Futures in Mind

Adult mental health strategy (2020-2025)

Cornwall and the Isles of Scilly Health and Care Partnership

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FOREWORD

I have found it a privilege to have been asked to write this document for those delivering and those receiving services across our communities in Cornwall and the Isles of Scilly.

Having worked in the field of mental health and wellbeing for over 25 years, I believe that the increased emphasis at a national policy level, combined with an upwelling of support across our communities for a wider conversation around mental health, provides a strong opportunity for us to develop truly innovative and positive advances in improving and maintaining the mental health and wellbeing of our local communities.

This strategy follows extensive collaboration and coproduction with many partners and stakeholders over the last year and a half. In listening to people receiving services, as well as those delivering care and support across our sectors, we have been able to truly understand and reflect the needs of the local population and how people see the future of health and social care provision developing.

It has been extremely encouraging to see people's commitment, passion and enthusiasm for change, and I sincerely thank all those who have worked so hard to support the development of this strategy. I look forward to the journey ahead and to building on the strong partnerships already established to deliver the very best outcomes, where people can live long and healthy lives.

Tim Francis
Head of adult mental health and learning disabilities joint strategic commissioning
NHS Kernow Clinical Commissioning Group

It is really great to see the work which has been taking place to create this adult mental health strategy.

All parts of the country have to create a mental health strategy and Cornwall and the Isles of Scilly is ahead of the curve in bringing the community together to create the best possible plan for local people. Like all areas there are some real challenges to overcome but the fact that people are talking about mental health and the whole community is committed to thinking about how best to support people with mental health issues is a really good first step.

One of the key challenges is to ensure that the strategy reaches the whole of the community, not just those already accessing services. This includes people who might be struggling and not realising that their mental health is deteriorating, whether that is older or young people. The NHS also has to ensure that it has the right workforce in place to provide help and support.

No plan about mental health should be devised without the involvement of those who use mental health services. It is absolutely vital that these programmes and these approaches are co-produced and co-created in a way that means they are not just responding to the system, but are truly responding to the needs of the individual. Whether it is 16 year old struggling with the early signs of depression, or a bereaved woman who may be feeling isolated and low – organisations need to listen to those voices and then work together to create the best possible services.

Cornwall and the Isles of Scilly has the opportunity to create some very interesting solutions to bring more people into working for the NHS to deliver these services, to support the mental health of its staff, and to develop better engagement with local communities.

This strategy demonstrates the commitment of partners to bring together all sections of the community to develop these solutions and I look forward to seeing them delivered in the coming years.

Paul Farmer, chief executive of Mind

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 their personal experiences of mental health and wellbeing.

> It's 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

In recognition of the personal experiences which have been shared, this strategy captures the national 'must do's' alongside the priorities we have identified with local people. Through the implementation of this strategy we hope to develop plans which will deliver positive outcomes for people across Cornwall and the Isles of Scilly.

This strategy talks about mental health. Mental health includes our emotional, psychological, and social wellbeing. It affects how we think, feel, and act. It covers states of mind which can be both positive, negative and includes diagnosable conditions. It also helps determine how we handle stress, relate to others, make choices and contribute to society. Mental health is important at every stage of life, from childhood and adolescence through to adulthood. We all have mental health, but its negative impacts can be disabling and are often hidden (Better Mental Health for All, 2019 and World Health Organisation, 2014).

Lots of things affect our mental health. These include difficult life experiences, trauma, the relationships we have with others, our lifestyles, housing, employment and the environment. By working together we can address many of these factors and improve people's mental health.

To achieve this, we will need to be better at spotting the early signs of mental ill health, typical risk factors and intervening earlier.

In the delivery of this strategy we will take into account the needs of local people, the inequalities people face. We will provide integrated solutions to provide wrap around care and support. To ensure we achieve our goals this strategy incorporates health, monitoring through data management and evaluation.

Our vision

We want everyone in Cornwall and the Isles of Scilly, across our diverse mainland and island communities to enjoy the best possible mental health and wellbeing throughout their life.

This means we need to focus on the whole person; tackle mental health issues and their causes with the same energy and priority we use to respond to people's physical health needs.

We want people to work together to ensure our communities stay as healthy as possible for as long as possible. We will provide support to help everyone remain as independent as possible.

We want everyone to be proud of the services provided and confident they deliver the very best outcomes consistently and efficiently.

Our ambition

Our overarching ambition is to ensure people:

- Feel supported and able to access care and treatment
- Have choice in the support and care that they receive
- Reach their own personal recovery goals
- Live longer, in good health
- Feel positive about the services they receive

SCOPE

This strategy has been developed in response to the health needs of the local population (Joint Strategy Needs Assessment (JSNA)) and in consultation and partnership with local people, partners and stakeholders.

This strategy is for adults aged over 18 years living across Cornwall and the Isles of Scilly. It particularly focuses on those who are at risk of developing a mental health problem because of their lifestyle and people who are experiencing poor mental health and wellbeing.

This strategy focuses on the whole person and their individual journey through life. It places an emphasis on prevention, keeping healthy and the delivery of evidence based, specialist care for people who need it.

While this is an adult mental health strategy it pays particular attention to the needs of young adults who are transitioning into adult services. As such, it sits alongside the work which is taking place to transform mental health services for children and young people. This strategy also focuses on people with long-term needs, those who are in high risk groups, as well as older members of our communities who feel vulnerable and lonely.

This strategy informs our local mental health implementation plan, which will be overseen by the Long Term Plan (LTP) Steering Group and the overarching Mental Health Board. These are multi-agency groups which include cross-sector represetnatives and meet bi-monthly.

1 in 4

adults experience at least one mental health problem in any given year

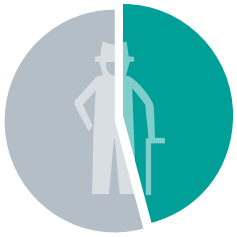
9% of people in Cornwall and the Isles of Scilly report **long term mental health problems** which is higher than nationally

THE NEEDS OF OUR POPULATION

Parity of esteem is essential. One in four adults experiences at least one diagnosable mental health problem in any given year across England.

Adults with a mental health problem have a shorter life expectancy (20-25 percent) when compared to the general population. Statistics show they are two to four times more likely to die from a range of chronic conditions which include cancer, circulatory and respiratory diseases. Almost half (46 percent) of people with a serious mental illness (SMI) are thought to suffer from a long-term physical health condition, while two thirds of deaths are from avoidable and treatable conditions. In addition we have to consider the factors of self-harm and suicide[1].

Failure to address mental health problems is costly for both the people affected and our society. The NHS estimates the economic and social cost in England to be £105 billion annually, and the cost of dedicated mental health support to be £34 billion.



46%

of people with serious mental illness **also have one or more long term physical conditions**

According to Public Health England[2] mental health problems in Cornwall and the Isles of Scilly represent one of the largest contributors to years lived in disability. This is a public health priority because the numbers affected are predicted to increase.

The Office of National Statistics (ONS) estimates that in 2018, 568,210 people lived in Cornwall and the Isles of Scilly. Locally in 2017/18, approximately 40,866 adults were diagnosed with depression, and 4,894 people were registered with a SMI by GPs in Cornwall and the Isles of Scilly[3].

While depression rates are lower in Cornwall and Isles of Scilly (8.7 percent) when compared to England (9.9 percent), the proportion of adults with depression varies considerably by GP practice (2.8 to 23.3 percent); exceeding the national average in some practices. Similarly, in 2017/18 sixteen GP practices registered more adults with an SMI (up to 1.6 percent in some practices) than the national average (0.9 percent). Additionally, people with a long-term mental health condition increased to 9.4 percent of the local population[4].

15%

We have one of the **highest suicide rates** when compared to England

Cornwall and the Isles of Scilly have more emergency hospital admissions for intentional self-harm (244 per 100,000 persons) when compared to England averages (186 per 100,000 persons)[4]. People who self-harm are 100 times more likely to die by suicide than people who don't self-harm. We 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)[4]. Addressing the number of suicides is one of our local public health priorities[5].

There are a number of factors or health inequalities which impact adversely on people with a mental health problem. These include a range of lifestyle choices, employment, housing and access to services (figure one). For example, a survey of 11,247 people living across Cornwall and Isles of Scilly highlighted being a younger adult; living in an area of deprivation; having poor general health; living in poorly maintained housing or in the rental sector; as well as experiencing issues with neighbourhood and community safety which also reduce mental wellbeing.

What can you do to help

We know there are things we can do to protect our mental wellbeing. These include:

- Having more social contact
- Being physically active
- Participating in volunteering[6]

Figure one: Factors affecting people's physical health[7]

FACTS ABOUT MENTAL HEALTH IN CORNWALL AND THE ISLES OF SCILLY

Number of **people aged 18+ affected by mental ill health is predicted to rise** until 2030

Number of **people aged 18+ with an antisocial personality disorder is predicted to increase** until 2035

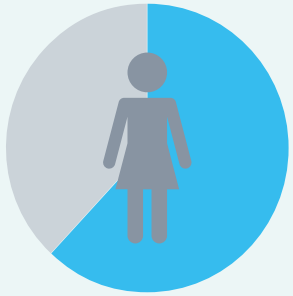
40,886 people with **depression**

1,065 people with **depression and anxiety**

Rates of admission lower to **secondary mental health services** when compared to the rest of England

Depression overtook obesity as the **second most common condition** since 2018

50,900 people have a **common health disorder**



62% of those were **women**

In 2021, we expect to see a **rapid rise in the number of 85+ year olds experiencing depression**

15.7% of the **most deprived suffer from depression and anxiety** compared to 10.8% in the least deprived

1 in 5 older people **affected by depression** which is the most common, treatable and reversible mental health illness

Prescribing rates lower for psychoses and related disorders **than the rest of England**

Higher rates of adults use improving access to psychological therapies treatment for depression and anxiety than across England

4% **increase** between 2016/17 and 2017/18 in the prevalence of **long-term mental health problems**

People with a physical illness and/or in hospital or living in a care home are **three times more at risk**

Given the diverse factors which can impact on someone's mental wellbeing, we must, through this strategy, improve people's involvement and use the lived experiences and aspirations of those with a mental health problem in the development of future services. To achieve this, we will encourage services to adopt the Equally Well Charter. This charter aims to improve the health outcomes of people with a mental health problem, and uses co-production to guide future service delivery[8].

What the national policy tells us

There has been a transformation in mental health over the last 40 years, with a myriad of policy and regulatory frameworks supporting an urgent need to prevent and address mental health problems. These make a 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[9].

A range of national strategies have emphasised the importance of prioritising prevention and the delivery of treatment that delivers parity of esteem. The Prevention Concordat for Better Mental Health 2017, takes a prevention-focused approach to improving mental health and promotes evidence-based planning and commissioning to increase the impact on reducing health inequalities. Sign up to the concordat means organisations must undertake cross-sectoral action that incorporates prevention and transforms the health system[10]. Other key policies include No Health without Mental Health, the Mental Health Five Year Forward View and most recently the NHS Long Term Plan, which set out key plans to improve and expand mental healthcare.

Key deliverables

- Maintain an emphasis on prevention and early intervention
- Increase access to psychological talking therapies
- Reduce waiting times for talking therapies
- Improve recovery rates for talking therapies
- Provide specialist psychological support for long term conditions
- Provide specialist perinatal mental health services
- Provide 24/7 mental health liaison services in accident and emergency
- Improve crisis and home treatment services
- Eliminate all out of area placements for care and treatment
- Reduce suicide rates
- Improve physical health for those with a serious mental illness

The Mental Health Delivery Plan (2019-24) for Cornwall and the Isles of Scilly sets out our ongoing commitment to deliver the final phase of the Mental Health Five Year Forward View.

The NHS Long Term Plan set's out NHS England's priorities for the next decade. Our local strategic plans will respond to this plan which has major implications for the nation's mental health, prevention and the future of mental health services across our communities. Many of its pledges expand on the recommendations of the Five Year Forward View and other existing mental health policies and strategies.

The Long Term Plan's implications for mental health cover a range of areas and include specific proposals for both children's and adult mental health[11].

While committing to increased investment to support community based care, the NHS Long Term Plan recognises the importance of personalisation and prevention while emphasising the need to focus particular attention on those aged of 0-25 years.

Specific objectives within the Long Term Plan include:

- A £2.3 billion additional 'ring fenced' investment by 2023/24
- A particular focus on the mental health of 0–25 year olds
- Expanding crisis care and developing a single point of access
- Recruiting and developing a skilled workforce
- Expanding the availability of specialist perinatal services
- 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
  - Alternative and complimentary crisis support
- A targeted suicide prevention programme
- The elimination of all out of county placements for mental health care and treatment

This strategy sets out our commitment and key objectives to meet the needs of local people and how we will develop services to achieve this over the next five years. Our implementation plan will set out how we will deliver the NHS Long Term Plan, as well as our local strategic objectives set out in this document. This plan will be made publicly available.

The views of people who deliver and receive support

We have taken time to capture the views, experiences and aspirations of people across Cornwall and the Isles of Scilly who deliver mental health services and of people with a mental health problem, their friends and carers.

We have used the JSNA, as well as local and national survey findings to inform the development of this strategy. We also held a range of stakeholder events in 2018/19. This included a multi-agency workshop in October 2018, which brought people together from a range of sectors and organisations, including those delivering and receiving support.

The co-produced Independent Mental Taskforce Report identified a number of key themes from its survey of over 20,000 people who had used services, carers and people across health and social care that provide services. This feedback informed the development of the Five Year Forward View for Mental Health which has the three key themes of; prevention, access and quality.

We will continue to work with Healthwatch Cornwall (HC) to help us draw on the insights of individuals, families and communities to drive transformation and deliver real improvements to our services. The outcomes of the HC appreciative inquiry carried out in 2019 has supported the development of this strategy. More details on this approach and our findings are set out below in 'appreciating what we are doing well'.

From looking at the Isles of Scilly Health and Wellbeing Survey 2017, it is clear that island residents felt there was a lack of support on the islands and that travel restrictions added to the challenge of accessing specialist support on the mainland.

We also know people can struggle to navigate services and find the support they need.

Mental and physical health needs are often treated in isolation. There can be long waiting times to access mental health services and receive a diagnosis. People can be confused by the different terminology organisations use, are frustrated by multiple assessments, referral processes and the bureaucracy around these. People feel they don't always get the same level of service, are not listened to or involved in decisions that affect them.

Understanding the needs and views of younger adults, including those in further and higher education has been a key area of focus for us. During 2019, we met with students, teachers and leaders based at Falmouth University and Truro College. This included people who rely on existing support provided by the educational establishment's wellbeing support services and those with additional educational needs.

The key themes from our conversations were:

1. **The need for joined-up and flexible approaches**
2. **Accessible, reduced waiting**
3. **Personalised, consistent care**
4. **Offer of more counselling approaches**

A number of recommendations and priority actions have been identified during the development of this strategy. These are grouped into four broad areas:

Care which is holistic, flexible, inclusive, local and co-located

Services that focus on the needs of people and offer choice, early help and high quality comprehensive crisis and hands-on care

Early intervention, prevention and recovery and providing consistent, compassionate and community focused care

Integrated and less fragmented services

"UNDERSTANDING THE VIEWS OF YOUNG ADULTS IS A KEY AREA OF FOCUS"

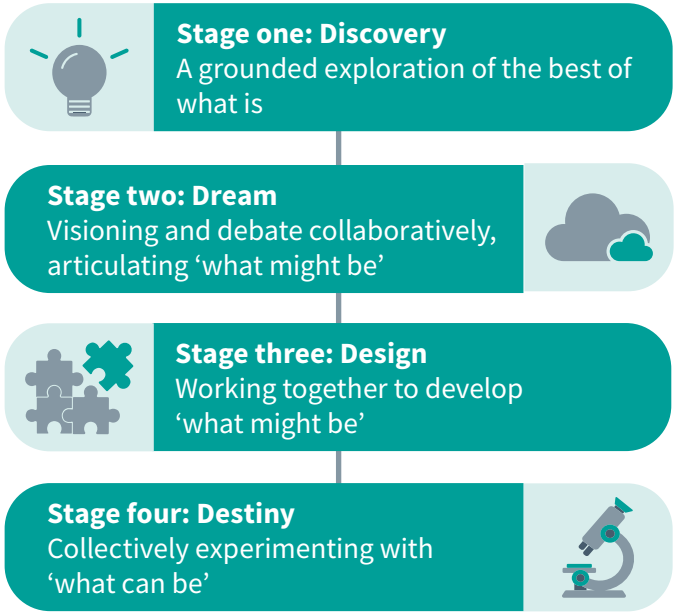
Appreciating what we are doing well

In 2018, NHS Kernow commissioned Healthwatch Cornwall to carry out an appreciative inquiry (AI) engagement report into commissioned mental health services in Cornwall.

This activity engaged staff in a strengths-based approach to research to generate new ideas and opportunities for organisational and service development. This approach focuses on an 'appreciative' perspective which helps teams to identify existing strengths, achievements and successes and enables a positive core to be built upon (discovery and dream).

The explicit objective was to inform the development of this strategy and ongoing work (design and destiny).

Figure two: stages of an appreciative inquiry (AI)



Healthwatch Cornwall carried out sessions early in 2019 with approximately 230 people from 30 mental health teams across the county, so key themes could be identified and presented to the commissioning team.

Healthwatch Cornwall reported that staff were very keen to take part in their engagement and were clearly very passionate and enthusiastic about their work, and felt supported by the organisations they work for. In particular it was evident that staff were:

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

Staff were keen for there service pathways and referral routes to be reviewed and for there to be better clarity about their remits across the system. They were also keen to ensure timelier access and appropriate journey's for people within and between services. Staff also wanted a greater emphasis to be placed on early intervention and for preventative community services to be more widely available.

Staff were generally positive about the learning and development opportunities available to them, but wanted to strengthen the workforce increasing the opportunities for them to build their skills, share good practice; they also wanted to 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 acceptance that teams and services could work better together to provide the best care for people. HC were struck by the overwhelming nature of staff going 'above and beyond' to support the people who used their services which included helping with many aspects of their daily lives eg providing help with financial matters or housing related issues.

Healthwatch Cornwall's report made a number of recommendations for future developmental work. These informed the formal engagement and involvement phase of this strategy. The full report can be viewed at www.healthwatchcornwall.co.uk.

STRATEGIC INTENTIONS

Over recent years there has been significant investment in mental health services in Cornwall and the Isles of Scilly. This has been made in line with the national requirement to invest in more preventative activities and transform services.

Organisations in Cornwall and the Isles of Silly signed the prevention concordat for better mental health to meet the national Mental Health Investment Standard (MHIS) before many other areas of the country. This enabled us to start our journey of transformation and service enhancement early.

This investment and early formation of key strategic intentions demonstrated our local commitment to parity of esteem. The local commitment to deliver against the key national deliverables, in the Five Year Forward View for Mental Health (2019-24) have delivered significant service transformation and improvement with tangible evidence of improved outcomes for a significant number of local people. The number of people accessing and benefitting from newly commissioned services continues to grow and reflects the themes identified through our local engagement.

We need to prioritise prevention, early intervention and access to evidence based support as well as offering people a greater choice and more personalised services.

Our local system wide strategic objectives have a strong sense of partnership and collaborative working. Our commitment to ensure everyone works together will remain a guiding principle to achieve change and the development of services which meet the needs of local people.

Our objectives focus on achieving mental wellbeing throughout our lives by concentrating on prevention and the promotion of resilience to help people stay well. As well as providing person-centred care this will help us deliver a timely, hands on response which avoids needless delays in treatment.

We will take a strong, cohesive approach to increase integration and secure the best outcomes for the people of our communities. This strategy calls on health, social care, schools, business, the voluntary and community sector, to work alongside people with mental ill health, their families, carers and friends to achieve our ambitions.

This holistic approach will help improve mental health and wellbeing locally while maintaining sustainable and stable services.

> “PRIORITISE PREVENTION, EARLY INTERVENTION AND ACCESS TO EVIDENCE BASED SUPPORT”

System wide quadruple aim

Healthy communities

Healthy start

Healthy bodies

Healthy minds

Our objectives

- 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 everyone can be proud of and which deliver value for money

Our key priorities

- Preventative approaches
- Easier access to care and support
- Personalised care and greater choice
- Recovery focused and resilience forming
- Greater integration
- Embracing new technology

PREVENTION APPROACHES

Prevention is everyone's business. It will be fundamental to the provision of improved outcomes. This will require greater collaboration and coordination across the system to make best use of resources.

Prevention means taking action to improve people's quality of life and reduce their chance of getting a mental and physical health condition.

It is important to view people not purely in the context of their ill-health, but 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.

Preventative action allows us to act in order to avoid risk factors which contribute to poor mental health and wellbeing. To help us plan effectively and provide the right support in the right place at the right time, we will approach things according to three levels of prevention as set out in on page 14. This reflects a recognised approach and will help us maintain consistency.

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 sets out how we plan to improve the identification of need, offer intervention, support recovery and build resilience and independence for people under 18. These preventative actions must be delivered alongside other key strategies such as Turning the Tide and the local transformation plan. This will help address other key areas of risk such as the transition between childhood and mental health.

Public health aims to improve the health of the population, by promoting and protecting health and wellbeing, preventing ill-health through tackling the factors which impact upon it eg housing, employment and lifestyles. This provides a way for us to proactively influence the mental wellbeing of people.

The Five Ways to Wellbeing identifies actions we can all take to improve our mental wellbeing. These include:

1. **Connecting with people**
2. **Being active**
3. **Taking notice of people around us**
4. **Continue to learn**
5. **Giving to others.**

The council and the NHS must encourage and promote improvements in:

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

Level of prevention	Population health	Wellbeing care	Early intervention
Primary (universal)	Preventing the onset of disease by reducing risk (eg 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.

The following priority areas in the Public Health England's Prevention Concordat for Better Mental Health identified the following priority areas to help reduce the risk of mental health problems and their impact:

1. **Children**
2. **Parents and parenting**
3. **Workplace**
4. **Debt management**
5. **Maternity**
6. **Older people and social isolation**
7. **Long term conditions**
8. **Suicide and self harm**

"WE WILL WORK TO BETTER UNDERSTAND HOW PEOPLE COPE WITH ADVERSITY AS WELL AS DEVELOP THEIR OWN PERSONAL RESILIENCE AND HOPE"

Looking after our health
We can all do things to help our health and wellbeing for example, be smoke free, eating well and maintaining a healthy weight, moving more, get regular sleep and being alcohol aware. Spending time with our friends or giving something back to our community by volunteering all help our wellbeing.

Age well
Looking after our bodies and minds helps us to age well. When offered we should all take advantage of health checks. We should also all do our bit to look after older or vulnerable people in our communities.

Healthy homes and communities
Living in a safe, warm, affordable place makes us feel better. Spending time with friends, good social networks, participating in community activities and using local shops and outdoor spaces helps ensure we live in happy, healthy communities.

Healthy minds
We should be aware of our mental health at home, whilst in education/training and work and know what we can do to keep minds happy and healthy. We should all do whatever we can to reduce stigma and ensure there is easy access to psychological services and support for whoever needs it.

Healthy schools, training and work
Learning new skills and meeting new people help our overall health. We need schools which teach mental resilience. We should do what we can to promote training and career opportunities, and help people return to work. When people need it, we should ensure we help them with financial advice and debt management.

Healthy healthcare
Our health services should utilise the skills and knowledge of a variety of practitioners, using technology wherever possible. We should be creative and think about how we can work together to provide alternatives to admission. We should use what's available in our communities though social prescribing to help people stay well.

Public Health Cornwall leads on the local Prevention Concordat for Better Mental Health. They have adopted the eight key areas of the prevention concordat set out on page 14.

These areas will also form part of this strategy and will be an integral component of the implementation plan. These actions will be delivered alongside the Health and Wellbeing Strategy, which focuses on healthy communities, a healthy start, healthy bodies and health minds.

This strategy provides an opportunity to the delivery of local actions including the recommendations made by the adult mental health joint needs assessment and focus paper on the physical health of those with a mental health condition.

Plans are underway to develop key objectives in order to provide improved experiences and measurable outcomes for people. This includes the mapping of all existing contracted prevention services and the retendering of some of these in order to improve social inclusion and promote independence. In future we will expect providers to improve the integration of prevention within their services.

In addition to this strategy, Public Health Cornwall is delivering a range of mental health prevention activities to address the risk factors previously highlighted in figure one. Their approach will include work with our partners to provide healthier living environments and access to natural spaces. The aim will be to deliver better outcomes from early childhood, throughout adulthood and into older age in support of the prevention concordat.

These activities form part of this strategy and will be detailed in its implementation plan. They will include collaborative initiatives to improve mental health for example:

- An adult social prescribing programme to address issues such as social isolation, physical and mental health
- Workplace health programme and health checks
- Mental health training eg Making Every Contact Count (MECC), Applied Suicide Intervention Skills Training (ASIST), mental health first aid and Connect 5
- Public health campaigns
- Physical activity interventions like Get Set Go

Our collaborations will be with organisations like Pentreath who run the Recovery College, the Citizens Advice Bureau and Department of Welfare and Pensions to support the mental wellbeing of those currently unemployed and people who are in debt.

We will also undertake specific activities to target people who are more vulnerable and which include people with autism and/or learning disabilities, and lower income households in fuel poverty.

Suicide prevention is an extremely important area of focus given our higher prevalence rates. Local plans are in place, through the Zero Suicide Collaborative and projects which provide support after self-harm, to reduce the number of deaths by suicide across Cornwall, in line with the national target of 10 percent.

> “SUPPORT VULNERABLE YOUNGER AND OLDER MEN VIA THE USE OF SPORTS”

These include supporting vulnerable younger and older men via the use of sports. We will support GPs to better identify and manage vulnerable people, through a rolling programme of free training. We will expand this work to include the development of a Single Safety Plan. This will improve access and consistency in the way we provide personalised care and manage risk. We will also progress our Suicide Safer Towns initiative to deliver bespoke and local support in key areas of need.

We are extremely proud of our local ‘postvention’ service. Following a suicide, this offers people face-to-face support from experienced mental health professionals, which includes liaison with statutory and voluntary services. The service also delivers an eight-week evidence-based psycho-education course for people who are at least six months post-bereavement and preferably post-inquest. We will review this service to ensure it is fit for the future. In addition, we will establish a multi-agency surveillance process to reduce the long-term and wider detrimental effects of bereavement by suicide.

In response to the outgoing Five Year Forward View for Mental Health priorities and the newly established objectives described in the NHS Long Term Plan, we will continue to build on our commitment to secondary prevention and keeping vulnerable people safe. We have already established a number of targeted early interventions for people aged 18+. We are also expanding our range of community alternatives and complimentary crisis services to provide a better response and more choice. Some of these services are available to people from the age of 14 upwards. These include:

- **Crisis café:** This project, run by Redruth based charity Valued Lives, offers a community based alternative to our secondary care crisis service. It is available 24/7 to people aged 14+ and aims to stop people reaching crisis point and requiring an admission to hospital. Pop up café support is being made available across Cornwall to target key groups including unskilled workers, low income households and the unemployed.
- **Out of hours helpline:** Introduced in September 2018 and available to people over the age of 16 and under the care of Cornwall Partnership Foundation Trust (CFT). Support is available between 5pm and 9am 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 8pm and 10.30pm. This enables the team to offer 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 located in the emergency department (ED) at Royal Cornwall Hospital in Truro as part of the national uplift to the CORE24 standard to provide 24/7 specialist mental health support in a general hospital setting. This means anyone experiencing a crisis will be assessed and receive appropriate support within four hours of arriving at the ED or being referred from a ward. We will also enhance the services offered at University Hospital Plymouth, to expand the current psychiatric liaison serves up to the same CORE24 standard as we have in Truro. This will ensure residents from east Cornwall receive the same standard of high quality care and treatment.

We will establish a fully operational integrated multi-agency prevention and assessment of crisis teams (IMPACT) Hub at Royal Cornwall Hospital Trust (RCHT). Staff from safeguarding; psychiatric liaison, complex care and dementia, drug and alcohol, housing, advocacy, child and adolescent mental health and specialist perinatal mental care health teams will work together in a single location to provide timely, 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 to ensure people are 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 (SPoA) for adults, to work alongside services already in place for children, with appropriate support across NHS 111, ambulance and the emergency department. This will ensure fully integrated, open access and guarantee a response to anyone who requires support if they deem themselves to be vulnerable or in mental health crisis.

We will establish equitable community based preventative alternatives to the more specialised crisis and home treatment services. We will consider emerging national and local evidence and focus on solutions which are integrated and inclusive. To achieve this we will work with statutory and voluntary partners.

A review, redesign and recommissioning of our jointly funded voluntary and community sector smaller mental health providers will be undertaken. This will help us to identify gaps in our provision, for example in the provision of independent and supported accommodation. This will also help us to shape the market to develop alternatives and address the current reliance on residential care. We will ensure the model we introduce complements the current service provision by offering vulnerable people greater wrap around support, choice and continuity of care.

EASIER ACCESS TO TREATMENT

Some people require care and support for a range of conditions which may span a number of years during their lifetime.

Alongside providing treatment, we will seek opportunities to help people achieve their own recovery goals and to enjoy a good quality of life. To achieve this, we will continue to work to increase people's choice of services, improve accessibility and provide services where people feel they are active participants and are part of decisions about what works for them.

We will work to improve the links between health and social care staff and services to ensure treatment pathways are clear for people with multiple and complex conditions. We will ensure all staff have a basic understanding of mental health and its impact on people's lives and behaviours. Working together more efficiently will improve the overall support we are able to offer.

While there are various factors which influence and impact on our mental health and wellbeing, we will pay particular attention to the key transition points in people's lives. For example, transitions between child and adult services offer an opportunity to improve people's experiences and deliver long-term positive outcomes. We will also look at the way other services interface with mental health care to provide holistic support. This will bolster people's ability to cope, recover and thrive when faced with financial crisis, unemployment, homelessness anxiety[12].

We will develop and strengthen our wider networks to deliver the most effective and appropriate support where choice, access and delivery are provided seamlessly and boundaries between organisations are not noticeable.

Improving access to evidence based talking therapies remains one of this strategy's core must dos. We will ensure services deliver positive and sustainable outcomes by providing consistent care with clear waiting time standards. These services will meet 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. This will enable us to increase the amount of people we help each year.

Highly skilled practitioners will continue to offer cognitive behaviour therapy (CBT) and eye movement desensitisation reprocessing (EMDR) alongside other psychological support for depression, anxiety and post-traumatic stress disorder (PTSD). We will explore newer treatments, for example acceptance and commitment therapy (ACT) and interpersonal psychotherapy (IPT).

We will ensure there is equitable access for veterans as well as pregnant women in line with national best practice guidance.

We will continue to expand the offer to deliver specialist psychological support for people diagnosed with long term conditions, particularly people with diabetes and coronary heart disease (CHD). We will do this by co-locating trained therapists in physical health settings in line with the national evidence based recommendations.

We will pay particular attention to the availability and delivery of specialist psychology. This will ensure people who require intensive, specialised and longer term support receive the care they need from appropriately skilled professionals; enabling them to achieve their best outcomes. This will include targeted interventions for psychosis, personality disorder and other long term, complex conditions.

Through this strategy we are committed to driving forward change to deliver parity of esteem. This strategy makes the following recommendations:

- The physical health of people with serious mental health problems will be a key priority in our integrated care system and partnership. This will improve outcomes for people whilst reducing the cost of care.
- Local strategies will target key risk factors and promote activities that enhance people's mental wellbeing.
- Cornwall's integrated care system should adopt the principles of the Equally Well UK Charter. This will help us to address the areas highlighted as requiring improvement in the 2018 Care Quality Commission report.
- We will ensure systems are in place to recognise the risk of suicide in people with serious mental illness, multiple conditions or who self-harm.
- Interventions and programmes which focus on improving social and economic, eg. education, employment, housing and reducing isolation; opportunities for people with a serious mental illness will be prioritised.
- A variety of methods to assess the barriers which prevent people accessing high quality care will be used to collect data. The findings will be used to inform action plans.
- We will take steps to improve the way data is shared between primary care and secondary services to increase the uptake of physical health checks by people with a serious mental illness, learning disability or in high risk groups. We will learn from other areas eg. Bradford, where there is a standardised physical health check template and shared care protocol in place.
- Improve access to information and support to help people with a serious mental illness, at risk of cardiovascular or metabolic syndrome to change their behaviour and improve their health.
- Analyse mental health data across the health and care system to understand how people with a mental illness, access and use services. This will help inform future service planning and strategies.
- Improve the support provided to people with mental health conditions including psychosis who attend the emergency department.
- We will promote a model of home based care; focussing on placing people in the least restrictive environment and getting them home as soon as they are ready for discharge. This will release capacity and improve access.
- We will place a focus on diagnosis in primary care and community based support provided by locality based, multi-disciplinary teams for people with dementia.
- We will streamline services to reduce duplication. A SPoA will provide timely, easy access to services. As a result, services will offer inclusive, integrated support for people who feel they need help with their mental health.
- We will encourage self-referrals into a service which provides a choice of treatment options. Our aim will be that no-one is turned away when they feel they are in need.
- We will work across the boundaries of all organisations involved in providing mental health support to ensure we look after the mental well-being of military veterans.
- We will build on the work undertaken to develop this strategy to increase the ways we involve people with lived experiences of mental ill health and their carers to help co-produce, quality assure and transform services.
- We will develop place-based support where multi-agency teams work together to decision make and deliver support.

> "EXPAND AND IMPROVE OUR RANGE OF EVIDENCE BASED PSYCHOLOGICAL THERAPY SUPPORT"

Perinatal mental health

Perinatal mental health, which occur during pregnancy or in the first three years after the birth of a child, affect up to 20 percent of women, and covers a wide range of conditions. Left untreated, perinatal mental health can have a significant, long lasting effect 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. This is focused on improving access to and experience of care, early diagnosis and intervention, and greater transparency and openness[13].

Expand access to evidence-based psychological therapies
To also include parent-infant, couple, co-parenting and family interventions.

Offer fathers and partners evidence-based assessment for their mental health
Signposting to support and therapy including digital options; in a maternity setting.

Integrate maternity, reproductive health and psychological therapy
For women experiencing mental health difficulties directly arising from, or related to their pregnancy within maternity outreach clinics.

Our objectives

- We have already recruited a team of professionals which includes a psychologist, nursery nurses, mental health nurses, occupational therapists and social workers. This has enabled women locally to access prevention advice, pre or post pregnancy support for their mental health or prescribed medication for up to 12 months after their child's birth. New projects, which have been developed locally, include craft based peer support and Finding Yourself Again groups.
- We are extremely proud of our local specialist perinatal mental health service. We will continue to evaluate and monitor the service to ensure a wide range of evidence based therapies is available to women. We will ensure the service continues to be delivered in line with national expectations under the local maternity services transformation programme. We will continue our work to improve access for women who live in our more rural communities, particularly in the east of the county.
- We will build on existing work to improve the links with the mother and baby unit in Exeter. Outreach workers are already helping to deliver improved access. This marks a huge step forward in the care available to women across Cornwall and the Isles of Scilly.

Care in hospital

In line with the expectation set out in the Long Term Plan, we will ensure our inpatient environments are therapeutic. They should provide people with positive outcomes, an improved experience and timely recovery.

We will pay particular attention to people who need to stay in hospital for longer periods of time for acute psychiatric care. We will ensure their rehabilitation is planned around their individual needs and overseen by competent and highly skilled professionals.

Every year, large numbers of people with more severe mental health problems are cared for in locked rehabilitation wards. This is often for long periods of time and requires people to be treated far from home, with highly variable rates of actual rehabilitation or recovery[14].

Our recent commitment to the commissioning of a twelve bed rehabilitation and step down unit in Redruth has meant that no one who has required mainstream adult acute inpatient care have been sent outside of Cornwall. However, the evidence tells us that each year some local residents are being cared for and supported in locked rehabilitation units outside the county due to the absence of local specialist provision.

We will therefore explore local alternatives to avoid this. Our intention is that local people will have access to in county, sustainable, specialist in patient services so they can recover, and return to independent living while remaining close to friends and family.

Serious and enduring mental illness

Specialist treatment for people with a serious and enduring mental illness will remain a top priority. In addition to the areas of transformation already established and aligned to the Mental Health Five Year Forward View, we will continue to work in close collaboration with our secondary mental health providers to ensure local services are delivered in accordance with National Institute for Health and Care Excellence (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 our local priorities:

1. **Services to meet the needs of treatment resistant depression**
2. **Eating disorders**
3. **Psychological interventions for psychosis**
4. **Personality disorder and complex trauma**
5. **Crisis care and home treatment**
6. **Specialist rehabilitation to avoid use of out of area care**

Early intervention psychosis

Specialist early intervention psychosis (EIP) services will remain a core priority in line with the national objectives set out in the Mental Health Five Year Forward View.

We will work with the service to ensure they meet the national standards as detailed in the national EIP matrix. We will support the service to expand in order to meet the National Institute for Health and Care Excellence (NICE) concordant standards. This will incorporate 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 carers are able to participate in a carer education programme; and that more people experiencing their first episode of psychosis are able to access the evidence based cognitive behaviour therapy (CBT) for psychosis.

Nationally there is a requirement for all EIP services to be ageless and instead use an at risk mental state' (ARMS) model. We will continue to work with the service to deliver transformation in line with national expectation.

"SPECIALIST TREATMENT FOR PEOPLE WITH A SERIOUS AND ENDURING MENTAL ILLNESS WILL BE A TOP PRIORITY"

Dementia

Improved access to support before, during and after a diagnosis of dementia is critical. Awareness of the support available will encourage people to seek a diagnosis and lead the best lives they can. A diagnosis helps people with dementia to have access to relevant information, resources and support; to make the most of their abilities and benefit from drug and non-drug treatments. An early diagnosis gives someone the chance to explain to family and friends the changes happening in their life[15].

Although early diagnosis is encouraged, access to support services for people with dementia and their families is not dependent on diagnosis. Services such as memory cafés are open to anyone with dementia or memory loss and their carers regardless of formal diagnosis.

Through this kind of support network, we will work with people to identify what prevents them seeking a diagnosis and put in place measures to address our findings. Diagnosis can be made by GPs or in more complex cases following referral to memory clinics or specialist services.

Once a diagnosis of dementia is made, a person may be prescribed drug and non-drug support. Both the person and their family will also be offered support in the community. This will include access to information, guidance, community groups, benefits advice and post diagnostic counselling.

Receiving a diagnosis of dementia can be challenging and support is available to help people lead their best lives.

Dementia Friendly Communities

We are committed to increasing the number of dementia friendly communities. These are communities which help people with memory loss and the symptoms of dementia and also support their carers, which is essential. We are lucky that Cornwall and the Isles of Scilly is made up of these communities. They will be fundamental to helping us provide sustainable support. Carers groups and memory cafés are able to access funding from NHS Kernow Clinical Commissioning Group and Cornwall Council to help them deliver this support.

> “SERVICES SUCH AS MEMORY CAFES ARE OPEN TO ANYONE REGARDLESS OF FORMAL DIAGNOSIS”

Physical health

The physical wellbeing of people with mental health problems is well documented, with objectives set out in the Mental Health Five Year Forward View and the Long Term Plan. We will work with GPs and specialist providers to ensure as many people as possible receive an annual physical health check.

As part of this commitment and to achieve national targets, plans are being developed locally. This work has identified four key areas; system reporting, piloting new approaches, improved communication, and awareness raising. We will:

- Review all community mental health team (CMHT) policies and procedures
- Establish local data sharing protocols
- Develop a universal reporting template
- Create physical health led roles across our front line services
- Deliver a targeted training programme across our communities
- Ensure equipment is available to deliver health checks
- Re-establish locality hubs to bring lead professional together including GPs
- Undertake spotlight audits on key specialist pathways such as early intervention psychosis
- Ensure all clinical record systems accommodate new reporting formats
- Promote the uptake of mental health first aid and stress management training
- Make Every Contact Count (MECC)

We aim to continually improve and deliver beyond the national requirements. We will make sure people with serious mental health conditions have access to the full range of physical health services so they are able to maintain healthy lives.

We will:

- Improve access to the NHS Health Check programme.
- Facilitate mental health practitioners to work with GP clusters and involve the voluntary sector.
- Support the suicide safer primary care and the Get Set to Go exercise programme for suicide prevention in all integrated care areas.
- Expand 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. This will increase the support available to 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 people who have suffered distressing experiences in childhood or adulthood. Through the move to a resilience based psychological model we will help vulnerable people become more resilient and help prevent them from developing into debilitating conditions.
- Encourage services to develop an understanding of the impact of adverse childhood experiences (ACE) acknowledging the approach developed by Dr Warren Larkin. We will work 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 - as highlighted in the Care Act 2014 - to provide support for them in their own right, as well as enabling them to better support their loved ones.
- Extend the work of the Transforming Care Partnership (TCP) to meet the needs of people with a learning disability with complex co-existing conditions.
- Target approaches to meet the physical health needs of people with an eating disorder.

> “ENSURE AS MANY PEOPLE AS POSSIBLE RECEIVE AN ANNUAL PHYSICAL HEALTH CHECK”

Multiple conditions

It is widely recognised that service provision does not always meet the recovery needs of people with multiple problems or conditions. For example, people with co-existing substance use and mental health conditions who are often referred to has having a dual diagnosis. People often struggle to get to the right place to receive the right support to meet their needs. Sometimes this is because services believe people's symptoms are too complex or their presenting vulnerabilities are beyond the scope of their service. Sometimes a person's alcohol or drug use prevents them from accessing support; and on occasions they are excluded because of their behaviour or a lack of engagement/motivation.

The services we commission for people with complex needs are not always able to manage the complexity, or access the additional specialist support which would help people to recover and flourish. We will continue to focus on the way we support substance use and mental health improvement. We will work across health and social care, alongside stakeholders and partners to understand the complexity of people's needs and review the care and support available to them. We will support the work of the Making Every Adult Matter (MEAM) initiative. We will explore new approaches to ensure services are inclusive, wrap around people and remain in proactive contact with them.

For people with a co-existing mental health and learning disability and/or autism, we will ensure services work together, promote inclusive access to care and treatment to avoid people slipping through the gaps or falling foul of competing thresholds and access criteria.

We will ensure that people who have a protected characteristic under the Equality Act have equal access to services. We will ensure reasonable adjustments are put in place to enable people's engagement and enable them to access the care and support they require to recover.

To help address local and national workforce challenges, we will explore opportunities to training 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 Cornwall Partnership NHS Foundation Trust, to better determine the value to people who receive care and support. We will review the return on investment both economically and in respect of the system wide capacity benefits.

We will maintain our joint commitment to our workforce strategies and consider upskilling existing teams to respond to emerging needs and demands. We will reflect national guidance and incorporate approaches which deliver the best value and the best outcomes.

> "PROMOTE INCLUSIVE ACCESS TO CARE AND TREATMENT"

PERSONALISED CARE AND GREATER CHOICE

We want to empower people so they have greater choice and control over the way their health and care is delivered. To do this we will have to have a different conversation with people.

Care plans and personalised support should be developed collaboratively with the person receiving support. We want services to listen and respond to the people who use them. Each individual should be responded to with care and respect from services which respond safely and appropriately to their individual needs. We will:

1. Offer a safe, accessible, welcoming service that has boundaries and values the individual
2. Ensure there is an underlying therapeutic philosophy to embrace, enable and validates whilst accepting and challenging people in support of their recovery
3. Ensure services are consistent, respectful and value people
4. Offer services which are compassionate and work in collaboration with people as they identify and work towards their recovery goals
5. Provide people with information and support to manage their own mental health and wellbeing, or support family and friends
6. Use social resources and therapists from the community to enable care planning which is adaptable and flexible
7. Provide environments which are therapeutic/ conducive to the delivery of personalised care
8. Ensure that through our safeguarding processes people are protected from abuse and neglect

We will expand the use of personal health budgets (PHBs) to help people access the services they feel they need to improve their health and wellbeing. This includes accessing complimentary therapies, creative opportunities, intensive psychotherapy and hydrotherapy. We will expand personalisation within social care by encouraging the uptake of direct payments. This will allow people to take more control over the care and support they receive.

Health and social care services will continue to evolve and change. We are committed to ensuring the best possible support is available to carers who are often directly involved in supporting their vulnerable family members, friends and loved ones.

While the Care Act 2014 places an expectation on health and social care services to consider the specific needs of carers, we also recognise the valuable contribution they make. We want to ensure their personal needs are identified and supported by the mental health services they come into contact with.

The support available to carers is inclusive of everyone with a caring role. It seeks to encourage resilience for the carers themselves and the people they look after. It is extremely important carers have the opportunity to feedback and comment on services. We will work in close collaboration with those delivering services to ensure they identify, signpost and support people to access the range of services available to them and maintain the principles set out in the triangle of care[16].

To improve the accessibility of mental health support, we will:

- Work in partnership and co-produce services with clinicians, people with lived experience, their families and carers.
- Develop models of care to ensure integrated, effective and accessible services are available to all.
- Ensure services are provided with humanity, dignity and respect.
- Respond to the uniqueness and diversity of our communities. We will deliver consistent, inclusive and accessible services which are sensitive to the needs of everyone for example, people from ethnic or other minority groups and people from our LGBTQ community. We will apply reasonable adjustments wherever these are required to facilitate access.
- Encourage services to ask: “what matters to you” rather than “what’s wrong with you”.
- Work with criminal justice partners to support offenders with mental health problems to recover and reduce crime. We recognise the need to improve the co-ordination of custodial and community services to support people with mental health problems who are in contact with the justice system.
- Collect and share information more effectively.
- Develop innovative ways to support hard to reach groups.
- Continue to prioritise and deliver support to veterans and their families who may be effected by trauma, anxiety or depression.
- Reduce relapse, build resilience and sustained recovery by improved continuity of care and providing better support when people are discharged from acute services.

“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

RECOVERY FOCUSED AND RESILIENCE FORMING

Resilience is commonly defined as the capacity to recover from setbacks or the ability to bounce back. We have an innate capacity to heal from trauma albeit, in most cases, gradually.

When people experience a trauma, they can also experience significant distress or discomfort after the event. In contrast other people will experience a new appreciation for life, a sense of personal strength, new possibilities and spiritual growth[17].

In response, we need to consider re-evaluating and reconfiguring existing community services to give people in psychological distress the best chance of recovery. A shift to a resilience based psychological model may help vulnerable people, who would otherwise be at risk of developing debilitating symptoms in future, become more resilient.

A local recovery college has been developed through a partnership agreement between a range of local providers from the statutory and third sector. Funded for a three year pilot by the European Social Fund, the aim is to support recovery from mental ill health through learning. The model encourages people to be the agents of their own recovery and moves them from patient to student mind-set.

The project will support 350 people over three years with the aim of moving 20 percent closer to employment. The project is subject to formal research and evaluation to determine the effectiveness of this approach in terms of recovery and cost effectiveness. We will collaborate with this project and draw on the evaluation to inform local planning and service design.

The impact of traumatic life experiences is increasingly recognised as a contributing to our health wellbeing throughout our lifetime. These traumatic experiences can occur at any time during our life - in childhood or later in life and range from physical, mental or sexual abuse, to natural disasters or war and conflict. Developing a system which is responsive to people with complex needs and a history of trauma and abuse, will be key to helping them to have a successful, inclusive and healthier future. Evidence tells us that particular groups of people, including people with learning disabilities and autism, are more likely to experience trauma and for this to adversely affect their mental health.

Trauma informed approaches (TIA) are based on a complete understanding of how exposure to trauma affects a person's neurological, biological, psychological and social development[18]. This approach enables professionals to operate in a way which is mindful of the effects of trauma and as a consequence considers how they interact with people to build safe, secure and trusting relationships, and avoid re-traumatisation.

The core values considered by Harris and Fallot[19], required to provide 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.

Evidence suggests that the provision of counselling alongside other treatments gives people greater choice. This is especially true when no formal mental health diagnosis has been identified. Alternative treatment options can provide greater support for those who do not respond to, or meet the thresholds for standard treatment or who do not find them acceptable[20].

Specialist providers often target intervention to people with the most severe presentations for example, people with post-traumatic stress disorder (PTSD). As a result, we need to consider how we meet the needs of people who do not meet service thresholds. This is currently an area of unmet need.

We will prioritise evidence based care and support for people with a trauma while we promote integrated approaches to provide greater choice and enhance people's outcomes and experience. We will explore alternative approaches where research has demonstrated value but where the evidence base is still emerging.

Maintaining our commitment to supporting people's recovery will mean services will need to continue to review and integrate new evidence based approaches as they emerge at a local, national and international level. We will encourage services to work in greater collaboration, using integrative contractual processes to modernise and achieve cohesion across diverse networks to influence and develop tertiary services which maintain people's wellbeing.

> "PROMOTE INTEGRATED APPROACHES TO PROVIDE GREATER CHOICE AND ENHANCE OUTCOMES AND EXPERIENCE"

GREATER INTEGRATION

Integrated community services have proved extremely beneficial in developing more efficient health and social care systems. We will work across organisational boundaries to deliver place-based, person centred care and support.

We will move away from a reliance on bed based residential care models to provide health and social care to people at home and in the community.

We will change the balance of healthcare provided in hospitals and the community (where appropriate). This will enable more people to receive care at home or as close to home as possible. We will ensure social care is embedded in our future integrated community approach so people have the best possible experience of personalised care and support. This will mean delivering high quality services that wrap around people. We will involve services which can help to support others in the place where the person lives. This will include their family, friends, neighbours and volunteers.

A place and strengths-based approach to health and social care values the capacity, skills, knowledge, connections and potential of all individuals in the community. Staff in the health and social care sector will work in collaboration with the people who access services and their local communities. They will help people to do things for themselves as much as possible and in so doing become co-producers of support which is fit for the future.

This will require a shift towards a locality-based new model of care.

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

How we will deliver this vision

- Promote wellbeing and prevent, reduce and delay a person's need for care and support
- Empower people to take control of their own lives with help from supportive workers
- Provide person-centred and outcome focused care as close to home as possible
- Operate without barriers across different teams and organisations
- Include members of the community – so they can work in partnership with NHS, social care, independent and voluntary sector colleagues
- Make safeguarding personal, to ensure the voice of the person is heard and the most vulnerable are protected from abuse and neglect
- Work with individuals and partners to address the social determinants of mental health, including ensuring adequate housing, employment and healthy lifestyles

Strong partnerships and joined up working between practices and organisations will be pivotal to our future success. The interface between primary and secondary healthcare, as well as between health and social care, will be an area of focus over the coming years with the aim of developing place-based networks of support.

Building strong relationships, supported by agreed ways of working across our health and social care system, is fundamental to the creation of services which will provide prevention, early intervention and meet the needs of people who are most at risk.

We will work together to establish a clear set of objectives with consideration to information sharing, access to expert advice and guidance,and better use of information technology to promote integrated services. We will review the Section 75 contractual mechanism, including the pooling of budgets to support the delivery of jointly operated services. This virtual integration model will help ensure our approach is fit for purpose and future proof. This will help to guarantee we deliver a modernised and efficient environment where every pound of public money spent delivers the very best outcomes in the most efficient way.

The evidence in support of multidisciplinary team approaches is undeniable. Bringing skilled professionals together in close collaboration to plan and deliver care will achieve longer term integration and sustainability. This is in line with the intentions set out in the Long Term Plan and the Care Act. We will work across our communities to develop and support this approach.

We will ensure the recommendations from the Association of Directors of Adult Social Services (ADASS) regarding social work for better mental health are considered in the redesign of integrated community mental health services. This will enable people to access statutory social care and promote the personalised social care ethos. In accordance with the Care Act we will ensure the social care assessment and support planning process is not just a gateway to care and support, but a means to help people to understand their situation, their needs, and to reduce or delay the onset of greater needs.

It will help people to understand their strengths and capabilities and the support available to them in the community or through other networks and services. We will continue to offer support from integrated and multi-disciplinary community mental health teams to people with severe and enduring mental health. We will support our secondary care provider to explore new ways of delivering and deploying their specialist skills across our communities. We will ensure people receive equitable and responsive care. We will apply the principles set out in the responsible commissioner guidance[21] in respect of people residing in our communities, particularly when they live in specialist care settings.

Integration across communities on the Isles of Scilly is of equal importance to those on the mainland. We recognise that the geographical location of the Isles of Scilly and its health and care workforce, require innovative and integrated solutions.

A coordinated mental health integration role has been re-established in response to these needs. The aim is to offer coordinated specialist support to ensure services wrap around people at risk and those who require more general mental health support. The scheme is funded by the Better Care Fund and forms part of the island's ambitions to develop a single service, estate and workforce solution for health and social care. The project evaluation of this test and learn approach will provide evidence for other rural integrated care areas enabling the adoptions of similar innovative approaches.

> "INTEGRATION ACROSS COMMUNITIES ON THE ISLES OF SCILLY IS OF EQUAL IMPORTANCE TO THOSE ON THE MAINLAND"

We will continue to support the following projects and initiatives:

- **Social prescribing** - improving people's health is not just about traditional medication. We know loneliness and isolation have a serious impact on people's health and wellbeing. We are working with partners to encourage GPs to use social prescribing to help people lead more connected, healthier and happier lives.
- **Social inclusion** - to complement social prescribing, Adult Social Care has commissioned a social inclusion service for anyone who wants to improve their health and wellbeing and needs help to make links in the local community and to access volunteers and peer support groups.
- **Employment and community links** - support is available for people with mental health conditions to prepare for, gain and maintain employment, and participate in their local community. Help is available at a community level offering non-clinical support to people in crisis. We will coordinate a project to work with people who access and provide these services to review what is delivered and ensure it meets people's needs.
- **Mindful Employer initiative** - mental ill-health costs employers in the UK approximately £30 billion every year. This is as a result of lost production, recruitment and absence. Promoting positive mental health in the workplace can be hugely beneficial. Staff members with good mental health are more likely to perform well, have good attendance levels and be engaged in their work. 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.

- **Social work** - people have told us the pathway to access a social care assessment is confusing. We will work to remedy this by mapping the pathway. We will make any required adjustments so we provide a more integrated model which ensures the Care Act is considered within the care programme approach.
- **Domiciliary care** – this is provided by care agencies to people assessed as having eligible social care needs, who 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. We will review the domiciliary care provision and ensure a focus on self-management and independent living skills.
- **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 evaluate the outcomes and consider the possibilities for the future commissioning of this resource.

We will deliver high quality integrated community-based services which wrap around people. We will do this by:

- Increasing the use of social prescribing and social inclusion services. We will work closely with health and social care agencies, GP surgeries, the voluntary and charitable sector to promote social prescribing and social inclusion plans. Both help people lead more connected, healthier and happier lives. This will include the promotion of social and interest groups, such as walking groups and art-based activities.
- Working with the voluntary and community sector to build capacity to offer wellbeing support through volunteers. We will make sure small community groups are able to access grant funding so they are able to set up local projects to help to reduce loneliness and social isolation. By building community resilience we will help communities to help themselves and each other.
- Building on the success of the peer support movement nationally. This is where people use their experiences to help others through debriefing, mentoring and community groups[22]. We will support local initiatives and further develop this approach within our communities.
- Encouraging and supporting 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.
  - Encouraging employers in Cornwall and the Isles of Scilly to sign up to the Mindful Employer initiative.
- Working with people who access our current supported employment services. We will review what is being provided to make sure it meets people's 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 provides an evidence-based position to support people who access community NHS mental health services to gain employment. We will review the support available for people who 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.
- Taking a strengths and asset based approach, we will move from the traditional model of providing mental health services to consider what makes us healthy, rather than what makes us ill. Our community health and social care 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 healthier lifestyles. We will make sure there is a clear pathway for people to access preventative services and to receive a social care assessment if appropriate, in order to access outcome focused care and support in the community.
- Moving away from the use of residential care home provision to offer purpose built or refurbished housing with a built in care and support provision. This is commonly known as 'supported living' for working age adults and extra care for older people. Local analysis suggests there is benefit in establishing additional support in this area including on-site care and 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 of the housing requirements, including locations and types of accommodation, to share with the housing market. We will take steps to ensure the most appropriate and therapeutic environments are available to promote the wellbeing of people living with and recovering from mental health problems.

EMBRACING NEW TECHNOLOGIES

Advances in the use of technology offer new opportunities to millions of people around the world who experience a range of mental health conditions.

The development of system data dashboard has been enhanced by a specific mental health dashboard. Produced by NHS Kernow in 2018, this collaboration between commissioner and providers has enabled an improved understanding of the value of services. It has supported the development of more efficient and sustainable services. An example is the use of existing data to help design an alternative crisis services, reduce attendances at emergency departments and deliver improved outcomes 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 push boundaries and nurture a culture which is committed to 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 for as many people as possible. We will continue 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. This represents the use of experiential technology and demonstrates a commitment to collaborative working with academic colleagues to drive rigour in understanding the real world benefits of emerging tools.

The embedding of new technology is not without its challenges. We will work hard to gather evidence which supports the implementation, educates people on the use of these approaches, highlights the benefits to the general public and people who deliver services. This will align to our ongoing commitment to the NHS Local Digital Roadmap programme.

In response to what young people have said about the importance of being able to-connect, we will explore and develop improved web based support. GP practices will work together across primary care networks (PCNs) areas within the framework of integrated care communities. The focus will be on utilising technology to create and develop new models of care that can be delivered locally, reducing the need for care to be delivered in a specific care environment unless clinically or operationally necessary.

The first steps towards this ambition are to optimise digital technology across primary care. This will provide the foundations upon which we can build the new models of care. We will be deliver a significant uplift of digital platforms and capability across primary care. With a 20 percent reduction in our core allocation for GP IT capital, prioritisation is being given to the must do priorities.

Our priorities

- Upgrading core health and social care network (HSCN) infrastructure with full migration
- Upgrading all end user devices in the primary care estate to Windows 10
- Consolidating GP IT systems in north and east Cornwall integrated care area to support collaborative working
- Creating a digital shared care planning solution which all care providers and people who use services can access - this will be particularly important for people 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
- Exploration of the options available to expand technology enabled care across health and social care
- Consolidation and rationalisation of GP IT systems to enable clusters of practices in Carrick and Kerrier localities to work collaboratively
- Enablement of mobile and remote working solutions to support primary care clinicians and staff to work effectively outside their base practice (eg. care homes, in people's homes, acute and community settings or from their own home)
- Further roll out of online consultation programme across general practice
- Electronic discharge communication and other IT solutions to reduce the administrative burden
- Investment in cloud-based telephone 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.

The LHCR will develop a sustainable and affordable IT solution, which will bring together clinical and social care information for the benefit of direct patient care. Cornwall and the Isles of Scilly are part of the One South West cohort. This is planning to implement a local solution linked with Devon, Somerset, Bristol, Swindon, Gloucestershire and Wiltshire, to create a patient record for health and social care staff by 2021/22. Following this, LHCR solutions across the country will link together to create a joined-up patient record across the UK. This will be accessible whenever and wherever a person needs treatment.

The aim of the LHCR programme is to create an information sharing environment which enables health and care services to continually improve the treatments we use. This will help ensure care is tailored to the needs of each person and that people are empowered to look after themselves and make better informed choices about their own health and care.

There is a real enthusiasm about the potential of technology enabled care (TEC) to enable better care and support and help to improve people's quality of life. We will remain open minded and responsive to developments in this area. We will explore ways we can utilise the value of emerging approaches to benefit people.

Online support to help people get the most out of the support available to them is really important. Schemes such as 'Learn Scilly' offer support to people in island communities helping them to navigate online systems. It provides valuable outcomes for people who want to order their prescriptions online or access treatment via such technology such as Skype. We will explore this further to improve access to talking therapies and to offer online therapy.

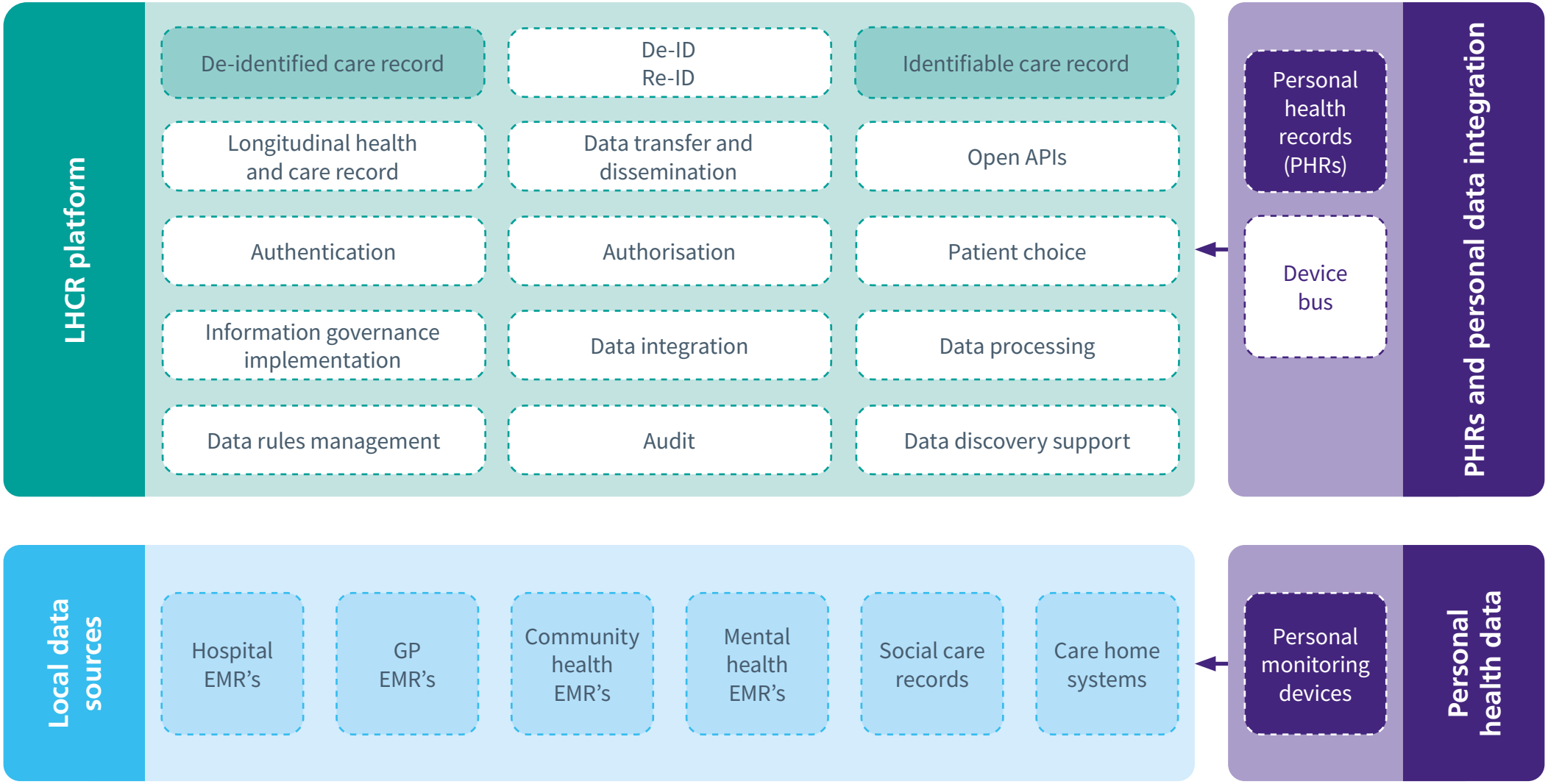
We will explore mental health apps and build these into our resource development plans. We will encourage providers to improve signposting in order to help people help themselves. We will review innovative IT to deliver remote clinics and the use of avatar therapy and other associated approaches which are currently under development. These include local developments such as:

- EpsMon - an app for patients to self-monitor risk factors associated with epilepsy (a partnership project between Cornwall Partnership NHS Foundation Trust and Plymouth University)
- Use of satellite technology in healthcare (a partnership project between Cornwall Partnership NHS Foundation Trust and Falmouth University)
- Use of Virtual Reality software to reduce patient distress (a partnership project between Cornwall Partnership NHS Foundation Trust, Falmouth University and the Invictus Trust)
- Stress self-monitoring app to support junior doctors (a partnership project between Cornwall Partnership NHS Foundation Trust and Falmouth University)
- Computerised diagnostic tool (a partnership project between Cornwall Partnership NHS Foundation Trust and Portheden)

We will explore the emerging use of screening and assessment technology as well as the use of artificial intelligence (AI) in diagnostics and predictive planning.

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

Figure two: Local Health and Care Records (LHCR) high level architecture



API = Application programme interface | EMR = electronic medical records | LHCR = local health care record

Figure three: Summary of our strategic intentions

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.

People will feel supported and able to access care and treatment
We will prevent people becoming unwell and ensure mental health and physical health share a parity of esteem

People will have choice in the support and care that they receive
We will provide easier access to care and treatment, delivering better outcomes and improved experiences

People will reach their own recovery goal, live longer and in good health
We will develop integrated community services and ensure excellence remains at the heart of everything we do

People will feel positive about the services they receive
We will provide greater choice and personalised support, to help people achieve recovery and resilience

Preventative approaches

Prevention should be everyone's business.

- Follow the Five Ways to Wellbeing and in particular lifestyle, connections and environment
- Deliver intervention programmes in accordance to place based approaches that meets eight key priority areas of the Prevention Concordat for Better Mental Health to reduce health inequalities
- Establish a real time surveillance system
- Establish an IMPACT Hub at RCHT
- Develop our crisis care support offer by providing 24/7 support

Easier access to care and support

Supporting people to achieve their own personal recovery.

- Provide greater choice and accessibility
- Give particular attention to the key transition points in people's lives
- Look to develop and strengthen wider networks of support to deliver the most effective and appropriate support
- Explore newer treatment options
- Ensure that there is equitable prioritisation of veterans as well as pregnant women

Personalised care and greater choice

Empower people to have greater choice and control.

- Provide the info and support they need
- Use social resources and therapists from the community to enable adaptable care planning
- Provide therapeutic environments which are conducive with the delivery of personalised care
- Expand the use of personal health budgets (PHBs)
- Deliver improved service models and reinvest into further service improvements
- Develop models of care that ensure integrated, effective and accessible services

Recovery focused and resilience forming

People need to made aware of capacity to heal from trauma.

- Continue to prioritise evidence based care and support for those with a trauma
- Develop a system of support which responds to people with a range of complex needs alongside a history of trauma and abuse

Greater integration

Emphasise integrated place-based community services.

- 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 organisations
- Include members of the community working in partnership
- Deliver care in a person's own home unless it is clinically or operationally necessary for it to be delivered in a specific care environment

Embracing new technologies

We will strive to push boundaries and nurture innovation.

- Gather evidence which supports the use of new technologies
- Explore and develop improved web based support
- Utilise technology to create and develop new models of care that can be delivered locally
- Optimise digital technology across primary care to provide the foundations upon which to build the new models of care

SECURING POSITIVE OUTCOMES

Over recent decades, a wide range of measures and reporting frameworks have been developed. These include 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[23].

The engagement we have carried out so far, confirms there are varying views as to the value of some measurement tools particularly in respect of qualitative tools to measure people's actual experience of the services they receive and what they feel has been valuable on their journey through care. It is evident that some people question the value in measuring and reporting which can in turn impact on people's engagement and ultimately their sense of empowerment. We will therefore consider the way we use clinical and non-clinical measurement and rating tools to determine best value.

We will review the evidence base of such tools and in some cases redesign 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 providers to adopt a consistent way of measuring and achieving positive outcomes by adopting approaches such as the recovery star, Inspire and the Warwick-Edinburgh tools[24].

In the delivery of 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 We will 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 able to share their successes to drive 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 well for people will be paramount to a successful and sustainable future. We will share our learning with others for the greater good of regional and national peers. We will promote practice based learning and support development initiatives from the bottom up where the knowledge and skills of frontline staff is harnessed to shape and inform co-production and service design.

The delivery of new approaches requires us to think imaginatively about how we use the resources available to us and 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 friends 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 clear set of intentions. These will enable us all to meet the needs of local people.

Our commitment

- Aim to prevent people becoming unwell
- Provide easier access to treatment
- Ensure mental health is as important as physical health
- Support personalised care and greater choice
- Support people toward their own recovery
- Help develop people's resilience
- Develop integrated, local services
- Deliver better outcomes and improve experiences
- Make excellence our goal in everything we do

Delivering this strategy

We will know we have delivered this strategy because people will:

- Know what support is available to them and where to access it
- Receive support at the right time, in the right place
- Feel listened to and at the centre of their care and support
- Feel supported by services who work together
- Enjoy healthier and more hopeful lives
- Receive support which feels meaningful and valuable

ENGAGEMENT AND INVOLVEMENT

The process of engagement and involvement has been fundamental to the co-production and design of this strategy document and started in the autumn of 2018 with the establishment of the initial stakeholder workshop and culminated in the conclusion of a four month formal process which came to an end in December 2019.

A wide group of stakeholders and partners from across our diverse communities have taken the time to comment and provided not only useful content but also some constructive and valuable reflection and feedback which we have built into the final version of this document.

The materials gathered over this extensive period can be viewed on the NHS Kernow website and includes specific responses to each element to feedback on a thematic basis.

> “IT HAS BEEN EXTREMELY ENCOURAGING TO SEE PEOPLE’S COMMITMENT, PASSION AND ENTHUSIASM FOR CHANGE”

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ACKNOWLEDGEMENTS

We would like to send sincere and heartfelt thanks to everyone who supported the development of this strategy document, in particularly, the following individuals:

- Tim Francis, head of adult mental health and learning disabilities joint strategic commissioning, NHS Kernow
- Dr Paul Cook, GP and mental health clinical lead, NHS Kernow
- Dr Richard Sharpe, advanced public health practitioner, Cornwall Council
- Amanda Stratford, Jody Wilson and Natalie Swann, Healthwatch Cornwall
- Trudie Hornby-Clark, lead administrator, NHS Kernow
- Tracey Marsh, Stuart Cohen and Nory Menneer, commissioning managers, NHS Kernow
- Sarah Fisher, head of communications, NHS Kernow and Cornwall Partnership NHS Foundation Trust
- Laura Patrick, head of communications, NHS Kernow
- Leanne Baker, communications officer, NHS Kernow
- Jim Kane, design consultant
- Patricia Hewitt, communications consultant
- Paul Farmer, chief executive officer, Mind
- Marth Reed,–adult social care manager, Cornwall Council
- Aisling Khan and Bob Dawson, Council for the Isles of Scilly
- David Dickinson, director of student services, Falmouth University
- David Walrond, college principle, Truro and Penwith College
- Cheryl Mewton, assistant principle, Truro and Penwith College
- Dr Ellen Wilkinson, medical director, Cornwall Partnership NHS Foundation Trust
- Professor Martin Pitt, Exeter University

As well as the many residents across our wonderful mainland and island communities, who gave of their time to share their views, experiences and opinions.

“CORNWALL AND THE ISLES OF SCILLY IS AHEAD OF THE CURVE IN BRINGING THE COMMUNITY TOGETHER TO CREATE THE BEST POSSIBLE PLAN FOR LOCAL PEOPLE”

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