Report Title:	Wellbeing Service Report
Contains Confidential or Exempt Information	No - Part I
Cabinet Member:	Councillor Carroll, Cabinet Member for Children's Services, Education, Health, Mental Health & Transformation
Meeting and Date:	Schools Forum – 17th November 2022
Responsible Officer(s):	Lin Ferguson Director of Children's Services AfC Rebecca Askew Head of Service
Wards affected:	All

www.rbwm.gov.uk Royal Borough of Windsor & Maidenhead

REPORT SUMMARY

The purpose of this report is to provide the Schools Forum with:
The current and future service provision from the Wellbeing Service based on local SEMH considerations and developments to support increasing SEMH needs.

1. DETAILS OF RECOMMENDATION(S)

RECOMMENDATION: That Schools Forum notes the report and:

i) Proposal 1 – Provides continued grant funding of £120,000 per annum to the Wellbeing Service.

2. REASON(S) FOR RECOMMENDATION(S) AND OPTIONS CONSIDERED

Table 1: Options arising from this report

Option	Comments
Continued grant funding of £120,000 from the Schools Forum to the Wellbeing Service. **This is the recommended option**	This will support the continuity of the service and help to address the demand for Wellbeing services.
No action The Wellbeing Service does not continue to receive grant funding from the Schools Forum.	The cases will need to be signposted to CAMHS (further increase in wait times for these vulnerable children and young people). South East region CAMHS referrals have increased by 300% since the start of the pandemic. Increased generation of requests for SEMH, Education, Health & Care Plans.

3. KEY IMPLICATIONS

Table 2: Key Implications arising from this report

Outcome	Unmet	Met	Exceeded	Significantly Exceeded	Date of delivery
The Wellbeing Service does not continue to receive grant funding from the Schools Forum	Early Help & CAMHS wait times will increase. Reduction in preventative & early intervention for mental health in order to meet EHH referral and Social Care requirements. Increased pressure on high needs block budget for SEMH needs.	Continued delivery of preventative, early and targeted intervention for mental health in order to meet EHH referral and Social Care requirements Reduction of Early Help wait times for Dyadic Developmental Psychotherapy and Play Therapy.	Further collaborative support can be extended to AfC teams e.g. Young Carers and children/young people who are ERSA/EHE with Mental Health and Wellbeing Needs as a primary concern and support Social Care colleagues with managing and understanding therapeutic needs of complex SEMH cases.	None	17th November 2022 – 17th November 2023

4. FINANCIAL DETAILS / VALUE FOR MONEY

4.1 There are no new financial implications arising from this report.

5. RISK MANAGEMENT

Table 3: Impact of risk and mitigation

Risk	Level of uncontrolled risk	Controls	Level of controlled risk
NIC increases from 13.8% to 15.05% this financial year, however current guidance from the government outlines that this will be for 1 year.	Medium	Increases outlined for a finite period.	Medium

Salary costs are incremental so any year on year uplifts would have to be found within the current budget potentially increasing overspends.	Medium	N/A	Medium

6. POTENTIAL IMPACTS

6.1 Equalities. With regard to not agreeing the recommended option a detrimental and/or disproportionate impact on particular groups is likely. This is particularly pertinent to service users and public groups with disabilities who are disproportionately represented as having a higher incidence of mental health and wellbeing needs which is evident in the referrals received for Wellbeing and Getting Help Teams support via the Early Help Hub and Social Care. An EQIA is available as Appendix A.

6.2 Climate change/ sustainability. The service continues to develop quality assured digital based interventions managing anxiety webinars for parents/carers and therapeutic packages that are successfully delivered online.

6.3 Data Protection/GDPR. There are no data protection/ GDPR risks arising from this report.

7. BACKGROUND DOCUMENTS

7.1 This report is supported by the following background information:

- The Wellbeing Service – Overview
- Referral rates and wait times
- Wellbeing Service - output and intervention data September 2021 - August 2022
- Developments to support strategic and local SEMH planning and service delivery
- National and local SEMH considerations
- Getting Help Team
- Mental Health Support Team
- SEMH Interventions

The Wellbeing Service was set up in 2015 in response to increasing concerns about the mental health and wellbeing of children & young people (C&YP) and was specifically identified by school audits as an area of need. The purpose of the team is to support children and young people and their families at the earliest stages to understand and effectively manage (where appropriate) mental health concerns. This was to ensure schools and other professionals feel supported with the aim to reduce the need to escalate to specialist services both in CAMHS and Social Care.

Support from the service is open to all children and young people in RBWM schools (5-18 years) with the exception of private/independent schools. It was agreed that this team would offer both direct work such as consultation and initial assessment, time limited focused therapeutic interventions, such as Cognitive Behavioural Therapy (CBT) informed strategies, Play Therapy, Dyadic Developmental Psychotherapy/Filial Therapy and group work/workshops with children and young people and indirect work such as training, Early Help meeting support and signposting.

Members of the team have continued to support children and young people known to the Social Care Pods through the provision of Dyadic Developmental Therapy based consultations and clinical reflective consultations for staff.

There are currently three Wellbeing Practitioners employed in the Wellbeing Service:
Counsellor 0.2fte (volunteer)
Play Therapists 0.6fte (PTUK volunteers)
Cognitive Behavioural Therapist 0.4fte
Play Therapist 0.8fte
Play and Creative Arts Therapist and Dyadic Developmental Psychotherapist 0.7fte (Team Lead)

With the implementation of the Getting Help Team there is an additional 1.5fte of practitioner time (CBT) available to RBWM. The Getting Help Wellbeing Practitioners are employed by Berkshire Healthcare Foundation Trust (BHFT) but offer support within the Wellbeing Service using the Early Help systems.

The development of one Team Lead Post within the Wellbeing Team at Grade 7 (£33,018 - £36,613 1.0fte) has been actioned as agreed at Schools Forum in July 2020.
Responsibilities include:

- Attendance at Early Help Hub
- Line management, staff training and team development
- Supervision and appraisals
- Intervention, project and evaluation monitoring
- Recruitment and induction

This has ensured that the Service Manager capacity is increased to allow for additional focus on strategic planning. This will be crucial for the development of mental health support through Social Care, both to enhance Social Workers understanding of mental health and available interventions in order to develop consistency in referrals. In addition, it allows for further focus on the continued implementation and planning of the Mental Health Support Teams and collaborative developments within East Berkshire CCG/Frimley ICS to meet the priorities in the Local Transformation Plan.

Developments have also been discussed within the Social Care resource panel to reduce the overall expenditure to external providers through enhancement of mental health data sets in Social Care, conducting assessments of therapeutic need, increased scrutiny in panel meetings and the potential establishment of Systemic Family and DDP Therapy team working alongside the Wellbeing Service. Funding has been agreed and Systemic Family Therapy posts are currently being advertised.

The budgeted cost to run the Wellbeing Service is £120,000 per annum. The contribution from the Social Care Pods equates to a further income of £15,000 per annum. RBWM Social Care access a range of quality assured and accountable therapeutic services via the Wellbeing Service as per the agreement totalling 660 hours of therapeutic time per year.

Referral Rates and wait times

CBT - not holding a wait time for CBT.
Play Therapy – 5 month wait.
DDP - 9 months

Wellbeing Service
Outputs September 2021 – August 2022

- 172 young people were referred to the Wellbeing Service between September 2021-August 2022. This represents a decrease in cases being referred during this reporting period (due to implementation of the MHST). This is 28 less cases referred, as compared to the last reporting period (September 2020-August 2021, where 200 cases were referred in total).

- 27 young people in total accessed group and individual therapy sessions during this period, of these 10 parents attended the Managing my Child's Anxiety course (online) and 6 attended one of the Child Parent Relationship Therapy Group.

- 16 parents accessed a parent group with the Wellbeing Service during this period.

- 2 young people accessed CBT 1:1 interventions with the Wellbeing Service.

- 17 young people (65% male and 35% female) accessed individual Play Therapy, the average age 8 years old.

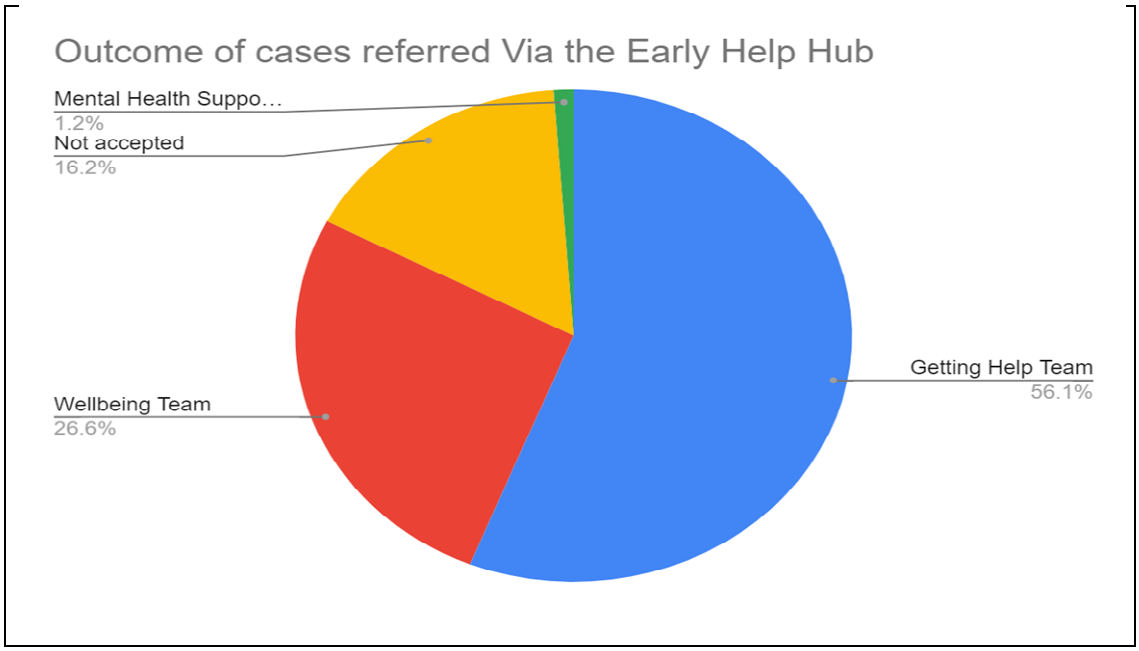
- 2 families accessed Dyadic Developmental Psychotherapy/ Attachment Focused Family Therapy (consultation model and therapeutic intervention model).

- 5 young people (3 male and 2 female) completed a counselling/ trauma informed counselling intervention of 12-18 weeks.

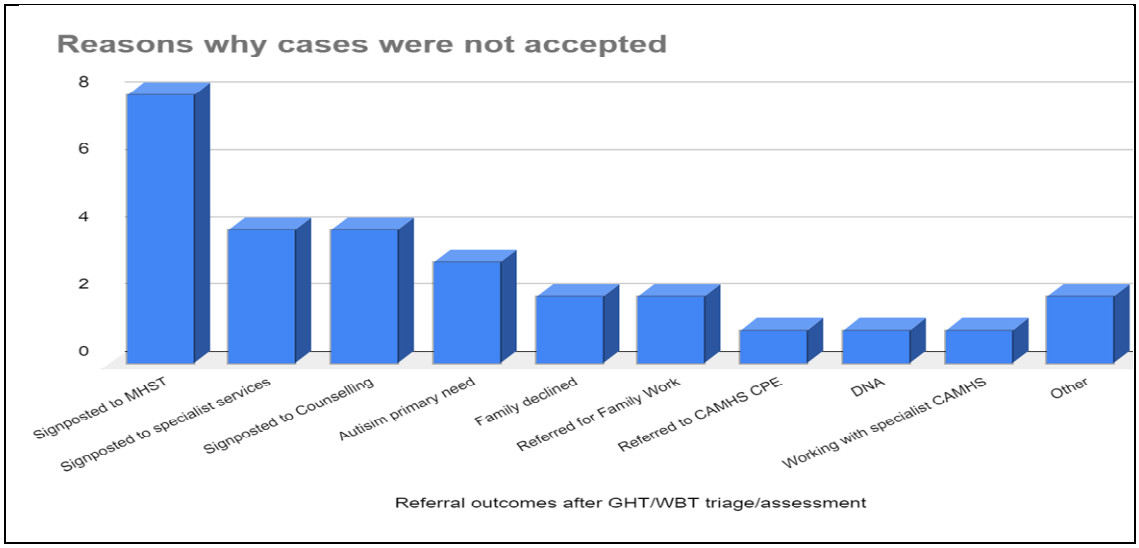
- 51 young people attended the Emotional Wellbeing Champions course in 2022.

From September 2021- August 2022 a total of 172 individuals (42% males and 58% females) were referred to the Wellbeing and Getting Help Team from 55 RBWM schools. All cases were referred via the Early Help Hub, the pie chart below shows the destination of the cases referred.

The chart below shows the majority of cases (56%) were seen by the Getting Help Team for assessment and/or treatment with The Wellbeing Service picking up 26% of cases for a direct intervention. 16.2% of cases were 'not accepted' following the initial discussion at the Wellbeing, Getting Help Team and Mental Health Support Team's weekly Joint Referrals and Allocation meeting.

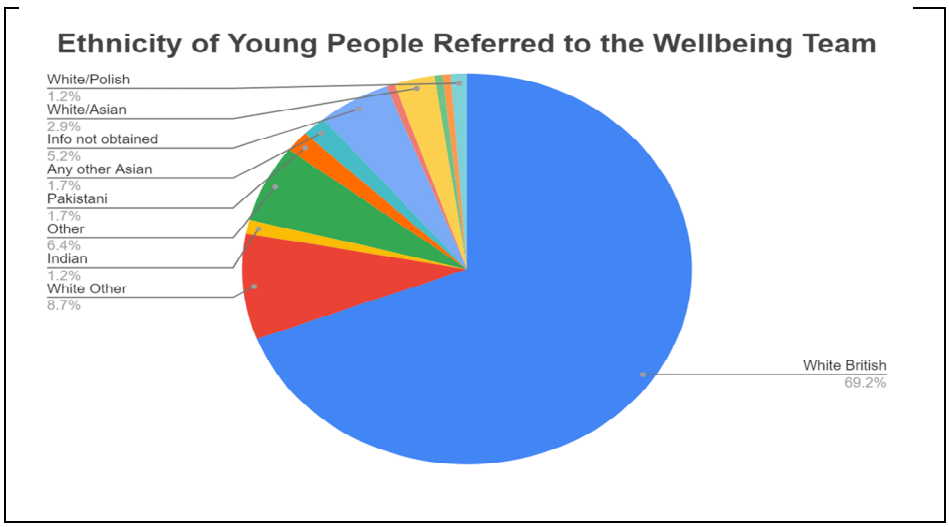


28 cases were not accepted by either the Wellbeing or Getting Help Team (GHT). The reasons for this are shown in the chart below. The highest category of cases not accepted (a total of 8 cases) were referred to the school's Mental Health Support Team (MHST). During this period there remained some work around supporting MHST schools with understanding the thresholds and referral routes for young people in need of low intensity CBT interventions. The Early Help Hub Advisory Service, Mental Health Support Teams (MHST), GHT and WBT collaborate to help clarify and embed referral pathways for the MHST provision and we anticipate this number to reduce in the next reporting period. The second highest category of cases not accepted were referred onto specialist services such as SAFE, prisoner support and Information Advice Services (IAS) or to community/ school counselling.



** CAMHS CPE= Child and Adolescent Mental Health Service Common Point of Entry, DNA= Did Not Attend, MHST- Mental Health Support Teams.*

The pie chart below shows the ethnicity of young people referred to the Wellbeing Service. The majority were 'White British', with this group accounting for 69.2% of referrals. The second largest group referred (at 15%) was 'White Other'. 'White Western European', 'Pakistani British' and 'White and Black Caribbean' are represented by the three colours not labelled on the chart and each represents less than 1% each.



Team Activity

Schools supported by the GHT/ WBT	55
Total individual referrals from the Early Help Hub	172

This year the service focus has shifted from offering CBT informed interventions towards the provision of Play Therapy, family focused therapeutic interventions (i.e. the Child Parent Relationship Group and the Attachment Focused Family Therapy) and Counselling. This has been in response to the continued high demand for these interventions and the increased capacity of low intensity CBT interventions via the Getting Help and Mental Health Support Teams. The Wellbeing Service continue to complete assessment and triage as part of case work but tend not to offer stand alone wellbeing assessments.

Summary of the presenting difficulties of young people referred to the Wellbeing Service September 2021- August 2022

It should be noted that some cases had more than one presenting difficulty. Following initial assessment and consultation a primary need was identified and appropriate intervention was suggested.

Primary Concerns on referral	Number of Pupils
Anxiety (unknown)	96
Other	24
Low Mood & Depression	12
Attachment Difficulties	11
Emotional Regulation	10
Anger Management/Behavioural Difficulties	6
Separation Anxiety	3
Self-Esteem/Confidence	3
GAD (Generalised Anxiety Disorder)	2
Bereavement	1
PTSD (Post Traumatic Stress Disorder)	1
Phobia	1
Panic	1
Self-Harm	1
Total	**172**

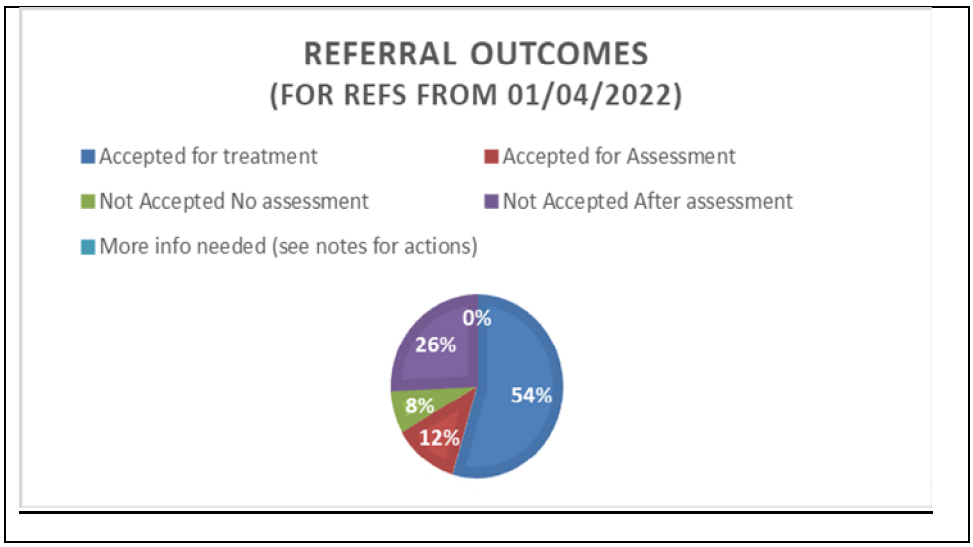
9.3% of the cases referred to the Wellbeing Team had Emotional Related School Avoidance (ERSA) as a co-existing issue alongside the primary presenting issue noted above.

Cognitive Behavioural Therapy

The Getting Help Team now delivers the majority of the low intensity Cognitive Behavioural Therapy (CBT) for RBWM. The Getting Help Team gathers their data from April to April, which differs from the Wellbeing Service reporting period. Where the data shown refers to a specific reporting period, this will be made clear.

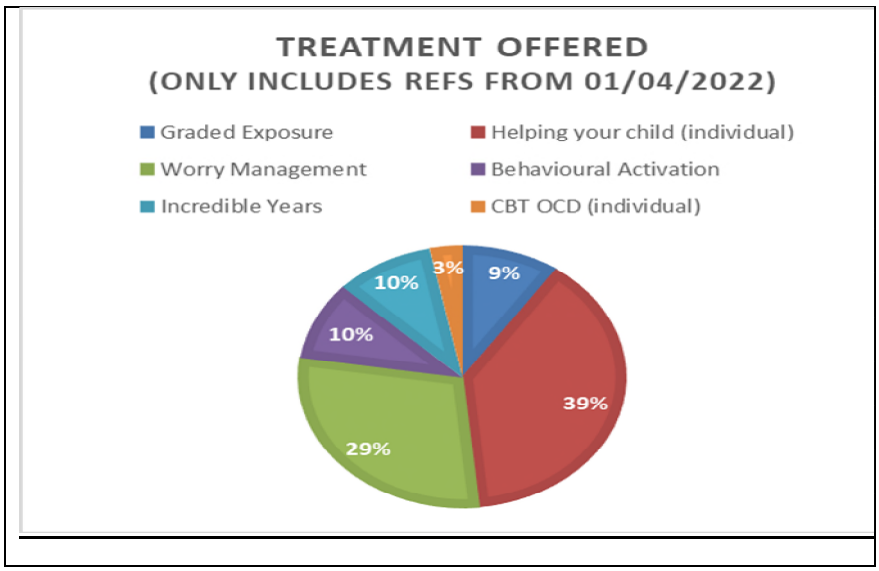
The graph below shows the numbers of referrals per month from September 2021-August 2022. This shows the highest number of referrals for the Getting Help Team was in March 2022 (19 referrals) and by comparison October 2021 had the lowest number (3 referrals).

The following data is for the five month period from April 2022- September 2022. The chart below shows that in this period 36 cases were accepted by the Getting Help Team for treatment and 6 sessions were accepted for assessment only. 5 cases were not accepted and were not offered an assessment. 17 cases were not accepted after assessment, this appears to be an increasing number and the GHT will be analysing the data to better understand this. On first review they believe a high proportion of cases not accepted after assessment are where neurodiversity is the primary need and therefore another service would be better placed to offer support.



The chart below shows the breakdown of interventions offered during this period. This shows that the 1:1 6-8 week 'Helping Your Child' intervention was the most common intervention, with 12 cases being offered this support. This correlates with the high rates of primary need for a referral being anxiety based. CBT for Obsessive

Compulsive Disorder (OCD) was the least frequently offered intervention. The reason for this is OCD requires a high intensity CBT intervention which would normally be provided by specialist CAMHS, but the GHT team are currently able to offer this intervention via a CBT high intensity trainee who is placed within their team.

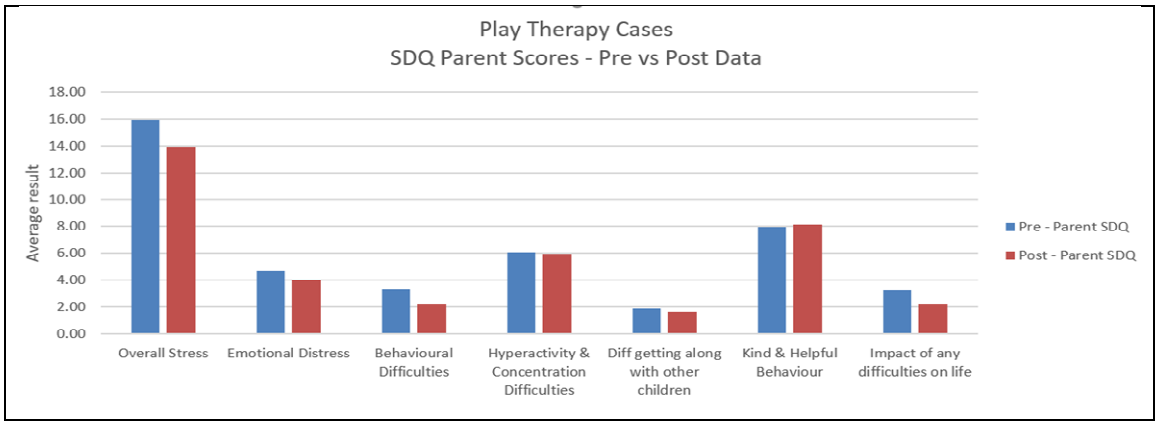


Play and Creative Arts Therapy

Due to the younger age of the cohort, the primary tool used to measure the impact of the Play and Creative Arts Therapy intervention was the Parent Strengths and Difficulties Questionnaire (SDQ). Goal based outcomes and 'blob tree' evaluations are also used in some cases to measure the impact of interventions for young people. Outcome measures were taken before and after the intervention to help evaluate impact. The results from cases with a complete set of pre and post data from either parent and/or school SDQ evaluations are shown below. It should be noted, these results are taken from a small number of cases so caution should be taken when drawing conclusions from the data.

Parent/Carer pre and post SDQ results

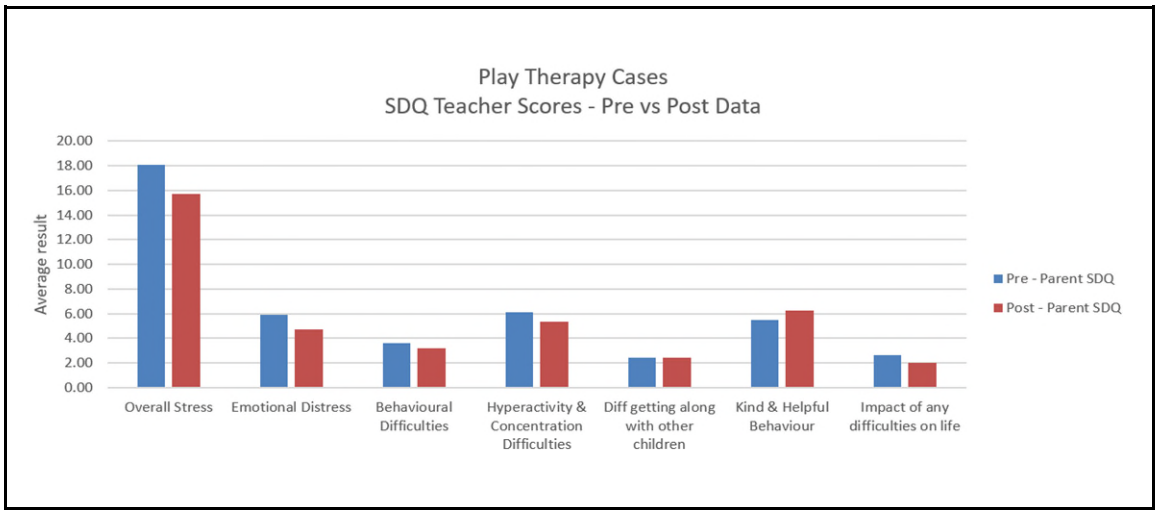
The graph below shows the parent pre and post questionnaire results for children who accessed a Play Therapy intervention. 13 out of the 17 parents whose child accessed a Play Therapy intervention returned the post intervention evaluation.



This graph shows parents saw a reduction in overall stress, emotional and behavioural difficulties and on the impact these difficulties were having on the child's life following the Play Therapy intervention. The only subset not to reduce (it remained static) was hyperactivity and concentration difficulties. There was a very slight decrease in difficulties getting on with other children and a slight increase in kind and helpful behaviour.

School pre and post SDQ results

The graph below shows the teacher pre and post questionnaire results for children who accessed a Play Therapy intervention. 11 out of the 17 schools who had a child accessing a Play Therapy intervention returned the post intervention evaluation.



Attachment Focused Family Therapy Impact Study

Rachel, age 12

Referral Background

This case was referred via a Social Worker in the Duty and Assessment team. The case had been referred to them for a single assessment after the young person had reported they had been physically chastised by her father's girlfriend. Rachel also said both parents regularly shouted at her and she appeared to have a difficult relationship with them both. While Social Care concluded there was no evidence of abuse towards Rachel, there was evidence of a high degree of parental acrimony between Rachel's birth parents, which appeared to be contributing to 'within child' difficulties of low self-esteem and behavioural (lying and stealing) and peer difficulties.

Aim of Therapeutic Support

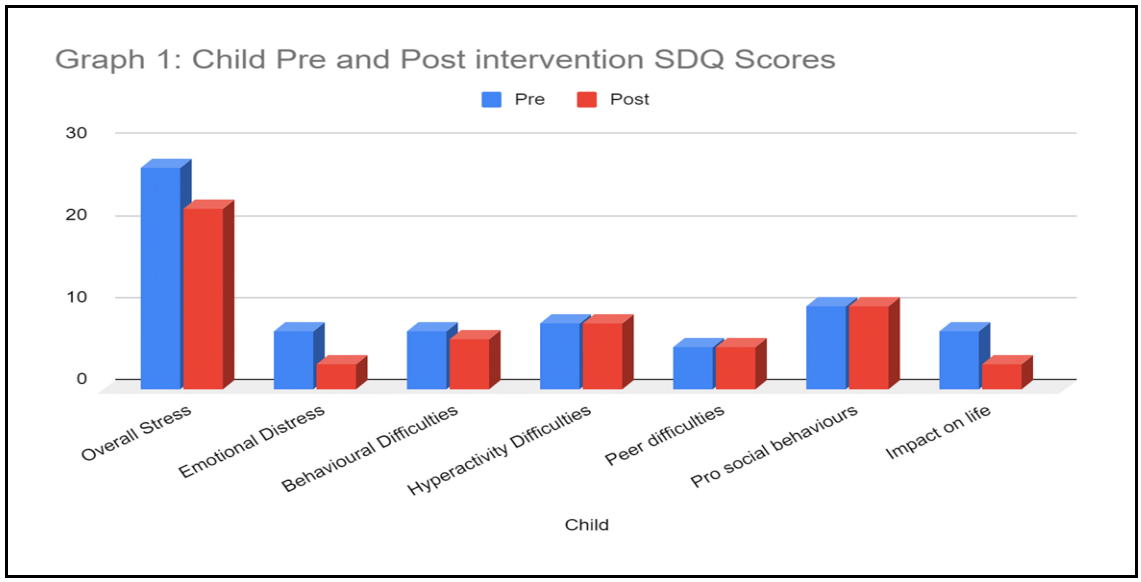
At assessment Rachel spoke about feeling torn between her mother's and father's homes, she also spoke about feeling unable to share her thoughts and feelings. I observed Rachel was very enmeshed with her mother and her narrative of the difficulties with Rachel's birth father. The agreed aim of the therapy was to 1) Work towards more open communication within the family (i.e. Rachel and her mother/ father) and 2) Rachel to feel safe to share her thoughts and feelings with her parents. I also wanted to help the mother shift her thinking around birth dad to a more neutral position, in order to enable thinking around dad and his thoughts, feelings, behaviours and hopes which helped Rachel to make sense of her dad and thus build her relationship with him.

Overview of Wellbeing intervention

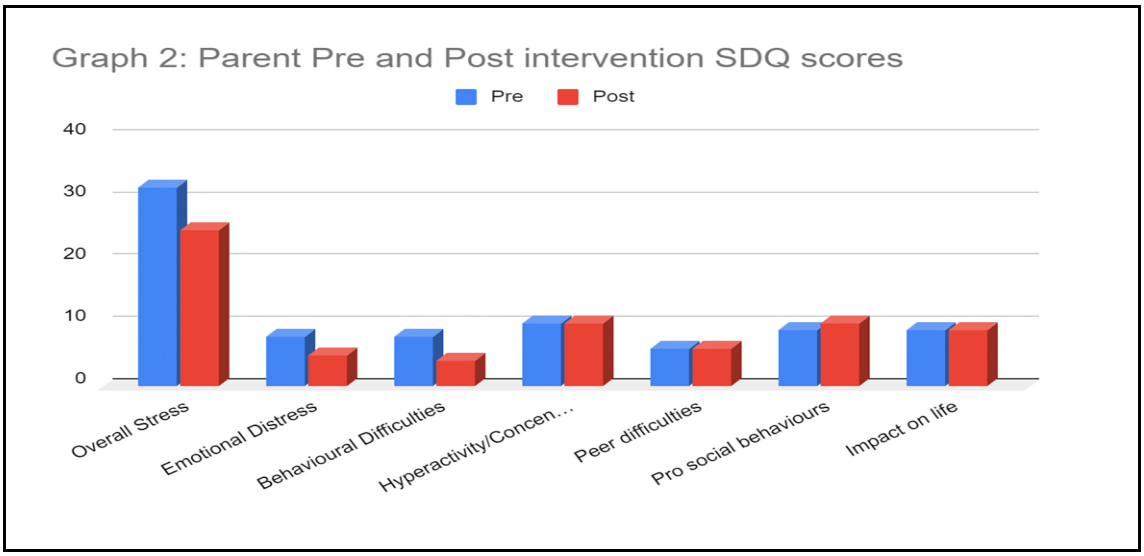
Twelve Attachment Focused Family Therapy sessions took place with Rachel and her mother over a period of 6 months, the sessions were often fortnightly with some breaks to accommodate the family's needs. From the 3rd month onwards I was the lead professional for the Early Help Plan for which we held 8 weekly review meetings with home and school. I had suggested to Rachel that either dad could be included in the sessions, or we could hold some sessions for just the two of them, Rachel declined this and preferred to have sessions with her and her mother.

Outcome measures pre and post evaluation

The results from the young person's pre and post SDQ's (see below) indicate a reduction in overall stress and a significant reduction in emotional difficulties and the impact the difficulties are having. There was a small reduction in behavioural difficulties and hyperactive and peer difficulties remained the same. This mirrors the qualitative feedback from the young person who spoke throughout the process of therapy that they had gained insight into the thoughts and feelings which sit behind how they behave. The young person said they felt like they could express their feelings through the work and it felt safe to do this. This was the core aim of the work which was to help the family communicate more openly and also to support the young person to articulate their thoughts, feelings and needs without feeling like it would damage the familial relationships.



Graph 2 (below) shows the results of the parent's pre and post SDQ's. These mirror the young person's scores in the reductions shown in overall stress, emotional difficulties and behavioural difficulties, however the differential in the pre and post scores for overall stress and emotional distress is less marked as compared to the young person's scores. There has been a greater improvement in symptoms related to behavioural difficulties when compared to the young person's scores, while both showing a reduction in this area. The other subsets (hyperactivity, peer difficulties and impact on life) remain the same with a very slight improvement in the prosocial scores.



Recommendations and next steps:

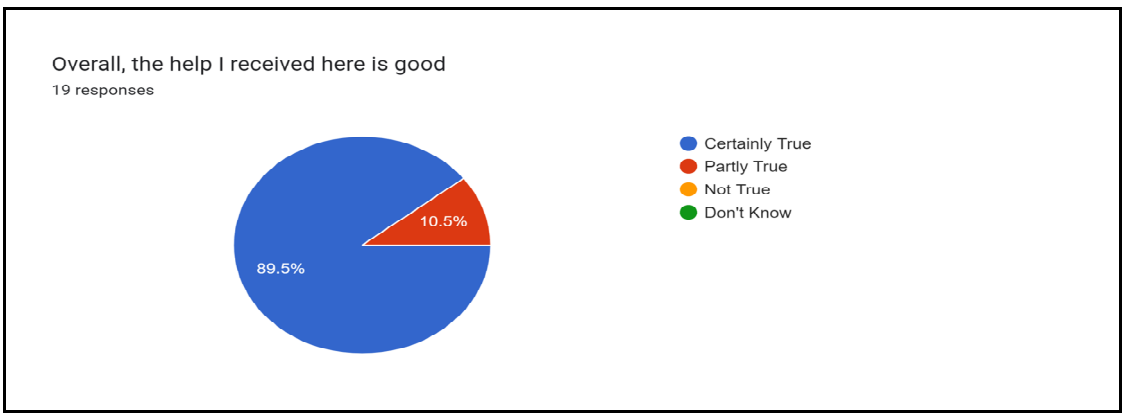
At the end of the intervention the family and Rachel reported being in a better place, they said they had valued the intervention and both said they had felt safe to talk about feelings during the sessions. When rating changes (on a scale of 1-10 where 10 means things have improved and 1 means there has been no improvement) Rachel gave a 7 and her mother an 8.

Rachel had just started engaging in positive activities in the community where she described herself as 'popular', school reported a significant improvement in Rachel's resilience (as measured by a reduction in her need for reassurance, a reduction in poor behaviour points and an increase in house points for good behaviour. Rachel remains on the waitlist for assessment for Attention Deficit Hyperactivity Disorder (ADHD) and is now accessing a peer therapy group focused on self-esteem school. Rachel felt like she did not need to access counselling in school, but knew support would be available to her should she need it.

Service Evaluation

Following a therapeutic 1:1 or group intervention with the Wellbeing Service parents were sent a service user evaluation form. 19 parents completed this questionnaire which is a significant increase from the 2020-21 reporting period.

The results (see below) show that the majority (89.5 %) of parents who completed the form felt that the help they received from the Wellbeing Service was good and 10.5% felt this was partly true.



The table below shows the themes that arose from the qualitative comments from parents when asked ‘What was really good about your care?’ The most commonly noted themes were the ‘skills/ qualities of the practitioners’ and the ‘helpfulness of practitioners. Some parents added a number of comments; therefore the total number of comments is greater than the number of respondents.

Theme	**Frequency**
Skills/ qualities of the practitioner	5
Helpful practitioners (i.e. gave advice and support)	4
Feeling listened to (child and/ or parent)	3
Developing a support network	3
Good communication with the team	2
Good bond with child	2
Supporting school/ others to better support the child	2
Child enjoyed the work	2
Feeling supported	2
Learning new ideas	2
A good understanding of my child's needs and the work needed	2
Improvement in child's mental health	1

The following comments were made by parents about the impact of working with the Wellbeing Service.

[They] …listened and helped me and my daughter manage a lot of emotions and feelings. And also with school because I feel the school wasn't very supportive at the start and [the practitioner] has also made the school help more and understand more.
[The practitioner] has developed a very special relationship with my daughter through understanding her needs and her issues.
Knowledgeable people who suggested good ideas and were supportive

Managing My Child’s Anxiety Group - Online

The aim of the programme is to help parents build a range of CBT informed (Cognitive Behavioural Therapy) strategies to help them and their child manage their anxiety to increase their sense of wellbeing. The objectives of the programme are to explore anxiety and provide advice and guidance, leaving parents feeling more confident to:

- understand possible causes of anxiety in Children and Young People
- recognise signs and symptoms
- identify the role a parent plays in the maintenance of anxiety
- aid their child in developing strategies to build resilience and manage anxiety
- identify steps to guide their child towards the right support

- recognise the importance of their own self-care and wellbeing

There is a strong evidence base for this course which indicates guided, parent-delivered Cognitive Behavioural Therapy based interventions are effective in reducing children's anxiety. 10 Delegates attended the online Managing My Child's Anxiety course between September 2021- August 2022, with two cohorts being run during this period (in September 2021 and February 2022). To evaluate the 'Managing My Child's Anxiety' pre and post parent RCADS are obtained. Regrettably we were only able to gather the post RCADS data from a small number of parents on both cohorts, which means we are unable to use this measure to evaluate the impact of the course on the young person's anxiety and depression symptoms. We were able to gather other evidence from parents to evaluate the impact of this course, this is shown below.

Parents were asked to complete a course evaluation, from those who responded, the data showed.

- 100% of respondents were either *mostly satisfied* or *extremely satisfied* with the course.
- Parents indicated they found the 'introduction to anxiety' and' thought challenging and worry management' modules the *most helpful*.
- 100% of respondents would recommend the course to a friend.

While the number of parents accessing this course is small, the impact for the parents who attended is valuable. Parents told us the impact of attending the course was in *increasing their confidence in dealing with their child's anxiety* and *learning new strategies for managing their child's anxiety.* When asked what participants valued most about the course, the following themes arose; *support from other families, feeling supported (and not judged), the support from the wellbeing team, the format worked well (being able to share examples and apply techniques quickly in life).*

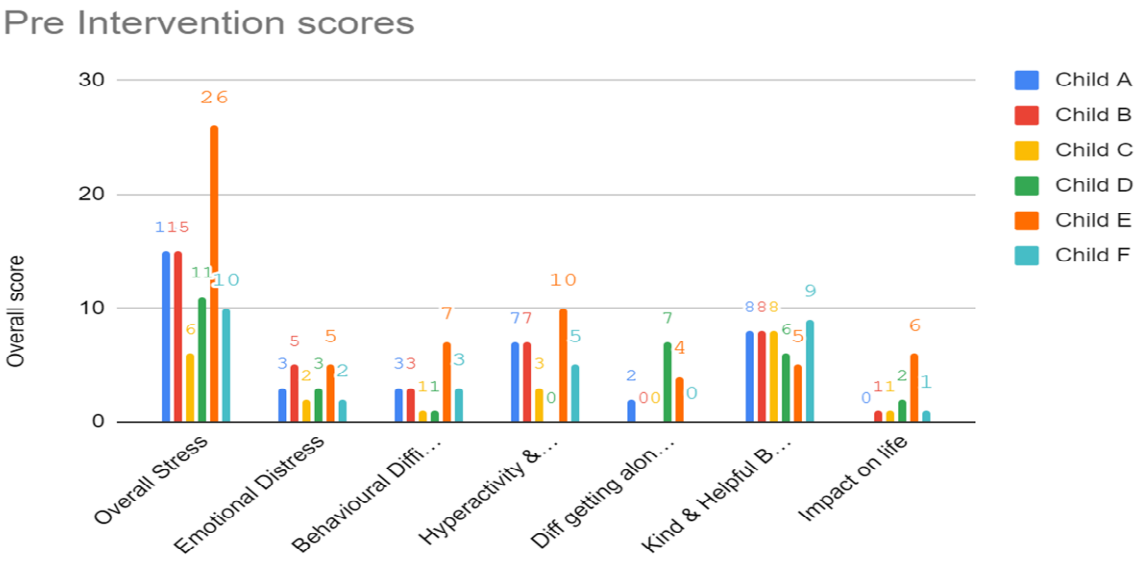
Parents were asked how we could improve the course, they replied that they would like face to face sessions and they would like to cover more material. We have taken these comments into consideration and, in response, we will be running a face to face parent led CBT course in collaboration with the Getting Help Team in October 2022. There will be an increased number of sessions over the duration of the course and each will be longer than the online sessions.

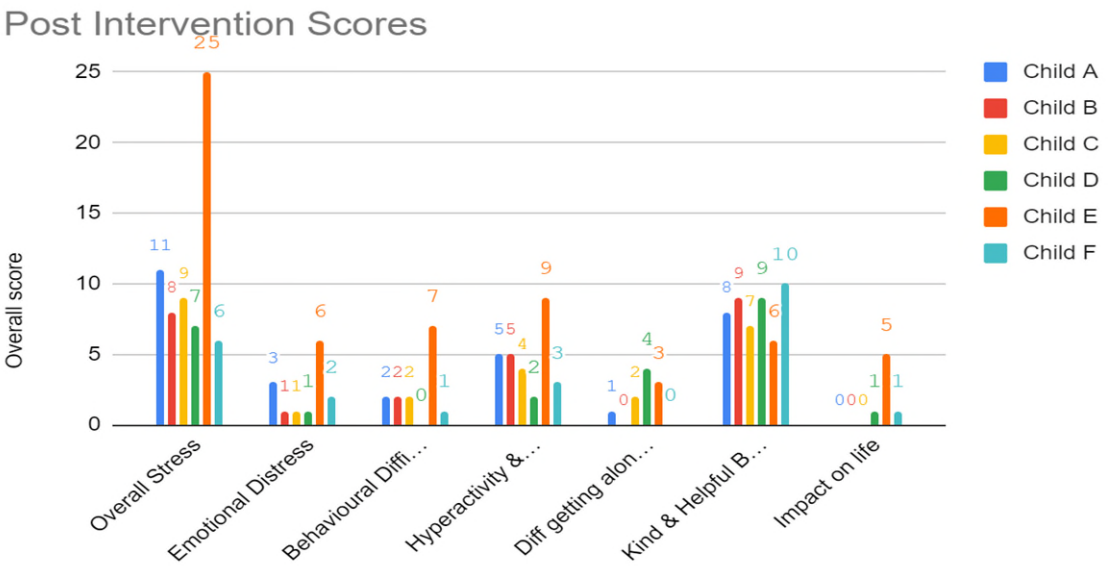
Child Parent Relationship Therapy

Child Parent Relationship Therapy (CPRT) is based on the theories of Child-Centred Play Therapy, where children use toys to explore their experiences, thoughts and feelings; play is the child's language. It uses a Filial therapy model and principles from VIG (Video Interactive Guidance) as parents record special play sessions with their children.

CPRT is a 10 week parent group where parents/carers are taught to have special structured 30-minute playtimes with their child using a kit of carefully selected toys and resources, in their own home. Parents/carers learn how to respond empathetically to their child's feelings, build their child's self-esteem, help their child learn self-control and self-responsibility, and set therapeutic limits.

Two groups were run in the year September 2021 - August 2022. To evaluate the CPRT group parent SDQs and other goal based outcomes are obtained:

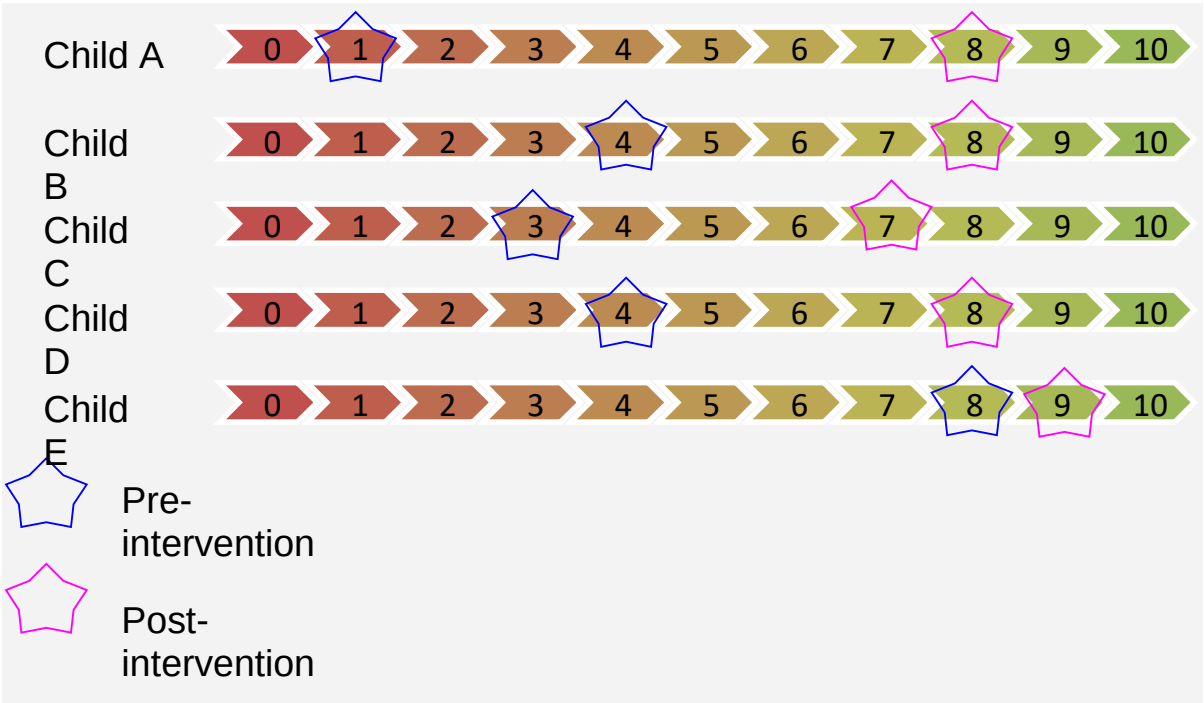




The SDQ post scores showed a decrease in the children's overall stress for the majority of the participants. There were also decreases in scores for Behavioural Difficulties and Hyperactivity/Concentration Difficulties. Overall, the majority of participants showed an improvement across all areas measured. Some participant's results showed an increase in some areas, such as Emotional Difficulties. This could be due to increased awareness in the parent as to the emotional needs and difficulties of their child. The scores for the impact on the child's life reduced for nearly all participants.

Impact Scoring

Each parent, except one, gave a score for where they felt they were at the beginning and end of the intervention, relating to their specific goals. There were significant improvements for all participants:



Emotional Wellbeing Champions

This programme requires children and young people selected by their schools to set up and run a wellbeing campaign throughout the school year. To facilitate this, the Wellbeing Service provides a training day, the aim of which is to raise students' awareness and knowledge of positive mental health, and to create an open, supportive culture around mental health and wellbeing in schools.

This year, due to the COVID-19 pandemic, the training day was postponed for the safety of all staff and students. We therefore set up online engagement sessions so the Wellbeing Champions could start generating ideas for and launch their campaigns. We provided a lesson plan and accompanying videos, encouraging the champions to consider what makes an 'emotionally healthy' school. This meant that when the training day took place in April 2022, schools had already been able to start their campaigns and could share ideas and feedback with the other schools in attendance.

Staff training

Schools were asked to provide a link person who would be supporting the champions with their campaigns. We provided online training for these staff members, with the aim of helping them to feel confident in supporting their champions. 5 staff members attended this training. 100% of participating staff felt that the training met their expectations, that it was helpful, informative, set at an appropriate level and length, and enjoyable. The following bar chart shows the impact of the training on staff thoughts and feelings around supporting the children and young people with the Champions programme:

Alongside this, 80% of participating staff answered *agree or strongly agree* to the question 'I feel confident in my role as EWBC lead'.

Children and young people training

The Emotional Wellbeing Champions training was divided into two separate days one for Primary and one for Middle and Secondary schools:

- 44 students from years 4-6, from 7 different primary schools attended the primary school training.
- 1 other primary school took part in the campaign, but were unable to attend the in-person training day due to a COVID-19 outbreak.
- 7 students from years 8 and 9, from 2 middle/secondary schools, attended the middle/secondary school training.

Students completed a post training evaluation form.

Feedback from the Primary school students:

1. 98% of participating students answered *agree* or *strongly agree* to the following questions:
   - 'The training day increased my knowledge about mental health and wellbeing.'
   - 'I learned some new self-care tips and ideas.'
   - 'I feel confident in sharing what I learnt with others in my school'
2. 96% of participating students answered *agree* or *strongly agree* to the question 'The learning was easy to understand.'
3. 93% of participating students answered *agree or strongly agree* to the question 'I understand what can affect someone's wellbeing.'
4. 89% of participating students answered *agree* or *strongly agree* to the question 'The activities were fun and engaging.'
5. 87% of participating students answered *agree or strongly agree* to the question 'I feel confident in recognising feelings in myself and others.'

When considering the programme as a whole, 96% of participating primary school students felt that it was beneficial to their school as a whole, and 91% shared that they now felt more confident in talking about their feelings.

The results from the evaluation forms showed that overall the children and young people attending the primary day training felt that the training day was successful in helping them to learn more about positive mental health and wellbeing and how to create an open, supportive culture around mental health and wellbeing in their school.

Some of the campaigns that the champions ran in their schools included:

- Having a worry bench for students to use at break times.
- Presenting assemblies to the whole school / forms / classes.
- Introducing worry boxes and/or positivity boxes within the school.
- Using badges to help others identify who the champions are.
- Providing opportunities to learn Makaton (sign language) to be able to sign feelings and therefore make it more accessible and inclusive for all.
- Using slogans to help their messages be more memorable.
- Sharing the 'stress bucket' activity with others in the school.
- Using new ways to communicate with people.
- Creating videos to share with classes and parents around the theme of 'worries'.
- Using stories to help generate discussions.

Following the training day, the Wellbeing Service held 1:1 follow up sessions with the champions in their schools to gather further feedback on how successful and effective they felt their campaigns had been. This, along with further, more detailed feedback from a trainee EP involved in the project, showed the following areas for improvement which we are taking forward into the 2022-2023 programme:

- Further and continued sharing across schools, to share and develop ideas and discuss how to overcome potential barriers.
- Encouraging school staff to map the campaigns onto whole-school objectives and incorporate the aims of the programme into every-day learning/activities within the school.
- Further involvement and support from the Senior Leadership Teams within schools.
- Encouraging further parent involvement within individual schools.
- Clarity around the champions role (a 'job description' has now been generated).
- Consideration into how to recruit more secondary schools, as well as how to develop the middle/secondary training day to be more age-appropriate, engaging and effective, in order to have more of a lasting impact within the schools. The Wellbeing Service will therefore facilitate C/YP focus groups, which will provide opportunities for young people to co-design the programme and training. This is to include boys, as we have found the attendance of male young people to be significantly lower for secondary schools training.

Developments to Support Strategic and Local SEMH Planning and Service Delivery

There will be continued development of the early intervention offer as outlined in the Local Transformation Plan for Children and Young People's Mental Health (East Berkshire October 2021-October 2024). This will help RBWM to realise the NHS Long Term Plan's ambitions and increase the number of children and young people accessing services. Building on the principles of:

- Strengthening crisis support
- Supporting Children with complex needs
- Transition arrangements

- Addressing eating disorders and disordered eating
- Embedding MHST principles across all schools
- Enhanced parenting support
- Addressing gaps in provision
- Developing formal partnership arrangements as a new model of working
- Responding to the impact of COVID-19

Between January and May 2022 RBWM implemented **The Link Programme**. Education settings and RBWM agencies were invited to engage in The Link Programme (in collaboration with The Anna Freud Centre). The programme aims were to improve joint working in mental health and wellbeing between NHS mental health services, Local Authorities including Public Health, and VCSE services. An action plan has been collated which supports the Local Transformation Plan for Children and Young People's Mental Health priorities.

National and local SEMH Considerations

There is a rising demand for social, emotional, wellbeing and mental health support. Waiting times for completion of triage within specialist CAMHS are increasing particularly for those young people who need non-urgent assessment and intervention. Many of these cases are therefore referred through to Early Help in addition to requests from schools and other professionals e.g. Social Workers.

In September 2022 Louise Noble (Head of CAMHS) provided the following updates at the RBWM Mental Health and Emotional Wellbeing Network:
There is a sustained increase in the number of young people who need help and support with their emotional well-being and mental health. Referrals to Berkshire Healthcare are up 9% this year so far. The service has implemented QI projects to reduce waiting times however demand continues to outstrip capacity in all areas. There is a sustained increase in self harm as a method of coping with difficulties, and in the complexity of young people who are presenting to our services. There are several programs being supported to improve access for children and young people with an eating disorder. There are national access and waiting time standards for eating disorder care in children and young people under the age of 18. NHS England have recently changed the time scale by which those standards must be met, due to growth of referrals and workforce challenges. CAMHS are engaged in a dedicated, funded project called FREED (First Episode Rapid Early Intervention for Eating Disorders) that is aimed at extending those access and wait time standards and to provide early help up to age 25. CAMHS are also working with a national program called PEACE which will develop interventions for children and young people up to 18 but will extend to 25 who present with an eating disorder comorbid with neurodiversity. Other developments are taking place in how CAMHS support young people with ARFID (Avoidant Restrictive Food Intake Disorder). During COVID there was an explosion in the number of young people presenting with this difficulty, but there is no one service or intervention that has all the expertise that's needed. A business case is being collated for the required funding in the short term. In the interim CAMHS attend a monthly complex case forum bringing together various staff groups for advice and consult on providing a joined-up care plan around those complex cases. Eighteen months ago, a model was developed for a home treatment component for children and young people that has been missing for a long time. We have an almost fully recruited team which is now live, this will sit alongside the CAMHS Crisis Service to provide more intensive support. CAMHS are also waiting to

hear from the ICB (Integrated Commissioning Board) regarding funding to expand service for children in care and how we might start to take that forward. There is a need for an intensive service for children with learning disabilities, autism, and behavioural challenges. There is work taking place collaboratively across Frimley and Berkshire West on the Bob Integrated Care System to move forward with some provisions in place in the next 6 months. Under the digital work stream, online interventions will be provided in working with families waiting for an anxiety intervention, to identify what is suitable and to help reduce wait times.

Impact of COVID-19

- Wider impact and scale of bereavement due to COVID-19 of family and others close to CYP – not the usual opportunity for grief.
- Heightened anxiety and emerging depression. Increase in the requests for Cognitive Behavioural Therapy Therapeutic Support.
- Increased impact on vulnerable (already seen through lockdown) with increasing complex cases needing greater resources likely to continue alongside demand increases.
- CYP have deferred existing intervention as online or telephone is not preferred, preventing good flow of YP through service – creating backlogs and it decreases effectiveness due to waiting.
- Consequences of economic downturn, loss of jobs in families and communities and increasing effect of poverty on household mental health.
- Staff wellbeing and arrangements, anxiety/ fatigue, skill and confidence as returning to in person arrangements or delivery with social distancing rules in place.

Getting Help Teams

- The Getting Help Team is employed by Berkshire Healthcare but sits within RBWM Early Help Hub.
- They work with children and young people who need quick, short-term support (around six to eight sessions) with mild to moderate mental health issues.
- This help could take the form of participating in a group, or individual one to one informed CBT therapy.
- They can also signpost to other services that may be able to better support the child/young person. Including access to the AnDY clinic or specialist CAMHS if needed.

Mild - moderate
Stress/exam Pressure
Anxiety
Low Mood/ depression
Common Behavioural problems
Hyperactivity
Low self-esteem
Friendship issues
Issues stemming from social media

Mental Health Support Teams

- Provide interventions for CYP with mild to moderate needs in schools and colleges across their patch,

- Work with school or college staff – including designated mental health leads - to ensure mental health and wellbeing is supported as part of a 'whole school' approach.
- Work as part of integrated referral system with CYP mental health services
- Each MHST consists of 7.5WTE to cover population of 8000
- Prescribed function and interventions

- Within RBWM the new Mental Health Support Team (MHST) became fully operational in September 2021.
- This supports children and young people who have emerging, mild or moderate mental health difficulties which may be affecting their day to day life.
- Depending on the age of the child or young person, they'll either work directly with them or with their parents. They also work with school staff and offer support on different levels, with the aim of developing and supporting a whole school approach to mental health.

Individual clinical	**Group clinical**
CBT-based interventions for Anxiety, Low mood, self harm PT Interventions for conduct problems Behavioural intervention	For anxiety, low mood, social problems Mild conduct problems & managing ADHD Multi family groups based on social learning theory
Group low intensity – child & parent/carer workshops for anxiety, self harm, bullying, eating problems, behavioural problems	

The MHSTs are employed by Berkshire Healthcare NHS Foundation Trust (Berkshire Healthcare) but form part of the Local Authority Early Help teams working peripatetically in the cohort of selected education settings. In RBWM this includes: Altwood, Charters, Churchmead, Cox Green, Dedworth Middle, Holyport College, Larchfield Primary, Manor Green, St Luke's Primary, Trevelyan Middle, Wessex Primary, Woodlands Park Primary, Windsor Boys, Wraysbury Primary and the Virtual School.

Young Health Champions
The Family Hubs have started recruiting for 16–17-year-olds to become young health champions, they will receive a level 2 accreditation from the Royal Society of Public Health.

Oxwell Survey
In partnership with researchers at the University of Oxford, in February/March 2023 RBWM will again be offered the opportunity for schools to take part in this study aimed at pupils aged 9 to 18 years (Years 5 to 13). This study investigates school pupils' health and wellbeing by asking young people to log in anonymously to an online survey. This survey is funded by a University of Oxford COVID-19 Research Response Fund so schools can take part at no cost.

The aim of the survey is to help inform schools and local services across health, education and social care includes questions regarding lifestyle and school life, factors assessed in the survey include mental wellbeing, anxiety, indicators of vulnerability, sleep patterns, online safety, protective factors such as exercise and healthy eating, and attitudes to accessing mental health support. The online system enables schools to generate reports (e.g. for Ofsted) and identify areas where pupils most need support. Additionally, the survey can be used for more strategic planning across Health, Education and Social Care.

8. CONSULTATION

Name of consultee	Post held	Date sent	Date returned
Mandatory:	*Statutory Officers (or deputies)*		
Adele Taylor	Executive Director of Resources/S151 Officer		
Emma Duncan	Director of Law, Strategy & Public Health/ Monitoring Officer		
Deputies:			
Andrew Vallance	Head of Finance (Deputy S151 Officer)		
Elaine Browne	Head of Law (Deputy Monitoring Officer)		
Karen Shepherd	Head of Governance (Deputy Monitoring Officer)	2/11	2/11
Mandatory:	*Procurement Manager (or deputy) - if report requests approval to go to tender or award a contract*		
Lyn Hitchinson	Procurement Manager		
Mandatory:	*Data Protection Officer (or deputy) - if decision will result in processing of personal data; to advise on DPIA*		
Emma Young	Data Protection Officer		
Mandatory:	*Equalities Officer – to advise on EQiA, or agree an EQiA is not required*		
Ellen McManus	Equalities & Engagement Officer	2/11	2/11
Other consultees:			
Directors (where relevant)			
Tony Reeves	Interim Chief Executive		
Andrew Durrant	Executive Director of Place		
Kevin McDaniel	Executive Director of People Services		
Heads of Service (where relevant)			
	Head of …….		
	Head of …….		
	Head of …….		
External (where relevant)			
N/A			

Confirmation relevant Cabinet Member(s) consulted	Councillor Stuart Carroll, Cabinet Member for Children's Services, Education, Health, Mental Health, &	Yes/No

	Transformation	

REPORT HISTORY

Decision type: For information	**Urgency item?** No	**To Follow item?** No
Report Author: Rebecca Askew -Senior Specialist Educational Psychologist - Wellbeing 07775220788		

Glossary of Terms

A&D	Anxiety and Depression (pathway)
AnDY	Anxiety and Depression in Young People Clinic
BHFT	Berkshire Healthcare Foundation Trust
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CPD	Continuing Professional Development
CPE	Common Point of Entry
CWP	Children's Wellbeing Practitioner
CYP/C&YP	Children and Young People
DDP	Dyadic Developmental Psychotherapy
DfE	Department for Education
EHE	Elective Home Education
EHH	Early Help Hub
ERSA	Emotionally Related School Avoidance
Fte	Full time equivalent
MH	Mental Health
MHST	Mental Health Support Team
NR	New Referral
OCD	Obsessive Compulsive Disorder
PPEPCare	Primary Principles in Education and Primary Care
PTSD	Post Traumatic Stress Disorder
PTUK	Play Therapy UK
SEMH	Social Emotional and Mental Health
TR	Treatment
WTE	Working Time Equivalent

APPENDIX A - EQUALITY IMPACT ASSESSMENT

Essential information

Items to be assessed: (please mark 'x')

Strategy		**Policy**		**Plan**		**Project**		**Service/Procedure**	x

Responsible officer	Rebecca Askew	**Service area**	Education	**Directorate**	Children's Services

Stage 1: EqIA Screening (mandatory)	Date created: 03/11/2022	**Stage 2 : Full assessment (if applicable)**	Date created : N/A

Approved by Head of Service / Overseeing group/body / Project Sponsor:
"I am satisfied that an equality impact has been undertaken adequately."

Signed by (print): Rebecca Askew

Dated: 03/11/2022

Guidance notes

What is an EqIA and why do we need to do it?

The Equality Act 2010 places a 'General Duty' on all public bodies to have 'due regard' to:

- Eliminating discrimination, harassment and victimisation and any other conduct prohibited under the Act.
- Advancing equality of opportunity between those with 'protected characteristics' and those without them.
- Fostering good relations between those with 'protected characteristics' and those without them.

EqIAs are a systematic way of taking equal opportunities into consideration when making a decision, and should be conducted when there is a new or reviewed strategy, policy, plan, project, service or procedure in order to determine whether there will likely be a detrimental and/or disproportionate impact on particular groups, including those within the workforce and customer/public groups. All completed EqIA Screenings are required to be publicly available on the council's website once they have been signed off by the relevant Head of Service or Strategic/Policy/Operational Group or Project Sponsor.

What are the "protected characteristics" under the law?

The following are protected characteristics under the Equality Act 2010: age; disability (including physical, learning and mental health conditions); gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

What's the process for conducting an EqIA?

The process for conducting an EqIA is set out at the end of this document. In brief, a Screening Assessment should be conducted for every new or reviewed strategy, policy, plan, project, service or procedure and the outcome of the Screening Assessment will indicate whether a Full Assessment should be undertaken.

Openness and transparency

RBWM has a 'Specific Duty' to publish information about people affected by our policies and practices. Your completed assessment should be sent to the Strategy & Performance Team for publication to the RBWM website once it has been signed off by the relevant manager, and/or Strategic, Policy, or Operational Group. If your proposals are being made to Cabinet or any other Committee, please append a copy of your completed Screening or Full Assessment to your report.

Enforcement

Judicial review of an authority can be taken by any person, including the Equality and Human Rights Commission (EHRC) or a group of people, with an interest, in respect of alleged failure to comply with the general equality duty. Only the EHRC can enforce the specific duties. A failure to comply with the specific duties may however be used as evidence of a failure to comply with the general duty.

Stage 1: Screening (Mandatory)

1.1 What is the overall aim of your proposed strategy/policy/project etc and what are its key objectives?
The purpose of this report is to provide the Schools Forum with an overview of service provision from the Wellbeing Service and to secure continued grant funding of £120,000 for the Wellbeing Service.

1.2 What evidence is available to suggest that your proposal could have an impact on people (including staff and customers) with protected characteristics? Consider each of the protected characteristics in turn and identify whether your proposal is Relevant or Not Relevant to that characteristic. If Relevant, please assess the level of impact as either High / Medium / Low and whether the impact is Positive (i.e. contributes to promoting equality or improving relations within an equality group) or Negative (i.e. could disadvantage them). Please document your evidence for each assessment you make, including a justification of why you may have identified the proposal as “Not Relevant”.

Protected characteristics	Relevance	Level	Positive/negative	Evidence

Age	yes	High	Positive	*The evidence for the purpose/positive impact of maintaining the Wellbeing Service for the 5-18yr age range is to continue to provide accessible advice and support to schools, CYP and their families.* *In mid-2019 the estimated resident population of East Berkshire CCG was 436,701. Children and young people aged 0 to 17 made up 25% of this population, compared to 21% in England.* *Even before the coronavirus pandemic, mental health services for children and young people were already seeing an increase in demand. All our current planning must take into account the additional short- and long-term demand generated by the pandemic, and the extra pressure it is placing on services and on our CAMHS workforce.* *The Mental Health of Children and Young People in England Survey 2017 provides England's best source of data on trends in child mental health. The follow up report published in July 2020 found that rates of probable mental disorders in children aged 5 to 16 had risen to one in six. Children and young people with a probable mental disorder were more likely to say lockdown had made their life worse (54.1% of 11- to 16-year-olds and 59% of 17- to 22-year-olds), than those unlikely to have a mental disorder (39.2% and 37.3% respectively).* *An audit looking at children and young people presenting with a mental health crisis to Frimley Park Hospital's emergency department in the first six months of the reporting year 2020 to 2021 saw an initial decrease of 55.1% compared to the previous quarter's attendances. As schools and colleges reopened, the hospital quickly saw the numbers of CYP attending the emergency department in crisis rising again. During the first six weeks of returning*

				to school, there was a 121% increase in attending in crisis compared to the same period the year before.
Disability	yes	High	Positive	*In January 2021 there were a total of 2,764 children and young people in East Berkshire with an education, health and care (EHC) plan. A total of 1,742 CYP have social, emotional and mental health (SEMH) needs identified as the primary need for the EHCP. The Wellbeing Service offer CYP and/or staff mental health and wellbeing support with an awareness of their disability and the differentiation/reasonable adjustments that may be required.*
Gender re-assignment	N/A			
Marriage/civil partnership	N/A			
Pregnancy and maternity	N/A			
Race	N/A			*Key data: The 2011 Census indicates that 86.1% of the local population is White and 13.9% of the local population is BAME. The borough has a higher Asian/Asian British population (9.6%) than the South East (5.2%) and England (7.8%). The forthcoming 2021 Census data is expected to show a rise in the BAME population. [Source: 2011 Census, taken from Berkshire Observatory]*
Religion and belief	N/A			*Key data: The 2011 Census indicates that 62.3% of the local population is Christian, 21.7% no religion, 3.9% Muslim, 2% Sikh, 1.8% Hindu, 0.5% Buddhist, 0.4% other religion, and 0.3% Jewish. [Source: 2011 Census, taken from Berkshire Observatory]*

Sex	N/A			*Key data: In 2020 an estimated 49.6% of the local population is male and 50.4% female. [Source: ONS mid-year estimates 2020, taken from Berkshire Observatory]*
Sexual orientation	Yes	Medium	Positive	*Unfortunately, at the moment there is no reliable prevalence data available on how many LGBTQ+ children and young people there are in the general population. However, LGBTQ+ young people are known to have higher rates of poor mental health (including depression and anxiety), self-harm and suicide than their non-LGBTQ+ counterparts. Data from Stonewall shows that nearly one in four LGBTQ+ young people have tried to take their own life at some point, and more than half deliberately harm themselves. The Wellbeing Service offer support and advice for Wellbeing as well as further guidance regarding LGBTIA+ signposting.*

Outcome, action and public reporting

Screening Assessment Outcome	Yes / No / Not at this stage	Further Action Required / Action to be taken	Responsible Officer and / or Lead Strategic Group	Timescale for Resolution of negative impact / Delivery of positive impact
Was a significant level of negative impact identified?	NO	N/A	N/A	N/A
Does the strategy, policy, plan etc require amendment to have a positive impact?	NO	N/A	N/A	N/A

If you answered **yes** to either / both of the questions above a Full Assessment is advisable and so please proceed to Stage 2. If you answered "No" or "Not at this Stage" to either / both of the questions above please consider any next steps that may be taken (e.g. monitor future impacts as part of implementation, re-screen the project at its next delivery milestone etc).

Stage 2 : Full assessment

2.1 : Scope and define

2.1.1 Who are the main beneficiaries of the proposed strategy / policy / plan / project / service / procedure? List the groups who the work is targeting/aimed at.

2.1.2 Who has been involved in the creation of the proposed strategy / policy / plan / project / service / procedure? *List those groups who the work is targeting/aimed at.*

2.2 : Information gathering/evidence

2.2.1 What secondary data have you used in this assessment? *Common sources of secondary data include: censuses, organisational records.*

2.2.2 What primary data have you used to inform this assessment? *Common sources of primary data include: consultation through interviews, focus groups, questionnaires.*

Eliminate discrimination, harassment, victimisation

Protected Characteristic	Advancing the Equality Duty : Does the proposal advance the Equality Duty Statement in relation to the protected characteristic (Yes/No)	If yes, to what level? (High / Medium / Low)	Negative impact : Does the proposal disadvantage them (Yes / No)	If yes, to what level? (High / Medium / Low)	Please provide explanatory detail relating to your assessment and outline any key actions to (a) advance the Equality Duty and (b) reduce negative impact on each protected characteristic.
Age					
Disability					
Gender reassignment					
Marriage and civil partnership					
Pregnancy and maternity					
Race					
Religion and belief					
Sex					
Sexual orientation					

Advance equality of opportunity

Protected Characteristic	Advancing the Equality Duty : Does the proposal advance the Equality Duty Statement in relation to the protected characteristic (Yes/No)	If yes, to what level? (High / Medium / Low)	Negative impact : Does the proposal disadvantage them (Yes / No)	If yes, to what level? (High / Medium / Low)	Please provide explanatory detail relating to your assessment and outline any key actions to (a) advance the Equality Duty and (b) reduce negative impact on each protected characteristic.
Age					
Disability					
Gender reassignment					
Marriage and civil partnership					
Pregnancy and maternity					
Race					
Religion and belief					
Sex					
Sexual orientation					

Foster good relations

Protected Characteristic	Advancing the Equality Duty : Does the proposal advance the Equality Duty Statement in relation to the protected characteristic (Yes/No)	If yes, to what level? (High / Medium / Low)	Negative impact : Does the proposal disadvantage them (Yes / No)	If yes, to what level? (High / Medium / Low)	Please provide explanatory detail relating to your assessment and outline any key actions to (a) advance the Equality Duty and (b) reduce negative impact on each protected characteristic.
Age					
Disability					
Gender reassignment					
Marriage and civil partnership					
Pregnancy and maternity					
Race					
Religion and belief					
Sex					
Sexual orientation					

2.4 Has your delivery plan been updated to incorporate the activities identified in this assessment to mitigate any identified negative impacts? If so please summarise any updates. *These could be service, equality, project or other delivery plans. If you did not have sufficient data to complete a thorough impact assessment, then an action should be incorporated to collect this information in the future.*