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Progress and challenges in London

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This paper aims to explore the opportunities available to create stronger and more consistent partnerships between health and education, both in terms of the challenges facing schools and the issues surrounding local strategies that link the two sectors. In doing so, it also seeks to identify some of the ways that these improved partnerships can reduce health inequalities between children.

About the author

Kate Healey joined the King's Fund as a project officer in May 2000 from the Bromley-by-Bow Centre – a community organisation and healthy living centre in east London. She went on to run the Imagine London programme at the King's Fund, with the help of a steering group of young people aged 12–18. Kate is also the author of the research summary A Good Place to Learn? What young people thinks makes schools healthy published by the King's Fund. She left the Fund in August 2003 to pursue a career in law.

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Foreword

In this study, the King's Fund, a partner in the London Health Commission, has brought together the perspectives of key education and public health stakeholders, and children and young people, to explore the range of strategies and initiatives for linking children and young people's health and education across London.

As Chair of the London Health Commission, I welcome this paper, which highlights learning from good practice and identifies ways forward for us to work together to improve health and educational outcomes and reduce inequalities for all of London's children and young people.

Tackling inequalities in the health of London's children is a major concern for us all and has been identified as a priority of the London Health Commission. Children born into poverty are more likely to experience direct and indirect damage to their health. They are more likely to be born small, or early, or both, to die from an accident in childhood, to smoke and be exposed to passive smoke, to have poor nutrition, to give birth to or father a child at a younger age than more affluent peers, to become a lone parent, and ultimately – because of the pervasive effects of childhood events on adult health – to die younger.

The same determinants that affect child health also impact on educational attainment. The worst attainment and prospects in health and education are found in the same individuals and groups of children. The two issues also affect each other: poor health works against educational success, and educational attainment strongly affects social and economic prospects and choices about health.

The scale of the challenge is huge: 1.62 million children under the age of 18 live in London – over one fifth of the population. Taking account of housing costs, 41 per cent of children in Greater London live in poverty, compared with 31 per cent nationally. In inner London, half of all children are living in income poverty.

This paper focuses on how stronger partnerships can help tackle health inequalities; working in partnership across sectors is key to securing a better, healthier future for London's children. Health and education have mutually supportive goals and targets: these include improving levels of school attendance, reducing the risks to children's emotional and social development within the family setting, preparing children from deprived areas to thrive at school, and giving support to extended schools. It is only through concerted partnership action that we can begin to reach these goals.

I commend the findings of this study to all individuals, organisations and partnerships across London that are concerned with health or education and urge you to redouble your efforts to work in partnership to make a real difference to the well being of children and young people across London.

Len Duvall
Chair – London Health Commission

If we are serious about reducing inequalities in educational attainment for London's children, we must also tackle the health inequalities that currently exist. We owe it to all children in London, but especially those from more deprived backgrounds, to approach their needs with co-ordination and commitment. This paper suggests practices we need to explore to encourage that.

Recognition of the interdependency of some of the key goals of both the education and the health sectors is the first step in the right direction. We then need to ensure that targets are mutually supportive and that there is investment is there to make sure results are delivered across sectors. There are many positive examples of initiatives, policies and ways of working that can be built upon, not only in schools but across children's services, to help children reach their potential in terms of education and health, both physical and mental.

During a decade in Birmingham I realised just how important work between the health and education services is, and as chief education officer explored practices linking the sectors that would make a real difference. We tried to recruit associate speech therapists, drawn from the community to work with parents and health visitors on language issues during a child's first two years of life. We also relocated pre-school workers to health clinics, to pick up the baton from the health visitor. We resolved to change job descriptions within both services to ensure that health and education professionals worked together, and the Director of Public Health and I put health and education objectives in our respective performance contracts.

I commend the findings of this study as a timely exploration of the issues facing us. I urge readers to reflect upon the opportunities for action that it presents, so that we all become champions of this exciting and much needed partnership agenda.

We need action now if our most challenged and disadvantaged families are to have a fair deal.

Tim Brighouse
Visiting Professor at the Institute of Education, University of London

Acknowledgements

The London Health Commission

The London Health Commission (LHC) is a high-level strategic partnership that works to reduce health inequalities across the capital and to improve the health and well-being of all Londoners. The LHC promotes a co-ordinated approach to the factors that influence health in London by:

■ building partnerships involving the health sector, local and national government, the private sector, community and voluntary groups

■ influencing decision-makers

■ providing support for local action.

Summary

Stronger links between health and education would be good for children's health and help them do better at school. Schools have a vital role to play in safeguarding and promoting health and healthy children have higher levels of attendance and attainment at school.

In London, some schools are working well with health organisations, but others are not. This paper examines:

■ benefits to children of stronger and more consistent partnerships between health and education

■ government programmes that require or encourage schools and health organisations to work together

■ barriers to effective partnership working

■ opportunities for overcoming the barriers

■ recommendations for improving working arrangements between the education and health sectors.

The study seeks to understand issues surrounding local strategies for linking child health and education, and the challenges facing schools that are trying to improve the health of their students, and it identifies examples of positive practice in London. It focuses on three areas identified by children and young people as most important to them – nutrition, mental health and physical exercise – and on how stronger partnerships can help tackle health inequalities.

Research methods included interviews with key stakeholders, an exploratory workshop, case studies in three schools in different parts of London, a review of literature on positive practice, and a final workshop to review a draft report.

Benefits to children

There is clear evidence that a good education can lead to better mental and physical health, and that poor health inhibits learning. Education can help overcome social and economic disadvantages and so help combat health risks associated with poverty and social exclusion.

■ Nutrition Poor diet in childhood is linked with poor health in childhood and adulthood, and may hinder a child's cognitive development.

■ Mental health Being bullied at school is linked with anxiety and depression. Schools are recognised as an important setting for promoting mental well-being.

■ Physical activity Regular physical activity is strongly associated with academic achievement, and with improved health in childhood and later life.

■ Health inequalities Schools that are actively engaged in the Healthy Schools initiative and that have a relatively high proportion of children from deprived backgrounds are improving at a faster rate than other schools in terms of pupil behaviour, standards

of work, quality of personal, social and health education (PSHE), and the management and support of pupils.

The policy context

The study identified 17 national government initiatives that may help to bring health and education services closer together. These are listed in the report and discussed in more detail below (see 'Opportunities', p 4). The more substantial schemes include:

■ Children's Fund partnership groups

■ children's trusts

■ Connexions

■ extended schools

■ local strategic partnerships

■ National School Fruit Scheme

■ National Action Programme for Tackling Health Inequalities

■ Sure Start.

In September 2003, the Government published Every Child Matters, the Green Paper on children at risk, which sets out proposals for reorganising children's services. It aims to improve early intervention and effective protection, to support parents and carers, to improve workforce skills, accountability and co-ordination, and eventually to integrate key services under children's trusts.

At local level, the study found that initiatives linking child health and education involved many different players and partnerships, which varied from one London borough to another. Many were under the auspices of local strategic partnerships (LSPs). In addition to local representatives of the schemes listed above, important contributors included behaviour and education support teams, mental health service providers in the statutory and voluntary sectors, local authorities and housing departments, local education authorities (LEAs), primary care trusts (PCTs), pupil referral units, social services, police and youth justice boards, and youth offending teams (YOTs). Schools trying to improve health and education faced complex challenges that are explored further in the paper.

Barriers to effective partnerships

The research identified barriers in three main areas: access to the relevant partners, engaging with partners, and delivering action.

Access

■ Teachers in some boroughs were too busy to go to partnership meetings.

■ Those working in education did not see themselves as obvious contributors to health improvement – a view shared by those in the health sector.

■ There were no clear routes into individual schools or GP surgeries, and people wanting to make links did not know who to contact.

Engagement

■ PCTs were preoccupied with their own development and recent structural changes in health, and did not always recognise the importance of schools' contributions to population health.

■ The two sectors had different targets and incentive structures to which they gave priority, and they spoke 'different languages'.

■ Budgetary constraints meant there were not enough staff to devote to partnership working.

■ A profound cultural change was required to adopt a holistic approach to the well-being of children, in which health and education were seen to be mutually reinforcing.

■ There was insufficient sharing of knowledge about the practice and benefits of linking health and education.

■ Statutory and voluntary bodies had different imperatives and did not have equal status on partnership boards.

Delivery

■ Health funding did not easily cater for children who lived in one borough and went to school in another.

■ Interventions that relied on a single individual or on time-limited funding were not always sustainable.

■ Schools raised funds by promoting unhealthy foods such as crisps and chocolates.

■ Initiatives were clustered in the most deprived areas, so that some schools suffered from overload and others were left out.

■ Staff shortages and high turnover at all levels, in all relevant sectors, undermined effective delivery.

■ Teachers had no training in PSHE.

Implications for health inequalities

■ Children living in poverty in better-off areas did not benefit from many important schemes aimed at improving child health and education.

- Some of the most vulnerable children were not involved in schemes for a range of reasons, including segregation, lack of time or confidence, and communication problems.

- Insufficient funding meant that some children's needs, such as for language and speech therapy, could be identified but not met.

- Children with complex needs often lived outside the borough where they went to school, making co-ordination of health and education services more difficult.

Opportunities

Success factors

Schemes worked better when:
- there was a simple formula that could be repeated, such as the National School Fruit Scheme
- there was flexibility at the delivery stage
- staff were well resourced and thoroughly prepared
- both sides acknowledged the mutually reinforcing benefits of health and education
- they made better use of existing services
- enthusiastic teachers understood that pupils' needs play a leading role.

Promising developments

- The research showed that people working in public health and education took a similar view of the factors that contributed to children's well-being. They recognised the importance for health and education of issues such as income and housing, and the physical and emotional environment.

- The National Lottery's New Opportunities Fund has taken a keen interest in linking health and education.

- Hybrid posts, such as nurses working as school assistants and teenage pregnancy co-ordinators, helped to bridge the gap between the sectors, as did school visits by primary care practitioners, mental health promotion in schools, and schemes such as 'Saving Londoners' Lives', run by the London Ambulance Service.

- School inspections now include sex and relationship education.

- New guidelines on shared information, referral and tracking should improve co-ordination between sectors.

- Two newly appointed children and adolescent mental health service (CAMHS) workers should help forge better links between agencies.

■ Local children's partnerships, set up under the auspices of LSPs, reflected and should reinforce the 'joined-up' nature of work involving children and young people – especially those who are most vulnerable.

Opportunities offered by central government initiatives

■ The Children's Fund aims to reduce poverty. Its objectives are to improve attendance and attainment at school, improve health, and reduce crime and anti-social behaviour. In order to access funds, a local authority must set up a partnership including health and education. So far, the emphasis has been on social services more than on education or health. This could change if fund-related work were more closely linked with health targets.

■ Children's trusts are being piloted in 35 'pathfinder' schemes, including eight in London. They aim to integrate planning and commissioning of all services for children, including health and education, in one locality, to improve quality and outcomes. Information-sharing, professional boundaries, pooling of resources and different organisational cultures may prove problematic. Success will depend on how pooled resources are put to use, and whether children and families notice a difference.

■ Connexions aims to identify and remove barriers to learning and achievement among 13–19 year olds. Personal advisers are intended to co-ordinate relevant services, including health and education, for individual young people. Every borough has a one-stop shop to provide information and advice. Links with health are stronger in some boroughs than others, often depending on individual managers.

■ Extended schools aim to provide a wider range of services to the local community, by opening school facilities during evenings, weekends and holidays. Services may include health as well as parenting support, family learning, childcare, sports, arts and lifelong learning. Ideas for promoting health through extended schools include breakfast clubs, making school nurses available for families, advice on healthy eating, sexual health, contraception and mental health, intergenerational work, community kitchens and community sports.

■ The Green Paper Every Child Matters aims to reduce the number of children who experience educational failure, engage in offending or anti-social behaviour, suffer from ill-health or become teenage parents. It sets out measures for improved support for parents, information-sharing, early intervention, better accountability and a more highly skilled children's workforce. It includes plans to establish a commissioner for children and to integrate key services within children's trusts, under the auspices of the Minister of State for Children.

■ The National Healthy Schools Scheme aims to reduce health inequalities and make schools better and more socially inclusive. Schools volunteer to work towards a Healthy Schools award, with a local co-ordinator in each borough and national co-ordination by the Health Development Agency. A national target is to involve all schools with more than 20 per cent of pupils eligible for free school meals and to demonstrate an impact by 2006.

■ The National School Fruit Scheme provides one piece of free fruit per day for all 4–6 year olds in participating schools, which include 85 per cent of London primary schools. A popular and successful scheme, it involves a wide range of school staff

rather than just teachers, and has led to further healthy eating measures being introduced into the schools, as well as providing topics for curriculum-based learning.

■ Sure Start aims to improve opportunities and life chances for 0–3 year olds by co-ordinating services, including health, childcare, support for parents and early education. Many Sure Start workers have been trained in mental health awareness. The scheme is popular locally, encourages partnership working, and is said to have established good links between the different sectors and the communities it serves.

Opportunities for tackling health inequalities

The research showed that:
■ schools provided relatively easy access to target groups in deprived areas, with access to children from different socio-economic, ethnic and cultural backgrounds. Interventions delivered to a whole school were non-stigmatising
■ more and better use could be made of schools by PCTs working to tackle health inequalities. Extended schools offered excellent opportunities – for example, for on-site clinics serving poor communities
■ partnerships that included social services as well as health and education stood the best chance of successfully tackling health inequalities
■ the interdependence of health and education could be valued – and measured – most readily among particular groups of children and young people, such as teenage parents and their children, and looked-after children. Health and arts activities were seen to be especially useful in helping to educate challenging children with complex needs
■ some schools stressed the importance of integrating health-improving functions with their mainstream activities, rather than treating them as extras.

Moving forward

The study identified factors that could help overcome barriers, make the most of opportunities, and help to strengthen links between health and education. The key themes that emerged focused on leadership, creating the right conditions, learning, and how to turn learning into action.

Leadership

■ Local champions were needed to promote the necessary cultural change, establish partnerships, and plan and deliver joint action.

■ Building effective partnerships took time and required sustained impetus from the most senior levels.

Creating the right conditions

■ Local strategic partnerships should include top-level representatives of education.

■ It was important to understand and cater for the distinctive working conditions and objectives of the different sectors, and to help school staff to get involved – for example, by holding meetings on their premises.

■ Links should be made across different services, not just between schools and PCTs, but also with youth and leisure facilities, so as to achieve a rounded approach to children's well-being.

■ Agencies outside the education sector should be sensitive to teachers' hectic timetables and help them get involved with standalone projects that would enable them to 'bite off in bits' the agenda for linking health and education.

■ Schools were more likely to adopt projects that clearly served educational objectives and where the development stage had been worked out for them, so that they did not have to start from scratch.

■ Both sectors needed to see how they could benefit from joint working, rather than just what they could contribute to the objectives of other partners.

Learning

■ Voluntary sector organisations have a lot to offer partnerships, and should be given more recognition.

■ It is important to listen to children and young people and empower them to make their own decisions.

■ Primary care professionals should go into schools more often, to learn from the pupils as well as to make their services more accessible to them.

■ Examples of good practice that can bring mutual benefits to health and education should be more widely disseminated in both sectors.

■ Key players in health and education should be given more time together, to foster mutual understanding and informed dialogue.

■ There should be an accessible practical guide to working with the different sectors for busy people in the field.

■ Joint training of professionals would help develop common ways of working.

How to turn learning into action

■ The Healthy Schools scheme should be given priority through local education and health delivery plans.

- The two sectors should adopt some shared targets, such as early literacy rates and pre-natal health.

- There were clear benefits to schools of investment in mental health and emotional well-being, and a focus on this could help to strengthen partnerships.

- School nurses should play a broader role in developing healthy schools.

- Local education authorities also had a lot to offer – for example, by issuing guidelines on the nutritional content of school meals.

- Detailed recommendations on food, mental health and physical exercise are set out in the paper.

Recommendations

The following recommendations are drawn from the research and focus on what would assist the child health and education partnership agenda – first, in terms of government policy, and second, in terms of school policy.

Policy recommendations

- The Government's approach to health and education should be more integrated, with departments working more closely together.

- Ofsted should inspect schools' progress towards health targets.

- Key professionals should receive joint training, to instil core values and competencies across sectors, including police, social services, education and health. Child health and well-being should be a core component in teacher training. Teachers should also be trained in PSHE.

- There should be special funding to support the transition to partnership working – for example, by releasing people from their 'day jobs' to develop new ways of working.

- External facilitators could help to engage key players in learning from successful schemes. Examples of what works in practice should be made available through a central website.

- A guide for teachers should be prepared showing how health issues can be linked into different stages of the curriculum.

- There should be more investment in the Healthy Schools scheme.

Recommendations for schools

- The school curriculum should include health in subjects other than PSHE, bullying should be included earlier than Year 11, and health education should be adapted to

different age groups. More use should be made of outside agencies and voluntary groups to facilitate learning on health-related topics such as sex education, where teachers are not always best placed to offer advice.

- Teachers need more support, including time off to participate in partnership working, working conditions that address their physical and mental health needs, performance management that does not burden them with unnecessary paperwork, and support networks at all levels.

- Listening to children and young people must be central to this agenda, and must take place at all levels. Peer-led initiatives, including mediation and conflict resolution, should be encouraged and supported by appropriate facilitation, to promote an inclusive approach. Active and respected school councils, with election by secret ballot to avoid 'popularity contests', could have a significant and positive effect on children's well-being.

- The whole school should be involved in measures to promote health, with support from senior management, and buy-in from teachers and support staff.

- Links with health professionals could be promoted through one-stop shops offering advice and information on a range of issues, including health, and based on school premises.

- Links with the community should be fostered by inviting parents and community groups to participate in school-based activities, school visits to community organisations, and raising awareness of the impact of schools on the local environment.

1 Introduction

Background to the research project

Schools have a vital role to play in safeguarding and promoting children's health, and healthy children are more likely to do well at school. It is widely acknowledged that children would be better served if schools and local health organisations could work together in stronger and more productive partnerships than they do at present. Three main questions lie at the heart of this study:

■ What policies and practical arrangements are currently in place that address children's health in London's schools?

■ What are the barriers and opportunities faced by key players trying to build better links between health and education?

■ What could be done to strengthen those links and make them more productive?

The study builds on a recent King's Fund survey of health in schools, A Good Place to Learn?, which was designed by a group of young people aged 12–18. Its purpose was to find out what a sample of secondary school students across London felt should be done to create healthier schools (Healey 2002). Three key concerns emerged: the quality, price and appropriateness of school food; the problem of bullying and its impact on emotional well-being; and the lack of provision for regular, enjoyable exercise. We therefore designed our research with a special focus on these areas. We have sought to reach a better understanding of local efforts to link child health and education, to consider the main challenges faced by schools trying to improve their students' health, and to identify examples of positive practice in London.

Our research methods are set out in Appendix 1. In summary, we reviewed relevant literature, interviewed a wide range of stakeholders in the health, education and voluntary sectors, convened an exploratory workshop with local practitioners, and conducted three in-depth case studies of individual schools. In total, more than 100 people participated in the study, which began in March 2003 and ended in June 2003.

The case for linking child health and education

The Government's cross-cutting review on tackling health inequalities (Department of Health 2002) pointed to:
■ the importance of education in breaking the cycle of health inequalities
■ a substantial evidence base linking educational attainment to specific health outcomes (Acheson 1998)
■ the role of education in ensuring that children have the practical, social and emotional knowledge and skills to achieve a full and healthy life (Ibid).

There is strong evidence that poor health inhibits learning (World Bank 1993, World Health Organization 1996, Devaney et al 1993) and that there is a strong relationship between health and educational outcomes, including exam grades, classroom performance, and students' behaviour and attitudes (Symons et al 1997). Poor educational attainment is also a strong predictor of future economic and social status as well as health status in adulthood.

'Looked-after' children in local authority care who have a mental health problem are nearly twice as likely as other children in care to have marked difficulties with reading, maths and spelling, according to a 2002 study by the Office of National Statistics. In terms of overall scholastic ability, teachers estimated that 62 per cent of these children were at least one year behind in their intellectual development, compared with 17 per cent of children in local authority care with no mental health problem. This clear link between children's mental health and their capacity for educational attainment highlights the importance of preventive measures that promote children's mental health and increase their resilience (Office of National Statistics 2002).

Food and nutrition

There are growing concerns about the diet of children and young people in the UK. These focus in particular on:
- the movement away from regular meals, especially breakfast
- increased snacking
- low consumption of fruit
- high consumption of chips (Currie et al 1997, Roberts et al 1997).

Over the past decade, the average intake by children of sugar-sweetened drinks has increased by 919 kcals a week. Over the same period, children's intake of savoury snacks has increased by 21 per cent and intake of confectionery by 12 per cent (Currie et al 1997, Roberts et al 1997). Poor diet in childhood is associated with poor child and adult health. Children in the UK are often deficient in micro-nutrients and regularly miss meals, which may hinder cognitive performance (Lucas 2003). Moreover, unskilled groups eat about 50 per cent less fruit and vegetables than professional groups (Department of Health 2001b).

Schools can play a major role in dietary change by providing healthy choices in the canteen, teaching about food and nutrition, and working in partnership with parents and the wider community (Young 1993). However, the Education Act 1980 released school meals services from nutritional requirements, made the provision of milk discretionary rather than obligatory and withdrew fixed price controls for school meals. The Local Government Act 1988 then introduced compulsory competitive tendering from local education authorities (LEAs) for their school meal services.

Local management of schools has meant that schools are now responsible for their own budgets. New regulations came into force in April 2001, introducing standards based on food groups. The National Heart Forum and other health and consumer organisations have expressed disappointment that the new standards were not based on the nutrients that the meals should contain.

There is some evidence that the knowledge that children acquire at school about healthy eating seems to be undermined by the meals available at school and the experience of

mealtimes (Kurtz and Thomas 2000). And the commercial promotion within schools of foods high in sugar and fat, using incentives such as vouchers, is of growing concern.

Bullying and emotional well-being

Research shows that being bullied in school correlates with anxiety and depression (Salmon et al 1998). Over half the respondents in the King's Fund's recent schools survey had been bullied (Healey 2002). Despite the introduction of anti-bullying policies by schools, the charity Childline still speaks to around 20,000 children a year who feel their lives are being ruined by bullying (www.childline.org.uk). One-in-five children suffers from mental health problems (Audit Commission 1999). Mental health problems in children are associated with educational failure, family disruption, disability, offending and anti-social behaviour, all of which increase the volume of demand on social services, schools and the youth justice system (Department of Health 2003).

School has a significant influence on the behaviour and development of all children (Curtis and Roberts 1995) and the importance of school as a setting for mental health promotion is recognised in guidance issued by the Department for Education and Skills (DfES 2001).

Schools can help reduce the impact on health and learning of social, economic and racial inequalities. However, they can also reinforce inequalities. More children from minority ethnic groups are likely to experience bullying (Curtis and Roberts 1995). One-in-five children in the King's Fund survey reported having experienced racism in school (Healey 2002).

Physical activity

There is considerable evidence of a positive association between regular physical activity and academic performance (Symons et al 1997, World Health Organization 1996). The short- and long-term health benefits of physical activity are well documented (Health Education Authority 1998b). Yet British children play less sport than those in most other European countries (Performance and Innovation Unit 2002). Some 33 per cent of boys and 38 per cent of girls aged 2–7 are not meeting the recommended activity guidelines. Activity levels for girls start to drop off even more from about the age of 8–10, such that 64 per cent of 15-year-old girls are classed as 'inactive'. Activity levels for boys tend to peak between the ages of 10 and 13, before a decline during adolescence (British Heart Foundation 2000, Prescott-Clarke and Primatesta 1998).

The Department of Culture, Media and Sport and the DfES are committed in their Public Service Agreement to increase the proportion of school children spending a minimum of two hours a week on 'high-quality' physical education and sport from 25 per cent in 2002 to 75 per cent by 2006.

Child health inequalities

Children from minority ethnic communities are over-represented in the numbers of children excluded from school (Curtis and Roberts 2003). African-Caribbean young

people are six times more likely to be excluded than white students (SEU 1998). While the achievements of black African pupils at GCSE level are currently rising faster than those of their white peers, there is hardly any increase in attainment levels of Pakistani pupils and that of Bangladeshi pupils is actually falling (DfES 2001). Qualitative studies have highlighted the role of social factors, such as poverty (Curtis and Roberts 1995).

London has the highest incidence of child poverty of any region in Britain. Forty-one per cent of children in London are living in poverty. In inner London, the proportion rises to 53 per cent. In 2001 about 42 per cent of maintained secondary school students in inner London were eligible for free school meals, compared with 16 per cent nationally and 18 per cent in outer London. Approximately 50 per cent of 15-year-old students in England overall and in outer London achieved five or more A–C grades in GCSEs in 2001, compared with only 38 per cent in inner London. Attainment levels among black and Bangladeshi students are lower than for white and Indian students (GLA 2002).

The National Healthy Schools Scheme (NHSS) has reported that schools working under the Healthy Schools umbrella are improving, in terms of educational achievement, at faster rates, especially in deprived areas. Ofsted inspections suggest that 'there are a number of key areas where schools [involved in the NHSS] are making improvements at a rate faster than schools nationally.' These areas include pupil behaviour, standards of work, quality of personal, social and health education (PSHE), and the management and support of pupils (Department of Health 2003).

The policy context for partnership between health and education

National policy context

Our research identified the following national policies and mechanisms that may help bring health and education services closer together. Some are more substantial than others, but we have arranged the list in alphabetical order. What it shows is the very considerable volume of initiatives, most of them fairly new, focused on children's health and well-being. Though they are co-ordinated by the Minister of State for Children in the Department for Education and Skills (DfES), it not yet clear what effect they will have – separately or together – on local partnerships between health and education. (Some are dealt with in more detail later – see pp 23–29.)

■ Behaviour improvement programmes The DfES is offering funding to 34 LEAs in support of action to improve the attendance and behaviour of pupils.

■ Children and Families Directorate This is a new directorate within the DfES that brings together children's special education, social services and family law under the new Minister of State for Children.

■ Children's centres These encourage the integration of health and family support services with early-learning and day-care services, and build on local provision in deprived wards. Children's centres provide families with a child aged 0–5 years with early-learning, day-care and family support services, and links with JobCentre Plus.

■ Children's Fund partnership groups These are set up by the local authority and including representatives of health, education and social services, youth offending teams (YOTs) and voluntary sector/community groups (see p 24).

■ Children's National Service Framework (NSF) Key objectives of the NSF are to put children and families at the centre of their care, to develop effective partnership working so that the needs of the child are always considered, and to deliver needs-led services.

The first part of the children's NSF 'standard for hospital services' was launched in April 2003. As we went to press, the rest of the NSF was due to be published later in 2004.

■ Children's trusts Thirty-five 'pathfinder trusts' were launched in 2003 to integrate health, education and social services and other partners within a local authority area (see p 24).

■ Connexions This is a scheme to support young people aged 13–19 in learning and achievement (see p 25).

■ Extended schools These enable the community to use school space and equipment after school hours and at weekends (see p 26).

■ Green Paper on Children at Risk This was launched for public consultation in September 2003. It responds to Lord Laming's inquiry into the death of Victoria Climbié (see p 26).

■ Health Inequalities Programme for Action This guidance from the Department of Health provides a toolkit for local organisations to change the way they deliver services to improve the health of disadvantaged groups. It has a very relevant section on mothers, children and families.

■ Local preventive strategies Since April 2003 local authorities, the health service, the police and key criminal justice agencies have had to agree local preventive strategies for children and young people, to improve services for children at risk. This includes developing effective systems to identify children and families needing support, to exchange information between agencies, and to track progress through referrals.

■ Local strategic partnerships (LSPs) The aim of the LSPs is to bring together at local level the various parts of the public sector, as well as the private, business, community and voluntary sectors, to facilitate mutual support and joint working between initiatives and services.

■ National Healthy Care Standards This programme has designed a national standard for children who are looked after in care. This is to ensure that all care settings provide a healthy, caring environment, quality provision of health assessments, health care and treatment, and promote health and well-being. The National Children's Bureau (NCB) and the Schools and Young People's Health Network (YPHN) at the Health Development Agency are working together to pilot the draft National Healthy Care Standard in four authorities by supporting and developing local partnerships across health services, social services and education, and including youth services, the voluntary sector, Connexions and private providers.

- National Healthy Schools Scheme The three core aims of the Healthy Schools schemes are reducing health inequalities, school improvement and school inclusion (see p 27).

- National School Fruit Scheme This is part of the Government's programme to increase fruit and vegetable consumption (see p 28).

- School Sports Co-ordinator Programme This programme provides funding for staff to be released from their normal duties to fulfil the role of school sports co-ordinator within their school. The main aims of the programme include raising the profile of physical education and sport, raising the levels of achievement in sport, improving health, and tackling disaffection among children and young people.

- Sure Start local programmes These work with all local services, including health visitors, to provide services in addition to those already available to young families (see p 28).

Local policy context

Local authorities are required to extend and strengthen partnership working, to meet the needs of residents more effectively. Under the children's NSF, most of the interventions suggested to promote health and well-being and prevent illness refer to the role of schools (Department of Health 2003). Similar interventions, along with anti-bullying strategies, were identified as priorities by secondary school students taking part the 'Good Place to Learn' survey (Healey 2002).

Our research found that initiatives linking child health and education formed a series of complex activities and partnerships, which varied from one London borough to another. Many initiatives had been developed through children and young people's strategic partnerships, as subsets of LSPs. The following were identified as important contributors to partnership initiatives:
- behaviour and education support teams
- a wide range of statutory and non-statutory providers of mental health services to children and young people
- Connexions
- the Healthy Schools scheme
- housing services
- local authorities
- local education authorities
- Primary care trusts
- pupil referral units
- social services
- Sure Start
- the Police and Youth Justice Board
- youth offending teams.

The research highlighted some of the complex challenges faced by schools that were trying to improve child health and simultaneously improve educational attainment, which varied according to local circumstances. The research illustrated barriers as

well as opportunities, and pointed to what may be required to make progress at the interface between child health and education. These themes are examined in the following sections.

Examples of local approaches to linking child health and education

Barnet

Barnet's Healthy Schools programme is linked through a series of themed modules to the borough's health improvement programme. Module leaders, who support initiatives in schools on substance misuse, food and nutrition, emotional health and well-being, family life and relationships, physical activity and the environment, are jointly funded by the PCT and the LEA. Module leaders go into schools and help to get health promotion included in the curriculum in a co-ordinated way. In primary schools, health promotion is built into maths, science, art and other subjects. In secondary schools it is included predominantly through the PSHE curriculum. The Healthy Schools scheme steering group includes representatives of the education and youth and leisure services, Middlesex University, the children's and young people's service within the PCT, the council's environmental services and two teacher representatives – one from a primary school and one from a secondary school.

Camden

The London Borough of Camden has a Children's and Young People's Strategy Group responsible for co-ordinating Sure Start, local authority services and health services. The group's membership includes the police, social services, the PCT, and education and housing services at director level and the group arose out of their 'best value' review. Camden also has a local health partnership to address health inequalities (and the Healthy Schools co-ordinator is part of its officers group), a teenage pregnancy strategy, a Sure Start programme board for the whole borough, a separate section within the local development plan concerned with children (as all local authorities do), and a professional executive lead for children. Young people and children are a priority strand within its suicide prevention strategy.

Croydon

A young people's development pilot project in Croydon has input from health services. The borough's Healthy Schools work is supported through a local 'think tank' budget provided jointly by the Council and the PCT. Croydon has a Healthy Schools steering group and a children and young people's strategic partnership, which comes under the LSP and looks at children's issues across agencies. It also has a children's trust pathfinder, and a health inequalities joint planning team within the Healthy Croydon Partnership, which takes a strategic overview of health inequalities in relation to schools. Work addressing health improvement in schools is funded through the Healthy Schools co-ordinator and the PCT–council 'think tank' budget. The PCT health inequalities budget has funded specific work in schools – for example, on smoking and teenage pregnancy.

2 Research findings

Barriers

The research aimed to provide an understanding of the barriers and challenges that prevent partnerships from developing and implementing effective strategies linking child health and education. The following key themes emerged from the research:

■ access – getting the relevant partners together

■ engagement – making the partnership work

■ delivery – turning ideas into action.

The three key themes are examined in detail below, followed by some observations on how barriers may affect health inequalities. Italicised quotes are from personal interviews conducted for the research.

Access – getting the relevant partners together

■ 'It's really difficult to get education round the table.' Interviewees reported that representatives of the education sector were rarely present at meetings aimed at promoting shared working with the health sector. This was said to be due to the considerable demands of teaching, which imposed 'huge workloads'. Teachers referred to the added pressures caused by having to follow a closely specified curriculum.

■ The extent to which education was represented in local partnership initiatives varied from one borough to another. For example, there were no representatives from the education sector on health and social care partnerships in Lambeth and Southwark. However, in Lewisham a new forum for headteachers had been set up and some of its members had gone on to join other strategy groups.

■ It was felt that local education authorities (LEAs) did not work together very well, and nor were they used to seeing themselves as contributors to schemes concerning health. Although the NHS was closely linked with social care through joint teams and posts – for example, through work on mental health and elderly people, the health sector did not see LEAs as obvious partners.

■ 'How do you actually engage with schools?' The Department for Education and Skills (DfES) and LEAs often lacked routes into individual schools. There was no regional body to help agencies gain access to schools.

■ 'Who should you contact to make things happen?' Schools and GP surgeries presented similar difficulties for those trying to influence them from outside. Both prized their independence and offered no central point of contact. Just as primary care trusts (PCTs) could control only to a certain extent what GPs would and would not do, so LEAs had less power over schools and less information about what they did, than in the past. 'By and large schools are quite self-contained.' Interviewees and workshop participants both asserted that much depended on the personality

of the headteacher – a factor that hindered universal and consistent access to schools by other agencies.

The fact that PCTs were newly formed and preoccupied with the process of establishing themselves meant that their progress on the child health–education partnership agenda was slower than it might have been for more mature organisations.

Engagement – making the partnership work

The research asked what prevented projects and partnerships from getting off the ground, even where the relevant partners could gain access to one another without too much difficulty. Tackling barriers to learning and the broader determinants of ill-health were seen as pointing to the same policy agenda. Discussions on this generated a series of questions about the respective priorities of health and education services. In particular, was public health more or less important than clinical health services, and was the purpose of education more about developing the whole child or getting exam results?

Interviewees and case study participants said there was a connection between progress on the child health–education partnership agenda, and individuals or local organisations giving priority to public health or to developing the whole child in schools. However, there were barriers to progress, which included different incentive structures and ways of working, and an absence of appropriate bodies to provide co-ordination at regional level.

■ Interviewees reported that many meetings took place where enthusiastic individuals from the health sector talked about schools and health, but no one was there to represent the education sector. This was attributed to the fact that success in education was judged according to other criteria, such as standard attainment test (SATs) results.

■ Different performance-management and planning mechanisms, and different targets and priorities were said to 'drive a wedge through partnerships'. For example, the central government health target of increasing the number of children using mental health services competed with the central government education target of increasing the number of children receiving A–C grades. Interviewees found it difficult to see how a narrow pursuit of these quantitative targets would lend itself to partnership working between health and education. The two sectors appeared to be focused on different outcomes.

■ Interviewees maintained that PCTs and education services were both subject to strong guidance from central government, which meant that time and resources were focused on targets and standards. Well-documented budget deficits in education had led to 'non-essential' services and posts being cut – including those involving partnerships between health and education.

■ The schools in our case studies struggled to establish and maintain a school ethos that supported the development of the whole child. Interviewees stressed that in many London schools, responding to that challenge would mean asserting a radically new culture – and one that would need to be adopted by the whole of the school.

- It was reported that there was not enough dissemination of good practice in schools. Interviewees attributed this to the fact that there was no longer a regional education authority, such as the Inner London Education Authority (ILEA) to co-ordinate such dissemination and promote the benefits of joint working.

- Interviewees and workshop participants suggested that PCTs were not really engaging with Healthy Schools, as they did not believe there was enough evidence to justify the scheme. Also, they asked, how did it meet NHS targets? Was it a priority? What difference would it make if PCTs ignored, for example, the Children's NSF?

- This led interviewees to question whether PCTs would be ready and willing to pick up the costs should central government attempt to mainstream funding for some key child health–education partnership initiatives. For example, would the Department of Health eventually expect PCTs to fund the National Fruit Scheme without increasing its allocation of resources to the trusts? Without such an increase, interviewees felt that the response from the trusts was likely to be that they would not be able to continue the scheme, as it was not a high enough priority.

- Interviewees reported complicated dynamics between different sectors due to different ways of working and power imbalances. For example, it was felt that organisations in the voluntary sector had an explicit agenda about what they were trying to achieve, but could not afford to be represented in partnership groups if this did not bring them any money. This particularly affected black and minority ethnic groups. The presence of the statutory sector in partnership groups, on the other hand, was much larger.

- Statutory bodies were reported to like having authority on partnership boards, but were less innovative than other partners, and liable to try and simply repackage their work to make it appear preventive in order to make use of available funds.

- Local strategic partnerships (LSPs) had varied and inconsistent ways of operating. They were originally intended to have a co-ordinating role, but interviewees were not clear whether they were having the intended effect. Some were broad and unwieldy but representative, others were quite effective but less inclusive, and all were indirectly appointed which meant their degree of accountability varied.

- The different use of language in different sectors was identified as another barrier.

Delivery – turning ideas into action

Interviewees and workshop participants reported that the infrastructures that existed to support health improvement initiatives within schools, such as the National Healthy Schools scheme, did not have sufficient resources. They identified the following barriers at the delivery stage of partnerships and projects:

- A major barrier in London was the difficulty of working across borough boundaries to cater for children who were educated outside the borough in which they lived. PCTs were providing services only for those living in the area for which they were responsible and their funding was ringfenced in accordance with these geographical boundaries.

- Doubts were expressed about the sustainability of many interventions that relied upon specific individuals to drive them forward.

- Workshop participants also reported a lack of funding for these interventions and difficulty in accessing appropriate funds. Dependence on time-limited funding with tight targets was reported to have had a negative effect on staff confidence. Short-term planning could also prevent projects from getting off the ground.

    For example, the Renewal Fund provided one year's funding for a project in Brent on female genital mutilation. It was impossible in the one-year period to build up enough trust and meet the ambitious targets set, so it was decided not to apply for funding for a second year. Those involved maintained that, without any certainty about funding beyond the second year, it would have been insensitive to start developing relationships of trust with the intended beneficiaries, which would have been crucial for the project to succeed.

- Schools were tempted by commercial schemes that might have negative health effects, because they were short of funds. A teacher from one of the case studies explained that their school decided to collect tokens from Walker's crisps for its 'Books for Schools' programme, despite the fact that they were struggling to improve the school canteen and encourage healthy eating. They did this because their literacy budget had been halved and, on balance, they felt that getting books was more important than avoiding crisps.

    Another company, the confectionery firm Cadbury, was offering sports equipment in exchange for vouchers from its chocolate bars as part of a new 'Get Active' campaign. The campaign promised to donate up to £9 million in sports equipment to schools, but lobby groups claim that measures of this kind have contributed to the problem of 31 per cent of children being overweight and 17 per cent being obese.

- Interviewees warned of initiative overload, and the difficulty of preventing clusters of schools, rather than all schools in a borough, from benefiting. Sometimes all of these initiatives took place only in the most deprived wards, which could isolate schools just outside that ward, who were often coping with equally big problems.

- It was reported that project staff had sometimes had to abandon projects because there were no managers to support them, so interviewees felt that the problem was not just a lack of funding, but also a lack of investment in staff at all levels to implement projects and monitor expenditure.

- Many local authorities were so financially depleted that it was possible for someone to be appointed to take charge of cycle and road safety teaching, for example, while there were no staff to send out to schools.

- It was difficult to recruit and retain teachers. Workshop participants put this down to inadequate pay, heavy workloads, poor conditions and pupils' disruptive behaviour.

- Interviewees reported that staff turnover in schools was very high. This meant that training could be wasted and projects rendered unsustainable. For example, one class had nine teachers in a single year. It also meant that teachers had to be especially highly motivated to make time for extra curricular activities or personal, social and health education (PSHE).

■ Workforce problems in the health sector were reported to be worse for mental health services and worse still for child and adolescent mental health services (CAMHS).

■ It was also reported that Sure Start suffered from shortages of speech and language therapists and health visitors.

■ In some boroughs, there were 40 per cent vacancy rates for school nurses, and in many cases one school nurse had to be shared between three schools. Interviewees observed that the role of school nurses was still administrative and functional, with the focus on immunisation.

■ Interviewees and workshop participants identified as a major barrier the fact that teachers were not trained in PSHE or health promotion, despite the fact that many teachers were nervous about teaching such sensitive issues and lacked the necessary skills to teach them. Teachers said that as a consequence, PSHE was a low priority in some schools.

Impact on health inequalities

The following points show how these reported barriers affected the challenge to reduce health inequalities:

■ Interviewees criticised the fact that services were not provided on a universal basis. This meant that a child living in poverty in one borough or ward could receive much poorer services than a child living in poverty in another borough or ward. For example, Sure Start only covered one-third of children in poverty, as it excluded those who did not live in deprived wards.

■ Vulnerable children identified through government schemes such as Quality Protects were seen as problems, so they were not integrated into whole-school policies. The point was made that this could prevent consideration of what refugee children, for example, had to offer in positive terms.

■ It was reported that Healthy Schools schemes sometimes looked for volunteers for school councils, gardening and so on without planning a sensitive and inclusive selection process. Those least engaged would not automatically volunteer. So children with communication problems or young carers who did not have time to go to after-school clubs would find it difficult to take part, unless activities were designed specifically for them.

■ Young refugees had major problems in getting school places. Lambeth, Southwark and Lewisham Health Action Zone's Young Refugee Project was said to have demonstrated how lack of education affected the health of young refugees and asylum-seekers.

■ Interviewees asserted that children who were disengaged from the educational process, such as children in pupil referral units with complex needs, suffered disproportionately from a general lack of resources.

■ There were statutory requirements for services such as dental checks, health checks and immunisation, but these services depended on children being brought in by their parents, and children in most need tended not to turn up, even if they were in school.

Interviewees felt that the problem was very simple in some cases. For example, the checks required parental consent, but often there was a language barrier and yet the letters went out in English.

■ It was reported that statutory authorities did not have sufficient funding to do the necessary follow-up work for services for which they were responsible, such as speech and language therapy. This meant that even if a school had identified an individual child's need, the appropriate action often was not taken by the statutory services.

■ Another broad area of contention identified by the research participants was the difficulty in sharing the costs of children with complex needs (including those concerning health) who lived outside the borough where they went to school.

Opportunities

Education is a fixed point in a child's life, and therefore the interface between child health and education presents a range of opportunities for action on, for example, mental health promotion, knowledge about nutrition, smoking cessation, exercise and sex education or PSHE. Many of the problems in these areas require a combined approach by health and education sectors.

For example, 73 per cent of children and young people with mental health disorders do not have access to specialist health services (Office of National Statistics 1999), which may lead to disruptive or withdrawn behaviour, causing problems for schools. Interviewees felt that the child health and education partnership initiatives represented an exciting agenda as people started to realise that 'working in silos doesn't deliver what people want'.

In this section, we examine the findings from our research on the opportunities currently available to improve the links between child health and education. We look first at factors that were most likely to indicate successful partnerships, and at developments that were considered by our interviewees to be helpful. We then consider the opportunities offered by selected national programmes affecting child health and education. Finally, we draw some conclusions about the significance of these opportunities for health inequalities. Quoted text is from personal interviews conducted for the research.

Success factors

Research participants identified successful partnership initiatives between child health and education as those that:
■ stuck to a very simple formula that could be replicated, such as the National School Fruit Scheme
■ were flexible at the delivery stage
■ used good-quality resources and well-prepared staff
■ recognised the interdependence of health and education targets. For example, education action zones (EAZs), mostly disestablished now, worked on nutrition, exercise and well-being, in order to achieve their education targets. In Lambeth, EAZ

breakfast clubs improved behaviour so much that support assistants were no longer needed in classrooms

■ used existing local authority resources such as leisure services to help schools

■ were initiated and supported by enthusiastic teachers and headteachers who clearly understood their pupils' needs.

Promising developments

The following developments were identified as helpful in the child health and education partnership agenda:

■ The Government was giving a higher priority to health improvement than ever before.

■ Workshop participants welcomed interest from relatively big funders such as the New Opportunities Fund in the interaction between health and education in schools.

■ Interviewees noticed that joint posts had been developed, leading to hybrid roles – for example, non-teaching school assistants trained in nursing. Teenage pregnancy co-ordinator posts, created to help address health inequalities and reduce teenage pregnancies, were thought to have successfully linked Healthy Schools and PCTs in some areas. For example, in Camden, primary care specialists were persuaded to go into schools as part of the PSHE curriculum, and this was very popular with schools.

■ It was reported that Ofsted inspections in schools now included sex and relationships education, and that there was a new Ofsted questionnaire for pupils, designed to get feedback on school performance from the pupils themselves.

■ Some large-scale partnership projects, such as the 'Saving Londoners' Lives' project run by the London Ambulance Service, were highlighted as examples of best practice.

■ Interviewees welcomed the new government guidelines on information, referral and tracking to encourage a more co-ordinated approach between services and overcome professionals' anxieties about data protection and sharing information across sectors.

■ Mental health promotion in schools was reported as an area where useful links were starting to be made. Interviewees and workshop participants hoped that the two new CAMHS regional development worker posts that have been created in London would help forge better links between various agencies.

■ It was reported that most local authorities had begun setting up children's partnerships as sub-sets of LSPs. These structures were welcomed as it was felt that they reflected the 'joined-up' nature of any work required to deal with children and young people, especially vulnerable children:. 'Barriers are being reduced, but there is still a long way to go.'

Opportunities offered by central government initiatives

Interviewees and workshop participants broadly welcomed the initiatives outlined below. Many had reservations about how they would work out in practice, but felt on balance

that they offered more opportunities than barriers for furthering the partnership agenda between child health and education.

Children's Fund

The main aim of the Children's Fund is to reduce poverty. It recognises that families with problems do not respond to the statutory sector, so that it is therefore important to include other partners. The local authority is required to set up partnership groups including health, education and social services, youth offending teams (YOTs) and voluntary sector or community groups. A needs analysis is then conducted for the borough, including health data, which leads to a strategy for working towards the fund's objectives of improving attendance, attainment and health, and reducing crime and anti-social behaviour.

The types of services that the London local authorities have funded include pre-school clubs, after-school activities, domestic violence initiatives, and projects for refugees and asylum-seekers. It was reported that most of these were not working directly on health issues, as the majority of programme managers were not from health backgrounds.

The fund was seen to concern social services first and foremost, then education, and then health, so the health sector was not always very well represented on the boards. However, interviewees also commented that this might be improved by developing output measures that linked more explicitly to health targets, as well as outputs that reflected more obvious education targets, such as reducing truancy and exclusions.

The Children and Young People's Unit (CYPU) has commissioned a large-scale evaluation of the Children's Fund from Birmingham University, which will compare different areas and local case studies. Every local authority is now covered and the funding is secured until 2006.

Children's trusts

Thirty-five 'pathfinder trusts' are developing the 'children's trust' initiative, including eight in London. Many seek to commission and/or provide health, education and social services to all children and young people, aged either 0–19 or 0–24, within a single locality. Children's trusts will include a range of partners, including schools, PCTs, voluntary organisations, YOTs, Connexions, CAMHS, Police, Youth Justice. Some of these partners will be able to pool budgets. All partners will be part of the children's trusts planning process and will share in the focus on outcomes for children, young people and their families. Many bids are based on local preventive strategies, that focus on early intervention and support for children and young people most likely to experience difficulties in later life, with a view to addressing health inequalities.

Children's trusts represent a step beyond informal partnerships and are based on improved governance models, with a view to providing better accountability, shared objectives and planning, a pooled budget, and integrated service commissioning and/or provision. At an operational level there will be common assessments, better information-sharing, joint training, multi-disciplinary teams, and perhaps multi-disciplinary professionals.

Interviewees expressed the view that children's trusts had the potential to integrate planning, commissioning and service delivery for children and their families in all local authority areas. They said they should help ensure that health, education, social services and other local partners were properly 'joined up', and that available funds were directed at securing the best outcomes for children, young people and families.

Proposals from the London pathfinder trusts were said to be quite innovative, with real 'buy-in' from PCTs and senior managers. This, interviewees reported, was partly due to the fact that PCTs and local authorities in London covered the same geographical areas. However, it might be difficult to secure acute sector buy-in to the trusts (for example, from CAMHS) and relationships between LEAs and schools might prove problematic. One barrier particular to London (noted earlier) was the movement of children across boroughs: no joint bids for pathfinder trusts across borough boundaries were submitted by local authorities.

The children's trusts were thought to offer a real opportunity to work holistically. One interviewee commented: 'It does seem that education has bust its guts to improve standards and got to the end of line without doing something different. Also with health.'

In the education sector, narrowing the attainment gap was reported to be the main challenge – one that involved addressing complex barriers to learning. The range of partners engaged in children's trusts might make this easier. It was anticipated that problems might arise around such issues as information-sharing, professional boundaries and different organisational cultures. Interviewees commented on degrees of latent animosity between local authorities, PCTs and NHS trusts, for budgetary, cultural and professional reasons.

There was said to be some nervousness among health sector partners about loss of control and the difficulties of retaining professional accountability when working across sectors. Problems with ringfencing costs were also anticipated. It was felt that success would depend on how the pooled resources were put to use year on year and whether children and families noticed a difference.

Connexions

This is a nationwide government initiative to support the learning and achievement of young people in the 13–19 age group. It involves identifying and removing individuals' learning barriers, which could be connected with, for example, housing or drug use. Approximately £2 million per borough has been allocated for work carried out by personal advisers, whose role is to ensure that the relevant services affecting each young person are not working in isolation. The idea is that advisers assess individual cases, where there may be multiple needs, and help professionals such as teachers liaise with social services and families. However, some headteachers complain about personal advisers taking children out of class.

As part of Connexions, every borough now has a one-stop shop, to provide information and advice on a range of issues. It was reported that in general, these were becoming increasingly multi-agency, but interviewees said that a lot depended on individual managers' backgrounds. For example, the manager in Islington was from a health background, so Connexions recruited personal advisers to deal with health issues such as STDs and teenage pregnancy. Interviewees reported that in some colleges for further education, Connexions had formed strong relationships with health services,

involving regular surgeries and showcase weeks. However, in others, no such relationships had been formed.

Extended schools

The primary objectives of this policy are motivation, attendance, achievements and attitude. The Education Act 2002 gave schools the power to provide a wider range of services, but it is up to schools to decide what they do, in consultation with the community. The idea is to enable the community to use school space and equipment after school hours and at weekends, and for some schools to make space available during school time.

Twenty-five national 'pathfinder' initiatives, including London pathfinders in Newham and Greenwich, have been completed. Initially, the scheme will be focused on areas of disadvantage, but by 2006 all LEAs should be covered. Most of the funding will be spent on co-ordinators and managers, but there will be some full-service extended schools that will receive extra funding. These extended schools will have to provide a range of services, which may include health and social care, study support, parenting support, family learning, childcare, sports and arts facilities and lifelong learning.

Interviewees felt that facilitating links through schools to other services, such as health and social care, should help individuals overcome learning barriers. It was hoped that extended schools would therefore complement the Healthy Schools agenda and encourage more linkage and integration with Sure Start. Interviewees hoped that full-service extended schools would be designed specifically to deal with health issues. They suggested they might provide:

■ breakfast clubs

■ make school nurses available for families

■ offer advice on sexual health, contraception and mental health (including counselling for families)

■ work with older people and between generations

■ provide community kitchens, healthy eating advice and sports.

It was reported that heads of extended schools were convinced that the additional services they provided were having a positive impact on exam results, but this might be difficult to prove as the various contributing factors could not be isolated. Most of the evidence so far about the impact of extended schools was anecdotal, but the forthcoming evaluation of the pathfinder initiatives would help to fill the gap.

Every Child Matters Green Paper

The biggest reorganisation of children's services in England in 30 years was outlined in the Green Paper on children at risk, Every Child Matters, which was launched for public consultation in September 2003. The Green Paper responds to Lord Laming's inquiry into the death of Victoria Climbié. It aims to reduce the number of children who experience educational failure, engage in offending or anti-social behaviour, suffer from ill health, or become teenage parents. Some of its most significant proposals include:

Supporting parents and carers

- creating a 'parenting fund' of £25 million over the next three years to deliver through universal services, such as schools, health and social services and childcare, as well as targeted and specialist support.

Early intervention and effective protection

- improving information-sharing so that basic information follows the child across services
- identifying a lead professional for each child known to more than one specialist agency
- encouraging multi-disciplinary teams based in and around schools and children's centres.

Accountability and integration

- creating a 'director of children's services' post, accountable for local authority education and social services
- identifying a lead council member for children in each local authority
- in the longer term, integrating key services under children's trusts
- establishing a new children's commissioner as an independent champion for children who is accountable to Parliament
- encouraging joined-up working through an integrated inspection framework to assess children's services, overseen by Ofsted
- co-ordinating policies across government through the new Minister of State for Children in the DfES.

Workforce reform

- improving skills and effectiveness of the children's workforce through a 'children's workforce unit', based in the DfES.

The Green Paper does not meet all of the recommendations in Laming's report. For example, it does not propose a national database listing children at risk. Nevertheless, children's charities and campaigners, such as Childline, welcomed the paper. The main proviso related to funding. The proposals outlined will need resources to make them work. This is necessary to ensure that young people do not become victims of a 'postcode lottery' in terms of provision at the expense of local flexibility.

National Healthy Schools Scheme

The three core aims of Healthy Schools are reducing health inequalities, school improvement and school inclusion (that is, helping schools to become more socially inclusive). Schools volunteer to get involved, and there are three levels at which they can do so. At least 51 per cent of schools (a mix of primary, secondary and special schools) are currently participating. Local Healthy Schools programmes have been

set new targets to work towards recruiting every school in the LEA. One interviewee commented: 'Ultimately we should be doing ourselves out of a job.'

The scheme is run by local co-ordinators. Some are from the health sector, some from education and some are jointly employed and jointly managed. The way co-ordinators are funded varies, but the Government intends to mainstream the funding into local budgets to put an end to reliance on central government money.

Interviewees felt that the Healthy Schools scheme had provided some examples of good work and clearly understood the child health and education partnership agenda. Some schools had been put off by its bureaucratic hurdles, while other schools, including one of the schools in the case studies, had been inspired by the scheme and relied upon it for support. In general, it was felt to be 'just scratching the surface – lots more needs to be done before all schools embrace it.' For example, local implementation of the scheme varied widely.

The involvement of the health and education sectors at senior level was regarded as crucial. In the case of health, this was usually the director of public health. In education, either the head of inclusion or head of improvement was involved. It was reported that if the senior education lead was in charge of inclusion rather than improvement, a broader health inequalities agenda was more likely to be embraced.

A national evaluation of the National Healthy Schools scheme was due as we went to press, in early 2004. Interviewees and workshop participants anticipated that it would reinforce anecdotal evidence that Healthy Schools work could help schools with special problems to achieve their education targets.

National School Fruit Scheme

This scheme aims to increase children's consumption of fresh fruit and vegetables. All 4–6 year olds in participating schools receive one free piece of fruit every day. It has been implemented in 85 per cent of primary schools in London.

Interviewees felt the scheme had been a success because it was a simple logistical exercise that schools could adapt in different ways, and it was not foisted upon them. The scheme did not rely solely on teachers, but was flexible enough to involve caretakers, nursery nurses or kitchen staff. Interviewees and workshop participants said the scheme was most successful in the schools that had extended it by introducing fruit tuck shops and access to drinking water. Teachers were reported to have recognised a beneficial impact on concentration levels as a result of the scheme and local people also recognised its value. The Department of Health was credited for having briefed project workers thoroughly, presenting the scheme to schools with clear explanations, and answering all questions. Interviewees felt that it had had a significant impact, even if only on the age group entitled to the free fruit.

Sure Start

Local Sure Start programmes have health targets. These include speech and language therapy, reducing smoking among mothers, promoting breast-feeding, preventing accidents, improving post-natal support to reduce depression, offering baby massage and community mothering. The programmes work with health visitors to provide these

services in addition to those already available to young families. The Sure Start programme is offered to the most deprived wards. It tries to avoid stigmatisation by being open to everybody, but also by differentiating between people according to their needs. All families are visited, and drop-in services such as playgroups offered. In addition, Sure Start uses local community groups for outreach work, to help identify people with special needs.

Interviewees welcomed many aspects of the Sure Start scheme. For example, it was reported that the scale of the London programmes, covering small geographical areas of 2–3 square miles, had enabled good links to develop between various sectors and the community. Interviewees also found it encouraging that Sure Start workers had been trained in mental health awareness. They welcomed Department of Health targets for CAMHS to increase by 10 per cent year on year, but felt that it was important for organisations to develop their own capacity to respond appropriately to mental health issues as well.

The evidence provided by Sure Start case studies suggest that the scheme is popular, and parents feel it is making a difference locally by raising levels of self-esteem and confidence, and by improving access to services for themselves and their children. Many programmes have now been running for three years and interviewees reported that PCTs and local authorities were starting to spread new ways of working beyond Sure Start.

Impact on health inequalities

The following points raised during the research highlight some of the opportunities available to reduce health inequalities through the child health and education partnership agenda:

■ It was recognised that schools provided a 'captive audience' in deprived areas and access to a range of groups from different socio-economic, ethnic and cultural backgrounds. Interviewees pointed out that interventions in schools could help meet NHS health inequalities targets on teenage pregnancy, smoking, cancer and coronary heart disease, and that such interventions could be non-stigmatising if delivered to the whole school. It was therefore suggested that schools should be linked into other sources of funding targeted at health inequalities – for example, PCT funding – to enable more projects to be set up to link public health professionals with schools and out-of-school provision for children and young people.

■ Interviewees highlighted the role of extended schools, in particular for their potential to decrease health inequalities through initiatives such as on-site access to clinics.

■ Participants from all parts of the research stressed that if partnerships included social services as well as health and education, initiatives to address health inequalities had a better chance of succeeding for vulnerable groups of children and young people.

■ It was suggested that certain groups of children and young people could provide useful indicators for measuring the interdependence of health and education. Obvious examples included teenage parents and their children, and looked-after children who were currently under-achieving educationally and also experiencing health problems.

■ During the research, interviewees kept returning to the controversial debate about whether additional 'health-improving' functions should be extras or integral to children's education. Deptford Green School in Lewisham was cited as an example of a school that felt its 'health-improving' functions were integral. This school's citizenship department was bigger than any other department. Deptford Green recognised the value of school-based health and arts activities in helping to educate challenging children with complex needs.

Moving forward

Interviewees recognised the need for different sectors to work together productively and to avoid meeting just for meeting's sake. They felt that effective partnership working required the health and education sectors to understand each other's different structures and protocols. Those working both in public health teams and in the education sector saw the factors contributing to children's future well-being in social rather than medical terms – an important shared perspective. For example, they both recognised the importance of issues such as poverty and housing, and they both tended towards broader, holistic models of health, as opposed to traditional models that did not take into account the effects of physical and emotional environments on health and well-being.

The following themes emerged from the research on ways to overcome some of the barriers that had been identified and to improve the links between child health and education:

■ leadership
■ creating the right conditions
■ learning
■ acting on the learning.

Leadership

■ Interviewees and workshop participants felt that a cultural shift was required to move forward on the child health and education partnership agenda, and that this would require local champions. For example, managers from the health sector in charge of commissioning services could be more proactive in suggesting where links could be made. It was recognised that such changes would have to be adopted at a strategic level so that there was not too much reliance on individuals.

■ It was reported that in some areas there were quite harmonious relations between the health authority and the LEA on most issues. The political context and any history of partnership working were identified as contributing factors. Successful partnership working was felt to depend on 'years of hard work'.

■ Interviewees also stressed that the impetus must come 'from the top'. Where the chief executive and directors supported partnership working, officers could persuade people to work together.

Creating the right conditions for successful partnerships

■ Interviewees said that it was important that local strategic partnerships involved education representatives at the highest level. It was suggested that the reason senior education representatives had not attended in the past was because LSPs did not always reflect the education sector's concerns about school attendance and achievement, but focusing instead on those of social services, such as inclusion issues and family support. However, it was reported that some social services departments had worked very hard to develop relations and create the right conditions for education representatives to join LSPs. This involved acknowledging the differences in working cultures and objectives between the sectors.

■ Suggestions on how to encourage education partners to attend meetings included holding meetings in schools, and finding heads and deputy heads who were prepared to act as local champions.

■ It was recognised that changes in party leadership within a council could prove very disruptive. They stressed the importance of keeping all partners involved and committed regardless of any changes.

■ The opportunity for health professionals to make links with youth and leisure facilities as well as with schools was mentioned as important, to avoid too much reliance on just one avenue of access or one type of approach: 'A multi-agency approach is needed, but also a multi-disciplinary approach and a multi-programme approach.'

■ Workshop participants suggested that outside agencies create standalone projects for keen teachers to 'bite off in bits', and others to build on later. For example, the National Fruit Scheme could be extended through fruit tuck shops and healthier school meals. It was felt that outside agents should be careful when building relationships with teachers not to make them feel guilty, and should plan sensitively and appreciate teachers' hectic timetables, as 'teachers are usually the most positive people'.

■ Interviewees said that the most effective strategy for outside agencies working with schools might be to 'sell' them one or two ideas that fit with education priorities – for example, the links between eating and concentration – and work out the development stage on their behalf, instead of expecting schools to start from scratch on every issue.

■ It was asserted that the potential benefits of joint working needed to be advertised for both sectors from the beginning to ensure equal and committed partnerships. The children's NSF was highlighted as an example of a health-driven policy. It appeared to prescribe challenges for education rather than challenges for health from an educational perspective. Interviewees suggested that this could just be a question of presentation, but that in any event, the NSF should focus on how health can help the education and social care sectors to deliver their own targets as well:

All partners must feel equal. We all have separate imperatives – often government-driven – with many overlaps but some individual priorities that we cannot escape. It is not about what the rest of us contribute to the health agenda, it is about what we can each contribute to the children–young people's agenda.

Learning

■ Interviewees and workshop participants valued the involvement of the voluntary sector, and felt that it should be given more recognition in partnerships.

■ The importance of listening to children and young people was emphasised. The empowerment of children to make their own decisions was recognised as a legitimate goal, both for the health and the education sectors, and it was hoped that citizenship lessons would help achieve this.

■ It was suggested that primary care professionals should go into schools more often and try to overcome some of the barriers, such as sensitivity or embarrassment, that prevented teenagers from getting help from GPs. One interviewee said that primary care professionals needed to 'get out of their bunkers and listen to children and parents', and that it is important to remember that children 'are not mini adults'.

■ Interviewees stressed that more information was needed on how health and educational improvements were linked and on the mutual benefits of work at the interface between health and education. A campaign was suggested to publicise case studies that demonstrated links between better health and an improvement in educational achievement. Many professionals now recognised that health initiatives such as breakfast clubs could improve educational attainment, so that it would be 'working with the grain'. However, the health sector needed persuading about the contribution that education could make to health and well-being.

- Specifically, interviewees called for more demonstration projects to illustrate the practical value to schools of health improvement initiatives.

- It was recognised that partners might be meeting regularly but continuing to make assumptions about each other's ways of working, and that this could create long-term negative effects within the partnership. It was necessary for partners from different sectors to spend time together in order to test their shared understanding. Camden Council was highlighted as an example of this approach. Its Beacon status (government 'Beacon' awards identify local authorities to act as centres of excellence) provided an opportunity to bring key players from the health and education sectors together for 24 hours so that they had time to discuss important issues.

- An 'idiot's guide' to working with the different sectors was suggested to overcome a general lack of understanding about the opportunities for linking programmes. It was felt that the current support and advice on these issues was not sufficiently practical.

- Joint training of professionals was valued as one important way to develop common ways of working and protocols.

Acting on the learning

- The Healthy Schools scheme was seen as important. Interviewees and workshop participants felt that this should be given priority through local educational delivery plans and the local delivery plans or health improvement and modernisation plans (HIMPs) of PCTs. It was suggested that advocates, such as Healthy Schools co-ordinators, should be made familiar with such key documents in order to influence partners. Interviewees also felt that teenage pregnancy boards, drug action teams, and emerging children's planning fora linked to LSPs should include representatives of the Healthy Schools scheme.

- Interviewees and workshop participants maintained that shared targets should be agreed between the health and education sectors. For example, when Professor Tim Brighouse was chief education officer in Birmingham, he took on pre-natal health as a target and the director of public health took on early literacy rates.

- Innovative investment in mental health and emotional well-being was highlighted as one area with considerable potential for achievement on the child health and education partnership agenda. Interviewees cited clear links between mental health and the education sector's learning agenda, as improved mental health was known to increase an individual's capacity for learning. PCTs have committed themselves in their local delivery plans to increasing investment in mental health between 2003 and 2006, and to providing a comprehensive service. In order to do this, interviewees suggested, they might have to look beyond traditional NHS providers and models.

- Interviewees suggested that the school nurse service should be adequately resourced so that it could broaden its scope beyond immunisation. They felt that this would be welcomed by schools, and recognised that where there was an exceptionally dynamic school nurse, a great deal could be achieved. For example, in Lambeth a school nurse was in charge of reviewing the roles of all the school nurses in the borough.

- The role of the LEA was seen as important. Interviewees identified policies that could work well at this level, such as guidelines or rules on the nutritional composition of school meals.

Key areas

In A Good Place to Learn?, a research summary published by the King's Fund, young people identified key concerns in the three areas of:

- food and nutrition
- bullying and emotional well-being
- physical fitness.

These themes also emerged in the present research, and the findings are set out below to demonstrate the barriers identified by the research participants, but also the related opportunities that they identified and their suggestions for moving forward in these areas.

Food and nutrition

Vision	Barriers	Opportunities	Moving forward
Free, good-quality and healthy school dinners in a nice, clean venue	Current nutritional standards for schools merely require some representation from all the major food groups.

The presence of fizzy drinks and sweets dispensers and the promotion of unhealthy snacks by commercial sponsors in schools create very mixed messages about healthy eating for children. | Food policy and implementation: Ofsted inspections can provide an incentive to put food policy on the agenda, with initiatives such as breakfast clubs, catering, curriculum and healthy tuck shops, as it affects classroom behaviour.

Some 95% of state primary schools in London are on the National School Fruit Scheme. This could work as a lever for more Healthy Schools work as the nutrition agenda draws in schools that are not part of the National Healthy Schools Scheme (NHSS). For example, they may be amenable to setting up healthy tuck shops, growing projects, and looking at their policies on vending machines. | A holistic approach to whole-school nutrition should be adopted, as outlined by the School Nutrition Action Groups of the Health Education Trust.

There should be access to clean drinking water for all children

Healthy eating workshops for parents and staff should be offered, and children taught practical cooking skills.

Reward schemes could be used for young people who choose healthy meals instead of going to the chip shop.

The message should be reinforced through the curriculum – for example, plotting healthy eating |

		Nutritional standards for schools could be more demanding and insist upon healthy, good quality food.	patterns in design and technology or maths exercises that would be very easy to introduce.

Bullying and emotional well-being

Remember that kid

Remember that kid that sat on his own
Remember the kid who you thought was a geek
Remember the kid who everyone hated
You hated him, why?

Remember the kid who you punched and kicked
Remember the kid you gave a black eye
Remember the kid who ran home crying
You hated him, why? Because he was different.

Remember the kid who prayed every night
Remember the kid who was left in the gutter
Remember the kid who prayed for the laughing to stop
Well, he remembers you.

He remembers every blow, every kick
He remembers every insult, every evil eye.
He remembers the running, the hiding
He remembers the pain, physical and mental.

Have you ever felt that God hates you
Have you ever felt the wack of your head against the wall
Have you ever felt anything back then did,
Well I have.

by Lee Crucefix, Year 8

Vision	Barriers	Opportunities	Moving forward
Socially inclusive schools that provide emotional support and where bullying really is not tolerated	Many schools are understaffed and under-resourced. Teachers that are themselves overworked and stressed are having to deal with serious mental health problems (there may be as many as one-in-five children who need extra attention).

Interviewees identified the lack of training for teachers on child development as 'an extraordinary omission'.

PCTs do not seem to want to get involved with voluntary providers in mental health intervention as the PCTs are focused on the areas in which they are performance-managed – for example, problems with current NHS providers and conditions such as chronic heart disease and diabetes.

Adopting a genuinely whole-school approach is a particularly complex task in large secondary schools. Yet without it, some staff will effectively undo what others achieve. | The requirement for PCTs to increase CAMHS investment in 2003/06 may encourage alternative provision

Some teachers have a personal interest in the issues, but the interest needs to be more systemic.

The new Connexions one-stop shops offer information on lots of things, including mental health. Voluntary sector organisations and mental health charities have produced some very useful teaching resources.

There are a growing number of schools employing school counsellors or working with voluntary sector providers in mental health intervention, such as The Place2Be. | Whole-school policies on anti-bullying need to be adopted and strictly adhered to.

Universal access to school counsellors and non-stigmatising services that are not dependent on location or funding should be available.

Mental health interventions in schools should be used to increase awareness of mental health issues and problem-solving techniques taught through role play.

Schools need staff and pupil awareness training in diversity, and minority and vulnerable group issues. This training should be conducted by external providers. |

Physical fitness

Vision	Barriers	Opportunities	Moving forward
Resources for physical activity and recognition of a broader range of activities (not prescriptive).	There is currently limited time on the curriculum for sport and fitness. Many schools have sold their playing fields.	The School Sports Co-ordinator programme may provide opportunities for sport and fitness to move up the agenda in schools. New government targets aim to increase the proportion of school children spending a minimum of two hours a week on 'high quality' physical education and sport, from 25 per cent in 2002 to 75 per cent by 2006.	More time and resources should be dedicated to physical activity. However, schools also need to make exercise more attractive – especially to girls. Schools should pool their resources so that green space is shared.

Recommendations

The following recommendations are drawn from the research and focus on what would assist the child health and education partnership agenda – first, in terms of government policy, and second, in terms of school policy.

Policy recommendations

There are huge numbers of initiatives and requirements emanating from central government. Behaviour improvement programmes are the latest. They can help partnership working in some cases, as they require people to work together but they are very demanding and can push and pull in contradictory directions. For example, the policy on getting tough on youth crime may conflict with the social inclusion and social care agenda. However, it should be possible to achieve a greater alignment of targets – targets that complement rather than work against each other, whatever their intrinsic differences. The NSF or a cross-cutting review of children in need could help align targets, but guidance on how this could be achieved and performance-managed would be required if such a review were to be carried out on the ground.

The Government's approach could be more integrated. Family support schemes, children's centres and Sure Start programmes have all developed separately, though there is the potential to review these initiatives in the light of overarching aims and objectives for children and their families, and to draw them together within a children's trust. Government departments could also work more closely together, especially to share and disseminate information. This has been demonstrated recently by the new

Children and Families Directorate within DfES, which brings together children's special education, social services, and family law under the new Minister of State for Children. Cross targets should also be developed. In particular, Ofsted inspections of schools should include health targets.

Joint training is needed to instil core values and core competencies in all sectors, including police, teachers, social services, doctors and nurses. This would require resources and careful planning, but the first step for the health sector is to understand how education services are managed, and vice versa. Joint training should also aim to overcome barriers arising from hierarchies, professional jealousies and so on, as emotional issues such as these are often overlooked. Transitional funding is needed to drive change, for example, to release people from their jobs so they can develop new ways of working, particularly to facilitate the voluntary sector's involvement and to support teachers.

To prevent a huge variation in engagement with this agenda across boroughs, external facilitators could help local authorities, where attitudes or practice have become 'stuck', to deliver schemes that have been successfully piloted elsewhere. More investment in Healthy Schools is needed. Current central government funding does not cover the wages of one co-ordinator for each borough, and does not provide administrative support for them.

There is a definite need for initial teacher training to address child health and well-being as a core subject rather than as an optional component. Teachers also need PSHE training — they are currently struggling without it. It would be helpful for teachers if one central website such as the DfES website, and/or that of the Health Development Agency, co-ordinated all available resources and examples of what works in practice. There should also be a document that makes it clear how health issues can be linked to the curriculum: 'Teachers are wary of taking on something new unless they can see a direct link.' There needs to be a stronger access point for outside agencies into schools and a channel through which information could be fed to schools.

Recommendations for schools

The following recommendations concentrate on what needs to be done within schools to address the child health and education partnership agenda effectively.

The school curriculum

- PSHE should not be the only subject in which health topics are taught. More effort could be made to bring health issues into the curriculum, especially through biology and citizenship. This might just involve some forward planning to recognise opportunities to link subjects.

- Bullying is a curriculum topic in Year 11 humanities 'conflict and co-operation'. This should also be taught at a younger age.

- Health education should be repeated for different age groups, responding to the changing conditions that young people experience.

■ The role of outside agencies in delivering projects and the expertise of the voluntary sector are particularly useful where teachers are not well equipped to deal with such issues as sex education, which could also be taught through theatre and in out-of-school settings.

Supporting teachers

■ Teachers must be given release time so they can engage in health-related work.

■ Teachers' health and mental health needs should be addressed and more support given to ensure an adequate work–life balance for teachers.

Listening to students

■ Young people need to be consulted at all levels in a sustained way – for example, at school, local and national levels. Listening to children may require a profound culture change.

■ Peer-led initiatives deliver at least as good outcomes as other initiatives and moreover have huge benefits for those taking part. They need facilitators who let children take control and who proactively engage vulnerable and excluded children.

■ School councils that function effectively and are 'not just rubber stamping', alongside peer mediation and conflict resolution, could have a significant and positive effect on children's health and well-being.

■ Systems that use secret voting based on an agreed set of desired personal qualities could prevent school council elections from being seen as 'popularity contests'.

Involving the whole school

■ It is very important that senior management support the work.

■ However, in order for the work to be sustained, the attitudes of other members of staff are crucial. Projects rarely work where teachers are just told to do something by the headteacher.

■ All staff within a school should be consistent in their behaviour and develop common approaches to discipline that reinforce rather than erode children's self-esteem. This should include 'dinner ladies' and support staff as much as teachers themselves.

Links with health professionals

■ One-stop shops, based on school sites, offering information and advice on a range of issues, would link health professionals with children and their families.

■ Schools may benefit from developing personal links with service-providers. For example, Kingsbury High School had an hour-long meeting with the local CAMHS and the two now work much more effectively together.

Links with the community

■ Participation may be more effective than leaflets as a way of promoting health and well-being, and feeling engaged in a community can have a protective effect in terms of mental health.

■ Schools need to be more open and welcoming to parents and the wider community. Inviting community groups to the school and vice versa can help facilitate this.

■ It is important to offer parents choices in school projects. Events-based activities, for example making fruit smoothies, sometimes work better than a more challenging approach.

■ Schools could benefit from working more closely with each other and sharing resources.

■ The environmental health impact of schools could be given more attention – for example, issues such as adequate provision of cycle storage and green spaces, and recycling schemes.

Conclusions

Developing and implementing effective strategies at the interface between child health and education is a complex task. Education and health are most clearly segregated at the point where the pressure to achieve educational attainment targets is all-consuming and where PCTs are completely caught up with improving health services. However, it is widely recognised that public health, including health promotion activities and preventive strategies, fits closely with the school inclusion agenda and with efforts to overcome barriers to learning. So the potential for linking child health and education is greatest where health promotion and school inclusion are local priorities.

The present research found that partnership working is viewed as necessary. However, boroughs are prevented from reaching their full potential in this respect due to practical barriers. These include budget cuts, a lack of joint funding, and workforce problems regarding, for example, recruitment, retention and management capacity. Local mechanisms that would enable a range of partners to become involved vary considerably. Some boroughs lack the necessary points of access between the education and health sectors and, in general, the absence of a regional layer of support is felt.

There are many examples of positive practice from which others could learn. Yet these are often fragmented across a range of initiatives, and rely on enthusiastic local champions to drive them forward. Boroughs would benefit from greater dissemination of examples of good practice and more resources to invest in developing shared aims and objectives between health and education partners.

It was recognised that the opportunities available for improving health within schools are greater than ever before. However, because of the independence of schools, headteachers can 'make or break' the opportunities for individual schools, and there is a great amount of variation between schools in terms of their engagement with this agenda.

Despite huge teacher workloads and pressures, there are numerous examples of good practice within schools, often involving outside agencies and the voluntary sector. Healthy Schools is a key mechanism for some, while other schools prefer to work independently and often focus on one or two priority areas. Many of the schools that are working to improve health are convinced that it helps them to meet their education targets, but they do not have time to evaluate their work.

It was felt that health could be given a more mainstream position through creative links with the curriculum. Guidance on this and on promoting good practice are key opportunities for moving forward, as is teacher training in PSHE, citizenship and health promotion, release time for staff to develop partnerships with external organisations, and a culture change towards listening to children and young people themselves.

3 Case study A: The Link – Peer listening and anti-bullying project

Canons High School, London Borough of Harrow
Contact: Ms Kala Nair, Peer Listening and Anti-Bullying Co-ordinator

The school

> Canons High School is a mixed community comprehensive school in Harrow with a roll of 702 pupils aged 12–16, 406 boys and 296 girls. There is a significant level of pupil mobility... About 14% of the pupils are refugees, including asylum seekers; the predominant country of origin is Afghanistan. The school population reflects the rich diversity of local communities and about 85% of the pupils are from ethnic minority backgrounds. There are more than 40 home languages, the main ones being Punjabi, Somali, Gujarati and Farsi. 64% of the pupils have English as an additional language... Almost 30% of the pupils are on the special educational needs register, including 26 pupils with statements. Both figures are above the national average. Many pupils come from relatively disadvantaged homes. 26% of the pupils are eligible for free school meals, which is above the national average. The attainment on entry is below average and pupils' English language skills are well below average...Pupils make good progress and perform very well in the GCSE examinations compared to pupils in similar schools.
> (Ofsted Inspection 2002)

■ The school does not qualify for inner London funding such as Excellence in Cities. However, 30 per cent of its students have free school meals. A neighbouring school in Brent within the inner London funding zone has only 10 per cent of children eligible for free school meals.

■ Canons has not gone for Healthy Schools or Investors in People status. It would like to, but it does not regard these schemes as sufficiently high priority in the best interests of its students. Independently, it has managed to improve the canteen and the school environment (regarded as a priority by the school council) to run the peer listening scheme and to employ a part-time school counsellor.

■ As regards links with local health services, it has put in a school-cluster-based Private Finance Initiative (PFI) bid to get a 'one-stop shop', to provide information on a range of issues, and primary care services on site. The bid was submitted through the local authority. This initiative is supported by 'People First', which is directed by Harrow's ex-director of education. The headteacher says the main barrier is the problem of getting people together. The school wants to address children's needs with a co-ordinated approach but this is not happening at the moment. One of the main frustrations is too many fragmented services. Connexions was set up to deal with this but the school feels it understands its children's needs and does not need another layer of 'experts'. An extra member of staff would enable it to build contacts with external agencies and better connect the school to children's services.

Background to the scheme

The Link was set up in 1999 by an anti-bullying working party, led by Kala Nair. By national standards, the scheme is considered very progressive. It has been reported in 16 articles, including in local papers, London Borough of Harrow special publications, Relate in Schools, the peer support Forum's online magazine, Relate News, and the school's own publications. The scheme was positively accredited in a Mental Health Foundation Study for the DfES. Every year, exceptional peer listeners have been awarded the Princess Diana Award, and this year the school was awarded the Princess Diana Silver Award for outstanding work.

The scheme was prompted by the presence of the offices of counselling charity Relate in the local area. Relate contacted local schools to see if any of them were interested in training. It now provides the training for The Link for approximately £2,000 a year, so the scheme is not very expensive to run, but pupils and staff have to go out of school for a couple of days each year to attend the training course. The school also had to provide a base for the peer listeners to meet in, so a room in the student support centre was specially decorated for the purpose, and is now a dual-use room.

The funding originally came out of the staff training budget, and subsequently the scheme, together with a part-time school counsellor, was funded for two years with inclusion project money, obtained through a local authority bid, from the European Social Fund. Now the school budget is having to cover the cost, which the headteacher regards as something of a problem. However, the school hopes that it will soon be able to use a central government grant from the Standards Fund for the project and the counsellor.

Aims

■   to help address and reduce bullying in the school
■   to create a good ethos in the school
■   to develop individuals as citizens
■   to allow students to be successful in a range of different ways.

'Schools are about much more than passing exams.'
(Bruce Goddard, Headteacher)

How the scheme works

Peer listeners are a group of specially trained upper-school students who form The Link. They operate a daily drop-in service, run by students for students, at lunchtime to discuss any worries confidentially. In exceptional circumstances when a student's health or safety is at risk, the peer listener will discuss the case with their staff mentor in a de-briefing session, and the staff mentor will pursue the matter further.

Students are recruited to be peer listeners in Year 10, through an application form. Every student who applies is interviewed by older, trained peer listeners. Successful candidates have to show maturity, empathy and an ability to listen and be committed to the ethos of anti-bullying. In a year group of about 165 students, up to 100 take

application forms and 60 actually apply. A maximum of 18 can be chosen for the course. To date, 62 students and 16 members of staff have received the three-day training, which is provided by Relate.

The Link team also conducts other anti-bullying and student support activities. These include:

- several assemblies
- Personal, Social, Health and Citizenship Education (PSHCE) workshops
- linking with the English department to produce an annual poetry anthology written by Year 8 students, called Listen Up!, about feelings, concerns and hopes
- linking with the art department to run an annual poster contest
- linking with PSHCE and the drama department to bring in an anti-bullying performance called Silent Scream for Years 8 and 9 and some students from Year 10.

Peer listeners also mentor tutor groups and individuals. They produce materials to advertise the service (posters, a video and bookmarks, and letters to parents). They organised and hosted the first-ever peer listening conference, and ran an assertiveness workshop at the third conference in 2003. They also took part in a recent national Childline conference.

The Link has just launched a service called 'The Box', where any student can anonymously report a bullying incident. Every report will be investigated by the peer listening and anti-bullying co-ordinator, who has outlined a staff protocol based on existing practice for bullying incidents. Consultation on the protocol is currently taking place. Named bullies will be spoken to by the peer listening and anti-bullying co-ordinator or another more suitable member of staff. The student will be told about how and why bullying is not allowed in school but will also be told of help available to change their behaviour. They will then be closely watched. False naming of bullies will be treated as a bullying incident itself, and will therefore be investigated.

Peer listeners are sometimes approached by teachers to talk to a class about bullying in general, as a way of addressing an incident without stigma. The Link team has produced a letter to parents to be printed as part of the student planner, to give information about the support available for their children both in school and elsewhere.

Achievements

In March 2003, the peer listening and anti-bullying co-ordinator analysed the confidential records of the daily lunchtime drop-in service. Since it started in January 2000, 60 students had used the service (approximately seven per term). Figures from September 2002 to March 2003 show that the number may be rising. This is good in comparison with other schools that have asked for advice on how to get more people using their own peer listening schemes. The service was used 56 per cent by girls and 44 per cent by boys, contradicting the expectation that very few – if any – boys would use it. All years used the service, but mostly Year 8 students (in their first year at the school), who represented 56 per cent of the total.

Students came to talk about a range of issues – friendships, family problems, physical bullying, name-calling and loneliness. Confidentiality needed to be broken when a student threatened suicide and reported physical abuse from home. One student

reported sexual harassment and another said they had been threatened with physical violence. The feedback from those who had used the service was generally very positive.

In April 2003, The Link conducted a bullying survey with Years 8 and 9. In it, bullying was defined as an act by a group or individual using power and causing upset or distress to another. Of the students surveyed, 85 per cent felt that bullying was a problem and 98 per cent thought that The Link was a good idea. Bullying was more prevalent in Year 8 than in Year 9. Among Year 8 students, 60 per cent had witnessed bullying, 45 per cent had been victims of bullying and 15 per cent had bullied someone; 82 per cent said they would use The Box, and 34 per cent said they would talk to a peer listener. Among Year 9 students, 55 per cent had witnessed bullying, but only 15 per cent had been victims of bullying and 11 per cent had bullied someone. Over half (54 per cent) of this year group said they would use The Box, and 25 per cent said they would talk to a peer listener. The most popular alternative choice of people to talk to, for both year groups, was friends or family. Teachers were also ranked highly for Year 8 students but ranked much lower for those in Year 9.

The headteacher is convinced that the scheme has improved behaviour by providing role models and creating a caring school environment and ethos.

Children with special needs

The school counsellor was felt to represent the extreme end of what peer listening was trying to achieve. Several children at the school had been diagnosed with psychiatric illness, which had contributed to their challenging behaviour. CAMHS referrals in the area take months, and require parents to become involved and attend therapy sessions. In the case of one family where children had been physically and sexually abused, a psychiatrist had to make a court order to force the parents to attend sessions, but they still have not been seen.

The school felt that having a school counsellor would enable vulnerable children to develop a strategy for coping. Some of the students have mental health problems that have a huge impact on their behaviour. For example, a child was very close to being excluded before staff realised his father had died. Other students have had to cope with a murder in the family and will not acknowledge what has happened.

The special educational needs (SEN) co-ordinator gave the school counsellor a list of children in need when she started work at the school, and the counsellor left discreet notes for these children in the class register. They were asked to attend a counselling session at least once, but many chose to attend sessions regularly. For some, counselling has really helped. These children have left notes for the counsellor to show their appreciation. The counsellor has dealt with issues of child abuse, foster care, stress, anger problems and bullying. The benefits for the school have included taking pressure off the teachers and allowing children to offload their problems so that they can concentrate at school.

Plans for the future

The peer listening and anti-bullying co-ordinator believes that the key to success is to provide a diverse range of high-quality, informative activities, and has identified the following actions to move the scheme forward:

- Conduct a short course on anti-bullying and assertiveness for interested Year 10s who do not make it on to the final peer listening shortlist, then give them visual recognition (for example, a badge) for their part in maintaining the anti-bullying ethos of the school.

- Develop links with humanities as another curriculum area where links could made, for example, in their work on bullying.

- Peer listeners conduct an assertiveness workshop for students on the Year 7 induction day.

- Develop the use of badges to promote the anti-bullying ethos and give a sense of status to those students involved.

- Approve a staff protocol for dealing with bullying incidents that reinforces practice.

- Produce a confidential register of those who have bullied and of victims, to help staff combat bullying.

- Check the anti-bullying policy against government guidelines issued in 2003.

Learning points

Studies suggest that peer listening programmes can potentially benefit the users, the school internally through an ethos of care, the school externally through an improvement in its reputation, and peer supporters through an increase in their self-confidence and achievements. Ofsted has linked peer support programmes in schools with high standards in those schools. Studies identify teacher and staff support as crucial because staff attitudes are communicated to the students.

Reasons for success

- It is supported by the headteacher, who went on the training course himself.

- The peer listeners de-stigmatise the scheme by mentoring during registration, building friendships and trust. Every class is allocated a link supporter to help do this.

- It is well publicised – 80 per cent of the students knew about it.

- Its aims are crucially strengthened through the provision of a school counsellor three mornings a week to see students with perhaps more serious problems, who are either self-referred or referred by teachers.

■ The school counsellor is highly qualified.

■ The school has addressed cultural barriers that prevent students from using counselling or peer support, through personal introductions and assemblies.

■ Peer listeners are taught to be discreet around the school and clear about boundaries.

■ The room that they use is very private – they have moved from their earlier venue to a room on a corridor that is used for other purposes, so that children who are seen in that part of the school will not attract suspicion from others.

■ Peer listeners feel respected in the school.

■ Staff are trained, as well as students. This improves student and staff relations and helps staff professionally.

Possible improvements

■ Better publicity is needed – approximately 20 per cent of students did not know what The Link was and 30 per cent did not know what The Box was, despite continuous efforts to advertise the service, so visibility is clearly an important issue with peer listening and student support schemes. However, the peer listeners felt that the was improving, and much better than when the scheme was first set up.

■ The peer listeners would like to develop the scheme so that more people could train. More funding would be needed to do this, but the students felt that the training is important as it teaches life skills, such as assertiveness and communication, which the whole school would benefit from if more students were trained.

■ The peer listeners particularly supported the idea of training victims of bullying and bullies themselves. 'There is a fine line between a person who is a bully and a person who is a victim. A bully must be hurting somewhere inside to do that to someone else' (Year 10 peer listener). Staff also felt that students who would benefit most should be targeted for training.

■ Assertiveness skills could be taught in PSHCE.

■ Teachers reported a few students boasting that they had invented problems to discuss in groups in PSHCE, displaying disregard for the scheme – due to jealousy, perhaps. The scheme might have more kudos if the peer listeners ran more classes on it.

■ A greater 'whole-school buy-in' is needed. There was a perceived split between staff who felt that children should get on with things no matter what, and those who were more sympathetic to the scheme and the counselling. The split was felt to be largely 'between those who have had children and those who have not'. Among other differences noted was teaching style – for example, authoritarian versus more power-sharing teachers.

■ Refresher courses for staff would be helpful.

■ The school would like more information-sharing with social services and CAMHS so that staff know how to deal appropriately with individual children with special needs. The school has two child protection officers but they are not informed by social services about the individual circumstances of children.

Wider learning points

■ There is a stigma attached to being bullied but The Link has allowed people to talk about it without calling it bullying.

■ Some children are clearly more comfortable talking to their peers than to teachers or other adults.

■ Peer listening is becoming more and more popular. The Canons peer listeners attend conferences to share ideas and learn. 'Lots of schools are jumping on the band-wagon' (Year 10 peer listener).

■ One difficulty with these kinds of schemes is how to make sure that those less likely to put themselves forward for the training do benefit, as the process naturally favours confident, 'emotionally literate' children. However, the Canons students themselves recognised the potential benefits of widening the training, and of perhaps targeting, for example, victims and bullies.

■ One of the issues that secondary schools have to face when grappling with improving emotional well-being is the size of their school. The size of secondary schools can make children feel anonymous and therefore much less happy than at primary school. 'I hate school because... in my other... we had one nice cosy classroom' (Year 8 student, Canons High School). This issue was brought up by young people at the 'Imagine London' emotional well-being event (King's Fund 2001). Teachers have also made this point generally through debates in The Times Educational Supplement, and it was raised at Canons High School as well. The relatively small size of Canons was felt to be an advantage in comparison with bigger secondary schools.

■ The training was very useful for support staff from the learning department. They see things that teachers do not see, and are often felt to be more approachable, so they have more practical experience of dealing with bullying.

■ The peer listeners felt that bullying happened in every school and could not be stopped completely, but that what was important was making sure students did not have to face bullying on their own. They said that teenagers already faced so many stresses and since they came to school every day they needed some support there, to feel safe and listened to. 'That little bit of extra help from your peers can make a big difference... it will lay the foundations for the rest of your life' (Year 10 peer listener).

■ Boys tend to use the service in groups, and may use it to bring up a problem they have with their friends.

■ The peer listeners felt that the scheme used to be a place of last resort but that students were now becoming more proactive about using it for conflict resolution.

- The scheme relied on a pioneer – the peer listening and anti-bullying co-ordinator – who was also a full-time drama teacher and head of performing arts. She had to put in a lot of time and effort supporting the peer listeners, which might not have been necessary had they been sixth-formers. She had no release time and devoted a lot of her own time and energy to making it work.

- Staff felt that even if it did not lead to better grades, the children's quality of life was a greater priority.

- The training gave peer listeners transferable skills and confidence, which they valued very highly.

- The scheme gave peer listeners a sense of power that they did not feel they had to the same degree in other aspects of school life, even less at home and least of all in society as a whole.

- All the peer listeners strongly agreed that if you are happy at school you will learn more and that bullying should be taken seriously, as should support for the bullies.

Hope

Hurt and bruised
You walk home
Without a clue about what to do,
How to explain to your parents,
About the conditions you're in.

Then suddenly there is a shining light at
the end of the tunnel,
You've found the key to the locked up door,
The way to happiness and love,
And suddenly you're full of hope
The hope that someone may care

By Dimple Purohit, Year 8 (later a peer listener)

4 Case study B: A whole-school approach to emotional well-being

The Millennium Primary School, London Borough of Greenwich
Contact: Amanda Dennison, Headteacher

The school

Annandale Primary School provides for pupils aged from four to eleven, and also for children below school age in the Nursery unit. It is about the same size as most primary schools. There are 170 pupils on roll taught in seven classes... Pupils come from a wide range of backgrounds in the immediate locality, which is an urban area of council housing and private accommodation. Parents of 34% of pupils, above average for the type of school, claim for free meals. The school has identified 26% of pupils as having special educational needs, and eight pupils have statements of special educational need. Both figures are above average. 28% of pupils are from minority ethnic backgrounds, and there are 32 pupils (19%) for whom English is an additional language, which is a high percentage. Children show a wide and broadly average range of attainments on entry to the school... Teaching is very good and pupils' attainments by the time they leave school are, overall, above average.
(Ofsted Inspection 2000).

The school was moved from Annandale to the new Millennium school building with improved facilities in February 2001. Staff feared that it would lose its special ethos when they moved to the bigger school, and had to work hard to sustain it.

Background to the work

■ Artists in residence were funded through a two-year 'creative partnerships' grant. However, the rest of the school's work is funded from the school budget. The school was awarded Beacon status in April 2001, which links it to other schools.

■ As regards links to health services, there is a health centre next door to the school. When the school first arrived at the new site the school and health centre jointly produced a leaflet on the services provided by the centre. A GP from the health centre came into the school for healthy-eating role-play sessions and the health centre gave free 'taster' sessions in activities such as massage and reflexology, at its 'healthy summer fair'. A nurse came in and taught hygiene to a whole class, to address the needs of a particular child who had had problems in this respect, without singling the child out. The school also has positive links with social services. There are local plans to develop a one-stop shop for the whole community on the same site, particularly for the benefit of parents.

■ The school has been awarded Healthy School status but has not formally engaged with this scheme, as it has done most of its Healthy Schools work independently.

Aims

We believe that through developing children's emotional intelligence we are underpinning the achievement agenda in our school. If our children can develop their emotional intelligence, they will have a greater chance of becoming successful learners, have good relationships and have richer and more fulfilling life experiences.

Extract from Developing Emotional Intelligence In Our Children, published by the Millennium Primary School

How it works

Peer supporters and peer mediators

These are chosen from every year group, including the infants, through interviews with other children. Being chosen is a reward for good behaviour. Peer supporters need to be kind, and capable of avoiding getting into arguments. They help with conflict resolution and sort out problems in the playground, negotiate and keep people separate to prevent fights. They also help people make up after a quarrel and look out for new students joining a class to help them settle in.

Peer supporters have two days of training with the headteacher, working in pairs and in role-play, and then are awarded badges in assembly. They wear their badges so that they can easily be recognised and approached.

Peer mediators also help to resolve conflict. They make sure that people stick to certain ground rules when working through arguments, and make suggestions such as encouraging people to count to ten before they react.

School council

The school council looks after issues about the school environment , and aims to encourage citizenship skills. The children vote for two representatives per class. The class 'reps' in each year group brainstorm issues to discuss with their peers. They give their ideas to four reps from Year 6, who set the agenda. The Year 6 reps take it in turns to chair meetings and take minutes. Minutes with agreed action points are then written up and sent round to all children. Sometimes the school council announces decisions in assemblies to give them more impact, particularly when they have decided to ban something. The headteacher attends the meetings to signal their high profile and checks the agenda. Improvements the council has made to the school include:

- improvements to the school toilets, including new 'Flush the toilet' and 'Wash your hands' signs
- new goal posts for the football pitch
- banned Pokémon cards because they contributed to conflict in the playground
- 'no smoking' signs around the school
- sold skipping ropes on a 'skipping day'

- organised a 'golf day'
- researched other schools' lunch menus and brought new, healthier ideas to the chef
- bought new fruit bins out of its budget so that children could eat fruit at playtime
- decided how to spend £1,000 from a fundraising event on new play equipment.

The Place2Be

The Place2Be operates in this school and the school's staff feel that it is really beneficial. (See Appendix 2: Examples of positive practice.)

Staff well-being

- There is a special staff meeting every term, when staff relax, drink smoothies, have massages, play games, share books and decorate the place with fairy lights and candles. Picnics are also arranged, to include the entire staff team.

- Staff meet every Friday to have lunch together – the headteacher will ring staff to remind them to be there.

- Teachers' salaries are prioritised so that most teachers are paid at the top of the pay scale.

- The school budgets for release time, which teachers can bid for to give them time out, to work on developing their curriculum areas.

Teaching methods

- A lot of work goes into drawing up ground rules and co-operating with classes at the beginning of each school year. For example, in one class, children were randomly put into new co-operative groups within the class each half term and had to write down their own aims and communicate with other groups.

- Alastair Smith, author of a book on holistic learning, visited the school, which invited other schools to come, as part of its Beacon work. He introduced concepts such as the 'brain gym', where children do exercises to join up both sides of their brain when their concentration starts to wane, learning timetables to rap music, and the importance of drinking water.

- The school invited another speaker in to talk about the science of emotions and why, for example, taking deep breaths helps to make you calm.

- Listening to children is a priority – one class had its own 'class concerns box' as a strategy to reduce stress in the classroom, and the school has a 'concerns box' where children can post their concerns, anonymously if they wish.

- Little things, such as making eye contact with each child when taking the register, were felt to be important.

- One teacher was attending a creative teaching course, from which she could share new ideas.

- Other ideas included:
  - Finding what works for each class – for example, using classical music to help concentration
  - Encouraging children to rate how they are feeling using a scale of 1–10 when the register is taken so that problems can be identified
  - Encouraging the spread of ideas – sitting in on colleagues' lessons and experimenting with seating arrangements and so on makes it more stimulating for teachers
  - Weekly circle time – children do not have to speak if they do not want to, and the various classes use it in different ways, but it is used on a timetabled basis in each class, from the nursery onwards
  - Staff inset days to make new staff aware of the school's approach.

School activities

- Children set their own targets that are not purely academic through 'wells' – plans that focus on all aspects of their learning and well-being.

- Staff make their own 'wells' too, and children and staff talk about some of their targets in assembly.

- Water is available for children whenever they want it, and they can get water throughout their lessons.

- Children set their own ground rules for behaviour at the beginning of the school year.

- The school has monthly values, so each month the school emphasises a particular topic such as 'health and well-being'.

- Motivational comments are placed around the school – new ones are brought to the children's attention for each monthly theme.

- There are after-school activities, such as a gym, dance classes, music, languages and football. Some are funded by the New Opportunities Fund (NOF) and the children contribute a small amount.

- Two years of funding from the national 'Creative Partnerships' initiative has allowed the school to bring artists in to work with each year group for ten weeks. The school was lucky to get this funding but putting the application together required a lot of initiative and teacher-time.

- In a new playground initiative, the school is employing a team of drama specialists to find out what the children want from their playtimes, and to teach them new games.

Targeting children with low self-esteem

Sixteen underachieving boys in Years 5 and 6 were targeted for an intensive ten-week dance course led by a professional dancer, which resulted in a performance to the whole school. The boys were felt to be underachieving for a number of reasons, mostly related to low self-esteem and a lack of confidence that was starting to manifest itself in their behaviour. Teachers saw an improvement in the children's self-esteem as a result of this course.

Links with the on-site nursery

The state-run nursery has a similar ethos to that of the school and is on the same site.

- The nursery encourages children to bring one piece of fruit in each week to chop up and share. This is to supplement the more standard fruit, such as apples, bananas and oranges, which they get through the National Fruit Scheme.

- Eating is a social event – six children share a table with one adult.

- School dinners are quite well balanced and parents can see the menus.

- The nursery conducted a healthy eating study with the local health centre next door, and a dental nurse came in to talk to the children, using puppets and role play.

- The staff at the health centre are very supportive and are happy to come in as and when they are needed. For example, they organised a baby-care class when it happened that many of the mothers of the nursery children were pregnant.

- The nursery has links with the reception class at the school.

- The children take part in school assemblies.

- The nursery shares a toy library with the school and a toddler group. This is funded separately by Children in Need and Awards for All, as is the toddler group. It was initially funded by Sure Start but the school is no longer in a Sure Start area.

- Two parents from the nursery are on the school PTA.

- The nursery took part in a fundraising event and ran its own sponsored fitness circuit activities alongside the school's fitness circuits.

Achievements

- Following the move from the old school site at Annandale School, older peer supporters feel that there are now fewer conflict and behaviour problems because there are more peer supporters.

- Staff feel that there is less aggression in the playground and better behaviour, thanks to the peer support and peer mediation: 'If there was only a couple of peer supporters I think there would be a lot of bullying and arguments' (peer supporter, Year 2).

- There is 'not really any bullying in our school' (peer supporter, Year 5). Peer supporters were very clear about the difference between arguments or fights and bullying – the difference being about power: 'Bullies are people you are scared of – who rule you.'

- Staff reported a big decrease over the years in issues that needed addressing in circle time.

Learning points

Reasons for success

- The staff felt that good management and leadership were very important in giving higher profile to the school ethos and work.

- It is important that all staff believe in a school's ethos so that it is not merely tokenistic.

- Senior management need to lead by example to set expectations about staff looking after themselves – taking lunch breaks and so on. All the children spoken to felt that their school was a happy school. Almost all the peer supporters thought that their roles were an important part of this, but almost half felt that other factors were more important. These were mostly to do with the friendly staff, who care about the children's well-being. They mentioned a game they played in class to 'weigh' their happiness, called 'Get it out of your head' which allowed children to offload problems if they wanted to. 'There is always something new for us to think about. The teachers don't just care about learning.'

- Other 'happy' factors include the fact that the school highlights particular values, that the school council can make decisions about the running of the school, and that there is a good balance between fun and learning. For example, the children appreciated the fact that they were rewarded with a week of fun activities after SATs, including a cinema trip, and athletics day, sport, music and outings. They also mentioned fun ways of learning, such using a puppet to demonstrate how to clean teeth properly and a clown to teach about friction and gravity, which had obviously helped them to remember the lessons they had learned.

- Pictures in the hall identifying peer supporters were felt to be helpful.

- The peer support scheme is not expensive because the capacity to carry out the training in school has been developed. The headteacher is a counsellor for Childline

and originally had release time to train with someone outside the school. Now she has supervision once a month.

■ At first, peer supporters were selected by teachers; now children recruit them and the process is popular.

■ Teachers' well-being is regarded as very important. There is recognition of the pressure caused by the variety of agendas generated from within the school, regionally and nationally.

■ A wide range of intelligence levels is acknowledged in the school's 'policy to promote learning and teaching', which aims at enabling all children to fulfil their potential.

Possible improvements

■ Keeping systems working requires attention to detail. Peer supporters felt they could be better at remembering their playground duty timetable, and there were complaints about the 'concerns box' not being emptied frequently enough.

■ A survey is needed to assess the level of bullying in the school

■ The peer supporters suggested having a book for children to write down who they would like to talk to. This means they could be approached, instead of their having to approach a peer supporter themselves, which some children find difficult.

■ The whole-school approach needs strengthening. The children mentioned a difference in discipline styles between that of the teachers (who shared the school ethos) and that of other support staff such as 'dinner ladies'.

Wider learning points

Peer supporters

The peer supporters at the Millennium School reported that their role was sometimes made difficult by responses from other children. This did not seem to be the case at Canons High School so perhaps the considerable age difference made it harder for the younger children to carry out the role of peer supporter. At the Millennium School, their peers were more likely to express resentment and jealousy at their roles, teasing them with names like 'cheer supporters' and threatening to take their badges away from them (which can happen if a peer supporter behaves badly or displays a bad attitude).

These difficulties were thought to be caused by a small minority of people, but clearly raise issues about the need for sensitivity and the potential for division between peer supporters and a resentful minority whose jealousy perhaps relates to their own low self-esteem. The peer supporters reported that these problems occurred even though the headteacher encouraged children who were not peer supporters to get involved in resolving conflict as well, because the scheme was not meant to be exclusive.

Peer supporters also reported sometimes being blamed if they missed an argument or failed to notice a problem: 'It makes you really angry when people say that.'

The school includes a special unit for children with autism. The peer supporters said this made their role more challenging, as it was hard to intervene in cases where these children were involved and to calm them down, despite the fact that they may often be involved in pushing incidents and so on.

However, the peer supporters felt that the benefits outweighed the challenges and were proud of their roles: 'You feel more confident, as if you've actually achieved something.' They felt respected by staff and children, and they also felt empowered by their role – particularly by taking part in conferences with adults to share learning: 'Sometimes older people don't listen to you as much as younger people do, and it makes you feel equal with the adults.'

The peer supporters seemed to represent a range of backgrounds and were all extremely assertive and 'emotionally literate'. In a group discussion with them, they kindly admonished the present researcher when the level of noise became too high by reminding her that she had failed to set any ground rules at the beginning about how to join in.

Staff motivation

The fact that the headteacher also works for Childline has obviously benefited the school, as she has been able to implement ideas about child-friendly environments from Childline.

Staff felt that teaching had a social responsibility attached to it, as teachers were role models in the community. A holistic approach was crucial, they stated. Sometimes this required more effort, but after the first half-term the difference it made was noticeable. They pointed out that with schools now taking in children with special needs, questions of inclusion could no longer be ignored.

Barriers for other schools identified by staff included SATs and the pressure of league tables, which can prevent teachers from being creative. Yet schools should be allowed to take risks and free up the curriculum. In order to do this, it is important to maximise local links and strengths through parents and the community and be opportunistic: 'If you don't ask, you don't get.' For example, a community college student helped plan their sports day and deal with the sensitive issue of including autistic children, as the student needed the opportunity as part of their course. This involvement did not cost the school anything.

Staff also felt that emotional well-being work needed to be given a higher profile to encourage other schools to be more child-centred. For example, the Millennium School has Beacon school status. Although its emotional intelligence work is inspected as part of this, the school is more often inspected on its skills in areas such as ICT. The PSHE curriculum is very welcome and encourages emotional well-being in schools, but much more support is needed on how to implement it. This highlights a missed opportunity in teacher training, as many Post Graduate Certificate of Education (PGCE) students are interested in holistic learning but are not adequately supported to teach in this way.

5 Case study C: Promoting healthy lifestyles

Fairchildes Primary School, New Addington, Croydon, Surrey
Contact: Kris Stewart, PSHE and Healthy Schools Co-ordinator

The school

Fairchildes is a very large primary school for pupils aged 3 to 11 located on the eastern edge of the London Borough of Croydon. There are around 500 pupils at the school as well as a large group of under fives who attend the nursery part-time. The school serves a large estate of mainly Local Authority housing. Almost all the pupils live on the estate in close proximity to the school... Almost all pupils are of white United Kingdom origin, with some families long established in the area... About one-third of pupils are on the school's special needs register, a figure well above the national average. Four pupils have a statement of special educational needs. Just over half of all pupils are entitled to free school meals; this is more than double the national average. Overall, attainment on entry to the school is below national averages. In September 1998 the school became part of the Education Action Zone Initiative. (Ofsted Inspection 1998)

Background to the work

In May 2000 the school had a Healthy Schools audit. It decided to go for Healthy Schools status and the local Healthy Schools co-ordinator then came in once a term to help the school meet the nine criteria. Developing a sex and relationships education policy was essential. Drafting this policy, using national guidelines, took four-and-a-half months of weekly meetings involving two teachers, one school nurse, one governor and two parents. Overall it took the school two-and-a-half years to achieve Healthy Schools status.

Aims

- to encourage children at the school to lead healthier lifestyles, particularly with regard to healthier diets
- to achieve Healthy Schools status
- to address the needs of the whole child.

How it works

The school carries out Healthy Schools work based on food and nutrition, healthy lifestyles, and recycling.

Health and fitness weeks

- The school has run 'health and fitness' weeks for the past three years. The first one, in July 2000, was organised by the PSHE co-ordinator and the PE co-ordinator with practically no funding from the school. They used the neighbouring High School's halls and PE equipment. Croydon Sports Partnership, funded by the local education authority (LEA), provided staff who worked intensively with one or two year groups. A former school governor who is also a former athlete also did some training with the children. The week culminated in a Sports Day. A nurse and a dentist saw everyone in the school and the children were therefore exposed to a great deal of health knowledge. This was a one-off opportunity: the dentist will now come to the school for only two days a year, so will not be able to see everybody.

- In Summer 2001, the school built the week around a partnership with global company Sodhexo, which offers services from technical maintenance to recreation, medical care, waste removal and water treatment to catering. Five of Sodhexo's catering graduate students organised the week's activities, which was appreciated because it meant the teachers did not have to get involved. They made smoothies and pizzas with the children, and showed great enthusiasm for the event.

- In Summer 2002, the event was organised by one student on his own, but he managed to see everyone. Sodhexo contributed prizes such as electric toothbrushes, and hats with the Sodexho logo on them.

- A drugs officer at the local primary care trust (PCT) is now planning to make resource boxes to help other schools in New Addington to run health weeks. These should be really helpful and will contain 'fun things', such as glitter soap, and a UV torch that shows up dirt on the skin.

School council

Fairchildes has a school council that is run by the headteacher and meets once a fortnight. Two children from each class, from Year 2 upwards, are elected to the council and hold their posts for one year. The improvements the council has made to the school include:

- new playground equipment
- an assembly about toilet hygiene
- new toilets, after the school council complained about the old ones
- a school newspaper
- a campaign for better school dinners
- smoother playground surface
- litter volunteers
- an after-school football club
- classes swapping books so that the children have more books to read.

Healthy eating

Healthy packed lunches

Each week the school concentrates on one food item as a component of a healthy lunchbox, for example, a healthy drink, fruit or dairy product. Every child who brings in that particular week's healthy food item in their lunchbox gets a ticket which enters them into a weekly prize draw. Winners get £5 WH Smith vouchers or similar vouchers. To supplement this work, the Year 5 students are working on healthy meals and exercise.

Fruit trolley

The school council requested a fruit trolley. The school's Healthy Schools co-ordinator buys fruit from the local food market and sells it for 20p per piece of fruit. The school makes a small profit, which pays for the prizes for the 'Healthy Packed Lunches' prize draw.

Theatre production

The school benefited from a theatre production called Captain Cholesterol and the Grannies from Mars, which Quantum Theatre Productions performed for numerous schools in Croydon. It was organised and funded by the local Healthy Schools scheme (with local health authority and LEA money). Staff felt that having external visitors really helped reinforce the school's messages from its 'health and fitness' weeks.

Catering

The school's current catering contractors have a monopoly in Croydon. They charge £1.40 per meal and spend 35 pence. The school wants to get rid of the contractors and take charge of the catering itself so that the food provided is healthy, local and much less processed. It is a big undertaking, and the school expects to make the changes gradually. The school is situated in farmland, so it wants to use local suppliers for fresh fruit and vegetables and to create a menu using a local nutritionist. Staff now working for the catering firm will stay on and the school will have to assume responsibility for the ordering and the personnel. Another local school now manages its catering by itself, but has not improved the food nutritionally; instead it makes £10,000 profit per term. Fairchildes would like to make a profit but its main aim is to improve the quality of the food provided.

Breakfast club

The school currently has a breakfast club, which was one of the initiatives co-ordinated by the local education action zone (EAZ). The EAZ also subsidised the club. The EAZ is now coming to an end, but Excellence in Cities, a targeted programme to bring additional resources to address the needs of core urban areas, is taking over responsibility for the breakfast club. The club involves the families and is seen by staff as a really good thing. About 50–60 children attend, and their parents are also starting to. The children have to pay 30p but craft activities are provided and there is a very good atmosphere. However,

the food currently provided is not very healthy (including white bread, jam, sweetened breakfast cereals and bacon). When the school terminates its current catering contract, it will introduce healthier foods, such as porridge, baked beans and eggs.

Sex and relationships

The school uses a resource called 'Living and Growing' for its sex and relationships education. This includes three videos for different age groups. It complements the school's science work, presenting sex in the context of relationships. The children really enjoy the videos and ask plenty of questions. In the summer term, the school nurse talks to Year 5 about body changes. She also does four sessions with Year 6 on body changes, puberty and reproduction, and single-sex question sessions for girls and boys using an anonymous question box. A teenage pregnancy co-ordinator working at New Addington Health Centre used to come into the school during the 'health and fitness' weeks when she was a student. However, since she qualified she no longer has the time to devote so much attention to one school.

Drug education

The school uses drug education programmes run by the external agency, Life Education Centre. The Life Education Centre's van visits the school once a year, and its education sessions about drugs raise moral dilemmas that would not usually be discussed during normal lessons. Staff feel that the sessions work so well because they are interactive and different, so the children remember what they have learned. The teacher who runs the scheme said she could tell that the children had remembered things from the previous year, and that they were really receptive to the education sessions. The Life Education Centre's van also provides activities for the younger age groups.

The cost works out at about £1.90 per child. The school part-funded this through two bursaries it received from the Healthy Schools scheme for speaking to other schools about its 'health and fitness' weeks. Given the cuts in their budgets, it will now ask for a £1 per child contribution from parents – but it will not get these from all families: 'If the government health and education departments funded it for everyone it would be the biggest step in the right direction' (PSHE Co-ordinator).

Recycling

To satisfy the sixth Healthy Schools criteria, the school implemented a recycling initiative and worked with the local authority's environment and sustainability manager, who gave a presentation in assembly to start the work off. The children wrote letters to the council, and were given a £200 environment grant, which they spent on recycling bins for each classroom. An organisation called Green Recycling supplied the recycling bins outside the school free of charge, but only white paper and newspaper can be put in these bins – not card. The council team helped the school win a BT Citizenship Award worth £2,000.

The school's next project is a community garden. It will use some of the Citizenship Award money on this, and encourage parents to work in the garden with the children.

Fairchildes uses the 'You Can Do It' educational materials to support its PSHE work. The materials, which they obtained through the EAZ, are lesson-based and aim to build confidence, persistence, organisation and the ability of children to get along together.

The school is also supported by the Place2B's counselling and mental health intervention programme, which is funded through the EAZ. (See Appendix 2: Examples of positive practice.)

Achievements

- Fairchildes has achieved Healthy Schools status.

- The 'You Can Do It' work is felt to be having an impact, particularly in building persistence and confidence.

- The school has improved children's lunchboxes, making them healthier.

- The SATs results have continued to improve. The headteacher believes that this is partly thanks to better concentration levels, which are the result of the breakfast clubs, and to its Healthy Schools work. The evidence is anecdotal, as the school does not have time or resources to evaluate its work.

Learning points

Reasons for success

- The headteacher is supportive and interested in innovation.

- The 'You Can Do It' materials are useful. They are quite prescriptive but can be modified and adapted.

- In Croydon, schools can borrow topic boxes from the PCT on subjects such as nutrition, keeping fit and mental health – these are free and if schools are aware of them can be linked to the curriculum. These are important, as everyone's PSHE budgets are now being shaved because of school budget cuts.

- The school has been quick to take up opportunities for partnership working.

- Outside help is important in delivering sex and relationships education, as external workers are unlikely to be disconcerted by the questions that the children ask and children also take more notice of people from outside school; moreover, sex is hardly dealt with at all in the science curriculum.

- The headteacher says the school council helps some of the more responsible children to 'bubble up to the surface'.

Some problem areas

■ The school tried to ban chocolate and crisps but got a negative reaction from parents. This led to the current focus on different elements of a healthy lunchbox and rewards for children.

■ The older children can fill in the 'healthy packed lunchbox' tickets themselves, but teachers had to take on the extra tasks of filling in the forms for the younger children and checking lunchboxes. Now they check the class randomly once a week instead.

■ Security is a major local issue. Two classrooms have been burned down. Replacing windows is expensive and the playground fence has had to be replaced ten times in the last four years.

■ Teachers face a lot of aggression from parents. Social services do not always tackle the worst problems concerning these families, even though they have the protection of the police. The teachers do not have this protection, and some of the families have reputations for violent behaviour.

Wider learning points

■ The school's healthy schools co-ordinator gets some release time for her work but not enough, so she does some of it in her own time.

■ The co-ordinator would like to have the local nurse and dentist in to see every child once a year. The need is great in such a deprived area. Some children do not even own a toothbrush.

■ The school nurse's role is mostly about checking children's eyesight and looking out for children in need identified by the special educational needs (SEN) co-ordinator. She has no time for anything extra.

■ PSHE is not mandatory until Key Stage 3, but staff feel it ought to be.

■ The headteacher's attitude was that 'if you're in education you have to be in it for the whole child'.

■ Some of the school's work is started because the staff feel instinctively that it should be, while some is based on research about what works. The school takes ideas from others and adapts them to fit Fairchildes.

■ The school has had partnerships with more than five companies. All these links were developed through the EAZ. The companies have provided valuable volunteers.

Appendix 1: Methodology

The research focused on three areas:

- an understanding of the issues surrounding the development and implementation of local strategies linking child health and education
- a consideration of some of the challenges faced by schools that are trying to improve the health of their students
- collation of examples of positive practice within London.

The research began in March 2003 and ended in June 2003.

A multi-method approach (Robson 1993) was used in the research process, which consisted of the following three activities:

- Interviews were undertaken with 28 key stakeholders in health and education across London to provide an understanding of the issues surrounding the development and implementation of local strategies linking child health and education. Interviewees were asked to identify what they saw as the barriers to effective delivery as well as the opportunities for change.

- An exploratory workshop was held for a range of practitioners working at a local level to improve child health in schools or improve the links between health and education partners. Participants were asked to identify barriers and opportunities at the implementation level and share examples of best practice. Thirteen people attended the workshop.

- Case studies (Yin 1989) were undertaken with three schools in various parts of London. Qualitative techniques were used to obtain detailed information. These included observational techniques, and one-to-one and group interviews with students, teachers and other staff at the schools. In total, 56 people were interviewed for the three case studies. Relevant documentation was also analysed. This included two school surveys from Canons High School, the school's policy documents at the Millennium Primary School and the Healthy Schools folder at Fairchildes Primary School.

The case studies were chosen to illustrate a wide range of activities and approaches after an initial scoping exercise. The criteria for choosing the schools included:
- innovation in practice
- holistic approaches
- high levels of student involvement
- commitment to partnership working
- potential to provide useful learning for other schools.

A review of literature highlighting positive practice was also undertaken.

A final workshop was held in July 2003, which brought together 30 participants from a range of London-wide organisations. They commented at length on an early draft and influenced the final paper. Six people sent in written responses.

Appendix 2: Examples of positive practice

A PAUSE

This is an innovative schools-based sex education programme. A PAUSE uses a peer-led, theatre-for-development model in the classroom and has been cited as one of only three school-based sex education programmes in Britain to rigorously evaluate the outcomes of a major sex education intervention. It has changed knowledge, beliefs and behaviour but up until now has not significantly changed young teenagers' beliefs in their ability to negotiate sexual aspects of their relationships. To address this problem, A PAUSE has piloted the theatre-for-development process to promote the autonomy of peer educators and empower participants.

For more information, contact 01392 403 146. Email: apause@exeter.ac.uk

Child-to-Child

Child-to-Child (CtC) projects have been conducted in over 70 countries worldwide. The first CtC programme in London was set up in Lambeth, Southwark and Lewisham in 1999. The project aims to empower children to take action to improve the health and well-being of themselves, other children, their families and communities. The two key principles that underlie the CtC approach are popular education and child participation. The methodology can be applied in a variety of settings including schools, youth services and health services. Schools that were unsure about how it would fit in with the curriculum at the beginning have now linked it in with many areas of the curriculum, for example, letter-writing skills and citizenship. A practical guide and an evaluation report are available from the contact below.

For more information, contact Sara Gibbs on 020 7771 3423.
Email: Sara.gibbs@southwarkpct.nhs.uk

Courses at medical schools

Guy's, King's and St Thomas' medical schools offer medical students a 'special study module' as part of their General Medical Council electives, teaching health promotion to primary school pupils. The project was set up in collaboration with the social and health education adviser for Southwark and school nurses from Optimum Health Care Trust. Students, allocated in pairs to a local primary school and attached individually to a class, discuss with the class teacher topics to fit with the national curriculum. Popular topics include dental hygiene, healthy eating, smoking, alcohol and drugs. Students are encouraged to use imaginative teaching methods and a variety of resources to interest the children.

Cited in: Seabrook M (2001). 'Early learning', The Health Service Journal, III, 5766, p 32. For more information, contact the medical schools direct.

Education Link Project

This project, based at the Hurley Clinic, was set up to develop community links between primary care and primary schools, to improve the quality and quantity of health education in primary schools and to raise the profile of health on the school agenda. The project works with 27 primary schools in Lambeth. It sends local health professionals into primary schools, works closely with school nurses and other agencies, provides a range of resources for health education sessions, writes curriculum material to support the teaching of PSHE and runs Early Start projects in Lambeth nursery schools to help foster communication and literacy skills among parents and their children.

For more information, contact Joanna Watson on 07967 352 909.
Email: ela_hurley@hotmail.com. Website: www.healthykids.org.uk

Genesis Project

This project, run by the Children's Society, is currently working in five secondary schools in south-east London, all with over 900 students each and a rich cultural and ethnic mix. The core aims of the project are to:

■ develop and promote the inclusion of all children and young people in mainstream education

■ influence systems to bring about positive change that will benefit young people, schools and the wider community

■ develop and facilitate forums that give young people a voice and promote participation and involvement in decision-making processes.

Project workers provide information, advice, support, counselling, advocacy, mediation and training to children and young people, their families and school staff. These services are provided on an individual and group basis and through citizenship programmes. The children and young people who use the project are generally not fully participating or included in school, are experiencing difficulties at home, are at risk of exclusion or have a record of exclusion, and/or are truanting.

The project's impact includes a reduction in temporary or permanent exclusions, a reduction in unauthorised absence, a reduction in incidents relating to behaviour, and an increase in self-esteem and social skills, etc. One of the project's schools, Deptford Green School, has increased the percentage of pupils achieving five or more A–C grades in GCSEs from 25 per cent in 1999 to 40 per cent in 2001.

For more information, contact Pauline Kennedy, Genesis Project Manager, on 020 8692 2699. Email: Genesis-Project@childrenssociety.org.uk

Grab 5!

Grab 5! is an initiative launched by Sustain, the alliance for better food and farming, to increase consumption of fruit and vegetables among children aged 7–11, with a focus on low-income families. Lambeth was one of three national pilot areas. Consumption of fruit and vegetables increased by 30 per cent and staff did not feel overburdened because they could choose how they implemented the scheme.

Sustain is now developing a workable model for a national programme of fruit and vegetable promotion which incorporates strategies for sustainability.

For more information, contact Kate Bowie or Richard Siddall at Sustain on 020 7837 1228. Website: www.grab5.com

'H.A.P.P.Y.' project

'H.A.P.P.Y.' stands for 'Healthy Activities and Practices with Pre-school Years'. It was set up for 0–4 year olds in Barnet, and is a Department for Education and Skills example of best practice for early years. It was developed by a Barnet multi-agency working party, and currently includes representatives from the following health authority and local council services: the accident prevention centre, a nursery, the community dental service, the early years and play service, environmental health, health promotion service, the health visiting service, the inspection and advisory service, Barnet Pre-school Learning Alliance, and Barnet Healthcare Trust children's services.

The project works to reduce health inequalities and to raise achievement in the foundation stage of education by providing free resources, advice and support from health topic facilitators and access to free training in early-years settings.

For more information, contact H.A.P.P.Y. co-ordinators on 020 8359 3855.

Healthy food swipe cards

Healthy food is provided for students at Copthall School, Barnet, by catering contractor Team Barnet. The school canteen runs a swipe-card system that rewards students with points for healthy food – healthier foods create more points. The points are stored on the cards, and when they reach certain levels (such as 2,000, 10,000, or 20,000 points) the students are rewarded with prizes and their names are publicised in the school newsletter. The catering contractors obtain the prizes through sponsors such as Body Shop and local leisure services. Students can forgo a prize to save for a bigger prize if they want to. The scheme is in its second year now, and has an impact on the vast majority of students at the school. It is supported through a whole-school focus on food and nutrition, which includes cookery classes and a fruit tuck shop, and has made a real difference to the students' diets.

For more information, contact Lynn Gadd, Headteacher on 020 8959 1937. Email: l.gadd@easymail.copthall.barnet.sch.uk

Lunchtime clubs

Underhill Infants' School in Barnet tries to provide a wide curriculum to balance the current focus on numeracy and literacy. Teachers voluntarily run a number of free lunchtime clubs for the children to supplement the national curriculum and create something to occupy pupils who get bored at lunchtime. Sometimes qualified coaches are brought in and the children have to make a small contribution to the costs. There are clubs for many activities, including dance, gym, football, art, drama, French and a choir,

as well as an after-school swimming club. The whole school benefits from the clubs through presentations and performances in assembly. The school has completed the active module of the Healthy Schools award scheme.

For more information, contact Elizabeth Moore, Headteacher, on 020 8449 2962.

The Place2Be

The purpose of the Place2Be's direct work in schools is to provide early intervention through emotional and therapeutic support to children (aged 4–11) within the school environment. A school working with the Place2Be will have a dedicated room on site, which is a space devoted entirely to therapeutic work with children and containing play and art materials. The range of support offered includes:

- individual work
- group work
- the Place2Talk (a self-referral drop-in provision for children, run at lunchtimes)
- the Place2Think (a service offering consultation to school staff who may be concerned about an individual child or group of children)
- work with parents and carers in support of the needs of children.

Through the support provided by the Place2Be, children are able to express their worries or difficulties and have the opportunity to work through them. The Place2Be's annual audit report for the academic year commencing in September 2001 showed that teachers and parents described a significant change in behaviour within participating schools.

Training is provided for volunteer counsellors in specific aspects of working therapeutically with children through the Place2Be. A range of accredited training programmes are also available for school-based staff such as learning support assistants and midday supervisors, who wish to improve their skills of communication and emotional support for young children.

For more information, contact The Place2Be on 020 7780 6189.
Email: development@theplace2be.org.uk

Positive practice in Croydon

- Immunisation and vaccination team There is a shortage of school nurses in Croydon, so the primary care trust (PCT) has funded an immunisation and vaccination team to allow school nurses more time to do public-health-related work, especially with regard to teenage pregnancy and sexual health.

- Exercise referral scheme There are plans to extend this to include children at risk of obesity. This will involve referrals to a specially tailored programme of activity and referrals taken from health and education professionals.

- Preparation for Parenting This project aims to reduce teenage pregnancies and to develop positive and responsible attitudes towards parenthood by teaching young people effective parenting skills, which include child development and family life. Courses are individually tailored to schools' PSHE programmes. This project is

delivered by schools staff and staff from other agencies. Schools receive £692 per year to run the programme, and courses are planned according to the individual needs of the schools. The courses are designed for Year 9 or 10 pupils and they last one term.

Lessons make use of videos, virtual reality dolls, speakers, discussion, worksheets, role-play and group work. Topics covered include conception, reproduction, birth, contraception, ante- and postnatal care, responsibilities of parenthood (practical, emotional, financial), problems and responsibilities of teenage pregnancies, and dysfunctional parenting or families.

- Food strategy This is a partnership between the council and the PCT. Once agreed, it will be publicised with all health visitors and food co-operatives. It aims to take a holistic approach to food and nutrition, incorporating environmental concerns about food production and consumption. The strategy includes a practical action plan involving a variety of local stakeholders, including schools.

- Food forum Croydon also has a food forum, which incorporates a vegetable box scheme funded by the PCT out of Health Inequalities money, using New Addington's farmers' market. Resource packs are being created for schools that do work on the issue of food procurement and encourage teaching about the origins of food and sustainability.

- Food and Nutrition in the Primary Curriculum This is a guidance pack for schools, produced by the community dietician. It incorporates nutrition into the national curriculum for science at Key Stage 1 and 2.

For more information on the food strategy, contact Rachel Janes.
Email: rachel_janes@croydon.co.uk

Sure Start on the Ocean

This is part of the national Sure Start initiative to improve the social, health and emotional well-being of children aged 0–4, and to support parents. It is a partnership of some 17 local organisations, including community groups from the Ocean Estate, London Borough of Tower Hamlets, and Tower Hamlets PCT. Sure Start on the Ocean uses a community development approach to try to build on the expertise of the community rather than simply extending services. Programmes include:
- Bethany Project – a therapeutic service specialising in autism, behaviour difficulties and depression
- Tower Hamlets Opportunity Group – providing inclusive and integrated therapeutic sessions of play development for children with disabilities and complex needs
- Newpin Ante- and Post-Natal Project – a new way to support pregnant women, using trained volunteer 'befrienders', who are local parents themselves
- Mainstream Health Visitor and Midwifery Services enhanced by a network of Sure Start projects
- Ocean Breastfeeding Project
- Shaftesbury's child safety scheme
- toy libraries
- playgroups and play and learn sessions

- 'Chat-a-way' speech and language development service
- a community development and family support team.

Sure Start on the Ocean has built a partnership with Ocean New Deal for Communities and the local authority to build a new complex including a nursery school, infant school and training facilities for parents. This will function as an Early Excellence Centre. It expects to be able to offer full-time day-care provision from September 2004.

For more information, contact Sabes Sugunasabesan on 020 7791 3049.
Email: sabes.sugunasabesan@thpct.nhs.uk

Appendix 3: Resources

Antidote – the campaign for emotional literacy – carries out work for schools, at www.antidote.org.uk

Barnardos What Works in Inclusive Education? and We can work it out. What works in educating pupils with social, emotional and behavioural difficulties outside mainstream classrooms?, at www.barnardos.org.uk/resources

Department for Education and Skills Eating Well at School – three free booklets offering practical guidance to help governors, headteachers, policy-makers and catering contractors to introduce and sustain the provision of healthy food in their schools. Available from Tel 0845 6022260.

Department of Health The Child Health in the Community Guide to Good Practice. London: The Stationery Office, 1996, at www.doh.gov.uk

Eco Schools offers schools an opportunity to make environmental issues a part of the school curriculum, develop young people's decision-making skills and make financial savings. It does this through curriculum materials, project ideas, access to a network of support agencies, links with other schools and an award scheme, at www.eco-schools.org.uk

King's Fund Partnerships Under Pressure – a commentary on progress in partnership-working between the NHS and local government, at www.kingsfund.org.uk

London Health Commission Health Impact Assessment of the Mayor's draft Children and Young People's Strategy, including points on education, at www.londonshealth.gov.uk/pdf/children.pdf

Mentality is affiliated to the Sainsbury Centre for Mental Health and provides resources for schools to promote mental health, at www.mentality.org.uk

Mind out for mental health also provides good resources, at www.mindout.net

Sustain for information on how to implement a school food policy and why, as well as teaching resources, at www.sustainweb.org. Also find the following three documents on the Sustain initiative Grab 5!'s own website, at www.grab5.com:
■ The Grab 5! action pack – toolkit
■ The Grab 5! curriculum pack – that supports the Key Stage 2 curriculum
■ The Grab 5! model school food policy – a practical guide.

Health Education Trust The Chips are Down – a guide to food policy in schools, at www.healthedtrust.com

Woodcraft Folk – good resources for teaching, including a calendar of healthy food, at www.poptel.org.uk/woodcraft

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