NHS
Cumbria
Clinical Commissioning Group

Appendix 1

Better Mental Health for All

Mental Health Strategy for Cumbria: The Model of Care (1)

April 2016

Contents

Forward

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 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 provides a starting point for the development of a model of care for mental health services in Cumbria. It sets out principles that will underpin service development and identifies some issues to address ('food for thought') through this work. We know, from the experience of other areas, that developing a model of care is not a quick and easy process if it is to be developed through a process of coproduction with all relevant stakeholders actively engaged. However, the potential benefits are significant, for example:

- Creation of a fundamental shift in focus and resources from diagnosis and treatment to prevention and wellbeing
- Addressing the fragmentation of services
- An opportunity to identify gaps in service provision
- Strengthened interfaces between services/ agencies
- Enabling a cultural shift in the delivery of mental health services so that professional and organisational/ stakeholder boundaries are open and transparent
- The promotion of mental health and wellbeing of the whole population, increasing the resilience of local communities, tackling discrimination and promoting equality of access to services
- Offering an optimistic, holistic, recovery focused approach to all people who use mental health services, upholding the values of dignity, choice and respect
- Meeting 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
- Clarity for all service providers about where they fit in the model of care and the role of other organisations, i.e. a framework for service providers against which to describe their service and recognise the interdependencies and impacts of any service changes.

- It will provide a commissioning tool to allow commissioners to see the 'big picture' of what needs to be achieved, identify gaps and commission services accordingly
- It would enable the whole system to prioritise and phase implementation against a clear picture of where we are going.

Service Principles

The model of care will deliver services that:

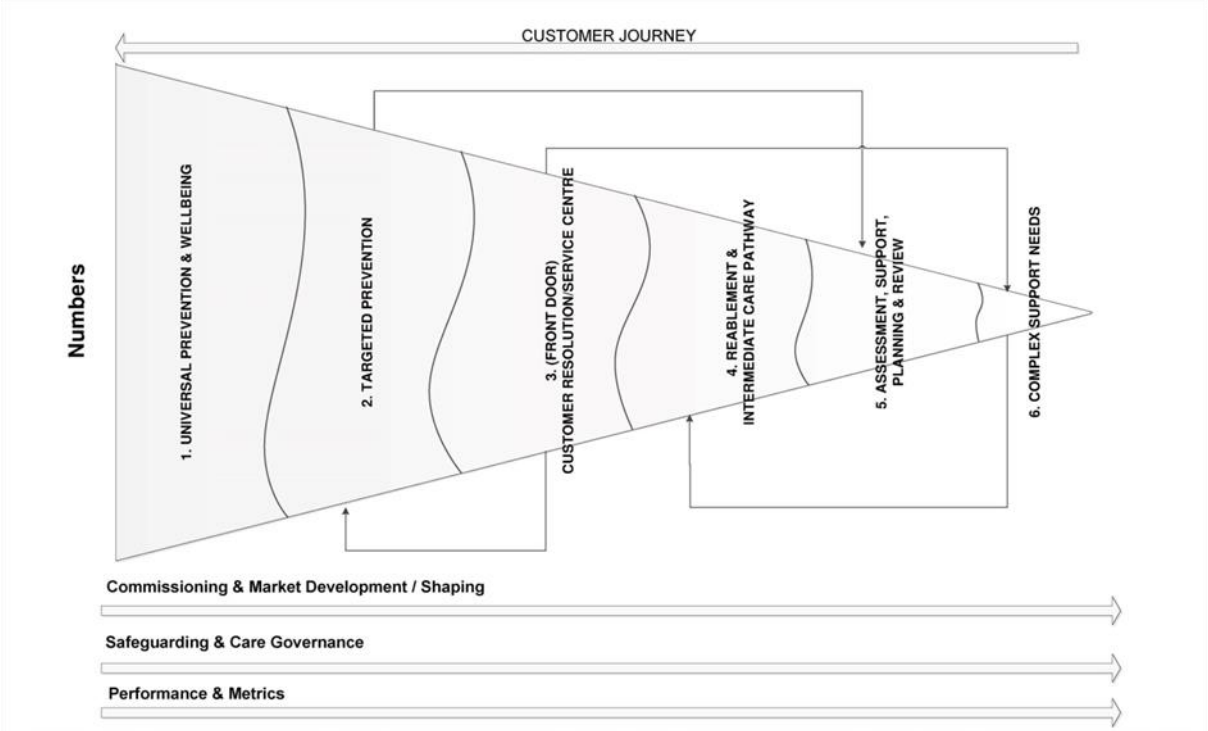
1. **Are safe:** services that ensure the safety of individuals, their carers, staff and the wider public
2. **Are built on best practice:** commissioning services and treatment options that build on evidence of effectiveness drawn from a range of sources including academic research, user led research, national expert programmes and local service evaluations; and demonstrate improved outcomes over time that enable individuals to recover and regain a meaningful life.
3. **Are service user and carer focused:** empowering service users and carers so that they can influence and inform commissioning and service improvements; offering a range of assessment and treatment options that are effective and beneficial for service users; services that value diversity.
4. **Support service inclusion:** ensuring that the system is not simply a 'mental illness' service but reinforces that mental health and wellbeing is 'everyone's business'; seeks to promote and destigmatise disability in communities through education and awareness raising; with effective links and partnerships with organisations that can provide housing, work opportunities, social networks and educational opportunities ie that wherever possible, needs should be met through ordinary daily living solutions and community services, not disability services
5. **Work in Partnerships:** delivering well coordinated pathways that prevent organisational boundaries from inhibiting the delivery of high quality services. These pathways must include enabling people to return to or maintain good physical health
6. **Are local, timely and equitable:** ensure the provision of services close to where users and carers live, with specialist services being concentrated to ensure sustainable clinical quality, ensuring equity of access and quality is not dependent on where services users and carers live.
7. **Are efficient and cost effective:** making use of benchmarking information to ensure we get the maximum benefit from the 100% of resources used to improve the health and wellbeing of people with mental health problems.

Framework for the model of care

Colleagues in adult social care are working on a commissioning strategy for care and support and as part of this they have been considering a model of care that would result in a comprehensive programme of service remodelling that would deliver efficiencies and savings to address the upcoming challenges and mitigate developing pressures.

The model they have consulted on is broadly consistent with that used in other areas to describe several levels of potential service activity that must be delivered at the optimum level, and coordinated in order to deliver a coherent 'care continuum' or patient pathway. In Cumbria, too much resource is committed to higher-level services which are often of a 'one-size-fits-all' nature, and which fail to meet the individually-defined needs of people who use them. In addition the current model will not deliver a shift in focus and resources from diagnosis and treatment to prevention and wellbeing so that, in the future, we make the best use of limited resources to deliver the best outcomes and improved mental health for the population of Cumbria. The objective would be to minimise duplication and to prioritise upstream, preventative solutions above reactive crisis-driven approaches.

The model of care currently being considered for adult social care is represented in the diagram below:

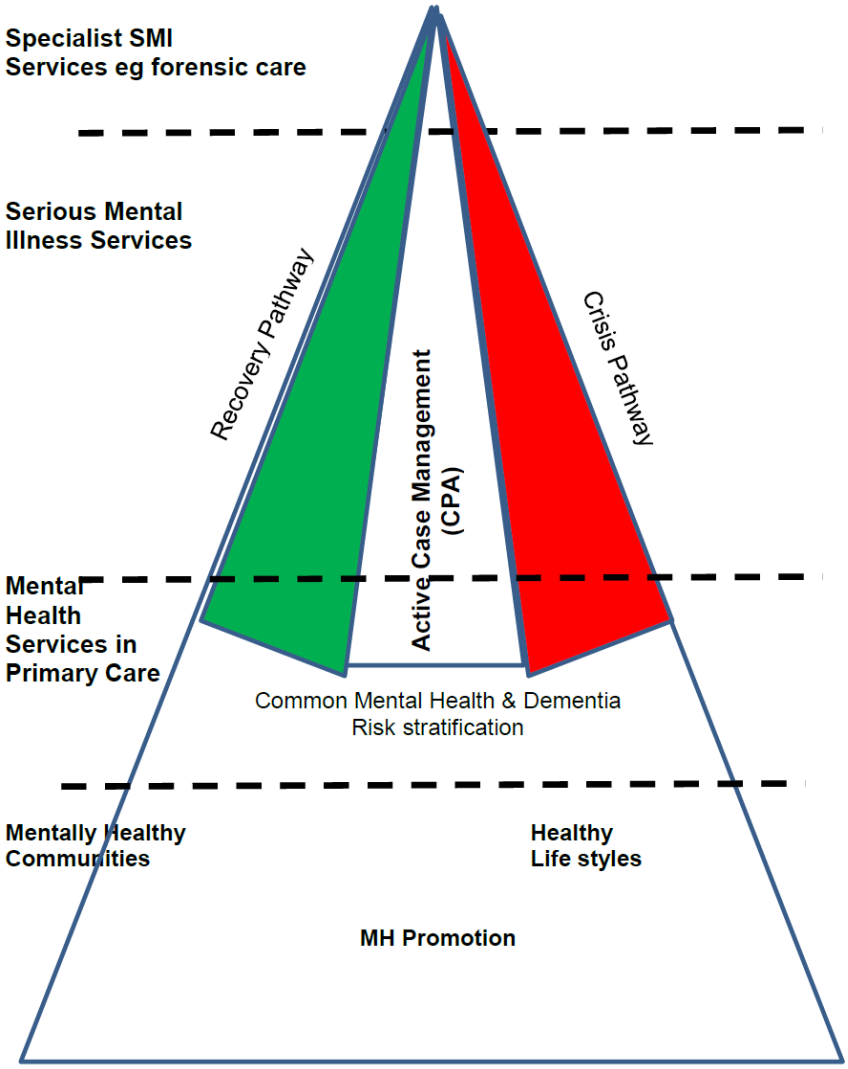


In this model the default priority becomes the meeting of people's needs as near to community, home and independence as possible, and to avoid unnecessary escalation to high-level, bed-based (e.g. residential/nursing care, acute hospital) services. In order to do this, the Health and Care Services investment in commissioned and directly provided services must shift accordingly, as follows.

From	**To**
Hospital	Community
Specialist	Generalist
Institutional	Individual
Reactive	Proactive
Urgent/emergency	Planned
Bed-based	Home-based

To support the development of a co-produced whole-system model of care for mental health across Cumbria, we are using a framework illustrated below, to support the redesign of critical clinical pathways and a greater transparency and understanding of how services are provided and work together to deliver improved outcomes and better service user experience of care. The framework will also allow us to quantify the balance of investment made across the full range of mental health provision and support, so that we can make informed choices about how we will shift the balance of resource down the triangle of the framework, and into more locally accessible alternatives to hospital care.

Mental Health Model of Care framework



Model of care stakeholder engagement event – 5th January 2016

A wide stakeholder event including all partner organisations, service users and carers was convened to engage stakeholders in the co-production of a model of care, leading to a comprehensive programme of service remodelling that would deliver

efficiencies and savings to address the upcoming challenges and mitigate developing pressures. Participants at the workshop identified the key design principles for the new model of care. These have been grouped under themes which are listed below with a summary and comments made.

Evidence based consistent services – provide consistent services using evidence based interventions, ensuring service user expectations are realistic and are met with consistency.

Supported self-management - to support healthy lifestyles, self-management and reduce dependence on clinical services

Coproduce the model and implementation plan – interagency working with common 'one goal' polices and improved engagement with carer's organisations. Inclusion of all agencies, including third sector at all levels, ensuring the service user is seen as a person not an illness. Treatment and care is transparent, personalised, joined up and practical in delivery; building on prevention with the acknowledgement of shared expertise. Interoperability of IT systems. Accommodation that is not only fit for purpose but in the right location.

Equal and fair access – equal access to services across the county with shorter waiting lists, more choice and less variation. Signposting in both urban and rural communities to the right care, in the right setting. Increasing resources to meet demand in the areas that are currently over stretched and underfunded. Utilising digital IT based therapies

Becoming a learning system – interlink all communications together ensuring effective data sharing and easy access with relevant services. Well led services that not only meet people's needs but has trust and confidence in its services. Improved engagement of mental health commissioning provision in the Success Regime and Better Care Together. Networking should take place between statutory and non-statutory agencies with accomplishments voiced, as well as failures, leading to a balance between positive stories and learning lessons. Outcome measures should be improved and mapping exercises carried out to avoid duplication. It is essential that there is better liaison between primary and secondary care.

Explore now ways of using resources (commissioning) – Ensure mental health commissioning effective and that there is a consistent approach county wide; utilising inventive contracting and creative commissioning. Strengthening 3rd sector across the county, utilising 'match' and 'core' funding from statutory sources. Encouraging joint bids between 3rd sector and public sector and ensuring the funding process is structured in a way as to not discourage applications. Care to be provided by people with the correct skill set.

Designed around what patient's value – multi organisation person centred approach

Shared decision making – by active listening and discussion build service user trust that decision making will be a shared two way process between the professionals and the service user.

Promoting independence - support for people to live independently within the community. Peer support champions in the community, with accommodation based support and supported living that offer quality environments.

Recovery focus underpins everything – Resilient community support where recovery pathways are part of the wider system approach. Discharge is not an appropriate concept; it is a transfer of care.

Participants also described the need for an inclusive culture of attitudes/resources with service users/carers assisting in creating new assessment processes and pathways for a person centred recovery model. **Our principles should be ageless** and transparent as wellbeing is ageless and not just for working age adults. Public Health should strive to promote anti stigma work and enhance mental health involvement; building mental health in to our current approaches to prevention eg emotional resilience. Finally, participants highlighted the need to maintain, fund and support care within primary care and only use secondary care when totally necessary.

The model in development is broadly consistent with that used in other areas to describe several levels of potential service activity that must be delivered at the optimum level, and coordinated in order to deliver a coherent 'care continuum' or patient pathway. In Cumbria, too much resource is committed to higher-level services which are often of a 'one-size-fits-all' nature, and which fail to meet the individually-defined needs of people who use them. In addition the current model will not deliver a shift in focus and resources from diagnosis and treatment to prevention and wellbeing so that, in the future, we make the best use of limited resources to deliver the best outcomes and improved mental health for the population of Cumbria. We have undertaken a Quality Impact Assessment (see Appendix 1) of our plans to keep a focus on improving quality of care and better outcomes.

The objective would be to minimise duplication and to prioritise upstream, preventative solutions above reactive crisis-driven approaches. The outputs and views from stakeholders at the event will form the foundation of emerging clinical model of care, a development to be led by a Clinical Leadership Group within the Mental Health Transformation programme.

The Mental Health Partnership, Mental Health Service User and Carer Forum, Mental Health Provider forum and the stakeholders at the workshop described above, supported the **prioritisation of improving mental health crisis care and the need to prevent escalation of mental health problems through effective primary care therapies and community support.**

Mental Health Crisis Pathway

Stakeholders and the Mental Health Partnership have identified the need to deliver effective services and the commitment made by agencies in the Crisis Concordat. Access to timely mental health assessment and support when people experience a mental health crisis, with a range of support as close to home as possible is the aim. Mental health hospital services are a necessary part of the crisis pathway, but should be used as a last resort, providing a therapeutic environment and the best quality of care.

Experience of mental health crisis is unique to individuals, but may show in:

- suicidal behaviour or intention
- panic attacks/ extreme anxiety
- psychotic episodes (loss of sense of reality, hallucinations, hearing voices)
- other behaviour that seems out of control or irrational and that is likely to endanger the self or others

However this list is not exhausted as crisis impacts on people in different ways and with very different outcomes. Some will require specialist support whilst others will benefit from more holistic and generic community responses. When considering our local crisis services, stakeholders at the model of care engagement event on 5th January 2016 gave the following responses when asked about what works well, what needs improvement and where service gaps exist:

Crisis services that are in place and working well: we have passionate committed staff. We received positive comments and feedback following crisis pathway episodes. The 72 hour pathway is working well, as is the support provided by Lowther Street crisis house. There are an increased number of people seen quickly (within 2 hours) and the vast majority of people coming into services in acute distress leave the service much better.

Crisis service in place, but needs improvement: crisis teams are in place, but service user expectations are not being met. Response times and availability of service vary and may not meet expectations. An alternative to A&E for people who are in crisis is needed. Once the need for admission to an acute mental health bed is identified, the time taken to find a vacant bed and admit is excessive.

Where are service gaps and opportunities for improvement: access to services and support for young people, including transition through services, is a gap. Better crisis care planning is needed, with trauma aware approaches for both adults and children and young people; with quicker access. The crisis team should follow through referrals made to Community Mental Health Teams or the 'First Step' community therapy services.

The feedback and comments from the engagement workshop have shaped the proposal to make a step change in how the whole of the mental health system responds to people experiencing a mental health crisis and will ensure the principles set out in the Cumbria Crisis Care Concordat are respected and achieved, as follows:

- Access to support before crisis
- Urgent and emergency access to crisis care
- The right quality and treatment and care when in crisis
- Recovery and staying well, and preventing future crisis.

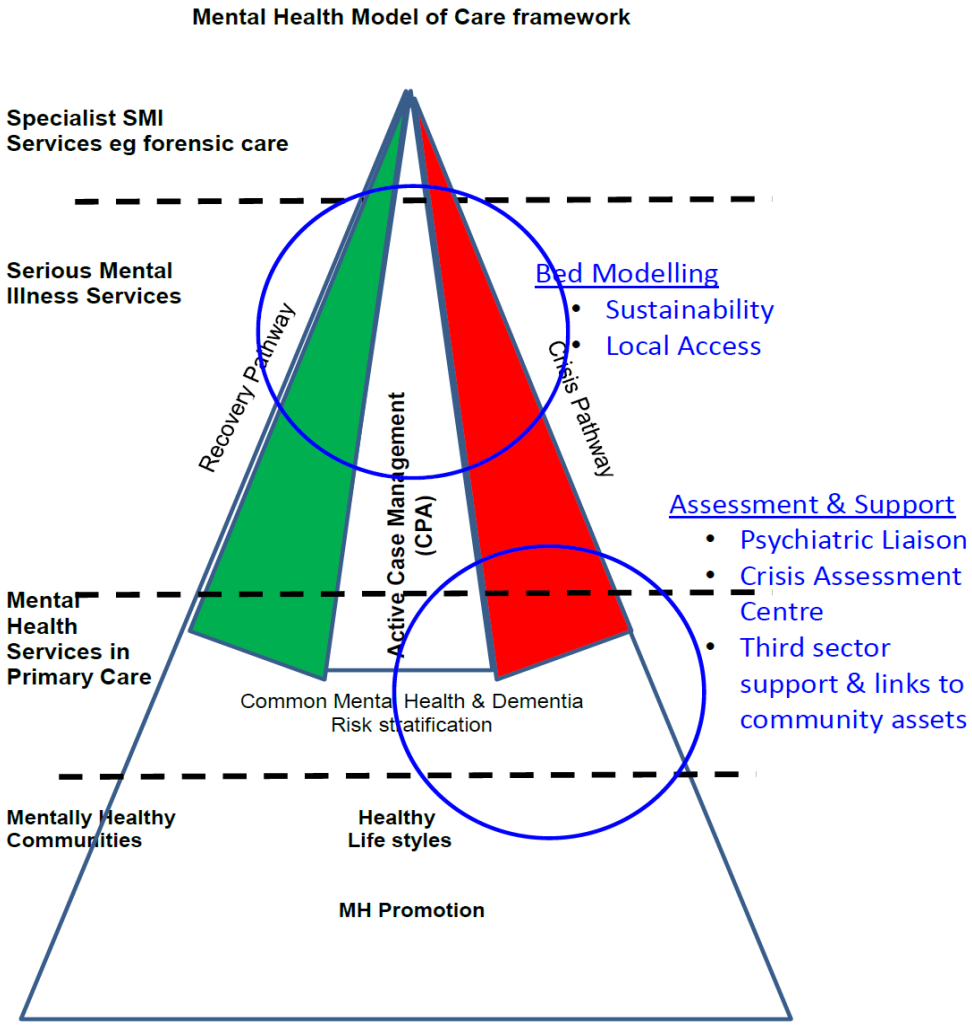
There is extensive evidence that it is best for people in a mental health crisis to be supported and treated at home or in another community setting, such as intensive day support, whenever possible. Most service users and carers prefer home-based treatment and research has shown that clinical and social outcomes achieved by community-based treatment are at least as good as those achieved in hospital. This was further reinforced by the national report from the Mental Health Taskforce (February 2016).

Treatment at home or in the community reduces the stress and anxiety of people who are acutely unwell and enables them to stay in touch more easily with friends and family, to maintain their independence and their normal routine, to continue making choices about their lives.

We need to radically improve the mental health crisis pathway by focusing on three key areas of improvement:

- Enabling access to crisis assessment and support through a proposal to development of a multi-agency assessment and crisis centre;
- Developing community-based crisis support through a proposal to develop a range of third sector crisis support as alternatives to hospital admission; and
- Reconfiguration of our mental health acute hospital services to ensure that they are fit for purpose, offer excellent experience and provide best quality of care in sustainable and safe environments.

The framework illustrates how the mental health crisis pathway starts in communities, promoting healthy life styles and access to self-care and accessible digital solutions. The pathway continues, as an individual's mental health need increases, right through to the provision of local intensive psychiatric care hospital services



Agencies providing different elements of mental health assessment and crisis support services are sometimes fragmented from each other and access to them maybe limited by eligibility criteria. This can result in inconsistent support and 'hand offs', a term to describe how services limit their response to assess, treat and support people based on different factors, such as, age, level of intoxication or someone with a learning disability. We need to make a step change in how we respond to people presenting in crisis, that is, agencies need to work as 'one team', ensuring that all people presenting in mental health crisis should be assessed and supported to get the right point of care. The 'right point of care' could result in providing someone with information about a local support group, a GP referral for someone needing anti-depressant treatment, or arranging for admission to hospital.

To address these issues and test out new ways of working to support the redesign of mental health crisis care, agencies providing the different elements of mental health crisis care have developed a 'proof of concept' proposal. A multi-agency bid to the national Police Innovation Fund, submitted in December 2015, was approved in March 2016. This will result in an additional £1.4m in 2016/17 and £1.9m in 2017/18, to add to the £336 (total over 2 years) already committed by the Cumbria Police and Crime Commissioner to start a 24/7 telephone triage service.

This additional funding will allow us to test out the best service design and workforce deployment, demonstrate benefits across the health and care system and build a business case to disseminate the model in other areas across the county. It will also give us a head start in addressing the issues and recommendations of the Mental Health Task Force Five Year Forward View report, as the proposal is entirely consistent with the national direction of travel.

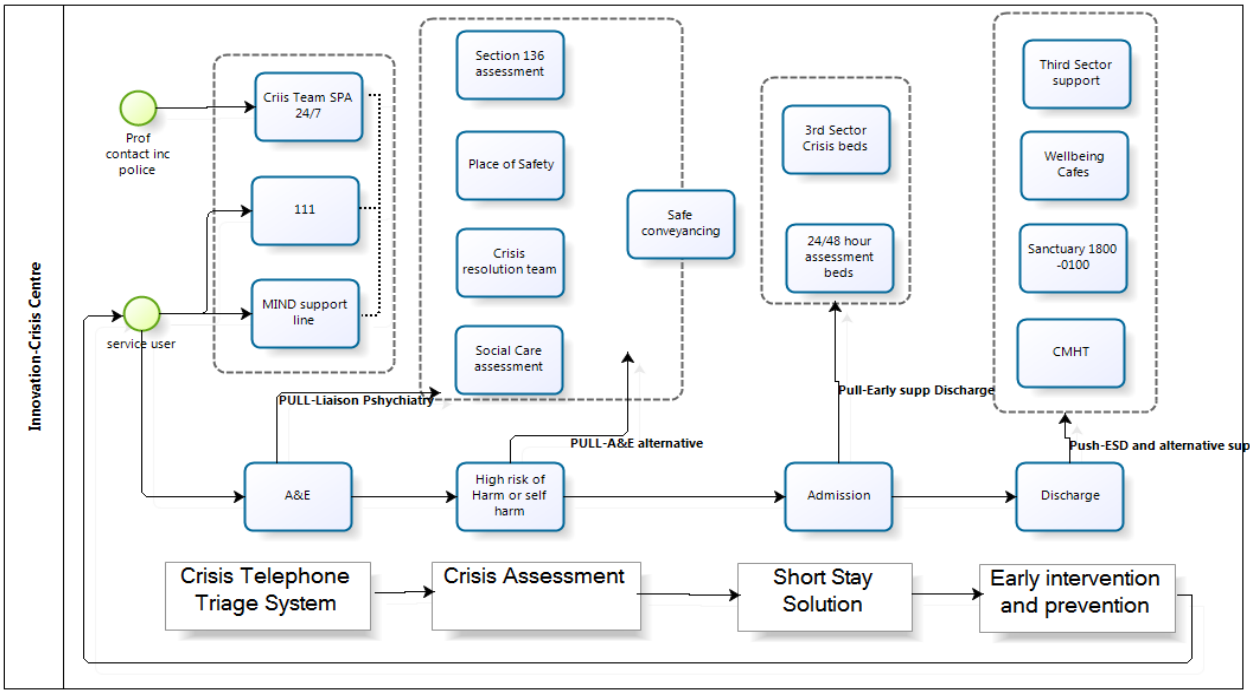
The proposal aims to enable effective crisis assessment and support through a multi-agency crisis assessment centre, to provide a safe evidenced based pathway for people requiring access to services who find themselves in mental health crisis. This will improve the quality of timely appropriate assessments and signposting for individuals of all ages when in contact with the service. This includes effective use of mental health crisis provision, accessing health professionals in one location where needed, providing a suitable place of safety and reducing the inappropriate use of police cells. This will also ensure that the right resources are available at the right time and see other benefits, including transport resources and the reduction in use of police time.

The multi-agency crisis centre will act as a hub, co-locating health and social care professionals, blue light services and partner organisations. Mental health professionals will have access to health and social care systems and resources interlinked with 3rd sector. This will ensure timely and appropriate assessments are conducted and the person receives services in the right place and at the right time to recovery from their crisis. This will also provide essential support to police officers who attend the centre allowing them to resume patrol quickly making them more proactive and efficient.

Issues that the proposal will address:

- Lengthy waiting times and inappropriate responses to people in mental health crisis
- Problems with identifying individuals with mental health issues and unclear care pathways
- Lack of Multiagency integration and co-ordinated resources
- Inappropriate use of ‘blue light’ resources and skills
- Inappropriate detentions in police stations and use of S136
- Lack of crisis support for young people and older people

The model demonstrated below will provide commissioning opportunities by introducing pilot initiatives that will redesign mental health services in Cumbria. This will be a vehicle to provide a integrated service and place of safety for a person in mental health crisis and significantly reduce police time spent on mental health crisis.



The model is to trial a multi-agency crisis assessment centre as the first point of contact and place of safety for people in mental health crisis. Supporting a pathway for people experiencing mental health crisis will provide an alternative to police custody and inpatient units for persons detained under s136 of the MHA. The proof of concept will evaluate appropriate referrals and detention under S136 of the MHA, see a reduction in police time and resources and whether such an alternative could provide a better experience for patients who are awaiting mental health intervention during crisis.

The service will provide 24/7 telephone advice line operated by Mental Health professionals with access to AMHPs and S12 doctors and providing a place of safety with access to crisis/respite beds to avoid hospital admission.

Integration with the 3rd sector will support the ongoing success of the service. It will utilise expertise whilst galvanising new partnership working. It will provide that vital link between commissioned services and the community.

Mental health services in primary care

Nine out of ten adults with mental health problems are supported in primary care. There has been a significant expansion in access to psychological therapies, following the introduction of the national Improving Access to Psychological Therapies (IAPT) programme. However, there is considerable variation in services, with a waiting time of just over six days in the best performing areas and 124 days in the worst performing areas in England during 2014-15.

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 Integrated Care Communities (ICCs). 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 integrated 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 would be with The Success Regime and Better Care Together programmes which has seen the concept of Integrated 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 aligned to this proposal to deliver a better integration of mental health services. The ICC subgroup of the Proactive and Urgent Care workstream in the Success Regime has agreed that the Mental Health Clinical Leadership Group will make recommendations on the mental health element of the ICC development.

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, 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.

It is important to recognise the challenge of cultural change which a fully integrated system would require, as the Better Care Together strategy and Success Regime deliver their changes, the Mental Health Transformational Programme needs to keep pace and ensure alignment.

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

The programme does not end after five years, but becomes a way of working that is embedded into the delivery of an integrated community of providers.

Ensuring mental health needs in communities are met through the Integrated Care Community development will be challenging as mental health services have not been well coordinated with physical health services, particularly in primary care. There have been some successful initiatives which have challenged this particularly the Improved Access to Psychological Therapies (IAPT) which was launched to increase mental health service provision and capacity in the primary care sector, to provide better access to therapies for people with mild to moderate mental health problems.

Achievements through the IAPT provision should be built into outcomes set in this proposal as well as outcomes from the report, "*No Health without Mental Health*" (Department of Health 2011):

- The improvement of the mental health of the Primary Care population through prevention work
- The promotion of recovery from mental health problems and improve quality of life
- Improvement in the physical health of people with mental health problems
- Improvement in the patient experience of the care they receive
- Improvements in patient safety
- To see a reduction in stigma and discrimination.

The recent Kings Fund report, in 'Bringing together physical and mental health: A new frontier for integrated care' (March 2016), highlighted ten areas that the Kings Fund researchers had identified where the significant opportunities for quality improvement and cost control could be made. These are outlined in the table below.

Prevention/public health	1. Incorporating mental health into public health programmes 2. Health promotion and prevention among people with severe mental illnesses
General practice	3. Improving management of 'medically unexplained symptoms' in primary care 4. Strengthening primary care for the physical health needs of people with severe mental illnesses
Chronic disease management	5. Supporting the mental health of people with long-term conditions 6. Supporting the mental health and wellbeing of carers
Hospital care	7. Mental health in acute general hospitals 8. Physical health in mental health inpatient facilities
Community/social care	9. Integrated support for perinatal mental health 10. Supporting the mental health needs of people in residential homes

Cumbria health and social wellbeing system

Whilst one in four people experience mental health problems in their lives, most people are able to maintain good mental health by accessing support from family and friends, using self-help materials/approaches and exercising to build personal resilience.

Colleagues in public health have already identified an approach for progressing public mental health and the development of a comprehensive model of care would give us an opportunity to embed this work within a wider context.

The overall aim is to improve how people access support and advice that promotes their health and social wellbeing (including mental wellbeing) through:

- Provision of universal digital wellbeing support, which is quickly and easily accessible (and builds on the Connecting Cumbria programme)
- Making public health everyone's business, by making every contact count. This means providing training and support to ensure that as many people as possible feel confident in offering wellbeing advice as part of their working and volunteering lives
- Better coordination and improved commissioning arrangements that build on existing community assets, in order to create a network of hubs that provide activities and information to support health and social wellbeing
- Offering advice and practical 1-to-1 support to vulnerable people, in order to help them achieve social and health-related wellbeing. By promoting self-resilience, evidence shows that people can better face future social challenges, make positive behaviour choices and avoid future crisis. This includes support and advice around money and debt, housing, lifestyles and social wellbeing
- Improving signposting and referral pathways into, and out of, specialist health and social needs services

There will be different elements to the system (including 1-to-1 support, online guidance, activities), which means there are likely to be a number of different organisations delivering the system approach across Cumbria. This is likely to include the third sector and primary care – such as GPs and pharmacists. They will however all use the same cohesive branding so that the system is recognisable for the public.

We will commission services where mental health users benefit from a stepped care approach, enabling them to step up or step down between services to receive the right care at the right time. This flexibility is facilitated by good communication and liaison between their GP and mental health professionals.

Empowering service users and carers so that they can influence and inform commissioning and service improvements (Service principle 3)

People First ran a wide consultation in June 2014 to inform the future Mental Health Commissioning Strategy, entitled, 'Your voice in shaping Mental Health Services in Cumbria' and it is essential that we build this work and further engagement into the development of the model of care.

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

A Mental Health Service User and Carer Forum now meet monthly to proactively engage people in shaping the strategy and, as co-producers of future services.

Third sector organisations have significant input to the Mental Health Provider Forum and will act as a conduit to people that they are in contact with across the county.

"… the critical element of success will be to put the individual with their own lived experience of mental health at the heart of each and every decision which is made. We have much to be proud of in the progress that has been made in empowering people to make their own decisions, and for services to be co-designed. We now have to go a step further and truly produce services which are led by the needs of the individual, not the system" (Five Year Forward View for Mental Health, February 2016, p20)

Governance

We will use the transformational programme to 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 Mental Health transformational programme (Appendix 2), reporting into the Mental Health Partnership (see Appendix 3 for terms of referrance) covers five years (2015 – 2020) and considers the whole spectrum of mental health care and support from prevention through to specialist service provision for people with 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 **development of the model of care will be led by a new Mental Health Clinical Leadership group**, which meets for the first time in April 2016. This group will be comprised of mental health GP leads and the full multi-disciplinary team representation from senior specialist practitioners. The Mental Health Programme will ensure appropriate liaison and reporting arrangements are put in place with the CCG Quality Review and Quality Surveillance Groups.

The Mental Health Transformation programme will continue to work into both the 'Success Regime' and the 'Better Care Together' programmes, in order to support the improvement of mental health care and expertise in primary, community and acute care services through the various projects. The emphasis of the approach will be to ensure parity of esteem between mental and physical health, including addressing the health inequalities experienced by mental health service and learning disability service users, particularly in respect of primary and community care and the development of the Integrated Care Communities. Links will also be established to promote and incorporate the use of the community-based Dementia Pathway within work addressing the needs of frail older people to integrate mental and physical health provision. Consequently, **the development of an integrated model of physical and mental health care in primary care and communities will now be the priority area action by the Mental Health Clinical Leadership Group.**

Quality Impact assessment **Appendix 1**

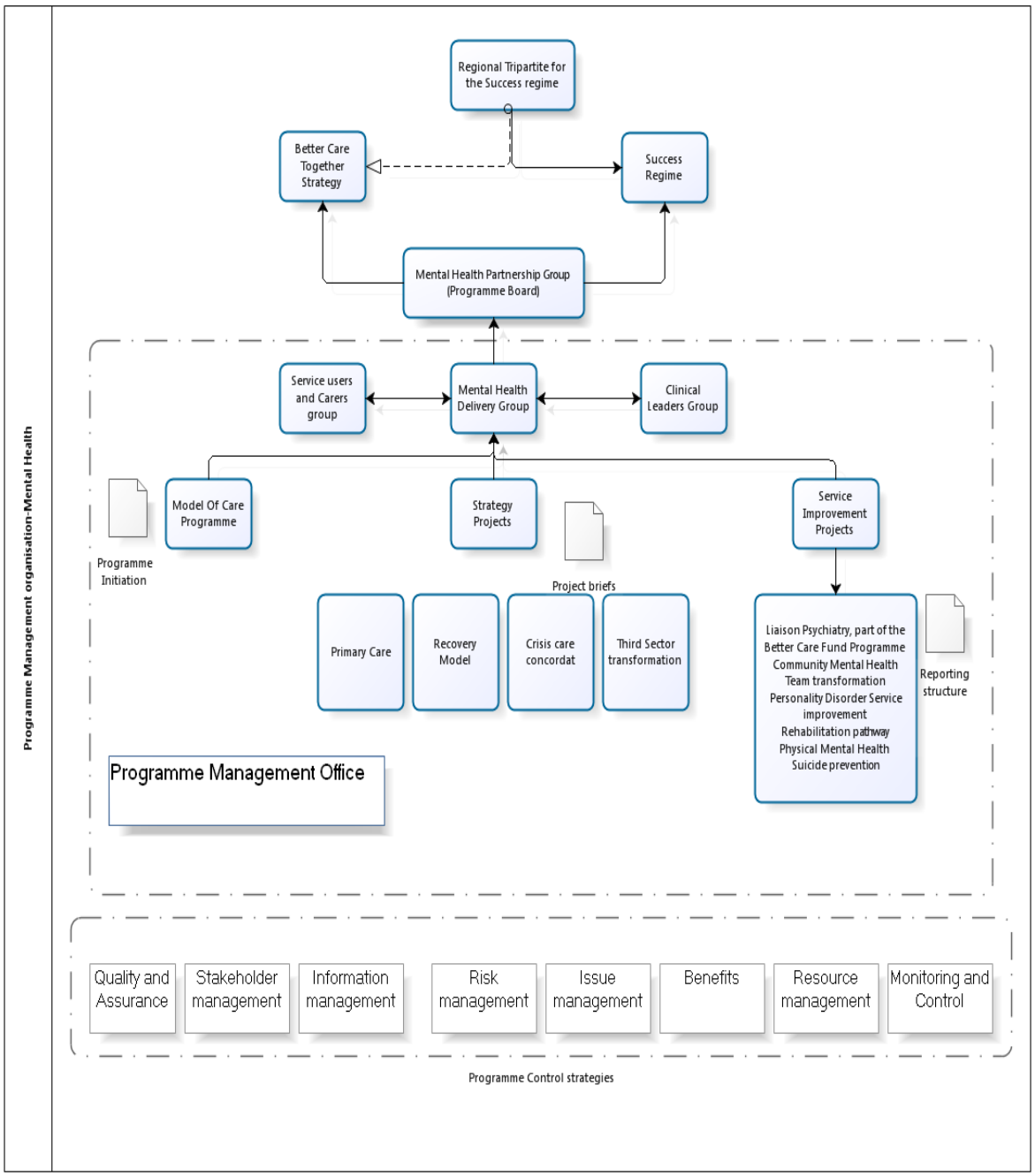
What impact will this piece of work have on the following areas (for guidance questions please see the QIA notes), and which indicators will you monitor to measure this impact?		
Domain	**Impact – positive or negative**	**Indicator to measure impact?**
Outcomes	This proposal is guided by the national strategy 'No Health without Mental Health' as well as the Mental Health Taskforce five year forward view Feb 2016 which led to the definition of 6 key outcomes we should seek to achieve for our local population through the delivery. • 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	Health and wellbeing measures which will demonstrate reductions in self harm and suicide. More direct service level KPI's within each of the proposals will demonstrate the expected, outcomes including metrics for; • Patient and public satisfaction • A&E attendance • In hospital admissions for self-harm • Improve LOS for mental health patients • Under 75 mortality rates • Mortality rates for people with severe and enduring Mental health problems • IAPT access rates • Service users on CPA • Mental Health Act assessments
Safety	Those patients who are the most acutely unwell and in crisis will get safer more intensive care than is delivered from the current fragmented service model. Rehabilitation and Recovery services will develop to deliver more effective care through greater emphasis on social inclusion focussed outcomes.	Metrics to support the improvements in patient safety will include • Reductions in SUI • YLL for indicators for suicide • Standard indicators for safety across all partners will be developed to include privacy, dignity and wellbeing

Effectiveness	The Crisis Care system will be positioned to achieve a better response to relapse through more effective care coordination provided across all organisations. Those supported in crisis in the future model of care will be less likely to need intensive care from a an inpatient setting because of the more effective care and treatment available from the community network of providers. Improved access to services and interventions, resources and support will help prevent more serious mental health problems or help with recovery in line with individual aspirations and goals. The role of technology, which is vital in such a large, rural county is a vital aspect to deliver effective services.	Metrics on clinical effectiveness will be determined at pathway and service level however they will seek to provide a collective view of effectiveness across the whole system and include; • Access to services and response rates and times • Transfers of care and whether this is delayed as we aim to have a seamless transition. • Care packages for nationally recognised pathways, particularly first episode psychosis • Access and responses in receiving crisis support • Access to prevention and self-management services and utilisation of third sector providers.
Experience	Patients will benefit from a model of care and whole system that better supports their personalised recovery. The proposals will increase the numbers of people managed and supported within the whole system which will make the service provision seem less exclusive. The design of the model of care is intended to be more flexible in response to relapse and crisis as well as the need for in hospital treatment through the collaborative focus of the operating models. The proposed models are designed based on recovery principles with even greater emphasis placed on personalisation.	Metrics to support patient satisfaction will be coordinated through all partner organisations to share experiences and inform a continuous improvement approach Compliments and complaints measures and results should be shared for lessons learned. Open and transparent reporting of patient experience will be standard.

	A process for patients with early signs of relapse will have access to support from the team they have been supported by previously.	
Workforce planning and staff	The change is intended to further promote a shift in culture within the services towards personalised recovery and socially inclusive support. Clear leadership towards a shared vision across all stakeholders is enabled by the change that brings all parties into closer alignment to a single Model of Care. Alongside the proposals will be a bed modelling simulation and a joined up workforce planning process utilising the WRaPT methodology hosted by Health Education North West.	Metrics to support workforce planning will be widespread and cross organisational. There will be a requirement to deliver workforce planning from a clearly understood baseline of competency, WTE, attrition at service level and wider age profiling and succession planning process Workforce planning will work alongside the capacity and demand modelling for the 5 year forward view and bed modelling simulation to profile a future state and inform the wider Training and development plan
Training and education	Training and development plans will be inclusive to support the model of care and also cross reference to the wider strategic Training and development requirements in the Integrated care communities. There will be a requirement to utilise the OD work stream to support significant cultural changes and also to support the clinical leadership of the delivery plan.	Baseline of current skills and competency alongside the workforce planning process will inform the training and development requirements. Succession planning within PDP's and appraisals will inform the requirements to skill the workforce for the future.

Appendix 2

Mental Health Transformation Programme Governance



Appendix 3

NHS Cumbria Clinical Commissioning Group
Mental Health Partnership Group
Terms of Reference

1. Purpose	
The Mental Health Partnership Group (MHPG) will oversee the delivery of the Cumbria Mental Health Strategy and ensure all providers deliver high quality, person centered, therapeutic services. The MHPG will make sure the people of Cumbria have the right services and support available for people with mental health problems, their families and carers. The MHPG will focus on adults (over 18) with mental health issues and ensure that effective and robust links are made with Child and Adolescent Mental Health Services (CAMHS) **Objectives** • Oversee the development, implementation and continuous review of the Cumbria Mental Health Strategy. • Ensure national policies and best practice are delivered across all providers of mental health services. • Identify the priorities for improvement and have oversight of the improvement programme. • Commission task and finish groups to undertake agreed pieces of work aligned to the strategy. • Ensure six monthly reports available to all members to report on progress and highlight any areas of concern. • Provide opportunities for users, carers and families to have a voice and be listened to. • Ensure cooperation between all agencies is at the heart of delivery.	
2. Membership	
Core Membership of the group will be:	
Chair	CCG Clinical lead (12 months initially)
Vice chair	Representative of people with personal experience of mental illness

	Service User/Carer Representatives (four people)
	CCG
	Public Health/Adult Social Care
	3rd Sector representative
	Cumbria Partnership Foundation Trust
	Police
Invitees from other organisations for specific issues e.g. housing, CAHMS etc.	
3. Quorum	
A quorum of 6 is required to agree on a vote or resolution. This quorum should include a minimum of one service user/carer, one from CCG, one from CPFT and one from the local authority.	
4. Frequency of the meetings	
The group will meet every two months with the opportunity to hold extraordinary meetings (as and when required). Task and finish groups will meet as and when required by MHPG.	
5. Support arrangements	
Support to the MHPG will be provided by the joint Mental Health & Learning Disabilities Commissioning Team.	