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Julia studied visual science at City University and became a member of the College of Optometrists in 1991. Her career has included work as a visiting lecturer at City University and visiting clinician at the Royal Free Hospital, working with south London Primary Care Trusts and as a Director of the UK Institute of Optometry. She specialised in diabetes and founded Julia Manning Eyecare in 2004, a home and prison visiting practice for people with mental and physical disabilities, using the latest digital technology. She sold the practice to Healthcall (now part of Specsavers) in 2009. Experiences of working in the NHS, contributing to policy development, raising two children in the inner-city and standing in the General Election in Bristol in 2005 led to Julia forming 2020health at the end of 2006. Julia is a regular commentator in the media and is a Fellow of the RSA.

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Foreword

How much exercise children take, what they eat and how content they are has always been an important part of the school environment in an age where children are under ever greater pressure to be ‘the best’. In this report we discuss the importance of wellbeing, particularly with the obesity crisis facing our young people, with one in three 10–11 year olds classed as either overweight or obese. Wellbeing is not just physical: emotional needs are just as important, yet as highlighted, 75% of school children and young people living with mental illness go undiagnosed.

Wider educational reforms have put greater pressure on teachers and parents, particularly in relation to funding, school curriculum and the perpetual debate about structural reorganisation. Interestingly, recent health reforms have forgotten the importance of the school setting for health promotion and support for children with a health need. We think the topic of Wellbeing can add value and cohesion to both policy agendas with a Wellbeing Strategy for schools.

The reforms have done little to promote an approach to look after the whole child and indeed the whole school culture. Nuffield Health and 2020Health hope to address this by co-ordinating support and guidance for Wellbeing at a whole-school level through a new dedicated role of Head of Wellbeing.

This role should coordinate support for staff, the school sports curriculum, healthy eating, personal and social education, and onsite health; it should also promote integration, building health and social care links and developing these for the school in its community. An emphasis on Wellbeing should provide encouragement for children to take part in extra-curricular activities with their friends as well as vital emotional wellbeing support. It would also help schools and parents tackle the issue of bullying more effectively through awareness and help to prepare our children as they become young adults.

Wellbeing is not just important to our children but to all of us. For us to be a healthy, productive nation we need to think of good wellbeing as a fundamental achievement in life. This has become mainstream in many workplaces over the past decade and we believe the same can happen in the education setting.

Dr Andrew Jones
Managing Director Wellbeing
Nuffield Health

1. Executive Summary

The health and wellbeing of young people has never been so topical. This is perhaps not because we as a society are more informed and progressive, but because we are being compelled to wake up to a national health and wellbeing crisis. The pressures facing secondary-school pupils today are possibly at their greatest ever. Surrounded by consumerism, bombarded by social media, distracted by screen-time, destabilised by family breakdown, stressed by academic targets, deceived by digitally-altered celebrity images and exposed to damaging messages of on-line pornography, it is no wonder that many children find making the most of their education a tall order.

There is progress to celebrate, such as the national reduction in alcohol consumption, smoking, drug misuse and pregnancy amongst adolescents, even if we recognise that this is not uniform across the country. But what of the obesity crisis, widespread (and in some cases rising) STI rates, poor diet, and low and decreasing engagement in non-curricular physical activity? (HSE, 2012; DfE, 2010.) And what of the plight of 75% of children and young people living with mental illness who go undiagnosed, the rising rates of depression among adolescents, and increasing incidents of cyber-bullying? (CMO, 2013; HBSC, 2011; Diana Award Survey, 2013.)

The school environment is second only to the parental home as the most important influence on children's and young people's development. And schools need to understand that as educational achievement benefits wellbeing, so wellbeing benefits educational achievement: it is a virtuous circle (Miller et al, 2013).

And what of staff wellbeing? Again, the word 'crisis' is not out of place, with teachers reporting some of the highest levels of stress of any profession. A Teachers Assurance survey of 2013 showed 70% of respondents claiming their stress levels to be moderately high to unbearably severe. A significant majority (73%) of staff felt their job had a negative impact on their health and wellbeing. Such levels of teacher stress, and a lack of support in many schools, is bad news not just for staff themselves, but also for the educational welfare and wellbeing of pupils, school budgets (with supply costs) and the NHS, not to mention the longer-term implications for the national economy.

1.1 Exploring the 'Head of Wellbeing' concept

It is against this background of pressures that we decided to explore the possibility of a new over-arching, full-time post for state secondary schools. The 'Head of Wellbeing' concept was informed by four key considerations. The first was opinion from education professionals who see a clear need to raise wellbeing support within the whole-school community, for both pupils and staff. The second was the wide evidence base that acknowledges the health benefits – and economic sense – of prevention and early intervention. The third was that pupil wellbeing support is not always widely available, meaningful and coordinated: it is all too easy for schools to turn wellbeing initiatives into tick-box exercises. And the fourth, in an age of rising demand, sustainable health and wellbeing support has to include an 'asset-based' approach, drawing upon the skills, knowledge, connections and potential in a community.

1. Executive Summary

It was clear that a Head of Wellbeing concept would prove strong if it:

1. reduced, rather than added to, current staff workload;
2. maintained impetus, year on year, for high standards of health and wellbeing;
3. brought about coordination of existing wellbeing initiatives, inside and outside the school;
4. was not considered an ‘optional extra’, liable to the vagaries of funding cycles;
5. was able to sustain a strong business case (short and long term cost benefits).

1.2 Research and workshops

Through desk-based research we were able to review professional opinion on both targeted and whole-school health and wellbeing, and strategies considered necessary to raise outcomes. However to understand grass-roots opinion on the Head of Wellbeing concept, we arranged a series of workshops at six state secondary schools in England. The workshops were not intended to produce robust data: the aim was to begin gathering front-line opinion on whether a ‘Head of Wellbeing’ post could lead to improved achievement and wellbeing outcomes at the whole-school level.

Findings

A rapid evidence review of published literature revealed several key strategies to improved whole-school wellbeing, including:

1. regular measurement of pupils’ wellbeing;
2. staff training on identifying early warning signs of mental health illness in young people (especially deriving from stress, bullying, family breakdown and abuse);
3. staff training on stress-coping strategies and work-life balance;
4. increased parent education (via schools) on child health and wellbeing;
5. more effective wellbeing education (PSHE, SRE, other), especially around nutrition, sex and relationship education, emotional intelligence, stress coping strategies, resilience and other ‘soft life-skills’;
6. greater engagement of young people in physical activity through a broadening of opportunities.

In direct response to the potential of the Head of Wellbeing concept, staff workshop opinion (live and online) indicated that priorities should include whole-school mental health support and service coordination; specific support for staff wellbeing; and raising parent involvement in, and support for, the school’s wellbeing agenda.

According to pupils in our workshops, some of the most important health and wellbeing interventions should involve more enrichment opportunities, clubs especially, but also more career discussion opportunities and a wider choice of physical activity.

1. Executive Summary

At the end of each staff workshop we asked participants to vote anonymously as to whether they saw the need for a Head of Wellbeing as a standard post within the state secondary system. The all-staff response revealed 59% in favour, 21% not sure and 20% against.

1.3 A Head of Wellbeing job description?

From our early conversations, we do not expect there to ever be a definitive job description for a Head of Wellbeing. The workshops revealed the importance of flexibility within the Head of Wellbeing's potential remit, although there would be core similarities between posts.

One model could be a 'top-down' role, with a strong focus on staff wellbeing, but also working to raise pupil health and wellbeing outcomes. A second model could be more pupil-orientated, with tasks including wellbeing education coordination (and possibly some wellbeing teaching). A third model suggests a post-holder with a counselling and/or medical background who would be equipped to support (if necessary) inclusion, SEND, school counselling and the school nurse.

1.4 Does the Head of Wellbeing post have a business case?

Until Head of Wellbeing posts are piloted, and at length, any discussion of Return on Investment is pure speculation. However the business-case rationale is compelling since the Head of Wellbeing concept is strongly associated with the argument for prevention and early intervention. We should also consider a business case via increased coordination and integration of existing wellbeing programmes and services, as well as commercial opportunities through corporate sponsorship.

1.5 Conclusion

Findings from this project have given us a foundation to further explore the concept of a Head of Wellbeing post as an integral part of state secondary school infrastructure. Indications are that a Head of Wellbeing would be welcomed by most staff and could well give the much needed focus, coordination and impetus to raising whole-school wellbeing outcomes. Importantly, it could allow a named member of staff to oversee, coordinate and signpost wellbeing support for those pupils with mild to moderate needs not severe enough to require formal statutory input. To enable prevention and early intervention must surely be seen as a priority.

We recognise the need to undertake more research to understand how a Head of Wellbeing might most effectively impact whole-school health and wellbeing, and we aim to do this by developing plans to pilot and evaluate the role. It will also be vital to form further partnerships with health and education experts, schools and organisations who would like to explore this concept with us.

We would welcome contact from interested partners at the earliest stage. Updates to progress on our Head of Wellbeing project will be posted on the 2020health website.

2. Introduction

Promotion of health by schools helps schools achieve their 'core business' of increasing educational attainment and enhancing later life chances. A refocusing of school health services is needed.

Chief Medical Officer's report 2012.

The relationship between wellbeing and academic achievement is statistically significant using six of the most common measures of wellbeing, taking into account psychological factors, school engagement, and family and peer relationships (Miller et al, 2013). It is also widely recognised that investment in early interventions to raise health and wellbeing outcomes for children and young people can bring about cost-savings in the long term (CMO, 2012; NFER, 2012).

All state-maintained schools in England have a statutory duty to promote pupil wellbeing and community inclusion (Education and Inspections Act, 2006). The Foresight Report (2008) defines wellbeing as 'a dynamic state, in which the individual is able to:

1. develop their potential;
2. work productively and creatively;
3. build strong and positive relationships with others;
4. contribute to their community.

Wellbeing is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society.'

In promoting wellbeing, schools must have regard to the Children and Young People's Plan (CYPP, 2004), which encourages a model that 'without compromising on its core mission of educating children to their full potential, contributes...to all aspects of a child's well-being, with a focus on early identification and prevention'.

Local authorities, working with schools and families, have statutory duties to improve the wellbeing of children with special needs or disabilities (SEND), as defined in the Children and Families Act (CFA, 2014). CFA SEND guidance (Chapter 6, Part 3) recognises child and young person wellbeing in terms of:

- a. physical and mental health and emotional wellbeing;
- b. protection from abuse and neglect;
- c. control by them over their day-to-day lives;
- d. participation in education, training or recreation;
- e. social and economic wellbeing;

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- f. domestic, family and personal relationships;
- g. the contribution made by them to society.

These correlates of wellbeing may be seen as equally true for all children and young people, with or without special needs.

Whole-school programmes and action

Recent years have seen a number of key policies, such as the National Healthy Schools Programme (1999) and Every Child Matters (2003), designed to raise health and wellbeing standards among all pupils at the whole-school level; PSHE and Citizenship, and SRE, are key programmes through which health and wellbeing can be taught.

The question is, are current school-based policies and strategies effective? In some respects they may be; witness the reductions in smoking, alcohol consumption, drug misuse and teenage pregnancy, and a notable increase of curriculum PE (HBSC England, 2011; HSCIC, 2013a; DfE, 2010).

But why did the Chief Medical Officer in 2012, highlighting the benefits of ‘prevention’, call for a ‘refocusing of school health services’? Indeed, why does almost every authority on health and education tell us ‘more needs to be done’? The evidence for new or increased action stems from some sobering data (highlighted in Section 3) on undiagnosed child/adolescent mental health illness, high rates of STIs, weight problems, poor diet and low engagement in physical activity. There is also wide consensus that schools need to be doing more to raise levels of functional literacy, especially focusing on the socially underprivileged, as well as increasing education around ‘soft skills’. We found strong belief that school initiatives such as PSHE and the Healthy Schools Programme are liable to become mere tick-box exercises unless they are joined up within a tightly-focused whole-school wellbeing programme. Could a more coordinated approach to health and wellbeing bring about improved engagement, behaviours and attainment?

Undertaking this project we were also keen to consider a refocus on school staff wellbeing – therefore taking a truly holistic, whole-school approach. Teachers, especially, report some of the highest levels of stress of any profession and support structures in schools often appear inadequate to meet their needs. The problem is perhaps most acute for newly qualified teachers (NQTs), but exacerbated for all staff by a pervasive stigma attached to mental health support and counselling. No staff member wants to appear ‘weak’ – especially if they seek career progression – so suffering happens in silence until the strain is simply too great to conceal.

2. Introduction

2.1 The Head of Wellbeing concept

Our decision to explore the concept of a Head of Wellbeing post in state secondary schools was informed by four key considerations. The first was opinion from education professionals who see a clear need to raise wellbeing support within the whole-school community, for both pupils and staff. The second was the wide evidence base that acknowledges the health benefits – and economic sense – of prevention and early intervention. Calling for increased preventative action on child and adolescent health and wellbeing, the Chief Medical Officer urged a ‘refocusing of school services’ (CMO report, 2012). The third was that pupil wellbeing support is not always widely available, meaningful and coordinated: it is all too easy for schools to turn wellbeing initiatives into tick-box exercises. And the fourth, that in an age of rising demand, sustainable health and wellbeing support has to include an asset-based approach, drawing upon the skills, knowledge, connections and potential in a community.

Our focus on secondary schools is not to deny interest in the concept at the primary level: due to the different challenges presented at contrasting life-stages (primary, secondary), there was simply not scope in the project to examine both cases.

Towards the end of our project we discovered the ‘Head of Wellbeing’ role to be not entirely without precedent. For example the private school Dulwich College has a Head of Wellbeing who gives on average one day per week to HW duties, which include managing the wellbeing teaching curriculum and arranging staff health and wellbeing INSET. St Luke’s Primary School in Tiptree, Essex, employs a full-time ‘Wellbeing mentor’, with counselling qualifications, who leads the pastoral team, which itself makes a significant contribution to the whole-school aspect of PSHE education.

We consider it useful to have initiated our project from a blank-slate position, reviewing published evidence around wellbeing in secondary schools – both staff and pupils – and seeking information and opinion at grass-roots level from teachers, supporting staff and pupils themselves. This way we were able to better operate in listening mode, rather than seeking to present specific ‘learning’ from outside the state secondary school system.

Challenges of our present age

- By age 18 the average European young person will have spent a full four years of 24-hour days in front of a screen (Sigman, 2010).
- In England, the proportion of 11–15 year old boys recorded as obese in 2011 was 23.8%. There has been no significant change in prevalence in this age group over the last six years (HSCIC, 2012a).
- Participation in non-curricular physical activity has declined since 2008, with the downward trend particularly significant among boys: 28% in 2008 to 21% in 2012 (HSCIC, 2012a).
- Nearly one in ten children aged 5–16 living in Britain has a clinically diagnosed mental disorder (ONS, 2004).
- Around three-quarters of children and young people living with mental illness are not known to services (CMO, 2013).

2. Introduction

2.2 Project methodology

The project began with a rapid evidence review of pupil health and wellbeing, particularly focusing on 11 to 16 year-olds (year groups 7–11). We also undertook a review of staff health and wellbeing, with emphasis on the pressures of the school environment and staff mental health.

We then conducted a series of workshops at six state-funded schools across England. Visiting schools/academies in areas of low and high deprivation, we met separately with staff and pupils and obtained both spoken and written questionnaire feedback. In total 68 staff members and 91 students took part.

As a counterpart to the staff workshops, we also conducted a virtual workshop online, with the participation of 23 staff members from at least 11 (perhaps as many as 14¹) state secondary schools throughout England. The workshop format allowed all ideas, comments and opinion to be presented anonymously.

This project was undertaken between February and July 2014. At the outset we convened a Steering Group with a range of unpaid experts to help focus direction, raise questions, guide research and scrutinise findings.

2.3 Report structure

Section 2: Introduction

Section 3: Critical challenges facing pupil and staff health and wellbeing

Section 4: 2020health School Workshops: exploring the ‘Head of Wellbeing’ concept

Section 5: Head of Wellbeing: roles and job specifications?

Section 6: Business case considerations

Section 7: Conclusion and next steps

1. Eleven schools were identified through specific school email addresses. Not all participants used their school email, so identification of all schools would have been impossible without making contact with these individuals directly.

3. Critical challenges facing pupil and staff health and wellbeing

In this section we spotlight some of the critical challenges facing schools today. We take a holistic, whole-school overview by considering both pupil and staff health and wellbeing. The first section, on pupils, is logically longer than that for staff due to the prime function of school as an institution to educate and nurture a large body of young individuals. The staff section is primarily concerned with the effects of the school environment on teachers' mental and physical health.

3.1 Adolescent health and wellbeing: an overview

The foundations of lifelong obesity, smoking and other substance misuse, sexual health and mental health are all established in childhood and adolescence.

Chief Medical Officer's report 2012.

An examination of young people's health and wellbeing over recent years reveals a very mixed picture. Trends suggest that some messages and interventions, for example around drugs, alcohol and smoking, are having an encouraging impact on school children. Teenage pregnancy is at a historic low (nationally, at least), and obesity among young teenage girls appears to have reduced (HSCIC 2012a, 2013a).

Other trends serve as a salient reminder that considerable challenges remain. Young people frequently fail to eat a balanced diet (CMO, 2012), and the vast majority do not manage recommended physical activity levels (HBSC, 2011; HSCIC, 2013a). Obesity among adolescent boys remains close to its historic high (HSCIC, 2013a). And while we may note the lower teenage pregnancy rates, we do not find a corresponding reduction of STIs – indeed data suggest little-changed, and in some cases rising, infection rates (PHE, 2013). While young people may have an increased awareness of, and access to, the 'morning after pill', they are not demonstrating increased safety in sexual behaviour.

Few would contend with the claim that the greatest challenge of all concerns child and adolescent mental health illness and emotional distress. The challenge is not just the significant numbers affected, but also the issue of diagnosis, since around three quarters of children who develop mental illness are unknown to any services (CMO, 2013).

The average seven-year-old will have already watched screen media for more than one full year of 24-hour days. By age 18 the average European young person will have spent a full 4 years of 24-hour days in front of a screen.
(Sigman, 2010).

The parental home is undoubtedly the most important environment for the learning of healthy behaviours; equally, it is also the environment in which unhealthy and antisocial behaviour may be developed (e.g. Understanding Society, 2013). Parents teach much by

3. Critical challenges facing pupil and staff health and wellbeing

example: if the parents are eating unhealthy food and spending five hours in front of a screen a day, likely as not the children are also. Parenting style is also critical: it has been shown that warm, authoritative and responsive parenting is usually central to the building of resilience among children. Parents who develop open, participative communication, and who demonstrate the ability to compromise, tend to manage stress well and help their children do likewise (Utting, 2007).

After parents, schools are the next major influence on how children develop (Legatum Institute, 2014). Often contending with unhealthy behaviours learnt in the home, schools routinely have to challenge and contradict parental standards. In some cases the teacher becomes something akin to a surrogate parent – and with increasing family breakdown, this occurrence appears to be on the rise (Dunford, 2008). For some young people school is the only setting where they experience clear moral boundaries. For many it is the only setting in which they are likely to participate in sport, clubs and other enrichment activities; learn about sex and relationships; or be encouraged to volunteer and contribute to their community. The potential influence of the school environment has arguably never been greater.

3.2 Health and wellbeing in focus

3.2.1 Child and adolescent mental health

“Half of all diagnosable mental health conditions start before the age of 14 and 75% by the age of 21, so identifying children at the earliest opportunity is crucial in setting them on the best path in life.”

Dr Raphael Kelvin, child psychiatrist and clinical lead for the MindEd programme

An ONS survey of 2004 found that nearly one in ten children aged 5–16 living in Britain had a clinically diagnosed mental disorder. Mental health disorders appear to be on the rise (CMO, 2012) and approximately three-quarters of children and young people with these disorders are not detected or treated (CMO, 2013).

The average secondary school in England accommodates approximately 950 pupils; there are well over 1,500 schools that have a pupil population of 1000 or more, with 320 of those having in excess of 1,500 (DfE, 2014). In many schools there will be a very significant number of pupils developing mental health illness unrecognised by staff or supporting services.

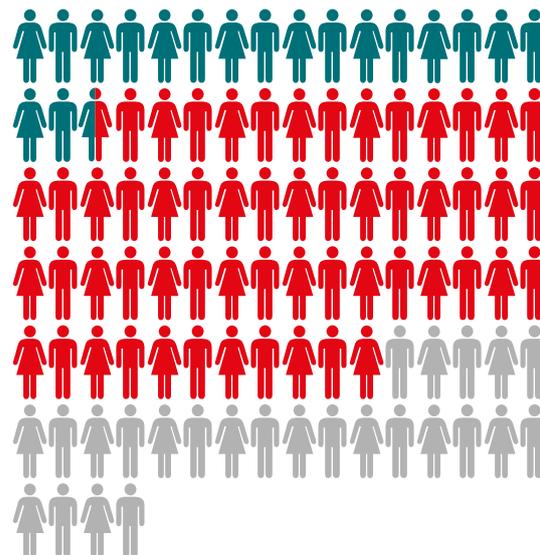
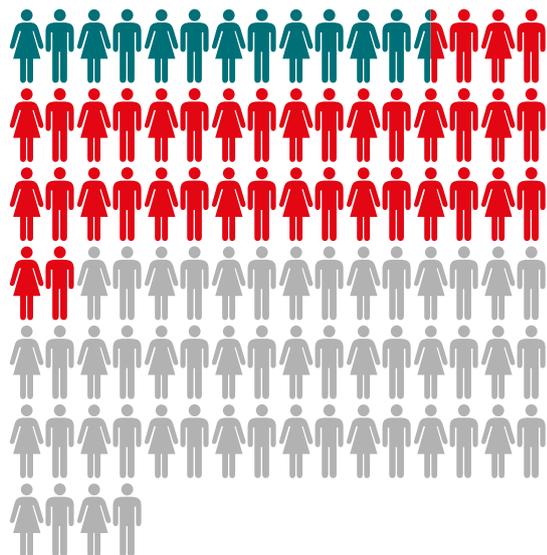
3. Critical challenges facing pupil and staff health and wellbeing

Diagram 3a: Mental illness in children and young people.

Only around 25% of children and young people living with mental illness are known to services.

50% of mental illness, excluding dementia, begins by age 14.

75% of mental illness, excluding dementia, begins by age 21.



Proportion with
mental illness
identified



Proportion with
mental illness
not identified



Proportion not
yet started
mental illness

School-based counselling services (essentially distinct from Child and Adolescent Mental Health Services, CAMHS) are to be found in the majority of schools in England, with most (around 70%) funded through the school's own budget. Normally referred by staff or the pastoral team, clients of these services are typically in the 13–15 age range, the majority female, with around two-thirds experiencing psychological difficulties at 'abnormal' or 'borderline' levels. There may be more than one counsellor employed by the school, although service provision is not full-time: counsellors are on average available for five to nine sessions of counselling per week (Cooper, 2013).

3. Critical challenges facing pupil and staff health and wellbeing

MindEd Programme (2014): survey of 2,100 adults

- One third were unsure of signs of depression in children.
- Half would be worried about saying anything if they did suspect a mental health problem, for fear of being mistaken.
- More than two-thirds supported the notion that every school should have a dedicated member of staff on site for children to approach about mental health and wellbeing issues.

3.2.2 Emotional wellbeing

Adolescent emotional wellbeing is never static. While around 5% of 11–16 year olds have a diagnosis of anxiety or depression (Green et al, 2005), issues such as irregular sleep patterns, cyber bullying, social isolation, exam stress, confusion around sexuality, rejection, bereavement and family breakdown will be affecting a much wider cohort, acutely or chronically. Thus self-reported anxiety and depression is much higher than diagnosed disorders: for example, recent research has found as many as one in five (20%) of girls in Year 11 (age 15/16) reporting anxiety or depression (Nuffield Foundation, London, 2012).

The Association of Young People’s Health reports that young people generally recognise that injury to mental health often results from an accumulation of stressors, rather than a single factor (AYPH, 2010). Socio-demographic correlates of mental/emotional disorders include age, sex, family type, employment status of parents, household income and parental educational qualifications. The detrimental impact of high deprivation on mental health and emotional wellbeing is well established (DH, 2013).

An HBSC (Health behaviour in school-aged children) survey of 2011 found around 30% of young people reporting a level of emotional wellbeing that can be considered as ‘low grade’ poor mental health; that is, they regularly feel low, sad or down. It also confirmed adolescent girls to be more susceptible to low moods and stress than their male peers:

.....
Between age 11 and age 15, the proportion of young people with low levels of subjective wellbeing almost doubles.

NatCen Social Research, 2008
.....

‘Nearly half (over 45%) of all 15 year old girls reported either feeling low or suffering from complaints such as headaches or backaches at least once a week. The proportion of girls reporting these forms of stress has shown a small but steady increase over time.’ (HBSC, 2011)

3. Critical challenges facing pupil and staff health and wellbeing

3.2.3 Weight problems in adolescents

The HSCIC record that in 2011/12 around a fifth (19.2%) of pupils in Year 6 (aged 10–11) were classified as obese (HSCIC, 2013a); according to National Child Measurement Programme data, a further 14.7% were overweight. Thus one in three children aged 10–11 may be classified as overweight or obese.

Table 3a: data showing an average annual rise in overweight and obese 10–11 year olds, 2007/8 to 2011/12. Source: HSCIC

Year 6 (aged 10–11)	2007/8 (%)	2008/9 (%)	2009/10 (%)	2010/11 (%)	2011/12 (%)
Overweight	14.3	14.3	14.6	14.4	14.7
Obese	18.3	18.3	18.7	19.0	19.2
Overweight including obese	32.6	32.6	33.4	33.4	33.9

Specifically examining obesity levels among 11–15 year olds, the HSCIC identified an increase among boys from 13.9% in 1995 to 24.3% in 2004; by 2011 it had fallen just slightly to 23.8%. The corresponding age group among girls saw more pronounced trends, with obesity increasing from 15.5% in 1995 to 26.7% in 2004, decreasing to 16.5% by 2011.

The proportion of 11–15 year old boys recorded as obese in 2011 was 23.8% (among the highest levels recorded) and there has been no significant change in prevalence in this age group over the last six years.

Health Survey for England

If the data on young teenage girls appears encouraging, we also need to bear in mind the apparent increase of eating disorders in recent years, particularly amongst young women in this age group. Hospitals recorded 2,290 eating disorder admissions in the 12 months to June 2012, a 16% rise on the previous 12 month period. Children and teenagers aged 10 to 19 accounted for more than half of admissions (55% of the total). Women accounted for 91% of all eating disorder admissions, with the most represented age group 15-year-old girls – nearly 10% of all such admissions (HSCIC, 2012b). Latest figures from the HSCIC reveal an 8% increase in admissions in the 12 months to October 2013 (HSCIC, 2014). Such hospital admissions represent only the tip of the iceberg: some adolescents will be referred on to Tier 3 CAMHS, while others go undiagnosed.

In 2010 almost half of girls said they were ‘too fat’ at age 15, and 25% were engaging in weight loss strategies.

HBSC England

3. Critical challenges facing pupil and staff health and wellbeing

It is important to recognise that there is no single cause for anorexia, bulimia and related eating disorders. Aspiring to a particular body shape is only part of the problem – no doubt exacerbated by media pressure from fashion, pop music and celebrity culture (Morris & Katzman, 2003). The cause, rather, appears to involve many factors, including those that are genetic, biological, sociocultural, behavioral, emotional and psychological (RC Psych, 2013).

3.2.4 Physical activity

In accordance with WHO guidelines, the UK Government recommends that children and young people should achieve a minimum of 60 minutes (and up to several hours) of at least moderate intensity physical activity each day, every day of the week (NICE, 2009b).

.....
Participation in regular physical activity can increase self-esteem and reduce stress and anxiety. Physical activity can help play a role in preventing mental health problems and improve the quality of life of those experiencing it.

Mental Health Foundation

.....

The 2012 Health Survey for England (HSE) affords some revealing insights into child and adolescent physical activity. A minority of boys (21%) and girls (16%) aged 5–15 are currently meeting the national daily physical activity target. Moreover, physical activity decreases with age: only 14% of boys and 8% girls aged 13–15 are meeting the recommended physical activity levels.

Whilst participation in two hours of curriculum PE per week among 5–15 year olds has significantly increased in recent years (DfE, 2010), HSE recorded decreased non-curricular physical activity since 2008, with the downward trend particularly significant among boys: 28% in 2008 to 21% in 2012.

HSE 2012 recorded that 51% of boys and 45% of girls aged 5-15 reported doing at least seven hours of activity in total ‘in the last week’. Approximately two thirds of girls aged 13–15 surveyed were not taking part in any ‘formal’ physical activities.²

3.2.5 Substance misuse and smoking

Data on substance misuse and smoking behaviours among schoolchildren are encouraging. The HSCIC reports a decline in drug use by 11–15 year-olds over recent years: in 2001, 29% reported ever having taken drugs, compared to 17% in 2011. Alcohol consumption has followed a similar trend: in 2001, 26% of pupils reported having consumed alcohol during the previous week, compared to 12% in 2011.

2. ‘Formal’ implying structured or purposeful exercise, such as team sports, jogging, gym workout, aerobics, dance session, swimming

3. Critical challenges facing pupil and staff health and wellbeing

A downward trend is also apparent in smoking: in 2001, 10% of 11–15 year olds claimed to be smoking regularly; by 2011 this had decreased to 5%. Whilst a decrease may be noted across all ages groups during this period, this 50% reduction among 11–15 year olds is more marked than in the adult population, where the proportion of adult smokers declined by around a quarter, from 27% to 20% (HSCIC, 2013b; Cancer Research UK, 2014).

3.2.6 Teenage pregnancy

Conception rates among under-18s have been falling almost year on year since 1998. Only in 2002 and 2007 were slight rises recorded on the previous year. In 2012 there were 27,834 conceptions in women aged under 18 in England and Wales, compared with 31,051 in 2011, a decrease of 10%. Conception rates in this age group in 2012 were at their lowest level since 1969 (the first year for which comparable data exists).

The conception rate among 13–15 year-olds has followed a similar trend, decreasing from 8.1 conceptions per thousand in 2007 to 5.6 in 2012. Again, conception rates in this age group in 2012 were at their lowest level since 1969 (ONS, 2014).

The Office for National Statistics attributes the declines in teenage pregnancy to:

- the programmes invested in by successive governments (for example sex and relationships education, improved access to contraceptives and contraceptive publicity);
- a shift in aspirations of young women towards education;
- the perception of stigma associated with being a teenage mother.

Comparing England's teenage conception rates to those of other European countries is problematic due to the lack of comparable data. However the United Kingdom remains with one of the highest number of births per 1,000 women aged 15–17 in the European Union (ONS, 2013).

3.2.7 Sexually transmitted infections

Trends in sexually transmitted infections (STIs) indicate that many teenagers have not heeded advice about safe sex. Precise trends for specific diseases are difficult to accurately describe for the previous ten years due recent changes in data reporting in England (PHE, 2013). While chlamydia remains the most common STI, with tens of thousands of adolescents infected every year, a 7% fall in diagnoses was recorded during 2010–11 for 15–19 year olds; however, occurrence in under 15s saw a 7% rise for the same period.

3. Critical challenges facing pupil and staff health and wellbeing

Anogenital herpes saw a 2% rise among 15–19 year olds between 2010 and 2012. For the same cohort and period, gonorrhoea increased by 21%, while syphilis (rare among teenagers) increased by 9%.

The picture may be mixed, with decreasing, close to static and increasing prevalence of particular infections, but it appears that sex education has not significantly changed teenage sexual behaviour.

The divergence of data for teenage pregnancy and STIs perhaps suggests that teenagers have better access to the morning after pill. The widespread availability of online pornography, which typically demonstrates risky sexual behaviour, may be a contributing factor in the rise of STIs among those who have been exposed at a young age (Sinkovic, Stulhofer & Bozi, 2012).

3.3 School-based health and wellbeing programmes: how effective are they?

Education itself is, of course, directly correlated to wellbeing, particularly English, maths and ITC when taught to a standard that enables high levels of functional literacy. There exists a virtuous circle: as educational attainment benefits health and wellbeing, so health and wellbeing benefits educational attainment.

Many schools and academies have introduced bespoke health and wellbeing interventions that are beyond the scope of this short review. It is also important to recognise the variable levels of sports, clubs and other enrichment activities that increase social interaction and opportunities for personal achievement, all of which have a major impact on pupil wellbeing. An increased sense of integration and belonging to the school through such activities is also correlated to wellbeing (CMO, 2012).

A useful framework for considering pupil health and wellbeing has been provided by the Every Child Matters (ECM) initiative, launched in 2003, which promoted a collaborative approach to supporting all children in:

1. staying safe;
2. being healthy;
3. enjoying and achieving;
4. promoting economic wellbeing;
5. making a positive contribution.

3. Critical challenges facing pupil and staff health and wellbeing

Strategies linked to the ECM framework include the National Healthy Schools Programme (NHSP, actually pre-dating ECM), PSHE and Citizenship Education, and Sex and Relationship Education (SRE). While these appear to have provided schools with useful tools to encourage various forms of wellbeing, measuring the success of any specific ‘whole-school’ intervention is extremely difficult.

The reduction of teenage pregnancy rates, for example, may well be attributable in part to SRE and nurse-led activity within the Healthy Child Programme. Reduced rates of smoking, alcohol consumption and drug misuse may be attributable in part to PSHE Education, but no corroborating (quantitative) data exists.

Evidence pertaining to the effectiveness of school-based counselling is more robust. While less than 10% of schools in England appear to be using a standardised outcome measure for their school-based counselling, data indicate that the service is consistently associated with significant reductions in psychological distress. School staff and service users perceive school-based counselling as an effective means to enhance young people’s capacity to engage with studying and learning (Cooper, 2013).

The effectiveness of school-based strategies around prevention and early intervention in mental health will be in part determined by the perceptive abilities of staff (the principal referrers) to recognise the sometimes subtle warning signs, such as loss of appetite, weight loss, irritability or poor concentration. That most young people developing mental health disorders are not known to services indicates a lack of knowledge among staff to recognise and act on these early indicators.

.....
Failure to provide high quality, age-appropriate sex and relationships education may leave young people vulnerable to inappropriate sexual behaviours and exploitation.

Ofsted, 2013
.....

At a wider level, national trends indicate that health and wellbeing strategies in a significant amount of schools are making little or no impact on specific behaviours. It is also noteworthy that, in the estimation of Ofsted, the quality of PSHE education is below acceptable standards in 40% of schools, and the quality of SRE below acceptable standards in around one third (Ofsted, 2013). And since the Healthy Schools Programme is now implemented and monitored on a ‘schools-led’ basis, ‘Healthy Schools Status’ indicates only that a school conforms *some* of its protocols to NHSP standards. For example, once a school has gained the award with healthy lunches, there is nothing to stop it from serving burgers from its canteen at break-time.³ It is all too easy to turn health and wellbeing initiatives into tick-box exercises. This in turn creates a low-impact, fragmented school wellbeing programme, one liable to frustrate staff as a timewasting exercise that interferes with the business of raising educational outcomes.

3. Authentic example given at 2020health school workshops, May 2014.

3. Critical challenges facing pupil and staff health and wellbeing

3.4 Multi-agency support for schools

It is important to acknowledge that all state-funded schools rely on support from external agencies. In brief, the support available for schools and academies may be split into two categories: statutory services and non-statutory services.

1. Statutory services include: Health, Safety and Wellbeing Service; Access to Education; Assessment, Statementing and Review Service (ASRS); Safeguarding Children Board; education psychology; substance misuse support; Safer Schools Partnership; Healthy Child Programme; CAMHS (Child and Adolescent Mental Health Service)
2. Non-statutory services include: Parent Teacher Association; sports partners; performing arts providers and charities; external PSHE and SRE educators; various counselling/therapeutic services; educational support; external mentoring services; youth workers, careers advice, on-site after-school clubs

Local Authorities (LA) are responsible for many of the statutory services to community schools, though only for some of the services to academies. With greater budgetary control, academies (and Free Schools) are able to choose their providers and thereby purchase services either from the LA or other provider organisations.

However LAs have an obligation to ensure that all children and young people in their area receive a suitable education. This means ensuring fair and equal access to education, a remit that usually demands considerable support for disadvantaged children. Commissioning responsibility for special educational needs in both schools and academies lies with the LA; and each LA should have a register of children accessing alternative provision full-time away from mainstream school. LAs also now (since 2013) hold commissioning responsibility for school nursing and have oversight of the Healthy Child Programme. With this governance, and as hosts of Health and Wellbeing Boards, LAs are, in theory, well placed to improve joined-up working across education, health and social care.

3.5 Considerations

An essential step in responding to the outstanding challenges facing schools today is to recognise the root-causes of poor health and wellbeing. For certain, poverty and parental mental health status are strongly correlated to wellbeing outcomes in children and adolescents. But as the data indicate, poor health and wellbeing outcomes are pervasive: mental health, sexual health, diet and physical activity are concerns that extend across all socio-economic status (SES) groups.

The strengthening of the family unit (through mealtimes, sports, games, quality time), creating a strong sense of belonging, has a significant impact on maintaining and

3. Critical challenges facing pupil and staff health and wellbeing

improving wellbeing (CMO, 2012). From the perspective of some schools, therefore, support for parent education in child wellbeing, alongside greater parental involvement in the school's wellbeing initiatives, may well be part of the solution.

Solutions should also include the increased teaching of life-skills in school: that is, expanding wellbeing teaching to instil better understanding of empathy, forgiveness, altruism, self-control, self-worth, perseverance and resilience. These traits are in turn linked to higher subjective wellbeing in adult life (O'Donnell et al, 2014). As we will note in Section 4, most of the well-educated and confident pupils we surveyed in good and outstanding schools are not yet recognising the wellbeing values of forgiveness, kindness and volunteering.

Many agree that increased intervention is needed. The authors of Wellbeing and Policy (O'Donnell et al, 2014), commissioned by the Legatum Institute, identify three core activities by which every school can raise pupil wellbeing:

- systematic structured teaching of life-skills and values throughout school life;
- the regular measurement of children's wellbeing;
- the training of all teachers in mental health and the management of child behaviour.

To this list we would add consideration of:

- increased parent involvement and support around health and wellbeing;
- increased enrichment opportunities (non-curriculum sports, clubs, activities) within school;
- proactive, asset-based community engagement, maximising local resources through relationships and strong lines of communication.

Psychometric testing: a targeted response to behavioural problems

Disruptive behaviour by the few often has a detrimental effect on the wellbeing and learning of the entire class. There is evidence that whole-school outcomes might be raised through psychometric testing, specifically targeting students under achieving or exhibiting disruptive behaviour. This has been piloted with compelling results at St Benedict's Catholic School in Bury St Edmunds, Suffolk. The process enables pupil understanding of their own strengths and weaknesses, and how best they learn; staff, in turn, discuss the results with pupils and are able to respond with greater understanding of personality attributes. The process has been a revelation to students and staff alike. The TES (September, 2012) wrote of the pilot:

'Before the pilot project started in 2010/11, the [60] pupils involved had received 11 temporary exclusions from school and the number who had been removed from class stood at 47. In the year after the tests, those numbers fell to one and three respectively.'

3. Critical challenges facing pupil and staff health and wellbeing

Diagram 3c & 3d: Teachers Assurance survey results (continued)

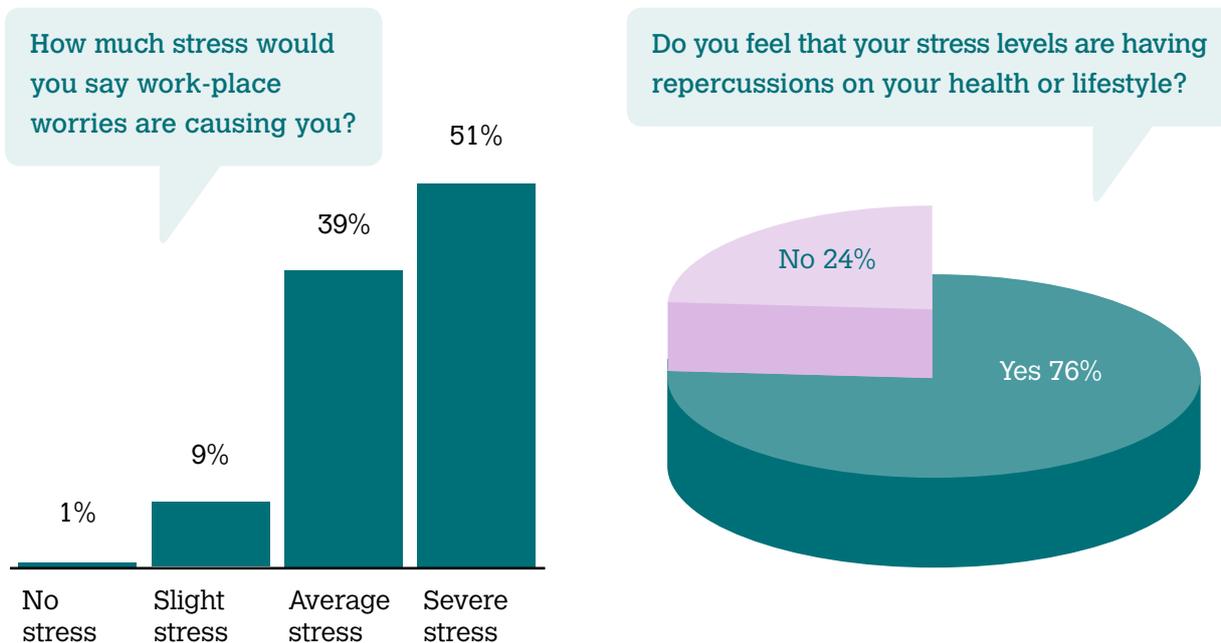
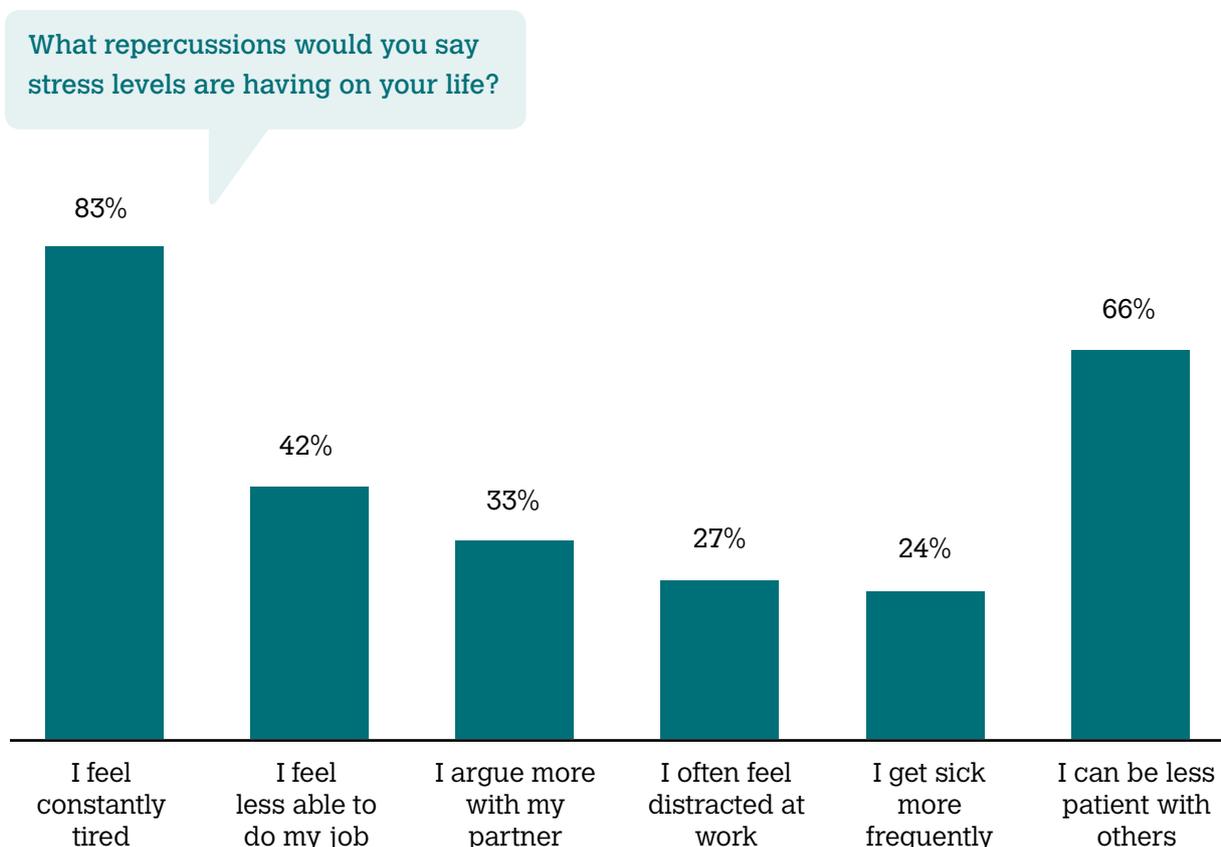


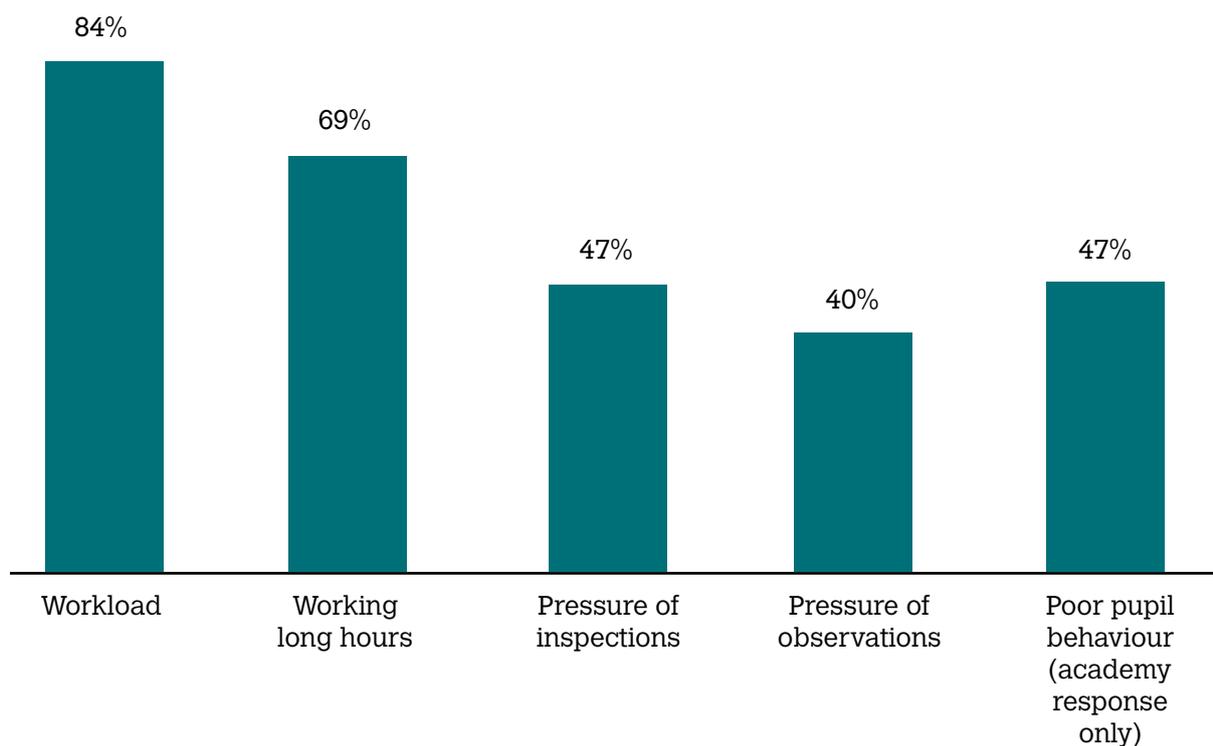
Diagram 3e: Teachers Assurance survey results (continued)



3. Critical challenges facing pupil and staff health and wellbeing

Despite the timing of the Teachers Assurance survey, the findings are very similar to a previous survey by the Association of Teachers and Lecturers (ATL), published April 2012. A significant majority of staff felt their job had a negative impact on their health and wellbeing (73%), professional ability and confidence (64%), and relationships with friends and family (62%). The causes of stress recorded in this survey, not primarily financial, are shown in Diagram 3f.

Diagram 3f: Key causes of stress (ATL survey)



Workload and long working hours are of course directly correlated, and half of all those surveyed said they usually worked more than 50 hours a week during term time. Importantly, the ATL survey found 43% of respondents saying their workload had increased over the last two years (since 2010), with 36% saying it had increased significantly.

3. Critical challenges facing pupil and staff health and wellbeing

3.7 Support for staff health and wellbeing

Support for staff wellbeing is for the most part contained within managerial structures and peer relationships. The head teacher is ultimately responsible for the wellbeing of staff, but the scope of support she or he can offer is limited for logistical and professional reasons. External counselling services are normally available to staff, though some might choose more discrete support from organisations like the Teachers Support Network, which has a free 24/7 advice line.

According to the ATL survey already quoted, around a third of schools do not have policies to deal with stress, mental health or wellbeing. In schools that do have policies, approximately a third of staff respondents were not satisfied with the policies in place. Thus about half of respondents claimed that such support policy was either non-existent or inadequate.

Responding to questions on wellbeing support structures at the 2020health workshops, staff members said they typically sought support from each other, from family or friends, or (more rarely) the school's pastor, nurse or counsellor.

The perception of stigma in seeing a counsellor, and fear of disclosure of this activity to managers or peers, is very real for many teachers. At the 2020health workshops we frequently heard teachers say that they would not want to show senior management any sign of weakness, particularly out of fear of being passed over for career progression. An additional problem, identified by a 2010 study by Compass, is that although help for stressed teachers is available – on the internet, through GPs and via teacher support helplines – many are too exhausted, depressed or mentally fragile to pursue it (TES, 2012).

In terms of (additional) measures to help reduce stress levels, the ATL survey recorded: reducing workload (67%), receiving more support from the head teacher (41%), and allowing more flexible working (37%). Better communication was considered very important for support staff, who said having regular meetings and updates (52%) would help them.

We do not want to detract from the fact that teaching is for many a very rewarding career with high levels of job satisfaction. Not all teachers are on the verge of burn-out or resigning by any means. However, low levels of wellbeing within the teaching community give great cause for concern. In a 2013 survey by NASUWT, almost two thirds of teacher-respondents (65%) had considered leaving their job in the past year, while more than half (54%) had considered leaving teaching entirely (BBC, 2013). This may be significantly related to disaffection with performance-related pay and pension cuts, but historic data suggest more or better provision is needed to support the mental and emotional wellbeing of school staff. And this is not a matter confined to lower and middle-grade staff members; in the ALT survey, 81% of leadership team members felt their job had a negative impact on their health and wellbeing.

3. Critical challenges facing pupil and staff health and wellbeing

Important strategies (multiple sources) for reducing staff stress could include:

1. advice on workload management
2. advice on stress/anxiety coping strategies
3. more flexible working
4. better communication among SLT and lower-tier staff
5. independent mentoring for NQTs (i.e. not line manager)
6. increased signposting support
7. easy and discrete access to counselling services
8. reduced stigma around counselling
9. advice on finance
10. encouragement/advice on healthy living
11. reduced out-of-hours school contact
12. increased multi-agency/parent support for extra-curricular activities

4. 2020health School Workshops: exploring the ‘Head of Wellbeing’ concept

As stated in this report’s introduction, the rationale for exploring the concept of a ‘Head of Wellbeing’ derived from opinion that the school environment would greatly benefit from both whole-school and targeted action on an ongoing fixed basis. The concept would appear strong if it:

1. reduced, rather than added to, current staff workload;
2. maintained impetus, year on year, for high standards of health and wellbeing;
3. brought about coordination of existing wellbeing initiatives, inside and outside the school;
4. was not considered an ‘optional extra’, liable to the vagaries of funding cycles;
5. was able to sustain a strong business case (short and long-term cost benefits).

To help investigate the Head of Wellbeing concept we conducted a series of workshops at six state secondary schools/academies in England. Each school had either a good (2) or outstanding (4) ranking by Ofsted and was selected as one of the first respondents from around 20 schools invited to participate in the workshops. At each school we held separate workshops with staff members and pupils.

As a counterpart to the ‘live’ workshops we also ran an on-line workshop to understand majority opinion on the tasks a Head of Wellbeing might undertake, should the position exist. The virtual workshop saw participation of 23 staff members from at least 11 (identified) schools.

Neither the live nor virtual workshops were intended to produce robust data: the aim was to begin gathering frontline opinion on whether a ‘Head of Wellbeing’ might be able to increase health and wellbeing outcomes at the whole-school level, and whether the post was considered necessary.

4.1 On-site staff workshops: purpose and format

At the on-site staff workshops our purpose was to listen to debate on the ‘Head of Wellbeing’ concept. We wanted to know whether staff felt the need for a new full-time post and, if so, what the post-holder’s activities could be. To better understand grass-roots thinking we did not steer discussion by setting out a theoretical model of a Head of Wellbeing (HW).

Setting context and rationale for thinking about a new intervention, we presented recent data on both pupil and staff wellbeing. We also presented some standard health and wellbeing outcomes (pupils and staff), and reminded participants of the broad range of health and wellbeing provision in schools currently.

4. 2020health School Workshops: exploring the 'Head of Wellbeing' concept

Participants were asked not to debate funding streams: with the role not as yet defined, it was considered premature to suggest how it might present its business case. To establish need or otherwise for a Head of Wellbeing, participants were invited to consider:

1. how an HW might bring added value to their school (tasks/roles);
2. the arguments for not having an HW, discounting funding issues;
3. the potential place of an HW within the school's staff structure.

Attendance at the staff workshops ranged from 8 to 14 participants, with an average (mean) attendance of 11; in total 68 staff members took part. The majority of participants were teaching staff; in all but one of the workshops there were non-teaching staff present also. The workshops ran for 45 minutes and staff were also invited to fill in a short multiple choice questionnaire on health and wellbeing provision in their school.

It is of course important for us to note that those present at the workshops were not necessarily a representative body of the school's entire workforce, even if we considered the opinion and evidence gathered to be valuable. For this reason we have anonymised the participating schools.

4.2 Staff workshop feedback and results

The majority of the staff workshop time was devoted to debate. In addition to the three questions presented to staff, we also asked questions to further explore concepts that participants were debating or to follow up particular challenges noted by staff about their school environment.

The strengths of the Head of Wellbeing concept were considered first, before discussion of potential weaknesses and pitfalls. In each meeting minutes were taken, and these were compared on completion of all six workshops.

4.2.1 Head of Wellbeing: common themes and strengths of concept

The suggested tasks for a Head of Wellbeing, outlined below, were not necessarily considered mutually exclusive, although it was acknowledged that the post-holder could not be a one-size fits all solution to (nor an expert in) each and every area of school health and wellbeing.

4. 2020health School Workshops: exploring the ‘Head of Wellbeing’ concept

1. Staff support

The most consistent theme to emerge in the workshops was the need for increased support for teaching staff, although there was some differing opinion on the nature of the support itself. Five out of six schools identified the usefulness of increased staff support, with the HW functioning (variously) as:

- a) a non-teaching, impartial member of staff with a medical or counselling background (or qualifications) who staff can talk to about workplace stress and problems;
- b) a staff coach in stress management/coping strategies; monitor of work-life balance;
- c) a non-teaching independent member staff, with a background in education, to provide mentoring services to newly qualified teachers (NQTs);
- d) a sign-posting expert for all staff.

.....
“Outcomes could be more staff-orientated to impact both staff and students.”
.....

Some made clear that if an HW was offering counselling to teachers, many would not take the ‘risk’ of meeting with this person either at the school or outside, for fear of peer-identification or sensitive information being passed on (deliberately or accidentally) to others within the school. Confidentiality was a major concern expressed in the workshops: even as sign-poster, confidentiality would be vital to the role.

The other proposed staff-supporting roles did not appear to be divisive. Some staff pointed out that better staff support would impact pupil health and wellbeing, particularly through fewer workplace-related absences, improved teaching quality and continuity, and a less stressful school environment.

2. Coordinator of services

Staff at four schools identified a potential role for the HW as a coordinator of services, working across education and pastoral teams and beyond into the community. The general impression was that if the HW was involved in coordinating and joining up services, they should have a senior leadership position.

.....
“The [Head of Wellbeing] could play a role in bringing multiple agencies together and would therefore need to be a good manager and well organised.”
.....

The strength of a ‘senior coordinator’ was seen by some as a way of introducing a new role to the school that was less likely to duplicate or replace some of the care and support work already in place. There was some nervousness about a new role being created that would take away from what others were doing currently.

4. 2020health School Workshops: exploring the 'Head of Wellbeing' concept

3. Extra layer of support for school counsellor, SENCO/SEND staff

Linked to the coordinator of services concept was the idea that the HW could provide an additional layer of support to the special educational needs coordinator

(SENCO) and/or the school counsellor. Five schools had discussions on this. There was opinion expressed in two schools that the counselling service was reactive, with one noting problems of pupil access. Support to increase prevention and early intervention in pupil mental health was considered important, as was work to reduce stigma around mental illness.

.....
"We have a school counsellor but they have a waiting list and a caseload of 10-15 children only."
.....

4. Improving whole-school pupil health

Four schools discussed measures to raise pupil health. Diet/nutrition was the most prominent theme, with two schools noting the absence of food technology, cooking courses or clubs to help combat the pervasive culture of unhealthy eating. Engagement in physical exercise was considered extremely problematic at one school (see below), and another noted some problems in pupil cleanliness and appropriate clothing. An HW role could be to identify target areas of improvement and engage bespoke interventions to combat problems.

.....
"A Head of Wellbeing could help the school fight the pervading culture of poor parenting, inactive lifestyles and poor diet."
.....

Resources to support the mental health of specific students were not always thought of as effective; staff at one school claimed there were no formal procedures to address concerns about a particular student's mental state. The HW could be the principal contact for staff to seek support and advice. (Perhaps surprisingly, the need for staff training to spot signs of mental illness and deal with issues appropriately was mentioned only at one school.)

5. Furthering the PSHE and citizenship agenda

Participants at three schools made reference to furthering the PSHE agenda with the help of an HW as coordinator. It was admitted by

some that PSHE is not always taken seriously as a subject, and that the teaching or design of the lessons could be improved to impact students more effectively.

.....
"PSHE lessons may not be hitting hard enough"
.....

6. Increasing parent engagement

Three schools identified work to increase contact with, and support from, parents. It was thought that the HW could raise awareness among parents around good parenting skills and the importance of regulated screen-time, increased physical activity and balanced diet.

4. 2020health School Workshops: exploring the 'Head of Wellbeing' concept

The HW might be a useful person to engage with hard-to-reach parents; they could also work to ensure suitable support for recent immigrants who might not be familiar with English culture. It was also speculated whether an HW as a non-teacher might be more approachable from parents' point of view.

“Many parents don’t have the knowledge of healthy eating”

Proposed action was clearly targeted at specific parents. Some staff felt that, on balance, parents were responding well to school, media and government messages about child wellbeing, particularly healthy eating and regular physical activity.

7. Increase student physical activity

Pupil engagement in physical activity was considered good at most schools. Only two schools specifically mentioned the need for more pupil engagement with physical activity. The exact intervention of an HW was unclear, but there was strong opinion from an inner city school that physical inactivity among its students was largely attributable to the lack of available space for sport. Staff generally did not discuss the widening of choice in physical activity.

“Many girls won’t take part in physical activities because they don’t like to compete in public and be seen not to win”

4.2.2 Opposition to the Head of Wellbeing concept

The following summarised objections represent a major sample of those raised. These are not presented in order of frequency of occurrence, since most were raised on no more than two separate occasions.

1. In terms of pupil outcomes, one HW would not improve standards by much at all, especially at a school where activity around health and wellbeing is already extensive.
2. An HW could present a complication to a strategy that appears to be working effectively.
3. The money made available for an HW would be better spent on an extra maths teacher/admin/mentor etc.
4. The money would be better spent on health and wellbeing target areas that require more investment. The staff to coordinate it are in place already.
5. With so much being done already there would not be enough for the HW to do.
6. It is impossible for the HW to be an expert in so many areas, so how can the post be filled?
7. Stress on teachers often derives from Government policy, thus an HW is not necessarily addressing the root of various problems.

4. 2020health School Workshops: exploring the ‘Head of Wellbeing’ concept

There was also some concern expressed as to how an HW would fit into the existing structures of the school. There was virtually no discussion of any reconfiguration of staff structures in response to the introduction of this new post. This may suggest reluctance to consider structural adaptation.

.....
“Unless a Head of Wellbeing is taking on some of my workload, I don’t see how talking to him or her is going to solve the pressures and stress of long working hours.”
.....

4.2.3 Other staff opinion

- An HW could report to the school governors independently, thus having a degree of independence from the head. It would also make the head more accountable.
- It would be helpful if the HW had a counselling qualification
- It would be important for the HW to exercise professional confidentiality
- An HW could address staff concerns and look into why students are not getting on and enjoying school
- The post-holder could be a full-time employee on a year-round contract to address student problems during holiday periods
- A regional HW may be a better solution
- Heads of Wellbeing could meet at a local level and share learning and facilitate cooperation

The workshops included discussion as to where within the staffing structure the post-holder might sit. There was some important variation of opinion, partly attributable to the key roles that the HW might assume. We will return to this theme in Section 5.

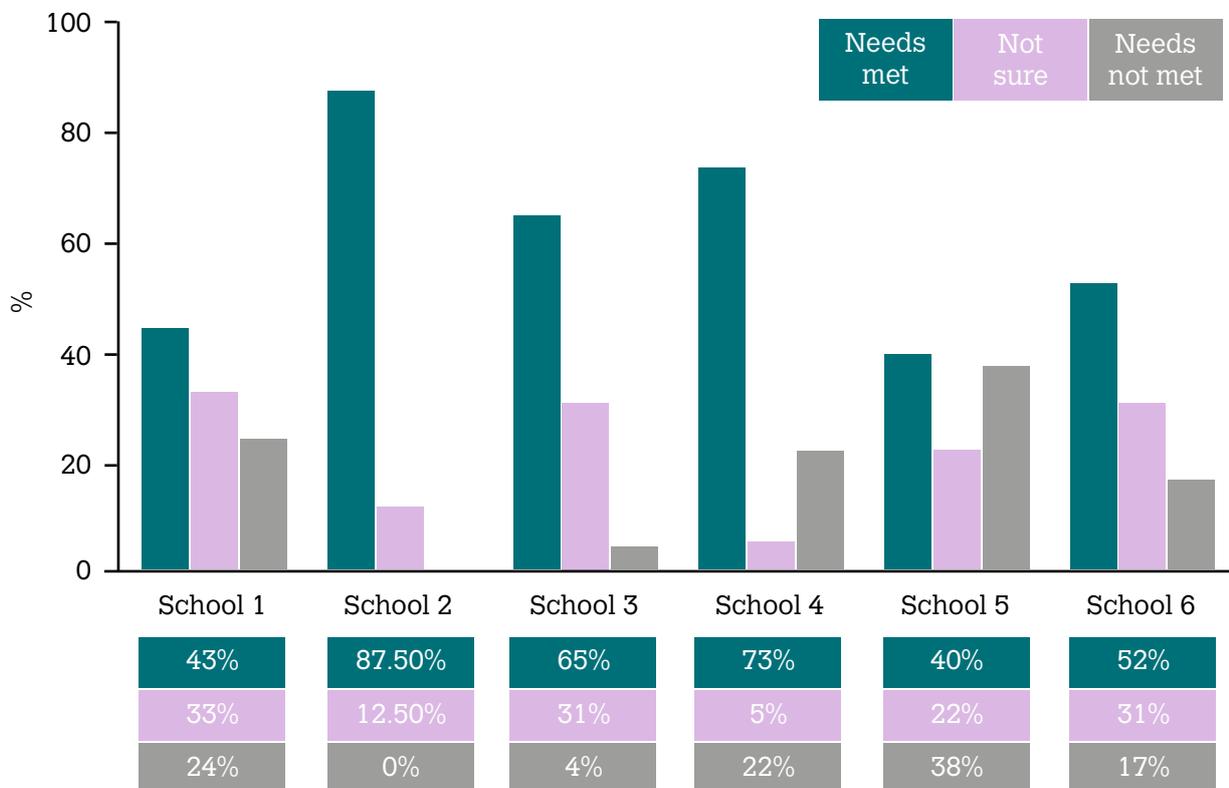
4.2.4 Staff Workshop: anonymous feedback

At the start of each workshop staff were asked to answer seven multiple choice questions on health and wellbeing provision in their school (see Appendix B for questions). These responses gave us a crude mechanism by which to ‘score’ staff opinion on how well they thought their school supported health and wellbeing.

Diagram 4a displays the opinion of participating staff (only a small proportion of the school’s workforce) on whether staff and pupil health and wellbeing needs are being met in their school. Due to the limited number of participants and the subjective nature of the responses, it does not necessarily follow that these results accurately reflect how well each school is meeting needs: staff highlighting more shortfalls in provision may simply be more aware of how much more could be done.

4. 2020health School Workshops: exploring the 'Head of Wellbeing' concept

Diagram 4a: Summary of staff self-evaluation on health and wellbeing provision in school.



Accompanying notes to diagram 4a

- The schools are positioned in order of their locality's position within the DfE's table of indices of deprivation, 2010, from low deprivation (1) to high (6).
- The majority opinion of staff participants in four (2,3,4,6) of the six schools was that their school was doing moderately to very well in meeting the health and wellbeing needs of staff and pupils.
- In four schools (1,3,5,6) there was a significant number of staff participants (a large minority or majority) not convinced that their school was doing as much as it could or should to meet health and wellbeing needs of staff and/or pupils.
- In two schools (1,5) the majority of staff participants were not convinced that their school was doing as much as it could or should to meet health and wellbeing needs of staff and/or pupils.

4. 2020health School Workshops: exploring the 'Head of Wellbeing' concept

The list below gives a more accurate description of the area deprivation index. Schools in areas with an IDACI score closer to one are situated in the more deprived districts. The 'rank' reflects the locality's position within the 32,482 'super-output areas' of England: a rank of 32,482 would represent the least deprived area, the rank of 1 the most deprived.

Schools visited, listed in low-to-high order of area of deprivation.

- 1. School 1 (South London)**
 - District IDACI Score: 0.0457668, Rank of IDACI: 28408
- 2. School 2 (S-W Essex)**
 - District IDACI Score: 0.1224762, Rank of IDACI: 18615
- 3. School 3 West Sussex**
 - District IDACI Score: 0.2576941, Rank of IDACI: 10035
- 4. School 4 South London**
 - District IDACI Score: 0.3647098, Rank of IDACI: 5820
- 5. School 5 East London**
 - District IDACI Score: 0.5533465, Rank of IDACI: 1292
- 6. School 6 West Yorkshire**
 - District IDACI Score: 0.5935529, Rank of IDACI: 844

It is worth remembering that schools situated in areas of high deprivation will typically face the greatest challenges to the raising of health and wellbeing outcomes. Diagram 4b shows staff response to the question of the need for a Head of Wellbeing.

4. 2020health School Workshops: exploring the 'Head of Wellbeing' concept

Diagram 4b: "Do you see the need for a full-time post of Head of Wellbeing within the state secondary school system?"

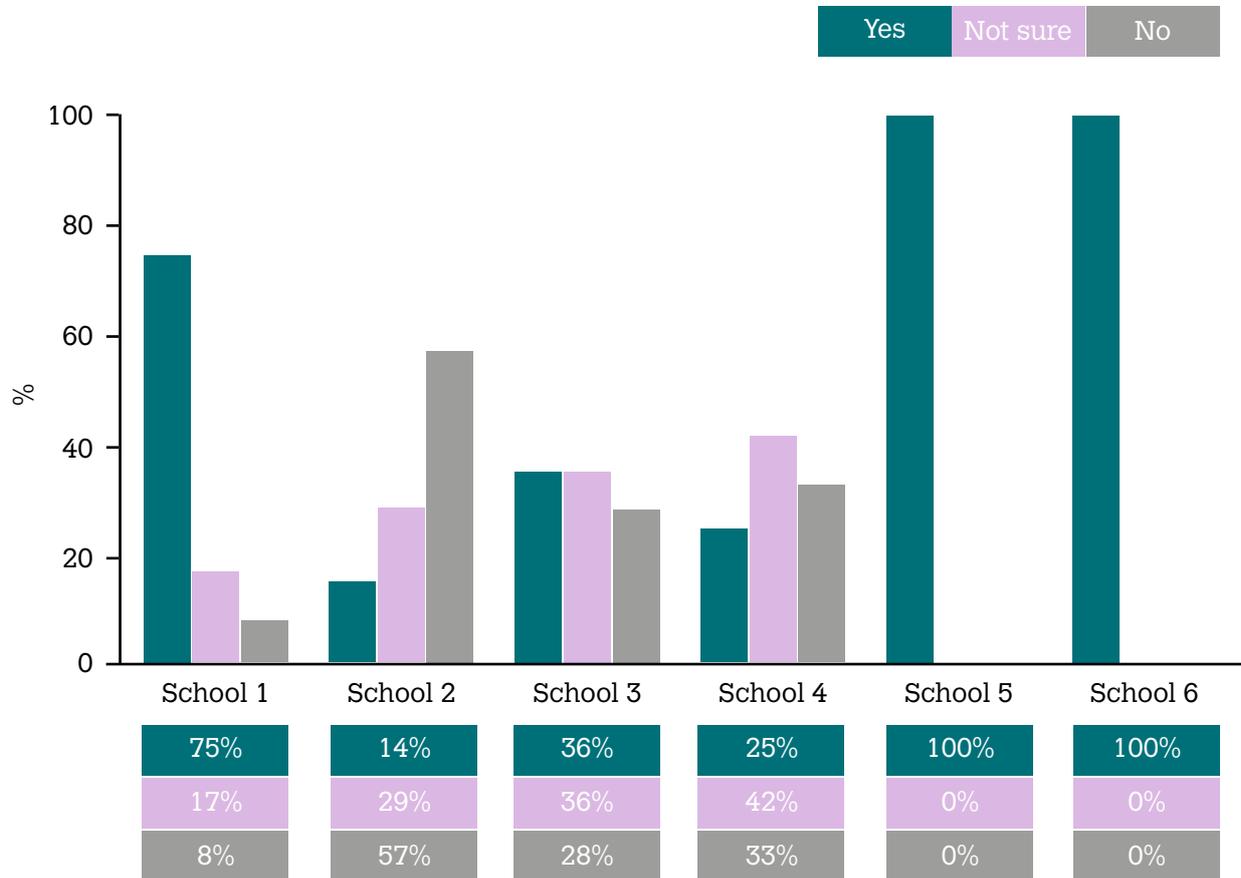
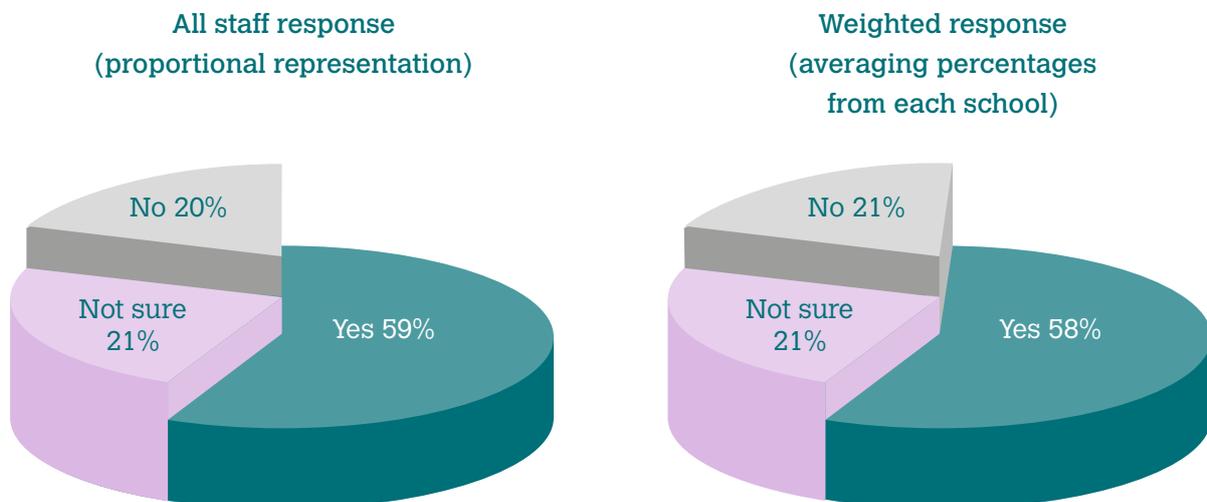


Diagram 4c: Pie-chart display of responses to the question: "Do you see the need for a full-time post of Head of Wellbeing within the state secondary school system?"



4. 2020health School Workshops: exploring the 'Head of Wellbeing' concept

Feedback from staff on health and wellbeing provision in each school correlated to opinion on the need for a Head of Wellbeing post in secondary schools more generally. Where staff members considered their school to be already responding very well to both staff and pupil wellbeing, they had less enthusiasm for the Head of Wellbeing concept overall. However, as the results show, the majority of staff members across the six schools support the concept, even when the results are collated with equal weighting.⁴

That schools in the two most deprived areas we visited voted anonymously and unanimously in favour of such a post is possibly significant. Six workshops of this kind are not enough to produce statistically meaningful results, but the anecdotal results are at least an indication that the type of responsibilities discussed for the Head of Wellbeing resonated in schools that are accommodating large numbers of pupils from deprived districts.

The results also show, however, that support may not derive exclusively from schools in the more deprived areas. The majority of staff at School 1, located in an area of low deprivation, saw a clear need for such a post; staff participants at School 4, located in an area of fairly high deprivation, were for the most part not convinced.

It is worth reminding ourselves that London's Dulwich College, an eminent private school educating boys from typically 'privileged' backgrounds, has deemed it appropriate to instate a Head of Wellbeing, part-time at least. This fact raises interesting questions about school culture and the appetite for innovation.

4.3 On-line staff workshop

The on-line workshop was designed to crowdsource opinion on priority tasks for a Head of Wellbeing, should the post exist. To our knowledge, of the 23 participants, just one had taken part in the live workshops. Most participants worked at schools (nine, at least) that had not taken part in the live workshops.

The crowdsourcing system we used (CleverTogether.com) allowed participants to post ideas, comment on other contributors' ideas, and vote on what they considered to be the best ideas or answers. We asked participants to respond to the following question:

If your school introduced a full-time Head of Wellbeing, what tasks would you like to see the post-holder prioritise?

We were able to identify six categories of suggested activity at the close of the workshop. The four most popular and commented on activities were, in order of popular vote:

1. whole-school mental health support/coordination, particularly working around prevention;

4. That is, listing staff opinion within each school as a percentage, not a number, and combining with equal weighting to find averages across all schools.

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- = 2. increasing parent awareness and engagement in their own child's (or children's) health and wellbeing;
- = 2. wellbeing activities coordinator;
- 3. advice to senior management on increasing pupil participation in activities beneficial to wellbeing.

Other proposed Head of Wellbeing activities included improving the personal hygiene of pupils and a ground-level pastoring role serving both pupils and staff.

The least popular suggestion was to increase teaching on wellbeing and happiness through the expansion of PSHE. However the comments made on this suggestion included a 're-focusing of PSHE', or 'keeping health and wellbeing as a separate entity on the curriculum to maximise profile and impact'. Indications were that the activity was less popular for its association with PSHE, rather than unwelcomed as such.

4.3.1 Sample responses

Mental health support/coordination

"Mental health amongst children and staff is a priority at the moment; looking for the signs and responding accordingly, ensuring that all stigma is removed."

"The focus should be on the pupils and ensuring appropriate opportunities are provided for them to assist in overcoming mental health problems. To take on staff issues would require a post more akin to that of a counsellor and this should not be what this role is about."

"It is crucial that the wellbeing of staff is taken into consideration. We are people too! Neglecting this issue leads to staff absence which obviously has a knock-on effect on pupil progress and also costs the school much-needed money."

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A senior team member, increasing parent awareness and engagement

"This has to be a priority as this is such an important step in establishing this crucial role and will get lost or not be prioritised at a lower level."

"It should be neither senior management nor middle management, they should be a separate entity (and not a teaching post). Though obviously they would have to work closely with the Child Protection Officer (when dealing with pupil issues)..."

Wellbeing activities coordinator

"They should arrange sessions on mindfulness, meditation, yoga for pupils and staff. They should look at nutrition and ensure lunch options are healthy. They should work to make wellbeing a priority in school, rather than a side-issue. They should help senior management move towards a point where every decision made in schools should rest upon the question 'how does this new move affect the wellbeing of pupils and staff?'"

Advisor to senior management on pupil wellbeing

"The Head of Wellbeing should be responsible for identifying trends and proposing initiatives to senior management to increase pupil participation in activities likely to enhance wellbeing/mental health. They should not be running these activities themselves, otherwise they will simply become a Head of Extra-Curricular Activities/Sports."

"... a strategic role that would involve coordinating a range of local stakeholders pertinent to each locality."

Results from the on-line workshop suggested overwhelming favour for a post-holder providing mental health support and coordinating the whole-school health and wellbeing programme. There was, however, some disagreement as to whether the HW should be focused exclusively on pupils, or serving (in some capacity) both pupils and staff.

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4.4 On-site pupil workshops

The workshops with pupils sought to gather opinion on what 11–16 year olds thought constituted health and wellbeing, and what they would like done in their school to improve it. The pupils were selected by the school for their ability to participate and behave well in a group situation. They were therefore not a true representation of the wider pupil year groups.

A significant amount of time was devoted to setting context, encouraging participants to consider the meaning of health and wellbeing. We asked pupils to answer a short confidential questionnaire about their own perceptions on health and wellbeing in school. We also encouraged open discussion, and concluded with a brainstorming exercise to consider how a school HW might organise or facilitate improvements to pupil health and wellbeing.

In total, 91 pupils took part in the school workshops, with an average (mean) attendance of 15. Attendance was in fact highly variable across the schools, ranging from 10 to 20 participants, also in terms of year-group representation. The results nonetheless gave some interesting insight on wellbeing perspectives and learning when collated from all six schools.

The majority feedback (indeed at each school) was positive with regard to current sports provision and how schools were encouraging their students to be happy. However there appeared to be a distinct lack of understanding of various correlates of wellbeing.

Examining the responses from years 7–11 only (n = 88):

- 69% of students said they learn about health and wellbeing in PSHE and Citizenship.
- The majority of students (62% average) from these year groups did not equate insult, spreading lies and making fun of others with health and wellbeing.
- An even greater majority (73% average) did not equate forgiveness, volunteering and unexpected acts of kindness with health and wellbeing.
- Nearly two thirds (64%) claimed they had not discussed handling relationships (of any kind) in any classes.

4. 2020health School Workshops: exploring the 'Head of Wellbeing' concept

Brainstorming

We asked pupils to suggest tasks and activities that could be undertaken by a member of staff whose full-time job it was to support the wellbeing of pupils in school. The most common answer was an increase of clubs, of various kinds. We found it interesting that this particular enrichment opportunity, and how to facilitate it, was barely mentioned in any of the staff workshops.

Pooling responses from pupils across all six schools, the most popular school-based interventions to raise health and wellbeing included:

1. More clubs (e.g. philosophy, circus skills, karate, acrobatics, enterprise, art, dance, yoga)
2. School counsellor/psychiatrist (or increased availability of)
3. More career discussion opportunities
4. Volunteering opportunities
5. More visiting speakers
6. More sport / alternative physical activities
7. Healthier food
8. Quiet room
9. More school trips / lessons outside classroom
10. More open space



4. 2020health School Workshops: exploring the 'Head of Wellbeing' concept

4.5 Observations

We believe that findings from the workshops encourage the further exploration of the Head of Wellbeing concept. The workshops tell us that any school employing a Head of Wellbeing would require that person to respond to some specific school needs, even if common tasks can be identified. Common tasks appear to include work to increase support for pupil and staff mental health, as well as coordination of the school wellbeing programme. We next consider potential job descriptions and key competencies for a full-time Head of Wellbeing.

5. Head of Wellbeing: roles and job specifications?

Sections 3 and 4 demonstrate that academics, clinicians, policy shapers, school staff and pupils have at once similar and divergent opinions on activities that should be prioritised to raise standards of wellbeing in schools.

For example, the ‘systematic, structured teaching of life skills and values throughout school life’, encouraged by O’Donnell et al (2014), did not appear to be a priority concern of staff in our workshops; however, staff did agree that improved mental health support via training opportunities was of primary importance.

Unlike staff, pupils were keen to consider further enrichment opportunities, such as a greater range of clubs and voluntary projects – activities that would in turn bring a heightened sense of fulfilment and belonging within the school community.

The divergence is important to note because it indicates that a Head of Wellbeing may need to undertake work that is not considered a priority by all members of staff. And yet, for effective action, the Head of Wellbeing needs significant buy-in from governors, staff, pupils and parents.

5.1 Potential HW models

A Head of Wellbeing, moving into post, would need to begin work with a ‘health and wellbeing audit’ – a comprehensive assessment of current need and wellbeing provision within the school.

Since the Head of Wellbeing’s role would be significantly informed by such an audit, we can only consider theoretical models of activity at this point. For the purposes of this discussion, we limit the basic models to three, but more variants are of course possible. All three models entail some degree of support for both staff and pupil health and wellbeing – see Table 5a.

Model One

Model one is a role requiring a post-holder with middle or senior management experience (in school or elsewhere), with counselling qualifications and experience, and ideally with teaching experience.

Counselling experience is necessary not because this person should take on one-to-one counselling. Rather, it enables any school seeking to appoint an HW to see clear evidence of people skills, emotional intelligence and professionalism around confidential matters. Counselling experience would also help the HW in their role as staff/pupil signposting and services coordinator, enabling greater understanding of appropriate action. It might also allow them to take on direct staff health and wellbeing INSET: e.g. workshops on stress management and work-life balance, and staff training on identifying emerging mental health problems in children.

5. Head of Wellbeing: roles and job specifications?

Model Two

A more pupil-orientated role, model two requires the HW to have teaching experience, if not management experience. A counselling or medical background would also be desirable, but perhaps not essential if the role does not entail staff signposting and more specific mental health support. A highly organised individual, they would need to demonstrate strong people skills and emotional intelligence. A key task for this post-holder would be that of wellbeing education coordinator/manager.

To support staff they would ideally take on the planning of Health and Wellbeing INSET, arranging workshops on stress management and work-life balance, and staff training on identifying emerging mental health problems in young people.

Model Three

Model three may not require someone with teaching experience, although knowledge of the school environment and its structures would be important. It would be ideal that this person have counselling (or educational psychology) qualifications to support and even raise access to counselling provision.

Working closely with pupils, and perhaps assisting inclusion and home-school liaison, the post-holder would ideally sit at middle-management level. This would help them engage with the SLT on steering whole-school change around health and wellbeing. The post-holder could be actively involved in teaching PSHE and SRE.

This model might well suit someone with community nursing experience as well as counselling experience. If so, they may be able to directly train and advise staff on a variety of health and wellbeing issues.

5. Head of Wellbeing: roles and job specifications?

Table 5a. Head of Wellbeing models. *Y = Yes, P = Possibly, D = Desirable, N = No*

Core tasks		HW Model 1 Priorities: managerial and strongly focused on staff support; whole-school pupil support	HW Model 2 Priorities: pupil H&W support and education; additional staff support	HW Model 3 Priorities: mental and physical health of pupils; wellbeing education
P U P I L S	Pupil mental health: prevention coordination	Y	Y	Y
	Wellbeing ed coordinator (PSHE and Citizenship, SRE, other wellbeing classes)	P	Y	P
	Teaching PSHE & Citizenship/ SRE or other wellbeing ed	N	P	Y
	Support for Inclusion, SENCO/ SEN staff/mentors/EWO	P	P	Y
	Enrichment coordinator (clubs, events, etc)	Y	Y	Y
	Physical activity liaison	Y	Y	Y
	Signposting pupils	Y	Y	Y
	Resourcer for counsellor ed/psych	P	P	Y
	Resourcer for school nurse	P	P	Y
STAFF/PUPILS	Manager of whole-school health and wellbeing programme	Y	Y	Y

(continued overleaf)

5. Head of Wellbeing: roles and job specifications?

Core tasks		HW Model 1 Priorities: managerial and strongly focused on staff support; whole-school pupil support	HW Model 2 Priorities: pupil H&W support and education; additional staff support	HW Model 3 Priorities: mental and physical health of pupils; wellbeing education
S T A F F	Staff mental health support/ signposting	Y	Y	Y
	Staff physical health programme	Y	P	P
	Staff absence follow-up	Y	P	P
	Strengthening multi-agency working (across education and pastoral teams, local services)	Y	Y	P
	Staff health & wellbeing INSET, training or facilitating (incl. stress management; identifying mental health problems in adolescents)	Y	Y	Y
	Support to increasing parent engagement (on pupil health & wellbeing specifically and generally)	Y	Y	Y
Expected H/W experience & qualifications				
Management (middle or senior)		Y	Y	D
Teaching		Y/D	Y	D
School environment		Y	Y	Y
Counselling (and/or medical)		Y	D	Y

5. Head of Wellbeing: roles and job specifications?

5.2 Further considerations

As this is a new post, the Head of Wellbeing's role would no doubt evolve, with both on the job training and a widening of expertise the reality. Whilst a Head of Wellbeing might be externally recruited, a suitable internal candidate may be already known for their interest in whole-school wellbeing, their emotional intelligence, management and coordinator's skills.

Schools may (therefore) want to consider developing this role part-time with an existing staff member, with an appropriate reduction of teaching load and/or extra-curricular duties where necessary. As already noted, the private school Dulwich College has appointed a Head of Wellbeing, a maths teacher who currently gives hours totalling one day a week to Head of Wellbeing duties. This person's remit is fairly close to that described in Model 2, with recent activity now including staff INSET on health and wellbeing.

6. Business-case considerations

The business case for the Head of Wellbeing post, demonstrating the potential for return on investment (RoI), can only be made following extensive piloting with robust evaluation. Nevertheless, the opportunities for savings in the long term, through prevention and early intervention, the better coordination of services, changing behaviour and the raising of educational attainment via enhanced wellbeing, are very real.

The Chief Medical Officer's (CMO) 2012 report, 'Our Children Deserve Better: Prevention Pays', presents a wide selection of evidence from both within the UK and abroad supporting the economic logic and long-term societal benefits of increased investment in prevention and early intervention.

The CMO's call to action is prompted in part by the nation's vast expenditure on what are, to varying degrees, avoidable health and social problems. Her report estimates the current annual short-term costs of emotional, conduct and hyperkinetic disorders among children aged 5–15 to be in the region of £1.58 billion, with long-term costs at £2.35 billion. A single admission to inpatient child and adolescent mental health services has a median cost of £24,000. Long-term health and societal costs of childhood obesity lie somewhere between £588–686 million per year, while educational under-achievement is estimated to cost the nation £22 billion per generation.⁵ The CMO's report makes clear that savings can be made through better prevention strategies, even if exact savings are difficult to define.

Another significant area of potential savings derives from improved staff management and a healthier workforce. The associated costs of staff illness, primarily brought on by workplace stress, are substantial, bearing in mind the impact on school budgets of supply teachers, the health service, and the quality and continuity of teaching (thus the educational progress of pupils). It has been estimated that schools lose productive time to the value of over £500 million yearly through teacher sickness absence; around 60% of school business managers believe there is scope for schools to make savings through better absence management (Audit Commission, 2011).

In terms of Head of Wellbeing feasibility, we should also be looking beyond the public sector: the private sector, after all, is an increasingly important funding stream for academies. And in this new age of school-based business enterprise and corporate partnership, a Head of Wellbeing, working with the school principal, business manager and a corporate partner, might facilitate business growth of the school's 'wellbeing resources' by opening up provision to the local community. This may involve the school's sports facilities and grounds, conference or class rooms, or its health-food canteen.

5. We infer (from the Chief Medical Officer's report) 'generation' to imply 'school generation'.

6. Business-case considerations

If a Head of Wellbeing has scope for RoI, we must nevertheless acknowledge the significant barriers to investment in prevention at this time of government austerity. Barriers include the time lag between investment and benefit, the disaggregation of budgets to fund new initiatives that seek greater integration, and concrete proof that interventions will lead to promised outcomes (CMO, 2012).

These various challenges thus emphasise the importance of extensive piloting to test out the Head of Wellbeing concept. The launch of a Head of Wellbeing pilot will require team-playing pioneers who are willing to take financial risks largely for the potential benefit of young people, but also the school workforce. If successful, the pilot should help answer questions about funding streams; that is, who, or what bodies, should ultimately be responsible for the funding of this new post? After all, schools, the NHS, Local Authorities and Central Government are all potential beneficiaries.

Head of Wellbeing pupil-focused activity that could create savings long term:

- enabling mental illness prevention and early intervention through staff training (on timely identification) and work to increase enrichment activities; establishing pupil support groups
- supporting better understanding of how particular students engage with learning (e.g. psychometric testing)
- improving education on pupil wellbeing, self-control, resilience and other soft skills
- broadening of physical activity opportunities and raising engagement
- targeting rates of obesity and malnutrition:
 - i creating practical opportunities for pupils to learn about healthy eating
 - ii improving in-school nutrition; liaising with Local Authority to curb expansion of fast food outlets close to the school
- raising parental awareness of and involvement in the school's health and wellbeing vision
- improving sex education (reducing rates of STIs), relationship and parenting education
- raising buy-in from local business to invest in the welfare of young people

7. Conclusion and next steps

Findings from this project have given us a foundation to further investigate the concept of a Head of Wellbeing post as an integral part of state secondary school infrastructure. Indications are that a Head of Wellbeing would be welcomed by most staff and may well give the much needed focus, coordination and impetus to the raising of whole-school health and wellbeing outcomes.

We are confident that most parents would welcome such a post. Public desire to see wellbeing given stronger priority in schools was recently demonstrated in a survey by the MindEd Consortium (2014), which suggested that more than two-thirds of adults (69%) support the notion that every school should have a dedicated member of staff on site for children to approach about mental health and wellbeing issues (RCPCH, 2014).

It is vital to stress that the wellbeing agenda is in no way a distraction from academic targets; it is rather a central component to achieving them. An increase of curricular and non-curricular physical activity, for example, is likely to raise academic results, not lower them through a lack of time devoted to class-room subjects and homework (US DHHS, 2010). Thus a key objective remains to better promote the understanding that as academic attainment benefits wellbeing, so wellbeing benefits academic attainment: it is a virtuous circle.

We have seen how the Head of Wellbeing concept could respond to a number of key recommendations emerging from health and education experts. This activity (support, coordination, resourcing) includes:

- regular measurement of pupils' wellbeing
- staff training on identifying early warning signs of mental health illness in young people (especially deriving from stress, bullying, family breakdown and abuse)
- raising parent awareness, involvement and support around child health and wellbeing
- increasing school-based enrichment opportunities (clubs, drama, dance, music, visiting speakers)
- more effective, systematic wellbeing education (PSHE, SRE, other) throughout the school years, especially around nutrition, sex and relationship education, emotional intelligence, stress-coping strategies, resilience and other 'soft skills'
- greater engagement of young people in physical activity through a broadening of opportunities
- staff training on stress-coping strategies and work-life balance
- proactive, asset-based community engagement

7. Conclusion and next steps

We believe the Head of Wellbeing role needs to be further explored as a dynamic constituent of health and wellbeing provision at the whole-school level. Clearly, it will not solve all the great health and wellbeing challenges facing pupils – and staff – today, but it may well prove critical to increased classifiable whole-school health and wellbeing outcomes, and vital to more pupils being able to make the most of their education.

Next steps

Confident of interest in the Head of Wellbeing concept, and noting some precedents for this post, we would like to: i) initiate plans for a dynamic pilot analysis of the HW role and ii) compile more resources to support the HW project through:

- involving stakeholders in role development – health and education experts, schools and organisations
- facilitating the sharing of ideas and learning, with emphasis on recent health and wellbeing interventions and pilots
- developing case-study business strategies
- reviewing the few Head of Wellbeing (or similar) posts already identified
- 2020health operating as a go-to organisation for schools interested in exploring the Head of Wellbeing concept
- devising baseline health and wellbeing audit and gap analysis templates for schools
- identifying funding streams and sponsors
- securing support from schools as pilot sites

We would welcome contact from interested partners at the earliest stage. Updates to progress on our Head of Wellbeing project will be posted on the 2020health website.

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Head of Wellbeing
An essential post for state secondary schools?

Appendix A: Steering group members

Name	Position	Organisation
Dr Iseult Roche	Chair: Fit-for-School workstream	2020health
Dr Susan Askew	Programme Leader: MA Curriculum, Pedagogy and Assessment	Institute of Education, University of London
Dr Raj Patel	Impact Fellow, UK Longitudinal Studies Centre	Institute for Social & Economic Research (ISER), University of Essex
Jeff Burn	Division Director	TTS Group Ltd
Andy Reed OBE	Director	Sports Think Tank
Dr Janice Allister	GP (FRCGP); Clinical Champion for Child Health, RCGP	Park Medical Centre, Peterborough; RCGP
Julia Manning	CEO	2020health
Jon Paxman	Senior Researcher	2020health

Appendix B: Staff questionnaire

School Name:

workshop

Staff multiple choice questions (mark with X).

This is an anonymous survey –
please do not identify yourself on your copy.

Are pupil health and wellbeing needs sufficiently met
with present resources at your school?

Has your school the appropriate multi-agency support
to meet whole-school health and wellbeing objectives?

Has your school the appropriate support from parents
to meet whole-school health and wellbeing objectives?

Does your school offer opportunities for pupils to build
on their non-academic abilities and interests within and
outside of class?

Does your school create opportunities for young people
to feel valued as individuals and contribute to the wider
community of the school?

Does your school provide suitable support for staff
struggling with high levels of stress?

Is there someone impartial you, as a staff member,
can talk to in confidence, if you are struggling with
relationship conflicts (with other teachers, managers,
parents, governors, pupils)

Two questions to be answered at the end of the
workshop:

Do you see the need for a full-time post of Head of
Wellbeing within the state secondary school system?

If the post existed, would you agree with this statement:
The Head of Wellbeing needs to sit within the senior
leadership team to exercise appropriate authority.

No

Not
sure

Yes

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Please feel free to provide any additional comments.

2020health's mission

Making health personal

2020health is an independent, social enterprise think tank whose mission is to "Make Health Personal". Through research, evaluation, campaigning and relationships we aim to both improve individual health and create the conditions for a healthy society.

2020health research and activity includes the following workstreams

**Fit-for-school / Fit-for-work / Fit-for-later life:
Forgotten conditions / Integration / International
Innovation / Social Care**

'With a balance of strong research and professional acumen this report highlights the crucial ways that schools can work for the wellbeing of children, young people and staff.'

Janice Allister GP
RCGP senior adviser in Child Health

'A thought provoking investigation of a new staff role that addresses a growing need and may one day become standard in secondary schools.'

Andy Reed OBE
Chair, Sport and Recreation Alliance

'A valuable Discussion Paper on the importance of supporting children (and teachers) to ensure long-term wellbeing in their physical and mental health.'

Raj Patel
Understanding Society
Institute for Social and Economic
Research (ISER).

'This report begins to form an evidence base about an issue rarely high up the national agenda – the wellbeing of pupils and staff. As such, it makes a valuable contribution to this debate and raises issues that teachers and school leaders will want to consider.'

Baroness Morris of Yardley
Former Secretary of State for Education

'The Head of Wellbeing is an advocate for pupil and staff welfare and has proved exceptionally well placed to deliver our core messages to parents, Governors, peers and pupils. We now find that the concept of wellbeing is integral to all we do and I can't imagine being without a Head of Wellbeing any more than I can imagine being without a Head of an academic department or Head of Year.'

Dr Joe Spence
The Master, Dulwich College

'The central recommendation of the recent parliamentary Health Committee inquiry into Children and Adolescents' Mental Health Services, was the value of investing in prevention and early intervention for mental illness in young people. I welcome this thoughtful report and support the proposal to pilot Heads of Wellbeing within secondary schools and to explore their potential to improve wellbeing across the whole school community.'

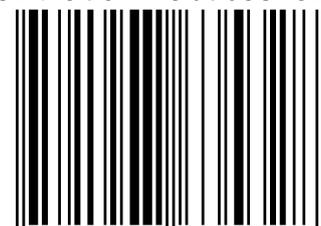
Dr Sarah Wollaston MP

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