THE HEALTH AND WELLBEING OF SCHOOL AGED CHILDREN AND YOUNG PEOPLE IN BIRMINGHAM

An Assessment of the Need for School based Services to Support Student's Health and Wellbeing

1. INTRODUCTION

1.1. **The origins of a school based health service** first emerged with the introduction of compulsory school education. An organised and school based health service, funded initially by Local Authorities, has existed for more than 100 years and emerged at the introduction of legislation for Local Authorities to provide meals for children at school (1907). In addition there were concerns about the fitness of our children to become workers and/or be enlisted in the defence of the country in times of war.

1.2. After the First World War this was a largely physical health focus with early detection of significant disease, especially rickets and TB, by routine physical examination by a Doctor and Dentist, assisted by nurses. Nurses would see and assist with the treatment of simpler conditions, particularly skin and eye infections. Some areas initially preferred to advise families to use local medical services which would charge the family. It is important to recognise that this service originated and developed prior to a National Health Service, free for all at the point of need.

1.3. The need for medical expertise reduced with the decline of the prevalence of these major conditions as the result of improved nutrition and housing and sanitation standards, although a nursing role particularly the early detection of lice remained.

1.4. An understanding of the important role that educating children about growth and development (physical, sexual, and emotional) plays in their future health developed during the 1990s and resulted in a shift in the focus for the school health service. The increased importance of primary prevention by education about nutrition, physical activity, and exploratory behaviours (especially smoking, alcohol, sex and drugs) resulted in further changes. The educators of our children and young people have since incorporated much of this within the curriculum, although there is evidence of variation in quantity and quality of the delivery in these areas.

2. THE RANGE AND SCOPE OF INFLUENCES UPON CHILDREN & YOUNG PEOPLE'S HEALTH & WELLBEING[1, 2]

2.1. The influences upon children's health and wellbeing are wider than the school environment in their cause and impact (Appendix A) and differ over the life course of childhood (Appendix B). Tackling these influences is not just the responsibility of schools neither are they all amenable to intervention in the school environment.

2.2. **Child poverty**, leading to impoverished childhoods, is a major determinant of health, wellbeing, and achievement in childhood. Marmot[3] and Field[4] separately have articulated this in great detail. The remedy of child poverty is multifaceted and requires more strategically joined up actions than has hither to been achieved in Birmingham or most communities.

2.3. **Speech & language development** is a significant factor in the development of social and intellectual skills in Early Years and Primary education settings. Delay in these attributes reduces the development of communication and reading skills which in turn reduces social and educational attainment over the rest of childhood and adulthood.

2.4. **Family relationships** are the early foundation of emotional and social resilience with opportunities for early acquisition of speech, language, and cognitive functions. This influence is sustained through the Primary education setting. In both primary and secondary education settings family relationships can disturb the emotional resilience and reduce the engagement of students with consequent reduction in achievement.

2.5. **Adults' behaviours & health** can be directly harmful to the health and wellbeing of children and young people from abuse and neglect due to parents' experiences of abuse, mental illness, substance misuse, or physical illness. Violent parents, involving only adults or including children, exert a particularly strong adverse impact upon children in the family at all ages.

2.6. **Personal resilience & esteem** is the foundation of much of the impulse and emotional controls we acquire during childhood. Factors or events that undermine the personal resilience and esteem result in conduct disorders of early years and Primary Education or the more extreme use of exploratory behaviours in Secondary education students[5]. Improving resilience by "exposing them to low doses of challenge to develop and strengthen their ability to act effectively in later life"[1] is an important challenge to parents and schools.

2.7. **Exploratory behaviours** or potentially health harming behaviours can, individually, result in short term or longer term impacts upon health & wellbeing. Bellis et al found a correlation between Adverse Childhood Experiences (ACE) (Table 2.1) and the acquisition of Health Harming Behaviours (Table 2.2).

2.8. The more Adverse Childhood Experiences a young person has encountered the more likely they are to engage in Health Harming Behaviours, although some behaviour was more predictable than others (Table 2.3). These adverse experiences are not all routinely measured but doing so could become an important way of prioritising action to improve children's health and wellbeing. In the meantime staff assessing children and Young People should include the Adverse Childhood Experiences of Table 2.1 as a means of being more alert to the likelihood of Health Harming Behaviours or other family dynamics potentially having an adverse impact upon their Health & Wellbeing. This should be done whether children are referred for assessment because of concerns or self-referring in open session[6].

2.9. **Personal, Health, & Social Education** is an opportunity for children and Young People to develop an understanding of the importance of social and emotional attitudes and behaviours. This might be through a course of study but it also greatly influenced by the attitudes and behaviours of peers and adults with whom they meet and relate. Trying to teach it like a course of Biology or maths has failed to impart much understanding and Ofsted has consistently found the quality of PHSE in schools unsatisfactory[7]. The development of the school as a Healthy Setting is considered to improve the quality of the education of these life skills and issues. The revival of a Healthy School Programme locally would contribute significantly to our Young People's Health and Wellbeing.

2.10. **Safe social space** in which to practice the acquired learning of PHSE is fundamental to the acquisition of the life skills required to live in a family and community. Some of the Primary School active play, play leadership schemes and circle time initiatives help develop this. There is less obvious development, beyond school councils and vertical tutor groups, in secondary school settings to nurture these opportunities to practice the skills. Again the school as a Healthy Setting would facilitate this further.

2.11. The greater challenge is to develop safe social spaces outside the school gates. The Council run Youth Clubs may have had their day but many Faith communities have thriving groups which may not be restricted to families of their own faith. A balance between a *one sizefits all* universal approach and *a community sensitive/initiated movement* is required, but who will champion this?

Table 2.1: The Definition of Adverse Childhood Experiences

Adverse Childhood Experiences	Definition
Parental separation	Were your parents ever separated or divorced?
Domestic violence	How often did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up?
Physical abuse	How often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? This does not include gentle smacking for punishment
Verbal abuse	How often did a parent or adult in your home ever swear at you, insult you, or put you down?
Sexual abuse	How often did anyone at least 5 years older than you (including adults) ever touch you sexually?
	How often did anyone at least 5 years older than you (including adults) try to make you touch them sexually?
	How often did anyone at least 5 years older than you (including adults) force you to have any type of sexual intercourse (oral, anal, or vaginal)?
Mental illness	Did you live with anyone who was depressed, mentally ill, or suicidal?
Alcohol abuse	Did you live with anyone who was a problem drinker or alcoholic?
Drug abuse	Did you live with anyone who used illegal street drugs or who abused prescription medications?
Incarceration	Did you live with anyone who served time or was sentenced to serve time in a prison or young offenders' institution?

All ACE questions were preceded by the statement "While you were growing up, before the age of 18…"

Table 2.2: Health Harming Behaviours

Health Harming Behaviours	Definition
Unintended teenage pregnancy	Did you ever accidentally get pregnant or accidentally get someone else pregnant before you were aged 18 years?
Early sexual initiation	How old were you the first time you had sexual intercourse? (<16 years)
Smoking	In terms of smoking tobacco, which of the following best describes you? (I smoke daily)
Binge drinking	How often do you have 6 or more standard drinks on one occasion (Weekly or daily or almost daily)
Cannabis use	How often, if ever, have you taken the following drugs…cannabis? (any level of use)
Heroin/crack cocaine use	How often, if ever, have you taken the following drugs… heroin/crack cocaine? (Any level of use)
Violence perpetration	How many times have you physically hit someone in the past 12 months? (Any frequency)
Violence victimization	How many times have you been physically hit in the past 12 months? (Any frequency)
Incarceration	How many nights have you ever spent in prison, in jail or in a police station? (Any number of nights)
Poor diet	On a normal day, how many portions of fruit and vegetables (excluding potatoes) would you usually eat (one portion is roughly one handful or a full piece of fruit such as an apple)? (<2 portions)
Low physical activity	Usually, how many days each week do you take part in at least 30 minutes of physical activity that makes you breathe quicker, like walking quickly, cycling, sports or exercise? (<3 days)

Questions on alcohol consumption were drawn from the AUDIT C tool, and participants were provided with information on what constitutes a standard drink (UK = 10 mg of alcohol).

Table 2.3

Outcome	All		Adverse Childhood Experience %				χ^2trend	P
	%	n	0	1	2to3	4+		
Sexual Behavior								
Unintended teenage pregnancy (<18 years)	5.5	3836	2.9	5.6	8.3	17	106.097	<0.001
Early sexual initiation (<16 years)	16.8	3374	10	19.4	23	37.8	164.629	<0.001
Substance use								
Smoking (current)	22.7	3885	17.7	21.8	28.3	46.4	127.022	<0.001
Binge drinking (current)	11.3	3885	9.3	13.2	12.6	16.7	18.579	<0.001
Cannabis use (lifetime)	19.5	3878	12.2	21.5	27	47.7	241.57	<0.001
Heroin or crack cocaine use (lifetime)	2.2	3882	0.9	1.5	4	9	84.106	<0.001
Violence and criminal justice								
Violence victimization (past year)	5.3	3883	2.4	4.2	10.7	16.1	137.578	<0.001
Violence perpetration (past year)	4.4	3884	2	3.6	8.7	13.9	119.609	<0.001
Incarceration (lifetime)	7.1	3879	3.1	8.1	10.2	24.5	182.58	<0.001
Diet, weight and exercise								
Poor diet (current)	15.6	3879	13.3	15.9	18.3	25.1	31.679	<0.001
Low physical exercise (current)	43	3881	44.1	41.4	41.2	42.7	1.434	0.231

2.12. **Formal education** is acknowledged by Marmot[1] as an important precursor to child hood achievement and the foundation for improved socio-economic prospects in adulthood with improved health and wellbeing outcomes. Ofsted attempts to quantify the quality of the formal educative processes using the curriculum but the only outcome that is taken seriously is the aggregated performance of students in public examinations. There is no attempt to track individual's progress and capture any sense of personalised achievement against the odds in preparation for adult life.

2.13. Children who cannot attend school due to health issues cannot engage in education. Children who do not engage in education do not usually achieve their full potential in adulthood. Children who do not want to attend and /or engage pose a different challenge to the current educational paradigm.

2.14. There are fewer **physical health** issues which impact upon childhood health & wellbeing in population terms. At an individual level however the impact can be significant and include:

2.14.1. **Preconception parental health** is important to the healthy growth of a baby during pregnancy. International research links preconception health, particularly vitamin deficiency; drug therapies; smoking; alcohol; and mental illness, with poor infant outcomes and some future health and development adverse impacts.

2.14.2. **Variation in neuro-development and overcoming that variation** are challenges of prevention and management. Preventing these conditions occurring includes paying attention to preconceptual parental health, outlined at 2.13.1, but many have no known cause. Identifying individuals developing signs of delay and clearly assessing the needs as the focus of a care management plan[14] are very important to parents and families, including if possible a diagnostic label.

2.14.3. **The development of life threatening disease** will disrupt the health and wellbeing of individuals and families, although relatively rare at a population level. The natural history and prognosis will influence the size of the impact of any serious illness in childhood. The NHS Healthcare service response to these events ought to include an assessment of the impact, including an attempt at prognosis and length of impact, with some mitigating emotional and physical support to the individual and family, and a partnership with public and voluntary providers of additional supports.

3. What Is It Like Living In The UK And Birmingham As A Child?

3.1. In section 2 it was noted that a major influence and impact upon children's health and wellbeing is child and family poverty. Birmingham has more families and children in poverty than the national norm[8] with 77,500 children under 16 in poverty (32.2% compared with England's 20.6% and the lowest area of 6.9%).

3.2. The poverty is not shared equally across the City (Figure 3.1). It is interesting to note that over time, including the recent financial crisis; more families in households in affluent areas (quintile 5) have experienced poverty (Figure 3.2).

Figure 3.1: Child Poverty by Electoral Ward in Birmingham (2010)

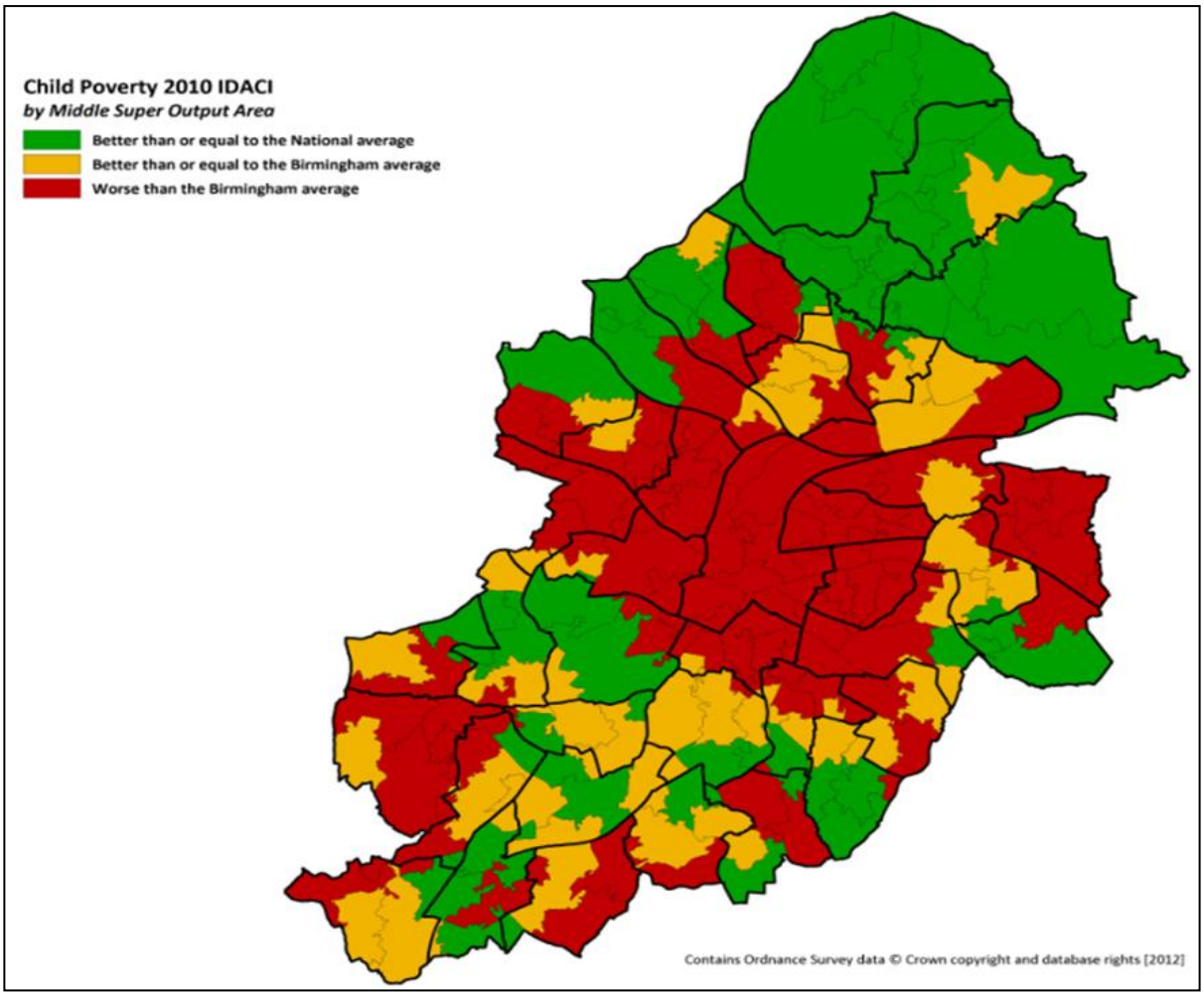
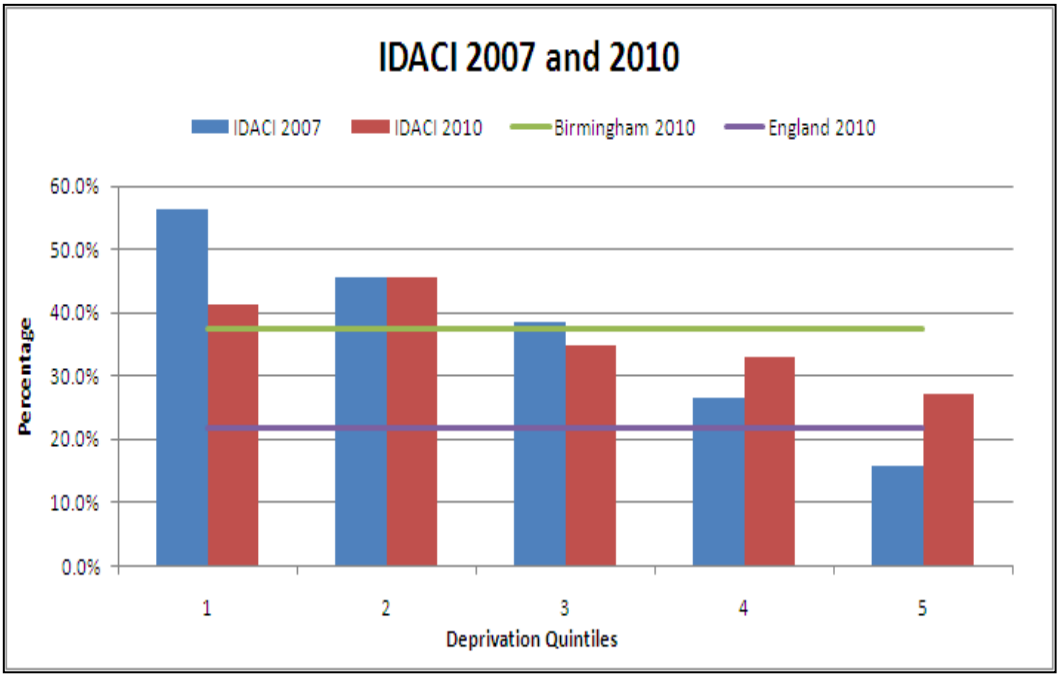


Figure 3.2: Comparison of Poverty in Birmingham over time (2007 and 2010)



3.3. Poverty is an important feature of undermined health and wellbeing in children and Young People and will require action across a number of sectors of City life. The announcement of a Child Poverty Commission is a significant first step to securing that action. Reversing the

trends and impacts however will take some time. In the meantime service provision to Children, Young People, and families must take this factor into account when planning the distribution of resources and effort.

3.4. Evidence in the UK of suggests a mixture of challenges to children's health & wellbeing[9] (Table 3.1). Personal wellbeing is rated favourably. Family relationships are a little more mixed with children talking about things that matter (Mothers more than fathers) and 57% of children eating together as a family frequently. However quarrels with parents (28% Mother and 20% Father) are quite common and more so than bullying at school.

Table 3.1: Measures of Children's Wellbeing (ONS 2014)

Wellbeing measure	Proportion of children	
PERSONAL WELLBING		
Medium/high level of life satisfation	77%	
Medium/high level of happiness yesterday	74%	
Medium/high level of things worthwhile in life	75%	
OUR RELATIONSHIPS		
Talk to a parent about things that matter >once a week	63%	Mother
	40%	Father
Eat a meal with family 3+ times in last week	75%	
Quarrel with a parent more than once a week	28%	Mother
	20%	Father
Have been bullied more than 4 times in last 6 months	12%	
WHAT WE DO		
Participated in any sport in last week	89%	
Engaged in arts or cultural event >3 times in past year	94%	
Belong to a Social Networking site	86%	
WHERE WE LIVE		
Been a victim of crime in past year	13%	
Feel a bit or very unsafe walking in neighbourhood alone after dark	44%	
Like living in their neighbourhood	88%	
EDUCATION & SKILLS		
Relatively high happiness with their school	83%	
Would like to go on to full time education at college or university	62%	
HEALTH		
Relatively high level of happiness with their appearance	74%	

3.5. Children also seem to be engaged in sport or cultural activities. Social Networking sites are clearly a common feature of children's lives now (80%). They like living in their neighbourhoods and are relatively happy with their school. Almost half feel a bit or very unsafe walking alone after dark and a small proportion have been a victim of crime or are worried about becoming a victim of crime.

3.6. There is an annual sample survey of students aged 7-18 years in Birmingham[10]. Each year schools across Birmingham are invited to participate in the survey (since 2006/7). The school then arranges for pupils in the school to complete the survey online. The survey was

designed the Social Research Unit (Dartington) to cover the main areas of the Every Child Matters Outcomes Framework.

3.7. Over the past five years children have reported similar levels of physical health.

3.7.1. 3% of 12-18s said they drink at least once a week but consumption has decreased over the years and have been similar in last two years.

3.7.2. 9% of 12-18s said they smoke and 4% of 12-18s said they had used drugs in the last month and have been similar in last two years.

3.7.3. 9% of children identified they had emotional problems which has been stable for the past five years

3.7.4. 8% of 7-11s and 14% of 12-18s have significant problems with pro-social skills (e.g. being considerate of others feelings, sharing, being helpful if someone is hurt, being kind and volunteering to help etc.)

3.7.5. 8% of 7-11s and 2% of 12-18s have significant problems with peer relations (e.g. preferring to play alone, not having at least one good friend, being picked on by other children etc.). These are significant numbers of children and should shape our school based approaches more.

3.8. On average over the past 5 years 70% of 7-11 year old and 50% of 12-18 year old children report enjoying going to school with 80% and 58% always getting on well with their teachers. Interestingly bullying is reported more often in 7-11 year olds (20%) than 12-18 year olds (10%). This surprising finding should shape our school based response in terms of differences in approach in Primary and Secondary schools.

3.9. Over the past five years children's expressions about their future aspirations have remained stable, with the exception of 12-18year olds view on the importance of a College qualification (varies between 69 and 79% but without any time related pattern). 70% of 7-11 year olds and 60% of 12-18 years olds considering it important to go to university but 85% of both age groups consider it important to have a job that is well paid.

3.10. Only a third of children reported feeling safe in their neighbourhood at all time. This means that 60+% feel unsafe *at any time* compared to the national picture where almost half feel *a bit or very unsafe walking alone after dark.*

3.11. It would seem that living in Birmingham results in similar experiences and impacts to the national experience for children except for feeling safe in the streets and household family poverty.

4. The Evidence of Benefit of a School Based Health & Wellbeing Provision

4.1. If students are unable to attend and engage in school due to physical or emotional barriers they will not achieve their full potential and be fit to engage the next stage of their journey into adulthood. If this is the case they are more likely to join the spiral into poverty, under achievement and increased physical and emotional ill health with shortening of disability free life years and shortened expectation of life.

4.2. A school based Health Advisory Service is only one of a number of settings in which Children and Young People are to be found and engaged with (Appendix B). However they are in school for 55% of their waking year (Table 4.1) and it is reasonable to consider this

setting as at least providing a significant opportunity to engage with the majority of children.

4.3. The history of a School Health Service, briefly summarised in section 1, records a changing purpose for the service. The current governmental view on its form and function[11], but not necessarily purpose, focusses on the 05-19 Healthy Child Programme.

4.4. The Healthy Child Programme emerged at a time of serious concern about the school based health service and at the time of the most significant refocussing of children's services with the publication of the Education Act (2004) and Every Child Matters Programme. It built upon the experience of the national Healthy Schools Programme which funded, through the local authority, a framework award to systematically develop health promoting practices, cultures and teaching opportunities in schools.

4.5. The Health Education Service were commissioned in 2012 to survey Birmingham schools on the role that the School Health Service contributed to their efforts to enhance children's health & wellbeing[1]. The reported that:

> 4.5.1. Schools spoke about how they have previously valued the input of the school health service, but feel any provision now is sporadic, inconsistent and does not meet their needs. In discussing what they would like to see from school nurse there is an increased focus on support to parents and the ability to run parent work-shops and drop in sessions, in addition to inputs to curriculum, pupil drop-in, and health checks. **Schools speak of the need for a regular and consistent service**.

4.6. There have been two local surveys assessing **pupil's perception of need for a school based service**[12,13]. These revealed that:

> 4.6.1. Every group of pupils consulted either thought there was no school nurse or thought the person who provided first aid was the school nurse. The majority had never seen the school nurse although a few remembered being weighed and measured. All thought there should be a school nurse but their ideas of the role were limited to providing first aid. One secondary school pupil talked about them being someone to talk to about issues you didn't want school to know about[1].
>
> 4.6.2. When asked if they would like school nurse advice or support on a variety of issues, the proportion of young people who would like advice or support was between 16% and 26%, with the proportion varying across the different issues, and with slightly higher levels of interest from BME respondents.[2]

4.7. The time that students are available to access school nurses poses a significant challenge. Most of a student's time is spent in the 'classroom'. Students spend 55% of the days in their year (200/365 days) and 30% of their waking year (200 x 7 hour days or 1,400/4745 hours) at school (Table 4.1). Only 21% (1.5 of the 7 hour days comprising lunchtime and 15 mins before and after school) of each of those days is potential contact time with school nurses.

Table 4.1

SCHOOL YEAR	DAYS	HOURS		
40 weeks of 5 days	200		55%	of students whole year
		1400	30%	of students waking hours
Spent in classroom		1100	79%	of school year hours
Lunch & pre/post school		300	21%	of school year hours

Table 4.2

SCHOOL YEAR	DAYS	HOURS		
If School nurse on site one day every week they could have face to face contact for:	40	60	4%	of all school time where schools only allow contact in non teaching time.
	40	280	20%	of all school time where schools allow contact in teaching time as well.

4.8. If school nurses are in school for one day each week (40 days per year) there will only be 60 hours per school year of potential face to face contact out of classroom time. (Table 4.2) This equates to 4% of out of classroom time in a school year and 20% of all school time should the school allow contact at any time of the school day.

4.9. There appears to be a significant constraint on universal accessibility with a day a week arrangement, even if the school were to allow contact at any time of the school day. Lightfoot (2000)[14] reports the desire of some students to have more time from a school nurse they can identify and know. At the same time she acknowledges that only a small minority of students choose to contact them, as evidenced in the local survey[10], although more might be seen following concerns by teaching staff.

4.10. Universal self-controlled access (Drop in sessions out of classroom time) may be important for pupils accessing advice, particularly at secondary school, but it cannot be the whole story of a school based health service.

4.11. Lightfoot recognises the reluctance of students to visit local General Practice because of the risk of meeting adults they know or know the family, not necessarily that practice staff would divulge to parents confidential information. The students were clear that there is a need for out of school access to community based provision of Young People friendly Healthcare advice and support.

5. ISSUES TO CONSIDER

5.1. It is important to use the described evidence to shape the role and purpose of a school based health advisory service, form should always follow function.

5.2. The role for the current service, within the 5-19 national Healthy Child Programme, is out of touch with the current governance arrangements of schools and ambiguous due to a lack of demonstrable outcomes[15]. It is a process map without purpose and valid metrics.

5.3. **Should this advisory service be school based?** The key to this question should lie in the sub question: Who will it advise?

5.4. If the individual student is the recipient of this advice through universal self-controlled access then the time available to identify and address issues they present is inadequate. A model that remains focussed on self-controlled access for individual advice would have to have access portals outside of school and should be seen as a Young People Friendly Primary Care service. Is this the responsibility of General Practice as the current providers of this service or the development of a new NHS commissioned community based service?

5.5. If schools are the recipients of the advice then **what is the purpose of the advice?** Schools have a clear responsibility to support students with health needs[16]. A significant proportion of school absences are attributed to 'medical reasons', including physical and emotional conditions. Section 4 opened with a link between attendance, engagement in learning, and achievement. The fusion of these strands would lead to a clearer measureable purpose for a school based Health Advisory Service and is outlined in the broader model of need in Appendix C.

5.6. The model in Appendix C has four themes which should be considered separately as they are or could be commissioned differently.

5.7. The left hand (red) stream is the **health protection** function. This is commissioned by NHS England. They have indicated a preference to commission a separate vaccination team with surge capacity and covering other communicable disease scenarios or develop a service through General Practice. If the General practice route is favoured and achievable it might create the opportunity to explore a synergy through General Practice to deliver the middle (orange) stream.

5.8. The right hand (purple) stream is support to the **corporate development of a school**. This was previously facilitated by the National Healthy Schools Programme and although school nurses played an important supporting role, the real driver was the City wide support to school staff planning and delivering PHSE and developing the school culture. The development of a Be Healthy School Award locally is an important initiative in assisting schools with their responsibilities. It is also important in delivering elements of the Childhood Obesity Strategy supported by the Health & Wellbeing Board. There is no evidence however that it could be delivered by or through a School Health service and alternative expertise will need commissioning.

5.9. The middle (orange) stream works with **individual pupils and students directly**. It includes the systematic joint management of students absent due to physical or emotional ill health, particularly repeated or long term absentees.

5.10. At the heart of the work in this model is the face to face assessment which by its very nature and volume may need to move into the classroom time. This may be more acceptable to schools if the purpose is to enable students to attend, engage and achieve in the longer term. This student assessment will be supported by a toolkit of brief interventions and assessment tools with clearer referral pathways to community specialist resources where appropriate.

5.11. This stream however should not include participation in teaching groups of students, even puberty or sex education 'talks'. If schools wish to utilise the personal skills of particular staff members this ought to be in negotiation with the provider concerning the funding.

5.12. The blue bubble stream reflects the discussion at 5.4 concerning the development of a Young People Friendly community/Primary Care approach.

5.13. There is no explicit reference to the **safeguarding of pupils and students**. This is a core professional responsibility and will not change. The involvement in the various screening processes, when concerns are raised or families with children are involved in incidents of violence in the home, needs to become more focussed and purposeful without consuming time available for direct student contact. If Health Advisory staff have no useful intelligence to bring to strategy or conference then they ought not to be involved. However where a health component that is to be delivered in a school setting is identified the staff role in supporting family plans ought to become more focussed.

5.14. There is no reference to the **mandated National Child Measurement Programme**. This is a core component of the Childhood Obesity Strategy and could be a service commissioned through that route using an appropriate provider and need not be part of this function.

5.15. Although this is a proposal as a school based service, due consideration needs to be given to those children not in school e.g. excluded children, NEETs, vulnerable groups educated in other settings, and home schooled children. One potential model would be for the school based service also to provide services for those children living in geographic proximity to the school, either through home visiting or using local community provision, or as a virtual team.

5.16. It has been established that the health and wellbeing needs of children and young people vary depending on their individual needs and circumstances but some of the overriding issues may require different approaches dependent upon age, so it may be appropriate to have a different model or approach by age group 5-11, 11-16, 16-19.

6. CONCLUSIONS

6.1. If children spend 55% of their year in a school setting, it is an important place to engage them.

6.2. The purpose of their attendance is to engage in educative activities and prepare for adulthood. The Health Advisory Service should address physical and emotional health issues which are preventing full attendance and /or engagement in that educational endeavour.

6.3. The function of the Health Advisory Service is to assess individuals and assist the school in mitigating the impact of physical or emotional health issues. This requires a systematic assessment process with connections to local specialist resources should the need arise.

6.4. The Health Advisory Service should be a key partner with the school to deliver Child Protection or In Need plans in the school setting. Plans that have a component of health response that is delivered out of school time or setting should be addressed through Primary Care.

6.5. Serious consideration should be given to the commissioning of resource to support the:

- **6.5.1.** development of the school as a Healthy Setting;
- **6.5.2.** Health Protection responses including routine immunisation and vaccination programmes through NHS England; and

6.5.3. A community Young People Friendly healthcare advice and care service.

7. ENDWORD

7.1. This document draws on available evidence of the need for a school based Public Health approach. The next step is to consult upon the issues identified in order to procure an appropriate Health Advisory Service for schools or other acceptable suitable arrangements.

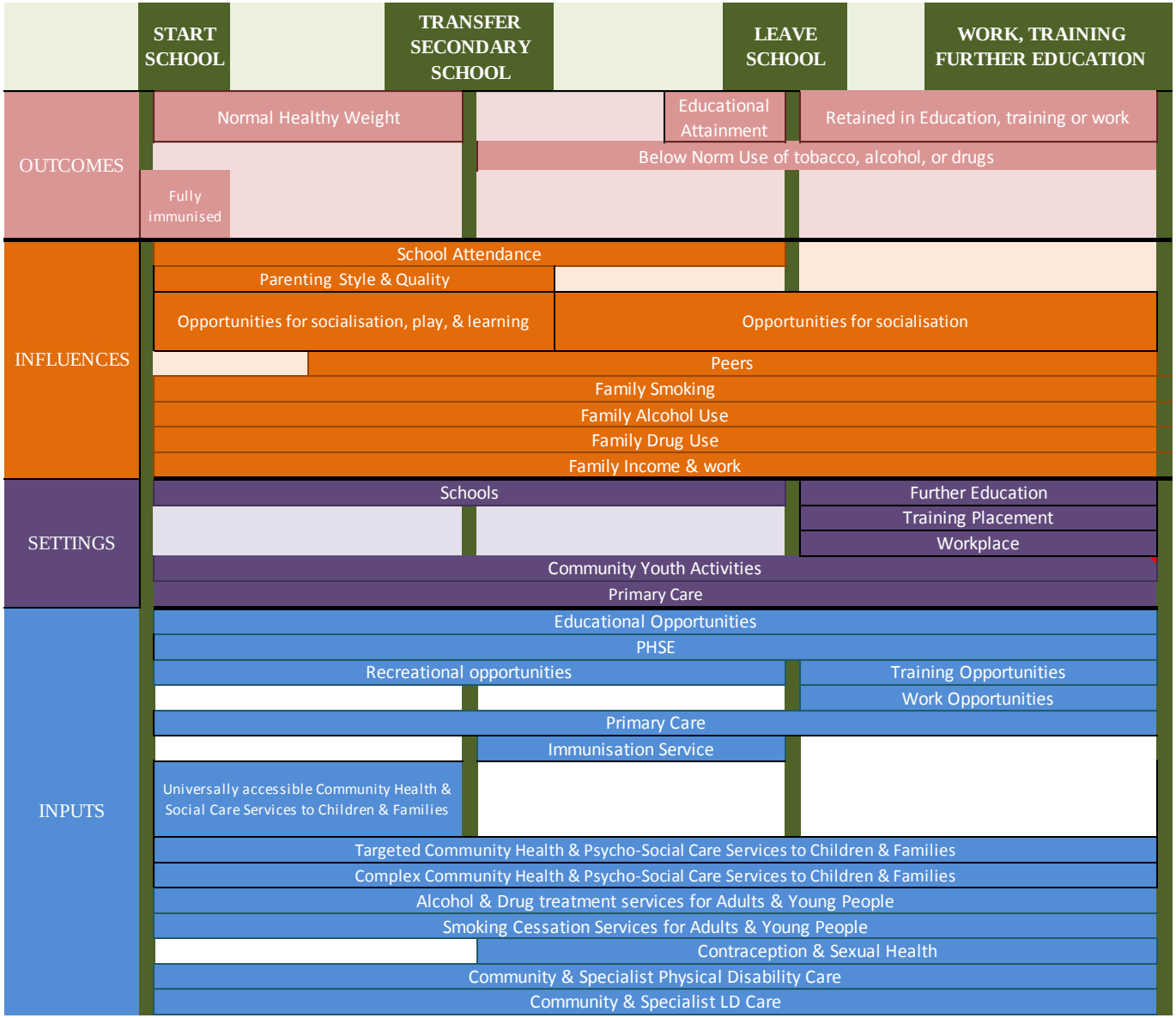
Dr Dennis Wilkes
Public Health Consultant Lead for Children, Young People and Families
Birmingham City Council
04 September 2014

APPENDIX A

IDENTIFIED INFLUENCES UPON CHILDREN AND YOUNG PEOPLES HEALTH & WELLBEING

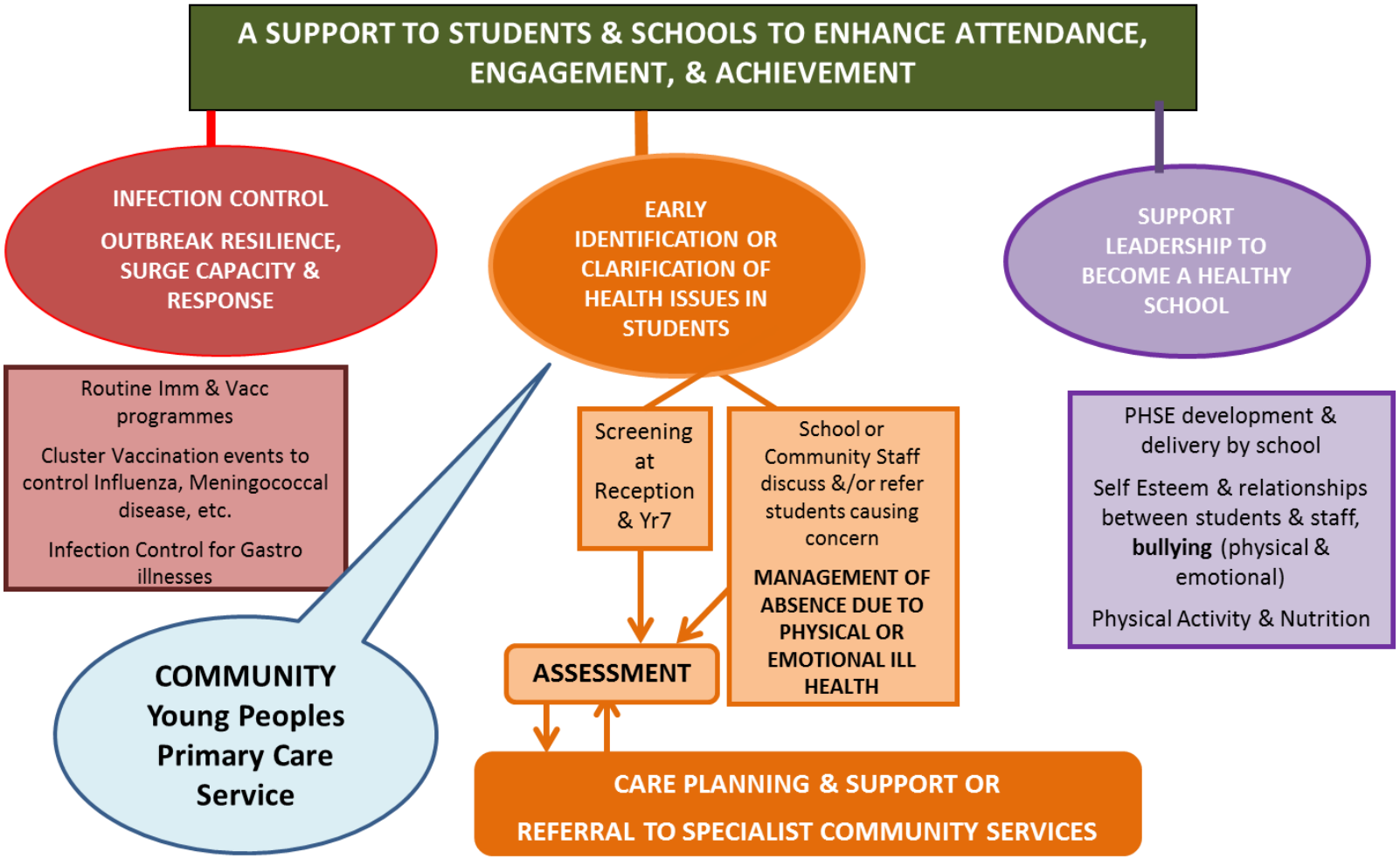
<table>
<tr><th>ISSUE IMPACTING UPON HEALTH & WELLBEING</th><th colspan="4">SOURCE IDENTIFYING CONCERN</th></tr>
<tr><td>FAMILY ECONOMICS & WORKLESSNESS</td><td>2010 Field Review: Improve attainment of poorest children by improving Foundation Stage resources and targeting. Improve the life chances of poorest children reduce the likelihood of next generation family poverty by reducing low skilled work and worklessness.</td><td>Tackling Child Poverty (NCB 2013): Identifies effective approaches and proposes national action to implement these. Acknowledges the rhetorical commitment producing the Child Poverty Act but……</td><td>LAs & Child Poverty (CPAG 2013): Impact of welfare Reforms on families and Las responses.</td><td>WM LAs Children living in families receiving out of work benefits 2011</td></tr>
<tr><td>FAMILY RELATIONSHIPS</td><td rowspan="2">Identified as important in Early Intervention summary. Local picture explored.</td><td colspan="3"></td></tr>
<tr><td>ADULTS' BEHAVIOURS & HEALTH</td><td colspan="3">Includes Mental illness, substance & alcohol misuse, domestic abuse</td></tr>
<tr><td>SPEECH & LANGUAGE DEVELOPMENT</td><td rowspan="2">Identified as very important in 0-5s data review.</td><td colspan="3"></td></tr>
<tr><td>PERSONAL RESILIENCE & ESTEEM</td><td colspan="3">Will the Big Lottery project give us the insight we need?</td></tr>
<tr><td>EXPLORATORY BEHAVIOURS</td><td>2013 CMO Annual Report identifies the range and scope of these behaviours and attempts to normalise them while recognising their potential for short and long term impacts.</td><td>Includes Tobacco, alcohol, & other substance use/misuse</td><td>Includes extreme speed and sports accidents</td><td>Includes Sex</td></tr>
<tr><td>PHSE</td><td rowspan="2">Identified as important in all Young People surveys and feedback</td><td>This was the premise of the National Healthy Schools Programme</td><td>OFSTED reviews have found this to be of poor quality.</td><td>Should this be taught/delivered differently from academic subjects?</td></tr>
<tr><td>SAFE SOCIAL SPACE</td><td colspan="3">Is this an alternative to the school setting that could enhance the quality of the encounter?</td></tr>
<tr><td>FORMAL EDUCATION</td><td colspan="4">Marmot (2010) recognises the link between formal education attainment and future socio-economic attainment and adverse health impacts</td></tr>
<tr><td>PARENTAL HEALTH PRECONCEPTION</td><td colspan="4">International research links preconception health, vitamin deficiency, drug therapies, smoking, alcohol, and mental illness with poor infant outcomes and future health impacts for survivors.</td></tr>
<tr><td>DEVELOPMENT OF BIOLOGICAL VARIATION</td><td colspan="4">2013 CMO Annual Report identifies the range and scope of these neurodevelopmental disorders, recognising their potential for short and long term impacts.</td></tr>
<tr><td>OVERCOMING BIOLOGICAL VARIATION</td><td colspan="2">2013 SEND Data & needs analysis identifies local variation in occurrence and service delivery/outcome.</td><td colspan="2">Children & Families Act 2014 implements Health & Education Plans</td></tr>
<tr><td>DEVELOPMENT OF LIFE THREATENING DISEASE</td><td colspan="2">Local Health usage data shows geographical variations of use and admission.</td><td colspan="2">2012-13 CDOP Report explores local trends in death, especially Infant mortality.</td></tr>
</table>

APPENDIX B


START SCHOOL
TRANSFER SECONDARY SCHOOL
LEAVE SCHOOL
WORK, TRAINING FURTHER EDUCATION
OUTCOMES
Normal Healthy Weight
Educational Attainment
Retained in Education, training or work
Below Norm Use of tobacco, alcohol, or drugs
Fully immunised
INFLUENCES
School Attendance
Parenting Style & Quality
Opportunities for socialisation, play, & learning
Opportunities for socialisation
Peers
Family Smoking
Family Alcohol Use
Family Drug Use
Family Income & work
SETTINGS
Schools
Further Education
Training Placement
Workplace
Community Youth Activities
Primary Care
INPUTS
Educational Opportunities
PHSE
Recreational opportunities
Training Opportunities
Work Opportunities
Primary Care
Immunisation Service
Universally accessible Community Health & Social Care Services to Children & Families
Targeted Community Health & Psycho-Social Care Services to Children & Families
Complex Community Health & Psycho-Social Care Services to Children & Families
Alcohol & Drug treatment services for Adults & Young People
Smoking Cessation Services for Adults & Young People
Contraception & Sexual Health
Community & Specialist Physical Disability Care
Community & Specialist LD Care

APPENDIX C

SUPPORTING SCHOOL AGED CHILDREN MODEL
A School Health Visiting Service



REFERENCES

[1] *Our Children Deserve Better: Prevention Pays* Annual Report of the Chief Medical Officer 2012

[2] British Medical Association *Growing up in UK* 2013

[3] Marmot *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010* February 2010 www.ucl.ac.uk/marmotreview

[4] Field F *The Foundation Years: Preventing Poor Children Becoming Poor Adults* The Cabinet Office December 2010

[5] Bellis M, Hughes K, Leckenby N, Perkins C, Lowey H *National Household Survey of Adverse Childhood Experiences and Their Relationship with Resilience to Health Harming Behaviours in England*

[6] Department of Health *Maximising the School Nursing Team Contribution to the Public Health of School-Aged Children: Guidance to Support the Commissioning of Public Health Provision for School Aged Children 5-19* April 2014

[7] Ofsted *Not Yet Good Enough: Personal, Social, Health, and Economic Education in English Schools* May 2013

[8] Public Health England *Child Health Profile* March 2014

[9] Office for National Statistics *Children's Wellbeing 2014* March 2014

[10] Syed Z *Child Wellbeing Survey 2012-13*Birmingham City Council April 2014

[11] Department of Health *Getting It Right for Children, Young People, and Families: Maximising the Contribution of the School Nursing Team, Vision & Call to Action* March 2012

[12] Birmingham Health Education Service *Schools' Engagement with Public Health* 2012

[13] Solihull LiNK *Report on Young People's Views of the School Nursing Service in Solihull* 2012

[14] Lightfoot J, Bines W *Working to Keep School Children Healthy: The Complementary Roles of School Staff and School Nurses* Journal of Public Health Medicine 2000 20(1) 74-80

[15]Department of Health *Healthy Child Programme: From 5-19 years* October 2009 http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108866.pdf

[16] Department for Education *Supporting Children with Medical Conditions: Statutory Guidance for Governing Bodies of Maintained Schools and Proprietors of Academies in England* April 2014