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EVALUATION OF THE IMPACT OF THE NATIONAL HEALTHY SCHOOL STANDARD

FINAL REPORT

TCRU

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March 2004

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ACKNOWLEDGEMENTS

We would like to thank all respondents in schools, local partnerships and at regional and national levels for the insights they provided into work in schools, the running of local programmes and the operation of the NHSS as whole.

We would also like to thank the members of our Advisory Group, who provided valuable suggestions to guide the research, and helpful comments on the draft report:

- ◆ Antony Morgan Health Development Agency
- ◆ Dr Kathryn Milburn University of Edinburgh
- ◆ Prof John Gray University of Cambridge
- ◆ Diane Fenner Cambridgeshire County Council
- ◆ Kirsten Jowett London Healthy Schools Coordinator
- ◆ Sarah Maclean Department for Education and Skills
- ◆ Karen Turner Department of Health
- ◆ Dr Catherine Dennison Department of Health
- ◆ Marilyn Toft Health Development Agency
- ◆ Colin Noble Health Development Agency
- ◆ Natalie Owen Home Office (formerly DfES)

At TCRU, thanks also are due to our Research Associates who were involved in fieldwork and discussions about the implementation of work in schools and with local partnerships:

- ◆ Tashmin Khamis
- ◆ Abigail Knight
- ◆ Sangeeta Leahy
- ◆ Lisa Ruxton
- ◆ Stuart Watson
- ◆ Ekuia Yankah

We would like to thank the DfES, the DH, Ofsted and the Schools Health Education Unit for supplying and/or granting permission to use their databases for our analysis.

Steff Hazlehurst and Penny Mellor (TCRU) and Sue Stoddart (NFER) provided invaluable administrative and secretarial support to the project.

The views expressed in this report are those of the authors and not necessarily those of the DH, the DfES and the Health Development Agency.

EXECUTIVE SUMMARY

Introduction

The National Healthy School Standard (NHSS) is part of the Healthy Schools Programme, led jointly by the Department of Health (DH) and the Department for Education and Skills (DfES), in partnership with the Health Development Agency (HDA). It has three strategic aims: to contribute to reducing health inequalities, to promote social inclusion and to raise pupil achievement. Local health and education partnerships have been created in each English local education authority (LEA) or Primary Care Trust (PCT). Schools are encouraged to adopt a whole-school approach to developing their work on a range of health and education-related themes.

On behalf of DH and DfES, the Thomas Coram Research Unit (TCRU) at the Institute of Education, University of London and the National Foundation for Educational Research (NFER) have conducted an evaluation of the impact of the NHSS. The aims were twofold: to conduct an in-depth evaluation of the implementation of NHSS activities to date, and to develop a set of national outcome indicators, to assess the extent to which the NHSS is meeting its strategic aims.

Key findings

- ◆ Schools generally valued their involvement in the NHSS and local healthy schools programmes and appreciated the flexibility the framework provided.
- ◆ Participation in the NHSS improved the status of health-related work in schools, and worked best where partners had a history of working together and a shared understanding of improving health in schools.
- ◆ With a relatively modest budget, the NHSS has provided a useful infrastructure through which health-related work can take place with schools.
- ◆ More active participation of children and young people in the programme is essential to its continuing and future success.
- ◆ Of the many quantitative outcomes investigated, relatively few indicated significant differences between schools at Level 3 of the NHSS (the most intensive level of the programme) and other schools, and even these tended to be quite small.
- ◆ An analysis of Ofsted inspection ratings yielded the most positive results – Level 3 schools were rated higher on most relevant scales (e.g. enthusiasm for school, PSHE provision), after controlling for other background factors.
- ◆ Findings from the analysis of data from pupil surveys appeared to be somewhat random, but there was a degree of consistency between these findings and the Ofsted ratings.

About the Study

Work to assess local and national perceptions of impact included:

- ♦ Fieldwork in 20 schools involved in local programmes (interviews took place with two groups of pupils, school staff, parents/governors, and health professional attached to the school), and telephone interviews with 11 schools not involved in a local programme
- ♦ Visits to nine local partnerships and telephone interviews with 21 others
- ♦ Interviews with each regional coordinator as well as 12 national stakeholders drawn from education, health and other fields.

Indicator development involved:

- ♦ Identifying appropriate education and health-related indicators, in consultation with the DH, DfES and the national NHSS team
- ♦ Identifying and securing access to existing relevant datasets
- ♦ Analysing the performance of Level 3 schools against these indicators to see whether, after controlling for relevant background factors, they scored higher than other schools.

Perspectives on Success

As part of NHSS work, schools had developed a range of activities, including those addressing: pupil diet and nutrition, physical activity, problem behaviours and health care involvement, as well as staff professional development. These activities were appreciated by *pupils*, who particularly valued improvements in school ethos and the quality of social relationships. While all pupils appreciated being listened to and consulted, those in secondary schools highlighted the importance of confidentiality and expressed concern that change should actually take place as a result of consultation.

Teachers, parents and governors valued the changes that had come about as a result of NHSS participation. Particularly appreciated was the programme's flexibility. This allowed schools to integrate hitherto disparate activities addressing physical and emotional well-being into a coherent programme of work. Central to success was enthusiasm, support from the school's senior management team, the selective use of external experts, and dedicated funding. Taking a 'whole school approach' to healthy schools was easier in primary and special schools than in secondary. This was due to the greater size of secondary schools (making it harder to work with all pupils and every member of staff), and the specialist subject commitments of some secondary staff.

Local partnership members stated that the NHSS had raised the status of local healthy schools work, had extended the framework of existing schemes, and had given support to local programme development. Local partnerships worked best where members had a history of working well together, where there was a shared understanding of 'health', where consultation took place to agree priorities, and where funding was available. Problems arose where re-

organisation of services disrupted established working relationships. More could be done to improve consultation with, and the participation of, young people.

Regional coordinators indicated that they often lacked time to support local programmes as best they might, wishing to develop their roles more fully with respect to advocacy, as well as monitoring and evaluation. *Nationally*, there were said to be initial high expectations of the NHSS, despite its modest funding compared to some other national initiatives. There was an increasing awareness that the Standard would add ‘leverage’ to other programmes working for school and health improvement.

The Development of an Indicator Set

A ‘long list’ of possible impact indicators was identified, and permission obtained for a range of relevant datasets to be analysed. A database was compiled of schools that had attained Level 3 (the highest level of NHSS involvement). For each analysis, all available background factors at pupil and school level were included, in order to look for significant relationships between outcomes of interest and Level 3 status. Each outcome was first investigated using linear or logistic regression. This identified outcomes for which there was a possible effect of NHSS, and these outcomes were subject to further analysis by multilevel modelling, to determine whether the difference was genuine.

The most fruitful of the pupil databases explored was that derived from responses to the Health-Related Behaviour Questionnaire (HRBQ), which includes questions on many outcomes of interest. Findings for secondary schools were very positive (but less so for primary schools). Students in Level 3 schools scored higher than those in other schools on a composite measure of health-related behaviour, and Level 3 schools were more likely than others to improve their average scores over time.

The HRBQ database and other databases derived from pupil surveys revealed a few significant differences in individual outcomes, but these were not all in a positive direction. Analysis of the National Pupil Dataset yielded little evidence of an association between Level 3 and attainment in core subjects.

Analysis of the Ofsted inspection database yielded more positive findings, especially for primary schools. After controlling for other factors, Level 3 primary schools were likely to score higher on all but one of the 11 scales investigated. For secondary schools, there was a positive association with five of the scales.

In view of the broad and locally-determined nature of NHSS activities, and the fact that some of these may directly affect only a small proportion of pupils within a school, it is perhaps unrealistic to expect a large measurable impact on pupil attitudes and behaviour. However, there was a degree of consistency between the findings from pupil surveys and the results of Ofsted inspections. Taken together, they suggest that the NHSS is beginning to have an influence, particularly in areas related to social inclusion.

Future Monitoring and Evaluation

The study highlighted the value of drawing on perspectives at different levels to identify what sorts of expertise, indicators and existing information could be used in future monitoring and evaluation. For example, some local partnerships had developed sets of questions to help audit and review school-based work, and members of health and education partnerships and of senior management teams in schools outlined the range of existing data that could be used to measure progress.

Building on these perspectives, it is likely that the future impact of the NHSS will best be evaluated through the use of existing information and the addition of periodic and complementary school and pupil surveys. These could provide the advantage of showing change in schools across time and differences between schools (and pupils) participating or not in local healthy schools programmes. Such a national dataset might be useful for the evaluation of future national initiatives concerned with children's and young people's health and well-being.

While the school survey would chiefly measure activities and services set up, the pupil survey would draw on measures of health and social inclusion, and could utilize questions used in existing surveys as well as develop new sets in areas outlined as important by pupils (perceptions of the quality of social relationships, for instance). Other evaluation indicators might usefully examine the impact of healthy schools' work on the ethos of the school, the curriculum (both formal and informal, and the styles of teaching and learning), partnerships (including utilising health professionals) and processes of recognising achievement.

Implications

Overall, the NHSS was highly valued by the majority of respondents. Future activities to help develop the programme include:

- ♦ Giving greater attention to strategy and advocacy to embed the programme more fully at national, regional (strategic health authority and government region) and local levels (LEAs, Children's Trusts and PCTs);
- ♦ Extending the role of the national team and regional coordinators so as to improve monitoring and evaluation, and to involve regional coordinators more fully in local programme support;
- ♦ Improving the involvement of young people so as to enhance their role as decision-makers at national, regional, local and school levels;
- ♦ Resourcing so as to enhance the role of local coordinators and support local partnerships in recruiting and sustaining the involvement of schools;
- ♦ Developing and embedding evaluation activities into the programme to examine whether the NHSS is having an impact at school and pupil level, and to understand how and why change is, or is not, taking place.

1. INTRODUCTION

1.1 Background

Schools have long been recognised as important settings in which to improve the health and emotional well-being of children and young people. Government reports, including *Excellence in Schools* (1997), *Saving Lives: Our Healthier Nation* (1999) and the *Independent Inquiry into Inequalities in Health* (1998) have highlighted the important role that schools can potentially play in promoting health, and in reducing health and other forms of social inequality.

The National Healthy School Standard (NHSS) was launched in October 1999 following pilot work in eight sites across England. It forms part of the Healthy Schools Programme, led jointly by the Department of Health (DH) and the Department for Education and Skills (DfES), with the national team being located at the Health Development Agency (HDA). The national standard offers support for local programmes and provides an accreditation process for education and health partnerships. The NHSS has three strategic aims, namely to contribute to:

- ♦ reducing health inequalities
- ♦ promoting social inclusion
- ♦ raising pupil achievement.

Supported by national advisers and local coordinators, local partnerships have been created in each of the 150 English Local Education Authorities (LEAs). These encourage individual school participation¹ in the NHSS, with schools being encouraged to adopt a whole-school approach to developing their work around a range of health and education-related themes. National assessors provide external assessment of local healthy schools partnerships, based on the requirements of the NHSS. School(s) partnerships can gain accreditation if they meet national quality standards in three fields: partnership, programme management and working with schools.

¹ Participation is open to maintained and independent nursery, primary, middle and secondary schools, as well as special schools and pupil referral units

There are three levels of involvement in the NHSS: Level 1 indicates a general awareness of the NHSS and its goals; Level 2 requires schools to have accessed training and/or support through the scheme; Level 3 requires schools, in addition, to have begun the detailed process of auditing, target-setting and action planning.

In December 2002, the DH and the DfES commissioned the Thomas Coram Research Unit (TCRU) at the Institute of Education and the National Foundation for Educational Research (NFER) to jointly conduct an evaluation of the impact of the NHSS. Interim findings were reported in July 2003. This final report draws together the findings from the whole evaluation and considers the implications for policy and practice.

1.2 Aims of the Evaluation

The overall aims of the evaluation were to:

- ◆ Conduct an in-depth, qualitative, local evaluation of the implementation of NHSS activities to date, with an emphasis on illuminating inputs and history, processes, outputs, impacts and outcomes. Findings from the qualitative strand aimed to inform an assessment of progress to date and feed into the development of an indicator set, as described below (Component 1).
- ◆ Analyse available data sources to determine whether, and to what extent, the NHSS is achieving its strategic aims, and develop a set of quantitative national outcome indicators which could be used to analyse and monitor the future progress of the NHSS (Component 2).

1.3 Methodology

Researchers at the TCRU had overall responsibility for the component one, whereas NFER had responsibility for component two. Although each component had a distinct aim, there has been cross-fertilisation between them at all stages of the study.

Component 1: perspectives on programme implementation

Through Component 1, data relevant to the aims of the evaluation was elicited at four different levels: national, regional, local partnership and schools.

We sought, among other things, to identify perceptions of:

- ♦ The impact of the NHSS on local programmes
- ♦ The work of local programmes and their impact on recruitment of, and work in, schools
- ♦ The nature of, and activities associated with, healthy schools work
- ♦ National, organisational and individual factors that helped and hindered partnership working (including young people's involvement)
- ♦ Arrangements for reviewing and recognising success and areas for development.

These issues were explored via a series of semi-structured interviews.²

National level

Face-to-face interviews were conducted with 12 key individuals in the following national organisations:

- ♦ Department of Health (DH) (x 2)
- ♦ Department for Education and Skills (DfES)
- ♦ Health Development Agency (HDA) (x 2)
- ♦ National Assessor (x 2)
- ♦ National Children's Bureau (NCB)
- ♦ National PSE Association for Advisers, Inspectors and Consultants (NScoPSE)
- ♦ National Health Education Group (NHEG)
- ♦ Office for Standards in Education (Ofsted)
- ♦ Qualifications and Curriculum Authority (QCA).

Regional level

At regional level, all nine regional coordinators were interviewed either face-to-face or by telephone.

² The interview schedules used are included in Appendix V.

Local partnership level

Three to four local partnerships were contacted within each region, with data being collected from health and education leads and other professionals located in 31 partnerships. Interviews took place between March and July 2003.

In four of the nine partnerships visited, data was also collected from schools.

Although no specific criteria for the sampling of partnerships were identified in the proposal, in consultation with the Project Advisory Group and NHSS national team, it was agreed that partnerships would be selected according to criteria that might help illuminate critical issues relating to the implementation of the NHSS at local level.

Following consultation with Regional Coordinators and the NHSS national team, a range of partnerships was identified which varied by geographical location, type of areas covered (urban/rural), whether they were led by a partner in health or education, and whether they were perceived to be working well or facing difficulties of one kind or another (such as not being able to recruit a health lead to the partnership or having difficulties involving schools). With regard to the latter criterion, it was indicated that the work of partnerships changes over time and judgements about quality of work were based on information from latest visits made by members of the national team.

The final list of partnerships contacted is as follows:

- ◆ Visits to partnerships and schools within NHSS regions
 - East Midlands (1 partnership)
 - London (1 partnership)
 - North West (1 partnership)
 - South West Region (1 partnership)

- ◆ Visits to partnerships
 - East of England (1 partnership)
 - North East (1 partnership)
 - South East (1 partnership)
 - Yorkshire and Humber (1 partnership)
 - West Midlands (1 partnership)

- ◆ Telephone interviews with partnerships
 - East of England (2 partnerships)
 - East Midlands (2 partnerships)
 - London (3 partnerships)
 - North East (3 partnerships)
 - North West (2 partnerships)
 - South East (3 partnerships)
 - South West (2 partnerships)
 - West Midlands (2 partnerships)
 - Yorkshire & Humber (2 partnerships).

Individual school level

Schools were sampled from one local partnership within four of the nine NHSS regions. Within each partnership, visits were made to two Level 3 secondary schools, two Level 3 primary schools and one special school or PRU. In addition, telephone interviews were conducted with two to three schools at Level 1 and/or Level 2.

Information was collected from 31 schools. Visits were made to 20 Level 3 schools and telephone interviews were carried out with 11 Level 1 or Level 2 schools. For the selection of primary and secondary schools, members of local partnerships selected one that was doing well and another less well, according to Ofsted reports.

During visits to schools, interviews were carried out with the healthy school coordinator, a member of the senior management team, an external health professional, and where possible, one or two parents/governors and two groups of pupils (around 6-8 pupils in each group). To help identify a range of perspectives among children and young people, teachers were asked to identify one group of pupils most likely to know about activities and projects related to healthy school work, and another group of pupils least likely to know about these. For telephone interviews with Level 1 and 2 schools, the person most likely to know about the local healthy school scheme was contacted. School interviews were carried out in the East Midlands, London, North West and South West NHSS regions.

Development of interview schedules

A series of interview schedules was developed in consultation with the DH, the DfES, the Evaluation Advisory Group and the NHSS National Team. Separate but related schedules were developed for national players, regional coordinators and local partnerships. Comments on the schedule for local partnerships were received from the Healthy Oxfordshire Schools Award Scheme.

In addition to consultation with the project Advisory Group members and the NHSS team, schedules for use in schools were piloted in schools attached to the Hull Positive Health in Schools Award. Schedules for Level 3 schools included (i) one for teachers, members of the senior management team and health professionals attached to the school, (ii) one for parents/governors, and (iii) one for pupils. For special schools and Pupils Referral Units (PRUs), and in order to respond to the different abilities of pupils, pupil schedules were adapted for use in each school in consultation with the healthy school coordinator. Separate schedules were developed for telephone interviews with Level 1 and Level 2 schools.

Component 2: developing an indicator set

Over the course of the evaluation, the development of the quantitative indicator set involved the following:

- ◆ Identifying appropriate education and health-related outcome indicators, in consultation with the DH, the DfES and the NHSS team, to be considered for inclusion in the final indicator set.
- ◆ Identifying and obtaining access to existing datasets which would provide the required data.
- ◆ Analysing the performance of Level 3 schools against these indicators (comparing Level 3 schools with other schools, to see whether, after controlling for relevant background factors, those schools scored higher on the outcomes being investigated).
- ◆ Identifying an indicator set for ongoing use.

Initially, it was proposed that a pupil survey would be designed and conducted if considered necessary i.e. if other data sources did not cover all of the indicators being ‘tested’ in the evaluation. However, data covering almost all indicators was provided by other sources, and thus an additional survey was

not deemed necessary, or appropriate given the burden it would place on schools.

1.4 Structure of the Report

The following four chapters focus on the findings from Component 1: Chapter 2 includes school-level findings, Chapter 3 focuses on views of the NHSS at local partnership level, Chapter 4 explores the views of regional coordinators, and Chapter 5 explores views of national representatives. The findings from Component 2, which concentrates on the development of national indicators to measure the impact of the NHSS, are discussed in Chapter 6. Conclusions emerging from the two components are discussed in the final chapter, as are recommendations for the future development of the NHSS.

2. SCHOOL PERSPECTIVES

This chapter reports on findings from interviews conducted at school level with pupils and adult stakeholders, and outlines in particular:

- ♦ Pupils' perceptions of:
 - health and healthy school activities
 - setting priorities and consultation
 - building supportive social relationships
 - active involvement and participation
- ♦ Professionals' and parents'/governors' perceptions of:
 - the nature of healthy school work
 - recruitment into a local programme
 - developing a shared understanding of healthy school work, and
 - bringing about change within a school

2.1 Pupil Perceptions

We asked school staff, among other things, to identify the range of activities they had developed as part of their healthy school work. Pupils were then invited to outline what they understood both 'health' and a 'healthy school' to be, and then to comment on activities developed as part of healthy school-related work. This included whether they knew healthy school activities had taken place as well as what they thought of them. Pupils were also asked to comment more generally as to whether they perceived the school to be a place where everyone felt safe, felt good about themselves, and were helped to do their best.

Perceptions of health and healthy school activities

Overall, pupils often understood 'health' to encompass physical and emotional well-being, and 'healthy schools' as places in which such well-being would be promoted or at least not compromised. For pupils, health included:

How you feel – feeling positive; eating well, not smoking, having a healthy mind – being tolerant and open-minded; good diet, good nutrition – eating fruit; not too much fizzy pop as it rots your teeth; not hurting people and not hurting yourself. (Combined quotes from schools)

And healthy schools were places in which:

They have a range of healthy foods available; there is a non-bullying environment; there are people to talk to about your problems; areas should be clean and litter free; there are playground games; there are after-school clubs. (Combined quotes from schools)

A range of activities had taken place as part of the healthy school-related work. These included:

- ◆ Improving awareness of, and access to, healthy diets, such as fresh fruit, salads and pasta in school canteens, improving lunchboxes, holding ‘healthy living’ and ‘healthy eating’ weeks, making drinking water accessible to pupils (including within classrooms).
- ◆ Increasing opportunities for physical activities, such as making playgrounds safer with softer surfaces, clearing litter, planting grass and trees, and improving gymnasium and other sports facilities.
- ◆ Addressing problem behaviours, such as preventing and responding to bullying via training pupils to support their peers and/or having staff member with responsibility to support bullied pupils.
- ◆ Supporting pupils’ emotional well-being, such as through the use of circle time to discuss problems and/or use of ‘worry boxes’ (where pupils can anonymously write down their concerns for a teacher to read), having ‘playground friends’ (where some pupils are trained to support others).
- ◆ Improving health care, such as use of medical room with school nurse and holding regular check-ups, reviewing policy on medications for ill pupils.
- ◆ Improving pupil involvement such as setting up a school council and consultation (particularly in relation to SRE, drug use and healthy eating).
- ◆ Improving consultation with parents, such as asking them about SRE policy and/or canteen and lunchboxes.
- ◆ Addressing staff development and well-being, such as consulting them about workloads and work-related stress, informing them of health-related work, involving them in healthy school-related activities.
- ◆ Improving teaching and learning related to PSHE, such as revising and updating school policies that might impact on health, starting SRE with an earlier year group, using external visitors, and raising awareness of other staff members about PSHE-related issues, revising school day (so that more learning activities provided during the morning), setting up small team for teaching of PSHE (rather than form tutors).

On the whole, but with some exceptions, pupils valued the changes that had taken place as a result of healthy school activities. It was rare, however, that they spoke of these activities as part of a whole-school approach to improving health; they tended

rather to talk of them as specific initiatives such as the *'playground project'*, *'peer mediation scheme'* or simply changes to the canteen.

When talking about their understandings of 'health' and 'healthy schools', pupils often mentioned that certain types of food and drinks were healthier than others. Water, pasta, fruit and salads were equated with health; sugary, fizzy drinks, on occasions chocolate, but more usually chips and *'deep fat fried stuff'*, were linked with ill-health, or commonly, with becoming fat. Younger pupils with access to fresh fruit daily at school appreciated being able to try out healthier foods.

We have fruit every day in class ... and have tasted new ones like kiwi and banana (Primary, school 4)

Other initiatives such as 'Bites in Boxes' (supporting parents to provide healthy packed lunches) were also spoken of positively. As one group of primary school pupils put it, healthy packed lunches *'make your brain feel better so you can work'*.

Secondary pupils, while still understanding what constituted a healthier diet, were more doubtful about the contribution of the school to this. Having a range of food from which to choose was seen as important. Still, even with such a range the food's cost and freshness were important factors in pupils' choices. Furthermore, negative feelings could be attached to eating healthy food, particularly when all around were eating chips. Some pupils suggested that healthy eating days would help normalise new food choices.

Chips are available every day ... there isn't the range of healthy food ... it's difficult to eat healthily as there's no brown bread and lots of mayonnaise ... Some people feel stupid sometimes eating healthy food when everyone else is eating chips ... there should be a healthy day about once a month.. (Secondary, school 18)

The school has a range of healthy foods, pizza, fish, vegetarian ...But salads are expensive and the fruit doesn't look so good ...And water fountains get vandalised and are old. (Secondary, school 19)

Of importance to many pupils was the quality of relationships within their school. Primary school children in particular explicitly mentioned issues related to having friends or being lonely, and what could be done to improve relationships. Knowing that adults in general would be supportive and helpful appeared as important as having special people (such as trained peers) who could provide assistance.

When, like, someone is lonely, they [adults in the school] help them ... if they've got a problem... It makes people feel happier instead of them being on their own ... some people don't like talking to an adult ... If you get shouted at all the time it makes you feel bad inside, but if you get nice people and get on well with them then you feel good inside. (Primary, school 8)

Outside in the playground we have pupils you can go to... it's about making friends ... they wear special caps and badges, and if people are lonely they come to us and we'll sort something out... pupils put suggestions in the box and we discuss them ... this and the school council is really good... I like it because you can make the school improve. (Primary, school 15)

Improvements to the physical environment of the school related to perceptions of the culture and ethos promoted within it. Pupils in one secondary school that had been under special measures talked of the school having had a 'poor reputation' in the local community. Improvements to one school, noted in a recent Ofsted report, were related by pupils to new science laboratories, new IT rooms and a new common room. These were said to have made a 'real difference' to their experiences of coming to school and pupils added, 'The environment makes you want to work.' (Secondary, school 18).

Setting priorities and consultation

Nonetheless, responses from staff and pupils about what improvements should best take place did not always coincide. For example, one issue that was rarely mentioned by staff, but one which troubled pupils, was access to clean and hygienic toilets. Although drinking water was being made more available to pupils through drinking fountains and/or having bottled water in classes, permission to go to the toilet was not always given when pupils felt it was needed.

You can't go to the toilet when you want to go ... Toilets aren't clean and have tissues stuck on the ceiling. (Primary, school 17)

Even formal mechanisms for consultation and decision-making did not necessarily guarantee that an issue would be addressed. The following group echoed the voices of other pupils in highlighting concerns about canteens, personal problems, litter and toilets. However, seeing no improvements taking place had led to a degree of disillusionment about the value of raising issues through the school council.

The school council has discussed the canteen, problems we're having, toilets, rubbish outside the school... but it does not make a difference as there are a lot of issues they mention, but not much changes... For example, the toilets haven't changed, they're a mess ... no locks or paper. There's no point. (Secondary, school 6).

Dissatisfaction with consultation provided an insight into the value attached to pupils' involvement in decisions that affect their lives. Where changes took place as a result of being listened to, pupils highlighted their feelings of being valued.

We wanted different physical activities and different packed lunches and they got changed, so you feel listened to and valued. If you want something changed, most of the time it gets done (Special, school 16).

Furthermore, participation in decision-making was said by some pupils to be fun, and provided them with a sense of involvement or, in their words, being '*part of what happens*'.

The following group of primary school pupils noted that they '*felt good*' about being listened to. However, they seemed less troubled than secondary pupils when their suggestions for improvement were not addressed, in some instances due to expense.

We are part of what happens... we decided what should be in the playground... it makes us feel good that they listen to our suggestions ... it's good fun really 'cos you get to choose what you want and they [school staff] say 'Yes', or 'No' if it's too expensive... it makes us happier. (Primary, school 13)

Building supportive social relationships

As noted, primary school pupils in particular mentioned the importance of supportive social relationships within a school. However, secondary school pupils too outlined the importance of having someone to talk with, '*if you're down*', and appreciated both being treated like adults and being afforded a degree of independence. Effective listening and consultation, an element of building supportive social relationships, was often closely tied to issues of confidentiality.

We talk about our problems... but they don't get mentioned outside the circle... We have a worry box where you put your problems, but they don't mention names. (Primary, school 8)

Everyone gives their view and the best thing is it remains confidential and that has given people confidence. (Secondary, school 3)

Primary school pupils appeared more likely to trust that what they wanted to remain confidential would do so. In contrast, some secondary school pupils noted their concern about confidentiality being breached. Although this could happen with

teachers, some respondents spoke of their uncertainty as to whether pupils running a counselling service might tell others of their problems.

If you are bullied you can go to Signs [a peer counselling service]... It's run by pupils, but because it's run by people like you, by pupils, you're always worried that people might tell... You can text them, which is a good idea because you are not seeing everybody and they don't know who you are... but you're never sure if it's confidential. (Secondary, school 11)

These pupils' concerns about confidentiality contrasted with responses from other pupils at the same school who were involved in the counselling service and who took part in another group interview. The learning and confidence gained through participation in peer counselling was notable, even though they viewed the provision of the service in the school and its use by younger pupils as relatively unproblematic.

[The anti-bullying] training we had helped us deal with different situations... it feels like younger students could come and talk to us... you learn a lot of stuff and it's a bit of a laugh as well... it's boosted my confidence a lot. Yesterday I had to talk to 200 people at County Hall and without this I wouldn't be able to. (Secondary, school 11)

In part prompted by our questions about whether the school was a safe place for all pupils, bullying, or rather the absence of it, was often pointed to as a feature of a healthy school. More often than not, primary school pupils stated that they mostly felt safe as they could get help from teachers, or write down what had happened and put it into a problem box (where they were in place) so that action could be taken somewhat anonymously. Some schools took particular steps to address racism and associated bullying. Actions might include talking about racism in school assemblies, having an identified person to talk with about bullying, and learning about the qualities and characteristics of different ethnic groups.

The importance of 'having someone to go to' when bullied, left out or alone was also mentioned from time to time by secondary school pupils.

If someone gets bullied the teacher counsels them... There are teachers on patrol with radios to prevent bullying or to help those who get hurt... If you feel left out or alone there is always someone to help you. (Secondary, school 3)

However, and as was the case with most health-related issues, secondary school pupils were more critical than those in primary about the school being a safe place for all. One group acknowledged that bullying takes place in one form or another in every school and that their peer mediation scheme played an important part in

reducing bullying. Another reported that there was a place in the school, unknown to staff, where younger pupils in particular were bullied by pupils who were already breaking school rules by smoking. This, along with the inconsistent or ineffectual responses of teachers to bullying, and coalescing with concerns about who to talk with in confidence, left one group of pupils sceptical that their school was as safe as it could be.

Not everyone can feel safe because no school is free of bullying, but the peer mediation scheme has reduced bullying. (Secondary, school 18)

Teachers aren't really interested in bullying ... sometimes they sort it out straight away but other times they just ignore it ... [name of teacher] is head of anti-bullying, he has a word with the bullies but it would happen again, it always does ... Also, there is an area in the school where the smokers go that they, staff, don't know about, and Year 7s get bullied there ... Buddies do not make much of a difference as no-one goes to them ... there are drop-in sessions with an [adult] mentor, you can talk to her about any issues ... but it isn't right as it's someone you know ... and with teachers you think they might tell someone else. (Secondary, school 6).

Active involvement and participation

After-school clubs and groups were seen by many pupils as a valuable addition to the school day. Pupils at one primary school spoke of a range of activities that helped them 'feel happy', 'chill out' and 'be healthy'. This drew attention to the reality that, for these children at least, 'health' was not perceived as an outcome of one-off events, but came about through ongoing experiences in their day-to-day lives. Thus, working in gardens, making the most of new toys in the playground and participating in sports clubs were to good health what eating sweets, sitting too often at desks, and doing little else than watching television were to ill-health, or more specifically, to obesity.

We have a gardening club ... you feel happy because our garden isn't a mess ...It makes people want to see our school ... We also have new toys in the playground and when you get breaks you can chill out in the playground ... We also have sports clubs after school, you get to see your friends and you get exercise in clubs. If we didn't get exercise we would all be sat at our desks and wouldn't be healthy ... we'd all be sat there and would be quite fat, but now we do stuff ... so you can still eat chocolate but work it off ... If we were just sat at our desks and didn't do anything, then go home and watch TV, it just won't be healthy. (Primary, school 8)

Secondary school pupils also valued access to after-school activities, although noted that attendance at them depended on pupils' interest in them. Sports clubs, for example, appealed to those with an interest in sports and, even at one school that

specialised in sports, pupils noted that a range of after-school activities should be made available.

During the school day too, certain health-related activities were appreciated by pupils; in particular, PSHE lessons that enabled discussion and problem solving. Primary school pupils talked chiefly of *'circle time'*, when they would have an opportunity to talk about and solve problems, so making them feel better. They welcomed the kindness of teachers in helping them to do their best.

We have circle time, we all do it, There is a 'worry box' ... we solve problems and we're not allowed to mention names ... it makes people feel better. (Primary, school 8)

If we are sad, adults do not ignore us but are kind to us ... the staff are kind by listening to what we want when we tell them ... teachers do not get angry, they help us do our best. (Primary, school 4)

In secondary schools, pupils were as concerned to note that their *active* involvement in learning helped them to gain new understandings of the lives of others and of themselves. Rather than proscriptions and prescriptions, developing insights into the *'real world'* were better generated by pupils' informed decision-making. To assist with this process, discussions with adults other than teachers (such as school nurses or people faced with challenging life circumstances) often helped pupils to *'actually talk'* about issues and problems. Even so, those teachers who provided activities that supported more effective learning were valued for the way they kept the class *'on task'* and for making learning enjoyable.

[In PSE] we can actually talk about issues and problems ... nurses talk to us about stress, pregnancy and issues such as anorexia ... also some young parents have come in and we have found it helpful and useful to talk about teenage pregnancy ... it has helped us not to stereotype and be more understanding of each other. (Secondary, school 3)

Teachers keep everyone on task ... we do brain gym warm-up exercises which help you get going ... it [PSHE] is fun, it's different from other lessons it gives insight into the real world ... it's changed from telling people 'You will not do this and that,' to informing people so that they can make the right decisions. (Secondary, school 11)

2.2 Perceptions of Professionals and Parents/Governors

2.2.1 The nature of healthy school work

As noted, staff and governors worked with their local healthy school scheme to support a range of new projects and activities within their school. From re-making playgrounds to setting up school councils, from fresh foodstuffs in tuckshops and canteens to improved PSHE curricula, from new medicines policies to anti-bullying measures, respondents were keen to highlight the changes that had come about as a result of their work. These included tangible changes, such as a new policy, the existence of a school council and changes to playground surfaces and new equipment, yet also encompassed outcomes that were harder to pin down, such as the *'feel'* of the school, pupils assisting others within a calm environment, listening more, improved attention, and pupils *'looking forward'* to events.

Our school council came about because of healthy schools ... and some very obvious changes such as improvements in the playground, like soft flooring ... things like playground friends and the playground games and equipment. (HS Coordinator, primary, school 8)

My own role is in medical provision primarily, but I have also developed a new medical policy that encompasses child protection, medication for children and care of children with special needs. There was never a specific policy before ... As part of the new policy all Year 9 students go through first aid training ... this has enabled them to assist a pupil having an epileptic attack ... By the time I came to the scene the student had been taken care of in a calm environment. (School nurse, secondary, school 2)

An offshoot is that we're now part of the fruit scheme. The children all sit around with the teachers and eat fruit together and it's had an impact on behaviour. The children are calmer ... when they eat their fruit and are read a story they listen more. It's improved their attention skills. It's something they look forward to. (Headteacher, primary, school 4)

Parents and governors too were convinced that they had noticed a change to school life as a result of healthy school-related work. Their evidence for this more often than not came through their individual personal and professional experiences, whether related to noticing changes in their own child at home, or through their activities as a school governor.

The children are very interested in the after-school clubs. My son doesn't watch half the TV that he used to watch... It's also making him lose weight through being active as he attends karate. (Parent/governor, primary special, school 1).

The children are coming home and talking more about the content of their PSHE lessons. Maybe they are finding it more stimulating. (Parent/governor, secondary, school 11)

There is a far stronger caring ethos than there was before ... children are perceived by the public to be better behaved as well ... the school used to have a poor reputation, it's turned a corner ... the staff are now aware of the mental health of children and that if children are happy and healthy they learn better ... the children come from the same disadvantaged areas as they always did, but the standards of the school have gone up. A specific example is having assembly at the end of the day on a Friday, which they could never have contemplated before, it would have been dead time before. (Parent/governor, primary, school 15)

Children have more fruit. My young son who is six loves fruit a lot more now even at home. He even tells me he eats the whole pear right to the core. He does seem to eat more fruit at home than before, so I buy more fruit now because the kids eat it. (Parent/governor, primary, school 4)

School staff and parents/governors often recognised that it would be hard to measure some of the changes they themselves had witnessed. They suggested that verification of the changes brought about by healthy school-related work could take place during school visits. For example, useful evidence would include displays of pupils' work around the school and seeing pupils in action; whether within a school council, during PSHE lessons or at an assembly. Videos too could provide a summary of key changes and events and could be made available to those not able to visit a school.

I think there have been a lot of improvements but it is difficult to show in a physical sense because it is implicit in the feel of the school ... we could show others the displays in the school, take them to a school council meeting, see a circle time happening and let them observe a PSHE lesson. (Senior teacher, primary, school 13)

I would walk them around the school and point out its welcome nature ... show them the work in corridors done by students, for example on bullying and animal rights ... I'd probably tell them to come into a PSHE lesson ... and show them the leaflets the children have done on bullying, which was supported by the police liaison officer ... Show a video of what's happened in the school, for example MPs' visits to schools ... and they can see the confidence of the children. (PSHE Coordinator, secondary, school 11)

The best thing to see the healthy school ethos is to see a school concert ... Diwali Indian fashion show, dhol drummers, to see how pupils are involved and support each other. (Parent/governor, secondary, school 2)

Other respondents noted that paper-based evidence, routinely created as part of managing a school, could be used to show evidence of change. A school nurse, for

example, noted that more pupils were coming to student services to discuss and talk about issues. This highlighted that the service was now perceived to offer more than treatment for accidents and injuries (records of which were kept by the nursing service). One teacher noted that new schemes of work and new resources provided evidence of changes to teaching practice, and added that tallies of pupils' participation in school activities and attendance at school might show differences across time.

We have records of students that come into student services including those that come for accidents and injuries. There has been an increase in those coming for advice. Not for anything serious, they just feel comfortable talking to us. (Nurse, secondary, school 2)

I'd show them new schemes of work, new resources, attendance and exclusion rates, numbers of pupils participating in school activities. (PSHE Coordinator, secondary, school 19)

A reduction in exclusions and expulsions was routinely mentioned as a useful gauge of a school's inclusivity and relevance to pupils' needs. Falling absences were another measure. As one respondent noted, absences might be as useful to track among staff as among pupils, as an improved school ethos and environment could have an impact on staff performance. Members of senior management teams also developed the idea of using routinely collected data to assess progress. Although not explicitly stating that evidence could be triangulated to provide different perspectives on the changing dynamics of school life, this was implicit in some accounts when they outlined the uses to which different data could be put. Thus, Performance and Assessment data, Ofsted reports and the views of LEA advisers could be pooled with observations of pupils' behaviours, surveys of pupils' attitudes and practices, pupils' and parents' views drawn from consultations, written outputs (such as school development plans and policies), the extent and range of expert input into PSHE, and pupils' own work (perhaps contained in records of achievement).

Number of pupils expelled is falling. There are changes in attitudes towards drugs [using HRBQ]. I would show an outsider the peer mentors, and we now have a bullying council. There are new policies, a decrease in serious bullying and pupils aren't afraid of reporting bullying any longer. There is less staff absence. Pupils are able to identify support that is in place for them, and we have a range of extra-curricular activities. (Healthy School Coordinator, secondary, school 10)

I'd show them the school development plan and that the healthy school work and anti-bullying work now have action plans ... pupils also have their own records of achievement and someone could look at those ... they could look at the school tuck shop set up by students and invite them to school council meetings. (Assistant Deputy Head, primary, school 17)

I'd show them reports from LEA advisers, reports from Ofsted inspectors ... And we do a bullying questionnaire twice a year to pupils and there has been a continuous trend in the right direction for a reduction in bullying ... At Ofsted time there was a questionnaire on behaviour and that showed a trend in the right direction ... I have observed that more children from reception class will choose fruit at lunch ... the school nurse now comes in to do more on sex education and personal hygiene ... I'm also looking at Performance and Assessment data to improve. (Headteacher, primary, school 15)

Although these measures encompass a number of inputs, outputs and outcomes, they nonetheless highlight the breadth of indicators that staff and governors perceive as important in evaluation. A problem remains however. No respondents were able to state with confidence that any changes could be tied solely to work associated with the healthy school scheme. Although some activities were a direct result of participation in the scheme (such as making improvements to a playground), changes only came about because they complemented and built on existing and ongoing developments already in place. Indeed, and as noted below, staff would only allow their school to be recruited into a local healthy school scheme if they perceived the scheme to contribute to school improvement. As the following respondents commented,

It's a difficult one to separate out the effect of healthy schools from other initiatives ... it's a very useful skeleton of what needs to be done. (Healthy School Coordinator, secondary, school 14)

The school was under special measures for five years ... health promoting schools was seen as part of other support work put into the school. (Healthy School Coordinator, secondary, school 18)

2.2.2 Recruitment into a local programme

Across interviews, respondents generally agreed that one of the most useful aspects of their local scheme was the structure it provided for health-related work to take place. Many schools were already carrying out a number of health-related activities in one way or another. Through self-evaluation, the local healthy school scheme enabled staff to draw together what were sometimes understood as disparate activities. Parents/governors and staff usually indicated that the school responded to a number of initiatives, but would only do so if these fitted in with existing priorities, often outlined in school development plans. The breadth of local schemes, in terms of the health-related topics and issues that could be addressed within the school, helped those in schools craft the scheme to their own circumstances.

What we liked about it was the emotional health and well-being side, and we knew that drugs was something we needed to look at, and SRE ... we felt that the healthy school scheme gave a vehicle ... we do a lot of initiatives, but we look at how they fit in with what our school priorities are, and PSHE was coming up as a big priority on the School Development Plan ... I saw it [the healthy school scheme] as a way of getting some outside stimulus to work with parents and raise awareness with them. (Healthy School Coordinator, primary, school 7)

We were keen on the process of self-evaluation, that is, a way of evaluating what we were already doing ... It gave us a framework to develop our work. Although health issues were on the agenda, we had no framework before. We used the healthy school's work to guide us and help us put theory into practice ... we don't just go for initiatives, they have to fit in with our organisation and the ethos of the school. (Deputy headteacher, secondary, school 6)

Both the framework and the scheme's flexibility were important to staff in a newly constituted special school. Staff had not been part of many other initiatives and suggested that those they had were difficult to tailor and customise to the circumstances of their school. While plans to address health-related issues were already in place, the healthy school scheme provided a structure through which these issues could permeate throughout the life of the school, rather than being taken up through a parallel yet separate process.

We felt very much that healthy school work actually allowed us to do what we were planning to do, but it gave us a framework that we could easily adopt ... It would be fair to say that as a new school we felt that new initiatives we would have to look very carefully and critically at, because we don't want things that just bolt onto the school ... As a special school the flexibility of the scheme is great. It is unusual for us to be able to set our own pace and tamper with it a bit. It has been really refreshing. (Deputy headteacher, special, school 9)

Other respondents also working with pupils with special educational needs noted that the principles underpinning the local healthy school scheme corresponded well with those underpinning the development of their new centre. Not only could the scheme's guidelines be used to focus on health issues among pupils and parents, they also lent authority to addressing staff well-being, especially given the stressful nature of the work.

When I heard about the scheme I thought 'This covers all the things we want to be part of this centre', So we did it right from the start of setting up the centre. I think the big impact was having that set of guidelines about what is a health promoting school, which gave credence to the things we wanted to be about, including caring about your staff ... we have systems of working together as a staff team, we model respect and support towards each other ...

at 3pm each day we sit down and talk about the day. This is an opportunity to let off steam, as it is intense and draining work at times. (Headteacher, special, school 16)

The framework provided by the local scheme, with its initial emphasis on supporting a review or audit of health-related activities, enabled some staff to broaden their view of what constituted a healthy school.

The most useful piece of paper was the framework ... I hadn't thought about ethos and environment ... and I had never thought about staff health before. (Healthy School Coordinator, special, school 1)

Still, while some respondents were enthusiastic about the initial review process, others were more critical of it. In particular, the paperwork associated with self-review was felt by one respondent to be off-putting and for another did not provide tangible effects swiftly enough. Nonetheless, these respondents soon found themselves working on their own priorities.

The first stage of the healthy school scheme was a bit of a paper exercise ... it was just pulling together what we did already ... The problem with the first phase of the healthy school scheme is that you can't see anything from it as it is a lot of paperwork, so the kids see nothing from it. So, I wanted something we could see in an instant, so we did the school council. (Healthy School Coordinator, primary, school 7)

I think initially what is off-putting [with the scheme] is a lot of paperwork and hoops to jump through ... but after that you select your own targets. (PSHE Coordinator, secondary, school 11)

One respondent, not yet part of a local scheme but open to the ideas behind it, nevertheless felt daunted by the amount of paperwork involved. Through involvement in other initiatives, all of which were perceived as overly bureaucratic, inadequate returns were thought to arise from the amount of time and effort invested.

I know that to get the certificate, it does require a lot of paperwork for little return ... as a school, we are very much pro the ideas behind it, but the problem lies in the bureaucracy, with little financial help ... we are involved with other initiatives and it's non-stop with all these schemes ... it's difficult to get teachers to take on extra responsibility. They say 'No thank you,' because of all the stress it brings ... You can't respond to everything ... Some schools need to get money to use as they wish ... if you are a better-off school in the way they measure you then you get less money. (Headteacher, level 1,2)

At another school, not yet involved in the scheme but whose staff wished to be, participation had been postponed on the advice of the local coordinator who stated

that the criteria for recruitment had changed. For this school, staff felt that involvement in the scheme would enable them to draw together *ad hoc* activities.

... we have already addressed the drinking water issue and have a healthy tuck shop. We would like to be further involved but don't meet the current criteria. If when we are part of the scheme I would look for the structure and prioritising of issues for us. We're addressing issues but rather on an ad hoc basis so I would hope that healthy schools would broaden our view of what healthy schools are and help us define what our priorities should be. (Headteacher, level 1,2)

No respondents from Level 3 schools talked about an award or plaque they might receive upon successful completion of healthy school work as a justification to become involved with a local programme. Indeed, awards and plaques were more likely to be mentioned by respondents in Level 1 and 2 schools. One headteacher indicated that the school had already addressed health-related issues and explained, 'We don't have to have a badge and jump through hoops to show all the work we have been doing'. And with a strong personal interest in healthy eating, the headteacher felt the local programme did not address their own dietary concerns relating to additives in food: 'The healthy school scheme,' s/he argued, 'is a joke if they don't do anything about 'e' numbers.'

Although in agreement with the general aim and thrust of the health-related work in schools, another headteacher of one primary school felt that staff had to be behind an initiative for it to benefit them and the school. 'My worry', s/he noted,

is about dual standards ... going 'gung ho' with the programme and having staff eating chocolate bars in front of the school ... I have seen some schools involved in other initiatives and nothing really changed. (Headteacher, level 1,2).

Staff at one other school were said to 'stay away' from new initiatives. Bidding for these was felt to compromise the cohesiveness of the school, and awards were seen to be of little use when the school was already thought to be doing some of the work involved.

Sport marks, art marks etc., ... our feeling is that various initiatives could be good, but they focus the school in a certain way ... and it should be in the curriculum ... not an add-on or something you have to squash in ... we do work on health issues, but we don't want recognition ... we wouldn't want to beholden staff to achieve the certificate ... we have a philosophy in the school about the bidding and initiatives culture, that it is against the cohesive feel about the school. (Headteacher, level 1,2).

2.2.3 Developing a shared understanding of healthy school work

A key feature of local schemes appreciated by respondents was the broad concept of 'health' that infused them. Respondents noted that a drawback of the scheme might be that people perceive it to be chiefly about improving physical health, or more particularly, encouraging changes to pupils' diets. Some schools certainly did use the scheme to promote learning about healthier eating, to change the sorts of food provided in tuck shops or canteens and to make drinking water more readily available to pupils. But they also undertook activities to enhance the more general ethos and environment of the school.

It's not designed to cut out chips. An awful lot of people seem to think that a healthy school actually means healthy eating. It's not just that. It's about improving the whole of the learning and health experience of the school ... A wrap around experience for a healthy future. (Parent/governor, primary, school 13)

[The healthy school scheme] enabled us to move out and expand from PSHE ... a healthy school is more than just PSHE, it's more than just eating fruit ... it really opened up our minds and it created an excitement and a motivation. (HS Coordinator, primary special, school 1)

It was questioned by one respondent whether all staff needed a thorough understanding of the scheme. More important was putting healthy school-related work into the school improvement plan, having a person to lead the health-related activities, and ensuring that pupils' views were identified.

I will be honest to say that not every member of staff understands healthy schools, but it begs the question, 'but why should they need to?' The coordinator needs to understand the overarching picture, and the people need to do their little bit in the jigsaw puzzle ... they need to understand the holistic needs of the child and giving children a voice ... the [healthy school] action plans are given to all staff in the school improvement plan. (Healthy School Coordinator, secondary, school 10)

More usually, however, the scheme was used to stimulate a shared understanding of health, to build a common sense of the importance of health and well-being to learning, and to identify and work on health-related priorities. To achieve this, staff from across the school were drawn together. There was, however, little evidence to show that this process involved other school constituencies (such as pupils and parents) in anything other than minor ways. When talking about a 'whole-school approach', this more often than not appeared to refer to involving as many teaching staff as possible. Respondents spoke of the benefits this brought about: raising the profile of health, setting priorities, developing planning mechanisms, developing

coherence across policies, helping staff critically reflect on their practice, and raising the awareness of the range of health issues that needed to be addressed among pupils.

Respondents also highlighted the differences that might exist between primary and secondary schools when taking a whole-school approach. The numbers of staff in secondary schools, their departmental affiliations and the competition for resources brought about by departments responding to new initiatives were felt by some to compromise collegial activities.

It provides an opportunity for staff to work together and support each other in different ways ... It has to be a whole-school approach because however brilliant your PSHE Coordinator is, you can't do it on your own ... We have just eight class teachers, the logistics of working with all staff in a secondary school must be very difficult. Working together makes you reflect more on your own practice and give time to healthy school themes. (HS Coordinator, primary, school 5)

We started by holding a meeting to share what our understanding of 'health' is and mapped where we were and where we wanted to be. We saw it as an opportunity to link together work going on under different departments, and one-off work on health issues, to a common goal under the umbrella of the HSS [healthy school scheme]. Participating in the scheme served to raise the profile of health in the school and to look at what we're doing, what we had missed and use a whole-school approach... Coordinating whole-school and all-staff involvement is hindered due to many departments working in isolation. A large staff of 200 and time pressures makes it difficult to link departments together. The school responds to many new initiatives, some of which are thrust on the school, so staff compete for staff development in each of their areas. (Teacher, secondary, school 2)

Even so, it appeared that the very idea of a whole-school approach enabled staff in secondary schools to work together in new ways. The cross-departmental nature of the scheme, while not doing away with departmental allegiances, enabled new forms of association to develop within some schools. This was often said to engender a sense of motivation, a feeling of being part of a team, and helped individuals to carry forward new initiatives knowing that support would be forthcoming from others.

The healthy school's work has motivated staff and helps keep them on the go ... it draws everyone together, other initiatives tend to go to departments, but this is a whole-school approach ... it has meant we have commonalities across policies, statements about how things are done. (PSHE coordinator, secondary, school 6)

It's about team building ... we are all so much more part of this now that we feel much more part of a team. We are all from different faculties and areas, but this initiative has actually brought us together. If someone wants to do

something, they know they've got a team of people. That has come from healthy schools. It is the first real initiative on a major scale that we've had that has brought lots of people from all over the school, teaching staff and non-teaching staff, everybody. It has blended us together. (Deputy headteacher, secondary, school 6)

2.2.4 Bringing about change within a school

While respondents noted that a number of changes had arisen in relation to healthy schools work, there appeared to be one key underlying theme that drew together their accounts; respondents noted that pupils' active involvement in activities was a key to their success. Participation in after-school clubs could mean a child watched less television. Involvement in playground activities was perceived to lead to fewer quarrels and also meant pupils would settle more quickly once back in the classroom. Actually tasting and trying out new fruit in school could lead to changes in consumption within a home.

Yet involvement and participation also depended on the activities being seen as relevant by pupils and of interest to them. The range of after-school clubs enabled choices to be made about which to attend; whether karate, gardening or other specialist provision. Being attuned to pupils' emotional needs and asking them about what they would like to happen, enabled adults to tailor activities and school life to their interests and concerns.

As for the playground project, the pupils had a chance to design the playground as they would like it ... children are more involved in activities, and because they are more involved they have less quarrels, it has improved their behaviour. The activities give them a chance to play together. (Parent/governor, primary, school 4)

The school has become far more supportive of children's emotional needs. I've seen it when I've sat on the disciplinary committee ... all avenues are followed to support a child. (Parent/governor, secondary, school 2)

Staff often struggled to respond as fully as they wished to the views of pupils and parents. Although talked about as an important feature of working towards a healthy school, staff felt challenged to move beyond rhetoric. Circle time was said to be an important way to learn about the views of pupils, and some schools had undertaken surveys on specific issues. But setting up a school council too quickly (see above), or doing so to meet the requirements of the accreditation process, did little to enhance the credibility of work associated with a local programme.

The school council has been set up, but a lot of us felt it was just being set up for healthy schools, and since setting it up, nothing has been done since ... I felt that a few things were done just to get accreditation ... I hadn't noted many changes although there were a lot of things that needed addressing ...the whole-school approach often involves just teachers, and they are supposed to disseminate information down ... only a few parents understand it [the concept of healthy schools] information has gone out but not in a way they understand ... They probably think it is about clean drinking water and fruit on the table. (Parent/governor, secondary, school 11)

The challenges associated with involving parents were also outlined by other respondents. Although one or two successes were noted, these related chiefly to work in primary schools. Substantial parental involvement was said to be more difficult in secondary settings. Even though this lack of involvement was not seen as a hindrance to health-related work in schools, it does open to question how best to make the scheme relevant to children, young people *and* their parents.

Everyone got involved in fundraising for the playground project. This sowed the seed for a whole culture change in the school, everyone got involved in an area of development. It just evolved. An outcome is that there is now more parental involvement. (Teacher, primary, school 4)

We have great problems getting parents involved here. You can get some involved, but you'll never get 1000 involved ... they're not hindering [healthy school's work] they're just not all interested. (Deputy headteacher, secondary, school 6)

If respondents had little to say about pupil consultation and involvement in the decision-making processes associated with the scheme, they were clearer about what range of other factors had enabled changes to come about. Time and again respondents made clear that the involvement of the senior management team (SMT) was central to a scheme's success.

I couldn't have done it without the backing of the headteacher ... it is critical to have their support ... I was involved in mentoring other schools when they came on board with healthy schools and some of them were very concerned about the lack of support from the headteacher ... it ended up by them saying 'We don't have the time, we don't have the resources, we already have enough to do'. (HS Coordinator, primary, school 5)

Although pivotal, SMT support acted only as a catalyst that enabled motivated staff to carry forward healthy school activities. The work of individual staff enabled resources within and outwith the school to be utilised. True, monetary resources were not often mentioned as critical to a scheme's success, but were nonetheless appreciated and helpful in developing and implementing healthy school activities.

Furthermore, the capital inherent in external professionals' expertise could be invested into a scheme where good working relationships existed. The enthusiasm of key players, their commitment to healthy schools, their shared understanding of the range of pupils' health-related needs, and access to sufficient material resources operated in concert.

What led to the changes? Support of the leadership team, people to understand children holistically, support from LEA, work that individual staff do to run different components, not much in way of physical resources, bringing in external visitors (such as a theatre group), not being rigid in the way you approach pupils and what you expect of them. (Healthy School Coordinator, secondary, school 10)

To be honest the success was due to the work of individuals, mostly me. It [the playground project] was my little pet project. It needs someone to lead on it. (Headteacher, primary, school 4)

[The local LEA and healthy school scheme] always provides money as an incentive to attend training days. Heads are more likely to come round to the idea of healthy schools if in this current climate they are getting financial remuneration ... The school is open to new initiatives because of the head, but the healthy school has taken off because I feel very strongly about it ... The healthy schools adviser in the LEA, she's very forward thinking, she eats, lives and breathes it, she loves healthy schools, her enthusiasm has infected everyone else. (Healthy School Coordinator, primary, school 5)

One respondent who wished the school to be involved further in the scheme noted that, due to high staff turnover, s/he had found this difficult to do. Nevertheless, the school's own problems had been exacerbated by poor communication with the local healthy school coordinating team. This underscored the need for ongoing communication and swift feedback in order that school staff felt supported, and so carried forward their involvement in healthy school-related work.

Communication with the local coordinating team could have been better. A lot of 'phone calls and messages went unanswered ... we would have liked to have received more support from the team ... we have not received any feedback from an audit carried out by the coordinating team ... because of that, much of the initial excitement about the award application has died down. (Teacher, level 1,2.)

When asked, almost every parent/governor said they would recommend the scheme to others. Activities associated with the scheme were said to promote not only pupils' physical health, but also their social understanding and ability to learn.

I would definitely recommend the scheme to others. It gives children a better understanding of the world around them, socially and learning-wise. They are

healthier, not just eating-wise, but social attitudes as well. (Parent/governor, primary, school 8)

However, a few caveats need to be sounded. The scheme was perceived to work due to its voluntaristic nature. As noted already, the recruitment of schools depended on staff, especially members of the SMT, viewing the scheme as a likely contributor to school improvement. It had to 'fit' with other initiatives and the desired ethos of the school. Although 'health' was the idea that organised and brought together various activities associated with physical and emotional well-being in schools, the exact topics and issues addressed were locally determined; building as they did on local needs and interests and drawing on the leadership and competencies of key staff.

I have recommended it to other schools but it should be at the right time for them. They should be gently led rather than using a sledge hammer to take this on. (Parent/governor, primary, school 13)

Yes, I'd recommend the scheme to others, there are a tremendous number of plusses ... the coordinator has been on fire for this, believes in it and has taken people along with her ... there has to be someone at the helm who's a good leader and believes in what they're doing. (Parent/governor, secondary, school 14)

3. LOCAL PARTNERSHIP PERSPECTIVES

In this chapter, the findings from interviews conducted at local partnership level are reported, in particular, professionals' perspectives on:

- ♦ Recruiting and involving schools
- ♦ Developing local programmes
- ♦ Working in partnership
- ♦ Financing the work of local programmes
- ♦ Support from the national team
- ♦ Involving young people, and
- ♦ Reviewing and evaluating progress.

3.1 Recruiting and Involving Schools

As noted earlier, school-based respondents contacted as part of the evaluation stated that involvement in a local healthy school scheme had helped them address a range of health-related topics and issues. At the local partnership level too, respondents listed a range of achievements that their partnership had made possible. These included:

- ♦ multi-agency working (partnerships, strategic groups, operational groups, support networks);
- ♦ sharing of good practice in involving schools;
- ♦ raising awareness among local professionals of links between health and educational attainment;
- ♦ specific health-related initiatives (such as drinking water, addressing mental health and emotional well-being issues, healthy eating and food);
- ♦ having named health governors in schools;
- ♦ creating a regional youth council;
- ♦ establishing a regional youth forum;
- ♦ providing, and stimulating access to, training;
- ♦ developing locally relevant resources;
- ♦ and developing and implementing a validation and accreditation process for healthy schools.

The recruitment of schools and the provision of support to them was helped by the overall framework or model provided by the NHSS. It enabled many of those in local partnerships to consider how the organisational structure, culture and priorities of school life could be utilised to introduce a range of health-related activities. A number of respondents indicated that, since the main business of schools was education, some of those who worked in health services held unrealistic expectations regarding whether, what and how health topics and issues were addressed. Through local partnerships, professionals were provided with opportunities not only to check out each others' priorities, but also to identify a process through which schools could engage with these – whether at the whole-school level or through the utilisation of the expertise of health and other professionals. Respondents from two different partnerships in the South West outlined how they had developed their work with health partners.

Some things that health say they want to do and what they realistically can do in schools, are quite different. Before the healthy schools programme I would more often come across some poor soul who's been given an appointment to look at something and they may have spent six months trying to find out. It is less like that now as health will say 'We want to look at 'X', can we come and speak to you first and link it in?' We do a major task in helping health understand what schools are about, what is happening in schools and the way in which we as an LEA work within schools. And we have a much clearer idea as an LEA what their health targets are. (South West)

The earlier scheme used so-called experts rather than teachers, and although the experts knew their subject they often had very little idea of how best to interact with the kids ... the difference now is that the partnership recognises that teachers know their pupils and know best how to meet the needs of their kids. (South West)

Specific strategies, supported on occasions by new financial resources, were used in some areas to bring schools into a local scheme and included the use of school staff already successfully involved in a scheme as advocates. Direct contact with head teachers in particular was said to be a necessary antecedent to recruitment.

We have used schools to talk for us to other schools ... schools which are successful ... we give them a small amount of money and ask them to release someone to come and talk and maybe buy some resources and share them, or to network with others. (East Midlands)

The value placed on the scheme by Ofsted helped members of partnerships to recommend to headteachers (including those leading schools out of special measures), that the scheme could help them meet school priorities. Headteachers were said to be

driven by Ofsted targets but, if unaware of Ofsted's recognition of the NHSS, would not see its relevance to school improvement.

We've won over heads as many were cynical. [This area] has been overrun with initiatives and many heads are fed up with it. But many now are asking and volunteering to be involved. (North West)

Often those which we have failed to recruit at all will have an issue such as the headteacher is retiring soon so they are waiting until the new person comes in. Schools in special measures often tend to want to be left alone, and all you can do is offer support and say, 'Even if you're not going to start yet, just to say you've been recruited looks good when you're being Ofsteded', and a couple have done that. (East Midlands)

There is an issue around schools that are in special measures which seem unable to move away from a target driven approach of, 'This is what Ofsted want us to do'. ... we have offered them money and to work alongside them. We have found it's better to wait until they're ready rather than push them. (South West)

Recruitment was said to partly depend on the type of school: special, primary or secondary. Most respondents noted that they had few problems in bringing on board primary and special schools, as staff generally had an understanding of the nature and development of children that corresponded to the principles of the NHSS. Once in secondary school, a different view took hold, one that separated academic achievements from pupils' physical and emotional well-being. Furthermore, the size and organisational structure of secondary schools, with the attachment of teaching staff to departments, could make it difficult to take up health issues as part of a whole-school approach.

Primary and special schools are easy [to recruit and involve in the scheme] as we are all after improving the health of children generally. In secondary schools it's different as they're not as interested in the child as a person as they are in the child as a learner and achiever. (AHP1)

We had problems with high schools and we have just got our first high school through the scheme and the head was very forward thinking and he has managed to get specialist college status partly through the use of healthy schools. Since then we have had a couple of other heads phoning saying they want the same status and what can they do to join the scheme so it's about sharing good practice ... High schools tend to work in departments ... we make sure they have a taskgroup set up which has to have a member of senior management on board. (East England)

We have had no problems recruiting special or primary schools, but high schools are a different kettle of fish because of their size and complexity ... it's very difficult in schools where there's 120 staff and 2000 pupils. (North West)

However, the personal experience of members of a local partnership also played its part. Respondents noted that some of their partnerships were missing representation from particular types of schools, making it more difficult to recruit them. And a respondent with a background in secondary school teaching had found these relatively easy to recruit compared to special schools.

I haven't had problems with recruiting secondary schools, perhaps because I used to work in secondary schools. I only have one special school on board. I don't really know how to support special schools so this is an area of development. (East Midlands)

The geographical areas covered by some local partnerships were said to create their own challenges, whether in terms of the time it took to get to meetings, or a particularly complex mix of PCTs, or the juxtaposition of deprived and affluent localities. The size of schools was perceived by one respondent not only to affect recruitment, but also to influence the time staff took to achieve validation. Furthermore, targeting of schools in areas of deprivation could, it was suggested, have an unanticipated impact on perceptions held by staff in selective schools of the relevance of a local scheme. Moving away from a universal to a targeted approach was said by some respondents to pay little heed to factors associated with rural deprivation, such as access to health and related services.

Recruitment has been fine. We're very good at recruiting. It's getting them through the validation in the two years that we find has been more difficult. We've found the primary schools have been achieving validation at much faster rate than secondary schools. We're looking at why this is and it seems to be that the bigger the school, the more difficult it is to do the validation ... because of numbers, the pressures of school improvement and the diversity of teachers' practices. They don't meet as much as the teachers do in smaller schools. With targeting, we started in areas of deprivation and there were merits and disadvantages. If you only go for schools at the bottom of the pile, you put off the selective schools and the grammar schools. I think there probably needs to be a mix of schools. (South East)

The more targeted areas of [name of area] receive a lot of money via other sources, but the rest of the county is very rural and there are issues around rural deprivation that, nationally, urban populations don't have a clue about. It's a real shame that the targeting of schools seems to have overtaken the universality of the entitlement of healthy schools for all, which was the initial idea. So, where do we end up targeting but that one part of the city that seems to be awash with extra funding anyway? That's one of the reasons why healthy schools has been a success in some of the peripheral areas as they are fed up of not getting funding from other sources and they are pleased to see a helpful face from our team despite their rural location. (West Midlands)

There is a difference between urban and rural health needs ... 50 per cent of our population here are in rural areas ... the biggest issues that have impact on health and access to health services are transport and infrastructure. (South West)

3.2 Developing Local Programmes

In many areas of the country, a ‘healthy school’ or ‘health-promoting school’ scheme had already been in place prior to the piloting and establishment of the NHSS. One respondent noted that feelings of ownership, along with a concern that issues and topics should remain locally determined, had led to initial doubts about the value of a national standard. However, as the national NHSS team had consulted with those running local schemes, local achievements could be consolidated and built upon. Indeed the NHSS had enabled further activities such as conferences to take place and made it possible to engage a number of strategic players in PCTs.

We originally had reservations about the National Scheme ... it was ours and we didn't want anything to be imposed. But in actual fact it worked really positively and [the National Coordinator] came up trumps in enabling recognition for what we had already done; it could easily have gone the other way. Without the national scheme we couldn't have run the conferences that we have, engaged with the PCTs nor got senior managers involved. (East England)

Perceptions of the ‘value added’ by the NHSS were echoed by other respondents. A major theme related to the process of how best health issues were raised with, and addressed by, those in schools. Although health issues were already part of schools’ curricula, these were rarely, if ever, tied in to school improvement. The NHSS provided a framework that helped translate health priorities to those more relevant to the work of school staff and governors.

The awards used to be very health-oriented. Since the NHSS there is an absolutely substantial self-improvement model for schools so it is vastly different. It is now not just about health, but health and education are now working together and it's seen as important by the LEA. It is valued that we have 60 per cent of schools on board and there is great sharing of good practice. (North West)

And in another partnership in the same region, the accreditation or validation process that schools went through was summed up as,

I would see the model to be: self-review, action planning and portfolio development and then an accreditation visit to check the portfolio and double check by observations in the school and talking with pupils. (North West)

In some areas of the country, challenges were said to remain in creating a shared understanding of the holistic and longer-term processes that were needed to bring about organisational change. Raising awareness about health among those in schools was more than health education, but involved a developmental process encompassing consultation, needs assessment and evaluation.

... as an ex-teacher I had a clear understanding of the school's role ... the difficulty has been getting people to understand that a sustainable process is more important than the product. A process with consultation and needs assessment and evaluation is more important than the one-week healthy eating week ... people don't see the raft of things that need to be brought in to bring about any sort of change. A lot of people like elected members don't understand what a health-promoting environment means. (South West)

The 'raft of things that need to be brought in' did not relate solely to healthy school scheme activities. Although a few respondents stated that the NHSS had done little or nothing to broaden their understanding of how best to carry out health-related work in schools, certain other initiatives, such as the teacher PSHE Certification Programme, were said to have complemented the work of a local scheme.

No. I have a teaching background anyway and have strategic overview about school improvement in the LEA ... many schools are on board and they are now leading the agenda. Progress has been slower in health ... but the certification for PSHE and school nurses is helping. (North West)

As well as providing a conceptual framework and the requirement to set up local partnerships with members from health, education and other agencies (such as local Connexions services, teenage pregnancy coordinators and Drug Action Teams (DATS)), the NHSS also brought with it some monetary resources. These were used to employ people to lead and/or support the partnership and assist those in schools to release staff time and/or to buy written materials. A number of respondents also noted that the NHSS had added credibility to local schemes by raising the status of health-related work in schools through a more visible national profile.

We got some money from the NHSS which helped phenomenally in engaging schools and others within [name of place] to work with us. It facilitated the employment of people to carry out the work. Having a national standard means the local scheme is accountable and this makes a difference to the other partners because it is a bit of a lever ... and gives it a bit of kudos. Schools like being part of something national with a local flavour. (North West)

The national profile of the NHSS helps with their credibility locally. Having the DH and DfES logos stamped on resources gives it all an official air that is very important in getting schools to read our approaches to them. Without

that most of the letters would just go straight in the bin because schools get bombarded with stuff. (South West)

Although welcomed, some respondents questioned the level of resources available to develop and implement the scheme. As the following respondent noted, given the level of work required of school staff in particular, and given the funding available for other school initiatives, more resources for the NHSS might well have been expected.

I have nothing really negative [to say about the NHSS}, although there is a great deal of work expected from school and there isn't the same level of funding that one would expect for an initiative such as this. (North East)

There were other criticisms too. In one area without a pre-existing healthy school scheme, the local partnership had worked to the target to recruit *all* schools. A later national target to recruit and work with schools with a certain percentage of pupils entitled to free school meals (FSME) had made it difficult to build on earlier work. Furthermore, it was felt that local effort had been wasted in producing local resources which were more or less replicated by those produced by the national team.

In another area with a pre-existing scheme, the initial target to recruit all schools had compromised the quantity and quality of support provided to each school.

There wasn't a scheme before. The NHSS has provided a framework and shows schools that they are part of a bigger picture. The whole school approach has been useful ... but some of the developments from the national level have been a bit late. For example the free school meals criteria would have been useful before because we have gone after a lot of schools that don't meet the criteria. The same goes for resources. We've produced some and now there are some from the national team. (Yorkshire & Humber)

... in negative terms, the targets to recruit certain schools. We worked hard to achieve these targets, but as we were being driven by these targets to recruit all the schools we allowed the rigour of the local scheme to drop and we didn't have the capacity to support the schools. (East England)

A further factor in successful recruitment was the setting of local health priorities that were seen by school staff as relevant to the needs of their school. As one respondent put it, achieving this was a '*creative tension between national and local priorities*' (South West). Another respondent illustrated the process:

We work with our PCT on priorities and the DAT and Teenage Pregnancy. We also affect their priorities. We also hear from the children. Audits are done by each new school and they get a flavour of what's needed. So, local priorities are set as a mixture of what national research, policy and guidance is saying, the school's needs and what we suggest too. (North West)

3.3 Working in Partnership

While most respondents noted their achievements in developing local partnerships, some also outlined their difficulties in consolidating or sustaining them. A number of respondents stated that they had spent considerable time drawing together partners with different organisational commitments and priorities, consulting with them and then building on their professional expertise. Partners included representatives from: local Connexions services; DATs; Quality Protects initiatives; Sure Start programmes; the police; youth organisations; Children's Fund projects; catering departments; social services departments: Health Action Zones (HAZs); Education Action Zones (EAZs); young people's forums and councils in local authorities; as well as school nurses and teenage pregnancy coordinators. Respondents indicated that it was often easier to involve professionals at an operational rather than at a strategic level.

Where there was a history of partnership working between health and education, this often made joint work relatively unproblematic. On occasions, senior staff in public health who were said to understand the nature of health promotion had made resources available to a local scheme.

We have worked well with our health partners and our aims have dovetailed well ... that is something we have invested a lot of time in and it has been worth it. (North East)

We adopted the right approach as we treated people as professionals and consulted with them properly rather than simply telling them what to do like some other initiatives. (East England).

We have had a long history of health and education working together and both have funded permanent posts [for healthy school work]. Public health has always taken a settings approach, even before it was called that. We have a good relationship with the Regional Director of Public Health and the work with schools is seen as a way of delivering on health targets in the regional strategy. (East Midlands)

Yet, just as common were accounts of difficulties in holding together partnerships. The impact of this could lead to the 'stagnation' or 'stalling' of communications and activities and reduced the effectiveness of the partnership. No respondent indicated that they had not put time and effort into sustaining a network of professional relationships. Rather, staff changes (more commonly in relation to the reorganisation of health services into Primary Care Trusts (PCTs) than changes in education), had

led to a lack of continuity of individuals serving on a partnership, or to the removal of key staff altogether.

Due to staff changes, we haven't had a Steering Group and therefore cannot be as effective as we'd like to be. (Yorkshire & Humber)

We have a Strategic Partnership Group ... but there have been changes in education so this has been problematic for the partnership such as having no PSHE/Citizenship lead at present ... a change in partnership really does stall things. (North West)

Our partnership was initially very strong but went through tensions due to poor relationships between certain key individuals. There was mistrust and a period of inertia and stagnation within the partnership when it wasn't possible to have an open debate. However, we kept going. It's been difficult to get a balance between education and health due to the change over to PCT ... we have gone from four health promotion staff all involved with healthy schools' work to some degree, to having it as just a tiny part of one person's role. (East England)

As highlighted earlier, poor working relationships between individuals could compromise the work of a partnership. But there was also a cultural challenge to be faced in drawing together the perspectives of some in education and health. While understandings of the developmental needs, interests and concerns of children and young people held by those in primary and secondary schools could impact on school recruitment, professionals' understandings of 'health' could impact on their involvement in a partnership. The illness/treatment-led view of health, held by some professionals in health authorities and PCTs, was said to hinder their involvement in the local healthy school scheme; they could not see the relevance of the scheme's holistic view of health to the health outcomes they wanted to achieve in order to work towards their own organisational aims. And, with the advent of PCTs, there were many more potential partners in health to persuade.

Both at the strategic level and operationally we have failed to engage with the PCT. The relationship between health and education is no better now than it was three years ago. It's something to do with personalities and also the cultures of the two organisations are very different. The PCT's job seems to be to reduce the number of people who are ill and not to create healthy, happy young people. (West Midlands)

The hardest thing has been to engage health partners at a strategic level and to get the support of the Director of Public Health. The health service is still led, and probably always will be, by a treatment-led agenda. We have been able to get support at a higher strategic level within education than within health ... the NHSS was mentioned in the Health Authority HIMP but now we

have to make sure that we are in four PCT HIMPs and of course also in the local authority's Local Development Plan. (South East)

3.4 Financing the Work of Local Programmes

Most local partnership leads indicated that their local programme was more or less working to capacity in recruiting and supporting schools. However, some partnerships had been more able than other to identify financial resources to extend their capacity and build on the commitment and expertise of local professionals. Indeed, in one or two instances, the relevance and commitment of partners was partly measured through the funding they could make available to support the scheme.

The most important factor is that the scheme has been given financial resources. Partnerships were already in place at the emotional level ... but the short-termism in funding is a headache, and this hinders our development of the scheme ... [We] approached health promotion staff first of all but this was ineffective as they had no control over budgets. This meant that the health organisations often were unaware of the scheme and it had a low profile at organisational level. (East England)

We don't believe that the signatories to the partnership are 100 per cent behind us, as there's no money for this but there is for other things. You get excluded from so many things including knowing about bids. And education still say 'You' and 'Us' as opposed to healthy schools and partnerships. (West Midlands).

Some partnerships had been successful in raising funds from, among other sources, the Single Regeneration Budget, the Children's Fund and the Neighbourhood Renewal Fund. However, most of those who spoke about generating funding told of the amount of time it took to do so. A single proposal, for example, could not be submitted to different funding bodies. Even after the effort put into consultation, proposal writing and submission, there was no guarantee that funds would be forthcoming. Chasing funding was often seen to detract from the work itself, that is, recruiting and working with schools.

Money has been important. We have had 50 per cent from the LEA school effectiveness fund and the other 50 per cent we have raised ourselves from SRB and the Children's Fund. (North West)

Lack of finances and people power means we can't do much work on the group plus we can't set things up. This year we have no funding apart from wages so we can't do any projects. We have some money from Neighbourhood Renewal but this means we have to fit into their criteria. We spend a lot of time on the phone to try and get money from people rather than spend time on project work. (London)

3.5 Support from the National Team

On the whole, the national team were said to have productively supported the work of local partnerships.

The national team have been excellent. I have a lot of time for them. Highly professional, easy to get hold of, extremely helpful. I can't praise them enough. (South East)

While there was concern among respondents that the guidance documents produced nationally replicated local efforts, most respondents had found them useful, and said that those they worked with in schools did too. More often than not they were said to help guide local projects and were also valued for another reason; they provided an opportunity for local schemes and schools to showcase their work. This form of recognition was appreciated by those whose work was included, but NHSS materials were felt by one respondent not to encompass as many local schemes as best they might.

I hope the support documents never disappear as they are excellent and the schools find them useful as well. Two of our schools were put into [one of them] and they are delighted that their work has been recognised. (East England)

We have been told our scheme is good [by the national team], but if that were the case why aren't we consulted more? If one of the guidance documents comes out, we are never asked to input. (West Midlands)

A few respondents noted that information from the national team tended to go to a single person within a partnership. It could be argued that, where partnerships were working well, information would be disseminated swiftly within them. But as noted above, partnerships operated more or less effectively at different points in time. Moreover, sending information to one person or another did little to reinforce the principle that health and education professionals had an equal stake in leading the partnership.

Information is circulated to one lead only. This doesn't percolate and doesn't come first hand. Equal partners should be able to access information equally. (North East)

There was further criticism too that the NHSS lacked presence in national policies, guidance and media. On the one hand, this contributed to a sense of distance between a local partnership and members of the national team. On the other hand, it did little to build interest among schools not so far involved in their local scheme.

It feels like [members of the national team] are down there in London. There is little press or media coverage about healthy schools and the Standard does not seem to have a national presence. (Yorkshire & Humber)

The scheme is not widely publicised nationally so if schools are not involved they don't know about it. (North West).

Another respondent took this criticism further in identifying that little had been done at national level to 'join up' initiatives at government departmental level. Particularly useful, and echoing concerns about accessing funds through numerous local sources, would be a single funding stream from which partnerships could draw. Furthermore, claims about the effectiveness of the NHSS made by the national team did not necessarily recognise the range of school improvement initiatives, many of which were rolled out nationally by government departments, and each of which could contribute to improvement in schools and local communities.

A lot of the barriers are at national level; lack of clarity of thinking, or lack of joined up thinking, or the stupidity of the way funding comes to us in so many different streams. The DfES and DH don't always have realistic expectations

... There are also claims for healthy schools that are like saying 'God will come down and cure everything.' The new video that healthy schools has provided nationally is a very good thing and the aims are very clear. But it doesn't take account of all the other people going in and effecting improvement. I don't think it's provable. (South West)

3.6 Involving Young People

Where mentioned, respondents generally acknowledged that they could do more to involve young people more fully, particularly at the strategic level. Nevertheless, there were reported to be some successes in stimulating the development of school councils. How best to make the most of the expertise of young people, either through school councils or other fora, was left somewhat unclear.

With young people we've had a big push on school councils, and we have a big increase in the number of schools, especially primary, which have school councils. (North East)

We work through a person in the local council who is appointed specifically to work with young people and give them a voice ... we don't want to do something different ... almost all schools have a school council, but we haven't looked at ways we would actively encourage young people to be involved in our programme ... we would probably be seen to fall short in involving young people in their action plans in their schools and that does

lead back again to the targeted piece of work we're doing around secondary schools and how they involve young people. (South West)

3.7 Reviewing and Evaluating Progress

Almost every respondent was keen to develop their capacity to evaluate work in schools. At issue, though, was how best to evaluate without overburdening teachers while at the same time addressing what were viewed as harder to measure changes.

The feedback from teachers is that they have been scrutinised to death and they are feeling harassed ... The government seems to see children as products that can be programmed to have specific outcomes at the end of their school career and targets don't necessarily lead to positive outcomes ... the value of the NHSS is that it sees young people in a holistic way and the whole school approach has positive outcomes on less tangible things like pupil and staff morale and mental health. (London)

When asked about what sorts of information could be used to show that change had come about, there was no shortage of suggestions about what could or might be measured at the school and partnership level. Suggestions included: local teenage pregnancy rates; drops in accidents; range of in-school and out-of-school activities and level of pupil participation in them; existence of breakfast clubs; rise or falls in school attendance; attitudes of pupils and staff towards the school; community awareness of healthy schools; reductions in exclusion rates and staff absence rates; percentage of meals with two or more vegetables each day; number of schools with healthy vending machines; number of PCT job descriptions including healthy schools; number of PCTs which fund healthy schools posts; number of playtime incidents requiring contact with PCT; participation of pupils in school life; number of schools that are smoke-free sites; extent to which pupils feel good about themselves; perceptions of pupils about access to support services; levels of physical activity; levels of bullying (and type, such as racist bullying); building of social capital; existence of school council; parents' perceptions of healthy school scheme.

Respondents were aware also that information could be drawn from, among other things, PANDAS, Ofsted reports, local health surveys and pupils' records of achievement.

Such a range of potential indicators reflected the different sorts of activities that schools were putting in place for different reasons; a valued feature of the scheme that

enhanced recruitment but brought with it difficulties when wishing to make comparisons across schools.

... One example is breakfast clubs. Some schools have come up with outcome measures for breakfast clubs but the problem is different schools want to measure different things so you can't compare schools. Some schools are measuring how ready the children are to learn, in another school they're measuring behaviour, another is looking at the nutritional value of the meals at the breakfast club. Therefore, how do you compare them? This is the same with all other issues. (Yorkshire & Humber)

In some partnerships, there was criticism that little had been done to put targets and indicators in place prior to the rolling out of the national scheme. In other areas, much effort had been put into developing locally relevant indicators. Members of one partnership had brought professionals together to draw up a series of indicators that related to guidance from the NHSS. Not only useful for evaluation, these indicators were also helpful during consultation and action planning.

We took the guidance materials from the national healthy schools and turned eight whole-school issues and related themes from this into 11 objectives during a two day multi-agency workshop. On each objective we have come up with about 15 indicators and when we go into schools we use these indicators as prompts and talk to parents, staff and the wider community around all these indicators. So we build a picture of their perceptions and where the school is at in relation to these objectives ... we come up with a plan with targets ... we visit schools regularly on a termly basis and complete a school visit review form and we provide help and support to help them achieve their targets. (South East)

External evaluation instruments had been tried out in other partnerships and were found by some to be useful, to others, wanting. For example, taken together, respondents often came across as being somewhat ambivalent about the Health-Related Behaviour Questionnaire (HRBQ).³ A number of respondents found it a useful tool that helped them measure progress. Others, while wishing they could carry out regular surveys, found the whole process too costly – as were external evaluators from a local higher education institution (HEI). Yet others found the wording of questions not as locally relevant as they might be. Whatever their views, no-one suggested that a survey, on its own, would capture the range and types of changes to which a local healthy school scheme would contribute.

... Recently we've done a trawl of progress reports and case studies and schools have reacted favourably to being able to flag up the good work

³ Findings from an analysis of HRBQ data are reported in Section 6.5.2.

they've done. I think where you can combine monitoring and evaluation with celebration, that's where it's been most successful, as schools feel they're being recognised for their good work ... We have used the HRBQ and last did it three years ago. I have reservations about it, for the cost involved and I would prefer to develop something more locally appropriate. For the kind of information we got from [the HRBQ] I would question the investment. We did talk about bringing in external experts linked to the local university, but we didn't have funds in the end. (East England)

We monitor at different levels. We look at what schools are doing and what their priorities are in their plans. We monitor schools which have been in the scheme for more than two years to see what they've achieved and we see if they've reached the standard on particular issues such as SRE and drugs. We have monitoring forms and visit schools twice a year ... We did a qualitative evaluation in the first year and have used the HRBQ, but we tend to use the HRBQ for secondary schools to see whether schools are offering what students need, so it isn't directly used on healthy schools' work. (London)

Finally, respondents in one or two partnerships suggested that they themselves would appreciate a more systematic way of reviewing their work so as to develop and extend their expertise. They had found the initial accreditation process useful and wished to understand more fully how their current work compared with schemes of a similar nature across the country.

The accreditation process for us was good, but there is no process or re-review or re-accreditation. We would like to benchmark ourselves against programmes of a similar standard/level to see how things are going. (Yorkshire & Humber)

4. REGIONAL COORDINATORS' PERSPECTIVES

The findings from interviews with nine regional coordinators are the focus of this chapter, in particular their perceptions about:

- ♦ The nature of healthy school work
- ♦ Achievements and areas for development, and
- ♦ Reviewing and evaluating the NHSS

All the regional coordinators were experienced in health-related work with young people and had worked for many years in this area prior to taking up their current post. Although one coordinator noted that s/he looked forward to later in the year when s/he would have an extra day a week to contribute to the NHSS, s/he, along with the others, expressed concern that their contract was currently for only one day per week. All noted that, in reality, they contributed more to the programme than they were paid to do.

4.1 The Nature of Healthy School Work

On the whole, coordinators felt that they could explain the concept and aim of the NHSS to others, whether they be in health or education. One noted that,

The concept of healthy schools was much more difficult pre-Standard. The NHSS has firmed up understanding and helped forge greater links with other areas like teenage pregnancy and drugs and links into school health improvement. (RC 1)

Most coordinators indicated, however, that while some potential partners in health and education understood the NHSS as a process of change management, they came across people who could not get beyond health topics and themes, or as one put it, 'chips and skipping'.

Coordinators noted that it was useful to show how the NHSS could contribute to partners' 'delivery on targets', whether these be related to school improvement or NHS modernisation.

Although all coordinators stated that they were working towards the three NHSS aims, just one specifically highlighted a series of regional targets to which s/he worked.

One other noted that while there might be a regional vision among some partners that healthy schools work was a priority, it being included in local policy documents, funding did not appear to match this expressed commitment. For example, while health and housing (a top regional priority) had been provided with £20 million, just £100,000 had been earmarked for healthy schools work (the second priority).

4.2 Achievements and Areas for Development

On the whole, coordinators stated that their main achievements related to being able to develop local support networks, contribute to the accreditation of schools, share best practice, contribute to local policies (such as the Teenage Pregnancy Strategy and local drugs strategies) and develop strategic links. Such links were essential to increase the visibility of the NHSS and to develop a '*coherent and coordinated*' approach to promoting the well-being of pupils.

Specific achievements included developing an '*influential Children and Young People forum*' and getting a substantial sum of private sector money for getting water into schools (and raising the importance of making drinking water accessible to pupils).

Still, there was much left to do. Three coordinators were concerned that they had little time to collate information on progress and support monitoring and evaluation. One local partnership was described as '*... a black hole for information and I have highlighted the need for passage of information to the NHSS national team*'. (RC 3). Another candidly noted the challenges of identifying best practice:

All schemes regionally work very differently. There are real strengths and weaknesses and there has been a lot of lost learning because I have not had the time to collate this. (RC 2)

Furthermore, despite the building of partnerships, the reorganisation of health authorities into primary care trusts (PCTs) had meant that health partners' roles had changed. Some had been 'lost' from a partnership and were now unable to contribute to the strategic development of the NHSS. As one coordinator noted:

The advent of PCTs has created extra work. It would be good to have more advocates who could open doors at regional level to get access to the leaders and other initiatives and also leverage to more funds. (RC 9)

One key contribution to achievements was the support provided by the NHSS national team. As one coordinator stated ‘... *they have their finger on the pulse and the team is accessible*’ (RC4), and another added ‘... *the national team is tremendously supportive and always available. Even the administration team is helpful*’. (RC 6).

Nonetheless, two coordinators were somewhat more critical. One felt that there had been a ‘*loss of understanding*’ between the local and national teams and added:

The NHSS has been developing on a shoestring and even minor changes in organisations would break the scheme. It really is very vulnerable at local level ... The success of local schemes depends too much on the goodwill of the local organisers to go the extra mile and it takes advantage of their dedication. The whole scheme needs to be reinvigorated by more national support and much better funding. I would like a much clearer dialogue and understanding by the national team of our difficulties. (RC2)

One other coordinator, who nonetheless had praised the national team, wanted greater clarification

...of when our responsibility stops and theirs begin. There are issues of job boundaries and knowing when it is appropriate to ask the national team questions. (RC 2)

4.3 Reviewing and Evaluating the NHSS

Coordinators were aware that more evidence was needed to show whether, and how, the NHSS was contributing to change. One noted that it was difficult to identify what specific change could be attributed to NHSS-related activities.

Four coordinators mentioned how some sort of common dataset could be developed, perhaps by drawing on a collection of indicators and using those appropriate to local circumstances. Some coordinators indicated that they already used common targets to focus their activities, such as data about schools with 20 per cent or more pupils eligible for free school meals. Common indicators would help comparisons to be made across areas.

One coordinator felt it to be an ‘*absolute minefield*’ to develop indicators that were acceptable to both health and education partners. Process rather than outcome

indicators might be the most useful, but whichever they were they should be clear. Indicators were needed for both whole-school, and focussed health topics and themes.

However, there were concerns about the purpose of evaluation and the use of data. As one coordinator noted:

There are too many requests for information at short notice, especially from the national team who seem to think that we are all in London and not that we have such intensive involvement at local level ... We also need to make local programmes aware of the usefulness of collecting data. At the moment it is largely seen as paper chasing ... What if we don't achieve a target, what happens? Who knows about it? (RC 3).

5. NATIONAL STAKEHOLDERS' PERSPECTIVES

The findings from interviews carried out with 12 national players are discussed in this chapter. In particular, we report on their views about:

- ♦ Setting up and running the NHSS
- ♦ Expectations of impact, and
- ♦ How best to evaluate the NHSS

5.1 Setting up and Running the NHSS

On the whole, respondents who were involved in either running or assessing NHSS work showed a good understanding of the processes involved in the Standard. Local partnerships between health and education professionals were first set up. They then worked with schools to assist them in establishing a 'whole-school approach' to pupils' personal, social and health-related development via a process of school self-review. If successfully undertaken, and exemplified via a portfolio of evidence, the local partnership accredits the school as a healthy school.

Schools are categorised as being at Level 1, 2 or 3. While there initially appeared to have been some degree of disparity in the definition of each level, these are now laid out as follows in the NHSS document *Confirming Healthy School Achievement* (Health Development Agency, 2003):

Level 1 schools know about and understand the benefits of involvement in the local healthy schools programme through published materials eg via newsletters or briefing events

Level 2 schools know about the local programme and are involved through accessing quality assured training/initiatives/projects related to the healthy schools programme either through the LEA or the health providers or some other agency (...)

Level 3 schools know about the local programme and are involved through accessing training. They will have demonstrated a more intensive level of involvement by having undertaken a process of auditing, target setting and action planning. The impact of activities is assessed through school

monitoring and evaluation with a particular focus on pupils' learning outcomes.

The process of accreditation of local partnerships was seen by some national respondents working on the NHSS to be, at least in part, a means of bringing both health and education professionals into the NHSS. As one of them commented,

Our expectation with the Standard was that it was unrealistic to expect a local partnership to achieve the requirements of the Standard 100 per cent. There was a best-fit model. So the strengths of the local programme would have to outweigh its weaknesses in relation to the judgements of the Standard ... the partnership may have met the Standard, but not fully, there are areas which it needs to develop. This is the action plan that it will now be working on in order to meet those areas of development. Those action plans are monitored. So it's part of an ongoing process. (National respondent 02)

And as another stated,

There was a political imperative to get everybody through ... the Standard itself wasn't devalued. It's about using standards as a vehicle to raise the status of PSHE, citizenship, healthy schools' work and to get people in the right direction. (National respondent 06)

Those national respondents who did not work so directly on the NHSS tended not to speak so fully of work involved in developing the scheme, or the setting up and monitoring of local partnerships. There was some recognition of the consultative process adopted by the NHSS, but concerns remained about the appropriateness of too high a degree of flexibility.

...one of the interesting things and challenges has been the level of flexibility with which people have set this up and the variability of setting it up and that's coming back to haunt us now. So in a way maybe that's how you've got to do it then, to get people engaged. It's been a bit more didactic on the teenage pregnancy side ... quite prescribed ... something more prescriptive might be good to think of for the next phase. (National respondent 01).

Two other respondents suggested that the validation of local partnerships should not be seen as a one-off event, but as an ongoing process. Local programmes, their quality vulnerable to changes in staff, should be re-visited to check their operation. Perhaps it was now timely to have a more rigorous process where, if requirements of the Standard were not met, the local partnership would not be re-accredited.

The assessment programme was excellent. But it happened and then went quiet. There was a loss of emphasis. Local programmes are vulnerable to change of staff. (National respondent 05)

The schemes seem to vary in quality. Some are rigorous and others not. Support is effective in some places and sloppy in others ... we have to have people who fail, we can't have standards that are too flexible ... if you don't meet or keep up the quality then you fail. The meeting of requirements is important. (National respondent 10)

The NHSS was seen to be a 'good vehicle' for both the 'rolling out' of initiatives (such as the teacher PSHE Certification Programme) and the 'delivery' of 'health messages' to schools. It was also seen to have raised the status of PSHE. One respondent suggested that there had been one or two 'inappropriate' initiatives promoted via the NHSS, in particular an initiative on bullying that had not been focused as best it might. Nonetheless, as long as new work related firmly to the NHSS themes, such as a new 'toolkit' on emotional health that was being developed, the NHSS infrastructure was felt to provide a useful way of getting to schools' 'captive audience' of young people.

At its very core it has raised the status of PSHE and citizenship ... It has helped people make sense of a burgeoning series of initiatives. People who have taken it on are saying, 'It's brilliant. It's given us a framework for making sense of things.' It's also helped with dissemination, such as the SRE guidance was disseminated through the NHSS. (National respondent 06)

However, the NHSS was also described not as an intervention but as 'offering leverage', a way to assist in promoting organisational cultures that promote positive health- and education-related patterns of behaviour.

It's [the NHSS] saying, if you get to these points, you get this reward or you get labelled in this way. What we are not doing is giving schools lots of money in order to get them to that point ... It was thought 20 years ago that schools were just a convenient venue to get to kids and in that the purpose of getting to kids was to get them to behave properly, to stop smoking, taking drugs and eating junk food etc. Although there are impressive results from intensive interventions elsewhere ... schools can't arrange intensive interventions and sustain them in the kinds of ways that produce behavioural outcomes ... It's a non-starter ... we realised that schools were organisations ... you get different patterns of behaviour with different forms of school organisation and ethos. (National respondent 04)

There were some concerns that the NHSS was not as fully understood as best it might be by those in schools. On the whole, teachers were said to be more concerned with academic attainment than with the three broad aims of the NHSS. And with 'health' being seen in a narrow way by those in schools, respondents indicated that teachers may not always see the relevance of healthy school schemes to the main business of a school. Furthermore, some schools were said to focus too much on the use of a logo

on their headed notepaper, rather than engaging with health-related projects and activities. A more rigorous examination of PSHE and the contribution of the NHSS was said to be being put in place by Ofsted.

There's not a common vision, not one that's necessarily shared. The majority of teachers are driven by getting results at the expense of broader factors that might help pupils. Attainment is all that matters. They do not understand that health is broader than healthy eating. (National respondent 12)

Some schools see it as a 'standard', something for their headed notepaper, rather than a process. How they perceive 'health' is limited in scope. Good schools and visionaries understand it, others don't ... To some schools it may be seen as a quick-fix solution, and these get written up as case studies ... Ofsted is looking much more closely at PSHE. Inspectors will ask schools if they are involved in the NHSS and what difference it has made. There will be an annual report by the Chief Inspector ... An important feature will be the extent to which pupil opinions are taken into account ... and the measuring of impact via pupils' views. (National respondent 07)

However, it was chiefly among colleagues at the national level that the potential of the NHSS was said not to have been as fully appreciated as it might be. This, it was argued, had implications not only for the national team itself, but also for the sponsors of the NHSS located in government departments. Embedding the NHSS into new national initiatives might not only raise its national and local profile, but could assist local partnerships anticipate new priorities they could address when seeking local funding.

The presentation of the NHSS is flat, splashy PR opportunities are not grasped. There has to be a champion in the NHSS national team, government people need schmoozing ... lots of ringing around is needed, getting on people's agendas. There should be a split between strategic and operational management, perhaps more similar to the Teenage Pregnancy Strategy. (National respondent 11)

What's been lacking, and it could be the fault of the two sponsoring departments, is the long-term vision and the honing of the, I don't like the word, but 'brand'. What is it? If you talk to people outside health and education and you say 'Healthy Schools', they don't really understand the programme. That's the problem. (National respondent 03)

There are a hell of a lot of new initiatives on behaviours and exclusions, race equality and emotional literacy. We need to swiftly feed information about new initiatives to local partnerships so discussions can happen at local level and possibly help with access to funding ... If more is seen to be embedded within government departments, then it's more likely to embed at local level. (National respondent 09)

However, even on the occasions when a national respondent had acted as an advocate for the NHSS (in terms of seeking its inclusion in new government guidance), there had been resistance to such inclusion. The NHSS was perceived, not as an overarching framework through which new health-related issues could be rolled out, but as just one more way that a topic might be covered.

In the first draft of the participation guidance from the DfES they did not include the NHSS 'Giving Pupils a Voice' criteria. When challenged they said, 'Oh, we're tied up for space.' When I say it's going to smack 500 people in the mouth who have been working through the Standard they say, 'Oh, it's just one way of doing it and there are very clear criteria that will help with other work' ... It's like, well, you either want this programme to work and you put in the commitment to make it work or you don't. In which case, stop messing around with everyone's time. (National respondent 06)

To raise the profile of the NHSS, and to assist with its strategic development, some respondents talked about the organisational location of the programme. One respondent argued that, to have easy access to civil servants, the NHSS would be better placed within the DfES. It was felt that those in the HDA, not immediately involved with the NHSS, did not appreciate its importance. However, another respondent valued the programme's distance from the civil service and stated that its current location at the HDA enabled it draw on the views of those with expertise in public health.

The national team need easy access to the civil service and should be located in the Children and Families Directorate ... the problem with it being located at the HDA is that they do not see the NHSS as a gem. (National respondent 11)

It's good to have the NHSS at the HDA as it is one step removed from the civil service. Also, we can have links with Strategic Health Authorities as well as the Government Regional Offices. Also there is lots of expertise at the HDA about piggy-backing initiatives on the back of public health system and there are specialist advisers here about health issues and topics. (National respondent 12)

The NHSS national team was generally praised by national respondents for the way in which the Standard had been implemented across the country. Even so, there were some questions raised as to whether all the publications produced by the national team were fully aligned with priorities and ideas held by government departments.

There is too much stuff coming out from the national team, too many publications, and some of them could be better quality, such as the citizenship guidance. Maybe they should slow down in the development of these and tie

more closely into QCA and Ofsted and DfES views. They really need to follow the government line. (National respondent 10)

Another set of concerns among national respondents related to the evaluation of the NHSS, particularly in relation to the perceived absence of convincing evidence about its impact. In part, this was said to relate to the way the Standard had been set up in the first place. With a focus on schools as organisations, it may have been more useful to have considered setting up standards for young people. Still locally determined, such standards would have focused on change among young people.

I guess that if you were starting all over again you probably wouldn't have a school standard, you would have a young people's health standard. So you would have a teenage pregnancy coordinator, a DAT coordinator and everyone else on board including young people working out what they need to do for young people. (National respondent 06)

Key figures in the national team were described as '*instrumental*' in getting work off the ground and '*tremendous*' in developing new initiatives. While the project team were described as '*fantastic at doing what they do*', this respondent added that greater effort was needed to produce convincing evidence about the impact of the NHSS for senior policy makers.

Those working more directly on the NHSS recognised that this was a potential area for development. Added to the suggestion that support for a national evaluation had been requested some years ago, one respondent noted that civil servants in both the DH and DfES had hitherto lacked clarity about what they wanted from the Standard.

A couple of years ago, with both departments in the room, they were asked 'What do you want from the programme?' and they couldn't articulate it. It was at that time that there was a strong argument for a national evaluation, for an independent evaluation. They wouldn't commit themselves. (National respondent 02)

Another respondent took a pragmatic view about getting the balance right between running with a good idea while ministers were interested, and waiting to put in place an ideal model that might miss out on funding.

There are always things that you take your opportunity with and do it, or you wait and you don't. If you wait nine months while an evaluation is set up, ministers get bored or have forgotten about it. These are the political realities to deal with ... I'm sure the NHSS was a good idea ... We'd always like [there to be evaluation]. But sometimes there's not. That's life. (National respondent 04)

5.2 Expectations of Impact

Respondents indicated that they would expect the NHSS to have an impact on individual schools in relation to each of the three strategic aims: raising pupil achievement, promoting social inclusion and reducing health inequalities. However, emphasising the first of these would be the most likely to encourage headteachers to seek to involve their school in the scheme. As one respondent stated,

A headteacher will say to you, 'What's in it for me?' You have to be very clear about how the Standard articulates with the core business of education in the school. The Standard offers to help pupils to do their best and to perform well and to achieve, not just academically, but through a whole range of different areas. So it's about addressing the needs of pupil's personal and social developments, with a view to helping them to perform well and do their best at school. (National respondent 02)

Another respondent indicated that they would expect the chief impact of the scheme to be in terms of pupil achievement,

...not in terms of GCSEs because a lot of children are not going to get them. But it's in terms of satisfactory, 'I've been through this school and I've come out now and I'm really good at...' whatever it is. And I feel good about myself and this is because my school has been a good place. It's somewhere where I want to go to every day. (National respondent, 01)

There was perceived to have been a change over the last year or so in expectations of the health-related impact of the NHSS. Early on, ministers and civil servants attached to the DH were said to have expected the NHSS to bring about more or less immediate pupil health-related behavioural change. There was now felt to be less pressure to bring about such changes.

I think there has been an improved understanding by DH colleagues about how focussing on education will actually in the longer term contribute to positive health outcomes and health improvement. (National respondent 02)

The problems are not unusual for a new government initiative; there is an unrealistic expectation of impact. Evaluation will always show small gradual changes, such as four or five years down the track for the national curriculum. (National respondent 07)

However, another respondent indicated that there still remained a tension about perceptions of the impact of the NHSS. While agreeing that there had been a change of view among health ministers, there remained concerns about what achievements had come about, particularly in relation to what could be 'evidenced' by the NHSS national team:

...you end up with these discussions at extreme ends. On the one hand a former minister would actually ask the question 'How many fewer kids smoke now as a consequence of the NHSS?' which is not a sensible question to ask of such an initiative. On the other hand we end up with 'We've got a 100 per cent record on achieving partnerships throughout England. And that's it. For me there are an awful lot of steps between those two extremes. (National respondent 04)

Respondents noted that the earlier government target set for April 2002 had been met in that all local education and health partnerships across England had achieved the requirements of the Standard. Consultation had also taken place to ensure that the requirements of the Standard built on existing good practice and engaged with the needs of local practitioners so that they felt a sense of ownership of the scheme.

Another achievement mentioned by a national respondent was said to be through the use of the Standards Fund. Resources were made available via LEAs to maintain and develop the work of local education and health partnerships.

Respondents considered what had been achieved with the £7 million put into the NHSS. This level of resourcing was compared with other initiatives, such as the many tens of millions of pounds being made available for the extended schools programme, or the £50 million allocated to support the literacy and numeracy strategy. One respondent noted that this would make it difficult to isolate the effects of the NHSS on school improvement, although comparisons between Level 1 and Level 3 schools could still be made. Another felt the NHSS ran on a 'very low budget', especially compared to other government programmes, which might have neither the breadth nor depth intended for the NHSS.

In addition, there was some disquiet about the short-term nature of the funding. One national respondent, who had picked up concerns from local partnerships about funding, noted:

I have worries about short-term funding. There is a plea to assessors from local programmes, 'It's too important to rely on short-term funding.' Longer-term funding is needed to build up the programme. (National respondent 05)

5.3 How Best to Evaluate the NHSS

With concerns about the need to identify evidence of whether and how changes have arisen as a result of the NHSS, came comments about how best to evaluate the work associated with the Standard. All respondents indicated that the process should be

more rigorous than anything that had hitherto been put in place, this sentiment being summed up by the following comment:

It's only just come to light since we have been doing this year's planning and we have been trying to recruit those schools with 20 per cent or more of pupils on free school meals ... we don't even have a database of all the schools. How do we know whether there are 8000 schools at Level 3, which is the figure that is used? (National respondent 01)

Although the NHSS national team were said to have spent time developing targets and indicators for evaluation, a usable set of indicators had not yet been agreed. Indeed, one respondent noted, echoing concerns from respondents in schools and local partnerships, that it would be hard to distinguish the effects of the NHSS from other initiatives:

I'm sceptical that we will find evidence of the NHSS leading directly to educational attainment. We've introduced citizenship, we are going to have new pupil participation guidance, there is a whole host of things going on at the same time, a new push on drugs and the updated drugs strategy ... the results are difficult to tease out. (National respondent 03)

One respondent, who stated they were a 'great fan' of school self-assessment 'if done critically', echoed the views of others in stating that a way should be found of distinguishing the achievements of Level 3 schools when compared to those at Level 1 or 2, but added:

The NHSS consists of about £7 million input. It's not a serious intervention but a mechanism for levering extra effect. So disentangling the contribution of the NHSS from other initiatives is a pretty fruitless exercise. [Many tens of millions of pounds] goes into extended schools. That completely swamps any effects. So it would be silly to try too hard to disentangle the effects. But at a global level you might be looking at what are the differences between schools that have reached Level 1 and Level 3 across their range of indicators. (National respondent 04)

A respondent attached to the NHSS national team stated that noticeable and measurable changes should come about after a school has been at Level 3 for 12 months.

In measuring change, one respondent suggested that schools should be supported to become better at identifying intended outcomes (paying regard to money and time put into the work), and then measuring progress according to these outcomes. This rigorous and critical process, supported by the NHSS, could require individual schools to identify and measure change in a number of areas (such as general and

particular pupil skills, information and values) valued by both health and education professionals.

Rather than evaluation activities adding to the amount of paperwork involved in running the scheme, one respondent suggested that much data already collected by schools could contribute to reviewing the success of health-related work within these settings.

It's important to encourage people to identify evidence that is valued by the school system anyway, such as playground incidents. They should use evidence that is collected by the school anyway. We should tap into local indicators rather than identify new outcomes and indicators. This would make the programme more sustainable as it addresses local partners' priorities. (National respondent 05)

All respondents noted the value of evaluation, and indicated that individual schools appreciate the opportunity to compare their own work with schools in similar circumstances. And, central to measures of success, should be whether pupil participation is embedded in the life of the school. Included among such measures should be ones that enable comparisons to be made across schools.

If you are going to call yourself a Level 3 school ... we need something that we can compare across different regions to say, 'What does it mean?' It might just be a couple of indicators, it does not need to be much. But I think if it is to have a longer-term future it does need a bit more rigour. (National respondent 03)

Schools often look to others 'down the road' as it were. It's important to use local newspapers as they often cover local school events. Celebrating successes keeps the school in the public eye. (National respondent 07)

One of the key issues in terms of changes we would expect is that pupil involvement in terms of decision-making is embedded across the school ... there should be school and class councils operating on a democratic basis, not having issues driven by adults. (National respondent 08)

6 THE DEVELOPMENT OF AN INDICATOR SET

As stated earlier, the aim of the quantitative element of the evaluation was to analyse available data sources to determine whether, and to what extent, the NHSS is achieving its strategic aims, and to develop a set of quantitative national outcome indicators which could be used to analyse and monitor the future progress of the NHSS.

In this chapter, a description of the activities undertaken is given, along with a discussion of the findings.

6.1 Agreeing Indicators

The first stage of the quantitative component was to identify a preliminary set of outcome indicators to be ‘tested’ during the course of the evaluation and considered for inclusion in the final indicator set. Initially, the research team received background information relating to the NHSS from key organisations (including the DH, DfES and NHSS team at the HDA) in order to inform the development of the preliminary set of indicators. This included details of suggestions emerging from consultation with local programmes.

After all relevant information had been collated, a draft long list of indicators was produced. During a meeting at the DH in early March, attended by representatives from key organisations, the long list was agreed and finalised (see Appendix I). It was intended that this long list of indicators would be ‘tested’ during the evaluation, in order to select those for which data was readily available, and which discriminated effectively between Level 3 NHSS schools and other schools.

It should be noted that, although the aim of the evaluation was to develop a set of outcome indicators to measure the impact of the NHSS, it is difficult to measure outcomes related directly to health. It is to be hoped that effective health education will lead ultimately to improved health and the reduction of illness, but this is a very long-term prospect. Within the scope of the evaluation, it is unlikely that NHSS activities would have a direct impact on these outcomes. Therefore, we needed to

focus on health-related behaviour, the intermediate step between health promotion activities and impact on health. For example, effective tobacco education could persuade young people not to smoke, which, in turn, could ultimately lead to a reduction in the prevalence of lung cancer.

6.2 Seeking and Obtaining Access to Suitable Data Sources

Once the agreed list of indicators had been finalised, the research team explored data sources available to provide the required data. Detailed information about the data sources deemed suitable for the evaluation, and the indicators they relate to, is included in Appendix II.

Some of the relevant surveys had been undertaken by NFER, although permission was still required from the project sponsors in order to gain access to the data for the purpose of this evaluation. In addition, permission needed to be sought to use data collected by other organisations.

Permission was granted for the following data sources to be analysed:

- ◆ National Pupil Datasets, including value-added performance measures and pupil background data from the Pupil-Level Annual School Census (PLASC)⁴
- ◆ The Office for Standards in Education (Ofsted) school inspection scales
- ◆ Health-Related Behaviour Questionnaire (HRBQ, developed by the Schools Health Education Unit)
- ◆ Office for National Statistics (ONS) Health Statistics (particularly data relating to conceptions)
- ◆ Citizenship Education Longitudinal Study (undertaken by NFER for the DfES)
- ◆ Excellence in Cities evaluation (undertaken by NFER for the DfES)
- ◆ Survey of Smoking, Drinking and Drug Use (undertaken by NFER and the National Centre for Social Research (NatCen) for the DH).

Further details of these datasets is provided in Appendix II.

⁴ PLASC includes pupil-level data such as ethnicity, English as an additional language (EAL), special educational needs (SEN) and eligibility for free school meals (FSM). In order to make valid comparisons between pupils in Level 3 schools and those in other schools, it was necessary to control for a number of background factors, the data for which was available from PLASC.

In addition, permission to use the following data sources was sought, as they were deemed relevant to a number of indicators of interest, although they were not included for the reasons explained:

- ◆ The British Association for the Study of Community Dentistry (BASCD). Data was only available at PCT or Strategic Health Authority level, which does not match LEA boundaries. As the relevant indicators were covered by alternative data sources, this was not pursued.
- ◆ The Health Survey for England (carried out by the National Centre for Social Research, NatCen). Permission was granted for the data to be used, although timescale difficulties faced by NatCen meant that data was unable to be transferred to NFER during the course of the evaluation.
- ◆ The Health Behaviour in School-aged Children study (a World Health Organisation collaborative study - data collection for England coordinated by the Health Development Agency). Data is collected every four years, and we were informed that the most recent data (2001/2) would not be available until the end of 2005, long after the completion of the NHSS evaluation.
- ◆ Sodexo School Meals and Lifestyle Survey. Gaining access proved problematic, and as data for the relevant indicators was available from other sources it was not pursued.
- ◆ Youth Cohort Study. Gaining access proved problematic, and as data for the relevant indicators was available from other sources it was not pursued.

The data sources which were accessed covered almost all of the indicators being ‘tested’ for the evaluation (see Appendix I for a full list). Those which could not be addressed were:

- ◆ age of first sex
- ◆ use of contraception.

However, other indicators categorised under the broad heading of sexual health were explored.

6.3 Producing a Database of Level 3 Schools

In order to analyse the performance of Level 3 schools against other schools and against the indicators, all Level 3 schools had to be flagged on the NFER Schools Database, and matched to the schools which had participated in the surveys relevant to the evaluation. As the NHSS team did not hold a complete list of Level 3 schools, they had to approach all local partnerships for updated information at the outset of the

evaluation, which took a considerable amount of time to collect. Database Production Group (DPG) staff at NFER received the final lists of schools at the beginning of May, when they were able to compile a database of Level 3 schools.

A total of 7,652 Level 3 schools was included in the database. Level 3 schools were fairly evenly spread across the country (38 per cent in the South, 32 per cent in the North and 30 per cent in the Midlands). Level 3 schools were predominately in the lower bands for overall educational performance at key stages 1-4, and the higher bands of FSM eligibility.

It should be borne in mind that across the country, in practice if not in theory, NHSS partnerships tend to operate with different definitions of what it means for a school to be at Level 3; caution therefore needs to be used in interpreting the results of comparisons between Level 3 and other schools.

The information provided on the database included the date at which the school had become Level 3, or the length of time it had had that status (from which DPG staff were able to calculate an approximate start date). It also included an indication of the particular focus chosen for each school's healthy schools work; however, for nearly 40 per cent of the schools represented on the database, this information was missing or unclear. The research team, in consultation with the NHSS team, developed a list of 14 broad categories and attempted to classify the stated focus areas accordingly (see Appendix IV for details), but in some cases it was difficult to do this with a high degree of reliability.

6.4 Analysis

As discussed above, several data sources were analysed for the purpose of the evaluation. For each analysis, all relevant available background factors at pupil and school level were controlled, in order to look for significant⁵ relationships between outcomes of interest and factors related to Level 3 status.

The following variables were defined to investigate the possible impact of Level 3 status:

⁵ Significant in the statistical sense means that the probability of an association occurring by chance is lower than a pre-set value, taken in this report as five per cent unless stated otherwise

- ◆ an indicator of whether or not the school has Level 3 status, regardless of when it achieved this status
- ◆ an indicator to mark the length of time at Level 3.

It was important to include both variables, as they fulfilled different but related functions. If Level 3 schools perform significantly better (or worse) than other schools on a particular outcome, the association is not necessarily causal; it could mean that those schools have something in common (other than belonging to Level 3) which has influenced the outcome.

In order to test whether the difference is due to Level 3 itself, it is important to take into account the length of time individual schools have had that status. Clearly, if a school became Level 3 only in 2002, for example, that could not have influenced the results of a survey undertaken in 2001. Conversely, if Level 3 status was having a positive impact, we would expect the variable denoting length of time to have positive statistical significance; if that is not the case, it is likely that the enhanced performance of Level 3 schools is due to other factors beyond the scope of the analysis.

In cases where two datasets (relating to the same survey conducted in consecutive years) were combined, the following variables were also defined:

- ◆ an indicator to mark the cohort of pupils, depending on the year in which the outcomes were measured
- ◆ an indicator to show if the year-on-year changes were different for Level 3 schools.

The first variable indicates an overall change in outcomes when two sets of data are explored, and the second indicates whether any change is greater or smaller for Level 3 schools.

The main analysis techniques used were linear (or logistic) regression, and multilevel modelling (see glossary of technical terms in Appendix III for full definitions). When dealing with pupil data, multilevel modelling is the preferred method of analysis, as it takes account of the fact that pupils in the same cohort and/or school may have more in common than pupils in different schools. However, multilevel modelling is technically complex and time consuming, and as we were examining a wide range of outcomes on a variety of different datasets, it would not have been feasible to construct a model for every individual outcome.

A two-stage process was therefore adopted, whereby each outcome was first investigated by using linear or logistic regression. This is a simpler and quicker process, but (in comparison with multilevel modelling) may tend to exaggerate the significance of differences identified. Therefore, any factors identified as significant in a regression analysis need to be further explored by multilevel modelling, in order to confirm whether the difference is genuine; on the other hand, if factors do not appear as significant in regression analysis, we can be confident that they are not significant, and no multilevel modelling is necessary.

Thus, the preliminary regression analysis undertaken for every outcome of interest identified those outcomes for which there was a possible effect of NHSS. Those outcomes only were subject to a further analysis by multilevel modelling. In some cases, this confirmed that there was indeed an impact of NHSS (because Level 3 schools were significantly different from others, after controlling for other relevant variables); in other cases, it showed that the difference identified by regression was apparent rather than real. The results reported as significant below are those which have been confirmed by multilevel modelling.

Further details of the analysis undertaken specifically in relation to each data source are given in Section 6.5.

6.5 Analysis of and Key Findings from the Data Sources

This section focuses on the analysis undertaken in relation to each of the data sources used for the evaluation, and a discussion of the findings relevant to each.

6.5.1 National Pupil Datasets

Analysis undertaken

Value-added data was analysed in order to explore the impact of Level 3 status on educational achievement across key stages. The National Pupil Datasets make it possible to explore progress during individual key stages (e.g. key stage 3, by comparing key stage 2 and key stage 3 results) and also across the whole of compulsory secondary education (by comparing key stage 2 and GCSE results). The following datasets were analysed:

- ♦ key stage 1-2
- ♦ key stage 2-3
- ♦ key stage 3-GCSE
- ♦ key stage 2-GCSE

The following background factors were included in the model:

pupil-level

- ♦ prior attainment at the end of the previous key stage in relevant core subjects
- ♦ sex
- ♦ age
- ♦ FSM eligibility
- ♦ ethnicity
- ♦ special educational needs
- ♦ whether the pupil was in the same school at the start of the key stage.

school-level

- ♦ percentage of pupils eligible for free school meals (FSM)
- ♦ school type (e.g. grammar, specialist, Beacon etc)
- ♦ whether or not the school was known to be Level 3
- ♦ whether or not the school was known to be Level 3 prior to the survey.

Data for 2002 and combined 2001-2 was analysed first by linear regression, and then by multilevel modelling, as explained above. Below we report those outcomes where an NHSS impact was detected and confirmed by multilevel modelling.

Key findings: analysis of key stage 1-2 data

Key stage 2 scores obtained in 2002 were analysed for each of the core subjects (mathematics, English and science) as well as average score. Data was available for 564,606 pupils, of whom 197,654 (35 per cent) were in Level 3 schools. Once background factors had been controlled, pupils in Level 3 schools had higher average point scores (in value-added terms) than pupils in other schools. However, Level 3 status achieved later than 2001 could not have had an impact on the 2002 results. And Level 3 status achieved prior to September 2001 was of negative significance for average score and mathematics score (there was no significant difference for science

or English scores). Evidently, therefore, although pupils in Level 3 schools overall achieved better than expected results in value-added terms, the link could not be due to cause and effect.

Key stage 1-2 data was not available for 2001, so a combined analysis could not be undertaken.

Key findings: analysis of key stage 2-3 data

Data for 2002 was available for 509,835 pupils, of whom 190,574 (37 per cent) were in Level 3 schools. Overall average scores were explored, as were scores for the core subjects. Level 3 status was not a significant factor in any outcome.

For 2001/2002 combined data for key stage 2-3, data was available for 952,665 pupils, of whom 356,818 (37 per cent) of pupils were in Level 3 schools. The following findings emerged:

- ♦ for all pupils (Level 3 and non-Level 3), average scores and scores for all core subjects declined from 2001 to 2002, although the decline in overall average score and score for English was slightly smaller for pupils in Level 3 schools
- ♦ pupils in Level 3 schools overall had lower average scores than other pupils, and lower scores for English in value-added terms. There was no additional effect of having been Level 3 long enough to influence results.

It appears, therefore, that the NHSS had no impact on pupil attainment in primary schools.

Key findings: analysis of key stage 3-4 data

Data for 2002 was available for 494,162 pupils, of whom 183,602 (37 per cent) were in Level 3 schools. Analysis of four GCSE outcomes was carried out: the 'Best 8' total point score, total GCSE score, average score and total GCSE entries. The analysis showed that students in Level 3 schools took slightly more GCSEs, although the difference was very small (equivalent to about one twentieth of a GCSE). Level 3 status was not a significant factor in any other outcomes. Furthermore, there were no significant effects of being Level 3 before 2001.

For 2001/2002 combined data for key stage 3-4, data was available for 956,225 pupils, of whom 356,710 (37 per cent) of pupils were in Level 3 schools. Five GCSE

outcomes were investigated (total and average score, English and mathematics, and the number of GCSE entries). The following findings emerged:

- ♦ scores for three GCSE outcomes (total score, average score and mathematics score) declined from 2001 to 2002; this applied equally to Level 3 and other schools
- ♦ students in Level 3 schools as a whole took slightly more GCSEs, but had slightly lower GCSE mathematics scores
- ♦ however, the negative impact of Level 3 on mathematics scores did not apply to students in schools that became Level 3 in 2001 or earlier; their performance was if anything very slightly better than that of pupils in non-Level 3 schools.

There were no other significant differences for Level 3 schools.

Key findings: analysis of key stage 2-4 data

Data for 2002 was available for 478,836 pupils, 178,627 (37 per cent) of whom were in NHSS Level 3 schools. Analysis was carried out on key stage 4 GCSE outcomes (as above), but Level 3 status was not a significant factor in any of them.

For 2001/2002 combined data for key stage 2-4, data was available for 940,899 pupils, of whom 351,736 (37 per cent) of pupils were in Level 3 schools. The following findings emerged:

- ♦ scores for GCSE outcomes (except for the number of GCSE entries) declined from 2001 to 2002; for mathematics scores, the decline was slightly steeper in Level 3 schools
- ♦ Level 3 schools overall performed slightly worse than would be predicted in terms of average GCSE score and mathematics score
- ♦ however, the negative effect on mathematics did not apply to schools that had been Level 3 for some time; their students performed as well as those in non-Level 3 schools.

In summary, there is little evidence of an association between Level 3 and attainment in the core subjects. It must be noted that the differences identified above were very small, and relationships not necessarily causal.

6.5.2 Health-related behaviour questionnaire

Analysis undertaken

The HRBQ, developed by the Schools Health Education Unit (SHEU), provides an evaluation of the current patterns in health-related behaviour of primary and secondary schools, many of which are Level 3 schools. In fact, it is the only pupil-level survey covering the primary age range for which data was available to this evaluation. The survey covers almost all of the long-list indicators related to health inequalities, and one relating to social inclusion, and was therefore considered extremely useful. The relevant indicators are:

Health inequalities indicators

- ♦ drugs
- ♦ healthy eating
- ♦ dental health
- ♦ physical activities
- ♦ leisure pursuits
- ♦ sexual health
- ♦ general sickness

Social inclusion indicator

- ♦ emotional well-being/mental health.

It should be noted that the survey does not cover a nationally representative sample of schools, as individual schools across the country opt to participate. However, for our purposes (i.e. to compare Level 3 and other schools) this was not necessary; the important point is that the sample should include a balanced mix of Level 3 and other schools, and that we could control statistically for other factors which might influence the outcomes.

Primary and secondary HRBQ data was available for 2000, 2001 and 2002, covering 361 schools (of which 227 were Level 3; 63 per cent). The proportion of *pupils* in Level 3 schools is shown in Table 6.1 below.

Table 6.1 The proportion of pupils in Level 3 schools responding to Surveys (2000-2002) the HRBQ

	Total number of pupils who responded to HRBQ survey	Total number of pupils surveyed who were in Level 3 schools	Percentage of pupils surveyed who were in Level 3 schools
Primary	37,008	22,004	59
Secondary	53,549	29,225	55

Primary and secondary school data was analysed separately. The following background factors were included:

Pupil-level

- ♦ sex (boy/girl)
- ♦ age
- ♦ ethnicity.

School-level:

- ♦ percentage eligible for free school meals
- ♦ the school's overall KS2 (primary) or KS3 (secondary) results
- ♦ whether or not the school was known to be Level 3
- ♦ whether or not the school was known to be Level 3 prior to the survey
- ♦ focus of NHSS activity.

The following analysis was carried out with this data source:

- ♦ Comparison of Level 3 schools with other schools in relation to HRBQ **individual outcomes** e.g. healthy eating, general sickness, participation in activities.
- ♦ Exploration of NHSS Focus areas e.g. to investigate whether the focus of NHSS activity has a significant impact on any relevant outcomes (for instance, whether pupils in schools which focus on healthy eating eat more fruit and vegetables than pupils in other schools).
- ♦ **Comparison of total scores.** Given the broad scope of the NHSS, and the fact that schools may choose to emphasise some areas rather than others, it is possible that the impact of the NHSS might not be measurable for any individual outcome, but that Level 3 schools might achieve a higher overall rating on a composite indicator. To test this hypothesis, a number of outcome measures included in the HRBQ survey were used to calculate a total score. The scores of pupils in Level 3 schools were then compared with the scores of pupils in other schools.

- ♦ **Comparison of change in scores over time.** The DH and the NHSS team were particularly interested to know what impact becoming Level 3 had had on the schools concerned. It was therefore necessary to compare the performance of Level 3 schools over time (as well as comparing their performance with that of other schools). For schools which had data available for 2000 and 2002, an average total score was calculated for each year, and the difference between the two scores was compared, in order to see whether Level 3 schools had improved more than others.
- ♦ Exploration of the **differential impact of Level 3 status** on schools with different proportions of pupils eligible for free school meals. It was suggested that the NHSS might be having a greater impact on schools with a higher proportion of FSM pupils. To investigate this, an interaction term (see glossary) was included in the model, which would indicate whether the impact of the NHSS varied according to the proportion of FSM pupils.

The summary of findings below is based on the multilevel modelling analysis of the combined 2000-2002 data. In order to investigate the possible impact of the NHSS, schools which were Level 3 prior to the survey have been compared with other schools. Findings reported are significant at the ten per cent level.⁶

Key findings for primary schools: analysis of individual outcomes

In relation to the analysis of individual outcomes:

- ♦ pupils in schools which were Level 3 prior to the survey were less likely to be afraid of bullying
- ♦ but they were also less likely to eat fruit.

There were no significant differences for the other outcomes.

Key findings for primary schools: analysis of focus areas

There were no significant effects relating to the focus of NHSS activities in primary schools. While this may seem disappointing, it should be borne in mind that schools' choice of focus area may in some cases at least reflect a known area of weakness. For example, a school which recognised that children were eating unhealthy diets might focus on healthy eating. If they started from a low base, the fact that they were still

⁶ As the HRBQ survey appeared to be the most fruitful source of evidence for Level 3 impact, it was decided to look at significance at the ten per cent level. This increases the probability of detecting Level 3 effects, although it also increases the probability that effects detected may be due to chance.

below average in terms of fruit consumption would not necessarily imply that their campaign had failed.

Key findings for primary schools: total score

A total of 12 different outcome measures from the HRBQ primary questionnaire (one numeric and 11 binary⁷) were used to calculate a total score for each pupil (sufficient data was available for approximately 36,000 pupils). The outcomes are listed in Table 6.2 below. The total score was used as the outcome in regression analysis, controlling for pupil background factors, including being in a school which had become a Level 3 school prior to the survey.

Table 6.2 Outcomes included in the primary HRBQ score

Positive outcomes	Negative outcomes
Self-esteem score	Smoked in last week
Regularly eat fresh fruit	Drank alcohol in last week
Regularly eat vegetables	Do not eat breakfast normally
Regular dental check-ups	Dental fillings at last visit to dentist
Brush teeth twice a day or more	Watched TV for more than one hour after school yesterday
Drink water regularly	Afraid of school due to bullying

There was **no significant difference** between the total scores obtained by primary pupils in Level 3 schools, and those obtained by pupils elsewhere. This indicates that the NHSS was not having an impact on primary pupils in terms of health-related behaviour overall.

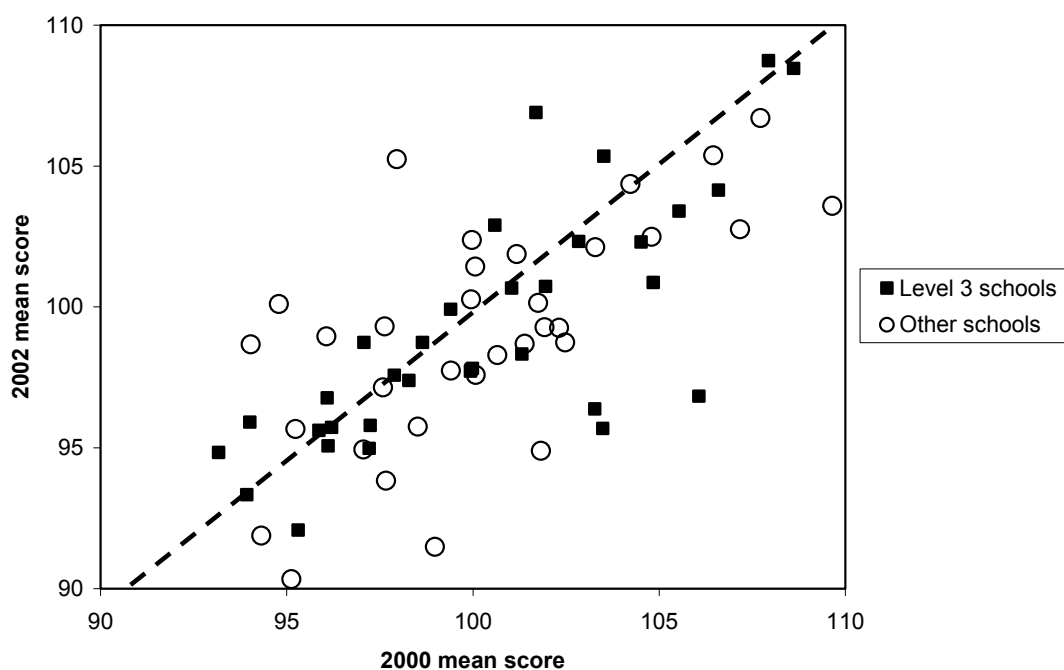
Key findings for primary schools: change in scores over time

Sixty-eight primary schools participated in both the 2000 and 2002 surveys. For each, an average total score was calculated, and change over time was investigated. Figure 6.3 below plots the average scores for 2000 against the average scores for 2002. The black squares represent Level 3 schools, whereas the circles represent other schools.

⁷ A binary outcome is the response to a yes/no question, e.g. did you smoke last week? The only non-binary outcome used in the primary score related to self-esteem, where a score was calculated based on pupil response to a series of statements. This was rescaled to a mean of zero and combined with the binary measures. They were included in the total score as +1 or -1, depending on whether they were felt to be positive or negative indicators of healthy behaviour.

Where symbols appear above the line, it means that the average total score for the schools represented were higher in 2002 than in 2000. As shown in Figure 6.3, some schools (both Level 3 and others) had improved scores, others did not. Level 3 schools were no more likely than other schools to improve their scores between 2000 and 2002.

Figure 6.3 Primary Schools' Average Total Scores in 2000 and 2002



Key findings for primary schools: the impact of the NHSS in relation to eligibility for free school meals

One of the NHSS team's aims is for all schools with more than 20 per cent of pupils eligible for free school meals to reach NHSS Level 3 status by 2006. The Level 3 primary schools included in the above analysis had a higher average percentage of pupils eligible for FSM than the other primary schools (22 per cent compared to 15 per cent eligibility). This suggests that the NHSS is succeeding in its target of reaching schools with high FSM eligibility.

It was suggested by members of the evaluation advisory group that the NHSS might be having a stronger impact on schools with high proportions of pupils eligible for FSM. We were asked to explore this hypothesis, and did so by including in the statistical model an interaction term which would indicate if the impact of the NHSS varied according to level of FSM eligibility. This proved to be the case in relation to some outcomes, but the findings were not always as might be expected.

The analysis revealed that pupils in Level 3 primary schools with higher FSM eligibility were (slightly) more likely to drink water than would otherwise be predicted, but also more likely to smoke cigarettes, drink alcohol and have nothing for breakfast, and less likely to have regular dental checkups and eat vegetables. These findings suggest that, overall, the NHSS has had a greater impact in primary schools with *lower* FSM eligibility, although the differences were very small.

Key findings for secondary schools: individual outcomes

Secondary school pupils who were in schools which were Level 3 prior to the survey:

- ◆ were less likely to have used drugs
- ◆ were more likely to feel at ease when visiting a doctor
- ◆ had higher self-esteem scores
- ◆ were more likely to know where to get free condoms.

There were no other significant findings.

Key findings for secondary schools: analysis of focus areas

The analysis showed that students in Level 3 schools with a focus on physical activity were less likely to watch TV for more than an hour after school.

Key findings for secondary schools: total score

A total of 19 different outcomes (four numeric outcomes and 15 binary) from the secondary questionnaire were used to create a total score for pupils (sufficient data was available for approximately 52,000 pupils). The outcomes included are listed in Table 6.4 below.

Table 6.4 Outcomes included in the secondary HRBQ score

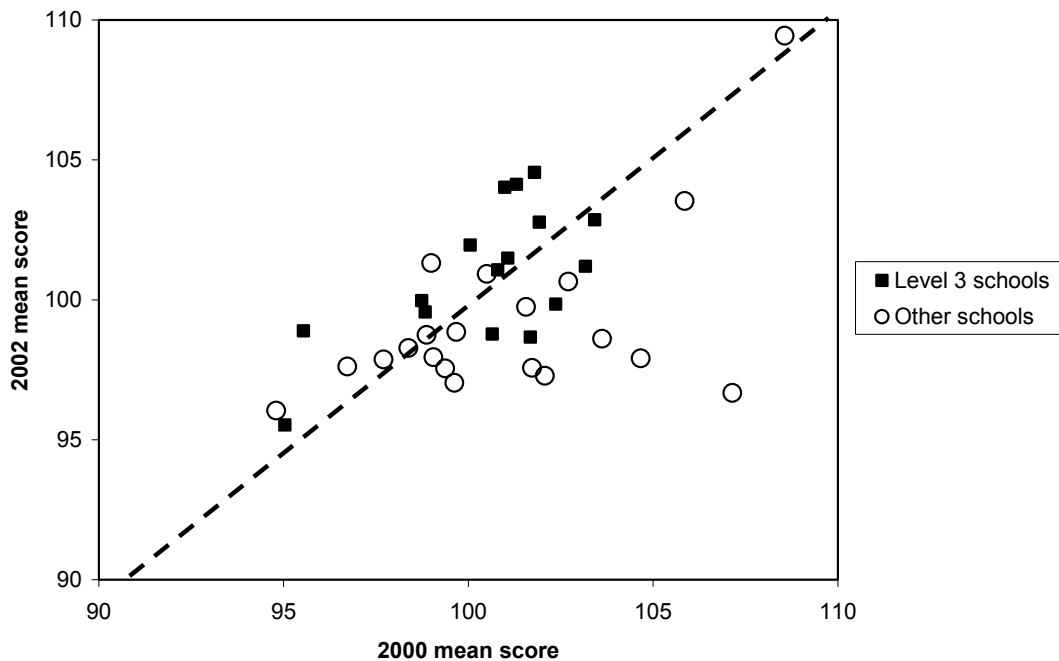
Positive measures	Negative measures
Self-esteem score	Total alcohol units consumed in last week
Number of regular sports or activities	Whether smoked in last week
Number of irregular activities	Drinks alcohol
Regularly eat fresh fruit	Ever offered cannabis
Regularly eat vegetables	Ever offered other drugs
Regular dental check-ups	Ever used drugs
Know where to get free condoms	Dental fillings at last visit to dentist
Feel at ease with the doctor	Watched TV for more than one hour after school yesterday
	Play computer games for more than one hour after school
	Visited doctor in last year
	Afraid of school due to bullying

There was a **significant positive relationship** between the total score and being Level 3 prior to the survey (thus, pupils in secondary schools which were Level 3 prior to the survey scored higher than pupils in other schools). It seems that, for secondary pupils (unlike primary pupils) attendance at a Level 3 school did have an impact on knowledge and behaviour related to health and social inclusion.

Key findings for secondary schools: change in scores over time

The average total score for secondary schools participating in 2000 and 2002 (37 schools) was calculated for each year. Figure 6.5 below plots the average scores for 2000 against the average scores for 2002. Again, the black squares represent Level 3 schools, whereas the circles represent other schools. Where symbols appear above the line, it means that the average total score for the schools represented were higher in 2002 than in 2000. In this case, as shown in Figure 6.5, the majority of black squares are above the line, while a high proportion of the circles are below. This shows that Level 3 secondary schools were more likely than other schools to have **improved scores over time**. It suggests that Level 3 secondary schools (unlike Level 3 primary schools) were having a positive influence on pupils' health-related behaviour.

Figure 6.5 Secondary Schools' Average Total Scores in 2000 and 2002



Key findings for secondary schools: the impact of the NHSS in relation to eligibility for free school meals

Level 3 secondary schools included in the above analysis had a higher average percentage of students eligible for free school meals than other secondary schools, although the difference was not as striking as for primary schools (20 per cent compared with 17 per cent of students eligible).

Students in Level 3 secondary schools with higher FSM were more likely to eat fruit than would otherwise be predicted. However, they were also more likely to have been offered cannabis and to play computer games, and less likely to eat vegetables; they also had lower self-esteem. Again, these findings suggest that the NHSS has had a greater overall impact in schools with *lower* FSM eligibility, although it should be noted that (as with primary schools) the differences were very small.

Summary of HRBQ findings

It is interesting to note that the findings from the analysis of the HRBQ datasets is, overall, very positive for secondary schools and less so for primary schools. There was a significant difference between Level 3 and other schools for only two of the primary outcomes, and one of these was not in a positive direction. There were no significant differences relating to focus areas, total score, or change over time.

With secondary schools, however, there was a significant difference on four individual outcomes, all in a positive direction. Further, students in Level 3 schools with a focus on physical activity were less likely to spend a lot of time watching television. Students in Level 3 schools scored higher on a composite measure of health-related behaviour, and Level 3 schools were more likely to improve their average scores over time.

6.5.3 Previous NFER surveys

As discussed above in Section 6.2, data from three secondary school surveys conducted by NFER was analysed for the purpose of the evaluation of the NHSS. These were:

- ♦ **Excellence in Cities Evaluation:** relevant to health inequalities indicators (participation in sport outside lesson time) and social inclusion indicators (participation in non-curricular activities, attitudes to school and teachers, and truancy).
- ♦ **Survey of Smoking, Drinking and Drug Use:** relevant to health indicators (smoking, being offered and/or using drugs, and drinking alcohol) and social inclusion indicators (truancy and fixed-term exclusions).
- ♦ **Longitudinal Survey of Citizenship Education:** relevant to health inequalities indicators (participation in sport in and out of school and watching television), social inclusion indicators (participation in groups e.g. religious, debating, computer clubs) and raising achievement indicators (aiming to go on to further and/or higher education).

Analysis undertaken

The data gathered from these three surveys was first analysed using linear and logistic regression. Certain differences between Level 3 schools and other schools emerged as significant, and these outcomes were subject to further analysis by multilevel modelling, as explained in Section 6.4.

Background factors included in the analysis were:

Pupil-level

- ♦ sex
- ♦ individual eligibility for free school meals
- ♦ age
- ♦ ethnicity

School-level

- ♦ percentage in the school eligible for free school meals
- ♦ the school's overall key stage 3 results, coded into five groups
- ♦ whether or not the school or not the school was known to be Level 3
- ♦ whether or not the school was known to be Level 3 prior to the survey being carried out
- ♦ focus of NHSS activity.

In the sections below, only findings which multilevel modelling confirmed as significant are reported. We cannot say definitely that there are no other effects, rather that the analysis did not provide any conclusive evidence of their existence.

Key findings: Excellence in Cities

The analysis found that, in schools which were Level 3 prior to the survey:

- ♦ Students in Year 8 were more likely than Year 8 students in other schools to participate in non-curricular activities
- ♦ Students in Year 7 were more likely to have positive attitudes towards teachers
- ♦ Students in Year 9 played truant less often.

There were no significant differences for the other year groups, or for other outcomes.

Key findings: Smoking, Drinking and Drug Use Survey

Findings shown to be significant by the multilevel modelling were as follows:

- ♦ Students in schools which were Level 3 prior to the survey were less likely to have used opiates
- ♦ Students in schools which were Level 3 prior to the survey were more likely to have had fixed-term exclusions, although the difference was small and it is unlikely to be a causal association.

There were no significant effects for other outcomes.

Key findings: Longitudinal Survey of Citizenship

Multilevel modelling revealed no significant differences between schools which were Level 3 prior to the survey and other schools. This is perhaps not surprising, as the questionnaire was completed by Year 7 pupils in the second term after their entry to

secondary school; it may have been too soon for Level 3 schools to have had an impact.

6.5.4 Ofsted Inspection Scales

Analysis undertaken

Data was received from Ofsted based on school inspections carried out during the academic years 1999/2000 to 2002/2003. Usable data was received for 7,666 primary schools (2,518 of which were Level 3; 33 per cent) and 1,402 secondary schools (545 of which were Level 3; 39 per cent).

The Ofsted scales received related to a number of **social inclusion** indicators relevant to the evaluation of the NHSS, in particular emotional well-being, behaviour, participation and attitudes to school. Specifically, the 11 scales used were:⁸

1. Attitudes to school
2. Behaviour including exclusions
3. Personal development and relationships
4. Enthusiasm for school
5. Interest and involvement in activities
6. Behaviour
7. Absence of oppressive behaviour (e.g. bullying)
8. Provision for PHSE
9. Monitoring and promoting good behaviour
10. Monitoring and eliminating oppressive behaviour
11. Monitoring and supporting personal development

It should be noted that these are school-level rather than pupil-level scales, i.e. Ofsted inspectors rate schools rather than individual pupils. It is interesting to compare the outcomes with those from the pupil-level surveys discussed above, and such comparisons are made where relevant. It is also important to note that the Ofsted scales are based on the judgement and discretion of teams of school inspectors, which may vary. Moreover, there is a possibility that if an inspector is aware that a school is Level 3 this might influence the outcomes of the inspection; for example, s/he could assume that Level 3 status means that the school must be good at health education and

⁸ It should be noted that Ofsted scales are ordered with one being the best rating and seven being the worst. If the analysis were carried out using these scales as they stand, then a positive relationship would be indicated by a negative coefficient and vice versa. To avoid confusion, each scale was reversed so that the best rating was six and the worst zero

promotion, and that knowledge could therefore contribute to a positive assessment on some scales.

Analysis was carried out separately for primary and secondary schools, and in each case the following school-level background factors were included in the model:

- ◆ an indicator (on a scale 1-5) of the school's overall performance, as judged by the latest available national curriculum assessment results
- ◆ the percentage of pupils at the school known to be eligible for free school meals
- ◆ the size of the school (number of pupils on roll)
- ◆ an indicator of the year in which the inspection was conducted
- ◆ whether or not the school is currently Level 3
- ◆ whether the school was Level 3 before the inspection was carried out
- ◆ the focus of NHSS school activity.

For the reasons explained in Section 6.4, the key variable to consider was not Level 3 status per se, but whether the schools concerned had achieved Level 3 status prior to the Ofsted inspection which had generated the scales.

The findings from the analysis are discussed below.

Key Findings: Primary school analysis

Table 6.6 summarises the results of the analysis, carried out using multiple regression (see glossary), for the primary schools.

The figures shown in Table 6.6 indicate the 'strength' of the relationship between the given Ofsted scale and each background factor, when all other factors are taken into account (i.e. a positive figure illustrates a positive relationship between the scale and the background factor).

Table 6.6 Analysis of Ofsted Scales (Primary Schools)

	% FSM	Size	Performance	Level 3 before inspection
	%	%	%	%
Attitudes to school	-11	+3	+27	+5
Behaviour including exclusions	-11		+25	+3
Personal development & relationships	-11	+3	+25	+4
Enthusiasm for school	-10		+27	+4
Interest & involvement in activities	-12	+5	+27	+5
Behaviour	-11		+25	+3
Absence of oppressive behaviour	-9		+25	+4
Provision for PHSE			+12	+9
Monitoring & promoting good behaviour	+5	+4	+12	+5
Monitoring & eliminating oppressive behaviour	+4	+3	+15	+6
Monitoring & supporting personal development			+12	

The relationship with FSM eligibility was mostly negative for primary schools overall; as might be expected, schools with higher proportions of FSM pupils had lower ratings on most criteria. However, those with a high percentage of pupils eligible had positive relationships with monitoring and eliminating oppressive behaviour and monitoring and supporting personal development. There was a positive relationship between all 11 scales and performance;⁹ the outcomes were more positive for schools with higher performance. Larger schools had more positive relationships with five of the 11 scales (illustrated in the ‘size’ column).

Allowing for these background factors, the results were extremely encouraging for Level 3 primary schools; there was a significant positive relationship between being a Level 3 school prior to inspection and ten of the 11 scales. The relationship with provision for PSHE was particularly positive (indicated by the figures in Table 6.6).

⁹ Performance is based on an indicator (on a scale of 1-5) of the schools’ overall performance as judged by the latest available national curriculum assessment results.

The only scale where no significant relationship was evident was ‘monitoring and supporting personal development’.

However, it should be noted that these findings were more positive than the outcomes from pupil-level surveys focusing on similar issues (see Section 6.5.2-3).

Key findings: secondary school analysis

Table 6.7 below summarises the results of the Ofsted analysis for secondary schools. In contrast with primary schools, in schools with higher FSM eligibility there were positive relationships with all 11 scales. However, the relationship with size was largely negative (i.e. larger schools had lower ratings). The relationship with school examination performance was much stronger (more positive) than was the case for primary schools.

Allowing for these background factors, the findings regarding Level 3 status were not as impressive as those for primary schools, although there was a positive relationship between being a Level 3 school prior to inspection and five of the 11 scales (indicated by positive figures in Table 6.7). Similarly to the primary findings, the relationship with provision for PSHE was particularly positive. Interestingly, the relationship between being a Level 3 secondary school prior to inspection and monitoring and supporting personal development was equally positive (this was the only scale where no positive relationship existed for primary schools which were Level 3 prior to inspection).

Again, it should be noted that the Ofsted findings were more positive than the results of pupil-level surveys discussed earlier. It is also interesting that Ofsted findings were more positive for primary schools than for secondary, while the HRBQ data provided greater evidence of impact on pupil behaviour in secondary schools (see Section 6.5.2).

Table 6.7 Analysis of Ofsted Scales (Secondary Schools)

	% FSM	Size	Performance	Level 3 before inspection
	%	%	%	%
Attitudes to school	+12	-8	+66	+5
Behaviour including exclusions	+11	-9	+60	
Personal development & relationships	+18	-6	+62	+5
Enthusiasm for school	+12	-10	+67	+5
Interest & involvement in activities	+10		+60	
Behaviour	+10	-9	+59	
Absence of oppressive behaviour	+20	-13	+57	
Provision for PHSE	+13		+16	+10
Monitoring & promoting good behaviour	+23	-7	+42	
Monitoring & eliminating oppressive behaviour	+26	-8	+46	
Monitoring & supporting personal development	+19		+37	+10

6.5.5 ONS Conception Data

Analysis undertaken

Data on teenage conception rates (measured as the number of conceptions by women under 18 per 1000 women aged 15-17) is compiled by the Office for National Statistics (ONS) and publicly available. For our purposes, however, the difficulty is that such data is not available at school level. It is therefore not possible to compare the 'performance' of Level 3 and other schools in terms of teenage conceptions, and it was necessary to make a less direct comparison.

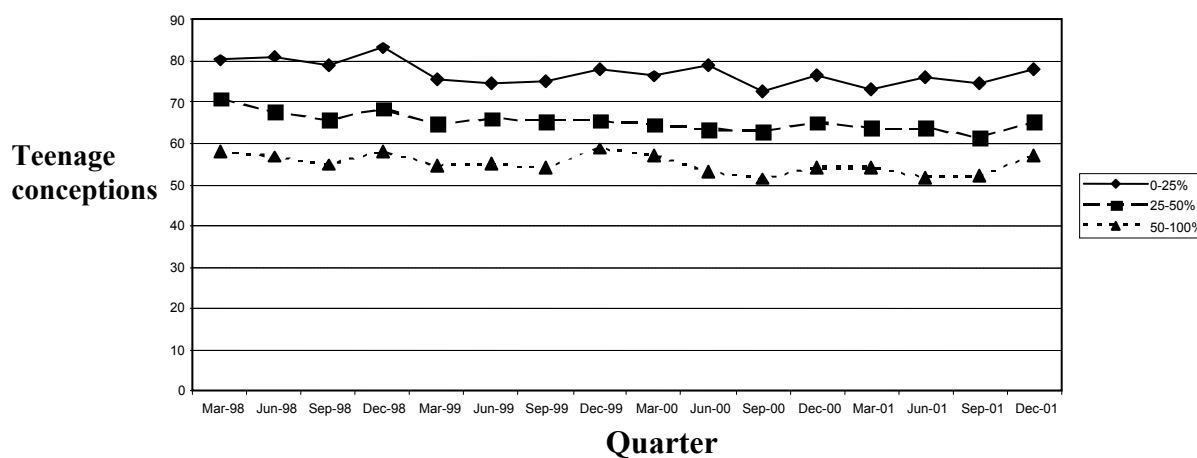
Teenage conception data *is* available at LEA level, and quarterly data from the period 1998-2001 was used for the purpose of the evaluation. As all Level 3 schools were logged on the NFER's Schools Database, the percentage of primary and secondary school pupils in Level 3 schools in each of the 148 LEAs in England and Wales could be calculated. Matching this information to teenage conception data enabled us to

determine whether there was a relationship between teenage conceptions and percentages of pupils in Level 3 schools. If the NHSS was having an impact, then it might be expected that rates in the areas where it was strongest (i.e. where high proportions of pupils were in Level 3 schools) would show a downward trend. The rates would not necessarily be lower in absolute terms, because other factors would be influential. However, if the NHSS was helping to prevent teenage pregnancies, then we would expect to see a steeper downward trend in areas where the NHSS presence was strongest.

Key findings: impact on conceptions

The analysis of ONS teenage conception data showed that there was indeed a strong negative relationship between percentages of pupils in Level 3 schools and conceptions: LEAs with more pupils in Level 3 schools had lower rates of teenage conceptions. Figure 6.8 below shows the relationship between teenage conceptions and the percentage of pupils in Level 3 secondary schools.

Figure 6.8 Teenage Conceptions over Time



Curiously, however, there was a stronger relationship with primary NHSS than with secondary; moreover, there was no evidence of change over time. Therefore, care should be taken with the interpretation of the results. They are unlikely to be caused by the NHSS programme, as if this was the case we would expect a stronger link with secondary rather than primary NHSS, and some evidence of change over time which could be attributed to the impact of the programme.

7. SUMMARY AND RECOMMENDATIONS

In this final chapter, we summarise findings from both strands of the evaluation, and provide recommendations for the future development and monitoring of the NHSS.

7.1 The Implementation of the NHSS

According to most of those with whom we spoke, the NHSS was perceived to be an important programme that had stimulated health-related work in schools, raised its profile and status (particularly in relation to PSHE), encouraged the needs of staff to be addressed, and contributed, at least in some small way, to school improvement.

Pupils we spoke with, while not uncritical, generally appreciated the efforts made to improve the school in ways that would contribute to their emotional, physical and intellectual development. Where it occurred, pupils enjoyed being listened to and having their views taken into account. They highlighted that, where problems were being discussed, confidentiality was paramount.

Both pupils and adults, however, indicated that more could be done to improve the involvement of children and young people in strategic and day-to-day decision-making processes.

Drawing on young people's accounts, a series of potential areas for the development of indicators for use in evaluation were identified. Some of these topics are already covered in questionnaires such as the HRBQ (although new forms of wording may improve their validity); others may require the development of new questions and perhaps even new forms of data collection. Areas perceived by pupils as important included:

- ◆ Cleanliness (not dirty, no litter), of:
 - toilets, playgrounds, playing fields.
- ◆ Safety:
 - safe environments (such as no areas in which bullying takes place, playgrounds with soft surfaces)
 - knowing that adults (and other pupils) are keeping an eye on pupils.

- ◆ Drugs:
 - smoking – whether there are areas at school in which pupils smoke
 - other drugs – whether they are available within school
 - having awareness raised about drugs (rather than being told).

- ◆ Friendliness and approachability:
 - between pupils in general
 - between younger and older pupils
 - between pupils and staff.

- ◆ Having someone to speak with/approach about problems:
 - staff
 - other (trained) pupils
 - school nurse (or other staff in school who is not a teacher)
 - being able to talk in confidence.

- ◆ Relations with the local community:
 - interesting visitors (such as police or other ‘experts’)
 - visits to services that help people (such as old people’s homes).

- ◆ Healthier food and diets:
 - access to (affordable) fruit, salads, drinking water and something instead of chips
 - having a range of foods from which to choose.
 - feeling supported to choose healthy diets

- ◆ Within PSHE (and in school in general):
 - being listened to, being informed rather than being told
 - feeling motivated by being at school, feeling helped while at school
 - being helped to feel confident about oneself
 - pupils working well together.

- ◆ Helping out with/feeling involved in running of school and special events
- ◆ Having access to sporting activities/physical activities
- ◆ Being rewarded for doing things well.

Professionals also suggested a range of areas around which indicators might be developed. They appeared more likely to highlight measures related to the concrete provision of services, whereas pupils appeared more concerned with the quality of social relationships that imbue services. Ideas from professionals in schools and local partnerships included:

- ◆ Measures of and about pupils' physical health and well-being
 - changes in local teenage pregnancy rates
 - drops in accidents
 - number of playground incidents that require contact with PCT
 - levels of physical activity
 - rise and falls in school attendance
 - levels of bullying (and types of bullying)

- ◆ Measures related to pupils' attitudes and emotions
 - extent to which pupils feel good about themselves
 - attitudes of pupils and staff towards the school
 - perceptions of pupils about access to support services
 - parents' perceptions of healthy school schemes

- ◆ Measures related to service provision
 - range of in-and out-of-school activities (and levels of pupils participation in them)
 - existence of breakfast clubs
 - percentages of meals with two or more vegetables
 - numbers of schools with healthy vending machines
 - number of PCT job descriptions that include healthy schools
 - number of PCTs that fund healthy school posts
 - number of schools that are smoke-free sites
 - existence of school council.

The scheme worked well in the minds of respondents for a number of reasons. First, financial resources enabled staff to dedicate time to the work, although most indicated that they contributed more days than that for which they were paid. Second, the collaborative and consultative nature of the scheme enabled professionals from different organisations and with different priorities to agree to take common routes to address health issues with schools. Third, a pro-active local lead drew together local key players and acted as a catalyst and advocate for the work. Fourth, the conceptual framework of local schemes (and the action-planning cycle) enabled schools to draw together and develop existing activities for pupils and staff under an idea of 'health', and allowed them to determine which issues to address further in order to contribute to school improvements. Fifth, the involvement of a school's senior management team was necessary for the work to be given priority in a school. Sixth, disseminating successes among schools that had taken part in local schemes was seen to be useful when recruiting new schools to the scheme.

Other key factors hindered the operation of the programme. Respondents indicated that more effort could be made to position the programme strategically in relation to regional and national initiatives and structures. One key challenge was the restructuring of health services into PCTs and the need to work more fully with Strategic Health Authorities. The reorganisation of children's services (including education) as envisaged in the Green Paper *'Every Child Matters'* will present further challenges and opportunities to the operation of local partnerships. Some discussion also took place about the most appropriate organisational location of the NHSS national team. While opinions differed, the HDA was felt to provide the best prospect of utilising public health expertise while not limiting a sense of ownership among health *and* education professionals.

Taking a whole-school approach was said to be easier in primary and secondary schools. While healthy schools work could both stimulate new activities with pupils as well as bring about new working arrangements among staff, these were said to be harder to develop in secondary schools due to the size of the school and its organisation into departments. Furthermore, some respondents noted that staff in primary schools were often more attuned than those in secondary to addressing pupils' emotional needs and the contribution this could make to children's overall development.

For schools not yet involved with a local programme, some respondents were wary of the level of paperwork involved, or uncertain about what returns they could expect from what were seen to be substantial investments of time and resources in yet another national initiative.

The limited and short-term nature of funding was said to present a challenge to the quality of support that could be provided to schools. Some respondents in local partnerships requested that funding be rationalised wherever possible so that they had fewer funding sources from which they had to draw.

There was some discussion about the quality of written materials produced by the national team. When spoken about, those in local partnerships found them useful, although commented that their development could more fully include examples of good work from a range of partnerships. National respondents were more critical and not only questioned the number of materials, but felt that the issues addressed did not correspond as best they might to advice and guidance from government departments.

Finally, the changes brought about by the scheme were rarely measured and reported in any systematic sense. While respondents were not unwilling to verify outcomes, they often had limited capacity (in terms of funding, knowledge or time) to do so. Furthermore, it was seen as unhelpful to consider separating out the effects of the NHSS from those that might have been brought about by other programmes and activities. Indeed, the value of the NHSS was perceived to be its complementarities with other school improvement initiatives.

7.2 Development of an Indicator Set

A key goal of the evaluation was to develop a set of quantitative national outcome indicators, which could be used to monitor the future progress of the NHSS. In order to do this, a long list of indicators was compiled, and available datasets were analysed to see which of the indicators discriminated effectively between Level 3 schools and others. Of the many possible outcomes investigated, relatively few indicated significant differences, and even these tended to be quite small. This may seem disappointing, but there are three points to bear in mind.

First, it may be unrealistic to expect to find a large measurable impact on pupil attitudes and behaviour (for reasons which are explained in Section 7.3 below). To find any differences at all may therefore be regarded as a success. Second, the analysis undertaken was effectively a baseline measure, as most schools had been Level 3 for a relatively short period of time when the relevant survey was conducted. Even a small difference could therefore indicate an area which is worth monitoring, because it suggests that the NHSS has the potential to make an impact. Third, although the pupil outcomes where differences were detected may appear to be somewhat random, there was a degree of consistency between these findings and the results of Ofsted inspections. This is illustrated in the following summary of significant findings, grouped under the three strategic aims of the NHSS.

Reducing health inequalities

Drugs: The HRBQ secondary data showed that students in Level 3 schools were less likely to have used drugs. Similarly, the smoking, drinking and drug use survey showed that students in Level 3 schools were less likely to have used opiates.

Sexual health: The HRBQ secondary data indicated that students in Level 3 schools were more likely to know where to get free condoms.

Healthy eating: The HRBQ primary data indicated that pupils in Level 3 schools were *less* likely to eat fruit than their peers in other schools, a finding which is not easy to explain.

Promoting social inclusion

Self-esteem: The HRBQ secondary data showed that students in Level 3 schools had higher self-esteem scores.

Behaviour: The Ofsted primary analysis indicated a positive impact of Level 3 on pupil behaviour in general, behaviour including exclusions, and ‘monitoring and promoting good behaviour’.

Truancy: The Excellence in Cities data indicated that Year 9 students in Level 3 schools played truant less often than Year 9 students in other schools.

Bullying: The HRBQ primary data showed that pupils in Level 3 schools were less likely to be afraid of bullying. Consistently, Ofsted reports indicated a positive impact of Level 3 schools on ‘the absence of oppressive behaviour’, and on ‘monitoring and eliminating oppressive behaviour’.

Participation: According to the Ofsted ratings, there was a positive impact of Level 3 primary schools on ‘interest and involvement in activities’. Analysis of Excellence in Cities data showed that Year 8 students in Level 3 schools were more likely than other Year 8 students to participate in non-curricular activities.

Attitudes to school: Ofsted data (both primary and secondary) indicated that Level 3 had an impact on attitudes to school, and enthusiasm for school. Analysis of Excellence in Cities data showed that Year 7 students in Level 3 schools were more likely than other Year 7 students to have positive attitudes towards teachers.

Raising achievement

The analysis of National Pupil Datasets yielded little evidence of an association between Level 3 and attainment in core subjects.

Of the many outcomes investigated, it would appear that those listed above (under ‘Health’ and ‘Social inclusion’) have the greatest potential as indicators to measure

the impact of the NHSS at national level. It is worth noting that the same outcomes emerged as key themes of the qualitative research. Pupils interviewed saw health in terms of both physical and emotional well-being; they spoke about healthy food, but also of after-school clubs, school councils and absence of bullying. It would seem therefore, that the findings of both strands of the research suggest that the areas identified should be reflected in the final indicator set.

7.3 Perspectives on NHSS Outcomes

It was noted that the teachers and local coordinators interviewed as part of the qualitative strand of the research tended to be very positive about the impact of the NHSS. Within the quantitative strand, the strongest evidence of impact was found in the Ofsted reports. Yet evidence of impact in the pupil surveys analysed was relatively hard to find. How can we account for this discrepancy? There are a number of points to bear in mind.

First, the adult interviewees were regional NHSS coordinators, coordinators of local healthy school partnerships, or staff (and parents/governors) attached to Level 3 schools. This means that they were all involved in the NHSS and most (if not all) had a strong commitment to it. It does not mean, of course, that they would invent or exaggerate stories of success. But they would rightly highlight achievements due to the NHSS, even if these affected only a small proportion of the total student body. Such impacts would be ‘diluted’ when outcomes for a whole cohort, or a whole student population, were being explored. For example, if a school sets up a project which directly affects a small number of pupils from each year group, participation may have a dramatic impact on the attitudes and behaviour of those pupils, and this would rightly be regarded as a success. But if a survey of attitudes to school is undertaken, the change in that group of pupils may not be enough to significantly increase the school’s average rating in terms of pupil attitudes.

It is probably for this reason that a similar discrepancy is often observed in the evaluation of national initiatives, even those which are much larger (in terms of scope and funding) than the NHSS. The locally determined nature of the NHSS, perceived as a major strength, presents a further challenge with regard to evaluation. As individual schools are allowed to decide the focus of their Level 3 work, is it reasonable to expect that there will be an overall impact on any single national indicator? This difficulty was acknowledged by schools and local partnerships. Moreover, NHSS work overlaps to a considerable extent with other national and local

initiatives. For example, if children in a Level 3 school start eating more fruit, is that due to the NHSS, or to the fact that the school is piloting the National School Fruit Scheme? If a Level 3 school runs a successful anti-bullying campaign, is that due to the NHSS or to the introduction of citizenship education? Hence no interviewees were able to state with confidence that any changes observed could be attributed to the healthy school scheme in which they were involved. Providing the outcomes were positive, this may not matter, and given the nature of the NHSS it is perhaps inevitable and possibly even desirable – but it does make it difficult to evaluate the impact of the NHSS.

A word needs to be said about Ofsted inspections, since it was noted at the beginning of this section that they provided the strongest evidence of NHSS impact within the quantitative strand of the research. Unlike the teachers and coordinators interviewed, it is reasonable to assume that Ofsted inspectors are not directly involved in the NHSS, nor committed to its success in a particular context. It is possible, however, that their awareness of the school's involvement in the NHSS could have influenced their assessment on related criteria. For example, knowing that a school had achieved Level 3 status might reasonably lead an inspector to infer that they must be doing good work in PSHE, and this knowledge might therefore contribute to a positive assessment. Nevertheless, the importance of the Ofsted evidence should not be underestimated, as it showed that Level 3 schools were ahead of others on an impressive range of criteria (ten out of 11 scales explored for primary schools, and five for secondary).

7.4 Options for Future Monitoring and Evaluation

In the light of the fieldwork and the statistical analysis undertaken as part of this project, what kind of monitoring and evaluation is needed to assess the progress of the NHSS? We must begin by acknowledging that monitoring and evaluation already takes place at a local level, although coordinators were aware that more evidence was needed to show whether, and how, the NHSS was contributing to change. They were keen to develop their expertise in monitoring and evaluation, yet limited in their capacity to do so. Local review processes need to be strengthened and perhaps the national team should include a member with specific expertise in monitoring and evaluation, with a remit to extend and develop the evaluation capacity of those at all levels in the NHSS.

If, however, there is a perceived need to evaluate the *national* impact of the NHSS, new processes would need to be set in place. Although the procedures currently implemented at local level follow a similar pattern, there is no uniform data collection which would be needed in order to analyse the impact of the NHSS at national level. It would not be feasible to rely entirely on the use of secondary data sources, as has this evaluation. Although we were able to find evidence for almost all of the desired indicators, it would not be safe to assume that such data would be available on a regular basis. Some surveys were undertaken in the context of fixed-term projects, which will come to an end in the fairly near future. Other surveys have other limitations; for example, they take place infrequently or they cover only some of the relevant areas. While it might be possible to find a number of surveys which **together** yielded all the required information, they would not be run at the same time, and (for the purpose of regular monitoring) it would be preferable to collect all of the data from schools at the same time.

A new, standard form of data collection would therefore be required. It would be important, however, to ensure that this was integrated with local requirements, and could ideally be used at local as well as national level. Schools and partnerships would not wish to be burdened with additional paperwork to complete, and it would be against the spirit of the NHSS to do so.

With this caveat in mind, we suggest that a national evaluation would require, on a regular basis, a school survey, a pupil survey, or both. What they would comprise, and the advantages and disadvantages of each, are outlined below.

School survey

It was felt by some interviewees that process indicators would be more useful than outcome indicators. A regular (possibly but not necessarily annual) survey of a sample of Level 3 schools would enable an assessment to be made of work carried out and changes which had taken place. The survey could ask questions about provision, and enable the NHSS team to monitor the proportion of Level 3 schools which (for example) had established school councils, provided drinking water and healthy food, ran peer mediation schemes etc.

We assume that the survey would encompass a representative sample of Level 3 schools, since surveying all schools would be expensive and unnecessary. A sample of, say ten per cent of Level 3 schools would be sufficient to provide a picture of

progress, and would mean that (if the survey was undertaken annually) each individual school would be required to participate on average once every ten years. It would be possible to conduct a parallel survey of non-Level 3 schools, which would enable comparisons to be made, but if the object was to assess the development of Level 3 schools year on year, this might not be considered necessary.

The advantage of a school survey is that it would provide the kind of information required, and would be relatively cheap and simple to administer. However, the information which it would provide would be limited, being mainly concerned with process and provision (what do the schools offer pupils?) rather than impact (what effect does this have on the pupils concerned?). The two are clearly related, but not the same. For example, the provision of drinking water would be of limited value if pupils were not provided with the opportunity and the encouragement to access it. The existence of a school council may not impact on pupils' attitude to school unless they perceive it as an exercise in true democracy. If it is considered important to monitor the impact on pupils of the NHSS, it would therefore be necessary to conduct a pupil survey.

Pupil survey

In order to assess the impact of the NHSS on pupils – and thus determine whether it was succeeding in its strategic aims – it would be necessary to carry out a survey of a representative sample of the pupils in Level 3 schools. As with the school survey, it would be possible to conduct a parallel survey of an equivalent sample of pupils in non-Level 3 schools, if it was considered desirable to compare responses and see in what areas, and to what extent, pupils in Level 3 schools differed from their peers in other schools. If the goal was simply to monitor the year-on-year changes in Level 3 schools, this would not be necessary.

The survey could fulfil two distinct though related aims. First, it could ask for pupils' views of relevant features of their schools; if a school survey was also undertaken, it would be interesting to compare the reports of pupils and staff. For example, teachers might report the establishment of a staff council; it would be interesting to assess pupils' awareness and perceptions of its effectiveness. Teachers might report that their school provided a good selection of healthy food in the canteen; it would be interesting to see whether pupils found the range of food attractive.

The second aim would be to ascertain the impact of the NHSS on pupil behaviour (as in other surveys, this would of course be self-reported behaviour, as it would not be

possible to assess actual behaviour directly). As noted above, the provision of after-school clubs, healthy food etc. is of limited value if children do not make use of the opportunities provided. The NHSS team would presumably wish to know whether schools had succeeded, not just in providing healthy eating options (for example) but in establishing a culture where choosing them was seen as a natural thing to do. So the survey could ask children how many clubs they went to, how often they chose salads in preference to chips, and so on. It could also seek to establish the reasons for their behaviour – for example, if they did not choose healthy eating options, was this due to cost, personal preference or peer influence?

In order to explore areas such as self-esteem, it would be necessary to adopt a more indirect approach, asking pupils to agree or disagree with statements about themselves which would enable a self-esteem rating to be calculated. This is a well-established technique, used in many of the surveys from which data was analysed during the course of this project. Of course, in order to identify the impact of the NHSS, it would be necessary to have a baseline against which to compare the findings. As suggested above, this could be either a comparison group of pupils in non-Level 3 schools, or an earlier cohort of pupils in the same schools (or, ideally, both).

In Section 7.2 above, we reported the areas where there was some evidence of difference between pupils in Level 3 schools and others. To recap briefly, these were:

- ♦ use of drugs
- ♦ sexual health (specifically, knowledge of availability of contraception)
- ♦ healthy eating (specifically, consumption of fruit, although this was negative for pupils in Level 3 primary schools)
- ♦ self-esteem
- ♦ behaviour in general, and with specific reference to truancy and exclusion
- ♦ bullying
- ♦ participation in non-curricular activities
- ♦ attitudes to school.

It would in theory be possible to repeat the analysis undertaken in future years, which would avoid the need for fresh data collection, but would rely on surveys being repeated and made available for re-analysis. It would in any case be more effective to have a single survey, with content and respondents chosen specifically for the purpose of assessing the impact of the NHSS. Such a survey should certainly cover the items in the above list, but could also include other areas seen as core to the aims of the

NHSS, where there might be hope or expectation of change, even if this is not evident at present. It could also include areas which were shown by the qualitative work to be central to pupils' concept of a healthy school (clean, safe and available toilets, for example – see Section 7.1 for full list). The survey instrument could be a modular questionnaire, with core sections and options from which schools could select those relating to their focus areas.

A great advantage of such a survey would be that it could provide useful feedback at different levels. It would provide information about the progress of the NHSS nationally; breakdowns could provide similar information at regional level; and feedback could also be provided to individual schools. This would enable schools to compare the views and self-reported behaviour of their pupils against those for the whole sample of pupils and see where they were doing well, and where there was scope for improvement. One disadvantage of such a survey would be the cost.

Moreover, it should be acknowledged, in the light of issues discussed in Section 7.3 above, that the findings might not provide much clear evidence of an NHSS impact. The survey would also involve staff time in administration, although if pupils in only a sample of schools were surveyed each time, the task would not need to be undertaken very often.

It will have been noted that the kind of survey we are suggesting would be similar (in terms of content) to the Health-Related Behaviour Questionnaire (HRBQ) administered annually by the Schools' Health Education Unit (SHEU) at Exeter. This covers many of the topics which an NHSS survey would need to include. The schools surveyed, however, are not a representative sample, but those which buy into the survey, individually or as a group. It would of course be possible for the DH and /or DfES to commission an independent survey totally unrelated to the HRBQ. However, we see two possible problems with this: first, the SHEU might not unreasonably complain of plagiarism if the new instrument proved to be very similar to theirs, and second, certain schools might find themselves in both samples, and would not be keen to administer two very similar questionnaires to their pupils.

We think, therefore, that, if such a survey is to be commissioned, the possibility of an arrangement with SHEU should be considered. This arrangement could take a range of different forms. At one extreme, the HRBQ survey could be extended (at the expense of DH/DfES) to cover a representative sample of schools, providing the SHEU were willing to tailor the questionnaire as required, and had the capacity to

draw an appropriate sample, administer a large-scale survey and undertake the necessary complex analysis to identify the impact of the NHSS. At the other, SHEU could perhaps be paid a fee to use and adapt the questionnaire, and then commission another agency to undertake the survey (with liaison to ensure that the same schools were not included in both samples).

A final point to consider is that such a survey could be very useful for a number of purposes, beyond the immediate aim of assessing the impact of the NHSS. As suggested above, the content would be wide-ranging, covering not just issues directly related to health (e.g. consumption of fruit and water) but broader issues such as self-esteem, behaviour and attitudes to school. We now have (in the National Pupil Datasets) comprehensive data relating to attainment, with pupil-level background data so that value-added analysis can be calculated with a high degree of accuracy. However, there is no comparable national source of attitudinal and behavioural data. Perhaps the DH and DfES should consider jointly funding a periodic survey of a representative sample of schools which would explore these important issues. This could provide useful feedback to participating schools, and would be very valuable for research purposes. It would facilitate national and possibly international comparisons. It could be used to assess the impact of the NHSS and of other initiatives, and the cost would not have to be met from a single budget.

7.5 Recommendations

We give below our recommendations for the further development, monitoring and evaluation of the NHSS.

Perceptions of the impact of the NHSS

Overall, the NHSS was highly valued by most respondents from school, local partnership, regional and national levels. Reports from Ofsted indicated that involvement in a local healthy schools programme often supported other school improvement initiatives. At the national level, the NHSS was seen to provide an infrastructure through which other initiatives could be rolled out to schools. Local partnerships were viewed as valuable forums in which education and health professionals could jointly develop and implement health-related projects and activities. Perceptions of the value of a school's involvement in a local programme were harder to ascertain among pupils. We recommend that:

- ◆ the work of the NHSS continues, provided that the recommendations outlined below are addressed.

Strategic and advocacy issues

Respondents at the national and local partnership level indicated that more could be done to raise the national profile of the NHSS. We recommend that:

- ◆ members of the NHSS national team should further develop their strategic role through:
 - better liaison within and across the DH and DfES to ensure that, wherever possible, the NHSS is embedded within new and ongoing initiatives
 - considering how best to raise the profile of the NHSS through articles and reports in national and specialist media.

Respondents noted that the changing structure of health services was presenting particular challenges in working with PCTs. Furthermore, the changes proposed in the Green Paper *'Every Child Matters'*, suggests that major changes will be made in the local provision of services for young people. We recommend that:

- ◆ the role of Regional Coordinators should be extended to enable them to work strategically with Strategic Health Authorities and Local Government Regions to advocate for the NHSS to be included in local government and PCT planning processes.

Operational issues

Respondents from local partnerships noted that they valued support provided by Regional Coordinators and members of the national team. However, national team members were occasionally viewed as being 'distant' from local partnerships. We recommend that:

- ◆ to enable the national team to work more strategically, and to provide more localised support to partnerships, the role of Regional Coordinators should be enhanced to provide operational support to local partnerships.

Some respondents at the national level expressed concern about the quantity and quality of written resources. When mentioned, respondents from local partnerships valued nationally produced resources, yet wished for greater involvement in their development. We recommend that:

- ♦ prior to the development of further written materials, the national team consult with other national players about whether and what issues should be addressed. Greater consultation should take place with local partnerships to extend the coverage of good practice in materials and not to duplicate locally produced resources.

Participation of young people

Respondents at the school, local partnership, regional and national levels recognised that the involvement and participation of young people as decision-makers could be more fully developed. We recommend that:

- ♦ young people, and their representatives and advocates, are more fully included at all levels of the NHSS. This would include their strategic involvement at national, regional and local partnership level, and their participation at school level
- ♦ monitoring of partnerships should be extended so that young people's strategic involvement is promoted and extended
- ♦ as part of the accreditation process, partnerships should raise their expectations of schools in involving pupils. Lessons from studies into effective pupil participation should be disseminated to those in local partnerships.

Resourcing of the NHSS

Respondents at the local partnership, regional and national level expressed concern about the expectations of the impact of the NHSS held by those in government, given the level of resourcing of the initiative when compared to other programmes. We recommend that:

- ♦ DH and DfES representatives should consider extending the funding of the scheme to:
 - enhance the role of Regional Coordinators
 - provide greater support to local partnerships and schools to be involved in the NHSS
- ♦ consideration be given to providing a single funding stream from which members of local partnerships can draw, and/or enhancing the capacity of local partnerships to enable bids to local funding sources to be made without compromising work with schools.

The organisational location of the national team

National players expressed some concern about the organisational location of the national team. Suggestions were made about moving the team to the DH or the DfES. We recommend that:

- ♦ in order to ensure that the scheme continues to be viewed as a partnership between health and education, it should not move into the DfES, the DH or the Children, Young People and Families Directorate but remain at the HDA or be within an environment in which the interplay between health and education is explicitly addressed.

Monitoring and evaluation

Respondents noted that they were keen to develop their expertise in monitoring and evaluation yet were limited in their capacity so to do. We recommend that:

- ♦ consideration be given to systematically collating and reviewing school-, local- and national-level routinely collected education and health information (such as, healthy school action plans, Local Delivery Plans and Ofsted reports) to generate evidence of whether and how healthy school programmes are contributing to change
- ♦ the national team be extended to include a member with specific expertise in monitoring and evaluation whose remit is to extend and develop the evaluation capacity of those at all levels in the NHSS
- ♦ regional coordinators, in liaison with the national team evaluation expert, extend their role to support the development of evaluation among local partnerships.

Use of national indicators

The analysis of existing datasets showed that a number of key indicators (drawn from the long list agreed by stakeholders) could be used to assess the year-on-year progress of Level 3 schools, and to compare their performance with others. We recommend that:

- ♦ a periodic survey is undertaken of schools and pupils
- ♦ the topics included should cover health-related behaviour and social inclusion (national data is already available to investigate raising achievement)
- ♦ account should be taken of existing surveys in this area, notably HRBQ.

This evaluation has confirmed the potential of the NHSS, and the implementation of these recommendations will we believe help to guide its future development and monitoring.

REFERENCES

ACHESON, D. (1998). *Independent Inquiry into Inequalities in Health Report*. London: The Stationery Office.

GREAT BRITAIN. PARLIAMENT. HOUSE OF COMMONS (1997). *Excellence in Schools* (Cm. 3681). London: The Stationery Office.

GREAT BRITAIN. PARLIAMENT. HOUSE OF COMMONS (1999). *Saving Lives: Our Healthier Nation* (Cm. 4386). London: The Stationery Office.

HEALTH DEVELOPMENT AGENCY (2003). *Confirming Healthy School Achievement* (National Healthy Schools Standard). Wetherby: Health Development Agency.

APPENDIX I: INDICATORS AND DATA SOURCES

In the matrix below, the first column shows the areas which were explored, grouped under the three strategic aims of the NHSS. The second column lists the possible indicators within each area; this list was compiled in consultation with the DH, DfES and the NHSS team at the HDA. The third column shows which data sources contained information relating to each indicator, although we were not able to access all of these (see Section 6.2 for full explanation).

Area	Indicator	Source of data
1. Health Inequalities Drugs	Do you smoke? (Y/N)	1. Drink, Drugs and Smoking Survey 2. HBSC 3. Health Survey for England 4. HRBQ
	Measure of smoking intensity	1. Drink, Drugs and Smoking Survey 2. HBSC 3. Health Survey for England 4. HRBQ
	Do you drink alcohol? (Y/N)	1. Drink, Drugs and Smoking Survey 2. HBSC 3. Health Survey for England 4. HRBQ
	Measure of drinking intensity	1. Drink, Drugs and Smoking Survey 2. HBSC 3. Health Survey for England 4. HRBQ

Area	Indicator	Source of data
	Have you been offered drugs?	1. Drink, Drugs and Smoking Survey
	Use of different types of drugs e.g. solvents	2. Drink, Drugs and Smoking Survey 3. HBSC 4. HRBQ
1. Health Inequalities Healthy Eating	How much water do you drink?	1. HBSC 2. Sodexho
	How often do you eat breakfast?	1. HBSC 2. Sodexho 3. HRBQ
	What do you eat for breakfast?	1. HBSC 2. Sodexho 3. HRBQ
	How much fruit do you eat each day?	1. HBSC 2. Sodexho 3. HRBQ
1. Health Inequalities Dental Health	Dental health care/visits to the dentist	1. BASCD 2. HRBQ
	How often brush teeth	1. HRBQ
1. Health Inequalities Physical Activity	How do you get to/from school?	1. HBSC 2. Sodexho
	How much time do you spend playing sport outside school hours?	1. HBSC 2. Sodexho 3. Citizenship Study 4. HRBQ 5. EIC

Area	Indicator	Source of data
1. Health Inequalities Leisure Pursuits	How much TV do you watch?	1. HBSC 2. Citizenship Study 3. HRBQ
	How long do you spend playing on the computer?	1. HBSC 2. HRBQ 3. Sodexo (asks about computer/TV)
1. Health Inequalities Sexual Health	Number of teenage conceptions (at LEA Level)	1. ONS Health Statistics
	Age first had sex	1. HBSC
	Use of contraception	1. HBSC
	Knowledge of sources of help/advice available if needed	1. HRBQ
1. Health Inequalities General Sickness	Questions on blood pressure, self-assessed general health, longstanding illness and acute sickness	1. Health Survey for England
	Visits to doctors	1. HRBQ
2. Social Inclusion Emotional well-being/mental health	Self esteem indicator	1. HRBQ 2. Citizenship Study
	Experience/fear of different types of bullying	1. HBSC 2. HRBQ 3. Ofsted
2. Social Inclusion Behaviour	Ofsted scales on behaviour	1. Ofsted

Area	Indicator	Source of data
2. Social Inclusion Participation	Pupils' participation and involvement in decision-making e.g. student councils, peer mentoring	1. Citizenship Study 2. EIC 3. Ofsted
2. Social Inclusion Exclusions/Absence Truancy	Permanent exclusions	1. PLASC 2. Drink, Drugs and Smoking Survey
	Fixed term exclusions (suspensions)	1. Drink, Drugs and Smoking Survey
	Truancy	1. Drink, Drugs and Smoking Survey 2. Citizenship Study 3. EIC
2. Social Inclusion Relationships/Attitudes to School	A range of items on how people feel about school e.g. pupil/teacher relationships, environment, recognition of achievements	1. HBSC 2. EIC 3. Citizenship Study 4. Ofsted
3. Raising Achievement Key stage 4	Average/total point score for GCSE/GNVQ results (value added)	1. PLASC/NPD
	Individual subject point score for GCSE results (value added)	1. PLASC/NPD
	Number of GCSEs taken	1. PLASC/NPD
	Pupils leaving with no formal qualifications	1. PLASC/NPD
	Pupils going on to further/higher education	1. Youth Cohort Study 2. EIC

Area	Indicator	Source of data
3. Raising Achievement Key stage 3	Average score for National Curriculum tests	1. PLASC/NPD
	Individual subject scores for NC tests	1. PLASC/NPD
3. Raising Achievement Key stage 2	Average score for National Curriculum tests	1. PLASC/NPD
	Individual subject score for NC tests	1. PLASC/NPD

APPENDIX II: DEFINITIONS OF DATA SOURCES USED

Citizenship Study (Citizenship Education: Longitudinal Study) The overarching aim of the study is to assess the short-term and long-term effects of citizenship education on the knowledge, skills and attitudes of young people aged 11–16. A longitudinal survey is being carried out, which is based on a complete cohort from a sample of 75 schools (approximately 11,250 students). Young people are surveyed following entry to Year 7, and again in Year 9, Year 11 and at age 18. There is also a biennial cross-sectional survey of approximately 2,500 students in each of Years 8, 10 and 12. The surveys are school-based and nationally representative. The evaluation is commissioned by the Department for Education and Skills and is undertaken by NFER.

We were given permission to use the 2002/3 Year 7 data. The surveys are relevant to the following indicators: physical activity, leisure pursuits, self-esteem and further/higher education.

EiC (Excellence in Cities) is an evaluation of the Government initiative which aims to raise educational standards, promote educational partnerships and disseminate good practice. Annual tracking surveys of whole year groups of pupils in Years 7, 8, 9, 10 and 11 in EiC schools are carried out, with follow-up into Year 12. The evaluation is commissioned by the DfES and is carried out by the NFER in collaboration with The Centre for Educational Research (CER) at the London School of Economics (LSE), The Centre for Economic Performance (CEP) at LSE and The Institute for Fiscal Studies (IFS).

We were given permission to use current (2002/3) data. The surveys are relevant to the following indicators: physical activity, participation and further/higher education.

Drink, Drugs and Smoking Survey (*Survey of Smoking, Drinking and Drug Use Among Teenagers*) is an annual survey commissioned by the Department of Health, which is currently carried out by NFER in collaboration with the National Centre for Social Research. The main aim of the survey is to collect data on use and knowledge of, and attitudes towards, smoking, drinking and drugs among young people aged 11 to 15 (12 to 16 in Scotland) in order to inform Government strategies. Data is school based and nationally representative.

Permission was granted for the analysis of 2001 and 2002 data. The survey relates to the following indicators: smoking, alcohol, drugs, exclusions and truancy.

HRBQ (Health-Related Behaviour Questionnaire) was developed by the School Health Education Unit (SHEU), and forms the basis of an annual survey which provides a detailed evaluation of current patterns in health-related behaviour of pupils in primary and secondary schools. The full array of questions provides baseline information on pupils' lifestyles, attitudes and feelings with respect to aspects of citizenship, knowledge and experience of drugs, emotional health and well-being, bullying, dietary patterns, physical activity, safety, and sex and relationships.

Relevant datasets were supplied by SHEU, by arrangement with the DH. The survey relates to most of the indicators of interest.

The National Pupil Datasets include information relating to all individual pupils in English schools. Much of the data is derived from the annual Pupil-Level School Census (PLASC) which all maintained schools are required to complete. This data includes sex, age, ethnicity, special educational needs and FSM eligibility. It also includes details of pupil attainment at the end of each key stage, which makes it possible to carry out a value-added analysis of pupil progress.

We have permission to use current data (2002), and findings based on it are included in this report.

Ofsted (*The Office for Standards in Education*) provides the regular inspection of all 24,000 schools in England which are wholly or mainly state-funded. Inspectors rate schools on a large range of scales, which include ethos, behaviour, attendance, bullying etc. These ratings are recorded on a scale from 1 (best) to 7 (worst) and stored in the Ofsted Numerical Database.

Data from inspections carried out between 1999 and 2003 was supplied by Ofsted. The data is relevant to the following indicators: bullying, behaviour, participation, and attitudes towards school.

ONS Health Statistics include data on conceptions. Numbers and rates by area of usual residence and outcome are available. A report in Health Statistics Quarterly 17 contains provisional estimated numbers and rates of conceptions for women usually resident in England and Wales in 2001.

Quarterly data from the period 1998-2001 was downloaded from the ONS Website and used for the purpose of this evaluation. The data relates to the sexual health indicators on teenage conceptions.

Datasets were matched to the NFER's Schools Database, and Level 3 schools were identified. A summary of the contents of pupil-level datasets is provided in the following table.

Survey	Details of schools involved	Years for which analysis carried out	Total pupils	% in Level 3 schools
National survey on smoking, drinking and drugs	National sample of all secondary schools	2001 and 2002	19,216 (ages 11 to 15)	37%
Longitudinal study on citizenship education	National sample of schools with Year 7 pupils	2002-03	18,583 (Year 7)	43%
Evaluation of Excellence in Cities	All responding schools in EiC areas	2001 and 2002	112,804 (Years 7 to 11)	41%
National pupil datasets KS1-2, KS2-3, KS3-4 and KS2-4	All maintained schools in England	2001 and 2002	KS1-2: 564,606 KS2-3: 952,665 KS3-4: 956,225 KS2-4: 940,899	35% 37% 37% 37%
Health-related behaviour questionnaire (HRBQ)	Individual schools across the country opt to participate (not nationally representative)	2000, 2001 and 2002	Primary: 37,008 Secondary: 53,549	59% 55%

APPENDIX III: GLOSSARY OF TECHNICAL TERMS

Regression analysis (linear)	This is a technique for finding a straight-line relationship which allows us to predict the values of some measure of interest ('dependent variable') given the values of one or more related measures. For example, we may wish to predict schools' GCSE performance given some background factors, such as school size, and percentage of pupils eligible for free school meals (these are sometimes called 'independent variables'). When there are several background factors used, the technique is called multiple linear regression. If just a single background factor is used to predict, we have simple linear regression, and the results may be plotted as a straight line on a graph.
Logistic regression	A form of regression in which the outcome of interest is binary, i.e. just takes two values – for example: passing an exam or not; going into further education or not; achieving 5+ A* to C grades at GCSE etc. A set of background variables can be used to predict the probabilities of the binary outcome, as in conventional regression analysis, but the interpretation of the coefficients is less straightforward.
Multilevel modelling	Multilevel modelling is a recent development of linear <i>regression</i> which takes account of data which is grouped into similar clusters at different levels. For example, individual pupils are grouped into year groups or cohorts, and those cohorts are grouped within schools. There may be more in common between pupils within the same cohort than with other cohorts, and there may be elements of similarity between different cohorts in the same school. Multilevel modelling allows us to take account of this hierarchical structure of the data and produce more accurate predictions, as well as estimates of the differences between pupils, between cohorts, and between schools. (Multilevel modelling is also known as hierarchical linear modelling.)
Statistical significance	We say that there is a statistically significant difference between two groups in some quantity if the probability of that difference arising by chance is less than a preset value (in the analysis reported here, this is taken as five per cent unless otherwise stated). Similarly, we say that there is a significant relationship between two variables if the observed results have a low probability of arising by chance, that is by random fluctuations when the two variables are really unrelated.

Interaction term

It is sometimes the case in regression models that the relationship between one of the variables and the outcome measure is different for different groups – for example the relationship between achievement and prior attainment may be different for boys and girls. This is modelled using an *interaction term*, which takes account of this possibility. If statistically significant, it implies that the strength of the underlying relationship is not the same for all groups.

APPENDIX IV: FOCUS OF ACTIVITY CATEGORIES

The information about Level 3 schools passed to NFER included the area identified by each school as the focus of its NHSS activity. There was a very large number of focus areas, and in order to use this information in the analysis, it was necessary to reduce these to a more manageable number of categories. Fourteen broad categories were identified in consultation with the NHSS national team. Focus areas were then classified into the most appropriate categories, as shown below.

It should be noted that a large number of schools did not provide information about their focus areas, and in some other cases the wording given was not sufficiently clear for a positive identification to be made.

1. Sex and Relationships Education

SRE

Contraception

A PAUSE

Sex

Relationships

2. Safety

Child protection

Health and safety

Sun safety/sun shade

Accidents

First Aid

Road Safety

Cycling safety

Fire safety

3. Careers

Careers

Connexions

4. Environment

Eco schools

Garden/sensory garden

Playground

Quiet area

Toilets

School grounds/grounds
Buildings
Wildlife
Recycling
Litter bins

5. Participation

Decision-making
Pupil participation
Pupil involvement
Pupil voice
Peer mentoring/Buddy/Buddying

6. Drug Education

Smoking
Alcohol
Drinking
Tobacco
Substance
Illegal drugs
Managing incidents
DAT
Drug prevention

7. Emotional well-being

Drop-in centre
Self moderation
Behaviour
Self esteem
Self discipline
Counselling
Bullying/anti-bullying
Mental health
Emotional health
Incidents in playground
Peer mentoring/Buddy/Buddying
Health and well-being
Health and welfare
Playground watch
Circle time
Loss and change
Bereavement and loss

8. Staff well-being

Staff morale
IIP (Investors in People)

Staff development
Staff induction
Staff well-being

9. PSHE

PSE
PSHCE/PSHEC
Health week
Health education
HE

10. Citizenship

Active citizenship
Community
Citizens

11. Healthy eating

Fruit/Fruit scheme
School meals
Breakfast club/ Br Clb
Food and nutrition
Drinking facilities
Water/drinking water
Oral hygiene
Tuck shop
Healthy snacks
Diet

12. Physical activity

Exercise
Sports
Walk to school
PE
Bodyzone
Outdoor activities
Play equipment
Fitness
Walking
Cycling
Healthy routes to school

13 School priorities (unspecified)

14 Local priorities (unspecified)

APPENDIX V: INTERVIEW SCHEDULES

*Thomas Coram Research Unit
Institute of Education, University of London
&
National Foundation for Educational Research*

Evaluation of the Impact of the National Healthy School Standard

Schedule for use with pupils

Two focus groups (about 6-8 in each group)

- For groups, ask for two of the following:
 - a One group of pupils that would be expected to know a lot about their school's healthy school scheme
 - b One group of pupils that would be least expected to know about the school's healthy school scheme
 - c (It would be good if there could be as many pupils on free school meals as possible in both these groups)
 - d If one group is hard to find/interview for one reason or another, then members of school councils would be a good alternative for group (a)
- Checklist (things to find out before talking with pupils)
 - a Info from local co-ordinator about the school
 - b Relevant pages from latest OFSTED report
 - c Names of SMT and person responsible for co-ordinating healthy schools
 - d What areas the school has been addressing and how long it has been at level 3
 - e What staff expect pupils to know about the healthy schools award

Introduction

- We are finding out from pupils and staff about some of the good things and not so good things about this school. We are visiting around 20 schools across England.
- We work at the Institute of Education which is part of the University of London
- We will not report back your views to teachers. We will report what you say in a report to the government, but neither your names nor the name of the school will be mentioned
- No one has to take part, only talk about what you want to talk about, and you can leave at any time
- Is it ok if I use a tape-recorder?
 - If they don't give agreement let them know that you will be writing a lot of notes as they speak.

Introductions – round (2 mins)

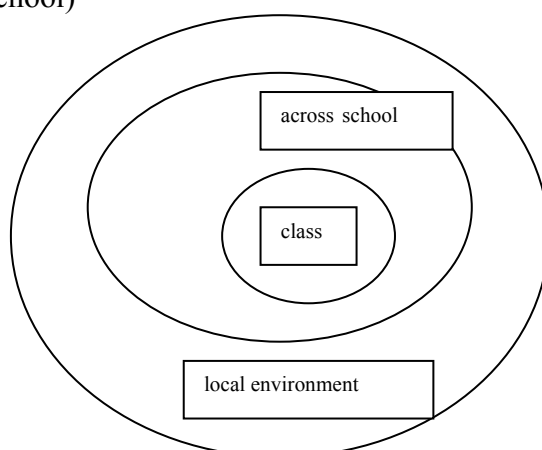
1) Icebreaker

- a) Brainstorm on flipchart about what is health: " Health is....."
- b) In two small groups ask them "What do we mean by a school which is healthy?". Ideas to be written on flipchart paper and then feedback their group work. (This should be given no more than 5 mins)

Note for primary schools: where there might be concerns over ability to write ask them to nominate someone in the group who likes writing. Alternatively, if it is a much younger group you could give them the option to draw a healthy school.

2) Activities being done to make your school a healthier place

- a) We want to look at what is being done in your school to make it a healthier place
- b) On flipchart paper outline the 3 areas of the school and explore:
 - i) What happens in classrooms
 - ii) What happens across the school (ask them to identify the key areas outside the class as this varies from school to school)
 - iii) What happens in the local environment of the school (and also visitors to the school)



Prompts:

Use school specific background information on the themes the school is working on, and specific activities/initiatives/changes.

- c) What do you think about these activities/initiatives?
- d) What difference have they made?
- e) How does it make you feel seeing these changes/being involved in making these changes?

3) The impact of the healthy school work - The Human Line

- a) We'd like you to think about everything you have described to us about work being done to make the school a healthy school. We want to look at how that makes you feel about your school
- b) The following statements are read out in turn. 'True' and 'False' are posted on opposite ends of the room. Pupils are asked to stand up and move to the position on the true/false continuum, and then asked to justify their position.

- c) Where appropriate, probe to make links with what they have said earlier about the various health-related initiatives in the school.

Statements:

- The school is a place where *everyone* is safe (safe from bullying, safe to ask for help when they need it)
- The school is a place where *everyone* is helped to do their best
- The school is a place where *everyone* is helped to be feel good about themselves

(Each of these could be written in large words on cards and the cards turned over one at a time)

Thank them for all their time

Evaluation of the Impact of the National Healthy School Standard

Interview Schedule – Parents

- We are carrying out an evaluation of the National Healthy School Standard (NHSS) to identify its impact on schools
- The National Healthy School Standard has different names in different areas, but each local scheme aims to promote the development of healthy schools.
- The findings from this study will be used to inform the development of the national and local schemes
- We would like to ask you about your views of the scheme/award in which your school is involved
- Any information we receive from you will be reported anonymously.
- The interview will last about 30 minutes
- If it is ok with you, I'll tape record the interview. This will help us check out later the themes and issues you address.
 - *Check that the interviewee agrees to the tape-recording*

Background information

1) Interview information

- a) Name of interviewer
- b) Date

2) Information about the respondent/school

- a) Name
- b) Name of school
- c) Type of school (primary/middle/secondary/special)
- d) Name of healthy school award

Questions

- 3)** First, could you say a little about yourself and your involvement with the school?
- 4)** Could you say a little about the aims of the healthy school scheme/award in this school?

5) What changes have you seen in the school as a result of it being involved in the healthy school standard/award?

Prompt

- a) Changes that were expected and unexpected
- 6) What would you show to others (such as other parents) to convince them that changes have actually come about?
- 7) How would you describe the scheme to other parents?
- 8) Would you recommend that other schools adopt the scheme?
- 9) Any other comments you'd like to make about the school's involvement in the local healthy schools award/scheme?

Thanks

END

Evaluation of the Impact of the National Healthy School Standard

Interview Schedule – School-based professionals

- We are carrying out an evaluation of the National Healthy School Standard (NHSS) to identify its impact.
- The findings from this study will be used to inform the development of the NHSS as well as to produce a set of indicators that can possibly be used for future national evaluations
- We would like to ask you about two key areas:
 - Your perceptions about whether your involvement in your local healthy school has had/begun to have an impact, what sort of impact this might be, and why or how any changes have come about, and
 - Your ideas, comments and suggestions about possible indicators/targets/or outcome measures that you think could be used to verify the impact of your involvement in the healthy school award in the future
- Any information we receive from you will be reported anonymously.
- The interview will last about 20-30 minutes over the ‘phone or about 45 mins face to face
- If it is ok with you, I’ll tape record the interview. This will help us check out later the themes and issues you address.
 - *Check that the interviewee agrees to the tape-recording*

Background information

(Much of this information to be gathered in advance from Ofsted report, NHSS documentation, school prospectus etc)

1) Interview information

- a. Name of interviewer
- b. Date

2) Information about the respondent/School

- c. Name
- d. Name of school
- e. Type of school (primary/middle/secondary/special)
- f. Name of healthy school award

- g. Key themes and issues being covered in relation to healthy schools work
- h. Length of time school has been at level 3
- i. Relevant contextual factors
 - i. Rural/urban
 - ii. Faith based (please state which)
 - iii. Single sex/mixed
 - iv. Size of school
 - v. Other factors – please highlight any that seem important

Interview

3) First, could you say a little about yourself and what you do?

Prompt

- i) How long in this post/role?
- ii) Work related to the healthy school award

4) Why is your school involved in the National Healthy School Standard?

5) Do you find that people (teachers, pupils, governors, parents etc) understand the concept of healthy schools?

a) How would you describe the healthy schools standard/award to people such as pupils, parents, colleagues, governors or other professional?

Prompt:

- i) What do people find useful to know about?

6) What changes have you seen in the school as a result of being involved in the healthy school standard/award?

Prompts:

- a) Changes to the school (ethos, physical environment)
- b) Whether the scheme/award has contributed to whole school improvement
- c) Changes among pupils (particular groups of pupils?)
- d) Changes among staff (leadership, retention and recruitment)

7) What led to these changes?

Prompts:

- a) Interplay between key factors that helped and hindered
 - i) The resources put into the work
 - ii) The processes (who took a lead and who else carried out related work)
 - iii) The coordination of initiatives across the school
 - iv) How it feeds into school improvement (e.g. the school's development plan)
 - v) The extent to which a whole school approach has been taken
 - vi) The context of the school (existing academic, social and physical environment, the nature of the local community and pupils/parents)

8) Were there any changes that were unexpected?

9) What would you show to others to convince them that changes have actually come about?

Prompt:

a) Monitoring and evaluation procedures (especially in relation to assessing, recording and reporting pupil achievements in this area)

10) Are there things related to the healthy school award/scheme that you wanted to achieve but have not yet managed to do so?

Prompts:

a) Why not? (Prompts under 5a might be relevant here)

11) Could you say a little about the involvement of the following people who may have helped or hindered your school developing as a healthy school?

a) Members of the senior management team/governors

b) Staff

c) Pupils

d) Parents

e) Key external professionals (including those in local partnerships/HS programmes and those at national level)

f) Others?

12) We would like to get your suggestions about appropriate indicators/targets/outcome measures to identify whether the local healthy school award/scheme is making an impact in relation to contributing to:

- Reducing health inequalities
- Raising pupil achievement, and
- Promoting social inclusion

a) What indicators would you be happy to be judged against in your school in terms of working towards these aims?

13) Any other comments you'd like to make about being involved in your local healthy schools award/scheme?

Thanks

END

Evaluation of the Impact of the National Healthy School Standard

Interview Schedule – Members of Local Partnerships

- We are carrying out an evaluation of the National Healthy School Standard (NHSS) to identify its impact.
- The findings from this study will be used to inform the development of the NHSS as well as to produce a set of indicators that can possibly be used for future national evaluations
- We would like to ask you about two key areas:
 - Your perceptions about whether your local healthy school scheme/award has had/begun to have an impact, what sort of impact this might be, and why or how any changes have come about
 - Your ideas, comments and suggestions about possible indicators/targets/or outcome measures that you think could be used to verify the impact of the healthy school scheme/award in the future
- Any information we receive from you will be reported anonymously.
- The interview will last about 20-30 minutes over the ‘phone or about 45-60 mins face to face
- If it is ok with you, I’ll tape record the interview. This will help us check out later the themes and issues you address.
 - *Check that the interviewee agrees to the tape-recording*

Background information

1) Interview information

- a. Name of interviewer
- b. Date

2) Information about the respondent

- a. Name
- b. Name of local scheme/award

3) Information about the local partnership

- a. Partnership lead in health or education?

Interview

4) First, could you say a little bit about yourself and what you do?

Prompts

- a. Role in relation to local healthy school scheme/award
- b. Other relevant work

5) What are the things the local partnership ultimately aims to bring about through the local scheme/award?

6) Was there an existing healthy school scheme/award before the National Healthy School Standard was set up?

Prompts

- a. If so, what are the positive (and negative) influences the NHSS has made to work at the local level?

7) Has your involvement in the local scheme/award influenced the way you understand the role of schools in promoting educational and health gain?

Prompt

- a. What are your experiences of helping others to understand the work of healthy schools to other people (at regional, local and school level)?

8) What have been the major achievements of the local scheme?

Prompt

- a. Around 3 key achievements

9) What has led to these achievements?

Prompts

- a. Inputs/financial resources
- b. Ways the partnership has worked
- c. Other things (please say what)

10) In your own view, what has the local partnership been unable to do?

Prompt

- a. Around 3 things
- b. Barriers to preventing these from going ahead

11) What has been your experience of bringing local schools into the scheme/award?

Prompt

- a. Things that have helped and hindered for different types of schools: special & PRUs, infant/primary/junior/middle, secondary.
- b. Have you targeted any particular schools – on what basis?

12) Could you say a little about your local partnership? We're particularly interested in the things that help and hinder in the recruitment and work with local schools.

Prompts

- a. Best balance between those with a background in health or education?
- b. Changes to local partnership over time?
- c. Other issues?

13) Could you say a little about the relationships with other key players? Again, we're particularly interested in things that help and hinder the recruitment and work with local schools

Prompts

- a. With national level players (such as the NHSS national team)
- b. With regional players
- c. Relationships and partnerships with children and young people (to inform work at a regional level)
- d. With staff on other programmes (such as Connexions, Sure Start, Quality Protects, EAZ, HAZ etc)
- e. Other (please say what)

14) Could you say a little about the ways that local priorities are set for healthy schools work?

Prompts

- a. Influence of national, regional and local agendas

15) What have been your experiences in relation to carrying out monitoring and evaluation of the healthy school-related work (both positive and negative)?

Prompts

- a. Experience of any tools/questionnaires (such as Health Related Behaviour Questionnaire)
- b. Experience of support from external experts (such as higher education institution; health and education authority staff)

If any local written evaluation materials have been produced, ask if we could have a copy

16) We would like to get your comments and suggestions about appropriate indicators/targets/outcome measures to identify whether the NHSS is making an impact in relation to contributing to:

- Reducing health inequalities
 - Raising pupil achievement, and
 - Promoting social inclusion
- a. Keeping in mind these three areas, from your own viewpoint as a member of a local partnership, what targets or indicators might best be in place to verify or substantiate the impact of
 1. The achievements of schools?
 2. The contribution of the local partnership to the work in schools?

17) Is there anything about the impact of the local scheme and/or how it has operated at local level that you would like to add?

Thank you

End.

Evaluation of the Impact of the National Healthy School Standard

Interview Schedule – Regional Coordinators

- We are carrying out an evaluation of the National Healthy School Standard (NHSS) to identify its impact.
- The findings from this study will be used to inform the development of the NHSS as well as to produce a set of indicators that can possibly be used for future national evaluations
- We would like to ask you about two key areas:
 - Your perceptions about whether or not the NHSS has made an impact, what sort of impact this might be, and why or how any changes have come about, and
 - Your ideas, comments and suggestions about possible indicators/targets/or outcome measures that you think could be used to verify the impact of the NHSS in the future
- Any information we receive from you will be reported anonymously.
- The interview will last about 20-30 minutes over the ‘phone or about 45 mins face to face
- If it is ok with you, I’ll tape record the interview. This will help us check out later the themes and issues you address.
 - *Check that the interviewee agrees to the tape-recording*

Background information

1) Interview information

- a. Name of interviewer
- b. Date
- c. Place of interview

2) Information about the respondent

- a. Name
- b. Region

3) First, could you say a little about yourself and what you do?

Prompt

- a. Background (health and/or education and/or other)
- b. How long in post as a regional coordinator?
- c. How much time spent doing NHSS regional work?
- d. Other work and links to NHSS activities?

4) How easy (or difficult) is it to explain and get across the concept of ‘healthy schools’ to potential new partners and/or schools?

Prompt:

- a. What do people find useful to know about?

5) Is there a broad vision, or are there strategic aims, that guide(s) you in your work?

Prompt:

- a. To what extent are these shared among colleagues (national, regional and local)

6) Over the last 12 months or so, what have been the major achievements you as a regional coordinator have helped bring about in working towards your vision or aims?

- *Ask if they could list around 3 aspects of their work*
- What evidence could s/he point at to verify or substantiate achievements?
- What led to these highpoints?

Prompts:

- a. Inputs/financial & human resources;
- b. Processes/ways of working/partnerships;
- c. Local factors/context
- d. Involvement of children and young people

7) Again, in relation to working towards a vision or broad aims, what have been the areas that you as a regional coordinator have been unable to develop as fully as you would want?

- *Ask if they could list around 3 aspects of their work*
- What led to these?

Prompts:

- a. Inputs/financial & human resources; processes/ways of working/partnerships; local factors/context
- b. Involvement of children and young people?

8) Could you say a little about your professional relationships and partnerships? We’re particularly interested in the things that support you in your work, and those that hinder you in your work.

Prompts

- a. Relationships and partnerships with national level players
- b. Relationships and partnerships with other regional players
- c. Relationships and partnerships with local partnerships and programmes
- d. Relationships and partnerships with children and young people (to inform work at a regional level)
- e. Relationships at the international level

- 9) We would like to get your comments and suggestions about appropriate indicators/targets/outcome measures to identify whether the NHSS is making an impact in relation to contributing to:
- Reducing health inequalities
 - Raising pupil achievement, and
 - Promoting social inclusion
 - Keeping in mind these three areas, from your own viewpoint as a regional coordinator what targets or indicators might best be in place to verify or substantiate the impact of:
 - a. Your own work as a regional coordinator
 - b. Those working at the national level
 - c. Those working in local programmes/partnerships
 - d. Those in schools
 - *If any written materials have been produced about this, ask if we could have a copy*
- 10) In our next round of interviews, we are keen to work with some local programmes. Are you able to guide us on one or more local programmes that are:
- Typical for the region
 - Working exceptionally well
 - Having difficulties or facing special challenges
 - *Ask for details of these*
- 11) In terms of exploring the possible impact of the NHSS at the regional level, is there anything else you think or feel has been missed out?

Thank you

END

Evaluation of the Impact of the National Healthy School Standard

Interview Schedule – Key National Players

- We are carrying out an evaluation of the National Healthy School Standard (NHSS) to identify its impact.
 - The findings from this study will be used to inform the development of the NHSS as well as to produce a set of indicators that can possibly be used for future national evaluations
 - We would like to ask you about two key areas:
 - Your perceptions about whether or not the NHSS is beginning to/has made an impact, what sort of impact this might be, and why or how any changes have come about, and
 - Your ideas, comments and suggestions about possible indicators/targets/or outcome measures that you think could be used to verify the impact of the NHSS in the future
 - Any information we receive from you will be reported anonymously.
- The interview will last about 20-30 minutes over the ‘phone or about 45 – 60 minutes face to face
- If it is ok with you, I’ll tape record the interview. This will help us check out later the themes and issues you address.
 - *Check that the interviewee agrees to the tape-recording*

Background information

1) Interview information

- a. Name of interviewer
- b. Date

2) Information about the respondent

- a. Name
- b. Title and place of work

3) First, could you say a little about yourself and what you do?

Prompt

- a. Background (health and/or education and/or other)
- b. How long worked with NHSS?
- c. How much time spent in NHSS related work?
- d. Other work and links to NHSS activities?

- 4) In your view, is there a broad vision that guides the NHSS?
- Prompts**
- a. What is it? How does it influence what people do?
 - b. To what extent is the vision shared among colleagues (national, regional and local)?
- 5) We would like to get your views about the successes and areas of development of the NHSS
- a. From your own perspective, could you identify any key successes?
- Prompts**
- i. Impact on perceptions of need for healthy schools work; impact at national, regional, local and school levels
 - ii. Impacts on health, education and other areas?
 - iii. Unanticipated benefits/successes?
- b. What factors have helped and hindered?
- Prompts:**
- iv. Departmental support; coherence/'joined up-ness' of strategies and activities at national, regional, local and school levels
 - v. Key people and individuals who have made a difference
 - vi. Other things?
- 6) What, would you say, are the key weaknesses and/or areas of development for the NHSS?
- Prompts**
- a. What led to these weaknesses/areas for development?
 - b. Any unanticipated weaknesses/challenges/areas of development?
- 7) Are there particularly important criticisms or concerns about the impact or processes of the NHSS that we (as an evaluation team) would do well to be aware of?
- Prompts:**
- a. Uncertainties about/resistance to, the whole 'healthy school' approach
 - b. Criticisms or uncertainties from senior and/or influential national figures (such as government ministers; heads of professional associations or voluntary organisations).
- 8) Given your role in relation to the NHSS, what sorts of information (or evidence or findings) would you find most useful and relevant to inform or persuade others about the achievements (or otherwise) of the Standard?
- 9) In your view, what are the key steps or directions that those associated with the NHSS should now take to maximise its impact?
- Prompt**
- a. Role of key players at national, regional, local and school levels
- 10) Are there any other aspects of the NHSS you think it important to highlight?

Thank you

End