**Purpose of Report:**

The purpose of this report is to provide an update on mental health to the Governing Body Members since the last report in April 2015. This will include information on the further development of the mental health strategy for Cumbria, seeking support for the direction of travel described within the vision document; the governance arrangements currently being put in place to support implementation of the strategy; and information on the priority areas for action agreed recently by the Mental Health Partnership Group and how they will be progressed.

**Key Issues/Considerations:**

- The Mental Health Partnership Group, chaired by NHS Cumbria CCG with Cumbria Partnership Foundation Trust, Cumbria County Council, Public Health, Best Life Wellbeing Network (BLWN) and service user and carer and third sector provider representation has continued to meet on a bimonthly basis since its inception in November 2014.

- Work on Better Mental Health for All: mental health strategy for Cumbria 2015 - 2020 has continued over recent months. The final draft of the strategy comprises three key elements that together, will provide a comprehensive approach to improving mental health and mental health services and support for the population of Cumbria. The three elements are:
  - An overarching vision (attached) that will be owned by the Mental Health Partnership Group and will provide the direction of travel for service development and commissioning for the period 2015 – 2020 against which all proposals for service development will be tested. It is important to note that this vision document is largely based on the work that has been undertaken to date, the new elements focus on translating the vision into service delivery and commissioning.
  - A proposal for the development of model of care that will translate the vision into a framework of service delivery that spans emotional health and wellbeing to specialist care.
- A draft framework for a joint commissioning strategy for Cumbria Clinical Commissioning Group (CCCG) and Cumbria County Council (CCC) that will describe how commissioners will bring together their commissioning resources to deliver the vision and model of care.

- At the September meeting of the Mental Health Partnership Group the overall structure and themes covered in the draft strategy were welcomed and agreed. A small number of further comments have been received and it will go to the service user and carer forum for wider comments in coming weeks, with a view to final approval at the Mental Health Partnership Group meeting at the beginning of November. It is presented here therefore as work in progress that will be completed in November.

- The Mental Health Partnership Group also agreed a draft governance framework to support implementation of the strategy (attached separately for ease of access). A key issue highlighted by the group was the importance of integrating mental health within the two Programmes for Cumbria: Better Care Together and Together for a Healthier Future. This is important to ensure a consistent approach in areas such as out of hospital service development; the interdependencies between physical health and mental health and the need to ensure consistency of approach across the enabling programmes such as informatics and workforce development.

- In order to progress the priority areas for action identified by the Mental Health Partnership Group and to support implementation of the vision, within the resources and capacity available across the system, the work has been divided into three areas:
  - Transformation, which will focus on the development of the model of care
  - Strategy Projects, which will focus on mental health in primary care; establishing a recovery model across the system; continuing the implementation of the crisis care concordat and transformation of the third sector
  - Service Improvement Projects which will be led by Cumbria Partnership Trust with multi agency involvement and they include areas such as mental health liaison services, Community Mental Health Team development, personality disorder service improvement, rehabilitation pathway improvement

This work will be supported by a Programme Management Office and a standard approach to project management and reporting to make the best use of the resources available. Progress will be reported to the Mental Health Partnership Group who will oversee the work and provide system leadership and support.

Recommendations:

The Governing Body is requested to receive this report and the associated attachments and to provide support for the direction of travel set out within them.

CCG Objectives:

- Improve the quality of existing services
- Develop two out of hospital systems, north and south
- Develop our system leader role and our effectiveness as a partner
- Develop a system financial plan
- Maintain and lead a health CCG

**Assurance Framework:**

The Mental Health Partnership Group will oversee the governance of the implementation of the strategy and the work programme described above.

**Implications/Actions for Public and Patient Engagement:**

**Service user / carer engagement survey**

- NHS Cumbria CCG engaged the Best Life Wellbeing Network (BLWN) throughout the summer of 2014 to conduct a survey on its behalf to identify how mental health services are performing and how they could be improved. This work has been fed into the development of the strategy.
- Provider stakeholder events were also hosted by NHS Cumbria CCG during early summer of 2014 to provide opportunities for providers to express their priorities and ideas for improvements to the services.

**Mental health service user and carer forum**

- It was widely agreed that the active involvement and engagement of service users and carers with contemporary experience of mental health service delivery was fundamental to the effectiveness of the Cumbria Mental Health Partnership Group, to properly inform its thinking and decision making. An active and independent Vice Chair, also with contemporary carer experience has been appointed – Professor Rob Hulme.
- BLWN has supported the development of a mental health service user and carer forum which has nominated four representatives to attend the Partnership Group. The objectives of the forum being to:
  - Provide a mechanism for representatives of all stakeholders with an interest in the effective delivery of mental health services to inform the thinking and decision making processes of the Cumbria Mental Health Partnership Group.
  - Provide a mechanism for effective two way communication between Commissioners and decision makers and representatives of all relevant stakeholders.
- To date the forum has
  - Commenced planning how best to liaise with a wider network of service users and carers through more locally based groups led by forum members.
  - Actively engaged members to be involved in the Working Groups to support the development of the mandates to deliver the Mental Health Strategy.
  - Reviewed the April draft of the Mental Health Commissioning Strategy for Adults and submitted a summary of feedback to the Partnership Group.
**Equality Impact Assessment:**

The CCG is committed to fulfilling its duty under the Equality Act 2010 and to ensure its commissioned services are non-discriminatory.

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<thead>
<tr>
<th>Lead Director</th>
<th>Laura Carr, Lead Nurse and Clinical Director Mental Health and Learning Disabilities</th>
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<tbody>
<tr>
<td>Presented By</td>
<td>David Rogers, Medical Director</td>
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<tr>
<td>Contact Details</td>
<td><a href="mailto:Laura.carr@cumbriaccg.nhs.uk">Laura.carr@cumbriaccg.nhs.uk</a></td>
</tr>
<tr>
<td>Report Author</td>
<td>Janice Horrocks, Deputy Director of Mental Health and Learning Disabilities</td>
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<td>Date Report Written</td>
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Better Mental Health for All

Mental Health Strategy for Cumbria: The Vision

DRAFT
<table>
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<tr>
<th>Date</th>
<th>Author</th>
<th>Version</th>
<th>Summary of changes</th>
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<tr>
<td>25/8/2015</td>
<td>Rosemary Granger</td>
<td>V2.0</td>
<td>Version to be discussed at MHPG on 1/9/15</td>
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<tr>
<td>22/9/2015</td>
<td>Rosemary Granger</td>
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**Foreword**

Partners across health and social care, the third sector and service users and carers in Cumbria have agreed to develop a Mental Health Strategy for Cumbria, building on the Cumbria Wellbeing and Mental Health Strategic Framework 2011 – 2014 and further work that has been carried out since the establishment of the Mental Health Partnership Group in Cumbria in November 2014. The Group has commissioning representatives from the CCG and Cumbria County Council Adult Social Care, Public Health, Providers, People First and crucially people with lived experience of mental illness (i.e. service users) and carers. They are agreed that this strategy needs to respond to national drivers, the local context and recommendations from reviews of current services that have been undertaken in recent years. It will describe an approach to adult mental health and wellbeing in Cumbria that ranges from promotion of mental wellbeing and reducing the risk of people developing mental health problems to providing care and support for people with specialist mental health needs.

Cumbria has been identified as being a financially challenged health economy and the local authority is equally striving to meet considerable efficiency targets. Other partners are no different, for example the police. Generally, smaller and more localised providers are facing real financial difficulties and with that, a resulting squeeze on what it’s possible to deliver.

We need to find new and innovative solutions to how people can be supported to achieve recovery that’s meaningful to them personally, and how individuals and communities can be supported to look after their own mental health and wellbeing using all of the assets available to them.

We will use this strategy to design and deliver new and innovative ways to provide a high quality, person centred response in order to keep people as healthy as possible, and to develop services and systems which work together across organisational boundaries.

The term ‘services’ is used throughout this document and is used as a catch-all to describe interventions, treatment, services, resources, skills or knowledge which independently or in combination can improve mental health.

The strategy comprises three key elements that together, will provide a comprehensive approach to improving mental health and mental health services and support for the population of Cumbria. The three elements are:

- An overarching vision that will provide the direction of travel for service development and commissioning for the period 2015 – 2020 against which all proposals for service development will be tested
• A model of care that will translate the vision into a framework of service delivery that spans emotional health and wellbeing to specialist care. It will be innovative and strengthen the interfaces between services/agencies to meet users’ requirements for assessment, treatment, care, protection, recovery and quality of life through timely access to services and resources designed around the needs and aspirations of service users and carers.

• A joint commissioning strategy for Cumbria Clinical Commissioning Group (CCCG) and Cumbria County Council (CCC) that will describe how commissioners will bring together their commissioning resources to deliver the vision and model of care.

This document sets out the overarching vision for improving mental health and mental wellbeing in Cumbria and has 4 distinct sections as follows:

Section 1 identifies the vision, principles, ethos and scope of the five year strategy
Section 2 sets the strategy in context by identifying key national drivers in mental health, the local context that together create the case for change.
Section 3 focuses on the potential impact of delivering the vision and highlights some of the key areas that need to be addressed to achieve this
Section 4 sets out the arrangements required to deliver the vision.

This Vision document is owned by the Mental Health Partnership Group and as such the members of the group will hold each other, and their organisations, to account for its delivery and will test any proposals for change for consistency with the principles and ethos set out in this vision.

SECTION 1

Our Vision is to deliver better mental health and best mental health care and support for the people of Cumbria, delivered sustainably.

Our overarching aim is to make a real difference to people’s mental health and wellbeing in Cumbria through a person centred and holistic approach. People will be treated with dignity and respect at all times. We recognise that mental wellbeing is multi-faceted, it is at the core of our approach and includes an individual’s psychological, social, physical and spiritual wellbeing. Mental wellbeing is more than an absence of mental illness and is a state “in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” We aim to ensure that people accessing mental health services in Cumbria will experience “parity of esteem” in relation to service availability, accessibility and resource allocation.

In order to do this, we believe we need to:

• Create a fundamental shift in focus and resources from diagnosis and treatment to prevention, wellbeing and early intervention.
• Create a cultural shift in which all organisations, sectors and communities in Cumbria recognise mental wellbeing and improving mental health as being everyone’s business
• Ensure that people who develop mental health needs that require more support receive the help they need as quickly as possible to reduce the impact their mental distress has on their day to day lives, their families, friends and community.

We want to create healthy environments for all those who live in Cumbria. Environments that are inclusive, that promote self-esteem and are non-stigmatising: in short, environments that prevent the onset of mental health problems and that enable people experiencing distress to get the help they need.

Principles that will underpin delivery of the vision
The strategy will be underpinned by a system wide commitment to:
• Meaningful engagement with service users and carers in planning and review of services
• Build a recovery movement across Cumbria
• Measure safety, quality and experience outcomes to inform joint planning and commissioning
• Financial sustainability and value for money
• Continuous service improvement, workforce development and organisational development to ensure we have a system fit for purpose and the scale of change we envisage
• Use innovative solutions to challenges e.g. technology, assets based community development
• Help the local third sector to flourish
• Build greater resilience in the community
• Support social inclusion
• Work in partnership
• Make mental health everybody’s business

The strategy is built around the five pillars of effective and integrated services that are safe, ensuring high quality treatment and support; delivered through competent staff, who give resilience and confidence to support people to adopt self-directed support and peer support thereby intervening early and enabling people to live well with a mental health problem and recover.

Ethos
Through our commissioning arrangements, we are seeking to build a recovery movement in Cumbria, and want this to be woven throughout primary care, all of the services we commission and the staff delivering them.

In “No health without mental health” the outcome of recovery is set out as “people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose,
the skills they need for living and working, improves chances in education, better employment rates and a suitable and stable place to live”.

We must purposely develop and design the services, resources and interventions for mental health with these factors in mind and the services provided by the NHS and Local Authority are only one part of the help needed. They cannot work in isolation from the understanding and support provided by close family, friends, the local community, employers and other providers of services to individuals.

Local service users and carers have highlighted some key points that need to be taken into account as we develop this approach. They have stressed that one major failing of many recovery models is the assumption that this is a linear situation whereas more often it is cyclical with people needing to seek support when they relapse, work through this relapse and then return to recovery. They suggest that recovery should not be described as an outcome in itself but rather an ongoing situation that needs to be constantly kept under review and carefully maintained.

The ethos by which we will commission services is set out most clearly in 'A Practical Guide to Recovery Oriented Practice’. This is an internationally recognised tool which describes a recovery movement that seeks to improve the lives of people with mental health needs. It recognises that recovery means the process through which people find ways of living meaningful lives with or without ongoing symptoms of their condition. Recovery emphasises that whilst people may not have full control over their symptoms, they can have full control over their lives.

In summary:

- **Care and Support is oriented to support recovery:** It is driven by the goals of the individual, appreciating what is possible and facilitates an individual’s effort towards recovery in whichever form it takes at the time. It offers people hope;

- **Care and Support is strengths based:** the focus is not on deficits and symptoms but instead on an individual’s remaining, co-existing areas of health, assets, strengths and competencies. Emphasizing the negative can lead to a sense of hopelessness and despair;

- **Care and Support is community focused:** focus does not necessarily mean locus, but rather it is Care and Support which is provided in a person’s natural environment and which facilitates the development of relationships with other community members, and works to combat stigma and increase access to community resources;

- **Care and Support is person driven:** this means the person with mental health needs reflects their own wants, needs and preferences and practitioners learn that they should do nothing without the person’s approval, involving them in decision making at every stage; this can mean people don’t always get it right, but need to be supported with making those decisions;
• **Care and Support allows people to offer something**: giving up your own time or skills is known to be therapeutic and there is value in people sharing what they can; practitioners should treat people as equals and facilitate them developing valued social roles and involvement in meaningful activities;

• **Care and Support is culturally responsive**: it should be tailored to an individual’s needs and cultural identity across race, ethnicity, religion and sexual orientation;

• **Care and Support is grounded in the person’s life context**: acknowledge, appreciate and build on each person’s unique life history, experiences, developmental trajectory and aspirations - people with mental illness had a life beforehand and practitioners need to understand the impact being marginalized may have had on individuals;

• **Care and Support addresses the social context of a person’s life**: poverty and disconnection from resources such as education, work and social networks impact upon people being marginalized; understanding someone’s need for housing, income and social support helps someone find their place in society;

• **Care and Support is effective when it recognises the importance of the relationship between practitioner and individual**: practitioners must believe in people even if they don’t yet believe in themselves and be able to envision a future for their client, based on the individual’s own desires and values; this can require persistence, consistency and approaching things in a non-traditional way;

• **Care and Support makes the most of the support available**: minimise the role of practitioners and ‘professionally’ delivered services and maximise the role of natural and more informal supports such as friends, family, neighbours, volunteering opportunities, sports clubs, arts and other community members; develop new ties and strengthen old ones; this kind of knowledge does not come from sitting in an office and for some individuals will require practitioners to make early connections themselves.

Appendix 1 provides further details about our approach to building a recovery movement.

**The scope of the strategy**

This strategy covers the next five years 2015 – 2020 and considers the whole spectrum of mental health care and support from prevention through to service provision for those people with specialist mental health needs and their carers, but focusing on our adult population. It therefore considers:

• The whole population mental health of adults, including older adults with mental health problems but not organic illnesses such as dementia
• The transition of mental health services between children’s and young people’s services to adult service provision
• People who have mental health needs arising from learning disability, autistic spectrum disorders, attention deficit hyperactivity disorder, drug and alcohol misuse problems and long term physical health conditions (the term ‘dual diagnosis’ is often used for people with substance misuse problems in addition to mental illness but it is important to remember mental health needs can arise from other disorders and problems too).
• The needs of and services for people with dementia are not included in this strategy

SECTION 2    Setting the strategy in context
This section identifies the key national policy drivers and the local context that together create the case for change.

This strategy is guided by the national strategy ‘No Health without Mental Health’ which defines the 6 key outcomes we should seek to achieve for our local population:

• More people will have good mental health
• More people with mental health problems will recover
• More people with mental health problems will have good physical health
• More people will have a positive experience of Care and Support and support
• Fewer people will suffer avoidable harm
• Fewer people will experience stigma and discrimination

National Policy drivers
The most relevant legislation and policy documents which inform our strategy are:

• ‘No Health without Mental Health’
• ‘No Health without Mental Health: implementation framework’
• ‘Talking Therapies’
• ‘Preventing suicide in England’
• ‘Caring for our future: reforming Care and support’
• ‘Public Mental Health Priorities: Investing in the evidence’
• ‘Closing the Gap’
• NHS Constitution
• Foresight report
• Health & Social Care Act 2012
• Care Act 2014
• Children and Families Bill 2014
• The Mental Health Crisis Care and Support Concordat
• Parity of esteem (see below)
• Armed Forces Covenant
Local context

As described in the scope of the strategy above, this strategy is for adults with mental health needs and their carers, but we recognise the critical interfaces with a number of interlinked local strategies and pieces of work:

- The Cumbria Dementia Strategy and action plan
- Local Children’s services plans and Cumbria’s whole system model to ensure the emotional wellbeing and mental health of our children and young people
- Cumbria County Council vision for adult social Care and Support services
- Cumbria’s Multi-agency Suicide Prevention Strategy 2014-17 and action plan to prevent avoidable loss of life through suicide
- Cumbria Alcohol Strategy 2014-17 and substance misuse plans
- The whole system work currently taking place in the south and north of the county through the ‘Better Care Together’ and ‘Together for a Healthier Future’ programme boards, to shift more care and support into the community and to primary care and support
- The Mental Health Crisis Care and Support Concordat and related Declaration Statement, signed by key stakeholders across the county in December 2014 (see Appendix 2)
- The work that is currently underway and being led by Public Health in Cumbria County Council in relation to reducing stigma and improving population mental health
- The Cumbria Safeguarding Adults Board and their three year strategy, committing agencies to promote and protect the safety of adults at risk from abuse and neglect in Cumbria
- The Cumbria Local Safeguarding Children Board and their three year Business Plan committing agencies to promote and protect the safety of children at risk from abuse and neglect in Cumbria.

The key areas where the adults and children’s mental health systems need to work closely together include:

- Transition
- Modelling a potential ‘young person’s’ service
- Crisis Care including Out of Hours assessment, use of S 136 facilities
- Engagement with Primary care communities
- Development of a whole system model eg training and development of general workforce (police, A & E) in awareness of MH and pathways associated with it

Making effective connections with this range of local strategies and local initiatives is daunting and the Mental Health Partnership Group will have a key role in supporting this.

This strategy responds to a number of factors set out below, that drive the need to change, in addition to our collective ambition to continuously improve the care and support we provide, deliver evidence based support and treatment and best practice.
• What people with mental health problems, carers and staff tell us about their experience of current mental health services
• The most recent needs assessment work which has taken place to look at local changing demographics and population mental health needs xx
• The suicide rate in Cumbria, which is higher than the England average
• National commissioning guidance for mental health xxI (the Joint Commissioning Panel for Mental Health) which shows there are considerable gaps in current service provision, and our strategic ability to fill these will require innovation and transformation if we are to get close to comprehensive services, within currently available resources.
• Statutory obligations and in particular the Care Act 2014 xxxv, which sets out a new framework of local authority duties in relation to the arrangement and funding of social Care and Support; it enshrines the principle of individual wellbeing and places more emphasis than ever before on prevention (further detail is available on page 23)
• Guidelines from the National Institute for Health & Clinical Excellence xxII, and in particular the ‘Quality standard for service user experience in adult mental health’ xxIII
• Initial consultation and feedback on previous drafts of this document
• ‘Supporting Recovery in mental health services: quality and outcomes’ guidance xxIV
• ‘Bridging the Gap: The financial case for a reasonable rebalancing of health and Care and Support resources’ document from the Royal College of Psychiatrists & Centre for Mental Health xxV
• Cause for Concern: Quality Watch Annual statement 2014 xxVI
• ‘Lethal Discrimination’ xxVII

The context for delivering this strategy presents a number of challenges:

Cumbria is the second largest county in England covering an area of 2,635 square miles with many remote and rural communities; this means it isn’t possible to benefit from the efficiencies of scale which might exist in more urban areas and this is further compounded by our demographics of an ageing population with a reducing proportion of people of working age. Further information is provided at Appendix 3
Population projections:

Population by Gender & Age, Cumbria v England. 2014
The proportion of residents from black and minority ethnic (BME) groups is low at 4.5% compared to 19.5% nationally. However, the proportion of Black and Minority Ethnic residents has increased in recent years but at a much slower rate than the rest of England.

Prevalence of mental health problems:
14.28% of population aged 16-74 in Cumbria are estimated to have any common mental health disorder, compared to England 15.62 % and North West 19.23% (based on figures for 2014/15) xxviii

Adults with depression known to GPs:
7.2% of all patients on the GP register have depression which is higher than for England at 6.5% and broadly consistent with the North West at 7.4% xxx

Psychotic disorder:
An estimated 0.34% of people aged 16+ in Cumbria have a psychotic disorder, compared to 0.4% for England and 0.45% for the North West. xxx

Health outcomes
- Health outcomes across Cumbria’s districts are poorest on average in Barrow-in-Furness and Copeland.
Barrow-in-Furness is the third most deprived district in England in terms of health.

In contrast both Eden and South Lakeland have high levels of health and wellbeing.

Cumbria’s overall performance in a range of health and wellbeing indicators disguises significant inequalities in health outcomes. There is a 19.5 year gap between the wards in the highest and lowest life expectancies in the county, with life expectancy in some areas 8.4 years below the national average.

As in the rest of England, cancer and circulatory disease are the main causes of premature mortality. Premature mortality due to injuries, including suicide, is the third most common cause in Cumbria and is higher than the national average.

Dementia prevalence is expected to rise as our population ages.

Importantly, a baseline review of the effectiveness of the mental health services which are currently provided by Cumbria Partnership Foundation Trust (CPFT) was undertaken in 2014 informed by a consultation by People First. A Review of the Integrated Social Care and Health Community Mental Health Services (RISCHES) was carried out in 2013. Key trends from the reviews and consultation described priorities for Cumbria as:

- Primary care mental health development and community mental health
- Services transformation
- The response at times of crisis and resources to support suicide prevention
- Workforce development
- Development of the third sector
- Improved communication and better joint working between all services and support networks
- Implementation of pathways for complex care and support and in particular
- Personality disorder and rehabilitation.
- Development of a recovery movement in all areas

SECTION 3  The potential impact of delivering the vision and the key areas that need to be addressed to achieve this

Based upon the national policy drivers, our local context and challenges, the whole health and care system in Cumbria needs to be transformed to meet the future mental health needs of local people.

Our high level, system wide approach to the components of good mental health services, interventions and resources looks like this:
If we think about each of these three broad areas and reflect upon what’s currently available for people and what they tell us the gaps are and what they need, our response looks like this:

<table>
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<th>People living in Cumbria must be able to</th>
<th>The difference this will make is</th>
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| Access the services, interventions, resources and support they need to help prevent more serious mental health problems or help them to recover in line with their individual aspirations and goals. This will include the role of technology, which is vital in such a large, rural county | • People will get the right support, in the right place, at the right time.  
• It will help providers of services be clearer about their role and their sustainability  
• It will ensure the most efficient, high quality and appropriate response  
• It will enable development and better working together for more integrated and localised services  
• Technology provides an infrastructure to enable access to other systems as well as online facilities which are developing to offer support. |
| Be informed about the support that is available in their local communities | • It will help people to help themselves and their families  
• It will also help communities to connect and understand each other  
• This has the potential to help reduce |
| Have a choice and control over the services and support they need | It will give people different options to better meet their needs and will help to empower them and their families |
| Expect services to be commissioned so that they’re joined up and seamless across transitions where necessary | People won’t fall between gaps in services or providers.  
It will also ensure referrers have options available to them, including informed signposting |
| Inform and be involved in planning, service changes, commissioning, development and evaluation | Services and resources will be more relevant and tailored to what people say makes a difference for them |

In order to deliver the vision described in this paper and meet expectations described above, there are a number of areas that must be addressed as essential elements of the strategy and there are some ways of working that will help us achieve our vision.

**Areas to address as part of the vision:**

**Outcomes**

We have listened carefully during the engagement undertaken to date to inform this strategy. Based on what we’ve heard from people with mental health problems, carers and other stakeholders we want to use this strategy so that people who use services can say their quality of life is improved and they feel part of the community they live in because:

- I know that services are designed around me and the needs I have
- I have personal choice and control or influence over the decisions about me (see next section which describes in more detail our approach to personalisation)
- I am able to access the treatment and support I need
- I can report a positive experience of Care and Support
- I am treated with respect and dignity, regardless of how I may present
- I am given the information I need and can make choices about my treatment and care
- I received services sufficiently early to prevent avoidable deterioration of my mental health
- My physical health needs are taken into account
- After my illness, when I needed to get life back on track I was helped to build skills and confidence
- I receive treatment and support to allow me to recover and to sustain that recovery
As part of developing our model of care, we intend to work with service users and carers to develop outcome measures for each of our priorities; these can then be used as part of our contractual arrangements with providers.

**Personalisation**

In 2011 the Department of Health defined personalisation in ‘No Health Without Mental Health’ as being about, ‘...respecting a person’s human rights, dignity and autonomy, and their right to shape and determine the way they lead their life. Personalised support and services are designed for the purposes of independence, wellbeing and dignity. Every person who receives support should have choice and control, regardless of the care or support setting.’

Working together, Cumbria CCG and Cumbria County Council are committed to ensuring that individuals are supported to take control of their mental health and able to regain or retain their own choice, control and independence. This is very different to a ‘one size fits all’ system of individuals having to fit into services which already exist.

The Council’s vision for Adult Social Care Services is:

- To Support Older and Vulnerable People to Live Independent and Healthy Lives
- To enable communities to live safely and shape services locally
- To promote health and wellbeing, and tackle poverty
- To be a modern and efficient Council

The principles underpinning this statement are:

- Promoting people’s wellbeing and independence
- Working together and working locally
- Commissioning for Quality and Value

We want to see people take control of their own mental health and retain their daily independence as much as possible. Three things are key to this:

- people being at the core of decision making about them – person centred planning
- people being able to exercise choice and control about their rehabilitation/recovery - support for the use of personal budgets
- people being informed about what their options are – information and advice about what is available and where
Mental health is everyone’s business – the role of public health and communities
Cumbria Health & Social wellbeing system

A crucial factor in good mental health is the ability to be resilient to the changing pressures and challenges life brings. This is about the personal qualities and skills individuals have, and the support they can gain from family and relationships, home, their community, education and employment. In everyone’s life are the kind of pressures and difficulties that can lead to mental ill health and distress.

However, as with physical health conditions, much can be done to prevent people developing diagnosable mental health problems in the first place; to minimize the impact of mental health ill-health by intervening early and providing appropriate support to help people recover; and by responding quickly when people with mental health problems relapse. Our strategic focus as commissioners will be on prevention at what we call these primary, secondary and tertiary levels. One way in which we are already working to prevent mental illness is by building an ‘eco-system’ across schools and communities to support the emotional resilience of children and young people and enable them to ‘bounce back’ when they face life’s inevitable difficulties. This is happening through Cumbria’s Headstart programme. Other examples of potential opportunities which can reduce the need for people to receive specialist treatment might include housing related support, employment retention support and support for people with mental health problems who are out of work.

The Health and Wellbeing system programme team at Cumbria County Council are the lead on primary prevention, to take a population based approach to mental ill health prevention and the building of greater community resilience. It is recognised that people may have multiple issues which impact on their health and wellbeing.

In order to approach this from an holistic perspective, the Health and Wellbeing team at Cumbria County Council are leading on the development of a county-wide health and social wellbeing system which will start to be delivered in the early years of this five year strategy. The system will aim to support people to achieve their health and social wellbeing goals in general, rather than there being lots of services that can only help with one thing at a time. So if for example, someone is worried about money and this is making them anxious and unable to sleep, the service will provide welfare support, as well as advice on how to relax and manage stress.

Reducing stigma

People who use Services in Cumbria have told us that tackling stigma and discrimination should be a high priority area. We believe that in order to reduce the stigma surrounding mental health, it’s important to get people to talk about their mental health. It’s crucial that people in Cumbria aren’t afraid of talking to their family, friends or colleagues about how they are feeling and are able to seek help when they need it.
Our strategic aim is to develop and implement a local plan to tackle stigma about mental health. This is partly about addressing people’s attitudes and behaviour, and improving their understanding of what people experiencing mental health problems may be going through. It is also about changing the way workplaces, support agencies, and wider society act to prevent mental illness and to support people experiencing problems. A recent report by the charity MIND about workplace and mental health sets out a vision of what needs to be done to create a system that works, and we will use this to guide our approach. \textsuperscript{xxxi}

Stigma and discrimination can be magnified for specific communities where mental health problems may be considered taboo, or where people already experience stigma and discrimination on account of a protected characteristic, such as the Lesbian, Gay, Bisexual and Transgender community. National campaigns, such as ‘Time to Change’ offer us an opportunity to share materials and develop a cohesive campaign approach to raising awareness and tackling attitudes and behaviours. We aim to work with a wide range of local stakeholders - such as schools, multicultural groups and employers - to take as broad an approach to this as possible in order to start to effect change.

\section*{Suicide Prevention}

Although suicide prevention is not one of the five legally mandated public health functions of local authorities, Cumbria County Council’s public health team continues to lead the local strategy and to chair the non-statutory multi-agency Cumbria Suicide Prevention Leadership Group, which assures delivery of the Cumbria Suicide Prevention Strategy and action plan. Cumbria’s suicide prevention strategy is informed by the best available evidence of ‘what works’, and local intelligence including repeated in-depth audits of suicides.

On average, one person dies each week as a result of suicide in Cumbria. Gathering intelligence about suicide enables the identification of high-risk groups, risk factors and issues which might increase that risk. All of these things can inform the development and implementation of local suicide prevention efforts.

A total of 78 suicides in 2012 and 2013 were reviewed \textsuperscript{xxxiv} in order to inform the refreshed Suicide Prevention Strategy. Further details about the findings are available at Appendix 4. A key message from the review is that the circumstances surrounding suicide are often complex and characterised by a range of risk factors, things that might increase those risks and other precipitating factors present in an individual’s life. Often there is no single attributable factor.

The results found that the common risk factors for suicide such as relationship breakdown, unemployment, mental health diagnosis and alcohol/substance misuse continue to be prevalent risk factors for suicide in Cumbria. Overall, it appears that Cumbria is not significantly different to the national picture in terms of risk factors; however the suicide rate in Cumbria does continue to be significantly higher compared to the England rate. This may suggest a need to revisit the best practice guidance and the fundamentals of suicide prevention.
Using the arrangements for the existing strategy and remit of the multi-agency Suicide Prevention and Safeguarding forums, additional action is planned during the lifetime of this strategy to:

- Reinforce the importance of talking about suicide and emphasise best practice guidelines
- Agree and disseminate key suicide prevention messages across the Cumbrian workforce, based on the following:

  - **One Cumbrian dies every week by suicide**
  - **Suicide CAN be prevented**
  - **Ask it won’t harm. Listen it might help**: Open, honest talk about suicide can save lives by reducing the stigma and enabling people to feel more able to talk about their feelings and any thoughts of suicide. Talking about suicide with someone does not increase the risk of suicidal behaviour
  - **Most people with thoughts of suicide do, in some way, ask for help** – if we can make people alert to the signs we can help reduce suicides

- Consider workforce suicide prevention awareness raising and training needs based on the recommendations of the suicide prevention training and awareness raising strategy. In particular, a comprehensive and integrated system for suicide awareness training should be agreed by the heads of the agencies concerned, providing leadership in bringing about the required levels of commitment and support within agencies. This includes, in light of audit findings, making suicide prevention training a priority for GPs and primary Care and Support staff
- Ensure that staff of Citizens Advice Bureaux, Housing Associations, Job Centres and GPs that come into contact with individuals in distress as a result of benefit changes and other types of economic loss, know where to signpost individuals to appropriate support services
- Educate health care professionals to consider the impact of chronic pain and other long term conditions in connection with other known risk factors and escalators when carrying out individual suicide risk assessments
- Task the Mental health and Criminal Justice steering group in Cumbria to investigate and recommend actions in relation to individuals in recent contact with the criminal justice system.
- Ensure the inclusion of other risk factors, including domestic and sexual violence in the suicide prevention training and response.

**Parity of esteem**

The Royal College of Psychiatrists (2013) report *Whole-person care: from rhetoric to reality: Achieving parity between mental and physical health* stated, “In essence, ‘parity of esteem’ is best described as: ‘Valuing mental health equally with physical health’ and it went on to describe six characteristics of parity of esteem as follows:
.... equal access to the most effective and safest care and treatment
.... equal efforts to improve the quality of care
.... the allocation of time, effort and resources on a basis commensurate with need
.... equal status within healthcare education and practice
.... equally high aspirations for service users; and
.... equal status in the measurement of health outcomes.

Our approach to delivering this vision should encompass these characteristics and the MHPG will take every opportunity to promote parity of esteem for mental health and work with the whole system to achieve this.

Research has shown that people in contact with specialist mental health services are more likely to die prematurely than the rest of the population:

**Premature Mortality and Serious Mental Illness**

There is clear evidence that people with serious mental illness refer tend to have poorer lifestyles including consuming more alcohol and smoking more. This in turn leads to higher rates of cardiovascular disease. This has a significant impact upon life expectancy. Research in 2012 highlighted that:

- A male with a serious mental illness can expect to live 12.9 years less than average
- A woman with a serious mental illness can expect to live 11.8 years less than average.
- People with depression can live between 7 and 10 years less than the national average.

These are stark statistics. Yet data shows that people with mental health problems have a significantly different level of contact with physical health services compared
with other patients. Pilot data from April to August 2014 across England shows that people with a known mental health problem accessed acute hospital care twice as often as people who were not known to mental health services during that time. It is well known that people with more severe mental health problems are less likely to be registered with a GP.

Public Health led work will seek to impact upon the individuals who are dying earlier because of a lack of parity of esteem between mental and physical health. That will take significant commitment from across the Cumbrian system, but we are serious about improving life expectancy.

Therefore, as a commissioning and Public Health partnership, one of our five year strategic aims is to reduce tobacco addiction for mental health service users. We will do this by working closely with people who have mental health problems and carers, and with support from partners in all organisations delivering mental health services. A more detailed plan of action will be developed during 2015/16. In addition, we will use future tendering opportunities, such as for Drug & Alcohol services, to ensure alignment with this strategy.

**Good transitions for Young People and Older Adults**

Poor transition between stages of the life course, or services, can contribute to poor outcomes in the short, medium and long term. It can impact upon a person’s chance of achieving employment, accessing education, maintaining independence, moving on from services or accessing services in the future. Conversely, effective transition can have a positive effect on people’s life chances and their future mental health and wellbeing.

Transition for young adults is particularly important. Its aim should be to help to improve the chances of recovery and independence through the provision of high-quality, effective health and social care services that continue seamlessly as the individual moves from adolescence to adulthood. We want to ensure that the transition for children and young people to adult mental health services and the transition for adults to older people’s mental health services is improved as part of our life course approach to mental health and wellbeing.

As part of our coordinated work to design new pathways of support for children and young people, we will ensure that they take account of the life events that impact on young people with mental health problems, including leaving education, leaving home, leaving family, emerging autonomy.

As part of developing our model of care, we want to explore the feasibility of developing a young people’s service spanning 14 – 25 years so that there is continuity of support during the critical period that usually includes the life events described above.

The principles of good practice in transition include:
• Starting up to 4 years before the 18th birthday for those young people whose needs are expected to continue into adulthood
• Care planned jointly by children’s and adults’ practitioners
• A clear plan setting out how needs will be met and milestones when responsibility for meeting them passes from one group of clinicians to another
• The plan will be developed with the young person concerned and agreed with them and their family

The issues surrounding transition for young people must form an important part of the way in which we need to shape local services. The transition for existing adult service users to older adult community services and ensuring we meet the needs of older people who develop mental health problems such as depression and anxiety are areas that requires further focus, allied to thinking about those people who may develop organic disorders such as dementia.

We will support the review of current community pathways for older adults with a functional mental health problem, in the context of our developing plans for integrated care in the county.

Mental Health in Primary Care

This will include:
  • Primary Care Communities

It is recognised that for patients, communities and staff there is much to be gained from working in an integrated way, serving natural communities built up from patient lists and reflecting natural community clusters. The description of these cluster arrangements have been captured through the term Primary Care Communities (PCCs). There are examples of how General Practices and partners are working together already and there have been many discussions across practices, localities and Cumbria about doing this more significantly and consistently, with freedoms to innovate and work flexibly in the best interests of the patients and the local community. Working as primary care communities is the foundation upon which organisations want and are committed to build upon for our health and care system of the future.

A crucial relationship for embedding mental health provision within PCCs will be with The Better Care Together Programme and Together for a Healthier Future Programme which have seen the concept of Primary Care Communities emerge as the mechanism by which we change working practice and embed the Out of Hospital model that has been designed through a clinically led process. This concept is one that can be adopted by the ‘Better Mental Health for All’ Strategy and deliver a better integration of mental health services.

The benefits of having mental Health services integrated into primary care communities will focus on the success of whether patients feel the NHS is working
for them holistically and coordinating their care around their individual needs and not those of each service.

Providers will recognise benefits from being able to offer more flexible solutions to holistic healthcare services and provide higher quality and safer services. Primary care will see benefit from less ‘hand offs’ for patients and easier access and navigation through care services. Commissioners will recognise improvements across the health and social care system that will meet the key performance measures for Primary care communities and will also find a sustainable health and social care system integrated around the patient and communities in which they live.

The vision within Primary care communities is to transform the care provided to create a seamless experience for the patient. It doesn’t matter whether a person is receiving care in their home, their community, or hospital. The new model of care will be centred on the patient rather than the care setting and will focus on quality of the services being delivered rather than the organisation that delivers them.

The Better Care Together programme and Together for a Healthier Future will transform our services to support people to live a healthy and happy life within their usual level of health and wellbeing. They will also aim to deliver a better experience of care whether living with a long term condition, experiencing short term illness or experiencing an acute exacerbation of usual health and wellbeing. This aim is relevant for both mental health and physical health to support holistic health improvement and maintenance of good health. PCCs will contribute to the overall aims of:

- Proactively managing care in the right place and with the right teams
- Managing patient need regardless of professional boundaries
- Improving access, quality, safety and experience of care services for patients and carers
- Reducing inappropriate use of services across the health and social care system
- Providing sustainability in health and social care economy
- Promoting self-care and maximising inputs from the asset base within our communities
- Keeping the health economy in financial balance and fit for the future

The benefits will take time to evolve and a transition of a new integrated system is expected to evolve over a 2 year period. There will be continuous steps towards greater integration within a 5 year period of the collective strategies thereafter.

Integrating mental health alongside the Primary Care community development will challenge the historical belief the mental health services have not been well coordinated with physical health services, particularly in primary care.
Mental Health Liaison with Primary Care

The vast majority of mental health care is provided in primary care yet primary care liaison is an under-developed aspect of mental health provision. Patients being supported by GPs for physical illnesses often have co-morbid mental health problems. Equally, GPs support many people whose primary problem is a common mental health disorder.

The traditional model of referral from primary care to specialist secondary care mental health services is appropriate for patients with potentially severe or enduring mental health diagnoses. Equally, referral to IAPT services for talking therapy is a useful recent addition to pathways for people with less severe or enduring problems. There remains, however, a need for people to be supported by GPs when a referral is not the appropriate course of action. Patients may need the support of their GP for low level or intermittent mental health problems, in those situations when they are reluctant to be referred or for maintaining their mental well-being after transfer from specialist services.

Primary Care Teams in some localities in Cumbria are supported by small teams of mental health professionals with a range of skills and competencies which enables them to offer more comprehensive support to their patients and manage the interface between primary and secondary care more effectively. This model can also offer developmental support to primary care personnel re mental health issues and signposting to specific forms of support (e.g. debt counselling, Relate etc).

As we consider developing mental health liaison and shared care with primary care, thought will also be given to offering training and support to primary care colleagues.

Mental Health and Physical Health

We can do more to support people with physical health problems to manage their condition. There is significant national evidence to support the provision of talking therapies and other forms of psychological support for people with long-term conditions and serious acute illnesses. Little is currently provided but evidence suggests that dependence on Primary and Secondary care NHS services and on social care support services reduces among these patients groups when they receive appropriate psychological support.

Increased access to psychological support services for people with long-term conditions and serious acute health illnesses is needed to achieve these outcomes. This need not be commissioned directly from mental health providers but could be embedded in physical healthcare services and social support services.
Ways of working that will need to change and/or develop to enable us to deliver the vision:

The role of the third sector

The third sector has a vital role to play in the delivery of the mental health vision and model of care for Cumbria. Third sector provided services are an essential part of the range of services provided to people with mental health problems from mild mental health problems to severe and enduring mental illness. They increase the choice available to people, they are sometimes acceptable to service users at a time when accessing statutory services does not feel like an option, they can be more flexible and accessible than statutory services and as such they are valued by service users and carers. It is important that we work with third sector organisations to develop a clearer commissioner provider relationship and commission services based on contracts rather than the pre-existing culture of grants where there was lack of accountability and governance for what would be provided. This arrangement potentially leaves the commissioner with little assurance about the quality of what is provided and the providers vulnerable to lack of process to manage increasing or decreasing demand.

Since the beginning of the economic downturn, third sector organisations have been under increasing financial pressure and there are real concerns that without concerted action by commissioners in Cumbria to develop a clearer role for the third sector in relation to support for prevention and for recovery, valuable assets, skills and knowledge will be lost as organisations fold due to lack of funding. Urgent action is required this year (2015-16) to stabilise and support the third sector to enable a step change in their role supporting mental health and wellbeing. As part of this we will clarify the specific role for the third sector which makes best use of its links to communities, and its skills and ensure that resources are in place which will allow it to deliver appropriate and high quality services sustainably, in partnership with the public sector.

In the last two years or so initiatives such as Wellbeing Hubs and the Neighbourhood Care Independence Programme (NCIP) have provided opportunities to incorporate third sector provision into integrated service provision. Wellbeing Hubs, modelled on the Cockermouth Centre for the Third Age, in which CPFT funded 6 new wellbeing hubs in 2013. Serving a small local area which is likely to match the footprint of Primary Care Communities, these provide a personal contact and enabler to liaise between health, social care, and the resources available through the third sector, community groups and volunteers. Hub co-ordinators also form new groups and organise one-off events to meet demand. While the Hubs’ main focus to date has been on older people, and tackling social isolation, these hubs have the potential to meet a range of health and wellbeing challenges. Closely allied to the concepts of Assets Based Community Development (ABCD).

The Neighbourhood Care Independence Programme (NCIP) was launched in April 2013 in partnership with the third sector, and provides a range of interventions to
sustain the independence of vulnerable adults in their neighbourhoods. By facilitating prevention activities and using existing networks to help provide support to individuals and communities, it aims to reduce demand for statutory services. The offer includes: information and advice, community bridge building, promotion of health and well-being, and linking with local associations to help develop caring neighbourhoods. It is currently supporting thousands of adults who need extra support from time to time to remain independent.

These are just two examples of a way of working we want to develop further to support implementation of this vision. They have explored the potential to promote wellbeing by connecting people to resources in the community. These initiatives vary in the extent to which they offer signposting and/or more intensive one-to-one support; and to which they specifically address mental health. However they have in common a holistic approach, and an appreciation of the relationship and interaction between physical mental, social and material needs, and of the importance of social inclusion.

Local evaluation has, in the main, been consistent with the evidence in support of ‘social prescribing’ approaches, whereby health and care professionals can refer on to non-medical sources of support – whether to improve participants’ skills, help them overcome material difficulties, or reduce loneliness and isolation. GPs had also begun to refer to the Hubs and other services, and their feedback was positive in terms of reduction in appointments and medication needs. Positive social and economic outcomes included finding employment; gaining new skills; and enhanced social interaction.

These initiatives show that third sector organisations can complement statutory agencies, especially with a view to preventing problems identified early getting worse, and to recovery from episodes of mental illness. It is likely that some current gaps in provision and support across the county could be met by third sector providers, thus reducing pressure on secondary mental health services. This diversification of the provider market has the potential to improve efficiency and outcomes, as well as increase choice.

However, recent experience also highlights the need for a co-ordinated, sustainable approach to commissioning from the third sector. Charitable/voluntary agencies tend to grow in an organic way, based on the special interests of individuals and groups, and to be more numerous in more affluent areas. Geographic distribution in relation to need should be taken into account in developing the third sector offer.

**Involvement of people who use services and their carers & families**

Valuing the input of service users, carers and families by involving them in service planning, commissioning, implementation and evaluation activities is a fundamental part of how we as commissioners, working jointly, and our commissioned providers need to operate
As well as being fully involved in the implementation of this strategy through the programme arrangements which are being set up to support it, we expect the priority Project Working groups to devise and design services which might potentially offer opportunities, including paid employment, for people who have experienced mental health problems.

CCC and the CCG have commissioned Carers Support Cumbria Limited to identify carers, provide information, assess carers’ needs and provide support planning activities to enable carers to continue in their valued role. This has increased the capacity to provide statutory carers assessments in line with the Care Act 2014. CCC has an ongoing aim to try to ensure that carers are able to access support from their community first; the approach is one which seeks to protect carers from prematurely becoming service users themselves.

People First ran a wide consultation in June 2014 to inform the future Mental Health Commissioning Strategy being developed with lead from CCG, titled ‘Your voice in shaping Mental Health Services in Cumbria’. Key trends via the various consultation methods were:

- Access to MH services and lack of information
- Community MH Team improvements – consistency of service, staffing levels and availability
- Improved MH awareness from all including GPs
- Improved waiting and referral times
- Improved range of therapies and treatments
- Improved availability of structured activity including more activities and support groups in the community
- Improved communication and better joint working between all services and support networks
- Improved confidentiality
- More beds available for those in crisis

Integration across health and social care

It has been identified nationally that integration of health and social care systems offers a significant opportunity to improve service delivery, experience and outcomes for people with mental health needs. It can enable efficiencies too. Integration through joint commissioning is important in enabling a change to how services are funded and how they work with each other to improve outcomes. Consideration is being given by Cumbria CCG and Cumbria County Council to the establishment of a strategic health and social care commissioning team to progress to joint commissioning of adult mental health services. This will enable the achievement of effective outcomes for individuals by bringing together relevant expertise, knowledge and experience in one place. Moreover, it will improve the speed of response to identified needs by ensuring better use of resources, reducing communication failure and increasing satisfaction with services.

There are a number of other strategic intentions which are deliverable through joint commissioning of services, including:
• The development of integrated care and support pathways across primary and secondary care and into the community
• Integrating service delivery across providers more fully so that providers work together across a pathway from prevention to early intervention to treatment, support, rehabilitation and recovery the development of joint outcome measures across health, social care and the third sector.

We believe that integrating commissioning and in turn, some of the key parts of service delivery, will mean people who use mental health services can have more control over their care support and treatment, in services which are more adequately designed to help people on their personal recovery journey.

**System collaboration**

We intend to use this strategy to improve the way partners across Cumbria work together. Collaboration and relationships are vital to the success of transforming our service offer. We acknowledge that the health and social care system by its very design does not aid the delivery of joined up health and social care services. We will support providers, service users and carers locally to build trust and work together in order to help us to achieve our strategic priorities. For example, we will seek to ensure our Strategy working groups design pathways which give clarity to who leads on which stage of the pathways, how funding works and what good provision looks like.

**The Care Act 2014**

This Act received Royal Assent in May 2014. It sets out a new framework of local authority duties in relation to the arrangement and funding of social care, along with a number of changes to the regulations of social care providers.

The Care Act places care and support law into a single, clear modern statute and enshrines the principle of individual wellbeing as the driving force behind it:

- It ensures that people will have clearer information and advice to help them navigate the system, and a more diverse, high quality range of support to choose from to meet their needs
- It places more emphasis than ever before on prevention – shifting from a system which manages crises to one which focuses on people’s strengths and capabilities and supports them to live independently for as long as possible
- It seeks to make the care and support system clearer and fairer for those who need it
- The Government will set a national minimum eligibility threshold to help people better understand whether they are eligible for local authority support.

For the first time, carers will be put on the same legal footing as the people they care for, with extended rights to assessment, and new entitlements to support to meet their eligible needs.
Provisions also include:

- Duties on local authorities to carry out their care and support responsibilities with the aim of promoting greater integration with NHS and other health-related services
- Requirements on local authorities to manage and develop the market for care in their area, having regard to ensuring a sufficiency of provision and to ensure the market has the information it requires (e.g. through the issuing of a Market Position Statement) so that it can respond effectively to meet demand
- Ensuring plans are in place to reduce the risk of provider failure and to manage a failure should it occur (financial stability is considered a key factor)
- Engagement of providers and service users to inform local commissioning strategy and service requirements


SECTION 4 Delivering the strategy

In order to translate the vision set out here into tangible change, within the resources we have and within a reasonable timescale, we need to be clear about the arrangements that will continue, or be put in place, to make this happen, and the governance and the deliverables required.

Delivery of whole system change can only be achieved through genuine partnership between providers, clinicians, service users, carers and commissioners and we need to develop mechanisms to make this degree of partnership a reality.

Governance:

The Mental Health Partnership Group (MHPG), as the place where all the key partners come together, will retain oversight of the delivery of the strategy, including the vision and the development of the model of care. The Group has commissioning representatives from the CCG and CCC Adult Social Care, Public Health, Providers, People First and crucially people with lived experience of mental illness and carers. A service user representative has recently been recruited to act as Vice-Chair for the group; in time they will become Chair. The group is directly informed and supported by Service Users, Carers and a Lay Forum.

Whilst the Joint Commissioning strategy is primarily the responsibility of the commissioners to develop, they will be doing this under the umbrella of the Mental Health Partnership Group and as part of the development and implementation of the strategy.

The MHPG is not a statutory body and as such its decisions will be in the form of recommendations to the various statutory decision making bodies to implement the strategy and it is important that clear lines of reporting are in place.
Proposed Mental Health Programme structure:

Finance:
All organisations are experiencing financial pressure and it is critical that these issues are shared openly so that we understand the impact across the system (see Single Version of the Truth below) There is an urgent need to develop and agree a financial strategy that will support implementation of the vision and a new model of care. It is essential therefore that a financial strategy is developed to form an integral element of the commissioning strategy.
This strategy needs to:

- Demonstrate how we will create a shift in resources from diagnosis and treatment to prevention, wellbeing and early intervention
- Demonstrate how we will make best use of the total current investment in mental health through redesign, decommissioning and commissioning
- Describe an agreed approach to protecting resources for mental health e.g. retaining any savings made to reinvest in mental health
Single version of the truth:

In the early days of the Better Care Together Programme, they developed a ‘single version of the truth’ which established a starting point for the whole system so that there was agreement on the key parameters against which they could judge the success of their joint endeavours and to support the development of a clear narrative about what they wanted to change.

It has been suggested that we should develop a single version of the trust for the mental health programme and work is ongoing to develop an outline proposal for this.

Current thinking would see the following elements included, although it must be stressed that there are further discussions to take place to reach agreement on what a SVT for mental health might look like and this may not reflect the final version:

- Patient/ service user experience
- Safety
- Quality
- Outcomes
- Workforce
- Access
- Activity
- Financial overview

The intention is to

- Include as much benchmarking as possible with peers and to include trends wherever possible
- To take whole system perspective wherever possible and provide data, if it is available, for all providers (e.g. all providers delivering services to Cumbrian service users, statutory and non-statutory) or commissioners (i.e. CCC and CCCG) and to span primary care through to tertiary care.

Progressing urgent priorities

As a result of recent reviews and consultation with service users and carers, a number of urgent priorities have been identified and discussed at the MHPG in recent months. Mandates had been developed to support progressing all of the priority areas. However, it has become clear that making better connections between the Programme priority areas and the CPFT improvement programme would be beneficial and more efficient, thereby reducing the demand on the system to support the original number and range of mandates, whilst ensuring that progress is made in these priority areas. Clarity about how these areas are being taken forward, how they connect with CPFT internal improvement programme and how progress will be monitored over the next twelve months is an urgent issue for MHPG.
Integration of the mental health strategy and model of care development with the other two key programmes in Cumbria: Better Care Together (Vanguard) and Together for a Healthier Future (Success Regime).

It is essential that we develop an approach that achieves this integration for the following reasons:

- To address the parity of esteem agenda
- To maximise the potential benefits that excellent mental health services can deliver for physical health services
- To address the physical health inequalities for people with mental illness described in the public health section of this document.
- To avoid duplication and promote integration
- To contribute to the creation of a cultural shift in which all organisations, sectors and communities in Cumbria recognise mental wellbeing and improving mental health as being everyone’s business

New models of commissioning and providing

As part of our drive to make the best use of limited resources, we will explore new models for commissioning and providing, for example outcomes based payment for mental health care and forms of contracting that could support such an approach e.g. lead accountable provider models. Monitor has recently published a paper on this and we will use this as our starting point for exploring this area. xxxvi

Summary

This document seeks to set out the vision that will guide the development of adult mental health services in Cumbria for the next five years. It describes our ambitions for better mental health for all in Cumbria against which any proposals for development and change should be assessed.

It sets the strategy in context and focuses on the areas where we need to have the greatest impact during the next five years and it describes the delivery arrangements that will be required to make the vision a reality.

Within the increasing public sector economic constraints and the need to maintain focus on quality, we are attempting to set out a blueprint for a radical, transformative approach which seeks to refocus our efforts on prevention, choice and control, at the same time as ensuring individuals have the opportunities and tools to help them to achieve meaningful recovery.
It is vital that we work hand in hand with people who experience the services we commission, and that we are organised and focused when it comes to knowing how we are doing. Our new arrangements to govern this strategy and its delivery will help us a great deal with making that happen, supported by an infrastructure which allows the crucial work to be done to prepare, define, design, evaluate, present and commission our priorities between now and 2020.

Next steps to progress the urgent priorities that need to be addressed and to deliver this vision will require the development, at pace, of a joint action plan across health, social care and the third sector that will be owned and monitored by the Mental Health Partnership Group.

This vision document should be read in conjunction with the other two key elements of the strategy as and when they are completed:
- The model of care document
- The joint commissioning strategy
Appendices:
Appendix 1: Defining recovery
Appendix 2: Crisis concordat
Appendix 3: Demographic information and headlines from the JSNA
Appendix 4: Suicide review – data and findings
### Defining Recovery

<table>
<thead>
<tr>
<th>To me, recovery means.....</th>
<th>As a provider, I can support people in their recovery by.....</th>
<th>As a manager I can lead teams or an organisation that supports recovery by.....</th>
<th>We will know that we are working together toward recovery when.....</th>
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<tbody>
<tr>
<td><strong>Being supported by other people</strong></td>
<td>-having people I can count on -being loved and accepted as I am -having people in my life who believe in me -having something to give back -feeling like a worthwhile human being -being able to help others when they need me</td>
<td>-helping people develop lasting connection to communities and natural supports -being willing to include these natural supports in recovery planning -being willing to help people get their basic needs met eg. food, shelter &amp; safety -believing in people &amp; sharing that with others too -being an advocate and a provider -valuing &amp; exploring spirituality</td>
<td>-educating staff and others about natural support networks and how to build them -developing structured education for families &amp; members of natural support networks -valuing and fostering use of peer support &amp; self-help</td>
</tr>
<tr>
<td><strong>Finding your niche in the community</strong></td>
<td>-getting involved in activities I enjoy -having nice places to hang out with friends -having a routine I enjoy -making new friends -catching up with old friends -filling my day with things I like</td>
<td>-supporting involvement in valued social roles -highlighting employment as a path to recovery -promoting leisure activities &amp; hobbies -completing a strengths based assessment relating to education, work &amp; leisure -being knowledgeable about the full range of community</td>
<td>-view reconnection to the community as primary goal of services -designate some staff to be the lead on community integration initiatives, ensuring all staff understand and value them -have services that open beyond traditional working hours eg. in the evening -establish outcome measures that evaluate services and provide based on how providers</td>
</tr>
</tbody>
</table>

**Appendix 1**
<table>
<thead>
<tr>
<th><strong>Redefining self</strong></th>
<th><strong>Incorporating illness</strong></th>
<th><strong>Managing symptoms</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>-seeing myself as a person with strengths and resources -knowing my illness is only a small part of who I am -not allowing ‘label’ or ‘diagnosis’ to take control of my life -exploring life outside of the mental health system -learning what I have to offer -proving wrong the people who said I’d never do anything with my life</td>
<td>-knowing when I need to ask for help -not feeling defeated -avoiding the things that make me feel bad -knowing how to take care of myself in good and bad times -accepting there are some things I can’t do yet -being proud of the things I can do -taking each day at a time</td>
<td>-learning how my illness affects me -asking questions when I don’t understand -having ways to</td>
</tr>
<tr>
<td>-helping people become more involved in valued social roles -being responsive to their cultural values &amp; preferences -focusing on the whole person -using person first language -having the skills to allow people to share their personal experiences -helping people plan for their life beyond ‘the system’ -working with and not for people</td>
<td>-following their lead and supporting them in their unique path to recovery -learning more about recovery processes through education by people in recovery -refer to prominent role models who have experienced success and happiness despite mental illness</td>
<td>-providing access to education about a variety of methods -providing culturally responsive care -understanding</td>
</tr>
<tr>
<td>-promoting, using &amp; remaining faithful to a new language that reflects recovery and person-first principles -supporting concept that treatment involves helping people find their niche in the community -conduct asset mapping of community resources -establish relationships with community organisations beyond the mental health service system</td>
<td>-organise staff training or conference and invite people in recovery to share their stories -value the input of people in recovery by employing or paying them for time spent on service planning, implementation and evaluation activities</td>
<td>-cultivate an organisation in which management of symptoms is not done in a clinical vacuum but crosses disciplines and aims to reduce impact on</td>
</tr>
<tr>
<td>-staff are knowledgeable about special interest groups and community activities -staff are diverse in terms of culture, lifestyle, ethnicity and interests -exit criteria are clearly defined</td>
<td>-the organisation provides formal opportunities for people in recovery, family members, service providers and relevant others to learn about recovery -people in recovery facilitate staff training</td>
<td>-provision of a variety of treatment options -offering specific services and support for people in a personalised way -procedures are in</td>
</tr>
<tr>
<td>Assumining control</td>
<td>Cope and be good to myself</td>
<td>Medication is only one tool in the recovery toolbox and that not everyone needs it to recover</td>
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<tr>
<td>---------------------</td>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>- knowing when &amp; how to voice my opinion</td>
<td>- controlling symptoms so they don’t get in the way of my life</td>
<td>- working with people to develop relapse prevention strategies</td>
</tr>
<tr>
<td>- having control over my life and treatment</td>
<td>- understanding what medication can and cannot do</td>
<td>- teaching illness self-management so people use their own experiences and knowledge to apply strategies that work best for them</td>
</tr>
<tr>
<td>- taking risks and trying new things</td>
<td>- finding other tools to help me in recovery</td>
<td>- avoiding 'professional knows best' attitude and treating people as equals</td>
</tr>
<tr>
<td>- accepting the consequences and learning from mistakes</td>
<td>- knowing when to ask for help</td>
<td>- understanding symptoms do not have to be eliminated to pursue recovery</td>
</tr>
<tr>
<td>- being able to appreciate someone else's view and compromise</td>
<td>- taking time to relax</td>
<td>- letting people express their feelings without attributing this to symptoms or relapse</td>
</tr>
<tr>
<td>- telling people what I want &amp; need from them</td>
<td>- giving myself some slack</td>
<td>- encouraging the use of peer support and recovery-based coping models eg. WRAP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overcoming stigma</th>
<th>- feeling good about myself</th>
<th>- avoiding stigmatising language and</th>
<th>- educating staff members, consumers, family</th>
<th>- the organisation provides structured educational activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>- learning ways</td>
<td>- controlling symptoms so they don’t get in the way of my life</td>
<td>- working with people to develop relapse prevention strategies</td>
<td>- regularly collect satisfaction surveys from people in recovery and use result to inform service development</td>
<td>- providing training in evidence based practices such as illness self-management</td>
</tr>
<tr>
<td>- avoiding threats or coercion</td>
<td>- knowing when &amp; how to voice my opinion</td>
<td>- having control over my life and treatment</td>
<td>- collecting satisfaction data in a manner that allows people to freely express feedback and criticisms</td>
<td>- achievement of goals is celebrated</td>
</tr>
<tr>
<td>- accepting the consequences and learning from mistakes</td>
<td>- taking risks and trying new things</td>
<td>- taking risks and trying new things</td>
<td>- establish formal grievance procedures to address dissatisfaction with services and fully inform people about these on a regular basis</td>
<td>- risks are encouraged</td>
</tr>
<tr>
<td>- being able to appreciate someone else's view and compromise</td>
<td>- telling people what I want &amp; need from them</td>
<td>- understanding symptoms do not have to be eliminated to pursue recovery</td>
<td>- avoid aversive and coercive strategies to promote engagement</td>
<td>- the voices of people in recovery are listened to</td>
</tr>
<tr>
<td>- telling people what I want &amp; need from them</td>
<td>- giving myself some slack</td>
<td>- letting people express their feelings without attributing this to symptoms or relapse</td>
<td>- enforce ethical practice with human resource oversight that holds staff accountable for giving people maximum control over their treatment</td>
<td>- providing opportunities for choice and options to choose from</td>
</tr>
<tr>
<td>- giving myself permission to be human</td>
<td>- giving myself permission to be human</td>
<td>- encouraging the use of peer support and recovery-based coping models eg. WRAP</td>
<td>- people in recovery can choose and change their service provider</td>
<td>- providing opportunities for choice and options to choose from</td>
</tr>
</tbody>
</table>

| - avoiding threats or coercion | - accepting the consequences and learning from mistakes | - being able to appreciate someone else's view and compromise | - telling people what I want & need from them | - giving yourself some slack |
| - giving yourself permission to be human | - giving myself some slack | - giving myself permission to be human | - telling people what I want & need from them | - giving yourself permission to be human |

<p>| - feeling good about myself | - avoiding stigmatising language and | - educating staff members, consumers, family | - the organisation provides structured educational activities |</p>
<table>
<thead>
<tr>
<th>to overcome negative views of others</th>
<th>labels</th>
<th>members, and the community about the harm caused by stigma</th>
<th>to community and employers about mental illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>- finding places in the community where I feel at home</td>
<td>- helping transform communities into more accepting environments</td>
<td>- involving people in recovery who can share their stories</td>
<td>- becoming an empowered citizen</td>
</tr>
<tr>
<td>- being proud of myself</td>
<td>- being able to confront personal prejudices</td>
<td>- developing relationships with local media to publicise success stories</td>
<td>- feeling like I have choices</td>
</tr>
<tr>
<td>- having role models</td>
<td>- teaching how to manage stigma by advocating for themselves and others and getting involved in stigma busting work</td>
<td>- establishing structures to link services across professional disciplines, sectors and contexts</td>
<td>- choosing where I live and how to spend my time</td>
</tr>
<tr>
<td>- not letting people put limits on me</td>
<td>- not wearing badges when working with people in the community</td>
<td>- becoming a responsible citizen</td>
<td></td>
</tr>
<tr>
<td>- knowing when I'm being discriminated against</td>
<td>- knowing when I deserve better and demanding it</td>
<td>- having other people respect me</td>
<td>- being a responsible parent, caring friend or good neighbour</td>
</tr>
<tr>
<td>- standing up for myself when mistreated</td>
<td>- not buying into stereotypes of mental illness</td>
<td>- making a difference in my community</td>
<td>- making a difference in my community</td>
</tr>
<tr>
<td>- realising other people have problems too</td>
<td>- realising other people have problems too</td>
<td>- taking responsibility for my recovery</td>
<td>- taking responsibility for my recovery</td>
</tr>
<tr>
<td>- knowing when I deserve better and demanding it</td>
<td>- creating opportunities for people in recovery to genuinely influence service planning, commissioning and implementation</td>
<td>- creating opportunities for people in recovery to genuinely influence service planning, commissioning and implementation</td>
<td>- staff help people become involved in the community</td>
</tr>
</tbody>
</table>

**Becoming an empowered citizen**

<p>| - feeling like I have choices | - listening to people and respecting their choices | - involving people in recovery in all aspects of service planning, development and implementation | - people in recovery are involved in the planning, commissioning and review of services |
| - choosing where I live and how to spend my time | - helping people find their voice and encourage involvement in advocacy activities | - understanding and teaching people how they are protected by mental health law | - people in recovery are regular members of advisory groups |
| - voicing my opinion | - involving people in recovery in all aspects of service planning, development and implementation | - referring people to appropriate oversight bodies | - providing training and requiring staff to be knowledgeable about mental health law |
| - giving back and sharing my experiences with other people working toward recovery | - encouraging people to be responsible citizens | - supporting the development of person centred recovery planning | - supporting the development of person centred recovery planning |
| - being a responsible citizen | - valuing assertiveness and creating opportunities for people in recovery to genuinely influence service planning, commissioning and implementation | - holding the organisation accountable for responding to recommendations of people in recovery | - holding the organisation accountable for responding to recommendations of people in recovery |</p>
<table>
<thead>
<tr>
<th>independence as growth and reducing supports in response to this growth</th>
</tr>
</thead>
</table>
Appendix 2

Crisis Concordat for Cumbria

Crisis Care Concordat declaration

The Mental Health Crisis Care Concordat is a national joint statement published by the Government and signed by senior representatives from organisations committed to improving mental health care. In addition to listing a set of core principles, the document includes a national action plan agreed by the organisations who have signed the Concordat.

A Crisis Care Concordat Signing event was hosted by the Police & Crime Commissioner for Cumbria on 12th December 2014.

Each region has committed to the national agreement by signing a local declaration and developing a country-wide action plan. This is Cumbria’s declaration:

**The 2014 Cumbria Declaration on improving outcomes for people experiencing mental health crisis August 2014**

We, as partner organisations in Cumbria, will work together to put in place the principles of the national Concordat to improve the system of care and support so that people in crisis because of a mental health condition are kept safe. We will help them to find the help they need – whatever the circumstances – from whichever of our services they turn to first.

We will work together to prevent crises happening whenever possible, through intervening at an early stage.

We will make sure we meet the needs of vulnerable people in urgent situations, getting the right care at the right time from the right people to make sure of the best outcomes.

We will do our very best to make sure that all relevant public services, contractors and independent sector partners support people with a mental health problem to help them recover. Everybody who signs this declaration will work towards developing ways of sharing information to help front line staff provide better responses to people in crisis.

We are responsible for delivering this commitment in Cumbria by putting in place, reviewing and regularly updating the attached action plan.

**This declaration supports ‘parity of esteem’ (see the glossary) between physical and mental health care in the following ways:**

- Through everyone agreeing a shared ‘care pathway’ to safely support, assess and manage anyone who asks any of our services in Cumbria for
help in a crisis. This will result in the best outcomes for people with suspected mental health problems, provide advice and support for their carers, and make sure that services work together safely and effectively.

- Through agencies working together to improve individuals’ experience (professionals, people who use crisis care services, and carers) reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.

- By making sure there is a safe and effective service with clear and agreed policies and procedures in place for people in crisis, and that organisations can access the service and refer people to it in the same way as they would for physical health and social care services.

- By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to patients, carers, staff and service users or the wider community and to support people’s recovery and wellbeing.
We, the organisations listed below, support this Declaration. We are committed to working together to continue to improve crisis care for people with mental health needs in Cumbria.

<table>
<thead>
<tr>
<th>Signed By</th>
<th>On Behalf of</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Signature]</td>
<td>Cumbria Clinical Commissioning Group (Nigel Maguire – Chief Executive)</td>
</tr>
<tr>
<td>[Signature]</td>
<td>Cumbria County Council (Councillor Beth Furneaux – Cabinet Member for Health and Care Services)</td>
</tr>
<tr>
<td>[Signature]</td>
<td>Cumbria Constabulary (Jerry Graham – Chief Constable)</td>
</tr>
<tr>
<td>[Signature]</td>
<td>British Transport Police (Superintendent Edward Wylie)</td>
</tr>
<tr>
<td>[Signature]</td>
<td>Office of the Police and Crime Commissioner (Richard Rhodes – PCC)</td>
</tr>
<tr>
<td>[Signature]</td>
<td>Cumbria Partnership NHS Foundation Trust (Dr Andrew Brittlebank – Medical Director)</td>
</tr>
<tr>
<td>[Signature]</td>
<td>North Cumbria University Hospitals NHS Trust (Ann Farrar – Chief Executive)</td>
</tr>
<tr>
<td>Awaiting signature</td>
<td>University Hospitals of Morecambe Bay NHS Foundation Trust (Jackie</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
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<td>------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Daniel</td>
<td>North West Ambulance Service (Bob Williams – Chief Executive)</td>
</tr>
<tr>
<td>Bob Williams</td>
<td></td>
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<tr>
<td>Bob Williams</td>
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<tr>
<td>Neil Margerison</td>
<td>Cumbria Health on Call (Neil Margerison – Medical Director)</td>
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<tr>
<td>Neil Margerison</td>
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<tr>
<td>Jonathan Ingram</td>
<td>Cumbria 3rd Sector Forum (Jonathan Ingram – Chief Officer MIND, South Lakes)</td>
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<td>Jonathan Ingram</td>
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<tr>
<td>Gill Green</td>
<td>Greater Manchester West Mental Health NHS Foundation Trust (Gill Green - Director of Nursing and Operations)</td>
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<td>Gill Green</td>
<td></td>
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<tr>
<td>Mike Prentice</td>
<td>Cumbria, Northumbria, Tyne and Wear Strategic Clinical Network (Dr Mike Prentice - Acting Area Director)</td>
</tr>
<tr>
<td>Mike Prentice</td>
<td></td>
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<tr>
<td>Sarah Ward</td>
<td>National Probation Service, Cumbria (Sarah Ward – Director of Operations)</td>
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<td>Sarah Ward</td>
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</tr>
<tr>
<td>Colin Cox</td>
<td>Public Health Cumbria (Colin Cox – Director of)</td>
</tr>
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<td>Colin Cox</td>
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<tr>
<td>Awaiting signature</td>
<td>Public Health)</td>
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</tr>
<tr>
<td>Awaiting confirmation</td>
<td>Cumbria Housing Provider Forum</td>
</tr>
<tr>
<td><strong>Concordat</strong></td>
<td>A document published by the Government. The Concordat is a shared, agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental-health crisis need help. It contains a set of agreements made between national organisations, each of which has a formal responsibility of some kind towards people who need help. It also contains an action plan agreed between the organisations who have signed the Concordat. Title: Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis Author: Department of Health and Concordat signatories Document purpose: Guidance Publication date: 18th February 2014 Link: <a href="https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessibe.pdf">https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessibe.pdf</a></td>
</tr>
<tr>
<td><strong>Mental health crisis</strong></td>
<td>When people – of all ages – who present with mental distress that is likely to put the person (or other people) at risk.</td>
</tr>
<tr>
<td><strong>Parity of esteem</strong></td>
<td>Parity of esteem is when mental health is valued equally with physical health. If people become mentally unwell, the services they use will assess and treat mental health disorders or conditions on a par with physical illnesses. Further information: <a href="http://www.england.nhs.uk/ourwork/qual-clin-lead/pe">http://www.england.nhs.uk/ourwork/qual-clin-lead/pe</a></td>
</tr>
<tr>
<td><strong>Recovery</strong></td>
<td>One definition of Recovery within the context of mental health is from Dr. William Anthony: “Recovery is a deeply personal, unique process changing one’s attitude, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of</td>
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</table>
psychiatric disability” (Anthony, 1993)

Further information http://www.imroc.org/
Appendix 3

*Demographic information and Headlines from Joint Strategic Needs Assessment 2010*

Demographics:

The county has experienced a rise in population since 2001, however growth has been slower than the national trend and by 2017 it is projected that Cumbria’s population will decrease by 1,400 people (-0.3%). Cumbria has an older population profile than England & Wales, with lower proportions of residents in younger age groups and higher proportions of residents in older age groups.

Cumbria’s population is ageing rapidly, particularly in rural areas. Since 2001, the number of residents aged over 65 has increased by 15%, a faster increase than the national average of 11%. In addition the number of young people aged 14 and under has decreased in Cumbria over the last decade by 9.6% compared to an increase of 0.6% in England and Wales.

The most recent population projections\(^1\) show that in Cumbria, the numbers of residents in the three youngest age-groups have decreased between mid-2012 and mid-2013. During the same time period, numbers of residents in each of the four oldest age groups have increased. Cumbria’s decreases in 15-29 and 30-44 year olds were much more pronounced than the decreases seen nationally for these age groups. In contrast, the county’s increases in residents aged 45-59, 60-74 and 85+ years were less pronounced than the national average. However, Cumbria’s increase in 75-84 year olds was more pronounced than the national increase.

In relation to residents aged 65+ years, the ONS project that the number of residents aged 65+ in Cumbria and England will increase each year to 2037. By 2017 the number of residents aged 65+ will increase by 12,300 persons (+11.4%) across Cumbria (England +11.6%) and the proportion of residents aged 65+ will increase to 24.1% across Cumbria, the 6th greatest proportion of all counties (England 18.2%). All Cumbrian districts will have greater proportions of residents aged 65+ than the national average.

The proportion of residents from black and minority ethnic (BME) groups is low at 4.5% compared to 19.5% nationally. However, the proportion of Black and Minority Ethnic residents has increased in recent years but at a much slower rate than the rest of England.

**Joint Strategic Needs Assessment 2010: headlines**

The latest 2010 Joint Strategic Needs Assessment for mental health in Cumbria highlights some challenges compared to the rest of England including:

- higher than average number of suicides
- higher admissions for self-harm
- high levels of unemployment in pockets across the county, with employment status being a key determinant of mental health

\(^1\) Office for National Statistics 2012
significant pockets of deprivation, again being a key determinant of mental health. Health outcomes are poorest in Barrow-in-Furness and Copeland. Barrow-in-Furness is the third most deprived district in England in terms of health. In contrast both Eden and South Lakeland have high levels of health and wellbeing. Cumbria’s overall performance in a range of health and wellbeing indicators disguises significant inequalities in health outcomes. There is a 19.5 year gap between the wards in the highest and lowest life expectancies in the county, with life expectancy in some areas 8.4 years below the national average.

a large predicted increase in older people with mental illness, driven by demographics.

Based upon benchmarking with the rest of England, mental health indicators show for example that:

- there are a higher than average number of people with a mental health diagnosis recorded
- the number of patients with a comprehensive care plan is significantly lower than average
- the number of detentions under the Mental Health Act per 100,000 population is significantly lower than average
- attendances at A&E for a psychiatric disorder per 100,000 population are significantly higher than average, as are the number of admissions for self-harm
- a significantly higher than average suicide rate
- an average number of adults who are part of the mental health Care Programme Approach who are in employment
- an average number of people are in contact with mental health services per 100,000 population.
Suicide review - data and findings

78 suicides in 2012 and 2013\textsuperscript{2} were reviewed in detail in 2014. 60 were males. The review used coroner information, primary care files, and secondary mental health care files (where applicable).

Hanging was the most common method of male suicide, and drug related poisoning was the most common method of female suicide; this mirrors national findings. Male suicide by hanging has increased considerably over the last 9 years. There were 21 (27\%) individuals who were known to have consumed alcohol at the time of death. The proportion of narrative verdicts delivered by Cumbria's coroners has increased more than two-fold since 2006. These commonly make reference to a mental health illness. The increase in narrative verdicts mirrors an increase seen at a national level.

Most individuals who died by suicide in Cumbria consulted with their GP in the year prior to death (81\%), and over one fifth consulted in the week prior. Non-attenders were all male and most were under the age of 44 years. Mental illness and self-harm are well-documented risk factors for suicide, and in Cumbria 49 (63\%) of individuals had a diagnosis of a current/on-going mental health condition at the time of death, most commonly depression, and 33 (42\%) individuals had a history of self-harm. Alcohol and/or drug misuse/dependence was diagnosed in 13 (17\%) individuals, over half of whom had a dual diagnosis (depression). The most commonly prescribed psychotropic drugs were selective serotonin reuptake inhibitors.

There were 49 (63\%) individuals who had some previous contact with specialist mental health services in their lifetime. Nationally, 33\% of individuals who died by suicide in 2011 had contact with mental health services in the 12 months prior to death (patient suicide) and this review found that in Cumbria there were 28 (36\%) patient suicides. Of those 49 individuals who had specialist mental health service contact, 17 (35\%) had been admitted to a psychiatric in-patient ward in their lifetime. Of the 28 patient suicides, 9 (32\%) had been admitted to a psychiatric in-patient ward in the 12 months prior to their death.

Alongside risk factors well documented in the literature, three emergent risk factors were noted in Cumbria:

\begin{itemize}
  \item welfare reform: in 5 (6\%) cases a confirmed or potential change to an individual's benefits was described to have caused worry, distress or anxiety in the days prior to death
  \item chronic pain and long term conditions: 18 (23\%) individuals had a pain condition at the time of their death which often coexisted with a number of other suicide risk factors such as alcohol misuse/dependence
  \item individuals in contact with the criminal justice system were also identified as a particular risk group, with 13 (17\%) individuals being in contact in the 2 months prior to death.
\end{itemize}

\textsuperscript{2} 58 registered in 2012 and 20 registered in 2013
References:


II/III: Department of Health 2011

IV: Department of Health 2012

V: Department of Health 2011

VI: Department of Health 2012

VII: Department of Health 2012

VIII: Annual advocacy report of the Chief Medical Officer, Department of Health, 2013

IX: Department of Health 2014

X: Department of Health 2015


XI: www.foresight.gov.uk 2008

XII: HM Government February 2014

XIII: Cumbria PCT, July 2010

XIV: (i) to support older and vulnerable people to live independent and happy lives (ii) to enable communities to live safely and shape services locally (iii) to promote health and wellbeing and tackle poverty (iv) to be a modern and efficient council


XVII: http://www.bettercaretogether.co.uk/

XVIII: http://www.cumbria.gov.uk/elibrary/Content/Internet/327/949/41962135959.pdf

XIX: http://www.cumbria.gov.uk/elibrary/Content/Internet/537/6683/6687/6690/418141615.pdf

XX: http://www.cumbria.nhs.uk/YourHealth/PublicHealthInformation/MentalHealthandWellbeingAssessment/CumbriaMHJSNASummary2010.pdf, Cumbria PCT 2010

XXI: http://www.cocpmh.info/

XXII: http://www.nice.org.uk/guidance/qs14


XXIV: Implementing Recovery through Organisational Change (ImROC) 2014 http://www.imroc.org/

XXV: https://www.rcpsych.ac.uk/pdf/bridgingthegap_fullreport.pdf


XXXI: ‘We’ve got work to do: Transforming employment and back to work support for people with mental health problems’, MIND December 2014

http://www.mind.org.uk/media/1690126/weve_got_work_to_do.pdf

XXXII: Schizophrenia, Schizoaffective disorder, Bi-polar affective disorder

XXXIII: http://www.mentalhealthcare.org.uk/media/downloads/Life_expectancy.pdf


XXXVI: https://www.gov.uk/government/publications/local-payment-example-outcomes-based-payment-for-mental-healthcare


XXXVIII: https://www.england.nhs.uk/commissioning/armed-forces/armed-forces-cover/
Draft Governance Structure for the implementation of Better Mental Health for All: mental health strategy for Cumbria 2015 - 2020