Public Document Pack

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 7 June 2016
TIME:	4.00 pm
VENUE:	Reception Room, Barnsley Town Hall

AGENDA

5 BCF Plan 2016/17 (HWB.07.06.2016/5) *(Pages 3 - 32)*

8 Mental Health Strategy, Action Plan and 'You Said, We Listened' Report (HWB.07.06.2016/8) *(Pages 33 - 124)*

11 Accountable Care Partnership (HWB.07.06.2016/11) *(Pages 125 - 128)*

To: Chair and Members of Health and Wellbeing Board:-

Councillor Sir Steve Houghton CBE, Leader of the Council (Chair)
Councillor Jim Andrews BEM, Deputy Leader
Councillor Margaret Bruff, Cabinet Spokesperson - People (Safeguarding)
Councillor Jenny Platts, Cabinet Spokesperson - Communities
Diana Terris, Chief Executive
Rachel Dickinson, Executive Director People
Wendy Lowder, Interim Executive Director Communities
Julia Burrows, Director Public Health
Nick Balac, NHS Barnsley Clinical Commissioning Group
Lesley Smith, NHS Barnsley Clinical Commissioning Group
Tim Innes, South Yorkshire Police
Emma Wilson, NHS England Area Team
Adrian England, HealthWatch Barnsley
Steven Michael OBE, South West Yorkshire Partnership NHS Foundation Trust
Richard Jenkins, Barnsley Hospital NHS Foundation Trust

Please contact Peter Mirfin on 01226 773147 or email governance@barnsley.gov.uk

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REPORT TO THE HEALTH AND WELLBEING BOARD

7 June 2016

Better Care Fund Plan 2016/17

Report Sponsor: Lesley Smith/Rachel Dickinson
Report Author: Jamie Wike
Received by SSDG:
Date of Report: 22 March 2016

1. Purpose of Report

1.1 To provide the Board with an update on contents of the Better Care Fund Plan for 2016/17 along with a copy of the final draft plan submitted on the 21 March 2016 for assurance.

2. Recommendations

2.1 Health and Wellbeing Board members are asked to:-

- Note the contents of the report along with the Better Care Fund Planning Submission Template and supporting narrative and agree that any amendments to the plan as a result of the assurance process be agreed and signed off by the Chair and Vice Chair of the Board.

3. Introduction/ Background

3.1 The Better Care Fund 2016/17

3.2 Following confirmation during late 2015 that the BCF would continue into 2016/17, the Department of Health and Department for Communities and Local Government published the '2016/17 Better Care Fund' Policy Framework in December 2015. This was followed by more detailed planning guidance on 24 February 2016.

3.3 Alongside the guidance, the Better Care Fund allocations were also published. As anticipated the total minimum requirement for the fund is at a similar level to 2015/16. The total value of the fund in 2016/17 will be £20,594k (£20,374k in 2015/16). £2,331k of this is provided from grants made directly to the Local Authority for Disabilities Facilities and the remaining £18,358k is provided from the CCG baseline allocation.

3.4 The BCF policy framework and guidance included details of proposed changes including the introduction of two new national conditions and the removal of the mandatory requirement for a payment for performance framework based upon delivery of the target to reduce emergency admissions. The two new national standards are:

- Investment in NHS Commissioned out-of-hospital services
- Agreement of a local action plan to reduce delayed transfers of care (DTOC) and improve patient flow

3.5 The Board approved the proposed approach to BCF planning and the proposal to roll forward the 2015/16 Plan as appropriate at the meeting on 5 April 2016. This approach was proposed to allow the BCF to continue into 2016/17 whilst the broader approach to transformation and integration is considered, developed and included as part of the refresh of the Health and Wellbeing Strategy and the development of other associated plans such as the Sustainable Transformation Plan for Health and Care across South Yorkshire and Bassetlaw and the Barnsley Integrated Transformation Plan. The Board also agreed that the plan from 2015/16 be updated to reflect the new national conditions and the removal of the payment for performance element of the fund.

4. 2016/17 Better Care Fund Plan

5.1 In line with the agreed approach to roll forward the plan from 2015/16, updated as appropriate to reflect required changes, the current BCF plan remains relevant and continues to describe the BCF plans in Barnsley. The planning guidance for 2016/17 required the submission of a BCF planning submission template by 21 March 2016. This was submitted for assurance along with a supporting narrative which describes the changes from the 2015/16 plan and details how the new national conditions are to be achieved. The final BCF planning submission template for 2016/17 and the supporting narrative are attached as appendix 1 and 2.

5.2 The BCF 2016/17 Headline Narrative (Attached at Appendix 2) provides a description of how each of the national conditions will be met, linking back into the original BCF plan and providing an update where changes have been made and where new conditions have been introduced. This includes information in relation to:

- How plans have been jointly agreed;
- How provision of social care services will be maintained;
- Details of the approach to delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate;
- How data sharing between health and social care, based on the NHS number will be improved;
- The approach to joint approach to assessments and care planning;

- The agreed investment in NHS commissioned out-of-hospital services;
- The agreed local action plan to reduce delayed transfers of care and deliver the BCF target.

5.3 The BCF Planning Submission Template attached at appendix 1 provides details of the funding sources and expenditure plans for the BCF. These are in line with the original BCF plan with updates to reflect slight changes to the overall fund.

5.4 The template also sets out the agreed targets for 2016/17 against the following six key metrics

- Non elective admissions to hospital
- Admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care
- Patient/service user experience of GP and out of hours services
- Proportion of people with long term conditions who feel they are supported to manage their condition

5.4 In 2015/16 the key relating to non-elective admissions to hospital was subject to a stretch target and the payment for performance regime. In 2016/17 the planned level of non elective admissions to hospital is in line with the CCG plans for non elective activity and takes account of underlying trends which resulted in continued increases in the level of admissions during 2015/16. The aim is therefore to minimise future increases with growth of no more than 1%.

5.5 For each of the other key metrics the targets for the BCF are in line with the Council's Corporate Plan targets and CCG planning targets, aiming to continue to improve performance from 2015/16.

6. Conclusions

6.1 The Board are asked to note the contents of the report along with the Better Care Fund Planning Submission and supporting narrative and agree that any amendments to the plan as a result of the assurance process be agreed and signed off by the Chair and Vice Chair of the Board.

Officer: Jamie Wike **Contact:** 01226 433702 **Date:** 31/05/16

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Template for BCF submission 3: due on 03 May 2016

Better Care Fund 2016-17 Planning Template

Sheet: 1. Cover Sheet

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board (HWB) on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

All data that has been pre-populated in the yellow cells has been taken from submission 2 templates submitted by Health and Well-Being Boards, where a submission 2 template was not received the submission 1 data has been used instead."

On the cover sheet please enter the following information:
- The Health and Wellbeing Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the CCGs and Local Authority in the HWB area. Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 6 cells are green should the template be sent to england.bettercaresupport@nhs.net

You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

ase prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for ich it is provided.

resents a summary of the first BCF submission and a mapped summary of the NEA activity plans received in the second iteration of the "CCG NHS ared Planning Process".

Health and Well Being Board	**Barnsley**
completed by:	Jamie Wike
E-Mail:	jamie.wike@nhs.net
Contact Number:	01226 433702
Who has signed off the report on behalf of the Health and Well Being Board:	Rachel Dickinson and Lesely Jane Smith

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
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Template for BCF submission 3: due on 03 May 2016

Sheet: 2. Summary of Health and Well-Being Board 2016/17 Planning Template

Selected Health and Well Being Board:

Barnsley

Data Submission Period:

2016/17

2. Summary and confirmations

This sheet summarises information provided on sheets 2 to 6, and allows for confirmation of the amount of funding identified for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please enter the following information:
- In cell E37 ,please confirm the amount allocated for ongoing support for adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from information provided in the 'HWB Expenditure Plan' tab. If this is the case then cell F37 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F47 please indicate the total value of funding held as a contingency as part of local risk share, if one is being put in place. For guidance on instances when this may be appropriate please consult the full BCF Planning Requirements document. Cell F44 shows the HWB share of the national £1bn that is to be used as set out in national condition vii. Cell F45 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F49 will show any potential shortfall in meeting the financial requirements of the condition. The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary of the return.

3. HWB Funding Sources

	Gross Contribution
Total Local Authority Contribution	£2,330,936
Total Minimum CCG Contribution	£18,263,441
Total Additional CCG Contribution	£0
Total BCF pooled budget for 2016-17	**£20,594,378**

Specific funding requirements for 2016-17	Select a response to the questions in column B
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	Yes
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes

4. HWB Expenditure Plan

Summary of BCF Expenditure (*)

	Expenditure
Acute	£1,700,000
Mental Health	£0
Community Health	£6,718,000
Continuing Care	£0
Primary Care	£0
Social Care	£12,176,378
Other	£0
Total	**£20,594,378**

Please confirm the amount allocated for the protection of adult social care	If the figure in cell E37 differs to the figure in cell C37, please indicate the reason for the variance.
Expenditure	
£12,176,378	

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool (**)

	Expenditure
Mental Health	£0
Community Health	£6,718,000
Continuing Care	£0
Primary Care	£0
Social Care	£0
Other	£0
Total	**£6,718,000**

BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share

	Fund
Local share of ring-fenced funding	£5,189,952
Total value of NHS commissioned out of hospital services spend from minimum pool	£6,718,000
Total value of funding held as contingency as part of local risk share to ensure value to the NHS	£0
Balance (+/-)	**£1,528,048**

5. HWB Metrics

5.1 HWB NEA Activity Plan

	Q1	Q2	Q3	Q4	Total
Total HWB Planned Non-Elective Admissions	8,182	7,687	8,023	7,895	31,787
HWB Quarterly Additional Reduction Figure	0	0	0	0	0
HWB NEA Plan (after reduction)	8,182	7,687	8,023	7,895	31,787
Additional NEA reduction delivered through the BCF					£0

5.2 Residential Admissions

		Planned 16/17
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	675.8

5.3 Reablement

		Planned 16/17
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Annual %	86.0%

5.4 Delayed Transfers of Care

		Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	146.5	147.0	146.5	145.6

5.5 Local performance metric (as described in your BCF 16/17 planning submission 2 return)

	Metric Value Planned 16/17
Proportion of people who feel they are supported to manage their long term conditions	70.0

5.6 Local defined patient experience metric (as described in your BCF 16/17 planning submission 2 return)

	Metric Value Planned 16/17
The proportion of people reporting poor experience of General Practice and Out-of-Hours Services (average number of negatives reponse per 100 patients) Numerator and Denominators are not available on the Levels of Ambition Atlas.	5.3

6. National Conditions

National Conditions For The Better Care Fund 2016-17	Please Select (Yes, No or No - plan in place)
1) Plans to be jointly agreed	Yes
2) Maintain provision of social care services (not spending)	Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes
4) Better data sharing between health and social care, based on the NHS number	Yes
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes

Footnotes

* **Summary of BCF Expenditure** is the sum of the self-reported HWB amounts allocated to the 7 different 'areas of spend' that have been provided by HWBs in their plans (from the HWB Expenditure Plan tab), where:

Area of Spend = Acute, Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other

** **Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool** is the sum of the amounts allocated to the 6 individual out of hospital 'areas of spend' that have been provided in tab 4. HWB Expenditure Plan, where;
Area of Spend = Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other (everything other than Acute)
Commissioner = CCG, NHS England or Joint (if joint we use the NHS% of the value)
Source of Funding = CCG Minimum Contribution

Template for BCF submission 3: due on 03 May 2016

Sheet: 3. Health and Well-Being Board Funding Sources

Selected Health and Well Being Board:

Barnsley

Data Submission Period:

2016/17

3. HWB Funding Sources

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

These cannot be changed. The sheet also requests a number of confirmations in regard to the funding that is made available through the BCF for specific purposes.
On this tab please enter the following information:
- Please use rows 16-25 to detail Local Authority funding contributions by selecting the relevant authorities and then entering the values of the contributions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box in column E to detail how contributions are made up or to allow contributions from an LA to split by funding source or purpose if helpful. Please note, only contributions assigned to a Local Authority will be included in the 'Total Local Authority Contribution' figure.
- Please use cell C42 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 45 to 54 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C. There is a comment box in column E to detail how contributions are made up or any other useful information relating to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contribution' figure. - Cell C57 then calculates the total funding for the Health and Wellbeing Board, with a comparison to the 2015-16 funding levels set out below. - Please use the comment box in cell B61 to add any further narrative around your funding contributions for 2016-17, for example to set out the driver behind any change in the amount being pooled.The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

cal Authority Contribution(s)	Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
rnsley	£2,330,936	This represents the DFG allocation.
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
Total Local Authority Contribution	**£2,330,936**	

CCG Minimum Contribution	Gross Contribution
NHS Barnsley CCG	£18,263,441
Total Minimum CCG Contribution	**£18,263,441**

Are any additional CCG Contributions being made? If yes please detail below;	No

Additional CCG Contribution	Gross Contribution
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
Total Additional CCG Contribution	**£0**

Comments - please use this box clarify any specific uses or sources of funding

Total BCF pooled budget for 2016-17	**£20,594,378**

Funding Contributions Narrative
Contributions are set at minimum as per national allocations announcement.

The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

Specific funding requirements for 2016-17	**Select a response to the questions in column B**	**Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.**
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	Yes	
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	

4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	

Template for BCF submission 3: due on 03 May 2016

Sheet: 4. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:
Barnsley

Data Submission Period:
2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.
On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

										Expenditure		
Scheme Name	Scheme Type (see table below for descriptions)	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	if Joint % NHS	if Joint % LA	Provider	Source of Funding	2016/17 Expenditure (£)	New or Existing Scheme	Total 15-16 Expenditure (£) (if existing scheme)
Support for 7 day working services	7 day working		Acute		CCG			NHS Acute Provider	CCG Minimum Contribution	£1,700,000	Existing	£1,700,000
Intermediate Care Services	Intermediate care services		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£6,718,000	Existing	£6,718,000
Reablement and Social Services	Reablement services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£3,246,000	Existing	£3,246,000
Maintaining Eligibility Criteria for Social Care (Core Service)	Other	Social Care	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£3,501,000	Existing	£3,501,000
Maintaining Eligibility Criteria for Social Care (Demographics)	Other	Social Care	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£1,244,000	Existing	£1,244,000
Additional Reablement Funding	Reablement services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£49,000	Existing	£49,000
Disabilities Facilities	Assistive Technologies		Social Care		Local Authority			Local Authority	Local Authority Social Services	£2,331,000	Existing	£2,016,000
Provision of Funding to Carer's Groups	Support for carers		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£51,000	Existing	£51,000
Short-Term Residential Care	Support for carers		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£710,000	Existing	£710,000
Care Act Implementation	Other	Social Care	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£700,000	Existing	£700,000
Intermediate Care Services	Improving healthcare services to care homes		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£344,378	Existing	£439,000

Template for BCF submission 3: due on 03 May 2016

Sheet: 5. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:
Barnsley

Data Submission Period:
2016/17

5. HWB Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

5.1 HWB NEA Activity Plan

- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)

Contributing CCGs	% CCG registered population that has resident population in Barnsley	% Barnsley resident population that is in CCG registered population	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total (Q1 - Q4)	
			CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**
NHS Barnsley CCG	94.4%	98.2%	8,539	8,061	8,016	7,568	8,368	7,900	8,235	7,774	33,158	31,304
NHS Doncaster CCG	0.3%	0.3%	9,391	25	9,494	25	9,494	25	9,287	25	37,666	100
NHS Greater Huddersfield CCG	0.2%	0.2%	6,352	11	6,347	11	6,594	12	6,445	12	25,738	46
NHS Rotherham CCG	0.3%	0.3%	6,960	21	6,733	20	7,231	22	7,010	21	27,934	85
NHS Sheffield CCG	0.2%	0.4%	13,672	23	13,324	23	13,940	24	13,399	23	54,335	93
NHS Wakefield CCG	0.4%	0.6%	10,533	40	10,533	40	10,533	40	10,534	40	42,133	159
		100%	**55,447**	**8,182**	**54,447**	**7,687**	**56,160**	**8,023**	**54,910**	**7,895**	**220,964**	**31,787**

anning on any additional quarterly reductions?	No							
ase complete HWB Quarterly Additional Reduction Figures								
arterly Additional Reduction Figure								
A Plan (after reduction)								
arterly Plan Reduction %								

Are you putting in place a local risk sharing agreement on NEA?	No
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share ***	£5,189,952
Cost of NEA as used during 15/16 ****	£2,216
Cost of NEA for 16/17 ****	

Please add the reason, for any adjustments to the cost of NEA for 16/17 in the cell below.

Additional NEA reduction delivered through the BCF								
HWB Plan Reduction %								

* This is taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level, extracted on 12th April 2016.

** This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)

*** Within the sum subject to the condition on NHS out of hospital commissioned services/risk share, for any local area putting in place a risk share for 2016/17 as part of its BCF planning, we would expect the value of the risk share to be equal to the cost of the non-elective activity that the BCF plan seeks to avoid. Source of data: https://www.england.nhs.uk/wp-content/uploads/2016/02/bcf-allocations-1617.xlsx

**** Please use the following document and amend the cost if necessary in cell E54. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477919/2014-15_Reference_costs_publication.pdf

5.2 Residential Admissions

- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15*****	Planned 15/16*****	Forecast 15/16	Planned 16/17	Comments
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	697.5	628.7	657.8	675.8	Our approved target for 2016/17 is a rate of 675 admissions per 100,000, which based on the population estimated below equates to 308 admissions. This appears to reflect a slight increase in planned admissions from 2015/16 however this is to reflect changes to the calculation. Historically where a person comes out of residential or nursing care within a set time period these have not been counted as permanent admissions. The figures will now include all cases where there is an 'intention to admit permanently' and therefore, based on current rates this would mean an increase of around 5% so the 16/17 target is in effect set to maintain current rates
	Numerator	307	281	294	308	
	Denominator	44,015	44,694	44,694	45,574	

*****Actual 14/15 & Planned 15/16 collected using the following definition - 'Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population'. Any numerator less than 6 has been supressed in the published data and is therefore showing blank in the numerator and annual rate cells above. These cells will also be blank if an estimate has been used in the published data. Planned 15/16 rate has been amended for 6 HWBs to show the rate as calculated by using the numerator and denominator shown in the table.

5.3 Reablement

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15*****	Planned 15/16	Forecast 15/16	Planned 16/17	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	81.8%	85.0%	85.0%	86.0%	We are currently forecasting to achieve the 2015/16 target and work is ongoing to finalise year end performance.
	Numerator	165	170	241	244	
	Denominator	205	200	283	283	

*****Any numerator or denominator less than 6 has been supressed in the published data and is therefore showing blank in the cells above. These cells will also be blank if an estimate has been used in the published data.

5.4 Delayed Transfers of Care

- Please use rows 93-95 (column L for Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figures in cells L94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells L93-P93. Please add a commentary in column Q to provide any useful information in relation to how you have agreed this figure.

		15-16 plans				15-16 actual (Q1, Q2 & Q3) and forecast (Q4) figures				16-17 plans				
		Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	183.6	224.4	54.6	127.0	126.8	231.3	212.7	228.7	146.5	147.0	146.5	145.6	2016/17 plans are for DTO to be in line with the level set out in the target for 2015/16
	Numerator	346	423	103	241	239	436	401	434	278	279	278	278	
	Denominator	188,489	188,489	188,489	189,785	188,489	188,489	188,489	189,785	189,785	189,785	189,785	190,962	

5.5 Local performance metric (as described in your BCF 16/17 planning submission 2 return)

- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your BCF 16-17 planning submission 2 template - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
Proportion of people who feel they are supported to manage their long term conditions	Metric Value	70.0	70.0	Based on the most recent performance period the planned performance in 2015/16 is unlikely to be achieved however this remains an important area of work and therefore the target will be retained for 2016/17
	Numerator	1,208.0	1,208.0	
	Denominator	1,725.0	1,725.0	

cal defined patient experience metric (as described in your BCF 16/17 planning submission 2 return)

y also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your BCF 16-17 planning submission 2 template - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
rtion of people reporting poor experience of General Practice and Out-of-Hours Services (average number of negatives reponse per 100 patients)	Metric Value	5.3	5.3	The baseline used for originally setting the target for this measure was 2012/13 and performance was 5.3. This was positive compared to comparator CCG's and therefore the aim was to maintain performance. When the 2013/14 survey results were published this showed that prior to commencement of the BCF the performance had dropped to 7.3 meaning to achieve the target over the 2 year period would require substantial improvment and that as the measure is based on experience, the actions being taken would be unlikely to have immediate impact upon responses to the patient survey. The BCF target set out for 2015/16 is unlikely to be achieved however the ongoing investment in and development of primary care are expected to have a positive impact and therefore the target has been retained for 2016/17.
Numerator and Denominators are not available on the Levels of Ambition Atlas.	Numerator	0.0	0.0	
	Denominator	0.0	0.0	

Template for BCF submission 3: due on 03 May 2016

Sheet: 6. National Conditions

Selected Health and Well Being Board:

Barnsley

Data Submission Period:

2016/17

6. National Conditions

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework and further guidance is provided in the BCF Planning Requirements document. Please answer as at the time of completion. On this tab please enter the following information:

- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017.
- Please use column C to indicate when it is expected that the condition will be met / agreed if it is not being currently.
- Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.

National Conditions For The Better Care Fund 2016-17	Does your BCF plan for 2016-17 set out a clear plan to meet this condition?	Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.
1) Plans to be jointly agreed	Yes	
Maintain provision of social care services (not spending)	Yes	
Agreement for the delivery of 7-day services across health and social care to prevent necessary non-elective admissions to acute settings and to facilitate transfer to rnative care settings when clinically appropriate	Yes	
4) Better data sharing between health and social care, based on the NHS number	Yes	
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	

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Barnsley Health and Wellbeing Board

Better Care Fund 2016/17 – Headline Narrative

The 2016/17 Better Care Fund (BCF) in Barnsley is a continuation of the plans from 2014/15 and 2015/16 reflecting the original principles that the BCF is part of the wider system wide transformation. This narrative is therefore intended to be read alongside the current BCF plan and provide an update on developments and the plans to meet the additional conditions of the BCF introduced for 2016/17.

Overall planning for 2016/17 is taking account of the changing landscape and ensuring the alignment to developing the Sustainable Transformation Plan (STP) for South Yorkshire and Bassetlaw and the Barnsley Integrated Transformation Plan which will underpin delivery of the wider STP.

The original Better Care Fund Plans for Barnsley were signed off by the Health and Wellbeing Board and the plan to retain the current plans as outlined above have been agreed by the Health and Wellbeing Board along with the updates included in this narrative ensuring ongoing support and sign up to delivery of the plan in the context of the wider planning arrangements by all partners.

The Vision for Health and Care Services in Barnsley

In Barnsley the Better Care Fund (BCF) is set in the context of the wider Health and Wellbeing Strategy and Vision and is seen as one strand in helping to deliver a transformation of the health and care system across the Borough. Unless considered in this context the BCF would not be able to have the impact that we would like to see across the whole system.

The Barnsley Health and Wellbeing Strategy 2014-19 was developed in this context and describes how collectively the key agencies are working better together to ensure the health and care system is delivering improved health and wellbeing outcomes for the people of Barnsley.

The strategy sets out the strategic vision for health and wellbeing over the 5 year period to 2018/19. It describes what is being done to improve health and care outcomes for Barnsley people and how the work of the health and care system will deliver improvements against national outcomes whilst driving up quality, experience and meeting the needs and expectations of local people. In delivering the strategy the Health and Wellbeing Board will also ensure that activity is integrated with that included in NHS plans for areas such as public health, primary care and specialised health services as well as wider social care.

Whilst the Health and Wellbeing Strategy remains current, it is being reviewed and refreshed as part of the 2016/17 planning arrangements and will be published alongside the STP and Integrated Transformation Plan for Barnsley.

The current Health and Wellbeing Vision for Barnsley is:

"Barnsley residents, throughout the borough, lead healthy, safe and fulfilling lives and are able to identify, access, direct and manage their individual health and wellbeing needs, support their families and communities and live healthy and independent lifestyles"

The ongoing review of the Health and Wellbeing Strategy has resulted in a proposal to refine the overall vision. The revised vision is still to be agreed however the current proposal sets out the vision as:

"People take control of their health & wellbeing, (able to access integrated services) and enjoy happy healthy and longer lives, in safer and stronger communities, regardless of who they are and wherever they live"

The focus of the revised strategy will be for communities, the public sector and other organisation's to work together to ensure:

- Children start live healthy and stay healthy
- People live longer, healthier lives
- People live in strong and resilient communities
- People have improved mental health and wellbeing
- Health Inequalities are reduced

The strategy will be underpinned by clear shared principles based around strong partnership working (with local people and communities), building on our strengths, reducing duplication and increasing efficiency and focussing on making a difference. The strategy will also describe how we will deliver system wide objectives to upgrade prevention, embed a culture of integrated care, ensure system resilience and accelerate the implementation of key system enablers to support transformation.

We recognise that in many cases, achieving improved health and wellbeing outcomes is a longer term ambition requiring a reorientation of current systems towards prevention and addressing the wider determinants of good health and the recently published Public Health Strategy 2016-2018 set out the approach to addressing the local public health priorities in Barnsley.

We are however also clear that service integration can make a significant contribution to those longer term ambitions whilst delivering better outcomes for service users and a much improved patient/service user experience and we intend to use the BCF as a catalyst for change.

Our approach therefore continues to be one of pathway integration and redesign rather than necessarily structural integration in line with our original Pioneer Integrated Care and Support proposals to fundamentally shift the focus from statutory health and care agency interventions, to more holistic engagement and a citizenship approach at individual, family and community level.

The provision of information, advice and signposting, is key alongside access to flexible and integrated service pathways which support people to maintain control and enable self-management wherever possible, including through improved access to telecare and other equipment and adaptations which allow people to remain independent and safe. Based on

an asset, not a deficit model to create social value, we are confident that this will bring about the change required across Barnsley communities based on engagement and behaviour change, both in professionals and those in receipt of services.

The Evidence Base

The evidence base for the Barnsley BCF plan is set out in sections 1 and 3 of the original BCF plan particularly in relation to the population needs and the financial challenges faced across the health and care economy. Further work has taken place to understand the population needs and financial challenges building on the JSNA and other data sources and this has fed into planning processes for 2016/17 and informing our plans however many of the challenges remain consistent. This is particularly the case in relation to longer term health needs of the Borough and health inequalities.

Life expectancy is a clear example, whilst overall life expectancy has been increasing slightly over recent years with the gap between Barnsley and the national average 1.3 years for men and 1.5 years for women, the health life expectancy for both men and women has actually reduced over the last 5 years. Healthy life expectancy for men is 56.3 years compared to the national average of 63.3 years (7 years less) and for women it is 56.2 years compared to 63.9 years (7.7 years less). There is also a marked difference within the borough with life expectancy still significantly lower in the most deprived communities.

Key health factors contributing to the gap in life expectancy remain consistent with circulatory disease, cancer and respiratory diseases being among the main contributors to the gap in life expectancy.

The need to address the health inequalities and improve health outcomes is clear in our overall approach to planning, with a clear focus on prevention and embedded in the revised aims of the Health and Wellbeing Strategy.

Over the period of the original BCF plans (2014/2016) the number of emergency admissions to into hospital and numbers overall accessing urgent care have continued to increase and therefore, alongside prevention, we will continue to focus on delivery of the schemes which are intended to reduce pressures on the urgent care system, ensure people have access to the right care at the right time and in the right place and supporting people to live independently in their own homes.

Many of the schemes identified in our better care fund plans remain ongoing developments with evaluation planned during 2016/17 to inform future developments. There have however been some successes already during 2015/16 with one example being the introduction of Rightcare Barnsley (care co-ordination centre) to support health care professionals including GP's to identify alternative packages of care for patients at risk of an urgent hospital admission, thereby avoiding admission where this is not the most appropriate care for the individual. This has seen up to 35% of referrals for hospital admission being provided with an out of hospital package of care.

As there are no new schemes included in the BCF for 2016/17 and work is taking place to pull all transformation and integration into the integrated transformation plan for Barnsley there are currently no significant risks identified with delivery of the plan in 2016/17.

A Co-ordinated and Integrated Plan

Governance Arrangements

Section 6 of the original BCF plan set out how the BCF aligns with other plans and how our planning process ensure the alignment between organisational plans, the BCF and the H&WB Strategy.

The strategic governance arrangements for the Better Care Fund remain the same as over the last 2 years with oversight being provided by the SSDG and responsibility for the plan ultimately sitting with the Health and Wellbeing Board. The section 75 agreement which will be updated to reflect changes in 2016/17 sets out the detailed management arrangements for the BCF plan. There have however been some changes to the supporting governance infrastructure particularly the programme board structures described in section 2c of the original BCF plan.

There were originally six programme boards which operated under the auspices of the Health and Wellbeing Board. Three sat within the 'Stronger Barnsley Together' Programme and the other three were more focussed on clinical delivery and transformation and were health led Boards focussed in delivering the transformation plans and priorities set out in the CCG strategic commissioning plan. The work of all the programme boards contributed to delivery of the BCF Plan and the wider Health and Wellbeing Strategy.

A review of the programme board structures and the 'Stronger Barnsley Together' Programme was undertaken in 2015 resulting in the programme boards being disbanded. A Clinical Transformation Board (CTB) was established and first met in June 2015, providing a simpler structure with strong clinical leadership and for the delivery of health and care led transformation. The CTB is a CCG Board however it is also attended by senior representatives from BMBC (Director of Public Health and Director of People) and the Medical Directors of Barnsley Hospital NHS Foundation Trust and South West Yorkshire Partnership NHS Foundation Trust as the main providers of Acute, Community and Mental Health Services for Barnsley residents.

The key functions of the Clinical Transformation Board are:

- Service transformation
- Pathway redesign
- Commissioning for improved outcomes
- Quality improvement through service redesign
- Reducing health inequalities and prevention
- Providing clinical leadership to integrated commissioning and service transformation
- Evaluation of transformation programmes, ensuring benefits realisation and informing future years commissioning.

More recently, building on the work which has been undertaken to develop stronger and more resilient communities, a new partnership Board has been established which will oversee much of the work previously linked to the Stronger Barnsley Together Programme. The multi-agency Stronger Communities Partnership brings together responsible authorities, statutory and voluntary services, and local people to provide system-wide leadership to the community and early help offer. The Stronger Communities Partnership acts as the executive body for activity being delivered across: Early Help; Anti-poverty; and Strong, resilient & healthy communities.

The Stronger Communities Partnership membership consists of the following agencies:

- Barnsley Metropolitan Borough Council
- The Health and Wellbeing Board - Provider Forum
- South Yorkshire Police
- Berneslai Homes
- NHS Barnsley Clinical Commissioning Group
- Voluntary Action Barnsley
- Health Watch
- Barnsley Healthcare Federation
- South West Yorkshire Partnership Foundation Trust

The partnership's priorities will be progressed through three Delivery Groups:

- Resilient and Healthy Communities - key themes will include volunteering and social action, behaviour change, Be well Barnsley, activity focussed on stronger resilient communities, area councils (evaluation), market development (Provider dimension), Social Value Toolkit, current view of VCS.
- Early Help and Prevention - having a focus on early help for adults, children and families. The complexity of existing arrangements has promoted a twin track approach to the Early Help aspect of the work; ensuring that the more progressed activity associated with children and families can continue while the emerging activity associated with communities and a universal offer can be developed effectively. Key themes will include Think Family, Troubled Families, Supporting People, Substance Misuse, Housing Advice, Domestic Violence, Offenders.
- Anti-Poverty - aligned to the revised anti-poverty delivery plan.

Both the Clinical Transformation Board and the Stronger Communities Partnership will provide updates into the SSDG and to the Health and Wellbeing Board with these including as appropriate updates on schemes which relate to the BCF Plan

There are also other governance structures in place where activities associated with the BCF plan are discussed and agreed, for example the System Resilience Group where action is agreed to ensure resilience across the health and care system. This includes specific activity to reduce pressures on urgent care through the development and delivery of a sustainable system action plan aimed at reducing the numbers accessing urgent care, supporting patient flow through and ensuring timely discharge from care. This plan will link to the DTOC improvement plan and also support the delivery of the planned levels of non-elective hospital admissions included in the CCG and H&W Board plans.

As set out in the introductory paragraph, the BCF planning process and plan is also being aligned to other key plans including the STP, Integrated Transformation Plan and the new Health and Wellbeing Strategy.

The final Better Care Fund Plan 2016/17 will be approved by the Health and Wellbeing Board.

National Conditions

Approach to risk sharing and contingency

In 2015/16 there was a formal risk share arrangement in place between the CCG and the Council based around the planned level of reductions to non-elective admissions to hospital. The purpose of the risk share was to offset the potential financial risk of continuing to fund non-elective admissions should the levels not reduce in line with the BCF plan. In 2015/16 the level of non-elective admissions continued to increase and therefore £1.9m was retained by the CCG in line with the national guidance and the section 75 and risk sharing agreement.

For 2016/17 it has been agreed that whilst every effort will still be made to reduce emergency admissions there will not be a risk share or contingency fund in place as part of the BCF.

The BCF schemes such as Rightcare Barnsley, Intermediate Care and Urgent Care Practitioners which are designed to prevent hospital admission have been taken into account as part of the CCG operational planning however whist these schemes can individually be seen to be delivering benefits they do appear to be avoiding admissions but not reducing the overall admissions as the underlying trends, increasing in people with complex needs and the ageing population are all contributing to higher numbers coming into healthcare services.

Other schemes such as ‘Be Well Barnsley’ are longer term and will not begin to have a positive impact for a number of years and therefore planned growth in non-elective admissions has been included within the CCG operational plan and financial plans.

In line with current arrangements to risk associated with any overspend against the services commissioned through the BCF will remain with the Commissioner.

Joint agreement of plans and engagement

The BCF plan is a jointly agreed plan of the Health and Wellbeing Board. The approach to planning and engagement is included within the original BCF submission and plans for 2016/17 have been agreed in line with this.

The main acute, community and mental healthcare providers and local housing authority are members of the health and wellbeing board and have been engaged in development of all

plans. The H&W Board Provider Forum are also engaged in the planning process to ensure that the wider network of providers are able to influence planning decisions and are aware of potential implications.

As the plan for 2016/17 is a continuation of the original plan the implication for providers is not expected to change and resources are in place to deliver each of the ongoing schemes.

As part of the wider planning and the development of the Barnsley Integrated Transformation Plan which will support the SY&B Sustainability and Transformation Plan, there will be a specific work stream focussed upon ensuring the that the workforce is in place to support the new ways of working and to develop plans for supporting the current workforce to adapt and change.

Maintaining the provision of Social Care

The approach to protecting the provision of social care remains in line with the current BCF plan and the level of funding allocated from the BCF to maintain social care provision is in line with in 2015/16, with some growth to reflect increases in funding in relation to the disabled facilities grant.

Funding also remains in place to support cares and continue to meet the duties resulting from the care and support reforms of the Care Act 2014. Details of this are included within the BCF planning Template.

7 Day Services

The approach to seven day services continues to be in line with the current BCF with the services highlighted in the plan moving towards 7 day provision and meeting the Keogh standards where these relate to acute care.

The specific funding identified to support 7 day services within the Better Care Fund is in line with the agreement in 2014/15 and 2015/16 to support the Acute Trust in moving towards achievement of the Keogh Standards. This funding was always anticipated to be required over a number of years to support transition and ensure the hospital have the required resources to deliver contracted activity until the national tariff payment system covers the cost of 7 day delivery and therefore is continuing in line with agreed plans.

Delivery of the Keogh standards included in contract arrangements with providers is being monitored by the CCG Clinical Quality Board.

7 day social work to support discharge from hospital is also in place (part of SRG plans – CCG funding) with additional capacity deployed to enable timely assessment and access to care packages for patients leaving hospital with continuing social care needs. A review of the impact of this scheme is being undertaken in early 2016/17 to identify the impact of the additional capacity and inform a decision of any required service changes and continued investment through 2016/17.

Better Data Sharing

Data sharing is recognised as an important element of integrating and transforming services in Barnsley. The current BCF sets out the arrangements in place and the governance arrangements to support this.

A key development in 2015/16 has been the introduction of the Medical Interoperability Gateway (MIG) across primary care enabling primary care providers to view (share) GP medical records. This has enabled the IHEART Barnsley Service, which is providing increased primary care capacity and is supported by the Prime Ministers Challenge Fund, to deliver a wide range of GP services from 2 hubs in Barnsley with full access to read patient records and ensure appropriate account can be taken of these when seeing and treating patients. In 2016/17 there are plans to consider the roll out of the MIG to other providers as part of the IT strategy and the implementation of the emerging digital roadmap.

The Digital Roadmap and associated plans is currently being developed alongside the STP and Barnsley Integrated Transformation Plan to ensure IT and Information are effective enables to transformation and integration of services. A key strand of this work will include better access to and sharing of data to improve care planning and delivery.

A joint approach to assessments and care planning

The approach to assessment and care planning continues to be in line with the current BCF. There has been increased focus on care planning through the implementation of the Year of Care approach in primary care and the implementation of Rightcare Barnsley has also supported improvements to care planning through the brokerage service offered to health care professionals which ensures patients have access to the right care at the right time and in the right place – out of hospital where it is safe and appropriate..

Out of Hospital Services

The Better Care Fund in Barnsley is predominantly based around out of hospital services in support of the strategic direction to deliver care closer to home where appropriate. NHS commissioned out of hospital services funded from the BCF is in excess of the previous Payment for Performance element of the fund and is included to ensure continued delivery of intermediate care services to support the urgent care pathways by providing step up and step down services which avoid admission to hospital and ensure timely, well planned discharges avoiding any unnecessary delays.

The review of Intermediate Care which was included within the original BCF resulted in the development of a revised service model which has been implemented as a pilot during 2015/16 and will continue into 2016/17 to enable a full evaluation of the impact and to identify if and how intermediate care services should be commissioned in future. The pilot is currently planned to run until September 2016, with evaluation ongoing during this period and this will be followed by a decision on future commissioning. During 2016/17 the level of funding for Intermediate Care Services has therefore being maintained.

Delayed Transfers of Care

The level of DTOC in Barnsley remains low in comparison to neighbours and levels seen nationally however there have been some increases in the levels of DTOC during 2015/16 and therefore we have set a target for 2016/17 which looks to reduce levels of DTOC back towards the average level in 2014/15. The shared DTOC action plan which is included at appendix 1 sets out the activities which have been agreed to reduce the DTOC level in line with the target.

In developing the plan we have reviewed best practice tools and resources including the High Impact Change Model for managing transfers of care and included actions as appropriate in response to the 8 identified changes. This plan will remain fluid and will be reviewed and amended to reflect performance through the year and ensure it brings together all actions that are aimed at reducing the level of delayed discharges including those identified by the System Resilience Group and included within the Sustainable System Action Plan for Urgent and Emergency Care, those actions and initiatives included in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan and those which are included in the Barnsley Integrated Transformation Plan is in development and will be in place and included in the final BCF plan for 2016 and monitored alongside delivery of the plan by SSDG. There is also a role to play for the Barnsley SRG and therefore the SRG will also be inputting to and contributing to the delivery of the DTOC plan.

National Metrics

The approach to developing the targets for the national metrics is set out in the comments section of the BCF planning return template. The approach is consistent with previously and based on delivering continuous improvement where possible but recognising the current position and challenges faced in 2015/16 and expected in 2016/17.

In relation to non-elective admissions, no additional level of reduction in included in the BCF plan as the level set out in the CCG operational planning template is reflective of recent trends and all expected changes as a result of service changes, transformation and policy changes. This includes the impact of services funded through the BCF as well as other initiatives as part of the wider system transformation plans. The level of activity included within plans is included within financial plans and contracts and will therefore be proactively monitored and managed as part of BCF performance reporting as well as through the CCG contract management and reporting processes.

The target relating to the long term support needs of older people by admission to residential and nursing care homes has been agreed at a rate of 675 admissions per 100,000, which based on the population estimates would equate to 308 admissions during the year. This appears to reflect a slight increase in planned admissions from 2015/16 however this is to reflect changes to the calculation following discussions across the region to ensure consistency in applying the definitions of Adult Social Care Outcome Framework measures. Historically where a person comes out of residential or nursing care within a set time period these have not been counted as permanent admissions. The figures will now include all cases where there is an ‘intention to admit permanently’ and therefore, based on current

rates this would mean an increase of around 5% so the 16/17 target is in effect set to maintain current rates.

There has been a change in focus locally around reablement aimed at assessing the outcomes at the end of reablement rather than just focussing on the 91 day measure as there are many reasons why someone may not remain at home after 91 days. There does however continue to be a desire to help people to maintain their independence at home and therefore a target has been set which aims to continue to improve the proportion of people still at home after 91 days.

The rationale for the target for delayed transfers of care is set out in the section above with the target being to reduce the level of DTOC back towards the levels in 2014/15.

The local measures included in the BCF reflect local plans and targets included as part of operational plans and are retained to ensure a continued focus upon these areas particularly given that initial targets have not yet been achieved.

Barnsley Better Care Fund Delayed Transfers of Care (DTOC) Action Plan 2016/17

Introduction

The Barnsley the Better Care Fund (BCF) Plan 2016/17 is set in the context of the wider Health and Wellbeing Strategy and Vision and is seen as one strand in helping to deliver a transformation of the health and care system across the Borough. Unless considered in this context the BCF would not be able to have the impact that we would like to see across the whole system.

Overall planning for 2016/17 is taking account of the changing landscape and ensuring the alignment to developing the Sustainable Transformation Plan (STP) for South Yorkshire and Bassetlaw and the Barnsley Integrated Transformation Plan which will underpin delivery of the wider STP.

The DTOC action plan has been developed in the same context, recognising that the work to deliver the STP and the Urgent and Emergency Care Network Plan will have an impact upon patient flows and patterns of activity across the system, the DTOC plan builds upon the good work already taking place and the improvements which have been made to services during the last few years.

The level of DTOC in Barnsley remains low in comparison to neighbours and levels seen nationally across both NHS and Social Care. The BCF schemes such as the introduction of Rightcare Barnsley, the new target operating model in social care alongside some of the additional capacity which has been supported through the System Resilience Group such as increased social care assessment capacity over 7 days, enhanced intermediate care bed capacity and increased therapy support have helped to maintain this positive performance. There have however been increases in the levels of DTOC during 2015/16 and therefore the DTOC action plan aims to deliver some additional improvements which will reduce the number of delays during 2016/17.

In the context of the recent trends of increasing numbers of attendances at A&E and increases in the number of non elective admissions to hospital, we have set an ambitious target for 2016/17 which looks to reduce levels of DTOC back towards the average level in 2014/15. This will be challenging however we believe that patients should not be in hospital any longer than they need to be and that it is important for the patient to be receiving the right care in the right place and to return to there home with the right support in place as soon as possible.

In developing the plan we have reviewed best practice tools and resources including the High Impact Change Model for managing transfers of care and aligned planned actions as appropriate against the 8 identified high impact changes. The plan will remain fluid and will be reviewed and amended to reflect performance through the year and ensure it is aligned with the other complimentary activity being undertaken by the System Resilience Group to develop a Sustainable System plan for Urgent and Emergency Care as well as the emerging priorities and actions included in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan and those which are included in the Barnsley Integrated Transformation Plan.

The DTOC action plan will be monitored alongside delivery of the overall BCF plan by Senior Strategic Development Group of the Health and Wellbeing Board and progress will also be reported to the System Resilience Group.

DTOC Action Plan 2016/17

Theme	Activity/Actions	By When	Responsibility / Lead Organisation	Expected Impact	RAG	Comments / Progress Updates
Early Discharge Planning	Review of current discharge planning processes (discharge pathway) and revision to establish processes which support joint planning for discharge at the point of admission to both acute care and community services	July 16	BHNFT/ SWYPFT	Increased understanding of demand and capacity Improved communication between organisations and teams		
	Review Social Care 'discharge' assessment processes to ensure input as early as possible to discharge planning	July 16	BMBC	Earlier input to discharge planning Timely establishment/ re-establishment of packages of care		
Systems to monitor patient flow	Continuation of daily situation reporting across the system and SitRep calls	Ongoing	BCCG/BHNFT / SWYPFT / BMBC / YAS	Daily understanding of capacity, expected demand, pressures, delays. Ability to respond quickly to emerging pressures		
	Implementation of Medworx Clinical Utilisation Review system Phase 1 Acute Phase 2 Community Beds	Phase 1 Sept 2016 Phase 2 TBC	BCCG/BHNFT /SWYPFT	Clear understanding of patient acuity and level of care required Better understanding of patient flow issues Earlier intervention to maintain flow		

Multi Disciplinary Working	Continue to enhance the role of Rightcare to support discharge.	Dec 2016	BCCG/BHNFT /SWYPFT	Phase 3 of the service is to provide a single point of referral to discharge support services for the hospital wards and departments for patients who require community services in order for them to return home, following a hospital presentation or admission and the development of management plans for those identified at risk of readmission.		
Home first/Discharge to Assess	Access to 'spot purchase' respite and recuperation beds in the community	Ongoing	BCCG	Timely discharge of patients with ongoing support needs to enable assessment and choice for patients regarding long term care		
	Build on review of discharge planning and processes to establish Discharge to Assess model	Mar 2016	BHNFT/ SWYPFT / BMBC	Reduced admissions to care homes People are able to return home earlier with support		
Seven Day Service	Review impact of additional social care capacity to support 7 day assessment and agree approach	May 2016	BCCG/ BMBC	Increased weekend discharges Timely patient flow and discharge 7 days		
	Consider the model and access arrangements to domiciliary care provision particularly at weekends as part of re-procurement	Sept 2016	BMBC	Improved timeliness of access to domiciliary care packages Increased flexibility of care packages to meet patient needs.		

Trusted Assessor	Establish a 'Trusted Assessor' function for patients returning to Care Homes	Sept 2016	BMBC/BCCG	Reduction in delays for discharges of patients returning to care homes		
Focus on Choice	Develop support services with voluntary sector providers with a presence in Hospital to provide advice and ongoing input to support discharge	Sept 2016	BHNFT/BCCG	Improved support to patients returning home Improved patient understanding of choices and options for ongoing care		
Enhancing Health in Care Homes	Community Nursing Review to ensure community health and care teams work care homes and support patients in care homes	March 2017	BCCG	Reduced unnecessary admissions and improved hospital discharge		
	Intermediate Care specification to ensure access to high quality community beds in care homes for reablement and rehabilitation	Oct 2016	BCCG	Reduction in delayed discharges for patients awaiting reablement support Reduction in variation in quality of care in different settings.		

Organisations:
BCCG – Barnsley Clinical Commissioning Group
BHNFT – Barnsley Hospital NHS Foundation Trust
BMBC – Barnsley Metropolitan Borough Council
SWYPFT – South West Yorkshire Partnership NHS Foundation Trust
YAS – Yorkshire Ambulance Service

BARNSLEY

ALL-AGE MENTAL HEALTH AND WELLBEING COMMISSIONING STRATEGY

2015 – 2020

It's everyone's business

BARNSLEY
Metropolitan Borough Council

NHS

Barnsley Clinical Commissioning Group

Putting Barnsley People First

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EXECUTIVE SUMMARY

This strategy describes the work that is needed over the next five years to ensure that the residents of Barnsley have improved mental health and where necessary receive the right support at the right time and in the right place to support them through to sustained recovery.

The scale of the challenge ahead cannot be underestimated. Barnsley has poorer outcomes than the national average in many areas with higher levels of depression and anxiety. Barnsley is the 37th most deprived Borough in England with higher levels of unemployment than its South Yorkshire neighbours. Educational attainment is lower in Barnsley than the national average. There is a close relationship between education, employment, accommodation status and health needs and how these elements affect each other and impact upon a person's general mental health and wellbeing are key elements explored within the strategy.

We have heard from service users that the services they have received have not always been personalised or integrated enough. Therefore one of the main aims of this strategy is also to improve service user experience through the commissioning of how services are delivered with a continued emphasis on transformation and further integration with the third sector.

Through discussion with partners and from the wider engagement process this strategy will focus on the following priority areas:-

1. Prevention and early intervention for mental health and wellbeing
2. Improving access to mental health services and reduce waiting times from referral to assessment/treatment to ensure that the most appropriate support is delivered at the right time, in the right place
3. Reduction of stigma and discrimination
4. Improvement of recovery and resilience - provide service users with the information required for them to be able to make the most appropriate choices in how support is delivered to them to aid their recovery.
5. Improvement of the support provided to families and carers.

The best way we can improve outcomes is by acting early: early in planning; early in life; early in the condition; early in the crisis. The strategy outlines the commitments of the CCG and its partners (refer to Section 5) to deliver improved mental health outcomes for all Barnsley residents.

The delivery of this strategy will be driven by the governance of the CCG's Clinical Transformation Board, through to Barnsley's Health and Wellbeing Board, to ensure that user informed and evidenced based actions deliver this important legacy that the people of Barnsley can benefit from in years to come.

INTRODUCTION

Mental health is everyone's business - individuals, families, employers, educators and communities all need to play their part to improve the mental health and wellbeing of the people in Barnsley and to keep people well, by improving the outcomes for people with mental health problems.

At least one in four of us will experience mental health problem at some point in our life – often not diagnosed nor requiring specialist services. Around half of the people with lifetime mental illness experience their first symptoms by the age of fourteen[1]. People with a diagnosed severe mental illness die up to twenty years younger than their peers in the UK, predominantly due to higher rates of poor physical health. By promoting good mental health and intervening early we can help prevent mental illness from developing and support the mitigation of its effects when it does.

It is estimated that mental ill health in England costs in the region of £105 billion each year and treatment costs are expected to double in the next 20 years. It is imperative, on a local level, to ensure that the 'Barnsley Pound' is spent effectively and efficiently to improve people's mental health and wellbeing.

It has been evidenced that when mental health services are integrated with the local public, private and voluntary sector agencies and work collaboratively, they help people to overcome disadvantage and fulfil their potential. This is why Barnsley Clinical Commissioning Group (BCCG) and Barnsley Metropolitan Borough Council (BMBC), together with their partners, have developed this 5-year, all-age mental health strategy (dementia being considered separately) for Barnsley. This strategy will identify those actions needed to tackle the issues that Barnsley people have clearly articulated, including:

- **Managing their own mental health and wellbeing - resilience**
- **Quick and easy access to treatment and help when needed – especially when in crisis**
- **Early intervention and prevention**
- **Recover with support if required, to become as independent as possible**
- **Support for family and carers**
- **Live in families and communities without fear of stigma or discrimination**

In recognition of these views Barnsley's mental health services work hard to keep people out of hospital and as such there is a high focus on outreach.

[1] The Office of National Statistics Adult Psychiatry Morbidity Report 2007

The first contact for most people in relation to their mental health however is likely to be their GP. We are aware that we need to make it easier for GP's to speak directly with the mental health service providers and are supportive of the development of a single point of access (SPA) to enhance this process. We are also supportive of the development of discharge passports to ensure prompt and appropriate action and access back into services where patients needs deteriorate within a short time following their discharge from mental health services.

As part of the work being undertaken to transform mental health services locally, one of the key aims is to ensure greater integration and strengthen the links between primary care and mental health.

The Barnsley all-age Mental Health and Wellbeing commissioning strategy continues to build on the six objectives identified within the National 'No Health without Mental Health Strategy'[2]:

i. **More people have good mental health**

ii. **More people with mental health problems will recover**

iii. **More people with mental health problems will have good physical health**

iv. **More people will have a positive experience of care and support**

v. **Fewer people will suffer avoidable harm**

vi. **Fewer people will experience stigma and discrimination**

We are aware that in Barnsley we need to improve the mental health services offered to our children and young people, focusing much more on prevention and early interventions to improve their emotional health and wellbeing.

Led by Barnsley CCG, a 'Local Transformation Plan' (LTP) Group, consisting of a range of key stakeholders, have worked collaboratively together to develop a transformation plan that will significantly improve the emotional wellbeing and mental health outcomes for the children and young people of Barnsley over the next 5 years and beyond http://www.barnsleyccg.nhs.uk/local-transformation-plan-for-children-and-young-peoples-mental-health.htm

The transformation plan has built on the extensive and robust consultation with children, young people and their families that commenced in 2013. Barnsley's transformation plan builds on key remedial work we have been undertaking to improve access to local Child and Adolescent Mental Health Services (CAMHS) but, more importantly, prioritises prevention at its heart.

[2] No Health without Mental Health: A Cross Government Mental Health Outcomes Strategy for People of all Ages. Feb 2011 available at www.dh.gov.uk/mentalhealthstrategy

Nationally, NHS England have established a Mental Health Taskforce whose principal task is to develop a new five year national strategy for mental health covering services for all ages. The national strategy is expected to be published in early 2016 and this will be the first time there has been a NHS England-led strategic approach to designing mental health services for all ages spanning the health and care system.

Key themes being considered by the Taskforce are known to be prevention and empowerment, integrated care and support, attitudes and experience and access to services. These themes are reflected throughout the local strategy for Barnsley.

A key theme for Barnsley is ensuring that the mental health services are accessed as close to home as possible, reducing the need for service users and their families to have to travel many miles from their home. It is acknowledged however that some out of area care may be needed, particularly when service users require access to specialist mental health services that may be commissioned on a regional or national basis.

In line with the national mental health strategy, a key focus of Barnsley's strategy is prevention. The success of this relies heavily on all partners working together across a number of key areas, including health, social care, police, education and the voluntary sector.

This work is already underway in terms of the partner collaborations response to the recommendations within the 'Future in Mind' Report of the Children and Young Peoples Mental Health Task Force. It is also linked to the transformation work that has been undertaken and led by South West Yorkshire Partnership NHS Trust (SWYPFT) and by strengthening links with the Barnsley Public Health Strategy.

Delivering Barnsley's Mental Health Strategy is a challenge facing everyone and with this in mind, a supporting delivery plan is being developed to run alongside the strategy which will link with the CCG overall one year Operational Plan and the Five Year Sustainable Transformation Plan.

The CCG and its partners will work together to ensure that Barnsley receives the available national funding to enable achievement of the aims and priorities contained within this strategy. All partners are working together to ensure that mental health services within Barnsley are transformed to ensure that national targets and quality standards are both achieved and sustained. As a minimum we will expect national averages to be achieved. Local targets and key performance indicators are already included within the contracts with mental health service providers but where necessary we will develop additional, robust, metrics to ensure that the desired outcomes are achieved.

This strategy provides an overview of how Barnsley Clinical Commissioning Group and Barnsley Metropolitan Borough Council will work together with their partners to ensure mental health and wellbeing is central to planning and service delivery to achieve these objectives for the residents of Barnsley.

2. POLICY CONTEXT

2.1 Outcomes Frameworks

Outcome frameworks are national documents published by the Department of Health that provide a vision for what we want to achieve and a mechanism for measuring outcomes linked to that vision.

There are three outcome frameworks that are linked to this strategy:-

i. NHS Outcomes Framework 2015/16
ii. Public Health Outcomes Framework 2015/16
iii. Adult and Social Care Outcomes Framework 2015/16.

These have been summarised in Appendix 1, together with the outcome measures specific to mental health that will be captured nationally.

2.2 National Policies

There are a number of national and local policies that inform this strategy (outlined in Appendix Seven) but there is a particular focus on the cross-government mental health outcomes strategy for people of all ages (2011) No Health without Mental Health Strategy and the later document 'Closing the Gap: Priorities for essential change in mental health' (2014)[3]

In No Health without Mental Health, government stated that 'mental health must have equal priority with physical health, that discrimination associated with mental health problems must end and that everyone who needs mental health care should get the right support, at the right time'. It was also recognised that more must be done to prevent mental ill health and promote mental wellbeing.

Mental health is moving up the policy agenda across government. The Prime Minister recently announced almost a billion pounds of investment to enhance mental health services across the country:-

- £ 290 million to provide specialist care to mums before and after having their babies

- First ever waiting time targets to be introduced for teenagers with eating disorders and people experiencing psychosis

[3] Closing the Gap: Priorities for essential change in mental health, Feb 2014 available at https://www.gov.uk/government/publications/mental-health-priorities-for-change

- Nearly £ 250 million for mental health services in hospital emergency departments

- Over £ 400 million to enable 24/7 treatment in communities as safe and effective alternative to hospital.

As Simon Stevens, Chief Executive of NHS England stated:-

"Putting mental and physical health on an equal footing is a far reaching idea whose time has now come. A sea change in public attitudes coupled with an increasing range of effective mental health treatments mean that now's the time to tackle the huge unmet need that affects families and communities across the nation".

3. MENTAL HEALTH AND WELLBEING IN BARNSLEY

3.1 Local Demographics

In line with the Barnsley's Joint Strategic Needs Assessment (JSNA)[4] this strategy is based on the principle that understanding people's mental health and wellbeing first requires an understanding of the **people** who live and work in Barnsley and the **place** and the **influences** on health across their life course (being born, growing up, being an adult and growing old in Barnsley).

The key aspects from the JSNA 2013 outlined below have helped to inform the Mental Health and Wellbeing Commissioning Strategy:

Barnsley has a population of 237,843 (ONS mid 2014 estimates)[5] and is projected to increase to 241,000 by 2017. The most significant increases are in the under 16's population and in people over 65.

96.6% of Barnsley residents were born in the UK; 96.1% describe themselves as White British (2011 Census).

20.3% (30,120) of the working age population in Barnsley are receiving out of work benefits. This is the highest in South Yorkshire. Of the 30,120 residents who are on out of work benefits, 41% are claiming due to mental health and behavioural disorders.

There is a close relationship between education, employment, accommodation status and health needs and how these elements affect each other and impact upon a person's general mental health and wellbeing are key elements explored within the strategy.
Figures from DWP show that in February 2015, 20,590 (13.7%) of Barnsley residents aged 16 to 64 years were claiming the Main Out of Work Benefits (Job

[4] Joint Strategic Needs Assessment 2013 (BMBC) available at https://www2.barnsley.gov.uk/services/public-health/joint-strategic-needs-assessment-jsna

[5] Office for National Statistics 'Annual Mid-year Population Estimates 2014

Seekers Allowance, Employment and Support Allowance (ESA) and Incapacity Benefits, Lone Parents and Others on Income Related Benefits). The Barnsley rate was the highest in South Yorkshire, and higher than the regional average (11.0%) and the national average (9.4%).

23.1% (55,048) of the population of Barnsley is under the age of 20 (ONS mid 2014 estimates)[6]. This is projected to increase to 56,181 by 2020 (ONS 2012 based population estimates).

6.7% of school children aged 5 – 16 years (1,794) are from a black or minority ethnic group (Public Health England Child Health Profile, June 2015).

The level of child poverty is worse in Barnsley with 23.8% of Barnsley's children under 16 years living in relative poverty compared with the England average of 19.2%. It is estimated that 21.5% of children in Barnsley, aged 0–18 years, are reported as living in a household that is reliant upon out of work benefits (DWP, May 2014).

The Marmot Review (2010)[7] is unequivocal in stating the critical importance and need to prioritise physical, emotional, social and cognitive development in early years and this strategy outlines the actions being taken in Barnsley to improve the emotional wellbeing of children and young people within the Borough.

The teenage pregnancy rate is significantly higher in Barnsley than the national average. Evidence is suggesting nationally that there is a link between teenage conceptions and alcohol misuse.

There is some indication that alcohol related hospital admissions are higher among young people in Barnsley but hospital admissions generally for alcohol related harm are also significantly higher in Barnsley when compared to the England average. It is clear that there needs to be a continued focus on evidence based interventions in relation to alcohol and substance misuse.

Overall, health in Barnsley is worse than the England average. Life expectancy at birth for the Barnsley population (2011 – 2013) is 78.1 years for men and 81.6 years for women compared to 79.4 years and 83.1 years nationally.

There is marked variation in life expectancy across the Borough with a gap of 7.1 years between the wards with the highest and lowest life expectancy for men and a gap of 6.2 years for women. The lowest life expectancy can be found in the East of the Borough.

The three major causes of premature death in Barnsley – cancer, CVD (Cardio Vascular Disease) and chronic lung disease are strongly linked to deprivation. The impact of unemployment, poverty and poor housing conditions will potentially worsen

[6] Office for National Statistics 'Annual Mid-year Population Estimates 2014

[7] Fair Society, Health lives – The Marmot Review (2010)

these conditions and will have an adverse impact on peoples' mental health and wellbeing. This is likely to create additional demand on both Primary Care Services and Community Mental Health Services.

On average around 24 people died each year by suicide or injury of undetermined intent in Barnsley in the period between 2012 and 2014. The suicide and undetermined death rate for Barnsley is currently reported by the Public Health Outcomes Framework (PHOF) as 10.4 per 100,000 for the period 2012 – 2014. The England average for the same period was of 8.9 per 100,000. This is not significantly different. The vast majority (86%) of deaths from suicide and undetermined death are males. Trend data shows the Barnsley male mortality rate is generally higher than the average for England and the Yorkshire and the Humber average, but not significantly so. The current Barnsley rate is 17.6 per 100,000 in 2012-14, compared to 14.1 in England and 15.0 in Yorkshire and the Humber. A Barnsley Suicide Prevention Group was established in November 2015 by Public Health, Barnsley Council. The purpose of this group is to develop and deliver a suicide prevention action plan with the aim of reducing the number of suicides and suicide attempts in Barnsley and establish better support for people bereaved and affected by suicide.

Barnsley's levels of successful completion of drug treatment for both opiate (5.3%) and non-opiate (34.6%) users, whilst improving, is still significantly lower than the England average of 7.8% and 37.7% respectively (Public Health Outcomes Framework, August 2015).

The percentage of adults with a diagnosis of depression is higher in Barnsley at 8.8% compared with an England average of 6.5% (QOF 2013/14).There are clear links between levels of deprivation and levels of depression/anxiety.

The proportion of older people in Barnsley is forecast to increase. One person in every 200 in Barnsley has been diagnosed with Dementia and with the growing elderly population this number is expected to increase. A separate Dementia strategy for Barnsley is currently being developed.

There is a high prevalence of behavioural risk factors apparent within Barnsley, particularly smoking but also in terms of diet and exercise and levels of alcohol consumption, leading to higher levels of obesity and diabetes in Barnsley compared with the national average and this contributes to the higher levels of premature death. All of these factors are wider determinants of people's general mental health and wellbeing and therefore the core elements of this mental health commissioning strategy need to be embedded within all other local strategies.

3.2 Local Context

3.2.1 **Primary Care and Mental Health**

Nationally a large number of people with mental health problems are supported by their GP's working collaboratively with other services. This is no different in Barnsley. Primary mental health care services therefore have a clear role to play in the prevention and early identification of mental health issues and the promotion of self-management.

GP's in Barnsley are seeing increasing numbers of patients with depression and anxiety issues much of which is the result of changes in societal infrastructure leading to financial worries (debt, house repossessions, poor housing conditions) and social isolation. In previous years the voluntary third sector organisations were key contributors in providing financial/debt advice services and helping people to resolve their difficulties thereby reducing the adverse impact on peoples' mental health and wellbeing. Likewise third sector/voluntary organisations provided many 'social prescribed' services such as befriending people who were lonely.

These services are no longer provided in Barnsley on the scale of previous years and the impact of this is clearly seen within primary care services. In recognition of this Voluntary Action Barnsley, in conjunction with Barnsley's Clinical Commissioning Group are piloting a Social Prescribing service to support GP surgeries (in the first instance) with possibilities at a later stage to include other health services.

The idea behind offering this service is to help patients with long term health conditions access further support. For example:-

- A patient with low self-esteem might like to go to meet with others in a community venue but doesn't know what there is in their community, who to ask and how to get there.
- A patient might benefit from meeting with Health Trainers to start a gentle exercise programme.
- There are family issues e.g. debt and housing difficulties which are affecting a patient's recovery.

Social prescribing has positive potential for most people: it links patients with non-medical support which can make a huge difference to how someone copes with an illness or condition at home.

Sometimes the problems people are dealing with, like debt or loneliness can have a huge impact on their health. All those social problems can't be solved with a pill. Social prescribing offers GP somewhere to signpost people to, so they can get the advice and ongoing support they may need.

GPs work closely with voluntary and community sector partners who offer a wide range of support, and this service will take that to a new level.

Wherever possible opportunities will be taken to develop a more robust voluntary/third sector economy so that by all agencies working together people's mental health and wellbeing can be improved and maintained whilst utilising resources efficiently and effectively.

3.2.2 **Adult Services**

In response to local mental health service user feedback, national and local priorities and targets and stretched resources, Barnsley's Community Mental Health Service provider South West Yorkshire Partnership Foundation NHS Trust (SWYPFT) supported by BCCG and BMBC have embarked upon a significant transformation in how they deliver mental health and wellbeing services.

The transformation of SWYPFT's Acute and Community services is based on the following underpinning principles:-

- Enabling people to reach their potential and live well in their community (resilience)
- Service user first and in the centre (choice and understanding those choices with the service user able to influence the care they receive)
- Right Care, Right Place, Right Time (Early Intervention, Crisis)
- Clinically led
- Increased integration and links to alternative community based services, promoting partnership working (seamless services)
- Optimise the use of technology.

These principles reflect the views of service users and carers gathered during SWYPFT's own consultations and which have been mirrored in the feedback received from the consultation and engagement work carried out to inform this strategy.

Appendix 4 outlines the mental health services currently commissioned within Barnsley.

3.2.3 **Children's Services**

One in ten children aged 5–16 have a clinically significant mental health problem with approximately 50% of lifetime mental illness starting before the age of 14. It is estimated that up to half of these problems are preventable and that with the right services and support early on, future health problems and onset of symptoms can be minimised. Mental health problems in childhood predict the adoption of unhealthy lifestyles in adolescence.[8]

Self-harming in young people is not uncommon (10-13% of 15–16 year olds have self-harmed).[9] In 2013–14 there were 209 hospital admissions as a result of self-harm for Barnsley children and young people aged 10–24 years old; this is significantly higher than the national and regional averages.

The most recent data from the Office for National Statistics (ONS) indicate that in 2013 there were 135 deaths of 15–19 year olds from suicide or undetermined injury in England and Wales. This is a rate of 3.9 deaths per 100,000 population aged 15-19 years (ONS Suicide in the UK, 2013 registrations) which if we apply to the population of Barnsley would equate to an estimate of 1 death from suicide or undetermined injury per year.

In a Children and Young People survey recently undertaken by Healthwatch Barnsley[10] 76.1% of the children who responded stated that they had felt stressed over the past 12 months and 54.5% of the children surveyed stated that they often felt stressed.

The Select Committee Report on Children's and Adolescents' mental health and CAMHS, November 2014[11] stated that:-

"compelling arguments have been made…..that the focus of investment in CAMHS should be on early intervention – providing timely support to children and young people before mental health problems become entrenched and increase in severity, and preventing, wherever possible, the need for admission to in-patient services".

Demand for access to Children and Young People's Mental Health Services (CAMHS) has been rapidly increasing over recent years and continues to climb. This demand far exceeds the resources currently available and as a

[8] Fergusson DM, Horwood LJ, Ridder EM. Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood. J Child Psychol 2005; 46:937-49

[9] Hawton K, Rodham. K, Evans E and Weatherall R (2002) Deliberate self-harm in adolescents: self-report survey in schools in England. British Medical Journal 325: 1207 - 1211

[10] Report on Emotional Health and Wellbeing with Children and Young People, (March 2015), Healthwatch Barnsley

[11] Health Committee – Third Report: ' Children's and adolescents' mental health and CAMHS', House of Commons, (Nov 2014)

consequence there are very long waits for children to their first appointment and equally long waits to the commencement of treatment. This theme of difficulty in accessing CAMHS services and long waits prior to treatment commencing reflects both the national picture and the top priority to be addressed within Barnsley Children's Mental Health Services according to Barnsley people.

Everyone agrees that long waits are unacceptable and earlier this year, the Children and Young People's Mental Health Task Force made numerous recommendations, contained within the Future in Mind[12] publication, which included:-

i. Introducing more access and waiting time standards for services
ii. Tackling stigma and improving attitudes to mental illness
iii. Establishing 'one stop shop' support services in the community, and
iv. Improving access for children and young people who are particularly vulnerable.

In response to this the Government have pledged approximately £1.25billion over 5 years for capacity and capability to be built within local mental health services for children and young people.

To access the Government funding available Barnsley CCG and its partners have worked collaboratively to develop a Local Transformation Plan that will ultimately improve the quality of life outcomes for children and young people in Barnsley by supporting them to build resilience, understand how to maintain their wellbeing and enable self-care
http://www.barnsleyccg.nhs.uk/local-transformation-plan-for-children-and-young-peoples-mental-health.htm

Barnsley's Local Transformation Plan has built on the extensive and robust consultation with children and young people and their families, commenced in 2013. The focus of transformation work in Barnsley will be to provide support to children and young people at the earliest possible time to prevent escalation of their problem(s) and to support their emotional health and wellbeing throughout their childhood and adolescence into adulthood.

Barnsley's national funding allocation in relation to 'Future in Mind' is £517,000 per annum for the next five years, of which £146,000 per annum

[12] Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing (Department of Health), March 2015

must be utilised to develop an evidence-based community eating disorder service for children and young people. Barnsley's Local Transformation Plan can be accessed using the link above or directly via either the CCG or BMBC websites.

Implementation of the Local Transformation Plan will be challenging but all partners are committed to delivering this key prevention work and early years support which will be fundamental in successfully supporting specialist services by enabling a sustainable reduction in overall demand, creating capacity and capability within the whole system.

Child Sexual Exploitation (CSE) is a reality in all towns and cities in the UK and Barnsley is no exception. Health and Social Care Organisations in Barnsley are working very closely together with its partners (including South Yorkshire Police, SWYPFT and Voluntary Sector Organisations (namely BSARCS – Barnsley Sexual Abuse and Rape Crisis Services)) to ensure that the children (and on occasion adults) involved in such exploitation receive the specialist treatment necessary to enable them to reach full recovery. Work will also be undertaken to raise the awareness of CSE within the community to reduce opportunities for such exploitation to occur and to work with perpetrators to prevent future exploitation in this way.

Appendix 4 outlines the mental health services currently commissioned within Barnsley for children and young people.

3.2.4 **Maternal Mental Health**

Mental health during pregnancy and post birth is a major individual, family and public health issue. Treatable, and often preventable, mental illnesses are causing substantial suffering, disability and death of mothers, and jeopardising the future wellbeing and life chances of their children.

More than 1 in 10 women will be affected by a mental illness during pregnancy or after the birth of their baby[13](NICE (2007).

A wide range of mental health problems can occur at this crucial time in the lives of women and their families, including depression, anxiety disorders such as panic attacks and obsessive compulsive disorder, bipolar disorder, postpartum psychosis and post-traumatic stress disorder.

Depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point; many women will experience both (NICE Clinical Guidance 192).

[13] NICE (2007) Clinical Guideline 45, Antenatal and postnatal Mental Health. http://guidance.nice.org.uk/CG45

Sometimes the term 'postnatal depression' is used to refer to all mental health problems experienced by women in the perinatal period, but this can be misleading as it is just one of a number of conditions.

If perinatal mental illnesses go untreated they can have a devastating impact on women and their families. In extreme cases, these illnesses can be life-threatening - they are one of the leading causes of maternal deaths in the UK [14]. These conditions can affect babies in pregnancy, as stress hormones pass through the placenta and affect foetal development[15]. After birth, they can influence the way that a mother interacts with and cares for her baby, and can increase the risk that children will experience behavioural, social or learning difficulties and fail to fulfil their potential.

However, with good care most women, their relationship with their infant and the child's development all make a good recovery. Early and effective action can save lives and distress, and reduce the risks of disadvantage to dependent children.

It is important that services recognise the important role that fathers and other family members play in supporting women with perinatal illnesses, and also act to mitigate the impact of illness on infants, and other children and family members. Universal services – midwives, GP's, nurses and health visitors - are a crucial part of the care pathways.

The Maternal Mental Health Alliance (a national body) supports the creation of Specialist Mental Health Midwife posts, to enable every maternity service to better respond to the needs of women at risk of, or suffering from, maternal mental health problems.

Many areas across the country have a dedicated Perinatal Mental Health Service. Currently, Barnsley does not, however, due to an increasing demand for specialist midwifery care for women in Barnsley suffering with mental health issues and following publication of the 'Specialist Mental Health Midwives – What they do and why they matter', Barnsley Hospital NHS Foundation Trust have employed a midwife on a twelve month pilot to lead this development.

The Specialist Midwife's role includes:-

- Contributing to the provision of a comprehensive and accessible Maternal Mental Health service throughout Barnsley providing a

[14] Saving Mothers Lives: The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (2011) British Journal Obstetrics and Gynaecology. 118, S1, http://onlinelibrary.wiley.com/doi/10.1111/bjo.2011.118.issue-s1/issuetoc

[15] Glover V. (2013) Maternal depression, anxiety and stress during pregnancy and child outcome; what needs to be done. Best Practice Research in Clinical Obstetrics and Gynaecology: S1521-6934(13)00132-6

specialised knowledge, expertise, advice and guidance to women and their families within the hospital and community setting to support them with their maternal health in pregnancy and in the early post-natal period

- To act as a source of expertise and advice for Midwives and other health care professionals, providing maternal mental health advice and education

- To work within the multidisciplinary team and wider partners in health to provide optimal care throughout all aspects of the Maternal Mental Health pathway in both hospital and community settings.

Throughout the 12 months of the pilot outcomes will be collated to provide local evidence as to the need for this specialist post.

Improving perinatal mental health is a key government priority which is why they are investing £ 290 million in the years up to 2020. The intention is that this will mean that at least 30,000 more women each year will have access to specialist mental healthcare before and after having their baby. For example, through perinatal classes, new community perinatal teams and more beds in mother and baby units, mums with serious mental health problems can get the best support and keep their babies with them.

3.2.5 **Crisis Care**

At every level within society, there is an increasing awareness of the need for organisations to work together to support and help those who are vulnerable or in need of assistance through mental ill health.

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work better together to ensure that people get the help they need when they are having a mental health crisis. The joint statement made by all partners under the Crisis Care Concordat states that:-

"we commit to work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first.

We will work together, and with local organisations, to prevent crises happening whenever possible through prevention and early intervention. We will make sure we meet the needs of vulnerable people in urgent situations.

We will strive to make sure that all relevant public services support someone who appears to have a mental health problem to move towards Recovery."

Following sign-up to the Concordat, Services and agencies within Barnsley (e.g CCG, BMBC, South Yorkshire Police, Service Providers, third sector organisations, NHS England) came together and developed a Mental Health Crisis Care Concordat Action Plan to improve the care and support of the Barnsley population. Implementation of the Action Plan is overseen by a multi-agency group and the action plan itself is revised and updated on a regular basis.

The Mental Health Crisis Care Concordat Action Plan can be freely accessed at www.crisiscareconcordat.org.uk

Often, when in crisis due to mental illness, it is the Police who are first on hand to provide assistance. In recognition of this, South Yorkshire Police have developed their protocol 'Management of Mental Health Crisis Interagency Partnership Agreement Between South Yorkshire Police and Health and Social Care Agencies' to support the principles of the 'Crisis Care Concordat', which recognises that when people present or are presented to the Police in a mental ill health crisis state, working together with health and social care partners is both a necessity and a priority. All professionals agree to ensure that the welfare and dignity of the patient is at the heart of any negotiation.

The intentions of the protocol are summarised as:

- To minimise the risks to individuals and the wider community, facilitating access to the most appropriate care at the earliest opportunity – Maximising the effectiveness of the police and partnership resource deployment

- To ensure the use of a Health Based Place of Safety (HBPOS) for S136 detentions and following execution of a S135(1) warrant in all but the most exceptional cases, exemplifying best practice

- To ensure swift, appropriate, efficient, effective and dignified assessment arrangements for all persons either detained in a place of safety under the Mental Health Act or detained for an offence in Police custody who present with mental disorder in a crisis state

- To facilitate the swift and safe return of patients who are recorded by the Police as missing
- To ensure that the transfer and conveyance of mentally ill or otherwise mentally disordered persons is provided by the most appropriate means in a timely fashion

- To ensure that while working in partnership for the benefit of the vulnerable person each organisation is considerate and respectful of the responsibilities of the other and utilises each other's resources in the most appropriate way

- To encourage appropriate sharing of information and to ensure that information shared is for a justifiable purpose, that it is in the public interest and is proportionate to the situation with due regard shown to the implications of the Human Rights Act 1998 and the Data Protection Act 1998

- To work jointly across organisational boundaries in achieving these intentions.

Access to effective mental health crisis provision outside 'normal' office hours is, at present, limited. The issue of the Mental Health service providers to provide a comprehensive crisis service during these hours is of concern to all partners but significantly so to South Yorkshire Police.

Nationally, a number of police forces, in partnership with mental health providers, have introduced a triage programme, designed to reduce the impact of mental health incidents on police, health and social care resources, whilst improving the care provided to those with mental health needs.

In January 2015 a Mental Health Street Triage was piloted in Barnsley over a period of 6 months. The model piloted was of the planned provision of a police vehicle crewed with a police officer and a mental health professional. This vehicle was deployed to 'live' police incidents where there is a suggestion from the nature of the incident report, or from officers attending, that mental health is at least an impact factor. By using a joint approach, individuals are able to be rapidly and effectively signposted to appropriate treatment, and diverted away from police actions which may otherwise have the effect of appearing to criminalise those with mental health needs.

In circumstances where police officers require advice from mental health professionals about individuals with whom they have contact, then the ability to have immediate access to a mental health triage facility could have significant impact on South Yorkshire Police resilience and the provision of a high quality service to those who have mental health needs.

The pilot scheme in Barnsley proved successful but sadly there were insufficient funds to be able to continue the scheme beyond the initial 6 months. Partners are working together to identify possible funding streams to develop a sustainable Mental Health Street Triage service.

People detained by the police under section 136 of the Mental Health Act must be taken immediately to a safe place where a mental health assessment can be undertaken. This should be a 'health-based place of safety', located in a mental health hospital or an emergency department at a general hospital. They should only be taken to a police station in exceptional circumstances.

In October 2014 the Care Quality Commission (CQC) published a report about health based places of safety for people experiencing mental health crisis.

The key findings outlined in the report are:-

- Too many health-based places of safety are turning people away or requiring them to wait for a long time with the police because they are already full or because there are staffing problems. A quarter of providers told CQC that they did not believe that the provision of health-based places of safety in their locality was sufficient.

- Too many providers are operating restrictions which exclude some people from specific groups from accessing a health-based place of safety. This includes young people, people who are intoxicated, and people exhibiting disturbed behaviour.

- Too many commissioners are not adequately fulfilling their oversight responsibilities in relation to people who are detained under section 136. This limits their awareness of a key issue which should inform their commissioning decisions.

- Too many providers are failing to monitor their service effectively, making it difficult to assess whether provision of health-based places of safety is meeting the needs of their localities. Many health based places of safety were unable to provide CQC with basic data about the use of their service or how often people were turned away or excluded.

Barnsley has a dedicated 'health based place of safety' operating at Kendray Hospital and managed by Barnsley's mental health service provider South West Yorkshire Partnership Fund. The CQC visited Barnsley in 2015 as part of their national themed programme on mental health crisis services and were very complimentary and supportive of the work undertaken in this area. The CQC made a number of recommendations following their visit, the majority of which have now been implemented.

Barnsley (and other South Yorkshire localities) has been identified as an area where national funding could be utilised effectively to strengthen its Crisis Care Pathway. There are South Yorkshire-wide discussions being held to determine the possibility of developing a 'health based place of safety' to accommodate under 18's, as this is a facility lacking within the region.

Barnsley's Mental Health Crisis Care Concordat Group are discussing ideas as to how best to use this funding, which will be accessible during 2016/17, and in addition to developing 'health based places of safety' it is hoped that the Barnsley Mental Health Street Triage scheme could be resurrected.

In recent months Barnsley CCG has received £138,000 to further enhance the existing psychiatric liaison service which is delivered by SWYPFT within the A&E Department at Barnsley hospital. Already achieving the recommended 'core 24' standard this funding has enabled the service to include under 18's and people with dementia, both categories previously excluded.

The national funding received is part of the governments' pledge to invest £247 million over the next 5 years to make sure that every emergency department has mental health support and that these services are available 24 hours a day, 365 days a year.

In recent announcements the government has also pledged over £400 million for crisis home resolution teams to deliver 24/7 treatment in communities and homes as a safe and effective alternative to hospitals. These teams aim to assess all patients being considered for acute hospital admission, to offer intensive home treatment rather than hospital admission if feasible, and to facilitate early discharge from hospital. Key features of such services include 24-hour availability and intensive contact in the community, with visits twice daily if needed.

Barnsley already invest significantly in an Intensive Home Based Treatment service and this service is very successful in treating people within their own homes without the need for admission to hospital.

3.2.6 **Vulnerable Groups**

Some groups of people are known to be at higher risk of developing mental health problems than others. Partners are working closely together to ensure equity of access to everyone, whatever their gender, race, religion or defining category which may make someone 'different' to their neighbour. All partners agree that we need to improve access to services for all 'hard to reach'/ previously disenfranchised groups/people to ensure that we get it right for everybody all of the time.

We asked Barnsley people who they particularly felt to be vulnerable and they identified the following groups within Barnsley:

i. Looked After Children (Looked after by Local Authorities)

The cross Government mental health strategy identifies looked after children as one of the particularly vulnerable groups at risk of developing mental ill health.
Research carried out in the UK has shown that looked after children have significantly poorer mental health than the rest of the population[16].

Children's mental health and wellbeing is primarily nurtured in the home but public services can make a difference, especially for those known to

[16] Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households. Ford, T. Vostanis, P. Meltzer, H. and Goodman, R. British Journal of Psychiatry 2007, 190, pp 319-325

the health and social care services. A secure parent/child relationship is an important building block to help give children emotional strength.

Barnsley's Children and Young People Improvement Plan includes actions specifically targeted at improving the mental health and wellbeing of children looked after by Barnsley Metropolitan Borough Council.

ii. Deaf Community

People with hearing impairment are no more likely to experience significant mental disorders than other people, e.g. schizophrenia, but they are more likely to experience emotional, behavioural and adjustment disorders such as anxiety, depression and personality disorder. These disorders are generally effectively treated within primary care (e.g. GP's) or if not, a primary care practitioner may refer the client to secondary care mental health services. However, it has been well-documented that this community have difficulties accessing GP services and thus any additional services that they require (Sign Health, 2009)[17].

We are aware that British Sign Language (BSL) does not have the same order and syntax as spoken or written English and therefore conventional formats and media of written English are not satisfactory for many deaf people. We know due to these communication difficulties that deaf people often leave health consultations unclear, confused and upset. We are exploring ways to improve access at GP Practices, not only to BSL (British Sign Language) interpreters but to BSL interpreters who have an understanding of the Deaf Culture and Deaf Community. We are looking at how GP consultation times might be extended for Deaf patients to ensure that they have sufficient time to express their issues confidently, without rushing and to fully understand the treatment options available to them. This will go some way in reducing the discrimination felt by deaf people when accessing healthcare services and improving their health outcomes.

Barnsley's community mental health service provider SWYPFT (South West Yorkshire Partnership NHS Foundation Trust) have a South Yorkshire Service for Deaf People with Mental Health needs which consists of a Community Psychiatric Nurse (CPN) and Support Worker. The service covers Rotherham, Doncaster, Barnsley and Sheffield and is offered to adults of working age (16–65 years old).

iii. People with Long-Term Conditions

[17] The Health of Deaf People in the UK: Sick of it, SignHealth (2014)

People with long term conditions are two to three times more likely to experience mental health problems. Conversely, individuals with mental health problems are twice as likely to experience a long-term illness or disability.

Poor mental health problems complicate physical health conditions which leads to more time spent in hospital, poorer clinical outcomes, lower quality of life and a need for more intensive support from health services. It is clear that health services need to focus as much attention and resources on improving a person's mental health and wellbeing as it does on a person's physical health and wellbeing if we are to truly improve the quality of life for people in Barnsley.

iv. Older People

People over the age of 65 have a much higher rate of depression than younger people[18]. As Barnsley's over 65 population is projected to continue to increase demands on its elderly mental health services, both primary and secondary, will also continue to increase and we will plan now to ensure that the services are in place to meet that need as and when it arises.

SWYPFT currently provides a needs-led rather than an age based service with a flexible provision for people which responds to their presenting need and level of vulnerability making adjustments or acknowledging their age related need/frailty.

v. Offenders

Entering the criminal justice system impacts on a person's ability to gain employment, this in turn adversely impacts on their mental and physical health. Crime levels are associated with both illness and poverty, thereby increasing the burden of health on those communities least able to cope.

The Bradley report (2009)[19] highlights the needs of people with mental health and learning difficulties in the Criminal Justice System. Evidence suggests there are more people with mental health problems in prison than ever before and there is a growing consensus that prison may not always be the right environment for those with severe mental illness.

[18] http://www.equalityhumanrights.com/uploaded_files/triennial_review/how_fair_is_britain_ch9.pdf

[19] The Bradley Report : 'Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system' . Department of Health. 2009

For young offenders in Barnsley, the Barnsley's Youth Offending Service offers a health provision which includes professionals from CAMHS (Children and Adolescent Mental Health Services), Learning Disabilities, Education Psychologist and drug and alcohol workers, all of whom work together to improve the emotional health and wellbeing of these vulnerable children and young people who may, otherwise, find it difficult to engage with services.

NHS England have recently commissioned SWYPFT to provide a Liaison and Diversion from Custody service which is ageless and incorporates both YOT (Youth Offending Team) and CAMHS (Children and Adolescent Mental Health Service). This is a positive step forward.

vi. Substance Misuse

Substance abuse covers misuse of a range of mind-altering substances. It can have a severe impact on a person's functioning as well as their physical health.

Drugs, alcohol, nicotine, solvents and even food can start as 'props' to help you get through difficult times. But the feelings of relief are only temporary and, as the problems don't disappear, you may use more and more of these substances and risk becoming dependent on them – which in itself creates new problems.

Alcohol dependence is the most common form of substance misuse, but any drug, including heroin, cocaine, crack and cannabis, comes into this category, as does the misuse of glue and aerosols.

Most forms of substance abuse may give you a temporary feeling of well-being or of being in control, but all of them can ultimately damage your health.

For people with mental health problems who are also substance misusers (Dual Diagnosis), the mental health team will normally encourage contact with a specialist substance misuse service for help.

Dual diagnosis is a term for when someone experiences a mental illness and a substance abuse problem simultaneously. Dual diagnosis is a very broad category. It can range from someone developing mild depression because of binge drinking, to someone's symptoms of bipolar disorder becoming more severe when that person abuses heroin during periods of mania.

Either substance abuse or mental illness can develop first. A person experiencing a mental health condition may turn to drugs and alcohol as a form of self-medication to improve the troubling mental health

symptoms they experience. Research shows though that drugs and alcohol only make the symptoms of mental health conditions worse.

Abusing substances can also lead to mental health problems because of the effects drugs have on a person's moods, thoughts, brain chemistry and behaviour.

About a third of all people experiencing mental illnesses and about half of people living with severe mental illnesses also experience substance abuse. These statistics are mirrored in the substance abuse community, where about a third of all alcohol abusers and more than half of all drug abusers report experiencing a mental illness.

Men are more likely to develop a co-occurring disorder than women. Other people who have a particularly high risk of dual diagnosis include individuals of lower socioeconomic status, military veterans and people with more general medical illnesses.

In Barnsley there are currently dual diagnosis link workers embedded within teams at BTRN and the Harm Reduction Service, as well as in various mental health services including early intervention, inpatient, community Mental Health and Access teams.

6% of those starting a new drug treatment journey, and 7% of those starting a new alcohol treatment journey in Barnsley during 2013/14 had a recorded dual diagnosis. Based on research this figure is likely to be a marked underestimate of actual prevalence. If, as research suggests, up to 93% of those in contact with substance services have some level of concurrent mental health issue, up to 718 clients entering the Barnsley treatment system in 2013/14 may have some mental health needs. Many of these will be at a level that need minimal intervention and/or can be managed appropriately by substance misuse services; some will have more complex mental health needs requiring onward referral and collaboration between mental health services and substance misuse services. Ensuring continued work to identify substance misuse treatment clients with mental health needs, and vice versa, will help to embed and sustain the necessary collaborative work.

vii. Veterans

On leaving the armed forces, most people successfully transition back into civilian life. But some individuals can experience very traumatic situations whilst serving in the military before facing the additional challenges of moving back into civilian life, all of which can take a severe toll. While mental health awareness is improving, more can be done to identify issues not just with Post-Traumatic Stress Disorder but with wider problems linked to anxiety and depression.

Many veterans who need help with mental illness will find that mainstream services are able to provide the help they need. However, for those veterans unable to access mainstream services, further help is required.

In response to the Murrison report 'Fighting Fit: a mental health plan for servicemen and veterans', first published in 2010, the following national services were established:-

- On-line psychological support services – Big White Wall
- Specialised inpatient PTSD (Post Traumatic Stress Disorder) services – delivered by Combat Stress
- 10 regional Veteran Mental Health Services.

The Veteran Mental Health Services are specifically for veterans. They enable specialist staff to care for ex-forces personnel with mental health needs, direct them to the most appropriate service and give them effective treatment. The regional Veteran Mental Health Service covering Yorkshire and Humber is based in Hull and since its inception approximately 60 veterans from Barnsley have been referred to this service and helped by them. Initially this service was set up as a 3 year pilot and then extended for a further year but the funding will cease on 31 March 2016. CCG's within the Yorkshire and Humber region are working collaboratively to ensure that this vital service is sustained beyond March 2016.

In January 2016 NHS England has asked armed forces veterans to share their experience of mental health services and help improve future care across the country. The launch of a national survey is hoped to help improve the care available for veterans as they move from military to civilian life. The survey is a chance for veterans to share their experiences and views of existing mental health services and to understand the reasons why some people have not sought or received support and treatment. In addition to seeking views from veterans, family members and carers, as well as staff and organisations that are providing treatment and support in this area are all able to take part.

viii. People with Learning Disabilities

People with learning disabilities are thought to be more vulnerable to mental health issues. Estimates of prevalence of mental health problems of people with learning disabilities range from 25 – 40%, depending on the population sampled and the definitions used.

'No Health without Mental Health' notes the increased risk of mental health problems faced by people with learning disabilities and sets two

aims for improvement:-

- Inclusivity of mainstream mental health services for people with learning disabilities who have mental health problems; and

- Development of appropriate skills and provision of adjustments to meet the individual needs of people with learning disabilities and autism.

Within Barnsley, BCCG and BMBC commission SWYPFT to provide community health and social care services for people with a learning disability. SWYPFT have a Learning Disabilities team who work closely with all partners to ensure the best outcomes for people with Learning Disabilities, in both their physical and mental health and wellbeing.

In addition, Barnsley have a Mental Health and Learning Disability Interface Group, which is a group of people who meet regularly throughout the year to share good practice, ensure the development of appropriately robust pathways of care and discuss any concerns.

ix. Black and Minority Ethnic Groups (BME)

In general, rates of mental health problems are thought to be higher in minority ethnic groups in the UK than in the white population[20] . In addition two thirds of refugees are thought to have experienced anxiety and depression[21], which may often be linked to war, imprisonment, torture or oppression in their home countries, and/or social isolation, language difficulties and discrimination in their new country.

Although Barnsley has a small population of people from BME groups, it is essential that they are provided with equal access to all health and social care services within Barnsley. This may require information/ consultations to be provided in different languages, different media to ensure that people from BME groups are aware of the choices available to them and understand how and when to access health and social care services.

Of Barnsley's school age population (5-16 years) 6.7% are from a BME group and with the continuing world refugee crisis and the flow of

[20] Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England p.10, National Institute for Mental Health in England, Leeds: NIMHE, (2003)

[21] Burnett A, Peel M, Health Needs of Asylum Seekers And Refugees, British Medical Journal, 322 pp544-547 (2001)

economic migrants it is likely that Barnsley's BME population will grow.

x. Lesbian, Gay, Bisexual and Transgender (LGBT)

Although nationally attitudes towards gay people are improving, most lesbian, gay and bisexual people have experienced difficulties in their lives. Being gay does not, in and of itself, cause mental health problems. Instead, homophobic bullying, rejection from family, harassment at work and poor responses from healthcare professionals are still commonplace for many lesbian, gay and bisexual people[22].

It is evident that lesbian, gay and bisexual people are more likely to have experienced depression or anxiety, attempted suicide or had suicidal thoughts, and self-harmed than men and women in general. For young lesbian, gay and bisexual people who have experienced homophobic bullying, levels of suicidal thoughts and depression are far higher than amongst those who have not been bullied.

Recommendations of the Stonewall organisation of steps that health and social care services can take to improve the mental health of lesbian, gay and bisexual people are:-

- Whenever possible, identify patients who are lesbian, gay or bisexual and take proactive steps to enable them to receive the best possible care
- Work alongside schools and other education organisations to focus on early intervention and tackle homophobic bullying
- Train staff on the specific mental health needs of lesbian, gay and bisexual people.

4. ENGAGEMENT

In preparation for developing a Mental Health Strategy for Barnsley work commenced in 2013. A full open consultation was carried out and the key themes highlighted were the need to increase access and reduce waiting times, bring services closer to home, improve crisis services, earlier intervention and the need to tackle stigma and discrimination.

More recently this has been built upon utilising a more intense, short period of engagement has taken place (see full Engagement Report: Appendix 3) with service

[22] www.healthylives.stonewall.org.uk/includes/documents/cm_docs/2012/m/mental-health.pdf

users and their families, service providers, clinicians, GP's, voluntary local and national bodies and the Barnsley general public via on-line questionnaires and/or face-to-face discussion /forums.

In addition to this we have looked at National and Local Policies and together with the feedback from our consultation process we now have a clear understanding of the issues in Barnsley which impact on people's mental health and wellbeing, people's vision for the types of services they would like to be able to access and the resources available to deliver those services and the barriers that we need to overcome.

This strategy outlines our vision for Barnsley's mental health and wellbeing as allowing people in Barnsley with functional mental health issues to:

"exercise the maximum possible choice and control of their lives and the outcomes they and their families want. Through the provision of a range of local, flexible community and hospital based services, which have a strong recovery focus and promote social inclusion."

5. DELIVERING DESIRED OUTCOMES

Through discussion with partners and the wider engagement process it is evident that this strategy needs to focus on the following priority areas:-

1. Prevention and early intervention for mental health and wellbeing

2. Improve access to mental health services and reduce waiting times from referral to assessment/treatment to ensure that the most appropriate support is delivered at the right time, in the right place

3. Reduce stigma and discrimination

4. Improve recovery and resilience - provide service users with the information required for them to be able to make the most appropriate choices in how support is delivered to them to aid their recovery.

5. To improve the support provided to families and carers.

These priorities will be delivered over the course of this strategy in the following ways:-

- We will commission high quality, patient centred, mental health services with an emphasis on recovery

- We will commission services that are needs-led

- We will commission services that help to build resilience and self-management

- We will work with services to ensure that, as a minimum, national waiting time standards are achieved

- We will work with partners to continually develop and further improve prevention and early intervention services

- We will continue to support the transformation of mental health services currently being undertaken by SWYPFT (Barnsley's mental health services provider) to ensure that the models of service delivery improve outcomes for service users and their carers

- We will ensure that adults will continue to be given the right to make choices about the mental health care they receive. To assist this objective we will develop the use of Personal Health Budgets informed by national strategy

- Where the need is evident we will improve access to appropriate psychological therapies for both adults and children and young people

- We will work with partners to improve the emotional health and well-being of children and young people by implementing the recommendations contained within the 'Future in Mind' report of the Children and Young People's Mental Health Taskforce, as contained within Barnsley's Local Transformation Plan

- We will work with service providers to ensure that children and young people have a positive experience when transitioning, at the appropriate time, to adult services

- We will work with partners to ensure the continued implementation of Barnsley's Mental Health Crisis Care Concordat Action Plan thereby ensuring that that no one experiencing a mental health crisis will ever be turned away from services and will receive the care they need

- We will work with partners to ensure that mental health care and physical health care are better integrated

- We will work with partners to see how we can better support new mothers in order to minimise the risks and impacts of post-natal depression
- We will work with partners to develop a more vibrant, robust third / voluntary sector serving the Barnsley community

- We will work with partners to identify how we can best help people with mental health problems who are unemployed to move in to work and we will support employers to help people with mental health problems remain in work

- We will work with partners to identify what more can be done to ensure that more people with mental health problems are able to live in homes that support their recovery

- We will work with partners to ensure that the mental health needs of Veterans are met and that we adhere to the principles of the Armed Forces Covenant

- We will work with partners to review the impact of domestic violence on families and the community and develop services to improve the health and social care outcomes associated with domestic violence

- We will work with partners to ensure seamless provision of services for those people who have mental health problems and also have issues with substance misuse (namely drug and/or alcohol) in order to improve the outcomes of this client group

- We will work tirelessly with partners to inspire a culture where discrimination has no place and where stigma is challenged; we will help to raise awareness and understanding of mental health issues throughout the community and promote mental wellbeing

6. GOVERNANCE

Barnsley's Mental Health and Wellbeing Commissioning Strategy builds on the learning and requirements of national strategies and documents whilst greatly benefitting from engagement with people with mental health problems, carers, service providers, clinicians, public sector and voluntary organisations.

The strategy will be endorsed by all partners at the Clinical Commissioning Group's Clinical Transformation Board and thereafter, an Annual Report will be submitted to the Clinical Transformation Board to formally report its progress.

Through the Joint Commissioning Unit (CCG and BMBC Commissioner) the actions identified in section 5 will become the basis for a detailed action plan which will be monitored by the JCU and the CCG's formal meetings with the provider:-

- Clinical Quality Board
- Contract Management Executive Board

With each Annual Report all of the actions contained within the strategy will be assessed for the difference each action has made to the mental health and wellbeing of Barnsley people. The stated actions will be revised as necessary in order to sustain continued improvement to the mental health and wellbeing of people resident in Barnsley.

Appendix 1: Outcomes Frameworks

NHS Outcomes Framework

The NHS Outcomes Framework 2015/16 sets out the outcomes and corresponding indicators that will be used to hold NHS England to account for improvements in health outcomes, as part of the Governments mandate to NHS England.

Indicators in the NHS Outcomes Framework are listed below with some of the improvement areas and indicators specific to mental health within each of those domains:

Domain	Performance Indicator
Domain 1: Preventing people from dying prematurely	• Under 75 mortality rate in adults with serious mental illness • Under 75 mortality rate in adults with common metal illness • Suicide and mortality from injury or undetermined intent among people with recent contact from NHS Services
Domain 2: Enhancing quality of life for people with long-term conditions	• Health-related quality of life for carers • Employment of people with mental illness • Health-related quality of life for people with mental illness
Domain 3: Helping people to recover from episodes of ill health or following injury	• Total health gain as assessed by patients for elective procedures i. Psychological therapies ii. Recovery in quality of life for patients with mental illness • Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services • Proportion offered rehabilitation following discharge from acute or community hospital
Domain 4: Ensuring that people have a positive experience to care	➢ Patient experience of community mental health services
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	➢ Patient safety incidents reported

Public Health Outcomes Framework

The vision of the Public Health Outcomes Framework is to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest. It concentrates on how to:-

- Increase health life expectancy
- Reduce differences in life expectancy
- Health life expectancy between communities

Domain	Objective
Domain 1: Improving the wider determinants of health	Improvements against wider factors that affect health and wellbeing, and health inequalities. Indicator: • Children in poverty • First time entrants to the youth justice system • % of adults in contact with secondary mental health services who live in stable and appropriate accommodation • People in prison who have a mental illness or a significant mental illness • Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate
Domain 2: Health Improvement	People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities. Indicator: • Emotional wellbeing of looked after children • Self-reported wellbeing - people with a low satisfaction score • Self- reported wellbeing - people with a low worthwhile satisfaction score • Self-reported wellbeing – people with a low happiness score • Self-reported wellbeing – people with a high anxiety score • Average Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) score

Domain 3: Healthcare and premature mortality	Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities. Indicator: • Suicide rate • Health-related quality of life for older people

Adult Social Care Outcomes Framework

This framework highlights key aspects in recovery:

- Earlier diagnosis and intervention mean that people are less dependent on intensive services
- When people become ill recovery takes place in the most appropriate setting and enables people to regain their wellbeing and independence

Domain	Outcome measure
Domain 1: Enhancing quality of life for people with care and support needs	• Proportion of people who use services who have control over their daily lives • Proportion of people using social care who receive self-directed support, and those receiving direct payments • Carer- reported quality of life • Proportion of adults in contact with secondary mental health services in paid employment • Proportion of adults in contact with secondary mental health services living independently, with or without support • Proportion of people who use services and their carers, who reported that they had has much social contact as they would like
Domain 2: Delaying and reducing the need for support	• Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
Domain 3: Ensuring that people have a positive experience of care and support	• Proportion of carers who report that they have been included or consulted in discussions about the person they care for

	• Proportion of people who use services and carers who find it easy to find information about support
Domain 4: Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	• The proportion of people who use services who feel safe

Appendix 2: Community Mental Health Profiles 2014

The following areas have been identified in the Community Mental Health Profiles 2014[23] as being areas where Barnsley has significantly worse rates compared to the England national average:

Area for improvement	Barnsley	England average	England best
Levels of mental health and illness			
Depression: QOF prevalence (18+)	8.0%	5.8%	2.9%
Depression: QOF incidence (18+)	1.4%	1.0%	0.5%
% reporting a long-term mental health problem	6.5%	4.5%	2.5%
Treatment			
Patients with a diagnosis recorded	3.9%	17.8%	63.2%
Patients assigned to a mental health cluster	62.4%	69.0%	94.8%
Patients with a comprehensive care plan	83.1%	87.3%	95%
Patients with severity of depression assessed	84.8%	90.6%	97.8%
Antidepressant prescribing (ADQ's/STAR-PU)	8.1%	6.0%	2.7%
People in contact with mental health services per 100,000 population	3,764	2,160	115
Outcomes			
%CPA adults in settled accommodation	52.2%	61.0%	94.96%
%CPA adults in employment	2.7%	7.0%	22.7%
Emergency admissions for self-harm per 100,000 population	200.9	191.0	49.8
Suicide rate	9.5	8.5	4.8

[23] The Community Mental Health Profile 2014 published by Public Health England http://fingertips.phe.org.uk/profile-group/mental-health/profile/cmhp/data

Appendix 3: Engagement Report

NHS Barnsley Clinical Commissioning Group

Internal report detailing the outcome of the Mental Health and Wellbeing Strategy Engagement – Phase Two

September – November 2015

1. Background

We are currently working alongside our partners within health and social care in Barnsley to lead the development of an all age (i.e. children, working age adults and the elderly – excluding dementia services) local Mental Health and Wellbeing Commissioning Strategy to cover the next five years. This is being developed to reflect recent mental health policy guidance and to complement the work currently being undertaken to transform mental health services in Barnsley.

In order for us to develop a meaningful strategy we need to capture and recognise the views and wishes of service users, their carers and mental health professionals from across Barnsley.

Overview of first phase of engagement

NHS Barnsley Clinical Commissioning Group (CCG) and Barnsley Metropolitan Borough Council (BMBC) along with our key local partners who are working to commission and deliver Mental Health services across Barnsley wanted to understand the experience of service users and carers who seek help when it is needed, and to understand what assists them in their journey of "recovery". In essence we needed to find out what is working and what is not; what helps at those decisive moments and what does not? We also wanted to understand what this is like from the perspective of those professionals and organisations responsible for delivering Mental Health Services in Barnsley.

To date we have already collected lots of feedback from local services and events over the past year. From this work, the main areas that people have told us matters to them were as follows:

- Improved access to services
- Bringing services closer to home
- Earlier intervention
- Improved crisis services
- Tackling barriers to employment
- Tackling stigma and discrimination.

During August 2015, we carried out our first phase of targeted engagement with mental health professionals, partner organisations, service users and carers to see if the areas highlighted above were still of the highest importance, also to give the opportunity for additional people to have their say and for respondents to add any other areas they think might have been missed from the list above.

In order to help us to achieve the above, we designed two brief surveys to gain feedback from (a) service users and carers about their views and experiences of both accessing and using Mental Health across Barnsley and (b) mental health professionals and associated stakeholder organisations about their views of delivering Mental Health services locally.

We particularly asked for feedback (drawn from personal experiences where possible) in relation to the following questions from all groups:

- **What do you think is particularly good about Mental Health Services in Barnsley and what do you feel needs improving? (Please tell us the reasons for your answers)**

- **If you could change three things about mental health services and support what would they be?**

We also specifically asked service users and carers to also tell us what helps to keep them well and for the professionals working in the field of mental health we asked them specifically what changes they felt were required to support them to deliver mental health services in Barnsley.

The survey was posted online on the NHS Barnsley CCG website (www.barnsleyccg.nhs.uk) and also kindly circulated by local partners working across the health and social care economy. This was also circulated, to members of the NHS Barnsley CCG Patient Council and to members of the OPEN (Our Public Engagement Network) Database. Paper copies were also available on request and copies were circulated to MIND for them to host in their reception area.

The survey was also promoted to the local press and on social media via the CCG Facebook and twitter pages on a regular basis throughout the engagement period.

In addition to the above Healthwatch Barnsley kindly provided us with patient and carer experience data that they had collected locally in relation to mental health services and we were also able to utilise the local data captured as part of the National Mental Health Taskforce Survey undertaken earlier in 2015 in order to inform the Five Year National Strategy for Mental Health in England.

Feedback received for first phase of engagement

Overall in relation to the two specific surveys that we undertook as part of this phase of engagement, we received feedback from 62 people covering a varied range of aspects of mental health.

This feedback has been added to the wealth of information kindly collected and shared with us by our partner organisations in order to help to try to give a fuller picture of people's experiences of mental health services locally. The collective comments and themes were then fed back to Patrick Otway, the lead Mental Health commissioner within the CCG in order to inform the draft first version of the strategy.

Due to the number of comments received, example comments were highlighted in relation to each of the themed areas rather than including every single comment received. A copy of the summary report detailing feedback from the first phase of engagement can be accessed via the NHS Barnsley CCG website at www.barnsleyccg.nhs.uk

2. Acknowledgements

We would like to take this opportunity to express our gratitude and to sincerely thank all of the individuals and organisations who have taken the time to share their extremely valuable views and feedback over both phases of engagement.

We would particularly like to thank Alison Rumbol, Senior Commissioning Manager for BMBC for providing us with a wealth of information and feedback that she has previously sourced in order to inform the new strategy and also for helping to share the opportunity for people to be involved and provide their feedback as part of this process far and wide.

Our thanks also goes to Antonia Borneo (NHS England) and Amy Bachelor (Rethink Mental Illness) for providing us with the area specific data that was gathered as part of the National Mental Health Taskforce Survey undertaken earlier in 2015 in order to inform the Five Year National Strategy for Mental Health in England.

We would also like to acknowledge the assistance received from our local partners with particular thanks to Healthwatch Barnsley who provided their help in promoting both engagement periods and gaining such valuable feedback from local service users and their carers to help inform this process and ultimately the new strategy, and also Health Deafinitions who gained and provided us with really valuable and constructive feedback and insight in terms of the British Sign Language film developed to support the engagement.

3. Our Engagement Approach for Phase 2

Throughout both phases of engagement we set out with the aim to carry out engagement activity that would:

- Obtain views and feedback from the general public and relevant service user / carer groups from across Barnsley. With the overall aim that this would help shape the strategic direction for the member organisations of the Barnsley Mental Health Partnership over the next five years.

- Provide robust local intelligence and insight to ensure that future commissioning plans relating to mental health and wellbeing are based around the needs and wants of the local community.

- Meet the statutory duty to engage in accordance with the Health and Social Care Act 2012 which introduced amendments to the NHS Act 2006 highlighting two specific legal duties which require CCGs and commissioners to enable:

  1) Patients and carers to participate in planning, managing and making decisions about their care and treatment, through the services they commission and

  2) The effective participation of the public in the commissioning process itself, so that services provided reflect the needs of local people.

This first engagement phase was carried out between the end of July and September 2015. Following the end of this first phase the information received was collated into a summary feedback report and fed back to the lead commissioners to be used to inform the draft strategy which was compiled by Patrick Otway, Head of Commissioning for Mental Health Services for NHS Barnsley CCG for this further stage of engagement (Phase 2) which has been undertaken from September to November 2015.

The original deadline for feedback was to be Wednesday 14 October. However, following the feedback received from Service Users, Carers and our local partner organisations regarding the timescales for comments; the deadline for responses for this phase of engagement was extended to Friday 13 November 2015. It was felt to be preferable to undertake an extended second period of engagement, with those people who had contributed in the first phase, focused specifically upon the content of the draft strategy to ensure that any further patient and public views could be taken into consideration before the strategy is signed off in early 2016.

For the second phase of engagement, we carried out a targeted engagement process inviting views on the draft strategy from across the Borough and specifically from previous respondents. This was publicised and included within the appendix, the summary report detailing feedback from the first phase of engagement. A copy of the report was sent directly to all respondents from the first phase of engagement that have provided their contact details along with further information as to how they could provide feedback regarding the draft strategy.

Details of how to provide feedback were posted online on the NHS Barnsley CCG website (www.barnsleyccg.nhs.uk) and also kindly circulated by local partners working across the health and social care economy. This was also circulated, to members of the NHS Barnsley CCG Patient Council and to members of the OPEN (Our Public Engagement Network) Database.

The information was also promoted to the local press and on social media via the CCG Facebook and twitter pages on a regular basis throughout the engagement period.

Healthwatch Barnsley also kindly provided their assistance by circulating the information to the groups and individuals on their database and in receipt of their e-bulletin.

We also developed a British Sign Language Short Film version of the draft strategy following feedback we had received during the first phase. We circulated this to the appropriate colleagues and asked for them to share this with their forums locally in order to gain their feedback on the suitability of the film, it's content and any lessons that we could take forwards for the future in terms of developing these type of short films as a way in which to engage with members of our local deaf community.

This report details the feedback received from the second phase of engagement that took place in order to request feedback on the draft strategy document. We specifically requested feedback as to whether people felt that the draft Barnsley–wide Commissioning Strategy for Mental Health and Wellbeing reflected the views of patients and carers on their experiences of mental health services across Barnsley and if the draft Strategy had been sufficiently informed by the feedback that had been provided previously. We particularly invited comments and feedback from people if they had any specific points they wished to raise about perceived weaknesses in the draft Strategy or wanted to suggest amendments/ additions for consideration/ inclusion.

4. Overview of Feedback Received

During this second stage of targeted feedback, we received often detailed and sometimes very personal comments/feedback from twenty different sources (mixture of individual and organisational responses).

Due to the lack of further feedback we received from the people who were directly contacted (who had provided their views and feedback as part of the first phase of engagement) and the nature of the majority of the comments from the feedback that we did receive, it is anticipated that the lack of response in large number indicates that the draft strategy in the main covers the right areas that local patients and carers wished to see included following the feedback that they had kindly provided as part of the first phase of engagement, with some additional information/ areas/ sources suggested for inclusion or further emphasis.

All of the individual feedback was received in writing and due to the relatively small number of responses received they have been highlighted in full below where appropriate (although they have been anonymised in order to protect the identity of the respondents). We have also included the broad themes covered relating to any concerns and positives expressed relating to the draft strategy document.

Response 1 – Received 28/09/15 – GP (Out of Hours Care)

Thanks for opportunity to comment.

Hope Dementia gets discussed as well, as this to my mind is a more major issue in Out of Hours.

General Themes	Positives	Suggestions/ Concerns
Dementia	N/A	N/A

Response 2 – Received 29/09/15 – Respondent from Barnsley Metropolitan Borough Council

Query regarding opportunity to input into the strategy from South Yorkshire Police and statistics collected from them to inform the draft strategy.

Low level Mental Health issues and demands as presented to the police significant issue and challenge rose at the Police and Crime Commissioner Workshop in context of reducing resources in the police over next two years

General Themes	Positives	Suggestions/ Concerns
Input and linkages to South Yorkshire Police in terms of Mental Health Strategy	N/A	N/A

Response 3 – Received 02/10/15 – Respondent from Barnsley Metropolitan Borough Council

I have briefly looked through the strategy for mental health and I note an omission relating to dual diagnosis which is a significant area of concern. In addition substance misuse generally and mental health is an area of concern that is not reflected in the strategy.

In Barnsley, there are currently dual diagnosis link workers embedded within teams at BTRN (Phoenix Futures and SWYFT) and the Harm Reduction Service (Addaction), as well as in various mental health services including early intervention, inpatient, community (CMHT) and Access teams.

6% of those starting a new drug treatment journey, and 7% of those starting a new alcohol treatment journey in Barnsley during 2013/14 had a recorded dual diagnosis. This is lower than the national identification levels indicated by NDTMS (18% for drug and 19% for alcohol treatment clients), though it should be noted that these figures reflect only those with a formal mental health diagnosis for which they are receiving intervention at the start of their treatment. Based on research this figure is likely to be a marked underestimate of actual prevalence.

If, as research suggests, up to 93% of those in contact with substance services have some level of concurrent mental health issue, up to 718 clients entering the Barnsley treatment system in 2013/14 may have some mental health needs. Many of these will be at a level that need minimal intervention and/or can be managed appropriately by substance misuse services; some will have more complex mental health needs requiring onward referral and collaboration between mental health services and substance misuse services. BTRN already prioritise referral of clients thought to have serious undiagnosed mental health concerns.

Ensuring continued work to identify substance misuse treatment clients with mental health needs, and vice versa, will help to embed and sustain the necessary collaborative work. Can you confirm if this is an oversight?

N.B. Respondent contact details passed to lead commissioner for follow up

General Themes	Positives	Suggestions/ Concerns
Dual Diagnosis Substance Misuse and links to Mental Health integration, collaboration and working in partnership across services	N/A	Omission of linkages to substance misuse and Mental Health / Dual Diagnosis

Response 4 – Received 02/10/15 – Respondent from Barnsley Metropolitan Borough Council

Now I have had opportunity to read this strategy … I'm quite shocked that it acknowledges the link between poor mental health and poor housing and associated issues, yet then does not include substance misuse as a specific vulnerable group.

Also, the inclusion of looked after children is welcome – but ought to be wider to reflect not all vulnerable young people housed away from their parents are 'looked after' but again – this doesn't mention the huge problem faced by this group of the cliff edge in service delivery when they reach 18, and CAHMS is withdrawn, and they find their issues do not meet the criteria for adult services, or if they do, available services are inappropriate.

N.B. Respondent contact details passed to lead commissioner for follow up

General Themes	Positives	Suggestions/ Concerns
Consultation process Substance misuse and links to Mental Health Vulnerable groups - criteria Transition between child and adult services	Inclusion of looked after children	Criteria too narrow relating to vulnerable groups Lack of link to Substance Misuse and Mental Health Transition between CAMHS and Adult MH Services

Response 5 – Received 04/10/15 – Service User Response

I recently read through the new strategy for mental health in Barnsley and just had a few comments regarding the approach to mental health provision generally.

As someone with a mental health issue myself who has been trying to access services for the past couple of years I completely concur with the general consensus that waiting times are appalling. This is one of the main problems - I was told I'd have to wait 12 months to access psychological treatment so I have sought out a specialist eating disorder service, SYEDA, which is now about to start operating in Barnsley but last year I could only access it in Sheffield. Also there is a payment for this service.

I have a couple of points:

Firstly, I think there needs to be more specialist provision for eating disorders. The services available on the NHS seem to be more suited to anxiety and depression and there doesn't seem to be much knowledge of eating disorders, hence why I have gone to a specialist service. Eating disorders are on the rise so getting services ready now to serve the demand is important.

Secondly, good mental health is something we all need to function; it is with us every day and at every moment so if we are struggling with any kind of mental health problem this will affect every aspect of our lives.

With this in mind - as well considering the lack of availability of services and the long waiting times - I believe mental health services need to be integrated into everyday life. By this I mean one or two counsellors could be made available in every place of work and educational institution. I believe in the long term this will save a lot of money; fewer people will be off sick which costs companies a huge amount of money. Also, it means services are more readily available and accessible, as having services for a large area located in one place makes access very difficult.

Alongside this kind of provision, small specialist services could also be available for more specific problems. I understand this is a completely different delivery model but with access and availability being the main two issues I really think it could work. Long waiting times is, for a lot of people, a life or death situation. Having someone on hand on the day that you need them is vital. It will prevent people's problems from escalating. I believe it could be more efficient.

I would like to know what happens with feedback. Will I receive a response on my comments?

General Themes	Positives	Suggestions/ Concerns
Unacceptably long waiting times to access services Lack of availability of specialist services on NHS (Eating Disorders)	Specialist services and support - SYEDA Acknowledgment in strategy of unacceptable waiting times to access support services	Lack of wide range of specialist services available on NHS to meet growing demand. Payment for specialist services incurred by service users - eating disorder

More generalist services and integration of MH Services into everyday life e.g. via work and education access to counsellors due to growing need ensuring service is accessible and responsive to need. Change to model of delivery and suggested approach		Waiting times to access services

Response 6 – Received 09/10/15 – Respondent from Barnsley Hospital NHS Foundation Trust

After reviewing the draft strategy my comments naturally surround maternal mental service provision.

Within the national maternity priorities maternal mental health is a key priority with a regional group in place to review current service provision, expected national guidance from DH/ Nice and how to implement locally.

I can find very little specifically around maternal mental health in the draft strategy and I believe this is an opportunity missed for an extremely vulnerable group. We have had several meetings over the past years … and find it extremely disappointing that the work discussed and progressed by BHNFT is neither referenced, nor acknowledged in the draft strategy, or of the work we were in agreement needed to happen.

The issues with maternal perinatal mental health can impact enormously upon the foetus/new-born and child growing up, and thus public health not only now but in the generations to come.

I do acknowledge MH is everyone's business however I do think you should specifically reference and consider this specific client group who are extremely vulnerable in pregnancy and post-partum more than the current strategy appears to.

I am happy to share some of the work we have progressed in maternity services, but there is so much more to do to improve maternal emotional wellbeing in Barnsley.

On a positive note it is really good to see children and CAMHS in the strategy.

N.B. Respondent contact details passed to lead commissioner for follow up

General Themes	Positives	Suggestions/ Concerns
Maternal Mental Health Provision - key national priority Perinatal Mental Health and specific issues relating to this and impact Child and Adolescent Mental Health Services (CAMHS)	Inclusion of CAMHS in the strategy	Lack of acknowledgement for Maternal Mental Health in the strategy and work that has already taken place both locally and nationally which can hopefully be rectified

Response 7 – Received 12/10/15 – Respondent from Barnsley Hospital NHS Foundation Trust

On reading the Mental Health Strategy for Barnsley I am aware a significant amount of work has been done, both with providers and service users to ensure a well-developed and thought out strategy is developed. However there seems to be an absence of information regarding the mental health of pregnant women.

There is significant research to show that pregnant women's mental health can be affected both during and after pregnancy. I work within Barnsley Hospital NHS Foundation Trust as a Pregnancy Loss and Pre and Post Termination counsellor. At present I am only employed one day a week but have a waiting list of several weeks.

In reading the strategy I am aware that one of the areas service users complain about is the length of time they have to wait for an appointment. Many of my clients when they ring for an appointment have reached a point where they feel they can no longer cope on their own and require support and to be told they will have to wait a few weeks for an assessment appointment and then a few weeks more for ongoing counselling sessions can be very detrimental to their emotional health and wellbeing.

At present I cannot take referrals from sources outside BHNFT … therefore the Mental Health Access Team and GP's have to ask their patients to self-refer into my service, this in itself is an enormous challenge for people who are struggling mentally. My clients can self-refer in or be referred from gynaecology or midwifery services.

If we can work with women when they are feeling mentally vulnerable and improving their mental health this can have a positive impact on future pregnancies, thus reducing unnecessary medical costs.

I see women who have experienced pregnancy loss/terminations many years after the event, often they have presented to their GP with low mood and symptoms of depression and anxiety which can be traced back to their pregnancy and loss related issues.

If you require any further information on the service offered I am more than happy to meet with you. I feel it is extremely positive the Mental Health Strategy for Barnsley is being developed and will I'm sure be instrumental in improving the mental health of residents in the area.

N.B. Respondent contact details passed to lead commissioner for follow up

General Themes	Positives	Suggestions/ Concerns
Maternal Mental Health Provision - key national priority Perinatal Mental Health and specific issues relating to this and impact Waiting times and referral criteria for specific service. Importance of early intervention	Development and aim of the strategy	Lack of acknowledgement for Maternal Mental Health in the strategy and work that has already taken place both locally and nationally. Waiting times and referral criteria for specific service Access to specialist services

Response 8 – Received 12/10/15 – Respondent from Barnsley Hospital NHS Foundation Trust

Mental health is vital in the perinatal where women are a vulnerable group however there is only a small amount written in the draft.

After the recent incidence in Sheffield of a woman who committed suicide there is not enough support for these women.

I have just started as a mental health midwife in June with only 22 hours allocated which is not enough as I have been inundated with women that have mental health many that are on medication and need regular support through this period.

I therefore believe that perinatal needs to be a priority for these women that use our service in Barnsley…

General Themes	Positives	Suggestions/ Concerns
Perinatal Mental Health and importance of its inclusion in the strategy Lack of specialist support to meet local need	N/A	Perinatal Mental Health and importance of its inclusion in the strategy Lack of specialist support to meet local need

Response 9 – Received 12/10/15 – Comments received from South West Yorkshire Partnership Foundation Trust staff

Thank you for sending the first draft of the Mental Health Strategy which is helpful in setting out the national and local priorities from a commissioning trajectory perspective.

In our discussions and also feedback from other senior healthcare professionals, Clinical Senate and other professional groups there have been gaps/less than optimal provision identified in our current mental health commissioning and as a consequence service provision.

I do hope there is scope for these areas to be addressed/ mitigated given the commissioning resource implications. I appreciate that a high level document will not be able to do justice to specifics of contract architecture and agreeing KPIs.

General Themes	Positives	Suggestions/ Concerns
Concern relating to gaps in current Mental Health commissioning/ service provision Contracting and Key Performance Indicators - effectiveness monitoring	National and local context perspective	Concern relating to gaps in current MH commissioning/ service provision Contracting and KPI's - effectiveness monitoring

Response 10 – Received 14/10/15 – Response on behalf of South West Yorkshire Partnership Foundation Trust

Thank you for the opportunity to comment on the draft Strategy document which we found to be consistent with our vision, values and direction of travel for our services. Please find below some comments that we would like to be considered as the strategy is developed further;

Adult Mental Health - Reference to services for older people with mental health needs – SWYPFT currently provides a needs led rather than age based service with flexible provision for people which responds to their presenting need and level of vulnerability making adjustments or acknowledging their age related need/ frailty.

It would be helpful to understand where ASC and ADHD services for both adults and children fit into the strategy. These services can be expensive and traditionally underfunded and new ways of working need to be explored across the whole pathway to find innovative and cost effective solutions.

Services for Offenders – there are currently no references to the newly commissioned Liaison & Diversion from Custody service which is ageless and incorporates YOT and CAMHS - this could be acknowledged as a positive step forward and for further development as part of the strategy as NHSE are taking a significant interest in this area of service provision.

Veterans are an identified vulnerable group which has not been mentioned - there is a lot of ongoing partner networking taking place in Barnsley at present and there are national requirements around support.

Carers - and support for Carers are referenced only briefly. Not only are Carers essential to the care of many service users with mental health issues, the provisions within the Care Act prescribe much more structured support which all services need to be in a position to respond to positively.

CAMHS - The Trust notes the context whereby the reduction in voluntary and third sector provision has affected people who used these services to manage their difficulties early. This has been particularly noticeable for CAMHS services as much of the support that was previously available to children, young people and their families is no longer available people are therefore referred to CAMHS instead and there is not the third sector support available to support people when discharged or whilst they are waiting for an intervention.

It is good that the strategy acknowledges that the NHS Tier 3 CAMHS service is a small one, unable to meet the demand placed on it and with the consequent long waiting lists for children, young people and their families. Although the Trust has embarked on a plan to ensure that it is providing the most efficient and effective use of its resources, without further investment, it is likely that waiting lists will continue.

We note the national investment in Eating Disorder services, which will be positive for people in Barnsley.

We agree that Looked After Children are a particularly vulnerable group – and that other areas have invested in dedicated services (sometimes joint with the local authority) to ensure that this group of children are prioritised and receive targeted services.

The Trust believes in the importance of early intervention, but the increase in emergency referrals for CAMHS has meant that opportunities for early intervention and outreach has been lost due to the demand in meeting emergencies. Unfortunately, other urgent work has to be prioritised over important planned work at a time of limited resources.

We note that much of the stakeholder concern relates to long waits for a diagnosis of ASD. A new pathway has recently been implemented recently and is very much welcomed.

It is clear from the engagement feedback that the long waits for what is a complex multi-agency task have caused a great deal of concern to parents. Although long waits for an ASD diagnosis are common to many authorities – it is important that we clearly identify the waits for an assessment for a diagnosis as different from waiting for a CAMHS intervention, as they require different solutions and approaches to supporting children, young people and their families.

General Themes	Positives	Suggestions/ Concerns
Consistency within draft to SWYFPT Vision and Values and Direction of travel for their services. Comments for consideration relating to the following; Adult Mental Health and CAMHS	Consistency within draft to SWYFPT Vision and Values and Direction of travel for their services Positive acknowledgement relating to small CAMHS team and their constraints Positive national investment in Eating Disorder services to benefit local people Good to see Looked after Children included as a particularly vulnerable group.	Need to link to ASC and ADHD services for adults and children and where they fit in the strategy No current reference to services for offenders (Liaison and Diversion from Custody Service) No reference to Veterans as a key vulnerable group or no reference to work currently being undertaken in Barnsley around this More reference required in terms of carers and support for carers as a key group Lack of third sector support relating to CAMHS (gap in commissioning) and early intervention particularly - concern that without further investment in NHS Tier 3 CAMHS waiting lists will continue Limited resources for CAMHS and demand exceeding supply thus impacting on opportunities for early intervention Differentiation between waits for diagnosis (ASD) and waits for CAMHS intervention as they require different solutions and approaches

Response 11 – Received 14/10/15 – Respondent from Mental Health Service Provider Organisation

Regarding Mental Health Services in Barnsley, we support young people aged 16-21 years old. We have clients with mental health issues and have been seeing mental health professionals from 13 years of age.

The issues we have as an organisation is when a young person is 18 years old they are referred to adult services and then has to wait for many months for an appointment/assessment. If adult and children's services worked more in partnership and prepared more for when the young person is 18 years old then the gap for support from MH services wouldn't be as long.

It isn't only MH Services in Barnsley there are other services where when young people reach 18 they seem to be abandoned by services. It seems they are left to fend for themselves in the big wide world. If a young person has been seeing MH professionals from 13 years of age there is obviously a need for adult services or the young person would have being discharged beforehand.

These are some of the issues we have in our young person accommodation service. The young person we are supporting has grown attached to her MH professional and when told she wouldn't be seeing the worker again as she was resulted in this young girl self-harming. I suppose in an ideal world there should be a smooth transition from children's services to adult services.
There have already been vast improvements to services but with cuts in services it is the young people who are most vulnerable and feel abandoned by the MH services. We are only a small service but a large organisation. I can only speak for the service we provide in Barnsley. I have attended many meetings where it has been discussed about sharing information but I feel there is still a long way to go before we have reached our/your objectives. If you require more information or feedback feel free to contact me.

N.B. Respondent contact details passed to lead commissioner for follow up

General Themes	Positives	Suggestions/Concerns
Issues relating to transition from CAMHS to Adult MH services and waiting times experienced to access services - lack of integration to ensure smooth transition	Improvements to services already but some way to go for most vulnerable	Issues relating to transition from CAMHS to Adult MH services and waiting times experienced to access services - lack of integration to ensure smooth transition

Response 12 – Received 16/10/15 – Respondent from Mental Health Service Provider Organisation

Our voluntary organisation has just received [funding from the lottery], reaching communities for five years to run a wellbeing centre for young people aged 11 to 18! I would like to be part of [discussions with] the commissioning group and share our services with local providers! I have already met with CAMHS and we have tentatively agreed a way forward. Could you please contact me to discuss further?

N.B. Respondent contact details passed to lead commissioner for follow up

General Themes	Positives	Suggestions/Concerns
Future partnership working relating to CAMHS	Future partnership working relating to CAMHS	N/A

Response 13 – Received 19/10/15 – Respondent from Barnsley Metropolitan Borough Council

Feedback on the Mental Health & Wellbeing Strategy:

Vulnerable Groups – to include 'Current and ex-service personnel' – BMBC have signed an Armed Forces Declaration to support those current and ex- service people.

Need something to reflect: Ensuring referrals to other partners/services that support physical and mental wellbeing. You name SWYPFT as the provider for mental health services but … would it be better to refer to them as the 'Provider' rather than stating their name?

Appendix 7: link to Public Health Strategy and the Suicide Prevention Strategy Page 27: …..issues with substance misuse (namely drugs and alcohol – could you include tobacco) – 44% of consumed tobacco is by those with mental health issues.

General Themes	Positives	Suggestions/Concerns
Vulnerable groups - include military and veterans Physical and mental wellbeing integration Link to other strategies Expansion of substance misuse categories to include tobacco	N/A	N/A

Response 14 – Received 22/10/15 – Response from South Yorkshire Police

I have read through the draft CCG Mental Health & Wellbeing Commissioning Strategy and compared it to the Force MH Strategy and the new MH Interagency Partnership Protocol. There are tentative links to both documents but my overall observation is that it's completely health focused with minimal links to the wider partnership.

The documents referred to in the strategy are limited and restrict the inclusion of other cross cutting- themes which would influence actions and partnership working

There are clear opportunities for the Police to support the NHS that link to the main issues raised by service users and the key actions within our MH Strategy…

N.B. Some specific points were highlighted for consideration at this point linked to direction of travel for South Yorkshire Police in terms of Mental Health and respondent to be contacted by lead commissioner to progress this.

General Themes	Positives	Suggestions/Concerns
Large number of themes covered within comprehensive feedback and sections stated with suggestions for linkages and broader collaborative working. Feedback broadly covers the following areas - CAMHS, Suicide prevention for CYP, Waiting times. Opportunities to work closer around pathways and support mechanisms, mapping of local services etc.	Scope for partnership and closer collaborative working - suggested opportunities to enable this	Very health focused - more scope for links and partnership working with police Links to national strategies more explicit - e.g. suicide prevention Perceived lack of joined up working relating to some of the local work taking place.

Response 15 – Received 23/10/15 – Response from the Quality Improvement Lead- Maternity, Yorkshire and Humber Strategic Clinical Network, NHS England

I would suggest that the strategy makes reference to the following;

[Include] perinatal Mental Health (PNMH) statistics within the introduction. More than 1 in 10 women develop a mental illness during pregnancy or within the first year after having a baby (maternal mental health alliance website)/training staff/early identification of women with existing MH issues and those that develop them during or soon after pregnancy/work with partners to minimise the risk and impact of all perinatal mental health issues.

The following links may be helpful:-

The RCM document Maternal Mental Health includes the following: Education commissioners and providers should review pre-registration and continuing professional development programmes to ensure that midwives gain the knowledge, skills and confidence to deal with perinatal mental health issues. Once qualified, midwives should be encouraged to attend refresher training related to perinatal mental health/Commissioners and providers of maternity services must develop and implement a perinatal mental health strategy in order to ensure that: The needs of women with perinatal mental health issues are recognised and addressed/ Funding arrangements support preventative work and promote multi-professional collaboration/Commissioning, planning and service delivery are based on accurate information, so that issues are identified early and women get the support that they need.

Wellbeing is one of the priorities in The Leeds Maternity Strategy on page 16.

General Themes	Positives	Suggestions/Concerns
Maternal Mental Health Provision - key national priority Perinatal Mental Health and specific issues relating to this and impact Advice and good practice relating to section for inclusion on this subject in the strategy	N/A	N/A

Response 16 – Received 23/10/15 – Respondent from Barnsley Hospital NHS Foundation Trust

Please find my response to the Mental Health Strategy:

One of the key national Maternity priorities is Maternal Mental Health. In this draft strategy there is only one sentence about a woman's mental health and this only refers to after birth, there is nothing in about pregnancy or support for fathers.

As a maternity service we have been attending a regional group chaired and supported by PHE reviewing current service provision across Yorkshire and the Humber, looking at everything from training staff to supporting a perinatal mental health service which is one of the key recommendations in NICE (National Institute for Health and Care Excellence) and working together to share ideas and support each other.

This is a group of women who are extremely vulnerable and their mental health will have long lasting implications for their child and family for the rest of their life. We need to get it right for the women and their babies in pregnancy.

I have attached the project overview for the Perinatal Mental Health Task and Finish Group which gives in much more detail the research, the background and why maternal mental health is so important.

We have had many meetings [locally with lead commissioners in support of] our quest to raise awareness and commission a Maternal Mental Health Midwife which is a recommendation of the 'Specialist Mental Health Midwives, What they do and how they Matter' which is supported by the Maternal Mental Health Alliance, NSPCC and Royal College of Midwives. There is no reference to this in the strategy. I hope you will consider these suggestions and review the regional task and finish group overview as attached.

Thank you

General Themes	Positives	Suggestions/Concerns
Maternal Mental Health Provision - key national priority Perinatal Mental Health and specific issues relating to this and impact Advice and good practice relating to section for inclusion on this subject in the strategy	N/A	Lack of acknowledgement for Maternal Mental Health in the strategy and work that has already taken place both locally and nationally. Waiting times and referral criteria for specific service Access to specialist services

Response 17 – Received 06/11/15 – Respondent from Mental Health Service Provider Organisation

I have been looking through the draft mental health and wellbeing strategy and feel somewhat frustrated that we/I had not contributed to the stakeholder consultation you organised over the summer months. This was entirely my fault as I was alerted … that a consultation process was taking place.

As you may be aware we are currently developing a range of services for people affected by an eating disorder (sufferers and carers) in Barnsley. This has been made possible due to a 3 year funding award from the big lottery.

Much of my time has been preoccupied with developing the infrastructure to meet our stated objectives. This has meant that I have not directed my attention to a number of important tasks including sharing our experience and perspective with stakeholders during the consultation process.

My email therefore is concerned with two questions; firstly are there still opportunities for us to be involved in the development of the strategy, aside from the feedback and comments already invited, and secondly if there are opportunities for us to contribute what information would you think helpful in preparation for that.

Please accept my apology for asking for something that has already been offered in the past and for potentially adding to your workload but I am very anxious that eating disorders are not overlooked when decisions are being taken about what services are needed in Barnsley. Please do not hesitate to contact me if you wish to discuss any of the above.

N.B. Respondent contact details passed to lead commissioner for follow up

General Themes	Positives	Suggestions/Concerns
Specialist services and support Desire to be involved in development of local service and local transformation planning	N/A	Ensure that eating disorder services not overlooked as part of decision making

Response 18 – Received 11/11/15 – Response received from Michael Dugher, MP for Barnsley East

The comprehensive feedback letter sent to Dr Nick Balac, Chair of the CCG covers a number of areas including the following; CAMHS, Adult MH, links between employment and MH, Early Intervention, Evaluation and Measurement of Strategy Goals, Care closer to home, Integration of care and partnership working, importance of working with service users and carers, and the engagement process.

Please find the link to the letter in full which can be accessed via the news section on Mr Dugher's website here

General Themes	Positives	Suggestions/Concerns
Letter covers a number of areas including the following; CAMHS, Adult Mental Health, Links between employment and MH, Early Intervention, Evaluation and Measurement of Strategy Goals, Care closer to home, Integration of care and partnership working, Importance of working with service users and carers as part of the overall engagement process.	Welcomed development of strategy and prioritisation of CAMHS and early intervention. Focus on prevention and integration	Communication between CAMHS and schools - need to include on list of delivery mechanisms Increased emphasis between employment and mental health and planning for increase in people who need access to MH services Care closer to home and inclusion of where people can access treatment locally Inclusion of Mental Health Specialists in Primary Care - viable option? Early intervention - integrated services to help prevention How will the strategy be achieved? Action Planning? Measurement of targets and inclusion of local performance indicators Include timescales and milestones for regular review against targets to ensure strategy remains current Lack of accountability for failure to deliver - governance More detail relating to finance and how delivery of the strategy will be funded. Gaps left by voluntary sector activities and support and how these will be filled Future engagement - more explicit references to service users and carers alongside

		reference to partners in document as lack of this currently Engagement process - concerns over promotion of opportunity to feedback. Lack of demographic information relating to feedback stated in initial engagement report. More reference to full and ongoing engagement as concerns over diversity of responses and whether respondents specifically targeted rather than wider engagement carried out.

Response 19 – Received 12/11/15 – Service User Response

Thank you for the opportunity to comment on the first draft of this important strategy, it is a good first step in producing a way forward to improve the mental health for all residents in Barnsley. In my opinion there are two important parts of the document, the community mental health profiles and the results of the public and professionals engagement exercise.

For the levels of mental health illness, I note that Barnsley population is worse than the England Average, surely as a minimum one of the goals of this strategy should be to get to that average over the lifetime of this strategy, this should be clearly stated as a goal in the strategy.

For treatment in all cases Barnsley is below the national average, again achieving the national average should be a minimum goal for this strategy to achieve. Again this should be clearly stated. The people in contact with mental health services should be separate as it is not really a treatment goal.

On outcomes the Barnsley data is again worse than the England average, again achieving the national average should be a minimum goal for this strategy to achieve. Again this should be clearly stated.

The phase one engagement was an excellent piece of work and showed a high level of agreement between patient, parent and carers responses and those of professionals which provides in my opinion a high level of confidence in the results of this exercise. The main areas of concern are ease of access to services and waiting times for assessment and then the waiting times for treatment.

I note in the report mention is made to yet unpublished national waiting times. However it is not known if these will cover all services and specialities. A table detailing waiting time average and maximum for all areas and specialities should be included in this strategy to provide a picture of the problem. I feel an explicit goal should be added that a maximum waiting time to access all services will be xx months and for treatment to commence after assessment should be yy months. It is understood that staff recruitment and retention has a considerable effect on this metric, but this should not stop an aim being clearly stated. On the individual responses, I am not sure that "medication, no other support" is a positive, as it implies that no other services are available for that individual.

On specific matters, I have the following points which might be considered;

Discharge passports - will they apply to all users of secondary mental health services or just those on Care Plan Approach, should a target be set in this strategy?

How will improvements in service delivery outcomes by SWYFT be assessed as an improvement in services for service users and carers?

The five year NHS plan states that additional training will be provided to GPs to provide extra mental health expertise; this is not mentioned in the strategy. This should result in lower level of referrals to secondary mental health services, should this be mentioned in the strategy and a metric developed?

Also should consideration be given to developing more shared care guidelines for mental health treatment, so that more secondary mental health care patients can be discharged back to primary care services?

General Themes	Positives	Suggestions / Concerns
Community mental health profiles and links to national average in terms of mental health Waiting times for treatment more information to give picture of what happens currently and aims for the future. Discharge passports Service Delivery Outcomes Monitoring for providers GP Mental Health Training Integration and shared care protocols between primary and secondary care	Good first draft Phase one engagement process	One of key goals should be meeting national average and should be stated Waiting times for treatment should be included in strategy to give picture of average and maximum waits and should be clear aim to get these down stated Points for consideration – Discharge passports Service Delivery Outcomes Monitoring for providers GP Mental Health Training Integration and shared care protocols between primary and secondary care

Response 20 – Received 12/11/15 – Response received from Public Health Specialist, Barnsley Metropolitan Borough Council

Inclusion of Suicide and Suicide Prevention and inclusion of further demographic statistics

N.B. Comments and updated statistical information incorporated into draft strategy document and fed back to lead commissioner for inclusion

Feedback received in relation to the short British Sign Language Film based on the Draft Strategy Document

As highlighted previously in section 3, we developed a British Sign Language Short Film version of the draft strategy following feedback we had received during the first phase. We circulated this to the appropriate colleagues and asked for them to share this with their forums locally in order to gain feedback on the suitability of the film, it's content and any lessons that we could take forwards for the future in terms of developing these type of short films as a way in which to engage with members of our local deaf community

Unfortunately the feedback we received was not very positive as the intended audience i.e. members of the local deaf community felt this was confusing and not easily understandable and digestible in the way in which this subject matter had been approached. The comments highlighted that members of the deaf community require more than just a 'translation' of the written information in order to make information understandable to them and enable them to fully engage in what is being asked.

Ultimately the invaluable feedback we received was very constructive in terms of how we could seek to improve upon our approach to this and big lessons learnt. It also provided us with local contacts that would be willing to work with us going forwards to develop our future approach to this and ensure that the type of product delivered is one which works alongside members of the community and takes into consideration the many issues which affect communication and understanding among the deaf community.

5. Summary of Key Trends from Feedback Received

The key trends taken from this engagement are as follows:

A good proportion of respondents highlighted a number of positive comments and suggested additions/ amendments in relation to the first draft Mental Health and Wellbeing Commissioning Strategy for Sheffield covering a wide range of areas. A number of respondents highlighted that they felt that the strategy could if implemented fully and effectively monitored in terms of progress, result in real change for the better for people across the borough that require support in terms of mental health.
A number of respondents provided highly detailed feedback covering a number of different areas, requested clarification on a number of key points and suggested additions and amendments to the strategy that have been fed back to the lead commissioner for addressing in the final version of the strategy
We received significant feedback relating to redressing the balance and strengthening the links in the next draft of the strategy in terms of maternal mental health, the links to substance misuse, CAMHS, suicide prevention, links to the work and direction of travel in terms of mental health for South Yorkshire Police and specialist services e.g. eating disorder. We also received some constructive feedback in terms of our engagement approach that we will take forwards.
A number of the more in depth comments received have been signposted on to the relevant person for following up/progressing.
A high proportion of respondents for both phases of engagement commented on the need for the services to be flexible, integrated, and person-centred in order for people to be able to access the right type of services for them as what works for one person may not be so successful for another.
Many of the respondents for both phases expressed the need for more information, advice and support relating to local services and what is available in terms of clinical and non – clinical support services.

6. Next Steps

This second phase of engagement was carried out in order to enable the CCG and partners to test out the content and proposed direction of the draft borough-wide Mental Health and Wellbeing Commissioning Strategy with those patients, carers and Mental Health professionals whose initial feedback regarding their experiences of accessing, being in receipt of and delivering Mental Health services in Barnsley had helped to shape and develop the content and direction of the document in the first place.

This brief feedback report will be fed back to the lead commissioners for their consideration and will help inform the final version of the strategy, and their decision making relating to the agreement and sign off of the strategy as being fit for purpose. A 'You said, We did' report detailing feedback from both phases of engagement and where this has influenced the final version of the strategy alongside our lessons learnt to take forward for future engagement will also be compiled and made publically available with direct feedback provided to those respondents who have requested it.

Again we would like to reiterate our thanks to all respondents who have given their time to share their views with us during both phases of engagement and to all partners who have helped us to gain their feedback. The feedback received has helped to inform and shape the development of the strategic direction for the commissioning of Mental Health and Wellbeing Services across Barnsley for the next five years.

Emma Bradshaw
Engagement Manager
13 January 2016 - Version 3

Appendix 4: Mental Health Services

Adult

GPs/Nurses
IAPT - Low and high intensity psychological interventions (e.g. Cognitive Behavioural Therapy, facilitated self-help, brief psychological therapy, psycho-education)
Community Mental Health Team – (Brief Intervention, 'intensity-plus' therapy, psychological, medical and nursing outpatient clinics)
EIP – Early Intervention in Psychosis
Enhanced Multi-Disciplinary Teams (specialist high intensity multidisciplinary team interventions and care coordination)
Intensive Home Based Treatments
In-patient services
Advocacy services
Agencies providing counselling, Community Support, Criminal Justice, social inclusion services
Family and carer support

Children and Young People

Child and Adolescent Mental Health Services (CAMHS)
Multi-Systemic Therapy (an intensive family and community based treatment programme)
School-based services
School Nurse Service
Youth Service
Strengthening Families (evidence based parenting and intervention where substance misuse is a significant factor)
School Educational Psychologist Service
Stronger Family Team
Substance Misuse Services
Youth Offending Team
Family Intervention Team
Children's Centres

Specialist Services – Commissioned by NHS England

Secure (Forensic) Mental Health Services
Tier 4 Child and Adolescent Mental Health Services
Specialised Services for Eating Adult Disorders
Perinatal Mental Health (Mother and Baby Units)
Gender Identity Service
Tier 4 Severe Personality Disorder Services (Adult)

Appendix 5: Risks to this Strategy

There are a number of significant changes in the national and local commissioning and operational environment that may have a substantial impact on the development and implementation of this strategy between now and 2020.

Resources

Financial resources available to commission mental health services are finite. It has been acknowledged that historically investment nationally in mental health services has lagged behind investment in other health and social care services. This imbalance is being tackled but will take time and innovative ways of delivering services if we are to achieve the national and locally agreed targets and standards on a sustainable basis.

The labour pool is also a finite resource – if people with the right skill mix to deliver the required range of mental health services cannot be attracted to Barnsley the necessary improvements outlined in this strategy may be limited.

Payment by Results

Payment by results for mental health has been introduced in shadow form in Barnsley and the current intention is that it will form the basis of contracting for all secondary mental health services from April 2016.

Work is being undertaken to develop a robust evidence-base on which to set a realistic local tariff for mental health Payment by Results services in 2016/17. This will be based on the best possible estimates of activity and the appropriate allocation of staff and resources to ensure that service users receive the right care in the right place at the right time.

Personal Health Budgets

The Government have widened the accessibility of Public Health budgets from April 2015 to people with long-term conditions. Mental health clients are among the groups who can be offered personal health budgets and for people who have mental health problems whose needs cross health and social care boundaries it may be possible to have integrated budgets across health and social care.

For personal budgets to work well in mental health, a fundamental change in culture is necessary, from a service-based to a person-centred approach. Work is ongoing to better understand the future financial risks to ensure appropriate and effective investment. Some voluntary sector organisations in Barnsley may require support to adapt in order to be sustainable during this transition period to continue to provide effective community support.

Future Health and Social care quality improvement and financial efficiency targets

Future health and social care improvement and financial efficiency targets and other financial pressures within stakeholder organisations may adversely affect the implementation of this strategy.

Appendix 6: Links to Other Relevant Documents and Strategies

Barnsley College Emotional Wellbeing Pilot Project Report. Chilypep (2015)

Barnsley Councils Corporate Plan 2015-18

Barnsley's Health and Wellbeing Strategy 2014-19

Common Mental Health Disorders – Identification and Pathways to Care. Clinical Guidance 123. NICE (May 2011)

Fighting Fit: a mental health plan for servicemen and veterans. Murrison A. Ministry of Defence (August 2010)

Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing. Department of Health (March 2015)

Guidance for developing a local suicide prevention action plan. Public Health England (September 2014)

Management of Mental Health Crisis Interagency Partnership Agreement Between South Yorkshire Police and Health and Social Care Agencies. South Yorkshire Police (2014)

No Health without Mental Health: A cross government Mental Health Outcomes Strategy for People of All ages. Department of Health (Feb 2011)

Perinatal mental health experiences of women and health professionals. Boots Family Trust, Netmums, Insitute of Health Visiting and The Royal College of Midwives (2013)

Preventing Suicide in England – a cross government strategy to save lives – https:/www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/preventing-suicide.pdf

Specialist Mental Health Midwives – What they do and why they matter. Royal College of Midwives (2015)

References

Adult and Social Care Outcomes Framework 2015/16

Barnett A Peel M Health Needs of Asylum Seekers and Refugees, British Medical Journal, 322 pp544-547 (2001)

Closing the Gap: Priorities for Essential Change in Mental Health (February 2014)

Fair Society, Healthy Lives – The Marmot Review (2010)

Ferguson DM, Horwood LJ, Riddes EM – Show me the Child at Seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood. J Child Psychol 2005; 46:937-49

Future in Mind: Promoting, Protecting and Improving our Children and Young People's Mental Health and Wellbeing (Department of Health) March 2015

Glover V (2013) Maternal Depression, Anxiety and Stress During Pregnancy and Child Outcome; What Needs to be Done Best Practice Research in Clinical Obstetrics and Gynaecology: S1521-6934(13) 00132

Hawton K, Rodham K, Evans E and Weatherall R (2002) Deliberate Self-Harm in Adolescents: Self report survey in schools in England. British Medical Journal 325: 1207-1211

Health Committee – Third Report: 'Children's and Adolescents Mental Health and CAMHS', House of Commons (November 2014)

Healthy Lives - Stonewall

Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England p10 National Institute for Mental Health in England, Leeds: NIMHE (203)

Joint Strategic Needs Assessment 2013

NHS Outcomes Framework 2015/16

NICE (2007) Clinical Guideline 45, Antenatal and Postnatal Mental Health

No Health without Mental Health: A Cross Government Mental Health Outcomes Strategy for People of All Ages (February 2011)

Public Health Outcomes Framework 2015/16

Psychiatric Disorder among British Children Looked After by Local Authorities and Compassion with Children Being in Private Households. Ford T Vostams, P Meltger H & Goodman R. British Journal of Psychiatry 2007 190, p319-325

Report on Emotional Health and Wellbeing with Children and Young People (March 2015), Healthwatch Barnsley

Saving Mothers Lives: The Eighth Report of the Confidential Enquiries into Maternal Deaths in the UK (2011) British Journal Obstetrics and Gynaecology 118, S1

Specialist Mental Health Midwives – What they do and why they matter. Royal College of Midwives (2015)

The Bradley Report – 'Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System'. Department of Health 2009

The Health of Deaf People in the UK : Sick of it. Signhealth (2014)

The Office of National Statistics Adult Psychiatry Morbidity Report 2009

The Office of National Statistics: Annual Mid-Year Population Estimates 2014

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Strategic Action Plan for the Barnsley All – Age Mental Health and Wellbeing Commissioning Strategy – 2016/17

This action plan has been compiled in order to aid the delivery of the aims and objectives set out within the Barnsley All – Age Mental Health and Wellbeing Commissioning Strategy (excluding Dementia). The strategy has a five year lifespan from 2015 – 2020.

RAG Rating:

Not started	**No progress**	**Work started**	**Work on track**

Review of the strategy and strategic action plan:

- **It is anticipated that the strategy will be reviewed on an annual basis between 2016 and 2020.**
- **The supporting action plan will be reviewed on a six monthly basis throughout the lifespan of strategy in January to coincide with the annual review of the strategy itself and also in July.**
- **It is the intention for this action plan to be used as a working document. It is to be updated by partners on a regular basis to aid the monitoring of progress against the areas highlighted below.**

Key Partners - Organisational Key

NHS Barnsley CCG (BCCG)
Barnsley Metropolitan Borough Council (BMBC)
Barnsley Hospitals NHS Foundation Trust (BHNFT)
South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)
Healthwatch Barnsley (HB)
South Yorkshire Police (SYP)
NHS England (NHSE)
Department of Health (DH)

Action Plan

Area for action	Our commitment	Key Partners	Progress Update/ Indicator	RAG Rating
1) Prevention and early intervention for mental health and wellbeing	CCG/BMBC will work with partners to continually develop and further improve prevention and early intervention services	**CCG / BMBC / SWYPFT / Schools / Third sector orgs**	EIP – Assured – Plans within Service Development Implementation Plan (SDIP). Implementation of Future in Mind Transformation plan covering resilience; Therapeutic team development; Young Commissioner training; Information Access; Enhancing NHS CAMHS service; link to Family Centres and Early Years work Quarterly progress reports to NHS England BMBC Indicators	
	CCG/BMBC will work with partners to ensure that mental health care and physical health care are better integrated	**CCG / BMBC/ SWYPFT BHNFT**	National CQUIN Kings Fund research – Implement recommendations where appropriate. Include within SDIP NHS Outcomes Framework (Domains 1 and 3)	
	CCG/BMBC will work with partners to see how we can better support new mothers in order to minimise the risks and impacts of post-natal	**CCG / BHNFT**	Specialist Mental Health Midwife role. Perinatal pathway review. Utilise Apps where appropriate Developing appropriate indicators	

Area for action	Our commitment	Key Partners	Progress Update/ Indicator	RAG Rating
	depression			
2) Improve access to mental health services and reduce waiting times from referral to assessment/ treatment to ensure that the most appropriate support is delivered at the right time, in the right place	CCG/BMBC will work with partners to improve the emotional health and wellbeing of children and young people by implementing the recommendations contained within the 'Future in Mind' report of the Children's and Young People's Mental Health Taskforce, as contained within Barnsley Future in Mind Local Transformation Plan	**Schools / SWYPFT / Public Health / Third Sector / CCG / BMBC**	Development of a Community Eating Disorder Service. Developing Peer Mentoring within College / Secondary schools. Parenting programmes. School Nursing Service CSE Quarterly Assurance to NHS England and Executive Commissioning Group. Achievement of Access and Waiting Time Standards	
	CCG/BMBC will work with services to ensure that as a minimum, national waiting time standards are met	**CCG / SWYPFT**	Access and Waiting Time Standards for EIP; Eating Disorders; IAPT (Adult and Children); Psychological Therapies	
	Where the need is evident CCG/BMBC will improve access to appropriate psychological therapies for	**CCG / SWYPFT**	Achievement of all national targets relating to IAPT – Access and Waiting Times; Recovery; desk-top review by NHS England's Intensive Support Team; widen	

Area for action	Our commitment	Key Partners	Progress Update/ Indicator	RAG Rating
	both adults, children and young people		access to people with Long Term Conditions CYPIAPT Performance Data	
	CCG/BMBC will work with service providers to ensure that children and young people have a positive experience when transitioning at the appropriate time, to adult services	**CCG / SWYPFT / BMBC**	Adhere to National Guidance / NICE Recommendations LD Transforming Care Agenda and implementation of the resulting Transformation Care Plan	
	CCG/BMBC will work with partners to ensure the continued implementation of Barnsley's Mental Health Crisis Care Concordat Action Plan thereby ensuring that no one experiencing a mental health crisis will ever be turned away from services and will receive the care they need.	**Crisis Care Concordat Partners**	Continually refresh Crisis Care Concordat Action Plan and monitor implementation. Psychiatric Liaison Service in Emergency Department – maintain Core 24 service specification. S136 Place of Safety – under 18 provision / capital funding South Yorkshire Police data on S136 Place of Safety use Framework Outcomes Reported Measures – Liaison Psychiatry (FROM-LP)	

Area for action	Our commitment	Key Partners	Progress Update/ Indicator	RAG Rating
	CCG/BMBC will work with partners to ensure that the mental health needs of Veterans are met and that we adhere to the principles of the Armed Forces Covenant	**BMBC / CCG**	Ensure implementation of Armed Forces Covenant ethos – Link with BMBC's Armed Forces Covenant Group. Continued support of the Veterans Mental Health Outreach Service Encourage GP's to identify the veterans cohort within their practice to evidence the health needs of this vulnerable group (use appropriate Reed Code)	
	CCG/BMBC will work with partners to ensure seamless provision of services for those people who have mental health problems and also have issues with substance misuse (namely drug and/or alcohol) in order to improve the outcomes of this client group	**BMBC / CCG**	Substance Misuse Outcome Measures Alcohol related hospital admissions (as a primary and / or secondary cause)	
3) Reduce stigma and discrimination	CCG/BMBC will work with partners to inspire a culture where discrimination has no place and where stigma is challenged; we will help to	**Public Health** **BMBC / CCG**	Awareness Campaigns Work in schools (Future in Mind; Samaritans) Encourage local organisations to sign-up to 'Time to Change'	

Area for action	Our commitment	Key Partners	Progress Update/ Indicator	RAG Rating
	raise awareness and understanding of mental health issues throughout the community and promote mental wellbeing			
4) Improve recovery and resilience – provide service users with the information required for them to be able to make the most appropriate choices in how support is delivered to them to aid their recovery	CCG/BMBC will commission high quality, patient centred, mental health services with an emphasis on recovery	**CCG / SWYPFT / BMBC**	IAPT Recovery targets. Psychological Therapies – reduce waiting times CAMHS – maintain a three week wait for first appointment and significantly reduce waiting times to start of treatment Recovery college - outcomes	
	CCG/BMBC will ensure that adults will continue to be given the right to make choices about the mental health care they receive. To assist this objective we will develop the use of Personal Health Budgets informed by national strategy	**CCG / SWYPFT**	Number of Personal Health Budgets offered / accepted Number of complaints where 'choice' is a key theme	
	CCG/BMBC will work with partners to develop a more vibrant, robust third/voluntary	**BMBC / CCG**	Consider the outcomes of BMBC's review of the Third Sector in Barnsley Future in Mind partnership working	

Area for action	Our commitment	Key Partners	Progress Update/ Indicator	RAG Rating
	sector serving the Barnsley Community			
	CCG/BMBC will work with partners to identify how we can best help people with mental health problems who are unemployed to move in to work and we will support employers to help people with mental health problems remain in work.	**BMBC / CCG / CVS**	Links to Social Prescribing NHS Outcomes Framework (Domain 2)	
	CCG/BMBC will work with partners to identify what more can be done to ensure that more people with mental health problems are able to live in homes to support their recovery	**BMBC / CCG / CVS**	Identify relevant targets – Outcome Framework Indicators	
5) To improve the support provided to families and carers	CCG/BMBC will work with partners, families and carers to understand their support needs and develop mechanisms and put	**BMBC / CCG**	National Consultation re Carer Support – consider recommendations Age UK Report	

Area for action	Our commitment	Key Partners	Progress Update/ Indicator	RAG Rating
	measures in place that meet these needs			
	CCG/BMBC will work with partners to review the impact of domestic violence on families and the community and develop services to improve the health and social care outcomes associated with domestic violence.		Link with BMBC 'Hub' development	
6)Mental Health Outcomes	CCG and BMBC will undertake work to ensure that the Mental Health Outcomes established for Barnsley are achieved by effective and efficient use of all available resources	**CCG / BMBC**	Mental Health Outcome Indicators Public Health Intelligence – Right Care Atlas indicators Commissioning for Value	

Associated key documents and plans

Document Name	Web link (if applicable)	Brief Description
Future in Mind Transformation Plan		
Barnsley Mental Health Crisis Care Concordat Action Plan		

Bringing together physical and mental health – A new frontier for integrated care		
Early Intervention Psychosis Access and Waiting Time Standards		
Five Year Forward View for Mental Health – Taskforce Report		
Learning Disability Transformation Care Plan		

Version Control	**V4 – 26/5/16**
Last updated by	**Patrick Otway (BCCG)**

27/5/16

NB – This document is still 'work in progress' and will be finalised shortly. A Dashboard is being developed to show progress 'at a glance'

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BARNSLEY Metropolitan Borough Council

NHS Barnsley Clinical Commissioning Group

Developing a Mental Health and Wellbeing Strategy for Barnsley

'You Said, We Listened' Summary Report

March 2016

1. Background

NHS Barnsley Clinical Commissioning Group (CCG) and Barnsley Metropolitan Borough Council (BMBC) have been working along with our key local partners within health and social care in Barnsley to lead the development of an all age (i.e. children, working age adults and the elderly – excluding dementia services) local Mental Health and Wellbeing Commissioning Strategy to cover the next five years.

The aim in undertaking our dedicated engagement regarding this was:-

- to ensure that as many people and organisations as possible were aware that this work was taking place and;

- that they were given the opportunity to provide their feedback relating to their own experiences of either accessing or delivering mental health services in Barnsley to help to shape the initial draft strategy and latterly the content of the draft strategy document itself.

We would like to say a big thank you to everyone who contributed and took the time to provide us with their views and feedback. We would also like to thank our partner organisations and members of the community who helped us to publicise our engagement exercise.

We received some invaluable feedback throughout our two dedicated phases of engagement carried out between July and November 2015 to help shape the direction and content of the final version of the strategy which has now been approved. You can access a copy of this document via our website at www.barnsleyccg.nhs.uk

We have compiled a report documenting the engagement process and highlighting the type of feedback we received. This report can be found as an appendix to the strategy or a copy can be accessed via our website.

2. 'You said, we listened'

This report shows how what Barnsley people and mental health professionals told us is important to them has been taken into account in the final version of the Mental Health and Wellbeing Commissioning Strategy for Barnsley.

We want local people and partners to know that we have listened to their thoughts and views, and incorporated them into our planning for how we want to commission better mental health and wellbeing services for Barnsley.

Our responses cross reference the areas which were highlighted throughout our engagement as key focal points to include within the strategy and where these are linked or can be found within the final version of the strategy document

We know that we don't always get it right, but we hope that this report openly and honestly provides answers to the comments received and shows how changes are

taking place or being proposed in order to benefit the population of Barnsley and provide access locally to quality mental healthcare services.

2.1 'You said, we listened'- Feedback from Service Users and Carers

We asked for feedback from service users and carers regarding their personal experiences of local services and particularly in relation to the following question to help shape the direction of the Mental Health and Wellbeing Commissioning Strategy for Barnsley;

If you could improve three things about mental health services in Barnsley what would they be and why?

You said	We listened
✓ *Improve access to services - Reduce waiting times*	Key priority area and one of five main desired outcomes defined within strategy (Section 5) linked also to national standards and targets as set out within local transformation plans (Section 3.2.3)
✓ *Improved crisis services – access to out of hours support and telephone line*	This links to the work detailed as part of the Crisis Care Concordat (Section 3.2.5) and the development of the Mental Health Liaison Service
✓ *Early intervention*	Highlighted as a key priority area within both Adult Services (Section 3.2.2) and Children's Services and the local transformation plan (Section 3.2.3) and one of the five main desired outcomes defined within the strategy (Section 5)
✓ *Education and awareness raising to tackle stigma and discrimination*	Highlighted as a key priority area within Children's Services and the local transformation plan (Section 3.2.3) and one of the five main desired outcomes defined within the strategy (Section 5)
✓ *Holistic and person centred services, care planning and therapies rather than one size fits all approach*	Linked with delivering the desired outcomes (Section 5) and the NHS Outcomes Framework (Appendix 1)
✓ *Increased access and signposting to information relating to both individual and peer support services for service users, carers and families (mainly non-clinical)*	Highlighted within Primary Care and Mental Health (Section 3.2.1) linking to social prescribing

✓ *Increased integrated working of services especially primary and secondary care*	Linked to Primary Care and Mental Health (Section 3.2.1)
✓ *Increased provision and resources in terms of staffing and specialist services*	This features within the following parts of the strategy; Adults Services (Section 3.2.2), Children's Services and the local transformation plan (Section 3.2.3), Maternal Mental Health (Section 3.2.4) and Vulnerable Groups (3.2.6). This also links to the South West Yorkshire Partnership Foundation Trust (SWYPFT) transformation of mental health services work.
✓ *Access to mental health training for primary care professionals*	Linked to Primary Care and Mental Health (Section 3.2.1)
✓ *Increased service user and carer input into decisions relating to the commissioning and provision of mental health services in Barnsley*	Referenced within the following sections; Adults Services (3.2.2), Children's Services and the local transformation plan (Section 3.2.3), Engagement (Section 4) and delivering the desired outcomes (Section 5). This will also be a key component of developing the supporting action plan to achieve the aims set out within the strategy.
✓ *Additional resources to cater for child and adolescent mental health with a focus also on the transition from child to adult mental health services*	Highlighted as a key priority area within Children's Services and the local transformation plan (Section 3.2.3) and referenced in support of delivering the desired outcomes (Section 5)
✓ *Improve the levels of both written and verbal communication with services users and carers and also between individual service lines.*	Linked to the Adults Services (Section 3.2.2) and referenced in support of delivering the desired outcomes (Section 5). This also links to the South West Yorkshire Partnership Foundation Trust (SWYPFT) transformation of mental health services work.
✓ *Help to access training and support to get back to work*	Highlighted within Primary Care and Mental Health (Section 3.2.1) linking to social prescribing. Also referenced within Domain 2 of the NHS Outcomes Framework (Appendix 1)

2.2 'You said, we listened'- Feedback from Mental Health Professionals

We asked for feedback from mental health professionals regarding their personal experiences of local services and particularly in relation to the following question to help shape the direction of the Mental Health and Wellbeing Commissioning Strategy for Barnsley;

Which three positive changes do you feel would most support the people who work in delivering mental health services in Barnsley and why?

You said	We listened
✓ *Change of emphasis from targets to improved patient experience / Patient centred services*	Highlighted within the South West Yorkshire Partnership Foundation Trust (SWYPFT) transformation of mental health service work with reference to Adults Services (3.2.2) and the focus of Domain 4 of the NHS Outcomes Framework (Appendix 1). This is also referenced with Children's Services and the local transformation plan (Section 3.2.3)
✓ *Flexible ways of working and increased use of technology to assist clinicians and service users/carers*	Contained within the South West Yorkshire Partnership Foundation Trust (SWYPFT) transformation of mental health services work with reference to Adults Services (3.2.2)
✓ *Increased resources – finance and staffing*	Referenced within the introductory section and also specifically relating to Children's Services and the local transformation plan (Section 3.2.3), Maternal Mental Health (Section 3.2.4) and Crisis Care (Section 3.2.5)
✓ *Improve access to services - Reduce waiting times*	Key priority area and one of five main desired outcomes defined within strategy (Section 5) linked also to national standards and targets as set out within local transformation plans (Section 3.2.3)
✓ *Improved crisis services – access to out of hours support and telephone line*	This links to the work detailed as part of the Crisis Care Concordat (Section 3.2.5) and the development of the Mental Health Liaison Service
✓ *Education and awareness raising to tackle stigma and discrimination*	Highlighted as a key priority area within Children's Services and the local

	transformation plan (Section 3.2.3) and one of the five main desired outcomes defined within the strategy (Section 5)
✓ *Increased access and signposting to information and low level support options*	Highlighted within Primary Care and Mental Health (Section 3.2.1) linking to social prescribing and also to the South West Yorkshire Partnership Foundation Trust (SWYPFT) transformation of mental health services work highlighted within Adults Services (3.2.2)
✓ *Increased integrated working of services especially primary, secondary and social care – holistic service pathways*	Links to the following sections; Primary Care (Section 3.2.1), Adults Services (3.2.2), Children's Services and the local transformation plan (Section 3.2.3), Crisis Care (Section 3.2.5) and Vulnerable Groups (Section 3.2.6) and Delivering the desired outcomes (Section 5). This will also be a component of developing the supporting action plan to achieve the aims set out within the strategy.
✓ *Increased provision and resources in terms of staffing and specialist services*	This features within the following parts of the strategy; Adults Services (Section 3.2.2), Children's Services and the local transformation plan (Section 3.2.3), Maternal Mental Health (Section 3.2.4) and Vulnerable Groups (3.2.6). This also links to the South West Yorkshire Partnership Foundation Trust (SWYPFT) transformation of mental health services work.
✓ *Access to mental health training and support for healthcare professionals*	Links to the following sections; Primary Care (Section 3.2.1), Delivering the desired outcomes (Section 5). This will also be a component of developing the supporting action plan to achieve the aims set out within the strategy.
✓ *Additional resources to cater for child and adolescent mental health with a focus also on the transition from child to adult mental health services*	Highlighted as a key priority area within Children's Services and the local transformation plan (Section 3.2.3) and referenced in support of delivering the desired outcomes (Section 5)
✓ *Clearly defined criteria within pathways of care and lines of*	This features within the following parts of the strategy; Primary Care (Section

communication between services	3.2.1), Adults Services (Section 3.2.2), Children's Services and the local transformation plan (Section 3.2.3), Maternal Mental Health (Section 3.2.4) and Vulnerable Groups (3.2.6). This also links to the South West Yorkshire Partnership Foundation Trust (SWYPFT) transformation of mental health services work.
✓ *Access to specialist support and colleagues / Peer review and support/ Dedicated provision for the commissioning of specialist services within the strategy*	This features within the following parts of the strategy; Adults Services (Section 3.2.2), Children's Services and the local transformation plan (Section 3.2.3), Maternal Mental Health (Section 3.2.4) and Vulnerable Groups (3.2.6). This also links to the South West Yorkshire Partnership Foundation Trust (SWYPFT) transformation of mental health services work.
✓ *Improved environments and choice in terms of the delivery and provision of services for the benefit of people locally*	Referenced in support of delivering the desired outcomes (Section 5)
✓ *Importance of staff, service user and carer involvement and engagement in all aspects of NHS design and delivery/ Input from expert patient panels and ongoing engagement in evaluating and monitoring services to promote continuous improvement and ensure that the agenda remains current and at the forefront.*	Referenced within the following sections; Adults Services (3.2.2), Children's Services and the local transformation plan (Section 3.2.3), Engagement (Section 4) and delivering the desired outcomes (Section 5). This will also be a key component of developing the supporting action plan to achieve the aims set out within the strategy.

3. 'You said, we listened' – Our engagement process

You said	We listened
✓ *Extend the timescale for the second phase engagement period to enable more people to feedback*	The original deadline for feedback for our second phase of engagement was to be 14 October. However, following the feedback received from Service Users, Carers and our local partner organisations regarding the timescales for comments; the deadline for responses for

	this phase of engagement was extended for a further month to 13 November 2015
✓ *Develop a British Sign Language short film version of the draft strategy to enable feedback from the deaf community*	We developed a British Sign Language Short Film version of the draft strategy following feedback we had received during the first phase. Unfortunately the feedback we received was not very positive as the intended audience i.e. members of the local deaf community felt that this was confusing and not easily understandable and digestible in the way in which this subject matter had been approached. The invaluable feedback we received was very constructive in terms of how we can seek to improve upon our approach to this and will enable valuable lessons learnt for us to take forwards for future engagement of this kind.
✓ *I would like to know what happens with feedback. Will I receive a response on my comments?*	A copy of the strategy containing the engagement report plus a copy of this report will be sent to everyone who provided their contact details when they provided us with their feedback.
✓ *Full and continuing engagement is essential to enable success of a strategy such as this*	Referenced within the following sections; Adults Services (3.2.2), Children's Services and the local transformation plan (Section 3.2.3), Engagement (Section 4) and delivering the desired outcomes (Section 5). This will also be a key component of developing and monitoring the supporting action plan to achieve the aims set out within the strategy.

4. Next Steps

Barnsley's Mental Health and Wellbeing Commissioning Strategy builds on the learning and requirements of national strategies and documents whilst also greatly benefitting from engagement with people with mental health problems, carers, service providers, clinicians, public sector and voluntary organisations.

The strategy has now been endorsed by all partners at the Clinical Commissioning Group's Clinical Transformation Board and thereafter, an Annual Report will be submitted to the Clinical Transformation Board to formally report its progress.

Through the Joint Commissioning Unit (CCG and Barnsley Metropolitan Borough Council (BMBC) Commissioner) the actions identified in Section 5 will become the basis for a detailed action plan which will be monitored by the JCU and the CCG's formal meetings with the provider:-

- Clinical Quality Board
- Contract Management Executive Board

With each Annual Report all of the actions contained within the strategy will be assessed for the difference each action has made to the mental health and wellbeing of Barnsley people. The stated actions will be revised as necessary in order to sustain continued improvement to the mental health and wellbeing of people resident in Barnsley.

As with the strategy, it is the intention for the supporting action plan to be co-developed in partnership with service users, carers and mental health professionals.

5. Contact us

We hope that you found this report useful. It is our aim to produce this type of report going forwards in order to provide feedback regarding the actions we have taken as a result of our ongoing engagement activity.

If you have any comments or feedback regarding this report, you can contact the CCG Communications and Engagement Team via the following ways:

Email: barnccg.comms@nhs.net
Telephone: 01226 433773/ 721

Thank you for your interest and support in our work.

Report compiled by Emma Bradshaw - Engagement Manager
NHS Barnsley CCG
Updated: 29/03/16

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REPORT TO THE HEALTH AND WELLBEING BOARD

7th June 2016

Development of an Accountable Care Organisation in Barnsley

Report Sponsor: Lesley Smith
Report Author: Jeremy Budd & Jade Rose
Received by SSDG: NA
Date of Report: 26th May 2016

1. Purpose of Report

1.1 To update the H&WB on progress to date in exploring the development of an Accountable Care Organisation in Barnsley.

2. Recommendations

2.1Health and Wellbeing Board members are asked to:-

- Note the contents of the report for information.

3. Introduction/ Background

3.1 The CCG along with key partners in health and care across Barnsley, have been exploring the development of an Accountable Care Organisation (ACO) for some months now. The pace of the work is now accelerating, supported by a dedicated Programme Management Office.

The purpose of the Accountable Care Partnership Board (ACPB) is to explore the development of an Accountable Care Organisation in Barnsley. The ACPB is not the ACO itself.

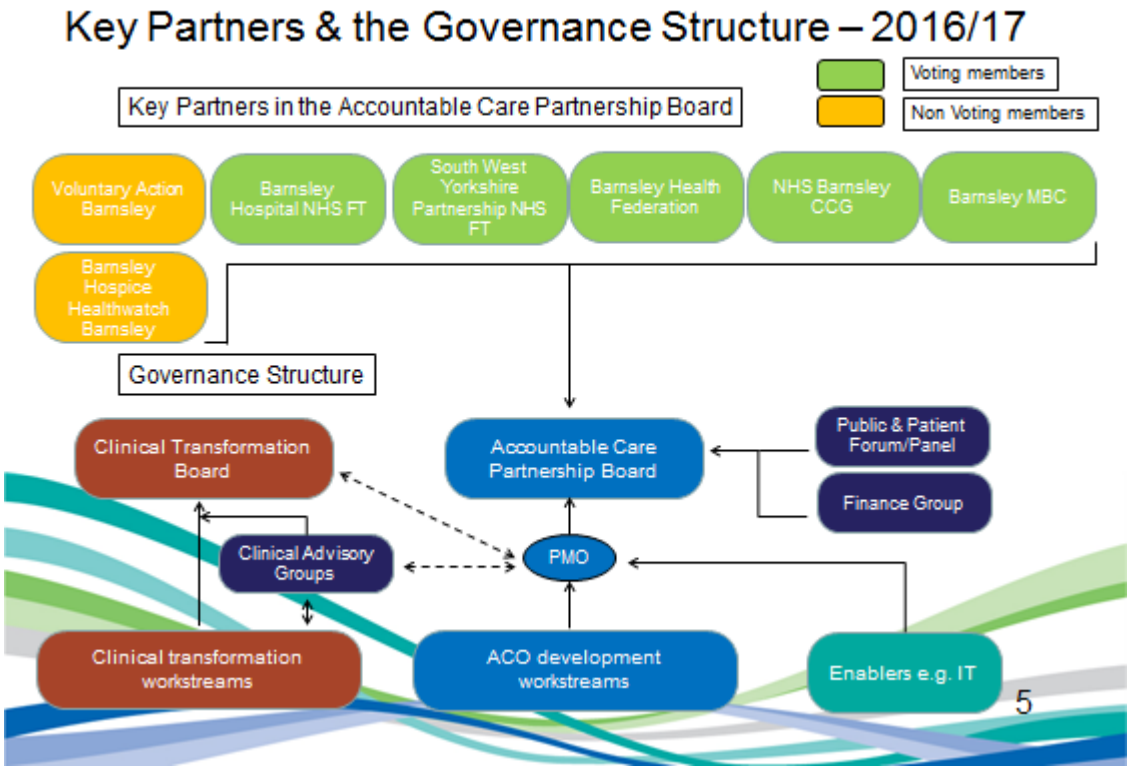
For clarity, an Accountable Care Organisation is a group of providers (through a single accountable provider or structure) who agree to take accountability for all care and care outcomes for a given population for a defined period of time under a contractual arrangement with a commissioner. It is also envisaged that the ACO may also contain some functions that currently sit within the CCG including tactical or operational commissioning.

The first meeting of the ACPB has now taken place (27th April 2016) and this paper updates the H&WB on the key points to arise from that, including the governance arrangements that have been put into place, as well as subsequent work that is being undertaken.

4. ACO Development Update

A number of issues were discussed at the ACPB on the 27th April. The key items that the H&WB should note are:

1. The Terms of Reference for the ACPB were discussed and after a few minor amendments were agreed. Key partners who have voting rights include the CCG, South West Yorkshire Partnership NHS FT, Barnsley MBC, Barnsley Health Federation and Barnsley Hospital NHS FT. Additionally, Voluntary Action Barnsley, Healthwatch Barnsley and Barnsley Hospice will be invited to attend as non voting members.
2. The governance structure for the ACO development programme was discussed and agreed. It is shown in the diagram below. The Senior Responsible Officer for the ACO development programme will be Barnsley CCG's Chief Officer.



The ACPB will oversee the ACO development programme, which will be implemented by the dedicated Programme Management Office (PMO). The PMO will also work closely with the Clinical Transformation Board in order to ensure that clinical transformation activities related to ACO development are completed in a way that is supportive and timely.

3. ACO vision & objectives. There was agreement that the vision and objectives of the ACO should be focused on out of hospital care initially. There was agreement that further work needed to be undertaken to deepen joint understanding of what changes are desired, understand which outcomes the ACO should be asked to deliver and agree how we expect the ACO to be able to deliver these changes more effectively and efficiently than the current system allows. This work will ensure that we have a strong collective

message to communicate about why we are pursuing the development of an ACO. A further workshop was held on the 18th May, where we developed thinking around what benefits we need the ACO to deliver in order to achieve a step change in the way health and care services are delivered in Barnsley.

4. Additionally, there was discussion about how broad the remit of the ACO should be. In addition to providing integrated pathways of care, would it for example host shared back office infrastructure? Work to a joint operating plan and joint financial plan? There was broad support for all these concepts (which would be introduced over time) and the PMO was asked to include a further work stream in the ACO development programme that would look at shared infrastructure opportunities.
5. Workstreams. The ACPB approved work to commence on the following initial workstreams:
    a. Vision, strategy and outcomes
    b. Governance and compliance
    c. Population profile and scope
    d. Commercial model – funding mechanisms
    e. Patient and community involvement
    f. Share infrastructure opportunities

    Clinical transformation and procurements will be overseen by the Clinical Transformation Board.

5. Conclusion/ Next Steps

5.1 The exploration of the ACO is progressing and there will be monthly meetings of the ACPB. The next scheduled meeting is for the 22nd June 2016.

6. Financial Implications

6.1 None in the short term. In the medium term the ACO is expected to deliver financial efficiencies. These have not yet been scoped and agreed.

7. Consultation with stakeholders

7.1 An engagement and communications work stream is being developed. A key focus of this engagement will be with patients and the public in order to understand what needs to change and why, from their perspective.

8. Appendices

8.1 None

9. Background Papers

9.1 None

Officer: Jade Rose Contact: jade.rose2@nhs.net Date: 26.05.2016

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