PSHE Informal Member Advisory Group

Report

December 2008

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Introduction

Scene Setting

1.1.1 In October 2007, the Leader of the Council requested that an informal member advisory group (MAG) was set up and chaired by Mrs Sarah Hohler. This MAG was to focus on Personal, Social, Health and Economic Education (PSHE), in particular it was to oversee the implementation of certain recommendations of the previous PSHE select committee, chaired by Ms Jane Cribbon.

1.1.2 The PSHE Select Committee's report had been published in March 2007 and presented eighteen recommendations. A list of these recommendations can be found in **Appendix 1**. Recommendation ten of aforementioned report states that a strategy for a more systematic Personal, Social and Health Education delivery, coupled with more robust assessment and monitoring methods, be written and adopted in all the primary and secondary schools in Kent.

1.1.3 By monitoring the implementation of such a strategy, the PSHE MAG hoped to change the view of three-quarters of 11-18 year olds that their sex and relationship education was poor.

1.1.4 The Group has met on nine separate occasions to receive oral and written evidence from several witnesses working for the Children, Families and Education Directorate and other partner agencies. The Group has also visited three schools.

1.1.5 The PSHE MAG was established to work in tandem with existing steering groups. These groups are: -

- **The PSHE Strategy Group** chaired by Allan Foster and Lynne Miller.
- The **Drug Education Steering Group** – chair to be appointed.
- The **Sex and Relationships Education Steering Group** chaired by John Taylor.
- The **Anti-bullying Strategy Steering Group** chaired by Peter Heckel.
- The **CAMHS (Child and Adolescent Mental Health Service) Steering Group**.
- The **SEAL (Social and Emotional Aspects of Learning) Steering Group** – This group was formed in September 2007 to oversee the implementation of the SEAL programme.

The Terms of Reference

1.2.1 The Terms of Reference of the informal member group were as follows:

- To oversee the development of the Kent PSHE Strategy.
- To oversee the development of a Kent PSHE curriculum which emphasises responsibility and relationships.
- To identify opportunities to improve the quality and quantity of PSHE in Kent.
- To promote the role of PSHE as a key driver for ensuring the wellbeing of young people.
- To ensure young people are involved at every stage with the design and delivery PSHE.

1.2.2 In addition, every member of PSHE MAG was asked to champion PSHE and to convey the significance of PSHE and its impact to schools that were not signed up to the agenda.

1.2.3 The Group decided to look at all elements of the PSHE curriculum not merely sex education and sexually transmitted diseases.

1.2.4 It was originally intended that the group would be time-limited and run for 12 months from September 2007. It was envisaged that the strategy would be completed by June 2008 and all new resources completed in time for the 2008/09 academic year.

1.2.5 It was proposed that the strategy and the curriculum would be developed by expert KCC officers in conjunction with multi-agency professionals (including headteachers), who lead in the field of children's and young people's health, and young people themselves. The professionals would act within the direction set by the elected members and would report back to elected members at regular intervals throughout the year.

Group Membership

The Group consists of eight members of Kent County Council (KCC): five Members of the Conservative Party; Two Members of the Labour Party; and one Member of the Liberal Democrat Party

Mrs Sarah Hohler

Conservative Member for Malling North

Chairman of PSHE MAG

Mrs Ann Allen

Conservative Member for Wilmington

Mr Gordon Cowan

Labour Member for Dover Town

Ms Jane Cribbon

Labour Member for Gravesham East

Dr Tony Robinson

Conservative Member for Tonbridge

Mr John Simmonds

Conservative Member for Canterbury West

Mr Roland Tolputt

Conservative Member for Folkestone South

Mr Martin Vye

Liberal Democrat Member for Canterbury City South West

Findings of the PSHE MAG

In chapter two, this report summarises the findings of the Group and outlines its recommendations for future work.

2.1 Teaching and Prioritisation

2.1.1 Why teaching and prioritising PSHE matters?

2.1.1.1 In meetings of the Group, evidence suggested that the majority of PSHE lessons are taught by non-specialist teachers and several schools do not teach the subject.

2.1.1.2 Members of the Youth County Council commented on the detriment to their education caused by the lack of PSHE lessons.

2.1.2 Factors contributing to poor or a lack of teaching?

2.1.2.1 Headteachers commonly cite the fact that PSHE is non statutory, the demands of other curriculum subjects and the lack of qualified PSHE teachers as reasons why PSHE does not take a more prominent part of the curriculum.

2.1.2.2 There is no dedicated university course to train future teachers to teach PSHE.

2.1.2.3 It is difficult to attract people to the area of nursing. There is a limited pool of nurses, who have a School Nurse Diploma. Currently, every school has a designated nurse, but not a school nurse. The designated nurses need to spread their time between a number of schools.

2.1.2.4 In some schools, there is a lack of permeability between staff and children, which prevents dialogue when children have issues. Highly praised are Folkestone Academy and Marlowe Academy where teachers and pupils have lunch together.

2.1.2.5 Some schools do not offer young people to chance to express their ideas of what topics should be covered in PSHE and in which style.

2.1.2.6 The schools displaying best practice with regard to PSHE have a holistic approach to education; unfortunately, a holistic view is not shown in every school. This is true internationally; New South Wales and British Columbia incorporate PSHE and behaviour management into the wider vocational curriculum and have less substance misuse, teenage pregnancies and so forth. In the Netherlands, the whole community, not just the school, view it as their responsibility to teach pupils responsibility. Matters pertaining to sex education and sexual health are talked of openly in schools, youth settings and is common within families.

2.1.3 Addressing teaching

2.1.3.1 Kent County Council is running PSHE teacher training. This training was commended by the headteacher at Pilgrims' Way for its usefulness. The current enrolment statistics for PSHE training are as follows: In 2007, there were 47 teachers and 2 school nurses who attended the course; In 2006, there were 36 teachers and no school nurses. In 2008 there are currently 30 teachers and no school nurses enrolled on the national CPD programme.

2.1.3.2 There are cluster-based teachers, specialising in teenage pregnancy and sexual health, in Maidstone, Gravesham, Tonbridge and Malling, and Ashford; these teachers are funded from a dedicated budget.

2.1.3.3 Richard Murrells is talking to Christchurch to see if training courses can be changed to produce more nurses with the School Nurse Diploma. . ASK are also looking at collaborative opportunities to work with CCU to develop joint CPD for teachers.

2.1.3.4 The members of Kent Youth County Council spoke to officers of their confusion on when PSHE is taught and what is in the curriculum as several schools do not teach the subject separately. They have therefore expressed an interest in working with the CFE Directorate to develop a PSHE and Wellbeing charter for secondary schools, which has been accepted. This charter will act as a checklist so young people know if there are any gaps in their education.

2.1.4 Recommendations

2.1.4.1 It is recognised by the Group that a county-wide team of trained and accredited PSHE teachers for deployment in Kent schools and places of education would aid Kent's young people's personal, social, emotional and economic well-being.

2.1.4.2 A suggestion to schools would be the use of Public Health Practitioners (recently renamed from school nurses) or youth workers. Youth workers receive PSHE training, their professional youth work qualification and other extensive learning and development programmes, which would make them suitable for this role.

2.1.4.3 The Group recommends that headteachers encourage teachers to undertake accredited PSHE training. This would help overcome the recruitment difficulties and would be in line with the Government's target to have an accredited PSHE teacher in every secondary school.

2.1.4.4 A greater use of individuals, who have experienced some problems relating to drugs, alcohol, sex, financial problems, in school lessons, would be beneficial. The Group knows of some teenage parents who would be willing to do this.

2.1.4.5 An audit be undertaken on which PSHE topics are taught in schools.

2.1.4.6 Schools be encouraged to have a holistic, 'whole school' approach to PSHE and be shown the necessity of getting governors, headteachers, and teachers involved.

2.2 Teenage Pregnancy

2.2.1 Why Teenage Pregnancy Matters?

2.2.1.1 The United Kingdom has the highest teenage pregnancy rate in Western Europe. Although the number of conceptions in Kent has fallen, this is not a sustained or significant reduction. In 2005, there were 38 conceptions per 1000 females aged 15-17 in Kent and this figure fell to 37 in 2006. This is significantly higher that the 'Towards 2010' target of 21 conceptions. Furthermore, the under-18 conception rate continues to increase in

some districts, for instance there has been a 28% in conceptions in Maidstone between 1996 and 2006.

2.2.1.2 Contrary to popular belief, the conception rates for East and West Kent are both considerable. There are fewer births in West Kent, but this is explained by the higher abortion rate.

2.2.1.3 Also, the prevalence of sexually transmitted diseases is not accurately known. The chlamydia national screening target is 15% of all 15 year olds but, in Kent, only 3% have been screened.

2.2.1.4 Inspectors believe that more must be done in Kent to combat teenage pregnancy. The Joint Area Review (JAR) inspectors said Kent's performance with regard to teenage pregnancy was acceptable in some places, but there was a wide variation in conception rates reflecting, in their opinion, a difference in commitment. There was a lack of data collection and IT infrastructure in Genito Urinary Medicine (GUM) outreach settings is underdeveloped. The inspectors recognised that Kent County Council and the two Primary Care Trusts knew that they had to do more.

2.2.2 Factors contributing to a higher teenage pregnancy rate

2.2.2.1 Teenage pregnancy is a highly complex issue and many factors contribute to the high level of conceptions in Kent. The lack of research to show the underlying causes has made it difficult to convince headteachers of the impact of implementing PSHE policies and strategies.

2.2.2.2 One key issue is self-esteem or rather the lack of it. In Finland, low teenage pregnancy statistics resulted from the children having higher self-esteem. Evidence from Kent Police described how some teenagers had such low self-esteem that they would accept full sex and domestic violence as a token of pride and this, perversely, raised their confidence.

2.2.2.3 Shyness or a lack of self-esteem affects girls and boys differently. Whereas girls are happy to discuss their thoughts in front of the boys in PSHE lessons, boys are not. Also, there has been a number of cases were boys bullied for having homosexual tendencies have engaged in sex to prove to those bullying them that they are not gay.

2.2.2.4 Another issue is the lack of information. The NFER survey shows that most young people believe they do not receive enough information on relationships and sexual health. Young people are not often aware of sexual health clinics which they could access.

2.2.2.5 Sometimes the services are inaccessible. There is a government target that people must be able to have 48 hour access to GU screening clinics, however, the GU clinic for Maidstone is located at Preston Hall, which poses transportation difficulties for young people. Also, school nurses can only be accessed for advice from 9am to 5pm, Monday to Friday and during term time. There are also not enough school nurses; one young person who spoke to the Group mentioned how only 1 in 4 of his classmates had spoken to the school nurse due to the nurse's time limitations.

2.2.2.6 Not enough is being done by some schools to reduce the conception rate. Evidence provided by the Director of Health shows some teachers are unaware of how prevalent teenage pregnancy is in their area because the majority of the young females that become pregnant at 16+ years have left school, and so sex and relationships education (SRE) is not their priority. However, it is the young person's last year of school that is critical in persuading these young people not to engage in risk taking behaviours before they leave the education system. The problem is that young people who are disengaged or excluded from school are more likely to become pregnant.

2.2.2.7 Further evidence shows that little time is devoted to SRE in PSHE lessons. Schools prefer to cover the science of conception in biology lessons and not link this to PSHE lessons.

2.2.2.8 The housing policy of some district councils encourages pregnancy as a method to leave home. For example, Maidstone Borough Council's housing policy is to provide accommodation to girls who are pregnant rather than waiting until the girls have given birth; this has caused the Park Wood statistics to rise above what they would otherwise have been.

2.2.3 Addressing Teenage Pregnancy

2.2.3.1 The main method for reducing teenage pregnancies is the implementation of the Shepway model in other

districts in Kent. Between 1996 and 2006, there was a 40% reduction in conception figures in Shepway. The key reasons why the Shepway model has been such a success are that there is improved access to sexual health services, nurses provide good SRE teaching in some schools, and there is a community development approach that resulted from employing outreach workers.

2.2.3.2 A high ratio of outreach workers has a significant impact on the conception rate. Eastern and Coastal PCT originally employed 2 outreach workers, but has recently employed another 4 workers. West Kent PCT had no outreach workers originally, but has now employed 6. Outreach workers deliver targeted work and work thematically using a mapping tool to implement the Shepway community development model.

2.2.3.3 An Interreg project has been launched by the EU which will explore how we can develop self-belief in young females. The PSHE MAG wait for the project review with interest and hope its key message will be absorbed by CFE as creating a sense of self-belief is a core driver in encouraging girls to abstain from sex.

2.2.3.4 There will be more services for young people from now on. There will be a sexual health clinic located in each cluster from now on. Eastern and Coastal PCT are funding this service in East Kent, and the Teenage Pregnancy monies are funding the service in West Kent.

2.2.3.5 Services are being targeted at the most vulnerable groups: outreach workers are to be directed to young people known to the Youth Offending Service and to Unaccompanied Asylum Seeker Children.

2.2.3.6 Kent County Council is also ensuring that it will receive current and accurate information. The Director of Health is revising all district based trajectories on teenage pregnancy at this moment in time.

2.2.3.7 An agreement has been reached with the maternity service to provide Kent County Council with data on the number of births to teenage mothers and also the number of terminations carried out. This is a significant breakthrough as, under the previous system, it took health some time to validate the teenage pregnancy statistics.

2.2.3.8 The role of public health nurses is going to be reviewed before it gets rolled out in West Kent. It does seem to

have worked well in Thanet, where 10 schools combined their resources to pay for one nurse (as the PCT felt it was not able to fund the nurse at that time). This nurse spends half a day a week in each school.

2.2.3.9 The public health nurses are visiting schools to lower teenage pregnancy levels. The nurses talk with individual children as opposed to teaching an entire class; this is alongside the C-card scheme, mobile van service and the text service (a nurse promises to text back within 24 hours if you have a question).

2.2.3.10 A project, called the Christopher Winter Project, is underway in Hackney, where teachers are supported in the teaching of PSHE. Three sessions take place with a class. In the first session, a professional trainer takes the lesson, whilst the teacher observes. In the second lesson, the teacher and trainer both run the lesson. Finally, the teacher takes the third session, but with the trainer watching in order to feedback advice. The benefits of this model are the teacher is trained in the classroom and evidence suggests that it is better for pupils to be taught by a familiar face. This Christopher Winter Project has not been tested in Kent, but members would like such a pilot to be undertaken.

2.2.4 Recommendations

2.2.3.11 The Group recommends that the teenage pregnancy statistics are monitored on a regular basis, even though the target is not within the second Local Area Agreement. Where rises in district conception rates are noticed, action planning and closer monitoring be undertaken.

2.2.3.12 The Group asked the Managing Director and Cabinet Member to consider implementation of the Christopher Winter Project in Kent for a pilot period.

2.3 Children's Health Services

2.3.1 Why Children's Health Matters?

2.3.1.1 Poor children's health impacts upon educational outcomes. An American study has shown that girls who

are obese or depressed have a lower grade point average by 0.8 points (on a 4-point scale).

2.3.2 Factors contributing to poor Children's Health

2.3.2.1 Prior to the restructure of Kent's Primary Care Trusts (PCT), there was an inconsistency of service between the various trusts and a lack of integrated commissioning. Children from across Kent were not aware of which services were available to them in their areas and low numbers of children accessed the PSHE-related clinics. For example, in East Kent there is a texting service for young people who want sexual health advice, but this did not get expanded further and does not work out of hours, so is underused. (see paragraph 2.2.3.9 above).

2.3.3 Addressing poor health

2.3.3.1 The PCTs have received £70k towards designing a self-health check, which is to be targeted at young mums and young people. This will show them whether they need to improve their health and if so, in which area they should focus their attention.

2.3.3.2 The Director of Health is going to analyse the core responsibility of school nurses as there are clear differences between the work of school nurses from East and West Kent, even though equal money is spent.

2.3.3.3 The Eastern and Kent Coastal PCT are encouraging new mothers to breastfeed for the first 3 weeks of a baby's life through social marketing. Breastfeeding enhances immunity. In Sheerness, the Sure Start centre has managed to break down many of the social barriers surrounding breastfeeding.

2.3.4 Recommendations

2.3.4.1 The Group supports the Director of Health's work and are keen to be kept updated on progress.

2.4 Obesity

2.4.1 Why obesity matters?

2.4.1.1 There is a growing prevalence of childhood obesity, which will place extra demands on the health services in future years. The prevalence of obesity can be found in all areas and is not correlated to deprivation.

2.4.1.2 The issue is of great importance as we are also not aware of the extent of obesity growth, so cannot commission services effectively. The measure of childhood obesity has only just started: a child's weight is measured in the reception year and in year 6, unless the school or parent opts out.

2.4.1.3 Being obese increases an individual's risk of suffering from cancer and type 2 diabetes. Obesity influences circulation, and kidney and eye functions. It was extremely rare to see type 2 diabetes (where insulin does not have the desired effect on the body) in teenagers previously, but this is rising.

2.4.2 Factors contributing to Obesity

2.4.2.1 A lack of physical exercise by young people is assisting the rise in obesity. If a child does exercise, even when obese, their chance of diabetes decreases. It was recommended that primary school children undertake 2 to 3 hours of physical activity each week.

2.4.2.2 A large number of parents are not providing/cooking healthy meals for their children and 70% of children do not have school meals. An example given to the Group was a school in Swale where several parents are taking their children to McDonalds everyday of the week for breakfast.

2.4.2.3 Some parents are unaware of how unhealthy certain foods are because they do not understand food labelling. Some parents refer only to levels of saturated fat in a product, without considering the number of calories. This is not advisable as sugar contributes to obesity and fructose metabolises to fat; only the number of calories reflects how much of these compounds are in a product. In addition, sugar is bad for dental health.

2.4.2.4 The cost of healthy foods has lead to a rise in obesity. Kent Youth County Councillors have listed the cost of

healthy meals as the deciding factor in choosing what to eat. Other issues such as peer pressure also impact on a young person's decision.

2.4.3 Addressing obesity

2.4.3.1 A target to reduce childhood obesity by 50% by 2010 is included in the second Local Area Agreement and careful monitoring of obesity has begun. Furthermore, the Local Authority has a target to reduce childhood obesity in the reception year, so more early intervention services have been commissioned. These commissioned services will be reviewed once NICE's (National Institute of Health and Clinical Excellence) emerging evidence is available whicht shows which sort of strategies local authorities should adopt.

2.4.3.2 Central Government has created a 'Healthy Weight' Team, which is one of a number of teams working to support local areas and partnerships that are struggling to achieve their targets in relation to choosing health priorities. The team is currently working with Eastern Kent Coastal PCT, which is focusing on reducing obesity. The PCT is performing an analysis on childhood obesity and this will be reported back in due course.

2.4.3.3 A rising number of Kent's schools has obtained 'healthy school status'; this is laudable. However, a note of caution: healthy schools status does not mean the children are automatically reaching obesity targets. There are approximately 22 targets that a school must achieve before gaining healthy school status. These targets relate to physical and emotional health, PSHE, sensible eating, and so forth, but there is no obesity target. There is a national audit currently underway which will evaluate whether schools achieving this status are reducing their obesity figures.

2.4.3.4 The tackling obesity policy will be worked into other strategies and services, such as the parenting strategy.

2.4.3.5 Many schools have been considering the whole school environment and so have removed vending machines due to escalating obesity figures. Also, Produced in Kent is working with KCC to provide fresh local fruit to primary schools.

2.4.4 Recommendations

2.4.4.1 The Group considers parental influence has a great impact, so wish to see obesity as a key issue in the parental strategy.

2.4.4.2 The Group wishes to see schools encouraged to play competitive team sports in schools, particularly in the run up to 2012.

2.5 Drugs and Alcohol Abuse

2.5.1 Why Drugs and Alcohol Abuse Matters

2.5.1.1 The number of Kent's year 7 pupils getting drunk at least once or twice a week is 5.7% compared to 33% of year 11 pupils.

2.5.1.2 Although ahead of the national target, there still were 540 under 18 year olds in treatment in January 2008. The youngest person in treatment was an 11 year old.

2.5.1.3 50% of young people, who have substance misuse problems, drink alcohol on a regular basis. Cannabis use accounts for 40% of substance misuse, and a very low percentage of substance abusers use Class A drugs.

2.5.1.4 The youngest child, who has been frequently very intoxicated, and has come to the attention of KDAAT is 8 years old.

2.5.1.5 Seven young people accessed prescribed methadone last year and there were no detoxification requests.

2.5.1.6 The misuse of substances by parents has a severe impact on young people's education in some deprived areas. At Pilgrims' Way primary school, more children lost their parents through substance and alcohol misuse than through the war in Iraq and Afghanistan (an army barracks is located nearby).

2.5.2 Factors contributing to Drug and Alcohol Abuse

2.5.2.1 There has been a recent reduction in the national drug and alcohol grant. Previously, the funding for alcohol and

drugs schemes was placed in one pot and pledged for three years; however, this three year period has now come to a close. Central Government has reduced the funding for the next three years.

2.5.3 Addressing Drug and Alcohol Abuse

2.5.3.1 There is a new Local Area Agreement target about working on the public perception of substance misuse and services. This arises from the community safety agenda highlighting that alcohol is one of the key public concerns. On this matter, the leader is moving ahead with his hard hitting campaign on drugs and alcohol. Saatchi is designing this campaign.

2.5.3.2 The government has produced a tool to measure the prevalence of substance misuse in communities that will allow KDAAT to target their resources efficiently and help reduce substance misuse.

2.5.3.3 KDAAT run a Drug Intervention Support Programme (DISP), which helps a young person, found handling cannabis at school, to remain at school and stop taking drugs.

2.5.3.4 A group that works with children of substance misusing parents has been set up, which required the consent of the parents involved. The group has proven to be successful with the children's attainment increasing.

2.5.3.5 Recommendations of the alcohol select committee have been incorporated in the alcohol action plan.

2.5.3.6 With regard to drug and alcohol misuse, the inspectors felt that appropriate actions were being taken.

2.5.4 Recommendations

2.5.4.1 The Communities Directorate be commended for their hard work and the Group is eager to learn of progress in due course.

2.6 Financial Matters

2.6.1 Why financial management matters?

2.6.1.1 The level of personal debt and the number of house repossessions has never been so high. Young people grow up in a consumerist society and must learn to save to prevent destitution in later life.

2.6.2 Addressing poor financial management

2.6.2.1 Evidence from the curriculum lead of PSHE shows there are numerous resources to support the financial elements of PSHE; for example, KCC work with HSBC on a project called 'what money means'. In addition, there are CD-ROMs and web-based resources on finance, which are available to teachers.

2.6.3 Recommendations

2.6.3.1 The Group is impressed by the level of resource attributed to financial matters and suggests other elements of the PSHE curriculum be focused upon at the present time.

Developments

3.1 There have been many developments in the field of PSHE since the initial meeting of PSHE MAG.

3.2 The members of the Group have worked with officers to produce the PSHE Strategy, which was launched at the Secondary Headteachers Conference in November 2008. This has been distributed to all schools. (This can be found following the three letters at Annex A).

3.3 In October 2008, the Government announced that PSHE will become a statutory part of the school curriculum from Key Stage 1 to 4 (ages 5 to 16).

3.4 The announcement comes in response to the principal findings of both the National Review of Sex and Relationships Education (SRE) in Schools and the report by the National Advisory Group on Drug and Alcohol Education, which both recommended that good PSHE was vital to providing a healthy, rounded education. In addition, the PSHE MAG Group lobbied Rt Hon Ed Balls MP by letter asking for PSHE to become a statutory subject.

3.5 It was also announced that headteacher, Sir Alasdair MacDonald, will lead a review into how best to make PSHE compulsory, ensuring that there is a place in the timetable and flexibility in the curriculum to take schools' ethos, pupils' needs and parents' values into account. Updated guidance will also be produced covering the content of the curriculum, based on the existing non-statutory programme of study. The Group wait expectantly for this guidance.

Options for the future

The Group has accomplished the objectives outlined in the original terms of reference. This has given the Group a chance to reflect on how the Group should function, if at all, in the future. Four possible options are described below.

4.1 Option One – Disband PSHE MAG

4.1.1 The first proposal to consider is the disbandment of PSHE MAG. The advantage would be the release of staff time to provide front-line services and to implement the recommendations of the Group. There are officer groups that monitor PSHE delivery.

4.1.2 One disadvantage of this proposal is that the influence of members would be lost. Members would not act as champions of PSHE. Furthermore, Graham Badman praised the Group for providing a 'layman's' perspective, which would disappear.

4.2 Option Two - Continue PSHE MAG until 2010

4.2.1 The second proposal would be the continuation of PSHE MAG until PSHE has become a statutory part of the curriculum. If PSHE MAG were to continue, the Group would provide a service similar to the Members Monitoring Group and the Children's Champions Board. The Group would monitor the progress of the CFE directorate in implementing the PSHE strategy. It could ensure new guidelines, such as Sir Alasdair MacDonald's were included in a revised PSHE Strategy. The Group could potentially informally audit the PSHE lessons in the county by frequent visits to schools. Also, as Local Children Service Partnerships are relatively new, they have not had time to monitor PSHE.

4.2.2 The disadvantage could be viewed as the extra time commitment which would have to be made by members and officers.

4.3 Option Three – The inclusion of PSHE as a standing agenda item on CFE POC.

4.3.1 If members, due to time limitations, could not make the commitment to the continuation of the group, then members could propose to CFE POC that PSHE be added as a standing item to the agenda. Members would therefore

monitor the subject. However, the intensity and possibly the frequency of scrutiny would be lower than currently.

4.3.2 The disadvantage of CFE POC is that the NHS do not report to the group, whereas professions from the NHS would be happy to report to PSHE MAG.

4.4 Option Four – Indefinite Continuation of PSHE MAG on a less frequent basis

4.4.1 From 2009, the Director of Health will receive the local monitoring dataset statistics of 260 indicators, which will show whether the PSHE strategy has made an impact. Those schools or partner agencies that are shown to be underperforming could be challenged by PSHE MAG and be asked to report to the next meeting showing how they intend to improve their school's teaching.

4.4.2 As mentioned in the other options, this would be a time commitment for officers and members.

4.4.3 The recommendations of the former Select Committee are being implemented through an action plan to support the PSHE Education Strategy. There is a role for the PSHE MAG to maintain a monitoring role of this action plan.

Immediate actions of PSHE MAG

The Group will be asked at the meeting on 26th January 09 to review this report and consider which option the members wish to pursue.

Report by Sarah Robinson
December 08 - Ext 7000 4118

Addendum

At the meeting of PSHE MAG on 26th January 2009, option four was chosen. The newly revised terms of reference for the Group are attached to this report (**Appendix 3**).

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