Further reading index

Some colleagues may be keen to extend their knowledge about children and young people's health and wellbeing and the Healthy Schools approach. For these colleagues we have provided some further reading.

Title	Page	Purpose
Introduction to health behaviour change	2	Information about the theoretical basis of the Healthy Schools approach.
Using qualitative data	7	Tips for collecting qualitative data from children and young people.
Health and wellbeing needs analysis, priorities and outcomes (training session)	12	A plan for a school staff training session about analysing and interpreting health and wellbeing data to determine a priority and develop outcomes.
Principles and examples of evidence-informed practice		Principles and examples of evidence-informed practice relating to issues such as alcohol, drugs, healthy eating, physical activity, sexual health and tobacco. This document is in the 'school examples' download.
Learning from the Southwest Healthy Schools Plus evaluation	17	Summary of findings from a qualitative evaluation of schools working on improving the health and wellbeing of children and young people.
Considerations for special schools	20	Information to support special schools using the Healthy Schools toolkit

Further reading

## Introduction to health behaviour change (1/5)

The Healthy Schools approach is based on an understanding of how best to promote health and wellbeing effectively in the school setting and how to influence health behaviour change. The information below summarises the theories and insights that have informed the development of Healthy Schools.

Health, health promotion and the settings approach

The World Health Organisation defines health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.' Healthy Schools uses this holistic definition of health and wellbeing and considers the physical, emotional, social and intellectual needs of children and young people – this is also known as taking a **whole child approach.**

Healthy Schools recognises that whilst schools have a contribution to make to addressing the health and wellbeing of children and young people, their contribution must be viewed in the context of **wider determinants of health**. Dahlgren and Whitehead's model (1991) illustrates these wider influences on the health status of individuals *(see diagram on right).*

Healthy Schools draws on health promotion principles and the **healthy settings approach** which takes an organisational or whole systems approach with the aim of integrating health and wellbeing within the ethos,
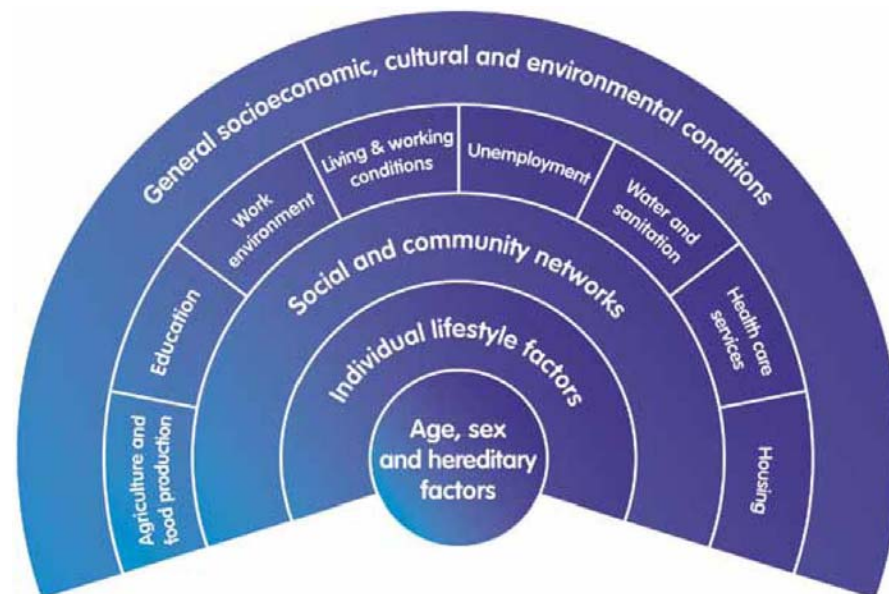
culture, routine life and core business of the school setting. Healthy Schools describes this as a **whole school approach**, which includes:

- leadership, management and managing change
- policy development
- learning and teaching, curriculum planning and resourcing
- school culture and environment
- giving children and young people a voice

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Further reading

Introduction to health behaviour change (2/5)

- provision of support services for children and young people
- staff continuing professional development (CPD) needs, health and wellbeing
- partnerships with parents/carers and local communities
- assessing, recording and reporting the achievement of children and young people

There are theories and principles of successful planning, delivery and evaluation in relation to changing behaviour (NICE, 2007). The Healthy Schools 'plan-do-review' approach reflects these generic principles, specifically:

	Information extracted from NICE guidance on principles for effective behaviour change
PLAN	• Take into account the local and national context when planning interventions aimed at changing behaviour. • Work in partnership with recipients. • Base interventions on sound understanding of needs of the target audience and build upon existing skills and resources. • Set out which specific behaviours are to be targeted and why.

PLAN *contd.*	• When deciding on what interventions to deliver build enough time in to consider what up-to-date evidence says about the effectiveness of interventions aimed at changing behaviour. • Specify the theoretical link between the intervention and its intended outcome.
DO	• Ensure interventions are based on the best available evidence of effectiveness and cost effectiveness.
REVIEW	• Ensure wherever possible that the interventions are evaluated using appropriate process or outcome measures.

Insights from the science of behaviour change are informing policy development and, in particular, ways of identifying low cost, low pain ways of 'nudging' people into new ways of acting (Thaler and Sunstein, 2008). An example of a nudge would be placing healthy foods in a school cafeteria at eye level, while putting less healthy foods in harder to reach places.

A framework, captured by a simple mnemonic – MINDSPACE - has been developed to summarise nine of the most robust influences on behaviour. The checklist (see next page) is being advocated as a tool to help inform policy but schools might also like to consider its

Further reading

Introduction to health behaviour change (3/5)

relevance when considering opportunities for, and barriers to addressing behaviour change.

M	Messenger	We are heavily influenced by who communicates information
I	Incentives	Our responses to incentives are shaped by predictable mental shortcuts such as strongly avoiding losses
N	Norms	We are strongly influenced by what others do
D	Defaults	We 'go with the flow' of pre-set options
S	Salience	Our attention is drawn to what is novel and seems relevant to us
P	Priming	Our acts are often influenced by sub-conscious cues
A	Affect	Our emotional associations can powerfully shape our actions
C	Commitments	We seek to be consistent with our public promises, and reciprocate acts
E	Ego	We act in ways that make us feel better about ourselves

The **assets-based approach** focuses on individuals' and communities' positive capacity to identify problems and activate solutions centred around promoting factors which support health and wellbeing, rather than focusing on factors which cause disease. This is more positive and inclusive, as opposed to identifying the problems and needs of the population (as has often been done previously) which has a tendency to define communities and individuals in negative terms. Assets can be internal (e.g. individual characteristics) and external (e.g. family/community factors).

Schools may want to become familiar with the determinants (assets) that help children and young people to have positive health and consider in the PLAN phase what actions/interventions would ensure all the children and young people in their school have these assets.

Concepts drawn from psychological models have been helpful in informing the Healthy Schools approach. The following table summarises the key relevant principles:

Further reading

Introduction to health behaviour change (4/5)

Model	Key principles
Stages of change model (also known as the Transtheoretical Model of Behaviour Change, Prochaska and DiClemente, 2005)	• People go through a sequence of steps to change behaviour. The model identifies five stages: pre-contemplation, contemplation, preparation, action and maintenance. People move through the stages at varying rates and may move back and forth between stages a number of times before attaining the goal of maintenance. • Tailoring interventions to match a person's readiness to change is essential.
Health belief model (Rosenstock, 1966, and modified by Brecker, 1974)	For behavioural change to take place people need to: • Have an incentive to change; • Feel threatened by their current behaviour; • Feel a change would be beneficial in some way and have few adverse consequences; and • Feel competent to carry out the change.

Model	Key principles
The theory of planned behaviour (Ajzen, 1991)	• Behaviour change is preceded by a person's intention to change. • Intention is determined by a person's attitude towards the behaviour, and beliefs about what other people think the person should do, as well as the person's motivation to comply with the opinions of others. • A person's perceived control over the opportunities, resources and skills necessary to change a behaviour is an important aspect of the behaviour change process.

Further reading

Introduction to health behaviour change (5/5)

The main applications of these theories to Healthy Schools practice are:

- A focus on knowledge and skill development can be an important and appropriate part of the behavioural change process, and one which schools are well placed to address.

- There is value in trying to understand and assess existing health beliefs and values held by children and young people prior to taking action intended to address specific behaviours.

- The potential to engage with children and young people as individuals, as well as members of groups with some shared and some dissimilar needs, concerns and interests.

- When evaluating the impact of interventions/ actions intended to influence longer term behaviour change consideration needs to be given to realistic and appropriate measures of success in the short/medium term – these may well be process and impact milestones linked to eventual outcomes.

References

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Institute for Government and Cabinet Office (2010) Mindspace: Influencing behaviour through public policy- discussion document

Morgan, A., Ziglio, E., & Davies, M. (2010). Health Assets in a Global Context: Theory, Methods, Action: Investing in Assets of Individuals, Communities and Organizations. Springer, 1st Edition.

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Rosenstock, I (1966) Why people use health services, Millbank Memorial Fund Quarterly 44: 94-121

Thaler and Sunstein (2008) Nudge: Improving Decisions about Health, Wealth, and Happiness.

Further reading

Using qualitative data (1/5)

Valuing what children and young people say is an important part of being a Healthy School. Here we offer some ideas to help you extend your current practice. This section covers:

- the purpose of gathering qualitative data from children and young people; and

- tips on robust methods for collecting and using qualitative data.

We recommend you refer to this when you carry out your health and wellbeing needs analysis and as you review whether your school has achieved its priority.

Qualitative data means subjective information such as children and young people's perceptions and self-reported behaviour. Qualitative data can still be presented in figures and percentages, but the data is based on the results of surveys and opinions, rather than objective measures.

The purpose of gathering qualitative data

By listening to children and young people's perceptions you can:

- better understand why they are making certain choices;

- identify issues affecting their health and wellbeing;

- shape services and teaching to be more sensitive to their needs; and

- send a powerful message that children and young people have an important contribution to make.

The following questions can help you decide what method, or mixture of methods, to use to gather qualitative data:

- Why am I collecting this information?

- What size of sample do I need? – class, whole school or specific group?

- What are the ages and abilities of the children and young people involved, including any children in challenging circumstances?

- How much time do I have to prepare and complete the exercise?

- Would it be beneficial to repeat this exercise to build up trend data?

Further reading

Using qualitative data (2/5)

Healthy Schools

Tips to make your research robust

Bear in mind that, while qualitative data forms an important part of the overall picture, it is only a snapshot at the point in time you seek children and young people's views. Here are some pointers for collecting robust qualitative data:

- Timing – other things going on in school (such as exams, the coverage of topics in the curriculum, time of day or mood of the class) may have an impact on your findings.

- Context – you are likely to get different findings if children and young people are prepared through circle time, lessons or homework tasks.

- Rules of anonymity/confidentiality – make it clear whether the exercise is anonymous and if it is not, agree rules of confidentiality, including actions that will be taken to safeguard participants. Be clear about your safeguarding procedures in school should a child disclose information that indicates they may be at risk.

- Supporting staff – ensure there are mechanisms to support staff that are less experienced or less confident in this area of work, through mentoring or coaching.

- Designing questions/sessions – questions should be neutral and not favour a particular answer. Be clear which are open questions and which are closed. Try to pilot your survey questions beforehand.

- Data protection – ensure arrangements are in place to comply with data protection law when recording and saving information gathered from children and young people.

- Ethics – make it clear through briefings that staff facilitating surveys, discussions and interviews should avoid imposing their own values and beliefs to influence children and young people.

Methods

Methods of gathering qualitative data can be broken down into three main categories:

- Surveys

- Discussion groups

- Interviews and observations

Choose the most appropriate method for the group of children and young people.

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Further reading

Using qualitative data (3/5)

Healthy Schools

Surveys

Surveys are a good way to gain the views of a large or medium-sized sample. They are also a useful way to build up trend data. It is worth considering training children and young people to become researchers so they can develop and administer their own surveys.

Surveys should be tailored to suit the ability of the sample of children and young people, using appropriate language, emotion symbols or, for those with limited communication abilities, by using a language system such as Makaton. Find ways to include children and young people with English as an additional language (EAL).

Surveys can be organised to be completed anonymously, or not. The advantage of anonymity - especially when looking at more sensitive aspects of health and wellbeing - is that children and young people may be more open and honest about their views and experiences. The disadvantage is that it is not possible to follow up an issue with an individual.

When drafting a survey, choose to use either open-ended questions (free text answers) or closed questions (often multiple choice or scaled responses), or a mixture of the two. Open-ended questions enable children and young people to offer more information but are more difficult to analyse. Closed questions are easier to analyse but offer less opportunity for children and young people to elaborate on an issue. For example:

Open-ended: What would make you feel safer in the toilets at school?

Closed: Do you feel safe in the toilets at school? (always/usually/never)

Tips for good surveys

- Surveys are good for tracking trends, provided the same questions are repeated in each survey and similar methods used each time.

- It is good practice to pilot survey questions with a small group of children and young people. In this way you can be confident the questions are clear and being interpreted consistently.

- For a quick survey consider a simple poll using free, online resources such as 'Survey Monkey', or a text poll via mobile phones.

- Surveys can be shared within a cluster of schools, to produce a larger sample size.

- Challenge your school to consider whether a survey is the best method to use.

Further reading

Using qualitative data (4/5)

Healthy Schools

Discussion/focus groups

The main advantage of discussion/focus groups is they provide an opportunity for children and young people to explain the reasons they feel or behave in certain ways, giving greater insight into the issues and challenges. Discussion groups are less useful if you want to seek the views of a large number of children and young people.

In addition to school and class councils or circle time, which are already established in schools, staff-led discussion groups give a means to gather views on a specific theme and can successfully involve more vulnerable or less articulate children and young people. Discussion groups are a particularly good way to gather views on a new development or to explore how to maintain improvements when reviewing a health and wellbeing outcome. If you are using a School Council, class council or student panel consider how representative it is of the children in the school.

Some schools also use 'buzz groups', which are informal discussions between a group of children and young people, observed and recorded, rather than led by an adult. These can be a natural development for established peer mentor systems.

Tips for discussion groups

- Discussion groups produce a lot of information. Consider the time needed to summarise and analyse this information.

- Groups should be planned around specific, typically 'open' questions to encourage discussion.

- Record the discussion by taking notes or using recording equipment.

- Involve groups already established for children and young people who are in challenging circumstances, such as lunch clubs for those who struggle in the playground, or a support group for young carers.

- Encourage small groups of children and young people to produce vodcasts (video) and podcasts (sound), to dramatise their views about life at school, or to use other creative approaches to express themselves freely.

- Establish clear rules of conduct at the start of a discussion group covering how information will be used/shared, rules on taking turns to speak, and anonymity.

Further reading

Using qualitative data (5/5)

Healthy Schools

- Provide adequate adult support to enable children and young people to participate fully, including those who require extra support because of their age, ability or experience.

Interviews and observations

There are already arrangements for interviews and observations taking place in schools. For example, many children and young people attend one-to-one meetings to discuss and agree targets and progress with a class teacher or tutor. Some children and young people have regular meetings with specialist colleagues, for example with the Special Education Needs Co-ordinator. It is useful to consider whether these existing interviews present an opportunity to ask specific questions about your health and wellbeing priority.

Tips for interviews and observations

- Incorporate a relevant health and wellbeing focus into existing observations in school. This could include lesson observations, playground observations or scrutiny visits by governors.

- Train children and young people as peer interviewers or observers and involve them as researchers in learning walks or as part of the tutorial process.

- Include one or more questions about your health and wellbeing priority into existing one-to-one meetings with children and young people as part of target-setting or tutorial work.

- Young children unable to read or write fluently and children and young people with additional needs are often able to communicate their views through drawings.

Further reading

Health and wellbeing needs analysis, priorities and outcomes (1/5)

These materials provide a **plan for a 90-minute training session**, which you could facilitate at a staff meeting, as part of an INSET day or at a health and wellbeing group meeting. After the session, participants will:

- be better able to work with relevant health and wellbeing data;
- be able to identify needs, select priorities and define outcomes and milestones.

As facilitator you will need:

- flipchart paper and pens
- print outs of the **session handouts**, which you can find in the 'further reading' download

Example timings	Suggested content
9.00	Introductions and timings Key messages for the session: • Remind participants that the Healthy Schools approach is in line with a school improvement model. • Health and wellbeing practice is developing in schools. • Encourage a 'learning together' approach; no one has all the answers.
9.05	• The main aspects that will be less familiar are the language, and the analysis and interpretation of health and wellbeing data. The session will include: • tips about drafting outcomes and milestones; • time to practice defining outcomes and milestones; and • opportunities to clarify key issues.

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Further reading

Health and wellbeing needs analysis, priorities and outcomes (2/5)

9.10 Give out handout 1 Give out handout 2	Prompts for developing health and wellbeing outcomes Introduce the definitions handout. Talk about the definitions handout – emphasise there is more information elsewhere in the toolkit. Be clear about the definitions. Talk through the example outcomes given and consider the difference between the non-measurable examples and the measurable ones? Introduce the public health indicators handout. These public health indicators illustrate relevant priority areas for children and young people. Sources of relevant data in school include quantitative (school management data, assessment of pupil progress (APP), attendance) and qualitative (self-reported survey or pupil evaluation data). See also using qualitative data.

9.20 Give out handout 3	Introduce the analysis of example secondary school data. Work in groups using the example school health and wellbeing data. Participants should read through the data on their own then work as a group to identify examples of data that indicate high, medium / mixed, or low performance using flipchart paper. Ask each group to feed back. If there is time, consider any issues about the quality of the data. Referring to the facilitator prompts included with the session handouts, challenge any misinterpretations of the data by participants.
9.35	Introduce the identification of a priority. Informed by the data and public healthy indicators, each group should now identify one possible area of priority for the fictitious school. Ask them to explain their thinking.

Further reading

Health and wellbeing needs analysis, priorities and outcomes (3/5)

	Write the proposed priorities on the flipchart. Then ask each group to choose a priority to work on from the list on the flipchart. You could recommend selecting from healthy weight, EHWB (linked to truancy rates), sexual health, anti-bullying (linked to self-reported wellbeing), or substance misuse. Note, it doesn't matter if more than one group chooses the same priority.
9.45	Introduce the section on drafting health and wellbeing outcomes. Ask participants to continue working in groups to draft at least two health and wellbeing outcomes for their chosen priority based on the school data in the handout. Remind them to make sure their outcomes are SMART. A targeted focus is not required in this activity because participants have not been provided with enough example data for this.

10.00	Come back together and share the outcomes you have all drafted. Record outcomes on flipchart and make any comments / clarifications. SHORT BREAK
10.20	Introduce the section on developing milestones. Take your priorities and associated outcomes (at least two per priority). Drawing again on the school data, identify milestones (including timescales for these). Participants should spend a few minutes on their own, thinking about the improvements being conceived for the school as a result of their priority and outcomes. Consider: • What might the school be like in three years time when the outcomes have been achieved?

Further reading

Health and wellbeing needs analysis, priorities and outcomes (4/5)

Give out more paper if needed	• What will you see in the outside areas, in classrooms, in the reception area? • What will you hear in teaching areas, in the staffroom, at break time? • How will the school feel for the children and young people? • How will it feel for members of staff? Allow time to think individually. Then ask participants to reach some consensus in their groups and record how the school will look and feel, in relation to their priority and outcomes.	10.45	A useful question for fine tuning milestones is – what are the events the SLT will need to know about in order to monitor progress? By this time, aim for all groups to be working on drafting wording for milestones. They should try to cover both of their outcomes and to include hypothetical dates. As facilitator, it's important you circulate at this point and help groups with any issues they are having wording their milestones. Try to ensure: • Groups do actually try to draft their milestones, not just talk about them. • People are thinking about impact milestones and the likely steps over a 2-3 year period. • People are referring back to what the data told them.
10.30	Thinking about how the school will look in three years' time, what key milestones will indicate progress towards achieving your outcomes? Ask each group to record their milestones. Remind participants that milestones are key points of progress rather than ongoing activities.		

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Further reading

Health and wellbeing needs analysis, priorities and outcomes (5/5)

11.05	Time for discussion and reflection. Ask each table to consider what they have learned and what they would pass on to a colleague. As facilitator you could feed in other positive points you have noted when circulating around each group.
11.15	Draw attention to the planning framework for milestones in the information section of the toolkit. Ask participants to consider if there is sufficient breadth in the planned milestones participants have recorded? Revisit and reflect on the session objectives. You may want to ask participants to complete an evaluation of the session.

11.20	What next? Participants may need to consider: • gathering and summarising real health and wellbeing data; • interpreting the health and wellbeing data; • discussing their interpretation of the data with the health and wellbeing group and deciding on a priority to recommend to the SLT; and • planning health and wellbeing outcomes and milestones for the school's agreed priority. END OF SESSION.

Further reading

Learning from the Southwest Healthy Schools Plus evaluation (1/3)

Southwest Healthy Schools Plus (SWHSP) was the pilot for the Healthy Schools health behaviour change approach as described in this toolkit (plan-do-review).

This summary is based on case studies from 12 schools that participated in South West Healthy Schools Plus in 2009-10. The purpose of the case studies was to describe and explain the processes and challenges that schools faced when engaging in health behaviour change.

Three main **benefits of participation** were described by schools:

- Flexibility, which enabled schools to tailor their activities/interventions to fit with recognised needs and existing provision.

- The effectiveness of programme support; schools could draw on written support materials and one-to-one advice.

- The opportunity to reinforce and reinvigorate their own Healthy Schools work.

Managing and coordinating in school

To engage effectively in health behaviour change:

- Leadership from senior staff is important, as it gives the necessary authority to drive through new activities/interventions and approaches.

- The Healthy School coordinator needs to play a central role in the programme of activities/interventions.

- Coordination requires designated time, together with flexibility to share Healthy Schools workload with colleagues.

Designing activities/interventions to fit local needs and school needs

A wide range of activities/interventions were delivered in the 12 schools. Staff welcomed the opportunity to tailor these to fit with existing work or to develop new areas.

Local area and school level data was made available to each school. This was helpful in identifying student needs and for selecting a priority for the school to focus on.

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Further reading

Learning from the Southwest Healthy Schools Plus evaluation (2/3)

When addressing health inequalities through work with children and young people in challenging circumstances, schools found it was most effective to identify individual children (for example, with low self-esteem or exhibiting disruptive behaviour). This worked better than trying to work only with those in a 'disadvantaged' category (for example children in care).

When working to improve healthy weight, schools developed a number of 'quick win' activities/interventions. When addressing a more complex priority, such as emotional health and wellbeing, schools found it more effective to concentrate on a single main activity/intervention, and to recognise the time and sensitivity required to achieve an impact.

Whilst recognising the value of whole school consultation, schools found it was important to be clear about the right level of involvement for staff, students and parents/carers at different stages of planning and delivery.

Improvements were most likely to be sustained where funding/resources were used for reusable resources (for example, improving the dining area, purchasing teaching packs to deliver improved learning opportunities), or to cover the set-up costs of an activity/intervention.

Monitoring outcomes

Measuring healthy behaviour before and after activities/interventions is essential in order to demonstrate impact. Schools found that careful planning was necessary for effective monitoring, and that access to support helped make it as effective as possible.

Effective approaches that were identified in the case studies:

- Use existing data on children and young people's health and wellbeing.

- Refer to example materials, such as the school examples in the Healthy Schools toolkit.

- Set milestones that are specific and realistic within the timeframe.

- Consider issues of data quality and validity from the planning stage.

- Decide when is the most appropriate time to take a measure of impact.

Further reading

Learning from the Southwest Healthy Schools Plus evaluation (3/3)

Activities/interventions that impacted on health and wellbeing

The case studies identified examples of activities/interventions that were shown to have an impact on student learning and behaviour, and also on staff and parents/carers (in terms of improved knowledge and awareness).

Healthy weight - gardening club, cycle to school week, healthier choices in school meals.

EHWB – a programme of learning about rights and responsibilities, learning to build positive and constructive relationships with other children and young people.

Sex and relationship education – increased access to sexual health information, increased understanding of inappropriate sexual behaviour as part of lessons in a special school.

Substance misuse – greater reflection about the negative outcomes of misusing drugs, as part of secondary PSHE education.

One of the main challenges in developing successful activities/interventions was engaging children and young people's interest. It is important to build ownership, and to aim activities/interventions at the right level.

How did the programme make a difference?

Engaging in health behaviour change made a difference to schools' approaches by:

- Giving renewed impetus to their Healthy School development and providing a framework within which work could progress (i.e. an evidence base, an action planning process, and the measurement of outcomes).

- Allowing schools to develop activities/interventions in a more coordinated way, which contributed to a better, healthier ethos.

- Facilitating closer links between schools, and between schools and providers of services and training for children and young people.

- Providing support and advice through written support materials and colleagues in the local area.

Further reading

Considerations for special schools (1/7)

When improving health and wellbeing in children and young people, here are some considerations for special schools.

PLAN: Health and wellbeing group membership

It can be challenging for school staff to commit additional time to promoting health and wellbeing (HWB). To ensure that staff can prioritise time towards activities/interventions, schools could include their responsibilities as part of performance management targets.

The HWB group should represent the whole school community. Special schools may find engagement with parents/carers particularly challenging due to large catchment areas and the distances travelled by children and young people. Home link workers, who have existing relationships with parents/carers, can facilitate consultation with them.

Special schools may not find it appropriate to include children and young people as members of the HWB group. Their views can be represented via other means, including existing participatory mechanisms such as School Councils. Teaching assistants may also fulfil a valuable role by canvassing the views of children and young people.

PLAN: Using data to determine needs and priorities

Special schools often have large catchment areas, which means a needs analysis based on the location of the school may be less appropriate. In these cases, special schools may need to gather data from beyond their immediate local area. Where this data is difficult to aggregate, schools should focus on those areas where the majority of children and young people live.

There can be challenges in collecting qualitative perception data from children and young people due to the nature of their learning needs and disabilities. Data collection can be facilitated by using creative methods including surveys with visual aids and assistance and support from teaching assistants.

Existing clusters or networks of special schools can be used to share practice and learning.

Special schools often have a range of health and wellbeing priorities linked to the school improvement plan. Linking priorities to the school improvement plan will both reduce the overall burden on the school and help drive existing priorities forward.

Further reading

Considerations for special schools (2/7)

It is good practice for special schools to consider the relevance of national and local priorities alongside the needs of their children and young people.

PLAN: Defining outcomes and identifying milestones

All children and young people attending special schools have additional and often unique needs but this does not preclude identifying common needs amongst specific groups of children and young people. Special schools should use the needs analysis to look at vulnerable groups, such as children and young people eligible for free school meals, looked-after children, and those with low self-esteem, with a view to defining targeted outcomes.

Outcomes need to be meaningful to children and young people as well as to the school. A school is much more likely to successfully achieve a Healthy Schools outcome when children and young people understand why the issue is important. Special schools will need to look at other ways they have successfully engaged children and young people to make sure they understand the relevance of issues.

DO: Selecting activities/interventions

Special schools often have existing partnerships with external organisations (including voluntary sector bodies) whose expertise can support planning and implementation of activities/interventions (e.g. supplying data to inform baseline measures).

Baseline measures that involve understanding children and young people's attitudes, perceptions and behaviours can be challenging for special schools. In some schools, support staff can provide one-to-one help so that children and young people can participate in surveys and creative methods of gathering data (e.g. food diaries).

Special schools often have capacity to be flexible with their curriculum, and can create opportunities to focus on activities/interventions to improve health and wellbeing.

Special schools are already expert in prioritising the health and wellbeing of their children and young people. The Healthy Schools toolkit provides a tried-and-tested approach and may add extra impetus without placing additional burdens on the school.

There are no special considerations for the REVIEW phase.

Further reading

Considerations for special schools (3/7)

Here are some frequently asked questions.

PLAN phase

Q1. Our staff roles are different to mainstream schools. Which staff should sit on the health and wellbeing (HWB) group?

A. There is no prescribed list of staff roles that should sit on the HWB group though it is a good idea to involve staff whose roles already reflect HWB priorities. We have seen a wide range of approaches to this in special schools. For example, membership may include representatives of the senior leadership team, governors, staff who lead on SEAL, inclusion, attendance and PSHE, the school chef, food technology teachers, nurses, physiotherapists, the head of PE, teaching assistants and members of the local community.

Q2. All the children and young people at our school are 'vulnerable' – does it make sense to try and identify particular groups?

A. Yes. A closer analysis of existing data can sometimes reveal patterns among vulnerable groups that have previously gone unnoticed. For example, one school discovered that looked-after children were significantly under-represented at after-school and holiday clubs.

Q3. We routinely collect data about our children and young people's health and wellbeing as a core part of our work. Do we need to collect more?

A. Most special schools have a range of existing data sources: annual reviews with parents; PSHE progress data; attendance data; medical records etc. These may well be enough to assess the needs of children and young people and to monitor progress towards outcomes. However, a needs analysis should be needs-driven rather than data-driven; don't select a priority simply because you have a lot of existing data on it.

Q4. Can we use data collected by partners?

A. Some monitoring information may come from partner organisations working with the school. For example a school worked with a voluntary sector partner to improve access to positive activities for disabled children in the local area and made use of their surveys of out-of-hours activity rather than collecting 'new' data. There is likely to be a range of partners with useful data. Schools should make sure data sharing agreements are in place and data protection is prioritised.

Further reading

Considerations for special schools (4/7)

Q5. Local data reflects the general population and not the particular needs of the children and young people in our school. Should we be influenced by it?

A. It is worth looking at the local data (such as the Joint Strategic Needs Assessment (JSNA)) as it may help identify local priorities relevant to your school. However special schools often have supplementary health-related data about their children and young people that can ensure relevance for the school population. Health professionals working in the school may provide a useful perspective on local and school health priorities.

Q6. We are worried that the milestones we have set lack ambition.

A. It's important to set realistic targets. We know that in some special schools with high-need children and young people, achieving even a very small health improvement can be a huge achievement.

Q7. We would like the views of children and young people to be represented in our Healthy Schools work. How can we make sure children and young people's views are heard?

A. Some special schools have successfully included children and young people on the HWB group and have found this useful. For example, in one school children and young people on the HWB group were the key to influencing the school chef. In other cases this may not be possible and you should use your judgment about adopting other methods of representation for children and young people.

Some special schools have existing participation mechanisms such as School Councils that can be used to consult with children and young people. Having the member of staff responsible for convening the School Council as a member of the HWB group with a clear remit to feedback, will strengthen children and young people's voice. Other ways of engaging children and young people include: discussion during assemblies or quiet class time; involving support staff in one-to-one discussions that can be fed back to the HWB group; using simple questionnaires with pictures (that children and young people complete with parents/carers or teaching assistants); and using ICT and PECS symbols to support participation. Teaching assistants can provide valuable support when consulting children with communication difficulties.

Further reading

Considerations for special schools (5/7)

Q8. We rarely see parents/carers as our children and young people are bussed to school. How can we consult effectively with them?

A. Special schools may have a home link worker who has established relationships with parents/carers that can be used to canvass their views. Parents/carers can be invited to sit on the HWB group, to participate in health days, or to work with their children in after-school clubs. Regular reviews with parents/carers may also be used as an opportunity to encourage them to get involved, e.g. during parents'/carers' evenings.

Q9. Our parents/carers may struggle to complete a survey. How can we get around this?

A. When you survey parents/carers there are a number of ways of helping them respond. Some schools have undertaken short telephone surveys of parents/carers or used regular parent/carer meetings at the school to discuss activities/interventions aimed at improving health and wellbeing. Others have made sure that parents/carers have access to teaching assistants to support the completion of short questionnaires.

DO phase

Q10. Healthy Schools work can be challenging to implement in a special school and we are concerned we are not doing it well. How can we get more support?

A. In some areas a network of Healthy School leads from local special schools has formed so leads can share good practice and talk through the challenges with others who understand the implications of implementing Healthy Schools in a special school.

Q11. Healthy Schools work can be time-consuming for staff who already have high workloads. How can we limit the additional burden on staff?

A. This issue is not unique to special schools, although it has been raised as a particular problem for them. Special schools have found it helpful to select members of the HWB group on the basis of 'fit' with existing staff duties relating to the health and wellbeing of children and young people (for example the PSHE coordinator and the lead on inclusion). In some cases this might involve limiting the time span of membership to suit the current focus of activities/interventions. Other special schools have reflected outcomes and milestones for health and wellbeing improvement in individual
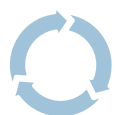
Further reading

Considerations for special schools (6/7)

performance management targets to ensure that staff can prioritise and be credited for achievements.

Q12. Our school has a number of ongoing agendas, objectives, pilot schemes etc. each of which has regular meetings. Can we combine our Healthy Schools work with these?

A. Some special schools have extended the remit of existing working groups to include improvements in health and wellbeing instead of setting up a new group. Examples include a pre-existing healthy eating groups and a SEAL working group. Prioritising health and wellbeing using the Healthy Schools toolkit need not entail 'new' work, but rather can be used to reinforce existing objectives. Linking health and wellbeing priorities to other projects in the school is a good idea and will reduce workload.

Q13. Our school has an improvement plan as well as a number of ongoing objectives, pilot schemes etc. We would find it hard to implement yet another set of objectives.

A. Health and wellbeing improvement outcomes targeted via the Healthy Schools toolkit can often match or complement objectives already identified within the school, for example efforts to become an 'eco-school'. Objectives in the school improvement plan such as improving school attendance can be also outcomes for improving health and wellbeing.

Q14. We share space with a mainstream school. Can we work on joint HWB outcomes and milestones, despite the differences between our children and young people?

A. Yes – there are examples of special and mainstream schools running joint activities to improve physical activity and emotional wellbeing.

REVIEW phase

Q15. The health and wellbeing of children and young people is one of the key priorities in our school. We spend a greater proportion of our time working on this issue than mainstream schools because of the needs of our children and young people. How do we ensure that Healthy Schools actually adds value to what we do already?

A. The 'plan-do-review' approach works well and is a familiar approach for most schools. It can be a way of further engaging parents/carers in the health and wellbeing (HWB) of their children and, as part of the HWB group, giving them real opportunities to shape policy and practice in school.

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Further reading

Considerations for special schools (7/7)

Engaging with the Healthy Schools toolkit should add value. This might be through a more comprehensive needs analysis or a re-think about how outcomes might be achieved. The identification of outcomes and milestones may encourage more activity and monitoring of success, perhaps better evidencing value for money of ongoing activities /interventions.

Q16. Our children and young people often have a limited understanding about their own health and wellbeing and this makes it difficult to involve them in assessing needs and monitoring outcomes.

A. This has been addressed in some schools by improving understanding before addressing behaviour change. For example, one school asked children and young people to record their intake of '5 A DAY' but soon recognised that few children and young people knew what counted as fruit and vegetables. As a result, the outcome set by the school was to increase children and young people's understanding of the '5 A DAY' concept, before attempting to raise the percentage of children and young people achieving it.

The following pages present two school stories from special schools.

Further reading: Special school story

Langley School Birmingham (1/2)

February 2011

About our school

We are a happy, family-friendly school providing education for primary-age children with moderate learning difficulties (MLD). Many of our children also have English as a second language. We have recently relocated into a new building on a shared site with a mainstream primary school, including communal outdoor spaces and eating areas. Our partnerships with parents/carers, health professionals and mainstream schools are really important to providing good support for our children's health and wellbeing. Particularly important is our strong partnership with Coppice Primary School, with whom we share the site.

Healthy Schools has been a priority for us for many years and our health and wellbeing (HWB) group has overseen our activities. Recent developments have sharpened our focus on the health improvements we wish to see among our children and given us specific successes to celebrate across the whole school.

What needs did we identify?

We identified and gathered existing data, which helped us to better understand our children's health and wellbeing needs at a school level. This included PSHE progress and expected targets, parent/carer satisfaction questionnaires, records of annual reviews with parents/carers, student questionnaires, walking and activity diaries, and data from existing school initiatives such as PE and School Sport for Young People (PESSYP) data.

Our recent relocation has resulted in a smaller outdoor space, which our children need to learn to share with children from the mainstream school. We were concerned about the effect of this on wellbeing.

We gathered local data that included community information, local authority plans and PCT health data to identify the main, local health priorities. We made this as practical as possible by focusing on data referring to areas where the majority of our children live.

Following discussions at our HWB group we selected two priorities: improving emotional health and wellbeing, and the prevalence of healthy weight among children and young people.

How do we plan to address the needs?

Among the outcomes that we identified are:

- Increase from 0 to 60 per cent the number of children (years 2, 3 and 4) who say they are happy with their outside environment.

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Further reading: Special school story

Langley School Birmingham (2/2)

- Increase from 0 to 75 per cent the number of children (years 2, 3 and 4) who actively participate in joint school life.

- Decrease from five to three the number of children with behavioural, emotional and social difficulties (BESD) who exhibit challenging behaviours at lunchtimes.

- Increase from 15 to 60 per cent the number of children from year 2, 3 and 4 who participate regularly in physical activity clubs.

What activities are we developing?

We have made changes to the outdoor environment to improve emotional and physical health by creating a new grass area, bike storage space and by investing in play equipment. We have worked with Coppice Primary to create joint activity clubs at lunchtime and a joint Friends Against Bullying (FAB) club to improve understanding between the two groups of children. Some of our children have been trained as play leaders and help to organise lunchtime activities.

We have built on our active involvement in the local schools sports partnership to successfully encourage external partners to run activities for free, including street dance, golf, and tennis. Year 11s from a local grammar school also run a lunchtime athletics club for our children.

What next?

We are beginning to monitor our early milestones, which will provide us with evidence of the impact we are already having on our children's knowledge and health behaviours. We are about to start a 'food growing club' so that children can learn practically about benefits of fruit and vegetables. We hope to coordinate with the school kitchen so that produce can be used in some school dinners. In this way children will better understand how their food is prepared and cooked. We also plan to encourage parent/carer involvement in the food growing club to promote their understanding of healthy eating and increase parent-school engagement.

'As a school, it has made us think about our priorities. For us it's been a good process to actually record the steps and to be able to show that there has been an impact.' **Healthy school coordinator and PE subject leader.**

Description: Community special school for 3-11 year olds. 89 children.

Context: 51% FSM, 100% SEN

Further reading: Special school story

Calthorpe School Sports College Birmingham (1/2)

February 2011

About our school

We are a large special school providing education for children and young people with severe, complex and profound learning difficulties from across Birmingham. Many of our children and young people have additional sensory difficulties such as hearing or visual impairment and, for two thirds, English is an additional language. We hold specialist status in three areas: sports, mathematics and computing, and modern foreign languages. We have been committed to Healthy Schools for over five years.

We aim to provide as stimulating and inspiring a learning environment as possible for every one of our children. We include in this opportunities to learning outside the school, both in local community activities and at mainstream schools. Our drive to provide the best in health and wellbeing support to our children and young people is overseen by our health and wellbeing (HWB) group. This is led by one of our assistant head teachers and participants include a cross-section of staff and our school nurse.

What needs did we identify?

Our HWB group discussed the areas that our needs analysis should consider. We then used existing data, including data on attendance, teacher questionnaires looking at children's emotional health and wellbeing, and surveys of parents/carers and teaching assistants regarding children's health and wellbeing needs and behaviours. For example, we looked at how many fruit and vegetables children were eating on a typical day. We also collected information about vulnerable groups in the school and identified as a need the limited participation in wider school activities by our looked-after children. We accessed local area data too and looked at the health priorities and statistics across the five PCTs in Birmingham. As a result we decided our priorities for health improvement would be: improving

 emotional wellbeing and improving the prevalence of healthy weight among our children and young people.

How do we plan to address the needs?

Among the outcomes we identified are:

- Increase the proportion of children and young people who participate in out-of-school physical activity clubs from 20 to 40 per cent, by summer 2011.

Further reading: Special school story

Calthorpe School Sports College Birmingham (2/2)

- Increase the number of overweight and obese children who have accessed targeted support from 0 to 12, by summer 2012.

- Increase the numbers who show improved self-confidence (as monitored through public speaking and peer support) from 41 to 62 children and young people, by summer 2012.

- Increase the looked-after children who feel well-supported at school (monitored through the number of students accessing inclusive activities) from 9 to 45 percent, by summer 2012.

What activities are we developing?

We have now set up nutritional workshops for parents/carers of children who are obese and overweight. We agreed with the PCT that, in addition to delivering the workshops, they would approach the parents/carers directly to offer further support, for example a parents'/carers' healthy cooking session.

We have developed a targeted approach to involving looked-after children who have lower attendance at out-of-school activities by regularly monitoring attendance and proactively encouraging their participation. Our teachers now have easy access to information about our looked-after children, and they track their progress across the curriculum as well as participation in activities.

What next?

We are now looking at how we can use and adapt our SEAL programme to further improve the self-confidence of children and young people. We have recently introduced SEAL mornings, which parents/carers are invited to attend.

Each morning has a theme of an aspect of emotional health and wellbeing. Parents/carers can find out about the knowledge and skills their children are developing relating to emotional health and wellbeing. We are also currently identifying a range of opportunities for children to speak publicly within school and build their self-confidence in this way.

Description: Large specialist sports college providing special education to 2 – 19 year olds. 290 students.

Context: 43% FSM, 100% SEN, 74% BME

Entry level qualification passed: 29%.