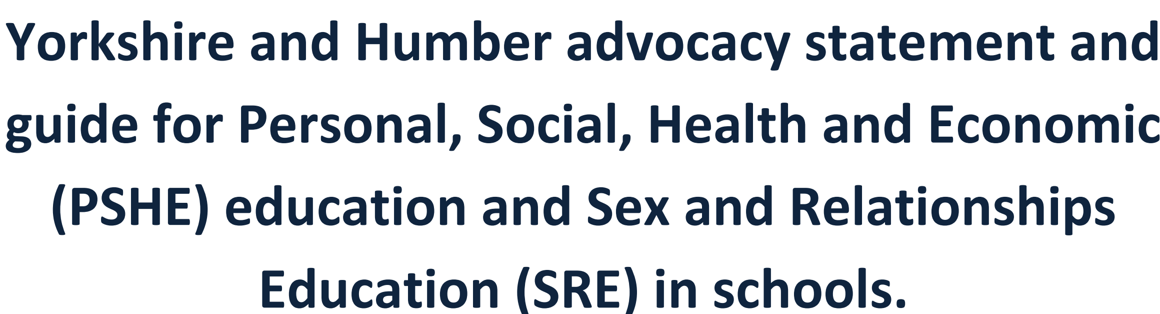


Yorkshire and Humber advocacy statement and guide for Personal, Social, Health and Economic (PSHE) education and Sex and Relationships Education (SRE) in schools.

Author: Yorkshire and Humber Children and Young People's Community of Improvement

Published: February 2017

Review date: February 2018

Summary of statement and guide

The Yorkshire and Humber ADPH have a role in advocating for effective public health interventions. Locally there is role in advocating for every school to deliver effective PSHE and SRE in the absence of legislation. The goal of the strategic advocacy statement and guide is to reenergise discussion and prompt action across the local authority areas in engaging appropriate stakeholders to ensure that PSHE provision is universal and based on need and evidence.

The purpose of the statement and guide is twofold: firstly to set out the position of the Yorkshire and Humber Association of Directors of Public Health (ADPH) on Personal, Social, Health and Economic (PSHE) education and Sex and Relationships Education (SRE). Secondly to assist local areas in advocating for universal high quality whole school approaches to PSHE and SRE.

The Yorkshire and Humber Association of Directors of Public Health and Public Health England Yorkshire and Humber Centre believe that there should be a **universal requirement for schools and colleges to teach age appropriate PSHE and SRE. The quality of this should be assessed by Ofsted alongside the core curriculum.**

The public health workforce should **advocate for statutory status of PSHE and SRE**, and **engage all schools, colleges and alternative education providers to deliver comprehensive and quality PSHE and SRE based on an assessment of need and monitored and evaluated for its impact.**

Schools should be supported to take a "**whole school approach"** to PSHE and SRE where teaching and learning is complemented by actions to promote a positive ethos and environment and partnerships with parents, carers and the local communities. Actions taken should be based on pupil needs.

There is good evidence that interventions that promote health and wellbeing have potential to promote attainment. When delivered effectively PSHE can provide pupils with the necessary life skills to enable them to succeed academically and in the workplace; as well as stay safe and live physically and emotionally healthy lives.

PSHE education is a non-statutory subject on the school curriculum, despite evidence demonstrating its effectiveness to improve health and wellbeing and attainment and ongoing lobbying from various groups. Pupils across Yorkshire and Humber may be missing out on the full benefit of PSHE and SRE education. The Directors of Public Health want to advocate for the benefits of young people receiving good quality PSHE and SRE.

Yorkshire and Humber advocacy statement and guide for Personal, Social, Health and Economic (PSHE) education and Sex and Relationships Education (SRE) in schools.

The Yorkshire and Humber Association of Directors of Public Health and Public Health England Yorkshire and Humber Centre believe that there should be a **universal requirement for schools and colleges to teach age appropriate PSHE and SRE. The quality of this should be assessed by Ofsted alongside the core curriculum.**

The public health workforce should **advocate for statutory status of PSHE and SRE**, and **engage all schools, colleges and alternative education providers to deliver comprehensive and quality PSHE and SRE based on an assessment of need and monitored and evaluated for its impact.**

Schools should be supported to take a "**whole school approach"** to PSHE and SRE where teaching and learning is complemented by actions to promote a positive ethos and environment and partnerships with parents, carers and the local communities. Actions taken should be based on pupil needs.

1. Purpose

The purpose of this guide is twofold: firstly to set out the position of the Yorkshire and Humber Association of Directors of Public Health (ADPH) on Personal, Social, Health and Economic (PSHE) education and Sex and Relationships Education (SRE). Secondly to assist local areas in advocating for universal high quality whole school approaches to PSHE and SRE.

Strategic advocacy for PSHE has been identified by the Directors of Public Health (DsPH) in Yorkshire and Humber as a way to promote PSHE and engage schools in light of the changes to the role of Local Authorities and their influence over schools. The ADPH and Public Health England (PHE) have a role in advocating PSHE and SRE at a strategic level nationally, whilst directors of public health and their local authority colleagues can influence locally.

The Educational excellence everywhere[1] White Paper (2016) proposals to force all schools to become academies have since been scrapped but schools and colleges across the system are increasingly being given greater freedom around what should be taught. This guide identifies levers we could use to influence schools to prioritise PSHE.

[1] Department for Education and Rt Hon Nicky Morgan(2016) , Educational excellence everywhere, https://www.gov.uk/government/publications/educational-excellence-everywhere

2. Background

PSHE education is a non-statutory subject on the school curriculum, despite evidence demonstrating its effectiveness to improve health and wellbeing and attainment [2] [3] and ongoing lobbying from various groups. Pupils across Yorkshire and Humber may be missing out on the full benefit of PSHE and SRE education. The Directors of Public Health want to advocate for the benefits of young people receiving good quality PSHE and SRE.

The following guide has been developed using information gathered at the Children and Young People's Community of Improvement. This network is sponsored by the DsPH across the region.

PSHE can be defined as:

- a planned programme of learning that equips pupils with the knowledge, understanding, skills and strategies required to live healthy, safe, productive, capable, responsible and balanced lives
- that is delivered as part of a whole school approach
- which focuses on Health alongside Relationships and Living in the Wider World [4]

3. Why is there a need to advocate for PSHE and SRE?

The Yorkshire and Humber ADPH [1]have a role in advocating for effective public health interventions. Locally there is role in advocating for every school to deliver effective PSHE and SRE in the absence of legislation. The goal of the strategic advocacy statement and guide is to reenergise discussion and prompt action across the local authority areas in engaging appropriate stakeholders to ensure that PSHE provision is universal and based on need and evidence.

There is good evidence that interventions that promote health and wellbeing have potential to promote attainment.[5] [6] [7] When delivered effectively PSHE can provide pupils with the necessary life skills to enable them to succeed academically and in the workplace; as well as stay safe and live physically and emotionally healthy lives.

Although section 2.5 of the national curriculum states that all state schools 'should make provision for personal, social, health and economic education (PSHE), drawing on good practice', the quality of PSHE and SRE in schools, on the whole, is not adequate. Research has found that young people in England consistently say that the SRE they receive is not good enough. Just over a quarter of pupils

[2] Public Health England (2014). The link between pupil health and wellbeing and attainment. https://www.gov.uk/government/publications/the-link-between-pupil-health-and-wellbeing-and-attainment

[3] PSHE Association (2016) A curriculum for life- the case for statutory PSHE. https://www.pshe-association.org.uk/curriculum-and-resources/resources/curriculum-life-case-statutory-pshe-education

[4] Public Health England (2014) Education Select Committee Inquiry into Personal, Social, Health and Economic education (PSHE) and Sex and Relationships Education (SRE) in schools

[5] Ofsted (2013) 'Not Yet Good Enough' – PSHE http://www.ofsted.gov.uk/resources/not-yet-good-enough-personal-social-health-and-economic-education-schools

[6] Bonell,C; Humphrey, N; Fletcher,A; Moore, L; Anderson, R and Campbell, R (2014) Why schools should promote pupils' health and wellbeing, BMJ 2014;348:g3078

[7] Gutman and Vorhaus (2012) The impact of pupil behaviour and wellbeing on educational outcomes, Department for Education, 2012; www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-RB253

(27%) stated their SRE as 'bad' or 'very bad' and 25% reported they had learned nothing about HIV and AIDS.[8] A recent Cochrane Review[9] examined the effect of SRE programmes on biological outcomes such as pregnancy or sexually transmitted infections (STIs) rather than just on knowledge or self-reported behaviour change. It found little evidence that educational programmes alone are effective in reducing STIs or adolescent pregnancy and this needs to be combined with provision of contraception and condoms and reiterates the importance of involving young people in decision-making about services that best meet their needs. Whole school approaches that encourage young people, particularly girls, to stay in education need to be delivered alongside curriculum-based education.

The picture across the region is variable in terms of provision and how schools are supported to deliver a PSHE and SRE. Examples of different approaches to PSHE can be found in appendix 1.

4. Health behaviour among young people in Yorkshire and the Humber

During the past decade overall trends in certain health behaviours of children and young people in England show reductions in the proportions who are drinking, smoking and using drugs[10], and falling rates of teenage pregnancy.[11]

Despite improvements, there is evidence of a worsening picture in relation to some health outcomes as well as variation across the region, for example:

- Teenage conceptions in Yorkshire and Humber are also falling but rates remain significantly higher than the England average
- Young people aged 15-24 carry the burden of sexually transmitted infections[12]
- The What About Youth (WAYouth) survey in 2014 showed that more young people in Yorkshire and the Humber smoke regularly, have tried electronic cigarettes, drink regularly and admit to having been drunk in the past four weeks than the England average. More young people in our region reported three or more risky behaviours. However, fewer young people report having used cannabis or other drugs in the past month than the England average[13]
- Child obesity prevalence is similar to England levels and increases significantly between the first and last years of primary school; one in five children in Reception are overweight or obese, rising to one in three children in Year 6

[8] Sex Education Forum Survey Report 2011, Young Peoples experiences of HIV and AIDS Education

[9] Mason-Jones A, Sinclair D, Mathews C, Kagee A, Hillman A and Lombard C, 2016. School-based interventions for preventing HIV, sexually transmitted infections and pregnancy in adolescents. Cochrane Database of Systematic Reviews. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006417.pub3/full

[10] NHS Digital. *Smoking, drinking and drug use among young people in England in 2014*. http://content.digital.nhs.uk/catalogue/PUB17879/smok-drin-drug-youn-peop-eng-2014-rep.pdf

[11] Office for National Statistics. Conceptions in England and Wales, 2014. http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2014

[12] Public Health England. Sexually Transmitted Infections: annual data tables https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables

[13] https://fingertips.phe.org.uk/profile/what-about-youth/data#page/0/gid/1938132904/pat/6/par/E12000003/ati/102/are/E08000016

There are low levels of engagement among school-age population in relation to protective lifestyle behaviours such as regular physical activity and healthy eating. The WAYouth survey showed fewer than half of respondents in Yorkshire and Humber ate the recommended five portions of fruit and vegetables each day, 70.6% had a mean daily sedentary time of over seven hours, and only 13.7% were physically active for more than an hour a day, seven days a week.

Data from the public health outcomes framework and local needs assessments demonstrate that across the region and within local authority areas there is variation in health outcomes for children. Children living in areas with high levels of deprivation face persistent health inequalities and have poorer health outcomes.

5. Position statement on PSHE and SRE from The Yorkshire and Humber Association of Directors of Public Health and PHE

The DsPH have an important role in advocating for health. Given the evidence, the Yorkshire and Humber ADsPH are very supportive of universal PSHE and SRE across the educational sector. The Yorkshire and Humber ADsPH suggest local public health teams, with support from regional and national PHE where appropriate, work closely with their Council colleagues and their local schools to advocate for a whole system approach to ensure PSHE and SRE is a key element of the curriculum – given the same status as English, maths and science.

The Yorkshire and Humber Association of Directors of Public Health and Public Health England Yorkshire and Humber Centre believe that there should be a **universal requirement for schools and colleges to teach age appropriate PSHE and SRE. The quality of this should be assessed by Ofsted alongside the core curriculum.**

The public health workforce should **advocate for statutory status of PSHE and SRE**, and **engage all schools, colleges and alternative education providers to deliver comprehensive and quality PSHE and SRE based on an assessment of need and monitored and evaluated for its impact.**

Schools should be supported to take a "**whole school approach"** to PSHE and SRE where teaching and learning is complemented by actions to promote a positive ethos and environment and partnerships with parents, carers and the local communities. Actions taken should be based on pupil needs.

6. A guide to advocating for personal social, health and economic (PSHE) and sex, relationships education (SRE) in Yorkshire and Humber schools

6.1. Purpose and aim

To raise the profile of effective PSHE and provide assurance that all young people are receiving good quality PSHE.

Success would be seen as the delivery of high quality comprehensive evidence based PSHE delivered in **all** school, colleges and education providers.

6.2. The Evidence linking pupil health and wellbeing to attainment

There is a vast amount of evidence demonstrating the positive impact PSHE. The key points from the evidence[14] are:

- Pupils with better health and wellbeing are likely to achieve better academically.
- Effective social and emotional competencies are associated with greater health and wellbeing, and better achievement.
- The culture, ethos and environment of a school influence the health and wellbeing of pupils and their readiness to learn.
- A positive association exists between academic attainment and physical activity levels of pupils.

6.3. Identifying Target Audience

Identifying the target audience is essential for any type of advocacy. Being clear about who the key decision makers are and who really has influence must be established at the start. The list below identifies some of the key decision makers.

- Headteachers
- School governors
- Safeguarding Children's Board
- Elected members(particularly the children's and Public health portfolio holders)
- Scrutiny boards
- Children's services within Local Authority
- Children's Trust Board
- Academy/Multi-academy trust boards
- Health and Wellbeing boards
- Parents and carers
- School Nurses
- Sport England

Questions that will help you identify key influencers in your area:

- Who are the influencers?
- What do they need to hear
- Who else can help?
- Which partnerships or boards should we be using and how can you engage them?
- What do we have in place already that can help Y&H CYPs group advocate for PSHE?

School governors at multi-academy trust boards were seen as a huge opportunity given the power and influence they have over the priorities of a number of

14 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/370686/HT_briefing_layoutvFINALvii.pdf

schools.

6.4. Selecting the a messenger

The right messenger is also important and may vary depending upon the audience you are targeting. It is important to select people who would be seen as influential and authoritative as well as being an effective spokesperson.

Questions to consider:

- Who are the effective spokes people?
- Who has influence over the target audience?
- How do you motivate others to advocate? Maximise

6.5. Using safeguarding as a lever

PSHE education and safeguarding are inextricably linked. The statutory Department of Education guidance *Keeping Children Safe in Education*[15] emphasises that governing bodies should ensure pupils are taught about safeguarding, including from online abuse. This should be delivered through teaching and learning opportunities, as part of providing a broad and balanced curriculum. This may include covering relevant issues through PSHE education. Specific issues referred to in the document include child sexual exploitation, domestic violence, female genital mutilation, forced marriage, substance misuse, sexting, relationship abuse and preventing radicalisation.

Schools also have duties in relation to promoting pupil wellbeing and pupil safeguarding, defined in the Children Act 2004[16] as 'the promotion of physical and mental health; emotional wellbeing; social and economic wellbeing; education, training and recreation; recognition of the contribution made by children to society; and protection from harm and neglect'.

6.6. Linking PSHE to Ofsted

The Academies Act 2010[17] states that Ofsted inspections will consider the extent to which a school provides such a curriculum:

- which is balanced and broadly based
- promotes the spiritual, moral, social, cultural, mental and physical development of pupils at the school and within society
- prepares pupils at the school for the opportunities, responsibilities and experiences of later life

PSHE education can make a significant contribution to whole school judgments under the Ofsted *Common Inspection Framework*, particularly in the areas of safeguarding, personal development, behaviour and welfare, as well as leadership and management. It will be significantly easier for schools to adequately evidence that they are meeting inspection criteria in these areas if they have a planned, developmental PSHE and Citizenship programme in place. Ofsted's inspection framework[18] makes clear that the responsibilities placed on governing bodies, registered providers, proprietors and management committees include: 'making sure children and learners are taught how to keep

---

[15] Keeping children safe in education. https://www.gov.uk/government/publications/keeping-children-safe-in-education--2

[16] Childrens act 2004. http://www.legislation.gov.uk/ukpga/2004/31/contents

[17] Academies act 2010. http://www.legislation.gov.uk/ukpga/2010/32/contents

[18] School inspection handbook. https://www.gov.uk/government/publications/school-inspection-handbook-from-september-2015

themselves safe', with Ofsted's PSHE Lead Janet Palmer HMI stating that 'it is difficult to see how safeguarding can be good if PSHE education is poor'. North Yorkshire County Council has written a document that identified links between Ofsted and PSHE. Please see section 8 "useful documents "for contact details.

6.7. Demonstrating need using school and local data

A number of LAs have developed school based surveys which identify health and wellbeing needs on a school by school basis. Examples of these can be found in the case studies. Public Health England also publishes children's health data on a local authority level. https://fingertips.phe.org.uk/

6.8. Legal Duties

The Equality Act 2010[19] places duties on schools not just to address prejudice-based bullying but also to help to prevent it happening, and in doing so to keep protected characteristic groups safe. PSHE education, with its focus on identity and equality, can help schools to fulfil this duty.

Key messages

To increase the salience with the target audience a small number of key messages should be used. These messages should always be backed up by evidence. A PowerPoint presentation has been included in section 8which highlights some key messages.

Questions to consider

- What are the strengths and weaknesses of yours and the opposition's position?
- How can we make sure the target audience hears the key messages?
- What are the key talking points?
- How can this issue be personalised/real life stories?
- How do we incorporate children's and Young people's voice?

Key messages

General	Audience
PSHE education is a planned, developmental programme of learning through which children and young people acquire the knowledge, understanding and skills they need to manage their lives now and in the future. As part of a whole-school approach, PSHE education develops the qualities and attributes pupils need to thrive as individuals, family members and members of society.	All
Whilst not mandatory, PSHE is recommended in the National Curriculum. The guidance states PSHE education is an important and necessary part of all pupil's education. All schools should make provision for PSHE, drawing on good practice.' (https://www.gov.uk/government/publications/personal-social-health-and-economic-education-pshe/personal-social-health-and-economic-pshe-education and https://www.gov.uk/government/publications/national-curriculum-in-england-framework-for-key-stages-1-to-4/the-national-curriculum-in-england-framework-for-key-stages-1-to-	Headteachers School governors Academy school boards Directors of Children's Services Elected members

[19] Equalities act 2010. https://www.gov.uk/guidance/equality-act-2010-guidance

4)	
There is good evidence that interventions to promote health and wellbeing have the potential to also promote attainment. [20]	Headteachers Elected members Directors of Children's Services School Governors Academy school boards Parents and carers
There is strong evidence to suggest that the focus of PSHE education on health, wellbeing and key skills has the potential to significantly aid academic attainment.	Headteachers Elected members Directors of Children's Services School Governors Academy school boards Parents and carers
Pupils with better health and wellbeing are likely to achieve better academically.	Headteachers Elected members Directors of Children's Services School Governors Academy school boards Parents and carers
The culture, ethos and environment of a school influences the health and wellbeing of pupils and their readiness to learn.	Headteachers Elected members Directors of Children's Services School Governors Academy school boards Parents and carers
Ofsted has identified a strong correlation between schools that achieved a high grade for personal, social, health and economic education (PSHE) and those that were graded outstanding for overall effectiveness.[21]	Headteachers School governors Academy school boards Parents and carers
Young people's participation in the design and personalisation of PSHE/SRE content is important.	Headteachers School governors Academy school boards
Teachers and other school staff involved in PSHE education and SRE should be trained effectively to equip them with the knowledge, understanding and skills to respond to the holistic health and wellbeing needs of pupils.	Headteachers School governors Academy school boards
Health and wellbeing	**Audience**
Promoting physical and mental health in schools improves attainment and achievement, which in turn improves their health and wellbeing and enables them to thrive and achieve	Headteachers Elected members Directors of Children's

[20] Ofsted (2013) 'Not Yet Good Enough' – PSHE http://www.ofsted.gov.uk/resources/not-yet-good-enough-personal-social-health-and-economic-education-schools
[21] Ofsted (2013). Not yet good enough: personal, social, health and economic education in schools

their full potential.	Services School Governors Academy school boards Parents and carers
Effective social and emotional competencies are associated with greater health and wellbeing, and better achievement.	Headteachers Elected members Directors of Children's Services School Governors Academy school boards Parents and carers
A positive association exists between academic attainment and physical activity levels of pupils.	Headteachers Elected members Directors of Children's Services School Governors Academy school boards Parents and carers
PSHE education can promote positive outcomes relating to emotional health while reducing stigma and helping pupils learn where to go if they have mental health concerns.	Headteachers Elected members Directors of Children's Services School Governors Academy school boards Parents and carers
Educating pupils about their health reduces risk-taking behaviours such as drug or alcohol addiction and improves diet and exercise levels, in turn boosting long-term life chances.	Headteachers Elected members Directors of Children's Services School Governors Academy school boards Parents and carers
Taking a 'whole school approach' has a positive impact in relation to outcomes including: body mass index (BMI), physical activity, physical fitness, fruit and vegetable intake, tobacco use, and being bullied. Whole-school approaches have been associated with improvements in children's diets and their food choices.	Headteachers Elected members Directors of Children's Services School Governors Academy school boards Parents and carers
Sex and relationships education	**Audience**
Sex and relationship education (SRE) is statutory for state maintained secondary schools in England. It is not statutory for academy schools but all schools providing SRE, regardless of status, are required to take account of guidance from the	Headteachers School governors Academy school boards Directors of Children's

Secretary of State. https://www.gov.uk/government/publications/sex-and-relationship-education	Services Elected members
Good quality sex and relationship education equips young people to understand consent, stay safe from coercive and exploitative sex and make positive and well informed choices about their relationships and sexual health. There also is no evidence that SRE hastens the first experience of sex or increases the frequency of sex.[22] Young people who report school as their main source of SRE are less likely to be pregnant before 18.[23]	Headteachers Elected members Directors of Children's Services School Governors Academy school boards Parents and carers
When pupils receive lessons on healthy relationships, their first sexual activity occurs later and they are more likely to report abuse and exploitation. PSHE education is considered vital in promoting the safe use of technology and addressing online abuse.	Headteachers Elected members Directors of Children's Services School Governors Academy school boards Parents and carers
Preparation for adulthood	**Audience**
The teaching of social skills and the methods used to facilitate skill development is important in promoting a range of health behaviours[24] [25] [26] and increasingly recognised as essential for employment.	Headteachers Elected members Directors of Children's Services School Governors Academy school boards Parents and carers
The non-academic skills and attributes acquired through PSHE education – often termed 'character' – have a positive impact on academic performance and life chances as well as being key to boosting the employability of school-leavers and improving social mobility.	Headteachers Elected members Directors of Children's Services School Governors Academy school boards Parents and carers
Societal benefits	**Audience**
School-based interventions, including delivery within the curriculum derive cost-benefits for society. Interventions to	Head teachers Elected members

[22] Kirby D, Emerging Answers (2007) Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases, National Campaign to Prevent Teen and Unplanned Pregnancy, 2007

[23] The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (NATSAL-3)

[24] Schaalma, Abraham, Gillmore and Kok, (2004) Sex education as health promotion: what does it take? Arch Sex Behav. 2004 Jun;33(3):259-69

[25] Alcohol and Drug Education and Prevention Information Service (2014) Qquality standards for effective alcohol and drug education in schools http://mentor-adepis.org/wp-content/uploads/2014/03/Quality-standards-for-effective-alcohol-and-drug-education1.pdf

[26] NICE public health guidance 12 and 20 http://www.nice.org.uk/PH012 and http://www.nice.org.uk/nicemedia/live/11991/45484/445484.pdf

tackle emotional learning are cost saving in the first year through reductions in social service, NHS and criminal justice system costs and have recouped £50 for every £1 spent.[27] Drug and alcohol interventions can help young people engage in education, employment and training bringing a total lifetime benefit of up to £159 million.[28]	Directors of Children's Services School Governors Academy school boards

One of the most important messages to get across that the culture, ethos and environment of the school have an enormous impact on the health and wellbeing of pupils. Below are the eight principles to promote emotional health and well-being.

Source: Promoting children and young people's emotional health and wellbeing. A whole school and collage approach.

7. Measuring the impact of advocacy

Measuring the impact of advocacy can be considered on 3 levels

- Reach of campaign- short to medium term
- Impact of campaign- short to medium term
- Outcomes for young people- long term

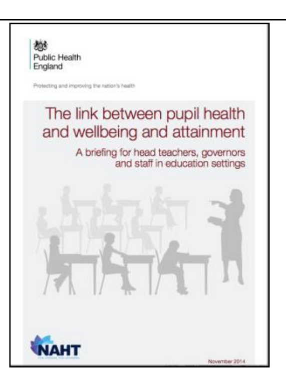
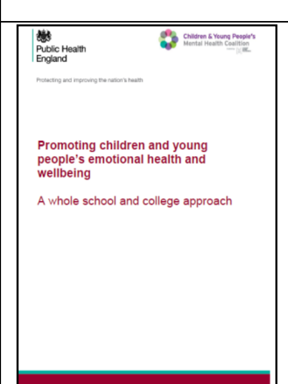
[27] Knapp, M, McDaid, D, Parsonage M (eds) (2011) Mental Health Promotion and Prevention: The economic case. London: Personal social Services Research Unit, London School of Economic and Political

[28] PHE (2013) Alcohol and drugs prevention, treatment and recovery, why invest?

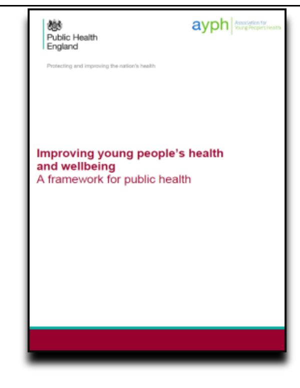
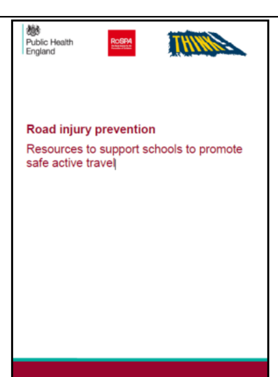
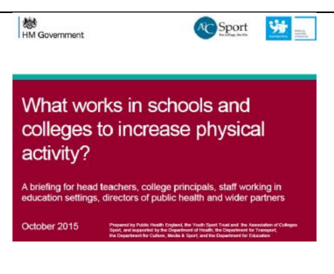
Monitoring and evaluating advocacy often relies upon measuring the reach and impact in the short to medium term. This will include frequency of news stories, audience reach, and presentations to strategic bodies etc. In other words how far and wide have you spread the message? Secondly is about measuring what impact has it had. Are school governors now insisting that the schools demonstrate how they deliver effective PSHE, has school clusters demonstrating how they assess the needs of their pupils and taking steps to support them through PSHE? Finally the long term impact of your advocacy should demonstrate improved outcomes for children's as measures through local surveys and measures used of the public health outcomes framework.

The extent to how well you monitor and evaluate advocacy is a local decision. There are several guides on measuring the impact of advocacy available to help shape how you do this. A framework has been developed by UNICEF[29] which you may find useful.

8. Useful resources

The link between pupil health and wellbeing and attainment **https://www.gov.uk/government/publications/the-link-between-pupil-health-and-wellbeing-and-attainment** For: head teachers, governors and school staff Aim: to provide a summary of the key evidence that highlights the link between health and wellbeing and educational attainment.	
https://www.gov.uk/government/publications/promoting-children-and-young-peoples-emotional-health-and-wellbeing For: head teachers, college principals, school and college governing bodies and staff working in education settings, school nurses, local public health teams, academy chains, others with a role of promoting health and wellbeing of children and learners. Aim: to describe 8 principles, informed by evidence and practice, for promoting emotional health and wellbeing in schools and colleges.	

29 Unicef Advocacy toolkit. https://www.unicef.org/evaluation/files/Advocacy_Toolkit_Companion.pdf

Improving young people's health and wellbeing: a framework for public health For: local councilors, health and wellbeing boards, commissioners, providers and education and learning settings. Aim: to provide a framework for national and local action to address and promote health outcomes of young people.	
https://www.gov.uk/government/publications/road-injury-prevention-resources-to-support-schools For: head teachers and leaders, school governors, teachers/educational professionals, school nurses, local authority public health teams, local authority road safety / transport teams. Aims to: highlight key data; signpost to support/resources and share practice examples.	
What works in schools and colleges to increase physical activity (October 2015) For: head teachers, college principals, staff working in education settings, directors of public health and wider partners Aim: to highlight emerging evidence that suggests an association between being physically active and academic attainment and attention.	
A public health approach to promoting young people's resilience **http://www.youngpeopleshealth.org.uk/public-health** Funded by PHE, and developed by the Association for Young People's Health with input from the Early Intervention Foundation. Provides a new focus on public health approaches to supporting young people's resilience. It highlights ways that services have successfully worked together, provides links to useful interventions and other resources, and draws on the perspectives of young people about what works well for them. The resource is an interactive PDF with embedded hyperlinks	

Measuring and monitoring children and young people's mental wellbeing: A toolkit for schools and colleges http://www.annafreud.org/services-schools/mental-health-in-schools/schools-in-mind/resources-for-schools/mental-health-toolkit-for-schools/ For: senior leadership teams and those with particular responsibilities for Special Educational Needs and Disabilities (SEND), inclusion, Personal Social Health and Economic education (PSHE), welfare or pastoral support and mental health support. It will also be of interest to partners from the health, voluntary and community service sector who are supporting schools and colleges to improve mental health outcomes for children, young people and their families. Aim: the aim of this toolkit is to make schools and college staff aware of the range of validated instruments that can be used to measure and monitor student mental wellbeing.	
PSHE slide set The slide set outlines the role of PSHE and its links with Ofsted. Author: Yorkshire and Humber PHE centre.	 PSHE Slide set.pptx
North Yorkshire Personal Social Health Education (PSHE) and Citizenship Guidance for schools including the curriculum entitlement framework North Yorkshire County Council has developed guidance to support schools in delivering a planned progressive programme for PSHE and Citizenship. The guidance provides an overview of the requirements for schools relating to these topics, best practice in PSHE and Citizenship, Entitlement Frameworks, the North Yorkshire ladder of progress for PSHE/Citizenship and information on resources to support its delivery. To access these resources please contact Clare Barrowman.	Clare Barrowman Clare.Barrowman@northyorks.gov.uk
Hull PSHE Audit – Secondary Schools The aim of this audit is to map the current levels of delivery of key aspects of PSHE in Hull schools. This will include what is delivered, to whom, how often and who schools work in partnership with to deliver this. It will also look systems in place to ensure effective delivery in line with national guidance For more information please contact Gail Teasdale gail.teasdale@hullcc.gov.uk	 Hull PSHE Audit final.docx

Appendix: Examples of school based work across the region

1. Public Health in Schools – using the voice of the child to help children and young people in Calderdale to be healthy, happy and safe

Authors: Ben Leaman, Consultant in Public Health & Helen Saunders, Public Health in Schools Coordinator

1) Brief summary

Calderdale undertakes an annual survey of the health and wellbeing of young people in Calderdale in Years 5, 6,7,10 and 12, known locally as the electronic Health Needs Assessment (eHNA). The survey is structured around three key themes – healthy behaviours, avoiding harms and emotional health and wellbeing. Schools are encouraged to use the results to inform the way they provide health and wellbeing support for their students and students, in line with OFSTED recommendations.

The Public Health in Schools Coordinator works directly with schools to help them develop health and wellbeing plans based on their results and tailored to meet the needs of their students. The aggregated survey results are also used to inform service development and delivery across the local system – both by commissioners and providers.

The Public Health in Schools Coordinator has also developed a Youth Health Champions model in Calderdale secondary schools and rolled out a Youth Mental Health First Aider training offer across all Calderdale schools and other frontline workers.

2) What was the timescale for the project?

The eHNA was offered for the first time in 2010 to Years 7 & 10, and extended to Years 5 & 6 in 2012 and then Year 12 in 2014, giving us trend data to demonstrate impact over time. The survey will continue to be offered annually.

The Public Health in Schools Coordinator role was recruited to in 2015 on a fixed-term basis and has recently been made permanent given the impact the role has had.

A Youth Health Champions programme was delivered to four of our secondary schools in Calderdale in 2015, and is being rolled out to all schools this academic year.

A Youth Mental Health First Aider training programme has just launched and will also run throughout this academic year – and beyond if demand exists.

3) What was the setting and population covered?

The eHNA is offered to all mainstream primary, secondary and sixth form schools and colleges in Calderdale (including the Pupil Referral Unit). In 2016, all secondary schools took part, with coverage of 83% of Year 7 & 10 students. Three quarters of primary schools took part, with coverage of 82% of year 5 & 6 pupils. The Year 12 survey is ongoing (it takes place in the autumn term whereas the other surveys take place in the summer term), but in 2015 all sixth form providers / colleges took part.

We recognise the eHNA is not an appropriate way of establishing the needs of all of the young people in Calderdale, and in particular is not appropriate for use in special schools. We will continue to explore options for capturing the needs of pupils and students in special schools over the next year and aim to develop an appropriate way of doing so in time for next year's eHNA.

The Public Health in Schools Coordinator works with all educational establishments, spending more time proportionally where need is greatest.

4) What were we seeking to achieve?

Essentially, we're trying to maximise the physical and emotional health and wellbeing of children and young people in Calderdale. We want to do that by hearing what they say and doing something about it, in a joined up way across teams and organisations wherever possible. We also want them involved in developing ways of improving health and wellbeing.

5) Why did we decide to take action?

Whilst we have undertaken the eHNA since 2010 we felt there was no real support for them to take forward the findings and develop meaningful approaches to change within their schools. We were also aware that the public health offer to schools was not coordinated, so schools were receiving information from various bits of the system and felt bombarded. We weren't really involving young people in developing solutions. And finally, we felt that schools should be sharing what they were doing to improve the health and wellbeing of children and young people but didn't really have the mechanisms in place to do so.

6) What did we do?

The eHNA is a means to an end, not the end itself. We ensure that the system understands it what you do with the data that is important, not just the collection of the data. Following the survey results, the Consultant in Public Health prepares aggregated reports with trend data and shares that widely with a range of stakeholders – from the Children and Young People's Partnership Executive to the Safeguarding Children's Board. The reports are also publically available on the JSNA. We also take a whole system approach to ensure the data are used to inform commissioning as part of the commissioning cycle and providers to ensure that services are delivered where the need is greatest (for example substance misuse education in schools).

We have taken the Royal Society of Public Health's Youth Health Champions model of peer support within schools and developed a number of local trainers to enable us to deliver cost-effectively within Calderdale – starting in four secondary schools and rolling out to all secondary schools this year.

We have also started to deliver Youth Mental Health First Aid training, designed to teach parents, family members, caregivers, teachers, school staff, peers, health and social care workers how to support a young person who might be experiencing mental and emotional distress. Again, we have developed a number of local trainers to deliver the national model of training.

The most important thing we did was establish a Public Health in Schools Coordinator role. This role is very much outward-facing, working with schools to provide support across the public health

agenda and signposting schools within the system to respond to school-level needs. The Public Health in Schools Coordinator works closely with schools to help them develop action plans in response to their eHNA results so they can improve areas that they identify when comparing school data with the Calderdale average. She also works with school clusters to share emerging themes and facilitate the sharing of ideas between schools. Helen has also led the introduction of the Youth Health Champions model and the Youth Mental Health First Aid training.

7) Why did we choose this approach?

Nothing we have done is radical. It has however taken a dedicated role to pull together the things we were doing with things we wanted to do – and identify additional areas of work too. We wanted a more sustainable model of public health in schools, with a more co-ordinated response from the team as a whole and a single point of contact for the schools. We wanted to improve how we use the data we get from the eHNA practically, to improve the services we and others commission for children and young people. We wanted to improve knowledge of schools about who and how to signpost to in terms of public health services and interventions. We wanted to develop the public health skills of children and young people and develop a cohort of peer mentors in schools.

8) What was the outcome?

Since Helen started in post, the number of primary schools taking part in the eHNA has doubled. Schools are developing health and wellbeing action plans and now have well established health and wellbeing clusters. We showcase the school's work at an annual Public Health in Schools Conference. Youth Health Champions are leading health improvement work within their schools and peer group – four schools at the moment but in all secondary schools by the end of the academic year. And we're equipping schools with the tools to recognise emotional health and wellbeing issues and how to deal with them – either themselves or through appropriate referral.

9) What did we learn?

If you're working with schools, know your OFSTED! Involve schools and their students / pupils in the design of projects (and even then don't assume they'll all jump on board). Stay focussed on the outcome, tell that story to anyone who will listen (we have advocates for the approach all over the place now). Keep it simple…you need to be able to explain what you are doing, why you're doing it and what's in it for them to schools.

10) What is the single most important one line of advice which we can give to others starting a similar project?

Offer bespoke support to each school. They all want different thing, they all have different needs but helping them set realistic, achievable goals ensures they engage (most of the time).

11) What is happening next with this work?

We are committed to the eHNA and the role of Public Health in Schools Coordinator. We will also continue to run the Youth Mental Health First Aider training whilst demand exists – developing it into a traded service if we need to. And we will continue to evaluate the impact of the Youth Health Champions model to assess whether we continue with that going forward.

12) Where can people find out more?

Contact Details: Helen Saunders, Public Health in Schools Coordinator
helen.saunders@calderdale.gov.uk

2. Improving Social and Emotional Mental Health and Resilience in Young People in Barnsley through the use of the Thrive Approach in Primary Schools

Suzy Jubb, Wellbeing Project Manager, Barnsley Council

1) Brief summary

NHS England funding was secured over 5 years as part of the 'Local Transformation Fund' money which was available in 2015 as part of the work towards achieving the national aims set out in the document 'Future in Mind'. In Barnsley, part of this work aims to improve social and emotional wellbeing and resilience of children through funding staff in Primary schools to become licensed Thrive Practitioners so that their school can start using the Thrive Approach. The Thrive Approach is an evidence based way of working with all children based on neurological evidence of brain development. It helps all children learn to regulate their emotional responses & develop resilience.

2) What was the timescale for the project?

The Project began in 2016 and funding will continue until end of March 2020.

3) What was the setting and population covered?

The project covers the whole of the borough of Barnsley in South Yorkshire which has a population of around 220,000. The focus of the project is Primary School age children within a Primary School setting. The aim was to improve social and emotional wellbeing support for all Primary school children.

4) What were we seeking to achieve?

The purpose of the project is to improve the social and emotional wellbeing & resilience of young people in Barnsley, through increasing the number of Primary schools providing exemplary mental health support for their pupils. Initially this will be through increasing the number of Primary schools using the Thrive Approach.

5) Why did we decide to take action?

This work came about following publication of the National report 'Future in Mind' in 2015. There was funding attached to this to support areas to work towards achieving the ambitions set out in the document. This project forms just one part of our 'Local Transformation Plan' which sets out how we hope to achieve these ambitions in Barnsley. In addition to this, national data suggests that half of all mental ill health starts before the age of 14 and that potentially half of this is preventable. There is also a wealth of evidence around a whole school approach as a means to improving social and emotional wellbeing.

6) What did we do?

Through this project, funding is available for Primary schools to have members of staff trained to become licensed Thrive Practitioners to enable them to start using the Thrive Approach in their school. Thrive is an evidence based approach and generates evaluation data through the use of

their online assessment tool. Alongside this, the schools who get involved will be asked to complete independent evaluation data for one class. This includes the Strengths and Difficulties Questionnaire, academic engagement measure and attainment measure and a pupil subjective measure to happiness and wellbeing. There are several phases of training and schools can apply for funded places for 2-3 members of staff to attend. They will also then receive a funded whole school awareness session.

7) Why did we choose this approach?

We were lucky to have funding attached to the project which of course hugely increased our options and choice of approach. Thrive was chosen as the preferred approach as they were the only organisation that met all our project requirements. This included:

- A strong evidence base including the ability to measure impact on groups as well as individuals, robust data capture systems and evidence of wider benefits of the approach
- Evidence of working with and supporting schools to improve social and emotional wellbeing and resilience
- Promotion and commitment to a whole school approach
- A breadth of experience of having worked nationally but also with local knowledge and experience

8) What was the outcome?

This project is ongoing and has a further 3 years to run. There are currently 23 participants from 8 schools taking part in the first training course. A further 2 training courses for new schools are planned in so far which will enable a further 48 members of staff to be trained to implement the approach in a further 16 schools. Of the 10 schools that were already using the Thrive approach when the project started, 7 of these schools are also having a further 3 members of staff trained to enable them to expand the approach. A 'train the trainer' course is booked in for 2017 to enable 5 people to become licensed trainers for Thrive – this will increase the possibilities for further licensed practitioner training across Barnsley. Thrive is an evidence based approach which generates evaluation data through the use of their online assessment tool. Alongside this, the schools who get involved will be asked to complete independent evaluation data for one class. This includes the Strengths and Difficulties Questionnaire, academic engagement measure and attainment measure and a pupil subjective measure to happiness and wellbeing. Schools will also be asked to share learning through case studies and attending meetings to talk to other interested schools.

9) What did we learn?

As this project is in its early stages and still has 3 years left to run, learning is still at the early stages.

This project is offering a fantastic opportunity to schools to access funded training places but it is important to recognise that it is also a big commitment in terms of staff time and embedding the approach through a whole school approach. It is therefore vital to promote the additional

benefits to schools such as links to academic attainment, as well as being aware of issues and barriers for them.

10) What is the single most important one line of advice which we can give to others starting a similar project?

Share learning and examples from local schools who are currently using the approach, this is most meaningful in terms of highlighting the benefits of the approach to other schools.

11) What is happening next with this work?

In the short term the focus is on promoting the training opportunity to all Primary schools to enable them to access the opportunity. In the medium term the project aims to have 5 members of Primary school staff locally trained to trainer level in order to try and sustain the work. In the longer term the aim is to have a consistent approach to social and emotional wellbeing in Primary schools across the borough through schools using the Thrive Approach, which leads to improved social and emotional wellbeing of young people.

12) Where can people find out more?

https://www.thriveapproach.com/the-thrive-approach/

Contact Details: Suzy Jubb, Wellbeing Project Manager, Barnsley Council
suzyjubb@barnsley.gov.uk

3. My Health My School Pupil Perception Survey

Authors: Health and Wellbeing Service: Steve Body (PSHE Consultant)

Emma Newton (Health & Wellbeing Officer)

1) Brief summary

The My Health My School survey is a pupil perception survey, available freely to all primary and secondary schools in Leeds. The online survey covers a range of health topics and is aimed at young people in years 5, 6, 7, 9 and 11. The survey supports schools to meet Ofsted requirements and enables them to identify emerging health issues within their school. Data is also used at a cluster and city-wide level to inform strategic neighborhood, city and individual service action plans e.g. Physical Activity Health Needs Assessment.

2) What was the timescale for the project?

The My Health My School survey was developed in 2007 and as a result we now have 9 years of trend data. The survey is reviewed on an annual basis and all stakeholders are consulted with in order to ensure the survey continues to accurately measure health issues affecting young people. The survey is available annually for pupils to complete.

3) What was the setting and population covered?

The My Health My School survey is available to all primary and secondary schools in Leeds. In 2016 187 schools registered for access to the survey with109 schools completing. This resulted in over 9000 children and young people completing the survey. In response to a request from the Catholic Diocese a ‘catholic version’ of the survey has been created to ensure equality of access for all young people.

4) What were we seeking to achieve?

The main aim of developing the online survey was to create a consistent tool for measuring the changing trends of young people’s health and wellbeing in Leeds, over a specified period of time.

5) Why did we decide to take action?

We appreciate that schools put an enormous amount of hard work into promoting and improving the Health and Wellbeing of their pupils. So it’s important to be able to measure the impact of this to demonstrate evidence of behaviour change to school Senior Leadership Teams, Strategic citywide action groups, Ofsted and Local Authorities. Ofsted must have regard to the views of pupils (through surveys) and local data when making their overall judgements of the school and when they are evaluating the effectiveness of the PSHE curriculum. The online survey has therefore been created, to measure the effectiveness of the work in schools and to support their work on Healthy Schools.

6) What did we do?

We created an anonymous, online pupil survey which enabled schools to have instant access to their pupil’s health and wellbeing needs.

7) Why did we choose this approach?

We created this survey as it was a cost- effective, efficient way of measuring the health and wellbeing needs of young people at both a school, cluster and city wide level.

8) What was the outcome?

The survey is now in its 10th year and we currently have 9 years of trend data. Survey data has been used at a school level to inform PSHE, Healthy eating, Physical activity and Social, Emotional and Mental Health (SEMH) curriculum development, healthy schools assessments and school action plans. In addition city wide survey results currently inform strategic city-wide plans.

9) What did we learn?

Schools want an analysis tool which is quick and easy to use both in terms of the young people completing the survey and school managers who then analyse the data.

10) What is the single most important one line of advice which we can give to others starting a similar project?

Ensure you give yourself enough time to consult with partners, make amends and test the survey before making the survey available to schools.

11) What is happening next with this work?

We are committed to the evaluation and development of the existing survey and are currently considering creating a survey for Post 16.

12) Where can people find out more?

www.schoolwellbeing.co.uk

www.myhealthmyschool.co.uk

Contact Details: Steve Body steve.body@leeds.gov.uk

Emma Newton emma.newton@leeds.gov.uk

3. Reducing Teenage Pregnancy through effective SRE and peer education

Gail Teasdale – Integrated services manager (CYP Health) – Hull City Council

1) Brief summary

Over the course of the strategy Hull has made excellent progress in reducing under 18 conceptions including repeat conceptions as well as providing holistic support to improve outcomes for those who do become teenage parents. The successful implementation of the local strategy builds on the national strategy and evidence base. This has seen Hull progress from having one of the highest rates in the country (twice the national average and the 4th highest in the country) to achieving one of the largest reductions nationally (over 50% reduction).

A key aspect in achieving this success has been delivery of age appropriate SRE across Hull's secondary schools. This includes topics such as self-esteem and assertion, resisting peer pressure, delaying early sex, gender, sexuality, condom use and negotiation skills, healthy relationships, sex and alcohol, contraception, HIV/AIDS and other STI's and accessing services.

This SRE is led by teachers with some aspects delivered by peer educators who are trained and supervised by the local young people's sexual health provider Cornerhouse.

These peer educators also provide drop-ins in the community to provide a link between school based learning and access to services.

Cornerhouse also provides training for staff both in schools and in the community on sexual health and healthy relationships

2) What was the timescale for the project?

The Project began in 2008 as a pilot. It has since been embedded in our local model of delivery for young people's sexual health. The currently commissioned service is funded until December 2017

3) What was the setting and population covered?

The project covers the whole of Hull which has a population of around 257,700 of which 61,900 are children and young people in Hull aged 0 – 19; representing 24.0% of the total population of Hull. Approximately 18,000 of these are young people aged 11-16 year olds representing 7.2% of the city's population.

The focus of the SRE delivery is young people aged 11-16 within a secondary school setting with links to community services. The aim is to improve knowledge and understanding of sex and relationships, the development of skills to negotiate and make positive health choices, reduce risk taking behaviours and access services at the earliest opportunity.

4) What were we seeking to achieve?

The aim of the project is to ensure young people have the skills and knowledge to make informed positive health choices and reduce risk taking behaviours. This in turn contributes to

the reduction in under 18 conceptions and improved access to sexual health services and contraception. The use of peer educators is to ensure SRE challenges the perceived peer norms and myths and replaced them with correct information from a credible source e.g. their peers.

5) Why did we decide to take action?

Hull had the 4th highest teenage pregnancy in the country and SRE across the city was inconsistent and focused mainly on biology. Access to sexual health services was poor. This work was developed as part of the local strategy to reduce under 18 conceptions (teenage pregnancy). Improving SRE is one of the 10 factors for an effective local strategy identified nationally to achieve a 'whole systems' approach to improving sexual health and reducing teenage pregnancy. It remains a key part of Hull's local strategy. It also reflects the findings of local consultation and research which said young people listen to their friends and peers when it comes to information on sex and relationships.

6) What did we do?

The project works with schools to ensure that SRE delivery is comprehensive and covers a range of issues which impact on young people's health choices e.g. peer pressure. It also trains and supports young people to become peer educators. These peer educators deliver classroom based sessions to young people in secondary schools. They also volunteer in community based drop ins as a link from the classroom sessions to young people's sexual health services. The peer led sessions evaluate well with young people and feedback from the schools is positive. Peer educators have also been involved in developing campaigns.

The project also provides training for school and community staff on a range of issues e.g. sex and the law, sexuality, working with boys and young men etc.

7) Why did we choose this approach?

There is a strong evidence base that comprehensive SRE improves knowledge and skills to reduce risk taking behaviour and improve access to sexual health services.

This development also reflected research and findings in local consultations with young people that they often sought information and advice from their peers and that these messages from other young people were more powerful than from adults alone.

8) What was the outcome?

The projects evaluates well both through project evaluations which include feedback from pupils and teachers.

It is also reflected in the findings of the Hull young People's Health and Lifestyle survey which shows improved knowledge of issues and services. The numbers accessing young people's sexual health services has also increased while the rate of conceptions has reduced by over 50%. The survey is completed by approximately 4000 young people aged 11-16 every 2-3 years.

The current commissioned service runs until December 2017.

The work of Cornerhouse was featured as an example of best practice in the LGA and PHE report on teenage pregnancy (Good progress but more to do – Teenage pregnancy and young parents – 2016)

9) What did we learn?

That the use of peer educators contributes to effective delivery of SRE which is a key aspect in the successful reduction of under 18 conceptions.

Peer educators also gain valuable skills which contribute to their future employability.

10) What is the single most important one line of advice which we can give to others starting a similar project?

Listen to young people to understand what works and what doesn't in delivering effective SRE.

11) What is happening next with this work?

This project continues to deliver. The project is also now a franchisee for delivery of the tender project in Hull schools. This is an arts project which aims to work with young people to prevent domestic abuse and sexual violence by promoting healthy relationships based on equality and respect.

Hull has just completed a comprehensive PSHE audit in secondary schools to map provision and share good practice between organisations.

Cornerhouse were identified by schools as a key partner in SRE delivery.

12) Where can people find out more?

Contact Details:

Gail Teasdale – Integrated services manager **–** gail.teasdale@hullcc.gov.uk

Tish Lamb – Chief Executive - Cornerhouse - manager@wearecornerhouse.org