Department for Education

Evaluation of the Mental Health Services and Schools Link Expanded Programme

Final report

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Diarmid Campbell-Jack, Laurie Day, and Natasha Burnley – Ecorys UK

Contents

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Glossary

AFNCCF	Anna Freud National Centre for Children and Families
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CYP	Children and Young People's
CYPMH	Children and Young People's Mental Health
CYPMHS	Children and Young People's Mental Health Services
DfE	Department for Education
EWB	Emotional Wellbeing
EWB&MH	Emotional Wellbeing and Mental Health
FTE	Full-Time Equivalent
GP	General Practitioner
LTP	Local Transformation Plan
MH	Mental Health
NHS	National Health Service
PMHW	Primary Mental Health Worker
SLT	Senior Leadership Team
SPOC	Single Points of Contact
VCS	Voluntary and Community Sector
VCSO	Voluntary and Community Sector Organisation

A note on report terminology

The pilot programme was funded to strengthen joint working arrangements between schools, colleges and specialist CYPMHS (Children and Young People's Mental Health Services). For the purpose of consistency in the report, we have made a distinction between the following:

- **National Health Service (NHS) Children and Young People's Mental Health Services (NHS CYPMHS)** – statutory children and young people's specialist mental health services funded by the NHS and commissioned locally via Clinical Commissioning Groups (CCGs), who provided the primary mental health workers (PMHWs) to link with pilot schools
- **Other Children and Young People's Mental Health Services (Other CYPMHS)** – all other professionals within the wider network of organisations working with children and young people at different levels of need, including but not restricted to: school nurses, educational psychologists, counsellors and provision funded and provided via the voluntary and community sector (VCS)

Throughout this report, we refer to CYPMHS as opposed to CAMHS (Children and Adolescent Mental Health Services) following the decision taken by the Evaluation Steering Group in January 2017 as part of the previous report. This decision was taken to better reflect the feedback from children and young people that was incorporated in the Future in Mind priorities, and to avoid the risk of misunderstanding concerning the terminology. As the term 'NHS CAMHS' is still in widespread use, and was included within the original primary research tools for the evaluation, this terminology has been retained where the authors are reporting upon verbatim quotes or survey questions within the report.

A more detailed description of the designated roles and responsibilities of the different key stakeholders on the pilot programme can be found in Chapter 1 (Introduction). The local variations in the staffing model for the individual pilots are explained in Chapter 2 (Design and set-up of the expanded programme).

For the sake of brevity, the programme is referred throughout as the Mental Health Services and Schools Link Expanded Programme. The programme was open to a range of different education providers, with primaries, secondaries, specialist/PRU/alternative providers and colleges attending workshops.

Executive summary

In summer 2015, NHS England and the Department for Education (DfE) jointly launched the **Mental Health Services and Schools Link Pilots**. The pilot programme (henceforth referred to as the "original pilot") was developed in response to the 2015 report of the Children and Young People's Mental Health Taskforce, *Future in Mind*, which outlined a number of proposals to improve access to mental health support for children and young people. This original pilot was implemented in 22 areas across England, covering 27 CCGs and 255 schools, with £50,000 funding per CCG provided by NHS England to allow staff to be released (expected to be matched by CCGs) and £3,500 per school to backfill staff time to participate in workshops and follow-on activities.

Following evaluation of this original pilot[1], an updated and scaled-up programme (henceforth referred to as the "expanded programme") was introduced to test the viability of the Single Points of Contact (SPOC) model in the context of business as usual. In contrast to the original pilot, no 'additional' funding or resources were provided centrally as part of the expanded programme as additional resources had already been allocated to CCGs.

A total of 23 areas, incorporating 23 CCGs and 1,104 educational organisations (primarily primary and secondary schools, but also PRUs/special schools/alternative providers and colleges) successfully applied to take part in the expanded programme. This therefore represented a significant increase in the mean average of schools per area compared to the original pilot (48 compared with 12), allowing the model to be tested at greater scale than previously.

Overview of the programme

The basic delivery model for the expanded programme followed the approach taken in the original pilots. An NHS CYPMHS representative and a school lead[2] from each area were expected to participate in two joint planning workshops, involving other professionals from their local CYPMHS network. These included, but were not restricted to, school nurses, educational psychologists, counsellors and voluntary and community

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/590242/Evaluation_of_the_MH_services_and_schools_link_pilots-RR.pdf

[2] As a result, throughout the report we use 'School Leads' to refer to this group, although it may be that some of those attending either workshop and, potentially, responding to the survey did not have this specific role.

sector organisations (VCSOs). The local programmes were led by CCGs and/or local authorities, depending on the local area.

The joint planning workshops were commissioned by DfE and facilitated by a consortium led by the Anna Freud National Centre for Children and Families (AFNCCF), using a framework developed in advance of the original pilot programme (CASCADE) and involving a combination of reflection, action planning and review to benchmark local collaborative working. In the majority of areas, there was a gap of approximately 6-10 weeks between the first and second workshops to allow for areas to progress plans and reflect on progress in the second workshop.

Overview of the evaluation

In September 2017, Ecorys (UK) was commissioned by the DfE to undertake an independent evaluation of the expanded programme. A mixed methods design was deployed, incorporating survey research, research observations and qualitative case studies in a sample of areas in the expanded programme. In addition, a similar suite of survey research and qualitative interviews was undertaken across original pilot areas to assess longer-term outcomes and sustainability. The data collection took place between January 2018 and November 2019, with quantitative data collection among workshop participants taking the form of a baseline survey and a follow-up version completed after a ten month interval (see Table 1.1 for additional details). As a result, the follow-up survey took place approximately 7-8 months after the second workshop for most areas, allowing reflection on the workshops and resultant actions over a relatively long time period.

Key findings

Overall, the expanded programme resulted in measurable improvements to some aspects of communication and joint working between schools and NHS CYPMHS, although the results were not all at the level achieved by the original pilots.

The outcomes varied between areas within the programme, but were generally stronger where CASCADE data showed lower joint working levels at baseline (although overall scores were generally low across all areas). This suggests the potential greater relative benefits of the model for areas with relatively low levels of joint working, albeit also requiring a certain level of infrastructure and capacity to change. Areas where specific joint working plans had been implemented showed more positive signs than those where plans had been put on hold as a result of wider contextual issues, most often while awaiting outcomes of funding applications. Likewise, cross-organisational commitment and strategic buy-in were key factors in ensuring success.

At an overall programme level, the evaluation found quantifiable improvements to the following self-reported outcomes among workshop participants taking part in both baseline and follow-up (at +10 months) surveys:

- awareness and knowledge of risk factors and mental health issues relating to children and young people
- understanding of referral pathways across different professionals
- understanding of evidence-based practice

These findings were largely reinforced by the qualitative evidence, which showed that the workshops and action planning had started to catalyse wider changes across the participating areas. This included “myth busting” around the roles and remits of CYPMHS, and the development of improved channels of communication.

Improvements were also seen in the extent to which school staff felt that referral pathways were understood by different professionals. The qualitative evidence showed that the workshops had improved the clarity of service pathways in certain areas, and that some local areas had instituted new referral processes and protocols.

In contrast to the knowledge and awareness-related outcomes, there was less evidence of changes to behaviours and professional practices, when compared with the original pilots. The overall improved awareness of referral routes had not translated into increased satisfaction with the quality and timeliness of referrals among schools, or increased frequency of reported contact between schools and CYPMH organisations. Moreover, schools were no more likely to report that support to identify mental health issues was available to all teachers following the workshop. This is wholly consistent with CCGs supporting greater numbers of schools within a given locality in the expanded programme, and doing so within existing resources. Put simply, the outcomes were not the same in the absence of regular direct contact between schools and Primary Mental Health Workers (PMHWs), which was a feature of many of the original pilots.

The workshops were generally viewed very positively, with high levels of satisfaction among both school and CYMPHS staff attending, due largely to the quality of facilitators and content, as well as the opportunity for networking. Potential improvements included further efforts to work with local leads to ensure breadth of attendance (e.g. including VCSOs), that attendees could attend both sessions and that they were fully prepared in terms of workshop aims and expectations.

These results suggest that the expanded programme delivered a number of valuable benefits over the course of the evaluation, albeit largely depending on the overall context for joint working in each area. Moreover, feedback on the workshops suggests that this is

an appropriate format for any future, wider roll-out of similar joint working training, while taking account of the recommendations suggested.

Any further roll-out should pay particular attention to ensuring that long-term sustainability is built into delivery throughout the entire delivery period, particularly in terms of strategic leadership and organisational commitment going forward. This would maximise outcomes and reduce the possibility (as with many programmatic interventions) that outcomes fade-out over time. This is particularly relevant given evidence from following-up original pilot areas that initial gains were not always maintained in each area, especially where organisational commitment changed, significant staff turnover took place and resources became constrained. Expanded programme workshop attendees noted particular risks to sustainability in terms of a lack of capacity within both schools and NHS CYPMHS, staff turnover within schools, and changes in funding arrangements.

Aims and objectives of the expanded programme

The overall aim was to test the extent to which joint professional working between schools and NHS CYPMHS can improve local knowledge and identification of mental health issues and improve the quality and timeliness referrals to specialist services.

The expanded programme centred on 2 joint planning workshops for local stakeholders from CYPMHS in each of the 23 areas. The workshops were designed and facilitated by a consortium led by the AFNCCF, using a bespoke framework (CASCADE). Each workshop involved a single cohort from each area, with a cohort generally aiming to include approximately 20 schools and colleges and a similar number of mental health professionals. Most areas had two or three cohorts in total, although one area had five cohorts in total.

The original pilot programme was implemented in 3 phases:

- Phase 1: forming partnerships – workshop 1 (January to September 2017)
- Phase 2: embedding and building sustainability – workshop 2 (March to November 2017)
- Phase 3: supporting ongoing learning through 4 national events (November 2018 to February 2019)

As noted, no additional funding was provided to support participation, e.g. by backfilling staff time.

Early development

The 23 areas were selected purposively to include a mix of rural and urban settings, different local leadership arrangements, including CCG and LA led partnerships, and varied levels of joint working between CYPMHS and schools. This set the background context for how the local programmes were designed and developed.

Most areas sought to build on existing EWB&MH (Emotional wellbeing and mental health) provision, to address gaps in coverage, and to consolidate their specialist NHS CYPMHS offer to schools. In particular, Local Transformation Plans (LTPs) [3] set the framework and exerted a strong influence over how the programme was positioned within many of the areas.

The areas within the expanded programme had longer than the original pilots to recruit schools and CYMPH services, which allowed for a greater degree of targeting. Some areas organised their delivery around clusters of secondary schools and their feeder primaries, or targeted schools with higher levels of socio-economic disadvantage. Alongside this, most also sought to raise awareness of the programme as widely as possible, to meet the minimum requirements for numbers of schools.

The main challenges for recruitment included: accessing and maintaining accurate contact information for individual schools, and engaging VCSOs, who often lacked capacity to attend the workshops. Leads were nominated as part of the application process and tasked with recruiting schools, mobilising workshop attendees and ensuring the long-term sustainability of the programme. This included ensuring that workshop attendees were clear around the nature of the workshops and their ongoing involvement.

Lessons learned from implementation

Overall, the workshops achieved a wide range of representation from the education sector and CYPMHS, although areas experienced varying success with engaging VCS organisations.

Most participants rated the tailored content and expert facilitation positively. Networking, a shared understanding of services, and the CASCADE framework as a self-assessment tool were valued. However, some participants identified a need for greater contextualisation of the CASCADE framework, in particular to ensure that it was more

[3] Future in Mind set out the requirement for areas to develop joint agency CYPMH Local Transformation Plans. These are locally agreed and owned documents that set out plans to improve services and outcomes for children, young people and families. Governance is through local systems, with a planning footprint determined locally. CYPMH LTPs are refreshed and republished annually.

flexible to the needs of their area and that each domain was fully understood by all participants.

Actions agreed at the workshops ranged from ‘quick wins’, such as updating referral processes, committing to additional staff training and using evidence-based practice, to longer-term commitments for more complex system changes. Factors affecting the implementation of workshop actions included: the actions being realistic and clear, actions being tied into current work, follow-up on implementation and there being less evidence for joint working already in existence prior to the programme.

The lead contact roles within NHS CYPMHS most commonly involved creating a single point of access via a central duty team, or raising awareness of existing arrangements. Despite the challenges of delivering at scale, a number of local areas also identified a designated lead contact(s) in NHS CYMPHS for schools and colleges. These arrangements typically required additional LTP and / or external funding.

At a strategic level, local areas reported relatively few changes to overall local systems leadership arising directly from the programme. In a smaller number of areas, however, the programme helped to develop new multi-agency working arrangements, joint service commissioning or joint plans that were not in place prior to the programme.

At an operational level, there were clearer signs that the programme had directly influenced the development or expansion of mental health forums or networks involving schools and colleges, often supported by NHS CYPMHS, although in some cases these arrangements were still at an early stage in being developed, and remained ‘commitments’ rather than having been fully realised.

A number of positive outcomes were developed among both school and CYMPHS attendees as a result of involvement in the expanded programme, primarily in terms of increasing professional knowledge, awareness and understanding in key areas. Awareness of risk factors, knowledge about mental health issues and how to support children and young people with different mental health needs all increased, although aspects of how to ensure support for young people in these areas had not.

There were positive signs of increased awareness of the roles and remits of different partner organisations, reflecting feedback that the workshops functioned well in helping explain different elements of the system and “myth-busting” incorrect assumptions around roles, in particular helping to explain referral processes where these had been misunderstood. The focus in the workshops on evidence-based practice helped increase understanding in this area, although this had not always resulted in practice changes.

While these increases in knowledge, awareness and understanding provided a solid basis, there was a mixed picture in terms of whether they were followed by subsequent changes in joint working. While participants often perceived there to be improvements

(either from CASCADE ratings, or reported in follow-up surveys), longer-term statistically significant change in joint working practices could not be identified in the survey (see ”Strengths and Limitations” in Chapter 1). The notable exception was in terms of referral pathways, with school leads (but not CYPMHS staff) feeling they were better understood, backed up by qualitative evidence that the workshops often provided clarity on referral processes, which were positively received by schools.

The surveys showed no statistically significant increases in ease or frequency of contact across organisations. Staff did not report increased opportunities to meet up, with CYPMHS respondent data not showing statistically significant changes in feeling school staff were using their expertise or that feedback mechanisms were working. Qualitative evidence did point to instances where joint working had improved. These were primarily areas where changes had been made to processes and systems, and where these were coupled with changes to existing systems or the development of new networks and links.

Often these were areas where strategic level buy-in was achieved and there was widespread organisational commitment. There was also evidence that joint working may have improved more in areas where it was at a particularly low level at the start as opposed to those where elements of good practice were more likely to exist.

The lack of statistically significant changes to actual joint working practices may reflect that some areas had not yet fully rolled out their planned model from the programme. Others had paused on deciding the best approach for wider rollout, pending the outcome of other potential funding sources,[4] although this was not always the case.

Sustainability

While areas involved in the expanded programme were largely positive about the potential benefits and were often looking to implement small-scale changes, most were at a relatively early stage in making specific plans for sustainability. This was largely due to many putting plans on hold while awaiting the result of major funding applications (e.g. Trailblazer funding)[4] or internal restructuring.

Where sustainability was felt to be most likely was in one area where clear accountability structures were developed together with incorporation of agreed actions into official plans

[4] These primarily related to applications for Trailblazer funding for new mental health support teams to provide support to up to 8,000 young people across 25 schools and colleges in each of 25 areas, starting from 2019 (see: https://www.gov.uk/government/news/nhs-and-schools-in-england-will-provide-expert-mental-health-support)

in a very structured approach. This was aided within some local areas through the close links to LTP funding and objectives.

Longer-term feedback from the original pilots showed that sustainability was mixed and inconsistent. Achieving sustained joint working was most challenging in areas where the model relied on substantial direct work by CYPMHS staff in schools. In these cases, staff turnover was a particular issue, especially when key CYPMHS staff members left their roles and communication across organisations was not retained at the same level.

Methodology

The evaluation was funded between September 2017 and November 2019 to provide an assessment of the effectiveness of the design and implementation of the expanded programme and the outcomes achieved over the course of the evaluation:

- A mixed methods approach was used to evaluate the 23 expanded programme areas, comprising of pre/post online surveys with workshop attendees (baseline prior to the initial workshops and follow-up at +10 months); post-workshop light touch data collection with area leads; workshop observations; and 6 local area case studies.
- In addition, data collection was undertaken with areas that participated in the original pilots to ascertain longer-term outcomes and sustainability. This comprised of short online surveys of area leads, and qualitative follow-up telephone interviews.

Further details on sampling, data collection, analysis and reporting are provided in Chapter 1.[5]

The evaluation design and achieved sample sizes were sufficiently robust to allow for a good level of confidence in the results in comparison to data collected during the original pilot evaluation. The comparison of survey outcomes relates to the cohort of schools participating in the pilot programme. A matched pair approach was used to ensure that there was no variation from baseline to follow-up survey in terms of respondents.

Commentary in the report highlights differences that are statistically significant at the 95% confidence level, most usually in reference to changes in workshop attendee survey

[5] School lead contact survey, baseline n = 481 respondents, follow-up n = 108 respondents.
NHS CYPMHS lead contact survey, baseline n = 345 respondents, follow-up n = 53 respondents.
Case studies covered six of the expanded programme areas and n= 47 different member of staff, comprising interviews with the CCG strategic lead, NHS CYPMHS strategic and operational staff, school lead contacts and teaching staff, and partner organisations from CYPMHS.
There were n=10 survey responses from strategic area leads at baseline, and n=8 at the follow-up stage
In-depth qualitative interviews with original pilot areas, n = 13 interviews, across seven different areas
Light touch data collection with original pilot leads, n = 17 (15 schools leads, 2 CYPMHS)

responses from baseline to follow-up stage. The final achieved sample size for both groups of attendees (school and CYPMHS leads) was larger than those achieved in the original pilot. As the evaluation was able to detect statistically significant changes during the pilot phase for a very similar intervention with smaller sample sizes, it is reasonable to conclude that the expanded programme was less effective. The reasons are detailed with the report and summarised in the conclusions, and point towards the fact that the expanded programme delivered a similar model on a larger scale, without the equivalent additional Primary Mental Health Worker (PMHW) resource within schools that was made possible with NHSE funding during the pilots.

1.0 Introduction

In September 2017, Ecorys (UK) was commissioned by the Department for Education (DfE) to undertake an independent evaluation of the **Expanded Mental Health Services and Schools Link Programme**. This final report presents the summative findings from the evaluation, which was carried out between January 2018 and November 2019, covering all 23 local areas, and adopting a mixed methods approach. The study also included a strand of follow-up research with representatives from the original pilot areas.

In this introductory chapter, we give an overview of the policy context and origins of the programme, its aims and objectives, and how it was structured. We then go on to explain the aims and research methods that were deployed for the evaluation, and we outline the data, caveats and limitations framing the analysis within the report.

Background to the programme

The expanded Mental Health Services and Schools Link Programme was initiated following a series of key policy developments, and a successful piloting phase.

In September 2014, the Government established the *Children and Young People's Mental Health Taskforce,*[6] bringing together children and young people, with leaders from key national and local organisations across health, social care, youth justice and education sectors. Published in March 2015, the Taskforce report, *Future in Mind*[7] outlined key recommendations to help improve outcomes for children and young people with mental health problems, particularly by ensuring system join-up by those commissioning or working with under 18 year olds. The proposals included the establishment of a named point of contact within NHS CYPMHS and a named lead within each school. The report also recommended the development of a joint training programme for named school leads and NHS CYPMHS.

In early summer 2015, NHS England and DfE asked for expressions of interest from CCGs to join with local specialist NHS CYPMHS and schools to pilot the named lead approach and a joint training programme. A total of 22 areas (27 CCGs) and 255 schools were selected. The overall aim of the original pilot programme was to test how or whether training and joint professional working between schools and NHS CYPMHS can improve

[6] Children and Young People's Mental Health and Wellbeing Taskforce: Terms of Reference. (Accessed 3 January 2017)
[7] Department of Health. Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing. 2015. London: NHS England. (Accessed 3 January 2017)

local knowledge and identification of mental health issues, and improve the quality and appropriateness of referrals to specialist services. Specifically, the programme aimed to:

- improve joint working between school settings and specialist NHS CYPMHS
- develop and maintain effective local referral routes
- test the concept of a lead contact in schools and specialist NHS CYPMHS

The original pilot programme centred on 2 joint professional planning and development workshops for local stakeholders from CYPMHS in each of the 22 participating areas, including CCGs, local authorities, NHS CYPMHS, pilot schools and other key partner organisations such as Educational Psychology, School Nursing Services and VCSOs.

The workshops were facilitated by a consortium led by the AFNCCF, using a bespoke framework (CASCADE) and involving a combination of reflection, action planning and review to benchmark local collaborative working using a number of key criteria (see Appendices). NHS England made funding of £50,000 available per CCG, to cover NHS CYPMHS capacity. CCGs were expected to match-fund this amount. Funding of £3,500 was made available per school to backfill staff time.

Evaluation of the pilot phase

In September 2015, Ecorys (UK) was commissioned by the DfE to undertake an independent evaluation of the original pilot programme. A mixed methods design was deployed, incorporating survey research, research observations and qualitative case studies in a sample of 10 areas. The data collection took place between September 2015 and 2016, and the report was published in September 2017.[8]

Overall, the evaluation found that the pilots had considerable success in strengthening communication and joint working arrangements between schools and NHS CYPMHS. This was often the case even where relationships were said to have been weak at the start of the original pilot programme, although the extent of change varied between pilot areas.

At a programme level, the evaluation found quantifiable improvements to the following self-reported outcome measures, between a baseline and follow-up at +10 months based on results from school leads:

[8] Day, L., Blades, R., Spence, C., and Ronicle, J. (2017) *Evaluation of the Mental Health Services and Schools Link Pilots - Final report.* London: DfE Publications. https://www.gov.uk/government/publications/mental-health-services-and-schools-link-pilot-evaluation

- frequency of contact between pilot schools and NHS CYPMHS
- satisfaction with communication and working relationships between pilot schools and NHS CYPMHS
- understanding of the referral routes to specialist mental health support for children and young people in their local area among school lead contacts
- knowledge and awareness of mental health issues affecting children and young people, among school lead contacts

There was an increase in the frequency of contact between school lead contacts for the pilots and other school-based mental health professionals. These varied between schools but included educational psychologists, counsellors and school nurses.

While harder to quantify, the interviews strongly suggested that the programme contributed towards improvements in the timeliness of referrals and helped to prevent inappropriate referrals within many areas. However, the report found mixed views with regard to the sustainability of the pilots. It also highlighted the likely challenges of replicating the pilots at scale, given that they involved small numbers of schools and additional funding, and recommended further testing under 'business as usual' conditions.

The evaluation of the original pilots was cited in the 2017 Green Paper on children and young people mental health, *Transforming children and young people's mental health provision*. On the strength of the pilot phase, the Green Paper announced the commitment to a national rollout. It also announced plans to introduce Mental Health Support Teams (MHSTs), linking schools and colleges with specialist NHS-led provision, alongside designated leads for mental health in schools and colleges, and trials for a four-week waiting time for access to specialist NHS CYPMHS. At the time of writing, 25 Trailblazer areas (see Footnote 4) for the MHSTs had been confirmed, and training of Education Mental Health Practitioners started in January 2019.

Aims and objectives of the expanded programme

In autumn 2017, the DfE awarded the delivery contract for an Expanded Mental Health Services and School Links Programme to a consortium led by the AFNCCF. The expanded programme set out to test the workshop model at scale (including CASCADE), with greater numbers of schools and without the additional funding element offered to the pilots.

As a result, the expanded programme differed from the original pilot primarily in terms of the greater scale in each LA (on average 48 schools per LA compared to 9 previously) and the absence of additional funding (none in the expanded programme compared to £50,000 per CCG and £3,500 per school in the original pilot).

Between January and November 2018, the AFNCCF developed and delivered workshops incorporating the CASCADE framework to 23 Local Authority (LA) areas, reaching 1,104 schools and colleges and 1,031 mental health professionals. The programme comprised of two full-day workshops delivered six weeks apart, and culminated in a series of national dissemination events in late 2018/early 2019. Due to the increased scale of delivery in areas, each was split into multiple cohorts to attend workshops separately to ensure a manageable number at each. The number of cohorts differed by area, ranging from some areas with two separate cohorts to one area with five separate cohorts.

This report uses CASCADE framework data to contextualise more specific evaluation findings where required. This data was standardly collected across all workshops, with each table discussing framework elements and then scoring themselves accordingly as an area. Data was collected at both the initial and second workshops to enable progress to be measured. Results from this source are treated as indicative due to the self-reported and group-based nature of data collection.

Qualitative feedback suggests that, as in the original pilot, there may have been a different mix of participants for each area across workshops, due mainly to staff availability.

Evaluation aims and methodology

In September 2017, Ecorys (UK) was commissioned by the DfE to undertake an independent evaluation of the expanded programme, and to conduct a light touch follow-up exercise with areas that took part in the original pilots. The aims were as follows:

With regard to the expanded programme:

a) to understand how areas set up and deliver with fewer constraints on numbers of schools, compared to original pilot
b) to explore how areas go about setting up models which are scalable and sustainable
c) to understand costs and decisions made about funding, approaches taken to funding the delivery model
d) to test whether the changes to pre-workshop set up enhances areas' experiences of the approach, and
e) to produce reporting outputs which are of use to other schools/areas in setting up this approach.

With regard to areas that participated in the original pilots in 2015-16:

a) to explore whether and how areas progress from the initial pilot period to deliver sustainable delivery, and how and whether they scale up the approach,
b) to explore specifically the approaches taken to funding the models used.
c) to understand changes made after end of first phase of pilot, what impact this has had on joint working if activity scaled back, where areas already had plans in place and how implementation has gone

A mixed methods approach was deployed for the evaluation, including quantitative and qualitative data collection and analysis within a framework mapped to the evaluation aims and objectives, and a final synthesis of the evidence. Data collection took place between January 2018 and November 2019. The main elements included the following:

Expanded programme areas

- **Desk research** – a desktop review of key programme documentation, including Expressions of Interest (EOIs) and scoring data for all 23 successful areas, and CASCADE data collected by AFNCCF at each of the workshops.
- **Online survey research** – three sets of online surveys were designed, piloted and implemented, as follows:
    - **Pre and post surveys of those attending workshops (lead contacts in schools and CYPMHS) for the programme,** to measure changes over time in levels of knowledge and awareness and joint professional working, using Likert-scale classifications. The questionnaires mirrored the pilot evaluation, to allow for some comparisons. Baseline measures were taken prior to the first workshop (*n* = 481 schools, and *n* = 345 CYPMHS), with follow-up at an interval of +10 months from baseline (*n* = 108 schools, and *n* = 53 CYPMHS).
    - **Qualitative surveys of strategic area leads**, a shorter email-based pro forma was issued to the 23 area leads in CCGs or LAs – first towards the start of the programme, to capture their aspirations and initial views on workshop delivery (n=10), and again in spring 2019 with a focus on outcomes and plans for sustainability (n=8). This exercise was mainly qualitative in nature.
- **Case study visits to six of the expanded programme areas**, sampled purposively to provide a broad spread of provision in terms of areas and models. Specific criteria used included:
    - Local authority type
    - Level of socio-economic disadvantage
    - Whether they were an Opportunity Area or not

- Baseline position for joint professional working (low/fair/high) from initial CASCADE ratings
- Areas of potential good practice

In total, this included interviews with 47 different members of staff, comprising interviews with the CCG strategic lead, NHS CYPMHS strategic and operational staff, school lead contacts and teaching staff, and partner organisations from CYPMHS.

An additional case study was also conducted in a further area which had commissioned workshops themselves subsequent to the original pilot but not as part of the expanded programme.

Original pilot areas

- **Follow-up surveys with strategic area leads** – a short email-based pro forma was issued to schools, NHS CYPMHS, CCGs and LAs who participated in the research for the original evaluation in spring 2018 (*n*=17), with a mixed profile of respondent types across the areas. The purpose was to capture light touch feedback on actions taken following the end of the initial pilot, and the barriers and enablers to sustaining joint working initiated during the pilots.
- **Qualitative telephone interviews** – semi-structured interviews were conducted with a mix of school, CCG and NHS CYPMHS representatives (*n*=13) in summer and autumn 2018, exploring the topics covered in the survey in further depth.

Evaluation Timeline

This overall approach resulted in the following evaluation timeline, showing activities split out for both the expanded programme and original pilot areas. Relevant time periods for delivery activities in the expanded programme are included in italics for reference:

Table 1.1: Programme and evaluation delivery timetable

Activity	Time Period
Expanded Programme	
Expressions of Interest for applicants closing date	*October 2017*
Successful applicants selected	*October/November 2017*
Desk research	October 2017 onwards
Workshop One	*January – September 2018*
Baseline survey of workshop attendees	January – September 2018
Workshop Two	*March – November 2018*
Case study research (main, n=6)	November 2018 – March 2019
Follow-up survey of workshop attendees	December 2018 – July 2019
Baseline qualitative survey of area leads	January – March 2018
Follow-up qualitative survey of area leads	March – April 2019 & September – November 2019
Original Pilot	
Follow-up surveys with area leads	July-August 2018
Qualitative telephone interviews	August 2018 – January 2019

Analysis

The quantitative survey data was extracted and cleaned before matching the baseline and follow-up responses to measure change across different outcome measures. The results were then compared by respondent type and area. Paired t-tests[9] were used to test for statistical significance and to establish the confidence levels in the results.

The notes from the qualitative interviews were entered into a structured grid, based on the agreed topic framework, and supplemented with verbatim quotes and examples from the transcribed interviews. A framework analysis was undertaken, to manually compare and contrast the views of the different respondents under common topic headings from the qualitative interviews. Attention was given to key similarities and differences in perspectives, according to pilot area, stakeholder type and professional roles. The findings from the interviews and case-study research were then triangulated with the

[9] T-tests were used to compare the quantitative variables in the data, thereby enabling us to go beyond comparison of sample means to make inferences generalisable to the populations of interest

survey data, to establish the degree to which the different data sources support or refute each other. Emerging themes were discussed with the steering group at the interim reporting stage, with feedback and adjustment prior to final reporting.

Strengths and limitations of the evidence

The qualitative strand of the research was based on a total of 47 interviews with a good cross-section of staff from schools and CYPMHS. The ability to sample the case-study areas and schools using the surveys and workshop data allows for a good level of confidence in the results. As with all case-study research, the findings do not claim to be exhaustive (particularly given certain areas being selected on the basis of good practice being in place), and the case studies in the expanded programme were conducted at a relatively early stage in the formulation of local strategic planning, post workshops.

The responses to the quantitative survey of school lead contacts and CYPMHS dropped-off between baseline and follow-up stage, but nonetheless proved sufficient to measure statistically significant changes for a wide range of outcome variables.

Commentary in the report text and tables shows where change from baseline to follow-up stage (in either the original pilot or expanded programme evaluations) is statistically significant at the 95% confidence level only. Statistical significance is not intended to imply substantive importance. In addition, base sizes for variables should be taken into account given that, all else being equal, a larger base size increases the chance that any difference in results will be statistically significant.

Care should also be taken when making any comparison of statistical significance across evaluations – in certain cases text may state that change from baseline to follow-up in the original pilot was statistically significant but that it was not statistically significant in the expanded programme (or vice-versa). As this analysis is based only on whether change in each evaluation meets the specific 95% confidence threshold for each individual variable it should not necessarily be taken as proving statistically that there was “more” of a change in one evaluation than another.

Report structure

The remainder of this report is structured as follows:

- **Chapter 2** examines the design and set-up of the expanded programme. It reviews the local aims and characteristics of the local areas before the start of the programme, and the lessons learned from recruiting schools and CYPMHS.
- **Chapter 3** considers the lessons learned from implementing the workshops and CASCADE framework. It then examines the staffing arrangements for the lead points of contact in schools and NHS CYPMHS, and how these compare with the pilot phase, and the structures established to support joint working.
- **Chapter 4** reviews the evidence for outcomes from the expanded programme, considering in turn the knowledge, awareness and understanding measures, joint professional working and communication, and systems transformation.
- **Chapter 5** reflects on the sustainability of the original pilots, drawing on the evidence from the follow-up research. It then considers the plans for sustainability under the expanded programme, and early signs of their success.
- **Chapter 6** presents the overall conclusions from the evaluation, and a set of recommendations for the DfE and for schools and CYPMH services.

2.0 Design and set-up of the expanded programme

This chapter considers the initial design and development stages of the expanded programme. It starts with an overview of the 23 local areas that were successful in bidding to take part, reviewing how they were selected; the arrangements at a local level for joint working between CYPMH services and schools prior to intervention; and the specific local aims and objectives for taking part. It then reviews the lessons learned from identifying and recruiting schools and partner organisations to the programme.

Key findings

Local arrangements for CYPMH services prior to the programme

- The 23 areas were selected purposively to include a mix of rural and urban settings; different local leadership arrangements, including CCG and LA led partnerships, and varied levels of prior joint working between CYPMHS and schools.
- While the programme included areas ranging from high to low levels of prior joint working, the baseline CASCADE scores were slightly higher on average in the expanded programme than in the original pilots across virtually all statements.
- A broad range of EWB&MH provision was already reported to be in place within the areas prior to the programme. However, most areas reported gaps in coverage, and a need to consolidate their specialist NHS CYPMHS offer to schools.

Local aims and objectives for the programme

- Local Transformation Plans (LTPs) set the framework and exerted a strong influence over how CASCADE was positioned for the expanded programme. They also shaped the more specific aims for CCGs, LAs, and providers at a local level.
- Local areas commonly aimed to use the programme as a vehicle for building capacity within the system for CYPMHS; to strengthen early intervention and prevention, and to create stronger and better understood pathways to MH support.
- The locally-specific aims differed to some extent from the original pilots (potentially due to less focus on single point of contacts), in that there was a greater emphasis

on the link between EWB&MH and SEND, behavioural support and school exclusions, and links with children's social care.

Early programme development

- Strategic leads commonly sought to raise awareness of the programme as widely as possible across the local area. This was necessary to generate the level of demand to meet minimum requirements for numbers of schools.
- Areas often also used specific geographical criteria as part of their overall targeting strategy. These criteria included:
  - organising delivery around clusters of secondary schools and their feeder primaries, with a focus on supporting transitions, and / or
  - targeting schools with higher levels of socio-economic disadvantage.
- A smaller number of areas had designed their programme based on specific school characteristics:
  - one such approach was to target schools according to demand and / or perceived levels of need for support.
  - another was to include a mix of schools with recognised elements of 'good practice' to support schools where joint working was weaker.
- In practical terms, most local areas took a multi-faceted approach towards recruitment for the workshops. This activity typically started with established local EWB&MH forums or networks and pilot projects, and worked outwards.
- Other areas aimed to widen participation among schools by reaching out to specific school communities where engagement was limited historically.
- The main challenges for recruitment included: accessing and maintaining accurate contact information for individual schools, and engaging VCSOs, who often lacked the required capacity to attend the workshops.

Characteristics of the local areas within the programme

As with any place-based programme, **it is important to understand the characteristics of the local areas taking part and the infrastructure that was already in place**. The 23 areas were selected via an application process to include a mix according to the strategic area lead (CCG or LA-led); evidence of their ability to recruit sufficient numbers of schools, area type, and regional coverage. This was facilitated by a call for Expressions of Interest (EOIs), where prospective bidders were asked to outline their proposed approach under common headings. This process also enabled the Delivery Partner to make an initial assessment of the stage of implementation for joint working between schools and NHS CYPMHS, with a view to recruiting areas at different starting points. This assessment was subsequently tested further using the CASCADE framework – as noted earlier, results from this source are to be treated as indicative given the self-reported and group-based nature of data collection.

As Table 2.1 illustrates, the final set of 23 areas included a good mix according to the primary selection criteria. They included both rural and urban settings, CCG and LA led partnerships, and areas with varied previous joint working arrangements. Joint working relationships are grouped according to the CASCADE rating at baseline into four broad categories: very low; low; fair and high. These groups reflect the relative position of different areas, with no individual area scoring over 6.5 out of 21. While the programme included areas at different levels with regard to joint working, it should also be noted that **the baseline CASCADE scores were slightly higher on average in the expanded programme than in the original pilots across virtually all statements** – at a mean score of 0.2 to 0.9 per statement, compared with 0.1 to 0.7. This is consistent with, although not necessarily attributable to, the more advanced stage of most areas in rolling out their Local Transformation Programmes (LTPs) and potentially an increased focus in mental health in schools recently.

Table 2.1: Local areas within the programme, and joint working arrangements – CASCADE scores and rating at baseline

Area	Lead	English region	C	A	S	C	A	D	E	Relative overall rating
Area W	CCG	North East	1	1	1	0.5	0.5	1	0.5	Fair
Area A	LA	Eastern	0.3	1	0.3	0	0.7	0.7	0.7	Very low
Area V	LA	London	1	1	0.5	0	1	1	0.5	Fair
Area B	CCG/LA	East Midlands	1	0.7	0.7	0.7	1	1	1	High
Area U	CCG	North East	1	1	0.7	0	1	1	1	Fair
Area C	CCG	London	0.7	1	1	0.3	1	1	0.7	Fair
Area T	LA	Eastern	1	0.3	0.3	0	0.7	0.3	0.7	Low
Area D	CCG	South East	1	1	1	0.7	1	1	1	Low
Area S	CCG	North West	1	1	0.5	0	0.5	0.5	1	Low
Area E	LA	London	1	1	1	0.7	1	1	1	High
Area R	LA	South East	1	1	1	0.5	1	1	1	High
Area F	LA	North East	1	1	0.3	0	1	0.7	0.7	Low
Area Q	LA	Eastern	1	1	0.3	0	0.7	0.7	1	Low
Area G	LA	South West	0.7	0.3	0.3	0	1	0	0	Very low
Area P	LA	North East	1	1	1	0.5	1	1	1	High
Area H	LA	East Midlands	1	1	0.7	0.7	1	1	0.7	High
Area O	LA	North West	1	1	0.3	0	1	1	1	Fair
Area I	CCG	West Midlands	0.3	0.7	0.3	0	1	0.7	1	Low
Area N	CCG	South West	1	1	1	0.7	1	0.7	1	High
Area J	CCG	West Midlands	1	1	0.7	0	0.3	0.3	0.7	Low
Area M	LA	North West	1	1	0.5	1	1	1	1	High

[10] Source: CASCADE assessment data (2017-18). Scoring undertaken at the first workshop and averaged across measures and cohorts for each area. Each of seven CASCADE elements scored on 0-3 scale, giving an overall total of 0-21. Key: <4: Very low, 4-4.9: Low; 5-5.9: Fair, and >6: High, with the definitions designed to show the relative position of different areas as opposed to a judgement as to the absolute level achieved.

Area	Lead	English region	C	A	S	C	A	D	E	Relative overall rating
Area K	LA	West Midlands	1	1	0.5	0	1	1	1	Fair
Area L	LA	South East	1	1	1	0	1	0.5	1	Fair

Local arrangements for CYPMH services prior to the programme

An analysis of the EOIs and interview data provides further insights to CYPMH services in the 23 areas, prior to the programme. Specifically, the analysis shows that:

- **All local areas within the expanded programme had existing approaches or activities in place focussed on Emotional Wellbeing (EWB) and academic resilience**. This ranged from area-wide EWB strategies or frameworks, to more specific services or projects, such as mindfulness or peer support programmes within schools or colleges. It also included measures to raise the profile of EWB within the curriculum, typically delivered through PSHE or Healthy Schools Programmes.
- **Local areas were also at varying stages in rolling-out mental health training for school or college-based professionals**. This provision differed from area-to-area according to the provider, source(s) of funding, and coverage of the training provided. Examples included MHFA training, anti-stigma, and preventative interventions in schools. Training was accessed from a range of sources, including Public Health, Education Psychology, third sector and independent providers.
- **Many of the areas had undergone recent service remodelling for NHS CYPMH services**. Most notably, four of the areas had already adopted the THRIVE Framework for the delivery of specialist CYPMHS, while a further five areas were at early stages in adopting the framework or this was identified as a future action within their LTP.
- **Most areas reported measures in place relating to the links between CYPMHS, and SEND, behaviour and exclusions**, including EWB&MH training for SEND services provided by NHS CYMPHS; targeted support for young people at risk of exclusion, and for other behaviour and attendance-related issues, such as specialist support for Anxiety-Related Non-Attendance (ARNA).
- **A good number of the local areas had piloted single points of contact (SPOCs) in schools and NHS CYPMHS at some stage prior to the programme,**[11] while others had recently set in place single points of access and contact telephone line or email address for schools. Area N had placed PMHWs in schools as part of a previous initiative, while Area C intended to explore the business case for doing so as part of the current programme. As with the original pilots, these arrangements tended to be time-limited, and usually covered a finite number of schools.

[11] Area W, Area U, Area C, Area Q, Area H, Area K, and Area N

This backdrop to the programme is important, as it helps to frame an understanding of the conditions within which the programme was developed and implemented within the local areas. As can be seen, none of the areas were starting from scratch, and indeed some had quite a broad range of EWB&MH provision in place at the outset of the programme which, therefore was typically an enhancement to now significant existing local education-focussed EWB&MH activity. However, most areas reported gaps in coverage and a need to consolidate their offer to schools. As with the original pilots, the prospect of accessing additional clinical expertise provided by NHS CYPMHS was also a major selling point for schools joining the programme.

Local aims and objectives for the programme

LTPs exerted a strong influence over how the programme was positioned, and also shaped the more specific aims for the programme at a local level. Indeed, while many of the original mental health schools link pilots also referred to the LTPs, it was apparent that the programme arrangements were more explicitly linked to LTP objectives at the start of the expanded programme. This is likely to reflect that fact that LTPs were in their third iteration[12] at the stage when the EOIs were submitted, and the EOI forms explicitly asked for information on how the programme and its longer-term sustainability fitted into LTPs. Applicants for the programme were asked to state the extent that the programme and any longer-term sustainability would fit into LTPs and with other work in their locality.

Local areas commonly aimed to use the programme as a vehicle for **building capacity within the system for CYPMHS**. This included an aspiration to scale-up existing joint working with schools and colleges, and using the workshops as a platform to strengthen and deepen multi-agency partnership working. In Area W and Area G, the local programme aimed to accelerate the rollout of Mental Health Champions in schools, and was positioned as a springboard for training and workforce development, including the delivery of light touch interventions in schools. In Area D, the partners aimed to use the programme to "*test… embed, scale and spread*" models of effective joint working between schools and other CYPMH services, delivered by a new integrated CYPMH service. In Area M, the programme was positioned to meet unmet need by boosting capacity for NHS CYPMHS provision, and testing the potential for a new combined targeted and specialist offer to provide the necessary capacity for an in-reach service to schools.

A particular advantage of the CASCADE framework was the potential to improve consistency of practice across schools and CYPMHS, and to address gaps in coverage

[12] The first LTPs were developed in 2015-16 and refreshed annually

across the local area. In Area L, for example, a key stakeholder described the importance of setting in place a common set of standards and vision, authority-wide:

> *"I saw [the programme] as a lever to drive the pace of our work…. There were examples of good practice on the ground, but it was not necessarily consistent and there was no strategic framework behind it. The commissioning team were not looking at it from a system-wide perspective… so although there were some services focussed on school-age children. It was piecemeal".*
>
> (Strategic Lead, Area L)

In a number of areas, the aim was framed more explicitly in terms of **supporting the delivery of the LTP, and particularly around early intervention and prevention** objectives. In Area S, the local programme aimed to scope the longer-term leadership and governance arrangements for the LTP, by bringing together the key partners. In Area O, the local programme aimed to support the implementation of specific plans relating to the LTP and framework approaches to mental wellbeing.

Another core aim of the local programmes was **to create stronger and better understood pathways to MH support across the local area**. In the case of Area C, for example, the level of provision was felt to have been relatively strong prior to the programme, but was spread across four separate services, with a lack of clarity for schools and colleges about the offer. Similar objectives were identified in Area P, while in Area G and Area N the local partners also identified a specific aim to map EWB&MH service pathways for vulnerable children and young people.

Intended outcomes from the programme at a local level

A review was undertaken of the outcome measures and indicators proposed by the local areas within their Expressions of Interest, with these being explored further through the qualitative interviews. The locally-specific aims differed to some extent from the original pilots, in that there was a greater emphasis on the link between EWB&MH and SEND, behavioural support and school exclusions, and a stronger emphasis on crisis prevention. A number of the local areas also identified outcome measures relating to improved joining-up between school and college-based provision, and community and adult MH services. This would seem to be due in part to the fact that the expanded programme was delivering at a larger scale; included a greater focus on transitions; and that there was a stronger link to LTPs.

Table 2.2: Intended outcomes from the programme

For education and health professionals

- Improved skills and knowledge of mental health issues affecting children and young people among school and college-based professionals
- Improved awareness of the school environment and issues encountered by teachers and other school-based professionals, among NHS CYPMHS staff
- Improved clarity and understanding of referral routes to specialist NHS CYPMHS
- Improved wellbeing and reduced anxiety among education professionals

Organisational level

- Improved school climate and culture towards EWB&MH, including reduced levels of stigma towards MH issues among staff and students
- Better quality and more timely referrals to specialist NHS CYMPHS
- Crisis prevention, measured by reduced numbers of calls to emergency services from schools, and reduced numbers of A&E visits by young people in distress

System level

- Stronger and more coherent local system leadership across CYPMH services
- A shared understanding of service pathways across the wider CYPMHS network, including the provision available from NHS CYPMHS, Counselling, Educational Psychology services, School Nursing, and third sector providers
- Improved quality and frequency of communication between schools and colleges, NHS CYPMHS, and other professionals working with children and young people, including education, health and children's social care

Service user outcomes

- Earlier access to support for children and young people experiencing mild to moderate mental health problems
- Increased access to CYPMH services among minority communities
- Reduced numbers of school exclusions for children and young people, where behavioural issues have an EWB&MH dimension
- Improved quality and consistency of support for children and young people's EWB&MH at transition points, including primary to secondary, post-16, and improved support for transitions from child to adult services

Early programme development

Identification and targeting of schools and partner organisations

The local areas adopted a wide range of strategies to identify and engage schools and CYPMH organisations to participate in the expanded programme. Although the scale and scope of the local programmes was considerably greater than during the original pilot, the local areas also benefited from having additional time to plan their recruitment. On balance this meant that it was possible to adopt a more strategic approach, mitigating against the risk of skewing the programme towards 'already engaged' schools.

One of the main areas of variation between the local areas was the extent to which the programme was pitched as an opportunity for *all* schools and colleges, and the extent to which it was targeted at schools according to their level of 'need' for specialist MH provision, and / or the strength of existing engagement with NHS CYPMH services.

The most widespread approach was to **raise awareness of the programme as widely as possible across the local area**, to generate the necessary level of demand to meet the minimum requirements for numbers of schools set by the Department, and with the aim of achieving a good mix of educational provider types. As noted, the extended programme included a number of specialist/PRU/alternative providers and colleges. The main **factors driving the selection in this scenario were mainly geographical** – i.e. to mirror LA and CCG administrative boundaries covered by the local programme, and often mapped to established locality teams for education and children's services. However, a number of areas applied more specific geographical criteria as part of their overall targeting strategy, which included:

- organising programme delivery around clusters of secondary schools and their feeder primaries, with an explicit objective of supporting young people's transitions (e.g. Areas C, D, F, G, K, Q and P).
- combining a more open offer to schools across the local area covered by the programme with a focus on localities with higher levels of socio-economic disadvantage (e.g. Areas F, M and P).
- mapping programme delivery onto established local multi-agency partnership arrangements established within Opportunity Areas (OAs), while seeking to extend engagement to schools in adjacent areas (e.g. Areas O, Q and T).
- clustering with a view to developing local EWB&MH hubs, bridging school and community-based provision (e.g. Areas L and U).

In Area W, the geographical targeting was more simply defined as operating on a city-wide basis, while in Area N the pilot was considered sufficiently small-scale to proceed without geographical clustering. In this case, the schools network overseen by the

Teaching School Alliance was thought to provide the necessary infrastructure to support a potential wider rollout beyond the programme period.

In addition to the examples discussed above – and sometimes implemented as part of a geographically targeted approach, a smaller number of areas had designed their programme centred around **a more targeted approach based on specific school characteristics**. One such approach was to target schools according to demand and / or perceived levels of need for support. This was achieved by varied means, at a local level:

- A first approach was to prioritise schools that had self-identified as requiring additional support, through their feedback to NHS CYPMHS or via other local EWB&MH forums. Area M started with schools that had registered their interest in becoming Emotionally Healthy Schools with the local PSHE network, while Area S used survey feedback. Area Q targeted secondary schools that had identified mental health as a priority in their School Improvement Development Plan (SIDP), alongside suggestions provided by the Safer Schools Partnership.

- A further approach was where the LA or CCG made an independent assessment of schools that might stand to benefit the most from taking part in the programme. Areas A, H and K drew up priority lists by combining proxy measures from NHS CYPMHS and LA administrative data, such as referral numbers and exclusion, with intelligence from NHS CYPMS teams regarding schools that had proven difficult to engage.

- In addition to identifying schools with greater levels of need, Areas H and K further aimed to engage a mix of schools at varying levels with regard to EWB&MH support, and to introduce a peer-to-peer element. Area H approached local schools with recognised elements of ‘good practice’, while Area K looked to their local special schools to perform a mentoring role within the programme, drawing on their extensive experience of links with NHS CYPMHS.

Area C’s strategy combined many of the above elements, incorporating a focus on primary to secondary transitions, with objectives to improve communication between CYPMH services and schools within minority and historically marginalised communities. The CCG was also able to draw upon NHS CYMPHS administrative data identifying the 250 children in the borough approaching primary to secondary transition who were the ‘most vulnerable’ according to EWB&MH indicators. These data helped to further target the programme towards schools where there was an identified need for support.

Recruitment of schools, colleges and partner organisations

In practical terms, most local areas took a multi-faceted approach towards recruitment for the workshops. This activity typically started with their established links with schools and

other education providers through local EWB&MH forums or networks and pilot projects, and worked outwards – engaging at a strategic level with the main local Education and Health Strategic Partnerships, and at an operational level via SENCO forums and VCO networks (see Table 2.3). In Area G, for example, the LA first invited all schools via the Council's 'school noticeboard' – a well-established communication forum, which is widely used by schools, before approaching Executive Head-teachers of all Academy Trusts operating within the authority, and engaging at a more grassroots level via Primary PHSE Coordinators, and through the membership of the Healthy Schools Programme.

Table 2.3. Overview of recruitment methods for the programme

Strategic level

- Engagement with Local Education and Health Partnerships, Behavioural Improvement Programme, and / or Healthy Schools Partnerships
- Engagement with EWB&MH forums or networks, including SENCO or PSHE coordinator networks, and existing local Mental Health Forums
- Links with Opportunity Area (OA) Partnership Boards (if applicable)
- Teaching School Alliance (TSA) networks
- Awareness-raising at special events or conferences, e.g. LTP days

Operational level

- Recruitment of schools from established local projects, to provide support and challenge (e.g. Headstart, Schools in Mind, Time to Change, locally specific)
- Engagement with children and young people's VCOs and umbrella associations
- Head-teacher networks / residential days
- Surveys or online consultation with CPMPH services and schools; awareness raising campaigns or marketing and communications activity
- Outreach visits or meetings with community organisations and parent forums

In Area D, the delivery of the programme as a core element of the LTP helped to justify the release of additional Transformation funding to support recruitment. The CCG and partners acknowledged that high levels of take-up for the programme would support the implementation of the local EWB&MH Strategy.

Other areas aimed to **widen participation among schools by reaching out to specific school communities where engagement had been more limited historically**. In Area M, one of the aims of the programme was to boost levels of engagement with

independent schools, who had expressed dissatisfaction with NHS CYPMH services and with a perceived lower level of access to targeted and specialist services than mainstream schools. The leadership of the local programme by the LA proved to be an advantage, as the LA chaired a longstanding network with the heads of the 16 local independent schools, and was able to make use of these relationships to recruit to the programme.

In Area C, recruitment drew heavily on community organisations and partners, including access to BAME communities via a VCSO focusing on young black males – an established community mental health project supporting primary to secondary transition by working with school staff to improve cultural competency and to support with parental engagement. A further series of stakeholder events were held with Minority Community Schools, to discuss their requirements and aspirations for the programme.

One of the main challenges for recruitment was **accessing and maintaining accurate contact information** for individual schools or colleges. Where links were made at an operational level in particular, staff turnover was found to be an issue, and staffing lists became outdated quite quickly. The accuracy of lists was often improved where area leads were able to check with SENCO or EWB&MH networks regarding active members, although this typically only provided partial coverage of schools locally. In Area J, NHS CYMPHS administered an online questionnaire of schools to compile more accurate information for the programme. These examples underline the importance of maintaining an accurate database of contacts for local CYPMHS networks.

3.0 Lessons learned from programme implementation

Key findings

Workshop planning and delivery

- Workshops were delivered in 2 full-day sessions followed by a series of national learning events, with external facilitation and tailored inputs from the CCG lead.
- A wide range of representation was achieved from the education sector beyond the participating schools and colleges themselves and from CYPMHS, although areas experienced varying success with engaging VCSOs. Participants generally valued the mix of disciplines and range of seniority.
- There was a good level of overall satisfaction with the workshops. Participants generally positively rated the content, experienced facilitators and opportunities to network. These elements were achieved with varying success across the 23 areas.
- Increased shared understanding of services and provision, and the CASCADE framework as a self-assessment tool were important aspects of the workshops. Some participants identified a need for this to take account of, or be based on, the local context as much as possible.

Action planning and review

- Actions agreed at the workshops ranged from ‘quick wins’ to more complex initial commitments to change in some areas. They included updating referral processes, providing additional staff training, and a commitment to evidence-based practice.
- Factors affecting the implementation of actions included: the actions being realistic and clear, actions being tied into current work, follow-up on implementation and levels of joint working prior to the programme.

Post-workshop rollout of joint working arrangements

- At an overall strategic level, the programme largely took place within pre-established governance arrangements. As such, the local areas reported relatively few changes to overall local systems leadership arising directly from the programme.
- In a smaller number of areas, however, the programme helped to develop new multi-agency joint working arrangements at a strategic level that were not in place

prior to the programme. These included joint service commissioning and joint plans.

- At an operational level, there were clearer signs that the programme had stimulated the development of mental health forums or networks involving schools and colleges in some areas, although this work was at an early stage.
- The lead contact roles within schools and colleges were not found to differ significantly from the original pilots, although more schools had already identified a lead for EWB&MH. The 2017 Green Paper was thought to have been a factor.
- The lead contact roles within NHS CYPMHS most commonly involved creating a single point of access via a central duty team, or raising awareness of existing arrangements. Areas commonly updated referral forms, and service pathways.
- Alternative access arrangements were needed in cases where schools were unable to refer directly to NHS CYPMHS. This typically comprised of a range of new measures such as mental health forums, service directories, and training for schools.
- Despite the challenges of delivering at scale, a number of local areas also identified a designated lead contact(s) in NHS CYMPHS for schools and colleges. These arrangements typically required additional LTP and / or external funding.
- The factors that supported joint working largely mirrored the pilots, and included the need for strong local systems leadership, and an active NHS CYPMHS presence. As with the pilots, representation from the wider CYMPHS network was mixed.
- The call for expressions of interest for the Green Paper Trailblazers for Mental Health Support Teams exerted a strong influence, and most areas used CASCADE to inform their applications. This created some uncertainty, however, and longer term plans were put on hold while awaiting the outcome.

Workshop planning and delivery

Following on from the successful original pilot in 2015/16, the AFNCCF were commissioned to expand the roll-out of the project to include a greater number of schools and colleges across England. Between 2018 and 2019, workshops were delivered across 23 CCGs and LA areas, reaching 1,104 educational establishments (as noted previously, primarily primary and secondary schools) and 1,031 mental health professionals.

Aims and structure of joint workshops

The objectives of the workshops were to develop joint working between education and mental health professionals and offering training to improve joint working. Through bringing together representatives from schools/colleges and their local CYP mental health services, the workshops aimed to build stronger links and communication between these professionals.

The workshops were delivered in 2 phases:

- Two full day workshops delivered five to six weeks apart between January and November 2018
    - Day 1- Forming school/college and CYP Mental Health Partnerships
    - Day 2- Embedding Partnerships and building sustainability
- National learning events held in four locations (London, Gateshead, Manchester and Cambridge) to facilitate shared learning and discuss achievements

The workshops were co-ordinated and facilitated by experts who were contracted to, or engaged by, AFNCCF, with inputs by the CCG lead contact to provide a contextual overview and to embed within the local context. Each workshop was delivered by two trainers; one a clinician and the second with a background in education.

Each workshop followed a common structure with opportunities for variation based on the local context. Attendees were expected to attend both workshops. The first workshop aimed to provide a shared understanding of the strengths and limitations of capabilities and capacities of both the education sector and CYPMHS. The workshop provided an informational element, including an overview of common tools and outcome measures. The CASCADE framework was a focus of the first workshop, using the self-assessment tool to provide a benchmark in identifying what is currently working well and how things may be improved. Workshop two considered joint working practices using the CASCADE tool to reflect on successful methods of joint working since the last workshop, with ideas also being shared for further improvement to joint working locally.

Workshop attendance

The workshops aimed to include **representation from both education and wider CYPMHS networks**. Participants valued the mix of disciplines and the range of seniority levels of attendees. The representation at workshops varied across areas, many felt that VCSOs were poorly represented amongst the attendees, this was felt to be a “missed opportunity”. In smaller boroughs, such as Area P, the workshop still achieved good representation through encouraging input from the wider CYPMHS network including the VCS, CYPMHS, educational psychologists and a clinical psychologist. In terms of

education attendees, participants welcomed the mix of representatives from a range of school settings including primary, secondary and academy schools.

Workshop feedback

In general, there was consensus amongst participants that the workshops were delivered to a high standard with good quality content. The follow-up survey found that 82% of MH professionals and 84% of school staff were satisfied overall with the workshop ('very satisfied' or 'quite satisfied'). The workshops were a forum for attendees to view children and young people's mental health as a whole system rather than through the perspective of their individual services. This was welcomed by participants, who also agreed that the gap of five to six weeks between workshops allowed them to reflect on their learning and implement actions.

The structure of the workshops was seen to allow adequate time for learning, reflections and sharing. However, while many were happy with the agenda, there were a small number who felt it may have been too rigid:

"I felt very constrained by the agenda, which was dictated to us. They had a one-size-fits-all approach".

[Commissioner, Local Authority, Area L]

The qualitative interviews show the value of **knowledgeable and experienced facilitators** in the delivery of the workshops. Participants noted that the "delivery was fantastic", with the content being presented in a way that was clear and made relevant to their local context. In Area Q, the local authority had made connections with the workshop facilitators and drawn on their expertise to support their own project to ensure that the learning was embedded within their framework.

The majority of participants were positive about the **content** of the workshops, feeling it was clear, concise and relevant to the local context, albeit that some felt the local context was not necessarily made explicit in their workshops. Participants felt that the content flowed from workshop one to two, in that points from the first workshop were readdressed and linked to the content in the second. The reaction to the CASCADE model was mixed, but in general, participants saw this as a valuable tool to make them consider joint working provision. Education professionals appreciated that the workshops acknowledged that there was a knowledge gap on both sides, not just from the perspective of schools. Participants felt that the delivery partner and the workshop facilitators pitched the content at the correct level for the expertise of the attendees, which was well received:

“[The delivery partner] don’t assume that you know nothing, [they] treat you with a great respect”.

[School MH Lead, Area P]

The qualitative interviews showed that **networking** with representatives across a variety of organisations within a supportive environment was often considered to be a primary benefit from attending workshops. Generally, the workshops served as a forum to facilitate discussion between the representatives that have resulted in a greater feeling of mutual understanding and connectivity, although the implementation of the table-based structure meant some participants felt that opportunities for networking were limited. Nonetheless, the benefits came through strongly in the interviews. For example, on participant said:

“It was great for raising awareness and reminding us about what services there are... and a good networking thing to get ideas from colleagues. Multidisciplinary things like that are very helpful and useful… I think the future is particularly the links between schools and mental health”.

[Assistant Head, SENCO, Area P]

Through networking and discussions, both school and MH representatives were able to gain a **better understanding** of how NHS CYPMHS and the education sector are structured. Representatives were able to clarify their role, capacities, capabilities and challenges, allowing them to **dispel myths and misconceptions** around their services and provisions and address some of their barriers to accessing CYPMHS. For example, in the Area Q workshop, through networking opportunities with a clinical psychologist, a school was able to clarify some of their misunderstandings around the thresholds and criteria of the CYPMHS referral system. As a result of their learning, the school successfully referred a vulnerable student into CYPMHS. Similar feedback came from a number of other participants.

There was some initial frustration amongst schools that CYPMHS were not meeting the current level of MH demands of children and young people. Participants noted that the opportunity to gain clarification around the challenges that CYPMHS in England are facing helped to alleviate some of these frustrations. Particularly in instances where CYPMHS cannot take on a case, the attendees felt they had a better understanding of alternative local resources where they could seek support. Additionally, participants noted that it often seemed as though education and CYPMHS speak different languages, so the ability to come together to discuss things first hand was particularly valuable.

Case study: Increased understanding of CYPMHS across the region

In Area U, the workshops gave organisations the opportunity to share what mental health services they could offer children and young people. This allowed the sharing of information and the **clarification of "myths"**, particularly around the capacity and capabilities of the CYPMHS.

The workshops also brought benefit to the organisation themselves in that they could gain an insight into the provision of wider CYPMHS across to the county. This allowed the service to **identify where efforts were being duplicated** and consider possible joint working opportunities in the region. From the workshops, the organisation were able to identify possible scope for multi-agency training and the co-delivery of training across organisations.

In addition to a greater understanding of CYPMHS by schools, the workshops also allowed MH professionals a **valued insight into the needs to the education sector**, particularly relevant in light of the current restructuring of services in some areas. For example, in Area Q specialist mental health provisions are being redesigned. Through the workshop, CYPMHS professionals were able to better understand what a 'comprehensive' service offer would look like for schools in the local area.

During the original pilot, the workshops appeared less well suited to areas with more significant **underlying tensions** between the education sector and CYPMHS. During the expanded programme it appears this remained the experience of some areas. For example, in Area P, it was felt that schools in particular could be "damning" and negative due to underlying dissatisfaction with CYPMHS. Whilst other areas acknowledged the prospect of the networking opportunity becoming a forum of negative discussion, they hoped they had successfully addressed this and it was not an issue during the workshop:

"You have to manage it not being a moaning shop, a room full of people who all have grievances about each other".

[Area L]

Response to the **CASCADE framework** used in the workshop content was varied. In general, participants valued the framework for gathering an understanding of where they are in their joint working and where improvements could be made. For example, in Area Q the framework helped them to focus and reflect on the service they provide, realising that they were implementing more joint working than first realised. In Area P, participants felt the framework enabled them to identify action points based primarily on improving their communication within the borough, including regular meetings and defining a common language between stakeholders:

"I think it was good, I liked the CASCADE thing because it allowed you to think about where you want to be".

[Deputy Head, Area P]

"As I say it was a bit frustrating when you look and think… well that's where I want to be. But it was a good way of evaluating yourself and evaluating how you are performing and sort of look at different things and how you need to develop in areas that you might be better at".

(Deputy Head, Area P]

However some respondents felt that the framework needed to be contextualised better, both in terms of how it was presented within the workshop and within the content of the framework itself. Participants felt they needed a narrative behind the domains rather than simply "ticking of a box" and questioned how well the framework was explained and contextualised to take account of their local situation before being handed out in the workshop. The CASCADE framework was also viewed as being too prescriptive, with participants expressing the need for more flexibility in identifying their needs and challenges.

Action planning and review

Actions agreed

The actions agreed by workshop attendees ranged from quick win actions, achievable in a short timeframe to more complex operational level changes. The follow-up survey found that 65% of MH professionals and 84% of school staff felt that action points had been agreed at their workshop.

The qualitative interviews showed that many areas were investing in **additional training for staff**. For example, Area U made the action to deliver CPD sessions in emotional health and wellbeing to all staff members in schools/colleges using a modified version of the AFC slides. It was also hoped that they could disseminate these slides to other schools. Some schools looked to expand their training opportunities to reach parents:

"We are looking at putting more of it into the curriculum. Developing helping parents to understand mental health. Really raising awareness of mental health for children in schools… it's about engaging parents in a way that they understand".

[Deputy Head, Area P]

CYPMHS professionals noted that the workshops were key in working with schools to increase their understanding of the **referral process**. Therefore, many areas included referral processes as part of their action planning. Schools have actioned new referral forms and updated staff guidance on the referral processes.

Some areas created clearly defined actions of joint-working to address key issues. For example, in Area U schools acknowledged that a barrier to accessing mental health services was through parents forgetting appointments and not reading letters, particularly in cases where the parents experience mental health concerns themselves. Schools recognised that they can play a vital role in encouraging parents to attend services through reminding them in person. CYPMHS and schools within the area hope to work together to ensure that schools are aware of appointments so that this action may be implemented.

The importance of ensuring current CYP MH provisions are **evidence-based practice** was an action point for a number of areas. In Area U, a framework was actioned to make communication around MH and MH provision consistent across the region, this includes opening up discussions around the evidence base of current provisions and sharing best practice. The importance of commissioning evidence based services was also recognised in Area P, illustrated below:

Case study: Private therapy in schools

In Area P, private therapy services are commissioned by schools for their children and young people. The workshops highlighted that there was no governance framework in place within this area to ensure that these private services are evidence based. An action point for the schools in the region was for them to consider the evidence base of the services that they buy in.

"A lot of schools, could see they were beginning to think about it and what they buy in, so was helpful to begin to think about that".

(CYPMHS Primary Mental Health Worker, Area P)

A number of areas agreed on **smaller actions** to implement within their services. These 'quick wins' were viewed as achievable and realistic, prompting an ownership of joint working in attendees of all levels. Small actions included creating a directory of services, delivering a short presentation on the new referral processes and sending staff members on mental health first aid courses.

"Felt empowering that there didn't need to be large-scale change but that accumulation of little actions could add up to something quite worthwhile".

[Senior Educational Psychologist, Area U]

Other actions agreed included: creating a MH Lead role within schools, a termly meeting between school MH Leads and CYPMHS to discuss good practice, updating school

strategic plan with a 2-year “vision for mental health” and the CCG lead introducing themselves in a face-to-face visit to all schools in the area.

Implementation of actions

The level of implementation of actions following the workshops was mixed across areas, with around half of attendees (46% of CYPMHS professionals and 49% of school staff members) being ‘very’ or ‘quite’ satisfied with the implementation of actions when asked as part of the follow-up survey and most of the remainder not knowing. Where actions were not implemented tended to be among some school participants, with this partly being due to **unrealistic timeframes** being set, resulting in this element of the workshops being perceived as “a bit of a missed opportunity”.

“I am glad we’ve been a part of it. Schools are looking at it saying ‘it’s been good so far’… they’re waiting to see if there is the follow-through they’re hoping for and that’s fair enough”.

[Senior Educational Psychologist, Area U]

Actions agreed during the first workshop, tended to be relatively **small actions** that could be implemented within the following 6 weeks and allow learning to be discussed in the second workshop:

“People came back [at day two] and sometimes did something slightly different. Often this is a sign that it had gone quite deep as have given it more thought”.

[Senior Educational Psychologist, Area U]

“They were very clear there was a PowerPoint there and we were sent copies afterwards. It was pretty clear because we were all done a task to do as a result of the first training sessions which we were very clear about and given steps to take before the next session”.

[SENCO Assistant Head, Area P]

As would be expected, qualitative interviews suggested joint working outcomes were more likely in areas where workshops had been seen to deliver clear actions. The box below illustrates one example:

Case study: Changing school relationships with General Practitioners (GPs)

Prior to the programme, schools within Area L had expressed some dissatisfaction with the support provided by GPs where children and young people were referred with a mental health issue. From the perspective of the schools, the role of the GP was too often simply "just signing a letter" authorising a period of absence without additional support or follow-up.

The engagement of GPs at the workshops was reported to have made a real difference. The schools in found being around the same table as local GP's very helpful, allowing them to share their experience, concerns and future needs.

As a result of the workshop, GP's have now got together with schools and are having GP/school team meetings and school-practice meetings - talking together about specific young people and opening doors.

"Out of that came understanding about articulating things, but also a commitment to tackling it"

[Area L]

In areas where the implementation of **actions have coincided with other work**, service level changes may be easier to embed. In Area Q where the CYPMHS is going through restructuring, the actions are hoped to become the new "normal" for service delivery. The area is establishing a single point of contact and is looking to test this with teachers in the local area. This is also seen in Area P:

"Progress between the sessions was really good because it coincided with a lot of other work and gave me clarity of thought to pull things together".

[SENCO Assistant Head, Area P]

Where momentum was lost and attendees were unsure as to whether actions were implemented, qualitative interviews suggested participants felt that a lack of capacity and resources have led to some actions not being put into practice. This was exacerbated by the breadth of possible actions identified meaning a lack of strategic focus on key issues where significant difference could be made.

"The difficulty is always the link because everybody goes back to their own workplaces and… it's difficult to plan for that and actually put it into practice".

[SENCO Assistant Head, Area P]

A barrier to the implementation of actions was the **lack of follow up** once the workshops had concluded. Attendees were unsure how they would be held accountable for the delivery of their action points and whether their progress would be monitored or followed up. In Area L this lack of follow up was described as “a bit of a void”.

“Did have concerns about what could really be done in two days- could they not have a third day 18 months down the road? Schools will say they often do things because they know you are coming back.... Having someone coming back to look at what they have done and possible offer of support would have been useful”.

[Senior Educational Psychologist, Area U]

While areas were encouraged to have responsibility and ownership of achieving gold standard status this was not always consistently understood by those attending:

“Perhaps it would have been helpful to have some more guidance from the AFC on how to achieve ‘gold standard’ and some sort of follow up support to do this”.

[Area Lead, Area M]

The **level of joint working prior to the programme** may have an effect on the actions proposed, the subsequent level of implementation and final outcomes. CASCADE data was collected during the first workshop, with the combined mean score across all areas being 5.2 (range 3.3 to 6.7), averaging at 0.9 for each of the seven indicators. By comparison, the mean score across all indicators during the original pilot study was 0.4, showing that the level of self-appraised joint working *prior to the programme* was higher in the expanded programme than was previously seen in the pilot. This higher level of joint working may have potentially been the result of the application/recruitment process in the expanded programme as well as the increased level of attention for mental health in schools since the inception of the original pilots.

Post-workshop rollout of joint working arrangements

The influence of the workshops as a whole (including the CASCADE approach) over joint working arrangements beyond the workshops was a key test for the programme. Here, we consider the governance and partnership arrangements within which the workshops were rolled-out, the joint working arrangements that were established and any relevant enablers/barriers.

It should be noted that some areas were still receiving workshops in autumn 2018, meaning that multi-agency partnership arrangements were still under development. Moreover, workshops were often delivered as one strand of a wider range of transformation measures. The case study examples are intended to illustrate the

contribution of the programme, therefore, rather than suggesting that any changes may be solely attributable to it.

Local governance and partnership arrangements

At an overall **strategic level**, the continuation of activities initiated as a result of the workshops largely took place within pre-established governance arrangements. As such, relatively few changes were reported to overall local systems leadership. This is perhaps largely to be expected, given that the workshops were planned and implemented within the wider framework provided by LTPs rather than as a stand-alone project within most areas. In Area U, Area N, and Area G, for example, the legacy activities from workshops fell within the remit of the working group tasked with overseeing the implementation of the LTP. This ensured continuing representation from education and health and formalised the commitments made during the programme.

In a smaller number of local areas, the programme was a contributing factor in developing new multi-agency joint working arrangements at a strategic level that were not in place prior to workshops. The workshops in Area U started a strategic conversation between NHS CYPMHS and Children's Social Care, which had developed into plans to set-up new joint working group to review ongoing links between the two agencies and to support a more integrated approach to joint working on EWB&MH and safeguarding. In Area L, the programme served as a catalyst in reviewing a much broader range of multi-agency joint working arrangements, as described in the following case study.

Case study: Workshops as a catalyst for multi-agency partnership working

In Area L, the LA used the momentum from the workshops to launch a series of consultations with service leads and directors on commissioning arrangements for EWB&MH training, with a view to developing an integrated offer for schools and colleges. The LA also planned to draft a Memorandum of Understanding for local partnership boards, to establish a commitment to EWB&MH issues over the coming year. This included a specific piece of work to develop a multi-agency approach towards addressing emotionally based school avoidance. The lead described how this would start with multi-agency planning workshops, inspired by the workshop format and the CASCADE approach.

At an **operational level**, there were clearer signs that the programme had directly influenced the development of already existing mental health forums or networks involving schools and colleges, often supported by NHS CYPMHS. In several areas, the workshops raised awareness of forums that had already been set-up at a local level, with the potential for larger scale rollout. A forum convened half-termly for high schools in

Area M was extended to include primary schools, and to include the school nursing and counselling services, alongside NHS CYPMHS.

Case study: Scaling-up local EWB&MH forums for schools and colleges

In Area J, the workshops revealed a consensus around the need for more regular meetings between schools, colleges and CYPMH services. In particular, schools wanted a forum where they could bring cases to discuss. The discussions highlighted an existing locality forum, chaired by NHS CYPMHS, offering support on EWB&MH issues affecting schools.

"We went to a few of the forum meetings, to discuss on a smaller scale what schools wanted… and we realised that [the forum] is very comprehensive… so why would you reinvent that? [The strategic lead] has agreed to open up [the forum] to provide larger locality meetings for schools, if there is demand".

(NHS CYPMHS representative, Area J)

In other areas, the programme offered a vehicle for setting-up new EWB&MH forums to sustain joint working between schools and NHS CYPMHS, where they did not exist before. This was the case in Area V, where the programme was used to "scope and shape" mental health forums across the local area, and in Area N, where it was similarly used to map key stakeholders within the CYPMHS network in each authority area, and to launch two new EWB&MH networks following the workshops.

Models of joint working between schools and NHS CYPMHS

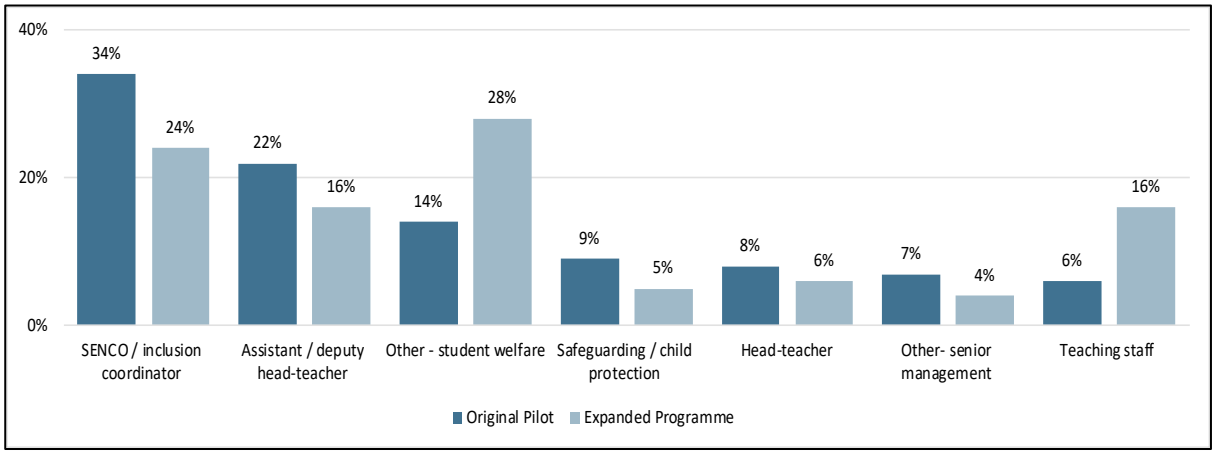
The case study visits and follow-up survey provided an opportunity to examine the ways in which joint working arrangements were developed between schools and NHS CYPMHS within the expanded programme. Whereas the original pilots incorporated both the workshops and additional dedicated funding for NHS CYPMHS,[13] the areas within the expanded programme set out to deliver the workshops at scale, and to do so within existing resources (noting that the NHS England CYPMH Transformation Programme included year on year increases in CCG baseline finance). The rationale was to test the programme under 'business as usual' conditions, in order to provide a realistic view of the outcomes achieved.

[13] During the original pilots, NHS England made funding of £50,000 available per CCG, to cover NHS capacity to release specialist staff to take part. CCGs were expected to match-fund this amount.

The arrangements were not found to differ significantly from the original pilots, regarding **lead contact roles within schools and colleges**, although it should be noted that schools were required to back-fill from their own budgets.[14] Schools were tasked with identifying a designated lead to participate in the workshops, and to establish a link at senior management level (if the workshop representative was not a senior manager). The following chart (Figure 3.1) compares the profile of school leads who responded to the survey for the pilot evaluation, with those who were surveyed for the expanded programme.

As the following figure illustrates, the lead roles largely correspond with the profile from the original pilots, with a mix of specialised support staff and management. There remains a good level of representation from senior staff, including head teachers, deputy head teachers and senior managers, with it being possible that the increase in lead contacts with specific student welfare roles (14% in original pilot, 28% in extended programme) is in line with the expectations relating to designated senior leads being identified included in the 2017 Green Paper[15].

Figure 3.1: Lead contact arrangements in schools – a comparison between the original pilots and the expanded programme



Base: Original Pilot: 177; Expanded Programme: 481

One of the main differences from the original pilots was that more of the areas had already taken action to identify designated leads for mental health in schools and colleges, following the publication of the 2017 Green Paper. In Area G, for example, it was reported in the lead survey that 68% of schools had already identified a lead contact or had nominated 'de facto' leads who attended mental health network meetings, prior to

[14] During the original pilots, in contrast, funding of £3,500 was made available per school to backfill staff time to participate in the CASCADE workshops and follow-up activities.
[15] DHSC and DfE. (2017). Transforming children and young people's mental health provision: a green paper: Department of Health and Social Care and Department for Education.

the workshops.[16] Several areas had also commenced large scale training programmes for prospective lead contacts in schools, as illustrated by the following example.

Case study: CASCADE Workshops as a springboard for further training

In **Area Q**, the County Council and CCG has commissioned a consortium to deliver a programme of Mental Health Champion training to designated lead contacts for mental health in universal settings, including schools, Early Years providers, GP practice professionals, health visitors and children centre staff. Upon completion of the foundation training, which includes guidance on referrals into specialist services, the leads can qualify for specialist training and access in-house consultations.

A strategic key stakeholder reflected on how the CASCADE workshops provided a platform to secure the engagement of schools and other CYPMH services, and to build trust. Moreover, the County Council and CCG intend to use the CASCADE framework as one of a number of tools to assess the impact of Mental Health Champion training.

It is also possible to draw comparisons with the original pilots, with regard to **staffing arrangements within NHS CYPMHS**. The final report from the pilot evaluation identified three main models summarising the working arrangements on the 'health' side. These models are summarised below, and are further described in Appendix 2.

a) NHS CYPMHS named lead with contact time in schools on a regular basis, delivering services and support directly to staff and young people
b) NHS CYPMHS named lead offering dedicated training and support time to school-based professionals
c) NHS CYPMHS named lead or duty team with designated responsibilities for the pilot, offering a single point of access

While the original pilots generally adopted models b) or c), the arrangement among the areas in the expanded programme typically appeared closest to model c), offering a **single point of access to schools and colleges to a central NHS CYPMHS duty team**. Here, the programme was used to streamline referral processes between schools and NHS CYPMHS – sometimes engaging schools in co-designing a new referral form or protocol (Area U), and / or to raise awareness of the NHS CYPMHS duty team and their

[16] Data from the Winter 2018 teacher omnibus (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/817604/The_School_Snapshot_Survey-Winter-2018_July19.pdf) shows 82% of state-funded schools stating they had a designated lead in place, an increase from 70% the previous year. This was largely driven by an increase at the primary school level from 67% to 81%

availability for advice and consultations (Area J). It was not uncommon for NHS CYPMHS to offer a range of different communication channels, and to reinforce this through face-to-face contact with PMHWs at network meetings. In Area Q, where rurality issues pose a particular challenge, the single point of access arrangements were reinforced by other measures (funded via the LTP budget) to extend the opening hours of the specialist NHS CYPMHS team, and to commission an online platform to improve their reach. This offer was generally the least resource intensive and potentially more sustainable as a result. However, this approach arguably was less likely to deliver outcomes in the short-term than alternative approaches.

Alternative access arrangements were needed in cases where schools were unable to refer directly to NHS CYPMHS. In Area G, for example, primary schools must refer via GPs, while SENCOs in secondary schools can only refer after completing specialist training with NHS CYPMHS. A suite of measures was introduced through the programme to provide extra support for schools. This included three mental health forum meetings per year for school leads; a quarterly mental health newsletter, and a new directory of EWB&MH services. An expanded offer of specialist training was also put in place, in response to demand from schools at the workshops.

Despite the challenges associated with working with far greater numbers of schools than during the original pilots, a number of the areas also ran the workshops alongside measures to introduce (or scale-up) a **named lead contact(s) in NHS CYMPHS offering dedicated training and support to school-based professionals** (i.e. closest to model b) from the pilot phase). In Area S, the programme provided an opportunity to work with schools to develop a new specialist CYMPHS link pathway, and to pilot a new NHS CYPMHS link worker post for schools. This post was made permanent following the workshops and developed into a clinical offer. Similarly in Area O, the perceived success of the pilots was sufficient to secure Opportunity Area funding to establish a school link service, and three new NHS CYPMHS link worker posts had been approved at the point when the last of the fieldwork took place for the evaluation in spring 2019. Area M and Area H had also secured additional resources to support the continuation of a link worker service, via the CCG and Trailblazer funding respectively.

Case study: Rolling out a new NHS CYPMS link worker service to schools

In Area H, the workshops was rolled out alongside a new PMHW Service, offering consultations and training to schools with the aim of improving the quality of referrals to specialist NHS CYPMHS.

The workshops showed a demand from schools for peer networks to share processes and protocols. The Future in Mind Programme Lead was tasked with developing the networks, which were included within the county's successful Trailblazer application.

The networks and PMHW service will be assimilated within the model for the Wave 1 Trailblazer Mental Health Support Team (MHST).

The ongoing work coming out of schools link programme now forms part of Area H's LTP Action Plan. Accountability feeds up to the Children and Young People's Mental Health Executive and ultimately to the Health and Wellbeing Board.

Perhaps unsurprisingly, given the scale of delivery across multiple schools and colleges, very few of the areas within the expanded programme made a commitment to provide **specialist NHS CYPMHS contact time in schools on a regular basis**. This had been the case in the original pilot, due to the additional funding for NHS CYPMHS and the smaller scale of the pilots with fewer schools to cover. Indeed, there were mixed views on the effectiveness and efficiency of such a model within the expanded programme. NHS CYPMHS representatives from one local area contrasted the responsiveness of their existing duty team, which is available daily and can respond immediately to inquiries, with a named link worker in NHS CYPMHS, who could potentially take 24 hours or more to respond in the event of a heavy schedule of clinics. Others voiced similar concerns to those raised during the pilot phase, regarding the cost effectiveness of PMHW drop-ins to schools.

Nonetheless, one of the areas had used the pilot to scope an 'in reach' model providing direct school-based specialist support, as illustrated by the following case study.

Case study: In-reach to schools from specialist PMHWs

In Area C, the LA and partners combined the workshops with two other strands of activity for schools identified within their LTP:

- time from School Improvement Partners, to support schools with auditing their EWB&MH provision and to develop action plans, and
- deployment of specialist NHS CYPMHS workers in schools, for between 0.25 and 1 day per week, guided by the needs identified within their EWB&MH action plan.

This enhanced offer was made to 40 schools in the first instance, representing half of the schools within the area, with a view to a potential rollout. This represented 4.7 FTE (Full-time equivalent) PMHW time, plus management, clinical supervision and administrative costs.

The in-reach model was still at an early stage of implementation when the evaluation fieldwork took place, but all 40 schools had action plans in place. Project staff

considered that the action plans were an effective accountability mechanism, requiring schools to make a case for extra PMHW resource based on evidence of need.

Barriers and enablers to the rollout of joint working

The evaluation evidence points towards a number of factors that helped or hindered joint working, many of which chime with the findings from the original pilot evaluation.

First, with regard to enablers, **strong local systems leadership** combined with commitment and visibility from the CCG and LA was key to securing buy in from schools and other partner organisations. Several of the CCG-led partnerships reported a setback when LA representation was missing from the workshops, while in other areas **representation from NHS CYPMHS** was critical to schools' willingness to engage in subsequent stages of the process. A number of the local programmes had active involvement from commissioners, and this proved important when identifying ways to embed the programme and to lever-in additional resources – often from LTP budgets.

The **Green Paper** on CYP mental health clearly provided extra validation for the programme, and helped to ensure that schools and CYPMH services were receptive. However, the timing of the recruitment of Trailblazers proved to be something of a double-edged sword. While most areas took the opportunity afforded by the programme to test ideas that informed their Trailblazer applications, the competitive process and uncertainty regarding future funding meant that longer-term plans were put on hold to some extent in certain areas. For areas that were successful, the workshops provided a structure upon which to build Mental Health Support Teams (MHSTs), but for those that were not, it postponed decisions about wider rollout.

With regard to barriers, **service restructuring and recommissioning** – especially within local health services, proved to be widespread, and resulted in turnover among some of the key senior managers who had supported the original bid. **Procurement and commercial considerations** were also a factor in how far areas were able to take joint working and joint commissioning – where local EWB&MH provision was split between multiple providers, this inevitably made of a more complex local landscape.

Finally, and despite strong multi-agency partnerships at bidding stage, gaps emerged in **representation from the wider CYPMH network**. Some respondents felt that too much of an emphasis was placed on recruiting schools and specialist NHS CYPMHS at the expense of other key partners. While this was not always the case, Children's Social Care and Early Help were involved in follow-up arrangements to a varying extent, and VCSOs representation was lower than expected in some areas. These findings underline the importance of sustaining partner involvement throughout the programme.

4.0 Outcomes

This chapter examines the extent to which the expanded programme achieved its intended outcomes and whether any additional outcomes have occurred. This includes separate sections examining professional knowledge, awareness and understanding; and joint working practices and service/systems outcomes.

Key findings

Professional knowledge, awareness and understanding

- Statistically significant increases were seen in basic knowledge and awareness across school leads, e.g. in awareness of risk factors; knowing about mental health issues, and how to support children with different mental health needs.
- There were signs of increased awareness of roles and remits, with workshops providing an opportunity to challenge incorrect preconceptions around different organisations, primarily CYPMHS.
- Levels of understanding around evidence-based practices had increased among school and CYPMHS leads, but this had not led to a statistically significant increase in adopting shared approaches to measurement.
- There was a statistically significant change for school staff around knowing how to help young people with mental health issues access support, and the extent that support to identify mental health issues was available for all teachers.
- Improvements were seen over time in the extent to which school staff felt that referral pathways were understood by different professionals.
- This was backed up by qualitative evidence, showing that the workshops had succeeded in some areas in both initial clarification around pathways, and in helping develop and update referral processes and protocols.

Joint working practices and service/system outcomes

- Overall, the improvements to knowledge, awareness and understanding had not translated into changes to behaviours or professional practices, which was evident to a greater extent within the original pilots. A number of factors are likely to help explain why this might be the case. These include:

- The higher overall baseline for levels of joint working among schools and CYPMHS in the expanded programme, according to the CASCADE data, which provided less 'headroom' for improvement than was the case for the pilots
- The more advanced stage in rollout of Long Term Plans and funding than was the case during the pilots, and greater momentum for mental health support in the wake of the Green Paper, contributing to the same issue as above.
- A combination of CCGs needing to work at scale with greater numbers of schools during the expanded programme, and within existing budgets (i.e. no additional £50,000 funding for PMHW resources), which would seem to have diluted the NHS CYPMHS support available to individual schools, and
- Related to the above, a greater propensity for CCGs to adopt a model whereby the main focus was on improved clarity of referral processes and pathways, but without the equivalent direct contact between school-based professionals and PMHWs that was a characteristic of many of the original pilots.

- The CYPMHS survey did not show improvements in the extent to which staff felt that referral pathways were understood by different professionals, or the quality of initial information they received from schools following a referral. There were, however, indications from qualitative interviews that where processes and protocols had been updated that this may have improved.
- While CASCADE data showed improvements across workshops in there being an agreed point of contact and access to specialist mental health services in schools, analysis of longer-term survey results showed little change in joint working.
- Neither school nor CYPMHS staff results showed statistically significant increases in ease of contact, having opportunities to meet up or in terms of actual reported frequency of contact. CYPMHS staff did not show any change in feeling school staff used their expertise or that feedback mechanisms were working.
- Qualitative evidence did however point to instances where joint working had improved and notable changes had been made to processes and systems, enabling organisations to link together through the revitalisation of existing systems or the development of new networks and links.
- Evidence suggests that joint working may have improved more in areas where it was at a particularly low level at the start as opposed to those where elements of good practice were more likely to exist. Strategic level buy-in and organisational commitment was also key.

- In particular, a number of areas were awaiting results from Trailblazer applications and had postponed some changes to joint working approaches or system development, hence limiting potential outcomes over the time period of the evaluation.

Within this chapter, issues are examined in turn on a thematic basis drawing on evidence from across different data sources as required. This relies largely (but not solely) on four different sources of evidence:

- CASCADE data collected as a standard element of each workshop.[17] Each table at workshop one and two discussed and self-evaluated themselves, providing a single score for each of seven categories
- Follow-up survey questions asking respondents to state the extent they agreed or disagreed the workshops and subsequent actions had led to certain outcomes on an individual basis
- Comparison of baseline and follow-up survey data to assess the extent that statistically significant changes occurred in joint working practices across the two points
- Qualitative data from a range of sources on similar issues, primarily using case study data from areas purposively sampled to show promising practice

In summary, evidence from these data sources suggests that while there are statistically significant improvements in terms of improved knowledge, awareness and understanding, this only currently translated into identifiable improvements in of school staff knowing how to help young people with mental health issues access support and not other practice or system/service outcomes.

Professional knowledge, awareness and understanding

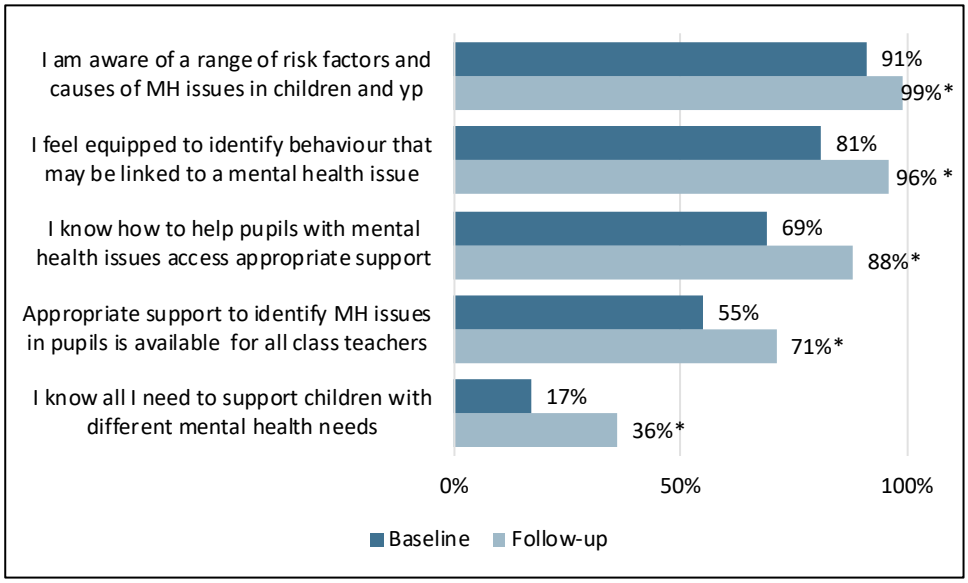
This section examines staff awareness and identification of mental health issues; understanding of organisational roles; and their knowledge, understanding and usage of resources.

[17] CASCADE rating used a nominal scale (Major challenge; good elements; widespread good practice; gold standard). For ease of analysis, this is presented throughout the report on a mean score basis and showing the proportion stating that an issue was a major challenge

Awareness and identification of mental health issues

School leads were asked the extent that they agreed or disagreed with the following statements relating to their knowledge of children and young people's mental health, with results for each statement being shown in the following figure:

Figure 4.1: Prompted statements on knowledge/confidence about knowledge of children and young people's mental health (% agreeing at all)



QC1 (Baseline): To what extent would you agree/disagree with the following statements about your knowledge of children and young people's mental health
Base (total sample): 108
**=significant at the 95% confidence level*

As in the original pilot, there was a statistically significant increase from baseline to follow-up in basic knowledge and awareness among school leads. Increases were seen in the proportion agreeing that with all statements, showing an increase in knowledge of both issues and risk factors; being able to identify behaviour linked to mental health issues; whether support is in place; support being in place and being able to access that support.

Qualitative evidence suggests the workshops played a substantial role in this increase in knowledge and awareness. School leads welcomed the information provided in the workshops on specific issues, e.g. anxiety, and the wider mental health system, feeling this provided a level of detail often lacking in teacher training. The workshops also helped develop other areas of interest and learning, such as parental engagement and staff mental health.

Understanding of organisational roles

CASCADE data suggested a slight increase in the proportion of workshop participants feeling there was clarity on roles and remits of partners, with the mean score (on a scale

from 0 as “major challenge” to 3 as “gold standard”) increasing from 0.9 to 1.2 and those saying there was at least widespread good practice increasing from 0% to 27%.

Workshop attendees generally spoke very positively around the opportunities that workshops provided to create a better shared understanding across stakeholders. Occasionally this was due to making contacts and discussing agencies that participants had not been aware of at all, but more often it was the result of increased communication and deepening understanding across existing partners.

Establishing this shared understanding within workshops was not always straightforward and could be challenging depending on previous experience of joint working. It was recognised, however, that where this was particularly difficult was where it was arguably most necessary. Providing the opportunity for GPs and schools in one area to “vent” about mental health services required careful handling, but was a vital first stage:

“Out of that came understanding about articulating things, but also a commitment to tackling it”.

[Local Authority staff, Area L]

Staff were particularly positive around the role of the workshops in “myth-busting” incorrect conceptions around organisational role and remit. Information on CYPMHS and their specific role in referrals was particularly useful, helping clarify role and processes and thereby reducing frustration caused by not understanding why certain cases were not being actioned. A number of areas looked to build upon the shared understanding developed during the workshops by developing contact lists or directories of local organisations across their locality.

Knowledge, understanding and usage of resources and evidence-based approaches

Feedback showed a mixed picture in terms of the impact on awareness and usage of resources and evidence. CASCADE self-reported data showed no change over time in the extent workshop participants either felt they were able to draw on best practice (mean change from 0.9 to 1.1; widespread good practice or better from 0% to 14%), or whether they were adopting an evidence-based approach (mean 0.8 to 1.0; widespread good practice or better from 0% to 8%). Around two-thirds of both school (67%) and CYPMHS leads (60%) did, however, perceive that the programme had helped improve their knowledge of available resources, and just under half (44% and 43% respectively) felt that they were using existing resources more effectively and efficiently.

Qualitative responses showed a number of participants were positive about the additional resources provided as part of the workshops, either as a direct source of information or a set of documents that they could signpost people towards:

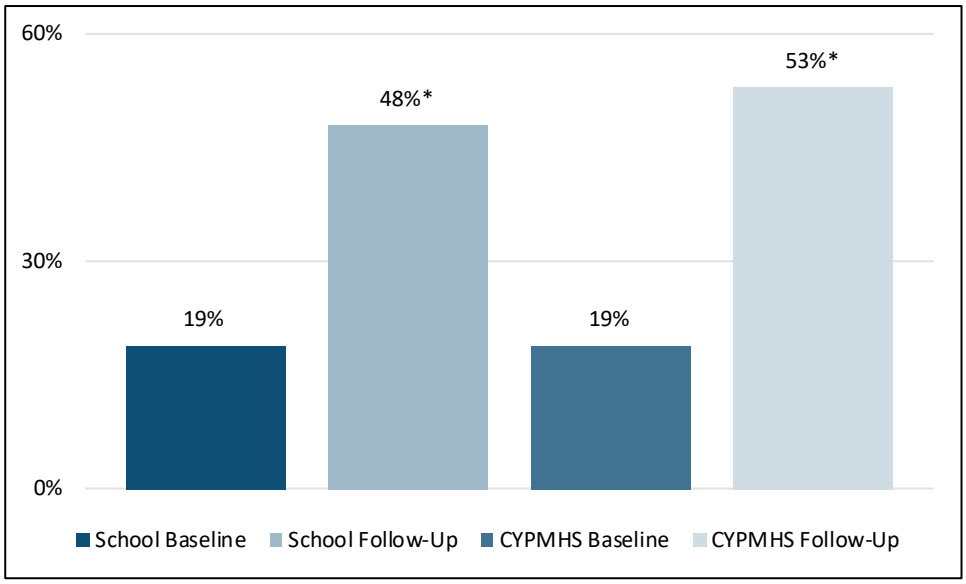
"I think everyone involved found the resources discussed in the workshops invaluable and I have had a number of requests for links to these and also schools sending me links to YouTube and other guidance so they can be shared with attendees".

[Area lead, Area H]

Less direct approaches also had an impact, with one school accessing additional resources through being connected with the delivery partner as a pilot school for other, separate projects in their region.

Both school and CYPMHS leads were asked at baseline and follow-up stages the extent that they agreed with two statements relating to outcomes and evidence.

Figure 4.2: Agreeing at all that there is a common understanding around evidence base

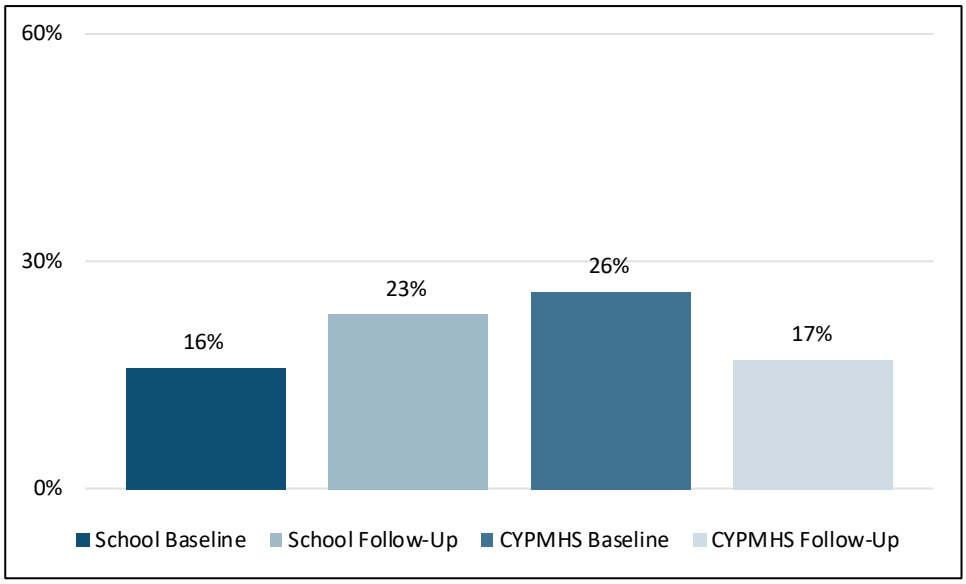


Base: Schools 108; CYPMHS 53
QB5 (Schools), QB1 (CYPMHS): To what extent do you agree with the following statements about Children and Young People's Mental Health Services in your area: There is a common understanding amongst professionals regarding evidence-based practices and how to access them

Results showed that there was a statistically significant increase in school and CYPMHS leads agreeing there was a common understanding around evidence-based practices and how to access them. Qualitative interviews suggested this was at least partly due to the CASCADE tool increasing awareness of the need for a common approach to outcome measurement, with some areas looking into how this could be practically implemented following workshops.

The following figure shows the proportion among each sample agreeing at all that children and young people's mental health services in their local area had a common approach for measuring outcomes.

Figure 4.3: Agreeing at all that there is a common approach for measuring outcomes



Base: Schools 108; CYPMHS 53
QB5 (Schools), QB1 (CYPMHS): To what extent do you agree with the following statements about Children and Young People's Mental Health Services in your area: Children and young people's mental health services in my local area have a common approach for measuring outcomes

The increased common understanding seen previously had not yet translated to an increase in local services actually having a common approach for measuring outcomes in place by follow-up interview stage, with no statistically significant change having occurred for either school or CYPMHS leads.

Communication about young people's mental health issues

There was no change following the programme in the proportion of school leads who spoke on a daily basis either to young people (49% at baseline compared to 54% at follow-up) or to parents/carers (14% compared to 18%) about young people's mental health and wellbeing. Results did, however, show a statistically significant increase in the confidence school leads felt in speaking to young people about their mental health and wellbeing (86% feeling very or quite confident at baseline compared to 96% at follow-up) and in speaking to parents about their children's wellbeing (78% compared to 89%).

Joint working practices and service/system outcomes

The following section examines the potential impact of the programme across a number of specific themes, namely resources and evidence; roles and referrals; organisational contact and access; and joint working practices.

While the patterns of endorsement are slightly different for each particular theme, they generally showed that despite small increases in CASCADE ratings and notable

proportions of school and CYPMHS leads feeling that the programme had helped achieve certain outcomes, few statistically significant changes to joint working had been achieved from baseline to follow-up stages.

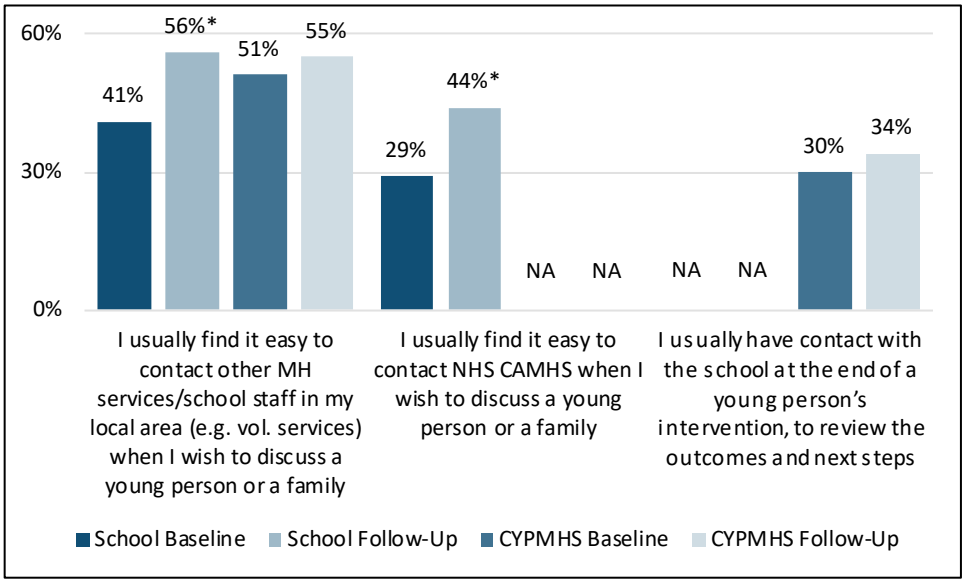
Organisational contact and access

CASCADE rating data showed some changes in rating in relation to organisational contact and access. These included:

- An increase in the rating for there being an agreed point of contact in schools and CYPMHS, with the mean score increasing from 0.9 to 1.2 and those stating there was at least widespread good practice increasing from 0% to 25%.
- Just under half of CYPMHS staff (45%) agreed at follow-up stage that the Programme had improved access to specialist mental health services in schools.

Change from baseline to follow-up in organisational contact and access was also assessed via three separate prompted statements, as outlined in the following figure:

Figure 4.4: Prompted statements on organisational contact/access (% agreeing at all)

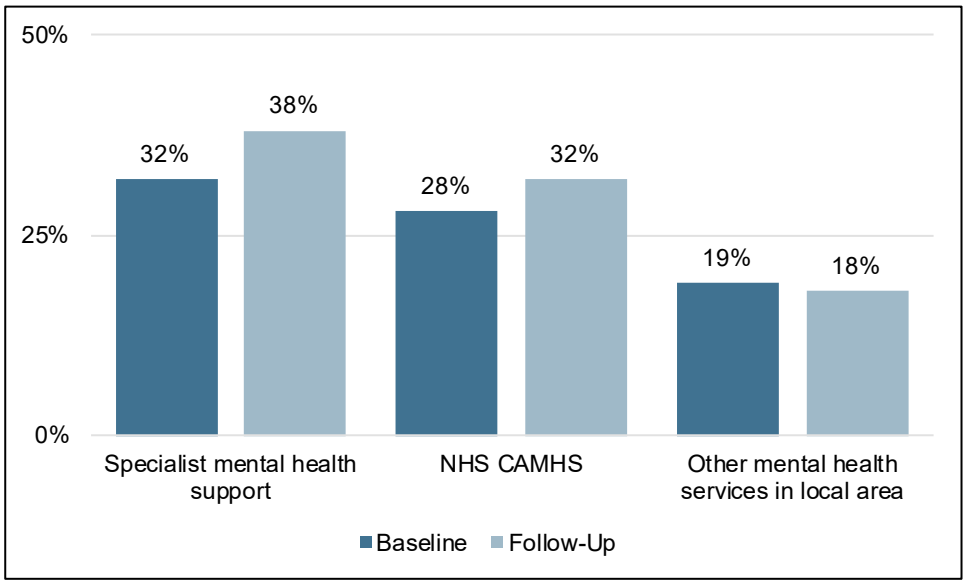


Base: Schools 108; CYPMHS 53
QB5 (Schools), QB2 (CYPMHS): To what extent do you agree with the following statements about Children and Young People's Mental Health Services in your area

When change from baseline to follow-up was examined there was a more positive perception among school leads than CYPMH contacts. The former were statistically more likely to state that they found it easier to contact both other mental health services and CYPMHS staff, while the latter showed no significant change in perceived ease of contact with school staff when discussing a young person or at review stage.

This was backed up by data showing that, unlike in the original pilot evaluation, the proportion of school leads having continuous or monthly contact across a range of mental health providers had not changed.

Figure 4.5: Continuous/monthly contact with mental health professionals (school leads)



Base: 108
QC1 (Baseline): Approximately how often did you have contact with the following mental health professionals?
QB1 (Follow-Up): Approximately how often did you have contact with the following mental health professionals, during the past year?

Additional analysis showed there was also no increase in the nature of contact between school leads and each type of service in terms of seeking professional advice; attending multi-agency panels; or attending multi-agency training (although there was among school leads in professionals understanding referral routes – see following section). In certain areas, school staff felt that expectations that a shared understanding with CYPMHS around processes and referrals would lead to increased contact had not been met:

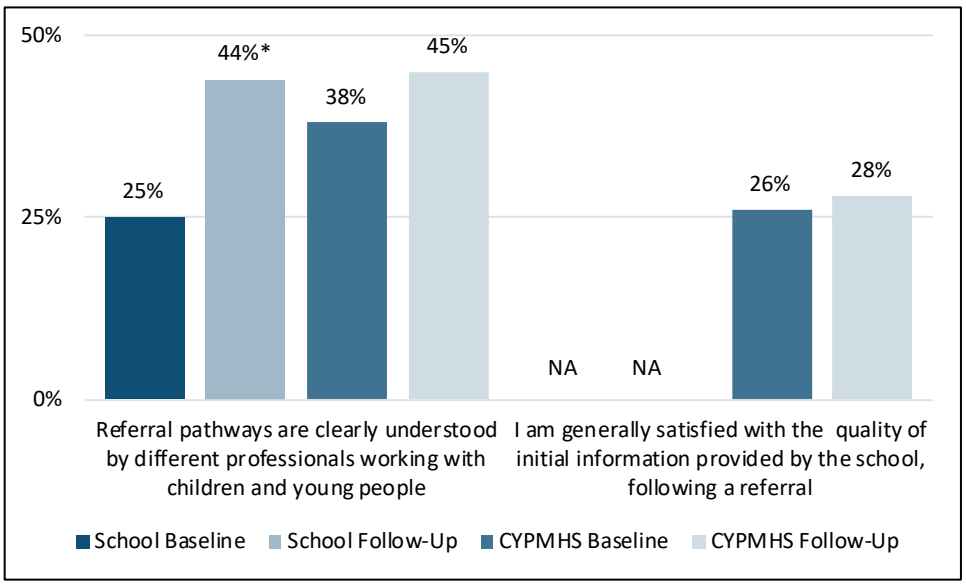
> *"However, some schools although they have a better understanding of the working relationships, what to expect etc., have not had the support they were promised from CAMHS, i.e. PMHWs linked to schools have not visited".*
>
> [Area lead, Area G]

Referral routes and processes

Two separate prompted statements were asked relating to referral routes, one relating to understanding of pathways by different professionals working with children and young people (asked for both school and CYPMHS leads) and one on quality of information provided by schools (CYPMHS leads only). These statements are designed to understand overall perceptions relating to this issue and do not take account of the extent

that certain settings have had additional (or any) experience of making referrals during the baseline to follow-up period.

Figure 4.6: Prompted statements on referrals (% agreeing at all)



Base: Schools 108; CYPMHS 53
QB5, QC1 (Baseline): To what extent do you agree with the following statements about Children and Young People's Mental Health Services in your area

Data showed a statistically significant increase in the proportion of school leads, but not CYPMHS leads, stating that referral pathways were clearly understood by different professionals. Here, it is important to note the phrasing of the question. The data does not suggest that CYPMHS leads personally reported no increased awareness (as it might be expected that their level of professional awareness should be high). Rather, it suggests that they did not perceive an improved level of awareness among 'different professionals' within the system (i.e. including schools and other organisations).

Qualitative feedback suggests that the perceived improvements by schools were facilitated by two different, but potentially complementary, approaches. In many areas, either discussions and/or presentations at the initial workshops **clarified the basic process** of making referrals, thereby reducing misunderstandings (particularly among school staff) as to the process involved. In a smaller number of areas, this was then built upon by **introducing concrete changes** to the referral process to ensure stakeholders were fully guided and supported through the process (see case study below).

There was no evidence that this led to changes in the number of referrals across areas, with a significant increase (76% at baseline to 81% at follow-up) in school leads reporting that they had contacted NHS CYPMHS to make referrals. Qualitative interviews suggested that where this may have happened, crucial factors in establishing improved referrals were the **overall level of engagement** in the workshop and the extent to which actions relating to the quality and appropriateness of referrals were **formalised, taken**

forward and embedded. Where this was systematically established there could be considerable improvement in the overall process.

Case study: Improvements to the clarity and consistency of referral processes

Prior to the workshops in Area U, there was not a clear, shared understanding across organisations and, particularly, among school staff as to the referral process. Some school staff were not aware that they could refer directly to CYPMHS and the quality of referral information was often lacking, leading to difficulties for CYPMHS staff.

The workshops provided the opportunity to address these issues:

- The exact referral process was outlined in introductory slides, discussions took place during the workshop to clarify misunderstanding and there was a shared commitment across organisations to take action.
- A number of concrete steps were taken following the workshop, including changing their referral form to use a “SBARD” model designed to facilitate communication across organisations. This helped provide clear guidance to school staff as to the information that they needed to include and acted as a concrete reminder of requirements covered in the workshops.
- A feedback process was instituted so school staff could learn about why referrals were accepted or not accepted, and schools were also provided with questionnaires used by CYPMHS staff to ensure a consistent approach was taken across referral cases where possible.

Feedback with regards to this multi-pronged approach was positive. Staff welcomed the more open relationships created by the workshops, with organisations being more willing to be clear around expectations and what would or would not be accepted, potentially leading to better referrals. School staff felt the revised form was considerably clearer and helped support them in making appropriate referrals.

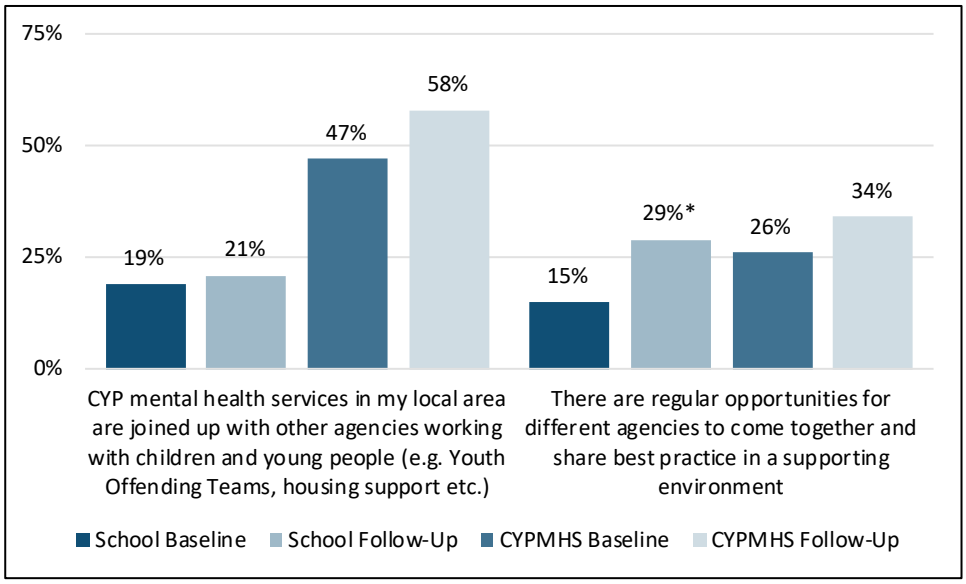
Staff felt that these actions had increased the appropriateness and overall quality of information in referrals, making it easier for school staff to complete and process forms. Initial signs were that referrals from schools had increased by 12% since the first workshop, suggesting a possible increase in usage of more appropriate referral routes. Further analysis is being undertaken by the local authority to assess if referrals from GPs have seen a decline (given anecdotal evidence that school staff had previously been referring through GPs rather than directly) and whether there has been an overall change in the total number of referrals to CYPMHS across any route.

Joint working practices

CASCADE rating showed positive changes over time in terms of perceived joint working, with slight increases in terms of the development of integrated working (mean from 0.8 to 1.1; at least widespread good practice changing from 0% to 13%) and, in particular, structures being in place to support shared planning and collaborative work (0.6 to 1.1; 2% to 10%). In addition, a majority of CYPMHS (69%) and school (58%) initial workshop attendees felt the Programme had helped create a shared understanding of the strengths and limitations of education and mental health professionals, with a large minority agreeing it had contributed to improved joint working between education and mental health professionals.

Two separate statements on joint working were asked at both baseline and follow-up stages for both CYPMHS and school leads (see Figure 4.7).

Figure 4.7: Prompted statements on joint working (% agreeing at all)

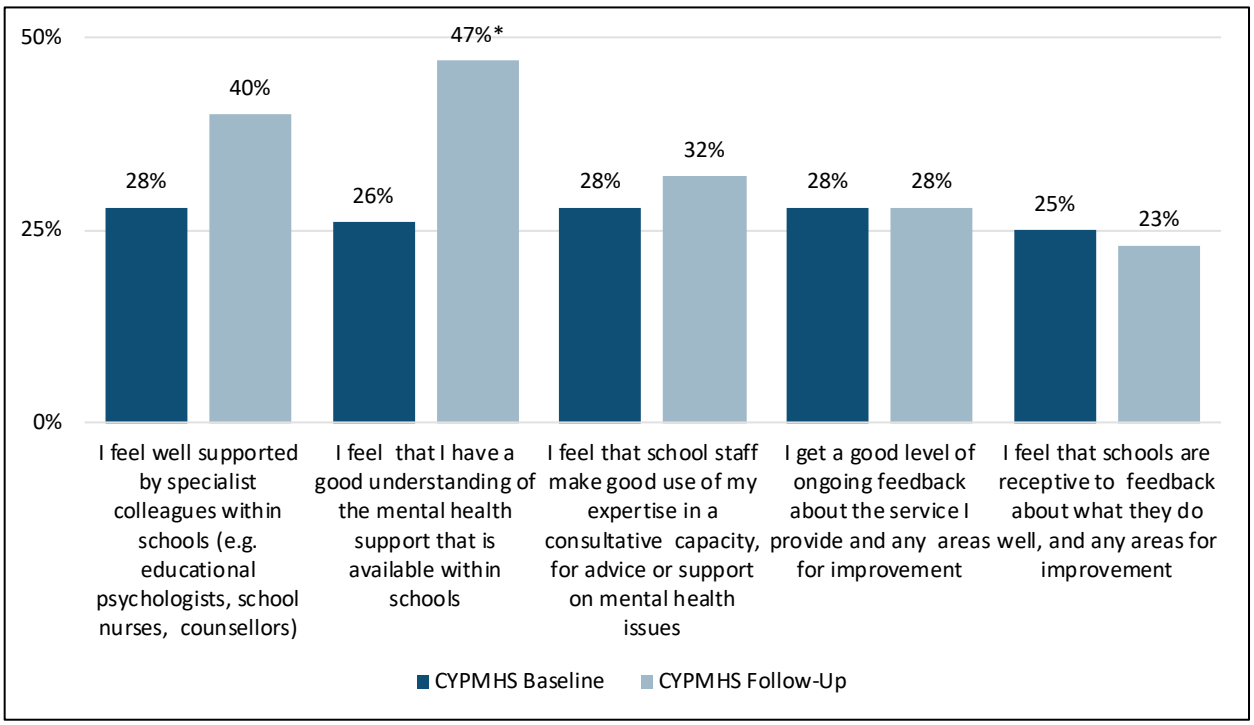


Base: Schools 108; CYPMHS 53
QB1, QC5 (Baseline): To what extent do you agree with the following statements about Children and Young People's Mental Health Services in your area

Results for these statements showed that, despite the positive perceptions around joint working, the only significant change was the increase among CYPMHS leads stating that there were regular opportunities for agencies coming together to share best practice. CYPMHS leads were notably more positive at both baseline and follow-up stage than those in schools as to whether they were linked into other agencies. This may reflect a generally higher positivity among CYPMHS leads than school staff around the extent they are joined up or that CYPMHS have a clearer and different view as to the extent that they are joined-up with other organisations.

A number of additional statements on joint working were asked only for CYPMHS leads as outlined in Figure 4.8.

Figure 4.8: Prompted statements on joint working (% agreeing at all): CYPMHS only



Base: CYPMHS 53
QC5 (Baseline): To what extent do you agree with the following statements about Children and Young People's Mental Health Services in your area

Analysis of these additional statements showed no significant change in CYPMHS leads experience of direct joint working with schools, with the exception of the greater proportion stating that they now have a greater understanding of the support available in schools. No significant change was seen in terms of the perception of CYPMHS staff that schools were using their expertise; whether they felt supported by specialist colleagues in schools; or the feedback provided and received by schools.

Qualitative feedback did suggest that there were individual areas where joint working was successfully improved and where changes to policy and processes had already begun. These included changes in referral processes, and other actions developed directly as a result of the Programme, including the creation of directories of services; schools contact network meetings; Mental Health Newsletter created and disseminated; and increased training opportunities following consultation with schools. While these outputs provided a solid basis for joint working in some areas, this was not necessarily consistent, with some areas showing few clear signs of definitive improvements to joint working.

Joint working: barriers or enabling factors

A number of factors relating to improving joint working were suggested by participants. These include:

- Strategic level buy-in and organisational commitment
- The wider local context
- The extent of prior joint working
- Accountability and oversight mechanisms being in place

Fundamental to joint working was the need for **strategic level buy-in** and **organisational commitment** to the Programme from the outset. In one area where the workshops worked well, the area lead reflected that the "big enabling" factor was a recognition among schools that mental health was a growing priority and required action, with workshops helping catalyse an effective process for moving forward to deal with the issue. Another area felt that the release of the Government's "Transforming Children and Young People's Mental Health Provision: a Green Paper" had helped put young people's mental health as a priority for schools and encouraged their initial engagement in the Programme.

Where initial commitment was lacking it was difficult for the workshops to function as planned:

"We have fragmented services across our patch and third sector providers did not have the time to release someone for a whole day. I also had this 'complaint' from the local authority commissioner who said they were unable (despite their commitment) to release staff to attend and support the workshops. This was a massive disappointment and put a lot of strain on a few to attend and support".

[Area lead]

In these circumstances it is unlikely that the workshops would be able to make any significant contribution to joint working and may arguably have worked to entrench negative perceptions.

A number of factors were important in whether joint working took place following the second workshop. Particularly key was the **wider local context**, with it being seen as more difficult to embed specific changes when the system was in flux due to potential broader changes. Some areas had plans in place that they were in the process of developing anyway (e.g. a more comprehensive mental health policy, an approach to triage of referrals) or wider changes were happening meaning that it did not necessarily make sense to push forward certain actions:

“I think that changing local services has limited the possible impact of the workshops. We have had a change in commissioner, the Local Authority faces many changes and these impact on the programme and what people agreed. Probably a need for some form of ongoing workshops but this has not been set up”.

[Area Strategic Lead, Area C]

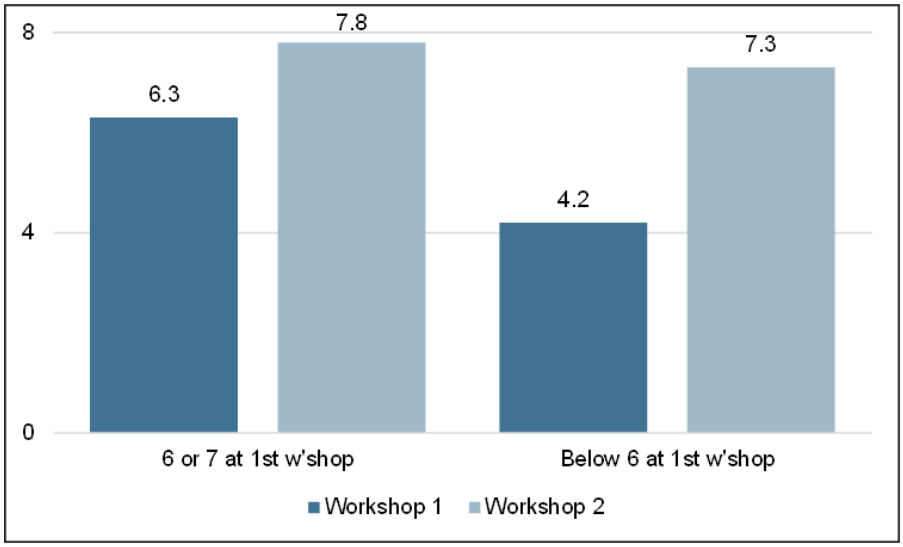
In particular, while the Green Paper and Trailblazer process may have encouraged initial engagement in some areas, embedding joint working had stalled in some areas as they were waiting to see if they were successful in accessing Trailblazer or other large-scale funding. These areas made less progress than those that had either not applied or had pressed ahead with embedding joint working regardless of any application.

As seen in Chapter Two, many attendees saw the workshops as an opportunity to develop plans for Trailblazer applications by discussing the requirements among themselves and accessing information from those leading the workshops. While some “quick wins” were identified and taken forward, many more substantial changes were proposed which depended upon additional funding being in place. For some, this funding was seen as vital in embedding changes to make sure that they would “not be throwing schools in cold to sink or swim”.

This approach ran the risk that if bids were not successful that momentum was lost and plans that were based on accessing additional resources and funding would require substantial reassessment to take account of their new situation. In one area in particular, positive system changes were developed and implemented despite awaiting the outcomes of their Trailblazer application. These tended to be “quick wins” or sustainable changes that did not depend on additional finances from this source.

Analysis of the CASCADE data suggests that a key factor may be the **extent of prior joint working**. The following figure shows the overall total score across all seven CASCADE elements for workshop 1 and workshop 2 (out of a maximum of 21). Results are split into two groups depending on whether they were one of the 20 cohorts scoring 6 or 7 at the first workshop or one of the 21 which scored below 6 at the first workshop.

Figure 4.9: CASCADE scores by workshop



Base: Cohorts completing CASCADE at both workshops (scored 6 or 7: 20, scored below 6: 21)

The results for the group who scored 6 or 7 in the first workshop showed a slight increase over time, from an average total score of 6.3 to 7.8. There was a notably larger increase for the group scoring below six in the first workshop, with their average total score changing from 4.2 to 7.3. Although these results may have been influenced by confounding factors,[18] these suggest that the workshops may have had more impact in areas where there was less joint working in place at inception.

Finally, whether **accountability and oversight mechanisms** were in place was particularly vital. In areas where positive changes were made there was a clear reporting structure, often involving embedding actions within existing plans (e.g. Long Term Plan, Future in Mind groups etc). It was notable that one area, where considerable momentum was in place following the workshops, had integrated actions into their plans separately from their Trailblazer application, thereby ensuring that they could be taken forward regardless of the success or failure of any application.

Further information on a number of these enabling factors / barriers is contained in the following section on sustainability, examining many of these in terms of the longer-term evidence from the original pilot or perceptions around their importance from the expanded programme.

[18] For example, it may be that those with higher or lower scores at first workshop had different issues or profiles of attendees, with it being these factors that impacted any change in scores as opposed to the workshops themselves

5.0 Sustainability of joint working arrangements

This chapter provides information on potential sustainability, focusing on two key areas of learning. Firstly, qualitative feedback from the original pilot is assessed, to understand whether the models implemented for these pilots has been sustained over the long-term and the particular enablers or barriers that may have played a role in the sustainability of different models. Secondly, the situation of the current, expanded programme is assessed to understand the extent and approach to embedding sustainability, barriers and enablers and what may work best in different settings.

Key findings

Lessons on sustainability from the original pilot

- The extent to which sustainability in individual areas was achieved was relatively mixed.
- Sustainability at original levels was more challenging where the initial model involved substantial direct work by CYPMHS staff in schools.
- Where a solid, initial basis for possible joint working did not exist before the workshops it was difficult to achieve and sustain outcomes.
- The ability to ensure sustainability could also have been impacted by expectations (particularly among school staff) not being clear and by staff turnover, especially among CYPMHS link workers.

Plans for sustainability under the expanded programme

- Areas recognised the benefits of the expanded programme and welcomed the possibility of ensuring sustainability long-term.
- A number of areas had put plans for sustainability on hold while awaiting results of major funding applications or internal restructuring.
- As a result, few areas had put in place concrete plans for sustainability – important small-scale individual actions were being implemented but a systematic approach to ensuring sustainable action was often lacking.

- Where sustainability was viewed most positively was in one area where clear accountability structures were developed and agreed actions integrated into official plans.
- A range of factors were identified as being important to ensuring sustainability, most notably internal resourcing. Despite being identified as a key issue in original pilot sites, staff turnover was not identified as a likely issue in most areas at this initial stage.

Lessons on sustainability from the original pilot

This section outlines the lessons from the original pilot, outlining the original pilot models and approaches to sustainability, the extent that these have been sustained, and the barriers or facilitators that have impacted upon this.

Original approach to sustainability

As part of the original pilot, a total of 22 areas, incorporating 27 CCGs and 255 schools, were funded to establish named lead contacts within NHS CYPMHS and schools. The original pilot programme was implemented in three phases:

- Phase 1: forming partnerships – workshop 1 (September to December 2015)
- Phase 2: embedding and building sustainability – workshop 2 (January to March 2016)
- Phase 3: supporting ongoing learning through 2 national events (May 2016)

NHS England made funding of £50,000 available per CCG, to cover NHS capacity to release specialist staff to provide extra FTE primary mental health worker resources to support schools (as opposed necessarily to attend workshops). CCGs were expected to match-fund this amount. Funding of £3,500 was made available per school to backfill staff time.

Findings from the original pilot also describe evidence from an additional case study conducted at a later date that commissioned workshops themselves to fit with their existing plans to recommission their CYPMHS service.

Initial model and outcomes

The original evaluation[19] showed that many of the pilot areas were exploring options for working at scale, without diluting NHS CYPMHS contact time with schools. This generally included a combination of the following basic models:

- a traded offer, whereby a proportion of the costs were passed on to schools; this was sometimes based on a tariff system or menu of options
- cluster or locality-based support, whereby NHS CYPMHS lead contacts linked with a number of schools via established local multi-agency teams
- a single point of access for schools, generally based around a triage and duty system, with NHS CYPMHS workers responding on a rota basis; some areas had combined this with a telephone helpline and email address for professionals

In addition, in some areas there was a focus on making full use of the wider network of CYPMHS – rather than focusing solely on specialist NHS CYPMHS and schools; some areas were reviewing the potential for educational psychologists, school nurses and VCSOs to an active contribution towards widening access to mental health support within schools. There was also often a focus on training and capacity building, often based around a foundation tier of training for potentially large numbers of schools, with the option of higher-level training

A smaller number of areas had already secured the funding and political commitment from the school community and NHS CCG with local authority support to scale up joint working when the evaluation fieldwork took place.

Sustainability

The original pilot evaluation showed that:

- There was widespread recognition of the need to achieve sustainable improvements to the quality of communication between schools and NHS CYPMHS
- Pilots were generally developed with a view to informing a wider roll-out, with very few treating it as a stand-alone project

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19 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/590242/Evaluation_of_the_MH_services_and_schools_link_pilots-RR.pdf

- There was broad support for the principle of continuing the Single Point of Contact in schools and NHS CYPMHS

These perceptions were backed up in the additional data collected in this evaluation. With the exception of one area (where those involved felt that the initial workshops had not overcome major historical obstacles to joint working), stakeholders felt positively around the programme and workshops at the outset; that positive outcomes had resulted; and felt there was a step-change in joint working. They spoke positively about the support provided across schools, the specific SPOC role, and were supportive of sustaining and developing joint working. Where this worked as a package, it changed culture across and within organisations, including at a whole school level:

"[The model] did meet expectations from when we began the trial. The schools lapped it up and wanted lots more of joint working. Everyone was on board and there was a huge amount of positive good news stories at the strategic meeting about how well this had worked – schools feeling that it has really benefitted them".

[CYPMHS staff]

"So much emphasis has been placed upon the whole academy community's mental health and wellbeing which is fantastic".

[School staff]

When reflecting back over the longer-term as part of the current evaluation, those involved saw the main benefits of the programme largely in terms of increased awareness and knowledge for those involved; improved communications across CYPMHS, schools and other organisations; and better knowledge around referral processes. School leads reflected on a range of specific actions that had been taken in the intervening period, including developing their PSHE curriculum; training and upskilling staff on mental health needs and signposting; and becoming involved in wider school networks.

While these changes were viewed positively by those involved, the picture of sustained joint working was less consistent, with most areas reflecting that positive initial changes had not been maintained. This was largely due to changes in the extent that the initial model of working across schools and CYPMHS was sustained:

"The CAMHS single point of contact has not worked and accessing information about the status of support for students in the system can be difficult".

[School staff]

On occasion, this reflected a perceived wider breakdown in communication across stakeholder groups:

"We are not being listened to for the things we need in schools, CAMHS are just giving us stuff we don't want".

[School staff]

The perceived sustainability of the programme differed slightly across school and CYPMHS staff. Whereas the latter often pointed to changes in their approach and new approaches being adopted, the former tended to see less of a change at the granular level. In some cases this may have reflected the different scales at which organisations worked and the nature of changes made – in one original pilot area certain school staff could have the view that there was little change and that the Programme was "rudderless" while, due to their broader scale of delivery, CYPMHS and local authority staff spoke positively around engaging schools, delivering training and embedding support.

Key factors

A number of factors were particularly important in whether benefits from the initial programme were successfully sustained in individual areas.

In some areas the original model (or expectations around the model) were seen not to have worked over the longer term, primarily with school staff feeling that insufficient time and/or support was in place:

"The link arrangements worked well at the time of the input however, like most things, once the light is not on them any more then the services are not so accessible"

[School staff]

The **initial local context and organisational commitment** within which the original programme was situated had a notable impact, with a reasonably positive attitude or approach to joint working being necessary but not sufficient to programme success. In one area where the programme did not succeed from the outset this was largely due to the prerequisites for successful joint working being absent. There was no shared culture of joint working and a perceived lack of funding, resources and support across organisations. As a result, there was no direct link between CYPMHS services, schools and other organisations prior to the pilot and this situation did not change following the workshops. Equally, where the programme worked really well over the longer-term was in areas where there was a solid basis for joint working, with one area referring to the success of the programme in terms of allowing them to "refine" their approach rather than implementing something more radically different.

In a number of areas, **expectations** across stakeholders were not clear, leading to the perception across staff (mainly school staff) that the programme had not achieved what was originally planned. This largely related to a lack of clarity around roles and responsibilities from the outset of the programme in certain areas, especially among school staff who had been led to expect that the implementation of the model would result in a significant increase in regular, face-to-face contact with CYPMHS staff.

For example, in one area school staff expected there to be specific input from CYPMHS staff, such as delivering counselling support, but felt the CYPMHS worker did not have clear expectations and was not used to direct work in a school environment. In another area where all schools were to have a link worker, school staff expected CYPMHS to make visits across a 'huge' number of schools and were frustrated with the amount of contact time that was possible. In another, staff welcomed advice and guidance from CYPMHS in helping young people, but wanted instead to have direct input and support with the referral process. These issues relating to expectations were sometimes linked to the presence or absence of clear **communication channels or networks** across organisations that could potentially work to clarify differences or misunderstandings.

The importance of the **CYPMHS link worker role** was regularly noted. This role worked well when they were readily available and responsive to school needs, allowing staff to generate and develop ideas with the support of the link worker. Regular, face-to-face contact was valued as a means of fostering supportive relationships. One concern was ensuring that staff **turnover** did not affect the availability of this role, with CYPMHS link workers leaving being noted as a challenge by a number of schools. In one area the CYPMHS link was hospitalised with no immediate replacement for several months. While CYPMHS ensured support was still available by phone, the lack of a direct contact stopped further progress occurring.

> *"Initially things started really well, however, we have had a number of different CAMHS workers during this time. More recently, the support has not seemed as dedicated as previously, with the worker not as available and not as hands on when in school".*
>
> [School staff]

Other stakeholders noted that **school staff turnover** could make it difficult to embed training and, hence, sustain knowledge in a school setting. This was particularly the case in one area where school training had been targeted at specific groups of staff rather than being rolled out across everyone. Close relationships with schools and clear offers being provided was seen as a way to mitigate against the possibility that a change in lead might not be communicated to all stakeholders. School staff in one area noted that changing head teachers had an impact due to different levels of commitment to mental health and making it difficult to embed new practices.

The importance of a supportive Senior Leadership Team (SLT) or head teacher was mentioned frequently as a key factor in enabling sustainability. This was seen to help foster or sustain a positive change in school ethos to facilitate more granular level changes in processes or approach:

> *"We were all on board with it. The head teacher was 100% behind it, and governors… everybody was 100% on board with it all and could see the benefits".*
>
> [School staff]

A number of other factors were seen to be important in sustaining delivery and/or outcomes, including a number of questions around ongoing **resourcing**. Certain areas reflected on the difficulty in accessing funding on an on-going basis to maintain their model, especially where this involved a high level of direct CYPMHS time working in schools. Particularly key was ensuring that school staff had sufficient time and resources to be involved appropriately, including time to meet CYPMHS contacts, develop resources, undertake reflection and debriefs and develop strategies for individual children. In one particular case, changes in school type (i.e. moving to academy status) had implications in terms of resources and the level of buy-in to sustain mental health developments such as those implemented as a result of the original pilot.

Plans for sustainability under the expanded programme

This section examines the demand for sustainability of the models developed within the expanded programme, the steps taken to help ensure sustainability, and key factors that were seen to potentially impact upon sustainability in the future.

Stakeholders felt that they had seen initial benefits from the workshops and there was the potential for these to be developed within their local setting and joint working practices continued. When surveyed, around half of school/college (56%) and CYPMHS (57%) were confident around sustainability (albeit more being *quite* than *very confident*), although the remainder were either not confident or stated they did not know, reflecting a certain amount of caution at the follow-up stage of surveys.

Table 5.1: Confidence in sustainable/long-term improvements

Level of confidence	Schools	CYPMHS
Very confident	7%	13%
Quite confident	48%	43%
Not very confident	30%	21%
Not at all confident	6%	6%
Don't know	9%	17%
Base (total sample)	*(108)*	*(53)*

Schools. QC9 (Follow-Up): How confident are you that having a single point of contact within NHS CAMHS and schools will help you to meet the needs of school staff and students in the longer-term?
CYPMHS. QD10 (Follow-Up): How confident are you that CASCADE workshops and follow-up will result in sustainable improvements to joint working between schools and CAMHS in the longer-term?

In most areas there was a reluctance to state definitively whether sustainability was likely, with the sole exception of the one area (see case study below) where reporting structures and plans were developed for the next two or three years. While this was felt to safeguard their situation for this period, there was an awareness that this may not be the case afterwards. Where plans had not been embedded to this extent, sustainability was seen as less guaranteed and particularly contingent upon a range of different factors. As a result, some felt that they could "easily be back in the same situation in two or three years' time".

While there was a general confidence in most areas around sustainability, one area lead who felt positive around certain aspects of the initial workshops felt that the programme was already not sustainable, largely due to a lack of organisational and senior level buy-in throughout. Local authority staff were not able to attend the workshop, *with an on-going lack of* commitment from some meaning sustainability was not possible:

"Due to the poor commitment from commissioners and changes in management there has not been any accountability or governance structures in place. The programme itself was a challenge… [to] sustain and I am disappointed to say has not been supported at a strategic level due to changes in senior level in Health – CCG provider and in local authority".

[Area lead]

Interviews with participants showed that their main long-term consideration was sustaining provision and further implementing best practice as opposed to potentially any scale-up of further provision. Where scale-up was considered, this was mainly engaging those that had not been part of the original workshops, e.g. contacting "missing" schools.

Areas differed substantially in the extent to which clear steps were taken to embed sustainability. Certain areas had worked on smaller-scale actions but had not started planning for sustainability as they were awaiting potential changes to their systems and/or funding. In one area, a number of services were being redesigned – this was felt

necessary to ensure that good practice from the workshops could be embedded but had resulted in an absence of action. A number of other areas were waiting for the outcome of applications for Trailblazer funding, with more comprehensive plans having been held back as a result.

Where there were significant concerns around sustainability tended to be among stakeholders in areas where ongoing joint working was seen to depend upon accessing large-scale funding. One stakeholder felt that failure to access this funding could result in a return to a "more traditional commissioning" in the form of a top-down approach of telling people what to do as opposed to a more relationship based approach across organisations. A stakeholder in another area spoke of how without Trailblazer or similar funding there would effectively be additional demands on capacity, with the potential that mental health work may not be prioritised by school staff in particular.

Sustainability of models developed and implemented

Where on-going, long-term sustainability was most likely to be viewed positively, work had been undertaken to clearly embed actions and approaches in structures and processes, and that this had been undertaken regardless of future possible funding streams. This was the case primarily in Area U, where a systematic approach to sustainability was being taken.

Case study: Embedding the programme within established local structures

Area U had a comprehensive approach to ensuring sustainability based upon early identification of relevant structures so that key aspects of work were appropriately owned as part of their existing system. As a result, staff were confident that they had clear plans in place for the next two to three years, thereby ensuring sustainability in the medium term.

Key to this was ensuring that actions were owned by an existing strategic group focusing on mental health wider children and young people, with this feeding directly into existing strategic plans and targets. This not only ensured clear ownership and oversight, but meant the work was effectively linked into a wider range of stakeholders than would have been otherwise possible. While this covered relatively large-scale and strategic aims, other actions were being built into their ongoing Mental Health Leads network that was being established in each locality as a means of making sure that key services in each locality were able to keep momentum around workshop actions and other developments. In particular, this aimed to ensure that the "myth-busting" valued in the workshops could continue on a regular basis as required.

In Area H, a large-scale application for additional funding was successful, with their involvement in the Programme being a notable contributing factor. This additional resource is enabling them to help sustain actions over the longer-term and create structures to enable joint working to become embedded. This includes the development of peer support networks for schools which allow mental health professionals to feed into and provide guidance and information.

While Area U was undertaking these steps while waiting for the outcome of large-scale funding applications, this was not the case in other areas. Actions had been undertaken that were seen to help ensure sustainability, including:

- School staff embedding within their internal plans, e.g. as part of an annual Action Plan or a specific Mental Health plan
- Ensuring certain actions linked in to strategic task and finish groups that are part of Strategic Boards in the Local Authority or other similar boards
- Continuing or developing informal meetings and contact across stakeholders
- Creation of a memorandum of understanding to enable partnership boards to join up appropriately around children and young people's mental health

In most cases, these actions were underway or planned but had not yet been fully implemented across areas. While areas saw sustainability as vital, recent actions were generally relatively piecemeal, individual approaches to sustainability as opposed to a clearly overall approach, with it not being clear for most stakeholders how actions proposed in the workshops would be tracked and where accountability for ensuring their completion was situated. There was a recognition that sustainability was vital, but concrete work had not generally been undertaken to ensure changes were incorporated into the system. One CYPMHS worker explicitly noted that the concern in their area was not around willingness to drive forward change, but the gap in bringing the system together to constantly review and understand about how to jointly move forward in regards to mental health.

Key perceived risks (barriers and enablers)

Potential barriers and enablers with regards to sustainability largely focused on similar issues/topics to those identified in areas that had taken part in the original pilot. All survey respondents were asked to state whether they saw certain risks as being a high, medium or low risk nor not a risk at all (with the option to say they did not know). Results in Table 5.2. show the proportion of each group saying that they saw certain aspects as a "high" risk:

Table 5.2: Risks to effective joint working

Risks	Schools	CYPMHS
Staff		
Staff turnover for MH support within schools	12%	34%
Negative attitudes towards MH among school staff	6%	13%
Lack of capacity		
Within schools for MH support	34%	57%
Within CAMHS	64%	60%
Leadership		
Changes to school leadership	14%	17%
Lack of systems leadership for CYP MH services	19%	13%
Process		
Lack of priority afforded to joint working with schools within NHS CAMHS	29%	25%
Poor communication between CYP MH services	24%	21%
Lack of clarity about referrals and service pathways	22%	15%
Systems change		
Changes in national policy for CYP MH	19%	15%
Changes in funding arrangements for CYP MH	51%	51%
Organisational restructuring within the NHS CYPMHS	26%	17%
Base (total sample)	*(108)*	*(53)*

Schools. QD11 (Follow-Up): Looking ahead, to what extent do you consider that the following factors pose a risk to sustaining effective joint working between schools and NHS CAMHS in your local area?
CAMHS. QC10 (Follow-Up): Looking ahead, to what extent do you consider that the following factors pose a risk to sustaining effective joint working between schools and NHS CAMHS in your local area?

These results suggest a wide variety of potential risks, primarily in terms of a lack of capacity, either within schools or CYPMHS, and changes in funding arrangements for Children and Young People's Mental Health. The main factors identified as high risk were:

- Lack of capacity, both within schools, particularly for CYPMHS respondents (57%) and within CYPMHS (64% for schools, 60% for CYPMHS)
- Changes in funding arrangements for CYP mental health (51% for both school and CYPMHS)
- Staff turnover for MH support within schools, particularly for CYPMHS respondents (34%)

Most respondents who did not state that a factor was high risk tended to feel it was medium risk, further suggesting a wide variety of potential barriers to sustainability. More detailed discussion in case studies provided further feedback on these and other possible issues. In line with the quantitative findings on lack of capacity, these discussions highlighted a significant concern around ongoing sustainability related to **resourcing** at a school and CYPMHS level. For schools, there was the perception that school staff are

under pressure generally to deliver more work across different areas without any increase in capacity. Schools were reported to often feel “snowed under”, with the potential result that willingness to push forward programme results may not translate into meaningful, sustained action.

> *“[The absence of] funding does have a negative effect, but on sustainability we can sustain what we have got but the problem is we can’t necessarily improve on it massively”.*
>
> [School staff]

Potential issues around resourcing may suggest that sustainability may be particularly relevant in the expanded programme as compared to the original pilots given the fewer opportunities for additional in-school support in the former via PMHW time dedicated to schools. This model was made possible in the original pilots due to the smaller number of schools and funded NHS CYPMHS lead contact roles in each area.

At a CYPMHS level, there was a concern that demand for their services was already outstripping supply and that this situation would be exacerbated in future. Any increased pressure on CYPMHS was seen as likely to result in a need to focus on an increasing number of clinical cases, resulting in further pressure on schools to deal with cases that did not meet required thresholds. Meanwhile, cuts to wider NHS provision and social care budgets would possibly result in similar downstream pressure on mental health provision for young people.

One potential challenge identified across areas was ensuring that **communication** took place on a regular basis across relevant organisations to ensure a solid basis for future joint working. Some school staff across areas stated that they had not been kept up-to-date with progress following the workshops, resulting in the perception that little or no action had taken place and that the value of the workshops had not been maximised. Other stakeholders reflected upon the general difficulty in keeping school staff informed, particularly where relevant school networks did not exist or were partial. While one area was using the workshop delegates list as the basis for regular e-mail updates on actions taken as part of the programme, there was a concern that school staff did not always necessarily read their e-mails.

More positively, stakeholders in Area L (see case study below) reflected on how clear, innovative approaches to communication had worked to link together stakeholders:

Case study: Developing shared ownership and vision for the programme

Local Authority staff in Area L developed a 5-foot picture of their 'path' towards achieving their 2020 vision. This provided clarity on the current situation, immediate planned activities and how these would link towards their particular goals and aspirations, including aims for communication, responsive and effective services, ongoing learning, protocols and referral routes, and clarity of roles and responsibilities.

The tool was seen as valuable in itself, particularly in terms of engaging schools and ensuring a shared sense of ownership, building upon their positive experience in the initial programme workshops. This was part of a wider plan to sustain joint working and catalyse a change in attitudes. Staff spoke of developing a sense of shared ownership and vision, with this helping to spread involvement and reduce risk of dependence on a small number of key individuals.

Other potential barriers included the need to **maintain staff mental health** in a potentially increasingly challenging context, **senior level buy-in** and ownership, and the need to ensure that accountability arrangements for mental health in schools are further strengthened e.g. via the Ofsted inspection framework). While the importance of having the **correct staff in place** was mentioned occasionally, the potential implications of staff turnover were not generally recognised to the same extent as in areas involved in the original pilot, potentially suggesting that this is an issue that might not be taken into consideration in initial planning to the extent that is required. Where it was mentioned, staff spoke around potentially mitigating against risks by ensuring that the specific role (as opposed to the person) is protected, that succession planning takes place and that training and knowledge is spread out so is not dependent wholly upon a small number of individuals.

6.0 Conclusions and recommendations

This report has presented the findings from an evaluation of the *Mental Health Services and Schools Link Expanded Programme,* drawing upon evidence from quantitative and qualitative data collection and analysis carried out between January 2018 and November 2019. In the previous chapters, we looked at how the 23 local programmes were designed and developed, the role of the joint planning workshops, and the lessons learned from implementation. We then went on to consider the evidence for the outcomes from the programme and the prospects for ensuring their sustainability.

In this final chapter, we draw together the main findings from the report and conclude upon whether the programme achieved its original aims and objectives. We end with some recommendations for the potential future development of the programme.

Overall conclusions on the expanded programme

The expanded programme provided an opportunity to test whether the CASCADE framework and workshops achieve the same benefits when delivered at scale and without assistance from NHS and DfE pilot funding.

Overall, the evidence is consistent with the findings from the original pilot evaluation with regard to improved knowledge, awareness, and understanding of the roles of different professionals, and of local service pathways. These outcomes were quite strongly associated with the joint planning workshops, which remained similar in format between the two phases. In contrast, however, there was less evidence of changes in behaviour or practices, such as the quality and frequency of contact between schools and CYPMH lead contacts.

The evidence considered for the evaluation suggests at least three potential explanations for these results:

- First and foremost, it is important to consider differences in programme design between the pilots and expanded programme. The expanded programme areas delivered to a greater number of schools and colleges across their local area, and, due to the overall expansion in CYPMHS there was no separate funding stream for CCGs as was included in the pilot stage to support NHS CYPMHS participation. Consequently, areas were more likely to adopt less intensive NHS CYPMH service models and fewer areas were in a position to offer regular PMHW contact time to individual schools on a regular basis as was the case at pilot stage.

- Secondly, the qualitative research indicates that many areas had reached a more advanced stage in rollout of Long Term Plans and funding than was the case during

the pilots, while there was also greater momentum for mental health support in schools countrywide in the wake of the Green Paper on Children and Young People's Mental Health. These developments indicate a climate of joint working between schools and NHS CYPMHS that was not always present during the pilots, which across the sector as whole might entail smaller margins for improvement.

- However, the evaluation found mixed results for whether or not relationships were better developed between the specific schools and their counterparts in NHS CYPMHS at the start of the expanded programme. While the reflective CASCADE data indicates that the areas within the expanded programme were starting from a higher baseline, the survey data shows that school leads within the original pilots reported more frequent ongoing contact with their counterparts in NHS CYPMHS, whereas schools in the new areas were in less frequent contact and more of this contact involved referrals. This shift may reflect the tendency to move to a more limited model on the part of NHS CYPMHS and illustrates the complex nature of joint working, and that different data sources paint a varying picture of activity at a local level.
- Lastly, some areas were waiting to find out whether they would be in a position to implement Green Paper Trailblazer proposals before pursuing alternative models of joint working. This was because their bids included plans on joint working that were contingent on Trailblazer funding, and success or otherwise would have a substantial bearing on the scale of what it was possible to achieve at a local level and the corresponding resources.

The report has shown that, **even when delivery was scaled-up across greater numbers of schools and partner organisations, school-based professionals reported improvements in their knowledge and awareness** - of mental health issues, of referral pathways, and of the roles of different professionals in supporting children and young people. These self-reported outcomes were statistically significant. Furthermore, the expanded programme evaluation found improvements to the knowledge and awareness of evidence-based practice among school professionals – results from the original pilot on this measure had not been statistically significant.

The expanded programme also provided an opportunity to test the equivalent outcomes among participating wider CYPMHS organisations. This was made possible through the inclusion of all partner organisations within the pre / post survey (the survey was limited to NHS CYPMHS during the original pilot, which meant that the numbers were too small to explore these outcomes quantitatively). The findings were again positive with regard to knowledge and understanding, with **statistically significant outcomes found for CYPMHS organisations in relation to understanding evidence-based practices, and with regard to perceptions of the effectiveness of multi-agency working**. Views on this subject were more positive among health professionals than schools both before and

following the workshops – this may be because step changes in multi-agency working were more visible for CYPMH services, within their day-to-day remit, than for leads within schools, for whom this is a smaller part of their professional role.

In contrast to the knowledge and awareness-related outcomes, there was less evidence of changes to behaviours and professional practices, when compared with the original pilots. The overall improved awareness of referral routes had not translated into increased satisfaction with the quality and timeliness of referrals among schools, or increased frequency of reported contact between schools and CYPMH organisations. Moreover, schools were no more likely to report that support to identify mental health issues was available to all teachers following the workshop than they were beforehand (CYPMHS also did not report statistically significant improvements in the extent to which school-based professionals were making use of their expertise). This is wholly consistent with CCGs supporting greater numbers of schools within a given locality in the expanded programme, and doing so within existing resources. Put simply, the outcomes were not the same in the absence of regular direct contact between schools and Primary Mental Health Workers (PMHWs), which was a feature of some of the original pilots.

Similarly, **an increased awareness of evidence-based practices had not resulted in a routine use of shared approaches to measuring outcomes.** Given that the follow-up interval was the same as during the pilot phase (10 months from baseline), these findings would seem to suggest that the workshops were less effective in levering short term changes to practice in this particular outcome than under pilot conditions. Funding and scaling were the two main differences between the pilots and the expanded programme, and are likely to account for the differing outcomes. Namely, it would be reasonable to infer that pilot conditions would be likely to register changes at a practice level more quickly than where the programme was delivered across multiple schools and with more limited in-school Primary Mental Health Worker (PMHW) support.

Levels of joint professional working were found to be higher on average at baseline within the expanded programme areas than within the original pilots, according to CASCADE (although the survey data is more ambiguous in this respect[20]). This would suggest that there is less leeway for improvement and a greater push might be needed to achieve a clear, measurable step change in joint working. And indeed, the greater relative progress made on average by schools that started from a lower baseline position would seem to support this explanation. These findings should also be viewed in the context that local areas were at a more advanced stage in implementing their LTPs than was the case in 2015/16, which often included other measures to build system capacity. The effects of

[20] For example, our survey data on frequency of contact between schools and CYPMHS was reported to be higher for the pilot schools than the expanded programme schools. This might be partly due to the different methodologies used and rationale for each source of data.

the workshop approach may have been lost against this background ‘noise’ regarding the influence of other programmes and mental health training in schools, to at least some extent.

Learning from the original pilots – sustainability messages

The evaluation provided a rare opportunity to follow-up with participants in an original pilot programme at an interval of 18 months or more following the end of the funding period. In this instance, the interviews showed **a very mixed picture regarding the longer-term fortunes of the original pilot areas**. Views were more positive where there was a well-established link between health and education at a local strategic level; clarity of expectations for the level of ongoing contact between schools and NHS CYPMHS in particular, and suitable local CYPMHS forums or networks.

Nonetheless, staff turnover was an issue in the longer term, even where the initial commitment was high. The continuity of the availability of NHS CYPMHS staff was a major factor in schools’ levels of optimism or otherwise. It was generally those areas where the model involved heavier levels of in-school PMHW time during the pilots where sustainability proved the most challenging, and in some instances this resulted in the single point of contact no longer being in place. While the follow-up only provided a snapshot for a smaller number of the original pilot areas, the common message was that embedding improved working arrangements required further investment, potentially including also a renewal of the CASCADE format or an equivalent means of gathering organisations within local CYPMHS networks to avoid a drop-off in levels of communication over time.

Concluding thoughts

Looking forward, **the evaluation concludes that the workshop approach has a continuing role to play in the expanding landscape for CYPMH provision within schools and localities**. The ‘whole system’ approach, the external facilitation and expertise, and the CCG or LA leadership role were not routinely found within local areas outside of the context of the programme. In contrast, pre-existing local CYPMH forums were often reported to be more directly practice-oriented rather than involving more strategic oversight. With the rollout of Mental Health Support Teams (MHSTs), and designated leads for mental health in schools and colleges, the workshops arguably provide a framework that can be readily adapted to a wide range of local contexts. Indeed, as the report highlighted, the timing of the expanded programme meant that CASCADE provided a test bed for joint working in number of the successful Trailblazers.

Specifically, the evaluation concludes that strategic workshops and action planning are beneficial because they:

a) facilitate the development of joint professional relationships

b) allow for a frank discussion of issues between representatives from schools and CYMPHS, and allow for “myth-busting”

c) secure inputs from a variety of different stakeholders in a way that can be facilitated easily

d) allow local areas and leads to be involved in delivery in a visible way and to promote ownership

e) enable networking and personal contact, and

f) support accountability, as individuals are visible and can report back to the group as part of the second workshop

Recommendations for policy and practice

On the basis of the report, a number of recommendations are proposed for future policy and practice development. We have separated these into recommendations at a local level, for CCGs, LAs and areas seeking to implement joint working with a self-assessment element for leads in schools/colleges and CYPMHS, and those for the DfE, NHS England and national delivery partner(s) to consider.

Recommendations for CCGs, LAs and areas seeking to implement the CASCADE framework

Recommendation 1:

- **To develop clear information materials and to establish communications with schools, to raise awareness of the aims and format well in advance**

  Despite the availability of various information materials, the case study visits and surveys showed that some schools were unclear about the workshop aims and content, and that teachers and other professionals attended expecting focused mental health training as opposed to examining cross-organisational joint-working. Further steps might be beneficial to ensure that the workshop agenda and the emphasis on joint planning is made available to school staff well in advance. This should also include ensuring that area leads are identified from the start, are able to attend both workshops and are able to drive forward change.

Recommendation 2:

- **To identify appropriate measures to support the participation of VCSOs**

  The feedback at the case study visits and in the follow-up survey of strategic area leads indicated that VCSO engagement had been disappointing in a number of the areas .The main reasons given related to cost and perceived relevance. Namely, for smaller VCSOs in particular, releasing staff to attend two days of training was often considered infeasible. Local areas might wish to consider potential ways of boosting participation, ranging from engagement via local VCSO umbrella bodies or membership associations (e.g. Councils for Voluntary Youth Services, CVYSs), to the opportunity to participate remotely (e.g. via Skype), or to input to the CASCADE assessment process beforehand.

Recommendation 3:

- **To monitor and evaluate workshop attendance, with reference to the intended target groups, and to maintain accurate lists of lead contacts**

  The evaluation highlighted disparities within some areas, between the strategy for recruiting schools identified within the Expression of Interest for the programme, and actual patterns of attendance. It was not always clear whether CCGs and LAs monitored participation in the workshops, or whether they had taken follow-up action where schools (or CYPMH organisations) had dropped-out. Given the risks of the workshops skewing towards the 'already engaged', it is recommended that areas delivering the programme maintain accurate data on participation, and adjust their approach where some organisations require encouragement.

Recommendation 4:

- **To ensure that actions identified within workshops are progressed appropriately and transparently, including as appropriate in existing or new local or regional forums**

  While in many areas important actions identified during the first workshop were progressed appropriately, this was not always the case, with some staff reflecting that attendees were unsure what they had committed to doing and unable to report on any progress made between workshops. In addition, in some areas there was a lack of progress reporting, resulting in the perception that developments have not occurred or been sustained.

  Given the importance of ensuring that positive momentum is established at an early stage, any approach taken in future should ensure that there is clarity in the first workshop around identified actions in terms of accountability, timescale and reporting on progress. Where appropriate, attendees should be reminded of any requirement to report on progress in the second workshop.

  Consideration should also be given to developing a clear, RAG-rated reporting tool to provide clarity on actions being taken and progress – this will ensure that there is transparency on progress and that all staff involved in the workshops will be able to identify progress and be clear around how to input into any relevant actions on an on-going basis.

Recommendation 5:

- **To align any future programme with delivery of the NHS Long Term Plan objectives and, in the short term, Local Transformation Plans for CYPMH**

The evaluation showed that the links between the programme and Local Transformation Plans were stronger overall in the expanded programme. This was usually reported to be advantageous, as it meant that the programme was nested within a wider set of local priorities, that there were clear lines of accountability, and – in some instances – that the programme was supported by local transformation funding. Where achieved, this helped ensure sustainability in the short-term and potentially over a longer period.

This included several instances where new NHS CYPHS link roles were secured longer-term. Other areas implementing workshops or similar approaches may wish to consider a similar approach and how such roles align with initiatives identified in the Green Paper – Transforming Children's Mental Health. This should include the Mental Health Support Teams and Senior Mental Health Leads programme. The NHS Long Term Plan requires plans for children and young people's mental health to align together, and commits to continued roll out of Mental Health Support Teams to 20-25% of England by 2023/4.

Recommendation 6:

- **Ensure any similar workshop approach embeds sustainability and accountability from the outset**

  Results from the original pilot and expanded programme illustrated the potential for initial positive attitudes and actions to be lost or diminished over time, resulting in a lack of sustainability.

  A number of options are possible depending on the overall format of any workshop or similar approach taken in future, in addition to the previous recommendation on aligning delivery to wider plans and objectives. These should ensure that sustainability is built into the programme from the very outset, while recognising that sustainability is likely to be influenced to a significant extent by factors internal to each area (e.g. existing structures, attitudes etc).

  The recommended changes include that:

  a) The expression of interest used in the expanded programme should be amended, to ensure that information is provided separately on long-term sustainability plans and fit with other work in the locality (as opposed to being covered in the same question).

  b) It should be made clear to applicants that they are expected to have clear plans for sustainability, accountability and embedding actions that will be taken into account in the scoring at any application stage.

  c) This approach should then be carried through in the workshops, with an expectation that by the end of the second workshop that area leads will be

able to produce and disseminate a plan illustrating how sustainability will be achieved and that this will be made available across the local area.

d) Delivery partners should ensure that sufficient time is in place to allow discussions and feedback, and that supporting material, guidance and advice is available to ensure that staff are supported in this action.

e) Finally, risk management plans should be developed in each area to ensure that common issues relating to sustainability (e.g. staff turnover) have mitigating actions and contingencies identified and implemented as appropriate.

Detailed consideration should be given as to ensuring that longer-term accountability is embedded within any joint working approaches or workshops that are implemented in the future. Different options may be required depending on progress within each area, taking into account that where actions have taken place and joint working is successfully embedded within local structures there may be less of a requirement for support than in areas where sustainability has not been achieved.

Recommendation 7:

- **To identify and/or develop appropriate forums for regular sustained contact between schools and CYPMH services, including periodically refreshing the workshop format**

  There was consensus among local stakeholders regarding the need to find ways to capitalise on the momentum generated by the workshops. Opportunities were lost where joint working relationships were perceived to have been allowed to 'slip back'. Even in areas where the workshops were considered a success, there was scepticism at how links might be maintained without a more regular forum – especially given staff turnover (identified as a risk to sustainability by well over one third of schools responding to the survey).

  CCGs and LAs implementing a similar workshop format might consider setting-up a standing forum to drive and sustain joint working and to continue strategic development. This might anticipate or support the implementation and governance of the Mental Health Support Team programme.

  While expanding existing local CYPMHS networks proved to be a cost effective method in some programme areas, there might also be merits in re-running the 'full' workshop format periodically (e.g. annually or bi-annually), to undertake a whole system review, chaired by the CCG or LA.

Recommendations for DfE and the national delivery partner(s) should they wish to maintain and/or expand a similar workshop approach

Recommendation 8:

- **To establish a national community of practice around workshops, ensuring alignment to relevant, existing forums for areas to network and exchange practices**

  The case study research and lead contact surveys showed an interest among LAs and CCGs in sharing experiences of joint working, along with case studies, practice models and tools developed following the programme. This appetite for learning and networking was also demonstrated at the two national dissemination events. The DfE may therefore wish to consider supporting an online network or learning community of some kind, to support the national rollout. This could potentially be peer-led, and also serve as a forum to share learning, including in relation to Mental Health Support Teams and wider LTP implementation.

Recommendation 9:

- **To further develop the potential of CASCADE and the evaluation tools to facilitate ongoing self-assessment/evaluation and benchmarking**

  While some areas found the CASCADE scoring helpful to support reflective practice, others felt that the format was mainly intended to validate the workshops rather than as a tool for continuous improvement.

  The DfE and national delivery partner should consider developing guidance to support on-going self-evaluation, drawing upon CASCADE and the tools developed for the pilot and programme evaluations. The areas within the programme had some clear ideas, which could be developed into a basket of indicators (see Table 2.2). The surveys developed for the evaluation could also be re-purposed in this way, as a means of benchmarking and measuring progress. Any self-evaluation tools should, however, allow sufficient flexibility for areas to set and measure indicators that reflect their local aims and context, alongside the standard measures.

Recommendation 10:

- **To develop additional materials, to scaffold the workshops for areas at different levels, and to facilitate progression to 'Gold' standard**

  Related to Recommendation 7, there was a demand from some CCGs and LAs for a practice toolkit to extend the programme model beyond the two initial workshops. One of the local area leads liked the concept of striving towards 'Gold' standard for CASCADE, for example, and saw this as a direction in which to develop the model.

The evaluation of the expanded programme also seemed to indicate that areas starting from a lower baseline made the greatest gains during the programme, on the condition that there was stable leadership and a clear set of actions arising from CASCADE and the workshops themselves. This would suggest that a graduated set of tools might be useful as part of any self-reflection scoring approach used in the future, to support implementation for areas at different stages. A more challenging format might help to engage those areas where joint working is already higher, with the aim of achieving improved outcomes from the workshops.

Recommendation 11:

- **To consider how a workshop model can support and complement the development of the Mental Health Support Teams Trailblazer programme and, in particular, the training for Senior Mental Health Leads**

  The evaluation has underlined the potential synergies in aims between the school links programme and the rollout of Mental Health Support Teams and training for Senior Mental Health Leads. The DfE and local areas should consider how the learning from the programme might be utilised by all of the MHST Trailblazer areas e.g. by ensuring that training takes advantage of the presence of schools, colleges and health professionals to ensure clarity relating to roles, responsibilities and joint working. Areas should be supported to ensure that resources are developed to ensure that this understanding is embedded in induction processes and widely/easily available throughout the organisation. Consideration of other potential longer-term developments should also be prioritised to future-proof any approach, including meeting current DfE commitments to incorporate training into the "National Professional Qualifications (NPQ) curriculum, teaching schools and initial teacher training curriculum"[21]

[21] https://www.corc.uk.net/media/1923/vivmccotter-green-paper-presentation-november-2018.pdf

Appendix 1: CASCADE framework for collaborative working between schools and mental health providers

Table A1.1 Comparison of baseline and follow-up survey schools – by school type

	Major challenge	Good elements of practice	Widespread good practice	Gold standard
Clarity on roles, remit and responsibilities of all partners involved in supporting CYP mental health	No shared knowledge of the range of support available and poor links between partners	Some shared knowledge of the range of support available some links between partners	Shared knowledge of the range of support available and good links between partners	Full mapping of all sources of support kept up today and accessible with strong links between all partners
Agreed point of contact and role in schools and CYP mental health services	No identified points of contact	Some identified points of contact with some partners	Agreed and shared points of contact with most partners	Agreed and shared points of contact with all partners that are kept up to date as staff change
Structures to support shared planning and collaborative working	No structures to support shared planning and collaborative working	Steering group/partnership agreement or other structure to support shared planning and collaborative working, but membership attendance patchy or frequently cancelled	Steering group/partnership agreement or other structure to support shared planning and collaborative working but not fully linked to other groups	Steering group/partnership agreement or other structure to support shared planning and collaborative working, embedded well with other relevant groups
Common approach to outcome measures for young people	No shared outcome measures and no sharing of information	Some overlap of outcome measures but no shared information	Most shared outcome measures and limited sharing of outcomes	Routine use of shared outcome measures that are routinely shared
Ability to continue to learn and draw on best practice	No forum for shared learning	Some sharing at joint events with some partners or access to good practice networks but limited	Widespread sharing of best practice with most partners but not always acted upon	Widespread sharing of evidence-based best practice with all partners that drives initiatives
Development of integrated working to promote rapid and better access to support	Little to no integrated working and complicated and/or slow path(s) to support	Some integrated working with partners to improve access	Widespread integrated working with most partners to	Widespread integrated working with all partners to improve

	Major challenge	Good elements of practice	Widespread good practice	Gold standard
		despite complicated and/or slow paths to support	improve access with clear path to support	access with clear and/or rapid path to support
Evidence-based approach to intervention	Little or limited training available to support intervention and not grounded in evidence	Some routine training available, but not always evidence-based; some interventions in place	Most staff accessing regular targeted training with interventions in place	Clear training programme for all staff with some joint training alongside interventions

Source: Developed by the Anna Freud National Centre for Children and Families. © Miranda Wolpert (2015).

Appendix 2: Typology of delivery models from the pilot evaluation

Table A2.1 Typology of delivery models from the pilot evaluation

a) NHS CYPMHS lead with contact time in schools on a regular basis, delivering services and support directly to staff and young people		
Key characteristics • named lead point of contact in NHS CYPMHS offering a regular presence in schools (for example, weekly/fortnightly advisory sessions) • delivery of advice, training and one-to-one support to lead points of contact within schools • direct young person-facing work, potentially including classroom observations, workshops and sometimes individual appointments • may include some assessment and case-holding responsibilities • often performed by a single NHS CYPMHS primary mental health worker, linking with specific schools with back-office support • school single point of contact working within wider pastoral team	**Potential advantages** • regular direct face-to-face contact conducive to building trusting and supportive relationships • scope to support and consult to school staff in relation to their role and individual students • support to build schools' capacity to deliver light-touch interventions, joint pieces of work involving individual young people • NHS CYPMHS staff able to observe young people directly and identify any concerns • enhances and supports the interventions delivered by specialist NHS CYPMHS • in some schools with greater need, the investment may release equivalent internal resources	**Potential drawbacks** • time- and resource-intensive model for schools and NHS CYPMHS to sustain, over a longer period • challenges arising from varying levels of need between individual schools • not necessarily the most cost-effective model where schools gave lower levels of need • risk of setting unrealistic expectations with the school, parents and young people, if the provision is time-limited only and will not be sustained
b) NHS CYPMHS named lead offering dedicated training and support time to school-based professionals		
Key characteristics • named lead point of contact in NHS CYPMHS offering advice and consultative time to their counterparts within designated schools	**Potential advantages** • regular ongoing contact conducive to building trusting and supportive relationships • scope to gain a detailed understanding of the needs of individual schools	**Potential drawbacks** • tensions can arise where schools expect/require higher levels of in-school support

• scoping of individual schools' needs, support and advice on updating policies and protocols, communicating pathways • often involves the delivery of mental health awareness training • flexible menu of support; may include some school-based work, but on a more ad hoc basis • may occasionally involve limited, one-off direct contact with pupils - often jointly with school staff	• sustainable approach, based on school-by-school quality. assurance and capacity-building • develops and supports school capability to support CYPMH, improving outcomes for students and reducing pressure to refer to specialist service • may be most efficient response for schools with lower level mental health needs (for example, smaller/primary schools)	• more limited opportunities to observe school staff and pupils, and to embed practices directly • fewer co-productive opportunities • commitment to having a single named point of contact requires minimum time commitment • risk of setting unrealistic expectations with the school parents and young people, if the provision is time-limited only and will not be sustained
c) NHS CYPMHS named lead or duty team with designated responsibilities for the pilot, offering single point of access		
Key characteristics • systems-oriented model – focus on improving transparency and clarity of communication channels and referral pathways; commitment to better ongoing dialogue and feedback to schools • single point of access to specialist NHS CYPMHS, via telephone helpline/email or online contact • duty team and triage model – service is available when needed for advice, consultations or information; often using a rota system • schools may also have a named contact person in NHS CYPMHS but largely on an advisory basis • often supported with forums, and regular mental health awareness training for (groups of) schools	**Potential advantages** • ability to operationalise more quickly, and potentially less time and resource intensive to manage and implement • guaranteed single point of access to specialist NHS CYPMHS brings clarity and reassurance • supports information-sharing • more open communication and feedback between schools and NHS CYPMHS means less risk of miscommunication • increased scope for scalability	**Potential drawbacks** • tensions can arise where schools expect/require higher levels of in-school support • fewer opportunities to observe school staff and pupils, and to embed practices directly • fewer co-productive opportunities • onus is on schools to maintain a proactive approach in the event that the lead contact leaves or changes role • risk of unnecessary referrals to NHS as more CYP are identified

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Any enquiries regarding this publication should be sent to us at:
MH.RESEARCHPROGRAMME@education.gsi.gov.uk or
www.education.gov.uk/contactus

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