Public Document Pack

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 4 April 2017
TIME:	4.00 pm
VENUE:	Reception Room, Barnsley Town Hall

AGENDA

1 Declarations of Pecuniary and Non-Pecuniary Interests

2 Minutes of the Board Meeting held on 31st January, 2017 (HWB.04.04.2017/2) *(Pages 3 - 6)*

3 Minutes from the Children and Young People's Trust Executive Group held on 20th January, 2017 (HWB.04.04.2017/3) *(Pages 7 - 16)*

4 Minutes from the Provider Forum held on 8th March, 2017 (HWB.04.04.2017/4) *(Pages 17 - 20)*

5 Minutes from the Stronger Communities Partnership held on 14th February, 2017 (HWB.04.04.2017/5) *(Pages 21 - 26)*

6 South Yorkshire and Bassetlaw Sustainability and Transformation Plan Collaborative Partnership Board held on 13th January, 2017 (HWB.04.04.2017/6) *(Pages 27 - 38)*

For Decision/Discussion

7 Questions at future meetings of the Health and Wellbeing Board (HWB.04.04.2017/7)

8 Director of Public Health Annual Report 2016 (HWB.04.04.2017/8) *(Pages 39 - 42)*

9 Health and Wellbeing Board Action Plan and Progress Update (HWB.04.04.2017/9) *(Pages 43 - 58)*

10 Future In Mind Transformation Plan - Presentation (HWB.04.04.2017/10) *(Pages 59 - 244)*

11 All Age Early Help Strategy (HWB.04.04.2017/11) *(Pages 245 - 258)*

Items for Information

12 Additional Funding for Adult Social Care (HWB.04.04.2017/12) *(Pages 259 - 262)*

13 The Future Of One Barnsley (HWB.04.04.2017/13)

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

Councillor Sir Steve Houghton CBE, Leader of the Council (Chair)
Dr Nick Balac, Chair, NHS Barnsley Clinical Commissioning Group (Vice Chair)

Councillor Jim Andrews BEM, Deputy Leader
Councillor Margaret Bruff, Cabinet Spokesperson – People (Safeguarding)
Councillor Jenny Platts, Cabinet Spokesperson – Communities
Rachel Dickinson, Executive Director People
Wendy Lowder, Executive Director Communities
Julia Burrows, Director of Public Health
Lesley Smith, Chief Officer, NHS Barnsley Clinical Commissioning Group
Scott Green, Chief Superintendent, South Yorkshire Police
Emma Wilson, NHS England Area Team
Adrian England, HealthWatch Barnsley
Dr Richard Jenkins, Medical Director, Barnsley Hospital NHS Foundation Trust
Rob Webster, Chief Executive, SWYPFT
Helen Jaggar, Chief Executive Berneslai Homes

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

Monday, 27 March 2017

BARNSLEY Metropolitan Borough Council

MEETING:	Health and Wellbeing Board
DATE:	Tuesday, 31 January 2017
TIME:	4.00 pm
VENUE:	Reception Room, Barnsley Town Hall

MINUTES

Present

Councillor Sir Steve Houghton CBE, Leader of the Council (Chair)
Nick Balac, Chair, NHS Barnsley Clinical Commissioning Group (Vice Chair)
Councillor Jim Andrews BEM, Deputy Leader
Councillor Margaret Bruff, Cabinet Spokesperson - People (Safeguarding)
Councillor Jenny Platts, Cabinet Spokesperson - Communities
Rachel Dickinson, Executive Director People
Ann O'Flynn for Wendy Lowder, Executive Director Communities
Julia Burrows, Director Public Health
Lesley Smith, Chief Officer, NHS Barnsley Clinical Commissioning Group
Scott Green, Chief Superintendent, South Yorkshire Police
Adrian England, HealthWatch Barnsley
Steve Wragg, Barnsley Hospital NHS Foundation Trust
Sean Rayner, South West Yorkshire Partnership NHS Foundation Trust

51 Declarations of Pecuniary and Non-Pecuniary Interests

There were no declarations of pecuniary or non-pecuniary interest.

52 Minutes of the Board Meeting held on 6th December, 2016 (HWB.31.01.2017/2)

The meeting considered the minutes of the previous meeting held on 6th December, 2016.

RESOLVED that the minutes be approved as a true and correct record.

53 Minutes from the Children and Young People's Trust Executive Group held on 24th November, 2016 (HWB.31.01.2017/3)

The meeting considered the minutes from the Children and Young People's Trust Executive Group held on 24th November, 2016.

The meeting noted the reference in minute 7 to the Healthy Lifestyle Services and proposals to launch the Daily Mile in primary schools, with the request that all partner organisations adopt it in some form. The meeting also noted the work to refresh the Continuous Service Improvement Plan, highlighted in minute 11, which had been commissioned following a joint meeting of the Children and Young People's Trust and the Barnsley Safeguarding Children Board in November 2016.

RESOLVED that the minutes be received.

54 Minutes from the Barnsley Community Safety Partnership held on 23rd November, 2016 (HWB.31.01.2017/4)

The meeting considered the minutes from the Community Safety Partnership held on 23rd November, 2016.

The meeting noted proposals to negotiate the adoption of the Information Sharing Protocol with both Barnsley Hospital NHS Foundation Trust and the South West Yorkshire Partnership NHS Foundation Trust, although this was understood to be mandatory, rather than negotiable. The application of the Protocol would be discussed further at the next meeting of the Partnership.

RESOLVED that the minutes be received.

55 Minutes from the Provider Forum held on 7th December, 2016 (HWB.31.01.2017/5)

The meeting considered the minutes from the Provider Forum meeting held on 7th December, 2016.

RESOLVED that the minutes be received.

56 Minutes from the Stronger Communities Partnership held on 22nd November, 2016 (HWB.31.01.2017/6)

The meeting considered the minutes from the Stronger Communities Partnership held on 22nd November, 2016.

RESOLVED that the minutes be received.

57 Health and Wellbeing Board Risk Register (HWB.31.01.2017/7)

The meeting received a report on the position on key risks identified in the Health and Wellbeing Board Risk Register following a review and refinements made by the Senior Strategic Development Group (SSDG), noting the control and mitigation actions in place in response to these risks.

RESOLVED:-

(i) that the refinements made to the Health and Wellbeing Board Risk Register, set out at Paragraph 3.4 and Appendix 1 to the report, be approved;

(ii) that the Risk Register be reviewed again by the Board at its meeting in June 2017, with more detailed consideration given to specific risks, if considered appropriate by Board members or SSDG.

58 Suicide Prevention Action Plan (HWB.31.01.2017/8)

The meeting received a report and presentation giving an overview of the latest cross-government suicide prevention strategy and an update on work in Barnsley. The presentation highlighted data in relation to suicide in the borough, drawn from a recent audit, and the meeting noted the focus of an action plan to achieve a 10%

reduction in suicides by 2021. Members noted the extent to which suicide was preventable, given the right focus and support for vulnerable people, and welcomed the use of social media and engagement with local media, such as the Barnsley Chronicle, to get the message across. The meeting considered what more could be done to make contact with people who might be at risk, and the meeting noted particular opportunities presented by making links with Barnsley College and the Registrars' Service.

RESOLVED:-

(i) that the progress to date on suicide prevention work be noted;

(ii) that the development of the suicide prevention action plan outlined in the report and presentation be supported;

(iii) that contact be made with Barnsley College and Registrars' Service to consider how they might provide support to the action plan in their contacts with young people and those who have suffered a bereavement respectively.

59 Future in Mind Transformation Plan - Presentation (HWB.31.01.2017/9)

This item was deferred.

60 End of Life Care (HWB.31.01.2017/10)

The meeting received a report on the current provision for palliative and end of life care in the Borough, following the recent publication of the Government's response to the recent independent review of choice in end of life care.

RESOLVED:-

(i) that the priorities of the Barnsley End of Life Care Strategy and the outcomes of a review of the Strategy, together with the extent to which local service provision for palliative or end of life care, in the Borough, is continually informed through developments in policy, including the Government's recent response to the independent review, be noted;

(ii) that the Minister for Community Health & Care be advised of Barnsley's position on this matter.

61 CCG Commissioning Intentions 2017/18 - 2018/19 (HWB.31.01.2017/11)

The meeting received for information a report on the NHS Barnsley Clinical Commissioning Group commissioning intentions for 2017/18 to 2018/19.

RESOLVED that the report be noted.

Chair

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Minutes of the Children and Young People's Trust Executive Group Meeting held on 20 January

Present:

Core Members:

Rachel Dickinson (Chair)	BMBC, Executive Director: People
Cllr Margaret Bruff	Cabinet Member: People (Safeguarding)
Cllr Tim Cheetham	Cabinet Member: People (Achieving Potential)
Alicia Marcroft	BMBC, Head of Public Health
Mel John-Ross	BMBC, Service Director of Children's Social Care & Safeguarding
Scott Green	South Yorkshire Police Chief Superintendent
Margaret Libreri	BMBC, Service Director for Education, Early Start & Prevention
Dr Jamie MacInnes	Barnsley Local Medical Committee GP representative
Margaret Gostelow	Barnsley Governors Association Chair
Dave Whitaker	Executive Headteacher representing Secondary Schools
Brigid Reid	Barnsley CCG, Chief Nurse
Dave Ramsay	South West Yorkshire Partnership Foundation Trust (SWYPFT) Deputy Director of Operations
Wendy Lowder	BMBC, Acting Executive Director Communities
Jenny Miccoli	Barnsley College, Vice Principal Teaching, Learning and Student Support

Deputy Members:

Katherine Clarke	Headteacher, Hoyland Springwood Primary School (for Gerry Foster-Wilson)

Adviser:

Richard Lynch	BMBC, Head of Commissioning, Governance and Partnerships

In attendance:

Angela Fawcett	BHNFT Named Nurse for Safeguarding Children (shadowing Brigid)
Jonathan Banwell	Head of Children in Care (for item 7)
Claire Strachan	SWYPFT General Manager of Barnsley CAMHS New Street Health Centre (for item 8)
Rebecca Clarke	BMBC Public Health Specialist Practitioner (for item 10)
Julie Govan	BMBC Children's Social Care and Safeguarding Improvement Programme Manager (for item 12)
Denise Brown	BMBC, Partnerships and Projects Officer

			Action
1.	Apologies		
	Julie Green	BMBC Strategic Lead, Procurement and Partnerships Manager	
	Anna Turner	BMBC School Models and Governor Development Manager	
	Amanda Glew	BMBC Organisation Development Manager	
	Sandra Newman	Barnsley Hospital NHS Foundation Trust, Interim Head of Nursing and Midwifery	
	Bob Dyson	Independent Chair of the Barnsley Safeguarding Children Board	

		Action
	Gerry Foster-Wilson Executive Headteacher representing Primary Schools Christine Drabble Voluntary Action Barnsley, Chief Executive Corporate Services Rachel welcomed everyone to the meeting, and extended a particular welcome to anyone attending the meeting for the first time.	
2.	<u>Information Sharing</u> (Richard Lynch) Richard extended Sara Hydon's apologies and provided a verbal update. This agenda item had come about following previous discussions regarding how well information is being shared across agencies to ensure that vulnerable families are not failed by the systems in place and that better outcomes are achieved. It is important to ensure that the right information is captured by agencies working with families and that it is appropriately shared. A group of key managers was convened by Richard to discuss the concerns raised by TEG around whether IT systems were appropriately connected to ensure families' information could be shared systematically, where necessary. Richard fed back that the group, although understanding of the concerns, was keen to highlight to TEG that there are broader programmes of work which have and will continue to attempt to address this longstanding issue. One idea discussed is to develop a function which will allow the exchange of vital information from the various systems in use (Capita, TED etc.) transferring to a data warehouse which agencies can access as appropriate. Such an approach would require substantial commitment to drive forward and the question was raised as to how much oversight TEG would like to retain over this workstream. A new Information Technology Strategy Group has been convened, attended by key people including Sara Hydon from BMBC. Wendy suggested that there needs to be greater clarity and understanding around the relationship between the IT Strategy Group, the refresh of the IT Strategy, the Sustainability & Transformation Plan (STP) and the Senior Strategic Development Group (SSDG). (Rachel explained that the SSDG is the chief officer group which sits under the Health and Wellbeing Board (HWB), of which TEG is a formally constituted group). **It was agreed that** it would be helpful for a baseline position to come back to TEG, including capacity across the partnership and the status of information sharing protocols.	Sara / Wendy
3.	<u>Feedback from the front line</u> • Managing risk. Mel John-Ross had spoken recently to children in care. In a few cases children have needed to be placed outside the borough and it is important to consider how, as a partnership, risk is managed. This is a challenge across the partnership and thought is being given to arranging a conference to discuss this further and to share interventions that work. It was agreed that this would be brought back to a future TEG meeting. • Safety measures introduced at Springwell Learning Community. Dave informed the meeting that a decision had been taken by the Governing Body to introduce the use of metal detecting wands to search pupils for knives. The decision had not been taken lightly but was felt to be	Mel/ work prog.

		Action
	necessary to respond to the perception of teaching staff that pupils were carrying knives. Whilst it was acknowledged that it was right to respond to the concerns of the teaching staff, it was also felt that there may be other ways of ensuring their safety and it was agreed that Scott and Dave would meet to discuss this further. • Young people at Shafton Academy say they love being at their school and want to be able to learn. Margaret Libreri shared that during pupil voice meetings held as part of a peer review at Shafton Academy there was a resoundingly strong message from the pupils that they love being at their school. Regimes had been introduced by the school to discourage poor behaviour, and young people commented that they want to be able to learn when they are at school, and the change in focus on good behaviour meant that they could learn more. It is therefore important for schools to find ways to challenge poor behaviour without excluding pupils, and to develop different approaches for those with behavioural difficulties.	Scott/ Dave
4.	<u>Identification of confidential reports and declarations of any conflict of interest</u> The Continuous Service Improvement Plan is to be treated as confidential. There were no conflicts of interest declared.	
5.	<u>Minutes of the Trust Executive Group meeting held on 24 November 2016</u> The minutes were approved as an accurate record of the meeting subject to the following amendments on page 7: The fourth bullet point to be amended to read: 'Secondary School systems can be very different to those in Primary Schools and, whilst every effort is made in all schools to improve attendance of vulnerable children, there is an increased risk that some vulnerable children will be excluded in Secondary School.' The penultimate bullet to read: 'It was noted that schools are encouraged to put appropriate provision in place for the children in their school, and that protocols are in place to keep managed moves between schools to a minimum.' Margaret added that a discussion had taken place at a recent Secondary Heads meeting regarding tightening up the criteria of the managed moves protocol and being more challenging. It was noted that draft minutes should not be circulated further or made public until they had been approved.	
5.1	<u>Action log / matters arising</u> The following updates against actions were received: Outstanding actions from previous meetings: 9 – It was agreed that the learning from the evaluation of working cultures associated with the work of the Barnsley Hub and Placed Based Teams would be shared with TEG if relevant. 11 – Children's Workforce Development. A copy of the multi-agency training brochure had been sent to Jakki Hardy to circulate within the Police. 15(i) – Kevin Bowman had been appointed as the new Head of Nursing and Midwifery for the BHNFT but was unable to attend today's meeting.	

		Action
	Outstanding actions from 24 November 2016: 5 – JSNA. A meeting had been scheduled on 31 January for Liz and Sharon to discuss the JSNA. 6 – Dave Ramsay to follow up the action to provide Richard with an update on work being undertaken by SWYPFT in relation to system management. 7 – Rachel was pleased to note that TEG Champions would be attending a meeting with members of the Youth Council to consider the outcomes in the CYP Plan monitoring template. 10 – A further report on attendance and exclusions has been written and will be taken to the Closing The Gap group following January TEG.	
For discussion		
6.	<u>Review of vulnerable children with SEN</u> (Margaret Libreri) The report provides an overview of outcomes for SEND pupils in Barnsley from Early Years Foundation Stage to Key Stage 4, highlighting the differences between outcomes for Barnsley and national averages. Although the overall percentage of students identified as SEN in Barnsley is similar to national figures, Barnsley has a lower percentage identified as SEN support and a higher percentage of pupils with statements or education health care plans. This raises the question of whether there are children being inappropriately progressed to statements or care plans. Paragraph 2.4 of the report compares the percentage of Barnsley children in secondary mainstream schools with identified primary needs against the national average as follows: 1. Moderate learning difficulty: Barnsley 46% - national average 25% 2. Social, emotional and mental health needs: Barnsley 20% - national average 19% 3. Specific learning difficulties: Barnsley 9% - national average 22% It is therefore questionable whether needs are being accurately identified and it was suggested that the competence and skill of the workforce needs to be improved to ensure greater understanding and ability to identify moderate learning difficulties. The report also highlights in paragraph 2.6 that Barnsley's weekly spend per pupil with a statement or EHC plan is £40 compared with a national average of £98. However it was pointed out that the reported spend will be based on local authority outturns and is potentially skewed. However this was worth further investigation. SEND students have lower rates of attendance and higher rates of exclusions both locally and nationally. Attendance needs to improve for all pupils. The percentage of pupils on SEN support who are excluded is concerning and it is important to maintain a focus on these vulnerable groups. The gap between SEN and non-SEN pupils needs to be improved. Paragraph 4.9 of the report highlights the widening gap at Key Stage 4 and it was suggested that the reasons behind this need further investigation. It was suggested that it would be helpful to look at the children's JSNA by ward to identify particular areas of Barnsley to target resources where there is the most need.	

		Action
	The outcomes highlight the extent of the challenge and there is a lot to do in terms of exploring some of the emerging messages more deeply. It is important that everything possible is done to get behind this important agenda to improve outcomes for SEN pupils. **It was agreed that:** • The SEN Strategy Group had the right people in place to progress this work and drive forward the identified work streams at pace. • The TEG work programme would be updated to receive a progress report at a future meeting.	Margaret
7.	<u>Looked After Children Sufficiency Strategy/ Foster Carer Placements / North East Pilot</u> (Richard Lynch/ Jon Banwell) A presentation was given during which the following points were noted: • There is a renewed drive to attract and retain more foster carers in Barnsley, particularly for teenage young people. • Work is taking place with a team from the North East to share good practice which has generated great enthusiasm and excitement about the potential for progress. • Mel stated that an external review is being undertaken of Barnsley's Fostering Service and as issues are raised they are being dealt with immediately. The outcome of the review is expected to be available soon. • There is a presence on Twitter and Facebook, but posters and flyers are also available to promote fostering. • Brochures have been reviewed and a suite of video clips have been prepared including Barnsley carers and young people which will go onto the website. There were a number of suggestions and offers of support: • Jenny invited Jon to take part in a 'market place' at the Barnsley College development day on 27 February to promote fostering. • Kath suggested that an article be included in the Schools Bulletin and Newsletters, including a flyer. • Rachel suggested that it would be helpful for staff working in communities to be in a position to promote fostering and to be able to signpost anyone who is interested. • Wendy agreed to ensure that Area Councils are aware of how relevant and important this agenda is to them. • Scott offered to arrange for SYP Officers to hand out information leaflets at Barnsley Football matches. He pointed out that young people who are not fostered locally end up spending time travelling back to the area that is familiar to them, which puts them at increased risk. • Brigid suggested that Jon contact Sharon Galvin to circulate posters to health settings including GPs practices, and that a link to the videos be included on the CCG website and possibly be displayed on TVs in waiting rooms. Rachel thanked Jon for the helpful presentation and it was agreed that an evaluation of progress would be reported to TEG in six months' time.	Jon/ work pro.

		Action
8.	<u>Access to therapeutic support and waiting times/ CAMHS Future in Mind Local Transformation Plan</u> (Brigid Reid/ Claire Strachan) Brigid introduced Claire Strachan, SWYPFT General Manager of Barnsley CAMHS New Street Health Centre, who had been in post for 8 months. In the Children and Young People's Plan 2016-19, one of the three key areas for improvement is 'emotional health and wellbeing, including access to services'. At the joint TEG/BSCB event care leavers had expressed how important it is to provide early access to good services to support emotional health and wellbeing. The CAMHS Future in Mind Local Transformation Plan report was submitted to the Senior Strategic Development Group (SSDG) meeting on 17 January where it was agreed that a short presentation with headline messages will be delivered to the Health and Wellbeing Board meeting on 31 January, providing an update on the Local Transformation Plan and the improvement programme. It was noted that Barnsley's action plan was considered by NHS England to be exemplary. The increased need for CAMH Services has increased waiting times, however due to service improvements this had been reduced to, and sustained at, three weeks which is a significant improvement. A lot of work has taken place to improve access to treatment through a number of initiatives including 4:Thought; THRIVE; a peer-mentoring service; training of young commissioners by Chillypep; priority access to CAMHS for young people accessing the Youth Offending Team and for looked after children; development of an information service for children and young people; development of a community based eating disorder service. It was noted that there had been significant changes over the last few months to be celebrated, even though we are not yet where we want to be. Mel commented that progress is being made by working in partnership to support looked after children and vulnerable young people, by ensuring that a skilled workforce and a team of professionals is able to put the right support around a child. Mel queried what the targets are for Barnsley and whether partners could describe what a good emotional support service would look like locally? e.g. fewer inappropriate referrals and fast access for some groups of people including those who are at high risk. Brigid pointed out that the rate of success would vary depending on staff resources and there is a danger of not defining the young person's need appropriately, referring the young person to CAMHS rather than considering the range of pathways available. Kath felt that while there is an increasing awareness of mental health there needs to be a threshold of descriptors for the different aspects and levels of mental health. Claire stated that the revised referral form describes what is considered to be an emergency and what types of need the CAMH Service will respond to. It was agreed that Claire would send the revised referral form to Denise to circulate, and Rachel suggested that it also be included in the Schools Bulletin. It was acknowledged that more work is needed to target Primary Schools.	Claire

		Action
	It was agreed that: • It is good to see the progress being made. • An item be included on the work programme to receive an update at a future meeting. • It is important to understand where we are, what the next stages of development are, where we are trying to get to and how that is expressed in the continuous service improvement plan. • The revised CAMHS referral form would be circulated to members and included in the Schools Bulletin.	Work pro. Claire/ Denise
9.	<u>Healthy Start 0-19</u> (Alicia Marcroft) A briefing note providing the current position of the Healthy Start scheme in Barnsley was circulated, noting that it is the duty of the Local Authority to ensure the provision of Healthy Start vitamins to eligible families. It was recommended that: • The Healthy Start scheme would be considered as part of the 0-19 service review. • All staff receive a training update of the Healthy Start Scheme. **It was agreed** that as there was no local or national data available at this stage, an update would be provided to the TEG meeting in March. *(Wendy Lowder and Dave Whitaker left the meeting)*	Alicia/ Agenda
10.	<u>National Child Measurement Programme (NCMP)</u> (Rebecca Clarke) The NCMP records the height and weight of children aged 4-5 and 10-11. The report provided an overview of the data for Barnsley 2015/16, highlighting the following: • Participation in the programme was high for Barnsley with 98.7% participation of 4-5 year olds and 95.6% of 10–11 year olds. During 2014/15 there had been a decline in participation rates which has affected the robustness of the data for that period of time. • 1 in 5 (21.5%) Year 6 students (10–11 years) are considered to be obese. • Barnsley's data for both Reception and Year 6 is slightly higher than the England averages, but not significantly different. • Nationally, it was noted that boys in both age groups have a higher prevalence of being obese. • Geographical areas in Barnsley will be comparable once an enhanced dataset is available. During the discussion the following points were noted: • The challenge is whether, as a partnership, we are doing all that we can to improve this outcome. • It would be helpful to know how many schools had signed up to the Daily Mile programme. • The 0-19 service is looking at following up those children who are considered obese, and actively supporting them to access services available. It was acknowledged that this needs to be a family approach and to consider what it would take to encourage parents to make healthy food and lifestyle choices as a family. • It is important to consider the availability of good quality information through early years' settings and family centres to promote healthy lifestyle choices	

		Action
	including a lifelong interest in exercise. • Rachel queried what information was available about children in care and Mel undertook to find out, and also what work was done with foster carers to ensure good outcomes for children in their care. • There is a healthy school meals strategy for maintained schools but not for academies, and it was agreed that an agenda item would be included at the next meeting that Rachel and Margaret attended with Chief Executives of Academies. • A plan will be developed that brings all the different elements together to ensure that progress is being made. • It is important for partners to remain engaged in this agenda and to consider what opportunities are available through community shops, food banks, social marketing and getting parents on board. **It was agreed that** an item would be included on the work programme for TEG to receive an update at a future meeting.	Rachel/ Margaret Work pro.
Updates on progress		
11.	<u>Children and Young People's Plan monitoring template</u> At the last TEG meeting it was agreed that the outcomes of the six CYP Plan objectives may need to be re-considered following what young people had said at the joint TEG/BSCB meeting, and that TEG Champions would discuss the outcomes with members of the Youth Council. To facilitate this Julie Green has arranged for TEG Champions to meet Youth Council members at 5.45 for an hour in the Town Hall on 20 February, after which a revised version of the monitoring template will be circulated. Richard flagged up that thought will need to be given to the Workforce Development Lead. Rachel to discuss with HR colleagues.	Rachel
Standard agenda items		
12.	<u>Continuous Service Improvement Plan</u> – confidential (Mel John-Ross/ Julie Govan) At the joint TEG/BSCB event it was agreed that the CSI Plan needed to be refreshed by the Officer Group to reflect the next steps in the improvement journey. Rachel commended the work of the Officer Group. The refresh has moved the plan from recommendations into aspirations for children and young people in Barnsley, and continues to follow the journey of the child. What has already been achieved has been archived and the refreshed plan is about the next steps. The revised plan opens up opportunities for building on what has already been achieved as a partnership, and takes us to the next level on our improvement journey and to where we want to be for children and young people in Barnsley. TEG members were asked to reflect on the draft revised plan to ensure that they are comfortable with the aspirations to drive the improvement work over the next year or so, and to send any comments and suggested amendments to Julie Govan.	Members

		Action
13.	TEG work programme review (Richard Lynch) The revised work programme for 2017 was considered. It is proposed that the CYP Plan monitoring template is updated and submitted to TEG on a quarterly basis and that once a year there is a scheduled agenda item for each of the six priorities which will provide an opportunity for a more in-depth report. The following comments and amendments were noted: • CYP Plan Strategic Priority leads to reflect on what agenda items need to be included under their strategic priority, and the timing of these items being reported into TEG • Work from the healthy weight alliance to be included • Tom Smith is the named lead on 'Careers, advice and guidance' • The named lead for items 2.6 and 2.6.3 is Alicia Marcroft. • Rachel and Richard to consider what agenda items need to be included to reflect the three key areas in the CYP Plan. **It was agreed** that the work programme would be amended and considered at every meeting.	CYP Plan leads Rachel/ Richard
14.	Any other business Mel stated that following the peer review of early help in October 2015, it is proposed that a self-assessment be carried out to take stock of where we are, to acknowledge progress made so far and to affirm where we hope to be.	

Agenda items for the next meeting on 3 March 2017

1. Tackling child poverty and improving family life: Sub-group report and performance highlights (Andrea Hoyland/ Jayne Hellowell)
2. Local Area Special Educational Needs Ofsted Inspection (Margaret Libreri)
3. Supporting young people to make healthy lifestyle choices (Public Health)
   - Public Health Strategy/ Implementation Plan
   - Preventing young people smoking
4. Transport issues raised by young people – progress report (Matt Gladstone)
5. Stronger Communities Partnership update on progress (Paul Hussey)
6. All Age Early Help Strategy (Paul Hussey)
7. Workforce Development/ Skills – update on progress (Amanda Glew)
8. BSCB Minutes of 27 January 2017 highlights (Bob Dyson)
9. Continuous Service Improvement Plan (Julie Govan)
10. TEG Work Programme (Richard Lynch)

Dates of future meetings in 2017	**Time**	**Venue**
3 March (Friday)	13.30 – 16.30	Gateway Plaza Boardroom Level 4
28 April (Friday)	09.30 – 12.30	Westgate Plaza Level 3, Room 3
9 June (Friday)	09.30 – 12.30	Westgate Plaza Level 3, Room 3
21 July (Friday)	09.30 – 12.30	Westgate Plaza Level 3, Room 3
29 September	09.30 – 12.30	Westgate Plaza Level 3, Room 3
13 November	13.30 – 16.30	Westgate Plaza Level 3, Room 3

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Health and Well Being Provider Forum

Minutes of the meeting held on Wednesday 8 March 2017

Present

Helen Jaggar	Berneslai Homes (Chair)
Pauline Kimentas	Age UK
Andrew Pearce	Caremark
Cindy Mitchell	SYHA
Richard Walker	TLC Homecare
Nicola Lang	SWYPFT
Jo Clark	CAB
Anne Simmons	Alzheimers Society
Kevan Riggett-Barrett	BPL

	ACTION
Item 1 – Apologies Apologies were received from Sean Rayner, SWYPFT; Michelle Hall, Mencap; Julie Ferry, Barnsley Hospice; Phil Parkes, SYHA; Carolyn Ellis, VAB; Sam Higgins, Phoenix Futures; Carianne Stones, VAB; James Barker, Barnsley Healthcare Federation, Sharon Clark, BMBC	
Item 2 – Minutes of meeting held 7 December 2016 These were agreed as an accurate record. **Item 2.1- Matters arising** Item 9 i. –Social Inclusion Project, Penistone Area – P Kimentas provided an update on this contract that had been awarded to Age UK by Penistone Area Council. The contract commenced on 15/1/17 and a launch event has been held and two workers have been recruited. One worker is setting up the Good Neighbour Scheme which will put practical and social support in place for people on a one to one basis and a Transport Scheme. This will provide lifts for older people who do not have a car and cannot use public transport or need a travel companion to build up confidence in using public transport. The other worker will look at community development work in terms of offering any support to groups already in place and identifying any gaps. A. Simmons referred to work that dementia/volunteer services undertake in the area such as Making Space and P. Kimintas agreed to check whether any links had been made with these organisations. A leaflet outlining the objectives of the Project and how people can get involved was distributed. Members of the forum agreed to ensure the Project was highlighted in their networks and from an employer perspective promote this to staff who may wish to get involved in a volunteering capacity. The Forum felt it would be beneficial if other Area Councils undertook this type of project.	

Item 2.1.1 – Drivers of Health & Wellbeing Service Transformation in Barnsley – HJ stated that SSDG had been responsive to the forum's request and an explanatory diagram had been produced which illustrated how the various strategies and plans that fall under the wellness theme fit together and this was tabled for information/future reference.	
Item 3 – Health and Wellbeing Board HJ provided an update from meeting held on 31st January 2017. Key items discussed were the Health and Wellbeing Board Risk Register and 2 specific plans from Public Health in respect of Suicide Prevention and End of Life Care. Plans embedded below as it was felt these may be of particular interest to providers.	
tem 4 – Stronger Communities Partnership Due to apologies PP had provided a summary document of the items discussed at the SCP Board held on 14/2/17 together with updates from the 3 Delivery Boards (Anti Poverty Board held on 30/1/17, Early Help (Children and Families) on 23/1/17 and the Adult Early Help Board held on 14/2/17 which were noted. It was noted that the scope of the Oversight Board is quite large and is in its early stages. In respect of Early Help (Children and Families), Sam Higgins, Phoenix Futures had previously attended. However HJ reported that the Council have recently re-commissioned a number of services which has resulted in Phoenix Futures no longer providing the substance and misuse service across Barnsley. Details of the newly commissioned providers were noted as: Domestic Abuse and Sexual Violence - IDAS Multiple Needs Service (16-24) - Centrepoint Multiple Needs Service (25+) - Barnsley Futures (West Yorkshire CRC) Substance Misuse - DISC The forum agreed that HJ contact the newly commissioned providers extending an invite to join the forum. Although the forum does not have direct representation on the Delivery Groups, PK/JC/AS and SWYFT who attend on behalf of their organisation agreed to provide any relevant feedback/highlight reports as done by P. Parkes to future meetings of the forum. AS provided an update on the Dementia Friend Sessions and work that	**HJ** **PK/JC/AS SWYFT**

is taking place across the borough by the Alzheimers Society and other providers. AS reported that work is also taking place with PCSO's who have attended these sessions and GP surgeries to offer support to groups and make links with local communities. AS raised the difficulty in keeping track of the number of sessions that have taken place and people attending as this is reliant on providers who deliver the sessions updating the database. AP agreed to check whether Caremark are inputting this data. The forum felt that providers needed to have an understanding of what work is taking place therefore AS agreed to look at what data could be obtained to provide an updated position. It was felt that most organisations are dementia friends or are currently working towards this. The alternatives to holding a session to become a dementia friend e.g. signing up on line were noted.	**AP** **AS**
<u>Item 5 – Social Prescribing – My Best Life</u> CM provided an update. The service is operational from 1st April 2017. Six advisors have been recruited who will commence on the 20th March and will be based in communities across the borough together with the Team Leader, Natalie Dunn. CM agreed to provide the forum with details of the bases where the advisors will be located. The Office Manager and Team Leader will be located at Westmeads. Liaison is currently taking place with the Council and Be Well Barnsley to ensure there is no duplication in work, as well as GPs and C. Ellis at Barnsley VAB who are working in partnership with SYHA. CM reported that there are still issues with the secure electronic referral process which are currently being looked at. The forum had previously discussed the issue of referrals and any opportunities in the long term to widen the referral route as this currently is predominantly through GPs. ZF had therefore agreed to liaise with PP on the possibility of RW having representation on the Steering Group on behalf of the forum during the pilot. PK reported that the first meeting of the Steering Group had taken place and agreed therefore to forward RW's contact details to ZF so this could be followed through. The voluntary sector's capacity to absorb the potential number of referrals on a day to day basis with no extra resource was also discussed. The forum felt it was important they had an understanding of contacts, providers who will receive referrals together with the referral process. CM said it is intended to have a referral process in place that reflects the system GPs use and that N. Dunn is currently undertaking mapping work in terms of providers and what they are able to offer. It was agreed therefore that ND be invited to the next meeting of the forum to provide an update on the mapping and communication work being done. CM agreed to progress this.	**CM** **PK** **CM**

Item 6 – Barnsley Place Based Plan Apologies had been received from J. Wike who was to provide an update on this item. HJ therefore outlined, and the forum considered the presentation received from JW in respect of the plan. The presentation referenced how the NHS are looking to reframe available funding options in terms of provision, the 3 gaps that have been identified which include a £571 m+ financial gap across South Yorkshire and Bassetlaw by 2021, and the priority areas for Barnsley. HJ stated that although the gaps, and areas they wish to focus on have been established, no decision has yet been taken by CCG on how this will be undertaken. The forum felt it would be beneficial therefore for JW to attend the next meeting to discuss any views/ideas CCG have on how this will be approached. HJ agreed to progress this. JW had asked that information be relayed to the forum in respect of consultation that is taking place. Healthwatch have been commissioned by CCG to lead on various engagement events across the borough on the future of health services in Barnsley. A focus group is being held on the 21st March which providers could attend to ensure their views were obtained. Details of this event and how to book could be found on line on the Healthwatch Barnsley website. However JW had said that if the forum wished a separate session could be arranged with them to obtain views. However the forum felt this may be difficult to schedule due to timescales. In terms of the Plan HJ reported that this had been tabled at Berneslai Homes Board meeting on the 2nd March 2017 in order to obtain their commitment to this.	**HJ**
Item 7 – Future Agenda Items 14 June 2017 - standard agenda items, Barnsley Place Based Plan, subject to JW's availability, Early Help Adults Workshop – facilitated by K. Dodd. Items to be tabled at subsequent meetings – Smoke Free Generation & Suicide Prevention (both Public Health).	
Item 8 – Date of next meeting – 14 June 2017, 10.00 – 12.00 noon at Gateway Plaza. Future meeting dates – 13 September & 13 December 2017	

BARNSLEY METROPOLITAN BOROUGH COUNCIL
COMMUNITIES DIRECTORATE

STRONGER COMMUNITIES PARTNERSHIP
TUESDAY, 14 FEBRUARY 2017

Attendees:-
Councillor C Lamb, BMBC (Chair)
Councillor J Platts, BMBC
Wendy Lowder, BMBC
Keith Dodd, BMBC
Margaret Libreri, BMBC
Paul Hussey, BMBC
Lennie Sahota, BMBC
Lisa Wilkins, BMBC/CCG
Gill Stansfield, SWYPFT
Christine Drabble, VAB
Adrian England, Healthwatch
Phil Parkes, SYHA
Tom Smith, BMBC

Apologies:-

Jade Rose, CCG
Chris Millington, CCG
Carrie Abbot, Public Health, BMBC
Dave Fullen, Berneslai Homes
Marie Hoyle, Practice Manager, Kakoty Practice

MINUTES

1 **Welcome and Introductions**

(a) **Declarations of Interest**

None

(b) **Minutes of Last meeting**

Amendments :

Page 1
- List of attendees – Gill Stansfield represents SWYPFT not BCCG.

Page 2
- Marie Hoyle reported on a Dementia Champions event taking place on 6 December 2016 and a Social Prescribing Champions Awareness session on 7 February 2017

(c) **Action Log**

Wendy Lowder has asked Sara Haydon, Head of Service Management, BMBC IT to provide a position statement on current systems integration and data sharing across health and social care in Barnsley

Dave Fullen was unable to attend the meeting but will provide an update on the roll-out of Universal Credit at a future meeting

2 **Progress Updates**

(a) Adults Group

Paul Hussey reported that the majority of actions within the delivery plan were on track. The Early Help (Adults) Delivery Group had held a workshop jointly led by South Yorkshire Fire and Rescue and South Yorkshire Police on Safe and Well Checks and the Local Intervention Falls Episodes (LIFE) Team. The outcome of independent research into outcomes achieved by the pilot in Sheffield was awaited.

The group had also held a discussion about the revised configuration of Community Nursing Services which afforded a number of opportunities for joint working on a locality basis.

Key activities for the next period would include providing input to the formulation of detailed actions within the Private Sector Housing Strategy, forming a task and finish group to develop an Ageing Well Strategy, and completing the mapping of peer support activity within the borough.

The meeting discussed the breadth and diversity of related activity happening across a range of partnership groups and meetings. Wendy referred to the responsibility of everyone to adopt a 'brokerage role' across the groups they were involved in to help keep making the connections.

Lisa referred to the potential for the Early Help (Adults) Group to lead some of the initiatives around older people set out in the local Transformation Plan.

(b) Anti-Poverty Group

Councillor Platts reported on the establishment of the Alexandra Rose Fruit and Vegetable Voucher Scheme – 25 families have already been helped and drop in sessions are being held at the Better Barnsley Shop to help families avoid the cost of an additional bus journey.

The second Community Shop has opened in Athersley and a complimentary 'growing project' has been established on adjacent land.

Councillor Platts and others had met with Dan Jarvis MP and 'Feeding Britain' and had exchanged ideas on projects to relieve and prevent hunger. Barnsley has agreed in principle to take part in a national pilot project around food poverty.

The meeting discussed various facilities now established within the borough to address food poverty but agreed that the crucial point was to identify and begin to address the underlying causes of need through signpositing to other forms of support. Ideally we should have no one in need of foodbank services

Wendy enquired about progress with workforce development activity to ensure all staff with client contact are equipped to spot and address signs of poverty.

Action: Andrea/Michelle to re-vamp the programme of workforce development

Councillor Lamb raised the potential impact of poverty on the workforce across our respective agencies. The meeting agreed that it was important to make all staff aware of the various services and support available within the borough so that they and/or their families could make use of them should they need to. It was agreed that it would be useful to raise this issue with Trade Union representatives.

Action: Andrea/Michelle to discuss approaches to supporting staff who may be suffering the impact of poverty with Trade Unions

(c) Children's Group

Margaret Libreri reported that the Early Help (Children) Delivery Group had further developed its performance management approach. There has been an increase in Early Help Assessments following the change from Children's Centres to Family Centres and the development of integrated pathways. Performance management is now beginning to focus on impact and the number of cases closed. Audits of the quality of assessments are taking place including cases where thresholds for social care support have not been met. Early help managers are also supporting colleagues through a professional conversation offer where needed.

Links have been made with the THRIVE programme which is aimed at supporting children's emotional development.

A video promoting the early help approach for children and families is currently in production.

Work has also been done to audit the effectiveness of support where a step down from statutory social care services has been achieved. Overall the approach has seen a reduction in statutory child protection plans.

Lisa enquired about the proportion of Early Help Assessments that are originating from primary care. Margaret said that this was low at the moment but agreed to present some statistics at the next meeting on the sources of early help referral sources.

Action: Margaret to provide data on early help referral sources for the next meeting.

3 **SCP Delivery Framework**

Paul Hussey introduced the latest iteration of the Partnership Delivery and Performance Framework. He explained that the recent completion of an All-age Early Help Strategy would provide an opportunity to re-define the outcomes, objectives and performance measures for the Partnership's work.

The meeting went on to discuss the future approach to assessing the impact of the Partnership's activities. There was a consensus that attempts to measure and manage performance across a range of numeric performance indicators would not be productive and would be largely duplicative of activity already happening across individual agencies. It was felt that the use of case studies and stories were more helpful in demonstrating effectiveness but Lisa cautioned that this approach could not evidence impact at the population level. Wendy felt that we would still need a small suite of high level performance indicators to support the new strategy. Lisa cited the number of hospital admissions as a result of injuries from falls as a possible example indicator to support this approach.

It was agreed that the Partnership could usefully devote one of its future session to considering how best to demonstrate the impact of work on early help.

Action: Partnership Coordinator to plan a future meeting to consider the approach to measuring impact

4 **Social Prescribing**

Phil Parkes gave a presentation on the Social Prescribing service to be established in Barnsley from April 17, managed by South Yorkshire Housing Association.

He explained that there are many different models of social prescribing in place across the country but essentially the aim is to divert non-medical problems away from GP's and other health care professionals to a link worker who can begin to help them address underlying causes such as employment, debt, housing, isolation, etc. Often this will be via supporting people to access services provided by the voluntary sector.

The service will be aimed at:

- People with low level mental health problems
- A long term managed health condition(s)
- Social isolation
- Frequent attendance at GP practices or other Health and Social Care services
- A&E frequent attendees

- Six advisors will be allocated by locality across the borough and will aim to work with a minimum of 3,380 customers over the 3 years. Referrals will be accepted from all clinical primary care staff (GP's, surgery staff, neighbourhood nurses). Each person referred will receive a home visit from a community based staff team member and will be supported to develop a plan to improve their health and wellbeing. A Follow up contact will take place after three, six an nine months to evaluate outcomes.

Phil asked all agencies to support an publicise the service and to continually give feedback (positive and negative) as the service develops.

Christine advised that voluntary sector organisations were a little nervous about their capacity to meet demands that may emanate from the social prescribing service. Lisa said that there was some evidence that despite this worry referrals from a social prescribing approach had helped to revitalise many voluntary organisations and that some of those referred had gone on to take a management role within such organisations.

Wendy emphasised the need for intelligence gathered from the service to be fed into the Area Councils and other bodies to influence commissioning decisions.

Councillor Lamb referenced the numerous organisations, groups, clubs and societies that would have something to offer those referred to the service and asked how all such bodies could be connected to the social prescribing offer. Keith advised that the progressive development of Live Well Barnsley, an on-line directory of community based services, would provide an invaluable tool to help with this.

Public Services Hub

Paul Hussey gave a presentation on the development of the Public Services Hub (PSH) and Neighbourhood Teams. He explained that the approach was in-line with the Partnership's ethos of early help and prevention. It also responds to recent reviews of Community Safety and Enforcement, Housing Options and Welfare Services as well as providing an opportunity to restore some degree of neighbourhood policing.

The public services hub will bring service together to increase capacity, capability and resilience and allow a more coordinated targeting of interventions where individuals have complex and multiple issues. It should facilitate a move to a proactive, early intervention model, reduce overall demand and improve long-term outcomes.

In practical terms the PSH will provide a referral, triage and case management function that will target support to those most vulnerable to help prevent and reduce referrals into specialist services.

Phase 1 of the approach (Oct 16 – Mar 17) will see Council Safer Communities Teams co-located with the Police. Phase 2 (April 17 onwards) will see the implementation of integrated area based arrangements between the councils community safety team and the police. Phase 3 (throughout 2017) will broaden the scope of the model with other services located in the hub.

The meeting then held a detailed discussion based around the following questions:

- What are the opportunities to develop common design principles?
- How can we work together to model demand?
- How can service delivery be best integrated to focus on those most vulnerable?
- How can we best ensure a focus on early intervention and prevention?
- What are the barriers and opportunities in moving to a place based (locality) model

The title 'Public Services Hub' was discussed – the PSH's focus is primarily on crime and anti-social behaviour as opposed to an open public service referral point. This was accepted but the difficulty in finding a suitable alternative was also clear.

Tom suggested that there was a clear link to support for those who are economically inactive and that there were a number of imminent funding opportunities to support this kind of activity, notably via Sheffield City Region.

Wendy highlighted the many other potential links including mental health services, Multi-agency Safeguarding Hub (MASH). Family Centres, substance Misuse services, domestic violence services, etc. She suggested that some external support might be beneficial to assist with modelling impact on reducing demand.

Margaret referred to the need to clearly define outcomes both in terms of impact on services and the individuals and families who are helped.

Phil felt that it would be helpful to draw a profile of the kinds of individuals and their circumstance that the Hub would focus on.

Councillor Platts suggested that knowledge held within communities could help to focus attention in terms of early intervention and prevention.

Wendy stated that the model would help to define what successful placed based working might look like and that it might be beneficial to focus on one locality first to gain better understanding.

6 **Any Other Business**

None

7 **Date and Time of Next Meeting**

Tuesday, 23rd May 2017 at 1.30 pm at Shaw Lane

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Paper A

South Yorkshire and Bassetlaw Sustainability and Transformation Plan

Collaborative Partnership Board

13 January 2017, The Birch and Elm Room, Oak House, Rotherham

Decision Summary

Ref	Item	Lead
1	**Minutes of the meetings held 11 November and 16 December 2016**	
02/17	(a) that the minutes of the previous meeting held 11 November 2016 and 16 December 2016 were ratified to be made publicly available subject to amendments recorded	**ALL**
	(b) that a query around the Sustainable Hospital Services Review terms of reference and research raised at the previous meeting would be discussed outside the session	**WILL CLEARY-GRAY, MIKE PINKERTON**
	(c) that discussions by the local authorities were still taking place around a proposal for focused support in each area.	**LOCAL AUTHORITY LEADS**
2	**Summary update to the Collaborative Partnership Board (CPB)/ Transformation funding to support clinical priority areas**	
04/17	(a) that the Mental Health and Learning Disabilities and Cancer transformation funding bids would cross reference one another	**KATHRYN SINGH, JACKIE PEDERSON, LESLEY SMITH**
	(b) that the summary update on next steps, when fully developed, would be shared with all for use when updating organsiations	**WILL CLEARY-GRAY**
	(c) that CPB supported the proposal that work would take place on the workstreams and priorities to ensure clarity on deliverables, enabling the STP to track back what the ask was of the financial gap, working with place and having focus on the SYB outputs	**WILL CLEARY-GRAY**
3	**Communications and engagement approach to public consultation**	
05/17	(a) that an agreed approach on discussions with stakeholders and the public on the STP would be taken forward at place level and be consistent across the patch	**ALL**
	(b) that a draft report on the public consultations for Hyper Acute Stroke Services and Children's Surgery and Anaesthesia would be given to the STP CPB in March 2017	**HELEN STEVENS**
4	**Health, disability and employment**	

06/17	(a) that the STP CPB approved the work in principle and further detail including baseline metrics would be presented to the STP CPB in due course	**GREG FELL (CHRIS SHAW)**
5	**Healthy lives**	
07/17	(a) that the STP CPB committed to aspirations outlined in principle requesting that constituent organisations be consulted and a considered approach be delivered back to the STP CPB for final approval in April/May	**GREG FELL**
6	**STP governance Terms of Reference (ToR)**	
08/17	(a) that the STP CPB supported the ToR presented	**ALL**
7	**Workforce Terms of Reference**	
09/17	(a) that the STP CPB supported the ToR and agreed to contribute to this work where required.	**ALL**
8	**Social Kinetic 3De proposal**	
12/07	(a) that the STP CPB supported the proposal and would work with Social Kinetic 3De on leadership and development at the meeting on 3 February 2017	**ALL**

South Yorkshire and Bassetlaw Sustainability and Transformation Plan

Collaborative Partnership Board

Minutes of the meeting of 13 January 2017, The Boardroom, 722 Prince of Wales Road, Sheffield

Present:

Andrew Cash, South Yorkshire and Bassetlaw STP Lead/Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust (CHAIR)
Adrian Berry, Medical Director, South West Yorkshire Partnership NHS Foundation Trust (Deputy for Rob Webster, Chief Executive)
Dominic Blaydon, Associate Director of Transformation, The Rotherham NHS Foundation Trust (Deputy for Louise Barnett, Chief Executive)
Catherine Burn, Director, Voluntary Action Bassetlaw
Julia Burrows, Director of Public Health, Barnsley Metropolitan Borough Council (Deputy for Diana Terris, Barnsley Metropolitan Borough Council)
Will Cleary-Gray, Director of Sustainability and Transformation, South Yorkshire and Bassetlaw STP
Jeremy Cook, Interim Director of Finance, South Yorkshire and Bassetlaw STP
Mike Curtis, Local Director, Health Education England
Chris Edwards, Accountable Officer, NHS Rotherham Clinical Commissioning Group
Adrian England, Chair, Healthwatch Barnsley
Idris Griffiths, Interim Accountable Officer, NHS Bassetlaw Clinical Commissioning Group
Richard Jenkins, Medical Director, Barnsley Hospital NHS Foundation Trust
Alison Knowles, Locality Director North of England, NHS England
Ainsley Macdonnell, Service Director – North Nottinghamshire and Direct Services, Adult Social Care, Health and Public Protection, Nottinghamshire County Council (Deputy for Anthony May, Chief Executive)
Richard Parker, Interim Chief Executive, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Jackie Pederson, Accountable Officer, NHS Doncaster Clinical Commissioning Group
Matthew Powls, Interim Director of Commissioning, NHS Sheffield Clinical Commissioning Group (Deputy for Maddy Ruff, Accountable Officer)
Mathew Sandford, Associate Director of Planning and Development, Yorkshire Ambulance Service NHS Trust (Deputy for Rod Barnes, Chief Executive)
Steve Shore, Chair, Healthwatch Doncaster
Kathryn Singh, Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust
Paul Smeeton, Chief Operating Executive, Nottinghamshire Healthcare NHS Foundation Trust (Deputy for Ruth Hawkins, Chief Executive)
Lesley Smith, Accountable Officer, NHS Barnsley Clinical Commissioning Group
John Somers, Chief Executive, Sheffield Children's Hospital NHS Foundation Trust
Richard Stubbs, Acting Chief Executive, The Yorkshire and Humber Academic Health Science Network
Kevan Taylor, Chief Executive, Sheffield Health and Social Care NHS Foundation Trust
Neil Taylor, Chief Executive, Bassetlaw District Council
Jon Tomlinson, Assistant Director of Commissioning, Doncaster Metropolitan Borough Council (Deputy for Jo Miller, Chief Executive)
Mark Tuckett, Assistant Director of Public Service Reform, Sheffield City Council (Deputy for John Mothersole, Chief Executive)

Apologies:
Louise Barnett, Chief Executive, The Rotherham NHS Foundation Trust
Des Breen, Medical Director, Provider Working Together Programme
Frances Cunning, Deputy Director of Health and Wellbeing, Public Health England
Greg Fell, Director of Public Health, Sheffield City Council
Ruth Hawkins, Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust
Richard Henderson, Chief Executive, East Midlands Ambulance Service

Sharon Kemp, Chief Executive, Rotherham Metropolitan Borough Council
Jo Miller, Chief Executive, Doncaster Metropolitan Borough Council
Leaf Mobbs, Director of Planning and Development, Yorkshire Ambulance Service NHS Trust
Paul Moffatt, Chief Executive, Doncaster Children's Services Trust
Tim Moorhead, Clinical Chair, NHS Sheffield Clinical Commissioning Group
Simon Morritt, Chief Executive, Chesterfield Royal Hospital NHS Foundation Trust
John Mothersole, Chief Executive, Sheffield City Council
Mike Pinkerton, Chief Executive, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Maddy Ruff, Accountable Officer, NHS Sheffield Clinical Commissioning Group
Diane Wake, Chief Executive, Barnsley Hospital NHS Foundation Trust
Rob Webster, Chief Executive, South West Yorkshire Partnership NHS Foundation Trust
Janet Wheatley, Chief Executive, Voluntary Action Rotherham

In Attendance:
Chris Shaw, Director of Health Improvement, Sheffield City Council
Susan Hird, Consultant in Public Health, Sheffield City Council
Lynsey Hamilton, Transformation Board Manager, Health Education England
Helen Stevens, Associate Director of Communications and Engagement, Commissioners Working Together
Janette Watkins, Programme Director, Providers Working Together Programme
Kate Woods, Programme Office Manager, South Yorkshire and Bassetlaw STP

Minute reference	Item	Action
01/17	**Welcome and introductions** The Chair welcomed members.	
02/17	**Minutes of the meetings held 11 November 2016 and 16 December 2016** The minutes of the meetings held 11 November and 16 December were accepted as a true and accurate record subject to the comments below and were ratified by the STP CPB. The minutes will be published. Amendments were recorded as: 11 November 2016 minutes: John Somers to be removed from apologies list and organisation for Neil Priestley to be amended to Sheffield Teaching Hospitals NHS Foundation Trust. The STP CPB noted that all actions arising from 11 November 2016 were complete. Actions outstanding from 16 December 2016 were noted as: **Sustainable Hospital Services Review** **(Item 24/16 refers)** A query about research raised previously would be discussed outside the meeting. **SYB STP resources** **(Item 26/16 refers)** It was confirmed that discussions by the local authorities were still taking place on a proposal for focused support in each area.	**WILL CLEARY-GRAY, MIKE PINKERTON** **LOCAL AUTHORITY LEADS**

03/17	**National update from the STP Lead** The STP CPB were updated on a time-out for the STP leads taking place in January 2017 and it was anticipated that a further national update would be available at this session. LS updated the group on an STP summit, highlighting a case study presented to this group by Simon Stevens. There was also reference at the session to ensuring fragmentation between organisations was proactively resolved. Discussions had taken place on the challenges to come together for the planning of the STP and therefore consideration was required around ensuring there was capacity to deliver the plans. Discussions had taken place around leading at an organisational level as well as leading across the wider footprint to underpin the STP and that engaging Councilors as part of the process was crucial. There had been a focus at the session on ensuring systems were not "stifled by regulation." The group noted that local contracts were signed off, highlighting a shift in behaviours between systems and organisations to achieve this at such an early stage. It was anticipated that the direction of travel for the STP would emerge shortly and would move from plan to implementation. A delivery timetable would be developed collaboratively. An electronic update would be circulated weekly sharing work and best practice within the STP.	
04/17	**Summary update to the Collaborative Partnership Board/ Transformation funding to support clinical priority areas** The STP CPB was updated on work within the Mental Health and Learning Disabilities and Cancer work streams. **Mental Health and Learning Disabilities** The group noted that a Mental Health and Learning Disabilities Steering Group had been established and would review the Case for Change and agree next steps for four priority focus areas. An initial meeting of the Mental Health Provider Alliance between RDaSH and SHSCT would be held in January. It was noted that capacity had been identified as the main risk. An update on the transformation bid was given: **Integrated IAPT** The purpose was outlined: to expand the IAPT workforce to offer psychological therapies to long term conditions pathways and for people with medically unexplained symptoms, evidence for highest savings from Diabetes, Cardiovascular and Respiratory Disease. This supported the five year forward view (FYFV) access target that by 2020/21, at least 25% of people with common mental health conditions could access services each year. The total national funding available was highlighted as £20m in 2017/18. **Urgent and Emergency Mental Health Services**	

	The purpose was outlined: to pump prime and accelerate existing plans to expand acute hospital liaison mental health services so that they operate at the required standard within one year of receiving the funding. This supported the FYFV target that by 2020/21, all acute hospitals would have all-age mental health liaison teams in place, and at least 50% of these would meet the required standard service standard as a minimum. The total national funding available was highlighted as £19m in 2017/18 and 2018/19 and the approach taken was outlined to the group. **Learning Disabilities – Reducing reliance on specialist inpatient care** The purpose was outlined: supporting the implementation of the Transforming Care Partnerships three year plans for reforming services, in line with *Building the Right Support*, October 2015. This had included strengthening support in the community and reviewing specialist inpatient services. The total national funding available was highlighted as £15m in 2017/18 and £15m in 2018/19. **Reduction in children placed away from their home and local community** The purpose was outlined: providing Positive Behavioural Support based services for children to improve support for children and young people that display behaviour that challenges and prevents escalation and the need to be looked after away from home. The total national funding available was highlighted as £1m in 2017/18 and 2018/19. **Cancer** The STP CPB was asked to note that the current process covered 2017/18 and 2018/19 only. Colleagues from the South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance member organisations had supported the development of the Delivery Plan and Transformation Fund Bid. A draft Delivery Plan and bid was supported in principle by the Cancer Alliance Board. The Delivery Plan added to the next level of detail onto the work undertaken by the STP Cancer work stream. Includes funding to support the Cancer Alliance in 2017/18 & 2018/19. An update on the transformation bid was given: **Cancer Transformation fund bids** **Early Diagnosis** The purpose of the bid was outlined: the funding would be to support the interventions on early diagnosis in the Cancer Alliance delivery plan. The bid proposed a package of interventions. **Recovery package** The purpose of the bid was outlined: existing funded Living With And Beyond Cancer programme with Macmillan and all localities within our Cancer Alliance footprint and therefore the bid focused on integrating	

	‘electronic holistic needs assessments’ into existing Trust systems. In response to a query, it was confirmed that the early diagnosis bid would be focused on reducing inequalities and to move the Cancer Alliance agenda forward. It was agreed that the Mental Health and Learning Disabilities and Cancer bids would cross reference one another, acknowledging the work to be done. **Diabetes** The STP CPB noted that the bids were being developed locally. The bids being submitted were structured into four components; education, NICE treatment targets, multi-disciplinary foot care teams, and inpatient specialist nursing services. There were links between places for some elements of the bids. All transformation bids would be submitted on behalf of SYB by the STP PMO by 18 January 2017 (IAPT bid due 25 January 2017). As part of a general update, the STP CPB noted key next steps for the coming months. The group was reminded of the approach taken to develop the STP, and how this had been worked through in terms of the STP process. The themes and priorities of the STP were highlighted, using place plans and the submission of the STP. An outline on establishing the workstreams was delivered. Collaborative programmes, projects and the task and finish groups were outlined, showing where there was a clearly defined project and programme to deliver and where this was under development that would change and evolve. The group was invited to comment. In response to a query around demonstrating place on the diagram, it was confirmed that place colleagues had been asked to overlay workstream information with local work taking place alongside the work of across SYB. Strategic direction and coordination would take place at SYB level for those workstreams for those workstreams that SYB coordinate for whole system delivery. The presentation would be developed further to reflect this. In response to a query around community integration, it was confirmed that the programmes outlined in the presentation to STP CPB were collaborative, connecting with place. Discussions would be required around what was taking place at South Yorkshire and Bassetlaw level and local. Key outputs over the past year were highlighted to the STP CPB, including the STP, Commissioning Intentions, the cases for change, the implementation plan, and place plans. System wide objectives were noted by the STP CPB. An update was given on the financial strategy noting triangulation between the financial plans submitted in December and the STP submitted in October 2016. Changes in assumptions were outlined to	**KATHRYN SINGH, JACKIE PEDERSON, LESLEY SMITH**

	the group which may reflect increased financial risk, noting deterioration in the underlying position, Clinical Commissioning Group (CCG) allocation adjustments to reflect changes in national tariff and identification rules, non-recurrent income not reflected in control totals, that clinical negligence scheme for trusts premium increases may not be cost neutral as assumed in the STP plan, that financial plans between commissioners and providers may not be aligned, and the delivery risks on provider Cost Improvement Programme plans and commissioner Quality, Innovation, Productivity and Prevention plans. It was proposed that work would take place on the workstreams and priorities to ensure clarity on deliverables, enabling the STP to track back what the ask was of the financial gap, working with place and having focus on the SYB outputs. This was supported. Work was also taking place around how the STP would develop as a whole system. Workshops had taken place around how this would happen. There existed already cross-working between collaboratives. A proposal would be taken to both programme boards to set out how to best align the delivery teams to support the STP. The STP CPB noted that the current meeting schedules would be readdressed. Work would take place around this and a proposal given to the group. It was agreed that the narrative presented was helpful and would be used to update organisations across the patch. This would be further developed and circulated. The presentation would also be circulated in its current format for information.	**WILL CLEARY-GRAY** **WILL CLEARY-GRAY** **KATE WOODS**
05/17	**Communications and engagement approach to public consultation** HS updated the STP CPB on work undertaken with communication and engagement colleagues across the partnership. The group had been developing the shape of discussions with the public. An approach and principles had been agreed. The STP CPB noted these: • That this must be an open conversation • That the difficult issues faced should be outlined and ask for views and what is important • That public conversations would be led by Healthwatch and the voluntary sector, with commissioner support • That staff conversations would be led by provider teams, with STP support • That political conversations would be led by STP partners, with STP support • That these discussions would happen at place level. The governance approach for this was outlined; a task and finish group to be established made of representatives from all areas, co-	

	creating the plan and timelines. A report would be delivered to the STP CPB in April 2017. It was agreed that actions at local level must be cohesive and consistent. In response to a query, it was confirmed that discussions and engagement with members would take place in February 2017. An update was given on the HASU and Children's Services consultation. A piece of work had been undertaken at the midpoint of the consultation, and as a result of the outcomes of this review, the deadline had been extended to 14 February. At the end of this process, an independent analysis would take place to show key themes and feedback. The draft report would be given to the STP CPB and Joint Healthy Overview and Scrutiny Committee before being taken to the Joint Committee of Clinical Commissioning Groups.	**HELEN STEVENS**
06/17	**Health, disability and employment** The STP CPB noted the data presented around the numbers of unemployment across the patch and the landscape across the city region and that initiatives were taking place across the city region/city. Money was available across the city region and what was required now was coordination and potentially to collaborate. The STP CPB was invited to comment. It was noted that two elements that would impact on health were employment and cessation of smoking. A request was made to ensure links were made to the workforce workstream, particularly around possibilities with apprentices. It was highlighted that discussions and engagement with employers was crucial to ensure occupational health services were utilised appropriately in organisations. It was noted that access to support must be simplified and links to IAPT for this was important. The STP CPB approved this work in principle. Further detail including baseline metrics would be brought back to the STP CPB.	**GREG FELL (CHRIS SHAW)**
07/17	**Healthy Lives** The STP CPB noted the Healthy Lives workstream related to three elements; scaling up primary care, workforce and healthy lifestyles. A key recommendation for this was employment and smoking. The STP was asked to sign up to a 10% prevalence for smoking in SYB. Detail around work that all could collaborate on was also highlighted. The group was invited to comment. It was highlighted that the 10% prevalence target felt ambitious. The timescale was confirmed as 5 years. In response to a query it was confirmed that the resource	

	requirements for this work had been included in the STP plan. It was commented that there was work that acute providers could do to support this. A discussion took place around smoking and mental health and that the work needed to align with the MH workstream to change the prevalence trend. The STP CPB committed to aspirations outlined in principle requesting that constituent organisations be consulted and a considered approach be delivered back to the STP CPB for final approval in April/May.	**GREG FELL**
08/17	**STP governance terms of reference** The STP CPB was sighted on detail of the establishment of the Governance Group. Two initial pieces of work were agreed at the first meeting; to draft out the terms of reference (ToR) and to produce a summary of the governance as it currently existed and to work with boards and members to consider what future governance could look like. Two gaps were noted in membership for Local Authority and Medical Director representation which would be considered further. A discussion took place, noting that Neil Riley was linked to this work with experience in his previous role of board secretary. The STP CPB supported the ToR.	
09/17	**Workforce terms of reference** The STP CPB were updated on the Local Workforce Action Board which had a programme of work established. A briefing would be developed, giving a comprehensive overview of the workforce landscape. A briefing would then be delivered to the board in 3-4 months time. A workstream lead was required. HEE would fund this. Business intelligence would be provided by HEE but links would be required locally. The STP CPB supported the ToR and agreed to contribute to this piece of work where required.	
10/17	**Independent review of hospital services** The STP CPB were updated on the progress around the Sustainable Hospital Review, noting the draft ToR had been agreed, steering group membership was being established and that the first meeting was taking place 7 February 2017. A project plan was being developed as well as a business case to engage support from NHS England and NHS Improvement. In response to a query, it was noted that an initial task of the steering group would be to define what sustainable services would mean. It was confirmed that the amendments to the TOR in light of discussions at the previous meeting around researched were accepted.	

	An update would be given at the next meeting.	
11/17	**Review of commissioning** The STP CPB were updated on the review of commissioning, noting that an external consultancy would be engaged to work with CCGs and that a fuller scope would be developed. A senior commissioning operations group would be established, the first meeting of which was taking place 13 January. The ambition outlined was for shadow commissioning arrangements to be in place by April 2017, aligning with the pace of the hospital services review.	
12/07	**Social Kinetic 3De proposal** The group was updated on a meeting that had taken place around the leadership work with Social Kinetic and the proposal was that the STP CPB would engage with this group and utilise a future meeting to start this work. The STP CPB supported taking this work forward.	

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BARNSLEY METROPOLITAN BOROUGH COUNCIL

This matter is not a Key Decision within the Council's definition and has not been included in the relevant Forward Plan

Report of the Director of Public Health
22nd March 2017

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2016

1. Purpose of report

The aim of this report is to provide Cabinet members with information about the Director of Public Health 2016 annual report.

2. Recommendations

That the contents of the Director of Public Health 2016 annual report be noted.

3. Introduction

3.1 National context

The Director of Public Health (DPH) is as independent advocate for the health of the population and system leadership for its improvement and protection. The independence is expressed through the DPH Annual Report – an important vehicle for providing advice and recommendations on population health to both professionals and public – providing added value over and above intelligence and information routinely available.

The annual report is the DPH's professional statement about the health of local communities, based on epidemiological evidence, and interpreted objectively. However it is not just the annual review of public health outcomes and activity. The annual report is an important vehicle by which the DPH can identify key issues, flag up problems, report progress and thereby serve their local populations.

It is a valuable process for internal reflection and team prioritisation as well as external engagement and awareness raising.

3.2 Local context:

For most people, what matters is not so much how many years they live, but being healthy for the years that they are alive. Many people are keen to state they do not want to live an extra ten years, if for those years they are suffering.

The Office for National Statistics publishes 'healthy life expectancy' figures. In Barnsley healthy life expectancy for men is 57.5 years and for women 56.3 years. This is the number of years lived in 'good' health.

Barnsley residents will spend a significant proportion of their lives not in good health and this begins early and well before retirement age. For women, almost a third of their lives could be spent in ill health.

The DPH annual report (2016) is a short film which aims to find out what 'being healthy' means to those living and working in Barnsley and how our approach to promoting good health might need to change from the decisions we make to the services we provide.

4. Proposal and justification

This short film will be used to communicate the work of the public health within BMBC to the public, BMBC staff and partners.

5. Consideration of alternative approaches

Instead of a traditional long paper report, a short video has been produced which will make the content more accessible to a wider audience. The video is easily understandable for members of the public and those professionals who are not public health specialists.

6. Implications for local people / service users

The video provides the views and opinions on what 'being healthy' means to those living and working in Barnsley to inform the Council's decision making with regards to improving healthy life expectancy.

7. Financial implications

There are no financial implications.

8. Employee implications

There are no employee implications.

9. Communications implications

The Director of Public Health's 2016 annual report will be publicly launched on 6th April 2017. A communications plan has been produced with a significant focus on the use of social media.

10. Consultations

The theme of the report has been shared with People, Place and Communities.

11. The Corporate Plan and the Council's Performance Management Framework

The film and subsequent actions to be taken will contribute to the 3 priorities within the Corporate Plan:

- thriving and vibrant economy
- people achieving their potential
- strong and resilient communities

12. Promoting equality, diversity, and social inclusion

The film and subsequent actions will ensure that commissioned services and programmes of work continue to promote equality, diversity and social inclusion.

13. Tackling the Impact of Poverty

There are no issues relating to tackling the impact of poverty.

14. Tackling health inequalities

The film and subsequent actions will ensure that commissioned services and programmes of work continue to tackle health inequalities

15. Reduction of crime and disorder

The film and subsequent actions will not impact on the reduction of crime and disorder.

16. Risk management issues

There are no risk management issues to consider.

17. Health, safety, and emergency resilience issues

There are no health, safety and emergency resilience issues to consider.

18. Compatibility with the European Convention on Human Rights

Not applicable

19. Conservation of biodiversity

Not applicable

Officer Contact: Diane Lee Telephone No: 01226 776367 Date: 22nd March 2017

Financial Implications / Consultation    …… *(To be signed by senior Financial Services officer where no financial implications)*

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REPORT TO THE HEALTH AND WELLBEING BOARD

4th April 2017

BARNSLEY HEALTH AND WELLBEING BOARD ACTION PLAN AND PROGRESS UPDATE

Report Sponsor: Richard Lynch
Report Author: Karen Sadler
Received by SSDG: 21st February / 21st March 2017
Date of Report: 4th April 2017

1. Purpose of Report

1.1 To report progress made against the key objectives and strategic priorities of the Borough's Health and Wellbeing Action Plan, during Quarter 3 (2016/17).
1.2 To propose the recommendations from the Senior Strategic Group to focus on 5 actions where the Board can add value and go further, faster to deliver the board's health and wellbeing ambition for the borough.

2.0 Background

2.1 The Board considered and approved the Health & Wellbeing Strategy on 4th October 2016 and Barnsley's Integrated Place Base Plan on the 6th December. As part of its Borough wide ownership and adoption the executive boards of all partner organisations on the Board have subsequently approved and adopted both documents.

2.2 The Health & Wellbeing Board Action Plan draws together Barnsley's Health & Wellbeing Board (H&WB) Strategy and Barnsley's Integrated Place Based Plan. The H&WB action plan outlines a number of key actions to be pursued in order to achieve the Vision, key objectives and strategic priorities of the Health and Wellbeing Strategy & Barnsley's Integrated Place Base Plan. The action plan is attached as the Appendix 1 to this report. It sets out the progress made against these actions.

2.3 For an overview of the drivers of health & wellbeing service transformation in Barnsley. Please see appendix 2.

3.0 Current Position

3.1 A progress report on the Health & Wellbeing Board Action Plan was submitted for consideration by the Senior Strategic Development Group (SSDG) at its meeting on 21st February. It was felt that the progress report was really useful to provide all partners with an overview of all the work taking place across the borough, and to support the role of system leadership.

3.2 The proposal is to provide a progress update against the actions in the attached plan to the Board twice yearly.

3.3 Summary Of Performance

3.3.1 Current Strengths

These include the following:

- Targeted Approach to improving oral health of children - all family centres across the borough have been engaged to set up a brushing club, distributing free toothbrush/paste packs to the most vulnerable families. The recent superhero campaign has been a huge success, with resources being used by all dentists and primary schools across Barnsley. A consultant from Maxillofacial Surgery at Barnsley Hospital has recently been engaged which has opened up opportunities for work targeting the most vulnerable families that are attending for children's dental extractions.
- Ensure physical activity opportunities and healthy eating are embedded in school based programmes – resources have been designed to encourage all Barnsley Primary schools to deliver a 15minute health and wellbeing scheme called the Daily Mile. An awareness campaign was implemented across the month of March 2017 which included a visit from the Daily Mile founder, Elaine Wyllie on 23rd March 2017.
- Encourage positive relationships and strengthen emotional health - Since October 2016, 19 Primary schools have signed up for training to enable them to start using the Thrive Approach in their schools. Eight of these schools started their training in October 2016 and the approach is already becoming embedded in their schools. In addition to this, 7 schools who were already actively using Thrive have had additional staff members trained.
- Create a smoke free Barnsley –smokefree playparks are being rolled out across the Borough with work underway to make all playparks across the borough smokefree before the end of Easter 2017.
- Design an improved information and advice offer that supports self-reliance - The Early Help (Children) Sub Group has produced an Early Help booklet and circulated to stakeholders setting out the Barnsley model of early help.
- Deliver the Anti-Poverty action plan - The Alexandra Rose Fruit & Vegetable Voucher Scheme is now live and the second Community Shop opened in Athersley in December 2016.

3.3.2 Areas For Development

- Early Help for Mental Health – although some good work is taking place such as the Thrive programme in primary schools, mental health training courses offered to local businesses and the initiatives funded/supported by Sheffield City Region, work has yet to get underway to establish a planned, integrated and strategic approach to early help for mental health. However, the All Age Mental Health Strategy, recently approved by Cabinet will help to pave the way for this work stream.
- Local Digital Road Map – although the Local Digital Road Map is in place, no funding is available to implement many aspects of the plan.

4.0 **Actions where SSDG/HWB can add value**

4.1 At the meeting on the 21st March 2017, the SSDG engaged in a further prioritisation of the action plan, assessing those actions that require alignment of effort, against the triple challenge:

- Ability to reduce the 'Health & wellbeing Gap'
- Ability to reduce the 'Care Quality Gap'
- Ability to reduce the 'Finance Gap'

4.2 The following six priorities for the SSDG were agreed:

1. Improve early help for mental health.
2. Improve services for older people: falls
3. Improve services for older people: dementia
4. Alcohol Alliance.
5. (a) Increase individual and family capacity for self-reliance and self-care.
   (b) Improve the range, availability and coordination of services that provide early help and prevent care and support needs escalating.
   (c) Stronger Communities and Place Based Approaches.
   The SSDG suggested, that for the purposes of the HWB action plan, these priorities be grouped as one as they are very similar.

4.3 The proposal is for the HWB and SSDG to take a focused approach on each of the above priorities by inviting the SSDG lead officer and/or partnership lead officer to fully engage SSDG on a twice yearly basis through a workshop format in order to identify and agree ways to overcome any barriers and challenges as part of a systems based approach.

5.0 Recommendations

5.1 To note the progress made against the Health & Wellbeing Board Action Plan.

5.2 To receive the Health & Wellbeing Board Action Plan progress report twice yearly.

5.3 To consider the suggested priorities for a focused approach by the HWB & SSDG

6.0 Appendices and Background Papers

5.1 Appendix 1: Barnsley Health and Wellbeing Strategy (2016-20) Action Plan - Progress against key actions (Quarter 3, 2016/17)

5.2 Appendix 2: Drivers of health & wellbeing service transformation in Barnsley.

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	A	B	C	D	E	F
1	**Actions**	**SSDG Lead**	**Partnership (Partnership Lead Officer)**	**Timescale for delivery**	**Quarter 3 Progress Update (submitted by 14.02.17)**	**Quarter 1 Progress Update (submitted by 14.07.17)**
2	**HWB PRIORITY** Support all children, young people and families to make health choices:	Rachel Dickinson	Children & Young People's Trust (Richard Lynch/Alicia Marcroft)			
3	Ensure the 0-19's integrated public health service for children and young people will make a major contribution to the development of self-esteem; positive relationships; and healthy behaviour and lifestyle choices.				The transition of the 0-19 service to BMBC and challenges to future public health funding necessitate a level of service delivery remodelling. The changes present an exciting and welcome opportunity to influence the way in which these services are delivered in the future, taking the national HCP framework and adapting this to meet local needs with a clear vision for improving the health and wellbeing outcomes of our children, young people and families across the Borough. The new service model will be focused on the below high impact areas. The six early years high impact areas are: • Transition to parenthood and the early weeks • Maternal mental health • Breastfeeding (initiation and duration) • Healthy weight, healthy nutrition (to include physical activity) • Managing minor illnesses and reducing hospital attendance/admissions • Health, wellbeing and development of the child aged 2: Two year old review (integrated review) and support to be 'ready for school' The six school aged years high impact areas are: • Resilience and emotional wellbeing • Keeping safe: Managing risk and reducing harm • Improving lifestyles • Maximising learning and achievement • Supporting complex and additional health and wellbeing needs • Seamless transition and preparation for adulthood	
4	• A targeted approach to improving the oral health of children.				Since 2007/8 the proportion of 5 year olds free from tooth decay in Barnsley has improved by almost 10%. Although this is still below the England average our rates are improving faster which is closing the gap. A significant amount of work across the borough has contributed to this. An evidence based Action Plan is in place and this work is led by the multi-agency Oral Health Improvement Advisory Group (OHIAG). The work includes all family centres across the borough having set up a brushing club, distributing free toothbrush/paste packs to the most vulnerable families via food banks, and the development of an e-learning package for frontline staff on oral health. The recent superhero campaign has been a huge success, with resources being used by all dentists and primary schools across Barnsley. As part of the campaign a competition was held with primary school children to design a poster. The campaign, using the tag line 'Brushing twice a day is the super hero way', is helping to encourage children to brush their teeth, visit the dentist and to encourage parents to ask for fluoride varnish at the dentist. A consultant from Maxillofacial Surgery at Barnsley Hospital has recently joined the OHIAG, which has opened up opportunities for work targeting the most vulnerable families that are attending for children's dental extractions. An Oral Health Needs Assessment is currently in development and the recommendations from this will be incorporated into the OHIAG Action Plan.	
5	• Reduce childhood obesity starting with a focus on the areas of highest prevalence.				An overview of the National Child Measurement Programme (NCMP) data for Barnsley (2015/16) was presented to TEG on 20th January 2017. Further analysis to understand variation by electoral ward and school is being undertaken by the Research and Business Intelligence Team using an enhanced data set. The output of this analysis correlated with other datasets such as participation in the Daily Mile programme will provide a focus on the areas of greatest need.	
6	• Ensure sexual health services, including contraceptive services, are accessible, personalised and effective, and reduce under-18 conceptions.				Sexual Health services offer a hub and spoke model to ensure equity of access and target those most vulnerable to poor sexual health outcomes and teenage pregnancy. All service meet the 'You're Welcome' Quality Criteria which ensures services are young person friendly in terms of accessibility, environment and monitoring and evaluation of services.	

	A	B	C	D	E	F
7	• Ensure physical activity opportunities and healthy eating are embedded in school based programmes				Physical inactivity is a big problem across Barnsley, with one of the highest levels of inactivity across South Yorkshire. Being physically active in childhood is proven way of reducing the likelihood of a range of chronic conditions such as obesity, type II diabetes and heart disease as well as improves educational attainment. One of the ways we are looking to reverse this trend is by working in partnership with Yorkshire Sport Foundation and Team Active to encourage all Barnsley Primary schools to deliver a 15minute health and wellbeing scheme called the Daily Mile. • The Daily Mile is a 15 minute, run, jog or walk outside of the school classroom environment in addition to regular PE lessons and break times. • An awareness campaign will be implemented across the month of March 2017 which includes a visit from the Daily Mile founder, Elaine Wyllie on 23rd March 2017, who will be presenting a question and answer session at Barnsley Town Hall. • We have designed resources to help encourage schools to participate. • We are encouraging all schools to engage with the project and send their experiences, photos and videos of delivering the scheme to #BarnsleyMile.	
8	• Work with early years services to ensure children are ready for school and opportunities are identified to tackle the causes of child poverty.				Child poverty and deprivation is one of the most important factors determining health inequalities in childhood and throughout life. The 0-19 service promotes and supports parents with early attachment which is critical to the growth and development of babies and children's physical, social and cognitive development which strongly influences their school readiness and educational attainment, their employment chances and general health and wellbeing outcomes through to adulthood and older age. There is overwhelming scientific and research evidence those events which occur when a baby is developing in the womb and in the early years play a fundamentally important part in later life and in the lives of future generations.	
9	**HWB PRIORITY** Encourage positive relationships and strengthen emotional health: • Strengthen and maintain the capacity of the workforce within universal services to promote emotional health and wellbeing and to support all children, young people and their families to respond appropriately. (Delivery of Barnsley's Local Transformation Plan)	Rachel Dickinson	Children & Young People's Trust (Richard Lynch)		The wider programme on mental health workforce development has not yet commenced. However, implementation of a 'whole school approach' (TRHIVE) to targeted Primary Schools in Barnsley to improve resilience is underway. Since October 2016, 19 brand new Primary schools have signed up for training to enable them to start using the Thrive Approach in their schools. Eight of these schools started their training in October 2016 and the approach is already becoming embedded in their schools. In addition to this, 7 schools who were already actively using Thrive have had additional staff members trained. We also have 5 people (from 3 schools) due to start the Thrive Train the Trainers course in June 2017. This should enable us to provide more cost effective training courses across Barnsley and therefore help to sustain this approach.	

	A	B	C	D	E	F
10	**Actions**	**SSDG Lead**	**Partnership (Partnership Lead Officer)**	**Timescale for delivery**	**Quarter 3 Progress Update (submitted by 14.02.17)**	**Quarter 1 Progress Update (submitted by 14.07.17)**
11	**HWB PRIORITY: Reduce smoking** Create a Smoke Free Barnsley	Julia Burrows	Tobacco Control Alliance (Diane Lee)		The smokefree Barnsley programme is being led by the Smokefree Barnsley Tobacco Alliance, which includes partners from across Barnsley; working together to see the next generation of children in Barnsley born and raised in a place free from tobacco, where smoking is unusual. The Smoke Free Barnsley Action Plan (2016 – 2018) is currently being refreshed by the Alliance to reflect the work that has been undertaken since its launch. A 10% prevalence ambition will be adopted by the group to match the target set at STP level by the STP Collaborative Partnership Board. The smokefree Barnsley programme of work is well underway, starting with the successful launch of smokefree playparks at Locke Park on 25 January 2017. The launch, working in partnership with local schools, received substantial interest from the local press, gaining coverage in the Chronicle, Hallam FM, Dearne FM and Radio Sheffield. Local Primary School children designed the signage that will be used in all the key parks across the borough. The initiative was fully supported by the majority of park users with the consultation showing that 9 out of 10 users want them to be fully smokefree. This message was also used on the signage as part of the social norms approach. Elsecar Play Park went smokefree on 14 February 2017 and it will be rolled out to the rest of the parks across the borough before the end of Easter 2017. Plans for smokefree schools and smokefree town centre zones are under development, working with key stakeholders, to launch these elements of the programme before the end of 2017. In order to ensure the Smokefree Barnsley Tobacco Alliance is working as effectively as possibly to reduce smoking prevalence a 'CLeaR' self assessment is currently being undertaken followed by a peer assessment. CLeaR is an evidence based improvement model which helps develop local action to reduce smoking prevalence and the use of tobacco. This will enable the Alliance to evaluate local action on tobacco; ensure that local activity follows the latest evidence-based practice and identify priority areas for development. It is anticipated that the outcomes of the CLeaR assessment will be presented to SSDG in July.	
12	**HWB PRIORITY: Reduce smoking** Reduce the rate of smoking in pregnancy	Julia Burrows	Tobacco Control Alliance, Children & Young People's Trust & BHNFT Board (Diane Lee, Richard Lynch, Bob Kirton)		In 2016, Public Health secured £30,000 funding from Barnsley's CCG to review and improve services in Barnsley. Following an independent review of services in Barnsley, a number of recommendations have been developed to improve the service to women and their significant others, to reduce Smoking at the time of delivery' (SATOD). The recommendations have been compiled into a Smoking in Pregnancy Acton Plan, which is being delivered by the Smoking in Pregnancy Task & Finish Group. The next Task & Finnish Group is due in early March and this should identify a series of key working themes and identify a number of projects that will receive part of the remaining funding. The current Barnsley CCG 'Midwifery Care Bundle' includes all aspect of midwifery care, except, the provision of stop smoking support. The review suggested there could be further benefits if the specialist provision for smoking in pregnancy be integrated into the range of services offered by maternity services to make it part of the normal care pathway. BMBC and Barnsley's CCG are in discussions to consider jointly funding and co-producing a new model for Barnsley, to include the provision of stop smoking support into the 'Midwifery Care Bundle'. This would enable the delivery of a more efficient and holistic pathway and a better experience for pregnant women in Barnsley. Work in ongoing locally and regionally to review the process for SATOD data collection. At present data submitted by Barnsley's CCG does not include the numbers of women that were registered with a Barnsley GP but had given birth in another hospital/district or; include women registered with a GP outside of Barnsley that had given birth in Barnsley. If the regional data collection process does not follow recommended guidelines, this will mean that all SATOD data within the Yorkshire and Humber region will be affected and not just the Barnsley rate.	
13	**HWB PRIORITY : Improve early help for mental health** Development of a mental health alliance	Julia Burrows	Mental Health Alliance (in development) (Diane Lee)		Interviews with senior stakeholders will take place in early March to gain views on how we can increase stakeholder engagement at a strategic level and build on our existing structures to bring together prevention, early help and commissioning. A workshop will take place in May to engage wider with stakeholders and communities. Recommendations will go to SSDG in June.	

	A	B	C	D	E	F
14	**HWB PRIORITY: Improve early help for mental health** Mental Health workforce development	Julia Burrows	Mental Health Alliance (Diane Lee)		Work on mental health workforce development has not yet commenced.	
15	**HWB PRIORITY: Improve early help for mental health** Implement of the All Age Mental Health & Wellbeing Action Plan: 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 6. Mental Health Outcomes	Julia Burrows Rachel Dickinson & Wendy Lowder	Adult Joint Commissioning Board (Patrick Otway), Children & Young People's Trust, (Richard Lynch) & Stronger Communities Partnership (TBC)	2015 -2020	The All Age Mental Health Commissioning Strategy and supporting action plan are in place. The intention is to review the strategy on an annual basis and the supporting action plan bi-annually. Areas of progress (work on track) identified in the most recent update of the action plan (Feb 2017) include: • The commissioning of a Specialist Mental Health Midwife role. • Review and Implement the Perinatal pathway. • Development of a Community Eating Disorder Service. • Developing Peer Mentoring within College / Secondary schools. • Increased awareness of H&SC proffessionsals of the needs of Armed Force Veterans and their families through professionals having access to : HEE on-line resource & HEE free study day • Work in schools (Future in Mind; Samaritans) – publish a report which highlights the work undertaken in schools to promote resilience and mental wellbeing Areas identified in the action plan as halted/not on track include: • Psychological Therapies – reduce waiting times • Publish an evaluation of the 'Employment Advisors' pilot (linked to IAPT) being commissioned to commence April 2017	
16	**HWB PRIORITY: Improve services for older people - Falls** Develop integrated care pathways for the prevention and management of falls and osteoporosis that is clinically and cost efficient and has sufficient capacity to have a population impact	Rachel Dickinson	Adult Joint Commissioning Board (Brigid Reid)		In Barnsley a new concept is in development to utilise universals services to provide a more efficient effective falls prevention and intervention pathway borough-wide. This is done by conducting more detailed assessments and intervention options at an earlier stage (where appropriate), thus diverting the need for specialist services and treatment, and enabling Barnsley residents to live a fuller and more active life. A workshop for engagement of stakeholders will be held in March to proof the concept. Invitees will be from across the health and social care system, voluntary sector and other provider services. Following this event a project plan will be developed to deliver a new Falls offer for Barnsley commencing with pilot proof of concept working with selected care homes and neighbourhood nursing teams. The Falls and Bone Health Group will go on hold until work on the proofing of the new concept is complete. Other developments include: • The launch of the Fire Service's Safe and Well Checks in Barnsley has been postponed until October 2017. The checks will incorporate a falls assessment and onward referral if required. • Work is continuing on a pilot protocol in care homes. This work is to support care homes with the process of falls assessment and management, and is being supported by a clinician in SYWPFT Falls Service. • Public Health colleagues are currently submitting an expression of interest to Sport England for funding to support Strength and Balance Training in Barnsley. • Independent Living At Hone Service (re-enablement/assistive living) are in the process of developing protocols for early assessment and intervention option.	

	A	B	C	D	E	F
17	**HWB PRIORITY: Improve services for older people - Dementia** Further develop services for people with dementia in order to deliver an integrated pathway for dementia ensuring high quality care throughout the pathway that reflects the priorities within the Prime Minister's Challenge on Dementia 2020.	Rachel Dickinson	Adult Joint Commissioning Board (Brigid Reid)		The memory assessment and support service (MASS) has achieved a 79% dementia diagnosis rate in Barnsley. This exceeds the national average of 67%. National guidance is awaited on standards and measures for Evidence Based Treatment Pathways to change the focus from diagnosis to post diagnosis support. The MASS is increasingly supporting integrated pathway through the dementia advisor (DA) roles within the service. DA's are co-located in GP practices and their role is to help with early identification, support pathways to early diagnosis and remain as a support to the person and their families throughout their life journey. This enables the person with dementia and their families/careers to connect with other wide ranging support services/resources in their communities. Other developments include: • The Mayor focus on dementia has raised fund to support one off projects/seed investments within the community, to improve quality of support. Some of these seed investments and services will become part of an integrated pathway (for example, the support in care homes) and other will inform the range of future options. • The Barnsley Dementia Action Alliance brings together organisations and businesses in Barnsley including statutory, non-statutory, VCS and private sector to promote dementia awareness and dementia friendly communities. • Barnsley's Alzheimer's society continues to be active through supporting (signposting, information and advice, carers support) people with dementia and their careers.	

	A	B	C	D	E	F
18						
19	**Actions**	**SSDG Lead**	**Partnership (Partnership Lead Officer)**	**Timescale for delivery**	**Quarter 3 Progress Update (submitted by 14.02.17)**	**Quarter 1 Progress Update (submitted by 14.07.17)**
20	Establish an Alcohol Alliance and a comprehensive programme which creates a culture where sensible drinking is the norm.	Julia Burrows	Alcohol Alliance (in development) (Diane Lee)		Work is underway to refresh the existing alcohol strategy. This will be done through the development of an alcohol alliance to ensure a systematic and coordinated approach. Several programmes of work are underway in relation to alcohol related crime and a sensible drinking culture.	
21	Implement a work place health charter across the public sector and other local businesses	Julia Burrows	More & Better Jobs Taskforce (Tom Smith - with PH Support from Julie Tolhurst)		The support offered under workplace health is to assist employers across Barnsley to improve the health and wellbeing of their employees. The support offered to a business will depend on what the business already has in place and what the issues are that the business wants to address. This could range from a business starting by making small changes such as supporting health campaigns or alternatively progression to the new national award 'Workplace Wellbeing Charter National Award for England'. To enhance business engagement with employers the Barnsley offer includes the following :- • Sharing of workplace health information eg local events, newsletters, local activities, health campaigns • Free workplace health visit – following an initial assessment a business will be advised on how it can make changes to fit the business • Model policies and procedures –designed to help businesses particularly with accreditation to the national award • Provision of training through courses and workshops . This training is 'in house' such as health champion training, Mental Health First Aid and Absence Management training or bespoke training commissioned through external providers . To keep up momentum with businesses on the work and health agenda workplaces are encouraged to appoint workplace health champions. The workplace health champions receive training and are invited to quarterly network meetings which share good practice and also provide information and advice on public health topics. The inaugural network meeting was held in October 2016 and there have been three health champion training courses held since April 2016. The next workplace health champion network meeting is due to be held in March. Two Mental Health First Aid Training Courses have been offered to local businesses since April 2016 and currently engagement is taking place with the local area councils and the police to deliver this training to them.	
22	Increase/enhance support for people with mental health problems and learning disabilities to stay in and get into work	Julia Burrows	More & Better Jobs Taskforce (Tom Smith - with PH Support from Julie Tolhurst)		Links have been made with the Clinical Commissioning Group (CCG) and Health and Wellbeing Board to ensure employment is on the health agenda at a strategic level. A paper was well received at the Senior Strategic Development Group (SSDG) and a further paper is going to the Health and Wellbeing Board in April to take the work forward. Coordinated and led locally on the development and implementation of the following employment pilots: • Health Lead Innovation Trial (SCR): Work and Health Unit (WHU) funded pilot across SCR for people unemployed by virtue of MSK / Mental health conditions - £10m over 3 years. • Building Better Opportunities (BBO): Big Lottery Funded project using Individual Placement Support (IPS) approach, supporting those with mental health conditions / complex needs into employment. Links have been made with learning providers, adult social care and local businesses to improve opportunities for work placements, in work support and mentoring, support more appropriate placements develop referral pathways for vulnerable people, building on skills and expertise from each area and support referrals into new pilot projects. Continued to build links with SWYT, BMBC commissioners and local providers looking at opportunities and referral pathways for people with mental health problems, focusing on Individualise Placement Support (IPS).	
23	Implement Making Every Contact Count	Julia Burrows	TBC Cath Bedford			

	A	B	C	D	E	F
24	Redesign homecare support	Rachel Dickinson	Adult Joint Commissioning Board (Jane Wood)		Procurement nearing completion. Further details to be provided in the next update.	
25	Develop consultant advice and guidance to GPs • Implement Map of Medicine • Support the development of RightCare Barnsley • Continue to enhance direct access to diagnostics and the clinical interpretation and management advice on reports	Lesley Smith	Clinical Transformation Board (under review) (Katie Roebuck)		**MoM:** Map of Medicines implementaion underway across primary care. Detailed mobilisation plan in place, key actions: application integration across primary care,updated referral forms for all pathways, comms and engagement across primary care.	
26	Improve cancer diagnosis and care: • Work with primary care to increase early diagnosis of cancer • Develop a primary care training programme • Increase screening uptake • Develop shared care pathways across primary and secondary care • Maximise opportunity to further develop the Survivorship Programme (Living with and Beyond Cancer) • Revitalise the Cancer Care Review Process • Implement the End of Life Strategy	Lesley Smith	Clinical Transformation Board (under review) (Katie Roebuck)		Detailed discussions underway with BHNFT to improve cancer diagnosis and care. Work underway across the STP footprint to improve shared pathways. **Living with and beyond cancer:** BHNFT are considering completing a funding bid to macMillan to further develop this programme of work.	
27	Heart of Barnsley –Diabetes and CVD • a programme of healthy public policies and lifestyle services/interventions • enhanced clinical management of CVD risk factors • the National Diabetes Prevention Programme. • secondary prevention in primary care and secondary care	Lesley Smith	Clinical Transformation Board (under review) (Katie Roebuck)		Service review of the CVD and Diabetes clinical pathways underway in collaboration with service Providers. **NDPP:** SY&B Wave 2 implementation site. Detailed mobilisation plan in place. Recruitment of NDPP programme manager underway.	
28	Implementation of integrated clinical pathways for musculoskeletal diseases	Lesley Smith	Clinical Transformation Board (under review) (Katie Roebuck)		Service review of the MSK clinical pathways underway in collaboration with service Provider.	
29	Develop/strengthen integrated locality based health and wellbeing teams • Connect primary and community services more closely and support families to manage common childhood conditions in the community	Lesley Smith	Clinical Transformation Board (under review) (Jackie Holditch)			
30	Implement our Local Digital Road Map	Lesley Smith	IT Strategy Group (Chaired by Tom Davidson)		System wide LDR Implementation Group has been created to understand what the key priorities are within each organisation currently and across the system. eMBED have been engaged to develop a plan on a page for the implementation of the LDR in Barnsley over the next 4 years. Both areas of work report into the IT Strategy Group chaired by Tom Davidson.	
31	Implement the GP Forward View to strengthen primary care	Lesley Smith	Clinical Transformation Board (under review) (Jackie Holditch)			
32	Explore the development of an Accountable Care Organisation in Barnsley	Lesley Smith	Accountable Care Partnership Board (Jade Rose / Jeremy Budd)		The ACPB is exploring the creation of an Accountable Care Organisation. A multi-disciplinary Accountable Care Delivery Team has been created to support 4 separate work streams to progress this work further.	
33	Implementation of integrated clinical pathways for: • Respiratory services • Diabetes • Intermediate Care • Community Nursing	Lesley Smith	Accountable Care Partnership Board (Jade Rose / Jeremy Budd)		The Accountable Care Partnership Board will act as the Leadership Board to oversee successful implementation of these integrated clinical pathways. This is supported by the Alliance Management Team which met for the first time in February 2017 with a preliminary focus on Intermediate Care.	
34	Improve personalisation and choice in maternity services	Bob Kirton	BHNFT Board	This is year 2 of a 5 year plan. (2015/16 - 20/21)	Work is on track, key achievements/actions to date include: -Birth plans in place for all women -National maternity information standard in place -Community hubs in place -Confirmed Board lead: Director of nursing and quality -Positive CQC visit for maternity services, rated “good” -Yorkshire and Humber clinical dashboard in place -Neonatal review underway as part of the STP -Maternity/obstetrics STP workstream under way	

	A	B	C	D	E	F
35	**Actions**	**SSDG Lead**	**Partnership (Partnership Lead Officer)**	**Timescale for delivery**	**Quarter 3 Progress Update (submitted by 14.02.17)**	**Quarter 1 Progress Update (submitted by 14.07.17)**
36	Increase individual and family capacity for self-reliance and self-care:	Wendy Lowder	Stronger Communities Partnership (Keith Dodd / Mel Fitzpatrick)			
37	• Design an improved information and advice offer that supports self-reliance		Customer Strategy Implementation Board. (Keith Dodd)		This is now under the governance of the Customer Strategy Implementation Board. In terms of progress, a Project Manager has been appointed and a PID is in development. The Early Help (Children) Sub Group have produced an Early Help booklet and circulated to stakeholders setting out the Barnsley model of early help.	
38	• Develop and implement a systematic approach to health literacy and self-care that supports individuals and communities		Cath Bedford			
39	• Review the effectiveness of Be Well Barnsley		Carl Hickman		The service has worked hard to increase referrals from Primary Care and is working with Barnsley Hospital to increase referrals for stopping smoking. We have increased the number of GP practices the service is based in, and set up a number of new groups and projects, including working with a number of primary schools and community organisations.	
40	• Deliver the Anti-Poverty action plan		Anit-Poverty Delivery Group (Andrea Hoyland/Michelle Kaye)		The Anti-Poverty delivery group meets six weekly. The membership has representation from key partners across the borough, and attendance is generally good with key action owners attending and providing regular updates against their contributions to the Action Plan. Colleagues from CCG, Credit Union and Schools Alliance are not regularly represented. The review of the Action Plan has been finalised in October 2016 with completed actions removed, and new and refreshed actions added. KPI's have been agreed and a quarterly performance report is in draft to be agreed in December 2016. Achievements: • The Alexandra Rose Fruit & Vegetable Voucher Scheme is now live • The second Community Shop opened in Athersley in December 16. • On Friday 20th January, members of the Anti-Poverty Delivery group attended a round table facilitated by Dan Jarvis around 'Feeding Britain.' Barnsley may become part of a national pilot around food poverty. This is subject to a further discussion at the Anti-poverty Delivery Group on the 27th February.	
41	Improve the range, availability and coordination of services that provide early help and prevent care and support needs escalating :	Wendy Lowder	Stronger Communities Partnership (Keith Dodd / Mel Fitzpatrick)		The Early Help (Children) Sub Group have: • Produced an Early Help booklet and circulated to stakeholders setting out the Barnsley model of early help. • Launched a Workforce Development Programme, Sept 16 - positive feedback from participants • Begun production of an early help promotional video	
42	• Implement Social Prescribing and evaluate its impact		Lisa Wilkins			
43	• Ensure a cohesive and connected approach to falls prevention (WL to confirm)		Jane Wood/Emma White		See above update (line 16)	
44	• Plan the sustainability and future development of the ILAH service (ALT) and consider integration of other related services (DFG, adaptions, community equipment store)				A revised Business Plan has been produced and is due to be presented to the ILAH Board	
45	• Develoment and implementation of the Private Sector Housing Plan.					
46	Promote strong and resilient communities	Wendy Lowder	Stronger Communities Partnership (Keith Dodd / Mel Fitzpatrick)			
47	• Procure VCSE infrastructure support & support development of strong challenging leadership in the sector.		Phil Hollingsworth		The Earky Help (Adults) Sub Group is commissioning future voluntary sector infrastructure support based around 4 outcomes: volunteering; sector advice and support; maximising funding opportunities; and engagement and leadership.	
48	• Develop a system wide carers strategy.		Elaine Equeall		The Earky Help (Adults) Sub Group is progressing the development of a refreshed carers' strategy and co-produced Barnsley Carer Offer	

	A	B	C	D	E	F
49	• Evaluation of Area Governance Arrangements		Phil Hollingsworth		The Earky Help (Adults) Sub Group has commissioned and independent evaluation of the Council's area governance arrangements with a view on areas for future development	
50	• Develop/review and implement a system wide volunteering strategy (ongoing)		Phil Hollingsworth			
51	• Map peer support networks, identify gaps and build new networks where required		Phil Hollingsworth			
52	Pilot a place based health and wellbeing approach in one locality (this action requires additional resources to implement)	Wendy Lowder	TBC (Paul Hussey)			
53	Implement a multi-agency public sector hub with South Yorkshire Police and partners	Wendy Lowder & Scott Green	Safer Barnsley Partnership (Paul Branon, Jayne Hellowell & Jakki Hardy)			

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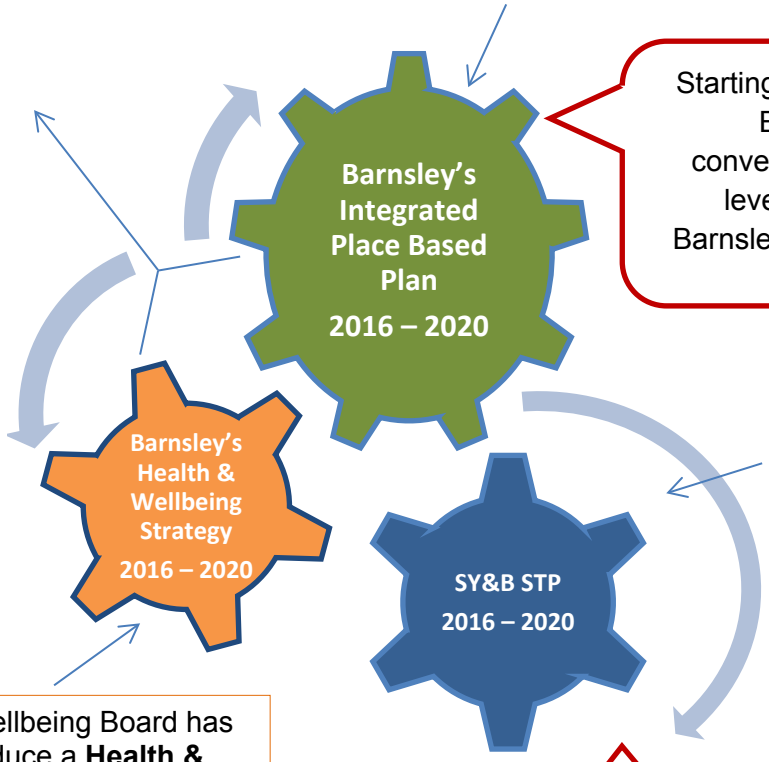
Drivers of Health & Wellbeing Service Transformation in Barnsley

Health & care service transformation in Barnsley is overseen by Barnsley's Health & Wellbeing Board.

Barnsley's Integrated Place Based Plan (BIPBP) combines the vision and ambition set out in the SY&B STP and expands on the priorities set out in Barnsley's Health & Wellbeing Strategy. BIPBP builds on exist programmes of work in Barnsley including the Better Care Fund, the Integrated Pioneer Programme and the Integrated Personalised Commissioner Demonstrator. BIPBP is expected to deliver 70% of service transformation in Barnsley

Action Plan		
What	Who	When

The actions from the Health & wellbeing Strategy and the Barnsley Integrated Place Base Plan have been integrated into a single **Health & Wellbeing Board Action Plan**. Public consultation will inform the implementation and bi-annual progress reports will be published.



Starting in March 2017, Healthwatch Barnsley will be hosting conversations at a neighbourhood level to engage the people of Barnsley in the solutions for our local health & care system

The **South Yorkshire & Bassetlaw Sustainability and Transformation Plan** is a regional plan to deliver NHS England's 5 Year Forward View.

The SY&B STP footprint, includes Barnsley, Doncaster, Rotherham, Sheffield and Bassetlaw.

Regional service transformation, driven by the SY&B STP is expected to account for 30% of the overall service transformation in Barnsley.

Barnsley's Health & wellbeing Board has a statutory duty to produce a **Health & Wellbeing Strategy (HWBS).** The **HWBS** draws intelligence from the Joint Strategic Needs Assessment and identifies 4 themed priorities:

1. Improve outcomes for children & young people,
2. Reduce smoking,
3. Improve early help for mental health,
4. Join up services for older people.

Before any decision is made at a regional level, a wide scale consultation will take place at a local level to inform decisions the decision making process

- Implementation and delivery of Barnsley's HWBS and BIPBP, via the Health & Wellbeing Board Action Plan, is the collective responsibility of the partners of Barnsley's Health & Wellbeing Board.
- Implementation and delivery of South Yorkshire and Bassetlaw Sustainability and Transformation Plan is the collective responsibility of the partners of the STP Collaborative Partnership Board.

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Appendix 2

‘Future in Mind’
Barnsley
Transformation Plan

for

Children and Young People’s
Mental Health & Emotional Well Being

2015 - 2020

REFRESH

October 2016

CONTENTS

1. EXECUTIVE SUMMARY

Barnsley has welcomed the opportunities provided by the additional national resource supporting the Future in Mind recommendations and are utilising the whole of this resource to impact positively on the emotional health and wellbeing of children and young people and their families. We have entered the second year of this 5 year transformation plan to improve the emotional health and wellbeing of children and young people in Barnsley and this is the first annual refresh of the 5 year local transformation plan (LTP).

A Future in Mind Stakeholder Engagement Group has been established, consisting of a wide range of key stakeholders, who have worked tirelessly and enthusiastically together to implement the agreed priorities within the original transformation plan and to further develop the plan to significantly improve the outcomes for the children and young people of Barnsley over the next 5 years and beyond.

This refreshed transformation plan has been developed with all partners through the Barnsley Future in Mind Stakeholder Engagement Group. Children and young people represent themselves as part of this group. Barnsley's transformation plan continues to build on the existing knowledge and expertise within its services whilst also acknowledging the key challenges still faced within the areas of workforce, funding and data capture and utilisation. Importantly however, prevention and early intervention remain at the heart of the transformation.

The focus of transformation work in Barnsley continues to 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. This is exemplified by the fruition of two key programmes of work in the first year:-

- a school-led therapeutic team, now known as **'4:Thought'** aimed at 11 – 18 year olds
- the implementation of the **THRIVE** resilience programme for 5 – 11 year olds.

Services are being planned and will be provided in a multi-disciplinary way with all partners involved in the care pathway – with universal and early help practitioners being empowered to support children and young people with their emotional health and wellbeing needs through training, clinical support and oversight.

Through the Stakeholder Engagement Group it has been recognised that better links could be developed with Barnsley's Early Help offer and these links are now in the process of being formed.

The outcomes that will be delivered by the implementation of the transformation plan, driven by the Children and Young People's Trust, will enable the children and young people of Barnsley to be more emotionally resilient and effectively supported to prevent reduced prevalence of escalation of any mental health problems they may have.

The enhancement of the key prevention work and early years support that is being delivered by implementation of this transformation plan is fundamental in successfully supporting specialist services by enabling a sustainable reduction in demand, creating capacity and capability within the whole system.

2. STRATEGIC CONTEXT

Children and Young People's Mental Health forms an essential part of Barnsley's Health and Social Care priorities. The opportunities derived from the national resource is enabling Barnsley to respond positively to the challenges outlined in Future in Mind.

Mental health problems in children are associated with educational failure, family disruption, disability, offending and anti-social behaviour which places demands on social services, schools and the youth justice system. If mental health problems are left untreated, it can create distress in the children and young people, as well as their families and carers, continuing into adult life and affecting the next generation.

Barnsley has developed an 'All-age Mental Health and Wellbeing Commissioning Strategy' providing an umbrella for the work on children and young people's mental health. The Transformation plans are pivotal to successfully improving the outcomes for the children and young people of Barnsley.

Building resilience within our children and young people to enable them to enjoy robust mental health and wellbeing or to intervene early to prevent escalation of mental ill health are at the core of our transformation plans. The cost benefit of early intervention, particularly early in an infant and parent relationship, is obvious, and although it takes time, is a focal point of our plan.

3. EVIDENCE OF NEED - LOCAL CONTEXT

This section presents an analysis of the emotional health and wellbeing needs of Barnsley undertaken by Public Health. It highlights the most detailed and recent mental health data available including our Joint Strategic Needs Assessment and the latest ChiMat child health and CAMHS profiles. Local data however tends to be limited and is often generated as estimates from national survey intelligence or identified through NHS Digital.

Population

There are 54,900 children and young people aged 0 – 19 living in Barnsley (table one). This is 23.3% of the total Barnsley population (235,800).

The number of children and young people (0 – 19 years) is predicted to increase by 4.5% to 57,390 by 2020.

Currently 6.7% of school children in Barnsley are from an ethic minority heritage.

Table one Number of Children and Young People Living in Barnsley

	Barnsley	**Y&H**	**England**
Age, 2013			
0-4	14,600 (6.2%)	(6.3%)	(6.3%)
0 - 19	54,900 (23.3%)	(24.0%)	(23.8%)
0-19 projected 2020	56,200 (22.9%)	(23.6%)	(23.6%)
School children from ethnic minority groups, 2014	1,794 (6.7%)	(22.3%)	(27.8%)

Numbers of Children in Care

Barnsley has seen a recent increase in the numbers of looked after children (301 as at September 16) although this increasing trend has now levelled. Children out with the borough continue to be placed in Barnsley.

Determinants of health that may impact on the emotional health and wellbeing of children (or be affected by mental health)

Child poverty and deprivation is one of the most important factors determining health inequalities in childhood and throughout life. Research demonstrates that a child's physical, social and cognitive development during the early years strongly influences their school readiness and educational attainment, their employment chances and general health and wellbeing outcomes through to adulthood and older age.

There is often a complex/cyclical relationship between determinants of health and mental health with exposure to adverse environmental, social and educational conditions leading to increased risk of emotional and wellbeing issues but also that mental health problems can in themselves lead to subsequent deterioration of a person's social, educational, employment and housing conditions.

For children and young people the health and social wellbeing of parents and the family as a whole may impact on a child's or young person's emotional health and wellbeing.

Compared to England, in Barnsley the Public Health Outcome Framework, PHE Health Profile and Children's profile for Barnsley shows that:-

- **Deprivation**

  The indices of Multiple Deprivation (IMD) 2015 is the official measure of relative deprivation for small areas in England. Levels of deprivation are high in Barnsley, with the Borough ranked as the 39th most deprived Borough of 326 English Boroughs (where 1 is the most deprived); a decline from 2010 when it was the 47th most deprived area.

  21.8% of areas in Barnsley are amongst the 10% most deprived in England.

  The largest change from 2010 to 2015 for Barnsley is in the Health Deprivation and Disability Domain (HD&DD); within HD&DD Barnsley is ranked 20 out of 326 (where 1 is the most deprived).

  The proportion of children living in poverty is higher in Barnsley than nationally, with 23.8% of under 16s in Barnsley living in poverty compared to 19.2% nationally.

- **Education**

  Educational attainment in Barnsley has continued to improve but remains below the national average at all stages of education. However, between the ages of 7 and 11 pupils in Barnsley make the same or more progress than pupils nationally.

  The percentage of children achieving 5 GCSEs A - C including English and Maths, is significantly lower (47.1% compared to 56.8%);

  Pupil absence rates are significantly higher (5.2 compared to 4.5% half days missed).

  Number of 16 – 18 years old not in education, employment or training, is significantly higher (5.4% compared to 4.7%).

  The recent Joseph Rowntree Foundation report on the causes of poverty adds digital skills to the traditional basic skills of literacy and numeracy (Joseph Rowntree Foundation 2016). Recent data from OFCOM and GO ON UK suggests that (Ofcom 2015, GoON UK 2015):-

  - 27% of Barnsley residents lack basic digital skills
  - 30% of households do not have a fixed broadband connection, and
  - 18% of adult residents have never been online

- **Crime**

  The rate of first contact with youth justice system is nearly 50% higher than the national average (597/100,000 compared to 409);

  Rate of domestic abuse incidents recorded by the police per 1,000 population is higher than national average (30.4 compared to 19.4);

  Admission rates due to injury from violent crime is significantly higher (74 compared to 52 per 100,000).

- **Housing**

  For the Barnsley population in general there are lower rates of statutory homelessness than nationally (0.1/1000 households compared to 2.3).

- **Unemployment**

  Long term unemployment rates in those aged 16 – 64s is significantly higher than national rates (11.1 compared to 7.1/1000).

- **Risk Taking Behaviour**

  In general the Barnsley population continues to have higher than national average levels of smoking, alcohol intake and low levels of physical activity and poorer health food choices.

  The proportion of young people who are regular drinkers at 11.3% (2014 What About Youth Survey) is almost twice the England average of 6.2%.

  Hospital admission rates for adult women from alcohol related conditions are significantly higher than the national average
  (DSR 580 compared to 475/100,000)

  Nearly a quarter of young people undertake three or more risky behaviours (smoking, drinking alcohol, drug use, inactivity, poor diet). This is significantly higher than the England average of 15.9%. Girls (26.7%) are more likely to undertake 3 or more risky behaviours than boys (18.4%)

  The rate of hospital admissions for under 18s from alcohol related conditions has been falling and is similar to the national rate. (Chart One).

  Teenage pregnancy rates, however, are high (Chart Two).

Chart One

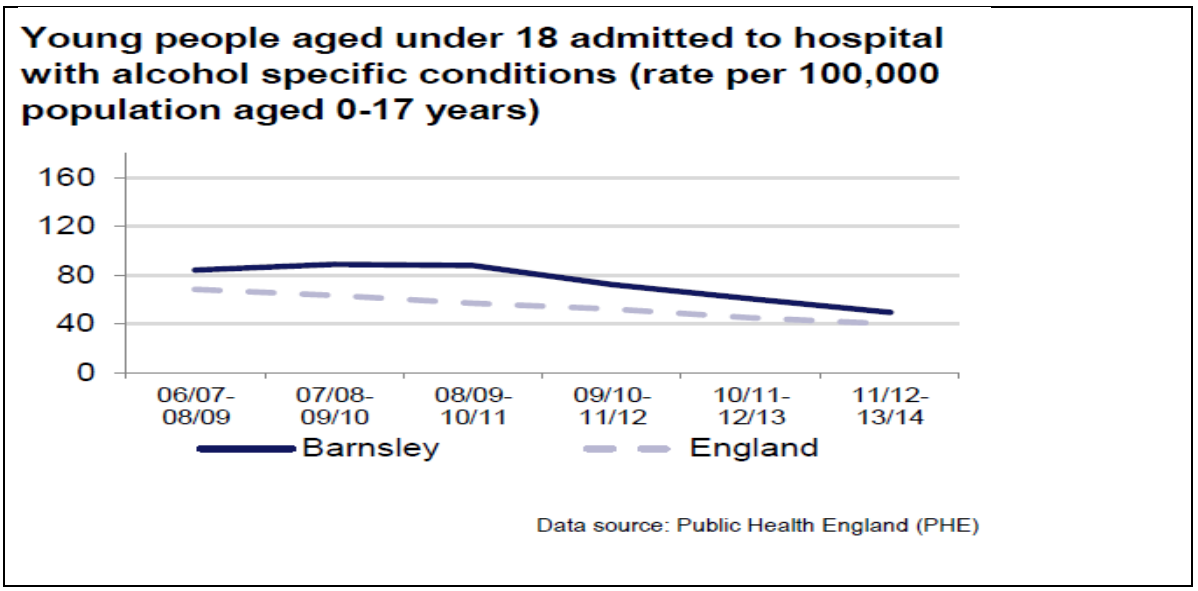
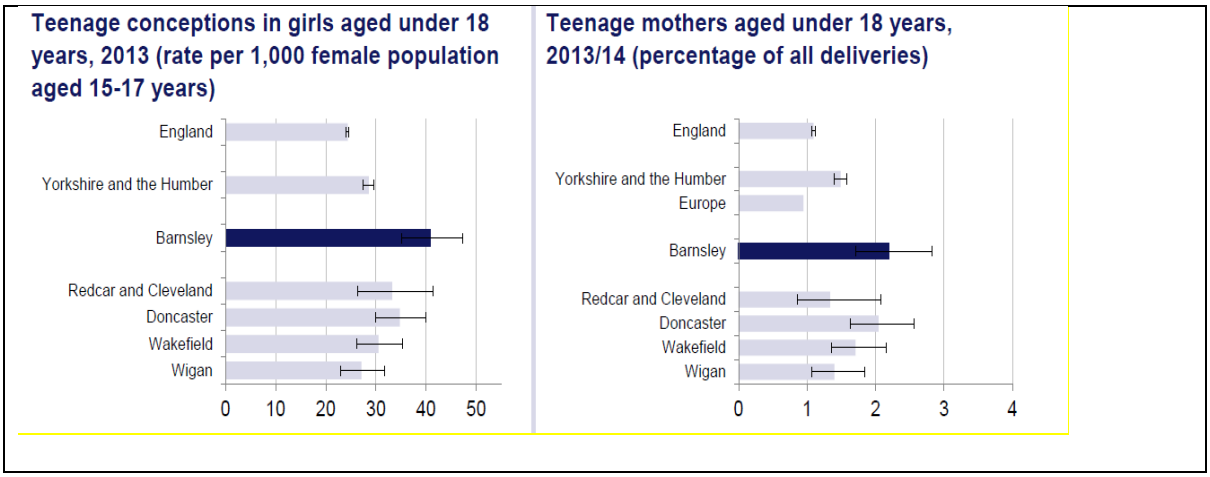


Chart Two



Mental Health of Children and Young People

Nationally

The Future in Mind report highlighted that:-

- Over half of all mental illness starts before the age of 14 & 75% by age of 18;
- The prevalence of mental health disorders in children and adolescence in the last Office for National Statistics survey in 2004, estimated that 9.6% of young people between ages of 5 and 16 years have a mental health disorder (7.7% for those aged 5 – 10 and 11.5% for of 11 – 16's);
- 5.8% of children and young people have a conduct disorder;
- 3.3% an anxiety disorder;
- 0.9% are seriously depressed;
- 1.5% have severe ADHD;
- Bullying is reported by 34 – 46% of school age children. There is a strong relationship between mental and physical health.

Future in Mind notes:-

- 12% of children have a long term condition;
- The presence of a long term condition increases the risk of mental disorder 2 – 6 fold;
- 12.5% of children have medically unexplained symptoms, one third of whom have anxiety or depression;
- People with severe mental health problems such as schizophrenia or bipolar disease die on average 16 – 25 years earlier than the general population.

In Barnsley

The PHE child health profile shows that children and young people in Barnsley are slightly less likely than the national average to be admitted to hospital because of a mental health condition but this is not significantly lower (62.7 per 100,000 age 0 - 17 compared to 87.2%). However, in Barnsley hospital admissions due to:-

- Self-harm – are significantly greater in those aged 10 – 24 (DSR 508 / 100,000 compared to 412);
- Substance misuse - are significantly greater in those aged 15 – 24 (DSR 124/100,000 compared to 81).
- The last Public Health 'Year 10 Survey' for Barnsley was carried out in 2013 and included a section on emotional health and wellbeing. Notable findings of the survey are:-

    - Nearly 10% of respondents felt anxious due to bullying either 'often or daily'
    - Over 20% felt anxious about how they look either 'often or daily';
    - Nearly 10% had been worried about eating problems either 'often or daily';
    - Nearly 12% said they 'never' felt happy at school;
    - Over 12% said that they didn't have anybody to talk to about their Problems. In 2014/15 a company called 'Social Sense' were commissioned to carry out their survey, with schools in Barnsley, which is called 'R U Different', they surveyed year 9 pupils in 6 schools (4 mainstream and 2 special schools). Some of the relevant findings are:-

        - 16% of respondents said they 'often' felt bullied at school;
        - 24% said they felt anxious or depressed 'most days';
        - 29% said that they had harmed themselves as a result of feeling depressed or anxious.

- Barnsley College's Annual Student Survey highlights a year on year;
- Barnsley College's Annual Student Survey highlights a year on year increase in reported loneliness and self-harm.

4. CURRENT SERVICE

The Child and Adolescent Mental Health Services (as a broad term reference) in Barnsley are commissioned through the Children and Young People's Trust. The NHS CAMHS provision is delivered by South West Yorkshire Partnership Foundation Trust (SWYPFT). This multi-disciplinary team provides an evidence-based, comprehensive service to children and young people aged up to 18 years who have a range of clinical needs.

It predominantly provides what were previously known as Tier 3 level services which are out-patient based specialist mental health services. The service is part of the Children and Young People Improving Access to Psychological Therapies (IAPT) Programme that works in partnership with children and young people to help improve and monitor services.

SWYPFT Barnsley CAMHS has reflected the current national trends in terms of rising demand and insufficient capacity as highlighted in the Future in Mind report. As such the service has not had the capacity for robust provision in lower levels of support (previously referred to as Tier 1 and 2 services), consequently it has been hard to influence a reduction in demand successfully, some of which does not require higher levels of support (though will if not effectively addressed). Implementation of the Transformation Plan is beginning to address this imbalance.

Waiting times for both the initial choice appointment and the wait to see an appropriate clinician following choice appointment were unacceptably long. Efforts over the past 12 months have been focused on reducing the wait to the choice appointment, which was 18 weeks, downwards to just 3 weeks. This has been accomplished and a maximum 3 week wait to the choice appointment is being sustained. Efforts are now being refocused on reducing the much longer wait to the start of treatment (Appendix 1: CAMHS Performance data)

It is evident from both the national context and the local referral data that demand for CAMHS has increased significantly over the last 5 years. In order to reduce demand for CAMHS locally the service continue to:-

- Provide and facilitate regular mental health training sessions which are offered to the children's workforce via a safeguarding training brochure, which includes Awareness Level Training and Attachment and Awareness of Mental Health Disorders Training;

- Offer consultation and advice to referrers via a Single Point of Access (SPA) when a referral is made but it is not clear if the child needs specialist services or not. Through the LTP operation of the SPA has been enhanced through investment of additional resource;

- Hold consultation meetings with professional networks for Children in Care, exploring the mental health needs of Looked After Children and who is best placed to provide support / therapeutic input. With additional resources allocated via the LTP, Looked After Children are prioritised when accessing CAMHS services;

- The local CAMHS service does not have the capacity to meet the current, ever increasing demands placed upon it, in part due to there being a lack of lower level support offered within Barnsley. The core of the transformation plan therefore continues to focus on developing robust, lower level support for children and young people's emotional health and wellbeing to assist in reducing the referrals in to specialist services;

- Early intervention and prevention, as a whole system approach, is the focus of the Future in Mind investment in Barnsley (Appendix 2: FiM Funding Allocation). Prevention and intervention in emotional wellbeing and mental health targeted at children and young people will result in greater benefits and savings than interventions at any other time in their life span (DH 2011)[1]. It is the intention that the investment will enable the delivery of evidence based outcome specific services.

[1] Children and Young Peoples Emotional Wellbeing and Mental Health National Support Team – The Learning: 'What good looks like, (April 2011, DOH)

5. TRANSFORMATION WORK

The vision for Barnsley is for early intervention and prevention models to provide innovative wellbeing and prevention focused service(s) that can meet the needs of the children and young people already known to services and professionals across the borough, in addition to identifying others with needs that are currently not being met or supported by other services and extending the ability to recognise and offer support to all those with emotional wellbeing needs.

The work is delivered on an asset model and will focus on promoting factors that support human health and wellbeing (salutogenic) resources that build the self-esteem and coping abilities of individuals and communities, eventually leading to less dependency on professional services.

The services are operating within the context of wider systems to maximise synergy, reduce duplication and ensure impact across the existing systems and future developments, enabling the adults who form the child and young person's environment (teachers, professionals, parents, carers etc.) to role model high self-esteem and personal resilience, which in turn will allow children and young people in Barnsley to 'break the cycle' of low aspirations and improve mental and physical health associated with wellbeing.

The expected outcomes of the early intervention and prevention model include:-

- Improved quality of life outcomes for children and young people by supporting them to build resilience, understand how to maintain their wellbeing and enabling self-care;

- Improved confidence and competence of children and young people facing staff to identify, comfortably and compassionately engage with and signpost children and young people into services via a clear pathway;

- Improved entry assessment and final evaluation outcomes of CAMHS by providing step up/step down services;

- Reduced number of referrals into secondary care/higher level services (for mental health/wellbeing);

- Reduced number of refused referrals submitted to CAMHS;

- Reduced emergency admissions to hospital for Children and Young People with Long Term Conditions – children and their parents are less anxious and have access to information that allows them to effectively self-care;

- Reduced incidence of bullying in schools;

- Reduced incidence of child sexual exploitation;

- Reduced number of children and young people prescribed anti-depressants;

- Increased early identification at key development ages within existing services;

- Improved information, advice and support available for children and young people, and their families and carers, enabling them to effectively self-care and support the emotional wellbeing of themselves and those around them.

In recognition of resource constraints the Future in Mind Stakeholder Engagement Group agreed to focus the additional investment primarily on the implementation of a Resilience model, as developed by Public Health colleagues and partners and the further development of a Therapeutic team proposed by Springwell Academy in collaboration with the local CAMHS service and fully supported by primary and secondary schools within the Borough. The Therapeutic Mental Health Team will also provide support to those children and young people waiting for their first CAMHS appointment.

4:Thought (Previously known as 'BETTER PLUSSS')

This school-led mental health therapeutic team is now known as '4:Thought', following a competition among Barnsley's children and young people to name the team. The winner of the competition (a client of CAMHS) is currently working with the team to design its branding.

'4:Thought' has been developed in partnership with NHS CAMHS, Chilypep, Barnsley TADS (Therapies for Anxiety, Depression and Stress) and SYEDA (South Yorkshire Eating Disorder Association).

'4:Thought' consists of:-

- 3 mental health practitioners;
- 1 parent counsellor;
- 1 family practitioner;
- 1 teacher;
- Educational Psychologist input from the local team.

'4:Thought' is based at Springwell Alternative Academy in Kendray with each of the 10 **Secondary Schools** in Barnsley being allocated to one of the teams' three mental health practitioners. A website has been developed to enable any one to access information about the service, its governance arrangements and information about referrals (http://springwelllearningcommunity.co.uk/contact-4-thought/).

Aligned to the development of '4:Thought' partners are providing training to all staff at each of the 10 Barnsley Secondary schools. The training provided to staff includes:-

- Youth Mental Health First Aid;
- Mental health awareness, self-harm and suicide;
- Anxiety and depression;
- Alcohol and substance misuse;
- Eating disorders;
- Building the confidence and self-esteem of young people;
- Exploring the issues affecting young people and signposting;
- Self-help strategies to support young people's wellbeing.

It is expected that this service will provide:-

- Emotional Well Being (EWB) focused peer support;
- Peer led EWB events;
- EWB training and support for peers;
- Engagement campaign to de-stigmatise mental health/promote emotional wellbeing with positive messages;
- Therapeutic group work and EWB sessions including creative, active, discursive and artistic;
- Improved access to early intervention therapeutic support through outcome focused 1-1 work, where appropriate/clinically indicated;
- Practical interventions, supporting children and young people to develop their own safety plans if/where appropriate;
- Attendance at school, college and community events where appropriate, promoting the service and self-care/prevention messages;
- A comprehensive training programme;
- An interactive website.

As evidenced by models of delivery similar to ‘’4:Thought’ elsewhere in England, it is anticipated that upwards of 200 children and young people per annum will have their needs met by this service on a 1:1 basis and a further 75 children and young people within group sessions. Appropriate outcome metrics are currently being developed to evidence the effectiveness of 4:Thought.

Engagement With Children & Young People

Children and Young People’s Empowerment Project (Chilypep) are undertaking work alongside children and young people aged 8 – 25, to find fun and creative ways of involving them in decisions that affect their lives. As part of the transformational work in Barnsley, Chilypep have been commissioned to develop and provide training for ‘young commissioners’ in order that the ‘young commissioners’ can directly influence the commissioning of children’s services in Barnsley (Appendix 4: Recruitment Poster)

In addition, Chilypep have also re-launched their ‘Peer Mentoring’ programme at Barnsley College (Appendix 3: Pilot Evaluation Report). This early intervention and prevention programme was initially piloted in Barnsley college from 1 November 2014 – 31 July 2015. The video link below shows the positive impact of the work undertaken and highlights the benefits of the programme to the current and future students. https://www.youtube.com/watch?v=BWg1VMcq364

Overall, Chilypep have consulted and engaged over 113 children and young people to date as part of the transformation work.

TADS (Therapies for Anxiety, Depression and Stress)

Barnsley TADS is a Charitable Unincorporated Organisation who provide free complimentary therapies to the people of Barnsley. Barnsley TADS did not form part of the original transformation plan but through the extensive engagement, development and promotion of ‘4:Thought’, they have become and enthusiastic and committed collaborative partner.

Barnsley TADS have established a 'TADS Young People's Wellbeing project' which includes:

- Running a drop in service twice a week between 3:30pm and 5:30pm;
- Offering a five-week wellbeing workshop teaching young people different ways to handle their issues;
- Provide therapies such as Indian head massage, reflexology, reiki, hypnotherapy and EFT (Emotional Freedom Techniques);
- A dedicated, confidential email and text messaging service for advice and/ or support;
- Barnsley TADS are also one of the partners involved in the development of '4: Thought' and they provide some elements of this service.

THRIVE (Previously known as 'BETTER')

The focus of this project is early intervention and prevention to promote resilience in young people. The project is led by Barnsley's Public Health Team and is aimed at Barnsley's **Primary School Children.**

The aim of the project is to improve the social and emotional mental health (SEMH) and resilience of young people in Barnsley through increasing the number of Primary schools providing exemplary mental health support for their pupils delivered through a whole school approach.

The overwhelming evidence is that as well as a whole school approach, interventions need substantial dedicated time to produce benefits. This project aims to support schools to be able to achieve this, initially through enabling them to implement the 'Thrive approach' as part of a whole school approach to SEMH.

Due to the limited resources available it was necessary to identify priority schools. The priority schools were identified by several factors, including the area of deprivation, numbers of exclusions, numbers of unauthorised absences and numbers of CAMHS and Educational Psychology referrals.

Phase 1 of the project commenced in October 2016 with 3 staff from 8 priority schools undertaking the Licensed Practitioner Course. Phase 2 will see a further 24 staff undertaking the Licensed Practitioner Course in March 2017 as well as 5 members of school staff undertaking Train the Trainer courses. Phase 3 is aimed at schools in Barnsley who have already adopted the Thrive approach and a further 24 staff members of these schools will undertake the Licensed Practitioner course.

The expected outcomes to be delivered include:-

- Improved levels of SEMH as measured by the Strengths and Difficulties questionnaire (SDQ) – the SDQ is a well validated brief screening questionnaire for 4 – 17 year olds;
- Reduced requirement for additional higher level mental health support (longer term reduction in CAMHS referrals);
- Improved levels of happiness and feeling safe (pre and post intervention pictorial questionnaire);
- Improved behaviours in home and school (SDQ / teacher and parental questionnaires) - including reductions in low level disruption and bullying;

- Longer term improved academic attainment (school academic data);
- Longer term improved school attendance (school data).
- Longer term reduced instances of exclusions;
- Longer term reduced instances of unauthorised absences (school data);
- Improved development of the social and emotional skills and attitudes that promote learning and success in school and throughout life;
- Improved staff wellbeing and happiness - reduced stress, sickness and absence;
- Improved levels of resilience may mean that young people are more able to cope with, for example, low-level anxiety, frustration and anger, recovering from setbacks and being persistent in the face of difficulties;
- Reduction in risky behaviours.

This work with schools is supported by Public Health who will ensure that this work complements that of the 0 – 19 health and wellbeing service (Health Visiting School Nursing). The steering group for this project is the Barnsley Schools Alliance 'Closing the Gap' group which includes schools representatives. The Project Manager is a member of the Public Health team in Barnsley and a member of the Future in Mind Stakeholder Engagement Group.

NHS CAMHS

CAMHS services have generally been delivered in line with the four-tiered national framework with Tiers 1 and Tier 2 providing lower levels of emotional health and wellbeing support, often provided by mental health specialists in universal services such as GP's, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies. NHS CAMHS is a specialist CAMHS service provided at Tier 3, a much higher level of emotional health and wellbeing support to children and young people. Tier 4 relates to in-patient treatment and is commissioned by NHS England.

There is often a misunderstanding that a child or young person will move up through the Tiers as their condition is more complex but the needs of children and young people do not fit neatly into the Tiers and in reality, some children require services from a number of (or even all) Tiers at the same time. In Barnsley we are therefore moving away from the idea of tiered support and focusing on developing services tailored to meet the emotional health and wellbeing needs of children and young people within the Borough.

The Barnsley Child and Adolescent Mental Health Service (CAMHS) is based at Upper New Street, Barnsley and provides a comprehensive and quality service to children and young people in the Barnsley area. The services are provided to children and young people up to their 18th birthday who are experiencing a wide range of behavioural, psychological and emotional problems, difficult relationships, trauma or abuse. 100% of young people presenting to Barnsley CAMHS in an emergency are seen within 24 hours.

Barnsley CAMHS is part of the children and young people improving access to psychological therapies (IAPT) programme that works in partnership with children and young people to help improve and monitor services.

Barnsley CAMHS is made up of four teams:-

- Child and Adolescent Unit;
- Young People's Outreach Team;
- Community Early Intervention Team;
- Learning Disabilities and Development Disorders Team.

The services are provided in a variety of settings including health centres, clinics, schools or in service user homes. There is a range of support and interventions offered to children, young people, families and carers who use the Barnsley CAMHS service. Examples of this support includes:-

- Brief solution focused therapy (a goal directed therapy that focuses on solutions instead of problems);
- Cognitive behavioural therapy (CBT) (a talking therapy that can help you manage your problems by changing the way you think or behave);
- Evidence based parenting interventions;
- Eye movement desensitisation reprogramming (a treatment used to reduce the symptoms of post-traumatic stress disorder);
- Family therapy;
- Group therapies;
- Play therapy;
- Psychiatric assessment and diagnosis;
- Psychologist assessment and interventions.

The specialist team includes psychiatrists, specialist nurses, psychologists, specialist social workers and therapists who help children, young people and their families, on both an individual and group basis. Barnsley CAMHS also offer their mental health expertise across children's services in the area, providing consultation, training and advice to carers, families and other professionals.

Long waiting times to the commencement of treatment in Barnsley CAMHS continues to be an issue. Significant progress has been made in reducing the initial wait for an appointment from 18 weeks to 3 weeks but children and young people may then wait almost a year before their treatment begins. This is unacceptable and commissioners and service providers are working closely together to significantly reduce the waiting times.

Actions to date include additional investment to enhance the operation of the CAMHS Single Point of Access and to enhance CAMHS support to the Youth Offending Team and for priority access to CAMHS for Looked After Children. Re-design of the ASD / ADHD pathway has been undertaken and the pathway is working well although the funding for this service needs to be re-modelled to further consider CAMHS capacity. The Future in Mind investment is being utilized to develop lower level emotional and wellbeing support to children and young people in Barnsley to prevent escalation to crisis point and additional non-recurrent monies from NHS England will be used to increase the capacity of CAMHS to offer greater access to CBT.

Barnsley CAMHS have been an important partner in the development of '4:Thought', working closely with the schools lead, Springwell Academy, and will continue to work in partnership with schools to ensure '4:Thought' provides a robust, evidence-based service to the children and young people of Barnsley.

Barnsley CAMHS had previously initiated the development of a **Single Point of Access (SPA)** but its operation was limited. As part of the transformation work funding was allocated to the NHS CAMHS service to enhance and further develop the SPA, utilising learning from Barnsley's own brokerage service, Rightcare Barnsley, to ensure children and young people receive the right treatment, in the right place at the right time. Further work is required to fully operationalise this in 17/8.

Exposure to crime and anti-social behaviour are one of the determinants of poor emotional health and wellbeing in children and young people. In recognition of this Future in Mind funding has been utilised to increase CAMHS capacity to provide additional input into the **Youth Offending Team**. This is enabling timely access to the support needed by this vulnerable group of children and young people.

Community Eating Disorder Service

A community eating disorder service provided by CAMHS has been established in Barnsley in accordance with the recommendations of the guidance for 'Access and Waiting Time Standard for Children and Young People with Eating Disorder'. The Barnsley service has been established through a collaborative commissioning arrangement with four other CCG's, these being Wakefield, Kirklees, Greater Huddersfield and Calderdale.

Through the consultation for Future in Mind we identified the need for more CBT and Family Therapy which has been reflected in the regional model. The number of Barnsley children and young people anticipated to be able to be seen through the eating disorder pathway will be triple the numbers that had previously been seen.

The regional group are focusing on producing an outcome based model, and are working collaboratively with our provider to explore the current provision and how to effectively implement the service. Barnsley, Wakefield, Kirklees, Calderdale and Greater Huddersfield have redesigned service provision to ensure we are compliant with the waiting time standards set out in the guidance. (See Appendix 5 for full implementation plan).

Children and Young Peoples Improving Access to Psychological Therapies (CYP IAPT)

Barnsley CAMHS has participated in the national programme since the first implementation phase in 2012. The service is part of the North West CYP IAPT Learning Collaborative. There are currently 20 partnership members of the collaborative - supported by Greater Manchester West Cognitive Behavioural Therapy Training Centre (GMW CBTTC)/The University of Manchester.

CYP IAPT is a pivotal factor in delivering the Five Year Forward View in Mental Health objective of enabling an additional 70,000 additional children and young people in England to access emotional health and wellbeing support by 2020.

A key component of CYP IAPT is the training of practitioners (and supervisors) in NICE approved and best evidence based therapies. Historically, NHS England has funded the backfill posts to enable staff to undertake this training, but the level of future funding is reducing.

It is vital that this training continues and that it is incorporated into the workforce plan. In recognition of this, an element of the Future in Mind resource will be allocated recurrently for this purpose.

Accessible Information

In both previous and current consultations with children and young people in Barnsley it is evident that there is a general lack of awareness among children and young people as to the emotional health and wellbeing support that is available to them, locally and nationally and that even when the children and young people are aware of services, they are not always aware of how to access them.

To remedy this an element of the Future in Mind funding has been utilised to look at the development of a 'one-stop-shop' model of accessible service information. Links have been made to the work being undertaken by Chilypep and to the Local Authority's own 'I Know I Can' website, as well as to the Family Centres Information Advisory Service, the CAMHS SPA and '4:Thought'.. Learning is being shared and all partners are working towards delivering a robust, real-time information service to all children and young people in Barnsley.

Perinatal Mental Health

Barnsley's Perinatal Mental Health pathway has been reviewed (Appendix 6) and reflects the engagement with in-patient and outreach services to prevent relapse. There are close links with Barnsley's IAPT (Improving Access to Psychological Therapies) service who are supporting up to 300 women per year. However, a gap still exists with regards to pre-conception support and this is an area that will be targeted locally with the impending future national resource.

A key priority however, and the key to substantially enhancing the perinatal support in Barnsley, is the development of a Specialist Perinatal Mental Health Team. The numbers of births in Barnsley (approximately 3,000 per year) are not high enough to warrant developing such a specialist team locally but it could be effective on a sub-regional basis.

With this in mind, Barnsley have recently supported a collaborative bid, with Kirklees, Calderdale and Wakefield CCG's, to NHS England's' Service Development Fund to establish a sub-regional Specialist Mental Health Service.

A Maternal Mental Health strategy group, led by Barnsley Hospital NHS Foundation Trust leads on developing a perinatal mental health strategy, perinatal mental health being a key priority outlined in Barnsley's All-age Mental Health and Wellbeing Commissioning Strategy.

Looked After Children

Outcomes for Looked After Children often fall behind that of other children and young people simply due to their life experiences which lead them to becoming looked after by the Local Authority. This inequity has been recognised and in response Future in Mind resource is being utilised to ensure that Looked After Children have priority access to CAMHS to ensure that they receive the most appropriate treatment in a timely manner to prevent escalation to crisis.

Child Sexual Exploitation

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 partners (including South Yorkshire Police and SWYPFT and voluntary sector organisations (namely BSARCS – Barnsley Sexual Abuse and Rape Crisis Services)) to ensure that the children involved in such exploitation receive the specialist treatment necessary to enable them to reach full recovery. The local authority and CCG have recently jointly commissioned an enhancement to the BSARC service to ensure children receive timely therapeutic support post episodes of sexual violence. The Transformation Plan needs to ensure this function is resourced recurrently

Work is also 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. CSE awareness is built into resilience work.

Mental Health Crisis Care

Barnsley CCG and its partners continue to work closely together to implement the Barnsley Mental Health Crisis Care Concordat Action Plan to improve the crisis care of anyone in Barnsley who requires such help, where and when they need it.

Barnsley's Mental Health Crisis Care Concordat Group are currently refreshing the Concordat Action Plan and improving the crisis care for under 18's is a key focus. Regionally, within South Yorkshire, there are plans to develop a health-based place of safety suitable for young people to be taken whose mental health crisis warrants the police to use S136. Very few young people in Barnsley have been placed on a S136 order (one in the last 3 years) but when the need arises a health based place of safety is needed for them that is a safehaven but is not frightening (police custody cells were used prior to November 2015).

If children and young people present at Barnsley Hospital A&E in mental health crisis they are currently seen by Barnsley CAMHS. The Psychiatric Liaison service based at the hospital only covers adults (18 year olds and over) but plans are being considered to develop an appropriate NICE recommended psychiatric liaison model that will incorporate 16 and 17 year olds. Commissioners and providers are working together to develop appropriate metrics based on the Liaison Psychiatry Frequently Reported Outcome Measures (Appendix 7).

0 – 19 Health and Wellbeing Service

The aim of the Healthy Child Programme delivered through a 0 – 19 Health and Wellbeing service is to protect and promote the health and wellbeing of children, young people and their families. The service will work in partnership with other agencies and offer a needs-led offer in line with the key health and wellbeing outcomes including supporting children, young people and families to be empowered to make positive choices in leading happy, healthy lives.

From October 2016 Barnsley Metropolitan Borough Council became responsible for delivering the 0 – 19 health and wellbeing service. Although the transition of the service to the Local Authority may cause some initial teething problems it will undoubtedly provide valuable opportunities for collaborative, effective working among partners.

6. COLLABORATIVE WORKING WITH NHS ENGLAND

Mental Health Specialised Commissioning Team

NHS England has commenced a national Mental Health Service Review and now has an established national Mental Health Programme Board to lead on this process. The Mental Health Service Review will be locally directed and driven so that the services meet the needs of local populations. Yorkshire and Humber commenced procurement of general adolescent and psychiatric intensive care inpatient services ahead of the national timescales. The way that the procurement is organised will mean that the Yorkshire and Humber area will be divided into three geographical Lots; the first Lot to be procured will be services for Hull, East Riding of Yorkshire, North and North East Lincolnshire.

The remaining two Lots are Lot 2; West Yorkshire, North Yorkshire and York, and Lot 3; South Yorkshire. Timescales for these areas are yet to be announced.

A detailed piece of work has been carried out to assess the numbers of beds required and in which geographical locations (Appendix 8 – Tier 4 Bed usage). Lot 1 bed requirements are 11 in total which incorporates General Adolescent beds with psychiatric intensive care beds. This service will provide for the populations of Hull Clinical Commissioning Group, East Riding of Yorkshire Clinical Commissioning Group, North Lincolnshire Clinical Commissioning Group and North East Lincolnshire Clinical Commissioning Group.

NHS England is leading a new programme, announced in the Planning Guidance 16/17, that aims to put local clinicians and managers in charge of both managing tertiary budgets and providing high quality secondary care services. Tees, Esk and Wear Valley Foundation Trust was selected as one of the providers selected as the first-wave sites, working towards a go-live date in October 2016 to cover the North East and North Yorkshire. This will provide the incentive and responsibility to put in place new approaches which will strengthen care pathways to:-

- improve access to community support;
- prevent avoidable admissions;
- reduce the length of in-patient stays and;
- eliminate clinically inappropriate out of area placements.

It is clear from the CAMHS benchmarking that has taken place that there is significant variation in usage of Tier 4 beds as well as the length of stay in these units. The data shows that there is a link between this 21tilization and lack of Intensive Community CAMHS services available in a CCG area; it is envisaged that the development of the LTP is a significant opportunity to develop Intensive Home Treatment and Crisis Services to reduce the need for admission. In order to improve the quality and outcomes for children and young people we will work closely with identified lead commissioners in Y&H to ensure that CAMHS Service Review and local plans link with Sustainable Transformation Plan (STP) footprints. This will enable better understanding of the variation that currently exists across YH to help identify opportunities to challenge this in order to ensure equity of access, outcomes and experience for all patients.

The aim is to develop greater understanding of patient flows and the functional relationship between services to work with commissioners and providers to support new and innovative ways of commissioning and providing services, in order to improve quality and cost effectiveness. This work will continue to carry out collaboratively through the Children and Maternity Strategic Clinical Network which includes all relevant stakeholders.

Health and Justice

High numbers of children who offend have health, education and social care needs, which, if not met at an early age, can lead to a lifetime of declining health and worsening offending behaviour, with significant long-term costs to the taxpayer and to the victims of these crimes. In recent years national policy on sentencing for children who offend has changed, with around 97% now subject to community supervision as opposed to custodial sentencing.

All children who come into contact with youth justice services are vulnerable by virtue of their young age and developmental immaturity. Many however, are doubly vulnerable – that is, they are disadvantaged socially, educationally and also because they experience a range of impairments and emotional difficulties. It is well established that children who offend have more complex health and support needs than other children of their age.

Evidence suggests that between a third and a half of children in custody have diagnosable mental health disorders and 43% of children on community orders have emotional and mental health needs. Research studies consistently show high numbers of children in the youth justice system have a learning disability, while more than three-quarters have serious difficulties with literacy and over half of the children and young people who offend have themselves been victims of crime.

Children who are, or who have been, in care are over-represented among the offender population. Research shows that 42% of children on custodial sentences had been ‘held in care’, while 17% were on the child protection register.

The case for priority access to CAMHS is particularly strong for those identified with early behaviour problems and ADHD (both of which are known to have strong associations with offending behaviour, substance misuse and later mental health problems), those who have suffered previous maltreatment, young females (who have high levels of mental health and other needs), young people from BME communities (who remain over-represented in custody settings), and those with mild to moderate learning disabilities and communications difficulties, who currently fail to access community services.
Children who offend don’t always get early help with health needs – yet early intervention will lead to better outcomes. NICE guidance (2013) supports clearer evidence of what works to support children’s and community outcomes – working with families and systems around the young person.

Commissioners across the whole system need to work together to ensure integrated care pathways to enable young offenders with mental health problems at all stages of the criminal justice pathway can get the most appropriate care at the right time by the right person.

The success of the YOT model has been widely acknowledged as an effective way of providing children who offend with the right mix of care, supervision and rehabilitation. The importance of integrated service provision within the Youth Offending Service (YOS) with clear care pathways is vital in the youth justice system where mental health problems in children who offend may be identified for the first time, but with a limited window of opportunity to assess need, plan for and deliver an appropriate intervention. Challenges include:-

- Threshold for acceptance into CAMHS is high and can exclude children with lower level, multiple and often complex mental health needs. Children under the supervision of youth justice services and those identified as being at risk of offending must not be marginalised and they should have equal access to comprehensive CAMH services;

- Specialist YOT CAMHS workers, or clear pathways into CAMHS, are needed to support children with a community sentence and should be available for those on release from secure accommodation.

Effective parenting work is also undertaken by both the Youth Offending Team Service and the Multi-Systemic Therapy service. Complementing these services is the parenting work undertaken through CAMHS, voluntary partners and Early Years services. Enhancing parenting initiatives within the Borough will result in wide ranging benefits for the child, the family and the community as a whole and will be a focus of the 2016/17 funding allocation.

Children referred to Forensic CAMHS (FCAMHs) may be involved with the youth justice system or be at high risk of being so in the future. They are likely to present with behavioural problems like violence and aggression towards others, harming themselves, fire setting or engaging in sexually inappropriate behaviour. FCAMH services work collaboratively with other agencies working in the youth justice system, there should be a dual emphasis on promoting and enabling individual recovery and independence, while also ensuring the protection of the public.

Challenges in service delivery include:-

- The time of highest risk for children is during the transition between different parts of the pathway – it is essential this transition is managed safely and effectively. This is particularly the case for the transition from secure accommodation to increased independence and responsibility in the community. There is a need for children on release from the secure estate to be referred to a community forensic CAMHs if they have been assessed within the estate as needing a service, but the sentence has been too short to start or complete an intervention;

- The principle of ‘equivalence of care’ established that people (including children) in prison should have the same standard of care that is available to the wider (non-imprisoned) population. The 3 secure establishments for children in Yorkshire and Humber, namely HMYOI Wetherby, Aldine House and Adel Beck Secure Children’s Homes all have access to FCAMHS but there is often no community service to provide treatment or follow-up available.

Liaison and Diversion (L&D) services operate by referring offenders who are identified with having mental health, learning disabilities, substance misuse or other vulnerabilities to an appropriate treatment or support service. At the point of arrest, there is an opportunity to identify these needs early on, to link to young people and their families with the support they need and to reduce the chance of people going in and out of the youth justice system. Most adults with poor mental health first present with symptoms during their teenage years so early intervention is critical to promote children's life chances and reduce multi-sector costs. An independent evaluation found that young people involved in L&D services took longer to reoffend and showed significant improvements in managing depression and reducing self-harming.

Challenges in service delivery include:-

- Following assessment by the L&D practitioner the child is referred to the most appropriate mainstream, YOS, and voluntary health and social care services to meet their mental health needs. Clear care pathways, linked with schools and other settings/partners as part of referrals, need to be established into comprehensive CAMHS for children that are on the fringes of early criminal activity right up until their resettlement after custody;

- Pathways from L&D services will need to include services for those with mental health and behavioural difficulties as well as care pathways for those comorbid mental health and learning disabilities.

7. GOVERNANCE

Barnsley has had well-developed partnerships and integrated working arrangements for some time which has enabled strong partnerships to be developed to ensure delivery of the objectives of the transformation plan.

The Future in Mind Stakeholder Engagement Group (Appendix 9: TOR) is accountable to both the Children and Young People's Trust (formed in 2007) and the Trust Executive Group (TEG) which was established to ensure a partnership approach to encourage integration in the Children's workforce to prevent the developing of isolated solutions to system-wide issues. Membership of TEG include the following:-

Barnsley Metropolitan Borough Council (BMBC)

- Executive Director for the People Directorate;
- Service Director, Children's Social Care and Safeguarding;
- Service Director, Education, Early Start and Prevention;
- Head of Public Health;
- Interim Head of Barnsley Schools Alliance;
- BMBC Cabinet Members;
- Spokesperson for Achieving Potential;
- Spokesperson for Safeguarding;
- Barnsley Safeguarding Children Board Independent Chairperson;
- Voluntary Action Barnsley;
- Barnsley Hospital NHS Foundation Trust;
- Head of Midwifery;
- Barnsley Association of Head-teachers of Primary, Special and Nursery Schools;
- The Association for Secondary Head-teachers working in Barnsley Local Authority;
- Barnsley Clinical Commissioning Group – Chief Nurse;
- Barnsley College - Vice Principal Teaching, Learning and Student Support;
- South Yorkshire Police – Chief Superintendent;
- South West Yorkshire Partnership Foundation Trust (SWYPFT) - Deputy Director of Operations;
- South Yorkshire Community Rehabilitation Company (CRC), Sheffield/ Barnsley Cluster - Assistant Chief Executive;
- Barnsley Local Medical Committee – GP;
- School Governors;
- Youth Council;
- Job Centre Plus (to be invited as and when required).

BMBC

- Head of Commissioning, Governance and Partnerships;
- Strategic Lead, Procurement and Partnerships;
- Performance Improvement Officer;
- Governance, Partnerships and Projects Officer.

The seniority of the members of the TEG (which reports directly to the Health and Wellbeing Board) reflects the influence that each is able to bring to their organisations. Each member is committed to delivering the transformation plan and this commitment is pivotal in ensuring that the required culture change is effected, this being essential for the transformation plan to succeed.

Reporting to TEG is the Children's Executive Commissioning Group (ECG). Both the TEG and ECG are chaired by Rachel Dickinson, Executive Director for the People Directorate at Barnsley Metropolitan Borough Council, who is also a member of Barnsley's Health and Wellbeing Board.

The Children's Executive Commissioning Group membership includes the following:-

- BMBC Executive Director People (Chair);
- BCCG Chief Nurse;
- BMBC / BCCG Children's Services Commissioners;
- Public Health;
- BMBC Service Director Education, Early Start and Prevention;
- BMBC Service Director Children's Social Care and Safeguarding;
- NHS England.

The Future in Mind Stakeholder Engagement Group is led by the CCG's Chief Nurse and reports directly into the Children's Executive Commissioning Group, in recognition of the fluidity of the group and the access required to key stakeholders to enable partners to drive forward the implementation of the transformation plan.

Barnsley CCG is the nominated lead commissioner for the Future in Mind project and therefore co-ordinates and chairs the Future in Mind Stakeholder Engagement meetings and updates ECG on a monthly basis. These clear and robust governance arrangements are effectively ensuring delivery of the priorities within the transformation plan (Appendix 10: Governance flowchart)

8. NEXT STEPS

We are in the second year of a five year transformation plan to improve the emotional health and wellbeing of children and young people in Barnsley. Barnsley's transformation plan focuses on providing lower level emotional health and wellbeing support to children and young people and to date, has focused on the development of '4:Thought' for secondary school students and implementation of the THRIVE Resilience programme for primary schools. It has been acknowledged however that more could be done to improve links with Barnsley's Early Help Offer, particularly in relation to the services provided by the Family Centres.

The Early Start and Families service aims to ensure high quality delivery of integrated services and strategies which impact on the outcomes and life chances of children, young people and families pre-birth to 25 years including the implementation of key statutory duties.

Family Centres bring together practitioners from a range of universal, targeted and specialist services in each local area including schools, police, social care, private and voluntary sector and some adult services.
Services delivered will vary in each area depending on the needs of families and the wider community.

Early help services are co-ordinated and delivered through Family Centres and:-

- Support children to be ready for school and thrive in school
- Support parents and carers to develop their parenting skills
- Support parents and carers to develop personal skills, access training and education and enhance their ability to access employment
- Support parents and carers to keep children safe
- Help children to achieve their full potential and reduce inequalities in their health and development
- Support the development of healthy lifestyles for children
- Support families to build their own resilience

Partners within the Future in Mind Stakeholder Engagement Group will collaborate closely to ensure that services offered are as effective as possible and accessible by everyone who needs them. For example, both Family Centres and CAMHS offer parenting programmes and these services will work together to develop a more robust, effective service.

It has also been acknowledged that implementing the THRIVE approach may not be appropriate for all primary schools in Barnsley. Alternatives, such as developing school counselling services are therefore being considered.

The level of lower level support needed in relation to eating disorders among children and young people is relatively unknown in Barnsley but evidence is building which suggests that there is a growing unmet need. Consideration is therefore being given to the possibility of developing a school eating disorder counselling service aimed at the children and young people themselves to both provide the support needed and to prevent escalation of the eating disorder to such a level that specialist treatment is required.

9. SUMMARY

It is evident within Barnsley that there is still much that can be done to improve the emotional health and wellbeing of the children and young people resident within the Borough. Bringing all of the agencies together to work collaboratively to deliver evidence based services commissioned against outcome specifications is beginning to achieve positive results.

The investment opportunities being made available are welcomed by all of the parties and key stakeholders involved and we are determined to ensure that a real difference is made to the lives of the children and young people in Barnsley by focusing on those elements that will have greatest impact.

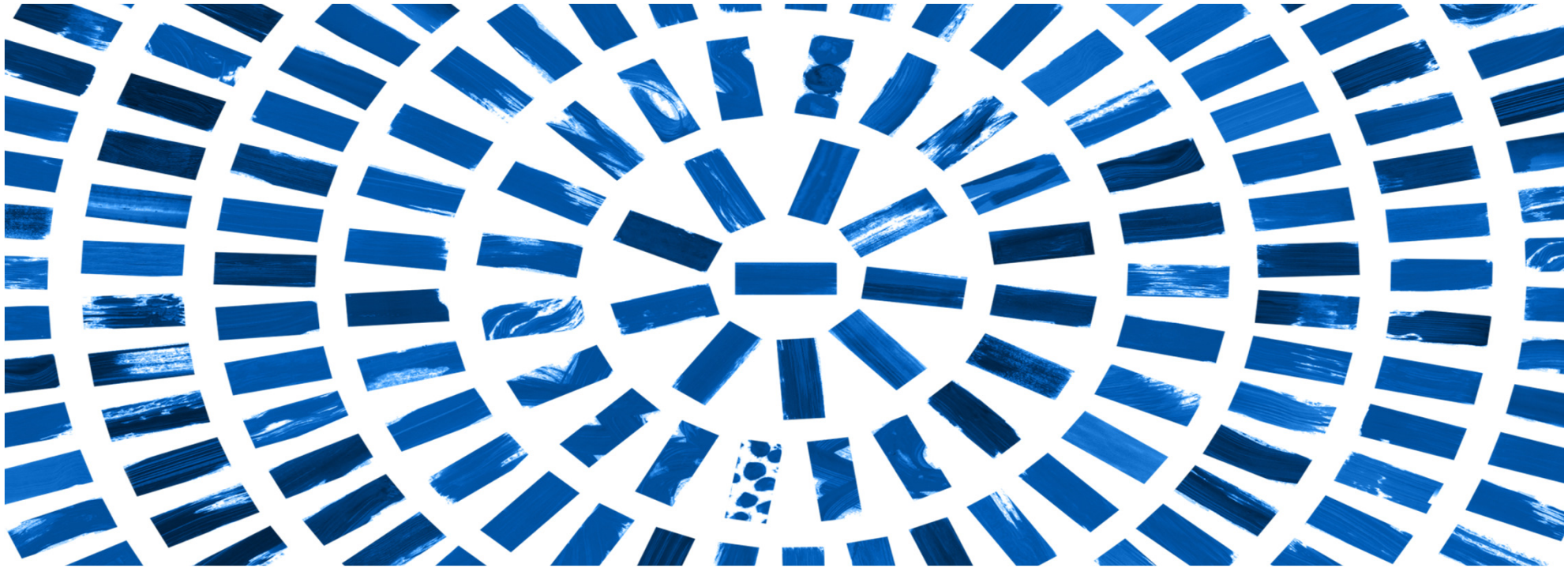
The focus of the investment in Barnsley will continue to be based on early intervention and prevention models, improving the resilience of the children and young people to prevent the need for access to intensive support, such as CAMHS, and providing support to those children and young people on the CAMHS waiting list to prevent further deterioration within the whole setting approach.

The continued investment in 2016/17 will enable the initial developments to be evaluated and where successful rolled-out across the Borough to ensure equity of access for all Barnsley's children and young people.

South West Yorkshire Partnership NHS
NHS Foundation Trust

CAMHS Key Performance Indicators

Barnsley



August 2016

With **all of us** in mind.

Contents

Supporting Information

For the following KPI topics, activity and performance are reported based on the CCG of the client:

- Referrals
- Contacts
- Waits
- Did not attend (DNA)
- Caseload

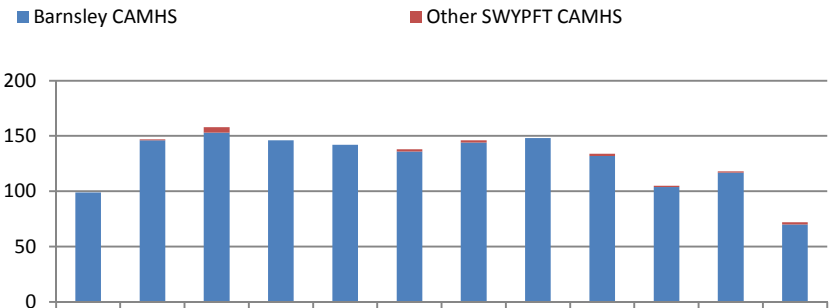
- For example - Total referrals received KPI: contains any Calderdale CCG client no matter which SWYPFT CAMHS service they have accessed.

- The CCG of a client is determined by the GP practice the client is registered with.

- Since the upgrade to the RiO clinical system in November 2015, there has been intermittant problems accessing the system that have hampered real time data capture and created problems with extracting data for reporting purposes across the organisation, particularly during January. Data for November to March should be used with caution.

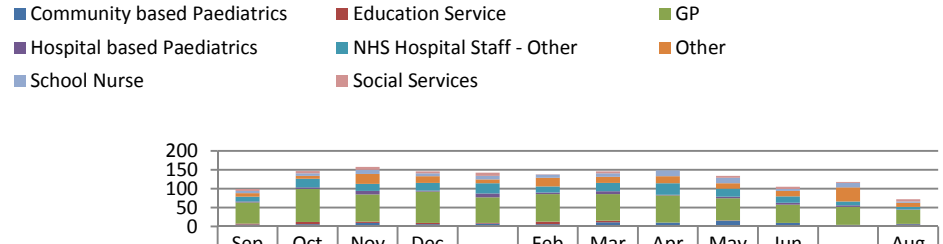
Referrals Received

Total Referrals Received



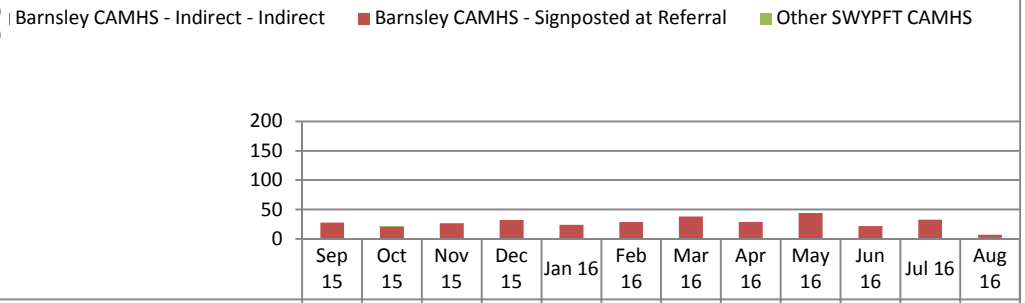
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Other SWYPFT CAMHS		1	5			2	2		2	1	1	2
Barnsley CAMHS	99	146	153	146	142	136	144	148	132	104	117	70

Referrals Received by Source



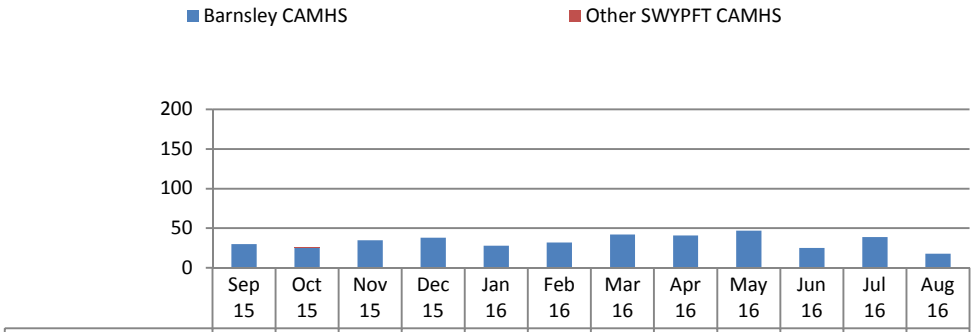
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Social Services	5	6	8	5	8	1	5		5	6	3	6
School Nurse	6	7	11	8	9	8	10	15	15	5	12	3
Other	9	8	26	18	11	23	16	19	14	14	37	11
NHS Hospital Staff - Other	13	23	19	20	27	16	22	30	21	17	10	7
Hospital based Paediatrics	2	4	9	3	10	4	7	2	4	5	4	1
GP	56	87	72	83	68	73	71	72	59	49	48	37
Education Service	3	6	4	3	1	7	4		1			1
Community based Paediatrics	5	6	9	6	8	6	11	10	15	9	4	6

Signposted Referrals



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Other SWYPFT CAMHS		1										
Barnsley CAMHS - Signposted at Referral	28	21	27	32	24	29	38	29	44	22	33	5
Barnsley CAMHS - Indirect - Indirect												2

Inappropriate Referrals



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Other SWYPFT CAMHS		1										
Barnsley CAMHS	30	25	35	38	28	32	42	41	47	25	39	18

Referrals Received Cont.

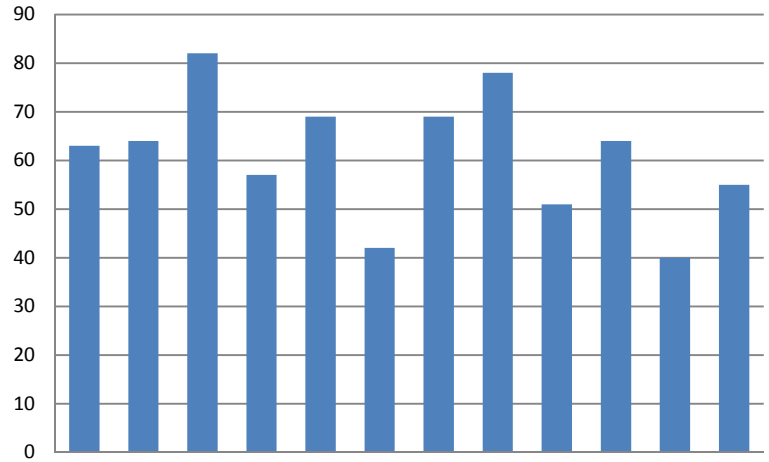
Description: Description:
Referrals received includes all referral sources, urgencies and inappropriate referrals.
Total inappropriate referrals includes all referrals marked as "inappropriate","inappropriate advice/liaison given" or "inappropriate (signposted)" upon discharge. This could be done as soon as the referral comes in to the service or may happen after the initial or choice appointment. It does not include any clients where they have been signposted to another organisation/agency after treatment with the service.
Signposted referrals are a subset of the total inappropriate referrals.

Comments: Signposted/Inappropriate referrals include referrals from previous months dependent upon time seen i.e. rejected from Choice/Initial Assessment, etc Also Inappropriate total included those signposted.

Signposted Referrals for Aug 16 - 5 were all signposted at point of referral, they have not had a face to face contact.

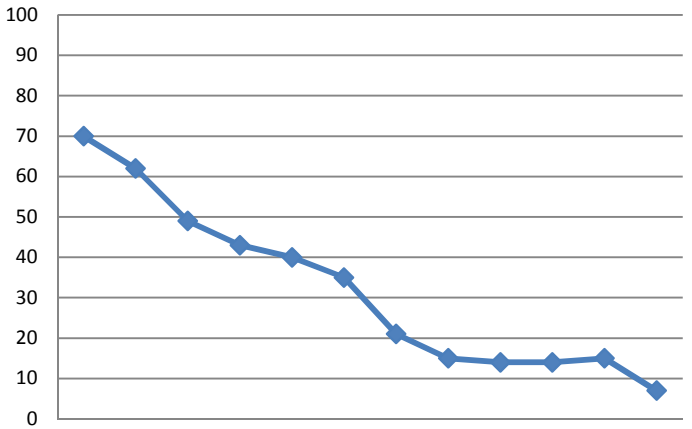
Assessment (Choice)

Total Choice Contacts



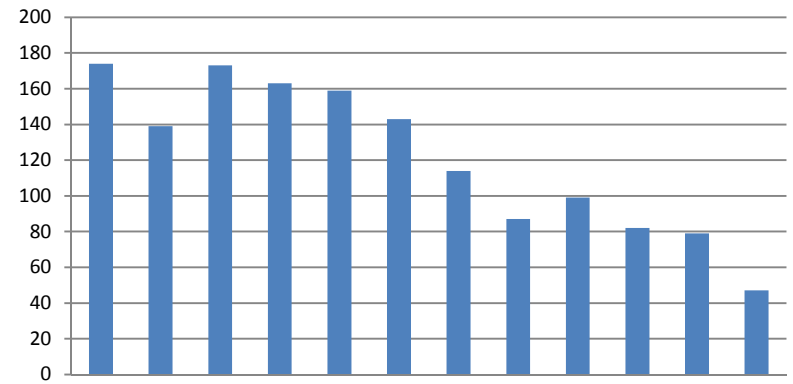
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley CAMHS	63	64	82	57	69	42	69	78	51	64	40	55

Average Wait to Next Available Clinic Slot



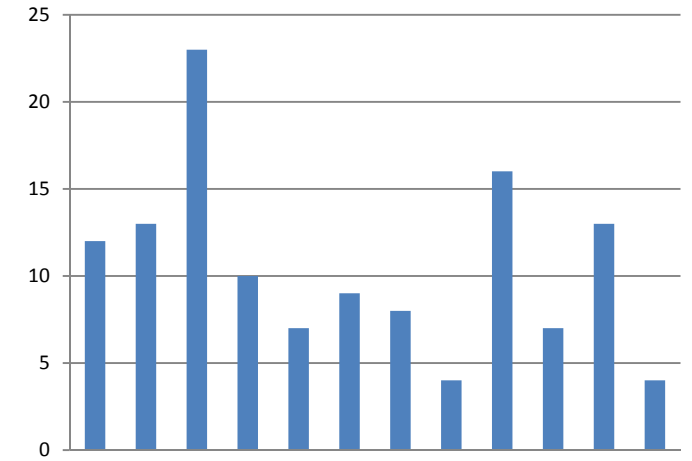
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley CAMHS	70	62	49	43	40	35	21	15	14	14	15	7

Total Referrals Waiting for Choice Contact



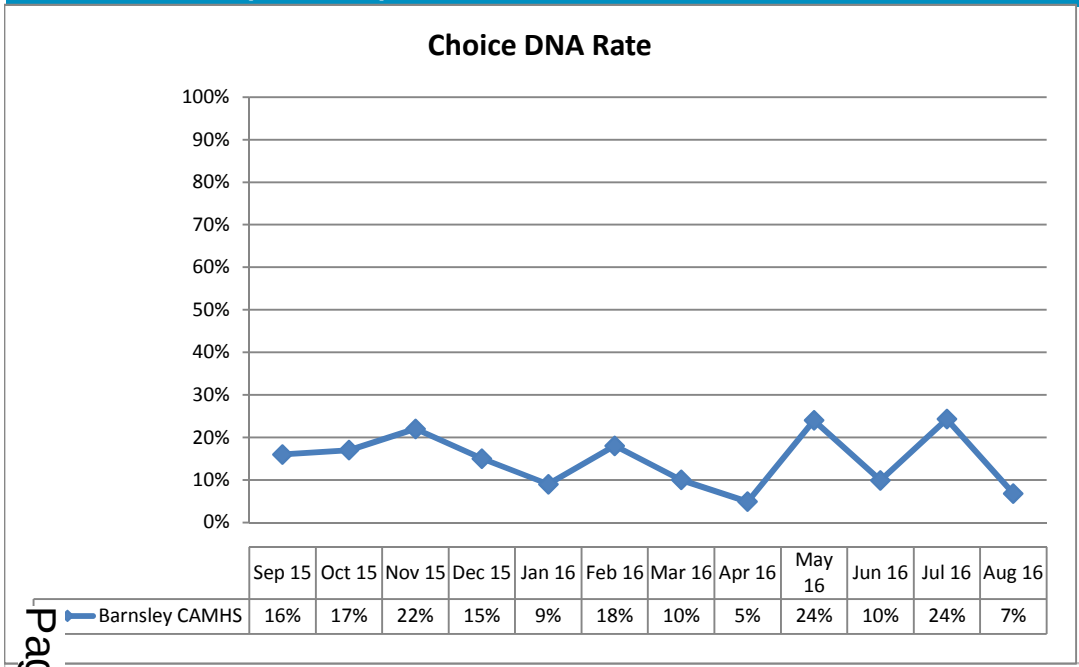
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley CAMHS	174	139	173	163	159	143	114	87	99	82	79	47

Choice DNA



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley CAMHS	12	13	23	10	7	9	8	4	16	7	13	4

Assessment (Choice) Cont.



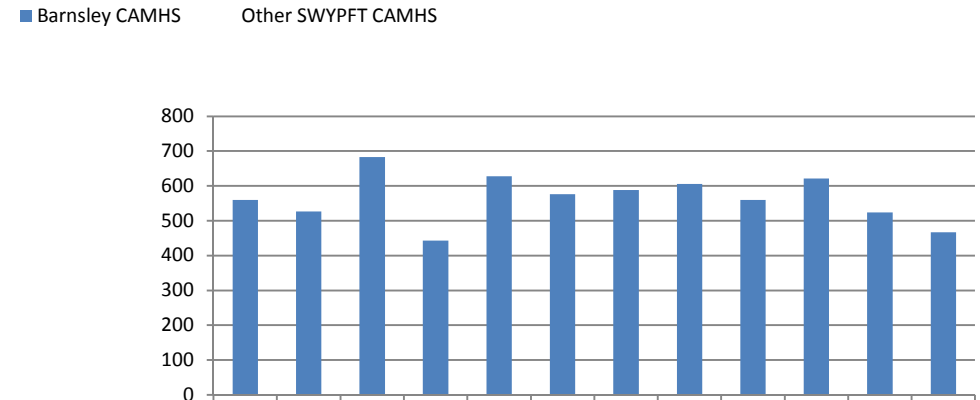
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley CAMHS	16%	17%	22%	15%	9%	18%	10%	5%	24%	10%	24%	7%

cription:
Total number of assessment (Choice) contacts reflects all choice contacts where the client attended that have an outcome attached to them.
e average wait is given in days. Please note that whilst appointments may be available, clients may choose an appointment that suits them better outside of 4 weeks.
The total referrals waiting for assessment (Choice) is a snapshot at month end; these clients could have a Choice appointment booked but not yet attended.

Comments:
The next available appointments as at 14/09/2016:
1. New Street - 22/09/16
2. Grimesthorpe 20/09/16
3. Hoyland 21/09/16

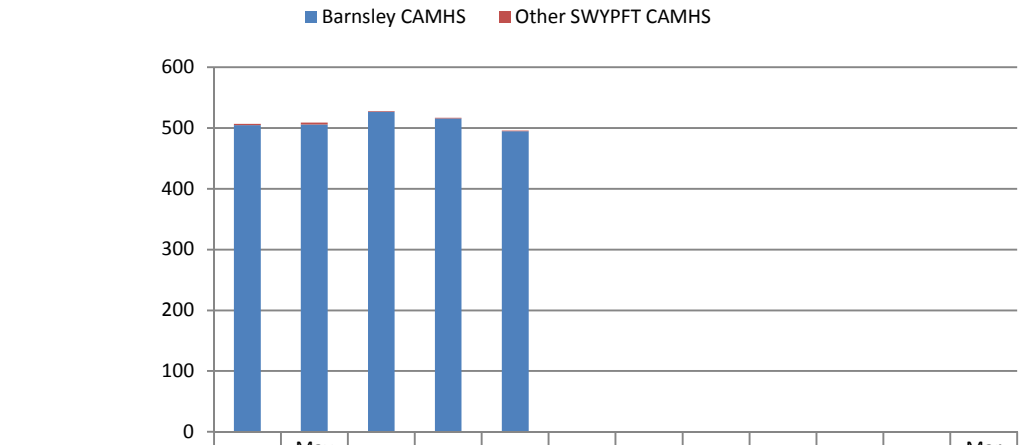
Treatment (Partnership) Contacts

Total Partnership Contacts



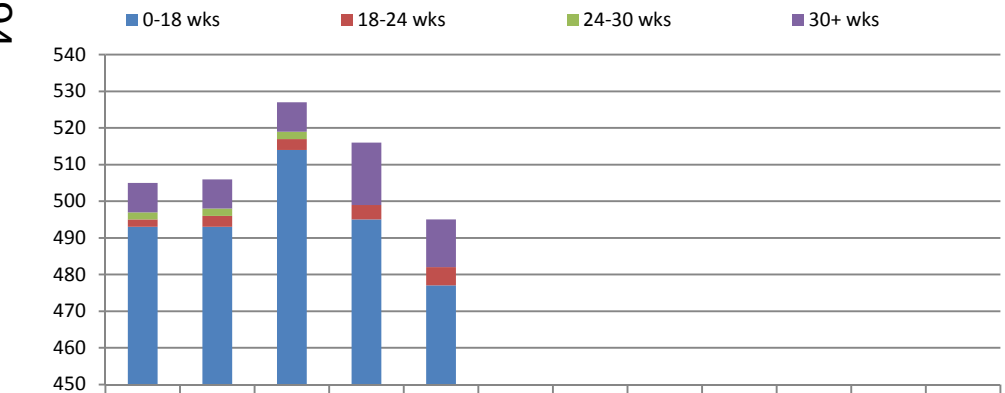
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Other SWYPFT CAMHS	3	7	4	5	4	5	3	10	7	3	1	
Barnsley CAMHS	560	527	683	443	628	576	588	606	560	621	524	467

Total Waiting



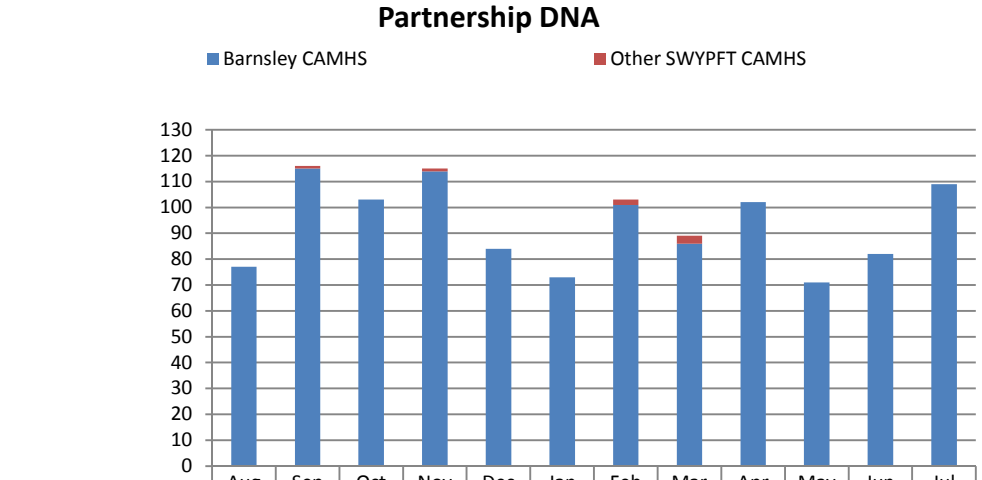
	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Other SWYPFT CAMHS	2	3	1	1	1							
Barnsley CAMHS	505	506	527	516	495							

Partnership Current Waits - Barnsley CAMHS

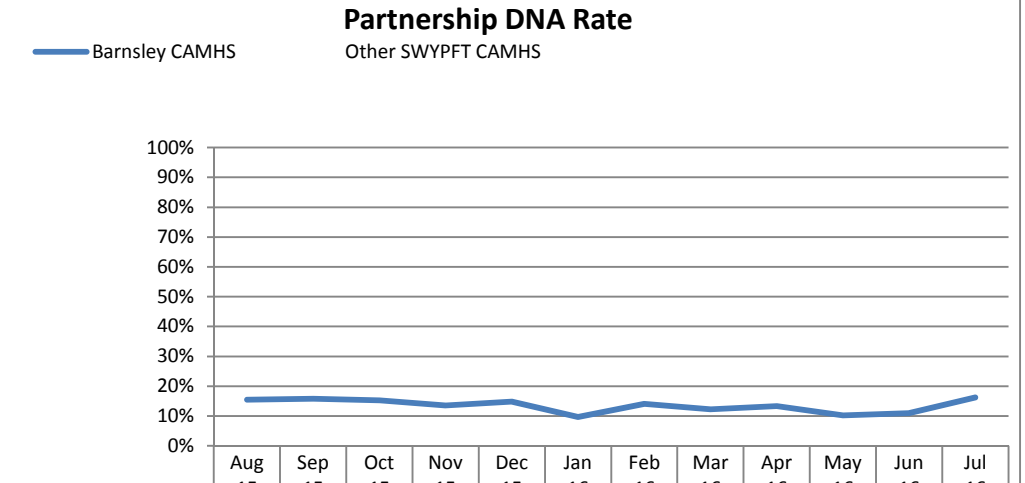


	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
30+ wks	8	8	8	17	13							
24-30 wks	2	2	2									
18-24 wks	2	3	3	4	5							
0-18 wks	493	493	514	495	477							

Treatment (Partnership) Contacts



	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16
Other SWYPFT CAMHS	0	1	0	1	0	0	2	3	0	0	0	0
Barnsley CAMHS	77	115	103	114	84	73	101	86	102	71	82	109



	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16
Barnsley CAMHS	15%	16%	15%	14%	15%	10%	14%	12%	13%	10%	11%	16%
Other SWYPFT CAMHS	0%	25%	0%	20%	0%	0%	29%	38%	0%	0%	0%	0%

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scription:
: total treatment (Partnership) contacts includes all outcomed treatment contacts.
: total waiting for treatment (Partnership) and current waits by time band are a snapshot at month end.
The average length of wait to treatment (Partnership) is a year to date position in days based on clients who have had their first treatment contact (referral receipt date to date of 1st treatment contact).
DNA = Client did not attend.

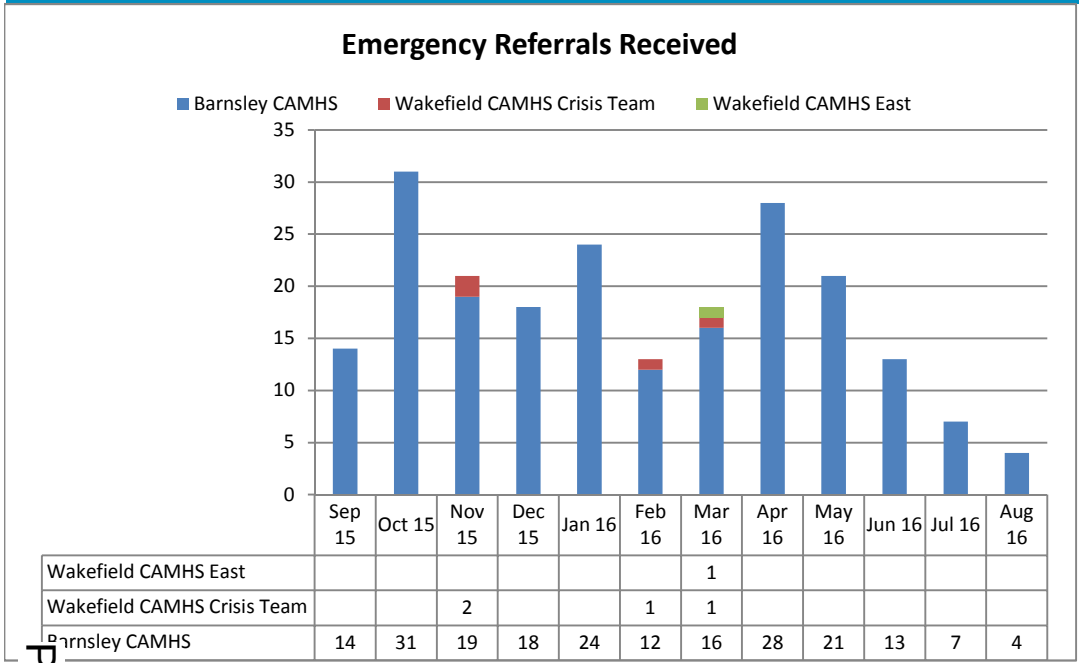
Comments: The pathway and MDT process are currently being implemented across the service. From the 1st June the pathway MDT will begin reviewing/prioritising and allocating the waiting lists with a view that all processes to be fully implemented by the end September 2016.

Other SWYPFT CAMHS data relates to clients previously with an address, and/or GP, from other SWYPFT CAMHS area's

There are no ASD for the Partnership information. The total waiting includes ADHD clients of which it is estimated to be a minimum of 150 clients from the Complex behaviour Pathway.

The Service is undertaking a data quality activity regarding a number of appointments that have not yet had an outcome recorded in the system.

Emergency Referrals



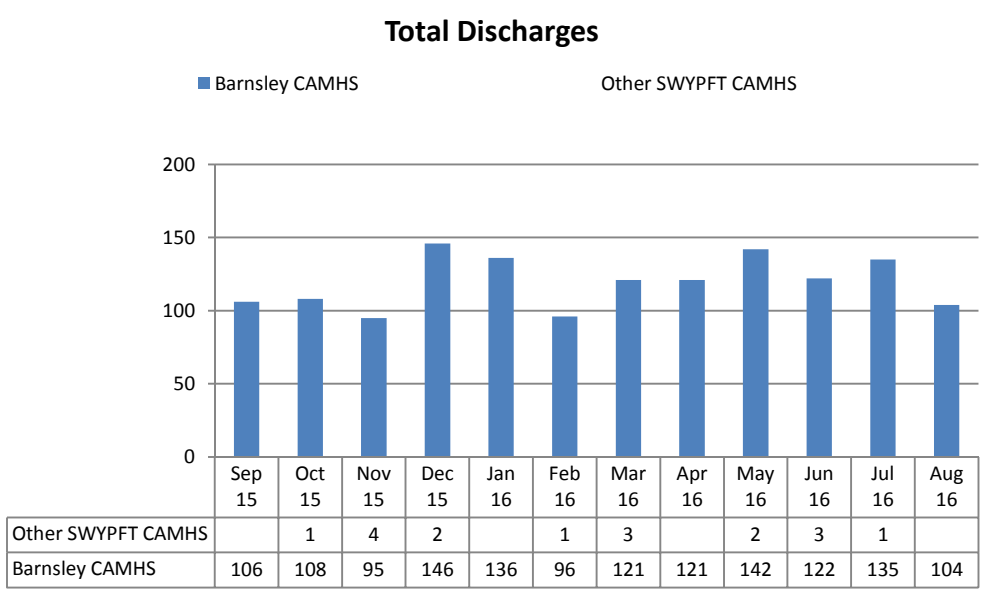
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Wakefield CAMHS East							1					
Wakefield CAMHS Crisis Team			2			1	1					
Barnsley CAMHS	14	31	19	18	24	12	16	28	21	13	7	4

Description:
Emergency Referrals Received counts any referral with an urgency of "Emergency".

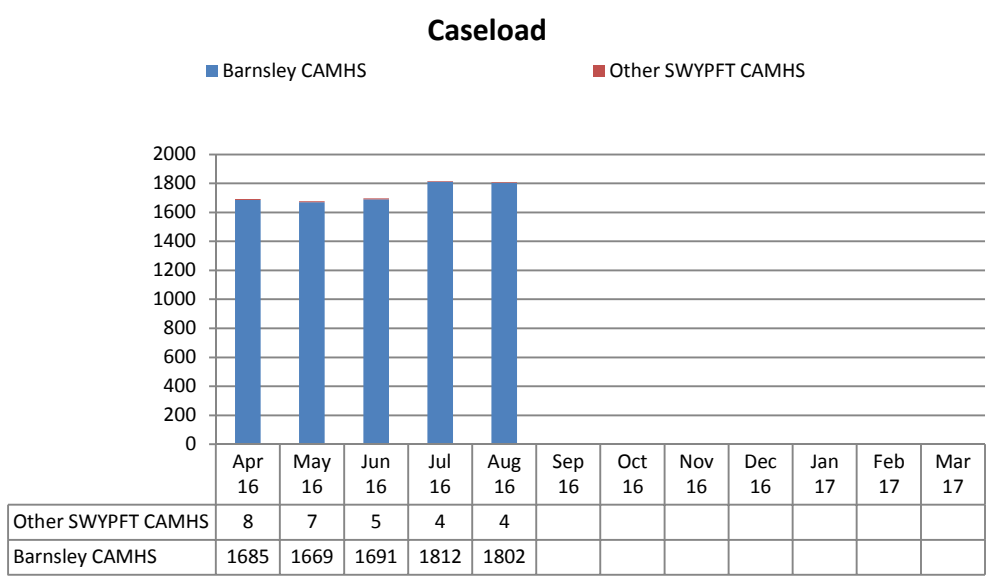
Comments: Other SWYPFT CAMHS data relates to clients previously with an address, and/or GP, from other SWYPFT CAMHS area's.

In August there were an additional 7 that are believe to be Face to face contacts and total Duty = 13 inc telephone contact.
There is a delay in the duty (emergency daytime) contacts/referrals being inputted on to RiO.

Other Information



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Other SWYPFT CAMHS		1	4	2		1	3		2	3	1	
Barnsley CAMHS	106	108	95	146	136	96	121	121	142	122	135	104



	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Other SWYPFT CAMHS	8	7	5	4	4							
Barnsley CAMHS	1685	1669	1691	1812	1802							

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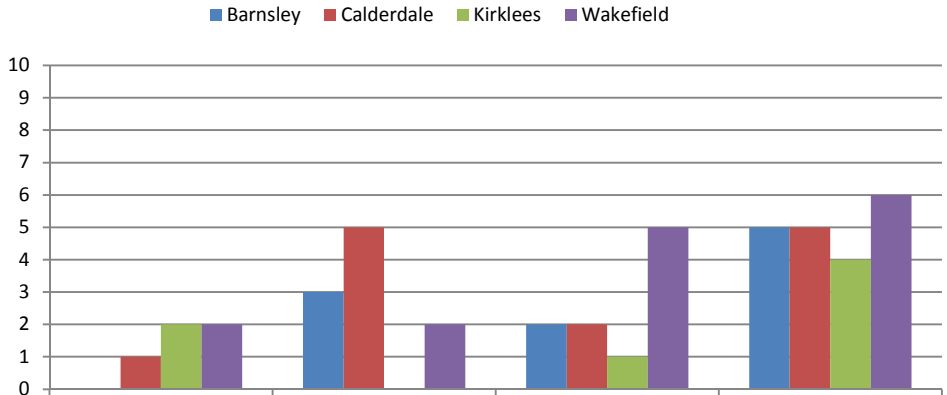
cription: Total Discharges and Total caseload.

nments: Other SWYPFT CAMHS data relates to clients previously with an address, and/or GP, from other SWYPFT CAMHS area's

The total caseload includes those children waiting for an ASD assessment who were accepted when the pathway was hosted by Barnsley CAMHS. As at the end of June this totalled 96 cases of which 48 have been waiting over 12 months. The service has 43 assessments in progress or with appointments booked to start assessment in July. The service continues to offer the Cygnet carer support programme and due to demand plan to offer 2 groups in the Autumn to meet demand.

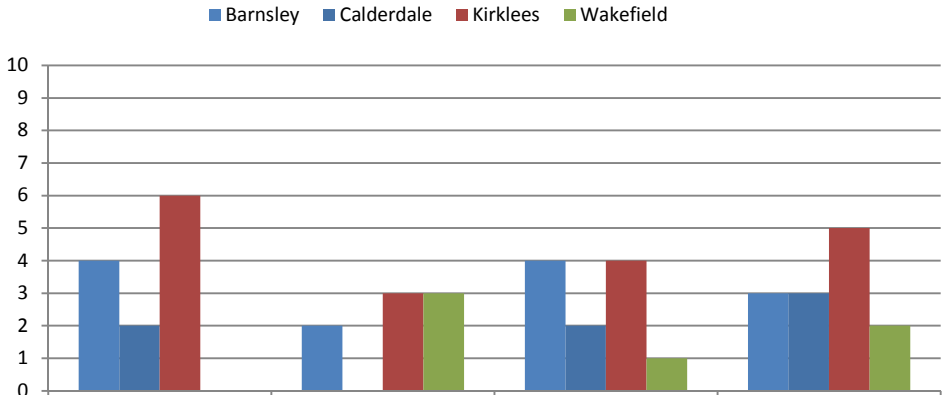
Patient Experience

Total Compliments



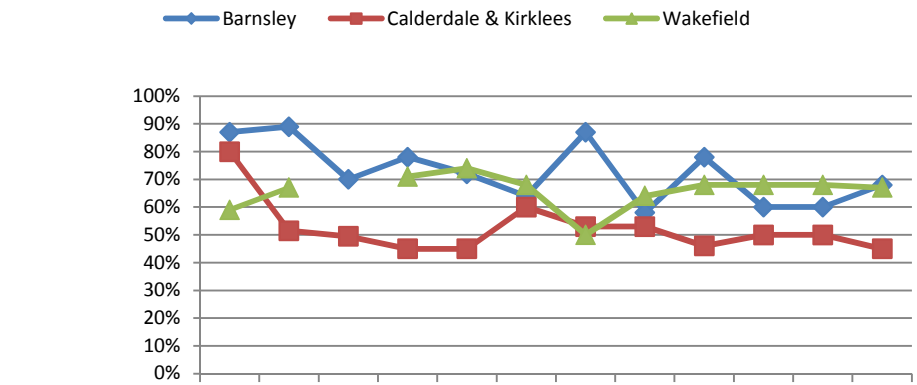
	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	0	3	2	5
Calderdale	1	5	2	5
Kirklees	2	0	1	4
Wakefield	2	2	5	6

Total Complaints



	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	4	2	4	3
Calderdale	2	0	2	3
Kirklees	6	3	4	5
Wakefield	0	3	1	2

% People Extremely Likely or Likely to Recommend Place of Care



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	87%	89%	70%	78%	72%	64%	87%	58%	78%	60%	60%	68%
Calderdale & Kirklees	80%	52%	50%	45%	45%	60%	53%	53%	46%	50%	50%	45%
Wakefield	59%	67%		71%	74%	68%	50%	64%	68%	68%	68%	67%

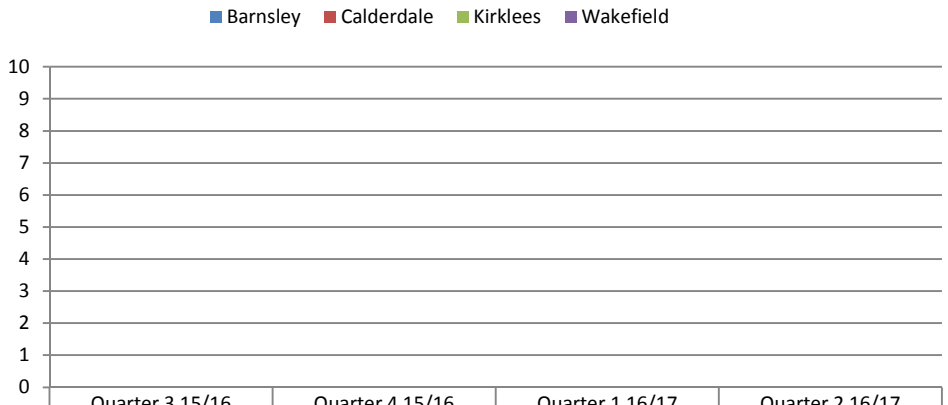
Patient Experience cont.

Description:
The number of Information Governance breaches as reported on SWYPFT's DATIX system.
The total number of compliments per quarter that are logged with SWYPFT customer services team. There is no goal for this indicator. Data is representative of quarter to date.
The total number of complaints per quarter that are logged with SWYPFT customer services team. There is no goal for this indicator.
Data is representative of quarter to date.
The percentage of people who are 'Extremely likely ' or 'Likely' to recommend our services to their family and friends as a place to receive care and treatment (National FFT question).

Comments:

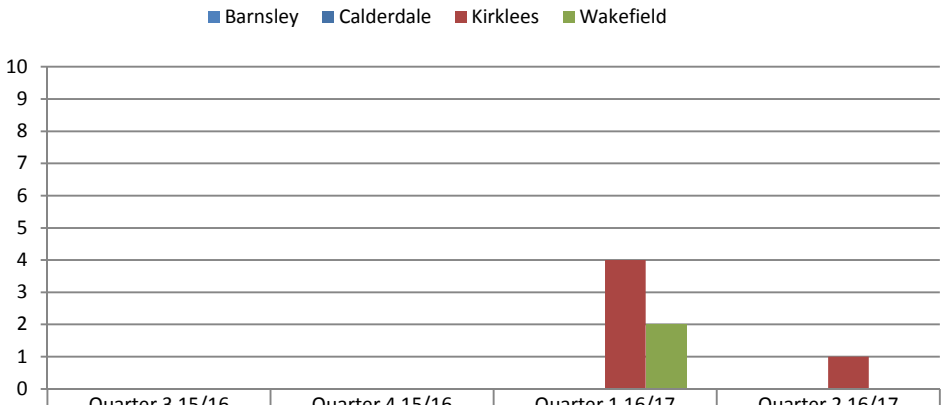
Patient Safety

Admissions of Under 16s to Adult Wards



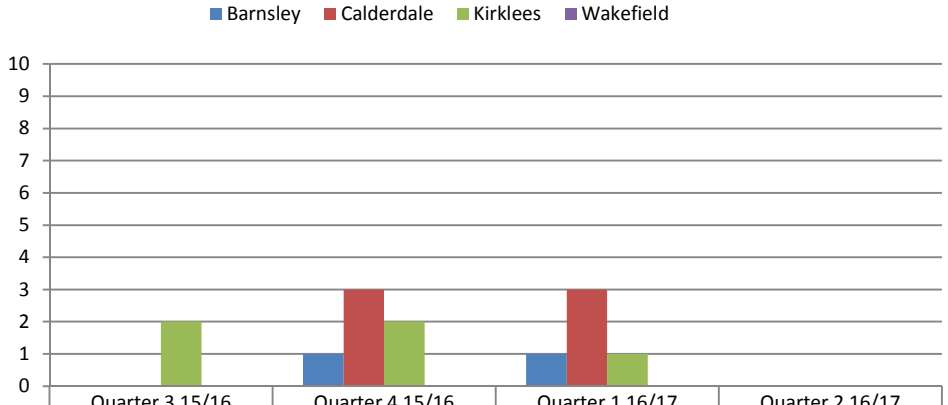
	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	0	0	0	0
Calderdale	0	0	0	0
Kirklees	0	0	0	0
Wakefield	0	0	0	0

Admissions of 16 & 17 Year Olds to Adult Wards



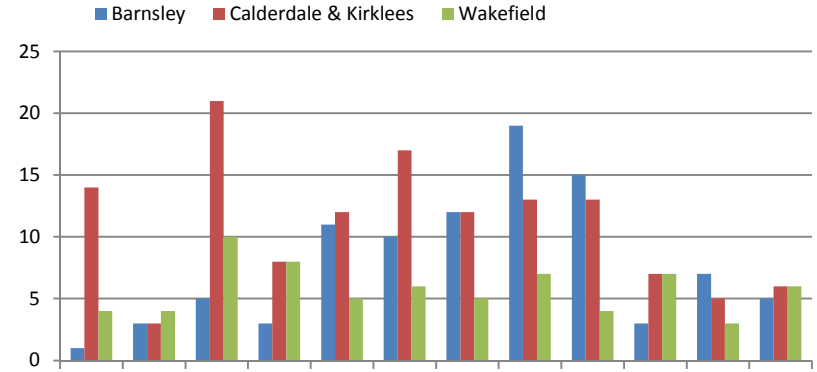
	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	0	0	0	0
Calderdale	0	0	0	0
Kirklees	0	0	4	1
Wakefield	0	0	2	0

Serious Incidents



	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	0	1	1	0
Calderdale	0	3	3	0
Kirklees	2	2	1	0
Wakefield	0	0	0	0

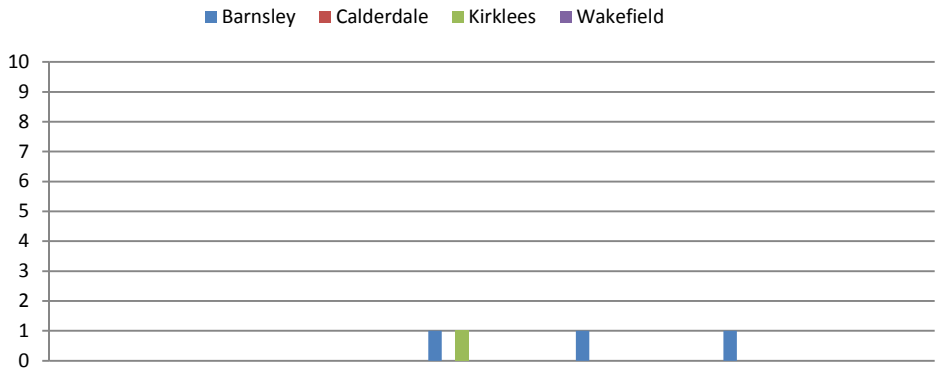
Incidents - All Grades & Severity



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	1	3	5	3	11	10	12	19	15	3	7	5
Calderdale & Kirklees	14	3	21	8	12	17	12	13	13	7	5	6
Wakefield	4	4	10	8	5	6	5	7	4	7	3	6

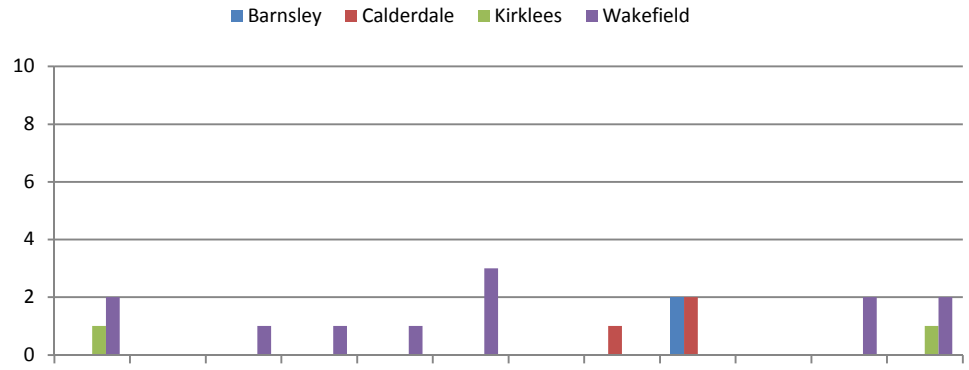
Patient Safety Cont.

Duty of Candour Incidents



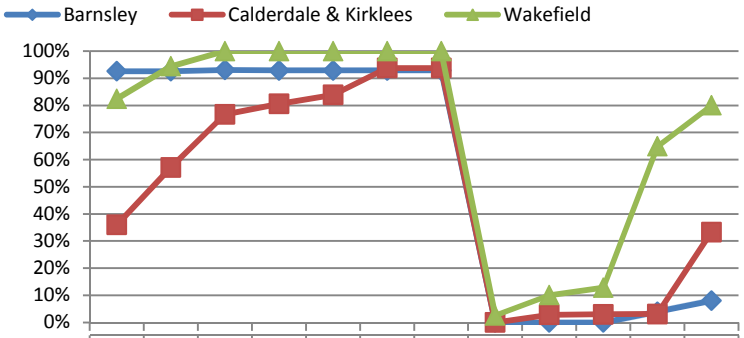
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	0	0	0	0	0	1	0	1	0	1	0	0
Calderdale	0	0	0	0	0	0	0	0	0	0	0	0
Kirklees	0	0	0	0	0	1	0	0	0	0	0	0
Wakefield	0	0	0	0	0	0	0	0	0	0	0	0

Assessments Under Section 136 (MHA, 1983)



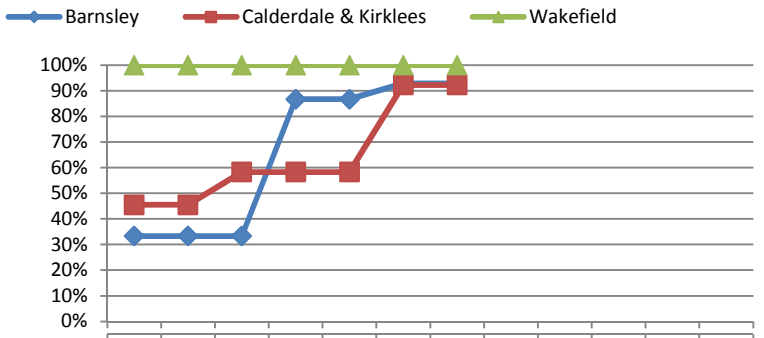
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	0	0	0	0	0	0	0	0	2	0	0	0
Calderdale	0	0	0	0	0	0	0	1	2	0	0	0
Kirklees	1	0	0	0	0	0	0	0	0	0	0	1
Wakefield	2	0	1	1	1	3	0	0	0	0	2	2

Percentage of Staff Having Received an Appraisal - Band 6 & Above



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	93%	93%	93%	93%	93%	93%	93%	0%	0%	0%	4%	8%
Calderdale & Kirklees	36%	57%	77%	81%	84%	94%	94%	0%	3%	3%	3%	33%
Wakefield	82%	94%	100%	100%	100%	100%	100%	3%	10%	13%	65%	80%

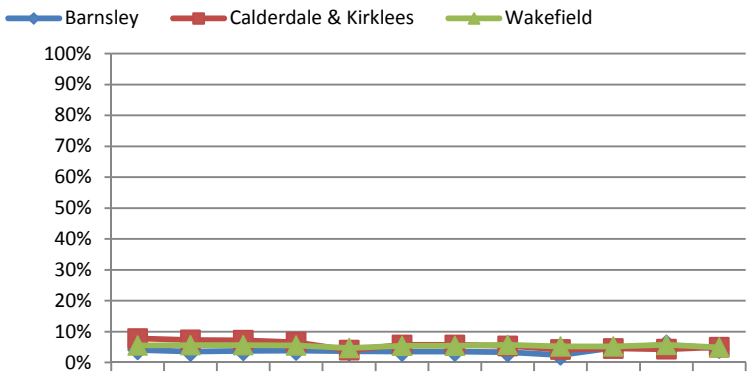
Percentage of Staff Having Received an Appraisal - Band 5 and below



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	33%	33%	33%	87%	87%	93%	93%					
Calderdale & Kirklees	46%	46%	58%	58%	58%	92%	92%					
Wakefield	100%	100%	100%	100%	100%	100%	100%					

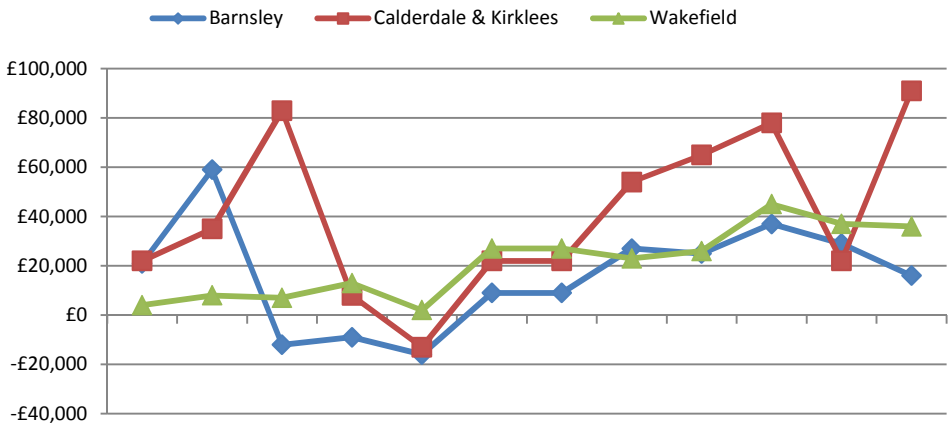
Patient Safety Cont.

Sickness Rate



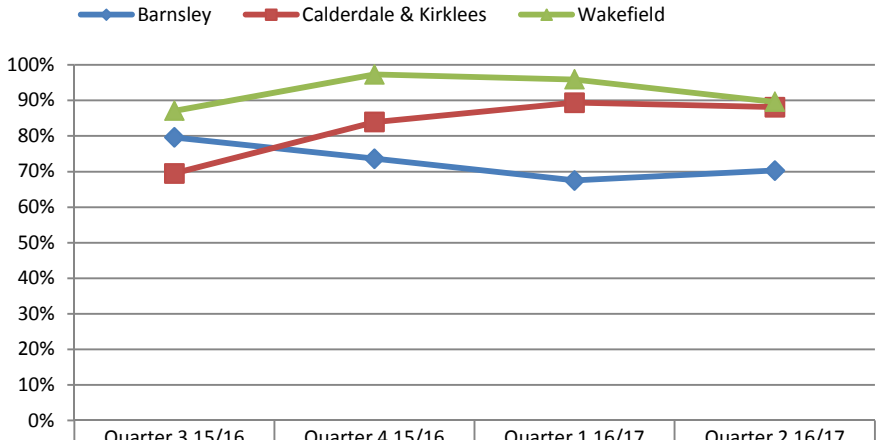
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	4%	4%	4%	4%	4%	4%	4%	3%	2%	5%	6%	5%
Calderdale & Kirklees	8%	7%	7%	7%	4%	6%	6%	5%	4%	5%	4%	5%
Wakefield	6%	6%	6%	6%	5%	5%	5%	6%	5%	5%	6%	5%

Agency Staff Usage



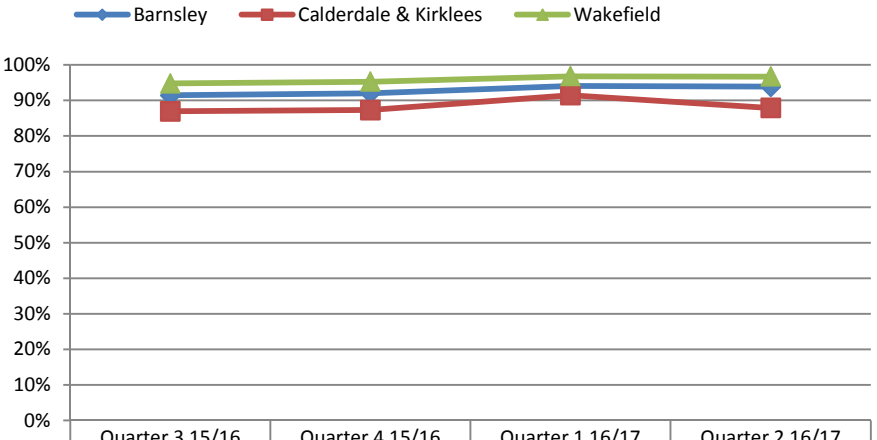
	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	£21,000	£59,000	-£12,000	-£9,000	-£16,000	£9,000	£9,000	£27,000	£25,000	£37,000	£29,000	£16,000
Calderdale & Kirklees	£22,000	£35,000	£83,000	£8,000	-£13,000	£22,000	£22,000	£54,000	£65,000	£78,000	£22,000	£91,000
Wakefield	£4,000	£8,000	£7,000	£13,000	£2,000	£27,000	£27,000	£23,000	£26,000	£45,000	£37,000	£36,000

Mandatory Training - Aggression Management



	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	80%	74%	68%	70%
Calderdale & Kirklees	70%	84%	89%	88%
Wakefield	87%	97%	96%	90%

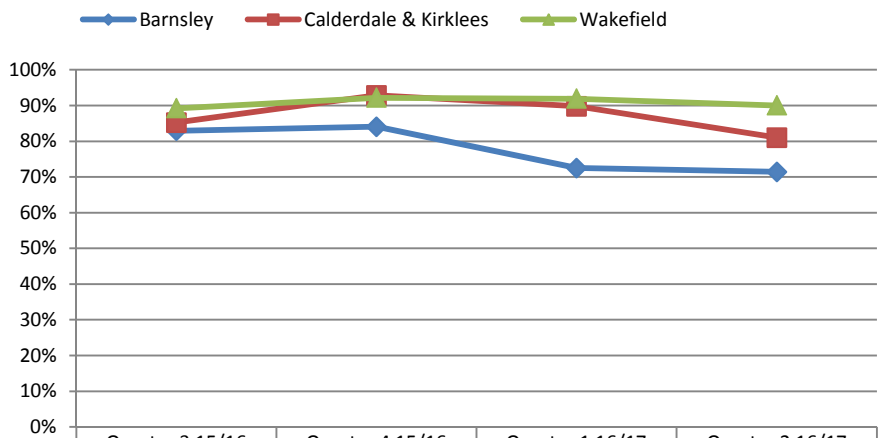
Mandatory Training - Equality & Diversity



	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	91%	92%	94%	94%
Calderdale & Kirklees	87%	87%	92%	88%
Wakefield	95%	95%	97%	97%

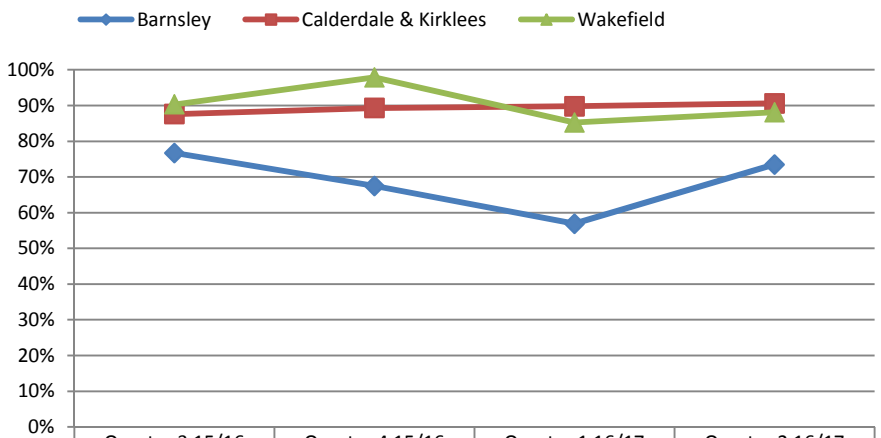
Patient Safety Cont.

Mandatory Training - Fire Safety



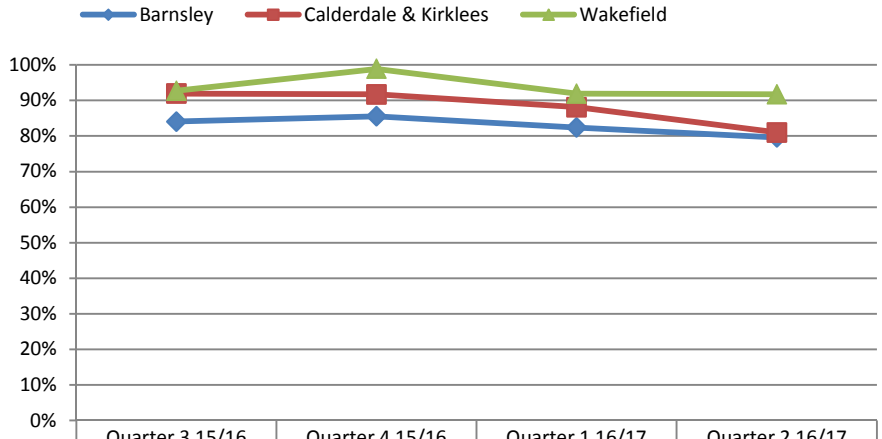
	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	83%	84%	73%	71%
Calderdale & Kirklees	85%	93%	90%	81%
Wakefield	89%	92%	92%	90%

Mandatory Training - Infection Control & Hand Hygiene



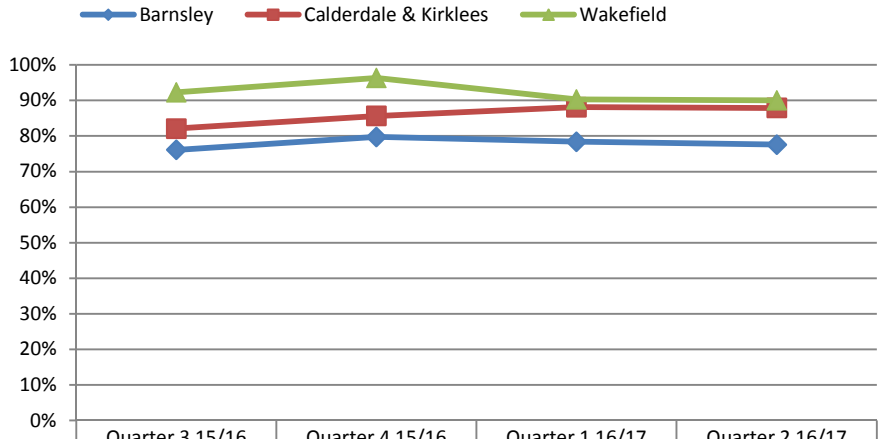
	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	77%	68%	57%	74%
Calderdale & Kirklees	88%	89%	90%	91%
Wakefield	90%	98%	85%	88%

Mandatory Training - Information Governance



	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	84%	86%	82%	80%
Calderdale & Kirklees	92%	92%	88%	81%
Wakefield	93%	99%	92%	92%

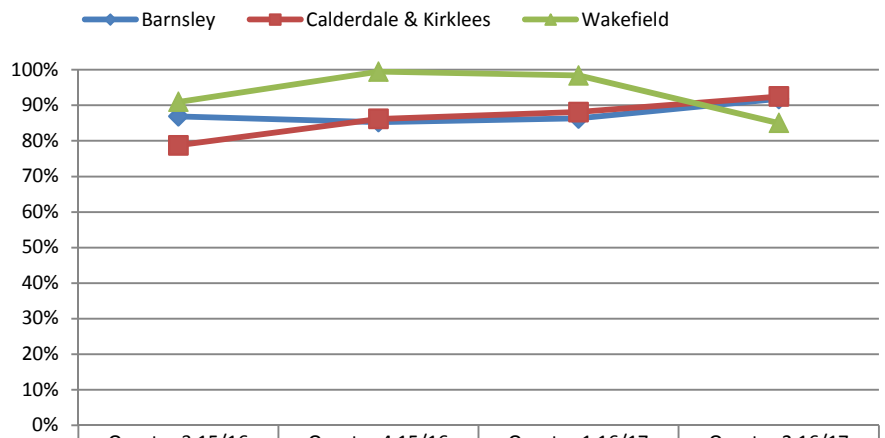
Mandatory Training - Moving & Handling



	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	76%	80%	78%	78%
Calderdale & Kirklees	82%	86%	88%	88%
Wakefield	92%	96%	90%	90%

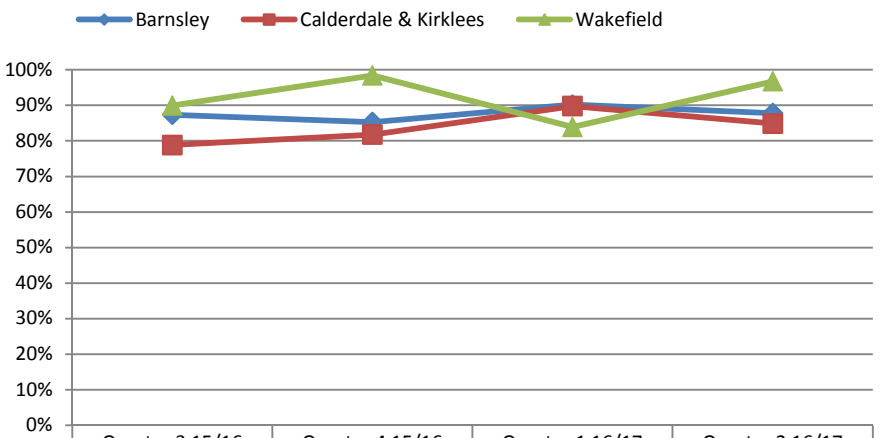
Patient Safety Cont.

Mandatory Training - Safeguarding Adults



	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	87%	85%	86%	92%
Calderdale & Kirklees	79%	86%	88%	93%
Wakefield	91%	99%	98%	85%

Mandatory Training - Safeguarding Children



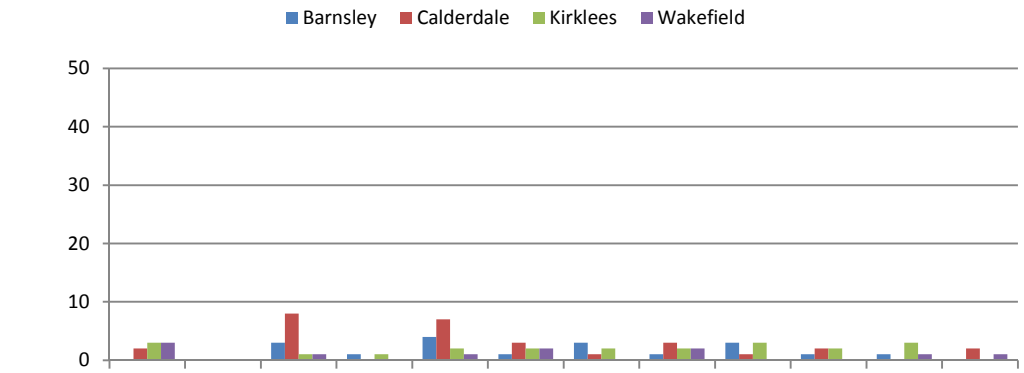
	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Barnsley	87%	85%	90%	88%
Calderdale & Kirklees	79%	82%	90%	85%
Wakefield	90%	98%	84%	97%

Description: The number of admissions of children, under the age of 16, into SWYPFT's adult wards. Data is representative of quarter to date.
The number of admissions of children, aged 16 or 17, into SWYPFT's adult wards. Data is representative of quarter to date.
The number of serious incidents graded amber or red as reported on SWYPFT's DATIX system- this is not exclusively STEIS reportable incidents. Data is representative of quarter to date.
The total number of incidents reported on DATIX, by grade.
Duty of candour - incidents where we recognise that our care or treatment may have an impact on a person in terms of harm. Data is representative of quarter to date.
The number of assessments (for age 17 and under) that have taken place under section 136 of the Mental Health Act. Data is representative of quarter to date.
The number of staff , band 6 and above who have received an appraisal . Goal is 90% by end of Q1. Data is re-set at end of March.
The number of staff , band 5 and below who have received an appraisal. Goal is 90% by Q2. Data is re-set at end of March.
The percentage of staff who are absent from work as a result of illness. The figures above represent a year to date percentage. Goal is 4%
Agency expenditure by service line.
Aside from Information Governance (95%), all mandatory training targets are based on achieving 80% at year end.

Comments: Percentage of staff having received an appraisal for Band 5 and below - the data will not be available until after September 16.

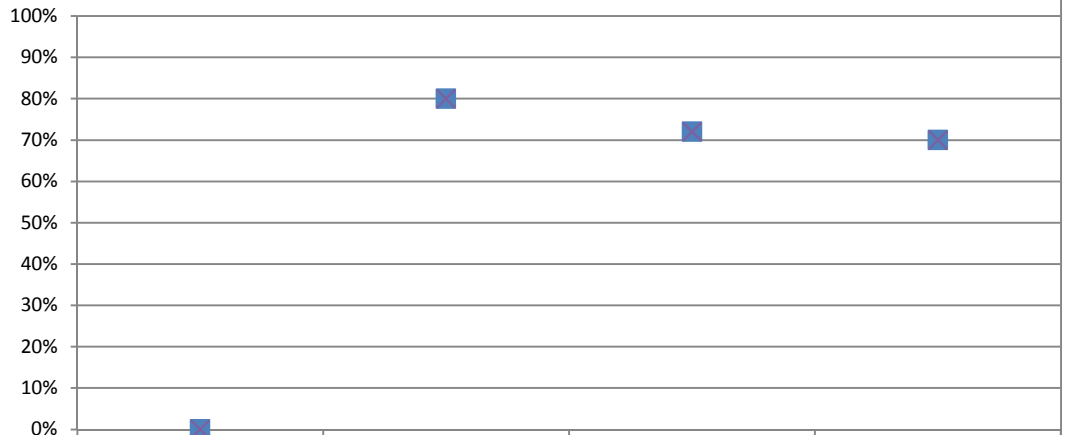
Clinical Effectiveness

Information Governance Breaches



	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Barnsley	0	0	3	1	4	1	3	1	3	1	1	0
Calderdale	2	0	8	0	7	3	1	3	1	2	0	2
Kirklees	3	0	1	1	2	2	2	2	3	2	3	0
Wakefield	3	0	1	0	1	2	0	2	0	0	1	1

% of Staff Recommending SWYPFT as a Place for Care



	Quarter 3 15/16	Quarter 4 15/16	Quarter 1 16/17	Quarter 2 16/17
Total	0%	80%	72%	70%

Description:
The number of Information Governance breaches as reported on SWYPFT's DATIX system.
The percentage of staff who would recommend our services as a place for care and treatment. Data was sourced from the Staff Friends and Family Test administered through a staff communication and engagement survey.

Comments:

Future in Mind - 5 year Funding Allocation

WORK-STREAM PRIORITY	FiM Investment Year 1 2015/16 £	FiM Investment Year 2 2016/17 £	FiM Investment Year 3 2017/18 £	FiM Investment Year 4 2018/19 £	FiM Investment Year 5 2019/2020 £
1. Developing a Community based Eating Disorder Service (Collaborative arrangement with Calderdale, Wakefield, Greater Huddersfield and Kirkless CCG's)	146,000	143,000			
2. Building resilience in Primary School Children (THRIVE) (Public Health led)	111,000	98,000			
3. School-led mental health therapeutic team (Springwell Academy taking the lead - based on the Stockport model)	145,000	335,500 (Incorproates Peer Mentoring work undertaken by Chilypep plus training provided by TADS /SYEDA)			
4. CAMHS: SPA / YOT (CAMHS is provided by South West Yorkshire Partnership NHS Foundation Trust)	60,000	103,500			
5. Training Young Commissioners (Led by Chilypep)	30,000	20,000			
6. Accessing information ('One-stop- shop') (Led by YOT Manager)	20,000	0			
TOTAL INVESTMENT	**512,000**	**710,000**			

BARNSLEY COLLEGE EMOTIONAL WELLBEING PILOT PROJECT REPORT 2015

This report evaluates the impact of Chilypep's early intervention and prevention pilot programme within Barnsley College, commissioned by Barnsley CCG from 1st November 2014-31st July 2015.

The report also acts as a 'how to' guide for those looking to implement a 'whole school or college approach' to emotional wellbeing, providing useful hints and tips that we have picked up along the way!

CHILYPEP
Children & Young People's Empowerment Project

NHS
Barnsley Clinical Commissioning Group

Barnsley College
Together We Achieve

CONTENTS

Contact Details

If you would like more information about Chilypep and the work we do we would love to hear from you!

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Tel: 0114 234 8846

www.chilypep.org.uk

facebook.com/Chilypep

@Chilypep

EXECUTIVE SUMMARY

From 1st November 2014 to 31st July Chilypep (The Children and Young People's Empowerment Project) worked with Barnsley College to pilot an early intervention and prevention project within Barnsley College.

RATIONALE

School and college is where young people spend a lot of their time and, with 1 in 10 young people in every classroom having a diagnosable mental health problem, schools and colleges have a major role to play around **early intervention and prevention**. We know that mental health runs along a continuum and that we can often prevent young people from reaching crisis if they are able to access support early on. Giving young people the **space and time to explore** their own emotional wellbeing in a safe and supportive environment is therefore vital if we are to create a **culture of wellbeing** within schools and colleges. Then and only then can we make a sea change in attitudes, perceptions and responses around mental health.

METHODOLOGY AND KEY ACHIEVEMENTS

The project aimed to build the resilience of students within college to be able to support themselves and others around their mental health, as well as increasing the confidence of college staff to be able to recognise the signs of mental ill health amongst students and have conversations with them around mental health. By adopting a 'Whole College Approach' to mental health we aimed to normalise conversations and discussions around mental health, giving 'mental health' visibility within college, and destigmatising mental ill health.

What do we mean by the term 'mental health'?

Chilypep has worked with young people over the years to look at definitions of mental health and what this term means to them. Young people have highlighted the importance of viewing mental health across a continuum; mental health is in this sense something that we all have and it can be positive or negative. We might live with a diagnosed mental illness and experience positive mental health. Equally we all have the potential to experience 'mental ill health' even with no diagnosable mental illness, and again this operates on a continuum. Our ability to 'bounce back' from periods of mental ill health can often depend on the coping mechanisms and support we have in place as well as our 'resilience'.

Throughout this report 'mental health' and 'emotional wellbeing' are both used somewhat interchangeably.

Chilypep's 'Whole College Approach' to emotional wellbeing focused on three core areas of work:

1. **Mental Health Awareness:** Building the resilience of young people through the delivery of mental health educational workshops and tutorials across college sites

Chilypep's research with young people has highlighted that they would like to see opportunities created for young people to talk, and learn, about emotional wellbeing and mental health within school and college settings. Over the course of the pilot we Reached 265 students through the delivery of 50 mental health awareness workshops. Following tutorial evaluations young people often quoted changes in their perceptions of mental health, such as *"I've learnt that mental health is something everyone has, it can be good or bad just like our physical health".* This would seem to indicate a change in perception around mental health, and a reduction in stigma following young people's involvement in college tutorials.

2. **Developing Peer Support Models:** Building the resilience of young people to manage their own mental health and support their peers through the development of Barnsley College 'Emotional Wellbeing (EWB) Champions'

Chilypep supports children and young people to develop positive mental health and emotional well-being, and promotes empowerment and participation practice as integral to supporting young people's positive mental health and emotional well-being. Through recruiting and training 10 young people with lived experiences around mental health as 'EWB Champions' young people were able to have a voice and influence in the project design and delivery; this in turn improved their own mental health and increased their resilience and ability to cope when things were affecting them. By the end of the project 100% showed an increase in their sense of wellbeing, quoting that they felt good about themselves more often as the project went on.

"Before I started 'EWB Champions', I didn't feel like I could talk to anyone. Now I find that I have a number of people I can talk to and they can also talk to me."

"This project has helped me to manage my stress and anxiety, allowing me to share my experiences with others to help them."

Chilypep actively promote Peer Mentoring approaches because we have found that:

- Young people tend to engage better with other young people than with older adults
- Our EWB Champions use engaging tools and approaches designed by them to ensure they capture the interest of young people
- The stigma around mental health problems means that this can be a difficult subject to discuss unless you feel shared interests and experiences with the facilitator as you do with a peer-facilitator.
- EWB Champions get access to training and support from Chilypep increasing their confidence, resilience and skill base.

- The college or school becomes a healthier place for students to be, improving the college environment for both staff and young people, whilst supporting the education and attainment of pupils.

3. **Staff training and development:** Building the knowledge, understanding and confidence of staff to enable them to respond to students' mental health and emotional wellbeing needs

The project aimed to create a culture of empathy, non-judgment, and support within the college environment. We did this by building the skills and confidence within staff teams to enable them to speak to young people about their mental health. Chilypep delivered mental health awareness training to 18 front facing college staff, 95% of whom reported an increased understanding around youth mental health following the workshop, and 73% reporting increased confidence in supporting young people around their mental health. We then went on to train 12 college staff members in Youth Mental Health First Aid. Following the training 100% reported increased confidence in supporting young people around their mental health, and similarly 100% reported a significant increase in their knowledge and understanding around youth mental health.

RECOMMENDATIONS

Education and Awareness

1. Embed an interactive and engaging educational offer that involves young people from the start
2. Establish a safe and supportive environment where students can openly explore mental health and emotional wellbeing
3. Encourage and enable peer to peer learning
4. Work with young people to co-design services

Peer Support Models

1. Involve young people from the start
2. Provide training to support young people's involvement
3. Take the time for young people to learn about mental health and emotional wellbeing and develop their own resilience and coping strategies
4. Be flexible and enable young people to steer their own project developments
5. Ensure there is sufficient capacity and resources in place to sustain young people's meaningful involvement

Staff Training and Development

1. Put in place an ongoing mental health and emotional wellbeing training offer to school and college staff
2. Enable effective information and signposting for young people
3. Involve young people in the recruitment and training of staff
4. Encourage joined up working

BACKGROUND

Chilypep were commissioned by Barnsley CCG to pilot an **early intervention and prevention programme** with Barnsley College from 1st November 2014 to 31st July 2015. This report details the work undertaken by Chilypep throughout the pilot period, and an evaluation of the **impact** of this work. Whilst the pilot took part within a college setting this model could be readily transferred across to a school setting. This report therefore acts as a **'how to'** guide for professionals working to establish a **whole school or college approach** to emotional wellbeing, containing **hints and tips** and **key learning** gained from the pilot.

ABOUT CHILYPEP

The Children and Young People's Empowerment Project works alongside children and young people aged 8 to 25, to find fun and creative ways of involving them in the decisions that affect their lives and to build their confidence, skills and abilities. This develops their personal, social and emotional skills, raises their aspirations and helps them to achieve their potential.

Chilypep is a nationally registered charity based in Sheffield where the majority of our work has taken place. We have worked in some of the most disadvantaged areas of Sheffield and with some of the most hard to reach groups of children and young people, supporting them to make a positive contribution to their communities and neighbourhoods. Our models, tools and training techniques have been nationally recognised by the government and the National Youth Agency in published good practice guidance, national evaluations and in Sheffield City Council's Joint Area Review inspection.

Chilypep's aim is to ensure that children and young people are empowered to take more control of their own lives and choices, and can meaningfully participate in the

decisions that affect their lives as individuals, as receivers of services, and as members of their communities, neighbourhoods and the wider world. From one-off consultation events and long term participation projects, to strategic planning and policy development, our key principle is to work in partnership with children, young people and the organisations and agencies that affect them.

We support children and young people to develop positive mental health and emotional well-being, and promote empowerment and participation practice as integral to supporting young people's positive mental health and emotional well-being.

We were one of 2 delivery partners within the Sheffield Right Here programme. Right Here enabled both delivery partner organisations to develop and use a combination of therapeutic and youth work methods to engage and empower young people, by drawing on the expertise of emotional wellbeing and youth work and empowerment practice. Our premise is our belief that by actively practicing youth work principles across young people's services, young people's lives are improved and the relationships between decision-makers, workers and young people are transformed, something which young people have said is key. Right Here gave us the opportunity to explore and refine how this can work in practice, and to work with partner organisations to support them to develop a more participative youth work approach to mental health service development and delivery.

BARNSLEY COLLEGE EMOTIONAL WELLBEING PILOT PROJECT

NHS Barnsley Clinical Commissioning Group commissioned Chilypep to pilot an early intervention and prevention programme with Barnsley College from 1st November 2014 to 31st July 2015.

The pilot aims and objectives were:

- To product test a range of emotional wellbeing (EWB) interventions
- To investigate time, cost and resources required to replicate piloted interventions at scale across Barnsley and compile in reusable format for future developments
- To produce qualitative and quantitative evaluation of impact against attainment, attendance and self-reported EWB outcome measures (including resilience)
- To work collaboratively with existing EWB services, pastoral staff, College Youth Council etc. across all departments of Barnsley College to maximise impact and ensure full inclusion across all college sites
- To engage with students to understand their needs and issues and to develop innovative, effective and scalable solutions and interventions to address these
- To provide children and young people facing staff with skills and confidence to undertake Brief interventions (BI) for emotional wellbeing
- To develop and trial a range of training/awareness raising sessions to children and young people facing professionals in cross sector organisations
- To evaluate pre-post and follow up impact of training

NATIONAL/ LOCAL CONTEXT AND EVIDENCE BASE

One in ten children aged 5 to 16 have a clinically significant mental health problem. Approximately 50% of lifetime mental illness starts before the age of 14, and it is estimated that, potentially, half of these problems are preventable. With the right services and support early on, future health problems and onset of symptoms can be minimised.

60–70% of children and adolescents who experience clinically significant mental health problems have not been offered evidence-based interventions at the earliest opportunity. (Meltzer et al, 2003)

Prevention and intervention in emotional wellbeing and mental health targeted at children and young people will result in greater benefits and savings than interventions at any other time in their life span (DH, 2011)

The No Health Without Mental Health: Implementation Framework states “to improve people’s mental health and wellbeing, everyone needs to play their part, and that local leaders need to take action to ensure a range of services work together to promote wellbeing, to tackle the causes of mental ill health, and to act quickly and effectively when people seek the support they need to make their lives better” (DH, July 2012).

More recently ‘Closing the Gap: Priorities for essential change in mental health’ (DH, 2014) supports the continued improvements to prevent mental ill health and promote mental wellbeing, and many government departments have as a major policy priority identified joint working between agencies as essential in improving outcomes for people with mental health problems.

The Children Act (2004) proposed a national outcomes framework in order to ensure delivery of the five key outcomes for all children and young people. This remains the central policy driver for all work in this area. The Children Act places a duty upon all Local Authority partners to work together to ensure all children are able to: Stay Safe; Be Healthy; Enjoy and Achieve; Achieve Economic Wellbeing; and Make a Positive Contribution.

At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time.[i] One in ten new mothers experiences postnatal depression.[ii]

Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid-20s.[iii] Self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed).[iv] Mental health problems in childhood predict the adoption of unhealthy lifestyles in adolescence.[v]

Mental health problems associated with physical illness can increase healthcare costs by more than 45% according to some international studies, which, if applied to NHS expenditure could mean that £8-13 billion of long-term physical health care costs are due to poor mental health.[vi] (Kings Fund, 2012)

Treatments for mental illness such as anti-psychotic medications have been shown to increase the risk of physical ill-health.[vii]

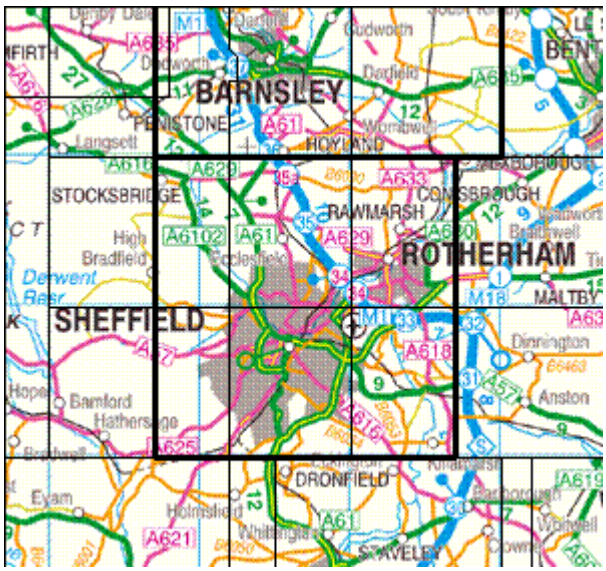
Barnsley has high levels of deprivation and although some improvements have been made in recent years, some individuals and communities continue to make high risk lifestyle choices that will impact on their future health outcomes and needs.

Barnsley still has higher than national average levels of smoking, alcohol intake and low levels of physical activity and healthy food choices, leading to: obesity, diabetes, heart disease, COPD, dementia, mental health problems and some cancers (JSNA 2013).

The proportion of Barnsley residents living with a limiting long term illness is 24.4%. This is significantly higher than England's average of 16.9%. This has a direct correlation to the increased health need in our population.

Our population continues to grow, and in particular, we have a growing elderly population. By 2021, 20% of Barnsley's population will be aged over 65 years; the elderly population is growing at a rate of 3% per year. Although life expectancy has improved, not all the added years to life are enjoyed in good health and we still have major issues in relation to disease prevalence and the requirement for care for people with complex health and social care needs.

People with long term conditions are twice to three times more likely to experience depression and estimates suggest that 20% of people with long term conditions have depression.



Barnsley's current population is approximately 233,700 (JSNA 2013), there are 54,711 young people living in Barnsley, of which 10,500 children under 16 living in poverty. 35.8% (19,564) of young people are living in areas that are amongst some of the most deprived in England.

Barnsley is the 47th most deprived Local Authority of the 326 English Districts.

The most recent data from the Office for National Statistics (ONS) indicate that in 2005 there were 125 deaths of 15 to 19 year olds from suicide or undetermined injury in England and Wales. This is a rate of 3.6 deaths per 100,000 population aged 15 to 19 years (ONS Vital Statistics and 2005 ONS Mid-Year Population Estimate). If applied to the population of Barnsley CAMHS Partnership this would equate to an estimate of 1 death from suicide or undetermined injury per year.

WHOLE SCHOOL/ COLLEGE APPROACH – CHILYPEP'S MODEL

The pilot focused on three main areas of work:

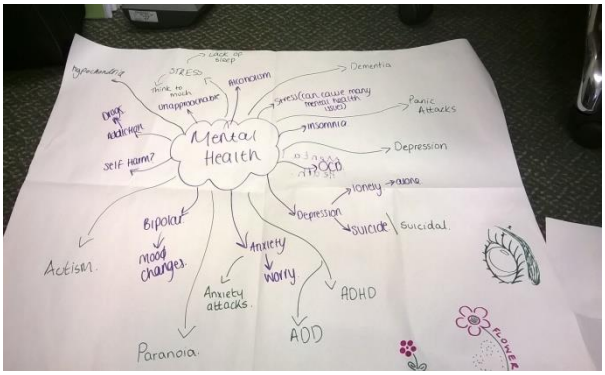
1. Mental Health awareness raising tutorials

Initially a consultation was carried out with young people from the college during fresher's week, and with STAMP, a well-established mental health participation group based in Sheffield, around what should be included in educational tutorial sessions. From this sessions were developed and piloted within tutorials across college sites and further consultation was carried out with young people about specific issues they would like more tutorials or workshops on. As we developed our Emotional Wellbeing Champions (EWB) Programme, young people were trained to co-facilitate tutorials, which were delivered in line with what these consultations in college told us.

2. Development of peer support models

Chilypep recruited and trained a group of young people, who were passionate about mental health and emotional wellbeing, as 'Emotional Wellbeing Champions' within the college. The EWB Champions went on to co-deliver tutorials, develop and run anti-stigma projects within the college, and get involved in mental health awareness work outside of the College. In the new term they hope to develop one-to-one peer support networks across the college, putting their peer support training into action.

3. Staff training and development



Young people told us that often they feel unable to talk to tutors and other professionals about their mental health, with tutors telling us they wanted more training and development to enable them to better recognise, and respond to, the emotional wellbeing needs of their students. Frontline college staff were therefore offered mental health development workshops, and access to 'Youth Mental Health First Aid' to build their own skills and confidence to support students around mental health.

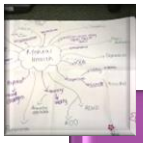
A WHOLE SCHOOL / COLLEGE APPROACH TO WELLBEING – THE PILOT MODEL

Education & Awareness

- Consultation - understanding student needs & wants
- Development & delivery of tutorial offer across sites
- Engagement of students in anti-stigma campaigns
- Evaluation

Peer Support

- Consultation - working with young people to define the offer
- EWB focused peer support
- Peer-led EWB events
- EWB training & support for peers
- Evaluation



Training & Development

- Consulation - understanding staff training & development needs
- Development & delivery of mental health awareness workshops
- Youth Mental Health First Aid Training
- Evaluation

1. EDUCATION & AWARENESS

Throughout the pilot, Chilypep aimed to **increase awareness and understanding** of mental health and emotional wellbeing amongst young people across college sites. We wanted to **get people talking** about their own wellbeing, raising awareness of mental health, and **reducing the stigma** that so often goes with it. School and college is where young people often spend the majority of their time, yet with mental health education still not embedded within the national curriculum, young people have told us that they don't often get to explore mental health whilst in education.

Giving young people the **space and time** to explore their own emotional wellbeing in a **safe and supportive environment** is vital if we are to create a culture of wellbeing within schools and colleges.

INVOLVING YOUNG PEOPLE FROM THE START

Chilypep believes that to empower children and young people is to involve them at all stages of planning, development, delivery and evaluation. We therefore worked with young People from our existing group STAMP who helped us to develop questionnaires and consultation methods to carry out with students from the college and to develop the initial sessions to deliver to them. Further consultation with students from the college highlighted the areas they wanted the tutorials to cover. These included:

- Mental health awareness
- Stress management
- Exploring and challenging stigma
- Self-harm awareness
- Self-help and resilience building

Students helped Chilypep to develop interactive session plans, to actively engage young people in the educational offer.
A typical tutorial session would include:

- Icebreaker & Introductions
- Group agreement
- Celebrity myth busting quiz
- 'Stand Up Kid' DVD
- Mental Health vs Physical Health word blast

- Stress Management
- Session evaluation

Top Tip: Feedback from young people has shown us that they engage well in these sessions because they are interactive and engaging as well as covering some serious content. Why not mix it up a bit and use interactive methods to deliver some of the 'heavier' stuff! We worked with young people to develop a 'play your cards right' game to deliver statistics so young people engage better, and use balloons to engage young people in thinking about what causes them stress; at the end of the session they can then burst the balloon once they've learnt some stress management tips!

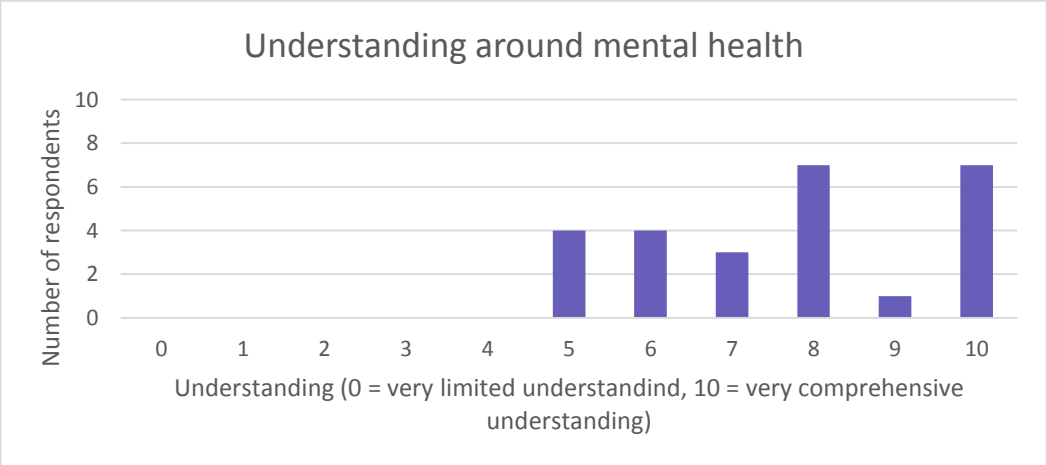
Useful links to resources can be found in the Appendix of this report if you are looking at facilitating emotional wellbeing sessions with young people!

PEER RESEARCH

Chilypep regularly involves young people in research and consultation to inform our work, and organisational priorities. As the Barnsley project began we therefore worked with young people from STAMP to develop an online survey for Barnsley college students to inform the planning and development of the pilot. In particular we wanted to gain an understanding of young people's knowledge and understanding around mental health, the support networks around them, and their knowledge of 'where to go' if they needed support, both within college and external to the college environment. In total 26 young people completed the questionnaire. Here are some of the results.

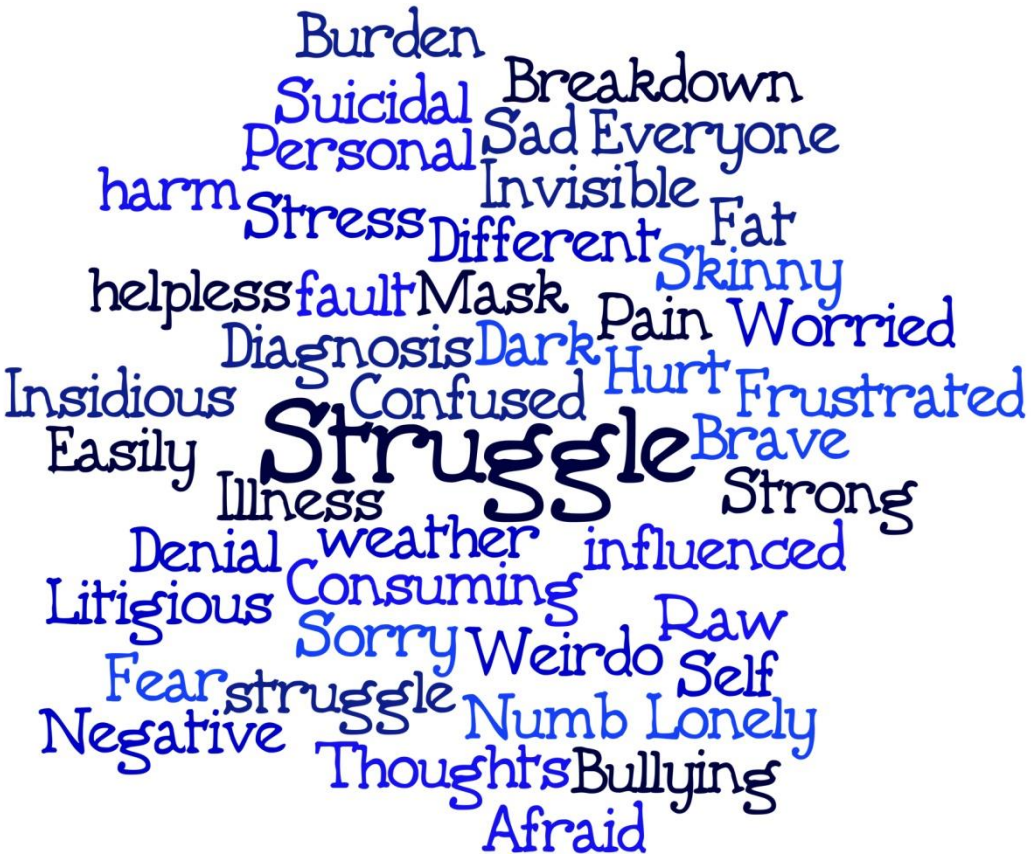
UNDERSTANDING AROUND MENTAL HEALTH

We asked young people to what extent they felt they had a comprehensive understanding of mental health. 100% of respondents indicated at least an average understanding around mental health, with 58% of respondents indicating a very comprehensive understanding around mental health.



Within tutorials however we often found that when exploring mental health with students they soon realised that their understanding of mental health was less comprehensive than they first thought, with students finding it difficult to define what 'mental health' meant. Furthermore we found that the term 'mental health' was often perceived in a negative light, with words such as 'breakdown', 'lonely', and 'struggle' coming to the forefront of people's minds.

Words young people commonly associated with mental health included…

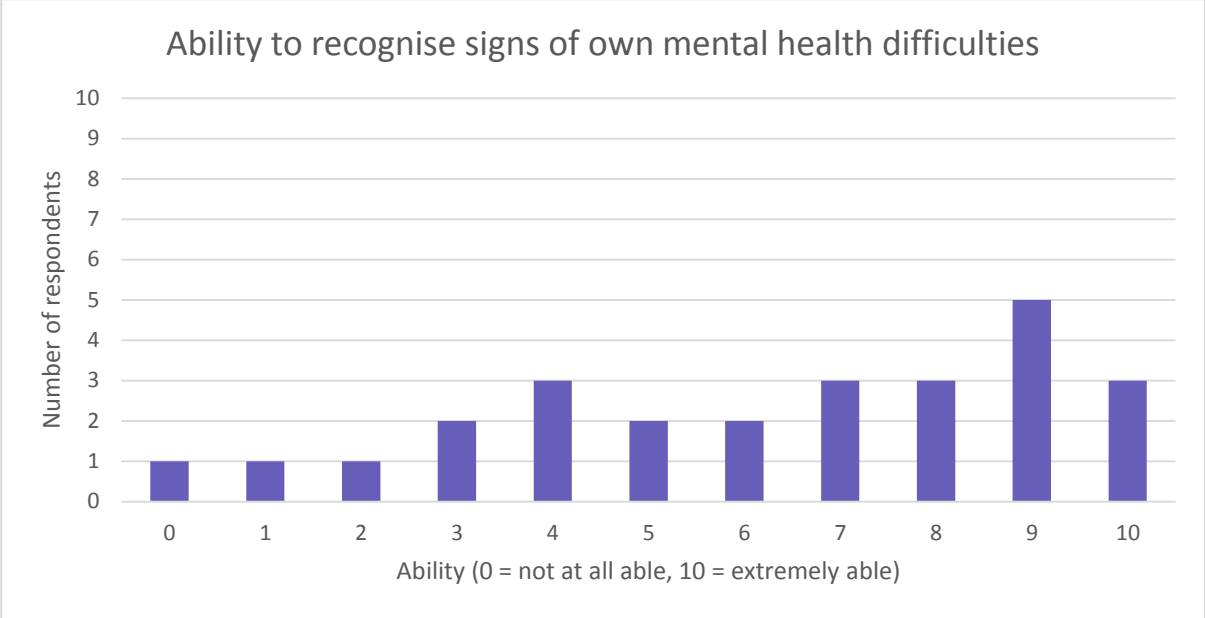


Following tutorial evaluations young people often quoted changes in their perceptions of mental health, such as *"I've learnt that mental health is something everyone has, it can be good or bad just like our physical health".*

This would seem to indicate a change in perception around mental health, and a reduction in stigma following young people's involvement in college tutorials. This highlights the need for young people to have the opportunity to explore mental health within college environments if we are to increase young people's understanding around mental health and wellbeing, and reduce the stigma that can accompany the term 'mental health'.

RECOGNITION OF MENTAL HEALTH DIFFICULTIES

From initial consultations with STAMP, we learnt that not being able to recognise signs of mental health difficulties in oneself had prevented young people from getting timely access to support. We therefore asked students how able they felt they were to recognise signs of mental health difficulties within themselves. The responses were varied, indicating that whilst the majority of young people completing the questionnaire felt they had a good understanding of mental health, they were less confident in recognising mental ill health within themselves.



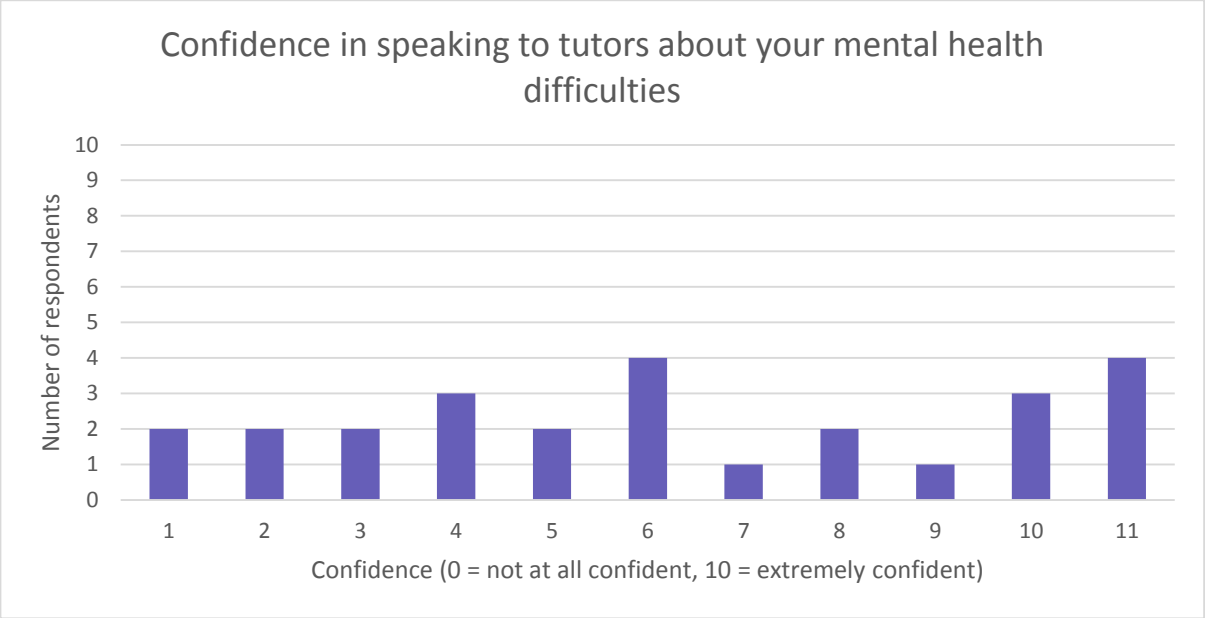
Recommendation: **All** students need to be taught about the signs and symptoms of mental ill health to enable them to seek help early on. Building the emotional intelligence of young people at an early age could also help young people to develop their own coping strategies, preventing them from becoming unwell when they notice their own wellbeing slipping.

CONFIDENCE SPEAKING TO TUTORS ABOUT MENTAL HEALTH

Previous research undertaken by Chilypep has revealed the importance of relationships within mental health support, and college environments. Whilst some young people will feel comfortable approaching a tutor about personal issues relating to their wellbeing, others have told us that they would not feel comfortable talking to a tutor, and would prefer to speak to a friend, or even someone completely removed from the situation.

We therefore asked students how confident they would be to speak to a tutor about their mental health. Again the responses were varied with each option being indicated at least once. The greatest percentages of respondents (15%) were either: neither confident nor unconfident in talking to their tutors about their mental health; or were

very confident in talking to tutors. 39% of respondents had a less than average confidence in talking to their tutors about their mental health. 42% of respondents had a greater than average confidence in talking to their tutors about their mental health.



Recommendation: There are many reasons why students may not feel confident in speaking to their tutors. From previous research Chilypep has found that this is often down to the relationship built and the confidence of the tutor themselves to engage in conversation around mental health with students. It is therefore recommended that tutors undergo training to recognise signs and symptoms around mental health and increase confidence in speaking with students.

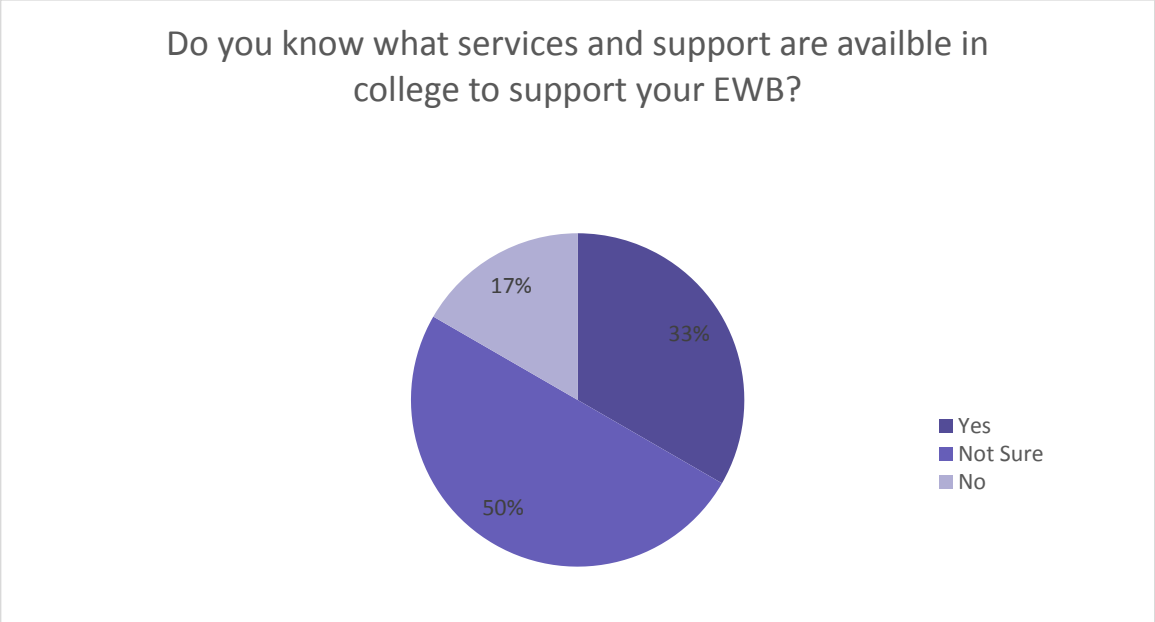
Some students did tell us that they would prefer to talk to someone outside of college (often so as to retain anonymity) or to a peer. It is therefore recommended that more visible information about other services and signposting information is available throughout the college, and work to continue and grow peer support networks within the college environment is undertaken.

KNOWLEDGE OF SERVICES AND SUPPORT AVAILABLE IN COLLEGE

Barnsley College has a range of services and support in place within the College to support the health and wellbeing of students. However half of respondents were unsure what support is available in college to support their emotional wellbeing. 33% of the respondents were aware of what mental health services/support is available in college, whilst 17% of the respondents indicated that they were completely unaware.

Those who said they knew where to go in college for support highlighted the following areas of support within college:

- The health and wellbeing centre
- Talking to a counsellor
- Personal tutors

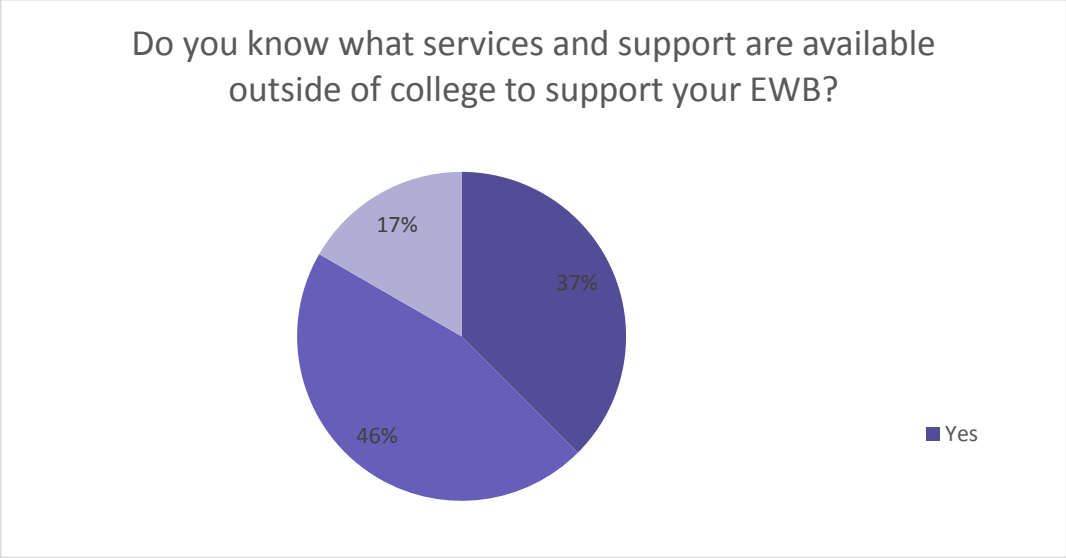


Recommendation: Whilst there are a number of services available to students in college to support their mental health, these are unknown to many students. It is therefore recommended that available services are promoted more widely across the college. The College could utilise the EWB Champions to support this process.

KNOWING WHERE TO GO…

The world of mental health support is often one that is very complex for young people to navigate, with many young people telling us that they would not really know where to go to for support. We therefore asked students if they knew what services were in place that they could access outside of the college environment.

Over half of the respondents (63%) were either unsure (46%) or totally unaware (17%) of what support and serves were available to them outside of college. Respondents were however more aware of mental health and wellbeing services and support available to them outside of college (37%) than services and support provided to them within college (33%).



The majority of places quoted were those providing formal mental health support, such as GP, mental health services, or helplines, with some young people saying they would go to friends and family for support. Interestingly, although young people seemed to know of some mental health support services, no specific local services were quoted. This may indicate the need for more signposting awareness amongst students as to what is 'out there' and how they can access it.

Services young people identified were:

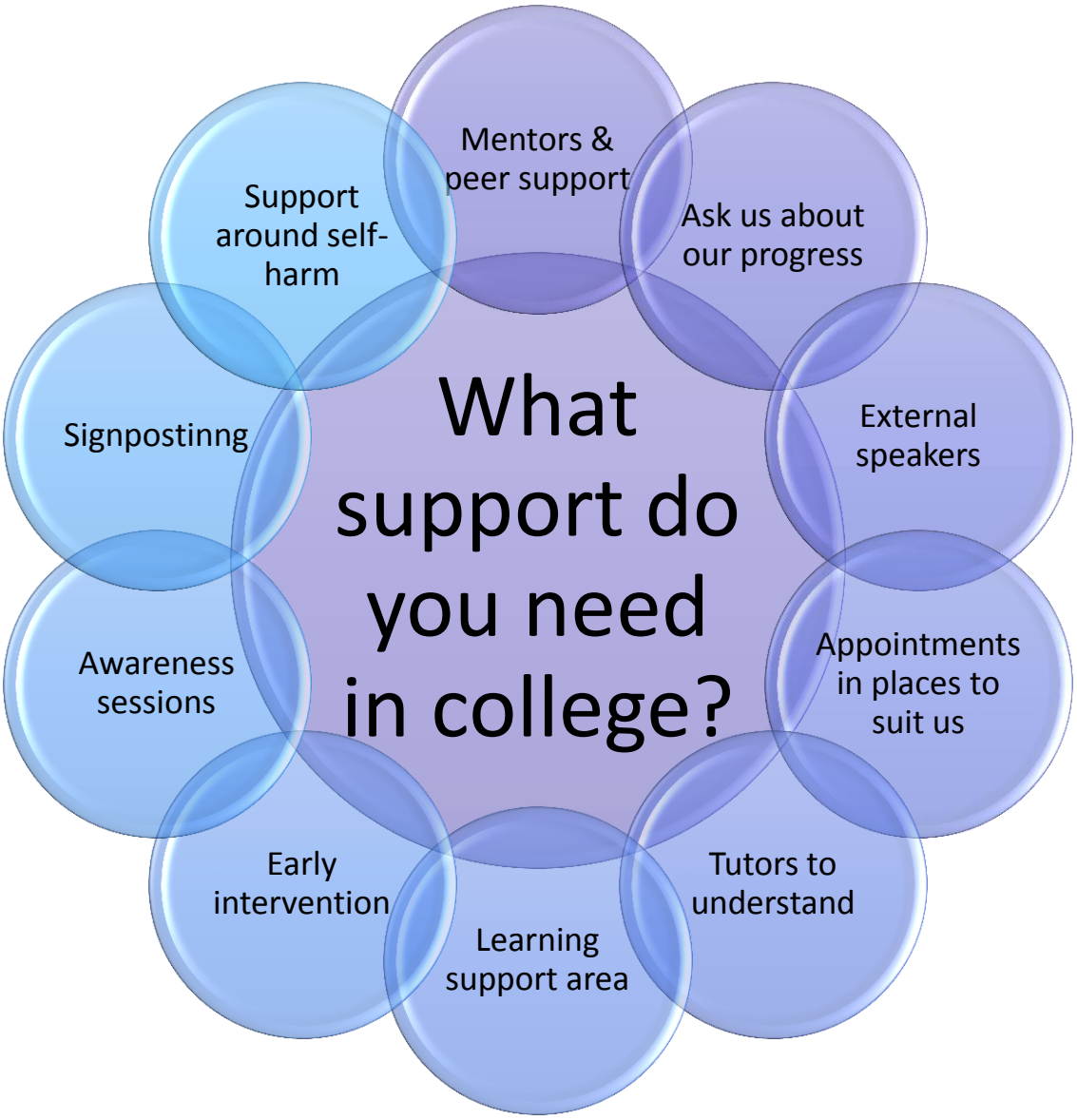
- Your GP and counselling sessions
- Counselling, friends and family
- CAMHS, your GP, doctors
- You can talk to your doctor and counsellor
- Mental health phone lines, support worker
- Suicide hotline, friends

Recommendation: Future work with could include working with the Emotional Wellbeing Champions to carry out a mapping of support and services in the local area. They could then develop a 'where to go' information leaflet or online forum that students could access to find help and support. (You can find out more about online support and signposting in the appendix resources area!)

WHAT SUPPORT DO YOUNG PEOPLE WANT?

Chilypep used time within tutorials to further unpick what support young people would like to see in the college environment to better support their emotional wellbeing.

Key recommendations from young people we spoke to included:



Recommendation: It is recommended that the College and Barnsley CCG take on board young people's recommendations in order to improve the emotional wellbeing support students receive within the college.

TOP TIPS TO POSITIVE MENTAL HEALTH

We asked young people during tutorials what things they could do to support their own mental health. They said…

- De-stress time
- Do fun things
- Films, TV, Video games
- Positive quotes & thoughts
- Don't hold back your opinions
- Understanding from tutors
- Get professional help if you think you may need it
- Have a diagnosis
- Listening to music
- Be open, honest and happy
- Pub
- Mates get on and understand me
- Work with others
- Peer support

TOP TIP: In order to sustain positive mental health it is really important to develop a sense of what helps you to help yourself. Young people are experts in own lives and therefore in maintaining their own wellbeing! Why not ask young people what they need and support young people to identify the things that help them stay well? Visit www.actionforhappiness.org for some great tools that can help you with this.

LET'S TALK ABOUT MENTAL HEALTH

Over the course of the pilot project Chilypep delivered a total of 50 tutorials, engaging 265 young people across college sites.

Within the short space of an hour Chilypep often noticed young people's perceptions around mental health shift quite dramatically, with often quite stigmatizing language being used at the beginning of a given session, and by the end young people expressing an interest in becoming involved in the pilot project, or disclosing around their own mental health.

Over the course of the tutorials Chilypep received 11 disclosures from young people; disclosures were commonly around self-harm, depression, anxiety and difficulties sleeping. Of those young people disclosing mental health problems, approximately 5 went on to receive support through the college services, such as IAPT and the wellbeing centre. Others said they did not want to access anything within the college environment and so were signposted to alternative sources of support.

In addition to disclosures during, or following, tutorials, young people were signposted to the project's facebook page. We found that giving young people access to an online forum led to further disclosures, with young people contacting Chilypep's Emotional Wellbeing Worker directly via facebook to seek further support. In one case this led to a young person speaking to the worker about how he did not know where to go to for support. He was not registered with a GP and did not know of any local services.

Chilypep's Emotional Wellbeing Worker encouraged them to register with a GP, which they did, and they then went on to get some emotional wellbeing support. This highlights the need for alternative forms of communication, such as online forums, where young people often feel more comfortable to seek additional support.

The fact that young people felt able to disclose their own concerns around their mental health following brief interventions, demonstrates how actively engaging young people in informal mental health education can not only open up discussion around mental health, but can lead to young people taking the step towards accessing support.

Recommendation: Both staff and young people highlighted the value of the tutorial offer. It is therefore recommended that this continue across college sites and it becomes embedded within the college culture.

2. PEER SUPPORT – BARNSLEY EWB CHAMPIONS

Learning from the Right Here project highlighted the importance of peer support models in improving the emotional wellbeing of young people. An integral element of the Whole School/ College Approach was therefore the development of the Barnsley 'Emotional Wellbeing Champions' Programme.

EMOTIONAL WELLBEING CHAMPIONS

Chilypep gathered previous learning around engaging 14-25 year-olds in discussing mental health and well-being, based on the idea that everyone has mental health and should be supported to look after their mental health on a daily basis to prevent deeper issues becoming entrenched. From this the idea of EWB Champions was developed to offer young people in schools, colleges and communities the opportunity to develop their skills, knowledge and confidence to speak out around mental health issues, offering peer support and guidance to their peers.

As an 'EWB Champion' young people received training such as consultation and research skills to enable them to understand the issues young people face; facilitation training to enable them to deliver peer led healthy conversations to other young people; and influencing and campaigning training to enable them to make a difference to mental health at a strategic level.

Chilypep actively promote Peer Mentoring approaches because we have found that:

- Young people tend to engage better with other young people than with older adults
- Our EWB Champions use engaging tools and approaches designed by them to ensure they capture the interest of young people (these include a board game, exercise and smoothie-making to discuss mental health and well-being).
- The stigma around mental health problems means that this can be a difficult subject to discuss unless you feel shared interests and experiences with the facilitator as you do with a peer-facilitator.
- EWB Champions get access to training and support from Chilypep increasing their confidence, resilience and skill base.
- The college or school becomes a healthier place for students to be, improving the college environment for both staff and young people, whilst supporting the education and attainment of pupils.

BARNSLEY COLLEGE EMOTIONAL WELL BEING CHAMPIONS

Initially ten young people were recruited to become EWB champions, with eight going on to complete the peer mentoring training programme, and six remaining actively engaged at the end of the project.

DEVELOPING A PEER MENTOR TRAINING PACK

For young people to be able to meaningfully engage within the EWB Champs project it was necessary to develop a comprehensive Peer Mentoring training package. Chilypep worked with the EWB Champions to ask them what their training needs were and adapted training we had delivered in the past and adapted these to match the skills the EWB Champions were wanting to develop.

The ongoing training programme Chilypep delivered to the EWB Champs included:

- Team building – Icebreakers, energizers, team work activities
- Setting project/ role expectations - Hopes, fear, expectations
- Communication skills – speaking, listening, mirroring
- Leadership skills
- Facilitation skills
- Equal opportunities/ assumptions/ perceptions
- Myth busting
- Assertiveness
- Child protection, safeguarding, boundaries, confidentiality

In addition to this we also ran sessions with young people to discover what the issues are that young people may be facing. This included looking at a diverse range of topics such as sexual health, relationships, social problems, and of course an in-depth exploration of mental health and mental health problems that young people might face. For more information about our training visit www.chilypep.org.uk .

Stamping Out Stigma!

The Emotional Wellbeing Champions ran a week long anti-stigma campaign around college to showcase that mental health is something we all have and encourage others to speak about mental health. Over the course of the week we ran tutorials with the EWB Champs, and took over part of the college putting up a 'Wellbeing Tree' where students were encouraged to write down what was going on for them, and how they could support themselves to feel good.

Peer-peer facilitation

Once trained the EWB champions felt more confident to support Chilypep's Emotional Wellbeing Worker in the delivery of college tutorials. As part of the tutorial Chilypep plays 'Stand Up Kid', a time to change film where a young person, having been off school with depression, stands up on a chair in the middle of the classroom to tell his story. Following the showing of this film during one session a member of the EWB Champs group, who was co-facilitating, took the impromptu move to 'stand up' and tell his own story to the class. This demonstrates how one young person through such a project can themselves become empowered to share their story with their peers in order to raise more awareness and reduce stigma around mental health.

Going one step further…

The EWB Champions did not only take part in the college project but were keen to get involved in other aspects of Chilypep's work. Shortly after starting the programme, we invited the Champions to a regional 'Voice and Influence' residential organised by British Youth Council.

The majority of the young people were youth council, or youth parliament representatives and this was at first quite intimidating to the young people who attended. However on the second day some of the Champions stood up and told their own stories and shared their passion for campaigning around mental health for young people.

In addition to the residential, members of the EWB champions, supported Chilypep in the development and filming of two short films; one in relation to young carers, and the other in relation to mental health. The films can be found here:

Young Carers Need Care Too: https://www.youtube.com/watch?v=_5pfgvFGSi4

Move Forward with Mental Health: https://www.youtube.com/watch?v=k5o5ei_FxFA

CASE STUDIES

Drew, Age 17.

Drew, aged 17, took part in the EWB Champions Programme. In preparation for a visit from Barnsley CCG he prepared his own story of why it was important to him to be involved in the project:

"Hello, my name is Drew Brewster. I am 17 years old, unfortunately I am not able to make it today to read this myself, let me paint a picture, medium height, brown eyes and hair, and very good lucking no, just a little joke. This is my story.

My childhood was bad, my father was in and out of prison for many things like breaking and entering, robbery, drugs etc my father also used to beat me, this is where it all started I felt victimised and singled out, as I have a brother and 3 sisters, yet I was the only one who got abused, I believe this is the root of my illness, I love my mother, as most people do, but it's different, my mother had cancer at the age of 12-18 years old, she is a very strong person, and pulled through, kicked cancer right where it hurts, when I was young, she was my safe haven, and she used to protect me from my dad whenever she could, when my father left, I became 'the man of the house' and helped my mum raise my brother and sisters. I didn't attend school, as my situation at home was more important. I fell behind massively, and got bullied, this only motivated me at year 9 to get my head down.

I'm now studying A-level chemistry, biology, physics and math. When I was 8 my mother developed a heart condition, severe enough that she had to have a heart transplant, this was a very hard time for me, I was 10, when she went for her procedure, I was without my mother for 4 month, no contact at all, this was horrible, imagine someone smashing there hand through your chest and ripping out your heart, and keeping it in a box for 4 month, when I did get to see my mother for the first time, she couldn't move, nor speak, this was weird more than anything, because my mother could never sit still, you could almost see the energy in her eyes, this made this especially funny when a few week later she kicked my sister for making a funny joke about me, it was so unexpected, anyway my mother made a full recovery, against all the odds, she is like a steel wall, unbreakable, well that's until the 9th of October 2010 when she passed away due to a blood clot in her leg. After everything, she died over a bit of thick blood.

This was the lowest point of my 17 years of life, I hit rock bottom, I became depressed, a day after my mother's death, on the 10th of October 2010, I self-harmed for the first time, this was also my 12th birthday. My self-harming got bad, really bad. I put myself in hospital on two occasions with severe lacerations to my legs. I got called a freak, emo, attention seeker. My auntie and uncle, who I moved it with after a short stay in care did all they could to support me, but I was driving them away, making my auntie Ill with stress. I attended camhs, school nurse, but nothing worked, I am now on antidepressants, self-harming is still an issue but not to the extent it used to be, a year ago I managed to stay cut free for about 3 month, but I relapsed, and now I haven't self-harmed in over 3-4 month, and still going strong, with the help of all the amazing people here at chilypep, as one of the newest members, I feel like I am part of a family, a healthy atmosphere, and I know chilypep, us, we, are going to help many more people with mental illness. Thank you. For your time and support you have invested in chilypep."

Grace, Age 17

Grace was one of the young people from Barnsley College to take part in the EWB Champs programme. She has since gone on to engage in a number of other projects with Chilypep, including co-facilitating the peer mentoring training to a group of NCS (National Citizen Service) young people over August 2015, and, as the pilot drew to an end, becoming a 'Peer Befriender' to young people with mental ill health in North Sheffield.

"When I first started the EWB program at Barnsley College I wanted to achieve a better understanding myself of mental health and how to talk about it effectively with people who have little prior understanding of mental health currently. I believe that I have successfully achieved this over my time with the group. I also wanted to improve the steps the college takes when it comes to a student's mental health. Which I believe we have/ will due to our group implementing out peer mentor scheme. Throughout the program I have developed many skills such as being able to sympathise and empathise much better with situations I hadn't before. I have also built my confidence levels so that I can challenge stigma, making people stop and listen effectively. In my opinion this

program must continue as in the short space of time it hasn't just helped one person yet it has set out to effectively improve mental health standards for the future at Barnsley and all the people that have taken part in the emotional wellbeing group will continue to make an impact throughout the rest of our lives."

Grace, Emotional Wellbeing Champion, age 17.

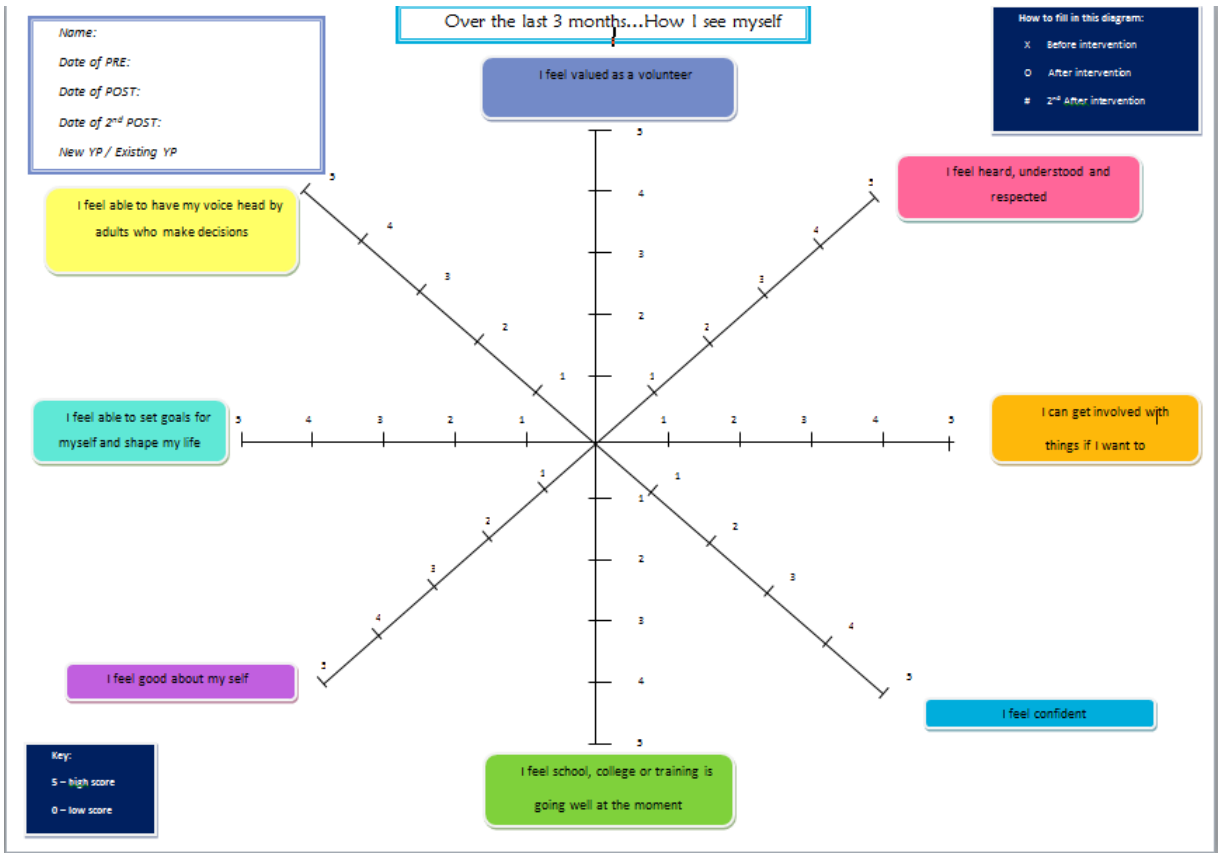
BARNSLEY COLLEGE EWB CHAMPIONS – OUTCOMES FOR YOUNG PEOPLE

Young people engaging in the programme highlighted how their involvement became a means not only to improving the emotional wellbeing of other students, but in turn improved their own mental health:

"My confidence has grown a lot and my mental health has improved."

"Being involved in 'EWB Champions' has helped my confidence grow and made me feel like I can talk to more people."

Chilypep has developed a measurement tool, a participation Spidergram that can record participation levels in children and young people and how this impacts on mental health and emotional wellbeing. The participation Spidergram was used throughout the project to measure how involvement and participation within the EWB Champions programme impacted on our EWB Champs' Wellbeing and Mental Health. An example of the Spidergram can be seen below:



The purpose of the tool is to demonstrate how participation in activities such as this programme can impact on and improve a child or young person's mental health and wellbeing. The tool was used to record young peoples' feelings and behaviours, by asking where they believe they were at the start and end of the process, with interim data also recorded.

The Participation Spidergram has been modelled on the Outcomes Star (a tool for measuring change when working with people www.outcomesstar.org.uk), with the Mental Wellbeing Checklist (National Mental Health Development Unit) http://www.mhfe.org.uk/sites/default/files/nmhdu-briefingmental-health-strategy.pdf provided the framework for developing the Spidergram. The checklist was developed as part of the MWIA toolkit for well-being and identifies the major influences on mental wellbeing. The checklist is evidence based and provides information on what protects individual and community mental wellbeing, what the wider determinants of mental well-being are and which populations face the greatest inequalities in mental well-being.

For this project measures were selected across the areas the Checklist identifies as influential and which relate to the work of Chilypep, and a series of questions were generated to translate these into tangible questions, which could easily be understood by young people of all ages, abilities and back grounds.

For the Emotional Wellbeing Champions programme the chosen measures were:

Measures	**Questions**
Belief in own capabilities and self-determination *(e.g. setting & pursuit of goals, ability to shape own circumstances)*	• *I can achieve things*
Opportunities to influence decisions *(e.g. at home, school, work, with services or decision makers, or in the community)*	• *I think my ideas and opinions can make a difference* • *I feel I have a role in taking action in my community*
Opportunities for expressing views and being heard *(e.g. in groups, public meetings).*	• *I feel listened to* • *I am confident to express my voice and opinions.*
Emotional Wellbeing *(e.g. self-esteem, self-worth, confidence, hopefulness, optimism, life satisfaction, enjoyment and having fun).*	• *I feel good about myself*
Having a valued role *(e.g. group member, volunteers, governor, carer)*	• *I feel valued as a volunteer/participant*
Feeling involved *(e.g. in the family, group, school, community or at work)*	• *I enjoy being part of a team*

We asked the EWB Champions to complete the Spidergram when they became involved in the project, and then at regular intervals throughout. In total 9 young people completed the Spidergram, with 6 completing these on a regular basis. We have therefore calculated the results of the Spidergram based on the six young people who remained engaged throughout the entire process.

100% of young people reported increased sense in their beliefs that they could achieve things.

5 out of 6 young people reported an increase in thinking that their ideas and opinions could make a difference, with one young person remaining the same.

5 out of 6 young people reported an increased feeling of having a role to play in taking action in their community, with one young person remaining the same.

100% of young people showed an increase in feeling like they were listened to.

100% felt more confident to express their voice and opinions as a result of their involvement.

100% showed an increase in their sense of wellbeing quoting that they felt good about themselves more often as the project went on.

100% showed an increase in feeling valued as a volunteer/ participant within the project.

100% showed an increase in their levels of enjoyment of being part of a team.

EWB CHAMPIONS – THE BENEFITS ON THE INDIVIDUAL

"My confidence has grown a lot and my mental health has improved."

"It has helped widen my understanding of mental health."

"I feel as though I have matured loads! – I now know how to be a representative to my best ability."

"Being involved in 'EWB Champions' has helped my confidence grow and made me feel like I can talk to more people."

IMPACT OF PARTICIPATING IN THE EWB CHAMPS PROGRAMME

"This project has helped me to manage my stress and anxiety, allowing me to share my experiences with others to help them."

"Before I started 'EWB Champions', I didn't feel like I could talk to anyone. Now I find that I have a number of people I can talk to and they can also talk to me."

"It has allowed me to know much more about mental health."

"I have recently started counselling and I am starting a behavioural management course, as well as seeing a dietician."

"My mental health has improved amazing, along with it helping me making steps to further improve and to effectively help friends with their mental health."

THE PROGRAMME HELPED OTHER YOUNG PEOPLE TOO!

"People now feel freer to talk to other people and are more aware."

"Helped others to open up to us more, in a trusted environment."

"People know who they can turn to if awaiting counselling."

"People now know who to come to for help and support when no-one else is available."

PERSONAL AND PROFESSIONAL DEVELOPMENT OF YOUNG PEOPLE

Many noted career changes, or didn't know what to do before…

"I now want to work with young people."

"I would like to relieve my stress through working and helping animals."

"I hope to become a mental health nurse."

"I want to attend university to study a degree in 'Mental health nursing' at UCL."

PEER MENTORING TRAINING

"I understood the training, in the way it was delivered."

"Learnt loads – may need a refresher in a few months please?"

"It were aimed towards us and so wasn't just babble, it were good information, meaning my understanding has improved."

"Peer mentor training were great, we learnt lots of ways of helping people through hard times."

"Awesome."

"Extremely informative – I can't wait to be a 'Buddy'."

BUT, THERE IS ALWAYS ROOM FOR IMPROVEMENT!

"Sessions could have been more regular."

"Maybe starting tutorials slightly earlier – due to exam dates disrupting final tutorials."

"This group to start earlier."

"Sessions could last longer."

OVERALL FEEDBACK

"It's been amazingly fun and brilliant! I have made life-long friends, done things I wouldn't have imagined myself doing and my confidence has grown."

“It’s been an amazing experience, I have loved every minute of it and we learnt so much.”

“Amazing! I feel as if I have made so many memories and am ready to help others! Woo!”

“Amazing! Great memories, great friends! Made such an improvement in my mental health and made steps to improve it further.”

“My mental health has improved loads!”

“Keep it up! We want more!”

TOP TIPS TO RECRUITMENT

Staff at Chilypep are regularly asked how they go about recruiting young people to our projects and particularly how we ensure they remain engaged in the long term. This section of the report therefore sets out some of Chilypep's 'Top Tips' to recruiting and retaining volunteers.

VALUE BASED PROJECT DESIGN

Chilypep has a core set of values that we believe helps guide our work with young people:

1. We believe that to empower children and young people is to involve them in all stages of planning, development and making things happen and work well.

2. We believe that children and young people should decide what's important to them. Our job is to help them make choices and decide what they want to do about them.

3. We believe that the way we work with young people is just as important as the end results. This means making sure they are safe, protecting them if they are in danger, respecting them, treating them as equal partners, recognising and celebrating the differences between everyone, and helping them to be tolerant and supportive to each other.

4. We believe that all children and young people have the right to be involved in decisions that affect them and that for young people things are not equal or fair, so we need to make sure they are not left out.

THE WIPPY WAY

Chilypep ensure they work to the 'WIPPY principles' to ensure that young people have a positive experience working with us. The WIPPY principles are a set of principles that were developed by a former Sheffield networking group WIPPY (Working In Participation Projects with Children and Young People). Whilst this group no longer meets, the principles continue to be held in high regard, acting to outline how workers can carry out consultation or participation projects in a respectful way, so that children and young people have a positive experience.

Working through the WIPPY principles before you start a project will ensure that you have considered the things you need to make sure your project is meaningful, inclusive and rewarding for children and young people. It can also act as a tool for workers to be clear with what it is they are wanting to achieve.

There are 6 key areas to the WIPPY principles:

HONESTY

- Being honest with children and young people about what can and can't be done
- Identifying a clear purpose about what the process wants to find out and why
- Agreeing that any record keeping is a true reflection of children and young people's views and ensuring that permission is sought for use of their work

COMMUNICATION

- Using processes that are children and young people friendly, which respect different ages, understanding, abilities and styles
- Using children and young people's words whenever possible and avoiding the use of jargon
- Involving children and young people at all stages of the process, including planning and feedback in a manner that works for them

REALISM

- Giving only commitments that we can honour
- Ensuring sufficient resources and funding are identified to carry out the agreed work
- Committing sufficient time to ensure a process of high quality that is respectful to children and young people

INCLUSION

- Increasing access for a diverse range of children and young people, not merely the most visible
- Involving children and young people in all parts of the process appropriate to their age, skills, experience and abilities
- Developing appropriate strategies that work towards equal opportunities practice throughout the process

RESPECT

- Making sure children and young people's voices are heard and acted on; and they are told what has and has not changed as a result
- Working without prejudging the outcome or the contributions of the participants
- Offering support in order for children and young people to speak freely and power gaps to be bridged
- Providing a process that is a positive experience for children and young people

RECOGNITION

- Genuinely acknowledging the contribution from children and young people of the time and skills they contribute

- Acknowledgement that expenses may be incurred by the children and young people and that these are supported within the work resources
- Offering incentives and rewards appropriate to the children and young people we work with
- Providing appropriate access to accreditation opportunities.

Top Tip: Chilypep have some great planning tools that can help you put the WIPPY Principles into action – just contact us for more information!

WHAT DID WE DO DIFFERENTLY?

Chilypep always ensures that young people are at the centre of our work, and that our work in led by young people. This means building up a true partnership between young people and adults, and ensuring young people are involved from the start.

By involving young people in the planning, design and delivery of our projects we ensure that 'the offer' remains appealing to young people; that it meets the needs of young people and is delivered in a fun and engaging way. This means being on a level with young people, understanding what their needs are, and making sure young people are respected.

Chilypep recommends keeping in mind the 7 principles of youth work to make any project successful:

1. Young people choose to take part
2. Start with the young person's view of the world
3. Treat young people with respect – by listening to what young people say
4. Seek to develop young people's skills and attitudes rather than seeking to remedy 'problem behaviours'
5. Help young people develop stronger relationships and collective identities
6. Respect and value difference
7. Promote the voice of young people – all young people have a right for their voices to be heard

3. STAFF TRAINING & DEVELOPMENT

Staff training and development formed a core element of Chilypep's offer, recognising the vital role staff play in embedding a culture of wellbeing across school and college sites, and in supporting young people around their mental health and emotional wellbeing.

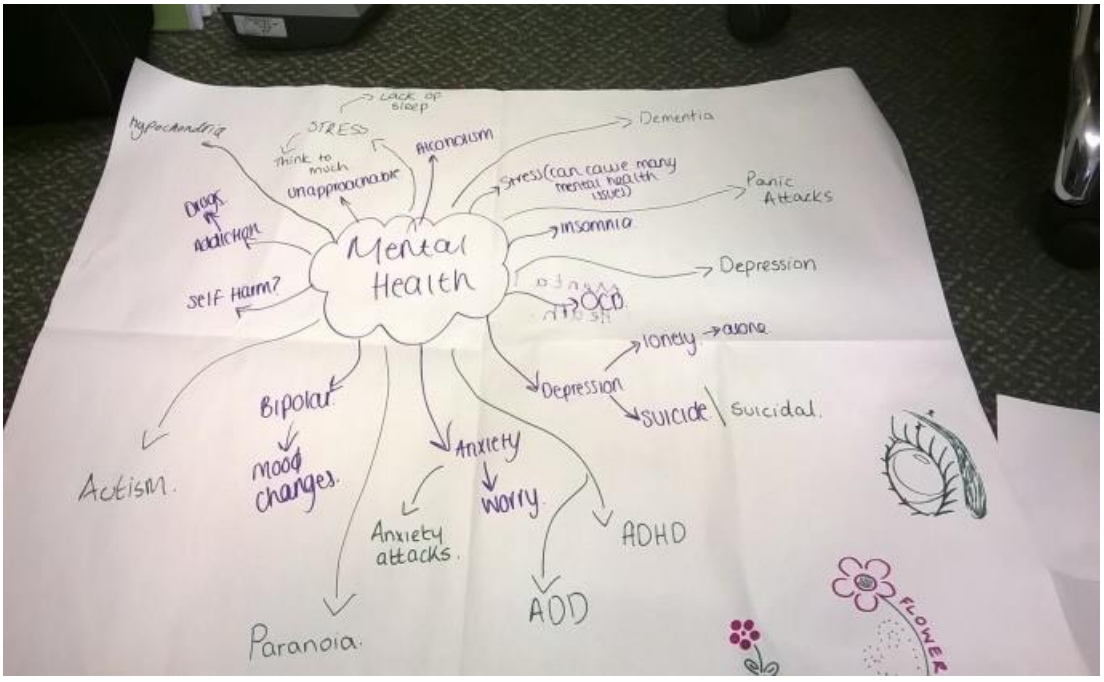
There were 3 main elements to staff training and development:

1. Continuous Personal and Professional Developlent of staff through attendance at tutorials, access to Chilypep's Emotional Wellbeing Worker onsite at College, and regular visits from Chilypep team to staff meetings and tutor learning sessions
2. Mental Health workshops offer to college staff
3. Access to 'Youth Mental Health First Aid' certificated training course

STAFF RESEARCH FINDINGS

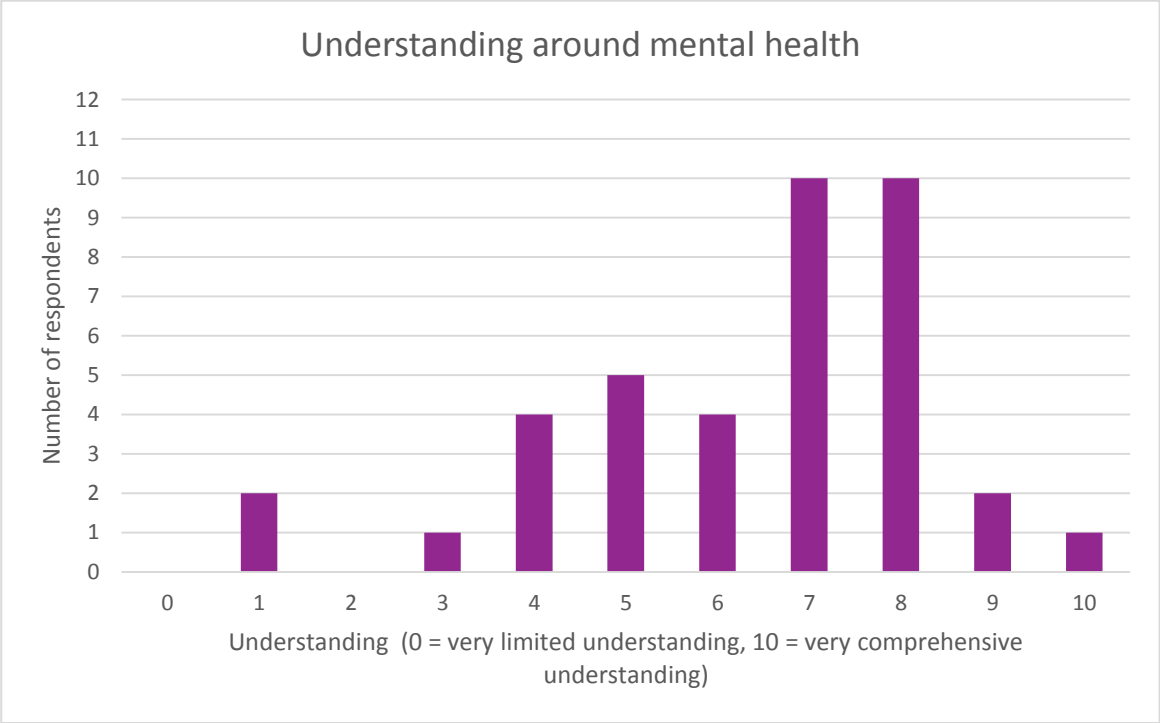
Chilypep aims to ensure that any project delivered is designed in conjunction with the needs and wants of those we are working with. Chilypep therefore carried out initial research into staff needs in relation to the pilot project. We did this initially by visiting team leader tutorials to tell them about the project, gage their understanding around the mental health and emotional wellbeing needs of students, and gain an insight into the training and development needs of staff themselves.

In addition to staff members completing paper based questionnaires during tutorials, 39 staff members across college sites completed an online survey monkey. The data gathered informed the training and development offer.



UNDERSTANDING AROUND MENTAL HEALTH

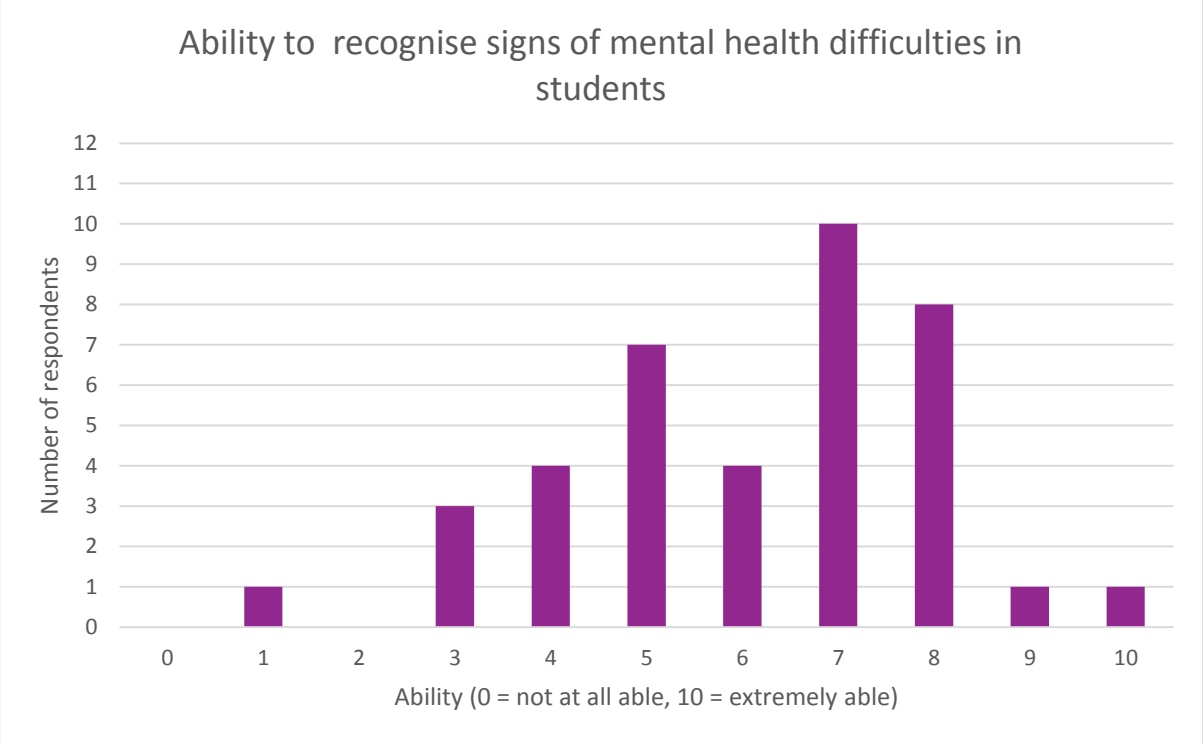
We asked staff about their understanding of mental health. The responses to this question varied, with at least one respondent indicating all but two of the options. 3 respondents (8%) indicated a limited understanding, and 13 respondents (33%) indicated an average understanding. The majority of respondents, 23 (59%) indicated a comprehensive or very comprehensive understanding around mental health.



Recommendation: Whilst the majority of staff indicated that they had a moderate to high understanding around mental health, there were also relatively high percentages of staff stating that they had a low to medium understanding. In initial tutorial consultations with staff many stated that whilst they felt they had a basic understanding around mental health, they did not always feel confident working with students around mental health and could benefit from further training.

It is recommended that there be an ongoing training offer to staff across college sites in relation to mental health and emotional wellbeing.

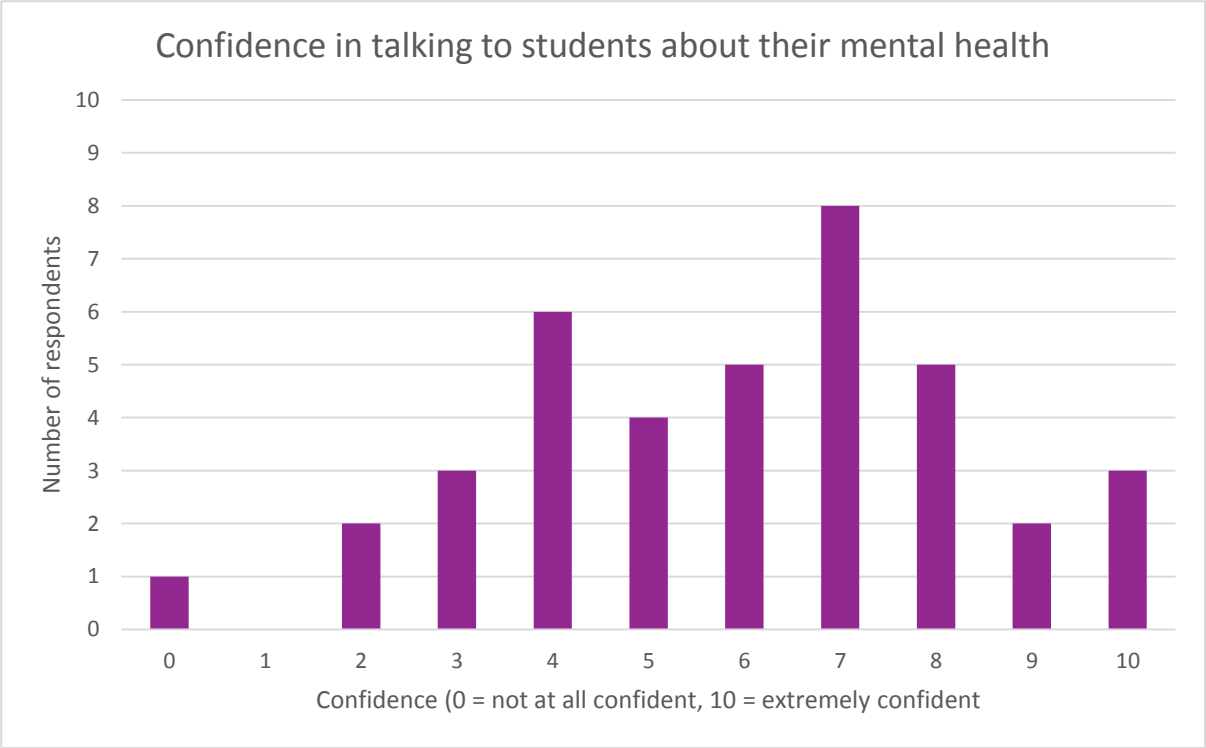
ABILITY TO RECOGNISE SIGNS OF MENTAL HEALTH DIFFICULTIES IN STUDENTS



The ability to recognise signs of mental health difficulties in students varied. 10% indicated they did not feel able to recognise signs of mental health difficulties in their students, 38% indicated they felt somewhat able to recognise signs of mental health difficulties in their students, and the majority of respondents, 20 (52%) indicted they felt able to recognise signs of mental health difficulties in their students. However, of these only 2 respondents (5%) indicated they felt extremely able to do so.

Recommendation: Students we have worked with in the past have told us how their stories may have been different if they had got help early on. Young people have told us they want to raise awareness about the issues affecting young people to the adults around them, so that they can recognise mental ill health in young people and offer support. It is recommended that the college offer more training and support to staff to enable them to feel more confident in recognising signs of mental health difficulties in students. Young people themselves could be involved in the design and delivery of such training!

CONFIDENCE TALKING TO STUDENTS ABOUT THEIR MENTAL HEALTH

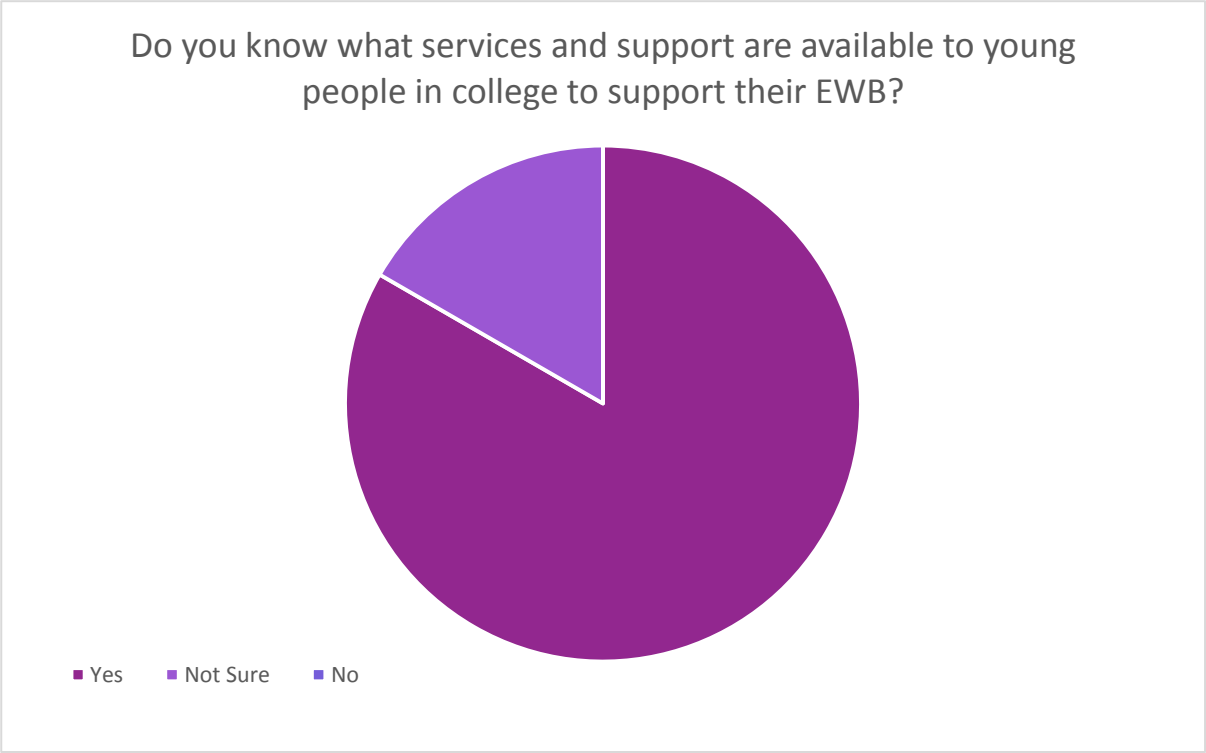


The confidence staff had on talking to students about their mental health again varied greatly. 6 respondents (15%) indicated they had little confidence in talking to their students about mental health, with 1 respondent (3%) indicating they had no confidence in doing so; 5 respondents (39%) indicated they were somewhat confident in talking to their students about mental health; 18 respondents (46%) indicated they were confident talking to their students about mental health, with 3 respondents (8%) indicating they were extremely confident.

These results are in line with previous research we have undertaken, that has highlighted a lack of confidence with teachers/ tutors and other adults talking to young people about their mental health. Reasons for this are varied, including a fear of making things worse, or safeguarding issues arising, as well as a general anxiety around having such conversations.

Recommendation: It is recommended that there be more CPD for staff at college sites around talking to young people about their mental health, as well as training around signposting for further support. The college may want to consider having mental health as a standing item on team meetings, and putting in place designated 'go to' staff acting as mental health champions within their teams.

KNOWLEDGE OF SERVICES AND SUPPORT WITHIN COLLEGE

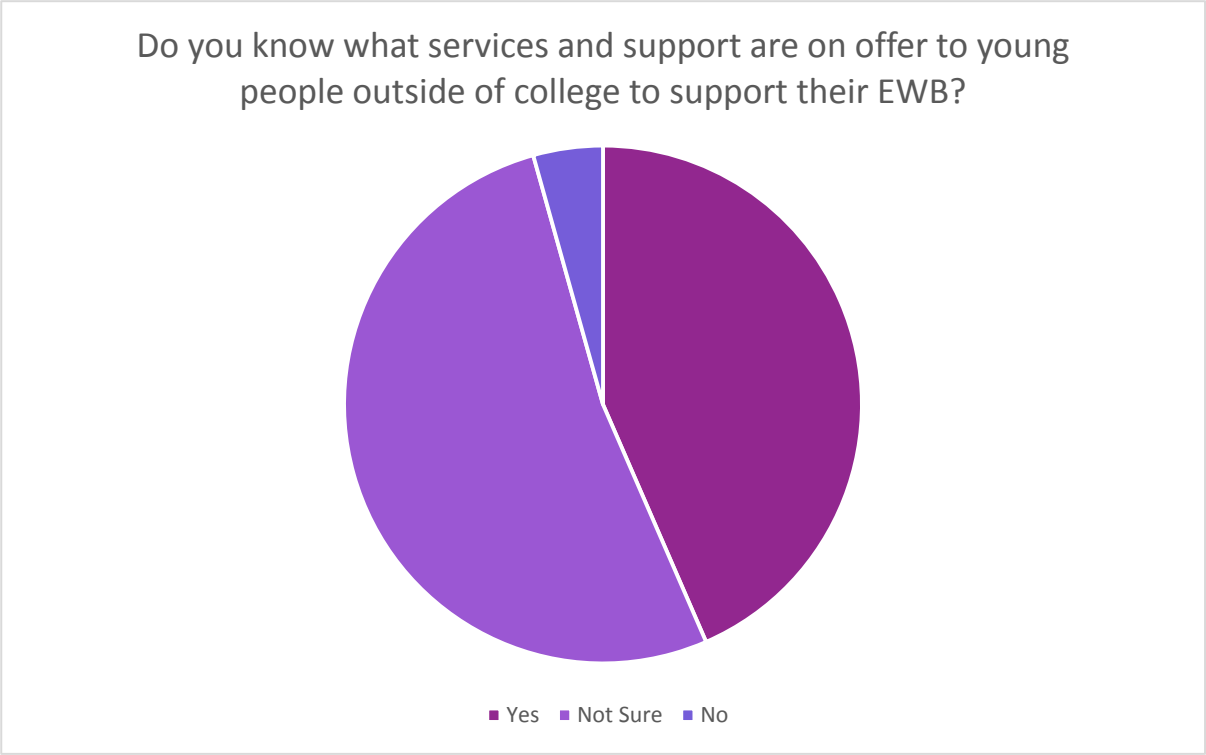


Only 24 of the 39 respondents answered this question (62%). 0% of respondents indicated they did not know what services were available to young people, and only 4 respondents (17%) were unsure. The vast majority of respondents, 20 (83%) indicated that they did know what services and support is available to young people in college to support their Emotional Wellbeing

Of those who felt they did know what services and support were available:

- The most common answers given were: **The Health and Wellbeing Centre, The College Counselling Service,** and **Student Services**
- 2 respondents also mentioned the **IAPT Service** within college

SUPPORT AND SERVICES AVAILABLE OUTSIDE OF COLLEGE



Only 23 of the 39 respondents answered this question (59%). Only 1 respondent (4%) indicated they did not know what services were available to young people outside of college, however 12 respondents (52%) indicated that they were unsure about what services were available. 10 respondents (44%) indicated that they knew what services were available to young people outside of college.

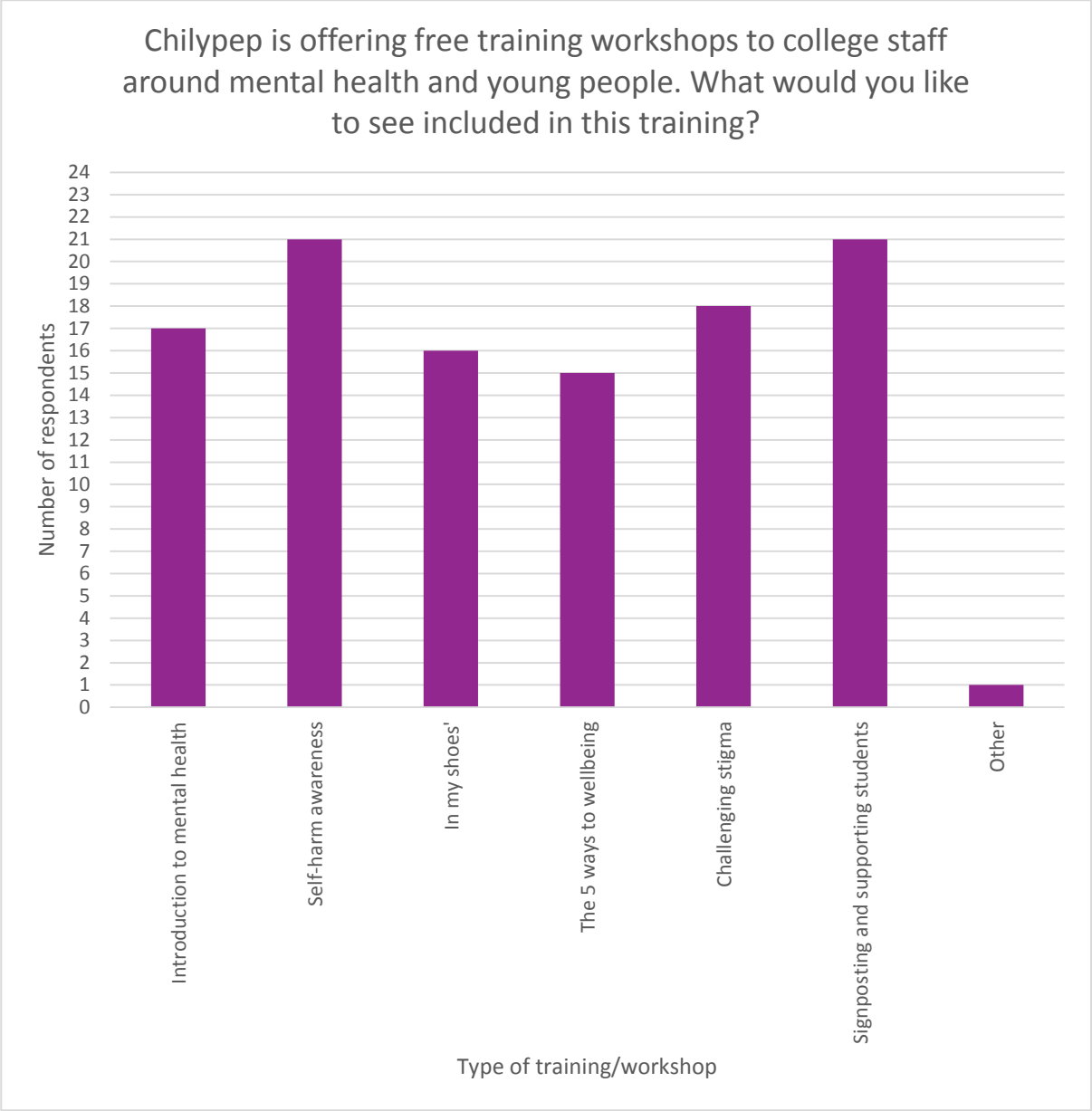
A wide range of answers were given:

- National Charities and NGOs **(Young Minds, MIND, the Samaritans)**
- Local organisations **(BSARCH)**
- The NHS **(GPs, CAHMS, IAPT services)**
- The Council **(Connect to Support Barnsley)**

Recommendation: It is recommended that there be an online resource area for staff with signposting information and services/ support they can access to be able to refer young people to. This could include national organisations and helplines, as well as a mapping of local support services.

TRAINING AND DEVELOPMENT

In order to find out whether staff were interested in receiving training and development from Chilypep around students' emotional wellbeing and mental health, and to shape what this might look like, we asked staff if they would be interested in receiving training and what they would like to be included in this.



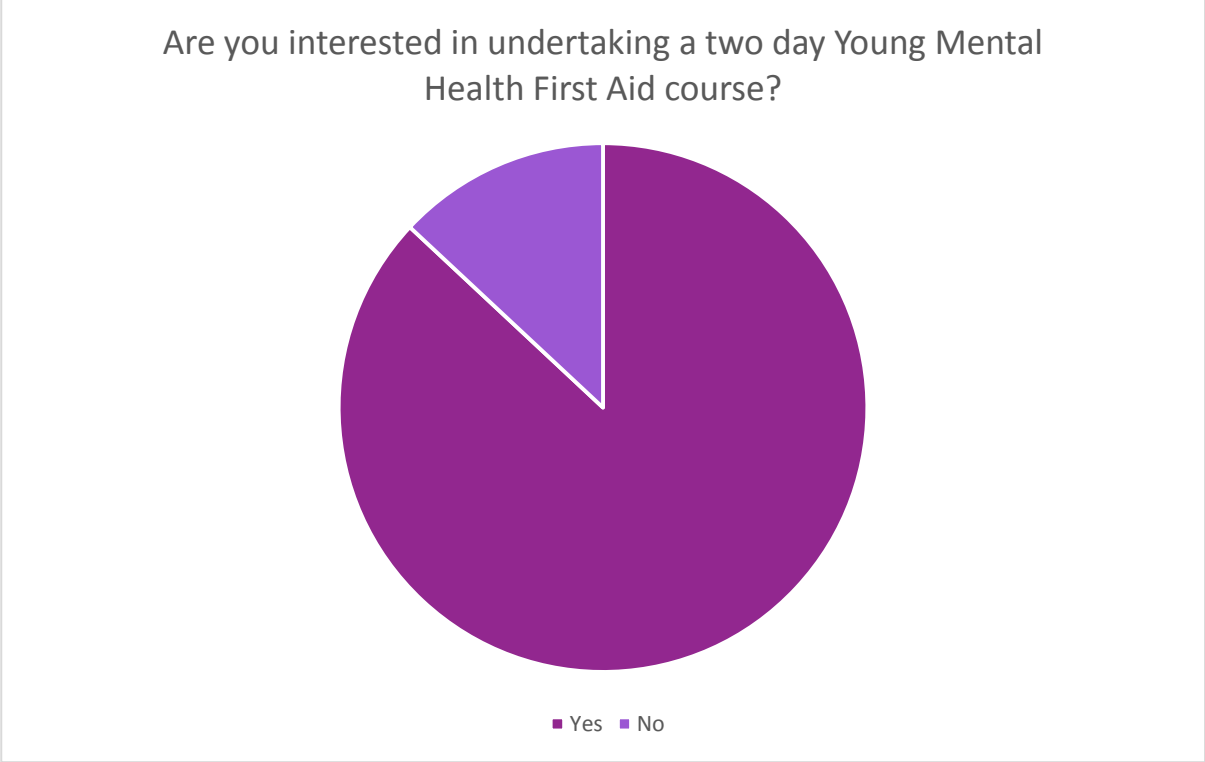
22 of the 39 respondents answered this question (56%), with all but one of the respondents indicated they would be interested in more than one type of training.

Self-harm Awareness and **Signposting and Supporting Students** were the most popular choices, closely followed by **Challenging Stigma, An Introduction to Mental Health, In My Shoes** and **The 5 Ways to Wellbeing**.

The respondent who indicated **Other** said: *"Eating disorders (this is a hugely common problem which is often a secret coping mechanism). I believe that it is often neglected because of this."*

YOUTH MENTAL HEALTH FIRST AID

As part of the training and development of staff Chilypep was keen to offer access to the 'Youth Mental Health First Aid' certificate. This is an internationally recognised certificate, equipping adults with the necessary knowledge and skills to support young people experiencing mental ill health. We therefore asked staff if they were interested in accessing this course.



23 respondents answered this question (59%), with the vast majority of respondents, 20, (87%) stating that they were interested in the training, and only 3 (13%) indicating that this was not something they were interested in doing.

Recommendation: From our consultation it was evident that there is a willingness and desire from staff to undergo further training and development in relation to supporting young people with their mental health. It is therefore recommended that such training be offered to staff on an ongoing basis so as to meet their identified development needs.

STAFF FEEDBACK ON TUTORIALS

Staff present at the tutorials Chilypep delivered to young people across college sites, cited the benefits to both themselves and young people of these sessions. Staff commonly stated that they themselves learnt a great deal during the sessions, and were often surprised at the level of engagement of students within the session.

Below is a sample of some of the feedback we received from staff:

> The sessions … sound really interesting and extremely useful for students

> The 'chilled out' and open environment makes [students] able to talk without fear of judgement.

> This is absolutely fabulous

> Outstanding, brave and inspirational presentations

> We will welcome you in from September if that is possible

> The workshop was very active and engaging and a positive response was given by learners

> Just. Wow. Thanks very much to all of you! Keep up the amazing work!

> All staff agreed that it would be of great benefit to have a programme that ran over a few weeks so that learners could engage as the topic has a high prevalence within our department

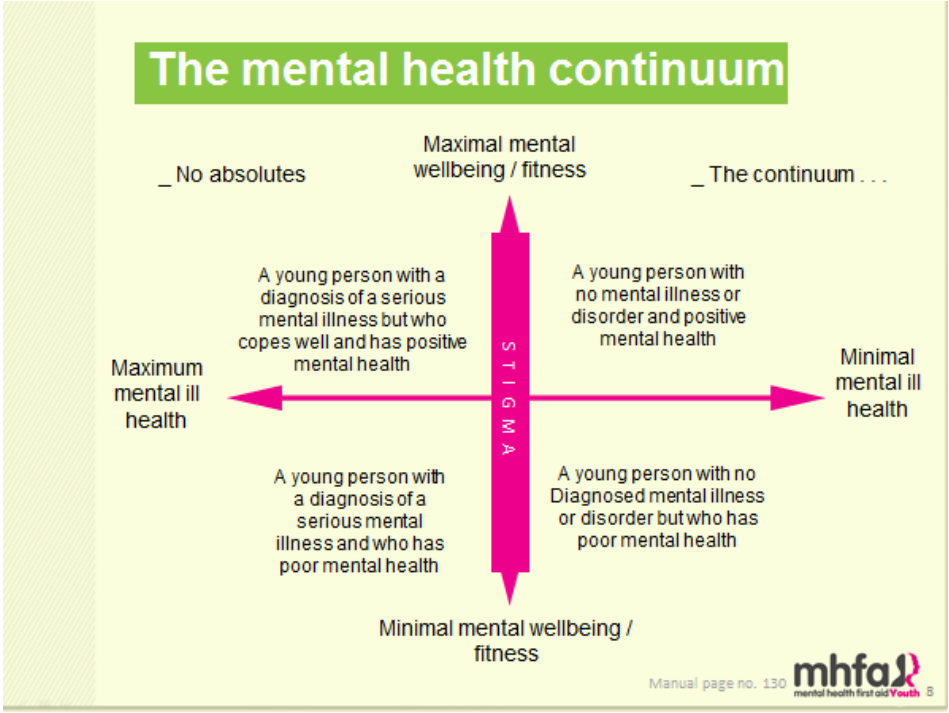
Based on the feedback from the staff survey, Chilypep designed and delivered a two hour workshop to 18 front facing college staff.

The workshop included:

- Introduction to mental health
- Signs & Symptoms of mental ill health
- Risk factors for mental ill health in students
- 'In My Shoes' workshop exercise
- Responding to, and signposting for, mental health

Much like our young people's training offer, the training workshops with staff involved interactive and engaging methods of delivery to ensure active learning and participation.

The session began by exploring 'what is mental health', using similar methods as were used with young people; this included a board blast around mental health vs physical health. As we found in tutorials with young people, 'mental health' was more commonly associated with negative words, and stigma, whereas 'physical health' brought up language such as 'exercise', and 'healthy eating'.



In order to look at the signs and symptoms of mental ill health, and risk factors for students staff were asked to design their own character, painting

a picture of what their world may look like. The case studies related to the four quadrants of Mental Health First Aid England's 'Mental Health Continuum'.

'In my shoes' is a workshop that was developed with STAMP to explore the experiences of young people in relation to mental health; the issues young people face, the systems they have to navigate, and the struggle to find support. This exercise involves a volunteer sitting in the middle of a circle, with their eyes closed, whilst those around them read out young people's stories. The idea is that the person in the middle takes on the stories as if they were their own, and feedbacks to the group how it felt to be that young person, highlighting key issues back to the group. This exercise has proven to be very successful, with participants able to 'step into the shoes' of young people and their lived experiences around mental health.

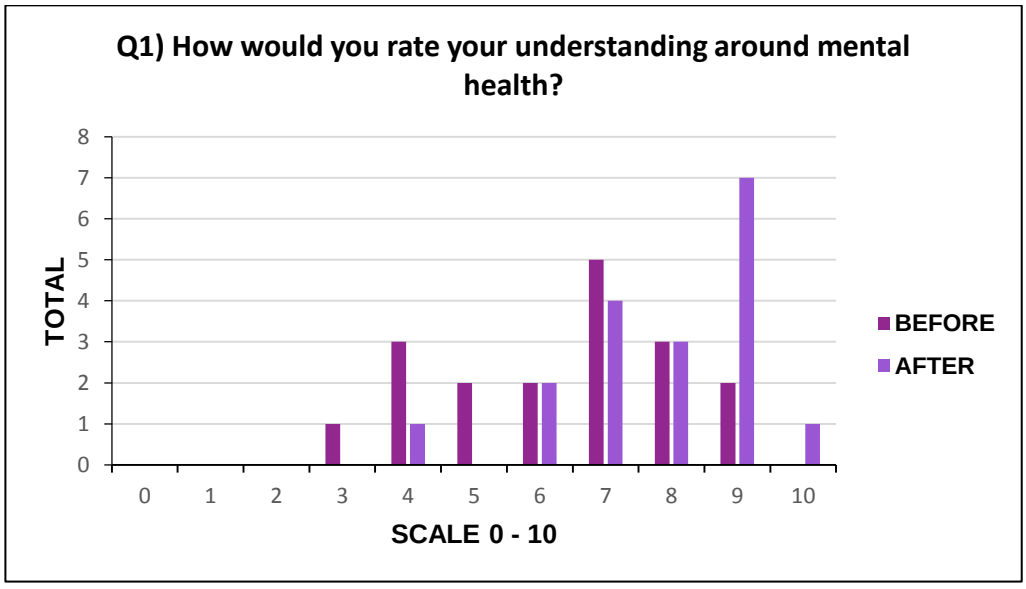
Through our initial research with staff, signposting information came out as an area for development, with staff wanting to receive more training around supporting and signposting young people to services, both within and outside of college. The final part of the workshop therefore focused on ALGEE, the five steps within Youth Mental Health First Aid, as well as a look at where staff could signpost young people to.

OUTCOMES OF THE WORKSHOP

Throughout the workshop staff remained engaged, taking part in all activities and asking questions and sharing their own experiences in relation to supporting students and young people.

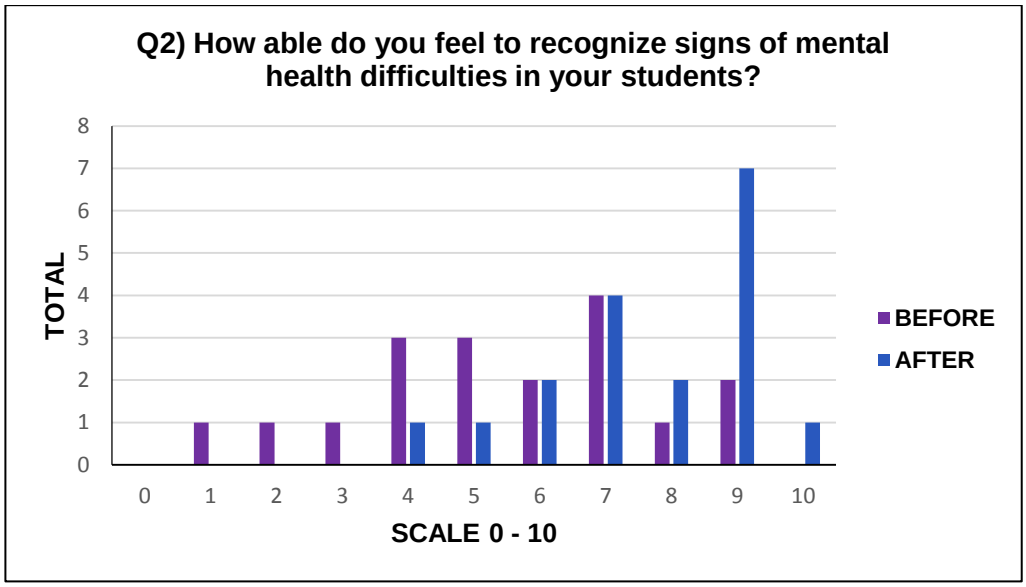
In order to evaluate the workshop we carried out a baseline assessment of staffs understanding around mental health, ability to recognise signs of mental health difficulties in students, and their confidence to talk to students around their mental health.

Increased confidence in understanding of mental health



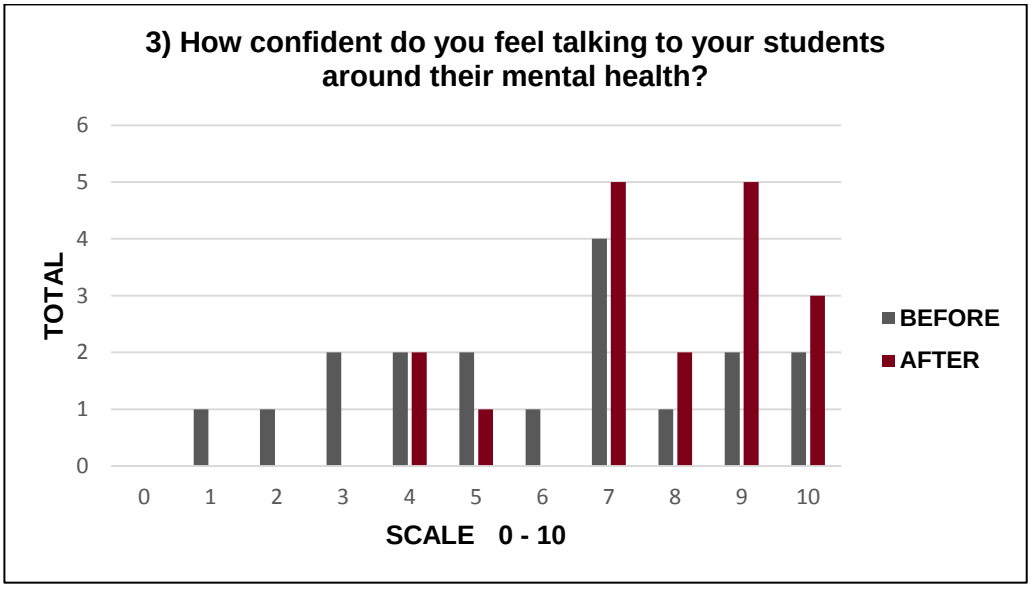
- 95% of participants reported an increased understanding around mental health following the workshop.
- 1 participant felt they had a decreased understanding following the workshop. They said that this was due to the fact that on delving into mental health in more detail they had realised that they did not know as much as they had first thought.

Increased ability to recognise signs of mental ill health in students



- 84% of participants reported that they felt more able to recognise signs of mental ill health in their students following participation in the workshop.
- 11% reported no change
- 5% reported a decrease in their ability to recognise signs of mental ill health in students.

Increased confidence to talk to students about their mental health



- 73% of participations said that they felt more confident following the workshop to be able to talk to students about their mental health.

- 17% felt less confident following the workshop around talking to students about their mental health. One participant commented that they felt there was a lot more to mental health than they had first considered, and this made them nervous in terms of being able to support students and talk to them about mental health.

What did you gain from the workshop?

It was good to have the whole team experience this training. I am a certified peer support trainer so this is great for others in our team.

A better understanding of supporting signs of mental health issues.

How to speak to students who are suffering from feeling down, for instance discuss ways to make them feel better.

In my shoes gave me a real insight.

How to positively help young people and recognising signs and how to help them and taking a more positive approach to helping.

Already had an understanding but helped reassure extra information.

More confident that I could recognise signs of mental health issues

I found it useful and would like to look into the mental health first aid more – thank you!

I feel able to recognise the signs of mental health difficulties now.

Gained more confidence in speaking to students about their mental health and reminder to think more about external/ home factors.

Confidence to talk to students about their mental health as they must need someone to talk to if the issue is raised.

Mental health issues should be dealt with seriously and professionally; in education we should be regularly kept in the know, alert and in line with other colleagues.

Could anything be improved?

Include case studies around adults

I enjoyed the activities so activities are good!

More visual aids

Longer workshop

More strategies on speaking to students about mental health

YOUTH MENTAL HEALTH FIRST AID TRAINING

12 members of staff from Barnsley College underwent the Youth Mental Health First Aid Training on 29th and 30th June.

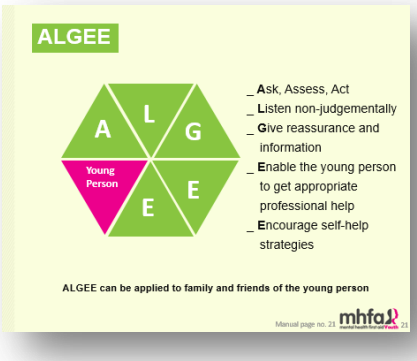
Youth Mental Health First Aid is an internationally recognised coursed designed specifically for those people who teach, work, live with or care for young people aged 8-18. The course is split into four sections:

1. **What is mental health?**
2. **Anxiety and depression**
3. **Suicide and psychosis**
4. **Self-harm and eating disorders**

Within each section, participants learn how to:

- Spot the signs of a mental health problem in young people
- Feel confident helping a young person experiencing a problem
- Provide help on a first aid basis
- Help protect a young person who might be at risk of harm
- Help prevent a mental illness from getting worse
- Help a young person recover faster
- Guide a young person towards the right support
- Reduce the stigma of mental health problems

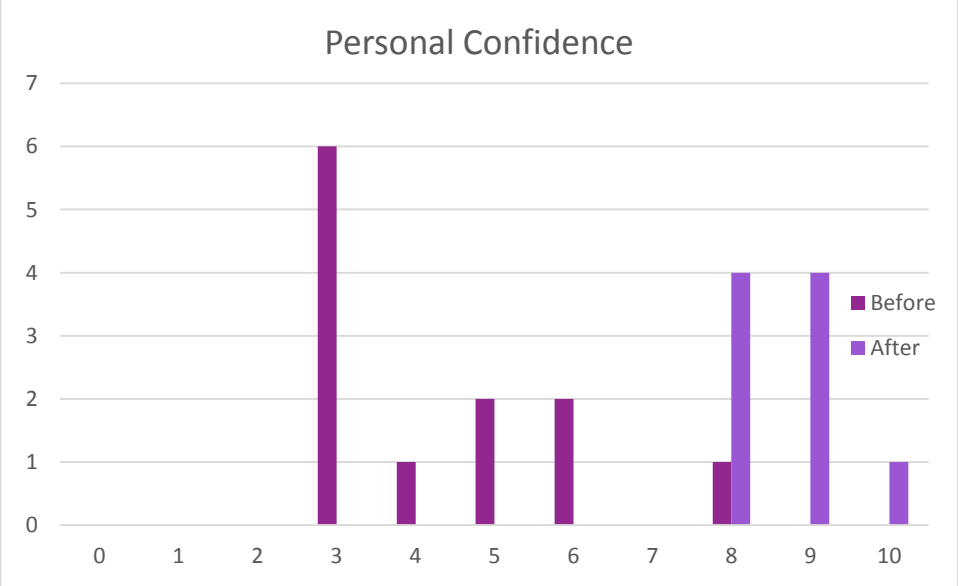
Youth Mental Health First Aid is different to a basic mental health awareness workshop, both in the depth it goes into, and the use of 'ALGEE', the steps to take in relation to mental health first aid.



The course is a two day certified course, giving participants the opportunity to really explore mental health and young people, and develop their knowledge around mental health, whilst also gaining practical skills to enable them to support young people.

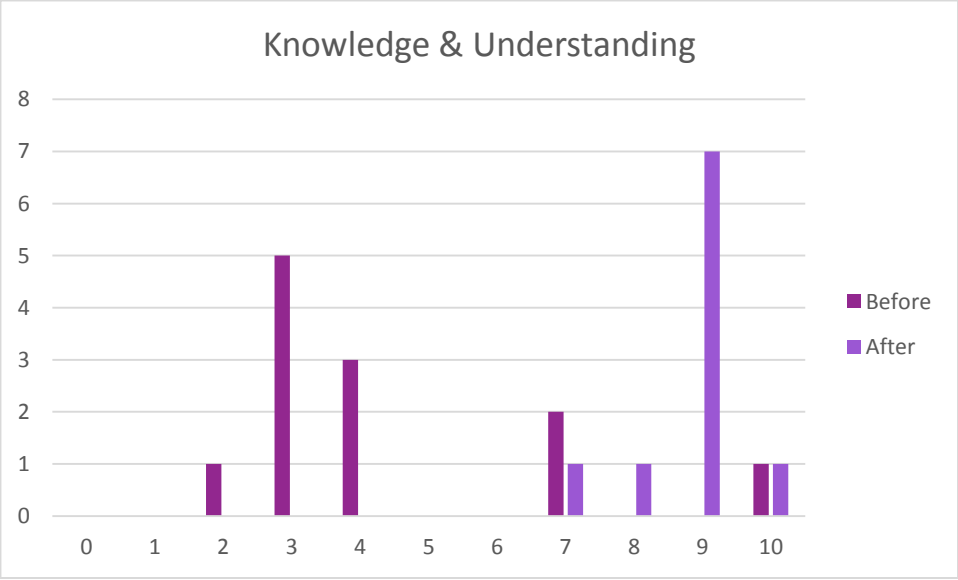
In order to evaluate the impact of the training on staff, we carried out a baseline questionnaire looking at staff's confidence in supporting young people with their mental health, their knowledge and understanding around mental health. The same information was then captured at the end of the two days. In addition to this we gathered information around course content, delivery methods, and materials. A more in-depth evaluation capturing this information can be found in the appendix.

CONFIDENCE TO SUPPORT YOUNG PEOPLE – BASELINE DATA



- 100% of participants reported an increase in their confidence to support young people around their mental health following the two day course.

KNOWLEDGE AND UNDERSTANDING – BASELINE DATA



- 100% of participants reported an increase in their knowledge and understanding around young people's mental health following the two day course.

HOW WOULD YOU RATE THE INSTRUCTORS?

100% of staff rated the instructors as ‘very good’:

“Both instructors were engaging, professional, listened and answered questions”.

“Very confident. Informative.”

“Excellent trainers. Knew slides inside out”.

“Good, informative, flowed well.”

FEEDBACK

“Really enjoyed the course. Lots of detailed information. Would recommend to other staff. Thanks”

“I put environment as I didn’t like the rooms very much. Loved the active listening and hearing voices exercises. This has been really worthwhile. I have learnt so much.”

“Both instructors were very helpful. I felt like I could ask them anything without being judged, no matter how silly some questions seemed. Knew everything what they was on about and overall very good training to do. I enjoyed it.”

“Both instructors provided specialist information in different areas. E.g. substance misuse/ mental health. Adapted to the needs of the group. Haribos were a winner ☺”

“Very informative. Delivered very well by evidently informative staff/ instructors.”

“The presentation allowed me to understand the definition and different ways of mental health.”

“Very interesting trainers and excellent trainers who clearly knew their subject”.

KEY LEARNING AND RECOMMENDATIONS

SUMMARY AND KEY LEARNING

The College staff were open to and supportive of the pilot and welcomed the project and staff. This helped greatly with getting the project going and developing it across all the sites. The project was highly visible and students and staff were aware of and engaged with it.

The Youth Work approach of the project was different to the day to day activity in the College, but worked really well and showed how informal methods of engagement and activity can complement a more formal structured learning environment. This was partly due to the shared ethos of the College and Chilypep, both organisations having the benefit and development of young people at their core.

Emotional Well Being Champions made a commitment to the project and most stayed throughout. They reported a significant improvement in their own understanding and well-being and want to carry the work on, having written a proposal of what they would like to do. They also engaged in other projects and activities outside college

The tutorials were a great success, and showed how even a short intervention can have a significant impact on students understanding and well-being. The interactive and participative methods used appealed to staff and students and engagement was high. They provided and opportunity for some young people to seek additional help and support, who said they would otherwise not have done so.

College staff gained confidence and greater awareness from the tutorials, workshop and Youth Mental Health First Aid training, and requested more training for more staff across the College.

Although much was achieved, the project would have achieved more if we had been able to start at the beginning of the College year.

It has been difficult to gain information on the effect of attainment and attendance as the College was winding down before we had completed the work and we didn't give enough notice as to when we would need the information, as we are not used to working to 'term time' timetables.

There was not sufficient time to embed the Peer Mentors into the college and at the point young people were ready to begin this role the college was winding down. A project such as this needs a minimum of 18 months, ideally 2 College Years, to train Peer Mentors, set up the systems for them to be able to operate, and train staff so that they can support them to carry on.

RECOMMENDATIONS: EDUCATION AND AWARENESS

1. **Embed an interactive and engaging educational offer that involves young people from the start**

All students need to be taught about the signs and symptoms of mental ill health to enable them to seek help early on. Building the emotional intelligence of young people at an early age will help young people to develop their own coping strategies and resilience, preventing them from becoming unwell when they notice their own wellbeing slipping. It is therefore recommended that schools and colleges embed mental health across the curriculum, ensuring that all students are able to have open discussions around mental health and emotional wellbeing.

Chilypep engaged 265 young people in college tutorials from November 2014-March 2015. Feedback from young people and tutors was that, due to the sessions being delivered in a creative and interactive way, students readily engaged within the topic areas. Young people and tutors highlighted the value of external speakers coming in to engage in this work. It is recommended that when designing a school or college educational offer around mental health and emotional wellbeing that this be designed in consultation with young people, involving them from the start in choosing which elements of mental health they would like to explore, and working with students to develop delivery methods for this that they will engage well with.

2. **Establish a safe and supportive environment where students can openly explore mental health and emotional wellbeing**

At the beginning of each session Chilypep staff and volunteers worked with young people to develop group agreements for the session in order to create a safe and supportive environment. Young people and college staff said that they valued having external workers come into the college to run sessions with them, and that the youth work style of delivery helped to make the sessions feel fun whilst also fostering an open space for discussion.

“I think that what you've been doing is just the right tone and is certainly helping students to identify areas within their own lives that might need addressing. The 'chilled out' and open environment makes them able to talk without fear of judgement. I also think that they are showing real acceptance of students with mental health issues. I don't know if you saw but a couple of student gave the student who had to leave a hug and some kind words when they passed him on the corridor....it actually made me fill up. You're doing really good work.” *Tutor, Barnsley College.*

3. **Encourage and enable peer to peer learning**

Chilypep trained some of our Emotional Wellbeing Champions in facilitation skills to enable them to co-deliver tutorial sessions across the college. This was a great confidence booster for the Emotional Wellbeing Champions and also encouraged peer to peer learning, something which young people have told us they value.

During one tutorial, one of the Emotional Wellbeing Champions, after showing ‘Stand Up Kid’ to the class, himself stood up and disclosed his own story around his mental ill health. This in turn encouraged students within the class to share their own experiences and helped to create a safe space for shared learning, whilst also breaking down some of the stigma associated with mental health.

4. **Work with young people to co-design services**

Barnsley College have their own student ‘wellbeing centre’ on site. The majority of young people we spoke to were aware of the centre, but numbers of young people accessing it were comparatively low. It is recommended that schools and colleges work with young people to co-design mental health and emotional wellbeing services within colleges so that they meet the needs of the young people who use them. More information and guidance around involving young people in mental health service design and commissioning can be found at www.chilypep.org.uk

RECOMMENDATIONS: PEER SUPPORT MODELS

1. **Involve young people from the start**

Peer support models in improving the emotional wellbeing of young people. By involving young people from the start in shaping what they wanted the peer support group to look like gave young people ownership over the project and enabled them to meaningfully influence the project design and delivery. Young people were able to name the group themselves, come up with their own project plans and training requirements, and steer the project from start to finish. This meant that it met their own needs, and was young person friendly and engaging to the wider college student population. It is recommended that this youth led model be used within all whole school and college approaches to mental health.

2. **Provide training to support young people’s involvement**

In order to meaningfully participate, young people require training and development as identified by them. It is recommended that workers support young people to come up with their own personal and professional development plans and design training in partnership with young people. The skills young people gain can in turn improve their own mental health and emotional wellbeing, as well as supporting them to achieve and aspire.

3. **Take the time for young people to learn about mental health and emotional wellbeing and develop their own resilience and coping strategies**

When working with young people with lived experiences of mental health it is vital to take time to enable young people to learn about mental health and develop their own resilience in relation to their own mental health and emotional wellbeing before they can go on to support their peers. This includes working with young people to explore common mental health issues young people and adolescents may face, and developing coping strategies and resilience building in relation to these.

4. **Be flexible and enable young people to steer their own project developments**

Meaningful youth-led participation projects naturally grow and develop as young people themselves grow in confidence and become engaged in project design and delivery. It is important to be flexible and enable and encourage young people to steer their own project developments. Within Barnsley College young people instigated additional activities relating to mental health promotion, such as running their own anti-stigma events, taking part in film-making projects to raise awareness about mental health, and engaging in mental health campaigns outside of the college setting. Being able to have a voice and influence within one's community is a protective factor for young people's mental health and should be supported and encouraged as part of any peer led project.

5. **Ensure there is sufficient capacity and resources in place to sustain young people's meaningful involvement**

Towards the end of the Barnsley College Pilot Chilypep worked with the Emotional Wellbeing Champions to develop future plans around their peer support project. This included training tutors in Youth Mental Health First Aid to enable them to 'buddy' the Emotional Wellbeing Champions and support them to further develop the peer support offer within college. However without a trained dedicated staff member to continue to meet with the group on a regular basis, offering them ongoing contact, support, training and advice, sustaining young people's meaningful involvement will be difficult. It is therefore recommended that when thinking about setting up a peer support project that there be sufficient capacity and resources committed for a sustained period to enable young people's meaningful and ongoing involvement.

RECOMMENDATIONS: STAFF TRAINING AND DEVELOPMENT

1. **Put in place an ongoing mental health and emotional wellbeing training offer to school and college staff**

Whilst the majority of staff indicated that they had a moderate to high understanding around mental health, just 52% of staff we consulted with felt able to recognise the signs of mental ill health within their students. In initial tutorial consultations with staff many stated that whilst they felt they had a basic understanding around mental health, they did not always feel confident working with students around mental health and could benefit from further training.

It is recommended that there be an ongoing training offer to staff across college sites in relation to mental health and emotional wellbeing. It is recommended that any training offer to staff within college be informed by staff and designed, and where possible delivered, by/with young people. The college may want to consider having mental health as a standing item on team meetings, and putting in place designated 'go to' staff acting as mental health champions within their teams.

2. **Enable effective information and signposting for young people**

Our research showed us that young people often do not know where to go for support around their mental health. Staff who completed our research were aware of services in college but knowledge of support outside of the college environment was more limited. It is important to be able to give young people effective information and signposting following tutorial to enable them to access support as required. Teachers and tutors should be trained around signposting and support available to young people to enable effective signposting to take place. It is recommended that there be an online resource area for staff with signposting information and services/ support they can access to be able to refer young people to. This could include national organisations and helplines, as well as a mapping of local support services.

Future work could include working with the Emotional Wellbeing Champions to carry out a mapping of support and services in the local area. They could then develop a 'where to go' information leaflet or online forum that students could access to find help and support.

3. Involve young people in the recruitment and training of staff

Previous research undertaken by Chilypep has revealed the importance of relationships within mental health support, and college environments. Young people want to seek support from teachers or other professionals that they feel understand them and from those who have a genuine interest in supporting them. It is recommended that young people be involved in the recruitment and training of staff.

4. Encourage joined up working

Some young people said they would not feel comfortable talking to a member of staff around their mental health, but would prefer to seek support outside of the college environment. It is therefore recommended that schools and colleges collaborate with external organisations and agencies to build on their emotional wellbeing support offer and to give young people a choice about the sort of support they may want to access.

RESOURCE BANK

Mental Health Apps & Websites for young people

Innovation Labs: http://www.innovationlabs.org.uk/

A site with useful apps and sites designed with/by young people around mental health. Including:

Doc Ready – help and support preparing for a GP visit

Find Get Give – signposting website

Madly in Love – Platform for young people around relationships

Mood bug – mood app

Well informed – for professionals working with YP around MH

In Hand – recovery app

Head Meds – Information about medication for YP

NHS Choices: Health Apps library http://apps.nhs.uk/

Epic Friends: http://epicfriends.co.uk/ - site for young people with lots of information about MH and how to support their friends

Feeling H-Appy? A young person from STAMP (Chilypep participation group) review of mental health apps: https://stampsheffield.wordpress.com/2012/11/07/feeling-h-appy/

Action for Happiness: http://www.actionforhappiness.org/

NORMEN – Self Harm Conference Downloads: Loads of really useful resources for working with self- harm http://www.asknormen.co.uk/self-harm-and-suicidal-ideation-conference-resources/

Films & Talks

'On the Edge': A film made by young people from STAMP (Chilypep mental health participation group) detailing their experiences of Mental health crisis and crisis care services https://www.youtube.com/watch?v=px5boQGN66I

Young Carers Need Care Too: A film made by young people from VOYCE PG (Views of Young Carers Explained) in partnership with Fixers UK, highlighting the issues affecting young carers https://www.youtube.com/watch?v=_5pfgvFGSi4

Move Forward with Mental Health: A film made by young people from STAMP in partnership with Fixers UK, highlighting young people's experiences around mental health and the need to 'Move Forward' with mental health https://www.youtube.com/watch?v=k5o5ei_FxFA

The Voices in my head: Eleanor Longden's TED Talk on her experiences of living with voices https://www.youtube.com/watch?v=syjEN3peCJw

Stand Up Kid: https://www.youtube.com/watch?v=SE5Ip60_HJk

Mindreel | Mental health film resource: Mindreel is an initiative to create a valuable learning resource using educational films that about mental health.
mindreel.org.uk/

Useful sites for further information & reports

http://www.right-here.org.uk/resource-centre/

http://www.youngminds.org.uk/

http://www.mentalhealth.org.uk/

http://ww.chilypep.org.uk/

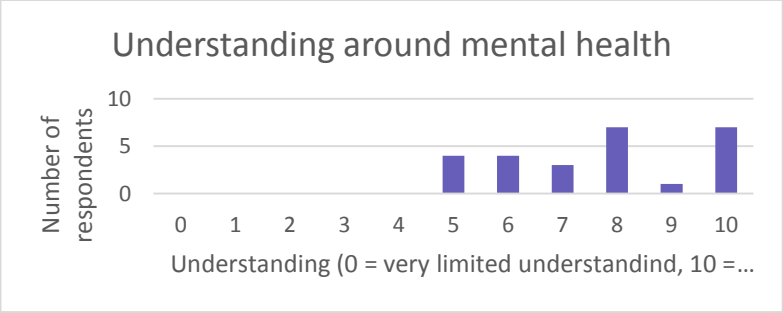
APPENDIX

YOUNG PEOPLE'S FEEDBACK

26 college students completed a questionnaire on emotional wellbeing and mental health. They were asked nine questions, both closed and open-ended, in relation to their knowledge and understanding around mental health, the services available to them at college, and their key areas of interest in relation to mental health.

QUESTION 1

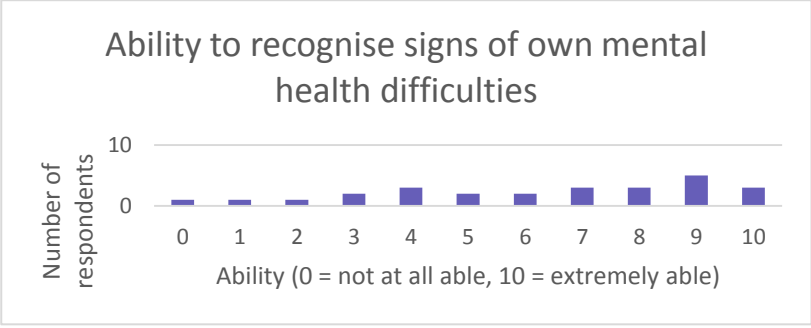
On a scale of 0-10 how would you rate your understanding around mental health? (0 = very limited understanding, 10 = very comprehensive understanding)



- All 26 respondents answered this question
- 100% of respondents indicated at least an average understanding around mental health (indicating 5 or more)
- 15 respondents (58%) indicated a very comprehensive understanding around mental health, answering 8, 9 or 10

QUESTION 2

On a scale of 0-10 how able do you feel you can recognise signs of your own mental health difficulties? (0 = very limited ability, 10 = very comprehensive ability)

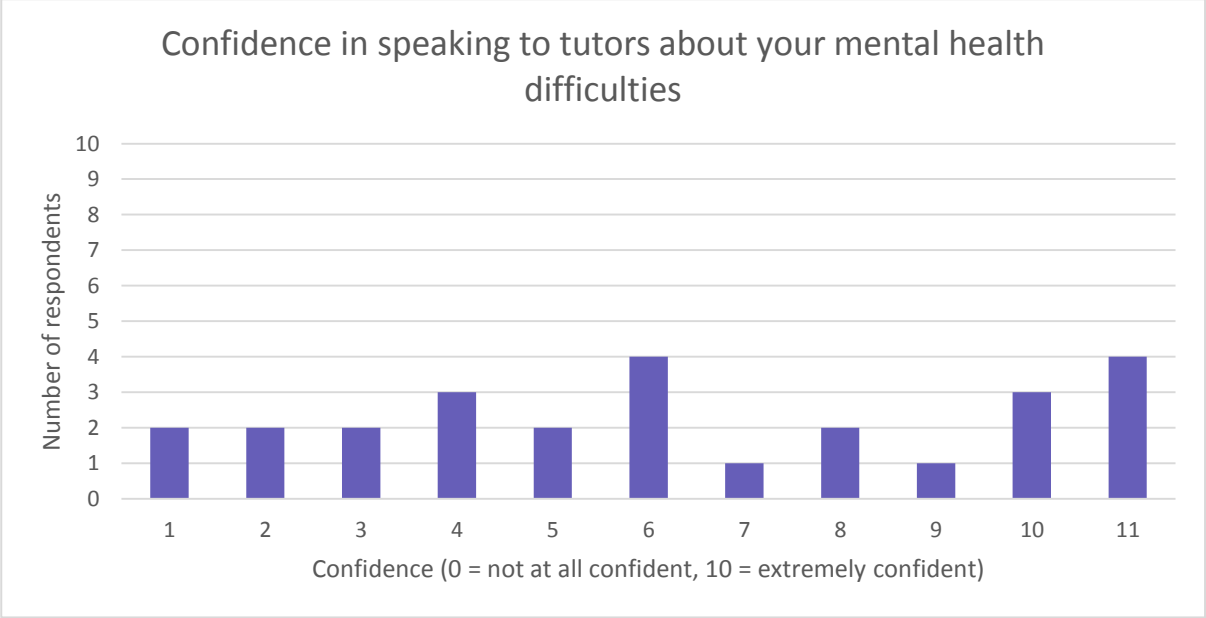


- All 26 respondents answered this question
- The responses to this question were varied, with each number being indicated at least once. This indicates that there was a broad range of ability to recognise signs of own mental health difficulties amongst respondents

- However, the majority of respondents, 18, (69%) indicated they had an above average ability to recognise their own mental health difficulties by answering 5 or more

QUESTION 3

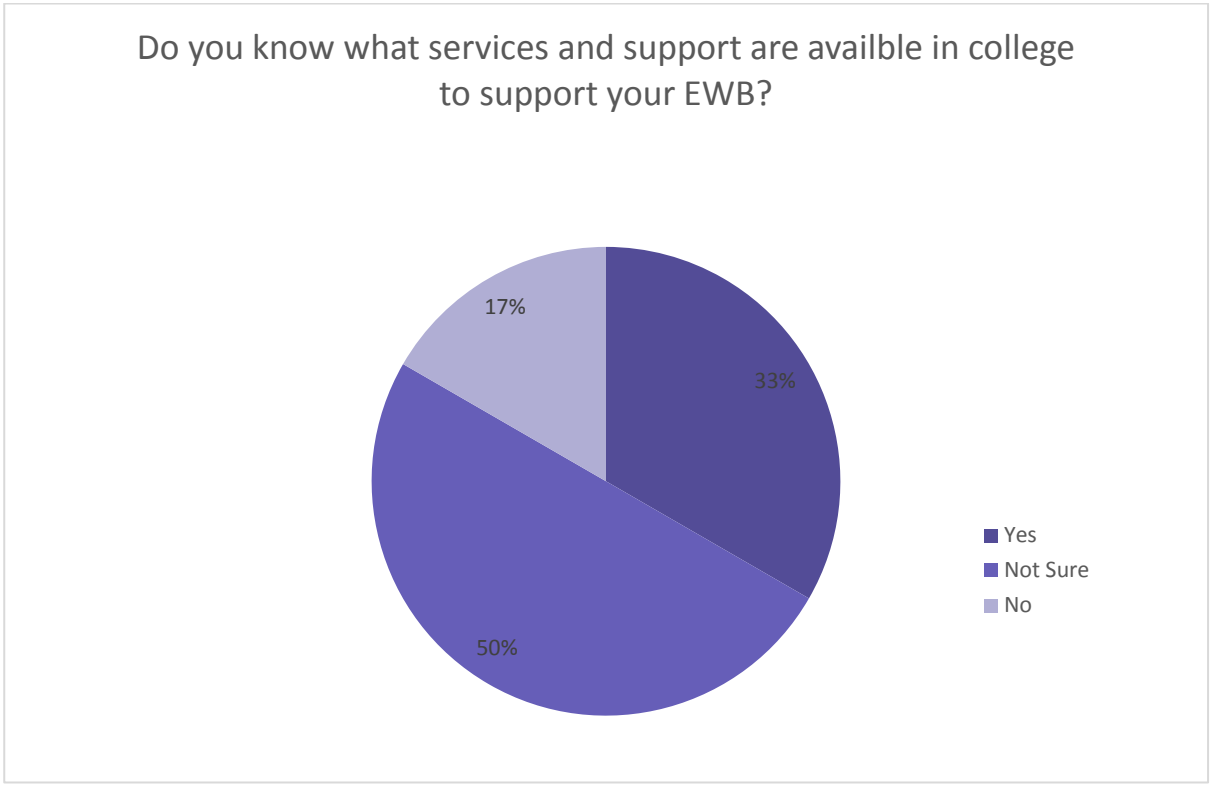
On a scale of 0-10 how confident do you feel talking to your tutors around your mental health? (0 = not at all confident, 10 = very confident)



- All 26 respondents answered this question
- There was a broad range of respondent's confidence in talking to tutors about mental health, with each number being indicated at least once.
- The greatest percentages of respondents (15%) were either: neither confident nor unconfident in talking to their tutors about their mental health (indicating 5); or were very confident in talking to tutors (indicating 10).
- 39% of respondents had a less than average confidence in talking to their tutors about their mental health (indicating 0-4)
- 42% of respondents had a greater than average confidence in talking to their tutors about their mental health (indicating 6-10)

QUESTION 4

Do you know what services and support is available to you in college to support your EWB?



- 25 of the 26 respondents answered this question
- Half of the respondents (50%) were unsure what support is available in college to support their emotional wellbeing
- 33% of the respondents were aware of what mental health services/support is available in college, whilst 17% of the respondents indicated that they were unaware.

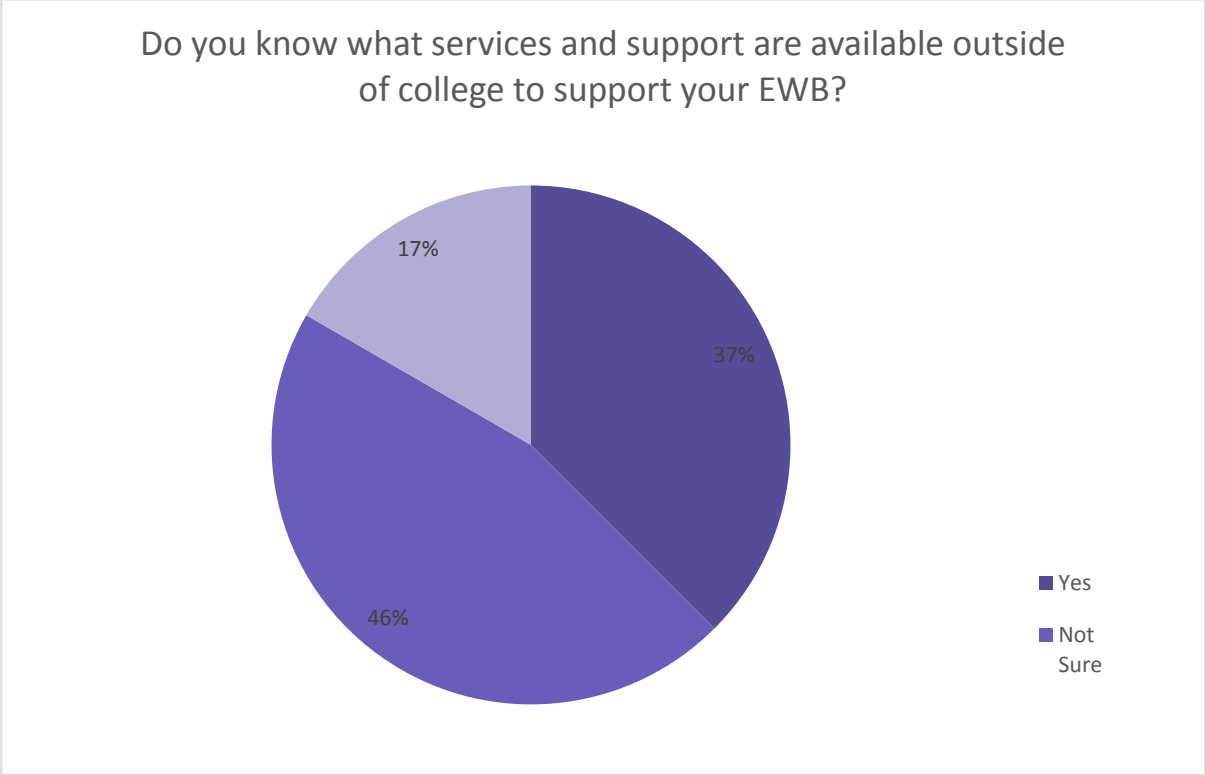
QUESTION 5

If yes, what services and support are available?

- Health and wellbeing
- Support, health and wellbeing
- Health and wellbeing in main college
- They have got a health and wellbeing centre
- Tutor, wellbeing
- Talking to a counsellor
- Personal tutors

QUESTION 6

Do you know what services and support are on offer to you outside of college to support your EWB?



- 24 of the 26 respondents answered this question
- Over half of the respondents (63%) were either unsure (46%) or totally unaware (17%) of what support and serves were available to them outside of college
- Respondents were more aware of mental health and wellbeing services and support available to them outside of college (37%) than services and support provided to them within college (33%)

QUESTION 7

If yes, what services and support are available?

- Your GP and counselling sessions
- Counselling, friends and family
- CAMHS, your GP, doctors
- You can talk to your doctor and counsellor
- Mental health phone lines, support worker
- Suicide hotline, friends

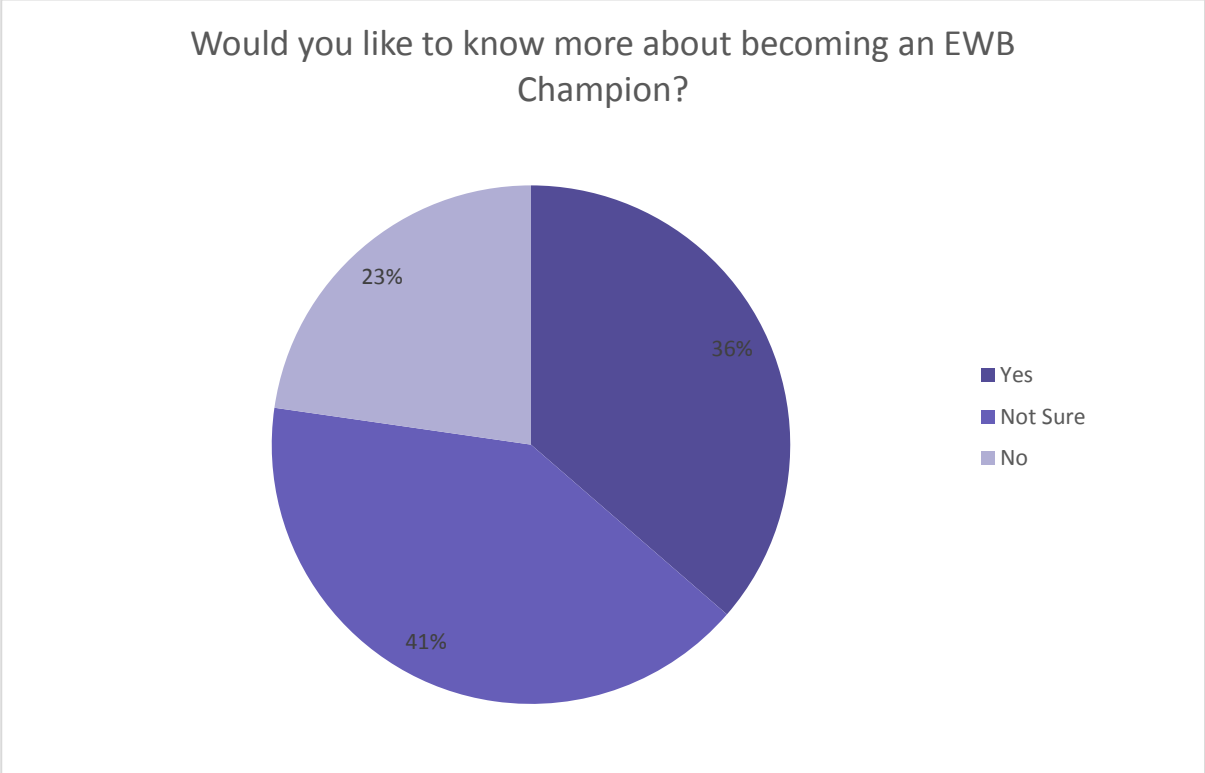
QUESTION 8

Chilypep is offering free training, workshops, residential, aiming at promoting an anti-stigma campaign in college. Also to train young people to be peer educators around mental health. Would you be interested in the below? (tick all relevant)

- 21 of the 26 respondents answered this question
- Respondents were allowed to tick all relevant answers and as such there were 61 responses
- 18 of the 21 respondents to this question indicated more than one type of training that they would be interested in
- The most popular training indicated was an ‘Introduction to Mental Health’, indicated by over a quarter (26%) of respondents
- This was followed by the ‘In My Shoes’ training (18%), The 5 Ways to Wellbeing (16%) and training to become an EWB Champion within college (15%)
- The less popular training opportunities indicated were Self-harm Awareness (13%) and Challenging Stigma (11%). No respondent indicated ‘Other’ (0%)

QUESTION 9

Would you like to know more about becoming an EWB champion for your college?



- 22 of the 26 respondents answered this question
- 36% of respondents indicated they would like to know more about becoming an EWB Champion
- 41% (the largest percentage) of respondents indicated that they were unsure whether they wanted to learn more about becoming an EWB Champion
- 23% of respondents indicated that they did not want to learn more about becoming an EWB Champion

TO BE ENTERED INTO A FREE PRIZE DRAW TO WIN £100 PLEASE TELL US BELOW WHAT YOU WOULD SPEND THIS ON TO IMPROVE YOUR EMOTIONAL WELLBEING

- Things that would make me happy & confident & help me through things
- By putting support groups out there
- I lost my sister in a car crash and there is too many memories in the village so it would be nice to have a weekend break
- Cigs
- By putting support groups out there
- I would spend the £100 on things that would keep my mind occupied buy games for my xbox and clothing, also take my mum out for a meal
- I would give it to charity to help the people who do need it
- I would buy a gym membership and get myself out there. Also I would go to such things like coffee mornings to socialise with others
- I would spend it on a day out with as many people as I can get doing something everyone wants to do (or more than one day out)
- Maybe a short time away to get away from your stress and problems. Going away with a friend where you can have the perfect opportunity to talk about your

problems and ways that you can de-stress with whenever you need to. Find out where you can go for the help

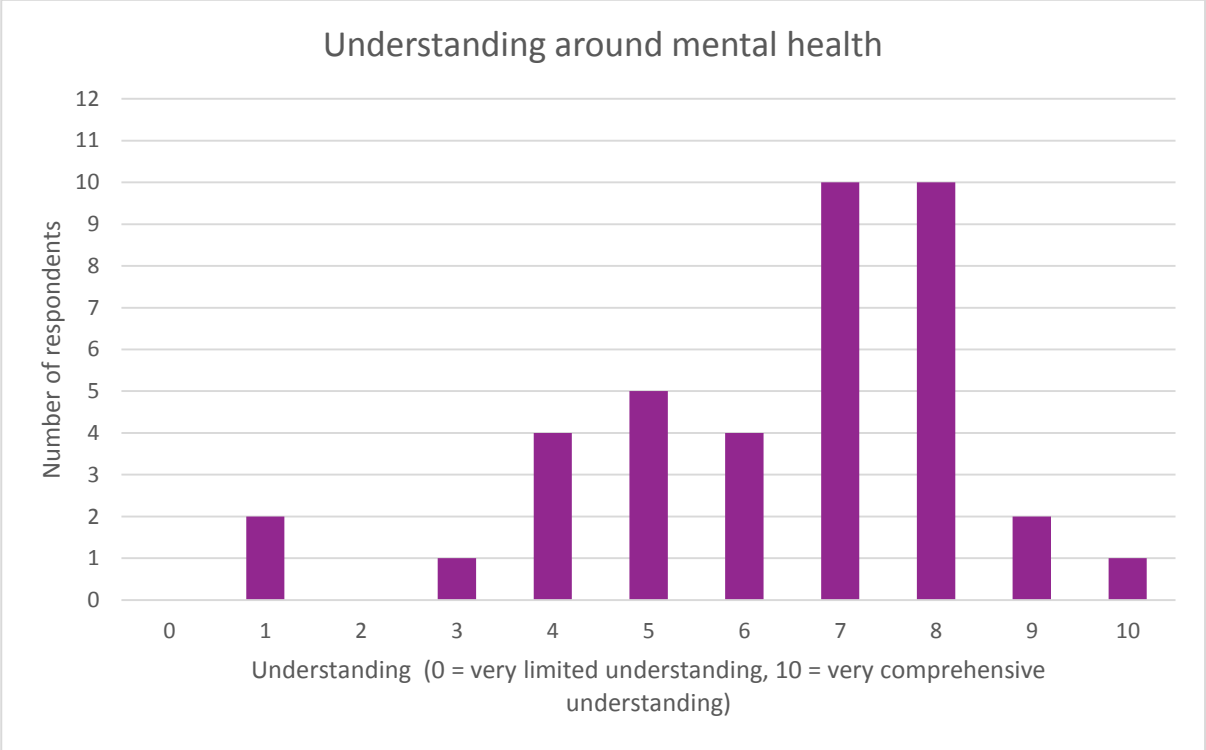
- Gym membership, de-stressing activities
- Buy rugby gear and plan a trip to another country to clear the mind and help the mental aspects
- Learn to drive so maybe I could get a job
- I would buy more fruit and get a gym membership
- I would spend the money on me and my mum to go to a hotel for a night to relax
- A day out with my mum
- Take my family out for a meal somewhere nice maybe go to the cinema as well
- Running shoes, and gym membership
- Buy a Bob Marley album and book a trip out to somewhere like Flamingo Land
- I would save the money because money makes me happy, whenever I have spare money I am much happier

STAFF FEEDBACK

39 members of staff completed a Survey Monkey questionnaire on the mental health and emotional wellbeing of their students. They were asked nine questions, which were both closed and open-ended. They were also asked to give written feedback about the sessions and tutorials given to students by CHILYPEP. 12 staff members also undertook Youth Mental Health First Aid Training, and their feedback from this can be found below.

QUESTION 1

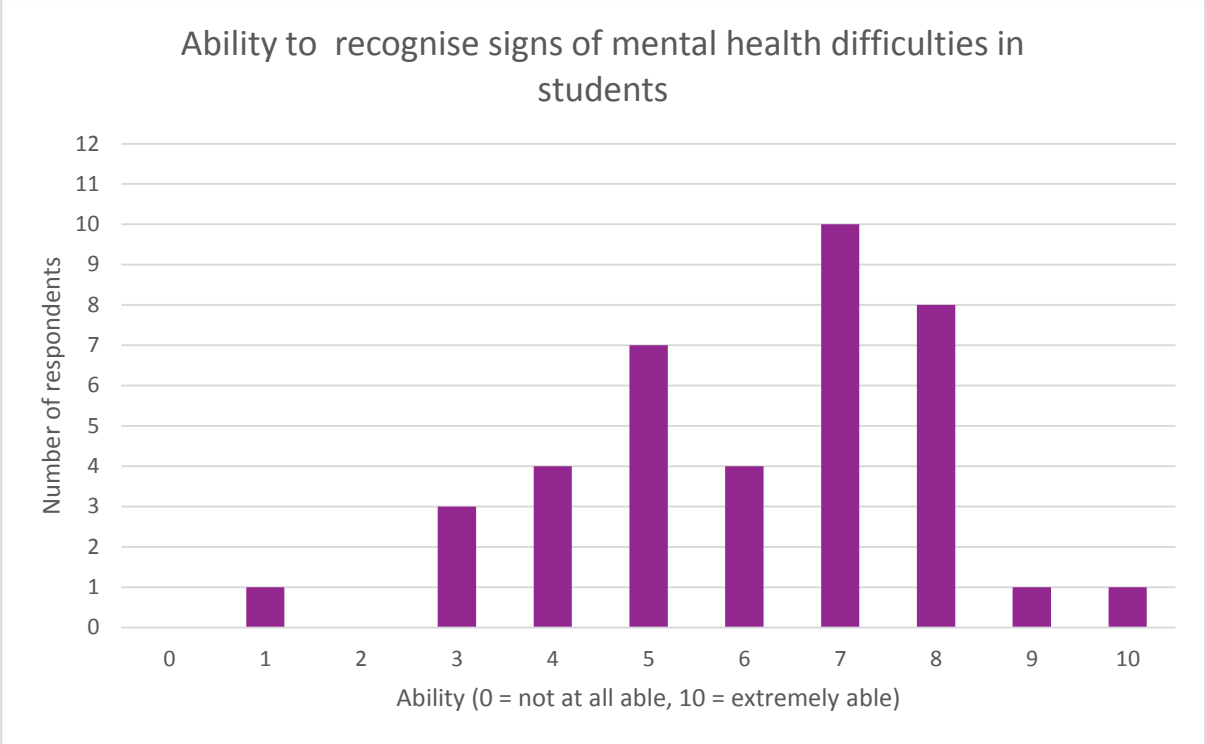
On a scale of 0-10 how would you rate your understanding around mental health? (0 = very limited understanding, 10 = very comprehensive understanding)



- All 39 respondents answered this question
- The understanding around mental health varied, with at least one respondent indicating all but two of the options
- 3 respondents (8%) indicated a limited understanding, and 13 respondents (33%) indicated an average understanding.
- The majority of respondents, 23, (59%) indicated a comprehensive or very comprehensive understanding around mental health

QUESTION 2

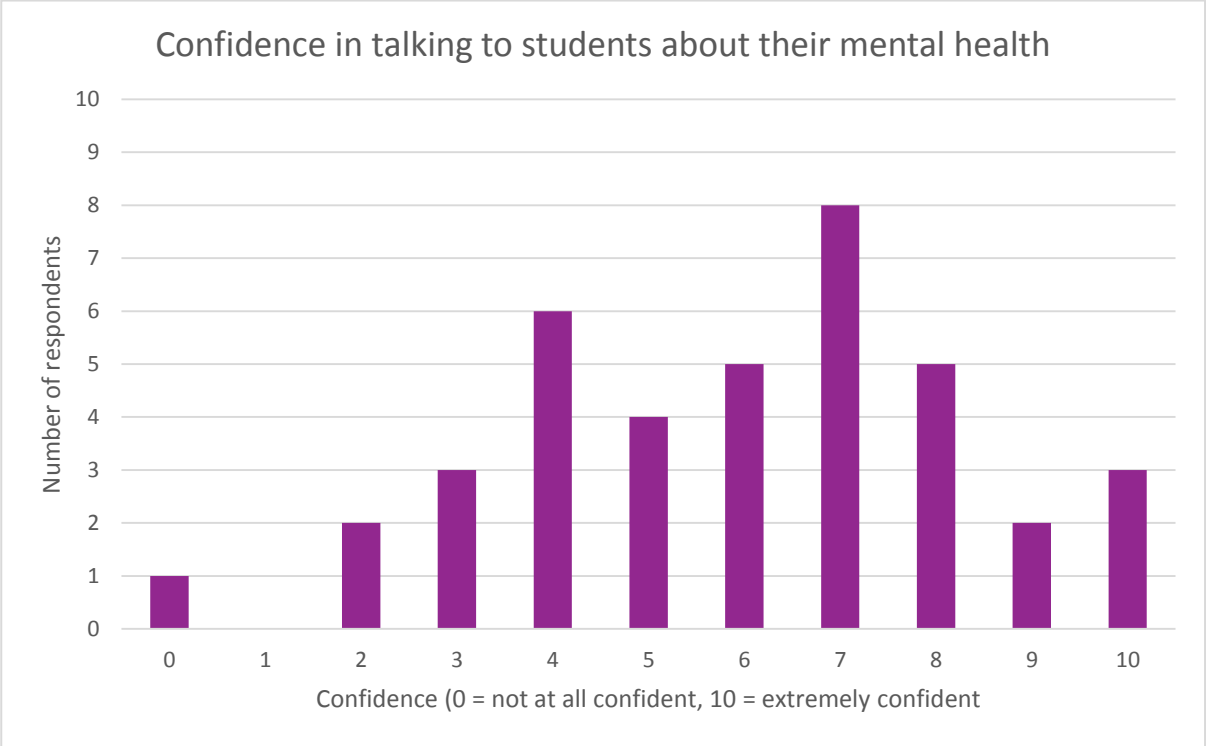
On a scale of 0-10 how able do you feel you can recognise signs of mental health difficulties in your students? (0 = not at all able, 10 = extremely able)



- All 39 respondents answered this question
- The ability to recognise signs of mental health difficulties in students varied with at least one respondent indicating all but two of the options
- 4 respondents (10%) indicated they did not feel able to recognise signs of mental health difficulties in their students
- 15 respondents (38%) indicated they felt somewhat able to recognise signs of mental health difficulties in their students
- The majority of respondents, 20, (52%) indicted they felt able to recognise signs of mental health difficulties in their students. However, of these only 2 respondents (5%) indicated they felt extremely able to do so

QUESTION 3

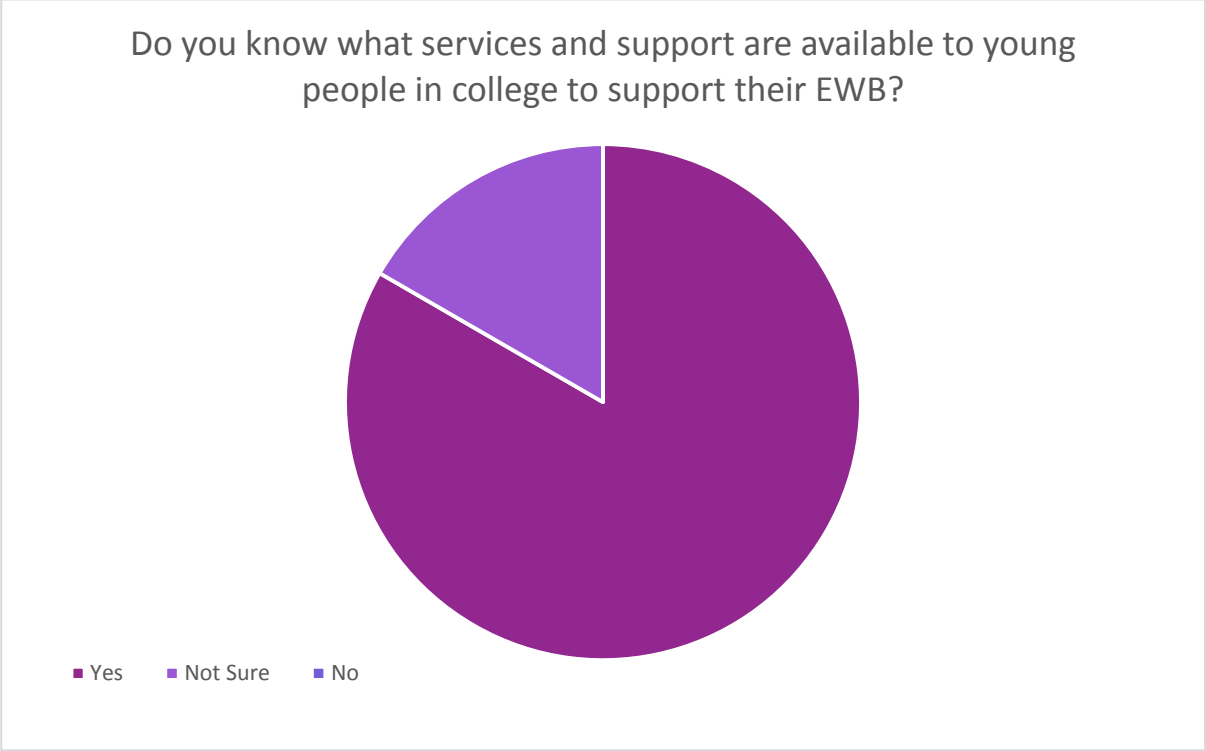
On a scale of 0-10 how confident do you feel talking to your students about their mental health? (0 = not at all confident, 10 = very confident)



- All 39 respondents answered this question
- The confidence staff had on talking to students about their mental health varied, with at least one respondent indicating all but one of the options. There was no clear majority response to this question
- 6 respondents (15%) indicated they had little confidence in talking to their students about mental health, with 1 respondent (3%) indicating they had no confidence in doing so
- 15 respondents (39%) indicated they were somewhat confident in talking to their students about mental health
- 18 respondents (46%) indicated they were confident talking to their students about mental health, with 3 respondents (8%) indicating they were extremely confident

QUESTION 4

*Do you know what services and support is available to young people **in** college to support their Mental Health and Emotional Wellbeing?*



- Only 24 of the 39 respondents answered this question (62%)
- 0% of respondents indicated they did not know what services were available to young people, and only 4 respondents (17%) were unsure
- The vast majority of respondents, 20, (83%) indicated that they did know what services and support is available to young people in college to support their Emotional Wellbeing

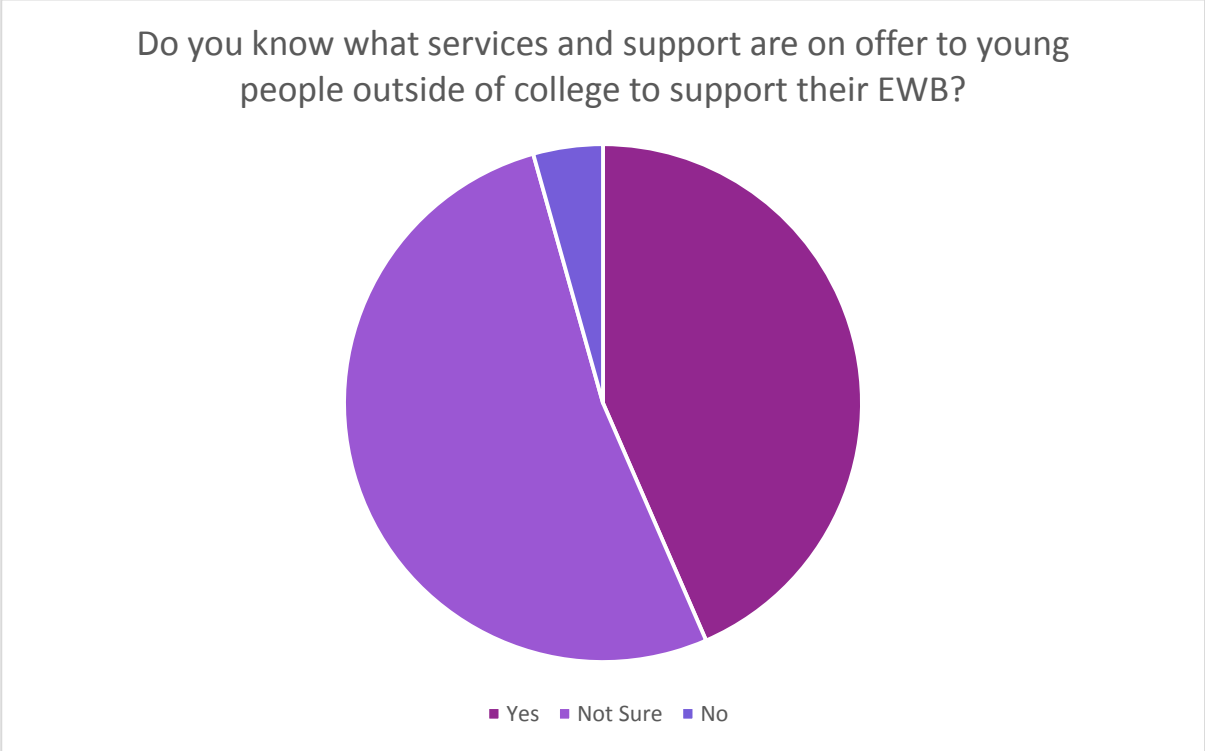
QUESTION 5

If yes, what services and support are available?

- 18 respondents answered this question
- The most common answers given were: **The Health and Wellbeing Centre, The College Counselling Service,** and **Student Services**
- 2 respondents also mentioned the **IAPT Service** within college

QUESTION 6

*Do you know what services and support are on offer to young people **outside** of college to support their EWB?*



- Only 23 of the 39 respondents answered this question (59%)
- Only 1 respondent (4%) indicated they did not know what services were available to young people outside of college, however 12 respondents (52%) indicated that they were unsure about what services were available
- 10 respondents (44%) indicated that they knew what services were available to young people outside of college

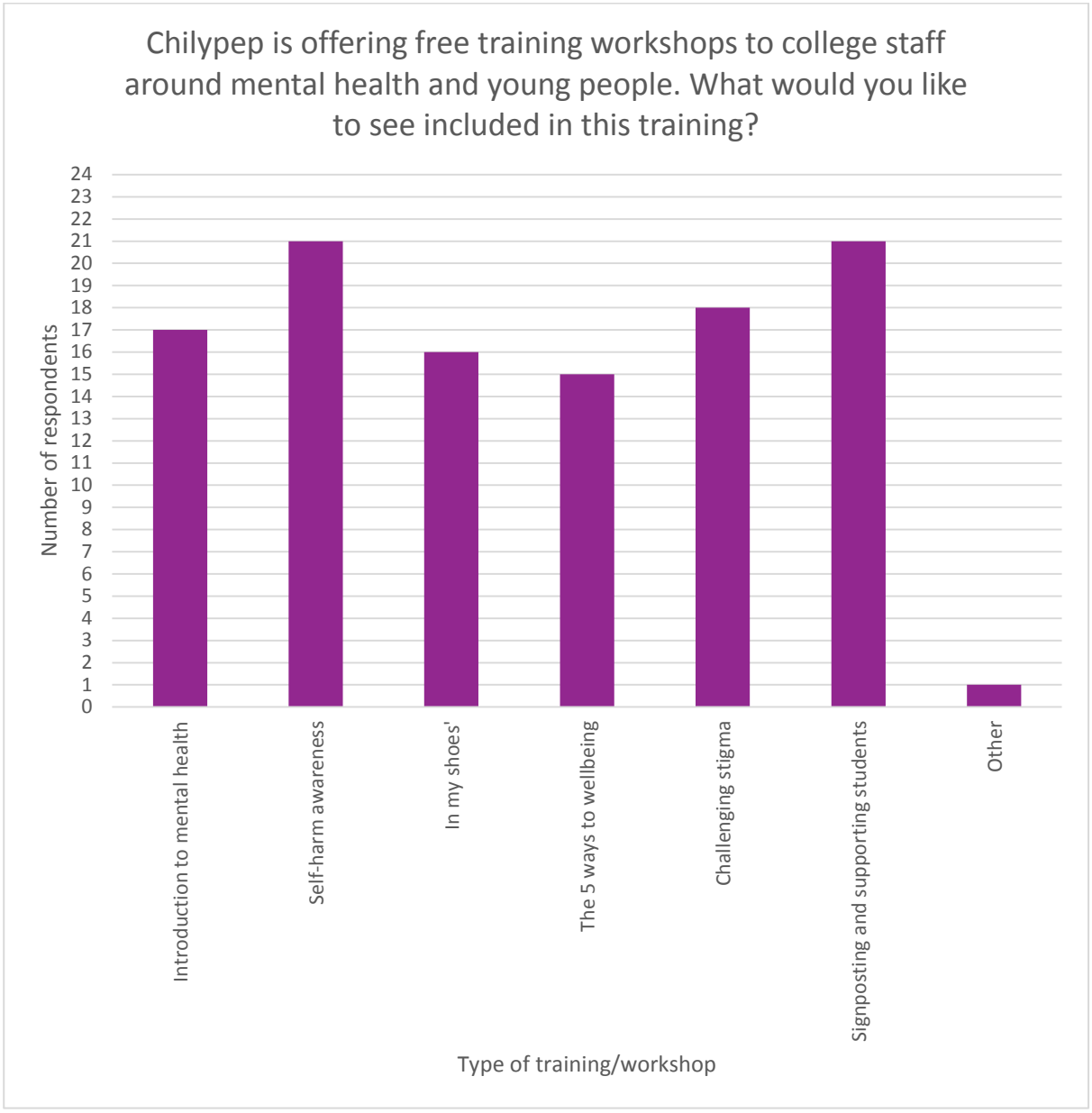
QUESTION 7

If yes, what services and support are available?

- All 10 respondents who indicated 'Yes' to question 6 answered this question
- A wide range of answers were given:
    - National Charities and NGOs **(Young Minds, MIND, the Samaritans)**
    - Local organisations **(BSARCH)**
    - The NHS **(GPs, CAHMS, IAPT services)**
    - The Council **(Connect to Support Barnsley)**

QUESTION 8

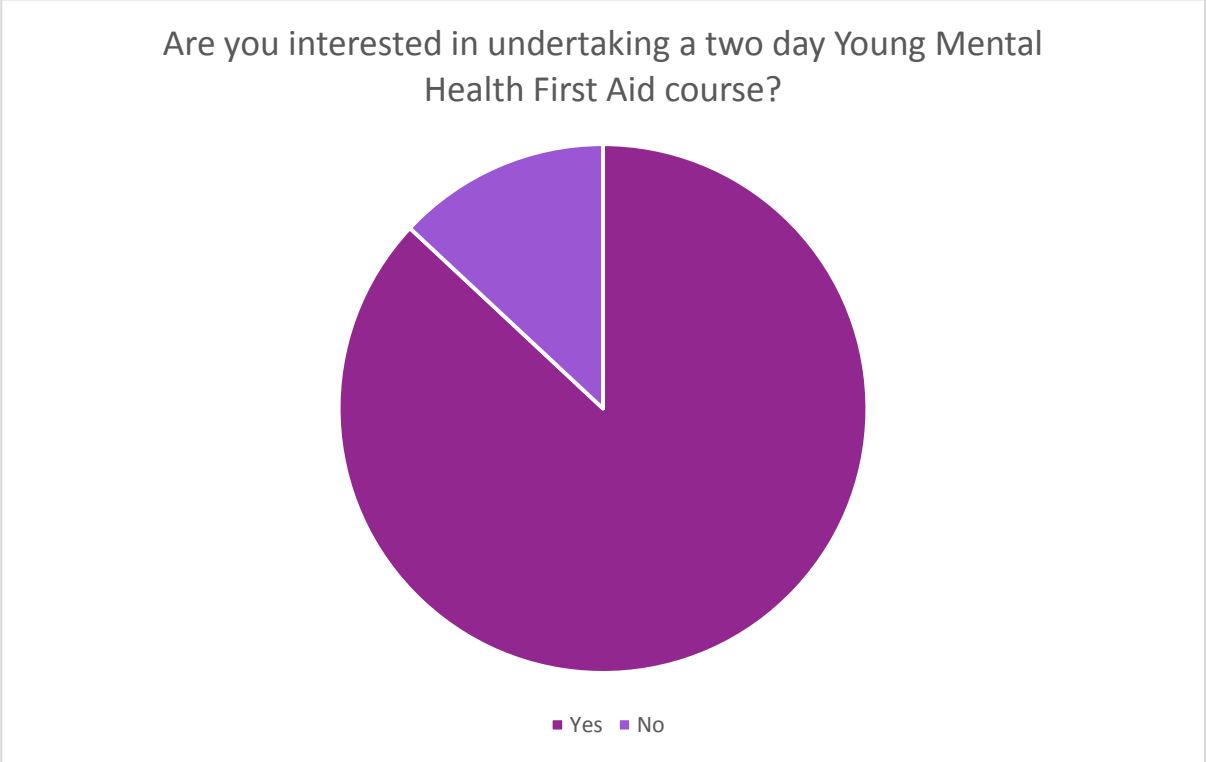
CHILYPEP is offering free training workshops to college staff around mental health and young people. What would you like to see included in this training? (Tick all relevant)



- 22 of the 39 respondents answered this question (56%)
- All but one of the respondents indicated they would be interested in more than one type of training
- **Self-harm Awareness** and **Signposting and Supporting Students** were the most popular choices, closely followed by **Challenging Stigma, An Introduction to Mental Health, In My Shoes** and **The 5 Ways to Wellbeing**.
- The respondent who indicated **Other** said: *"Eating disorders (this is a hugely common problem which is often a secret coping mechanism). I believe that it is often neglected because of this."*

QUESTION 9

Would you be interested in receiving the 2 day certified course, Youth Mental Health First Aid training, from CHILYPEP?



- 23 respondents answered this question (59%)
- The vast majority of respondents, 20, (87%) indicated that they were interested in the training, with only 3 (13%) indicating that this was not something they were interested in doing.

FEEDBACK FROM YMHFA TRAINING, 29TH-30TH JUNE

12 members of staff from Barnsley College underwent the Youth Mental Health First Aid Training on 29th and 30th June. Youth Mental Health First Aid is an internationally recognised coursed designed specifically for those people who teach, work, live with or care for young people aged 8-18. The course is split into four sections:

5. What is mental health?
6. Anxiety and depression
7. Suicide and psychosis
8. Self-harm and eating disorders

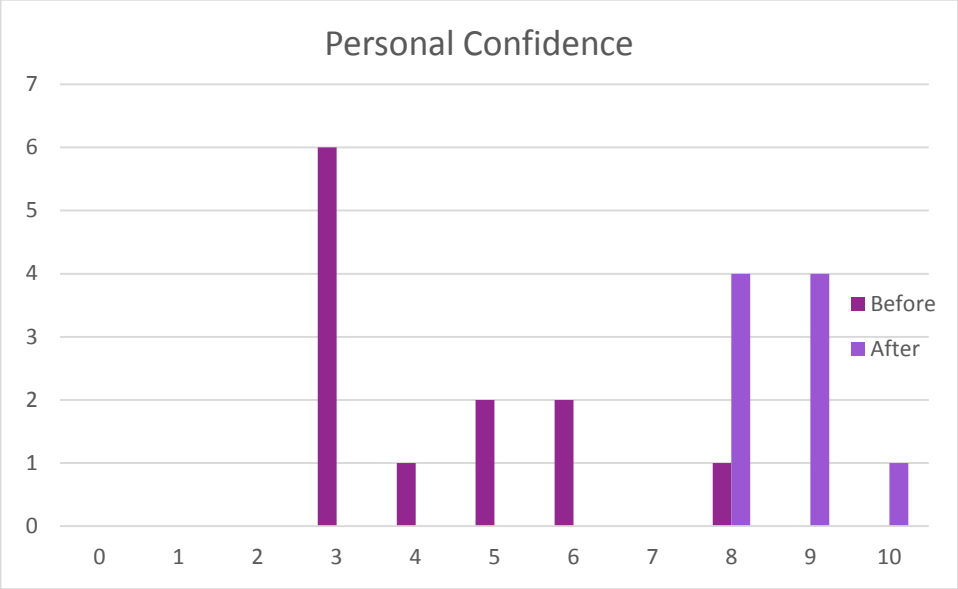
Within each section, participants learn how to:

- Spot the signs of a mental health problem in young people
- Feel confident helping a young person experiencing a problem
- Provide help on a first aid basis
- Help protect a young person who might be at risk of harm
- Help prevent a mental illness from getting worse
- Help a young person recover faster
- Guide a young person towards the right support

- Reduce the stigma of mental health problems

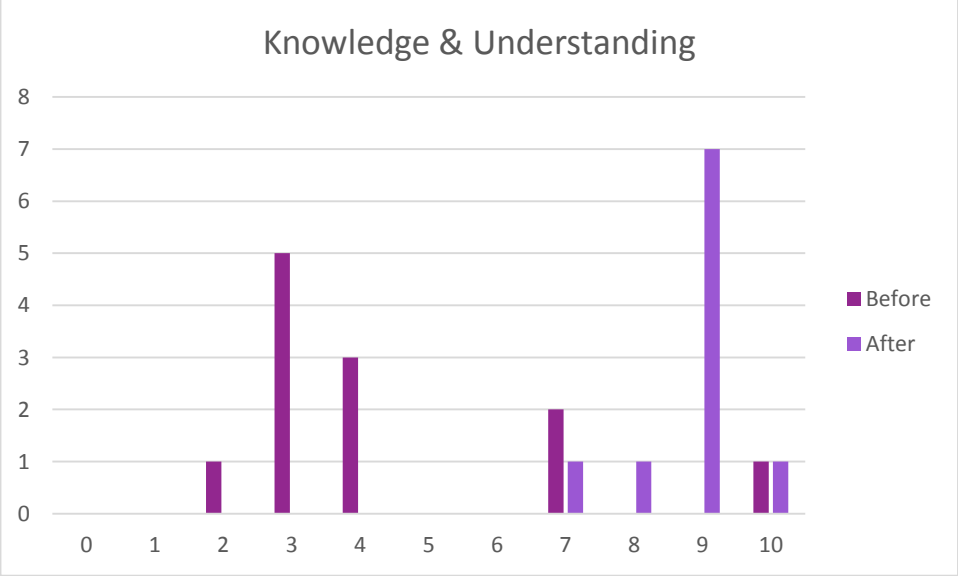
CONFIDENCE TO SUPPORT YOUNG PEOPLE – BASELINE DATA

Please score your personal confidence of how best to support young people with their mental health.



KNOWLEDGE AND UNDERSTANDING – BASELINE DATA

Please score your knowledge and understanding of how best to support young people around their mental health.



QUESTION 1

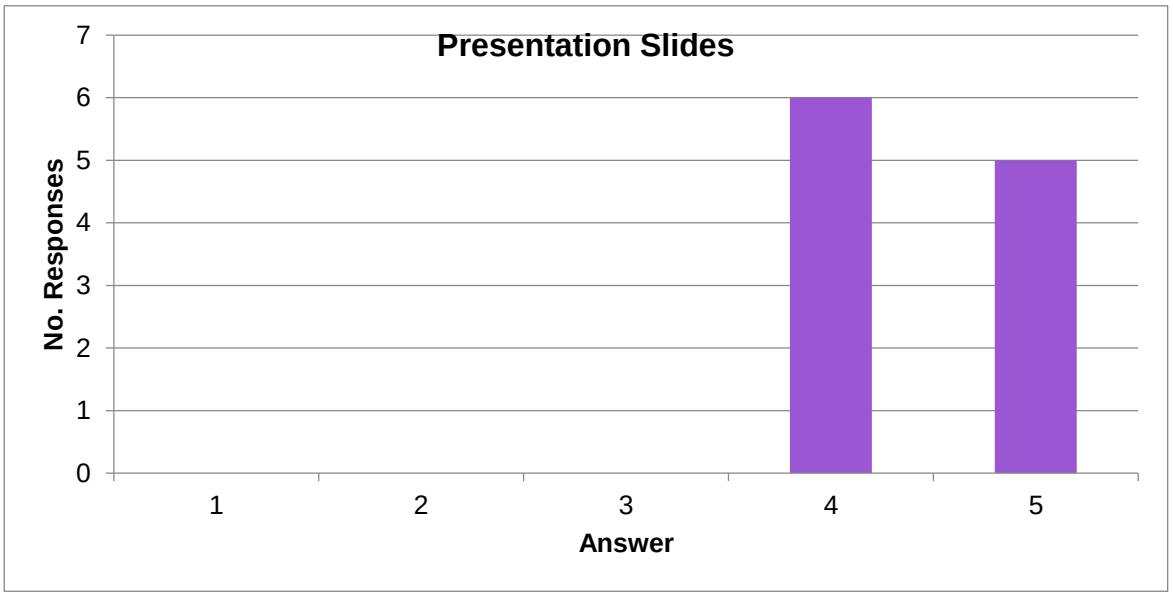
How would your rate the Instructors?

- 12 members of staff rated the instructors as ‘very good’

- “Both instructors were engaging, professional, listened and answered questions”.
- “Very confident. Informative.”
- “Excellent trainers. Knew slides inside out”.
- “Good, informative, flowed well.”

QUESTION 2

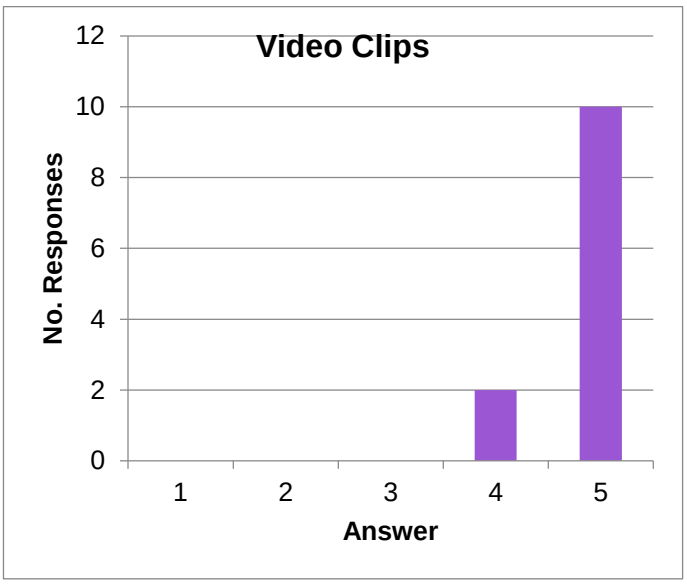
How would you rate the presentation slides?



- There were 11 responses to this question
- 6 members of staff rated the slides ‘good’, 5 rated them ‘very good’

QUESTION 3

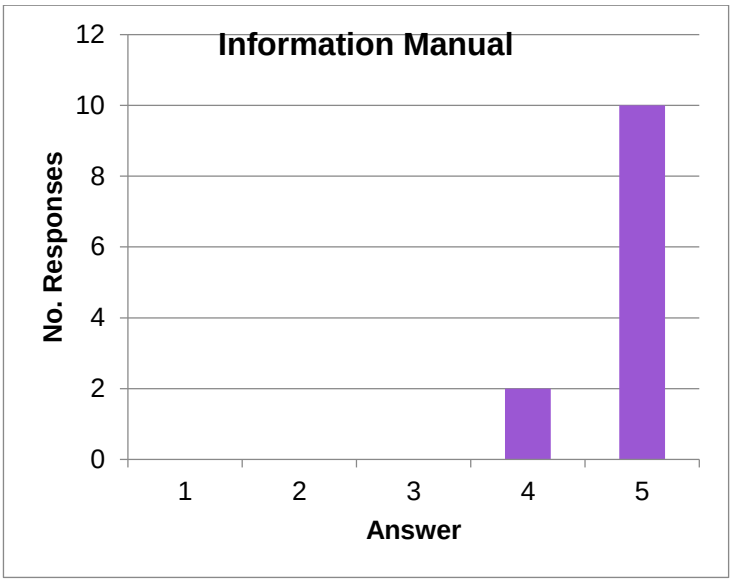
How would you rate the video clips?



- 10 staff members rated the video clips ‘very good’, 2 rated them ‘good’
- “Powerful, made the issues very real”

QUESTION 4

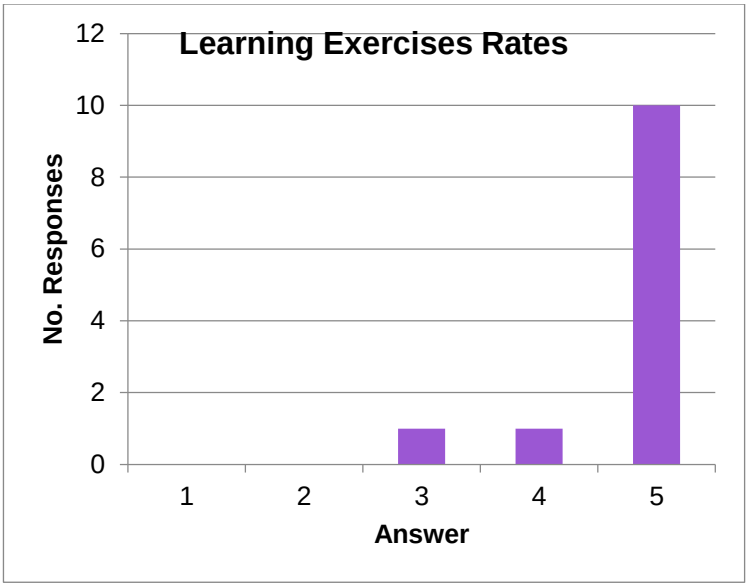
How would you rate the information manual?



- 10 participants rated the manual ‘very good’, 2 rated it as ‘good’
- “Loads of information, good to be able to take it here”

QUESTION 5

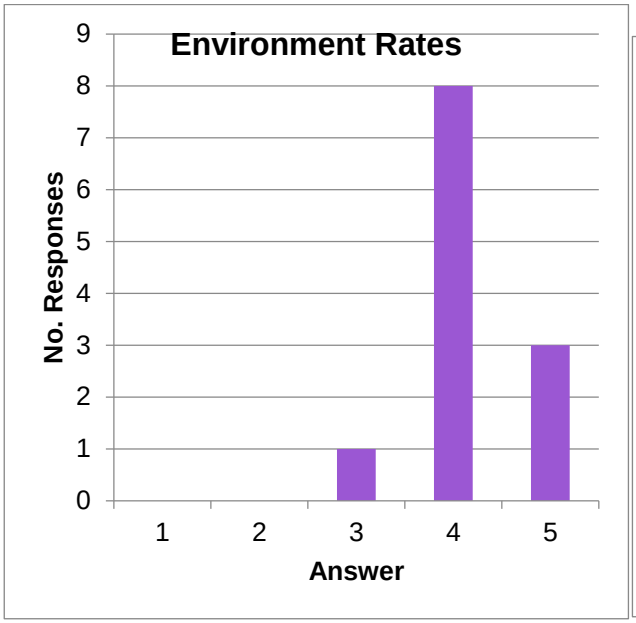
How would you rate the learning exercises?

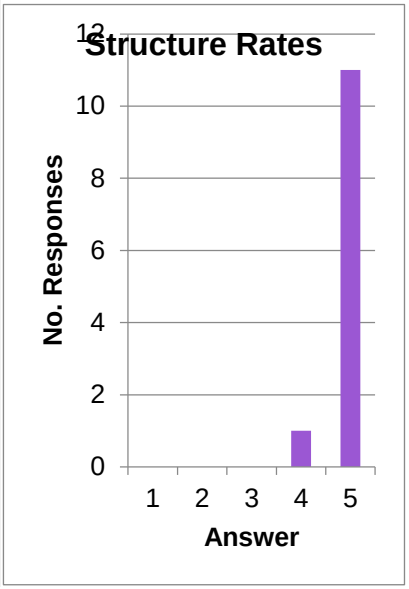


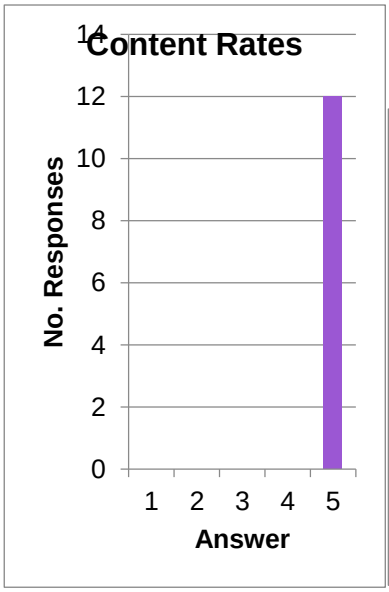
- “I enjoyed some of them, but others didn’t seem too helpful”

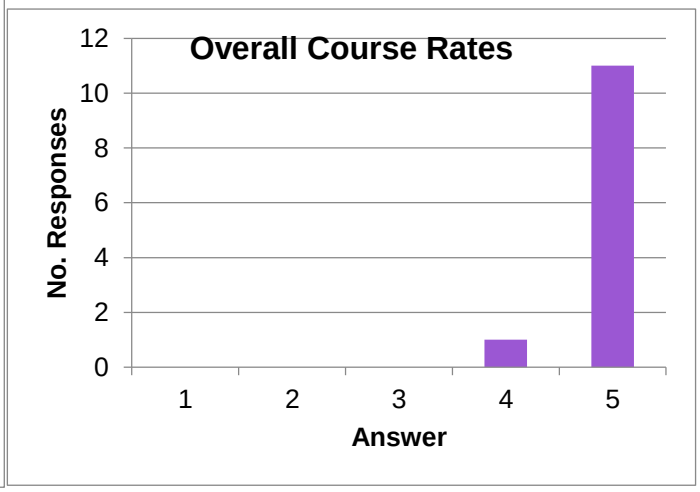
QUESTION 6

How would you rate the environment? Structure? Content? Overall course?









"Good on day one, not as good on day 2 as was a bit cramped"

"Really enjoyed the course. Lots of detailed information. Would recommend to other staff. Thanks"

"I put environment as I didn't like the rooms very much. Loved the active listening and hearing voices exercises. This has been really worthwhile. I have learnt so much."

"Both instructors were very helpful. I felt like I could ask them anything without being judged, no matter how silly some questions seemed. Knew everything what they was on about and overall very good training to do. I enjoyed it."

"Both instructors provided specialist information in different areas. E.g. substance misuse/ mental health. Adapted to the needs of the group. Haribos were a winner ☺"

"Very informative. Delivered very well by evidently informative staff/ instructors."

"The presentation allowed me to understand the definition and different ways of mental health."

"Very interesting trainers and excellent trainers who clearly knew their subject".

WRITTEN FEEDBACK ABOUT TUTORIALS DELIVERED BY CHILYPEP AT BARNSLEY COLLEGE

Below is a sample of written feedback from staff about the mental health tutorials delivered at Barnsley College by CHILYPEP and the Emotional Wellbeing Champions.

Outstanding, brave and inspirational presentations

The sessions … sound really interesting and extremely useful for students

This is absolutely fabulous

All staff agreed that it would be of great benefit to have a programme that ran over a few weeks so that learners could engage as the topic has a high prevalence within our department

The workshop was very active and engaging and a positive response was given by learners

We will welcome you in from September if that is possible

Just. Wow. Thanks very much to all of you! Keep up the amazing work!

The 'chilled out' and open environment makes [students] able to talk without fear of judgement.

i McManus s, Meltzer h, Brugha T et al. (2009) Adult Psychiatric Morbidity in England, 2007: Results of a household survey. leeds: nhs Information centre for health and social care.

ii Gavin n, Gaynes B, lohr k et al. (2005) Perinatal depression: a systematic review of prevalence and incidence. Obstetrics and Gynaecology 106: 1071–1083.

iii Kessler R and Wang P (2007) The descriptive epidemiology of commonly occurring mental disorders in the united states. Annual Review of Public Health 29: 115–129.

iv 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.

[v] 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

[vi] Naylor C, Parsonage M, McDaid D, Knapp M, Fossy M, Galea A. Long term conditions and mental health – the cost of co-morbidities.The King's Fund and Centre for Mental Health. 2012.

[vii] Lieberman J, Stroups TS, McEvoy JP, Swartz MS *et al*. Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. N Engl J Med 2005;353(12): 1209-23.

Aged 11-25?

Want to have a real say in what services and support are out there for young people?!

Contact


chantelle.parke@chilypep.org.uk


Text/Call: 07896 131676


Facebook.com/Chilypep.


@Chilypep

www.chilypep.org.uk

Become a Young Commissioner!

Barnsley Clinical Commissioning Group

CHILYPEP
Children & Young People's Empowerment Project

Aged 11-25 and want to make a real difference and gain new skills?!

Become a Young Commissioner!

Chilypep is a charity that works to help young people get their **voices heard** to **make change** and we want young people to **have a say** in the services they want and need....

So, we are training young people as **"young commissioners"** - this means that you get to choose, alongside adults, which services should be funded, particularly around **mental health** and wellbeing!

You will get to take part in a **FREE training** programme, **rewards** for taking part, have something great to put on your **CV**, meet **new people**, gain **new skills**, **have FUN** and **make a difference!**

Important Dates

Make a DIFFERENCE!

Help improve services

Find out more about young commissioners!

- Wednesday 26th October 2016, 5-7pm venue to be confirmed

We will meet every two weeks from 5-7pm at a central venue:

- Wednesday 9th November
- Wednesday 23rd November
- Wednesday 7th December

Have your VOICE heard!

For more information and to get involved contact:

Email: chantelle.parke@chilypep.org.uk

Text/Call: 07896 131676

Have FUN!!!

Gain new skills!

Meet new people!

NHS Barnsley Clinical Commissioning Group

CHILYPEP Children & Young People's Empowerment Project

South West Yorkshire Partnership NHS
NHS Foundation Trust

Barnsley, Wakefield, Calderdale and Kirklees Community Eating Disorder Service: Implementation Plan progress report.

Dave Ramsay: Deputy Director of Operations

Claire Strachan: General Manager Barnsley CAMHS

August 2016

www.southwestyorkshire.nhs.uk

With all of us in mind.

1. Purpose

1.1
This paper outlines South West Yorkshire Partnership Foundation Trust's (SWYFT) implementation plan for establishing a community eating disorder service for children and young people across the districts of Barnsley, Calderdale, Kirklees and Wakefield.

1.2
As agreed following submission of the initial service proposal (January 2016 paper)[1] this paper provides an update by means of an implementation plan and progress against key milestones to include further detail with respect to staff recruitment, pathway development and performance metrics. It also offers additional financial detail, specifically in relation to 2015/16 start up costs.

As requested it also provides an outline of the service model and variation from the National Specification and an illustration of how the crisis element of the funding is provided and the interface with specialist CAMHS in this regard. It is further demonstrated how the SPA function and duty / crisis response in the specialist CAMHS service general offer is integral to the delivery of the Eating Disorder service.

2. Service Model

2.1
The proposed service model is broadly equivalent to that defined in the *Access and Waiting Time Standard for Children with an Eating Disorder*[2] as '*Model B - a team that operates via a network of smaller teams of eating disorder clinicians in neighbouring areas, via a hub and spoke model'*.
It builds on existing eating disorder pathways and multi-disciplinary team arrangements within the three local teams/areas (Barnsley, Calderdale/Kirklees and Wakefield) and will be integrated within the generic Child and Adolescent Mental Health Service (CAMHS) management arrangements. The 'hub' will comprise a Consultant Psychiatrist and the Eating Disorder pathway leads (specialist clinicians) from each local team alongside the CAMHS Clinical Lead and Practice Governance Coaches. The 'hub' will perform an important professional leadership and learning network role across the full service thus ensuring robust and consistent approaches to staff development and quality assurance. However, the initial focus is on strengthening the local resource bases and pathways, investing in increasing the capacity and skills set of the current multi-disciplinary teams.

2.2
As described in the proposal paper the core service elements will include;

Specialist assessment and therapy/treatment: founded on NICE guidance Eating disorders in over 8s: management (CG9)[3] and with an identified care coordinator.

Physical health assessment and support: through close liaison with paediatricians and robust shared care protocols with GP's.

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[1] D Ramsay (2016) Proposal Barnsley, Calderdale, Kirklees and Wakefield Community eating Disorder Service

[2] National Collaborating Centre for Mental Health (2015) *Access and Waiting Time Standard* for Children with an Eating Disorder available at : https://www.england.nhs.uk/wp-content/uploads/2015/07/cyp-eating-disorders-access-waiting-time-standard-comm-guid.pdf

[3] NICE Eating disorders in over 8s: management available at : https://www.nice.org.uk/guidance/cg9

Dietetic support: including nutritional rehabilitation planning

Education and training: targeting primary care, education and social care professionals.

Crisis and Intensive Home-Based Treatment: 24/7 access to emergency assessment (typically in A&E departments and paediatric wards) and subsequent short-term intensive support.

2.3
The agreed pathway is illustrated at Appendix 1. Referral to the eating disorder pathway will be via existing local single point of access (SPA) arrangements for CAMHS. A move to e-based and self-referral will be managed as part of ongoing developments in SPA commissioning and functionality. Following referral direct contact will be made with the child/young person and/or parent/carer to clarify presenting risk/urgency in accordance with national standards (Appendix 1). Treatment will commence within 1 week (7 days including weekends) for all emergency/urgent cases with a care plan and identified care coordinator. For routine cases treatment will be received within a maximum of 4 weeks (28 days including weekends) from first contact. The clock will start in this regard when the request for an eating disorder assessment is received by SPA as the primary reason for referral and / or this is recognised as such and recorded, regardless of the agency making the request.
Where it is an emergency case initial contact will be made within 24 hours and a comprehensive assessment will take place within 1 working day. This first contact for support may be provided by the Generic CAMHS duty / crisis team or the Out of Hours service. Out of Hours the clock will start when the referral is received and an eating disorder is recognised as the reason.

2.4
Children, young people and their families must understand how to ask for help and all those working with children and young people with mental health problems must know how to recognise eating disorders and how to access appropriate care when needed. On this basis the implementation plan will include a proactive approach to relationship-building with key service stakeholders and service promotion. Particular attention will be paid to promotional work with potential referrers (GP's and schools) and children/young people and their families. This work will include a strengthened digital communication platform.

2.5
Robust systems of staff recruitment and retention will be maintained and will complement a service focus on ongoing professional development and staff supervision. A learning network will be created across the locality eating disorder services ensuring routine service audit/evaluation/benchmarking (and associated action planning) and exploring opportunities for involvement in research etc. Professional development will be further supported through involvement in the Children and Young Peoples Improving Access to Psychological Therapies (CYP-IAPT) programme. In addition, we will commit to participating in the national quality improvement network (as established by CCQI) - seeking relevant accreditation(s) as/when the necessary frameworks are developed by CCQI.

3. Performance Monitoring

3.1
Data collection/reporting templates will be established to meet the specified requirements of the *Access and Waiting Time Standard* (*Table 10: Outcome Measures)* with all items mapped to MHSDS. PROMs and PREMs data will be collected at relevant stages of the care pathway with routine use of the Eating Disorder Examination Questionnaire (EDE-Q) version 6.0. The metrics below are proposed as a starting point for contract performance monitoring and ongoing service improvement. Monthly reports will be made available to commissioners (and separated by CCG) outlining the monthly and cumulative (year to date) position. The relevant data was planned for collection from 1 April 2016 with the first report made available to commissioners in May 2016 however the development and validation of the data packs has been delayed. It is expected that reporting will commence from August 2016 and be presented to commissioners in September 2016.

Future data will be presented in the usual graph format from the Trust Performance and Information Team.

Section 3.3 below presents in table format the manual data collected by the service to provide reasonable assurance that progress is being made with regard to data capture and validation for the purpose of this paper.

Figure 1:

Indicator	Target
Number of referrals (emergency/urgent/routine)	
Number of referrals by source	
% emergency referrals contacted within 24 hours	100%
% urgent referrals commenced treatment within 5 days	100%
% routine referrals commenced treatment within 4 weeks	100%
Number of discharges	
Number of open cases at end of the period	
Number of ED referrals to Tier 4	
Number of ED transitions to adult mental health services	
% cases with at least two completed EDE-Q (6.0)	100%

Note: the definitions for clock start/stops defined in *Guidance for Reporting Against Access and Waiting Time Standards*[4] will be used for reporting purposes.

3.2

It must be noted that the ability of services to meet the access targets specified in the *Access and Waiting Time Standard for Children and Young People with an Eating Disorder* (NHSE, July 2015) guidance will be monitored at a national level in 2016. It is anticipated that the standard will be refined for implementation from 2017–18 with data collected in 2016 informing trajectories for incremental percentage increases, with the aim of setting a 95% tolerance level by 2020. Data will also be reported consistent with the revised MHSDS arrangements - with CAMHS (and eating disorder service) data returned to the HSCIC.

3.3

The implementation timetable at section 5 identifies a phased process of local service development the initial proposal offered assurance that access targets for emergency, urgent and routine referrals would be consistently met from 1 April 2016 i.e. 95%+.

Manual Data provided by services related to the number of referrals and performance against the national access times standards is provided below. In order to meet the access target criteria, a referral must have a referral reason of "eating disorder"; the clock will stop once treatment has commenced (use of treatment activity codes as supplied nationally).

The manual data has been reviewed on a case by case basis as treatment activity codes have not always been consistently used and a case summary has been provided for assurance / exception reporting purposes.

The clock starts at the date of referral when the primary reason for referral is suspected Eating Disorder or where this is identified at triage. Where Eating Disorder is not suspected at triage the clock starts when suspicion is first raised. The clock stops when NICE approved treatment starts or waiting time ends for non-treatment when a clinical decision is reached not to treat as an Eating Disorder.[4]

[4] NHSE (2016) *Guidance for reporting against access and waiting time standards: Children and Young people with an Eating Disorder. Available at : https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/tech-cyped-eip.pdf*

The lessons learned from the cases that have breached the access target will be shared at the clinical network meeting to inform any actions required both locally and hub wide.

Commissioners requested a sample of cases scenarios however due to timescales the families have not been approached for consent and therefore a single high level case summary of a referral in August has been presented in section 3.5 alongside outline case summaries within the data tables below.

Barnsley: As at 31st July 2016 open cases on the ED pathway was 21.

Month	Referral numbers	Type	Access target met	Case Summary
April 2016	2	1 x urgent	No	Referral received 14.04 16 via SPA and passed to generic urgent initial assessment. Seen 25.04.16 and concerns about ED confirmed and seen 29.04.16 by ED staff. Did not meet target as went to generic urgent assessment not into ED assessment. Not into treatment for 15 days and correct intervention stop clock coding not used.
		1 x routine	No	Referral 28.04.16 SPA triaged as Anxiety. Seen for initial assessment on 19.05.16 where suspicion re ED raised although no concerns re W4H. Routine clock start as of this date and seen on 05.07.16 therefore not into treatment for 37 days.
May 2016	0			
June 2016	0			
July 2016	0			

NB: Week commencing 1st August 2016 3 referrals received of which 1 was urgent and 2 were routine.

Wakefield: As at 31st July 2016 open cases on the ED pathway was 14

Month	Referral numbers	Type	Access target met	Case summary
April 2016	3	3 x routine	No	Referred 13.01.16. Eating issues noted but not triaged as ED. Initial assessment 03.03.16 where ED should have been suspected *(clock start)* and not discussed with ED team until 11.04.16 and then seen 27.04.16 = 55 days into treatment.
			No	Referred 21.04.15. Waiting for therapy and concerns raised re potential ED by agency on 12.02.16 (clock start) and seen 21.04.16 for generic assessment and ED team consulted and saw 25.05.16 decision to discharge and not treat for ED = treatment wait clock stop 61 days
			No	Referred 04.03.16 and ED suspected 18.04.16 (clock start) and ED Initial treatment appointment 11.05.16 cancelled by client and seen 19.05.16 = 31 days into treatment
May 2016	1	1 x routine	No	Referred 07.03.16 and ED suspected 22.04.16 (clock start) and ED team notified 11.05.16 with appointment for 31.05.16 not attended. ED team liaison with family on 31.05.16 and decision not to treat therefore clock stopped = 42 days.
June 2016	1	1 x urgent	Yes	Referred 03.05.16 and ED suspected 07.06.16 and seen 13.06.16 = 6days
July 2016	0	1 x urgent	No	Referred 13.07.16 and SPA attempts to secure height and weight from referrer delayed for 5 days and ED team advised urgent on 18.07.16. Seen on 21.07.16 by ED team = 8 days into treatment.

NB: Week commencing 1st August 2016 1 referral received of which was urgent

Calderdale and Kirklees: As at 31st July 2016 open cases on the ED pathway were 68 cases of which 23 are within Calderdale and 45 within Kirklees.

Month	Referral numbers	Type	Access target met	Case Summary
April 2016	5 referrals (2 Kirklees) (3 Calderdale)	1 x urgent 4 x routine	Yes	Referred 23.03.16 (routine clock start) and triage for routine ED. Decision not to progress as ED 05.04.16 treatment wait clock stop at 12 days.
			No	Referred 09.02.16? ED issues noted. New referral from GP 08.04.16 ED (urgent clock start) appointment offered 11.04.16 client DNA and failed contacts by service discussed on 03.05.16 and GP advised re non engagement 25.05.16 and tests requested seen 02.06.16 = 55 days.
			Yes	Referred 16.03.16? ED issues noted. 29.03.16 ED suspected (routine clock start) seen 26.04.16 = 28 days
			Yes	Referred 19.04.16 which was redirected to CAMHS 25.04.16 and primary referral reason not ED although issues noted. Initial assessment 18.05.16 ED suspected (clock start routine) and decision not to treat as ED 31.05.16 (treatment wait clock stop) = 13 days
			Yes	Referred 14.12.15 with other primary reason suspicion re ED raised 19.04.16 (routine clock start) and treatment started 10.05.16 = 21 days
May 2016	7 referrals (4 Kirklees) (3 Calderdale)	3 x urgent 4 x routine	No	Referred 03.05.16 (routine clock start). GP contacted for information re weight for height (W4) and again on 17.05.16 and secured on 20.06.16 and in normal limits information re ED presentation requested from GP which was not secured therefore decision not to treat and discharged 22.07.16 = treatment wait stop clock at 80 days.
			No	Referred 14.04.16 (routine clock start) appointment 09.06.16 cancelled by family and decision not to treat after assessment on 12.07.16 = treatment wait stop clock at 89 days
			Yes	Referred 04.05.16 (urgent clock start) and treatment started 06.05.16 = 2 days

			Yes	Referred 03.05.16. ED suspected at Initial assessment on 11.05.16 (routine clock start) GP tests requested and decision not to treat 08.06.16 = treatment wait clock stop at 28 days
			No	Referred 13.05.16 (urgent clock start) assessed by crisis team 19.05.16 and passed to ED team therefore treatment not started. ED team 25.05.16 (clock stop) = 12 days
			Yes	Referred 13.05.16 (routine clock start) and seen by ED team 01.06.16 = 18 days
			No	Referred 12.05.16 (urgent clock start) ED initial contact 20.05.16 = 8 days
June 2016	6 referrals (4 Kirklees) (2 Calderdale	2 x urgent 4 x routine	No	Referred 08.06.16 (routine clock start) and had contact with crisis team to assess risk on 15.06.16 seen by ED team 13.07.16 (clock stop) =35 days
			Yes	Referred 11 .06.16. Suspicion re ED raised 15.06.16 (routine clock start) into treatment (CBT self-help 28.06.16 (clock stop) = 13 days
			No	Referred 20.06.16 (routine clock start). Family unable to attend appointments and seen by ED team 25.07.16 (clock stop) =35 days
			Yes	Referred 24.06.16 (urgent clock start) and seen and treatment started 27.06.16 (clock stop) =3 days
			Yes	Referred 28.06.16 (urgent clock start) and into treatment 01.06.16 (clock stop) = 3 days. **Case monitored by school nursing and a case review would be beneficial re delay to escalate to CAMHS ED.
			Yes	In service and Re-emergence of previous ED symptoms noted 28.06.16 (routine clock start) ED treatment started 13.07.16 (clock stop) = 15 days
July 2016	5 referrals (5 Kirklees).	Data in report provided by and informatics		

3.4
Learning from data review

A cross service discussion / peer review of sample cases to be discussed at the clinical hub to establish and provide assurance regarding:

- Consistent use of clinical activity codes to inform clock start / stops
- Application of consistent criteria for Eating Disorder
- Timely recording when a clinical decision is reached not to treat cases for Eating Disorder
- Prompt liaison with GP to determine physical observations to ensure access times are met (Note: the referral to discharge pathway [Appendix 1] was updated in July and the use of the updated screening tool [Appendix 3] was also promoted in July).
- What education and support should be provided to universal and 'Tier2' services to facilitate early intervention

**** Calderdale and Kirklees:** Consideration should be given by the ED hub as to the benefits of seeking consent for a case review for the urgent case referred 28.06.16. The focus is with regard to what education and support should be provided to universal and 'Tier2' services to facilitate early intervention and facilitate consultation / referral to CAMHS in a timely manner.

3.5
Case Study

Child X was open to the service and during an appointment on 3 August 2016 concerns were raised regarding suspicion of Eating Disorder and a referral to the Eating Disorder pathway was made on the same day (urgent clock start). Family had identified physical health concerns and triage by SPA took place using the ED Screening tool (Appendix 3) on 4 August 2016. The GP was contacted on 4 August 2016 at 1pm. The family were asked to contact GP to attend an urgent appointment to record weight and height, sitting and standing BP, temperature, and bloods tests. A home visit and full eating disorder assessment was completed 5 August where treatment started with guided self-help and W4H body percentage was noted as 75.27% (treatment clock stop at 2 days). An ECG was booked and an appointment with a Consultant Psychiatrist took place on 9 August 2016 and a referral to dietician was made on 10 August 2016.

Based on learning from cases breached and the use of activity codes the team used the Screening tool and met all access times and the child entered treatment in a timely manner. However correct codes for activity are still not recorded and will be addressed as part of the learning.

4. Finance and Staffing

4.1
The proposed service budget and staffing establishment is outlined below in Figure 2 with an updated position as at July 2016 provided in Figure 3:

Figure 2:

	Barnsley		**Calderdale/ Kirklees**		**Wakefield**		**Total**	
	wte	£	wte	£	wte	£	wte	£
Psychiatrist	0.1	11486	0.0	0	0.0	0	0.1	11486
Band 7 Lead	0.6	29060	1.0	56146	0.8	44917	2.4	130123
Band 6 Therapist	1.0	40394	2.0	80788	1.4	56552	4.4	177734
Band 6 Dietician	0.2	8079	0.4	16158	0.0	0	0.6	24236
Band 6 MHP (Crisis)	1.0	40394	2.0	80788	1.0	40394	4.0	161576
Band 4 Support	0.0	0	1.5	40002	1.0	26668	2.5	66670
Band 4 Admin	0.0	0	0.5	13334	0.0	0	0.5	13334
Estate		0		0		0		0
Travel		5600		10800		6400		22800
Agile Equipment		1300		2500		1600		5400
Other non-pay		580		1480		840		2900
Sub totals	**2.9**	**136892**	**7.4**	**301996**	**4.2**	**177370**	**14.5**	**616258**
Indirect costs & overheads		9487		22341		18145		49973
TOTAL RECURRENT COST		**146379**		**324337**		**195515**		**666231**
2015/16 set up								
Training (including backfill)		36275		8300				44575
Medical staffing		3000		3000		3000		9000
Nursing staffing (incl. agency)		78054		38339		33928		150321
Therapy staffing (incl. agency)		4652		20781		4652		30085
Admin and data management		2760		2760		2760		8280
Resources		12506						12506
Management costs		9132		8820		4410		22362
2015/16 SET UP COSTS TOTAL		**146379**		**82000**		**48750**		**277129**

Figure 3: Barnsley recruitment update

Barnsley					
Proposed structure			**Actual structure as July 2016**		
	wte	**£**		**wte**	**Service update**
Psychiatrist	0.1	11,486	Psychiatrist	0.2	In post and identified lead for Barnsley and attends hub meetings and alongside staff grade psychiatry sessions to the ED pathway medical review averages an additional 0.1 wte.
Band 7 Lead	0.6	29,060	Band 7 Lead	0.6	Agency Cognitive Behavioural Therapist in post since April pending substantive recruitment
Band 6 Therapist	1.0	40,394	Band 6 Therapist	1.0	Additional Recruitment to 1 wte Band 6 post in crisis / outreach service since April 2016. This provides care coordination across the team. Further Band 6 recruitment undertaken and offer to dedicated Eating Disorder Band 6 clinician to be made by 8th August.
Band 6 etician	0.2	8,079	Band 6 Dietician	0.2	Provided from Trust wide dietic service
nd 6 HP risis)	1.0	40,394	Band 6 MHP (Crisis)	1.0	Additional Recruitment to 1 wte Band 6 post in crisis / outreach service since April 2016. Provision of daily advice to SPA and direct contact with families to establish urgency. Provision of emergency ED assessment in hours (M- F :9-5)
			Band 8a Nurse Specialist	0.3	Currently released from the generic service to attend the hub meetings and coordinate the Eating Disorder pathway to ensure robust implementation pending recruitment to the Band 7 lead post. This Nurse also holds a caseload of Eating Disorder cases.
			Dedicated Admin	Daily	Released from the generic service to support the MDT and SPA functions
			SPA function	Daily	Integral component of generic service to ensure
			Out of Hours (OoH)	Daily	Integral component of service to ensure access to OoH assessment provided from generic service
			Line management and clinical supervision	Daily	Integral component of service provided from generic service
			Note: The service is reviewing job plans for the generic service and exploring the options for provision of Band 3 Health Care Assistant time to the ED pathway from the generic team.		

Figure 4: Wakefield recruitment update

Wakefield					
Proposed structure			**Actual structure as July 2016**		
	wte	**£**		**Wte**	**Service update**
Psychiatrist	0.0	0	Psychiatrist	0.2	Psychiatry time is job planned and this consultant attends the clinical network hub meetings and takes a lead role at the clinical network hub.
Band 7 Lead	0.8	44917	Band 7 Lead	1	A substantive band 7 senior mental health practitioner is in post and attends the clinical network hub meetings
Band 6 Therapist	1.4	56552	Band 7 Therapist	1	The service has recruited 1 wte Band 7 Cognitive Behavioural Therapist and attends the clinical network hub meetings
Band 6 MHP (Crisis)	1.0	40394		Daily	Provided by current crisis and Intensive home based treatment team
Band 4 Support	1.0	26668	Band 3 Support	1	The service is recruiting 1 wte Band 3 Health Care assistant to support the ED service and crisis team
nd 4 min	0.0	0			
			Band 8a family Therapist	0.6	A substantive family therapist is in post and attends the clinical network hub meetings
			Admin	As required	Released from the generic service to support the MDT. Admin function under financial review.
			SPA function	Daily	Integral component of generic service
			Out of Hours (OoH)	Daily	Integral component of service to ensure access to OoH assessment provided from generic service
			Line management and clinical supervision	Daily	Integral component of service provided from generic service and ED pathway lead.

Figure 5: Calderdale and Kirklees recruitment update

Calderdale and Kirklees					
Proposed structure			**Actual structure as July 2016**		
	wte	**£**		**Wte**	**Service update**
Psychiatrist	0.0	0	Psychiatrist	Daily	Crisis team psychiatrist covers as required no dedicated provision
Band 7 Lead	1.0	56146	Band 7 senior mental health practitioners	2.4	1.4 wte Band 7 are in post.
					1 wte Band 7 senior mental health practitioners was in post until July and was re- recruited to in August. Cover is currently provided by agency staffing.
Band 6 Therapist	2.0	80788	Band 7 family therapist and psychologist / counselling psychologist	1.6	Band 7 0.6 wte family therapist is out to advert and 1wte psychologist is currently out to advert and cover is currently provided by agency staffing for both posts.
nd 6 etician	0.4	16158	Band 6 Dietician	0.6	Provided from Trust wide dietic service and out to recruitment was in post until July 2016
nd 6 MHP risis)	2.0	80788	Band 6 MHP (Crisis)	Daily	Provided by current crisis and Intensive home based treatment team
nd 4 Support	1.5	40002	Band 3 Support	1.2	0.6 wte Band 3 Health Care assistant in post and 0.6 out to advert
Band 4 Admin	0.5	13334	Band 3 Admin	0.6	0.6 wte Band 3 is currently out to advert
			Band 8a Psychologist pathway lead	0.6	A substantive psychologist is the pathway lead in post and attends the clinical network hub meetings
			Out of Hours (OoH)	Daily	Integral component of service to ensure access to OoH assessment provided from generic service
			Line management and clinical supervision	0.4	Integral component of service and provided from the crisis team manager

5: Implementation Timetable

An outline implementation plan is attached at Appendix 2. Progress against the plan will be closely monitored and reported through the monthly contract management meetings. A summary against each of the overarching themes of the implementation is provided below.

Recruitment:

- Recruitment has been undertaken and the current position is illustrated in Figures 3 , 4 and 5 above

Professional Development:

- A multi-disciplinary clinical learning network has been established and meets monthly and operates as the hub. Nominated staff from each locality attend the meeting and share learning and develop shared protocols.

- Local services have an understanding of the skills of staff however a robust training needs analysis is to be undertaken once all newly recruited staff are in post. The service is currently awaiting a cost for a CAMHS wide team profile using The Self Assessed Skills Audit Tool (SASAT)[5]. This cross locality information will enable the service to commission appropriate training for both existing and new staff and build sustainability (including via supervision) across services.

- The requests for CYP-IAPT training have been submitted to the regional collaborative meeting and the services are awaiting a decision regarding the allocation of places. Places have been requested for Evidence Based Psychological Therapies for Children & Young People in: Cognitive Behaviour Therapy, Systemic Family Practice – Eating Disorder, Interpersonal Therapy for Adolescents with Depression and also the shorter Enhanced Evidence Based Practice Programme for Children and Young People. Supervisory places for the therapies have also been requested.

- It is noted that NICE guidance for the treatment of Eating Disorder recommends adapted forms of CBT which include CBT – E and CBT – BN. The Wakefield service has a CBT therapist who has accessed CBT –E training and as part of the Training Needs Analysis the service will establish which staff may be eligible for extended training and the financial costs.

Pathway development and promotion

- The Wakefield service has developed an Eating Disorder pathway which is being finalised prior to final approval. Localised versions are under development for the spoke teams.

[5] National CAMHS Workforce Programme, National CAMHS Support Service (NCSS) (2010)SASAT tool http://www.chimat.org.uk/resource/item.aspx?RID=103044

- The overarching pathway flowchart has been discussed at the August hub meeting and has been revised to include Routine Outcome Monitoring (Appendix 1)

- The Clinical Nurse Lead from the Barnsley service has further developed an existing CAMHS Triage and assessment form that is currently being piloted (Appendix 3). This form includes more detailed guidance for the SPA team on the expectations and timescale for liaison with families in line with the national access times[2.]

- The DNA process has been discussed at the clinical meeting and the services are working to the Trust policy and undertaking

- Standardised GP letters that give clear treatment direction are being developed and shared across the services

- The service is currently discussing CCQI / QNCC membership to enable the ED service to access the benefits of service evaluation / peer review and n accreditation

- The Trust is finalising the systems and processes for introducing a text reminder service and this is anticipated to be available for consenting families in September 2016

- The services will also be considering options to develop self-referral and education to universal services with Barnsley giving consideration for developing a pilot using the SCOFF Questionnaire for ED amongst primary care staff to inform referral / SPA triage. [6]

Service monitoring and evaluation

- The multi-disciplinary clinical learning network has agreed to share suggestions for resources and self-help guides for discussion at the September meeting to promote consistency across the services. Once agreed the services will review how these resources can be promoted on the Trust website.

- The service has yet to review and develop paediatric liaison protocols and this will be an agenda item for the September meeting.

- The data packs are in the process of being built and tested so services do not have any validated automated data available at the time of writing this report. It is anticipated that the automated reports will be tested during August and all teams are working with the Trust Performance and Information department to review data to enable the monthly reporting to commence. It is expected that automated reporting will be available from late August .Subsequent evaluation of service outcome data (including FFT) will follow.

[6] Kings College London (undated) SCOFF Questionnaire. Available at: http://cedd.org.au/wordpress/wp-content/uploads/2015/04/SCOFF-Questionnaire.pdf

Meeting the access standards

- All teams have been issued with the necessary information regarding the access standards and this has been discussed at the multi-disciplinary clinical learning network

6: Service model variation from the National Specification for Hub and Spoke services

- The model requires an organisational chart to ensure the structure and overall leadership is clearly defined. The General Manager (Barnsley CAMHS and Consultant Psychiatrist Wakefield have been identified to lead the implementation)

- Not all services have staff who can offer the full range of psychological interventions for Eating Disorder e.g. CBT –E, CBT-BN, Cognitive Analytic Therapy (CAT), Interpersonal therapy, focal psychodynamic therapy and Family Therapy.

- The service is not delivering a systematic training programme to raise awareness of eating disorders amongst universal services and this will need to be agreed as part of the service offer and Local Transformation Plans

- The service is not systematically involving young people and families in all aspects of the service design. A workshop event is planned for 30th September hosted by Eva Musby which will bring together staff and parents [7]

- The service has yet to confirm its decision regarding which national quality improvement and accreditation network it will progress membership. Currently existing QNCC members.

- The service has yet to receive confirmation regarding which CYP-IAPT courses are on offer to the partnership sites for 2016 / 17.

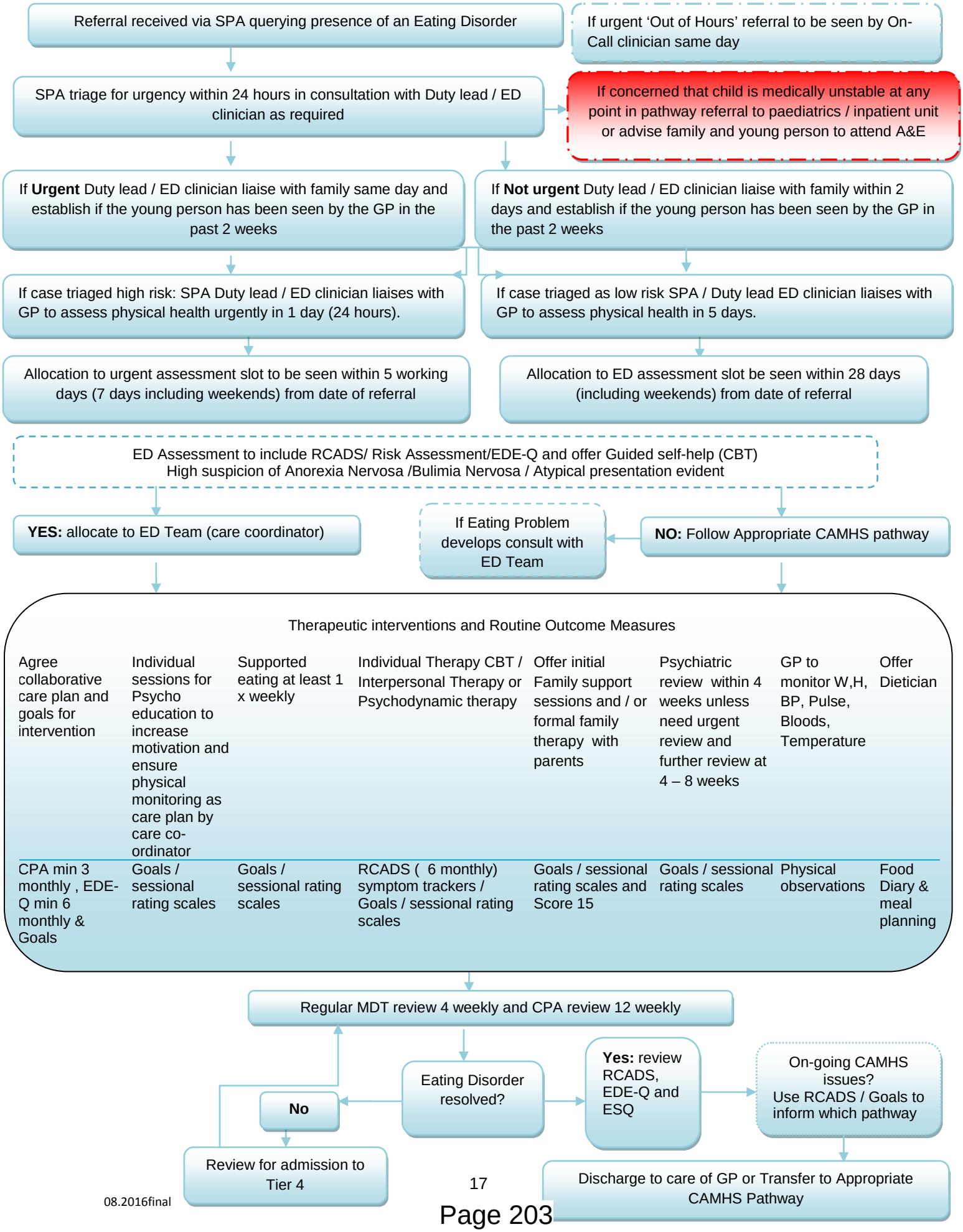
- The data is not validated regarding referral rates to inform robust staffing ratio evaluation as per workforce calendar by population and referral numbers.
  There is not dedicated psychiatry time in all localities.

- Robust protocols between GP's and Paediatric services are yet to be developed and tested.

- Extended opening hours are not yet available.

[7] Website undated 'Anorexia and other eating disorders : how to help your child eat well and be well http://evamusby.co.uk/events/

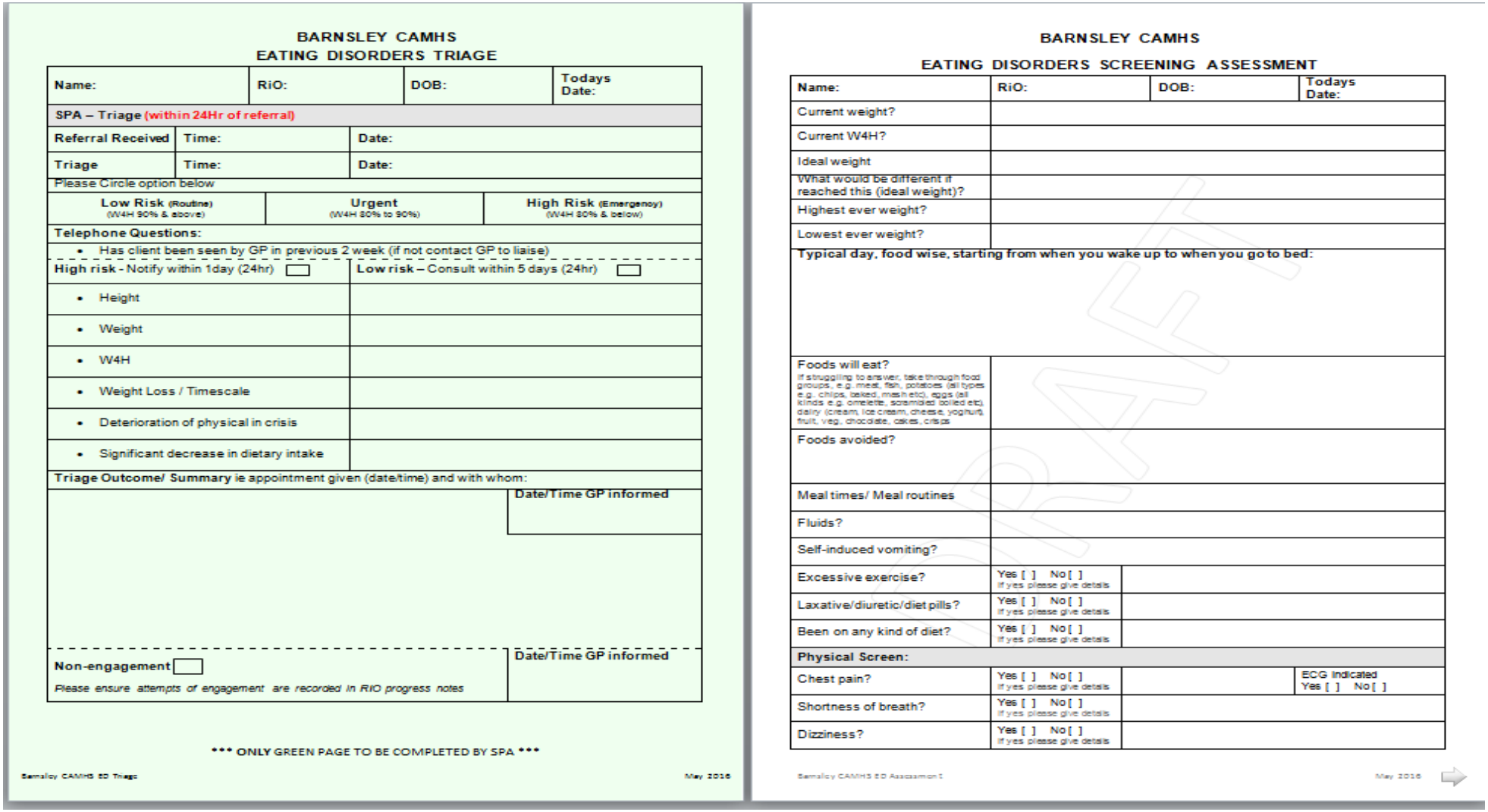
Appendix 1: Referral to discharge pathway where an Eating Disorder is suspected



Appendix 2: Implementation plan

camhsedimplementationappx2.xlsx

APPENDIX 3: Barnsley Eating Disorder Triage Profroma (Page 1 and 2)



BARNSLEY CAMHS
EATING DISORDERS TRIAGE

Name:	RiO:	DOB:	Todays Date:

SPA – Triage (within 24Hr of referral)

Referral Received	**Time:**	**Date:**
Triage	**Time:**	**Date:**

Please Circle option below

Low Risk (Routine) (W4H 90% & above)	**Urgent** (W4H 80% to 90%)	**High Risk** (Emergency) (W4H 80% & below)

Telephone Questions:

- Has client been seen by GP in previous 2 week (if not contact GP to liaise)

High risk - Notify within 1day (24hr) ☐	**Low risk** – Consult within 5 days (24hr) ☐
• Height	
• Weight	
• W4H	
• Weight Loss / Timescale	
• Deterioration of physical in crisis	
• Significant decrease in dietary intake	

Triage Outcome/ Summary ie appointment given (date/time) and with whom:

	Date/Time GP informed

Non-engagement ☐ *Please ensure attempts of engagement are recorded in RIO progress notes*	**Date/Time GP informed**

*** ONLY GREEN PAGE TO BE COMPLETED BY SPA ***

Barnsley CAMHS ED Triage — May 2016

BARNSLEY CAMHS
EATING DISORDERS SCREENING ASSESSMENT

Name:	RiO:	DOB:	Todays Date:

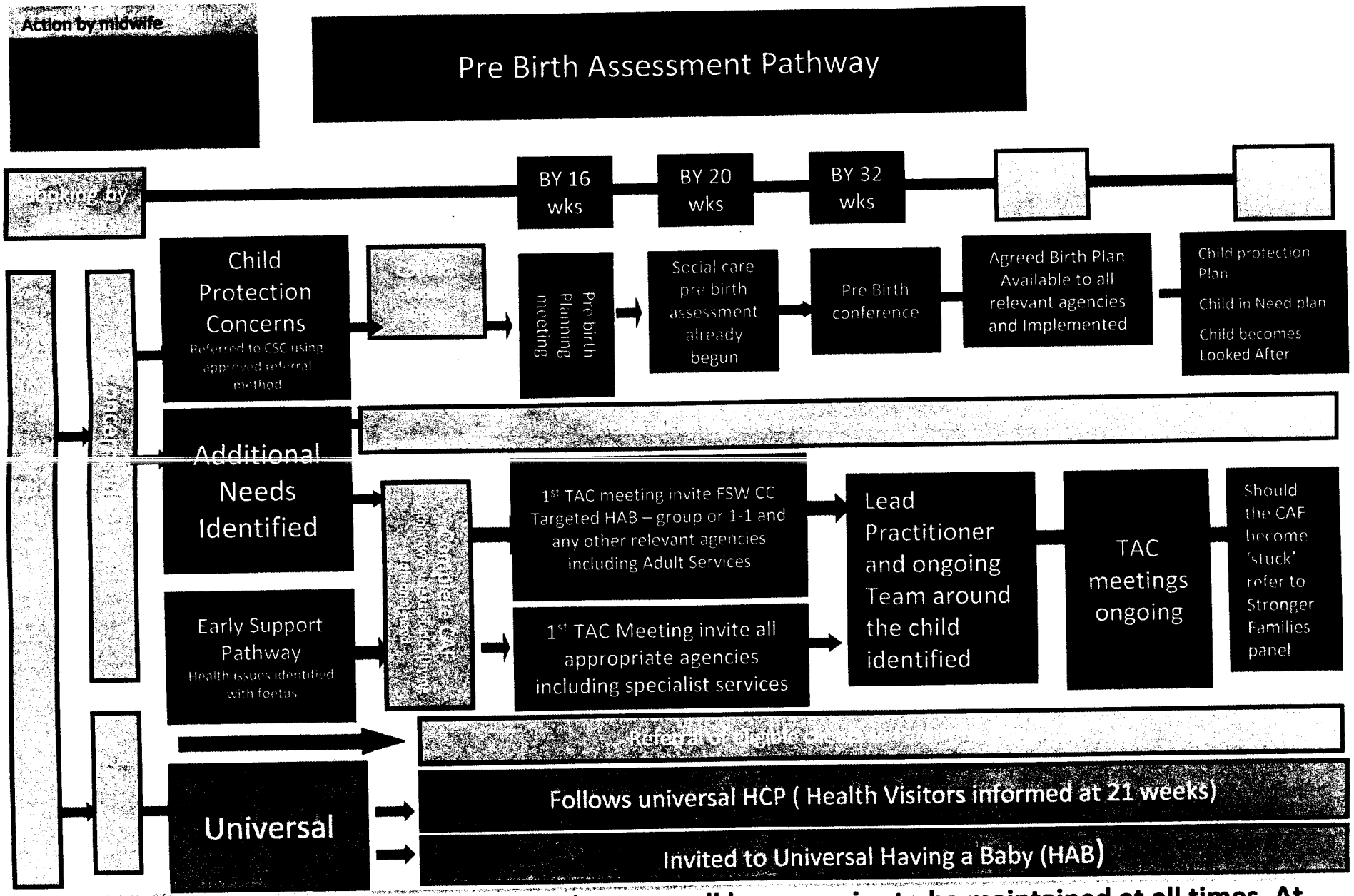
Current weight?			
Current W4H?			
Ideal weight			
What would be different if reached this (ideal weight)?			
Highest ever weight?			
Lowest ever weight?			
Typical day, food wise, starting from when you wake up to when you go to bed:			
Foods will eat? If struggling to answer, take through food groups, e.g. meat, fish, potatoes (all types e.g. chips, baked, mash etc), eggs (all kinds e.g. omelette, scrambled boiled etc), dairy (cream, ice cream, cheese, yoghurt), fruit, veg, chocolate, cakes, crisps			
Foods avoided?			
Meal times/ Meal routines			
Fluids?			
Self-induced vomiting?			
Excessive exercise?	Yes [ ] No [ ] If yes please give details		
Laxative/diuretic/diet pills?	Yes [ ] No [ ] If yes please give details		
Been on any kind of diet?	Yes [ ] No [ ] If yes please give details		
Physical Screen:			
Chest pain?	Yes [ ] No [ ] If yes please give details		ECG Indicated Yes [ ] No [ ]
Shortness of breath?	Yes [ ] No [ ] If yes please give details		
Dizziness?	Yes [ ] No [ ] If yes please give details		

Barnsley CAMHS ED Assessment — May 2016

APPENDIX 3: Barnsley Eating Disorder Triage Pro-forma (Page 3 and 4)

Faints?	Yes [ ] No [ ] If yes please give details	
Abdominal pain?	Yes [ ] No [ ] If yes please give details	
Constipation?	Yes [ ] No [ ] If yes please give details	
Cold extremities?	Yes [ ] No [ ] If yes please give details	
Headaches?	Yes [ ] No [ ] If yes please give details	
Dry skin/hair/hair falling out?	Yes [ ] No [ ] If yes please give details	
Periods – absent, reduced frequency, heavier, lighter?		
Blood results (Circle as necessary)	FBC U&E Glucose (random) Bicarbonate LFT/ GGT TFT Calcium Phosphate Magnesium Creatinine Kinase B12/ Folate Cholesterol	
Other Blood results (please specify):		
Blood pressure/pulse:	Sitting:	Standing:
Weight (no shoes, oat/jumpers off)		
Calculate ideal weight; weight to height ratio; 85% wt for ht and 75% wt for ht; i.e. critical weight.		
Psychiatric Screen:		
Self-image		
Distorted body image?	Yes [ ] No [ ] If yes please give details	
Compulsive thoughts?	Yes [ ] No [ ] If yes please give details	
Mood		
Sleep		
Appetite		
Family stability		
Concentration		
Ambition / Aspiration		
Suicidal thoughts/plans/actions?	Yes [ ] No [ ] If yes please give details	
Energy		
Motivation		
Interest (loss of)	Yes [ ] No [ ] If yes please give details	

Family history of any eating disorder?	Yes [ ] No [ ] If yes please give details	



Communication/sharing of information between all key agencies to be maintained at all times. At any point a child could move between the four tracks if circumstances change.

.10 Children At Risk Where A Parent Has A Mental Health Problem

print

Contents

Introduction

1. The mental health of a parent or carer does not necessarily have an adverse impact on a child but it is essential to assess the implications for the child. If any agency has concerns that a child is at risk of harm because of the impact of the parent/carer's mental health they should check to see if the child is subject to a **Child Protection Plan – see Recording that a Child is the subject of a Child Protection Plan Procedure.**

2. Children are at greatest risk when:

    - the child features within parental delusions
    - the child becomes the focus of the parent's aggression.

    In these circumstances the child should be considered at immediate risk of harm and a referral made to Children's Social Care Services in accordance with the **Referrals Procedure.**

3. Where it is believed that a child of a parent with mental health problems may be at risk of significant harm, a **Strategy Discussion/Meeting** should be held and consideration should be given to undertaking a **Section 47 Enquiry**

4. In circumstances whereby a parent/carer has mental health problems it is likely there are a number of professionals involved from different services. It is important that these professionals work together within enquiries and assessments to identify any links between the parent's mental health, their parenting, and the impact on the child. Any assessment should include an understanding of the needs of the family and children and an identification of the services required to meet these needs.

Guidelines for Joint Working

6. It is essential that staff working in adult mental health and child care work together within the application of child protection procedures to ensure the safety of the child and management of the adult's mental health.

7. Joint work will include mental health workers providing all information with regard to:

    - treatment plans
    - likely duration of any mental health problem
    - effects of any mental health problem and medication on the carer's general functioning and parenting ability.

8. Child protection workers must assess the individual needs of each child and within this incorporate information provided by mental health workers.

9. Mental health professionals must attend and provide information to any meeting concerning the implications of the parent/carer's mental health difficulty on the child. These will include:

    - **Strategy Meetings**
    - Initial and Review **Child Protection Conferences**
    - **Core Groups.**

10. Child care professionals must attend Care Programme Approach (CPA) and other meetings related to the management of the parent's mental health.

11. All plans for a child including **Child Protection Plans** will identify the roles and responsibilities of mental health and other professionals. The plan will also identify the process of communication and liaison between professionals. All professionals should work in accordance with their own agency procedures/ guidelines and seek advice and guidance from line management when necessary.

Contingency Planning

12. Child care and mental health professionals should always consider the future management of a change in circumstances for a parent/carer and the child and how concerns will be identified and communicated. This may include:

Mentally ill parents and children's welfare

By Richard Green (February 2002)

Key points

The extent to which parental mental illness effects the standard of parenting and children's safety or welfare hinges on a number of factors. A small number of children die or are seriously harmed by a mentally ill parent. Many more children suffer less dramatic effects as their own development or mental health becomes compromised. There is a *'hidden problem'* around children who care for a mentally ill parent ('young carers') who may miss out on many opportunities. The *'scale of the problem'* is not known but it has been estimated that psychiatric morbidity amongst parents is about 16%. There are many barriers - legal, structural, professional, financial - to the creation of services which tackle both parental mental illness and children's welfare but some interesting initiatives have been set up.

The impact upon children

Parental mental illness takes many different forms. Its impact upon children varies according to a host of factors. One is the severity and duration of the illness. For instance, a temporary and minor illness handled by primary care services is likely to be much less disruptive to family life than a severe and chronic psychotic illness requiring lengthy hospitalisation. Other variables include the child's age and resilience, the presence or absence of a *'well'* parent/ carer and the extent to which the illness pervades all aspects of family life (Rutter, 1989). It is tempting, but inadvisable, to give undue weight to the psychiatric diagnosis. As Reder et al (1993) point out, the telling factor is not the diagnosis as such but the parental *behaviour*.

So, how does parental mental illness affect children? The research can be distilled into three sub-headings the impact upon parenting, direct effects on children and children who care for a mentally ill parent.

Effects on parenting

There is a body of literature and research (Murray, 1996; Ethier et al, 1995; Dore, 1993; Sheppard, 1993) which points to those suffering mental illness having impaired social performance and disproportionately conflictual relationships. Parenting may be adversely affected. Ethier et al (1995), for instance, found that clinically depressed mothers were more likely to speak less often to children, enforce obedience unilaterally and react in more hostile and irritable fashion. Murray (1996) produced similar findings of social disadvantage, relationship problems with children and the latter having increased levels of behaviour difficulties.

A small study of parents who use mental health services (Hugman and Phillips, 1993) showed that all thought their relationships with their children had suffered at some point. It is generally held that parental mental illness is a risk factor in respect of child abuse (Sheppard 1993). Forthcoming research into serious injuries sustained by children under 24 months suggests many parents had poor mental health (Dale, Green and Fellows, forthcoming) though a formal diagnosis of mental illness was relatively rare. Research (cited in Dore, 1993) which has inquired into causal relationships between parental mental illness and abuse has produced mixed findings

Direct effects on children

There is a second body of literature/ research which has covered much of the same territory but from the perspective of child welfare. A pioneering paper by Kempe et al (1962) posited that psychiatric factors were probably *'of prime importance'* (Kempe et al, 1962, p.17) in the aetiology of child abuse. Subsequent research has suggested that the causes of child abuse are generally more complex and multi-factorial. Nonetheless, Bell et al (1995) found parental mental illness recorded as a factor in 13% of cases referred for child protection concerns. A number of children suffer permanent injury or die at the hands of mentally ill parents (Falkov, 1995), typically during an acute

phase of an illness. Also a small number are seriously harmed or die as a

consequence of a carer, generally the mother, suffering from Munchausen's Syndrome by Proxy (see e.g. Bools et al, 1994).

Nonetheless, the greatest risk to the majority of children is not one of life and limb. It is rather the threat to their own attachments, development and mental health (Rutter, 1989). Rutter and Quinton (1984) concluded that one-third of the children of new psychiatric cases exhibited a persistent disorder, this being twice the rate found in the control group. A recent study (Singer et al, 2000) found high rates of psychiatric disturbance within a small sample of children of psychiatric in-patients, many of these children being unknown to services. Reid and Morrison (1983) suggested that young children are particularly vulnerable, as are the children of psychotic parents. The issue of whether psychosis poses more risk than, say, depression is a typically complex one within this field and, as with many issues, best treated with caution. For instance, Cassell and Coleman (1995) posit that children are at increased risk if incorporated into parental psychotic ideation conversely, other research (see Dore, 1993) showed no differences in outcomes between children of psychotic and depressed parents.

Children who care for a mentally ill parent

Finally, there is a third germane body of literature/research which focuses on children who care for a mentally ill parent. These are commonly referred to as young carers though this is mostly employed as a generic term encompassing children who care for parents for a number of different reasons, including parental physical disability or physical illness. Estimates of the numbers of young carers nationwide vary between 10,000 and 40,000, of which about one-third care for a mentally ill parent (Dearden and Becker, 1995). Care is more likely to be provided by girls than boys and may well have a physical and emotional component. It is also likely to be provided to younger siblings as well as ill parents. A number of personal accounts (Marlowe, 1996) and reports (SSI, 1996) point to the difficulties experienced by a proportion of young carers. The problem is not the caring per se - indeed, many young carers report a wish to undertake this role. It is the missing out on educational, social and leisure activities that is sometimes concomitant with this role. Young Carers are something of a *'hidden problem'*, being either unknown to services or being left to cope.

Our own study (NSPCC, 1997) contained some poignant accounts of children acting as carers and of the costs thus incurred. It also showed that many of these children had significant experiences of loss, self-blame and stigma.

The scale of the problem

Accurate data as to the percentage of mentally ill parents who have dependent children is not systematically recorded (Falkov, 1997). Indeed, at the point of first contact with mental health professionals many recipients of mental health services are not identified as parents (Blanch et al, 1994). Thus, information as to the scale of the problem is largely based on estimates. Within this context, Gopfert estimates that one half of all mentally ill adults are parents living with dependent children (Gopfert et al, 1996). Meltzer et al (1995) estimate the psychiatric morbidity among parents nationally to be 16%.

There are a number of studies which examine the prevalence of mental illness amongst adults (not necessarily parents) which suggest that prevalence is governed to some extent by gender, ethnicity and class. It is known, for example, that twice as many women as men suffer from depression (Sheppard, 1993) and that depression is a particularly common disorder amongst women of child-bearing age (Downey and Coyne, 1990). A seminal work established that working class women were four times more likely to suffer from a psychiatric disorder than their middle class counterparts (Brown and Harris, 1978). There are differential rates of prevalence within different cultures. This may reflect a link between social stress (racism unemployment, poverty etc) and mental illness (see e.g. Littlewood and Lipsedge, 1989). However, the picture is complex as there is not a clear one-to-one relationship between social disadvantage and mental illness. One difficulty is that the term *'mental illness'* is itself culturally-bound; mental health may manifest itself differently in different cultures. Community based studies suggest that prevalence rates are about 1% for schizophrenia, 5% for depression, 10% for personality disorders and 10-30% for anxiety disorders (quoted in Cleaver et al, 1999).

Research into the field of mental illness is mired in definitional / methodological difficulties. For instance, a number of studies might all examine *'mental illness'* but be looking at very different phenomena. Some studies are drawn from samples of psychiatric in-patients whilst others are drawn from the community at large, depending mostly on respondents' self-report. It does not necessarily follow that the findings drawn from a psychiatric sample examining psychosis can be compared or integrated with those examining those suffering depression in the community. Equally, some studies include alcohol and substance abuse whilst others exclude these.

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Other organisations to contact

- **Association for Child and Adolescent Mental Health**

www.acamh.org.uk

- **Mental Health Foundation**
  www.mentalhealth.org.uk
- **MIND**
  www.mind.org.uk
- **YoungMinds**
  www.youngminds.org.uk

This research briefing is based on a review of research and literature. It reports the findings and views of a range of authors. These views are not necessarily the views of the NSPCC.

Although the websites listed here are checked regularly the constantly changing nature of the internet means that some sites may alter after we have viewed them. The NSPCC is not responsible for, nor does it necessarily endorse, the content of these external websites.

Help for children & young people
0800 1111

Help for adults
0808 800 5000

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

FR/LP/02

Framework for Routine Outcome Measurement in Liaison Psychiatry (FROM-LP)

Faculty of Liaison Psychiatry
Royal College of Psychiatrists

FACULTY REPORT

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Faculty Report FR/LP/02

May 2015

Contents

Background

Over the past few years there has been an increasing focus upon outcome and performance measurement in liaison psychiatry services. Various options and approaches have been considered, but without identification of an agreed way forward. This has become particularly important due to the fact that, although there is mounting evidence for the economic benefit of liaison psychiatry services, there is a relative lack of information and evidence relating to clinical and other outcomes (Fossey & Parsonage, 2014).

Over the same period there has been an increasing emphasis, across the NHS, upon the need to establish the collection of outcomes data as a matter of routine. All of this has been moving forward in the context of the NHS quality agenda (Dept. of Health, 2011):

- Effective services
- Safety
- Positive patient experience

Three main types of outcome measures have been proposed, and are now seen as an absolute requirement within NHS services:

1. CROMS - Clinician-Rated Outcome Measures
2. PROMS - Patient-Rated Outcome Measures
3. PREMS - Patient-Rated Experience Measures

Attempts have been made, particularly by the RCPsych Faculty of Liaison Psychiatry, to reach a conclusion as to what measures should be recommended for use across all liaison psychiatry services, in order to promote a consistent approach. This has involved work by a range of individuals at strategy days and in workshops at two annual residential conferences.

Elements of this were fed into the work then carried out by colleagues at the Centre for Mental Health, which led to the production of a report entitled Outcomes and Performance in Liaison Psychiatry: developing a measurement framework (Fossey & Parsonage, 2014). This important report provided a clear and structured account of the issues faced in attempting to measure outcomes consistently in liaison psychiatry, and suggested some possible ways forward.

The aim of this paper is to build upon the clarity of approach provided in the aforementioned report, by providing a framework for routine outcome measurement across liaison psychiatry services, with the inclusion of specified measures for all services to use.

Key Points to consider, from the Centre for Mental Health Report:

- Outcome and performance measurement in liaison psychiatry services is at present very variable in content and quality.
- Liaison psychiatry services operate in a number of different settings and clinical environments, carrying out a wide range of different activities in support of patients suffering from many different types of clinical problems.
- Most measurement frameworks for assessing quality and performance of services build upon the longstanding "logic model" developed in the 1960's, with the focus upon the following three aspects:
  1. **Structure;** the key resources or inputs available in the settings concerned.
  2. **Process;** what is actually done in the delivery of healthcare in terms of specific activities, with measurement based on quantifiable outputs such as the numbers of patients seen/ treated.
  3. **Outcome;** referring to any consequence of healthcare in terms of changes or benefits which result from the activities and outputs of the service in question.

(Donabedian, 1966)

As also identified in the Centre for Mental Health Report:

a. The best strategy for assessing quality and performance is to include a mix of indicators drawn from the three dimensions of structure, process and outcome: the so-called "balanced scorecard" approach.
b. The complexity and heterogeneity of the service provision in liaison psychiatry necessarily rules out any (single) very simple, all-purpose approach to the measurement of the outcomes of performance in this context.

FROM-LP

Building upon all of this, there is a clear need for an explicit framework defining, across the various settings and in relation to the various actions carried out by liaison psychiatry teams, what should be measured and how. No single instrument can be universally applied across the whole of liaison psychiatry, necessitating the need for different groups of outcome measures (ie scorecards) in different contexts, but it will be crucial to ensure that the approach is as simple, as easy and, therefore, as consistently deliverable as possible.

In line with this aim, and considering all of the above, it is proposed that the **Framework for Routine Outcome Measurement in Liaison Psychiatry (FROM-LP)** is adopted across all liaison psychiatry services in the NHS. This would enable consistency of data collection and the effective reporting of outcomes in individual liaison psychiatry services, in a way which would allow our various 'customers' (patients, carers, referrers and commissioners) to understand and have confidence in the beneficial effects of liaison psychiatry services. This initiative is being introduced at a critical time, when liaison psychiatry services need to move rapidly to a position of being able to say something useful about what they do, from an outcomes perspective.

Improvements in the approach may come later, perhaps as a result of experience of using the Framework, but we need to move forward with this as a matter of some urgency. To continue to discuss and attempt to find a "perfect" approach before introducing anything would be unwise.

In consideration of the "logic model", outlined above, the proposal is for Structure (inputs) to be an issue for local services and for the Psychiatric Liaison Accreditation Network (PLAN).

FROM-LP will focus upon brief, simple, easy and deliverable data collection regarding Process and, in particular, Outcomes (spanning clinician-rated clinical outcomes, patient-rated clinical outcomes, patient-rated satisfaction, and referrer-rated satisfaction).

In order to keep this as simple and deliverable as possible, FROM-LP defines only **two clinical case types**, according to whether they involve a **single clinical contact** or a **series of clinical contacts** by the liaison psychiatry team. This is of course partly determined by the setting, but for routine and simple outcome measurement the setting need not determine the measurement approach.

(It is acknowledged that services may have some additional local data collection requirements, beyond those stipulated in this Framework.)

FROM-LP outcome measurement requirements:

1 CASE TYPE 1: SINGLE CONTACT

(ED, SH assessments, in-reach assessment, etc)

Process

- Response time (routine/urgent/emergency - avoidance of breaches)
- Identify the aim / rate achievement of the aim (see "IRAC" tool below)

Outcomes (clinician-rated)

- CGI-I

Outcomes (patient-rated)

- Generic - Nil
- Condition specific - Nil

Patient satisfaction

- Patient satisfaction scale
- Friends and family test

Referrer satisfaction

- Referrer satisfaction scale (case by case or as a regular survey - see below)

2 CASE TYPE 2: SERIES OF CONTACTS

(Clinics, brief or longer-term interventions, in-reach interventions, etc)

Process

- Response/waiting time (waiting list - avoidance of breaches)
- Identify the aim / rate achievement of the aim (see "IRAC" tool below)

Outcomes (clinician-rated)

- CGI-I

Outcomes (patient-rated)

- Generic - CORE-10
- Condition specific (see Appendix 2)

Patient satisfaction

- Patient satisfaction scale
- Friends and family test

Referrer satisfaction

- Referrer satisfaction scale (case by case or as a regular survey - see below)

(The relevant tools and scales are shown in Appendix 1.)

FROM-LP: summary table

	CASE TYPE	
MEASUREMENT		
	SINGLE CONTACT	**SERIES OF CONTACTS**
PROCESS:	**1) Response time** **2) IRAC**	**1) Response/waiting time** **2) IRAC**
OUTCOMES (clinician-rated)	**3) CGI-I**	**3) CGI-I** (at beginning and end of series of contacts)
OUTCOMES (patient-rated)		**4) CORE-10** (at beginning and end of series of contacts)
PATIENT SATISFACTION	**4) Patient satisfaction scale** **5) Friends and family test**	**5) Patient satisfaction scale** **6) Friends and family test**
REFERRER SATISFACTION	**6) Referrer satisfaction scale** (as a regular survey if frequent referrers)	**7) Referrer satisfaction scale** (as a regular survey if frequent referrers)

NOTE:

These measures are to be collected routinely (ie in all relevant cases).

They are at the level of the individual contact and the intention is that they are simple and easy to administer, to achieve consistent collection.

For Case Type 1: Experience suggests that it is too much to ask of our very frequent referrers (eg ED, or medical wards which routinely take self-harm admissions, etc) to complete the Referrer Satisfaction Scale for every case. In such settings, a regular survey of the relevant staff (referrers) is recommended instead, eg quarterly (every 3 months) But in relation to services which refer less frequently, the Referrer Satisfaction Scale should be used on every occasion.

For Case Type 2: In addition to using CORE-10 as a generic patient-rated outcome measure, consideration may be given to the use of condition specific measures (see Appendix 2).

For cases which do not involve direct patient contact (ie are at a systemic / clinical team level) use:

1. IRAC
2. Referrer satisfaction scale

Other measurement of:

- Patient demographics, referral source, referral profile, discharge destination, etc
- Structure (resources and inputs)
- Process in a broader sense (eg number of patients seen/treated)
- Education and training of general hospital staff/teams
- Impact on local health service use
- etc

will necessarily be via local monitoring systems.

APPENDIX 1

Relevant scales

1 IRAC: Identify and Rate the Aim of the Contact

Specify the main aim of the contact (tick one box):		Was this achieved?
Assessment and diagnosis/formulation	[ ]	
Providing guidance / advice	[ ]	Fully achieved 2
Signposting / referring on	[ ]	
Assessment and management of risk	[ ]	
Assessment of mental capacity	[ ]	Partially achieved 1
Assessment re: Mental Health Act	[ ]	
Medication management	[ ]	
Management of disturbed behaviour	[ ]	Not achieved 0
Brief psychological interventions	[ ]	
Treatment (other)	[ ]	

(Trigwell P, 2014a)

2 CGI-I: Clinical Global Impression - Improvement scale

Compared to the patient's condition at the start of assessment, his/her condition is:						
Very much improved	Much improved	Minimally improved	No change	Minimally worse	Much worse	Very much worse
1	2	3	4	5	6	7

(Guy W, 1976)

(The wording of the CGI-I has been altered slightly, to enable it to be applicable to single contact episodes and to the context of liaison psychiatry work, by replacing "at admission" with "at the start of assessment".)

3 Patient satisfaction scale

How would you rate the service you have received from (name of service)?				
Excellent	Good	Average	Poor	Very poor
4	3	2	1	0

What has been good about the service you have received?
What could be improved?

(Persaud A et al, 2008)

4 Friends and family test

How likely are you to recommend this service to friends and family if they need care or treatment?					
Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know
1	2	3	4	5	6

(Department of Health, 2012)

5 Referrer satisfaction scale

For an individual case:

In relation to this patient's care, how would you rate the service received from (name of service)?				
Excellent	Good	Average	Poor	Very poor
4	3	2	1	0

For a staff/referrer survey:

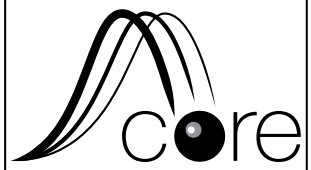
In general, how would you rate the service received from (name of service)?				
Excellent	Good	Average	Poor	Very poor
4	3	2	1	0

Also, for either:

What has been good about the service you have received?
What could be improved?

(Trigwell P, 2014b / after Persaud A et al, 2008)

6 CORE-10 (example sheet)



CORE - 10

Site ID

letters only | numbers only

Client ID

Therapist ID | numbers only (1) | numbers only (2)

Sub codes

Date form given D D / M M / Y Y Y Y

Age

Male

Female

Stage Completed

S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last Therapy Session
X Follow up 1
Y Follow up 2

Stage

Episode

IMPORTANT – PLEASE READ THIS FIRST

This form has 10 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week	Not at all	Only Occasionally	Sometimes	Often	Most or all the time
1 I have felt tense, anxious or nervous	0	1	2	3	4
2 I have felt I have someone to turn to for support when needed	4	3	2	1	0
3 I have felt able to cope when things go wrong	4	3	2	1	0
4 Talking to people has felt too much for me	0	1	2	3	4
5 I have felt panic or terror	0	1	2	3	4
6 I made plans to end my life	0	1	2	3	4
7 I have had difficulty getting to sleep or staying asleep	0	1	2	3	4
8 I have felt despairing or hopeless	0	1	2	3	4
9 I have felt unhappy	0	1	2	3	4
10 Unwanted images or memories have been distressing me	0	1	2	3	4

Total (Clinical Score*)

* **Procedure**: Add together the item scores, then divide by the number of questions completed to get the mean score, then multiply by 10 to get the Clinical Score.

Quick method for the CORE-10 (if all items completed): Add together the item scores to get the Clinical Score.

331/29

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

(Barkham et al, 2013)

Register free to use CORE-10 and to download forms at:
www.coreims.co.uk/Downloads_Forms.aspx

APPENDIX 2

Condition Specific Measures

The Liaison Psychiatry Faculty of the RCPsych is currently carrying out work to clarify appropriate condition specific measures which can and/or should be used in clinical work within liaison psychiatry services. This initiative is expected to lead to a conclusion during 2015.

Possibilities identified to date (in accordance with relevant NICE Guidance, where available):

1	Dementia:	ACE-R
2	Depressive disorders:	PHQ-9
3	Postnatal depression:	Edinburgh Postnatal Depression Scale
4	Anxiety disorders:	GAD-7
5	Psychosis:	HoNOS
6	Alcohol:	AUDIT-C
7	Eating disorders:	BMI
8	MUS:	EQ-5D-5L

NO specific measures recommended for:

1. Delirium
2. Self-harm
3. Personality disorders
4. Violence

Other related work

Progress in this area will also be informed in time as a result of the recently commissioned National Institute for Health Research HS&DR project **LP-MAESTRO (Measurement and evaluation of service types, referral patterns, and outcomes)**, being led by Professor Allan House, Dr Peter Trigwell and colleagues. Both PLAN and the Liaison Psychiatry Faculty of the RCPsych are linked with and involved in this important project.

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Contents

Admissions 2014/15

CCG	Adolescent	Child
NHS Barnsley CCG - 02P	9	1

Service Category 2014/15

CCG	Adolescent	Child
NHS Barnsley CCG - 02P	11	1

Occupied bed days 2014/15

CCG	Adolescent	Child
NHS Barnsley CCG - 02P	370	13

ED	LD	Low Secure	Medium Secure	PICU

ED	LD	Low Secure	Medium Secure	PICU

ED	LD	Low Secure	Medium Secure	PICU

Grand Total
10

Grand Total
12

Grand Total
383

Admissions 2015/16

CCG	AC	CLD
NHS BARNSLEY CCG	11	

Service Category 2015/16

CCG	AC	CLD
NHS BARNSLEY CCG	13	

Occupied bed days 2015/16

CCG	AC	CLD
NHS BARNSLEY CCG	781	

ED	Low	Med	PICU	UKNC
1				1

ED	Low	Med	PICU	UKNC
1				1

ED	Low	Med	PICU	UKNC
18				3

Grand Total
13

Grand Total
15

Grand Total
802

CAMHS / All Placement Reasons

CCG of Patient	Average Distance from Home (Miles)	Greatest Distance from Home (Miles)
NHS Barnsley CCG	17.67	36.16

Least Distance from Home (Miles)	% Patients Placed In-Region
11.21	81.82%

Spend per CCG and per provider	Sum of total costs
NHS BARNSLEY CCG	£622,184
Sheffield Children's NHS Foundation Trust	£622,184

Barnsley Clinical Commissioning Group

Putting Barnsley People First

Future in Mind – Local Transformation Plan Implementation Group

Terms of Reference

NHS Barnsley Clinical Commissioning Group
Future in Mind – Local Transformation Plan Implementation Group

1. Introduction

1.1 Barnsley CCG and partners have established a Future in Mind Implementation Group to ensure delivery of the assured Barnsley Local Transformation Plan. Oversight of the performance of the higher level support CAMHS services (previously referred to as Tier 3 services), within the Barnsley system of care and support for children, young people and their families will be undertaken via the normal contractual mechanisms and the appropriate Clinical Quality Board.

2. Purpose

2.1 The primary purpose of the 'Future in Mind' Group is to work collaboratively with all parties to ensure effective implementation of and continuous monitoring of the Barnsley Local Transformation Plan to enable delivery of sustained improvement in the emotional Health and Wellbeing of the Children and Young People in Barnsley. The 'Future in Mind' Group will also further develop plans for continued delivery of these improved outcomes over the next five years.

3. Responsibilities

3.1 The responsibilities of the Group will be as follows:-

- To provide a forum for open, honest and transparent dialogue to ensure implementation of the actions outlined within the Local Transformation Plan.

3.2 To agree who/which organisation will lead the delivery of each of the Local Priority Streams outlined in the LTP and to work collaboratively to ensure organisational barriers do not impede effective delivery of the desired outcomes of the Plan;

- To develop metrics/KPIs against which effective delivery of the LTPs objectives can be measured;

- To provide quarterly assurance to NHS England of the appropriate investment of FiM monies and the impact this investment has on the emotional health and wellbeing of children and young people in Barnsley.

4. Stakeholders

(a) Barnsley CCG Chief Nurse (Chair)
(b) Barnsley CCG Head of Commissioning Mental Health, Children's and Specialised Services
(c) Barnsley CCG Clinical Lead

(e) BMBC Family Centres & Early Years
(g) BMBC Education Psychology
(h) BMBC Youth Offending Team
(i) Public Health
(j) Secondary Schools Representative
(k) Primary Schools Representative
(l) SWYPFT District Director – Forensics & CAMHS and/or SWYPFT Deputy Director CAMHS
(n) SWYPFT Clinical Lead/Senior Clinician

(q) School Nursing Service

The Group will be serviced by the administrative support to the Chief Nurse.

5. Meetings

5.1 There will be 2 Stakeholder Engagement Events held each year (March and September).

5.2 Local Priority workstream leads will meet on a monthly basis and these meetings will be facilitated by the CCG

6. Governance

6.1 The Group will be a Sub-Group of the Children & Young People Executive Commissioning Group.

7. Reporting Arrangements

7.1 Agendas and papers will be distributed to Stakeholders / workstream leads by email, one week prior to the relevant meeting.

7.2 The minutes/action log will be distributed to stakeholders / workstream leads, by the administrative support to the Chief Nurse, no later than two weeks after the relevant meeting.

7.3 A highlight report will be agreed and submitted to the Children's Executive Commissioning Group following each Stakeholder Engagement event. A verbal update as to progress of the implementation of the Transformation Plan will be given at every ECG.

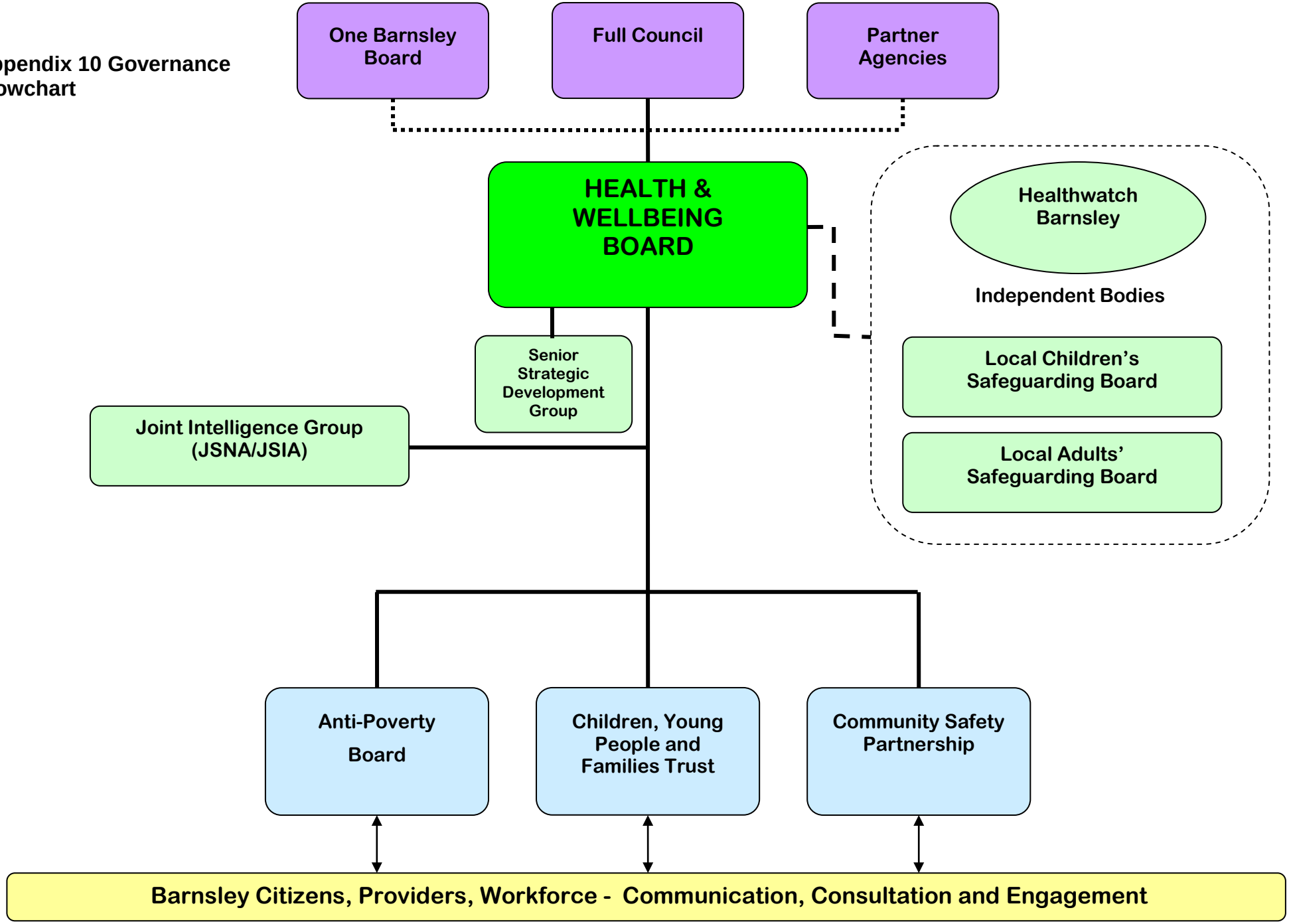
7.4 Trackers will be submitted by the Chief Nurse's administrative support to NHS England on a quarterly or as required basis.

9. Duration

9.1 The Stakeholder Events and monthly workstream leads meetings will continue until such time as the members agree that a system wide sustainable low level emotional health & wellbeing support for Children & Young People exists in Barnsley and is delivering desired outcomes.

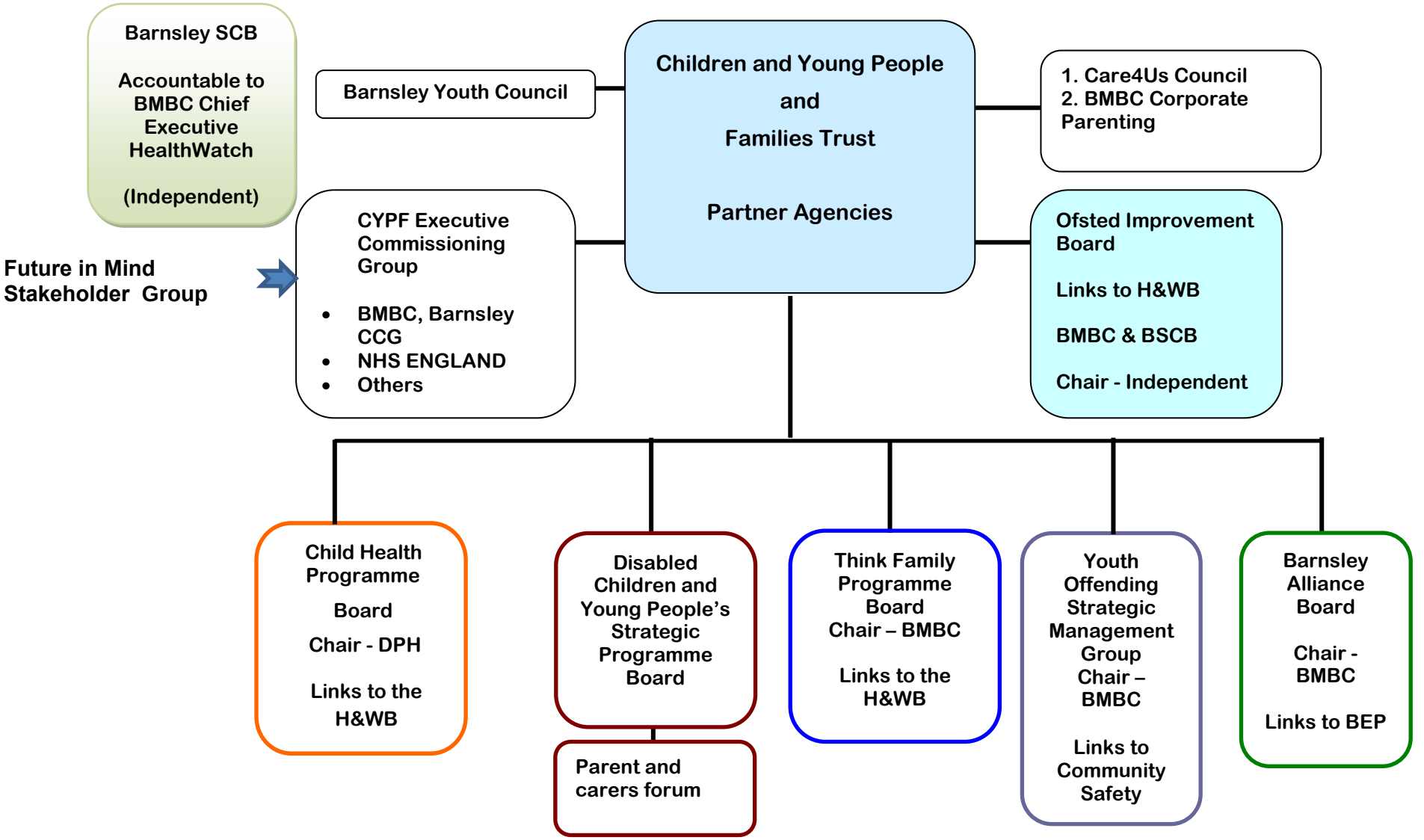
Last Reviewed: July 2016
Next Review Due: July 2017

Appendix 10 Governance Flowchart



Proposed networks for the Barnsley Children, Young People and Families Trust

Partnership groups connected to the CYPFT



BARNSLEY
Metropolitan Borough Council

ALL AGE EARLY HELP STRATEGY 2017-2020

CONTENTS

FOREWORD

The All Age Early Help Strategy (2017–2020) for Barnsley identifies a series of priorities where we feel collectively, that we can make a difference to achieve the best outcomes for individuals, families and communities within the borough.

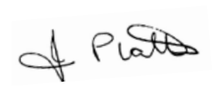
It is important that in such times where resources are reducing and demand for specialist services is increasing, that we work together and pool our resources to ensure people in our communities get the right support, at the right time, in the right place to tackle problems early. Early help minimises the risk of problems becoming more severe and entrenched, and ensures that people are supported to achieve their full potential and lead fulfilling and rewarding lives.

The Barnsley Strong Communities Partnership reports to the Health and Wellbeing Partnership, bringing together a range of public, private, voluntary, community and social enterprise partners. This strategy will maximise capacity and builds the resilience of individuals, families and communities. It will promote collective ownership and accountability for the delivery of our visions and priorities. Working across all sectors, we acknowledge that strong and resilient communities form the solid foundation on which to deliver this strategy.

The strategy outlines our strategic intentions and approach to ensure early help is understood, accessible and firmly embedded within the working practices of all agencies, promoting lifetime and whole-family planning to deliver effective early help in Barnsley.

We are therefore pleased to announce this strategy, and look forward to working together to ensure that local people and communities can reach their full potential and that together, we can achieve a brighter future, a better Barnsley.

Councillor Lamb, Barnsley Council,
Chair of Stronger Communities Partnership



Councillor Platts, Barnsley Council,
Chair of Stronger Communities Partnership

INTRODUCTION AND OVERVIEW

The All Age Early Help Strategy is one of a number of strategies and plans which contribute towards the Health and Wellbeing Partnership vision, enabling the people of Barnsley to:

BE HEALTHY
STAY SAFE
ENJOY AND ACHIEVE
BE AN ACTIVE CITIZEN
EARN A GOOD LIVING

It recognises that well-timed support and intervention in one aspect of a person's or family's life can lead to resilience, confidence and achievement in other aspects of life. There is also an emphasis on the importance of working together effectively with other local partner organisations in the public and voluntary sector, and with local communities, to promote shared ownership of the outcomes we want to achieve.

What is early help?

Early help is a simple concept; it is about changing our culture from an often late reaction and re-focussing our approach along with our resources on the root causes of problems. By doing so, outcomes for children, young people, families and vulnerable adults improve and costly statutory interventions are avoided.

Early help is about giving people the help they need as early as possible, and supporting individuals, families and communities to do more for themselves. Central to our early help approach is the early identification of children, young people, families and vulnerable adults who would benefit from early Help and a co-ordinated early assessment and response to help people improve their outcomes.

Early help may occur at any point in an individual's life, and can involve interventions early on in life as well as interventions early in the development of a problem.

Whose responsibility is early help?

Early help is everyone's responsibility. Individually and collectively we all have a responsibility for developing self-resilience, ensuring people are supported to build on their strengths, recognise when help is needed early and to develop tools to tackle root causes of problems to maintain their independence and overall wellbeing.

Resilient and connected communities are crucial to not only helping each other and themselves to recognise when early help might be needed, but also to ensure there is strength and capacity to help vulnerable individuals and families to help themselves wherever possible.

An effective early help approach requires cross-sector integrated working to ensure opportunities to support vulnerable individuals, families and communities are maximised and people get the early help they need. All sectors including the public, private, voluntary and community have an important role to play in supporting vulnerable people in our communities to recognise early when help is needed and to access the right support, at the right time in the right place.

Working together in a smarter and more joined up way, means that we can achieve greater efficiencies, reduce demand on high-cost services and help vulnerable individuals and families to a position where they are safe, secure and confident and can be effectively supported by universal services and their broader communities to achieve the best possible outcomes.

Working together locally

The Early Help Strategy provides the high level shared vision, outcomes and priorities that partners across the Health and Wellbeing Partnership will collectively work towards over the period of 2017 to 2020. Due to the nature of early help, these are supported by the following connected strategies, plans and commissioning intentions:

LINKS BETWEEN STP AND ALL AGE EARLY HELP STRATEGY

The strategic intentions and direction of these strategies, plans and associated equality scheme requirements align to ensure that, collectively, we work together to deliver effective approaches to early help. This will achieve the best possible outcomes for and in partnership with local people and our communities and keep people safe from harm.

Barnsley Place-based Plan Priorities	EarlyHelp Strategy shared Priorities
IMPROVING HEALTHY LIFE EXPECTANCY	
• Improving mental health and wellbeing • Improving support for older people	• The right early help, in the right place at the right time
• Changing the way we work together (new models of care)	• Ensuring a whole system approach to early help with strong partnership working and system leadership
• Building stronger communities and being in control of my wellbeing	• Empowering local people and communities to build capacity and resilience to enable them to do more for themselves

OUR PRINCIPLES AND COMMITMENT

Our vision for early help in Barnsley is…

Individuals and families are safe, healthy and resilient, having the confidence and skills to thrive and achieve their full potential so that collectively, our communities achieve the best possible outcomes for themselves, their families and each other.

In order to realise our vision, we have developed the following guiding principles:

Addressing root causes and building resilience

People are supported to build on their strengths, to understand underlying factors and develop tools to tackle the cause of problems, building on the resourcefulness of their families and broader communities.

Holistic service pathways

We will work together to deliver an early help offer which is appropriate and tailored to individual and family needs, rather than organisational boundaries.

Early help is everyone's responsibility

As part of our wider community engagement strategy and "Barnsley Deal". This strategy recognises individual self-awareness, responsibility and accountability. We will work together to ensure individuals and families receive the right support, at the right time in the right place to build resilience and achieve their maximum potential.

Wraparound transitional support

Individuals and families are supported to ensure that needs are met as early as possible with appropriate step-up and step-down.

There is 'no wrong door'

We will make every count, ensuring that pathways are accessible and clear so that people get the right, timely support regardless of the first point of contact.

Whole lifetime planning

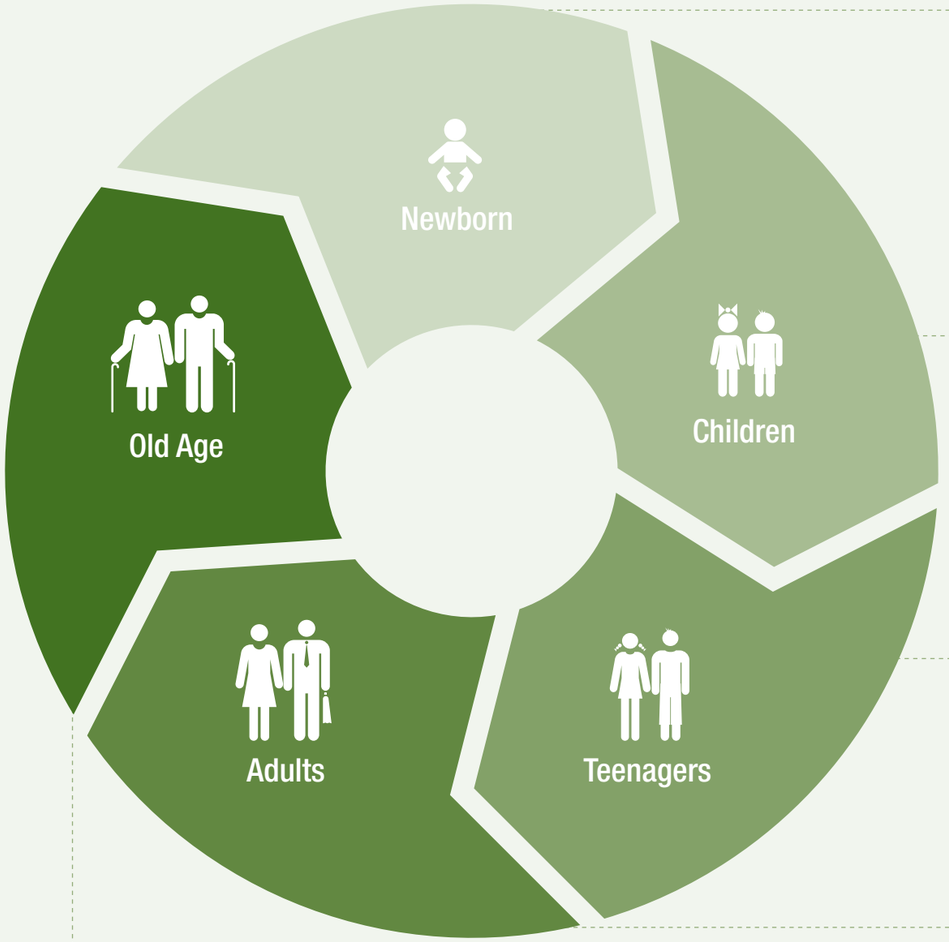
Working together, people are supported across the life course, ensuring that early help needs are identified and support is put in place ensuring smooth transitions between all stages of life.

SETTING OUR PRIORITIES FOR 2017–2020

Understanding our local needs

The Joint Strategic Needs Assessment uses all available data and information to assess the current and future health and wellbeing needs of our local residents and communities. The Older and Vulnerable Persons' Needs Assessment, the Housing Strategy and Area Profiles are other key pieces of research which underpin our understanding and inform the setting of priorities. Such information is used to inform how resources are allocated across the borough in accordance with identified needs, ensuring the best possible health and wellbeing outcomes are achieved whilst also reducing health inequalities.

The following diagram provides an overview of the key findings from the most recent Joint Strategic Needs Assessment and other intelligence sources, and includes extracts from relevant equalities impact assessments. The diagram reflects the common risk factors associated with the need for early help. It is recognised that as part of the delivery and performance frameworks associated to the strategy there will be ongoing work undertaken in relation to life stages, and where appropriate, protected characteristics.



Poverty and Deprivation: Where you live in Barnsley has a significant impact on your likelihood of experiencing child poverty, fuel poverty, pensioner poverty and health issues.

KS2 School Attainment: Barnsley children are behind the expected levels at both Early Years and Key Stage 2.

Primary Attendance: Broadly in line with national rates.

Obesity: 22.1% of 4–5 year-olds, and 33.5% of 10–11 year-olds are overweight or obese.

Mental Health: Barnsley has lower rates of people entering and completing the IAPT service.

KS4 Results: Higher than the expected level in Barnsley.

Secondary Attendance: Broadly in line with national rates.

Youth Offending: Rates reducing in Barnsley despite the England average increasing.

Poverty and Deprivation: 11.3% Fuel Poverty Rate.

Employment: 6.3% Unemployment Rate.

Skills: 27% of adults lack basic digital skills, 11% have no formal qualifications.

Offending: 8.8% decrease in adult re-offending rate.

Crime: 6% rise in overall Crime Rate. Violence against a person +39.4%; sexual violence +20.8%; criminal damage +9.0%; robbery -9.4%; theft -5.1%.

Obesity: 70% of adults are overweight or obese.

Poverty and Deprivation: 1 in 5 pensioners claim Pension Credit.

People with long-term conditions: Accounts for about 50% of all GP appointments, 64% of all outpatient appointments and over 70% of all inpatient bed days (nationally).

OUR APPROACH

All partners are committed to improving the lives of individuals, families and communities in the borough. This requires a multifaceted approach to early help, identifying people at risk and providing wraparound services which promote the principles of prevention, early help, early intervention, and short term targeted support, including step-up and step-down between tiers of need.

By working together and sharing information, we can ensure the best possible outcomes for individuals, families and communities underpinned by the support they need to improve general health and wellbeing:

Be healthy

Enjoy good physical and mental health and live a healthy lifestyle throughout the life course

Earn a good living

Achieve sustainable employment to be successful and reach full potential in life

Be an active citizen

Take responsibility and play an active role in the local community

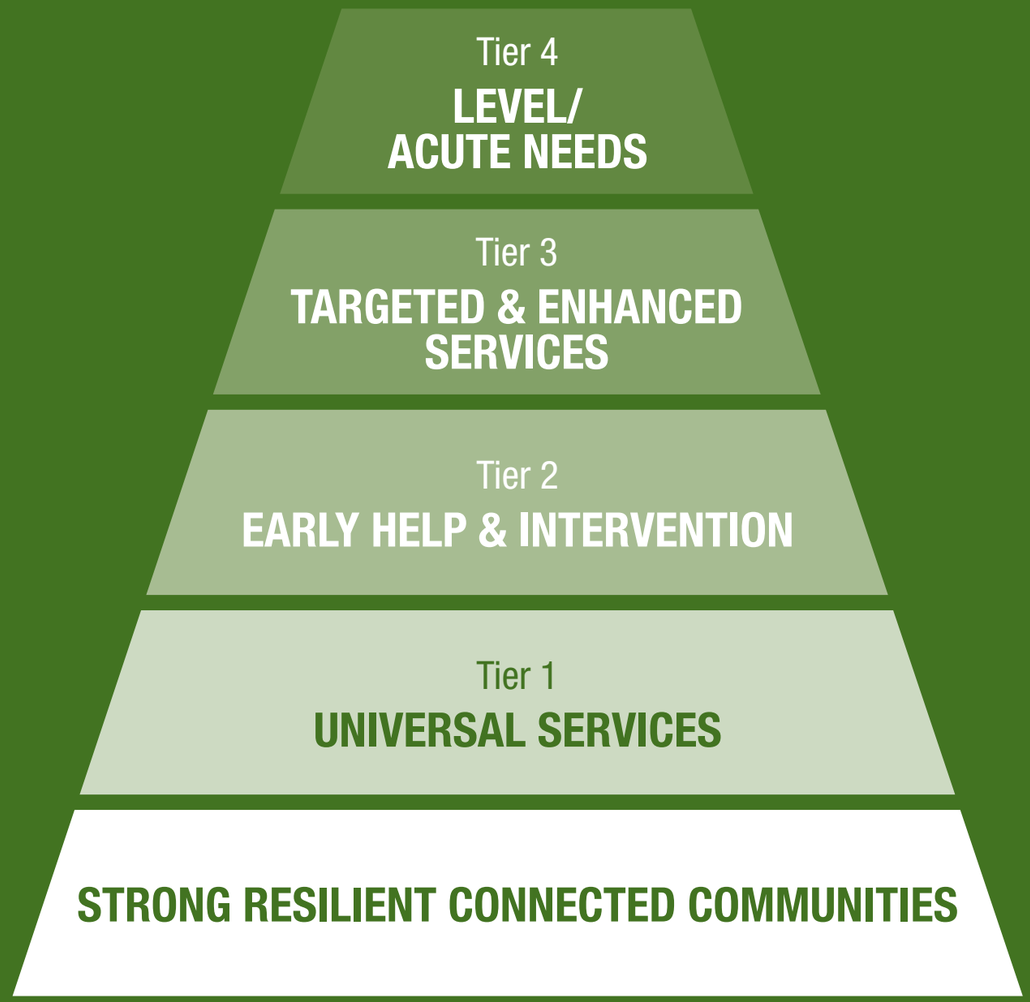
Enjoy and achieve

Get the most out of life and achieve full potential

Stay safe

Be protected from threat, harm and risk

At the heart of this multi-agency approach to delivering early help is integrated working across the whole system. A co-ordinated workforce will provide a more holistic, wraparound package of support to those who need it, at an early stage when interventions are most important. This is primarily focused on tier two vulnerable people, although it is important to emphasise that early help spans across the full spectrum of need.



OUR JOURNEY SO FAR

The strategy will build on the successful work of the Stronger Communities Partnership and our communities in delivering effective early help across Barnsley. Early help is already firmly embedded in our collective approaches, and much success has already been achieved including through the work of our Family Centres, our Think Family Programmes and the invaluable work of our communities.

The following case studies help to illustrate some of the real benefits of effective early help to individuals, families and communities. We will continue to be ambitious, innovative and work together to build on our successes so that better outcomes can be achieved for and in partnership with individuals, families and communities.

SARAH DEVELOPED THE SKILLS AND CONFIDENCE TO LIVE HER LIFE INDEPENDENTLY, DEVELOP BETTER FINANCIAL STABILITY AND REDUCED HER STRESS AND ANXIETY LEVELS

Sarah's Story

Sarah recognised her needs early and self-referred to access early help support. Sarah was on out of work benefits, had mental health needs and required support with finding work.

The Think Family Employment Advisor worked with Sarah to find a local volunteering opportunity. Sarah had previously suffered with anxiety and low confidence, but with support was able to take up a work experience placement at a local pharmacy. Sarah developed new skills and grew in confidence. She secured paid employment a few weeks later.

Sarah settled into her job and continued to access support to build her confidence and self-esteem. Since gaining employment, Sarah feels less stressed and anxious and has developed the skills and confidence to take up further training opportunities. Sarah no longer needs ongoing medical support for anxiety and is really proud of her achievements.

Sarah developed the skills and confidence to live her life independently, develop better financial stability and reduced her stress and anxiety levels. She is now able to better support her family and is looking forward to her future having achieved her long-term goal of gaining employment.

SHE WAS FULLY SUPPORTED, REASSURED AND MOTIVATED. REGAINING THE CONFIDENCE TO ACHIEVE PREVIOUS LEVELS OF INDEPENDENCE WITHIN 4 WEEKS

Hilda's story

Hilda is a highly independent 81-year-old lady who sustained a fall, resulting in a leg fracture requiring surgery.

After being discharged from hospital to Pathway 3 Re-ablement, she was fully supported, reassured and motivated, regaining the confidence to achieve previous levels of independence within 4 weeks.

Hilda is now able to mobilise indoors (for example up and down the stairs) and outdoors independently with no need for supervision. This has really enhanced her quality of life.

Hilda also has a Careline giving her reassurance knowing that help is at hand when needed.

AS A RESULT OF THIS EARLY HELP, THE FAMILY DEVELOPED THE NECESSARY SKILLS TO GROW THEIR CONFIDENCE TO MOVE FORWARD THEIR LIVES INDEPENDENTLY

Thompson family's story

The Thompson family, two parents under 25 with a baby born with a number of health complications, were referred for early help with a number of support needs including benefits advice, budgeting, bereavement and building bonding and attachment.

The family worked with a Family Support Worker for four months to holistically address their individual needs as adults, developing the families parenting skills as well as ensuring that the individual needs of the child were met.

The Family Support Worker supported the family through a range of suitable approaches to meet their needs; expanding their skills in areas such as child development, money management and parenting, as well as supporting Mum to access mental health support.

As a result of this early help, the family developed the necessary skills to grow their confidence to move forward with their lives independently. The family went on to access local groups and were able to benefit from peer support from other parents taking care of a child in special care. They have built strong connections in their community, helping to reduce social isolation, maintain their independence and improve their quality of life.

OUR PRIORITIES FOR 2017–2020

The Stronger Communities Partnership has agreed a number of priorities to deliver the vision for 2020. The following statements recognise the continued focus on building our workforce, community capacity and self-resilience.

Shared priority

The right early help, in the right place at the right time.

Outcome

Individual's families and communities are self-aware, able to identify when they need support, and engage appropriate services to maintain their independence and overall wellbeing.

Our focus

We will:

- Ensure whole system early help pathways are developed which are clearly understood and embedded in practice.
- Ensure that early help thresholds are clearly defined and applied consistently.
- Ensure that evidence-based practice is coupled with insight and innovation to deliver the best possible approach to early help.
- Work with all agencies to put in place a workforce development plan to provide a whole system workforce response to our early help offer.
- Embed an outcome-focussed approach, ensuring that we can demonstrate the impact and difference made to, and in partnership with, our communities through the delivery of a whole system early help offer.

What difference will it make?

- People in Barnsley will know what advice and support is available to them and their families, to help them respond to problems or needs arising due to changing circumstances.
- They will know where and who to go to for support, and what to expect.
- People will be able to deal with issues or problems before they become more severe or complicated; and be independent and resilient enough to support themselves in the longer term, appropriate to their particular needs.

Shared priority

Ensuring a whole system approach to early help with strong partnership working and system leadership.

Outcome

Mature and adaptive partnerships which have shared ownership and accountability for the delivery of an effective early help offer.

Our focus

We will:

- Co-produce with local communities and embed a shared understanding and commitment of our all age early help offer.
- Ensure that all learning across the early help spectrum is shared to celebrate successes, but also learn from areas of improvement.
- Ensure that Early Help is not seen as something at the periphery of service design and delivery, but is embedded as mainstream.
- Align our commissioning approaches to ensure we have a shared focus on outcomes to support the delivery of the Early Help vision and priorities for Barnsley.

What difference will it make?

- Service delivery agencies will work together to minimise duplication, share knowledge about services available, and ensure that vulnerable people don't fall through gaps in processes.
- People in Barnsley will be able to access a range of advice and support services through one point of contact.

Shared priority

Empowering local people and communities to build capacity and resilience, to enable people and communities to do more for themselves.

Outcome

Strong, connected communities supporting themselves and each other to lead happy and fulfilling lives, thereby reducing the demand on statutory services.

Our focus

We will:

- Ensure that the premise of early help is underpinned by an asset-based approach to community development and resilience.
- Enable individuals, families and communities to self-help, and access services independently through maximising the use of technology, ensuring everyone is well informed about the service and support available.
- Promote independence by encouraging and enabling individuals to maintain a good quality of life accessing provision in their communities (helping them to help themselves).
- Recognise the need for strong connectivity with universal services to ensure people who need help are identified early, and effective step-up and step-down practices are in place.
- Ensure that the voice of the individual is at the centre of the early help offer, and individuals, families and communities are empowered to take control of their lives.

What difference will it make?

- People will have the knowledge and confidence to get involved or take a lead on community-based activities and projects, tailored to the skills and needs of their local areas.
- People will feel enabled to be independent but aware of how to seek support services when needed.

MONITORING THE DELIVERY OF OUR PLAN

Delivering our priorities

The Stronger Communities Partnership has overall responsibility for the co-ordination and of the strategy. Early help is everyone's business and therefore there are many organisations, partnerships and community groups, which together, will support the delivery of the strategy. The Stronger Communities Partnership whilst working alongside the Safeguarding Boards, the Safer Communities Partnership and the Children's Trust will ensure the strategic priorities are translated into operational delivery resulting in a co-ordinated and connected approach to early help in Barnsley.

Integrated partnership action plans will be developed and all actions will have lead officers and be time bound to ensure impact can be monitored and measured. The plans could be developed to reflect geographical boundaries I.E. area councils/borough or at a practice level to ensure local needs are met. Performance against key outcomes will be assessed in order to measure our success in delivering the strategy. Qualitative measures including feedback from individuals, families and communities will provide valuable insight and will be monitored alongside the delivery plan and performance measures to ensure that together, we achieve the best possible outcomes for and in partnership with our communities and the residents of Barnsley. It is important that in delivering our priorities we ensure appropriate connections are made to the actions of other strategies.

Resources

Public services are going through an unprecedented time of austerity measures where resources are and will continue to shrink. Our focus is therefore on targeting our resources appropriately in accordance with identified needs, thereby helping us to achieve the best outcomes for and in partnership with local people and communities.

Early help is an approach, not necessarily a service. Now more than ever there's a need to pool our resources across sectors acknowledging that strong and resilient communities will form the solid foundations to the successful delivery of this strategy.

Review

The Early Help Strategy covers the period 2017–2020 and will be reviewed annually to ensure the plan remains agile and focused on the emerging needs of local people and communities. The reviews will also enable an assessment to be made on progress to the previous year and provide means to harness commitment to deliver the future year's aspirations. This will also include equality analysis.

We will also continuously review our delivery plans to ensure there is a clear golden thread from the strategic priorities, outcomes and focus priority areas.

CONTACT US

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If you would like to read this strategy online go to
www.barnsley.gov.uk

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NHS Improvement

NHS England

All NHS Provider Trust Chief Executives
All CCG Accountable Officers
All CCG Clinical Leaders
Copy to Local Authority Chief Executives

Gateway Reference: 06600

9th March 2017

Dear colleague,

Action to get A&E performance back on track

We are writing to thank you and your staff for your work over what has been a highly pressurised winter, and - following the Chancellor's Budget statement yesterday - to let you know about the action now needed to turnaround A&E performance in 2017. Further detail will be provided in the NHS Delivery Plan being published in three weeks' time.

Throughout this winter, there have been three consistent themes relating to urgent and emergency care: difficulties in discharging inpatients when they are ready to go home; rising demand at A&E departments, with the fragmented nature of out-of-hospital services unable to offer patients adequate alternatives; and complex oversight arrangements between trusts, CCGs and councils.

To avoid a repeat next winter of this past winter, we need to make concrete changes on all three fronts.

Freeing up hospital bed capacity

First, we know that difficulties with discharging emergency inpatients has reduced the effective availability of beds in which to care for both emergency patients presenting in A&E, as well as patients needing planned surgery. It is therefore vital that, together with our partners in local government, we ensure that the extra £1 billion the Chancellor has made available for social care is in part used to free-up in the region of 2000-3000 acute hospital beds. We would ask that you immediately now engage with the senior leadership of your local adult social care departments to discuss how those patients stuck in hospital needing home care or care home places can access those services.

It is also, however, indisputable that there are places which have still not adopted best practice to enable appropriate flow, including better and more timely hand-offs between A&E clinicians and acute physicians, discharge to assess, 'trusted assessor' arrangements, streamlined continuing healthcare processes, and seven day discharge capabilities. You now need to ensure these happen everywhere, and well before October 2017.

Managing A&E demand

Some estimates suggest that between 1.5 and 3 million people who come to A&E each year could have their needs addressed in other parts of the urgent care system. They turn to A&E because they are unclear about the alternatives or are unable to access them.

You therefore now need to:

- Ensure every hospital implements a comprehensive front-door streaming model by October 2017, so that A&E departments are free to care for the most urgent patients. Yesterday's Budget has made available an extra £100 million of capital to be deployed in the next six months to support this. Proposals will need agreement with the Department of Health and we will be letting you know proposed allocations of this within the next six weeks.
- Strengthen support to your Care Homes so as to ensure that they have direct access to clinical advice, including where appropriate on-site assessment. We are making available £30 million to support universal roll-out of this model via 111, in order to reduce the risk of care home residents being admitted to hospital.
- Implement the recommendations of the Ambulance Response Programme by October 2017, freeing up capacity for the service to increase their use of Hear & Treat and See & Treat, thereby conveying patients to hospital only when this is clinically necessary.
- Proceed with the standardisation of Walk-In-Centres, Minor Injury Units and Urgent Care Centres, so that the current confusing array of options is replaced with a single type of centre which offers patients a consistent, high quality service.
- Roll out evening and weekend GP appointments, to 50% of the public by March 2018 and 100% by March 2019.
- Increase the number of 111 calls receiving clinical assessment by a third by March 2018, so that only patients who genuinely need to attend A&E, or use the ambulance service, are advised to do this.

Aligned national support and oversight

Given the national importance of improving NHS urgent and emergency care performance, we intend to simplify the focus of the 30% performance element of the Sustainability and Transformation Fund (STF) for 2017/18, so that it will focus on A&E rather than requiring providers to focus on multiple objectives. For individual trusts it will be linked to effective implementation of the actions set out above as well as achieving performance before or in September that is above 90%, sustaining this, and returning to 95% by March 2018.

In order to ensure complete alignment between NHS England and NHS Improvement in supporting and overseeing urgent implementation of the above actions, we have appointed Pauline Philip as the single national leader accountable to us jointly.

Furthermore, from 1st April we are nominating a single, named Regional Director drawn from NHSI and NHSE to support this implementation work and hold accountable both CCGs and trusts through their local STP's A&E Delivery Boards. Each RD will therefore act with the delegated authority of both NHSI and NHSE in respect of urgent and emergency care.

Thank you for your ongoing leadership on this critical part of what the NHS does for the people of this country.

Yours sincerely

Simon Stevens
CEO, NHS England

Jim Mackey
CEO, NHS Improvement

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