

Healthy body: healthy mind

How headteachers are managing their
schools to help improve children's health

SCHOOL LEADERS

Report

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1. Introduction

A number of recent reports have expressed unprecedented concern related to the physical and mental health of children. Increased obesity, drug use, behavioural and serious psychological problems combined with high teenage pregnancy rates are all waiting in the wings ready to make a dramatic entrance onto the future adult stage. In response to a recent UNICEF report in 2007, "Child Well Being in Rich Countries", the Children's Commissioner for England, Professor Sir A. Aynsley-Green stated:

"We are turning out a generation of young people who are unhappy, unhealthy, engaging in risky behaviour, who have poor relationships with their family and their peers, who have low expectations and don't feel safe." (BBC 2007)

The even more recent "TellUs2" survey conducted by Ofsted (2007) confirmed that schools still need to do more to secure a healthy future for our young people. The Chief Inspector, Christine Gilbert, acknowledged the work that schools were already engaged in but emphasised that:

"More needs to be done to address children and young people's worries and concerns about how safe they feel; about exams and tests; and about what would help them learn better and where they need to go for help when they have a problem." (Ofsted 2007)

How can schools address such problems? Although this study does not claim to provide all the answers, it does identify effective strategies that some schools have identified as being significant in improving the health and well being of the young people they serve.

Healthy lifestyles are established when children are young. Primary schools clearly have a major part to play in promoting the physical and mental health and general well being of children, in addition to delivering higher academic standards. It is interesting to note that the "TellUs2" survey (Ofsted 2007) found that *"the biggest worry on the minds of children is exams (51%)"*. The pressure to produce ever improving test results and meet challenging targets can create an unhealthy environment for children, but our study provides evidence that schools can successfully meet the sometimes conflicting demands by using a much wider range of criteria to judge success. All the senior managers who contributed to the study appreciated the importance of high academic standards but also recognised the importance of developing healthy well-balanced young people. It is the way the senior managers structured their schools and the strategies they put in place in order to achieve both aims which provides the main focus for this study.

This report is intended for senior managers in primary schools and anyone working in the field of health promotion. Schools work with a wide range of professionals and this study is an attempt to share good practice across the many different agencies. A wide range of primary schools in the Merseyside region provided the evidence for the study. The schools had been identified as outstanding examples of health promotion. A team of four headteacher researchers visited the schools, and senior managers together with other key personnel were interviewed. In order to extend the survey further, a focus group of headteachers was also interviewed and the findings from the group included in the final report.

Literature review

St Leger (1999) highlighted the difficulty in evaluating the degree of success of any health promotion activity in schools. The effectiveness of any initiative may take years to accurately measure and St Leger argues that health professionals have placed too much emphasis upon statistical data and have neglected the more individual needs of the schools. To a large degree the development of "Healthy School" status has been a top down model and has been designed to address the needs of aims of the Health Service more than the schools. St Leger concludes that:

"The health promoting primary school, which shows great promise, will only gain momentum if it is owned and used more intensively by teachers and schools." (St Leger, 1999:63)

The article suggests that initiatives outside the classroom will be just as important as those inside the classroom in future developments.

Deschesnes, Martin and Hill (2003) identified four key factors which contribute to the success of health promotion in schools. The first key factor relates to systematic planning and coordination and emphasises the need for one key person to take overall responsibility. The second condition relates to the importance of "the partnership between school, family and community and the need for shared vision, positive working climate, effective leadership and participatory decision making process." (Deschesnes, Martin and Hill, 2003:3)

This point is further supported by Ofsted (2006), which found that successful schools generally took a whole-school approach" to health promotion, and "consultation, with both parents and pupils was a key factor in successful practice." (Ofsted 2006:7)

The third condition relates to political and financial support sustained over a long period of time and a need to move away from "a tendency to invest in one-time interventions of low intensity, producing few lasting changes." (Ofsted 2006:7)

The final condition is linked to evaluation and can be directly linked to the school improvement process, with practice being changed to meet new needs. The authors maintain that the four conditions are crucial if the promising work already done is to be developed further.

Weare (2002) also emphasises the importance of "vital factors" which contribute to effective health promotion in schools. She stresses the need for children to think for themselves and develop the "autonomy" which will enable them to make informed decisions as they move through adolescence and into adulthood. The skills required to develop this "autonomy" are developed through every aspect of school life. She also emphasises the importance of "clarity", which for younger children will manifest itself as trust and consistency. In common with many other pieces of research, Weare stresses the importance of "participation" and the feeling of engagement and ownership felt by everyone working in a school. Weare also identified "relationships and the emotions" as being important and the strength or weakness of this factor will dictate the effectiveness of the school in all areas of school life but will particularly affect health promotion work.

O'Rourke (2005) argues that society in general and more specifically schools have taken too much of a "paternal" approach to health promotion and that we should adopt a more "utilitarian or functional approach". Health promotion in schools will

ultimately result in healthier citizens in the future, reduced sickness levels and adults more able to contribute more effectively to society. He stresses the value of health promotion in promoting critical thinking, analysis, decision making and problem solving. O'Rourke raises the issue of funding and the costs associated with health promotion programmes. The long-term nature of many of the benefits, together with the emphasis placed upon developing basic literacy and numeracy skills has resulted in a reluctance to allocate sufficient funds in order to have a significant impact. More evidence of short-term benefits (e.g. reduced absenteeism rates, improved assessment levels) could perhaps persuade more reluctant school leaders to allocate sufficient funding to the initiative.

The "Healthy Minds" report (Ofsted 2005) identified that the best schools actively promoted the health and well being of pupils by building a culture of respecting and valuing others. The successful schools worked closely with other agencies and parents. The report also highlighted weaknesses in schools, particularly a lack of awareness about the Healthy Schools agenda for emotional health and well being at the time of the report. The follow up report, "Healthy Schools: Healthy Children" (Ofsted 2006) identified that good schools promoted health through Personal Social Health Education programmes, by creating the right ethos and environment, developing the wider curriculum and strengthening links with other agencies linked to health promotion.

Hornby and Atkinson (2003) provide a useful framework for schools to focus on promoting children's mental health. They identify the growing problem concerning children's mental health and stress the role teachers should play and the importance of the impact teachers can have. Hornby and Atkinson suggest four areas on which to focus: school ethos; whole school organisation; pastoral provision; classroom practice.

Gott (2003) also emphasises the importance of mental health amongst young people and warns against launching into initiatives around children's mental health without careful consideration. He warns of the dangers of identifying pupils who have mental problems but not having strategies to deal with them. The link with specialists is essential in order to address this problem. There are also important implications for staff training in order to deal with problems. He stresses that schools should focus on developing approaches that promote children's mental health and these should be central to school policies and approaches.

2. Method

Eight schools in the Merseyside region, representing a range of catchments and characteristics, were selected for visits. All the schools were recognised as exemplars of good practice by Local Authorities, in Ofsted reports or through awards for health promotion. Each had adopted successful approaches to the promotion of children's health whilst sustaining good levels of academic progress. Members of staff who played a key role in health promotion were interviewed using a common framework of questions. A focus group of primary headteachers was also interviewed. The schools had a variety of different catchments and characteristics. The combined reports were summarised and similarities and differences in approaches analysed.

In order to provide consistency, a common framework of questions was used to explore areas of management. These questions were:

- How have you diagnosed the health needs of your school and the children?
- What links have you developed with external agencies to support children's health? What has been particularly successful/why?
- How have you managed the curriculum to support the health needs of your children?
- How have schools successfully engaged parents in delivering and supporting children's health?
- What have been and are the barriers and aids to successful practice?

3. Key findings

3.1 Identification of need

Our research findings show that the expansion in pre-school provision over recent years has resulted in more extensive information being provided for schools on entry.

At the time of writing, children's centres were being established and the schools where these centres were located reported improvements in the multi-agency working and early identification of children's health needs. Link workers provided support within mainstream (reach) schools, working with families and children in the schools to identify and address needs.

However, some schools found that the quality and range of information received from the private and voluntary sector was variable. Even though the foundation profile provides a structure for tracking physical, social and emotional development, there was inconsistency in interpretation of the statements within the profile.

Working with parents

Schools identified the direct contact with parents as invaluable in early identification of needs. Some schools used home visits with staff who had defined responsibilities, whilst other schools encouraged parents to have discussions prior to entry. These arrangements were dependent on staffing resources and need but were seen as essential for providing information.

The most effective schools used the strategies identified above in order to map provision needed for the school, the different cohorts and for individuals. The importance of links with parents and other agencies in identifying need was also identified by Ofsted (2006a, 2005). The value of working with other agencies was highlighted by one of the schools in the study. Another school, situated in a very deprived area, identified poor diet as a major factor as part of a project with the local health care trust. This resulted in the setting up of cookery classes for parents and children in a resourced base and was an excellent example of multi-agency working resulting in successful outcomes for children.

Health services

All schools recognised the value of the detailed information they had received from the Schools Dental Service. The information has been easily accessible and has helped schools to understand the level of dental decay. The information has been used to support change in the provision of school meals, healthy snacks (e.g. toast, fruit), fluoride, milk and the curriculum. Schools have also found the information useful in working with parents to improve diet. Feedback from the dental service has provided evidence that the work in schools has made a difference.

The information available from the National Health Service had been less useful and limited. Systematic reviews by the Health Service at entrance and exit points to the school have provided useful information. The schools would have appreciated more comprehensive information on the children in their care and such information would have enabled them to tailor their provision to match the needs of their pupils.

One school was part of a locally based health study, the NHS Health initiative 'NHS Live'. This was felt to be extremely beneficial in giving detailed information about the health needs of their children. Most schools however, have been left to attempt to identify the health needs of their pupils using their own strategies.

Information and advice provided by the School Nursing Service was found to be extremely useful in schools where there was regular contact. Two headteachers commented: "We have an excellent link with the nurse through the 'drop in' service, in addition to asthma workshops and training staff on diabetes. She is excellent and very supportive to our parents."

The effectiveness of the school nurse's contribution was highlighted in the Ofsted report, Healthy Schools: Healthy Children as providing, 'invaluable input and support for the PSHE curriculum' (Ofsted 2006:21). However, not all schools within the study appeared to receive the same quality of service. From the evaluation of headteacher responses, there appeared to be no clear criteria for the allocation of dedicated time from the school nurse.

Schools had analysed contextual information on health data, including adult heart disease, teenage pregnancy, cancer rates, diabetes etc. to get a clear picture of the needs of their community. The analysis helped schools to develop their approach to supporting health and well being. In response to information from the Healthy School Team, parent questionnaires and pupil data, one school created a chef club for parents in order to encourage them to be more actively involved in developing healthy eating.

Schools found the identification of parent need is essential in supporting the health needs of children both individually and collectively. One school used a range of questionnaires, offering incentives for return. It also set up sub-committees to deal with specific issues, and focus groups and pupil consultations were established in order to identify the health needs of the children.

National initiatives

Schools in the study found that the range of national initiatives is very useful in assisting them to identify gaps in provision. These initiatives also provide consistency of approach across the schools.

The Healthy Schools, Schools Sports Coordinator Schemes, Extended Schools and Travel Plans all provide useful frameworks for review and identification. They each involve a wide range of strategies for gathering information, such as consultation

meetings with children staff and the community. They also use questionnaires, surveys and focus groups, and as noted above, the need to include the children, staff and the community is recognised by Weare (2002).

Evidence from one school identified the link between food and drink and behaviour patterns. Behaviour deteriorated in afternoons, which was thought to be linked to poor diet and resulted in schools investigating better provision. An audit completed by the school revealed that a significant number of children were arriving at school without having eaten breakfast. The school funded the setting up of a breakfast club and improved the quality of food served at lunchtime, including promoting healthy packed lunches. As a result of these initiatives, the school noticed an improvement in behaviour and concentration levels improved.

In another school, assessment of physical fitness, identified that many children both boys and girls displayed very poor levels of fitness. The scheme successfully supported teachers in ensuring that all children received two hours of quality physical education and in many schools it expanded the after school sports provision.

All the schools identified the need for structured physical activities at lunchtime and identified staff for training, provided through the School Sports Coordinator (SSCo) scheme.

3.2 Management structures

A key factor in all the schools in the study was the quality of leadership, vision and commitment of the head.

Deschesnes et al (2003) identified, as a key factor in successful health promotion, the need for one key person to take overall responsibility. All the headteachers recognised the importance of promoting health and its positive impact on well being of staff and pupils, standards and the general ethos of the school. Heads had a clear view of the needs of their children and took action to structure teams and define roles accordingly.

The schools which had made the greatest impact on health had responded to the "Every Child Matters" agenda by constructing leadership teams, led by a senior manager (not necessarily the headteacher), with a specific responsibility for health promotion in the widest sense. For example one primary school headteacher said that the school had:

"....re-structured TLRs [teaching and learning responsibilities payments] and ensured child well-being was on all job descriptions. A new pupil welfare team became responsible for children's well being. The Governors are more involved in school as a result of the re-focus on emotional and social care of the children; parent governors found that they had a knowledge and clear purpose they are now unafraid of getting involved."

A small school in this study appointed a coordinator for well being and provided a half day per week for development of this area.

A common element of successful practice was a whole school approach to health promotion, including teaching staff, classroom assistants, parents, pupils, health professionals and other members of the school community. The setting up of a team drawn from these members, depending on the size of school, with a clearly defined

purpose was crucial to the success of health promotion. The headteacher as an active participant, but not necessarily the Chair, gave high status to the initiative.

For example, in one school the school caretaker, who provided an effective link between school and the wider community, led the team. The team also included representatives from across the school, including teaching assistants, teachers, lunchtime and administrative staff. This was a good example of leadership using the talents and motivation of all staff and not being hampered by a hierarchy. As the headteacher said: “ The system is; everybody is accountable and everyone has a duty.”

A very effective model in a small one form entry school in a deprived area had a team led by the headteacher, which included a health worker; home economist and learning mentor and had whole school commitment. The strength of the team was that it included a wide range of skills. The health worker provided invaluable information from the health service, which was not always available in other schools in the study. The home economist, using her specific skills, was able to work with children and parents on improving basic life skills including food preparation and balance, as this was identified as a major issue for the school. The school provides an excellent example of what Deschesnes et al (2003) calls “a partnership between school, family and the community” which she identifies as a key factor in successful health promotion.

All schools had well established working groups and health promotion was an important element of the school improvement plan. Procedures were in place to review and amend action plans in the light of new information. Effective schools were responding on a day-to-day basis to the needs of their pupils. Senior managers, however, provided leadership and as one headteacher stated: “Keep the focus and see how all the different initiatives connect together.” The leadership structure in the schools in the study was mainly determined by the size of the school and the number of staff employed. The larger schools had far more staffing resources and could share out responsibilities far more easily than smaller schools, where one member of staff might have responsibility for many different aspects of the health agenda. Smaller schools did, however, have faster lines of communication, which assisted a quick response. Information gathering was easier and schools were able to respond faster to specific issues.

3.3 Working with others

All senior managers identified the support provided by external agencies as essential in ensuring the success of health promotion initiatives.

Healthy Schools

All the schools specifically identified the Health Promoting Schools scheme as a major support agency in addressing health issues.

Ofsted recognised this in its report *“Healthy schools, healthy children?”* (Ofsted 2006a) which concludes that the National Healthy School Programme and the introduction of the Every Child Matters agenda have had a positive impact on schools and made them more active in dealing with pupils’ health and well-being.

“The schools which contributed most effectively to pupil’s health and well being had leadership teams which recognised the link between physical well being and the readiness to learn and achieve. They created an ethos which

promoted health and which engaged pupils, parents and staff. The most successful schools were ones where the curriculum messages were also borne out in practice, for example through the schools' fruit and vegetables scheme and ensuring pupils had two hours of physical activity each week."
(Ofsted 2006a)

The focus group felt that "provision mapping and multi-agency working is the key to success". The Health Promoting Schools programme provided a clear framework for schools to analyse and identify the health needs of their pupils. The scheme also provided external support for school staff and access to a wide range of health professionals. The recognition gained through involvement in the scheme was also found to be highly motivating.

The Healthy Schools initiative gave schools a clear focus for reviewing and developing curriculum provision, e.g. drugs programme, sex and relationships education, healthy eating. Good practice was identified in schools where health promotion was integrated across the curriculum and became more of a way of life.

Some schools had far greater access to support agencies than others. Often support for children and their parents was a "postcode lottery" with schools in more socially deprived areas being able to access services not available to other schools. One school highlighted the number of children who lived within the postal areas for particular counselling services but could not access them because the school was outside the area.

The school nursing service provided a valuable resource for all schools, but access to the service was variable. The nursing service was seen as a vital link between health and education but required more time to fulfil its responsibilities effectively.

A number of schools had seized the opportunity provided by falling rolls to extend the service they provided. Spare capacity within schools had enabled new health initiatives to be implemented. One school re-located its nursery to create a "Family Centre". It was equipped with a medical room, dining area, cooking facilities, lounge, reception area used by parent groups, staff and children to meet the various needs of children and the community. Comments from parents showed the value placed on the opportunity to meet and be supported by the school. Although grants were available to set up the centre, the school now had to support it fully. The room is invaluable in providing a base for external agencies as and when needed, to work with parents.

A particularly interesting and effective initiative was "NHS Live" which brought together many different agencies involved in the health and well being of children in a primary school for a period of a year. This enabled the school to access staff and resources otherwise not available.

The project focused upon issues such as emotional health and well-being, nutrition, dental health, asthma care, attendance and academic attainment, and was very successful. Benefits had quickly been identified from this approach, for instance the opportunity for staff to meet and work across organisational boundaries and for children and families to realise health benefits.

Mental Health

A growing concern for many schools was the increasing number of children with social, emotional and behavioural difficulties.

These schools had responded by identifying staff and providing training for them to support children's emotional needs e.g. anger management and self-esteem programmes. The Social Emotional Aspects of Learning Programme (SEAL) programme had provided a good structure to support schools but the most effective work had involved tailoring the material to suit the needs of individual schools. The schools visited had all integrated national and local initiatives based around PSHE into their curriculum. This is expanded in the curriculum section of this report.

Working with parents

All schools recognised the importance of involving parents in their efforts to improve the health of their children. As stated in Ofsted's paper: Healthy schools, healthy children, (2006), Ref 2563. The contribution of education to pupils' health and well being, Page 5:

*"The successful schools generally took a whole school approach to this work. For example, several schools had set up healthy living task groups. They usually consisted of the PSHE coordinator, a governor, school nurse, and members of senior staff, non-teaching staff, teachers, **parents** and pupils. The groups carried out audits, identified effective practice and, because they were led by senior managers, were able to bring about change quickly and efficiently." (Ofsted 2006)*

Many of the schools in the survey found that working parties made up of parents, representative of the whole school community, were particularly effective. By enlisting the support of parents, the key healthy messages were far more likely to succeed beyond the boundaries of the school. All staff acknowledged the limited impact they could have upon home circumstances, but there was evidence that where parents learnt alongside their children, the chances of lasting long-term benefits was greatest. One particularly successful initiative involved parents and pupils completing a "healthy cookery" course provided by the local authority's lifelong learning service. One school had used money available through the extended schools project to work more closely with parents as part of a holistic long-term programme. Extended schools should help make the school an integral part of the community, meeting the changing needs identified. One school had used funding to appoint an "Extended School Health Co-ordinator" whose role was to forge links between the health and education services. This was felt to be very successful but the funding is coming to an end and the role will cease due to lack of funds.

Schools found the establishment of a team dedicated to health promotion with representatives from different elements of the school had been particularly successful. One headteacher noted the importance of the structure of the team and said "you not only need the right passengers on your bus but you need them sitting in the right seats."

School Sports' Co-ordinator Scheme (SSCo)

All schools agreed that the School Sports Co-ordinator Scheme (SSCo) had had a significant impact upon the physical well being of pupils. The amount of time devoted to physical exercise had increased, staff were better trained and schools were better resourced.

The development of more active playgrounds, with organised physical activities, has resulted in greater physical activity and added to the enjoyment of school. Children have been more ready to learn, particularly in afternoon sessions and have assisted social development.

Increased extra-curricular activity, supported by the SS Co scheme, had helped to strengthen the school's position within the local community. The extension of the school beyond the barriers of the traditional school day had had a positive impact upon children's readiness to learn. Schools in more socially disadvantaged areas had noted the impact on learning as a result of providing "Breakfast Clubs". One particular school felt that it had such an impact that it used the school budget to fund the provision. Another school structured their morning timetable around a "milk and toast time" which provided an opportunity for calm reflection and discussion.

National initiatives such as the SS Co and National Healthy Schools schemes have assisted these schools to promote children's physical and emotional well being by providing expertise and a clear framework for schools to develop successful practice.

The financial constraints placed upon schools and the uncertainty of long-term funding inhibits schools' ability to plan provision over the longer-term and therefore the sustainability of programmes. Current initiatives, such as SS Co, Health Promoting Schools [HPS] and extended schools are all temporary funding streams and are not directly devolved to schools. All these schools identified the pressure on staff time as being a significant barrier to implementing programmes fully. A crowded curriculum, with limited time allocated to health promotion was seen as a further barrier, particularly at the upper end of the primary school. The importance placed upon the end of key stage 2 results was also identified as having a negative impact upon both the breadth of the curriculum and the health and well being of pupils. Schools felt frustrated that they were able to identify the needs of their pupils but were unable to access the support quickly enough to have an impact. The schools were not always fully aware of the range of agencies available to provide support and a central database, which all schools could access, would be particularly useful. A lack of coordination across agencies and a failure to work together on common issues also hindered effective practice.

3.4 Curricular changes

All the schools visited had developed a whole school approach to the creation of an environment which promoted a healthy lifestyle for all its members. The leadership involved the whole school community in the development of a positive attitude towards learning how to be healthy both in body and mind. One headteacher commented that:

"As the change to incorporate a more physical approach to learning had been staged carefully with all staff and parents signing up to this shift in emphasis, then the 'well being' of children was very high on the agenda for school improvement and was integral to all learning opportunities."

The PSHE elements of the curriculum had taken on a greater profile with schemes of work created to meet children's needs within their own contexts. Each school had modified its curriculum quite radically but in different ways. In four schools, the Social Emotional Aspects of Learning Programme (SEAL) had been particularly successful.

The staff had noticed big improvements in the attitudes of children both to their learning and to their relationships with one another. One school had a 'Feelings Board' to flag up the feelings of children at the beginning of the day. The board was colour coded and changed twice each day to gauge the children's change in moods throughout the day. Another school used the same strategy but in the form of a 'Mood Tree' where children hung coloured baubles depending on how they felt. Both

schools felt that these strategies were very effective in enabling children to express and discuss their feelings. Another school felt that the programme had proved very effective in helping children understand their feelings and express their fears and frustrations and so enabled them to develop and maintain friendships. However, one school, although very positive about the programme, felt that the materials did need to be 'personalised' to meet the needs of specific children. To further encourage the emotional well being of the children, one school had created special areas within each classroom to encourage relaxation. These were called "BLISS" areas and were created with fairy lighting, wind chimes, vaporisers and comfortable seating. Children were encouraged to use relaxation techniques which were actively promoted through literature.

Some of the schools visited had "blocked" the curriculum to devote whole weeks to the promotion of healthy lifestyles. These weeks were packed with activities such as the promotion of good hygiene, drugs awareness, self defence, looking after the teeth, good diet, road safety, baking and many physical activities. Other schools had identified certain days to focus on the promotion of good health. The science curriculum had been reviewed in all schools to ensure that every opportunity was identified to link with PSHE content and to promote physical and emotional well being. All of the schools had adopted creative approaches to learning and teaching.

The evolution of this more creative, interactive and practical approach ensured that the learning opportunities challenged and motivated children whilst taking into account their different learning styles. Schools found that children were far more active and responsive in their learning and felt more in control. As part of the Mind Friendly approach to learning, some schools have created a 'Mind Friendly State' in their school and classrooms. These strategies ensure that the learning environment was 'emotionally positive' and supportive to each child. Another school had built in a fifteen minute session during the morning to accommodate a period for calm reflection. Milk and toast accompanied story time, circle time or SEAL activity. This had been very effective in the promotion of good relationships, which supported the emotional well being of children as well as providing nutrition for those children who do not have breakfast.

All of the schools had adopted a range of strategies to promote the physical well being of the children. Children were encouraged to bring water to school and drink throughout the day. Healthy packed lunches were promoted and monitored. Two schools began the day with 'Wake and Shake' activities. These sessions had proved to be very successful in preparing the children and staff for the morning activities. All schools had ensured that children received at least two hours of physical education each week. The School Sports Programme had introduced a range of sports into the curriculum. In three of the schools, the staff had received training in PE skills from the Local Authority and found themselves to be far more confident in teaching specific activities. In all schools, opportunities for physical activity were identified throughout the school day. Two schools which used Brain Gym exercises throughout the day noticed an improvement in children's concentration and attitudes to learning, particularly for vulnerable groups. One school ensures that during PPA time each day, the children are involved in ten minutes of physical activity such as running or skipping. The staff have noticed, over a period of time, the gradual improvement in the children's fitness.

A great variety of after school clubs to encourage fitness had been introduced in all the schools. This included basketball, cross-country, dance, athletics, mat ball and many more. However, most of these activities catered for the older children with an identified gap in provision for the children in key stage one.

All schools visited have involved the community in the promotion of the 'well being agenda' for the children. One school had further promoted the home school link with the creation and adoption of a Travel Plan , which identified many ways in which the children can promote healthy lifestyles as well as encouraging them to walk to school and be safe. In one school there were plans to create a walking bus.

Research has shown that the curriculum in all schools has been modified to ensure that the physical and emotional needs of the children are catered for within their own context. Therefore, the shape of the curriculum in each school is different, but effective for the children it serves.

Schools who have embraced the need to cater for different learning styles have noted that learning is a far more active experience and has increased enjoyment. Senior members of staff interviewed felt that where there were more opportunities for pupils to be more actively involved in their learning, there was a greater impact upon achievement and enjoyment. This view is supported by Weare (2002), who states:

“Approaches to learning which use a range of methods have been shown to be more effective than those which use a limited range. Work on learning styles has shown that people learn in many different ways, so using a range of styles allows for the use of a range of learning experiences to match these different styles as well as helping learners to develop a wider repertoire than their usually preferred style.” (Weare 2002: 102)

3.5 Main Challenges

Throughout this report, it is evident that there are many challenges for aspiring schools that wish to create and sustain effective health provision for all children.

School leadership has been identified within this study as critical to the success of the healthy school's agenda; it was considered essential that the headteacher had the vision, commitment and skills to ensure children's health and well being was a school priority.

Against a changing legislature of flexible working, the challenge for Governing Bodies and Local Authorities is to recruit, retain and promote school leaders to replace the number of headteachers due to leave their posts. Once appointed, the leadership challenge becomes one of harnessing the talent and motivation of staff employed within the school to meet the needs of children, at the same time as making everyone accountable for the statistical outcomes of pupil attainment.

A further challenge is the creation and sustainability of an effective management structure, providing relevant training for school staff to facilitate inclusion and the Extended School's agenda. In addition, there are many significant demands upon school leaders to effectively manage the varied range of external human resources and support agencies required to respond to inclusion issues and health promotion. These demands were too often dependent on school size and location. Indeed, the variation in health provision within the focus schools has been described as a 'postcode lottery' and is reflected throughout the report.

The pressure to improve and sustain annual test results against a background of fluctuating pupil cohorts with increasing numbers of children who have social and

emotional difficulties is intensely felt by senior leaders. There is a tension in delivering high standards in core subject areas whilst maintaining a broad and balanced curriculum that will support children's health and well being. The challenge facing schools is to make use of the health data available to them to demonstrate the impact of action taken to improve the health and well being of children. Attainment outcomes for children over time are not the only indicators of the quality of school provision.

For those schools fortunate to be targeted with support by Local Authorities, easy access to health promoting resources was less of an issue for school leaders. However, smaller schools, those with poor outdoor facilities and those located within less disadvantaged areas, the challenge to promote health and well being was significant. All schools experienced problems in managing swift referral of children with additional needs. School leaders also have to manage the financial implications of health and well being; the short term funding of initiatives requires all schools to sustain health promoting options beyond initial start up.

Conclusion

From the research, the common characteristics of the schools that demonstrated effective leadership and management of children's health and the factors that they found useful were:

Leadership and management strategies

- The commitment of senior leaders to improving the health and well being of the school community.
- The ownership and engagement of the school community in decision making and the allocation of resources in health initiatives.
- Identified time for strategic planning and communication on health matters.
- Committed staff, who were open to change and drawn from across the school community.
- A whole school approach was developed which implemented successful and **sustainable** improvements.
- Staff trained to deliver their respective roles including Special Educational Needs Co-ordinators (SENCOs), learning mentors, sport coordinators.
- Clear roles within a structure and time to give targeted support as appropriate.
- Effective systems for gathering and using health information and for tracking the changing needs of children.
- The establishment of flexible intervention strategies that are responsive to changing needs.
- Establishment of close links with external agencies, which help schools to target and support pupils e.g. Health Service.

Supporting factors

- The national focus on improving the health and well being of children.
- The importance of health as an aspect of the school inspection process.
- Every Child Matters, with health as an important integral element has encouraged schools to look at the curriculum and structure of the school.

- The integration of health in the School Self Evaluation Form (SEF), has helped schools celebrate achievement and to focus on all aspects of health.
- Services were most effective when they were **based in the school** and, therefore, at the heart of the community.
- Long term sustainable projects, not time and resource limited.
- Resources for particular schemes e.g. Healthy Schools, Sports initiatives, SEAL were valuable and encouraged schools to be focused.
- Free fruit scheme meant all Foundation and Key Stage One children had fruit

What headteachers said would help

- Less pressure to achieve high standards measured by tests of core subjects. Being judged by results in English, maths and science meant schools felt they had to justify time spent on other areas and on their approach.
- Better information sharing between children's services
- Swift action following referral to external agencies and excess demand leading to delays.
- Equality of access to support services across schools and local authorities.
- Improved support from speech and language services; schools felt they were often required to deliver their own language programmes. Speech therapy was consistently inadequate and communication with schools was poor.
- Increased support and resources for schools to meet the demands of increasing numbers of children with social and emotional difficulties.
- Clear messages about health from a wide range of sources as often schools and parents have mixed messages.
- Schools would make better provision if they could fund more human resources to tackle children's emotional health and special needs. Limited resources meant there was a tension between meeting the needs of individuals and the needs of the majority.

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Schools visited

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