Are trainee teachers being adequately prepared to promote the health and well-being of school children? A survey of current practice

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ABSTRACT

Background Teachers are a key part of the wider public health workforce in England. We conducted a survey to find out how they are trained for this role during their initial teacher education (ITE).

Methods Between 2011 and 2012, we sent an online questionnaire to 220 ITE course managers and conducted semi-structured interviews with a purposive sample of 19 course managers to explore issues in more depth.

Results The response rate to the questionnaire was 34% (n = 74). Although most of the course managers felt inclusion of health and well-being training in ITE was important, provision across courses was variable. Topics which are public health priorities [e.g. sex and relationships education (SRE) and drugs, alcohol and tobacco] were covered by fewer courses than other topics (e.g. child protection, emotional health and anti-bullying). Perceived barriers to training included lack of time and a belief that health and well-being were low priorities in educational policy.

Conclusions Not all of tomorrow’s teachers are being adequately prepared for their role in helping to address public health priorities. Educational policy does not appear to be supporting the priorities of public health policy, and this is a key barrier to health promotion training in ITE.

Keywords children, educational settings, health promotion

Introduction

Internationally schools have been seen as an important setting for health promotion for many years, with teachers having an integral role as promoters of health.¹–⁴ In the UK, teachers are a key part of the wider public health workforce,⁵,⁶ as they are in a unique position to promote the health and well-being of children and young people, through teaching personal, social, health and economic education (PSHEc) (the current term used for this aspect of education, which now includes economic well-being),⁷,⁸ their pastoral care role and the promotion of whole school approaches to healthy lifestyles.⁹ Health promotion in schools can encompass a broad range of topics such as sex and relationships education (SRE), drugs, alcohol, smoking, mental health, physical activity and healthy eating. This is of utmost importance when for example one-fifth of pupils in Year 6 (aged 10–11) are classified as overweight or obese,¹⁰ young adults between the ages of 15–25
years experience the highest rates of sexually transmitted infections\textsuperscript{11} and alcohol is a contributing factor in over a quarter of all deaths in males aged 16–24 years.\textsuperscript{12}

The public health white paper Healthy Lives, Healthy People\textsuperscript{13} emphasizes the role of schools and teachers in promoting health and preventing risky behaviours, with responsibility for public health currently being devolved from the National Health Service (NHS) to Public Health England and local authorities (LAs). Communities will be at the forefront of addressing health needs and health inequalities in their areas,\textsuperscript{13} and schools are an important setting to help address these inequalities. The part that schools can play in promoting health has been set out in public health policy, though is not fully reflected in educational policy. The Department of Education white paper The Importance of Teaching\textsuperscript{14} acknowledges the fundamental role of schools in pupils’ health and well-being. However, PSHEe is not statutory,\textsuperscript{15} despite the Macdonald reviews\textsuperscript{6,8} recommendations to that effect and that all initial teacher education (ITE) courses should include PSHEe training. The new framework from the Office for Standards in Education, Children’s Services and Skills (Ofsted)\textsuperscript{16} considers fundamental aspects of PSHEe during routine school inspections, such as the behaviour and safety of pupils at school, including pupils’ ability to assess and manage risk appropriately and to keep themselves safe, and their spiritual, moral, social and cultural development. Key public health concerns, however, no longer significantly feature in the framework, although PSHEe lessons may be observed alongside other subject lessons, or may be the focus of subject-specific survey visits, and are expected to meet the same high standards.

Regardless of this policy gap, it is important that ITE prepares teachers to be effective in promoting health and well-being in schools, by providing them with knowledge, awareness, skills and confidence to be competent in taking on their varied health promotion role.\textsuperscript{6,8,17,18} A pilot study of inter-professional ITE curriculum change at one institution showed that incorporation of health promotion components led to increased knowledge, skills and confidence in teaching some health-related topics.\textsuperscript{19} Training in competencies to promote health can be provided in either college- or school-based training, or during school placements. Little is known, however, about how teachers are prepared during ITE in England to promote the health and well-being of children and young people. We therefore carried out a national survey of ITE providers to assess this. This paper focuses on selected findings with implications for improving the development of teachers as part of the public health workforce. Byrne et al.\textsuperscript{20} also report findings from this survey, discussed in relation to educational policy. Full details of the research can be found in Shepherd et al.\textsuperscript{21}

**Methods**

The survey of ITE providers comprised two components: a questionnaire and interviews with a subsample of the respondents. Ethical approval was provided by the University of Southampton Faculty of Medicine Ethics Committee.

**Online questionnaire**

A piloted, online questionnaire about the provision for health, well-being and PSHEe training on ITE courses was conducted with a sample of 220 ITE course managers in England during June and July 2011. It explored their views on the importance of health promotion training in ITE, the health and wellbeing content of their courses and external support for health promotion training. We surveyed course managers from a representative sample of the three types of ITE providers at the time: higher education institutions (HEIs), employment-based initial teacher training (EBITTs) and school-centred initial teacher training (SCITTs).

Institutions were selected from the 208 ITE providers listed on the Training and Development Agency website (now the Teaching Agency). We randomly sampled 50% of the HEIs (stratified by the number of courses offered to obtain a balance of institutions offering a high or low number of courses) and 50% of the EBITTs in each English geographic region using a computer random number generator, but sampled all the SCITTs in England as there were fewer of them offering fewer courses. We sent the questionnaire directly to course managers at EBITTs and SCITTs, but before sending the questionnaire to HEI course managers we contacted departmental heads to obtain the course managers’ contact details, because their websites did not always appear to be up-to-date. As more than one course could be offered by HEIs, at some institutions we sampled more than one course manager (the number of course managers sampled is shown in Table 1). To enhance response rates course managers were offered an incentive of entry into a prize draw for a £50 or £30 gift voucher and we sent a reminder e-mail to course managers 2 weeks after the initial e-mail.

Data were downloaded into a spreadsheet and were analysed using standard descriptive statistics (e.g. counts and percentages).

**Interviews**

The aim of the interviews with course managers was to build on the questionnaire data to investigate and elucidate further understanding about how courses covered health and well-being. The piloted interview schedule explored issues highlighted by the questionnaire, asked about interviewees’ backgrounds, and perceptions of barriers and facilitators to
health promotion training in ITE. We purposively sampled 25 course managers (22 questionnaire respondents and 3 others sampled from a region that did not return any questionnaires) to contact by e-mail, and then telephone, to request an interview. They were selected to reflect different course types, English regions, perceptions of the importance of health promotion training and approaches to it. Between January and March 2012, we did 18 semi-structured interviews with 19 course managers (15 face-to-face, conducted at the interviewees’ institution, and 3 by telephone; 2 were interviewed together at their request), lasting on average between 45 and 60 min. These were audiorecorded and transcribed verbatim. Informed consent was obtained verbally at commencement. Three did not respond and three refused due to lack of time. The transcripts were analysed using content analysis, which involved reading the interview transcripts and recording (coding) the frequency with which key terms and issues were mentioned. We set up a coding framework using NVivo software based on each question on the interview schedule. Researchers coded passages of text from each transcript according to which of the interview questions they related to, creating new sub-codes for categories of data if necessary or adding to existing sub-codes describing similar issues. Once all interviews were coded the team analysed the coded data in more detail to identify patterns and to form an explanatory framework for our findings. We present selected findings from the interviews below and have included interview quotes selected to be illustrative of some of the findings.

### Results

We have integrated the findings from the questionnaire and interviews, presenting findings under the key issues highlighted by the research: perceptions of importance of health promotion training; collaborative working with health and other agencies; health and well-being content of training; and barriers and facilitators to training. First, we provide details about the participants and their backgrounds.

#### Participant details and questionnaire response rate

Seventy-four of the 220 course managers sampled for the online questionnaire responded (34%). Their institutions were broadly representative of the ITE provider types in England (Table 1), but there was some variation in response by region. The courses provided included postgraduate and undergraduate, secondary and primary school level programmes. All of the course managers interviewed had a background in school teaching and 12 mentioned that they had either professional or personal experience or interest in health and well-being. The interviewees’ institutions were based in a variety of areas and nine talked about the socio-economic and cultural backgrounds that formed a back-drop to their courses and trainee teachers’ experiences on school placement:

‘There’s some very high levels of unemployment and second and third generation unemployment. Certainly they [trainee teachers] will come across children whose home lives are chaotic and... who are probably experiencing a lot of the things like drug, alcohol abuse’. (EBITT 9)

This did not necessarily influence the health and well-being content of their courses—only two said that they addressed local issues in their course curricula.

#### Perceived importance of training in health and well-being

In the online questionnaire, course managers most commonly reported that 5–9% of the time on their courses was spent covering health and well-being (Table 2). This could be

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**Table 1** Response rates and participant details

<table>
<thead>
<tr>
<th>ITE provider type</th>
<th>Online questionnaire participants (n = 74)</th>
<th>Interview participants (n = 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of course managers sampled (% of the sample)</td>
<td>Number of course managers who responded (% of those sampled)</td>
</tr>
<tr>
<td>HEI</td>
<td>135 (61)</td>
<td>43 (32)</td>
</tr>
<tr>
<td>SCITT</td>
<td>49 (22)</td>
<td>21 (43)</td>
</tr>
<tr>
<td>EBITT</td>
<td>36 (16)</td>
<td>10 (28)</td>
</tr>
</tbody>
</table>

Due to rounding, percentages may not sum to 100. The number of interview participants does not sum to the number of interviews (n = 18), as two interviewees were interviewed together at their request. ITE, initial teacher education; HEI, higher education institution; SCITT, school-centred initial teacher training; EBITT, employment-based initial teacher training.
considered a substantial amount of time, but the respondents commented that it was difficult to estimate the time spent on it, due to the broad range of topics in their curricula that could be considered to be health and well-being related and because it was variable whether or not topics were covered during the school placement component of their courses.

Of the questionnaire respondents, 89% stated that they felt it was either very important or important to emphasize the health and well-being of pupils in the ITE curriculum (Table 2). This attitude was reflected in the interviews, in which 13 interviewees expressed a holistic view of education and talked about the importance of teachers understanding the ‘whole child’, including the impact that pupils’ emotional well-being, development, physical health and cultural and socio-economic background can have on their learning:

‘Alongside the great pressure for children to learn phonics and add up . . . in many schools the students [trainee teachers] have to understand something about children’s lives before they can even start really’. (HEI 42)

However, fewer talked about the importance of teachers developing skills to teach PSHEe.

In terms of assessment of trainees’ learning related to health promotion training, which could be considered an indicator of the importance courses placed on it, 68% of the questionnaire respondents reported that they assessed some aspects. The interviews offered insight that the comprehensiveness of this varied between courses, from assessment as part of a PSHEe module to more indirect assessment, for example, through a trainee choosing a health topic for their research project. Some courses focused assessment on other subjects considered to be a higher priority.

### Collaborative working with health and other agencies

The majority (73%) of the questionnaire respondents reported that they used external agencies—most commonly local schools and LAs—to provide information, resources or teaching to support the delivery of the health and well-being aspects of their course (Table 2). Only 10 said that health professionals were involved in their courses. Furthermore, few interviewees mentioned working with people from external agencies to deliver training on specific health and lifestyle issues such as SRE and healthy eating, rather such training focused on topics such as behaviour management, special educational needs (SEN) and emotional well-being. They mentioned a number of barriers to working with health professionals including: it was not something they had thought about; not knowing who to approach; difficulties finding convenient times to work together and resistance from the health service to release staff:

‘We tried to build a relationship on a project to do with health and social care, where we tried to get teachers working with health professionals. Well I’ve never done anything as hard and achieved so much failure . . . Just because of the pressures that the Health Service is under in actually letting people out’. (HEI 27)
In 10 interviews however, course managers noted that working with people with health expertise from external agencies or other courses at their institution had been a successful aspect of their training:

‘We’re running that inter-agency day again this year... the evaluation from the students [trainee teachers], when we did run it compared to the years when we hadn’t, they felt much better prepared for working with people... from other services’. (HEI 30)

Indeed some of the more innovative approaches to delivering training that we identified involved ITE working with health-related agencies or professionals, including the inter-agency working day above, a ‘health day’ with workshops delivered by health professionals and alternative placements in health-related settings such as social services and children’s schools in hospitals.

### Health and well-being content of training

Although most of the course managers felt that training in health was important, their questionnaire responses showed variability in the coverage of health and well-being topics. All covered child protection, and nearly all covered emotional health and anti-bullying (Table 3). Fewer included training on

<table>
<thead>
<tr>
<th>Topic</th>
<th>Covered in any aspect of course, n (%)</th>
<th>Covered in college-based training, n (%)</th>
<th>Covered on school placement, n (%)</th>
<th>Covered on school placement only, n (% of course managers whose courses covered topic)</th>
<th>Unsure if covered, n (%)</th>
<th>Not covered, n (%)</th>
<th>No response (missing data), n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every Child Matters</td>
<td>68 (100)</td>
<td>67 (99)</td>
<td>38 (56)</td>
<td>1 (1)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Child protection</td>
<td>68 (100)</td>
<td>67 (99)</td>
<td>38 (56)</td>
<td>1 (1)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SEAL/emotional health</td>
<td>67 (99)</td>
<td>61 (90)</td>
<td>38 (56)</td>
<td>6 (9)</td>
<td>0</td>
<td>0</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Anti-bullying</td>
<td>66 (97)</td>
<td>50 (74)</td>
<td>34 (50)</td>
<td>16 (24)</td>
<td>0</td>
<td>0</td>
<td>2 (3)</td>
</tr>
<tr>
<td>Working with parents</td>
<td>65 (96)</td>
<td>55 (81)</td>
<td>43 (63)</td>
<td>10 (15)</td>
<td>0</td>
<td>1 (1)</td>
<td>2 (3)</td>
</tr>
<tr>
<td>Environment education</td>
<td>55 (81)</td>
<td>46 (68)</td>
<td>21 (31)</td>
<td>9 (16)</td>
<td>6 (9)</td>
<td>2 (3)</td>
<td>5 (7)</td>
</tr>
<tr>
<td>Physical activity</td>
<td>55 (81)</td>
<td>44 (65)</td>
<td>32 (47)</td>
<td>11 (20)</td>
<td>4 (6)</td>
<td>5 (7)</td>
<td>4 (6)</td>
</tr>
<tr>
<td>Healthy Schools</td>
<td>51 (75)</td>
<td>30 (44)</td>
<td>33 (49)</td>
<td>21 (41)</td>
<td>7 (10)</td>
<td>5 (7)</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Healthy eating</td>
<td>43 (63)</td>
<td>32 (47)</td>
<td>16 (24)</td>
<td>11 (26)</td>
<td>11 (16)</td>
<td>10 (15)</td>
<td>4 (6)</td>
</tr>
<tr>
<td>SRE</td>
<td>42 (62)</td>
<td>28 (41)</td>
<td>17 (25)</td>
<td>14 (33)</td>
<td>11 (16)</td>
<td>7 (10)</td>
<td>8 (12)</td>
</tr>
<tr>
<td>Trainee teachers’ health</td>
<td>39 (57)</td>
<td>30 (44)</td>
<td>13 (19)</td>
<td>9 (23)</td>
<td>12 (18)</td>
<td>10 (15)</td>
<td>7 (10)</td>
</tr>
<tr>
<td>Drugs education</td>
<td>38 (56)</td>
<td>23 (34)</td>
<td>17 (25)</td>
<td>15 (39)</td>
<td>13 (19)</td>
<td>8 (12)</td>
<td>9 (13)</td>
</tr>
<tr>
<td>Careers education</td>
<td>36 (53)</td>
<td>27 (40)</td>
<td>15 (22)</td>
<td>9 (25)</td>
<td>8 (12)</td>
<td>15 (22)</td>
<td>9 (13)</td>
</tr>
<tr>
<td>Alcohol education</td>
<td>28 (41)</td>
<td>16 (24)</td>
<td>13 (19)</td>
<td>12 (43)</td>
<td>18 (26)</td>
<td>11 (16)</td>
<td>11 (16)</td>
</tr>
<tr>
<td>Smoking prevention</td>
<td>23 (34)</td>
<td>10 (15)</td>
<td>13 (19)</td>
<td>13 (57)</td>
<td>17 (25)</td>
<td>16 (24)</td>
<td>12 (18)</td>
</tr>
<tr>
<td>Economic education</td>
<td>21 (31)</td>
<td>13 (19)</td>
<td>9 (13)</td>
<td>8 (38)</td>
<td>19 (28)</td>
<td>15 (22)</td>
<td>13 (19)</td>
</tr>
</tbody>
</table>

Sixty-eight of the 74 course managers who returned questionnaires provided some responses to a question about whether or not their courses covered the listed topics. ‘No response’ = the number and percentage of the 68 course managers who were missing data on particular topics. Due to rounding, percentages may not sum to 100. Topics could be covered in either college-based training or on school placement or both. SEAL, Social and Emotional Aspects of Learning.
specific public health priorities in either college-based training
or on school placement, e.g. healthy eating (63%), SRE
(62%), drugs and alcohol education (56% and 41% respect-
ively) and smoking prevention (34%). A further 16–26% were
unsure if they covered these topics at all, suggesting that
these issues were perhaps not considered to be a high priority
or were not prominent within course curricula. Of those
stating they provided training in these, 26–57% reported that
this was during school placement only rather than within
college-based training, indicating that a sizeable proportion of
providers were reliant on placement schools providing trai-
nees with experiences of these key aspects of PSHEe and
health promotion. Despite some reliance on school placement
experience, in the interviews course managers were often un-
certain about the nature of the training trainees received on
placement, with seven saying it was not planned or moni-
tored. Fifteen also said trainees’ experiences of health-related
activities and opportunities to teach or observe PSHEe on
placement varied from school to school, and depended on
factors such as whether PSHEe was prioritized in the school
and if topics or activities were delivered when they were there:

‘In primary, some of it [health] is addressed through the
science curriculum. So obviously it would be dependent on
whether that particular area of the curriculum is delivered
while the trainee is in school’. (EBITT 9)

In the interviews, only one course manager mentioned that
they raised their trainees’ awareness of sources of data on
local issues so that they could tailor their teaching to pupils’
needs; but this was data on socio-economic factors and SEN,
rather than health profile data.

Other barriers and facilitators to training
In the interviews, the most commonly mentioned barriers to
health promotion training were lack of time in the ITE cur-
riculum and a perception that health and well-being were
lower priorities than other aspects of education in new gov-
ernment educational policies (mentioned in 16 and 15 inter-
views, respectively):

‘It’s [health and well-being] dropped off the radar of this
current Government . . . there’s a limited amount of time
in the course] and if you don’t show that your programme
is emphasising the Government’s priorities, then when
Ofsted come along you’re in trouble. So . . . that’s what’s
driven, drives it out really’. (EBITT 6)

Interviewees also felt both training provider staff (five inter-
views) and trainee teachers (six) sometimes lacked knowledge
or were uncomfortable with health-related topics, particularly
for trainees with SRE.

The interviewees’ suggested that one of the main perceived
facilitators of inclusion of health in training was their own and
their colleagues’ beliefs about the importance of it, ensuring
that they included some aspects of it in their courses (13 inter-
views). Other facilitators included working with people from
external agencies or other departments with health-related ex-
pertise (10) and they or colleagues having contacts to access
this support (11), for example, through connections to an LA
training provider (as in EBITTs).

Discussion

Main findings of this study
Although the majority of ITE providers recognized the im-
portance of inclusion of health and well-being in the teacher
training curriculum in England and held a holistic perspective
on education, the results showed that there is currently a lack
of attention paid to public health priorities and little consist-
cy of provision across the country. While our survey found
a few examples of innovative practice, in general providers
placed more importance on topics perceived to be more closely related to pupils’ learning and education, such as emo-
tional health, rather than on skills needed to promote positive
health behaviours. Some providers were unsure about
whether or not health and lifestyle issues were covered at all in
either college- or school-based training, and many relied on
opportunistic experience during school placements, not rou-
tinely monitored or planned. The Chief Medical Officer’s
annual report24 has highlighted that tobacco use, harmful
alcohol consumption, drug abuse and poor sexual health are
among the top 10 risk factors for disability and early death in
England; risk factors often associated with deprivation. The
variability in the provision of training, and reliance in some
cases on serendipitous school placement experience, suggests
a lack of priority placed on health issues. This may lead to in-
adequate preparation of future teachers to help tackle these
issues and health inequalities as part of the wider public
health workforce. Given that sexual health, drugs, alcohol and
tobacco are also public health priorities for children and
young peoples’ health6,13,25–27 this is a substantial omission.

Only one course manager mentioned that trainee teachers
on her course were taught about using data sources to identify
local health needs, suggesting that courses are not preparing
teachers to be responsive to local needs and health inequal-
ities. The Macdonald review of PSHEe8 recommended
schools should use data to tailor their provision to the needs
of pupils and their communities, and this will become even
more important as responsibility for public health is placed with LAs.\textsuperscript{13}

In our survey, the low priority given to health and well-being in current Government educational policy was the main reason given for lack of inclusion of health and well-being in teacher training. Lack of time, resources and expertise, including lack of knowledge and confidence in teaching sensitive subjects, were also constraints. Very few providers accessed expert support from health professionals to contribute to training.

**What is already known on this topic**

Recent Ofsted research highlights that the delivery of PSHE\textsuperscript{e} in schools in England needs to be improved and that many teachers lack expertise in teaching sensitive topics, including SRE.\textsuperscript{28} They found that inadequate teaching was associated with a lack of teacher training in PSHE\textsuperscript{e}. Ofsted has recommended that teachers receive training, especially in sensitive issues. Our research shows that this training is lacking for some teachers during their ITE.

The variability in the provision of training on health and well-being highlighted in the survey echoes findings from our systematic review of ITE health promotion training,\textsuperscript{21} which showed little consistency in pre-service education for teachers internationally in terms of content and approach, and prioritization of information provision over skills acquisition. The emphasis on child protection, and children's mental health through initiatives such as the Social and Emotional Aspects of Learning (SEAL) and anti-bullying found in our survey, is of course welcome. However, health topics that were less frequently addressed in training, such as SRE, drugs and alcohol also have significant bearing on behavioural problems in school and children's educational achievement, implications which seem to have been neglected.

Studies of ITE show that trainee teachers value practical experience of teaching PSHE\textsuperscript{e} and training in realistic strategies for responding to children and young people's health and well-being issues.\textsuperscript{21} Yet, our study shows that practical experience on placement, which could provide some of these opportunities, is variable and not systematically planned. While some experiences may be positive, some providers' dependency on school experience demonstrates a lack of responsibility in ensuring these issues are covered. The lower status of PSHE\textsuperscript{e}, especially in secondary schools,\textsuperscript{29} means that positive opportunistic experience during placements is at best unpredictable. Our findings suggest that relationships between providers and partnership schools need to be strengthened. Our previous pilot research demonstrated the feasibility of directing trainee teachers' school experience of health and well-being by structuring their learning experience through the completion of a task driven portfolio requiring students to seek out information with regard to health policies and teaching in school.\textsuperscript{19}

The main barrier to inclusion of health and well-being topics cited in our survey was the lack of priority given to these subjects in educational policy. The priorities of health and education policy appear to be diverging rather than mutually supportive. Of course there are also constraints of time, resources as well as expertise, including lack of knowledge and confidence in teaching sensitive topics, as seen for PSHE\textsuperscript{e} generally\textsuperscript{18} and SRE, drugs, alcohol and tobacco education in both primary and secondary schools.\textsuperscript{29,30} Our survey found that very few providers used external support from health professionals, such as school nurses, to fill these gaps. The Government's scaling back of the 'Healthy Schools' programme and the national PSHE Continuing Professional Development (CPD) certificate, and severe reductions in LA advisory staff available to support development of school initiatives and staff capabilities has exacerbated this problem. However there may be new opportunities with the transfer of public health responsibilities to LAs and the establishment of Health and Well-Being Boards to access health professional support either to deliver part of ITE curricula or train trainers.

Although we have focused on ITE in this study, it should be acknowledged that teachers may also access health promotion training after they have qualified through CPD opportunities (e.g. the National PSHE CPD Certificate). Ofsted\textsuperscript{18} found that in schools that delivered PSHE education well, teachers had access to these opportunities. Our systematic review of ITE studies\textsuperscript{21} found that trainee teachers felt that further training in issues such as mental health and child protection would be useful once they were teaching in schools.

Health promotion training in ITE is important, but it should be viewed as a starting point within an ongoing development need for preparing teachers to teach and respond competently to these issues during their practice.

**What this study adds**

This is the first national, comprehensive survey of provision for health and well-being training in ITE. We conducted it at a time of much change in health and education policy in England, providing us with a unique position to explore the impact of this on courses. Despite school teachers being a part of the wider public health workforce and an emphasis on a need for their additional education and training,\textsuperscript{6,8,17,18} it is apparent, from this small sample of course managers who may have been more positive about the importance of health promotion training than non-responders, that there is little evidence of adequate preparation of future teachers to
maximize the contribution that they can make to promoting children’s health. This will not only affect educational outcomes, but longer term health outcomes as well. The changes in educational policy mean that current commitment to improving health and well-being within schools is superficial and unlikely to contribute to public health priorities for children and young people, unless there is a more consistent effort from both education and public health to move ‘upstream’ to equip new teachers with the skills, confidence and knowledge necessary to influence children’s health. This policy gap needs to be bridged at a local level by commissioning integrated services and enabling training providers and schools to access health advice and support.

In terms of research recommendations it would be useful to complement our study with a survey of mentors and tutors located in placement schools, and trainee teachers themselves, to ascertain barriers and facilitators to promoting health and well-being. This would be especially relevant given the increased emphasis on school or employment-based ITE. Research would also be valuable to assess the feasibility and effectiveness of inter-agency and inter-disciplinary collaboration in ITE, particularly given the re-organization of education and public health services (e.g. LAs and Health and Wellbeing Boards).

Limitations of this study
The main limitation of this study was the 34% response rate to the questionnaire. Course managers who were more enthusiastic about the importance of health and well-being topics may have been more likely to respond. Indeed, two-thirds of the interviewees had interests or professional experience in health. Therefore, our findings about the extent of training or importance placed on it may not fully reflect ITE in England; actual provision may be less than we have found. Further, it would have been advantageous to have surveyed all HEIs and EBITTs rather than a random sample. However, administration of the survey to all providers and their course managers was beyond available resources.

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