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Working Paper 138: Review of the Welsh Network of Healthy School Schemes, 2007-2008 Final Report, March 2009

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Athrofa y Gymdeithas, Iechyd a Moeseg Caerdydd

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1. Executive Summary

"We came to the conclusion a long time ago that the only way to raise academic achievement . . . is to try to work . . . with the whole pupil and the whole family and the whole community" (Headteacher)

1.1 Background

Since the Ottawa Charter affirmed that health was a "resource for everyday life" its concept of "supportive environments" for health promotion has been developed through the "settings" approach. The school is one setting where the relationship between individuals and their environment influences the maintenance and improvement of health more profoundly than health services.   The 'Healthy School' is one which takes responsibility for maintaining and promoting the health of all who "learn, work, play and love" within it not only by formally teaching pupils about how to lead healthy lives but by enabling pupils and staff to take control over aspects of the school environment which influence their health.

THE WELSH NETWORK OF HEALTHY SCHOOL SCHEMES (WNHSS)

The WNHSS consists of twenty-two local healthy school schemes, one in each unitary authority of Wales. The Welsh Assembly Government provides a framework for local schemes and funding for schemes which are partnerships between local Education and Health departments. Each scheme employs a healthy schools co-ordinator who recruits and supports schools and organises appropriate local training. Schools appoint their own in-school co-ordinators who work with the healthy schools co-ordinator to plan and carry out activities identified by the school. Schools are expected to introduce health improvement topics into three domains: the curriculum; the school's ethos and material environment; and relations with individuals and groups outside the school.

As schools progress through the scheme, health-improvement measures are expected to make a lasting difference to the way in which school life is organised. A logic model drafted by the Welsh Assembly Government outlines these and other outcomes expected in the short, medium and long term (Figure 1).

A Welsh Assembly Government official acts as a national co-ordinator with responsibility for monitoring and accrediting local schemes and training local healthy schools co-ordinators. All schemes assess their member schools and recognise those which are successful in completing each phase.

The WNHSS is a member of the Schools for Health in Europe (SHE) network, formerly the European Network of Health Promoting Schools, and the national co-ordinator for Wales is also the UK Co-ordinator for SHE.

1.2 The Review of WNHSS

The review used an embedded single-case study approach, aiming to assess the extent to which the WNHSS conformed to the Ottawa Charter's agenda for advocacy, equity and mediation and whether a social-ecological approach to health had been understood and implemented. The review also aimed to identify conditions associated with greater conformity to the social-ecological model; and to make recommendations for building on the strengths of the network.

Methods used in the research included a review of documentation at national level; interviews with all healthy schools co-ordinators; and a consultation questionnaire of stakeholders in all healthy schools in Wales. Case studies of six local schemes were carried out, including case studies of schools within the schemes. The case studies used observation, interviews, focus groups, and documentation review. A further set of interviews were carried out with international experts in school-based health promotion to place the Welsh scheme in an international context.

The Ottawa Charter provided the theoretical framework for "pattern matching" as the approach to analysis within the single-case study design. Findings were compared with what would be expected if WNHSS practice conformed wholly to the Ottawa Charter. In addition, findings were aligned with the expected short-term outcomes outlined in the logic model drafted by the Welsh Assembly Government.

The study benefited from review at key stages by a panel of UK experts on healthy schools (Appendix 1). Findings from interviews with healthy schools co-ordinators and the review of documentation at national level were presented at three regional stakeholder workshops in Mid and West Wales, North Wales and South East Wales, where the Expert Panel led discussion groups and discussed key topics. Data from the workshops were used alongside other data collected in the Review.

1.3 Key results:

1. The Welsh Assembly Government's Framework for Local healthy school schemes has provided clear and useful guidance which has contributed significantly to the smooth development of the Network. All schemes operate within the framework and adopt aims consistent with it. This means that the WNHSS as a whole is implementing European and ultimately Ottawa Charter principles of health promotion. The WNHSS compares favourably with school-based health promotion in other countries.

2. The logic model actions and outcomes of the WNHSS (Section 2) have been achieved or exceeded in the short term, testifying to a high standard of planning and administration. Before the end of the Review, more than 85% of schools had joined their local schemes.

3. There is effective partnership working at national level. The Health Improvement Division works jointly with Education Divisions and is developing links with other Departments. This level of partnership working is probably unique to Wales.

4. The WNHSS is widely respected as a Welsh Assembly Government scheme and the authority of the Welsh Assembly Government facilitates acceptance of healthy schools within local government partnerships and schools.

5. The WNHSS has inspired and facilitated the production and distribution of a large number of supportive materials for schools. The Welsh Assembly Government's role in providing resources for schemes to introduce into schools with training is important and useful for local healthy schools co-ordinators.

6. The network structure of the WNHSS has developed well over time and looks likely to prove adaptable and resilient to change without losing consistency of approach.

7. The power of the WNHSS to address inequalities in health varies at national, local and school level. Differences in local circumstances have led to inequalities between schemes in terms of their capacity to support schools.

8. Overall, schools had made significant progress in promoting health. However, standards required by local schemes were not always consistent across schools in the same scheme. There was also inconsistency of standards and assessment procedures across local schemes.

9. Health promotion is well integrated into many schools. In some, however, teachers perceive a conflict between their duty to deliver the curriculum and a commitment to health promotion.

1.4 Key recommendations:

o The role of the WNHSS in relation to inequalities in health needs to be urgently reviewed and addressed.

o It is suggested that a practical strategy statement is required to clarify the expectations of the role of the education service across Wales in relation to reducing inequalities in health.

o It is recommended that the Welsh Assembly Government continue to fund employment of healthy schools co-ordinators to provide at least current levels of support until 75% of schools can demonstrate that a specified minimum level of participation is contributing to health-improvement actions. It is suggested that schools should be able to demonstrate as a minimum that teaching staff, support staff and pupils contribute to and are fully informed about decisions on whole-school health improvement.

o Consideration should be given to funding full time national co-ordination of the WNHSS. This would help to meet the need for: a higher level of training to support the programme; expanding the programme to a wider group of schools; consultation with stakeholders on the further development of monitoring and evaluation systems.

o The integration of the WNHSS into health policy in Wales needs to be balanced by a similar level of integration into education policy.

o It is suggested that the Welsh Assembly Government explore strategies for securing more consistent support for schemes from senior local authority staff.

o Consideration needs to be given to ways in which schemes can support schools to secure the active participation of a larger number of groups (e.g. teachers, pupils, support staff, governors, parents) in determining and achieving the school's health promotion goals.

o Priority should be given in training and communications to increasing understanding of the interdependence of the educational excellence role of schools and the health promotion role.

o Consideration should be given to setting up a forum with the national co-ordinator, representatives of local co-ordinators, headteachers, teachers, advisers, Estyn and health promotion specialists to produce a consultation document on the future monitoring and assessment of the WNHSS.

A complete list of recommendations is given in section 10, pp 136-141.

2. Summary of achievements of the WNHSS so far and the extent to which expected outcomes have been achieved

The Welsh Assembly Government has drafted a logic model of the WNHSS (Figure 1) outlining the actions to be taken and the outcomes they were expected to produce in the short, intermediate and long term stages of the programme. The logic model was produced following a brainstorming process within the Welsh Assembly Government and consultation with two healthy schools co-ordinators and two members of the Schools for Health in Europe (SHE) group. The logic model is included in guidance to local schemes and has been presented at European meetings. Within the Welsh Assembly Government, civil servants use it to examine outcomes reported by healthy schools co-ordinators and to remind national and local decision makers that it is unrealistic to expect immediate health outcomes.

The Intermediate stage of the WNHSS began a year before the Review and it is clear that some intermediate and even long-term outcomes are already being achieved. For example, the Intermediate outcome target for three-quarters of schools to be involved by March 2008 has been exceeded and some schemes already include nursery schools (a long-term outcome). This section uses the headings of the logic model to summarise which activities and short-term outcomes the WNHSS has so far achieved, and suggests areas for improvement.

2.1 Activities

Links with local strategy development, development of effective partnerships, setting up of local schemes and production of supportive materials are shown in the logic model as leading to other actions and to the short-term outcomes of the WNHSS. Development of effective relationships with schools and provision of training continue through to the short-term outcomes. Evidence from the Review suggests that with the exception of the establishment of local schemes, these actions are not finite but in a constant state of growth and adaptation. The logic model indicates some of this complexity by the arrows linking the boxes but the actions were still being developed at the beginning of the Intermediate stage when the Review was carried out, and can be expected to carry right through into the long term.

FIGURE 1: DRAFT LOGIC MODEL OF EXPECTED OUTCOMES/OUTPUTS/IMPACT OF IMPLEMENTATION OF WNHSS SCHEME

History	Activities	Short-term (0-5 years)	Intermediate (6-10 years)	Long-term (10+ years)

ENHPS

Early pilot work

Links with local strategy development

L ½ Schools involved by March 2006

L ¾ schools involved by March 2008 All by March 2010

L Extension of scheme to e.g. nurseries, FE colleges

LS Increase in expertise in field to support scheme

LS Sustainable health actions

Effective partnerships develop national/local

LS Increased acknowledgement of health & education benefits by teachers & pupils

Reduction in health inequalities

Setting up WNHSS

Local schemes set up using national framework

S Expectations changed eg Water on desks fruit tuck shops self esteem

S Increased expectations in more schools Pupil benefits (HBSC) Teacher benefits School environment changes (Database)

Reduction in costs to health service of behaviour-related illness (food, fitness, tobacco)

Effective relationships developed with schools

S Health embedded in thinking of school

Supportive materials produced

LS Links to other programmes - PESS - Eco Schools - School Council -BSF -TSN

Changes in health behaviour (HBSC)

L Co-ordination of work at national, local & school level

Links to non-school programmes

Key:
L – effect will be seen at local level
S – effect will be seen at school level

LS Variable levels of commitment

Parents influenced

Training provided

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2.1.1 LINKS WITH LOCAL STRATEGY DEVELOPMENT

Achievements

Growth of links with local strategy development has been gradual and schemes are at different stages. Strong links have been developed in some areas, for instance where the healthy schools co-ordinator is a member of local strategic planning groups. In areas where the healthy school scheme has most effective links with local strategy development, there is a two-way influence, with healthy schools co-ordinators linking the aims of their schemes to achieving local policy outcomes as well as local policies recognising the role of the local scheme.

Areas for improvement

In some areas the healthy school scheme is not mentioned in the local Health, Social Care and Well Being strategies or in the Single Education Plan and the healthy schools co-ordinator may have little access to senior managers.

2.1.2 EFFECTIVE PARTNERSHIPS DEVELOP NATIONAL/LOCAL

Achievements

At national level, the WNHSS national co-ordinator has been answerable to the Minister for Health and Social Services and to the Minister for Education and Lifelong Learning. The Health Improvement Division works jointly with Education Divisions and is developing links with other Departments. Effective partnerships have been developed between the Welsh Assembly Government and healthy schools co-ordinators. At local level, healthy schools co-ordinators have developed effective partnerships with others working directly with schools; and heads of local Education and Health departments have co-operated to secure the grant funding for healthy school schemes. There are also very effective regional networks of healthy schools co-ordinators, who combine to share ideas, carry out assessments and offer training for schools.

Areas for improvement

Apart from contact involved in securing grants, no evidence was found that partnerships had been developed in relation to the WNHSS between the Welsh Assembly Government and local authority heads of Education and Health departments. The degree to which local Health and Education departments work in partnership at a more strategic level varies between schemes and in one area appeared to be in difficulty. There was little evidence of extension of senior partnership working to departments other than Education and Health except through strategic partnerships such as the Children and Young People's Partnership Groups, which may not include Environmental Health, Transport or Planning officers.

2.1.3 LOCAL SCHEMES SET UP USING NATIONAL FRAMEWORK

All twenty-two counties in Wales have set up local healthy school schemes which have fulfilled their role as set out in the national framework, e.g. in appointing local healthy schools co-ordinators; ensuring that each school has an in-school co-ordinator; and adopting aims in line with those in the national framework.

2.1.4 EFFECTIVE RELATIONSHIPS DEVELOPED WITH SCHOOLS

Achievements

Healthy schools co-ordinators have developed effective relationships with headteachers and in-school co-ordinators and most now work with school clusters to facilitate communication and dissemination. Local procedures and requirements have been adapted to meet the needs of schools e.g. by reducing paperwork and extending time allowed for completing Phases.

Many healthy schools co-ordinators have reported involvement of school councils and school governors in school assessment procedures.

Areas for improvement

Headteachers and in-school co-ordinators in some schools do not succeed in involving all stakeholders in healthy schools actions and thus relationships between healthy schools co-ordinators and these staff members do not necessarily equate to relationships with whole schools. In some schools, difficulties in gaining the support of members of the senior management team have reduced achievement. However, many healthy schools co-ordinators reported involvement of school councils and school governors in school assessment procedures.

Healthy schools co-ordinators, headteachers and in-school co-ordinators all acknowledged a difficulty in involving parents. Responses to the stakeholder consultation suggested that chairs of parent-teacher associations and parent governors had been less involved than other groups in healthy schools actions, with 19% of parent governors and 20% of PTA chairs who responded saying that before receiving the questionnaire they had not been aware their schools were members of local healthy school schemes. Response to the stakeholder consultation also suggested that support staff were not included in schools' work – for example, approximately 24% of questionnaires posted were not passed on to the members of support staff to whom they were addressed. Secondary schools may have difficulty in getting a majority of teachers involved - in one secondary school, all decisions about health improvement had been taken by the headteacher, the in-school co-ordinator and the CDT teacher.

2.1.5 SUPPORTIVE MATERIALS PRODUCED

Achievements

There was evidence that schools were using a range of supportive materials produced at national and local level in Wales and also from outside Wales. The Welsh Assembly Government has produced materials giving guidance and examples on how to assess, plan and carry out actions in schools, e.g. *In Perspective* (The National Assembly for Wales 2001b) and on specific topics, such as *Smoke Signals* (Welsh Assembly Government 2002a). Some schemes have produced their own resources for schools e.g. on food and drink; and also use resources developed in England by the public sector e.g. *Apause* (Health Behaviour Group 2006) and by private companies e.g. *Health Matters* (Health Matters Education 2007). There are websites for some schemes providing e.g. information about the scheme, templates for action plans and electronic resources for teachers to download. At least one scheme provides model health policies for schools to adapt. Some schemes have a vetting system for resources they recommend to schools, and offer schools training to accompany new resources.

Areas for improvement

The only gap identified by participants was by some healthy schools co-ordinators, who wanted the Welsh Assembly Government to set up a national healthy schools website to facilitate communication and sharing ideas and resources between healthy schools co-ordinators. However in view of the evidence regarding difficulties in involving some groups of stakeholders, there may be a need for more resources on developing skills and strategies for increasing participation.

2.1.6 TRAINING PROVIDED

Achievements

At national level, the Welsh Assembly Government provides training for newly appointed healthy schools co-ordinators and school assessors and facilitates regular training events for healthy schools co-ordinators, who organise the content as members of regional groups. Healthy schools co-ordinators organise and deliver training for school staff. Healthy schools co-ordinators were very satisfied with the quality of training they received and there was little evidence of dissatisfaction among school staff with the training provided by local schemes. There was also evidence that more than one staff member from each school had received training, thus contributing more effectively to the formation of a critical mass within schools: 62% of headteacher and in-school co-ordinator respondents who had received training through their local scheme reported that one or more others from their schools had also received training during the previous twelve months.

Areas for improvement

Some evidence suggested that not all healthy schools co-ordinators have skills which enable them to approach schools' training systematically and efficiently. For example, one healthy schools co-ordinator had tried to deliver all the training in person and another was not working with school clusters. There may be an argument for covering strategies for school training provision as part of the training for newly appointed co-ordinators, and for more sharing of good practice on management skills between schemes. At present much training for healthy schools co-ordinators is focused on the training support they provide for schools to accompany resources on specific topics or programmes such as Circle Time, with little emphasis on skills development for co-ordinators themselves.

Monitoring reports returned to the Assembly Government up to March 2006 have not enabled an accurate overview of the type and amount of training provided by local schemes for school stakeholders and have not requested information relating to the local co-ordinators' own training.

2.2 Outcomes

2.2.1 ½ SCHOOLS INVOLVED BY MARCH 2006

Achievements
Throughout Wales as a whole, more than half of all schools were involved in local healthy school schemes by March 2006.

Areas for improvement
 In March 2006, three schemes had recruited fewer than half of local schools.

2.2.2 INCREASE IN EXPERTISE IN FIELD TO SUPPORT SCHEME

Achievements

Expertise in partnership working appears to have increased between healthy schools Co-ordinators and workers for other programmes dealing directly with schools. In most areas they have combined to reduce work for schools by dovetailing support and sharing ideas. Many healthy schools Co-ordinators have increased their management expertise during the course of a significant change from working as the only co-ordinator supporting relatively few schools, to working as part of a team, often in a more senior position, with many more schools to support.

One way of increasing expertise is through training. Thirty-nine per cent of school stakeholders who returned questionnaires said that they had received training through the local healthy school scheme. Otherwise it has been difficult to ascertain how much training, and of what type, has been delivered to healthy schools Co-ordinators, school assessors, and school staff and stakeholders (please see section on training above). Training for school catering staff was being delivered in some areas as a result of the Welsh Assembly Government's Appetite for Life initiative, with a direct effect on the quality of school meals.

During visits to some schools, the expertise of staff was evident in a whole range of school practices around healthy food and physical activity as well as the PSE curriculum. However it was not clear how much this had increased following the school's membership of the healthy school scheme and certainly in some schools (PS1, S1) a degree of staff expertise pre-dated involvement with the scheme.

Areas for improvement

Some Co-ordinators have received more support than others from local employers in adapting to changes in their role and this could suggest weaknesses in some local Education or Health department management structures where schemes have not adapted easily.

2.2.3 INCREASED ACKNOWLEDGEMENT OF HEALTH & EDUCATION BENEFITS BY TEACHERS & PUPILS

Teachers and pupils did not say whether their awareness and acknowledgement of benefits had increased over time and it is not possible to report whether acknowledgement of benefits has *increased* without being able to compare data with an earlier estimate of this outcome. Therefore this section states what was acknowledged and suggests areas where teachers and pupils might be made more aware of and likely to acknowledge, benefits.

Forty-five percent of headteachers and in-school co-ordinators who took part in the stakeholder consultation thought one of the three most important specific areas influenced by the healthy school scheme was a reduction in the unhealthy behaviour of pupils. This was also one of their top three reasons for joining the healthy school scheme, suggesting that their expectations of the scheme in this respect have been fulfilled. Most pupils who took part in the stakeholder consultation, focus groups and school council meetings also demonstrated an awareness of the benefits of a healthy school on their health, for example in saying that new play equipment helped them to keep fit.

Some educational benefits to schools at an organisational level were acknowledged, with 13% of headteachers and in-school co-ordinators thinking one of the three most important influences was that the scheme had contributed to school effectiveness and 7% that it had helped the school to meet inspection standards. Only 6% thought that one of the three main influences of the scheme had been to increase the educational attainment of individual pupils. However, headteachers who took part in case studies reported that health-improvement measures had helped them to reduce pupils' behavioural problems which were interfering with learning. Seventeen per cent of teaching staff respondents thought an improvement in pupils' general behaviour was one of the three most important areas influenced by the scheme and this could be interpreted as an indirect acknowledgement of an education benefit. However there was some doubt about whether this could be considered to lead to educational benefits in terms of, for example, examination passes or even basic literacy *"because what really matters is the person, which is a much, much bigger picture".* (PS11) Two primary headteachers whose schools demonstrated very successful integration of health improvement pointed out that flexibility and confidence were required to use the curriculum as a tool for health promotion. In secondary schools there appeared to be even more difficulty in introducing health-improvement changes while meeting the demands of a crowded curriculum. Moreover, teachers were aware that an individual's level of educational attainment is a determinant of health and felt a duty to prioritise academic achievement.

The value of healthy schools as a way of improving pupils' general behaviour, and the importance of a good standard of behaviour as a foundation of learning have not yet been articulated clearly at national and local level as one of the educational advantages of the WNHSS. Some healthy schools co-ordinators told schools about evidence of a link between health and academic achievement but none reported talking about improvement in behaviour as a mediator of educational attainment. Responses from school councils to the stakeholder consultation suggest that bad behaviour is a matter of concern for pupils as well as teachers, for example:

"Sometimes people get unhappy [because] they are being bullied" (PSC029)

The potential of healthy schools to address such problems is likely to motivate both teachers and pupils.

Recommendation 25:	There appears to be a perceived conflict between the educational excellence role of schools and the health promotion role. This should be addressed as a priority in future training and communications as there is research evidence that there is no such conflict and that the two roles are intertwined and are mutually supportive of each other.

As well as teachers and pupils, governors, support staff and chairs of parent-teacher associations who responded to the stakeholder consultation acknowledged health and education benefits but their perceptions have not been included as outcomes in the logic model.

2.2.4 EXPECTATIONS CHANGED E.G. WATER ON DESKS; FRUIT TUCK SHOPS; SELF ESTEEM

Achievements

Water on desks was acknowledged by many participants as something that had not previously been allowed but was now accepted. During visits to schools, fruit tuck shops, toothbrushes in the classroom, and play equipment were pointed out to the review team as improvements made since joining the healthy school scheme which the pupils had now come to expect as part of the school day. For example, one headteacher said that when their usual teacher was on leave, children had reminded the supply teacher that they had to brush their teeth (PS41).

There was evidence that some stakeholders thought that high self-esteem was important in a healthy school and, during visits to schools, that many pupils and teachers had high self-esteem. It is more difficult to say whether expectations regarding self-esteem had *changed*. However, 32% of headteachers and in-school co-ordinators, and 45% of Directors of Education who took part in the stakeholder consultation thought that "high self-esteem of staff and pupils" was one of the three most important features of a healthy school. Changes in expectations may be inferred from the introduction in many schools of measures to improve emotional health, such as "buddy stops" in playgrounds and Circle Time; and what one school governor called the *"fringe side"* of increased participation of pupils through running fruit tuck shops:

> *"The tuck shop, it has given them something to constructively do, and the fact that it is a healthy thing is an absolute bonus to it. But it has given the children a positive sort of business to run, as they have to go round the offices and staff. They learn to communicate with them in a polite way, and this is a fringe side of it all and a very positive one for these children."* (S18)

There was other evidence from case studies that children in healthy schools were confident and communicative.   For example, in one school a pupil who was severely deaf initiated a conversation with a member of the review team during playtime (PS4).

There was some evidence from a special school to suggest a change in expectations regarding the self-esteem and more general health of school staff. The in-school co-ordinator said that going on a training course had been good for the self-esteem of classroom assistants and learning support staff (S12). At this school the headteacher thought pupils' health and staff health were both important:

> *"I want my pupils to feel good and to enjoy life and I want my staff to feel good – to feel empowered and feel good and enjoy life."* (PS51)

Staff at the school were offered therapy sessions to reduce stress; and there was a big emphasis on physical activity for both staff and pupils as the basis for good mental health.

Areas for improvement

Other evidence suggests that this school is exceptional. Support staff were less likely to be included in training (PS11) and slightly more likely than other groups to report negative effects on their work as a result of healthy schools. Effects on school staff

in general were among the least likely to be chosen by stakeholder respondents as reasons for joining the scheme, or as the most important features or benefits of healthy schools. The high prevalence of stress-related illness among teachers was raised as a matter of concern at one of the regional workshops. Although some healthy schools co-ordinators reported placing an emphasis on staff health as one of the areas to be addressed by schools, self-esteem of staff, and its implications for health, may not have been widely addressed as part of the WNHSS so far.

2.2.5 HEALTH EMBEDDED IN THINKING OF SCHOOL

Achievements

Where health had been embedded into the thinking of the school, it was not just a matter of seeing water bottles on desks or fruit tuck shops, almost as symbols of commitment to a course of action, but also how the motivation behind such initiatives had matured. Examples are given from one exemplary school (PS1):

- There was no "water on desks" policy. However, pupils taking part in a focus group more than once mentioned the importance of water as part of what the school did to improve health, for example:

  "We have our water bottles in the class and you can go and ask the teacher any time if you want to get your water bottle because [headteacher] says it's really important that you get your water and stuff"

- The importance of eating fresh fruit had also become so ingrained that dinner supervisors kept a stock of fruit in the kitchen which they handed out discreetly to new children who might be embarrassed by other children's surprise that they had brought chocolate bars or sweets to eat at break time. The children had instigated a rule that chocolates and sweets should be reserved for special treats and it was unusual for anyone to break this rule.

- The school had a "buddy" system for new pupils but they did not always go to their buddies for help, saying that all the other children were just as good. Behaviour of the pupils observed during lessons and breaks demonstrated the supportive ethos of the school. The headteacher said the need for Circle Time had reduced.

- The same clean, well maintained lavatory facilities were used by both staff and pupils. Presumably this was accepted as normal because no-one at the school commented on it – a contrast to the reports from school councils regarding poor hygiene and dilapidation of provision for pupils in some other schools.

Areas for improvement

Achievement varies greatly between schools. For example, in one secondary school student members of a focus group appeared to lack self-confidence; the teacher who introduced them made tea for herself, other teachers and members of the review team but did not offer the students a drink. The students did not appear to be aware of the role of the school council or who represented them on it and were reluctant to enter into a discussion.

Measures to improve staff health had not become embedded in most schools taking part in case studies. In the one school mentioned in the previous section where staff health had equal priority with pupils' health, the headteacher was an ex physical education teacher with a particular commitment to keeping physically fit which they passed on to the staff. So far the WNHSS does not seem to have been particularly effective in encouraging staff who do not have such a background to care for their own health.

2.2.6 LINKS TO OTHER PROGRAMMES – PESS; ECO SCHOOLS; BSF; TSN

Achievements

Ninety-seven headteachers and in-school co-ordinators answered a question on their schools' links with Welsh Assembly Government and local initiatives and priorities. The responses suggest that schools have developed links with a wide range of programmes. healthy schools co-ordinators also reported collaboration with an increasing number of workers on other programmes supporting schools (please see section above on increase in expertise), particularly Physical Education and School Sports (PESS) and Eco Schools. The growing influence of school councils was often mentioned by healthy schools co-ordinators and headteachers; and a meeting of one very effective school council was observed where decisions were minuted, with clear feedback being provided by the headteacher on issues previously discussed (SS34).

Areas for improvement

Responses to the stakeholder consultation suggest a tendency for links with other programmes to involve changes to the curriculum or school rules rather than to the material environment of the school, and not addressing concerns of school councils about the condition of lavatories and other aspects of the school site.   Similarly, there was no evidence that schools were linking to the Teacher Support Network (TSN), reflecting the more general tendency to focus on pupils' rather than staff health.

2.2.7 VARIABLE LEVELS OF COMMITMENT

At national level, commitment from the Health Department appears to have been greater than from the Education Department: healthy schools has been well integrated into some policy papers, but most of these are from Health, not Education (see Section 5)

At local level, commitment from schemes in terms of providing the best possible service to schools does not seem to vary significantly: all the healthy schools co-ordinators and members of healthy school teams who talked to the review team were enthusiastic and enjoyed their work. What did vary at local level was the commitment of senior officials and elected members in terms of leadership and management support available to the schemes.

At school level, nearly all schools were committed to a measure of health improvement. Healthy schools co-ordinators reported that they had not so far had to take active measures to recruit schools because they had a list of schools waiting to join.   Commitment to the healthy school scheme was more variable. Some headteachers said they would have taken action without belonging to the scheme, and the paperwork involved was perceived as a major drawback by headteachers in case study schools and also by nearly half of 125 headteachers and in-school co-ordinators who answered a question on barriers to participation as part of the stakeholder consultation. Two headteachers in case-study schools appeared to tolerate the scheme only because it gave them more authority to take action which they had already planned or begun. Fourteen heads of schools which had not joined a local scheme responded to the stakeholder consultation and of these only one did not want to join. But of 125 headteachers and in-school co-ordinators in healthy schools, 65% said they could foresee a time when their schools could continue to

maintain and develop health promotion without support from the healthy schools co-ordinator.

Levels of commitment to health improvement appear to vary widely *between* schools with the most significant differences between secondary and primary schools. The main issue in secondary schools appears to be time and teachers in one school felt that the only way to take things forward was to do a lot of work after the end of the school day. *"If you are really committed, that's when you allocate the time".* (SS15) They felt that this added to stress and "burnout" and was unsustainable.

Within schools, levels of commitment to health improvement varied between different groups involved in the school, with perhaps the greatest commitment seen in headteachers, in-school co-ordinators and primary school pupils. Some headteachers commented on the low level of commitment from parents, despite efforts to involve them in school activities, and others reported parental opposition to health-improvement measures, particularly those affecting food. However it was not clear whether this lack of engagement was a result of lack of commitment, or because parents were not being invited to participate in school actions in an appropriate way. Parent governors and chairs of parent-teacher associations, as well as support staff who responded to the stakeholder consultation were less likely than teachers to be offered the opportunity to demonstrate commitment by involvement in training or in some cases even by being made aware that the school had joined the healthy school scheme.

3. Introduction and background to the Review

3.1 The Welsh Network of Healthy School Schemes

The Welsh Network of Healthy School Schemes (WNHSS) was established to support maintained schools in Wales to integrate health improvement into all aspects of school life.   In 2000 the Welsh Assembly Government offered grant funding to local health and education partnerships to employ healthy schools co-ordinators to set up local schemes. All twenty-two authorities were awarded grants. Initial grants provided an allowance for setting up schemes (the same amount for all areas). Funding during subsequent financial years to 2005/2006 was based on the number of schools and recruitment targets in each area, and there was some variation in the detailed calculation of grants over this period.

Local healthy schools co-ordinators were expected to set targets which would fulfil national expectations that half the schools in Wales would be involved by March 2006, three quarters by March 2008 and all by March 2010. In accordance with the recommendations of the Acheson report (Acheson 1999), the Welsh Assembly Government recommended that recruitment of schools should be initially focused on, but not limited to, disadvantaged communities.   Within a national framework, local partners are encouraged to devise their own strategies for achieving change and in turn to support schools to set their own priorities and agendas in ways which leave individual staff and pupils free to decide how they will initiate and respond to changes in the school environment. A senior civil servant employed by the Welsh Assembly Government acts as national co-ordinator for the WNHSS, which as part of the UK is a member of Schools for Health in Europe (SHE), formerly the European Network of Health Promoting Schools (ENHPS).

Partnerships in each unitary authority must include as a minimum Education and Health, and employ a local co-ordinator with responsibility for recruiting schools to the local scheme and supporting them to make changes to improve health. Schools are expected to introduce health improvement topics into three domains -
  * the curriculum;
  * the school's ethos and material environment;
  * relations with individuals and groups outside the school.
As schools progress through the phases of the scheme, health-improvement measures are expected to make a lasting difference to the way in which school life is organised.

The national co-ordinator has responsibility for monitoring and accrediting local schemes and training local healthy school scheme co-ordinators. Local healthy school schemes are required to adopt aims consistent with those set out in the WNHSS framework (Box 1). Local healthy schools co-ordinators recruit and support schools to promote health; and organise appropriate local training of school staff and others involved in schools. Healthy schools co-ordinators develop working

relationships with other individuals and agencies who can offer a diverse range of support and expertise to schools. During each of the first three phases of the scheme, schools are required to make health-promoting changes in three areas of work which are reviewed and consolidated as the schools progress through subsequent phases. Schools appoint their own in-school co-ordinators who are assisted by the local healthy schools co-ordinator to make a plan based on needs identified by the school, and to carry out the work. All schemes assess their member schools and award plaques, supplied by the Welsh Assembly Government, to those which are successful in completing each phase.

Box 1: WNHSS aims (The National Assembly for Wales 1999)

- Actively promote the self-esteem of all members of the school community
- Actively develop good relationships in the daily life of the school
- Identify, develop and communicate a positive ethos and appropriate social values within the school community
- Ensure that all pupils have the opportunity to benefit from stimulating educational challenges.
- Take every opportunity to enhance the environment of the school
- Develop good school / home / community links and shared activities
- Encourage all staff to fulfil their health promoting role, through staff development and training
- Develop and implement a coherent health education curriculum
- Establish good links with associated schools to ensure smooth transition of pupils both socially and in relation to a developmental health education programme
- Develop the school as a health promoting workplace with a commitment to the health and well being of all staff
- Develop the complementary role of all school policies to the health education curriculum, such that the curriculum reflects the contents of the policy and the policy reinforces the curriculum.
- Develop partnerships with appropriate outside agencies and individuals, including the school health service, for advice and active support for health education and health promotion in the school.

The Welsh Assembly Government drafted a logic model (Figure 1) outlining the actions needed to establish an all-Wales network of healthy schools, and the outcomes expected in the short, intermediate and long term. These provided policy targets which could be used to assess progress (and which are compared against review data in Section 2)

3.2 Background to the WNHSS Review

Evidence from earlier surveys suggests that schools in Wales have not always completely understood the full extent of change necessary to incorporate health promotion into the life of the school. In Welsh secondary schools, the importance of action outside the formal curriculum was not always recognised (Nutbeam 1987). By 1989, secondary schools had begun the transition from a health education based approach, to a broader health promotion approach; however there was room for improvement in understanding of the healthy schools concept, particularly with

regard to the importance of the emotional and physical environment and schools' links with the community (Smith et al. 1992). During the early nineties, the gap between concept and practice was widespread in schools throughout Europe, including Wales (Nutbeam 1992). In 1991, a joint programme between Health Promotion Wales and the Curriculum Council for Wales funded five schools to integrate a health topic into the three health promotion domains (Bowker 2000). Evidence from the five case studies was then used to improve understanding of the healthy school concept throughout Wales (Health Promotion Wales; Curriculum Council for Wales 1994). In 1993 Wales enrolled twelve schools to take part in an ENHPS pilot project to 1997. Evaluation of the pilot project suggested that understanding of the concept remained incomplete, with schools tending to think of health promotion primarily in terms of the formal curriculum. It has been suggested (Young 2002) that this is not just an issue at the level of the classroom as the lack of understanding of the health promotion concept among education policy makers and education researchers occurs across Europe.

Further research to contribute to decision-making about school-based health promotion in Wales (Stears 1999) informed the WNHSS Framework document (The National Assembly for Wales 1999) which was distributed to all local health promotion teams, a few of which set up healthy school schemes using their own resources. When in 2000 the then National Assembly for Wales made funds available for a national network, all unitary authorities received grants and employed co-ordinators who established or developed local schemes from 2001. By 2005, all local schemes had been formally accredited by assessors employed by the Welsh Assembly Government, and by 2007 about 70% of schools in Wales had joined their local healthy school schemes.

In 2007 Cardiff Institute of Society, Health and Ethics (CISHE) at Cardiff University was commissioned to undertake an independent review of the WNHSS to examine the implementation of the network across Wales and to make recommendations to inform its future development. The Welsh Assembly Government specified that the review should have five components:

1. A review of literature and documentation
2. Interviews with healthy school co-ordinators
3. Stakeholder Consultation
4. Scheme case studies, with embedded school case studies
5. International expert commentary (interviews)
6. Oversight from an Expert Panel

The first four components were approached by the review team as a single-case study of the WNHSS at a nationwide level. The international expert commentary, the fifth component, has enabled the review to place the WNHSS in an international context through comparison of the WNHSS with school-based health promotion in other countries. In addition, the Welsh Assembly Government asked for preliminary findings to be reviewed by WNHSS stakeholders at regional workshops. Discussions at the workshops both assisted in interpreting, and added to, data collected elsewhere. Figure 2 outlines in diagram form how four components of the review and the Regional Workshops contribute to the single-case study and how the data as a whole are compared with the findings from the international expert commentary.
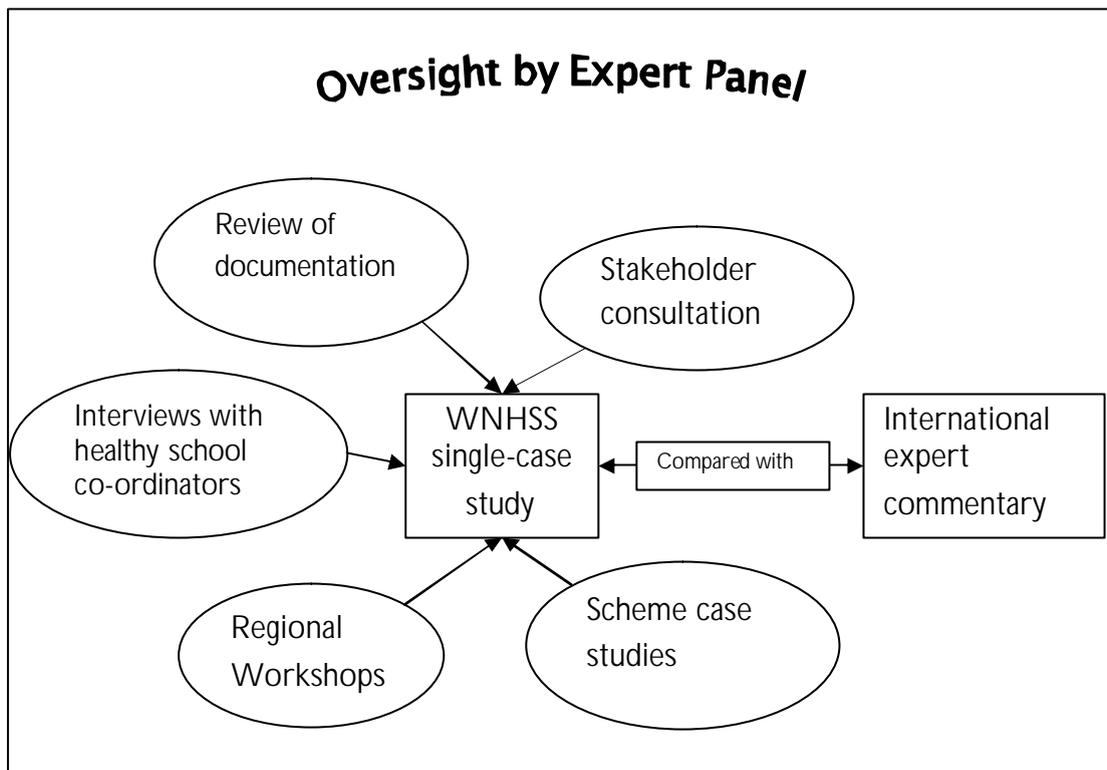
Figure 2: Diagram outlining the structure of the WNHSS Review

3.3 Theoretical Framework for the Review

The single-case study design required a theoretical framework to guide data collection and the analysis and interpretation of findings (World Health Organization 1997a; Yin 2003). From the literature review a theory was developed of how the WNHSS was intended to work and what characteristics it would have if it conformed to the theoretical principles described in the literature. The focus was on identifying, not exploring, concepts which could provide a clear, reliable route through the complexity of the programme and the variety of research methods required.

3.3.1 SOCIAL-ECOLOGICAL APPROACH TO HEALTH

The concept of the school's responsibility for health promotion in the broadest sense can be traced to the Ottawa Charter, which clarified that all sectors, organisations and individuals, not just the health sector carried responsibility for health. Linked closely with the wider social responsibility to promote health was the positive concept of health promotion as a way of enabling individuals to fulfil their potential. This shifted the emphasis of health promotion from the narrower medical priority of preventing disease to an affirmation that health was a "resource for everyday life" and established the concept of the more holistic "social-ecological approach" to health as the guiding principle of health promotion. In terms of settings such as schools it also moved the agenda from one of health education to the wider concept of health promotion. The role of schools in health promotion has been further strengthened by the first ENHPS conference at Thessaloniki which recommended further expansion of health promoting schools (World Health Organization 1997a) and the Egmond Agenda (World Health Organization 2002)

which outlined the practical steps needed to establish health promotion as an integral function of schools.

Another important development which formed part of the background to the change in the focus of health promotion during the 1980s was "salutogenic" theory. Antonovsky argued that the "pathogenic paradigm" based on prevention and treatment of disease was not appropriate for understanding how people maintained health, and was particularly unsuited to preventing chronic diseases (Antonovsky 1979, 1996). He proposed the Sense of Coherence as a framework for understanding salutogenesis, or the origins of health. The Sense of Coherence is defined primarily in terms of an individual's feelings about the meaning and value of life:

> *"a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges, worthy of investment and engagement."*
> (Antonovsky 1990)

It is suggested that confidence and skills in coping with stressful experiences are positively related to the extent to which people can make sense of their environment.

3.3.2 SETTINGS FOR HEALTH PROMOTION

The Ottawa Charter recognised five areas of action where the more positive concept of health promotion could be put into practice:

- Build healthy public policy;
- Create supportive environments;
- Strengthen community action;
- Develop personal skills;
- Reorient health services.

This idea of the supportive environment is expressed in the "settings" approach to health promotion, of which the healthy school is one example (Kickbusch 1997). This approach assumes that it is the relationship between individuals and their environment which influences health (Green et al. 2000) so that the way in which a specific environment is organised can influence many cohorts of people who "learn, work, play and love" (World Health Organization 1986) within it. The WNHSS clearly aims to create supportive environments by developing the capacity of schools to promote health; and schools in general have a key role in developing the ability of children and young people to make sense of the world and to accumulate the personal knowledge and skills which are necessary conditions of the Sense of Coherence. Health promotion which is integral to the school's organisation can be expected to increase the educational attainment of pupils. Equally, educational efforts which increase pupils' ability to understand and think independently will foster the autonomy and empowerment which are fundamental to health. Common benefits to both educational ability and health can be derived from actions such as involving pupils in decision-making and encouraging physical activity (International Planning Committee 2002). A WHO Expert Committee on school health concluded that *"research . . .demonstrates that school health programmes can simultaneously reduce common health problems, increase the efficiency of the education system, and further public*

health, education, and social and economic development in all nations." (Vince-Whitman 2001)

However the WNHSS programme as a whole encompasses not only the creation of supportive environments in schools but also all the other areas of action. Health promotion within the school is influenced by the way the scheme is organised outside the school - at unitary authority and Welsh Assembly Government levels. The nature of health itself, as conceived by the Ottawa Charter, also means that the boundaries between these areas become blurred through the process of "reciprocal determinism" (Bandura 1965) whereby health-promoting environments enable, rather than restrict, individuals who then engage with others at all levels to manage or change conditions affecting their lives. The settings concept thus raises the question of where the setting begins and ends and how its nature and size affect health promotion practice within it (Dooris 2004).

3.3.3 INFLUENCE OF THE OTTAWA CHARTER ON THE WNHSS

The agenda set by the Ottawa Charter has therefore been a driving force behind efforts to promote health in schools (Burgher 1999; Denman 2002). From the outset, it was clear that the WNHSS should be contextualised within the literature emerging from the healthy schools movement. A review of texts produced by ENHPS as well as Welsh government agencies helped establish an understanding of how the WNHSS could be expected to work. The International Planning Committee (IPC), The Technical Secretariat of the ENHPS and various ad hoc committees set up by the latter appear to have played an important role in driving forward the theoretical and practical development of healthy schools. For example, the Technical Secretariat at the WHO Regional Office for Europe arranged annual business meetings of national co-ordinators, workshops, meetings, seminars and training; offered advice and visits to countries and arranged to disseminate resources and information through electronic communication and regular newsletters between 1993 and 2005.

The ENHPS principles are clearly linked to the concept of health promotion as empowering, rather than informing or instructing, individuals. The organisation of ENHPS itself extends this approach to communities by enabling each member country to adapt its principles for use in varying national contexts (Burgher 1999; Viljoen 2005). In Wales, the WNHSS allows for adaptation at local (scheme) and school level (The National Assembly for Wales 1999). Box 1 lists the aims of the WNHSS, developed from ENHPS principles.

These aims are commonly categorised as belonging to the three major domains of the school's ethos and physical environment, including policies; the school's formal curriculum; and the school's relationship with pupils' families and others outside the school (Bowker 2000; Healy 1998). Health promotion action involving all three domains together would demonstrate the "social-ecological approach to health". Understanding the breadth of the concept and its implications for the whole school is a prerequisite for the "clear vision" which inspires and guides change (Vince-Whitman 2005). Freedom to adapt Healthy School principles to the specific needs of the school poses a potential danger if school staff do not have a broad grasp of the concept: they may focus only on one or two domains, and fail to make more comprehensive changes in the school's organisation and practice (Deschesnes et al. 2003).

The Ottawa Charter principles have thus been transmitted from international level to the WNHSS at national level through the World Health Organization and the European Network of Health Promoting Schools. This meant that the review should aim to estimate the extent to which the WNHSS as a whole demonstrates the social-ecological approach in practice. The Ottawa Charter also specifies three types of action which lead to achievement of the social-ecological approach – advocacy, enablement and mediation – and these were adopted as a practical guide for the review. Data collection and analysis were designed to collect evidence of all three types of action at national, local and school levels and to identify aspects of the different contexts which either facilitated or obstructed action. The focus of enablement is equity (World Health Organization 1998) and the term "equity" rather than "enablement" has been used throughout because it was felt to suggest the emphasis on fairness which appears to be an important motive underlying the WNHSS. The acceptance of differences in health determined by socioeconomic and environmental conditions is contrary to commonly accepted ideas of what is fair (Daniels et al. 2000). The theoretical framework distinguishes two main enabling processes leading towards greater equity. One is *action to reduce inequalities in health* arising from systematic differences in social conditions affecting the population. From its inception the WNHSS has been seen to have a role in Welsh Assembly Government policies to reduce inequalities in health; and a reduction in health inequalities is one of the Welsh Assembly Government's expected intermediate outcomes of the WNHSS (Figure 1). Equity in health care depends on provision according to need (Whitehead 1991) and in the same way equity in health may depend upon deployment of health promotion programmes according to population need. And Dahlgren and Whitehead recommend policymakers to increase equity in health by intensifying *"health promotion and prevention efforts – in particular, among socioeconomic groups at greatest risk"* (Dahlgren and Whitehead 2006). So individuals and schools could be expected to have access to the scheme's resources on the basis of need. This aspect of equity belongs more to local and national levels of the WNHSS, where there is capacity to frame policies and targets in ways which direct more resources towards "levelling up" the population of schools.

The other enabling process contributing to equity is action to encourage *individuals* to "increase control over the determinants of health" (World Health Organization 1998) through *participation* in the scheme. The capacity within the WNHSS for schemes and schools to decide their own priorities for action within nationally-defined aims suggests a construct of participation which matches the description by (Rifkin et al. 2000) of *empowerment*:

> *"Empowerment in its broad sense has come to mean 'people gain control in their own lives in the context of participating with each other to change their social and political realities' (Wallerstein, 1993, p. 219)."*

This type of participation is particularly suited to schools because the nature of education is itself empowering by helping individuals to develop skills, knowledge and confidence to contribute to decisions about conditions affecting their daily lives (Rifkin et al. 2000).

As a broad basis for school-based health promotion, these themes appear to be generally accepted and criticisms focus on issues around implementation. The most relevant for the WNHSS review is the commentary by McLaren, Leonardo and Perez which follows a chapter by Parcel, Kelder and Basen-Engquist about a school-based health promotion programme in the USA. The commentators find that programmes

such as the one described are "problematic . . . because they lack a heuristic for agency, or how people act *collectively* to produce liberatory health conditions." (p.135, italics in the original). That is, such programmes do not specify pathways for people to become active participants in promoting health. The use of the word "liberatory" is important here because it implies the concepts of equity as a human right and of health as a resource which promotes freedom (Sen 2000). Collective action can also result in the imposition of conditions which are unfair and oppressive to a minority (Olson 1965).

The concept of "complex adaptive systems" suggested a heuristic for collective action within the WNHSS and provided a practical guide for identifying relationships and behaviours which may be important influences on practice. Schools have been described as "complex adaptive systems" (Colquhoun 2005) – that is, they are loosely defined entities made up of many interactions and influenced by a range of external factors. The idea of complex adaptive systems can be extended to include healthy schools networks at local, national and international level.

Basic characteristics of complex adaptive systems are:
- fuzzy boundaries: people can be members of one or more systems
- internalised rules and mental models which are subject to change
- adaptation of systems over time
- embedding of one system within another: development of one system influences and is influenced by another
- acceptance of tension and paradox which may not be amenable to resolution
- synergy leading to innovative attitudes and actions
- a tendency towards "non-linearity": there is not necessarily a clear-cut relationship between one variable and another.
- inherent unpredictability: there are too many unknown influences to enable one to say how detailed aspects of a complex system will develop over time
- inherent pattern: overall, it is sometimes possible to make overarching observations about a complex system although the exact timing or nature of events within the system may be unclear.
- attractor behaviour: behaviour which occurs repeatedly within broad parameters determined by the interactions composing the system
- inherent self organisation through shared rules which are not imposed from outside the system

(Plsek and Greenhalgh 2001; Wilson et al. 2001)

Assuming that the first six characteristics are involved in reconciliation of potentially diverse interests, they have been included under the heading of "mediation" for the purposes of the review. The others were considered to relate more to the characteristics the WNHSS as a whole can be expected to display as evidence of a social-ecological approach. Figure 3 shows an outline of the theoretical structure.
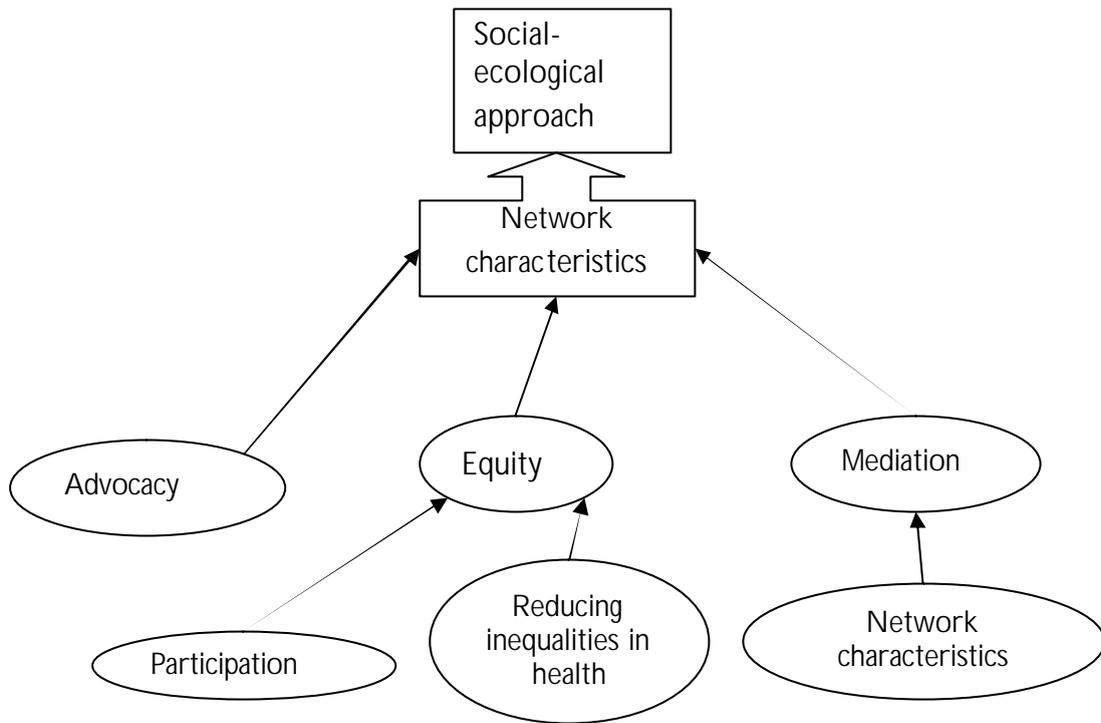
Figure 3: Theoretical framework for the WNHSS review

3.4 Outline of the report

The next section describes the methods used to collect and analyse data. Findings are presented in Sections 5, 6 and 7 under each of the three action area headings of the Ottawa Charter. Findings may not be true of a majority of schools or schemes, but are reported because they were supported by evidence from more than one source, except where stated otherwise. Some results from the Stakeholder Consultation questionnaire survey have been included where appropriate; a full account of survey findings is reported separately. Section 8 on the social-ecological approach reviews the extent to which the WNHSS has been found to conform to the theoretical framework and introduces evidence from the International Expert Commentary. A concluding section reflecting on the findings is followed by recommendations regarding ways in which the WNHSS could be strengthened and developed to increase its capacity to improve health.

Readers should bear in mind that the WNHSS, as a "complex adaptive network", does not stand still and that some of the findings presented here had been overtaken by events even before the end of the data collection.

4. Methods

4.1 Study Design

The overall approach used to explore the implementation of the WNHSS was that of the embedded single-case study (Yin 2003). That is, the review maintained a holistic focus on the single case of the WNHSS as a national programme and data from embedded case studies of schemes and schools were analysed as instances of its implementation. The single-case study design facilitated comparison of findings with (1) accounts from international experts of how health promotion in schools was undertaken in countries outside Wales and (2) what, in theory, could be expected if the WNHSS was found to adhere to the principles underpinning it. Table 1 outlines elements of the data collection under headings indicating which contributed to the context of the study; which to the WNHSS as a single-case study; and which provided examples of implementation at local and school level. The headings are derived from Yin (2003).

In addition, the WNHSS Review incorporated the opinions of Expert Review Panel members and of stakeholders in local healthy school schemes who attended three regional workshops. Both groups assisted in interpreting findings, and material from the workshop discussions was also used as data.

4.2 Expert Review Panel

The study was reviewed at key stages by a panel of experts on healthy schools (Appendix 1). The Welsh Assembly Government stipulated that members should be based outside Wales so that they could provide an independent perspective. The remit of the panel was to assist in the identification of key areas for investigation in the early stages of the work; to review emerging evidence included in the draft report for regional workshops (see below and Appendix 2 for details of regional workshops); to contribute to the regional workshops; and to agree the final report.

Table 1: Elements of data collection for the WNHSS review and their roles within the embedded single-case study design

Context	Case (WNHSS)	Scheme case studies (Embedded units of analysis at local level) (n=6)	School case studies (Embedded units of analysis at school level) (n=9)
		(Observation, interviews, focus groups, review of documentation)	
Literature review

Theory development

International Expert Commentary *(Semi-structured telephone interviews)* | Review of documentation

Attendance at all-Wales meetings of healthy school co-ordinators *(Minutes and notes made by CISHE review team)*

Interview with Welsh Assembly Government key informant *(Semi-structured face-to-face interview)*

Interviews with healthy school co-ordinators *(Semi-structured telephone interviews)*

Stakeholder consultation *(questionnaire survey)*

Data from discussions at Regional Stakeholder Workshops *(Notes made by CISHE review team and written and oral feedback from Expert Panel members)* | Scheme 1:

Scheme 2:

Scheme 3:

Scheme 4:

Scheme 5:

Scheme 6: | Special school Secondary school

Welsh-medium primary school Secondary school

Primary school

Primary school

Primary school

Primary school Secondary school |

4.3 Aims and objectives

The review was commissioned to review progress and achievements, and to make recommendations for the future development and support of the WNHSS. Objectives were:

- To review progress with the implementation of the WNHSS across Wales, assessing whether the Network had developed as was originally planned;

- To review the impacts of the WNHSS and the extent to which identified actions had been fulfilled;

- To identify strategic actions required to strengthen the network and provide advice on future levels of support;

- To advise on future monitoring and evaluation arrangements for WNHSS activities.

The logic model drafted by the Welsh Assembly Government (Figure 1) was useful in assessing the progress and impacts of the network by comparing findings with the specified activities and outcomes. As a basis for making recommendations for the future of the WNHSS, the review looked back to the history of the emergence of the WNHSS as part of the wider European Network of Health Promoting Schools (ENHPS). The principles of the social-ecological approach developed by the World Health Organization during the 1980s were helpful in identifying the processes involved in achieving outcomes and in accounting for variation between local schemes.

Therefore the review adopted a broader aim of estimating the extent to which implementation of the WNHSS demonstrated that a social-ecological approach to health had been understood and implemented in schools. Further aims were to identify conditions associated with greater conformity to the social-ecological model. The Ottawa Charter states that: 'Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a social-ecological approach to health.'

Further objectives were based on the three Ottawa Charter action areas (described in the introduction to this report):

- *Advocacy*
To identify (1) the extent of support for the WNHSS from a range of individuals and agencies, including leadership; (2) the extent and nature of practical administrative and management support; (3) the extent and nature of training; and (4) whether there is a realistic time-scale for change to be assimilated.

- *Equity*
To identify how the scheme helps to reduce inequalities in health and whether all stakeholders have an equal opportunity to participate.

- *Mediation*
To describe how potentially conflicting interests are reconciled and harnessed by the WNHSS and the extent to which it displays the characteristics of a successful network.

These three action areas, and the overarching concept of the social-ecological approach to which they contribute, formed the framework used to inform data collection at international, national, scheme (local) and school levels in Wales. Particular areas of enquiry were highlighted depending on the participant's role or position within the network.

4.4 General approach to data collection and analysis

4.4.1 DATA COLLECTION

A training seminar was held on 29th June 2007 at which the theoretical framework and draft protocols for each data-collection element were agreed by the Principal Investigator and all members of the data-collection team. Data-collection instruments used in the review were designed using the theoretical framework and revised following piloting and review by the Expert Panel. The concepts within the framework remained the same throughout the review but some revisions were made to their arrangement and relationships within the model as they became better understood. Written data were stored with NVivo software using codes based on the theoretical framework.

Limitations of the method

A potential limitation of this method was that important data which did not fit into the framework would be excluded. This risk was minimised by four more general features of the data collection:

- Awareness of all team members that the framework was to be used as a guide but if necessary should be modified in the light of increased knowledge about the WNHSS as the data collection progressed.
- Use of semi-structured schedules which gave participants the opportunity to talk about topics which had not been anticipated at the design stage.
- A team-working approach where at least two staff were involved in work on every element and site.
- Review by Expert Panel members and stakeholders who attended the workshops.

Data from interviews and focus groups were summarised, rather than transcribed, by members of the review team, introducing the possibility of bias through initial judgements made regarding the relative importance of findings. However data were triangulated by use of other methods within the review as a whole; and the team-working and review processes mentioned above also protected against individual bias. Therefore the data could reasonably be expected to have "synchronic reliability" (Kirk and Miller 1986).

4.4.2 DATA ANALYSIS

The theoretical framework provided the basis for "pattern matching" as the approach to analysis within the embedded single-case study design of the review. Findings were compared with what would be expected if WNHSS practice conformed wholly to the Ottawa Charter agenda. Organisation of data under each of the three action areas at national, local and school levels assisted in identifying contextual influences on practice which might lead to conformity or divergence from the model. Evidence from the International Expert Commentary was also compared with the theoretical model and used to assist in identifying implications for the further development of the WNHSS. Figure 4 outlines the main areas compared during analysis.
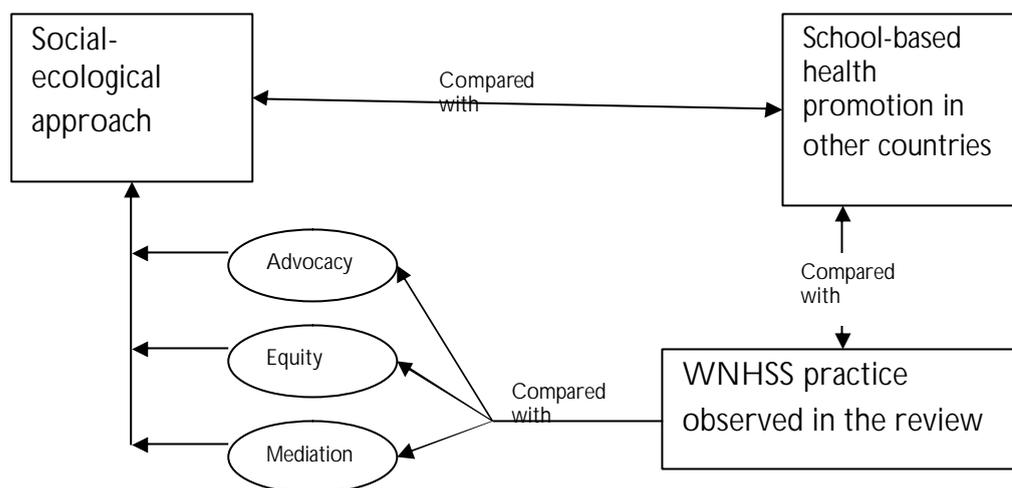
Figure 4: Outline of "pattern matching" in the WNHSS review

Analysis was carried out by retrieving and synthesising data stored under each heading of the theoretical framework and comparing them with propositions expressing what would have been expected if the network conformed completely to the theory.

Data collection and analysis methods specific to each element of the data collection are detailed below.

4.5 Methods specific to each area of the data collection

4.5.1 CONTEXT

4.5.1.1 Literature review

The literature review initially focused on identifying the theoretical framework described in the Introduction for use as a guide for data collection and analysis. The search did not aim to examine concepts in depth or to look closely at broader issues such as theories of health promotion and behaviour change.

Objectives were to identify key texts relating to:
(a) the history and structure of the WNHSS
(b) Welsh policy authorising and justifying the initiation, funding and management of the WNHSS
(c) theory underpinning the initiation and management of the WNHSS

Scope

The search was limited to literature published since 1985, focusing on work by advocates of school-based or settings-based health promotion. Wider literature (e.g. psychology or education theory) was excluded except to clarify material in the "healthy schools" literature. The national co-ordinator identified a variety of texts as important to our understanding of the WNHSS. Some literature was found by following up references in these papers. Further relevant texts were identified by searches of ASSIA, Biomed Central and Cardiff University library databases using key words *healthy schools; settings health;* and *WHO settings health promotion.* The Welsh

Assembly Government and National Assembly for Wales websites were searched for records of formal decisions on policy and/or funding for the WNHSS. Consultation and policy documents which mention the WNHSS or schools as a setting for health promotion were found via the websites with the help of the national co-ordinator.

4.5.1.2 International Expert Commentary

The aim of the International Expert Commentary (IEC) was to:

Describe how health promoting schools have been approached outside Wales in order that comparisons can be made with the Welsh Network of Healthy School Schemes (WNHSS)

In order to achieve this aim, a variety of international and national experts on health promoting schools in their regions were interviewed. Experts were asked about health promoting schools in general, and how these were achieved in their countries or regions. This information was then used to describe health promoting schools in each local context in order that comparisons with Wales could be made. This was also used to inform this report. Findings from the IEC are detailed in a separate report (Burgess et al. 2009).

Potential experts were identified by a key informant at the Welsh Assembly Government, by the research team's own review of the literature and through attendance at an international conference in June 2007 by some members of the research team. Potential respondents were selected on the basis that they had a good knowledge of the implementation of school-based health promotion within their respective countries / regions. Confirmation of this occurred during recruitment. International experts were also selected purposively to reflect a diversity of location and roles. Those invited to participate included national co-ordinators and academic experts, the one common factor being that they had all had various practical experience of health promoting schools. Of those approached, two were unavailable for interviewing. Table 2 lists the experts who were interviewed and the reasons why they were targeted for this study.

As requested by the Welsh Assembly Government, it was the original intention of the researchers to use the Scottish Diet Action Plan Review (Robertson 2006) as a basis for this International Expert Commentary. The permission of the report's author was sought to utilise the interview schedule that was used in the Scottish Diet Action Plan Review as a basis for the design of an interview schedule to be used in telephone interviews with experts in this study. This schedule was designed to reflect the same set of propositions used in the main report. This interview schedule was piloted with Ian Young, a member of the expert review panel that had been commissioned on the request of the Welsh Assembly Government, to provide advice and practical recommendations at each stage of the study. As a result of the pilot interview, and following advice from Ian, a decision was taken to revise the interview schedule. This was agreed with the Welsh Assembly Government and the schedule was altered to make it more open ended and better able to collect complex data on health promoting schools in a short space of time.

Table 2: Participants in the International Expert Commentary

Expert	Country/Region	Reason for interviewing
Vivian Barnekow	Denmark	Spent time heading up WHO Technical Secretariat responsible for European Network of Health Promoting Schools (ENHPS)
Goof Buijs	Netherlands	Coordinator of Schools for Health in Europe (SHE)
Gail Diachuk **Michelle Kilborn** (interviewed at the same time)	Canada: (Alberta)	Sat on the co-ordinating committee for Healthy Alberta School Communities. Gail represented Health and Michelle represented Education
Don Nutbeam	Australia: (New South Wales)	Has practical experience of health promoting schools at the strategic level in several countries (including Wales and England) and has written on the subject. Has knowledge of health promoting schools in New South Wales, Australia.
Peter Paulus	Germany	Has had a long-standing and central involvement with health promoting schools in Germany and at the European level
Janine Phillips	Australia: (South Australia)	Health Promoting Schools Coordinator for South Australia
Lawrence St Leger	Australia: (Victoria)	Has a long-standing research interest in health promoting schools and practical experience of developing these. Has written on the subject and has knowledge of health promoting schools in Victoria, Australia
Colin Noble[1]	England	Was the national co-ordinator for healthy schools Programme in England
Ian Young[1]	Scotland	Piloted initial interview schedule as a member of the Expert Review Panel commissioned to advise on the Review of Welsh Network of Healthy School Schemes. Has long been involved with developing, researching and writing about health promoting schools

[1]Pilot interviewees who allowed us to use their data

The revised interview schedule was successfully piloted with Colin Noble, an expert in Health Promotion from England. The feedback from this interview and responses from the Expert Review Panel were mostly positive regarding the changes to the interview schedule and meant that no further alterations were required.

Nine experts were originally identified and invited to take part in the study (Section 1.2). Of these, two were unavailable for interview. However, Gail Diachuk suggested that it would be useful for Michelle Kilborn to be interviewed alongside her in order to give the perspective from both the Health and Education sectors. As a result, nine

interviews were conducted with ten experts in nine different countries or regions. Experts were sent a copy of the interview schedule in advance of the interview and also asked to provide a graphic representation of the management/administrative structure of health promotion in schools as rolled out in their country or state. This was then referred to during the interview in order to help understand the achievement of health promoting schools in the experts' region.

Interviews were conducted via telephone and recorded. They were then summarised and this summary was returned to the expert who checked it for accuracy. Amended transcripts were analysed using NVivo 7 to identify important themes relating to developing and sustaining health promoting schools. These formed the basis for this report.

All experts were given time to consider their participation and ask questions prior to taking part. Signed consent forms were collected in advance of the interviews.

Interviewing one or two experts in each area allowed data to be collected on a number of contexts in the limited time available. The authors acknowledge the limitations of this method. However, given the procedure for identifying experts (above), they provided a useful range of perspectives on health promoting schools and their knowledge provided a useful basis for this analysis.

4.5.2 NATIONAL LEVEL (SINGLE CASE)

4.5.2.1 Review of documentation

The national co-ordinator assisted data collection through informal conversations during the course of the work. Following the literature review, further data and sources (Table 3) were selected as being likely to reveal how concepts in the theoretical framework were expressed in practice.

Welsh Assembly Government officials supplied information about funding and facilitated access to WNHSS files on local schemes. Online press releases from Welsh Assembly Government Education and Health departments and Estyn reports were examined to investigate the number of mentions made of *healthy schools* and *health promoting schools.* The main part of the search was carried out from March to August 2007.

Local Education Authority and Local Health Board online policies were searched for key words "healthy schools" and "health promoting schools" to reveal the extent to which local healthy school schemes had been incorporated into local health-promotion and education strategies, as an indication of mediation.

Some healthy schools co-ordinators supplied documents to illustrate what was discussed during interviews, or as a more efficient method of providing information about their schemes.

Table 3: WNHSS: Sources of data for Review of Documentation at national level

Data	Format	Scope
Scheme monitoring reports (6 monthly) completed by local co-ordinators or managers	Welsh Assembly Government paper records	All 22 schemes, 2001-2007
Press Releases by Ministers for Health and Education	Online	1999-2006
HM Inspectorate for Education and Training in Wales (Estyn) reports	Online	3 counties – one selected at random from each National Public Health Service (NPHS) area of Wales, 2001-2006
Excel tables showing funding for all 22 WNHSS local schemes	Electronic copies supplied by Welsh Assembly Government official	2000-2008
LEA Education Single Education Plan	Online	All 22 counties, 2006
LHB Health, Social Care and Well Being Strategy	Online	All 22 counties, 2005-2008

4.5.2.2 Observation of all-Wales meetings of local healthy schools co-ordinators

The national co-ordinator invited members of the CISHE review team to the healthy schools co-ordinators' Spring Term meeting held in Mid Wales on 29th March 2007. At this meeting, co-ordinators decided to devote part of the Summer Term meeting on 5th July 2007 to sharing with others the good practice developed within their own schemes. Members of the review team therefore sought permission to attend the Summer meeting as an opportunity to see examples of good practice. One team member attended both meetings, accompanied by a different team member on each occasion. Notes were written during and after the meetings; and discussed by the staff who had attended the same meeting. Minutes of the meetings attended, and of previous meetings, were provided by the national co-ordinator.

4.5.2.3 Interview with Welsh Assembly Government key informant

One face-to-face semi-structured interview was recorded with a Welsh Assembly Government officer from the Health Improvement Division to check and augment data from other sources at national level.

4.5.2.4 Interviews with healthy schools co-ordinators

Five researchers carried out the interviews by telephone, at times agreed beforehand with the interviewees. One co-ordinator from each of twenty-one schemes and two co-ordinators from one scheme took part (twenty-three interviews in all).

4.5.2.5 Stakeholder consultation

The method used was a postal questionnaire survey. Methods and results are the subject of a separate report. The total response rate from all stakeholder groups

was 19%. The response from each group ranged from 2% for school secretarial/administrative staff to 29% for headteachers of healthy schools. Of 71 WNHSS headteachers who responded, 44 also acted as in-school co-ordinators for their schools. In a further 27 schools, both the head and the in-school co-ordinator responded. Therefore the overall response rate from schools was 34%.

At local level, groups selected were:
- Directors of Education
- Directors of Public Health
- Chairs of Children and Young People's Partnership groups
- Heads of School Catering Services
- School nurses

At school level, the following groups were selected:
- Headteachers and in-school co-ordinators of healthy schools (treated as one group)
- Chairs of Parent-Teacher Associations
- School governors
- School councils
- Support school staff, except for school catering staff
- School catering staff
- Headteachers of schools which had not joined the network

A database of all schools in Wales supplied by the Welsh Assembly Government stratified by size, type of school and NPHS area, was used as the sampling framework.

At least one questionnaire was posted to every school participating in local healthy school schemes in Wales for completion by one or more members of any single stakeholder group. As an incentive to respond, names of schools returning completed questionnaires were entered into a prize draw for a chance of winning £200. One reminder postcard was posted to non-respondents offering to send a replacement questionnaire on request.

Questionnaires were posted to each group of stakeholders in turn between 29th November and 17th December 2007. Reminder postcards were mailed between 3rd and 11th January 2008.

4.5.2.6 Regional stakeholder workshops

Three workshops were held, one in each NPHS region, to discuss emerging findings from the review. Approximate numbers attending each workshop were:

Mid and West Wales	26
North Wales	17
South East Wales	50

Presentations were made by Welsh Assembly Government and CISHE staff explaining the background, structure and purpose of the review and outlining initial findings from the review of documentation at national level and interviews with healthy schools Co-ordinators. Expert Review Panel members contributed to plenary discussions on preliminary findings presented by members of the CISHE

review team and led smaller groups in debate around issues of sustainability, inequalities in health, and outcome measures (Appendix 3).

4.5.3 SCHEME AND SCHOOL CASE STUDIES (EMBEDDED UNITS OF ANALYSIS)

Case studies were carried out in six schemes to construct a view of what local characteristics influence conformity to the theoretical model, including how healthy schools concepts are disseminated across schemes; development and examples of good practice; and whether or not the health-improvement capacity of schools had been increased through membership of local schemes. Each of the six case studies included embedded case studies of one or two schools (a total of 6 primary and 3 secondary schools). Appendix 4 gives details of criteria for selection of schools and schemes and the number and types of schools and participants involved.

4.5.3.1 Observation

In addition to methods used elsewhere in the review, case studies included observation of meetings at scheme and school levels and of activity at different times and places in schools. Written schedules provided cues for contemporaneous handwritten notes made by the data-collection team and these were written up as soon as possible after observation periods.

4.5.3.2 Scheme case studies:

Documents

Local healthy school scheme documents were used to assess management and decision-making processes and systems for accreditation and delivering support to schools. Documents included policies, accreditation reports, records of meetings and supportive materials for schools.

Interviews

Interview participants in each case study included a senior member of the education department and a senior member of the public health team. Other interviewees were selected in consultation with Healthy School Coordinators and included representatives from outside agencies such as Eco-schools, Dragon Sport and PESS; and local services such as police or school nursing.

Observation

Members of the data-collection team attended meetings of the steering or other management group in each case study.

4.5.3.3 School case studies:

Documents

Documents at each case-study school were reviewed to assess how the school had progressed through Phases of the scheme; involvement of individuals and agencies from outside the school; and use of resources and support supplied through the scheme. Documents included policies, records of meetings, school-scheme contracts, portfolios compiled for assessments, supportive materials supplied by the scheme, communications between the school and external agencies and professionals and recent Estyn reports.

Interviews

Sixteen face-to-face interviews were carried out with school stakeholders identified by the in-school or local scheme coordinators. Five interviews were with headteachers, seven with in-school co-ordinators, one with a deputy headteacher and one with a Chair of Governors. Two group interviews were conducted: one with a headteacher, In-school co-ordinator and Craft, Design and Technology (CDT) teacher and another with a headteacher and in-school co-ordinator (Appendix 4).

Observation

Members of the data-collection team attended meetings of groups such as the school council and School Nutrition Action Group and also observed activity in different areas of the school at key times during visits.

Focus groups

One pupil focus group was held in each of five schools. In secondary schools the focus groups involved pupils in Year 9 or higher and in primary schools they involved pupils in Year 6 except for one school where pupils from all year groups were represented. Each focus group involved between 6 and 10 pupils and included both boys and girls. Two members of the review team attended each of four focus groups, one leading discussion and the other observing the group and helping with organisation and equipment. Because of limited time available at one school, the focus group there was led by one member of the review team while the other conducted an interview. Discussions were recorded with the permission of participants and summarised as soon as possible after the visit.

4.6 Ethics

The review was approved by the School of Social Sciences Research Ethics Committee at Cardiff University. All members of the review team had enhanced clearance from Criminal Records Bureau. Data have been anonymised to conceal the identity of individuals, schools and schemes. To preserve their anonymity, healthy schools Co-ordinators have not been distinguished by individual codes in this report and information and quotations are attributed to them using "HSC". Coding used for other participants is detailed in Appendix 4.

All interviewees were provided in advance with details of the study and informed that they had no obligation to take part. They were also given topic guides and were asked to sign consent forms giving permission for interviews to be recorded.

Permission was sought from Directors of Public Health and Directors of Education for schemes and schools in their area to be invited to take part in the stakeholder consultation and case studies. Headteachers willing to host case studies were asked to seek support from their governing bodies, parent/teacher and staff associations. A protocol was agreed with the headteacher of each case-study school describing how the review would be conducted on the school site, including detailed arrangements about seeking consent from parents and pupils. Schools were asked to distribute a letter and leaflet to all pupils and parents informing them about the study. For observation, an "opt-out" consent procedure was used which asked parents to notify the school if they objected to the review team carrying out observation of the school site. For focus groups, parents were asked to sign consent forms for children to take part. Pupils who were invited to take part in focus groups were provided with age-appropriate information in advance and were also asked to

give formal consent to participate and for the group discussion to be recorded.   All work was carried out in accordance with the requirements of the Data Protection Act 1998. Pre-printed information leaflets and consent forms supplied to case-study schools were addressed to pupils' parents by the schools so that the review team did not have access to personal information about pupils or their families.

5. Advocacy

5.1 The importance of advocacy within the theoretical framework

The Health Promotion Glossary (World Health Organization 1998) defines advocacy as:

> *"A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme."*

The Ottawa Charter's vision of health becoming integral to the way in which the social, political and material environments are organised, and being managed as a resource, implies that action restricted to a few individuals or to small, rigidly bounded settings will not work. To promote health in the way envisaged by the Charter implies a mass movement with many advocates who spread the word about how to maintain and improve health. Advocacy for health therefore entails *dissemination*, identified as a central theme in the development of healthy schools (World Health Organization 1997b) `and defined in an evaluation of the ENHPS (Piette et al. 2002) as:

> *"... the process of developing good practice or improving a wider audience's understanding of the health promotion approach."*

Distinguishing advocacy from other Ottawa Charter concepts is somewhat artificial for it works through mediation and takes an approach which values equity and inclusion. However, Vince-Whitman has specified four factors which appear crucial to the success of introducing change in schools, all of which disseminate the concept (Vince-Whitman 2005). Findings are reported under four headings representing these factors:

- Leadership "The leader's commitment, dedication, support and ability to articulate the vision and motivate and inspire others is key."
- Continuing administrative and management support
- A "critical mass" of people who share the same attitudes to change "... it is unrealistic to expect a single teacher or administrator returning home from off-site training to be able to effect change."
- Time and readiness for change – allowing time for new ideas to be understood and accepted.

A final section looks at some examples of good practice and which characteristics of the WNHSS might facilitate its development.

5.2 Leadership

Key findings:
- **Lack of formal policy setting out the role of the WNHSS has contributed to a tendency to identify the WNHSS with initiatives to improve nutrition and promote physical activity**
- **Local partnerships are more effective in areas where the healthy schools Co-ordinator's post is at senior management level**
- **Headteachers' professional commitment to their pupils is a very important driver of health promotion in schools which often pre-dates schools' membership of their local schemes.**
- **Leaders in secondary schools have to work harder than those in primary schools to advocate the scheme**

5.2.1 NATIONAL LEVEL

Administration

A steady commitment to the healthy schools concept, and a clear vision of what healthy schools could achieve, has characterised the development of healthy school schemes in Wales, initially by Health Promotion Wales and later by the Assembly's Health Improvement Division.

A key leader is the WNHSS national co-ordinator who has been in post since the start of the WNHSS and before that worked as a Curriculum Support Officer in health education, employed by Health Promotion Wales and the Curriculum Council for Wales. Starting in 1991, she was involved in carrying out case studies and pilots which led to the formulation of the Framework document for the WNHSS. In 2004, the Co-ordinator for Wales became the UK Co-ordinator for the ENHPS. Wales (along with Scotland, England and Northern Ireland) did not formally have separate membership of the ENHPS and this appointment opened up opportunities to put the WNHSS on the map as an independent programme. In 2000, Assembly Government funding was secured to enable the establishment of the WNHSS as an all-Wales programme.

Recommendation 8:	Consideration should be given to funding full-time national co-ordination of the WNHSS. This would help to meet the need for: a higher level of training to support the programme (see training recommendations); expanding the programme to a wider group of schools; consultation with stakeholders on the further development of monitoring and evaluation systems.

Elected members

Assembly Government Members have made many references to healthy schools during plenary proceedings. However, there is no formal policy passed by elected representatives defining what a Healthy School is. Instead, healthy schools are mentioned in a number of policy documents as instrumental in achieving broader political or strategic targets. While healthy schools are referred to in the first Strategic Plan for Wales *Plan for Wales 2001*(The National Assembly for Wales 2001d), they are missing from the second strategic plan, *Wales a Better Country* (Welsh Assembly Government 2003).

Assembly Government Ministers for Education and Health have made personal visits to local healthy schools events and Assembly Government Ministers have given a measure of personal support for the WNHSS through references to healthy schools in the context of wider political issues. In 2002 the Minister for Education made the keynote speech at an ENHPS conference in the Netherlands (Young 2002). The appearance of the Minister at the conference testified to and is likely to have augmented the good reputation of the WNHSS both across Europe and within Wales itself.

Recommendation 13:	More frequent ministerial press releases, jointly issued by Health and Education, and projecting an accurate image of the WNHSS, would be influential reminders of the Welsh Assembly Government's support for actions at school and local levels.

Strategic documents

The WNHSS is funded and co-ordinated from the Assembly Government Health Improvement Division, and where healthy schools are mentioned in policy or strategy, it is largely from a health perspective.

HEALTH:
In setting out a strategic health direction for post-devolution Wales, *Better Health, Better Wales* (Welsh Office 1998) placed an emphasis on tackling youth health. Its focus is predominantly on traditional school-based health promotion initiatives, even under the heading healthy schools. *Well Being in Wales* (Welsh Assembly Government 2002b) also appears to perceive the school as a setting for (curriculum-based) health education. More recently, some government policy and strategy has focussed on Health Promoting Schools. The Health Services document *Designed for Life* (Welsh Assembly Government 2005b) sets out milestones including the target that three quarters of Welsh state schools will participate in the WNHSS by March 2008, and all state schools will participate by 2010. The Children's National Service Framework (Welsh Assembly Government 2005a) sets national standards for service delivery in health and social care and makes links to other services including education. Key actions under the promoting Health and Well-Being standard include some pertaining to healthy schools. One of these is that all LEA maintained schools should participate in the WNHSS. However, a major role of healthy schools appears to be perceived as implementing initiatives, as demonstrated by the statement that schools should specifically implement food and fitness actions during their involvement.

There is also an argument that the appearance of the WNHSS in many different documents may help to embed the idea of school health within policy. And the final documents may not adequately represent the hours of detailed discussion preceding their formulation. As they stand, however, they do not adequately represent the WNHSS's role as a whole-school programme with a central role in organising school health promotion.

EDUCATION: *The Learning Country,* (Welsh Assembly Government 2006) the National Assembly's consultation document on education strategy, states an objective for all schools to join the WNHSS by 2010. This is mentioned in the Early Years (age 3-7) section of the document but is not related to other sections about the education of older children.

So although healthy schools has been well integrated into some policy papers, this process has not been universal, raising the potential for confusion over the priority for the WNHSS and uncertainty over the commitment of Education in particular. Without commitment to a formal policy by both Health and Education, there is a danger that neither department will continue to support the programme.

Recommendation 9:	With a view to securing the long-term future of the network through appropriate commitment within policy and strategic documents, all possible measures should be taken to remind Assembly Members of the importance of the WNHSS as a framework for public health and educational improvement in Wales.

In the absence of a formal policy setting out the role of the WNHSS, continued funding has been justified by demonstrating ways in which the Network can assist the Assembly in achieving policy targets. Expert Panel member Ian Young pointed out at a regional workshop that this situation is paralleled at European level, where Schools for Health in Europe (formerly the European Network of Health Promoting Schools) obtained funding from the European Commission on the grounds of its value in promoting healthy food and physical activity. As well as formal justifications to Ministers for further funding of the WNHSS, monitoring reports completed every six months by local schemes include questions linked to current national policy priorities such as "How many Fruit Tuck Shops are being run in schools in your area?" Responses help the national co-ordinator to provide current information relevant to Ministerial concerns and thus to demonstrate the ongoing utility of the WNHSS.

The need to demonstrate the value of the WNHSS in addressing broader policy issues, combined with the recent national emphasis on policies aimed at reducing the prevalence of obesity, have resulted in a tendency for the WNHSS to be identified with healthy food and physical activity. For example, one healthy schools Co-ordinator said that the local Education department tended to see the local scheme as a healthy eating project and had not grasped the full extent of their work. Promoting a more balanced view of the WNHSS is not straightforward because the holistic nature of the WNHSS is a complex idea which is not easily communicated in ways which capture the attention of Ministers or the wider public. In the words of Ian Young at the same workshop, *"the 'eco-holistic approach' is not a vote winner"* and *"we need to get good at explaining the Healthy School approach".*

Recommendation 12:	There is a need to investigate ways of presenting a more accurate image of the whole-school approach of the WNHSS in a way which is easily remembered and understood.

There was a view from stakeholders at one regional workshop that the identification of the WNHSS with a single health topic was not a problem. The current emphasis on food and fitness was an enabling characteristic and demonstrated the ability of the network to respond and adapt to changes in society. Concerns about the growing levels of obesity presented an opportunity for the WNHSS to tackle this issue. An interviewee also felt strongly that if all agencies in one area focused on one theme such as healthy eating, they were more likely to make an impact (CS114).

5.2.2 LOCAL LEVEL

Local healthy schools Co-ordinators have an important role as scheme leaders. Others from whom leadership might be expected at local level are Directors of Public Health, Directors of Education and elected council members.

Local healthy schools co-ordinators

Co-ordinators were asked to answer the question "What is a healthy school?" to see if they could articulate their vision in terms of the three domains of health-promotion action. Most found this difficult:

> *". . . because it's what you feel rather than putting into words. Because it's really about the whole ethos of the school . . . Basically it's a school where health is a way of life, that's our vision of a healthy school, where things are so embedded that they are a way of life."* (HSC)

Two co-ordinators quoted the World Health Organization in answering this question and one explained the healthy school by explicitly mentioning the three domains. Other aspects mentioned included the centrality of health in all activities of the school; ethos; the integration of health promotion in schools; involvement of everyone in the school and community; happiness of children; and practical issues.

In practice the co-ordinator's ability to articulate a holistic vision of health in schools does not seem to have been a very important factor in convincing schools of the value of undertaking health promotion and joining local schemes (see section on recruitment below). Of 126 headteachers and in-school co-ordinators of healthy schools who participated in the stakeholder consultation, 91 (72%) said one of their reasons for joining was a personal belief in the value of health promotion in schools. Of 14 headteachers who had not yet joined their local schemes, 10 (71%) also said this personal belief was one reason they wanted to join. This was by far the most important reason, the second most important being because 58 (46%) respondents from healthy schools and 3 (21%) from outside the network believed that membership of the scheme would contribute to school effectiveness.

Some headteachers had begun health-promotion action before joining the local scheme, out of a concern for the welfare of pupils. For example, one secondary school head had realised the importance of the holistic approach and started to work independently five years before joining:

> *"There's a crying need . . . We came to the conclusion a long time ago that the only way to raise academic achievement which is in the end what we're generally measured by, the only way to raise that is to try to work to some extent with the whole pupil and the whole family and the whole community. . . If the kids eat more healthily, then they'll be ill a bit less often – because attendance is an issue with us – poor kids do have bad health."* (SS15)

The main efforts of co-ordinators in promoting the scheme to schools were directed at encouraging schools to persevere in carrying out their action plans and assembling folders of evidence. Although schools are keen to join, some see the amount of extra paperwork involved as a major barrier to achieving targets. Time needed to assemble evidence for assessment was thought to be a barrier by nearly half of healthy schools staff (n=45, 49%) who answered this question as part of the stakeholder consultation (Table 4).

Table 4: Barriers to achieving targets in each Phase of the healthy school scheme: Answers from headteachers and in-school co-ordinators at healthy schools (n=92)

What, if any, have been the most important barriers to achieving targets in each Phase? (Please tick NO MORE THAN THREE boxes)	Number	*% of total valid responses (N=92)*
No barriers	23	*25*
Time needed to assemble evidence for assessment	45	*49*
Lack of support from healthy school co-ordinator to prepare for assessment	0	*0*
Unrealistic targets	3	*3*
Targets inappropriate to school needs	4	*4*
Too much work for staff	15	*16*
Obtaining support from pupils	1	*1*
Obtaining support from parents	16	*17*
Obtaining support from staff	9	*10*
Inadequate funding/resources	28	*30*
Obtaining support from LEA	0	*0*
Other	4	*4*

There was also evidence from case studies that record-keeping was a barrier for schools, for example:

> *(Did you have any doubts about being part of the healthy school scheme?)*
> *"Yes. The main doubt was about how much bureaucracy there would be involved in it and do we have to make long recordings and assignments and have to justify everything we do so that is always a doubt especially if you are already doing things…"* (PS51, translated from Welsh)

Co-ordinators approach this problem by showing staff examples of portfolios, by asking teachers from other schools to talk about how they had carried out health promotion actions, raising awareness of progress the school has already made in promoting health, and minimising paperwork. Many provide presentations for all new recruits. One, however, pointed out that there was a need to accept that *"a significant amount of additional work"* was required (HSC).

Recommendation 34:	It is recommended that local schemes should drop the portfolio as a requirement for schools' assessment and instead ask schools to produce a succinct record of the action taken, with evidence of a systematic approach.

Administrative department heads and elected council members

Leadership from councillors, school governors and senior staff in Education and Health was variable. For example:

> *"We've been quite lucky . . . the education lead councillor is fully supportive and even attended a school dinner conference in London last year because he really sees it as an important issue."* (HSC)

was balanced by

> "We have sent [local councillors] information, for three years they've been invited to the ceremonies, and they've been invited to sit on the steering group, but we haven't really got anywhere" (HSC)

Leadership from administrative heads was important: workshop participants reported that sometimes it could be difficult to engage directors of departments and where this happened it could then be a struggle to get others from that department involved. The status of healthy schools Co-ordinators is an important determinant of their ability to advocate the scheme to senior managers and councillors. One healthy schools Co-ordinator whose post was at management level pointed out that this allowed them to sit on strategic groups such as the Children and Young People's Partnership and have a strong input regarding healthy schools (HSC). The seniority of the post also meant that the scheme had a management group which was empowered to take decisions relating to budget, funding and priorities.

Recommendation 21:	It is suggested that the Welsh Assembly Government explore strategies for securing more consistent support for schemes from senior local authority staff. These might include measures to ensure that a senior management post carries responsibility for the scheme; specifying duties of management/steering groups; and a requirement that the healthy school scheme should be included in health and education strategic plans. Extra conditions of funding local partnerships might be useful in achieving a greater level of support.

Nearly all local co-ordinators wanted to get more publicity for their schemes. Most seemed to think of doing this by involving local press or local authority press officers. Those who considered local radio and TV, and using websites, were in a minority. Publicity seemed to relate more to schools without raising awareness of the scheme. Healthy schools Co-ordinators said the local press were more likely to report on healthy schools if approached directly by schools themselves, and many schools reported getting publicity in this way.

Recommendation 14:	Healthy schools co-ordinators should discuss ways of obtaining publicity for local schemes, as well as schools, in order to formulate guidance on best practice and generate practical strategies for promoting schemes.

5.2.3 SCHOOL LEVEL

Headteachers are key leaders at school level.

> "... heads talk to heads and they know what goes on and if it wasn't held in any esteem and it wasn't highly thought of I would sink in this borough" (HSC)

One head talked about healthy schools at every meeting he attended, to disseminate the concept locally. However, the "clear vision" of headteachers as leaders of health promotion in schools was found in some cases to be fundamentally an educator's vision, developed independently of the healthy school scheme.

"Anything we do, we do because we believe that it is important for the pupils and that it helps the pupils' school experience and in that sense, we are part of the WNHSS because their commitment and their beliefs tally with our shared ideas. I don't think that it is a case of saying we will . . . join the WNHSS because we share their values. It has come the other way really." (SS27)

In-school co-ordinators and senior management teams in schools also acted as leaders promoting action within schools and there was much evidence that they are very involved in and supportive of local schemes. However in some schools the extra payment awarded to teachers undertaking the co-ordinator's role had discouraged other staff from becoming involved because they were not getting paid to do so. This suggests there may be some weaknesses at school level in communicating a holistic vision of health promotion and in motivating staff.

Pupils are emerging in some schools as important leaders of change. For example, in one school the headteacher (a teaching head) said that *"[the scheme] just all seemed too complicated and too hard to get on board"* (PS11) but that pupils had driven it forward. In another, the headteacher had heard "on the grapevine" that the school council had decided it was unfair that staff were allowed to eat toast at break times, while children were not, and was waiting to hear officially from the pupils (PS41). (This headteacher thought the teachers would probably have to give up their toast – and that this would be a mark of progress.)

Leadership seems to be easier for primary school staff than for those in secondary schools:

". . . secondary schools get a bit more complex because the schools are so big and don't have enough staff. I tend to work with one person and that person tends to be on the Senior Management Team and they then report back to their senior management team" (HSC)

In one secondary school with eighty teaching staff, there were no regular meetings for all of the staff; and they took their breaks in different groups split up across the whole school site. The headteacher, the deputy head/in-school co-ordinator and CDT teacher had done a great deal of work to promote the health of pupils and the school was in Phase 3 of the scheme. However, there appeared to be no involvement of staff as a whole and decisions about actions and targets to meet scheme requirements were made by these three members of staff (SS15).

Another secondary school with 130 teaching staff demonstrated the extent of effort required to raise staff awareness of the school's part in the scheme:

"I think that being a member of the HSS network it has focused us to make every member of staff aware of what is going on in the school. [in-school co-ordinator] did a training day on [date] and we had it as a healthy staff day (walking and cycling) - in the afternoon we had activity but in the morning we had a circus of 20 minute information sessions so I did a session on risk assessment when taking pupils on trips and what you need to do to ensure pupil safety. [in-school co-ordinator] did a 20 minute session on the WNHSS and what we do and what the healthy schools network is and [teacher] did a session on pupil health, you know raising our awareness of pupils in school who need to use epi pens and pupils who are asthmatic etc." (SS27)

Recommendation 15:	Consideration should be given to setting up a working group tasked with producing guidance for local schemes regarding how they can best support secondary schools, including ways of increasing participation by identifying smaller groups within schools.

5.3 Administrative and Management Support

Key findings:
- **The support of the Welsh Assembly Government for local schemes gives them authority and credibility which promotes recruitment and implementation of changes in schools.**
- **There is a preference for stronger management and guidance for schemes at national level.**
- **Strong management systems at unitary authority level are important in supporting development of local schemes**
- **Schemes are valued by senior NPHS managers as an important framework to co-ordinate and deliver a broad range of health-promotion interventions in schools**
- **The forms of support most unequivocally valued by schools are the support schemes provide for planning actions and the extra opportunities the scheme affords to meet staff from other schools at training and other events.**

5.3.1 NATIONAL LEVEL

The national co-ordinator provides administrative and management support for the WNHSS. This role includes advocacy for continued national funding for local schemes; arranging regular meetings of local healthy school co-ordinators and facilitating their training; and passing on information and resources to local scheme co-ordinators. She is in regular contact with co-ordinators by phone and email.

The WNHSS framework document (The National Assembly for Wales 1999) has provided clear guidance on school, local and national roles and on the aims of the network. The Assembly Government has also produced other supportive materials such as the healthy schools Assessment Tool (The National Assembly for Wales 2001a) which gives detailed guidance on how to choose and carry through changes. The Logic Model (Figure 1) is evidence of the Welsh Assembly Government's systematic approach to planning and a guide to expected outcomes.

Schemes are required to submit six-monthly monitoring reports by completing a pro forma designed by Assembly Government officials. Overall, the co-ordinators found the reporting procedure reasonable: *"compared to other reporting procedures it is a nice one to complete in a way"* (HSC). Some mentioned that it was helpful in prompting a review of what they had achieved and where they needed to do more work – *"I feel it is a good procedure as it helps to focus"*. (HSC)

The national co-ordinator is a primary point of contact at the Assembly Government for all local co-ordinators and is accessible by phone and email. Healthy schools co-

ordinators welcomed her regular updates on Welsh Assembly Government initiatives and policy decisions and clear guidance on their responsibilities. Some examples given were notice of consultations; information about water, food handling and oral health; latest guidance on lunch boxes. Co-ordinators felt they had an important role in passing on information received from the Welsh Assembly Government because information sent directly from the Welsh Assembly Government to schools was not always recognised as important.

All-Wales meetings of healthy schools Co-ordinators organised by the national co-ordinator were also much appreciated as opportunities to discuss issues affecting local schemes. Some healthy schools Co-ordinators who worked alone felt that Assembly support enabled their schemes to perform to a higher standard than would otherwise have been possible. The new ESTYN guidance (Estyn 2007) requiring evidence that schools promote healthy living had been particularly helpful in raising schools' awareness of the value of healthy school schemes. This was felt to be due to the efforts of the national co-ordinator and an important aspect of the Welsh Assembly Government support. One co-ordinator commented that it had been important in raising awareness of the scheme in the Local Education Authority.

The most important aspect of Welsh Assembly Government support, however, may be the authority and credibility it affords to local schemes and schools. One healthy schools Co-ordinator said *"We are a respected scheme and we are respected at a high level"* and this co-ordinator points out to schools that the scheme is mentioned in Assembly documents *"so really it's not a Mickey Mouse, d'you see what I mean?"* (HSC) This effect was also observed at school level:

> *"I was naïve enough to think that I could do it without having a WAG initiative to make me do it and that it would happen because I believed in it. But I'm afraid being a WAG initiative has just made it happen a bit more easily."* (PS11)

Headteachers reported that Welsh Assembly Government ownership of the scheme made it easier to overcome opposition to change from parents and school staff.
> *"The scheme gave me the leverage to put in to place the kind of thing that I'd wanted to do for a very long time."* (CS610)

Some healthy schools co-ordinators had reservations regarding questions in the monitoring reports to the Assembly about the number of schools benefiting from other health-promotion initiatives. Firstly, some thought the questions were not relevant to the healthy school scheme:

> *"It's something the Welsh Assembly like to know because it's fixed and it's measurable. What they don't want to know is how much better our kids feel about each other because they've got a nicer environment and they've got peer mediation."* (HSC)

The other concern was the requirement to provide information regarding numbers of fruit tuck shops, water coolers, and so on. Co-ordinators did not need these data to run their own schemes:

> *"They always ask us . . . how many water coolers do schools have – how do we know?"* (HSC)

However some co-ordinators had dealt with this by setting up systems to facilitate reporting and one had found the database useful for informing local strategy. Another co-ordinator felt the Assembly should demand more e.g. by setting targets for the use of health promotion resources such as smoking packs. Workshop participants felt that provision of such facilities in schools could be used as an indicator of progress (see section on Monitoring and assessment below).

While access to the national co-ordinator was highly valued by a majority of healthy school co-ordinators, there was also a view that the degree of direct contact between National and local co-ordinators tended to blur lines of accountability:

> *"it's not always clear where the responsibility and decision-making lie with regard to how schemes work."* (HSC)

and that the Welsh Assembly Government should be forming stronger links with unitary authorities at a more strategic level. Many stakeholders at regional workshops also expressed a need for a more secure management framework at national level with a greater degree of cross-departmental co-operation and formal policy supporting healthy schools. In particular, short-term funding was felt to be a destabilising factor contributing to job insecurity and reducing confidence in the sustainability of local schemes:

> *"They say it's permanent at the moment but it's as permanent as they want it to be."* (HSC)

Recommendation 7:	Now that the WNHSS has entered an "establishment phase", it may be advisable to review the national co-ordinator's role. Possible changes might include an increased focus on strengthening links at strategic level both locally and nationally.

5.3.2 LOCAL LEVEL

Local healthy schools Co-ordinators support schools in much the same way as the national co-ordinator supports them. Most reported that schools can contact them by phone or email if they need to. They arrange healthy schools events which promote communication between staff from member schools; and organise and deliver training for schools.

With few exceptions, healthy schools Co-ordinators have good links with others who work directly with schools e.g. school nurses and PESS co-ordinators. In all schemes, the healthy schools Co-ordinator and others working directly with schools had worked together to some extent to plan their approach to schools so that they could help each other in bringing maximum benefit to schools. For example, in one area healthy schools, Community Focused Schools and Eco-Schools Co-ordinators meet staff from cluster groups regularly to plan how new policies such as Food and Fitness can be implemented (HSC).

The increase in numbers of schools belonging to local schemes has presented some challenges where resources may not have kept pace with the enlargement of the scheme. Co-ordinators in some schemes have found that they are no longer able to fund supply cover for a larger number of schools to release staff for training and healthy schools events. Many schemes have needed to recruit more assessors or to

make more demands on existing volunteers. Supporting larger numbers of schools has also prompted a reappraisal of healthy schools Co-ordinators' working practices so that they work more closely with other agencies involved in schools and make more use of existing schools networks:

> *"the lead officer in this area is . . . very enthusiastic, very industrious, very committed, and she's got some extra capacity now but also through our engagement with our other agencies and recognising that rather than going school by school, go cluster by cluster to get quick wins with individual schools who can then provide the leadership in the clusters which is then facilitated and supported by [healthy schools Co-ordinator] and her colleagues rather than [healthy schools Co-ordinator] having to do all the running."* (CS62)

It was clear that as this scheme developed, greater demands were made on the healthy schools Co-ordinator's management and team-working skills and that they were supported to develop professionally to meet this challenge. One interviewee pointed out that management support within unitary authorities has been essential to facilitate this kind of development by reviewing progress, setting priorities and managing resources because "people on the ground" do not generally have enough time to do this.

> *"To my mind it has to . . . be owned at that level, to be effective."* (CS56)

In this unitary authority, the healthy schools Co-ordinator had not recognised the importance of working with clusters and had received no guidance from a more senior level. This had hampered their engagement with schools and other local partners. A co-ordinator for another local project commented:

> *"the way it's been rolled out initially with only a number of schools on board, it was very difficult for us to get involved because we work on cluster basis and so if one school in a cluster does something we try and ensure that it is offered throughout the cluster"* (CS515)

Recommendation 19:	Working with school clusters appears to amplify the impact of the programme and all healthy schools Co-ordinators are recommended to make full use of these networks.

Weaknesses in management at unitary authority level were associated with organisational changes within the unitary authority, involving changes in posts, relocation of staff and changes in senior management personnel. Responses to the stakeholder consultation suggest that turnover at staff at senior level is high: most Directors of Education and Public Health who responded had been in post for three years or less (Table 5).

Table 5: Time in post: Directors of Education and Directors of Public Health who participated in the stakeholder consultation

Time in current role		Education Director	Public Health Director
Less than a year	n	0	2
1-3 years	n	3	4
4-6 years	n	1	3
7 or more years	n	1	2
Total	n	5	11

Directors were also under pressure because of heavy workloads; for example:

> "I think it is just the sheer capacity that means that I cannot sit on every partnership group in [unitary authority] because . . .we are contracted to actually only work part time on the local patch and then the rest of our role is to actually work for the national public health service at a regional and national level. . . . I am only contracted to work two days a week on the local work in [unitary authority] which . . . is really quite a small amount of time when you think about all of the partnerships that we should be involved with." (CS26)

This suggests that in those unitary authorities where healthy schools Co-ordinators and schemes have been assisted to cope with increased demands, management systems are in place which make local programmes more resilient to lack of capacity and changes in personnel at strategic level. One factor is likely to be seniority of the healthy schools Co-ordinator (see section on Leadership above).

There was evidence from case studies that Directors of Public Health and other senior managers felt that the healthy schools Scheme had great potential as a vehicle for co-ordinating and delivering health promotion in schools and therefore should have an important role in local strategy. However, local Education and Health strategies found online suggest that healthy school schemes had not yet been incorporated into local strategy, particularly Education strategy, in some areas. Of twenty-two Health, Social Care and Well Being Strategies for 2005-2008 found online, four made no reference to healthy schools. Only twenty Local Education Authority Single Education Plans for 2006-2008 were found online and four of these did not mention healthy schools.

Recommendation 17:	It is recommended that local authorities should consider the logic model as part of their work in developing bids for Children's and Young People's plans and Health, Social Care and Well Being strategies.

There may also be a danger that senior managers regard the healthy school scheme as a convenient tool for dealing with local health-promotion priorities without recognising its potential to achieve permanent improvements in all aspects of schools. Of twenty-two Health, Social Care and Well Being Strategies found online, only three demonstrated understanding of the social-ecological approach of the Scheme, for example:

"This programme clearly contributes towards improving health and well being of children and staff alike, together with aiming to strengthen ties with local communities." (Ceredigion)

Other strategies (4) mentioned healthy schools as one initiative among a range of others including PESS, Dragon Sports, Safe Routes to School, crime prevention, diet, Project Lydia and fruit tuck shops. Four plans mentioned the usefulness of the scheme in addressing food and fitness, mostly food. A further four strategies appeared to perceive the scheme as a vehicle for delivery of a range of specific health promotion topics, including nutrition.

Of twenty Single Education Plans, two mentioned "a whole-school approach". The contexts of other references were varied, and suggested some perception of the broader scope of the Scheme. Three plans related healthy schools to food and nutrition, and others mentioned school councils or pupil participation (5), ESDGC / Sustainable Schools / Eco schools (5), staff health (1), and partnership (1).

Recommendation 21:	It is suggested that the Welsh Assembly Government explore strategies for securing more consistent support for schemes from senior local authority staff. These might include measures to ensure that a senior management post carries responsibility for the scheme; specifying duties of management/steering groups; and a requirement that the healthy school scheme should be included in health and education strategic plans. Extra conditions of funding local partnerships might be useful in achieving a greater level of support.

5.3.3 SCHOOL LEVEL

For the most part, co-ordinators are sensitive to the needs of schools and adjust their approach accordingly.

> *". . . we start to work through with them rather than dictate to them and we'll support them in ways that they can do it in which they are comfortable."* (HSC)

> *"It comes back to the relationships that we've got with the schools just with working with the teachers involved and helping them to see the merits of being involved"* (HSC)

There was evidence of clear structure and planning with schools:

> *". . . they can see where they are going quite clearly with the set actions and set indicators to work to and on."* (HSC)

In one region of Wales, most schemes had adopted a "Ten Point Plan" specifying the commitment which all schools were required to make when joining the scheme. The plan was developed in one scheme where it is supported by local policy linked to the overarching education and health improvement strategies (HSC).

Many co-ordinators told us that they had tried to cut paperwork for schools to a minimum so that they were better able to reach their targets on time. For example:

> *"... we've heavily, massively reduced the amount of paperwork that schools have to do, and our more hands-on approach means that schools are assessed or evaluated constantly throughout the year so they haven't got a need to produce a hefty file"* (HSC)

Communication between schools is facilitated by cluster meetings, annual celebration events, training sessions and by local co-ordinators who can informally share and pass on good ideas and requests to their school contacts:

> *"... it's being talked about more, it's being communicated through headteachers' meetings, deputy headteachers' meetings, I think people know a lot more about it now than they did in 2001. People's perceptions of it might have changed in a positive way"* (HSC)

> *"One school had a sensory garden and other schools wanted that so I put them in touch and we went and visited the school with someone from the other school. That is how it tends to work."* (HSC)

All healthy school schemes offer regular visits to schools to help them to plan actions, set targets and prepare for assessments. healthy schools Co-ordinators make extra visits if they judge there is a need and they also invite schools to contact them in between planned visits if they require further support. Many headteachers and in-school co-ordinators made a point of praising the support they had received from healthy schools Co-ordinators, particularly in preparing for assessments, and 57 (45%) of those responding to the stakeholder consultation said that support had been "more than adequate". However there was some evidence from case studies that the support offered was not always appropriate. For example, one headteacher who had completed an audit using the healthy schools Assessment Tool before contacting the healthy schools Co-ordinator was "slightly irritated" to be asked to do it again (PS11). And secondary-school staff who were facing significant problems in carrying through actions were appreciative of the help they had received but when asked if they had received enough help, said they could have used more (SS15). The support of the co-ordinator may be almost irrelevant to some school leaders with an independent vision of what they want to achieve (please see section on leadership above). This was acknowledged by one co-ordinator, who said:

> *"I'm just a mechanism that actually gets them focussed on something."* (HSC)

Eighty–one (64%) headteachers and in-school co-ordinators who participated in the stakeholder consultation said that they foresaw a time when their schools could continue to carry forward health promotion actions without the support of the healthy schools Co-ordinators. The latter without exception thought that schools would always benefit from at a least a minimal level of support to keep them up to date with new initiatives, to offer training and resources and to maintain continuity when there were changes of staff.

The most useful features of schemes' administrative and management support for schools are the support for planning and the opportunities to share good practice provided by the scheme. Two headteachers had used the scheme as a way of addressing problems presented by the behaviour of some pupils in primary schools. One said:

[The school] had quite a bad name and we had quite a lot of difficult children here behaviour-wise so out of necessity we looked at our school from a very different point of view because we had some children from very chaotic families coming into school and we thought 'Unless they're ready to learn, unless they're in an emotional state to learn, they're not going to learn.' And so we really embraced the healthy schools from the aspect of discipline in school. We took on positive discipline, we looked at positive rules . . . and so we worked from that central core of our own need really. And then the healthy schools just developed from that and supported us in all that we were trying to do." (CS59)

This headteacher said that over ten years, numbers of children with behavioural problems had decreased from about half to very few.

Recommendation 16:	The value of the WNHSS in improving pupils' general behaviour as a basis for learning should be more widely promoted. Consideration might also be given to providing more support for teachers to reconcile any perceived conflict between delivering the curriculum and providing more pastoral care e.g. through funding to take time off from teaching for "pump priming" activities.

All headteachers and In-school co-ordinators said that they had benefited from using the healthy school scheme model to plan, set targets, implement and evaluate changes. Even the more self-motivated and independent headteachers felt that the model was a valuable tool which had helped them to set priorities and to focus on what they wanted to achieve. There was also much praise for training and other scheme events where they could strengthen and maintain links with local schools and hear about others' experiences.

5.4 Critical Mass

Key findings:
- **There is a need to address health issues during initial teacher training throughout the UK; training of teaching staff should not be left entirely to healthy schools Co-ordinators.**
- **Data provided to the Welsh Assembly Government on training of healthy schools Co-ordinators and of staff and others involved in healthy schools are insufficient to allow systematic management**
- **Schemes vary in their approach to provision of training to schools; disparities appear to be related to local availability of funding and resources and also to differences in Co-ordinators' experience and skills in managing this responsibility.**
- **So far, insufficient training has been offered to support school staff**

The idea of critical mass is derived from Diffusion of Innovations Theory (Rogers 1995) which explains how new ideas and practices are adopted by a population over time. The pattern of diffusion is often illustrated by an S-shaped curve (Figure 5) mapping the early adoption of the idea or practice by a few people (early adopters), the increase as more people (late adopters) are won over, and then the "cascade" of change as most members of the remainder of the population follow suit. The critical mass occurs at the "critical mass inflection point" on the curve when early and late

adopters reach a proportion of the total population which seems to make wider adoption inevitable, or *"the point where there are enough adopters that further diffusion becomes self-sustaining"* (Rogers et al. 2005).
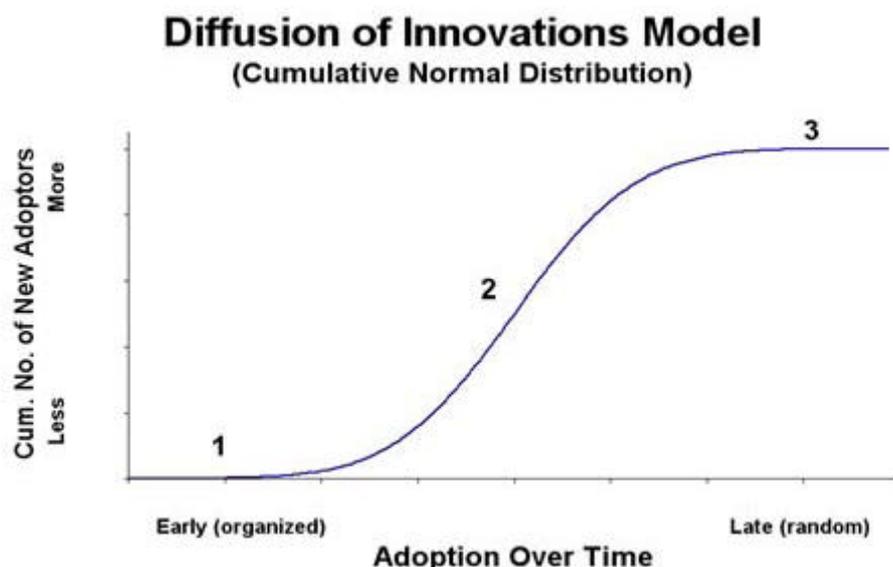
Figure 5: S-shaped curve describing the pattern of diffusion of innovation, from (Rogers et al. 2005) Point 2 is the "critical mass inflection point"

The process of creating such a critical mass includes recruitment of suitable people, training which enables them to share the same vision of change, and development of good practice demonstrating the desirability and feasibility of change (Vince-Whitman 2005). Specific actions contributing to the formation of a critical mass at national level are the Welsh Assembly Government's funding for local schemes, which prompted the establishment of schemes in all unitary authorities in Wales, and the appointment of healthy schools Co-ordinators in each authority as a condition of funding. The Welsh Assembly Government has also set targets for recruitment of schools: expected outcomes are that three quarters of schools will belong to the Scheme by March 2008 and all schools by March 2010 (Figure 1).

Development of critical mass at local level includes recruitment of schools; and training of staff, governors, and others involved in schools so that each school develops its own critical mass.

5.4.1 RECRUITMENT OF SCHOOLS

Recruitment of schools has been a major responsibility for co-ordinators leading the development of local schemes. Figure 6 illustrates percentages of schools recruited from 2001 to 2006, based on data from scheme monitoring reports. The Assembly's intermediate outcome expectation is that 75% of schools will be involved in local schemes by March 2008 (Figure 1). As the national co-ordinator reported at the Regional Workshops, this expectation had by late 2007 been exceeded at national level.
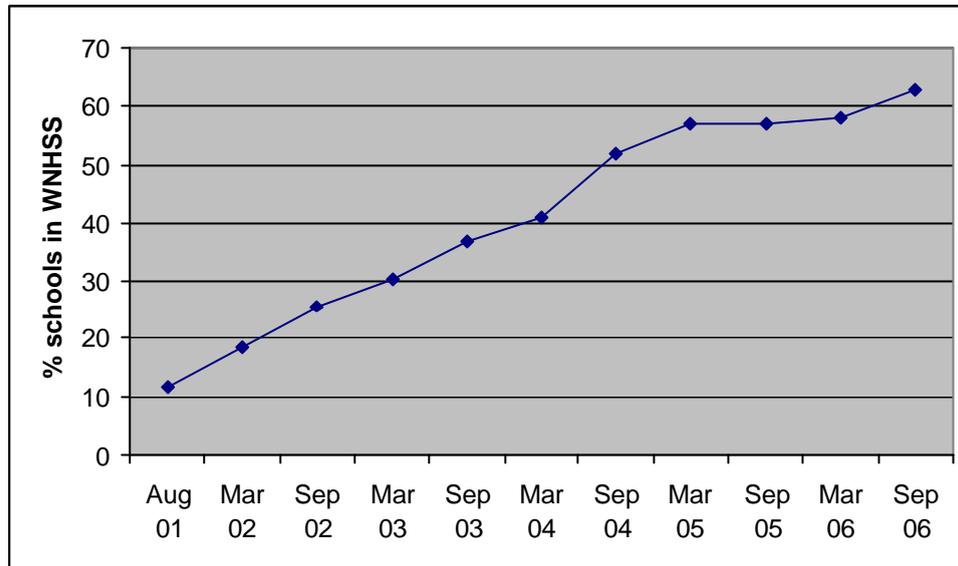
Figure 6: Percentage of schools in WNHSS 2001-2006

The national outcome conceals variation in recruitment figures for each scheme, with some having recruited 90-100% of schools and others only 40-70%. Evidence from case studies and interviews suggests that the slower progress of some schemes may be due to gaps in management support at unitary authority level where no-one takes responsibility for overseeing the scheme to review progress, assess priorities and allocate resources. In these circumstances the healthy schools Co-ordinator may receive little support to adapt scheme practice to a larger population of schools (see section on administrative and management support) and there may be little capacity to cover for the absence of a healthy schools Co-ordinator on holidays or sick leave. Other issues which may have affected recruitment are discussed in the section on Equity.

Within some scheme areas, the "critical mass" in terms of numbers had been achieved. When asked what evidence was most convincing in winning people over, one co-ordinator said:

"Telling them 67 schools are on board and them thinking if 67 schools are on board, it's got to be worth doing."

Most co-ordinators had always recruited new schools in stages, from a waiting list. However, many schools were already aware of a responsibility to improve health and did not need to be reminded of it.

> *"I don't think we need to win people over – everyone in [county] is on board already, all self-motivators."* (HSC)

One co-ordinator pointed out that teachers were well aware of their pastoral, as well as their educational role and that when they joined the scheme:

> *"They know they are doing right by the children"* (HSC)

This was consistent with other evidence (see section on leadership) that healthy school schemes were meeting a widespread need rather than introducing a new idea, and that the critical mass may have pre-dated the establishment of most schemes.

Co-ordinators were more likely to present arguments for the scheme when schools were committed to joining, or had just joined the scheme but were daunted by the prospect of doing a lot of extra paperwork. Some presented evidence about the prevalence of ill-health in the county to emphasise the need for health promotion in school, and evidence suggesting a connection between health and academic achievement.

The main barrier to recruitment had been the capacity of schemes to provide support. headteachers of schools which had not yet joined a local scheme were asked as part of the stakeholder consultation if they would like to join. Of thirteen who answered the question, twelve said they would like to join. Some schools waiting to join were already carrying out health promotion action and in one scheme the co-ordinator supplied them with written information, training and resources so that they could start working on health topics during the waiting period (HSC).

5.4.2 TRAINING

A workshop participant pointed out that initial teacher training at institutions throughout the UK should address healthy schools so that all new teachers qualified with an understanding of what healthy schools involved. Expert Panel Members Malcolm Thomas, Ian Young and Sharon Doherty agreed that this problem had not yet been adequately addressed in Wales, England or Scotland.

National level

At national level in Wales, training for healthy schools Co-ordinators is provided by the Welsh Assembly Government. The national co-ordinator organises and delivers training for newly appointed Co-ordinators and assessors; and facilitates two-day training events for healthy schools Co-ordinators every 8-9 months by organising venues and meeting travelling and subsistence costs. Most Co-ordinators find this training enjoyable, relevant and useful.

The national co-ordinator has recently delegated the planning of content to the Co-ordinators themselves and Co-ordinators' regional groups take it in turns to undertake this task. There were mixed views on this development. Some Co-ordinators found it burdensome, saying that time spent attending planning meetings meant less time devoted to schools; and that they did not always have the specialist knowledge to choose appropriate speakers and activities. A few however felt that this was an opportunity for professional development. One interviewee, not a Co-ordinator, felt that the Welsh Assembly Government should commission outside agencies such as consultant firms to organise and deliver training for healthy schools Co-ordinators.

The Welsh Assembly Government's provision and support of training suggest that it is a priority at national level. Training is organised at national level (for local co-ordinators and assessors) and at local level (for schools). However, the data collected through six-monthly monitoring reports do not provide an adequate level of detail to establish the number or type of courses delivered, who they were for, and how many people attended. More detailed mapping of training provision at national level could facilitate planning, monitoring of progress or the identification of problems. Information requested might include: date, time of day, duration, topic, venue, type of trainee (e.g. teachers, governors), one-off or part of a regular programme (if the latter, what programme, how long, how often), numbers attending from each school, name of trainer, source of funding.

The absence of detailed information is partly due to the wording of the question before a revision of the pro forma in 2007: "What training have the schools been offered since your last report?" (This has now been revised to "What other specific training has been organised during the year and how many schools have attended?") However it is also important to find out more about training provided not only for schools but also for healthy schools Co-ordinators. Co-ordinators and other team members from some schemes do not attend every training event and their needs may not always be met through their local employers.

Recommendation 26:	Revision of the monitoring report pro forma to collect more information about training would demonstrate that at national level, training is perceived to be of prime importance and give a clear lead for good practice at local level. Questions about training should be carefully framed and given more prominence in the pro forma. A separate question could ask for a similar level of detail on what training/education local co-ordinators and their teams have received during the reporting period.

Local level

At local level, an important part of the healthy schools Co-ordinator's role is to ensure that schools receive training to support their practice as scheme members. However there is no evidence that Co-ordinators themselves are trained or otherwise prepared for undertaking this responsibility in a systematic way. Practice varied between schemes. Some schemes plan at least part of the training for schools as part of a regular programme but others do not have the resources to plan very far ahead:

> "... we don't have a training programme every year because of the funding and capacity problems" (HSC).

Recommendation 27:	Curtailment of training offered to schools was reported in some schemes following an increase in numbers recruited. It is recommended that national and local co-ordinators should consider how disparities in available funding may be addressed so that local schemes can provide comparable levels of training.

Most healthy schools Co-ordinators deliver some training to schools in person but there was evidence that some might not take adequate time to assess the task or develop strategies for carrying it out by making more efficient use of school routines or linking with others who could share the work:

> "I was running around like a headless chicken, training in every school and soon realised it was difficult. I was doing whole schools days and going into every class and doing different topics. I didn't want to stop and it all to go to nothing so what I've got planned now is to get involved in the INSET training so they can cascade it." (HSC)

Recommendation 28:	Newly appointed healthy schools Co-ordinators do not always have the practical skills and experience which enable them immediately to adopt efficient methods for providing training to schools. Local employers should consider co-ordinators' needs for guidance and continued support on managing this aspect of their role.

Many co-ordinators organise "twilight sessions" at schools to carry out training with groups of teaching staff. Usually it is not practical for more than one member of staff from each school to attend training outside the school and if the scheme is unable to pay for supply cover, attendance rates tend to drop, so training within schools is one way of overcoming these difficulties. Co-ordinators are responsive to schools' needs for training on specific topics and offer training to accompany new resources for schools such as the Sense CDs (Sense Interactive CDs Undated).

As well as training for teaching staff, healthy schools Co-ordinators also offer training to others including support school staff, school nurses and governors. One headteacher pointed out the importance of involving *all* school staff in healthy schools and said this was made more difficult because training opportunities were most often offered to teaching staff. This headteacher had adopted a policy that *"whoever is free, goes"* (PS11) and had asked support staff to attend healthy schools meetings and training events to which only teaching staff had been invited.

One healthy schools team echoed the workshop participants who had identified the lack of preparation for teaching staff during initial training (see above):

> *". . . even at primary level, children do ask very difficult questions sometimes and without a background it's a lot to expect from teachers . . . that's just something that we thought was a bit of an issue, we haven't really come across it as a huge barrier but we are aware of it . . . there's nothing on that initial teacher training or before to help prepare them. And PSE is certainly getting a higher profile now, it used to be just something that you did on a Friday afternoon but it's not now."* (HSC)

5.5 Monitoring and Assessment

Key findings:
- **Many healthy schools Co-ordinators and other stakeholders are concerned about standards for healthy schools and perceive an advantage in developing common national standards.**
- **Varying standards of assessment were observed in different schemes where schools' achievements bore no consistent relationship to their progress through Phases of the scheme.**
- **Accreditation methods in some schemes lack independent scrutiny.**
- **Accreditation methods in some schemes place an over-reliance on portfolio evidence which may not be well supported by observation of the school and communication with staff and pupils.**

5.5.1 MONITORING OF LOCAL HEALTHY SCHOOL SCHEMES BY THE WELSH ASSEMBLY GOVERNMENT

An important aim of the WNHSS review is to make recommendations to the Welsh Assembly Government regarding the desirability and urgency of re-accrediting schemes. Evidence that schemes are supporting practice at variance with national guidance would suggest that re-accreditation is desirable and urgency would depend on the number of schemes which do not adhere to the guidance and the type of practice they support.

All schemes have been accredited on one occasion by assessors appointed by the Assembly. Otherwise the only formal routine method of monitoring local schemes has been through the six-monthly reports. While the latter have enabled the Welsh Assembly Government to keep track of recruitment of schools, they do not provide detailed information on training, quality and standards and there is a need to identify other indicators of progress.

National standardisation was seen as an important prerequisite for measuring the impact of the WNHSS. Many stakeholders at regional workshops thought that a shared definition of healthy schools was needed representing national and local agreement on what a Healthy School is. It was generally agreed that this would avoid large variation between schools and that the advantages of standardizing would be enhanced as by 2010 the scheme would be in the unique position of having contact with all schools. Many participants expressed a need for more clarity about what constitutes a school action and felt the Welsh Assembly Government had a role in providing authoritative leadership in this area. Some participants also called for a database setting out national standards for Healthy School actions over a broad range of health topics.

Other workshop participants were concerned about setting uniform standards for all schools. They felt that schools should not be asked to achieve the same standard because they did not start from the same baseline and that assessment should accredit the improvement of the school over time rather than achievement of a common standard.

Workshop participants also suggested that an annual re-affirmation of the partnership between local Health and Education departments would be useful and could be required as a precondition of involvement. Participants' views confirmed other review findings that the amount of engagement between Health and Education differed between authorities and they felt that the degree of engagement could be measured. Some thought that measuring the extent of engagement at Welsh Assembly Government level would also be desirable.

Estyn inspection requirements were considered at workshops and were seen to be important in encouraging schools to progress within the scheme. Some questioned if Estyn were qualified to make assessments relating to food and fitness, and were not sure how inspectors are to judge this. The fact that six months' notice of inspections is given to schools was considered a drawback as schools might use temporary expedients to pass the inspection. Participants also thought that schools should be given more credit in Estyn reports for health-related work.

Workshop participants also thought a measure of training provision would be a very important indicator. (See previous section.)

5.5.2 LOCAL SCHEMES' ASSESSMENT OF SCHOOLS

All schemes have a remit to monitor schools' progress and to carry out assessments of their work. Schools are required to produce portfolios for assessment. Plaques marking achievement and celebrating success are universally valued:

> *"It is amazing what a bit of wood does . . . I'm amazed how much they appreciate it and how much the children love getting that plaque to go up on their wall"* (HSC).

There appears to be no generally agreed method for setting standards that schools have to meet in order to be accredited. So schools may have done varying amounts of work to meet the targets set by different schemes. Workshop participants also commented on differences between schemes in the way they defined Phases and aims.

Accreditation of schools may be carried out by the person who supports the school or by trained members of the steering group and may lack independent scrutiny. Seven schemes involve external assessors to carry out assessment visits or to carry out quality assurance for assessments which are conducted by members of steering groups or other scheme personnel. In one scheme, external assessment is carried out every other year as funding does not allow more frequent use of independent scrutiny.

In two schemes, assessment is carried out mainly by healthy schools Co-ordinators and officers. Both schemes take measures to ensure that co-ordinators do not assess schools where they have provided ongoing support. One scheme sometimes uses members of the steering group as assessors but there are not enough to cover all schools.

All the other schemes have assessors recruited from steering groups or local authority staff, who are usually accompanied on visits by the healthy schools Co-ordinator. Some co-ordinators had doubts about whether this process was sufficiently independent.

In at least two schemes, assessors make judgements about accreditation based mainly on evidence in schools' portfolios and do not make assessment visits. However, many healthy schools Co-ordinators reported that portfolios did not always provide an accurate reflection of the quality of schools' achievements.

Workshop participants also thought that schools' portfolios were not reliable indicators of progress and they discussed what other indicators could realistically be used. Provision in schools of amenities such as healthy food and water coolers was thought to be measurable, with the stipulation that the manner of provision should be taken into account. For example, water coolers might not be accessible to everyone in the school. Measures of participation were also considered realistic: numbers of pupils taking part in initiatives or eating certain foods were seen to be achievable and comparable measures. Some participants emphasised the importance of collecting data on pupils' emotional health as well as factors affecting their physical health. Other indicators suggested were:

- inclusion/exclusion/absenteeism of pupils
- teachers' opinions on pupils' behaviour

- internet analysis of pupils' behaviour - reportedly used in Gloucestershire to study interaction and influence of the school environment
- the extent to which health is embedded in the curriculum – this had been done in one authority

Other indicators discussed at workshops were thought to be desirable but less practicable. Many participants mentioned school ethos but all acknowledged that this was very difficult to measure. Expert Panel member Sharon Doherty suggested the standard for ethos used in Lancashire healthy schools programme (http://www.lhsp.org.uk/getfile.php?src=74/Exemplar+material+Ethos.doc) might be useful in identifying relevant indicators. Teachers' health was thought to have a large and direct impact on school ethos and the high prevalence of stress-related illness among teachers was a matter of concern.

Provision of clean lavatories and hand-washing facilities was also considered. Participants thought encouraging pupils to keep lavatories clean and wash their hands was important and could have a big impact but would be too difficult to achieve in some schools. Individuals were said to be reluctant to accept responsibility for lavatory facilities and secondary headteachers reported there was no money to improve them. Participants also noted that drinking water was provided in lavatories in some schools and felt it was important to change this but that there was little money to do so. The stakeholder consultation suggested that school lavatories were also an important issue for pupils. By far the greatest proportion (46%) of responses from school councils about the worst aspects of schools related to the school site and buildings of which twenty-four responses (35%) indicated dissatisfaction with lavatories, for example:

"Unclean, lack of sanitation, vandalised" (SSC016);

"Mae nhw'n hen, wedi torri, drewi a lle diflas i fynd" ("They [toilets] are old, broken, stinking, and a dreary place to go") (PSC015).

Other responses indicated that facilities had no locks, no soap, and were malodorous.

Recommendation 36:	A mapping exercise to identify routinely-collected data available, and a consultation to determine which data are most relevant to activities of healthy school schemes, would assist in establishing systems to inform future monitoring of the WNHSS.

Visits to schools by the review team suggested that standards vary widely between schemes and supported workshop participants' and some healthy schools Co-ordinators' judgment that portfolios are not reliable indicators of schools' progress. One school in Phase 4 appeared to have integrated health promotion very successfully into all aspects of the school. This school had a rather sketchy portfolio compared with those seen in other schools: while there was a very comprehensive and well thought out policy on health promotion, there was no consistent written evidence of progress towards targets. In another scheme, a school in Phase 3 was hardly recognisable as a Healthy School except for the portfolio. In a third scheme, a school had reached Phase 6, with a comprehensive portfolio, but with little evidence of embedding of actions taken or involvement of the wider school community in deciding on actions. In this school, one of the targets for Phase 4 had been to set up

a school council but there was no evidence in subsequent phases that pupils were involved in decisions about actions undertaken in the school. The widespread practice by schemes of requiring schools to keep portfolios is an example of "attractor behaviour" which applies a common method of assessment used in schools – the portfolio – to the school's health promotion work. While it illustrates the success of the WNHSS as a network, in this instance there is no evidence that portfolios are a useful component of assessment, and they are not required by the WNHSS national framework (The National Assembly for Wales 1999).

Recommendation 32:	It is recommended that national standards for schools should be developed and applied to each Phase of the healthy school scheme.

Recommendation 34:	It is recommended that local schemes should drop the portfolio as a requirement for schools' assessment and instead ask schools to produce a succinct record of the action taken, with evidence of a systematic approach.

As well as indicators, workshop participants considered assessment methods. Self evaluation of schools had been tried in some areas using questions such as "has this worked?" and "how do you know?" which were felt to be quite easy to answer. There was a suggestion that school assessments could be carried out collaboratively with other agencies – most likely partners were Eco Schools and PESS. Many felt it was important to include pupils in assessments, such as student participation in health issues discussed on the school council, or choosing pupils at random and asking "Do you know what Healthy School aims are?" In one area Circle Time had been used to ask pupils what difference the scheme had made to them and this had produced a lot of information. Participants emphasised that pupils should not only be involved in assessments but that there should also be some estimation of the priority given to their views in planning changes to the school because in some cases pupils' views were expressed, but not acted upon. This view is supported by data from the stakeholder consultation suggesting that teachers and pupils have different priorities. Some participants said that much better use could be made of data already collected from schools.

Recommendation 31:	In the light of this review, consideration should be given to setting up a forum with the national co-ordinator, representatives of local co-ordinators, headteachers, teachers, advisers, Estyn and health promotion specialists to produce a consultation document on the future monitoring and assessment of the WNHSS.

Recommendation 37:	National standards should be defined for methods used by schemes to assess schools. Minimum requirements should include a measure of independent scrutiny and an on-site visit to the school[1].

Recommendation 38:	Re-accreditation of schemes is recommended and it is suggested that this should be carried out by the national co-ordinator with assistance from an independent expert, possibly a colleague from SHE.

[1] This requirement has already been introduced for Phase 6.

5.6 Time and readiness for change

Key findings:
- **Some schemes are accrediting schools for completion of Phase 4 and above in less than the two years recommended in Welsh Assembly Government guidelines.**
- **National guidelines on the minimum length of time for schools to complete phases may not be appropriate for secondary schools, which need longer to implement actions.**
- **At local level, due to the high rate of organisational change, the time factor is less important than others in ensuring that healthy school schemes are integrated into local policies.**

5.6.1 NATIONAL LEVEL

Schools, local authorities and the Welsh Assembly Government need time to assimilate changes involved in the introduction and growth of the WNHSS. At European and Assembly level, widespread dissemination is expected to result in national healthy school schemes such as the WNHSS becoming institutionalised (Piette et al. 2002) with a much reduced need for central government support. The time spent by the national co-ordinator on the WNHSS workload has decreased in recent years and is expected to be further reduced. To date the Welsh Assembly Government has funded local schemes for three-year periods, which appear to have been adequate to support the establishment and growth of the network so far, although some stakeholders have expressed a need for a more permanent commitment.

The Welsh Assembly Government has formulated guidelines for schemes on the length of time schools should allow for carrying out health improvement actions. Some confusion seems to have arisen regarding the time needed to achieve Phase 4 and later phases[2]. Some schools claim to be currently in Phase 7 but the national co-ordinator indicated that they cannot be if they have taken the recommended two years for each of Phases 4, 5 and 6 because they have not been in the network long enough. The danger is that actions from earlier phases will not be embedded and sustained if schools do not take time to review earlier actions and consolidate them as they enter each new Phase. Thus at national level there is a concern that schools should allow enough time but some evidence that this is not always considered at local level.

Recommendation 18:	Local schemes should adhere strictly to national guidance regarding the minimum length of time for schools to carry out work in each Phase of the scheme.

5.6.2 LOCAL LEVEL

Local Education and Health departments employing healthy schools Co-ordinators do not always seem to be allowed time in which to become ready for, and assimilate, change. Nearly all healthy schools Co-ordinators mentioned a range of departmental changes which had affected their work, including changes to posts, management structures, office location and allocation, and personnel. Against this background, the degree to which local healthy school schemes themselves have been assimilated

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[2] This situation has since been resolved.

into local policy and management structures varies (see earlier section on administrative and management support) and the extent of organisational change appears to have adversely affected scheme development in some areas. In counties where healthy school schemes have been more successful in recruiting schools, interviewees have reported that health has become a priority for education (HSC, CS114). This appears to be an indication that the scheme has been well assimilated into local authorities' policies and management structures. However, in the two schemes where this quality was evident, the time factor appears to be less important than qualities which assist in overcoming the instability of near-continuous organisational upheaval, such as leadership, continuity of personnel, and identification of common interests.

5.6.3 SCHOOL LEVEL

Many co-ordinators said the main change had been in schools' awareness and understanding of how health promotion could be integrated into the life of the school. Another big change was in the higher priority given to personal and social education topics in schools. One said that halfway through the second phase schools were starting to have a real awareness. By the third phase:

> *"it's just there in everything they do"* (HSC)

Other changes noted were the involvement of school councils in healthy schools; patterns of children's play in school yards marked out for games and with play equipment available during breaks; access to drinking water and healthy food; and teaching of sex education.

5.6.3.1 Secondary schools need longer

Some healthy schools Co-ordinators said they expected secondary schools to take longer than primary schools because they are bigger and it is not so easy to implement the whole-school approach. One secondary school had dealt with this problem when organising a whole-school fundraising event:

> *". . .if you are one of 1800 it is very easy to duck out and not be part and let it go over your head so what we do is take responsibility down to tutor group so each group of 25 – 30 children is asked to raise money for an Aqua box."* (SS27)

Secondary schools need a longer time to raise awareness and gain support from staff and pupils when introducing changes. One co-ordinator suggested that they required not only more time, but also a different approach.

More time to achieve phases
Many co-ordinators said that they were flexible in allowing more time for schools experiencing difficulty in meeting targets, usually due to circumstances like changes of staff, maternity leave or staff sickness.

> *"The essence of health promotion work is to work at your own speed, do it yourself and plan properly".* (HSC)

However some schemes had accredited schools for achieving Phases in less than the recommended time and also with insufficient evidence that actions had been embedded.

5.6.3.2 Examples of good practice

There were many examples of exceptionally good practice and the following list is not exhaustive. Good practice in schools was associated with pupils belonging to smaller groups, and a cross-curricular approach.

- All-Wales meetings and training events for healthy schools Co-ordinators

- Model health policies developed in a local Education department for use in schools across the whole county. This made it easier for individual schools to introduce health policies and increased consistency of practice. (HSC)

- The same scheme had set up a database to store statistics required to complete monitoring reports for the Welsh Assembly Government. This was helpful in informing local strategy.

- Regular meetings between healthy schools, Community Focused Schools and Eco-Schools Co-ordinators and school staff from cluster groups to plan how new policies such as Food and Fitness can be implemented (HSC).

- Specifying the commitment which all schools are required to make when joining the scheme and linking healthy schools aims to the overarching education and health improvement strategies (HSC).

- Training and celebration events held by schemes throughout Wales which enable school staff to meet and share experiences and good practice.

- The healthy schools support for action planning in schools which provides a framework and a focus for more effective action.

When asked for examples of good practice in schools, most healthy schools Co-ordinators said "Loads". Examples given were food in schools, a management team which included the caretaker, parents, cook and headteacher; school links with a local farm which they visited to plant and harvest crops and cook their own produce. But most co-ordinators were reluctant to single out specific examples of good practice. Many explained that it was the whole ethos of the school:

> "You can walk into a school and suss it in 2 or 3 minutes, that feeling in the reception area you can tell this is a true healthy school or one that is doing it to tick a box." (HSC)

One school visited by the review team was outstanding and the story of the school's progress in undertaking health promotion demonstrated Antonovsky's Sense of Coherence in action. There appears to have been a very successful and natural progression, developed from the headteacher's concern for the welfare and happiness of the children. For example, the school started with what the children were given to eat at school because the headteacher was concerned that additives in processed foods were affecting the children's behaviour and learning capacity. Then they moved on to consider the environment - where the food comes from - then started growing their own vegetables, which led to children becoming involved with the community, looking at where healthy food comes from and can be bought. Then the headteacher asked for parents' opinions. After about six months the school introduced a ban on chocolate and crisps. The headteacher talked to parents a lot

about adverse effects on children's behaviour of sweets, food additives etc. and a copy of a letter to parents about the adverse effects of food additives on children's behaviour was in the school's portfolio. The headteacher said if children's behaviour was presenting any problems, the school advocated removing all processed food and giving them fresh fruit and vegetables.

> *"By the summer of the first year, the children decided that they would ban chocolate, which was a bit of a backwards ban because we had already got a ban on chocolate and we had already got a ban on fizzy drinks but this was **their** ban on chocolate and fizzy drinks"* (PS11)

The small size of this school (fewer than 50 pupils) appears to be a key element in its success as it facilitates communication and involvement of all staff, pupils and parents. The cross-curricular approach is also important in securing pupils' support because they can understand the reasons behind what the school does and feel they can influence changes in ways which make sense to them.

Recommendation 29:	National guidance and associated training should explore the relationships and interaction of topics in the curriculum, to ensure that these are not treated in an isolated way that is inconsistent with an eco-holistic approach. For example physical activity/healthy eating/mental health; sexual risk taking /alcohol; mental health/substance misuse.

The secondary school mentioned above (SS2) recognised that greater participation and a sense of belonging to a group with a common purpose are more difficult to achieve in a large school, and assigned responsibility to the smaller tutor groups within which pupils could feel their contribution was valued.

5.7 Conclusion

The Welsh Assembly Government's leadership has supported the growth and progress of the WNHSS through the appointment of the national co-ordinator, a clear and useful framework for local schemes and provision of funding and other resources. The Assembly Government's leadership is important both locally and at school level in providing authority for them to work to fulfil WNHSS aims. An excellent standard of planning and administration at national level has underpinned the ability of local schemes to recruit and support schools, and the willingness of schools to join their local schemes. Against this background, two main issues require further attention. One relates to local management and the other to assessment standards and methods.

Firstly, there are differences between schemes' rates of recruitment of schools and these appear to be related to local management support for schemes. It is important to find ways of strengthening local management support in areas where lack of support is affecting progress.

Secondly, the review found that the phases of the healthy school scheme were not uniformly linked to standards of achievement. Many schemes have developed a method of assessment which recognises the "distance travelled" by each school rather than requiring schools with different levels of advantage to achieve the same standard. Furthermore, assessment by schemes may not incorporate an adequate

level of independent scrutiny; and most required schools to compile portfolios. Portfolios were not a reliable guide to schools' level of achievement and were perceived by many schools as a barrier to success. Setting national standards linking phases to achievement; and requiring independent scrutiny to be built into assessment methods would clarify schemes' responsibilities. Evidence from regional workshops suggests that national standards for schools would be welcomed and would enhance the reputation of the WNHSS. Portfolios are not required at national level and discouragement of their use would help to remove a barrier for schools.

There was evidence of widespread health improvement work in schools across Wales as a result of joining the WNHSS. Schools welcome the planning and target-setting which structure healthy schools work. Smaller size and involvement of a greater range of stakeholders were associated with more success in integrating health promotion into school life. For the future, further attention should be given to meeting the needs of secondary schools, whose size increases the difficulty of whole-school work; and all schools should be encouraged to focus upon methods of involving students, teachers, support staff and other groups, as well as on their chosen health-promotion topics. (Participation in healthy schools is considered in more detail in Section 6).

6. Equity

6.1 Introduction

The Ottawa Charter identifies equity as a focus of health promotion. Equity implies acting to reduce inequalities in health and supporting *everyone* to achieve their *"full health potential"* by exercising more control over their environment. Schools for Health in Europe *"seeks to reduce inequalities in health and education, with the introduction of carefully targeted activities aimed at vulnerable groups, and specific areas".* In the UK, the Strategic Framework for Better Health, Better Wales and the Acheson Report mention school-based health promotion as an important element in reducing inequalities and these documents form part of the background for the initiation of the WNHSS. At school level, *"The aim of the health-promoting school is to foster the emotional and social development of every individual, enabling each to attain his or her full potential free from discrimination"* (European Network of Health Promoting Schools 1997). At local level, a concern for equity may be expressed through policies designed to target schools serving deprived communities and at national level by giving the healthy schools programme a role in its overall strategy to reduce inequalities in health; and formulating policy and allocating funding in ways which encourage healthy school schemes to focus on deprived areas.

Equity also refers to the responsibility of stakeholders at all levels to promote a whole-school, or social-ecological approach to health. This can happen at the national level by embedding and promoting healthy schools through national policies and guidance. At the unitary authority level schemes can publish local policies also encouraging this, as well as providing more practical guidance and help for schools. Promoting partnerships between departments, such as Education and Health, as well as encouraging collaboration between schools and local organisations and encouraging community involvement in the scheme at a local level will also serve to increase equity. Within schools, involvement of the whole school community must be encouraged; including all teaching and support staff, as well as pupils and links to the community must be fostered with parental involvement an often difficult, but important aspect of the social-ecological approach.

6.2 Participation

Key Findings:
- **Healthy schools Co-ordinators rarely make decisions regarding the scheme in isolation, these are usually discussed with colleagues and other stakeholders before being taken to either a steering or management group for authorization. It is thought, however, that schools, particularly pupils and support staff are not sufficiently consulted in this process.**
- **School councils are recognised as an important means by which to encourage pupil participation in the scheme. This is seen to work well within primary schools and the main challenge now is to involve more young people in this process at the secondary school level.**
- **Encouraging parental participation in the healthy schools Scheme was seen as a challenge by all stakeholders involved with the scheme. This is especially true for those parents it is felt most important to involve.**

6.2.1 NATIONAL LEVEL

The WNHSS aims to support equity through an emphasis on *all* members of the school community. Although these aims focus on the school level, they are rolled out nationally to all local schemes and cover:

- Actively promoting the self-esteem of ***all*** members of the school community
- Developing the school as a health promoting workplace with a commitment to the health and well being of ***all*** staff
- Encouraging ***all*** staff to fulfil their health promoting role, through staff development and training.
- Ensuring that ***all*** pupils have the opportunity to benefit from stimulating educational challenges.

Recommendation 33:	National standards, if adopted, should focus on whether the school has involved staff, pupils, parents and others as evidence of schools' "organisational skills" in securing participation of a broad range of school stakeholders.

6.2.2 LOCAL LEVEL

An aspect of participation considered at the local level, particularly in the interviews with healthy schools co-ordinators, was the effectiveness of consultation with stakeholders in the development of scheme policy. Some schemes have undergone fundamental changes, adopting new management procedures, scheme structures, or even introducing a new set of scheme aims. One main driver of change was from the healthy schools co-ordinators themselves. Healthy schools co-ordinators reported that they rarely made decisions regarding the scheme policy in isolation, however, and that they were usually discussed with other colleagues, stakeholders and/or schools before being taken to a steering or management group.

In schemes where a steering group existed, this body was seen as an essential means of approving policy changes. Healthy schools co-ordinators described how they would generate ideas for changes in policy among themselves, or in meetings with colleagues or senior managers, but that these changes would then be presented to the steering group or management group for approval. Other sources of policy changes included suggestions from schools during healthy schools training days or school visits, working group recommendations and conclusions derived from workshops during a review of the scheme. One healthy schools co-ordinator did detail how changes were made to scheme policy without recourse to the steering group, but this was only after a group discussion between the healthy schools co-ordinators and senior line managers had taken place.

> *"It (changes to the role of the healthy schools coordinators) was based on the background that [other healthy school co-ordinator] and I had as teachers, we decided that that approach suited us and obviously the schools as well, and it's been put to the steering group as well. So it was an approach that suited the schools, ourselves and it went thorough our manager as well, it went through our link in the education authority so it was a combined approach."* (HSC)

An effective method of deciding upon scheme changes was set out by one healthy schools co-ordinator who described how they arranged a workshop to discuss all the major aspects of the scheme, including, "requirements of scheme, standards and

criteria they have locally, the way schools are recruited and accredited, the food and fitness grant, and the strategic partnership working." Written recommendations were made as a result of this workshop.

Unitary authorities' strategies relating to health and education were also an important source of change for scheme policies:

> *"We can't be seen to be doing something in education, it has to flow through other plans as well, it can't just go through the education plan it has to go through the Health, Social Care and Wellbeing strategic plan as well, it has be a whole authority approach."* (HSC)

Whilst some in-school co-ordinators did feel that they had an adequate input into the healthy school scheme policy in their area, as discussions with their healthy school co-ordinator during school visits reassured them that their views were taken on board, others felt that they had no influence on what the scheme's priorities were at a local level and that this agenda was set elsewhere. In fact there was little evidence of schools, and especially pupils, influencing scheme policy. This does not mean that this does not happen, but that it may take place on a more informal level than that described by the healthy schools co-ordinators.

6.2.3 SCHOOL LEVEL

Involving the whole school community

As part of the case studies, schools that had a positive experience of being a member of the healthy school scheme reported that all members of the school were involved in making decisions. For instance, the importance of consulting the staff within a school prior to joining the scheme was highlighted and it was felt by the senior staff that the whole-school approach could be successful only if all the staff in the school were committed to it. In one of these schools some of the support staff members were the focus of a healthy schools action which involved the midday supervisors receiving training in first aid and school emergency procedures. Another headteacher made a special effort to include support staff by sending them on training provided by the scheme at every possible opportunity. Support staff in this school responded positively to questions on the extent to which they could input into decisions on the scheme in their school with three out of four feeling they could input "totally ".

The stakeholder consultation provides some evidence for widespread lack of participation of support staff in the healthy school scheme. Questionnaires were sent out to the following groups of support staff: caretakers, classroom assistants, cleaners, nursery nurses, and secretaries/administrators. An examination of the numbers of questionnaires returned shows that of the total 488 sent out to support staff, 163 (33%) were returned; of these, 104 (64%) had not been completed by the person fulfilling the named role, leaving only 59 (12%) of the questionnaires that were completed and returned by the appropriate member of support staff. Most had been completed by headteachers and other members of the teaching staff, which could be a reflection of a lack of involvement of these support members in the scheme.

Through questionnaires sent to other school stakeholders, such as staff, school governors and PTA Chairs in healthy schools all stakeholders thought that one of the areas influenced most by healthy schools was that everyone in the school did something to improve health. PTA Chairs, however, were less likely to think that

actions had "Increased participation of pupils, parents and others in the life of the school". Of school governors, there was evidence that parent and community governors were less likely to be involved in healthy schools actions.

Pupil participation

The main finding relating to participation at a school level was the value that healthy schools co-ordinators put on the involvement of school councils. School councils were described by healthy schools co-ordinators as an effective way of stimulating the interest of pupils in the running of the healthy school scheme within individual schools. The national co-ordinator has pointed out that pupil groups were set up for healthy school schemes before school councils were promoted by the Welsh Assembly Government and that school council development work picked up good practice from healthy school schemes at the outset. The use of school councils in primary schools was noted as an especially useful tool for promoting the success of school actions as well as helping to ensure that the whole school approach became embedded. There were differing opinions, however, on how useful school councils were at the secondary level. One healthy schools co-ordinator pointed out that this approach in secondary schools was in its infancy because of a "tokenistic" level of membership, another healthy schools co-ordinator explained how difficult it was for secondary pupils to have a voice due to the much larger size of the school. It was generally agreed that school councils were effective at primary school and were the "future" at secondary level, with their development seen as a priority for the in-school co-ordinators. In one scheme, where school council involvement had been used, the healthy schools co-ordinators described how essential it was to include secondary school pupils in decisions that directly affected them e.g. regarding school canteens,

> *"So it's not what we perceive to be, or what teachers perceive to be the needs – it's what the pupils perceive to be the needs – it's up to them."* (HSC)

Evidence from the case studies further reinforced the necessity of capturing the pupils' interest and directing it towards the healthy school scheme. In one school the in-school co-ordinator talked about the headteacher suggesting things to the school council, who discussed them with the other children and decided whether to take them on board. It was apparent from the focus group and interviews at this school, the children were confident and polite but not deferential and clearly had ideas about what they felt it was right for the school to do.

As far as benefits of the scheme to the pupils are concerned, all responses from school councils in the stakeholder consultation gave examples of how pupils were affected by schools' efforts to promote health. One school council responded as follows:

> *What are the three best things about your school?*
>
> *1. "We have an Eco flag which means we are an Eco school, we all recycle as much as we can as we care for our school building and our environment*
> *2. "We sell fresh fruit and cartons of fruit juice, we are encouraged to eat and drink healthy snacks during our breaks. We also have a water fountain so we can have water to drink during the day.*
> *3. "We have many different after school clubs [this] encourages us to be more active and take more exercise."*

What are the three main things your school does to help people to be healthier?

1. "Traffic light Wednesdays, this makes children think about bringing more fruit and veg in their lunchboxes
2. "Walk to School Week, it encourages people to walk to school and so there is less pollution.
3. "We do not allow crisps, sweets or fizzy drinks for our snacks, we want everyone to have a healthy snack"
(PSC156)

But there is still room for improvement:

What are the three worst things about your school?

"Litter – a lot of litter gets blown through our school fence. We pick litter up every day but as our school is quite open, the litter comes back quickly."

What are the three main things your school does that do not help people to become healthier?

"Lunchboxes from home, the children are allowed to bring what they want and so not necessarily healthy snacks" (PSC156; only 1 answer to each question)

Although pupil participation is seen as a key area, the actual input pupils are able to have was questioned. By far the largest proportion (46%) of pupils' responses to the question about the "worst" aspects of school related to the site and buildings, particularly the lavatory facilities and lack of space inside and outside the school, and as one school council pointed out it is not within the school's power to alter many of these conditions. However, these issues appear to be a priority for children and there is no evidence from other parts of the review that they are being addressed. Toilets certainly seem to be an issue for schools with senior management feeling they are unable, due to a lack of funds, to improve them. Nevertheless, a majority of school councils thought their opinions mattered (40 [83%] of 48 who answered this question), and appear to have been acknowledged with explanation and discussion even when schools cannot deal with the issues raised.

Cause for concern: Alterations to school buildings and local organisation of some services affecting pupils are not encompassed by the WNHSS and are not therefore the subject of a recommendation.   However, lack of attention to basic cleanliness, and lack of space for recreation or dining, call into question the credibility of some schools' efforts to improve health and demonstrate that what is clearly an important concern for pupils has not been effectively addressed. The Welsh Assembly Government, Local Authorities and Local Health Boards are urged to consider how they may co-operate to deal with these problems.

Parental participation

Encouraging parental participation in the healthy schools scheme was seen as a challenge by healthy schools co-ordinators and much more difficult to initiate and maintain than pupil participation. One healthy schools co-ordinator illustrated this problem by referring to the "old scenario" of schools' attempts to encourage healthy lunchboxes being undermined by parents meeting their children at the school gates with unhealthy snacks and drinks. This healthy schools co-ordinator highlighted the

need for schools to increase parental understanding of the scheme, e.g. by inviting parents to attend healthy eating workshops at the school along with their children.

Many co-ordinators said it was difficult to engage parents, and in particular the parents that they particularly wanted to work with. Involvement of parents was facilitated by co-ordinators linking with initiatives such as Parents and Children Activities Together (PACT) and Cymru Cooks, attending parents' assemblies, or parents' evenings to run a healthy schools stand, producing parents' information sheets and running small projects to talk to parents about healthy lunchboxes.

The issue of engaging parents from different socioeconomic backgrounds was discussed at the regional workshops where one co-ordinator said that health improvement was more often undermined by parents of children in Communities First schools, although the issue of engaging parents was felt to be difficult across schools in all areas.

Recommendation 6:	It is recommended that the Welsh Assembly Government continue to fund employment of healthy schools co-ordinators to provide at least current levels of support until 75% of schools can demonstrate that a specified minimum level of participation is contributing to health-improvement actions. It is suggested that schools should be able to demonstrate as a minimum that teaching staff, support staff and pupils contribute to, and are fully informed about decisions on whole-school health improvement.

Recommendation 35:	Schools should be required to record the views of staff and pupils about the best and worst aspects of the school and to use this as a baseline against which progress should be measured, and priorities addressed. This would help to maintain motivation and ownership of school changes.

6.3 Reducing inequalities in health

Key Findings:
- **Schools in Communities First areas were among the first to be recruited to the WNHSS. There was some thought, however, that the criteria used to decide these areas missed many schools whose catchment areas were deprived and who then missed out on resources.**
- **Reduction in inequalities in health might be expected in the long term rather than within 6-10 years of establishment of the programme as indicated by the Welsh Assembly Government's logic model.**
- **Changes that could affect health related behaviours were extensively reported, such as improved access to drinking water and increased opportunities to consume fruit and vegetables during the school day, but there was a general consensus that it was too early to report on whether any significant reduction in health inequalities had taken place.**
- **Findings from stakeholder workshops support other evidence that healthy schools work well in reducing inequalities between individual pupils.**

6.3.1 NATIONAL LEVEL

Welsh Assembly Government grants were offered to all counties in 2000, initially giving a fair share of the available funding to each county, and since then calculating the amount of funding for each scheme on the basis of the total number of schools in each unitary authority.

Monitoring-report data collated by the Welsh Assembly Government suggest that schemes started by recruiting schools in Communities First areas before those in less deprived wards. This is in accordance with Acheson's recommendation that healthy school schemes should be "initially focused on, but not limited to, disadvantaged communities." There are no questions on the monitoring pro forma, and no further routine information supplied by schemes, about any special attention needed by more deprived schools. Applying standardised methods of assessment and accreditation to schools serving very unequal populations may be inadvisable if support is not adjusted to assist schools which may have more social barriers to overcome. However, the Welsh Assembly Government's Communities First programme providing targeted support for the most deprived areas will not always address inequalities affecting children, as many live outside Communities First areas.

The logic model used by the Welsh Assembly Government places "Reduction in health inequalities" as an intermediate expected outcome as a result of the implementation of the WNHSS Scheme. Whilst it was not within the remit of this study to measure any changes in health inequalities it was possible to ask healthy schools co-ordinators and other relevant stakeholders whether they had observed, or had any evidence of, changes in health inequalities as a result of the scheme. Changes that could affect health related behaviours were extensively reported, such as improved access to drinking water and increased opportunities to consume fruit

and vegetables during the school day, but there was a general consensus that it was too early to report on whether any significant reduction in health inequalities had taken place. Other research suggests that interventions need to be in place for more than six years before their effects on inequalities in health can be estimated (Stronks and Mackenbach 2006). The difficulty of attributing any reduction in health inequalities solely to the healthy schools scheme was also highlighted by interview respondents as well as during the regional workshops.

Inequalities between schemes

Six-monthly monitoring reports from local healthy school schemes recorded each scheme's progress in recruiting schools from 2001 to 2006. Although the Assembly Government's overall target for recruitment was met, there were clear differences in the progress of individual schemes. The two schemes which had recruited the most and least proportions of schools were examined to see if there were any features which might account for the difference in recruitment rates. Figure 7 shows that the overall gap in recruitment between the two schemes widened, from a difference of approximately 50% in 2001 to approximately 60% in 2006.
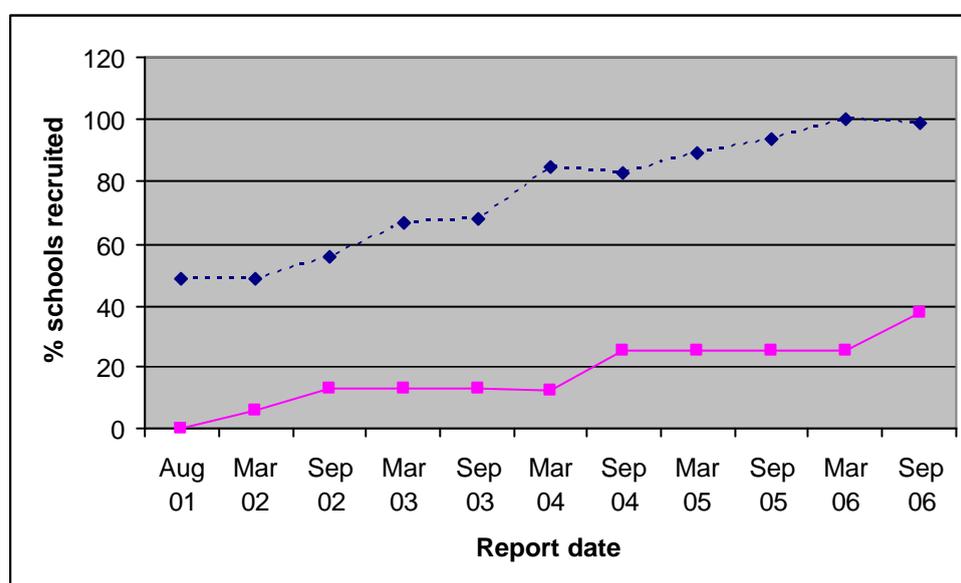
Figure 7: Percentages of schools in local healthy school schemes which had recruited the (a) highest (dotted line) and (b) lowest (solid line) percentages of schools by September 2006

There were five characteristics which appeared relevant in explaining the difference in progress of recruitment, summarised in Table 6. Firstly, in the area where the lower percentage of schools was recruited (b) there were almost twice as many schools as in the area of the scheme with the highest percentage (a). Secondly, when the Assembly Government offered grants to Local Authorities in 2001, Scheme (a) had already been established by the Health Promotion team and nearly half the schools in the area had joined. Thirdly, levels of deprivation vary greatly between the two areas, with Scheme (a) having much lower levels of deprivation than Scheme (b). Fourth, in Scheme (a) the healthy schools co-ordinator's post was funded by the local employer during the later period, leaving a large proportion of the Welsh Assembly Government grant for supporting training for schools and the employment of other staff on the healthy schools team. In Scheme (b), the healthy schools co-ordinator's post was funded solely from the Welsh Assembly Government grant without any local contribution, leaving a much smaller budget for other

requirements. Lastly, in Scheme (a) the same healthy schools co-ordinator had been in post before the funding started, and remained in post for the whole period. In Scheme (b) there was a period during which no healthy schools co-ordinator was in post and the scheme did not spend the entire grant. At this time Scheme (b) agreed lower targets for recruitment with the national co-ordinator, with the plan that the 2010 recruitment target would still be met.

Table 6: Characteristics of local healthy school schemes which had recruited the (a) highest and (b) lowest percentages of schools by September 2006

Characteristics of scheme thought to contribute to disparity in recruitment progress	(a) Scheme with highest % recruitment	(b) Scheme with lowest % recruitment
Approximate number of schools in Local Authority area*	<100	>100 [nearly twice the number in (a)]
healthy school scheme in place before 2001	Yes	No
Number (%) of Lower Layer Super Output Areas (LSOAs) falling within the !0% most deprived LSOAs in Wales*	2 (3%)	19 (29%)
% LSOAs falling within the 50% most deprived LSOAs in Wales**	41	75
Levels of deprivation in all of the 4 most deprived categories*	Lower than average	Higher than average
Funding for healthy schools Co-ordinator post	Funded locally for latest part of the period 2001-2006	Funded from Welsh Assembly Government healthy schools grant
Continuity in post of healthy schools co-ordinator	Yes	No

*Exact numbers have been omitted to maintain anonymity.
**(Welsh Assembly Government 2005d) (A Lower Layer Super Output Area is one of 1,896 areas in Wales having roughly the same number of people (minimum 1,000) and is the smallest level of aggregation for census data)

Initial funding for Scheme (a) in 2001 exceeded that for Scheme (b) by approximately 20%. In the years 2002-2006, Scheme (b) received between 11% and 17% more than Scheme (a) (Figure 8).
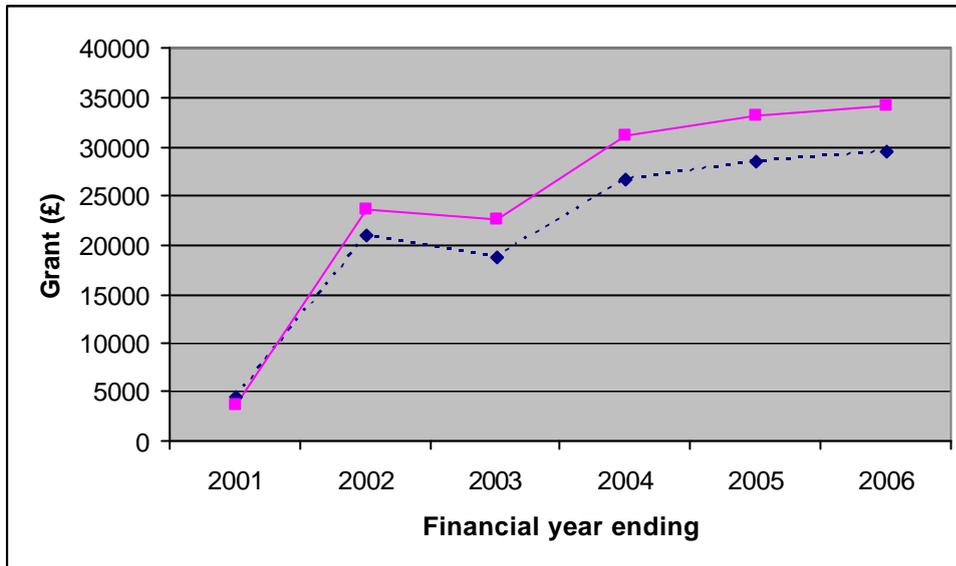
Figure 8: Amount of Welsh Assembly Government grants to local healthy school schemes which had recruited the (a) highest (dotted line) and (b) lowest (solid line) percentages of schools by September 2006

Consequently, schools in each area have had unequal opportunities to join their local healthy school scheme. The scope for local schemes to adjust support for schools according to need may also have been reduced after the Welsh Assembly Government set a target for all schools to join local schemes by 2010. Until the target was set, Scheme (b) had been prioritising recruitment of schools in Communities First areas but then changed to a strategy of recruiting clusters of schools (although this might have happened anyway because of reasons outlined in the previous section).   Scheme (b), serving a population more at risk of premature illness and death than Scheme (a), had recruited fewer than half the schools in the area whereas Scheme (a), in an area where the population were less at risk, had recruited 99% of schools. Thus the WNHSS might have inadvertently widened inequalities in health by not taking into account the starting points of schemes in 2001, local resources available to schemes, the total number of schools in the area, and area deprivation.

Recommendation 1:	The issue of the role of the WNHSS in relation to inequalities in health needs to be urgently reviewed and addressed. This review should cover aspects such as school support and funding levels to ensure there is no possibility that the WNHSS could have the unintended consequence of exacerbating this problem.

Recommendation 3:	It is suggested that the Welsh Assembly Government should consider ways in which inequalities between schemes could be addressed. For example, data on recruitment, training and numbers of schools in each Phase could be used by the Welsh Assembly Government to identify, and address at an early stage, any barriers encountered by local schemes in supporting schools.

Recommendation 10:	It is recommended that the logic model (Figure 1) be distributed and discussed more widely within the WNHSS and the Welsh Assembly Government and that it should be used as the fundamental guide to the future organisation of the WNHSS. This would involve a cycle of review and revision of the model in the light of ongoing changes. The logic model should indicate expected numbers of schemes achieving specified outcomes to enable quick identification of schemes encountering difficulties in meeting targets. Expected outcomes should include participation of stakeholders at school, local and national levels; and numbers of schools achieving specific Phases of the programme.

6.3.2 LOCAL LEVEL

Whilst healthy schools co-ordinators did feel that their schemes contributed to a reduction in inequalities in health, some stressed that changes could only be measured over longer time periods and by taking account of the cumulative effect of many apparently small changes,

> *"If you look at the scheme's involvement in the first year, three actions don't tend to make a difference, but if you look at it four years later ten actions do."*
> (HSC)

The potential and actual impact of local scheme policies on reducing health inequalities was discussed with healthy schools co-ordinators during the individual interviews and also at the regional workshops. Schemes varied in their approach. Some healthy schools co-ordinators reported that the healthy schools scheme was recognised as having a central role in reducing health inequalities. In some authorities the healthy schools co-ordinators had been personally involved in the needs assessment underlying the Health, Social Care and Well Being strategy. At the other end of the spectrum, one unitary authority had no policy at all to target schools in deprived areas and since many such schools had not volunteered to join the scheme, stakeholders thought that the scheme could actually widen health inequalities. Targeted recruitment was most often reported as a way in which schemes acted to reduce inequalities in health. Tailoring support from the scheme according to schools' need was a more complex issue.

Inequalities between schools in the same scheme

Healthy schools co-ordinators recognised differences in schools' starting points in terms of the facilities available to them, for example:

> *"You certainly see the differences, but it's things we can't control, you could go into one school and their grounds are fantastic and they've got playing fields, and you go into others and you've just got a concrete yard that's on a slope with a huge stone wall around it, they're making the best of what they've got but they're not always on an equal footing to start with are they?"* (HSC)

This healthy schools co-ordinator explained how differences in starting points were taken into account when assessing schools and that in schools where the baseline was low, *"it's about the distance travelled for that particular school"* when it came to judging what the school had achieved. Other healthy schools co-ordinators also expressed similar views and said that it was important not to discourage schools by

setting targets which they could not achieve within the usual time taken to complete a Phase of the scheme. Secondary schools were felt to need more support than primaries and one group felt there was a need to explore more effective ways of working with secondary schools.

Many workshop participants and healthy schools co-ordinators were concerned about the differences in resources available to schools within and outside designated Communities First areas.   Specific difficulties were:

- Schools may be almost side by side in adjacent streets but only one is in a Communities First area and entitled to resources such as the Cooking Bus – *"Then the perception from other schools is that these schools get everything and they get nothing"*
- Some areas suffer from rural deprivation for which they receive no extra funding
- There are pockets of deprivation within the catchment areas of most schools and pupils may come from a large range of socioeconomic backgrounds
- Reluctance to label schools as deprived or affluent
- One healthy schools co-ordinator felt that schools still on the waiting list to join the scheme were being neglected

All healthy schools co-ordinators felt they were in the best position to judge which schools were more in need of support and this did not usually relate to their status as Community First schools or to any other considerations of socioeconomic advantage.   Key factors mentioned were the enthusiasm of the headteacher, and whether the school was a secondary school or a primary school. Any resources which could not be distributed equally to all schools would be directed to those where they were most relevant to the actions being undertaken, not particularly to schools in deprived areas. The evidence suggests that it is difficult to maintain good relationships between co-ordinators and schools, and amongst schools themselves, against a background of unequal access to support from the local scheme. Thus local healthy school schemes, via the judgement of healthy schools co-ordinators, can adjust support to reduce social inequalities between schools but these inequalities relate to advantages and disadvantages of leadership and school organisation which do not necessarily coincide with national measures of social deprivation.

Some healthy schools co-ordinators felt that since schools in the most deprived areas were already receiving support from other agencies, schools outside these areas needed more support from the healthy school scheme. For example, one healthy schools co-ordinator felt that they could concentrate on schools other than those in Communities First areas because they already had *"the support from inequalities people and the grants."* Some healthy schools co-ordinators talked about their efforts to coordinate with other agencies to avoid overlapping of initiatives which could result in directing all the focus onto a Communities First area, trying to *"share it out a bit so that everything doesn't go to that one school".*

Some healthy schools co-ordinators did report tailoring support to the level of need in Communities First schools, for example:

> *"We've always worked that little bit harder and offer more support to disadvantaged areas"* (HSC)

and this usually included encouragement and support with applications for additional funding from "relevant agencies that we know have pots of money to help them." Other co-ordinators unequivocally stated that the support offered was the same for all schools, for example:

> *"The support is the same no matter where the school is, no matter where they are on the scheme, what they receive throughout is the same, whether they're just joining or whether they're second, third, or fourth year, it's ongoing and it doesn't differ according to area or need."* (HSC)

One co-ordinator offered the following explanation for the dichotomy:

> *"Pretty much all health-promotion work is targeted and always has been, whereas schools and education are a universal service."* (HSC)

Recommendation 2:	It is suggested that a practical strategy statement is required to clarify the expectations of the role of the education service across Wales in relation to reducing inequalities in health.

Recommendation 4:	It is suggested that healthy schools co-ordinators should have uniformly high expectations of every healthy school and that these expectations be supported by national standards for schools.

Recommendation 5:	Development of strategies for providing extra support to those schools which have more difficulty in attaining the specified standards should progress alongside the introduction of uniform standards.

6.3.3 SCHOOL LEVEL

6.3.3.1 Inequalities between pupils in the same school

Discussions at the three Regional Stakeholder Workshops were valuable in highlighting issues relating to inequalities between pupils in the same school. Different points were highlighted at each workshop and the views outlined below were those with which most participants seemed to agree and to feel most strongly about.

A participant at the South East Wales regional workshop said *"It's the school community itself that matters"* and other workshop participants broadly agreed in thinking that the enthusiasm of the headteacher and the ethos of the whole school were independent of the level of pupil, family or area deprivation. One participant said *"parents have lost the plot"* and that this was true of families with varying levels of social and economic advantage. One headteacher expressed abhorrence at the idea that they should distinguish between individual pupils in terms of their need to benefit from healthy schools' actions. They felt strongly that all children had the same needs regardless of socioeconomic background and culture and that an inclusive, whole-school approach addressed these issues. One healthy schools co-ordinator argued that children benefited from school actions according to need and that a healthy school by its very nature reduced inequalities between pupils. This point is a strong one: for example, a child who has not been taught tooth brushing at

home benefits more from tooth brushing at school than another who brushes their teeth regularly at home. Review Panel member Ian Young pointed out that schools are structures providing safety for vulnerable young people, and referred to Patrick West's finding that schools could slow up the impact of poverty on their pupils (West 2004). As well as helping to compensate for what may be lacking in individual homes, there was also a feeling at one workshop that children and young people as a group were more discriminated against in comparison with the whole population. Participants said the deprivation of individual children is likely to be missed, for example because they may have reduced access to health services; and because the criteria for determining the Welsh Index of Multiple Deprivation do not capture some of the factors affecting children's wellbeing.[3]

What emerged very clearly from the workshop discussions was that there is scope for the WNHSS, when translated into actions within the school itself, to be a powerful instrument for reducing inequalities in health because of its potential to support individual pupils in overcoming adverse circumstances, whether these originate within the home or as part of their wider social environment. At school level, the programme by its very nature provides support according to the level of individual need.

6.3.3.2 Teachers' health

Through the stakeholder consultation staff respondents did not consider their health, workload and working conditions to be important benefits or reasons for joining the scheme, or that aspects of the school affecting staff were among the most important features of a healthy school (Table 7).

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[3] The Assembly Government has since published for consultation details of a general approach and selection of indicators for a WIMD: Child Index Welsh Assembly Government. 2008. *Welsh Index of Multiple Deprivation* [Online]. Cardiff: Welsh Assembly Government. Available at: http://wales.gov.uk/topics/statistics/theme/wimd/?lang=en# [Accessed: 19/01/2009] .

Table 7: In your opinion, what are the three most important features of a healthy school? (Please tick no more than three boxes) Responses from healthy schools headteachers and in-school co-ordinators

	WNHSS Head (n=70)	In-school co-ordinator (n=55)
Everyone in the school contributes to improving health	50 (71%)	35 (64%)
Pleasant environment (school site and buildings)	14 (20%)	11 (20%)
High self-esteem of staff and pupils	20 (29%)	20 (36%)
Positive ethos and clear values for the whole school	43 (61%)	26 (47%)
Good relationships between staff and pupils	8 (11%)	13 (24%)
School is a health-promoting workplace for staff	0	2 (4%)
School policies which support health improvement	17 (24%)	10 (18%)
Well-structured, comprehensive curriculum for health education	17 (24%)	13 (24%)
Opportunities for staff development and training in health improvement	4 (6%)	2 (4%)
Good links and shared activities between home and community	14 (20%)	12 (22%)
Working with professionals who can support health improvement in the school	15 (21%)	10 (18%)
Good links between schools to assure continuity of pupils' health education and social welfare	2 (3%)	6 (11%)
Other	1 (1%)	0

Improving working conditions for school staff, and reducing the unhealthy behaviour of school staff, were among the least important reasons for joining the healthy school scheme given by in-school co-ordinators and by headteachers both within and outside of schemes (Table 8).

Table 8: What were the most important reasons why you wanted to join the healthy school scheme? (Please tick no more than 3 boxes) Responses from headteachers and in-school co-ordinators in healthy schools and from headteachers in schools which had not yet joined the healthy school scheme

What were the most important reasons why you wanted to join the healthy school scheme? (Please tick no more than 3 boxes)	WNHSS head (n= 71)		In-school co-ordinator (n=55)		Non-WNHSS head (n=13)	
	n	% (of 71)	n	% (of 55)	n	% (of 13)
Knew that it had worked well in other schools	15	21	10	18	6	46
Personal belief in value of health promotion in schools	54	76	37	67	10	77
Pupils, parents or others had already asked if the school could join	0	0	1	2	0	0
School staff had already asked if the school could join	2	3	2	4	2	15
Believed it would improve educational attainment of pupils	24	34	12	22	3	23
Believed it would improve working conditions for school staff	4	6	2	4	1	8
Believed it would improve access to training and educational resources	8	11	4	7	0	0
Believed it would help the school to meet inspection standards	3	4	5	9	3	23
Most other schools in this area had already joined	1	1	6	11	1	8
Access to funding for health actions	11	15	6	11	3	23
Believed it would contribute to school effectiveness	33	46	25	45	3	23
Believed it would improve the general behaviour of pupils	16	23	12	22	1	8
Believed it would reduce the unhealthy behaviour of pupils	27	38	27	49	2	15
Believed it would reduce the unhealthy behaviour of staff	1	1	3	5	0	0
Other reason	5	7	6	11	1	8

Creating a healthy workplace and opportunities for staff to learn more about health promotion were low down on the list of important general benefits of healthy schools (Table 9).

Table 9: What are the most important general ways in which healthy schools actions / areas of work have been beneficial in your school? (Please tick no more than three boxes): Responses from 123 headteachers and in-school co-ordinators

General ways in which healthy schools actions/areas of work have been beneficial	Number	*% of respondents who answered with 1-3 ticks (n=123)*
Improving the environment	62	*50*
Improving the confidence of staff and pupils	22	*18*
Producing a good atmosphere and clear values for the school	74	*60*
Encouraging good relationships between staff and pupils	18	*15*
Turning the school into a healthy place for staff to work	16	*13*
Creating school policies which support health	34	*28*
Well planned classroom teaching on health	31	*25*
Creating chances for staff to learn more about improving health	12	*10*
Pupils do better in their class work and exams	0	*0*
Good relationships with local community and families	23	*19*
Working with professionals who are experts in different types of health improvement	35	*28*
Easier for pupils to learn about health in secondary schools	5	*4*
Other	1	*1*

Few respondents thought the scheme's influences on staff were among the three most important and none said that healthy schools actions had reduced staff workload (Table 10).

In an interview one headteacher (PS41) said that they found it difficult to prioritise the needs of staff and pupils, but chose pupils because the school was in a deprived area, demonstrating a school-level approach to reducing inequalities in health. Therefore within the school setting staff may not share equally with pupils in reaping the benefits of healthy schools.

Table 10: Which of the following specific areas do you feel the healthy school scheme has influenced most in your school? (Please tick no more than three boxes) Responses from stakeholders at school level

Specific ways in which healthy schools actions/areas of work have been influential	WNHSS head (n=71)	In-school co-ordinator (n=55)	Governor (n=103)	Support staff (n=52)	PTA Chair (n=37)
Everyone in the school does something towards improving health	50 (70%)	35 (64%)	69 (67%)	23 (44%)	15 (40%)
Benefiting more disadvantaged pupils	13 (18%)	11 (20%)	24 (23%)	10 (19%)	6 (16%)
Increased participation of pupils, parents and others in the life of the school	27 (38%)	14 (25%)	33 (32%)	12 (23%)	5 (13%)
Increased motivation of school staff	2 (3%)	4 (7%)	9 (9%)	3 (6%)	1 (3%)
Increased educational attainment of pupils	6 (8%)	2 (4%)	5 (5%)	4 (8%)	2 (5%)
Improved working conditions for school staff	2 (3%)	1 (2%)	4 (4%)	0	1 (3%)
Improved access to training and educational resources	12 (17%)	8 (14%)	3 (3%)	4 (8%)	1 (3%)
Helped the school to meet inspection standards	4 (6%)	5 (9%)	17 (16%)	6 (11%)	6 (16%)
Improved links with other schools	1 (1%)	2 (4%)	4 (4%)	3 (6%)	2 (3%)
Reduced staff workload	0	0	0	0	0
Contributed to school effectiveness	26 (37%)	15 (27%)	0	0	0
Improved general behaviour of pupils	15 (21%)	7 (13%)	8 (8%)	7 (13%)	0
Reduced unhealthy behaviour of pupils	28 (39%)	29 (53%)	36 (35%)	18 (35%)	14 (38%)
Reduced unhealthy behaviour of staff	5 (7%)	5 (9%)	10 (10%)	7 (13%)	3 (8%)
Other	5 (7%)	3 (5%)	4 (4%)	1 (2%)	2 (5%)

In one of the workshops, individuals shared the view that schools did not look into staff health enough, as they saw it as the last thing they could deal with. They also felt that pupils notice how the senior management team treat staff within the school and that it was important that teachers evaluate how they are cared for as well. The stress teachers are under was recognised by co-ordinators who felt that staff needed to be listened to more.

Within the workshop it was mentioned that in some schools the working day had been cut down to save on heating bills and it was felt that this was leading to many teachers developing ill health due to conditions in the school. It was suggested that practical opportunities needed to be made for staff to relax and to improve their own health behaviours.

A co-ordinator from one unitary authority reported making a booklet for staff with phone numbers and contact details of essential services, as well as holding health events for teachers. In one event it was reported that out of the approximately 200 teachers that attended, 20% were referred to GPs for stress after measurements had been taken. It was acknowledged by both school staff and others in the workshop that there is a stigma attached to being off sick with stress such that staff did not want to be associated with it, so it was thought that independent people were needed to act as a point of sympathy for stressed staff. It was agreed by the majority of the workshop attendees that staff health was seen as something that should be an issue for unitary authorities as it also reflects on school ethos and affects pupils' experience of school.

6.4 Conclusion

During the early part of the review, the capacity of the WNHSS to reduce inequalities in health was approached in a general way without always discriminating between differences in its potential at individual, school and scheme level. Later on, it became clear that asking healthy schools co-ordinators to adjust support for schools according to levels of deprivation would be inappropriate and that neither co-ordinators nor school staff accepted that particular schools should be targeted because they were in deprived areas.   This section has tried to identify key points made by participants which suggest firstly that within schools, the WNHSS can be very effective in supporting children and young people to deal with adverse social conditions through actions taken by the school; the Welsh Assembly Government's target to recruit all schools by 2010 will therefore be favourable to reducing inequalities in health by making the benefits of healthy schools available to all pupils in Wales. Secondly, at local level there appear to be no changes which will render the WNHSS more effective in reducing inequalities in health and which would also be acceptable to a majority of healthy schools Co-ordinators and school staff. However, the Welsh Assembly Government might consider investigating ways of adjusting support so that there are fewer inequalities in the resources different schemes are able to offer schools in their respective areas.

Guidance in the WNHSS framework document states that schools should be helped to assess their own needs and choose actions which will help to meet them. This should result in an appropriately varied approach to supporting each school and tends to be empowering, but there is no specific guidance for schools serving relatively deprived populations and this leaves the WNHSS vulnerable to the operation of the Inverse Care Law (Tudor Hart 1971). The inverse care law states that the availability of good health care tends to vary inversely with the need for it in the population served. It is also possible that those who have least need for health care use the services more *effectively* than those with the greatest need. The risk that this phenomenon could restrict the benefits reaching those who need health promotion most is one which the scheme may need to actively consider.

7. Mediation

The Ottawa Charter calls for cross-sectoral co-operation and for health-promotion programmes to be adapted to local values, in order to mediate between potentially conflicting and diverse interests of different individuals and sectors. Funding for the WNHSS local schemes was offered to local health and education partnerships, thus entailing co-operation from two sectors. Such partnerships were facilitated in 2003 by the decision at national level in Wales to abolish the five local health authorities and replace them with twenty-two local health boards which are coterminous with local unitary authorities. Two features of the WNHSS further promote mediation: firstly, aims for WNHSS schools to develop links with families, outside agencies and other schools; and secondly, its network structure. A formal network facilitates informal sharing of information and development of good practice (World Health Organization 1997b). The inclusion within the WNHSS of individuals and agencies working at school, local, national and international level increases its effectiveness. "It is as important for local experience and expertise to inform national-level activities as it is for national-level activities to support the development of school health programmes on the local level." (World Health Organization 1997b) Within schools, the informal curriculum determining and forming part of the school environment may be influenced by the complex interaction of social factors within the network at various levels. A network which facilitates communication and understanding across a broad range of professional and organisational boundaries tends to improve working relationships and the review has sought to identify within the WNHSS the characteristics of complex adaptive systems identified by Colquhoun and others (see Introduction).

7.1 Collaboration

Key findings:
- **There is evidence of progress in collaboration and joint working at all levels. However, within schemes, the extent to which these processes occur varies.**
- **Key network characteristics have been identified in the WNHSS at national, local and school level which suggest that further establishment of mutually beneficial relations between diverse professional and organisational groups can be expected.**
- **Collaboration is recognised as crucial to the working of the schemes and takes place between schemes, schools and many organisations, all of which are seen to benefit from this.**
- **Healthy schools co-ordinators identified each other as an important source of support both nationally and through regional groups.   A central online bank of resources was suggested as a way of strengthening this support.**

7.1.1 NATIONAL LEVEL

As referred to in the expectations of the Welsh Assembly Government (Figure1) effective partnerships were developed at both a national and local level. These partnerships are more developed and pronounced at the local scheme level, but on some occasions links with national organisations, such as the NSPCC, allowed for a

consistent strategic approach to be adopted nationally and lent gravitas to initiatives. It was mentioned, however, that where initiatives were led by an organisation on a national basis it was more difficult for the healthy school co-ordinator to influence it on a local level.

7.1.2 LOCAL LEVEL

7.1.2.1 Collaboration between schemes and outside organisations

All local schemes worked in collaboration with a number of organisations and recognised the importance of these partnerships. The scheme itself was recognised as not having the capacity to provide everything the schools needed to progress in all areas, and on all topics, but it could act as a link between schools and organisations.

> *'Partnerships are the bread and butter of health promotion – we can't get anything done unless we have good strong partnerships because ultimately we're such small teams. We have to work through other organisations, we have to work through other health professionals and practitioners – that's always been a key way in which health promotion works'* (HSC)

The closeness of the collaboration differed from organisation to organisation, with some agencies being involved on a weekly basis, and others having a connection to one aspect of the scheme. Many organisations had representatives sitting on the steering groups, whereas others would be involved only when the focus was on their area of work within the scheme.

In some cases, co-ordinators sat on steering groups of other organisations and agencies, enabling links to be maintained, and the profile of the healthy schools scheme to be raised. Maintaining relationships was seen to be easy where agendas crossed and contact was regular. Personalities were recognised as crucial in maintaining these working relationships; when people moved on from organisations these relationships were seen to be vulnerable.

On occasions difficulties were had in finding organisations to carry out required work, due to work pressures on them. Other problems were encountered from organisations attempting to use the scheme to promote their business within the schools. In some authorities the scheme members review these organisations before schools work with them, with one scheme producing a protocol of what schools expect from outside organisations and what they should expect from schools, as guidance for both parties. It was recognised that working with outside agencies could cause extra paperwork for both school and scheme.

There was a range of organisations mentioned that collaborated with the local schemes, with Welsh Assembly Government programmes such as Communities First, and agencies such as school nurses and the police recognised by most schemes as important partners. Schemes made many links to other programmes such as Eco-schools and PESS – one of the intermediate outcomes in the Welsh Assembly Government's logic model (Figure 1) and local sport clubs and companies were also mentioned, as were some international links to schemes abroad.

On occasion, initiatives were set up at a local level with the help of an agency or organisation with the initiative then being run by the organisation, without further input from the co-ordinator.

7.1.2.2 Instigating collaboration

On many occasions collaborators were involved in the scheme through being contacted by the co-ordinator. Personalities were again seen as important in forming these links, with many local co-ordinators making use of contacts formed in previous employment. Sitting on a number of steering, or management groups also allowed contacts to be made. In small authorities it was felt that individuals and organisations knew each other due to the size of the borough and in some schemes E briefs were sent out to all organisations to keep them up to date with what was happening.

> 'They get involved at different levels – the shaping of the scheme itself, some of them sit on our steering group … they may be involved in quite a practical, operational way and generally we have a good knowledge of organisations who are supporting schools on health issues and we are very proactive in making links with them – asking them whether they want to be in our "useful contacts" file, whether they are happy for us to promote them to schools as being able to support schools.' (HSC)

The role of the healthy schools co-ordinator is also useful in allowing collaboration between agencies that they work with, these organisations also coming to recognise the healthy schools co-ordinator as an individual to approach regarding school issues. PSE advisers perceived that the healthy school scheme was a useful network they could use to consult pupils and parents when developing policies and approaches. PSE advisers also felt the scheme had assisted them in their work by encouraging a lot of schools to develop PSE by providing a focus for health topics. It was recognised that the scheme helped schools by providing a context for delivery of the PSE curriculum.

7.1.2.3 Collaboration between schemes

It was felt that a very cohesive, mutually supportive co-ordinator group had developed. The scheme had been set up in a non-competitive spirit which had led to an overall willingness to share. Email had allowed widespread sharing and requests for help, although some difference was highlighted in contacting people based in education and health due to working dates and times.

> 'That's the real plus for healthy schools, we do share as much as possible and I do know I can ring up anyone and ask for documents, everyone is willing to share and that is a credit to [national co-ordinator] because [they've] insisted from the beginning that we are all open, and it has been excellent.' (HSC)

Geographical location aided links and cluster groups and forums, such as ESIS, allowed for greater contact, with the three regional groups highlighted as important in allowing this. Each of these groups, situated in North Wales, South East Wales and Mid and West Wales, meet at least once a term, and have been used as a forum to share ideas, agree ways forward for the schemes and share good practice. Regions also worked together to develop and support accreditation, planning shared accreditation goals and utilising regional co-ordinators in the accreditation process, although this was something that was seen to need more development. Schemes also combined within their region when organising training events in which numbers attending would be low. All Wales co-ordinator meetings were also highlighted as helpful in promoting collaboration between schemes, with opportunities for co-ordinators to meet four to five times a year.

Suggestions to improve sharing between schemes included the formation of a central bank, within which strategic documents could be saved and downloaded from the internet. Similar things had been done regionally and it was felt this would allow co-ordinators to check a central bank before contacting other schemes individually.

> ' I do think, however, there is an area there that could be developed, we could have a central bank, I know [national co-ordinator] is intent that we are all responsible for our local areas but I do think there is some merit in having a central bank because often you are reinventing the wheel.' (HSC)

Recommendation 11:	A national website giving healthy schools co-ordinators and schools access to resources, and facilitating sharing of documentation and ideas, merits serious consideration. The presence of the WNHSS on the World Wide Web would also facilitate international communication at school and local levels.

All schemes recognised the importance of working with other schemes, although this was particularly the case for co-ordinators new to the scheme and ones working as the only co-ordinator in their authority. New co-ordinators found that more established ones were very open and receptive to their requests for help, and on occasions these new co-ordinators spent some time visiting other schemes to gain experience of how they were being run. However, each authority worked slightly differently, and a lack of consistency between schemes sometimes made it hard to carry these experiences over.

> 'What I did when I first came into post I just got on the phone screaming 'Hi I'm new in post and I don't know where to start' and everyone in [Regional Group], well all over Wales, but obviously [Regional Group] which I'm a part of was very supportive. So I've gone to and spent some time with a number of them to see what they had in place, what worked well and what doesn't and to pull on their advice.' (HSC)

More established co-ordinators recognised the value that new and young co-ordinators brought to the scheme, although with many new co-ordinators joining the scheme it was difficult to continually build relationships with everyone. It was also noted that with the wide range of backgrounds of the co-ordinators, it was possible to take advantage of individual expertise. Time was not seen as a handicap to sharing and collaboration between schemes, as this was an important part of the co-ordinator role, and it was up to individuals to organise their time to include it.

7.1.3 SCHOOL LEVEL

At the school level, effective relationships had been developed between schools and the scheme co-ordinators, as well as with external organisations and other schools (Appendix_).

> 'We contacted Eco-schools as a result of a visit from [healthy school scheme co-ordinator] saying you are doing this stuff anyway, have you thought about doing Eco-schools.' (PS31)

Collaboration with outside agencies helped schools in many areas, especially in-service training and delivering messages, educating the pupils as well as the staff, with teachers and pupils responding to what were seen as experts in their fields. This was

particularly the case in areas such as substance misuse and sex education, where curricula were seen as outdated and expert knowledge was appreciated. Benefits were also found in applying for funding for schools.

> *'A lot of it is down to capacity;* [substance] *misuse, sex and relationship education and safety are all very sensitive areas and having the police, youth service, school nurses and all the relevant agencies available helps to overcome the feeling of lacking in knowledge and confidence in the teachers.'* (HSC)

Cluster groups of schools have been formed through the scheme in some authorities to encourage this. Other schemes, such as Eco-schools and Communities First, also formed cluster networks of schools and in many cases co-ordinators of these other schemes would link their own work to the schools' healthy school agenda. On occasions schools reported that where a school had already successfully run an initiative, or action, within the authority that they were then keen to undertake, the local scheme co-ordinator would put the schools in touch in order to help them work together.

For some schools this link to, and collaboration with, local schools was seen as one of the most important aspects of the scheme.

> *'The best training tool you can have [is] listening to other good practice in schools. And to hearing how schools have developed something, their pitfalls, their successes, how they've put it right . . . healthy schools use that really really well.'* (PS41)

Recommendation 20:	Consideration should be given to providing a local framework which offers more formal opportunities for schools to take the lead on health promotion within clusters in order to provide a focus for schools to continue to maintain and improve good practice.

7.2 Awareness

Key findings:
- **Awareness of the scheme varied between authorities and it was felt that more could be done to promote the scheme at all levels: national, local and school.**
- **Incorporation of the scheme into strategies and policies at a national and local level helped to promote awareness to departments and stakeholders.**
- **The co-ordinator was seen as key to raising awareness at a local level, working with stakeholders directly and through sitting on a variety of partnership groups.**

7.2.1 NATIONAL LEVEL

It was suggested that the scheme should be promoted more at a national level and that more departments and individuals could be made aware of it. It was felt that this would help in terms of funding and in incorporating the scheme into national approaches and policies. Where the scheme had been included in national

documents, such as Appetite for Life, this was seen to help at many levels, both with schools, but also in working with education and health departments.

7.2.2 LOCAL LEVEL

The awareness of other local authorities, local organisations, and sectors to the healthy school scheme differed between authorities. The position of the co-ordinator on strategy groups, partnerships and within-department meetings was seen to increase awareness of the role of the scheme.

> *'It's getting better now, perhaps because I'm based in Education, I know it's something that [previous co-ordinator] struggled with, getting in to any education meetings, and even though my line manager now used to sit on the Steering Group it was still hard for [previous co-ordinator] to get in to certain meetings which now I'm at, so people are hearing it more.'* (HSC)

Inviting members to scheme events also helped. Involvement in, for example, the Children's and Young People's Partnership, meant that any agency involved with children and young people would be aware of the scheme. The place of the scheme in local strategies, policies, and targets leads to greater awareness, and although it was felt that not all individuals would always know of the scheme, all departments would.

> *'I think it's increased greatly, we're featured on the community plan, the health, social care and well-being plan … Whenever we have events we invite the Director of Education, the leader of the Council, councillors, we get people in the authority involved as much as we can.'* (HSC)

Within case studies the majority of stakeholders reported that they were kept aware of what was happening within the scheme through personal interaction with the healthy schools co-ordinator, although this differed by stakeholder. Those that worked in close conjunction with the healthy schools co-ordinator felt personal interaction was the most important way this happened.

> *'The healthy schools co-ordinator is based at the other end of the floor, I can see her office from my office, I see her all the time, talk to her all the time, we liaise all the time.'* (CS36)

Other ways that stakeholders mentioned they were kept up-to-date on what was happening in the scheme included regular updates at steering group meetings and other scheme events. In some authorities stakeholders that were not involved in steering groups and that had little contact with the healthy schools co-ordinator reported that they were not kept up to date on what was happening within the scheme.

> *'No (not kept up-to-date on what is happening in the scheme). There were the healthy schools forum meetings but they haven't happened for a long time. I did go to one when I first came into post but I've not been invited to another one. I'm not sure if they've had any more since.'* (CS515)

Table 11: Awareness of stakeholders of what is happening within the scheme (number of individuals)

	Great deal	Moderate	Small amount	Not at all	Total
Director of Education	2	2	1	0	5
Director of Public Health	8	1	2	0	11
Head of unitary authority catering	3	1	2	0	6
Chair of Children's and Young People's Partnership	2	1	0	1	4

7.2.3 SCHOOL LEVEL

All schools worked hard to raise awareness of the scheme at a school level by involving as many parties as possible in the decision making process.

> 'We don't introduce anything without introducing it to everybody, going through from staff meetings, to children, to school council, to parents, and then to governors and then bringing it all on board.' (PS41)

This awareness of the scheme at a school level varied enormously between schools. In some it was widely publicised and pupils, teachers and associated members of the school were aware of it and what was achieved by it. In others only those involved with the running of the scheme within the school really knew what was being achieved through it. The larger schools found it harder to raise this awareness due to capacity issues.

Recommendation 23:	At school level there is evidence of wide disparities in teacher awareness of the healthy schools programme. This suggests there is a need for more training, not only for school co-ordinators but for other staff in schools.

Where pupils were aware of the healthy school scheme within their school, it was felt that this led to a change of attitude towards health, with pupils feeling more able to input into decisions regarding the scheme within the school. In schools where pupils had not heard of the scheme, however, they were often still aware of the work the school had been doing towards improving health. Health benefits could be recognised by both pupils and teachers, as desired. but there was not always the association of these with the scheme itself. For example, while local co-ordinators were generally very positive about publicity arranged by schools for school achievements, there was little evidence that this raised awareness of the local scheme:

> "[Local newspapers] have fabulous pictures of them doing fruit tasting, and then they forget to mention the fact that they've done it as part of the healthy school scheme "(HSC)

Recommendation 14:	Healthy schools co-ordinators should discuss ways of obtaining publicity for local schemes, as well as schools, in order to formulate guidance on best practice and generate practical strategies for promoting schemes.

Raising awareness outside of the school was also seen as difficult, in particular amongst those parents that schools felt were most important to involve. Where parents were involved in school events, including those based around the scheme, it was generally felt that it was always the same group of parents. It was felt, however, that pupils talked to their parents about health issues due to actions that had been put in place through the scheme.

> *"[The] school learnt to involve parents, as we got bigger we've learnt that parental involvement is the best way to move forward. Where parents have been involved things have been achieved more easily and have been more effective in their approach."* (PS31)

Where parents were involved it was seen to lead to a greater chance of success of actions and the scheme within the school, as well as carrying these health messages out into the community. The challenge was seen to be to involve as many parents as possible.

The stakeholder consultation indicated that the vast majority of respondents were aware that the school was part of the scheme even if they were not involved on the teaching side (Table 12). All staff governors knew the school was part of the scheme but a proportion of both parent and community governors did not, although many schemes insisted governors should be consulted before the school joined the scheme and most schools reportedly consulted governors on many aspects of it. This could be indicative of changes to personnel and suggests that the scheme should be continually promoted and endorsed to school stakeholders.

Table 12: Before receiving this questionnaire did you know your school was part of the healthy school scheme? Responses from Governors, Chairs of Parent-Teacher Associations and support staff in healthy schools

Role of respondent	Yes n	No n	Total n
Parent governor	24	6	30
Staff governor	37	0	37
Community governor	31	4	35
Secretary/administrator	1	0	1
Caretaker	4	1	5
Cleaner	2	1	3
Nursery nurse	3	0	3
Classroom assistant	2	0	2
PTA chair	30	7	37
School caterer	34	3	37
Total	**168**	**22**	**190**

Recommendation 30:	Given the difficulties in most schools with involving parents and others, and with reconciling the demands of the curriculum with healthy schools actions, it is suggested that training and resources might be developed to help in-school co-ordinators to deal with these and related issues.

7.3 Resources

Key findings:

- **The key role of the Welsh Assembly Government in providing funding for resources and the resources themselves was recognised by the co-ordinators.**
- **A variety of resources produced at local and national level in Wales and from elsewhere, along with training, was made available to schools and had been seen to change expectations of both staff and pupils within the school.**
- **Many schemes produced their own resources in house to distribute to schools within their authority. These were often made available to other schemes although scheme capacity was an issue.**
- **The production of resources appropriate for Wales was seen as an issue.**

7.3.1 NATIONAL LEVEL

Healthy schools co-ordinators highlighted the role of the Welsh Assembly Government in providing national guidance as well as free bilingual resources. The bilingual Sense DVD (Sense Interactive CDs Undated), with training, was mentioned as an example of this. It was felt that where local schemes needed a resource or information on a particular topic, the Welsh Assembly Government would then make this available to all the schemes. Funding from the Welsh Assembly Government was also used to purchase resources for the scheme. The importance of the training provided by the Welsh Assembly Government was also highlighted.

On some occasions the Welsh Assembly Government would ask co-ordinators if they would like the resources sent straight to the schools or to the co-ordinator themselves, who would then distribute them to schools. Some co-ordinators preferred to distribute resources themselves to maintain relationships with the schools, especially where the resource could lead to tensions, such as packed lunch leaflets upsetting the school meals service. Others felt that sending resources directly to the schools from the Welsh Assembly Government saved them effort.

7.3.2 LOCAL LEVEL

All co-ordinators reported the benefit of a number of resources, with topics including smoking, substance misuse, healthy food, exercise and the whole school approach to health education. These resources included policies, curricula, teaching aids, and environmental resources such as hand washing inspection units.

When resources were not provided free, their need would be balanced against the cost of purchase. Some resources would be developed by the co-ordinator, and this

could then be shared amongst other schemes that would pay for costs for reprinting or reproduction. Capacity was an issue here, with smaller schemes unable to produce 'glossy work booklets' and they would instead focus on simple policies and action plans.

There were many organisations promoting resources to be used in schools, and co-ordinators would use strongly recommended ones that they felt were consistent with what was already being promoted in schools.

Schemes would also work with schools to help them obtain funding to purchase resources, although leaving the schools to buy the resource themselves could prove a barrier. One area that was felt needed addressing was the availability of material appropriate for Wales:

> *'I tend to use the British Heart Foundation ones, the PESS* [Physical Education and School Sport] *ones, the DELLS* [Department for Education, Lifelong Learning and Skills, now DCELLS] *ones. I wouldn't use an English healthy schools one, because English guidance is different to Wales, I'm conscious of making sure that it's the right nutritional information that's supported by the Foods Standards Agency, because we still get schools using food pyramids, instead of the "Balance of Good Health"* [now replaced by the "eatwell plate"]. *So it only takes one bad message from the healthy school scheme to get everywhere.'* (HSC)

Presentation days were organised where companies could promote their resources. On occasions the scheme team would evaluate and advocate the use of new resources on recommendations from reliable sources, such as other co-ordinators, or evaluations from organisations such as universities.

Many schemes had a library of resources to aid sharing, and the internet was recognised as a valuable tool in sharing them. One healthy schools co-ordinator had produced a booklet for schools to show what was available. Storage of resources was seen to be a problem within schemes.

7.3.3 SCHOOL LEVEL

Schools mentioned a variety of resources that had been made available to them through the scheme. These included policies, hand washing units, water coolers, toothbrushes, DVDs, books and computer programmes and all schools were grateful for the support in acquiring resources when they needed them.

Where relevant the resources were available to all schools within the scheme, and schools would communicate with each other about the resources, although it was felt that it was harder to get cross-curricular resources for secondary schools. Training was also organised for schools around resources where necessary.

On visiting schools it was often obvious how resources provided through the scheme had changed the expectations of what was available at the school by both pupils and teachers. In some schools fruit tuck shops, water on the desks, tooth brushes in the classroom, play equipment amongst many other things, had become embedded into the school environment and were used daily. In other schools, however, even some that had been in the scheme a long time, there was not this breadth of resources taken on board. This may be down to a local focus and an interest in developing policies and strategies within the scheme or school.

7.4 Integration of Education and Health

Key findings:
- **The majority of authorities reported a strong working relationship between education and health departments, the role of the healthy schools co-ordinator in promoting this was recognised and where the relationship between departments was poor this was seen to be to the detriment of the scheme.**
- **Senior staff in education and health departments felt that the scheme had actually led to closer working between the departments. The adoption of the scheme into both national and local strategies was also seen to promote joint working.**
- **The personalities of senior staff were seen to be important in allowing departments to work together and difficulties arose where they held different views on the role of the scheme.**

7.4.1 NATIONAL LEVEL

There were some authorities in which the scheme had been adopted more readily by either education or health strategies, but it was felt there had been an overall improvement in this due to the increased profile of the scheme, and guidance, both from central government and local authorities. Guidance from the Welsh Assembly Government, such as Appetite for Life, and The Food and Fitness Plan, helped to incorporate the scheme into local strategies (although as noted earlier, the emphasis on nutrition and physical activity could lead to schemes' being identified with these topics). The adoption of guidance on healthy living (Estyn 2007) as part of the Estyn inspections was also thought to encourage this.

> *"I don't think the education strategy has changed due to healthy schools but the healthy schools is actually embedded into the single education plan and having its own sort of line. There are other key targets in the strategy where healthy schools is featured below that as well, so it is interwoven into the strategy."* (HSC)

7.4.2 LOCAL LEVEL

7.4.2.1 Development of joint working

Most schemes recognised the importance of both health and education departments in the initiation of the scheme, although departments had varying levels of influence in different authorities. Often the scheme was based in one department at its commencement, which had led to this department having a greater role. An interest by senior staff within one department, and the role of that department on the steering group, also influenced their support for the scheme. Local funding issues and authority structures were seen to impact on this.

> *"Yes, right from the beginning within [authority] it's always been a partnership between education and health. Back then it was the health promotion team and the Advisory Service for Education and now it's turned into the NPHS but the link is still there with the Advisory Service for Education … so not even the partnership between education and health has remained static but has developed over time."* (HSC)

Most healthy schools co-ordinators reported a strong working relationship between health and education departments. This had often come about by involving senior

members of both teams in the management structure, such as the steering groups, or through gaining access to the directors of departments to build relationships and by promoting the virtues of the scheme. As the schemes developed their profile rose, and the involvement of both parties also increased, some co-ordinators promoting this by presenting evidence on the achievements of the scheme to both departments. The link between health and educational attainment was seen as important in encouraging interest from the education department, as was Estyn's adopting healthy living guidance into the inspection process.

On occasions, where education and health did not work so well together, this was often thought to be due to senior management having different views on the role, or need for the scheme and even tense personal relationships, with control of the scheme sometimes seen as an issue. Attempts made by the co-ordinators to forge links despite this did not always work, although a change in senior management in one department would often help.

> *"What I find is that I'm fortunate in* [authority] *in that I go into the offices of the health promotion* [department] *and there seems to be little difference between education and health, we seem to be joining together and we all seem to be aiming for the same thing. I think both health and education are learning from each other in various aspects. What we find is that education are quite good as regards doing practical things, the presentations to the pupil, whereas the health* [department] *is very good as regards the strategy and how to sort that out. So it is just the basics of how they work together."* (HSC)

Within case studies in unitary authorities where education and health departments had a good working relationship, senior members in both departments felt that the scheme had led to more collaboration. The healthy schools co-ordinator was seen as instrumental in promoting this, both through their personal approach but also through their roles working with both departments.

The majority of directors of both departments responding to the stakeholder consultation also reported that the scheme had led to closer working between education and health departments, although around one third felt there had been no change due to this (Table 13).

Table 13: How scheme has affected how closely departments work together

	Much more closely	More closely	No change	Total
Director of Education	2	2	1	5
Director of Public Health	0	7	4	11
Total	2	9	5	16

7.4.2.2 Role of the scheme in local strategies

The healthy schools scheme had been integrated into local strategies in most authorities. In some the scheme was a part of the single education plan, and the

health, social care and well-being strategy. In others it had been included in a number of local strategies such as physical activity, nutrition, community safety and the health alliance.

In some unitary authorities it was felt that the schemes had a role to play in the development of local policy, and co-ordinators and teams were involved in the development of single education plans, and health, social care and well-being strategies. It was felt these two strategies in particular gave the scheme a louder voice, as they led to a whole authority approach.

7.4.2.3 Healthy school co-ordinators' local employers

There was an approximate 50:50 split of co-ordinators employed by education and those employed by health. In some schemes co-ordinators were employed by one department and based in the other, with funding going to the department in which they were based. This situation was seen as advantageous as co-ordinators were involved in meetings within both departments.

Most co-ordinators saw the benefit of being placed where they were, as well as the costs of being in a different department. It was felt that the schemes had developed around their position, so they were now settled. Where support was lacking it was normally from the department in which the co-ordinator was not based.

> *"it's having school improvement behind you that's important, but it couldn't be a better situation because even though I'm employed by school improvement I'm based with the local public health team, it's important for you to have that, they've influenced my thought about health promotion, to understand the principles behind it, I've been able to mirror the way they've worked. But I don't think you get the credibility with schools unless you work for school improvement, I don't think the teacher thing is as important."* (HSC)

It was thought that working in education, by those based there, allowed the scheme to maintain close links with schools, and being based in school improvement gave the scheme credibility with them. It was also seen as an advantage to be located geographically close to other education departments. It was also thought that education focused more on pupils and teachers, whereas health looked at policies and objectives. It was felt, however, by those based in health that being based in education meant that other responsibilities, such as PSE, were added to the workload of the co-ordinator.

Some healthy schools co-ordinators reported that working for the education department led to more restrictions on their working practice. It was also felt that if the co-ordinator sat in education they would only pick up information regarding the health issues they specifically went looking for, rather than being exposed to all the health information as if they were sat in health.

For those based in health, it was perceived to be advantageous in making links to other health areas, and that co-ordinators could bring a different perspective, and more knowledge on health issues. It was thought that when the scheme was based in health, it was seen by schools to be supportive, whereas if it were to be based in education it would be seen to be making demands and setting targets.

In a very small number of schemes the healthy school team was split between health and education, which could lead to problems of communication, and as members of

the team were working under line managers in different departments, there were competing demands placed upon them.

In one unitary authority the scheme was based in neither Education nor Health but another department which was part of the health alliance. This again was seen to be advantageous as they were not subject to the demands of either.

Interviews with directors of departments within case studies showed some differences as to where senior staff felt the scheme should be situated at a local level. It was recognised by many that where the scheme was based in both this worked well. Some senior staff in education, however, felt that the scheme should be based in education as this gave it more respect from school staff and it was felt that health in schools was becoming an educational matter.

> *'Surprise, surprise, I'd say it's better within education myself because of that whole school aspect and being part of the whole school improvement because I think health and well-being it's almost a feature now, with you know, water fountains and coolers and making sure they get regular exercise and taking messages home etc and you know I think schools more and more cottoning on that if you've got a healthy active balanced diet child in your classroom you're more likely to get a better education.'* (CS11)

Some directors of health departments, however, saw the scheme as a public health programme and felt therefore that it should be led by individuals who understand public health, it was thought as it was not an education initiative members within education didn't have the expertise to lead on it.

> *"This is a public health programme and it needs to be led by people who understand the public health objectives. That's got to be very strong . . . There's not the same type of expertise in local authority education departments and my observation of schemes that have had a very heavy education leaning is they become very curriculum-focussed and it becomes almost like the advisory teacher ... What goes on in the curriculum is a component of the overall agenda, but that's not what this scheme's about."* (CS56)

Within the stakeholder consultation directors of both departments reported that the scheme would be better placed within their department than within the other. This was particularly the case with Directors of Public Health from whom more responses were received (Table 14).

Table 14: Opinions of where the scheme should be based from Directors of Education and Directors of Public Health

	Education	Health	Doesn't matter	Total
Director of Education	2	1	2	5
Director of Public Health	2	6	2	10

The different pay scales and responsibilities between education and health were also made reference to, as co-ordinators based in one would be on a higher pay scale

than the other. This had caused some discontent among healthy schools co-ordinators.

> Cause for concern: Differences in rates of pay are beyond the control of the WNHSS as co-ordinators' pay is determined by local employers. However the perceived unfairness could damage relationships amongst co-ordinators. The Welsh Assembly Government, Local Authorities and Local Health Boards are urged to consider how they may co-operate to deal with this problem.

7.4.2.4 Access to training and facilities for healthy school co-ordinators

In all schemes training was available from the employing department. Where training was not offered by the non-employing department this was seen to be due to poor working relationships, although it was felt these could be overcome by building personal relationships with individuals. It was also felt that where co-ordinators had not been offered training by the non-employing department if they were to look for it they could find it.

Some healthy schools co-ordinators did not seek training from the non-employing department and many felt that they controlled a budget for training and could therefore choose where to undertake it. Twelve out of fifteen co-ordinators who provided data on this topic had access to facilities in both education and health, and close relationships between departments aided this, with rooms and resources being provided free of charge by the non-employing department. Hot desks were also available in the non-employing department, and help was given for organising training events both by providing funds, and by allowing access to expertise in both education and health.

> *"I have often gone up to health promotion and they make a desk available to me even though I haven't got one allocated up there, I use their resources, they have a large resource room with lots of resources and we regularly take teachers up there to utilise those resources as well."* (HSC)

In some schemes where the relationship with the non-employing department was not so developed, no attempt had been made to use facilities provide by them, and therefore no comment could be made on their availability.

Data were reviewed from three healthy schools co-ordinators – one from each region - who all reported having access to training and facilities in both education and health. However no common features of their employment were identified which might be associated with greater ease of access.

Recommendation 21:	It is suggested that the Welsh Assembly Government explore strategies for securing more consistent support for schemes from senior local authority staff. These might include measures to ensure that a senior management post carries responsibility for the scheme; specifying duties of management/steering groups; and a requirement that the healthy school scheme should be included in health and education strategic plans. Extra conditions of funding local partnerships might be useful in achieving a greater level of support.

7.5 Network Characteristics

Key findings:
- **There was seen to be influence and interaction at all levels as well as between levels, although it was thought there was more top down influence i.e. from the Assembly to local schemes and from local schemes to schools.**
- **The scheme had adapted at all levels as it developed but particularly at the local level as capacity increased. This led to changes to the focus of the scheme and the role of the healthy schools Co-ordinators.**
- **Co-ordinators worked hard to avoid tensions between stakeholders and organisations working in the scheme but where they did occur steering or management groups would act as mediators between parties.**
- **The healthy schools approach has become embedded within schools as they have progressed through the phases.**

7.5.1 CO-ORDINATION OF WORK AT NATIONAL LEVEL

The Welsh Assembly Government was seen to influence the schemes to a large degree, particularly through funding and national directives. Research and guidance published centrally was seen to influence what schools and schemes would focus on, such as Food and Fitness and Appetite for Life, which would steer schemes to look at particular aspects of health, as well as providing information on funding to enable this focus.

In developing the schemes an overall structure had been provided centrally by the Welsh Assembly Government on how the scheme should be developed, under a broad framework, although it was felt that there was some flexibility to develop with a local focus and the running of the scheme, after its development was largely left to local teams. The twelve aims were used to develop the schemes locally but they could be adapted, although this was done in communication with the Welsh Assembly Government. This was also the case with direction provided over national issues but with flexibility allowed for a local focus.

The Welsh Assembly Government was seen as available to provide guidance when it was required and training and resources for individuals to provide training within their authority. The Welsh Assembly Government could also place items on the agendas of the regional cluster group meetings.

"They give direction over big issues but allow flexibility at a local level. They listen and give guidance and direction when necessary. For example they picked up the smoking ban. Parts of Appetite for Life and school health have made our job easier because of central advice." (HSC)

Local issues influencing the Welsh Assembly Government were less obvious to co-ordinators, but many did recognise it happening. It was felt that reports sent to the Welsh Assembly Government gave them an appreciation of local needs and peculiarities of the scheme in different areas, and that the Welsh Assembly Government was encouraging initiatives locally and would draw together good practice from local schemes, and share and formalise these approaches. Local pilots were used to assess initiatives, such as healthy vending and water machines, which were fed back to the Welsh Assembly Government before being shared nationally and carried into all-Wales policy.

It was felt that if a scheme had a local issue, efforts would be made to address it. An example of this was when many areas identified a DVD as a potentially useful resource for training for sexual health education.

"I know [authority] had a problem with water bottles, so obviously then we were all informed of it, they've let us know about the research that's been done in to that." (HSC)

"As far as they can, we said to [national co-ordinator] we were concerned here in [Regional Group] that there was a lack of resources for primary sexual health and [national co-ordinator] took that further and now we have a DVD and set up training for us to use that DVD so I do think things are fed back and as a result they do try and action on the point we are making." (HSC)

It was recognised that the all-Wales meetings allowed schemes to feed back issues to the Welsh Assembly Government that would then form the basis of training or policy development, and it was felt that the link between the schemes and the Ministers for Health and Social Services and for Education, Lifelong Learning and skills was short, as schemes fed back to the national co-ordinator who fed directly to the Ministers.

7.5.2 LOCAL LEVEL

Systems within individual schemes had adapted to take into account the local issues. There had been changes made to the assessment and reporting procedures required of schools, by many schemes, normally due to feedback from schools on the pressures of these procedures. As more schools were included in the scheme, teams and working practices were developed to allow for this greater capacity, and it was felt that the inclusion of schools from more affluent areas meant that the systems had to be adapted to take into account the different starting points of schools. Extra aims have also been introduced at scheme level as schools developed within it.

7.5.2.1 Scheme management changes

Co-ordinators that had been in post for some time had experienced many changes, often involving directors of department, and line managers, with one scheme experiencing four different Directors of Public Health, and three different Directors of Education. These changes were only felt to be unsettling where the incoming

individuals had different priorities. Many schemes also reported a change in the role or focus of the steering group from steering to a more advisory management role.

One healthy schools co-ordinator described how, after consultation with line managers, a decision had been made to disband the steering group as the time spent at meetings could be better used. In another area the use of the steering group was discontinued in favour of the introduction of a management group after a major review of scheme management conducted through a strategic workshop. One scheme formed a separate management group with a smaller number of senior staff from different departments to look after funds, accountability, and reporting structures.

Other changes that were mentioned included the move from a regional- to a county-based set up, and management by the NPHS rather than the NHS local trust. This sometimes led to more staff coming on board, and the co-ordinator taking a position with more responsibility. Change to management structure also meant that rather than reporting to one head of health promotion, there became a number of principal health promotion specialists, working under different groups.

> *"So whereas there was one person before, head of health promotion, now there are three principal health promotion specialists, and they are divided under the headings: Working with Communities, Healthy Living Network, and Children and Young People, and it's that person who would be my line manager."* (HSC)

Recommendation 39:	It is recommended that the Welsh Assembly Government agree minimum standards for participation of local authority leaders and senior management to be used as criteria for accreditation of local healthy school schemes.

7.5.2.2 Changes to healthy schools co-ordinator role

In general as the schemes developed and more schools came on board, this led to a greater degree of paperwork and the focus of the main co-ordinator's role towards a more strategic approach. Many co-ordinators started as the only, often part time, member of the scheme, which had now developed to involve as many as three extra fulltime support staff, as well as themselves, leading to a greater management role.

Many healthy schools co-ordinators have also been employed in other locally funded posts with further responsibilities outside of the scheme, such as PSE adviser positions and involvement in a greater range of groups and agencies, with growing confidence in inputting into these, down to developing experience and knowledge within health and education. These co-ordinators reported developing a more strategic role:

> *"The other two co-ordinators are involved a lot with the schools, whereas the strategy really comes to me now, so everything comes down from myself now as being the representative on the health and social care well-being strategies and those type of meetings, the sexual health meetings. I'm involved on the strategic side but at the same time I'm also able to be involved in actually presenting different stuff to schools."* (HSC)

7.5.2.3 Synergy and tensions due to working with other organisations

On occasion, co-ordinators have been influenced by other organisations, or individuals. For example, one co-ordinator acted as an assessor for Eco-schools, and found this role informed their own assessment process:

> *"I'm an Eco schools' assessor, so I went out on one of the assessments of a local school and I saw how, it opened my eyes, even though I'd come from teaching, to how much the children were capable of."* (HSC)

Different approaches to working had led to tensions in only a few of the schemes. In most of these, co-ordinators reported that if there were problems that could not be resolved on a personal level it would be referred to the steering or management group, which would act as a mediator between parties.

> *"Yes, there have been and that's where the steering group kicks in and helps to recover from it. We had one, a disagreement over an initiative* [another programme] *wanted to put out to the schools and there were disagreements with education about the content of it, and the appropriateness of it for schools, there was lots of duplication, so we acted as the mediators then in trying to reach a happy medium where* [another programme] *were still able to forge the links with the schools that they wanted, but without duplicating work that was already going on there. So we sat between them and worked it out, everybody could be kept happy basically."* (HSC)

Many healthy schools co-ordinators said they worked hard to avoid tensions by improving relationships and involving people in the decision making process. It was felt it was important to work with schools to see the benefit of the actions the schemes were proposing, and to receive feedback so that the scheme practices could be adapted such that pressures on the schools were minimised.

Where it was clear that conflict may arise due to departments feeling threatened by initiatives, such as the school meals service when working on nutrition, efforts were made to involve affected parties in all processes and this was thought to alleviate these tensions.

> *"I think the difficulties start straight away if people feel threatened really. The nutrition at the beginning, there was a lot of conflict between the school meal service and ourselves but once we sat down and talked about what the differences were there* [weren't] *problems."* (HSC)

7.5.2.4 Working across departments

Every co-ordinator sits on a number of committees across the two agencies, which they felt was a benefit for the scheme in opening lines of communication and raising the profile of the scheme. These committees included many local priority theme groups, sub groups of Health, Social Care and Well-being. It was felt that because of this, young people's health was being considered in areas in had not been before, and that an overall view of what was happening on the scheme could be built through these committees. On occasions, however, time was being wasted by attending meetings in which the co-ordinators had little to say.

Outside of education and health, co-ordinators were involved with, and took messages on healthy schools to, many groups including voluntary organisations, sports clubs, and schools through roles other than as the co-ordinator e.g. school governor.

> *"I'm on the PSE all Wales advisory group, I am on the Police advisory group, the accident injury prevention sub group on the LHB, the sexual health joint planning group, the [authority] nutrition forum, tobacco control forum, better health strategic group. I do spend a lot of time in meetings but it is time well spent because it gives an overall view of what is happening in [authority]."* (HSC)

7.5.2.5 Normalisation of education and health working together

It was generally thought that health had a greater influence on education than the other way around. This was mostly through highlighting specific needs and local issues through research and this being used to determine local policy. Where there were close links, health had adapted the way they approached issues with young people, and had worked with education to understand the schools system. Some co-ordinators felt these links could be improved to allow more working together, but different requirements of the departments were cited as making this difficult.

> *"I think it would be better if there were closer links and that maybe, we all got together and decided on policies in schools, which is something that will hopefully come in the future."* (HSC)

The NPHS was reported to lead on many strategies within the Health, Social Care and Well-being strategy, such as nutrition and physical activity, within which schools are heavily involved.

It was felt that relations between health and education were improving as people recognised the link between health and educational attainment, and that involvement with the scheme allowed individuals from education to sit on a number of Health steering groups that they would not normally have sat on. This influence, and working together between the departments, was also improved with a greater awareness of the LEA to the importance of the schools as a health setting, and the involvement of education staff in the development of health policy. Health had also actively involved education in events, as they were seen as the 'people on the inside' when it came to schools.

> *"I've got a really good relationship and we sit on lots of groups together, and I'm setting up a new nutrition group on our nutrition strategy, and then NPHS are linking in closely with that and in terms of other health agendas and other members of staff then their relationships are pretty much the same."* (HSC)

7.5.3 SCHOOL LEVEL

Schools reported that up to phase 3, actions were often seen as individual but beyond that the healthy schools concept became embedded in what the school did. As targeted by the Welsh Assembly Government (Figure 1) health became a part of everything they did without a conscious effort to include it.

Through the stakeholder consultation nearly all headteachers and in-school co-ordinators felt that the healthy schools approach had become embedded into the school to some extent (Table 15).

Table 15: Extent to which healthy schools actions/areas of work have been embedded into school

	Totally	To a large extent	To a small extent	Too early to say	Total
Headteacher	**14**	**47**	**7**	**1**	69
In-school Co-ordinator	14	31	4	0	49

Management changes within the school could affect the success of the scheme, either due to a change at headteacher level or a change of the in-school co-ordinator. Support for the scheme from senior management was seen as crucial to the success of it within the school.

A significant barrier to embedding healthy schools work in many schools was that the in-school co-ordinator was the only individual that dealt with the scheme to any great level. A change of personnel here made a difference. Encouraging all the staff within the school to take ownership of the scheme was very important.

For actions to be successful in schools it was felt that they had to be accepted by the whole school community and staff and pupils had to see the benefit of what was being carried out. It was felt that unsuccessful actions were those where the action lost its profile and individuals within the school could not see it working.

Recommendation 23:	At school level there is evidence of wide disparities in teacher awareness of the healthy schools programme. This suggests there is a need for more training, not only for school co-ordinators but for other staff in schools.

Recommendation 24:	Training should explore the social-ecological approach and concepts behind the healthy schools programme as well as practical issues. Very few teachers and education professionals are familiar with the language and concepts of fundamentals such as The Ottawa Charter. This can result in a lack of ownership across the school which can run the risk of undermining the programme.

7.6 Conclusion

The Welsh Network of Healthy School Schemes shows many of the characteristics of a true network, and there is much evidence of the workings between and throughout the different levels of the WNHSS. The Welsh Assembly Government provides guidance on how schemes should be set up at a unitary authority level while allowing for some flexibility at the local level. The Assembly Government produces guidance and resources on a national level in response to feedback from local schemes. Schemes collaborate well nationally, but particularly within regional groups, as well as trying to encourage this at a local level between schools and with other organisations and departments. Most schools reported collaborating with organisations through the scheme and although not all healthy schools co-ordinators

had seen that the scheme led to an increased collaboration with schools, where this was reported, it was seen as one of the most important aspects of the scheme.

Within the network many of the characteristics of a complex adaptive system can be observed. Fuzzy boundaries are obvious through the role of the healthy schools co-ordinators. As the schemes have developed and grown they have become involved with a number of different organisations and taken on roles to allow partnerships to develop as well as to increase the profile of the scheme. The extent to which this happens, however, differs between unitary authorities and is also influenced by which department healthy schools co-ordinators are based in.

Scheme systems have adapted over time. At the unitary authority level systems adapted as to where the scheme was based, working around the department within which it sat. The healthy schools co-ordinator's role and working practices changed as more schools were recruited and supported by the schemes. Schemes developed assessment criteria which took into account the point from which the school was starting and the "distance travelled" rather than judging all schools on equal criteria. There was also a move towards a whole school approach, throughout the network, as stakeholders became aware of the healthy schools concept.

National and local strategies have been influenced by the scheme, with scheme members often involved in their development. These included national strategies such as Appetite for Life, unitary authority strategies such as single education plans, and the health, social care and well-being strategies and local strategies such as physical activity and nutrition. There has also been a recognised embedding of healthy schools within school processes as schools progress through the phases.

Few of the healthy schools co-ordinators, or stakeholders within the scheme, acknowledged that there had been tensions whilst working with others, healthy schools co-ordinators tried to avoid any tensions occurring by working with parties between which these may arise, referring to steering or management groups when it was necessary. Schools did mention being encouraged by the scheme to take on topics they were not so keen to do, such as substance misuse, but accepted it was required and were grateful for the help provided by the scheme in delivering them.

There were many examples of synergy between organisations leading to innovative attitudes and actions due to the degree of collaboration taking place throughout the network. Partnerships were formed at a local level between the scheme and other organisations that led to new approaches being adopted in areas such as assessment. Individual actions were also influenced through collaboration. Many schools confirmed adapting a planned approach for an action after collaborating with another organisation or school.

8. Social-ecological approach

Key Findings: The social-ecological approach which underlies health promoting schools is certainly evident in the Welsh national co-ordinator's thinking, and in guidance for creating healthy schools produced at the Welsh level.

- **However, it is apparent that the social-ecological approach is not always accurately expressed at national level. This is important because approaches underlying healthy schools are concerned with cultural and organisational change across all levels in a setting and Wales is the setting for the WNHSS.**

- **Many schemes do appear to be committed to the actions in the three domains which will achieve a social-ecological approach within schools. It is difficult to disentangle the scheme commitment from the school commitment as both are important in achieving these domains. It is apparent that this commitment has increased as schools and co-ordinators have both developed more sophisticated understandings of the social-ecological approach.**

- **Where schemes fail to address all three domains, it is most commonly community links that are problematic, followed by ethos. All schemes address the formal curriculum. Local working practice at the scheme level further reflects the extent of a commitment to the social-ecological approach, and schemes should consider not only *who* they work with, but also *how* they work with them.**

8.1 National level

The importance of the social-ecological approach to health promoting schools, including settings approaches and the influence of the Ottawa Charter, is discussed in the introduction. There are four key pieces of evidence regarding the extent of commitment to the social-ecological approach at the Welsh level:

- past membership of the ENHPS and the new SHE programme;
- co-ordination of the national programme;
- national documentation;
- meetings and training.

8.1.1 MEMBERSHIP OF THE ENHPS AND SHE

Wales and the Welsh national co-ordinator (who has overseen the WNHSS since its beginning) have long-standing membership of the European Network of Health Promoting Schools (ENHPS). ENHPS has been steered by a group of academics and practitioners with a commitment to the social-ecological approach to healthy schools. Although it has recently been replaced by SHE (Schools for Health in Europe), ENHPS was perceived internally as a long-term, dynamic "strategic development" (Barnekow 2006) or "innovative programme" (European Network of

Health Promoting Schools 2007) that both facilitated the development and dissemination of health promoting school theory and practice and encouraged appropriate local implementation of this theory. The Technical Secretariat arranged annual business meetings of national co-ordinators, workshops, meetings, seminars and training; offered advice and visits to countries and arranged to disseminate resources and information through annual newsletters (Burgher 1999) in order to pass on the ideals of ENHPS to member countries, including Wales. Further, any country wishing to join the network needed a national coordinator who acted as the primary source of communication with the ENHPS and who was endorsed by both the health and education ministries (Barnekow Rasmussen and Rivett 2000). National co-ordinators facilitated the dissemination and appropriate local implementation of ENHPS ideals to individual countries. The requirement that the appointment of national co-ordinators be endorsed by both health and education also embodied the European emphasis on health and education partnerships (Barnekow 2006; Burgher 1999) in the structures of the ENHPS and resonated with the social-ecological approach.

However, despite the requirement of EHNPS that national membership is endorsed by both Health and Education ministries, there is also some evidence suggesting that the social-ecological approach to schools advocated by the ENHPS was not reflected in its own functioning. One of the international expert commentators participating in this review was Professor Peter Paulus, who was heavily involved with ENHPS from its beginning, and is now involved with the SHE planning committee. His description of changes at the European level suggested that SHE is able to adopt a much more social-ecological approach than did ENHPS.

Peter Paulus has argued that the introduction of SHE has been accompanied by a shift of emphasis to more active participation by the member countries and national networks involved in the European network than had happened under ENHPS. The original European network was funded by the World Health Organization (WHO) and, while those staffing the Technical Secretariat were very active and did the job well, the WHO model of organisation was fairly top-down and co-operation between countries themselves was minimal. Vivian Barnekow, who had headed up the Technical Secretariat, also suggested that when working with an organisation like WHO, there were rules and processes that must be adhered to. With new funding, this was now changing. SHE was now based in NIGZ (Netherlands Institute for Health Promotion and Disease Prevention) in Woerden in the Netherlands and the new co-ordinator for Europe, Goof Buijs, was looking at the network and how to bring into it more of the expertise that the countries themselves had. Peter Paulus explained that SHE wanted to build up a liaison office in Woerden and to increase participation of the member countries/networks as opposed to the WHO taking the lead and everybody having to follow the rules of WHO. So countries would be free to play a more active role because it would become more their network rather than a WHO network. This would include involving universities and experts from member countries. The role of experts was also changing and they now had defined work packages and deliverables and had to actively contribute something to the network. Professor Paulus thought and hoped that this would help create a real and cooperative network with more active participation of the countries/ networks that are involved.

While some of this change was possible due to changes in funding, perhaps there is also a point, after early leadership has necessarily driven forward a health promoting schools vision, when those involved have accrued their own expertise and can be

more closely involved with driving the project forward. This freedom for countries to play a more active role should also increase their sense of ownership over the network and it was hoped that this change will enable a more equal and transparent arrangement with more inter-country collaboration on initiatives. Despite the disadvantages to losing WHO funding, this new, apparently more democratic European model will arguably allow Wales to move forward its development of healthy schools and potentially increase expression of a social-ecological approach at a national level (see *Meetings and training* below).

8.1.2 CO-ORDINATION OF THE NATIONAL PROGRAMME

Co-ordination of the WNHSS at national level does not appear to have been greatly influenced by the top-down approach adopted by the ENHPS. Wales belongs to the ENHPS as a constituent member of the UK and the commitment of Ministers for Health and Education required as a condition of joining the ENHPS had been made at UK level before the National Assembly for Wales, and later the Welsh Assembly Government, came into being. Therefore ministers in Wales did not have the opportunity explicitly to demonstrate support for the WNHSS. During the years since 2000 as the WNHSS has grown, partnership working at national level has increased as Wales has developed as a devolved country of the UK and in 2004 Ministers supported the national co-ordinator to take on the role of Co-ordinator for the whole of the UK. The national co-ordinator is responsible to the Minister for Health and Social Services and to the Minister for Education and Lifelong Learning. At official level, the Health Improvement Division works jointly with Education on a range of issues such as the Food and Fitness implementation plan, evaluation of the primary school free breakfasts initiative and the Food in Schools Working Group and has linked healthy schools with Education for Sustainable Development in the Education Department and with Eco Schools in the Environment Department. Officials ensure Ministers are informed and are able to talk in an informed way about the way they work together:

8.1.3 NATIONAL DOCUMENTATION

It is possible to consider how national documentation supports social-ecological approaches. Two types of documentation were identified: national policy / strategy developed by the Welsh Assembly Government and documentation used specifically to deliver healthy schools in Wales. The place of healthy schools within Welsh policy documents has been outlined above. Arguably, healthy schools are not embedded in national policy as well as they could be. In addition, where they are mentioned, they are left undefined with an apparent focus on initiatives rather than whole-school, sustainable approaches, suggesting that national strategy fails to engage fully with the social-ecological approach that underlies health promoting schools theory. However, the guidance on healthy living recently adopted by Estyn (Estyn 2007) is evidence of a more holistic approach to health in schools and an advance in the development of a more substantial partnership between health and education in Wales. There is evidence from across Europe that most countries have not yet successfully achieved the goal of having Healthy School policies embedded in education sector policies but there is clear evidence of this being achieved in Scotland (Young and Lee 2008) where health promoting school policy statements are now integral to education policy.

Aside from national policy, specific documentation exists which supports the delivery of healthy schools in Wales via WNHSS. This documentation is more engaged with the social-ecological approach than national strategy. An important example of this is

the 1999 document *Welsh Network of Healthy School Schemes: framework for local schemes* (The National Assembly for Wales 1999). This document helped establish a foundation for the development of WNHSS. It highlighted the influence of ENHPS on Welsh thinking and demonstrated the intention of WNHSS to achieve the whole-school approach underlying health promoting school theory. This is illustrated by the following statement:

> ***A health promoting school*** *is one which actively promotes and protects the physical, mental and social health and well-being of its community through positive action by such means as policy, strategic planning and staff development with regard to its curriculum, ethos, physical environment and community relations* (The National Assembly for Wales 1999)

This demonstrates a commitment both to well-being and to preventive approaches to health (fundamental to a social-ecological approach). More prominently, a review of the twelve stated aims reveals a commitment of WNHSS to address three key domains that are often seen as important in facilitating health promoting schools:

1. The formal curriculum;
2. School ethos and physical environment (including policies);
3. Schools' relationship with pupils' families and others outside the school (community).

The logic model (Figure 1) demonstrates less balance of the three action areas in defining actions and expected outcomes for the programme. The majority of actions and outcomes relate to advocacy and mediation, with only two outcomes for equity – "Reduction in inequalities in health" (an intermediate outcome) and "Parents influenced" (an intermediate and long-term outcome). Evidence from the review suggests that involvement of school teaching and support staff, pupils, governors and others needs to be in place *before* "sustainable health actions", which are also expected at the intermediate stage, can be observed. And that although difficult to do, parents should be *involved* as well as *influenced* at an earlier stage too. Revision of the logic model to specify more actions and outcomes relating to participation would help the network to conform more closely to the social-ecological ideal.

A second point is that a reduction in health inequalities cannot be confidently ascribed to WNHSS and if they could, they are more likely to be observed during the long-term stage of the programme than at the intermediate stage. A reduction of inequalities between schemes would be a more achievable and measurable outcome. Differences in schemes' resources are likely to affect the support they can offer to schools, which could lead to differences in the benefits derived from healthy schools by pupils in different areas of Wales.

Recommendation 3:	It is suggested that the Welsh Assembly Government should consider ways in which inequalities between schemes could be addressed. For example, data on recruitment, training and numbers of schools in each Phase could be used by the Welsh Assembly Government to identify, and address at an early stage, any barriers encountered by local schemes in supporting schools.

8.1.4 MEETINGS AND TRAINING

The all-Wales Healthy schools Co-ordinator meetings are central to the support provided to schemes by the National co-ordinator. All-Wales meetings occur once a school term; they involve, and are much valued by, representatives from all local healthy school schemes. Communication and collaboration between all the schemes is clearly important in instilling a social-ecological approach across the Welsh Network as a whole and such meetings help to achieve this. The meetings did appear in some respects to echo the top-down approach of the ENHPS, with much of the business centering on the Welsh Assembly Government's needs to pass information to healthy schools Co-ordinators, and keep up to date with developments in local areas. However the national co-ordinator has introduced measures which give local healthy schools co-ordinators more control: they take turns to chair the meetings and organise all-Wales training focusing on topics they themselves identify.

Healthy schools co-ordinators have developed effective regional networks and it is in these groups, and the informal networks they created between schemes, that most between-scheme sharing of ideas and experience occurs. At the Spring 2007 meeting a national website or on-line forum was suggested and it was clear that many wanted more opportunities to share expertise and good practice at national level. The national co-ordinator took this on board and the review team were consequently invited to the next meeting, in the Summer of 2007, where the morning was given over to the sharing of resources between schemes. The feedback from those that took part was very positive, and this was widely considered a worthwhile activity. It is very clear, across the research, that healthy schools co-ordinators and their teams tend to be very open with one another, favour collaboration and would like more opportunity to do so at a national level. Just as the European-level has changed its approach, perhaps there is scope for Wales to continue its successful relationship with ENHPS/SHE and follow its lead in moving further forward by developing strategies to encourage even more active participation and co-operation of the increasing number of experts across the whole Welsh Network.

Recommendation 22:	It is recommended that the Welsh Assembly Government consider asking Local Health Boards or LEAs in each region to take turns to host and lead All Wales meetings of co-ordinators. Such a change might encourage more involvement in schemes by senior local authority staff.

8.2 Local level

The extent of commitment to the social-ecological approach at the scheme level can be assessed in two ways:

- The extent to which schemes address the three domains in their schools;
- local scheme-level working practice.

8.2.1 EXTENT TO WHICH SCHEMES ADDRESS THE THREE DOMAINS IN THEIR SCHOOLS

As outlined above, a social-ecological approach would involve schools addressing the following three domains:

1. The formal curriculum;
2. School's ethos and physical environment (including policies);
3. School's relationship with pupils' families and others outside the school (community).

We would therefore expect to see local scheme policy to require that this occurs, as stipulated by national guidelines.

Schemes report that they encourage schools to address the three domains and therefore adopt the social-ecological approach. Some respondents discussed how this was encompassed in the aims of the local scheme which were usually adapted, to various extents, from the national aims.

However, the most interesting information came from discussions of practice where variation in the extent to which it was reported that the three domains were addressed within schemes, and how, became apparent. Firstly, Table 16 summarises specific methods reported to address these three domains.

Table 16: Methods reported by local healthy school co-ordinators as being used to address the three domains

Domain	Methods listed
The formal curriculum	- Healthy living topics - Emotional health and self confidence topics - Healthy activity and fitness topics - Drugs awareness and sex education - PSE (including new PSE guidelines and the vast number of aspects of health included within it) - Health weeks - Linking specific themes across the curriculum - Schools conduct audits to establish how health topics are delivered across the curriculum - INSET training
School's ethos and physical environment (including policies)	- Healthy workplace focus - Safe environment focus - Smoke free environment - School ban on unhealthy foods - Working with eco-schools - Developing playground markings to encourage physical activity at break times - Water bottles on desks - Exercise for children in mornings - Children as 'buddies' at break times to look after playground and other children - Headteachers; chair of school governors and increasingly chair of school council sign healthy school contract to demonstrate whole school support - Outdoor classrooms (pupils learning about the environment in the environment – e.g. Forest Schools initiative)

(Continued . . .)

Table 16 continued: Methods reported by local healthy school co-ordinators as being used to address the three domains

Domain	Methods listed
School's relationship with pupils' families and others outside the school (community)	• Build partnership between schools, communities and the home • Surveys with those in the community about school issues • Links with Community Focused Schools • Activities with parents (e.g. healthy eating) • Actions within and information giving to community about being a healthy school (e.g. healthy food at parent events; displays in schools to promote healthy schools and their aims to visitors; displays in local dentist and GP waiting rooms to promote healthy schools) • Parents and governors assisting a teacher in-school co-ordinator • Written in contract that schools agree to share good practice • Working with caterers on nutrition • Work with other local authority and outside agencies to develop physical activity on offer to pupils after school
*Actions aimed at encouraging a whole school approach**	• Accelerated learning • School audits to facilitate progress towards being a healthy school (e.g. where are they; where do they want to go, considering the three domains, identifying weaknesses and what they need to work on) • Use of school development plans / improvement plans to embed healthy schools • Production of written criteria as to what a healthy school should look like which reflects a complex settings approach combined with the requirement of evidence demonstrating elements of this.

*A range of co-ordinated actions across all three domains also achieves a whole-school approach.

While many of these actions were reported by more than one local co-ordinator, some were reported by only one local co-ordinator – however it cannot be assumed that where these were not reported they did not occur. This is not an exhaustive list of every action undertaken across Wales and only serves to indicate the variety of approaches reported by healthy school co-ordinators. This variety can be identified within each domain. *Curriculum* approaches, for example, were largely either about specific topics or actions to ensure cross-curricular integration of health topics. Reported methods of addressing *ethos* also demonstrated varied strategies and foci attempting to build messages across the school environment. For example, some schemes ask schools to sign Healthy School contracts to encourage cross-school support and involvement in decision making by requiring that they are signed by both the headteacher and a governor. More recently, the additional requirement of the signature of the (pupil) chair of the school council on these contracts suggests a deeper engagement of pupils in decision making by some schemes.

The final domain, *community* engagement also demonstrates a variety of approaches. Some of these are fairly abstract (e.g. build partnerships) while the rest are either about informing the community about healthy schools, gaining opinion from the community or engaging with the local community around healthy schools. Generally, community engagement involved sessions for parents or negotiating with external agencies / other schools to facilitate the provision of healthy schools. However, two schemes reported that some schools had gone as far as to employ members of the community as assistants to the teacher who was the in-school co-ordinator.

In addition, some actions reported by local co-ordinators clearly attempted to work across the domains and specifically encourage a whole-school approach; hence they were included in a separate category. These four actions appeared, more than the others, to consider, promote and facilitate such a whole school approach. This last category also highlights how the majority of approaches appear to work within a specific domain of the social-ecological approach and suggests that perhaps there is scope for actions that work across the domains and therefore resonate more with the settings approach.

As well as variation in the type of actions that were reported, there was also variation in the extent to which individual schemes appeared to address these three domains. Many schemes apparently adopted a genuinely social-ecological approach to health promoting schools that operated across all three domains. This variation is likely to be influenced by the attitude of the healthy schools co-ordinator and their team as to what a Healthy School is. A time element to this was also evident, with several local co-ordinators suggesting that schools' understanding of the approach had become more complex over time and that many were now taking a true settings approach rather than a more curriculum-based health education approach. One co-ordinator also reported that actions had become more complex as had perceptions of the approach, something that was reflected when evidence from schools was to be found in a cross-section of portfolios belonging to different groups (e.g. school council; eco-schools) rather than in one healthy schools document. Other local co-ordinators reported that such changes meant that healthy schools was seen less as an 'add-on' now, and more as a support tool. To illustrate this change in understanding, one co-ordinator reported how an in-school co-ordinator in Phase 3 had said that if they had known what they were doing when they started, they would have done things very differently. This healthy school co-ordinator also said that she sympathised with the in-school co-ordinator as she had herself found it a slow learning process. This reinforces a sense in the data that, while healthy school co-ordinators focus on how school understanding of the approach has become more complex, although not really explicitly mentioned by local co-ordinators, perhaps as some co-ordinators, schemes and schools have grown together, they have adopted a mutually more complex understanding of the scheme.

When discussing practice, a smaller number of schemes appeared to focus on two domains rather than all three. This was regardless of the scheme rhetoric. Where schemes addressed two domains, it was always the community domain that was neglected. Evidently, this domain raised the biggest barrier to achieving the social-ecological approach. While this was most apparent through a lack of engagement with the domain during the interview, some healthy school co-ordinators explicitly pointed out the weakness of community links. In a smaller number of schemes, one domain seemed to dominate. In these cases it was always ethos that suffered, with the focus retained on the formal curriculum.

It should be remembered that, as shown by the types of actions reported by healthy schools co-ordinators, where schemes do work within specific domains, the ways in which they address this do vary. Finally, there is also potential for the adoption of approaches and actions that work across all three domains rather than addressing just one of these key areas of the social-ecological approach.

8.2.2 LOCAL WORKING PRACTICE

Partnerships between health and education; working with school cluster groups; between-scheme collaboration; and partnerships between healthy school schemes and other groups, departments and organisations reflect schemes' commitment to the social-ecological approach. For example, local healthy schools co-ordinators placed great value on their collaboration with other schemes within their region, which appeared to be ongoing and symbiotic, producing informal networks in which most sharing of ideas and experience occurred. However, it is important to consider how schemes and other bodies work with one another. In some cases this is clearly very well integrated, with multiple groups working together to achieve shared goals. In other cases, agencies are called in to fill an identified gap in provision or topic coverage. Elsewhere, work with other groups may be no more than inviting them to see your work in action. Consequently, it is important that schemes consider not only *who* they collaborate with but *how* in order to foster the genuine partnership and collaboration that is necessary to achieve the shared responsibility mentioned by the Ottawa Charter (World Health Organization 1986).

8.3 School level

As suggested above, schools appeared to vary in the extent to which they were able to implement a fully social-ecological approach. Some schools appear to find it easier to achieve this than others. Our observation suggested that several factors appeared to influence this. The attitudes and understandings of in-school co-ordinators were arguably important in driving the scheme forward, and getting everybody on board in a whole school approach. While the previous section suggested that school comprehension of the approach often increased over time, this was not always the case. For example, we visited one small, independent primary school which was only in the first phase of WNHSS, yet possibly has one of the most holistic approaches to health among the schools that we saw.

However, major barriers to becoming health promoting schools in Wales were school type and size. Primary schools tended to find it easier to become healthy schools than secondary schools. This was partly due to size, with smaller schools finding it easier to get everyone on board (particularly as smaller primary schools tended to manage it better than larger primary schools) However, it also seemed that something about the structure of a primary school, other than size, was fundamentally more akin to a Healthy School to start with. For example, in primary schools, teachers have closer, longer-term contact with pupils and are able to more easily build up the type of relationships fundamental to health promoting schools, with all pupils being better known to staff. Teachers tending to be responsible for one class also facilitated whole-school initiatives such as tooth-brushing as it was relatively easy to ensure that all pupils are exposed to the action. Whatever the reasons for these differences might be, the differences are evident. A clear challenge for the future of health promoting schools in Wales and elsewhere is consideration of how they may best be achieved in different types of school. Some of the international expert commentators supported these findings. For example, Lawrence

St Leger described a survey undertaken in Victoria , that found while the type of school (i.e. religious, state, independent) or whether it was rural or urban did not seem to make any difference to whether they could achieve health promoting school status, whether the school was a primary or secondary school did influence it. His thoughts on why this might be the case echoed our own conclusions:

> " . . . primary school's more holistic, more integrated, secondary more subject based."   (Lawrence St Leger)

He was questioned further about this:

> "That difference between primary and secondary schools, do you think that's due to the nature of primary schools and secondary schools?
>
> "Yes, exactly, I mean, you look at all the principles of Health Promoting Schools, it's about sharing, partnerships, collaboration, all the stuff that you unpack from the Ottawa Charter… you'll see most of those things actioned in a primary school, it's problematic with the intensity in some secondary schools." (Lawrence St Leger)

Similarly, when asked whether she thought that the processes and connections that she had previously reported to be fundamental to health promoting schools were traditionally present in schools, Janine Phillips said:

> "Not necessarily, I think it's more common in primary schools these days but high schools are set up in a way to make sure people get the scores for uni [university], it's very much around, you know, people are in silos, my view of the way many high schools is the staff don't work a lot together, they're big staff and they don't even know each other so there's not that sort of intrinsic connection, it's hard to have processes where there is student involvement and it probably requires more work than just a traditional school… that would be my feelings, in that not that schools don't necessarily have that but I don't think all schools do and I think if they don't have it, probably they need quite a bit of support to try and get that sort of stuff happening."   (Janine Phillips)

Given this distinction between the organisation of primary and secondary schools, it may be necessary to re-think and develop new strategies for helping secondary schools become healthy schools.

Recommendation 15:	Consideration should be given to setting up a working group tasked with producing guidance for local schemes regarding how they can best support secondary schools, including ways of increasing participation by identifying smaller groups within schools.

8.4 Minimum standards

8.4.1 NATIONAL LEVEL

The National Framework sets out guidelines on the role of local schemes, most of which appear to be in effect minimum standards. Some guidelines regarding the use of assessment tools with schools, the awarding of plaques to schools, and the time taken for schools to complete a phase, are less prescriptive. The guidelines include one that schemes "should decide if they wish to determine certain minimum standards for schools". The guidelines have been very effective in establishing the WNHSS as a functioning network. Interestingly, it is where the Welsh Assembly Government has left more scope for choice by local schemes that they seem to have diverged to some extent from the ideal social-ecological model of health promotion. A stronger requirement that schemes should use the assessment tool and that schools should be assessed against standards set at national level would arguably have increased equity within schemes by preventing ad hoc judgments (please see below) about what schools could reasonably be expected to achieve.   As mentioned in the advocacy section, schemes do not always appear to have required schools to spend enough time in each phase for actions to become embedded.[4] And while plaques or other rewards for achievement are important, the wish for a school to receive another plaque should not override the more sustained rewards to be derived from a thoroughgoing social-ecological approach which does not develop in pre-defined time periods.

There was evidence of dissatisfaction among stakeholders, particularly healthy schools Co-ordinators, regarding school standards and assessment. Some workshop participants wanted the Welsh Assembly Government to set minimum standards for schools because they were concerned about differences in standards achieved across Wales and also about variation in schemes' assessment methods. Some healthy schools Co-ordinators were not confident that their assessment of schools was sufficiently independent.

This evidence suggests that allowing greater choice and control at local level has resulted in a less social-ecological approach in some schemes, mainly affecting equity in the setting of different standards for different schools, and advocacy, where some schemes allow schools to progress through phases more quickly than they should.

Recommendation 18:	Local schemes should adhere strictly to national guidance regarding the minimum length of time for schools to carry out work in each Phase of the scheme.

Recommendation 4:	It is suggested that healthy schools co-ordinators should have uniformly high expectations of every Healthy School and that these expectations be supported by national standards for schools.

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[4] New guidance has addressed this issue.

8.4.2 LOCAL LEVEL

8.4.2.1 In-school co-ordinators

All schemes where there were data on this theme required schools to nominate an in-school co-ordinator. This is unsurprising as this is a Welsh Assembly Government requirement, as many healthy schools co-ordinators reported. Only one scheme reported that they thought it was preferable for a school to have two in-school co-ordinators. While some healthy school co-ordinators talked of them as contacts, and others as facilitators, there was a distinct sense that this was a crucial role that acted as a fulcrum around which a successful healthy school could be built. Without a co-ordinator, the move towards being a Healthy School would fall apart. As such, it was also necessary to have the right person in this role – an enthusiastic co-ordinator could drive the healthy school forward while the wrong person may mean the whole thing falls apart. As one healthy schools co-ordinator said:

> *"All you need sometimes is that enthusiasm of one and they can motivate the whole school – we've seen it happening time and time again"*

However, one healthy schools co-ordinator did point out that having a co-ordinator can lead to problems where if someone is given a management point for being the co-ordinator, other staff may feel that they have no obligation to help. Also, in some schools, there are departments that feel they are the only ones contributing to the healthy school. Clearly, this may undermine the whole school approach that is fundamental to the scheme. Related to this, one co-ordinator reported that they could not use the term in-school co-ordinator as this would mean that they should automatically get a pay increment, something which many of the schools could not afford. As a result, she calls them the healthy schools Contact.

The person selected to be the co-ordinator varied depending on the size/type of school. Some said that in primary /small schools this tended to be a headteacher whereas in secondary / large schools this tended to be PSE co-ordinator or other class teacher. Two schemes reported instances where parents and governors assisted the in-school co-ordinator in this role.

8.4.2.2. Achievement standards

The setting of minimum standards with regards school achievement was a key theme in interviews with local co-ordinators. Most commonly this related to whether schemes set minimum standards which schools had to achieve in order to progress to the next phase. Approaches of local schemes could be divided into 4 types:

In some schemes, there were *minimum requirements that all schools had to achieve.* This may have been a policy or actions that all schools should have or address. For example, two schemes require that all schools have addressed PSE policy and curriculum by the end of the second phase. While this minimum standard was fairly commonly reported, far less often schemes reported a minimum requirement that concerned a set of indicators laid out for each possible action that all schools had to achieve. One scheme in particular discussed the use of such actions. Another scheme also had minimum standards that schools had to address before they were allowed to join.

Other schemes set *minimum standards for schools to achieve but did this on a school by school basis,* with appropriate standards set for each school. As one healthy school co-ordinator reported, they had discussed minimum standards but decided against it

as all schools start from different places and it is the relative progress each school makes that is of interest rather than all schools meeting the same standard. As a result, their focus was on having sufficient action plans for each local context that are negotiated between the healthy school co-ordinator and the school. Or, as another co-ordinator put it, schools must decide where they want to be and plan their own journey towards it. Two schemes in particular adopted audit tools in order to facilitate such an approach. One healthy school co-ordinator reinforced that they took a "gentle" approach to enforcing minimum standards. This room for flexibility when assessing achievement of minimum standards seems to be another way of allowing for local context.

Other schemes set *no minimum standards for schools to achieve.* This appears to at least sometimes be an alternative solution to the same problem that led other schemes to develop locally negotiated standards, with one healthy school co-ordinator reporting that they had originally wanted minimum standards but the steering group had convinced him that this could alienate schools. Instead, they ensured that standards were maintained through rigorous monitoring systems, although there was no elaboration on how this worked. Elsewhere the healthy school co-ordinator highlighted the importance of keeping all data on schools, with their progress stored in a central and accessible format.

Alongside these three main categories, some schemes emphasised that they had had minimum standards or indicators that were desirable rather than essential.

8.4.2.3 Topics covered

The majority of schemes did not place any minimum standards on what topics schools should cover. Where schemes did require schools to address certain topics, this tended to be either because they found schools tended to ignore some topics (e.g. sex education) or where there were local issues or inequalities that needed addressing. One scheme said that they occasionally asked all schools to focus on one topic for the year, but where this was the case they provided the resources to allow them to meet these requirements. One healthy school co-ordinator said that they weren't sure where they stood legally with enforcing schools to address sex education as primary schools were legally allowed to opt out of providing it. Some schemes are now introducing requirements that schools should have covered a minimum range of topics by the time they complete Phase 3. Healthy schools co-ordinators are concerned that schools are reluctant to address "unpopular" topics such as sexual health and substance misuse.

8.4.2.4 Signing of the healthy schools agreement

As outlined when discussing the ethos domain above, several schemes required the signatures of both headteachers and the chair of school governors on the agreement / contract that has to be signed when schools engage with the scheme. This was in order to demonstrate whole school commitment to the project. A broadening of the definition of whole school commitment could be identified with some schemes starting to also require the signature of the chair of the school council on this form, demonstrating a commitment to giving pupils a voice in the decision-making process.

8.4.2.5 Smoke-free schools

These were often reported to be existing or early minimum requirements. However the introduction of the Welsh ban on smoking in public places has changed the emphasis on this within schemes.

8.4.3 SCHOOL LEVEL

Minimum standards within schools were largely influenced by decisions at the local scheme level as described above.

8.5 Conclusion

As a long-standing member of SHE (formerly ENHPS), the WNHSS has absorbed and to a commendable extent has expressed the social ecological approach of the Ottawa Charter. The Framework for local schemes and national training are rooted in social ecological principles. At national level there are good links between the national co-ordinator and officials in the Department for Children Education Lifelong Learning and Skills and the more participative approach of SHE promises further progress in implementing social ecological principles. The WNHSS has developed particular excellence in its network functioning.

At national level, the formal policy environment for the WNHSS does not at present demonstrate understanding of the social ecological principles underpinning the programme. While the review team take the view that this may endanger the sustainability of the WNHSS, the national co-ordinator and other Welsh Assembly Government officials feel that a formal policy is not required and would be out of place. Variation in local advocacy for schemes may jeopardise the capacity of the WNHSS to reduce inequalities in health and there is a need at national level to examine in more detail the ways in which inequalities between schemes may be reduced. At school level, there is room to increase participation in health-promoting actions and such an increase can be expected to address differences in local schemes' ability to advocate actions working across all three domains of the social ecological approach. National standards for schemes' assessment of schools would help to reduce inequalities between schools' levels of achievement.

Revision of the logic model and its use within the well developed administrative and networking framework of the WNHSS could be expected to achieve rapid improvement in participation and equity. It is important to remember that this Review was completed well before the 2010 deadline for recruiting every school in Wales, and that the issues of participation and equity have been identified by the review at a relatively early stage in the growth of the programme.

9. Conclusions

This has been a broad review of implementation of the WNHSS, and how it compares with the model of health promotion set out in the Ottawa Charter, following completion of the first stage of the WNHSS from 2001 to 2006. The aims were to find out whether a social-ecological approach to health had been understood and implemented in schools; and to identify conditions associated with greater conformity to the social-ecological model. The review has used mixed methods to collect data from hundreds of stakeholders in the WNHSS and has been supervised by members of the Expert Review Panel. Expert Panel member Ian Young commented as follows on the *"remarkable achievement"* of the WNHSS to date:

> *"In my judgement the WNHSS is one of the most developed and comprehensive health promoting school programmes in Europe. This is in part due to good leadership and continuity of this leadership at national level (previously in Health Promotion Wales and currently in the* [Welsh Assembly Government]*). The fact that Wales is a relatively small country has also been a factor in facilitating the spread of good practice from the national level to local schemes and individual schools. There is evidence from school and local co-ordinators that they feel part of a national programme and that they can effectively communicate their views to ministerial level. This is a remarkable achievement and is not the norm in such national programmes in education or health. There is also evidence of many examples of good partnership-working between the health and education sectors at government level, local scheme level and school level. This is not achieved easily or quickly and is usually a problem in most of Europe.*

> *Wales has passed through what could be termed an **early experimental phase** through a **strategic development phase** and is now in the early stages of an **establishment phase** (Young, 2005) in relation to healthy schools. In addition there is evidence of continuity of involvement and good leadership at local level and this has been essential in the roll out of the programme. Most countries in Europe are either in the first or second stage in my judgement and the Welsh scheme is more advanced than most other countries."*

9.1 The WNHSS and the Ottawa Charter

The ideal result of advocacy, equity and mediation enacted in the WNHSS would be that the social-ecological approach to health is demonstrated in all schools throughout Wales. The following conclusions attempt to summarise which features of the network appear to be important in supporting this result and to suggest the main areas where the network could be strengthened to increase the extent to which the WNHSS approaches the ideal during its ongoing development.

9.1.1 ADVOCACY

The establishment in all unitary authorities of Wales of schemes which in general have grown and functioned as anticipated testifies to the high standard of planning and management at national level. Continuity of leadership at national level has been

a great asset to the programme. The Welsh Assembly Government has given a clear lead to the WNHSS through its international links with SHE; careful piloting and evaluation; funding for local schemes; training for healthy schools co-ordinators and schools assessors; and the framework which defines roles and responsibilities within the network. The Welsh Assembly Government has also produced resources for healthy schools co-ordinators to distribute to schools; and facilitated communication between healthy schools co-ordinators through convening all-Wales meetings. The fact that the WNHSS is a Welsh Assembly Government programme is important in securing its acceptance and implementation.

The Welsh Assembly Government expects that the WNHSS will become more independent of the support it provides at present. The possibilities for sustaining the network were discussed by workshop participants, some of whom wanted a stronger management framework at national level, more support from formal policy and longer-term funding. So far continuation of funding for the WNHSS has been justified by demonstrating its utility in achieving broader policy targets; however, the more holistic aims of the WNHSS distinguish it from other programmes competing for funding. Recognition of this unique character of the WNHSS in a formal policy which defines the network's roles and responsibilities, and the nature of the Welsh Assembly Government's commitment to it, may be a key factor in sustainability.

Many schools visited during the Review demonstrated that a social-ecological approach to improving pupils' health can be achieved. Key factors associated with their success were small school size or the division of a larger school population into smaller groups; a cross-curricular approach to teaching; and the commitment of headteachers to increasing children's capacity to learn. Most schools taking part in case studies and in the stakeholder consultation were very appreciative of the support received from the healthy schools co-ordinator. Some schools where health improvement was well integrated had succeeded almost independently and 65% of headteachers and in-school co-ordinators who responded to the stakeholder consultation said they could foresee a time when they could continue without the healthy schools co-ordinator's support. Although reducing support from healthy schools co-ordinators might be considered as a future possibility it may not be advisable in the short term, with a substantial proportion of schools in some scheme areas still to be recruited. Most schemes are still growing, and include many newly recruited schools; many need to devise more appropriate strategies to address the needs of secondary schools. Schools have benefited greatly from the action planning framework used as part of the healthy school scheme and from the events organised for school staff. Any future proposals to reduce the amount of local support provided for healthy schools should consider preserving these benefits.

As mentioned above, an important factor in achieving the social-ecological approach in schools was the headteacher's drive to helping children to learn and seeing that improving their health was fundamental to improving their potential to learn. Some headteachers and in-school co-ordinators, including those in schools where health improvement was very well integrated, said that since becoming a healthy school the children's general behaviour had improved so that they were better able to participate in learning activities. Evaluations of community schools in the USA have also noted improvement in general behaviour as an outcome in some schools. This seems to be a key feature of the healthy school which perhaps deserves wider recognition as it is an early outcome of direct benefit to the school.

The assessment of schools by schemes has raised practical and philosophical issues. In some schemes where the number of member schools has recently increased, healthy schools co-ordinators have reported difficulties in finding enough trained people to carry out the assessment process, and in securing some measure of independent scrutiny. Schemes vary in the methods they use and in the degree to which they have overcome such problems. A further issue is the standards set for schools to pass each Phase of the scheme. Healthy schools co-ordinators were aware firstly that schools were often starting from very different baselines and secondly that it was important not to discourage schools by allowing them to fail an assessment. Therefore they felt that setting a common standard for schools with different levels of resources would mean giving equal recognition to very little effort in some schools, and a great deal of effort in others; so it was more reasonable and less daunting to assess the "distance travelled" rather than expect all schools to arrive at the same "destination". Visits to schools in different schemes confirmed that the number of Phases achieved was not a reliable guide to the standards observed.

The major issue for schools has been the production of the portfolio required for assessment, with many headteachers and in-school co-ordinators perceiving this as unnecessary and burdensome. The importance of the portfolio in the assessment process appears to vary between schemes. In some schools visited, the quality of the portfolio bore little relationship to the quality of health-improvement work. On a positive note, the common acceptance that portfolios are a necessary part of schools assessment demonstrates the power of communication across schemes and its good network functioning.

Expert Panel member Ian Young commented:

> "There is a need to consider if there are aspects of the measurement of the achievement of standards that could be made more sophisticated and systematic across Wales. It would **not** be helpful to do this if it produces a loss in motivation or ownership at local level, or an unhelpful increase in bureaucracy. Clearly this is a delicate balance but if there is greater standardisation of methods it may reduce duplication of work at local level and produce a higher degree of comparability across the country. The answer to this dilemma probably depends on the degree to which the authorities are interested in added value and improvement within individual school communities and/or the extent to which they wish national standards and good quality control of awards."

Training of healthy schools co-ordinators and school assessors provided by the Welsh Assembly Government and training provided by local healthy school schemes for schools has been extensive, relevant and generally of a high standard. However, records of training at national level may not be sufficiently detailed to allow effective planning of future provision. So far training has focused on specific health-improvement topics and has been provided mainly to in-school co-ordinators and headteachers. Possibilities for further development of the WNHSS might include a broader approach to the content of training so that skills as well as knowledge are addressed; and training is offered to a wider range of stakeholders.

9.1.2 EQUITY

Participation has emerged as the key factor in implementation and as the reason why small schools, or large schools where pupils and staff belong to smaller sub-groups, have an advantage in adopting a social-ecological approach. The greater participation of staff, pupils and parents in school activities in smaller schools is documented in

other research (Barker 1968; Slate and Jones 2005). The importance of participation at school level appears to have been somewhat overlooked during the early development of the WNHSS which has adopted a more topic-based approach. For example, there was some concern among healthy schools co-ordinators that schools might achieve Phase 3 of the scheme without having covered sex education or substance abuse; but no-one appeared to be uneasy that schools might have reached Phase 3 without having in some way involved a majority of the teaching staff in health-improvement actions. The Welsh Assembly Government's logic model does not specify actions or expected outcomes relating to participation in schools. Case studies included some schools where many people were significantly involved in health promoting changes and schools where only a few people were engaged: in neither kind of school did staff seem aware of, or reflect on, the importance of participation in determining successful implementation, or of what they did or did not do to promote involvement.

Evidence from this Review suggests that participation in healthy schools of all groups in some way involved with the school is unusual. School support staff and parents tended to participate less than teachers, pupils and governors, but in secondary schools there could be difficulty in involving a majority of a large teaching staff. Participation in the benefits of action was rarely shared equally between pupils and staff. This Review has identified several aspects of participation including the range of backgrounds of those who have an interest in the school; how many from each different background are involved; whose priorities are important in decision-making; who benefits from changes; and who implements change. More awareness of the different facets of participation, and reflection on their role in change processes, could form a useful basis for assessing standards of achievement in schools. Research is also needed to identify organisational features which promote effective participation in schools.

Discussions at regional workshops helped in distinguishing the issues at school and local level regarding the capacity of the WNHSS to reduce inequalities in health. The Healthy School was felt to benefit its pupils according to need and for many reasons participants felt it was inappropriate for schools to target pupils living in areas designated as deprived. This view regarding the "self-levelling" quality of the Healthy School is supported by a finding from a study in Scotland that a school with a narrow focus on educational achievement tended to increase inequalities between pupils because it did not meet the needs of vulnerable and less academically able pupils (Gordon and Turner 2003). Headteachers at regional workshops felt strongly that schools should have high expectations of all pupils, regardless of their background and this is in accordance with national policy (The National Assembly for Wales 2001c).

Although most schemes had initially targeted schools in Communities First areas, healthy schools co-ordinators had subsequently found it problematic to target schools in areas designated as deprived. They felt that schools' need for support was determined by factors other than deprivation as defined by the Welsh Index of Multiple Deprivation (Welsh Assembly Government 2005c) and that prioritising some schools over their neighbours caused difficulties in relationships between schools and between healthy schools co-ordinators and schools. Moreover, the efficiency of working with school clusters has been increasingly recognised since the establishment of the Network. Many healthy schools co-ordinators make a distinction between schools with different levels of advantage when setting targets for assessment. This practice appears inequitable because healthy schools deemed

to be advantaged will be asked to meet higher standards, and provide more benefits to pupils, than those judged to be less able.

More opportunities for the WNHSS to reduce inequalities in health exist at national level. For example, schemes which perform less well may be disadvantaged by a funding system based solely on school numbers and could benefit from more sophisticated assessment of need. And national standards for achievement of each Phase of the scheme would help to reduce inequalities between schools.

9.1.3 MEDIATION

Mediation within the WNHSS has been an outstanding success. A formal network facilitates informal sharing of information and development of good practice (World Health Organization 1997b) and this has been demonstrated by the WNHSS at school, local and national levels.   A key factor has been the appointment of co-ordinators with a remit to develop links with any agencies and individuals that can help in achieving the aims of the scheme. The production and sharing of resources for use by schools has also been a major achievement of the WNHSS and many local education and health departments reported working more closely together as the local scheme had developed.

Meetings and events where people could share ideas and good practice have played a major part in accelerating development of effective working relationships. This was evident at all-Wales meetings and training events for healthy schools co-ordinators; and scheme events were reported by school staff to be a major benefit of belonging to the scheme.

Working relationships may be vulnerable to changes in personnel and schemes vary in the degree to which intersectoral and collaborative working takes place. Further development of the formal network, perhaps in terms of policy and strategy requiring the commitment of key post holders to healthy schools at national, local and school level, could encourage mediation in schemes where its growth has been slow. The WNHSS could then be embedded into the organisation of local and national government as well as health has been embedded into the practice of some schools visited during the Review.

Schools appear to have found difficulty in making links with local communities. They reported community involvement less often than changes to the curriculum or to school policy and material environment. Parents were thought to be particularly hard to engage, and some schools had experienced at first hand the difficulties of reconciling conflicting views regarding the content of school meals and lunch boxes. *Within* schools, too, especially secondary schools, mediation had also presented difficulties. There is evidence that the views and interests of some groups in the school community may be disregarded or considered less influential than others' so that practice has been developed without benefiting them or without using the information and assistance they could provide.

The Review has found that the most powerful motive for headteachers joining local schemes is a wish to improve the learning ability of their pupils. Becoming a Healthy School provides them with a planning tool, a measure of support, and validation for addressing health issues which prevent children from learning. However, some teaching staff in case-study schools perceived a conflict between efforts to achieve high educational standards and providing the more pastoral support of a Healthy School. The perception of a conflict appears to result from demands such as the

curriculum, inspection processes and parental expectations which leave little time for teachers to consider and address *how well* pupils are learning in addition to *how much* they are supposed to learn. This apparent conflict has also been documented by Gordon and Turner (Gordon and Turner 2003) in their study of two schools in Scotland.

Above all, a healthy school is a springboard for learning well. While the inclusion of guidance on healthy living as part of school inspections has provided important support for what healthy schools are trying to achieve, there seems to have been no official acknowledgement that other expectations of schools, expressed through Estyn, most of the curriculum, and ultimately pupils and their families, may depend for their fulfilment on pupils' learning *well* and that the latter deserves greater priority. This is a barrier which requires mediation on a much wider scale than can be achieved through the WNHSS alone and illustrates the importance of WNHSS membership of SHE.

9.1.4 SOCIAL-ECOLOGICAL APPROACH

Evidence from this review suggests that advocacy and mediation in the WNHSS are clearly in line with best practice. There is scope for further measures to improve equity, by examining ways of broadening the range of groups participating in healthy schools, and increasing the programme's potential to reduce inequalities in health. The successful development of the Network so far suggests that it will adapt and improve from its present position of strength.

9.2 What makes a good local scheme?

Although the Review has found that each local healthy school scheme is unique, it has suggested the following general description of a local scheme with a well-developed social-ecological approach:

A local healthy school scheme is supported by the Welsh Assembly Government through the appointment of a (preferably) full-time national co-ordinator with responsibility for training; dissemination of information; and development and distribution of resources. It adheres to the WNHSS aims set out in the national framework. The scheme is inspected regularly by the national co-ordinator, with the help of an independent expert (e.g. from SHE).

There is a senior management post in the local education authority or the Local Health Board with clear responsibility for the scheme. There are contingency plans for provision of support to schools during any long-term absence of the healthy schools co-ordinator. The scheme's role in local education and health strategy is clearly documented in plans which demonstrate understanding of the scheme's social-ecological approach. Any or all of the following has demonstrated personal commitment to the aims of the scheme: The Director of Education, the Chair or Chief Executive of the Local Health Board; the Chair of the Children and Young People's Partnership group. Ideally, elected members are aware of the scheme and it is linked with senior managers in sectors outside the Education Department and the Local Health Board, such as Transport, Environmental Health and Planning.

There are good relationships and channels of communication between the healthy schools Co-ordinator and: other personnel working with or within schools; managers at strategic level in the unitary authority and Local Health Board; the national co-ordinator and other local scheme co-ordinators. The scheme organises

regular, relevant and affordable training for schools' teaching and support staff, school governors, school councils and parent representatives. Publicity for schools' achievements recognises the contribution of the scheme.

School actions are planned in consultation between the healthy schools co-ordinator and school staff, with clear links to priorities identified by the school. The scheme adheres to national standards for assessing schools. Such standards are linked to each phase and identify targets for participation of teachers, support staff, pupils and others in the process of achieving change in schools as well as the eventual change outcomes. The scheme has locally acceptable assessment and planning procedures to ensure provision of appropriate support to schools where there are barriers to attaining national standards within a reasonable time.

10. Recommendations

The Welsh Assembly Government is to be congratulated on the establishment of an excellent and respected network of healthy schools schemes. The following recommendations for improving the functioning of the WNHSS are offered with confidence in the power of the network to adapt and change to build further on what has been achieved so far.

Inequalities in health

1. The issue of the role of the WNHSS in relation to inequalities in health needs to be urgently reviewed and addressed. This review should cover aspects such as school support and funding levels to ensure there is no possibility that the WNHSS could have the unintended consequence of exacerbating this problem. (p. 83)

2. It is suggested that a practical strategy statement is required to clarify the expectations of the role of the education service across Wales in relation to reducing inequalities in health. (p.86)

3. It is suggested that the Welsh Assembly Government should consider ways in which inequalities between schemes could be addressed. For example, data on recruitment, training and numbers of schools in each Phase could be used by the Welsh Assembly Government to identify, and address at an early stage, any barriers encountered by local schemes in supporting schools. (pp. 83, 118)

4. It is suggested that healthy schools co-ordinators should have uniformly high expectations of every Healthy School and that these expectations be supported by national standards for schools. (pp. 86, 125)

5. Development of strategies for providing extra support to those schools which have more difficulty in attaining the specified standards should progress alongside the introduction of uniform standards. (p. 86)

Administration and management by the Assembly Government

6. It is recommended that the Welsh Assembly Government continue to fund employment of healthy schools co-ordinators to provide at least current levels of support until 75% of schools can demonstrate that a specified minimum level of participation is contributing to health-improvement actions. It is suggested that schools should be able to demonstrate as a minimum that teaching staff, support staff and pupils contribute to, and are fully informed about, decisions on whole-school health improvement. (p.79)

7. Now that the WNHSS has entered an "establishment phase", it may be advisable to review the national co-ordinator's role. Possible changes might

include an increased focus on strengthening links at strategic level both locally and nationally. (p. 54)

8. Consideration should be given to funding full-time national co-ordination of the WNHSS. This would help to meet the need for: a higher level of training to support the programme (see training recommendations); expanding the programme to a wider group of schools; consultation with stakeholders on the further development of monitoring and evaluation systems. (p. 45)

9. With a view to securing the long-term future of the network through appropriate commitment within policy and strategic documents, all possible measures should be taken to remind Assembly Members of the importance of the WNHSS as a framework for public health and educational improvement in Wales. (p.47)

10. It is recommended that the logic model be distributed and discussed more widely within the WNHSS and the Welsh Assembly Government and that it should be used as the fundamental guide to the future organisation of the WNHSS. This would involve a cycle of review and revision of the model in the light of ongoing changes. The logic model should indicate expected numbers of schemes achieving specified outcomes to enable quick identification of schemes encountering difficulties in meeting targets. Expected outcomes should include participation of stakeholders at school, local and national levels; and numbers of schools achieving specific Phases of the programme. (p.84)

11. A national website giving healthy schools co-ordinators and schools access to resources, and facilitating sharing of documentation and ideas, merits serious consideration. The presence of the WNHSS on the World Wide Web would also facilitate international communication at school and local levels. (p. 96)

The public face of the WNHSS

12. There is a need to investigate ways of presenting a more accurate image of the whole-school approach of the WNHSS in a way which is easily remembered and understood. (p. 47)

13. More frequent ministerial press releases, jointly issued by Health and Education, and projecting an accurate image of the WNHSS, would be influential reminders of the Welsh Assembly Government's support for actions at school and local levels. (p. 46)

14. Healthy schools co-ordinators should discuss ways of obtaining publicity for local schemes, as well as schools, in order to formulate guidance on best practice and generate practical strategies for promoting schemes. (pp. 50, 100)

Support for schools

15. Consideration should be given to setting up a working group tasked with producing guidance for local schemes regarding how they can best support secondary schools, including ways of increasing participation by identifying smaller groups within schools. (pp. 52, 124)

16. The value of the WNHSS in improving pupils' general behaviour as a basis for learning should be more widely promoted. Consideration might also be given to providing more support for teachers to reconcile any perceived conflict between delivering the curriculum and providing more pastoral care e.g. through funding to take time off from teaching for "pump priming" activities. (p. 59)

Local administration and management of healthy school schemes

17. It is recommended that local authorities should consider the logic model as part of their work in developing bids for Children's and Young People's plans and Health, Social Care and Well Being strategies. (p. 56)

18. Local schemes should adhere strictly to national guidance regarding the minimum length of time for schools to carry out work in each Phase of the scheme. (pp. 69, 125)

19. Working with school clusters appears to amplify the impact of the programme and all healthy schools co-ordinators are recommended to make full use of these networks. (p. 55)

20. Consideration should be given to providing a local framework which offers more formal opportunities for schools to take the lead on health promotion within clusters in order to provide a focus for schools to continue to maintain and improve good practice. (p. 97)

21. It is suggested that the Welsh Assembly Government explore strategies for securing more consistent support for schemes from senior local authority staff. These might include measures to ensure that a senior management post carries responsibility for the scheme; specifying duties of management/steering groups; and a requirement that the healthy school scheme should be included in health and education strategic plans. Extra conditions of funding local partnerships might be useful in achieving a greater level of support. (pp. 50, 57, 108)

22. It is recommended that the Welsh Assembly Government consider asking Local Health Boards or LEAs in each region to take turns to host and lead All Wales meetings of co-ordinators. Such a change might encourage more involvement in schemes by senior local authority staff. (p. 119)

Training

23. At school level there is evidence of wide disparities in teacher awareness of the healthy schools programme. This suggests there is a need for more training, not only for school co-ordinators but for other staff in schools. (pp. 99, 113)

24. Training should explore the social-ecological approach and concepts behind the healthy schools programme as well as practical issues. Very few teachers and education professionals are familiar with the language and concepts of fundamentals such as The Ottawa Charter. This can result in a lack of ownership across the school which can run the risk of undermining the programme. (p. 113)

25. There appears to be a perceived conflict between the educational excellence role of schools and the health promotion role. This should be addressed as a priority in future training and communications as there is research evidence that there is no such conflict and that the two roles are intertwined and are mutually supportive of each other. (p. 17)

26. Revision of the monitoring report pro forma to collect more information about training would demonstrate that at national level, training is perceived to be of prime importance and give a clear lead for good practice at local level. Questions about training should be carefully framed and given more prominence in the pro forma. A separate question could ask for a similar level of detail on what training/education local co-ordinators and their teams have received during the reporting period. (p. 63)

27. Curtailment of training offered to schools was reported in some schemes following an increase in numbers recruited. It is recommended that National and local co-ordinators should consider how disparities in available funding may be addressed so that local schemes can provide comparable levels of training. (p. 63)

28. Newly appointed healthy schools co-ordinators do not always have the practical skills and experience which enable them immediately to adopt efficient methods for providing training to schools. Local employers should consider co-ordinators' needs for guidance and continued support on managing this aspect of their role. (p. 64)

29. National guidance and associated training should explore the relationships and interaction of topics in the curriculum, to ensure that these are not treated in an isolated way that is inconsistent with an eco-holistic approach. For example physical activity/healthy eating/mental health; sexual risk taking /alcohol; mental health/substance misuse. (p. 72)

30. Given the difficulties in most schools with involving parents and others, and with reconciling the demands of the curriculum with healthy schools actions, it is suggested that training and resources might be developed to help in-school co-ordinators to deal with these and related issues. (p. 101)

Monitoring and assessment

31. In the light of this review, consideration should be given to setting up a forum with the national co-ordinator, representatives of local co-ordinators, headteachers, teachers, advisers, Estyn and health promotion specialists to produce a consultation document on the future monitoring and assessment of the WNHSS. (p. 68)

SCHOOLS

32. It is recommended that national standards for schools should be developed and applied to each Phase of the healthy school scheme. (p. 68)

33. National standards should focus on whether the school has involved staff, pupils, parents and others as evidence of schools' "organisational skills" in securing participation of a broad range of school stakeholders. (p. 75)

34. It is recommended that local schemes should drop the portfolio as a requirement for schools' assessment and instead ask schools to produce a succinct record of the action taken, with evidence of a systematic approach. (pp. 49, 68)

35. Schools should be required to record the views of staff and pupils about the best and worst aspects of the school and to use this as a baseline against which progress should be measured, and priorities addressed. This would help to maintain motivation and ownership of school changes. (p. 79)

SCHEMES

36. A mapping exercise to identify routinely-collected data available, and a consultation to determine which data are most relevant to activities of healthy school schemes, would assist in establishing systems to inform future monitoring of the WNHSS. (p. 67)

37. National standards should be defined for methods used by schemes to assess schools. Minimum requirements should include a measure of independent scrutiny and an on-site visit to the school[5]. (p. 68)

38. Re-accreditation of schemes is recommended and it is suggested that this should be carried out by the national co-ordinator with assistance from an independent expert, possibly a colleague from SHE. (p. 68)

39. It is recommended that the Welsh Assembly Government agree minimum standards for participation of local authority leaders and senior management to be used as criteria for accreditation of local healthy school schemes. (110)

Specific recommendations have not been made regarding two issues which were felt to be intractable. However the review team would like to record concern regarding:

- Differences in pay rates for healthy schools co-ordinators, according to whether they are employed by Education and Health. The perceived

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[5] This requirement has already been introduced for Phase 6.

unfairness of such differences could damage relationships amongst co-ordinators. (107)

- The unhygienic conditions in school lavatories, which were the subject of comment in many of the questionnaires returned by school councils. Lack of attention to basic cleanliness calls into question the credibility of some schools' efforts to improve health and demonstrates that what is clearly an important concern for pupils has not been effectively addressed. (p. 28)

The Welsh Assembly Government, Local Authorities and Local Health Boards are urged to consider how they may co-operate to deal with these problems.

Appendix 1: Expert Review Panel: Membership and attendance at Regional Workshops

Experts were nominated by the Welsh Assembly Government and by the CISHE review team and four experts were asked to form a panel. Of these, one was not available to participate. At the end of October 2007, one panel member was unable to continue and another could attend only one of the three regional workshops. A further five experts were approached, three of whom were not available to take part in the workshops. Of the two who joined the panel, one was based in Wales. The latter was available for one regional workshop but in view of the Welsh Assembly Government's original intention that the panel should provide an independent perspective from outside Wales, was not asked to contribute to further work. However, the other continued to provide support and guidance for the review until the end of the contract.

A1.1 Membership

Sharon Doherty, Health Promoting University Co-ordinator/Healthy Settings Development Unit Officer, University of Central Lancashire

Judy Orme, Reader in Public Health and Director of Centre for Public Health Research, University of the West of England

Dr. Malcolm Thomas, Director of Learning and Teaching, School of Education and Lifelong Learning, University of Wales, Aberystwyth

Katherine Weare, Professor of Education, University of Southampton

Ian Young, health promotion consultant, Edinburgh (formerly Head of International Development at NHS Health Scotland)

A1.2 Attendance at Regional Workshops

Mid and West Wales Regional Workshop, 28th November 2007:
Sharon Doherty
Ian Young
(with Simon Murphy, CISHE)

North Wales Regional Workshop, 29th November 2007:
Sharon Doherty
Malcolm Thomas
Ian Young

South East Wales Regional Workshop, 27th November 2007:
        Sharon Doherty
        Judy Orme
        Ian Young

Appendix 2: Regional stakeholder workshops

Three workshops were held, one in each NPHS region, to discuss emerging findings from the review. All members of local healthy school scheme teams; the Director of Education; and the local Director of Public Health were invited from each unitary authority.   In addition, each healthy schools co-ordinator was asked to nominate up to five stakeholders who could contribute to the workshop. Table A21 shows dates, regions and numbers invited.

Table A21: WNHSS review: Dates of Regional Stakeholder Workshops and numbers invited

November 2007	Region	Schemes	Number invited
Tuesday 27th	South East Wales	Blaenau Gwent Caerphilly Cardiff Merthyr Tydfil Monmouthshire Newport Rhondda Cynon Taff Torfaen Vale of Glamorgan	86
Wednesday 28th	Mid and West Wales	Bridgend Carmarthenshire Ceredigion Neath Port Talbot Powys Swansea	54
Thursday 29th	North Wales	Anglesey Conwy Denbighshire Flintshire Gwynedd Wrexham	46

From the Welsh Assembly Government Health Promotion Division, the WNHSS national co-ordinator attended all the regional workshops and the Head of the Research and Evaluation Branch attended the South East Wales and Mid and West Wales Workshops. From CISHE, the Principal Investigator, Project Manager and all members of the data collection team attended all the workshops. The Project Director from CISHE attended the South East Wales and Mid and West Wales Workshops and also contributed to the latter workshop as an expert, because only two Expert Panel members were available to attend.

Presentations were made by Welsh Assembly Government and CISHE staff explaining the background, structure and purpose of the review and outlining initial findings from the review of documentation at national level and interviews with healthy schools co-ordinators. Copies of the WNHSS logic model (Figure 1) and

summaries of CISHE presentations were circulated to delegates. Expert Review Panel members contributed to plenary discussions on preliminary findings presented by members of the CISHE review team and led smaller groups in debate around issues of sustainability, inequalities in health, and outcome measures. Welsh Assembly Government staff did not take part in group work and left the workshops during parts of the plenary sessions in case delegates felt they could not discuss some issues openly in front of them. However, they were available at any time during these periods if delegates wished to call them back. CISHE staff took notes of discussions during all plenary and group sessions.

Invitations sent to delegates asked if their preferred language was Welsh or English. Four of those who accepted invitations to the Mid and West Wales Workshop and five who accepted invitations to the North Wales Workshop preferred to speak in Welsh. Simultaneous translators attended plenary sessions at both workshops to translate from Welsh to English for delegates who were unable to understand contributors speaking Welsh. One member of the CISHE data-collection team was able to contribute to discussions through the medium of Welsh. In addition, at both the Mid and West Wales and North Wales Workshops a simultaneous translator attended the group discussions on sustainability; and at the North Wales workshop, the Expert Panel member leading the group spoke Welsh.

Appendix 3: WNHSS regional workshops: Work for discussion groups

(A)

What resources and structures will ensure the sustainability and effectiveness of the national network?

Led by:
Judy Orme (South East Wales)
Ian Young (Mid and West Wales – with simultaneous translator)
Dr. Malcolm Thomas, through the medium of Welsh (North Wales – with simultaneous translator)

Please use your knowledge and experience of your local healthy school scheme to discuss the following questions, and to provide examples of good practice.

1. How can schools organise to sustain effective health promotion action in the short and the long term?

2. What support do schools need in the short and the long term from (a) local networks and (b) the Welsh Assembly Government to develop organisational practices which sustain effective health promotion action – e.g. in terms of resources, cross-disciplinary working? Please include consideration of the following questions:

- What is already in place?
- What more is needed?
- Are there any barriers and facilitators?
- Do needs change over time?

3. How long will it take schools to develop the capacity to sustain effective health promotion action as an organisational norm?

(B)

How can the network address issues of health inequalities most effectively?

Led by: Sharon Doherty (South East Wales and Mid and West Wales)
Ian Young (North Wales)

Please use your knowledge and experience of your local healthy school scheme to discuss the following questions, and to provide examples of good practice, e.g. effective local policies used to address inequalities in health.

To what extent do local healthy school schemes help to reduce inequalities in health? Please include consideration of the following questions:

- What differences in need are there between schools in areas with different levels of socioeconomic advantage?

- What differences are there, if any, in support for schools serving children from more or less disadvantaged areas or with varying proportions of pupils who live in poverty?

- How do local healthy school schemes prioritise need in schools across the county?

- How do schemes work with other initiatives targeting areas of deprivation defined by the Welsh Index of Multiple Deprivation e.g. Communities First?

  o What more could schemes do to reduce inequalities in health?
  o What would help?
  o Are there any barriers?

- How should schemes assess schools with different levels of socioeconomic advantage?

- Are there any implications for the type of outcome indicators used to assess effectiveness and process measures used to understand change?

(C)

The identification of appropriate outcome measures for the ongoing monitoring and evaluation of the network and the use of information for improving local schemes.

Led by: Ian Young (South East Wales)
Simon Murphy (Mid and West Wales)
Sharon Doherty (North Wales)

Please use your knowledge and experience of your local healthy school scheme to discuss the following questions, and to provide examples of good practice.

1. What outcomes are desirable for the individual, school and scheme?
   a. How might we know that they are being achieved?

2. Is information relevant to the desired outcomes currently gathered within schools or local areas that could be used to monitor progress?
   a. Which organisations (e.g. schools, local authorities, local health boards) gather this information and how is it available?

3. Is there additional information that is needed to monitor the success of local healthy schools schemes?
   a. What information is required?
   b. Who might hold or be able to gather this information?
   c. How might it be used to improve the operation of the scheme?
   d. What barriers and facilitators exist to monitoring and evaluating the network using routinely collected data?

Appendix 4: Case study selection and participants

A4.1 Rationale for selection of schemes

(A)
North Wales, more rural than (B)
HSC involved since beginning of scheme and moved last year from education to health.

(B)
North Wales, rural/urban mix.
Utilising existing contacts.
2 HSCs one there for 5 years one recently joined.

(C)
Easy to access.
Largest urban scheme.
Some talk of communication problems with Assembly.
3 HSCs all relatively new to role.
Money goes via health used to go via education.

(D)
First scheme to be established.
Seen as good practice.
2 HSCs one in post since 1999.
HSCs employed by, and based in, Health funding goes to Education.

(E)
Originally failed accreditation.
Unitary authority covering largest area.
Strategic manager just in place.
2 other HSCs one there for 5 years the other around 1 year.

(F)
Rural/urban mix, easy to access.
3 HSCs, 1 in post for around 3 years the other 2 for around 1 year.
Strategic manager in post for around 1 year.

A4.2 Rationale for selection of school case studies

School selection was discussed with healthy schools co-ordinators who suggested schools which fitted the criteria most closely. The intention was to select for each

scheme one school that had been slow in completing phases and one that had been quick in completing phases; one of these would ideally be a long-term member of the scheme and the other a relative newcomer. Welsh medium and special schools were also represented. In the event only one school was recruited in each of three schemes.

(A)	**Primary school quick in completing phases in scheme short time** **Secondary school slow in completing phases in scheme long time**
(B)	Special school Welsh speaking school
(C)	Welsh speaking school Other school
(D)	Primary school slow in completing phases in scheme short time Secondary school quick in completing phases in scheme long time
(E)	Primary school quick in completing phases in scheme long time Secondary school slow in completing phases in scheme short time
(F)	Primary school slow in completing phases in scheme long time Secondary school quick in completing phases in scheme a short time

A4.3 Interviews at local level

		Stakeholder interviews					
		CS1	**CS2**	**CS3**	**CS4**	**CS5**	**CS6**
1	DoE	CS11	CS21				
2	Assistant DoE						CS62
3	School Health Adviser			CS33			
4	Schools Improvement Officer			CS34 (line manager for local Scheme)		CS54	
5	Head of Schools Catering						CS65
6	DoPH	CS16	CS26			CS56	CS66
7	HSC	CS17	CS27				
8	Healthy schools officer		CS28				
9	Ex steering-group member (Primary head)					CS59	
10	Steering-group member (retd Head)						CS610
11	Steering-group member (Manager, Educational Psychology Service)						CS611
12	Eco Schools Officer		CS212				
13	Information and Involvement Officer/ Manager CYP Partnership	CS113	CS213				
14	School Nurse Manager	CS114			CS414		
15	Active Young People's Co-ordinator					CS515	
16	Police Schools Liaison Officer					CS516	
17	HSC mentor	CS117					
18	Acting Health Promotion Manager			CS318			
19	PSE Adviser				CS419		

A4.4 Interviews, focus groups and meetings observed during nine school case studies

		PS1	PS2	PS3	PS4	PS5	S1	SS1	SS2	SS3
1	Headteacher interview	PS11			PS41	PS51	S11			SS31
2	In-school co-ordinator interview	PS12	PS22		PS42	PS52	S12		SS22	SS32
3	Pupil focus group	PS13			PS43			SS13	SS23	SS33
4	School council meeting			PS34	PS44		S14			SS34
5	Group interview with staff			PS35				SS15		
6	SNAG meeting								SS26	
7	Deputy Head								SS27	
8	Chair of Governors						S18			
9	Anger management meeting						S19			

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