Evaluation of the National Healthy Schools Programme

Final Report

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Date: June 2011

Prepared for: Department of Health
This is an independent report commissioned and funded by the Department of Health. The views expressed are not necessarily those of the Department of Health nor the Department for Education
Acknowledgements
This research was commissioned by the Department of Health. Thanks go to Dr Catherine Dennison and Fiona Feehan for their guidance and advice on the study. We are also grateful for the input of Richard Sangster and Claire Robson. Thanks also to Dr Lyndal Bond and Professor Laurence Moore for their comments on the draft report and advice on the study more broadly.

Our thanks, too, go to the schools who took part for giving generously of their time and thoughts in relation to the National Healthy Schools Programme. We hope the report does justice to their experiences and views.
Authors and contributors

Due to the length of this evaluation, a large number of people at NatCen have worked and contributed to it. We are extremely grateful to all of them. Those whose work contributed to the project are: Sue Arthur; Matt Barnard; Elizabeth Becker; Chris Creegan; Naomi Day; Kerry Devitt; Christopher Ferguson; Elizabeth Fuller; Nicholas Gilby; Dave Hussey; Lucy Lee; Jane Lewis, Gareth Morrell; Hayley Neil; Susan Purdon; and Helen Ranns.
## Glossary of terms and abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>EAL</td>
<td>English as an additional language</td>
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<tr>
<td>EHWB</td>
<td>Emotional Health and Well-Being</td>
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<td>FLO</td>
<td>Family Liaison Officer</td>
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<td>NHSP</td>
<td>National Healthy Schools Programme</td>
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<td>NHSS</td>
<td>National Healthy School Status</td>
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<td>PE</td>
<td>Physical Education</td>
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<td>PTA</td>
<td>Parent Teacher Association</td>
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<td>PSA</td>
<td>Parent Staff Association</td>
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<tr>
<td>PSHE</td>
<td>Personal, Social and Health Education</td>
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<tr>
<td>SEAL</td>
<td>Social and Emotional Aspects of Learning</td>
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<td>SRE</td>
<td>Sex and Relationships Education</td>
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Executive summary

Introduction

- **Aims and scope of the research**: The report presents the findings of the evaluation of the National Healthy Schools Programme (NHSP). The NHSP was launched in 1999 by the Department of Health and Department for Education with the aim of supporting schools to take a whole school approach to promoting the health and wellbeing of children and young people.

- The Programme’s strategic aims were to: support children and young people in developing healthy behaviours; help raise pupil achievement; help reduce health inequalities; and help promote social inclusion. Schools achieved National Healthy School Status (NHSS) if they met 41 criteria across the four themes of: Personal, Social and Health Education (PSHE), healthy eating, physical activity and Emotional Health and Well-Being (EHWB). The criteria encompassed key elements of the whole school approach. Schools self-reviewed and validated their performance against the NHSS criteria and local healthy schools programmes co-ordinated a quality assurance process.

In early 2007 the Department of Health commissioned NatCen to undertake an evaluation of the NHSP in order to ascertain whether the NHSP had impacted on the knowledge, attitudes and health-related behaviour of pupils and to identify the mechanisms facilitating or acting as barriers to change.

- The evaluation combined a quantitative and qualitative approach.

- The quantitative component focussed on ascertaining whether the NHSP had had an impact on pupil health related knowledge, attitude and behaviour and involved telephone interviews with healthy schools co-ordinators in schools working towards NHSS, and also a pupil paper-based self-completion survey in the same schools.

- The qualitative component focussed on describing schools' understanding of the NHSP, mapping the activities that had been undertaken to fulfil the NHSS criteria and identifying the mechanisms that led to school and pupil-level change. This involved interviews with the head teacher and/or healthy schools coordinator in 16 schools and 4 Pupil Referral Units (PRUs) and special schools.

- The schools taking part in the qualitative component were a sub-sample of those participating in the co-ordinator survey. They were originally sampled at the

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1 Since this research began, Personal, Social and Health Education has become Personal, Social, Health and Economic Education for Key Stages three and four, though not for Key Stages one and two. Throughout this report, PSHE refers both to Personal, Social and Health Education (in primary schools) and Personal, Social, Health and Economic Education (in secondary schools).
beginning of the study on the basis of being as close as possible to the start of the process of working towards the NHSP. The sample was also selected so as to ensure the inclusion of schools of different sizes and with different levels of free school meals (FSM). None of the schools in the sample had achieved NHSS at the point of the sample selection.

- **Evolution of NHSP**: During the period within which the evaluation took place (2007-2010) Healthy Schools evolved as a national programme. Achievement of NHSS increasingly became perceived as a marker demonstrating a school’s commitment to a universal foundation for pupil health and wellbeing. Schools were then encouraged to continuously review and improve their commitment to pupil wellbeing through engaging in a cyclical ‘plan, do, review’ process focused on addressing pupil health behaviour change.

- The following sections of the Executive Summary present summary findings of the impact of NHSP at a school level and on pupils’ health outcomes. These are presented initially in relation to the four NHSS themes, followed by a summary of the overall impact on school practice and pupils.

**Impact of NHSP – PSHE and EHWB**

- **School level change to PSHE and EHWB practice**:
  - Changes to PSHE practice during the evaluation period included: greater use of outside agencies (for example support and advice from police and fire service), work focused on addressing specific behaviours (e.g. anti-bullying week) and more generic approaches for example improving relationships between pupils. The proportion of schools with counselling services, active buddy schemes, peer support or mentoring schemes, and initiatives to support the health and well-being of staff significantly increased over the evaluation period. Some changes were said to have happened as a direct result of engaging with the NHSP, for example the appointment of a PSHE coordinator or the introduction of specific practices in order to meet the NHSS criteria. Overall, 87 per cent said that the NHSP had had a lot or a fair amount of impact on their schools’ provision of PSHE, with those working in secondary schools more likely to say this than those working in primary schools. Other schools found it difficult to attribute changes in the delivery of PSHE or EHWB to the NHSP, or to isolate specific factors influencing change because of a history of working in partnership with local providers and organisations to improve practice.

- **Pupil-level changes linked to PSHE and EHWB**
  - **Perceived impact of NHSP on pupil level changes**
    - Not all staff were able to identify examples of pupil impact and some found it difficult to link pupil impact to the school’s involvement with the NHSP given the likely interplay of a range of factors. Where staff were able to cite examples of impact these fell into three broad categories. Firstly an improvement in pupil knowledge and awareness of what constitutes a
healthy lifestyle and an understanding of equality and respecting difference. Secondly changes to pupil behaviour, including a reduction of smoking on school grounds, an improvement to the general courtesy and manners of pupils within the school, and greater engagement in lessons. Thirdly an improvement in pupils’ ability to deal with future challenges in later learning, adult life, and the workplace.

• Pupil impact – findings from the multivariate analysis of the pupil survey
The analysis found that within the two year timeframe a school’s engagement in the NHSP did not lead to any significant changes in pupil knowledge, attitude or behaviour associated with the themes of PSHE or EHWB, either at primary or secondary level.

Impact of NHSP – Healthy Eating

• School level changes to the promotion of healthy eating
Among the changes schools made to promote healthy eating during the evaluation period were improvements to the physical environment in canteens, introducing healthier menus, introducing practical cooking sessions and running gardening clubs. Some of the changes they made were attributed to schools’ participation in the NHSP, but other influences also came into play such as a need to adhere to government guidance, initiatives such as Licence to Cook, or structural changes facilitating new practice, for example moving to a new school site. Changes were also attributed to schools’ existing commitment to promoting healthy eating. Seventy-seven per cent of school co-ordinators said that the NHSP had a fair amount or a lot of impact on the provision their schools had made around healthy eating, with more co-ordinators in secondary schools stating this compared to those in primary schools.

• Pupil-level changes linked to healthy eating
  • Perceived impact of NHSP on pupil level changes
Four key impacts were identified as a result of changes made by schools in terms of their approach to healthy eating and food provision. These were: the take-up of school lunches; pupil behaviour in school; an increased awareness of nutrition and healthy food choices, and increased healthy eating outside of school. The extent to which a school could have an impact on pupils was influenced by the way changes were introduced and explained to students, the availability and access that pupils had to unhealthy food outside of school, the age of pupils, and the level of parental support and engagement.

• Pupil impact – findings from the multivariate analysis of the pupil survey
Analysis found that within the two year timeframe a school’s engagement in the NHSP did not lead to any significant changes in pupil knowledge, attitudes or behaviour in relation to healthy eating either at primary or secondary level.
Impact of NHSP – Physical Activity

- **School-level changes to the promotion of physical activity**
  - Changes to the promotion of physical activity in schools during the evaluation period included diversification of the range of opportunities available to pupils (for example introducing non-traditional games), the introduction of new ways to encourage parents and pupils to walk or cycle to school, and greater involvement of staff in supporting sports clubs. The survey of co-ordinators found that the proportion offering at least one lunchtime or after-school sports or exercise activity had significantly increased between autumn 2007 and autumn 2009, as did the proportion of secondary schools providing access to sports equipment at break-times or lunchtimes. Schools made changes in response to the NHSP criteria, but were also influenced by other factors. Among these factors were suggestions made by teachers in meeting schools' existing plans and targets and the support and training provided by local networks of sports’ providers and local schools. Seventy two per cent of school co-ordinators said the NHSP had a fair amount or a lot of impact on physical activity provision.

- **Pupil-level changes linked to physical activity**
  - **Perceived impact of NHSP on pupil level changes**
    Four key impacts for pupils were identified as a result of changes made by schools in terms of their approach to physical activity. These were: greater engagement and enthusiasm around physical activity; improved pupil behaviour in lessons; greater awareness and understanding of physical activity, and higher self-esteem and confidence through the sense of achievement pupils felt after learning new skills and discovering talents. The extent to which schools could affect pupil outcomes was underpinned by the degree to which schools were able to respond to the interest and needs of pupils, the involvement and encouragement of staff, and the influence of familial and cultural attitudes to health and fitness. It was also important that the value of physical activity was embedded within the school ethos and culture and discussed both formally and informally within lessons and discussions with teachers.

- **Pupil impact – findings from the multivariate analysis of the pupil survey**
  - Analysis found that within the two year timeframe a school’s engagement in the NHSP did not lead to any significant changes in pupil knowledge, attitudes or behaviour in relation to physical activity either at primary or secondary level.

**Overall impact of NHSP on health-related pupil outcomes**

- **Overall impact at pupil level**: The analysis of the pupil data collected at the baseline and follow-up surveys demonstrates that, within a two year timeframe, the NHSP did not have a significant positive impact on pupil health-related outcomes in either primary or secondary schools. Section 8.3 of this report demonstrates that this held true for outcomes relating to pupils’ knowledge and attitudes as well as pupil behaviour. Some of the possible factors influencing schools' ability to affect pupil outcomes in a two year timeframe are discussed in section 10.3.
• **Spill-over effects:** A secondary analysis project was conducted which aimed to use existing data to investigate whether there was any association between a school’s achievement of NHSS and other indicators of a school’s performance and whether there was any possible “spill-over effects” such as pupil attendance. Having or being close to achieving NHSS was shown to be related in a significant and positive way to most of the outcomes considered by the analysis. The strongest relationships were with Ofsted ratings (a measure of management effectiveness), but there were some small but significant relationships between NHSS and total absence levels, Contextual Value Added (CVA) scores, persistent absence and participation in high quality sport or Physical Education (PE). Most of the relationships were found to be sustained when the data for a two-year period (2006-2008) were analysed. However, it is important not to over-rate these relationships as, due to the self-selecting nature of the NHSP it is quite possible that engagement with the Programme is linked to some school characteristic that it is not possible to control for (for example, the quality of school leadership and management) that are also related to these outcomes.

• **Perception of impact at pupil level:** Co-ordinators however were positive about the impact the NHSP had on the knowledge, attitudes and health behaviour of pupils. They felt that the Programme had raised awareness about health in general and had led to healthier eating and to an increase in the sport or activities available to pupils or their participation in these. The majority of co-ordinators believed that these positive impacts applied to all pupils (rather than benefiting only specific groups).

**Impact of NHSP at school level**

• **Role of the NHSP:** The NHSP was cited as influencing school practice in four ways: instigating changes to practice in order for the school to directly meet the NHSS criteria; providing a justification for change amongst management teams; acting as a tool to re-evaluate existing practice; and raising awareness and the profile of health and well-being among staff.

• **Perception of overall impact at school level:** School co-ordinators were positive about the overall impact the NHSP had on their schools. A majority of co-ordinators said that the NHSP had a lot or a fair amount of impact on school health and wellbeing policies, on the day-to-day work of the school to promote health and well-being, and on school ethos. Most coordinators indicated that as a result of engaging in the NHSP their schools had made a few changes where necessary to existing practice, while around one-fifth of co-ordinators said that their school changed their practices in a significant way. A large proportion of co-ordinators agreed that, as a result of the NHSP, their school gained a framework to think about work on health issues, that staff improved their knowledge, and that staff re-evaluated and identified gaps in existing practice.

• **Typology of impact:** Overall the evidence suggests that NHSP had a variable degree of impact in schools. In some schools NHSP caused definite changes and
was a driver to implement new ways of working and delivering health and well-being. In other schools the NHSP had a limited impact – this was particularly the case in those schools that had already achieved the majority of the NHSS criteria. In this instance a school’s engagement with the NHSP was predominantly seen as a reflective process to audit and re-evaluate existing practice. Furthermore some schools regarded the NHSP simplistically as a tick box exercise to validate existing practice and in these schools there was minimal impact.

- **Factors affecting impact:** The time required for staff to invest in co-ordinating a school’s work towards achieving NHSS was identified as the primary factor influencing whether a school achieved status or not. Other influencing factors included access to support or guidance. Lack of governor and parental involvement were identified as the main barriers to successfully realising the whole school approach.

- **The influence of the local NHSP Programme:** Local healthy schools programmes (co-ordinated by the local authority and Primary Care Trust) also had an important role in influencing changes in schools. The types of support offered included assistance with conducting audits in relation to the NHSP criteria and help with the self-validation process, delivering NHSP training and awareness courses, and providing links to other support and resources. Local programmes also had an important role in securing the involvement of other staff and parents and facilitating a whole school approach. Some participants felt that the local healthy schools programme provided the impetus for schools to achieve NHSS, and provided support that gave school co-ordinators confidence in making changes to practice. The local healthy schools programme was seen as less helpful where it was reactive rather than proactive.

**PRUs and special schools**

- **PSHE and EHWW:** Overall PRUs and special schools made limited changes when addressing NHSS criteria as their approach to supporting the learning and behavioural needs of their pupils meant that in most cases the NHSS criteria were already being implemented. That said, changes in the provision of PSHE were cited, including an increased focus within the timetable and the creation of a single lesson for PSHE. Both PRUs and special schools faced particular challenges to achieving some of the NHSS criteria due to the learning and specific needs of their pupils.

- **Healthy eating:** PRUs identified two main barriers to achieving the healthy eating NHSS criteria. The absence of on-site cooking facilities limited the degree of control schools could have over the kind of food eaten on site and therefore the capacity to influence eating habits. A second challenge was engaging parents due to the high number who themselves faced behavioural or emotional problems. Special schools also experienced particular challenges in introducing healthier food where students had specific food requirements or restrictions.
• **Physical activity:** PRUs were less able to provide opportunities for two hours of physical activity compared to mainstream schools because they had limited access to equipment and resources and were more reliant on external facilities. In addition there were challenges to being able to offer extra-curricular activities to pupils given the wide catchment area of the schools and the fact that many pupils needed to catch prearranged transport home straight after school. Teachers also raised concerns that despite the opportunities made available within schools, pupils may not continue activities outside of schools due to a lack of confidence in interacting with peers.

Special schools also experienced challenges, particularly in engaging with parents. They faced resistance from some parents about pupils’ involvement in sporting competition outside of school due to concerns about how they would respond and interact in other environments. Also, as a number of special schools are residential, parents were less able to be involved in activities due to the distance between where they lived and the school.

**Understanding the impact of NHSP**

• **NHSP theory of change:** The NHSP's theory of change envisages the process of meeting the criteria (using the whole school approach) leading to changes in schools’ health promoting activities that in turn influence pupils' health-related knowledge, attitudes and behaviour towards health and well-being. This process involves two transition points. The first is between meeting the NHSS criteria and changes in schools’ health promoting activities (transition 1) and second, between changes in schools’ health promoting activities and changes to pupils’ health-related knowledge, attitudes and behaviour (transition 2).

• **Transition 1 - factors influencing changes to schools’ health-related practices:** The NHSP influenced the way schools promoted health and well-being through the changes schools made to achieve the NHSS criteria and the influence of the local healthy schools programme. However changes took place in the context of an existing momentum for change within schools, the involvement and impact of complementary initiatives, and existing local networks which help to develop and improve health-related practices in schools. Barriers and challenges to schools implementing change included negative attitudes of school staff towards the NHSP and an unwillingness to implement change and competing priorities such as managing poor performance in core subjects.

• **Transition 2 - factors influencing changes to pupils’ health-related knowledge, attitudes and behaviour:** School staff expressed caution over the extent to which they could affect pupil health outcomes, particularly in relation to behaviour outside of school. However they identified a number of factors which did influence change, such as the extent to which school co-ordinators could act as a driver for change and encourage staff, pupil and parental engagement, as well as other positive cultural influences (for example awareness in the wider
community of the merits of healthy eating). Staff identified barriers to change, which included the level of engagement of staff with the NHSP, the role of negative external influences (such as the behaviour of parents and peers), and schools' limited contact time with pupils.

- **Model of influences of health-related practices and pupil impact:** The research showed that in practice the process of change is influenced by factors that are NHSP-related and factors outside the control of the Programme. The corollary of this is that there are barriers which limit the extent to which the NHSP Programme can lead to change. Also the influence of other factors affecting change in practices and pupil behaviour and attitudes makes it difficult to isolate the impact of the NHSP.

**Conclusion**

- The context in which the NHSP operated evolved throughout the duration of the evaluation. The evidence presented in this report indicates that the NHSP is a useful facilitator of change at a school level but that it is not clear how changes at a school level transfer to changes at a pupil level. Schools’ own priorities and goals were described as being very much the driving force behind their actions, with the overwhelming message that the NHSP was helpful in supporting changes they would have made anyway.

- The NHSP chimed with much of what schools felt was important to them and where their priorities lay. In terms of lessons for the future it is important to be realistic about what it is possible for a Programme of this nature to achieve particularly in the short-term.

- The analysis of the pupil data demonstrated that the NHSP was unable to have a significant positive impact on health-related pupil behaviour within a two year timeframe. This suggests that health promotion work in schools which are not engaged early on in Programmes such as NHSP will not impact positively on pupils within a two year timeframe. Consequently, there has been an increased recognition that the time needed to achieve pupil impact is longer than the two years of the evaluation. The NHSP originally intended to affect pupils' health-related knowledge, attitudes and behaviours. However, it is likely that it is easier to impart knowledge, than to influence attitudes, and ultimately therefore change behaviour. Schools are working in an environment where there are powerful influences on pupils from parents and wider society which are beyond the schools' control. Further, it is possible that some of the impacts perceived by co-ordinators taking part in the qualitative component of the evaluation are based on hard evidence and hence “real” but that these impacts were too small-scale to be picked up in the main impact study. Therefore, the findings of this evaluation may not be a comprehensive assessment of the NHSP's overall success.
• The secondary analysis project suggested there were some significant “spill-over” effects of the Programme (for example in better management practices, total absence, Contextual Value Added (CVA) scores, and pupils’ participation in high quality sport or PE) but these were small. There was no clear pattern to the results, although many of the positive changes seen appeared to be sustained.

• In terms of future learning participants indicated that the more pro-active the local healthy schools programme can be, the more likely it is to have an influence on schools’ practice. The implication of this is that a more flexible, targeted approach such as the approach being advocated by the healthy schools behaviour change model is a positive development, but that this flexibility should not be at the expense of structure and guidance.
1 Introduction

This report builds on an interim report published in May 2009 which aimed to provide a picture of the journey towards gaining National Healthy School Status (NHSS) for the schools taking part in the early phase of the evaluation. It focused on descriptive data of what schools were doing at that point, rather than on impact and outcomes.

This report presents the findings of the second stage of the qualitative component of the evaluation of the National Healthy Schools Programme (NHSP) and of the quantitative impact evaluation. The introductory chapter first summarises the main elements of the NHSP and then goes on to discuss the aims and scope of the evaluation, providing detail on the separate evaluation components. Finally, the chapter sets out the structure of the rest of the report.

1.1 The National Healthy Schools Programme

The NHSP was launched in 1999 by the Department of Health and Department for Education with the aim of supporting schools to take a whole school approach to promoting the health and wellbeing of children and young people. The overall aims of the Programme were to:

- support children and young people in developing healthy behaviours;
- help raise pupil achievement;
- help reduce health inequalities; and
- help promote social inclusion

During its twelve-year history the Programme underwent a number of developments in light of an evolving policy context. Initially the focus was on supporting and accrediting the 150 local healthy schools programmes in England (coordinated by Primary Care Trusts and Local Authorities) to meet criteria set out in a national guidance framework, with the aim of enhancing and assuring the quality of health and wellbeing support provided to schools and pupils. In 2005 the definition of a ‘healthy school’ was clarified encompassing criteria related to the four core themes of Personal, Social and Health Education (PSHE), including Sex and Relationship Education (SRE) and drug education; Physical Activity; Healthy Eating and Emotional Health and Wellbeing (EHWB). The criteria covered aspects of the whole-school approach including: leadership, management and managing change; policy development; curriculum planning and resourcing including working with external agencies; teaching and learning; school culture and environment; giving pupils a voice; provision of pupils’ support services; staff professional development needs, health and welfare; partnerships with parents/carers and local communities and assessing, recording and reporting pupils’ achievement.
Schools were supported by local healthy schools programmes to self-review their practice against the criteria for National Healthy School Status (NHSS), to address any gaps and to self-validate once they were confident that the school met all of the criteria. Local programmes also fulfilled a quality assurance role and in light of national guidance validated a sample of schools practice thus ensuring the integrity of the Programme. The national policy context supported school engagement in the NHSP: the five outcomes for children set out in the Government’s strategy “Every Child Matters”; schools statutory responsibility for pupil wellbeing as set out in the Children’s Act 2004 and the emphasis of school Ofsted inspections on personal development and wellbeing. The NHSP provided schools with a framework for demonstrating their contribution to pupil wellbeing.

In 2009 the NHSP was refined further to provide an explicit focus on health behaviour change and a cyclical ‘plan, do, review’ process for schools to ensure they make continuous improvements and embed a commitment to child wellbeing within their organisations. Whilst the latter focus falls outside the scope of this evaluation the conclusion to this report highlights learning which may be relevant to the delivery of Healthy Schools in the future.

**NHSP Conceptual Model**

The NHSP literature distinguished between ‘inputs’, ‘impacts’ and ‘outcomes’ (Achieving NHSS Quality Assurance Framework Support Materials) the definitions of which are quoted below.

- **Inputs** – these refer to actions that schools take to bring about improvement e.g. writing of a whole school bullying policy or introducing healthier menus. Much of the criteria for the NHSS are ‘inputs’. They do not, in themselves, show change in learning, behaviour or attitudes.

- **Impact** – this comes as a result of successful inputs e.g. all staff and children/young people are aware of the bullying policy and know how to deal with incidents of bullying; children/young people know they have greater choice at lunch times. Impact is usually achieved over a longer period of time.

- **Outcomes** – qualitative outcomes refer to results that have changed learning, attitudes or experiences e.g. the school reports there is far less bullying; parents regard the school as ‘safe’ for children; lunchtime supervisors report few incidents of bullying etc. These can be numerical and the regular measuring of these outcomes will ensure greater validity and rigour. Quantitative outcomes (sometimes known as outputs) refer to those outcomes that carry a numerical measure and show a change in behaviour e.g. there is a 50 per cent increase in children/young people selecting school meals. Outcomes are usually brought about by a combination of successful inputs.
The definitions above can be translated into a simple conceptual model where fulfilment of the NHSS criteria manifests in changes to schools’ health promoting activities which in turn leads to changes in pupils’ health-related knowledge, attitudes and behaviour. This model is illustrated in Figure 1.1.

**Figure 1.1 NHSP conceptual model**

![Diagram of NHSP conceptual model]

For example if a school updates its food policy this might lead to the contents of packed lunches being monitored in order to ensure they are healthy which could lead to pupils knowing what a healthy packed lunch is (knowledge), wanting to have a healthy packed lunch (attitude) and bringing in healthy packed lunches (behaviour). This example is set out in Figure 2.

**Figure 1.2 NHSP example of change process**

![Diagram of NHSP example of change process]

The next section sets out how the evaluation fits in with this conceptual model.

### 1.2 Evaluation methodology

The overarching aim of the evaluation was to understand the effect of the NHSP on pupils and schools. Its specific objectives were to:

I. measure the impact of the Programme on the health-related behaviour, knowledge and attitudes of pupils
II. identify the mechanisms by which impacts were achieved or obstructed.

The objectives of the evaluation were met using a mixture of qualitative and quantitative methods. The relationship between the NHSP theory of change and the evaluation approach is set out in Figure 1.3.
A quantitative approach was used to measure the impact of the Programme on health related behaviour, knowledge and attitudes of pupils. Baseline and follow-up telephone interviews were undertaken with Healthy Schools co-ordinators and paper self-completion questionnaires were used with pupils. These measured the degree to which schools had moved towards gaining NHSS and the degree to which pupils’ health-related attitudes, knowledge and behaviour had changed.

In the summer term of 2007, NatCen identified 256 secondary and 302 primary schools that were not currently involved with the Programme but expected to become involved over the next one to two years. In one hundred and three (40%) secondary schools the co-ordinators took part in the baseline and follow-up telephone interviews, with 172 (57%) doing so in primary schools. Overall 275 co-ordinators complete the baseline and follow-up study, representing a response rate of 49 per cent. The baseline study took place in the autumn term of 2007 and the follow-up study in the autumn term of 2009.

Co-ordinators who took part in both the baseline and follow-up studies were sent packs containing all of the materials necessary to carry out the pupil survey, which included a covering letter, letters to be sent to parents, guidance for the teachers conducting the survey, and the questionnaires. Each school was asked to carry out the survey with classes from two year groups (estimated to be around 50 pupils): one class in year 4 and one in year 6 in primary schools, one class in year 8 and one in year 10 in secondary schools.

One hundred and fifty two schools (102 primary and 50 secondary) completed the baseline and follow-up pupil questionnaires. The baseline pupil study took place in autumn 2007 and spring 2008, and the follow-up pupil study in autumn 2009 and spring 2010. Thus the overall response rate at the school level for the pupil survey was 27 per cent (34% in primary schools and 20% in secondary schools). More details of the quantitative methodology can be found in a separate technical annex.

A qualitative approach was used in order to identify the mechanisms by which the impacts were achieved or obstructed. This explored:

- the understanding that school staff had regarding the aims and objectives of the NHSP, and what motivated them to engage with it;
- what organisational approaches had been used as a result of engaging in NHSP;
- the range of activities that schools undertook to meet NHSS, the mechanisms that led to these changes, and any barriers that inhibited change;

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2 22 additional schools had been recruited but were then excluded due to their participation in another NatCen study.
• the key mechanisms that led to changes in pupils’ health-related attitudes, knowledge and behaviour and any barriers that inhibited that change;

• the reflections of school staff on NHSP and recommendations for the future of the Programme.

As Figure 1.3 indicates, the qualitative component aimed to meet these objectives by describing what schools were doing at each point along the conceptual model (i.e. what they were doing to fulfil the criteria, what changes they made in health promoting practices etc) as well as identifying the barriers and facilitators that were involved in the flow of impacts from one point to another. The qualitative component of the study used a longitudinal approach so that the process of change could be captured in detail (with fieldwork carried out in 2007 and 2009).

There were two main stages of fieldwork for the qualitative evaluation:

**Stage 1** – at the beginning of the study (2007) interviews were conducted with either the head teacher and/or healthy schools co-ordinator in a sub-sample of 16 mainstream schools taken from the schools involved in the surveys. In addition four Pupil Referral Units (PRUs) and four special schools were also selected. The findings of this stage of the qualitative component were incorporated in the evaluation’s first interim report.³

**Stage 2** – half way through the study (summer 2009) interviews were conducted with the head teacher and/or healthy schools co-ordinator in each of the 16 schools and four PRUs and special schools. Interviews during this stage focused on two criteria in each theme. The criteria were chosen on the basis that they were those that schools were least likely to have achieved according to the baseline findings of the quantitative component of the evaluation along with an assessment by NatCen and DH of the criteria’s strategic importance. None of the schools in the sample had achieved NHSS at the point they were selected, however by the second wave a number of schools had done so. This report presents the findings from this stage of the research, along with the quantitative impact measures.

More details of the methodology are reported in a separate appendix.

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³ Ibid
Comparison of changes in fulfilment of NHSP criteria and changes in pupils’ attitudes, knowledge and behaviour between T1 and T2 gives measure of impact of Programme.
1.3 The evolving policy context and subsequent developments

During the time the evaluation was conducted there were changes to the context in which the NHSP was operating. There was also a growing appreciation that influencing health behaviour change is a long-term goal and initial expectations of what the NHSP might achieve within the evaluation timetable were revised in accordance with this understanding.

One of the original goals of the NHSP was for all schools to have in place a universal foundation for pupil health and wellbeing through achievement of NHSS. The context within which Healthy Schools was operating was one where a number of Education and Health strategies were being delivered - with similar objectives of engaging schools in work to promote child wellbeing, for example the Social and Emotional Aspects of Learning (SEAL) Programme and the Targeted Mental Health in Schools (TaMHS) Programme. In addition, some of the NHSS criteria corresponded to statutory requirements and normal practice for schools. The interaction of these factors meant that it was difficult to isolate the impact of the NHSP in a simplistic way which might be inferred by the conceptual model presented in section 1.1.

In 2009, South West Healthy Schools Plus, a programme based and delivered in the South West region, was launched as a continuation of the framework of work schools had achieved with the NHSP. The overall aim of this programme was to deliver measurable improvements in the health and well-being of children and young people by bringing about healthier behaviour, focusing on schools with the greatest health inequality. Programme work in participating schools was structured to target local needs, school needs and the needs of children in challenging circumstances. Schools were expected to identify realistic healthier behaviour outcomes to work towards, achieve these through actions that were evidence-based or that follow good practice guidelines and provide measurements of change. Interim reports from the evaluation of the SW Healthy Schools Plus programme are available on the programme website4.

Interpretation of the findings of the evaluation should also be made within the context of the developing perspective on the nature of influencing children through school-based Programmes. As the NHSP has evolved to a stage where it is now based on a health behaviour change approach for schools5, there has been a greater understanding of the timescale necessary for effecting change in the knowledge, attitudes and behaviour of pupils is longer than first envisaged. Therefore there are limitations in conducting an evaluation which seeks to measure behaviour change within a two-year period, and this is recognised in this report.

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5 See www.education.gov.uk/healthyschools
1.4 Structure of the report

The rest of this report sets out findings from the qualitative and quantitative components of the evaluation, reporting staff views on the implementation and impact of the NHSP, as well as an analysis of the impact on health-related pupil outcomes. **Chapter 2** describes the way in which schools sought to meet a number of NHSP criteria, focusing particularly on criteria that schools were least likely to have achieved. **Chapter 3** reports on the findings in relation to PRUs and special schools, drawing out particular issues for these types of schools where their experience and practice varied from mainstream schools.

**Chapter 4** begins to look at the impact of the NHSP, concentrating on the factors that affect impacts on schools and pupils, and describing how the pupil data has been analysed in order to evaluate the impact of the Programme on pupil outcomes. **Chapter 5** focuses on the impact the NHSP has had on provision for PSHE and EHWB and pupil outcomes related to these two themes. **Chapter 6** looks at the impact of the Programme in relation to healthy eating, and **Chapter 7** looks at the impact of the Programme in relation to physical activity. **Chapter 8** focuses on the different themes to examine the overall impact of the NHSP at pupil level, including analysis of the spillover effects of the Programme, and **Chapter 9** looks at the overall impact of NHSP at school level.

**Chapter 10** presents an overview of the impact of the Programme together with a commentary on the Programme’s conceptual model in light of the views and experiences of schools. Finally, **Chapter 11** draws together some conclusions about the NHSP and the extent to which it has influenced health-related pupil outcomes, and considerations for the Programme’s future development.

Although PSHE and EHWB are considered as two distinct themes within the NHSP, the report combines them (for the sections dealing with the qualitative research) as a consequence of the nature of the participants’ perspectives on these issues. In some cases, the issues were seen as overlapping and participants made strong links between the substance of the two themes. The report will discuss changes and impacts across both of the themes, but also identify clearly where participants’ experiences refer exclusively to one of the themes rather than both.

The main body of the report is supplemented by a separate appendix that describes the evaluation methodology and which includes the topic guides and questionnaires.
2 How schools meet NHSP criteria

This chapter describes the approaches taken by the schools in our sample to address specific NHSS criteria. The NHSS criteria selected for investigation were chosen on the basis that the baseline survey of co-ordinators highlighted that schools had made least progress in relation to achieving these criteria. The chapter draws on data from both qualitative and quantitative evaluation components; it is structured so that the relevant criteria are discussed under the following headings: pupil consultation and feedback, PSHE and EHWB, healthy eating and physical activity.

It is important to note that, as it was not possible to include a comparison sample of schools that were not participating in the NHSP, it is not possible to identify to what extent any changes in provision between the baseline and follow-up surveys were due to participation in the Programme. The issue of how we can attribute change to the Programme is discussed in more detail in chapter 4.

2.1 Mechanisms for pupil consultation and feedback

One of the NHSS criteria (1.11) requires schools to:

[Have] mechanisms in place to ensure all children/young people’s views are reflected in curriculum planning, teaching and learning and the whole school environment, including those with special educational needs and specific health conditions, as well as disaffected children/young people, young carers and teenage parents

We therefore asked co-ordinators what mechanisms were in place through which pupils could have a say in the running of the school.

Almost all schools (96%) already had a school council in place at the time of the baseline survey, and this continued to be the case at the follow-up survey (2 years on, when 97% had a school council).

As for other mechanisms through which pupils could have a say in the running of the school, no clear picture emerges (see Table 2.1). There was an increase in the proportion of co-ordinators who said that pupils in their school could feed back ideas through school surveys and questionnaires (from 9% at the baseline to 16% at the follow-up stage). There was a decrease in the proportion of schools mentioning specific class- or year-level councils (from 15% to 2%). All of the other possible mechanisms through which pupils could communicate their thoughts were mentioned in similar proportions at both the baseline and follow-up surveys.

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6 In both the baseline and follow-up telephone surveys we asked co-ordinators a series of questions about the facilities available at their school (that are related to health and well-being). In this section, analysis includes only the 275 schools that participated in both the baseline and follow-up surveys.
Table 2.1 Proportion of co-ordinators saying that their school provided different opportunities for pupils to have a say in the running of their school

<table>
<thead>
<tr>
<th>Stage of survey</th>
<th>Baseline</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class or year level council</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Circle time/ class discussions/ PSHE lessons</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>School surveys and questionnaires</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Prefects/buddies/mentors</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Suggestion box</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Assemblies</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Specific healthy schools group</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>Bases</strong></td>
<td><strong>275</strong></td>
<td><strong>275</strong></td>
</tr>
</tbody>
</table>

2.2 Personal and Social Health Education and Emotional Health and Well-being

2.2.1 PSHE Delivery

One of the NHSS criteria (1.1) requires schools to:

*Use…the PSHE framework to deliver a planned programme of PSHE, in line with relevant DCSF/QCA guidance*

The Department for Education’s guidance on PSHE delivery encouraged schools to move towards delivering PSHE through specialist teachers. For example, one guidance document states that:

*Head teachers should consider making plans for establishing dedicated teams of specialist PSHE education teachers.*

We asked co-ordinators at each stage of the survey what proportion of PSHE lessons were delivered by a specialist teacher, so that we could see what the outcome of this planning may have been. At the baseline survey, 20 per cent of co-ordinators that said that more than half or all of PSHE was delivered by specialist teachers. By the time of the follow-up survey, 25 per cent of co-ordinators gave this answer. The difference between these figures is not statistically significant.

NHSS also requires that each school:

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Statutory Guidance: Impartial Careers Education, DfE (October 2009)
Involves professionals from appropriate external agencies to create specialist teams to support PSHE delivery and to improve skills and knowledge, such as a school nurse, sexual health outreach workers and drug education advisers.

We therefore asked co-ordinators what external specialists had been into their school to talk to pupils about aspects of the PSHE curriculum. Table 2.2 presents the figure for the proportion of co-ordinators saying that different external specialists had been to their schools.  

The proportion of co-ordinators who said that a police officer had been into their school to talk to pupils about aspects of the PSHE curriculum rose from 83 per cent to 92 per cent between the baseline and follow-up surveys. The proportion saying that a member of the Fire Service had been to their school also increased, from 15 per cent at the baseline to 23 per cent at the follow-up survey. The proportion of people mentioning a representative from Connexions decreased from four per cent to one per cent between the baseline and follow-up. Other advisors were mentioned in similar proportions at both the baseline and follow-up surveys.

<table>
<thead>
<tr>
<th>Table 2.2  Proportion of co-ordinators saying that different specialists had been to their school to talk to pupils</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage of survey</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Nurse</td>
</tr>
<tr>
<td>Police officer</td>
</tr>
<tr>
<td>Drugs education advisor</td>
</tr>
<tr>
<td>Sexual health outreach worker</td>
</tr>
<tr>
<td>Fire service</td>
</tr>
<tr>
<td>Other health advisor</td>
</tr>
<tr>
<td>Road/railway safety</td>
</tr>
<tr>
<td>Connexions</td>
</tr>
<tr>
<td>Dental health advisor</td>
</tr>
<tr>
<td>Other safety³</td>
</tr>
<tr>
<td>Bereavement counsellor/ emotional support³</td>
</tr>
<tr>
<td>Religious advisor³</td>
</tr>
<tr>
<td>Careers advice³</td>
</tr>
<tr>
<td>Sports advisor³</td>
</tr>
<tr>
<td>Environment advisor³</td>
</tr>
<tr>
<td>Military³</td>
</tr>
</tbody>
</table>

8 The first four types of external specialist in the table (nurse, police officer, drugs education advisor, and sexual health outreach worker) were asked about specifically in the coordinator interview. Other answers have been coded from answers given when co-ordinators were asked whether ‘anyone else’ had been to their school to speak to pupils.

9 The codeframe was updated at the follow-up survey. Some of the answers coded at the follow-up survey may have been coded in an ‘other’ category at the baseline survey. Figures for the follow-up survey for these categories are therefore included for interest but do not necessarily represent an increase of the size that the table suggests.
We also asked in the quantitative surveys about initiatives that reflected a consideration of staff health and well-being (criteria 3.8 and 3.10). The proportion of schools with initiatives in place to support staff health and well-being increased significantly over two years. In 2007 43 per cent of all schools had such initiatives in place, rising to 55 per cent in 2009.

For the qualitative measures, schools were asked to discuss the steps they had taken to meet three specific NHSS criteria related to PSHE and EHWB:

- Assessment of pupil progress and achievement in line with Qualifications and Curriculum Authority (QCA) guidance for PSHE (criteria 1.3)
- Existence of a confidential pastoral support system (criteria 4.4, *NB also asked in quantitative component*)
- Provision of appropriate professional development opportunities for PSHE and for those in a pastoral role (criteria 1.10 and 4.7)

### 2.2.2 Assessing pupil progress (PSHE)

**Criteria 1.3**
Assesses pupils’ progress and achievement in line with QCA Guidance

NHSS minimum evidence:

- The School must have considered the QCA end of key stage statements in assessing progress and achievement, and this must help to inform (but not dictate) school practice
- The PSHE coordinator has a clear plan on how pupil progress and achievement in PSHE is assessed
- Pupils and staff can clearly identify progress
- Pupils are aware of how their progress and achievement in PSHE is assessed
- PSHE is referred to in the school’s assessment policy or the assessment system within the school

Schools described a range of approaches to assessing pupil progress in PSHE. This included schools that had made recent or pending changes to ensure the criterion was met, and some schools that had made little or no change and were aware that they did not meet the criterion.
A range of formal and informal assessment mechanisms were identified by participants from across the sample. A combination of these mechanisms were used by each school which together formed an approach to assessment that was either standardised and in line with all other taught subjects or represented a more *ad hoc* approach specific to the assessment of progress in PSHE. The manner in which PSHE was delivered appears to have an impact on how progress was assessed and whether it was possible to assess progress.

One approach was to assess PSHE in the same *standardised manner* as other subjects by integrating assessment of taught PSHE into central systems and pupil reporting schedules.

> The formative assessment is written all the way through the schemes of work. Obviously the assessment fits with the school’s policy on teaching and learning…it is all done in line with that, the same as every other subject.

Secondary School, large size, low FSM

Participants from some secondary schools described general assessment tools such as attainment scales, which provide set targets for pupils in all subjects that are measured consistently and throughout transitions between different Key Stages. It was noted by a number of participants that this was a change they were aiming to make in order to meet the criterion and would do so once PSHE was delivered consistently across the school. Schools already using this more standardised approach to assessment felt they were meeting the criterion. Changes made by schools to move towards a more formal and standardised approach to assessment were seen to have had an impact on how PSHE was actually delivered in a number of ways. Using the same assessment criteria across a school was seen as contributing to more coherent delivery of PSHE lessons as staff were able to identify gaps in delivery by assessing pupil progress over time. Also, a number of participants noted that assessing PSHE in the same way as other subjects contributed to giving the subject the same status amongst pupils. Consequently, some participants felt that pupils engaged better with PSHE and this made delivery more straightforward.

Other schools adopted an approach to assessment that was *specific to PSHE*; some still felt that this was sufficient to meet the criterion while others felt there were improvements they needed to make to do so. All primary schools used an assessment process specific to PSHE as did some secondary schools, notably all those that did not deliver PSHE as a discrete timetabled lesson. This suggests that the mode of delivery of PSHE has an impact on the type of assessment that is possible. Further evidence of this was provided by a secondary school that operated separate and often inconsistent assessment tools for each year group as a result of the separate delivery of PSHE lessons:
At the moment, PSHE is being delivered in a few different ways in the school…[Year] 10s and 11s are having themed days…that makes big problems for assessment, just having the themed days.

Secondary school, small size, high FSM

PSHE-specific mechanisms used by some schools for assessing pupil progress included lesson feedback forms, ‘before and after’ questionnaires as well as self- and peer-assessment approaches. Some schools felt that they had adopted a whole school approach to assessment by ‘embedding’ SEAL criteria into the assessment of PSHE as well as other subjects.

Some schools assessed progress by using only informal or non-standardised assessment such as behavioural observation or pupil quizzes at the end of lessons. Finally, there were also participants who were not aware of any assessment of pupil progress in PSHE. In some cases, this was because they were not sure what was being done by the PSHE co-ordinator, while others were unable to give a reason why there was no assessment in this area.

It was noted that the time and resources to implement a more effective approach to assessment were often not available. Some participants reflected that this was because PSHE and the assessment of PSHE were not or had not been seen as a priority. The delivery of PSHE in ‘tutor time’ or as a smaller slot in each timetabled lesson also made assessing pupil progress more difficult – without coherent delivery it was considered very difficult to assess progress coherently. Conversely, some participants noted the positive impact of a new head teacher who prioritised PSHE in order to give the subject the same status as other subjects.

2.2.3 Operating a system of confidential pastoral support

Criteria 4.4
Has a confidential pastoral support system in place for pupils and staff to access advice, especially at times of bereavement and other major life changes and that this system actively works to combat stigma and discrimination.

NHSS minimum evidence:
- children and young people say they understand the pastoral system and are able to easily access it
- the school has identified routes of referral for children, young people and staff
- children, young people and staff report they know how to seek help if they are upset or troubled
- children, young people and staff are aware of and can identify how the school is actively combating stigma and discrimination.
We asked co-ordinators several questions in our surveys about the kind of ways pupils could receive support and advice on issues relating to health and well-being. The proportion of schools in which counselling was available increased from 69 per cent at the baseline survey to 85 per cent at the follow-up survey. Another means of support that was asked about was whether the school had an active buddying, peer support, or peer mentoring scheme. There was an increase in the proportion of schools that had one of these schemes, from 69 per cent at the baseline stage to 81 per cent at the follow-up.

The qualitative interviews suggested that most of the changes under this criterion that had been made since wave 1 were not systemic but rather formalising an existing system into a policy or adding new practices at the margins of the system in place.

Each of the systems described by participants tended to be structured in a tiered fashion with a clear route of escalation for more serious issues. In some cases, the first port of call for a pupil seeking advice or emotional support would be the classroom teacher or form tutor. In other schools designated student support officers had responsibility for providing initial support and advice for a year group or a collection of classes. The systems described by participants had a number of routes for referring more serious issues to more senior or specialist staff. One approach was that specialist staff or counsellors were employed to provide additional support or provide outreach to parents. Another approach was to use expertise from the local authority or external agencies – in some cases agencies had a drop-in centre or permanent position in the school. The following table illustrates the range of actors who could be involved.

<table>
<thead>
<tr>
<th>General help</th>
<th>Specialist help</th>
<th>External help</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class teachers</td>
<td>Student support officers</td>
<td>Local authority counsellor</td>
</tr>
<tr>
<td>Tutors</td>
<td>Peer mentors</td>
<td>Connexions staff</td>
</tr>
<tr>
<td>Heads of departments</td>
<td>Learning mentors</td>
<td>Confidential Help and Advice for Teens (CHAT)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>advice service</td>
</tr>
</tbody>
</table>

A change which a number of schools had made since wave 1 or anticipated making in the near future, was the introduction of peer mentors as an additional layer of ‘front-line support’ so that if pupils felt uncomfortable talking to staff in the first instance then they could speak to an older pupil instead. Another innovative practice was to provide support through having a confidential email and SMS service. In some smaller schools, notably primary schools, PRUs and special schools, it was felt that the school’s approach to pastoral support could be relatively informal as respondents felt they had a close relationship with a higher proportion of their pupils than in secondary schools.

Participants across the range of schools included in the study felt that the system operated by their school was comprehensive and understood by pupils. It was felt that all pupils were aware of who they could speak to for advice and support. Some larger secondary schools had used surveys to assess this by asking pupils about their views.
of the support available and whether they felt the information shared would be treated confidentially and seriously.

Not all participants felt in a position to say whether or not children who were aware of the support would actually go on to use it. Some participants pointed to experiences of significant disclosures being made to staff and noted that the systems included anonymous routes to get support, such as 'worry boxes' and appointments with external organisations. There was, however, an acknowledgement that there are weaknesses in formal systems. Some participants felt it was also necessary to keep 'an informal eye out' or some issues would be missed. Others recognised that the school would always miss some issues and could never be totally confident that all pupils would seek support for all issues.

While schools were clear that confidentiality was a crucial aspect of the system in principle, it was also the nature of many systems that certain information would have to be shared amongst staff to ensure pupils got the right support. Participants described this balance between needing the trust of pupils but also being able to involve the right people for additional support if required as a central part of the system.

_They [pupils] are aware that any conversation that we have with the child, they are always made aware of the fact that if it’s something that they don’t want us to tell we always say look if it is of a serious nature we will have to go further with this, and we will have to tell somebody else about it, but you know we are here to look after you so they are made well aware at the beginning of the conversation._

Secondary school, small size, low FSM

### 2.2.4 Provision of suitable professional development opportunities

**Criteria 1.10** Ensures provision of appropriate PSHE professional development opportunities for staff – such as the Certification Programmes for teachers and nurses offered by DH/DfES

**Criteria 4.7** Provides appropriate professional training for those in a pastoral role

NHSS minimum evidence:
- There is a planned Programme for CPD linked to PSHE
- The school has a planned CPD Programme for all staff linked to personal and social development and to support the teaching of social and emotional skills
- Staff are aware of their role in responding to emotional issues e.g. children and young people and bereavement.

One approach to the provision of development opportunities was to create continuous professional development (CPD) plans for individual staff that were related to the
School Improvement Plan. It was felt that this pro-active approach encouraged staff to engage with CPD, with some participants describing this as contributing to the NHSS criterion of having ‘a healthy staff’. The other approach taken by schools was one where the onus was more on staff themselves to identify what training they felt they required and the opportunities to meet this need.

Professional development opportunities specific to PSHE and EHWB were provided in a number of different ways. An approach favoured by primary schools was for the head teacher to oversee which staff should attend particular courses or cascade information and expertise themselves. This was seen by other schools as the role of the PSHE co-ordinator, which could also be the schools Healthy School co-ordinator. All participants could identify some PSHE training opportunities that were available although there were some participants who were not aware of any opportunities in relation to EHWB.

Different strategies were also pursued to ensure that schools had sufficient expertise related to PSHE and EHWB. One approach cited was to provide training on a number of PSHE/EHWB-related subjects across the whole school or to all new staff. This was a recent change driven by a combination of the arrival of new senior staff and the need to meet NHSP criteria. An alternative approach was training specialists in certain aspects of PSHE and EHWB and relying on their expertise for the whole school. Rather than formal training, which some schools do not have resources for, examples of Inclusion Committees were also described, whereby staff can share knowledge and expertise.

Changes since wave 1 of the research were more apparent in the introduction of specific training courses rather than in schools’ approach to professional development. Dedicated training courses on PSHE in general and specific aspects such as delivering sex education and drug education were identified by participants as having taken place in the previous year.

Local healthy schools programme co-ordinators were a source of links to external trainers or speakers and also offered their own courses on bereavement counselling, difference and diversity and how to deal with situations where bullying might arise. In addition to training courses, participants also noted the value of resources provided by the local healthy schools programme or the national Healthy Schools website on how to develop skills in mediating circle time in primary schools, or leading brain gym exercises in class.

While some schools were clear that the professional development opportunities they provided were sufficient to meet the NHSP criteria, and there were no schools that said that their provision definitely did not meet the criteria, there were a number of schools that were unsure about whether it did or not. This was because they had identified a number of areas in which they felt provision needed to be improved. This was often related to the school’s mode of delivery.

*In some schools you have specific people who teach the PSHE...In our school all the form tutors teach it so it's quite, it can be quite difficult. There are specific*
Despite a largely positive attitude towards professional development, a number of participants noted that certain conditions are needed for a school to be able to provide suitable opportunities. One condition was the existence of sufficient financial resources and time to identify relevant training courses. It was also felt that specific training around PSHE or EHWB would be more likely to be available in a school that gives a similar level of priority to these areas as to core subjects.

### 2.2.5 Staff health and well-being

Several of the criteria take into account the health and well-being of members of staff as well as of children and young people within the school. For example, one piece of the minimum evidence required for Criteria 1.8 is that:

> Information for staff and children/young people from appropriate support agencies is promoted

While Criteria 3.10 states that schools must

> [Encourage] all staff to undertake physical activity.

We asked co-ordinators whether there were any initiatives in place in their schools to support the health and well-being of staff (for example, staff exercise and fitness classes). The proportion who reported that there were such initiatives in place increased from 44 per cent at the baseline stage to 55 per cent at the follow-up stage.

### 2.3 Healthy Eating

Schools were asked how they approached the two NHSS criteria of:

- Whole school food policy (2.3)
- Involvement of parents/pupils within guiding food policy and practice (2.11)
2.3.1 Whole school food policy

Criteria 2.3
Has a whole school food policy – developed through wide consultation, implemented, monitored and evaluated for impact

NHSS minimum evidence:
- Children, young people, staff, parents/carers, governors and caterers are/have been involved in policy development and can describe their involvement
- A policy is available covering all aspects of food and drink at school, including appropriate curriculum links, reference to policy regarding packed lunches/food brought into school and children or young people going off-site to purchase food
- The policy is referred to in the school prospectus/profile
- The policy is regularly communicated to the entire school community
- The policy and its impact is reviewed on an ongoing basis to reflect current DCSF standards

Perhaps surprisingly, having a whole school food policy was one of the NHSS criteria least likely to have been achieved during the baseline stage of the research. This was one area where the effect of the NHSP was easier to identify as a number of schools indicated they had written a food policy as a direct result of working towards NHSS. Similarly, there were schools that hadn’t developed a policy, but for whom working towards NHSS had prompted action. A reason cited for not having a food policy in place was the need to invest careful thought, preparation and the input of external experts in order to achieve this successfully.

Yeah, we have actually written it. We’ve discussed for a long time getting a dietician in and struggled for a long time to actually find one. The Healthy Schools initiative is very much around sort of school day as opposed to 24 hour curriculum which we run. And eventually by chance we found that the tutor who was covering some of our Domestic NVQ levels was also into nutrition, her qualifications, and was always prepared to support us through that which was great.

Special school

There were some schools that already had a policy in place, but had up-dated it since the previous year and there were also schools that had not developed a formal policy. One reason given for this was that although they felt that the school already operated a whole school food policy in practice, they simply did not have the time to write it down.

No, I haven’t got time, but we do it, we try and do it, but we haven’t written it down, we haven’t sat down, we haven’t had a meeting, [but we try to make
parents aware] through newsletters and through posters which are put up in the playground, in the dining hall windows.

Primary school, large size, high FSM

One school cited the fact that school lunches were provided by an external contractor as a barrier to them developing a food policy. This meant schools felt they had little control of the food available for pupils and that there was therefore little point in spending the time writing a policy they were not able to implement.

Schools that had written a policy, or were in the process of writing one, described a range of ways in which their engagement with Healthy Schools had impacted on practice. One way was by prompting them to re-evaluate their provision, including the food provided at lunchtime and for snacks, the use of food in reward systems and the kinds of food available in drinks and vending machines. A more subtle effect of the process was to prompt participants to reflect on the underlying values of their approach to food.

It's sort of what's in place already, why they are in place, what the school's general aims and objectives are with regard to food and healthy eating. Its not just about, I think its called the food policy rather than the healthy eating policy because its not just about eating healthy food, it's about attitudes to food, having a positive relationship with food, seeing food as, positive, eating as a positive social, activity as well so that like in part of Healthy Schools, Healthy Schools one of the criteria is to have a pleasant eating environment and to have enough time to eat and things like that.

Secondary school, large size, low FSM

While the value of a food policy was recognised by some schools, there were others who felt that producing a policy was largely a bureaucratic exercise as it simply reflected the shared views of staff. Another concern was the danger of applying policies in an overly rigid fashion. Instead, it was argued, policies needed to be applied flexibly depending on the different needs and circumstances of pupils and families rather than being seen as a one-size-fits-all model.

2.3.2 Involvement of parents/pupils in food choices

Criteria 2.11 Consulting for food choices

Consults children and young people about food choices throughout the school day using school councils, Healthy Schools Task Groups or other representative pupil bodies

NHSS minimum evidence:

- Children and young people say that they are regularly (at least termly) and appropriately consulted about food choices – including school meals and food and drink other than lunch
Across the range of schools, pupils had been asked to provide their views on current food provision through school councils, menu taster sessions, pupil questionnaires, and informal discussions at meal times.

Parents had the opportunity to comment on existing practice and make suggestions about food provision through questionnaires that asked for feedback on menus, question and answer sessions with cooks and caterers and parental involvement in NHSP school action teams. Involvement in action teams allowed parents to be involved in decision-making regarding food policy and provision, in some cases prompting them into unplanned action.

For the healthy fortnight that we had, one parent has, you know, gone off and got loads of free water bottles from (a parent), so she’s come to a meeting, been inspired, gone away and the next thing I know, we’ve got all these water bottles being delivered.

Primary school, small size, high FSM

Other forms of consultation included cooking workshops where parents and children learned to cook together, parents observing lunchtimes and events around healthy eating, and parental support for projects involving growing fruit and vegetables.

Whilst there was evidence of a range of approaches to consultation, participants also highlighted a number of challenges to the process. This was particularly the case in the absence of established consultation processes within the school. Schools felt that poor responses to workshops and questionnaires were due to parents having other commitments and priorities, and to difficulties some parents had in understanding information sent home due to literacy issues or where English was not their first language.

Getting our parents in is quite hard, a lot of them don’t speak English, a lot of them are either working or have got young children and find it inconvenient to come into school. We’ve tried holding meetings at just before home time so they just have to come a bit earlier, or just after home time and looking after the kids, it’s hard work getting them in but I think that’s probably where we need to go next.

Primary school, large size, high FSM

The impact of these barriers to engagement was that consultation could be limited to those parents who had an interest in healthy eating. Consultation was also limited in schools that took a less pro-active approach to involving parents in policy development. While these schools made policies accessible through letters home or policy statements on the school’s website, they did not explicitly seek out suggestions and comments.
2.4 Physical activity

Participants were asked to discuss how they met the following NHSS criteria:

- Provide opportunities for children to participate in activities promoting physical activity (3.4) – investigated quantitatively via pupil survey
- Two hours of structured activity (3.3) – investigated qualitatively
- Involvement of parents/carers (3.8) – investigated qualitatively.

2.4.1 Facilities and activities available for pupils

NHSS criteria 3.4 states that schools should:

*Provide* opportunities for all children/young people to participate in a broad range of extra curricular activities that promote physical activity

We also asked co-ordinators about the facilities and activities available to pupils in their schools.

Firstly, we asked co-ordinators whether their school provided lunchtime or after-school sports activities or exercise classes for pupils. The proportion of co-ordinators who said yes to this was high at both the baseline and follow-up stages – 99 per cent.

We then asked those co-ordinators that said their school did provide lunchtime or after-school sports activities or exercise classes how many of these were available to pupils in an average week. At the baseline survey, 48 per cent of co-ordinators said that there was at least one such activity every day, while at the follow-up survey this had increased to 60 per cent.

We also asked co-ordinators what activity facilities were available to pupils at breaktimes and/or lunchtimes.

Unsurprisingly, the proportion of schools that had a tarmac playground and a grassed playing field remained roughly the same at the baseline and follow-up stages of the survey. Ninety-six per cent of schools had a tarmac playground and 82 per cent had a grassed playing field at the baseline, and at the follow-up stage these figures were 96 per cent and 83 per cent respectively. There was also no change in the proportion of co-ordinators that said their school had an all-weather pitch (20% at the baseline and 21% at the follow-up), specific sports facilities (for example, tennis facilities; 42% and 39%), and indoor sports facilities (45% and 46%).

There was an increase between the baseline survey and the follow-up survey in the proportion of co-ordinators that reported that pupils in their school had access to sports equipment and playground games at break-times and/or lunch-times (from 81% to 89%). This difference was found only amongst secondary schools: while 95 per cent of primary schools had these facilities at the baseline survey and 98 per cent having them
at the follow-up survey, amongst secondary schools this figure increased from 57 per cent at the baseline to 76 per cent at the follow-up survey.

Similar proportions of co-ordinators working in primary schools said that pupils in their school had access to a soft play area at the baseline and follow-up surveys. At the baseline survey, 38 per cent said that pupils did have access to a soft play area, while 33 per cent gave this answer at the follow-up survey. Co-ordinators in primary schools also mentioned, in similar proportions at the baseline and follow-up surveys, that pupils in their school had access to playground apparatus (13% at the baseline stage and 14% at the follow-up stage), as well as a quiet area (1% at the baseline and 2% at the follow-up).

Co-ordinators were also asked about provision of a range of services summarised in Table 2.3 and were asked to say whether they applied to their school.

<table>
<thead>
<tr>
<th>Service</th>
<th>Primary schools</th>
<th>Secondary schools</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Follow-up</td>
</tr>
<tr>
<td>Breakfast club</td>
<td>40%</td>
<td>46%</td>
</tr>
<tr>
<td>Morning club (not serving breakfast)</td>
<td>11%</td>
<td>20%</td>
</tr>
<tr>
<td>After-school club</td>
<td>69%</td>
<td>74%</td>
</tr>
<tr>
<td>Walk Once a Week scheme</td>
<td>10%</td>
<td>17%</td>
</tr>
<tr>
<td>Bikeability or cycling proficiency scheme</td>
<td>69%</td>
<td>81%</td>
</tr>
<tr>
<td>Healthy tuck shop</td>
<td>27%</td>
<td>32%</td>
</tr>
<tr>
<td>Extended Schools</td>
<td>36%</td>
<td>59%</td>
</tr>
<tr>
<td>Sports Partnership</td>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td>Eco Schools</td>
<td>23%</td>
<td>13%</td>
</tr>
<tr>
<td>Food for Life Programme</td>
<td>6%</td>
<td>35%</td>
</tr>
<tr>
<td>On-site health services</td>
<td>5%</td>
<td>16%</td>
</tr>
<tr>
<td>Sports college status</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Food Partnership</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bases</td>
<td>172</td>
<td>172</td>
</tr>
</tbody>
</table>

In both primary and secondary schools, there was an increase between the baseline and follow-up surveys in the proportion of schools offering various services outside of normal school hours. The proportion of schools that offered Extended Schools services rose from 36 per cent to 59 per cent between the baseline and follow-up surveys in primary schools, while in secondary schools this increased from 43 per cent to 74 per cent. The proportion of primary schools offering a morning club (that did not serve breakfast) rose from 11 per cent at the baseline to 20 per cent at the follow-up, while in secondary schools this rose from 16 per cent to 29 per cent. In secondary schools
there was also an increase in the proportion of schools offering an after-school club (80% at the baseline and 93% at the follow-up).

There was also an increase in both primary and secondary schools in the proportion that offered a Bikeability or cycling proficiency scheme. In primary schools this rose from 69 per cent to 81 per cent, while in secondary schools this rose from 16 per cent to 30 per cent.

The proportion of co-ordinators in both primary and secondary schools saying that their school participated in the Food for Life Programme increased between the baseline and follow-up surveys. In primary schools this rose from 6 per cent to 35 per cent, while in secondary schools this rose from 3 per cent to 27 per cent. The proportion of co-ordinators in secondary schools whose school participated in the Eco Schools Programme also increased (from 30% to 44%), however in primary schools there was a decrease in the proportion of schools participating in this Programme (from 23% to 13%).

The proportion of primary schools offering on-site health services increased from 5 per cent at the baseline to 16 per cent at the follow-up survey. The proportion of secondary schools offering on-site health services was 39 per cent at the baseline survey and 50 per cent at the follow-up (although this difference was not found to be statistically significant).

### 2.4.2 Two hours of structured activity

**Criteria 3.3:** The school’s description of its provision adds up to a minimum of two hours structured activity each week. This can include Physical Education (PE), before- and after-school activities, travelling to and from school and supervised lunchtime activities.

**NHSS minimum evidence:**
- The curriculum for PE includes health-related fitness
- Children and young people can access a range of activities that add up to a minimum of two hours structured Physical Activity each week
- The school’s Inclusion Policy refers to how it is addressing the needs of all its children and young people with reference to Physical Activity

There was a degree of confusion among schools regarding what was required to meet the criteria of the provision of two hours of structured activity a week. This confusion centred firstly on the type of activity that they needed to provide to meet the criteria, for example whether it had to be structured PE lessons or whether it could also include extra-curricular activities. The second area of confusion was around whether schools needed to have two hours of physical activities planned for each pupil, or instead were required to provide the opportunity for pupils to have two hours of structured activity.
This confusion had a bearing on whether they perceived they had met the criteria or not. Schools can be grouped into three categories in relation to achieving the criteria, as described below.

**Already meeting the minimum criteria:** These were schools that had met the criteria before the second stage of the research, and had two hours of activity available to pupils. Opportunities for physical activity were available through structured PE lessons, activity within other lessons, and extra-curricular activities (e.g. after school clubs). There were also schools that wanted to extend current provision to meet new national targets set out in the Government's PE and Sport Strategy of offering five hours of high quality PE and sport a week by 2012.

**Made changes to achieve two hours of taught PE:** Some schools had perceived the criteria as a target of two hours of taught PE, and either made changes to the school timetable to incorporate this, or had introduced other physical activity within lessons, for example, brain gym and activities such as running on the spot as a break in class time. In one case a school was able to extend current provision for PE after they extended their school day to keep in line with DCSF guidelines for teaching and learning in a day.

**Working towards achieving two hours of taught physical activity:** These schools had also interpreted the criteria as providing two hours of taught PE and were working towards this as a target. They were unable to provide two hours of PE due to current timetabling and competing subject priorities, and limited access to hall space/resources. In fact some of these schools were meeting the NHSS criteria unknowingly due to their misinterpretation of the requirement for schools.

Some schools who had interpreted the criteria as needing to provide two hours of taught PE later received guidance from the local Programme that they only needed to provide the opportunity for two hours of physical activity, or were told that they could achieve the NHSS criteria without having two hours of taught PE, because they had a ‘good PE department’. This meant that these schools no longer saw the criteria as a barrier to achieving the overall theme of physical activity.
2.4.3 Involvement of parents/pupils

Criteria 3.8: Gives parents/carers the opportunity to be involved in the planning and delivery of Physical Activity opportunities and helps them to understand the benefits of Physical Activity for themselves and their children.

NHSS minimum evidence:
- Parents/carers are aware of the opportunities to learn about the benefits of Physical Activity
- Parents/carers say they are actively encouraged to take part in the planning and delivery of Physical Activity
- Most parents/carers report that they know why Physical Activity is good for them and their children

Schools had made few changes since the first wave of the research as to how they involved parents and carers in the planning and delivery of physical activity. Across the schools that did offer opportunities for parents/carers to be involved in physical activity, there was a variety of approaches as described below:

- **Involvement in after school clubs:** Parents/carers were seen as involved in the running of after school clubs through providing support with transport to or from activities.

- **Involvement in decision-making about type of activities available:** Parents/carers were given opportunities to suggest ideas for after school activities through surveys and questionnaires or discussing their ideas directly with teachers.

- **Attendance and support of sports activities:** Schools also felt that the involvement of parents/carers was evident through their attendance and support of children at sporting events and activities; however this was not a requirement needed to meet the criteria.

- **Schools extending provision to the whole family:** Schools offered opportunities to the parents and families of pupils to get involved in physical activity by running family sports groups and providing access to school sporting facilities to younger siblings through links with local primary schools. There were also examples where schools had established links with local sporting clubs and provided families with free tickets to sporting events.

- **Involvement in fundraising for resources and equipment:** Parents/carers took part in fundraising for resources and equipment for additional playground activities.
Not all schools felt they were able to meet the criteria, and two key barriers were identified. Firstly, schools felt that opportunities were not necessarily taken up by parents due to a lack of interest. They felt that parents would only make contact if they were not happy about the school's provision.

*Our parents are just so reluctant and so unwilling to take part and to help the teachers out with these sorts of things.*

Primary school, large size, high FSM

Interest could also change due to the type of activity, for example, parents were perceived as more interested in taking part in traditional games such as football than other sports. Some participants felt that a lack of involvement in sport reflected a wider problem with parental engagement within schools.

A second barrier to involving parents in the planning and delivery of physical activity was that parents would need to go through a lengthy process of CRB clearance to assist with activities. However, schools were more motivated to involve parents where they lacked the resources to supervise all the activities they wanted to run.

### 2.5 Chapter Summary

- **Mechanisms for pupil consultation and feedback:** Almost all schools had a school council in place to allow pupil consultation and feedback at the baseline and follow-up surveys. The range of other mechanisms available for pupil consultation and feedback changed little, although the proportion of schools carrying out school surveys rose between the baseline and follow-up surveys (while the proportion that had a specific class- or year-level council fell).

- **PSHE delivery and assessing pupil progress (PSHE):** Overall there was little change between the baseline and follow-up surveys in the level of PSHE being taught by specialist PSHE teachers or external specialists. Schools’ approach to assessment was either standardised and in line with other taught subjects or specific to PSHE. For some schools, an awareness of NHSS and the criteria had directly encouraged the development of an assessment policy for PSHE. For other schools, the NHSP had an indirect effect and provided a framework for further developing assessment approaches. There were also schools who suggested that NHSP had no impact on meeting this particular criterion, because they either felt they were doing most of what was already required of them or had been influenced by other factors that had led to assessment across all subjects being standardised.

- **Operating a system of confidential pastoral support:** Between the baseline and follow-up surveys, there was an increase in the proportion of schools in which counselling was available, as well as an increase in the proportion of schools that offered an active buddying, peer support, or peer mentoring scheme. Schools systems of pastoral support involved a combination of actors
with general and specialist skills, from within school and external agencies. Changes brought about by NHSP were not necessarily systematic, but rather in some cases formalised an existing system through describing it in a policy document or added new practices to the system. Schools that reported no changes as a result of the Programme felt that they were already doing a lot of what was expected under the criterion and had already benefited from the support from other local initiatives and agencies. It was generally felt that the systems worked well and met the criterion, but there was an acknowledgement that staff could never be fully sure that all issues were identified, and that their impact on children’s lives outside of school could be limited.

- **Provision of suitable professional development opportunities**: Schools either had a systematic, school-wide approach to staff training or left it up to individual staff to identify their own training needs. Similarly some schools disseminated knowledge about PSHE through cascading it from a coordinator or senior manager down to other staff while others delivered cross-school training in skills related to PSHE and EHWB.

Changes to schools’ approach to professional development involved the identification of new training opportunities and filling gaps in existing provision rather than wholesale changes to their approach. The identification of some of these opportunities and gaps were seen as a direct result of NHSP, due to the fact that it reinforced the importance of these areas within schools. However, other schools were unable to distinguish the impact of the Programme from alternative drivers of change, for example, where responsibilities for co-ordinating healthy schools and PSHE overlapped in the local authority.

- **Staff health and well-being**: There was an increase in the proportion of schools that had initiatives in place to support the health and well-being of staff (for example, staff exercise and fitness classes).

- **Whole school food policy**: Not all schools had met the criteria of having a whole school food policy in place. The reasons for not having a policy in place included a lack of time and preparation to review and develop a new policy or formally document practice that was already in place, and limited control over school food provision due to arrangements with external contractors. However, for some schools introducing a new school food policy was identified as a direct response to their involvement in the Programme.

- **Involvement of parents/pupils in food choice**: Schools consulted pupils through school councils, menu taster sessions, pupil questionnaires, and informal discussions at meal times. Parents had the opportunity to comment on existing and future practice through questionnaires, question and answer sessions with caterers, and parental involvement in NHSP school action teams. Challenges to facilitating the involvement of parents included the fact that they had other commitments, some experienced difficulties in understanding
consultation materials and information, and the absence of established consultation processes.

- **Facilities and activities available for pupils:** Between the baseline and follow-up surveys there was an increase in the proportion of schools that offered at least one lunchtime or after-school sports activity every day. There was also an increase in the proportion of schools that offered a Bikeability or cycling proficiency scheme.

  The proportion of schools that offered services outside of normal school hours (for example morning clubs and Extended Schools services) also increased, as did the proportion of schools offering on-site health services.

- **Two hours of structured activity:** Schools were required to have two hours of structured activity each week which could include taught PE, school activities before and after school, and supervised lunchtimes. Some schools were confused about whether they had met the NHSS criteria, because they were unclear about the type of activity which could be included (e.g. whether this could include extra-curricular activities), and whether they needed to ensure that they had in place plans for each pupil to have two hours of structured activity rather than having provided the opportunity for pupils to have access to at least two hours of physical activity.

- **Involvement of parents/pupils:** Parents and carers were involved in physical activity through the involvement of running after schools clubs, suggesting ideas for activities, attending and supporting sports activities, participation in whole-family events, and taking part in fundraising events for resources and equipment. Barriers to parents’ involvement in the planning and delivery of physical activity were a lack of interest by parents, and the amount of time taken to provide CRB clearance for parents.
3 PRUs and special schools

Although broadly speaking the themes discussed throughout this report also apply to PRUs and special schools, participants from these schools identified issues that were specific to their particular circumstances. These were largely related to the learning requirements of pupils they taught and the size and structure of the school. This chapter reports on the experiences and views of staff working towards NHSS in PRUs and special schools in relation to the four themes.

3.1 PSHE and EHWB

3.1.1 PRUs

In terms of changes in practice since wave 1, PRUs identified very little fundamental or overarching change in relation to the delivery of PSHE or EHWB as a result of their engagement in NHSP. Participants felt that the aspects of learning and support that PSHE and EHWB comprise are their core issues. Consequently, their staff are trained accordingly and their systems for delivering PSHE, assessing pupil progress and monitoring and evaluating quality are firmly embedded. As an illustration of this, PSHE is an accredited subject in some PRUs and all units in the sample felt that the themes covered by PSHE were the main focus of assessment. Many had daily personalised targets and reward systems, with many pupils receiving daily support on EHWB from several staff.

Despite this there was some more peripheral changes noted, such as using the school’s engagement in Healthy Schools to influence an increase in PSHE time in the timetable and moving to a single lesson for PSHE rather than having it split across other subjects. As with a number of the mainstream schools, it was felt that this move gave added importance to the idea of PSHE in the minds of both pupils and staff. Some PRUs had also identified CPD opportunities through the Programme. Even though it was noted that NHSP had had little impact on the actual delivery of PSHE, it was suggested that it had prompted schools to bring together what they already do in a series of PSHE related policies or, related to EHWB, a confidentiality policy. It was also notable that PRUs discussed how effective external speakers could be and participants highlighted the value of good relations with local police, fire services and health workers.

I think they tend to listen more if people from outside come in and talk to them. It seems to have more impact...’cos it’s a different face. If somebody else comes in they tend not to play up as much as they normally would…they get more out of the sessions.

Pupil Referral Unit

Although the main reason for the limited change amongst PRUs was that they had little need to change in order to meet the criteria, participants did identify some barriers to
change specific to their kind of school. For example, because of the small number of pupils a PRU is responsible for at any one time, some locally provided resources or services, such as school nurses, have to be shared with schools across the area which limits the relationships they can build up and the impact they can have.

3.1.2 Special schools
Participants from special schools could identify little change in practice since wave 1 in terms of their approach to PSHE delivery and very little that could be attributed to NHSP. As with the PRUs, PSHE and EHWB were considered to be core work for the school. An illustration of this is the “Bsquared” assessment approach that was identified by special schools as an example of a tool that is used to assess pupil progress and achievement across their curriculum. This was being employed prior to a schools’ engagement with the NHSP. There were also certain aspects of delivery that were specific to special schools in the sample such as the use of daily rewards systems for good behaviour, such as helping others and group work.

Any changes that were identified as a result of their engagement in the NHSS tended to affect provision at the margins rather than leading to systematic change. In some cases, the NHSP had identified some professional development opportunities for healthy school co-ordinators and also raised awareness of the need for a comprehensive approach to CPD in this area. Others had used the results of surveys conducted by the local healthy schools programme to revise how they taught sex education. Although not noting any direct impact of the Programme on delivery of PSHE, one school described how achieving NHSS had encouraged the organisation of an ‘enrichment day’ that they hope to be an annual event at which the schools celebrates what they are doing or have achieved in relation to health.

As for PRUs, some special schools faced particular barriers to achieving a number of the NHSS criteria related to PSHE and EHWB or felt that the criteria were inappropriate for some of their students. It was argued that confidentiality was a more difficult goal to achieve in a special school because pupils with certain types of special educational needs found it difficult to grasp the concept of confidentiality.

That [confidentiality] would be more difficult for our children to understand…because of their level of understanding about what’s a private thing, what’s a confidential thing…sometimes they’ll come in and blurt something out in the morning…and you have to say, Oh, let’s have a quiet talk about it later shall we? And sometimes they don’t even understand about personal things about themselves that you just don’t tell other people

Special school

A factor helping to facilitate change was the high staff to pupil ratio, which enables more effective sharing of expertise on these issues in which all the staff are trained.

No differences were noted in the way the quality of PSHE lessons were monitored with special schools describing a range of classroom observations and lesson evaluation by
teachers, department heads and senior managers. There was also no discussion of monitoring the EHWB of pupils as much of this is fundamental to daily target setting. Unlike any of the mainstream schools, however, this did include monitoring individual pupil attendance and participation in extra-curricular activities such as lunchtime clubs.

### 3.2 Healthy eating

#### 3.2.1 PRUs

PRUs experienced two main barriers in meeting the NHSS healthy eating criteria. The first was the absence of on-site cooking facilities, which meant they felt less able to influence pupils’ eating habits because they could bring their own food into school or were allowed outside school grounds at lunch times. One PRU had tried to introduce hot dinners to encourage the take-up of healthy food inside school. However, they faced problems with their suppliers delivering food at a regular time and then dealing with it when it did arrive, both of which could disrupt pupils’ routines.

It took much longer, the logistics, the bread and butter logistics of serving it, of keeping it hot, of choosing it and, you know, at the moment we’ve got a very, you know, we’ve got a routine that works for the kids and it disrupted all that routine it took longer so they weren’t getting out at the end to play.

Pupil Referral Unit

The second barrier in meeting the healthy eating criteria was the difficulty in engaging parents. Though this could also be an issue for mainstream schools, PRUs felt that they had particular problems in this area because the high proportion of parents who themselves faced significant behavioural or emotional difficulties. However, one strategy to try and strengthen general engagement with parents was the use of home support liaison officers, and an additional impact of this was that staff could observe first hand the food and nutrition available at home. This information could then be fed back to schools and be used to help the school look at ways that they could promote healthy eating among parents.

A particular impact of the Programme on PRUs was in relation to their reward systems. In the past sweets and unhealthy snacks had been used as rewards, but their involvement with NHSP had made PRUs reflect on the types of rewards that they offered. As a result some PRUs had introduced new types of rewards that were not based on food (e.g. vouchers for mobile phones) or promoted good health, for example, the use of sports equipment.

We’re changing our reward system completely to a thing called [xxx] and it’s where they save up their points to achieve things like sports equipment or vouchers instead of being rewarded with food.

Pupil Referral Unit
PRUs, like mainstream schools had experienced changes to pupils’ behaviour since the introduction of healthier food provision, through their take-up of school food provision, awareness of nutrition and healthy food, and general behaviour in school.

3.2.2 Special schools

Some pupils within special schools had particular requirements or restrictions around food due to their educational needs. As a result, staff in these schools felt that in comparison with mainstream schools there were greater challenges to introducing healthier food that would be accepted by pupils, and that the process had to be much more gradual.

*The reason it's problematic for the pupils is we have some children with autism here who eat a very limited diet, and for those children you have to move them to food changes very, very slowly... You've got a child who will only eat one make of crisps and one flavour, and four different brands of sweets.*

Special school

One strategy for addressing this was by seeking the help of nutritionists to create menus which their students would both accept and enjoy. However, there were also challenges meeting some of the other aspects of the healthy eating theme. In particular, they found it difficult to involve pupils in the decision-making about the range and types of food available because pupils found decision-making about any issue difficult. However, schools nevertheless tried to involve pupils by asking them informally about their views of the food provision available.

*We discussed offering them a choice and explained that we were not going to offer them a choice because there were a number of children who actually couldn't choose. You just see them standing trying to choose which colour pencil they will award themselves on a Friday, can take some time. So we don't offer choice. And also a lot with oppositional disorders so they would swear black was blue, that they haven't chosen that if you put that in front of them one day and what somebody else has got looks different. So we made a conscious decision not to involve choice. But at the same time we always sit adults with them when they are eating. So we discuss what they like and what they don't like.*

Special school

Another area that was particularly challenging for special schools was conveying the importance of healthy eating to general health and well-being if pupils experienced general barriers to learning, for example, if they were at a low functioning level on the autistic spectrum.

3.3 Physical activity

3.3.1 PRUs

Participants felt that PRUs faced particular challenges in meeting the criteria to provide the opportunity for two hours of physical activity a week. PRUs had limited access to equipment and resources and were instead more reliant on external facilities than
many mainstream schools. It was also difficult for PRUs to timetable PE lessons because pupils worked to individual timetables, and some pupils were based outside of the school whilst attending work placements. However, meeting the criteria was also facilitated by access and links to other schools and local leisure centres arranged through the local authority and sports partnerships. Schools also introduced opportunities for physical activity within lessons, for example, walks around the school site. PRUs additionally experienced barriers to providing extra curricular activity, due to the wide pupil catchment areas that they covered compared to mainstream schools. Pupils often had prearranged taxis/buses which provided travel to and from school, and the difficulty was that this transport would not be available for pupils staying later for after school activities.

PRUs shared the same challenges as mainstream schools in encouraging the involvement of parents/carers due to lack of engagement. However some felt this was a particular issue within PRUs, where there were also widespread difficulties engaging parents regarding other aspects of school.

Its always been the way. We’ve tried different strategies to get people involved and it’s the nature of a pupil referral unit I think.

Pupil Referral Unit

Like mainstream schools, PRUs discussed how school practice had affected the engagement of pupils with physical activity, along with their awareness and understanding, but spoke in particular about the benefits of outcomes such as improved behaviour and self-esteem for pupils who had behavioural problems. This was particularly significant for those pupils who were seen as lacking confidence in physical activity due to their experiences of taking part in mainstream schools.

They really enjoy it actually because we don’t have it in any kind of threatening environment, which is sometimes what they’ve experienced at school, because it’s very competitive and they’ve been pushed around and they’re not kids who can bounce back from that sort of environment.

Pupil Referral Unit

It was felt that specialist teaching which focused on providing a more supportive and less competitive environment could help pupils gain confidence in developing new skills and overcome wider issues of negative self image. Physical activity was also seen as a way of helping address other behaviour issues through encouraging cooperative learning and sustained engagement with an activity.

However, despite the changes that were being implemented, teachers raised concerns regarding the extent to which they could have a long-term or wider impact on pupils’ behaviour and attitude towards physical activity. It was felt that pupils may not continue with activities outside of school or after they left without the intensive support they had received, as some lacked the confidence to interact with peers outside of the school environment.
My concern now is how kids who have been going down to [Local sports facilities] really enjoying …PE, what are they going to do post-16 when they leave? How can I encourage them to … keep up doing sport and exercise and have it as part of their life? Because I’ve got one boy now who’s left [and asks] ‘can I come back and still do PE?’

Pupil Referral Unit

3.3.2 Special schools

Special schools felt that, like PRUs, they experienced specific challenges engaging parental involvement compared to mainstream schools. They reported meeting resistance from parents for pupils to take part in outside competition due to concerns regarding the how children would respond and interact in other environments.

A lot of our parents would be very nervous about having any of these children involved in sort of for example out-of-school football clubs as well. We’ve had one or two over the years but you know, they find it difficult to let them go and join anything at the local sports centre.

Special school

Also, as a number of special schools are residential, parents were less able to be involved in physical activities due to the distance and travel time.

As with PRUs, special schools were supported in delivering physical activity by specialists and external providers. Involvement with the NHSP had made some schools look at the accessibility of their current provision for students, and schools had introduced playground activities and resources which encouraged less competitive play and structured sporting activity.

Special schools suggested that some of the NHSP criteria failed to take into account how the needs and circumstances of their pupils differed from pupils from mainstream schools. For example, participants spoke about how it was hard to implement travel plans due to the further distances travelled by their students to school.

Some of the Healthy Schools criteria, they’re very written with a mainstream in mind. An example would be about cycling or walking to school. Its just not viable … we can talk with staff about ways to increase the amount of walking children do or getting more bikes on the playground so that as the children get older they may reach a stage when perhaps they’re a lot older, where they can use bikes … we have to look at different ways of doing things sometimes…there are only two children in the school that live within walking distance of the school, and both those children have quite challenging behaviour and will pose great problems with their families … if they attempted to walk them to school.

Special school
Like mainstream schools, special schools observed improvements to concentration and behaviour in class after physical activity, and were able to record this through the systems they had in place to monitor behaviour in all lessons. Some special schools used additional monitoring practices to those of mainstream schools, carrying out detailed monitoring of physical development, and implemented individual plans for students who were overweight and had issues around body image.

3.4 Chapter Summary

**PSHE and EHWB:** PRUs had made limited change to meet the criteria because they felt that what was expected largely comprised of core issues that were embedded in their overall aims and approach to support the learning and behavioural needs of their pupils. Where change was identified, this was through increasing PSHE in the timetable and creating a single lesson for PSHE. As with PRUs, special schools identified few changes to practice regarding PSHE and EHWB because they viewed the themes as the core work of the school. Schools had been using established assessment approaches, such as B squared, prior to involvement with the Programme. Changes that were identified by special schools were not systematic, but affected specific aspects of the provision, for example the identification of CPD opportunities. Both PRUs and special schools faced particular barriers to achieving a number of NHSS criteria or felt that the criteria were inappropriate for some of their students.

**Healthy eating:** Two barriers were identified as important for PRUs in meeting the healthy eating criteria: the absence of on-site cooking facilities, which limited control over the food eaten within school, and second, difficulties in engaging parents due to the high proportion of parents who themselves faced behavioural or emotional problems. Special schools also experienced particular challenges in introducing healthier food where students had specific food requirements or restrictions.

**Physical activity:** PRUs were less able than mainstream schools to provide opportunities for two hours of physical activity because they had limited access to equipment and resources and were more reliant on external facilities. In addition, PRUs experienced barriers to offering extra-curricular activities because many pupils needed to catch prearranged transport home straight after school due to wide catchment areas. Teachers also raised concerns that despite the opportunities made available within schools, pupils may not continue activities outside of schools due to a lack of confidence in interacting with peers.

Special schools also experienced challenges, particularly in engaging with parents. They faced resistance from some parents about pupils’ involvement in sporting competition outside of school due to concerns about how they would respond and interact in other environments. Also, as a number of special schools are residential, parents were less able to be involved in activities due to the distance between where they lived and the school. Some staff in special schools felt that the NHSP had failed to give specific attention to the unique circumstances of special schools.
4 Investigating the impact of the NHSP

4.1 Introduction

Chapters 4-10 discuss the evidence of the impact of NHSP on schools and pupils. Chapter 4 describes the methodology and factors affecting whether the Programme had an impact at school level and whether it influenced pupil knowledge, attitudes and health behaviour. Chapters 5-8 focus on the impact of the NHSP at school and pupil level for each of the four themes. Chapter 9 provides a summary and overall assessment of the impact of the Programme.

It should be noted that it was not always straightforward for school staff to attribute a particular change in policy or practice to NHSP. This was due in part to schools engaging concurrently with a number of similar and complementary programmes and initiatives such that isolating the impact of any one initiative or programme was difficult. This should be taken into consideration when interpreting the findings.

4.2 Factors affecting impact

A number of factors were identified as influencing the extent to which the NHSP had an impact on pupils or not. Some of these factors were related specifically to the nature of the NHSP or the school’s approach to PSHE and EHWB, while other contextual and external factors were also seen as important.

4.2.1 Factors outside schools’ control

Participating schools identified a number of factors affecting pupil knowledge, attitudes and health behaviour that were neither linked to the Programme nor within their control.

Those interviewed from secondary schools were keen to stress that while they could have some impact on pupils’ knowledge and awareness and behaviour in school time, they could not always be sure of the impact they had on behaviour outside of school. It was felt in particular that pupils in secondary schools were more likely to have established attitudes towards food, had greater freedom to opt out of eating new food provision (e.g. eating off site), and could make decisions about whether to eat or buy school dinners. One way to overcome this was to restrict children leaving school sites at lunch time, however, this could also lead to children skipping meals and not eating properly at lunchtime. Due to the difficulties in changing attitudes of older pupils, it was suggested that change either needed to be a gradual process so pupils could learn to accept new foods or should be taught from an early age at primary school.

It was also suggested that the school catchment area affects the degree to which a school can exert an influence on pupil behaviour. One view was that being based in a relatively affluent area meant that much of what schools were delivering was being
reinforced at home, while it could be more difficult to influence pupils from a more deprived background and unstable home life, or with diverse cultures and habits around food. An alternative view was that NHSP was having limited impact in affluent areas as many pupils learnt all of these skills or messages at home; on the other hand, some of the most significant impacts identified were amongst pupils that were thought to have a difficult home life and be relatively low achievers at school because these pupils had the highest level of need and therefore there was more scope for the Programme to make a difference. Schools tried to overcome socio-economic inequalities, for example through encouraging parents from lower socio-economic backgrounds to take up free breakfast provision for their children.

In relation to PSHE and EHWB, while some problems from outside would be brought into school and therefore allow the pupil to receive help through the school system, it was still considered possible that there could be hidden problems outside. One approach to addressing this was by actively encouraging engagement with parents through ‘home-link’ or outreach workers.

> We have three learning mentors…They work with parents, they, and make calls to parents, call parents in, hold parents meetings, they can do support sessions for parents, they can help parents deal with behaviour issues at home

Primary school, large size, high FSM

Conversely, other schools, as noted throughout this report, were concerned about the boundaries of their responsibilities and potentially coming into conflict with parents on some issues or, specifically in the case of EHWB, of breaching the confidentiality of the pupil.

### 4.2.2 Obstacles to achieving National Healthy School Status

Forty-eight per cent of the schools participating in the follow-up survey had not achieved NHSS at the time of the follow-up interview. We asked co-ordinators in these schools when they estimated they would achieve NHSS, and what obstacles they were facing. Overall, of the 129 primary and secondary schools that had not achieved NHSS, 31 per cent said they still faced major obstacles to their school achieving NHSS. These obstacles were not motivational. A large majority (90%) of co-ordinators said that the senior management in their schools were very or fairly committed to achieving NHSS, and seventy per cent of co-ordinators agreed that they had found it easy to motivate colleagues to help the school meet the 41 criteria.

The barrier most commonly cited as presenting an obstacle to achieving NHSS was not having enough staff time, with over half (58%) of those that said they faced a major obstacle citing this as a reason. As a result, most (61%) of co-ordinators, when asked whether they thought that trying to achieve NHSS had been something that all staff had been involved in or something that only some members of staff had done, said that they thought it was something that only some members of staff had been involved in.
Other barriers mentioned by co-ordinators included school organisational problems (mentioned by 16% of co-ordinators that said they faced a major obstacle), lack of parental support (11%), limited facilities (11%), and school policy (5%). A variety of other answers were also given by one or two respondents.

Co-ordinators in schools that had not achieved NHSS at the time of the follow-up interview were also asked whether they thought that there was anything that would help their school to achieve NHSS. Around half (48%) said that there was something that would particularly help their school to achieve NHSS. Of these, around a third (33%) mentioned some support or guidance, and around a third (30%) said that more time would help. Other things mentioned by fewer respondents included money, help overcoming a school-specific problem, and external assessments (in order to reduce paperwork for school staff).

4.2.3 Whole School Approach

One important aspect of the NHSP is that it aims at fostering a whole school approach – for example, one Healthy Schools publication says:

*The Whole School Approach (WSA) is central to the National Healthy Schools Programme (NHSP). It provides a model to support change and development involving children, young people, staff, parents/carers, and governors.*

We therefore also asked co-ordinators how much involvement people in various roles in schools had in the Programme, in order to see to what extent the co-ordinators felt that the Programme had been successful in fostering this approach.

One factor underpinning pupil impact was the involvement and encouragement of staff. Teachers felt it was important that schools encouraged awareness through communication across the staff, pupils and parents, so that change was not seen as a top down approach by head teachers. Staff could also have an influence on pupils by acting as role models, for example for physical activity, as well as talking informally about their own physical activity and explaining both the enjoyment and health benefits of exercise.

The coordinator survey found that sixteen per cent of co-ordinators said teaching staff had “a great deal” of involvement with the Programme, while 58 per cent said “a fair amount,” 23 per cent said “not very much,” and three per cent said “none at all.” Co-ordinators working in primary schools were generally more positive about the amount

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10 Please note these proportions are based on relatively small base sizes (of 38 co-ordinators that answered this question), so figures should be treated as indicative.
11 Please note these proportions are based on relatively small base sizes (of 40 co-ordinators that answered this question), so figures should be treated as indicative.
12 *Whole School Approach to the National Healthy Schools Programme* (11 Nov 2009), available at 
http://resources.healthyschools.gov.uk/v/c030df8d-a147-450b-8e31-9cbe0f16c10?c=8d5b6fca-39d1-4d7d-927a-9cb501033f69
of involvement that teaching staff had with the Programme than were co-ordinators in secondary schools: while 23 per cent of co-ordinators in primary schools said that teaching staff had “a great deal” of involvement in the Programme, only five per cent of co-ordinators in secondary schools gave this answer.

Fourteen per cent of co-ordinators said support staff had “a great deal” of involvement with the Programme, 47 per cent said “a fair amount,” 34 per cent said “not very much,” and five per cent said “none at all.” These proportions were broadly similar in primary and secondary schools.

We also asked about those not involved with the schools on a day-to-day basis. Almost half (47%) of all co-ordinators said governors had “not very much” involvement with the Programme, while five per cent said “none at all.” Forty-one per cent said “a fair amount,” and six per cent said “a great deal.” These proportions were broadly similar in primary and secondary schools.

The way in which change was introduced was felt to influence the impact that it might have on pupils. Schools felt it was important to engage pupils, firstly through ensuring they understood why changes had been made (for example the benefit that healthy eating would have to their future health) and second that they responded to the interest and needs of pupils. Consultation with pupils could identify barriers to the activity which could then be removed. One example of this was a school that ran a survey asking why pupils did not cycle to school. The school then introduced a bike repair workshop after learning that one barrier was pupils not knowing how to repair their bikes.

The majority (64%) of co-ordinators said that pupils had “a fair amount” of involvement with the Programme, while 23 per cent said “a great deal.” Eleven per cent said “not very much,” and three per cent said “none at all.” While similar proportions of co-ordinators in primary and secondary schools gave a positive response (with 85% of primary school co-ordinators and 90% of secondary school co-ordinators saying “a great deal” or “a fair amount”), a higher proportion of primary school co-ordinators said “a great deal” – 28 per cent of primary school co-ordinators gave this answer, compared with 15 per cent of secondary school co-ordinators.

Staff felt they could have influence by being role models, but also acknowledged the importance of familial and cultural attitudes. However, very few co-ordinators (1%) said that parents had a great deal of involvement in the NHSP, while 39 per cent said that parents had “a fair amount” of involvement. Over half (54%) of co-ordinators said that parents had “not very much” involvement, while five per cent said “none at all.” The proportion of co-ordinators saying that parents had “not very much” or no involvement with the Programme was higher in secondary schools than in primary schools: 72 per cent of co-ordinators in secondary schools gave one of these answers, compared with 52 per cent of co-ordinators in primary schools.

One particular issue was that schools found it difficult to discuss weight issues with pupils if parents themselves had problems around health and diet. One way this
difficulty was overcome was to encourage parents to take part in family activities where there was a focus on fitness for all family members.

Lastly, schools discussed the role of school ethos in affecting pupil outcomes. Teachers spoke about the importance of whether healthy activities (PSHE, physical activity, healthy eating) were embedded within the culture of schools. Where they were, the benefits were discussed throughout school both informally between staff and pupils, and formally within a range of different subjects This meant that it was seen as part of a ‘way of life’ for pupils rather than something additional only for those who were interested. With respect to PSHE in particular, a number of participants considered that delivering PSHE in a consistent way throughout a pupil’s time in the school had a greater impact. Conversely, in schools acknowledging that their delivery of PSHE was ‘disjointed’, participants felt that they were unable to build on what had been taught in previous years.

We asked co-ordinators to describe the level of commitment given by the senior management in their school to achieving NHSS, which might be expected to have an impact on the school ethos. The majority answered this question with a positive response: 51 per cent of co-ordinators said that the senior management in their school were “very committed” to achieving NHSS, while 40 per cent said “fairly committed.” (These proportions were similar in primary and secondary schools.)

We asked co-ordinators how much involvement outside agencies had with helping the school achieve NHSS. Half (50%) of co-ordinators said that outside agencies had “a fair amount” of involvement, while 13 per cent said “a great deal.” A third (33%) of co-ordinators said that outside agencies had “not very much” involvement, while five per cent said “none at all.”

Overall, a majority of co-ordinators said that teaching staff, support staff, pupils and outside agencies were involved with the Programme either “a fair amount” or “a great deal”. The whole school approach appears to be more embedded in primary schools than in secondary schools, with co-ordinators working in primary schools giving more positive answers when asked about the involvement in the Programme of teaching staff, pupils, and parents. Indications from the secondary analysis are that sustained (but very limited) spill-over effects (i.e. positive effects which may be related to the delivery of NHSP but were not intended by the Programme) were mainly seen in primary schools. This suggests that the success of the whole school approach could have some wider impact.

Two areas appear as possible barriers to the Programme achieving a truly whole school approach. Firstly, the level of involvement that governors had with the Programme is relatively low (with over half of the co-ordinators interviewed saying that governors had not very much or no involvement with the Programme). Secondly, the level of involvement that parents had with the Programme also appears to be low (with 59 per cent of co-ordinators saying that this was “not very much” or “none at all”, and only one per cent saying that parents were involved with the Programme “a great
4.3 Measuring impact at the pupil level

The main objective of the quantitative element of the study was to measure the impact of the Programme on health-related pupil outcomes. In the following four chapters the result of this impact study are set out for each of the four themes.

The impact study was carried out by analysis of data collected through paper self-completion questionnaires, which were completed by pupils in schools that had participated in the baseline and follow-up surveys of co-ordinators.

The pupil questionnaires included many questions for each “theme”, which were intended to give an accurate picture of each pupil’s behaviours and attitudes relating to that theme. For each question it was decided before the data was analysed, in consultation with DH, which answer or answers would be viewed as “positive” i.e. which were desirable health-related outcomes. (A full list of these metrics is included in section 1.4 of the appendices.) This made it possible to say for each question what proportion of each school’s pupils gave “positive” answers at each stage, and so to say what the level of “positive” change was for each question between the baseline and follow-up surveys.

The following section contains a brief explanation of the analysis.

4.3.1 Explanation of the analysis used to measure the impact of the National Healthy Schools Programme on health-related pupil outcomes

In order to measure the impact of the Programme on health-related pupil outcomes (i.e. the behaviours and attitudes of pupils in relation to the four themes), ideally we would compare the change in pupil outcomes in schools that are involved with the Programme to the change in pupil outcomes in schools that are not. However, at the time that the baseline surveys of co-ordinators and pupils were being implemented, the majority of schools in England were either involved with or planned to be involved with the Programme, making this type of approach impossible.

It was therefore decided that the baseline surveys of co-ordinators and pupils would be conducted with schools that had not yet achieved NHSS, and that a measure of “distance travelled” towards NHSS between the baseline and follow-up coordinator surveys would be developed. The change in health-related pupil outcomes in schools that had travelled a long way towards (or had achieved) NHSS could then be compared with the change in pupil outcomes in schools that had travelled a shorter or no distance towards NHSS. This would give an indication of the impact the Programme has on health-related pupil outcomes. Several measures of “distance travelled” were...
developed and used in the analysis – more explanation of these is provided below (in section 4.3.2).

A straightforward analysis to assess impact would involve measuring the relationship between changes in health-related pupil outcomes and distance travelled by schools towards NHSS. However, there would be a danger in overlooking other factors that could have an effect on pupil outcomes.

There are many factors other than participation in the Programme that are likely to have had an effect on the outcomes we are measuring, and therefore could affect the level of change seen between the baseline and the follow-up surveys. These factors are likely to be unevenly spread across participating schools, and without taking them into account, the effect of one of these other factors could be misinterpreted as an effect of the Programme. Similarly, an effect of the Programme may be masked by the effects of another factor working in the opposite direction. In order to more accurately measure the impact of the Programme on pupil outcomes, the data has therefore been analysed using a technique called multiple regression\(^\text{13}\): a statistical method that allows for the effect of particular ‘inputs’ (in this case NHSP participation) to be isolated after controlling for the effect of other factors.

This multivariate analysis aims to measure the relationship between changes in health-related pupil outcomes and distance travelled by schools towards NHSS, while taking into account a number of other factors that could influence the outcomes. A complete list of the factors included in the multivariate analysis can be found in section 1.5 of the appendices; this includes factors such as gender and school year of pupils, size of school, and the number of pupils per school that are eligible for free school meals (FSM).

Only schools which participated in the baseline and follow-up surveys, and for whom sufficient demographic data was available from external sources, could be included in the analysis. The number of cases included in this analysis is presented in Table 4.4. Note that in the follow-up survey, schools were asked to conduct the survey with extra classes in each year group if possible.

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<tbody>
<tr>
<td></td>
<td>Primary</td>
<td>Secondary</td>
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<tr>
<td>Number of schools</td>
<td>102</td>
<td>50</td>
</tr>
<tr>
<td>Number of pupils</td>
<td>4,182</td>
<td>2,474</td>
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\(^{13}\) The particular method of regression used takes into account the fact that the survey data on pupils is nested within a smaller sample of schools.
4.3.2 Measuring “distance travelled”

As mentioned above, several measures of the “distance travelled” towards Healthy School Status have been used in our analysis, the findings of which are presented in the following chapters. These four measures of distance travelled are:

- The level of engagement each school had with the Programme
- The level of impact co-ordinators reported the Programme having on the provision made by their school for each theme
- The increase in the number of criteria achieved by each school
- Whether or not schools had achieved NHSS at the time of the follow-up survey

A brief explanation of each these four measures is given below.

The first measure, which in following chapters will be referred to as “level of engagement,” is based on the answers to a number of questions included in the survey with co-ordinators in each school. (More information about what questions this was based on and how schools were grouped can be found in section 1.3 of the appendices.) This measure groups schools based on how co-ordinators thought their schools had engaged with the Programme. Of the four measures used, this is the one deemed by NatCen to be the truest indication of the extent of schools’ engagement with the Programme, and the one we believe to be most useful for the analysis outlined above.

The second measure, which in following chapters will be referred to as “self-reported impact,” is taken from the interviews with co-ordinators. We asked co-ordinators whether they believed the Programme had impacted on their schools’ overall provision for each of the four themes. In this case distance travelled is deemed to be greater in those schools where co-ordinators said the Programme had “a lot of impact”.

At both the baseline and follow-up surveys, co-ordinators were asked to complete a form that indicated which of the 41 criteria that are needed to attain NHSS had been achieved at that time. The third measure, which in the following chapters will be referred to as the “increase in the number of criteria achieved,” is the number of criteria that each school had not achieved at the baseline survey but had achieved by the follow-up survey.

None of the schools recruited had achieved NHSS at the time that the baseline survey was conducted. However, by the time that the follow-up survey was conducted, 86 of the 152 schools included in the analysis had achieved NHSS. The fourth measure of distance travelled compares schools that had and had not achieved NHSS by the time the follow-up survey was conducted.
4.4 Analysis of change reported by co-ordinators

In the following chapters, the change between the baseline and follow-up surveys with co-ordinators is examined, in order to give a picture of the way schools participating in the Programme have changed their provision and facilities for each of the four themes between these two points in time. A comparison of the spread of these changes between the different distance travelled groups enables us to see to what extent the level of engagement with the Programme or the increase in number of criteria achieved, for example, are associated with actual, structural changes within schools.

In order to do this, a selection of the questions relating to facilities and provision that were most closely associated with the Programme was taken (see section 1.4 of the appendices for the full list). For each of these questions, it was determined what would be a positive answer and what would be a negative answer. For example, an answer that a school has a school council would be a positive answer, while an answer that a school does not have a school council would be a negative answer. We then established for each question whether, between the baseline and follow-up surveys, each school went from a negative to a positive answer, stayed the same, or went from a positive to a negative answer. The changes recorded for each question were then combined to give an overall picture of whether each school had increased or decreased the overall number of positive answers they had given.

Below we explore the extent to which the different methods of measuring ‘distance travelled’ towards NHSS are related to the change in number of positive answers given to the questions outlined above.

4.4.1 Level of engagement

As described above, the ‘level of engagement’ measure of distance travelled groups schools based on how co-ordinators thought their schools had engaged with the Programme. Figure 4.1 shows the number of schools in each ‘level of engagement’ group where facilities and provision increased, decreased, or stayed the same according to the combined value described above.
The data presented in Figure 4.1 shows that the level of engagement measure is not related to the improvements in facilities and provision within schools. The joint highest proportion of schools which had made increases in facilities and provision was found in the group of schools that had engaged the least with the Programme. This could be for two reasons.

Firstly, it is possible that those schools that are most engaged with the Programme were more engaged early on in the Programme. If this were the case, these schools would have a good level of facilities and provision at the baseline survey, and would have found it difficult to improve in this way between the baseline and follow-up surveys.

The second possible explanation is that a number of schools that were working towards NHSS (as all schools in the sample reported doing) but who were not particularly engaged with the Programme in the way measured here have put a number of measures in place in order to meet criteria and gain NHSS, but without necessarily putting the resources and commitment into the Programme that more engaged schools had. This possibility of schools treating the Programme as a ‘box ticking’ exercise is why NatCen consider the measure of distance travelled that looks at the level of engagement, rather than the number of criteria achieved, as the most useful, as it is thought that the Programme would have more impact on health-related pupil outcomes in schools that are fully engaged with the Programme than in schools that merely fulfil criteria in order to achieve the award of NHSS.
4.4.2 Number of Criteria achieved

Figure 4.2 shows the number of schools that have changed their facilities and provision, split by whether they had increased the number of criteria they had achieved by eight or fewer or by more than eight.
The data presented in Figure 4.2 shows that those schools that had increased by more criteria were also more likely to have increased the number of positive answers given when asked about specific activities and facilities relating to health and well-being in their school. (However, this difference is not statistically significant.) This apparent difference is unsurprising, given that many of the activities and facilities asked about in the coordinator interview formed elements of some of the Healthy Schools criteria themselves.

### 4.4.3 Healthy School Status

The data presented in Figure 4.3 shows the number of schools that have changed their facilities and provision, split by whether or not they had achieved NHSS by the time of the follow-up survey. (Of the 149 schools included in this analysis, 86 had achieved NHSS by the time of the follow-up survey, while 63 had not.)
It is clear from the data presented in Figure 4.3 that whether or not a school had achieved NHSS by the time of the follow-up survey is not related to whether they changed the facilities and provision available in their school between the baseline and follow-up stages of the survey with co-ordinators.

4.5 Analysis of pupil outcome data by theme

The multivariate analysis was carried out at the pupil level and tells us, for each question, after controlling for the factors listed in section 1.5 of the appendices:

- What the relationship is between changes in health-related pupil outcomes (between the baseline and follow-up surveys) and the distance travelled by schools (i.e. the distance travelled towards NHSS, measured in one of the four ways outlined in section 4.3.2). This relationship is described as either positive or negative. For example, if (once all of the factors listed in section 1.5 of the appendices have been taken into account) schools that had travelled a long way towards NHSS were more likely to show an increase between the baseline and follow-up surveys in the proportion of pupils giving a positive answer, we would say that the outcome has a **positive relationship** with distance travelled; if the relationship is in the opposite direction we say that there is a **negative relationship**.
• Whether this positive or negative relationship is **statistically significant**. We have used the 5% level of significance which means that a relationship is deemed to be statistically significant if, under the hypothesis that the Programme had no effect on the outcome being tested, there is less than a five per cent chance that the observed relationship would occur due to random variation.

Findings are presented in an aggregate form: for each Healthy Schools theme, the number of questions which show a (significant) positive relationship and the number of questions which show a (significant) negative relationship are displayed in graphical form. We are interested mainly in the number of significant positive relationships. If the Programme has had an impact then we would expect to find a high number of these. However, we should bear in mind that, even if the Programme has not had an effect on health-related pupil outcomes, we would still expect to find a ‘statistically significant’ relationship for a small proportion of the questions tested just by chance (with perhaps half of these significant relationships being positive and half being negative).

An issue with this kind of research is what is sometimes described as a “type II error,” in which there is insufficient statistical power to detect significant differences that are actually occurring. For example, if the Programme has had a significant and positive effect on health-related pupil outcomes, but this change is not found to be statistically significant due to small sample sizes in the survey, this would be a type II error. If this were the case, we would expect to see a clear trend with many more positive relationships than negative relationships, regardless of whether or not these relationships are statistically significant. The prevailing direction of the relationships is therefore of interest as well as the number of significant positive relationships.
5 Impact of NHSP – PSHE and Emotional Health and Well-Being (EHWB)

This chapter looks at the impact of the Programme in the area of PSHE and EHWB, both at the level of school provision and at the pupil level. The findings presented here, as well as those presented in chapters 6 and 7 which look at the impact of the Programme on Healthy Eating and Physical Activity respectively, draw on several sources: the qualitative interviews with head teachers and/or healthy schools co-ordinators (sections 5.1 and 5.4); the telephone survey with healthy schools co-ordinators (sections 5.2, 5.3 and 5.5); and the paper self-completion survey conducted with pupils (sections 5.6 and 5.7).

5.1 Changes to promoting PSHE and EHWB

As already alluded to in chapter 2, schools approached the delivery of PSHE in a range of ways, in terms of who delivers it and how it is delivered as well as the importance it is afforded relative to other subjects. Changes in PSHE practice were related to systemic changes but could also be identified in health promoting practices outside timetabled delivery. Practices related to providing EHWB support, though linked to PSHE, appear to have been seen as a less coherent package and not ‘delivered’ as a subject in the same way as PSHE. Consequently, change in this area is more related to changes in specific initiatives.

A number of schools had introduced clear lines of responsibility for co-ordination with the role either being carried out by the Healthy Schools co-ordinator or a specific PSHE co-ordinator. Participants that had made this change recently described it as a positive move that enabled a whole school approach to PSHE and consistency across lessons. A range of staff members delivered the lessons. Some schools used form tutors to do so, while participants from other schools described various situations in which teachers with specific expertise for teaching PSHE would deliver lessons for different year groups. The latter approach tended to be associated with timetabled PSHE in secondary schools. An alternative approach saw PSHE conflated with other subjects, such as Citizenship, or embedded across the entire curriculum. Some participants that felt they still had some changes to make in order for PSHE delivery to be satisfactory described delivery in a more ad hoc way using one-off ‘drop-down’ days focusing on specific issues.

All schools had introduced new practices targeting specific elements of PSHE/EHWB. This section looks at the range of new practices identified by participants under the following headings: the use of outside agencies; practices related to improving relationships; and practices aimed at changing specific behaviour.
The use of outside agencies: A number of schools were keen to work with local agencies in providing relevant services on these issues. Local organisations providing advice and support around drugs were used in some schools, as were links with local youth offending services to develop drop-in services for pupils. More formal relationships had been set up in the last year with organisations like Connexions to provide employment and career support, with some schools now having a permanent base for the advisor in the school. Other participants described organising an annual Healthy Lifestyles Event where pupils go round and listen to short talks from a number of local agencies on the services they provide. In relation to EHWB and advice services, some schools had used external providers to provide a regular service fulfilling any requirements among pupils for more intensive counselling.

Practices related to improving relationships: a number of new practices aimed to improve pupils’ relationships with each other, with staff and with parents, and participants described a series of initiatives to encourage interaction and forge relations. In one example, arts and crafts workshops were run after school to nurture relationships between parents and children. This kind of activity also enabled schools to engage parents in the running of the school and their child’s education. Schools also involved parents in sex education and drug awareness sessions. Other activities aimed to encourage social interaction amongst pupils and improve awareness of their own and others’ emotions. Circle time, noted above as a common feature of PSHE lessons, enabled staff to deal with issues that might arise between pupils outside lessons in an open way. Some participants described a whole Programme of events around inclusion and engagement, some involving physical activities but with the aim of involving pupils with other pupils they might not otherwise know and boosting pupils’ confidence.

One thing that we’ve done is a Change in Tracks Programme, which is for children who are perhaps at risk of serious underachievement or even exclusion from school, involving them in…a Taiko drumming project, and…it’s been very positive for them. And that again is positive for the school as well because it means that they’ve got something to engage with in school.

Secondary school, small size, low FSM

Some primary schools had begun to develop more formal approaches to assisting pupils in their transition from year six into secondary school. This involved working with partner schools to have staff come in and develop an early relationship with pupils at the primary schools, and staff working together and sharing information around pupil progress in PSHE and any specific issues related to EHWB.

And then in years five and six were looking at transition, and that’s always a biggy for those Year sixes…it’s an anxious time for them…it’s always good to share their ideas...so we’ve got a seven week Programme in place for that with the funding that we’ve got.

Primary school, small size, low FSM
**Practices aiming at changing specific behaviour:** Another set of practices that had been introduced by schools in the last year focused more on affecting specific behaviours. A number of schools had held no-smoking or anti-drinking days or set up specific rooms providing pupils with information about the health risks associated with these activities. A range of initiatives were also identified around increasing awareness of bullying and reducing its prevalence. Schools reported that their involvement in anti-bullying week had in some cases led to school-wide discussions on defining bullying and the development of an anti-bullying ‘charter’. Educational sessions and support services around sexual relationships were delivered by the school nurse in a number of schools. In larger schools the school nurse was a permanent member of staff who would not only be available to provide reactive advice but would also deliver sessions as part of PSHE. In other cases, the school nurse was a local resource with responsibility for a number of schools in the area.

**Impact of NHSP on change**

Although all participants were able to describe some changes in their approach towards or delivery of PSHE and EHWB, they did not always find it possible to attribute this to NHSP or, in fact, any other isolated factor. However, as the co-ordinator survey data in sections 5.2 and 5.3 make clear, at least three-quarters of co-ordinators felt the Programme had a great deal or fair amount of impact in these areas.

There was a sense that a number of initiatives, Programmes and resources came together to affect practice in these areas. Some schools, for example, described how their relationships with local providers were longer-standing and more significant than their involvement with NHSP. Another significant factor effecting change in practice had been the arrival of new staff with relevant experience and expertise.

There were some participants, however, who did make direct links to their involvement in or awareness of the Programme and how they structured the delivery of PSHE. For some, the appointment of a PSHE co-ordinator or the Healthy Schools co-ordinator assuming this role had been a direct result of putting in place a structure that would enable the school to meet NHSS criteria. There were also examples where a PSHE audit, conducted in relation to NHSS, had led to employing separate PSHE and citizenship co-ordinators leading to a complete change in emphasis of the PSHE Programme, and where an NHSP audit of Continuing Professional Development had identified gaps in provision. Additionally, courses identified or run by the local healthy schools co-ordinator had been of significant value to some schools in terms of making staff think about exactly what they were trying to achieve when delivering PSHE or EHWB support. The survey of school co-ordinators (see sections 5.2 and 5.3) also found that the main perceived impacts of the NHSP in these areas were around profile raising and improving standards/practices.

School staff were complimentary about the range of the information and resources that were available through Healthy Schools. A participant from a rural primary school was able to find drug and alcohol related material pitched at the right level for the local context of her school:
R: Everything has to be monitored very closely to make sure we don’t upset and offend the children and their parents, so we have to be quite careful in what we deliver because of our ruralness really and our isolation.

I: Yes, and is the Healthy Schools Programme, the information that you get useful in that in helping to do that?

R: Very useful, yes, yes, big help, a big help, yes, definitely…they’ve got things for everybody…if you look at it and it’s not appropriate you don’t order it.

Primary school, small size, low FSM

More generally, it was also felt that NHSP had had an impact by raising the awareness and perceived value of PSHE and EHWB and where these issues related to other aspects of learning, as well as reinforcing what the school was already doing:

*I think [NHSP] kind of fits everything together…I wouldn’t say we’re doing lots of new things that we have never done before, I’m not saying that we never cared about the emotional side of children or anything but…I think its just like finding a sort of common ground for how all that fits and that’s how the Healthy Schools has probably made us look at where does it actually fit in our curriculum.*

Primary school, small size, low FSM

Other schools described the impact of NHSP in relation to the introduction of specific practices, for example as a result of engaging with and meeting the NHSP criteria one school had now made the entire site a no smoking area. Other schools linked the development of their peer mentoring systems or the addition of one-to-one mentoring to observing practice in other schools through NHSP. There were also participants who were able to describe pending changes that had been proposed partly as a result of NHSP. One school that was proposing the installation of a health drop-in centre suggested that working towards achieving NHSS may have helped when influencing governors to agree funding for the project, although it had not been the overarching driver for this decision.

*It possibly had a bit of impact on the governor that I work with… we’ve been trying to get in place for about three, four years now…the fact that doing the process, going through the process helped us reflect what we were doing across the board because it covers everything…[but] It wasn’t an instigator of something.*

Secondary school, large size, high FSM

It was also suggested that survey data had influenced how they provide services related to pupils’ emotional health. The results of the Pupil Attitudes to Self and School (PASS) survey, accessed through the local healthy schools Programme, had enabled staff to pinpoint particular EHWB issues in different year groups that are now being tackled in a different way.

Despite a largely positive attitude towards professional development, a number of participants noted that certain conditions are needed for a school to be able to provide
suitable opportunities. One condition was the existence of sufficient financial resources and time to identify relevant training courses. It was also felt that specific training around PSHE or EHWB would be more likely to be available in a school that gives these two areas a similar level of priority to ‘core subjects’.

5.2 Perception of impact of Programme on PSHE provision

When asked about the impact the NHSP had on schools’ overall provision of PSHE, the majority of co-ordinators gave a positive answer – 87 per cent said that the Programme had had a lot or a fair amount of impact on their schools’ provision of PSHE. This figure is higher than for the other three Healthy School themes of healthy eating, physical activity and EHWB. Co-ordinators working in secondary schools were more likely than those working in primary schools to say that the Programme had a lot of impact on provision of PSHE. In primary schools, 19 per cent of co-ordinators gave this answer, compared with 31 per cent of co-ordinators in secondary schools.

Co-ordinators that indicated the NHSP had had a lot of impact on the provision of PSHE in their school were asked to define the kind of impact. The most common answer in primary schools was that the Programme had raised the profile of PSHE teaching (7 co-ordinators gave this answer). Other answers given included that the Programme had led to a more structured or consistent approach to PSHE teaching (5 co-ordinators gave this answer) and that it led to an increase in the amount of PSHE provided (4 co-ordinators gave this answer). Less common answers included that it led to the school improving the standard of PSHE teaching (3 co-ordinators gave this answer), introducing the assessment of PSHE teaching (2 co-ordinators gave this answer), and employing new staff for PSHE (1 coordinator gave this answer).

The most common answer given by co-ordinators working in secondary schools was that the Programme led to the school improving the standard of PSHE teaching (mentioned by 10 of the 32 co-ordinators in secondary schools that were asked this question). Other answers given included that the Programme raised the profile of PSHE teaching and led to a more structured approach to it (7 co-ordinators gave each of these answers). Less common answers included that there was an increase in the amount of PSHE provided and that the Programme led to employing new staff for PSHE (3 co-ordinators gave each of these two answers), as well as leading to the introduction of assessment of PSHE teaching and improving the resources available for PSHE teaching (1 coordinator gave each of these answers).

5.3 Perception of impact of Programme on EHWB provision

Seventy-four per cent of co-ordinators said that the NHSP had a fair amount or a lot of impact on the overall provision around EHWB in their schools, with 16 per cent saying it had “a lot of impact.” These proportions were similar amongst co-ordinators working in primary and secondary schools.

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14 Figures for this question are reported as numbers rather than as percentages due to very low base sizes.
Over half of the co-ordinators¹⁵ in both primary and secondary schools that said the Programme had a lot of impact on EHWB explained that it helped the school to improve practices. Fifteen of the 28 co-ordinators working in primary schools and 10 of the 17 co-ordinators in secondary schools that were asked this question gave this answer. Another common explanation was that the Programme raised awareness (5 co-ordinators in primary schools and 6 co-ordinators in secondary schools gave this answer). Another answer given by co-ordinators was that the Programme helped identify areas for improvement. This answer was given by two co-ordinators in both primary and secondary schools.

5.4 Monitoring and evaluation

Schools invested varying levels of resources and adopted a range of approaches to monitoring and evaluating the delivery and impact of PSHE and EHWB support. The extent of a school's commitment or ability to monitor delivery in these areas was related to the overall attitude of the school and staff towards the importance of PSHE and EHWB.

As far as EHWB services and support were concerned, there was some generic monitoring of delivery related to the delivery of SEAL units, but otherwise, monitoring was conducted only on specific aspects of EHWB. The delivery of PSHE on the other hand, because of the structured and timetabled approach, was monitored by some schools in the same way as any other subject. Participants described standardised lesson observations that took place across the entire curriculum, in some cases using an OFSTED framework for assessment.

A variety of formal and informal processes were noted as being designed specifically to monitor the quality of PSHE delivery and EHWB support. Some schools used these in addition to the generic methods noted above while others relied entirely on these bespoke or ad hoc methods. These included the formal approaches identified below.

- **Evaluation activities embedded into PSHE lessons:** This included the use of feedback forms at the end of each lesson or longer feedback sessions at the end of term. It was noted that a consequence of this approach has been to engage children not only with the subject but also what they have learnt and how they have learned it.
- **Questionnaires:** In some schools, questionnaires were conducted across the whole school or they were conducted by the local healthy schools programme or another part of the local authority and took place across the entire region. These included the PASS Survey, as well as surveys related to specific EHWB services or with parents to obtain a rounded picture of pupils' progress.
- **Specific initiative monitoring:** Initiatives such as an ‘inclusion unit’, looking at supporting the integration of pupils outside of the mainstream of the school,

¹⁵ Figures for this question are reported as numbers rather than as percentages due to very low base sizes.

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would monitor the progress of particularly disaffected pupils and the impact of work among this group.

- **Incident monitoring**: Logging occurrences of bullying, racism and discrimination was carried out by some schools. Approaches varied from reporting to the head teacher and retaining the results for the school to reporting these incidents directly to the local authority using an online form.

Participants also described a number of informal approaches to monitoring and evaluation. Anecdotal observation was felt to be part of a teacher’s job with respect to PSHE as the nature of the subject means that it is important to be aware of the pupils’ engagement with the issues. This approach was underpinned by a perception that formal monitoring is not appropriate for issues dealt with in PSHE which can be personal to individuals or the class and, therefore, evaluation has to adapt to this.

There were schools that said they did not monitor the quality of their PSHE provision or the effectiveness of their EHWB support and advice at all. It was felt by participants that this was the side of PSHE or EHWB that they were yet to get round to. While some of these schools said that they aimed to begin a monitoring and evaluation Programme in the near future, others noted a number of issues that would act as barriers to doing so. It was felt that parents could object to questionnaires or feedback sessions on some more sensitive issues around drugs or sexual relationships. There were also questions raised as to whether monitoring and evaluating should be priorities, as these activities were seen as taking staff time out of core teaching activities. Another barrier was the feeling that planning and delivery of PSHE and EHWB needed to be the focus of activity rather than trying to monitor or evaluate it. These issues were also raised as barriers to effective evaluation in schools that were already undertaking some form of monitoring.

### 5.5 Schools’ perception of impact on pupils of changes in PSHE and EHWB provision

The impacts of changing practice on pupils that were identified by school staff can be grouped under three headings: impacts on pupil knowledge and awareness; impacts on pupil behaviour; and impacts on preparing pupils for future challenges.

**Pupil knowledge and awareness**: participants noted that a range of changes they had made, both related and unrelated to NHSP, had improved the general knowledge of pupils in relation to what constitutes a healthy lifestyle and an increased awareness of equality and respecting difference. Participants found it easier to identify the source of impacts on pupils displaying increased knowledge of more specific issues. Knowledge of the risks associated with behaviour such as smoking, drugs, alcohol and sexual relationships was felt to have improved. One participant described how this was evidenced in a visit by a local police officer to discuss drugs.

*The children are obviously engaging in the learning, ‘cos otherwise they wouldn’t be able to talk the way they did to the inspector…knowing that some drugs were...*
good for you, medicines, etc. Other drugs they knew weren’t so good for you, down to, you know, prohibited drugs, down to things like caffeine.

Primary school, small size, high FSM

Some participants also felt that pupils’ knowledge of choices that are available to them in relation to sexual relationships and their awareness of support that can be provided on a whole range of issues had improved. One school noted a direct link with NHSS in working with pupils who were victims of physical abuse as a result of a toolkit accessed through the Programme. Finally, awareness of how to act when pupils become aware of bullying, either of themselves or others was felt to have improved in some schools, in some cases in direct response to openly discussing what bullying is and developing a bullying charter. Related to this, an increase in reporting of bullying was noted by a number of schools, which was put down to greater awareness; other schools felt that the approach they had taken had reduced incidences of bullying.

**Pupil behaviour:** one way in which participants articulated the impact of changing delivery on pupils was changes in specific behaviours. For example, discussion of the risks of smoking and the implementation of a no-smoking policy on and outside school grounds had led to one school feeling that they had eradicated smoking as an issue on the school grounds. The impact on pupils in terms of drinking or taking drugs was considered difficult to assess as it would always take place outside of school.

When discussing the effects of changing practice on behaviour, a number of participants also felt that there had been an impact on general behaviour and pupil attitudes towards each other and towards staff. General manners and courtesy shown throughout the school was thought to be more apparent throughout a number of schools. Other participants were keen to note the wider impact of this changing behaviour during lessons, suggesting that a general improvement in behaviour had enabled pupils to become more engaged in learning. Activities that had stressed team work and inclusion, such as Taiko Drumming and dance sessions, were felt to have increased the confidence, self-esteem and self-recognition of some pupils, giving them the chance to be involved in a new activity they were good at.

Well it does have an impact. I mean I think that some of the children who've been involved in the archery, for example, have not actually done anything sustained very much before, but have won, you know, got badges and medals, which has helped them and built up their confidence.

Secondary school, small size, low FSM

Another theme that emerged in relation to the impact on pupil behaviour was pupils challenging the behaviour of parents. A number of participants noted that pupils had described to them how they had taken messages back home, particularly related to smoking, to try to influence their parents’ behaviour. While not all participants were sure of the impact this would have on parents or whether this should even be a concern for the school, the fact that children felt confident about challenging parents in this way was seen by participants as evidence that messages are getting across.
Preparing pupils for future challenges: another theme that emerged when discussing pupil impact was that much of the work schools were doing was about preparing pupils for future learning challenges, adult life or the workplace. For example, preparing primary school children to make informed choices as they moved to secondary school:

Well, that’s only delivered to the older children…as they get older, they need more knowledge, so that when they go up to the big school in XXX City Centre where things are different, that they are aware that these things do happen and that somebody at school might try to sell them drugs and we give them the strategies to make sure that they’re strong enough to say no.

Primary school, small size, low FSM

More generally, some schools considered that the role of their PSHE and EHWB provision was to provide pupils with skills for challenges outside school and in working environments. The comments of the participant quoted below illustrates this but also notes the difficulty schools have in assessing whether they are successful in doing so.

I really do think the stuff we do does help them outside of school. Because even some of them that don’t achieve anything academically you can tell that after they’ve been here for a few months they’ve like achieved respect for staff, and you know their attitudes towards different people, their politeness, their manners have brought on, and I think they are the sort of things that they take with them outside of school which can help them in any situation I suppose.

Pupil referral unit

Along with the difficulties in effecting change among pupils, it was felt that it was difficult to accurately assess this impact in relation to PSHE and EHWB. Some participants considered the issues too intangible and felt it was difficult to measure emotional health and happiness in any formal, quantifiable way; it was also felt that such measurement is only really possible on an individual level:

So sometimes the it’s very these are very difficult things to measure, a pupil’s happiness and you know, and self image, but I think you can see there are improvements with children in terms of them coming in a bit more of a positive frame of mind. [But] not all children all of the time.

Secondary school, small size, low FSM

A further difficulty was the fact that a lot of the support services around EHWB and some aspects of PSHE are necessarily confidential, making it difficult to obtain an idea of the impact across the school as a whole.

Section 5.6 reports the findings from the quantitative measures of the impact on pupils in the area of PSHE.
5.6 Impact study of PSHE among pupils

Primary schools

Figure 5.1 presents the findings of the analysis for the five questions related to PSHE for primary schools. These included questions measuring attitudes to smoking; current levels of smoking and drinking; whether pupils regularly have ‘circle time’ in school; and whether pupils feel that teachers listen to their ideas about making the school better.

![Figure 5.1 Multivariate analysis of pupil data, PSHE theme, Primary schools](image)

The green bars on the right hand side represent the number of questions on PSHE that are positively related to the given measure of distance travelled (i.e. the number of questions where there was an increase in the proportion of positive responses in schools which had travelled further towards Healthy Schools Status). If any positive relationships were found to be statistically significant, the number of statistically significant positive relationships would be presented with a shaded green section (there were none for any of the tests presented in Figure 5.1). The red bars to the left hand side represent the number of questions in the theme that were negatively related to the given measure of distance travelled, with the shaded red sections representing the number of questions for which this relationship was statistically significant.

For example, when using the increase in the number of criteria as the measure of distance travelled, there were no significant differences, with four of the five questions being positively related to distance travelled. Using the Level of engagement and Healthy Schools status measures of distance travelled, four of the five questions were negatively related to distance travelled (with none of these relationships being statistically significant). When using the self-reported impact measure of distance
travelled, three of the five measures were negatively related to distance travelled, with one of these relationships being statistically significant. Across the four different measures, there is no conclusive pattern that emerges.

Overall, the data presented in Figure 5.1 indicate that, within a two year timeframe, the Programme was unable to make a measurable impact on PSHE outcomes for pupils in primary schools.

Secondary schools

Figure 5.2 presents the findings of the analysis of the 27 questions related to PSHE for secondary schools. As well as the questions asked of primary school pupils, additional questions asked of secondary schools pupils covered topics such as attitudes towards and current levels of taking drugs; attitudes towards sexual relationships; and knowledge of access to advice about sexual relationships and sexual health.

When looking across all four measures used, there is no conclusive pattern that emerges. Overall, the data presented in Figure 5.2 show that, within a two year timeframe, the Programme was unable to make a measurable impact on PSHE outcomes amongst pupils in secondary schools.
5.7 Impact study of EHWB among pupils

Primary schools

Figure 5.3 presents the findings for the analysis of the 23 questions that related to EHWB in primary schools. These included questions asking about bullying and the pupils’ perceptions of how the school would deal with bullying; questions about pupils’ feelings about the school (for example, whether they feel happy about their school and whether they feel safe there); and questions about pupils’ feelings about their friends.

Across the four measures of distance travelled, no clear pattern emerges that would indicate an impact on EHWB outcomes amongst primary school pupils. Overall more questions show a negative relationship than show a positive relationship, while a similar number of questions show a significant positive relationship as show a significant negative relationship.
Secondary schools

Figure 5.4 presents the findings of the analysis of 24 questions relating to EHWB in secondary schools. These questions included all of those asked of primary school-aged pupils, as well as a question asking how useful pupils found teaching on friendships and family relationships.

![Figure 5.4 Multivariate analysis of pupil data, EHWB theme, secondary schools](image)

The questions for this theme show no consistent pattern. Overall, the data presented in Figure 5.4 show that, within a two year timeframe, the Programme was unable to make a measurable impact on pupil outcomes with respect to EHWB in secondary schools.

5.8 Chapter Summary

- **Changes in PSHE and EHWB practice**: Changes in PSHE practice were related to both systematic changes to the delivery of PSHE as a subject (for example the teaching and assessment of PSHE) and specific health promoting practices outside timetabled delivery. New practice implemented for EHWB was more likely to be related to specific initiatives, because the theme was delivered through individual services, than a coherent Programme of work delivered as a subject like PSHE. Changes to specific practices included the use of outside agencies (for example support and advice from local organisations), improving relationships between pupils, and introducing practices aiming to change specific behaviour (for example anti-bullying week).
• **Schools’ perception of impact on provision:** Some schools said the Programme had a direct impact on change in this area, for example, appointing a PSHE coordinator or introducing specific practice to enable a school to meet the criteria. Overall, 87 per cent said that the Programme had had a lot or a fair amount of impact on their schools’ provision of PSHE, with those working in secondary schools more likely to say this than those working in primary schools. Other schools found it difficult to attribute change to NHSP or isolate the role of one factor, because they had been working at improving practice in this area for a long time in partnership with local providers and organisations.

• **Monitoring and evaluation:** Changes in PSHE/EHWB were monitored through the use of feedback forms, questionnaires, and teachers’ observations of how engaged pupils were with topics and the lesson more generally. PSHE was not always subject to the same level of monitoring as other school subjects.

• **Schools’ perception of impact among pupils:** Not all schools identified pupil change, and schools’ experienced difficulties tracing pupil impact back to their involvement with the Programme where a number of non-NHSP influences were identified. Where schools had experienced change, three main types of impacts on pupil outcomes were identified (influenced by both NHSP and other factors). First, the improvement of pupil knowledge and awareness of what constitutes a healthy lifestyle and an understanding of equality and respecting difference. Second, changes to pupil behaviour, which included a reduction of smoking on school grounds, improvement to general courtesy and manners within the school, and greater engagement in lessons. Last, preparing pupils for future challenges in later learning, adult life, and the workplace.

Involvement in NHSP was predominantly seen as a facilitator to pupil impact. It was not always possible to identify the extent to which the Programme had an impact on change, but schools felt the Programme provided useful resources and information, reinforced the value of other initiatives used by schools, and encouraged a whole school approach to the delivery of PSHE which facilitated a wider pupil impact. Other factors which influenced pupil outcomes were the overall approach of the school to PSHE and whether there was consistent approach to delivery across a school. Factors that were neither linked to the Programme nor within the control of schools (for example the influence of school catchment area and socio-economic background of pupils) were also identified by participants.

• **Impact among pupils:** The analysis of the pupil data presented in this section demonstrates that, for PSHE/EHWB, within a two year timeframe the Programme was unable to have a significant positive impact on pupils in either primary or secondary schools.
6 Impact of NHSP – healthy eating

This chapter looks at the impact of the Programme on Healthy Eating, both at the level of school provision and at the pupil level.

6.1 Changes to promoting healthy eating

As discussed in the introduction to this report, meeting the NHSP criteria does not necessarily mean that schools introduce better practice in terms of food provision or promoting healthy eating. However, there had been changes in the way schools actively promoted healthy eating, and in some cases these changes were related to school’s participation in the Programme, though there were a range of other factors that influenced the change in practice. These included government guidance, the involvement in other initiatives, external changes to schools (for example, a move to a new school site), and the existing ethos and approach of schools. In some cases, although changes were discussed, it was difficult for participants to identify the reason for the change. The range of changes to schools’ practices and the factors influencing them are discussed below.

Healthier food provision: An improvement in the quality and nutritional value of food served at lunchtimes was reported by a number of schools. In some cases this was linked to NHSP, with schools saying they had implemented changes after reviewing their current food provision as part of the Programme. However schools were also influenced by the need to meet the requirements of DCSF schools food guidelines and by their own on-going commitment to the teaching and promotion of healthy eating. There were also cases where providers had improved the quality of food provision without any input from the school, or the improvements were the result of schools or local authorities changing providers. Another factor influencing change to food provision was the involvement of schools in other Programmes, such as the National School Fruit Scheme, while the need to increase the take-up of lunches in order to avoid making a loss was a final factor reported as influencing improvements in school catering.

Improving the school eating environment: School canteens had been improved through, for example, the introduction of seating organised in ‘family groups’ so that children of different ages sat together and staff were encouraged to eat with pupils at lunchtime by allowing them to eat school meals for free. This meant that staff were able to discuss healthy eating with pupils and praise children who were making healthy choices and who had good table manners. Another change was to replace plastic cutlery and crockery with metal and china, in order to make lunch times seem more important. Linked to this was the introduction of rewards, such as stickers and bracelets, for children who ‘ate well’ or finished their meals, and posters promoting healthy eating being put up in dining halls.
There were, however, also schools that had moved to new sites and considered the criteria and ethos of the healthy schools Programme when developing new canteen facilities. For example, one school had introduced a card system which monitored the food eaten by pupils and restricted them from making unhealthy choices.

**Practical sessions and external agencies:** Practical sessions and workshops delivered both by teachers and external agencies (including the local healthy schools Programme or other external specialists) had been introduced. Examples of these sessions included nutrition and taster events providing information for parents on how to devise a healthy lunch box and healthy meals as well as taster sessions to get pupils and parents to try school lunches. The national cooking Programme ‘Licence to Cook’ was also being run in some schools: it provided funding for equipment and ingredients and enabled students to learn to cook and understand the principles of diet and nutrition, food hygiene and storage, and the use of healthy ingredients. External providers and speakers, such as the Food Standards Agency ‘cookery bus’ and in one case a local rugby team, were also brought in to discuss healthy eating and the importance of nutrition. In some cases these activities were linked to the NHSP, or facilitated by local Programmes, although in other cases it was the result of the school’s own focus on the area of healthy eating.

**Gardening clubs:** An innovative approach to promoting healthy eating was the use of gardening clubs and vegetable gardens. These enabled schools to discuss with pupils the nutritional value of the food grown, and the produce was also used in practical sessions on how to cook and prepare food. Some schools had received funding through local and national Programmes (e.g. Grow it, Cook it, Eat it), and they noted that these Programmes had highlighted how their involvement could help them achieve the NHSS.

> When Grow it, Cook it, Eat it, was put forward to us they specifically said it helps with healthy schools, I do remember seeing that bit.

Primary school, large size, high FSM

**Body image workshops:** workshops addressing issues of body image were organised, either because schools themselves felt there was a need for them or because the local authority was organising a Programme of work in this area.

### 6.2 Perception of impact of Programme on Healthy Eating provision

Seventy-seven per cent of co-ordinators said that the Programme had a fair amount or a lot of impact on the provision their schools had made around healthy eating. However, co-ordinators in secondary schools were more positive than co-ordinators in primary schools – 30 per cent of co-ordinators in secondary schools said the Programme had “a lot of impact” on healthy eating, compared with 16 per cent of co-ordinators in primary schools.
When asked in what ways the Programme had a lot of impact on the provision made around healthy eating, the most commonly given answer amongst co-ordinators in both primary and secondary schools\(^{16}\) was that it led to a general focus on healthy eating (this answer was given by 11 of the 27 co-ordinators in primary schools and by 19 of the 31 co-ordinators in secondary schools that answered this question). In primary schools, other commonly given answers were that the Programme led to a change in the food provided by the schools, and that it led to a change in the food brought in from home (7 of the 27 co-ordinators gave each of these answers). Some co-ordinators working in primary schools also said that it led to a change in how food was provided in school (6 co-ordinators gave this answer), that it led to other healthy eating-related activities (for example, growing or cooking activities - 4 co-ordinators gave this answer), and that it had an influence on the attitudes of parents towards healthy eating (3 co-ordinators gave this answer). Some co-ordinators also said that it led to a consultation with pupils or the school council about food provision, while some said that it led to a healthy eating event (2 co-ordinators gave each of these answers).

In secondary schools, the other common answers included the Programme leading to a change in the food provided by the school and to a change in how food was provided in school (10 and 6 co-ordinators respectively of the 31 co-ordinators in secondary schools gave these answers). Two co-ordinators working in secondary schools also said that the Programme led to consultation with pupils or the school council about food provision, while one said that it led to a change in the food brought in from home.

### 6.3 Monitoring and evaluation

Monitoring was used by schools to keep track of lunch take-up and to further understand pupils’ views of food provision to assist the schools in providing healthy food that would appeal to pupils. Schools monitored food provision in three main ways:

- collecting data on the number of students eating, the money spent on school lunches and the use of the vending machine. In some cases this monitoring could become very sophisticated, with one school collecting biometric data on the types of food pupils ate.
- consultation to learn about pupils’ views and receiving suggestions for school dinner menus and food options to improve take-up by introducing the foods that pupils would be happy to eat.
- assessing pupils’ understanding of food as part of initiatives such as the ‘Licence to Cook’ Programme.

Although, schools had measures in place for monitoring, in general they felt that the evidence they collected could not necessarily give an indication of the impact that they had on pupils’ behaviour. In part this was because they felt that it was difficult to attribute impact to schools because other factors, such as pupil motivation and peer and parental attitudes, also influenced pupils’ behaviour and attitudes around food.

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\(^{16}\) Figures for this question are reported as numbers rather than as percentages due to very low base sizes.

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Other difficulties were that schools felt that they were unable to monitor and observe behaviour around food outside school, and that they did not have enough time to implement formal systems of monitoring, because delivering and assessing teaching in core subjects took priority.

There were also schools who felt that they should be cautious in how much they monitored healthy eating because they did not want to be seen to be telling parents what to do or imposing a ‘top down’ approach to the issue. Enforcing guidelines could also be counterproductive, they felt, as it would disrupt established relationships and communication with parents. Schools felt that it was important that praise and encouragement were used to encourage pupils to make healthy choices, rather than imposing change which might not be accepted.

I think if you’re encouraging children to have healthy lifestyles and to eat healthily then it doesn’t need to be you in charge of what they eat. It needs to be them that are in charge of what they eat, so that they’re saying, No I don’t want that but I do want this. And I think if you can get that from the children at this age then you’ve got some hope of actually achieving that in their life.

Primary school, small size, low FSM

6.4 Schools’ perception of impact on healthy eating among pupils

The impacts of changing practice that were identified by participants can be grouped under four headings: take-up of school food provision, pupil behaviour in school, increased awareness of nutrition and healthy food, and healthy eating outside school.

**Take-up of school food provision:** Changes to the type and range of food provision were felt to have had the effect of increasing the take-up of lunches within some schools but decreasing the take-up in other schools. Where there had been an increase in the take-up of lunches it was felt that this was due to the popularity of the greater range and types of food available to students. The new provision also appealed to parents and encouraged students to eat school dinners rather than bring in their own lunch boxes.

Schools also felt it was the result of actively encouraging pupils to try different options at lunch times by asking children to taste different foods and teachers providing role models for eating healthy food. It was felt that it was important to offer a choice of options to facilitate take-up, so that pupils were willing to try different healthy foods.

I mean we used to only get peas or sweet corn and carrots but we get cauliflower and broccoli as well as the salad, so if the children don’t want to have the vegetables, they can have salad or if they don’t want salad, they can have the vegetables and it’s mixed. He sends it in a mixed dish and they say, Oh, I only want the broccoli.

Primary school, small size, low FSM
A reduction in take-up of school meals was seen as a result of change being introduced too quickly by external providers, which it was felt meant that pupils did not have enough time to adapt to the new menus. The impact of this was that pupils were bringing unhealthy food into schools, missing or skipping lunch time meals, or eating snacks before school. This also had financial implications, with schools concerned about whether they could continue to provide lunches because they were running at a financial loss.

**Pupil behaviour in school:** Schools had informally observed improvements to pupil behaviour since introducing healthier food, with reduced incidences of disruption and better concentration in class. It was felt that the change in behaviour was particularly noticeable when pupils who had healthy lunches were compared to students who continued to bring in unhealthy food.

The students that have packed lunches [and] that sneak in the bad foods … they’re the ones that you get more issues from, but the students that have school dinners you don’t get the hyperactive running around completely headless chickens in the afternoon anymore, it’s nice, easier to teach.

Secondary school, small size, low FSM

**Increased awareness of nutrition and healthy food:** Changes to the school’s approach to food was seen as contributing to a shift in the degree to which nutrition and healthy eating had entered into the everyday ‘conversation’ of pupils.

The children say, oh, so and so has got chocolate in their lunch box, so we will discuss it, you know. If its just a chocolate sandwich and everything else is quite healthy … that’s not going against the rules because its not saying chocolate isn’t good for you or you shouldn’t ever have it, its about doing everything in moderation and having a healthy balanced diet …They are very keen now to talk about things like that. You know, you go into the little ones and you know, they are very aware. ‘I have five fruit and vegetables’, you know. And we talk about what they are having.

Primary school, small size, low FSM

**Healthy eating outside of school:** Schools felt that the profile of healthy eating within school had in some cases raised parental awareness and encouraged parents to engage in conversations about healthy eating in the home. Schools felt that one indicator of impact outside of schools was pupils asking if they can take recipes home from practical sessions to cook at home with their parents.
6.5 Impact study of healthy eating among pupils

Primary schools

Figure 6.1 presents findings for the five questions that are related to healthy eating in primary schools. These included questions asking about eating habits (for example, whether pupils regularly eat fruit and vegetables); asking about whether they like school dinners and whether they like eating healthy food; and asking whether they can always get a free drink of water at school.

Across the four measures used, there was no pattern in either direction, with as many questions showing a significant positive relationship as showing a significant negative relationship. Overall, the data presented in Figure 6.1 show that, over a two year timeframe, the Programme was unable to make a measurable impact on pupil outcomes with respect to healthy eating in primary schools.
Secondary schools

Figure 6.2 presents the findings of the analysis of the seven questions relating to healthy eating for secondary schools. As well as the questions asked of primary school-aged pupils, these questions included a question about how often pupils ate breakfast, and one asking how useful they found teaching on diet and nutrition.

<table>
<thead>
<tr>
<th>Measure of Distance Traveled</th>
<th>No. of questions showing a negative relationship</th>
<th>No. of questions showing a positive relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Engagement</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Self-reported Impact</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Increase in No. Criteria</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Healthy Schools Status</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

Overall, due to the lack of statistically significant relationships shown in Figure 6.2 we must conclude that, over a two year timeframe, the Programme was unable to make a measurable impact on pupil outcomes with respect to healthy eating in secondary schools.

6.6 Chapter Summary

- **Changes to promoting healthy eating**: Among the changes schools made to promote healthy eating were improvements to the physical environment in canteens, introducing healthier menus, introducing practical cooking sessions and running gardening clubs. Some of the changes they made were due to schools' participation in the NHSP, but schools were also influenced by the need to adhere to government guidance, their involvement in other initiatives, such as Licence to Cook, and structural changes that enabled them to implement new practice, for example moving to a new school site. Changes in this area were also attributed to schools' existing commitment to promoting healthy eating. Seventy-seven per cent of co-ordinators said that the Programme had a fair amount or a lot of impact on the provision their schools had made around...
healthy eating, with co-ordinators in secondary schools more positive than those in primary schools.

- **Monitoring and evaluation**: Schools monitored the impact of the changes they made to healthy eating practices by collecting data on the take up of school meals, surveys of pupils’ views of school meals, and assessing pupils’ understanding of food issues as part of initiatives such as ‘Licence to cook’.

- **Schools’ perception of impact among pupils**: Four key impacts were identified as a result of changes made by schools in terms of their approach to healthy eating and food provision. These were the take-up of school lunches, pupil behaviour in school, increased awareness of nutrition and healthy food choices, and increased healthy eating outside of school. The extent to which a school could have an impact on pupils was underpinned by the way changes were introduced and explained to students, the availability and access that pupils had to unhealthy food outside of school, the age of pupils, and the level of parental support and engagement.

- **Impact among pupils**: The analysis of the pupil data presented in this section demonstrates that, for healthy eating, within a two year timeframe the Programme was unable to have a significant positive impact on pupils in either primary or secondary schools.
7 Impact of NHSP – physical activity

This chapter looks at the impact of the Programme on physical activity, both at the level of school provision and at the pupil level.

7.1 Changes to promoting physical activity

Schools had made a variety of changes to the way in which they promoted physical activity since the first wave of research. In some cases participants said that these changes were influenced by NHSP although in others participants felt there was no link with the Programme (the coordinator survey data in section 7.2 shows that around three-quarters of co-ordinators felt the Programme had a great deal or fair amount of impact on physical activity provision). One way in which schools had changed was through diversifying the range of activities available to pupils (in both primary and secondary schools this was one of the main perceived impacts of the Programmes – see section 7.2). They had introduced non-traditional sports within PE lessons and their extra curricular Programmes so that had a broader appeal amongst students. They had also brought in new equipment and resources at play time, activities within the classroom, developed links with local schools and opportunities for inter school competition, and organised sessions and workshops run by outside organisations (e.g. local sports clubs).

In diversifying the opportunities available, schools had also introduced opportunities for pupils to be involved in sports leadership. This involved developing skills in coaching, planning, and delivering sports activities to other pupils. Secondary school pupils had opportunities to organise sports events for younger pupils in primary schools. Participants also discussed how schools had offered targeted activities for pupils identified as less engaged with physical activity, and pupils with behavioural problems and low academic performance. This consisted of exciting and new activities (e.g. archery and drumming) and opportunities for sports leadership.

We’ve actually started a course, Certificate Level 1 with the NCFE Examination Body for our pupils who do a support option. We had some particularly disaffected pupils. At the moment we’ve got two on this course, and this is a sort of very basic level course, but its focused on sports and leisure, and this is in addition to their normal PE, which can go well or can be difficult because they are children with quite significant behavioural difficulties. So we’ve been able to add and feed on into that by trying to set up some additional sporting activities to engage, and do some investigation and interviews, pupils interviewing people about how they got involved in sport and these kind of things.

Secondary school, small size, low FSM

NHSP had a direct impact on the changes described above through encouraging schools to review the opportunities they had on offer, which in turn prompted them to widen the activities available. The Programme also had an impact via local co-
ordinators who gave advice and guidance to schools on how they could provide greater opportunities, and in some cases local Programmes provided funding and resources. However, there were other schools who felt that changes in their practices had been facilitated by factors not connected with NHSP. Among the other factors identified by schools was the influence of individual teachers in suggesting and implementing new activities and schools’ existing targets and plans. In addition, the impact of changes to school facilities or the move to new school sites was identified as enabling schools to introduce new activities through new or additional facilities.

…I think the PE department has always wanted to [expand the activities offered] and they’ve just not been able to, they’ve just not been physically able to offer more things. They’ve already, straightaway that they got in here…now on a Thursday they’ve got this guy that comes in that does skipping, a skipping workout on Thursday lunchtime and they’ve … a studio thing that’s started and all sorts of different things that they are just trying out, [to] see what the uptake is and then they can put them in place more permanently next year.

Secondary school, large size, low FSM

While some schools were clear on whether the NHSP had affected them or not, there were other schools for which the influence of the Programme was more ambiguous. For example, changes in schools’ practices in some cases were related to the relationships formed within local networks of sports providers and local schools, which offered support, training and resources to implement a wider range of physical activity opportunities. However, there was confusion over whether or not the local sports partnerships/networks were linked with local healthy schools Programme. There were also schools who felt that their involvement with local sports partnerships had encouraged and supported their involvement with the Programme, rather than the other way round. This happened where local sports partnerships had highlighted how NHSP would benefit the school and how a school’s involvement in the local partnership could help provide evidence to achieve the physical activity theme.

Well, the ideas came in conjunction with the partnership, ok, so we sat down and said look, we need to boost our timetable, we can’t actually do it because we’ve got assembly in that time so we can’t move children in to the hall, what can we do? So, it was the partnership who suggested doing things like the in-class activities. Now, whether they’re being driven by the agenda on there or not I don’t know, but, and I suspect possibly part of the conversation was this will benefit the healthy schools initiative as opposed to right, this is what the healthy schools initiative says, lets do it, do you see what, see what I mean, so?

Primary school, large size, high FSM

There were also schools who felt that NHSP was one factor among a number of motivations influencing change, and were unable to indicate how significant NHSP compared to the other factors.
A second way in which schools had changed their approach to promoting physical activities was through introducing new ways to encourage parents and pupils to walk or cycle to school. They undertook travel surveys, developed school travel plans and improved access for cycling and walking by improving bike facilities, walking paths, and introducing bike repair workshops. They also tried to promote cycling by introducing opportunities to learn and enjoy cycling, for example, introducing cycling proficiency tests and encouraging pupils to cycle on the school site at lunch times.

*It started off just one family coming down walking, and it has grown from that. But we've also had the cycle proficiency in, and the children have it's the older children that have done it and we've encouraged the children to bring their bikes and cycle around in school during the break time. And the kids love it.*

Primary school, small size, low FSM

The encouragement of parents and pupils to walk and cycle was a criterion within the NHSP theme, and there were schools who felt that the changes they had made were a direct response to this. However, schools were also motivated by their commitment to environmental issues or involvement with eco-schools and by being asked to implement travel plans by the local authority school travel plan teams. Some schools were also influenced by the financial rewards offered by councils for developing plans.

A final way in which schools had changed in the way in which physical activity was promoted was through greater involvement of staff in supporting sports clubs. Some schools felt that their involvement with NHSP had raised the awareness and profile of physical activity amongst the staff within schools and had led to an increase in the involvement of staff who had not previously undertaken the delivery of physical activity. In some cases the greater involvement of staff was linked to increased staff engagement throughout the school, encouraged by school involvement in other initiatives and Programmes. For example, one school had gained the Arts Mark award which had provided extra money for facilities and had an impact on staff motivation to get involved in extra curricular activities across the board, not only including physical activity.

*I think its getting arts college status had had an impact on all of the school and the willingness of staff to do things. I think that has had a big impact on that. You know, we've got staff who are doing things who wouldn't have you wouldn't have they wouldn't have done anything before, but having lots of new facilities, some more money into the budget, having the publicity and the you know, it was a real morale boost I think to the school, and I think that has meant that, you know, people have also said well, they could do this, whatever. You see a lot of stuff going on after school now in school. And if people see someone else doing something, you know, they think, Well I could do that, I could do something as well.*

Secondary school, small size, low FSM
7.2 Perception of impact of Programme on physical activity provision

When asked whether the Programme had an impact on the provision their school had made around physical activity, 72 per cent of co-ordinators said that it had a fair amount or a lot of impact. This figure is lower than for the other three Healthy Schools themes. Twenty-nine per cent of co-ordinators said that the Programme had a lot of impact (with similar proportions giving this answer in both primary and secondary schools).

The most common explanation given by primary schools co-ordinators of how the Programme had a lot of impact on physical activity provision was that it increased the level of participation in extra-curricular sport (this answer was given by 19 of the 51 co-ordinators in primary schools that were asked this question). Another common answer given was that it increased the range of extra-curricular sport on offer (18 co-ordinators gave this answer). Other answers given included that the Programme increased the amount of time pupils spent in PE lessons, and that it led to the school setting up links with other schools or clubs (9 co-ordinators gave each of these answers). Other less common answers included that the Programme led to improved sport facilities and equipment, led to the employment of new staff related to physical activity, and that it opened sports clubs up to parents (2 co-ordinators gave each of these answers).

Amongst co-ordinators working in secondary schools, the most common explanation of why the Programme had a lot of impact on physical activity was that it led to an increase in the range of extra-curricular sport on offer (12 of the 20 co-ordinators in secondary schools that were asked this question gave this answer). The second most common answer was that the Programme increased participation in extra-curricular sport (11 co-ordinators gave this answer). Other answers given included an increase in the amount of time pupils spent in PE lessons, and that it led to schools setting up links with other schools or clubs (5 co-ordinators gave each of these answers). Less common answers included that the Programme led to improved sports facilities and equipment (2 co-ordinators gave this answer), and that it led to the employment of new staff related to physical activity (1 coordinator gave this answer).

7.3 Monitoring and evaluation

In general, schools placed more emphasis on monitoring than using data to evaluate the impact of participation in physical activity or efforts to promote participation. PE teachers measured pupils’ understanding of the importance and effect of physical activity as part of the curriculum assessment targets. Reviewing assessments across pupil year groups also allowed PE co-ordinators to look at where there were gaps in skills and knowledge. In addition, schools monitored the take-up of physical activity, for example, recording data on the attendance of after school clubs. However, while it was not necessarily used comparatively to measure change and impact, some schools felt

17 Figures for this question are reported as numbers rather than as percentages due to very low base sizes.

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Pupil consultation was also used to monitor attitudes and views towards physical activity and the existing opportunities available within schools. This was done through general pupil surveys, specific physical activity questionnaires, informal discussions, and speaking to students as part of departmental reviews. Schools also carried out surveys as part of their involvement with sports partnerships and their school travel plan Programme, which allowed them to review existing provision and identify gaps.

### 7.4 Schools’ perception of impact on physical activity among pupils

Participants identified three different kinds of impact linked to the changes in practice brought about in their school: improved engagement/enthusiasm around physical activity, pupil behaviour in school, and improved self-esteem.

**Improved engagement/enthusiasm around physical activity:** introducing a wider range of activities in schools had broadened the appeal of physical activity to pupils, and had led to greater engagement and take up of opportunities. Participants felt this was evidenced by a decline in pupils forgetting their PE kit for lessons and hearing pupils actively discussing wanting to take part in PE lessons.

> I think what it’s done is it’s allowed me to reach those children that don’t naturally do PE. So because of the different, I mean we borrowed some equipment to do Bocha, which is like a bowling game with soft balls, and we wouldn’t have been able to have done that. But that didn’t appeal to the kids that were really physical and wanted to go out and play hockey or whatever, but it did appeal to those people who perhaps don’t always take part in lots and lots of sport.

**Primary school, small size, low FSM**

There were also pupils who had pursued sports outside of school after trying them during PE and finding that they were good at them.

The emphasis on health and fitness, as well as the teaching within PE, had raised both the awareness of physical activity among pupils and their understanding. This increased understanding had real effects in terms of pupils’ engagement with activity and their ability to understand their bodies and react appropriately.

**Pupil behaviour in school:** teachers had observed improved behaviour within lessons of students with wider issues of engagement who had taken part in targeted activities. For example, one school had introduced boxercise lessons for a group of girls with a low level of academic achievement and who had problems managing their anger. The school felt there was an observable improvement in the girls’ general behaviour and interest in other activities in school, and it was hoped that this could have a further impact on the pupils’ learning and achievement.
Improved self-esteem: it was felt that by introducing additional opportunities, pupils discovered new skills and talents which in turn raised their confidence regarding physical activity and self-esteem more generally. Physical activity could also improve the self-esteem of vulnerable pupils by giving them a sense of achievement that they had not experienced in other areas of their school life. Pupils also had the opportunity to develop leadership skills through older pupils helping out younger pupils in the playground.

[We've had] playground sports buddies.. they all had hats and they organised their own rota as and that's just gone on and on and on, it's never really lost it's influence. It's been really popular, the kids have loved doing it. We had booster training to get them excited again, so they organised games for the younger children, and now we've got the younger children wanting to be a playground coach, so that's had a really, really positive impact and it makes them more responsible for things, you know, it makes them sort of leaders in their own right.

Primary school, large size, low FSM

7.5 Impact study of physical activity among pupils

Primary schools

Figure 7.1 presents the findings of the analysis of the eight questions related to physical activity in primary schools. These measured pupils’ behaviour relating to exercise and physical activity, for example whether they had done exercise two times or more in the past week and whether they cycle or walk to school, as well as asking whether pupils feel happy about doing exercise and whether the school provides sports clubs or teams for pupils after school or at dinnertime.
In general, although there were more questions that were positively related to distance travelled (however measured) than are negatively related, there were few relationships that are statistically significant.

**Secondary schools**

Figure 7.2 presents the findings of the analysis for the nine questions related to physical activity for secondary schools. These measured pupils’ behaviour relating to exercise and physical activity, as well as asking whether pupils feel happy about doing exercise and whether the school provides sports clubs or teams for pupils after school or at dinnertime. Secondary school-age pupils were also asked whether they found teaching on sports and exercise helpful.
Across all four measures of distance travelled, the majority of questions were negatively related to distance travelled, although few of these were statistically significant relationships. Overall, the data presented in Figure 7.2 show that, within a two year timeframe, the Programme was unable to make a measurable impact on pupil outcomes with respect to physical activity in secondary schools.

7.6 Chapter Summary

- **Changes to promoting physical activity**: Changes to the promotion of physical activity in schools included the diversification of the range of opportunities available to pupils (for example introducing non-traditional games), the introduction of new ways to encourage parents and pupils to walk or cycle to school, and greater involvement of staff in supporting sports clubs. Schools made changes in response to the NHSP criteria, but were also influenced by other factors. Among these factors were suggestions made by teachers in meeting schools existing plans and targets and the support and training provided by local networks of sports providers and local schools. Seventy two per cent of co-ordinators said the Programme had a fair amount or a lot of impact on physical activity provision.

- **Monitoring and Evaluation**: Monitoring of changes to physical activity was carried out by assessments as part of the PE curriculum targets, recording the attendance and take up of sporting activities, and consulting pupils about their attitudes and views of existing opportunities with schools. Collecting monitoring
data also allowed schools to review the existing provision of physical activity and teaching of PE by identifying gaps in the skills and knowledge of pupils.

- **Schools’ perception of impact among pupils**: The changes that schools implemented had four main impacts on pupils. These were greater engagement and enthusiasm around physical activity, improved pupil behaviour in lessons, greater awareness of and understanding of physical activity, and higher self-esteem and confidence through the sense of achievement pupils felt after learning new skills and discovering talents. The extent to which schools could affect pupil outcomes was underpinned by the degree to which schools were able to respond to the interest and needs of pupils, the involvement and encouragement of staff, and the influence of familial and cultural attitudes to health and fitness. It was also important that the value of physical activity was embedded within the school ethos and culture and discussed both formally and informally within lessons and discussions with teachers.

- **Impact among pupils**: The analysis of the pupil data presented in this section demonstrates that, for physical activity, within a two year timeframe the Programme was unable to have a significant positive impact on pupils in either primary or secondary schools.
8 Overall impact of NHSP at pupil level

This chapter summarises the impact of the Programme at the pupil level overall, across all four of the themes described in the previous chapters.

8.1 Overall Impact study results among pupils

Primary schools

Figure 8.1 presents the findings for the analysis of the 41 questions asked of primary school pupils, covering all four Healthy Schools themes.

Figure 8.1 Multivariate analysis of pupil data, all themes, primary schools

Overall, no clear pattern has emerged to suggest that, over a two year timeframe, the Programme was able to have an impact on health-related pupil outcomes in primary schools. When looking at the level of engagement and self-reported impact measures of distance travelled, more questions are negatively related than are positively related to distance travelled, and the number of relationships that are statistically significant is low and roughly the same in the negative direction as in the positive direction. When looking at whether or not schools have achieved NHSS as the measure of distance travelled, around half of the questions are positively related to distance travelled and around half of the questions are negatively related to distance travelled, with the same number of statistically significant differences in both directions.
When using the increase in the number of criteria achieved, around three-quarters of questions (30 out of 41) are positively related to distance travelled. However, of these relationships only three are statistically significant.

**Secondary schools**

Figure 8.2 presents the findings of the analysis for all 67 questions included in this analysis, across all four themes.

Overall, the analysis using the four different measures of distance travelled showed no consistent pattern. When using the self-reported impact measure of distance travelled, 40 of the 67 questions showed a positive relationship with distance travelled, with three of these relationships being statistically significant. Conversely, when using the increase in the number of criteria to measure distance travelled, 42 of the 67 questions were negatively related to distance travelled (with five of these relationships being statistically significant). When using the level of engagement and Healthy Schools status measures of distance travelled, slightly fewer questions were positively related than were negatively related to distance travelled.

Overall the pattern of findings presented in Figure 8.2 is consistent with a hypothesis of 'no overall NHSP effect' on pupils, and we have concluded that the data show that, over a two year timeframe, the Programme was not able to make a measurable impact on health-related pupil outcomes overall in secondary schools.
8.2 Spill-over effects of the National Healthy Schools Programme

The NHSP was designed to be more than a checklist of good practice for schools. The website\(^ {18}\) said it should help pupils “reach their full potential in terms of achievement and fulfilment” and that the process would help schools “develop the wider thinking and planning they will need to do to achieve better outcomes around health and well-being for children and young people”.

NatCen also carried out a secondary analysis project to try and identify any positive “spill-over” effects on both school management practice and pupils. This analysis was based on data collected during the school years 2006/2007 and 2007/2008. The sample included around 10,500 primary schools and 2,750 secondary schools\(^ {19}\). At the start of 2007/2008, 48 per cent of the primary schools and 40 per cent of the secondary schools had achieved NHSS. A further 20 per cent of primary schools and 19 per cent of secondary schools achieved NHSS during that school year. The remaining primary and secondary schools included a range of schools, from those close to achieving NHSS at the time to schools that had not engaged at all with the programme.

The aim of this research was to use existing data to investigate whether NHSS was related to indicators of a school’s performance, in areas directly related to the programme’s objectives and more broadly, for example in pupil attendance. The analysis used linear regression to explore the association between NHSS and various outcomes measured during 2007/2008. Data collected during the school year 2006/2007 were previously analysed using this approach\(^ {20}\), and the analysis in this report updates that approach. In addition, following discussions with the Department of Health and the Department for Education, it was agreed that in this report we would run some of the statistical models with data collected during both the school years 2006/2007 and 2007/2008. The aim was to explore more precisely the impact of a school achieving NHSS on school outcomes over time.

This analysis investigated whether schools that achieved NHSS were also experiencing positive “spill-over” effects. Having or being close to achieving NHSS was shown to be related in a positive way to most of the outcomes considered by the analysis.

Confirming earlier research, the strongest relationships were with Ofsted ratings, where the difference between schools with NHSS or close to achieving it and other schools was equivalent (in almost all cases) to one in ten schools receiving an improved rating. This was true for primary and secondary schools, and confirms earlier research\(^ {21}\). Notably, looking over two years (2006-2008), primary schools that had achieved NHSS

\(^{18}\) http://www.healthyschools.gov.uk
\(^{19}\) Schools where we did not have full data for all key variables were excluded from the analysis.
earliest also achieved significantly better ratings for all seven measures than primary schools that had achieved NHSS more recently. This suggests that, in primary schools at least, the achievement of NHSS could be having a sustained positive impact on management practice which grows over time.

Elsewhere, there were some small but significant relationships between NHSS and total absence levels, CVA scores, persistent absence and participation in high quality sport or PE. Most of the relationships were found to be sustained when the data for the two-year period (2006-2008) was analysed. These findings appear to be inconsistent with the results of the impact analysis of the pupil data, but the data in the secondary analysis measured different outcomes to the pupil survey.

Moreover, the associations for all these variables were small and not consistent; there were variations between primary schools and secondary schools or between schools that had achieved NHSS at the start of the year and those that were achieving it during the school year.

The relationships described here must not be over-rated. The schools that had NHSS were self-selected, and it is likely that schools with a strong commitment to the objectives of the programme were most likely to have engaged with it early and also to be closest to matching the criteria used for validation of NHSS.

The existence of relationships in 2007/2008 between NHSS and positive school-level outcomes does not mean that having NHSS directly led to these better outcomes. There might be other characteristics of schools that were not included in the models, but which may influence both a school’s participation in the NHSP and the outcomes of interest. Some associations shown here may occur because both engagement with NHSP and better outcomes arise from underlying factors, such as the quality of school leadership and management.

8.3 Alternative impact study analysis
As explained in the discussion of the theory of change in chapter 1, the programme aimed to influence pupil outcomes in relation to health and well-being in three key areas: pupils’ knowledge, attitudes, and behaviours. It is possible that the success of the programme at affecting change in pupil outcomes – especially within the two-year period over which the impact assessment was conducted – met with differing success in these three areas. For example, it might be expected that schools would find it easier to influence pupils’ knowledge than to influence their attitudes, and that changes in pupils knowledge might go on to influence their attitudes further down the line. Similarly, it might be expected that schools would find influencing attitudes easier than affecting behavioural change, and that influencing attitudes can be seen as a first step towards affecting behaviour change.

The sections below therefore examine the data from the pupil surveys in a different way than in previous sections of the report, looking across themes to see if outcomes
relating to the different areas of possible influence outlined above appear to have been changed to differing degrees. Due to the way the questionnaires were constructed, it is not possible to separate out outcomes relating to pupil knowledge, so outcomes relating to both knowledge and attitudes will be looked at together. Outcomes looking at behaviour are analysed separately. Again, each piece of analysis has used four different measures of distance travelled, as described in section 4.3.2.

### 8.3.1 Knowledge and attitudes

Figure 8.3 presents findings from the analysis of the 20 questions that relate to pupils' attitudes across all four themes, for primary schools. (The questions looking at pupils' knowledge were only asked of pupils in secondary schools.) The majority of these questions look at pupils' attitudes and opinions about school and bullying, while some look at their attitudes towards healthy food, physical activity, and smoking. (A full list of the questions included in this analysis can be found in section 1.4 of the appendices.)

Overall, no clear pattern has emerged to suggest that, over a two year timeframe, the Programme was able to have an impact on outcomes relating to pupils' knowledge and attitudes regarding health and well-being. For one test (the increase in the number of criteria achieved) the majority of questions show a (not statistically significant) positive relationship with distance travelled, while for the other tests more questions show a negative relationship with distance travelled than a positive one. Relatively few relationships in either direction are statistically significant, and there is the same number of statistically significant relationships in each direction.
Figure 8.4 presents findings from the analysis of the 41 questions that relate to pupils’ knowledge and attitudes across all four themes, for secondary schools. As well as questions asked of primary school pupils, this analysis also includes questions about pupils’ knowledge around sexual health and their knowledge about facilities for advice on these issues in their local area, as well as a number of questions about their attitudes towards smoking, drinking, drugs, sex and alcohol and how helpful they found teaching on these subjects.

Overall, no pattern emerges to suggest that, over a two year timeframe, the Programme was able to have an impact on pupil outcomes in secondary schools relating to knowledge and attitudes, over a two year timeframe. Schools in which teachers thought the Programme had a lot of impact on provision on certain themes appear to have had more success at changing pupils’ knowledge or attitudes in the corresponding theme, with 29 of the 41 questions showing a positive relationship with this measure of distance travelled, with three of these being statistically significant relationships. However, this number of significant relationships is low, and the other three measures of distance travelled (in particular the Level of Engagement measure, which we deem to be the most robust) do not show a similar pattern. This suggests that this finding is due to random variation rather than a real impact of the Programme.

We also looked at the questions relating to knowledge and attitudes for each theme separately, to see if the Programme was able to impact on one theme more than another. We found no evidence that this had happened over the two year timeframe in either primary or secondary schools.
8.3.2 Behaviour

Figure 8.5 and Figure 8.6 present findings for the questions across all four themes that relate to pupils’ behaviour. These questions cover behaviours around eating healthily; being physically active; smoking, drinking, and taking drugs (for secondary school pupils); and EHWB issues such as being happy, being bullied, confidence, and succumbing to peer pressure.

Figure 8.5  Multivariate analysis of pupil data, outcomes relating to pupils’ behaviour, primary schools

Base: Primary schools (102 schools)

<table>
<thead>
<tr>
<th>Measure of Distance Travelled</th>
<th>No. of questions showing a negative relationship</th>
<th>No. of questions showing a positive relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Negative (significant)</td>
<td>Positive (significant)</td>
</tr>
<tr>
<td>Level of Engagement</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Self-reported Impact</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Increase in No. Criteria</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Healthy Schools Status</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>

Base: Primary schools (102 schools)
Figure 8.6  Multivariate analysis of pupil data, outcomes relating to pupils’ behaviour, secondary schools

Base: Secondary schools (50 schools)

Amongst primary school pupils (Figure 8.5), no obvious pattern emerges to suggest that the Programme was able to have an impact on pupils' behaviour over the two year timeframe of the evaluation. Slightly more questions show a positive than a negative relationship with distance travelled for three of the four measures, but there are very few relationships that are statistically significant. Similarly, amongst secondary school pupils (Figure 8.6) there is no pattern that emerges to suggest that the Programme was able to have a positive or negative impact on pupils' behaviours.

We also looked at the questions relating to pupil behaviour for each theme separately, but did not find a pattern that would suggest the Programme was able to have a positive or negative impact on pupils' behaviour over the two year time period.

We have found no evidence to support a hypothesis that an impact may be seen amongst outcomes that are arguably more easily influenced in the given time period – those relating to pupils’ knowledge and attitudes.

8.4 Chapter Summary

- **Overall impact at pupil level**: The analysis of the pupil survey demonstrates that, within a two year timeframe, the Programme was unable to have a significant positive impact on pupil knowledge, attitudes or health behaviour outcomes in either primary or secondary schools. Some of the possible factors influencing schools’ ability to affect pupil outcomes in this timeframe are discussed in section 10.3.
• **Spill-over effects of the Programme:** The secondary analysis presented in this section used existing data to investigate whether NHSS was related to indicators of a school’s performance, in areas directly related to the Programme’s objectives and “spill-over effects” such as pupil attendance. Having or being close to achieving NHSS was shown to be related in a significant and positive way to most of the outcomes considered by the analysis. The strongest relationships were with Ofsted ratings (a measure of management effectiveness), but there were some small but significant relationships between NHSS and total absence levels, CVA scores, persistent absence and participation in high quality sport or Physical Education (PE). Most of the relationships were found to be sustained when the data for a two-year period (2006-2008) were analysed. However, it is important not to over-rate these relationships as, due to the self-selecting nature of the Programme, it is quite possible that engagement with the Programme is linked to some school characteristic that it is not possible to control for (for example, the quality of school leadership and management) that are also related to these outcomes.
9 Overall impact of NHSP at school level

This chapter looks at the overall impacts of the Programme at the school level, focusing on the survey of co-ordinators and qualitative research among school staff. Despite the fact that the analysis of pupil survey data was unable to demonstrate any positive impact of NHSP on pupil health-related outcomes over the time period of the evaluation, the views of school staff (as shown in this chapter) were that the Programme was having some impact, particularly at a school level in terms of the changes schools had made in a range of areas, but also on outcomes for pupils.

9.1 Perception of impact of Programme overall

Co-ordinators were asked about the level of impact the Programme had on their school’s policies on health and well-being generally, on the day-to-day work on health and well-being in their school, on their school’s ethos, and on outcomes for pupils in their school. Table 9.1 and Table 9.2 present the figures from the answers given to these questions.
Table 9.1 Level of impact co-ordinators report the NHSP having on different areas

<table>
<thead>
<tr>
<th>Area of impact</th>
<th>School policies on health and well-being</th>
<th>Day-to-day work on health and well-being</th>
<th>The school’s ethos</th>
<th>Outcomes for pupils</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary schools</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>A lot/fair amount of impact</td>
<td>81</td>
<td>76</td>
<td>62</td>
<td>76</td>
</tr>
<tr>
<td>A lot of impact</td>
<td>22</td>
<td>13</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>A fair amount of impact</td>
<td>60</td>
<td>63</td>
<td>52</td>
<td>61</td>
</tr>
<tr>
<td>Not a great deal/no impact</td>
<td>19</td>
<td>24</td>
<td>38</td>
<td>24</td>
</tr>
<tr>
<td>Not a great deal of impact</td>
<td>15</td>
<td>19</td>
<td>29</td>
<td>21</td>
</tr>
<tr>
<td>No impact at all</td>
<td>4</td>
<td>5</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td><strong>Bases</strong></td>
<td>172</td>
<td>172</td>
<td>170</td>
<td>170</td>
</tr>
<tr>
<td>Secondary schools</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A lot/fair amount of impact</td>
<td>79</td>
<td>82</td>
<td>67</td>
<td>86</td>
</tr>
<tr>
<td>A lot of impact</td>
<td>23</td>
<td>12</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>A fair amount of impact</td>
<td>57</td>
<td>71</td>
<td>51</td>
<td>68</td>
</tr>
<tr>
<td>Not a great deal/no impact</td>
<td>21</td>
<td>18</td>
<td>33</td>
<td>14</td>
</tr>
<tr>
<td>Not a great deal of impact</td>
<td>19</td>
<td>17</td>
<td>29</td>
<td>14</td>
</tr>
<tr>
<td>No impact at all</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td><strong>Bases</strong></td>
<td>102</td>
<td>102</td>
<td>102</td>
<td>98</td>
</tr>
</tbody>
</table>
Table 9.2  Level of impact co-ordinators report the National Healthy Schools Programme having on different areas

<table>
<thead>
<tr>
<th>Area of impact</th>
<th>School policies on health and well-being</th>
<th>Day-to-day work on health and well-being</th>
<th>The school’s ethos</th>
<th>Outcomes for pupils</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A lot/fair amount of impact</td>
<td>81</td>
<td>78</td>
<td>64</td>
<td>79</td>
</tr>
<tr>
<td>A lot of impact</td>
<td>22</td>
<td>12</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>A fair amount of impact</td>
<td>59</td>
<td>66</td>
<td>51</td>
<td>64</td>
</tr>
<tr>
<td>Not a great deal/no impact</td>
<td>19</td>
<td>22</td>
<td>36</td>
<td>21</td>
</tr>
<tr>
<td>Not a great deal of impact</td>
<td>16</td>
<td>18</td>
<td>29</td>
<td>18</td>
</tr>
<tr>
<td>No impact at all</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Bases</td>
<td>274</td>
<td>274</td>
<td>272</td>
<td>268</td>
</tr>
</tbody>
</table>

When asked how much impact the Programme had overall on school policies on health and well-being, 22 per cent of co-ordinators said that it had “a lot of impact,” while 59 per cent said it had “a fair amount of impact.” These proportions were similar in primary and secondary schools.

However, in the view of co-ordinators, the Programme has had slightly less impact on translating these changes into the day-to-day work of the schools and the school ethos. Looking at the day-to-day work on health and well-being, twelve per cent of co-ordinators said that the Programme had a lot of impact, while 66 per cent said “a fair amount of impact.” Similar proportions of co-ordinators in primary and secondary schools gave these answers.

When asked how much impact the Programme had on the school ethos, 13 per cent of co-ordinators said “a lot of impact.” Around half (51%) of co-ordinators said that the Programme had “a fair amount of impact” on school ethos. Eight per cent of co-ordinators in primary schools and four per cent in secondary schools said that the Programme had “no impact at all” on school ethos (this difference was not found to be statistically significant).

The findings in the previous three chapters and those in section 8.3 show that over a two year timeframe the Programme was unable to make an impact on health-related pupil outcomes. Nonetheless, the co-ordinators did perceive the Programme was making a tangible impact on pupils. Seventy-nine per cent of co-ordinators said that the
Programme had a fair amount or a lot of impact on outcomes for the pupils in their schools. Sixteen percent of co-ordinators said that the Programme had “a lot of impact” on outcomes for pupils. These figures were similar for co-ordinators in primary and secondary schools.

When those that answered “a lot of impact” or “a fair amount of impact” were asked in what ways the Programme had an impact on outcomes for pupils, just under half (48%) of co-ordinators said that this was by raising awareness about health in general. Around a quarter (24%) of co-ordinators said that the Programme had led to pupils eating healthier food, while around a fifth (21%) said that it led to an increase in the sport or activities available to pupils (or the level of participation in these). Another commonly given reason given (by 18% of co-ordinators) was that the Programme impacted on the curriculum or general education of pupils, and that it improved self-esteem or EHWB of pupils (10% of co-ordinators gave this answer). Less commonly given reasons included that it led to pupils being more involved in decision-making in school (8%), that it led to pupils being more focused on school (or to being less disruptive; 5%), that it improved PSHE provision in schools (5%), and that it made children feel safer (4%).

Co-ordinators who had said that the Programme had an impact on outcomes for pupils were asked whether they thought any particular groups of pupils had benefited from the Programme. The majority of co-ordinators (58 per cent of co-ordinators in primary schools and 54 per cent of co-ordinators in secondary schools) said either that all pupils benefited or that no group in particular had benefited more than any other. Thirteen per cent of co-ordinators (11% in primary schools and 15% in secondary schools) named a specific age- or year-group as benefiting in particular from the Programme, while eight per cent (5 per cent in primary schools and 12 per cent in secondary schools) said that vulnerable children benefited in particular. A smaller proportion of co-ordinators suggested pupils with social and emotional needs (6%), pupils from lower income families (4%), pupils who were not physically active before the Programme (4%), and pupils with special needs had particularly benefited (3%). A small number of co-ordinators working in primary schools also claimed the Programme had a particular impact on pupils with low self-esteem or confidence (2%) and pupils from single parent families (2%).

9.2 Perception of changes in school policy due to Programme

Co-ordinators were asked about what happened in their school as a result of the Programme. Twenty-three per cent of co-ordinators in primary schools and 17 per cent of co-ordinators in secondary schools said that their school changed their practices in a significant way as a result of the Programme. Fifty-nine per cent of co-ordinators in primary schools and 58 per cent of co-ordinators in secondary schools said that their school made a few changes where necessary. Thirty per cent of co-ordinators in schools that had already achieved NHSS said they were getting recognition for the work they were already doing.
Co-ordinators were asked to identify what had happened because of the Programme that would not have happened otherwise. Table 9.3 shows the proportion of co-ordinators that agreed with a range of answers.

<table>
<thead>
<tr>
<th>Table 9.3</th>
<th>What happened in schools that would not have happened otherwise, by type of school</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Type of school</td>
</tr>
<tr>
<td></td>
<td>Primary</td>
</tr>
<tr>
<td>Gained a framework to think about work on health issues</td>
<td>86</td>
</tr>
<tr>
<td>Staff and other stakeholders improved their knowledge</td>
<td>83</td>
</tr>
<tr>
<td>Staff identified gaps in existing practice</td>
<td>81</td>
</tr>
<tr>
<td>Staff re-evaluated existing practice</td>
<td>80</td>
</tr>
<tr>
<td>Learned from what other schools were doing</td>
<td>74</td>
</tr>
<tr>
<td>Could change things without people feeling that criticisms of the old ways were criticisms of them personally</td>
<td>70</td>
</tr>
<tr>
<td>Management/were given a push to change systems or practices</td>
<td>54</td>
</tr>
<tr>
<td>None of these</td>
<td>5</td>
</tr>
<tr>
<td><strong>Bases</strong></td>
<td>172</td>
</tr>
</tbody>
</table>

Eighty-six per cent of co-ordinators said that their school had gained a framework to think about work on health issues, and that staff and other stakeholders improved their knowledge as a result of the Programme. Eighty-four per cent of co-ordinators agreed that staff identified gaps in existing practice as a result of the Programme, while 79 per cent agreed that staff re-evaluated existing practice. Seventy-three per cent of co-ordinators agreed that the school learned from what other schools were doing as a result of the Programme. Seventy-one per cent of co-ordinators agreed that the Programme meant that the school could change things without people feeling that criticisms of the old ways were criticisms of them personally.

Co-ordinators in secondary schools were more likely than co-ordinators in primary schools to say that the Programme meant that management or governors were given a push to change systems or practices. Fifty-four per cent of co-ordinators in primary schools and 75 per cent of co-ordinators in secondary schools gave this answer. (This difference could reflect the fact that a higher proportion of people working as co-ordinators in primary schools were school heads).
Co-ordinators were also asked how useful participation in the Programme had been as a framework to organise the work of their school around health and well-being. Thirty-seven per cent of co-ordinators said that the Programme had been very useful, while 53 per cent said somewhat useful.

When asked in what ways the Programme had been useful as a framework, the most common answer (given by 36% of co-ordinators) was that it provided a way to formalise the school's work around health and well-being. The second most common answer (given by 26% of co-ordinators) was that it encouraged the school to audit or evaluate the work they were already doing around health and well-being. Eighteen per cent of co-ordinators said that the Programme gave their school new motivation or focus. Sixteen per cent of co-ordinators said that the Programme had allowed their schools to locate gaps in their work around health and well-being, while 16 per cent also said that it encouraged a whole school approach to work around health and well-being. Other answers given by co-ordinators were that the Programme gave clear goals to achieve (12% of co-ordinators gave this answer), that they received useful guidance from the healthy school coordinator website (5%), and that it gave official recognition to work their school was already doing (2%).

When asked to compare the impact the Programme had made with other initiatives that their school had been involved with, 36 per cent of co-ordinators felt that it had had more impact than other initiatives, 48 per cent said that it had about the same amount of impact, and 13 per cent said it had less impact than other initiatives. Thirty-nine per cent of co-ordinators in primary schools and 31 per cent of co-ordinators working in secondary schools said that the Programme had more impact than other initiatives (although the difference between these figures was not found to be statistically significant). It is worth noting for this question that we do not have information on schools' experiences with other Programmes, so we do not know – for example – if an answer of “less impact than other initiatives” is due to a perception that the NHSP had a low impact or due to a high regard for another Programme or Programmes.

Lastly, co-ordinators were also asked what they thought the value of achieving NHSS was. The most frequently given answer to this question was the impact the Programme had on pupils (41% of co-ordinators gave this answer). Other answers given to this question include that it gave official recognition to schools' achievements (28% of co-ordinators gave this answer), that it allowed for or encourages future progress (12%), and that it was something that parents are looking for or appreciate (7%).

Co-ordinators working in primary schools were more likely to say that achieving NHSS had no or limited value. Eight per cent of co-ordinators working in primary schools gave this answer, while no co-ordinators working in secondary schools said this.

### 9.3 Understanding the influence of the NHSP

From discussions with school staff, it was possible to identify four mechanisms by which the Programme influenced schools’ practice in terms of health and well-being.
• **Change to practice to directly meet the criteria:** schools made changes to meet the stated criteria, which then in turn had a direct impact on practice within schools. One example of this was explored in section 2.3 where schools had updated or written new food policies, which had encouraged a review of existing provision and changes to types of food available for children. However, meeting the criteria did not necessarily lead to change if schools felt they had existing good practice in place. Some schools felt that to meet the criteria they needed to make minimal changes to existing ways of working and policy, rather than significantly changing practice.

• **Provides justification for change amongst management teams:** The Programme provided a push for management teams and governors to discuss and implement change around health practice. For example, some schools incorporated the achievement of NHSP criteria within school development plans. However, it was felt that the changes would have been made without their involvement in the Programme, but the end goal of achieving NHSS provided the impetus to deliver change as a more immediate priority.

I suppose you’ve got an excuse. Saying you are doing it for healthy eating … or Healthy Schools, you’ve got a reason to do it so yes, you can push it, I think we did it a lot quicker through that. You know, we redesigned the kitchen over the summer and we put a dishwasher in there and we re-organised it so that it was much more efficient and the plates came in and all sorts. So I was able to use that as a, you know, as a bit of a carrot. We want to be accredited, the governors wanted to be accredited.

Primary school, small size, low FSM

• **Tool to re-evaluate existing practice:** The structured nature of the Programme and themes was used by schools to conduct a wide-ranging audit of their practice. Schools utilised the Programme as a means to assess current provision to identify gaps and look at areas where they could enhance their existing provision.

The good thing about the audit is it showed us what we weren’t doing so it showed us that we did have a weakness in PSHE, that we needed to improve the schemes of work, so the schemes of work have been improved and made adequate for the role, fit for purpose, and it just showed all the weaknesses that we had so we could then move on and put them into practice.

Secondary school, small size, low FSM

• **Raises the awareness and profile of each theme:** Involvement in the Programme provided an all round focus on the four core themes, and raised the profile of these areas of practice amongst staff. For example, as discussed in section 5.2 there were schools that viewed the Programme as raising the profile of PSHE in comparison with core subjects taught within the school. Raising the profile of
each theme highlighted where there were opportunities for health-related issues to be addressed in other subjects, informal discussions with pupils, and staff involvement in extra curricular activities.

9.3.1 Influence of the Local Healthy Schools Programme

There was evidence to suggest that the support provided by the local Healthy Schools programme was important in influencing the impact the NHSP had on a particular school. This section describes participants' perspectives on the nature of this support, the effect it had on the school and staff, and barriers and facilitators to accessing this support.

Nature of relationship and types of support

Schools that described their relationship with the local Healthy Schools programme in positive terms noted a pro-active approach in contacting the school and making it clear what type of support was available to them. One way in which this was expressed was in positive descriptions of the individual co-ordinator as being pro-active and engaged with the needs of the school.

While we were working through the Programme, she regularly came into school and we went through the criteria together. We talked through anything we were finding hard. That she was a great source of information for us. She knew someone who might have some information on that, who might push that forward, so that was a lot of one-to-one work ...helping us steer our way through the website at first, you know, when it, when it first went on-line. Finding people who could provide us with leaflets or information on things...we had one or two policies that we hadn’t got. She was able to point us to some good practice in policy writing and then she came and worked with us to adapt those policies to suit the setting, so she really is hands-on.

Special school

However, there were also schools that said they did not have a relationship with the local Programme and a range of reasons were identified for this. Firstly, some schools suggested that they had not been in contact with the local Programme as they had simply not required any support to make their desired changes to health-related practices. Similarly, of those schools that described their relationship as positive, some suggested that they would have used the Programme more had they needed to, suggesting that where schools had more significant changes to make to their practice or fewer resources to allocate in order to meet the criteria, they may have required more support and experienced a greater impact from their local co-ordinator. There were also schools that would have liked to have had support from the local Programme but had not been contacted nor had known who to initiate contact with in order to access it. In some cases schools acknowledged that this was because they had not had the time to pay enough attention to the Programme literature they had been sent, although there was also a sense that some participants felt that their co-ordinator had not been pro-active enough and that support should be more targeted to reach co-ordinators within schools.
I get the publicity but nobody rings up and says can I come and see you and can I measure it, can I monitor it [school progress]...monitoring visits [would be useful]...termly at the very least. Making sure that they know who’s got the role as the healthy schools co-ordinator...so a much more targeted specific approach with specific short term targets.

Secondary school, large size, low FSM

Local Programme co-ordinators provided a variety of types of support, some of which were one-to-one and pro-active and others more general or reactive. Participants that had received one-to-one support had benefited in particular from assistance with conducting an audit across the school in relation to the NHSS criteria and, subsequently, with the process of self-validation. Local co-ordinators had also been into schools to run basic training and awareness courses or chair meetings with staff and parents to raise awareness of the Programme and help generate support for its aims. Some local co-ordinators would also aim to help provide teaching cover to allow school co-ordinators to attend training courses. Other types of support were more reactive, such as dealing with queries from schools as they arose by providing links to other support and resources.

**Impact of local Programme**

The main influence of local Programmes was on changes to school practices, rather than direct impacts on pupil outcomes. Schools said that the local co-ordinator had an impact in securing the involvement of other staff and parents, and that this had enabled some schools to adopt what they felt was a whole school approach to health-related policy and practice. It was also noted that local co-ordinators played an important role in schools formally achieving NHSS. There were examples of schools that felt they would not or could not have done this without the support of the co-ordinator or the impetus to ‘get things done’ that they had provided. Another way in which the support can be seen to have an impact was that school co-ordinators felt confident introducing policies or making changes to practice with the local co-ordinator and the local Programme as a point of reference backing them up.

There were, however, a number of barriers to accessing or utilising the support and advice that was available from local Programmes. Schools that did not have a specific healthy schools co-ordinator or had changed this role recently found it difficult to access the right people at the local Programme, a situation that was exacerbated if the local co-ordinator was not pro-actively contacting schools:

I think initially I found it really difficult to get hold of someone from healthy schools program because the numbers I was given...that person happened to be on maternity leave, so that was rather frustrating initially cos I kept on phoning and kept on phoning and leaving messages and emailing and just no one was getting through to me.

Primary school, large size, high FSM
Other schools faced barriers in taking advantage of the support provided by local Programmes, for example when other commitments or difficulties finding teaching cover meant that some school co-ordinators were unable to attend training courses provided by the local Programme. Furthermore, in some instances, the support or materials available were not felt to be suitable or appropriate. In special schools and PRUs it was sometimes felt that they had had minimal support as they were not the priority for the local co-ordinator:

> Maybe they don’t see us as a priority, as often PRUs aren’t …I don’t think people mean to but you’ve got 360 schools and then you’ve got this unit or do they need help with healthy schools there with all the emotional stuff they should be doing anyway, shouldn’t they?

Pupil Referral Unit

It should be noted that other PRUs felt that the support they received from the local Programme was ‘invaluable’ and as with other schools it had kept them on track to achieve the status (see chapter 3 for discussion of PRUs and special schools).

### 9.4 Typology of Programme impact

As this chapter has illustrated, there were a wide range of influences on the changes schools made and it was sometimes difficult for participants to differentiate the influence of the Programme and other factors. However, overall the evidence indicates that the impact of NHSP fell into three categories: definite change; limited impact; and minimal impact. These are discussed in more detail below.

#### 9.4.1 Definite change in response to the Programme

There were schools that experienced the Programme as a driver to implement change through providing a framework for ongoing development, allowing schools to review practice and implement new ways of working and delivering health and well-being. These schools had made changes to school practice as a response to their involvement in the Programme, and implemented change through the mechanisms for change to school practice discussed above.

Schools felt that the Programme had strengthened their approach to health and well-being, but did not necessarily make substantial changes across all four themes. It was felt that the Programme had identified particular themes where change was important to improve existing practice to meet the criteria or highlighted a theme which needed a new approach as a whole. This had meant a significant change to practice within some themes, but limited impact in other themes where current delivery was seen as demonstrating good practice or where other external factors were a driver for change.
Case Example 1: Secondary school, large size, low FSM, Status not achieved.

This specialist language school was based in an urban area and had recently gained status as an International School. It had also recently moved to a new site, which allowed it to develop additional facilities across the school. The school’s involvement with the Programme raised the profile of health and well-being, and led to the appointment of a teacher who had part of their time dedicated to coordinating the school’s approach to health and who was paid extra for this role. However, the school had not yet applied for NHSS, though felt that it would be ready to complete the self evaluation process in a few months time.

Before the school’s involvement in NHSS, PSHE had not been a timetabled lesson, but instead had been incorporated into Citizenship lessons and one off sessions with pupils. The Programme had prompted the school to move to a structured approach to PSHE that was consistent across the whole school. It also prompted the school to review its delivery of PSHE, and in the next academic year it was due to implement an assessment tool into the schemes of work for PSHE, revise the content of the materials and topics, and introduce new units for PSHE.

Significant changes had also been made to the provision of food. This was influenced by the move to a new site which allowed them to improve their catering facilities. However, the school was also guided by NHSS criteria to ensure they were providing healthy provision. The school had put in place biometric monitoring of food bought in the canteen which ensured that pupils selected a balanced meal. The Programme had also encouraged the school to design the layout of the new canteen so that students had a pleasant environment to eat and which encouraged lunch time to be seen as a social activity. It was now felt that the school went beyond the minimum statutory food standards.

Limited change in response to the Programme

The Programme had a limited impact where it was predominantly seen as a reflective process rather than a driver for change. This was the case where schools felt they had an established ethos and approach towards health and well-being and had achieved the majority of the criteria needed across the themes, but still utilised the Programme to audit and re-evaluate existing practice. This process led to small changes to meet particular criterion needed to achieve the status (e.g. updating or writing policies) or highlighted areas where they already wanted to make changes.

*I think the fact that it actually the lines are blurred as to what’s come from Healthy Schools and what were actually doing anyway is a good thing… you could see it as an add on then its not part and embedded in your school and part of what is happening. So I think yes, I think it’s highlighted some areas that perhaps we would not necessarily have focused on quite so hard otherwise.*
Secondary school, large size, low FSM

However, despite the minimum change needed to meet the criteria, the Programme was still seen as a process to improve practice rather than simply a tick box exercise.

*It's a useful structure to sort of look through and I remember looking through it a while ago and thinking yeah, but there are things here that we can develop, we haven't cracked it all, it's not just a question of ticking things off, there are places for us to go that we need to move into*

Primary school, large size, high FSM

**Case Example 2: Primary school, small size, low FSM, status not achieved**

The school was based in a small rural community and the catchment area covered a number of surrounding villages, but it had had staff redundancies due to a decline in pupil numbers. This had meant there had been challenges in allocating staff time to healthy schools, which resulted in lack of consistency of staff co-ordinating the Programme. The school had achieved the Sports Mark through taking part in a local partnership school sports survey. They were now at the stage where they felt they had all the necessary practice in place to gain NHSS, but needed to collect evidence for the self evaluation process.

The school was happy with their current delivery and assessment of PSHE and EHWB. The school had accessed support and advice through the local Programme which allowed them to review current practice around raising pupil awareness of drugs, sex education, and bullying, as well as anti-bullying training via the local Programme which highlighted the use of SEAL and other techniques to prevent and manage incidents of bullying.

The Programme had made little difference to school practice around healthy
physical activity. There had been limited change to the school's delivery of PE, and where there had been change to practice, this was motivated by other national initiatives, such as Positive Play. There had been recent change in introducing healthier hot dinners, but this was motivated by a change to a new catering supplier, rather than the school's involvement with NHSP, though the Programme had prompted the school to write to parents with guidance around providing pupils with healthy pack lunches.

Overall, the school felt it had made few changes across the four themes to achieve NHSS, as the majority of the criteria were covered by existing practice or within the current curriculum. The school perceived the main impact of the Programme as the way it had enabled the school to audit their existing practice around health and well-being.

I think it kind of fits everything together. We’ve done lots, I wouldn’t say were doing lots of new things that we have never done before, I’m not saying that we never cared about the emotional side of children or anything but I think it perhaps gives it a clear heading of what it is and where it actually fits. I think in a small school you’re always aware of certain needs and types of things but there’s perhaps never been like an actual focus for it, but I think it just pulls together everything from when we counsel for grief and loss to when we do bike road safety and its just like finding a sort of common ground for how all that fits and that’s how the Healthy Schools has probably made us look at.

Minimal change in response to the Programme

Where schools perceived the Programme as a tick box exercise, NHSP was seen as having had a minimal impact. This was the case where schools felt they had existing good practice in place and met the minimum standards of the Programme. The implication was that the Programme was validating existing good practice rather than facilitating change. In some cases, schools who had achieved the required standards delayed their application for NHSS, because they felt that the self validation process was a time intensive process to collect and review supporting evidence, and not a priority for staff time. These schools could still be making significant changes to their practices, but they were not seen as linked to the Programme in any way.
Case Study Example 3: Primary school, small size, high FSM, status achieved

The school was located in an urban setting, with 25 per cent of students from ethnic minority backgrounds. NHSS had been achieved nine months previously, and since then there had been an appointment of a new head teacher and school NHSP co-ordinator. Since achieving the status, it was felt that parental and pupil voice had become more interactive, but it was felt this had been due to the encouragement of the new head.

The school felt that the requirements of NHSP regarding PSHE fitted in well with their existing approach to delivering PSHE. Since the second stage of the research, the school had decided to move to a thematic approach to teaching PSHE across the curriculum rather than just in dedicated PSHE classes, but this had been influenced by national proposals to provide greater flexibility within primary curriculum. There had also been changes to the delivery of school lunches with the introduction of a ‘pupil choice menu’, which meant that pupils could now choose from a range of hot and cold dishes and were guaranteed their first choices, a system that the new head had used in their previous school. However, NHSP had allowed them to think about how they could incorporate food technology within other subjects, and the school had built a kitchen to allow children to take part in practical food preparation sessions.

The school offered a range of after-school physical activities, such as street dance, which had been facilitated through links with external agencies and other local schools. However, these relationships were seen as independent from the school’s involvement with NHSP. At the time of the research, the school had less than two hours of taught PE for pupils, but aimed to make changes to timetable to allow them to increase it, and it was felt this move had been highlighted by the Programme.

The school felt that it promoted an ethos of equality and understanding between pupils, which it felt was reflected in a low level of reported incidences of bullying and discrimination. Since the change of head teacher, there had been a review of their policies regarding behaviour, praise, and rewards. This then supported their continued achievement of the theme, but NHSP was not the motivating factor to carrying out a review.

Overall, the school perceived that the majority of the activities that they had in place for promoting health and well-being had not changed, but had been re-labelled as ‘healthy schools’ activities. The Programme was then seen as providing a tick box of criteria to check against their existing practice and ethos towards promoting healthy lifestyles to pupils within the school.
There were also cases where schools experienced significant barriers to their involvement with the Programme which delayed or limited their engagement. This was particularly the case where the school’s NHSP co-ordinator lacked the support of the senior management team. In these instances, it was very difficult for them to implement anything that required organisational change, additional resources or school-wide support.

9.5 Chapter Summary

- **Perception of overall impact at school level:** Co-ordinators were positive about the overall impact the Programme had on their schools. A majority of co-ordinators said that the Programme had a lot or a fair amount of impact on school policies on health and well-being, on the day-to-day work of the schools on health and well-being, and on the school’s ethos. The most common assessment of the level of change schools underwent as a result of the Programme was that they made a few changes where necessary, while around one-fifth of co-ordinators said that their school changed their practices in a significant way. Large proportions of co-ordinators agreed that, as a result of the Programme, their school gained a framework to think about work on health issues, that staff improved their knowledge, and that staff re-evaluated and identified gaps in existing practice.

- **Perception of impact at pupil level:** Despite the findings presented in chapter 8, co-ordinators were positive about the impact the Programme had on outcomes for pupils. The most common assessment among those who felt the Programme had a great deal or fair amount of impact was that the programme raised awareness about health in general, while other impacts cited included that the Programme had led to healthier eating by pupils and to an increase in the sport or activities available to pupils or their participation in these. The majority of co-ordinators believed that these positive impacts applied to all pupils (rather than benefiting only specific groups).

- **Role of the NHSP:** One of the factors that influenced change within schools was the NHSP. Four mechanisms were identified by which the Programme influenced schools’ practice in relation to health and well-being, which were: changes in practice to directly meet the criteria; NHSP providing a justification for change amongst management teams: the Programme acting as a tool to re-evaluate existing practice; and, the Programme raising awareness and the profile of health and well-being among staff.

- **The influence of the local Healthy Schools programme:** The local Healthy Schools programmes also had an important role in influencing changes in schools. The types of support offered included assistance conducting audits in relation to the NHSS criteria and help with the self-validation process, delivering Healthy Schools training and awareness courses, and providing links to other support and resources. The local Programme also had an important role in
securing the involvement of other staff and parents and facilitating a whole school approach. Some participants felt that the local Programme provided the impetus for schools to achieve the status, and provided support that gave school co-ordinators confidence in making changes to practice. The local Programme was seen as less helpful where it was reactive rather than proactive.

- **Typology of impact**: Overall the evidence suggests that NHSP had three main types of impact: definite change; limited impact; and, minimal impact. Definite change was where schools experienced the Programme as a driver to implement new ways of working and delivering health and well-being. The Programme had a limited impact where schools had already achieved the majority of the criteria needed and the Programme was predominantly seen as a reflective process to audit and re-evaluate existing practice. Schools experienced a minimal change in response to the Programme, where they regarded the Programme as a tick box exercise to validate existing practice in place rather than facilitating change to practice.
10 Understanding the impact of NHSP

The overarching aim of the qualitative component of the evaluation is to understand the ways in which the NHSP affects schools’ practices and pupil outcomes. The previous chapters in this report have discussed these issues in relation to the individual themes within the Programme. The purpose of this chapter is to bring together these different strands and set out an analysis of the ways in which the Programme can influence change. The chapter starts by identifying an overarching model for change within schools and then goes on to discuss the influence of the NHSP within this context. It concludes by describing a simple typology of Programme impacts.

10.1 NHSP theory of change

In the introduction to this report a simple model of change for the NHSP was set out, and it is reproduced below for convenience.

Figure 10.1

Within this model changes to pupils’ health-related knowledge, attitudes and behaviour in relation to health and well-being are impacted by the Programme through a series of stages. The majority of the previous chapters have focussed on what has happened within each of these stages, in other words the ways schools have or have not met the NHSS criteria and why, the changes they have made to the activities they undertake to promote health and well-being and observed changes to the knowledge, attitudes and behaviour of pupils. This chapter now focuses on the barriers and facilitators in the key transitions between meeting the NHSP criteria and changes in schools’ health promoting activities (transition 1) and that between changes in schools’ health promoting activities and changes to pupils knowledge, attitudes and behaviour (transition 2). What will be clear from the previous chapters is that the NHSP has not been implemented in isolation. Schools experience a range of barriers and facilitators to change, both internally and externally, and the Programme is just one influence amongst many. Therefore, the next section of this chapter discusses an overall framework illustrating the range of influences on both transitions before going on to describe the ways in which the Programme fed into this process.
10.2 Transition 1: factors influencing changes to schools’ health-related practices

There were a wide range of pressures on schools to change and evolve their practices in terms of the way they promoted health and well-being behaviours and attempted to influence the knowledge and attitudes of pupils. Both the facilitators and barriers to changes to schools’ practices are set out below.

10.2.1 Facilitators

- *The Programme*: There were a number of ways in which the NHSP was seen to facilitate change. These impacts have been described in greater detail in section 9.3, but they include both the impact of the criteria and the influence of the local Programmes.

- *Existing momentum for change*: To varying degrees schools were already actively delivering much of what was required to meet the NHSS criteria. One view was that the NHSP had ‘set the bar too low’, and that rather than reinforcing good practice the Programme reinforced a minimum standard which all schools should be able to meet. Where there was an existing momentum for change factors such as the positive attitude of senior management and having staff with specific expertise in practice related to the four NHSS themes (such as healthy food or PSHE) supported the change process.

- *Complementary initiatives*: The broad ranging nature of the NHSP meant that there was overlap with other local and national initiatives. For example, participants noted that some changes in practice had been the result of initiatives such as the Eco Schools Programme or in order to achieve the Sports Mark. Similarly, locally-led initiatives, such as ‘waste-free’ healthy lunchtimes, were identified as having an impact in areas covered by the NHSP. While these other initiatives often had similar aims, their existence makes it difficult to assess the relative impact of NHSP on changing practice.

- *Existing local networks*: As noted throughout the report, many schools were involved in developing and changing their health-related practices prior to their involvement with NHSP. One of the key sources of support in doing so appeared to be the existence of networks that take advantage of local resources, for example with local sports clubs.

10.2.2 Barriers

- *Negative attitudes towards NHSP*: Schools had differing attitudes towards the aims of the Programme, which appeared to affect how readily they were willing to change practice in response to it. One perspective was that the principles of the Programme were worthy and in some cases necessary but that it was often too generic to have a major impact. Another view was that the Programme was too rigid and ‘top-down’, which meant that it was unable to take account of the
particular circumstances of a school and the degree to which it was more or less able to meet the criteria.

- **Competing priorities:** Schools noted that to some extent the aims of NHSP are competing with other teaching and learning priorities. This was illustrated specifically in discussions about how to fit PSHE or two hours of physical activity into pupil timetables. More generally, the Programme was competing for the attention and energy of staff with other responsibilities and deadlines and was in some cases viewed as a lesser priority.

- **Poor performance in core subjects:** While there may have been potential for the Programme to have more of an impact on schools starting from a lower base in terms of health-related practice and pupil outcomes, issues such as staff turnover or poor performance in core subjects acted as barriers to schools’ full involvement with the Programme.

## 10.3 Transition 2: factors influencing changes to pupils’ health-related knowledge, attitudes and behaviour

Schools expressed caution over the degree to which they felt they could influence pupils’ knowledge, attitudes and behaviour, and particularly behaviour outside of school. They identified a number of factors that they believed helped facilitate change in pupils but also significant barriers to change. As discussed in previous chapters, there was also an acknowledgement that it was difficult to get reliable evidence of the impact of their practices on pupils.

### 10.3.1 Facilitators

- **Teaching quality and staff engagement:** The school co-ordinator was seen as a key position and driver of change and quality in health-related practice, though their ability to do so was dependent upon the extent of teaching the individual had in addition to NHSP responsibilities. Participants also felt that co-ordinators who went beyond changing practice to actually promoting the ethos of NHSP among staff and students had a wider impact, particularly when targeted at students who might otherwise have not engaged with the Programme.

> You sort of have to identify those children and you have to actually encourage them, and it’s a bit more than just putting up a notice saying, ‘This is going to happen’, because those sorts of children will not be involved. You have to actually go out and see them and say, ‘Why don’t you come along?’

Secondary school, small size, low FSM

Furthermore, participants felt that staff acting as role models and being visibly seen to involve themselves in the Programme were also likely to increase the impact on pupils:
It’s very much the modelling and its everybody showing these children and talking about it and say ‘I do that’….think that’s the main thing, it’s the only way you can do it with some. You can’t tell them to do it. You’ve actually got to make them want to do it by your own example.

Primary school, small size, low FSM

- **Pupil engagement:** The type of school appears to be more of a factor at this transition. For primary schools, some participants suggested that behaviour change related to some of the themes was easier due to the age of the pupils. It also appears that there were fewer outside influences acting against school practice in comparison with secondary schools. It was also noted that where healthy practices incorporated activities that pupils had an interest in outside of school, such as dance or certain sporting activities, they were more likely to be taken up by pupils in schools and have an impact on their behaviour.

- **Healthy behaviours and engagement amongst parents:** Although views on the relative impact of socio-economic background were mixed, some participants felt that families from more stable and financially secure environments were more able and in some cases more willing to engage in the Programme as it chimed with their own outlook on a healthy lifestyle.

- **Positive social influences:** There was also a view that other social influences could have a positive influence on schools’ ability to influence pupils’ health-related behaviour. For example, increased awareness of the merits of healthy eating amongst the wider community had a positive influence on pupils’ behaviour.

### 10.3.2 Barriers

- **Disengaged or under-resourced staff:** In schools where staff were not fully engaged with the Programme, it was felt that even where practice might be changed in order to meet the NHSP criteria, the impact on pupils would be limited. One view was that the Programme could be approached as a ‘box-ticking’ exercise with staff not fully embracing the Programme’s aims. It was noted that resources could limit the extent to which staff were able to engage, particularly where the role of co-ordinator was not given sufficient time outside of teaching responsibilities to administer the Programme efficiently. In schools where the co-ordinator had been changed frequently, changes in practice had lost momentum and therefore had only limited or short-term impact on pupils.

- **Negative external influences:** One of the difficulties schools noted in not only trying to affect pupil behaviour but also in monitoring this impact was the influence of the behaviour of parents and peers outside of school. It was felt that experiences of home life played a role in existing pupil attitudes and behaviour as well as how susceptible these were to change. Another contextual factor that was identified was the rural or urban nature of a school’s location. There was a view that some issues covered by NHSP required a tailored approach for
different areas, particularly issues related to drug and alcohol use for example. Cultural influences were also noted as a barrier to pupil impact. For example, one view was that media images and advertising were seen as having a negative impact on healthy eating.

- **Limited contact time:** The above influences were seen as more difficult to combat due to the limited contact time the school has with pupils. Participants noted that pupils spend a relatively small amount of their lives in school making it challenging to have an influence on the kind of behaviour that NHSP is concerned with given that health issues are not exclusively school related. Furthermore, pupil impact in PRUs and special schools was difficult to determine given the short time spent at the former and the other influences on the learning of children with special educational needs.

### 10.4 Model of influences on school health-related practices and pupil impact

This chapter has so far described a range of factors that influence the nature of changing health-related practices within schools and the impact of this on pupils’ attitudes and behaviour. Figure 10.2 illustrates the complexity of these influences. It shows that there are barriers and facilitators that are both internal or Programme-related and others that can be considered as out of the control of the Programme with respect to changing practice or out of the control of schools in relation to the impact of this on pupils. There are two main implications of this holistic view of change and impact. First, the barriers that have been identified limit the extent to which the Programme can lead to changes in health-related practices and impact upon pupils. Second, the presence of other factors facilitating changes in practice or having a positive influence on pupil behaviour makes it difficult to isolate the impact of NHSP. The diagram below illustrates this model, with barriers illustrated in red and facilitators in green; the distinction between in-school factors and external factors is also made.
Figure 10.2

Changes in health-related policy and practice

- Influence of NHSP
- Existing momentum for change
- Quality of delivery
- Staff modelling and engagement

Impact on pupils’ knowledge, attitudes and behaviour

- Healthy home environment
- Positive cultural influence

In-school factors
- Negativity towards NHSP
- Inactive teachers
- NHS Patience
- Disengaged staff
- Limited contact time
- Negative cultural influence

External factors
- Complementary initiatives
- Existing local networks
- Disengaged parents
- Healthy home environment
- Quality of delivery
- Staff modelling and engagement

Transition 1
Transition 2
10.5 Chapter summary

- **NHSP theory of change:** The Programme’s theory of change envisages the process of meeting the criteria (using the whole school approach) leading to changes in schools’ health promoting activities that in turn influences pupils’ health-related knowledge, attitudes and behaviour towards health and well-being. This process involves two transition points. The first is between meeting the NHSP criteria and changes in schools’ health promoting activities (transition 1) and second, between changes in schools’ health promoting activities and changes to pupils’ knowledge, attitudes and behaviour (transition 2).

- **Transition 1 - factors influencing changes to schools’ health-related practices:** The way schools promoted health and well-being was influenced by the impact of the Programme itself through the changes schools made to achieve the criteria and the influence of the local NHSP Programme. However, change was additionally influenced by the extent to which schools felt they were already doing what was required of the Programme, the influence of an existing momentum for change within schools, the involvement and impact of complimentary initiatives, and existing local networks which help to develop and improve health-related practices. Schools also experienced challenges implementing change. Among these barriers were negative attitudes towards the Programme and schools’ unwillingness to implement change, the extent to which schools have other priorities, and the prioritisation of issues around poor performance on core subjects.

- **Transition 2 - factors influencing changes to pupils’ knowledge, attitudes and behaviour:** School staff expressed caution over the extent to which they could affect health-related pupil outcomes, particularly in relation to behaviour outside school. However, school staff identified a number of factors which facilitated change, such as the extent to which school co-ordinators could act as a driver for change and encourage staff engagement, pupil engagement, engagement amongst parents, as well as other positive cultural influences (for example awareness in the wider community of the merits of healthy eating). Schools also identified barriers to change, which included the level of engagement of staff with the Programme, the role of negative external influences (such as the behaviour of parents and peers), and schools limited contact time with pupils.

- **Model of influences of health-related practices and pupil impact:** The research showed that in practice the process of change is influenced by factors that are Programme-related and other factors that are outside of the control of the Programme. There are two implications of this holistic model of change. First, that there are barriers which limit the extent to which the Programme can lead to change. Second, that the influence of other factors in facilitating change
in practices and pupil behaviour and attitudes makes it difficult to isolate the impact of NHSP.
11 Conclusion

This evaluation study has yielded a wealth of information and learning about the implementation of the NHSP. This chapter seeks to summarise key learning about the impact of the Programme and to draw out lessons for future.

11.1 Potential to bring about change

The introduction to this report highlighted the fact that the NHSP has operated in a continuously evolving policy context and has as a Programme evolved accordingly. Our evidence indicates that the NHSP was a useful facilitator of change at a school level, though it is as yet unclear whether or how changes at a school level transfer to pupil level outcomes.

Nevertheless, the changes that have taken place at a school level are significant and the research has identified a number of ways in which NHSP aided the change process within schools. The NHSS criteria provided a framework for reviewing and auditing schools’ practice, raised the profile and status of health-related activities and provided a helpful rationale and justification for action. This was further enhanced by the work of the local Healthy Schools programmes, particularly through providing specialist advice, sign-posting to useful resources, and providing or funding training.

The facilitators for change need to be set in the context of the school environment. Schools are dynamic institutions that have to manage constant change, in terms of the pupils at the school and their parents and guardians, staff turnover, governor and government requirements and the local and cultural context within which they sit. Although the NHSP is a relatively high profile initiative, schools’ own priorities and goals were described as being very much the driving force behind their actions, with the overwhelming message being that for the changes they were making the NHSP was supportive and helpful but these changes would in the main have been implemented anyway.

The research particularly confirmed the perception that school staff felt they could have a limited effect on pupils’ health-related knowledge, attitudes and behaviour within the context of the school setting. Where co-ordinators whom we talked to in the qualitative component of the evaluation did perceive they had an impact, we do not know on what information they based their conclusions. However, there were significant doubts as to the extent to which they could have an influence outside of the school day. The influence of parents, peers, the media and the local culture were seen as extremely powerful forces and it was felt that it would take many years, and perhaps generations, to counteract these wider pressures.

11.2 Lessons for the future

The NHSP chimed with much of what schools felt was important to them and where their priorities lay. However, their reflections on it as a Programme indicate that there are a
number of lessons for its further development. The Programme’s aims are extremely ambitious, and the impression of research participants was that the Programme’s specific objectives were rarely articulated clearly and concisely. The evidence in this report indicates that it is important to be realistic about what it is possible for a Programme of this nature to achieve and to define a set of objectives that accord with the SMART formula (specific, measurable, achievable, relevant and time-bound), as has been done within the framework of the Healthy Schools health behaviour change model. This should ensure realistic expectations of what the Programme can and cannot achieve and so encourage appropriate assessments of whether it has met its targets.

In conjunction with a realistic set of aims and SMART objectives, it is vital that the Programme has a clear, evidence-based theory of change. This would set out the way in which the Programme is meant to achieve its objectives and the assumptions behind it. All these things would help the design and delivery of the Programme to be undertaken in a strategic way and its implementation assessed against this. Without them, there is considerable scope for key elements required to effect change being overlooked or underemphasised and for there to be significant variations in the understanding those involved have of what it is trying to achieve and how. The Healthy Schools health behaviour change model has discussed the issue of theories of change in a range of documents, both internal and in published guidance.

Linked to the need for clear objectives and a theory of change is the issue of evaluation. Schools felt that conducting evaluation is very difficult at a school level. A key policy question, then, is to what extent evaluating the Programme is important and if so what kind of evaluation is required. To be effective, these questions need to be asked at the design and initiation of the Programme and be part of its basic set up, as indicated by the ROAMEF model (Rationale, Objectives, Appraisal, Monitoring, Evaluation and Feedback) discussed in the treasury Green Book22. Without considering evaluation at the outset of the Programme, the ability to gather evidence about its impact can be seriously compromised.

In terms of the specific elements of the Programme that are worth taking forward, the participants indicated that the more pro-active the Programme can be, the more likely it is to have an impact. So providing a framework for review, specialist advice and access to high quality and relevant training all prompt enthusiastic responses from schools. It is also important to take into account the goals and priorities of schools themselves and to allow tailoring so that the Programme reflects the background of the pupils, the particular health and well-being issues relevant to them and the local environment. The implication of this is that the more flexible, targeted approach of the Healthy Schools health behaviour change model is a positive development, but that this flexibility should not be at the expense of structure and guidance. The South West Healthy Schools Plus programme is designed to take into account local and school priorities, and to tackle behaviour change. The evaluation of this programme is in progress.

22 See http://www.hm-treasury.gov.uk/data_greenbook_index.htm
Appendix A  The 41 Criteria

Personal, Social, Health and Economic (PSHE) Education

1.1 Uses the PSHE framework to deliver a planned programme of PSHE, in line with relevant DCSF/QCA guidance
1.2 Monitors and evaluates PSHE provision to ensure the quality of learning and teaching
1.3 Assesses children and young people’s progress and achievement in line with QCA Guidance
1.4 Has a named member of staff responsible for PSHE provision with status, training and appropriate Senior Leadership support within the school
1.5 Has up-to-date policies in place – developed through wide consultation, implemented, monitored and evaluated for impact covering Sex and Relationship Education, Drug Education and Incidents, Safeguarding, and Confidentiality
1.6 Has an implemented Non-Smoking Policy
1.7 Involves professionals from appropriate external agencies to create specialist teams to support PSHE delivery and to improve skills and knowledge, such as a school nurse, sexual health outreach workers and drug education advisers
1.8 Has arrangements in place to refer children and young people to specialist services who can give professional advice on matters such as contraception, sexual health and drugs
1.9 Uses local data and information to inform activities and support important national priorities such as reducing teenage pregnancies, sexually transmitted infections and drug/alcohol misuse
1.10 Ensures provision of appropriate PSHE professional development opportunities for staff – such as the National PSHE CPD Programme for teachers and nurses offered by the DH/DCSF
1.11 Has mechanisms in place to ensure all children and young people’s views are reflected in curriculum planning, learning and teaching and the whole school environment, including those with special educational needs and specific health conditions, as well as disaffected children and young people, young carers and teenage parents

Healthy Eating

2.1 Has an identified member of the Senior Leadership Team to oversee all aspects of food in schools
2.2 Ensures provision of training in practical food education for staff, including diet, nutrition, food safety and hygiene
2.3 Has a whole school Food Policy – developed through wide consultation, implemented, monitored and evaluated for impact
2.4 Involves children, young people and parents/carers in guiding food policy and practice within the school, enables them to contribute to healthy eating and acts on their feedback

2.5 Has a welcoming eating environment that encourages the positive social interaction of children and young people (see Food in Schools guidance)

2.6 Ensures that breakfast club, tuck shop, vending machine and after-school food service (where available in school) meets or exceeds current DCSF school food standards

2.7 Has a school lunch service that meets or exceeds current DCSF standards for school lunches

2.8 Monitors children and young people’s menus and food choices to inform policy development and provision

2.9 Ensures that children and young people have opportunities to learn about different types of food in the context of a balanced diet (using ‘The eatwell plate’), and how to plan, budget, prepare and cook meals, understanding the need to avoid the consumption of foods high in salt, sugar and fat and increase the consumption of fruit and vegetables

2.10 Has easy access to free, clean and palatable drinking water, using the Food in Schools guidance

2.11 Consults children and young people about food choices throughout the school day using school councils, Healthy Schools Task Groups or other representative pupil bodies

Physical Activity

3.1 Provides clear leadership and management to develop and monitor its physical activity policy

3.2 Has a whole school Physical Activity Policy – developed through wide consultation, implemented, monitored and evaluated for impact

3.3 Ensures a minimum of two hours of structured Physical Activity each week to all of its children and young people in or outside the school curriculum

3.4 Provides opportunities for all children and young people to participate in a broad range of extra-curricular activities that promote Physical Activity

3.5 Consults with children and young people about the Physical Activity opportunities offered by the school, identifies barriers to participation and seeks to remove them

3.6 Involves School Sport Co-ordinators (where available) and other community resources in provision of activities

3.7 Encourages children, young people, staff and parents/carers to walk or cycle to school under safer conditions, utilising the School Travel Plan

3.8 Gives parents/carers the opportunity to be involved in the planning and delivery of Physical Activity opportunities and helps them to understand the benefits of Physical Activity for themselves and their children

3.9 Ensures that there is appropriate training provided for those involved in providing physical activities

3.10 Encourages all staff to undertake Physical Activity
Emotional Health and Well-Being

4.1 Identifies vulnerable individuals and groups and establishes appropriate strategies to support them and their families

4.2 Provides clear leadership to create and manage a positive environment which enhances emotional health and wellbeing in school – including the management of the Behaviour and Rewards Policies

4.3 Has clear, planned curriculum opportunities for children and young people to understand and explore feelings using appropriate learning and teaching styles

4.4 Has a confidential pastoral support system in place for children, young people and staff to access advice – especially at times of bereavement and other major life changes – and this system actively works to combat stigma and discrimination

4.5 Has explicit values underpinning positive emotional health which are reflected in practice and work to combat stigma and discrimination

4.6 Has a clear policy on bullying, which is owned, understood and implemented by the whole school community

4.7 Provides appropriate professional training for those in a pastoral role

4.8 Provides opportunities for children and young people to participate in school activities and responsibilities to build their confidence and self-esteem

4.9 Has a clear Confidentiality Policy