Time for change? Personal, social and health education

At a time of considerable change for personal, social and health education (PSHE), this report evaluates the current provision: whether it is based sufficiently closely on the needs of young people and how the outcomes might be best achieved. It considers the pressures that children and young people face as they mature and discusses the significant role played by most parents in advising and supporting their children. Schools and PSHE programmes in particular, have a major part to play in the personal and social development of young people.

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Executive summary

This is a time of considerable change for personal, social and health education (PSHE): national developments are likely to extend its role in the curriculum. The guidance on Every Child Matters and revised standards for the National Healthy Schools Programme have helped to confirm the subject's importance. PSHE consists of the planned learning opportunities a school provides in order to promote the personal and social development of its pupils. It includes aspects of health education, including sex and relationships education and drug education, education for sustainable development, careers education and guidance, economic and financial awareness and parenting.

This report evaluates the current PSHE curriculum: whether it is based sufficiently closely on the needs of young people and how the outcomes might be best achieved. It draws on evidence from surveys of PSHE by Her Majesty's Inspectors (HMI) and whole-school inspection reports from the period 2001–06. It also refers to earlier reports which remain relevant. In preparing this report, Ofsted commissioned the Schools Health Education Unit, Exeter, to provide research evidence from its behavioural surveys.

The report considers some of the pressures that children and young people face as they mature. It indicates the significant role played by most parents in advising and supporting their children, but it also recognises that some pupils say they do not get the support they would like from their parents. Schools, therefore, have a major part to play.

In the last five years, the quality of PSHE programmes in schools has improved steadily. Effective PSHE ensures that pupils develop their knowledge and skills, and have opportunities to reflect on their attitudes and values. Aspects of PSHE frequently attract national attention and, occasionally, controversy.

It is important that sufficient time is allocated to PSHE and that good use is made of it. Too many schools do not base their PSHE curriculum sufficiently on the pupils' assessed needs. The area recruits few teachers with directly relevant qualifications to teach PSHE. Three quarters of secondary schools have developed specialist teams of teachers to teach it successfully. However, PSHE is taught by non-specialists in some schools and too much of this teaching is unsatisfactory. Assessment continues to be the weakest aspect of teaching.

The framework for the inspection of schools has prompted schools to realise that they know a great deal about the quality of their provision for pupils; however, they are less knowledgeable about its impact. Many schools focus narrowly on assessing pupils' knowledge rather than determining the impact of their PSHE provision on improving pupils' attitudes and skills. Schools have, therefore, become aware of the need to improve assessment and have drawn on advice from the Qualifications and

Curriculum Authority (QCA).[1] Even so, many schools do not know about this advice and have not yet taken steps to improve assessment.

The revised standards for the National Healthy Schools Programme (NHSP) have raised senior leadership teams' awareness of the importance of strong PSHE provision. The standards require participating schools, through a whole-school approach, to tackle the four themes of the programme – healthy eating, physical activity, emotional health and well-being – that lead to 'healthy school' status.

A school's PSHE programme has a major part to play in developing young people's knowledge, understanding and values, and in preparing them effectively for opportunities, responsibilities and experiences. The report evaluates the extent to which schools have succeeded.

Key findings

- Pupils' knowledge and understanding of PSHE have improved over the last five years. Primary schools have been particularly successful in defining achievement in PSHE more broadly to include pupils' attitudes and behaviour.
- The quality of teaching and learning has improved. In secondary schools, teaching by specialist teachers is better than that of non-specialist form tutors. Poor lesson planning contributes substantially to the unsatisfactory teaching. Assessment remains the weakest aspect of teaching.
- Although considerable progress has been made in reviewing and developing the curriculum for PSHE, pupils' needs have not always been identified clearly enough. Publication of the revised standards for the National Healthy Schools Programme has stimulated improvements in planning and provision.
- Transition arrangements between many primary and secondary schools are weak.
- Leadership and management of PSHE are good in nine in ten schools, although monitoring and evaluation remain the weakest aspects.
- Some school communities and their pupils are served effectively by local drop-in centres that provide advice for young people. Although progress towards establishing such centres more widely has been slow, the establishment of extended schools which provide a range of services are beginning to meet these needs.
- Young people report that many parents and teachers are not very good at talking to them about sensitive issues, such as sexuality. Teachers, governors

[1] *PSHE at key stages 1–4: guidance on assessment, recording and reporting* (QCA/05/2183), QCA, 2005.

and parents have not received sufficient guidance and support to deal successfully with these aspects.

- ❒ Action has yet to be taken nationally on some of the recommendations made in Ofsted's previous reports on PSHE.

Recommendations

The Department for Education and Skills (DfES) with the Department of Health (DoH) should provide further guidance for schools to use with teachers, parents and governors on dealing with sensitive issues within the PSHE curriculum.

Schools should:

- involve pupils in:
  - considering how the PSHE curriculum might meet their needs best
  - determining what the outcomes should be and how these should be achieved
  - improve the assessment of pupils' progress in PSHE by evaluating changes in attitudes and the extent to which pupils are developing relevant skills
- report annually to the governing body on the monitoring and evaluation of PSHE
- improve the monitoring and evaluation of the quality of PSHE provision
- ensure that work at Key Stage 3 takes sufficient account of pupils' learning at Key Stage 2
- develop constructive links with a range of support services through drop-in centres or extended school provision, in order to respond appropriately to the personal needs of pupils and their families.

Pupils under pressure

1. Young people live in a world far removed from that which their parents experienced in their teens. Conversations with pupils during inspections gave insights into what they wanted from adults:

   - not to be treated as small adults too early
   - support and encouragement from parents and other members of the family to help them meet challenges
   - help from schools to understand and respond to changes in their lives.

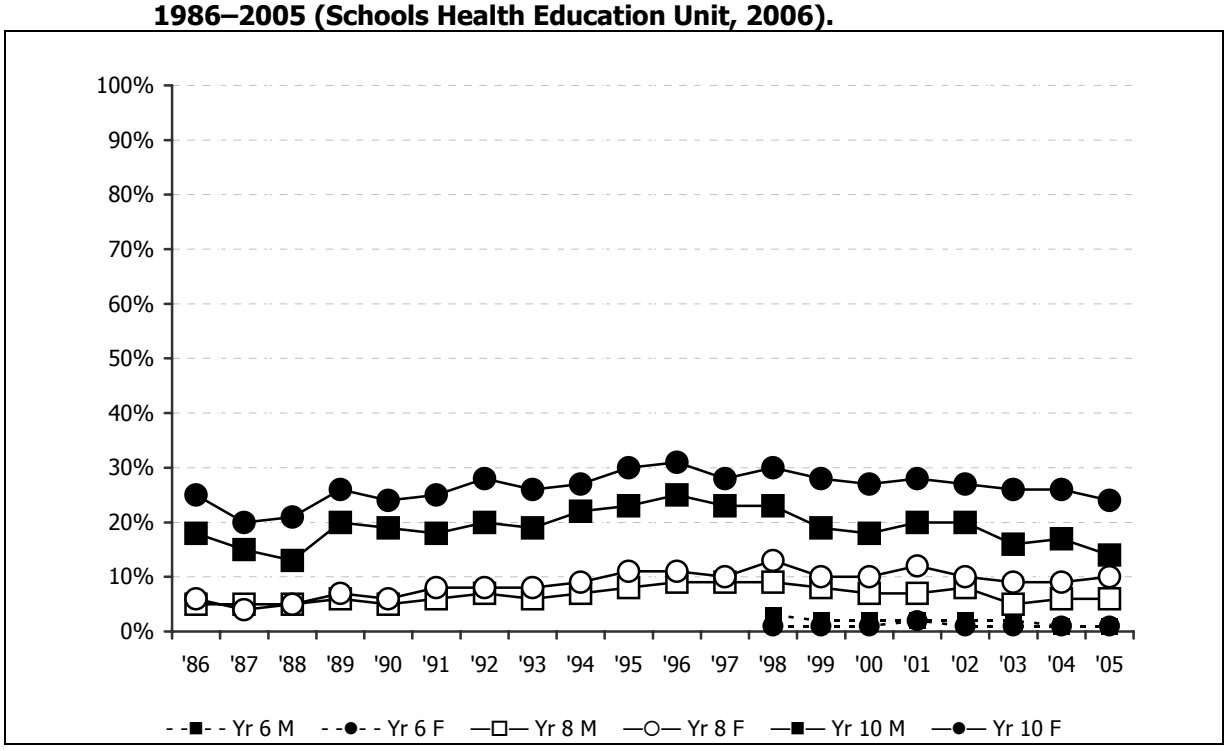
2. Schools have a major influence on their lives. At times, it is the school rather than the home that provides the moral code and, in its absence in the home, some children are put under additional pressures. In nearly all schools, the PSHE programme is the vehicle for tackling many of these pressures. For example, pupils generally have a good understanding of drugs and their effects,

although the skills needed to resist peer pressure are less well developed. In primary schools, role play and 'circle time' activities are often used effectively to counter the potential impact of peer pressure on pupils' behaviour. Pupils in secondary schools, however, have not always had the opportunity to explore and to be challenged about their values and attitudes towards drugs.

3. Despite the good attempts some schools make to discuss drugs, a lack of understanding of pupils' needs remains a problem. For example, many adults are concerned about young people's involvement with illegal drugs, but the overwhelming majority of young people identify correctly that tobacco and alcohol are, in fact, the greatest drug-related dangers.

4. Evidence from surveys by the Schools Health Education Unit shows the pattern of behaviour of young people in relation to drugs and alcohol. Figure 1 shows the percentages of young people, over the last two decades, who reported smoking any cigarettes in the previous week.

Figure 1: The percentages of young people smoking any cigarettes in the previous week, 1986–2005 (Schools Health Education Unit, 2006).



5. Smoking is probably the best researched area of health education, yet, as Figure 1 shows, it remains an intractable problem. Since the middle 1990s, there has been some decline in smoking, especially among boys, but the data on girls' smoking habits are a concern. Girls are susceptible to various perceived attractions of smoking but, in particular, they are more affected than boys by others at home who smoke.

6. Figures 2 and 3 show, more positively, the percentages of pupils who have

never smoked and those who wish to give up smoking.

Figure 2: The percentages of pupils who have never smoked, 1985–2005 (Schools Health Education Unit, 2006).

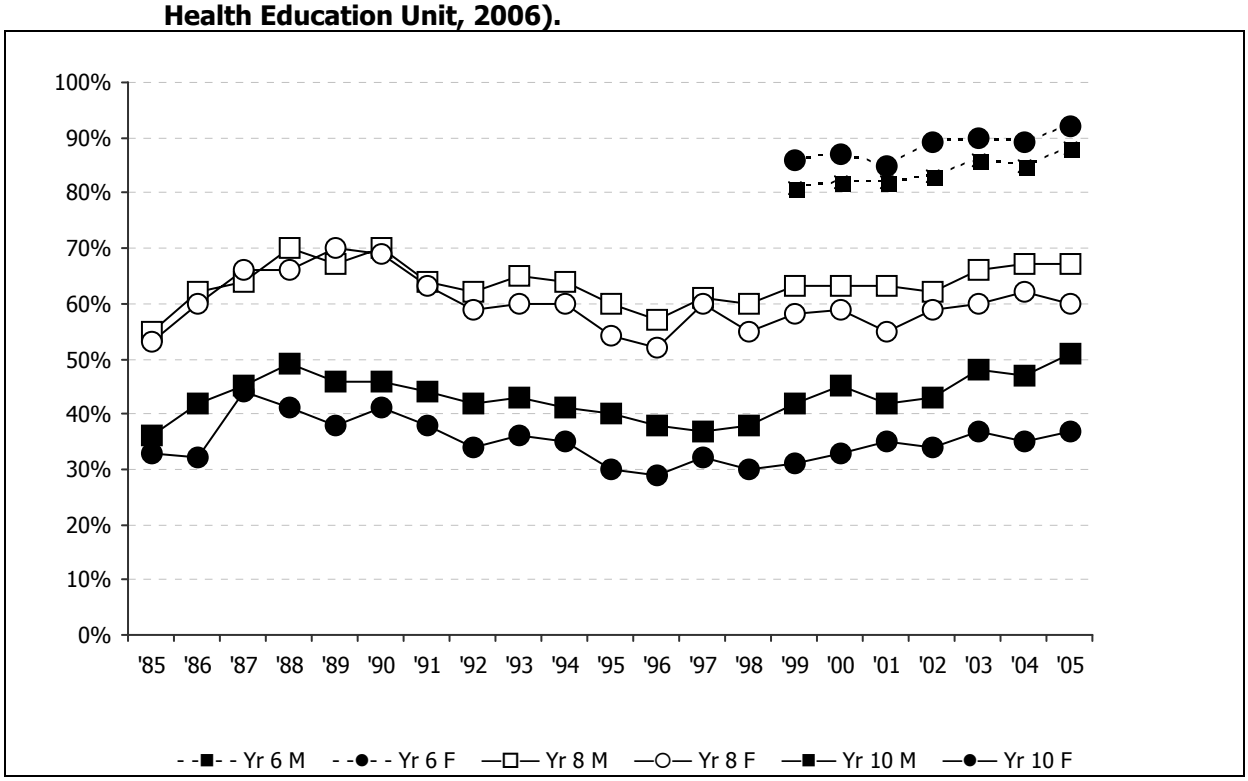
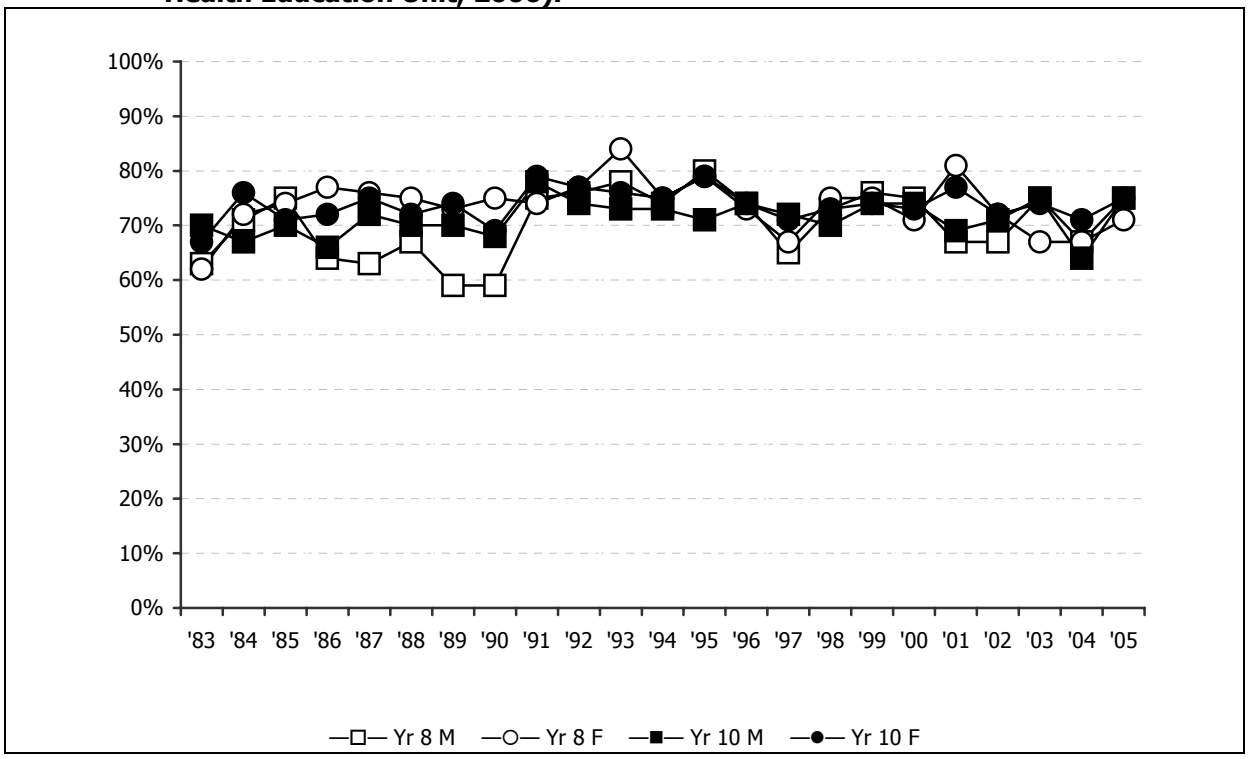


Figure 3: The percentages of pupils who want to give up smoking, 1983–2005 (Schools Health Education Unit, 2006).



7. The proportion of smokers who want to give up has remained roughly the same over the period 1983–2005. Schools and others need to respond positively to the fact that two thirds of pupils say they want to give up smoking. The smoking cessation groups in some schools are an initiative that should be adopted more widely.

8. There has been a long, although modest, decline in the proportion of pupils who reported drinking in the previous week. However, young people who do drink do so significantly more than in the past. In this respect they probably mirror changing habits in the 18–30 age group, frequently described as 'binge' drinking.

9. Pupils were asked about their alcohol consumption in the previous week (Figure 4), and, as a result, whether they were drunk on one or more days (Figure 5).

Figure 4: The percentages of pupils who had consumed an alcoholic in drink the previous week, 1990–2005 (Schools Health Education Unit, 2006).

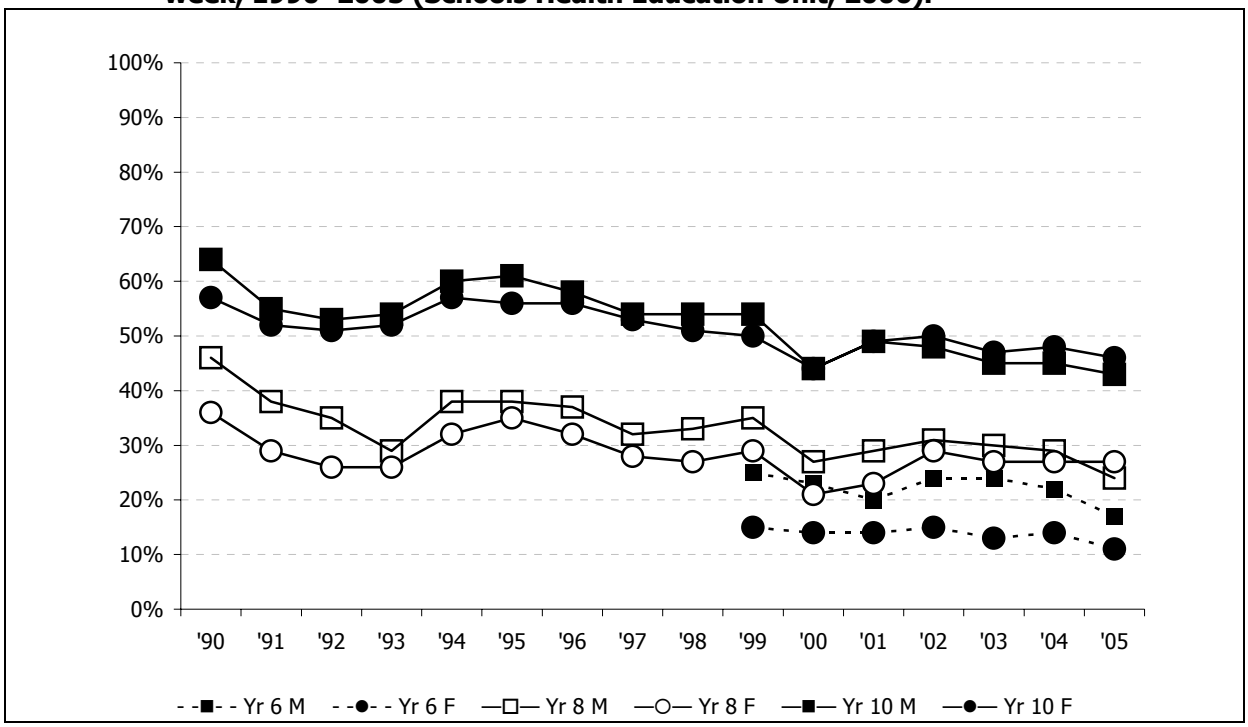
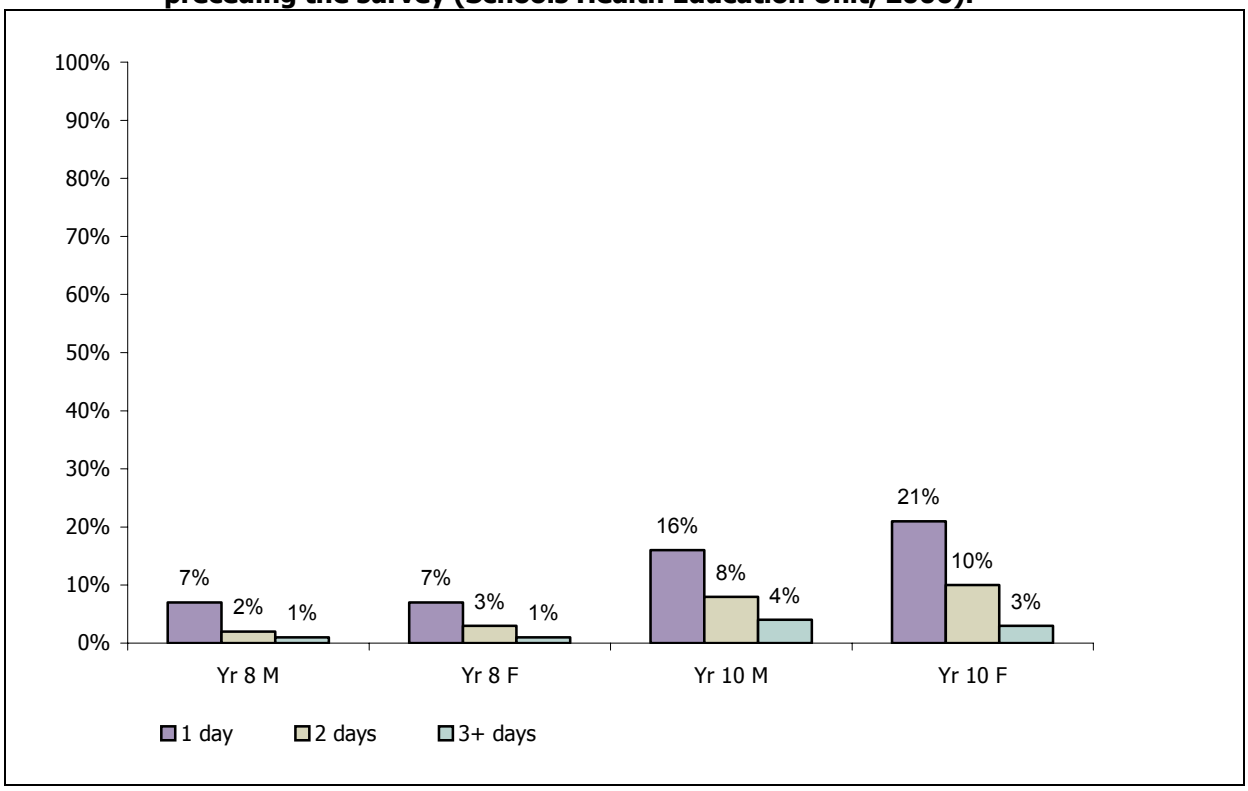


Figure 5: The percentages of pupils who were drunk on one or more days in the week preceding the survey (Schools Health Education Unit, 2006).



10. About one third of Year 10 girls reported 'getting drunk' in the previous week, some on more than one occasion. Given that so many young people are aware of the risks associated with drug use but, nevertheless, fail to modify their behaviour, this finding is worrying. Some were aware of the risks of consuming alcohol but did not understand the link between excessive alcohol consumption and a higher likelihood of unprotected sexual activity.

11. The following data (Figures 6 and 7) show the percentages of young people being offered and using cannabis. They indicate that, on some occasions at least, young people can and do refuse offers of drugs.

Figure 6: The percentages of young people ever using cannabis, 1987–2004 (Schools Health Education Unit, 2006).

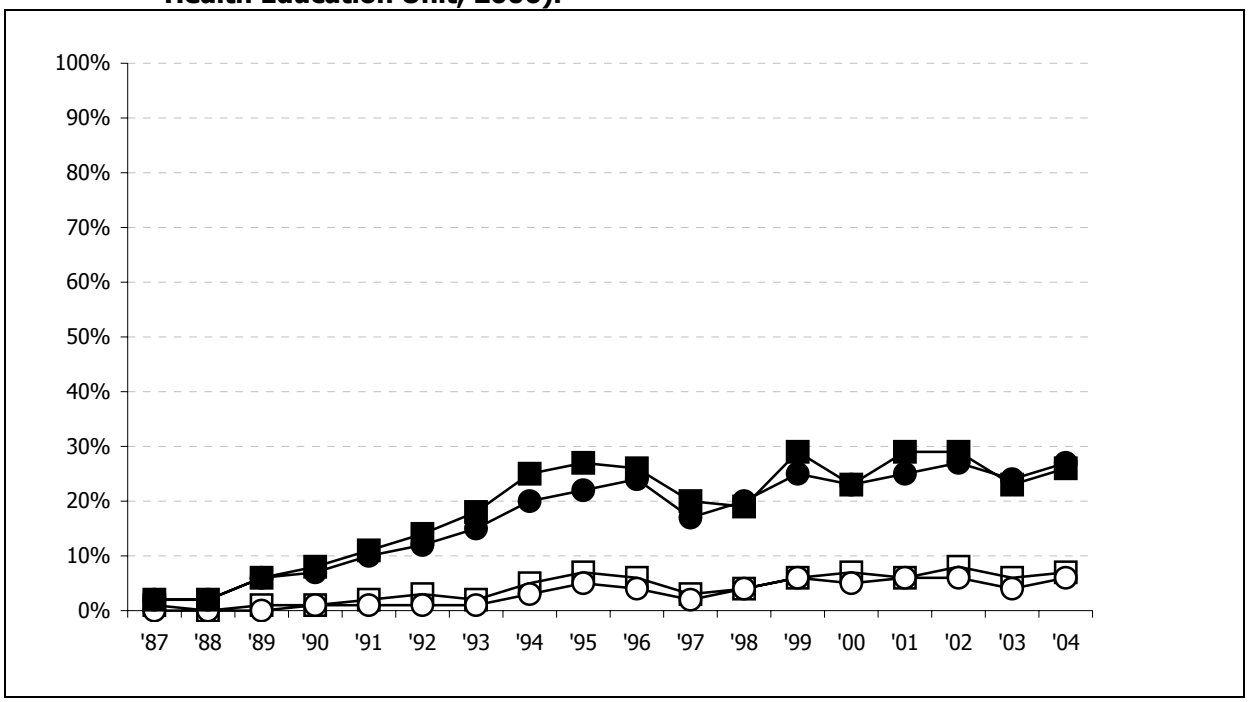
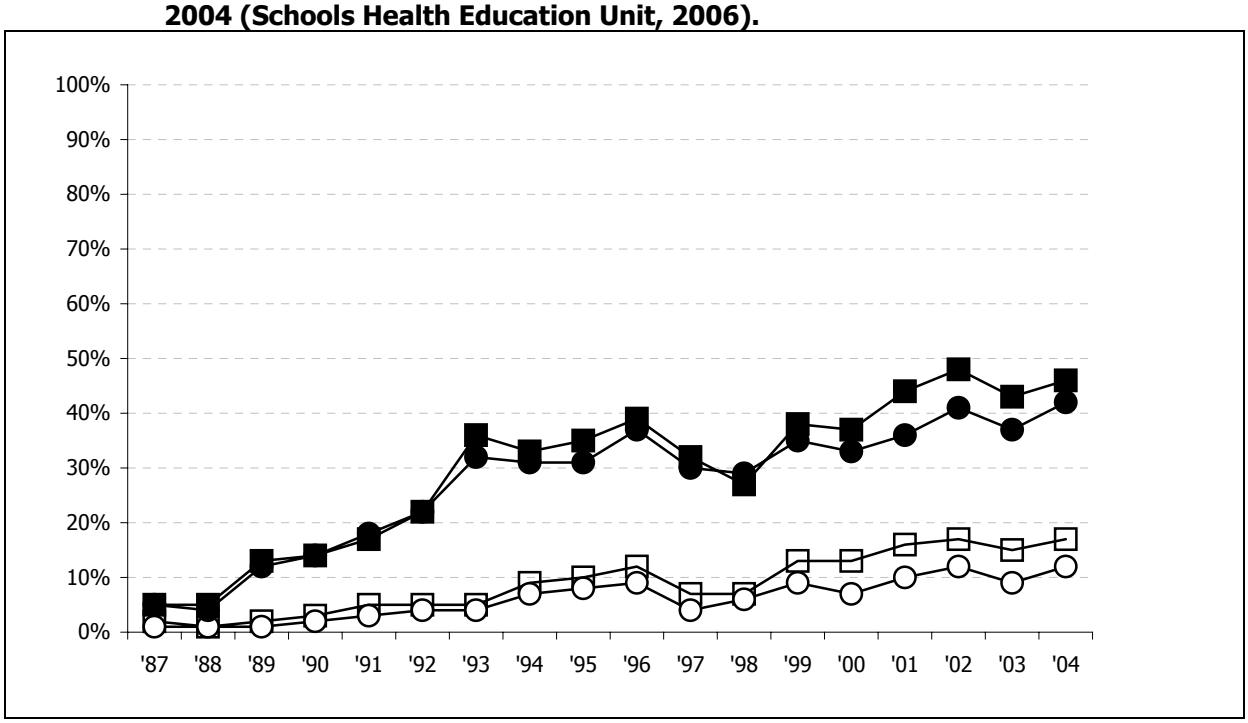


Figure 7: The percentages of young people having received an offer of cannabis, 1987–2004 (Schools Health Education Unit, 2006).



12. At some stage, most young people of school age will be occasional users of drugs for medicinal purposes and the majority of them will try tobacco and/or alcohol. Some will misuse illegal drugs, but very few of those who experiment will go on to become problem drug users. The majority have never used an illegal drug.

13. Effective drug education needs to increase pupils' knowledge, challenge their attitudes and enhance their skills as well as, most importantly, having an impact on their behaviour. One of the problems, however, is that it is still not known what approaches to education about drugs have the most significant impact on pupils' behaviour: there has been no overall review of the most effective method of education about drugs. Some studies have shown the impact of drug education programmes on pupils' attitudes, knowledge and resistance skills, but few have examined their impact on pupils' long term behaviour. Ofsted has recommended previously that a comprehensive evaluation of the effectiveness of drug education programmes in schools should be undertaken.[2]

14. The public debate on issues such as sex and relationship education (SRE) is often ill informed and does not take account of the real pressures on young people. Just as with drugs, young people need to be equipped to make informed choices about relationships and to be able to resist pressures to have sex, but a minority response to Ofsted's last report on SRE was a call to consider introducing 'abstinence-only' programmes as the only option for unmarried people of any age.[3] There is no evidence, however, that 'abstinence-only' education reduces teenage pregnancy or improves sexual health. There is also no evidence to support claims that teaching about contraception leads to increased sexual activity. Research suggests that education and strategies that promote abstinence but withhold information about contraception can place young people at a higher risk of pregnancy and sexually transmitted infections (STIs).

15. We can learn from the experience of other countries, and areas in the UK such as Camden, where levels of teenage pregnancy are lower than in the rest of UK. In these areas, adults give young people clear, consistent messages about their rights and responsibilities in sexual relationships, including the importance of protecting themselves and their partners, and all young people have access to effective support services. In these ways, they are encouraged to delay sexual activity until they are ready and know how to deal with unwanted pressures to have sex. Effective SRE programmes provide pupils with the knowledge they need but also deal with the issues of emotional development and self-esteem. They also ensure that discussion of issues of sexuality and different sexual choices takes place.

16. Many young people say that many parents and some teachers are not very good at talking about the more sensitive issues in PSHE, such as sex and relationships. They feel that parents and teachers often leave it too late and do

[2] *Drug education in schools* (HMI 2392), Ofsted, 2005.

[3] *Sex and relationships education in schools* (HMI 433), Ofsted, 2002.

not talk about such issues until they have reached puberty or have started feeling sexual desire. In the case of SRE, young people do not want just the biological facts but want to talk about feelings and relationships.

17. While most parents make every effort to ensure their children's personal safety, they need to consider whether they provide the advice and support their children need if they are to understand potential dangers, have the skills to cope with new experiences and know their parents' expectations. In discussion with pupils it became clear that some parents are not rising to this challenge.

18. This view is supported by current data from the Schools Health Education Unit (Figures 8 and 9). Young people were asked about who should provide advice and support. Parents were generally less likely than previously to be seen as the main source of advice; the decline has been particularly marked for Year 8 girls, a group, in the past, who regarded their mothers as the prime source of advice on personal matters.

Figure 8: The percentages of pupils stating that their main source of sex information is from parents, 1983–2005 (Schools Health Education Unit, 2006).

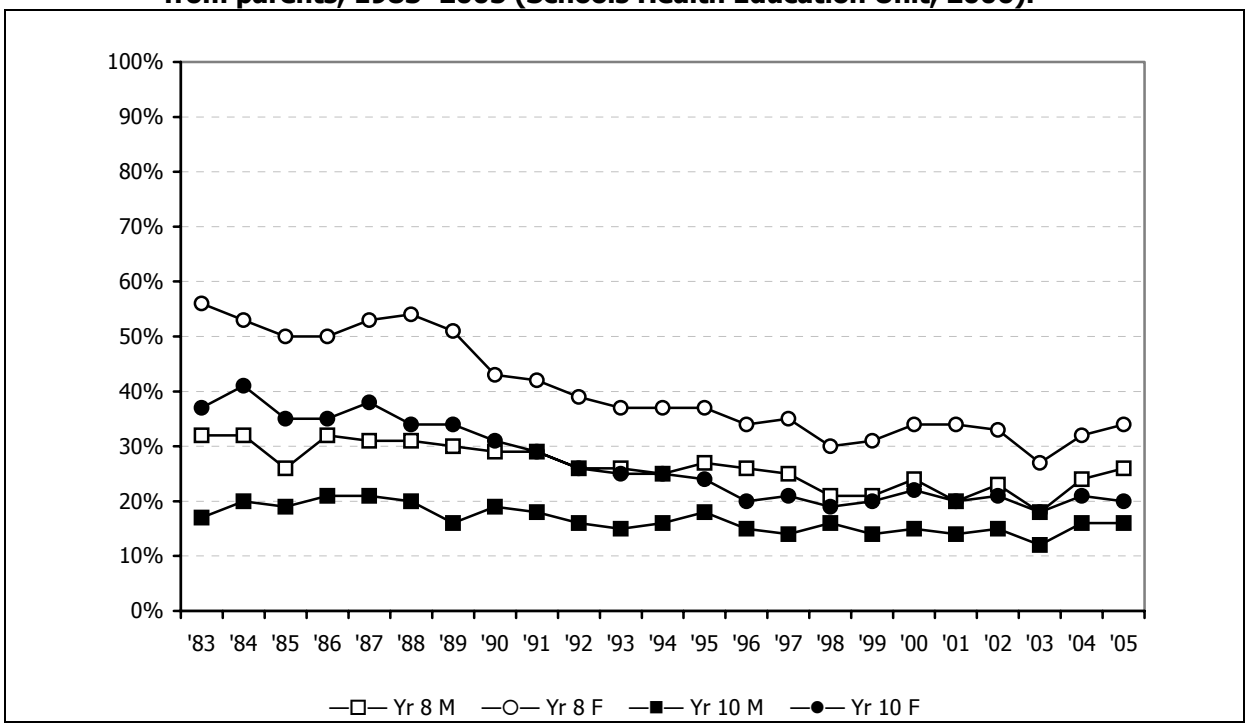
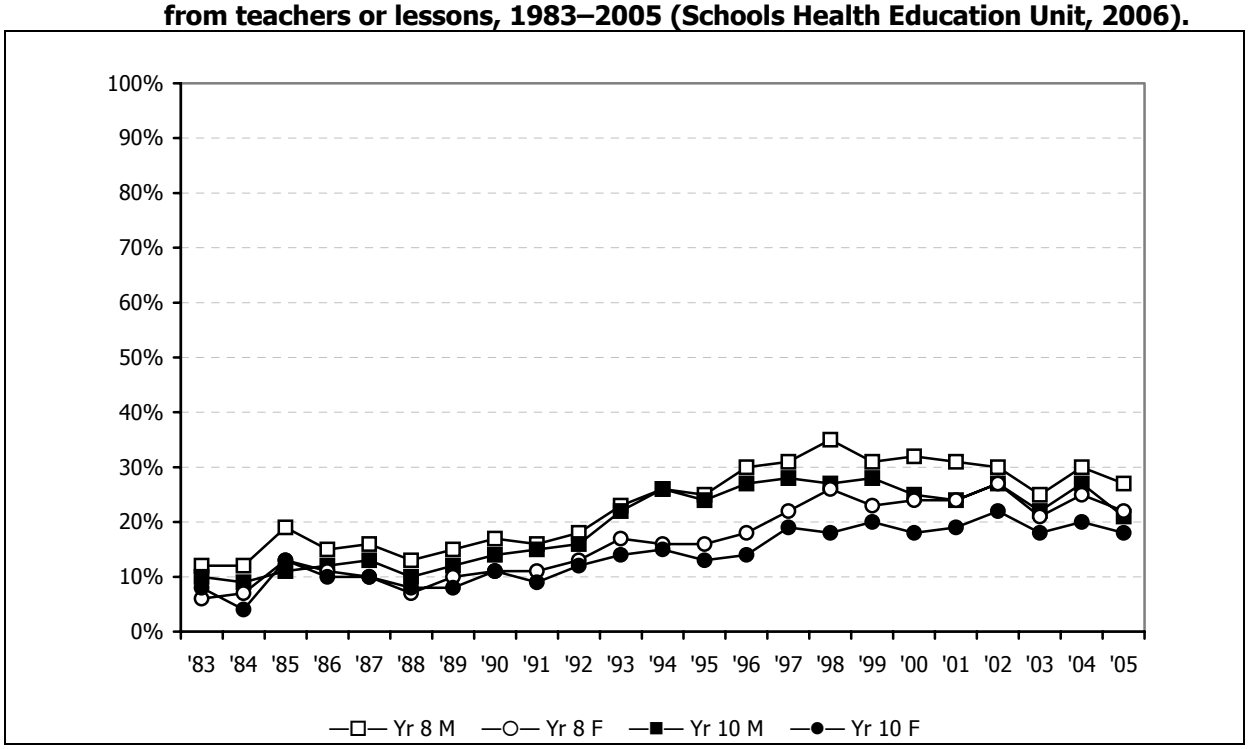


Figure 9: The percentages of pupils stating that their main source of sex information is from teachers or lessons, 1983–2005 (Schools Health Education Unit, 2006).



19. The more effective schools have developed successful and constructive links with a range of support services that can advise young people on a wide variety of issues and respond appropriately to the needs of pupils and their families. Many of these schools have established a base for external support agencies with, for example, the school nurse as the focus for providing advice and support. Along with the PSHE coordinator, school nurses can arrange visits from their colleagues in the community and work with them to promote health and improve young people's access to health services. School nurses can also provide a valuable service, particularly in terms of providing emergency hormonal contraception and advising on other forms of contraception. Progress towards establishing such centres has been modest, but many extended schools are now providing a good range of services.

20. In too many schools, mental health issues are either not recognised or tackled sufficiently effectively. In 2005, Ofsted evaluated schools' responses to developing pupils' emotional health and well-being. The report said:

> Schools' lack of knowledge of the DfES guidance results from a missed opportunity to improve the quality of provision for pupils with mental health difficulties. The large number of schools visited for this survey who were not working towards meeting the NHSS [National Healthy School Standard] is of serious concern. Only just over half of them were aware that such standards existed. Of these, only a very small minority of schools were working towards or had met the criteria for providing for pupils' emotional health and well-being. One barrier was the low level of awareness of the importance of the issue.
>
> It is unsurprising, therefore, that training for staff on mental health difficulties was found to be needed in three quarters of the schools. Most training tended to focus on strategies for managing pupils' behaviour rather than on promoting positive approaches to relationships and resolving conflicts.[4]

21. In discussion, pupils report that some of their parents have neither the knowledge nor skill to talk to them directly about sensitive issues. Parents often seek to approach personal, social and health issues with their children tangentially, if at all. As well as failing to provide the information themselves, some parents express concern about the suitability of information that young people receive from other sources, such as magazines, even when these could be useful. For example, the increase in the number of magazines aimed at young men, while at times reinforcing sexist attitudes, has helped to redress the balance of advice available to young people.

[4] *Healthy minds. Promoting emotional health and well-being in schools* (HMI 2457), Ofsted, 2005.

22. The range of topics and the explicitness in dealing with them have increased in many of the magazines read by young people.[5] While many magazines now stress the importance of safe sex, some communicate, inaccurately, the perception that all young people are sexually active. Nevertheless, the 'problem pages' in magazines remain a very positive source of advice and reassurance for many young people, but difficulties may arise if the messages clash with parental and cultural norms.

23. Parents' greatest challenge is to set clear expectations, and to be aware of and to accept responsibility for their children's behaviour. Some parents do not rise to this challenge. Pupils look to schools for help – hence the importance of high quality PSHE.

Improving PSHE: the challenge for schools

24. From the 350 PSHE inspections conducted over the last 5 years it is clear that PSHE has had some notable successes. Pupils' knowledge and understanding of drugs and their effects have improved. In primary schools, role play and 'circle time' are used effectively to counter the impact of peer pressure on pupils' behaviour. In secondary schools, by the end of Key Stage 4, pupils have a good knowledge of drugs and are aware of the associated risks. Effective SRE programmes provide pupils with the knowledge they need but also tackle the issues of emotional development and self-esteem.

25. These marked improvements in PSHE in recent years are reflected in a steady improvement in pupils' achievement in the subject. In the academic year 2005/06, in primary schools, pupils' achievement was good in about four out of five schools. There was little unsatisfactory achievement at either Key Stages 1 or 2. Pupils had opportunities to develop and use the skills necessary to make informed choices. In secondary schools, pupils' achievement was generally adequate or better.

26. However, this broadly encouraging picture conceals some variation. In a majority of the SRE lessons observed in primary schools, pupils' knowledge and understanding of factual aspects were no better than adequate; and in secondary schools, pupils' knowledge and understanding were good in only two lessons in three at Key Stage 3, compared with almost three lessons in four at Key Stage 4.

27. If pupils are to be able to analyse, reflect on, discuss and argue constructively about issues in PSHE, they need to develop appropriate skills. In good provision, pupils showed:

[5] *Sex and relationships education in schools* (HMI 433), Ofsted, 2002.

- communication skills, such as putting forward a point of view and listening to others
- decision-making, so that they could make sensible choices based on relevant information
- the ability to make moral judgements about what to do in actual situations and the potential to put these judgements into practice
- interpersonal skills, so that they could manage relationships confidently and effectively
- assertiveness skills
- the ability to act responsibly as an individual and as a member of various groups.

28. More needs to be done, however, to ensure consistently high quality in the PSHE curriculum. This is discussed further below.

Teaching and learning

29. Over the last five years, the quality of teaching and learning in PSHE has improved steadily. In primary schools, teaching and learning are at least adequate in nearly all lessons and good in three quarters. In these lessons, teachers have challenging but appropriate expectations and build on pupils' knowledge and skills. The best lessons are extremely well planned, teachers' knowledge of the subject is good and pupils are engaged fully. In the few lessons, mainly at Key Stage 2, where the teaching is less effective, the work does not take sufficient account of the pupils' differing levels of maturity and need. In secondary schools, the quality of teaching and learning has also shown a steady improvement, although variations remain in the quality of teaching about some key aspects.

30. One reason for the relatively high quality of teaching in primary schools is the contact between the teacher and the class. Typically, the primary teacher understands the pupils' individual needs very well and uses this in planning.

> Pupils in a Year 5 class were continuing their study of drug education. The lesson began briskly with a well prepared activity that required them to identify who might own and use the range of common non-prescription drugs displayed. Pupils' responses revealed that there was some confusion in their minds as to the difference between legal and illegal drugs. The teacher dealt with this immediately, using examples from the display and elsewhere to illustrate the differences.
>
> For the main part of the lesson, pupils selected and read out, in turn, a prepared statement about whether a drug was legal or illegal, then led a discussion on the statement's accuracy. In each case, pupils responded very well, presenting evidence about why the statement might or might not have been correct. The carefully selected statements, based on the teacher's evidence from previous lessons, enabled the pupils to challenge

each other's preconceptions of drugs and drug users. By the end of the lesson, they had clarified their understanding of legal and illegal drugs and why people might use or misuse them.

31. The quality of teaching about drugs is good in three quarters of lessons in secondary schools, but unsatisfactory in one lesson in 20. In the best drug education lessons, pupils develop their understanding and skills through enquiry, learning and problem solving. At Key Stage 4 in particular, in the relatively few lessons observed, teaching about contraception or parenting was good; in contrast, teaching about sexual health and the law in relation to sex was often inadequate.

32. In secondary schools, specialist teachers' planning is often good, but form tutors' is weaker because they rely too heavily on generalised, joint plans produced by the subject coordinator and do not adapt them to meet their own pupils' needs. In order to improve the overall quality of planning, subject coordinators and senior leadership teams need to make it clear that all teachers should play a full part in planning their PSHE lessons even if this is done jointly with the subject co-ordinator.

33. Unlike other subjects, PSHE recruits few teachers with directly relevant 'subject' qualifications. However, many secondary schools have sought to develop specialist teams with teachers who, through initial teacher training or subsequent professional development, have the necessary subject knowledge and teaching skills to teach one or more aspects of PSHE confidently. In some schools, specialist teachers teach throughout the school, in others, only in Key Stage 4. Although there is a growing trend towards such specialist teaching, in many schools non-specialists still teach PSHE, particularly form tutors. At Key Stage 4, one in five lessons taught by tutors was unsatisfactory, while teaching by specialists was never less than satisfactory.

34. Differences in the quality of teaching by specialists and non-specialists is not a new finding; Ofsted has cited it for several years. Even so, some schools defend their use of tutors for PSHE lessons on pragmatic or educational grounds. Principally, they make a link between the role of the tutor in pupils' personal and social development and the content of PSHE courses. While tutors have an important role in pupils' personal and social development, requiring them also to teach PSHE creates difficulties for the tutor and their pupils, largely because of the changed relationship of tutor and pupil when it becomes that of teacher and class. Many teachers who are good tutors do not have the knowledge and the understanding of appropriate teaching methods for many PSHE topics. They are also, perhaps understandably, reluctant to teach some topics. Pupils quickly notice a teacher's lack of knowledge or enthusiasm for the subject; they react negatively or are simply embarrassed.

35. In contrast, the impact of knowledgeable and confident teaching is considerable, as illustrated in this example.

> A specialist teacher's good knowledge of SRE was reflected in his confident introduction to a Year 11 class of the sensitive topic of STIs and, in particular, HIV/AIDS. An unembarrassed presentation, supported by excellent use of a PowerPoint presentation and very effective questioning, together with the skilful handling of pupils' responses, enabled him to ensure that all pupils had a good understanding of the risks of infection and how they could be avoided. All pupils were involved in all aspects of the lesson and felt sufficiently secure to ask questions as they discussed risk-taking behaviour and how to raise the issue of condom use.

36. Specialist teachers are more likely to use a broad range of teaching approaches, such as paired and group work, games and role play, rather than relying simply on printed resources that present information without giving pupils opportunities to engage actively with it and consider how the information might apply to them.

37. The following example of a Year 8 lesson on alcohol illustrates how good group work, with well-managed feedback, enhanced pupils' knowledge, involved them closely in their own learning and enabled them to feel sufficiently secure to share their opinions.

> The lesson began briskly with the teacher re-capping the earlier work. The pupils settled quickly and enthusiastically to their tasks relating to investigating the effects of alcohol. They were then asked to report back to the class on the issues arising. They listened carefully to each other and took note of and responded positively to different points of view. The feedback by the groups to the rest of the class went extremely well. All pupils spoke confidently, knowing that their contributions and differing points of view would be valued.

38. Although used only rarely in secondary schools, role play can be very effective in encouraging pupils to express their own views.

> Year 8 pupils considered how conflict could arise in a family and the ways in which it might be resolved. The teacher set the context of the lesson and revised the ground rules with the pupils. The pupils and teacher role-played the various possible parent–child responses when the child was seeking greater personal freedom. The groups then discussed their ideas before presenting them to the class through excellent role play. All pupils were eager to respond to the presentations. In the high quality concluding discussion, pupils often called on personal experiences, enhancing the quality of the debate.

39. If, despite the arguments in favour of developing specialist teaching teams, tutors teach PSHE, school leaders need to ensure that:

- tutors receive appropriate, and continuing, training and support to help

them improve their subject knowledge and their use of appropriate teaching methods
- Tutors work as part of a team which draws on the expertise of specialists in a planned approach
- tutors' teaching is monitored closely
- they challenge themselves rigorously about the quality of the PSHE provision.

40. Assessment continues to be the weakest aspect of PSHE teaching. It is sufficiently rigorous in only a minority of schools and unsatisfactory in half. One of the reasons for the lack of even simple assessment strategies is schools' belief that pupils' enjoyment of the subject is due, in part, to the absence of any assessment framework. This is misguided: teachers need to know if pupils have acquired the knowledge, understanding and skills they intended them to learn. In turn, this should influence planning to ensure that pupils continue to make progress.

41. Most schools focus narrowly only on pupils' progress in developing their subject knowledge and understanding. Relatively few schools attempt to assess changes in pupils' attitudes or their developing skills. Few schools have valid data which might be used to inform planning and, where the data are available, they are not used.

42. Good practice in assessing pupils' current knowledge includes using evidence from evaluations of teaching, assessment data, the outcomes of discussions with pupils, and behavioural surveys. To improve assessment, schools should:

- make good use of the QCA's new assessment guidance and end of Key Stage statements for PSHE
- determine pupils' current knowledge and understanding before a new topic is taught
- plan assessment as a key element of teaching and learning
- involve pupils in assessing their own progress
- gather evidence on pupils' knowledge, understanding and skills
- challenge pupils' attitudes and raise their awareness of how their actions have an impact on themselves and others.

43. With its focus on pupils' outcomes, the new school inspection framework strengthens the role of PSHE. However, in trying to identify and evaluate outcomes, schools are beginning to realise the inadequacy of much of their assessment. New advice from the QCA is starting to have an impact, although not all schools are aware of it.

The PSHE curriculum

44. National bodies, and schools themselves, often allocate additional topics to the PSHE curriculum without keeping the overall content manageable. In too many

cases, additions to the PSHE curriculum, such as aspects of citizenship, have reduced the time available for teaching other topics. Over one third of schools have recently included part or all of their provision for citizenship within PSHE without increasing time for the combined subject.

45. The extent to which the curriculum is based on pupils' assessed needs has improved, but it remains unsatisfactory in a quarter of schools. In discussions, pupils say that they are not spending enough time on what they consider to be the most significant topics, such as alcohol education.

Drug education

46. Ofsted has evaluated the quality of drug education in schools on four occasions in the last 10 years.[6] Although the quality of provision continues to improve, and there has been considerable progress in developing policies and curricula for drug education, supported by guidance from the DfES, there is no room for complacency.[7] Policies in one third of primary schools are unsatisfactory, often because they are out of date.

47. To guide planning for timely drug education, schools need to be clearer about the incidence and extent of children and young people's use of drugs. They must also accept responsibility for developing more effective drug education that:

- enables young people to make healthy choices
- minimises the proportion of users who adopt particularly dangerous forms of misuse
- persuades those who are experimenting with or misusing drugs to stop
- enables any pupils who are misusing drugs, or who have concerns about the misuse of drugs, to seek help.

Sex and relationship education

48. Planning for SRE also requires an understanding of young people's needs. Knowing about aspects of SRE does not, on its own, ensure a young person's personal safety and sexual health. Effective SRE should help pupils to develop the personal skills they will need if they are to establish and maintain relationships and make informed choices and decisions about their health and well-being.

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[6] The first Ofsted report on drug education was published in 1997. It was followed by two interim reports that evaluated progress on the key issues raised in the original report. In 2005, Ofsted published a further report on drug education.

[7] *Drugs: guidance for schools* (DfES/0092/2004), DfES, 2004.

49. An SRE programme is likely to be particularly effective if it enables pupils to:

- communicate a point of view clearly and appropriately, and listen to the views of others
- make sensible choices about what to do in particular situations
- manage relationships with friends confidently and effectively
- act responsibly as an individual and as a member of a group.

50. Ofsted's most recent SRE report expressed concerns about some aspects of the subject. In particular, schools gave insufficient emphasis to teaching about HIV/AIDS. Despite the fact that it remains a significant health problem, pupils appear to be less concerned about HIV/AIDS than in the past. Although most secondary schools recognise the importance of effective parenting education, they rarely give it sufficient attention. Finally, teachers, governors and parents need detailed advice on how to deal with some of the more sensitive aspects of SRE, such as sexuality. Schools have not received the guidance and support they need on these issues,

51. Most of the schools in this survey ensure that their aims and values are well known to pupils and their parents, and that they are adhered to consistently. They will often refer to personal morality, the effects of actions and choices, and the nature of relationships – concepts very relevant to SRE. However, some of the schools visited need to broaden their coverage of SRE and clarify what they mean by 'achievement' in this area, so that it includes developing pupils' values and attitudes.

52. Differences in interpretation can blur understanding and agreement about what is acceptable. In some secondary schools, for example, homophobic or sexist attitudes among pupils still go unchallenged. As a result, when problems arise, teachers have insufficient guidance on actually interpreting the school's values and being clear to pupils about what the school views as unacceptable language or behaviour.

Health education

53. Health education is a key element of PSHE. Schools have a role not only to teach children about being safe and healthy, but also to help them to adopt healthier lifestyles, enhance their self-esteem, eat and drink well, and stay safe. However, in some secondary schools, the contributions of different subjects towards these goals are poorly coordinated, so that messages about healthy living are not reinforced and the impact on pupils' behaviour in these areas is reduced. Schools that contribute most effectively to pupils' health and well-being recognise the link between physical well-being and pupils' readiness to learn and achieve.

Transition from Key Stage 2 to Key Stage 3

54. Primary schools recognise that many of their pupils mature earlier. As a result, they have begun to teach topics such as puberty in more depth. This has traditionally been taught at Key Stage 3 and some secondary schools have not adjusted their programmes accordingly.

55. Smooth transition is also hindered by inadequate assessment. In particular, work at Key Stage 3 takes insufficient account of pupils' prior learning and experiences at Key Stage 2. This mismatch is all the more stark because of recent changes to PSHE programmes in Key Stage 2.

Responding to individual needs: support services

56. Most PSHE lessons, through the inclusion of discussion and group work, give pupils opportunities to ask questions to clarify their understanding. However, such lessons cannot easily enable pupils to ask for more personal advice that they would not wish to discuss in front of their peers. Although most schools regard the class teacher/form tutor as the key adult to support individual pupils, some pupils find that they have better relationships with a subject teacher. Discussions with pupils during the inspections indicated that they would be reluctant to discuss some personal issues with any member of the teaching staff. This reluctance arises from their concerns about confidentiality and whether the teacher is able to advise them on more sensitive issues, such as sex and relationships.

57. To go some way towards resolving these concerns, successful schools have adopted approaches to support individual pupils which include:

- building pupils' confidence
- always taking seriously all issues raised by pupils
- handling information professionally and confidentially
- ensuring effective liaison with integrated support services
- focusing on a pupil's individual needs and avoiding a 'one size fits all' approach
- trying to bring together the work of mentors, counsellors and external support agencies with individual pupils and, if appropriate, with their families
- not being afraid to admit failure with some pupils; there will be some whose complex needs cannot be met within a school.

Leadership and management

The role of the PSHE coordinator

58. Almost nine in 10 PSHE coordinators provide good or better management and leadership. They have to work closely with other subject leaders to determine the extent to which aspects of PSHE might be taught elsewhere and to advise on teaching and learning so that, for instance, other subjects provide

opportunities for pupils to discuss and listen to points of view.

59. Effective monitoring and evaluation of PSHE includes full departmental reviews, discussions with pupils and regular lesson observations. Good lesson observations include detailed feedback to the teacher observed on the quality of the teaching and learning and on pupils' progress. In a significant minority of schools, however, much of the work of coordinators is concerned with input, with too little time spent evaluating effectiveness. In a minority of schools, the PSHE coordinator has insufficient seniority and/or support to influence whole-school developments and to coordinate the initiatives necessary to develop effective PSHE.

Training and development

60. The SRE report in 2002 said:

> Many teachers have approached the subject with diffidence in view of its nature and what they feel to be their own inadequate training or capacity to undertake it… The structure of in-service training about SRE and other PSHE topics should be reviewed so that teachers have the time and resources to make sure that the training influences the curriculum and teaching.[8]

61. In response, the DfES and the DoH established a jointly funded programme of continuing professional development. The programme has been running for four years and over 5,000 teachers and community nurses have enhanced their experience in teaching PSHE. Their enthusiasm, confidence and knowledge have improved, and many are able to support their colleagues better. Pupils have benefited from improved teaching and learning, including more varied and appropriate teaching methods. The aims of the programme have been met successfully.

The future for PSHE

62. Too much time and effort have been spent in discussing whether PSHE should be a statutory subject. Making something statutory does not ensure that it is provided effectively or, indeed, at all. Such a change would not tackle pupils' needs in terms of revising the content of the PSHE programme or ensuring that it is taught and assessed effectively.

    - The National Healthy Schools Programme (NHSP), sponsored jointly by the DoH and the DfES, was launched in September 2005. The publication of the

[8] *Sex and relationships education in schools* (HMI 433), Ofsted, 2002.

revised standards for the NHSP is probably the most important development to boost PSHE in the curriculum, since, to meet the standards, schools must have an effective PSHE programme.

63. Schools are required, through a whole-school approach, to deal with the four obligatory themes that make up the 'healthy school' status, to provide evidence against all criteria for each theme and to demonstrate outcomes that have made an impact on pupils' learning, experiences and/or behaviour. The four themes are:

- PSHE (including sex and relationship education and drug education)
- healthy eating
- physical activity
- emotional health and well-being (including bullying).

64. With these developments in mind and the concerns about the time currently allocated to this aspect of the curriculum, the on-going QCA review of the curriculum is timely and will address the curricular content and how PSHE outcomes might be achieved. Many schools are already considering how PSHE might support the five outcomes of the Every Child Matters agenda. Schools already recognise the importance of their PSHE programmes in either coordinating the contributions of different subjects or taking sole responsibility for dealing with the Every Child Matters agenda.

65. Care should be taken to ensure that the PSHE curriculum meets the needs of young people. Not all schools or national bodies establish effective ways to gather the views of pupils. Focus groups or school councils might help to shape wider discussions, although they should not be seen, necessarily, as representing the wider school population. The involvement of PSHE advisers and their local authorities would help to broaden consultation and secure access to the views of more young people, in that way helping to ensure that a future PSHE curriculum meets their needs successfully.

Notes

This report draws on inspection evidence relating to PSHE from the period 2001–06. This includes evidence gathered each year from the inspection of PSHE in samples of 30 primary and 30 secondary schools. Further evidence was gathered for each year from about 60 section 10 and, subsequently, section 5 school inspection reports.

As this report covers the period 2001–06, it also draws attention to earlier survey reports on PSHE in secondary schools, drug education, sex and relationship education, and healthy schools.

In preparing this report, Ofsted commissioned the Schools Health Education Unit, Exeter, to provide research evidence from its behavioural surveys.

Further information

Drug education in schools: an update (HMI 746), Ofsted, 2002.

Sex and relationships education in schools (HMI 433), Ofsted, 2002.

Drug education in schools (HMI 2392), Ofsted, 2005.

Healthy minds. Promoting emotional health and well-being in schools (HMI 2457), Ofsted, 2005.

Personal, social and health education in secondary schools (HMI 2311), Ofsted, 2005.

Healthy schools, healthy children? The contribution of education to pupils' health and well-being (HMI 2563), Ofsted, 2006.

The Annual Reports of Her Majesty's Chief Inspector of Schools from 2001/02 to 2005/06.

PSHE at key stages 1–4: guidance on assessment, recording and reporting (QCA/05/2183), QCA, 2005.

This assessment guidance can be downloaded from the QCA's website at: www.qca.org.uk/7835.html

The Schools Health Education Unit
www.sheu.org.uk