teach this subject on a national basis for some time. Therefore we recommend a blended delivery mechanism.

- We recommend that a small numbers of partners are selected nationally to work on and deliver elements of the standardised curricula in partnership with:
  - Teachers

  - The local community
  - Stakeholders such as Health Trainers, School Nurses and Community/ Young Health Ambassadors.
- This cohort of specialist trainers could be shared amongst a local group of schools, leveraging the 'hub and spoke' model that has worked so well in the delivery of sport and physical education.

- We also recommend that the health and wellness component of PSHE is more closely integrated into the PE curriculum and community sport initiatives, including the PE and Sport Strategy for Young People (PESSYP) 5-hour offer.

- We propose a national web-based system to capture the results of the health and wellness curriculum in order to build an evidence base for the purposes of retrospective assessment and real-time feedback.
  - We recommend that outcomes should be benchmarked and evaluated across a range of demographics.
  - Qualitative surveys should be carried out yearly on students as they are extremely effective in analysing behaviour change.
  - Results should be evaluated to inform continuous curriculum and policy improvement

10.5 Cost Benefit Analysis

In analysing health education, we have described a combination of prevention approaches to be delivered through standardised curriculum education and behaviour change interventions to be delivered in smaller groups as part of the extended schools framework.

The financial case for investing in health education is compelling, highlighting that cost-effectiveness can and will be achieved. A new DH report – *Enabling Effective Delivery of Health and Wellbeing*[182] forecasts that investing £3.1 million in measures to reduce rates of obesity, excessive alcohol intake and smoking could result in net savings of £6.7 million after five years. Speaking at the launch of the document, the former Health Secretary, Andy Burnham MP said: "*For every £1 spent on preventative healthcare, £1.20 is saved".*

In terms of health management, and taking the MEND Programme[XI] as an example, the National Economic Forum[XII] (NEF) have estimated that the improvements in child self esteem and confidence alone have generated £4.7m in social value across the 16,000 children that have already been through the programme (based on just the initial change).

They forecast that if £77 million were invested, a further 245,000 children over 3 yrs would be impacted, creating health and social outcomes worth £1.1 – £1.36 billion[183]. Furthermore this is likely to translate into longer term economic and income benefits for the individual and state. In practice, this means that children have more friends; participate in social activities;

[XI] MEND is a social enterprise running community based programmes for children and their families, based on behaviour change, nutrition and exercise.
[XII] http://www.nef-consulting.co.uk/

and/or have the confidence to do sport, and this is based on a successful Randomised Control Trial (2009, Sacher et al.), showing improvements on Harter scale at 6 months and 12 months

In addition, an interim York Health Economics[184] report found, the Incremental Cost-Effectiveness Ratio (ICER) of the MEND programme is £1,671.50 per Quality Adjusted Life Year (QALY) gained[185] (well below the widely accepted NICE threshold of £20,000 - £30,000 per QALY gained). [XIII]

10.6 Potential Delivery Partners

- The current number of PSHE education specialists is low and would not meet the demand of a national programme.

- Even in the long-term, there is likely to be a gap between the demand for health education and specialist people trained to deliver the subject[186].
  - The Macdonald Report states "Indeed, it may be that schools will *need to consider how best to share the expertise of a subject specialist across a cluster or federation of schools"*[187].

- We recommend that small numbers of partners be selected nationally to work on and deliver elements of the standardised curricula.

- Partnerships should be deployed in conjunction with teachers and frontline staff, the local community and stakeholders such as 'Young Health Ambassadors', health care professionals, local authority staff and commercial organisations.
  - This cohort of specialist trainers could be shared amongst a local group of schools, leveraging the 'hub and spoke' model that has worked so well in the delivery of sport and physical education.

- Finally, we must recognise the role of parents and carers in delivering and sustaining the benefits of health education.
  - The Macdonald report makes a specific recommendation that "*The DCSF should consider further ways of promoting pupil and parent engagement in the development and delivery of PSHE education, and how to disseminate good practice in this area"*[188].
  - We recommend that parents and carers are fully involved and present in the delivery of health management services, and are viewed as key partners in preventative health education.

Descriptions of some potential partner organisations are listed in **Appendix E**.

[XIII] QALY stands for Quality Adjusted Life Year(s). It is a measure of health outcome that seeks to quantify the net gain from a given healthcare intervention in terms of quality of life (morbidity) and survival (mortality). ICER stands for Incremental Cost-Effectiveness Ratio, and is the ratio between the incremental difference in costs and the incremental difference in outcomes (health benefits) of one healthcare intervention compared to another.

11.0 Summary of Recommendations

The three main political parties (and associated stakeholder groups) are all broadly in favour that the health and wellness component of the PSHE curriculum is essential and should become mandatory. There is wide agreement that targeted programmes (for those currently affected by the main health and wellness areas) should be provided (and potentially funded) as part of the Extended Schools initiative.

Therefore, we propose a **three-phase model**:

1) national campaigns targeted at specific groups to encourage behaviour change (aligned to a wider public health policy);

2) health education to form part of the core curriculum to ensure children, families and communities have sufficient information to make informed choices and take responsibility for their health and wellness; and,

3) targeted health management as part of Extended Schools, developed nationally and delivered locally, utilising community partnerships, families and specialist providers. [i]

As our detailed retrospective analysis shows, it is axiomatic that 13 years of Labour Government delivered little more than a plethora of ill-thought through and uncoordinated policies that were zestfully launched without a clear overall strategy linked to real outcomes and results, and without a proper cost-benefit analysis to foster a policy environment of value for money. We believe the above three-phase model would help to put outcomes and results at the heart of health education policy overcoming the previous problems of rosy rhetoric and gimmicky initiatives.

12.0 Concluding Thoughts

This report has highlighted the missed opportunity presided over by 13 years of Labour education policy. The education community needs a system that will deliver evidence-based evaluation data, and constant improvements in health education, in order to successfully tackle childhood obesity, teenage pregnancies and drug and alcohol abuse amongst the young.

It is the challenge, and indeed policy imperative, of the new Coalition Government to reshape the terms of reference of this critical policy debate, and push forward a real programme of reform to address the inadequacies of the prevailing approach to health education. This is seminal to the success of the Government's recently stated public health policy, and in turn the Prime Minister's personal pledge to prioritise and safeguard the NHS.

After over a decade of initiative inertia, important policy momentum has been lost and strategic focus has been badly skewed. This has left the argument in favour of health education in a more difficult place having badly stultified opportunities to revolutionise the way in which future generations approach daily and healthy living, and empirically demonstrate the economic desirability of a properly focused and coordinated policy.

Indeed, this is an absolute imperative should the UK be serious about tackling so many of the prevailing health problems and health inequalities currently afflicting many parts of wider society and, thinking one step further, should the UK be at all concerned about optimising economic efficiency by reducing productivity losses and absenteeism from ill-health through better healthy living and individual lifestyle choices – something that has to be ineluctably critical to the government's ongoing budget deficit reduction plan and any wider economic plan to put "UK PLC" on a firmer, sounder and more sustainable long-term footing.

If it is agreed that a country's greatest asset is its people, then having a healthy population and workforce is not just an optional asset, but rather a critical asset. Austere times equal austere measures, and there is no doubt deficit reduction is an absolute necessity. However, the UK cannot simply cut its way out of the current financial mess should a more prosperous and sustainable future be desired. The UK economy must also seek and sniff out growth opportunities and "get more for less" by optimising efficiencies and productivity. Both these imperatives necessarily demand an able-minded and healthy workforce and labour market.

Furthermore, although the last Labour Government has not measured the success of the health and wellness education initiatives over the past ten years, the statistics detailed in this report reveal that in the round no real or tangible improvements have been made to the key underlying targets of reducing childhood obesity, drug and alcohol use and teenage pregnancies. A more innovative and radical approach is therefore urgently needed.

However, when scratching a little beneath the policy surface it is not at all surprising that the multitude of Labour initiatives have largely failed. This is because of one simple reason: Labour's apparent obsession with placing the focus on 'what' should be done rather than concentrating on 'how' things can be done. Whilst local flexibility is critical, this report has demonstrated that the way health education is delivered is the determining factor in whether it is effective in producing a sustained improvement (rather than being ineffective or indeed making things worse). For future policy success to be achieved, the Department of Education must shift its thinking along these lines.

The new Government must now look to implement a coherent strategy based on evidence driven approaches, clear guidelines, localised resources, measured outcomes, and a partnership working model that spans families, the community and a cohort of delivery staff from a range of different backgrounds. This would go some way to help build the "big society" and put public health at the heart of education policy. After all, this is a matter concerning the future health of the UK and thus is as much an economic imperative as it could ever be a public health and social imperative. It is high time for the health to be put back in education. Without it, the UK will struggle to realise its full potential.

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12) **Mr. Brian Cattell** – Chairman of the Bow Group
13) **Dr. Tom Kelley** – Junior Doctor and Deputy Chairman of the Bow Group Health & Education Policy Committee.

For further information on the Bow Group Health & Education Policy Committee, please contact Stuart Carroll (Chairman) on health.policy@bowgroup.org.

Appendix A: Useful Websites

Alcohol Concern (http://www.alcoholconcern.org.uk/)

Association for Careers Education and Guidance (www.aceg.org.uk)

Association for Citizenship Teaching
(www.teachernet.gov.uk/content/www.teachingcitizenship.org.uk)

CBBC Newsround (http://news.bbc.co.uk/cbbcnews/hi/teachers/pshe_11_14/default.stm)

DCSF Sex and Relationship Education Guidance for Schools
(http://www.dfes.gov.uk/sreguidance/)

Drug Education Forum (www.drugeducationforum.com)

DrugScope (http://www.drugscope.org.uk/)

Every Child Matters (www.dcsf.gov.uk/everychildmatters/)

FRANK (http://www.talktofrank.com/)

Healthy Schools (www.healthyschools.gov.uk)

National Health Education Group (www.nheg.org.uk)

National Curriculum Online
(http://www.nc.uk.net/webdav/harmonise?Page/@id=6004&Subject/@id=4212)

National Children's Bureau (http://www.ncb.org.uk/)

NHS Sexual Health Awareness (http://www.condomessentialwear.co.uk/)

PSHE Association (www.pshe-association.org.uk)

PSHE and Citizenship Information Service (http://partner.ncb.org.uk/Page.asp?sve=781)

QCA Drug, alcohol and tobacco education units of work
(http://www.qca.org.uk/qca_7364.aspx)

QCA Sex and relationship education units of work (http://www.qca.org.uk/qca_7203.aspx)

Qualifications and Curriculum Development Agency (QCDA)
(www.qcda.gov.uk/7185.aspx)

QUIT (http://www.quit.org.uk/)

Sex Education Forum (SEF)
(http://partner.ncb.org.uk/Page.asp?originx_784wa_21042403840053g59p_200610203221g)

Teachernet (www.teachernet.gov.uk)

Teachernet - Government Drugs Guidance (http://www.dfes.gov.uk/drugsguidance)

The Children's Education Safety Foundation (http://www.csef.net/index.asp)

The Royal Society of Health (RSPH) - Human Papillomavirus Education Programme
(http://www.rsph.org.uk/en/policy-and-projects/projects/hpv-programme/)

Appendix B: PSHE Health Curriculum[189]

At Key Stage 1 (Ages 5-7)

Pupils should be taught:

- How to make simple choices that improve their health and wellbeing
- To maintain personal hygiene
- How some diseases spread and can be controlled
- About the process of growing from young to old and how people's needs change
- The names of the main parts of the body
- That all household products, including medicines, can be harmful if not used properly
- Rules for and ways of keeping safe, including basic road safety, and about people who can help them to stay safe.

Key Stage 2 (Ages 7-11)

Pupils should be taught:

- What makes a healthy lifestyle, including the benefits of exercise and healthy eating, what affects mental health, and how to make informed choices
- That bacteria and viruses can affect health and that following simple, safe routines can reduce their spread
- About how the body changes as they approach puberty
- Which commonly available substances and drugs are legal and illegal, their effects and risks
- To recognise the different risks in different situations and then decide how to behave responsibly, including sensible road use, and judging what kind of physical contact is acceptable or unacceptable
- That pressure to behave in an unacceptable or risky way can come from a variety of sources, including people they know, and how to ask for help and use basic techniques for resisting pressure to do wrong
- School rules about health and safety, basic emergency aid procedures and where to get help.

Key Stage 3 (Ages 11-14), Key Stage 4 (Ages 14-16)

Personal, social, health and economic education brings together personal, social and health education, work-related learning, careers, enterprise, and financial capability.

There are two new non-statutory programmes of study at key stages 3 and 4: personal wellbeing, and economic wellbeing and financial capability. The programmes of study are based on the Every Child Matters outcomes and build on the existing frameworks and guidelines in these areas.

Personal Wellbeing

This study area is the focus of PSHE for the purposes of this study, and provides a context for schools to fulfil their legal responsibilities to promote the wellbeing of pupils and provide a programme of sex and relationships education and drugs education. It also provides schools with an opportunity to focus on delivery of the skills identified in the framework for Social and Emotional Aspects of Learning (SEAL).

Healthy Lifestyles at Key Stage 3 and 4 covers:

1. Recognising that healthy lifestyles, and the wellbeing of self and others, depend on information and making responsible choices.

2. Understanding that physical, mental, sexual and emotional health affect our ability to lead fulfilling lives, and that there is help and support available when they are threatened.

3. Dealing with growth and change as normal parts of growing up.

Key Stage 3 (Ages 11-14) – Healthy Lifestyles

Content includes:

1. Physical and emotional change and puberty

2. Sexual activity, human reproduction, contraception, pregnancy, and sexually transmitted infections and HIV and how high-risk behaviours affect the health and wellbeing of individuals, families and communities

3. Facts and laws about drug, alcohol and tobacco use and misuse, and the personal and social consequences of misuse for themselves and others

4. How a balanced diet and making choices for being healthy contribute to personal wellbeing, and the importance of balance between work, leisure and exercise

Key Stage 4 (Ages 14-16) – Healthy Lifestyles

Content includes:

1. How the media portrays young people, body image and health issues

2. The characteristics of emotional and mental health, and the causes, symptoms and treatments of some mental and emotional health disorders

3. The benefits and risks of health and lifestyle choices, including choices relating to sexual activity and substance use and misuse, and the short and long-term

consequences for the health and mental and emotional wellbeing of individuals, families and communities

4. Where and how to obtain health information, how to recognise and follow health and safety procedures, ways of reducing risk and minimising harm in risky situations, how to find sources of emergency help and how to use basic and emergency first aid

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Appendix D: Glossary

PSHE:	The Personal, Social, Health, and Economic Education curriculum, which from 2011 will become a mandatory subject in primary and secondary schools.
ASDAN:	Approved awarding body offering programmes and qualifications to develop key skills and life skills.
Brook:	An organisation providing support and information regarding sexual health to 200,000 young people per year.
Change4Life:	National social marketing campaign launched in 2009 to promote healthy lifestyles.
Chief Medical Officer:	The Chief Medical Officer (CMO) is the UK Government's principal medical adviser and the professional head of all medical staff in England
CPD:	Continuing Professional Development.
DCMS:	The former Department of Culture, Media and Sport. Now superseded by DCOMS, the Department of Culture, Olympics, Media and Sport.
DCSF:	The now defunct Department of Children, Schools and Families, superseded by the Department of Education
DH:	The Department of Health
Every Child Matters:	A Government Green Paper published in 2003
Extended Schools:	The delivery mechanism for Every Child Matters (ECM)
FRANK:	A campaign launched in 2003 to reduce drug use by teenagers
HE3:	Level HE3 is the educational level that equates to an honours degree and aligns to practice in a specialist area.
Healthy Weight, Healthy Lives:	A cross government strategy launched in 2008 to support people to maintain a healthy weight.
HIA:	Health Impact Analysis
HSC:	Health Select Committee
ITT:	Initial Teacher Training
LA:	Local Authority
LEA:	Local Education Authority
NHEG:	The National Health Education Group

NHSP:	National Healthy Schools Programme
NHSS:	National Healthy Schools Standard
NICE:	The National Institute for Health and Clinical Excellence
NSPCC:	National Society for the Prevention of Cruelty to Children
Obese:	Obesity is a condition in which excess body fat has accumulated to the extent that it may have an adverse effect on health, leading to reduced life expectancy and/or increased health problems
Obesity Improvement Programme:	Additional funds linked to Healthy Weight, Healthy Lives to tackle obesity through partnership working
Ofsted:	Ofsted inspects and regulates to achieve excellence in the care of children and young people, and in education and skills for learners of all ages.
Overweight:	Overweight is generally defined as having more body fat than is optimally healthy
PESSCL:	The PE, School Sports and Club Links strategy for 5-16 year olds launched in 2003
PESSYP:	The PE and Sports Strategy for Young People aimed at improving the quality and quantity of sports undertaken by 5-19 year olds in England
Primary Care Trusts:	An NHS primary care trust (PCT) provides primary and community health services, and is involved in commissioning secondary care
PSD:	Personal and Social Development
QCDA:	The Qualifications and Curriculum Development Agency
SEAL:	The Social and Emotional Aspects of Learning. A curriculum resource for PSHE education comprising of booklets, posters and pictures
SRE:	Sex and relationship education
SSP:	School Sports Partnerships (SSP's) are families of secondary and primary schools that work together to enhance the quality of sporting opportunities, through the curriculum, Out of School Hours Learning, inter-school competitions and school to club links.
Strategic Health Authority:	Strategic health authorities were created by the government in 2002 to manage the local NHS on behalf of the Secretary of State
Sure Start Centres:	Sure Start is a programme to deliver children's services by bringing together early education, childcare, health and family support
TDA:	The Training and Development Agency for Schools

The 5 Hour Offer:	Plan to provide five hours of activity per week for 5-19 year olds
The Children and Families Bill:	Bill passed in April 2010 which included provision to make PSHE education statutory from September 2011The Childrens Act: The Children Act 2004 provides a legislative spine for a wider strategy to improve children's lives
The Childrens Plan:	The 10 year strategy for DCSF, launched in 2007
HCCf :	The Healthy Government Community Challenge Fund funded nine towns to make healthy lifestyles more accessible for local communities
The Macdonald Review:	Review published in 2008 into the implications of making PSHE education mandatory in schools
The Marmot Review:	An independent Review to establish the most effective strategies for reducing health inequalities from 2010 onwards
The Positive Futures Programme:	Aimed at vulnerable children between 10-19 years old to reduce alcohol misuse and anti-social behaviour
The PSHE Association:	The PSHE Association is the subject association for all professionals working in PSHE education.
QTS:	Qualified Teacher Status
Youth Alcohol Action Plan:	A joint strategy between DCSF, DH and the Home Office to reduce alcohol consumption amongst young people

Appendix E: Potential Delivery Partners

1 Drug and Alcohol Education Services (DAES)

Drug and Alcohol Education Services (DAES) is a community interest company that specialises in delivering training and awareness programmes. DAES design programmes to meet the specific needs of individuals, groups, communities or organisations who wish to develop their understanding of the problems associated with drug and alcohol use and how to respond. Each programme provides the opportunity to develop relevant skills and knowledge and improve effectiveness in dealing with a wide range of drug and alcohol issues[189].

DAES run Community Development Training Programmes that are designed to improve education and communication with a focus on the use, treatment and health implications of drugs and alcohol; and prevention, incorporating early detection, reducing risks and signposting to treatment services.

DAES also provide support to communities seeking to raise concerns and learn about government responses and current strategies supporting local communities. An example is the successful Parent and Carer Peer Education Programme, which covers the effects, risks, signs and how to raise concerns around drug and alcohol use. DAES also work in partnership with existing community groups providing informative workshops and participating in community events

In addition, DAES run Youth Drug Education Programmes that involve providing young people with opportunities to inform on the content and delivery of their workshops. The workshops themselves are an opportunity to access information from trained and informed adults on the subject of drug and alcohol use (where trained teams will listen without judging), and debate and discussing positive and negative consequences of drug and alcohol use. The programmes also cover current drug and alcohol law and provide an updated clear picture of current legislation.

2 Brook

Brook is the only national voluntary sector provider of free and confidential sexual health advice and services specifically for young people under the age of 25. The charity has 40 years' experience of providing professional advice through specially trained doctors, nurses, counsellors, and outreach and information workers to over 200,000 young people each year[189].

3 MEND

MEND (Mind, exercise, nutrition, do it!) is a social enterprise dedicated to reducing overweight and obesity levels through community-based programmes and campaigns. Using a range of funding sources and community partnerships MEND now delivers

programmes and campaigns covering a range of ages from toddlers to adults. By December 2009 over 32,000 participants had successfully completed a MEND programme, and over 230,000 children had benefitted from its campaigns.

MEND train local health, education and fitness professionals to implement and deliver programmes locally, and captures the outcomes and evidence nationally on a specially designed web-based system[189].

MEND also offers training courses for people who come into contact with overweight or obese children to support and signpost families to appropriate services. Finally they offer classroom-based resources aligned to the PSHE and Citizenship curricula to encourage healthy living for primary and secondary school children[189].