Futures in mind

Cornwall and Isles of Scilly

Adult Mental Health Strategy

(2019-2024)

Contents

Introduction

The development of this strategy has brought together a great number of people to share not only a wealth of knowledge and experience, but also individual experience of mental health and wellbeing. This strategy document aims to capture not only the wider national 'must do's' but also the things that people feel are most important to them, as well as those they may care for. The hope is that the plans which will be developed in response to these recommendations offer true meaning and result in positive outcomes and more hopeful futures for people across our community of Cornwall and the Isles of Scilly.

Mental health is defined as a "state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (World Health Organisation, 2014).

This includes mental health conditions, illnesses, and disorders through to mental wellbeing or positive mental health (Better Mental Health for All, 2016). In England, one in four adults experiences at least one diagnosable mental health problem in any given year (NHS, 2016a). Today, there is compelling evidence for a 'parity of esteem' and the need to treat physical and mental health conditions equally (Naylor et al., 2016).

Mental health problems are widespread, at times disabling, yet often hidden. Mental health affects many of us, which means that people in all walks of life can be affected and at any point in their lives. This is important to address now because mental health problems in Cornwall and the Isles of Scilly represent one of the largest contributors to Years Lived in Disability (PHE, 2018).

Failure to address mental health problems is not only bad for people, but it is expensive for society and healthcare systems too. The economic and social cost has been estimated at £105 billion annually in England, with the cost of dedicated mental health support estimated at £34 billion (NHS, 2016). The cost of mental illness in Cornwall and the Isles of Scilly is estimated at around £1 billion.

This strategy for Cornwall and the Isles of Scilly aims to lower the burden of mental health problems on adults, society and healthcare.

This will be achieved by recognising that our mental health is affected by many things – trauma and difficult life experiences, stigma and marginalisation, problems with relationships, unhealthy life styles, employment, housing and the environment. Many of these wider determinants of health are avoidable and represent an opportunity for prevention activities.
Our objectives will sit alongside the work which is taking place to transform mental health services for children and young people.

> It is time to consider changing our whole framework of understanding from a 'disease model' to a 'psychological model', for services to be equipped to address the full range of people's social, personal and psychological needs and also address prevention.
>
> Kinderman, 2014

Preventing or addressing these inter-related direct and indirect risk factors influencing mental wellbeing require a joined-up approach across many individuals and organisations across Cornwall and the Isles of Scilly. This means that addressing mental health cannot be

achieved by a single organisation. Consequently, everyone needs to come together in our local areas if we are to deliver the step-change we need to help prevent and protect mental health outcomes among adults.

Prevention is about taking action to improve people's quality of life and reduce the chance of getting a mental and physical health condition (Cornwall Council, 2019). Preventative action means that adults can take steps that can help avoid risk factors contributing to poorer mental health and wellbeing and improve day to day living which includes healthier and more active lifestyle, and the development of personal resilience. Prevention can be viewed on three levels as set out below (Figure 1) with targeted planning objectives set against each element.

Level of Prevention	Population Health	Wellbeing Care	Early Intervention
Primary (Universal)	Preventing the onset of disease by reducing risk. (e.g. healthy eating, not smoking) 'Stop it starting'	Support for anyone who wants to be as well as they can be.	Aimed at people who have no particular social care needs or symptoms of illness.
Secondary	Detecting asymptomatic disease at an early stage to slow or reverse disease progression. 'Catch it early and treat'	Support for people at risk due to particular health or social needs.	Aims to identify people at risk and to halt or slow down any deterioration, and actively seek to improve their situation.
Tertiary	Reduce the impact of disease and prevent disability. 'Minimise the consequences'	Specialist support for people with complex tertiary care needs.	Aimed at minimising disability or deterioration from established health conditions or complex social care needs.

Figure 1

Furthermore, empowering individuals and the wider system will help place greater emphasis on preventing mental illness. A key part of this means getting better at spotting the early signs of mental ill health and intervening earlier.

This strategy highlights the importance of parity of esteem, which is needed to address the physical health needs of those with a mental health problem. This is important to consider because around 46% of Serious Mental Illness (SMI) patients are thought to all suffer from a long-term physical health condition. This is important to consider because these vulnerable people die on average 15 to 20 years earlier than the general population. The causes of this health inequality are largely caused by preventable and or manageable conditions such as cardiovascular and respiratory diseases (Sharpe, R.A. & Wigglesworth, R., 2019).

To enable this to happen, local planning and decision making will need to take into account the local needs of the population, the need to address local inequalities and the determinants of poor mental health and wellbeing, and deliver integrated and joined up solutions to provide wrap around care and support, as well as incorporating effective data

management to enable effective population health monitoring, evaluation and intelligent design principles.

The ambitions and intentions in this strategy will apply equally to the residents of the Isles of Scilly. They will aim to meet the needs of everyone living in, and residing in our communities, be that on a short term basis as a visitor enjoying our beautiful surroundings, or a local resident living within our county.

Vision

We want everyone in Cornwall and the Isles of Scilly to enjoy the best possible mental health and wellbeing throughout the course of their life.

This means we need to focus on the whole person, tackle mental health issues and the cause them with the same energy and priority as people's physical health needs.

Our overarching ambition is to ensure that:

- People will feel supported and able to access care and treatment
- People will have choice in the support and care that they receive
- People will reach their own personal recovery goals
- People will live longer and in good health
- People will feel positive about the services they receive

Scope

This Strategy is for adults, aged 18 years and over, who are experiencing issues relating to poor mental health and wellbeing in Cornwall and the Isles of Scilly.

The Strategy will focus on the whole person and their individual journey through life, taking into account the full spectrum of needs associated with general wellbeing as well as specialist conditions. In doing so, an emphasis will be put upon prevention and the maintenance of healthy living as well as the delivery of evidence based and specialist care.

We will pay particular attention to the needs of younger adults, and those transitioning into adult services. We will focus on those with more enduring needs and higher risk groups, as well as older members of our communities who feel vulnerable and lonely.

The Needs of our Population

This strategy has been informed by a review of the mental health needs of those living across Cornwall and the Isles of Scilly. Our County represents a unique and varied landscape with a geography which includes urban, rural as well as island communities and a demographic population of at the 2011 Census of 536,000.

Nearly 9% of the population have been diagnosed with depression from their general practice and serious mental illness (SMI) affects 0.9% of the population. In 2017/18, there were 40,886 patients registered with depression (according to general practice [GP] registers) and a further 1,064 patients with both depression and anxiety (according to the GP patient survey). Additionally, more women (62%) than men are thought to have a mental health disorder. Also, the proportion of adults with a mental health problem varies considerably by location, with many General Practice having mental health prevalence rates that exceed the national average. The prevalence of all mental health disorders in Cornwall and the Isles of Scilly are predicted to increase (among adults aged 18+ years) until 2030. The number of adults with an antisocial personality disorder increases until 2035 [REF].

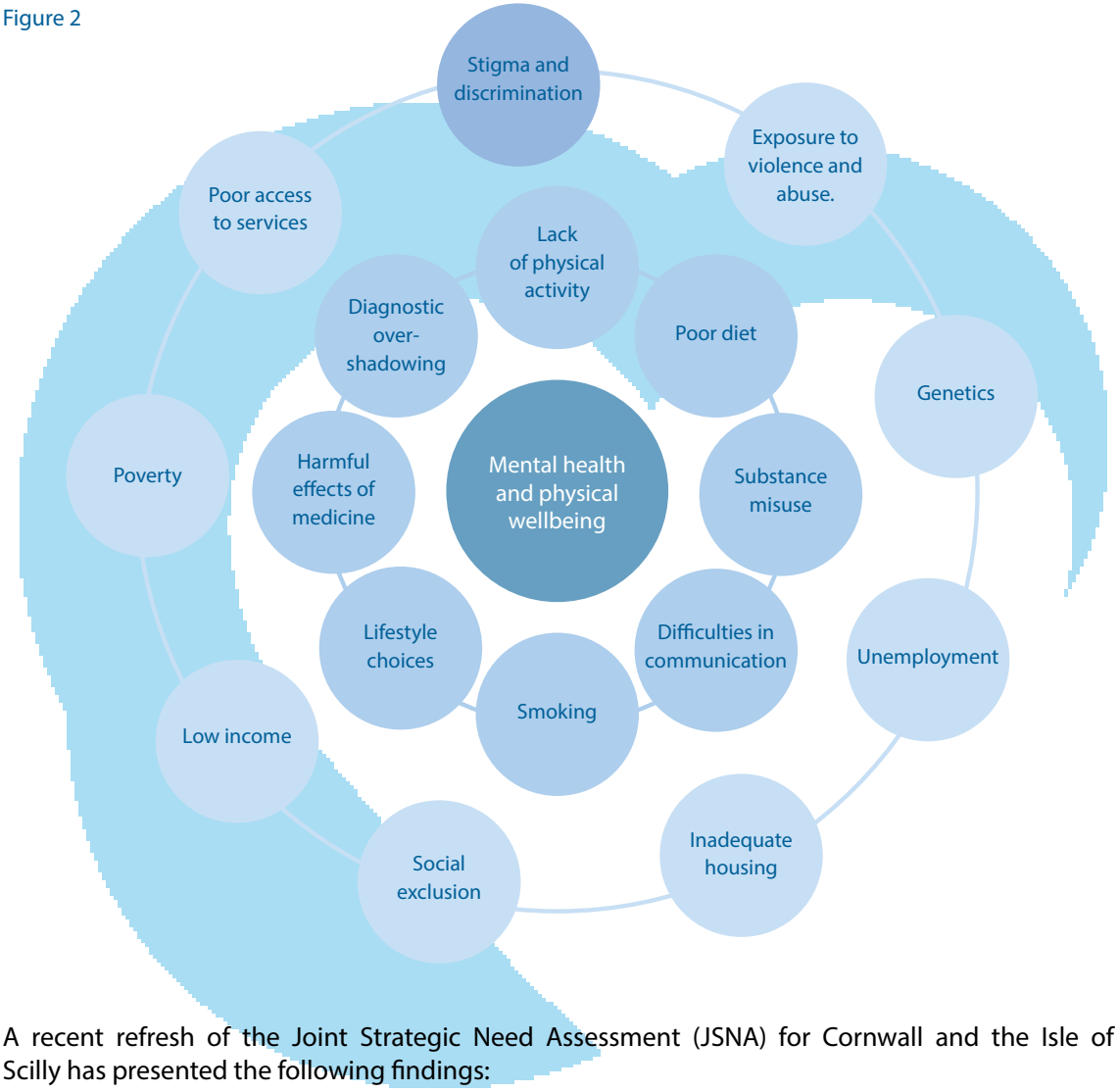
This is important to consider because more adults across Cornwall and the Isles of Scilly self-harm when compared to England averages, which increases the risk of suicide among this vulnerable population. Cornwall and Isles of Scilly also have one of the highest rates of suicide (14.5 per 100,000 persons) when compared to England (9.6 per 100,000 persons). Moreover, compared to the general population, adults with a mental health problem experience a 20–25% reduced life expectancy. They are also 2–4 times more likely to die from cancers, circulatory and respiratory diseases for example. This contributes significantly to the global burden of disease across Cornwall and the Isles of Scilly.

Mental health among adults aged between 15 and 69 years ranks the highest burden of disease when compared to other conditions such as cardiovascular and respiratory diseases (Cornwall Council, 2019).

Health inequalities experienced by those with a mental health problem can result from diverse inter-related risk factors, which includes wider determinants of health such as a range of lifestyle choices and access to services. This means that mental health prevention, early prevention and/or treatment can be improved by addressing a range of risk and protective factors influencing someone's mental well-being (Figure 2) [REF].

Factors affecting people's physical health (Nursing Midwifery and Allied Health Professions Policy Unit, 2016).

Figure 2

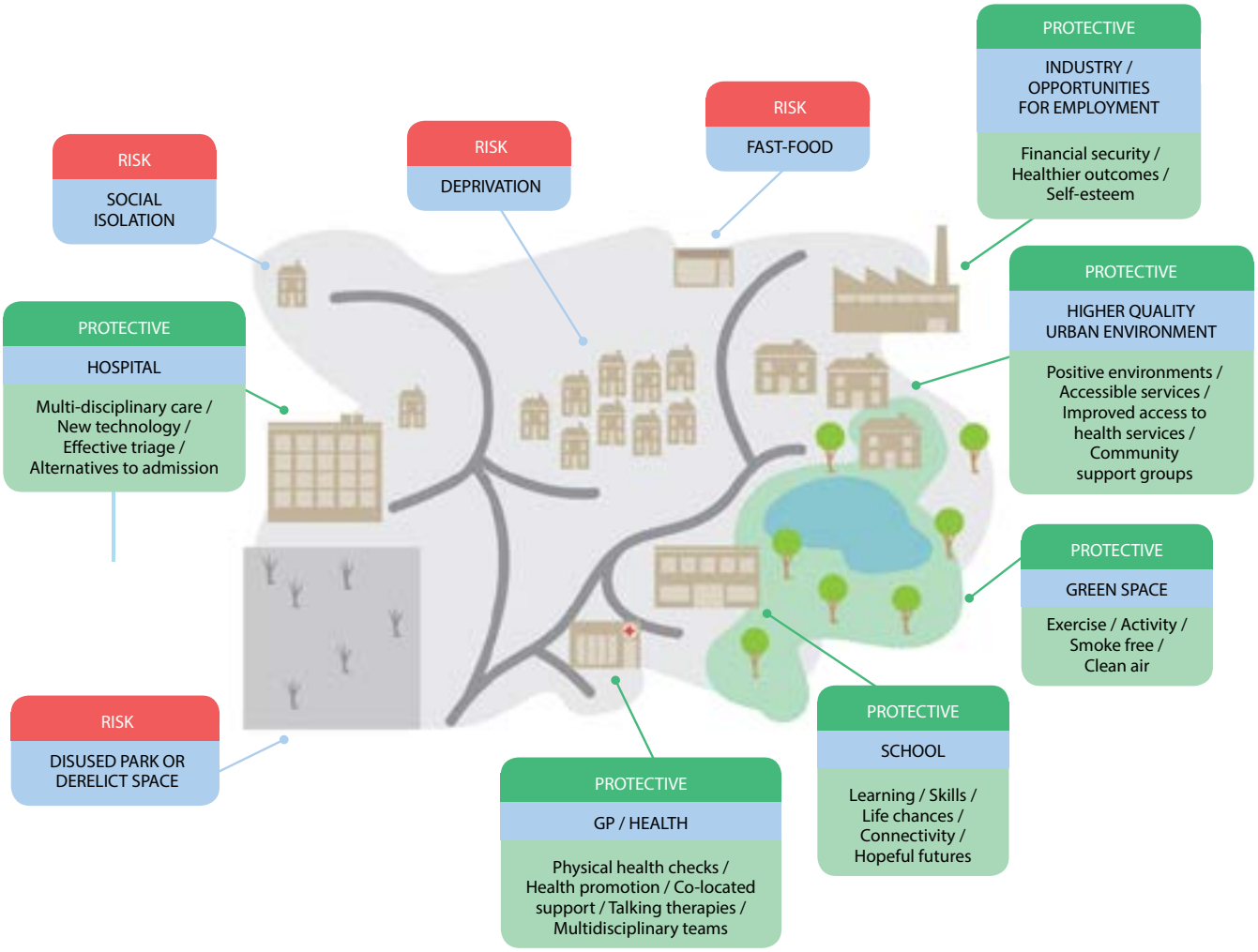


A recent refresh of the Joint Strategic Need Assessment (JSNA) for Cornwall and the Isle of Scilly has presented the following findings:

- The prevalence of all mental health disorders are predicted to increase (among adults aged 18+ years) until 2030. The number of adults with an antisocial personality disorder increases until 2035.
- The number of people predicted to have a common mental health problem broadly corresponds with GP practice registers. In 2017/18, there were 40,886 patients with depression (QOF) and a further 1,064 patients with both depression and anxiety (according to the GP patient survey).
- Sixteen GP practices across Cornwall and the Isles of Scilly have a higher mental health prevalence rate than across England (0.9%).The number of patients with a mental health disorder fluctuates considerably by GP practice. Not all practices have experienced a continued increase in number of patients with a mental health problem since 2013/14.
- The number of people with a long-term mental health problem (according to the GP patient survey) has increased in Cornwall and the Isles of Scilly.

- Depression rates have increased since 2013/14, making it the second most common condition in 2017/18 (9.9%) behind hypertension (13.9%); but overtaking obesity levels (9.8%) for the first time (NHS, 2018). In comparison to England, depression prevalence and incidents rates are lower across Cornwall and the isles of Scilly (8.7% and 1.1%, respectively).
- Adult depression prevalence rates vary significantly by GP practice. The prevalence of depression at the practice level ranges from 2.75% to 23.3% in Cornwall and the Isles of Scilly. Many of the practice prevalence rates exceed the national average.
- Among older adults, depression is the most common, treatable and reversible mental health illness, which is thought to affect one in five older people in the community. At particular risk are those with another physical illness and/or in hospital or living in a care home where the risk of depression triples (NHS, 2017).
- Depression is predicted to be higher among the 65 and 74 year olds, however, in 2021 there appears to be a predicted rapid rise in the number of 85+ year olds experiencing depression, which is due to the baby boomer cohort moving through the age profile.
- There does not appear to be a clear relationship between deprivation deciles and the prevalence of depression across our communities.
- In 2016/17, a total of 15.7% of the most deprived adults (most deprived decile) suffered from depression and anxiety. The prevalence of depression and anxiety was 10.8% in those living in the least deprived decile.
- There were between 160 and 185 per 100,000 admissions to secondary mental health care during each quarter of 2017/18, although this increased to 175 per 100,000.
- Rates of admissions are also lower in Cornwall and the Isles of Scilly when compared to the South West region and England. With the exception of Dorset, rates across the SW are lower than England.
- The number of attendances of mental health patients in 2017/18 was largely due to physical health (bottom two graphs). The average rate of physical health related emergency department attendances was 66.1 per 1,000 adults in contact with mental health services. This was higher than the rate of mental health related attendances (9.6 per 1,000).
- Despite an increasing trend, GP prescribing rates of drugs for psychoses and related disorders are lower than those across the SW and England. These GP prescription rates reached 56.9 per 1,000 people in 2017/18
- Prescribing rates of antidepressants remain relatively stable with a slight increasing trend. Despite a reduction in cost, the cost of these medications remains higher than England.
- People with a mental health problem are able to apply for the disability living allowance (DLA). The number of claimants was highest amongst the working age population (ages 25–64 years), but this is declining as benefit reforms transfer over to the employment and support allowance (ESA).

Risk and protective factors influencing mental well-being outcomes.
Figure 3



What our residents have told us

A recent large survey of the mental wellbeing of 11,247 residents living across Cornwall highlighted the importance of these wider determinants of health.

Participants were more likely to have low mental well-being if they were younger adults, male, living in an area of deprivation and had poor general health. The built environment was also important, with those living in social housing experiencing issues with neighbourhood and community safety and living in poor housing. However, the findings also showed that those with more social contact were physically active and participated in volunteering had a good mental well-being (Toqciu, R., Sharpe, R.A., & Williams, A., (2019).

This highlights a clear need for preventive actions, which tackle some of the high risk lifestyle and other factors associated with poorer health outcomes (Figure 4).

Adult mental health prevention (Cornwall Council, 2019).

Figure 4

Lifestyle Factors	Be smoke free	Eat well	Maintain a healthy weight	Group activities or volunteering
	Self-management of physical health	Healthy homes and communities	Move more	Cut down alcohol consumption
Other	Mental health literacy at work	Psychological support for physical health	Access to quality natural spaces	Reduce stigma
	Financial support and debt management	Support for people who self-harm	Healthy ageing and social connections	Support for vulnerable populations

The delivery of future interventions must consider the needs of local communities. Mental health services must improve patient involvement and use the lived experiences and aspirations of those with a mental health problem in the development of future services. The 'Equally Well' charter aims to improve the health outcomes of those with a mental health problem, and uses co-production as a means to guide future service delivery (Sharpe, R.A. & Wigglesworth, R., 2019).

Consistent with national trends, the number of people with an SMI has increased across Cornwall and the Isles of Scilly. People with a diagnosed mental health illness experience higher physical health inequalities and lower life expectancies. For example, those with severe and prolonged mental illness die on average 15 to 20 years earlier than those without, which represents one of the greatest health inequalities in England. It is estimated that two thirds of these deaths are from avoidable physical illnesses, including treatable heart disease, diabetes, respiratory disease, cancer and infections. These co-morbid mental and physical health conditions also increase the risk of an individual considering suicide. Cornwall and the Isles of Scilly have higher rates of self-harm and suicide when compared to England.

Around 46% of people with serious mental illness have one or more long-term conditions. This means that approximately 4,922 people in Cornwall and the Isles of Scilly could have an SMI and long-term condition. This increases to approximately 47,907 (8.5% of the total population) when considering other estimates for the number of people with a mental health problem and long-term physical condition. (PH Cornwall, 2019)

In addition to these key recommendations and in response to the newly published national Long Term Plan, we will need to quantify specific prevalence across the 0–25 year age ranges to enable us to develop targeted services and support to prevent early mental health conditions to best effect.

Addressing the mental health prevention and supporting those with a mental and physical health need (parity of esteem) is reflected across a range of policy, and the need to meet the demands of the estimated rise in prevalence rates across Cornwall and the Isles of Scilly.

What the national policy tells us

There has been a transformation in mental health over the last 50 years, with a myriad of policy and regulatory frameworks supporting an urgent need to prevent and address mental health problems. These make the strong moral and economic case for action beyond the treatment of physical and mental health problems; to intervene early, support recovery and prevent mental illness and poor physical and mental wellbeing. (Sharpe, R.A. & Wigglesworth, R., 2019).

A range of national strategies have emphasised the importance of prioritising prevention and the delivery of treatment that delivers parity of esteem. Most recently these include No Health without Mental Health (NHSE, 2011) and the current Mental Health Five Year Forward View (MHFYFV), 2016 which set out key plans to improve and expand mental healthcare, with key deliverables including:

- Increase access to psychological talking therapies
- Reduce waiting times for talking therapies
- Improve recovery rates for talking therapies
- Specialist Psychological support for Long Term Conditions
- Provide Specialist Perinatal Mental Health services
- Provide 24/7 mental health liaison services in A&E
- Improve crisis and home treatment services
- Improve physical health for those with a Serious Mental Illness

Locally, our Mental Health Delivery Plan for Cornwall and Isles of Scilly 2017/18, sets out ongoing commitment to deliver the MHFYFV.

The NHS Long Term Plan was published on 7 January 2019 setting out NHS England's priorities for the next decade. The Plan has major implications for the nation's mental health and the future of mental health services. Many of its pledges expand on the recommendations of the Five Year Forward View and other existing mental health policies and strategies. The Plan's implications for mental health cover a range of areas. There are specific proposals for both children's mental health and for adults. (Centre for Mental Health, 2019).

Whilst committing to increased investment to support community base care, The Plan recognises the importance of personalisation and prevention whilst emphasising the need to focus particular attention on those between the ages of 0-25 yrs. Specific objectives include:

- £2.3 billion additional 'ring fenced' investment by 2023/24
- Particular focus on the mental health of 0–25 year olds
- Expanding crisis care and developing a Single Point of Access

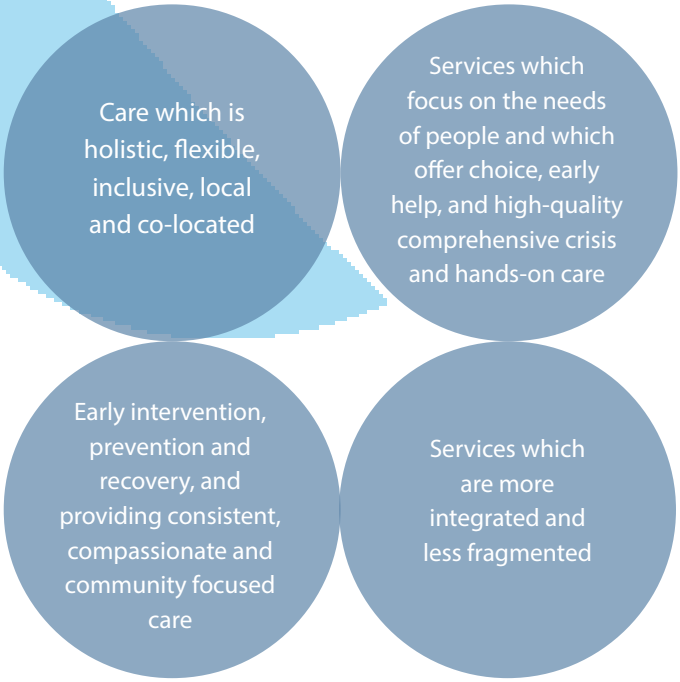
- Recruiting the developing a skilled workforce
- Expanding the availability of specialist perinatal services
- The expansion of psychological therapy services
- Testing waiting time targets for community mental health services
- Developing a wider range of community based services such as:
  - Employment support
  - Personalised and trauma informed care
  - Support for self-harm
  - Support for co-existing substance use and mental health
- Targeted Suicide Prevention programme

Whilst taking into account the national priorities set out above, this strategy will also set out the commitment and key objective to meet the local needs of our diverse communities and how we aim to develop our offer to people over the next five years.

The view of people delivering care and support

A range of stakeholder events in 2018/19 have informed the development of this Strategy, including a multi-agency workshop in October 2018 which brought people together from a range of sectors and organisations, including those delivering service and those receiving support.

Figure 5



The journey over past six months has been to capture the views, experiences and aspirations of people delivering mental health services, individuals with a mental health problem, their friends and carers across Cornwall and the Isles of Scilly.

A range of recommendations and priority actions have been identified by our key stakeholders and partners during the development of this draft strategy, and these are summarised in three areas:

- We should provide care which is holistic, flexible, inclusive, local and co-located
- Our services should focus on the needs of people and offer choice, early help, and high quality comprehensive crisis and hands-on care
- Our priorities should be early intervention, prevention and recovery, and providing consistent, compassionate and community focused care
- Our services should be more integrated and less fragmented

The view of people receiving care and support

We know from the results of previous consultation that people can struggle to navigate services and to find the support they need. Mental and physical health needs are often treated in isolation and there can be long waiting times to access mental health services and receive a diagnosis. People can be confused by the different languages that different organisations used, and frustrated by multiple assessment and referral processes, and all the bureaucracy around these. They don't always get the same level of service and often don't feel listened to or involved in decisions that affect them.

The co-produced Independent Mental Taskforce Report in 2015 concluded key themes from its survey of over 20,000 people who had used services, carers and those across health and social care who provide services. This feedback informed the development of the Five Year Forward View for Mental Health with three key themes; prevention, access and quality. (https://www.england.nhs.uk)

We are continuing to work with Healthwatch Cornwall (HC) to help us draw on the insight of individuals, families and communities to drive transformation and to deliver real improvements to our services. The outcomes of the Appreciative Inquiry carried out in 2019 have supported the development of this strategy. Reflecting on the Isles of Scilly Health and Wellbeing Survey, 2017, it is clear that local island residents felt that there was a lack of support on the islands and that travel restrictions added to the challenge of accessing specialist support on the mainland.

Understanding the needs and views of younger adults, including those in in further and higher education has been a key area of focus for us. We have met with students, teachers and leaders based at Falmouth University and Truro College, including those who rely on existing support provided within their well-being support services and those with additional educational needs. Key themes from our conversations were; need for joined-up and flexible approaches, accessible, reduced waiting, personalised, consistent and offering more counselling approaches.

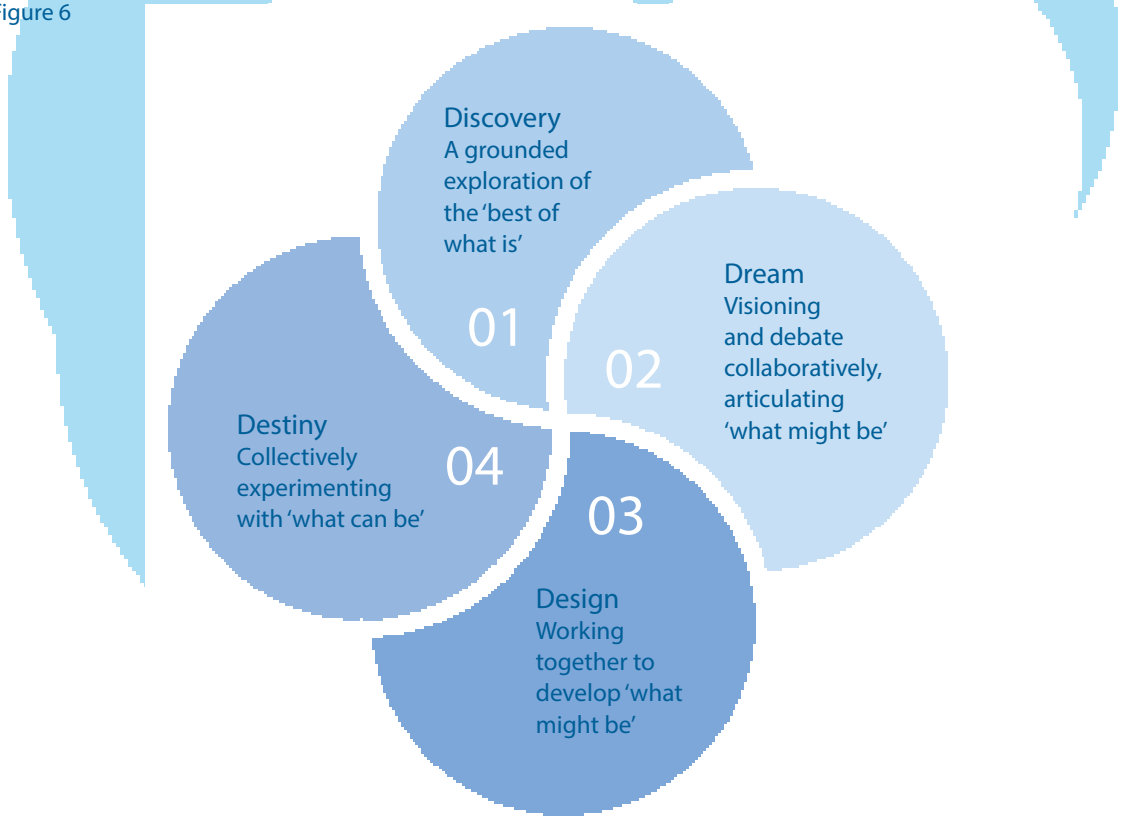
Appreciating what we are doing well

In 2018, NHS Kernow commissioned HC to carry out an Appreciative Inquiry (AI) style engagement report into commissioned mental health services in Cornwall.

The theory and methodology of this activity is to engage staff in a strengths-based approach to research to generate new ideas and opportunities for organisational and service development. The key feature of this approach is the 'appreciative' perspective which, rather than identifying problems that need to be 'fixed', helps teams to identify existing strengths, achievements and successes and enables a positive core to be built upon.

The explicit objective was that the information and insight gathered would be used to inform the development of a co-produced joint strategy for mental health for Cornwall and the Isles of Scilly and, importantly, to inform ongoing development work. HC carried out sessions early in 2019 reflecting the first two stages ('Discovery' and 'Dream') with approximately 230 people from 30 mental health teams across the county, so that key themes from this engagement approach could be identified and presented to the commissioning team as ideas that could be taken forward to the 'Design' and 'Destiny' phases.

Figure 6



HC reported that staff were very keen to take part in their engagement and were clearly very passionate and enthusiastic about the work of their teams, and felt supported within the organisations they work for.

It was evident that staff delivering mental health services were:

- Committed to providing a high quality service that is personalised
- Focused on promoting recovery and resilience
- Wanting to be involved in service development and innovation
- Wanting to see more people access treatment
- Wanting to offer a wider choice of flexible options

Staff were extremely forthcoming with their desire for there to be a focus on reviewing service pathways and referral routes, and for there to be better clarity about teams' remits across the system. This was presented with a clear aim to ensure a more timely and appropriate journey for clients within and between services. A desire for a greater emphasis on early intervention and preventative community services being more widely available was also evident.

It was also reported that, while staff were generally positive about the learning and development opportunities available to them, there was a desire to strengthen the workforce by offering more opportunities to build skills, share good practice, review existing roles/team structures and maintain an emphasis on recruitment and retention.

Teamwork was clearly recognised as strength across many teams but there was also a clear recognition that teams and services could work better together to ensure the best care for the people that they support. HC were struck by the overwhelming nature of staff going 'above and beyond' to support their clients, and were often assisting with many aspects of their clients' daily lives such as supporting with financial and housing related issues.

HC's report has made a number of recommendations for future developmental work and these will inform the formal engagement and involvement phase of the next stage of this strategy to explore 'what might be' and to commit to build an "appreciative learning culture" into all of the systems, procedures, and ways of working. The full report can be viewed via (www.healthwatchcornwall.co.uk)

Strategic Intentions

While we have already seen improvements in our mental health services over recent years, we know we need to do more if we are to meet our aim of ensuring that every single resident of Cornwall and the Isles of Scilly can enjoy the best possible emotional and mental health and wellbeing throughout the course of their life.

Reflecting on both our commitment to our local and national priorities, combined with what we have learned from our engagement work so far, we have identified six key priority areas:

- Preventative approaches
- Easier access to treatment ensuring parity of esteem
- Personalised care and greater choice
- Recovery focused and resilience forming
- Greater integration
- Embracing new technology

This document will set out how we aim to achieve these goals and deliver services which are fit for our communities and the future health and wellbeing of the people who live within them.

During the past two years there has been significant investment in mental health services in Cornwall and the Isles of Scilly amounting to just under £6 million pound of recurrent investment. Our early commitment to meet the national Mental Health Investment Standard (MHIS) before many other areas of the country enabled us to start our journey of transformation and service enhancement early.

This investment, and the early formation of key strategic intentions, demonstrates our local commitment to parity of esteem ensuring that the advance of mental health services is on a par with those of physical health and acute services.
The local commitment to deliver against the key national deliverables, set out in the Five Year Forward View for Mental Health, (MHFYFV) published in 2016, have delivered significant service transformation and improvement with tangible evidence of improved outcomes in many areas for significant number of people across our communities. The numbers of people accessing and benefitting from our newly commissioned services is growing all the time and can already be aligned to the themes of our local engagement process.

We believe a fundamental shift in focus which prioritises prevention, early intervention and access to evidence based treatments and a means of delivering greater choice and offering more personalised choices. Our objectives will be to work in support for people's personal recovery goals and promote resilience to help people stay well. All of this will required a strong and cohesive approach and we will drive up integration to enable us to secure the best outcomes for the people of our communities to improve mental health and well-being across Cornwall and the Isles of Scilly whist maintain sustainability and stability.

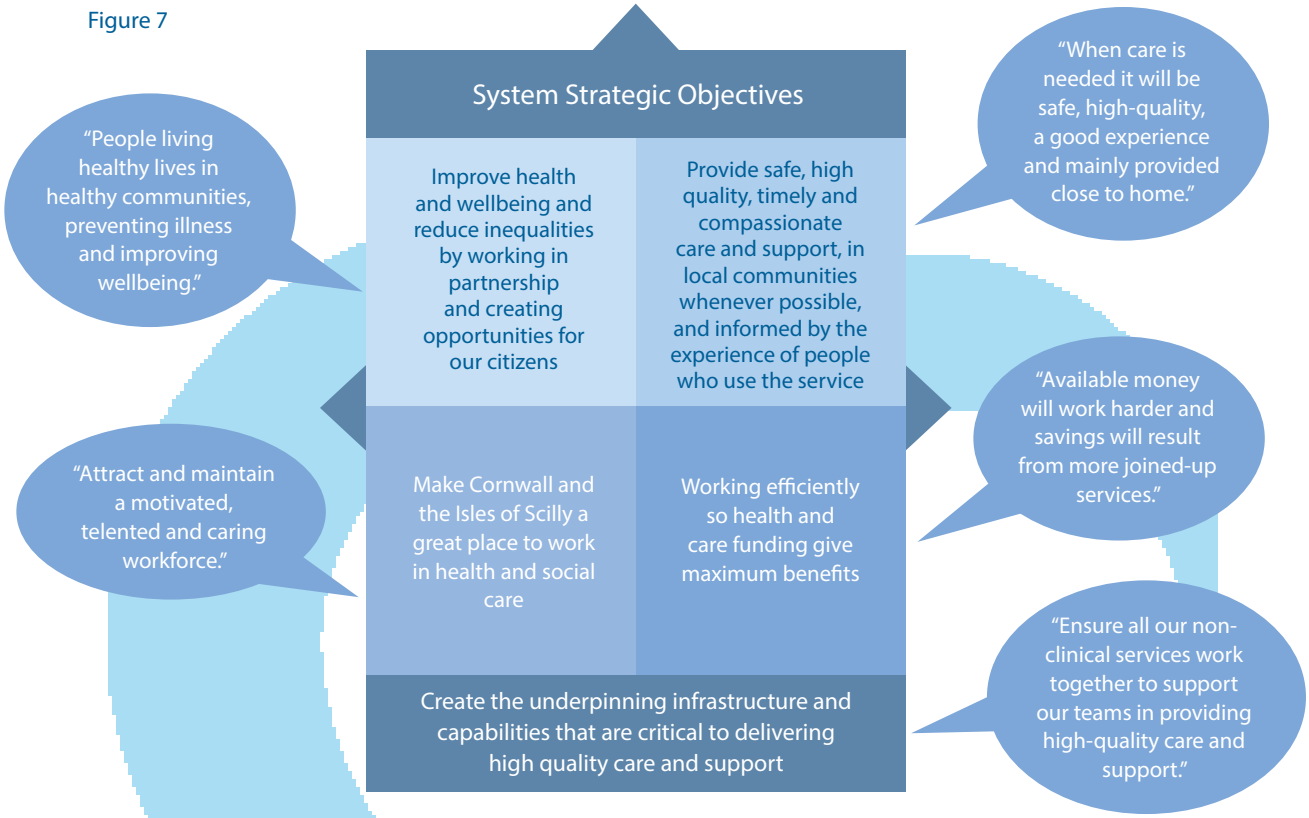
Our local system wide strategic objectives rely on a strong sense of partnership and collaborative working. Our commitment to ensure that everyone works together will remain a guiding principle to achieve meaningful change and the development of future which is fully capable to meet the needs of our communities.

- We will work together to ensure the people of Cornwall and the Isles of Scilly stay as healthy as possible for as long as possible.
- We will support people to help themselves and each other so they stay independent and well in their community.
- We will provide services that everyone can be proud of and reduce the cost overall

Our system wide 'Quadruple aim' (Figure 7) includes:

- Improve health and wellbeing.
- Improve people's experience of care.
- Reduce the cost of care per capita as a consequence of people using services less frequently and needing less expensive help.
- Improve people's experience at work.

Figure 7



Incorporating these principles will help address mental health across the life-course, as well as provide person-centred care whilst avoiding needless delays in treatment and offering a timely, hands-on response.

However, this cannot be achieved working in isolation so this strategy aims to incorporate community based approaches (e.g. affected individuals, their families and carers, schools and businesses, and the voluntary and community sector), a partnership approach across the system and collaborate with existing groups targeting mental health problems.

Preventative Approaches

Prevention should be everyone's business and will be fundamental to the success of our planning for improved outcomes and system wide efficiency. Coordination across the system is required to make best use of resources. The Council, NHS and providers must encourage locality approaches to promote

Lifestyle – Help people to make healthier life choices, self-manage their health and wellbeing and maximise their independence

Connections – Encourage social connections, build community resilience and reduce loneliness and social isolation

Environment – Design healthy work environments and neighbourhoods and ensure people have access to appropriate housing

The Prevention Concordat for Better Mental Health Programme aims to facilitate local and national action around preventing mental health problems and promoting good mental health. (www.gov.uk)

Public Health Cornwall are leading on the local Prevention Concordat with plans underway to develop key objectives which offer improved experiences and measurable outcomes for people across our community. This will include the mapping of all existing contracted prevention services and the retendering of some prevention services to improve social inclusion and promote independence. Future providers will be expected to reflect on how they can better integrate prevention into their service offer.

In addition to this and in response to the need to intervene earlier to address the emergence of mental health conditions in children, the Local Transformation Plan for Children and Young People already identifies how we plan to improve identification of need, intervention, support for recovery, and building resilience and independence for those aged under 18.

We believe that it is important to view people not purely in the context of their ill-health, but rather within their own frame of reference and as part of their individual life journey. With this in mind we will work to better understand how people cope with adversity as well as develop their own personal resilience and hope.

Feeling happier and being able to enjoy life to the full should remain our overarching goal and intention. With this in mind and reflecting on the evidence base, we will support the development and use of the 5 Steps to Mental Wellbeing approach to enable people to better connect, be active, keep learning, give to others and be mindful. (www.nhs.uk)

In response to the Five Year Forward View for Mental Health, and also our commitment to keeping vulnerable members of our communities safe, we have already in the last 2 years, established a number of targeted early interventions for the adult population (in some cases also below 18 years), including:

- Crisis Café pilot project – this project, run by Redruth based charity Valued Lives, offers community based alternatives to our secondary care crisis service and aims to be accessible to all on a 24/7 basis with an emphasis on community based support and integration.The service is available to those 14yrs and upwards and aims to stop people reaching crisis point and requiring admission into hospital by responding to them out of hours, either in their own home or at the crisis café. Investment from the Office of the Police and Crime Commissioner means the successful project is being expanded to deliver pop up café support across Cornwall to target groups such as unskilled workers, low income households and the unemployed.
- Out of Hours telephone line – this helpline, introduced in September 2018 and open to everyone over the age of 16 under the care of Cornwall Partnership Foundation Trust (CPFT), is available between 5pm and 9 am on weekdays, and 24 hours a day on weekends and bank holidays. Callers can access emotional and practical support via phone, text, email or web chat.
- Extension of Crisis Support – CFT's Home Treatment Team provides a 24/7 service with increased access to face-to-face care and support between the extended hours of 8.00 pm to 10.30 pm. This enables the team to offer increased evening visits, provide medication drops and respond more quickly to requests for urgent assessments, improve discharge transitions, reduce the length of stay in hospital and deliver care to people at home.

- Psychiatric Liaison – Mental health specialists are now located in the Emergency Department at RCHT as part of the national uplift to the "CORE24" standard to provide 24/7 specialist support or mental health condition in the general hospital setting. This means that anyone experiencing a crisis will have been assessed and receiving appropriate support within four hours of arriving at the ED or being referred from a ward. We will also be enhancing the services offered at the University Hospital Plymouth, Derriford, to expand the current psychiatric liaison serves up to the same CORE24 standard at RCHT, to ensure that residents from the East of our county who attend this hospital receive the same standard of high quality care and treatment.

Suicide prevention is an extremely important area of focus for us given our higher prevalence rates. Local plans are now in place to reduce the rate of death by suicide in line with the national target of 10% across Cornwall through the Zero Suicide Collaborative and projects which provide support after self-harm. These include supporting vulnerable younger and older men via the use of sports and offering support to GP's to better identify and manage vulnerable people with a rolling programme of free training for GP's. We will continue to expand this programme of work into year two which will include the development of a Single Safety Plan approach to provide greater access and consistency to personal care and risk planning. We will also progress our 'Suicide Safer Towns' initiative to deliver bespoke and local support in key areas of need.

As part of our ongoing commitment to reduce our suicide rates by over 10% we will also establish a multi-agency real time surveillance system to allow for timely post intervention to reduce the longer term and wider detrimental effects of being close to someone who suicides. We are extremely proud of our local 'Postvention' service, which offers face-to-face support delivered by experienced mental health professionals following a suicide, which includes liaison with statutory and voluntary services. The service also delivers an 8-week evidence-based psychoeducation course for people who are at least 6 months post-bereavement and preferably post-inquest. We will review the function of this service to ensure that it is fit for the future.

We will establish a fully operational Integrated Establishing a Multi-agency Prevention and Assessment of Crisis Teams (IMPACT) Hub at Royal Cornwall Hospital Trust (RCHT Treliske), where staff from safeguarding service; psychiatric liaison, complex care and dementia, drug and alcohol teams, housing support, Advocacy, child and adolescent mental health-in reach and specialist perinatal mental care health teams will work together in a single location to provide timely and joined up care for people who are vulnerable to, experiencing or recovering from a mental health crisis

In line with the NHS Long Term Plan we will develop our crisis care support offer to ensure that people feel supported when they feel at risk and vulnerable by providing 24/7 support and Home Treatment interventions. We will develop a 'Single Point of Access' for adults as well as children with appropriate support across NHS 111, ambulance and A&E services.

We will establish equitable community based preventative alternatives to the more specialised crisis and home treatment services delivered by Secondary Care. A new approach will consider emerging national and local evidence and be focused on the delivery of wider community integration and inclusivity. The approach will work in close collaboration with statutory as well as non-statutory partners and stakeholders, and we will ensure that the model complements existing service provision by offering vulnerable people greater wrap around support, choice and continuity.

Easier access to treatment ensuring parity of esteem

Some people require care and support for a range of conditions which may span a considerable amount of time and require a longer period of intervention across a life course. Supporting people to achieve their own personal recovery, as well as provide people with every opportunity to enjoy a quality of life whilst receiving ongoing treatment will be a continual focus. To achieve this, we will need to continue in our intentions to provide greater choice and accessibility as well as more personalised approaches where people feel they have control in deciding what works for them. This includes ensuring that services address the physical health needs of those with a mental health problem and vice versa. This strategy commits to delivering a range of recommendations to deliver parity of esteem amongst this population:

- The physical health of people with serious mental health problems should be a key priority in the emerging integrated care system and partnership, which could improve outcomes for people and reduce costs of care.
- Local strategies need to target key risk factors that worsen or protect mental health outcomes and ensure parity of esteem across physical and mental health services.
- Cornwall's integrated care system should adopt the principles of the Equally Well UK Charter and address areas highlighted as requiring improvement in the 2018 Care Quality Commission report.
- It is important that there are systems in place to recognise the risk of suicide amongst people with SMI and comorbid conditions, and self-harming behaviour.
- Interventions or programmes which focus on improving the social and economic opportunities for people with serious mental illness should be systematically prioritised. These include education or employment opportunities (via Individual Placement Support), appropriate housing, and reducing social isolation.
- Service providers should use a variety of methods to assess potential barriers experienced by this population in accessing high quality health care, including health equity audits, patient experience and research.
- Increase the uptake of annual physical health checks for people with serious mental illness across all risk factors (including e.g. blood glucose) by improved data sharing and collaboration between specialist mental health and primary care (such as in Bradford using a standardised physical health check template and shared care protocol).
- Provide access to integrated lifestyle behaviour change support (addressing all risk factors together e.g. smoking, physical activity) for people with serious mental illness at risk of cardiovascular or metabolic syndrome (in the community).
- Understanding the long-term trends associated with service use by this population will help inform future service planning and strategies. This will require a joint programme of work to analyse mental health data as a system.
- Increased focus on people with psychosis presenting at A&E and enhanced role of mental health liaison services could explore this further. The management of health of people with dementia should continue to be a focus of multidisciplinary integrated care teams at locality level.
- Increase the involvement of people with experience of mental ill health and patients and carers experiences to help co-produce, quality assure and transform services.

Whilst also acknowledging the interplay between various factors which influence mental health and wellbeing, we will also give particular attention to the key transition points in people's lives where there may be opportunities to engage and offer continued support to achieve longer term positive outcomes. Examples include transition points between existing health services from childhood support through to adult and older adult care as well as the entry points for other sectors. Developing and maintain these entry points should offer sectors an ability to engage with health and this would enable people to cope, thrive and recover from the consequences of financial crisis, unemployment, displacement and insecurity (WHO/Europe, 2019).

As well as focusing on enhancing current transition points, we will look to develop and strengthen wider networks of support to deliver the most effective and appropriate support where choice, access and delivery are ever more seamless and without boundaries.

Improving access to evidence based talking therapies will remain a core 'must do'. We will ensure that services deliver outcomes and provide standardised care within a set of waiting time standards meeting the national requirements.

We will continue to expand and improve our range of evidence based psychological therapy treatment under the Improving Access to Psychological Therapies (IAPT) programme across our communities in line with national and local expectation. Highly skilled practitioners will continue to offer cognitive behaviour therapy (CBT) and eye movement desensitisation reprocessing (EMDR) alongside other psychological support to address such things as depression, anxiety and post-traumatic stress disorder (PTSD) to increasing numbers of people every year across our communities in support of personal recovery.

We will also explore newer treatment options such as Acceptance and Commitment Therapy (ACT) and Interpersonal Psychotherapy (IPT). We will ensure that there is equitable prioritisation of veterans as well as pregnant women in line with national best practice guidance.

We will continue to expand the offer to deliver specialist support for people with a diagnosed with Long Term Conditions (LTC), in particular those with Diabetes, and Coronary Heart Disease (CHD) in line with the national evidence based recommendations by co-locating trained therapists within physical health settings.

We will also pay particular attention to the availability and delivery of specialist psychology to ensure that those who require intensive, more specialised and longer term support receive the care they need delivered by the appropriately skilled professionals to achieve the best outcome. This will include targeted interventions for Psychosis as well as Personality Disorder and more complex conditions.

Perinatal mental health problems are those which occur during pregnancy or in the first 3 years following the birth of a child. Perinatal mental illness affects up to 20% of women, and covers a wide range of conditions. If left untreated, it can have significant and long lasting effects on the woman and her family. A phased, five-year national programme is underway, to build capacity and capability in specialist perinatal mental health services, focused on improving access to and experience of care, early diagnosis and intervention, and greater transparency and openness. (NHS England, 2019)

Following the recruitment of a team of professionals from different disciplines, including a psychologist, nursery nurses, mental health nurses, occupational therapists and social workers, women can now access prevention advice and support pre-pregnancy, or support with their mental health or prescribed medication for up to 12 months after the child's birth. New projects include craft based peer support groups, "Finding Yourself Again" groups and outreach workers to improve access to the Mother and Baby Unit in Exeter. This marks a huge step forward in the care available to women across Cornwall and the Isles of Scilly.

We are extremely proud of our local Specialist Perinatal Mental Health service and will continue to evaluate and monitor the recent expansion of this specialist area to ensure that a wider range of evidence based therapies are made available for women across the county, and that the service is delivered in line with national expectations under the Local Maternity Services transformation programme.

We will continue to improve accessibility of the service for women who live in more rural communities, particularly in the East of the County, and continue to improve the links with the Mother and baby Unit. Our overarching objectives are:

- Expanding access to evidence-based psychological therapies within specialist perinatal mental health services so that they also include parent-infant, couple, co-parenting and family interventions;
- Offering fathers/partners of women accessing specialist perinatal mental health services and maternity outreach clinics evidence-based assessment for their mental health and signposting to support as required; increasing access to evidence-based psychological support and therapy, including digital options, in a maternity setting.
- Maternity outreach clinics will integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience.

Specialist Early Intervention Psychosis (EIP) services will remains a core priority in line with current national objectives set out in the MHFYFV.

We will work with the service to ensure that they are meeting the national standards as detailed in the national EIP Matrix and support the service to expand to meet the NICE concordant standards. This includes improvement in some areas such as ensuring people with their first episode of psychosis receive all relevant physical health checks in their first 12 months of treatment, ensuring that Carers are able to participate in a Carer Education Programme, and that more people with their first episode of psychosis are accessing the evidence based CBT for Psychosis treatment.

Nationally there is a requirement for all EIP services to become 'ageless' and that they move to an 'At Risk Mental State' (ARMS) model, and will continue to work with the service to transform it in line with national expectation.

Specialist treatment for people suffering from serious and enduring mental illness will remain one of our top priorities. In addition to the areas of pathway transformation already established and aligned to the MHFYFV we will continue to work in close collaboration with our specialist secondary mental health providers to development specific areas to ensure that local services are delivered in accordance with NICE Guidance and are fit for the future. Notwithstanding the priorities set out in The Long Term Plan, we will review the following pathways to identify local priorities:

- Service to meet the needs of treatment resistant depression
- Eating disorders
- Psychological Interventions for Psychosis
- Personality Disorder and Complex Trauma
- Crisis Care and Home Treatment
- Specialist Rehabilitation to avoid use of Out-of-Area placements

In line with the expectation set out in the Long Term Plan, we will ensure that inpatient environments are therapeutic and conducive with positive outcomes, improved experience and timely recovery. Particular attention will be paid to those individuals who have received longer periods of inpatient care for acute needs to make certain that their rehabilitation is planned around their individual needs and overseen by competent and highly skilled professionals.

The physical wellbeing of people with mental health problems is well documented, with objectives set out in both the MHFYFV and the Long term Plan. Ensuring that as many people as possible receive an annual physical health check with their local GP or with a trained practitioner within a specialist provider organisation is a key imperative.

As part of our commitment to meet that national target to improve the availability of annual physical health checks for individuals with an SMI, local plans and the development of a targeted strategy are underway as well as the establishment of four key work stream areas focusing on system reporting and the piloting of new approaches as well as improved communications and awareness raising.

Our commitment to this important area of work is ongoing and we are focusing on a series of key local deliverables which include:

- Reviewing all Community Mental Health Team (CMHT) policies and procedures
- Establishing local data sharing protocols
- Developing a universal reporting template
- Creating physical health lead roles across our front line services
- Delivering a targeted training program across our communities
- Ensuring that new equipment is available to deliver health checks
- Re-establishing locality hubs to bring lead professional together including GP's
- Spotlight audits on key specialist pathways such as Early Intervention Psychosis
- Ensuring that all clinical record systems accommodate new reporting formats
- Promoting the uptake of Mental Health First Aid and Stress Management training
- Making Every Contact Count (MECC)

We aim to continually improve and deliver beyond the national requirements into the future, to make certain that people with serious mental health conditions have access to the full range of physical health checks to maintain healthy lives. To ensure people with mental health issues have parity with those with physical health issues wherever they live we will:

- Improve access to the NHS Health Check programme for people with mental health issues.
- Facilitate mental health practitioners working with GP clusters and involving voluntary sector organisations in support.
- Support the 'suicide safer primary care' and the 'get set to go' exercise programme for suicide prevention in all Integrated Care Areas.
- Expand delivery of local Improving Access to Psychological Therapy services to deliver specialised, co-located support to people with long term physical health conditions.
- Embed the provision of psychological therapy in physical healthcare pathways expanding access to psychological therapies for people with long-term conditions or medically unexplained symptoms.
- Provide a specially adapted cognitive and behavioural approach to people on particular specialist physical health pathways.
- Manage trauma more effectively by providing help for those who have suffered traumatic experiences in childhood or adulthood. By moving to resilience based psychological model we will help vulnerable people to become more resilient and help prevent them from developing debilitating systems in the future.
- Encourage all our services to develop an understanding of the impact of Adverse Childhood Experiences (ACE's) acknowledging the approach developed by Dr Warren Larkin (www.warrenlarkinassociates.co.uk). We will work with services to develop these perspectives and incorporate routine enquiry into established practices in line with the evidence based benefits.
- Recognise the contribution made by families and carers, and the need – highlighted in the Care Act 2014 – to provide support for carers and families in their own right as well as to enable them to better support their loved ones.
- Extend the work of the Transforming Care Programme to meet the need for those with a Learning Disability to meet complex co-existing needs
- Targeted approaches to meet the physical health needs of those people suffering from an eating disorder

'Every year, large numbers of people with more severe mental health problems still enter 'locked rehabilitation wards' – often for long periods, too often far from home, with highly variable rates of actual rehabilitation or recovery.'

(NHS Digital 2018; Wright 2017)

Our recent commitment to the commissioning of a new twelve bedded rehabilitation and 'step down' unit based in Redruth has meant that no individuals requiring main stream adult acute inpatient care have been sent outside of our county for care. However, the evidence tells us that on some occasions Cornish residents are being cared for and supported in out-of-area 'locked rehabilitation' due to the absence of specialist provision locally each year.

We will therefore explore local alternatives to avoid a continuation of this reliance on external support. Our intention will be that local people have access to sustainable, specialist in-patient services 'in-county', in order that they can achieve their own recovery potential to enable a move back to independent living, closer to friends and family.

For many years it has been widely recognised that service provision nationally does not often meet the recovery needs of people experiencing multiple problems. In particular those with co-existing problems such as substance use and mental health conditions. Referrals are often rejected because individuals are seen as 'too complex' or 'too vulnerable'. Sometimes their drinking or drug use prevents them from accessing support. Sometimes they are excluded as a result of their behaviour or simply due to a lack of engagement often deemed as a lack of motivation.

Commissioned services for those with complex needs are not always able to manage the complexity of some or access the additional specialist support that could help people to recover and flourish. With this in mind, we will not only continue to commit to our ongoing focus on substance use and mental health improvement, but also work alongside key stakeholders and partners to better understand the needs of local people who experience complex needs and review the care and support currently available to them. We will support the work of the Making Every Adult Matter (MEAM) (http://meam.org.uk/) initiative but also support new approaches to ensure an inclusive future, where services wrap around complex individuals, remaining 'hands-on' and inclusive at all times.

For individuals with a co-existing mental health and learning disability and/or autism, we will ensure that services work together and promote inclusion to avoid people slipping through the gaps or falling foul of competing thresholds and access criteria. Our ongoing commitment will be to ensure that all individuals considered under the Equality Act as having a 'protected characteristic', have equal access to services and that any reasonable adjustments are put in place to support people's engagement, care and support toward personal recovery.

To meet the local and regional challenges associated with a limited skilled workforce, and to develop a more psychologically informed and sustainable future, we will explore opportunities to tap into additional training for graduate psychologists. The key objective will be to develop a flexible and resilient workforce which can provide specialised assessment; formulation and provide evidence based interventions. We will reflect the outcomes of the clinical associate psychologist worker scheme, initiated by CPFT, to better determine the value to people receiving care and support. We will review the return on investment both economically and in respect of the system wide capacity benefits. This may require the development of joint workforce and recruitment strategy to map the potential in a person's therapeutic career to drive up best value and impact across a wide system specialised support. Specific focus will be put on the value that this, and similar nationwide approaches has on our primary care environment and on the development of community based multi-disciplinary teams and primary care networks.

Personalised care and greater choice

We want to empower people to have greater choice and control over the way their health and care is delivered. This involves having a different conversation with people and developing a personalised support plan which is developed collaboratively with the person receiving support.

To enable and support people to move forwards we will:

- Offer a relationship that is safe, accessible, welcoming, has boundaries and is valuing
- Have an underlying therapeutic philosophy embracing humanism, enablement, validation, acceptance, challenge and patience
- Be congruent, respectful and valuing and do not try to fix!
- Offer compassion, collaboration and learning, transparency and ownership, not presenting ourselves as 'all-knowing' but collaborators in the process of change.
- Provide people with the information and support they need to manage their own mental health and wellbeing, or support family members or friends.
- Use social resources and therapists from the community to enable care planning the ability to adapt and be flexible
- Provide environments which are therapeutic and conducive with the delivery of personalised care

We will expand the use of Personal Health Budgets (PHB's) to enable people to access services they feel they need to improve their health. This includes accessing complimentary therapies, creative opportunities, intensive psychotherapy and hydrotherapy. To improve the accessibility of appropriate mental health services, we will deliver:

- Work in partnership and co-produce services with clinicians, experts by experience, families and carers
- Develop models of care that ensure integrated, effective and accessible services for all
- Ensure all services are provided with humanity, dignity and respect
- To encourage services to ask people 'what matters to you?'
- Work with criminal justice partners to support offenders with mental health problems to get well and recover, and reduce crime, recognising the high prevalence of mental health problems and the need to improve the co-ordination of custodial and community services
- Collect, share and provide information more effectively
- Develop innovative ways to support hard to reach groups across communities
- Reduce relapse and build resilience and sustained recovery by improving continuity of care and providing better support for people discharged from acute services

We recognise that Health and Social Care will evolve and change and but is committed to ensuring that the best possible support is also always available to our carers who are often directly involved in supporting the choices of their vulnerable family members, friends and loved ones.

> "A carer is anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid."
>
> NHS England

Whilst The Care Act 2014 places an expectation on Health and Social Care Services to consider the specific needs of those caring for vulnerable people, we also recognise the valuable contribution that carers make and therefore want to ensure that their individual needs are identified by any mental health service which they may come into contact with.

The support available to carers is inclusive of all those with a caring role and seeks to encourage resilience building for carers and those they look after. It is also extremely important that carers have an opportunity to feedback and comment on the services they receive. We will therefore work in close collaboration with all our mental health services to ensure that they adequately identify, signpost and support people to access the range of targeted services available to them and maintain the principles set out in The Carers Triangle of Care (Carers Trust, 2010).

Recovery focused and resilience forming

Resilience is commonly defined as the capacity to recover from setbacks and is the ability to "bounce back". People need to made aware of this innate capacity to heal from trauma albeit gradually, in most cases. Following trauma, people can not only experience significant distress or discomfort but positive developments as well —a new appreciation for life, a newfound sense of personal strength, newfound relationships with others, new possibilities in life and spiritual growth. (Collier, 2016)

If this is indeed the case, we need to consider re-evaluating and reconfiguring existing community based services in order to give people experiencing psychological distress the best chance to recover and lead meaningful lives. A shift in focus to a resilience based psychological model could also help vulnerable people who would otherwise be at risk of developing debilitating symptoms in future, become more resilient.

A local Recovery College for Cornwall has been developed through a partnership arrangement between a range of local providers from across statutory as well as the third sector. A three year pilot funded through The European Social Fund aims to support recovery from mental ill health through learning, encouraging people to be the agents of their own recovery and moving them from 'patient' to 'student'. The ESF project will support 350 people over three years with the aim of moving 20% closer to employment. The project is subject to formal research and evaluation to determine the effectiveness of this approach both in terms of recovery and in terms of cost effectiveness. We will continue to collaborate with this project and draw on the outcomes of the evaluation to help inform local planning and design.

The impact of traumatic life experiences is increasingly being recognised as a contributing factor to a range of health, social and emotional issues throughout the life course. These traumatic experiences may occur in childhood or later in life and range from physical, mental or sexual abuse, to natural disasters or war and conflict. Developing a system of support which responds to people with a range of complex needs alongside a history of trauma and abuse, will be key to a successful, inclusive and healthier future.

People with learning disabilities and autism are more likely to experience trauma and be subject to the determinants of mental ill-health.

Trauma Informed Approaches (TIA) can be defined as 'a system development model that is grounded in and directed by a complete understanding of how trauma exposure affects service user's neurological, biological, psychological and social development' (Paterson in Sweeney et al, 2016). It is a way of operating in which service providers are mindful of the effects of trauma and think about how to interact with service users to build safe, secure and trusting relationships, and avoid re-traumatisation.
The core values required in providing a trauma informed service are;

> 'ensuring physical and emotional safety, maximising trust through consistency, being honest and providing clear boundaries, maximising choice and control, collaborating and sharing power, and empowering survivors'
>
> (Harris and Fallot, 2001)

Evidence suggests that providing counselling alongside other treatments gives individuals greater choice, particularly where no formal mental health diagnosis has been achieved, and that alternatives can provide greater support for those who do not benefit from standard treatment, those who do not meet the thresholds for standard treatment or those who do not find them acceptable (Bower, Knowles, Coventry & Rowlands, 2011).

The biomedical model sees people's presentation as a product of an illness, rather than trying to understand the human reasons why they might be feeling or acting the way they feel, and the terrible things that have happened to them (Kinderman, 2014).

The challenge has been to determine how best to represent and provide for individuals across the spectrum of trauma where specialist providers often target intervention towards those with the most severe presentations of Post-Traumatic Stress Disorder (PTSD) leaving groups of individuals who appear 'sub-threshold' and representing an unmet need across our communities.

We will continue to prioritise evidence based care and support for those with a trauma whilst promoting integrative approaches to provide greater choice and enhance people's outcomes and experience. We will also explore alternative approaches where research has demonstrated value but where the evidence base is still emerging.

Greater integration

Integrated community services have proved extremely beneficial in developing more efficient care systems. Our plans for our community will include an emphasis on integrated 'place-based' community services. We want to change the balance of healthcare provided in hospitals and in the community (where appropriate) so more people receive care closer to, or at home. This means delivering high quality services which are wrapped around people, not systems, and involving those who can help to support others including their family, friends, neighbours and volunteers.

This will require a shift towards a locality-based model of care and approaches which helps us deliver the intentions set out in our Shaping Our Future system strategy. This will enable us to:

- Empower people to take control of their own lives with help from supportive workers
- Provide person-centred care as close to home as possible
- Operate without barriers across different teams and organisations
- Include members of the community working in partnership with NHS, social care, independent and voluntary sector colleagues

Care will be delivered in a person's own home unless it is clinically or operationally necessary for it to be delivered in a specific care environment. The starting point is building a relationship with local people and communities.

We expect GP practices and their registered populations to be the building blocks for a new model of service delivery based on primary care networks where practitioners and communities collaborate and optimise community assets.

We recognise that clinical and operational viability depends on differing population numbers and place-based care requires a number of planning footprints.

The majority of our GP practices applied to become primary care home sites and this model of care is a form of primary care network. Practices will be working together to agree their primary care network areas within the framework of our Integrated Care Communities.

Strong partnerships and joined up working practices between organisations will be pivotal to our future success and the interface between Primary and Secondary Care and will be a particular area of focus over coming years. Building strong relationships, supported by agreed ways of joint working across our care system, is integral to the creation of a future which works together to meet the needs of the most vulnerable, as well as provide the means of prevention and early intervention. We will work together with partners and key stakeholders to establish a clear set of objectives with consideration to such things as information sharing, access to expert advice and guidance and better use of information technology to promote joined up solutions and partnership working.

The evidence in support of multidisciplinary team approaches is undeniable. Bringing skilled professionals together to work in close collaborations to plan and deliver care, will deliver longer term integration and sustainability in line with the intentions set out in The Long Term Plan and we will be working across our communities to develop and support this approach. We will work in support of integrated and multi-disciplinary community mental health teams and support our secondary care provider to explore new ways of delivering an deploying their specialist skills across our communities.

We will ensure that people receive equitable and responsive care and apply the principles set out in the Responsible Commissioner guidance (NHS England, 2014) in respect of people residing in our communities particularly when placed in specialist care settings in Cornwall and the Isles of Scilly.

Integration across the Isles of Scilly communities is of equal importance to that of our mainland. It is also recognised that the geographical location of the Isles of Scilly and its health and care workforce, require innovative and integrated solutions for all aspects of care and supports community cohesion. A coordinated mental health integration role has been re-established in response to these needs. The aim of this is to offer coordinated specialist support to ensure wrap around services for vulnerable individuals and those requiring more

general mental health support. The scheme is funded by the 'Better Care Fund' (https://www.england.nhs.uk) and forms part of the islands ambitions to develop a single service, estate and workforce solution for health and social care in the future. The project evaluation of this test and learn approach is likely to provide evidence for other rural integrated care areas in our system footprint to adopt similar innovative approaches.

We will continue to support the following projects and initiatives:

- Social prescribing - Improving people's health is not just about prescribing traditional medication. We know that loneliness and isolation can have a serious impact on people's health and wellbeing and are working with partners to use social prescribing to help people lead more connected, healthier and happier lives.
- Social inclusion - To complement the social prescribing project, Adult Social Care is commissioning a service for people who have health and wellbeing needs and need a bit of help to make links in the local community and access to volunteers and peer support groups offering wellbeing support.
- Employment and community links - Support is currently available for people with mental health problems to prepare for, access and maintain employment and integrate into the local community. Help is also available at a community level offering non-clinical support to people in crisis. We will coordinate a project to work with people accessing and providing these services to review what is being delivered and ensure it is meeting needs.
- Mindful Employer initiative - Mental ill-health costs employers in the UK £30 billion every year through lost production, recruitment and absence. Promoting positive mental health in the workplace can be hugely beneficial. Staff with good mental health are more likely to perform well, have good attendance levels and be engaged in their work. Additionally, taking steps to better support the mental health of staff can help to reduce the severity, duration and quantity of mental ill health in the workplace. We are working with employers in Cornwall and the Isles of Scilly to sign up to the Mindful Employer programme.
- Domiciliary care is provided to people assessed as having eligible social care needs, who still live in their own homes (or supported housing), but who require additional support with household tasks, personal care or any other activity that allows them to maintain their independence and quality of life. People have told us that the pathway to get a social care assessment and for the care and support to be put in place, is confusing and needs to be made more clear. We will work to remedy this by mapping out the pathway of support.
- The Recovery College – The overarching objective of this local initiative has been to create: "Learning opportunities that facilitate, support and enable recovery through hope, agency, responsibility and opportunity".

We will deliver high quality community-based services which are wrapped around people by:

- Developing an asset based approach which moves from the traditional approach to providing mental health services to look at 'what makes us healthy' rather than 'what makes us ill'. Our community health services will work with a much wider range of community resources – such as charities, community groups, schools, housing and fire services – to support patients and their communities to manage their own care and promote heathier lifestyles. We will make sure that there is a clear pathway for people to access empowering independence services, and/or to receive a social care assessment if appropriate, in order to access outcome focused care and support in the community.

- Expanding the use of social prescribing and social inclusion services by working closely with GP surgeries, Active Plus, Volunteer Cornwall and other voluntary groups and charities to use social prescribing and social inclusion plans to help people lead more connected, healthier and happier lives. This will include the promotion the promotion of such things as walking groups and the pursuit of art-based activities.
- We will work with the voluntary and community sector to build capacity to offer wellbeing support through volunteers and to make sure that small community groups are able to access grant funding to set up local projects that help to reduce loneliness and social isolation. By building community resilience in this way we can help communities and people to help themselves and each other.
- Enabling and supporting employers - We will encourage and support employers to promote positive mental health and support those experiencing mental ill-health by:
  - Committing to improve mental health at work
  - Taking steps to improve the workplace
  - Educating the workforce about mental health
  - Encourage employers in Cornwall and the Isles of Scilly to sign up to the Mindful Employer initiative
- Employment and community links – We will work with people accessing current services and others to review what is being provided to make sure it is meeting needs. This includes the expansion of the Individual Placement and Support (IPS) model across Cornwall and the Isles of Scilly, following the successful bid for NHS England transformation funding. This approach provides an evidence-based position to supporting people accessing community NHS mental health services into employment. We will also review the support available for people that are not eligible to access community NHS mental health services or social care services, but need support to live independently in the community and access employment.

Building on the success of the Peer Support movement nationally where people use their experiences to help others with such things as debriefing, mentoring and community groups (Mind, 2016). We will support local initiatives and further develop this approach within our communities.

There is evidence of people in hospital who are medically fit but cannot be discharged. This can be due to not having any accommodation or having significant issues with their accommodation. The majority of existing supported accommodation for people with mental health represents shared housing and there is limited self-contained accommodation available across the county. We will therefore explore future opportunities to develop appropriate accommodation to meet the needs of those with complex and enduring mental health conditions.

Evidence ponts to the benefits of long term self-contained accommodation for a small group of complex and vulnerable people who require additional support within the community setting. Local analysis suggests that there is benefit in establishing additional support in this area including on site support. This may include a day time staffing requirement as well as a variety of security levels at night, ranging from monitored CCTV, to onsite all night staff presence. We will review the demand and supply of current supported housing in Cornwall and develop a profile on the housing requirements, including required locations and types of accommodation, to share with the housing market and to ensure that the most appropriate and therapeutic environments are available to promote the wellbeing of those living with and recovering from mental health problems.

Embracing New Technologies

Advances in the use of highly specialised technology is offering new opportunities to millions of people around the world who experience a range of mental health conditions. The development of system wide data dashboard has been further enhanced by the development of a specific Mental Health Dashboard by NHS Kernow in 2018. This collaborative work between commissioner and service providers has enabled an improved understanding of the value in what we provide as has supported the development of more efficient and sustainable services. An example of this has been the use of existing data to help us design alternative crisis services as well as reduce attendances at our accident and emergency departments and delivery improved outcome for vulnerable people.

The benefits of new technology will be balanced against the need for tried and tested approaches which people rely on. We will strive to push boundaries and nurture innovation and advance.

Given the unique geography of Cornwall and the Isles of Scilly, we need to think creatively about how we ensure access to support as many people as possible. We will continue with our openness to test and learn, by embracing digital solutions that drive genuine benefit to both quality of care and efficiency of service. Our response to digital technology within the primary care setting is developing, with the emergence of such things as 'Healthtech Sandbox' which represents the use of experiential technology and demonstrates a commitment to collaborative working with academic colleagues to drive rigour in understand the real world benefits of emerging tools.

The embedding of new technology is not without its challenges so we will work hard to gather evidence which supports the implementation and education on the use of these approaches as well as the benefits to the general public and those delivering services. This will to align our ongoing intention and commitment to the national NHS Local Digital Roadmap programme. (www.england.nhs.uk/digitaltechnology)

Combined with our response to what younger people have been saying about the importance of being able 'to-connect' we will be putting energy into exploring and developing improved web based support for the people across our communities. To achieve this GP practices will be working together across the Primary Care Networks (PCNs) areas within the framework of our Integrated Care Communities. The focus will be on utilising technology to create and develop new models of care that can be delivered "locally" and reduce the need for it to be delivered in a specific care environment unless it is clinically or operationally necessary.

The first steps towards this ambition are to optimise digital technology across primary care to provide the foundations upon which to build the new models of care. Our focus in 2019-20 will therefore be to deliver a significant uplift of the enabling digital platform and capability across primary care. With a 20% reduction in our core allocation for GP IT capital, prioritisation is being given to the "Must Do" priorities:

- Upgrading core Health and Social Care network (HSCN) infrastructure with full migration by April 2020
- Upgrading all end-user devices in the primary care estate to Windows 10 by January 2020
- Consolidation of GP IT systems in North and East Cornwall Integrated Care Area to support collaborative working

- A digital shared care planning solution that all care providers and users can access, particularly important for those with complex conditions and /or nearer end of life.
- Subject to appropriate funding sources being confirmed, we have a number of ambitions to optimise the use of digital technology in primary care, including
- Expansion of the CoIN (Community of Interest Network) to enable primary care clinicians and staff to have seamless access to their systems and data as they move between acute, community and GP care settings
- Consolidation and rationalisation of GP IT systems changes to enable clusters of practices in Carrick and Kerrier localities to work collaboratively
- Mobile and remote working solution enabled to support primary care clinicians and staff to work effectively outside their base practice (e.g. care homes; home visits; acute; community or from the home)
- Further roll out of online consultation (implemented in 20 practices in 2018-19)
- Electronic discharge communication solutions and other IT solutions to reduce the administrative burden
- Further investment in cloud-based telephony options enabling practices to switch calls and remove the dependence on obsolete analogue voice systems.

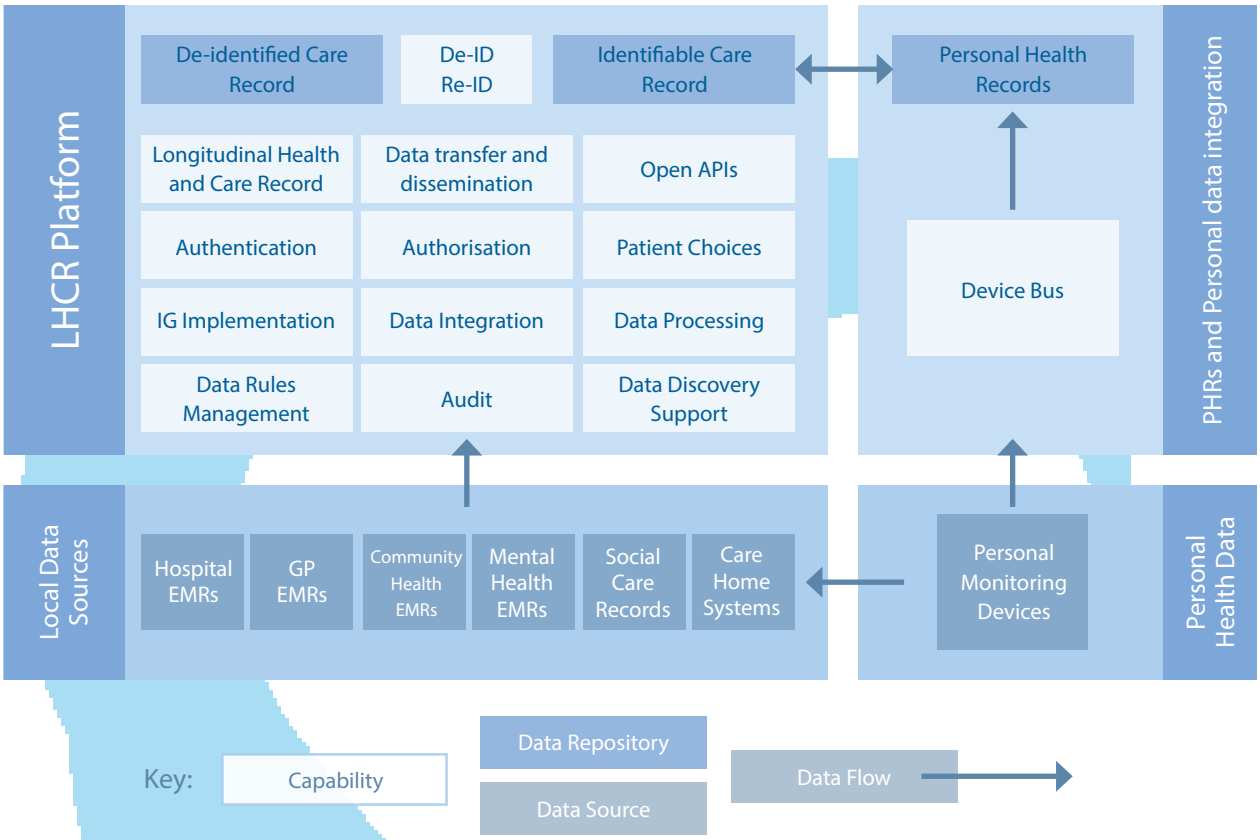
The NHS Long Term Plan describes a future where digitally enabled care will become mainstream across the NHS. The Local Health Care Record (LHCR) programme is tasked with achieving the delivery of a longitudinal health and care record platform linking NHS and local authority organisations.

LHCR will develop a sustainable and affordable IT solution, that will bring together clinical and social care information for the benefit of direct patient care. Cornwall & Isles of Scilly are part of the "One South West" cohort area, that is planning to implement a local solution linked with Devon, Somerset, Bristol, Swindon, Gloucestershire and Wiltshire, to create a longitudinal patient record for Health & Social Care staff by 2021-22. Following this, LHCR solutions across the Country will then link together to create a joined-up patient record across the UK, that will be accessible whenever and wherever a patient needs treatment.

The aim of the Local Health and Care Record programme is to create an information sharing environment enabling our health and care services to continually improve the treatments we use. This ensures that care is tailored to the needs of each individual, and can empower people to look after themselves better and make informed choices about their own health and care.

LHCR high-level architecture

Figure 8



There is a real enthusiasm about the potential for Technology Enabled Care (TEC) to enable better care and support and help to improve quality of life. We will remain open minded and responsive to the development of this area and explore ways in which we can utilise the value in emerging approaches to benefit those in our communities.

Online support to enable people to get the most out of the available support is really important. Schemes such as 'Learn Scilly' (www.scilly.gov.uk) offer support to our island communities to help people navigate online systems and provides valuable outcomes for people wanting to order their medication online or access online treatment via such things as Skype. This will be explored to better enable access to talking therapies where progress has been made in offering online therapy.

We will explore App based for mental health and build this into our resource development plans with service providers to improve signposting and help people develop their ability to self-help. This will include a review of innovative IT functions such as remote clinics and the use of avatar therapy and associated approaches currently under development.

We will explore the emerging use of screening and assessment technology as well as the use of Artificial Intelligence (AI) in such areas as diagnostics and predictive planning.

We will continue to develop our systems to better inform our understanding and enable us to design care and provision which is fit for the future. The use of the mental health dashboard will enable us to further explore ways of promoting timely and targeted services which meet the needs of our community in ever more responsive ways, promoting efficiency and sustainability.

Outcomes

Over recent decades, a wide range of measures and reporting frameworks have been developed, including questionnaires to assess the severity of particular mental health conditions such as anxiety or depression, and frameworks to assess broader aspects of people's lives.
(The King's Fund, 2019).

The engagement we have carried out so far, confirms that there are varying views as to the value in some existing measurement tools particularly in respect of qualitative tools to measure peoples actual experience of the services they receive and what they feel has been valuable on their journey through care. It is evident that some service users question the value in such measuring and reporting which in turn can impact on people's engagement and ultimately their sense of empowerment. We will therefore consider the current use of clinical and non-clinical measurement and rating tools to determine best value. We will review the evidence base for such tools and in some cases re-design the way we gather feedback from people who use our service to help us design care and support which has even greater value and impact.

We will work with our service providers to adopt consistent means of measuring and achieving positive outcomes by adopting approaches such as the 'Recovery Star', 'Inspire' and the 'Warwick-Edinburgh' tools (Mental Health Partnerships, 2019).

In delivering this strategy, we aim to be a voice for mental health on the national stage, providing leadership and striving for the highest quality standards. This will require improved data management strategies, health outcome monitoring and evaluation, to inform future strategic design, policy and practice

We will draw on up-to-date evidence and best clinical practice, and not be afraid to innovate and try new things. We will encourage the use of consistent reporting tools where we can to enable us to compare outcomes and the quality of services being provided.

Delivering consistency and benefitting from practice based and 'bottom-up' learning requires an openness and commitment to data sharing. We will encourage and nurture a culture of transparency, where services feel proud and enabled to share their successes to drive up excellence. This will be achieved by closer working partnerships and contracting arrangements which enable shared outcomes and the use of clear information sharing agreements.

Learning from 'what works for who' will be paramount to a successful and sustainable future. We will share our learning with other to the greater good to regional and national peers. We will promote practice based learning and support development initiatives 'from the bottom up' where the knowledge and skill of frontline staff can be harnessed to shape and inform service design.

Delivering new approaches requires us to think imaginatively about how we use the resources that we have available to us, and to work collaboratively to maximise the potential and direct our future. This will require us to draw on the strength and assets of people with mental health needs, their families, loved ones and friend as well as those delivering care and support. It will involve a continual cycle of community engagement and involvement, to ensure that we are truly co-designing the future of some of our most important services.

In Summary

The development of this strategy has identified a set of clear intentions which will enable us all to deliver against the areas of need explored and described in our work together. Our commitment to the people our community:

- We will aim to prevent people becoming unwell
- We will provide easier access to treatment
- We will ensure that mental health is as important as physical health
- We will support personalised care and greater choice
- We will support people toward their own recovery
- We will help develop people's resilience
- We will develop integrated, local services
- We will strive for better outcomes and improve experiences
- We will strive for excellence in everything we do

How will we know we have delivered our Strategy?

People will know what support is available and where to access it

People will receive support at the right time, in the right place

People will feel listened to and at the centre of their care and support

People will feel supported by services who work together

People will enjoy healthier and more hopeful lives

People will receive support which feels meaningful and valuable

Next Steps

Launch Draft (May 2019)	Formal Engagement & Involvement	Creation of Implementation Plan and Outcome Framework	Full Ratification (December 2019)

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Appendix

Contributors logos: