Children, Young People and Education Committee

Meeting Venue:
Committee Room 1 - Senedd

Meeting date:
Wednesday, 2 April 2014

Meeting time:
09.15

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Agenda

Private Pre-meeting - 09.15 - 09.30

1 Introductions, apologies and substitutions (09.30)

2 Inquiry into Child and Adolescent Mental Health Services - Evidence session 3 (09.30 - 10.30) (Pages 1 - 4)

Association of Educational Psychologists
CYPE(4)-10-14 - Paper 1

Mary Greening, Welsh Representative
Claire Leahy, Educational Psychologist

3 Inquiry into Child and Adolescent Mental Health Services - Evidence session 4 (10.30 - 11.30) (Pages 5 - 9)

Applied Psychologists in Health National Specialist Advisory group
CYPE(4)-10-14 - Paper 2

Rachel Williams, Head of Psychology in Aneurin Bevan Health Board

4 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business: (11.30)

Item 5

5 Consideration of Committee Forward Work Programme (11.30 - 12.00) (Pages 10 - 13)

CYPE(4)-10-14 - Private paper 3 - Committee Forward Work Programme
CYPE(4)-10-14 - Private paper 4 - Consideration of draft letter

6 Additional information provided to the Committee

Inquiry into Educational Outcomes for Children from Low Income Households - Additional information from CaST Cymru following the evidence session on 13 March (Pages 14 - 20)

CYPE(4)-10-14 - Paper to Note - Paper 5

Additional information from the Deputy Minister for Tackling Poverty following the meeting on 12 February (Pages 21 - 25)

CYPE(4)-10-14 - Paper to Note - Paper 6

Additional information from Estyn following the meeting on 19 March (Pages 26 - 30)

CYPE(4)-10-14 - Paper to Note - Paper 7

National Assembly for Wales

Children, Young People and Education Committee

Inquiry into Child and Adolescent Mental Health Services (CAMHS)

Evidence from : Association of Educational Psychologists

CYPE(4)-10-14 – Paper 1

Background to Submission

1. The AEP is delighted to provide this response to the Children, Young People and Education Committee's inquiry into Child and Adolescent Mental Health Services (CAMHS). The AEP currently has 3250 members across England, Scotland, Wales and Northern Ireland, representing 210 Welsh educational psychologists. It is the only trade union and professional association in Wales organised exclusively for and by educational psychologists (EPs). The AEP represents the collective interests of its Welsh members, promotes cooperation between EPs, seeks to establish good relationships between EPs and their employers and seeks to promote the overall wellbeing of children and young people across the country.

2. EPs work with children and young people aged from 0-19 but the majority of their time is spent with school-age children. EPs play a key part in helping shape how educational settings approach a vast range of educational issues including Special Educational Needs (SEN), emotional wellbeing and classroom practice. EPs carry out a wide range of statutory and non-statutory work that helps to improve learning, developmental and welfare outcomes for all children and young people, but especially those within the most vulnerable situations.

3. The role of EPs includes providing advice on identifying and addressing issues of concern related to children and young people's development and functioning, as well as training around a range of specific issues including management of behaviour, supporting children and young people with autism and promoting mental health.

The availability of early intervention services for children and adolescents with mental health problems

4. The AEP feels that the availability of early intervention services for children and adolescents is currently variable in the different parts of the country. At the earliest level (i.e. tier 1) the front line staff are typically teachers, nurses and health visitors. Early intervention would be the result of good practice in schools and nurseries utilising the skills and advice given by professionals such as specialist teachers or EPs. This would depend on the appropriate staff being in post and having the time available to do this work. Our experience has been that it can be difficult to get schools and parents to look at different ways of working as they seem to prefer having EPs undertake individual assessments. However, agencies such as Barnardos have been successful in undertaking some early intervention schemes many of which have been devised by psychologists.

5. It has been reported that Joint Assessment Family Frameworks (JAFF) refer to Primary Mental Health Teams when mental health is raised as an issue causing concern. However, we would stress that Primary Mental Health Teams are very poorly resourced and currently can only carry out very short pieces of work with minimum input.

Access to community specialist CAMHS at tier 2 and above for children and adolescents with mental health problems, including access to psychological therapies

6. In a similar vein to the first answer, the access to community specialist CAMHS is variable across the country. In some areas there are staff shortages in CAMHS and the models of working are not very efficient, with staff being mainly clinic based. This means that in some cases parents have huge logistical problems getting their children to appointments. As CAMHS work under health they have a very strict policy regarding failed appointments and will cross clients off the list if one appointment is missed. It can also be quite an obstacle course for professionals filling in numerous forms in order to enable a child to obtain an appointment at a CAMHS clinic.

7. We would like to raise concerns that some of our members have observed that referrals made are often refused for not meeting the criteria, which has not been discussed or explained. Often requests are made for more tier 1 interventions and these are limited. Referrals agreed are then put on very long waiting list. This has led to a situation in tier 1 where some pupils are waiting 10 months to see clinical psychologist and social communication clinic referrals are waiting over a year.

8. We have been pleased that the Welsh Government has supported school based counselling services and this has been helpful to date and an important resource in helping pupils parents and teachers. However we would query the sustainability of these services given the funding cuts. Some areas of the country currently seem to have Primary Mental Health Teams that have practitioners who go out into the community and undertake systems work and group work with vulnerable client groups. In other areas this model does not seem to exist.

The extent to which CAMHS are embedded within broader health and social care services

9. This would vary from area to area as some CAMHS services seem to operate very much as a free standing service whereas others are more embedded into health and social care. Generally CAMHS are not embedded within broader health and social care services. Individual CAMHS have built relationships locally between health, education and social services and there is good practice in this area, but this has not been driven by policy in the way it has in England. With increasing cuts to front line services and increased waiting lists, there is less time for multi-agency liaison and approaches.

Whether CAMHS is given sufficient priority within broader mental health and social care services, including the allocation of resources to CAMHS

10. CAMHS seems to be a 'Cinderella' service when it comes to funding. We believe that, because resources are scarce, CAMHS can be given lower priority for allocating funding – tough decisions have to be made and sometimes those making the decisions do not fully appreciate the need for CAMHS services. For example, we have heard reports from one member that a psychiatrist left and there were no plans to replace her job. We understand that there is a similar situation in clinical psychology. We would also like to make the point that there is a gap in provision: when children leave school they are no longer entitled to receive CAMHS but do not yet qualify for adult services.

Whether there is significant regional variation in access to CAMHS across Wales

11. Yes, there does seem to be regional variation which would depend on the priority the various Health Boards give to CAMHS and also how the particular CAMHS operates within the community. The AEP has found that there is a significant difference in how CAMHS services operate with EPs and that where robust protocols are in place then good practice generally occurs.

The effectiveness of the arrangements for children and young people with mental health problems who need emergency services

12. Our members have reported that there is a lack of suitable provision for young people in crises. This is a very demanding group of young people and the care and support that they need is specialised with staff involved needing to be well trained and supported. Often the staff have not received appropriate training and are not being sufficiently supported. Children who are admitted to hospital are receiving support. However, other children who have presented with mental health issues at accident and emergency but who are not admitted do not appear to have robust follow-up and support.

13. This kind of care is expensive and currently the funding is not available. We would like to see the Welsh Government invest in this area in future to ensure that these children and young people, who are most in need of support, benefit from early intervention.

The extent to which the current provision of CAMHS is promoting safeguarding, children's rights, and the engagement of children and young people

14. In our experience this varies from area to area but we would like to see more work to assess how effective CAMHS are in promoting safeguarding, children's rights, and the engagement of children and young people. Safeguarding, in this sense, should be early intervention and lowering the risk of more serious issues developing later. In an earlier question we have already commented on long waiting lists and difficulties accessing CAMHS, which do not promote either children's rights or safeguarding. Current provision

isn't fit for purpose. Children's rights are not protected as they are not receiving treatment and in some cases this leads to them being excluded from their school and so not receiving education.

Any other key issues identified by stakeholders.

15. Over the past few years AEP members have increasingly expressed concerns that children with behavioural difficulties are being prescribed drugs without full discussions with other professionals to see if other strategies or approaches could be used instead of, or at least alongside, the medication. It is of particular concern to the AEP that the number of children aged under six, and as young as three, who have been prescribed ADHD drugs to address challenging behaviour, including inattentiveness and hyperactivity, is rising substantially.

16. The AEP feels that there is insufficient evidence to have confidence in what the long-term neurological impact of these drugs might be on the developing brains of children and would like to see increased use of psychological treatments. NICE guidance advises that psychological treatments should occur first, however, the AEP does not feel this guidance is always being followed due to pressures of work and the shortage of time to make the multi-modal assessments advised by NICE.

17. Simply relying on medication is no solution; the AEP believes that the Quality Standard on ADHD developed by NICE should advocate a more collaborative approach to the treatment of children with conditions such as ADHD – involving GPs, teachers, EPs and healthcare professionals alongside the child's parents – that is not reliant on medication, but considers a comprehensive programme of treatment and therapies.

18. We would like to see the Welsh Government collect information on the number of children and young people being prescribed powerful psycho-stimulant drugs, such as Ritalin, and undertake a study into how current guidance on ADHD is being implemented. We would also like to see more done to ensure that health professions are better informed in supporting children with conditions such as ADHD via training.

For more information about the Association of Educational Psychologists, please contact Gary Jones at gary.jones@whitehouseconsulting.co.uk or 0207 463 0697.

National Assembly for Wales

Children, Young People and Education Committee

Inquiry into Child and Adolescent Mental Health Services (CAMHS)

Evidence from : Applied Psychologists in Health National Specialist Advisory Group

CYPE(4)-10-14 – Paper 2

The Applied Psychologists in Wales Specialist Advisory Committee is a subgroup of the Welsh Scientific Advisory Committee and represents clinical, counselling, educational, occupational and health psychologists working in any health setting whether part of the NHS, Local authority or third sector.

As a subcommittee of one of the seven statutory advisory committees constituted to advise Welsh Government, the Applied Psychologist in Health Specialist Advisory Committee is pleased to have the opportunity to comment on the Inquiry into Child and Adolescent Mental Health Services (CAMHS). As the role of this Committee is to provide expert professional advice to Welsh Ministers and Welsh Government officials on all matters relating to the scientific services professions, the Committee felt that it was incumbent on it to provide a view. The Committee hopes that you find the opinion expressed helpful and would be happy to engage further if required.

	<u>The Committee is interested in hearing about</u> **The availability of early intervention services for children and adolescents with mental health problems**
1.	1. The introduction of the Mental Health Measure Wales is an opportunity to increase access to early intervention within Primary Care Mental Health Support Services (PCMHSS) for individuals under 18 years of age. The introduction of PCMHSS across the age-span is an opportunity to take a more systemic approach to children and adults and to view their difficulties in the context of their social, familial and medical history in order to provide holistic treatment options. Concern has been expressed by Clinical psychologists working with children and adolescents in services across Wales that to date there has been a lack of training in systemic practice or in psychological interventions for children and families and as the majority of practitioners working in the PCMHSS have been recruited from services to working age adults they have continued with the practice that they are familiar with. Interventions provided by PCMHSS are not child/family specific as clinicians have little training in understanding child development or children's psychological distress. Some examples of good practice should be noted e.g. Hywel Dda University Health Board Specialist CAMHS service provides a Primary Mental Health Service although not funded through PCMHSS resources. Other services which can be identified as early intervention are localised. The FIT (Family Intervention Team) in Caerphilly works with children and families before other statuary services become involved. The service is hosted by Action for Children and led clinically by a clinical psychologist (ABUHB) – a good example of partnership working. Each intervention is informed by a psychological formulation and time limited. The external evaluation of the service has shown the high social economic value – saving £7 for every £1. An audit of the work showed that for 36 referrals requesting an ADHD assessment only 2 went on to a full assessment, thus, saving core CAMHS a huge resource. Despite this, statutory services have not yet sought to roll this out. Innovative practice and services rely on short term project money and are not embedded within core services. 2. There has been minimal investment in applied psychology posts based within PCMHSS reducing the opportunities for clinicians within PCMHSS to access high quality specialist supervision, training and support, which is likely to reduce their effectiveness and efficiency in assessing children, adolescents or families suffering psychological problems and in delivering psychological therapies appropriate for this client group. Where posts have been created the funding is often short term and time limited. In Aneurin Bevan UHB the Child and Family

	Psychology service has responded by putting together and delivering a comprehensive training package with follow up supervision. However, this has costs for service provision elsewhere, and is not a sustainable model without dedicated child expertise being funded to support the ongoing training and supervision needs of the service. There are no psychologists embedded within the PCMHSS and the time given is from the already very limited core service. 3. There appears to be little or no early psychological intervention available to children who are experiencing physical health conditions. Paediatric services appear to have high demand for such input but there is inconsistency (even within Health Boards) as to the ability to access early intervention psychological input. Again, some good practice is to be noted e.g. Hywel Dda UHB Specialist CAMHS Continuing Care Service providing consultation to the larger Continuing Care Service). 4. Funding for the only Education Psychology training course in Wales is due to be withdrawn and this will have a significant impact upon the ability of pupils to access early intervention services for emotional and mental-health difficulties. Educational Psychologists trained in England have to commit to working in England for two years following their training and without the incentives of improved salaries and working conditions they are unlikely to be attracted to working in Wales. They will also need considerable support to work within the bilingual context of Welsh and English. 5. Educational Psychology Services have a responsibility to provide interventions to address mental health difficulties of children and young people, whether at 'Tier 1' or 'Tier 2'. In practice there seems to be little access to psychological therapies within these services, thereby adding to the pressure to refer to specialist tier 2 services even where an intervention at Tier 1 might be effective. 6.The competencies of clinicians offering early intervention psychological therapies varies significantly across services in Wales and more investment in providing training in evidence-based psychological interventions is required to address this variation in access. A range of interventions will be required but should be offered on the basis of guidance about which will effectively address the presenting problems. School Counsellors tend to operate from a Person Centred/Humanistic frame, with little evidence of efficacy within this population, and anecdotal evidence suggesting that it could be unhelpful for some clients. 7. Secure emotional attachments are the building blocks for mental well-being characterised by individuals who can regulate emotion, form rewarding relationships and fulfil their learning capacity. There is a growing body of evidence from neuroscience research which demonstrates that the brain is structured to develop healthy attachments within in a dyadic relationship and on how this neurobiological development impacts on the child's emotional, cognitive and physical health (see the work of Porges, Baylon, and Shore). The emphasis in both PCMHSS and later in tier 2 CAMHS services is directed by a medical model of health care which identifies deficiency and disorder rather than on promoting mental health. Evidence of effective early intervention would therefore dictate a change in the model used to one which supports secure attachments within the family and wider community
	Access to community specialist CAMHS at tier 2 and above for children and adolescents with mental health problems, including access to psychological therapies
2.	1. Specialist CAMHS across the whole of Wales appear to be understaffed and underfunded. Figures from the Royal College of Psychiatry suggest that staff establishment in each of the Specialist CAMHS services in Wales falls below the recommended benchmark by between 30-50%. The CAMHS workforce often has additional non-clinical responsibilities which reduces their clinically available time, making the ratio of full-time staff to the population even lower. Low Staffing numbers mean that relatively tight criteria need to be implemented in order to maintain manageable workloads. This leads to the unintended consequence of reducing access to the service but also means that for those considered to have significant difficulties the response is quite rapid, though at the significant cost to those who fail to meet critieria. The prevalence of the medical model in the delivery of services inevitably leads to access criteria which focus on determining 'disorder'. There needs to be a debate as to whether this is a useful/ethical endeavour, and the risk that services reward a deterioration of difficulties, or crisis presentation because they are not able to respond to less severe presentations. 2. The emphasis in Together for Mental Health was on early intervention and building resilience. However the direction of travel seems to be in the opposite direction. CAMHS referral criteria are ever tightening towards diagnosable mental disorder which happens later in the trajectory and focusses on deficiency rather than resilience. 3. Specialist CAMHS' in different Health Boards are implementing different access criteria e.g. some CAMHS accept referrals for individuals with the developmental disorders ASD and

	ADHD in the absence of co-morbid mental-health difficulties, whereas others do not; the criteria for moderate and severe mental-health difficulties differs between services. 4. Referrers often find it difficult to access CAMHS. There is little attempt made to measure which referrals are rejected and what happens to the children once rejected. It is even harder to get an accurate picture of the number of potential referrals where the referrer has decided 'not to bother' because previous experience tells them there is no point. Subsequently, there is a huge, masked unmet need. When referrals are accepted some children and families are unable to make use of the traditional 'clinic' based delivery of service as it does not suit some of the most vulnerable, complex and traumatised families. Reaching out to these families in a more proactive/creative way is not possible with the pressure of target driven waiting times and the capacity/demand imbalance. 5. Competence to deliver an appropriate range of psychological therapies within CAMHS is variable. Not all CAMHS have sufficient establishment of clinicians to provide the appropriate range of therapeutic interventions at the appropriate intensity. There is an over-emphasis on medical model skills such as assessment and screening, and an under-emphasis on appropriately skilled delivery of psychological therapy. Further, it seems that certain therapeutic approaches have traditionally been associated with and thereby located within CAMHS' teams, despite there being a dearth of evidence supporting their efficacy and effectiveness. The provision of a particular therapeutic approach simply because it is available, rather than it being an appropriate (evidence supported) approach is an all too common occurrence and happens across all tiers, from Tier 1 to Tier 4. 6. There is a lack of recognition and understanding that for psychological therapies to be delivered in adherence to an evidence based therapeutic process it is essential for clinical supervision to be delivered by practitioners proficient in the therapeutic modality. Time and financial pressures means that there is often insufficient opportunity given to clinicians to access appropriate and competent supervision/consultation. This diminishes their therapeutic effectiveness and is a clinical governance issue. 7. There are few courses in existence that provide training in evidence-based psychological therapies for children and young people; there are even fewer in Wales. Those that are suitable are oversubscribed for a number of years. 8. Applied psychologists working in CAMHS have expressed concern that since the children and families seen come with layers of trauma (often trans-generational) and the time and skill required to allow a robust trajectory of change for a child is often not available. 9. Social media could be used beneficially to reach young people as this is a favoured communication and learning style. APHNSAG members recommend setting up a sophisticated and interactive, informative website as an initial step.
	The extent to which CAMHS are embedded within broader health and social care services
3.	1. The development of specialist tier 2 CAHMS services rather than more inclusive CAMHS which reach across all tiers of the service sometimes resulted in other parts of the health and social service organisations referring children and young people with any degree of emotional or mental health problem on to specialist CAMHS rather than recognising the extent to which they are responsible for meeting less severe mental health needs. A model of consultation and networking is used by some services. In Aneurin Bevan Health Board, networking meetings are used by the Child and Family Psychology services in order to support other professionals in their work with children. This is based on the philosophy that children are best helped within the contexts in which they live their lives and that is where the difficulties arise rather than a 'within' child problem model. There has been excellent evaluation of this work but it is difficult to sustain this model of working when existing data systems are 'patient/contact' driven. 2. CAMHS are relatively small services and require a strong identity within their organisation. Applied psychologists in Health have expressed the view that despite sitting within Health Boards they feel that specialist CAMHS are not fully embedded within any organisation. Their comments reflect a feeling that they have often been undervalued and disadvantaged in terms of resources and facilities within the larger directorates in which they are positioned. If placed within a Mental-Health Directorate they feel of secondary importance to services for working age adults and when placed within Children's (or Women and Children's) Services they are perceived as being less important than services for children and adolescents with physical health needs. 3. Within Local Authorities, Educational Psychology Services are increasingly being included within 'Children's Services', comprising Education and Social Services. However, the demands placed on Educational Psychologists means they have little time to provide input on mental

	health issues and, in effect are maintained within their traditional roles. 4. Some good practice examples of services were highlighted by APHSAG members e.g. Social Service Departments seeking to fund part posts within Specialist CAMHS for Psychologists, Psychological Therapists and Psychiatric Nurses within newly created specialist services, such as an Emotional Wellbeing Team, a service for children who engage in sexually harmful behaviours, psychologists working with Looked After Children and paid for by the local authority, psychologists working within third sector organisations (MIST, FIT, Skills for Living). These roles have shaped the services they work within and the benefit is two ways since they also bring a difference to the core services from which they come and invite innovative practice and question traditional practice. These developments are not consistent across Wales however.
	Whether CAMHS is given sufficient priority within broader mental health and social care services, including the allocation of resources to CAMHS
4.	1. Specialist CAMHS in particular, is an under valued and underfunded service. Funds are often not forwarded to such a small service, instead being absorbed by the larger organizations or services such as Adult Mental Health, Education or Social Services. For example, when specific funds are earmarked for CAMHS to provide ASD services. 2. Some specialist CAMHS report operating from inappropriate or inadequate buildings, providing poor accommodation and facilities where conditions run down, cramped, cold, damp, poorly decorated, and affording poor soundproofing and other aspects of confidentiality and security. 3. In many areas there is no access to clinical or other applied psychologists within paediatric health services despite having demonstrated the value of psychological models with diabetes, Cystic Fibrosis, feeding, encopresis. 4. In population terms there is a clear disproportionate resource given to adult services compared to children's services, see comment 2.1.
	Whether there is significant regional variation in access to CAMHS across Wales
5.	1. Access referral criteria are interpreted differently leading to different services being offered by CAMHS across Wales e.g. ASD and ADHD may be perceived as being mental health difficulties (seen in Specialist CAMHS) or developmental difficulties (seen in Pediatrics). 2. The service model adopted within Specialist CAMHS can also lead to regional variation. Services that are seen as being Psychiatry led tend to be diagnostic and rely on medication, whereas those that are more equal and multidisciplinary are more psychologically interventionist in their character. This can lead to resources within teams being allocated based on the medical model of diagnosis rather than focusing on a normative model of healthy psychological functioning which needs to begin in schools and the communities in which children live. 3. Within the wider CAMHS the failure of some Local Authorities to recognize mental health needs of children and adolescents means that services cannot be provided equally (e.g. sexually harmful behavior). The closure of the Education al Psychology course may cause difficulties in recruiting educational psychologists and have a negative impact on children's well-being in schools which will is likely to increase inappropriate referrals to CAMHS.
	The effectiveness of the arrangements for children and young people with mental health problems who need emergency services
6.	1. There appears to be little compliance to NICE Guidelines for children and young people who present at A&E having self-harmed or self-poisoned. They are sometimes admitted to wards, where their emotional and mental-health needs are not given appropriate priority. The paucity of psychology resources in paediatric services exacerbates this problem. 2. There is sometimes a failure on the part of Social Services staff to recognize children and young people who have attempted overdose as needing to be safeguarded. This a failure to recognize the very significant social elements within such behavior, preferring instead to perceive such acts as being indicative of mental illness and not their responsibility. All individuals who take an over-dose should be assessed by appropriate mental health trained

	clinicians and social services staff. The on call psychiatric assessment of children admitted into hospital often lacks psychological understanding of children's mental health and only has a psychiatric lens with which to understand the complex needs of children. 3. Feedback from parents suggests it is hard to get clear advice as to where to go in an emergency. A and E is the default option.
	The extent to which the current provision of CAMHS is promoting safeguarding, children's rights, and the engagement of children and young people
7.	1. Specialist CAMHS makes significant efforts to safeguard children by assessing risk. However, this may not be the case where children or adolescents present within other teams and the responsibility to assess risk is passed to specialist CAMHS e.g. following an over-dose the child/adolescent is often referred to Specialist CAMHS, rather than the assessment being completed in a timely way being completed by A&E or Ward staff. There needs to be a greater awareness of risk assessment for children and young people across all health care settings including the responsibility to make a Child Protection Referral or seek an assessment of home circumstances from Social Services. staff need to be able to negotiate safe, nurturing relationships and understand the importance of attachments as a basis for growth, can engage young people in meaningful activity within a living context, and are psychologically minded so all interactions are mindful and therapeutic. 2. Protecting children's rights and promoting their engagement is a major priority to Specialist CAMHS but is often poorly understood by other Services and service users. Social Workers (and occasionally parents) often fail to understand that when a child or young person is competent to make their own decisions as to their care, that their right to confidentiality needs to be respected. 3. Children may be admitted to adult wards which are not resourced to deal with children's needs at any level. Children tell us they care a lot about the physical environment. It needs to feel safe, welcoming, private but not too formal.
	Any other key issues identified by stakeholders
8.	1. The issue of ADHD diagnoses needs to be addressed. A huge amount of resource revolves around the delivery of a diagnosis which is controversial. Parents believe they need to pursue this in order to gain help and support for their children. This is a culture which should be challenged (see description of Caerphilly FIT work in comment 1.1).

End

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RESEARCH TO SUPPORT THE PYRAMID MODEL

1. Research evidence supporting the Pyramid approach

The Pyramid model

The Pyramid approach is a three-part package that was developed from 1978-82 in the London borough of Hounslow, in action research funded by the Economic and Social Research Council. The aim was to identify an effective 'integrated, preventive child care system' that could be replicated in any primary school, within existing resources and without interfering with teaching. The package of routines that emerged, consisting of screening, multi-agency consultation and activity group therapy, had been tried, tested and evaluated by teachers and support service staff involved in the project.

A secondary school follow-up of the experimental children and their controls four years later indicated substantial benefits from the Pyramid intervention. Four-fifths of the children who had been identified as vulnerable and who had participated in an activity group or club, were still holding their own in the mainstream of high school; by contrast, three-quarters of an untreated control group were either in pupil support units or had dropped out of school.[1]

Theoretical base for the Pyramid intervention - why short term groups?

In Newcastle in the late 1970s, a study of school-based methods of mental health promotion (by Kolvin) found that for primary age children, short-term therapeutic groups were the most effective technique, with benefits that appeared to increase with time. Three years after the start of the school-based experiment 78 per cent of children 'at risk of maladjustment' who had taken part in a ten-week playgroup could be taken off the 'at risk' register, compared with only 44 per cent of their untreated controls.[2] This research outcome chimed well with the American High Scope findings, where an enjoyable pre-school experience enabled many high risk youngsters to stay in mainstream education and mainstream life generally.

Why younger children in groups?

The American psychologist Mortimer Schiffer[3] argued that the over-riding 'social hunger' of latency-age children is for acceptance by their peers. An environment where this hunger is satisfied can heighten awareness, increase receptiveness to social learning, build confidence and accelerate personal growth. Group work provides such an environment.

The evidence for early intervention

Graham Allen's paper on Early Intervention[4] sets out the case for intervening early to tackle children's problems, including evidence from brain development research, attachment theory, the prevalence of mental health issues across the UK, and the fact that children with mental health difficulties usually grow into adults with mental health issues. It calls for early intervention for children aged 0-18. Every taxpayer pays the cost of low educational achievement, poor work aspiration, drink and drug abuse, teen pregnancy, criminality and unfulfilled lifetimes on benefits. But it is not just about money: it is about social disruption, fractured lives, broken families, and sheer human waste. The emphasis is on providing children with the social and emotional skills they need to live happy, fulfilled lives. We need to keep intervening to break inter-generational dysfunction and produce better parents for the future and all the evidence points to early intervention being less costly, more effective and more humane.

2. Evaluating Pyramid clubs – a summary of the academic work to date

2013 – Michelle Jayman – University of West London

Michelle is looking at the effectiveness of Pyramid as an early intervention in secondary schools. An important aspect of her research is looking at the impact of Pyramid on students numeracy and reading ability. Currently three secondary schools in North Wales are involved in this research.

2010 – Maddie Ohl, Thames Valley University

Maddie Ohl has published a number of papers arising out of her PhD work. This work involved a large sample and a control group, amounting to around 400 children altogether in the London borough of Ealing and in Manchester. The control group were not children who needed Pyramid, as the plan was to do some longer-term follow up and it would have been unethical to identify them as needing Pyramid but not allowing them to attend a club. Measures (using the Goodman's Strengths and Difficulties Questionnaire - SDQ) were taken before the club, immediately afterwards, and 18 months after the club, and found that the club children improved and sustained their improvement, whilst the control group got considerably worse. It was possible to analyse the data for effects on gender and ethnicity, and it was found that Pyramid was suitable for boys and girls and worked equally well for children from a range of ethnic backgrounds. The research involved an evaluation of the assessment methods used to identify children for clubs, whilst a further paper reports on focus groups with the children which found that the children themselves identified the same improvements that the SDQ picked up. Academic attainment levels will also be retrospectively analysed for the Ealing children.

2010 – University of Ulster (UU) with Barnardos in Northern Ireland

PhD student Aine McKenna is undertaking a review of the effectiveness of Pyramid in addressing internalising disorders, including depression, anxiety, social withdrawal and somatic problems. The research has divided children into three groups: those who would benefit from a Pyramid club and received one: those who would benefit from a club but were not initially offered one; and those do not need an intervention, nearly 400 children in total. Each group was measured using the Goodman's SDQ and a subjective well-being questionnaire. Initial results suggest that Pyramid clubs build personal efficacy in terms of autonomy and responsibility, and promote self-expression, playfulness and conflict resolution skills. The UU approach is a strengths-based one, based on Lerner's human flourishing theory, whereby competence, confidence, character, caring and connection lead to contribution by the individual. The most striking feature of the research to date is around human connectedness, with 91% of participants feeling that they had made a new friend and were now more friendly with other children. The work is due to be completed in September 2011 for publication.

2009 – Buckinghamshire Education Psychology service

Research carried out by an Education Psychologist in Bucks in 2008/9 took a different approach, and compared two groups of children selected for Pyramid: one group were offered a club straightaway while the other group had to wait a term (a 'wait list comparison'). As expected, the children who went to the first club improved whilst the group on the waiting list did not, until they too went to a club. Using the Goodman's SDQ, it was found that the Pyramid children's emotional difficulties decreased, as did their hyperactivity scores, whilst the comparison group's scores increased over the same period. On a different measure, the Loneliness and Social Dissatisfaction Scale (Cassidy and Asher 1992), the Pyramid children's scores also decreased by a statistically significant amount while the comparison group's increased, suggesting that the children felt less lonely and dissatisfied with their social relationships after the club than they did before. Buckinghamshire has been evaluating its Pyramid work since it started in 2002, involving over 400 children, and has consistently found significantly reduced emotional difficulties scores on the SDQ.

2009 – University of Manchester, C Graham and Z Goodwin

This study[5] looked at whether the impacts of Pyramid were sustained a year on from the club taking place, and reviewed the results for a group of Year 3 children and a control group when they had moved on to Year 4. The group size was 57, with 33 children attending a Pyramid club (16 girls and 17 boys) and 24 who did not (18 girls and 8 boys). The Goodman's SDQ was completed by teachers, but the children also completed self-assessment questionnaires and parents completed a questionnaire. The study found that the children who attended the club had significantly poorer social and emotional health than the non-attendees prior to the clubs running. One year on, the differences between the club attendees and the control group were not significant: however the study found that this was due to the significantly worsened scores for the control group, rather than the improved scores for the Pyramid club children. Their conclusion was that Pyramid is successful in halting social and emotional problems from escalating against developmental pressures that are experienced by this age group.

2009 – Lincolnshire Healthy Schools study on Mobile Pupils

Originally planned as a study into the children of migrant workers, this study expanded to look at how successful Pyramid was as an intervention to help children who moved schools at times other than the normal times.[6] The study measured levels of shyness, participation in class and in the playground, pro-social behaviours and emotional well-being, and also considered locus of control and academic progress. It found that the children who attended clubs experienced significant increases in classroom participation and a decrease in shyness, with some evidence for academic gains and a noticeable increase in confidence.

2007 – Thames Valley University and University of Limerick: Maddie Ohl, Kathryn Mitchell, Tony Cassidy and Pauline Fox[7]

This study involved 94 children in three schools in the London borough of Ealing, 42 Pyramid participants and 52 non-problem children. All children were screened using the Goodman's SDQ at the start and at the end of the club. This study compares the numbers of children in the normal, borderline and abnormal range of the SDQ scales. Prior to the club, 15 of the club children were in the abnormal range, 12 in the borderline and 15 in the normal range, whereas the non-club children had 6 in the borderline range and 46 in the normal range. After the club, 20 of the club children had moved to an improved range, 20 stayed the same and two had a lower banding, whereas for the control group, 4 had improved, 44 remained the same and 4 had a lower banding. The biggest improvements in the club children were seen among the children in the abnormal range: of the 15 children in the abnormal range prior to the club, 3 remained in the abnormal range, 3 moved into the borderline range and 9 moved into the normal range.

2005 Manchester University

Two Psychology undergraduates, Amy Mawson and Rebecca Murphy, volunteered at Pyramid clubs in Salford and wrote up their findings[8] as part of their dissertation. They were able to match the club children with children from the same schools who acted as a control group. Their focus was how effective Pyramid clubs are at improving self-esteem in children, and also how other socio-emotional experiences are associated with low self-esteem and whether Pyramid is successful in improving these factors as well. Pre-club, Pyramid children had low levels of self-esteem but this improved by 15% after the club, whilst controls stayed the same. The biggest areas of improvement were in relation to personal, school and peers. Post-club levels of self-esteem were close to the controls.

2001 C Cooper, University of East London

This follow-up study[9], five years after attending a Pyramid club provided interesting qualitative and quantitative data suggesting strongly that the Pyramid clubs had made a considerable, positive impact on the majority of the sample. It also concluded that the relationship with club leaders was very central to the process, which enabled them to talk and explore friendships.

1999/2000 Institute of Education at the University of London

The results[10] indicate that children attending Pyramid clubs show greater improvements in self-esteem, locus of control, reading and maths ability than matched children who did not attend. Children reported increased happiness, confidence and improved friendships with peers after attending Pyramid clubs.

1998/1999 University of Surrey

Improvements in academic performance for children who attended Pyramid clubs were found: in comparison to the non-Pyramid children, those attending Pyramid clubs showed greater, significant, improvements in the emotional and peer interaction elements of the study[11].

In terms of writing performance, analyses indicated:

- no differential improvements in the copying task
- a significantly greater reduction in the proportion of errors produced by the Pyramid children compared to those produced by the non-Pyramid controls in the sentence generation task
- larger improvements in ratings of the stories produced by Pyramid children compared to controls in the free writing task – two independent assessors produced ratings

1996 – T C Skinner

Skinner found that for all three criteria measured, that is, depression, immaturity and social withdrawal, the experimental, or club children were showing significantly greater improvements than the controls. Symptoms of depression decreased by 30 per cent in experimentals, but only 20 per cent in controls; symptoms of immaturity and social withdrawal decreased by 54 per cent in the experimentals, but only by 34 per cent and 29 per cent, respectively, in the controls.[12] Club children were able to answer questions relating to their perceived popularity and their happiness, both before and after their participation in clubs. On both scales, highly significant improvements in self-concept were reported after the club experience.

1995 – T C Skinner

This post-graduate researcher from **Surrey University** analysed a survey of teachers' reports on children who had been subjected to the Pyramid procedures during the 1994-95 school year. He found a significant difference between the progress reported for those who had participated in clubs and those who had not. The most robust effect was for self-esteem, where 58 per cent of the children who attended a club showed some improvement, but only 10 per cent of the controls. Similar differences were found in children's social skills (52 per cent of attendees improving), relationship with peers (49 per cent) and relationship with adults (41 per cent). Twenty-two per cent of club children, compared with only 7 per cent of the controls, also made progress in writing.[13]

3. Other evaluations of Pyramid clubs

2006-07 Bracknell Pyramid project

Bracknell evaluated[14] the impact of Pyramid using four of the five Every Child Matters outcomes as follows:

Being healthy – routine screening of emotional health and wellbeing of the whole year group identified early triggers for action and ensured that every child's emotional health was reviewed at the age of 8: the multi-professional identification group also ensured that additional appropriate interventions were identified. Club activities such as Circle Time, group games and cooking activities were used to encourage positive emotional and physical health, and healthy lifestyles were promoted to children.

Staying safe – the screening identifies potential problems and solutions for children, while the clubs provide a safe environment for children to develop resilience, and all clubs operate within the 'Working together to safeguard children' policy.

Enjoying and achieving – clubs deliver new opportunities to experience and enjoy, help them to develop personally and emotionally thus increasing their willingness to actively engage in education and enabling them to achieve their full potential.

Making a positive contribution – clubs help children to develop socially and emotionally, build resilience, enable them to manage change and respond to changes in their lives, and encourage their participation in the decision-making. These skills can then be transferred to the child's wider life.

The project also identified benefits from children's participation and partnership working.

2003-2006 Northern Ireland

Barnardos in Northern Ireland, funded by the Children's Fund, ran 43 clubs for 441 children in 22 schools over three years. Attendance rates at the clubs were exceptionally high, with between 97 and 100 per cent attendance. All of the children involved said they would like to do something similar again, 75 per cent said they liked school more since the club, 87 per cent would recommend it to other children, and 85 per cent of the Primary 7 children said they found Circle Time helpful to discuss issues and concerns.

All of the parents and teachers agreed the children enjoyed the club. In addition, 98 per cent of parents said their child talked about the club and 78 per cent felt it had benefited their child. Eighty-six per cent of teachers noticed an increase in class participation, 71 per cent felt the children were more confident in group activities, and 86 per cent felt that the children's emotional health had improved. Twenty-eight local volunteers were recruited, two of whom subsequently returned to work after prolonged absences having gained the confidence to apply for work after being involved with Pyramid clubs.

The Children's fund outcomes that the Northern Ireland project was working to were:
1. identify and target children who are experiencing social and/or emotional problems
2. enhance children's self-esteem and resilience and improve social skills leading to learning and better future life chances
3. to improve family ability and capacity to meet their children's needs
4. to enhance children's learning by providing an intervention that demonstrably works
5. to enhance the social and educational opportunities of children by involving the local community

The Children's Fund evaluation[15] was that all the outcomes had been achieved.

2005 South Gloucestershire

Building on work going back to 1998, the South Gloucestershire Pyramid project evaluated outcomes for children who had attended clubs in the current year, the previous year and 2/3 years previously. The Year 3 evaluation of 80 children showed improvements from an average SDQ score of 12.2 (0-11 normal, 12-15 borderline, 16-40 abnormal) pre-club to 7.5 post-club. On all the individual elements of the SDQ (Hyperactivity/Emotional Symptoms/Peer Problems/Conduct Problems/Prosocial Behaviour), significant improvements were made from pre-club scores.

SDQ results were also presented for Year 4 children, pre-club, post-club and one year on. Results for 60 children showed an improvement from pre-club score of 12.2 to a post-club score of 8.6 and a one-year on score of 8.7, showing that the improvements were maintained. On the individual component elements, there was a small increase from the post-club to the one-year on score, but the increases kept the child well within normal limits. The exception was for Peer Problems where the one-year on score was a significant *improvement* on the post-club score.

Years 5 and 6 in one school, supported by an LSA, the Children's Fund Participation Worker and the Pyramid co-ordinator, produced questionnaires for children, teachers, headteachers, parents, and club leaders, asking them about the impact of the club. These were then used at another school as well. Children overwhelmingly felt happier during playtime, in the classroom, talking to adults and teachers, and had made new friends in the club. Teachers thought children who would not otherwise receive help had received some, reducing social exclusion in the classroom. Headteachers thought the main benefit to the school was the increased confidence of the children and the skills developed by the school staff involved. Parents felt their children enjoyed feeling special as part of the club and were happier in school. Club leaders felt that they personally got a lot out of the club and were very pleased at the changes in the children.

2002/03 Gainsborough[16], Lincolnshire.

This research identified positive shifts on the emotional scale, on peer relations and reduced conduct problems particularly, all of which were statistically significant at the 1 in 200 level or higher, again using the Goodman's SDQ. Ninety per cent of children were thought to have made a positive change, and their teachers commented, most frequently, that they were more outgoing/confident and their social skills had improved.

Sept 2002 – Sept 2003 Wandsworth Schools Pyramid Project[17]

The London borough of Wandsworth, working with the NSPCC, carried out a major evaluation of the effects of Pyramid at ten schools that ran clubs in the academic year. Using the borough's Coping in Schools Scale, improvements were identified in behaviour (scores increased by 59 per cent), self-esteem (up by 63 per cent) and learning and literacy (up by 65 per cent).

2002 Cardiff Pyramid Project[18]

Teachers were enthusiastic about the programme and saw positive changes in the children's, confidence and behaviour both in the classroom and in the playground. The majority of teachers felt that there was very little increase in workload or demands on their time and any slight increase would be offset by the benefits to the children. All children enjoyed the clubs and 60 per cent or more felt more positive about school, got to make friends and believed their behaviour had improved.

September 2001 - March 2003 and January 2002 – July 2005 Buckinghamshire Pyramid project[19]

These two studies carried out by the Buckinghamshire Educational Psychology Service identified very significant improvements in prosocial behaviour and reductions in peer problems, emotional problems, hyperactivity and conduct problems, using the Goodman's Strengths and Difficulties Questionnaire (SDQ) pre and post attendance at clubs. Almost 350 children who attended clubs had their SDQ scores reviewed.

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[1] K Fitzherbert, 'Giving Positive Prevention a Chance' in Education, 15.3.1985

[2] I Kolvin et al, 'Help Starts Here', Tavistock Press, 1981

[3] Schiffer M. (1976) "The Synergy of Children's Groups, Psychotherapy and Child Growth and Development", Group Therapy - An Overview

[4] 'Early Intervention: The Next Steps', an independent report to Her Majesty's Government by Graham Allen MP, January 2011

[5] 'An Evaluation of a school-based intervention programme: are the social and emotional health impacts sustained for one year?' A study conducted by C Graham and Z Goodwin in 2009 at the Department of Psychology, University of Manchester, under supervisor Dr A Theakston

[6] 'Introducing Pyramid clubs to support mobile pupils', by Lucy Gillott as part of her Post-graduate Certificate in Education, February 2009.

[7] Published on line by Blackwell Synergy in Child and Adolescent Mental Health, December 2007 http://onlinelibrary.wiley.com/doi/10.1111/j.1475-3588.2007.00476.x/abstract

[8] A Mawson and R Murphy, Manchester University, 2005 (unpublished)
[9] C Cooper, University of East London, A small scale evaluation of the long-term outcomes for primary school children attending National Pyramid Trust therapeutic play clubs. (unpublished)

[10] C. Headlam Wells, Institute of Education, 2001 (unpublished)

[11] J Davies (1999) Children's Writing Improvements following participation in the Pyramid Schemes

[12] This evaluation was reported at the VIIIth European Conference on Developmental Psychology, in France from 3-7th September 1997
[13] These results were published in a poster presentation to the Annual Conference of the Developmental Psychology Section of the British Psychological Society on 13.9.96

[14] K Hooper, Children's and Adolescent Service Manager, East Berkshire Mind, 2007

[15] S Anderson and J Healy, Barnardo's Northern Ireland Policy and Research Team, 2007

[16] Helen Lygo, July 2003, Gainsborough Pyramid Clubs First Round, Evaluation Report
[17] R. Green, Development Co-ordinator, NSPCC Schools Team (London) Wandsworth Schools Pyramid Project, Evaluation Report, Sept 2002 – 2003

[18] E. Howarth, Cardiff Local Health Group, October 2002, Evaluating the Effectiveness of the Cardiff Pyramid Project

[19] Astrid Gregor and Francesca Post, Buckinghamshire Pyramid Trust Evaluation Report

Vaughan Gething AC / AM
Y Dirprwy Weinidog Trechu Tlodi
Deputy Minister for Tackling Poverty

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref:

Ann Jones AM
Chair of Children, Young People and Education Committee
Ty Hwyel
Cardiff Bay
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26 March 2014

Dear Ann

Thank you for inviting me to attend your Committee in February, and for giving me the opportunity to explain how the Welsh Government is delivering its anti-poverty policies and programmes.

At the meeting I agreed to update the Committee on a number of points. I am therefore writing to provide you with the further information and, where appropriate, clarification of issues discussed in Committee.

I agreed to provide the Committee with further information on the work carried out by Professor Edward Melhuish for us on the evaluations of Flying Start.

As you know, Flying Start is subject to a robust, independent programme of evaluation, and a series of reports was published between October 2013 and January 2014.

Professor Edward Melhuish was commissioned to:

- provide an independent, expert overview of findings from the National Evaluation of Flying Start reports;
- present an informed commentary on Flying Start as a social intervention within a UK policy context, paying particular attention to Sure Start; and
- consider implications for future delivery and practice.

His findings are currently being reviewed by officials. Once they have completed their review, Professor Melhuish's commentary will be published on the Welsh Government

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website as a supplementary document alongside the Flying Start evaluation reports by the end of May 2014.

I also agreed to provide the Committee with information concerning the uptake of all four elements of Flying Start. The methodology for data collection which we have agreed with local authorities does not facilitate the collection of data on the number of children benefiting from all four entitlements. I have asked my officials to further investigate the potential for this.

I also agreed to provide the Committee with more information on how we were progressing with the work aimed at improving programme join-up across the Flying Start, Families First, and Communities First programmes.

I have made it very clear that I want Communities First, Families First and Flying Start to work more closely and in a more joined-up way across Wales. Coherence between the three programmes is a clear Ministerial priority and it has been the theme of the four regional events we have organised to bring together staff, not just from these three programmes, but also from appropriate areas of local government, the health service and the Third Sector. I am pleased that to date there has been a positive buy in from all partners about the need for, and benefit to be gained from, a greater level of coherence. The move from coincidental joint work to a more consistent and coherent approach is consistent with the focus on work between local government, health, the voluntary sector and other partners on anti-poverty action.

It is also worth noting that in ESF Convergence areas, this alignment between the three programmes is being taken forward by the Communities First and Family Programmes Integration Project, which is led by a manager based with Welsh Government and four Regional Integration Officers whose posts are hosted by Carmarthenshire, Torfaen, Gwynedd and RCT local authorities.

With regards to the Families First programme, I said that I would provide the Committee with the outcomes for children and families that the Families First evaluation process will measure, and I am pleased to provide this at Annex 1.

Additionally, I said that I would provide the Committee with details of when the first set of data, measuring progress in these Outcomes, would be published.

Families First is still in its early stages and the first two years of the programme have focused on systems change. The first evaluation report was published in December 2013 and provides vital feedback about the implementation and delivery of the programme.

The first report concluded that national and local stakeholders endorsed the design of the programme. Families First was reported to drive better coordination and deeper integration of services for children and families through multi-agency working. Findings suggest the programme is addressing gaps and inefficiencies in previous ways of working. Local authorities reported that strategic commissioning promotes better multi-agency working and an outcome based culture.

I can also advise that all local authorities in Wales have now developed and embedded a ‘Team Around the Family’ (TAF) approach. Data that we have collected for the first two quarters of 2013 – 14 show that between March and September 2013, 1,492 Joint

Assessment Families Frameworks were conducted and at least 727 TAF action plans were in place for families across Wales. The TAF action plans detail the interventions that will be offered, along with details of the multiple agencies that will come together to provide a coherent service to the family.

We are keen to capture the impact on families. Therefore, a Family Outcome Tool has been developed which will provide information on the impact the whole family approach is having on these families. Details from this tool, including consideration of distance travelled measures for families will form part of the next phase of evaluation. The forthcoming evaluation report also incorporates case studies with families about the difference Families First has made to their lives.

I also discussed with the Committee the collaboration between primary and secondary schools for play based facilities.

Welsh Government policy and legislation, including that for play, are taken into account in the consideration of business cases for the 21st Century Schools Programme to ensure joined up implementation programmes. The programme focuses resources on the right schools in the right places, from early years through to post-16 (http://21stcenturyschools.org).

Creating a Play Friendly Wales, the statutory guidance to local authorities on assessing for sufficient play opportunities for children in their areas, requires them to assess the extent to which schools provide a good quality play environment for children both during and outside the school day.

Wales: A Place Where Children Can Play, the draft statutory guidance on securing sufficient play opportunities, which opened for consultation on 10th March 2014, gives examples of how local authorities and partners are increasing play opportunities available on school premises. These include:

- Projects to enable children and young people to experience richer play opportunities within the school day through the provision of play pods or storage containers and “loose parts” from a range of recycled material that can be used for active, imaginative and constructive play, during school breaks and after school.

- Accredited training for lunch time supervisors and teaching assistants so that children can be supported to use these resources at play/lunch time.

- The use of the Play Wales toolkit *Use of School Grounds for Playing out of Teaching Hours* to raise awareness and practical advice on improving school premises for play. (http://www.playwales.org.uk/eng/schoolstoolkit).

I hope that this fully addresses those issues where I agreed to provide more information. As ever, if you should require further clarification or information, please let me know and I will ensure that this is provided to you.

Yours sincerely

Vaughan Gething

Vaughan Gething AC / AM
Y Dirprwy Weinidog Trechu Tlodi
Deputy Minister for Tackling Poverty

Annex 1 - Children, Young People Committee

Families First Outcomes and Population Indicators

The outcomes for children and families that the Families First evaluation process will measure

Attached below are outcomes and indicators for children and families. We will monitor data against these measures to assess the impact of Families First.

Outcome 1

Working age people in low income families gain, and progress within, employment

PI 1 The proportion of children living in families in receipt of out of work (means-tested) benefits or in receipt of tax credits where their reported income is less than 60% of median income

PI 2 Percentage of Year 11 leavers not in education, employment, or training

PI 3 The proportion of 18 – 24 year olds claiming JSA

Outcome 2

Children, young people and families, in or at risk of poverty, achieve their potential

PI 1 Percentage of pupils eligible for free school meals who achieve the Foundation Phase Indicator (in teacher assessments) compared to pupils who are not eligible for free school meals

PI 2 The percentage of pupils eligible for free school meals who achieve the Core Subject Indicator at KS2, compared to pupils who are not eligible for free school meals

PI 3 The percentage of pupils eligible for free school meals who achieve the Level 2 threshold including a GCSE A*-C in English/Welsh and Maths, at the end of KS4 compared to pupils who are not eligible for free school meals

PI 4 Percentage of half day sessions (overall absence) missed by pupils of compulsory school age attending maintained primary schools and eligible for FSM compared to those pupils who are not eligible for FSM

PI 5 Percentage of half day sessions (overall absence) missed by pupils of compulsory school age attending maintained secondary schools and

eligible for FSM compared to those pupils who are not eligible for FSM

Outcome 3

Children, young people and families are healthy and enjoy well-being

PI 1 Percentage of children fully immunised by their 4th birthday

PI 2 Percentage of live births with a birth-weight of less than 2500g

PI 3 Numbers of conceptions under age 16 years per 1000 female residents aged 13 to 15

PI 4 The proportion of children in reception class who are overweight or obese

Outcome 4

Families are confident, nurturing resilient and safe

PI 1 The number of households with dependent children accepted as eligible, unintentionally homeless and in priority need

PI 2 The number of homeless households with dependent children in temporary accommodation at the end of the period

PI 3 Children in need by parental capacity (domestic abuse)

PI 4 First time entrants into the criminal justice system

Agenda Item 7.3

CYPE(4)-10-14 – Paper to Note – Paper 7

Questions on local authorities and regional consortia**:**

1. **The impact of poor performing local authorities on school standards and pupil outcomes;**

The migration of school improvement services from 22 local authorities to four regional consortia was completed by September 2013. However, the arrangements for governance and delivery in the four regional consortia have varied too much, as pointed out in the Hill report, and acted upon by the Minister for Education and Skills.
As a result the Welsh Government reviewed the first iteration of regional consortia and developed a national model for delivery of school improvement services. The regional consortia have to submit their business plans to the Minister for Education and Skills for his approval by the end of March 2014.

There remain issues of structural complexity and failures of capacity, capability and scrutiny in relation to the delivery of the range of education services for children and young people in a significant proportion of local authorities. Presently 15 local authorities are in follow-up, with six in special measures and one in need of significant improvement.

School improvement services remain a duty of each local authority but are delivered through the regional consortia school improvement services. Therefore the responsibility for school improvement and its impact on schools is now a shared responsibility.

Although Estyn has completed its core inspections of the 22 local authorities in this cycle, we are engaged in follow-up visits to 15 authorities. In both the core inspection and follow-up visits, the judgment about the performance of a local authority in Estyn inspections and in follow-up activity is based upon the performance of the authority's schools and the outcomes for pupils. The number of schools being placed into follow-up as a result of Estyn inspections and the number of schools coming out of follow up are a key indicator of the effectiveness of the local authority and its regional consortia.

In many of the authorities inspected or monitored recently, too many schools have gone into significant improvement or special measures following an Estyn inspection. In a few of these schools, officers were not aware of the issues that led to the school being placed in follow-up. Weaker authorities do not managed the quality of officer's work well enough to ensure that they provide a consistent and robust challenge to schools. In addition, too many local authorities have not make the best use of the regional school improvement service because they retained or commissioned additional officers or consultants whose work is not planned in partnership with the regional service. The result has been that schools have received often conflicting advice from their local authority officers and from officers of the regional consortium. As a result, schools are not clear about what it is they need to improve, and a minority do not improve quickly enough.

Local authorities that have less effective senior leadership and scrutiny arrangements do not challenge robustly enough the work of school improvement officers nor hold them to account sufficiently. This has a direct impact upon quality of challenge and support provided to schools by these improvement officers.

2. **Whether the restated powers for local authorities to intervene in schools causing concern (in the *School Standards and Organisation (Wales) Act 2013*) will encourage more local authorities to exercise those powers;**

We have commented in previous Annual Reports that the majority of local authorities have not used their powers well enough to intervene in schools causing concern, either by issuing warning notices or changing the arrangements for governing bodies. We welcome the clarity that the School Standards and Organisation (Wales) Act 2013 brings in relation to the powers of local authorities. In particular Section 2 of the Act clearly states the grounds for intervention and the escalating range of intervention powers at an authority's disposal. In recent Estyn inspections and follow-up visits we have seen greater use of warning notices and interim executive boards (IEB) by more local authorities.

3. **The level of effective challenge and support given by consortia to schools;**

In three of the authorities out of the eight inspected between 2012-2013, there was evidence that the regional consortia had begun to have an impact in improving the consistency of the challenge brought to schools, in improving the use of performance data to identify underperforming schools and in more rigorously categorising schools according to risk. However, in the other five authorities inspected, the regional consortia were yet to have an impact on provision for school improvement.

However, as explained in an earlier answer, we have completed the current cycle of core inspections for local authority education services in readiness for a short cycle of inspections of the regional consortia.

In autumn 2014 we will undertake a Ministerial remit reviewing the progress of regional consortia and we will publish the report on that review in March 2015. Estyn is working jointly with Wales Audit Office (WAO) on this remit. We will inspect the work and impact of individual regional consortia between September 2015 and December 2016.

4. **Whether regional working will help improve standards in local authorities;**

Please refer to the answer for question 1. The first set of verified performance data for schools and authorities served by the regional consortia will not be available until November 2014. Improvements in data on 2012-2013 outcomes could not be attributed directly to the impact of the regional consortia especially in the case of the North Wales consortia which only started operations in September 2013. The impact of regional consortia on standards in schools and their local authority will be a key performance indicator in reaching a judgement about performance in Estyn inspections of regional consortia from September 2015 and in the next cycle of local authority education service inspections after that.

5. **The impact of local authorities retaining statutory responsibility for schools and school improvement on regional working;**

Although school improvement remains a statutory duty of each local authority, under the collaborative arrangements of joint committees, the responsibility for the quality of a school improvement service and its impact on schools should now be a shared responsibility. It is for each local authority through its representation on joint committees of the regional consortia and its own scrutiny arrangements to ensure that its learners receive the highest quality service possible for its regional consortium. How well this operates in practice will

be tested in our review and in the subsequent inspections of regional consortia school improvement services.

6. **Whether there are concerns that regional working could have negative impacts on some services still being delivered by the local authority, for example, a lack of collaboration between ALN services and school improvement services;**

This is an area that we will examine as part of our review of regional consortia. We have some very partial evidence from Estyn follow-up visits that some regional consortia are collaborating effectively with one or two authorities to integrate the work of school improvement officers with local authority ALN staff but we do not have evidence of the impact of this upon pupil outcomes at this time.

7. **The rate of progress in providing school improvement services.**

Please refer to the answer to question 3 as this is same issue. The reconfigured regional consortia school improvement services start operating on 1st April 2014, once their business plans have been approved by the Minister for Education and Skills.

The Committee has already received evidence from Estyn in relation to Educational Outcomes for Children from Low Income Households. However, some of the issues identified in the Annual Report were not covered in her evidence in November 2013, so would you be able to provide a note on the following questions on poverty and disadvantage:

1. **The importance of whole school planning**;

Whole-school planning is crucial to tackling the effects of poverty. In our 2012 report 'Effective practice in tackling poverty and disadvantage in schools' we identified ten strategies that effective schools employed and noted whole-school planning as a top priority (the report is available on our website at http://www.estyn.gov.uk/download/publication/259977.9/effective-practice-in-tackling-poverty-and-disadvantage-in-schools-november-2012/) In particular, we found:

"that schools that raise the achievement of disadvantaged learners understand well the needs of these learners and the potential barriers to their progress in learning. We found that many headteachers believed that tackling disadvantage was implicit in their planning. However, schools that successfully raise the achievement of disadvantaged learners take a strategic and systematic approach to tackling the issues of poverty and disadvantage. This approach includes an explicit plan, with focused and quantifiable targets for achievement, and detailed operational proposals.

Successful schools emphasise raising the achievement of disadvantaged learners in their strategic planning. There is a consistent reference in school policy documents to tackling poverty and disadvantage. They have specific and measurable targets to improve outcomes for disadvantaged learners. In this way, these schools have a structured, cohesive and focused approach to raising the achievement of disadvantaged learners.

Effective schools in challenging circumstances use a range of strategies that particularly suit their individual context. They introduce processes that are targeted at the particular needs of the disadvantaged learners in their schools. The strength of

their planning is that the strategies are interrelated and provide a holistic, whole-school approach to tackling the key issues that affect disadvantaged learners."

2. **Training for staff in alleviating the effects of poverty on learners;**

Taking a whole-school approach to tackling the impact of poverty requires that all school staff understand the school's approach. The report quoted above also says:

"Many headteachers identify lack of staff commitment to raising the achievement of disadvantaged learners as a key barrier to overcome in tackling issues of poverty and disadvantage. These headteachers have found that staff training and development are needed to tackle this issue. Most successful schools invest significantly in developing the skills of leaders, teachers, support staff and governors to improve outcomes for disadvantaged learners. These schools understand well the specific needs of their learners and identify professional development opportunities that meet the particular needs of learners in their schools.

In terms of teaching, a focus on improving differentiation has had the most impact in schools that are effective in tackling poverty and disadvantage. Successful schools use their data-tracking systems to identify the specific needs of their disadvantaged learners and ensure that all staff can access information about individual learners. In many successful schools, teachers regularly re-examine teaching approaches, such as lesson-planning, to meet the needs of their disadvantaged learners.

Many of the successful schools have a strong culture of sharing good practice, both within and outside the school. These schools provide plenty of opportunities for teachers to observe one another and to share approaches to planning across the school. They have spent time on developing whole-school approaches in such areas as approaches to teaching literacy skills, promoting emotional wellbeing and raising boys' achievement. They have also identified training opportunities for staff to develop specialist skills such as those in play therapy or anger management.

Nearly all the successful schools use performance management processes to improve the standards and wellbeing of their disadvantaged learners. In these schools, all staff have specific and measurable improvement targets that are related to the school target of raising the achievement of disadvantaged learners. This makes all staff accountable for raising the achievement of disadvantaged learners and helps these schools to evaluate their progress."

3. **Leadership development opportunities.**

"Of the five secondary schools with excellent performance inspected this year, three have about a quarter or more of their pupils entitled to free schools meals and these pupils perform well. This is because the schools concerned take a whole-school, strategic approach to tackling disadvantage.

A common feature of these schools is strong leadership. Strong headteachers lead a structured, coherent and focused approach to closing the poverty gap by developing the expertise of staff, strengthening community links and engaging parental support."

Foreword Annual Report 2011-2012

“The multiple strands of a team approach to disadvantage should go beyond the school to include its local authority and regional consortia as well as relevant external organisations, specialist services and agencies, such as youth, health and social services. Establishing mutual understanding and aligning initiatives so they all pull in the same direction are key elements of this process.

High-level leadership skills are required for setting up these networks of agencies, enabling them to collaborate, and getting co-operation to achieve common goals. Currently, there are not enough leadership development opportunities available for headteachers and other senior school leaders to help them develop these leadership skills. Leaders lack a one-stop-shop of leadership expertise that they can call on for guidance and informal advice, sourcing of training courses, and the matching of partners for coaching and mentoring.”

Foreword Annual Report 2012-2013

The above quotes show that leadership is an important factor in reducing the effect of poverty. The last paragraph suggests that there have been insufficient leadership development opportunities. There are advantages to setting up a ‘one-stop shop’ for leadership development opportunities such as a national college of leadership.