REVIEW OF THE CURRENT NHS COMMISSIONED EMHT IN PRIMARY AND SECONDARY SCHOOLS 2023

Review conducted by Kath Fraser-Thompson on behalf of the Liverpool WSA Partnership.

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October 2023

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Acronyms

ASC: Autism Spectrum Condition

CAMHS: Child and Adolescent Mental Health Services

CEO: Chief Executive Officer

CORC: Child Outcomes Research Consortium

CYP: Children and young people

DfE: Department of Education

DoH: Department of Health

EDYS: Eating Disorder Young People's Service

EMHT: Education Mental Health Teams

HEE: Health Education England

LLP: Liverpool Learning Partnership

MDT: Multi-disciplinary team

MHL: Mental Health Lead

MHST: Mental Health Support Team

MYA: Merseyside Youth Association

NHS: National Health Service

NHSE: National Health Service England

NICE: National Institute for Health and Care Excellence

NMHDS: National Mental Health Datasets

PCL: Primary Care Liaison

PHE: Public Health England

RCADs: Revised Children's Anxiety and Depression Scale

ROMs: Routine Outcome Measures

RTT: Recruit to Train

SENCo: Special Educational Needs Coordinator

SEND: Special Educational Needs and Disability

SLA: Service Level Agreement

SLT: Senior Leadership Team

SMHL: Senior Mental Health Lead

WHO: World Health Organisation

WSA: Whole School Approach

WTEs: Whole Time Equivalents

YPAS: Young Person's Advisory Service

FOREWORDS

ELAINE REES – CEO LIVERPOOL LEARNING PARTNERSHIP & WSA BOARD CHAIR

When the first report into a Whole School Approach to Mental Health and Emotional Wellbeing was commissioned in Liverpool in March 2017, no one would have anticipated the following few years coping with the pandemic and the resultant impact on the mental health of our children and young people. In Liverpool, the Education Mental Health Teams (EMHTs) offer a wide range of support and interventions. Reviewing all that has taken place in those EMHTs to support young people prior to, during and since the pandemic is a complex and detailed piece of work, involving schools, a wide range of services and professionals as well as young people themselves.

As this report indicates, there are many areas of good practice; clear examples of strong collaborative partnerships that are directly supporting children and young people as well as their parents/carers. A huge amount of training has taken place in schools and the recommendations of the 2017 report have largely been addressed. Yet the offer is not equitable across the city and so much more is needed in the coming years. To that end, we need to build on existing best practice, bridge the gaps and continue to prioritise the mental health and emotional wellbeing needs of the children and young people in our city.

LISA NOLAN – SENIOR PROGRAMME MANAGER (MENTAL HEALTH) CHESHIRE AND MERSEYSIDE ICB, LIVERPOOL PLACE

Mental health support in schools has been commissioned for several years locally through a range of providers. More recently and since 2018 following the first Whole Schools Approach to Mental Health and Emotional Wellbeing review (2017) this support has been delivered as a collaborative partnership between health, education and VCSE organisations (Education Mental health Teams – EMHT). This has resulted in some excellent practice and positive outcomes for children, young people and families. Such positive outcomes were evidenced in the Whole Schools Approach to MHEWB impact report in 2022 and are highlighted throughout this report. However, there is still so much more to do.

Following a national pandemic, increased demand for mental health support and recent insight into what children and young people are saying about their wellbeing through the Oxwell survey, this review has been important to help shape future commissioning and delivery. We will use this intelligence and continue to work with children, young people, families, and schools to work as a partnership to ensure equitable access to mental health support across all education settings which is evidence based and of high quality.

EXECUTIVE SUMMARY

OVERVIEW

Demand for mental health support in schools has grown considerably in recent years. Education Mental Health Teams have been developed in Liverpool in response to this increasing demand. The offer has grown and diversified significantly over the past 5 years since Liverpool successfully became a Trailblazer site for Mental Health Support Teams. Navigating the challenges of Covid amidst the task of developing a brand-new service, the WSA partnership and schools have worked to develop the offer to date. There is much to be celebrated around what has been developed, and some areas highlighted that need to be improved. Once such area is that of data, which has been mentioned throughout the report as lacking consistency. Given the central role that data plays in a review such as this one, the challenges faced in gathering and analysing data across all services has flagged data recording, quality assurance and reporting as an area in need of urgent attention. Every effort has been made to present figures accurately within this report, however there are areas highlighted in the report that can only be taken as best estimates. This has meant that some service figures are potentially under-reported and may not fully capture the true extent of the work being delivered.

Partnership working between Alder Hey, YPAS, LLP and MYA are key to the success of the model, and this is evident throughout this report. The report highlights the cumulative effectiveness of services working together in a school and this should remain a priority for services moving forward. Several enablers of this model approach emerged. The most significant of these is the role of the Senior Mental Health Lead. When in place and embedded as part of a Whole School Approach, not only are pupils better supported but the offer is more consistently accessed. Additionally, the introduction of EMHT termly meetings in school to bring services and school mental health teams together to plan forwards. Where established, services and schools reported this to be having a positive effect on referrals and whole-school mental health development. Another enabler is cross-partnership project working, such as that seen during Children's Mental Health Week Livestream events or the creation of the REACT programmes. All services were keen to see more opportunities for this type of work in future. There are processes in place to enable services to collaborate and co-develop this multiservice offer, although these are not always being utilised to their full potential. Consistent attendance at multi-agency meetings was cited as a barrier, along with a lack of clarity/communication about what the offer is and who does what. Additionally commissioning arrangements could be further focused to ensure that partnership working is considered a requirement for EMHT services. Furthermore, equitable distribution of funding is needed to ensure that full cross-service provision is possible in all schools. Joint-commissioning opportunities require further exploration and development to ensure that this offer continues to expand as a coordinated approach.

The EMHT offer has been rolled out to all mainstream primary and secondary schools in Liverpool, although not all have equal access to the offer. Consistency in service staffing, availability of school Mental Health Leads and varying school size are key contributors to this. An audit around provision into Special Schools and Alternative Education Provision has been recommended to better understand need, but currently pupils in these provisions have little access to this offer. The report revealed that not all schools are utilising the offer effectively due to either a lack of engagement on their part, or issues to do with access to the service. Lengthy referral processes and narrow criteria have historically acted as barriers for schools. Whilst there was still some reference to this throughout the review, many schools reported an appreciation of the improvements made to the

referral process through the new digital One Platform. It was noted that YPAS still use their internal referral form for both Seedlings and Wellbeing Clinic referrals. The impact upon schools if this was changed to the One Platform common referral form was not considered within this report, however given the need to tighten up data reporting this could be worth exploring.

The report shows that demand in schools is higher than the provision being provided, though the true extent of this would require further data capture and analysis to fully understand what is needed. Triangulation of the need expressed through the Oxwell survey, schools' demand survey and national prevalence guidance suggests that significant further investment is needed. However, there are also indications that current provision isn't being fully utilised. Some of the reasons identified were schools not making referrals, some service staff working at below their intended capacity, and appointment DNAs. Further scrutiny of this information would be advised when planning around future expansion.

Finally, the Levels of Need model needs revision following this review. Whilst it has helped schools to understand need and given services a shared language, there are clear developments needed. These include changing some of the language used to describe need and rethinking how teams/interventions are mapped across the model. This will also inform further scrutiny of the pathways, which is needed to continue to make these school facing services accessible to all pupils needing support.

KEY PRIORITIES FOLLOWING THIS REVIEW

A full list of recommendations can be found on p 71. As a summary of these, the following key priorities are suggested:

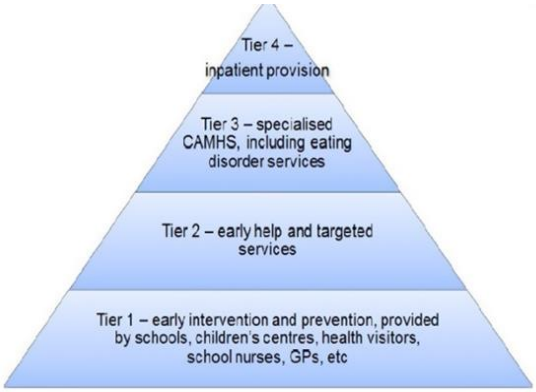
1. Data collection, quality assurance, reporting, and analysis requires further investment.
2. The secondary school offer needs further investment and development to bring it on par with the primary offer.
3. Further development and promotion of the Whole School Approach is needed in schools to support and develop Senior Mental Health Leads and ensure the offer is fully utilised.
4. The Levels of Need model needs revising in line with the interventions being offered – rather than in line with services.
5. Cross-partnership pathways need further development.
6. Commissioning arrangements should better support the development of cross-partnership pathways.

MENTAL HEALTH IN SCHOOLS

A growing recognition of the impact of increasing mental health problems on young people's education, coupled with the unique position of schools to offer support, has led to increased demand for mental health services to operate in schools[1]. With 1 in 6 having a probable mental health disorder (NHS Digital, 2021) discussions around mental health and emotional wellbeing have featured in educational dialogue over the past decade [2]. A report commissioned by Barnardo's in 2022 found that 66% of children and young people reported feeling sad or anxious at least once a month[3]. In Liverpool the 2023 Oxwell Survey, capturing views of just under 16,000 CYP, revealed that 39% of secondary pupils identified themselves as having a mental health problem that was affecting their daily lives[4].

The Department of Health promotes a multi-agency approach, suggesting that the mental health needs of pupils often need a multidimensional response that cannot be catered for by health services alone[5]. Public Health England has long advocated for the role of schools to support early identification and intervention within their tiered model of mental health (*see figure 1*). Though this has now been replaced in Liverpool by IThive[6], both delivery models still advocate for the role of schools in providing early intervention support.

Figure 1: Four-tier child and adolescent mental services model (NHS, 1995)



[1] Fazel, M., Hoagwood, K., Stephan, S. and Ford, T. (2014) Mental health interventions in schools in high-income countries. The Lancet Psychiatry, 1(5), pp. 377-387. <doi: 10.1016/s2215-0366(14)70312-8>.

[2] Carmel C., Celeste, Simões, Simona, C.S. Caravita (2021) A systemic, whole-school approach to mental health and well-being in schools in the EU. <doi: 10.2766/50546>.

[3] https://www.barnardos.org.uk/research/its-hard-talk-expanding-mental-health-support-teams-education

[4] Oxwell Liverpool report 2023.

[5] O'Reilly, M., Adams, S., Whiteman, N., Hughes, J., Reilly, P. and Dogra, N. (2018) Whose Responsibility is Adolescent's Mental Health in the UK? Perspectives of Key Stakeholders. School Mental Health, 10(4), pp. 450-461. <doi: 10.1007/s12310-018-9263-6>.

[6] https://implementingthrive.org/about-us/i-thrive-implementing-thrive/

Within both models' schools are viewed alongside other statutory services, such as GPs, school nurses and health visitors, as a first level of early intervention and prevention for the treatment of mental illness. Given the potential impact of poor mental health on the prospects of the current school-aged population[3], a drive to get mental health and wellbeing on every school leadership agenda could not come soon. Whilst pockets of good practice have previously existed around health education, its exclusion from the National Curriculum in the 1980s was considered a significant barrier to it being fully embedded in schools until recent years[7]. However, current changes in policy have led to mental health taking a central role in government-driven education priorities. Following the 2017 Government Green Paper[8], the Department for Education (DfE) proposes that schools and colleges have a vital role to play in supporting the mental health of their pupils as one of the wider systems surrounding them. According to Barnardos[3] 76% of children and young people surveyed said they would like more mental health support in schools, and 73% of parents believe there should be more funding available to provide this.

LIVERPOOL'S WHOLE SCHOOL APPROACH MODEL

Evidence suggests that the most effective way for schools to fulfil this mandate is with whole-school commitment rather than "piecemeal approaches" [9]. This view is supported by Carmel et al.[2] who suggest that, as indicated by Bronfenbrenner's[10] socio-ecological framework for child development, school based interventions have better outcomes when established within a systemic whole-school approach to mental health. Public Health England (PHE) set out eight principles in their WSA model to coordinate this type of WSA to mental health. The Liverpool WSA adopts and adapts this model to promote this at a citywide level *(see figure 2).* This model places an emphasis on leadership and management to promote, lead and make room for mental health initiatives across the school. As such it has been central to the Department for Education's (DfE) drive to see staff from schools across the country trained up as Senior Mental Health Leads (SMHLs) based on the recommendations of the Green Paper (2017).

> *"A senior mental health lead is a strategic role in a school or college responsible for overseeing the setting's holistic/whole school or college approach to promote and support children and young people's mental health and wellbeing."*[11]

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[7] Weare, K., 2000. Promoting mental, emotional, and social health: A whole school approach. Psychology Press.

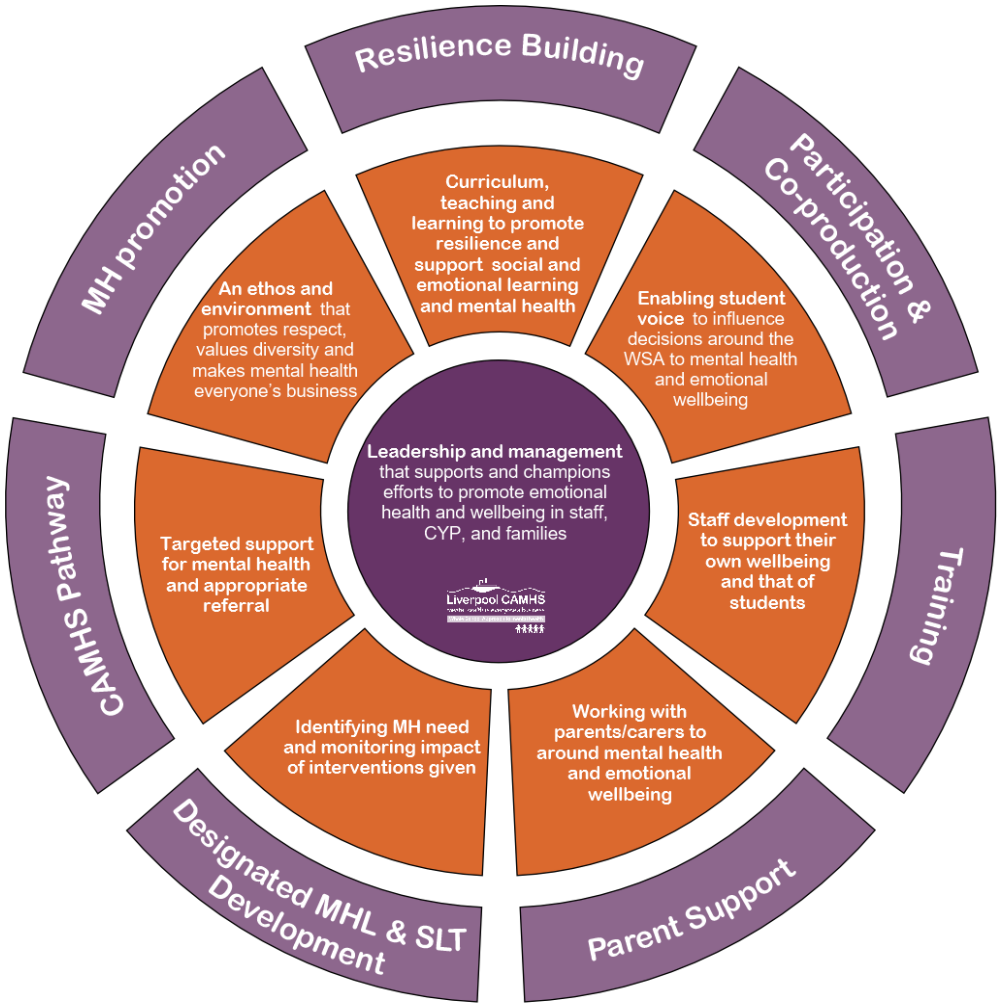
[8] Department for Education & Department of Health (2017) Transforming Children and Young People's Mental Health Provision: A Green Paper [Online].

[9] Stirling, S. and Emery, H. (2016) A whole school framework for emotional well-being and mental health. National Children's Bureau, London.

[10] Bronfenbrenner, U. (1979). The ecology of human development. Cambridge, MA: Harvard University Press

[11] Transforming children and young people's mental health implementation programme: 2023 data release (2023) GOV.UK. Available at:

Figure 2: Public Health England's WSA model adapted for use across Liverpool schools.
The outer ring of the model represents the work of the WSA city partnership in supporting mental health and wellbeing in schools. The inner rings are the areas of focus for mental health within a school setting.



At the time of writing 83% of schools in Liverpool have accessed this training, with 56% attending the locally developed one. Nationally 58% of eligible schools have accessed the training grant, so Liverpool is considerably higher in the uptake of this. Some of the potential barriers for schools not attending include budget and staffing pressures, lack of mental health training for the wider staff and the belief from some schools that mental health shouldn't be their remit[6]. In the 2023 data release for the government Green Paper, (2017), 47% of SMHLs said that they didn't have enough time

https://www.gov.uk/government/publications/transforming-children-and-young-peoples-mental-health-provision (Accessed: 07 August 2023).

within their roles to achieve their goals. Not all school leadership teams are willing and/or able to adopt the level of commitment needed to promote both staff and pupil wellbeing according to Glazzard (2019)[12]. Additionally, population size and location of schools have significant bearing on the funds available to school leadership teams which is likely to make it harder for some schools to prioritise this role. Unfortunately, government grants only fund the training itself and there is financial support for schools to resource the time needed to effectively carry out this role. This is a significant barrier that needs further national conversation. On a local level the city WSA partnership are doing what they can to support schools in developing these roles with the available resource. When asked, SMHLs cited shared resources, guidance around implementation and peer networks as some of the things that would help bring about 'effective change' in their schools through the outworking of their role[8]. All these suggestions fall within the aims of the Liverpool WSA partnership.

Within Liverpool there is an established city-wide Whole School Approach partnership whose membership includes local mental health service leads, local authority leads, public health officials, educational representatives, and commissioners. Disparities in mental health mental and physical health spending mean that only 15% of Integrated Care System spending is used for mental health, learning disability and dementia. Within this spending the gaps between CYP's provision and adult provision remain, and on average CYP mental health only receives 1% of all health and care funding[3]. These gaps in funding have often meant that CYP face a postcode lottery when trying to get support for their mental health[3]. In response to this the partnership collaboratively delivers a school-facing mental health pathway, training, WSA support and a mental health promotion offer. This offer is the focus of this review.

Liverpool CAMHS partnership's successful bids to get 5 Mental Health Support Teams has added significant resourcing to this area. When the review was initially requested funding for MHST had not been confirmed beyond 2024 – leaving much uncertainty about the future sustainability of this offer. Recent announcement from NHSE and DfE have confirmed continued funding of these teams beyond 2025[13].

NHS Cheshire and Merseyside ICB, Liverpool Place (previously Liverpool CCG) have commissioned Liverpool Learning Partnership (LLP) to support the coordination and development of the Whole School Approach to MHEWB. This has helped strengthen the partnership between education settings and mental health services and has been cited as good practice nationally. The Senior Development Lead at LLP has led this work in partnership with the Education Mental Health Teams and schools which has resulted in positive practice and outcomes.

[12] Glazzard, J. (2019). A Whole School Approach to Supporting Children and Young People's Mental Health. Journal of Public Mental Health. DOI: https://doi.org/10.1108/JPMH-10- 2018-0074

[13] https://educationhub.blog.gov.uk/2023/10/10/how-were-helping-look-after-the-mental-health-of-children-and-young-people/

REASON FOR REVIEW

Currently the NHS commission the following services to provide mental health support to schools in Liverpool:

- Mental Health Support Teams (MHST) including the Link Workers provided by Alder Hey NHS Children's Foundation Trust
- Seedlings provided by the Young Persons Advisory Service (YPAS)
- Children and Young People's Wellbeing clinics provided by YPAS
- Mental health promotion and resilience building provided by Merseyside Youth Association (MYA) – Note this service is commissioned on a city-wide footprint however does deliver some work into schools.

The above have been commissioned through individual contracts for several years at different times and through different NHS funding streams as outlined below. More recently as part of the Whole School Approach (WSA) to Mental Health and Emotional Wellbeing (MHEWB), the agreed approach was to work closer together as part of a wider EMHT. This approach has been in place since 2018/2019 and although there have been some positive outcomes which were outlined in the WSA Impact report and stakeholder feedback there is a need to review this offer for the following reasons:

- To gain a clearer understanding of pathways within the EMHT
- To gain a clearer understanding of pathways between EMHT and wider community services
- To understand demand and capacity of the EMHT with a focus on population need, activity and workforce roles, responsibilities, and challenges.
- To understand impact of the EMHT
- To understand the gaps in provision (with a focus on the work delivered by MYA) at school level and explore future commissioning.
- To outline good practice in addition to challenges
- To review models and good practice in other geographical areas
- To ensure an accessible, sustainable future model of delivery is agreed in addition to preparing for any increased investment which might become available from across the system.

Mental health support in schools is a priority outlined within the NHS Long Term Plan (LTP) to improve access for Children and Young People (CYP) to NHS funded mental health services. This is also a priority at Liverpool Place for health, education and the local authority which has resulted in establishing collaborative partnerships through the WSA to MHEWB and Education Improvement Board meetings. The collaborative and partnership approach has resulted in some positive outcomes for the CYP and

families within the city including more schools adopting and implementing a WSA to MHEWB. These outcomes have been evidenced in several local reports including in the recent WSA impact report. Such positive outcomes have been acknowledged nationally with Liverpool seen as an area of good practice.

Funding continues to flow through the NHS for the provision below:

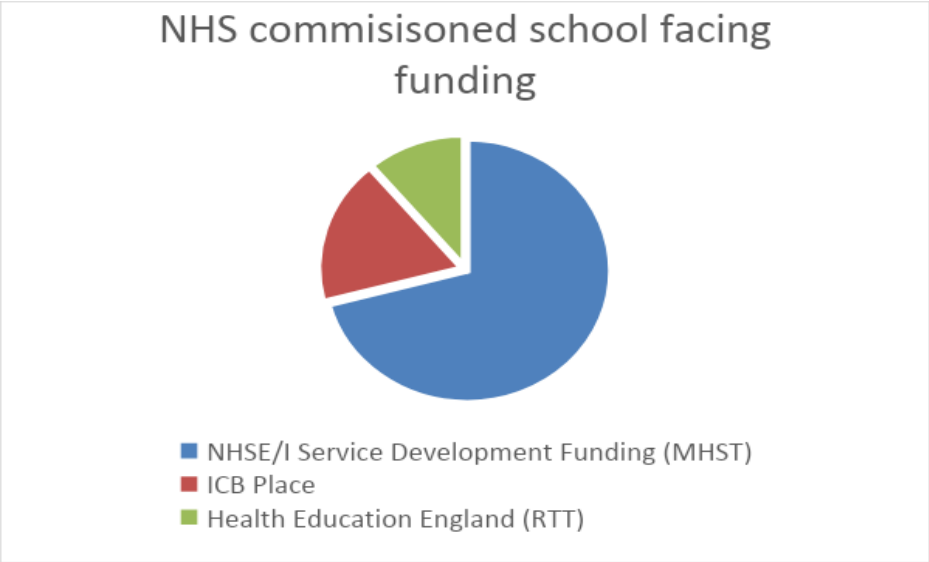
Service	**Organisation**	**Funding 23/24**	**Funding stream**	**Recurring/non-recurring**
MHST	Alder Hey, YPAS, LLP	£2,192,000	NHSE/I	Recurring
Seedlings*	YPAS	£184,500 £464,952 Total = £649,452	ICB Liverpool Place Schools' contribution	Recurring
CYP Wellbeing Clinics*	YPAS	£286,971	Alder Hey/YPAS sub-contract arrangement (£50,000) HEE (£236,971)	Recurring. Non-recurring
Link Workers*	Alder Hey	£129,820	ICB Liverpool Place	Recurring
TOTAL		**£3,258,243** **£2,556,320 (Liverpool Place Funded)** **£701,923 (HEE RTT & school contributions)**		

**Note – the above figures are 22/23 and may be subject to inflationary uplifts in 23/24. This has already been included in MHST*

NHS Cheshire and Merseyside ICB, Liverpool Place also commission MYA to provide city wide prevention services. Some delivery will be in schools. This is in addition to a wide community-based offer delivered by the Liverpool CAMHS Partnership.

The pie chart shown in *figure 3* outlines the split of funding within the different NHS funding streams.

Figure 3: Split of funding within the different NHS funding streams.



NHSE have recently confirmed the continuation of MHST funding beyond March 2024, which gives some security regarding the sustainability of these school facing services. However, there are still substantial areas of the model that operate through non-recurring funding. For example, YPAS currently deliver wellbeing clinics 1 day per week within all secondary schools. This is supported through Recruit to Train posts funded through Health Education England (HEE) on a 12-month basis.

The EMHT structure has not been reviewed since the model was agreed in 2018/2019. Since this time there have been several significant changes and events locally and nationally including:

- A national pandemic which has impacted on the MHEWB of CYP and their families and increased demand for support. This has also impacted on the existing workforce including staff retention, recruitment, and wellbeing.
- A restructure of NHS commissioning from CCG's to ICB's including Integrated Care Systems and new governance arrangements across Cheshire and Merseyside and at Liverpool Place
- A mapping exercise of generic CAMHS provision undertaken by AQUA which suggested a further deep dive of school MH pathways.
- The Oxwell survey which captured intelligence of the MHEWB of CYP at school level.
- Further developments as part of the WSA to MHEWB and Education Improvement Plan Priority 1 (Mental Health)

REVIEW METHODOLOGY

This review set out to gather the views of education and health professionals whilst also considering the views of children and young people, parents, and carers. Empirical evidence was gathered from the following sources:

Type of Data	Number of participants	Details	Intended outcome
Initial steering group conversations with service leads	8	Discussions with service operational strategic leads.	To further establish the scope of this review. Four areas of focus emerged: ● Clarity of the pathways into services ● Evaluation of the structure of the EMHT/model ● Equity across the model ● Recruit to Train and the national model – are they working?
Focus Groups	Approximately 6-10 per focus group	Focus groups were held with representatives from the following teams: ● Seedlings ● YPAS Parenting team & Wellbeing clinic ● MHST & Link workers ● RAISE Mental Health Promotion Team	To gather views & experience of staff from each of the services delivering across the EMHT.
Survey (Empirical, qualitative & quantitative)	7	Annual EMHT review survey completed school staff.	To gather the voice of schools who use the services
Demand & capacity information	All services completed this, 28 secondary schools (90%) and 60 (50%) primary schools.	Estimated demand figures from schools and capacity/staffing figures taken from June 23	To capture a snapshot from schools of the demand of each service and to compare this with current capacity within the EMHT
EMHT combined KPI data	All EMHT service data	KPI data taken from 22/23 dataset	To understand what the current EMHT can deliver across an average year.
School referral & engagement data	All Schools engagement data	KPI/school engagement data taken from 22/23 dataset	To understand how schools currently utilise the service

In addition to the above data this review refers to the following pre-existing data gathered in 2023:

- The 2023 Oxwell survey – gathering the voice of over 15,000 children and young people across Liverpool on a range of mental health related topics.
- The 2023 national data release for the government's 'Transforming children and young people's mental health implementation programme: 2023 data release'.
- Previously gathered local data analysis

The reviewer's positionality being part of the EMHT, yet external from the CAMHS partnership, has implications for this review. Being one step removed from the organisation forces reliance on second-hand accounts of their internal operation and procedures. This raises potential data validity issues which may be seen as a limitation of this study. Conversely the independent position of the

researcher is more likely to provide an objective perspective and less likely to be influenced by professional unconscious bias.[14] Similarly, the choice to combine in-person focus groups with anonymous surveys is intended to further mitigate against the potential for results to be swayed by the researcher. The review steering group has been consulted throughout the process and all gathered data has been accessible to this group via a shared Padlet.

METHODOLOGICAL APPROACH

The review scope was initially proposed by the ICB, and then further developed by the EMHT review steering group. A series of discussions with service leads revealed four focuses for further exploration. These were as follows:

I. Clarity of the pathways into services and across services

II. Evaluation of the EMHT structure/model

III. Equity across the model

IV. Recruit to Train and the national MHST model – are they working?

A combination of the commonly used semi-structured interview[15] and focus groups were the chosen approaches for exploring these themes. Key questions were formulated and used to guide the groups (see appendix I.) Questions were shared prior to the focus groups, giving the participants time to reflect and prepare. During the group the discussion was allowed to flow relatively freely in a bid to counter any interviewer bias and potential to manipulate the answers. Minutes were taken at each group and shared with the researcher. One could question the validity of data gathered through focus groups, given the social dynamics at play that influence the responses given by participants[16]. However, as this review looks at broad themes rather than scrutinising them in depth, the views elicited from the focus group will add to the overall picture being gathered. Further interrogation of the data could be carried out using anonymous surveys should the ICB wish to delve further into any of the presenting themes outside of the scope of this review.

[14] Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research inPsychology,3,77–101.doi:10.1191/1478088706qp063oa

[15] Brinkmann, S. (2014). Unstructured and semi-structured interviewing. The Oxford handbook of qualitative research, 2, pp.277-299.

[16] Somekh, Bridget & Lewin, Cathy. (2004). Research Methods in the Social Sciences.

Once gathered, this data was firstly organised by the focus areas listed above, and then further colour coded via thematic analysis to show emerging themes from across the datasets. The emerging discussion themes were as follows:

- Communication
- Clarity of roles (knowing what they/others do)
- Levels of need
- Partnership working
- Consistency
- Access
- Schools' understanding of pathways.
- Suggestions for development
- What is working well
- Funding

In addition, evidence was gathered via the school EMHT needs analysis survey. This consisted of a variety of question styles chosen to limit complexity of responses whilst also giving space for individual interpretation. Several open-ended questions were included to mitigate against research bias and data entry restraints.[17] Surveys were completed by 90% of secondary schools, 50% of primary schools, and 42% of special schools, which when combined exceeds the recommended 60% completion rate for academic research[18]. However, it is fair to say that feedback from schools is therefore most representative across secondary schools due to higher rates of completion.

Finally, capacity and demand data was gathered by mental health professionals working within the schools. A dip-sample carried out in June 2023 was used to ascertain the following pieces of information:

- Number of staff in each service team
- Current caseloads of practitioners
- Current numbers of CYP in school needing to be seen by that service

This data was triangulated with existing key performance indicator data, the 2023 Oxwell survey data and annual school EMHT engagement data. Results have been discussed in reference to the intended outcomes of this review.

[17] Scharp, K. M. and Sanders, M. L. (2019) What is a theme? Teaching thematic analysis in qualitative communication research methods. Communication Teacher, 33(2), pp. 117-121. <doi: 10.1080/17404622.2018.1536794>.

[18] Fincham JE. Response rates and responsiveness for surveys, standards, and the Journal. Am J Pharm Educ. 2008 Apr 15;72(2):43. doi: 10.5688/aj720243. PMID: 18483608; PMCID: PMC2384218.

CONTEXT - EDUCATION MENTAL HEALTH TEAMS

CURRENT EMHT OFFER

Three multidisciplinary Education Mental Health Teams currently operate across North, South and Central Liverpool schools serving a population of approximately 77,070 CYP[19] *(see figure 4*). School numbers have fluctuated over the past 12 months with new schools starting and some former infant and junior schools merging to become primary schools. At the time of writing this report EMHTs work across 120 primary schools, 32 Secondary schools (31 will be used for evaluation purposes as LIPA is still expanding its provision) and 12 Special Schools.

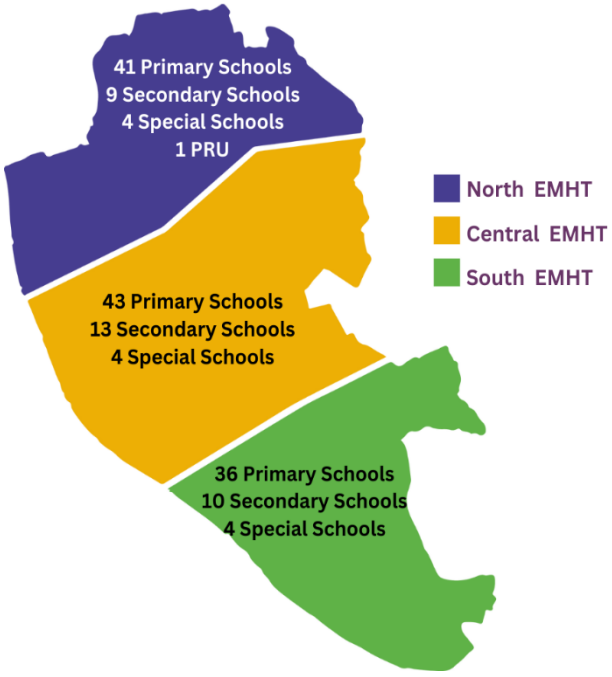


Figure 4: Liverpool EMHT maps with numbers of schools.

Liverpool's school-facing offer has developed based on the national recommendations for Mental Health Support Teams. These state that population coverage for a single team should be around 7500-8000 CYP across an average of 20 school settings. The team should typically be made up of 8 WTEs, including 4 WTE EMHPs, 3WTE senior clinicians/higher level therapists, 0.5 WTE team manager and 0.5 WTE admin support[20]. Therefore, based on Liverpool's school population figures, there should be 10 MHSTs[21] (approximately 80 WTE staff) operating across Liverpool to give full coverage[22]. Liverpool currently has half of this required allocation, and they are predominantly working in primary schools. In line with NHSE directive that MHSTs should add to and not replace existing provision, the school offer is extended using the existing Young Person's Advisory Service (YPAS) Wellbeing Clinic provision and YPAS Seedlings service. The offer is further enhanced

[19] Liverpool school census 2023.

[20] Mental Health Support Teams for Children and Young People in Education: An Operating Manual, Department of Health & Department of Education, March 2022

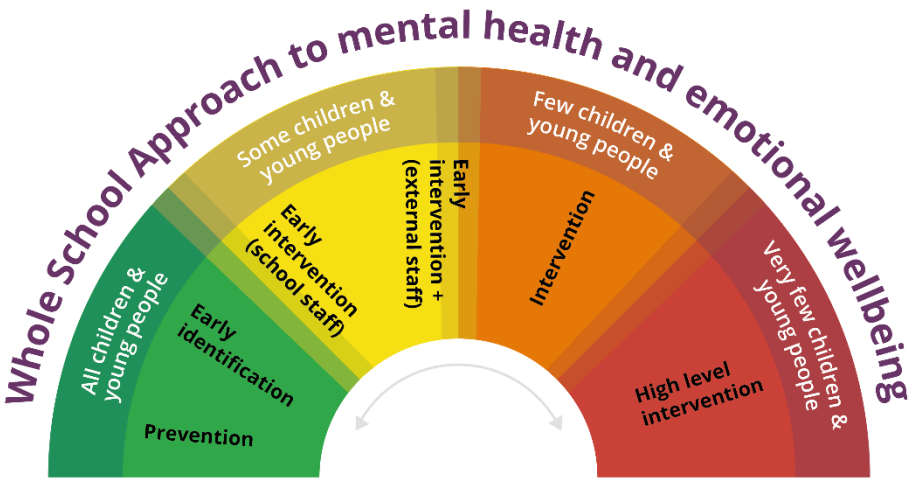
[21] 10.3 when using the population size of 7500.

[22] Number of MHSTs needed could be lower (8) if calculated on the number of school settings. However, Liverpool has a high proportion of larger than average schools, so population size has been used.

with Alder Hey Link Workers (who sit under MHST leadership) and access to a wider Mental Health Promotion offer delivered by Merseyside Youth Association (MYA RAISE). At the time of compiling this report there were 56.7 WTE EMHT clinical staff (including 8 MHST vacancies), 3 WTE admin staff (MHST), 1 WTE Strategic Clinical Lead (Alder Hey), 1 WTE Senior Development Lead (LLP) and 1 WTE operational lead (Alder Hey) – in total 62.7 WTE supporting the Liverpool EMHT offer. An additional 2 WTE Seedlings practitioners have been funded to help clear the Seedlings community waiting list[23].

This school facing offer sits as part of the Local CAMHS pathway and seeks to offer a full range of services across the green to orange levels of need, from prevention right through to intervention. The Whole School Approach Liverpool Levels of Need windshield is pictured in figure 5 and the current offer maps can be found in appendix i, showing where services fit across the windshield.

Figure 5: Liverpool WSA Levels of Need Windshield.



Services are mapped out across these levels of need in appendix ii. The Whole School Approach (WSA) and coordination of this offer is led by the Senior Development Lead for WSA who is based at Liverpool Learning Partnership. Queries over the accuracy and efficacy of the current levels of need mapping have been raised throughout the process of this review. These will be discussed later in the report.

Each service within the EMHT has their own leadership structure, however these are all coordinated through the Whole School Approach Partnership Board which feeds into the CYP MHEWB Strategic Partnership. Within this structure a three-team model was developed to mirror the three YPAS community hubs (North, South, Central) working across Liverpool. A suggested model for EMHT service governance and structure is illustrated in figure 6. This proposed model was presented to the WSA Partnership Board in 2019.

[23] These were funded for 6 months through ICB pressure paper funding.

Figure 6: A proposed structure of EMHTs as discussed in 2019.

Within this structure, operational senior management of each school-facing service work in partnership to oversee and jointly coordinate the schools' offer. This relies on shared operational processes, planning and communication which have been successfully developed in part. The suggested model requested the support of a strategic clinical lead to work across the model alongside the WSA Senior Project Manager (now WSA Senior Development Manager). Whilst this post was introduced it was done so within Alder Hey's MHST staffing structure to oversee both the Liverpool and Sefton MHST sites. There is currently no cross-partnership clinical oversight other than

the collaboration of service clinical leads. The reviewer would suggest that this role is needed to operationally bring service pathways and processes together.

The WSA Senior Development Lead seeks to coordinate this partnership approach acting both between the services and being a conduit with schools. Several meeting structures have been put into place to enable this joint working. At the time of writing this report these include:

- Half-termly strategic service leadership meetings – generating and overseeing the WSA/EMHT development plan, including cross pathway working.
- Termly levels of need service operational lead meetings (one for the primary offer and one for the secondary offer) – sharing operational updates and discussing opportunities for cross-partnership working and joining pathways.
- Termly WSA Board - Oversight of the WSA/EMHT development plan.
- Senior Development Lead attending service team meetings on a regular basis. This also includes representation on the Education Improvement Priority One steering committee (Liverpool City Council).
- Termly WSA Mental Health Lead networks – supported by all services.

Consistent attendance at these cross-partnership meetings by senior leads has been raised as an issue of concern at several WSA Partnership Board meetings. Attendance in quarters one and two of 2023/24 has been better according to the Senior Development Lead. Attendance at service team meetings by the WSA Development Lead has been more consistent with the MHST. Seedlings and Wellbeing Clinics have been more ad-hoc – this is largely due to the capacity of the WSA Senior Development Lead.

Achievements to date of this partnership model have been developing a shared Key Performance Indicator (KPI) dataset; working to a shared development plan for strategic WSA/EMHT aims; working on city-wide projects for key events such as Children's Mental Health Week; co-production of training and partnership inclusive recruitment and induction processes; and coordinated pathway offer for schools. In addition, training of school Senior Mental Health Leads, led by MYA and LLP, has enabled this offer to be promoted to schools. The efficacy of these shared achievements will be discussed later in this report.

REPORT FINDINGS

IMPACT OF THE EMHTS

Each of the EMHT services are valued by schools and this is evident with the feedback stemming from the 2023 Schools' Needs Analysis Survey.

> Really supportive and helpful and keen to keep improving the service offered.

> The sharing of good practices at WSA meetings and discussions on how to overcome problems has been really beneficial.

> Thank you to everyone who supports our school and makes a difference in all our children's lives to achieve the best possible outcomes. We really appreciate and value you.

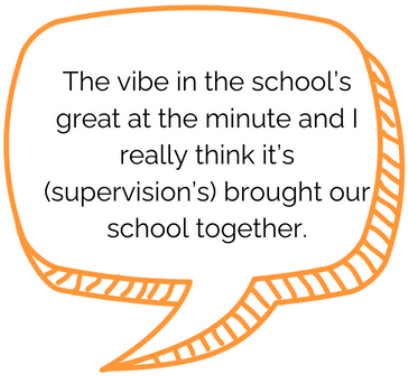
Quotes taken from EMHT Schools' Needs Analysis Survey 2023

Achievements, best practice, and challenges of services will be discussed working through the Levels of Need Model.

GREEN LEVEL

MERSEYSIDE YOUTH ASSOCIATION (MYA)

MYA is not centrally commissioned to provide a school facing offer; however, they support the EMHTs as part of their city-wide mental health promotion offer. This includes delivering a rolling Bitesize training offer; developing training and mental health promotion resources; and running the annual NOW Festival. Additional funding through Liverpool Learning Partnership and Liverpool City Council has commissioned some school facing provision from MYA over the past three years. This has included the development of ROAR response training; ROAR supervision training; development of REACT Anxiety and Low Mood and larger resource developments such as the WSA Audit Tool, and in 22/23 the Resilience Framework for schools. In 2022/23 this work reached 798 secondary school aged CYP through 5 Empower workshop days and 1165 primary children (across 47 schools) through their ROCKET resilience programme. The carousel-style Empower workshops covered 5 commonly presenting issues including body image, low-mood and coping strategies which incorporates aspects around self-harming behaviours. ROCKET has been used by many schools as their primary outlet for pupil voice around their WSA to mental health and wellbeing. 338 CYP (all ages) were involved in the 2023 NOW Festival, which focused on violence and resilience. 193 school staff accessed aspects of the ROAR training suite, including ROAR Response to Staff Wellbeing and Supervision in Education. Over three consecutive courses, 57 staff were trained with 100% saying that they would recommend the course to their colleagues. The course trains staff to understand what supervision is and equips them to develop a supervision model within their schools. Additional supervision for school mental health leads is provided via group coaching sessions and plans were made for senior MHST practitioners to provide 1:1 supervision for school mental health leads. There is evidence of this being actioned in a few schools, but this is not yet rolled out to all schools that have received training. Where it has been embedded, schools have reported back the positive difference that implementing this model has had.



SMHL talking about implementation of the ROAR Supervision Training, 2023[24]

Further funding to continue this training in 23/24 is needed. This will enable not only the delivery of the course, but also the necessary group coaching to allow schools to implement it in their schools.

> *The course delivery was amazing, informative, interactive, and fun too. The theory behind supervision in schools and the importance of it is clear. However, it can feel a little far out of the reach of reality in terms of implementing and embedding it within school. (ROAR Supervision delegate feedback).*

[24] https://vimeo.com/807465980/775aacffda?share=copy

A few suggestions for improvement were given by schools though the 2023 Needs Analysis survey. Secondary colleagues felt that at times ROAR training, particularly ROAR Secondary and ROAR Supervision were more aligned with primary school needs. There were also points made about training occasionally not being aware enough of school culture and behaviour policies.

> *ROAR secondary training is often very primary based, and not entirely sure helpful in terms of supporting students access education on a day-to-day basis and doesn't appear to have due regard to school behaviour policies and expected standards. 1 specific example, being told it is good practice to allow girls to wear make up to help with their self-esteem issues. (Extract taken from EMHT Schools' Needs Analysis Survey 2023)*

Further development of the training offer may be supported by development staff (MYA & LLP) spending some time shadowing the work of school MHLs. Although both organisations have staff with education backgrounds, taking time to experience, refresh and update this knowledge would be helpful to continue to hone what is an already highly praised offer.

Clarification around and further commissioning of MYA'S school facing offer is needed to ensure that the offer continues to be available for all schools. This would include funding to support representation on the EMHT strategic leadership and termly levels of need service operational lead meetings. Additional staffing & development funding could ensure that MYA developed resources can be distributed via train the trainer courses to EMHT services and school MHLs. This is expanded later in this report.

Mental Health Support Teams (MHSTs)

MHSTs support the green level offer providing workshops, assemblies and supporting school campaigns such as the Livestream events held in 2023 for Children's Mental Health Week. NHSE refer to these MHST roles as Function 2 & Function 3. Function 2 relates to staff development. MHSTs meet regularly with their school Mental Health Leads to discuss referrals and explore the needs of each school. This shared dialogue is intended to develop school Mental Health Leads by embedding knowledge around recognising and supporting mental health needs in schools. This function is supported by termly WSA networks (led by the Senior WSA Development Lead) and workforce training (MYA & LLP).

> *WSA meetings both primary and infants are beneficial and important to attend. The good practice sharing, support and advice on offer is invaluable, making such a demanding role that bit easier knowing help/advice is only a click or email away. (Extract taken from Primary Schools' Needs Analysis Survey 2023)*

Training provided by LLP/MYA is embedded with the regular support and presence of MHST staff in schools. For example, at the time of writing this report the MHST are delivering the 'Spotting the Signs' workshops into schools to support staff in recognising low level mental health needs. Function 3 (from NHSE) relates to the development of a Whole School Approach. In the 2022/2023 reporting period used to inform this review, the MHST recorded 6960 CYP accessing their workshops, assemblies, and transition live events. **Focus group discussions with MHST staff highlighted the importance of these workshops for helping CYP & staff to identify their own needs for support. These workshops also support resilience building and self-care.**

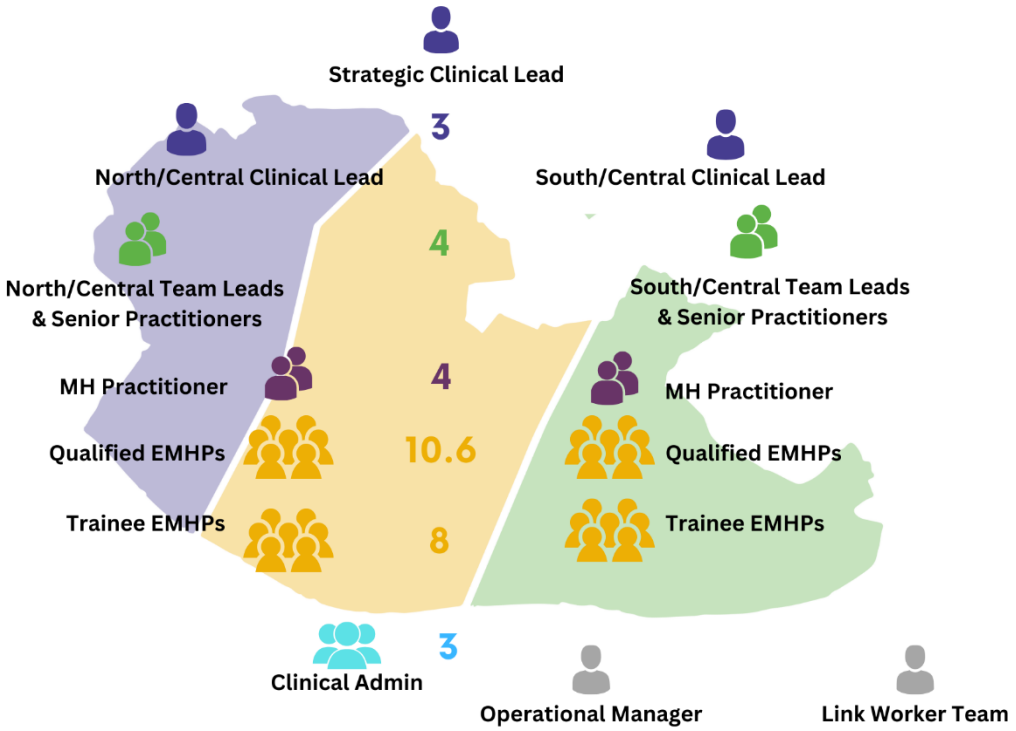
> *Creative opportunities such as the Livestream sessions have been hugely successful in getting information out to large numbers of CYP and school staff. These raise the profile of mental health in schools and are an excellent first line of prevention. In-school workshops and assemblies also help to embed practitioners into individual school communities. (Extract from Focus Groups' Summary, see Appendix iii)*

YELLOW LEVEL

MENTAL HEALTH SUPPORT TEAMS (MHSTS)

The Mental Health Support Teams work across all Liverpool Primary Schools providing low-intensity evidence-based support for children with emerging worry/anxiety, low-mood, sleep difficulties, and general behavioural concerns. As one of the national 'Trailblazer' sites (first 25 sites in the UK to have MHSTs) the Liverpool MHST offer has grown from reaching 25 schools in its pilot year (2018/19) to offering full school coverage (120 schools). The team grew from 3 full MHSTs in year 1 to then having another two full teams added in subsequent funding waves. The teams were initially modelled across the three city EMHT hubs (North, Central, South), but due to staffing challenges have moved to a two-team model. The front-facing offer still works across the three hubs and schools still relate to North, South and Central MHSTs. The Team structure is as follows:

Figure 7: MHST Team Structure June 2023



This structure consists of 3 Trailblazer funded MHSTs, 1 wave one MHST and 1 Wave 3 MHST. Additional roles (indicated as grey) support the function of the MHST but not funded through this funding stream. As a nationally directed programme, changes have been regular throughout the growth of these teams, with guidance documentation and data requirements still evolving. The most recent guidance gives the following suggested staffing structure stating that an MHST should typically be made up of 8 WTEs, including 4 WTE EMHPs; 3WTE senior clinicians/higher level therapists; 0.5 WTE team manager and 0.5 WTE admin support[25]. This would require 40 WTE staff in the Liverpool MHST – they currently have 32.6. Several mitigations apply to Liverpool's model including three of the higher-level therapist positions not being funded in the Trailblazer wave of funding. Underspend during year 1 of the project was used to fund three parenting practitioners from YPAS. This has continued to be budgeted for in subsequent years**. Whilst a working relationship has been established between YPAS and the MHST, these posts currently sit outside of the MHST staffing structure. This has been highlighted within focus groups as an area of frustration from both services.** Parenting practitioners voiced their desire to be more involved with school-facing delivery,

[25] Mental Health Support Teams for Children and Young People in Education: An Operating Manual, Department of Health & Department of Education, March 2022

particularly in the context of facilitating September MHST roadshow style promotion campaigns. Furthermore, a strategic clinical role across Liverpool and Sefton MHST was developed – as discussed earlier in the report. Finally, a WSA development post continues to be funded and hosted by Liverpool Learning Partnership. This post continues to support the data reporting process and WSA element of the MHST whilst also acting as a point of contact for the national team.

From the onset the MHST Trailblazer was set up as a cross-partnership project. Hosted within YPAS community hubs, the teams were made up of mainly Alder Hey employed staff, jointly line managed by YPAS and Alder Hey, and supported by the then project manager, who was hosted by Liverpool Learning Partnership. Data has been held and processed by YPAS and project oversight has been held by the WSA Partnership Board.

> *The cross-partnership delivery of the MHST has also, at times, led to confusion. Recently the teams have relocated to the Liverpool Innovation Park, which has positively impacted team cohesion and operational processes. The main reason for the move was the lack of space in YPAS hubs both during and following Covid. The risk of falling into silo working was raised several times throughout the focus groups, however staff also voiced determination to not allow this to happen. Communication and joint working are key to the success of this. (Extract from Focus Groups' Summary, see Appendix X)*

Whilst the MHST still retains some elements of cross-partnership working the need to adapt to the circumstances has negated the original intention of these teams to be multi-agency. The relocation of MHSTs' base from YPAS hubs has had a positive impact on practitioners but has unavoidably impacted on the cross-partnership nature of the team. Additionally, clashing operational processes and competing service requirements have created logistical challenges for both senior management and staff teams. This has been particularly felt by the clinical administration team. These staff are employed by YPAS and recently were seconded to Alder Hey in response to some of the issues voiced during this review process.

> *Frequent changes of personnel and processes was also highlighted as a challenge for the clinical admin team. With changes being made at both local and national levels keeping up with them has at times been difficult. It was also noted that different approaches around meeting chairing and triaging could be confusing for the clinical admin team who are required to attend a variety of these. In addition, the position of clinical admin being part of Alder Hey but managed operationally by YPAS was also mentioned as an area that lacked consistency. (Extract from Focus Groups' Summary, see Appendix iii)*

A further discussion around the staffing structure and partnership arrangements of the MHSTs is recommended outside of the scope of this review. This would also include the arrangements for recording and analysing data.

The menu of what MHSTs can offer has grown and developed since the onset of the project in 2017. Local and national learning from these teams is allowing the project to develop as they seek to meet the needs of local schools. Although schools in Liverpool initially struggled to see the need for yellow level low-intensity interventions, many schools have now embedded this offer and are seeing the benefits as part of a graduated approach. One of the initial barriers was the limited primary age-range for CBT-based interventions, which NICE guidelines state suitable for children aged 8+[26]. This has been addressed by the introduction of parenting groups and interventions to support younger children, along with a range of psychoeducation workshops for children and their families. At the time of writing this report the MHST were offering the following interventions:

- 1:1 evidence-based CBT informed support for Worry management, Low-mood, and phobias
- Cathy Cresswell parenting intervention for anxiety
- Parenting for behaviour support group
- Non-violence Resistance group
- Timid to Tiger parenting intervention group
- Triple P was also being offered through the secondary Link Worker

A Selection of Case studies can be found in Appendix iv highlighting some best practice work.

> *The support myself and my son have received via XXXXX has been incredible. In just 7 weeks, our life has transformed, we have both been provided with the tools and knowledge on how to overcome the issues we had both been struggling with and it has had a profound impact on my son, he is much more confident, calm in his approach and open to dialogue when faced with any issues that used to cause alarm, upset or in some instances trauma. Special thanks to XXXX for all the information and guidance throughout this process, it has been enlightening and insightful. (Parent/Carer feedback from MHST case study, Appendix iv)*

In 22/23 64%*[27] of CYP receiving interventions from the MHST had a measurable improvement on their Routine Outcome Measures paired score[28] when discharged. A Barnardo's report analysing similar outcome data across two MHST sites revealed an average improvement rate of 57%[3]. However, it must be noted that Liverpool paired outcome figures were not available for all cases seen throughout the year. These figures are representative of 34% of the total number of CYP seen for clinical interventions. This was reported as being a data entry/extraction issue as paired outcomes are standard practice within the MHST model**. As a recommendation from this report, the process of recording, extracting, and analysing data requires further investment and restructuring.**

[26] https://www.nice.org.uk/guidance/cg159/chapter/Recommendations#interventions-for-children-and-young-people-with-social-anxiety-disorder-2

[27] *of CYP (14.5%) who have paired outcomes available.

[28] Based on the Reliable Change Index used to calculate if a change is statistically significant, given the reliability of the measure.

The Liverpool MHST, guided by the then project manager, have developed their own internal method to capture and analyse non-clinical WSA activities. Nationally MHSTs are seen to have three functions[29]:

1. Function 1: To deliver evidence-based interventions for mild-to-moderate mental health issues.
2. Function 2: To support the senior mental health lead (where established) in each school or college to introduce or develop whole school or college approach.
3. Function 3: To give timely advice to school and college staff and liaise with external specialist services to help children and young people to get the right support and stay in education.

Currently the Mental Health Services Dataset (MHSDS) only captures data outcomes for Function 1. Functions 2 & 3 are vital to embedding and supporting a whole school approach to mental health and ensuring that schools can access the right support at the right time.

> *Creative opportunities such as the Livestream sessions have been hugely successful in getting information out to large numbers of CYP and school staff. These raise the profile of mental health in schools and are an excellent first line of prevention. In-school workshops and assemblies also help to embed practitioners into individual school communities. (Extract from Focus Group Thematic Analysis)*

The Liverpool MHST is recognised nationally for best practice due to its partnership delivery of this model. However, data feedback from the Cheshire and Merseyside ICS has shown Liverpool's MHST as performing at a lower capacity than other MHST sites across the region. NHSE suggested that each MHST should be seeing around 500 CYP per year which would amount to 2500 for Liverpool's 5 teams - this only takes into consideration Function 1. **In 22/23 the MHST received 899 referrals for clinical interventions (Function 1): 36% of their recommended target. However, when Functions 2 & 3 are included, a further 6960 CYP were seen by the MHST making an average of 1571 CYP per MHST - 314% of their recommended target.** NHSE are working with the Department for Education to look at standardising the capture of WSA activity data. The WSA Senior Development Lead and MHST Clinical Leads continue to advocate for this at both regional and national forums.

In 22/23 staffing shortages meant that the MHST had to cut back on their WSA offer. Some of this was subcontracted to MYA to deliver but this was from non-recurring underspend and lacked the proper planning that would have been in place if it was part of the funded offer. **It would be a recommendation of this report for further discussions to be had to define the purpose and functions of MHSTs in Liverpool to support senior leadership in steering this work according to national and local priorities.**

Key Challenges for the service 22/23:

- Staffing recruitment/retention and changing personnel.

[29] https://www.england.nhs.uk/mental-health/cyp/trailblazers/

- High numbers of trainee EMHPs with reduced caseloads.
- Staff sickness.
- Strategic leadership split across two very different MHST sites.
- Cross partnership arrangements for clinical admin.
- Data systems and processes
- Rapidly changing guidelines from the national team.

Key achievements of the service in 22/23:

- Widening the menu of interventions.
- Group interventions have worked very well in schools.
- Career development opportunities for staff to support retention.
- Invitation to share best practice at a national level.
- Full school coverage.
- Relocation of team to LIP which has brought stability and structure to the team[30].
- Audit and development across the service.
- Successfully getting EMHP trainees through their training.

YPAS Wellbeing Clinic

YPAS wellbeing clinics operate in Liverpool secondary schools. All secondary schools currently receive one full day per week from a Wellbeing Clinic Practitioner. The YPAS team of practitioners includes Information, Advice and Guidance (IAG) workers and Children & Young People's Wellbeing Practitioners (CYWPs). The Wellbeing Clinic aims to give young people, who may not have received any help before, access to mental health and emotional wellbeing support, early on, in a way that is convenient. They offer support for a variety of difficulties, such as:

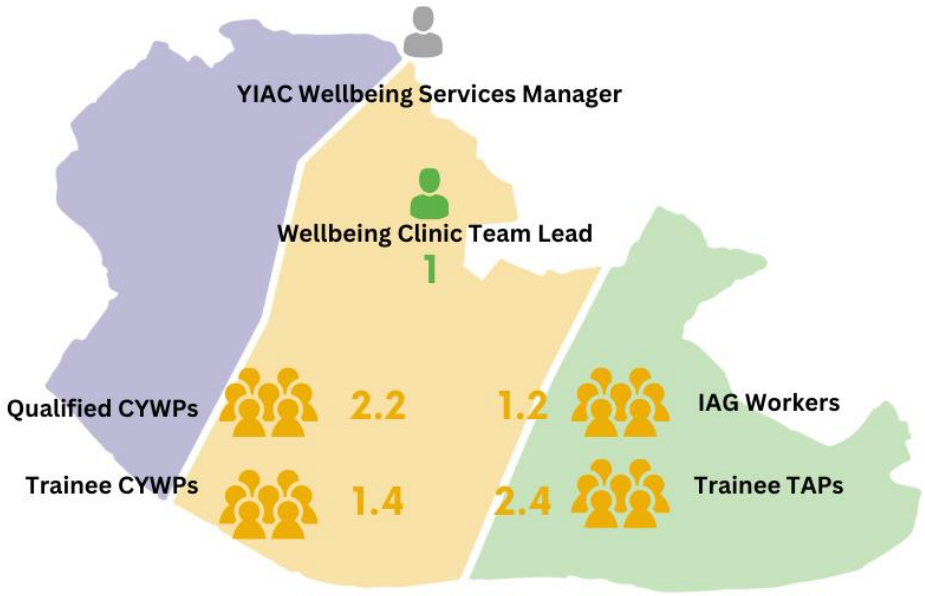
- Worries and anxiety
- Low mood and depression
- Problems with sleep
- Feelings of panic
- Phobias
- Understanding emotions
- Managing stress

Only 1.2 of the 8.2 WTE posts are funded through recurrent funding from the ICB Liverpool Place, with the rest being made available through national Recruit to Train funding (RTT) and MHST underspend that is currently funding 2 qualified CYWPs. YPAS have strived to keep a consistent provision in schools, but this has become increasingly difficult given the changing roles needed to sustain an offer in this way. Recent changes from Health Education England (HEE) means that from January trainee Children and Young People's Wellbeing Practitioners (CYWPs) will no longer be allowed to work in schools. This makes sustainability of this service even more uncertain.

[30] This is from an MHST perspective. From a wider partnership perspective this has potentially impacted the partnership element of the MHST.

The team staffing structure is outlined in figure 8. Overall management of the service sits outside of the current funding for the Wellbeing Clinic service and is provided by the YIAC Wellbeing Services Manager. The Wellbeing Clinic Team Lead, although listed here as 1 WTE, only has 0.2 WTE equivalent capacity to deliver interventions to schools due to other responsibilities within their job plan. **The sustainability and resourcing of this team needs to be addressed as a recommendation of this review.** This could potentially be sourced from a further MHST team or teams.

Figure 8: Wellbeing Clinic Team Structure



The Wellbeing Clinic delivers 1:1 intervention to support emerging and low-level mental health needs. They don't currently offer group work or any WSA workshops, although this was something that team members are keen to do.

> MHST and YPAS could work together to create a transition offer for secondaries and possibly deliver some group work into secondary. (Extract from Focus Group Thematic Analysis)

Throughout this review process several issues have been identified regarding data collection and reporting into the EMHT KPI document. When investigated by YPAS SLT it was suggested that this was down to the way that staff roles are split across their Wellbeing service. The process is now being reviewed but indicates an overly complicated staffing structure due to funding pressures. SLT are also now reviewing their data quality assurance and validation processes. **Having a dedicated data lead across all EMHT services would help to ensure that data collection, extraction and reporting was consistent across all services delivering the school-facing offer.**

In 22/23 we have data records showing that Wellbeing clinics saw 605 CYP through the Wellbeing Clinics. However, YPAS believe that this figure is significantly under-reported with estimated figures sitting at 1154 referrals. When discussed with staff at the focus groups one of the barriers reported back was a high number of DNAs (Did Not Attend). This could have potentially impacted data entry; however, it doesn't account for such huge variation. Further scrutiny of the data is needed to get a true picture of what is being delivered – this may not be possible for the 22/23 reporting period. Discrepancies in the 23/34 quarter 1 and 2 data are currently being investigated by YPAS SLT as numbers appear lower than the cases held by individual practitioners. For the rest of this report the figure of 605 CYP will be used as this is the figure that current data can assign to schools.

Analysis of individual school referral numbers revealed significant variance in school referral numbers across the year with a variable range of 4-50 referrals received[31]. School referrals will be discussed further later in the report however these inconsistencies do highlight the potential for wasted resources if all available slots are not being used. The role of school Mental Health Leads in coordinating school facing service offers is considered in the next section of this review.

In 22/23 66%*[32] of CYP receiving interventions from the Wellbeing Clinic had a measurable improvement on their Routine Outcome Measures paired score[33] when discharged. However, it must be noted that Liverpool paired outcome figures were not available for all cases seen throughout the year. These figures are representative of 10% of the total number of CYP seen for clinical interventions (based on a reported figure of 605). One reason for this is that not all interventions provided by the wellbeing clinic follow a clinical model. However, as mentioned earlier data capture, processing, quality assurance and analysis needs to be improved across all services. Having someone working across all services in the EMHT would support the transparency and accountability of these processes. This should include expert knowledge of the Iaptus system.

Best practice case study examples can be found in appendix iv. Whilst approaches vary between CYWP and IAG practitioners the case examples given both show significant improvement in symptoms using common outcome measures such as RCADS and Goal Based Outcomes. Parent/carer and young person feedback from these sessions are positive and this is supported by school satisfaction with the service.

> Overall, YP had tremendous progress during her time within the wellbeing clinic, originally scoring RCADs over the clinical threshold, YP had very low self-esteem and would regularly talk negatively about herself. By the end of the sessions, YP's RCAD scores had all decreased except her separation anxiety. On the last session her separation anxiety had gone up and she said this was because she was nervous to leave YPAS sessions. The language YP used prior to the sessions and towards the end was noticeable, YP would use more positive language and speak about herself in a kinder way than before. YP had also rebuilt her relationship with mum, was setting healthy boundaries and looking after her health. (YPAS IAG work Best Practice Case Study, Appendix iv)

The variation of practitioner roles within the teams (CYWPs, IAGS & TAPPs) could suggest inequity in the service that schools get. Whilst on the one hand some schools have relayed to YPAS that

[31] The validity of this data source is currently being reviewed for accuracy.

[32] *of the 60 CYP who have paired outcomes available.

[33] Based on the Reliable Change Index used to calculate if a change is statistically significant, given the reliability of the measure.

they prefer a certain type of support, it means that schools potentially miss out on specific intervention types. For example, only approximately 1/3 of schools have CYWPs working into them delivering interventions from a similar evidence-base as the MHST. This should be considered within the recommended discussions around future sustainability and development of this service.

Key Challenges for the service 22/23:

- Insufficient funding to operate the service.
- Staffing recruitment/retention and changing personnel.
- Reliance on trainee practitioners with reduced caseloads.
- Data systems and processes for reporting to the EMHT KPI
- Some schools are not engaging fully.

Key achievements of the service in 22/23:

- Continued to offer a full day per week despite funding challenges.
- Collaboration with the YPAS Link workers
- Career development opportunities for staff to support retention.
- Further RTT opportunities
- Successfully getting RTT staff through their training.

ORANGE LEVEL

SEEDLINGS

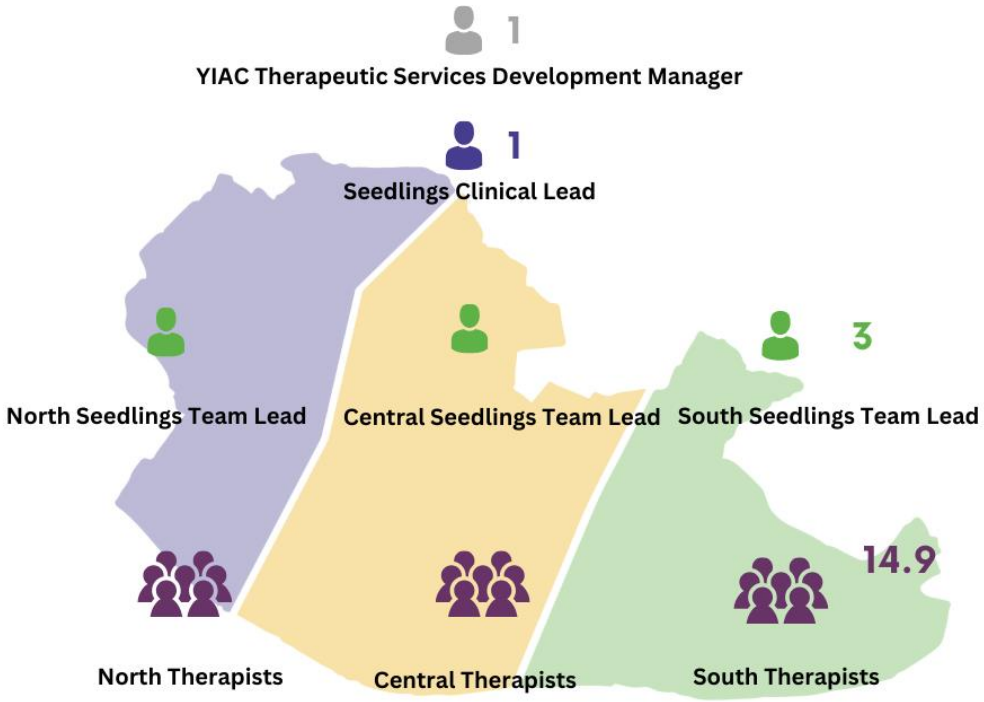
Seedlings is a creative therapy service for Liverpool primary schools, operated by YPAS. This CAMHS service was funded by Liverpool Clinical Commissioning Group for half a day per week in every primary school when it was first established in 2016. At the time of this review Seedlings was co-commissioned by Cheshire and Merseyside Integrated Care Board (Liverpool Place), formally Liverpool CCG, and 95 Liverpool schools who have SLAs with YPAS. The service sits at orange level on the Liverpool Levels of need windshield. However, the focus group discussions indicated that this service also supported at the yellow level depending on the needs of a child.

Realistically these services work across both levels depending on which intervention a child needs. For example, some referrals to Seedlings may be appropriate for early intervention, and some of the more targeted work delivered by the MHST may be applicable at the orange level. (Extract from Focus Group Thematic Analysis, see Appendix iv.)

Seedlings were found to have the most consistent staffing structure through this review process. Admin support is not included within the structure as schools refer directly to their Seedlings practitioner via the YPAS referral form. Data capture/reporting issues were also found with their figures entered in the shared EMHT KPI dataset. This is currently being investigated by YPAS SLT to ensure that future data recorded there is accurate. For this review figures reported are based on those held and shared by YPAS through their standard reporting processes.

Based on the proposed EMHT model shared earlier in their report, YPAS have modelled their Seedlings team around the 3-team EMHT model, as shown in figure 9.

Figure 9: Seedlings Team Structure[34]



At the time of writing Seedlings had an additional 2 therapists from additional ICB, Liverpool Place investment funding that was used to clear the waiting list in Seedlings community provision. This provision exists to support 25 schools, who do not co-commission Seedlings, to receive their ICS

[34] At the time of compiling numbers for this review (June 23) the Seedlings therapist staffing numbers were 14.9. As of October 2023, these are now 18.3 due to additional staffing.

Liverpool Place funded single weekly sessions. This offer was temporarily extended to support referrals coming into Seedlings from the online referral form (CAMHS Single Point of Access), but this led to an unmanageable demand. Referrals coming in through this route came from a variety of places including schools who already commission a Seedlings practitioner in their school. This provision has now reverted to only taking single referrals from those 25 schools.

Seedlings offer a variety of creative therapies and work on an 8 + 1 delivery model – with a clinical management system in place if the interventions required are deemed longer term. Top reasons for referral were: anxiety, anger, Low mood, behavioural disorders, and family issues. These very much mirror the needs seen by the MHSTs, although often these are more complex presentations. Focus groups revealed that the complexity of cases referred to Seedlings has increased along with the management of risk. This can often lead to extended provision being needed. **Feeling from the focus groups was that levels of need and commissioning models should not stand in the way of a child getting the right support.**

> *Similarly, Seedlings could occasionally be appropriate preparation to then access evidence-based support for a specific issue from the MHST. The school commissioned nature of Seedlings has potential to act as a barrier to this more joined approach. Termly EMHT school meetings help schools and services to take more of a joined-up approach (Extract from Focus Group Thematic Analysis, see Appendix iii).*

Termly EMHT meetings are initiated by Seedlings practitioners in primary schools and supported by MHST practitioners. These are a great example of partnership working and help schools to identify the best use of the services being offered.

Sustained commissioning of this service by schools is testament to the value that they place on it - especially with school budgets being continually stretched. However, the reliance on school funding means that schools have autonomy over which children get seen. Depending on the level of collaboration between school MHLs and EMHT practitioners, this could make it difficult to merge this service into the EMHT pathway. This arrangement also places additional strain on YPAS SLT who must manage uncertainty with their budgets on an annual basis, whilst also dealing with multiple invoices. **A singular commissioning arrangement with schools would be welcomed via the Local Authority or similar educational body.**

During 22/23, Seedlings supported 1425 CYP through their in-school provision. In addition, they saw 418 CYP in the community hub provision[35]*. Within these numbers 99 LAC children were supported by the service. Seedlings completed paired ROMs measures showed that children had a 28%[36] average of measurable improvement following interventions. This was noticeably lower than those from the MHST and Wellbeing Clinics. However, the measures for younger children are open to many flaws in practice, for example, some children self-report lower scoring in hope of carrying on with sessions with practitioners as they feel sad, they are ending. Conversely some children score higher

[35] * These numbers are higher than they should be for this element of the provision due to a backlog of referrals coming in via the One Platform.

[36] Based on 107 CYP with complete paired outcomes.

in hope to please practitioners or simply lack understanding of the measures in general. Finally, regarding parent data, historically the team struggled to obtain PDSQ/PRACD data for numerous reasons. Additionally, TSDQ is not represented in measurable change percentage as it is not a nationally run ROM but is utilised for every child referred into Seedlings.

A best practice case studies for Seedlings can be found in appendix iv. This case study highlights the support that Seedlings can wrap around a family whilst dealing with a range of complexities including trauma and ASC. The example utilises YPAS' Parenting Service and encompasses multi agency and cross sector partnership working. This example demonstrates the holistic support that Seedlings can provide, but perhaps also highlights the potential for MHST support to still be offered to provide specific targeted interventions once children/families are in a place to receive these. Such interventions could include those provided by MHST Senior practitioners. A re-evaluation of where services/interventions sit on the Liverpool Levels of Need windshield is recommended as one of the next steps following this review.

Key Challenges for the service 22/23:

- Individual school commissioning administration
- Data systems and processes for reporting to the EMHT KPI
- Some long-term staff sickness
- Unmanageable waiting list for community provision (due to external referrals)

Key achievements of the service in 22/23:

- Continued commissioning from schools despite tightening budgets
- Remodelling team structure to fit the hub-based model.
- Service/team stability

MHST/Alder Hey Link Workers

Although managed by and incorporated into the MHST, Link Workers are funded separately to support the secondary school offer in Liverpool. In 22/23 this role was streamlined to 2 WTE staff whereas previously it had been part of several Alder Hey CAMHS practitioners' roles. All secondary schools have access to approximately a half-day per month from Link workers to support them with mainly orange-level consultation and WSA advice and support. To try and facilitate this in a more accessible way for schools, the Link Workers piloted weekly consultation slots that schools could book onto as needed, rather than waiting for a monthly scheduled slot. For some schools this worked well, but most preferred to keep contact with the Link Worker via email and reach out to them as needed. Data shows that some schools make better use of this offer than others. In 22/23 the Link Workers completed 109 case consultations across the 26 schools (84%) that chose to utilise this offer and delivered 8 EMHT meetings across 6 schools. As part of their job role these practitioners also carry their own clinical caseload. These are often allocated cases from FRESH CAMHS, but these are not seen as part of the school-facing pathway.

The Link Workers have also supported several key WSA developments including the development of the WSA Critical Incident Aftercare training and support offer. In 22/23, Link workers supported two schools through critical incident aftercare procedures, providing advice and guidance throughout the process. They played a key role in containing school staff through these difficult incidents whilst managing school expectations of support. Schools have also made use of these staff to support LAC (Looked After Child) consultations, discuss staff wellbeing, attend Team Around the Schools (TAS) meetings, and give advice and guidance to school MHLs who were setting up their internal pathways.

One of the key challenges for these staff has been feeling that they aren't doing enough to support the high levels of need they see in these schools.

> ******** have a diverse range of students and SEN/Neuro diverse - school feeling swamped with the amount of perceived mental health within the school and the best approach to take - lots of worrying behaviours, potential exploitation, dysregulation, parental inability to support adequately, lots of anxiety, DSH and SI mentioned in school and low of low mood.*
>
> ******** have access to a number of services but continue to struggle, as services do not deal with DSH, SI, ED cognitions, dysregulation, high levels of anxiety and low mood. Less parental work noted at time of meeting.*
>
> *Meeting with *********, presentations with low mood/anxiety, dysregulation, parental issues/managing behaviours - 3 critical incidents within a year, DSH/SI, lack of being able to tolerate distress, interpersonal problems - lots of ACE's/LAC/Social Care children, parental criminality - estimated 25% of children have a parent in prison.*
>
> *(Extracts taken from Link Worker WSA data recording sheet, 22/23)*

Although 1:1 referral has not been possible (due to a lack of staff for equitable roll-out), the Link Worker offer has recently piloted some groups. The current menu from Link Workers for 23/24 is as follows:

1. Termly school education mental health meetings
2. Clinical consultation
3. Therapeutic Groups
    - DBT skills (distress tolerance, interpersonal effectiveness, emotional regulation, and focus/awareness) – year 9 upwards
    - Triple P parenting intervention – year 9
    - Non-violent Resistance Training - All years
4. WSA advice and guidance
5. Clinical supervision for Senior mental health lead/mental health lead (subject to completion of ROAR supervision training)
6. Support of critical incidents in schools

The team are still concerned about how to roll this out to all schools equitably and are exploring the possibility of running some of these groups online to allow for cross-school participation. The clinical supervision of ROAR trained staff is also something that needs further embedding. The future of ROAR supervision roll-out is subject to further funding of MYA's school-facing offer.

The potential of support offered by this team is there and schools that have tapped into this resource have spoken highly about the support that they have received. However, their lack of capacity to provide clinical support leaves both schools and the workers themselves frustrated over the role. At the time of writing this report Alder Hey confirmed provision for 3 WTE Link Workers. It would be good in future to see this role operating in a similar way to the MSHT senior practitioners in primary schools, offering a step-up for the wellbeing clinic to orange-level interventions and support. This might lead to greater job satisfaction for the Link Work staff and provide schools with much needed support for YP needing targeted support. Alongside this would be the recommendation for more of these staff to address the rising demand seen in secondary schools.

Key Challenges for the service 22/23:

- Understaffing
- Frustration of staff at not being able to deliver clinical interventions.
- Role still developing so lots of change and lack of clarity at times.

Key achievements of the service in 22/23:

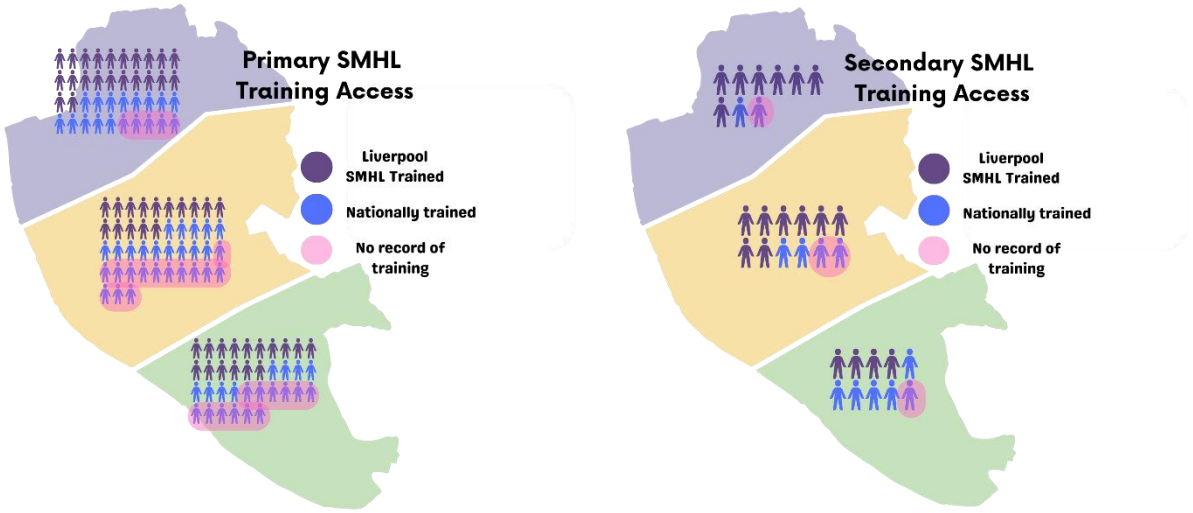
- Support of and development of the critical incident aftercare process
- Good relationships built with schools.
- Pilot of 3 group interventions to expand the offer.
- Cross-partnership relationships built with YPAS wellbeing clinic.

PATHWAYS WITHIN THE EMHT & BETWEEN EMHT & WIDER COMMUNITY SERVICES

SENIOR MENTAL HEALTH LEADS – A GATEWAY TO THE EMHT

The EMHT consists of education-facing services and **schools act as the main point of access** – usually through their designated Senior/Mental Health Lead. Mental Health Leads are appointed by schools and training is offered both locally and nationally. Core training for this role includes the DfE funded Senior Mental Health Lead (SMHL) training. In June 2023 90% (28) of Liverpool secondary schools and 75% (90) of primary schools had accessed this training, with 56% (74) of them attending the locally developed WSA training. These figures are shown in figure 10 and each person represents a single school. Across the 3 hubs primary schools attending the locally developed training were equally spread in South/Central hubs and high attendance was recorded from schools in the North of the city. Secondary schools had more North/Central schools attending Liverpool SMHL training, with considerably less in the South.

Figure 10: Map showing school access to SMHL training.



Triangulation with the 2023 Oxwell dataset[37] reveals a significant link between pupils knowing where to go for support and schools having a Liverpool trained SMHL lead in place. 100% of schools with 50% or more pupils knowing where to go for support [38] had a Liverpool trained Senior Mental Health Lead in place. 100% of these schools also had high levels of WSA engagement. Given the strategic role that SMHLs play in overseeing a setting's WSA[39] and acting as a gateway into the EMHT pathway, the importance of access to locally developed training cannot be underestimated.

> *The Mental Health Lead/Senior Mental Health Lead role is key to how well the mental health offer is embedded into schools. There is a lack of consistency in the value placed on this role across schools in Liverpool. It was also noted that there are inconsistencies within the training that schools have received, which impacts upon how schools' approach and utilise services. For example, in schools with prominent mental health leads, there were often consistent and effective systems in place for working with external services. Where this was not the case sessions were being missed due to no-one being available to get pupils, or pupils not even being aware they had a session. Not only does this waste valuable resources, but also can be demoralising for the practitioner. Practitioners reported that on rare occasions a full day could be wasted in this way. Several schools were praised for their consistent processes. Practitioners suggested that a shared and consistent approach could significantly improve the efficacy of the offer. A lack of consistency around mental health within individual schools ultimately leads to a lack of equity for CYP to receive appropriate support. (Extract from Focus Groups' Summary, see Appendix iii)*

Our 2023 EMHT/WSA needs analysis survey was completed by 28 secondary schools, 60 primary schools and 5 special schools. From this data, schools told us that 50% of Secondary SMHLs/MHLs had a full-time pastoral role in schools, whereas in primary schools this was reduced to 29%. Within primary many of the roles listed under 'other' were Headteacher or SLT. In secondary schools these were mainly SLT. We could also see that higher numbers of primary school leads are carrying out SMHL responsibilities alongside a teaching role (see figure 11 & 12).

[37] The Oxwell Study is an annual survey which asks school pupils how they experience school life and health-related issues.

[38] Oxwell Survey 2023

[39] Transforming children and young people's mental health implementation programme: 2023 data release 2023

Figure 11: Roles held by primary school SMHLs

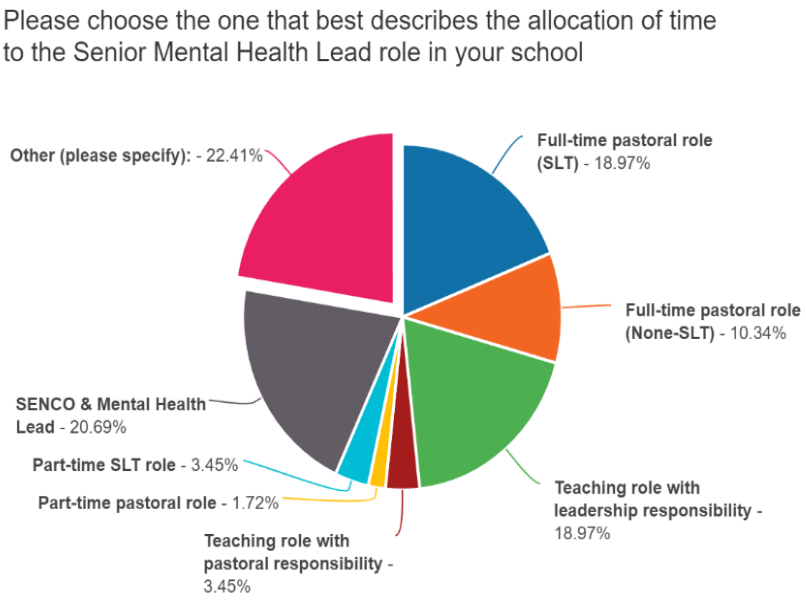
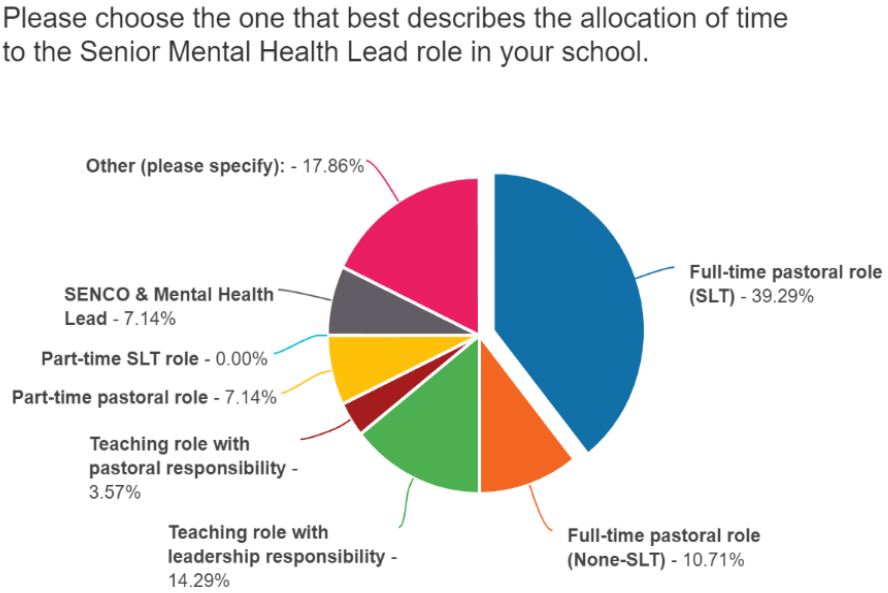


Figure 12: Roles held by secondary school SMHLs



Given the ratio of schools completing the survey was much lower in primary schools, we might assume that MHLs from these settings are likely to have struggled to do so due to other prioritised responsibilities. Presentation of these figures, along with the benefits of taking a WSA, would be recommended at Headteacher Associations and other educational forums following this review.

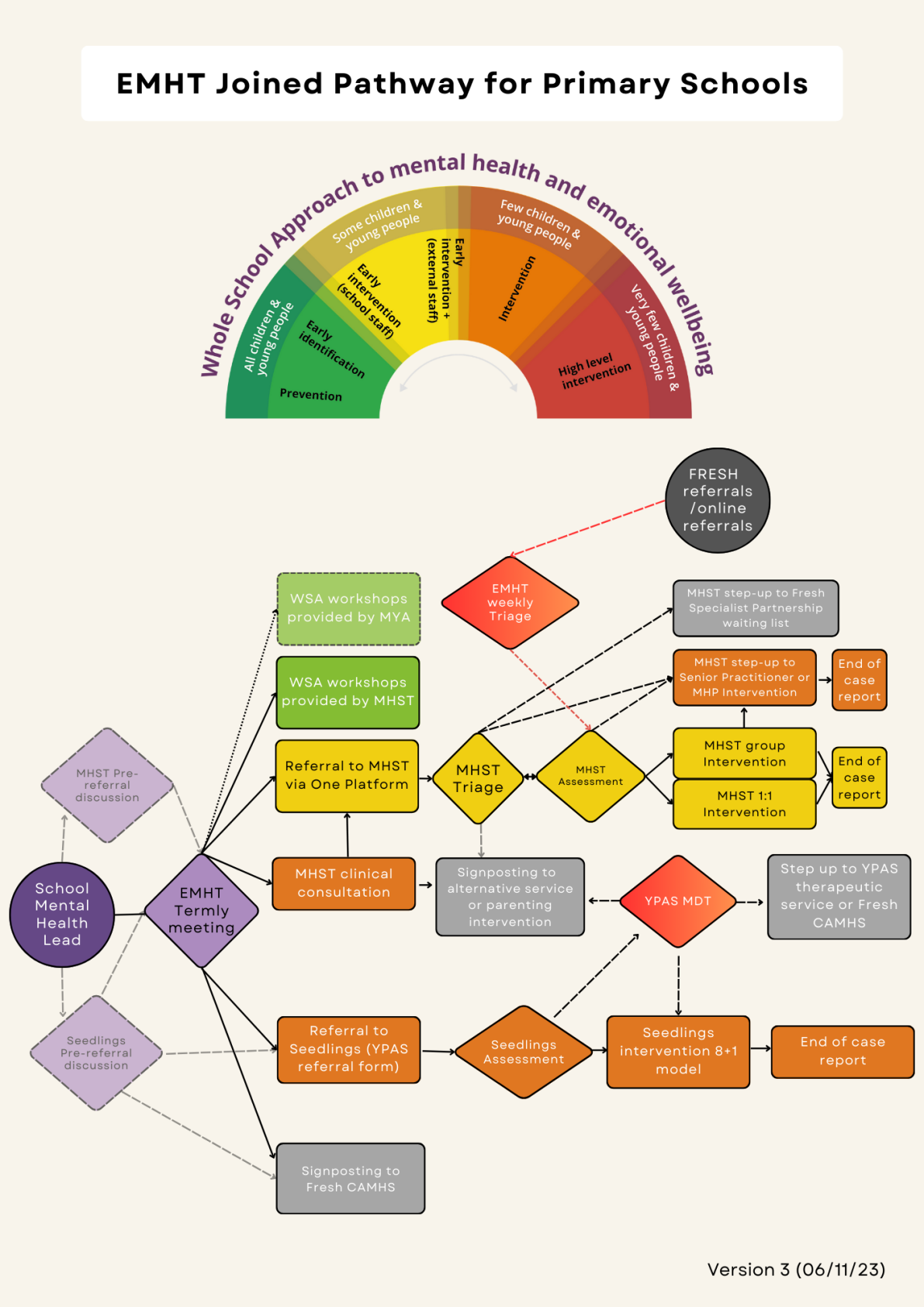
The EMHT Offer Pathways

EMHT Pathways offer interventions across all levels of need in primary schools and green to orange in the secondary schools. The allocation of these services across levels of need is illustrated in Appendix ii.

EMHT in Primary Schools

The offer is more comprehensive and cohesive for primary schools (*see figure 13*) due to NSHE funded Mental Health Support Teams who were brought in to boost the existing offer for this younger demographic.

Figure 13: EMHT joined pathway for primary schools:



The existing offer for primary schools was provided by Seedlings whose service complements the MHST and provides a consistent offer that is valued by the whole system. 83% of the 60 primary schools that completed the Needs Analysis survey said they had partially or fully embedded the MHST, with 5% of these schools (3) saying that they didn't use the service. 84% of the schools using the MHST, rated them as excellent or good, with 5% saying it needed further development. 82% of the 60 schools said that they commissioned Seedlings. 87% of schools using Seedlings rated them as good or excellent with 2% saying it could be improved in areas. Some of the reasons given for this were as follows:

> *We love the MHST service. It meets many needs for our children and families and is well organised and efficient in dealing with referrals.*
>
> *Unfortunately, we have not had a practitioner from MHST working with us for several months.*
>
> *As an infant school, the support we receive from the MHST is very limited and no direct work can be undertaken with the children as they are all under eight. There has been no consistency this academic year in the EMHP assigned to our school and we are currently on our third person who has also told us he is only stepping into the role on a temporary basis.*
>
> *As a lead with multiple responsibilities, I have struggled with the amount of information I have to gather for MHST in school referrals. This requires me to have a meeting/ long phone conversation with the parent and this MHST is then repeated by the MHST support worker. In comparison with Listening Ear (Knowsley service we buy into) I can complete a referral in half an hour. Our school has replaced Seedlings with the Listening Ear service.*
>
> *Both MHST and Seedlings are excellent services but unfortunately have a too high turnover of practitioners to rate as excellent.*
>
> *(Extracts taken from the Primary Schools' EMHT Needs Analysis Survey, 2023)*

Cases get stepped up and down both internally and across services, however the 'early-intervention/yellow-level' directive of the MHST has made it difficult for cases to get stepped 'down' from Seedlings into the MHST as they have often been seen as 'too complex'. It was reported by practitioners that, in some cases, children on the Seedlings list would benefit more from the specific targeted therapy offered by the MHST. Similarly, the creative approach from Seedlings could occasionally be useful preparation to then access MHST evidence-based support for a specific issue. However current interpretation of the offer would not encourage this. Additionally, the school commissioned nature of Seedlings also has potential to act as a barrier to collaboration given that it is heavily school directed. Access to both services is mostly via the school Mental Health Lead/s, although 'back-door' access has been given to primary-aged children sent over from the One Platform. This has at times over-stretched these school-facing services, particularly Seedlings who in 22/23 ended up with a large waiting list (over 100) for their hub-based practitioners. These hub-based practitioners are intended for children attending the 25 schools that don't currently commission Seedlings, along with children who are home-schooled or not in education.

Although the pathways are working well for many schools, there are still gaps in the knowledge of school staff regarding the pathways and offer from services. Schools often don't understand that the partnership services work together. Some schools are unsure of referral routes - particularly with the community Seedlings offer. Work has been done to further clarify and summarise the pathways for schools, but this would benefit from some animations and further promotional material.

(Extract from Focus Groups Summary, see Appendix iii)

The success of this current model relies firstly on schools having a competent and available school MHL in place who understands the levels of need model and which intervention is appropriate. EMHT termly meetings, where operating effectively, provide MHLs with support in doing this and are best practice for this model. Discussions held during EMHT termly meetings are effectively a pre-referral triage, and when facilitated by experienced practitioners ensure that children end up being supported by the most appropriate service. Termly meetings also open some of the wider work being offered by the RAISE team and help schools to access these as part of a joined offer, rather than ad-hoc.

EMHT termly meetings have been very helpful. Mental Health Leads, SENCO have regularly been included in these meetings. In some cases, school nurses have also been involved which has proven hugely beneficial. (Extract from Focus Groups' Summary, see Appendix iii)

Whilst being key to the effective delivery of this model, EMHT termly meetings are not happening in every primary school. For example, during the 2023 summer term (April-July) there were 23 EMHT meetings (19% of primary schools) recorded by MHST practitioners. Where this is the case, school MHLs rely on their own knowledge and separate conversations with individual service practitioners to determine referrals and access to the wider offer. This could lead to higher levels of inappropriate referrals, duplication of work and, in cases where the two services have different points of contact in schools, a disjointed offer.

Communication with MHST and Seedlings is good, however sometimes the schools don't link them. In most cases schools have one point of referral for both services, but in some they are different which can cause confusion and things to become disjointed. EMHT in-school termly meetings are key to supporting this. (Extract from Focus Groups' Summary, see Appendix iii)

The second key factor for successful operation of this model is that services work well together. According to practitioners whilst this happens behind the scenes, schools don't always recognise them as part of one offer. In addition to the termly meetings, the MHST and Seedlings have a weekly triage meeting to discuss cases that could benefit from support from the other service.

A cross-partnership weekly triage takes place for primary school referrals and is attended by MHST senior practitioners (rather than clinical admin). The inclusion of senior practitioners has greatly improved the process, with clinical admin now allocating extra cases from this triage to practitioners with capacity (Extract from Focus Groups' Summary, see Appendix iii).

This meeting is also used to triage and assign non-school generated referrals that have come through from the One Platform. This interface with the wider CAMHS offer has presented several challenges to services. Firstly, the level of presenting need has often been too high for the MHST, leaving many of these cases to be picked up by the community Seedlings offer. Where Senior Practitioners from the MHST have picked up some of these more complex cases, they have been seen to 'jump the queue' which has been raised by both schools and services as being inequitable. Similarly, schools have been dissatisfied when these Children are assigned to commissioning schools' Seedlings waiting lists.

The One Platform has made it much easier for schools to refer into the EMHT. However, it has also opened the services up to referrals from outside of schools. Parents/carers will sometimes, in desperation, refer to multiple agencies at once. This can clog up systems and ultimately cause CYP to end up on the wrong waiting lists. Another issue raised with this open-access approach is that CYP can end up jumping the queue to be seen when their cases are sent from SPA to the MHST or Seedlings. Often senior practitioners from the MHST are allocated to these cases, leaving less support available from them in schools. Demand for Seedlings has been high and resulted in a waiting list for the community hub, which was only intended for schools currently not commissioning the service. (Extract from Focus Groups' Summary, see Appendix iii).

Demand and capacity for these services will be discussed in a later section of the report, however the question raised here is whether this pathway should be solely school facing or extended into the early help element of the wider CAMHS offer. When fully functioning MHLs (access point to service) are in place and Seedlings/MHST work well together, the current pathways have shown to function well – with excellent feedback from schools. There are identified routes onto red-level service waiting lists, however these are not advertised as part of the school-facing offer. Without consistent EMHT termly meetings in place and/or competent and available MHLs, one could question the efficacy of these pathways.

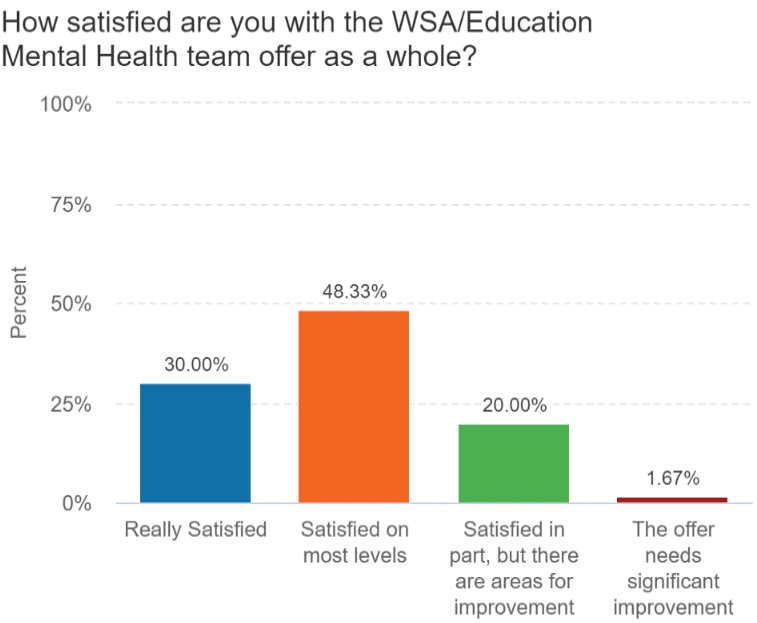
The variable commissioning arrangements of the offer is an added hindrance to developing an integrated pathway. If the whole offer was jointly commissioned, with one single referral route (via the online referral form and portal) coupled with a multi-agency triage, it could mean that CYP get allocated more efficiently to the right intervention. In addition, this would benefit from the inclusion of the RAISE team's school-facing mental health promotion offer, giving all schools access to green-level workshops, training, and psychoeducational interventions. Arguably some of the RAISE team mental health promotion tools/programmes (REACT, TOTEM & ROCKET) can stretch into yellow-level early intervention when delivered as interventions. A revision of the current Level of Need model has been discussed elsewhere in this report. The offer could be further strengthened with the inclusion of some targeted ND interventions given the high instances of ND presenting in both Seedlings and

MSHT referrals. The increased levels of presenting need mean that the inclusion of Senior Practitioners with varying modalities are an asset to this offer. Increasing the reach of these across Seedlings, the MHST and secondary schools would be another advantage of a jointly commissioned offer.

> *All services reported that the level of presenting needs has increased, and referrals are often more complex. Consultations help schools to think through their referrals before sending them in, but more referrals are coming through to the MHST at a higher level of need or with underlying Neurodiverse presentations where the issue is being caused by the learning environment. The desire to take a more 'upstream' approach was raised in several discussions where services felt more could be done around prevention. The lack of a consistent school-facing mental health promotion offer was raised across several focus groups. The MHST have had to cut back on workshops to meet their intervention targets which could be supported by MYA. MYA's offer lacks consistent funding for specific school-facing work making it difficult to incorporate into the EMHT offer. (Extract from Focus Groups' Summary, see Appendix X).*

Overall, most primary schools who completed the Needs Analysis Survey are satisfied with the offer, but unfortunately one school had not had a good experience and 12 said there was room for improvement (see figure 14).

Figure 14: Primary school overall satisfaction with the EMHT (based on 60 schools completing the survey)



> *Now that we have a reliable EMHP we are really seeing the benefits of this service.*
>
> *We are very happy with MHST and the support and advice that they offer but unfortunately for us the last two terms there hasn't been as much school involvement as there has been in previous terms.*

We have had a change of practitioner and as a result the regular/weekly school contact we had no-longer continued. Having weekly contact and a practitioner based in school one morning a week was beneficial and worked best for us. I have recently been informed that due to staff changing roles, we will have another practitioner who I'm hoping to meet in September. Moving forward I would like to introduce more referrals and workshops like we have previously done.

It is still challenging to have children accepted for EMHP support due to being too "extreme" even though these are some of our lowest level cases.

EMHP and Seedlings therapist working well to identify the correct support for families.

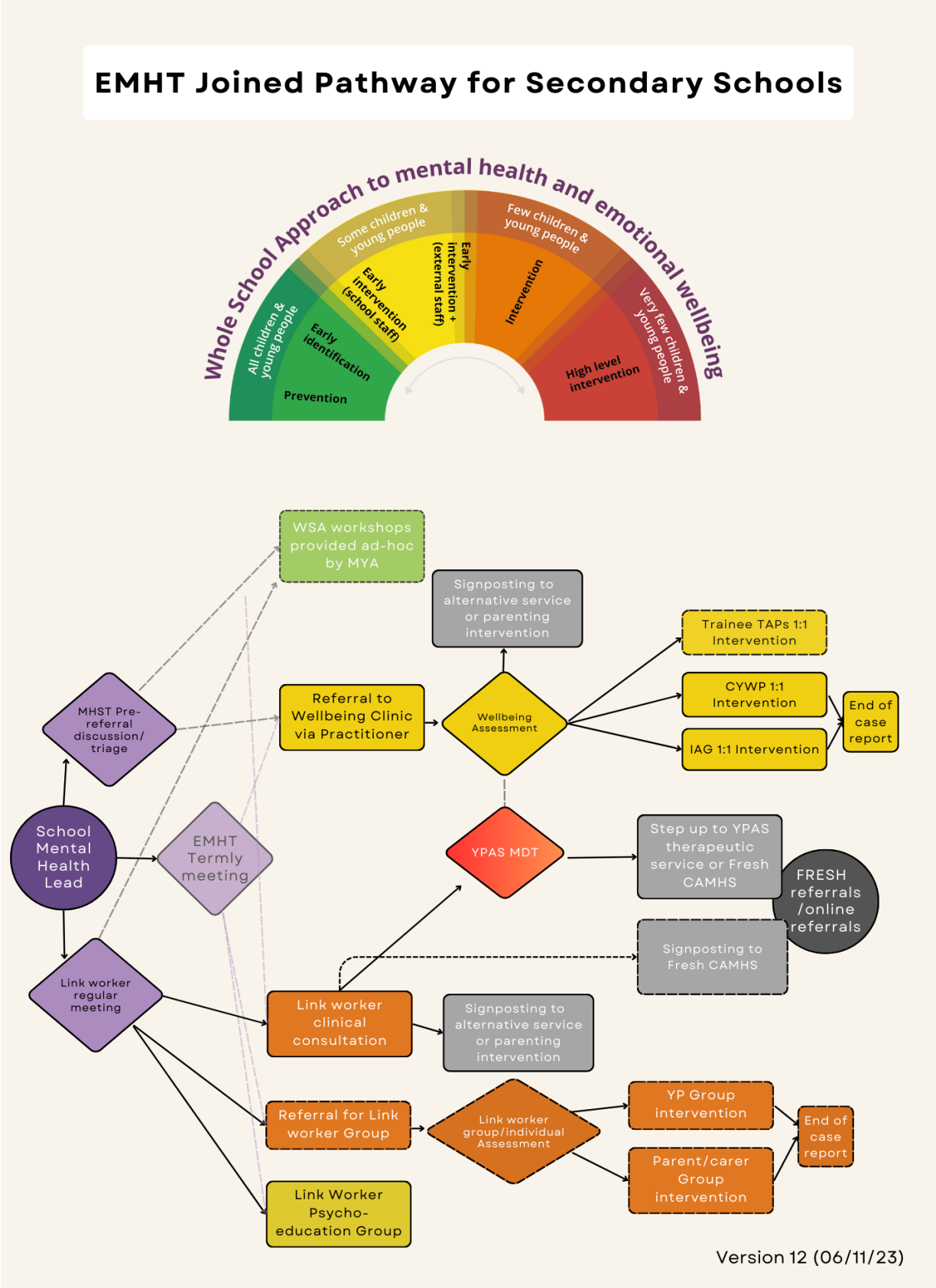
(Extracts taken from the Primary Schools' EMHT Needs Analysis Survey, 2023)

EMHT IN SECONDARY SCHOOLS

The secondary offer is still developing with the recent reform of the Link Worker role; however, it is largely provided via the YPAS Wellbeing Clinic. This pathway lacks the consistent prevention/early identification element seen in the primary offer. There is also little buy-in to EMHT termly meetings, which results in the Wellbeing Clinic and Link Work pathways operating independently from one another – albeit for behind-the-scenes collaboration between services. The desire is there from both services to work together, however the limited capacity of link workers along with the stretched capacity of the Wellbeing Clinic practitioners makes consistent collaboration unfeasible.

Within the secondary model (Figure 15), the MHL acts as the gateway into both the Wellbeing Clinic and Link Worker pathways. Secondary school data (EMHT Needs Analysis survey, 2023) shows a higher percentage of trained SMHLs in place with dedicated time to carry out the role. Having dedicated time for the MHL role implies that secondary schools are in a better position than their primary school equivalents to provide access to the EMHT. Through partnership working and the SMHL training, schools have moved from using their SENCO to access support from the Wellbeing Clinic to appointing this role to their MHL. This has helped to ensure that the Wellbeing Clinic is embedded into a Whole School Approach and utilised in conjunction with the wider offer. EMHT termly meetings have been promoted to schools but have proven difficult to implement in secondary settings. Link workers have taken on the co-ordination of these, but they have only run in a handful of schools.

Figure 15: EMHT joined pathway for secondary schools:



Due to the lack of consistent EMHT termly meetings, access to the wider green-level offer provided by MYA relies on individual Link Workers or Wellbeing Practitioners knowing what is available to signpost schools to. Termly EMHT Levels of Need meetings are the intended vehicle for this, however, focus groups revealed that information isn't always shared and relayed back to practitioners (see Appendix iii). Cross-partnership communication is something that will need to be developed further as a recommendation of this review.

Across the secondary schools there were few opportunities for green-level workshops as this is not currently commissioned via the Wellbeing Clinic or MYA. Cross-city projects supported by LLP, MYA and wider services have been the only offer of these available to all schools.

> *Creative opportunities such as the Livestream sessions have been hugely successful in getting information out to large numbers of CYP and school staff. These raise the profile of mental health in schools and are an excellent first line of prevention. In-school workshops and assemblies also help to embed practitioners into individual school communities. (Extract from Focus Groups' Summary, see Appendix iii)*

This is a huge gap in service delivery not only as an additional part of the offer for schools, but also to help embed the yellow-level offer into schools and provide a platform for the identification of appropriate referrals for the Wellbeing Clinic.

YPAS Wellbeing Clinics are a well-established and highly appreciated service for the secondary schools, however reliance on value-added staffing via Recruit to Train posts has stretched this service over recent years.

> *The YPAS provision for secondary schools also lacks consistent funding to deliver the service. Of the 8 WTE staff required to work a full day per week across all 31 secondary schools, only -1.5 are funded through recurring funds. The CYWP recruit to train 23/24 trainees cannot be used in the wellbeing clinics as they are not funded to be in schools. Lack of future funding of these roles also makes it difficult to retain staff and sustain the service. The Link worker role is a vital support for the secondary schools; however, this role is thinly spread. Additionally, many secondary age pupils in alternative education cannot receive mental health support as they are not included in the current funding. (Extract from Focus Groups' Summary, see Appendix iii)*

100% of schools responding to the survey (28 replied out of 31) said that they have accessed the Wellbeing clinic with 93% having embedded it partially or fully. When rating the service, 19 schools rated it as excellent, 5 good and 4 suggested there were some areas for improvement. Having trainees was referred to as an understandable limitation of the offer.

We have had a trainee Wellbeing Practitioner this year (understand that training needs to happen!) which has limited the types of referrals we can make. (Secondary staff 2023 survey)

Referrals across 22/23 (605 YP seen) are much lower than those seen in the previous year (1139 YP seen). This could be expected given the funding challenges experienced by the service during this period. However, throughout 22/23 YPAS have continued to maintain the same level of offer as in previous years which suggests that under-reporting is not giving the full picture. Better data processes are needed in future to ensure that nothing is missed. Additionally, the services' reliance on value-added staffing has meant moving around staff to fill gaps. This has resulted in reduction of CYWPs trained in the evidence-based intervention equivalent of the MHST. Furthermore, future sustainability is uncertain as the CYWPs are no longer being permitted to work in schools. Help to promote and launch it was requested by 5 schools completing the survey and a further 3 would like best practice examples of how it is working well in other schools. When asked whether we should extend the wellbeing clinic to include group work rather than just 1:1, 22 schools said yes and 6 said they were happy with 1:1 work.

We think this would encourage more students to engage with this service if group work was available. (Secondary staff 2023 survey)

Secondary schools also acknowledge the need for higher levels of support (orange level) which sits outside of the Wellbeing Clinic early intervention scope. Schools have largely filled this gap themselves using independent counsellors who are not always linked into the offer or quality assured. A feasibility pilot of a Seedlings-style model for secondary schools would be encouraged to support this, along with the possibility of utilising MHST Senior Practitioners, alongside Link Workers in secondary schools.

Schools' data told us that 71% of schools (who completed the survey) have partially or fully embedded the Link Worker Consultation support into their school. 11% said that they haven't used it and 18% use it now and again. The service was rated good or excellent by 78% of schools with 11% suggesting it was helpful but could improve in a few areas. **Help to launch or promote the work in school was the most common suggested method of improvement, changing of staff was the main cause of dissatisfaction.**

Would like a more structured approach Link worker consultation started well with regular meetings, change of Link Worker led to this tailing off. (Secondary staff 2023 survey)

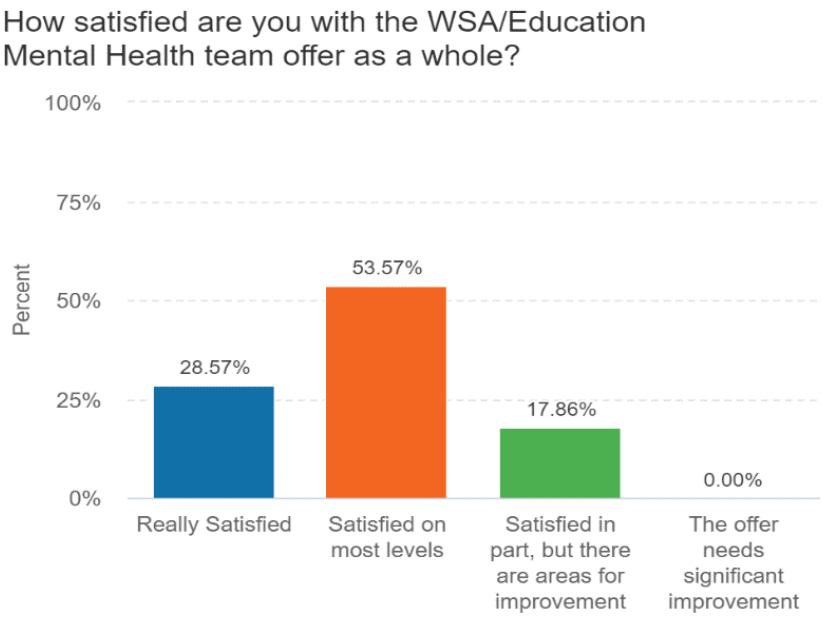
Our CAMHS Link Worker has recently changed. We have accessed some support already and lots has been offered. (Secondary staff 2023 survey)

Until recently the Link Worker role didn't include interventions within their pathway for support; they only offered clinical advice through consultations. From September 2023 this has been extended to include some group interventions along with psychoeducational groups. The efficacy of this

change would need to be evaluated outside the scope of this review. Link work capacity has been limited and at the time of review only 1 WTE was in post. In 23/24 this will be increased to 2 WTE posts consisting of 3 Senior Practitioners working across the 3-hub model. There is also potential for a step-up into red-level services from Link workers via the YPAS MDT meeting. This process is currently being refined and there is still some ambiguity around it. Suggestions were made during the review process that cases could in theory be stepped up directly to Senior MHST practitioners however this is seen as 'jumping the queue' to FRESH CAMHS via the school offer. The preferred route therefore is that cases requiring a higher level of support are taken to the YPAS MDT meeting and from there may be referred into FRESH CAMHS. Further clarity and communication of this process should be shared with EMHT staff, leadership, and schools as it has been clear from conversations and focus groups that there is differing understanding of how this pathway works.

Within the suggestions for improvement overall, schools highlighted needing more support as demand can be high. They also mentioned consistent service throughout the year - even when staff leave; and in-person training. 82% of schools are satisfied with the service in secondary schools (see figure 16).

Figure 16: Overall secondary school satisfaction of EMHT

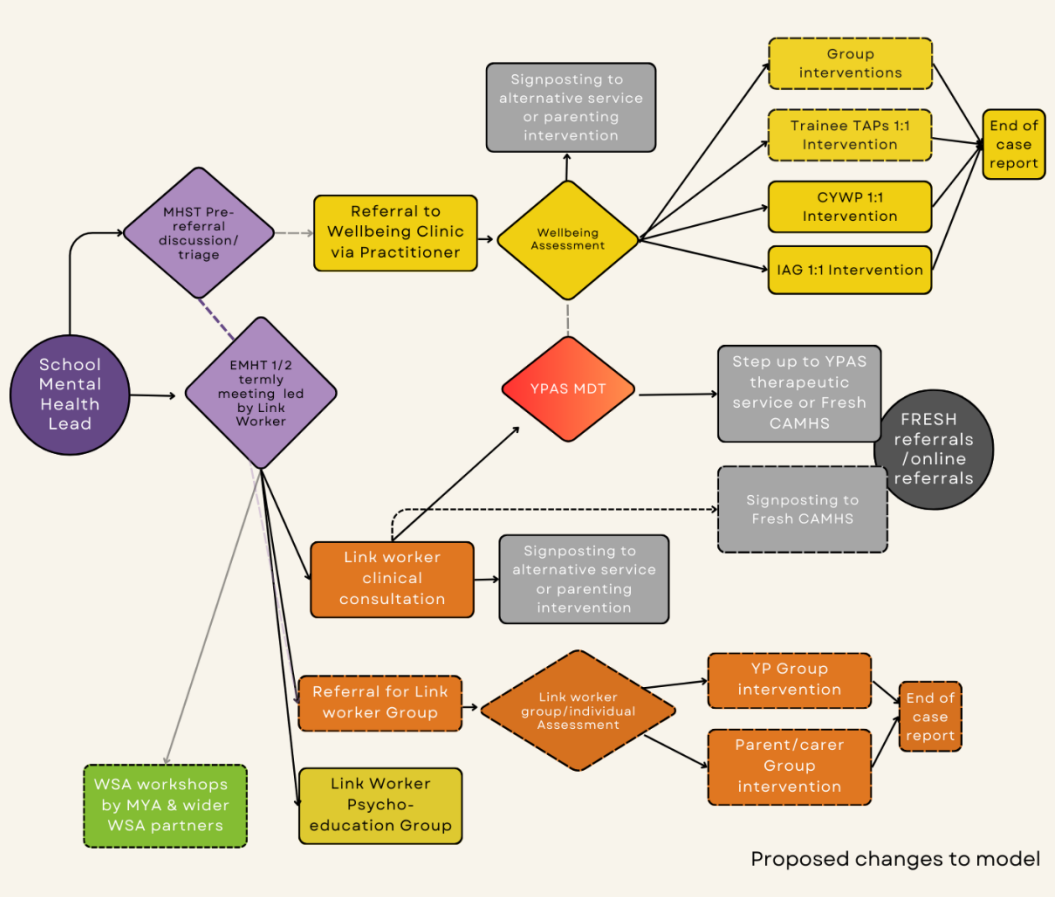


Within areas for improvement staff consistency and better communication of the offer to schools featured highly. Service understanding of school culture was also highlighted as an area for development. There was a feeling from some schools that services can support an 'excuse culture' in parents/carers and suggested that observations of children in school could provide a more balanced view. Waiting lists were raised by some schools along with the need for longer interventions in some cases.

"More capacity to enable us to support more students. Improve communication with all parties involved. Make the sessions longer term rather than short term over a 6-week period and have an exit strategy. What is the plan after these sessions over 6 weeks stop, what is the exit plan? Because the need doesn't stop". (Secondary staff 2023 survey)

Further emphasis on the Link Worker leading regular half-termly EMHT meetings (replacing existing school/link worker scheduled meetings) would help to support MHLs understanding of this offer and would further join the offer (see figure 17):

Figure 17: Suggested change to secondary pathway



Proposed changes also include the commissioning of schools facing mental health promotion and workshops for secondary schools and group interventions being offered via the Wellbeing Clinic.

Although the pathways are working well for many schools, there are still gaps in the knowledge of school staff regarding the pathways and offer from services. Schools often don't understand that the partnership services work together. Work has been done to further clarify and summarise the pathways for schools, but this would benefit from some animations and further promotional material. Another idea proposed in two of the focus groups was to provide annual workshops for schools to embed practitioners and remind schools of the offer. These were suggested to run during September as a start to the school year – perhaps in the style of a travelling roadshow. Parenting practitioners saw this fitting well with their roles. (Extract from Focus Groups' Summary, see Appendix iii)

PATHWAY LINKS TO THE WIDER CAMHS OFFER.

The main interface between the EMHT offer and wider CAMHS offer occurs via YPAS weekly Multidisciplinary Team (MDT) meetings. These offer opportunities for Seedlings and Wellbeing Clinic Practitioners to present any cases that they are not able to support through the interventions offered by these two services. This may be due to the case being unsuitable for their level of support or the case may benefit from the additional support that wider services can offer. Cases may be stepped up to FRESH CAMHS or YPAS therapeutic services or may be signposted for support elsewhere. Step-ups to FRESH CAMHS rarely happen via the MHST as they will usually see these cases using Senior Practitioners within their own team. Where cases require additional specialisms, such as support with eating disorders, or the issue is neurodevelopment, MHST practitioners would advise school MHLs to refer these children directly to the appropriate service.

Some concerns were raised about how joined up the pathways are to ensure that young people are gaining the correct support at the appropriate time. For example, if a YP was referred to EDYS and they deemed it not suitable for their service due to a mental health need such as anxiety, would they be referred on to EMHT? Cases may be bounced back to YPAS due to MHST being a school facing service. It was shared by GPs that when they have had referrals to EDYS declined, the referral has been sent back to them and not onto appropriate services. YPAS shared how the PCL can support these cases through the MDT process in the interim. (Extract from Focus Groups' Summary, see Appendix iii)

In 22/23 35 cases were presented to the YPAS MDT, 8 from the Wellbeing Clinic and 27 from Seedlings. Of these cases 4 (all Seedlings) were stepped up to Fresh routine appointments, 2 (1 Seedlings, 1 Wellbeing Clinic) were stepped up to FRESH urgent appointments, 1 (Seedlings) was stepped up to the LAC pathway and 3 (2 Wellbeing Clinic, 1 Seedlings) were stepped up to the YPAS 11-25 therapy pathway.

Pathway links to stepped-down cases from FRESH aren't prominent throughout the EMHT offer as it is school facing. Recent backlogs in Seedlings referrals to the community hubs has forced a re-structure

of their pathway to remove access other than via schools' Mental Health Leads. Wellbeing clinic cannot be accessed any other way than via a school Mental Health Lead. The MHST offers entry via the online digital platform (SPA triage) for cases referred that appear to meet the criteria for MHST. These are allocated to available practitioners across the service. Many of the cases coming into the service via this route have been deemed unsuitable for yellow-level EMHPs which has then meant they have needed to be allocated to one of the more senior practitioners. Given the limited capacity at this level, the equity of allocating and potentially prioritising this entry route must be considered in relation to capacity and demand of school facing services.

SUMMARY:

The process of mapping these offers has been a challenging one due to the wider variation of opinion amongst staff about what is being offered and how. Whilst this surely reflects the developing nature of the Education Mental Health Team, it is imperative that some of these anomalies are ironed out.

Whilst services do strive to work in partnership, commissioning arrangements, differing referral routes and time constraints make this difficult. EMHT termly meetings support this process where they are working effectively.

Based all the above, the following pathway recommendations are being made:

- **Further workshops by the strategic and operational EMHT leads to scrutinising the pathway map to ensure that services work more collaboratively throughout the journey of a CYP.**
    - **In an ideal world this would include a single referral route for all services with an MDT triage to allocate them onto the most suitable pathway.**
- **Consistent EMHT meetings to replace individual service meetings with school leads where possible to ensure a joined-up approach.**
- **Consistent green-level support to be enhanced across secondary schools.**
- **Service staffing changes to take place within set transfer windows rather than ad-hoc.**
- **Communication of the offer to be further developed both internally and externally.**
- **Data capture, extraction, analysis and quality assurance needs to be improved.**

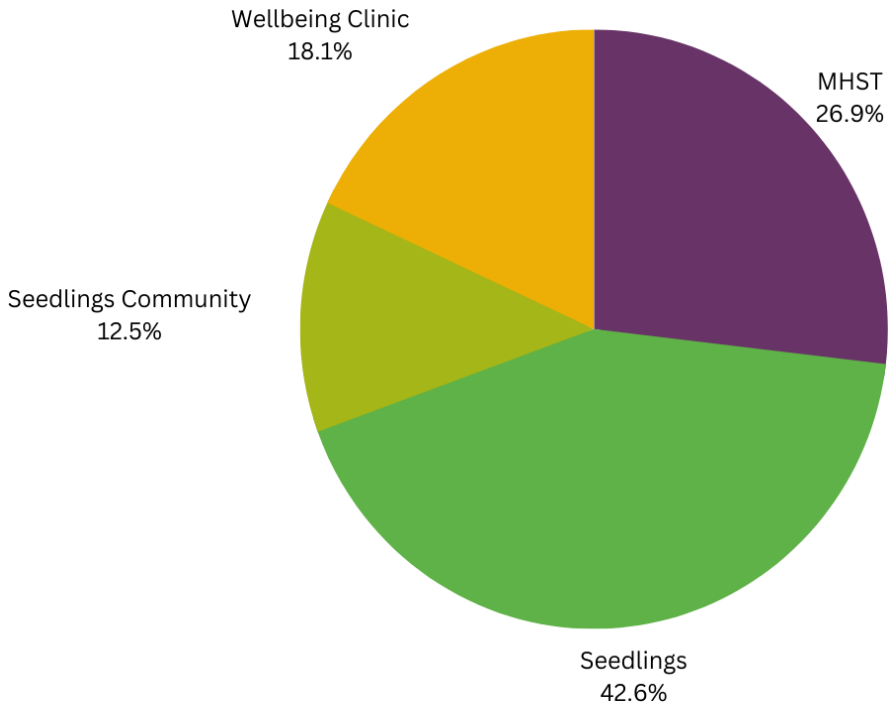
UNDERSTANDING THE DEMAND AND CAPACITY OF THE EMHT.

REFERRALS TO THE EMHT

This review utilises data gathered from the 22/23 financial year (April '22 – March '23). The analysis presented in this publication uses self-reported information from services and schools. The subsequent analysis relies on the quality of the data received, therefore the numbers presented here are our best estimates using the latest available data. It must be noted here that this review process revealed some data quality issues, particularly with the YPAS Wellbeing Clinic, whose figures initially were reported significantly lower than the final ones submitted. This issue is currently being addressed by YPAS leadership and should be resolved for the next data reporting period.

Throughout this 22/23 EMHT services combined provided clinical interventions for **3347** children and young people. This data is broken down across individual services as shown in figure 18.

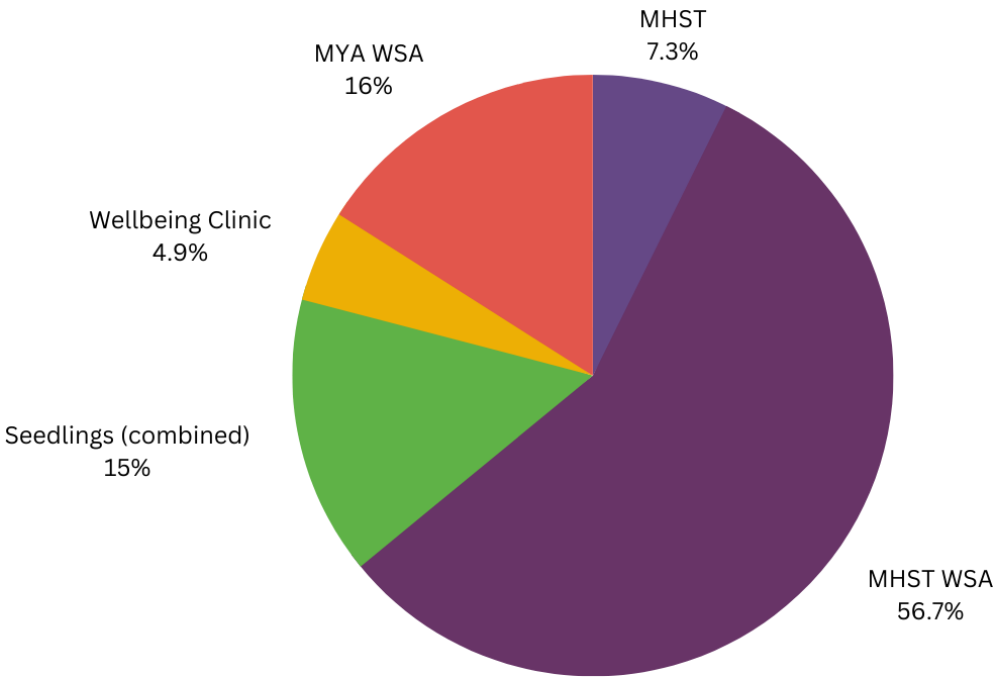
Figure 18: *CYP reached through referrals for clinical interventions during 22/23*



This figure accounts for 35.5% of the overall YPAS & Alder Hey CAMHS Partnership access figures (9,431) for this reporting period. When considered independently, the MHST access for 22/23 accounted for 9% of the overall CAMHS

Partnership access figures. This is less than the national average reported by NHSE who state that currently referrals to MHST account for 12% of CAMHS referrals. However, this doesn't take into consideration the amount of CYP supported through WSA activities that are not recorded on Iaptus referral system. In addition to clinical interventions, the MHST reached **6960** CYP with WSA activities and workshops. When added to the overall Liverpool CAMHS offer access figures this increases the MHST access rate to 46% of the overall CYP reached by Alder Hey and YPAS[40]*. In addition, **1165** CYP accessed ROCKET (resilience champions) workshops and **798** CYP took part in the Empower workshops – both delivered by MYA. When included in the EMHT figures the overall picture of support offered to CYP is as follows in figure 19.

Figure 19: CYP reached through referrals & WSA during 22/23.



This figure would further increase if other aspects of the Whole School Approach, including events delivered or coordinated by LLP, were considered. Through the WSA offer the EMHT collectively reached approximately **35,821** CYP through several livestream events hosted across the year. This included events for World Mental Health Day, Children's Mental Health Week, and the Transition Live events.

Given that WSA workshops are often only single session contacts whereas most of the therapeutic work operates on a 8+1 model, the distribution of work in terms of estimated contacts with CYP is shown in figure 20:

[40] *This would be reduced when factoring in all YPAS and Alder Hey contacts that do not get added to the referral system – this data was not available.

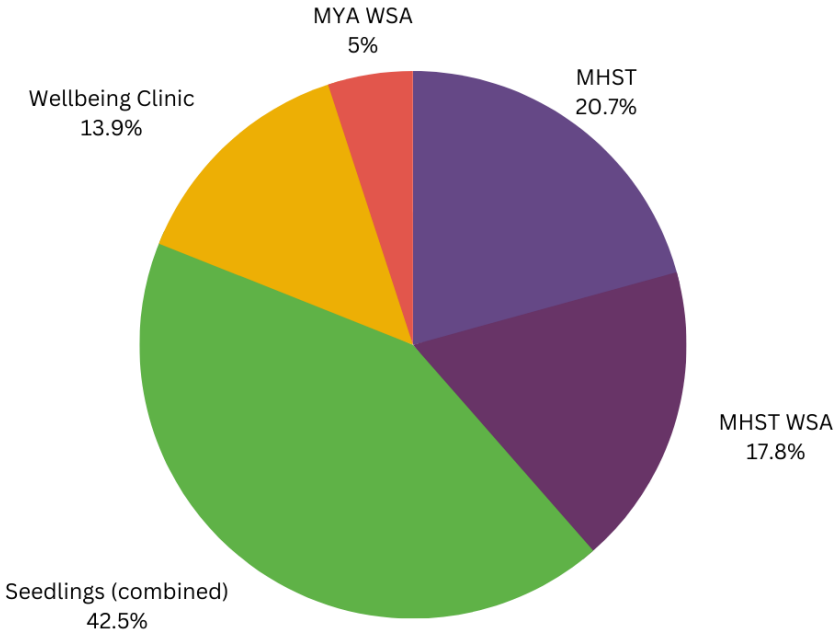
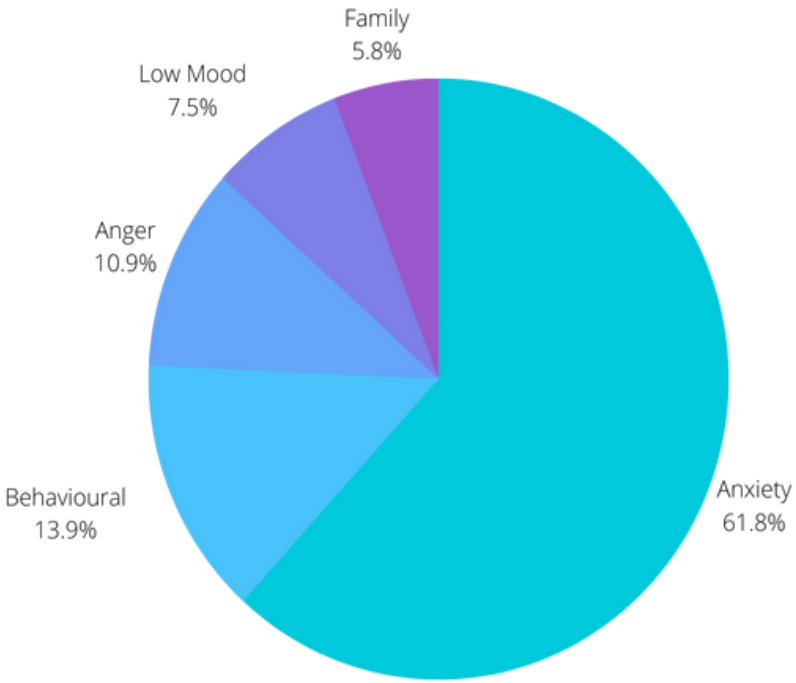


Figure 20: Schools'-facing work delivered by services broken down by estimated CYP contacts.[41]

PRESENTING ISSUES AND DATA DEMOGRAPHICS

The top presenting issue for referrals into the EMHT was anxiety (61.8%) with behaviour-based issues, anger, low-mood, and family concerns also appearing.

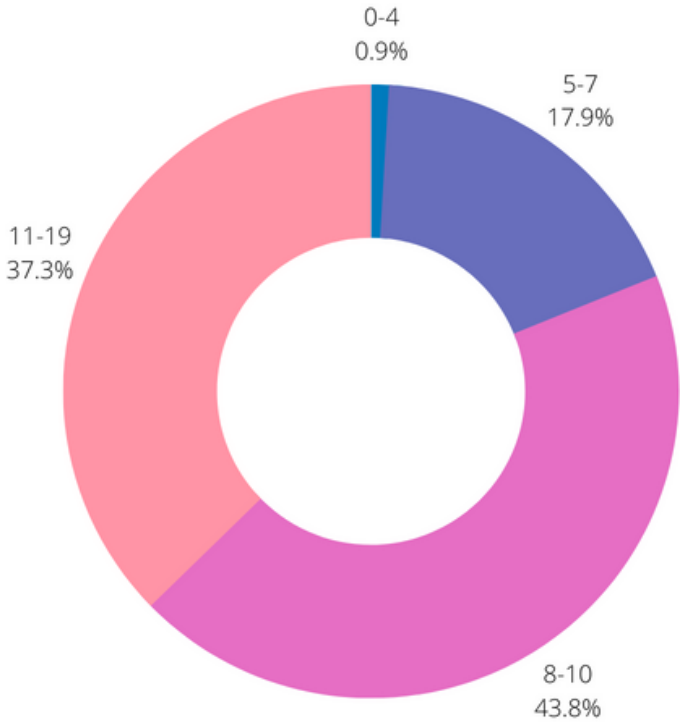
Figure 21: Top presenting issues for referrals into the EMHT



[41] Clinical intervention contacts have been calculated based on an average 8+1 model per CYP. True figures will vary slightly.

Based on data from CYP receiving a clinical intervention, most of the work was with children aged 8-10 years (see figure 22). This is not surprising given the positioning of MHSTs & Seedlings to support primary schools. 67% of clinical interventions went to primary school age pupils in the current EMHT structure. This figure will be higher when the possibility of 11-year-olds also being in primary school. These figures highlight the imbalance currently existing in the EMHT service delivery model between primary and secondary schools.

Figure 22: Breakdown of EMHT referrals in 22/23 by age.



In relation to other access demographics, more males were seen than females (52.8%). This figure aligns well with the local school population which in May 2023 was 50.7% male.

According to Oxwell 2023 figures on average 34% of Females were experiencing symptoms of anxiety and depression, as appose to 24% of Males. This could suggest that the EMHT needs to encourage more Females to use the service in future.

An average of 11% of CYP referred were from a non-White British ethnic group. This is below the national figures of CYP from other ethnically diverse backgrounds accessing CAMHS which currently sits at 17% with a further 6% not stated[42]. However locally the current school population percentage of CYP from ethnically diverse backgrounds is 31%. EMHT services are only reaching 1/3 of these CYP currently. Since compiling this review ethnicity school population figures have been added into the WSA master list that is used to compile key mental health contacts from schools and services. This has been done to raise awareness of the school culture population with practitioners. Further understanding of how these figures are split across the three locality hubs can be seen in figures 23 & 24.

[42] https://discovery.ucl.ac.uk/id/eprint/1476760/3/Wolpert_Ethnicity%20%20Access%20to%20CAMHS%20-%20REVISED%20FINAL.pdf

Figure 23: *Ethnicity breakdown for primary schools across the 3 EMHT locality hubs.*

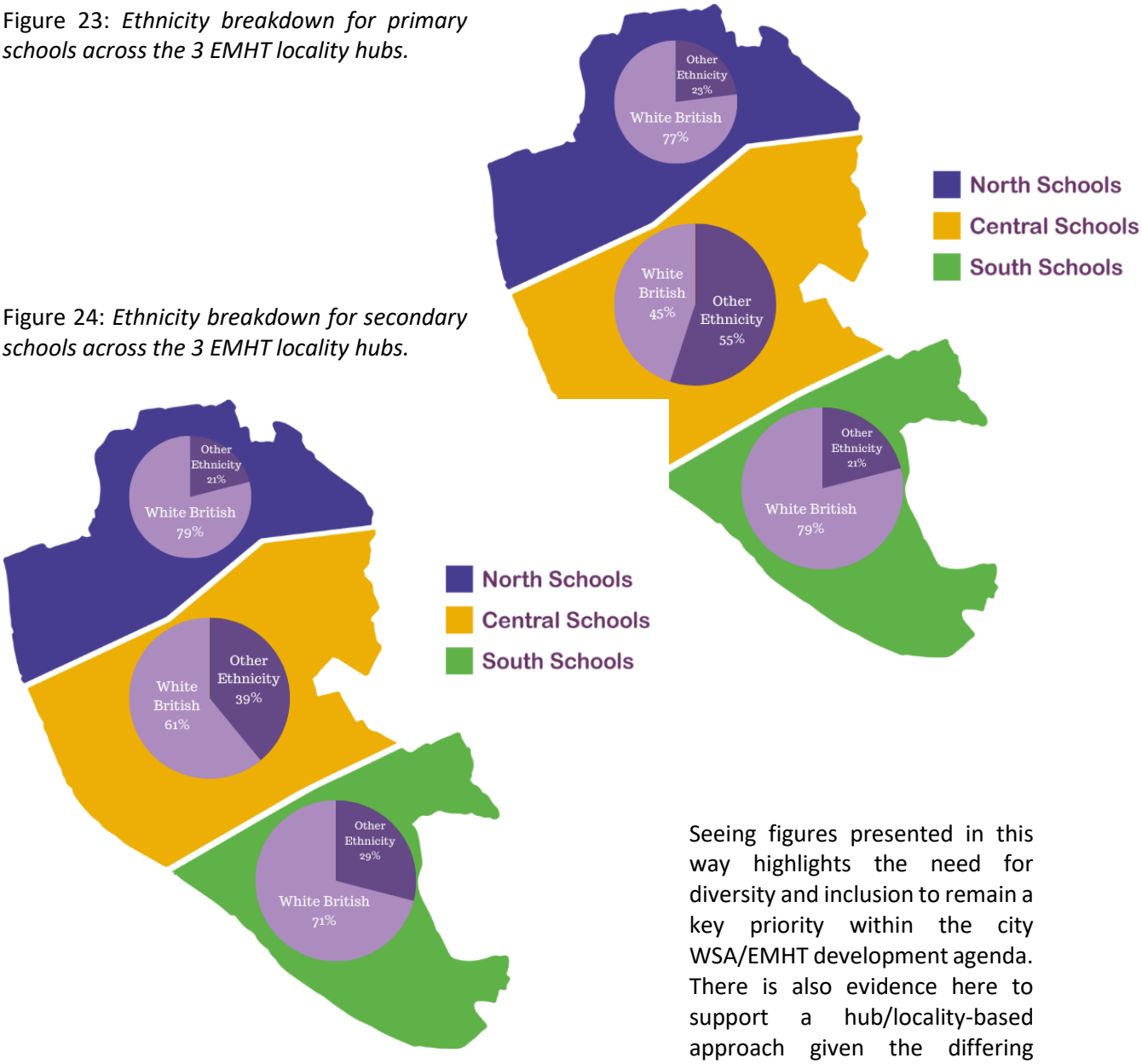


Figure 24: *Ethnicity breakdown for secondary schools across the 3 EMHT locality hubs.*

Seeing figures presented in this way highlights the need for diversity and inclusion to remain a key priority within the city WSA/EMHT development agenda. There is also evidence here to support a hub/locality-based approach given the differing needs of the three areas. Consideration of the differing needs of the three areas should be at the forefront of any future development discussions.

Whole School Approach activities provide great opportunities to reach a wider demographic and co-production/participation in these events from ethnically diverse groups support this. Services all have this on their development agendas and could further benefit from best practice sharing. MYA has developed ROAR Cultural to support professionals working with ethnically diverse demographics to better understand and engage with a wide range of people. This training requires specific commissioning to roll it out to schools and services in Liverpool.

UNIT COSTINGS PER ORGANISATION

Taking all activities into consideration the full EMHT offer (excluding MYA's school-facing offer which is not funded through ICB[43]) reached approximately 46,466[44] CYP in 22/23 across the levels of need offer. When valued against the overall cost of these combined school-facing provisions (£3,258,243[45]), the unit cost = £70.12 per CYP (Costing A). When WSA Livestream events are not considered within these figures (10,645 CYP seen), the unit cost is £306.08 per CYP (Costing B). Including MYA delivered workshops (1963 CYP) would further reduce costing B to £258.43 per CYP. If only clinical interventions are recorded the unit cost rises significantly to £973.48 per CYP (Costing C).

Based on 2023 projected ICB costings, the ICB cost of funding each service per CYP (not including Livestream figures) is estimated as follows:

MHST cost (£2,192,000) per CYP (7859) = £278.91[46]

Seedlings cost (£649,452) per CYP (1843) = £352.39[47]

Wellbeing clinic cost (£286,971) per CYP (602[48]) = £476.70[49]

According to national benchmarking figures from the children's commissioner, these figures sit above the average unit cost of delivering a course of six counselling or group CBT sessions (£229 per CYP) and below the average cost of referral to a community CAMHS service (£2338 per CYP)[50].

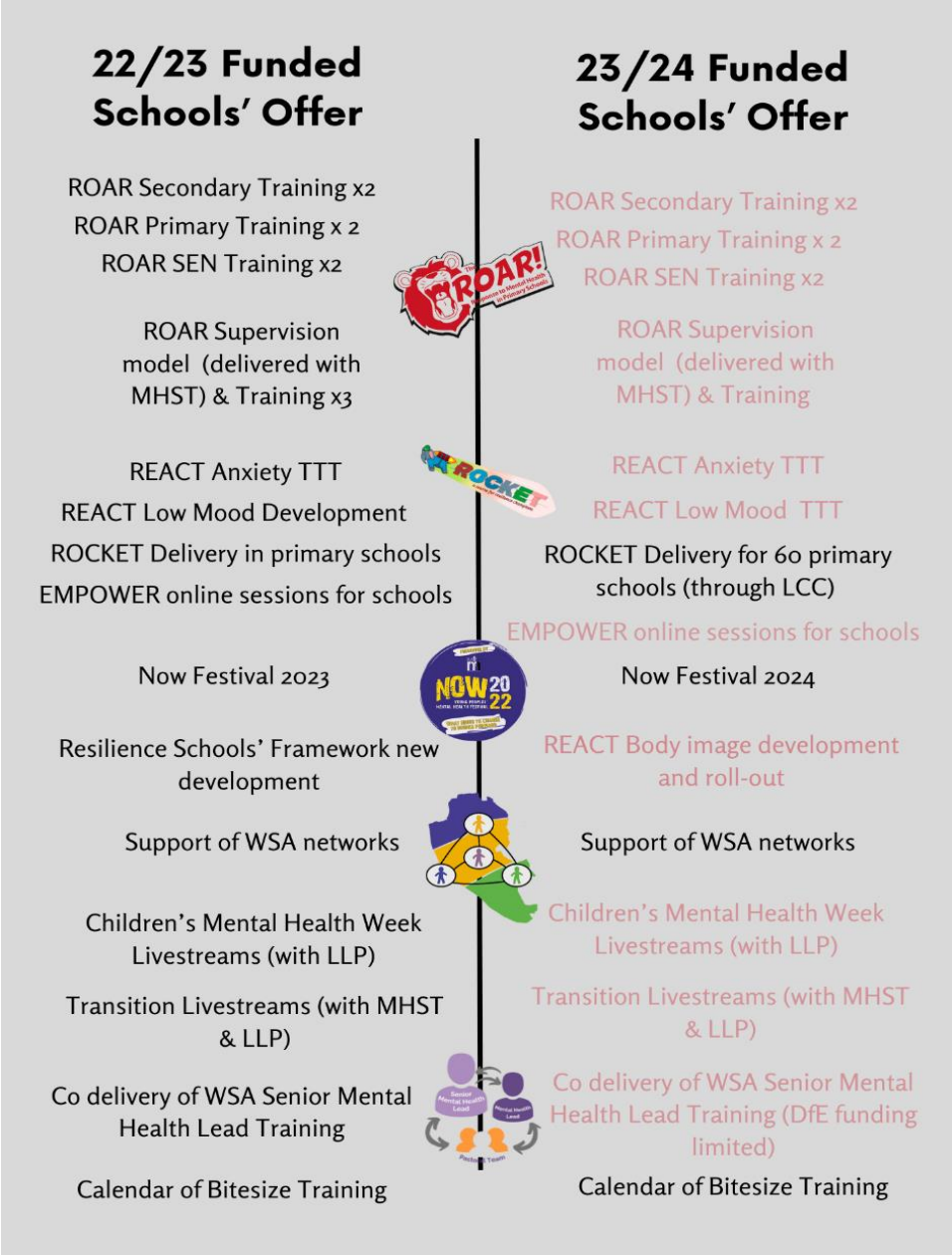
Whilst the MHST overall value per CYP is lower, it must be noted that inclusion of WSA figures greatly reduces the costing per pupil. Ongoing support from the MYA raise team has enabled the team to expand their delivery model to include REACT Anxiety (a short-term psychoeducation group). ROAR Supervision training and annual Livestream events into the data reported back to the national team. This has also been supported by the work of LLP. The development and delivery of REACT anxiety is a great example of a cross-partnership produced intervention. Developed by MYA and adapted with MHST Senior Practitioners and Clinical Leads, this is now being delivered by EMHPs across all primary

[43] 338 CYP involved in MYA's Now Festival are included in these figures as the ICB funds this.
[44] 3347 (clinical interventions) + 6960 (MHST WSA) + 35,821 (Livestream events) +338 (MYA Now Festival)
[45] £2,556,320 (Liverpool Place Funded) & £701,923 (HEE RTT & school contributions)
[46] This figure includes 899 CYP receiving clinical interventions and 6960 CYP being involved in MHST WSA workshops and activities, Without WSA activities the cost per CYP would rise significantly to £2446. Furthermore, the MHST offers varying levels of support from EMHPs to specialist practitioners. The unit cost will therefore vary depending on the support given.
[47] Cost to ICB (based on their contribution of £184, 500) = £100.10 per CYP
[48] Considerable under-reporting of referrals is believed have occurred. Considering estimated figures (1154) costing more likely to be £248.68 per CYP.
[49]Cost to ICB (based on their contribution of £50, 000) = £83.06 per CYP
[50] https://assets.childrenscommissioner.gov.uk/wpuploads/2019/02/childrens-mental-health-briefing-nov-2018.pdf

schools. The potential is there for a similar model within secondary schools working with the Wellbeing Clinic with the full REACT suite – including the development of REACT Body Image.

MYA supports schools as part of their wider MHP commissioned work, however funding for targeted school-based work has come from several sources since the 2018 WSA review. For the past two years LLP has been able to fund a large proportion of this work via Liverpool City Council Grants given for Covid-19 recovery. This funding has roughly worked out as a WTE member of staff. At the time of review funding for MYA's 22/23 targeted school-facing offer has not been identified – apart from 60 ROCKET courses being funded by LCC. The impact of this is illustrated in figure 25 with activities in red indicating no identified funding at the time of this review.

Figure 25: MYA 23/24 funded schools' offer comparison.

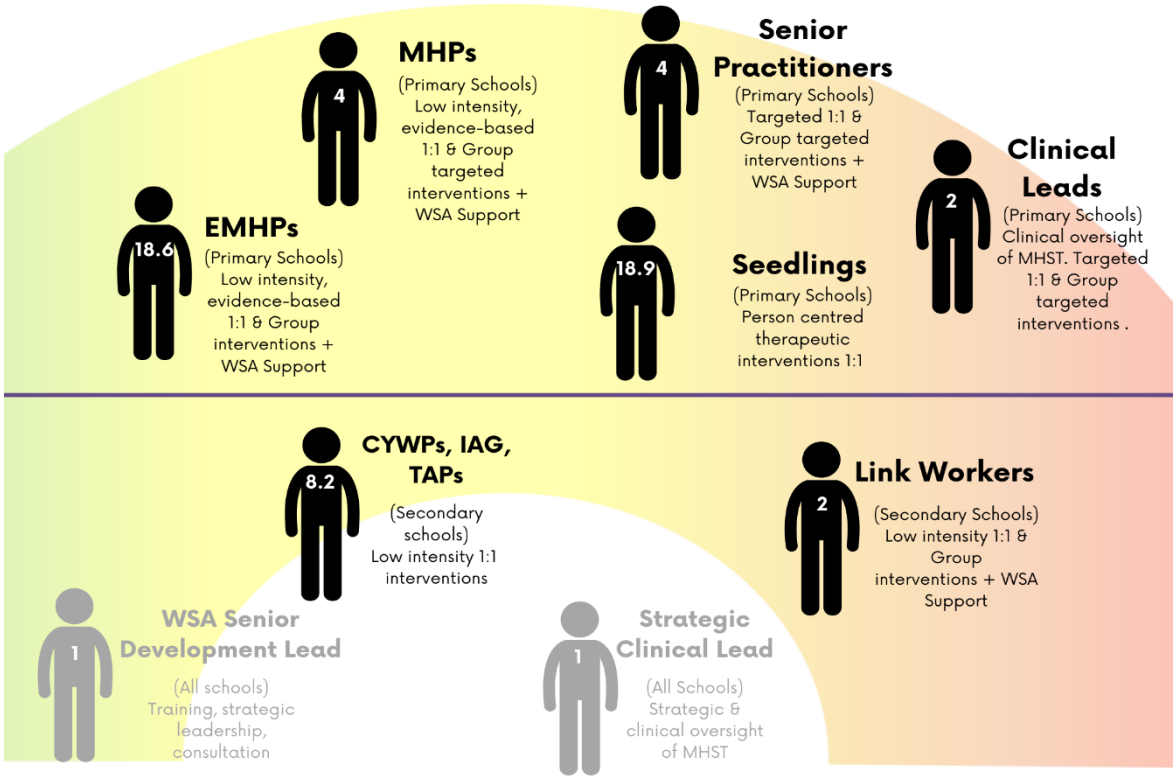


In 22/23 quantifiable contacts with CYP for this targeted schools' work was 1963 and 213 schools staff attended ROAR training (including WSA SMHL training). Based on the £30,000 grant given to MYA for this work in 22/23, this works out at an average costing of £15 per CYP. This doesn't include the estimated 35,921 CYP reach through the Livestreams that MYA supported delivery of. When considered against the overall unit cost per CYP for the full EMHT programme (inclusive of MYA's offer) this spending of £15 per CYP would result in an overall saving of £47.65 per CYP (see costing B).

CAPACITY

Trying to understand and summarise staff capacity across the EMHT was challenging due to the wide variation of how staff are being utilised across services – particularly in relation to RTT posts and split roles. In June 2023 (when a dip sample was taken), the combined EMHT reported having 56.7 WTE across all teams including 8 WTE vacancies within the MHST making a total capacity of 46.3 WTE school-facing staff all able to deliver therapeutic interventions along with WSA activities delivered by MHST practitioners (see figures 26 & 27).

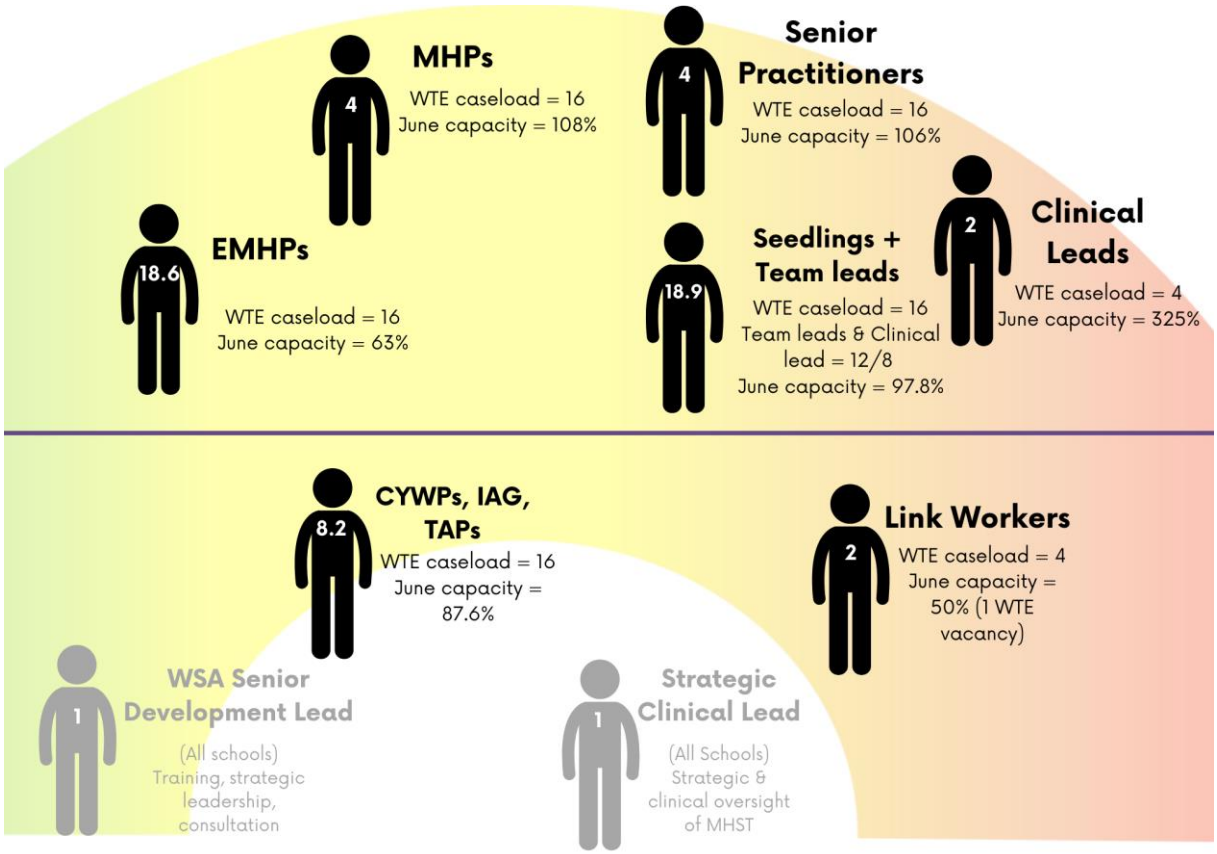
Figure 26: EMHT Staffing Map June 2023. Staff sitting above the line are primary schools and below are based in secondary schools. Faded figures work across both, but don't offer clinical interventions.



Fifteen of YPAS' school facing staff are value added by YPAS' Recruit to Train and are at risk due to non-recurrent funding. Some of these positions only have a further six months funding at the time of writing. Most of these positions are from the secondary school provision. Furthermore almost 60% of the Seedlings staff are funded through school commissioning which is subject to changing school budgets.

According to capacity figures provided by services, the EMHT at full capacity in June could see 688.8 CYP. Caseload figures supplied by services in June 2023 showed that the EMHT was supporting 596 CYP at the time of this review. Based on these figures the EMHT was operating at 87% capacity (see breakdown on figure 27).

Figure 27: EMHT Staffing Map showing June caseload capacity.



Within the MHST senior practitioners and clinical leads were operating at or above capacity, whereas EMHPs were operating at 63% capacity. Several factors have contributed to this including, staff sickness, low referrals from schools, lack of suitable cases for trainees and being between cases at the

time this sample was taken. June was also when the Transition Livestream sessions took place along with transition workshops, therefore EMHPs capacity for individual interventions may have been reduced. Seedlings therapists were operating at just above capacity (107%). They too had staff sickness but managed to cover this from other staff within YPAS. The Wellbeing clinics were operating at variable capacity with the average across the whole team being 87.6% capacity. This may be due to DNA's as mentioned earlier in the report. There are also potential issues with under-reporting that are being investigated.

The complexity evident when gathering this data highlighted the way services, particularly YPAS, have had to move staff around to continue to fund this offer. It was also testament to the partnership working that has enabled this to happen. Consistent and dedicated funding for this work is needed to support this offer moving forward. Furthermore, a dedicated data resource is needed to ensure data flowing is accurate and consistent. Pulling together the shared KPI spreadsheet has highlighted inconsistencies within the data being pulled through Iaptus and that being held by service providers.

DEMAND

A demand exercise carried out during this review was completed with 30 Secondary schools and 60 primary schools taking part. Schools were asked, in addition to the CYP being seen currently by services, how many more were waiting for support. Responses varied between schools with some stating that 30+ were waiting and others 1 or 2. When averaged out[51], this data indicated that the average demand per school (in addition to current provision) were 3 additional places for the MHST, 5 additional places for Seedlings and 9 additional places for the Wellbeing Clinics. When added to existing capacity and multiplied by the numbers of schools, figures were as follows:

Overall CYP needing support at yellow/orange level in Liverpool primary schools during June in 2023 = **1440 CYP[52]**

Overall CYP needing support at yellow level in Liverpool secondary schools during June 2023 = 14 CYP per school X 31 = **434 CYP[53]**

Combined these figures suggest that in June 2023, 1874 CYP across Liverpool schools needed yellow or orange level support. This figure is representative of 2.4% of the school aged population. Based on the 596 CYP being seen by the EMHT in June 2023, these figures would suggest that the EMHT **was only meeting 32% of the perceived demand from schools**.

[51] Numbers were added and divided across the schools taking part. Answers of 30+ were capped at 30 so true figures may be higher.
[52] Based on 2 existing MHST places, 2 existing Seedlings places and the 8 additional places needed per school based on the demand exercise.
[53] Based on 5 existing Wellbeing Clinic places and the 9 additional places needed per school based on the demand exercise.

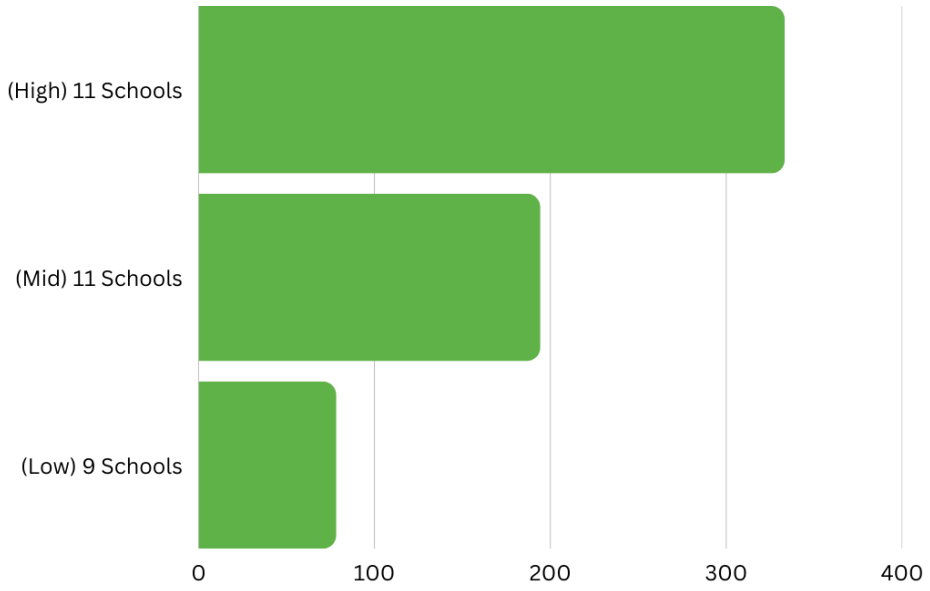
However, when considered against other known measures of need, this figure could be even higher. Nationally 1 in 6 or 17% of CYP are believed to have a diagnosable mental health condition according to NHS digital. For Liverpool's estimated school population (77,070 CYP) that would amount to approximately 12848 children and young people in Liverpool schools which is considerably higher than the estimated demand needs from school Mental Health Leads. Furthermore Oxwell 2023 figures indicate that on average 37% of secondary pupils report as having diagnosable symptoms of anxiety or depression. These combined figures suggest that the EMHT offer at present isn't scratching the surface of the need that is out there when it comes to clinical 1:1 intervention. These figures don't consider the wider community offer that is accessible to all school pupils, and further inclusion of these figures should be explored outside the scope of this review. The creative use of groups, workshops and livestream events can make it possible to the numbers indicated here, but evidence is not available surrounding the efficacy of such things. Liverpool is positioned well with its WSA and city-wide support of the Oxwell survey, to begin to test and establish evidence bases for this type of work in schools. This would be a welcomed response to the findings of this report.

OXWELL AND SCHOOL REFERRAL DATA FINDINGS

SCHOOL REFERRAL DATA - SECONDARY

Activity across all aspects of the EMHT offer varies significantly across secondary schools. In 22/23 the secondary school making the most referrals into the wellbeing clinic referred 50 pupils, whereas the lowest referring schools only referred 4. When grouped according to high (21-50), mid (14-20) and low (0-13) numbers of referrals this variation can be seen in figure 28.

Figure 28: Referrals to Wellbeing Clinics 22/23 grouped according to numbers of referrals.



100% of schools with high levels of referrals had a trained Senior Mental Health Lead (SMHL) – 57% of these were Liverpool trained. 89% of the lowest referrers had a trained SMHL with 50% of these being Liverpool trained. Therefore, there is not an obvious link between SMHL training and schools making referrals. However, the two lowest referring schools were also the two schools that had the highest number of YP needing support for anxiety and depression according to the 2023 Oxwell survey*[54]. Both schools also had high numbers of YP who found it difficult to access mental health support at school. These schools were listed as having low engagement in WSA activities and mid-low engagement with Link Workers.

SMHL training appears to support pupils knowing where to go to get support in schools. 100% of schools where 50% or above of pupils knew where to get support[55] had a Liverpool trained SMHL. All these schools also had good levels of WSA engagement. 29% of these schools had low levels (15% or less) saying it was difficult or quite difficult to get MH support in school. 43% had mid-levels and 28% had high levels. Therefore, it seems that pupils knowing where to go for support doesn't necessarily mean that they find it easy to do so. Further unpicking of this through pupil participation events revealed that this was often due to lack of availability of staff. Pupils also spoke about the fears they had of things being passed on, escalated, or getting back to parents/carers.

[54] * Only 17 secondary schools took part in the 2023 Oxwell survey so these figures are only representative of the whole picture.

[55] Oxwell 2023

One of the least engaged schools when it came to WSA also showed the highest overall levels of wellbeing and lowest symptoms of poor mental health. They were also a school that were utilising the Wellbeing Clinic offer well. Interestingly they scored lower on pupils knowing where to go for support in school which could also indicate lower levels of overall mental health awareness or even a stigma around this area. It would be interesting to explore further with this school to find out why their pupils had higher perceived levels of wellbeing. It may be that they have something in place that would benefit other schools that are currently not connected into the Liverpool WSA offer.

Overall, within the secondary schools there is a varied approach to engagement with the EMHT offer. 36% of secondary schools have a high-level of engagement with the WSA offer, 29% have a mid-level rate of engagement, 32% a low engagement rate and 3% have no engagement (1 school). The school with no WSA engagement hasn't completed any SMHL training. Feedback from the focus groups highlighted the important role that schools play, particularly their Senior Mental Health Lead, in accessing and getting the most out of the offer. Of the schools with low WSA engagement 33 % had completed the Liverpool WSA SMHL training (although 2 of these 3 are no longer in post), 56% had completed other SMHL training and 11% had not completed any training. Of the highly engaged WSA schools, 45% are also on the HEARTS programme and 64% took part in the 2023 Oxwell survey. The focus groups suggested that where more aspects of the offer are implemented and in place, the EMHT pathways work better.

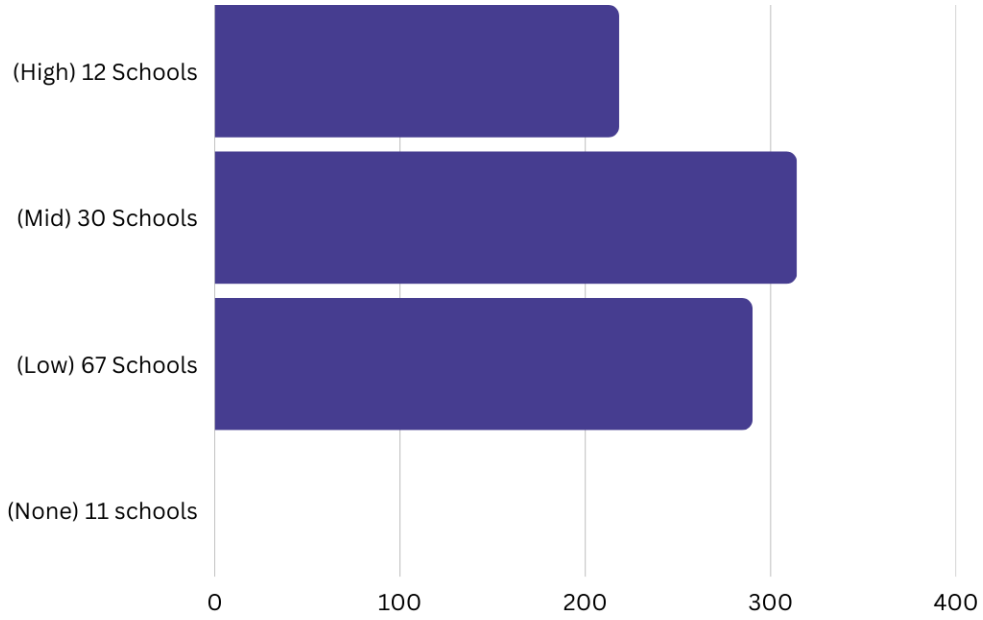
> *Feedback from the focus group suggested that the model works best in schools where more elements are implemented. For example, schools who have accessed Senior Mental Health Lead training, implemented ROAR & ROCKET and are working with MHST and Seedlings. (Extract from Focus Group Thematic Analysis)*

Ongoing engagement with the Liverpool training offer is recommended for schools to be aware of and able to fully utilise the EMHT offer. Furthermore, the work of Link Workers & MHST staff is vital in helping school MHLs to develop and embed the WSA training into the fabric of every individual school community.

School Referral Data Primary

In primary schools, numbers of referrals varied across schools. Schools have the option of 2 open cases at any one time, plus they can prioritise WSA workshops instead of clinical interventions within their allocated practitioner slots. The highest referring school made 33 referrals and the lowest made 0 referrals. In 22/23, 11 primary schools didn't refer any children to the MHST, although 4 of these schools did have mid-high usage of their WSA offer. School referrals can be seen grouped in figure 29.

Figure 29: *Referrals to MHST 22/23 grouped according to numbers of referrals.*



This highlights that many referrals to this service are coming from 42 schools which is only 35% of the 120 schools across Liverpool. Factors affecting this include staffing gaps within the service and schools not having consistently available SMHLs/MHLs in place to identify referrals into the service. Schools having space to hold sessions was also cited as a barrier.

> *Whilst many school Mental Health Leads are doing a great job some are difficult to get hold of and appear to not have time to carry out this role. This can make it difficult for services to contact them to arrange appointments which then makes access for young people difficult. Similarly, some schools don't have space available for services to come and see young people or their spaces are not suitable for therapeutic work. This can cause difficulties with scheduling appointments and can subsequently limit access. Frequent staffing changes in the schools have also challenged Mental Health Lead engagement. (Extract from Focus Group Thematic Analysis)*

Due to several staff leaving the MHST and delays in recruitment, several schools were left without a designated EMHP during 22/23. Referral data (at a school level) is not available for Seedlings at the time of this review, but all 95 schools who commission Seedlings were reporting to have fully utilised practitioner slots throughout the year.

When considered against the Oxwell data, 92% of the schools making the highest number of referrals also had a trained SMHL. The same percentage of these schools also commissioned Seedlings. Of the schools making no referrals to the service 82% had a trained SMHL, but only 2 out of the 11 had

received the Liverpool training. 87.5% of schools with the highest number of pupils (70% and above) who knew where to go in school for support had a trained SMHL in place. Overall, Oxwell data showed that primary school pupils were more informed about where to go for support than their secondary peers. The four schools that showed pupils with the highest level of depression/anxiety symptoms all had low levels of MHST referral engagement. They also had higher levels of YP saying it was difficult to get support. Two of these schools have a Liverpool trained SMHL, one has an externally trained SMHL and one didn't have a trained SMHL. However, in the two schools with a Liverpool trained SMHL there had been a break in MHST service due to staff absence which may have accounted for a lack of referrals in these schools. Out of the five schools whose pupils indicated lower levels of positive outlook and emotions, four schools had mid-high levels of WSA engagement, whereas one had low. Whilst there was no clear link between WSA engagement and wellbeing, four out of the five schools had low numbers of MHST referrals. Some of the interventions and workshops offered by the MHST would be ideal to target support for these pupils, therefore barriers to engagement with this service should be further unpicked to ensure access to this support.

Some of these barriers including schools' understanding of pathways and better understanding of neurodiversity in the context of mental health were cited during the focus groups.

> *There is an inequality in schools understanding the pathways, due to every school being individual this is hard to troubleshoot. Things such as network meetings, spotting the sign, one route to access MHST, have been put in place to improve the knowledge of schools regarding the pathways. To develop further, work can be done collaboratively. There needs to be more education for schools around mental health and neurodiversity as teams are frequently getting inappropriate referrals linked to ND. The triage meeting makes this better along with monthly EMHT meetings. However further training is needed to educate teachers about what is appropriate. (Extract from Focus Group Thematic Analysis)*

SUMMARY OF KEY FINDINGS

GENERAL THEMES

After consideration of both qualitative and quantitative data gathered from the variety of sources indicated in the methodology section of this report, several overall themes/findings have emerged.

1. DATA COLLECTION, QA AND DATA ANALYSIS NEEDS MORE FOCUS AND INVESTMENT

A Key finding of this review was that current data capture systems and processes are not adequate. Throughout the process of this review data collection and analysis has proven difficult due to variations in the data being reported – in one case three different sets of data were supplied for 22/23. Questions have been raised about data entry and extraction from Iaptus – an investigation into this is ongoing. Services need to feel confident in the data being collected and have the assurance that it is a true reflection of the work being delivered into schools. These inaccuracies have made this review process especially challenging. The breadth of this offer and the ever-changing requirements from national MHST reporting require a specialist in this field to lead and facilitate this area. This role would be welcomed across the partnership offer to uniform and streamline data collection for all EMHT services.

2. COMMISSIONING OF EMHT COULD BE CLEARER ABOUT HOW THEY SHOULD WORK TOGETHER – PARTICULARLY AROUND THE ROLE OF SERVICE SENIOR LEADS.

It is unclear how EMHT services are commissioned to work together. Partnership approaches are evident in leadership and staff practice but can at times lack substance and direction. The role of the WSA Senior Development Lead is key to supporting this approach. However, given their lack of operational management responsibility within these services, more clarity around this is needed. This role would benefit from the support of a senior cross-partnership clinical lead (as suggested in the 2019 proposed model), cross-partnership dedicated EMHT data specialist and even an additional WSA development worker. Some of these roles could sit within individual services but there would need to be formal terms of reference in place to govern this proposed team. Cross partnership meetings have been difficult to coordinate at times with key services missing around the table. Face to face meetings have not been possible. Whilst each of the strategic leads are 100% dedicated towards this partnership approach, service leads often have multiple roles and aren't always able to give the time needed for an EMHT senior leadership team. This would need to either be considered into existing staff job plans, or additional roles need to be developed to support this moving forward.

3. There is an Imbalance between primary and secondary offers

Liverpool WSA Partnership's decision to invest the full MHST offer into primary schools was based on the understanding that secondary schools already had a substantial offer in place. Whilst the service offered by YPAS Wellbeing Clinics has been consistently delivered to a good standard, evident in their rapport with schools, the funding of it has not been sufficient. There are gaps within the model at both the green and orange level of need. Partnership efforts have been made to support these areas, but they are inconsistent across all schools. Consistent commissioning of green-level WSA/Mental Health Promotion activities is required to support this offer to the level seen in primary schools. Some of this should include the development and distribution of resources by MYA, as seen with the REACT anxiety programme.

To continue to operate the Wellbeing Clinic model would require total funding of £325,220.00. This would cover 8.2 WTE wellbeing practitioners and the addition of a clinical lead at coordinator level (£38, 249) to mirror that seen in Seedlings and the MSHT. A feasibility pilot of a Seedlings-style model for secondary schools would be encouraged to further support this offer, along with the possibility of utilising MHST Senior Practitioners, alongside Link Workers in secondary schools.

This gap could also be supported by successful bids to gain additional MHSTs. These could be built into the existing Alder Hey model or could be fully embedded into YPAS – perhaps with clinical oversight from the strategic lead. There would be benefits and challenges to both approaches. When this model was first implemented it was understood that teams had to be based in NHS trusts. However, there are several MHST sites where they are fully based in Third Sector Organisations.

4. School mental health leads are key to making the offer work

The role of the SMHL is key to accessing and embedding the EMHT offer into schools. It is evident in schools that do value and resource this role, that access to the EMHT is increased and sustained. There is also evidence that in these schools Mental Health Leads have grown and developed professionally themselves through the support, training, and regular go-working with mental health professionals. Secondary schools appear to invest more into this role than primary schools, although there are examples of best practice in both. Not having a trained SMHL in place is a common factor in schools where pupils don't know how to access support for their mental health and wellbeing. While many schools have accessed DfE funded training, not all have accessed the locally developed one. This should continue to be promoted to schools. Whilst on the whole schools feel that the services are meeting their needs, there are some areas that appear slightly out of touch with school culture. Co-development of training and WSA activities with schools is evident especially in the development of Livestream events and other projects. However, service staff (particularly MYA & LLP) could benefit from shadowing school MHLs to gain a greater understanding of what is needed to support them further.

5. Partnership working is making a difference

There is much evidence of partnership working across the offer. Continued funding and evolution of the WSA Development Lead has played a central role in bringing this all together. The reach of this role could increase if further investment was made, and a team formed to extend this work. Specific projects, resource creation and events to celebrate key events have been instrumental in bringing services together and cultivating a partnership mindset. Each of the service offers have a cumulative impact in schools and best practice is seen where all aspects of the offer are present. One of the most effective areas of good practice seems to be the EMHT termly meetings. When implemented, these bring services and schools' mental health staff together to plan a coordinated offer into the school.

6. The offer is not being fully utilised

Although this offer is available to all mainstream Liverpool schools, there is significant variation in how schools make use of it. Based on combined figures of primary and secondary referrals (pages 61 & 63), 15% of schools are using 39% of the available resources[56]. There are several contributing factors to this, some school generated, and some service generated. The main contributing factor in schools is a lack of available MHLs to make referrals and to facilitate appointments. The first of these is more applicable in primary schools and the latter secondary. Services suggested that a standardised process model for external services being utilised in schools would be a welcomed development. Further training for Senior Mental Health Leads and better resourcing of this role in some schools would also support this area. Contributing factors from services include staff sickness and retention, staffing structure changes and, particularly within the MHST, referral processes that require administrative time. However, experienced/embedded MHLs have reported at network meetings about the long-term benefits of this extra administration when it comes to taking time to gather a full assessment of a child. Further sharing of this best practice can support this issue. Staffing changes have been an unavoidable element within the developing MHST and Wellbeing Clinics due to both services' reliance on trainees. Having an agreed transfer window may be one way of managing this moving forward.

7. The service is continually growing and diversifying.

These are services that respond to need and listen to what schools are telling them. Whilst change can bring with it frustration and uncertainty, it also brings opportunities for growth. All EMHT services have grown and developed over the past few years. Often this growth has factored in the voice of schools by responding to the key issues they are feeding back. This is seen though MYA's

[56] * This figure does not include Seedlings referrals and is based on 23 schools making 551 of the overall 1424 CYP seen by the MHST and Wellbeing clinics in 22/23.

changing menu of training; MHSTs expanding menu of evidence-based interventions; Link Workers' expanding roles; Seedlings' accommodation of changing school SLAs; and Wellbeing Clinics' creative use of their wider staff team to continue to offer needed interventions into schools. Sometimes funding, staffing capacity or lack of sufficient evidence-base, can hamper this growth, which has led to some schools not feeling that all their presenting needs are being met. This is particularly applicable to orange-level need in secondary schools. In the case of MYA, lack of continued funding has meant that some needed resources (reflected in needs analysis reports and Oxwell survey) are currently not in circulation due to staff capacity. As needs diversify, funding must also be sourced to meet these needs.

8. The offer isn't equitable to all CYP

Although the offer is available to all schools, not every school receives the same offer. Several factors have been identified as to why this is the case. Firstly, not every school is fully accessing or utilising the offer. As previously identified reasons for this can be both internal (lack of MHLs, reluctance to take a WSA) or external (service staffing issues, admin heavy access processes). Secondly schools vary in size meaning larger schools must spread the same resource further. MHSTs have addressed this in part by allowing practitioners to take extra cases across their area if their own school caseloads are not being fully utilised. This doesn't currently happen in the Wellbeing Clinic model. School size and other socio-economic factors impacts their available budget. Some schools can afford additional counsellors, Seedlings, and other resources to boost their WSA, whilst others cannot. One of the strengths of the Liverpool WSA is the vast amount of fully funded training and resources available to support schools. However, if schools can't afford the personnel to explore these things within their job role, these resources can be of limited benefit. Finally, the importance of individual practitioners must be recognised here. Qualified status, skill levels, skill types and general work ethic varies across individual staff practitioners. This has been evident thanks to the comprehensive WSA data collected by the MHST, and in consideration of the variety of staffing used in the Wellbeing Clinics. Within the MHST, the evidence-based offer is consistent across all staff, although the volume of cases seen and range of WSA work varies. Within the current Wellbeing Clinic staff there are a variety of different training and approaches being used. Therefore, while one school will be getting a similar evidence-based approach as the MHST, others get IAG works (Information Advice and Guidance) and others get Trainee Associate Psychological Practitioners (TAPPs). The efficacy of these approaches is not considered within the scope of this study, but the variance could indicate a lack of equity. YPAS do advocate for different approaches being needed by schools and a one-size fits all approach does not fit with the data variation seen through Oxwell survey and WSA intelligence from the local datasets. Different cultural and socio-economic needs are seen across the three hub localities, and these should inform a more flexible model to develop in response to them. Further exploration around this would be a useful next step from this review.

9. Special schools and AEP need further consideration

Although special schools and AEP have not been considered within the scope of this review, the focus groups and school needs analysis surveys do highlight the needs of CYP attending these educational provisions. There are pockets of practice happening throughout the EMHT offer. These include support provided by YPAS Wellbeing Clinic using their Youth Offending Team, and newly agreed support from the Link Workers into three AEPs. Alder Hey offers a consultation offer for Special Schools as part of the Learning and Disability pathway, but this has not been considered as part of this review as they do not currently offer therapeutic interventions. Consideration needs to be given as to where support should be targeted for CYP with additional needs. Other MHST sites have extended or even targeted their offer to support children in special schools, adapting the same interventions to suit their needs. With the EMHT and wider service offer staff have been trained in Postgraduate Certificate in Specialist Clinical Practice -Learning Disabilities and Autism Improving Access to Psychological Therapies (CYP IAPT)[57]. There is potential, with additional funding, to utilise some of these staff across the EMHT offer to adapt and extend the offer to special schools.

10. Better communication of the offer is needed both internally and externally.

Issues with communication were raised across several aspects of this review. The evolving nature of both services and schools means that it can't be assumed that people know what the offer is. Senior Mental Health Lead training, promotion through Bitesize courses and embedding by practitioners can help to support this in schools. Having a singular approach to working with schools would support service practitioners when delivering into multiple school communities. There are best practice examples operating in some schools that could be used to model this. The development of the new WSA Mental Health Lead Hub (launched in October 2023)[58] will support both schools and services as a reminder of what is available. Several cross-partnership working groups exist where information around service delivery is shared. However, this information is not always being shared back with teams. The WSA Senior Development Lead can play a further role in supporting this by contribution to service inductions and regular attendance at service team meetings.

11. Funding is not balanced across the offer.

Much of the EMHT funding sits within the MHSTs which are predominantly primary school based. Much of the funding is targeted at early intervention with only the Seedlings offer and step up through the MHST sitting at orange level. Secondary schools only have the Link Worker provision at orange level who only recently have been offering any interventions. There is no consistent funding

[57] https://www.gmmh.nhs.uk/cyp-postgraduate-certificate---learning-disability-autism-pathway/

[58] https://liverpoolwsadirectory.co.uk/

of MYA's mental health promotion despite their cost per unit value for money and ability to effectively scale-up resources for maximum access.

12. SERVICES NEED FURTHER INVESTMENT TO ADEQUATELY MEET DEMAND.

All available datasets show that demand in schools for yellow/orange support is higher than the available support from the EMHT. Even with teams operating at full capacity further support is needed. Based on national MHST roll out figures, 10 fully staffed teams are needed to cover all mainstream schools. However, when Oxwell and national data are considered, this need could be higher. Demand figures from the June schools' survey suggest that MHST support in primary schools needs to at least double with the demand for Seedlings being even higher. Secondary schools reported needing almost three times the Wellbeing Clinic support that they currently have – although it could be argued that if the provision was fully utilised by schools this would reduce to needing double. We have no figures from schools for orange level support at secondary level, but with Oxwell figures suggesting that 37% of secondary pupils have clinical symptoms of depression and anxiety,[59] we can assume that demand here is high. Current provision can only meet approximately 9.6% of this need[60]. Additionally, EMHT access figures do not represent the highly diverse nature of school populations in Liverpool – particularly in central schools. Although this is being looked at within individual services, a cross EMHT strategy to diversifying approaches should be considered as a next step from this review.

13. BEST PRACTICE IS WHEN SCHOOLS HAVE ALL PIECES OF THE OFFER WORKING TOGETHER.

EMHT provision is most effective where schools have all the provisions in place along with a Headteacher and Senior Leadership Team driving forward a WSA. There are several best-practice models visible in specific Liverpool schools that should be celebrated and promoted. Despite previous directives against developing Whole School Approach quality mark/awards to promote this, many schools have chosen to gain such awards through external bodies. Local awards such as School Improvement Liverpool's Healthy Schools Award and the YPAS delivered Rainbow Flag Award have integrated mental health and emotional wellbeing, but there are presently no local awards purely celebrating mental health. This may be something to investigate following this review.

14. CROSS-SERVICE PATHWAY PROCESSES COULD BE IMPROVED

Although pathways have developed and merged considerably over the past five years, they still feel quite separate in terms of how they operate. Separate funding streams, service policy & processes

[59] Oxwell Survey 2023

[60] Based on Oxwell figures indicating that schools may need approximately 386 pupils supported on average.

and the use of different referral routes all contribute to this. The use of EMHT termly meetings in schools when utilised help with bringing these pathways together. The step-up process within secondary schools is unified with all cases (Wellbeing Clinic and Link Work) being taken to YPAS' MDT meetings. In the primary schools two separate processes exist for MHST and Seedlings. Although there is potential for red-level cases to be seen in primary schools by MSHT senior practitioners, this is not happening due to perceived 'queue jumping'. Conversely it could be argued that utilising these resources within the school system could prevent these cases adding to the waiting times within Fresh CAMHS. The 'back door' entry from the One Platform adds a potential route for cases to jump the queue. However, demand figures suggest that the schools' provision is currently under-resourced for what is needed. Therefore, this review would suggest that such routes of entry should be removed, and adequate provision be available within community services.

15. Services work across multiple levels of need

The EMHT Levels of Need model illustrates services sitting at specific levels of need. In practice, most services work across at least two levels of need with some, MHST and MYA RAISE working across three or four. Training and documents to support schools' understanding of this model, although helpful in raising awareness of the levels, may lead school staff to an unhelpful understanding of the support being offered. For example, the use of terms such as 'low-level support' have given the impression that interventions being offered at this level were of less worth than those offered further along the spectrum. Understanding the offer according to the interventions being offered, rather than the services delivering them, may help professionals to navigate the offer in a more meaningful way. More flexibility across the windscreen rather than segregated sections could also better serve the needs of the CYP themselves. This was always the intention of the original model, but interpretation and presentation of this have naturally segregated them. Revision of this model by Senior Service Leads and the WSA Development Lead can address these issues. Consideration of the types of interventions offered, their impact and potential for building on the existing evidence base are important factors within this development.

RECOMMENDATIONS

Based on the findings of this report the following recommendations are being made:

DATA COLLECTION, QUALITY ASSURANCE AND DATA ANALYSIS NEEDS MORE FOCUS AND INVESTMENT

1. Data collection, quality assurance, reporting, and analysis requires further investment. This should include the following:
    i. Recruitment of a data specialist/lead to work across the EMHT.
    ii. Evaluation of data systems to see if they are fit for purpose.

COMMISSIONING OF EMHT COULD BE CLEARER ABOUT HOW THEY SHOULD WORK TOGETHER – PARTICULARLY AROUND THE ROLE OF SERVICE SENIOR LEADS.

2. The EMHT needs a more defined senior leadership. It would be helpful to have a designated EMHT SLT with clear job plans to support this role. This would need to either be considered into existing staff job plans, or additional roles need to be developed to support this moving forward.

THERE IS AN IMBALANCE BETWEEN PRIMARY AND SECONDARY OFFERS

3. The secondary school offer needs further investment and development to bring it on par with the primary offer. This could include the following:

    i. Consistent green-level support to be enhanced across secondary schools.

    ii. Sustainable funding to be sourced for the existing Wellbeing Clinic offer to be continued and further developed.

    iii. Bid for further MHST funding investment to add capacity into existing secondary schools' offer.

    iv. Re-evaluation of MHST purpose to better support secondary schools.

SCHOOL MENTAL HEALTH LEADS ARE KEY TO MAKING THE OFFER WORK

4. Further development and promotion of the Whole School Approach is needed in schools to support and develop Senior Mental Health Leads and ensure the offer is fully utilised. This should include the following:
    i. Continued accessible Liverpool WSA training for SMHLs.
    ii. SMHLs to be further developed and invested into across all schools.

5. Development of a single operational model to guide schools on how to engage with external services - with the aim of this model being implemented in all schools.

6. Staff from MYA and LLP shadow school MHLs to gain a greater understanding of current school culture and challenges. This will inform future training.

PARTNERSHIP WORKING IS MAKING A DIFFERENCE

7. Continued opportunities for collaboration on specific pieces of work should be identified throughout the year.
8. EMHT termly meetings should be used more effectively in secondary schools.
9. Continued involvement of the LLP staff team to ensure cohesion with schools.

THE OFFER IS NOT BEING FULLY UTILISED

10. Regular capacity monitoring to be carried out by service leads and shared with EMHT senior leadership.
11. Further promotion of the offer is needed to inform schools of the benefits of investing into a WSA.
12. Whilst changes in staffing are sometimes necessary and can be beneficial for sharing expertise, these should be done at set agreed transfer windows rather than ad-hoc.

THE SERVICE IS CONTINUALLY GROWING AND DIVERSIFYING.

13. Continued liaison with schools and services to ensure that needs are known and being met.
14. Continued advocacy at regional and national forums for WSA activities to be included within the national dataset figures.

15. Research and evaluation of resources & interventions should be implemented to expand the current evidence base for WSA practice.

16. Consideration should be given to orange-level interventions in secondary schools. This could include a feasibility pilot of a Seedlings equivalent in secondary schools, more Link Workers to pick up 1:1 cases, or introduction of Senior Practitioners through further MHST investment.

THE OFFER ISN'T EQUITABLE TO ALL CYP

17. Detailed evaluation of demand across individual schools to be cross-referenced with audit of EMHTs to ensure best use of available resources to meet need.
18. Consideration of the differing needs of the three geographical areas should be at the forefront of any future development discussions.

SPECIAL SCHOOLS AND AEP NEED FURTHER CONSIDERATION

19. Detailed audit of Special schools & AEP Mental Health Provision to ascertain needs and current provision.

BETTER COMMUNICATION OF THE OFFER IS NEEDED BOTH INTERNALLY AND EXTERNALLY.

20. Further digital promotion materials (e.g service animations) of the EMHT to be developed and added to the WSA MHL Hub.
21. EMHT senior leadership meeting and processes for reporting back to teams to be evaluated and further developed.
22. Funding for annual cross-service CDP events to be available.

FUNDING IS NOT BALANCED ACROSS THE OFFER.

23. Commissioning arrangements for EMHT services should be re-evaluated to ensure that funding is distributed across levels of need and school phases. This could include:

    i. Dedicated school-facing mental health promotion worker/s fully funded to support the offer.
    ii. Extend the link worker support as part of the offer for secondary schools.
    iii. Explore the possibility of schools contributing to a collective fund rather than each school having individual commissioning agreements for Seedlings.

SERVICES NEED FURTHER INVESTMENT TO ADEQUATELY MEET DEMAND.

24. Further investment into the EMHT offer is needed to meet demand – particularly at the orange level. This should take Oxwell findings into consideration and be explored through joint commissioning opportunities from Health, Education, and the Local Authority.
25. A cross-partnership EMHT strategy should be developed to diversify approaches and encourage better representation from Liverpool schools' ethnically diverse population.

BEST PRACTICE IS WHEN SCHOOLS HAVE ALL PIECES OF THE OFFER WORKING TOGETHER.

26. Further case studies, possibly through digital means, should be compiled to capture best practice in schools and promote the benefits to Headteachers of embedding these approaches.
27. Collaboration with Headteacher steering groups to find creative ways to encourage and support school leadership to adopt and invest into a WSA.

CROSS-SERVICE PATHWAY PROCESSES COULD BE IMPROVED

28. Further workshops should be arranged to scrutinise the pathway map to ensure that services work more collaboratively throughout the journey of a CYP. These would be aided by the identification/appointment of a cross-EMHT clinical lead.
29. A single referral route for all services should be considered with an MDT triage to allocate them onto the most suitable pathway.

SERVICES WORK ACROSS MULTIPLE LEVELS OF NEED

30. The Levels of Need model should be revised in line with the interventions being offered – rather than in line with services. *Thinking about what a child needs at each level rather than who is delivering it.*
31. Update of the language used on the Windshield model and across marketing and promotion to refer to low/high intensity rather than level.

'ONE WISH' STATEMENTS

These were some of the 'one wish' statements from service practitioners given in the review focus groups:

- Some flexibility in ways practitioners work in schools so that when YP aren't in the time can be used effectively.
- Extension of Seedlings provision to include extended therapy for more complex cases.
- Parenting practitioners would still like to attend the MHST MDT meetings.
- Not much funded for early years and they often feel like they are left out. MYA have work that they can offer but currently not funded for it.
- Peer mentoring/ROCKET equivalent needed in secondary.
- Seedlings offered in secondary schools.
- Keep including core training (e.g ROAR) in staff inductions. This needs to be funded.
- More SFP
- Transition from trainee to EMHP could be more gradual as it's overwhelming to jump from trainee caseload to full.
- EMHPs would like to see their skills expand to other evidence-based practice.
- A whole team across all levels of need, including mental health promotion, attached to each school.
- Better environment – nicer rooms – cleaner area for children in schools.
- For it to be compulsory for schools to have a skilled senior mental health lead in place to put a WSA in place.
- More opportunity to deliver workshops as it helps you to feel part of the school. Also, it offers a good variety for your own wellbeing.
- To continue to build on and grow group work, Rock Pool, BA clinics, thinking of a creative way to acknowledge these going forward. Supervision for staff in schools.
- Basic training for teachers to help rectify the way they occasionally speak to their students.
- Capacity – sitting in triage meetings. It would be better if all the MHST cases were looked at together as they tend to take 1/3 of the triage meeting and CA could be better used rather than waiting in this meeting.
- Data lead is based at YPAS. The team really needs a data lead based with them fully during data-pull periods - someone who has the expertise of data.
- MHST and YPAS could work together to create a transition offer for secondaries and possibly deliver some group work into secondary.
- Better communication from schools to parents/families about mental health and the EMHT offer – School-facing Mental Health promotion and training to support this.
- The Oxwell survey highlighted that if the relationship between practitioner and parent carer is strong, other connections appear to be working. Perhaps we need to invest more into the parent/carer work. This is also supported by Seedlings data. Parents/carers who bring children to the hub generally show better engagement.
- More emphasis within the EMHT Levels of Need meetings on collaboration and understanding of what services are doing operationally.
- Consistent EMHT meetings to replace individual service meetings with school leads
- Service leads need to ensure that information from strategic meetings is regularly shared with teams.
- WSA Mental Health Hub website development

- WSA Development Lead to play a bigger role in keeping service teams knowledgeable about the work of other services.
- Better communication from services back to the Raise Team about training and mental health promotion needs in schools.
- More opportunities for services to work together on projects such as the Livestream session.
- One consistent approach across schools for engaging with CAMHS school-facing services (West Derby flagged as a good example to follow).
- Whilst changes in staffing are sometimes necessary and can be beneficial, these should be done at set agreed transfer windows rather than ad-hoc.
- All schools should have a designated mental health lead with time dedicated to fulfilling this role.
- Update of the schools' model to be intervention rather than service-based
- School-facing Mental Health Promotion offer to be expanded.
- More emphasis on the importance of EMHT termly meetings with schools.
- Consideration of the different presenting needs across the city leading to a more flexible and bespoke offer.
- More orange-level support within the offer - particularly in secondary schools.

LIMITATIONS

This review has been compiled using already available data and additional data gathered as part of this process. Throughout the process of capturing and analysing this data, several inconsistencies have been identified. Whilst every effort has been made to scrutinise datasets, there are still some concerns surrounding accuracy. Therefore, service data used throughout the review has been considered by the reviewer as best estimates. Data gathered through the Oxwell survey and school Needs Analysis surveys was only available from some schools (on average 50%), therefore themes gathered from them are generalised. Further data scrutiny could be carried out as a next step from this review.

Whilst independent from the key services involved, the reviewer's role as Senior Development Lead for the EMHT undoubtedly influences the writing of this report. Several processes have been implemented to account for this, but there will still be an element of writer bias throughout this report. Where possible quotes have been taken directly from focus groups and woven throughout this report. The draft was also commented on by the EMHT steering committee and LLP CEO, before being finalised.

A further limitation surrounds the review scope which limits this report to the work of EMHT services working as part of the Liverpool CAMHS school facing offer. There are several other organisations delivering mental health services into schools that do not feature in this report. These include:

- ADHD Foundation
- LFC Foundation
- Everton in the Community
- Barnardo's
- NSPCC
- Bobby Colleran Trust
- School Improvement Liverpool
- Place2be

This list is not exhaustive but gives an indication of the services that all work as part of a city-wide schools offer to support mental health and wellbeing. Future reviews/reports might wish to include these services to get a true picture of the extent and efficacy of the whole offer.

Finally, this review has not focused on the offer being delivered to special schools, colleges, and Alternative Education Provisions. This was largely due to the current offer not serving these places of education. Auditing the needs and current offer for these provisions is one of the recommendations being made in this report.

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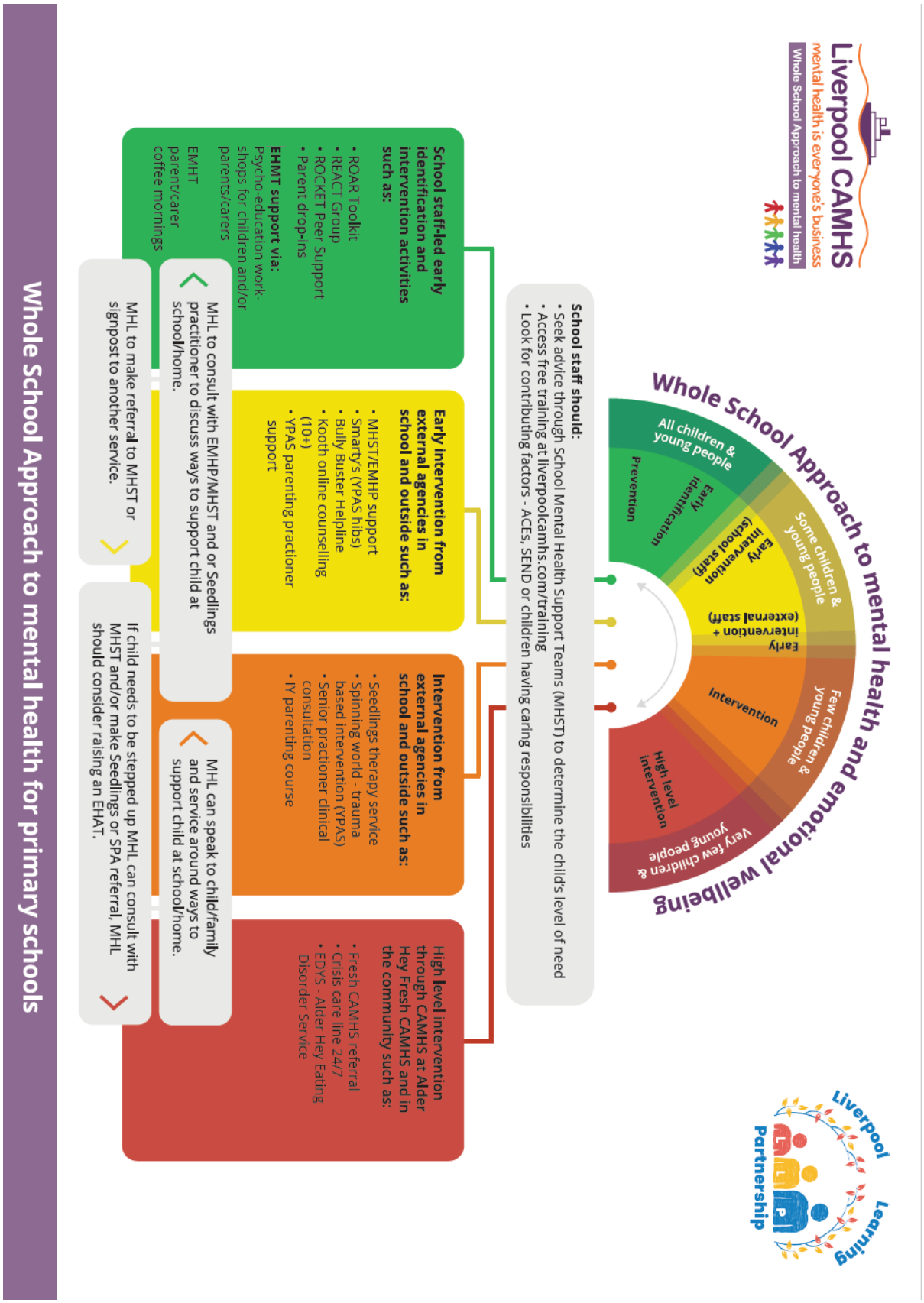
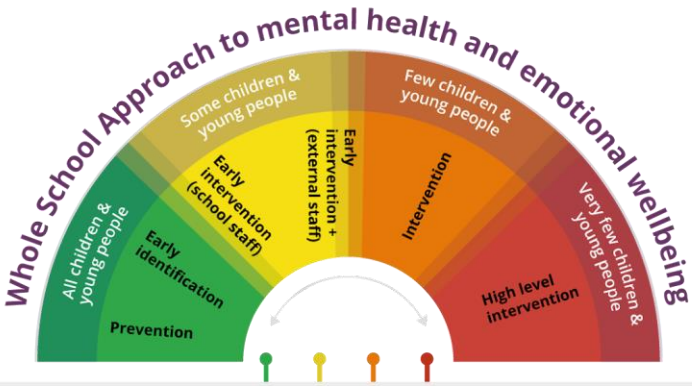
APPENDICES

I. Levels of Need document

II. Windshield models



Liverpool CAMHS
mental health is everyone's business
Whole School Approach to mental health



Liverpool Learning Partnership

School staff should:
- Seek advice through their wellbeing clinic or School MHST to determine the child's level of need
- Access free training at **liverpoolcamhs.com/training**
- Look for contributing factors - ACEs, SEND or children having caring responsibilities

School staff-led early identification and intervention activities such as:

- ROAR Secondary toolkit
- REACT Group
- Serious toolkit
- MHFA toolkit

EMHT support via:
Psycho-education workshops for young people and/or carers

Early intervention from external agencies in school and outside such as:

- Wellbeing clinic support
- MHST transition team support (yr 7)
- Bully Busters Helpline
- Kooth online counselling
- YPAS hub daily drop-ins
- Thrive groups (YPAS hubs)
- YC5 parent/carer group

Intervention from external agencies in school and outside such as:

- YPAS therapy service
- Clinical consultation from Senior Practioner
- Kooth online counselling
- Spinning World – trauma based intervention (YPAS)
- YPAS Daily drop-in

High level intervention through CAMHS at Alder Hey Fresh CAMHS and in the community such as:

- Fresh CAMHS referral
- Crisis care line 24/7
- EDYS Alder Hey Eating Disorder Service

MHL to consult with Wellbeing Practitioner on ways to support young person at school/home.

MHL can speak to young person/family and service around ways to support young person at school/home.

MHL to refer young person to wellbeing clinic or signpost to another service.

If young person needs to be stepped up MHL can speak to their wellbeing practioner, complete an EMHT consultation request form or refer directly to Single Point of Access. MHL should consider raising an EHAT.

Whole School Approach to mental health for secondary schools

III. EMHT Focus Group Thematic Analysis Extracts

Communication	Communication is stronger at a strategic level with gaps identified at an operational level. It would be helpful if practitioners could take turns attending team meetings to get a fuller understanding of what everyone is doing. The windshield picture makes it easy to understand where services sit, but the detail of what they do is unclear. This information is outlined in documents but not everyone has access to them or reads them. In the SLT consultation the importance of a thorough WSA induction process for new starters was highlighted. Communication around the whole offer could be embedded within this. Communication between services and understanding how to make a referral could be clearer. This included clarity of pathways to avoid referrals being passed from service to service. Some services felt that EMHT meetings are useful, but people don't share enough about what they are doing. It was noted that better communication occurred when services were working on something specific together – for example Livestreams. There was a request for more feedback around what's going on in secondary schools. The Raise team highlighted the role that service practitioners could play in feeding back key issues to the mental health promotion team. Communication with MHST and Seedlings is good, however sometimes the schools don't link them. In most cases schools have one point of referral for both services, but in some they are different which can cause confusion and things to be dis-jointed. EMHT in-school termly meetings are key to supporting this. Schools don't often communicate well with parents to let them know what their child is accessing. Often parents don't understand why their child is having a particular intervention and there is still some stigma about mental health. Parents are often shocked at being referred to the mental health support team as they feel their children don't have a mental health problem. Children need to be better informed about why they are being referred and offered therapy – schools often don't always communicate this. We all need to be clearer with the language we use as it can have negative connotations or give the impression that some difficulties shouldn't be taken as seriously as others. Spotting the signs has been a helpful piece of communication to schools. It would be good to be able to offer this to groups of staff from schools – but capacity in the MHST and referral targets are barriers to this. The new website will be helpful for schools and services to better understand the offer. There is opportunity for this to include clarification of the offer. Key suggestions for development are:

	● More emphasis within the EMHT Levels of Need meetings on collaboration and understanding of what services are doing operationally. ● Service leads need to ensure that information from strategic meetings is regularly shared with teams. ● Better communication from schools to parents/families about mental health and the EMHT offer – School-facing Mental Health promotion and training to support this. ● WSA Mental Health Hub website development ● WSA Development Lead to play a bigger role in keeping service teams knowledgeable about the work of other services. ● Better communication from services back to the Raise Team about training and mental health promotion needs in schools. ● More opportunities for services to work together on projects such as the Livestream session.
Knowing what each other services do/knowing what they should be doing	Although historically there has been a lot of work to strengthen the pathway and make it clearer, staff from across the partnership need to better understand what others are doing. At a grass roots level, it was clear that people didn't fully understand the operational function of other services delivering in schools. Elements requiring clarity included understanding where different services fit within the levels of need, how to access them and what exactly they are funded to deliver on the ground. This lack of clarity often led to the offer feeling disjointed and susceptible to duplication – particularly when schools are asking for specific things. "How can we offer effective mental health promotion if we don't know what we are promoting?" (Staff member from the RAISE Team) Some suggestions for development were as follows: ● Staff to shadow other teams. ● Simple sheets explaining the work of each service/team. ● Staff map showing who does what. ● Regular opportunities to spend time with other services. ● Repeat of the EMHT celebration event. ● Standard induction process for new staff to include a full overview of the EMHT offer and who delivers what. Similarly, the evolving nature of these services has led to a lack of clarity internally within teams. Changing leadership roles, operational processes and data requirements have at times caused confusion. However, there has been steady improvement in these areas according to staff across all levels of the workforce. These include regular cross-service triage meetings, cross-partnership WSA leadership, operational meetings, and the knowledge gains of having established staff in post.

	The cross-partnership delivery of the MHST has also, at times, led to confusion. Recently the teams have relocated to the Liverpool Innovation Park, which has positively impacted team cohesion and operational processes. The risk of falling into silo working was raised several times throughout the focus groups, however staff also voiced determination to not allow this to happen. Communication and join-working are key to the success of this.
Levels of need	Though several documents exist outlining levels of need, there is still confusion in some schools around what they are. Whilst documents exist to explain this, not everyone sees or refers to them. In several focus groups there was a suggestion to re-work the model slightly to present the specific interventions rather than talking about levels of complexity. School staff can often think they are getting a lower level of service when we talk about 'mild to moderate' and 'high-level' support. This is also applicable to the work of Seedlings who have been presented at the orange intervention level, whilst MHST sits at the yellow early-intervention level. Realistically these services work across both levels depending on which intervention a child needs. For example, some of the person-centred work delivered by Seedlings may be appropriate for early intervention, and some of the more targeted work delivered by the MHST may be applicable at the orange level. Similarly MYA suggested that the ROCKET course (currently within green level) that they deliver has been use for early intervention in some schools. A re-working of the model could list the types of intervention and who delivers them, rather than simply listing services. All services reported that the level of presenting needs has increased, and referrals are often more complex. Consultations help schools to think through their referrals before sending them in, but more referrals are coming through to the MHST at a higher level of need or with underlying Neurodiverse presentations where the issue is being caused by the learning environment. The desire to take a more 'upstream' approach was raised in several discussions where services felt more could be done around prevention. The lack of a consistent school-facing mental health promotion offer was raised across several focus groups. The MHST have had to cut back on workshops to meet their intervention targets which could be supported by MYA. MYA's offer lacks consistent funding for specific school-facing work making it difficult to incorporate into the EMHT offer. There are several processes in place to promote joint working across the MHST. Termly cross-service Levels of Need meetings take place. These could be improved by services sharing more about their work on the ground and considering how these might better work together. Cases get stepped up and down both internally and across services, however the 'early-intervention/yellow-level' directive of the MHST has made it difficult for cases to get stepped from Seedlings to the MHST. In some cases, children would benefit more from a specific therapy offered by the MHST. Similarly, the person-centred approach from Seedlings could occasionally be appropriate preparation to then access evidence-based support for a specific issue from the MHST. The school commissioned nature of Seedlings has potential to act as a barrier to this more joined approach. Termly EMHT school meetings help schools and services to take more of a joined-up approach. However, these aren't regularly taking place

	in all schools due to time constraints of both practitioners and school MHLs. A cross-partnership weekly triage takes place and is attended by MHST senior practitioners (rather than clinical admin). The inclusion of senior practitioners has greatly improved the process, with clinical admin now allocating extra cases from this triage to practitioners with capacity. The three-hub model has highlighted different types of need coming from each of these areas. This evidences the need for a bespoke and flexible approach to schools across Liverpool considering the unique needs to these communities. Key suggestions for development are: ● Update of the schools' model to be intervention rather than service-based ● School-facing Mental Health Promotion offer to be expanded. ● More emphasis on the importance of EMHT termly meetings with schools. ● Consideration of the different presenting needs across the city leading to a more flexible and bespoke offer. ● More orange-level support within the offer - particularly in secondary schools.
Working together more	It would be useful to investigate the internal and external processes within partner agencies as the cross-partnership element can be confusing. The strategic element of partnership seems to be working better but this doesn't always transfer to the operational side. Furthermore, there is often visible tension at meetings and sometimes underlying division between services. The move of the MHST from YPAS hubs may have created less of a relationship between the two as MHST staff no longer need to be present at the YPAS hubs so feel slightly disconnected. Similarly, points were raised around some of the historical partnership agreements for the MHST needing to be changed. For example, the agreements with the parenting team and clinical admin who are currently employed by YPAS but have an honorary contract with Alder Hey. Teams felt that staff contracts needed to sit within Alder Hey to eliminate confusion and cross overs for the staff involved. Both YPAS and Alder Hey agreed about this and emphasised their hopes to still work collaboratively to bring positive changes to the service. There have been some good examples of partnership working that can be built on in the future. Collaboration works well when working on a specific piece of work/project. The Children's Mental Health Week livestream events are a good example of this. We need to look at what's coming up throughout the year, key events, and continue to plan jointly with partners for these events. However, contracts and commissioning don't always prioritise this type of work. Similarly, there could be a more collaborative approach where the work of one team enhances and builds on the work of another. For example, the MHST can build on things after MYA deliver the promotion (ROCKET/REACT). Feedback from the focus group

	suggested that the model works best in schools where more elements are implemented. For example, schools who have accessed Senior Mental Health Lead training, implemented ROAR & ROCKET and are working with MHST and Seedlings. EMHT termly meetings in schools help with this and promote positive working between services. These have been a challenge in secondary schools, but where they have taken place have been hugely beneficial. Some concerns were raised about how joined up the pathways are to ensure that young people are gaining the correct support at the appropriate time. For example, if a YP was referred to EDYS and they deemed it not suitable for their service due to a mental health need such as anxiety, would they be referred on to EMHT? Cases may be bounced back to YPAS due to MHST being a school facing service. It was shared by GPs that when they have had referrals to EDYS declined, the referral has been sent back to them and not onto appropriate services. YPAS shared how the PCL can support these cases through the MDT process in the interim. Key suggestions for development: ● It is vital to work collaboratively from a leadership level through to an operational level. ● Opportunities for collaboration on specific pieces of work should be identified throughout the year. ● More networking opportunities should be created between services. ● Continue to embed the full offer into every school.
Consistency	The Mental Health Lead/Senior Mental Health Lead role is key to how well the mental health offer is embedded into schools. It is evident through the Oxwell Survey and referral data that the schools making good use of the offer, are schools with this role in place and embedded. There is a lack of consistency in the value placed on this role across schools in Liverpool. It was also noted that there are inconsistencies within the training that schools have received, which impacts upon how schools approach and utilise services. For example, in schools with prominent mental health leads, there were often consistent and effective systems in place for working with external services. Where this was not the case sessions were being missed due to no-one being available to get pupils, or pupils not even being aware they had a session. Not only does this waste valuable resource, but also can be demoralising for the practitioner. Practitioners reported that on rare occasions a full day could be wasted in this way. Several schools were praised for their consistent processes. Practitioners suggested that a shared and consistent approach could significantly improve the efficacy of the offer. A lack of consistency around mental health within individual schools ultimately leads to a lack of equity for CYP to receive appropriate support. Frequent staffing changes have contributed significantly to consistency across the EMHT. In addition to difficulties with recruitment and retention, services have had to re-shuffle staff throughout the year. Seedlings have had the most consistency within their staffing structure,

	although staff long-term absence did have an impact on several schools. Whilst schools found this changing of staff frustrating, there were some benefits cited by services. Across the locality hub different needs have been identified meaning that practitioners operating within these teams tend to get pigeonholed into delivering specific interventions. Regular swapping of teams has allowed practitioners to continue to gain a variety of experiences and develop their full range of skills. The ongoing requirements of recruit to train practitioners has also provided a challenge regarding consistency – this will be discussed in another section of the report. Frequent changes of personnel and processes was also highlighted as a challenge for the clinical admin team. With changes being made at both local and national levels keeping up with them has at times been difficult. It was also noted that different approaches around meeting chairing and triaging could be confusing for the clinical admin team who are required to attend a variety of these. In addition, the position of clinical admin being part of Alder Hey but managed operationally by YPAS was also mentioned as an area that lacked consistency. Key suggestions for development: ● One consistent approach across schools for engaging with CAMHS school-facing services (West Derby flagged as a good example to follow). ● Whilst changes in staffing are sometimes necessary and can be beneficial, these should be done at set agreed transfer windows rather than ad-hoc. ● All schools should have a designated mental health lead with time dedicated to fulfilling this role. ● Consistent approaches across meetings to support clinical admin staff. Equity for Liverpool children no matter their to be able to access good mental health support no matter what school they attend (primary or secondary).
Access	The schools-facing offer varies across phases. The offer to secondary schools is hugely supplemented by value-added funding, and the offer to special schools is limited to consultation from Alder Hey and some mental health promotion. There is no official school-facing offer for AEPs and colleges, other than some support from LLP and targeted YPAS support through their youth justice team. Whilst many school Mental Health Leads are doing a great job some are difficult to get hold of and appear to not have time to carry out this role. This can make it difficult for services to contact them to arrange appointments which then makes access for young people difficult. Similarly, some schools don't have space available for services to come and see young people or their spaces are not suitable for therapeutic work. This can cause difficulties with scheduling appointments and can subsequently limit access. Frequent staffing changes in the schools have also challenged Mental Health Lead engagement.

	Another reported barrier to access is the communication that schools have with parents/carers. Service practitioners reported multiple incidences of parents not fully understanding what their children had been referred for, resulting in withdrawal from the intervention or poor parental engagement. Often this communication barrier was due to different language and cultures. More could be done to help schools to build relationships with parents/carers and communicate the offer effectively. Schools should be encouraged to have open door access for parents to talk about concerns regarding their children. The One Platform has made it much easier for schools to refer into the EMHT. However, it has also opened the services up to referrals from outside of schools. Parents/carers will sometimes, in desperation, refer to multiple agencies at once. This can clog up systems and ultimately cause CYP to end up on the wrong waiting lists. Another issue raised with this open-access approach is that CYP can end up jumping the queue to be seen when their cases are sent from SPA to the MHST or Seedlings. Often senior practitioners from the MHST are allocated to these cases, leaving less support available from them in schools. Demand for Seedlings has been high and resulted in a waiting list for the community hub, which was only intended for schools currently not commissioning the service. Access to training is limited to the Bitesize offer, with ROAR and other school-facing training only running through non-recurring funding. Key suggestions for development: ● Adjustments to the model to ensure equity across all schools. ● Further discussion around whether this school-facing offer should be filling gaps in community provision. ● Training and support for schools around communication with families – particularly those facing cultural barriers. ● Training for Headteachers on the role/s and importance of mental health leads in schools
Schools' understanding of pathways	Although the pathways are working well for many schools, there are still gaps in the knowledge of school staff regarding the pathways and offer from services. Schools often don't understand that the partnership services work together. Some schools are unsure of referral routes - particularly with the community Seedlings offer. Work has been done to further clarify and summarise the pathways for schools, but this would benefit from some animations and further promotional material. Another idea proposed in two of the focus groups was to provide annual workshops for schools to embed practitioners and remind schools of the offer. These were suggested to run during September as a start to the school year – perhaps in the style of a travelling roadshow. Parenting practitioners saw this fitting well with their roles.

	There is an inequality in schools understanding the pathways, due to every school being individual this is hard to trouble shoot. Things such as network meetings, spotting the sign, one route to access MHST, have been put in place to improve the knowledge of schools regarding the pathways. To develop further work can be done collaboratively. There needs to be more education for schools around mental health and neurodiversity as teams are frequently getting inappropriate referrals linked to ND. The triage meeting makes this better along with monthly EMHT meetings. However further training is needed to educate teachers about what is appropriate. Teams would like to know whether having a good relationship with services improved the quality of referrals going into the system. Further enquiry into this would be valuable outside the scope of this review. Key suggestions for development: ● Animations and further promotional material to increase understanding of the offer ● Annual September roadshow/refresher sessions for schools ● Further training for schools around ND and Mental Health
Additional Suggestions for development made by service staff	● Some flexibility in ways practitioners work in schools so that when YP aren't in the time can be used effectively. ● Extension of Seedlings provision to include extended therapy for more complex cases. ● Parenting practitioners would still like to attend the MHST MDT meetings. ● Not much funded for early years and they often feel like they are left out. MYA have work that they can offer but currently not funded for ● Peer mentoring/ROCKET equivalent needed in secondary. ● Seedlings offered in secondary schools. ● Keep including core training (e.g ROAR) in staff inductions. This needs to be funded. ● More SFP ● Transition from trainee to EMHP could be more graduated as it's overwhelming to jump from trainee caseload to full. ● EMHPs would like to see their skills expand to other evidence-based practice. ● A whole team across all levels of need, including mental health promotion, attached to each school. ● Better environment – nicer rooms – cleaner area for children in schools. ● For it to be compulsory for schools to have a skilled senior mental health lead in place to put a WSA in place. ● More opportunity to deliver workshops as it helps you to feel part of the school. Also it offers a good variety for your own wellbeing. ● To continue to build on and grow group work, Rock Pool, BA clinics, thinking of a creative way to acknowledge these going forward. Supervision for staff in schools.

	• Basic training for teachers to help rectify the way they occasionally speak to their students. • Capacity – sitting in triage meetings. It would be better if all the MHST cases were looked at together as they tend to take 1/3 of the triage meeting and CA could be better used rather than waiting in this meeting. • Data lead is based at YPAS. The team really needs a data lead based with them fully during data-pull periods - someone who has the expertise of data. • MHST and YPAS could work together to create a transition offer for secondaries and possibly deliver some group work into secondary. • The Oxwell survey highlighted that if the relationship between practitioner and parent carer is strong, other connections appear to be working. Perhaps we need to invest more into the parent/carer work. This is also supported by Seedlings data. Parents/carers who bring children to the hub generally show better engagement.
What works well	The EMHT celebration was mentioned by all teams as a great opportunity to learn about other services and develop/maintain a joined approach. Teams would like this to be repeated annually with additional networking opportunities throughout the year. Similarly regular opportunities to network with wider partners, such as through the WSA collective, would be useful. Partners regularly contribute to the shared CAMHS newsletter. The 3-hub model works well for schools and the data collected highlights different issues in areas. Teams reported the varying approaches needed when working across the three hubs due to social and cultural variations within these areas. EMHT termly meetings have been very helpful. Mental Health Leads, SENCO have regularly been included in these meetings. In some cases, school nurses have also been involved which has proven hugely beneficial. Teams are facilitated well with the support of team leads across all services. Within the MHST the introduction of new Band 6 positions has improved staff morale and retention with new opportunities to aspire to. Staff who have entered the services through Recruit to Train were grateful for the opportunities provided by this and recognise other training opportunities within their services. Creative opportunities such as the Livestream sessions have been hugely successful in getting information out to large numbers of CYP and school staff. These raise the profile of mental health in schools and are an excellent first line of prevention. In-school workshops and assemblies also help to embed practitioners into individual school communities.
Funding	Funding is always a huge factor across many aspects of the EMHT – particularly those offered by the third sector. The school-facing Mental Health Promotion offer is boosted by non-recurring funding making it difficult to plan into the annual offer. It would be hugely beneficial for a schools Mental Health Promotion worker to attend meetings and deliver

	work alongside EMHT practitioners, but this is not currently funded. Due to having a deficit in funding, MYA must seek alternative funding for different pieces of work - often outside the scope of the EMHT. Successful pieces of work from previous years cannot be promoted again due to the loss in funding which creates a huge equity imbalance. The YPAS provision for secondary schools also lacks consistent funding to deliver the service. Of the 8 WTE staff required to a full day per week to all secondary schools, 1.5 are funded through recurring funds. The CYWP recruit to train 23/24 trainees cannot be used in the wellbeing clinics as they are not funded to be in schools. Lack of future funding of these roles also makes it difficult to retain staff and sustain the service. The Link worker role is a vital support for the secondary schools; however, this role is thinly spread. Additionally, many secondary age pupils in alternative education cannot receive mental health support as they are not included in the current funding. The Seedlings project thrives due to the commissioning of schools. However, this can raise challenges for service leads who must juggle things around as contracts change. Ideally the funding from schools would come from one collective pot so that the service can be offered equitably across all schools. Key suggestions for development: ● Look for further investment to extend the secondary offer model to mirror the offer in primary schools. This could include extending the MHST offer for secondary schools. ● Dedicated school-facing mental health promotion worker/s fully funded to support the offer. ● Extend the link worker support as part of the offer for secondary schools. ● Widen the offer to include dedicated support for special schools and alternative provision. ● Explore the possibility of schools contributing to a collective fund rather than each schools having individual commissioning agreements for Seedlings.

IV. Case Studies

MHST case study 1

1. The reason for referral

YP was referred to MHST via school. Concerns regarding anxiety for YP, separation from mum and transition to secondary school.

2. Young Person and Family background

YP lives at home with mum. Background of domestic violence with dad but no contact in 3 years. Ongoing court case regarding added complexity and YP had witnessed some domestic violence, drug misuse and controlling behaviours. YP accessed counselling support previously via court representatives.

Mum referred to 'traumas' a lot, even every day incidents were described with emotive language.

Final court date was 2 weeks into intervention.

3. The issues prior to service engagement with the young person and family

- Separation anxiety.
- Reassurance seeking behaviours with peers, school staff and mum.
- Avoidance from YP facilitated by mum.
- Historic difficulties.

4. Support offered within your service

Assessment and then offered intervention to mum - 6 session Cathy Creswell Parenting for anxiety. Sessions covered anxiety cycle and maintenance factors, use of open questioning, building communication, step by step plan and problem solving.

Signposting information to counselling for mum which she self-referred to for CBT.

5. Outcome

Mum being able to have difficult conversations and no longer avoiding things.

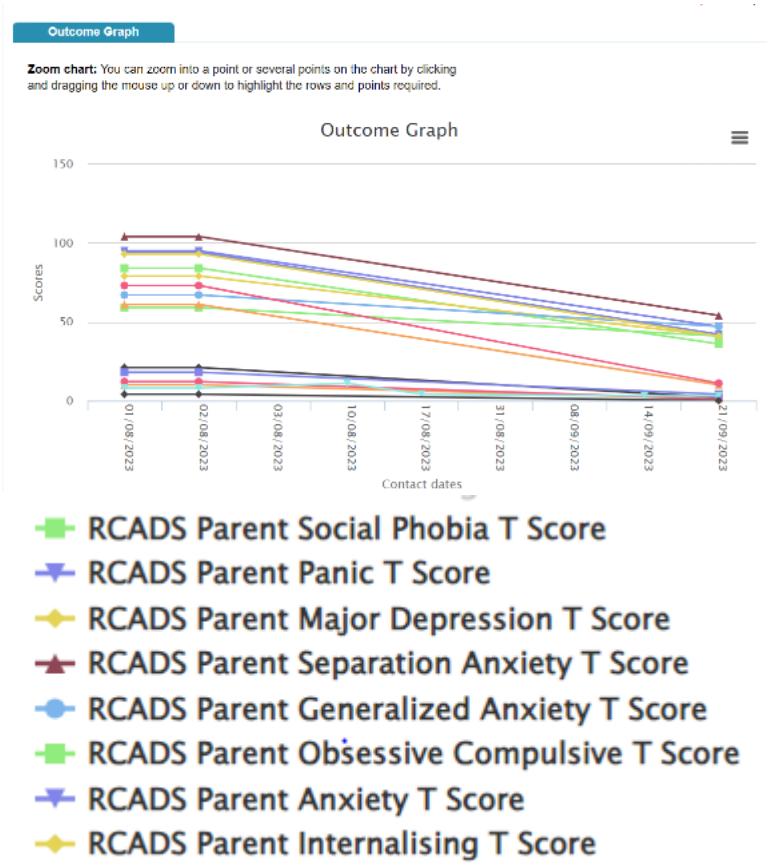
Developed mutual respect and honesty with validation for YP.

We can deal with blowouts in a calmer and reflective manner.

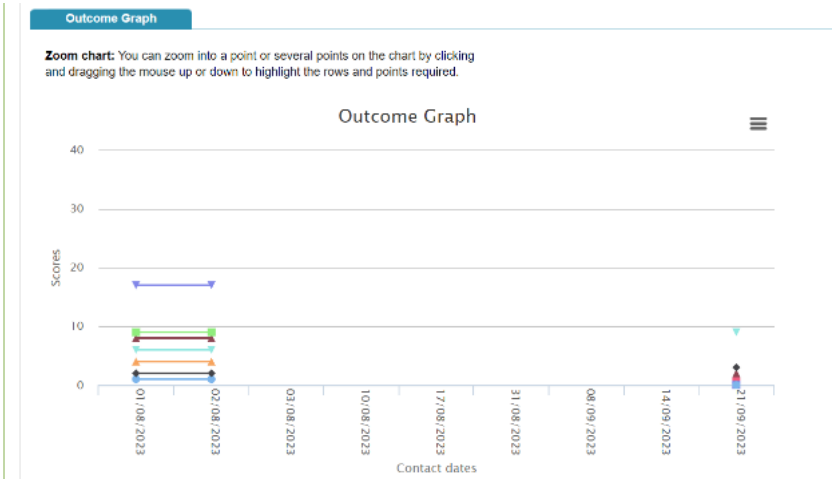
Confidence in dealing with anxiety and not underestimating YP ability to deal with things.

Parent RCADS and SDQ results.

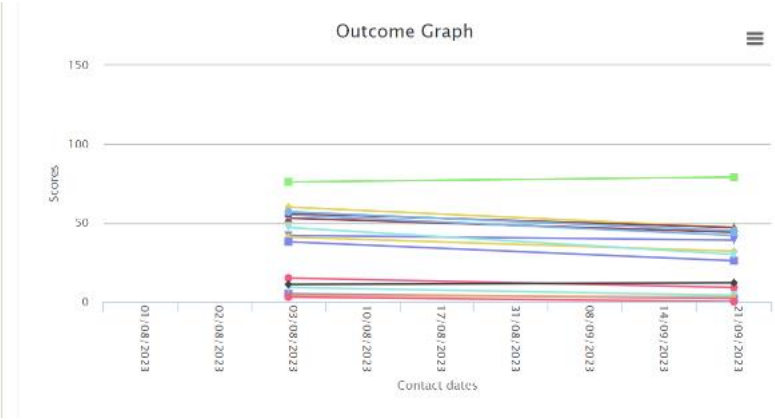
Parent RCADS



Parent SDQ



YP RCADS



Aug-02 2023	Aug-02 2023	Created: 08/08/23 at 16:31; Last Edited: 08/08/23 at 16:31	Miche

SCORES:

Separation Anxiety: 18.00
Generalized Anxiety: 8.00
Panic Disorder: 10.00
Social Phobia: 21.00
Obsessive-Compulsive: 4.00
Major Depression: 12.00
Total Anxiety: 61.00
Total Internalising: 73.00

Separation Anxiety - T Score: 104.30
Generalized Anxiety - T Score: 67.11
Panic Disorder - T Score: 95.43
Social Phobia - T Score: 83.73
Obsessive-Compulsive - T Score: 58.6
Major Depression - T Score: 79.20
Total Anxiety - T Score: 93.75
Total Internalising - T Score: 93.22

RCADSADCYP-RCADS-P - Revised Child Anxiety and Depression Scale Complete Pare

Sep-21 2023	Sep-21 2023	Created: 21/09/23 at 16:57; Last Edited: 21/09/23 at 16:57	Miche

SCORES:

Separation Anxiety: 4.00
Generalized Anxiety: 3.00
Panic Disorder: 1.00
Social Phobia: 2.00
Obsessive-Compulsive: 0.00
Major Depression: 1.00
Total Anxiety: 10.00
Total Internalising: 11.00

Separation Anxiety - T Score: 54.12
Generalized Anxiety - T Score: 47.03
Panic Disorder - T Score: 46.52
Social Phobia - T Score: 35.51
Obsessive-Compulsive - T Score: 41.3
Major Depression - T Score: 40.87
Total Anxiety - T Score: 41.92
Total Internalising - T Score: 41.12

Strengths and Difficulties Questionnaire Parent Assessment (4 - 17

Aug-02 2023	Aug-02 2023	Created: 08/08/23 at 16:26; Last Edited: 08/08/23 at 16:26	

SCORES:

Emotional score: 6.00
Hyperactivity score: 8.00
Prosocial score: 9.00
Impact score: 4.00

Conduct score: 1.00
Peer score: 2.00
Total Difficulties: 17.00

Strengths and Difficulties Questionnaire Parent Followup (4 - 17)

Sep-21 2023	Sep-21 2023	Created: 21/09/23 at 17:15; Last Edited: 21/09/23 at 17:15	

SCORES:

Emotional score: 0.00
Hyperactivity score: 1.00
Prosocial score: 9.00
Impact score: 0.00

Conduct score: 0.00
Peer score: 2.00
Total Difficulties: 3.00

Goals

1. YP to sleep in own bed increase from 0 - 8 (with 10 being achieved).

2. YP to leave mum and spend time with others. Increase from 0-10.

6. Feedback

ESQ feedback:

The support myself and my son have received via XXXXX has been incredible. In just 7 weeks, our life has transformed, we have both been provided with the tools and knowledge on how to overcome the issues we had both been struggling with and it has had a profound impact on my son, he is much more confident, calm in his approach and open to dialogue when faced with any issues that used to cause alarm, upset or in some instances trauma. Special thanks to XXXX for all the information and guidance throughout this process, it has been enlightening and insightful.

I firmly believe that our therapy sessions with XXXXX have enabled both myself and my son to put in place open dialogue, to allow my son to build resilience, problem-solving skills, and the confidence to move forward with building blocks that both he and I will use throughout our future.

YP Feedback (reported by parent):

Mum reported YP was enjoying freedom and being brave and had pulled her up for being 'too protective'. Mum felt YP was unsure about transition to bedroom but in other areas such as moving to secondary he is excelling and has joined a couple of clubs, walking home alone which she never thought would happen. She felt he was using problem solving skills rather than reassurance seeking.

Practitioner reflection on why intervention had such positive outcomes:

Intervention came at the right time due to transition to secondary, final court date hearings and mum being in the right place capacity wise to reflect and engage well with the intervention. Mum was open to any support and willing to challenge herself as she could identify that the 'blow ups' and avoidance were being maintained by her own anxiety and guilt about causing upset. From the first session she felt supported and could identify maintenance factors such as trying to over compensate for any distress potentially.

Practitioners own reflection:

Personally, for me as a practitioner it was a positive experience for a case I initially from first telephone call thought would be unsuitable due to mum's use of 'trauma' to explain behaviours. I used YP assessment carefully to fully understand their view which helped with the formulation of separation due to avoidance rather than past difficulties impacting now.

YPAS Wellbeing Clinic IAG Best Practice Case Study

1. The reason for referral

YP was referred to the school service because of their anxiety. Dad said they had been spending a lot of time in bed, had low confidence, and was struggling with their weight and how they looked. YP had stopped seeing mum due to alcohol misuse and there may be some impact of YP not having a female role model in their life and the breakdown of their parents' relationship.

2. Young Person and Family background

YP is very friendly but did struggle with low self-esteem and low mood. YP wanted to get back into contact with mum in a healthy way and was getting on better at home. YP had a good relationship with dad. Mum had a problem with alcohol misuse and because of this dad got full time custody of YP and their brother. YP gets on well with dad and brother.

3. The issues prior to service engagement with the young person and family

- Poor self-esteem and body image, YP wouldn't feel confident in their clothes and would allow friends to treat them poorly.
- Problems with setting boundaries with friends and family members – mum and allowing them to treat her poorly.
- Dissociation and daydreaming, YP would often find herself zoning out for extended periods of time and not being able to bring herself back. YP did not like this and felt she was missing out on her life.
- Easily triggered by loud noises and spaces, would cause her dissociation.
- Unhealthy lifestyle, eating poor meals and not looking after her body.

4. Support offered within your service

I offered YP 6 session Self-Esteem IAG support. YP accepted and following the assessment had 6 sessions within school focused on their self-esteem and their confidence. The sessions centred around self-esteem,

building confidence and setting boundaries through self-respect. The sessions also covered positive thinking and ways of improving how YP thought about herself.

5. Outcome

Overall, YP had tremendous progress during her time within the wellbeing clinic, originally scoring RCADs over the clinical threshold, YP had very low self-esteem and would regularly talk negatively about herself. By the end of the sessions, YP's RCAD scores had all decreased except her separation anxiety: on the last session her separation anxiety had gone up and she said this was because she was nervous to leave YPAS sessions. The language YP used prior to their sessions and towards the end was noticeable, YP would use more positive language and speak about herself in a kinder way than before. YP had also rebuilt her relationship with mum, was setting healthy boundaries and looking after her health.

6. Feedback

YP emailed ET a few weeks after their closing session asked if they could provide an update to ET on their life. ET said that if they have anything feel ET should or would like to know then to go ahead. YP then emailed the following.

Email 1:

"YES I DOOOOO well its kind of an icky update BUT IM SO HAPPY NOWWWW remember FRIEND? she was being bare rude and stuff lately and then she deicded to stop being friends which i was like calm do whatever makes you happy, AND IVE BEEN FEELING HAPPIER EVER SINCE and i feel like life is going gooooood ans i have been talking to myself in the mirror AND ITS SP FUN NOW but yes this is my mini update. how are you? i feel like if i dont ask i may be classified as rude LOL. :D"

Email 2:

"literal icon 🤭 i love the mirror activity now its become part of my routine, and it helps me remember things well too. also ive been doing tests recently and i think im doing really well. im glad youre doing well too 😁 😁"

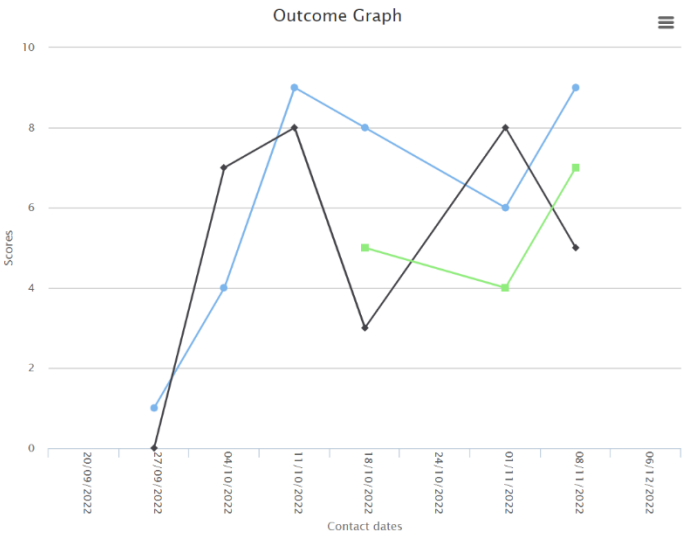
These emails describe how YP has been doing the activities recommended by ET and how not only did these have a positive impact on their self-esteem but have also helped them improve other aspects of life such as their education and remembering different things. YP also completed a CCC, regular SFQ and an ESQ which all give great feedback.

SFQ & ESQ

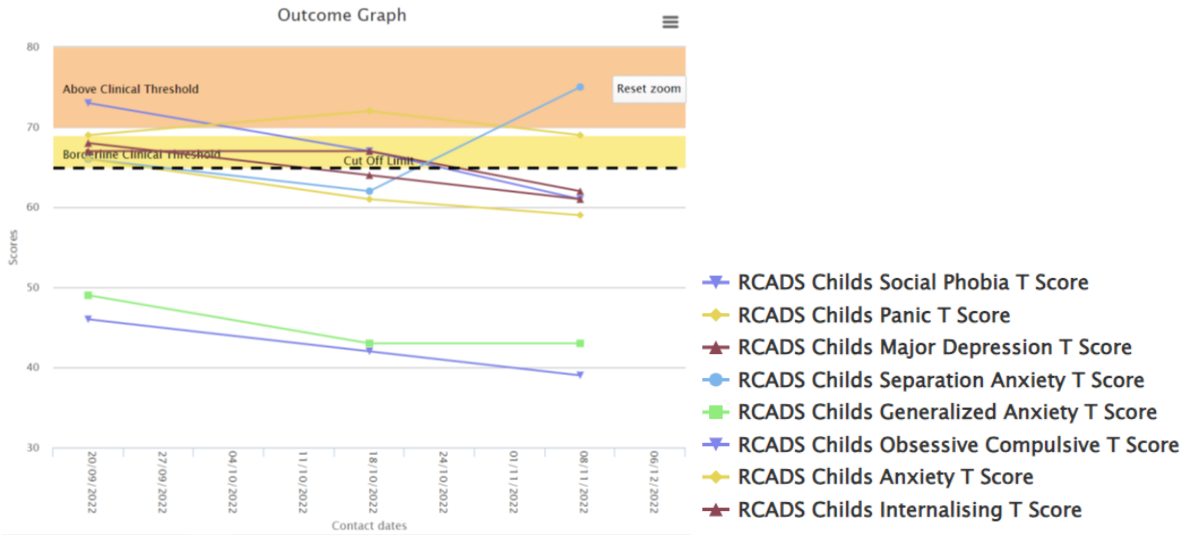
Sess Date	Date Completed	Notes	Entered By	Action
		SFQCYP - Session Feedback Questionnaire (SFQ)		
Sep-20 2022	Sep-20 2022	Created: 20/09/22 at 10:43; Last Edited: 20/09/22 at 10:43	Emily Taylor	View | Edit | Print
SCORES:				
SFQ Total score: 17.00				
		SFQCYP - Session Feedback Questionnaire (SFQ)		
Sep-27 2022	Sep-27 2022	Created: 27/09/22 at 10:52; Last Edited: 27/09/22 at 10:52	Emily Taylor	View | Edit | Print
SCORES:				
SFQ Total score: 17.00				
		SFQCYP - Session Feedback Questionnaire (SFQ)		
Oct-04 2022	Oct-04 2022	Created: 04/10/22 at 10:33; Last Edited: 04/10/22 at 10:33	Emily Taylor	View | Edit | Print
SCORES:				
SFQ Total score: 18.00				
		SFQCYP - Session Feedback Questionnaire (SFQ)		
Oct-11 2022	Oct-11 2022	Created: 11/10/22 at 11:03; Last Edited: 11/10/22 at 11:03	Emily Taylor	View | Edit | Print
SCORES:				
SFQ Total score: 17.00				
		SFQCYP - Session Feedback Questionnaire (SFQ)		
Nov-01 2022	Nov-01 2022	Created: 01/11/22 at 10:48; Last Edited: 01/11/22 at 10:48	Emily Taylor	View | Edit | Print
SCORES:				
SFQ Total score: 20.00				

		ESQCYP - Experience of Service Questionnaire		
Nov-08 2022	Nov-08 2022	Created: 08/11/22 at 10:49; Last Edited: 08/11/22 at 10:49	Emily Taylor	View | Edit | Print
SCORES:				
ESQ Total score: 36.00				

Goals



RCAD Results



YPAS Wellbeing Clinic CYWP Best Practice Case Study

1. The reason for referral

Anxiety in school and at home. The anxiety was beginning to impact Young Person's (YP) education as she was avoiding some lessons and increasingly using her timeout pass. Teachers had noticed YP becoming more withdrawn from friends in school. YP was becoming dependent on one teacher who she would spend most of her time out of class with when she was feeling overwhelmed.

2. Young Person and Family background

YP was in year 9 and had recently been through her Mum and Dad separating. YP lived with Mum and saw Dad regularly, but this was a relatively new routine. YP was still attending extra-curricular activities but found them hard to attend due to her worries around being judged by others. YP had recurring worries around feeling judged by others. Both Mum and Dad noticed the change in YP and believed their separation was to blame. YP said the anxiety has been present since returning after COVID, and although the separation of parents didn't help her anxiety, it was not the trigger. Mum and Dad continued to communicate amicably between each other, and both really invested in YP's wellbeing.

3. The issues prior to service engagement with the young person and family

- YP avoiding certain classes, ones she felt were out of control and loud.
- YP avoided using the busy corridors between lessons, and advised she doesn't speak as much as she used to in school or outside of school.
- YP has begun not getting the bus of a morning with friends, making this hard for Mum to commute to work after dropping her off.
- YP was still attending extra-curricular activities, but was using safety behaviours such as not speaking, staying on her own, leaving early, and no longer engaging.
- YP described her anxiety as intense, being up to an 8/10 and was occurring almost every day. No suicidal thoughts or self-harm (current or previous), but YP would pick her nails so much when she was anxious that they would bleed and scar.
- Mum struggled to get YP to get out of the house, such as going shopping or the cinema like they used to.

- YP had worries around being judged if she spoke or if she said something silly. The worries would occur in busy & social spaces, but also before attending a busy place, putting her off going to a lot of places.

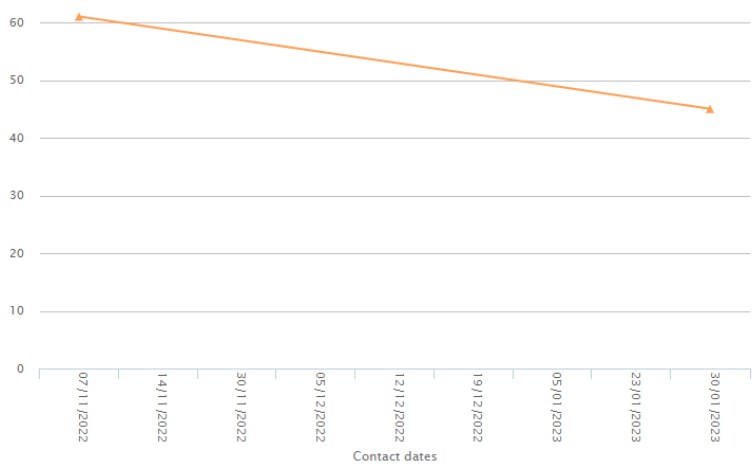
4. Support offered within your service

Based on the assessment, ROMs, and Supervision guidance, we had chosen Graded Exposure as the best suited intervention for YP. This is a low-intensity, evidence-based intervention which would be around 8 sessions within YP's school.

We worked collaboratively through the intervention and had regular communication with Parents to support from home (with YP's consent). The intervention consists of psychoeducation around anxiety, habituation, recognising safety behaviours, and facing your fears in a graded and safe way.

5. Outcome

YP was able to reach the top of their exposure ladder, conquering her biggest fear of walking through the busy corridor in school. YP had been able to attend her lessons again and felt her anxiety reduce the more she repeated each step. YP had recognised and dropped a lot of her safety behaviours, such as using her timeout pass less frequently. YP felt she was integrating back into her extra-curricular activities and was spending more time with friends. YP said though her anxiety was not as intense or frequent, she recognised her anxiety was still present. However, YP felt she knew how to overcome her worries independently after the intervention. YP still had goals in place to continue after the intervention.



Graph displaying YP's Social Anxiety prior and post intervention.

6. Feedback

Feedback from Parent below;

Reason For Referral

YP is 8 yr old male, presenting issues were anxiety, trouble regulating emotions. However, main reason for referral was due to trauma from severe bullying incident outside of school which involved the YP being made by their peers to share explicit photos online. The incident was recent and the YP was still in class with the children involved. Parents were aware that there was still bullying happening, but school denied this.

There was a social worker involved due to the nature of the incident. The family had felt a lot of humiliation from the incident and shared that they felt they were being blamed for what happened. The school had asked mum a lot of personal questions which had damaged mum's relationship with school. As far as the family was aware there had not been similar actions for the other children involved.

Family

The YP lived with mum and brother in council house, they were living near the families involved in the incident.

Parents were separated, YP lived mainly with mum but still saw dad and paternal grandparents. Mum had a good relationship with dad. English was second language for the parents, but both were mostly able to communicate fluently. YP could speak several different languages and went to language lessons.

Mum had a lot of past traumas and was very distressed by what was happening at school.

Mum had tried to get the YP moved to another school, but the school was refusing to send over necessary documents.

Assessment

At assessment mum was very grateful to be listened to as she had not felt supported before. We discussed parenting and mum accepted a referral. I was also put in contact with the social worker.

Sessions

I had sessions with YP in the hub, they were very chatty but struggled to make eye contact. They spoke passionately about various topics and told me a lot of facts. The YP struggled with contracting, they took a lot of information literally.

The YP asked to leave session early as they noticed the time and at this time, they always had their lunch and they had to have their lunch at school because that's what they always did. Although the YP only stayed for a short period in sessions it seemed evident that there was neurodiversity based on similar traits to other clients I had.

After a few sessions I spoke to mum about possibility of YP having ASD. Mum was very relieved and grateful that I had shared this, they felt that there were a lot of behaviours the child had that they couldn't explain but with that in mind they started to make sense. I spoke with dad about this separately as well, he shared that he thought he may have ASD but had never been diagnosed himself. I was able to share with the family how they can get an assessment without going through school and for dad to know how he could also get assessed or supported if that's something he wanted to do.

Outcomes

An example of partnership working is when I spoke with the social worker. We agreed that the social worker would speak with the school, they were able to negotiate that the child was separated during break times from the other children involved.

Unfortunately, it wasn't possible to separate them in class, but the teachers would be more vigilant.

Working with the social worker and mum we were able to come up with a plan moving forward, the social worker could help mum in getting YP into another school, they could help with housing. An ASD assessment was arranged for the YP.

Mum was offered parenting support but ultimately did not feel ready for this, I was able to offer mum alternatives and she decided that counselling would be a better fit.

Overall, the family were very grateful for the service.

APPENDIX I.