Public Engagement Report:
Joint Mental Health Strategy 2012-15

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1. About Us

1.1 The NHS Buckinghamshire and Oxfordshire Cluster

NHS Buckinghamshire and NHS Oxfordshire have now become joined or ‘Clustered’.
NHS Clusters have been established by the Department of Health to ensure that the NHS maintains business continuity of commissioning healthcare locally and to facilitate the change to the new structure of the NHS in 2013, including the move to Clinical Commissioning Groups (CCGs).

All NHS Clusters will have three principal functions:

- Delivery of the PCTs’ Operational Plans and driving clinical service change for 2011 to 2013 and ensuring financial stability for the handover to Clinical Commissioning Groups
- Ensuring and supporting development of Clinical Commissioning Groups and transferring of other current cluster functions to the new organisations yet to be established i.e. the National Commissioning Board, Public Health England, Health Education England, Health and Wellbeing Boards, public health to Local Authorities
- Creating the relevant commissioning support organisation for Clinical Commissioning Groups after post PCT abolition.

1.2 About Oxfordshire

We are ambitious about improving the health and wellbeing of local people. The NHS Oxfordshire & Buckinghamshire Cluster intends that, by 2013, the people of Oxfordshire will:

- be healthier, particularly if they are vulnerable or live in our most deprived communities
- be working with us to promote physical and mental wellbeing and prevent ill health
- be actively supported to manage their health and care needs at home when this is appropriate
- have access to high quality, personalised, safe and appropriate health services
- get excellent value from their local health services

Oxfordshire is the most rural county in south east England and has a large geographical area to cover as well as a diverse population to serve. The population of Oxfordshire ranges from a predominantly older, white population in the rural areas to very ethnically diverse populations in Banbury and Oxford city where one third of the population are students.

The NHS in Oxfordshire works with our communities and our partners to improve health in the area and to make sure that local people’s needs are being met. We also work with organisations from the voluntary, private and community sectors so that we can make sure that the organisations providing health and social care services are working effectively.
Area covered by NHS Buckinghamshire & Oxfordshire Cluster in Oxfordshire

The NHS in Oxfordshire serves a population of approximately 675,000 and covers the areas of Cherwell Vale District Council, Oxford City, South Oxfordshire, Vale of White Horse District Council and West Oxfordshire District Council.
2. Executive summary

2.1 Purpose of the public engagement
The Communications and Engagement directorate at NHS Buckinghamshire and Oxfordshire cluster embarked on a period of engagement from 30 August to 30 September 2011 to gather feedback on the Joint Mental Health Strategy 2012-15. This engagement project did not require formal consultation as no services are currently changing ‘on the ground’ for Service Users and Carers at the moment. However it was important to fully discuss the objectives identified with all stakeholders – particularly with some of the key changes such as the move to clinically-led commissioning and the inclusion of young people in the joint mental health strategy.

2.2 Process & Methodology
The primary method used to engage stakeholders and gather feedback on the Joint Mental Health Strategy was a one-day workshop style event on 21 September 2011. In addition, online engagement methods on the ‘Talking Health’ website were also used with an online survey and direct feedback via email, phone, or freepost available to stakeholders.

2.3 Key Findings
Analysis of the event and other online/direct engagement findings resulted in the following themes emerging:

- **Support for quality, but ensure consistency in mental health services**
The objective/outcome of quality was strongly supported from all respondents and was identified and the most important objective in the strategy. However, when discussing quality, consistency was the main theme and concern. This includes consistency in many areas of mental health including: quality of staff, accessibility of services, training, knowledge and awareness of mental health services by professionals, and consistency of eligibility criteria in young persons and adult mental health services.

- **More Carer involvement**
Many respondents highlighted the need for regular dialogue and more communication with Carers with recognition of the role they play in the care of individuals. More involvement of Carers in mental health service provision, and strategic involvement in the commissioning of services in the future was also identified.

- **Support for the inclusion of young people**
The inclusion of young people in the joint mental health strategy was widely supported with opportunities seen for improvements and seamless mental health services with more continuity of care. A few concerns were raised however that specialist young person’s mental health services might reduce or be diluted and that this would be a negative impact.
- **Education/awareness raising of mental health**
  Education/awareness raising of mental health was repeatedly raised as essential in many areas – including from a young age (in schools); as a preventative measure; to de-stigmatise mental health; to enable support for recovery from the wider community; to increase GPs’ knowledge of mental health and to ensure awareness of the mental health services that are currently available to those that need them.

- **Recovery is an individual concept, but should be embedded throughout the entire Strategy**
  Recovery was widely discussed and accepted to mean different things to different people. Whilst it was felt that motivation and support towards recovery is essential, it should not be a separate objective/outcome, but instead should be embedded throughout all objectives/outcomes in the strategy.

- **Confusion around clinically-led commissioning**
  Understanding of clinically-led commissioning, what this is, how it works, how this will be accountable and how the public, Carers and the voluntary sector can ensure their views, on mental health will be heard was clearly very mixed. The majority of people involved in this engagement project either only knew some of the facts or had received little or incorrect information about clinically-led commissioning through various sources.

- **Revise some terminology and definitions in the strategy**
  The objective/outcome of co-production was felt to be ambiguous and not very meaningful to most respondents and it was felt that the value and involvement of Service Users and Carers needs to be made clearer. A few people also highlighted the need to review the strategy and remove further jargon to enable greater understanding.

### 2.4 Conclusion

The report recommends that the participants’ concerns from the engagement activities are fully considered and as many of their comments and suggestions are incorporated into the final draft of the strategy and the resulting action plan for mental health services. The feedback received will also be fed into the next ‘Hearsay’ event for LINKs/HealthWatch in November 2011 and will help shape our interim and longer-term commissioning intentions.
3. Background

3.1 What is a joint Mental Health Commissioning Strategy?
A joint Mental Health Commissioning Strategy is a document that sets out how the County Council and the NHS in Oxfordshire will work together to plan for the needs of people with mental health conditions and what services have to be bought to deliver the results agreed in local and national policy for mental health and social care.

This strategy for planning and buying mental health services sets out the key principles and objectives for the contracts we hold with local health and social care providers. It does not set out the detail of which services will be available to service users ‘on the ground’, but it should identify the overall outcomes or results those services must deliver.

3.2 Why are we doing this now?
The current joint commissioning strategy, “Better Mental Health in Oxfordshire (BMHO)”, ends in 2012. It is therefore the right time now to be thinking about our strategy to support mental health and well-being going forward over the next 3 years.

There are also a lot of changes happening both nationally and locally and we need to make sure the new strategy reflects this. This includes:

- Managing the changes brought about by the responsibility for buying health services being passed to GP-led Clinical Commissioning Groups (CCGs)
- Taking forward national policy from the new national mental health strategy “No Health without Mental Health”
- Building on the good work that we have done to deliver mental health housing, well-being and recovery services under the programme for “Better Mental Health in Oxfordshire (BMHO)”

3.3 What might change and what will stay the same?
There are not expected to be any immediate ‘on the ground’ changes as a result of the strategy. The strategy will mean that:

- **We will continue to work** with a focus on quality, recovery, working with people to plan their own care and the wider system, and achieving value for money
- **We will put a greater emphasis** on improving the mental well-being of the whole population in Oxfordshire
- **We will find new ways** to support people in transition in mental health - whether between childhood and adulthood, on getting older, or in moving between services or institutions and the wider community
3.4 Summary of proposed objectives for 2012-15

The key challenge for this strategy is to develop a whole person, whole life approach to mental health and well-being that covers all ages and the needs of the wider population, not just those who become ill enough to need to use mental health services. We propose that the new joint Mental Health Commissioning Strategy should deliver the following outcomes:

1. **Quality** The services that we commission (buy) will be high quality, personalised and will ensure that the people they care for receive the highest possible standards of care.

   We need to make sure that when people are unwell, that services delivered in in Oxfordshire are safe, are respectful of people’s dignity and have positive outcomes for them on their journey to recovery. We also need to make sure that there is a process in place for you to tell us what goes well and alert us when things go wrong.

2. **Co-production and accountability** The services we commission (buy) will be integrated into the communities they serve and will be accountable to those communities for the quality of outcomes they deliver.

   We need to make mental health and well-being everybody’s business, and ensure that the services we buy meet the needs of everyone. We believe we can only do this with the active population of the communities in which the services operate.

3. **Well-being & stigma in the wider community** More people will be well and it will be easier for people living with mental health problems to participate in mainstream society.

   We need to address stigma, discrimination and improve well-being with people of all ages and backgrounds in Oxfordshire and help those living with mental health problems move towards recovery and stay living within their local communities.

4. **Transition** People in transition between services will be supported in a way that identifies their needs and ensures that the experience supports their well-being and recovery.

   We need to make sure that the step from childhood to becoming an adult, or stepping from an institution (such as the armed forces or prison) is properly supported and does not make people’s mental health worse.

5. **Recovery** More people will manage their own care as independently as possible in the wider community and live productive lives that reflect their hopes and ambitions.

   Recovery has underpinned our approach to commissioning since 2009 and we think this should continue. People tell us that they want support that encourages them and helps them meet their hopes and ambitions, and does not just get stop them getting worse.

6. **Efficient use of resources, and value for money** We will make best use of resources to deliver our commissioning objectives.

   During the lifetime of the new strategy the financial pressures on public services are likely to become greater. We believe that there are ways of managing this difficult challenge without compromising the outcomes we propose to set ourselves above.
4. Stakeholders

The stakeholders for the engagement activity to support the Joint Mental Health Strategy 2012-15 included all those individuals, organisations or groups with an interest in services for Mental Health, across all age categories.

4.1 Key stakeholders identified

The key stakeholders identified for this consultation included:

**Mental Health Service Users, Carers, families and friends**
This was the primary target group as these people will be using and/or will be most closely affected by any change in the mental health strategy for Oxfordshire.

**Current Service Providers (including the voluntary sector where appropriate)**
Current providers of mental health services were also contacted to disseminate information to the people that use their services and also for staff to share their feedback or attend the engagement event if they wished e.g. Rethink, MIND, Restore and mental health Carers’ support groups.

**All members of previous Better Mental Health in Oxfordshire (BMHO) consultations**
The current mental health strategy for BMHO has involved many specific consultations over the past 2 years looking at different areas of mental health e.g. Keeping People Well (mental health day services), Supported to Independent Living (housing), and Older People’s Mental Health Services. It was important to therefore invite all previous consultation participants to also participate and feedback on the new Strategy.

**Other organisations and groups with an interest in Mental Health Services**
E.g. LINKs (soon to be Healthwatch) and Oxfordshire Community and Voluntary Action (OVCA)

**Healthcare professionals/clinical staff**
Information on the Strategy and engagement event was also shared with clinicians and staff for further dissemination. E.g. using internal newsletters and the PCT intranet.

**Annual Public Meeting**
The draft Joint Mental Health Strategy 2012-15 was also shared with all attendees at the PCT’s Annual Public Meeting. Attendees included clinicians, councillors, staff and members of the public.

**Other**
When communicating this consultation with the key stakeholders listed above, encouragement was also given to share this information with any individual or organisation that may be interested in mental health services in Oxfordshire.
5. Engagement Event – 21 September 2011

5.1 Event Format
The engagement event for the joint Mental Health Strategy 2012-15 was held on 21 September 2011 at West Oxford Community Centre from 10 till 3pm and was attended by 52 stakeholders, including Service Users, Carers and representatives from key organisations across Oxfordshire.

An introductory talk was given by Ian Bottomley, service development manager for mental health at NHS Buckinghamshire & Oxfordshire Cluster, giving a brief insight into the joint mental health strategy and the proposed objectives and focus moving forward.

Question and answers were taken as the talk progressed to ensure clear understanding of the strategy and its objectives. Any issues or questions raised that were not relevant to the day were put on the ‘Park-it’ board, to be picked up by the Mental Health Sounding Board, the next ‘Hearsay’ event, the PCT, the County Council or the Oxfordshire Clinical Commissioning Group (OCCG) as appropriate.

There were two main practical exercises involving both group work (in groups of 6-8 people), as well as individual work.

5.2 Exercise 1
This was a group exercise. Attendees were given a total of 40 minutes for this exercise and were asked to think about each objective and to identify:

What would need to be included in the detail under each objective e.g. what would need to be included (for that objective) make things better for Service Users and Carers? How would the success of that objective be measured?

(Each group started with a different objective to ensure we gained good feedback and insight into all of them)

The feedback received and themes identified are shown under each of the strategy objectives below:

- Quality services - making people feel better

The top issues identified under this objective were about ensuring consistency in services, with good quality training/qualified staff as well as ensuring other skills such as interpersonal skills were high quality. It was also identified that good quality training for ‘staff’ should include training for Carers.

Consistency in the accessibility of mental health services was also raised as an issue.

"Need to outreach to isolated and hard to reach communities - raise awareness of services"
"Lots of services under used because people don’t know about them"

Another key issue regarding the objective of quality, was that services should be evidence-based whilst also being people-focused.

Discussions were had in the groups about how we could ensure quality is delivered and how this should be measured. Suggestions included;

"You need to gather measurable feedback from patients"

"There should be measurable outcomes for individuals and for the services"

- **Co-production and accountability – working together**

The key issue identified when discussing this objective was the dislike of the term ‘co-production’. Attendees felt this term to be confusing.

The other related issue raised was that the objective did not reflect sufficiently the importance of involving Service Users, Carers and the voluntary sector and that this should be specifically stated in the objective.

"Service user and Carer involvement - this objective needs better wording."

"Co-production is Service User and Carer Involvement and quality."

When discussing accountability, groups felt it was important to get feedback directly from Service Users as part of this, but also highlighted concerns for accountability in the future with clinically-led commissioning.

- **Well-being and stigma in the wider community**

The biggest theme in the discussions for this objective were that the key to tackling stigma was early intervention and that schools should be the focus of mental health awareness and anti-stigma campaigns.

"Education in schools to help prevent stigma."

"Promote greater awareness of mental health in schools and local community groups. Promote self care and look at ways to shift perceptions that mental illness is bad (it is not the person but the illness)."

"People we should prioritise: 1/Educators and 2/ Children and young people - particularly in schools, youth clubs, youth centres."

It was also identified that awareness of mental health should be raised in the wider community, and that this could help support a person’s recovery.

"A person’s individual recovery is helped by people having a sense that there is greater understanding of mental health/wellbeing in wider community."
• Supporting people in transition

Groups chose to spend longer on discussing this objective – this may be because the inclusion of young people in the joint mental health strategy is one of the biggest changes going forwards.

There were three key themes emerging in this objective. The first was the need for consistency throughout the transition from young people’s services to adult services in mental health.

“Eligibility when you become an adult - don’t necessarily meet criteria for adults as the criteria is different/doesn’t match well enough - consistency.”

“Professionals need to work seamlessly across transition”

“Reduction in constant change - more consistency.”

Closely related to this, the second theme identified was the need for a transition plan and better information to support those in transition.

“People receiving better and consistent, timely information about the transition.”

“Better transition planning needed and accountability.”

The third main theme was the need for greater Carer involvement throughout the care of an individual with mental health problems, and particularly for those in transition.

“Regular consultation with Carers through transition is crucial”

“Carers need better information about patient’s condition and care plan and medication.”

Other issues identified included suggestions to use the education system as transition model and that services need to fit more around the individual rather than the provider.

• Recovery

Many of the discussions around the objective of recovery raised the issue of what recovery means, with groups identifying that recovery is personal and related to achieving independence.

“Recovery = ‘Independent living' and achieving goals”

“Recovery is an individual thing - measuring success & recovery is about meeting own goals.”

“Recovery - Living with a managed condition as well as possible”
In addition groups highlighted that there are sometimes barriers to recovery and that these need to be identified. Also that Service Users might need help to recognise and get through these barriers, help to manage their expectations, as well as be given motivation to work towards recovery.

"Help people to be aware of trigger points."

Discussions also identified the need for more Carer involvement to support recovery and that more use needs to be made of the Care Plan.

"Needs to be more support for Carers to facilitate recovery."

"Ensure that everyone has a personal care plan and involve family and Carers, recording evidence of audit between Carer and professional."

- Efficient use of resources - managing with less money

Discussions around efficient use of resources identified the need for greater voluntary sector involvement and partnership working.

"Voluntary sector and public sector playing to strengths - working in partnership"

There were also concerns around the possibility of losing specialist mental health services in the process of making efficiency savings.

"Fear that bigger orgs will take over and specialisms decrease."

When discussing how the success of this objective could be measured it was identified that efficient use of resources should be closely linked with the objective of quality.

"Value for money should be assessed in different ways and linked to quality."

5.3 Exercise 2

This was an individual exercise. Attendees were given three sticky dots and were asked to prioritise the three objectives that they felt were most important in the strategy, and place a dot beside each of the three objectives they had identified. This exercise took place over lunchtime giving attendees the opportunity to think about their decision and potentially debate it with other attendees if they wished.

The results of the prioritisation exercise are shown in the graph below:
Following this exercise the results were discussed with the room.

One objective clearly came out as the top priority, which was providing high quality, personalised services to enable people to feel better. When this objective was discussed further with the room it was identified that the biggest issue with quality was that of consistency – that services currently varied greatly depending on where you lived, that quality of staff varied within a single service, and that availability of services also varied greatly.

One objective also clearly came out as the lowest priority, which was the objective of recovery, enabling people to manage their own care as independently as possible in the wider community and live productive lives that reflect their hopes and ambitions. This was surprising and so was also discussed with the room. A clear message came back that this was not a low priority, but instead attendees believed it to be an underlying theme that should be embedded in all objectives and so did not need to be an objective in itself.

Co-production and accountability, well-being and stigma, and supporting people in transition all were given very similar, medium/high levels of priority.

The objective of efficient use of resources was recognised in the room as something that was necessary in the current climate and should be done throughout all commissioning decisions, but should not be a priority. Instead the provision of high quality mental health services to support recovery should be the focus.
5.4 Exercise 3
In this group exercise, attendees were asked to think about the key changes in the Strategy. They were then asked to discuss and identify:
- What opportunities could these changes create for Service Users and Carers? (20 mins) and
- What challenges/risks could these changes create? (20 mins)

The feedback from this exercise is shown under each of the key changes shown below.

- The extension of the mental health strategy to cover people from when they are young, through adulthood and into older age

The extension of the mental health strategy to include young people was received positively by most attendees. The majority of groups identified this change as an opportunity for mental services to become seamless and more consistent.

"An opportunity for all age seamless and continuous services"
"All age - this is better for transition and will lessen the child/adult divide"

Another main theme in the discussions around this change in the strategy focused on the need for mental health awareness raising for young people in many areas, but particularly as a preventative measure in schools and sports clubs.

"Running coaches / PE / sport to include mental wellbeing awareness"
"If working with population from young age can increase awareness early on and reduce stigma"

One of the challenges identified by some groups was that the way mental health services are accessed is very different for young people and adults. Young peoples’ services were seen to be wrapped around the individual, whereas in adult mental health services it was perceived that individuals had to choose to pro-actively engage with and access services that they needed.

Other issues raised included concern that the inclusion of young people in the strategy might dilute specialist young persons mental health services; but also that there could be an opportunity for more peer mentoring.

- A whole person, whole life approach to mental health and well-being (not just those that become ill enough to need services and support)

The workshop groups spent the least amount of time discussing the opportunities and challenges of this change in the strategy. This is because a whole person approach was generally agreed to be a positive way forward and would help raise wider awareness of mental health.
“A whole person approach would increase awareness”

However there were also a couple of concerns voiced that a whole person approach could reduce the focus on specialist mental health services.

The main theme in discussions around a whole person approach was related to training and awareness raising. Attendees highlighted that training in mental health would be needed across many different organisations in order to enable a whole person approach to be successful in the wider community e.g. the police, schools, GPs, armed forces.

Other issues raised regarding this change in the strategy included that this could be an opportunity to develop services for different cultures or population sectors; that more holistic ‘one-stop-shop’ services for both physical and mental health could be based at GP surgeries and that services should reflect the age demographics of the county/local areas more.

- The transition to clinically led commissioning (buying) of services

The biggest theme when discussing the transition to clinically led commissioning of services was around the need for Service User and Carer involvement – with suggestions about how this might happen, as well as concerns whether enough involvement would take place.

"OCCG needs a representative Mental Health service user and professional from mental health services to be involved."

"How will the GP facilitate continuing involvement for the service user?"

"There is a challenge and opportunity to make the role of Service Users and Carers more prominent within the strategy."

Another big theme, which again was seen as both a challenge and opportunity was the knowledge and training of GPs in the area of mental health. It was felt that currently GP awareness of mental health and related services is low, however that this is an opportunity to change that and raise the profile of mental health.

"GPs need to have access to and knowledge of all areas of mental health and ensure their colleagues are involved in decisions."

"Ensure expertise in all areas and that mental health is on the agenda."

"Concern about lack of GP awareness of mental health issues."

Another challenge identified by many of the groups was the need for good communication between OCCG and the public and other key stakeholders.
“Need to make sure the consortium informs the public, and all agencies and stakeholders what is going on - not just through the formal process of Healthwatch.”

“Good communication with the public and Mental Health sounding board is needed.”

Other issues raised included a lot of confusion over how OCCG and clinically-led commissioning would work; concerns around the process of accountability in clinically-led commissioning; whether this would actually result in efficiency savings; and that GP surgeries could be used as a base for more for mental health services.

- **Other opportunities and challenges**

A number of other opportunities and challenges were identified as the groups discussed the key changes in the strategy. These included:

- Ensuring equality in mental health services and the need to reach out to more isolated communities e.g. those in poverty
- A need for a focus on efficient use of the money available e.g. using one administration, not many
- The challenge of ensuring that ex-service personnel that need mental health services and support can easily access these services and are aware of what is available.
- Increase awareness of the range of mental health services that are currently available - the strategy does not set out services currently available to the Service User/Carer.

**5.4 Other feedback**

**5.4.1 Q & A session**

A number of questions were raised around Payment by Results (PbR), with people needing more clarity about what this means, how it works and how it is measured. It was felt by attendees that it is quite a ‘dry’ concept and could be very limiting. It was explained however that this is a national requirement for mental health.

It was accepted that the PCT and County Council need to ‘work smarter’ in order to make the most effective use of money. However attendees highlighted that consistency in mental health services is not happening at the moment and that this needs to be addressed.

There appeared to be some confusion from attendees with a number of questions around public health money, commissioning money and what would happen with this money with the move to clinically-led commissioning. It was also clear that more communication is required on what clinically-led commissioning means and how the OCCG will operate and how they will involve the public, Carers and the voluntary sector. The consultation events
on the OCCG Draft Communications & Engagement Strategy were highlighted to attendees as an opportunity to find out more and have their suggestions and concerns heard by clinicians.

In addition more information and clarity was asked for on the future of LINKs/Healthwatch and how much influence this organisation would have on commissioning of mental health services going forward.

The duration of the strategy was questioned – particularly whether this would in fact run until 2015. Reassurance was given that this is a strategy that the OCCG would inherit and have to adopt, and that they are also currently part of the ‘sign-off’ approval process of the strategy at the moment.

5.4.2 ‘Park-it’ – issues raised

Some of the ‘parked’ issues raised during the event discussions that are to be followed-up at the next ‘Hearsay’ event/mental health Sounding Board/picked up by PCT or County Council staff appropriately included:

- Will all the good work regarding involvement be carried over to the new clinically-led commissioning body?
- How have services been monitored so far and how do we know they are good?
- Would like to see ‘addressing health inequalities’ included as this is a real issue
- Are there opportunities for the all age approach to the replicated in the wider social care sector?
- Mental Health services could employ more mental health staff with experience of ‘mental distress’
- Less bureaucracy is needed
- How exactly will services be affected by reduced budgets
- Are the transition problems felt to an equal extent at the adults/older people end of the spectrum?

The issue of redundancy and how this is affecting service men and women and their well-being, as well as their ability to access mental health services and potential funding for military mental health community projects was also raised. This is being taken forward by Ian Bottomley at a PCT meeting imminently.
7. Other Responses

7.1 Online

Only 9 people chose to respond online to the engagement about the joint mental health strategy using ‘Talking Health’. The issues raised from these respondents included:

- Access to mental health services for rural communities
- Concerns about the ability to deliver the objectives in the current financial climate
- The need for less jargon in the strategy document
- Discussion around the definition of recovery
- Ensuring that the joint mental health strategy also reaches out to the more isolated communities in the county e.g. refugees and asylum seekers.

In addition online respondents were asked to what extent they agreed or disagreed with the strategy objectives. The results are shown below.

![Survey Results]

Interestingly the results of this online survey question were similar to that of the priorities exercise at the engagement event. The majority strongly agreed with the objective of quality in mental health services. The objective that respondents agreed with least was that of recovery, however the online survey did not allow us to fully investigate the reasons behind this.
7.2 Children and Young People’s Sounding Board

The Children and Young People’s Sounding Board took place in September 2011 and the subject of discussion focused on young people and mental health in order that it could feed into this consultation and the Joint Mental Health Strategy 2012-15.

Again the need for better good quality services was highlighted, rather than just medication. They felt that services needed more face-to-face contact, but also that a variety of methods to communicate their problems and feelings should be offered – not just talking. Also participants indicated that services needed to be more consistent, with ongoing support – rather than services stopping at the age of 16.

Participants also highlighted the need for more education and awareness raising on mental health throughout school and suggested that this could even start from Primary School.

The biggest barriers to accessing services were seen to be the stigma associated with mental health as well as concerns around confidentiality/

To read the full report of the Sounding Board findings, please see Appendix A.
7. Recommendations
The engagement findings in this report support the following recommendations for the joint Mental Health Strategy 2012-15:

- Review the objectives/outcomes in the draft Strategy, to reflect respondents’ priorities, suggestions and feedback, ensuring that terminology and jargon are also addressed.
- The public concerns and confusion around clinically-led commissioning will be reported to the OCCG and also fed into the consultation on the OCCG Communications & Engagement Strategy.
- Incorporate respondents’ priorities, suggestions and feedback into the resulting action plans and projects that will follow on from this Strategy.

8. Next steps
A copy of this engagement report will be made available by electronic or hard copy to all those that participated in the workshop event, and the online and direct engagement. It will also be available for download on our website at: https://consult.oxfordshirepct.nhs.uk

The report will used by the NHS Buckinghamshire and Oxfordshire Cluster to help to inform and shape the final version of the joint Mental Health Strategy 2012-15 and will also inform the resulting projects/action plans that emerge as a result.
9. Supporting information

Definitions

- Stakeholders - A person or group with a direct interest, involvement, or investment in something. Stakeholders are individuals or organisations that have a direct interest in a service being provided.

Glossary

- BMHO – Better Mental Health in Oxfordshire
- Facebook - Social networking website
- OCCG – Oxfordshire Clinical Commissioning Group
- Intranet - A private computer network open to users working within an organisation to share information, news and documents
- NHS - National Health Service
- PCT - Primary Care Trust
- Twitter - Twitter is a social networking tool aimed at enabling its users to exchange up-to-the-minute news and opinions on specific topics.
- Talking Health - NHS Oxfordshire’s consultation and engagement area on our public website (see https://consult.oxfordshirepct.nhs.uk)

Appendix A - Children and Young People’s Sounding Board Report: September 2011

Please see separate PDF file.