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Healthy Schools

Setting the Standard:

Research linked to the development of The National Healthy School Standard (NHSS)

Conducted by

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CONTENTS

INTRODUCTION 5
The school as catalyst for health improvement 5
Healthy schools work in Britain 6
The development of the NHSS 6
Format of the report 7

1. SUMMARY OF THE RESEARCH 8
Audit of local programmes 8
Evaluation of pilot site activities 10
Evaluation follow-up study: perceptions of impact 11

2. AUDIT OF LOCAL PROGRAMMES 13
Method 13
Evidence base 13
Evaluation methods 14
FINDINGS 16
Partnership working 16
Links with the community, outside bodies and professionals 17
Planning and needs assessment 17
Working with schools 18
Recruitment of schools 18
Supporting schools 19
Schools' initial audit 20
Target setting in schools 21
Monitoring and evaluation 23
Recognition and dissemination 23
Recognition of achievement 23
Dissemination of learning between schools 24
Sustainability 25
Evidence of success 26
Benefit to schools 28
Future initiatives 28
Conclusions and recommendations 28

3. EVALUATION OF PILOT SITE ACTIVITIES 30
Method 30
Site activities 33
Cornwall 34
Doncaster 35
Durham & Darlington 36
Hounslow 37
Manchester 38
Norfolk 39
Staffordshire & the City of Stoke-on-Trent 40
West Sussex 41
Lessons learned 42
Partnership working 42

Broad range of partners and stakeholders....42
Pupils....43
Commercial partnerships....44
The time to develop partnership working....45
The importance of personalities....45
Networking and support mechanisms....45
Working with schools....46
Recognising existing pressures....46
Flexibility of the programme....46
School ownership of the initiative....46
Targeting needs....47
Continuing professional development....47
Monitoring and evaluation....47
National and local context....48
A national lead....48
Support from the national level....48
Views of other agencies....49
Quality standards and progress indicators....49
Conclusions....51
Recommendations....52

4. EVALUATION FOLLOW-UP STUDY: PERCEPTIONS OF IMPACT....54
Method....54
Case studies....56
Chapel Break First School, Norfolk....56
Chase Terrace High School, Staffordshire....57
Forest Hill Secondary School, Lewisham....58
Newall Green High School, Manchester....59
Parkside Special School, Norwich, Norfolk....60
St.Clements Church Of England Primary School, Manchester....61
Tanfield Comprehensive School, Stanley, Co. Durham....62
Conclusions....63
REFERENCES....64
APPENDIX A: Audit Research Instruments....65
APPENDIX B: Pilot Site Evaluation Research Instruments....66
APPENDIX C: Follow-up Study Research Instruments....75
APPENDIX D: Audit Data Sources....77

INTRODUCTION

Emerging from a supportive policy context for healthy schools work,the National Healthy School Standard (NHSS) was launched in 1999 to help develop the quality of local programmes across the country. The Standard was built from the ground up,taking into consideration the wealth of existing field expertise and research on healthy schools work at the chalkface. Through consultation and analysis,the NHSS — a joint initiative between the Department for Education and Employment (DfEE) and Department of Health (DH) — aimed to identify the key elements of a national framework that would be realistic,sustainable,and inspiring for those involved,while ensuring a standard of quality and support.

This report describes three pieces of research which informed the development of the NHSS. Commissioned by the NHSS team,the Thomas Coram Research Unit at the Institute of Education,University of London elicited the views of hundreds of implementors,participants and beneficiaries of programmes at all levels and fed these back to help create a framework within which programmes,and thus pupils,can thrive.

The school as catalyst for health improvement

There has been increasing recognition of the role and importance of school-based health promotion in providing young people with the tools for developing healthy and positive lifestyles. Educationalists and teachers have reported that healthy children are more likely to fulfil their academic potential at school than those who experience poor health.Broader concern for the health and well-being of all school members may lead to higher self-esteem in pupils and teachers,less unproductive stress, fewer instances of bullying and truancy, lower exclusion levels and raised academic standards. A recent overview of research findings confirms that education may exert an independent effect on medium- to longer-term health outcomes,and can play an important,albeit circumscribed, role in reducing health inequalities (Whitty *et al.*,1998).

It has also been suggested that by working in partnership with local communities and with local and national programmes such as Health Action Zones and Education Action Zones, schools can also enhance the educational and social well-being of pupils' families and whole communities.By establishing productive working relationships with health authorities,local authorities,other statutory agencies and the voluntary sector, schools can contribute to wider community-based strategies for health,addressing local needs and accessing local resources. There is,therefore,a reciprocal and potentially synergistic relationship between educational and health goals.

The concept of the healthy school was first developed by the World Health Organisation in the early 1980s as a means of encouraging a holistic,whole school approach to personal and community health promotion within the school setting. In the course of the early 1990s,the original concept was translated into practice in many countries across Europe,including England. There has been a steady growth of healthy schools programmes, including local awards,in the UK over recent years.

Healthy schools work in Britain

A recent survey of health promoting school programmes involving 200 health promotion units across England, Wales, Scotland and Northern Ireland in 1995 found that of 133 respondents, 68 (51%) reported the existence of a 'healthy schools' programme (usually a partnership between education and health authorities) in their district, 28 (21%) were planning one and only 37 (28%) had no programmes and no plans to initiate one (Rogers *et al.*, 1998). In 1997, a similar survey conducted for the Health Education Authority found that in England alone, almost three quarters of 119 respondents covering 71 local education authorities reported that a 'health promoting schools' programme, or similar set of activities, was running in their area (BMRB International Ltd, 1997). While a number of healthy schools programmes have been established across England, they vary widely in approach. Overall, however, programmes have shared the broad aim of providing schools with the kinds of support that might help them become increasingly health promoting.

Since 1997, issues relating to the role of education in promoting health, and the role of improved health in enhancing educational achievement, have been widely debated. Schools have increasingly been recognised as a key setting in which to promote the health of young people and the wider community. The Government White Papers *Excellence in Schools* (Department for Education and Employment, 1997) and *Saving Lives: Our Healthier Nation* (Department of Health, 1999) emphasise the goal for all schools to become healthy schools, and highlight their potential as settings for the improvement of young people's health. It is also envisaged that such work will have a wider impact. By embracing a healthy school philosophy and by actively promoting health through the school environment, curriculum and ethos, as well as through links with parents and local communities, there may be positive impacts on literacy, numeracy and the preparation of young people for citizenship, as well as health inequalities and social exclusion. The government is supporting this process through additional work undertaken by the National Advisory Group for Personal, Social and Health Education and the Qualifications and Curriculum Authority on the national curriculum.

The development of the NHSS

In May 1998, the Department for Education and Employment (DfEE) and the Department of Health (DH) announced their intention to collaborate on the development of a National Healthy School Standard (NHSS) in England[1]. The NHSS is part of the broader Healthy Schools Programme which includes the *National Healthy Schools Network, Wired for Health, Cooking for Kids, Safer Travel to School* and *Healthy Teacher* initiatives (see the DH newsletter *Target*, 3/99).

The aim of the NHSS is to build on the concept of the healthy school in order to promote educational achievement, health and emotional well-being and thereby support pupils in improving the quality of their lives. The Standard encourages schools to become healthy schools by establishing and consolidating partnerships, through alliances between local education and health authorities, so as to improve the health and well-being of pupils, staff and the wider community. By setting a national quality standard, the initiative hopes to provide recognition for existing good work, to encourage and support fledgling programmes and to ensure a consistent, high quality standard among those earning accreditation.

[1] At the time the research was carried out, programmes were referred to as 'schemes'.

The NHSS was developed through systematic consultation and research, exploring the drivers and barriers to success in local healthy school programmes across the country. National consultation was undertaken with all local healthy schools programmes via regional representatives of the National Health Education Group. The NHSS team also met with local programme and network representatives through field visits,gathering documentation on programmes and their evaluation. At the same time,two major pieces of research were commissioned from the Thomas Coram Research Unit at the Institute of Education,University of London to gather the learning from local programmes and partnerships. Finally, a follow-up exercise interviewed respondents at pilot site schools about their perceptions of change following the work they had undertaken. This report describes the research on which the NHSS was based[2].

Format of the report

The report covers:

- An audit of published and unpublished evaluation reports from local programmes nationwide,to provide greater insight into local experience developing,implementing and evaluating healthy schools programmes.
- An evaluation of the work of eight pilot education and health partnerships across England (Cornwall,Doncaster, Durham and Darlington,Hounslow, Manchester, Norfolk,Staffordshire & the City of Stoke-on-Trent,West Sussex).[3] These were each funded by DH/DfEE with £150k for healthy schools programme activities between October 1998 and March 1999.
- A follow-up study on the perceived impact of healthy schools work.

The evaluation of pilot work and the audit aimed to extract lessons learned so as to feed into the development of the national standard, focusing on identifying areas of difference and commonality, drivers and barriers to partnership working.Models of good practice were also identified to inform the development of the national standard, for example,effective ways of working with schools.The follow-up study aimed to capture,through case studies,the excitement and potential of healthy schools work to the whole school community.

This report includes a summary of all three studies at Section One, followed by their individual reports. The research instruments used are provided as appendices,as is a list of the programmes in which audit data were collected.

[2]For a discussion of the overall development of the NHSS,including the consultation process,see Sinkler and Toft, 2000.

[3] Although the sites are referred to as 'pilot sites,' the sites were not piloting a national programme,but developing local partnerships from which to draw learning for a national standard.

1. SUMMARY OF THE RESEARCH

Audit of local programmes:

Between February and April 1999,the Thomas Coram Research Unit conducted an audit of all local healthy schools programmes in the country which could be reached,using telephone interviews and desk research with health and education programme personnel. Sixty-five programmes were reported to be operating in England,covering 101 local authorities and over 2500 schools.

The audit aimed to summarise learning from local programmes,identify drivers for success and highlight examples of effective practice in order to feed into the development of the National Healthy School Standard.The main findings are outlined below.

- All programmes included in the audit were managed by a multi-agency steering or advisory group,comprised of representatives from local health and education services and which included programme personnel.The more successful partnerships tended to have agreed structured systems of working and identified clear roles.
- The level of commitment and control over planning and funding varied between programmes.Generally speaking,a greater proportion of funding came from local health authorities via health promotion services,while education authorities tended to support the programme by providing staff rather than funds.
- The majority of programmes are open to all schools in the local authority. Publicity which identified the benefits to schools was a key way of recruiting schools,and communications to head teachers indicating programme support from senior education officers were particularly successful.
- The two main types of programmes found were 'needs-led'and 'prescriptive'. Needs-led programmes commonly involved baseline audits of current health education practice within schools. Prescriptive programmes,on the other hand,tended to work towards a set of criteria devised by programme management and allied personnel.
- Most programmes required that a member of staff be nominated as co-ordinator of healthy schools activity in the school,and that health education issues be addressed within the curriculum in line with National Curriculum Council Guidance 5 (National Curriculum Council, 1990). Monitoring was a key component of local programmes and was usually carried out by programme co-ordinators and their colleagues. Programme personnel felt that evaluation was key to maintaining credibility, and many respondents suggested that support was required for undertaking rigorous external evaluation.
- Dissemination and recognition of achievement were felt to be important to programmes,in maintaining momentum, generating publicity, recruiting schools and sharing learning. Programmes suggested inter-school learning exchange and the development of a case study book of best practice as useful ways of sharing learning.
- Programme activity also helped stimulate wider links with the community for schools. One programme found that programme schools made more use of external support than those who were not involved in programmes.

- Issues of sustainability were rarely included in written evaluations of programmes,but most programmes were aware of its importance for consideration.The question of how to keep schools involved once they have reached a standard or achieved an award was given some thought.

- There was a consensus that programme activities had benefited schools and pupils. The programmes provided a structure for schools health promotion work,increased motivation for the work and made possible pro-active policy and curriculum development with relation to health. In some cases,activities also provided the evidence to demonstrate the effectiveness of healthy school work.Suggestions were made for constructive links to wider initiatives such as Healthy Living Centres,Health Action Zones and others,to enhance the support base and increase access to available resources.

- Three issues were particular difficult for programmes to address effectively:healthy eating (due to the use of external catering contractors);achieving smoke-free environments;and staff welfare and health.

- Factors facilitating the effective implementation of healthy schools activities included:staff commitment,support from senior school management,an overarching concern for pupils' health,pupil awareness of the programme and its work,and having obtained outside financial support.

- Barriers to success included a lack of time or resources,poor school facilities,curriculum pressures, forthcoming OFSTED inspection,and an ineffective system of internal communication.

The audit concluded that a wealth of learning exists among local programme co-ordinators,and that further support to help strengthen programmes (particularly in the area of school support) would enhance and extend the benefits so far delivered to schools as part of the programme. A number of recommendations were made,and a summary of these follows:

- The work of a programme requires a high profile at a senior level in health and local education authorities,senior level commitment at school level,and adequate human and financial resources,in order to be successful.

- Dissemination of learning, experience and tools (e.g.,audit,budget-setting) between schools should be facilitated by local programmes. Such exchange between programmes where feasible would also prove beneficial.

- While having a named school co-ordinator is a key to success,the establishment of a larger working group with broad representation (e.g.,parents, governors,school nurses,etc.) will further facilitate effective implementation and sustainability.

- Programmes must recognise the important contribution of all school staff and provide cover for attendance at training and related meetings.

- Schools must be supported in linking with the wider community and in consulting with pupils and other stakeholders.

- A system of assessment,including quality control of assessors,is necessary to ensure programme rigour and consistency and the provision of an effective service to schools.

Evaluation of pilot site activities

Eight pilot education and health partnerships across England (Cornwall, Doncaster, Durham & Darlington, Hounslow, Manchester, Norfolk, Staffordshire & the City of Stoke-on-Trent, West Sussex) were selected by Directors of Public Health in each NHSE Regional Office to receive Department of Health/Department for Education and Employment funding of up to £150k each for healthy schools initiative activities.[4] Pilot sites developed spending plans for a 6-month period.

The Thomas Coram Research Unit at the Institute of Education, University of London, undertook an evaluation of this pilot work to:

1) identify the sites', progress towards their explicit goals and;
2) extract lessons learned to feed into the national standard.

Researchers collected existing secondary data on each programme and interviewed key informants, including those based in schools, at all pilot sites, twice – in October 1998 and February 1999. A summary of the findings is presented below.

- Pilot sites used their funding in a variety of ways, depending on the stage of their healthy schools programme work. Those which were just beginning focused on setting up partnerships, consulting and developing frameworks for joint working, while those further down the line, or with existing programmes, widened their recruitment to the programme or added activities or other components to the current programme. The main report includes a short case study on each pilot site, describing what they did over the six-month period.

- Partnerships tended to work best when they included a wide range of stakeholders who developed a common vision, while respecting each other's differing priorities. Seminars bringing together likely representatives paved the way to developing plans for joint working.

- Stakeholders such as school governors and parents, while keen, seemed somewhat removed from the content and process of healthy schools activity, and from the views of young people about health. Young people tended to view health in broad and holistic terms, and tended to focus more on the ethos and relational environment of their school than on concrete or topic based health interventions such as healthy eating.

- It was considered essential that funders and policy makers understand and allow for the long lead-in times effective partnerships require, and that expectations are set at the appropriate level along project timelines.

- Networking and support mechanisms between programmes were viewed as very beneficial, and a variety of ways of disseminating good practice and exchanging learning were suggested by pilot sites. The sites also found the evaluation experience a useful way to reflect on and improve current practice.

- Respondents voiced caution about adding to the ever increasing set of demands on schools. Motivating and interesting schools in a national standard should not add to the administrative burden already upon schools but offer added value. A national initiative should take into account existing activity and achievements, and be flexible to allow for local and school priorities and particular ways of working.

[4] Although the sites are referred to as 'pilot sites,' the sites were not piloting a national programme, but developing local partnerships from which to draw learning for a national standard.

- There was on-going debate about a number of unresolved issues. These included whether to target the neediest schools in recruitment to the programme or be open to all,whether or not an 'award' programme is the appropriate route,and how both of these factors might impact on sustainability.

- Senior level support for co-ordinators,at programme and school level,and for relevant staff, was seen as crucial to success. In particular, the opportunity for continuing professional development was to be encouraged.

- Monitoring and evaluation were seen as key to maintaining consistency and quality standards. Respondents also suggested a number of quality standards which could be included in a national framework, focusing on process indicators such as consultation, multi-agency working,the involvement of young people and evaluation. Advice on outcome indicators was not as clear-cut,as respondents felt the time scale of their own experience was too short to draw conclusions as to what to expect from a healthy school.

- Input was also gathered from other national agencies with an interest in healthy schools work: the National Foundation for Educational Research,OFSTED and the TTA,all of whom supported the development of a manageable national standard.[5]

A number of recommendations were made by the research team, including:

- Many programmes still do not involve young people systematically. Models of good practice for doing so should be disseminated and encouraged,as their views need to inform the shape and scope of the programme and are key to its success.

- Programmes and partnerships should represent the community they are aiming to serve,and areas of need should be targeted. Work should also be tailored to local needs and priorities and take into account existing achievements.

- Health promotion needs to be given appropriate status and incorporated into local and school plans. Adequate time scales and support should be given to programme work,including for professional development,and care should be taken to ensure that expectations engage with local priorities and offer added value rather than extra burden.

- The dissemination of good practice would be welcomed by those working in programmes, and a range of formal methods of networking would facilitate this.

Evaluation follow-up study: perceptions of impact: A summary

In mid-1999,the Thomas Coram Research Unit was commissioned to undertake a small follow-up study to the evaluation of pilot sites. The aim of the study was to identify improvements in a range of aspects of school life which were observed by participants in healthy schools work — governors,teachers,non-teaching staff, parents and pupils.

Case studies were compiled from interviews and secondary data at seven schools, selected in consultation with the NHSS Team and local programme teams:in Durham and Darlington, Manchester, Norfolk and Staffordshire & the City of Stoke-on-Trent (all pilot site schools),and

[5]Invited representatives of the Qualifications and Curriculum Authority (QCA) were unable to participate due to unforeseen circumstances.

Lambeth,Southwark and Lewisham,a non-pilot site school with a long history of healthy schools work. The schools chosen were:

- Chapel Break First School in Chapel Break,Norfolk;
- Chase Terrace High School in Staffordshire;
- Forest Hill Secondary School in the London Borough of Lewisham;
- Newall Green High School,Manchester;
- Parkside Special School in Norwich,Norfolk;
- St.Clements Church of England Primary School,Manchester;and,
- Tanfield Comprehensive School in Stanley, County Durham.

The four key areas of investigation included teaching and learning;organisation and management; relationships;and the environment and facilities. Data was collected from 158 individuals. Interviewees identified examples of pupil and school improvement that had occurred and explored their perceptions of the contribution healthy schools work had made.

The study identified a number of common aspects of school life which had improved alongside healthy schools work:

- Local programmes were flexible enough to allow for diversity between schools and their priorities.
- Interestingly, many interviewees viewed healthy schools work primarily as an initiative to improve aspects of school life not directly related to academic achievement,although all schools showed attainment improvements and some programmes did include academic targets.
- Many improvements related to social relationships — between pupils themselves,pupils and teachers,schools and parents,and schools and the community.
- Other improvements noted included increased attendance rates,lower levels of bullying, improved self-esteem,and improved school environment.
- Working towards becoming a healthy school helped schools to structure not only their health-related curricula,but other aspects of school management and planning.
- Most interviewees felt that clear, measurable change resulting from healthy schools work will take years to achieve,but that along the way some invaluable benefits are already emerging.

2. AUDIT OF LOCAL PROGRAMMES

The aims of this audit,conducted between February and April 1999, were to:

- bring together secondary sources of data on local programmes such as evaluations,progress and monitoring reports;
- summarise and review learning from local evaluations (where such exist) of healthy schools programmes;
- analyse data thematically to identify areas of commonality and difference,and facilitating and inhibiting factors towards the successful running of local programmes;
- identify possible examples of effective working practice;
- offer feedback to the NHSS national co-ordinator, NHSS team and the evaluation team,with the aim of providing input into the development of the NHSS itself.

Method

Initial contact was made with regional contacts at the NHSS Consultation Workshop held on 8-9th February 1999 in Windsor, at which the consultants of the National Health Education Group (NHEG) provided overviews of healthy schools programme activity within their region. Following this meeting,each was interviewed by telephone to obtain details of their local authority contacts and ascertain if they were aware of any gaps in their coverage of the region and any written evaluations, reviews or reports on local healthy schools work. A list of names and contact details of personnel involved in 'healthy schools programmes','schools health promotion'or 'health education'within their region was requested to facilitate follow up interviews.

Upon receipt of the contact lists, education and/or health personnel within each local authority were systematically interviewed by telephone using a standard *pro forma* to collect data on each programme (Appendix A). The name of the local programme, geographical coverage and the professional role of the interviewee were recorded.The address,telephone, fax and E-mail contact details were also obtained to allow a database of healthy schools programme personnel to be constituted.At the end of the interview, a copy of any written evaluations, reports or reviews of the programme was requested,along with details of any further local contacts that might be of relevance to the audit.

The information received from regional consultants was checked for geographical coverage to ensure that every local authority was included in the audit.Where areas within England had been missed by regional consultants,the local health promotion department and health education or PSHE adviser within the education department were contacted.As a result,efforts were made within the constraints of the time available to identify every known 'healthy schools programme'within England.

Evidence base

Data was collected from a variety of professionals working not only in local authorities,but also in health authorities,including health promotion units,and LEAs. In total,sixty five healthy schools programmes were reported currently to be operating in England (including the eight NHSS pilot sites) covering a total of 101 local authorities.The majority of programmes were

county or borough-wide, covering schools in one or more local authority. Beyond the existing programmes,eighteen local authorities are currently planning a programme, five local programmes are in abeyance and three pilot projects are currently running.All reported that they are awaiting the publication of findings from the pilot NHSS sites to guide their future planning.Only thirteen local authorities reported not having a healthy schools programme and having at present no plans to initiate one. Overall,it was reported by respondents contacted that the local programmes currently included some 2,500 schools.

A broad cross section of geographical regions within England are represented in the data (see Figure 1).

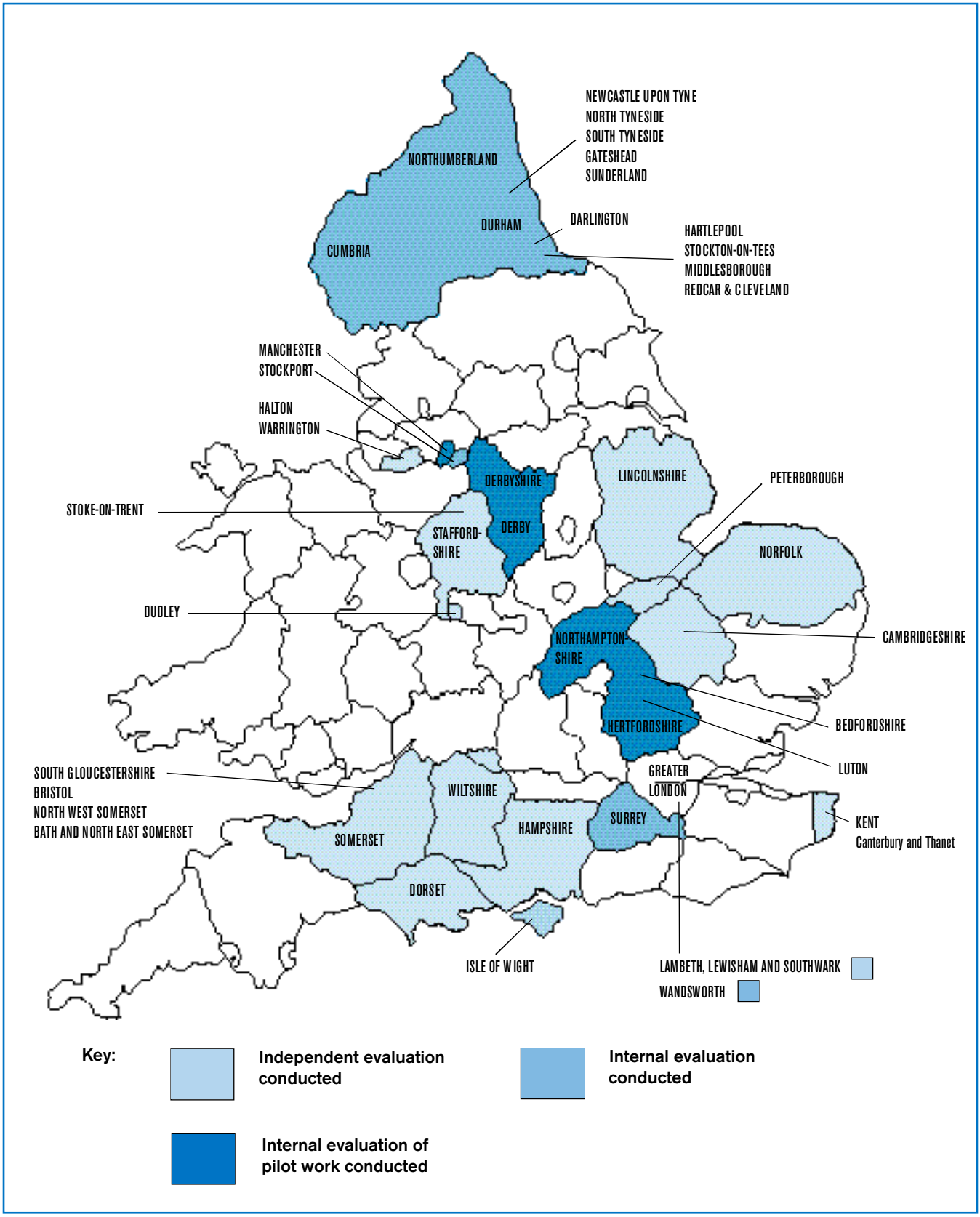
Evaluation methods

The majority of healthy schools programme evaluations included in this audit have aimed to identify the effectiveness of work in terms of its reported value to participating schools,and its success in meeting its aims within each school involved.The work carried out,as a formative evaluation, has primarily focused on processes rather than outcomes,in order to provide feedback on what has been accomplished so far and offer suggestions for future development. Evaluators have used a combination of quantitative and qualitative research methods including:

- questionnaires completed by school staff and pupils;
- semi-structured interviews with school co-ordinators,teaching and non-teaching staff, head teachers and members of the senior management team and school governors.Interestingly, only three programme evaluations have conducted interviews with key programme personnel to elicit their perceptions of the programme;
- observations carried out in schools,occasionally with the additional collection of video and photographic evidence;
- examination of policy documents and teaching plans;and
- case studies illustrating examples of working practice.

Several evaluations had also collected information from schools not involved in the local healthy schools programme in order to assess barriers and factors which inhibited participation.Two evaluations included an identification of programme outcomes,involving some quantitative analysis of effectiveness.Outcome measures included an investigation of changes in pupils'health related knowledge,attitudes and behaviour within the eighteen month to two year programme period.In both evaluations,this assessment was carried out by the repeat administration of the Health Related Behaviour Questionnaire (e.g.,Balding,1998).

Figure 1. Location of secondary sources of data gathered on healthy school schemes by local authority within England



FINDINGS

Partnership working

All of the programmes included in the audit were strategically managed by a multi-agency steering or advisory group comprised of representatives from local health and education services and which included programme personnel, most usually health promotion specialists, LEA advisory teachers, health authority (NHS Trust) and LEA senior management representatives. For example,the management structure of a Health Promoting Schools Award programme in the Midlands,described as 'truly healthy alliance as envisaged in the Health of the Nation White Paper' was managed by a joint steering group composed of a representative from each of the two health promotion units within the local authority and from the LEA with responsibility for the organisation and running of the programme.In addition,in some programmes head teachers,other teaching staff and school governors were actively involved in advisory groups.

For one programme in the East of England the education and health partnership was considered an essential element of the work undertaken.While schools appreciated the support that local health promotion services offered them,they felt that the programme would have had limited benefits and co-operation if the local education services had not been involved. Therefore a three tier multi-agency management structure for the programme was devised. Additional details of this arrangement are provided at the end of this section as an example of practice.

For many of the programmes,the alliance between health and education services has been a positive one. For example,in the case of a programme in the South-East,it was reported that the commitment and encouragement of the Director of Public Health and health authority staff and of the Chief Inspector and Head of Professional Development in the LEA,had been particularly motivating for project staff.The evaluation report stated that 'The "Healthy Alliance" between the borough LEA and the Health Authority has been one of the most positive and encouraging aspects of the ... project'.

In several other programmes,the alliance between health and education was reported as not having been so successful.A programme in the South West, for example, found that throughout the six years of the award,there had been extensive changes in the management and support structure available to sustain its aims and impact.Staffing levels on the programme had been reduced and for two years there had been no education authority representative on the steering group. Apart from the joint funding of the advisory teacher working on the programme, direct involvement of both the education and health authority, and liaison between them, was described in the evaluation report as being 'rather tenuous in the life-time of the Award programme'.

A key differentiating factor between these two programmes was the involvement of senior education and health management within the more successful alliance.This issue was also raised in a programme evaluation carried out in the North of England:

> 'It may be increasingly important that the alliance includes liaison at managerial level as work programmes,time allocation and priority initiatives – identified as barriers to successful working – are the concern of managers'.

These contrasting experiences of alliances between health and education services have also been highlighted in a recent national audit of health promotion and education staff (Scriven,

1995) where it was found that despite considerable enthusiasm from both parties,'policy shifts in education funding have introduced significant financial constraints to the formation of future effective healthy alliances'.

Links with the community, outside bodies and professionals

One of key aims of a healthy schools programme is to encourage involvement and co-operation with the wider community, outside bodies and local health promotion professionals.Many of the programmes reported being successful in doing this. For example,one programme found that programme schools made more use of outside agencies (using on average six or seven sources) compared with schools not in the programme,who on average utilised three or four.

Another programme in the South-East saw liaison with the wider community as an important factor influencing the success of the project in schools stating that 'A health promoting school cannot exist in a vacuum'.

Every effort was therefore made by the project manager to create good links with local groups within the community, service providers, retailers and manufacturers.Details of these efforts are provided at the end of this section as an example of practice.Other programmes reported also benefiting from liaison with the wider community and several evaluations recommend that these links be further developed and strengthened.

Planning and needs assessment

Despite the fact that all of the programmes reported being strategically managed by a multi-agency steering or advisory group,the level of commitment and control over planning and funding varied between them.Some programmes had been initiated and planned by the local health promotion unit which subsequently sought the support of the LEA,whereas in other areas the setting up of a local programme had been a joint venture from the outset.

As previously discussed,the majority of local evaluations focused on the operation of the programme at school level,and little information was provided on the development and planning (including assessment of local needs) associated with programmes.An exception was the pilot phase of an award programme in the home counties,where one of the project objectives had been to establish baseline data to inform health promoting work.

Telephone discussions with programme workers carried out as part of data collection indicated that the creation of local healthy schools programmes was seen by health and education professionals as a way of consolidating and formalising existing health promotion and education work in schools. Key personnel within health promotion and health education services had worked within their field for a number of years and were able to draw from their own professional experience.Many of the programmes were built on existing work and links with schools.

There was wide variation in the funding of local programmes,with some receiving joint funding from education and health authorities, while others lacked an identified budget and adequate funding was a constant source of concern. For example,a programme in the East of England reported having secured an overall total three year budget of over £100k. In comparison,a programme in the North-West reported receiving no formal funding at all.

Generally, a greater proportion of funding for programmes came from local health authorities via health promotion services.Education authorities were more likely to offer support in the form of 'time' by allowing the involvement of their advisory teachers and by providing cover to

enable school staff to attend training sessions and meetings, for example.

In Practice: Planning

Initial Review Exercise

In the South-West, an initial review exercise was conducted. A questionnaire designed by the Project Advisory Group was sent to each school locally. The questionnaire focused on particular aspects of a healthy school, e.g. the environment, ethos, staff and pupil well-being, the curriculum and community. The questionnaire consisted of a range of questions under each area and asked respondents to rate the extent to which each topic was addressed in their school on a scale of 1 to 4. A variety of school staff and other adults completed the questionnaire, including teaching and non-teaching staff, governors, parents and school nurses. Each school was asked to decide which groups they wished to give the questionnaires to for completion. In addition, the questionnaire was adapted for use by children and young people and administered within each school to a sample of year groups chosen by the school.

Each school was presented with a report on the findings from their questionnaire, consisting of tally charts of responses, analysis of these responses in terms of strengths and areas for development, and compilation of any additional comments made on the questionnaires. These reports were intended for use as the starting point for exploration of areas to be worked on the project.

Pupil needs assessment activity

In the South-East, a pupil needs assessment activity in which 1197 pupils were interviewed was conducted. The outcomes will inform policy and schemes of work, as well as contribute to the evaluation of the quality and effectiveness of teaching. An estimated 125 hours have been spent by the project team on this activity. As part of the same scheme, an audit of the physical environment has been conducted by a senior health promotion specialist in partnership with school staff, governors and pupils. The aim of the audit was to find out the extent to which the physical and social environment of the school contributes to the well being of staff and pupils, focusing on aesthetic, practical and safety issues in this context, taking account of equalities concerns.

The audit was found to be a tool which supports school staff and governors in reviewing and reinforcing priorities as well as focusing on sensitive issues such as staff smoking and alcohol policies.

Working with schools

Recruitment of schools

The majority of local healthy schools programmes are open to all schools within the local authority, and a number of publicity and promotion strategies are used by co-ordinators to inform schools about the programme and to encourage them to apply. Frequently used methods include sending letters,publicity material and newsletters to all head teachers;organising seminars,briefings and launches to publicise the programme;promotion through INSET training;and publicity via word of mouth.Several programmes have set an upper limit on the num-

ber of schools joining the programme each year to ensure that staff can provide adequate support. In such cases,schools are selected according to a pre-established set of criteria, for example, geographical location or particular need in terms of the socio-economic profile of the school.

One programme in the North-West, for example,collaborates closely with school health advisers (in this case school nurses) to select schools,and their role in recruitment is highly valued.LEAs took the lead in school recruitment in a Northern England programme.Here,the high level of initial publicity resulted in an increased awareness of the programme within schools.One of the recommendations from an evaluation of a South-East programme was that the local work would benefit from an increased profile within the local education authority and that in the future publicity letters sent to head teachers should also state that the programme has the full support of the Chief Education Inspector as this would add credibility and status.

Schools involved in the evaluation of a Midlands programme were reported as having made imaginative suggestions for recruiting new schools. Suggested methods included:

- teachers from schools which had gained an award visiting other schools to promote the programme to heads and staff;
- promoting the programme among 'cluster group pyramids'of schools;
- contacting new heads directly;
- finding ways to promote good practice;and
- giving more emphasis to the programme as a means of monitoring health education in preparation for OFSTED inspections.

Supporting schools

Evidence from the review of programme reports suggests that differing levels and type of support are offered to schools upon joining healthy schools programmes. Support services cited in reports included:

- training, consultancy and support from project staff to meet the individual needs of schools;
- training,loan of resources and equipment, information,advice and consultancy, resource development, action planning,curriculum development,policy development,networking, class-based support and good practice guidelines;
- intensive support from the programme co-ordinator, loan of resources and provision of training days;
- 'visitors'to support schools where LEA advisory teacher involvement was restricted due to a lack of funding. Visitors had a senior level background in education and a wide experience of PSHE;and
- support for planning,monitoring and evaluation.

As part of the evaluation process,all programmes reported that semi-structured interviews were conducted with school co-ordinators and other members of the school community. Interviewees were questioned about the amount and quality of support available to the school. The response from schools was on the whole favourable and the majority of evaluations reported a high degree of positive feedback.Schools were on the whole satisfied with the level of support they received from healthy schools programme workers,although one evaluation noted that support to schools in the programme was not always evenly distributed.

Three evaluations included interviews conducted with programme co-ordinators and health promotion and education services staff working on the programme to obtain their perspectives

on the support offered.Health and education consultants working on one programme reported that they had not always been sufficiently rigorous in the way that they worked with schools, and said they were not always sure of their role.It was recommended that more support be given to schools, particularly those in Health Action Zones.Staff working on another programme, for example, felt that they made themselves available to schools, but schools did not use this support as much as they would have liked. The need for more structured support with regular timetabled school visits was suggested.

Two other programme evaluations recommended the drawing up of a service level agreement between schools and the local health promotion service.

An evaluation carried out in the Midlands recommended that informal assistance between staff should be more formally encouraged through a system of pairing experienced school co-ordinators with new applicants in order to provide support and advice about the practical day-to- day running of the programme.Another programme evaluation similarly recommended using the experience of existing co-ordinators to facilitate local network meetings.

Schools in the Midlands programme reported that they would have welcomed the production of a guidance handbook for co-ordinators containing advice on the implementation of the award and what they might expect in terms of visits,support,monitoring,accreditation and assessment of progress in attaining the criteria.

Several examples were found in programme evaluations which highlighted the ongoing debate within the fields of school health promotion and health education regarding the use and benefits of financial incentives.Due to financial constraints, few programmes reported having been able to offer monetary incentives to schools to support their work.Among those who did,however, experience varied – some reported a positive impact on making progress,while others found the system hard to make equitable,and dropped it.

Schools' initial audit

In several programmes,conducting an audit of current health education and promotion practice within schools was an essential step towards identifying strengths and gaps in provision, and informed target setting and working for change in schools. Such an audit process was perceived as valuable in providing schools with baseline data and in enabling school staff to identify areas in which they wished to work. It also provided a useful evaluation tool for the future. However, it was found that not all schools were involved in such a process,and not all programmes were rigorous about carrying out school audits.

Each programme had developed its own audit tool for use in schools. For a programme in the West of England,an initial review exercise was considered crucial by members of the programme team and schools reported that it was a valuable process in providing confirming evidence and allowing school members to express their views.The Initial Review Exercise consisted of a questionnaire focusing on the four project areas,which was completed by a wide range of people involved in the programme,including pupils.

Another programme in the South-East considered the involvement of young people had been a key element in the audit process. Here,a large number of young people have been interviewed as part of a pupil needs assessment activity (see page 18).In addition,an audit of the physical environment carried out by a senior health promotion specialist has also been offered to schools.A programme in the East of England reported having consulted widely in the development of their Criteria Grid model,a grid matrix system in which schools plot their current position according to set themes and dimensions.

Target setting in schools

On the basis of the evaluation reports reviewed,two main approaches to the setting of health-related goals and targets for schools would appear to have been used - needs led and prescriptive.In programmes where an initial audit of current practice was carried out,health-related objectives and targets were determined by the school,corresponding to needs highlighted in this audit.Other programmes adopted a more prescriptive approach, with a set of criteria devised by programme personnel and management towards which schools have to work. Similarly, 65% of the programmes audited here reported having awards attached to them, although there was considerable variety in the way in which awards were made (for example, some programmes have an incremental system of bronze,silver and gold awards,while others have a single award).

Programmes that have adopted a needs led approach towards target setting ask schools to identify a number of health areas,normally three to five,to concentrate on,and schools receive support in setting specific targets within each area.The timescale set to achieve targets varies between programmes.On the whole,however, schools are expected to reach their targets or, in the case of programmes that have awards attached to them,achieve an award,in two to three years.

Regardless of the approach to target setting, the majority of programmes reported having two key criteria which all schools have to achieve:namely, identifying a member of school staff as a co-ordinator with responsibility for the programme;and addressing health education issues within the curriculum in line with the National Curriculum Council Guidance 5 (National Curriculum Council,1990). In addition to a named co-ordinator, several programmes have also advocated the formation of a school working party with wide representation,including pupils, teachers, governors,parents, youth workers,school health advisers (school nurses), welfare support staff and other members of the school community.

An interesting recommendation made by a number of schools participating in a Midlands programme was that targets could be related to curriculum Key Stages.Schools also reported that they would welcome the setting of more formal,structured criteria. Several programme evaluations advocated that there should be a periodic review of programme criteria to ensure that they are still relevant, responsive and applicable to new developments, for example curriculum changes and new governmental guidance, and changing local scenes.A summary of school health-related criteria reported in the programme evaluation reports are provided at the end of this audit report.

Several evaluations also stressed that it was essential that programmes take into account health education and promotion work already carried out in schools when setting targets. For example as stated in one evaluation report 'Schools do not come to the scheme as empty vessels'. When this is not recognised,problems can occur.Two head teachers interviewed as part of a programme evaluation in East Anglia, for example, felt unhappy that their schools'previous good work on health promotion had not been taken into account for the award,and felt that this needed to be addressed.

Finally, all of the evaluation reports reviewed highlighted how important it is for the programme and its targets to be reflected in the school development plan.Only in this way could the profile of the programme be maintained and adequate resources and monitoring be ensured.

In Practice: School health-related criteria

The table below lists some of the criteria used by local healthy schools schemes.

Criteria common to a number schemes

1. Curriculum: the school addresses health education within the planned curriculum. There is an agreed policy of Health Education based on the National Curriculum Council Curriculum Guidance 5.
2. The school has a named school co-ordinator or planning team.
3. The school is, or is working towards being, a smoke-free environment.
4. Nutrition: promotion of a healthy balanced diet.
5. Exercise and physical activity: promotion of appropriate healthy physical activity.
6. Environment: a safe, stimulating and tidy environment.
7. Equal opportunities: demonstrate equal opportunities in all areas of school life.
8. Wider community: commitment to working together with individuals, groups and organisations in the community to promote health.
9. Ethos: encourage mutual respect within the whole school community and promote the mental and emotional well being, in the broadest sense, of all those who work within it.
10. Substances: demonstrate a pro-active and re-active approach to smoking, alcohol and other substance misuse.
11. Sexual health: agreed written policy and programme for sex education.

Scheme specific criteria

1. The school should provide a private area for the school nurse to carry out her duties and enable her to offer a confidential service to students, parents and staff.
2. There should be support structures for young people and staff in need of them, either within the school or with other appropriate agencies, and there should be ease of access to information and advice.
3. The school should have been actively involved in a major health promotion initiative, e.g. a health week, No Smoking Day, a sponsored event in support of a health cause etc.
4. The school has set its own health promotion objectives for the next three years.
5. The scheme is reflected in the School Development Plan.

Monitoring and evaluation

Monitoring of progress was a key component of the local programmes reviewed and was usually carried out by programme co-ordinators and allied personnel. Several programmes had developed procedures for self evaluation within schools and appropriate protocols had been developed to facilitate this.Evidence used in school evaluations included a portfolio of evidence kept by the school co-ordinator, examination of written school policy documents and curriculum plans,and records of school visits made by programme personnel. Feedback from two programme evaluations indicated that help was needed by school co-ordinators in the development of the portfolio of evidence needed for accreditation.Guidance was particularly requested on the structure and format of portfolios.

The evaluators of a programme in the South of England felt that issues of assessment and validation of achievement were of crucial importance.Without adequate attention to standards and assessment procedures,some awards may be little more than promotional 'gimmicks'.The programme had therefore commissioned OFSTED inspectors to carry out an assessment when the school felt ready, using criteria developed to determine whether there has been sufficient progress to receive the award. Without this form of external assessment,which locates the award in the context of improving standards in education,the evaluation team considered the credibility of programmes to be questionable.

Two other programme evaluations suggested that monitoring of progress needs to be more rigorous and that there need to be arrangements for monitoring the work of the assessors themselves.There is also a need for the development of standard assessment tools to measure changes in school structure and process,and in pupil and staff knowledge,attitudes and behaviour. Quality control was felt to be necessary to ensure that the assessment of schools is consistent and based on a uniformly shared understanding of agreed indicators of performance.

A programme in the South-East identified the need to develop procedures for collecting and analysing the impact of programme activities in schools,with a particular focus on the influence of work on pupil learning outcomes and experiences.A programme in East Anglia also suggested that school evaluations should look at health and education outcomes (such as attendance rates,pupil achievement) rather than process targets alone (such as writing a policy, designing a programme of work).

Recognition and dissemination

Recognition of achievement

Many of the schools questioned during programme evaluations made it clear that,although winning the award itself was not the only reason they choose to enter the programme,they certainly valued it and celebrated its receipt.Methods of recognising achievement included award certificates, the use of a programme logo and the planting of trees in school grounds. Award events in schools or annual ceremonies held at the Town Hall or Civic Centre were commonplace.These events also proved useful in generating publicity and developing good public relations to promote the programme further.As one programme report put it:

> 'The public recognition from group presentations and displays in community centres in the presence of local dignitaries, governors,staff, press and a representative group of pupils has proved an important and valued event in the life of schools'.

Dissemination of learning between schools

The main methods used by programmes to disseminate learning between schools were regular network or cluster meetings of school co-ordinators,and the production of a programme newsletter promoting current achievements and offering up to date information and guidance to schools.

In the case of a programme in the South-East,dissemination of learning was considered a priority and the project team developed a project dissemination strategy with specific aims and approaches.This strategy included focused work with individual schools, which involved the use of documents such as policies and programmes of work.These were developed by schools already actively involved in the programme and were used as models to inform developmental work with new schools joining the programme.Other dissemination of learning strategies adopted included centrally organised courses,presentations,seminars,official visitors to project schools,production of a newsletter and contributing to the development of local and national initiatives.Additional details of these activities are provided at the end of this section as an example of practice.

A number of evaluations suggested that there should be an inter-school exchange of documentation and portfolios.The production of best practice case studies was also felt to be a valuable developmental resource.A directory of participating schools might also encourage networking between schools.This idea has been put into practice through the production of a publication by one programme in the Midlands. Details of this publication are provided at the end of this section as an example of practice.

In Practice: Dissemination

Dissemination of learning has been a priority for one scheme in the South-East. During 1997-1998, the aims of the dissemination strategy included:

- supporting development of targets and accompanying activity in new schools informed by learning from year 1 project schools;
- beginning to establish links between schools;
- raising the project profile as an example of best practice locally and nationally; and
- influencing national developments.

A range of approaches have been used:

- focused work with individual schools, for example support in developing policies and schemes of work;
- centrally organised courses;
- presentations, seminars and visitors to project schools; and
- publication of a scheme newsletter.

In the Midlands, one scheme has developed a manual to celebrate and disseminate information about local work. The manual can also be used to support schools and colleges reviewing their health promotion practices and to encourage them to become healthy educational settings.

The manual described a number of initiatives developed by schools and colleges that have participated in the scheme from 1993 to 1997. Lessons learned by school and colleges during the life of the scheme were also described.

The manual focuses on five key areas:

- Policy
- Curriculum
- Community
- Ethos and Environment
- Monitoring, Review and Evaluation

A series of examples of good practice were described in the manual, ranging from the simplest of ideas to very sophisticated initiatives.

Sustainability

Analysis of the local healthy schools programme reports revealed that issues of sustainability have rarely been included as part of programme evaluation.A number of programmes present awards to schools on a three year basis,and evaluations concluded that the issue of sustainability needs to be examined at the end of this period.Other evaluations simply reported that the issue of sustainability 'needs to be addressed'in the future.

Only two evaluations explicitly examined issues linked to the long-term future of the local programme.The issue of long-term sustainability appeared to be a particular problem with one programme.Here,seven schools had dropped out of the programme before achieving the local award,and the number of schools re-registering with the programme after the initial two year period was small.Continuity of work following completion of the award also seemed to be a problem,with little further development.Maintaining the level of activity which most schools put into achieving the award may be difficult,especially with the introduction of new government initiatives on literacy and numeracy among other issues.It is therefore important that the development of a healthy school is an integral part of school plans rather than the award being seen as an end in itself. Several suggestions were made to maintain continuity and to build on previous work:

- Extending the length of the award cycle.
- Ensuring continuity of development at re-registration so schools do not feel they are having to 'start again'.
- Ensuring that the award cycle coincides more closely with the planning and budgeting cycle for schools.
- Examining other ways of supporting ongoing development,such as encouraging clusters of schools,at different stages of development,to work together.

Another programme looked closely into the issue of sustainability but from a different perspective.The key issue was how to ensure the long term development of the programme by devising strategies to cope with the increasing strain on resources,both human and material.Several alternative strategies were considered of which two were felt to have most merit:

- A two tier award programme in which schools who achieve a first level award choose either to leave the programme at that point,or to progress to an advanced level.
- A three-year contractual programme in which the organising support team work with schools to help them attain the award.Here schools must make a commitment to a three-year programme of health promotion in their school development plan. At the end of the three years,schools leave the programme to make room for other schools to join.

It may appear from the lack of written evidence reported by programmes that the issue of sustainability has not yet been formally considered.However, anecdotal evidence from the telephone interviews conducted with programme workers suggests that while they may not have written about it,most programmes are conscious of their future development.Many programme workers reported awaiting the launch of and developments within the NHSS before addressing the issue of sustainability further.

Evidence of success

In all the programmes from which data was collected,there is a consensus of agreement that the overall effect in schools has been positive and schools have benefited in a number of ways:

> 'The Healthy School Award has provided a structure and focus for health education in secondary schools which has raised awareness of health issues,motivated and facilitated action for change in school management structures and processes, and influenced positively the health-related behaviour of pupils'.

> 'The award has achieved considerable success in promoting health education in the schools involved in this evaluation. Its evident credibility in schools is revealed in the way its principles have been embraced as fundamental to a school's ethos,and in the way in which its

successful completion is valued for the status afforded by securing the description of "Health Promoting School".'

'Changes may not be of great magnitude or always overtly apparent,but the process of developing health promotion has been accelerated under the stimulus of the scheme.'

One programme evaluation carried out in Southern England adapted a quasi-experimental study design which allowed a quantitative measure of programme effectiveness to be obtained. Changes in school health promotion were assessed by audit and re-examined after fifteen months involvement in the programme.Results showed that audit scores in all areas except physical activity and taking responsibility for health increased in schools,indicating positive award-related changes.Pupils'health-related knowledge,high at baseline, did remain unchanged, although there were some positive effects in the areas of smoking and drug use.

An indicator of success reported by another programme was that in both primary and secondary schools there were lower reported levels of conflict and bullying,and pupils felt more confident to report bullying.Some schools also reported an impact on exclusion rates and school refusers returning to school.

A consistent finding from all of the programmes was that schools experienced difficulties in achieving targets in three key health-related areas.These areas were healthy eating,achieving a smoke free environment and staff welfare and health.Schools often found developing links with the school catering service difficult,and experienced unwillingness to make changes to promote healthier choices as this was often in tension with the commercial interests of the contractor supplying the food.In addition,many schools rely on the extra financial income from tuck shops and vending machines.The promotion of a smoke free environment was reported to be more difficult in secondary than in primary schools on account of larger staff numbers with greater numbers of smokers. Finally, setting up projects on staff welfare and health were found to be difficult as staff traditionally discount their needs in favour of those of their pupils.

For some local authorities,although not all,the healthy schools programme provided a working example of the 'healthy alliance'between health and education.In addition,programmes offered schools the opportunity to access support from a number and variety of external agencies.

From the review of local healthy schools programmes,common facilitating factors towards successful completion of the award were identified by schools.These included:

- staff commitment;
- support from senior school management;
- an overarching concern for pupils'health;
- pupil awareness of the programme and its work;and
- having obtained financial support;

Inhibiting factors which created barriers towards success included:

- lack of time;
- lack of resources;
- poor school facilities,in particular within the school environment;
- curriculum pressures;
- forthcoming OFSTED inspections;and
- ineffective systems of internal communication.

Benefit to schools

From the perspective of schools,the reported benefits of joining a healthy schools programme included:

- generating ideas;
- providing a focus for health-related work;
- raising awareness of health promoting work;
- developing health issues across the curriculum;
- validating or reinforcing what the school was already doing;
- giving PSHE more status in school;
- providing a clearer idea of sources of support;and
- encouraging health promotion work that otherwise may not have taken place.

Future initiatives

Several of the programmes identified ways in which healthy schools programmes could be further developed.One programme, for example, suggested building relationships between healthy schools programmes and other local health-related projects such as healthy living centres.The setting up of healthy schools programmes within Health Action Zones was reported to be an excellent method of tacking inequalities in health issues. One programme in the North West also recommended that they could work alongside the 'Investors in People'initiative in schools, as it was in the pupils' interest that schools promoted the health and well-being of their staff. Finally, several of the more recent evaluations,from mid-1998 onwards,indicated that local authorities were looking forward to the launch of, and working with,the National Healthy School Standard.

Conclusions and recommendations

This audit of healthy schools programmes beyond the NHSS pilot sites demonstrates that,while some local programmes have been able to reach their targets and provide appropriate and adequate support for schools,additional support would strengthen local programmes. There is also a wealth of learning from which local programme co-ordinators may benefit. A number of local evaluations suggest that programmes require particular strengthening in the areas of supporting schools,ensuring continuity and long-term sustainability. On the basis of this audit,a number of recommendations might be made for the development of future healthy schools work:

1. Continued investment in programmes is required in monetary, human and resource form to ensure that programmes provide appropriate support to increasing numbers of schools.

2. Programmes must secure and maintain a high profile within the health authority and LEA.

3. Involving education services in the recruitment of schools will add credibility to the programme at school level.

4. The work of the programme should be identified in the school development plan.

5. Obtaining the formal commitment of senior school management is crucial to ensure support for the school co-ordinator. Senior managers are key sources of influence within schools and without their involvement and support there are unlikely to be many substantial and positive changes in school structures,budgets and resources provision.

6. The role of the school co-ordinator is key to the success of the programme.However the reliance on one person can cause problems – for example,the sheer volume of work involved,the risk of a lack of integration into the whole school and the disruption if the school co-ordinator is absent.The setting up of a school project team or working group – representing a broad range of stakeholders,such as parents, governors,school nurses,etc. – would help foster a whole school approach,boost profile and spread workload.In addition, there should be more training for school co-ordinators.

7. Provision of cover to facilitate school co-ordinators and other school staff to attend networking meetings and training sessions is particularly important.

8. Where school co-ordinators are new to this type of work,'pairing'with experienced co-ordinators is useful.

9. Sharing of policy documentation, portfolios of evidence and clearer guidance on programme paperwork and other opportunities for work between schools should be provided and supported by local programmes.

10. Programmes should recognise the important contribution of school support staff, most especially school nurses,who might work effectively alongside and support programme co-ordinators.

11. Programmes should develop standardised tools for use in schools,including those for auditing,target-setting and monitoring.

12. It is important to recognise prior learning and existing health promotion activities in schools.

13. Schools should be encouraged and supported in developing policies and curricula which address issues relating to mental health and self esteem, accident prevention, abuse,personal safety of staff and pupils, environmental issues and parenting skills.

14. Programmes need to work with schools to identify ways of increasing the involvement of the wider community and external agencies.

15. Similarly, schools must be supported in increasing consultation and involvement with pupils.

16. In order for programmes to become more effective and consistent,a system of standardised, independent and rigorous assessment of schools needs to be in place,including quality control assurance between school assessors and evaluators.

3. EVALUATION OF PILOT SITE ACTIVITIES

In 1998,eight sites across the country, representing each of the NHS Executive Regional Office areas, were nominated by NHS Executive Regional Directors of Public Health as exploratory pilot partnerships ('pilot sites') between education and health to develop local healthy schools programmes.[6] These were:

- Cornwall
- Doncaster
- Durham & Darlington
- Hounslow
- Manchester
- Norfolk
- Staffordshire & the City of Stoke-on-Trent
- West Sussex

These pilot sites were selected to represent both demographic diversity and different levels of existing partnership work.While some areas had long-established programmes to promote health in schools,others were just beginning to develop relevant partnerships. Each of the pilot sites was awarded the sum of £150k to disburse over the six month duration of the project. Some sites used the money to develop, extend and fine-tune existing work,whereas others used these new resources to establish the foundations for new activities. All of the sites worked in ways that sought to be responsive to the needs and priorities of their own locality. The learning from this exercise was then to be fed back into the development of the NHSS.

The Thomas Coram Research Unit was commissioned to undertake an external evaluation of the activities across all the sites involved in the pilot project.The principal aims of this evaluation were to:

- develop case studies describing the work undertaken at each pilot site,lessons learned and implications for partnership working;
- offer an overall assessment of progress towards each site's NHSS aims at two points in time, the first at the beginning of the research period (phase one),and the second towards the end (phase two);and
- provide feedback to partners at pilot sites,the national co-ordinator and the DH/DfEE management group throughout the duration of the research,so as to help shape the new NHSS to be launched in 1999.

Method

The evaluation had a two-phase research design.Each pilot site was visited by field researchers on two separate occasions in order to develop a clearer understanding of the processes involved in partnership working as well as outcomes.

[6] Although the sites are referred to as 'pilot sites,' the sites were not piloting a national programme,but developing local partnerships from which to draw learning for a national standard.

Table 1 summarises the methods of the evaluation. In Phase 1,individual interviews were undertaken with local steering group members and key stakeholders (all adults).In Phase 2, many Phase 1 interviewees were re-interviewed and the net cast wider to include other relevant local and national representatives,parents,pupils and governors. Parents,pupils and governors were interviewed separately in focus groups.Interviews lasted between 45 minutes and an hour and a half. The interview schedules can be found at Appendix B.

Table 1. NHSS Pilot Site Evaluation: Methodology

Phase	Fieldwork	Data collected
Phase I	October-December 1998	Review of secondary data at sites. Observation. In-depth, structured interviews with key partners and stakeholders, including school colleagues, where appropriate.
Phase II	February/March 1999	In-depth, structured interviews with key local partners and stakeholders and key individuals at national level. Focus group interviews with parents, school governors, young people.

Individual interviews were held with the following people (in some cases two interviews were held with the same individual,in which case that person is counted twice):

- 37 health promotion specialists
- 22 LEA representatives
- 15 health authority representatives
- 12 class teachers
- 11 head teachers
- 10 PSHE co-ordinators (school-based)
- 10 advisory teachers (PSHE)
- 9 school nurses
- 9 pupils
- 7 local authority representatives
- 6 school governors
- 5 youth and community workers
- 4 representatives from national agencies (OFSTED, the NFER,and the TTA)
- 3 independent evaluators
- 3 police officers
- 2 school catering advisors
- 2 advisory teachers (early years)
- 2 social services representatives
- 2 'Investors in Children'co-ordinators
- 2 dieticians
- 1 young gay and bisexual men's project officer

- 1 head of 6th form
- 1 general practitioner
- 1 representative of the Standing Conference on Religious Education (SACRE)
- 1 lunch time organiser
- Representatives of the Qualifications and Curriculum Authority were also invited to participate,but were unable to do so because of staff illness.

Focus group interviews were held with:

- 100 pupils
- 17 parents
- 5 governors

During phase two of the evaluation, researchers requested access to schools in order to interview young people and elicit their views about the nature of a healthy school. Evaluation design determined that a purposive sample of pupils was taken.Wherever possible,efforts were made to reflect the diversity of young people in the sample, by including girls and boys, young people from minority ethnic backgrounds and different socio-economic groups,as well as young people who achieve well academically and those who do not. In total,100 pupils were interviewed;the breakdown by site was as follows:

Cornwall	9 young people
Doncaster	6 young people
Durham & Darlington	6 young people
Hounslow	15 young people
Manchester	15 young people
Norfolk	20 young people
Staffordshire & Stoke-on-Trent	9 young people
West Sussex	20 young people

In the second phase of the evaluation,17 parents were also interviewed.They were accessed, where possible,through schools.The small number of parents interviewed reflects,to some degree,constraints in the timetabling for the evaluation study.Additionally, the parents who were interviewed were largely reflective of a minority of parents in terms of socio-economic background and demonstrated high levels of involvement in school activities. It is possible therefore that further research involving a wider and more diverse range of parents,might produce quite different findings.

Eleven school governors were interviewed.[7]

[7]It should be noted that some interviewees,including parents and key informants, were also school governors. Although they were not necessarily interviewed in this capacity, we might expect some of this perspective to be reflected in comments made when being interviewed in another role.

Site activities

At the outset,each of the eight sites was required to submit a spending plan for activities that they anticipated would take place over the course of the six-month project. It is possible to divide pilot sites broadly into sites where healthy schools work was in its infancy, and those where healthy schools initiatives pre-existed. In sites where healthy schools work was relatively new, the allocation of extra funds was primarily used to get partnerships started. In sites where work was already under way, funds were used to move work forward, fine tune and develop new components.

In interview, almost all respondents commented that they would have organised their activities somewhat differently had they had a longer timeframe to plan and implement their work. In particular, many commented that the planning process would have involved more consultation with the wider community and young people in particular. The identification of activities varied from site to site,and,on the whole, was based on:

- Results from local programme evaluation
- Building on existing programme plans
- Steering Group member expertise
- Evidence from local health surveys
- Interdisciplinary consultation
- National education and health priorities

Case study descriptions of work at each site were prepared.These offered a description of:

- Their prior local programme status
- How they identified site activities
- What work was undertaken
- Successes and challenges in carrying out plans

Cornwall

In Cornwall, healthy schools work was in its early stages at the start of the pilot project. There had been several previous attempts to establish a health promoting schools scheme in Cornwall which had not got off the ground. Prior to the involvement in NHSS, the local Health Education Action Group had, however, decided to collect information on activities and evaluations in schools and to develop a proposal for a healthy schools project. There was an awareness locally that there had been some duplication of work because of the absence of a defined partnership to take a lead on healthy schools. However, there was also clear evidence of successful local partnership working, including the Early Years Child Care and Development Partnership, which included representatives from health services, social services, the LEA, private nurseries and the voluntary sector, and which had received national recognition for the achievement of good results.

Local evidence from the health authorities' 'Health of the Population' document was used to feed into planning for the pilot project. Additionally, some of the work attempted to determine young people's health related needs so that this might influence future work, for example, the use of the Health-Related Behaviour Survey developed by Exeter University. Local schools were also supported in conducting their own audit in relation to their current practices in relation to health promotion and thus are better skilled to identify their own priorities.

Pilot funds were used primarily to launch a local scheme, develop a publicity strategy to promote the scheme, collect baseline data on pupils' health-related attitudes and behaviour, and prepare resource materials for schools. Planned local activities included a series of briefings for head teachers, PSHE co-ordinators and school governors (all of which took place) and the recruitment of twenty schools, which had yet to be achieved at the Pilot Project's end. A co-ordinator for the pilot project was identified to take a strategic lead on work in Cornwall. Locally, the goal was to develop a scheme which is not too prescriptive, but nonetheless provides certain rigorous criteria for schools to work towards.

Partners were particularly interested to benefit from the learning that is taking place nationally, especially in relation to sustaining the involvement of schools over a period of time. A particular challenge for partnership working in Cornwall is travelling distance. Interviewees noted that Cornwall has high levels of social deprivation. However, the geography of the country means that what happens in schools is very important to young people since some do not have easy access to health and other services. The relative geographical isolation of some rural communities means that schools constitute a key setting in which to promote the health of young people.

In Cornwall, where prior to the pilot project work was in its infancy, much groundwork was undertaken to establish a local healthy schools scheme. The original targets for recruitment of schools had not been met at the time of the second site visit, but there remained a high level of interest in the scheme and it was anticipated that greater numbers of schools would be recruited in the near future. Briefing meetings with schools were well attended, reflecting high levels of interest. The key partners in the scheme had, through participation in the pilot, been able to make links with a greater number of agencies than before their involvement. One respondent described the previous partnerships as being 'too cosy'. Additionally, the need for extending partnerships was recognised – for example, to include minority ethnic communities, including travellers, in healthy schools work.

Doncaster

In Doncaster, interviewees reported a long-established history of local partnership working. Doncaster has a number of unique factors which have facilitated partnership over the years, including a 'pyramid' structure whereby local primary schools, secondary schools, special needs provision and youth centres are grouped together. Several interviewees described Doncaster as a group of relatively self-contained, separate 'villages'. Additionally, the geographical coincidence of the local education authorities and health authority, and good personal relationships, facilitated partnership working.

Work on healthy schools was at an early stage, although local partnerships were already established between health and education on other activities, which provided a good base for developing the pilot work. Involvement as a pilot site led to the development of a plan for local activities, including the establishment of a forum group to steer work and the appointment of a facilitator and a network of local healthy schools co-ordinators. It was hoped that the local 'pyramids' would provide a focal point for the healthy schools work.

At the time of the first site visit to Doncaster, three key meetings had taken place locally – a preliminary meeting of core individuals, a meeting to disseminate information about intended pilot plans, and one forum group meeting. The forum group includes representation from across local agencies. Subsequently, funds were released for each local pyramid to employ a co-ordinator for one and a half days per week to support work for healthy schools.

An inclusive approach of inviting all schools to work within the healthy schools framework was adopted during the course of the pilot work. To facilitate this, most of the funding was directed to schools and to providing non-contact time for co-ordinators to work with clusters of schools. The key issues schools might work on – including those related to safety, emotional health and well-being, physical activity and sex and relationships education – were identified as being of particular local relevance.

Locally, there was an acknowledgement that schools had already undertaken much valuable health promoting work. For example, some local schools are already running Breakfast Clubs and undertaking drugs education. Most of the activities outlined in the Doncaster spending plan were about setting up a scheme that would have a high level of flexibility so that local pyramids and schools within them will be able to determine how they undertake health promoting work with young people.

Although there was no formal structure for involving local young people in decision-making, partners were aware that the success of the pilot work would depend upon finding a way of securing young people's participation. To this end, local partners were looking at ways of establishing young people's forums.

Durham & Darlington

In Durham & Darlington, an established healthy schools award had already been running for eight years. On being recruited as a pilot site, a steering group was established to produce their spending plan. The group was drawn together on the basis of recognised local expertise and broad representation of various agencies concerned with the health of young people. While the health authority covers both areas, there are two LEAs. Early on, the group decided that Durham & Darlington would divide funds on a per capita basis so that each might be able to closely reflect local needs in the activities undertaken as part of the pilot work.

In order to develop activities, steering group members tapped into on-going issues raised by local PSHE co-ordinators. Some of those involved in the group had also worked on the existing local healthy schools award and were able to feed in ideas based on this experience. A diverse range of activities was planned using a combination of approaches, including demonstration projects, topic work, training and resource development. Activities included training for local health education co-ordinators and teachers, the establishment of Breakfast Clubs, the development of a Theatre in Education project, and a Safer Routes to School scheme.

An example of local partnership working which incorporates a broad and holistic approach is 'Do the Locomotion', a Darlington-based demonstration project led by the Department of Environmental and Consumer Protection. The project is designed to encourage more parents and children to walk to school and is informed by a range of national and local priorities outlined in Local Agenda 21, the Air Quality Review, *Our Healthier Nation* and local Health Improvement Programmes. The initiative aims to promote improved fitness among children and parents, reduce accidents, improve air quality, and provide increased social opportunities for children and adults. During the second phase of the evaluation, those involved in this project were able to report success in recruiting parents in two local schools to take a lead in planning the launch of this project, which parents re-named 'The Walking Train'. Children also contributed to needs assessment and planning and had curriculum inputs in the classroom on related issues. The 'trains' aimed to be up and running after Easter.

The involvement of young people in the promotion of their own health was encouraged through the development of an alternative prospectus by pupils for their peers. This focused on the cross-transitional phase, and it was hoped that it would reduce bullying and the fear some young people experience on going to secondary school. A team of primary and secondary schools teachers, lecturers in journalism from local colleges, an artist-in-residence, an educational welfare officer, other professionals and young people themselves worked on the prospectus for the new in-take in September 1999. Another interesting approach was the involvement of those working on the local 'Investors in Children' initiative. Through this initiative, local agencies sign up to ensure that young people are consulted in the planning and development of services for them. This may increase the participation of young people locally.

Most of the training and projects planned during the early phase of pilot work either took place or were well underway by the end of the time period. Additionally, respondents reported that a number of changes in 'ethos' had taken place among partners steering the work. Most importantly, the importance of adequate involvement and participation of stakeholders was recognised, and one respondent commented that the involvement of young people locally would no longer be ' ... tokenist, tick-box activity, but rather meaningful participation' Another, who had worked closely with parents, commented that although he had found this process time and resource consuming, it had been worthwhile, since the whole school now felt a sense of ownership over project work.

Hounslow

Although Hounslow did not have a pre-existing healthy schools scheme, there is a local history of working with schools to develop health promoting work. Hounslow worked towards developing a local healthy schools programme in a somewhat different way from other sites, in that their work was focused on a number of key topics identified as particularly relevant locally, building on and extending already successful local health promotion initiatives in schools. Interviewees reported that national priorities identified in documents like *Our Healthier Nation* had helped to shape local planning, as had an awareness of pertinent local health issues, such as the high rate of unplanned teenage conceptions. The three areas of work chosen were:

(i) Continuing development of the Hounslow Drug Education Initiative in secondary schools;

(ii) Developing a whole school approach to sex and relationships education for pupils, staff, parents and governors; and

(iii) Developing a whole school approach to healthy eating.

Each of these three areas related directly to locally perceived needs, and were thus thought to be more motivating for schools. Hounslow has high reported rates of unplanned pregnancy among young people, for example, and recent analysis of opinions about schools meals revealed that respondents viewed the level of nutrition as unsatisfactory. Also, given the timeframe for the pilot site activities, local partners felt it would be most appropriate to build on and extend work that had already enjoyed a degree of success. Local work on sex and drugs education pre-dates Hounslow's involvement in the pilot.

Additionally, it was hoped that by offering schools support in the very areas in which they have regularly expressed the need for help and support, the foundations would be laid for the development of a sustainable healthy schools scheme. In this way it was hoped that schools will be keen to get involved in the future. While considered to be topical issues nationally, there was some awareness that the issues chosen so far 'are only a small part of a wider whole'.

Rather than having one steering group guiding the pilot work, three groups were established to steer work in the separate topic areas. However, a key individual based within the local authority was identified to guide strategy development and planning across the three groups. The targets set out in the spending plan for Hounslow were achieved. Additionally, interviewees locally reported that they had an opportunity to learn through working with other pilot sites across the country. Some respondents also reported that as a result of their involvement in the pilot work the local approach has shifted to a more strategic and broader one, as well as being schools-focused.

Manchester

The local award is a joint health promotion and education initiative which was initially launched in 1994. A steering group, with representation from education and health, was set up and met on a number of occasions. However, the purpose of that group was initially unclear and created what came to be perceived as another layer of bureaucracy. At the time, the management of the scheme was based at Manchester Health Promotion Unit. Regular meetings were set up with the health promotion support workers and the LEA Adviser with responsibility for health. In participating schools, teams included young people, parents, school nurses, teaching and non-teaching staff and governors. They met regularly with their support health promotion worker, undertook school self-assessment, and measured achievements against pre-determined tick-box criteria. The scheme was self-evaluating. This model was evaluated in 1996 and a three year development plan was created in Spring 1997.

Changes were already taking place when Manchester was invited to be a pilot site, which meant that developments could be extended. One of these developments involved the LEA establishing a dedicated health adviser post to work on the scheme. A sophisticated partnership has now developed between education and health.

Reviewing the scheme meant the development of tools for a baseline survey in schools and the development of school based targets which have been identified in the survey as areas to be worked upon in terms of ethos, environment and curriculum. Additionally, assessors from the Inspection and Advisory Service were trained to consider the evidence and determine health improvement targets with schools. The self-assessment process has been reviewed, an independent evaluator appointed, increasing involvement of school nurses encouraged, and mechanisms to increase the participation of young people in the scheme developed.

Proposed work included the development of a new healthy schools award pack, including a good practice guide with support materials on a wide range of topics; the recruitment of twenty pilot schools; increasing the participation of young people through, for example, high school debates; and developing the role of school nurses. Experience of running a local award scheme influenced the development of activities undertaken as part of the pilot project. While interviewees commented that the pilot project in Manchester was built largely on pre-pilot work, they also noted that recent government thinking – for example, the health targets set out in *Our Healthier Nation* – also informed the design of the pilot work.

Manchester's scheme, the Healthy School Award (HSA), has been a public relations success. High profile award ceremonies, which have attracted commercial sponsorship and celebrity appearances, are popular with school management and staff, young people and the press. HSA co-ordinators have ensured that the scheme remains high on the agenda of local health and education officials. The success of the HSA to date is reflected in the appointment of one of the HSA co-ordinators – a health promotion specialist – to work within the LEA, largely on the HSA, for the next three years. So, although the HSA was originally led by the local Health Promotion Unit, a sophisticated partnership has now developed between education and health services.

Norfolk

The Healthy Norfolk Schools Award (HNSA) has been operating since 1992. Interviewees reported that the award was developed in response to the progressive marginalisation of health education within the National Curriculum: 'Head teachers and co-ordinators in the great majority of HNSA schools felt that the award had provided a valuable framework for meeting their schools' health promotion priorities' (Independent Evaluation of HNSA, September 1998, 1.3). The six month period of the pilot work was used for review and development of the existing HNSA.

Approximately 80 schools had received the award to date, and the current intake was 26. The majority of schools (about 80 per cent) involved in HNSA were primary or middle schools. Examples of work undertaken in schools as part of the HNSA included the introduction of a 'buddy' system, which has reportedly helped reduce bullying, the development of a handbook on puberty and adolescence written by Year 7 pupils for younger children, and the siting of recycling facilities in a rural school. The period leading up to the award is structured to run for four terms. There are nine criteria, two of which, concerning whole school involvement and development of policy, are compulsory. After completing a self-audit, for which a tool has been developed, each school selects another two other criteria which it will seek to fulfil. School staff then set targets in relation to these criteria.

The HNSA is supported by a project team drawn from the local education and health sectors. There is a wide mix of skills in the team and interviewees report good working relationships. Additionally, a strategy group which includes some of the consultants, drawn from Norfolk Education Advisory Service, North West Anglia Health Authority and East Norfolk Health Authority, steers the HNSA. An independent local evaluation had already been undertaken and was being used to assist in the review and development process. Paid HNSA consultants, drawn from the education and health sectors, support the school and visit on at least three occasions. They also support the school's audit process and help gather evidence of achievement.

Pilot site funds were used primarily to review, fine-tune and extend the local award following an independent evaluation of the scheme. An expert conference in February 1999 was held as a consultative process designed to generate ideas and identify local needs. However, data collected using the Health-Related Behaviour Survey had already provided some local evidence for the key areas in which school improvement was important, including the training on policy, practice and teaching and learning strategies for health education co-ordinators that is identified in the spending plan. The local strategy group also decided to use their allocation of funds to build on the recommendations of the evaluation, and identified a number of areas for development in their spending plan. These included:

- Exploring issues of sustainability;
- Raising the profile of early years education through health education in pre-school settings;
- Providing training to school nurses in order to extend their role in the scheme;
- Promoting greater parental involvement in the HNSA;
- Developing a multi-agency training package to facilitate greater consultation; and
- Developing a tool to facilitate a minimum common standard for evaluation.

As a result of participation as a pilot site, respondents interviewed in the second phase of the evaluation reported that they had been able to engage in reflection on the pre-existing award. For example, they said they are moving away from their current 'award' model towards one which is closer to 'Investors in People', whereby participating schools have to demonstrate on-going commitment. Involvement in the pilot has also led to some consideration of quality standards and how to ensure more consistency between schools who are involved in the scheme.

Staffordshire & the City of Stoke-on-Trent

Staffordshire Health Promoting Schools Award (HPSA) was introduced in 1994 as a pilot programme and subsequently expanded into a three-year programme for all LEA maintained schools.

The award covers a large area in terms of both geography and the number of schools in the target area (545). HPSA is jointly funded by North and South Staffordshire Health Authorities and Staffordshire & Stoke-on-Trent LEAs. The initiative is run by a steering group comprised of representatives from Stoke-on-Trent City Council, North and South Staffordshire Health Promotion Units, Quality Learning Services and Staffordshire Country Council Education Authority and Stoke-on-Trent City Council Education Department. Part-time staff, initially referred to as 'visitors', but later re-named consultants, are employed to support schools participating in the HPSA.

In order to achieve the pre-existing award, schools had to reach a required level in each of nine criteria, of which one was the development of a whole school health related policy. An independent evaluation was commissioned by the steering group and the findings published in early 1998. The evaluation revealed high levels of local commitment and enthusiasm for HPSA among head teachers and PSHE co-ordinators in schools. The evaluation notes that the existence of HPSA has raised the profile of health education in schools and fostered positive attitudes among staff. Indeed, participating schools were found to be 'more active across the entire spectrum of health promotion planning, curriculum organisation and implementing healthy activities than their counterparts outside the scheme.' The contribution of visitors was judged to be central to the success of the HPSA. However, independent evaluation revealed that schools had not to date played a major part in the central planning for HPSA, and it was recommended that a consultative group composed of representatives from participating schools be established.

The initial HPSA was seen as a first phase of work. Involvement as a pilot site facilitated development of a second phase of activity whereby greater numbers of schools were included, more appropriate procedures for monitoring and evaluation were developed and improved dissemination strategies identified. An independent evaluation of the existing scheme had been conducted and, on being identified as a pilot site, local partners were able to produce a plan to help take forward some of the recommendations that had arisen from this, as well as bring 75 new schools into the local scheme. Plans were also based on a survey of young people's health related attitudes, knowledge and behaviour, the outcomes of which were used to inform target setting.

West Sussex

West Sussex's work was in the early stages of development. Selection for involvement as a pilot site provided the impetus for forming the West Sussex Health and Education Partnership (WSHEP) and for appointing two project co-ordinators. Partners in West Sussex are committed to working in a participative and consultative way and recruited a reference group to inform practice and guide the direction of the WSHEP. This group was formed at an expert seminar held in early December 1998 as part of pilot site activity and comprises eighteen people representing the health, education and voluntary sector and other interested services, including local district councils, mental health projects, education welfare, child health services, primary management teams and youth-action co-ordinators. The purpose of the reference group is defined as sharing practice, developing common understandings, defining roles and responsibilities and providing opportunities for discussion of issues. Importantly, partners in West Sussex have also developed a mechanism for consulting with young people in order to obtain feedback on key issues including emotional health and well-being, safe and supportive environments, aids to learning and preparation for adult life.

WSHEP has developed a Standard called 'Investors in Health' based on eight principles required for achieving a healthy school. Each principle is identified by evidence indicators within the school, which form the basis for both the initial school audit and final assessment. Each school has clear routes for improvement in principles identified as a result of the initial audit. Discussions were taking place to decide how to structure the 'Investors in Health'chartermark, and some partners favour three levels of evidence indicators for schools which may be characterised as bronze, silver and gold standards.

Partners in West Sussex are concentrating their early efforts on ten 'Planned Supporting Programmes' or particular projects. These include further development of circle time in primary schools, 'Passport II' in secondary schools (a pre-piloted PSHE curriculum framework), the training of PSHE co-ordinators in policy, practice and teaching and learning strategies, a 'girls and exercise' initiative and a mental health project designed to raise awareness among teachers.

In West Sussex, work has been largely formative and developmental, with an emphasis on the importance of the processes of establishing solid partnerships. Since the healthy schools initiative is only just beginning, it was not intended to recruit schools into 'Investors in Health' at this point. Instead, work has focused on establishing mechanisms for partnership and consultation and devising a mechanism of consulting with young people.

Overall, work in West Sussex has focused on laying the foundations for a healthy schools framework that aims to be rigorous, participative, relevant to schools and to have local credibility. Although it is anticipated by local partners that the work undertaken may eventually lead to 'better attendance, ... improved staff well-being ... [and] improved pupil performance', interviewees acknowledged these were long-term aims, and current work is focusing more on 'awareness raising'. Importantly, one respondent also commented that there will always be difficulties in attributing particular changes in performance to individual initiatives: 'It is quite superficial to think you can measure this and attribute positive outcomes to involvement in a specific project'.

Lessons learned

The aim of the evaluation was to extract lessons learned about health and education partnership working for healthy schools which could be incorporated into the national standard to make it as relevant and effective as possible. The principal lessons derived from the data are presented thematically below alongside illustrations and examples drawn from interviews.

Partnership working

Broad range of partners and stakeholders

Overall,a number of factors appears to contribute towards the development of effective partnership working. The most effective approaches appear to work towards including a broad range of professionals and stakeholders, fostering among them a shared ethos,while offering a set of shared benefits for all. Partnerships between different sectors and agencies concerned with the health of young people are crucial,but there was also a recognition among interviewees of the importance of consulting and involving other stakeholders,such as parents and young people.

The great majority of interviewees across the sites identified the importance of a common vision,shared goals,supportive management,honesty, open communication, clarity of roles and equity. In Durham, for example, an interviewee commented that it was crucial to have 'shared goals for all partners and shared benefits.'

In Manchester, interviewees said that partnership working had been facilitated by training. This had helped build a shared ethos between programme co-ordinators and others involved in the work.

In West Sussex,an initial expert seminar had led to the establishment of a local 'reference group'composed of professionals from schools,the youth and community service,school governors and others to steer work. An expert seminar had also been held in Norfolk for similar reasons. This model may be particularly appropriate for the setting up of new healthy schools programmes. In Manchester, the model adopted has been somewhat different,but equally successful. Here, key paid workers had taken activities forward,and have acted as advocates for the local programme, and their enthusiasm and commitment have been widely recognised as the source of success by all the local partners.

In Hounslow, where there is a particularly diverse local community, efforts have been made to ensure appropriate levels of minority ethnic representation.While awareness was expressed elsewhere about the importance of having representation from all sectors of the community in healthy schools partnerships,this still needs to be translated into practice.

School governors indicated strong interest in becoming involved in healthy schools work.One governor interviewed stated that she would not expect to be consulted at every turn,but would expect consultation on issues of policy. A governor in another site emphasised that governors can, if adequately involved,move healthy schools work forward. Unfortunately though, work sometimes gets no further than the head teacher's desk,commented this same respondent,due to competing priorities and demands.

Despite their enthusiasm,however, school governors interviewed did not always appear to be 'in touch'with the views of pupils, which may be a reflection of inadequate mechanisms for

fully involving governors (and pupils) in partnership working and consultation. For example, one governor commented on how much young people had enjoyed a particular school-wide event,but this was not a view shared by pupils interviewed in the same school.

School nursing services were identified as having an important role to play, but were felt to have been largely under-utilised by previous health promoting initiatives.There is an awareness that,while many school nurses may want to be involved,demands for screening and health surveillance sometimes inhibit their participation in the full range of health promoting activities. In an effort to address this issue,some pilot sites concentrated funds on working with school nurses.In Manchester, a school nurse has been seconded to develop the school nurse's role within the programme. In addition, school nurses are encouraged to join school teams,offering health information to and about schools and assisting in the health needs assessment process.

Clearly, models of partnership which involve parents and young people more fully might enjoy increased levels of success and improved outcomes. While interviewees in most sites identified the importance of parental involvement, few were able to offer concrete examples of substantial partnership working so far.There were,however, a few notable exceptions.In Darlington, one project (the 'WalkingTrain') was facilitated by a local partner, but steered and led by parents. In Cornwall,a school governor identified increased involvement for governing bodies as important in getting parents involved.In Norfolk,early years provision was seen as an important setting in which to promote parental involvement with health promoting initiatives and a 'route in'to working with them.This may be a model that can be adopted elsewhere to promote increased parental involvement in healthy schools work throughout the school career.

Interviews with parents suggest that for the most part they link healthy schools to specific interventions or conditions.Asked to define a healthy school,most did so primarily in terms of good support (medical) services,the physical environment,safety, healthy eating,physical exercise and cleanliness. Parents interviewed at a primary school, for example,described a healthy school by saying that 'The toilets are clean ...the packed lunches are monitored and everyone goes swimming'.

In another site,one group of parents talked about 'healthy schools'largely in terms of sponsored activities and initiatives such as 'walk to school' week.These activities were important to parents in terms of being one of the few ways in which parents can get involved in school life. In addition some parents stated that a healthy school should have 'a good atmosphere'. As one parent put it, 'A healthy school involves and informs parents'.

Pupils

One of the most significant findings of the evaluation came from interviews with pupils. The views of pupils towards health and its place in the school context,could be markedly different from that of adult interviewees,which underlines the importance of consulting and involving young people as key partners and stakeholders in the development of healthy school activities.

Interestingly, in almost all cases,the young people who participated in in-depth and focus group interviews defined 'healthy schools'in terms of an integrated and sophisticated approach to health that takes account of emotional well-being and mental health.If schools were healthy, respondents said,'I'd want to come to school'(Primary School Pupil). Other children and young people made links between happiness,learning methods and health:'If people enjoyed things they would learn a lot more.' (Secondary School Pupil)

In one site,the importance of an ethnically diverse community in a healthy school was specifically mentioned:'[a healthy school has] ...a multi-cultural community ...[with] different nationalities'(Secondary School Pupil).

Interestingly, children appeared to have a sense of balance in relation to healthy behaviours, and largely rejected prescriptive and 'don't do'models of health education:' [in a healthy school children] ...eat chips sometimes.' (Primary School Pupil)

So while pupils made occasional reference to issues such as a drug and tobacco-free environment,the absence of litter and the provision of healthy meals at lunchtimes,they tended to place greater emphasis on personal relationships. For example,primary school children commented that 'There are not bullies in a healthy school'. The importance of their relationships with adults,and a mutual respect, was also emphasised 'Being able to talk teachers'(Infant School Pupil).

Some the older pupils interviewed drew attention to the importance of greater equality between teachers and pupils: '[In a healthy school] ...teachers talk to you on a level.They speak to you rather than down at you'(Secondary School Pupil).

Older young people were keen to emphasise the importance of their involvement in decision-making: 'Being involved in decisions that are made. If there are new things happening in the school,being asked what we think about them'(Secondary School Pupil).

Finally, a healthy school was defined by some young people as a place where there might be expected to be personal growth as well as learning: '[in a healthy school students will have] blossomed as a person'(Secondary School Pupil).

While few young people were actively involved in work for healthy schools in most sites,there was an acknowledgement among most interviewees that there is a need to develop more formal structures for involving young people directly. In Cornwall,one interviewee expressed the hope that the National Healthy School Standard will be 'not another example of adults saying what young people need.' Yet another respondent commented that: 'Young people are experts at being young people'.

While work with young people at local programme level was largely *ad hoc* and unsystematic, work with young people in schools was more widespread.Manchester had a formal mechanism for involving young people in planning,and other sites are clearly developing this aspect of the work. Here,through 'schools teams', young people are able to feedback their ideas to a support health promotion worker, as well as being centrally involved in school self-assessment, target setting and monitoring and evaluation.In Hounslow, partners have consulted with young people in schools via student councils on how to get messages about drugs across to young people in schools.A respondent in Durham commented that the new local programme now has a client-centred approach (most especially consultation with young people) as its over-arching principle.To enjoy the greatest success,local programmes clearly must develop effective and appropriate mechanisms for involving young people.

Commercial partnerships

In some sites,commercial partnerships have been developed. In Manchester, partnerships with the private sector have helped the programme gain credibility as well as financial resources. Sponsors such as Marks and Spencer plc in the past programme,and now Asda plc

in the new programme,have provided some sponsorship for the local award.In Hounslow, there have been successful partnerships in the past with Brentford Football Club and Sky TV.

The time to develop partnership working

There was also a high degree of consensus across sites about the importance of time to build and sustain relationships between partners.In West Sussex,one interviewee said that partners needed 'time to share ideas,time to learn from other professionals,and time to talk.'

This may be particularly important in rural areas.In both Norfolk and Cornwall,interviewees commented that the physical distance in rural areas can make collaboration between partners especially difficult to organise.

One respondent in Darlington commented that through working closely and in a participative way with parents he had realised that 'You must work to other people's timeframe ...in partnership working the time needed is determined by the stakeholders'.

The importance of personalities

The importance of personalities in developing effective relationships cannot be under-estimated.Respondents across the sites reiterated the importance of having local co-ordinators who have good 'people'skills and high levels of enthusiasm.Interviewees were also asked to identify factors that hinder collaboration,and most frequently cited resistance from senior management,differences in cultural ethos and incompatible working practices.In Cornwall,interviewees said that previous successful partnerships had been facilitated by the appointment of an independent chairperson to lead steering groups. In this way some of the usual tensions had been avoided.

Networking and support mechanisms

In Hounslow, Staffordshire & the City of Stoke-on-Trent and most other sites, respondents reported that involvement in the National Healthy School Standard Pilot Project provided opportunities to gain information and learn from others involved in the pilot work. During the course of the project,a number of meetings have been held which have brought together partners from across the pilot sites. These were thought to have provided excellent opportunities to share learning and resolve problems.

A number of interviewees indicated that they would welcome a national conference to share learning between local programmes,although finding time for travel was difficult. In Manchester, respondents favoured the development of a national forum for the National Healthy School Standard,as well as the establishment of regional fora,which would be useful in terms of disseminating good practice. The use of websites or e-mail groups were also thought to be a good idea,allowing partners working on local programmes and in schools to establish dialogue directly between themselves.

Specifically, partners working in pilot sites would like to hear about other models for developing school curricula,alternative management structures,mechanisms for achieving quality standards,information about budgeting and finance, and sharing support materials.

Working with schools

Recognising existing pressures

Almost all the interviewees in each site commented on the importance of finding ways of working with schools which would not be too prescriptive,and which would not unduly increase the workload of teachers by fitting the programme into the existing working context of schools as far as possible. In Norfolk, for example,some concern was expressed about the amount of paperwork which teachers have to cope with under the pre-existing healthy schools award,and there was local will to ensure that this is lessened and not increased.An interviewee at another site commented that:'Schools have so many balls in the air, it is difficult to convince [them] of the worth of the National Healthy School Standard.'

One way in which local partners are attempting to overcome this problem has been by developing a programme that explicitly values the activities already being undertaken in schools. While many schools are undertaking health promotion work,it is not always labelled as such. The National Healthy School Standard might help provide a framework for this kind of work to fit into.

It is important then that partners emphasise to schools that the National Healthy School Standard is not something extra,but rather will allow staff to access the professional development,support and expertise they need to make their work easier and more effective.One interviewee said:

> ' ...teachers [should not] feel they have to start from scratch ...it is important to help [teachers] map out and see what they are already achieving,help them feel good about it, help them identify where they want to go,how to get there and how we can help.'

Flexibility of the programme

The development of a flexible programme was seen as important by almost all interviewees. In West Sussex,Durham & Darlington and in Manchester, interviewees said that any National Healthy School Standard must recognise and celebrate local diversity. In West Sussex, respondents wanted to be part of a National Healthy School Standard that is 'flexible enough to allow for regional innovation and creativity.'

It was suggested that some type of accreditation of prior learning should be built into any national standard so that schools that have achieved the local award can 'fit into'the standard. That way, schools which have already made progress towards becoming healthy schools might have their achievements recognised and acknowledged.

School ownership of the initiative

Another important issue was the need for schools to be able to identify their own priorities, rather than having them imposed upon them from outside. This was felt necessary to facilitate recruitment of schools and a sense of ownership. That said,being prepared to do some 'legwork' for schools in terms of providing frameworks, resources and lesson plans is crucial. In Hounslow, it was also reported that schools need to be offered some help in the areas which they have identified for themselves in order to get them become involved.In Durham & Darlington,interviewees were keen to:

'…provide schools with resources,procedures,programmes,guidance ...schools are short of time – off-the-shelf packages on policy, etc., for adaptation will be well-received.'

Targeting needs

In one site,some interviewees in phase one of the evaluation expressed concern about recruiting schools with the greatest need in terms of education and health inequalities,commenting that it is often the schools where the health promotion is most needed – for example those in areas of social disadvantage – that are the most difficult to recruit. Interestingly, interviewees in this site expressed slightly different views on this issue during phase two of the evaluation,and stated that a more strategic targeting of individual schools should take place to ensure that particular needs are met in schools that require special inputs. One key professional from the LEA stated that there are 'a disproportionate number of failing schools'locally, and that the key to school recruitment lay in promoting 'health improvement as whole school improvement'.

In Staffordshire & the City of Stoke-on-Trent and in West Sussex,some interviewees reported that there is interest locally in using the programme to support 'failing' schools and communities where there are marked inequalities and deprivation.

Continuing professional development

Ongoing opportunities for professional development and the need for a proper health education component in initial teacher training were recurrent themes across the sites.In Durham & Darlington one interviewee noted that 'there is a dire need for input on health issues in teacher training.' Interviewees in Durham & Darlington also stated that staff in schools need to have more opportunity to develop as reflective practitioners,since this would provide opportunities for teachers to think about how schools might become healthier places. One interviewee summed this up by saying:'The school must be a learning organisation - not just for kids,but lifelong learning for staff too.' In Norfolk,interviewees stated that training,not just for teachers but for other professionals involved in healthy schools initiatives,and sustainability are inextricably bound together.

Monitoring and evaluation

In several sites, rigorous monitoring and evaluation were reported as being crucial to the success of local programmes, and respondents identified the development of improved mechanisms for these processes as a key lesson.

Interestingly, a number of respondents across the pilot sites reported that the DH/DfEE external evaluation had also provided opportunities for reflection on practice. The evaluation process was thought to be supportive and participative,and had provided opportunities for discussion and critical analysis. In Durham,a key respondent commented that:

'The evaluation has provided a chance to sit back from daily work with colleagues and help you think through where the pilot is going. Even some of the questions asked by [the interviewer] have sparked issues to take back to colleagues'.

National and local context

A national lead

Clear examples of partnership working at national government level were cited as crucial by interviewees across the pilot sites. A number of interviewees reported having been encouraged by the lead so far taken at national level and said that this had helped foster a culture of partnership working at local level:

> 'this national lead has forced people at local level to establish partnerships.'

Interviewees at several sites reported being particularly impressed by the close working relationship between the Minister for School Standards and the Minister for Public Health.

Across all pilot sites,the view was expressed that fundamental changes to the school curriculum must take place if any National Healthy School Standard is to enjoy success.Presently, interviewees reported,there is some confusion in schools as to how and where to include formal teaching about health-related issues,and there was a call for a clearer presence for health education within the National Curriculum.

Opinion on the inclusion of healthy schools work in statutory inspections,or the use of awards, was divided.In most sites,the future inclusion of issues relating to health promotion,in its broadest sense,in OFSTED inspections was regarded as crucial and seen as critical for recruitment of schools into programmes. In others,however, interviewees felt strongly that this would not facilitate good partnership learning and there were some concerns about placing schools in competition with each other. In Doncaster, for example,interviewees had reservations about the making of awards,especially as this is not done for other curriculum areas.Schools in Manchester, however, have clearly identified that they want a progressive award programme that will enable them to move in stages towards becoming more 'health promoting'. Here,there would be no winners or losers, rather the award would allow for celebration at each stage of development. The issue of recognising success needs to be taken into account when developing the national standard.

Support from the national level

In Hounslow, interviewees commented that the role of a national co-ordinator is important for sustaining work in the long term. Not only does the existence of such a post lend credibility to the programme,it also serves as a reference point for local programmes wishing to learn more about each others' work.

In Manchester and Durham & Darlington,interviewees emphasised the role of the national standard in disseminating good practice,such as exemplar models and targets. One head teacher noted that 'There is currently no benchmark for health education in schools ...what is good practice?'

Additionally, in Manchester, interviewees also felt that a national standard could help foster networks between local programmes. In Norfolk,interviewees suggested the establishment of a national network linking programmes together and facilitating the sharing of experiences and good practice. Interviewees in Cornwall want access to evidence from other sites that might help them to develop their own programme and stop them 're-inventing the wheel.'

In several pilot sites interviewees said that the incorporation of a healthy schools approach

across all areas of relevant local planning is critical to success and sustainability. For example, inclusion of this work in the LEA's Education Development Plan (EDP) was considered crucial to the on-going success of the initiative and some advocated that it be mandatory. In Doncaster, Cornwall and Manchester interviewees talked of linking healthy schools work with planning for Health Improvement Programmes,Health Action Zones, Education Action Zones and Early Years Development Plans.In Norfolk,interviewees emphasised the importance of what was described as 'broadening multi-agency involvement.'

Views of other agencies

Representatives from OFSTED, the NFER and the TTA[8] were asked their views on healthy schools programmes,their foreseen future involvement in a national standard and suggested criteria for accrediting local programmes. There was no clear consensus on aspects of a quality healthy schools programme,although a healthy physical and social school environment was mentioned as a characteristic of a healthy school.

The representative of NFER strongly advocated the 'whole school approach' and that adequate provision for PSHE be made within the school curriculum.The representative of the TTA wanted to see evidence in schools of range,balance and appropriateness in the curriculum for health education, good planning and the full involvement of teaching and non-teaching staff, as well as parents and members of the wider community.

The representative from OFSTED could see a lot of opportunities for convergence between OFSTED guidance and any future national standard.He said he believes that current guidance is not clear enough with regards to health or health promotion,and a review which is currently underway will 'spell out more carefully to schools what inspectors are looking for'.

In addition to issues relating directly to the questions asked,these key respondents raised a number of important concerns which are worthy of note. The representative from the TTA was also concerned, for example,that:'there should not be a reductionist view of what teachers will think important'. The interviewee continued that although there may not be space for the inclusion of PSHE in the initial training of teachers in higher education,opportunities for teacher training in schools should be provided. Additionally he felt that 'motivators and levers' do not always derive from the inclusion of topics in initial teacher training,but might adequately be provided through a prestigious national standard with a recognised 'code of practice'. The representative of the NFER was concerned that former good practice should not be overlooked, and that the NHSS should have mechanisms for acknowledging good work already undertaken through local programmes and in individual schools.

Quality standards and progress indicators

During phase two of the evaluation,interviewees were asked their opinions about what should be included as criteria for approving local programmes in the National Healthy School Standard. The following criteria,which reflect the lessons learned as described above, were those most frequently mentioned across the sites:

[8]Representatives of the Qualifications and Curriculum Authority (QCA) were unable to participate due to unforeseen circumstances.

- whole school involvement in the planning, development,delivery and evaluation;
- multi-agency working;
- social inclusiveness;
- rigour and consistency;
- appropriate and timely mechanisms for local monitoring and evaluation;
- dissemination of learning at local agency levels;
- young people centrally involved in planning and delivering the programme in schools;
- joint partnerships between education and health;
- school nurses should be centrally involved;
- rigorous and measurable targets;
- multi-disciplinary teams should be evident in schools;
- partnerships with parents.

Interviewees from the national agencies offered a variety of similar ideas. These echoed the views of respondents in pilot sites and included:

- connectedness of curricula;
- opportunities for staff development;
- on-going needs assessment with pupils;
- inclusion of health promotion,in its broadest sense, in the school development plan;
- clear roles and responsibilities for teachers leading the work.

It was hoped that the evaluation would also gather suggested performance indicators for healthy schools programme activities. However, because change in health behaviour and outcomes is a long-term process,interviewees found it difficult to identify realistic outcome indicators based on their own experience, given the short time frame of the project.It is important to add here that many interviewees did not find this an easy, or indeed realistic, exercise,since so many variables remain unknown. In consequence, respondents tended to identify very general indicators of success. Overall, respondents across the sites included factors such as:

- number of schools involved in the programme;
- number of school teams established;
- number of assessors trained;
- support materials produced and used in schools;
- number of school nurses actively involved;
- range of partners and stakeholders involved;
- community awareness of the principles of local healthy schools programmes

as appropriate indicators of early success in the shorter term (one year).

Over a longer five year period, respondents would expect to see more concrete evidence of success, for example:

- a reduction in teacher turnover;
- lower levels of pupil exclusion;
- improved attendance;
- improved exam results;
- lower rates of unintended teenage pregnancy;
- inclusion of healthy schools work in School Development Plans;
- greater parental involvement.

Conclusions

Taking together the findings from phases one and two of the evaluation,it is possible to discern a number of recurrent themes. Interviewees across all the pilot sites agreed that the manner in which any future national standard is presented to schools will be crucial to encouraging involvement in the work,especially since schools are having to respond to a number of new initiatives.Schools need to be able to determine their own needs,to have access to good quality support,and to have existing good practice acknowledged. Accreditation of prior learning in schools where work is already taking place is considered desirable,especially where existing healthy schools programmes are up and running.

While some localities have a history of good partnership working,there was nonetheless some acknowledgement that healthy schools programmes need to become more inclusive and involve a larger number of partners such as school nurses who have an important role to play in promoting health,and private sector organisations and businesses.Broader representation from the wider community, including that of minority ethnic groups is also important.

At the end of the first phase of the evaluation, there appeared to be few existing mechanisms for involving young people themselves in planning. During the second phase of the evaluation, it became clear that key informants at all sites were beginning to think about ways of involving young people as well as other partners,such as parents,in the processes for developing and planning healthy schools work.In some sites,there was evidence that this was beginning to occur, and there was evidence of collaborative work with parents and pupils. It appears therefore that there has been a progressive change of culture in many sites in relation to developing formal mechanisms for the inclusion of the young people and the wider community, and many interviewees stated that they were keen to ensure that consultation is no longer just a paper exercise.

Shared goals are crucial in facilitating effective partnership working,and there is some evidence to suggest that training may be key in helping partners develop a shared ethos of what work should be about.Stakeholder participation is also central to the development of shared goals,as are clear policy frameworks.Evidence of partnership working at national level continues to be important in promoting the development of local partnerships.

Nationally, the profile of the work must remain high.A number of interviewees pointed to the importance of policy changes that might lead to a higher profile for PSHE in the National Curriculum,in initial teacher training and in the on-going professional development for teachers and healthy school partners. The mandatory inclusion of health and/or health promotion in Educational Development Plans and School Development Plans was considered crucial by most interviewees.There was,however, less agreement among interviewees about the inclusion of health-related criteria as part of OFSTED inspections.There were some fears expressed that if a narrow definition of the 'healthiness of schools' was to be included in inspection,health promotion in schools might lose some of its dynamism and become simply another task to be assessed.

Local partners and schools want a national lead,especially in relation to sharing of information and examples of good practice.Interviewees also stated that a process for dissemination of good practice from other sites,including those not involved in pilot work, would be welcomed. There is widespread agreement that multi-agency working needs to be formalised through the integration of any future national standard into other development plans such as local Health Improvement Programmes. Perhaps the strongest message of all from the pilot sites was the need for a flexible standard which acknowledges local differences and allows partners in edu-

cation and health to develop practices which are attuned to their specific needs.

There was considerable debate both within and between pilot sites about whether healthy schools programmes should have awards attached to them.While some interviewees expressed the view that formal awards help foster enhanced status of the programmes,encourage widespread school recruitment and help sustain good practice,others felt that awards engender competition among schools which can be counterproductive to the development of healthier schools.

Interestingly, the pupils interviewed in the second phase of the evaluation appear to demonstrate a highly integrated understanding of health issues which goes beyond the traditional health education topic areas of drugs,sex education and healthy meals (c.f. Aggleton et al., 1998). As well as rejecting narrow definitions of health,pupils tended to resist overly prescriptive models of health education which encourage them to abandon wholesale all behaviours viewed as undesirable. Instead,they appear to place high emphasis on emotional well-being and mental health, freedom from bullying, good inter-personal relationships between pupils and the adults who work with them and support them,and opportunities for involvement in decision-making. On the basis of this preliminary evidence,the pupils seem likely to be receptive to a healthy schools model that promotes health through a whole school approach and that involves pupils.

From the data collected in phase two of the evaluation it would also appear that parents and school governors had not yet been adequately involved in the processes of working towards a healthy school approach. They did not appear to have a concept of a healthy school which is shared with other partners,and this would suggest that a whole school approach has not as yet been widely achieved in this context.

Recommendations

A number of concrete recommendations for developing the proposed national healthy schools standard derived from evaluation of the work in all eight pilot sites:

1. As a result of the National Healthy School Standard Pilot partnerships,there is a greater awareness of the importance of consulting with and involving young people in the planning,development,delivery and evaluation of healthy schools work. However, in most sites there is still an absence of mechanisms for involving young people. Existing models of good practice for involving young people should be more widely disseminated and new, innovative ways developed.

2. Young people across the sites tend to have an integrated approach to healthy schools,and are particularly concerned about the quality of inter-personal relationships between pupils, between pupils and teachers,and between pupils and the other adults working with them. The national standard should take this into consideration when developing its shape and scope.

3 . A holistic and inclusive approach to health which takes account of young people's emotional well-being and issues of race and gender is helpful.

4. Recruitment to programmes needs to ensure that schools in the greatest need in terms of health and education inequalities are targeted; this issue needs to be addressed in any future national standard.

5. Local partnerships should adequately reflect the communities they are seeking to represent. Partnerships should ensure that there is proper representation for minority ethnic groups, for example.

6. Greater involvement of parents and school governors is required in order to develop a truly whole school approach.

7. Good inter-personal skills,enthusiasm and the commitment of key partners,including those responsible for steering work,appear to be crucial in taking work forward.

8. Adequate time-frames are necessary for developing and sustaining local work.There needs to be an acknowledgement at all levels,including nationally, that effective partnership working is time-consuming.

9. A well-received national healthy schools standard should be flexible enough to take account of regional differences and provide opportunities for local partnerships,including schools,to identify their own needs and plan appropriate ways of responding to them.

10. If multi-agency working is to be successful,issues relating to healthy schools need to be incorporated into local planning at all levels – for example in Health Improvement Plans, Education Development Plans and Early Years Development Plans.

11. Many interviewees are aware that schools are fielding a number of initiatives and that teachers are reluctant to add more activities to their burgeoning workload.Programmes need to acknowledge these issues and find ways of supporting schools in their endeavours to become health promoting environments.

12. Proper preparation for PSHE work must be included in initial teacher training and programmes of continuing professional development.

13. A good number of interviewees suggested that any national standard will lack success unless PSHE is valued and afforded a proper place in the National Curriculum.

14. Some interviewees,especially in sites with long-established local awards, would expect a national standard to include some system for accrediting prior learning in schools.

15. Further exploration of how programmes might be designed is required,especially in relation to recognising school achievement.

16. Interviewees in pilot sites are keen to hear about good practice elsewhere.Methods of ongoing networking and dissemination of good practice should be developed and shared,and supported by a national standard.

4. EVALUATION FOLLOW-UP STUDY: PERCEPTIONS OF IMPACT

In order to offer insight into the potential impact of healthy schools work on the attainment of individual,institutional and broader social goals,the Thomas Coram Research Unit were commissioned to approach schools involved in healthy schools work and explore their observations of changes which had taken place.

These case studies provide insight into local education authority, health authority, head teacher, staff, pupil, governor and parent perspectives of the work undertaken to date,and its broader contribution to individual achievement and school improvement.

Method

In close consultation with the NHSS Evaluation Advisory Group,the research team identified a number of sites in different parts of the country where healthy schools work had been underway for some time. Four of the sites – Durham and Darlington, Manchester, Norfolk,and Staffordshire and the City of Stoke-on-Trent – had participated in activities as part of the pilot site evaluation reported on above.A fifth,non-pilot,site was also selected: Lambeth,Southwark and Lewisham,which has a long-standing healthy schools programme.

Within each site,and in consultation with local programme co-ordinators and local authority advisers,one or two schools were selected where there was evidence of an association between healthy school interventions and the attainment of broader educational goals. These included enhanced pupil motivation,improved attendance rates,lowered rates of bullying as well as improved academic achievement.Appropriate secondary data provided by schools and through the DfEE's Finance and Analytical Services Division,including policy documents, OFSTED reports,SATs scores and external examination results, were also reviewed to help identify change.

In total,seven case studies were undertaken. The schools selected represented special,primary and secondary education. In recognition of the conclusions of the Acheson Report (1998) and others,which acknowledge that health promoting schools are one vehicle for addressing health inequalities,a disproportionate number of schools were selected from areas of social disadvantage. Individual case studies were developed at the following schools:

- Chapel Break First School in Chapel Break,Norfolk;
- Chase Terrace High School in Staffordshire;
- Forest Hill Secondary School in the London Borough of Lewisham;
- Newall Green High School,Manchester;
- Parkside Special School in Norwich,Norfolk;
- St.Clements Church of England Primary School,Manchester;and,
- Tanfield Comprehensive School in Stanley, County Durham.

In order to offer insight into healthy schools work and its possible consequences for pupil attainment and school improvement, four key areas of investigation were chosen (Appendix C). These were (i) teaching and learning,(ii) organisation and management,(iii) relationships,and

(iv) environment and facilities. Within each of these areas,a series of potential indicators of improvement was identified. In each selected school,interviewees were asked to select a minimum of three of these indicators,including one chosen from the compulsory area of teaching and learning,where evidence and examples of improvements consequent upon healthy schools work could be demonstrated. In this way, interviewees in different schools were able to focus on the particular issues which reflected their concentration of effort through local healthy schools work.

A range of interviewees were selected in each school,including head teachers and members of the management team, class teachers,support staff, governors,parents and pupils. In addition, external healthy schools programme support staff, usually representing the local health authority and local education authority, were also interviewed. In total,158 in-depth interviews were held across the seven schools,involving:

- 10 local healthy schools programme co-ordinators
- 7 head teachers
- 28 teachers
- 13 support staff
- 57 pupils
- 12 governors
- 25 parents
- 3 school nurses
- 3 youth workers.

The number of interviews held in each school varied according to size of the school and the numbers of individuals involved in the school-based healthy schools programme.

It is important to note that as an uncontrolled, retrospective study, causal links between healthy school activity and pupil or school improvement cannot be inferred. However, many of the schools did experience positive change alongside their programmes,and the aim of this study was to highlight the impact of healthy schools work which was perceived by those involved,on the community, the school,the pupils and themselves.

Case studies

Chapel Break First School, Norfolk

Chapel Break First School had 160 children on the roll in July 1999. The school sits in a socially disadvantaged catchment area. Thirty-three per cent of pupils qualify for free school meals,and 30% live with a lone parent. Chapel Break has been working towards the Healthy Norfolk Schools Award (HNSA) since July 1995,and achieved the award in March 1997.(see p.39 for an overview of HNSA pilot site work).

According to those interviewed,involvement in HNSA has led to a number of changes in the school, including increased consultation with parents. Staff had mentioned that some of the young parents of pupils in the school might benefit from courses on parenting skills. As part of its healthy schools work,the school held a number of courses for parents,including a food hygiene course and sessions on behaviour management,safety in the home and parental stress. The head teacher and colleagues interviewed at follow-up attributed improvements in the behaviour of several of the pupils to the participation of their mothers in parenting skills courses.

As a result of becoming a healthy school,health education has been integrated across the curriculum. For example,the reception class explore three health-related topics over three terms:'Me and looking after my body';'Me, my environment/community - growing and changing';and,'Me and my relationships - family and friends'. These topics provide opportunities to learn about health,but can also be explored through other areas of the curriculum,such as reading and maths.

While it was not possible in this study to attribute improvements in attainment directly to involvement with HNSA,there have been steady improvements in SATs at the end of Key Stage One over the last three to four years at Chapel Break. For example, in reading,57% of children achieved level 2 and 18% level 3 in 1996. Two years later in 1998,75% achieved level 2 and 30% level 3. Results in science are particularly good in comparison with other schools in similar contexts. The school's PANDA (Performance and Assessment) report shows that Chapel Break achieves the highest result (A*) in science when compared with other equivalent primary schools nationally. This is also reflected in SATs results for science. In 1999 all of the children at Chapel Break achieved level 2 or above in science (50% achieved level 3). Teachers interviewed felt that these results were achieved because of the adoption of an integrated approach to health issues and science in the school.

Interestingly, interviewees also commented that school-wide planning for the HNSA had an unexpected,positive knock-on effect for other planning and management systems within the school.

Chase Terrace High School, Staffordshire

Chase Terrace High School is an 11-18 co-educational comprehensive school administered by Staffordshire County Council Education Committee. There were 1274 pupils on the roll in July 1999, 3% of whom qualify for free school meals.

The school achieved the Staffordshire Health Promoting Schools Award in January 1996. Among other points noted, the awarding body said that the school had:

- addressed health education issues within the planned curriculum;
- agreed a health education policy;
- named a health education co-ordinator and planning team;
- developed a programme of sex education;
- provided and promoted a choice of healthy foods at mealtimes; and
- promoted physical activity.

The objectives set for 1996-1999 relate to raising greater awareness of teenage pregnancy, introducing the First Aid and Emergency course to Year 8 students, and developing parenting skills for all Year 10 students.

Personal and Social Education (PSE) encompasses both specific taught aspects and the school's broader pastoral work. It is integrated across the curriculum and is embedded in the school's Life Studies Programme, which includes work relating to education for citizenship, health education, careers education and guidance, economic and industrial understanding, and education about the environment. All of the teaching staff, including the head teacher and other members of the senior management team, are involved directly in the delivery of this programme, as are non-teaching staff and community representatives.

The healthy schools work had, according to staff interviewed, reduced feelings of 'us' and 'them' between staff and students, promoted life skills among students, helped reduce inappropriate behaviour and made teaching more successful. Instead of feeling stigmatised for doing well in school, pupils now valued their own attainment and took pride in their own successes as well as in the achievements of the school. Governors and parents highlighted the improved physical environment of the school which had taken place through healthy schools work – for example, refurbished toilets and improvements to the school grounds.

The social environment of the school was also thought to have improved. Pupils commented that there was now less shouting and violence among pupils than a few years previously. They were positive about many of their teachers, with whom they felt they could discuss both academic and personal difficulties. Sixth formers felt particularly involved in the school's decision making process.

The school's OFSTED inspection at the end of 1996, some months after achieving the local healthy schools award, noted the high quality ethos and environment of the school, stating:

> 'Chase Terrace High School is a most successful school. It is very well led by a head teacher who has vision and clarity of purpose. Pupils' academic and personal development is effectively promoted. Standards of attainment are generally good throughout the school. High standards of behaviour are maintained within a caring, supportive and harmonious environment. Pupils' attitudes to learning are very good. The relationship between the school and the local community is strong and mutually beneficial'.

Chase Terrace has also experienced improvements in pupil achievement. Over the last 3 years, the school has either matched or surpassed the Government targets for SAT results for pupils reaching the end of Year 9. In 1998, the percentage of pupils achieving A* to C grades in 5 or more GCSEs was 50%, compared to 47% in 1995. In 1999, the percentage rose to 57%, the school's best ever achievement. Between 1997-99 school attendance has shown a small improvement from 92% to 93%.

Forest Hill Secondary School, Lewisham

Forest Hill served 1250 pupils in July 1999, the majority of whom are boys, since girls attend only in the sixth form. Staff at the school and the local programme co-ordinator describe the school's catchment area as having pockets of considerable social disadvantage. Thirty-four per cent of children qualify for free school meals and 35.6% live with a lone parent. More than 50% of pupils come from different minority ethnic groups.

Forest Hill has been involved in Lambeth, Southwark and Lewisham's Healthier Schools Partnership (HSP) since 1996, although their involvement in HSP's research and development process dates back to 1992. The school has set a number of specific targets, including: the development of a drugs education policy; training teachers in health-related issues and active teaching and learning methods; and developing a strategy for improving the physical environment of the school. The school has achieved all of these targets, as well as taking on a number of additional special projects. These include a peer mentoring scheme for borderline C/D GCSE pupils, work on social and ethnic diversity, a high profile disaffection project with in-school support for children facing exclusion, and work on men and masculinity.

The respondents interviewed at Forest Hill report an improvement in general ethos. Teachers describe the school as 'high energy' and a 'healthy school'. The most recent OFSTED Report (1997) describes Forest Hill as an improving school which has had:

> '... considerable success in establishing a positive ethos ... reflecting strong values. Parents, pupils, governors, teaching and support staff are all firmly committed to the school and a positive platform has been built from which to move forward'.

Academic improvement has also been observed. The staff report improvements in SATs results at the end of Key Stage 3, and the percentage of pupils achieving five or more A*-C grade GCSEs/GNVQs has risen steadily from 23% in 1996, to 27% in 1998 and 34% in 1999. These are significant improvements in attainment, especially in the light of the pupil intake at Forest Hill, which is skewed to the mid- and bottom of the ability range, and the school catchment area, which is in parts severely deprived.

While it is acknowledged that Forest Hill needs to make further improvements in academic results, the school has made progress in difficult circumstances. On visiting the school in March 1999, the HMI cited the work being done to re-integrate disaffected pupils back into mainstream as 'exemplary practice'.

Newall Green High School, Manchester

In 1998/99, Newall Green High School had 900 pupils. An OFSTED inspection at the end of 1996 described the catchment area as: ' ... a community which suffers from severe social and economic deprivation and a high level of unemployment'. Forty-nine per cent of pupils qualify for free school meals. The school first became involved in the local Healthy Schools Award (HSA) four years ago. Newall Green has now achieved the gold award, the highest level locally.
The head teacher said the programme: '...gave us deadlines and helped us monitor how successful we were being' while the school nurse pointed out that it '...freed up time for [pupils] and us to think about the positive things we could do about health in the school'. From the beginning, efforts were made to ensure that everyone in the school could get involved. The school consulted with young people about health-related teaching, and developed a comprehensive framework involving all teachers in delivering PSHE. One teacher commented that there is now a high level of commitment to PSHE among teachers.

In an effort to increase parental and community involvement in school life, sports facilities at the school have been significantly improved and are now used more widely by local people. Initiatives to improve relations between pupils and older members of the community have been developed. Regular newsletters are now available for parents. Parents' evenings are now described by staff as 'more celebratory', a change due in part to the development of a 'record of personal achievement' for pupils through which they set achievement targets and earn rewards.

One target set as part of healthy schools work at Newall Green was to improve the atmosphere in the school during lunchtime and to boost uptake of healthier food. Pupils were consulted, following which the school kitchens were refurbished, teachers were encouraged to sit and eat with pupils, lunchtime organisers were trained in positive behaviour management and communication with young people, a breakfast club was initiated and local sports celebrities came to talk about the importance of diet in sports success. Since these changes, healthier meals uptake has increased by 50% and the atmosphere during lunchtime has changed. One parent interviewed said that the school is now 'a haven for kids'. Pupils also note the improvement in teacher-pupil relations: ' ... you can have a laugh, you can joke with them. They're down to earth'.

These improvements alongside other initiatives, such as the development and implementation of an anti-bullying policy, are perceived to have reduced bullying. One parent said that 'any incident is dealt with swiftly and thoroughly'; two pupils interviewed had recently moved from other schools and compared Newall Green favourably: 'bullying's better here! [laughter]. You know what I mean!'. Researcher: 'There's less bullying here?' Pupil: 'Yeah, a lot less.'

Since 1992/3, the attendance rate has improved by 20%, according to school records. The school has developed a 'first day response strategy' and has a dedicated member of administrative staff who contacts parents if any child has not arrived in school by 10am. If the parent does not have a telephone, the member of staff cycles to their house or workplace. Again, staff and parents report that this initiative has improved relations between the school and parents, who now know ' ... the school really cares about the children'.

The staff at Newall Green believe that the combined changes instituted at the school as part of the HSA have led to improvements in academic attainment. The numbers of young people now achieving at least one GCSE grade A*-G has increased from 88% in 1996 to 100% in 1998. Overall, pupils interviewed clearly have a lot of pride in their school, describing it as 'one of the best in Manchester', while one parent emphasised the positive atmosphere at Newall Green, saying that 'the school is welcoming and warm'.

Parkside Special School, Norfolk

Parkside Special School had 146 pupils in July 1999. The pupils have moderate learning difficulties and are aged between 8-16 years. Parkside was awarded the Healthy Norfolk Schools Award (HNSA) in July 1999. As a special school, it is particularly concerned with pastoral care and helping students to acquire appropriate life skills.

One important change noted by interviewees was improvement in lunchtime behaviour, formerly a particularly disruptive phenomenon at the school. As part of their work towards the HNSA, school staff implemented a programme of structured activities for lunchtimes, included clubs and activities such as juggling, disco-dancing and football. The local Healthy Schools Co-ordinator assisted school staff in developing an improved plan for seating arrangements, improved lunchtime supervision, and trained supervisors in facilitating playground games. A teacher commented that '[lunchtime] now has a calmer atmosphere, with more purposeful interactions'. Pupils also appreciated the improvement, mentioning the benefits of having their own places through assigned seating. The head teacher also commented that these improvements have led to better staff morale and less absenteeism.

During the HNSA assessment process, the external evaluator noted that: '[there has been] a dramatic change ... [it is now] an orderly period with pupils sitting in social groups eating lunch'. The head teacher also commented that Parkside's involvement in healthy schools work is in the preliminary stages. There are a number of related activities planned in the near future, including those designed to reduce major incidents in school even further. One such activity will be developing a structured approach to facilitating play for those children who do not want to join clubs or take part in organised activities during lunch times and break times. The head teacher said, 'We want to teach those children how to play'.

St. Clements Church Of England Primary School, Manchester

St. Clements Primary School had 251 pupils on the roll as of 1998/9. OFSTED inspectors noted in 1998 that '... the school is situated [in a ward] ... on the highest scale of deprivation as defined by both Manchester local education authority and the diocese'. Forty-five per cent of children attending St. Clements qualify for free school meals.

The school had been involved in local healthy schools work for some time. However, on the arrival of a new head teacher three and a half years before, this work was reviewed by a team which included parents, pupils, teaching and non-teaching staff. A number of initiatives were subsequently launched at the school, including those intended to:

- deliver a structured, integrated PSHE curriculum;
- improve the building and create a safer school environment;
- upgrade sports and other facilities;
- involve professionals such as firefighters, police officers and doctors in the school;
- improve relationships between pupils;
- develop staff through training;
- reduce litter levels in and around school;
- promote healthy eating and a better environment at lunchtimes.

Getting parents and the community involved in the school was seen as a priority target for HSA work at St. Clements. The school's HSA team achieved this by putting together the need to create a welcoming atmosphere for parents, with the recognition of financial help as of particular value within the community. They therefore negotiated with the local Credit Union to establish a branch in school to help parents financially, but also to get them to come into school in the first place. This initiative has proved a great success in increasing parental involvement in the school. In 1998/9, for example, parents organised the school's first summer fair in 10 years; they began to help develop materials for the implementation of the numeracy strategy in school; and also to identify the training they need in order to broaden their roles in school. The number of applications to be parent-governors of the school has increased, and the head estimates from his own observations that parental and community involvement in the school has increased by 80%. The head teacher said '... it is about giving parents real power and responsibility ... and demonstrating that they are equal partners'. The 1998 OFSTED report acknowledged this improvement and noted that:

'one of the strengths of the school is its very effective links with the community. The school and the parents support and value each other's contributions and this aids pupils' attainment and progress'.

In relation to healthy eating, the school surveyed children about their preferences and reasons for not choosing healthy options. One successful outcome from the survey was the discovery that some children did not drink milk because it was served lukewarm; it is now refrigerated, and consumption among the pupils has increased. Other initiatives to improve eating habits include: working with parents on preparing healthy lunch boxes; replacing the set menu with five choices; and the use of a 'flight-tray'. Lunchtime organisers also now ask children to try a small amount of food that is new to them, which children are often willing to do.

Tanfield Comprehensive School, Co. Durham

In July 1999 Tanfield Comprehensive School had 662 pupils, 14% of whom are entitled to free school meals. The school has been involved in the local Healthy Schools Award (HSA) since 1996 and achieved the award in March 1998. The staff at Tanfield take a broad and balanced approach to healthy schools work and their responsibility to educate young people generally. The head teacher pointed out that:

'[Education is not] just academic achievement. Schools are doing more than this ... we are preparing young people for a life which is multi-jobbed and for a life that will have challenges'.

The targets set for the HSA related mainly to mental health and emotional well-being, since the staff consider this an issue largely neglected in school life. Courses in stress management have been undertaken by both staff and students facing external examinations. The school nurse has established drop-in sessions for pupils to talk over problems such as bullying, relationships and difficulties at home. There has also been a drug awareness night for parents.

One teacher commented that involvement in HSA has facilitated the planning process in the school at all levels, not just for health-related work. All the teachers interviewed at Tanfield stated that mental health is of key importance and that the HSA has helped address issues related to this. A parent described how the school had supported her and her children through a bereavement.

The school is involved in a number of health-related initiatives in addition to its school award, including Eco Schools and Prince's Trust work (which targets disaffected pupils). There are considerable efforts at Tanfield to ensure that links are made between initiatives, and many emphasise links with the community. There are a number of peer projects running at the school, including a scheme whereby Year 10 pupils have been trained to work with poor readers in Year 7 for a ten week period. Mentors recruited from local business people and professionals also provide special support for students who are facing examinations and have been identified as being at risk of under-achieving.

Teachers commented that since the school's involvement in HSA, there is a greater awareness of the importance of consultation with pupils. Now, a school council and a school nutrition action group are in place. The staff are currently developing a questionnaire to determine students' needs for PSHE. Year 11 students have also worked together to develop a booklet on stress management during exam times for other pupils.

One governor interviewed said Tanfield 'is a happy school', while a parent commented that 'there is a caring atmosphere here ... kids of all abilities are equally valued ... Education is not all about getting A's and B's, but about fulfilling each child's individual potential'. The school nurse said '[there is a] good philosophy of caring and the school is very receptive to visitors.'

Conclusions

The case studies presented here represent a range of schools with different needs. Clearly, local programmes are largely flexible,acknowledging diversity between schools,and have endeavoured to help schools set targets that reflect their individual concerns. In some cases,schools have concentrated their efforts on one particular issue, for example improving lunch-times at Parkside Special School,whereas others have aimed to achieve multiple goals through healthy schools work, for example through the wide range of activities undertaken at Newall Green. This acknowledgement of the differences between schools (and indeed,between programmes in different LEAs) is an important feature of much healthy schools work to date.

Interestingly, many staff and parents viewed healthy schools work primarily as an initiative to improve aspects of school life which were not directly related to academic attainment. For example,in some schools,strengthening links with the wider community and working with parents as partners is considered to be an important end-product in itself, such as in St Clements and Chapel Break schools,which have had great success in motivating and involving parents. In other schools – like Newall Green and Parkside - attendance rate improvements alongside improvements in the general atmosphere provide food for thought. Other knock-on effects of healthy schools work was also evident: Chapel Break, Newall Green and St Clements used their local programmes to radically reshape their PSHE curricula;Tanfield and Chapel Break transferred the learning from planning for healthy schools work - consulting,auditing and target-setting - to other aspects of school life. This is clearly one of the strengths of the approach,is highly valued by teachers and other staff in schools and helps to bring about whole school improvement.

Some healthy schools programmes do seek to specifically target academic achievement. This is particularly apparent in Newall Green,which included an HSA target which stated that every pupil should leave school with at least 1 A*-G grade at GCSE. Many teachers interviewed believed that healthy schools work brings about a diverse range of gains,including improved academic performance. Staff from Chapel Break, for example, reported that working within their local programme had contributed directly towards enhanced academic attainment. And staff at Chase Terrace felt that healthy schools work had impacted positively on pupils'perceptions of their own attainment. Other healthy schools initiatives – like the stress reduction classes for pupils at Tanfield during exam-time – may also impact on academic standards.

Perhaps not surprisingly, however, many schools involved in healthy schools work to date have also tended to get involved in other initiatives designed to bring about positive changes in various aspects of school life. In order to maximise the effects of healthy schools work and other initiatives, for example,those designed to improve pupils'literacy or numeracy, schools often develop integrated approaches,making it difficult to determine the extent to which improved academic attainment can be attributed to healthy schools work. Indeed,it is characteristic of healthy schools to be outward looking,and to make creative and innovative links with other priorities, resulting in added value. With effective planning, working on a number of initiatives, including healthy schools,can make a palpable change for the better in many aspects of school life.

Finally, it is important to note that healthy schools work needs to be sustained over a period of time before we can hope to see maximum benefits.The consensus among the research community — and echoed among many interviewees — is that measurable health gains from healthy schools work would be likely to appear only in the medium to longer term. Similarly, all healthy schools programmes need to be dynamic and responsive to change. Interviewees in the pilot site evaluation spoke of the need for a healthy school forum through which to share

best practice and keep up-to-date with changing priorities nationally.

Nevertheless,the schools described here feel that they have clearly benefitted from the programmes already in place. Reduced exclusions,improved attendance,better exam results, increased uptake of healthy eating choices, refurbishment of school buildings and sports facilities,improved relations between pupils and between pupils and staff – all these benefits have been attributed to successful healthy schools work by interviewees during the course of this research. Longer term evaluation will be valuable over the next decade in helping to sustain the momentum and shape the future of this important work.

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APPENDIX A: Audit Research Instruments[9]

Telephone Interview Schedule Used with Local Healthy School Scheme Contacts

1. Name and Professional role (HA/ HP/ LEA?):
2. Name of local scheme (which area HA/ LEA does the scheme cover) and who is the local co-ordinator:
3. Address:
4. Telephone/ fax/ email:
5. When was the scheme started and details of how it was set up (role of HA and LEA):
6. How is the scheme funded (HA/ LEA sources) and how many members of staff are involved?
7. How many schools (primary, secondary and special) are involved in the scheme.Is there any provision for early years (under 5's)?:
8. Details of recruitment/ publicity strategies (any focus on regeneration or schools with an identified need? What type of award?) Request any publicity material.
9. Evidence of good practice/ lessons learned etc.Is there any particular aspect of the scheme which worked well/ was successful?
10. Request any written reports, evaluations and reviews (from 1992 to present). Does not have to be independent,can be report by local scheme steering group.Would like information/ written evidence on:
    - Strategic planning and management of scheme (steering/ management group and membership of these groups).
    - Process of auditing and target setting (at both scheme and individual school level).
    - Monitoring/ self review at school and local scheme level (e.g.self, OfSTED).
    - Dissemination of learning between participating schools in the scheme.
    - Any evaluation of the local scheme (when, by whom,details of any written reports).
    - Local scheme sustainability:In the light of possible school monitoring and scheme evaluation, are targets/ objectives reviewed? Is there a policy to maintain long-term sustainability of the scheme?

Who else should be contacted?

a) Name:
b) Professional role:
c) Contact details:

12. Thank for their help,and ask can we get back for further information.

[9]At the time the research was carried out,the draft national initiative was called the National Healthy Schools Scheme (NHSS),and local programmes referred to as 'schemes'. Although for clarity this report uses the current terminology (National Healthy School Standard;local healthy school programmes),the research instruments are presented as they appeared when used.

APPENDIX B: Pilot Site Evaluation Research Instruments

Evaluation of the National Healthy School Scheme

Phase 1 interview schedule - key informants

- As you know, we are carrying out an evaluation of the pilot National Healthy School Scheme to identify the key factors contributing to the development of the scheme.
- We are speaking with a number of key people,like yourself, to gather information about the factors in each site which might help and hinder the development of successful work.
- When the findings come to be reported, we will not mention any names,although we will be reporting people's titles in a general way
- We are tape recording each interview to help us record accurately what people say.The tapes will be erased at the end of the project after data analysis has taken place.Is it OK for us to tape what we discuss?

Background and interview information

1. Information about the interview

   a. Name of interviewer

   _____

   b. Site

   _____

   c. Date

   _____

   d. Time

   _____

   e. Where interview held

   _____

2. Information about the key informant

a. Name

_____

b. Job title

_____

c. Role in relation to the pilot project

_____

d. Place of work

_____

Site activities

3. Information about site activities (on separate sheet)

In the course of this interview, we are particularly interested in these issues *(read these from the list for each site; indicate that we are especially interested in these activities, even though there is other work going on in the site which it may also be interesting to talk about)*

Local assessment and planning

4. Could you describe what national or local evidence was used to decide upon this set of activities?

Working together

5. We are particularly interested in the sorts of 'partnerships'which have been set up. Could you say who the key people are who are working with you *(information about roles/ job titles)?*

Prompts:
i. How schools have been brought on board, or their involvement continued
ii. With private sector
iii. Across sites
iv. (Note if interviewees mention young people unprompted, if not, then prompt)

6. We are interested in how people work best together. Could you give us one or two examples of things which have actually helped you work together in (name of place)?

Prompts:
i. local *factors/support,*
(1) history of working together
(2) resources (financial/human/time)
(3) shared understanding of health education/promotion
(4) training
(5) key individuals/leadership
(6) other

Prompts:
ii. national *factors/support,*
(1) history of working together
(2) resources (financial/human/time)
(3) shared understanding of health education and health promotion
(4) training
(5) key individuals/leadership
(6) other

7. We're also interested in the factors which hinder people from working well together. Could you give us one or two examples of things which have hindered you from working well together?

Prompts:
i. local *factors/lack of support,*
(1) no history of working together
(2) lack of resources (financial/human/time)
(3) lack of shared understanding of health education/promotion
(4) training
(5) no key individuals/no leadership
(6) other

Prompts:
ii. national *factors/lack of support,*
(1) no history of working together
(2) lack of resources
(3) lack of shared understanding of health education/promotion
(4) training
(5) no key individuals/no leadership
(6) other

Relationship of activities to national, local and school priorities

8. Thinking again about your local activities, in what ways do you see them relating to national priorities for education and health?

9. How do your activities relate to local needs for education and health?

10.In what ways do you hope these activities will fit with priorities in schools?

Intended outcomes

11. What differences do you hope you will see in six months time among the schools involved in the local work?

Prompt:(after initial thoughts):
i. Pupils in schools
ii. People in local community (such as parents and governors)
iii. Professionals working in health and education

Monitoring and evaluation

12. Thinking about the changes you have just talked about,how will you know that changes have come about? In other words,what evidence will you collect to identify any changes?

Sustaining the work

13.How are you planning to carry on the healthy schools work after this initial funding period?

Prompts:
(1) what sorts of activities are you doing to make sure this happens?
(2) what national support in relation to the national healthy schools scheme would be helpful?

Relevant documentation

14. Are there any written plans or other documents you could pass to us?

Prompts:

(1) ☐ evaluation reports

(2) ☐ publicity about the work

(3) ☐ mission/value statements

(4) ☐ any aims,objectives,and other information over and above that contained in the spending plan

(5) ☐ conference reports

(6) ☐ minutes of meetings

15. Are there any potential interviewees you think it would be useful for us to speak with when we carry out further interviews early in the New Year?

- Feed-back about the evaluation

– Formally through briefing meeting on 19 January
– Informally through contact with the Scheme Co-ordinator or Evaluation Co-ordinator

Evaluation of the National Healthy School Scheme

Phase 2 interview schedule - key professionals

Information about the interview

- Name of interviewer

_____

- Site

_____

- Date

_____

- Time

_____

- Where interview held

_____

Lessons learned

- We are in now in the process of writing the draft of the final report of the Pilot National Healthy School Scheme.This is an opportunity for you to contribute something about what has been learned in <name of place> about the pilot healthy schools scheme.

- First of all,I'd like to ask a few questions about the lessons you have learned from taking part in the healthy schools scheme.Could I ask you a few specific things first?

- In terms of specific areas,are there any particular lessons you have learned in relation to:
  - Gathering information about local needs and priorities
  - Setting strategic targets
  - Recruiting schools/being recruited into the scheme

– Getting good value for the money which has been put into the scheme?
– Monitoring and evaluation

- Returning to evaluation for the moment what,in principle,do you see as realistic health and education related outcomes for a healthy schools scheme by the end of year 1 and year 5?
  – *Work through the table (on separate sheet) with respondents*

- Could you say how the local scheme has given/will give guidance and support to local schools?

As you know, one of the areas we are most interested in is about how people have,or have not, worked well together

– First of all,could I ask whether representatives of these groups have been involved in the local scheme

- ☐ social services
- ☐ youth services
- ☐ voluntary agencies
- ☐ education welfare officers
- ☐ school nurses
- ☐ educational psychologists
- ☐ health visitors
- ☐ governors
- ☐ parents
- ☐ young people
- ☐ people from Black and minority ethnic communities

Could you say one or two things about how you have worked together given that those involved in the scheme have different professional priorities?
– Example of problems
– Example of successes
– (prompt)

- If not mentioned,prompt on the importance or otherwise of key individuals taking a lead

Regional identities

Do you think that carrying out the work in <name of place>,as opposed to anywhere else,has influenced the character of what has been done?

Criteria and development

The national healthy schools scheme might,among other things,consist of a set of criteria for approving local schemes.What do you think these criteria should include?
– If examples are needed:
- Criteria relating to young people's involvement
- Criteria relating to having a representative Steering Group
- Criteria relating to recognising the achievements of schools

- Once a school has reached a recognised standard,how have you made sure (how will you make sure) that schools maintain and build on that success?

Networking and support

- A number of people involved in healthy schools schemes across the country have talked about the importance of learning from others involved in similar work.
  – Is this something that you yourself see as important
  – If so,
    - What sorts of activities would you yourself find helpful in order to learn from and support others?

- Once the National Scheme is launched,what sorts of guidance and support would you find helpful from those who work at the national level?

Thanks and end of interview

Anticipated Outcomes

	Examples of outcomes	Examples of evidence to collect about outcomes
By the end of year 1		
By the end of year 5		

Evaluation of the National Healthy School Scheme

Phase 2 interview schedule - parents, governors and young people

Information about the interview

- Name of interviewer

_____

- Site

_____

- Date

_____

- Time

_____

- Where interview held

_____

Preamble

- As you know, we are carrying out an evaluation of the National Healthy School Scheme to identify the key factors which contribute to the successes of, and difficulties associated with,the work you have been doing
- In November and December of last year, we carried out a series of interviews with people in <name of place> about their initial thoughts about the scheme
- We are now following up on that earlier work and are speaking with a number of other people,like yourself, about their views on 'healthy schools'
- When the findings come to be reported, we will not mention any names,although we will be reporting people's titles in a general way
- We are tape recording each interview to help us record accurately what people say.The tapes will be erased at the end of the project after data analysis has taken place. Is it OK to tape what we discuss?

4 *Could I just check some information with you?*

1. Information about the key informant *(state that this information is for our use only so that we can re-interview them at a later date.It will not be used when findings come to be reported).*

2. ☐ Parent

   a. ☐ Number of parents interviewed

3. ☐ Young people

   a. ☐ Number of pupils interviewed

   b. ☐ Year group of pupils

   c. Gender of pupils

      i. ☐ Numbers of females

      ii. ☐ Numbers of males

4. Governor(s)

   a. ☐ Numbers of governors interviewed

Main body

- If you were to describe a healthy school to another person,what sort of things would you point out to them?
- What sort of things would be happening to make you yourself feel you were really a part of a healthy school? / involved in a healthy school?
- What topics and issues would be addressed by those in the school to make the place feel healthy?
- In what sorts of personal ways might you benefit from being part of a healthy school?

APPENDIX C: Follow-up Study Research Instruments

Healthy Schools Evaluation – Phase 3

1. Background

Tell me about the scheme in [name of place]. What form has the scheme taken locally?
Does the scheme have key targets? What are they?
Which parts of the scheme have been adopted by the school?
When did you start the healthy schools work here?
Is the work ongoing?
Have you been given any kind of award or other recognition by the scheme for the work you've done?
Which professionals have come into the school to support the scheme that hadn't come in previously?

2. Basic Information

It's important that we have some basic information about your school:

Numbers on school roll.
Numbers on special needs register
Numbers of children/young people statemented
Numbers of free school meals
How long the head teacher has been in place
The ethnic mix of the school
The number of families in school
Attendance rates

3. Other information

We'd also like some information about how the school operates and what it achieves:

OFSTED reports
Action plans/School Development Plans/School Management Plans
SATs results (before,during and after scheme)
Policy documents
Literacy and numeracy strategies

4. Healthy Schools matrix

Relationships	Environment/facilities
• Decrease in bullying (physical attacks, name-calling, harassment, intimidation) • Increased community participation in school • Evidence of parents working as partners – e.g. increasing numbers at parents evenings • New professionals coming into schools • Improved relationships between staff and pupils • Improved relationships between staff • Improved relationships between pupils • Common understandings between young people and others of what a 'healthy school' means. Evidence of a shared commitment to healthy schools ethos. • Successful work to reduce effects of social exclusion in schools (e.g. in terms of poverty, sexuality, race, gender)	• Walking/cycling to school schemes • Availability of excellent sports facilities/playing fields • Introduction of breakfast clubs • Improved school meals (price, choice, quality, healthy options) • Improved snack facilities (tuckshops, vending machines – again in choice, cost, health, quality terms) • Improved physical environment e.g. school grounds, school toilets, classrooms, corridors • More/improved after-school clubs/extra-curricular activities • Less litter around the school • Presence of recycling schemes as part of healthy schools work
Teaching and learning (compulsory)	**Organisation and management**
• Improved exam results overall • Improved SATs • PSHE successfully integrated into the curriculum • Successful use of the community as a resource for teaching and learning • Wider range of teaching and learning strategies	• More effective action planning • Better pupil attendance rates • Improved punctuality rates • Reduced number of school exclusions • Reduced staff sickness • Reduced staff turnover • Improved behaviour management • Presence of policies on bullying, which include homophobia and racism • Successful implementation, monitoring and evaluation of policies • Young people now active in school decision making – e.g. school councils, central involvement in healthy schools work • Opportunities for staff training and development on healthy schools work

APPENDIX D: Audit Data Sources

The following local programmes were consulted as part of the audit,including those involved in the NHSS pilot site evaluation (marked as such).Notations such as 'No Programme'or 'In Planning'indicate the status of an official local programme at the time of the audit.

EAST REGION

Cambridgeshire & Peterborough - Cambridgeshire & Peterborough Health Promoting Schools Initiative
Essex - Essex Association of Health Promoting Schools
Lincolnshire - Lincolnshire Healthy Schools Award
Norfolk (NHSS Pilot Site) - Healthy Norfolk Schools Award
Southend-on-Sea (In Planning)
Suffolk - Suffolk Healthy Schools Initiative
Thurrock (In Planning)

HOME COUNTIES

Berkshire - Berkshire Healthy Schools Award
Buckinghamshire (No Programme)
Hertfordshire - Hertfordshire Health Promoting School Award
Luton & Bedfordshire - Healthy Schools Award (Health Promoting Schools In Luton & Bedfordshire)
Milton Keynes (No Programme)
Northamptonshire - Northamptonshire Healthy Schools Award
Oxfordshire (In Planning)
Surrey - Surrey Health Promoting Schools Award

LONDON REGION

Barnet - Barnet Health Promoting Schools Initiative
Barking,Dagenham & Havering (In Planning)
Bexley - Bexley Healthy School Award
Brent & Harrow (In Planning)
Bromley - Bromley Health Promoting Schools Award
Camden (Joint Programme with Islington)
Croydon - Croydon Healthy Schools Network
Ealing (In Planning)
Greenwich (In Planning)
Enfield & Haringey (In Planning)
Hammersmith & Fulham - Health Promoting Schools Project
Hounslow (NHSS Pilot Site)
Hillingdon (No Programme)
Islington - Joint Programme with Camden
Kensington,Chelsea & City of Westminster - Kensington,Chelsea & Westminster Healthy Schools Award
Kingston & Richmond - Health Promoting Schools
Lewisham,Lambeth & Southwark - Healthier School Partnership Project
Merton & Sutton (In Planning)
Redbridge & Waltham Forest (No Programme)

Tower Hamlets - Health Promoting Schools
Wandsworth - Wandsworth/ Tacade Health Promoting Schools Project

MIDLANDS REGION

Birmingham
Coventry - Coventry Healthy Schools Award (In Abeyance)
Derbyshire - Health Promoting Schools Award
Dudley - Dudley Healthy Schools Award
Herefordshire - Herefordshire Healthy Schools Award
Leicestershire - Healthy Schools Award
Nottinghamshire (Nottingham & North Nottinghamshire) (In Planning)
Sandwell (No Programme)
Shropshire (No Programme)
Solihull - Healthier School Community
Staffordshire & The City of Stoke-on-Trent (NHSS Pilot Site) - Staffordshire Health Promoting Schools Award Scheme
Walsall - Walsall Healthy School Award
Warwickshire
Wolverhampton (In Abeyance)
Worcester - Worcester Healthy School Scheme

NORTH REGION

Cumbria (No Programme)
Durham & Darlington (NHSS Pilot Site)
Gateshead & South Tyneside - Healthy School Award
Newcastle Upon Tyne & North Tyneside - Newcastle & North Tyneside Healthy School Award
Northumberland (No Programme)
Sunderland - Healthy School Award
Tees & District - Healthy School Award

NORTH WEST REGION

Bolton (In Planning)
Bury (In Abeyance)
Central & East Cheshire - Health Promoting Schools Project
Chester (No Programme)
Knowsley (In Abeyance)
Lancashire
East Lancashire (No Programme)
Morecombe Bay - Partners In Health
North West Lancashire (No Programme)
South Lancashire - Health Promoting Schools Award
Liverpool - Liverpool Healthy Schools Award
Manchester (NHSS Pilot Site) - Manchester Healthy Schools Award
Oldham - Healthy School Award
Rochdale - Healthy School Award
Salford & Trafford - Salford & Trafford Healthy Schools Scheme
Sefton (No Programme)
St. Helens (No Programme)
Stockport (In Abeyance)

Tameside - Healthy School Award
Warrington & Halton - Health Promoting Schools
Wigan - Health Promoting Schools & City Challenge
Wirral - Wirral Health Promoting Schools

SOUTH REGION

East Kent - The Health Promoting Schools Award
East Sussex (In Planning)
Hampshire - Healthy Schools Award
North Kent (Thames Gateway NHS Trust) (No Programme)
West Kent (In Planning)
West Sussex (NHSS Pilot Site)

SOUTH WEST REGION

Avon - Schools for Health Project
Cornwall (NHSS Pilot Site)
Devon North & East – Healthy School Award
Devon South & West
Dorset - Dorset Health Promoting Schools
Gloucestershire - Gloucestershire Healthy Schools Award
Somerset - Health Promoting Schools & Colleges
Wiltshire - Wiltshire & Swindon Healthy Schools Award

YORKSHIRE & LINCOLNSHIRE REGION

Barnsley - Health Promoting Schools
Bradford - Bradford Schools Health Promotion Award
Calderdale - Calderdale Healthy School Scheme
Doncaster (NHSS Pilot Site)
East Yorkshire,North & North East Lincolnshire - The Health Promoting School Award Scheme
Kirklees - Kirklees Healthy Schools Award
Leeds (No Programme)
North Yorkshire
Rotherham (Pilot Project)
Sheffield (No Programme)
Wakefield (No Programme)
Tanfield Comprehensive School,Stanley, Co.Durham